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
https://pebp.nv.gov

CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

MEETING NOTICE AND AGENDA – Amended 12/1/23

Name of Organization:	Public Employees' Benefits Program
Date and Time of Meeting:	December 7, 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=YxnGHx1bjkU

To submit written public comment, please upload your document to the *Public Comment Upload Form* located under *Contact Us* on the PEBP website, *https://pebp.nv.gov*, 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 "Video Conferencing" 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/85308591520
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 "Video Conferencing" field above.

Option #2 **Dial: (669) 900-6833. When prompted to provide your Meeting ID, please enter: 853 0859 1520 then press #. When prompted for a Participant ID, please enter #.**

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

To resolve any issues related to dialing in to provide public comment for this meeting, please call (775) 684-7020 or email jcrane@peb.nv.gov

Meeting materials can be accessed here: https://pebp.nv.gov/Meetings/current-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.nv.gov, 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 September 28, 2023 PEBP Board Meeting

   4.2 Receipt of quarterly staff reports for the period ending June 30, 2023

   4.2.1 Utilization Report

   4.2.2 Budget Report

   4.3 Receipt of quarterly vendor reports for the period ending June 30, 2023

   4.3.1 Q4 UMR – Obesity Care Management Program

   4.3.2 Q4 UMR – Diabetes Care Management Program

   4.3.3 Q4 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network

   4.3.4 Q4 Doctor on Demand Engagement Report through September 30, 2023

   4.3.5 Q4 Express Scripts – Summary Report

   4.3.6 Q4 Express Scripts – Utilization Report

   4.3.7 WTW's Individual Marketplace Enrollment and Performance Report Q1 2024

   4.3.8 Real Appeal – Utilization Report

5. Discussion and possible action regarding a proposed contract with Carrum Health to maintain a network of National Centers of Excellence. A portion of this item may be conducted in closed session to allow review of the results of the evaluation of proposals for the contract, in accordance with NRS 287.04345(4). Any action on the contract will occur in open session, in accordance with NRS 287.04345(5) (Michelle Weyland, Chief Financial Officer) **(For Possible Action**)
6. Executive Officer Report (Celestena Glover, Executive Officer) (Information/Discussion)
7. Discussion and possible action on plan design changes for Plan Year 2025, July 1, 2024 – June 30, 2025 (Celestena Glover, Executive Officer) (**For Possible Action**)

    7.1 Potential Plan Changes for Plan Year 2025

8. Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Third-Party Administrator, UMR, for the period of April 1, 2023 – June 30, 2023 (Claim Technologies Incorporated) **(For Possible Action)**

9. Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Third-Party Administrator, Via Benefits (WTW) for the period July 1, 2022 – June 30, 2023 (Claim Technologies Incorporated) **(For Possible Action)**

10. Discussion and possible action regarding UMR's performance under contracted Third-Party Administrator services (Celestena Glover, Executive Director) (**For Possible Action**)

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 https://pebp.nv.gov/Meetings/current-board-meetings/ (under the Board Meeting date referenced above). Contact Jessica Crane at PEBP, 3427 Goni Rd, Suite 109, Carson City NV 89706 (775) 684-7020 or (800) 326-5496
An item raised during a report or public comment may be discussed but may not be deliberated or acted upon unless it is on the agenda as an action item.
All times are approximate. The Board reserves the right to take items in a different order or to combine two or more agenda items for consideration to accomplish business in the most efficient manner. The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time.
We are pleased to make reasonable efforts to assist and accommodate persons with physical disabilities who wish to participate in the meeting. If special arrangements for the meeting are necessary, please notify the PEBP in writing, at 3427 Goni Rd, Suite 109, Carson City, NV 89706, or call Jessica Crane at (775) 684-7020 or (800) 326-5496, as soon as possible so that reasonable efforts can be made to accommodate the request.
Copies of both the PEBP Meeting Action Minutes and Meeting Transcripts, if such transcripts are prepared, are available for inspection, at no charge, at the PEBP Office, 3427 Goni Rd, Suite 109, Carson City, Nevada, 89706 or on the PEBP website at https://pebp.nv.gov. 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 https://pebp.nv.gov 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**)

4.1 Approval of Action Minutes from the September 28, 2023 PEBP Board Meeting

4.2 Receipt of quarterly staff reports for the period ending June 30, 2023:

- 4.2.1 Utilization Report
- 4.2.2 Budget Report

4.3 Receipt of quarterly vendor reports for the period ending June 30, 2023:

- 4.3.1 Q4 UMR – Obesity Care Management Program
- 4.3.2 Q4 UMR – Diabetes Care Management Program
- 4.3.3 Q4 Sierra Healthcare Option and UnitedHealthcare Plus Network – PPO Network
- 4.3.4 Q4 Doctor on Demand Engagement Report through September 30, 2023
- 4.3.5 Q4 Express Scripts – Summary Report
- 4.3.6 Q4 Express Scripts – Utilization Report
- 4.3.7 WTW's Individual Marketplace Enrollment and Performance Report Q1 2024
- 4.3.8 Real Appeal – Utilization Report

4.1

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

4.1 Approval of Action Minutes from the September 28, 2023 PEBP Board Meeting

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

3427 Goni Rd Ste. 117
Carson City, NV 89706
Video/Telephonic Open Meeting
Carson City

ACTION MINUTES (Subject to Board Approval)
September 28, 2023

MEMBERS PRESENT VIA TELECONFERENCE:	Mr. Jack Robb, Board Chair Ms. Michelle Kelley, Vice Chair Ms. Stacie Weeks, Member Ms. Betsy Aiello, Member Ms. Bepsy Strasburg, Member Mr. Jim Barnes, Member Ms. Leslie Bittleston, Member Ms. Janell Woodward, Member Dr. Jennifer McClendon, Member Ms. April Caughron, Member
FOR THE BOARD:	Ms. Radhika Kunnel, Deputy Attorney General
FOR STAFF:	Ms. Celestena Glover, Executive Officer Mr. Nik Proper, Operations Officer Ms. Michelle Weyland, Chief Financial Officer Mr. Tim Lindley, Quality Control Officer Ms. Jessica Crane, Executive Assistant
OTHER PRESENTERS:	Mandee Bowsmith - Division of Human Resource Management Richard Ward - Segal

1. Open Meeting; Roll Call

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

2. Public Comment

    - Terri Laird – RPEN
    - Kent Ervin – Nevada Faculty Alliance
    - Doug Unger – Nevada Faculty Alliance

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

4. Discussion regarding the recruitment process for a new permanent Executive Officer of PEBP. Recruitment open through September 28, 2023. (Jack Robb, Board Chair) (Information/Discussion)

5. Applicant Interview for position of the Executive Officer of PEBP (Information/Discussion)

    5.1 Applicant to be interviewed (approximately 1 hour per interview)

    - Celestena Glover

6. Discussion and possible action regarding appointment(from 1 above named applicant) of the Executive Officer of PEBP, subject to the Governor's approval, per NRS 287.0424(1) (Jack Robb, Board Chair) (**For Possible Action**)

BOARD ACTION ON ITEM 6
MOTION: Motion to offer Celestena Glover continuing role of PEBP Executive Officer
BY: Vice Chair, Michelle Kelley
SECOND: Member April Caughron
VOTE: Unanimous, Motion carried

7. 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.

    7.1 Approval of Action Minutes from the July 27, 2023 PEBP Board Meeting

    7.2 Receipt of quarterly staff reports for the period ending June 30, 2023:
        7.2.1 Budget Report

    7.3 Receipt of quarterly vendor reports for the period ending June 30, 2023:

        7.3.1 Segal – Estimate of IBNR as of June 30, 2023

        7.3.2 Sierra Healthcare Options – Utilization and Large Case Management

        7.3.3 WTW's Individual Marketplace Enrollment and Performance Report

        7.3.4 Doctor on Demand Engagement Report through August 2023

        7.3.5 Fiscal Year 2023 Other Post Employment Benefits (OPEB) valuation prepared by Segal in Conformance with the Governmental Accounting Standards Board (GASB) requirements

BOARD ACTION ON ITEM 7.2.1
MOTION: Motion to remove agenda item 7.2.1
BY: Vice Chair Michelle Kelley
SECOND: Member Bepsy Strasburg
VOTE: Unanimous, Motion carried

BOARD ACTION ON ITEM 7
MOTION: Motion to approve all the items and reports on the consent agenda
BY: Member Leslie Bittleston
SECOND: Member Bepsy Strasburg
VOTE: Unanimous; Motion carried

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

9. Discussion and possible direction from the Board to staff on potential program design changes for Plan Year 2025 (July 1, 2024 – June 30, 2025) for which the Board requests additional information and costs to be presented at the November 16, 2023 meeting (Celestena Glover, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 9
MOTION: Motion to accept recommendations of Segal for analysis and include the additional recommendations that were brought forward
BY: Member Leslie Bittleston
SECOND: Vice Chair Michelle Kelley
VOTE: Unanimous, Motion carried

10. Presentation and possible action on the status and approval of new PEBP contracts, contract Amendments and solicitations (Michelle Weyland, Chief Financial Officer) (Information/Discussion)

    10.1 Contract Overview

    10.2 New Contracts

    10.3 Contract Amendments

        10.3.1 Express Scripts

    10.4 Contract Solicitations

    10.5 Status of Current Solicitations

11. Public Comment

    - Kent Ervin – Nevada Faculty Alliance

12. Adjournment

    - Board Chair Robb adjourned the meeting at 11:40 a.m.

4.2

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

4.1 Approval of Action Minutes from the September 28, 2023 PEBP Board Meetings

4.2 Receipt of quarterly staff reports for the period ending June 30, 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 June 30, 2023:

4.2.1 Utilization Report

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CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item

[ ] Information Only

Date: December 7, 2023

Item Number: 4.2.1

Title: Self-Funded CDHP, LDPPO, and EPO Plan Utilization Report for the period ending June 30, 2023

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the PY 2023 period ending June 30, 2023. Included are:

- Executive Summary – provides a utilization overview.
- HealthSCOPE CDHP Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- HealthSCOPE LDPPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- HealthSCOPE EPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- Express Scripts Utilization Report – provides details supporting the prescription drug information included in the Executive Summary.
- Health Plan of Nevada Utilization – see Appendix D for Q4 Plan Year 2022 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q4 of Plan Year 2023 compared to Q4 of Plan Year 2022 is summarized below.

- Population:
  - 13.4% decrease for primary participants
  - 16.8% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 2.6% decrease for primary participants
  - 1.5% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 126 High-Cost Claimants accounting for 34.0% of the total plan paid for Q4 of Plan Year 2023
  - 4.17% decrease in High-Cost Claimants per 1,000 members
  - 5.0% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cancer ($6.6 million) – 22.1% of paid claims
  - Cardiac Disorders ($2.9 million) – 9.7% of paid claims
  - Infections ($2.0 million) – 6.8% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased 4.1%
  - Average paid per ER visit increased 19.1%
- Urgent Care:
  - Urgent Care visits per 1,000 members decreased by 2.2%
  - Average paid per Urgent Care visit decreased 28.6% (decrease from $70 to $50)
- Network Utilization:
  - 97.2% of claims are from In-Network providers
  - Q4 of Plan Year 2023 In-Network utilization decreased 0.8% over PY 2022
  - Q4 of Plan Year 2023 In-Network discounts increased 3.3% over PY 2022

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 14.1%
    - Total Gross Claims Costs decreased 8.1% ($3.8 million)
    - Average Total Cost per Claim increased 7.0%
      - From $108.02 to $115.56
  - Member:
    - Total Member Cost decreased 14.9%
    - Average Participant Share per Claim decreased 1.0%
    - Avg. Copay per Claim decreased 1.0%
      - From $26.49 to $26.23

- Plan
  - Total Plan Cost decreased 5.8%
  - Average Plan Share per Claim increased 9.6%
  - Net Plan PMPM increased 13.5%
    - From $89.52 to $101.62
  - Net Plan PMPM factoring rebates increased 8.5%
    - From $65.08 to $70.60

LOW DEDUCTIBLE PPO PLAN (LDPPO)

The Low Deductible PPO Plan (LDPPO) experience for Q4 of Plan Year 2023 compared to Q4 of Plan Year 2022 is summarized below.

- Population:
  - 69.8% increase for primary participants
  - 64.0% increase for primary participants plus dependents (members)
- Medical Cost:
  - 4.2% decrease for primary participants
  - 0.9% decrease for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 54 High-Cost Claimants accounting for 23.0% of the total plan paid for Q4 of Plan Year 2023
  - 19.7% decrease in High-Cost Claimants per 1,000 members
  - 16.6% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cancer ($4.5 million) – 34.7% of paid claims
  - Endocrine/Metabolic Disorders ($1.3 million) – 10.3% of paid claims
  - Trauma/Accidents ($1.2 million) – 9.3% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased 10.4%
  - Average paid per ER visit increased 28.1%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 14.1%
  - Average paid per Urgent Care visit decreased 18.3% (decrease from $120 to $98)
- Network Utilization:
  - 97.1% of claims are from In-Network providers.
  - As Q4 of Plan Year 2023 In-Network utilization decreased 1.5% over PY 2022
  - As Q4 of Plan Year 2023 In-Network discounts increased 1.1% over PY 2022
- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims increased 73.5%
    - Total Gross Claims Costs increased 97.2% ($12.4 million)
    - Average Total Cost per Claim increased 13.7%
      - From $108.33 to $123.14
  - Member:

        - Total Member Cost increased 75.8% (this can be attributed to the increase in the number of participants from 8,533 to 14,339)
        - Average Participant Share per Claim increased 1.3%
        - Average Copay per Claim (Member Cost Share) increased 1.3%
            - From $19.94 to $20.21
    - Plan
        - Total Plan Cost increased 102.0% (this can be attributed to the increase in the number of participants from 8,533 to 14,339)
        - Average Plan Share per Claim increased 16.5%
        - Net Plan PMPM increased 20.2%
            - From $101.49 to $122.00
        - Net Plan PMPM factoring rebates decreased%
            - From $91.16 to $88.39

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q4 of Plan Year 2023 compared to Q4 of Plan Year 2022 is summarized below.

- Population:
    - 14.3% decrease for primary participants
    - 14.3% decrease for primary participants plus dependents (members)
- Medical Cost:
    - 25.4% increase for primary participants
    - 25.4% increase for primary participants plus dependents (members)
- High-Cost Claims:
    - There were 54 High-Cost Claimants accounting for 32.9% of the total plan paid for Plan Year 2023
    - 37.0% increase in High-Cost Claimants per 1,000 members
    - 8.6% increase in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
    - Cancer ($4.2 million) – 30.6% of paid claims
    - Cardiac Disorders ($1.9 million) – 13.7% of paid claims
    - Pregnancy-related Disorders ($1.4 million) – 10.4% of paid claims
- Emergency Room:
    - ER visits per 1,000 members increased by 5.1%
    - Average paid per ER visit increased by 54.2%
- Urgent Care:
    - Urgent Care visits per 1,000 members increased by 2.2%
    - Average paid per Urgent Care visit decreased 15.7%
- Network Utilization:
    - 100% of claims are from In-Network providers
    - In-Network discounts decreased 5.0%
- Prescription Drug Utilization:
    - Overall:
        - Total Net Claims decreased 12.0%

        - Total Gross Claims Costs increased 2.1% ($0.4 million)
        - Average Total Cost per Claim increased 16.0%
            - From $128.48 to $149.01
    - Member:
        - Total Member Cost decreased 3.4%
        - Average Participant Share per Claim increased 9.7%
        - Avg Copay per Claim (Member Cost Share) increased 9.9%
            - From $22.03 to $24.22
    - Plan
        - Total Plan Cost increased 3.3%
        - Average Plan Share per Claim increased 17.3%
        - Net Plan PMPM increased 20.5%
            - From $180.65 to $217.75
        - Net Plan PMPM factoring rebates increased 5.5%
            - From $137.14 to $144.64

DENTAL PLAN

The Dental Plan experience for Q4 of Plan Year 2023 is summarized below.

- Dental Cost:
    - Total Dental claims paid decreased 4.0% (from $24.6 million for Q4 of PY22 to $23.6 million for Q4 of PY23)
        - Preventative claims account for 27.3% ($6.4 million)
        - Basic claims account for 33.0% ($7.8 million)
        - Major claims account for 15.6% ($3.7 million)
        - Diagnostic claims account for 24.1% ($5.7 million)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of CDHP HRA account balances as of June 30, 2023.

HRA Account Balances as of June 30, 2023			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	1,428	0	0
$.01 - $500.00	3,185	633,332	199
$500.01 - $1,000	1,796	1,201,159	669
$1,000.01 - $1,500	591	717,221	1,214
$1,500.01 - $2,000	367	641,623	1,748
$2,000.01 - $2,500	288	643,170	2,233
$2,500.01 - $3,000	184	511,930	2,782
$3,000.01 - $3,500	185	604,544	3,268
$3,500.01 - $4,000	156	581,286	3,726
$4,000.01 - $4,500	121	513,968	4,248
$4,500.01 - $5,000	88	419,145	4,763
$5,000.01 +	**619**	**5,220,783**	**224,086**
Total	**9,008**	**$ 11,688,160**	**$ 1,298**

CONCLUSION

The information in this report provides plan experience for the Consumer Driven Health Plan (CDHP), Low Deductible PPO Plan (LDPPO) and the PEBP Premier Plan (EPO) through the fourth quarter of Plan Year 2023. The CDHP total plan paid costs decreased 13.1% over the same time for Plan Year 2022. The LDPPO total plan paid costs increased 71.7% over the same time for Plan Year 2023. The EPO total plan paid costs increased 6.2% over Q4 of Plan Year 2022. For HMO utilization and cost data please see the report provided in Appendix D.

Appendix A

Index of Tables

UMR Inc. – CDHP Utilization Review for PEBP

July 1, 2022 – June 30, 2023

DATASCOPE™

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

UMR℠

Overview

- Total Medical Spend for PY23 was $88,479,381 of which 74.7% was spent in the State Active population. When compared to PY22, this reflected a decrease of 15.5% in plan spend, with State Actives having a decrease of 17.9%.
  - When compared to PY21, PY23 decreased 31.8%, with State Actives having a decrease of 34.1%.
- On a PEPY basis, PY23 reflected an decrease of 2.5% when compared to PY22. The largest group, State Actives, had an decrease of 4.4%.
  - When compared to PY21, PY23 decreased 3.4%, with State Actives decreasing 3.9%.
- 85.6% of the Average Membership had paid Medical claims less than $2,500, with 20.3% having no claims paid at all during the reporting period.
- There were 126 high-cost Claimants (HCC's) over $100K, that accounted for 34.0% of the total spend. HCCs accounted for 38.4% of total spend during PY22, with 160 members hitting the $100K threshold. The largest diagnosis grouper was Cancer accounting for 22.1% of high-cost claimant dollars.
- IP Paid per Admit was $26,453 which is a decrease of 22.1% compared to PY22.
- ER Paid per Visit is $2,396, which is an increase of 19.1% compared to PY22.
- 97.2% of all Medical spend dollars were to In Network providers. The average In Network discount was 68.4%, which is an increase of 5.1% compared to the PY22 average discount of 65.1%.

Paid Claims by Age Group

Paid Claims by Age Group																
	PY22						PY23						% 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	$ 4,550,238	$ 1,580	$ 21,972	$ 8	$ 4,572,210	$ 1,588	$ 5,181,350	$ 2,699	$ 34,144	$ 18	$ 5,215,494	$ 2,716	14.1%	71.1%
1	$ 520,539	$ 169	$ 24,554	$ 8	$ 545,093	$ 177	$ 486,016	$ 205	$ 36,705	$ 15	$ 522,721	$ 220	-4.1%	24.5%
2 - 4	$ 1,274,029	$ 120	$ 232,008	$ 22	$ 1,506,037	$ 141	$ 891,648	$ 119	$ 170,272	$ 23	$ 1,061,920	$ 141	-29.5%	-0.1%
5 - 9	$ 1,172,486	$ 54	$ 712,767	$ 33	$ 1,885,253	$ 87	$ 1,356,073	$ 82	$ 299,717	$ 18	$ 1,655,790	$ 101	-12.2%	16.2%
10 - 14	$ 2,707,686	$ 109	$ 430,033	$ 17	$ 3,137,719	$ 126	$ 1,731,650	$ 88	$ 340,380	$ 17	$ 2,072,030	$ 106	-34.0%	-16.5%
15 - 19	$ 4,673,018	$ 172	$ 918,293	$ 34	$ 5,591,311	$ 206	$ 4,387,437	$ 202	$ 690,093	$ 32	$ 5,077,530	$ 233	-9.2%	13.2%
20 - 24	$ 3,496,847	$ 114	$ 923,173	$ 30	$ 4,420,020	$ 144	$ 3,477,004	$ 130	$ 1,251,232	$ 47	$ 4,728,236	$ 176	7.0%	22.7%
25 - 29	$ 3,987,343	$ 168	$ 925,947	$ 39	$ 4,913,290	$ 207	$ 3,595,795	$ 197	$ 896,458	$ 49	$ 4,492,253	$ 247	-8.6%	19.0%
30 - 34	$ 5,182,871	$ 185	$ 1,671,194	$ 60	$ 6,854,065	$ 244	$ 5,254,060	$ 235	$ 961,196	$ 43	$ 6,215,256	$ 278	-9.3%	14.0%
35 - 39	$ 5,634,432	$ 186	$ 1,496,568	$ 49	$ 7,131,000	$ 236	$ 4,105,925	$ 168	$ 1,669,207	$ 68	$ 5,775,132	$ 237	-19.0%	0.5%
40 - 44	$ 6,307,115	$ 209	$ 2,141,997	$ 71	$ 8,449,112	$ 281	$ 4,561,901	$ 177	$ 2,219,537	$ 86	$ 6,781,438	$ 263	-19.7%	-6.2%
45 - 49	$ 7,912,859	$ 275	$ 2,671,471	$ 93	$ 10,584,330	$ 368	$ 5,337,965	$ 219	$ 2,254,193	$ 92	$ 7,592,158	$ 311	-28.3%	-15.5%
50 - 54	$ 11,038,518	$ 338	$ 4,241,055	$ 130	$ 15,279,573	$ 468	$ 9,184,369	$ 330	$ 4,070,171	$ 146	$ 13,254,540	$ 476	-13.3%	1.8%
55 - 59	$ 15,433,101	$ 438	$ 5,723,456	$ 162	$ 21,156,557	$ 600	$ 11,486,435	$ 373	$ 5,271,340	$ 171	$ 16,757,775	$ 544	-20.8%	-9.3%
60 - 64	$ 19,685,957	$ 479	$ 8,109,277	$ 197	$ 27,795,234	$ 676	$ 17,740,796	$ 490	$ 7,298,136	$ 202	$ 25,038,932	$ 692	-9.9%	2.4%
65+	$ 11,129,241	$ 432	$ 5,417,354	$ 210	$ 16,546,595	$ 642	$ 9,700,956	$ 402	$ 6,103,938	$ 253	$ 15,804,894	$ 655	-4.5%	2.0%
Total	**$ 104,706,277**	**$ 264**	**$ 35,661,119**	**$ 90**	**$ 140,367,399**	**$ 354**	**$ 88,479,381**	**$ 268**	**$ 33,566,719**	**$ 102**	**$ 122,046,100**	**$ 369**	**-13.1%**	**4.4%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,242	18,943	16,411	-13.4%	19,450	15,526	13,332	-14.1%	4	3	3	0.0%
Avg # Members	42,168	33,089	27,544	-16.8%	36,612	28,082	23,059	-17.9%	9	8	8	0.0%
Ratio	1.8	1.8	1.7	-4.0%	1.9	1.8	1.7	-4.4%	2.3	2.7	2.7	0.0%
Financial Summary												
Gross Cost	$167,612,161	$138,077,453	$116,590,277	-15.6%	$131,056,101	$106,593,460	$87,356,314	-18.0%	$45,142	$55,484	$42,591	-23.2%
Client Paid	$129,698,896	$104,706,277	$88,479,381	-15.5%	$100,360,791	$80,561,976	$66,125,338	-17.9%	$31,594	$38,304	$30,890	-19.4%
Employee Paid	$37,913,265	$33,371,175	$28,110,896	-15.8%	$30,695,310	$26,031,484	$21,230,976	-18.4%	$13,548	$17,181	$11,702	-31.9%
Client Paid-PEPY	$5,580	$5,527	$5,391	-2.5%	$5,160	$5,189	$4,960	-4.4%	$7,898	$12,768	$10,297	-19.4%
Client Paid-PMPY	$3,076	$3,164	$3,212	1.5%	$2,741	$2,869	$2,868	0.0%	$3,510	$4,788	$3,861	-19.4%
Client Paid-PEPM	$465	$461	$449	-2.6%	$430	$432	$413	-4.4%	$658	$1,064	$858	-19.4%
Client Paid-PMPM	$256	$264	$268	1.5%	$228	$239	$239	0.0%	$293	$399	$322	-19.3%
High Cost Claimants (HCC's) > $100k												
# of HCC's	173	160	126		124	115	94		0	0	0	
HCC's / 1,000	4.1	4.8	4.6		3.4	4.1	4.1		0.0	0.0	0.0	
Avg HCC Paid	$253,370	$251,190	$238,643	-5.0%	$251,442	$262,921	$233,021	-11.4%	$0	$0	$0	0.0%
HCC's % of Plan Paid	33.8%	38.4%	34.0%	-11.5%	31.1%	37.5%	33.1%	-11.7%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$893	$1,153	$995	-13.7%	$778	$1,028	$895	-12.9%	$0	$0	$0	0.0%
Facility Outpatient	$942	$939	$1,074	14.4%	$794	$821	$930	13.3%	$2,124	$3,554	$2,208	-37.9%
Physician	$1,176	$1,011	$1,143	13.1%	$1,112	$964	$1,043	8.2%	$1,339	$1,200	$1,653	37.8%
Other	$65	$62	$0	-100.0%	$56	$56	$0	-100.0%	$48	$34	$0	0.0%
Total	$3,076	$3,164	$3,212	1.5%	$2,741	$2,869	$2,868	0.0%	$3,510	$4,788	$3,861	-19.4%

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**Peer Index**
Enrollment									
Avg # Employees	3,269	2,981	2,711	-9.1%	519	433	366	-15.7%	
Avg # Members	4,936	4,486	4,049	-9.7%	611	514	427	-16.8%	
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	$25,102,026	-10.0%	$4,899,862	$3,549,442	$4,089,345	15.2%	
Client Paid	$25,416,793	$21,491,378	$19,194,786	-10.7%	$3,889,718	$2,614,619	$3,128,367	19.6%	
Employee Paid	$6,194,263	$6,387,688	$5,907,239	-7.5%	$1,010,144	$934,823	$960,978	2.8%	
Client Paid-PEPY	$7,774	$7,210	$7,082	-1.8%	$7,501	$6,033	$8,557	41.8%	$6,642
Client Paid-PMPY	$5,149	$4,791	$4,740	-1.1%	$6,362	$5,091	$7,321	43.8%	$4,116
Client Paid-PEPM	$648	$601	$590	-1.8%	$625	$503	$713	41.7%	$553
Client Paid-PMPM	$429	$399	$395	-1.0%	$530	$424	$610	43.9%	$343
High Cost Claimants (HCC's) > $100k									
# of HCC's	48	44	31		5	5	5		
HCC's / 1,000	9.7	9.8	7.7		8.2	9.7	11.7		
Avg HCC Paid	$234,370	$199,873	$213,853	7.0%	$280,896	$231,987	$307,109	32.4%	
HCC's % of Plan Paid	44.3%	40.9%	34.5%	-15.6%	36.1%	44.4%	49.1%	10.6%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,515	$1,808	$1,250	-30.9%	$2,727	$2,262	$4,005	77.1%	$1,190
Facility Outpatient	$1,954	$1,612	$1,838	14.0%	$1,599	$1,488	$1,591	6.9%	$1,376
Physician	$1,555	$1,280	$1,652	29.1%	$1,925	$1,227	$1,724	40.5%	$1,466
Other	$125	$91	$0	-100.0%	$110	$115	$0	-100.0%	$84
Total	$5,149	$4,791	$4,740	-1.1%	$6,362	$5,091	$7,321	43.8%	$4,116

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 32,773,018	$ 7,740,399	$ 1,067,575	$ 41,580,992	$ 23,807,910	$ 4,876,554	$ 672,073	$ 29,356,537	-29.4%
Outpatient	$ 47,788,958	$ 11,178,033	$ 1,505,371	$ 60,472,362	$ 42,317,427	$ 11,764,006	$ 1,882,153	$ 55,963,587	-7.5%
Total - Medical	**$ 80,561,976**	**$ 18,918,432**	**$ 2,572,947**	**$ 102,053,354**	**$ 66,125,338**	**$ 16,640,560**	**$ 2,554,226**	**$ 85,320,124**	**-16.4%**

Net Paid Claims - Per Participant per Month	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 433	$ 666	$ 350	$ 460	$ 413	$ 643	$ 384	$ 443	-3.7%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 435	$ 1,103,919	$ 162,350	$ 1,266,704	$ -	$ 398,052	$ 1,415,160	$ 1,813,211	43.1%
Outpatient	$ 37,868	$ 870,249	$ 478,101	$ 1,386,219	$ 30,890	$ 664,301	$ 650,855	$ 1,346,046	-2.9%
Total - Medical	**$ 38,304**	**$ 1,974,168**	**$ 640,451**	**$ 2,652,923**	**$ 30,890**	**$ 1,062,353**	**$ 2,066,014**	**$ 3,159,257**	**19.1%**

Net Paid Claims - Per Participant per Month	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 1,064	$ 1,006	$ 197	$ 505	$ 858	$ 790	$ 679	$ 714	41.3%

Paid Claims by Claim Type – Total Participants

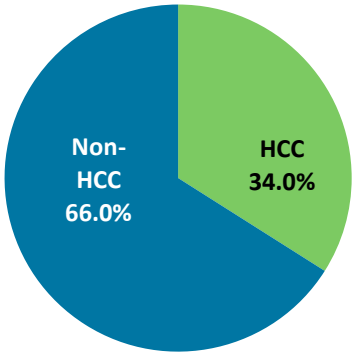
Net Paid Claims - Total Total Participants	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 32,773,454	$ 8,844,318	$ 1,229,925	$ 42,847,697	$ 23,807,910	$ 5,274,606	$ 2,087,232	$ 31,169,749	-27.3%
Outpatient	$ 47,826,826	$ 12,048,282	$ 1,983,473	$ 61,858,580	$ 42,348,317	$ 12,428,307	$ 2,533,008	$ 57,309,632	-7.4%
Total - Medical	**$ 80,600,280**	**$ 20,892,599**	**$ 3,213,398**	**$ 104,706,277**	**$ 66,156,227**	**$ 17,702,913**	**$ 4,620,240**	**$ 88,479,381**	**-15.5%**

Net Paid Claims - Per Participant per Month	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 433	$ 688	$ 303	$ 461	$ 413	$ 650	$ 477	$ 449	-2.6%

Cost Distribution – Medical Claims

PY22							PY23					
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
145	0.4%	$40,205,527	38.4%	$1,161,661	3.5%	$100,000.01 Plus	113	0.4%	$29,935,819	33.8%	$832,847	3.0%
174	0.5%	$12,795,665	12.2%	$1,244,768	3.7%	$50,000.01-$100,000.00	156	0.6%	$11,675,364	13.2%	$965,047	3.4%
319	1.0%	$11,603,448	11.1%	$1,855,020	5.6%	$25,000.01-$50,000.00	316	1.1%	$11,600,473	13.1%	$1,730,194	6.2%
826	2.5%	$13,400,718	12.8%	$4,416,797	13.2%	$10,000.01-$25,000.00	792	2.9%	$13,059,289	14.8%	$3,895,107	13.9%
1,285	3.9%	$9,513,163	9.1%	$4,498,339	13.5%	$5,000.01-$10,000.00	1,101	4.0%	$8,145,730	9.2%	$3,683,619	13.1%
1,831	5.5%	$6,764,746	6.5%	$4,405,068	13.2%	$2,500.01-$5,000.00	1,510	5.5%	$5,660,247	6.4%	$3,680,595	13.1%
18,030	54.5%	$10,367,660	9.9%	$13,422,212	40.2%	$0.01-$2,500.00	13,927	50.6%	$8,402,458	9.5%	$11,274,699	40.1%
4,231	12.8%	$0	0.0%	$2,363,074	7.1%	$0.00	4,043	14.7%	$0	0.0%	$2,048,788	7.3%
6,248	18.9%	$55,351	0.1%	$4,236	0.0%	No Claims	5,586	20.3%	$0	0.0%	$0	0.0%
33,089	**100.0%**	**$104,706,277**	**100.0%**	**$33,371,175**	**100.0%**		**27,544**	**100.0%**	**$88,479,381**	**100.0%**	**$28,110,896**	**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	46	$6,641,725	22.1%
Cardiac Disorders	90	$2,919,037	9.7%
Infections	67	$2,039,665	6.8%
Pregnancy-related Disorders	10	$2,016,445	6.7%
Gastrointestinal Disorders	78	$1,922,782	6.4%
Spine-related Disorders	27	$1,732,903	5.8%
Mental Health	47	$1,677,590	5.6%
Neurological Disorders	74	$1,517,060	5.0%
Congenital/Chromosomal Anomalies	7	$1,503,866	5.0%
Endocrine/Metabolic Disorders	55	$1,123,797	3.7%
All Other		$6,974,124	23.2%
Overall	**----**	**$30,068,994**	**100.0%**

Utilization Summary (p. 1 of 2)

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

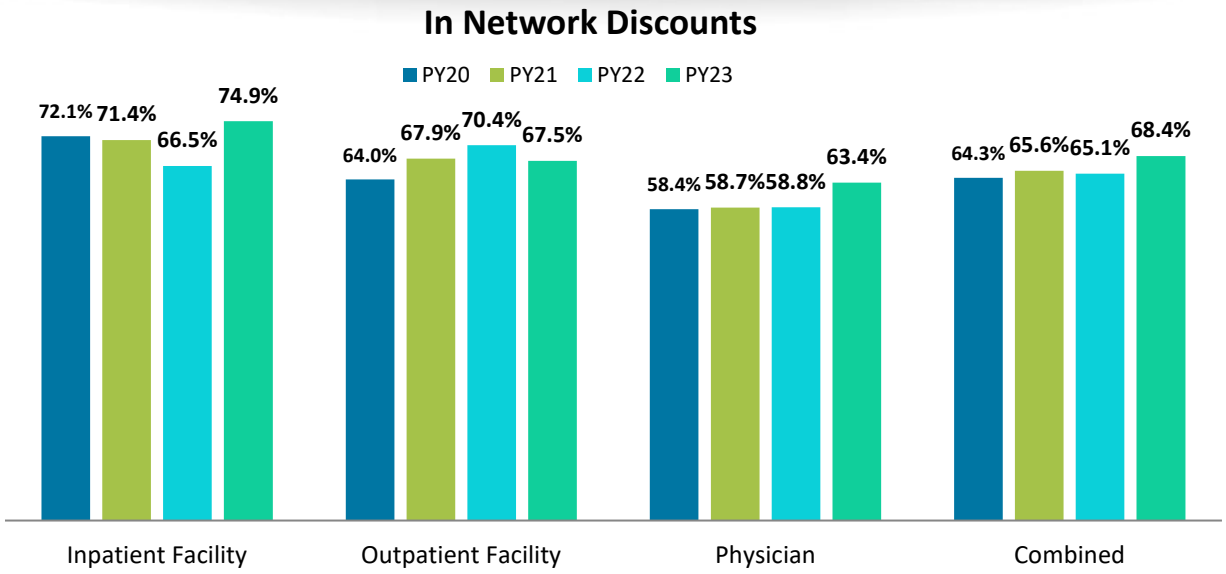
	Total				State Active				Non-State Active			
Summary	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	1,696	1,357	1,072		1,340	997	797		0	0	0	
# of Bed Days	11,106	8,861	6,155		8,828	6,471	4,533		0	0	0	
Paid Per Admit	$31,697	$33,963	$26,453	-22.1%	$31,250	$35,180	$26,882	-23.6%	$0	$0	$0	0.0%
Paid Per Day	$4,840	$5,201	$4,607	-11.4%	$4,743	$5,420	$4,726	-12.8%	$0	$0	$0	0.0%
Admits Per 1,000	40	41	39	-4.9%	37	36	35	-2.8%	0	0	0	0.0%
Days Per 1,000	263	268	223	-16.8%	241	230	197	-14.3%	0	0	0	0.0%
Avg LOS	6.5	6.5	5.7	-12.3%	6.6	6.5	5.7	-12.3%	0	0	0	0.0%
# of Admits From ER	912	780	613	-21.4%	674	516	419	-18.8%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	4	3.8	3.8	0.0%	3.8	3.5	3.5	0.0%	3.6	3.6	3.6	0.0%
Avg Paid per OV	$81	$82	$86	4.9%	$81	$84	$82	-2.4%	$89	$93	$108	16.1%
Avg OV Paid per Member	$322	$312	$324	3.8%	$305	$297	$284	-4.4%	$316	$339	$392	15.6%
DX&L Utilization per Member	7.7	7.4	9.4	27.0%	7.3	6.9	8.6	24.6%	7	15.9	11.4	0.0%
Avg Paid per DX&L	$55	$54	$48	-11.1%	$52	$50	$46	-8.0%	$362	$176	$78	0.0%
Avg DX&L Paid per Member	$428	$402	$457	13.7%	$381	$348	$398	14.4%	$2,537	$2,794	$884	0.0%
Emergency Room												
# of Visits	5,050	4,877	4,216		4,286	4,039	3,339		3	5	4	
Visits Per Member	0.12	0.15	0.15	0.0%	0.12	0.14	0.14	0.0%	0.33	0.63	0.50	0.0%
Visits Per 1,000	120	147	153	4.1%	117	144	145	0.7%	333	625	500	0.0%
Avg Paid per Visit	$2,209	$2,011	$2,396	19.1%	$2,234	$2,053	$2,508	22.2%	$6,703	$932	$3,452	0.0%
Urgent Care												
# of Visits	9,251	8,823	7,180		8,291	7,756	6,318		4	5	7	
Visits Per Member	0.22	0.27	0.26	-3.7%	0.23	0.28	0.27	-3.6%	0.44	0.63	0.88	0.0%
Visits Per 1,000	219	267	261	-2.2%	226	276	274	-0.7%	444	625	875	0.0%
Avg Paid per Visit	$78	$70	$50	-28.6%	$77	$70	$50	-28.6%	$99	$106	$83	0.0%

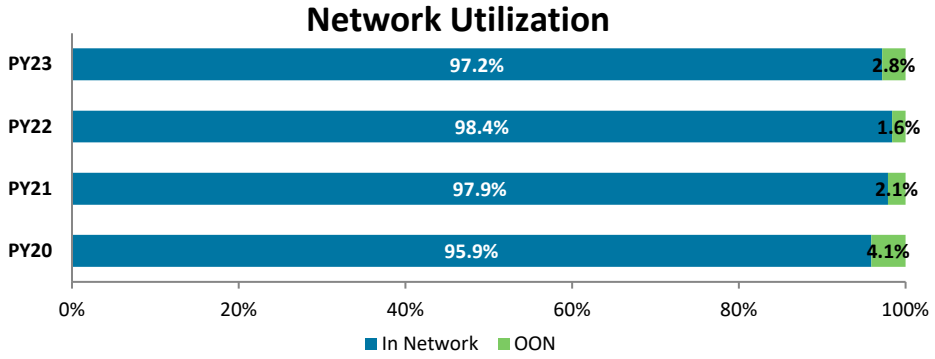
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**Peer Index**
Inpatient Summary									
# of Admits	297	302	222		59	58	53		
# of Bed Days	1,961	2,000	1,253		317	390	369		
Paid Per Admit	$33,206	$30,487	$25,483	-16.4%	$34,255	$31,145	$24,071	-22.7%	$18,822
Paid Per Day	$5,029	$4,603	$4,515	-1.9%	$6,376	$4,632	$3,457	-25.4%	$3,265
Admits Per 1,000	60	67	55	-17.9%	96	113	124	9.7%	70
Days Per 1,000	397	446	309	-30.7%	518	759	863	13.7%	402
Avg LOS	6.6	6.6	5.6	-15.2%	5.4	6.7	7.0	4.5%	5.8
# of Admits From ER	198	222	156	-29.7%	40	42	38	-9.5%	
Physician Office									
OV Utilization per Member	5.1	5.0	5.1	2.0%	6.9	6.8	7.7	13.2%	5.4
Avg Paid per OV	$85	$82	$109	32.9%	$56	$39	$41	5.1%	$96
Avg OV Paid per Member	$434	$410	$557	35.9%	$386	$268	$313	16.8%	$515
DX&L Utilization per Member	10.5	9.9	13	31.3%	12	9.6	19.4	102.1%	11.0
Avg Paid per DX&L	$69	$72	$58	-19.4%	$67	$58	$39	-32.8%	$50
Avg DX&L Paid per Member	$728	$717	$762	6.3%	$803	$557	$754	35.4%	$543
Emergency Room									
# of Visits	666	725	725		95	108	148		
Visits Per Member	0.13	0.16	0.18	12.5%	0.16	0.21	0.35	66.7%	0.22
Visits Per 1,000	135	162	179	10.5%	155	210	346	64.8%	221
Avg Paid per Visit	$1,995	$1,856	$2,125	14.5%	$2,412	$1,520	$1,165	-23.4%	$968
Urgent Care									
# of Visits	853	980	770		103	82	85		
Visits Per Member	0.17	0.22	0.19	-13.6%	0.17	0.16	0.20	25.0%	0.35
Visits Per 1,000	173	218	190	-12.8%	168	160	199	24.4%	352
Avg Paid per Visit	$80	$71	$53	-25.4%	$79	$39	$47	20.5%	$135

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$10,237,425	11.6%	$7,074,343	$2,467,404	$695,678	$4,784,458	$5,452,967
Gastrointestinal Disorders	$7,817,952	8.8%	$5,283,851	$1,245,231	$1,288,869	$3,491,628	$4,326,324
Health Status/Encounters	$7,030,536	7.9%	$4,398,502	$994,733	$1,637,301	$2,590,985	$4,439,551
Cardiac Disorders	$6,998,184	7.9%	$4,984,525	$1,877,898	$135,761	$3,596,554	$3,401,630
Pregnancy-related Disorders	$5,299,977	6.0%	$1,911,527	$621,964	$2,766,486	$1,119,276	$4,180,702
Musculoskeletal Disorders	$5,039,005	5.7%	$3,746,388	$816,584	$476,033	$1,995,695	$3,043,310
Trauma/Accidents	$4,681,114	5.3%	$3,242,810	$539,172	$899,133	$2,597,095	$2,084,020
Spine-related Disorders	$4,630,934	5.2%	$2,690,781	$535,440	$1,404,712	$1,311,518	$3,319,416
Infections	$4,250,628	4.8%	$3,049,990	$594,865	$605,774	$2,542,763	$1,707,866
Neurological Disorders	$4,249,889	4.8%	$2,601,532	$954,455	$693,903	$1,487,461	$2,762,428
Mental Health	$4,231,141	4.8%	$1,294,803	$401,351	$2,534,987	$1,251,155	$2,979,985
Renal/Urologic Disorders	$3,057,791	3.5%	$1,914,008	$731,798	$411,985	$1,807,286	$1,250,505
Eye/ENT Disorders	$2,900,381	3.3%	$1,865,965	$399,935	$634,482	$1,298,285	$1,602,096
Pulmonary Disorders	$2,843,126	3.2%	$1,881,898	$249,596	$711,633	$1,433,884	$1,409,243
Endocrine/Metabolic Disorders	$2,596,608	2.9%	$1,886,530	$581,963	$128,116	$1,387,873	$1,208,735
Gynecological/Breast Disorders	$2,037,378	2.3%	$1,518,597	$368,022	$150,758	$30,045	$2,007,332
Congenital/Chromosomal Anomalies	$1,923,696	2.2%	$74,351	$59,664	$1,789,681	$1,756,611	$167,085
Medical/Surgical Complications	$1,468,630	1.7%	$1,115,537	$193,559	$159,534	$902,353	$566,277
Hematological Disorders	$1,375,492	1.6%	$342,111	$899,701	$133,679	$1,018,440	$357,052
Diabetes	$1,176,532	1.3%	$962,293	$84,500	$129,739	$698,952	$477,580
Dermatological Disorders	$1,123,163	1.3%	$813,463	$171,224	$138,476	$611,054	$512,108
Non-malignant Neoplasm	$967,254	1.1%	$794,438	$128,662	$44,154	$272,024	$695,230
Vascular Disorders	$820,092	0.9%	$500,509	$301,729	$17,854	$403,614	$416,479
Miscellaneous	$733,366	0.8%	$456,215	$132,894	$144,257	$265,162	$468,204
Abnormal Lab/Radiology	$556,163	0.6%	$449,541	$84,285	$22,337	$241,401	$314,762
Medication Related Conditions	$161,882	0.2%	$71,960	$26,667	$63,255	$89,281	$72,601
Cholesterol Disorders	$150,207	0.2%	$125,184	$21,994	$3,028	$80,227	$69,980
Allergic Reaction	$53,080	0.1%	$15,108	$16,456	$21,516	$21,646	$31,434
Dental Conditions	$51,055	0.1%	$19,123	$164	$31,768	$35,457	$15,598
External Hazard Exposure	$16,398	0.0%	$13,953	$1,572	$873	$8,521	$7,877
Cause of Morbidity	$272	0.0%	$122	$26	$125	$148	$125
Social Determinants of Health	$29	0.0%	$29	$0	$0	$29	$0
Total	**$88,479,381**	**100.0%**	**$55,099,987**	**$15,503,509**	**$17,875,885**	**$39,130,881**	**$49,348,500**

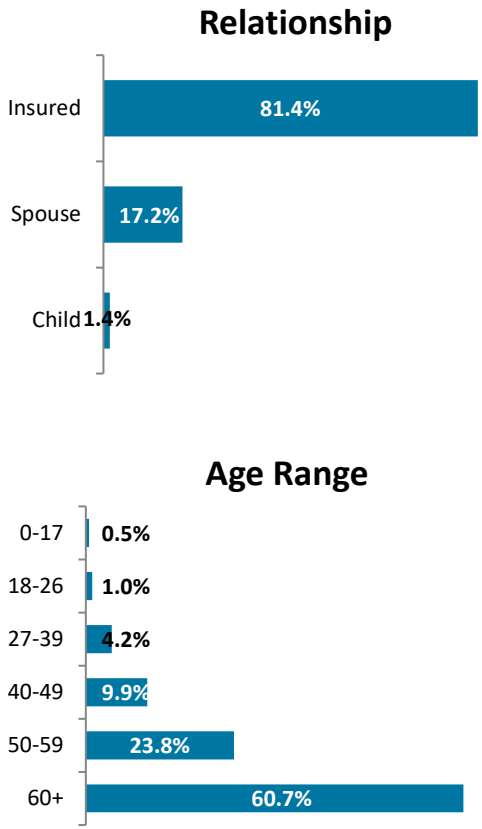
Mental Health Drilldown

	PY20		PY21		PY22		PY23	
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	974	$1,005,022
Developmental Disorders	144	$790,389	179	$1,179,402	113	$719,871	106	$1,143,180
Alcohol Abuse/Dependence	125	$868,472	136	$1,288,204	101	$873,612	129	$434,007
Mental Health Conditions, Other	1,222	$686,307	1,220	$771,034	911	$431,490	774	$383,973
Mood and Anxiety Disorders	1,791	$437,001	1,920	$638,818	1,486	$406,189	1,263	$370,422
Bipolar Disorder	327	$340,422	315	$464,418	225	$197,224	193	$202,937
Psychoses	55	$78,740	54	$86,357	32	$70,201	35	$108,586
Eating Disorders	47	$74,872	55	$647,596	44	$596,928	34	$112,463
Complications of Substance Abuse	47	$257,582	42	$202,208	22	$89,081	26	$88,753
Substance Abuse/Dependence	121	$1,068,150	140	$213,345	86	$540,594	81	$99,940
Schizophrenia	31	$43,420	26	$141,033	25	$110,357	21	$81,413
Sexually Related Disorders	51	$24,993	68	$90,021	42	$11,305	56	$109,156
Attention Deficit Disorder	433	$58,455	482	$72,965	374	$57,319	369	$42,820
Sleep Disorders	526	$40,584	564	$76,491	371	$46,254	347	$39,783
Tobacco Use Disorder	149	$6,011	126	$8,010	106	$6,184	103	$7,184
Personality Disorders	19	$18,981	25	$16,690	19	$13,480	8	$1,502
Total		**$5,931,821**		**$7,000,007**		**$5,449,334**		**$4,231,141**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	81	632	$3,541,962	34.6%
Breast Cancer	182	2,230	$1,420,244	13.9%
Cancers, Other	112	1,254	$1,199,129	11.7%
Secondary Cancers	67	490	$794,841	7.8%
Prostate Cancer	106	940	$476,580	4.7%
Lymphomas	39	520	$363,474	3.6%
Brain Cancer	12	230	$351,296	3.4%
Colon Cancer	43	496	$261,937	2.6%
Carcinoma in Situ	104	424	$238,194	2.3%
Bladder Cancer	18	212	$230,654	2.3%
Thyroid Cancer	59	296	$229,651	2.2%
Leukemias	32	594	$224,047	2.2%
Cervical/Uterine Cancer	45	391	$199,596	1.9%
Lung Cancer	23	244	$167,530	1.6%
Ovarian Cancer	25	293	$163,796	1.6%
Non-Melanoma Skin Cancers	293	681	$128,339	1.3%
Kidney Cancer	20	120	$101,657	1.0%
Myeloma	11	161	$63,638	0.6%
Melanoma	52	198	$51,851	0.5%
Pancreatic Cancer	4	56	$29,008	0.3%
Overall	**----**	**----**	**$10,237,425**	**100.0%**

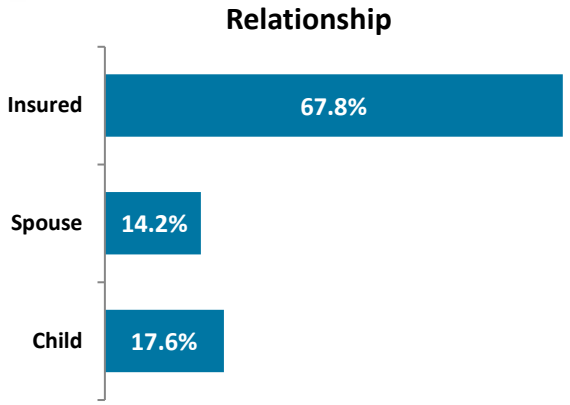
*Patient and claim counts are unique only within the category

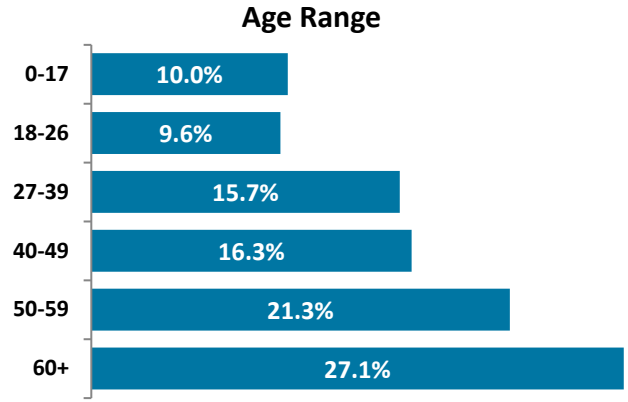


Diagnosis Grouper – Gastrointestinal Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
GI Disorders, Other	912	2,175	$1,195,030	15.3%
Abdominal Disorders	1,715	4,269	$1,120,809	14.3%
Hernias	222	775	$959,928	12.3%
Upper GI Disorders	843	2,075	$742,699	9.5%
GI Symptoms	1,096	2,447	$636,747	8.1%
Inflammatory Bowel Disease	88	495	$583,152	7.5%
Gallbladder and Biliary Disease	198	759	$552,065	7.1%
Appendicitis	44	298	$496,119	6.3%
Liver Diseases	321	651	$470,629	6.0%
Hepatic Cirrhosis	29	175	$301,826	3.9%
Diverticulitis	186	419	$253,318	3.2%
Pancreatic Disorders	38	151	$164,103	2.1%
Constipation	259	458	$109,288	1.4%
Ostomies	40	371	$108,867	1.4%
Hemorrhoids	193	330	$90,488	1.2%
Peptic Ulcer/Related Disorders	39	62	$19,143	0.2%
Esophageal Varices	8	24	$13,739	0.2%
	----	----	$7,817,952	100.0%

*Patient and claim counts are unique only within the category

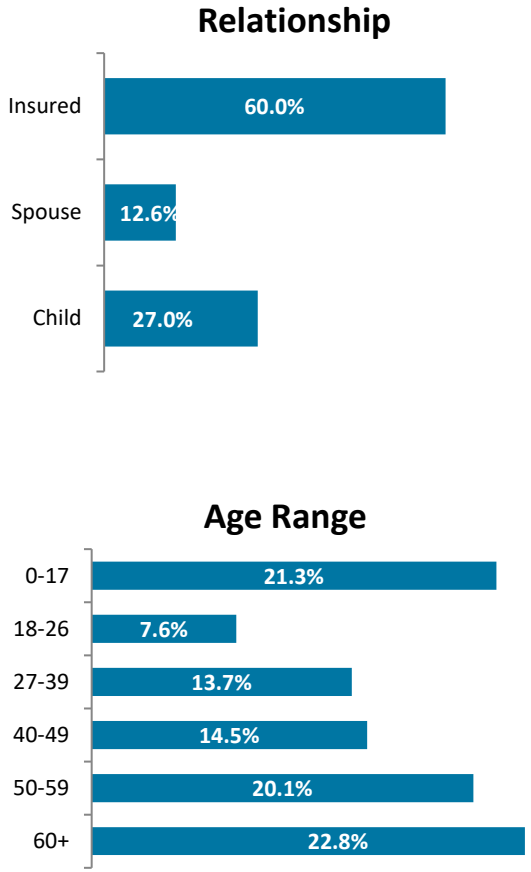




Diagnosis Grouper – Health Status/Encounters

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Screenings	6,989	14,570	$2,588,154	36.8%
Exams	9,165	18,330	$1,812,326	25.8%
Prophylactic Measures	4,221	5,874	$1,021,355	14.5%
Encounters - Infants/Children	2,816	4,304	$633,018	9.0%
Prosthetics/Devices/Implants	464	1,831	$286,942	4.1%
Personal History of Condition	848	1,518	$236,262	3.4%
Aftercare	486	1,061	$235,092	3.3%
Family History of Condition	184	273	$110,557	1.6%
Encounter - Transplant Related	40	300	$35,560	0.5%
Health Status, Other	149	206	$22,856	0.3%
Encounter - Procedure	53	67	$18,559	0.3%
Lifestyle/Situational Issues	112	258	$11,525	0.2%
Counseling	228	355	$7,966	0.1%
Acquired Absence	58	84	$6,717	0.1%
Miscellaneous Examinations	22	34	$1,927	0.0%
Follow-Up Encounters	14	31	$1,669	0.0%
Blood Type	2	2	$53	0.0%
Patient Non-compliance	1	2	$0	0.0%
Donors	1	1	$0	0.0%
Overall	**----**	**----**	**$7,030,536**	**100.0%**

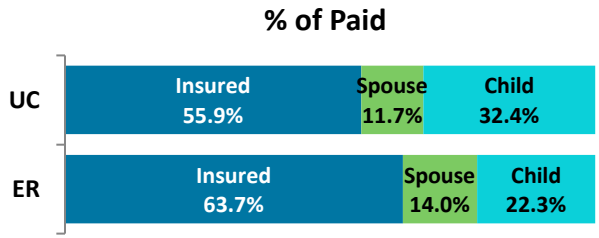
*Patient and claim counts are unique only within the category

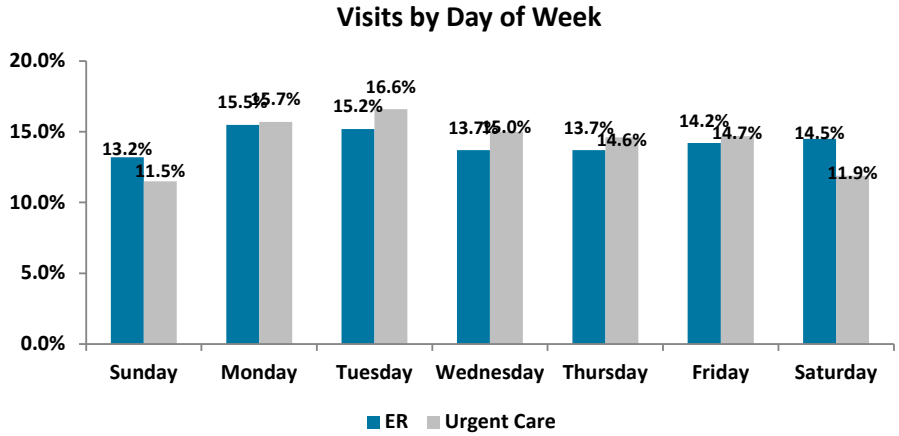


Emergency Room / Urgent Care Summary

	PY22		PY23		Peer Index	
	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	4,877	8,823	4,216	7,180		
Visits Per Member	0.15	0.27	0.15	0.26	0.22	0.35
Visits/1000 Members	147	267	153	261	221	352
Avg Paid Per Visit	$2,011	$70	$2,409	$50	$968	$135
% with OV*	84.4%	80.6%	81.0%	78.0%		
% Avoidable	14.2%	33.5%	15.7%	41.2%		
Total Member Paid	**$4,931,872**	**$977,662**	**$4,955,181**	**$863,690**		
Total Plan Paid	**$9,807,647**	**$617,610**	**$10,157,383**	**$360,133**		

*looks back 12 months





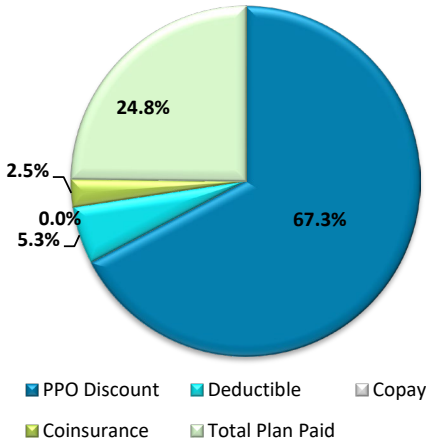
ER / UC Visits by Relationship						
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	2,533	154	4,214	4,380	6,747	411
Spouse	516	163	2,221	863	2,737	864
Child	1,167	146	745	1,655	1,912	240
Total	**4,216**	**153**	**7,180**	**261**	**11,396**	**414**

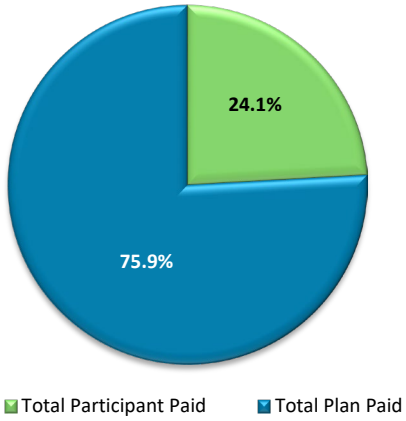
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$374,341,390	$1,901	100.0%
PPO Discount	$240,134,506	$1,219	64.1%
Deductible	$19,026,690	$97	5.1%
Copay	$81,610	$0	0.0%
Coinsurance	$9,002,596	$46	2.4%
Total Participant Paid	**$28,110,896**	**$143**	**7.5%**
Total Plan Paid	**$88,479,381**	**$449**	**23.6%**

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





Paid Claims by Age Range – Dental

Dental Paid Claims by Age Group												
	PY21		PY22		PY23		% Change	
Age Range	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM
<1	$ 9,549	$ 2	$ 10,139	$ 2	$ 8,515	$ 2	-16.0%	3.1%
1	$ 52,870	$ 8	$ 50,347	$ 10	$ 50,274	$ 11	-0.1%	6.6%
2 - 4	$ 393,519	$ 18	$ 411,560	$ 24	$ 404,140	$ 25	-1.8%	5.4%
5 - 9	$ 1,277,618	$ 32	$ 1,237,486	$ 37	$ 1,175,803	$ 37	-5.0%	1.1%
10 - 14	$ 1,310,428	$ 28	$ 1,279,857	$ 33	$ 1,295,455	$ 35	1.2%	5.6%
15 - 19	$ 1,569,052	$ 32	$ 1,442,554	$ 34	$ 1,493,927	$ 35	3.6%	3.9%
20 - 24	$ 998,778	$ 19	$ 919,674	$ 20	$ 879,120	$ 20	-4.4%	-2.4%
25 - 29	$ 945,482	$ 23	$ 868,582	$ 27	$ 753,936	$ 25	-13.2%	-7.8%
30 - 34	$ 1,232,155	$ 26	$ 1,140,186	$ 30	$ 996,206	$ 27	-12.6%	-10.1%
35 - 39	$ 1,426,515	$ 27	$ 1,360,917	$ 31	$ 1,229,651	$ 29	-9.6%	-5.9%
40 - 44	$ 1,421,590	$ 28	$ 1,405,195	$ 32	$ 1,382,499	$ 32	-1.6%	-1.0%
45 - 49	$ 1,508,670	$ 29	$ 1,465,920	$ 34	$ 1,368,193	$ 32	-6.7%	-5.6%
50 - 54	$ 1,770,185	$ 31	$ 1,750,235	$ 36	$ 1,731,395	$ 35	-1.1%	-2.1%
55 - 59	$ 2,066,423	$ 34	$ 2,018,842	$ 39	$ 1,922,113	$ 38	-4.8%	-1.6%
60 - 64	$ 2,548,711	$ 38	$ 2,535,229	$ 45	$ 2,332,023	$ 43	-8.0%	-4.6%
65+	$ 6,480,115	$ 40	$ 6,661,475	$ 48	$ 6,546,559	$ 47	-1.7%	-1.9%
Total	**$ 25,011,660**	**$ 31**	**$ 24,558,198**	**$ 36**	**$ 23,569,810**	**$ 35**	**-4.0%**	**-2.1%**

Dental Paid Claims – State Participants

Dental Paid Claims - Total State Participants	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 16,314,521	$ 2,156,411	$ 504,521	$ 18,975,453	$ 15,543,626	$ 2,149,425	$ 476,404	$ 18,169,456	-4.2%
Dental Exchange			$ 3,377,326	$ 3,377,326			$ 3,365,799	$ 3,365,799	-0.3%
Total	**$ 16,314,521**	**$ 2,156,411**	**$ 3,881,847**	**$ 22,352,779**	**$ 15,543,626**	**$ 2,149,425**	**$ 3,842,204**	**$ 21,535,255**	**-4.6%**

Dental Paid Claims - Per Participant per Month	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 52	$ 52	$ 56	$ 52	$ 50	$ 52	$ 56	$ 50	-3.9%
Dental Exchange	$ -	$ -	$ 49	$ 49	$ -	$ -	$ 49	$ 49	-1.4%

Dental Paid Claims – Non-State Participants

Dental Paid Claims - Total Non-State Participants	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 8,026	$ 145,233	$ 220,432	$ 373,691	$ 3,733	$ 97,091	$ 207,244	$ 308,068	-17.6%
Dental Exchange			$ 1,831,728	$ 1,831,728			$ 1,726,487	$ 1,726,487	-5.7%
Total	**$ 8,026**	**$ 145,233**	**$ 2,052,160**	**$ 2,205,419**	**$ 3,733**	**$ 97,091**	**$ 1,933,731**	**$ 2,034,555**	**-7.7%**

Dental Paid Claims - Per Participant per Month	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 100	$ 43	$ 42	$ 43	$ 52	$ 43	$ 42	$ 42	-2.2%
Dental Exchange	$ -	$ -	$ 44	$ 44	$ -	$ -	$ 43	$ 43	-2.9%

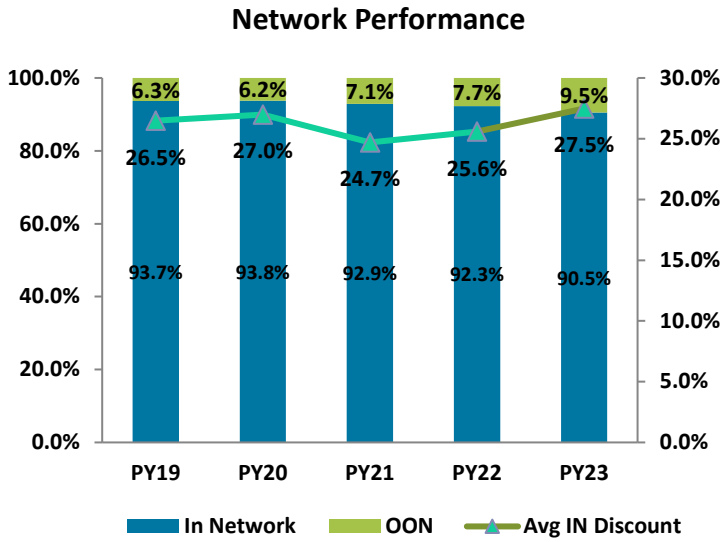
Dental Paid Claims – Total Participants

Dental Paid Claims - Total Total Participants	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 16,322,547	$ 2,301,644	$ 724,953	$ 19,349,144	$ 15,547,359	$ 2,246,517	$ 683,648	$ 18,477,524	-4.5%
Dental Exchange	$ -	$ -	$ 5,209,054	$ 5,209,054	$ -	$ -	$ 5,092,287	$ 5,092,287	-2.2%
Total	**$ 16,322,547**	**$ 2,301,644**	**$ 5,934,007**	**$ 24,558,198**	**$ 15,547,359**	**$ 2,246,517**	**$ 5,775,935**	**$ 23,569,810**	**-4.0%**

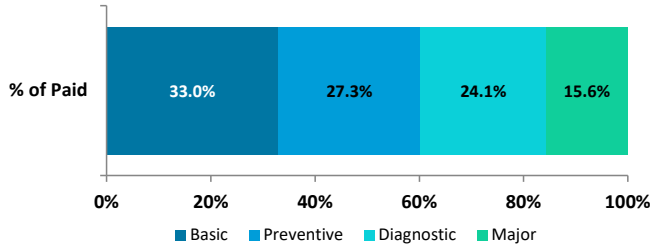
Dental Paid Claims - Per Participant per Month	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Dental	$ 52	$ 51	$ 51	$ 52	$ 50	$ 51	$ 51	$ 50	-3.8%
Dental Exchange	$ -	$ -	$ 47	$ 47	$ -	$ -	$ 46	$ 46	-1.8%

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	5,642	10.1%	30,858	25.2%	$10,120,842	42.9%	$5,783,416	55.8%
$750.01-$1,000.00	2,383	4.3%	10,988	9.0%	$2,471,792	10.5%	$1,211,710	11.7%
$500.01-$750.00	4,482	8.0%	19,086	15.6%	$3,245,709	13.8%	$1,205,645	11.6%
$250.01-$500.00	13,146	23.6%	41,441	33.8%	$5,621,177	23.8%	$1,327,962	12.8%
$0.01-$250.00	10,456	18.8%	19,629	16.0%	$2,110,290	9.0%	$792,116	7.7%
$0.00	298	0.5%	438	0.4%	$0	0.0%	$36,165	0.4%
No Claims	19,337	34.7%	0	0.0%	$0	0.0%	$0	0.0%
Total	**55,745**	**100.0%**	**122,440**	**100.0%**	**$23,569,810**	**100.0%**	**$10,357,015**	**100.0%**



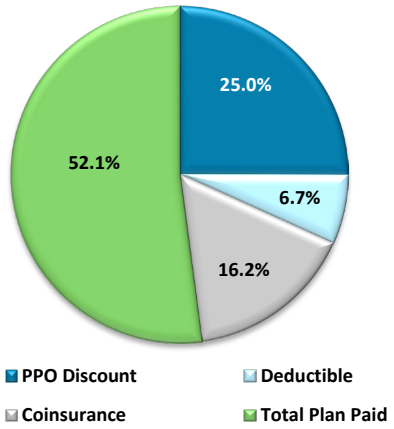
Claim Category	Total Paid	% of Paid
Basic	$7,766,736	33.0%
Preventive	$6,431,485	27.3%
Diagnostic	$5,686,777	24.1%
Major	$3,684,813	15.6%
Total	**$23,569,810**	**100.0%**

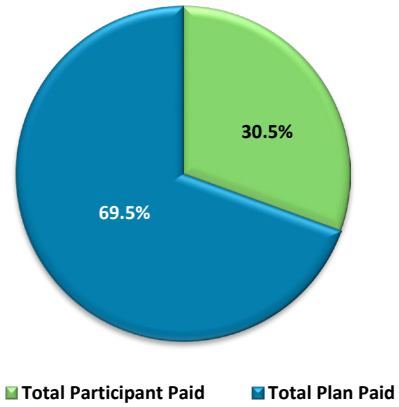


Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$44,984,457	$109	100.0%
PPO Discount	$11,337,378	$28	25.2%
Deductible	$3,011,489	$7	6.7%
Coinsurance	$7,345,526	$18	16.3%
Total Participant Paid	**$10,357,015**	**$25**	**23.0%**
Total Plan Paid	**$23,569,810**	**$57**	**52.4%**

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	1,018	985	33	96.2%
	<2 asthma related ER Visits in the last 6 months	1,018	1,017	1	99.9%
	No asthma related admit in last 12 months	1,018	1,016	2	99.8%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	220	212	8	96.4%
	Members with COPD who had an annual spirometry test	220	39	181	17.7%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	7	7	0	100.0%
	No ER Visit for Heart Failure in last 90 days	199	194	5	97.5%
	Follow-up OV within 4 weeks of discharge from HF admission	7	6	1	85.7%
Diabetes	Annual office visit	1,490	1,385	105	93.0%
	Annual dilated eye exam	1,490	568	922	38.1%
	Annual foot exam	1,490	649	841	43.6%
	Annual HbA1c test done	1,490	1,236	254	83.0%
	Diabetes Annual lipid profile	1,490	1,123	367	75.4%
	Annual microalbumin urine screen	1,490	1,042	448	69.9%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	4,078	3,292	786	80.7%
Hypertension	Annual lipid profile	4,144	2,858	1,286	69.0%
	Annual serum creatinine test	3,981	3,218	763	80.8%
Wellness	Well Child Visit - 15 months	167	162	5	97.0%
	Routine office visit in last 6 months (All Ages)	26,938	15,927	11,011	59.1%
	Colorectal cancer screening ages 45-75 within the appropriate time period	11,118	5,161	5,957	46.4%
	Women age 25-65 with recommended cervical cancer/HPV screening	8,343	5,685	2,658	68.1%
	Males age greater than 49 with PSA test in last 24 months	4,422	2,167	2,255	49.0%
	Routine exam in last 24 months (All Ages)	26,938	22,305	4,633	82.8%
	Women age 40 to 75 with a screening mammogram last 24 months	7,134	4,253	2,881	59.6%

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

Chronic Conditions Prevalence

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

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

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

Chronic Condition	# With Condition	% of Members	Members per 1,000	Admits per 1,000	ER Visits per 1,000	PMPY
Affective Psychosis	183	0.68%	6.64	211.65	577.23	$15,445
Asthma	1,144	4.24%	41.53	146.22	497.38	$12,348
Atrial Fibrillation	302	1.12%	10.96	330.04	593.33	$32,056
Blood Disorders	1,678	6.22%	60.92	307.01	474.54	$26,297
CAD	615	2.28%	22.33	271.62	504.45	$22,499
COPD	218	0.81%	7.91	301.23	832.50	$25,302
Cancer	1,076	3.99%	39.06	184.36	285.92	$25,589
Chronic Pain	685	2.54%	24.87	242.50	729.33	$21,500
Congestive Heart Failure	201	0.75%	7.30	694.42	871.07	$55,060
Demyelinating Diseases	71	0.26%	2.58	312.76	296.30	$37,899
Depression	1,656	6.14%	60.12	170.67	478.60	$12,870
Diabetes	1,654	6.13%	60.05	149.83	327.88	$16,495
ESRD	39	0.14%	1.42	818.90	1,322.83	$71,150
Eating Disorders	86	0.32%	3.12	417.77	1,109.24	$28,306
HIV/AIDS	38	0.14%	1.38	266.01	413.79	$68,396
Hyperlipidemia	5,072	18.80%	184.13	85.46	247.77	$9,926
Hypertension	4,191	15.54%	152.15	125.34	335.14	$12,471
Immune Disorders	109	0.40%	3.96	585.06	560.17	$63,307
Inflammatory Bowel Disease	99	0.37%	3.59	131.87	287.71	$38,130
Liver Diseases	539	2.00%	19.57	315.85	557.53	$25,576
Morbid Obesity	777	2.88%	28.21	226.01	445.48	$18,512
Osteoarthritis	1,078	4.00%	39.14	160.37	446.01	$16,456
Peripheral Vascular Disease	163	0.60%	5.92	368.49	744.99	$25,807
Rheumatoid Arthritis	162	0.60%	5.88	85.87	271.91	$25,571

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.

Appendix B

Index of Tables

UMR Inc. – LDPPO Utilization Review for PEBP

July 1, 2022 – June 30, 2023

DATASCOPE™

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

UMR℠

Overview

- Total Medical Spend for PY23 was $55,997,776 with a plan cost per employee per year (PEPY) of $7,606. This is a decrease of 4.3% when compared to PY22.
    - IP Cost per Admit is $24,480 which is 34.9% lower than PY22.
    - ER Cost per Visit is $3,126 which is 28.1% higher than PY22.
- Employees shared in 13.6% of the medical cost.
- Inpatient facility costs were 20.1% of the plan spend.
- 77.4% of the Average Membership had paid Medical claims less than $2,500, with 14.7% of those having no claims paid at all during the reporting period.
- 54 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 23.0% of the plan spend. The highest diagnosis category was Cancer, accounting for 34.7% of the high-cost claimant dollars.
- Total spending with in-network providers was 97.1%. The average In Network discount was 64.3%, which is 1.7% higher than the PY22 average discount of 63.2%.

Paid Claims by Age Group

Paid Claims by Age Group																
	PY22						PY23						% 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	$ 2,670,491	$ 2,618	$ 3,440	$ 3	$ 2,673,931	$ 2,622	$ 2,501,778	$ 1,345	$ 32,538	$ 17	$ 2,534,316	$ 1,363	-5.2%	-48.0%
1	$ 200,316	$ 167	$ 6,910	$ 6	$ 207,226	$ 173	$ 504,661	$ 279	$ 9,018	$ 5	$ 513,679	$ 283	147.9%	64.2%
2 - 4	$ 441,262	$ 108	$ 46,229	$ 11	$ 487,491	$ 120	$ 1,075,154	$ 167	$ 44,756	$ 7	$ 1,119,910	$ 174	129.7%	45.6%
5 - 9	$ 511,361	$ 71	$ 183,676	$ 26	$ 695,037	$ 97	$ 1,037,022	$ 88	$ 510,021	$ 43	$ 1,547,043	$ 131	122.6%	35.9%
10 - 14	$ 937,132	$ 113	$ 182,260	$ 22	$ 1,119,392	$ 135	$ 1,613,381	$ 127	$ 339,379	$ 27	$ 1,952,760	$ 154	74.4%	14.3%
15 - 19	$ 1,308,004	$ 152	$ 367,689	$ 43	$ 1,675,693	$ 195	$ 2,490,501	$ 170	$ 529,723	$ 36	$ 3,020,224	$ 207	80.2%	6.1%
20 - 24	$ 1,208,774	$ 140	$ 306,432	$ 36	$ 1,515,206	$ 176	$ 2,780,617	$ 200	$ 738,589	$ 53	$ 3,519,206	$ 253	132.3%	43.8%
25 - 29	$ 1,342,793	$ 203	$ 471,967	$ 72	$ 1,814,760	$ 275	$ 2,528,215	$ 226	$ 1,176,813	$ 105	$ 3,705,028	$ 331	104.2%	20.5%
30 - 34	$ 2,048,623	$ 262	$ 771,434	$ 99	$ 2,820,057	$ 360	$ 3,957,289	$ 299	$ 1,404,659	$ 106	$ 5,361,948	$ 405	90.1%	12.3%
35 - 39	$ 3,336,241	$ 370	$ 821,892	$ 91	$ 4,158,133	$ 461	$ 4,229,494	$ 282	$ 1,497,515	$ 100	$ 5,727,009	$ 381	37.7%	-17.3%
40 - 44	$ 3,230,859	$ 364	$ 1,076,833	$ 121	$ 4,307,692	$ 486	$ 4,705,186	$ 320	$ 2,080,302	$ 142	$ 6,785,488	$ 462	57.5%	-5.0%
45 - 49	$ 3,933,374	$ 498	$ 845,962	$ 107	$ 4,779,336	$ 605	$ 4,940,717	$ 383	$ 2,240,868	$ 174	$ 7,181,585	$ 556	50.3%	-8.1%
50 - 54	$ 2,500,999	$ 289	$ 1,380,718	$ 159	$ 3,881,717	$ 448	$ 5,958,170	$ 422	$ 2,958,706	$ 209	$ 8,916,876	$ 631	129.7%	40.9%
55 - 59	$ 4,152,582	$ 520	$ 1,197,870	$ 150	$ 5,350,452	$ 669	$ 6,680,393	$ 527	$ 2,758,808	$ 218	$ 9,439,201	$ 744	76.4%	11.2%
60 - 64	$ 4,237,914	$ 625	$ 2,160,900	$ 319	$ 6,398,814	$ 944	$ 8,807,144	$ 790	$ 3,625,065	$ 325	$ 12,432,209	$ 1,115	94.3%	18.2%
65+	$ 2,385,966	$ 938	$ 570,276	$ 224	$ 2,956,242	$ 1,162	$ 2,188,054	$ 511	$ 1,051,053	$ 245	$ 3,239,107	$ 756	9.6%	-34.9%
Total	**$ 34,446,692**	**$ 328**	**$ 10,394,487**	**$ 99**	**$ 44,841,178**	**$ 427**	**$ 55,997,776**	**$ 325**	**$ 20,997,812**	**$ 122**	**$ 76,995,588**	**$ 447**	**71.7%**	**4.5%**

Financial Summary (p. 1 of 2)

	Total			State Active			Non-State Active		
Summary	**PY22**	**PY23**	**Variance to Prior Year**	**PY22**	**PY23**	**Variance to Prior Year**	**PY22**	**PY23**	**Variance to Prior Year**
Enrollment									
Avg # Employees	4,336	7,362	69.8%	3,926	6,690	70.4%	1	1	0.0%
Avg # Members	8,762	14,368	64.0%	8,071	13,235	64.0%	2	2	0.0%
Ratio	2.0	2.0	-3.5%	2.1	2.0	-3.9%	2.0	2.0	0.0%
Financial Summary									
Gross Cost	$40,570,436	$64,817,531	59.8%	$35,366,785	$56,350,280	59.3%	$38,494	$17,911	-53.5%
Client Paid	$34,446,692	$55,997,776	62.6%	$29,933,591	$48,495,839	62.0%	$33,556	$13,953	-58.4%
Employee Paid	$6,123,744	$8,819,755	44.0%	$5,433,194	$7,854,441	44.6%	$4,938	$3,958	-19.8%
Client Paid-PEPY	$7,944	$7,606	-4.3%	$7,624	$7,249	-4.9%	$33,556	$13,953	-58.4%
Client Paid-PMPY	$3,931	$3,897	-0.9%	$3,709	$3,664	-1.2%	$16,778	$6,976	-58.4%
Client Paid-PEPM	$662	$634	-4.2%	$635	$604	-4.9%	$2,796	$1,163	-58.4%
Client Paid-PMPM	$328	$325	-0.9%	$309	$305	-1.3%	$1,398	$581	-58.4%
High Cost Claimants (HCC's) > $100k									
# of HCC's	41	54	31.7%	33	43	30.3%	0	0	0.0%
HCC's / 1,000	4.7	3.8	-19.7%	4.1	3.3	-20.5%	0.0	0.0	0.0%
Avg HCC Paid	$286,071	$238,672	-16.6%	$305,172	$238,047	-22.0%	$0	$0	0.0%
HCC's % of Plan Paid	34.0%	23.0%	-32.4%	33.6%	21.1%	-37.2%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,269	$783	-38.3%	$1,257	$725	-42.3%	$424	$0	-100.0%
Facility Outpatient	$1,043	$1,412	35.4%	$933	$1,292	38.5%	$5,152	$1,007	-80.5%
Physician	$1,567	$1,702	8.6%	$1,468	$1,647	12.2%	$9,883	$5,969	-39.6%
Other	$53	$0	-100.0%	$50	$0	-100.0%	$1,319	$0	-100.0%
Total	$3,931	$3,897	-0.9%	$3,709	$3,664	-1.2%	$16,778	$6,976	-58.4%

Financial Summary (p. 2 of 2)

	State Retirees			Non-State Retirees			
Summary	**PY22**	**PY23**	**Variance to Prior Year**	**PY22**	**PY23**	**Variance to Prior Year**	**Peer Index**
Enrollment							
Avg # Employees	388	644	66.2%	21	27	25.5%	
Avg # Members	657	1,091	66.1%	32	39	22.0%	
Ratio	1.7	1.7	0.0%	1.5	1.5	-2.6%	1.6
Financial Summary							
Gross Cost	$4,886,927	$8,012,597	64.0%	$278,229	$436,743	57.0%	
Client Paid	$4,252,910	$7,107,682	67.1%	$226,635	$380,303	67.8%	
Employee Paid	$634,017	$904,915	42.7%	$51,594	$56,440	9.4%	
Client Paid-PEPY	$10,968	$11,032	0.6%	$10,665	$14,261	33.7%	$6,642
Client Paid-PMPY	$6,473	$6,514	0.6%	$7,027	$9,669	37.6%	$4,116
Client Paid-PEPM	$914	$919	0.5%	$889	$1,188	33.6%	$553
Client Paid-PMPM	$539	$543	0.7%	$586	$806	37.5%	$343
High Cost Claimants (HCC's) > $100k							
# of HCC's	8	11	37.5%	1	1	0.0%	
HCC's / 1,000	12.2	10.1	-17.2%	31.0	25.4	-18.0%	
Avg HCC Paid	$193,399	$224,298	16.0%	$111,053	$185,019	66.6%	
HCC's % of Plan Paid	36.4%	34.7%	-4.7%	49.0%	48.7%	-0.6%	
Cost Distribution by Claim Type (PMPY)							
Facility Inpatient	$1,452	$1,476	1.7%	$675	$1,128	67.1%	$1,190
Facility Outpatient	$2,262	$2,697	19.2%	$3,333	$6,277	88.3%	$1,376
Physician	$2,676	$2,342	-12.5%	$2,969	$2,264	-23.7%	$1,466
Other	$83	$0	-100.0%	$50	$0	-100.0%	$84
Total	$6,473	$6,514	0.6%	$7,027	$9,669	37.6%	$4,116

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 11,497,713	$ 1,051,317	$ 3,435	$ 12,552,466	$ 11,601,072	$ 1,731,651	$ 34,322	$ 13,367,044	6.5%
Outpatient	$ 18,435,878	$ 3,111,169	$ 86,989	$ 21,634,036	$ 36,894,767	$ 5,134,903	$ 206,807	$ 42,236,477	95.2%
Total - Medical	**$ 29,933,591**	**$ 4,162,486**	**$ 90,424**	**$ 34,186,502**	**$ 48,495,839**	**$ 6,866,553**	**$ 241,129**	**$ 55,603,521**	**62.6%**

Net Paid Claims - Per Participant per Month	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 635	$ 960	$ 283	$ 660	$ 604	$ 952	$ 467	$ 632	-4.3%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 1,368	$ 19,252	$ 5,363	$ 25,983	$ -	$ 48,492	$ 564	$ 49,056	88.8%
Outpatient	$ 32,187	$ 156,385	$ 45,635	$ 234,207	$ 13,953	$ 114,559	$ 216,688	$ 345,200	47.4%
Total - Medical	**$ 33,556**	**$ 175,637**	**$ 50,998**	**$ 260,190**	**$ 13,953**	**$ 163,051**	**$ 217,252**	**$ 394,256**	**51.5%**

Net Paid Claims - Per Participant per Month	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 3,356	$ 1,237	$ 451	$ 982	$ 1,163	$ 1,052	$ 1,317	$ 1,188	20.9%

Paid Claims by Claim Type – Total Participants

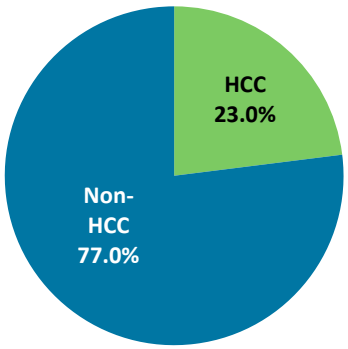
Net Paid Claims - Total Total Participants	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 11,499,081	$ 1,070,569	$ 8,799	$ 12,578,449	$ 11,601,072	$ 1,780,142	$ 34,886	$ 13,416,100	6.7%
Outpatient	$ 18,468,066	$ 3,267,554	$ 132,623	$ 21,868,243	$ 36,908,720	$ 5,249,462	$ 423,495	$ 42,581,676	94.7%
Total - Medical	**$ 29,967,147**	**$ 4,338,123**	**$ 141,422**	**$ 34,446,692**	**$ 48,509,792**	**$ 7,029,604**	**$ 458,381**	**$ 55,997,776**	**62.6%**

Net Paid Claims - Per Participant per Month	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 635	$ 969	$ 327	$ 661	$ 604	$ 954	$ 673	$ 634	-4.2%

Cost Distribution – Medical Claims

PY22							PY23					
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
37	0.4%	$11,728,917	34.0%	$214,673	3.5%	$100,000.01 Plus	47	0.3%	$12,789,533	22.8%	$211,287	2.4%
51	0.6%	$3,729,595	10.8%	$268,231	4.4%	$50,000.01-$100,000.00	81	0.6%	$6,325,231	11.3%	$361,408	4.1%
102	1.2%	$3,684,259	10.7%	$404,835	6.6%	$25,000.01-$50,000.00	198	1.4%	$7,156,895	12.8%	$756,235	8.6%
300	3.4%	$4,906,264	14.2%	$1,029,422	16.8%	$10,000.01-$25,000.00	638	4.4%	$10,590,927	18.9%	$1,838,747	20.8%
455	5.2%	$3,460,625	10.0%	$964,875	15.8%	$5,000.01-$10,000.00	830	5.8%	$6,225,819	11.1%	$1,559,993	17.7%
705	8.0%	$2,719,836	7.9%	$1,034,904	16.9%	$2,500.01-$5,000.00	1,454	10.1%	$5,554,427	9.9%	$1,625,903	18.4%
5,403	61.7%	$4,216,835	12.2%	$2,191,090	35.8%	$0.01-$2,500.00	8,922	62.1%	$7,354,945	13.1%	$2,460,696	27.9%
69	0.8%	$0	0.0%	$15,706	0.3%	$0.00	90	0.6%	$0	0.0%	$5,487	0.1%
1,641	18.7%	$362	0.0%	$10	0.0%	No Claims	2,108	14.7%	$0	0.0%	$0	0.0%
8,762	**100.0%**	**$34,446,692**	**100.0%**	**$6,123,744**	**100.0%**		**14,368**	**100.0%**	**$55,997,776**	**100.0%**	**$8,819,755**	**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	22	$4,467,968	34.7%
Endocrine/Metabolic Disorders	23	$1,321,655	10.3%
Trauma/Accidents	21	$1,204,705	9.3%
Cardiac Disorders	34	$1,114,439	8.6%
Pregnancy-related Disorders	6	$822,443	6.4%
Neurological Disorders	31	$789,059	6.1%
Medical/Surgical Complications	17	$670,852	5.2%
Renal/Urologic Disorders	23	$385,800	3.0%
Gastrointestinal Disorders	30	$371,828	2.9%
Pulmonary Disorders	30	$317,209	2.5%
All Other		$1,422,348	11.0%
Overall	**----**	**$12,888,306**	**100.0%**

Utilization Summary (p. 1 of 2)

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

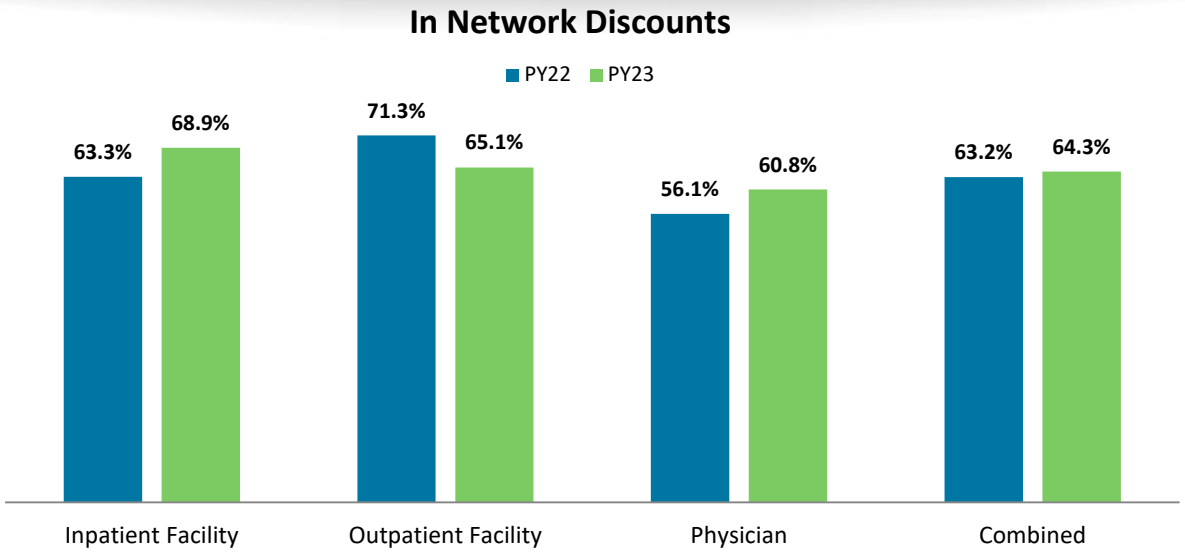
	Total			State Active			Non-State Active		
Summary	**PY22**	**PY23**	**Variance to Prior Year**	**PY22**	**PY23**	**Variance to Prior Year**	**PY22**	**PY23**	**Variance to Prior Year**
Inpatient Facility									
# of Admits	318	551		275	498		1	0	
# of Bed Days	1,769	2,359		1,628	2,125		1	0	
Paid Per Admit	$37,589	$24,480	-34.9%	$38,947	$23,382	-40.0%	$2,303	$0	-100.0%
Paid Per Day	$6,757	$5,718	-15.4%	$6,579	$5,480	-16.7%	$2,303	$0	-100.0%
Admits Per 1,000	36	38	5.6%	34	38	11.8%	500	0	-100.0%
Days Per 1,000	202	164	-18.8%	202	161	-20.3%	500	0	-100.0%
Avg LOS	5.6	4.3	-23.2%	5.9	4.3	-27.1%	1	0	-100.0%
# Admits From ER	164	266	62.2%	136	231	69.9%	0	0	0.0%
Physician Office									
OV Utilization per Member	4.7	5.1	8.5%	4.6	5	8.7%	13.0	13.5	3.8%
Avg Paid per OV	$124	$118	-4.8%	$120	$118	-1.7%	$335	$320	-4.5%
Avg OV Paid per Member	$589	$601	2.0%	$549	$583	6.2%	$4,351	$4,315	-0.8%
DX&L Utilization per Member	8.1	10.3	27.2%	7.8	9.9	26.9%	27.5	30	9.1%
Avg Paid per DX&L	$51	$60	17.6%	$49	$59	20.4%	$94	$54	-42.6%
Avg DX&L Paid per Member	$419	$618	47.5%	$382	$583	52.6%	$2,574	$1,628	-36.8%
Emergency Room									
# of Visits	1,170	2,129		1,090	1,957		1	0	
Visits Per Member	0.13	0.15	15.4%	0.14	0.15	7.1%	0.5	0	-100.0%
Visits Per 1,000	134	148	10.4%	135	148	9.6%	500	0	-100.0%
Avg Paid per Visit	$2,440	$3,126	28.1%	$2,425	$3,152	30.0%	$5,209	$0	-100.0%
Urgent Care									
# of Visits	2,734	5,111		2,578	4,843		0	3	
Visits Per Member	0.31	0.36	16.1%	0.32	0.37	15.6%	0.00	1.50	0.0%
Visits Per 1,000	312	356	14.1%	319	366	14.7%	0	1,500	0.0%
Avg Paid per Visit	$120	$98	-18.3%	$119	$98	-17.6%	$0	$159	0.0%

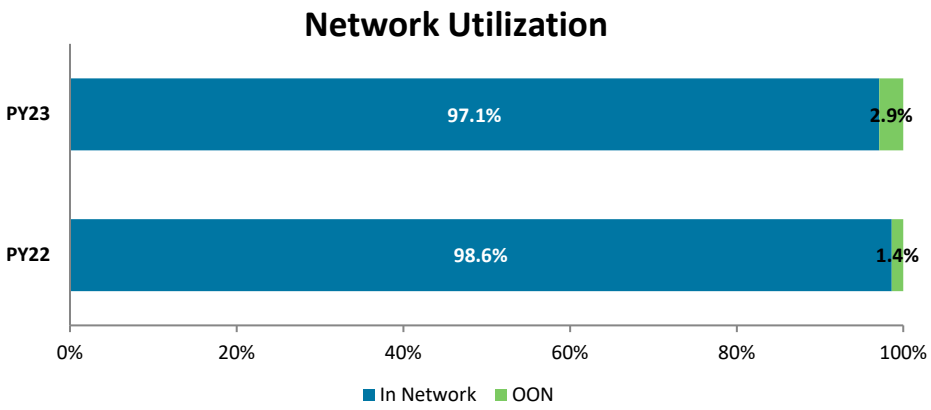
Utilization Summary (p. 2 of 2)

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

	State Retirees			Non-State Retirees			
Summary	**PY22**	**PY23**	**Variance to Prior Year**	**PY22**	**PY23**	**Variance to Prior Year**	**Peer Index**
Inpatient Facility							
# of Admits	35	52		7	1		
# of Bed Days	119	231		21	3		
Paid Per Admit	$33,826	$34,536	2.1%	$8,120	$48,492	497.2%	$18,822
Paid Per Day	$9,949	$7,774	-21.9%	$2,707	$16,164	497.1%	$3,265
Admits Per 1,000	53	48	-9.4%	217	25	-88.5%	70
Days Per 1,000	181	212	17.1%	651	76	-88.3%	402
Avg LOS	3.4	4.4	29.4%	3.0	3.0	0.0%	5.8
# Admits From ER	24	35	45.8%	4	0	-100.0%	
Physician Office							
OV Utilization per Member	6.4	6.7	4.7%	7.5	8.1	8.0%	5.4
Avg Paid per OV	$166	$120	-27.7%	$96	$89	-7.3%	$96
Avg OV Paid per Member	$1,059	$802	-24.3%	$721	$719	-0.3%	$515
DX&L Utilization per Member	12.5	14.9	19.2%	12.3	19.9	61.8%	11.0
Avg Paid per DX&L	$67	$69	3.0%	$78	$68	-12.8%	$50
Avg DX&L Paid per Member	$835	$1,020	22.2%	$954	$1,361	42.7%	$543
Emergency Room							
# of Visits	78	166		1	6		
Visits Per Member	0.12	0.15	25.0%	0.03	0.15	400.0%	0.22
Visits Per 1,000	119	152	27.7%	31	153	393.5%	221
Avg Paid per Visit	$2,622	$2,895	10.4%	$1,827	$961	-47.4%	$968
Urgent Care							
# of Visits	154	254		2	11		
Visits Per Member	0.23	0.23	0.0%	0.06	0.28	366.7%	0.35
Visits Per 1,000	234	233	-0.4%	62	280	351.6%	352
Avg Paid per Visit	$143	$100	-30.1%	$70	$64	-8.6%	$135

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$5,919,589	10.6%	$3,350,477	$2,415,613	$153,499	$1,916,120	$4,003,470
Gastrointestinal Disorders	$4,753,062	8.5%	$3,151,637	$949,916	$651,509	$1,613,939	$3,139,123
Health Status/Encounters	$4,549,871	8.1%	$2,500,667	$617,721	$1,431,483	$1,579,499	$2,970,372
Pregnancy-related Disorders	$4,042,412	7.2%	$1,696,556	$594,125	$1,751,731	$988,376	$3,054,036
Trauma/Accidents	$3,843,913	6.9%	$1,552,587	$1,377,613	$913,713	$1,499,211	$2,344,702
Cardiac Disorders	$3,603,221	6.4%	$2,323,177	$952,293	$327,751	$2,001,970	$1,601,251
Mental Health	$3,473,262	6.2%	$1,514,931	$528,695	$1,429,636	$1,289,047	$2,184,215
Neurological Disorders	$3,274,500	5.8%	$1,893,044	$568,634	$812,822	$1,069,799	$2,204,701
Musculoskeletal Disorders	$3,192,512	5.7%	$2,096,122	$682,211	$414,180	$1,211,907	$1,980,605
Eye/ENT Disorders	$2,583,932	4.6%	$1,333,977	$315,348	$934,607	$1,027,083	$1,556,849
Endocrine/Metabolic Disorders	$2,581,365	4.6%	$1,761,756	$628,727	$190,882	$492,209	$2,089,156
Spine-related Disorders	$1,977,875	3.5%	$1,441,889	$409,377	$126,610	$1,018,652	$959,223
Gynecological/Breast Disorders	$1,902,158	3.4%	$1,306,150	$372,183	$223,826	$45,261	$1,856,898
Pulmonary Disorders	$1,839,762	3.3%	$840,801	$349,474	$649,487	$984,348	$855,414
Renal/Urologic Disorders	$1,543,984	2.8%	$896,116	$308,528	$339,340	$578,812	$965,172
Infections	$1,438,677	2.6%	$774,575	$198,225	$465,877	$694,881	$743,796
Non-malignant Neoplasm	$968,082	1.7%	$710,505	$218,782	$38,796	$216,102	$751,980
Medical/Surgical Complications	$926,217	1.7%	$736,763	$83,269	$106,184	$491,841	$434,376
Dermatological Disorders	$604,659	1.1%	$358,310	$99,700	$146,648	$247,315	$357,343
Miscellaneous	$541,940	1.0%	$321,790	$92,029	$128,122	$200,966	$340,975
Diabetes	$521,960	0.9%	$320,288	$149,581	$52,091	$283,828	$238,132
Abnormal Lab/Radiology	$415,946	0.7%	$306,412	$84,543	$24,992	$127,549	$288,397
Congenital/Chromosomal Anomalies	$400,970	0.7%	$37,655	$147,778	$215,537	$314,709	$86,261
Hematological Disorders	$368,505	0.7%	$260,556	$51,876	$56,073	$171,205	$197,300
Vascular Disorders	$286,710	0.5%	$140,465	$131,365	$14,881	$155,000	$131,710
Medication Related Conditions	$168,078	0.3%	$85,781	$9,196	$73,102	$70,918	$97,160
Cholesterol Disorders	$161,613	0.3%	$128,403	$28,114	$5,096	$82,510	$79,102
Allergic Reaction	$59,120	0.1%	$16,964	$7,973	$34,183	$15,061	$44,059
External Hazard Exposure	$27,854	0.0%	$11,597	$374	$15,882	$5,920	$21,934
Dental Conditions	$23,970	0.0%	$6,522	$2,200	$15,249	$11,678	$12,292
Social Determinants of Health	$1,690	0.0%	$1,580	$110	$0	$435	$1,255
Cause of Morbidity	$367	0.0%	$26	$61	$280	$280	$87
Total	**$55,997,776**	**100.0%**	**$31,878,076**	**$12,375,632**	**$11,744,069**	**$20,406,433**	**$35,591,344**

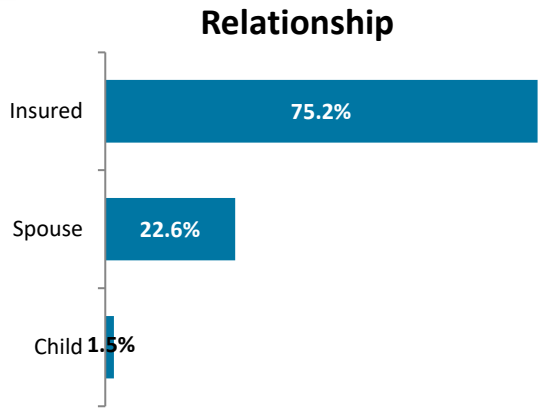
Mental Health Drilldown

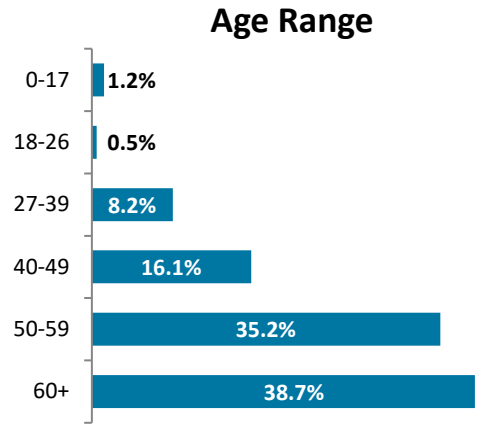
	PY22		PY23	
Grouper	Patients	Total Paid	Patients	Total Paid
Depression	453	$568,975	883	$898,381
Mood and Anxiety Disorders	613	$271,735	1,144	$681,784
Mental Health Conditions, Other	431	$351,519	805	$558,645
Alcohol Abuse/Dependence	20	$75,926	77	$344,280
Developmental Disorders	59	$215,640	108	$250,524
Bipolar Disorder	107	$247,201	189	$253,234
Attention Deficit Disorder	199	$80,894	414	$132,119
Eating Disorders	24	$147,776	44	$141,298
Schizophrenia	4	$2,259	12	$47,488
Sleep Disorders	124	$26,517	242	$63,421
Substance Abuse/Dependence	29	$68,285	51	$34,292
Sexually Related Disorders	28	$8,553	55	$30,340
Psychoses	6	$10,965	17	$18,602
Personality Disorders	14	$15,495	17	$12,003
Tobacco Use Disorder	16	$4,458	54	$3,385
Complications of Substance Abuse	6	$27,466	13	$3,466
Total		**$2,123,665**		**$3,473,262**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	33	211	$3,138,596	53.0%
Breast Cancer	85	993	$943,790	15.9%
Secondary Cancers	25	207	$281,607	4.8%
Cancers, Other	59	426	$270,505	4.6%
Brain Cancer	5	173	$255,238	4.3%
Non-Melanoma Skin Cancers	89	292	$254,136	4.3%
Prostate Cancer	31	288	$158,701	2.7%
Thyroid Cancer	32	165	$140,242	2.4%
Colon Cancer	10	163	$135,003	2.3%
Lymphomas	20	306	$110,111	1.9%
Leukemias	7	116	$43,513	0.7%
Carcinoma in Situ	42	113	$43,085	0.7%
Cervical/Uterine Cancer	14	53	$38,645	0.7%
Lung Cancer	10	137	$35,053	0.6%
Kidney Cancer	12	44	$26,424	0.4%
Melanoma	24	59	$21,052	0.4%
Myeloma	2	60	$18,680	0.3%
Pancreatic Cancer	2	41	$4,437	0.1%
Ovarian Cancer	4	9	$743	0.0%
Bladder Cancer	1	1	$29	0.0%
Overall	**----**	**----**	**$5,919,589**	**100.0%**

*Patient and claim counts are unique only within the category

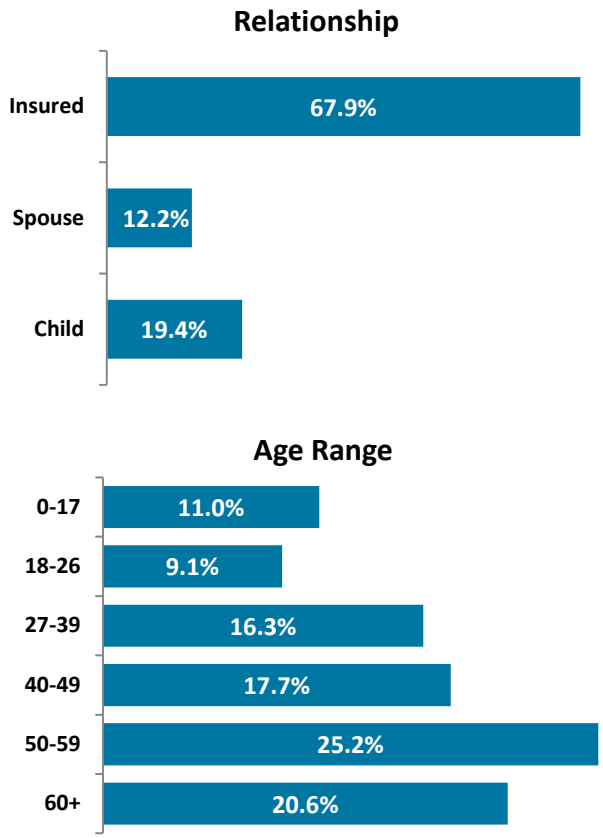




Diagnosis Grouper – Gastrointestinal Orders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Abdominal Disorders	1,108	2,833	$891,093	18.7%
GI Disorders, Other	577	1,438	$853,206	18.0%
Gallbladder and Biliary Disease	114	515	$637,565	13.4%
Upper GI Disorders	560	1,349	$524,004	11.0%
Hernias	111	348	$440,211	9.3%
GI Symptoms	692	1,448	$363,739	7.7%
Inflammatory Bowel Disease	65	349	$210,919	4.4%
Diverticulitis	93	211	$201,205	4.2%
Appendicitis	15	79	$196,221	4.1%
Pancreatic Disorders	24	111	$116,594	2.5%
Constipation	199	376	$92,615	1.9%
Liver Diseases	221	448	$81,796	1.7%
Ostomies	12	104	$63,330	1.3%
Hemorrhoids	134	252	$47,481	1.0%
Peptic Ulcer/Related Disorders	28	51	$23,563	0.5%
Hepatic Cirrhosis	15	35	$7,562	0.2%
Esophageal Varices	3	4	$1,959	0.0%
	----	----	$4,753,062	100.0%

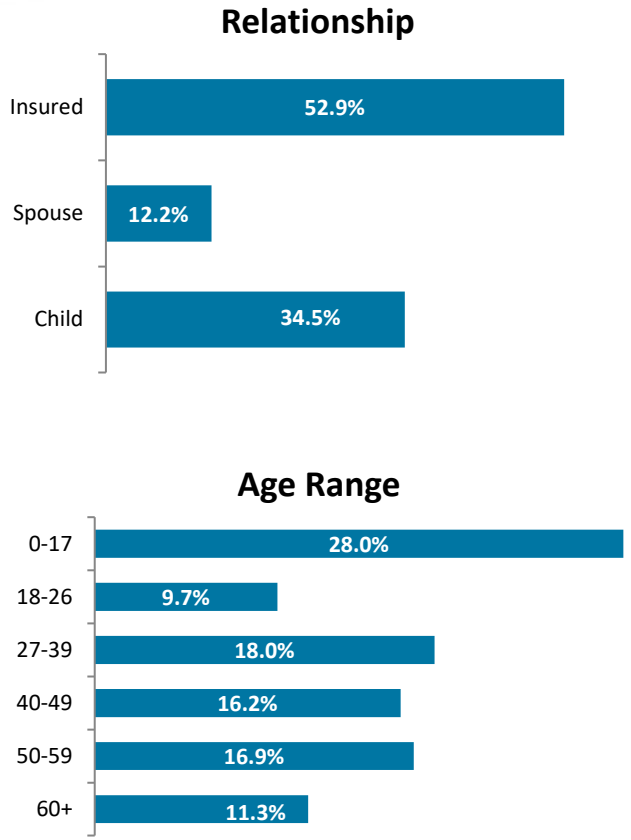
*Patient and claim counts are unique only within the category



Diagnosis Grouper – Health Status/Encounters

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Screenings	4,006	8,501	$1,368,317	30.1%
Exams	5,340	10,541	$1,146,117	25.2%
Prophylactic Measures	2,866	4,178	$827,522	18.2%
Encounters - Infants/Children	2,273	3,685	$541,828	11.9%
Personal History of Condition	503	1,009	$206,397	4.5%
Prosthetics/Devices/Implants	217	745	$156,337	3.4%
Family History of Condition	146	217	$88,998	2.0%
Aftercare	229	491	$81,552	1.8%
Follow-Up Encounters	5	17	$48,804	1.1%
Encounter - Procedure	67	85	$39,050	0.9%
Encounter - Transplant Related	14	93	$18,456	0.4%
Lifestyle/Situational Issues	58	126	$8,453	0.2%
Counseling	118	200	$7,638	0.2%
Acquired Absence	17	25	$4,634	0.1%
Donors	3	3	$2,625	0.1%
Miscellaneous Examinations	26	53	$1,755	0.0%
Health Status, Other	63	76	$1,389	0.0%
Overall	**----**	**----**	**$4,549,871**	**689.5%**

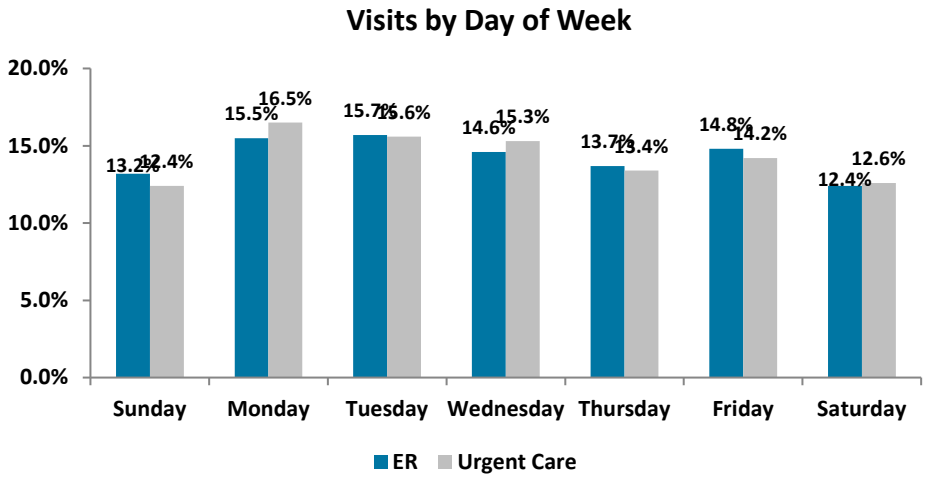
*Patient and claim counts are unique only within the category

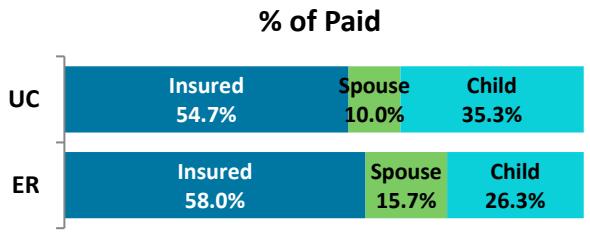


Emergency Room / Urgent Care Summary

	PY22		PY23		Peer Index	
ER/Urgent Care	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	1,170	2,734	2,129	5,111		
Visits Per Member	0.13	0.31	0.15	0.36	0.22	0.35
Visits/1000 Members	134	312	148	356	221	352
Avg Paid Per Visit	$2,440	$120	$3,126	$98	$968	$135
% with OV*	79.7%	77.0%	82.2%	76.7%		
% Avoidable	12.4%	36.0%	15.4%	43.2%		
Total Member Paid	**$699,986**	**$190,525**	**$1,416,716**	**$374,175**		
Total Plan Paid	**$2,854,800**	**$328,080**	**$6,655,359**	**$501,260**		

*looks back 12 months from ER visit





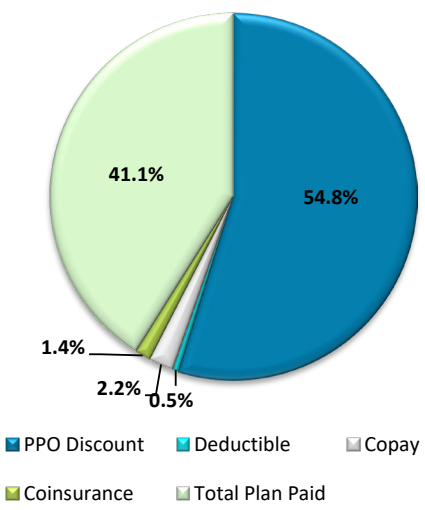
ER / UC Visits by Relationship						
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	1,107	150	2,768	376	3,875	526
Spouse	288	160	525	292	813	452
Child	734	141	1,818	349	2,552	490
Total	**2,129**	**148**	**5,111**	**356**	**7,240**	**504**

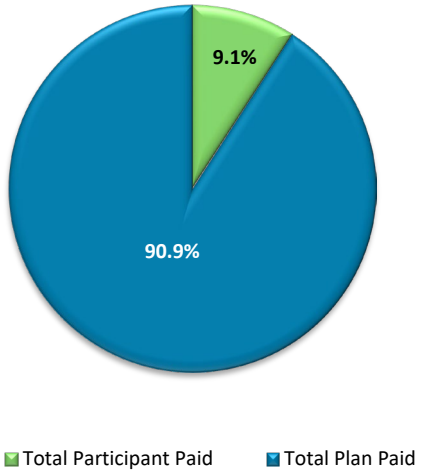
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$182,693,585	$4,417	100.0%
PPO Discount	$115,042,749	$2,781	63.0%
Deductible	$0	$0	0.0%
Copay	$4,911,538	$119	2.7%
Coinsurance	$3,908,216	$94	2.1%
Total Participant Paid	**$8,819,754**	**$213**	**4.8%**
Total Plan Paid	**$55,997,776**	**$634**	**30.7%**

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	714	692	22	96.9%
	<2 asthma related ER Visits in the last 6 months	714	713	1	99.9%
	No asthma related admit in last 12 months	714	707	7	99.0%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	65	61	4	93.8%
	Members with COPD who had an annual spirometry test	65	12	53	18.5%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	3	3	0	100.0%
	No ER Visit for Heart Failure in last 90 days	66	64	2	97.0%
	Follow-up OV within 4 weeks of discharge from HF admission	3	3	0	100.0%
Diabetes	Annual office visit	753	739	14	98.1%
	Annual dilated eye exam	753	272	481	36.1%
	Annual foot exam	753	336	417	44.6%
	Annual HbA1c test done	753	636	117	84.5%
	Diabetes Annual lipid profile	753	580	173	77.0%
	Annual microalbumin urine screen	753	525	228	69.7%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	1,961	1,650	311	84.1%
Hypertension	Annual lipid profile	1,754	1,346	408	76.7%
	Annual serum creatinine test	1,501	1,291	210	86.0%
Wellness	Well Child Visit - 15 months	144	130	14	90.3%
	Routine office visit in last 6 months (All Ages)	15,231	9,989	5,242	65.6%
	Colorectal cancer screening ages 45-75 within the appropriate time period	4,791	2,099	2,692	43.8%
	Women age 25-65 with recommended cervical cancer/HPV screening	5,049	3,179	1,870	63.0%
	Males age greater than 49 with PSA test in last 24 months	1,529	759	770	49.6%
	Routine exam in last 24 months (All Ages)	15,231	12,604	2,627	82.8%
	Women age 40 to 75 with a screening mammogram last 24 months	3,582	2,101	1,481	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**

Chronic Condition	# With Condition	% of Members	Members per 1,000	Admits per 1,000	ER Visits per 1,000	PMPY
Affective Psychosis	152	1.00%	10.58	238.64	502.84	$12,655
Asthma	767	5.03%	53.39	102.23	435.37	$13,848
Atrial Fibrillation	103	0.68%	7.17	283.08	516.92	$22,943
Blood Disorders	783	5.14%	54.50	234.52	424.54	$22,314
CAD	198	1.30%	13.78	231.97	451.41	$24,897
COPD	62	0.41%	4.32	418.85	691.10	$33,881
Cancer	419	2.75%	29.17	142.79	282.66	$29,104
Chronic Pain	365	2.40%	25.41	137.12	489.72	$22,098
Congestive Heart Failure	65	0.43%	4.52	594.25	747.60	$52,829
Demyelinating Diseases	40	0.26%	2.78	144.93	231.88	$49,480
Depression	1,288	8.45%	89.65	136.48	332.35	$11,015
Diabetes	785	5.15%	54.64	111.35	283.03	$17,223
ESRD	7	0.05%	0.49	947.37	947.37	$72,230
Eating Disorders	81	0.53%	5.64	212.53	523.16	$14,119
HIV/AIDS	18	0.12%	1.25	86.96	260.87	$40,338
Hyperlipidemia	2,353	15.44%	163.79	69.69	206.37	$12,170
Hypertension	1,767	11.60%	123.00	98.84	318.94	$13,573
Immune Disorders	83	0.54%	5.78	271.57	390.38	$50,583
Inflammatory Bowel Disease	71	0.47%	4.94	163.71	278.31	$25,546
Liver Diseases	303	1.99%	21.09	198.58	567.38	$21,070
Morbid Obesity	483	3.17%	33.62	200.67	401.34	$16,994
Osteoarthritis	441	2.89%	30.70	112.06	387.68	$16,388
Peripheral Vascular Disease	42	0.28%	2.92	249.35	374.03	$15,160
Rheumatoid Arthritis	101	0.66%	7.03	117.01	468.04	$33,186

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

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.

Appendix C

Index of Tables

UMR Inc. – EPO Utilization Review for PEBP

July 1, 2022 – June 30, 2023

DATASCOPE™

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

UMR℠

Overview

- Total Medical Spend for PY23 was $42,257,152 with a plan cost per employee per year (PEPY) of $12,259. This is an increase of 25.4% when compared to PY22.
  - IP Cost per Admit is $35,238 which is 1.6% higher than PY22.
  - ER Cost per Visit is $3,089 which is 54.2% higher than PY22.
- Employees shared in 9.1% of the medical cost.
- Inpatient facility costs were 27.4% of the plan spend.
- 68.6% of the Average Membership had paid Medical claims less than $2,500, with 9.9% having no claims paid at all during the reporting period.
- 54 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 32.9% of the plan spend. The highest diagnosis category was Cancer, accounting for 30.6% of the high-cost claimant dollars.
- Total spending with in-network providers was 100.0%. The average In Network discount was 54.9%, which is 8.3% lower than the PY22 average discount of 59.9%.

Paid Claims by Age Group

Paid Claims by Age Group																
	PY22						PY23						% 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	$ 2,127,155	$ 2,497	$ 4,190	$ 5	$ 2,131,345	$ 2,502	$ 2,371,577	$ 2,823	$ 16,074	$ 19	$ 2,387,651	$ 2,842	12.0%	13.6%
1	$ 252,827	$ 293	$ 2,975	$ 3	$ 255,802	$ 296	$ 276,620	$ 397	$ 1,567	$ 2	$ 278,187	$ 400	8.8%	35.0%
2 - 4	$ 501,660	$ 167	$ 14,723	$ 5	$ 516,383	$ 172	$ 709,797	$ 291	$ 15,497	$ 6	$ 725,294	$ 298	40.5%	73.0%
5 - 9	$ 441,983	$ 90	$ 58,755	$ 12	$ 500,738	$ 102	$ 372,847	$ 89	$ 68,943	$ 16	$ 441,790	$ 105	-11.8%	3.9%
10 - 14	$ 889,379	$ 135	$ 207,855	$ 32	$ 1,097,234	$ 167	$ 1,002,695	$ 178	$ 154,711	$ 27	$ 1,157,406	$ 206	5.5%	23.0%
15 - 19	$ 1,813,654	$ 230	$ 391,570	$ 50	$ 2,205,224	$ 279	$ 1,773,288	$ 264	$ 646,020	$ 96	$ 2,419,308	$ 361	9.7%	29.1%
20 - 24	$ 1,285,167	$ 181	$ 338,365	$ 48	$ 1,623,532	$ 229	$ 1,394,464	$ 222	$ 228,294	$ 36	$ 1,622,758	$ 258	0.0%	12.7%
25 - 29	$ 1,077,001	$ 331	$ 832,648	$ 256	$ 1,909,649	$ 587	$ 1,192,563	$ 460	$ 282,774	$ 109	$ 1,475,337	$ 569	-22.7%	-3.1%
30 - 34	$ 1,584,536	$ 369	$ 522,926	$ 122	$ 2,107,462	$ 491	$ 1,499,139	$ 432	$ 1,514,655	$ 437	$ 3,013,794	$ 869	43.0%	77.1%
35 - 39	$ 2,965,628	$ 502	$ 732,210	$ 124	$ 3,697,838	$ 626	$ 3,337,786	$ 692	$ 841,512	$ 174	$ 4,179,298	$ 866	13.0%	38.3%
40 - 44	$ 2,044,597	$ 338	$ 1,732,096	$ 286	$ 3,776,693	$ 624	$ 2,992,652	$ 580	$ 1,539,679	$ 298	$ 4,532,331	$ 878	20.0%	40.7%
45 - 49	$ 3,389,003	$ 495	$ 1,176,602	$ 172	$ 4,565,605	$ 666	$ 2,464,377	$ 431	$ 1,465,368	$ 256	$ 3,929,745	$ 687	-13.9%	3.0%
50 - 54	$ 3,795,666	$ 447	$ 2,177,505	$ 256	$ 5,973,171	$ 703	$ 5,159,525	$ 662	$ 2,069,596	$ 266	$ 7,229,121	$ 928	21.0%	32.0%
55 - 59	$ 7,416,060	$ 835	$ 2,374,310	$ 267	$ 9,790,370	$ 1,103	$ 5,756,991	$ 751	$ 2,528,164	$ 330	$ 8,285,155	$ 1,080	-15.4%	-2.0%
60 - 64	$ 6,933,282	$ 672	$ 3,862,693	$ 374	$ 10,795,975	$ 1,046	$ 8,456,113	$ 961	$ 3,714,588	$ 422	$ 12,170,701	$ 1,384	12.7%	32.3%
65+	$ 2,803,190	$ 613	$ 1,859,828	$ 407	$ 4,663,018	$ 1,020	$ 3,496,720	$ 825	$ 1,732,013	$ 409	$ 5,228,733	$ 1,234	12.1%	21.0%
Total	**$ 39,320,787**	**$ 437**	**$ 16,289,250**	**$ 181**	**$ 55,610,038**	**$ 618**	**$ 42,257,152**	**$ 548**	**$ 16,819,453**	**$ 218**	**$ 59,076,605**	**$ 766**	**6.2%**	**23.9%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**
Enrollment												
Avg # Employees	4,635	4,021	3,447	-14.3%	3,934	3,370	2,876	-14.7%	4	3	2	-29.3%
Avg # Members	8,519	7,491	6,421	-14.3%	7,566	6,579	5,601	-14.9%	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	$46,490,212	5.2%	$45,628,807	$37,820,607	$38,595,575	2.0%	$41,511	$4,744	$4,201	-11.4%
Client Paid	$53,783,772	$39,320,787	$42,257,152	7.5%	$42,531,149	$33,797,612	$35,128,252	3.9%	$39,013	$3,622	$3,335	-7.9%
Employee Paid	$3,747,895	$4,866,255	$4,233,060	-13.0%	$3,097,659	$4,022,996	$3,467,323	-13.8%	$2,498	$1,122	$866	-22.8%
Client Paid-PEPY	$11,605	$9,779	$12,259	25.4%	$10,811	$10,030	$12,216	21.8%	$9,753	$1,278	$1,667	30.4%
Client Paid-PMPY	$6,314	$5,249	$6,581	25.4%	$5,621	$5,137	$6,272	22.1%	$9,003	$1,278	$1,667	30.4%
Client Paid-PEPM	$967	$815	$1,022	25.4%	$901	$836	$1,018	21.8%	$813	$107	$139	29.9%
Client Paid-PMPM	$526	$437	$548	25.4%	$468	$428	$523	22.2%	$750	$107	$139	29.9%
High Cost Claimants (HCC's) > $100k												
# of HCC's	58	46	54	17.4%	43	40	43	7.5%	0	0	0	0.0%
HCC's / 1,000	6.8	6.1	8.4	37.0%	5.7	6.1	7.7	26.3%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$290,301	$237,083	$257,429	8.6%	$270,803	$246,357	$257,598	4.6%	$0	$0	$0	0.0%
HCC's % of Plan Paid	31.3%	27.7%	32.9%	18.8%	27.4%	29.2%	31.5%	7.9%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,531	$1,432	$1,804	26.0%	$1,194	$1,437	$1,735	20.7%	$0	$0	$0	0.0%
Facility Outpatient	$1,988	$1,442	$2,319	60.8%	$1,813	$1,382	$2,176	57.5%	$4,568	$27	$158	485.2%
Physician	$2,609	$2,259	$2,458	8.8%	$2,458	$2,209	$2,361	6.9%	$3,917	$1,142	$1,510	32.2%
Other	$185	$116	$0	-100.0%	$156	$109	$0	-100.0%	$518	$109	$0	-100.0%
Total	$6,314	$5,249	$6,581	25.4%	$5,621	$5,137	$6,272	22.1%	$9,003	$1,278	$1,667	30.4%

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**Peer Index**
Enrollment									
Avg # Employees	574	564	509	-9.8%	122	85	61	-28.1%	
Avg # Members	791	796	731	-8.2%	158	114	87	-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	$8,174,556	$5,794,991	$7,535,647	30.0%	$3,686,792	$566,699	$354,790	-37.4%	
Client Paid	$7,625,090	$5,071,309	$6,861,336	35.3%	$3,588,520	$448,244	$264,230	-41.1%	
Employee Paid	$549,466	$723,682	$674,311	-6.8%	$98,272	$118,455	$90,560	-23.5%	
Client Paid-PEPY	$13,276	$8,998	$13,493	50.0%	$29,354	$5,279	$4,326	-18.1%	$6,642
Client Paid-PMPY	$9,643	$6,373	$9,392	47.4%	$22,748	$3,946	$3,023	-23.4%	$4,116
Client Paid-PEPM	$1,106	$750	$1,124	49.9%	$2,446	$440	$360	-18.2%	$553
Client Paid-PMPM	$804	$531	$783	47.5%	$1,896	$329	$252	-23.4%	$343
High Cost Claimants (HCC's) > $100k									
# of HCC's	15	8	12	50.0%	2	0	0	0.0%	
HCC's / 1,000	19.0	10.1	16.4	63.5%	12.7	0.0	0.0	0.0%	
Avg HCC Paid	$144,889	$131,446	$235,373	79.1%	$1,509,798	$0	$0	0.0%	
HCC's % of Plan Paid	28.5%	20.7%	41.2%	99.0%	84.1%	0.0%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,565	$1,443	$2,534	75.6%	$17,532	$1,101	$183	-83.4%	$1,190
Facility Outpatient	$3,680	$2,015	$3,585	77.9%	$1,836	$940	$1,007	7.1%	$1,376
Physician	$3,977	$2,742	$3,273	19.4%	$2,993	$1,800	$1,832	1.8%	$1,466
Other	$420	$174	$0	-100.0%	$388	$106	$0	-100.0%	$84
Total	$9,643	$6,373	$9,392	47.4%	$22,748	$3,946	$3,023	-23.4%	$4,116

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 11,194,084	$ 1,290,181	$ 11,395	$ 12,495,660	$ 11,494,351	$ 1,267,256	$ 801,113	$ 13,562,720	8.5%
Outpatient	$ 22,603,528	$ 3,481,267	$ 288,466	$ 26,373,261	$ 23,633,901	$ 4,467,417	$ 325,550	$ 28,426,868	7.8%
Total - Medical	**$ 33,797,612**	**$ 4,771,448**	**$ 299,861**	**$ 38,868,921**	**$ 35,128,252**	**$ 5,734,673**	**$ 1,126,663**	**$ 41,989,588**	**8.0%**

Net Paid Claims - Per Participant per Month	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 837	$ 810	$ 344	$ 824	$ 1,018	$ 1,085	$ 1,382	$ 1,034	25.4%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 36,771	$ 95,905	$ 132,676	$ -	$ 14,081	$ 4,746	$ 18,827	-85.8%
Outpatient	$ 3,622	$ 159,667	$ 155,900	$ 319,190	$ 3,335	$ 78,421	$ 166,982	$ 248,738	-22.1%
Total - Medical	**$ 3,622**	**$ 196,439**	**$ 251,805**	**$ 451,866**	**$ 3,335**	**$ 92,502**	**$ 171,728**	**$ 267,565**	**-40.8%**

Net Paid Claims - Per Participant per Month	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 107	$ 483	$ 411	$ 429	$ 139	$ 554	$ 303	$ 353	-17.6%

Paid Claims by Claim Type – Total

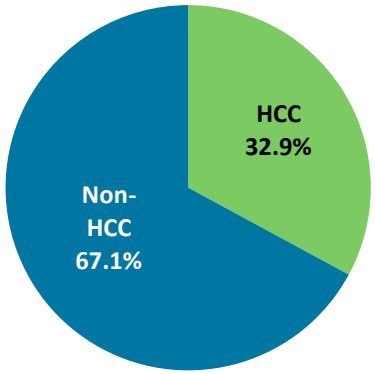
Net Paid Claims - Total Total Participants	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 11,194,084	$ 1,326,952	$ 107,300	$ 12,628,336	$ 11,494,351	$ 1,281,337	$ 805,859	$ 13,581,547	7.5%
Outpatient	$ 22,607,150	$ 3,640,934	$ 444,366	$ 26,692,451	$ 23,637,236	$ 4,545,838	$ 492,532	$ 28,675,605	7.4%
Total - Medical	**$ 33,801,234**	**$ 4,967,887**	**$ 551,666**	**$ 39,320,787**	**$ 35,131,586**	**$ 5,827,175**	**$ 1,298,391**	**$ 42,257,152**	**7.5%**

Net Paid Claims - Per Participant per Month	PY22				PY23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 836	$ 789	$ 372	$ 816	$ 1,017	$ 1,068	$ 940	$ 1,022	25.2%

Cost Distribution – Medical Claims

PY22							PY23					
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
40	0.5%	$10,905,829	27.7%	$151,891	3.1%	$100,000.01 Plus	50	0.8%	$13,901,178	32.9%	$215,964	5.1%
63	0.8%	$4,436,365	11.3%	$236,743	4.9%	$50,000.01-$100,000.00	67	1.0%	$4,962,218	11.7%	$231,401	5.5%
151	2.0%	$5,346,850	13.6%	$466,736	9.6%	$25,000.01-$50,000.00	199	3.1%	$6,991,359	16.5%	$548,257	13.0%
407	5.4%	$6,595,427	16.8%	$872,594	17.9%	$10,000.01-$25,000.00	386	6.0%	$6,197,687	14.7%	$770,272	18.2%
577	7.7%	$4,319,187	11.0%	$915,043	18.8%	$5,000.01-$10,000.00	536	8.4%	$3,908,538	9.2%	$774,562	18.3%
947	12.6%	$3,477,204	8.8%	$884,834	18.2%	$2,500.01-$5,000.00	774	12.0%	$2,905,516	6.9%	$707,442	16.7%
4,511	60.2%	$4,238,401	10.8%	$1,334,890	27.4%	$0.01-$2,500.00	3,713	57.8%	$3,390,658	8.0%	$984,390	23.3%
24	0.3%	$0	0.0%	$3,484	0.1%	$0.00	60	0.9%	$0	0.0%	$772	0.0%
770	10.3%	$1,525	0.0%	$40	0.0%	No Claims	636	9.9%	$0	0.0%	$0	0.0%
7,491	**100.0%**	**$39,320,787**	**100.0%**	**$4,866,255**	**100.0%**		**6,421**	**100.0%**	**$42,257,152**	**100.0%**	**$4,233,060**	**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	25	$4,247,764	30.6%
Cardiac Disorders	39	$1,899,781	13.7%
Pregnancy-related Disorders	3	$1,446,337	10.4%
Infections	22	$862,853	6.2%
Trauma/Accidents	20	$850,107	6.1%
Medical/Surgical Complications	16	$766,010	5.5%
Hematological Disorders	21	$723,350	5.2%
Gastrointestinal Disorders	32	$637,150	4.6%
Endocrine/Metabolic Disorders	32	$462,533	3.3%
Neurological Disorders	31	$368,957	2.7%
All Other		$1,636,336	11.8%
Overall	**----**	**$13,901,178**	**100.0%**

Utilization Summary (p. 1 of 2)

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

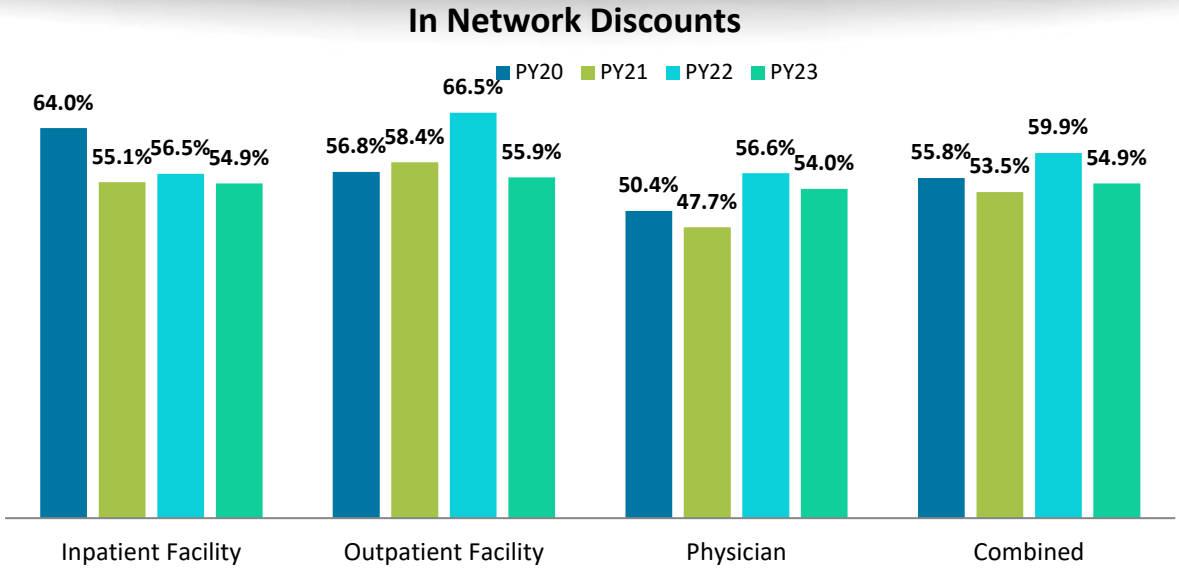
	Total				State Active				Non-State Active			
Summary	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	469	397	381		389	344	318		0	0	0	
# of Bed Days	3,065	2,419	1,912		2,295	2,081	1,540		0	0	0	
Paid Per Admit	$37,611	$34,699	$35,238	1.6%	$31,958	$35,114	$35,521	1.2%	$0	$0	$0	0.0%
Paid Per Day	$5,755	$5,695	$7,022	23.3%	$5,417	$5,805	$7,335	26.4%	$0	$0	$0	0.0%
Admits Per 1,000	55	53	59	11.3%	51	52	57	9.6%	0	0	0	0.0%
Days Per 1,000	360	323	298	-7.7%	303	316	275	-13.0%	0	0	0	0.0%
Avg LOS	6.5	6.1	5.0	-18.0%	5.9	6.0	4.8	-20.0%	0.0	0.0	0.0	0.0%
# Admits From the ER	244	205	176	-14.1%	187	167	141	-15.6%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	6.2	5.7	5.6	-1.8%	6.0	5.5	5.5	0.0%	4.8	5.3	5.0	-5.7%
Avg Paid per OV	$148	$151	$162	7.3%	$150	$152	$165	8.6%	$146	$169	$129	-23.7%
Avg OV Paid per Member	$910	$860	$915	6.4%	$892	$840	$902	7.4%	$706	$894	$645	-27.9%
DX&L Utilization per Member	10.4	9.6	11.7	21.9%	9.9	9.2	11.1	20.7%	16.4	5.6	22	292.9%
Avg Paid per DX&L	$69	$59	$70	18.6%	$68	$60	$71	18.3%	$56	$29	$17	-41.4%
Avg DX&L Paid per Member	$718	$569	$819	43.9%	$671	$551	$787	42.8%	$918	$165	$385	133.3%
Emergency Room												
# of Visits	1,383	1,327	1,196		1,209	1,139	1,009		2	0	0	
Visits Per Member	0.16	0.18	0.19	5.6%	0.16	0.17	0.18	5.9%	0.46	0.00	0.00	0.0%
Visits Per 1,000	162	177	186	5.1%	160	173	180	4.0%	462	0	0	0.0%
Avg Paid per Visit	$2,521	$2,003	$3,089	54.2%	$2,499	$1,972	$3,169	60.7%	$10,325	$0	$0	0.0%
Urgent Care												
# of Visits	2,546	3,025	2,649		2,318	2,733	2,395		1	0	0	
Visits Per Member	0.30	0.40	0.41	2.5%	0.31	0.42	0.43	2.4%	0.23	0.00	0.00	0.0%
Visits Per 1,000	299	404	413	2.2%	306	415	428	3.1%	231	0	0	0.0%
Avg Paid per Visit	$153	$153	$129	-15.7%	$154	$155	$130	-16.1%	$250	$0	$0	0.0%

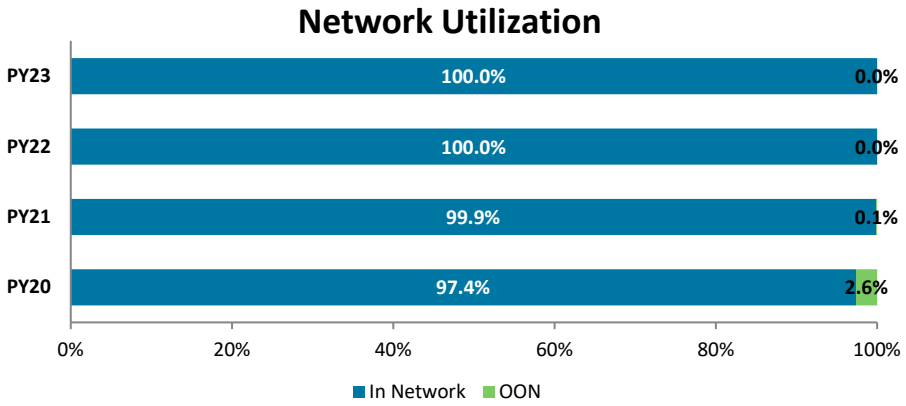
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**PY21**	**PY22**	**PY23**	**Variance to Prior Year**	**Peer Index**
Inpatient Summary									
# of Admits	71	45	60		9	8	3		
# of Bed Days	550	273	364		220	65	8		
Paid Per Admit	$31,982	$34,743	$35,179	1.3%	$326,375	$16,574	$6,422	-61.3%	$18,822
Paid Per Day	$4,129	$5,727	$5,799	1.3%	$13,352	$2,040	$2,408	18.0%	$3,265
Admits Per 1,000	90	57	82	43.9%	57	70	34	-51.4%	70
Days Per 1,000	696	343	498	45.2%	1,395	572	92	-83.9%	402
Avg LOS	7.7	6.1	6.1	0.0%	24.4	8.1	2.7	-66.7%	5.8
# Admits From the ER	50	32	33	3.1%	7	6	2		
Physician Office									
OV Utilization per Member	8.1	7.1	6.8	-4.2%	6.7	6.8	6.5	-4.4%	5.4
Avg Paid per OV	$135	$147	$157	6.8%	$138	$112	$77	-31.3%	$96
Avg OV Paid per Member	$1,088	$1,036	$1,069	3.2%	$920	$763	$502	-34.2%	$515
DX&L Utilization per Member	15	13.4	16.2	20.9%	12	9.2	12.8	39.1%	11.0
Avg Paid per DX&L	$78	$55	$69	25.5%	$61	$48	$35	-27.1%	$50
Avg DX&L Paid per Member	$1,165	$738	$1,114	50.9%	$729	$441	$449	1.8%	$543
Emergency Room									
# of Visits	149	168	162		23	20	25		
Visits Per Member	0.19	0.21	0.22	4.8%	0.15	0.18	0.29	61.1%	0.22
Visits Per 1,000	188	211	222	5.2%	146	176	286	62.5%	221
Avg Paid per Visit	$2,750	$2,357	$2,890	22.6%	$1,545	$775	$1,155	49.0%	$968
Urgent Care									
# of Visits	195	258	227		32	34	27		
Visits Per Member	0.25	0.32	0.31	-3.1%	0.20	0.30	0.31	3.3%	0.35
Visits Per 1,000	247	324	311	-4.0%	203	299	309	3.3%	352
Avg Paid per Visit	$142	$147	$124	-15.6%	$120	$64	$59	-7.8%	$135

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$5,040,636	11.9%	$2,893,427	$1,029,352	$1,117,857	$1,709,799	$3,330,837
Cardiac Disorders	$4,034,620	9.5%	$3,327,782	$576,163	$130,676	$2,510,520	$1,524,100
Pregnancy-related Disorders	$3,262,991	7.7%	$1,111,143	$304,737	$1,847,111	$586,272	$2,676,719
Gastrointestinal Disorders	$2,872,389	6.8%	$2,166,771	$387,330	$318,288	$1,214,529	$1,657,860
Health Status/Encounters	$2,703,711	6.4%	$1,648,655	$298,918	$756,139	$1,105,558	$1,598,153
Musculoskeletal Disorders	$2,571,831	6.1%	$1,842,694	$546,689	$182,448	$1,029,690	$1,542,141
Trauma/Accidents	$2,382,206	5.6%	$1,166,879	$672,422	$542,905	$1,340,569	$1,041,637
Spine-related Disorders	$2,173,522	5.1%	$1,692,829	$387,612	$93,081	$809,264	$1,364,258
Eye/ENT Disorders	$1,946,790	4.6%	$1,069,981	$192,793	$684,017	$835,772	$1,111,019
Neurological Disorders	$1,904,051	4.5%	$1,200,805	$531,669	$171,578	$700,975	$1,203,076
Infections	$1,823,447	4.3%	$1,273,747	$364,018	$185,682	$909,548	$913,899
Mental Health	$1,741,788	4.1%	$700,296	$209,289	$832,203	$546,943	$1,194,845
Endocrine/Metabolic Disorders	$1,492,010	3.5%	$1,248,640	$143,992	$99,378	$613,870	$878,140
Pulmonary Disorders	$1,397,100	3.3%	$718,251	$133,691	$545,158	$411,174	$985,927
Gynecological/Breast Disorders	$1,079,951	2.6%	$848,707	$151,564	$79,681	$8,854	$1,071,097
Medical/Surgical Complications	$942,262	2.2%	$629,572	$308,042	$4,648	$51,973	$890,289
Hematological Disorders	$869,037	2.1%	$773,727	$10,622	$84,688	$644,821	$224,216
Renal/Urologic Disorders	$774,300	1.8%	$587,431	$85,796	$101,073	$435,427	$338,873
Diabetes	$684,707	1.6%	$509,980	$140,094	$34,633	$514,585	$170,121
Non-malignant Neoplasm	$470,507	1.1%	$307,174	$151,450	$11,883	$165,523	$304,985
Dermatological Disorders	$423,079	1.0%	$273,573	$77,513	$71,993	$187,961	$235,118
Miscellaneous	$380,253	0.9%	$204,978	$67,609	$107,666	$158,721	$221,533
Congenital/Chromosomal Anomalies	$344,504	0.8%	$28,902	$23,414	$292,188	$138,106	$206,399
Vascular Disorders	$332,352	0.8%	$217,330	$110,678	$4,344	$213,767	$118,585
Abnormal Lab/Radiology	$297,987	0.7%	$237,607	$39,792	$20,589	$101,316	$196,671
Cholesterol Disorders	$122,278	0.3%	$108,635	$11,827	$1,816	$44,670	$77,608
Medication Related Conditions	$80,465	0.2%	$32,657	$28,205	$19,603	$20,293	$60,172
Allergic Reaction	$49,649	0.1%	$11,557	$1,134	$36,957	$32,195	$17,454
Dental Conditions	$35,328	0.1%	$11,466	$1,073	$22,790	$12,975	$22,353
External Hazard Exposure	$23,340	0.1%	$3,924	$326	$19,091	$1,194	$22,146
Social Determinants of Health	$58	0.0%	$58	$0	$0	$40	$18
Cause of Morbidity	$0	0.0%	$0	$0	$0	$0	$0
Total	**$42,257,152**	**100.0%**	**$26,849,176**	**$6,987,814**	**$8,420,162**	**$17,056,903**	**$25,200,249**

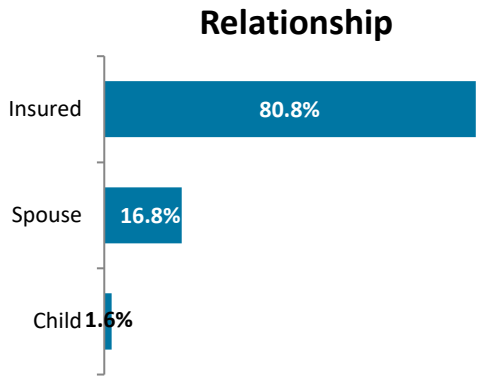
Mental Health Drilldown

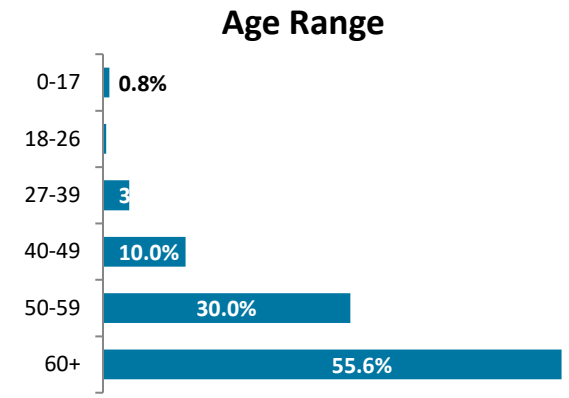
	PY20		PY21		PY22		PY23	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	598	$910,160	625	$833,183	505	$720,907	454	$529,695
Mood and Anxiety Disorders	665	$513,247	711	$655,375	636	$361,898	591	$339,214
Mental Health Conditions, Other	572	$599,986	609	$876,606	458	$367,897	394	$287,517
Alcohol Abuse/Dependence	47	$243,386	43	$163,692	37	$110,736	30	$167,010
Bipolar Disorder	149	$206,258	127	$261,349	107	$171,696	109	$84,620
Developmental Disorders	50	$123,894	65	$155,300	58	$89,043	47	$93,123
Attention Deficit Disorder	178	$84,996	180	$98,736	179	$76,754	202	$61,595
Eating Disorders	16	$86,923	24	$370,761	23	$51,995	19	$32,076
Sleep Disorders	180	$35,203	187	$38,478	148	$43,716	141	$25,583
Substance Abuse/Dependence	45	$74,263	57	$45,039	39	$14,853	35	$72,695
Schizophrenia	10	$9,300	9	$10,631	6	$2,286	9	$13,689
Complications of Substance Abuse	21	$116,313	14	$63,661	8	$12,407	7	$9,434
Personality Disorders	10	$10,154	14	$20,064	17	$47,043	15	$7,832
Psychoses	10	$6,353	7	$55,219	6	$9,762	9	$6,025
Sexually Related Disorders	16	$5,705	27	$81,154	27	$85,457	26	$8,339
Tobacco Use Disorder	45	$3,028	38	$4,775	36	$4,114	42	$3,344
Total		**$3,029,167**		**$3,734,023**		**$2,170,566**		**$1,741,788**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	20	141	$1,899,204	37.7%
Melanoma	13	105	$634,584	12.6%
Breast Cancer	40	450	$455,658	9.0%
Kidney Cancer	8	45	$390,956	7.8%
Cancers, Other	28	262	$350,991	7.0%
Brain Cancer	2	96	$241,916	4.8%
Secondary Cancers	10	98	$238,363	4.7%
Prostate Cancer	20	243	$157,422	3.1%
Carcinoma in Situ	31	95	$135,480	2.7%
Leukemias	7	114	$123,034	2.4%
Colon Cancer	7	147	$92,827	1.8%
Non-Melanoma Skin Cancers	90	217	$68,828	1.4%
Cervical/Uterine Cancer	8	43	$60,805	1.2%
Lung Cancer	3	53	$59,461	1.2%
Pancreatic Cancer	3	102	$54,665	1.1%
Lymphomas	9	88	$31,869	0.6%
Ovarian Cancer	4	39	$20,787	0.4%
Thyroid Cancer	12	43	$14,717	0.3%
Myeloma	1	7	$8,134	0.2%
Bladder Cancer	1	2	$936	0.0%
Overall	**----**	**----**	**$5,040,636**	**100.0%**

*Patient and claim counts are unique only within the category

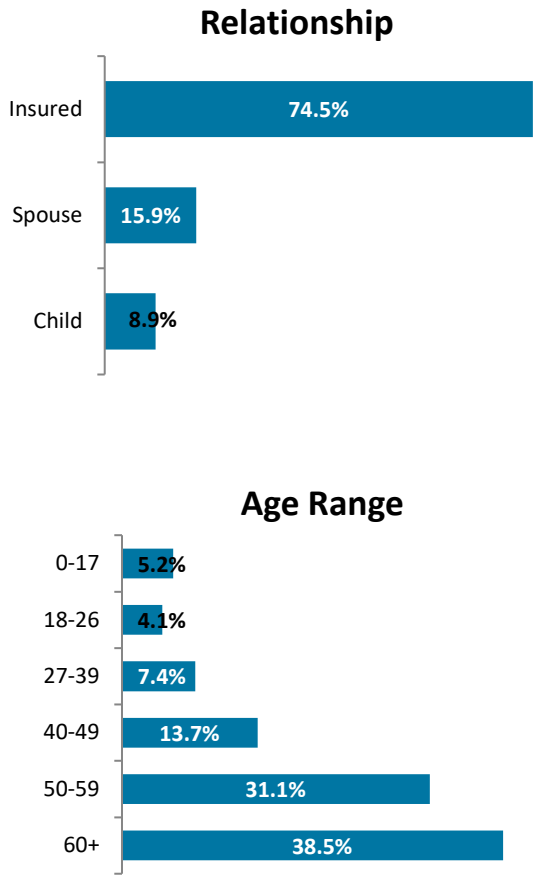




Diagnosis Grouper – Cardiac Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Atrial Fibrillation	63	323	$919,996	22.8%
Heart Valve Disorders	74	198	$606,958	15.0%
Chest Pain	287	766	$498,982	12.4%
Congestive Heart Failure	47	197	$335,981	8.3%
Coronary Artery Disease	104	304	$319,905	7.9%
Myocardial Infarction	16	95	$314,980	7.8%
Cardiac Arrhythmias	197	397	$292,714	7.3%
Hypertension	670	1,473	$234,662	5.8%
Pulmonary Embolism	18	88	$131,852	3.3%
Cardiac Conditions, Other	159	392	$126,331	3.1%
Cardio-Respiratory Arrest	31	83	$115,803	2.9%
Cardiomyopathy	22	54	$96,413	2.4%
Ventricular Fibrillation	2	4	$20,665	0.5%
Shock	5	60	$19,379	0.5%
Overall	**----**	**----**	**$4,034,620**	**100.0%**

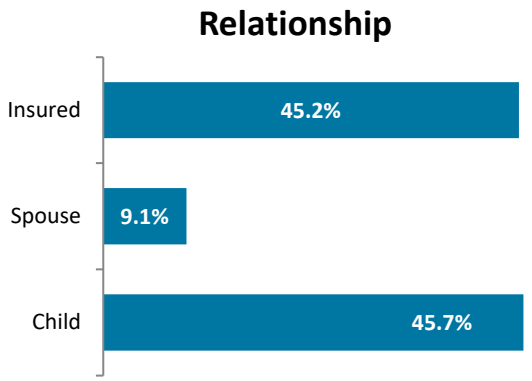
*Patient and claim counts are unique only within the category

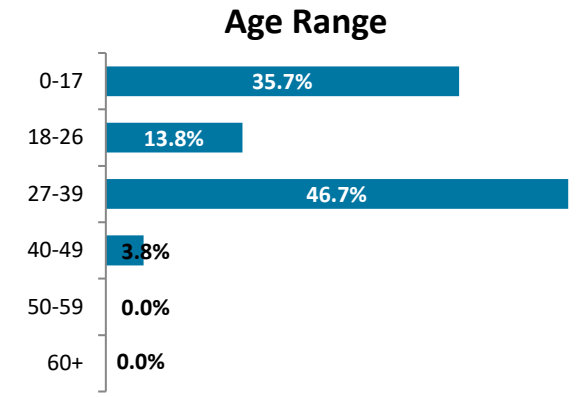


Diagnosis Grouper – Pregnancy-related Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Perinatal Disorders	36	212	$1,120,526	34.3%
Pregnancy Complications	111	668	$731,817	22.4%
Labor and Delivery Related	71	222	$659,570	20.2%
Liveborn Infants	75	221	$386,386	11.8%
Fetal Distress	3	193	$225,174	6.9%
Supervision of Pregnancy	117	693	$114,800	3.5%
Abortion Related	12	26	$14,103	0.4%
Cesarean Delivery	8	11	$6,511	0.2%
Prematurity and Low Birth Weight	2	4	$2,037	0.1%
Birth Injury	1	1	$1,973	0.1%
Ectopic Pregnancy	1	1	$93	0.0%
Overall	**----**	**----**	**$3,262,991**	**100.0%**

*Patient and claim counts are unique only within the category

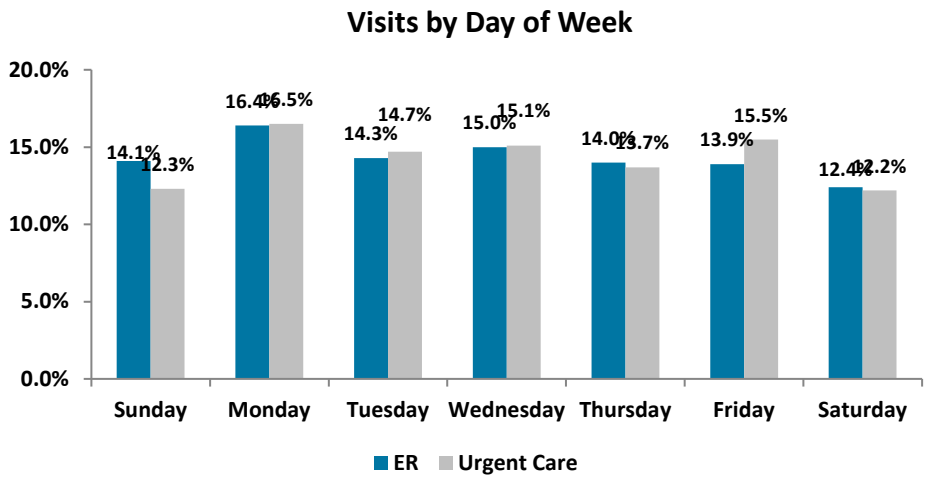


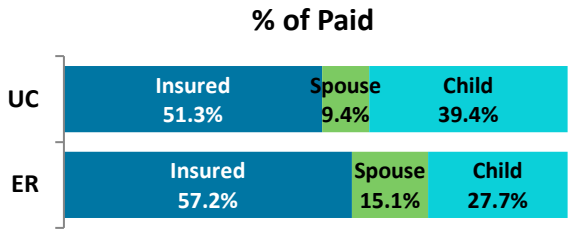


Emergency Room / Urgent Care Summary

	PY22		PY23		Peer Index	
ER/Urgent Care	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	1,327	3,025	1,196	2,649		
Visits Per Member	0.18	0.40	0.19	0.41	0.22	0.35
Visits/1000 Members	177	404	186	413	221	352
Avg Paid Per Visit	$2,003	$153	$3,089	$129	$968	$135
% with OV*	91.5%	89.9%	90.1%	88.4%		
% Avoidable	11.7%	35.5%	14.4%	42.2%		
Total Member Paid	**$751,552**	**$134,926**	**$666,263**	**$125,900**		
Total Plan Paid	**$2,657,981**	**$462,825**	**$3,694,614**	**$4,036,107**		

*looks back 12 months from ER visit





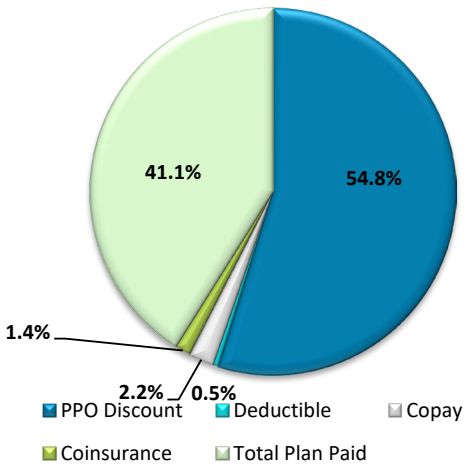
ER / UC Visits by Relationship						
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	647	188	1,371	398	2,018	585
Spouse	394	608	260	401	654	1,009
Child	155	67	1,018	438	1,173	504
Total	**1,196**	**186**	**2,649**	**413**	**3,845**	**599**

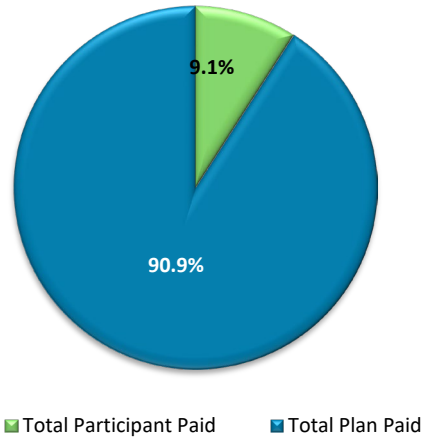
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$104,817,609	$2,534	100.0%
PPO Discount	$56,395,588	$1,363	53.8%
Deductible	$541,523	$13	0.5%
Copay	$2,268,567	$55	2.2%
Coinsurance	$1,422,970	$34	1.4%
Total Participant Paid	**$4,233,060**	**$102**	**4.0%**
Total Plan Paid	**$42,257,152**	**$1,022**	**40.3%**

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	411	404	7	98.3%
	<2 asthma related ER Visits in the last 6 months	411	411	0	100.0%
	No asthma related admit in last 12 months	411	407	4	99.0%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	75	72	3	96.0%
	Members with COPD who had an annual spirometry test	75	9	66	12.0%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	4	3	1	75.0%
	No ER Visit for Heart Failure in last 90 days	59	57	2	96.6%
	Follow-up OV within 4 weeks of discharge from HF admission	4	4	0	100.0%
Diabetes	Annual office visit	515	510	5	99.0%
	Annual dilated eye exam	515	261	254	50.7%
	Annual foot exam	515	234	281	45.4%
	Annual HbA1c test done	515	464	51	90.1%
	Diabetes Annual lipid profile	515	401	114	77.9%
	Annual microalbumin urine screen	515	382	133	74.2%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	1,130	911	219	80.6%
Hypertension	Annual lipid profile	1,148	815	333	71.0%
	Annual serum creatinine test	1,101	923	178	83.8%
Wellness	Well Child Visit - 15 months	55	55	0	100.0%
	Routine office visit in last 6 months (All Ages)	6,207	4,580	1,627	73.8%
	Colorectal cancer screening ages 45-75 within the appropriate time period	2,676	1,420	1,256	53.1%
	Women age 25-65 with recommended cervical cancer/HPV screening	1,886	1,464	422	77.6%
	Males age greater than 49 with PSA test in last 24 months	987	553	434	56.0%
	Routine exam in last 24 months (All Ages)	6,207	5,759	448	92.8%
	Women age 40 to 75 with a screening mammogram last 24 months	1,751	1,199	552	68.5%

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**

Chronic Condition	# With Condition	% of Members	Members per 1,000	Admits per 1,000	ER Visits per 1,000	PMPY
Affective Psychosis	112	1.80%	17.44	148.67	467.26	$28,809
Asthma	465	7.49%	72.42	140.80	414.43	$19,230
Atrial Fibrillation	72	1.16%	11.21	363.64	484.85	$36,448
Blood Disorders	476	7.67%	74.13	319.15	407.96	$45,938
CAD	164	2.64%	25.54	381.55	403.99	$38,605
COPD	74	1.19%	11.53	291.11	533.69	$36,725
Cancer	296	4.77%	46.10	254.90	262.86	$42,930
Chronic Pain	385	6.20%	59.96	152.72	500.41	$25,052
Congestive Heart Failure	59	0.95%	9.19	544.46	544.46	$65,066
Demyelinating Diseases	22	0.35%	3.43	347.11	495.87	$49,915
Depression	766	12.34%	119.30	127.27	427.95	$15,961
Diabetes	553	8.91%	86.13	153.17	276.12	$25,519
ESRD	10	0.16%	1.56	367.35	122.45	$39,134
Eating Disorders	37	0.60%	5.76	185.19	481.48	$18,086
HIV/AIDS	11	0.18%	1.71	0.00	208.70	$38,293
Hyperlipidemia	1,423	22.92%	221.63	113.74	253.02	$18,606
Hypertension	1,164	18.75%	181.29	136.24	293.60	$20,888
Immune Disorders	47	0.76%	7.32	724.64	550.72	$71,150
Inflammatory Bowel Disease	35	0.56%	5.45	94.24	282.72	$35,918
Liver Diseases	158	2.55%	24.61	338.38	569.46	$29,819
Morbid Obesity	332	5.35%	51.71	215.81	327.44	$22,757
Osteoarthritis	356	5.73%	55.45	197.01	426.27	$24,219
Peripheral Vascular Disease	39	0.63%	6.07	189.47	410.53	$24,729
Rheumatoid Arthritis	75	1.21%	11.68	116.50	276.70	$39,868

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

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.

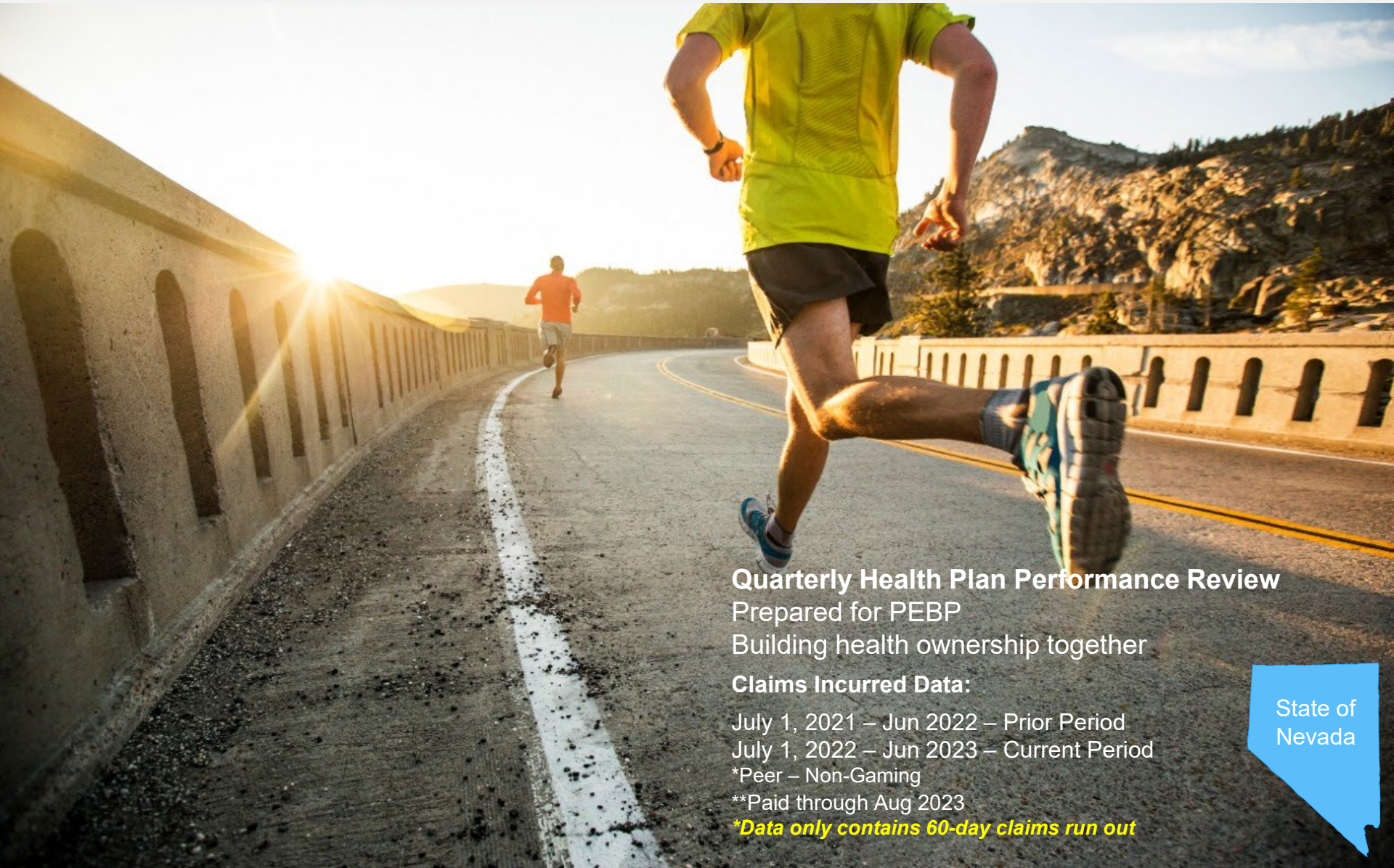
Appendix D

Index of Tables

Health Plan of Nevada –Utilization Review for PEBP

July 1, 2022 – June 30, 2023

Power Of Partnership.



Quarterly Health Plan Performance Review

Prepared for PEBP

Building health ownership together

Claims Incurred Data:

July 1, 2021 – Jun 2022 – Prior Period
July 1, 2022 – Jun 2023 – Current Period
*Peer – Non-Gaming
**Paid through Aug 2023
Data only contains 60-day claims run out

State of Nevada

Executive Summary

Spend and Utilization

Executive Summary Utilization & Spend

UnitedHealthcare

Population

- -4.3% decrease for employees
- -4.5% decrease for members

Medical Paid PMPM

- -25.7% decrease in overall medical paid
- -6.4% decrease in non-Catastrophic spend
- -52.4% decrease in Catastrophic spend

High-Cost Claimants

- 79 High-Cost Claimants accounted for 34.2% of medical spend
- -16.8% decrease in HCC from prior period
- Avg. Paid per case decreased -42.8%

Emergency Room

- ER Visits Per 1,000 members decreased -1.9%
- Avg. paid per ER Visit increased 9.8%

Urgent Care

- Urgent Care visits per 1,000 members decreased by -16.6%
- Avg. paid per Urgent care visit increased 9.8%

Rx Drivers

- Rx Net Paid PMPM increased 18.8%
- Specialty Spend increased 34.9%
- Specialty Rx driving 49.1% of total Rx Spend

Overall Medical / Rx

- Total Medical/Rx decreased -15.1% on PMPM basis

Executive Summary Utilization & Spend

UnitedHealthcare®

Claims Paid by Age Group														
	Claims data through 4Q2022						Claims data through 4Q2023						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	$7,334,937	$10,627	$3,041	$4	$7,337,978	$10,631	$382,739	$602	$1,522	$2	$384,261	$604	-94.8%	-45.7%
01	$166,779	$201	$5,513	$7	$172,293	$208	$291,737	$471	$4,649	$8	$296,385	$479	134.1%	12.8%
02-04	$645,522	$266	$15,028	$6	$660,550	$272	$685,951	$303	$23,087	$10	$709,038	$313	14.1%	64.9%
05-09	$780,247	$165	$58,571	$12	$838,818	$177	$842,385	$197	$70,303	$16	$912,688	$214	19.5%	32.9%
10-14	$2,159,299	$371	$347,348	$60	$2,506,646	$430	$952,068	$174	$333,824	$61	$1,285,891	$235	-52.9%	2.6%
15-19	$1,690,050	$271	$222,695	$36	$1,912,745	$306	$1,092,744	$174	$237,325	$38	$1,330,069	$212	-35.8%	5.9%
20-24	$1,102,386	$188	$342,573	$58	$1,444,959	$246	$802,551	$144	$197,568	$36	$1,000,119	$180	-23.1%	-39.1%
25-29	$968,401	$260	$398,410	$107	$1,366,811	$367	$1,340,142	$395	$359,457	$106	$1,699,599	$500	51.8%	-1.0%
30-34	$1,284,747	$298	$774,606	$180	$2,059,354	$477	$1,292,983	$316	$555,496	$136	$1,848,479	$452	6.1%	-24.4%
35-39	$2,084,416	$380	$664,877	$121	$2,749,292	$501	$1,534,676	$309	$987,452	$199	$2,522,128	$508	-18.6%	64.2%
40-44	$1,951,982	$339	$714,160	$124	$2,666,142	$463	$1,781,744	$338	$738,447	$140	$2,520,191	$477	-0.4%	12.8%
45-49	$2,098,410	$320	$891,894	$136	$2,990,304	$456	$2,517,939	$376	$1,135,535	$170	$3,653,474	$546	17.6%	24.8%
50-54	$4,719,978	$615	$2,150,101	$280	$6,870,079	$895	$3,605,754	$480	$2,381,916	$317	$5,987,670	$796	-22.1%	13.0%
55-59	$4,121,386	$542	$2,106,541	$277	$6,227,927	$819	$2,984,569	$408	$2,448,146	$335	$5,432,716	$743	-24.6%	20.9%
60-64	$3,872,707	$528	$1,810,139	$247	$5,682,847	$774	$4,527,392	$639	$2,397,168	$338	$6,924,560	$977	21.1%	37.2%
65+	$3,454,353	$695	$1,478,919	$298	$4,933,272	$993	$2,638,241	$527	$1,719,553	$343	$4,357,794	$870	-24.2%	15.4%
Total	$38,435,601	$480	$11,984,416	$150	$50,420,017	$630	$27,273,616	$357	$13,591,446	$178	$40,865,062	$535	-19.0%	-15.1%

Financial Summary

UnitedHealthcare®

Financial and Demographic												
	Total				State Active				Retiree (State/Non-State)			
Summary	Thru 4Q20	Thru 4Q21	Thru 4Q22	▲	Thru 4Q20	Thru 4Q21	Thru 4Q22	▲	Thru 4Q20	Thru 4Q21	Thru 4Q22	▲
Avg. # Employees	3,890	3,779	3,617	-4.3%	3,401	3,311	3,198	-3.4%	490	468	419	-10.4%
Avg. # Members	6,779	6,671	6,370	-4.5%	6,149	6,052	5,802	-4.1%	630	619	568	-8.2%
Ratio	1.7	1.8	1.8	-0.2%	1.8	1.8	1.8	-0.7%	1.3	1.3	1.4	2.4%
Financial												
Medical Paid	$29,136,579	$38,435,601	$27,273,616	-29.0%	$25,965,299	$33,712,146	$24,396,723	-27.6%	$3,171,280	$4,723,455	$2,876,892	-39.1%
Member Paid	$1,881,382	$2,653,685	$1,934,922	-27.1%	$1,162,414	$1,912,772	$1,386,248	-27.5%	$718,969	$740,913	$548,674	-25.9%
Net Paid PEPY	$7,487	$10,171	$7,540	-25.9%	$7,541	$10,110	$7,544	-25.4%	$7,112	$10,596	$7,512	-29.1%
Net Paid PMPY	$4,297	$5,762	$4,282	-25.7%	$4,171	$5,531	$4,157	-24.8%	$5,523	$8,018	$5,552	-30.8%
Net Paid PEPM	$624	$848	$628	-25.9%	$628	$843	$629	-25.4%	$593	$883	$626	-29.1%
Net Paid PMPM	$358	$480	$357	-25.7%	$348	$461	$346	-24.8%	$460	$668	$463	-30.8%
High Cost Claimants												
# of HCC's > $50k	76	95	79	-16.8%	62	78	69	-11.5%	14	17	10	-41.2%
Avg. paid per claimant	$129,088	$206,531	$118,100	-42.8%	$136,422	$217,060	$115,687	-46.7%	$96,605	$158,224	$134,751	-14.8%
HCC % of Spend	33.4%	50.6%	34.2%	-32.4%	32.8%	50.2%	33.1%	-34.1%	37.5%	52.9%	42.7%	-19.2%
Spend by Location (PMPY)												
Inpatient	$1,387	$2,479	$1,123	-54.7%	$1,337	$2,520	$1,296	-48.6%	$1,876	$3,852	$1,108	-71.2%
Outpatient	$1,061	$1,165	$1,245	6.9%	$1,049	$1,031	$1,116	8.2%	$1,219	$1,255	$2,114	68.4%
Professional	$1,850	$2,127	$1,908	-10.3%	$1,847	$1,383	$1,311	-5.2%	$2,030	$2,594	$1,906	-26.5%
Total	$4,298	$5,771	$4,276	-25.9%	$4,223	$5,570	$4,205	-24.5%	$5,125	$7,702	$5,128	-33.4%

Paid Claims by Claim Type

UnitedHealthcare

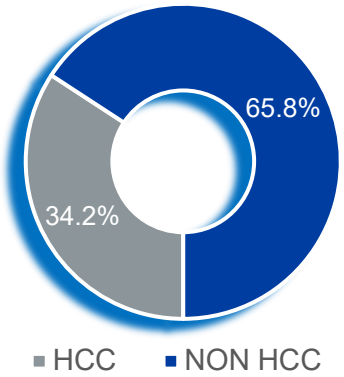
Net Paid Claims - Total Total Participants	Thru 4Q22				Thru 4Q23				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical									
InPatient	$14,386,668	$320,993	$1,826,396	$16,534,057	$5,778,111	$192,061	$1,181,587	$7,151,759	-56.7%
OutPatient	$19,822,838	$456,535	$1,622,171	$21,901,544	$17,803,611	$858,367	$1,459,879	$20,121,857	-8.1%
Total - Medical	$34,209,506	$777,528	$3,448,567	$38,435,601	$23,581,722	$1,050,428	$2,641,466	$27,273,616	-29.0%

Net Paid Claims - Total Total Participants	Thru 4Q22				Thru 4Q23				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical PMPM	$466	$465	$2,063	$480	$337	$699	$528	$357	-25.7%

Cost Distribution – Medical Claims > $50K

Thru 4Q22							Thru 4Q23					
# 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
20	0.3%	$10,433,285	27.1%	$2,411,266	23.1%	> $100k	10	0.2%	$1,717,288	6.3%	$941,415	54.8%
34	0.5%	$3,279,635	8.5%	$2,504,825	76.4%	$50k- $100k	27	0.4%	$2,952,445	10.8%	$2,022,279	68.5%
70	1.0%	$3,355,184	8.7%	$2,702,355	80.5%	$25k - $50k	78	1.2%	$3,015,748	11.1%	$2,140,545	71.0%
253	3.8%	$5,435,294	14.1%	$3,920,303	72.1%	$10k - $25k	217	3.4%	$4,617,647	16.9%	$3,289,261	71.2%
385	5.8%	$3,558,331	9.3%	$2,248,119	63.2%	$5k - $10k	379	5.9%	$3,294,037	12.1%	$2,201,237	66.8%

% Paid Attributed to Catastrophic Cases



HCC > $50k - AHRQ Chapter Conditions - Thru 4Q23			
Top 5 AHRQ Category conditions	# of Patients	Total Paid	% of Med Paid
Endocrine; nutritional and metabolic diseases	8	$1,890,211	20.4%
Injury and poisoning	11	$1,408,853	15.2%
Neoplasms	12	$1,383,633	14.9%
Diseases of the circulatory system	13	$1,138,289	12.3%
Infectious and parasitic diseases	7	$774,005	8.4%

Utilization Summary

UnitedHealthcare

Utilization Summary	Total			State Active			Retiree State/Non-State		
	Thru 4Q22	Thru 4Q23	▲	Thru 4Q22	Thru 4Q23	▲	Thru 4Q22	Thru 4Q23	▲
Inpatient									
# of Admits	439	356	-18.9%	350	321	-8.3%	89	36	-60.1%
# of Bedays	2,977	1,899	-36.2%	2,299	1,670	-27.4%	678	229	-66.3%
Avg. Paid per Admit	$37,603	$19,632	-47.8%	$40,395	$19,773	-51.0%	$26,649	$18,358	-31.1%
Avg. Paid per Day	$5,546	$3,683	-33.6%	$6,147	$3,797	-38.2%	$3,507	$2,853	-18.6%
Admits Per K	65.8	55.9	-15.0%	57.8	55.3	-4.4%	144.2	62.6	-56.6%
Days Per K	446.2	298.1	-33.2%	379.9	287.8	-24.2%	1,095.7	402.9	-63.2%
ALOS	6.8	5.3	-21.4%	6.6	5.2	-20.8%	5.5	5.9	7.3%
Admits from ER	216	170	-21.3%	167	149	-10.8%	49	21	-57.1%
Physician Office Visits									
Per Member Per Year	1.4	1.2	-14.8%	1.3	1.1	-14.7%	1.6	1.4	-15.1%
Paid Per Visit	$136	$153	13.1%	$141	$159	13.0%	$95	$107	12.7%
Net Paid PMPM	$15	$15	-3.6%	$16	$15	-3.6%	$13	$12	-4.3%
Emergency Room									
# of Visits	728	714	-1.9%	667	648	-2.8%	61	66	8.2%
Visits Per K	109.1	112.1	2.7%	110.2	111.7	1.3%	98.6	116.3	17.9%
Avg Paid Per Visit	$2,499	$2,744	9.8%	$2,537	$2,794	10.1%	$2,088	$2,248	7.7%
Urgent Care									
# of Visits	4,598	3,836	-16.6%	4,114	3,462	-15.8%	484	374	-22.7%
Visits Per K	689.3	602.2	-12.6%	679.7	596.7	-12.2%	782.5	659.0	-15.8%
Avg Paid Per Visit	$117	$115	-1.4%	$88	$90	1.5%	$85	$79	-8.1%

**Not Representative of all utilization*

**Data based on medical spend only*

Diagnosis Grouper Summary – Top 25

UnitedHealthcare

Top 25 AHRQ Category	Total Paid	% Paid	Insured	Spouse	Dependent	Male	Female	Unassigned
Thyroid disorders	$1,498,626	7.0%	$1,038,929	$452,980	$6,718	$1,539	$1,497,087	$0
Septicemia (except in labor)	$883,012	4.2%	$665,067	$94,064	$123,880	$246,331	$636,681	$0
Complication of device; implant or graft	$573,762	2.7%	$244,829	$87,802	$241,132	$219,738	$354,025	$0
Disorders usually diagnosed in infancy childhood or adolescence	$512,259	2.4%	$0	$0	$512,259	$430,316	$81,943	$0
Spondylosis; intervertebral disc disorders; other back problems	$488,683	2.3%	$376,891	$102,419	$9,373	$212,417	$276,266	$0
Other nervous system disorders	$460,912	2.2%	$278,626	$171,550	$10,736	$39,004	$421,908	$0
Diabetes mellitus with complications	$456,882	2.1%	$276,082	$47,866	$132,934	$302,844	$154,038	$0
Mood disorders	$378,453	1.8%	$140,976	$23,215	$214,261	$141,423	$237,030	$0
Cardiac dysrhythmias	$371,344	1.7%	$276,870	$93,908	$566	$139,644	$231,700	$0
Other screening for suspected conditions	$356,523	1.7%	$300,595	$50,662	$5,266	$119,293	$237,230	$0
Other nutritional; endocrine; and metabolic disorders	$337,540	1.6%	$187,369	$146,537	$3,633	$35,143	$302,397	$0
Osteoarthritis	$324,705	1.5%	$288,312	$36,393		$49,176	$275,529	$0
Viral infection	$321,977	1.5%	$125,025	$143,657	$53,295	$42,902	$279,075	$0
Non-Hodgkin`s lymphoma	$321,863	1.5%	$300,686	$21,176		$31,218	$290,645	$0
Acute myocardial infarction	$302,295	1.4%	$114,028	$188,268		$243,874	$58,421	$0
Cancer of breast	$293,158	1.4%	$216,831	$76,327			$293,158	$0
Complications of surgical procedures or medical care	$275,134	1.3%	$262,581	$12,444	$108	$201,106	$74,028	$0
Nonspecific chest pain	$265,389	1.2%	$175,551	$70,635	$19,203	$105,410	$159,978	$0
Abdominal pain	$259,888	1.2%	$206,029	$16,677	$37,182	$78,651	$181,237	$0
Maintenance chemotherapy; radiotherapy	$259,176	1.2%	$244,150	$15,027		$72,214	$186,962	$0
Hypertension with complications and secondary hypertension	$257,865	1.2%	$181,069	$76,797		$173,972	$83,893	$0
Medical examination/evaluation	$256,582	1.2%	$73,335	$12,981	$170,266	$108,903	$147,679	$0
Other gastrointestinal disorders	$254,187	1.2%	$164,709	$55,961	$33,516	$70,453	$183,734	$0
Cancer of prostate	$251,933	1.2%	$172,971	$78,962		$251,933		$0
Other complications of birth;	$230,641	1.1%	$166,962	$61,566	$2,114		$230,641	$0

**Not Representative of all utilization*

**Data based on medical spend only*

Mental Health Drilldown

UnitedHealthcare®

Top 10 Mental Health				
AHRQ Category Description	Thru 4Q22		Thru 4Q23	
	Patients	Total Paid	Patients	Total Paid
Disorders usually diagnosed in infancy childhood or adolescence	51	$676,285	46	$512,259
Mood disorders	528	$350,521	481	$378,453
Anxiety disorders	527	$147,859	466	$211,723
Adjustment disorders	200	$68,423	147	$74,885
Substance-related disorders	45	$24,907	37	$51,618
Suicide and intentional self-inflicted injury	19	$44,027	19	$38,764
Attention-deficit conduct and disruptive behavior disorders	137	$25,955	156	$38,302
Schizophrenia and other psychotic disorders	25	$241,871	15	$28,714
Alcohol-related disorders	33	$305,525	18	$22,728
Miscellaneous mental health disorders	71	$84,995	62	$21,917

**Not Representative of all utilization*

**Data based on medical spend only*

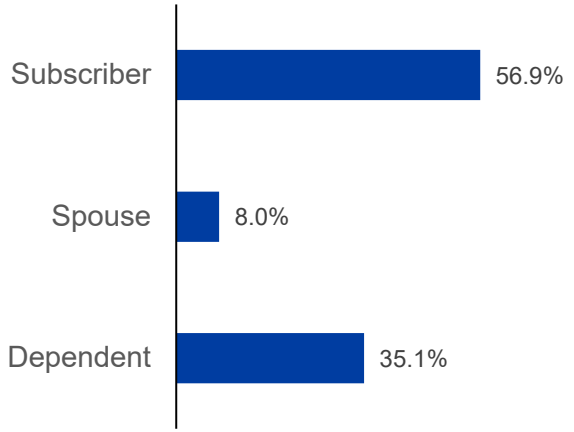
Respiratory Disorders

Top 10 Respiratory Disorders				
AHRQ Category Description	Patients	Claims	Total Paid	% Paid
Other upper respiratory infections	1,091	1,626	$180,634	16.5%
Other upper respiratory disease	512	1,615	$139,377	12.7%
Other lower respiratory disease	576	1,119	$138,694	12.6%
Asthma	278	579	$135,760	12.4%
Acute bronchitis	143	202	$131,762	12.0%
Pneumonia (except that caused by tuberculosis or std)	45	147	$118,454	10.8%
Respiratory failure; insufficiency; arrest (adult)	25	138	$101,158	9.2%
Chronic obstructive pulmonary disease	118	285	$55,732	5.1%
Pleurisy; pneumothorax; pulmonary collapse	41	97	$40,171	3.7%
Acute and chronic tonsillitis	78	135	$32,475	3.0%

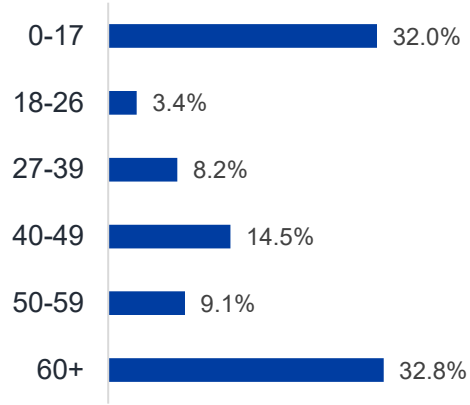
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



Spend by Age



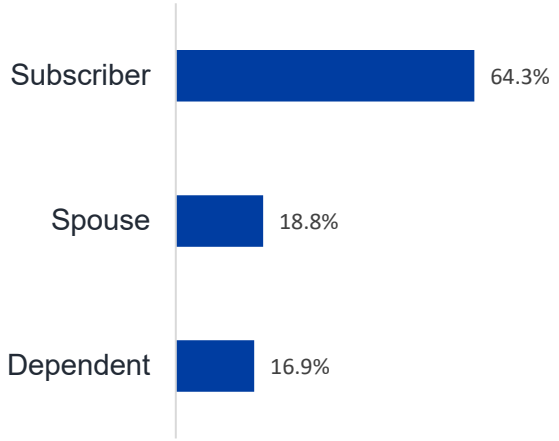
Infections

Top 10 Infectious and Parasitic Diseases				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Septicemia (except in labor)	25	99	$883,012	63.6%
Viral infection	521	875	$321,977	23.2%
Immunizations and screening	1,223	2,071	$159,419	11.5%
HIV infection	24	111	$10,052	0.7%
Bacterial infection; unspecified site	17	31	$4,279	0.3%
Hepatitis	19	84	$3,959	0.3%
Mycoses	134	194	$3,348	0.2%
Other infections; including parasitic	13	20	$772	0.1%
STD's (not HIV or hepatitis)	13	22	$662	0.0%
Tuberculosis	5	18	$0	0.0%

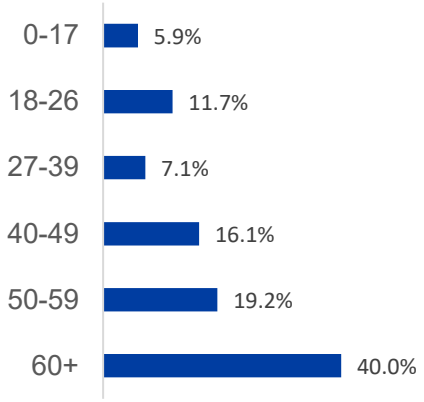
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



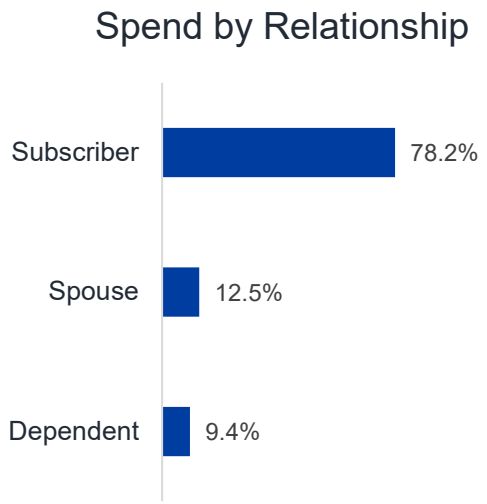
Spend by Age

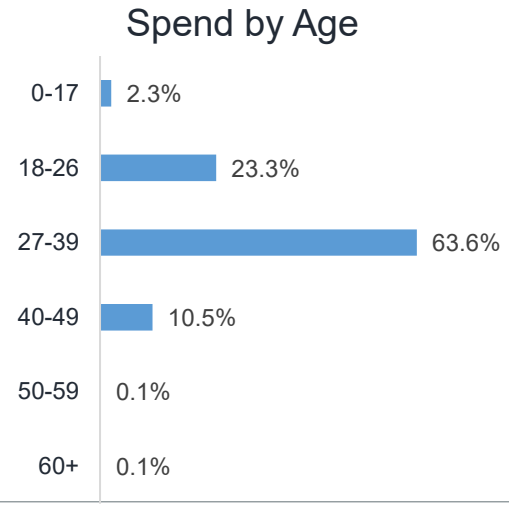


Pregnancy Related Disorders

Top 10 Complications of Pregnancy				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Other complications of birth	40	72	$230,641	21.1%
Polyhydramnios and other problems of amniotic cavity	16	40	$200,104	18%
Other complications of pregnancy	79	404	$123,941	11.4%
Other pregnancy and delivery including normal	93	457	$112,194	10%
Contraceptive and procreative management	212	458	$69,882	6.4%
OB-related trauma to perineum and vulva	7	8	$49,297	5%
Previous C-section	7	20	$48,030	4.4%
Umbilical cord complication	7	12	$47,195	4%
Prolonged pregnancy	6	8	$46,750	4.3%
Malposition; malpresentation	6	9	$39,349	4%

**Not Representative of all utilization*





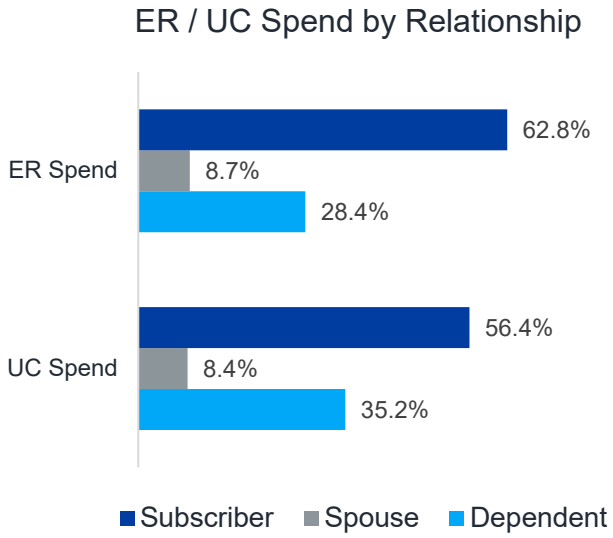
Emergency Room and Urgent Care

	Thru 4Q22		Thru 4Q23		Peer	
Metric	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
# of Visits	728	4,598	714	3,836		
Visits Per Member	0.11	0.48	0.11	0.54	0.07	0.17
Visits Per K	109.1	689.3	112.1	602.2	89.3	512.2
Avg. Paid Per Visit	$2,499	$114	$2,744	$128	$2,607	$126

**Not Representative of all utilization*

**Data based on medical spend only*

Emergency Room and Urgent Care Visits by Relationships Thru 4Q2023				
Relationship	ER Visits	ER Per K	UC Visits	UC Per K
Member	393	61.7	2,367	371.6
Spouse	65	10.2	336	52.7
Dependent	256	40.2	1,133	177.9
Total	714	112.1	3,836	602.2



Clinical Conditions by Medical Spend

UnitedHealthcare

Top 15 Common Condition	# of Members	% of Members	Members Per K	PMPM
Mental Disorders	798	12.5%	125.3	$12.94
Intervertebral Disc Disorders	715	11.2%	112.2	$6.39
Diabetes with complications	434	6.8%	68.1	$5.98
Hypertension	714	11.2%	112.1	$3.93
Breast Cancer	64	1.0%	10.0	$3.84
Acute Myocardial Infarction	11	0.2%	1.7	$3.95
Coronary Atherosclerosis	127	2.0%	19.9	$1.41
Chronic Renal Failure	79	1.2%	12.4	$1.77
Asthma	273	4.3%	42.9	$1.78
Congestive Heart Failure (CHF)	51	0.8%	8.0	$0.32
Colon Cancer	7	0.1%	1.1	$0.04
Diabetes without complications	519	8.1%	81.5	$1.36
COPD	118	1.9%	18.5	$0.73
Prostate Cancer	28	0.4%	4.4	$3.30
Cervical Cancer	37	0.6%	5.8	$0.04

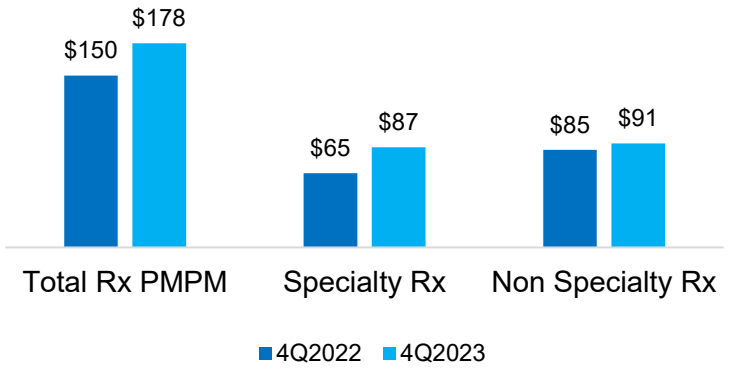
**Not Representative of all utilization*

**Data based on medical spend only*

Pharmacy Drivers

	Thru 4Q2022	Thru 4Q2023	Δ
Enrolled Members	6,671	6,370	-4.5%
Average Prescriptions PMPY	16.9	16.8	-0.4%
Formulary Rate	89.7%	89.8%	0.1%
Generic Use Rate	83.7%	85.0%	1.7%
Generic Substitution Rate	98.2%	98.3%	0.1%
Avg Net Paid per Prescription	$106	$127	19.3%
Net Paid PMPM	$150	$178	18.8%

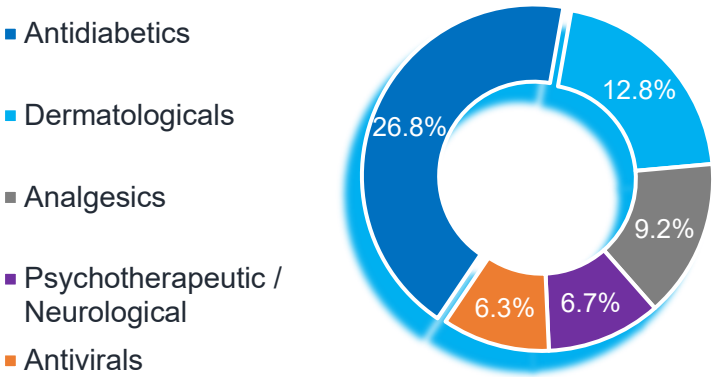
Total Rx Spend by Benefit and Type



Pharmacy Performance

- Rx spend increased of **18.8%**, (**$28 PMPM**) from prior period
- Avg. paid per Script increased **19.3%** (**$21 PMPM**) year over year
- Specialty Rx spend driving **43.9%** of Rx Spend
- Specialty Rx spend increased **34.9%** from prior period
  Specialty Rx Drivers:
  Ozempic (Antidiabetic) Spend up **5.2%**
  Jardiance (Antidiabetic) Spend up **2.2%**
- Tier 1 Rx drove **76.5%** of total claim volume, but only accounts for **8.4%** of overall Rx Spend

Top 5 Therapeutic Classes by Spend



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 June 30, 2023:

4.2.1 Utilization Report

4.2.2 Budget Report

JOE LOMBARDO
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
3427 Goni Road, Suite 109, Carson City, NV 89706
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www.pebp.state.nv.us

CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: December 07, 2023

Item Number: 4.2.2

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of September 30, 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 September 30, 2023, with comparisons to Fiscal Year 2023. 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 $68.1 million as of September 30, 2023, compared to $77.6 million as of September 30, 2022, or a decrease of 12.2%. Total expenses for the period have increased by $4.9 million or 4.8% for the same period.

The budget status report shows Realized Funding Available (cash) at $82.6. This compares to $125.1 million for last year. The table below reflects the actual revenues and expenditures for the period.

Operational Budget 1338

	FISCAL YEAR 2024			FISCAL YEAR 2023		
	Actual as of 9/30/2023	Work Program	Percent	Actual as of 9/30/2022	Fiscal Year 2023 Close	Percent
Beginning Cash	120,714,437	120,714,437	100%	148,854,786	148,854,786	100%
Premium Income	64,638,449	419,156,515	15%	69,200,105	357,314,962	19%
All Other Income	3,505,242	23,770,377	15%	8,396,850	36,548,418	23%
Total Income	68,143,691	442,926,892	15%	77,596,954	393,863,379	20%
Personnel Services	466,237	2,938,164	16%	471,421	2,320,130	20%
Operating - Other than Personnel	535,391	2,926,863	18%	743,043	3,400,154	22%
Insurance Program Expenses	105,168,351	457,819,158	23%	99,990,480	415,155,444	24%
All Other Expenses	39,316	187,157	21%	102,414	400,119	26%
Total Expenses	106,209,295	463,871,342	23%	101,307,358	421,275,847	24%
Change in Cash	(38,065,604)	(20,944,450)		(23,710,403)	(27,412,467)	
REALIZED FUNDING AVAILABLE	82,648,833	99,769,987	83%	125,144,383	121,442,319	103%
Incurred But Not Reported Liability	(52,874,000)	(52,874,000)		(51,030,000)	(51,030,000)	
Catastrophic Reserve	(41,762,000)	(41,762,000)		(38,426,000)	(38,426,000)	
HRA Reserve	(19,242,892)	(19,242,892)		(22,800,889)	(22,800,889)	
NET REALIZED FUNDING AVAILABLE	(31,230,059)	(14,108,905)		12,887,494	9,185,430	

Current Budget Projections

The following table represents projections for FY 2024. The projections reflect total income to be less than budgeted by 8.5% ($524.4 million vs $573.4 million), total expenditures are projected to be less than budgeted by 8.5% ($524.4 million vs $573.5 million); total reserves are budgeted at $113.9 million which includes a reduction to excess reserves in the amount of $14.7 million.

State Subsidies are projected to be less than the budgeted amount by $33.7 million (10.5%), Non-State Subsidies are projected to be more than budgeted by $.2 million (1.1%), and Premium Income is projected to be less than budgeted by $11.5 million (14.6%). This overall decrease in budgeted revenue is due in part to a reduction in State Subsidies and participant premiums as a result of average enrollment as compared to budgeted enrollment and a change in the mix of plan tiers. The mix of participants is as follows:

- 1.74% fewer state actives,
- 2.92% more state non-Medicare retirees,
- 2.31% fewer non-state, non-Medicare retirees
- 2.12% fewer state Medicare retirees, and
- 3.02% fewer non-state Medicare retirees

Budgeted and Projected Income (Budget Account 1338)						
Code	**Description**	**Budget**	**Actual 9/30/23**	**Projected**	**Difference**	
3817	Medicare Part D Subsidy	271,854	0	466,191	194,337	71.5%
4218	PPO Rx Rebates	22,401,637	3,504,821	18,197,196	(4,204,441)	-18.8%
4254	Miscellaneous Revenue	21,183	421	1,683	(19,500)	-92.1%
4319	Non-State Premium	4,584,990	665,205	2,660,820	(1,924,170)	-42.0%
4321	Non-State Subsidy	20,164,091	5,096,263	20,385,051	220,960	1.1%
4323	State Premium	74,425,047	16,203,131	64,812,525	(9,612,522)	-12.9%
4325	State Subsidies	319,982,387	42,673,850	286,302,652	(33,679,735)	-10.5%
4326	Treasurers Interest Distrib	1,075,703	0	1,075,703	0	0.0%
4611	Trans In Fed ARPA	0	0	0	0	
	Total	442,926,892	68,143,691	393,901,822	(49,025,070)	-11.1%
	Appropriations	9,813,825	9,813,825	9,813,825	0	0.0%
47	Beginning Cash	120,714,437	120,714,437	120,714,437	0	0.0%
	Total	573,455,154	198,671,953	524,430,084	(49,025,070)	-8.5%
Budgeted and Projected Expenses (Budget Account 1338)						
Category	**Description**	**Budget**	**Actual 9/30/23**	**Projected**	**Difference**	
01	Personnel Services	2,938,164	466,237	2,391,870	546,294	-18.6%
02	Out of State Travel	1,670	0	0	1,670	-100.0%
03	In State Travel	12,044	60	3,127	8,917	-74.0%
04	Operating	2,926,863	535,391	3,039,016	**(112,153)**	3.8%
26	Information Services	88,510	19,028	88,510	0	0.0%
30	Training	4,021	0	0	4,021	-100.0%
40	State Insurance Costs	396,437,575	97,486,165	362,471,907	33,965,668	-8.6%
42	Non-State Insurance Costs	7,657,002	948,184	4,168,229	3,488,773	-45.6%
44	Medicare Retiree Insurance Costs	49,429,501	6,734,001	26,939,441	22,490,060	-45.5%
80	DHRM Cost Allocation	9,897	2,474	9,897	0	0.0%
87	Purchasing Assessment	5,892	1,473	5,892	0	0.0%
88	St Cost Plan Recovery	62,230	15,558	62,230	0	0.0%
89	AG Cost Allocation	2,893	723	2,893	0	0.0%
93	Reserve for Reversion	0	0	0	0	0.0%
	Total	459,576,262	106,209,295	399,183,012	60,393,250	-13.1%
82	HRA Reserve	19,242,892	19,242,892	19,242,892	0	0.0%
84	IBNR Reserve	52,874,000	52,874,000	52,874,000	0	0.0%
85	Reserve Rate Stabilization	41,762,000	41,762,000	41,762,000	0	0.0%
86	Reserve	0	0	0	0	
	Total	573,455,154	198,671,953	524,430,084	49,025,070	-8.5%

Expenses for Fiscal Year 2024 are projected to be $60.4 million less than budgeted when changes to reserves are excluded. Operating expenses are projected to be more than budgeted by $0.1 million (3.8%). Employee and Retiree insurances costs are projected to be less than budgeted by $59.9 million (13.2%) when taken in total (see table above for specific information).

Recommendations

None.

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 June 30, 2023:

- 4.3.1 Q4 UMR – Obesity Care Management Program
- 4.3.2 Q4 UMR – Diabetes Care Management Program
- 4.3.3 Q4 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network
- 4.3.4 Q4 Health Plan of Nevada, Inc. – Southern Nevada HMO
- 4.3.5 Doctor on Demand Engagement Report through September 30, 2023
- 4.3.6 Q4 Express Scripts – Summary Report
- 4.3.7 Q4 Express Scripts – Utilization Report
- 4.3.8 WTW's Individual Marketplace Enrollment and Performance Report Q1 2024
- 4.3.9 Real Appeal – Utilization Report

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 June 30, 2023:

4.3.1 Q4 UMR – Obesity Care Management Program

DATASCOPE™

Obesity Care Management Report

Nevada Public Employees' Benefits Program

July 2022 – June 2023 Incurred,

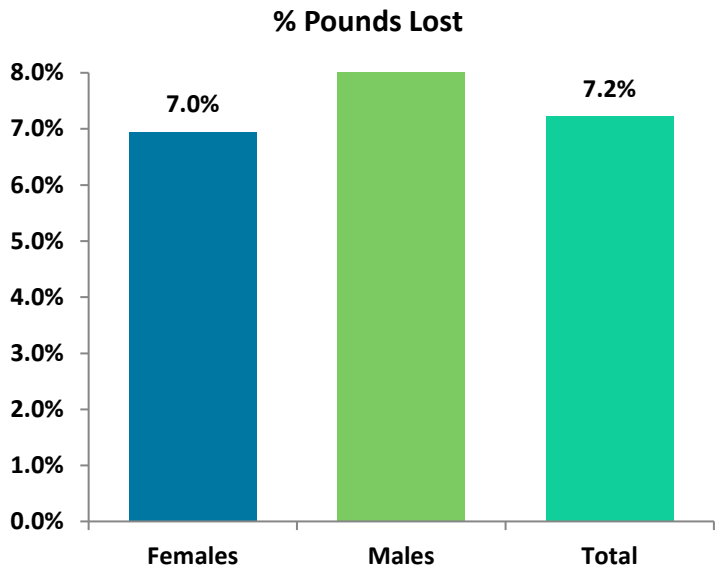
Paid through August 31, 2023

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

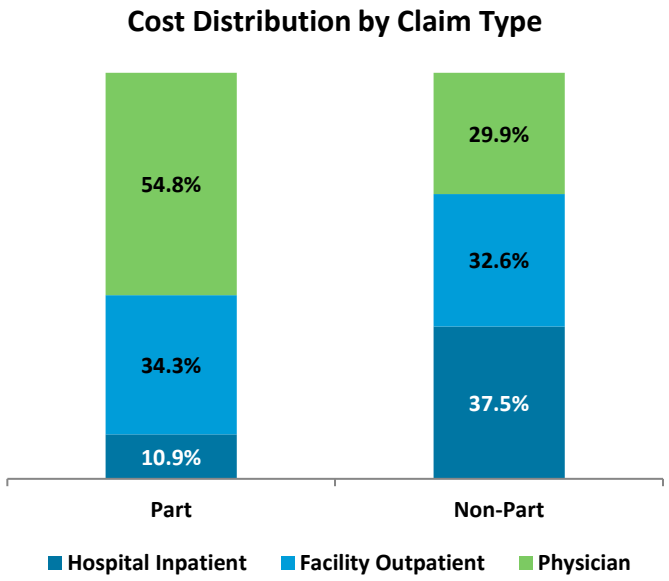
PY23			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	332	72	404
Average # Lbs. Lost	13.8	19.8	14.8
Total # Lbs. Lost	4,565.0	1,428.5	5,993.5
% Lbs. Lost	7.0%	8.3%	7.2%
Average Cost/ Member	$4,924	$3,581	$4,684



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	360	1,179	-69.5%
Avg # Members	394	1,427	-72.4%
Member/Employee Ratio	1.1	1.2	-9.1%
Financial Summary			
Gross Cost	$2,176,626	$21,308,277	
Client Paid	$1,730,992	$18,672,387	
Employee Paid	$445,634	$2,635,890	
Client Paid-PEPY	$4,126	$13,578	-69.6%
Client Paid-PMPY	$3,762	$11,217	-66.5%
Client Paid-PEPM	$344	$1,132	-69.6%
Client Paid-PMPM	$314	$935	-66.4%
High Cost Claimants (HCC's) > $100k			
# of HCC's	0	26	
HCC's / 1,000	0.0	18.2	0.0%
Avg HCC Paid	$0	$231,331	0.0%
HCC's % of Plan Paid	0.0%	32.2%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$411	$4,202	-90.2%
Facility Outpatient	$1,289	$3,658	-64.8%
Physician	$2,062	$3,357	-38.6%
Total	$3,762	$11,217	-66.5%



Obesity Care Management – Utilization Summary

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	12	255	
# of Bed Days	43	1,305	
Paid Per Admit	$14,814	$30,914	-52.1%
Paid Per Day	$4,134	$6,041	-31.6%
Admits Per 1,000	26	153	-83.0%
Days Per 1,000	93	784	-88.1%
Avg LOS	3.6	5.1	-29.4%
# of Admits From ER	7	133	-94.7%
Physician Office			
OV Utilization per Member	11.8	8.3	42.2%
Avg Paid per OV	$105	$110	-4.5%
Avg OV Paid per Member	$1,248	$916	36.2%
DX&L Utilization per Member	19.6	23.4	-16.2%
Avg Paid per DX&L	$36	$55	-34.5%
Avg DX&L Paid per Member	$714	$1,280	-44.2%
Emergency Room			
# of Visits	106	488	
Visits Per Member	0.23	0.29	-20.7%
Visits Per 1,000	230	293	-21.5%
Avg Paid per Visit	$3,296	$3,487	-5.5%
Urgent Care			
# of Visits	178	738	
Visits Per Member	0.39	0.44	-11.4%
Visits Per 1,000	387	443	-12.6%
Avg Paid per Visit	$87	$101	-13.9%

*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 June 30, 2023:

4.3.1 Q4 UMR – Obesity Care Management Program

4.3.2 Q4 UMR – Diabetes Care Management Program

DATASCOPE™

Diabetes Care Management Report

Nevada Public Employees' Benefits Program

July 2022 – June 2023 Incurred,

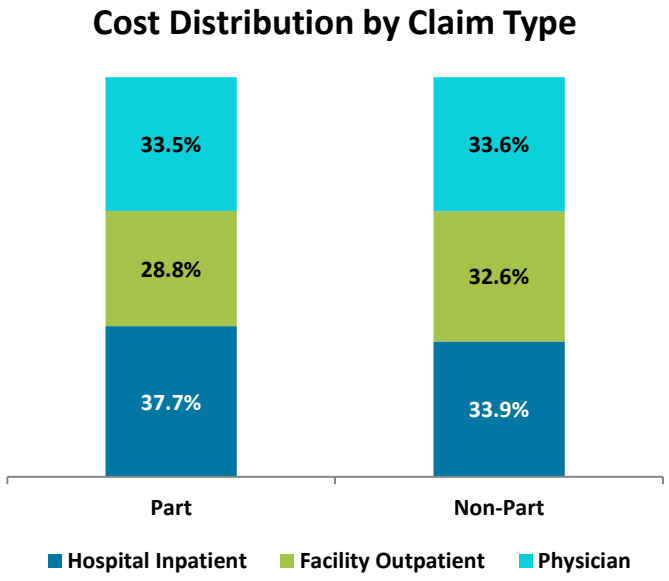
Paid through August 31, 2023

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	257	2,080	-87.7%
Avg # Members	348	2,619	-86.7%
Member/Employee Ratio	1.4	1.3	7.1%
Financial Summary			
Gross Cost	$2,807,581	$31,868,474	
Client Paid	$2,151,051	$27,785,619	
Employee Paid	$656,530	$4,082,855	
Client Paid-PEPY	$7,180	$11,453	-37.3%
Client Paid-PMPY	$5,301	$9,092	-41.7%
Client Paid-PEPM	$598	$954	-37.3%
Client Paid-PMPM	$442	$758	-41.7%
High Cost Claimants (HCC's) > $100k			
# of HCC's	2	45	
HCC's / 1,000	5.8	17.2	0.0%
Avg HCC Paid	$353,105	$235,643	49.8%
HCC's % of Plan Paid	32.8%	38.2%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$1,998	$3,080	-35.1%
Facility Outpatient	$1,527	$2,960	-48.4%
Physician	$1,776	$3,053	-41.8%
Total	$5,301	$9,092	-41.7%



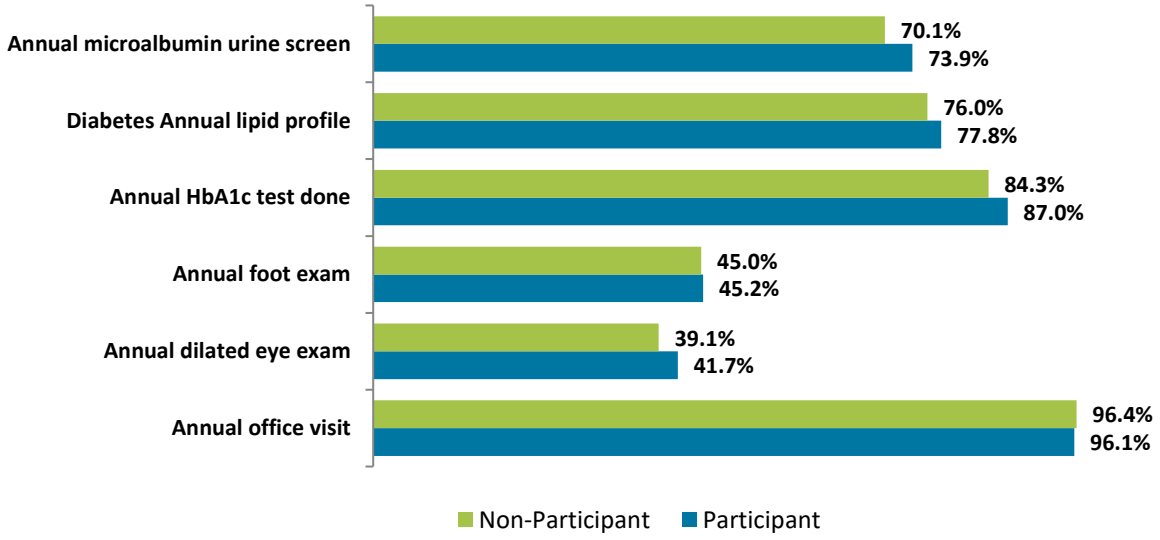
Diabetes Care Management – Utilization Summary

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

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	32	326	
# of Bed Days	310	1,807	
Paid Per Admit	$27,988	$31,150	-10.2%
Paid Per Day	$2,889	$5,620	-48.6%
Admits Per 1,000	79	107	-26.2%
Days Per 1,000	764	591	29.3%
Avg LOS	9.7	5.5	76.4%
# of Admits From ER	24	213	-88.7%
Physician Office			
OV Utilization per Member	6.9	7.1	-2.8%
Avg Paid per OV	$76	$125	-39.2%
Avg OV Paid per Member	$521	$883	-41.0%
DX&L Utilization per Member	22	23.6	-6.8%
Avg Paid per DX&L	$25	$56	-55.4%
Avg DX&L Paid per Member	$540	$1,329	-59.4%
Emergency Room			
# of Visits	87	678	
Visits Per Member	0.21	0.22	-4.5%
Visits Per 1,000	214	222	-3.6%
Avg Paid per Visit	$1,495	$3,316	-54.9%
Urgent Care			
# of Visits	105	999	
Visits Per Member	0.26	0.33	-21.2%
Visits Per 1,000	259	327	-20.8%
Avg Paid per Visit	$85	$95	-10.5%

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	230	221	9	96.1%	2,391	2,305	86	96.4%
	Annual dilated eye exam	230	96	134	41.7%	2,391	936	1,455	39.1%
	Annual foot exam	230	104	126	45.2%	2,391	1,075	1,316	45.0%
	Annual HbA1c test done	230	200	30	87.0%	2,391	2,016	375	84.3%
	Diabetes Annual lipid profile	230	179	51	77.8%	2,391	1,816	575	76.0%
	Annual microalbumin urine screen	230	170	60	73.9%	2,391	1,677	714	70.1%



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 June 30, 2023:

4.3.1 Q4 UMR – Obesity Care Management Program

4.3.2 Q4 UMR – Diabetes Care Management Program

4.3.3 Q4 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network

Network Repricing Quality - UMR		
PEBP PG Target	97%	
Q1 Results	99.9%	
Q2 Results	98.9%	
Q3 Results	99.1%	
Q4 Results	98.3%	

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	99.5%	99.5%

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	3	0%

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 June 30, 2023:

- 4.3.1 Q4 UMR – Obesity Care Management Program
- 4.3.2 Q4 UMR – Diabetes Care Management Program
- 4.3.3 Q4 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network
- **4.3.4 Q4 Doctor on Demand Engagement Report through September 30, 2023**

Virtual Care Engagement Monthly Report

UMR – STATE OF NEVADA

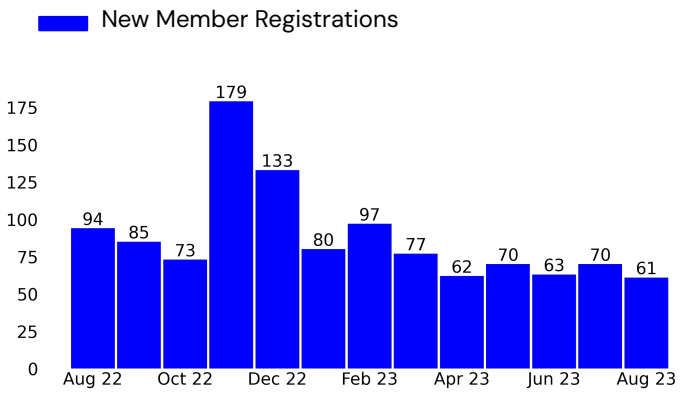
Reporting Period: 2023-08-01 to 2023-09-01

Member Engagement

61	223	285
Registrations This Month	Unique Visitors This Month	Total Visits This month

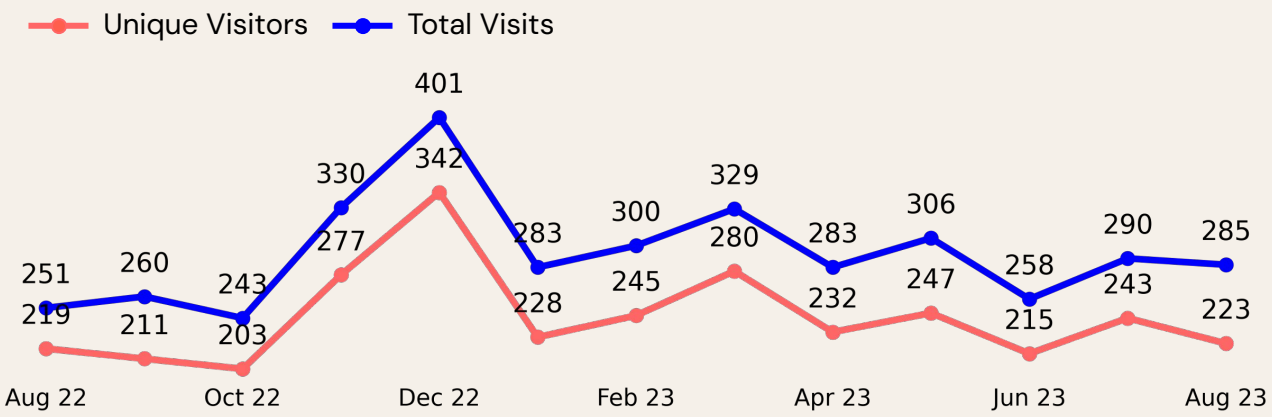
This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement 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	**2,691** Registrations Since Launch	Registration Rate Since Launch
Employee Covered Lives	**580** Registrations Year to Date	Registration Rate Year to Date

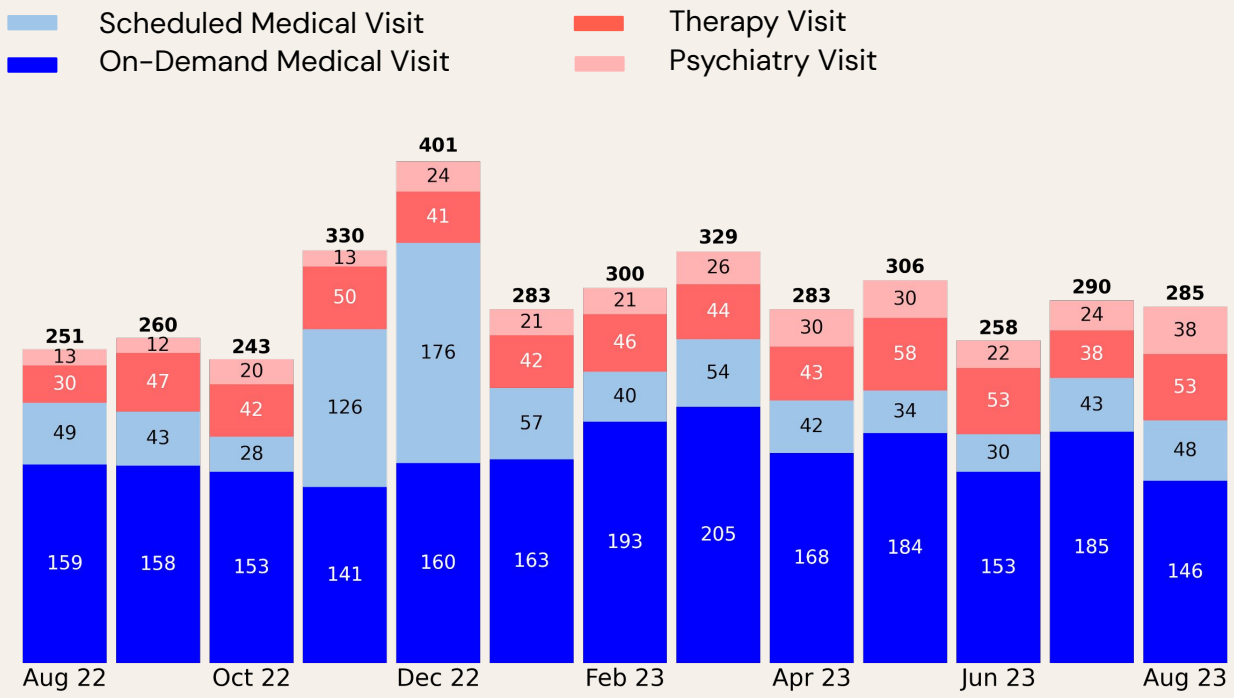
Visits Last 12 Months



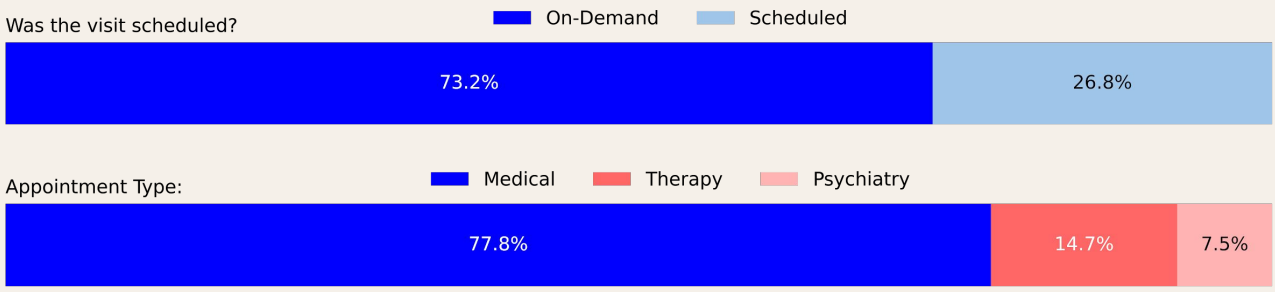
4,040 Visits Since Launch	**1,975** Unique Visitors Since Launch	**2.0** Average Visits Per Visitor Since Launch	Engagement Rate Since Launch (Visitors/Lives)	
2,334 Visits Year to Date	**1,281** Unique Visitors Year to Date	**1.8** Average Visits Per Visitor Year to Date	Engagement Rate Year to Date (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

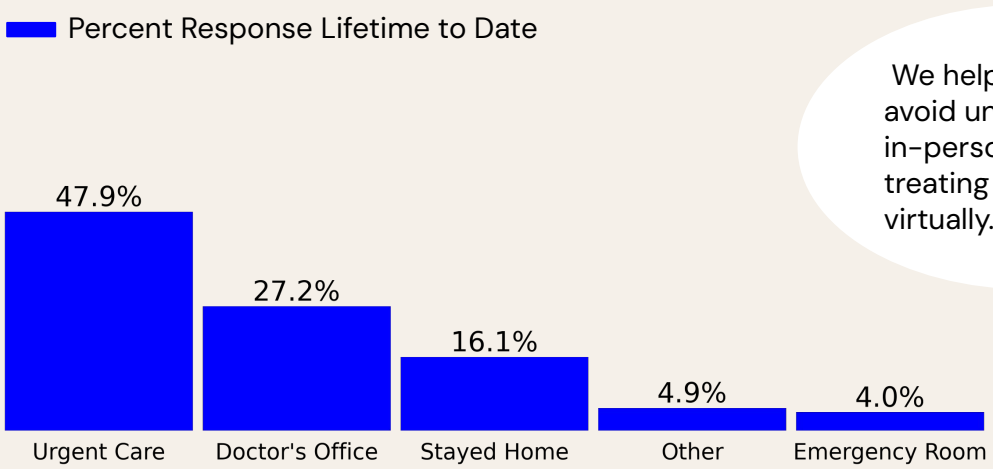
10AM – Noon

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

Member Access

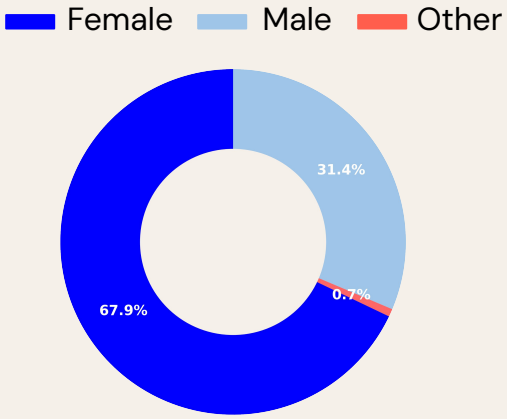
This section highlights our impact on increasing members' access to appropriate medical and behavioral health care, and their satisfaction with our services. We improve access to care by seeing members after hours (when brick & mortar providers are closed) and by making it easier to visit with a provider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

Without Included Health, where would you have gone?

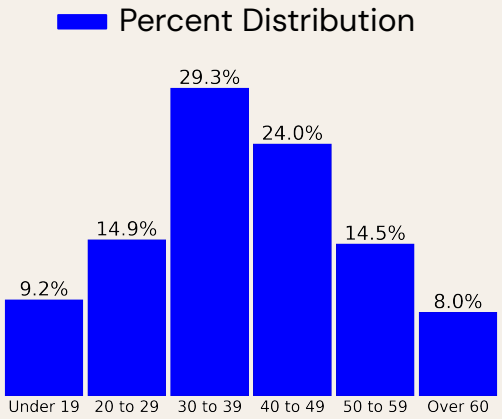


We help members avoid unnecessary in-person visits by treating their needs virtually.

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 (N = 197)	4.96 / 5 (N = 2,943)
Average Wait Time for On-Demand Medical Appointments	14.75 min	15.04 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	49	1,165
Cough	32	985
Fatigue / weakness	50	902
Headache	49	866
Sore throat	36	813
Difficulty sleeping	46	746
Nasal discharge	23	598
Fever	20	470
Difficulty / pain swallowing	12	433
Loss of appetite	20	407

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits This Month	Visits Lifetime to Date
Other upper respiratory infections	34	849
Anxiety disorders	62	637
Mood disorders	44	459
Urinary tract infections	28	366
Administrative/social admission	26	231
COVID-19	12	220
Cough, unspecified	5	181
Inflammation; infection of eye (except that c..	11	180
Adjustment disorders	28	180
Other upper respiratory disease	8	160

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

249	69.1%	74	4.0%
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	17	364
prednisone	8	268
nitrofurantoin monoh..	13	219
amoxicillin/potassiu..	11	206
albuterol	10	202
ipratropium nasal	10	182
fluticasone nasal	3	134
amoxicillin	2	119
methylprednisolone	1	115
nirmatrelvir/ritonavir	6	114

Top Labs	Count This Month	Count Lifetime to Date
Urinalysis, Complete..	10	50
Comprehensive Metabo..	3	48
CBC+diff	5	46
TSH with Reflex to F..	4	37
Lipid Panel	2	37
Hemoglobin A1c	2	30
Chlamydia/GC, Urine	4	28
Urine Culture, Routine	3	28
Vitamin D	2	22
HIV-1/2 Ag/Ab, 4th G..	4	20

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

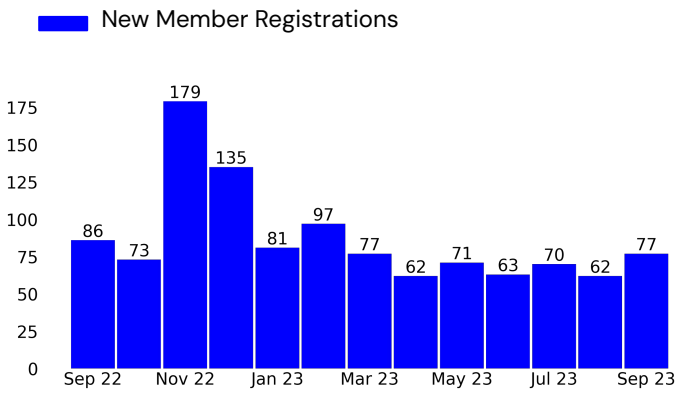
Reporting Period: 2023-09-01 to 2023-10-01

Member Engagement

77	251	304
Registrations This Month	Unique Visitors This Month	Total Visits This month

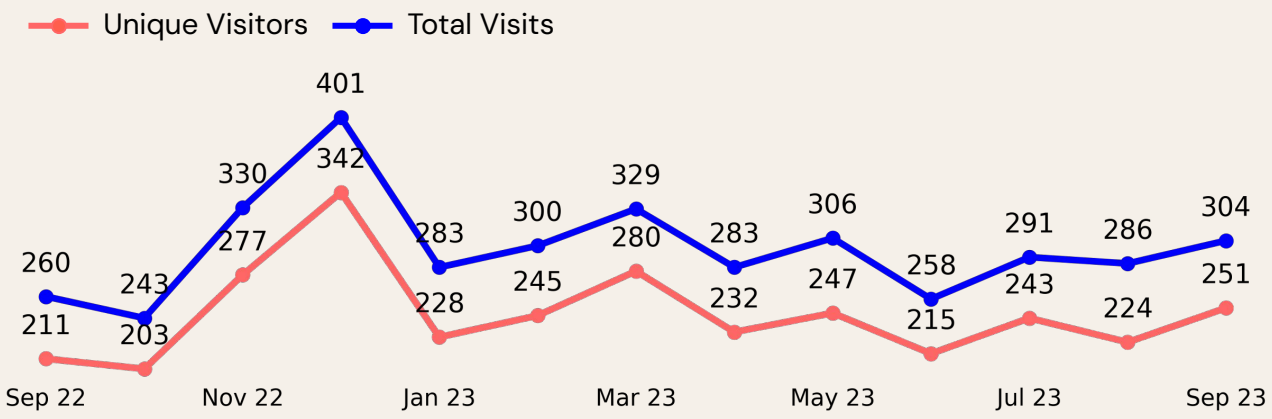
This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement 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	**2,839** Registrations Since Launch	Registration Rate Since Launch
Employee Covered Lives	**660** Registrations Year to Date	Registration Rate Year to Date

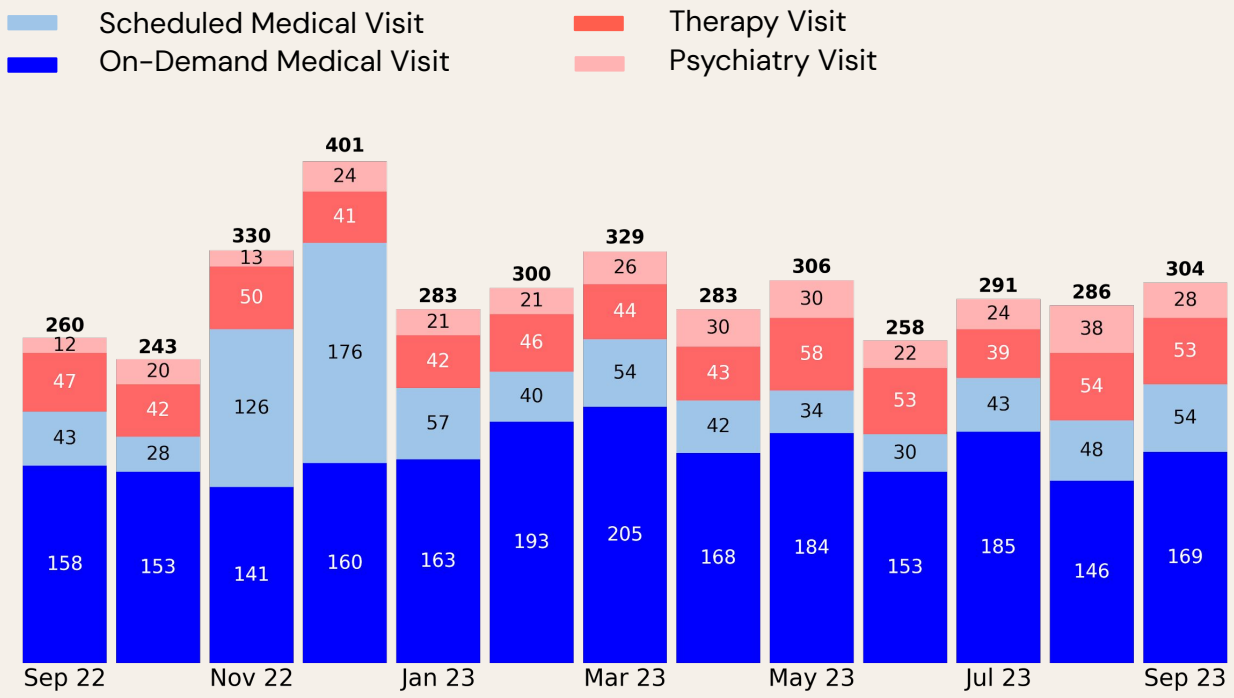
Visits Last 12 Months



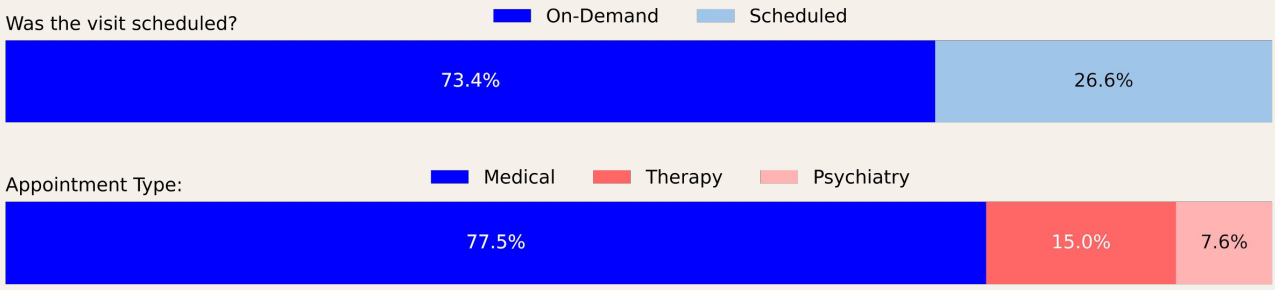
4,346 Visits Since Launch	**2,083** Unique Visitors Since Launch	**2.1** Average Visits Per Visitor Since Launch	Engagement Rate Since Launch (Visitors/Lives)	
2,640 Visits Year to Date	**1,416** Unique Visitors Year to Date	**1.9** Average Visits Per Visitor Year to Date	Engagement Rate Year to Date (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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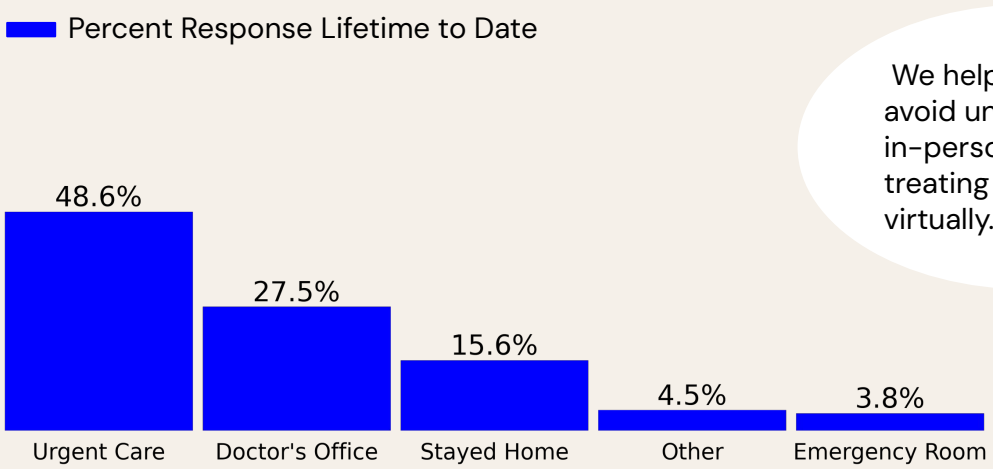

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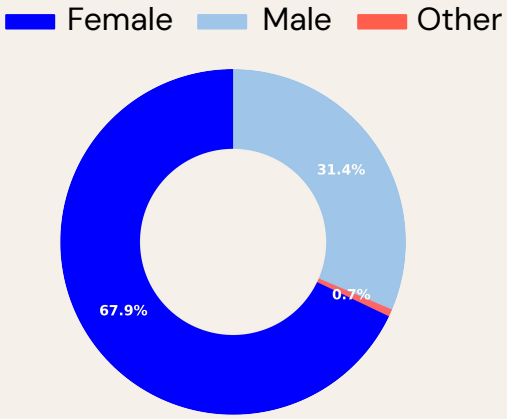
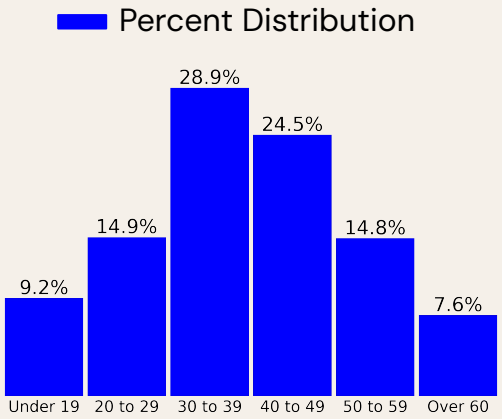
Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	This Month	Lifetime to Date
Average Member Rating	4.93 / 5 (N = 211)	4.96 / 5 (N = 3,156)
Average Wait Time for On-Demand Medical Appointments	16.75 min	15.16 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	79	1,244
Cough	49	1,034
Fatigue / weakness	57	959
Headache	56	922
Sore throat	58	871
Difficulty sleeping	57	803
Nasal discharge	45	643
Fever	37	507
Difficulty / pain swallowing	26	459
Ear pain	29	428

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits This Month	Visits Lifetime to Date
Other upper respiratory infections	42	891
Anxiety disorders	52	691
Mood disorders	46	505
Urinary tract infections	21	387
Administrative/social admission	19	250
COVID-19	29	249
Adjustment disorders	15	195
Inflammation; infection of eye (except that c..	14	194
Cough, unspecified	4	185
Other upper respiratory disease	7	167

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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

323	68.9%	9	3.8%
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Top Prescriptions and Testing Orders

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albuterol	8	210
ipratropium nasal	11	193
fluticasone nasal	4	138
nirmatrelvir/ritonavir	22	136
amoxicillin	7	126
methylprednisolone	10	125

Top Labs	Count This Month	Count Lifetime to Date
Urinalysis, Complete..	3	53
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CBC+diff		46
Lipid Panel	1	38
TSH with Reflex to F..		37
Hemoglobin A1c		30
Urine Culture, Routine	1	29
Chlamydia/GC, Urine	1	29
Vitamin D		22
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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 June 30, 2023:

- 4.3.1 Q4 UMR – Obesity Care Management Program
- 4.3.2 Q4 UMR – Diabetes Care Management Program
- 4.3.3 Q4 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network
- 4.3.4 Q4 Doctor on Demand Engagement Report through September 30, 2023
- **4.3.5 Q4 Express Scripts – Summary Report**

NEVADA PEBP FY23

Eaton, Cynthia

CYNTHIA EATON (CYNTHIA.EATON@EXPRESS-SCRIPTS.COM)

9/19/2023

Hello PEBP Team,

Attached you will find the FY23 summary files for the State of Nevada PEBP. I have highlighted the most impactful drivers of trend in the bullets below.

Trend Summaries:

CDHP – Plan Cost Net PMPM was $70.51, which increased 3.9%. Utilization (+5.5%), Unit Cost (-2.0%) and Cost Share (+0.4%).

From an indication perspective, the most notable areas are as follows:

- **Inflammatory Conditions** – The plan's top spend indication by Plan Cost Net. Plan Cost Net decreased $1.1M (-20.1%) to $4.5M. Patients declined from 308 to 279. Plan Cost Net PMPM decreased to $13.57 (-3.6%).
  - *Humira (CF) Pen* – The leading Inflammatory Condition prescription by Plan Cost Net. Patient count decreased from 46 to 42. Adj. Rxs decreased to 325 from 319, with a reduction of $41K (-2.4%) in Plan Cost Net.
  - *Stelara* – Ranked 2nd in spend by Plan Cost Net within Inflammatory Conditions. Patient count decreased from 13 to 10. Adj. Rxs decreased from 141 to 98 with decreased Plan Cost Net of $331K (-50.1%).
  - *Tremfya* – Ranked 7th (previously ranked 3rd) in spend by Plan Cost Net within Inflammatory Conditions. Patients decreased from 13 to 11. Adj. Rxs decreased from 109 to 71, with a reduction of -$271K (-60.7%) in Plan Cost Net.

- **HIV** – Ranked 4nd (previously 5th) in spend by Plan Cost Net. Plan Cost Net increased $198k (+12.9%) to $1.7M. Patients increased from 109 to 112. Plan Cost Net PMPM increased to $5.23 (+36.2%).
  - *Biktarvy*- The leading HIV prescription by Plan Cost Net. Patient count increased from 15 to 21. Adj. Rxs increased from 134 to 168, with an increase of $102K (24.8%) in Plan Cost Net.
  - *Apretude*- Ranked 8th in spend by Plan Cost Net within HIV. This is a newly utilized drug with a patient count of 6 and Adj. Rxs count of 28. Plan Cost Net for this period is $61K.
  - *Prezista* – Ranked 10th in spend by Plan Cost Net within HIV. This is a newly utilized drug with a patient count of 1 and Adj. Rxs count of 11. Plan Cost Net for this period is $22K.

- **Multiple Sclerosis** – Ranked 5th (previously 4th) in spend by Plan Cost Net. Plan Cost Net decreased $671k (-43.8%) to $860k. Patients decreased from 30 to 23. Plan Cost Net PMPM decreased to $2.60 (-32.3%).
  - *Gilenya* – Ranked 2nd (previously ranked 1st) by Plan Cost Net within MS. Patients remained constant at 5. Adj. Rxs decreased from 53 to 26, with a reduction of $99K (-36.9%) in Plan Cost Net.
  - *Dimethyl Fumarate* – Ranked 7th (previously 4th) in spend by Plan Cost Net within MS. Patients decreased from 6 to 2. Adj. Rxs decreased from 39 to 14, with a decrease of $150K (-80.4%) in Plan Cost Net.

- *Tecfidera* – Ranked 9th (previously 2nd) by Plan Cost Net within MS. Patients decreased from 6 to 1. Adj. Rxs decreased from 38 to 6, with a decreased Plan Cost Net of $220k (-86.2%).

- Peer Comparison: (ESI CDH Program) – CDHP PEBP continues to outperform their peer. Peer experienced Plan Cost Net PMPM of $74.60 compared to PEBP's Plan Cost Net PMPM of $70.48. The Peer experienced a trend of 11.9%, while PEBP CDHP experienced a trend of 3.9%.

EPO – Plan Cost Net PMPM was $153.72, which increased 14.3%. Utilization (+3.7%), Unit Cost (+10.2%), and Cost Share (+0.3%).

From an indication perspective, the most notable areas are as follows:

- **Endocrine Disorders** – Ranked 3rd (previously 4th) in indications by Plan Cost Net. Plan Cost Net increased $566K (+88.1%) to $1.2M. Patients increased from 35 to 37. Adj Rxs decreased from 232 to 227. Plan Cost Net PMPM increased to $15.65 (+119.6%)
  - *Korlym* – The leading Endocrine Disorders prescription by Plan Cost Net. Patients increased from 1 to 2. Adj. Rxs increased from 8 to 17, with increased Plan Cost Net of $566K (+100.5%)

  Changes in other Endocrine Disorder drugs weren't notable.

- **Inflammatory Conditions** – Leading indication in spend by Plan Cost Net. Plan Cost Net decreased $281K (-10.4%) to $2.4M. Patients decreased from 168 to 158. Plan Cost Net PMPM increased to $31.36 (+4.6%).
  - *Humira(CF) Pen* – The leading Inflammatory Conditions prescription by Plan Cost Net. Patient count decreased from 27 to 26. Adj. Rxs increased from 231 to 240, with increased Plan Cost Net Cost of $135K (+15.2%)
  - *Rinvoq* – Ranked 3rd (previously 8th) by Plan Cost Net. Patient count increased from 4 to 7. Adj. Rxs decreased from 30 to 54, with increased Plan Cost Net Cost of $79K (+77.4%)
  - *Humira Pen* – Ranked 5th (previously 2nd) by Plan Cost Net. Patient count remained constant at 6. Adj. Rxs decreased from 71 to 32, with decreased Plan Cost Net Cost of $168K (-57.9%)

- **Cancer** – Ranked 4th (previously 3rd) by Plan Cost Net. Plan Cost Net increased $86K (11.6%) to $827K. Patients decreased from 81 to 77. Plan Cost Net PMPM increased to $10.71 (30.2%).
  - *Piqray*- The leading Cancer prescription by Plan Cost Net. Patient count remained constant at 1. Adj. Rxs increased from 12 to 13, with increased Plan Cost Net of $30K (+15.2%).
  - *Mekinist* – Ranked 4th in spend for Cancer. This is a newly utilized drug with patient count of 1. Adj. Rxs count of 8, with Plan Cost Net of $52K this period.
  - *Tafinlar* – Ranked 5th in spend for Cancer. This is a newly utilized drug with patient count of 1. Adj. Rxs count of 8, with Plan Cost Net of $43K this period.

- **Skin Conditions** – Ranked 9th (previously 15th) by Plan Cost Net. Plan Cost Net increased $78K (31.8%) to $325k. Patients decreased from 652 to 570. Plan Cost Net PMPM increased to $4.21 (+53.8%).
    - *Dupixent (Pen & Syringe Combined)* – The leading Skin Conditions prescription by Plan Cost Net. Patient count increased from 12 to 13. Adj. Rxs increased from 88 to 120, with increased Plan Cost Net of $71K (+38.3%).
    - *Opzelura* – Ranked 3rd (previously 15th) in spend for Skin Conditions. Patients increased from 1 to 8. Adj. Rxs increased from 1 to 19, with an increase of $23K (+1,574.4%) in Plan Cost Net.

  Changes in other Skin Conditions drugs weren't notable.

- Peer Comparison (Government – West Region/SaveON) – This is a custom peer specifically created for PEBP. Population contains peers that are part of the Government – West region and have SaveOnSP in some or all of their plans. The Peer is outperforming PEBP. Peer has a Plan Cost Net PMPM of $93.55 compared to PEBP's EPO Plan Cost Net PMPM of $153.72. The Peer also experienced a lower trend of 6.9%, while PEBP's EPO Plan experienced trend of 14.3%.

PPO – Plan Cost Net PMPM was $84.22, which increased 9.3%. Utilization (+4.4%), Unit Cost (+3.7%), and Cost Share (+1.2%).

From an indication perspective, the most notable areas are as follows:

- **Inflammatory Conditions** – Leading indication in spend by Plan Cost Net. Plan Cost Net increased $1.4M (96.5%) to $2.8M. Patient count increased from 113 to 201. Plan Cost Net PMPM increased to $16.55 (+17%)
    - *Humira (CF) Pen* – The leading inflammatory condition prescription by Plan Cost Net. Patient count increased from 19 to 29. Adj Rxs increased from 125 to 233, with an additional $408K (+86.7%) in Plan Cost Net.
    - *Stelara* – Ranked 3rd (previously ranked 6th) in spend for inflammatory conditions. Patient count increased from 3 to 9. Adj. Rxs increased from 29 to 82, with an additional $190K (+217.6%) in Plan Cost Net.
    - *Skyrizi (Pen & Syringe Combined)* – Ranked 4th & 5th in spend for inflammatory conditions. Patient count increased from 4 to 14. Adj. Rxs increased from 26 to 116, with an additional $262K (+354.7%) in Plan Cost Net.

- **Diabetes** – Ranked 2nd in spend by Plan Cost Net. Plan Cost Net increased $992K (+106.3%) to $1.9M. Patient count increased from 527 to 1045. Plan Cost Net PMPM increased to $11.19(+22.7%)
    - *Ozempic* – The leading diabetes prescription by Plan Cost Net (previously ranked 2nd). Patient count increased from 58 to 206. Adj. Rxs increased from 413 to 1,278, with an additional $338K (+196.2%) in Plan Cost Net.
    - *Trulicity* – Ranked 2nd (previously 1st) in spend by Plan Cost Net within Diabetes. Patient count increased from 58 to 100. Adj. Rxs increased from 586 to 867, with an additional $134K (+60.5%) in Plan Cost Net.

        - *Mounjaro* – Ranked 3rd in spend for diabetes. This is a newly utilized drug with patient count of 93. Adj. Rxs count of 424, with Plan Cost Net of $189K this period.

    - **Enzyme Deficiencies**– Ranked 6th (previously ranked 9th) in spend by Plan Cost Net. Plan Cost Net increased $422K (+192.8%) to $640k. Patient count increased from 2 to 4. Plan Cost Net PMPM increased to $3.72 (+74.2%)
        - *Strensiq* – The leading Enzyme Deficiencies prescription by Plan Cost Net. Patient count remained constant at 1. Adj. Rxs increased from 1 to 11, with an additional $216K (+162.9%) in Plan Cost Net.
        - *Nexviazyme*- Ranked 2nd in spend for Enzyme Deficiencies. This is a newly utilized drug with patient count of 1. Adj. Rxs count of 4, with Plan Cost Net of $194K this period.

    Changes in other Enzyme Deficiencies drugs weren't notable.

    - Additional Notes: While not in the top 10 indications, PPO Plan saw new utilization of a very rare condition. Neuromyelitis Optica Spectrum, with one patient and Plan Cost Net of $210k

- Peer Comparison (Government – West Region/SaveON) – This is a custom peer specifically created for PEBP. Population contains peers that are part of the Government – West region and have SaveOnSP in some or all of their plans. PEBP is outperforming the peer. Peer has a Plan Cost Net PMPM of $93.55 compared to PEBP's EPO Plan Cost Net PMPM of $84.21. However, the Peer experienced a lower trend of 6.9%, while PEBP's PPO Plan experienced trend of 9.3%.

Total – Overall, Plan Cost Net PMPM Trend is 7.6%. Trend is driven by increases almost exclusively on NonSpecialty. The NonSpecialty trend was driven by all three components of trend: utilization, unit cost and cost share. Specialty had an almost flat trend of 0.2%, which was mitigating to the overall trend. Utilization was driven by an increase in days per member, heavily weighted on NonSpecialty. Membership declined -1.9% vs. NonSpecialty days increased +2.1%. Member Cost Share Net % decrease was driven, at least in part, by COVID-19 impact test kits, which have no member cost share. Unit Cost increases were driven by utilization of more expensive brand drugs.

Key Statistics:

- Membership -1.9% (928 less members)
    - Members utilizing the benefit -2.4% (1,915 less patients)
- Total (Adj.Rxs) claims +0.8% (5,984 more Adj. Rxs)
- Gross Cost/Adj. Rx increased $11.58 (+10.3%) to $112.46
- Plan spend +$9M (+14.5%)
- Rebates (estimated) increased $6.4M (41.9%)
- Plan Cost Net PMPM (factoring rebates) increased $6.05(+7.6%) to $85.68
- Generic Fill Rate (GFR) increased 0.6 points to 85.9%
- Generic Fill Rate after excluding COVID-19 vaccines, test kits, and antivirals from both periods decreased 0.3 points to 88.1%

- Mail Penetration Rate (MPR) increased 4.8 points to 33.0%; factoring R90 Maintenance utilization, 90-day utilization rate grew from 60.2% to 61.6% this period, an increase of 1.4 percentage points.
- Member Cost Share Net % decreased 1.1 points, down to 25.8%.

**The data contained herein is pulled from a specific point-in-time and is subject to change at any time without notice due to a variety of factors, including but not limited to changes related to Member behavior, population demographics, system updates, and product availability. The data does not represent a guarantee and should not be used for audit purposes*

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 June 30, 2023:

- 4.3.1 Q4 UMR – Obesity Care Management Program
- 4.3.2 Q4 UMR – Diabetes Care Management Program
- 4.3.3 Q4 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network
- 4.3.4 Q4 Doctor on Demand Engagement Report through September 30, 2023
- 4.3.5 Q4 Express Scripts – Summary Report
- **4.3.6 Q4 Express Scripts – Utilization Report**

Nevada PEBP FY2023 Report

7/1/2022 – 6/30/2023

Report Includes:

- CDHP Comparison Data from FY22 vs. FY23
- EPO Comparison Data from FY22 vs. FY23
- PPO Comparison Data from FY22 vs. FY23
- EPO, CDHP, PPO Breakout Data from FY22 vs. FY23
- Summary Comparison Data from FY23
- Key Metric Breakout Data from FY23

The data contained herein is pulled from a specific point-in-time and is subject to change at any time without notice due to a variety of factors, including but not limited to changes related to Member behavior, population demographics, system updates, and product availability. The data does not represent a guarantee and should not be used for audit purposes.

PREPARED BY CLIENT ANALYTICS

Cynthia Eaton (Cynthia.eaton@express-scripts.com)

9/19/2023

EXPRESS SCRIPTS® CHAMPIONS FOR BETTER™

STATE OF NEVADA PEBP – CDHP

Prescription Drug Utilization

FY22 vs FY23

	Total		
Membership Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Member Count (Membership)	27,535	33,195	-17.1%
Utilizing Member Count (Patients)	20,954	26,411	-20.7%
Percent Utilizing (Utilization)	76.1%	79.6%	-3.5

Claim Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Net Claims (Total Adjusted Rx's)	375,851	437,389	-14.1%
Claims per Elig Member per Month (Claims PMPM)	1.14	1.10	3.6%
Total Claims for Generic (Generic ARx)	325,222	374,126	-13.1%
Total Claims for Brand (Brand ARx)	50,629	63,263	-20.0%
Total Claims for Multisource Brand Claims (MSB ARx)	1,489	2,514	-40.8%
Total Non-Specialty Claims	371,917	433,115	-14.1%
Total Specialty Claims	3,934	4,274	-8.0%
Generic % of Total Claims (GFR)	**86.5%**	**85.5%**	**1.0**
Generic Effective Rate (GCR)	99.5%	99.3%	0.2
Mail Order Claims	105,990	107,819	-1.7%
Mail Penetration Rate*	32.0%	28.6%	3.5

Claims Cost Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Total Prescription Cost (Total Gross Cost)	**$43,434,385**	**$47,245,985**	**-8.1%**
Total Generic Gross Cost	$5,078,063	$6,251,801	-18.8%
Total Brand Gross Cost	$38,356,322	$40,994,184	-6.4%
Total MSB Gross Cost	$817,072	$1,091,814	-25.2%
Total Ingredient Cost	$41,937,535	$46,387,030	-9.6%
Total Dispensing Fee	$1,451,872	$834,084	74.1%
Total Other (e.g. tax)	$44,979	$24,872	80.8%
Avg Total Cost per Claim (Gross Cost/ARx)	**$115.56**	**$108.02**	**7.0%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$15.61	$16.71	-6.6%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$757.60	$648.00	16.9%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$548.74	$434.29	26.4%

*Mail Order % of Total Claims replaced with Mail Penetration rate- calculates % of mail days out of all days of therapy to normalize between channels.
Utilization represents data including compounds & powders, direct claims, SSG and zero net-cost claims. Excludes external claims & high AWP claims.

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STATE OF NEVADA PEBP - CDHP (CONT)

Prescription Drug Utilization

FY22 vs FY23

Member Cost Summary	Total Q1 - Q4 FY 2023	Total Q1 - Q4 FY 2022	Change
Total Member Cost Share	**$9,856,720**	**$11,587,059**	**-14.9%**
Generic Cost Share	$2,075,897	$2,991,246	-30.6%
Brand Cost Share	$7,780,823	$8,595,813	-9.5%
MSB Cost Share	$227,774	$264,240	-13.8%
Total Copay	$8,042,510	$9,130,124	-11.9%
Total Deductible	$1,814,211	$2,456,935	-26.2%
Avg Copay per Claim (Member Cost Share/ARx)	**$26.23**	**$26.49**	**-1.0%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.38	$8.00	-20.2%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$153.68	$135.87	13.1%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$152.97	$105.11	45.5%
Copay % of Total Prescription Cost (Member Cost Share %)	**22.7%**	**24.5%**	**-1.8**

Plan Cost Summary	Q1 - Q4 FY 2023	Q1 - Q4 FY 2022	Change
Total Plan Cost (Plan Cost)	**$33,577,665**	**$35,658,926**	**-5.8%**
Generic Plan Cost	$3,002,166	$3,260,555	-7.9%
Brand Plan Cost	$30,575,499	$32,398,371	-5.6%
MSB Plan Cost	$589,299	$827,574	-28.8%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$14,902,458	$14,743,056	1.1%
Total Specialty Drug Cost (Specialty Plan Cost)	$18,675,207	$20,915,869	-10.7%
Avg Plan Cost per Claim (Plan Cost/ARx)	$89.34	$81.53	9.6%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$9.23	$8.72	5.9%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$603.91	$512.12	17.9%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$395.77	$329.19	20.2%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$40.07	$34.04	17.7%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$4,747.13	$4,893.75	-3.0%
Plan Cost PMPM	**$101.62**	**$89.52**	**13.5%**
Non-Specialty Plan Cost PMPM	$45.10	$37.01	21.9%
Specialty Plan Cost PMPM	$56.52	$52.51	7.6%
Specialty % of Plan Cost	55.6%	58.7%	-3.04
Net Plan Cost PMPM (factoring Rebates)	**$70.51**	**$67.85**	**3.9%**
Non-Specialty Plan Cost PMPM	$27.90	$23.20	20.3%
Specialty Plan Cost PMPM	$42.61	$44.65	-4.6%

*Mail Order % of Total Claims replaced with Mail Penetration rate- calculates % of mail days out of all days of therapy to normalize between channels.
Utilization represents data including compounds & powders, direct claims, SSG and zero net-cost claims. Excludes external claims & high AWP claims.

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STATE OF NEVADA PEBP - EPO

Prescription Drug Utilization

FY22 vs FY23

	Total		
Membership Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Member Count (Membership)	6,437	7,514	-14.3%
Utilizing Member Count (Patients)	5,543	6,603	-16.1%
Percent Utilizing (Utilization)	86.1%	87.9%	-1.8

Claim Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Net Claims (Total Adjusted Rx's)	134,802	153,250	-12.0%
Claims per Elig Member per Month (Claims PMPM)	1.75	1.70	2.7%
Total Claims for Generic (Generic ARx)	115,393	130,971	-11.9%
Total Claims for Brand (Brand ARx)	19,409	22,279	-12.9%
Total Claims for Multisource Brand Claims (MSB ARx)	666	972	-31.5%
Total Non-Specialty Claims	133,120	151,707	-12.3%
Total Specialty Claims	1,682	1,543	9.0%
Generic % of Total Claims (GFR)	**85.6%**	**85.5%**	**0.1**
Generic Effective Rate (GCR)	99.4%	99.3%	0.2
Mail Order Claims	38,666	33,978	13.8%
Mail Penetration Rate*	31.6%	24.7%	6.9

Claims Cost Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Total Prescription Cost (Total Gross Cost)	**$20,087,261**	**$19,675,461**	**2.1%**
Total Generic Gross Cost	$1,994,720	$2,769,479	-28.0%
Total Brand Gross Cost	$18,092,541	$16,905,982	7.0%
Total MSB Gross Cost	$402,866	$317,462	26.9%
Total Ingredient Cost	$19,551,811	$19,488,599	0.3%
Total Dispensing Fee	$516,496	$177,955	190.2%
Total Other (e.g. tax)	$18,954	$8,907	112.8%
Avg Total Cost per Claim (Gross Cost/ARx)	**$149.01**	**$128.39**	**16.1%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$17.29	$21.15	-18.3%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$932.17	$758.83	22.8%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$604.90	$326.61	85.2%

*Mail Order % of Total Claims replaced with Mail Penetration rate- calculates % of mail days out of all days of therapy to normalize between channels.
Utilization represents data including compounds & powders, direct claims, SSG and zero net-cost claims. Excludes external claims & high AWP claims.

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Prescription Drug Utilization

FY22 vs FY23

	Total		
Member Cost Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Total Member Cost Share	**$3,267,229**	**$3,384,939**	**-3.5%**
Generic Cost Share	$767,336	$969,659	-20.9%
Brand Cost Share	$2,499,893	$2,415,280	3.5%
MSB Cost Share	$56,010	$37,221	50.5%
Total Copay	$3,264,742	$3,374,770	-3.3%
Total Deductible	$2,487	$10,169	-75.5%
Avg Copay per Claim (Member Cost Share/ARx)	**$24.24**	**$22.09**	**9.7%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.65	$7.40	-10.2%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$128.80	$108.41	18.8%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$84.10	$38.29	119.6%
Copay % of Total Prescription Cost (Member Cost Share %)	**16.3%**	**17.2%**	**-0.9**

Plan Cost Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Total Plan Cost (Plan Cost)	**$16,820,032**	**$16,290,522**	**3.3%**
Generic Plan Cost	$1,227,385	$1,799,820	-31.8%
Brand Plan Cost	$15,592,647	$14,490,702	7.6%
MSB Plan Cost	$346,856	$280,240	23.8%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$8,291,934	$8,709,373	-4.8%
Total Specialty Drug Cost (Specialty Plan Cost)	$8,528,097	$7,581,149	12.5%
Avg Plan Cost per Claim (Plan Cost/ARx)	$124.78	$106.30	17.4%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$10.64	$13.74	-22.6%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$803.37	$650.42	23.5%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$520.80	$288.31	80.6%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$62.29	$57.41	8.5%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$5,070.21	$4,913.25	3.2%
Plan Cost PMPM	**$217.75**	**$180.67**	**20.5%**
Non-Specialty Plan Cost PMPM	$107.35	$96.59	11.1%
Specialty Plan Cost PMPM	$110.40	$84.08	31.3%
Specialty % of Plan Cost	50.7%	46.5%	4.2
Net Plan Cost PMPM (factoring Rebates)	**$153.72**	**$134.53**	**14.3%**
Non-Specialty Plan Cost PMPM	$69.71	$64.75	7.7%
Specialty Plan Cost PMPM	$84.02	$69.78	20.4%

*Mail Order % of Total Claims replaced with Mail Penetration rate- calculates % of mail days out of all days of therapy to normalize between channels.
Utilization represents data including compounds & powders, direct claims, SSG and zero net-cost claims. Excludes external claims & high AWP claims.

STATE OF NEVADA PEBP - PPO

Prescription Drug Utilization

FY22 vs FY23

	Total		
Membership Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Member Count (Membership)	14,339	8,533	68.0%
Utilizing Member Count (Patients)	11,981	7,382	62.3%
Percent Utilizing (Utilization)	83.6%	86.5%	-3.0

Claim Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Net Claims (Total Adjusted Rx's)	203,944	117,974	72.9%
Claims per Elig Member per Month (Claims PMPM)	1.19	1.15	2.9%
Total Claims for Generic (Generic ARx)	173,375	99,355	74.5%
Total Claims for Brand (Brand ARx)	30,569	18,619	64.2%
Total Claims for Multisource Brand Claims (MSB ARx)	1,084	785	38.1%
Total Non-Specialty Claims	201,782	116,934	72.6%
Total Specialty Claims	2,162	1,040	107.9%
Generic % of Total Claims (GFR)	**85.0%**	**84.2%**	**0.8**
Generic Effective Rate (GCR)	99.4%	99.2%	0.2
Mail Order Claims	63,866	32,171	98.5%
Mail Penetration Rate*	35.9%	31.7%	4.1

Claims Cost Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Total Prescription Cost (Total Gross Cost)	**$25,113,901**	**$12,767,250**	**96.7%**
Total Generic Gross Cost	$3,197,740	$2,359,389	35.5%
Total Brand Gross Cost	$21,916,161	$10,407,860	110.6%
Total MSB Gross Cost	$579,414	$288,557	100.8%
Total Ingredient Cost	$24,285,157	$12,552,322	93.5%
Total Dispensing Fee	$795,375	$205,132	287.7%
Total Other (e.g. tax)	$33,369	$9,795	240.7%
Avg Total Cost per Claim (Gross Cost/ARx)	**$123.14**	**$108.22**	**13.8%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$18.44	$23.75	-22.3%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$716.94	$558.99	28.3%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$534.51	$367.59	45.4%

*Mail Order % of Total Claims replaced with Mail Penetration rate- calculates % of mail days out of all days of therapy to normalize between channels. Utilization represents data including compounds & powders, direct claims, SSG and zero net-cost claims. Excludes external claims & high AWP claims.

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Prescription Drug Utilization

FY22 vs FY23

Member Cost Summary	Total Q1 - Q4 FY 2023	Total Q1 - Q4 FY 2022	Total Change
Total Member Cost Share	**$4,122,321**	**$2,357,089**	**74.9%**
Generic Cost Share	$1,085,325	$719,438	50.9%
Brand Cost Share	$3,036,996	$1,637,651	85.4%
MSB Cost Share	$43,046	$25,112	71.4%
Total Copay	$4,122,321	$2,332,020	76.8%
Total Deductible	$0	$0	NA
Avg Copay per Claim (Member Cost Share/ARx)	**$20.21**	**$19.98**	**1.2%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.26	$7.24	-13.5%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$99.35	$87.96	13.0%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$39.71	$31.99	24.1%
Copay % of Total Prescription Cost (Member Cost Share %)	**16.4%**	**18.5%**	**-2.0**

Plan Cost Summary	Q1 - Q4 FY 2023	Q1 - Q4 FY 2022	Change
Total Plan Cost (Plan Cost)	**$20,991,580**	**$10,410,161**	**101.6%**
Generic Plan Cost	$2,112,415	$1,639,951	28.8%
Brand Plan Cost	$18,879,165	$8,770,210	115.3%
MSB Plan Cost	$536,368	$263,445	103.6%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$11,779,306	$6,262,475	88.1%
Total Specialty Drug Cost (Specialty Plan Cost)	$9,212,274	$4,147,686	122.1%
Avg Plan Cost per Claim (Plan Cost/ARx)	$102.93	$88.24	16.6%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$12.18	$16.51	-26.2%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$617.59	$471.04	31.1%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$494.80	$335.60	47.4%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$58.38	$53.56	9.0%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$4,261.00	$3,988.16	6.8%
Plan Cost PMPM	**$122.00**	**$101.67**	**20.0%**
Non-Specialty Plan Cost PMPM	$68.46	$61.16	11.9%
Specialty Plan Cost PMPM	$53.54	$40.51	32.2%
Specialty % of Plan Cost	43.9%	39.8%	4.0
Net Plan Cost PMPM (factoring Rebates)	**$84.22**	**$77.03**	**9.3%**
Non-Specialty Plan Cost PMPM	$46.20	$42.92	7.7%
Specialty Plan Cost PMPM	$38.02	$34.12	11.4%

*Mail Order % of Total Claims replaced with Mail Penetration rate- calculates % of mail days out of all days of therapy to normalize between channels.
Utilization represents data including compounds & powders, direct claims, SSG and zero net-cost claims. Excludes external claims & high AWP claims.

STATE OF NEVADA PEBP

Prescription Drug Utilization

FY23

Membership Summary	Total	LOB Breakouts for FY2023 EPO	CDHP	PPO
Member Count (Membership)	48,303	6,437	27,535	14,339
Utilizing Member Count (Patients)	38,313	5,543	20,954	11,981
Percent Utilizing (Utilization)	79.3%	86.1%	76.1%	84%

Claim Summary	Total	EPO	CDHP	PPO
Net Claims (Total Rx's)	714,597	134,802	375,851	203,944
Claims per Elig Member per Month (Claims PMPM)	1.23	1.75	1.14	1.19
Total Claims for Generic (Generic Rx)	613,990	115,393	325,222	173,375
Total Claims for Brand (Brand Rx)	100,607	19,409	50,629	30,569
Total Claims for Multisource Brand Claims (MSB Rx)	3,239	666	1,489	1,084
Total Non-Specialty Claims	706,819	133,120	371,917	201,782
Total Specialty Claims	7,778	1,682	3,934	2,162
Generic % of Total Claims (GFR)	**85.9%**	**85.6%**	**86.5%**	**85.0%**
Generic Effective Rate (GCR)	99.5%	99.4%	99.5%	99.4%
Mail Order Claims	208,522	38,666	105,990	63,866
Mail Penetration Rate*	33.0%	31.6%	32.0%	35.9%

Claims Cost Summary	Total	EPO	CDHP	PPO
Total Prescription Cost (Total Gross Cost)	**$88,635,547**	**$20,087,261**	**$43,434,385**	**$25,113,901**
Total Generic Gross Cost	$10,270,523	$1,994,720	$5,078,063	$3,197,740
Total Brand Gross Cost	$78,365,024	$18,092,541	$38,356,322	$21,916,161
Total MSB Gross Cost	$1,799,352	$402,866	$817,072	$579,414
Total Ingredient Cost	$85,774,503	$19,551,811	$41,937,535	$24,285,157
Total Dispensing Fee	$1,968,367	$516,496	$1,451,872	$795,375
Total Other (e.g. tax)	$97,301	$18,954	$44,979	$33,369
Avg Total Cost per Claim (Gross Cost/Rx)	**$124.04**	**$149.01**	**$115.56**	**$123.14**
Avg Total Cost for Generic (Generic Gross Cost/Generic Rx)	$16.73	$17.29	$15.61	$18.44
Avg Total Cost for Brand (Brand Gross Cost/Brand Rx)	$778.92	$932.17	$757.60	$716.94
Avg Total Cost for MSB (MSB Gross Cost/MSB Rx)	$555.53	$604.90	$548.74	$534.51

*Mail Order % of Total Claims replaced with Mail Penetration rate- calculates % of mail days out of all days of therapy to normalize between channels.
Utilization represents data including compounds & powders, direct claims, SSG and zero net-cost claims. Excludes external claims & high AWP claims.

EXPRESS SCRIPTS® CHAMPIONS FOR BETTER™

STATE OF NEVADA PEBP TOTAL SUMMARY

Prescription Drug Utilization

FY23

Member Cost Summary	Total	LOB Breakouts for FY2023 EPO	CDHP	PPO
Total Member Cost Share	**$17,246,270**	**$3,267,229**	**$9,856,720**	**$4,122,321**
Generic Cost Share	$3,928,558	$767,336	$2,075,897	$1,085,325
Brand Cost Share	$13,317,713	$2,499,893	$7,780,823	$3,036,996
MSB Cost Share	$326,829	$56,010	$227,774	$43,046
Total Copay	$15,429,573	$3,264,742	$8,042,510	$4,122,321
Total Deductible	$1,816,698	$2,487	$1,814,211	$0
Avg Copay per Claim (Member Cost Share/Rx)	**$24.13**	**$24.24**	**$26.23**	**$20.21**
Avg Copay for Generic (Generic Member Cost Share/Generic Rx)	$6.40	$6.65	$6.38	$6.26
Avg Copay for Brand (Brand Member Cost Share/Brand Rx)	$132.37	$128.80	$153.68	$99.35
Avg Copay for MSB (MSB Member Cost Share/MSB Rx)	$100.90	$84.10	$152.97	$39.71
Copay % of Total Prescription Cost (Member Cost Share %)	**19.5%**	**16.3%**	**22.7%**	**16.4%**

Plan Cost Summary	Total	EPO	CDHP	PPO
Total Plan Cost (Plan Cost)	**$71,389,277**	**$16,820,032**	**$33,577,665**	**$20,991,580**
Generic Plan Cost	$6,341,965	$1,227,385	$3,002,166	$2,112,415
Brand Plan Cost	$65,047,311	$15,592,647	$30,575,499	$18,879,165
MSB Plan Cost	$1,472,522	$346,856	$589,299	$536,368
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$34,973,699	$8,291,934	$14,902,458	$11,779,306
Total Specialty Drug Cost (Specialty Plan Cost)	$36,415,578	$8,528,097	$18,675,207	$9,212,274
Avg Plan Cost per Claim (Plan Cost/Rx)	$99.90	$124.78	$89.34	$102.93
Avg Plan Cost for Generic (Generic Plan Cost/Generic Rx)	$10.33	$10.64	$9.23	$12.18
Avg Plan Cost for Brand (Brand Plan Cost/Brand Rx)	$646.55	$803.37	$603.91	$617.59
Avg Plan Cost for MSB (MSB Plan Cost/MSB Rx)	$454.62	$520.80	$395.77	$494.80
Avg Non-Specialty Plan Cost per Claim (Plan Cost/Rx)	$49.48	$62.29	$40.07	$58.38
Avg Specialty Plan Cost per Claim (Plan Cost/Rx)	$4,681.87	$5,070.21	$4,747.13	$4,261.00
Plan Cost PMPM	**$123.16**	**$217.75**	**$101.62**	**$122.00**
Non-Specialty Plan Cost PMPM	$60.34	$107.35	$45.10	$68.46
Specialty Plan Cost PMPM	$62.82	$110.40	$56.52	$53.54
Specialty % of Plan Cost	51.0%	50.7%	55.6%	43.9%
Net Plan Cost PMPM (factoring Rebates)	**$85.68**	**$153.72**	**$70.51**	**$84.22**
Non-Specialty Net Plan Cost PMPM	$38.91	$69.71	$27.90	$46.20
Specialty Net Plan Cost PMPM	$46.77	$84.02	$42.61	$38.02

*Mail Order % of Total Claims replaced with Mail Penetration rate- calculates % of mail days out of all days of therapy to normalize between channels.
Utilization represents data including compounds & powders, direct claims, SSG and zero net-cost claims. Excludes external claims & high AWP claims.

EXPRESS SCRIPTS® CHAMPIONS FOR BETTER™

STATE OF NEVADA PEBP TOTAL SUMMARY

Prescription Drug Utilization

FY22 vs FY23

	Total		
Membership Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Member Count (Membership)	48,303	49,231	-1.9%
Utilizing Member Count (Patients)	38,313	40,228	-4.8%
Percent Utilizing (Utilization)	79.3%	81.7%	-2.4

Claim Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Net Claims (Total Adjusted Rx's)	714,597	708,613	0.8%
Claims per Elig Member per Month (Claims PMPM)	1.23	1.20	2.8%
Total Claims for Generic (Generic ARx)	613,990	604,452	1.6%
Total Claims for Brand (Brand ARx)	100,607	104,161	-3.4%
Total Claims for Multisource Brand Claims (MSB ARx)	3,239	4,271	-24.2%
Total Non-Specialty Claims	706,819	701,756	0.7%
Total Specialty Claims	7,778	6,857	13.4%
Generic % of Total Claims (GFR)	**85.9%**	**85.3%**	**0.6**
Generic Effective Rate (GCR)	99.5%	99.3%	0.2
Mail Order Claims	208,522	173,968	19.9%
Mail Penetration Rate*	33.0%	28.2%	4.8

Claims Cost Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Total Prescription Cost (Total Gross Cost)	**$88,635,547**	**$79,688,696**	**11.2%**
Total Generic Gross Cost	$10,270,523	$11,380,669	-9.8%
Total Brand Gross Cost	$78,365,024	$68,308,027	14.7%
Total MSB Gross Cost	$1,799,352	$1,697,833	6.0%
Total Ingredient Cost	$85,774,503	$78,427,952	9.4%
Total Dispensing Fee	$2,763,743	$1,217,171	127.1%
Total Other (e.g. tax)	$97,301	$43,573	123.3%
Avg Total Cost per Claim (Gross Cost/ARx)	**$124.04**	**$112.46**	**10.3%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$16.73	$18.83	-11.2%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$778.92	$655.79	18.8%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$555.53	$397.53	39.7%

*Mail Order % of Total Claims replaced with Mail Penetration rate- calculates % of mail days out of all days of therapy to normalize between channels.
Utilization represents data including compounds & powders, direct claims, SSG and zero net-cost claims. Excludes external claims & high AWP claims.

EXPRESS SCRIPTS® CHAMPIONS FOR BETTER™

Prescription Drug Utilization

FY22 vs FY23

	Total		
Member Cost Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Total Member Cost Share	**$17,246,270**	**$17,329,087**	**-0.5%**
Generic Cost Share	$3,928,558	$4,680,343	-16.1%
Brand Cost Share	$13,317,713	$12,648,744	5.3%
MSB Cost Share	$326,829	$326,573	0.1%
Total Copay	$15,429,573	$14,836,913	4.0%
Total Deductible	$1,816,698	$2,492,174	-27.1%
Avg Copay per Claim (Member Cost Share/ARx)	**$24.13**	**$24.45**	**-1.3%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.40	$7.74	-17.4%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$132.37	$121.43	9.0%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$100.90	$76.46	32.0%
Copay % of Total Prescription Cost (Member Cost Share %)	**19.5%**	**21.7%**	**-2.3**

Plan Cost Summary	**Q1 - Q4 FY 2023**	**Q1 - Q4 FY 2022**	**Change**
Total Plan Cost (Plan Cost)	**$71,389,277**	**$62,359,609**	**14.5%**
Generic Plan Cost	$6,341,965	$6,700,326	-5.3%
Brand Plan Cost	$65,047,311	$55,659,283	16.9%
MSB Plan Cost	$1,472,522	$1,371,260	7.4%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$34,973,699	$29,714,904	17.7%
Total Specialty Drug Cost (Specialty Plan Cost)	$36,415,578	$32,644,704	11.6%
Avg Plan Cost per Claim (Plan Cost/ARx)	$99.90	$88.00	13.5%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$10.33	$11.08	-6.8%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$646.55	$534.36	21.0%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$454.62	$321.06	41.6%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$49.48	$42.34	16.9%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$4,681.87	$4,760.79	-1.7%
Plan Cost PMPM	**$123.16**	**$105.56**	**16.7%**
Non-Specialty Plan Cost PMPM	$60.34	$50.30	20.0%
Specialty Plan Cost PMPM	$62.82	$55.26	13.7%
Specialty % of Plan Cost	51.0%	52.3%	(1.3)
Net Plan Cost PMPM (factoring Rebates)	**$85.68**	**$79.63**	**7.6%**
Non-Specialty Plan Cost PMPM	$38.91	$32.96	18.0%
Specialty Plan Cost PMPM	$46.77	$46.67	0.2%

*Mail Order % of Total Claims replaced with Mail Penetration rate- calculates % of mail days out of all days of therapy to normalize between channels.
Utilization represents data including compounds & powders, direct claims, SSG and zero net-cost claims. Excludes external claims & high AWP claims.

Prescription Drug Utilization

State of Nevada PEBP FY2023				
Description	Grand Total	EPO	CDHP	PPO
Avg Members per Month	48,332	6,437	27,535	14,339
Pct Members Utilizing Benefit	79.3%	86.1%	76.1%	83.6%
Total Plan Cost	$ 71,389,277	$ 16,820,032	$ 33,577,665	$ 20,991,580
Total Days	18,679,948	3,619,797	9,795,772	5,264,379
Total Adjusted Rxs	714,597	134,802	375,851	203,944
Plan Cost PMPM	$ 123.16	$ 217.75	$ 101.62	$ 122.00
Plan Cost Net PMPM	$ 85.68	$ 153.72	$ 70.51	$ 84.22
Plan Cost/Day	$ 3.82	$ 4.65	$ 3.43	$ 3.99
Plan Cost per Adjusted Rx	$ 99.90	$ 124.78	$ 89.34	$ 102.93
Nbr Rxs PMPM	1.23	1.75	1.14	1.19
Generic Fill Rate	85.9%	85.6%	86.5%	85.0%
Home Delivery Utilization	33.0%	31.6%	32.0%	35.9%
Member Cost %	19.5%	16.3%	22.7%	16.4%
Specialty Percent of Plan Cost	51.0%	50.7%	55.6%	43.9%
Specialty Plan Cost PMPM	$ 62.82	$ 110.40	$ 56.52	$ 53.54
Formulary Compliance Rate	99.5%	99.3%	99.6%	99.4%

Prescription Drug Utilization

State of Nevada PEBP FY2023 - Grand Total					
Description	Grand Total	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	48,303	41,843	5,900	12	557
Pct Members Utilizing Benefit	79.3%	78.3%	91.4%	75.0%	98.6%
Total Plan Cost	$ 71,389,277	$ 53,824,278	$ 15,357,029	$ 256,461	$ 1,951,508
Total Days	18,679,948	13,626,941	4,368,152	9,047	675,808
Total Adjusted Rxs	714,597	530,034	159,876	330	24,357
Plan Cost PMPM	$ 123.16	$ 107.19	$ 216.91	$ 1,780.98	$ 291.97
Plan Cost Net PMPM	$ 85.68	$ 75.40	$ 147.32	$ 1,420.76	$ 174.93
Plan Cost/Day	$ 3.82	$ 3.95	$ 3.52	$ 28.35	$ 2.89
Plan Cost per Adjusted Rx	$ 99.90	$ 101.55	$ 96.06	$ 777.15	$ 80.12
Nbr Rxs PMPM	1.23	1.06	2.26	2.29	3.64
Generic Fill Rate	85.9%	85.5%	87.0%	83.9%	87.6%
Home Delivery Utilization	33.0%	30.7%	39.4%	85.5%	37.8%
Member Cost %	19.5%	19.4%	19.4%	29.9%	20.9%
Specialty Percent of Plan Cost	51.0%	50.9%	51.8%	95.0%	42.7%
Specialty Plan Cost PMPM	$ 62.82	$ 54.55	$ 112.28	$ 1,692.55	$ 124.60
Formulary Compliance Rate	99.5%	99.5%	99.6%	100.0%	99.6%

Prescription Drug Utilization

State of Nevada PEBP FY2023 - EPO					
Description	EPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	6,437	5,611	737	2	87
Pct Members Utilizing Benefit	86.1%	85.2%	99.7%	50.0%	97.7%
Total Plan Cost	$ 16,820,032	$ 12,949,321	$ 3,567,713	$ 11,156	$ 291,842
Total Days	3,619,797	2,783,870	743,771	2,841	89,315
Total Adjusted Rxs	134,802	104,568	26,906	99	3,229
Plan Cost PMPM	$ 217.75	$ 192.32	$ 403.40	$ 557.79	$ 279.54
Plan Cost Net PMPM	$ 153.72	$ 135.63	$ 285.68	$ 280.09	$ 201.26
Plan Cost/Day	$ 4.65	$ 4.65	$ 4.80	$ 3.93	$ 3.27
Plan Cost per Adjusted Rx	$ 124.78	$ 123.84	$ 132.60	$ 112.68	$ 90.38
Nbr Rxs PMPM	1.75	1.55	3.04	4.13	3.64
Generic Fill Rate	85.6%	85.3%	86.3%	75.8%	89.8%
Home Delivery Utilization	31.6%	30.9%	33.8%	82.4%	33.4%
Member Cost %	16.3%	15.7%	17.8%	7.7%	22.8%
Specialty Percent of Plan Cost	50.7%	50.0%	53.3%	0.0%	53.2%
Specialty Plan Cost PMPM	$ 110.40	$ 96.12	$ 214.96	$ -	$ 148.71
Formulary Compliance Rate	99.3%	99.3%	99.5%	100.0%	98.9%

Prescription Drug Utilization

State of Nevada PEBP FY2023 - CDHP					
Description	CDHP	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	27,535	23,031	4,066	8	430
Pct Members Utilizing Benefit	76.1%	74.3%	88.6%	75.0%	98.4%
Total Plan Cost	$ 33,577,665	$ 23,128,420	$ 8,857,088	$ 117,413	$ 1,474,743
Total Days	9,795,772	6,459,780	2,789,054	3,516	543,422
Total Adjusted Rxs	375,851	254,049	102,113	133	19,556
Plan Cost PMPM	$ 101.62	$ 83.69	$ 181.53	$ 1,223.05	$ 285.80
Plan Cost Net PMPM	$ 70.51	$ 59.02	$ 124.34	$ 972.88	$ 160.07
Plan Cost/Day	$ 3.43	$ 3.58	$ 3.18	$ 33.39	$ 2.71
Plan Cost per Adjusted Rx	$ 89.34	$ 91.04	$ 86.74	$ 882.80	$ 75.41
Nbr Rxs PMPM	1.14	0.92	2.09	1.39	3.79
Generic Fill Rate	86.5%	86.0%	87.7%	88.7%	86.9%
Home Delivery Utilization	32.0%	28.5%	39.1%	81.3%	37.9%
Member Cost %	22.7%	23.2%	21.3%	30.9%	21.5%
Specialty Percent of Plan Cost	55.6%	56.2%	55.8%	99.1%	41.6%
Specialty Plan Cost PMPM	$ 56.52	$ 47.04	$ 101.34	$ 1,212.03	$ 118.88
Formulary Compliance Rate	99.6%	99.6%	99.6%	100.0%	99.7%

Prescription Drug Utilization

State of Nevada PEBP FY2023 - PPO					
Description	PPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	14,339	13,201	1,097	2	39
Pct Members Utilizing Benefit	83.6%	83.0%	97.0%	100.0%	105.1%
Total Plan Cost	$ 20,991,580	$ 17,746,537	$ 2,932,228	$ 127,892	$ 184,923
Total Days	5,264,379	4,383,291	835,327	2,690	43,071
Total Adjusted Rxs	203,944	171,417	30,857	98	1,572
Plan Cost PMPM	$ 122.00	$ 112.03	$ 222.75	$ 5,328.84	$ 395.14
Plan Cost Net PMPM	$ 84.22	$ 78.37	$ 139.54	$ 4,399.63	$ 284.57
Plan Cost/Day	$ 3.99	$ 4.05	$ 3.51	$ 47.54	$ 4.29
Plan Cost per Adjusted Rx	$ 102.93	$ 103.53	$ 95.03	$ 1,305.02	$ 117.64
Nbr Rxs PMPM	1.19	1.08	2.34	4.08	3.36
Generic Fill Rate	85.0%	85.0%	84.9%	85.7%	91.1%
Home Delivery Utilization	35.9%	33.9%	45.4%	94.4%	45.8%
Member Cost %	16.4%	16.5%	15.4%	30.4%	12.6%
Specialty Percent of Plan Cost	43.9%	44.6%	37.6%	99.6%	34.7%
Specialty Plan Cost PMPM	$ 53.54	$ 49.98	$ 83.86	$ 5,307.17	$ 137.08
Formulary Compliance Rate	99.4%	99.4%	99.5%	100.0%	99.6%

4.3.7

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

4.3 Receipt of quarterly vendor reports for the period ending June 30, 2023:

- 4.3.1 Q4 UMR – Obesity Care Management Program
- 4.3.2 Q4 UMR – Diabetes Care Management Program
- 4.3.3 Q4 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network
- 4.3.4 Q4 Doctor on Demand Engagement Report through September 30, 2023
- 4.3.5 Q4 Express Scripts – Summary Report
- 4.3.6 Q4 Express Scripts – Utilization Report
- **4.3.7 WTW's Individual Marketplace Enrollment and Performance Report Q1 2024**

Public Employees Benefit Program

Quarterly Update –1st Quarter Plan Year 2024

WTW's Individual Marketplace

November 6, 2023

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 1st Quarter Plan Year 2024

Executive Summary

Plan Enrollment:

- At the end of FY Q1 2024, PEBP's total enrollment into Medicare policies through WTW's Individual Marketplace increased to 11,418. Since inception, 121 carriers have been selected by PEBP's retirees with current enrollment in 2,045 different plans.
- Medicare Supplement (MS) plan selection remained consistent at 86% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 6,175 and 1,797 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 14%. Top MA carriers include Aetna with 578 individual plan selections and Humana with 285 individual plan selections. The average monthly premium cost to PEBP participants decreased to $9.

Customer Satisfaction:

- In Q1 2024, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 5.0 out of 5.0 based on fourteen surveys returned.
- For Q1 2024, the average satisfaction score for Service Calls was 4.4 out of 5.0 based on 244 surveys returned.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.4 out of 5.0 for Q1 2024.

Health Reimbursement Arrangement:

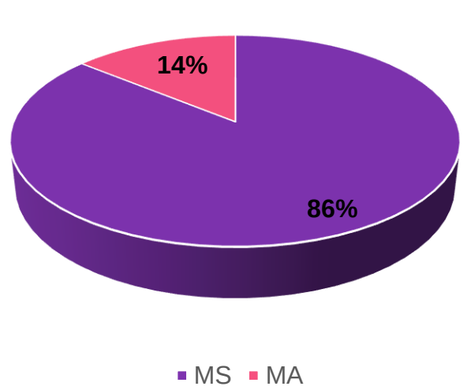
- At the end of Q1 2024 there were 13,653 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 115,935 claims processed in Q1, with 88.6% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 102,729 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q1 was $8,147,320.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 09/30/2023		Previous Qtr.
Total enrolled through individual marketplace	11,418	11,332
Number of carriers**	121	119
Number of plans**	2,045	1,905

Plan Type Selection Through 09/30/2023		Previous Qtr.
Medicare Advantage (MA, MAPD)	1,609	1,515
Medicare Supplement (MS)	9,843	9,816

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)	9,843	$149
Medicare Advantage (MA,MAPD)	1,609	$5 / $18
Part D drug coverage	6,716	$26
Dental coverage	886	$34
Vision coverage	1,619	$11

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

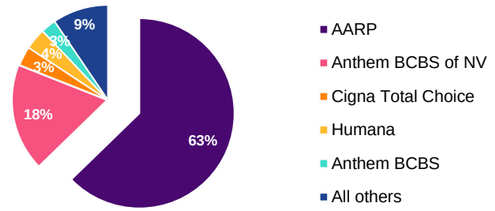
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 1st Quarter Plan Year 2024

Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,175
Anthem BCBS of NV	1,797
Cigna Total Choice	324
Humana	359
Anthem BCBS	247

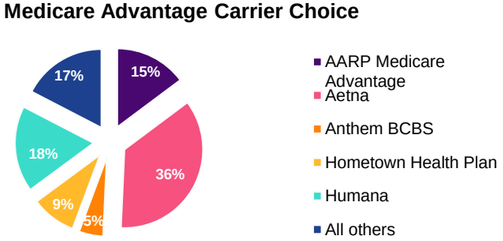
Medicare Supplement Carrier Choice



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

Top Medicare Advantage Plans	Total
Aetna	578
AARP	238
Humana	285
Hometown Health Plan	148
Anthem BCBS	80

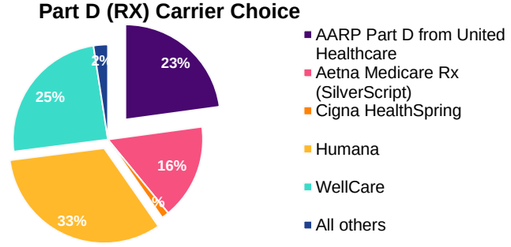
Medicare Advantage Carrier Choice



Cost Data For MA Plans	Cost
Minimum	$0
Average	$9
Median	$0
Maximum	$194

Top Medicare Part D (RX)	Total
Humana	2,166
WellCare	1,630
AARP Part D from United Healthcare	1,515
Aetna Medicare Rx (SilverScript)	1,076
Cigna HealthSpring	83

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

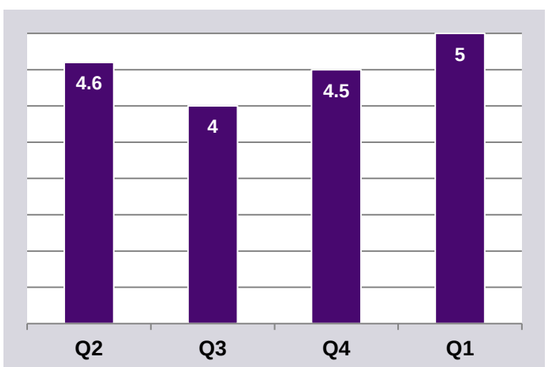
Quarterly Update – 1st Quarter Plan Year 2024

Customer Service – Voice of the Customer (VoC)

Individual Marketplace conducts phone and email surveys of all participant transactions. Each survey contains approximately 12-16 questions. Responses are scanned by IBM Mindshare Analytics which expose trends within an hour, alerting Individual Marketplace of issues and allowing for real-time feedback and adjustments

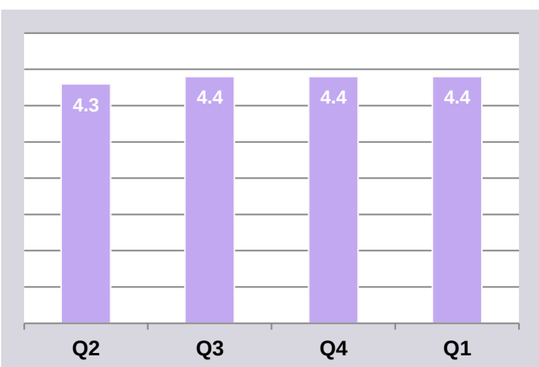
Q1 Enrollment Satisfaction

CSAT score	Count	%
5	14	100%
4	0	0%
3	0	0%
2	0	0%
1	0	0%
	14	**100%**



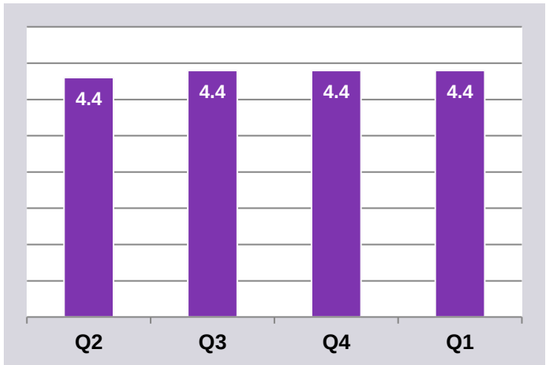
Q1 Service Satisfaction

CSAT score	Count	%
5	170	69%
4	35	14%
3	21	9%
2	7	3%
1	13	5%
	246	**100%**



Q1 Enrollment & Service Combined

CSAT score	Count	%
5	184	71%
4	35	13%
3	21	8%
2	7	3%
1	13	5%
	260	**100%**

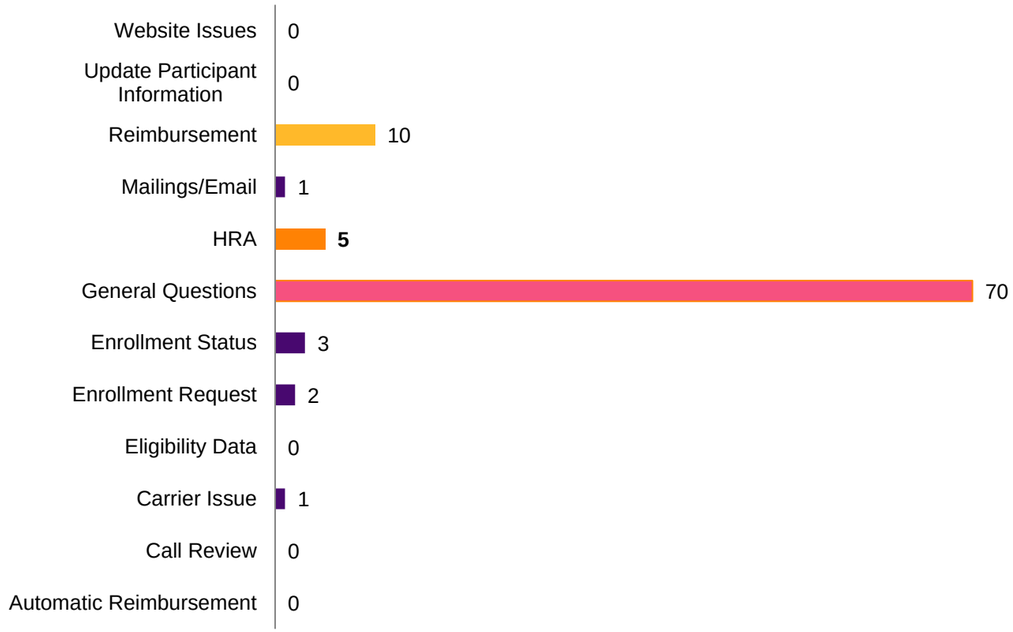


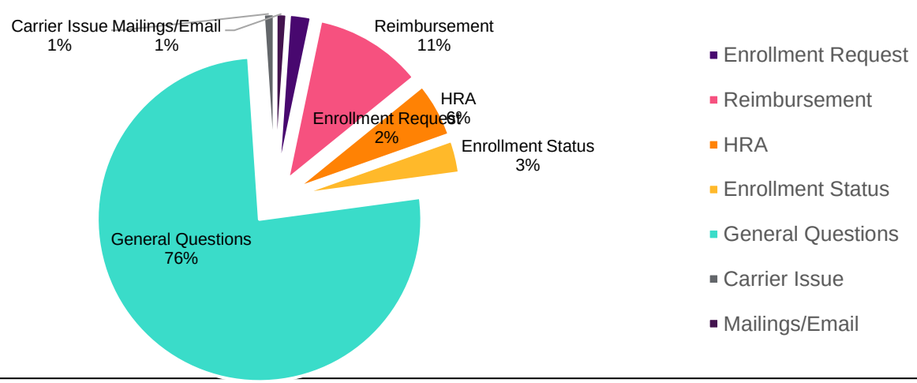
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 1st Quarter Plan Year 2024

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 Q1-PY24 is 92 and are associated with the following categories:





Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	13,653
Number of payments	51,258
Accounts with no balance	8,049
Claims paid amount	$8,147,320

Claims By Source	Total
A/R file	102,729
Mail	4,936
Web	5,678
Mobile App	2,583

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 1st Quarter Plan Year 2024

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.14 Days	Yes – Met for Annual Audit
Claim Financial Precision	≥ 98%	96.17%	No – Missed for Annual Audit
Claim Processing Payment Precision	≥ 98%	98.50%	Yes – Met for Annual Audit
Reports	≤ 15 business days	Met	Yes
HRA Web Services	≥ 99%	99.98%	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.	10 Seconds	Yes
Benefits Administration Customer Service Abandonment Rate Annual	≤ 5%	Annual	Yes
Customer Satisfaction	≥ 80%	92.31%	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 – 1st Quarter Plan Year 2024

Operations Report

Fall Retiree Meetings:

WTW and Nevada PEBP held two days of virtual retiree meetings with two meetings per day on October 16 and 17. 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
October 16 – 11:30 am PT	Pre-Medicare/Ageing into Medicare	121
October 16 – 2:00 pm PT	HRA/Medicare Open Enrollment	76
October 17 – 9:30 am PT	HRA/Medicare Open Enrollment	48
October 17 - 12:00 pm PT	Pre-Medicare/Ageing into Medicare	68

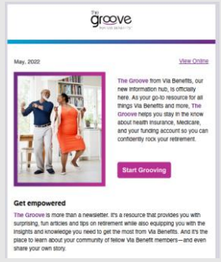
Communications:

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

- Fall “The Groove” Newsletter
  - “The Groove”, is our digital newsletter communication that is normally sent bi-monthly. The version that was sent in mid/late September and focused on educating participants on Medicare and the upcoming Medicare Open Enrollment Period that is from October 15 – December 7.

- HRA Qualification Reminder Notification
  - This communication reminds retirees that have a funding qualification requirement to contact Via Benefits during Medicare Open Enrollment if they want to change plans so they do not negatively impact their HRA qualification. This communication mailed in mid/late September.

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



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 June 30, 2023:

- 4.3.1 Q4 UMR – Obesity Care Management Program
- 4.3.2 Q4 UMR – Diabetes Care Management Program
- 4.3.3 Q4 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network
- 4.3.4 Q4 Doctor on Demand Engagement Report through September 30, 2023
- 4.3.5 Q4 Express Scripts – Summary Report
- 4.3.6 Q4 Express Scripts – Utilization Report
- 4.3.7 WTW's Individual Marketplace Enrollment and Performance Report Q1 2024
- **4.3.8 Real Appeal - Utilization Report**

Real Appeal

State of Nevada

Data through September 2023

Dashboard Report

1,022
Enrollment
Members enrolled since program inception

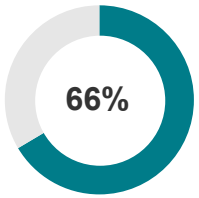
84%
At-Risk
Members with BMI > 30, or BMI between 25 to 29.99 and a qualifying comorbidity

550
Engagement
Members attending one or more coaching sessions

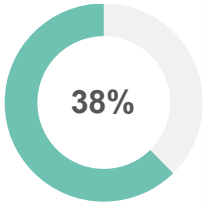
551
Currently Engaged
Members actively engaged due to logging activity within the last six weeks

At-Risk Attendance

4+ Sessions Attended

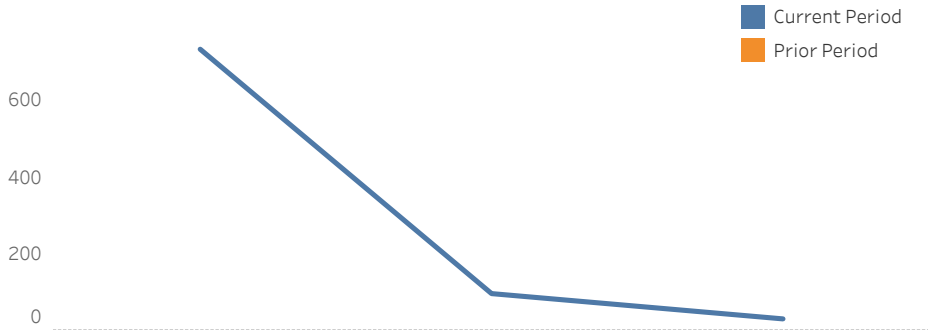


9+ Sessions Attended



At-Risk
Diabetes, Cardiovascular or other related conditions
Attend 4+ Sessions
Real Appeal Expectations **70%**
Attend 9+ Sessions
Real Appeal Expectations **50%**

At-Risk Enrollment



	Jul	Aug	Sep
Current Period	735	97	31
Prior Period			

At-Risk Weight Loss

Attended 4+ Sessions In Program 16+ Weeks

Attended 4+ Sessions In Program 16+ Weeks

410
Members Reporting Weight Loss

2,399
Total Pounds Lost

5%+ Loss: Real Appeal Expectations **33%**
5%+ Loss: Represents members that have reported weight loss

	2022	2023
Enrolled		**1,022**
Disqualified		**39**

Disqualification Criteria:

- Younger than 18 years old
- BMI under 23 (based on client set up)
- Anorexia or bulimia nervosa
- Severe chronic or acute illness
- Pregnancy

Optum Real Appeal

Enrollment Summary

1,022
Enrollment
Members enrolled since program inception

863
At-Risk
Members with BMI>30, or BMI between 25 - 29.9 and a qualifying comorbidity

0
Re-Enrolled
Members who completed the programs and enrolled for another period

551
Currently Engaged
Members actively engaged due to logging activity within the last six weeks

Enrollments by Year

Grand Total	2023
1,022	1,022

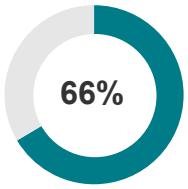
Enrollments by Month

Note: Enrollments by Month only displays the last three years.

Optum | Real Appeal

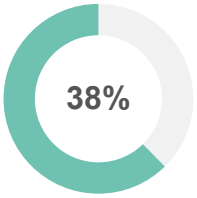
At-Risk Class Progression & Session Engagement

4+ Sessions Attended



357

9+ Sessions Attended



174

16+ Sessions Attended

0

Real Appeal Expectations

70% Will Attend 4+ Sessions

50% Will Attend 9+ Sessions

30% Will Attend 16+ Sessions

Currently in Week / Session Engagement

	1+ Attended	4+	Attended 4+	9+	Attended 9+	16+	Attended 16+	26+	Attended 26+
1 - 3 Weeks	13	0	0%	0	0%	0	0%	0	0%
4 - 8 Weeks	75	53	71%	0	0%	0	0%	0	0%
9 - 15 Weeks	462	304	66%	174	38%	0	0%	0	0%
16 - 25 Weeks									
26 - 52 Weeks									
Grand Total	550	357	66%	174	38%	0		0	

Optum | Real Appeal

At-Risk Outcomes

410
Members with Weight Loss

2,399
Pounds Lost

3.3% Book of Business

Your Results

At-Risk 5%+ Weight Loss

	All Weeks 1+ Attended	Began 16+ Weeks Ago 1+	4+	9+
1+ Attended	550			
3%+ Loss	30%			
5%+ Loss	11%			
Total Weight Loss *	1,208			
Avg. Start lbs.	214.7			
Avg. lbs. Loss	2.2			
Avg. % lbs. Loss	1.0%			

Real Appeal Book of Business

	All Weeks 1+ Attended	Began 16+ Weeks Ago 1+	4+	9+
3%+ Loss	37%	37%	45%	50%
5%+ Loss	22%	22%	28%	33%
Avg. Start lbs.	218.7	218.7	218.1	217.7
Avg. lbs. Loss	5.8	5.8	7.2	8.2
Avg. % lbs. Loss	2.6%	2.7%	3.3%	3.8%

* Note: Outcomes in above charts include members who may have weight loss, weight gain, or remain unchanged.

Optum | Real Appeal

Enrollee Characteristics & Outcomes

BMI

** 23-24.9	25-29.9	>=30
77 8%	289 28%	656 64%

Medical Need

At-Risk	Not At-Risk
863 84%	159 16%

Gender

Female	Male
847 83%	175 17%

Plan Member Type

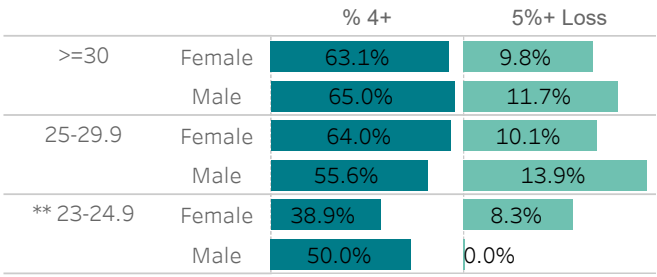
Employee	Spouse/Other
962 94%	60 6%

Age Range

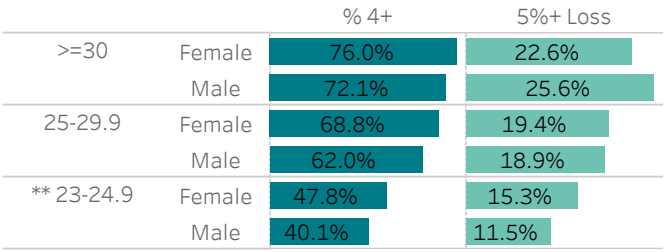
18-29	30-39	40-49	50-64	65-69	70+
70 7%	256 25%	259 25%	402 39%	27 3%	8 1%

**On occasion individuals with a BMI <23 will be included in this category.

Attendance & Weight Loss



Book of Business Attendance & Weight Loss



Optum | Real Appeal

Member Satisfaction

Member Satisfaction Rating

4.80

Book of Business 4.82

Average Rating
On a Scale 1-5
(with 5 being the Highest)

Total Ratings
Classroom Experience

1,152

Optum | Real Appeal

Registration & Enrollment

Relationship

	Relationship	Grand Total	2023
Registered	Employee	**998**	998
	Spouse/Other	**63**	63
Disqualified	Employee	**36**	36
	Spouse/Other	**3**	3
Enrolled	Employee	**962**	962
	Spouse/Other	**60**	60
At-Risk	Employee	**811**	811
	Spouse/Other	**52**	52
Not At-Risk	Employee	**151**	151
	Spouse/Other	**8**	8
Re-Enrolled	Employee	**0**	0
	Spouse/Other	**0**	0

Month

	Total	Jul	Aug	Sep
Registered	**1,061**	898	126	37
Disqualified	**39**	32	5	2
Enrolled	**1,022**	866	121	35
At-Risk	**863**	735	97	31
Not At-Risk	**159**	131	24	4
Re-Enrolled	**0**	0	0	0

Optum | Real Appeal

Appendix

Measure	Definition
Completed Registration	Based on valid insurance the member is eligible for the program. Member can be counted 1+ times in this section if they re-enroll.
At-Risk	Member medically qualified to participate in the program.
At-Risk Weight Loss	Members medically qualified to participate in the program and have tracked weight loss.
At-Risk Engagement & Attendance	Members who medically qualify to participate. % Engaged attended ≥ 1 session % Engaged attended 4+ sessions % Engaged attended 9+ sessions
Disqualified	Medically excluded or found ineligible.
Enrolled	Member has been identified to participate in the At-Risk or Not At-Risk program and has selected a class to participate in.
Engaged	Attended 1+ sessions
Active	Member in program for ≤ 52 weeks and has participated in the past 6 weeks
Average Pounds Start	Average weight when enrolled

At-Risk Measurements

Total Pounds Lost	At-Risk members with weight loss
3%+ Loss	At-Risk members who lost ≥ 3%
5%+ Loss	At-Risk members who lost ≥ 5%
Average Pounds Lost	At-Risk members average pounds lost (Total At-Risk Pounds Lost) / (At-Risk Members)

Outcomes

All	At-Risk participants regardless of class participation or length in program
1+	Members attended 1+ sessions
4+ Attended 16+ Weeks	At-Risk participants 4+ class participations, in program 16+ weeks

Optum | Real Appeal

5.

5. Discussion and possible action regarding a proposed contract with Carrum Health to maintain a network of National Centers of Excellence. A portion of this item may be conducted in closed session to allow review of the results of the evaluation of proposals for the contract, in accordance with NRS 287.04345(4). Any action o the contract will occur in open session, in accordance with NRS 287.04345(5). (Michelle Weyland, Chief Financial Officer) (**For Possible Action**)

JOE LOMBARDO
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
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www.pebp.state.nv.us

CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: December 7, 2023

Item Number: 5

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

5.1 Contracts Overview

Below is a listing of the active PEBP contracts as of November 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	$ 31,875.00	$ 354,625.00
Health Plan of Nevada Inc	Southern Nevada HMO	23802	7/1/2021	6/30/2025	$ 192,093,848.00	$ 100,271,491.16	$ 91,822,356.84
Diversified Dental Services Inc.	Dental PPO	23810	7/1/2021	6/30/2026	$ 1,601,613.00	$ 741,368.42	$ 860,244.58
Lifeworks	Benefits Management System	25935	5/10/2022	12/31/2026	$ 6,145,600.00	$ 2,412,082.80	$ 3,733,517.20
Express Scripts, Inc.	Pharmacy Benefit Manager	25582	5/10/2022	6/30/2026	$ 332,109,496.00	$ 109,756,250.92	$ 222,353,245.08
Willis Towers Watson (VIA)	Medicare Exchange	16468	7/1/2015	6/30/2025	$ 1,546,000.00	$ 1,233,741.92	$ 312,258.08
United Healthcare Insurance	Group Basic Life Insurance	25607	7/1/2022	6/30/2026	$ 12,824,248.00	$ 5,175,718.96	$ 7,648,529.04
Brown & Brown of Massachusetts	Health Plan Auditor	24030	4/13/2021	6/30/2027	$ 1,581,662.00	$ 445,569.00	$ 1,136,093.00
Segal Company, Inc.	Consulting Services	25557	7/1/2022	6/30/2027	$ 4,285,410.00	$ 2,710,837.50	$ 1,574,572.50
HAT LTD, DBA Manpower	Temporary Employment	23928	1/1/2023	12/31/2023	$ 189,500.00	$ 144,904.92	$ 44,595.08
Capitol Reporters	Court Reporting	27029	2/1/2023	6/30/2025	$ 31,932.00	$ 5,798.00	$ 26,134.00
UMR, Inc.	TPA and Other Services	25155	7/1/2022	6/30/2028	$ 65,413,106.00	$ 9,345,082.04	$ 56,068,023.96

Recommendation

No action necessary

5.2 New Contracts

Centers of Excellence – Travel Concierge pending discussion and action resulting from closed session (See paragraph 5.4)

Recommendation

Approve the contract for Centers of Excellence – Travel Concierge

5.3 Contract Amendment Ratifications

No contract amendments

Recommendation

No action necessary.

5.4 Contract Solicitation Ratifications

(Closed Session) – Results of the Request for Proposal for Centers of Excellence – Travel Concierge

5.5 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
Oncology Management Program	08/01/23	11/28/23		Jan. 2024

6.

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

JOE LOMBARDO
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
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https://pebp.nv.gov

CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[ ] Action Item
[X] Information Only

Date: December 7, 2023

Item Number: 6

Title: Executive Officer Report

SUMMARY

This report provides the Board and members of the public with updates on agency operations.

REPORT

INTERIM RETIREMENT AND BENEFITS COMMITTEE

IRBC has been scheduled for January 16, 2024, in Las Vegas (agenda pending). In accordance with NRS 287.0425, PEBP will be presenting information relating to Plan Year 2024 and 2025. In addition to the required reports already supplied to the committee, a supplemental report summarizing the decisions made at the December 7th PEBP Board meeting and when available the Fiscal Year 2023 Financial Statements will be delivered for presentation at that meeting.

STAFFING

Staffing levels at PEBP are beginning to improve, with several positions filled in the Member Services Unit. In addition, to positions in MSU, we have filled the position of Lead Insurance Counsel. Brandee Mooneyhan was PEBP's Deputy Attorney General and is very familiar with the program. We are happy to have her join the PEBP team. Finally, PEBP staff have participated in the Hiring Fairs put on by the Division of Human Resources Management and hope to fill additional vacancies soon. Currently the vacancy rate is approximately 21%

7.

7. Discussion and possible action on plan design changes for Plan Year 2025, July 1, 2024 – June 30, 2025 (Celestena Glover, Executive Officer) (**For Possible Action**)

    7.1 Potential Plan Changes for Plan Year 2025

JOE LOMBARDO
Governor

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https://pebp.nv.gov

CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: December 7, 2023

Item Number: 7

Title: Potential Program Design Changes for Plan Year 2025

BACKGROUND

At the September 28, 2023, PEBP Board meeting, staff presented a list of potential programs and plan design options so that additional research and analysis could be performed with results brought back to the December Board meeting for final consideration. With the assistance of vendor partners, the analysis has been completed on the items requested for the Board's consideration.

REPORT

- Per IRS requirements to continue offering Health Savings Accounts the Consumer Driven Health Plan (CDHP) deductible will increase to
  - $1,600 for single tier and
  - $3,200 for the spouse, children, and family tiers.
- See report provided by Segal.

RECOMMENDATION

1. Approve the increase in the deductibles to maintain the Health Savings Account offering.
2. Approve the renewal with Health Plan of Nevada for Plan Year 2025.
3. Approve the UMR Rx Coupon Program
4. Approve the required changes to bring both the LD PPO and EPO plan in compliance with the Mental Health Parity and Addiction Equity Act.
5. Approve the recommendation to implement a max copay for specialty medications not covered by SaveOnSP.
6. Do not approve the expansion of the Pharmacy Network.

7.1

7. Discussion and possible action on plan design changes for Plan Year 2025, July 1, 2024 – June 30, 2025 (Celestena Glover, Executive Officer) (**For Possible Action**)

7.1 Potential Plan Changes for Plan Year 2025

Board Meeting

Nevada Public Employees' Benefits Program

Potential Plan Changes for Plan Year 2025

December 7, 2023

Segal

Agenda

1. Open Access Pharmacy
2. Specialty Copay
3. Medical Pharmacy Variable Coupon Program
4. EPO/HMO
5. Mental Health Parity and Addiction Equality Act (MHPAEA)

Open Access Pharmacy

Consideration: Open access approach for 30- and 90-day fills

Why?

- Express Advantage and Smart90 networks implemented for PY22
- Requires members to use narrow pharmacy network(s)
- May not provide comparable access to all members
- Provides enhanced discounts compared to open network
- Members would have more local options

Next steps

- Compare access vs. cost/savings (for plan and members)

Open Access Pharmacy

Consideration: Open access approach for 30- and 90-day fills

- Open access will lead to higher costs for both the members and PEBP

Estimated Annual Cost Increase		
	Plan	**Member**
Retail 30	$500,000 - $750,000	$300,000 - $400,000
Retail 90	$125,000 - $150,000	$30,000 - $40,000
Total	$625,000 - $900,000	$330,000 - $440,000

- Improved Access will be minimal as current ESI networks provide access for nearly all members
- Many members changed pharmacies when implemented in PY22, but not all will return to the previous pharmacies if they are added back to the network.

Specialty Copay

Consideration: Eliminate specialty tier or implement a max copay

Why?

- Reduce costs for more vulnerable members since very few specialty medications have lower cost alternatives
- Current cost share provides incentive for SaveOnSP Rx participation, which results in $0 member copay and savings to the Plan from leveraging manufacturer coupons; however, not all specialty medications are eligible for the SaveOnSP Rx program
- Current cost share provisions provide significant exposure to members with specialty medications

Benefit	CDHP	Low Deductible (LDHP)	EPO	HMO
Specialty	20% after deductible	30% after deductible (30-day mail only)	20% after deductible (30-day supply only)	20% after deductible

Example: $10,000 medication = $3,000 member cost in the Low Deductible Health Plan (LDHP)

- Member cost share is capped at annual Out-of-Pocket Maximum, but costs may be prohibitive for first few months of the Plan Year

Next steps

- Compare member impact vs. plan cost/savings
- Maintain current cost share for medications that are eligible for SaveOnSP Rx

Specialty Copay

Consideration: Eliminate specialty tier or implement a max copay

- Confirmed: ESI can administer different cost share for drugs on the SaveOnSP drug list versus those that are not

	Option 1	Option 2
SaveOnSP Drugs	30% coinsurance still applies	
Non SaveOnSP Drugs	Same as Non-Specialty	30% coinsurance with $100/$250 min/max copay
Annual Cost*	$50,000	$20,000

* Most members on specialty medications reach the annual Out-of-Pocket Maximum

	EPO/LDHP	HDHP
Tier 1	$10	20% after annual deductible
Tier 2	$40	
Tier 3	$70	

Medical Pharmacy Coupon Program

Consideration: Implement coupon program for specialty drugs administered through the pharmacy benefit

Why?

- New option from UMR
- Leverages manufacturer coupons like ESI's SaveOnSP Rx, but for drugs administered in an inpatient setting
- SaveOnSP Rx applies only to outpatient medications

Next steps

- Review program details with UMR
- Evaluate member impact versus plan savings

Medical Pharmacy Coupon Program

Consideration: Implement coupon program for specialty drugs administered through the pharmacy benefit

How It Works

- UMR Copay Maximizer patient advocate team handles member outreach and support
- Patient advocates contact members to introduce UMR Copay Maximizer and enroll them in qualifying copay assistance programs
- Participation is voluntary and can be added or removed at any time by calling the patient advocate team
- Member receives billing for treatment that reflects $0 or low-cost share, thanks to copay assistance (terms can vary by coupon)
- Copay assistance amounts are excluded from accumulators that track deductible and out-of-pocket maximum (OOPM) amounts
- UMR retains 30% of savings to administer the program

UMR estimates $1.57 PMPM plan savings = $1,000,000 annually
$700,000 net of 30% administrative fee

Medical Pharmacy Coupon Program – How It Works

Illustrative Example provided by UMR:

- Drug has $2,500 available per claim in copay assistance
- Estimated cost is $4,000 per claim

Today

No copay assistance	
Coinsurance	**$800**
Copay card	$0
Member pay (20% coinsurance)	$800
Employer cost	**$3,200**
Applied to accumulators	**$800**

Copay assistance without UMR Copay Maximizer	
Coinsurance	**$800**
Copay card	$775
Member pay	$25
Employer cost	**$3,200**
Applied to accumulators	**$800**

With Program

Copay assistance with UMR Copay Maximizer	
Coinsurance	**$2,525**
Copay card	$2,500
Member pay	$25
Employer cost	**$1,475**
Applied to accumulators	**$25**

Note: All numbers are illustrative only.

With UMR Copay Maximizer, member saves $775 per claim and PEBP saves $1,725 per claim

EPO/HMO

Consideration: Review viability of EPO/HMO and consider alternatives

Why?

- HMO premium increases have been capped at 9.5% in previous years
  - Maximum rate increase for PY25 is 20% and Loss Ratio exceeds 120%
- EPO and HMO blended for rating purposes and EPO has benefited from lower HMO premiums
- HMO network and EPO network have significant provider overlap
- EPO and LDHP networks are the same and the difference in overall actuarial value is < 2% (plan design)
- EPO is in-network only and many employees enroll in EPO without understanding the limited/restricted network access
- UMR negotiates special case agreements with Out-of-Network providers to address access gaps.

Next Steps

- Develop specific options over the next year for PY26+
- Review cost impact and risk distribution
- Consider provider disruption and access to care

EPO/HMO – Plan Design Grid

- Below is a summary of the current in-network benefits for each plan currently offered by PEBP:

	Consumer Driven Health Plan (CDHP)	Low Deductible (LDHP)	Health Plan of Nevada (HMO)	Premier Plan (EPO)
Actuarial Value*	76.7%	85.2%	91.4%	88.3%
Service Area	Global	Global	Southern Nevada	Northern Nevada
Annual Deductible (medical and prescription combined)	$1,500 Individual $3,000 Family $2,800 Individual Family Member Deductible	$0	N/A With exception of Tier 4 prescription drug coverage	$100 Individual $200 Family $100 Individual Family Member Deductible
Medical Coinsurance	20% after deductible	20% after deductible	N/A	20% after deductible
Out-of-Pocket Maximum	$4,000 Individual $8,000 Family $6,850 Individual Family Member Max Out-of-Pocket	$4,000 Individual $8,000 Family $4,000 Individual Family Member Max Out-of-Pocket	$5,000 Individual $10,000 Family $5,000 Individual Family Member Max Out-of-Pocket	$5,000 Individual $10,000 Family $5,000 Individual Family Member Max Out-of-Pocket
Primary Care/ Specialist Office Visit	20% after deductible	$30/ $50 copay per visit	$25/ $40 ($25 with referral) copay per visit	$20/ $40 copay per visit
Urgent Care Visit	20% after deductible	$80 copay per visit	$50 copay per visit	$50 copay per visit
Emergency Room Visit	20% after deductible	$750 copay per visit	$600 copay per visit	$600 copay per visit
In-Patient Hospital	20% after deductible	20% after deductible	$600 copay per visit	$600 copay per visit
Outpatient Surgery	20% after deductible	$500 copay per visit	Ambulatory Facility $50 copay Hospital $350 copay	$350 copay per admit
Rx 30-days**	20% / 20% / 100% / 20%	$10 / $40 / $75 / 30% (mail only)	$10 / $40 / $75 / 20%***	$10 / $40 / $75 / 20% (mail only)
Employee Only Premium	$46.96	$68.14	$161.00	$161.00

* Actuarial Value based on FY22 and FY23 data.
** 30-day supply Tier 1 / Tier 2 / Tier 3 / Tier 4
***Deductible: $100 Individual, $200 Family

EPO/HMO – PY2025 Renewal Savings Summary

- At the September 2023 Board Meeting, the anticipated renewal was capped at 20%
- HPN has adjusted their renewal percentage increase. Below is a summary of the calculated savings compared to the rate cap

	Percent Increase	Premium – PEPM	Premium – Annual*
Calculated Renewal Action	28.67%	$1,355.15	$56,900,000
Renewal Rate Cap	20.00%	$1,263.84	$53,100,000
Final Renewal Action	12.09%	$1,180.53	$49,600,000
Cost Differential	7.91%	$83.31 ($40-45 impact on EPO/HMO)	$3,500,000

*Assumes 3,500 employees and retirees (State and Non-State)

MHPAEA Compliance Plan Design Changes

- Segal reviewed PEBP plan designs for compliance with MHPAEA requirements under the Qualitative Treatment Limit (QTL) and Non-Qualitative Treatment Limit (NQTL) testing requirements.
- **For QTL**
  - The CDHP was found to be compliant due to the plan applying deductible and coinsurance to both Medical/Surgical and Mental Health/Substance Use Disorder (MH/SUD) benefits
  - For the LDHP and EPO modifications for cost sharing provisions for **Other Outpatient Services** are needed to assure compliance with current standards and regulations
    - Options to bring Other Outpatient Services coverage in compliance for the EPO and LDHP include:

	Coverage Change	Specific Changes	Cost/(Savings)
Option 1	Medical Only	Add Copays to Med/Surg Diagnostic ($20/$30 for EPO/LDHP)	($3.0M - $4.0M)
Option 2	Medical Only	Add Copays to Med/Surg Diagnostic ($20/$30 for EPO/LDHP) AND Increase 80% coinsurance to 100%	($400K - $600K)
Option 3	Medical and MH/SUD Changes	Update all coinsurance to be 80% (both Med/Surg and MH/SUD)	($400K - $600K)
Option 4	MH/SUD Only	Remove copay from MH/SUD ($20/$30 for EPO/LDHP)	$300K - $400K

MHPAEA Compliance Plan Design Changes

- **For NQTL**
  - **There are some clarifications being recommended that will not affect the plans' cost share provisions or affect member out-of-pocket costs.**
  - **Some examples include:**
    - Adjustments to the Utilization Management Prior Authorization processes
    - Modifying/Clarifying some plan benefit exclusions
    - Updating key terms and definitions

Segal is working on this with PEBP to present updates and clarifications in detail in subsequent board meetings

Summary

Option	Description	PY24 Cost/(Savings)
Open Access Pharmacy Network	Expand ESI Retail 30 and Retail 90 networks	$625,000 - $900,000 (PEBP) $330,000 - $440,000 (members)
Specialty Copay (2 Options)	Reduce member cost share for specialty medications unless drug is on SaveOnSP drug list	$20,000 - $50,000
UMR Rx Coupon Program	Variable Coupon Program for medical Rx, similar to SaveOnSP for outpatient Rx	($1,000,000)
EPO/HMO	Accept HMO PY25 renewal	Cost Differential (12% vs. 20%): $3,500,000
MHPAEA Compliance (4 options)	For Other Outpatient Services, modify med/surg and/or MH/SUD benefits to bring LDHP/EPO into compliance	Savings range: ($400,000 - $4,000,000) Cost Range: $300,000 - $400,000

Questions

8.

8. Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Third-Party Administrator, UMR, for the period of April 1, 2023 – June 30, 2023 (Claim Technologies Incorporated) (**For Possible Action**)

JOE LOMBARDO
Governor

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CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: December 7, 2023

Item Number: 8

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 are separate from the Random Sample Audit results. The tables below illustrate additional penalties being assessed by PEBP for unmet performance guarantees not under in the fourth quarter (Q4) 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 the exceptions noted in the audited performance guarantees, there were four (4) guarantees reported to be "Not Met" with penalties calculated against total fees of $1,294,358.40:

Performance Guarantee	Result	Fees at Risk	Calculated Penalty
1.4 Claim Adjustment Processing Time	NOT MET	1.0%	$12,943.58
1.7 First Call Resolution Rate	NOT MET	2.0%	$25,887.17
1.8 Open Inquiry Closure	NOT MET	1.0%	$12,943.58
1.9 CSR Audit	NOT MET	1.0%	$12,943.58
Total		**5.0%**	**$64,717.92**

UMR Performance Guarantees Summary
December 7, 2023

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 $666,118.80:

Performance Guarantee	Result	Fees at Risk	Calculated Penalty
2.5 Provider Directory	NOT MET	0.5%	$3,330.59
Total			**$3,330.59**

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	$64,717.92
2. Network Administration	$3,330.59
3. Utilization Management and Case Management	$0.00
Total	**$68,048.51**

The penalties, totaling $68,048.51, are administratively and automatically assessed by PEBP to the vendor. In conjunction with the audited penalties totaling $25,887.16, the calculated penalties for the period ending 06/30/2023 total **$93,935.67.**

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT and Annual Operational Review

State of Nevada Public Employees' Benefits Program Plans

Administered by UMR Insurance Company

Audit Period: April 1, 2023 – June 30, 2023
Audit Number 1.FY23.Q4

Presented to

State of Nevada Public Employees' Benefits Program

December 7, 2023

CLAIM TECHNOLOGIES INCORPORATED

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EXECUTIVE SUMMARY

This ***Quarterly Findings Report*** is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of 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 April 1, 2023 through June 30, 2023 (quarter 4 (Q4) for Fiscal Year (FY) 2023). The population of claims and amount paid during the audit period reported by UMR Benefits:

Medical and Dental	
Total Paid Amount	$56,874,977
Total Number of Claims Paid/Denied/Adjusted	187,729

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

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

Auditor's Opinion

Based on these findings, and in our opinion:

1. UMR's Financial Accuracy and Overall Accuracy improved in Q4 FY2023, both performance guarantees were met, and no penalty is owed. Claim turnaround time performance decreased in Q4 and a penalty of 2% of administrative fees is owed.
2. CTI Recommends UMR should:
    - Review the financial errors identified in our random sample audit and determine if system changes or claim processor training could help reduce or eliminate errors of a similar nature in the future.
    - 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 met the Financial Accuracy and Overall Accuracy measurements, but did not meet the Claim Turnaround Time measurements for PEBP in Q4 FY2023 and penalties are owed. Reported administrative fees for the quarter totaled $2,447,881.20.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy (p.15)	99.4%	Met - 99.45%	NA	$0
Overall Accuracy (p. 16)	98.0%	Met – 98.5%	NA	$0
Claim Turnaround Time (p. 17)	92% in 14 Days 99% in 30 Days	Not Met – 90.5% Not Met – 95.9%	1% 1%	$24,478.81 $24,478.81
		Total Penalty	2%	$48,957.62

AUDIT OBJECTIVES

This report contains CTI's findings from our 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 our audit findings on the data and information provided by PEBP and UMR. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain reasonable assurance claims were adjudicated according to the terms of the contract between 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 all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

The objectives of CTI's audit of 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.

ANNUAL OPERATIONAL REVIEW

Objective

CTI's Operational Review evaluates UMR's claim administration systems, staffing, and procedures to identify any deficiencies that materially affect its ability to control risk and pay claims accurately on behalf of the plans.

Scope

The scope of the Operational Review included:

- Claim administrator information
  - Insurance and bonding
  - Conflicts of interest
  - Financial reporting
  - Business continuity planning
  - Claim payment system and coding protocols
  - Data and system security
- Claim funding:
  - Claim funding mechanism
  - Check processing and security
  - Large claim payment process
- Claim adjudication, customer service, and eligibility maintenance procedures:
  - Exception claim processing
  - Eligibility maintenance and investigation
  - Other insurance coverage and adjudication
  - Overpayment recovery
  - Network utilization
  - Utilization review, case management, and disease management
  - Subrogation and other third-party liability
  - Appeals processing
- HIPAA compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from UMR. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting a Statement on Standards for Attestation Engagements (SSAE) 18 audit of a service administrator. This attestation was developed to assesses controls at service organizations and includes the framework for SOC 2 reports, which evaluate the security, availability, processing integrity, confidentiality, and privacy of data and systems at a service organization. We modified that tool to elicit information specific to the administration of your plans.

We reviewed UMR's responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer PEBP's plans. This allowed us to conduct the audit more effectively.

Findings

We observed the following from UMR's response to the operational review questionnaire:

- UMR provided the following insurance coverage information:

Coverage	Amount
Errors and Omissions	$10,000,000
Crime	$5,000,000
General Liability	$10,000,000

- UMR was audited by Baker Tilly, for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report. Under the SOC 1, the administrator was required to provide a description of its system and controls, which the service auditor validated. CTI received a copy of the report for the period of January 1, 2022 to December 31, 2022. A bridge letter dated July 17, 2023 was also provided noting no material changes were made to internal controls. UMR indicated a copy of the SOC 1 report and bridge letter was also provided to PEBP.
- UMR stated it had incorporated all CMS National Correct Coding Initiative edits into their unbundling software.
- High dollar claims billed over $25,000 were processed by the large dollar claim team. Bill audit review was conducted if the allowed amount exceeded $80,000. PEBP received a large dollar notification when allowed amount was in excess of $100,000.
- UMR batched provider payments and issued payments to providers twice weekly for PEBP claim payments.
- UMR reported it honored assignment of benefits for non-network providers which allowed non-network providers to receive payment directly from UMR versus having to pay the member who would then have to pay the non-network provider. This is a best practice.
- UMR had adequately documented training, workflow, procedures, and systems.
- UMR received daily eligibility files; all changes, additions and terminations were processed daily by UMR.
- Verification of initial or continued coordination of benefits (COB) by UMR was not required by PEBP. When UMR was the secondary payor, it would never pay more than its total allowable amount. UMR did not provide a copy of a report showing COB savings for the PEBP plans for FY2023.
- UMR reported 92.72% of claims were received electronically during the audit period and 61.55% of claims received were auto adjudicated.
- UMR reported it had a $100.00 minimum dollar threshold to recoup an overpayment and could automatically recoup a refund from the next payment made to the same provider. UMR reported

it used vendors to perform overpayment recovery. An overpayment recovery report was not provided to CTI for FY2023.

- UMR used the OnBase appeal tracking system. UMR leadership monitored tracking daily to ensure timely responses to member appeals. UMR did not provide a member appeal tracking report to CTI for FY2023.
- UMR created system edits, developed review procedures, and provided special training to its claim professionals to help identify potential fraudulent situations.
- UMR used state websites to identify sanctioned or indicted providers; and indicated it did not make use of the Office of Inspector General's List of Excluded Individuals/Entities to identify sanctioned providers.
- UMR reported it received 92.31% of PEBP's claims and 95.46% of eligible charges from in-network providers. To help drive additional provider savings, UMR participated in programs such as Doctors on Demand, and Centers of Excellence for transplant care.
- UMR put policies and procedures in place to comply with the Transparency in Coverage Act (No Surprises Billing) that became effective January 1, 2022. UMR reported eight appeals and six inquiries received for the allowances made for out-of-network services. Five appeals and four inquiries were overturned.
- The UnitedHealthcare privacy office developed and implemented HIPAA compliance training. All new employees were required to complete HIPAA training and all employees were required to complete the training annually. UMR reported no breeches during the audit period.

QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with UMR. The results for Q4 FY2023 follow.

	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	92.50%	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	94.30%	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%	0.60%	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%	91.20%	Not Met
1.8	**Open Inquiry Closure:** addresses the time taken in hours and/or days by CSRs at the administrator's service facility to close open inquiries placed by participants of PEBP to the facility.	90.00% 48 Hours 98.00% 5 Business Days	93.80% 94.30%	Met Not Met
1.9	**CSR Audit, or Quality Scores:** determined by the process used to evaluate the effectiveness and accuracy of participant telephone call handling at the administrator's customer service facility.	97.00%	95.40%	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	92.59%	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.	95.0%	97.35%	Met
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):		5	
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	No custom reports requested	Met
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	99.50% 99.50%	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%	98.30%	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	No custom reports requested	Met
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%	100%	Met
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	0% 0/1 complaints	Not Met
2.6	**Website:** A website hosting a reasonably accurate and updated Provider directory must be available and accessible on all major browsers 99% of time.	99.00%	100%	Met

	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 calendar 10 days of end of reporting period or event as determined by PEBP.	100% 10 Calendar Days	No custom reports requested	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	99.99%	Met
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	100%	Met
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	100%	Met
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	97.7%	Met
3.9	**Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	95.00%	100%	Met
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%	100%	Met
3.11	**Return On Investment (ROI) Guarantee – Utilization Management/Case Management:** 2:1 Savings to Fees for Utilization Management/Case Management.	100%	100%	Met
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	100%	Met
3.13	**Unauthorized Transfer of PEBP Data:** All PEBP PHI or PII data will be stored, processed, and maintained solely on currently designated servers and storage devices identified in this contract. Any changes to those designated systems during the life of this agreement shall be reported to PEBP at least 60 calendar days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	100%	Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS®) software identified and quantified potential claim administration payment errors. PEBP and 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 our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- 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 and eligibility maintenance 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. Our 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 our ESAS process:

- ***Electronic Screening Parameters Set*** – We used your plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated your claim data, reconciled it against control totals, and checked it for reasonableness.
- ***Electronic Screening*** – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. Note 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 did not extrapolate results. We selected 50 cases and sent your administrator a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched 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.
- ***Eligibility Verification of Every Claim by Date of Service*** – We used ESAS to compare service dates against the eligibility periods provided to us by the eligibility vendor Lifeworks (now TELUS Health) to look for claims paid for ineligible members.

Findings

We are confident in the accuracy of our 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 pages 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.

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
29	$89.59	Agree. UMR agrees to 13 duplicate payment errors. We continue to work on upgrades to our duplicate logic system.	Procedural deficiency and overpayment remain. UMR paid duplicate charges.	☒ M ☐ S
30	$72.50			☒ M ☐ S
31	$140.00			☒ M ☐ S
33	$359.36			☒ M ☐ S
34	$93.00			☐ M ☒ S
36	$188.52			☐ M ☒ S
37	$119.95			☐ M ☒ S
38	$79.33			☒ M ☐ S
39	$89.59			☐ M ☒ S
40	$21.91			☒ M ☐ S
41	$25.00			☐ M ☒ S
42	$212.40			☒ M ☐ S
43	$2,521.00			☐ M ☒ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Plan Exclusions				
Attention Deficit Disorder (Hyperkinetic)				
26	$63.75	Agree. The claim is reviewed to see if additional diagnosis billed in addition to ADHD. If not, as such, we request a treatment plan. A treatment plan was requested, but not received prior to claim payment.	Procedural deficiency and overpayments remain. A treatment plan was not approved prior to payment of psychotherapy for treatment of ADHD.	☒ M ☐ S
Plan Limitations				
Chiropractic Care 20 Visits per Plan Year				
47	$48.00	Agree. System was manually overridden to allow additional services. These were manual overrides and the claim processors have been identified and coached.	Procedural deficiency and overpayments remain. The chiropractic plan limitation of 20 visits per plan year was exceeded.	☒ M ☐ S
48	$20.00			☒ M ☐ S
Bitewing X-Rays 2 per Year				
49	$19.00	Agree. The plan limitation of bitewing x-rays twice per plan year was exceeded.	Procedural deficiency and overpayments remain. The bitewing x-ray plan limitation of twice per plan year was exceeded.	☒ M ☐ S
50	$40.00			☐ M ☒ S
Potential Fraud, Waste, and Abuse				
Medical Equipment Over Medicare Allowance				
21	$3,185.07	Agree to error. Correct pricing was not used.	Procedural deficiency and overpayments remain. Billed charges were allowed instead of the correct allowable of $86.94.	☒ M ☐ S
Specialty Medication (Non Hospital)				
22	$4,968.50	Agree. Specialty medication claims pend to the CFR. AWP -12% for this contract. Pricing now has a Call Track for this claim.	Procedural deficiency and overpayments remain. Claim line paid billed charges instead of the contract rate of $73.92.	☒ M ☐ S
Copay Application				
Acupuncture				
5	$20.00	Agree. Acupuncture takes a $50.00 copay not the family medicine copay of $30.00.	Procedural deficiency and overpayment remain. Services were for acupuncture; the plan document states copay for acupuncture is $50.00, only $30.00 was applied.	☒ M ☐ S
Diagnostic Mammography				
11	$40.00	Agree. Diagnostic mammograms are subject to a $40.00 copay.	Procedural deficiency and overpayment remain. The EPO plan has a $40.00 copay for diagnostic mammography, and $0.00 was applied.	☒ M ☐ S
Case Management				
16	NA	Agree. Services were performed outpatient. There was no hospital admission to prompt that Case Management was needed. SHO will open an OPCM case for this member now and attempt outreach.	Procedural deficiency remains. Case management should have been initiated as well as reported to PEBP for high expense case. Claims for MS exceeded $126,000 for this member.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
PPO Provider Without Discount				
18	$214.30	Agree. ER claim checked UHC Choice pricing. Pricing group states claim was not repriced by UHC Choice Plus when it was received. It was not routed out and it wasn't sent manually for repricing. The hospital is in-network with Choice Plus and the claim could have been repriced at 95% of the amount billed which would have been $17,111.12.	Procedural deficiency and overpayment remain. The provider discount of 5% was not applied; the entire claim was overpaid by $900.59.	☒ M ☐ S
20	$1,125.25	Agree. Claims were not routed for pricing.	Procedural deficiency and overpayment remain. Claim paid without provider discount.	☒ M ☐ S
Preventive Services				
With Coinsurance Applied				
3	($7.49)	Agree. CPT 99392 should have paid 100% of the allowed amount.	Procedural deficiency and underpayment remain. The charge should have been paid at 100% of the allowed amount under the preventive benefit.	☒ M ☐ S

Annual Eligibility Verification

CTI electronically compared dates of service for FY2023 Q1 through Q4 and PEBP's electronic eligibility file received from TELUS Health. The screening revealed that some services were paid during the audit period for potentially ineligible claimants. The output was provided to TELUS Health for their review and comment. At this time, potentially overpaid amounts have been flagged into one of the following categories:

Employee Eligibility Screening Subcategory	Amount Paid
No Identification Match to Any Eligible Employee	$10,289
Payments Prior to Effective Date	$87,134
Payments During Gaps in Coverage	$17,285
After Termination Date of Employee's Coverage	$46,434
Subtotal	$161,142
Dependent Eligibility Screening Subcategory	**Amount Paid**
No Identification Match to Any Eligible Employee	$331,004
Payments Prior to Effective Date	$20,530
Payments During Gaps in Coverage	1,795
After Termination Date of Employee's Coverage	$49,292
Subtotal	$402,621
COMBINED TOTAL*	**$563,763**

**CTI notes that 0.30% of the PEBP's total medical expense processed by UMR was identified as paid for members who may not have been eligible for coverage. These results are normal compared to the less than 1% CTI generally reports.*

RANDOM SAMPLE AUDIT

Objectives

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

Scope

CTI's statistically valid Random Sample Audit included a stratified random sample of 200 paid or denied claims. 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

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

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information 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 PEBP 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 our 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 $778,628.37. The claims sampled and reviewed revealed $2,002.96 in underpayments and no overpayments. This reflects a weighted Financial Accuracy rate of 99.45% over the stratified sample. This is an improvement in performance from the prior periods. Detail is provided in the following table, Random Sample Findings Detail Report.

UMR met the Performance Guarantee for PEBP in Q4 FY2023 of 99.4% for this measure. No penalty is owed.

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 4 incorrectly paid claims and 196 correctly paid claims. This is 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		Frequency
	Underpaid Claims	Overpaid Claims	
200	4	0	98.0%

Overall Accuracy

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

Performance improved from the prior periods. UMR met the Performance Guarantee for PEBP in Q4 FY2023 of 98% for this measure. No penalty is owed. Detail is provided in the table below, Random Sample Findings Detail Report.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
196	4	0	98.0%

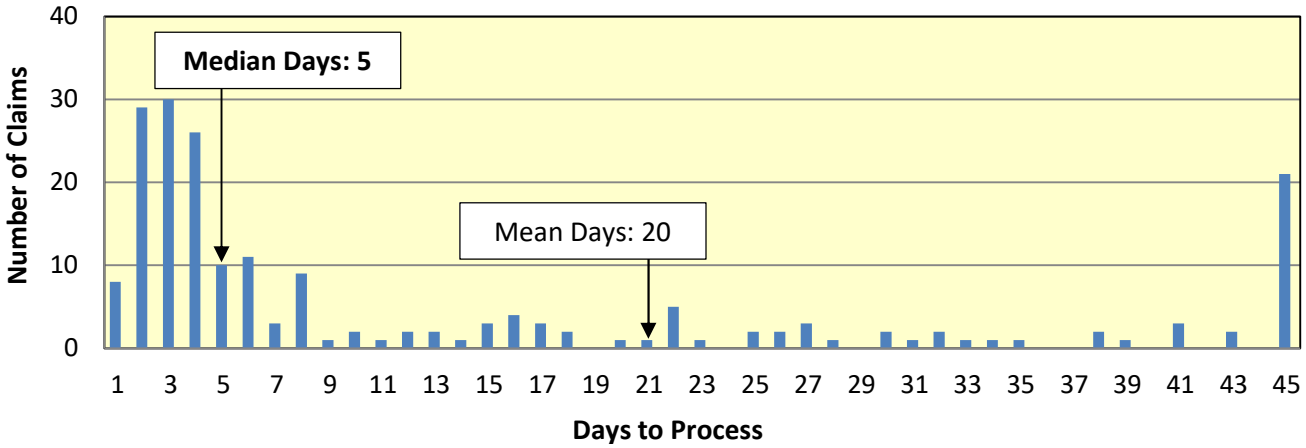
Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Denied Eligible Expense				
2023	($160.00)	Agree with error, claim sent to the adjustment team.	Procedural error and underpayment remain. Eligible expenses for denture repair were denied.	☒ M ☐ S
PPO Discount				
1096	($77.82)	Agree. CCN-xxxxxx4363 allowable amount should be $107.82 according to SHO pricing.	Procedural error and underpayment remain. An incorrect PPO discount was applied to the sampled claim.	☒ M ☐ S
1129	($1,261.71)	Agree. The provider network is SHO and doesn't appear on web claims. The initial claim was priced based on system contracting pricing but has been reprocessed based on updated pricing received.		☒ M ☐ S
1135	($503.43)	Agree. Per the contracted agreement I have supplied the pricing for each code on the claim. Total allowable is $2,367.43		☒ 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 just 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 Q4 FY2023 of 92% processed within 14 days and 99% processed within 30 days. This performance decreased from the prior period. The penalty owed for these two Performance Guarantees is 1.0% of the administrative fees of $2,447,881.20 for each metric, or $48,957.62.

DATA ANALYTICS

Medical Findings

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

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

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

Network Provider Utilization and Discount Savings

The Network Provider Utilization and Discount Savings report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in 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 all 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 provider received payment from UMR during the audit period.

NPI	Exclusion Date	Reinstatement Date	Exclusion Type	Provider Name	Claim Count	Total Charged	Total Allowed	Total Paid
1104912278	20191219	N/A	1128a4	SHELBY,JAMES,S,DDS	1	$1,484	$1,274	$479
				Totals	**1**	**$1,484**	**$1,274**	**$479**

According to the OIG, James Shelby was excluded on December 19, 2019 with for a felony-controlled substance conviction.

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.

Reports

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

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

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

CTI's analysis also found that 94.04% of the procedure codes identified as preventive services were paid by UMR at 100% when provided in-network. This total is net of claims denied as a duplicate of a preventive claim paid in a prior period.

NCCI Editing Compliance

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

Scope

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

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

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

PTP Edits Reports

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

Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary			Primary Description	Secondary Description	Line Count	Amount CMS Would Deny
Code	Mod	Code	Mod	Mod Use				
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	25	$17,098
					Standards of medical / surgical practice			
70496		70450		YES	CT ANGIOGRAPHY HEAD	CT HEAD/BRAIN W/O DYE	4	$7,901
					Misuse of column two code with column one code			
99213		99212		YES	Office/outpatient visit for E&M of estab patient, 20-29 m	Office/outpatient visit for E&M of estab pat	73	$5,229
					Misuse of column two code with column one code			
22612		95938	TC	YES	lumbar (with lateral transverse technique, when perform	SOMATOSENSORY TESTING	1	$3,365
					Misuse of column two code with column one code			
22612		95940		YES	lumbar (with lateral transverse technique, when perform	Ionm in operatng room 15 min	1	$2,938
					Standards of medical / surgical practice			
94626		94625		YES	Physician services for outpatient pulmonary rehabilitati	Physician services for outpatient pulmonar	9	$2,732
					Mutually exclusive procedures			
71275	TC	96374		YES	CT ANGIOGRAPHY CHEST	THER/PROPH/DIAG INJ IV PUSH	3	$2,458
					Standards of medical / surgical practice			
96402		96523		NO	CHEMO HORMON ANTINEOPL SQ/IM	IRRIG DRUG DELIVERY DEVICE	3	$2,167
					CPT Manual or CMS manual coding instructions			
76819	TC	59025		YES	FETAL BIOPHYS PROFIL W/O NST	FETAL NON-STRESS TEST	2	$1,986
					Misuse of column two code with column one code			
99284		99283		YES	Emergency department visit for E&M of patient requiring	Emergency department visit for E&M of pati	3	$1,877
					Misuse of column two code with column one code			
						Top 10 TOTAL	**124**	**$47,750**
						GRAND TOTAL	**391**	**$92,684**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary			Primary Description	Secondary Description	Line Count	Amount CMS Would Deny
Code	Mod	Code	Mod	Mod Use				
93503		99292		YES	INSERT/PLACE HEART CATHETER	CRITICAL CARE ADDL 30 MIN	1	$1,530
					CPT Manual or CMS manual coding instructions			
76856	26	93976	26	YES	US EXAM PELVIC COMPLETE	VASCULAR STUDY	5	$355
					Misuse of column two code with column one code			
84481		84480		NO	FREE ASSAY (FT-3)	ASSAY TRIIODOTHYRONINE (T3)	17	$331
					More extensive procedure			
97012	GP	97140	GP	YES	MECHANICAL TRACTION THERAPY	Manual therapy 1/> regions	3	$235
					Mutually exclusive procedures			
92609	GN	92507	GN	YES	USE OF SPEECH DEVICE SERVICE	SPEECH/HEARING THERAPY	2	$217
					Misuse of column two code with column one code			
19301	51	19285	51	YES	PARTICAL MASTECTOMY	Placement of breast location device(s) first	1	$198
					CPT Manual or CMS manual coding instructions			
84439		84436		NO	ASSAY OF FREE THYROXINE	ASSAY OF TOTAL THYROXINE	16	$151
					More extensive procedure			
97810		99204		YES	ACUPUNCT W/O STIMUL 15 MIN	Office/outpatient visit for E&M of new patie	1	$150
					CPT Manual or CMS manual coding instructions			
36566		36556		YES	INSERT TUNNELED CV CATH	INSERT NON-TUNNEL CV CATH	1	$138
					Mutually exclusive procedures			
76857	26	93975	26	YES	US EXAM PELVIC LIMITED	VASCULAR STUDY	1	$127
					Misuse of column two code with column one code			
						Top 10 TOTAL	**48**	**$3,432**
						GRAND TOTAL	**113**	**$4,912**

MUE Reports

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

CTI's MUE analyses are grouped into three separate reports, outpatient hospital, non-facility, and ancillary. Of note: the 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
31295	1	Nasal/sinus endoscopy, surgical, w dilation (balloon dilation) max	3	$3,046
		Rationale: CMS Policy		
88377	5	Morphometric analysis, in situ hybridization (quantitative or semi-	2	$1,761
		Rationale: Clinical: Data		
97811	2	ACUPUNCT W/O STIMUL ADDL 15M	16	$1,253
		Rationale: Nature of Service/Procedure		
95165	30	ANTIGEN THERAPY SERVICES	1	$1,068
		Rationale: Clinical: Data		
28470	2	TREAT METATARSAL FRACTURE	1	$947
		Rationale: CMS Policy		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	1	$800
		Rationale: Clinical: CMS Workgroup		
J9395	20	INJECTION, FULVESTRANT	1	$417
		Rationale: Prescribing Information		
30140	1	RESECT INFERIOR TURBINATE	2	$364
		Rationale: CMS Policy		
84182	6	PROTEIN WESTERN BLOT TEST	1	$272
		Rationale: Clinical: Data		
51798	1	US URINE CAPACITY MEASURE	1	$231
		Rationale: Nature of Service/Procedure		
		Top 10 TOTAL	**29**	**$10,159**
		GRAND TOTAL	**40**	**$11,220**

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
A4595	6	TENS SUPPL 2 LEAD PER MONTH	2	$1,036
		Rationale: Code Descriptor / CPT Instruction		
V2520	2	CONTACT LENS HYDROPHILIC	6	$550
		Rationale: Anatomic Consideration		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	6	$458
		Rationale: Nature of Equipment		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	4	$330
		Rationale: Anatomic Consideration		
V2020	1	VISION SVCS FRAMES PURCHASES	2	$220
		Rationale: Clinical: Data		
V2510	2	CNTCT GAS PERMEABLE SPHERICL	3	$220
		Rationale: Anatomic Consideration		
V2522	2	CNTCT LENS HYDROPHIL BIFOCL	1	$110
		Rationale: Anatomic Consideration		
V2523	2	CNTCT LENS HYDROPHIL EXTEND	1	$110
		Rationale: Anatomic Consideration		
A7038	6	POS AIRWAY PRESSURE FILTER	3	$100
		Rationale: Published Contractor Policy		
B4034	1	ENTER FEED SUPKIT SYR BY DAY	1	$25
		Rationale: Code Descriptor / CPT Instruction		
		Top 10 TOTAL	**29**	**$3,158**
		GRAND TOTAL	**29**	**$3,158**

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 that alerts the administrator special payment circumstances may exist. The administrator must also 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.

	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 without Modifier 24, 25, or 57	
Provider Id	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
880133501	32	$11,108	3	8.6%	$871	1	$144
880236758	3	$740	1	25.0%	$217	1	$133
954748861	0	$0	1	100.0%	$30	1	$32
880103557	3	$728	2	40.0%	$485	0	$0
860857176	2	$299	1	33.3%	$166	0	$0
844822939	0	$0	1	100.0%	$109	0	$0
834372348	0	$0	3	100.0%	$329	0	$0
821756034	2	$317	1	33.3%	$159	0	$0
813253496	3	$556	1	25.0%	$186	0	$0
472242077	0	$0	1	100.0%	$511	0	$0
Top 10	**45**	**$13,748**	**15**	**25.0%**	**$3,062**	**3**	**$310**
Overall Total	**50**	**$15,183**	**30**	**37.5%**	**$4,997**	**3**	**$310**

FY2023 REVIEW AND RECOMMENDATIONS

The table below presents a summary of UMR's performance against the FY2023 quarterly metrics based on CTI's random sample audit results. Results shown in red represent where UMR missed the metric.

Measure	Guarantee	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Financial Accuracy	**99.4%**	98.23%	97.5%	98.12%	99.45%
Overall Accuracy	**98.0%**	91.0%	97.0%	97.5%	98.5%
Claim Turnaround Time	**92% in 14 Days**	89.2%	92.9%	90.8%	90.5%
	99% in 30 Days	92.9%	97.5%	93.7%	95.9%

CTI has the following recommendations that represent recurring issues identified in the FY2023 quarterly audits:

1. UMR should review each of the financial errors identified in our FY2023 random sample audits and determine if system changes or additional claim processor training could help reduce or eliminate errors of a similar nature in the future. It should focus specifically on steps necessary to improve Financial Accuracy.
2. UMR should conduct a focused analysis of the errors identified through ESAS to determine if overpayment recovery and/or system improvements are possible and to reduce or eliminate similar errors going forward. For the issues identified by ESAS, CTI can prepare claim detail for UMR to use in its analysis.
3. PEBP should review the results of the eligibility screening and perform causal analysis to identify workflow and/or system improvements to reduce or eliminate paying claims on ineligible claimants.
4. UMR is using state sanctioned provider listings and should consider using the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) to exclude claim payments from sanctioned providers.

CONCLUSION

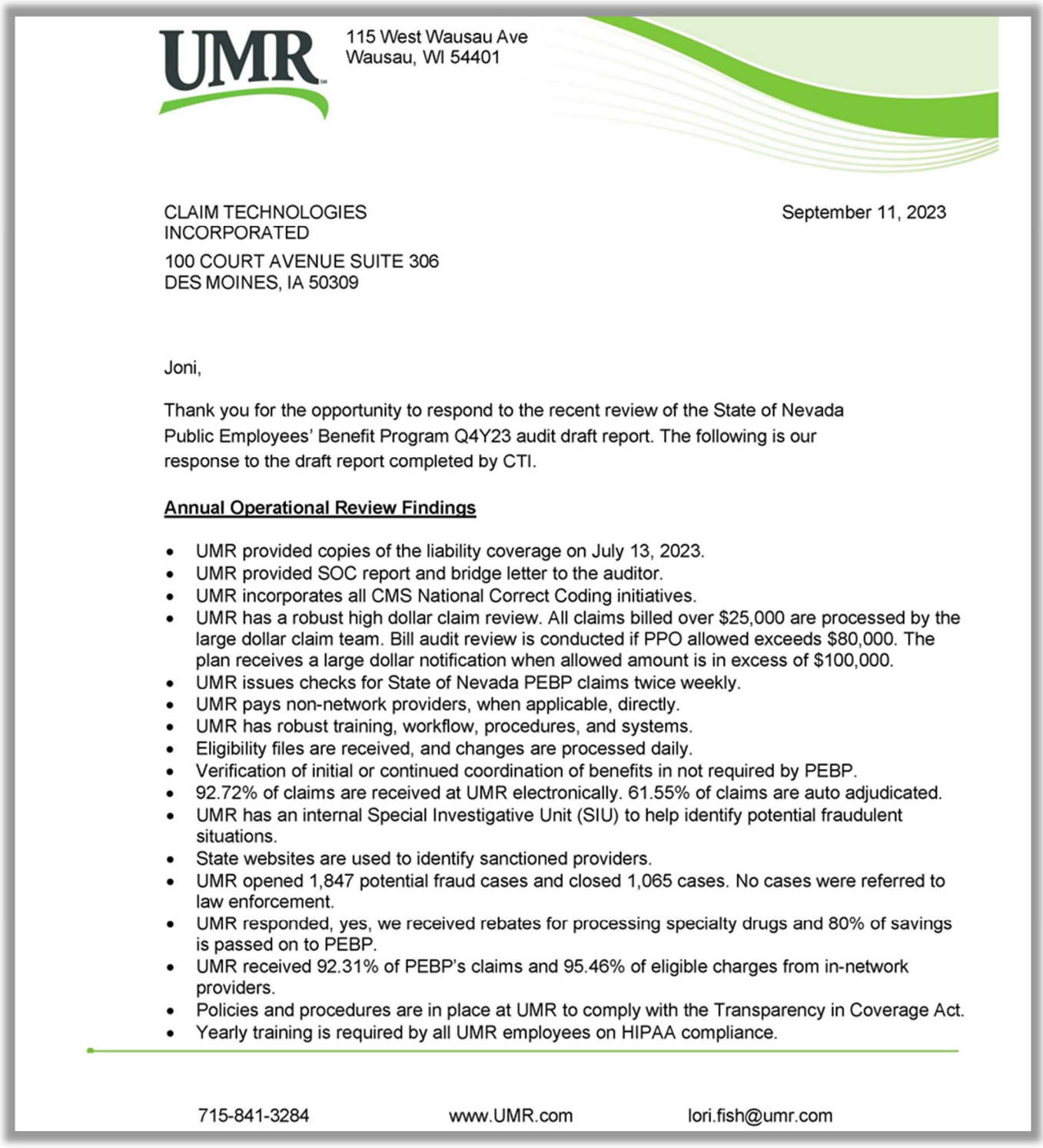
UMR did not meet the performance metrics for financial accuracy, overall accuracy or claim turnaround in the first three quarters in FY2023; in quarter 4, UMR met the performance metrics for financial accuracy and overall accuracy but continued to miss the metric for claim turnaround.

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

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

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



UMR

115 West Wausau Ave
Wausau, WI 54401

CLAIM TECHNOLOGIES
INCORPORATED

100 COURT AVENUE SUITE 306
DES MOINES, IA 50309

September 11, 2023

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q4Y23 audit draft report. The following is our response to the draft report completed by CTI.

Annual Operational Review Findings

- UMR provided copies of the liability coverage on July 13, 2023.
- UMR provided SOC report and bridge letter to the auditor.
- UMR incorporates all CMS National Correct Coding initiatives.
- UMR has a robust high dollar claim review. All claims billed over $25,000 are processed by the large dollar claim team. Bill audit review is conducted if PPO allowed exceeds $80,000. The plan receives a large dollar notification when allowed amount is in excess of $100,000.
- UMR issues checks for State of Nevada PEBP claims twice weekly.
- UMR pays non-network providers, when applicable, directly.
- UMR has robust training, workflow, procedures, and systems.
- Eligibility files are received, and changes are processed daily.
- Verification of initial or continued coordination of benefits in not required by PEBP.
- 92.72% of claims are received at UMR electronically. 61.55% of claims are auto adjudicated.
- UMR has an internal Special Investigative Unit (SIU) to help identify potential fraudulent situations.
- State websites are used to identify sanctioned providers.
- UMR opened 1,847 potential fraud cases and closed 1,065 cases. No cases were referred to law enforcement.
- UMR responded, yes, we received rebates for processing specialty drugs and 80% of savings is passed on to PEBP.
- UMR received 92.31% of PEBP's claims and 95.46% of eligible charges from in-network providers.
- Policies and procedures are in place at UMR to comply with the Transparency in Coverage Act.
- Yearly training is required by all UMR employees on HIPAA compliance.

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

ESAS Targeted Sample Analysis

Duplicate Payments
QID 29, 30, 31, 33, 34, 36, 37, 38, 39, 40, 41, 42, and 43 - UMR agrees to 13 duplicate payment errors. We continue to work on upgrades to our duplicate logic system.

Attention Deficit Disorder
QID 26 – UMR agrees with this error. Treatment plan was not on file prior to processing.

Chiropractic Care 20 Visits per Plan Year
QID 47, 48 – UMR agrees with these errors. System was manually overridden to allow additional services. These were manual overrides and the claim processors have been identified and coached.

Bitewing X-Rays 2 per Plan Year
QID 49, 50 – UMR agrees to these errors. Per the Master Plan Document Bitewing X-Rays all allowed 2 per plan year.

DME
QID 21 – UMR agrees with this error. Corrected pricing was not used.

Specialty Medication
QID 22 – UMR agrees to this error. Corrected pricing was not used.

Acupuncture
QID 5 – UMR agrees to this error. Acupuncture takes a $50.00 copay not the family medicine copay of $30.00.

Office Visits
QID 6 – UMR disagree with this finding. The member's out of pocket maximum was met prior to processing this claim. Once member meets their out of pocket, claims no longer take a copay.

QID 8 – UMR disagrees with this finding. Per HCR, contraceptive management regardless of diagnosis billed, is covered at 100%, no cost share.

Diagnostic Mammogram
QID 11 – UMR agrees with this error. Diagnostic mammograms are subject to a $40.00 copay.

Case Management
QID 16 – UMR agrees with this error. Case management should have been initiated.

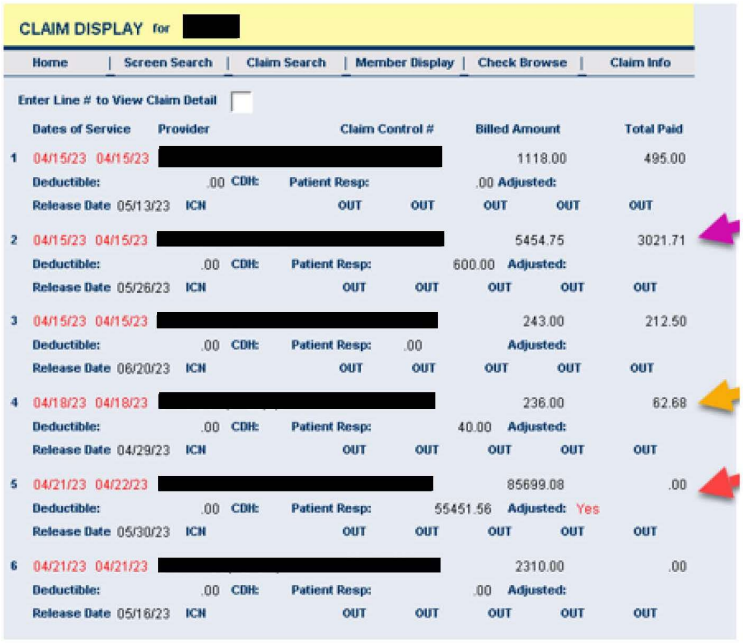
PPO Provider without Discount
QID 18, 20 – UMR agrees with these errors. Claims were not routed for pricing.

Preventive Services
QID 3 – UMR agrees with this error. CPT 99392 should have paid at 100%.

Random Audit

Denied Eligible Expenses

QID 1008 – UMR disagrees with this finding. The EPO Plan has no out of area benefit outside the 14 counties, per plan documents. This was an elective surgery. Member was seen at Carson Valley Medical on 4/15/23, treated, given a brace, and released. On 4/18/23, member had office visit with Dr. Swanson. Scheduled surgery was conducted on 4/21/23 at an out of area facility. This requires an approval from the UM vendor per PEBP guidelines. This claim processed correctly.



CLAIM DISPLAY for [redacted]

Home | Screen Search | Claim Search | Member Display | Check Browse | Claim Info

Enter Line # to View Claim Detail

	Dates of Service	Provider	Claim Control #	Billed Amount	Total Paid
1	04/15/23 04/15/23	[redacted]		1118.00	495.00
	Deductible: .00	CDH:	Patient Resp:	.00 Adjusted:	
	Release Date 05/13/23	ICN	OUT OUT	OUT OUT	OUT
2	04/15/23 04/15/23	[redacted]		5454.75	3021.71
	Deductible: .00	CDH:	Patient Resp:	600.00 Adjusted:	
	Release Date 05/26/23	ICN	OUT OUT	OUT OUT	OUT
3	04/15/23 04/15/23	[redacted]		243.00	212.50
	Deductible: .00	CDH:	Patient Resp: .00	Adjusted:	
	Release Date 06/20/23	ICN	OUT OUT	OUT OUT	OUT
4	04/18/23 04/18/23	[redacted]		236.00	62.68
	Deductible: .00	CDH:	Patient Resp:	40.00 Adjusted:	
	Release Date 04/29/23	ICN	OUT OUT	OUT OUT	OUT
5	04/21/23 04/22/23	[redacted]		85699.08	.00
	Deductible: .00	CDH:	Patient Resp: 55451.56	Adjusted: Yes	
	Release Date 05/30/23	ICN	OUT OUT	OUT OUT	OUT
6	04/21/23 04/21/23	[redacted]		2310.00	.00
	Deductible: .00	CDH:	Patient Resp:	.00 Adjusted:	
	Release Date 05/16/23	ICN	OUT OUT	OUT OUT	OUT

ER claim on 4/15/23 treated, given brace and sent home.

Office visit with Dr. Swanson 4/18/23

Scheduled surgery- non-emergent, on 4/21/23, at Out of Area facility. No prior authorization on file. This claim was billed with admission type, 3- see below. This claim was denied as per plan language. No error

This was a scheduled procedure, not ER related and as such would require an approval by UM vendor. PEBP Out of Area gap exceptions must be approved by UM vendor.

Type of Admission or Visit Codes

View Visit Code and Type of Admission/Visit.

1 = Emergency
2 = Urgent
3 = Elective
4 = Newborn
5 = Trauma Center
9 = Information Not Available

QID 2023 – UMR agrees to this $160.00 underpayment.

PPO Discount

QID 1096 – UMR agrees to this $77.82 underpayment.

QID 1129 – UMR agrees to this $1,261.71 underpayment.

QID 1135 - UMR agrees to this $503.43 underpayment.

QID 2028 – UMR disagrees with this procedural error. Children under the age of 19 have an unlimited maximum. In this case, the plan's annual maximum is not tracked as it is open ended due to the age of the patient. Patient is Robert, age 17 years.

Random Sample Summary

Six Claims are indicated on the Random Sample as errors.

- UMR disagrees with the findings on QID 1008 and has provided adequate data to have this error removed.
- UMR disagrees with the findings on QID 2028. The EOB does not show an annual maximum amount because the patient is under age 19. The plan has no annual maximum amount imposed on dependent children; therefore, no dollars are accumulated. UMR asks respectfully to have this error removed.
- UMR agrees to $2,002.96 in underpayments. These claims have been reprocessed.

If you have any questions regarding this response, please contact me at 715-841-3284.

Sincerely,

Lori Fish
UMR External Audit Coordinator

Claim Technologies Incorporated representatives may from time to time provide observations regarding certain tax and legal requirements including the requirements of federal and state health care reform legislation. These observations are based on our good-faith interpretation of laws and regulations currently in effect and are not intended to be a substitute for legal or tax advice. Please contact your legal counsel and tax accountant for advice regarding legal and tax requirements.

CLAIM TECHNOLOGIES INCORPORATED

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9.

9. Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Third-Party Administrator, Via Benefits (WTW) for the period July 1, 2022 – June 30, 2023.(Claim Technologies Incorporated) (**For Possible Action**)

Claim Administration Audit

HEALTH REIMBURSEMENT ARRANGEMENT

State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement Plan

Administered by Via Benefits from Willis Towers Watson

Audit Period: July 1, 2022 through June 30, 2023
Plan Year 2023

Presented to

State of Nevada Public Employees' Benefits Program

December 7, 2023

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

EXECUTIVE SUMMARY

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

Scope

CTI performed an audit of Via Benefits' administration of the PEBP HRA for the period of July 1, 2022 through June 30, 2023 (plan year 2023). The population of claims and amount paid during the audit period was taken from the paid claim file provided by Via Benefits.

Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$18,183,658
Total Number of Claims Paid/Denied/Adjusted	218,375

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

- Operational Review
- Random Sample Audit
- Eligibility Verification

Auditor's Opinion

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

1. Via Benefits showed improved service to PEBP's members and exceeded all but one of its performance guarantees for FY2023.
2. Although Via Benefits provided good service to PEBP's members, CTI recommends the following areas for improvement:
    - Track the reasons for overpayments to understand why overpayments occur and prevent them going forward.
    - Focus on increasing overpayment recovery percentage; it is currently at 6%.
    - Provide claim processors with coaching on the processing errors identified during the audit.

Summary of Via Benefits Guarantee Measurements

Based on CTI's Random Sample Audit results, Via Benefits met the Claim Processing Payment Precision and Claim Processing Turnaround Time measurements but did not meet the Claim Financial Precision for PEBP in plan year 2023.

FY 2023 Annual Metrics	Guarantee	Met/Not Met	Penalty
Claim Financial Precision	98%	Not Met–96.17%	$10,000
Claim Processing Payment Precision	98%	Met 99.00%	$0
Claim Processing Turnaround Time	Average 2 business days	Met – 0.41 days	$0
		Total Penalty	$10,000

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of Via Benefits from Willis Towers Watson (Via Benefits) administration of the State of Nevada Public Employees' Benefits Program (PEBP) Medicare Exchange Health Reimbursement Arrangement (HRA) plan. We provide this report to PEBP, the plan sponsor, and Via Benefits, the claim administrator. A copy of Via Benefits' response to these findings can be found in the Appendix of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by PEBP and Via Benefits. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain reasonable assurance claims were adjudicated according to the terms of the contract between Via Benefits 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 Via Benefits used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

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

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

OPERATIONAL REVIEW

Objectives

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

Scope

The scope of our review included:

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

Methodology

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

Findings

We observed the following from Via Benefit's response to the operational review questionnaire:

- Via Benefits provided the following insurance coverage information.

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

- Willis Towers Watson (WTW), parent company of Via Benefits, reported that it had been audited by KPMG LLP, for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report and provided CTI a copy of the report. We have asked WTW to forward a copy of the report to PEBP. Any questions regarding the report and impact should be discussed with WTW.
- The business continuity plan provided by Via Benefits included two approaches to data protection; 1) continuous off-site replication to a second, geographically distant location and, 2) the use of daily backups of files and databases.
- Via Benefits indicated no claim processing functions were outsourced; however, it did use subcontractors for other functions such as translation services, data entry, and mail services.
- Refunds and return checks were forwarded to PEBP to deposit to PEBP's bank account.
- Via Benefits indicated PEBP provided the allocation amount that participants were eligible. Effective May 31, 2021, PEBP implemented an $8,000 cap on the available balance.
- Via Benefits provided an HRA overpayment report for FY2023, that showed recovery of 6% of identified overpayments.
    - Overpayment Total: $11,411.25
    - Recovered Total: $683.38
    - Unrecovered Total: $10,727.87
- Via Benefits did not provide the reason for overpayments on the report; however, Via Benefits indicated that HRA eligibility was the biggest reason for overpayments.
- Customer service operations were available via phone Monday through Friday from 5:00 AM to 4:00 PM PST.
- The member online portal allowed claim submission, check claim status, check participant balances, supporting documents submittal, and viewing of historical information.
- Via Benefits communicated with account holders via mail or email. It provided digital newsletters approximately every two months, a one-time enrollment guide mailing when a participant aged into Medicare, and a one-time HRA welcome packet mailing upon initial qualification.
- Via Benefits reported it used secure system passwords and system authorization, as well as separation of duties for system security. It also limited access to eligibility maintenance and claim adjudication.
- Via Benefits' internal system control document provided a thorough overview including detail on data entry logic, duplicate logic, and overpayment logic as examples.
- Web-based security and compliance training was provided by Via Benefits annually to their staff.
- Via Benefits reported there were no privacy or security breaches identified during the audit period.

Performance Guarantee Validation

As part of CTI's audit of PEBP, we reviewed the Performance Guarantees included in its contract with Via Benefits. The self-reported results for plan year 2023 follow.

Metric and Service Objective	Actual	Met/ Not Met
Reports Annual Review: Reports provided within 15 days.	Met	Met
HRA Web Services Annual Review: 99% availability of web services for benefit information and HRA information exclusive of scheduled maintenance.	99.5%	Met
Customer Service Abandon Rate Annual Review: The percentage of incoming calls abandoned by participants be 5% or less.	1.34%	Met
Customer Service Speed to Answer Quarter Review: Incoming telephone calls answered in less than or equal to: Ninety seconds in Q1 PY 2023 Five minutes in Q2 PY 2023 Two minutes in Q3 PY 2023 Ninety seconds in Q4 PY 2023	 Q1 PY 2023 – 0:26 Q2 PY 2023 – 1:46 Q3 PY 2023 – 0:30 Q4 PY 2023 – 0:10	Met
Customer Satisfaction Quarter Review: At least 80% of participants surveyed will be satisfied with services.	Q1 PY 2023 – 88.8% Q2 PY 2023 – 90.1% Q3 PY 2023 – 92.1% Q4 PY 2023 – 90.5%	Met
Disclosure of Subcontractors Per Violation: additional subcontractors shall not be engaged, unless at least 60 days prior notice to the engagement of a new subcontractor.	Individual Marketplace Subcontractor list dated April 15, 2021	Met
Unauthorize Transfer of Data Per Violation: All data will be stored, processed, and maintained on designated servers. Any changes must have 60 days notification.	No changes reported	Met

RANDOM SAMPLE AUDIT

Objective

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

Scope

The Random Sample Audit included a random sample of 200 HRA claims paid or denied. Via Benefits' performance was measured for the following key performance categories:

- Claim Financial Precision
- Claim Processing Payment Precision

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

Methodology

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

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

Findings

CTI defines claim financial precision 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. Claim processing payment precision is defined as the total number of payments made correctly without a payment or nonpayment error compared to the total number of payments issued. The sampled claims were selected from the PEBP HRA claims processed during the 2023 plan year.

Via Benefits did not meet the performance guarantee for claim financial precision of 98% and a $10,000 penalty is owed. Via Benefits did meet the performance guarantees for claim processing payment precision and claim turnaround time.

Note: claim processing payment precision includes both financial and procedural errors. A summary of each finding follows the chart below.

Performance Measure	Claims Sampled		Sampled Claims with Errors		Results
	Claims	Dollars Paid	Claims	Dollars Paid	
Claim Financial Precision	200	$24,776.10	1	$949.00	96.17%
Claim Processing Payment Precision	200		2		99.00%
Claim Turnaround Time	Average 2 business days				0.41 days

	Random Sample Findings Detail Report			
Audit Number	**Overpaid**	**CTI's Observation**	**Via Benefits Response**	**CTI's Conclusion**
Financial Errors				
1193	$949.00	The claim was denied for lack of information. However, the image has all information needed to process the claim.	Agree.	Procedural error and overpayment remain. Claim denied in error.
Procedural Only Errors				
1128	NA	The claim submitted was for 2021, 2022, and 2023 and submitted in April of 2023. The claim was split into three claims: • 2021, denied for timely filing and entered January only – should be entered as 1/1/21 – 12/31/21. • 2022, claim was entered for whole year and denied for timely filing. However, since the claim was submitted in April of 2023, this claim should have allowed from April – December 2022. • 2023, was also denied for timely filing. The claims for these dates of service were also submitted via Pass Thru (online portal). The member has been made whole, and the sample claim should have been denied as a duplicate instead of denied for timely filing.	Disagree. The member was made whole via Pass Thru. No financial impact to participant. 2021 – No impact to the participant. The EOB only reflects the beginning date of the premium (End date not reflected Ex 31st) See the snippet of EOB below.	Non-payment/procedural error remains. The sample claim had incomplete dates and the denial reason on the explanation of benefits was incorrect.

Additional Observations

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

Audit Number	Observation
1015	This member died in February 2019 and eligibility was updated in April 2019 reflecting death. Out of sample claims with service dates in 2022 were still being paid creating overpayments totaling $976.36. Overpayments were subsequently identified, and refund pursued on 7/20/23. Conflicting information was passed to Via Benefits from the eligibility vendor, Lifeworks (now TELUS Health).
1099 and 1119	The claims took 15 days (1099) and 11 days to process (1119). Via Benefits stated the SLA was measured quarterly and met in both these quarters. CTI notes Via reported 100% of claims were processed within 5 business days.
1183	Two receipts were combined into one claim; best practice is to separate individual claims to identify and prevent duplicate payments. Via Benefits' protocol is to process claims as one payment for multiple receipts.
1175	The claim payment was approved, and funds were available. However, the claim payment was split unnecessarily. Via Benefits advised this is an information display issue on the member portal and won't affect duplicate claim detection. Via Benefits is investigating the issue.

ELIGIBILITY VERIFICATION

CTI electronically compared dates of service to PEBP's electronic eligibility file received from Lifeworks (now TELUS Health). The screening revealed that some services were paid during the audit period for potentially ineligible claimants. The output was provided to TELUS Health for their review and comment. At this time, potentially overpaid amounts have been flagged into one of the following categories:

Description	Claim Lines	Members	*Paid Amount
Member Not on File	597	63	$93,024.31
Incurred After Member Benefit End Date	292	129	$45,083.01
Incurred Prior to Member Benefit Begin Date	15	7	$2,380.71
TOTALS	**904**	**199**	**$140,488.03**

**CTI notes that 0.77% of PEBP's total medical spend processed by Via Benefits was identified as paid for members who may not have been eligible for coverage. These results are within the norm of less than 1% CTI generally reports.*

PLAN YEAR 2023 RECOMMENDATIONS

CTI has the following recommendations based on the findings of the Plan Year 2023 audit of Via Benefits:

1. The overpayment report provided by Via Benefits should specify the reason for overpayments. If the reasons are not currently captured and tracked, CTI recommends doing so. Tracking the reason for overpayments will allow both the PEBP and Via Benefits to understand why overpayments occur and help determine the steps necessary to prevent them going forward.
2. The overpayment recovery percentage of 6% is low and processes should be put in place by Via Benefits to attempt to increase the success rate of overpayment recovery.
3. Via Benefits should coach its claims processors on errors identified during the audit including:
    - Overlooked supporting documentation submitted with the claim
    - Incorrect denial reason
    - Incomplete date of service entered

CONCLUSION

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

APPENDIX – ADMINISTRATOR RESPONSE TO 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.

October 9, 2023

State of Nevada Public Employees Benefits Program:

On behalf of Willis Towers Watson (WTW) regarding the draft report of the Audit of the State of Nevada Public Employees' Benefits Program Health Savings Account and Health Reimbursement Arrangement for the period of July 2022-June 2023 please see our response to the report and the auditor's recommendations below:

- Claim Technologies Incorporated noted that of the 200 claims reviewed there were one financial error and two claims processing errors after review with the auditors, WTW disagrees to these findings. WTW agrees to one financial error, and one claims processing error.
    - Regarding claim # 1128: The claim was not flagged as duplicate because there was a difference in the service end date as mentioned. However, since the claim resulted in a denial, there was no payment or financial impact to the participant. This would be considered a Process Error as defined below (outside the scope of the Payment and Financial Accuracy measures listed in the PEBP audit).
        - **Definition:** Process accuracy measures the percentage of claim items adjudicated correctly in terms of instances. Process accuracy captures errors that do not affect the financial or payment outcome. Instead, it focuses on data entry, procedural compliance, and following best practices.

Observation #1:

This issue is related to participant, [redacted]). While Via Benefits did originally receive and load the date of death [redacted], several subsequent files were received that "revived" the account. The first file received and loaded that "revived" the account by not including the dated of death was loaded on [redacted] 2019. The date of death was then sent and loaded again on [redacted] 2019. However, a file was then loaded on [redacted] 2019 to remove the death status again. Via Benefits didn't receive and load a new file on the account until [redacted] 2023. This new file included a different date of death of [redacted].

In summary, it seems that the conclusions drawn may be influenced by inaccurate data received by Via Benefits from Nevada PEBP/LifeWorks.

In November 2022, Nevada PEBP agreed to allow Via Benefits to update death statuses and divorce statuses based on notification over the phone. For example, John Smith passes away on 6/15/2023. His son calls Via Benefits on 6/29/2023 to report that Mr. Smith has passed away. Via Benefits will manually update the death status on the account which will end the participants HRA eligibility and Mr. Smith will be included on a weekly "Death" status report that is made available to Nevada PEBP. This process will help eliminate overpayments as Via Benefits does not have to wait for a death status to be sent over on a file to be loaded to update the account and end the HRA eligibility.

Observation #2:

Per the claims processing turnaround time the vendor agrees that the processing of claims will typically require no more than two business days, a calculation commencing from the point of receiving a complete claim until its adjudication by an examiner. Additionally, they have committed to ensuring that 98% of all claims will be processed within a five-business-day turnaround time. This timeframe will be computed based on the total duration measured in business days/the count of total claims. The SLA metric results are provided to Nevada PEBP through the "Quarterly Update" reporting provided for the Nevada PEBP board meetings. Here is an example of how this information is provided in that report:

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.19 Days	Yes

The report indicates that Via Benefits met the average Claims Turnaround Time metric that "claims process will average two (2) business days or less" and provides the number of days for processing in the "outcome" section.

Observation #3:

Below is our logic and rules on why we combined the claim into one claim line instead of multiple lines:

The term, "Clubbing," refers to combining multiple expense amounts and/or dates of service found on supporting documentation and entering them into one claim line instead of several individual claim lines in the CPI.

Heath Care Expenses Only
Do not use Clubbing Rules for Catastrophic Drug Claims (CatRx) or Special Payment Claims.

Required Information
In order to "Club," expenses, the requirements below must be met. Eligible Health Care Expenses that are on the same document (EOB, receipt, statement, or invoice) and meet the criteria below, must be clubbed into one claim line entry if applicable.
Expenses must be for the same person (participant or dependent)

- Expenses must be on the same document (Please note that multiple individual strips or receipts that are put on one piece of paper should not be clubbed)
- Expenses must be for the same provider
- Expenses must be for the same Category/Claim Type
- Expenses must be for the same calendar year

Guidance
Common documentation that can be used to club expenses:

- Prescriptions
  - Cash register receipts (Meaning all eligible items contained in one receipt should be clubbed including tax on those items if applicable)
  - Ledgers from the pharmacy
- Dental Expenses
  - Invoice

- Statement
- Ledger
- EOB

- Medical Expenses
  - EOB
  - Invoice
  - Statement
  - Ledger

Claim Entry Instructions

- If there are multiple years on the same document, do not enter a line that crosses plan years when clubbing.
  - Processor must enter a clubbed line for expenses within the same year.
    - For example, if the ledger has dates from 2017 and 2018 - processor would club all expenses for 2017 and enter into one claim line and then enter a second line for expenses from 2018.
- If the required information listed above is not met, do not club the lines. Enter the Health Care Expenses on individual claim lines per claim processing guidelines.

Observation #4:

This is a display issue in the member portal. The claim and amount and EOB show the data is in one claim, however the portal is showing the payment split in two. As this is a display issue, this will not cause a duplicate claim issue. There is currently being research done as to why the portal is displaying this way.

Eligibility Verification:

The ability for claims to be reimbursed from a participants HRA is based on multiple factors such as eligibility, qualification, and the claim information and supporting documentation. Some participants may no longer be eligible for the HRA or qualified for the HRA, but the claim information submitted can still be used to process a reimbursement from the participants' account. For example, Via Benefits was able to confirm that some of the accounts that are part of the Eligibility Verification impact were deceased retirees where claims that were incurred when the participant was alive were submitted after the date of death. These claims were determined eligible and processed accordingly based on their date of service. Other accounts were determined to be participants that lost funding qualification due to an update from the carrier that was later corrected.

Recommendation #1:

The overpayment report provided by Via Benefits should specify the reason for overpayments. If the reasons are not currently captured and tracked, CTI recommends doing so. Tracking the reason for overpayments will allow both the PEBP and Via Benefits to understand why overpayments occur and help determine the steps necessary to prevent them going forward.

WTW Response:

The Overpayment Report does identify the type of overpayment that was created in two categories as described below.

- "Negative Account Balance" - In many cases these overpayments happen due to a late notification that the participant has passed away, so funding is removed from the account and claims paid from those funds are then denied and placed into overpayment. This can also happen if a participant has a retroactive loss of their HRA funding qualification.
- "Claims Overpayment" - These overpayments can be tied a claim that was approved but then later determined to be an ineligible expense, for example a claim that was later identified a duplicate claim.
- Our current overpayment report does not provide more detailed information on why a specific overpayment occurred on an account. Manual research would need to occur on the individual participant to confirm the specific reason for an overpayment.
- We are continuing to work on improving the overpayment process and participants can now resolve their overpayments through the portal. They have the option to pay online or submit a help ticket. The amount of calls we take regarding overpayments has decreased more than half because of this change.
- In November 2022, Nevada PEBP agreed to allow Via Benefits to update death statuses on notification over the phone. For example, John Smith passes away on 6/15/2023. His son calls Via Benefits on 6/29/2023 to report that Mr. Smith has passed away. Via Benefits will manually update the death status on the account which will end the participants HRA eligibility and Mr. Smith will be included on a weekly "Death" status report that is made available to Nevada PEBP. This process will help eliminate overpayments as Via Benefits does not have to wait for a death status to be sent over on a file to be loaded to update the account and end the HRA eligibility.

Recommendation #2:

The overpayment recovery percentage of 6% is low and processes should be put in place by Via Benefits to attempt to increase the success rate of overpayment recovery.

WTW Response:

Via Benefits either mails or emails participants multiple communications related to overpayments in an attempt to have the participant recover the overpaid amount back to the plan. Participants will receive an Explanation of Payment when a claim that was previously approved and reimbursed is subsequently denied and placed into overpayments. Via Benefits also sends participants Overpayment Notices on a monthly basis for up to 3 months after an overpayment is generated on an account. Note that overpayment recovery on a retiree HRA account is historically difficult as many overpayments are generated by participants who pass away and their account has claims automatically reimbursed until their death status is loaded to end their eligibility. In these cases, the participants estate would be responsible for recovering the overpayment.

Participants have the capacity to rectify overpayments via the self-service portal, accompanied by the option to assign a general reason for the occurrence of the overpayment, thus enhancing transparency in understanding its origins. These process refinements and overarching improvements have yielded a significant reduction in instances of overpayment.

Recommendation #3:

Via Benefits should coach its claims processors on errors identified during the audit including:

- Overlooked supporting documentation submitted with the claim.
- Incorrect denial reason

- Incomplete date of service entered.

WTW Response:

WTW's Claims Manager has confirmed that claim processors are coached on all identified errors, and we have shared the report broadly with the onshore team.

In conclusion this audit has provided valuable insights. We are confident the recommendations outlined in this report will contribute to the continued success of service to the participants. We appreciate the cooperation demonstrated by Claim Technologies Incorporated on behalf of the State of Nevada Public Employees' Benefits Program. We look forward to our continued partnership.

Claim Technologies Incorporated representatives may from time to time provide observations regarding certain tax and legal requirements including the requirements of federal and state health care reform legislation. These observations are based on our good-faith interpretation of laws and regulations currently in effect and are not intended to be a substitute for legal or tax advice. Please contact your legal counsel and tax accountant for advice regarding legal and tax requirements.

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10.

10. Discussion and possible action regarding UMR's performance under contracted Third-Party Administrator Services (Celestena Glover, Executive Director) (**For Possible Action**)

11.

11. Public Comment