JOE LOMBARDO
Governor

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

CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program
Date and Time of Meeting:	January 26, 2024 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://youtube.com/live/HXChbjuLr5s

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

To listen to and view the PEBP Board Meeting please click on the YouTube Link located in "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/86871834875**
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: 868 7183 4875 then press #. When prompted for a Participant ID, please enter #.**

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

To resolve any issues related to dialing in to provide public comment for this meeting, please call (775) 684-7016 or email 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 December 7, 2023 PEBP Board Meeting

   4.2 Receipt of quarterly staff reports for the period ending September 30 and December 31, 2023

   4.2.1 Q1 Utilization Report

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

   4.3.1 Q1 UMR – Obesity Care Management Program

   4.3.2 Q1 UMR – Diabetes Care Management Program

   4.3.3 Q1 Sierra Healthcare Options – Utilization and Large Case Management

   4.3.4 Q1 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network

   4.3.5 Q1 UnitedHealthcare – Basic Life Insurance

   4.3.6 Q1 Express Scripts – Summary Report

   4.3.7 Q1 Express Scripts – Utilization Report

   4.3.8 Q1 2nd MD – Utilization Report

   4.3.9 Doctor on Demand Utilization Report

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

5. Presentation and possible action on the status and approval of PEBP contracts, contract amendments and solicitations. With respect to a new proposed contract with Carrum Health to maintain a network of National Centers of Excellence, the Board previously reviewed the results of the evaluation of proposals for the contract in closed session pursuant to NRS 287.04345(4) in its December 7, 2023, meeting. To the extent that additional consideration of the proposed contract requires the Board's discussion of confidential material related to the contract prior to any Notice of Award being issued, *see* NRS 333.335(7), such portion of this meeting may be conducted in closed session pursuant to NRS 287.04345(4). All action on contracts will occur in open session pursuant to NRS 287.04345(5). (Michelle Weyland, Chief Financial Officer) **(For Possible Action)**

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

7. Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Third-Party Administrator, UMR, for FY2024 Q1 covering the period of July 1, 2023 – September 30, 2023. (Tim Lindley, Quality Control Officer) **(For Possible Action)**

   7.1 UMR Remediation Plan

8. Acceptance of Mental Health Parity and Addiction Equity Act Report including possible action on, but not limited to, the following items (Celestena Glover, Executive Officer) **(**Information/Discussion**)**

   8.1 Mental Health Parity and Addiction Equity Act Executive Summary

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

10. Discussion and possible action on recommended changes and updates to the Master Plan Documents for Plan Year 2025 (July 1, 2024 to June 30, 2025) (Tim Lindley, Quality Control Officer) **(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 December 7, 2023 PEBP Board Meeting

4.2 Receipt of quarterly staff reports for the period ending September 30 and December 31, 2023:

4.2.1 Q1 Utilization Report

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

4.3.1 Q1 UMR – Obesity Care Management Program

4.3.2 Q1 UMR – Diabetes Care Management Program

4.3.3 Q1 Sierra Healthcare Options – Utilization and Large Case Management

4.3.4 Q1 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network

4.3.5 Q1 UnitedHealthcare – Basic Life Insurance

4.3.6 Q1 Express Scripts – Summary Report

4.3.7 Q1 Express Scripts – Utilization Report

4.3.8 Q1 2nd MD – Utilization Report

4.3.9 Doctor on Demand Utilization Report

4.4 Acceptance of the annual PEBP Appeals and Complaints Summary for submission to the Nevada Division of Insurance and Department of Health and Human Services

4.1

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

4.1 Approval of Action Minutes from the December 7, 2023 PEBP Board Meeting

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

3427 Goni Road, Suite 117
Carson City, NV 89706

ACTION MINUTES (Subject to Board Approval)
December 7, 2023

MEMBERS PRESENT	Mr. Jim Barnes, Member
IN PERSON:	Ms. Betsy Aiello, Member Ms. Leslie Bittleston, Member Dr. Jennifer McClendon, Member Ms. Bepsy Strasburg, Member Ms. Stacie Weeks, Member
MEMBERS PRESENT VIA ZOOM:	Mr. Jack Robb, Board Chair Ms. Michelle Kelley, Vice Chair Ms. Janell Woodward, Member
MEMBERS EXCUSED:	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. Brandee Mooneyhan, Lead Insurance Counsel Ms. Jessica Crane, Executive Assistant
OTHER PRESENTERS:	Richard Ward, Segal Nancy Langland, Express Scripts Joni Amato, Claim Technologies Inc.

1. Open Meeting; Roll Call

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

2. Public Comment
    - Kent Ervin – Nevada Faculty Alliance
    - Margaret Kelly Osborne – Retiree

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 30th

    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

BOARD ACTION ON ITEM 4
MOTION: Motion to approve the consent agenda with the exception of 4.1 and 4.2.2
BY: Member Leslie Bittleston
SECOND: Member Jennifer McClendon
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 4.1
MOTION: Motion to approve agenda item 4.1 with the technical correction of changing wording on meeting minutes from video conference to in person
BY: Member Betsy Aiello
SECOND: Member Leslie Bittleston
VOTE: Unanimous, the motion carried

BOARD ACTION ON ITEM 4.2.2
MOTION: Motion to approve the budget report
BY: Member Betsy Aiello
SECOND: Member Bepsy Strasburg
VOTE: Unanimous, the motion carried

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**)

BOARD ACTION ON ITEM 5
MOTION: Motion to close the public meeting and go to Teams for a closed-room discussion on the contracts
BY: Vice Chair Michelle Kelley
SECOND: Member Betsy Aiello
VOTE: Unanimous, the motion carried

BOARD ACTION ON ITEM 5
MOTION: Motion to end closed session and return to open session (Motion made during closed session)
BY: Member Betsy Aiello
SECOND: Member Stacie Weeks
VOTE: Unanimous, the motion carried

BOARD ACTION ON ITEM 5
MOTION: Motion to continue negotiations and bring back the contract proposal for approval
BY: Member Stacie Weeks
AMENDED MOTION: Motion to continue contract discussions for the proposal for the Centers of Excellence travel concierge program and bring it back to the committee
BY: Member Michelle Kelley
SECOND: Member Leslie Bittleston
VOTE: Unanimous, the motion carried

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

BOARD ACTION ON ITEM 7
MOTION: Motion to not accept the open access pharmacy network at this time
BY: Member Stacie Weeks
SECOND: Member Leslie Bittleston
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 7
MOTION: Motion to accept implementation of a max copay for specialty medications not covered by SaveOnSP
BY: Member Bepsy Strasburg
SECOND: Member Betsy Aiello
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 7
MOTION: Motion to accept the renewal of the HMO as recommended
BY: Member Leslie Bittleston
SECOND: Member Jennifer McClendon
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 7
MOTION: Motion to approve required changes to the LD PPO and EPO for compliance with the MHPAEA
BY: Member Betsy Aeillo
SECOND: Member Bepsy Strasburg
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 7
MOTION: Motion to increase deductible as required by the IRS for the CDHP plan
BY: Member Betsy Aiello
SECOND: Member Leslie Bittleston
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 7
MOTION: Motion to request PEBP staff to complete further discussion and negotiation on the UMR RX coupon program and bring it back to the January meeting
BY: Member Betsy Aiello
SECOND: Member Stacie Weeks
VOTE: Unanimous; the motion carried

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**)

BOARD ACTION ON ITEM 8
MOTION: Motion to approve the audit finding for UMR as presented
BY: Member Leslie Bittleston
SECOND: Vice Chair Michelle Kelley
VOTE: Unanimous; the motion carried

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**)

BOARD ACTION ON ITEM 9 (Taken out of order, before Agenda Item 8)
MOTION: Motion to accept the audit findings as presented
BY: Member Leslie Bittleston
SECOND: Member Bepsy Strasburg
VOTE: Unanimous; the motion carried

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

BOARD ACTION ON ITEM 10
MOTION: Motion to bring agenda item back with additional information discussed during the meeting
BY: Vice Chair Michelle Kelley
SECOND: Member Leslie Bittleston
VOTE: Unanimous; the motion carried

11. Public Comment

- Kent Ervin – Nevada Faculty Alliance
- Kelly Osborne – Retiree
- Tess Opferman - AFSCME

12. Adjournment

- Board Chair Robb adjourned the meeting at 12:12 p.m.

4.2

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

4.1 Approval of Action Minutes from the December 7, 2023 PEBP Board Meetings

4.2 Receipt of quarterly staff reports for the period ending September 30 and December 31, 2023

4.2.1

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

4.2 Receipt of quarterly staff reports for the period ending September 30 and December 31, 2023:

4.2.1 Q1 Utilization Report

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CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: January 26, 2024

Item Number: 4.2.1

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

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the PY 2024 period ending September 30, 2023. Included are:

- Executive Summary – provides a utilization overview.
- UMR Inc. CDHP Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- UMR Inc. LDPPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- UMR Inc. EPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- Express Scripts Utilization Report – provides details supporting the prescription drug information included in the Executive Summary.
- Health Plan of Nevada Utilization – see Appendix D for Q1 Plan Year 2024 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q1 of Plan Year 2024 compared to Q1 of Plan Year 2024 is summarized below.

- Population:
  - 11.5% decrease for primary participants
  - 13.5% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 7.3% increase for primary participants
  - 9.8% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 18 High-Cost Claimants accounting for 17.9% of the total plan paid for Q1 of Plan Year 2024
  - 23.3% increase in High-Cost Claimants per 1,000 members
  - 24.6% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cancer ($2.1 million) – 14.1% of paid claims
  - Health Status/Encounters ($1.7 million) – 11.6% of paid claims
  - Cardiac Disorders ($1.4 million) – 9.4% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased by 10.1%
  - Average paid per ER visit increased by 35.4%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased 16.7%
  - Average paid per Urgent Care visit decreased 45.2% (decrease from $31 to $17)
- Network Utilization:
  - 97.2% of claims are from In-Network providers
  - Q1 of Plan Year 2024 In-Network utilization decreased 0.2% over PY 2023
  - Q1 of Plan Year 2024 In-Network discounts decreased 0.5% over PY 2023

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 11.2%
    - Total Gross Claims Costs decreased 4.2% ($0.4 million)
    - Average Total Cost per Claim increased 7.9%
      - From $113.95 to $122.90
  - Member:
    - Total Member Cost decreased 12.3%
    - Average Participant Share per Claim decreased 1.3%
    - Net Member PMPM increased 1.9%
      - From $34.03 to $34.68

- Plan
  - Total Plan Cost decrease 1.2%
  - Average Plan Share per Claim increased 11.3%
  - Net Plan PMPM increased 14.9%
    - From $91.33 to $104.92
  - Net Plan PMPM factoring rebates increased 9.9%
    - From $56.65 to $62.23

LOW DEDUCTIBLE PPO PLAN (LDPPO)

The Low Deductible PPO Plan (LDPPO) experience for Q1 of Plan Year 2023 is summarized below.

- Population:
  - 36.0% increase for primary participants
  - 34.0% increase for primary participants plus dependents (members)
- Medical Cost:
  - 10.0% increase for primary participants
  - 11.6% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 13 High-Cost Claimants accounting for 12.2% of the total plan paid for Q1 of Plan Year 2024
  - 18.3% increase in High-Cost Claimants per 1,000 members
  - 4.4% decrease in average cost of High-Cost Claimant paid.
- Top three highest cost clinical classifications include:
  - Cancer ($1.7 million) – 10.2% of paid claims
  - Health Status Encounters ($1.5 million) – 9.4% of paid claims
  - Gastrointestinal Disorders ($1.3 million) – 8.3% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased 17.8%
  - Average paid per ER visit increased 18.3%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 7.8%
  - Average paid per Urgent Care visit decreased 1.9% (decrease from $104 to $102)
- Network Utilization:
  - 98.2% of claims are from In-Network providers
  - Q1 of Plan Year 2024 In-Network utilization increased 0.4% over PY 2023
  - Q1 of Plan Year 2024 In-Network discounts increased 2.1% over PY 2023

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims increased 36.9%
    - Total Gross Claims Costs increased 60.3% ($3.5 million)
    - Average Total Cost per Claim increased 17.0%
      - From $123.46 to $144.51

  - Member:

        - Total Member Cost increased 38.2%
        - Average Participant Share per Claim increased 0.9%
        - Net Member PMPM increased 3.1%
            - From $23.12 to $23.82
    - Plan
        - Total Plan Cost increased 64.6%
        - Average Plan Share per Claim increased 20.2%
        - Net Plan PMPM increased 22.8%
            - From $117.24 to $143.98
        - Net Plan PMPM factoring rebates increased 20.06%
            - From $75.73 to $91.33

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q1 of Plan Year 2024 compared to Q1 of Plan Year 2023 is summarized below.

- Population:
    - 11.4% decrease for primary participants
    - 11.9% decrease for primary participants plus dependents (members)
- Medical Cost:
    - 19.7% increase for primary participants
    - 20.3% increase for primary participants plus dependents (members)
- High-Cost Claims:
    - There were 7 High-Cost Claimants accounting for 12.8% of the total plan paid for Q1 Plan Year 2024
    - 33.3% increase in High-Cost Claimants per 1,000 members
    - 3.7% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
    - Cancer ($0.7 million) – 9.1% of paid claims
    - Health Status/Encounters ($0.7 million) – 8.5% of paid claims
    - Musculoskeletal Disorders ($0.6 million) – 7.5% of paid claims
- Emergency Room:
    - ER visits per 1,000 members increased 13.8%
    - Average paid per ER visit increased by 3.3%
- Urgent Care:
    - Urgent Care visits per 1,000 members increased 19.6%
    - Average paid per Urgent Care visit increased 9.1%
- Network Utilization:
    - 97.3% of claims are from In-Network providers
    - In-Network utilization increased 1.2%
    - In-Network discounts increased 2.1%

- Prescription Drug Utilization:
    - Overall:
        - Total Net Claims decreased 10.0%

        - Total Gross Claims Costs decreased 1.5% ($.1 million)
        - Average Total Cost per Claim increased 9.4%
            - From $144.92 to $158.50
    - Member:
        - Total Member Cost decreased 16.8%
        - Average Participant Share per Claim decreased 7.6%
        - Net Member PMPM decreased 5.1%
            - From $40.24 to $38.18
    - Plan
        - Total Plan Cost increased 1.4%
        - Average Plan Share per Claim increased 12.6%
        - Net Plan PMPM increased 15.6%
            - From $210.84 to $243.80
        - Net Plan PMPM factoring rebates increased 14.2%
            - From $139.16 to $158.92

DENTAL PLAN

The Dental Plan experience for Q1 of Plan Year 2024 is summarized below.

- Dental Cost:
    - Total of $6,781,648 paid for Dental claims.
        - Preventative claims account for 24.5% ($1.7 million)
        - Basic claims account for 33.2% ($2.2 million)
        - Major claims account for 20.1% ($1.4 million)
        - Diagnostic claims account for 22.3% ($1.5 million)

HEALTH REIMBURSEMENT ARRANGEMENT

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

HRA Account Balances as of September 30, 2023			
$Range	# Accounts	Total Account Balance	Average Per Account Balance
$ -	1,006	$ (3,059.03)	$ (3.04)
$.01 - $500.00	4,624	$ 1,262,583.92	$ 273.05
$500.01 - $1,000	13,031	$ 8,421,381.87	$ 646.26
$1,000.01 - $1,500	2,085	$ 2,558,321.01	$ 1,227.01
$1,500.01 - $2,000	1,082	$ 1,866,658.34	$ 1,725.19
$2,000.01 - $2,500	474	$ 1,056,882.40	$ 2,229.71
$2,500.01 - $3,000	305	$ 823,003.40	$ 2,698.37
$3,000.01 - $3,500	239	$ 774,003.54	$ 3,238.51
$3,500.01 - $4,000	171	$ 637,300.57	$ 3,726.90
$4,000.01 - $4,500	174	$ 739,307.90	$ 4,248.90
$4,500.01 - $5,000	123	$ 582,638.48	$ 4,736.90
$5,000.01 +	772	$ 6,475,565.40	$ 8,388.04
Total	**24,086**	**$ 25,194,587.80**	**$ 33,135.80**

CONCLUSION

The information in this report provides plan experience for the Consumer Driven Health Plan (CDHP), Low Deductible PPO Plan (LDPPO) and the PEBP Premier Plan (EPO) through the first quarter of Plan Year 2024. The CDHP total plan paid costs increased 7.3% over the same time for Plan Year 2023. The LDPPO total plan paid costs increased 10.0% over Q1 of Plan Year 2023. The EPO total plan paid costs increased 19.7% over Q1 of Plan Year 2023. The change in the plan paid year over year is based on the per employee per year costs (PEPY). 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, 2023 – September 30, 2023

DATASCOPE™

Nevada Public Employees' Benefits Program
HDHP Plan
July – September 2023 Incurred,
Paid through November 2023

UMR℠

Overview

- Total Medical Spend for 1Q24 was $14,697,249 of which 77.4% was spent in the State Active population. When compared to 1Q23, this reflected a decrease of 5.0% in plan spend, with State Actives having a decrease of 5.5%.
  - When compared to 1Q22, 1Q24 decreased 23.5%, with State Actives having a decrease of 25.1%.
- On a PEPY basis, 1Q24 reflected an increase of 7.3% when compared to 1Q23. The largest group, State Actives, had an increase of 7.0%.
  - When compared to 1Q22, 1Q24 increased .7%, with State Actives decreasing .6%.
- 96.8% of the Average Membership had paid Medical claims less than $2,500, with 47.2% having no claims paid at all during the reporting period.
- There were 18 high-cost Claimants (HCC's) over $100K, that accounted for 17.9% of the total spend. HCCs accounted for 22.5% of total spend during 1Q23, with 18 members hitting the $100K threshold. The largest diagnosis grouper was Cancer accounting for 25.8% of high-cost claimant dollars.
- IP Paid per Admit was $18,385 which is a decrease of 2.5% compared to 1Q23.
- ER Paid per Visit is $2,324, which is an increase of 35.4% compared to 1Q23.
- 97.2% of all Medical spend dollars were to In Network providers. The average In Network discount was 67.9%, which is a decrease of .7% compared to the PY23 average discount of 68.4%.

Paid Claims by Age Group

Paid Claims by Age Group																
	1Q23						1Q24						% 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	$ 908,346	$ 1,655	$ 300	$ 1	$908,646	$ 1,655	$ 102,629	$ 261	$ 24	$ 0	$ 102,653	$ 261	-88.7%	-84.2%
1	$ 71,998	$ 109	$ 557	$ 1	$72,555	$ 110	$ 69,123	$ 159	$ 26,441	$ 61	$ 95,564	$ 220	31.7%	99.7%
2 - 4	$ 173,075	$ 88	$ 42,433	$ 21	$215,508	$ 109	$ 125,291	$ 77	$ 32,583	$ 20	$ 157,874	$ 97	-26.7%	-10.9%
5 - 9	$ 426,199	$ 99	$ 42,654	$ 10	$468,853	$ 109	$ 224,011	$ 65	$ 86,141	$ 25	$ 310,152	$ 90	-33.8%	-17.2%
10 - 14	$ 380,727	$ 75	$ 73,377	$ 15	$454,104	$ 90	$ 419,505	$ 100	$ 156,245	$ 37	$ 575,750	$ 137	26.8%	52.1%
15 - 19	$ 985,395	$ 176	$ 187,388	$ 33	$1,172,783	$ 209	$ 560,657	$ 113	$ 127,792	$ 26	$ 688,449	$ 139	-41.3%	-33.7%
20 - 24	$ 644,210	$ 95	$ 246,498	$ 36	$890,708	$ 131	$ 422,239	$ 71	$ 473,566	$ 80	$ 895,805	$ 151	0.6%	15.5%
25 - 29	$ 785,930	$ 165	$ 227,385	$ 48	$1,013,315	$ 212	$ 449,933	$ 114	$ 97,997	$ 25	$ 547,930	$ 139	-45.9%	-34.4%
30 - 34	$ 1,121,299	$ 192	$ 277,940	$ 48	$1,399,239	$ 239	$ 877,403	$ 180	$ 197,654	$ 40	$ 1,075,057	$ 220	-23.2%	-8.0%
35 - 39	$ 633,006	$ 102	$ 347,087	$ 56	$980,093	$ 157	$ 917,303	$ 172	$ 324,815	$ 61	$ 1,242,118	$ 233	26.7%	48.7%
40 - 44	$ 807,807	$ 123	$ 464,125	$ 71	$1,271,932	$ 194	$ 833,215	$ 142	$ 423,165	$ 72	$ 1,256,380	$ 215	-1.2%	10.6%
45 - 49	$ 800,634	$ 130	$ 520,322	$ 84	$1,320,956	$ 214	$ 912,512	$ 169	$ 543,294	$ 101	$ 1,455,806	$ 270	10.2%	26.0%
50 - 54	$ 2,070,352	$ 292	$ 928,294	$ 131	$2,998,646	$ 422	$ 1,372,156	$ 221	$ 988,171	$ 159	$ 2,360,327	$ 380	-21.3%	-9.9%
55 - 59	$ 1,961,822	$ 250	$ 1,233,676	$ 157	$3,195,498	$ 407	$ 1,889,334	$ 276	$ 914,407	$ 134	$ 2,803,741	$ 410	-12.3%	0.8%
60 - 64	$ 2,504,622	$ 270	$ 1,781,601	$ 192	$4,286,223	$ 461	$ 3,638,649	$ 438	$ 1,673,138	$ 202	$ 5,311,787	$ 640	23.9%	38.9%
65+	$ 1,198,951	$ 197	$ 1,398,679	$ 230	$2,597,630	$ 427	$ 1,883,291	$ 332	$ 1,604,138	$ 283	$ 3,487,429	$ 615	34.3%	44.0%
Total	**$ 15,474,372**	**$ 182**	**$ 7,772,316**	**$ 92**	**$ 23,246,688**	**$ 274**	**$ 14,697,249**	**$ 200**	**$ 7,669,573**	**$ 104**	**$ 22,366,822**	**$ 305**	**-3.8%**	**11.2%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	19,387	16,758	14,834	-11.5%	15,913	13,583	11,992	-11.7%	3	3	3	0.0%
Spouses	4,147	3,373	2,827	-16.2%	3,299	2,583	2,142	-17.0%	1	1	1	0.0%
Children	10,550	8,156	6,809	-16.5%	9,793	7,509	6,239	-16.9%	4	4	4	0.0%
Total Members	34,084	28,288	24,470	-13.5%	29,005	23,675	20,373	-13.9%	8	8	8	0.0%
Family Size	1.8	1.7	1.7	-2.9%	1.8	1.7	1.7	0.0%	2.7	2.7	2.7	-1.1%
Financial Summary												
Gross Cost	$30,138,301	$24,743,098	$23,737,814	-4.1%	$23,550,658	$18,886,283	$17,971,228	-4.8%	$5,957	$7,455	$7,763	4.1%
Client Paid	$19,209,638	$15,474,372	$14,697,249	-5.0%	$15,196,144	$12,046,374	$11,380,069	-5.5%	$857	$2,557	$3,655	42.9%
Employee Paid	$10,928,663	$9,268,726	$9,040,565	-2.5%	$8,354,514	$6,839,909	$6,591,159	-3.6%	$5,099	$4,898	$4,108	-16.1%
Client Paid-PEPY	$3,936	$3,694	$3,963	7.3%	$3,820	$3,547	$3,796	7.0%	$1,143	$3,409	$4,873	42.9%
Client Paid-PMPY	$2,254	$2,188	$2,403	9.8%	$2,096	$2,035	$2,234	9.8%	$429	$1,278	$1,828	43.0%
Client Paid-PEPM	$330	$308	$330	7.1%	$318	$296	$316	6.8%	$95	$284	$406	43.0%
Client Paid-PMPM	$188	$182	$200	9.9%	$175	$170	$186	9.4%	$36	$107	$152	42.1%
High Cost Claimants (HCC's) > $100k												
# of HCC's	27	18	18	0.0%	20	13	14	7.7%	0	0	0	0.0%
HCC's / 1,000	0.8	0.6	0.7	23.3%	0.7	0.6	0.7	15.0%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$163,951	$193,351	$145,790	-24.6%	$174,359	$197,111	$153,037	-22.4%	$0	$0	$0	0.0%
HCC's % of Plan Paid	23.0%	22.5%	17.9%	-20.4%	22.9%	21.3%	18.8%	-11.7%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$798	$647	$558	-13.8%	$742	$589	$538	-8.7%	$0	$0	$0	0.0%
Facility Outpatient	$660	$744	$980	31.7%	$573	$675	$886	31.3%	$40	$1,278	$1,774	38.8%
Physician	$748	$797	$865	8.5%	$736	$771	$811	5.2%	$389	$0	$53	0.0%
Other	$48	$0	$0	0.0%	$45	$0	$0	0.0%	$0	$0	$0	0.0%
Total	$2,254	$2,188	$2,403	9.8%	$2,096	$2,035	$2,234	9.8%	$429	$1,278	$1,828	43.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	3,018	2,785	2,506	-10.0%	453	387	333	-14.0%	
Spouses	779	736	644	-12.5%	67	54	39	-27.2%	
Children	735	627	553	-11.8%	18	17	14	-17.6%	
Total Members	4,532	4,147	3,703	-10.7%	538	458	386	-15.7%	
Family Size	1.5	1.5	1.5	-1.3%	1.2	1.2	1.2	-3.3%	1.6
Financial Summary									
Gross Cost	$5,840,912	$4,829,975	$5,116,537	5.9%	$740,774	$1,019,385	$642,286	-37.0%	
Client Paid	$3,643,511	$2,793,575	$3,032,619	8.6%	$369,125	$631,866	$280,905	-55.5%	
Employee Paid	$2,197,401	$2,036,400	$2,083,917	2.3%	$371,649	$387,519	$361,382	-6.7%	
Client Paid-PEPY	$4,829	$4,013	$4,840	20.6%	$3,259	$6,525	$3,378	-48.2%	$6,297
Client Paid-PMPY	$3,216	$2,695	$3,276	21.6%	$2,743	$5,514	$2,911	-47.2%	$3,879
Client Paid-PEPM	$402	$334	$403	20.7%	$272	$544	$281	-48.3%	$525
Client Paid-PMPM	$268	$225	$273	21.3%	$229	$460	$243	-47.2%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	6	3	4	33.3%	1	2	0	-100.0%	
HCC's / 1,000	1.3	0.7	1.1	54.3%	1.9	4.4	0.0	-100.0%	
Avg HCC Paid	$138,675	$167,466	$120,422	-28.1%	$107,427	$207,741	$0	-100.0%	
HCC's % of Plan Paid	22.8%	18.0%	15.9%	-11.7%	29.1%	65.8%	0.0%	-100.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,151	$738	$725	-1.8%	$913	$2,825	$59	-97.9%	$1,149
Facility Outpatient	$1,197	$1,062	$1,388	30.7%	$840	$1,436	$1,989	38.5%	$1,333
Physician	$805	$895	$1,163	29.9%	$912	$1,253	$863	-31.1%	$1,301
Other	$63	$0	$0	0.0%	$78	$0	$0	0.0%	$96
Total	$3,216	$2,695	$3,276	21.6%	$2,743	$5,514	$2,911	-47.2%	$3,879
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

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

	Total				State Active				Non-State Active			
Summary	**PY22**	**PY23**	**1Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**1Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**1Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	18,943	16,411	14,834	-9.6%	15,526	13,332	11,992	-10.1%	3	3	3	0.0%
Spouses	3,974	7,866	2,827	-64.1%	3,134	7,223	2,142	-70.3%	1	4	1	-75.0%
Children	10,172	3,266	6,809	108.5%	9,421	2,504	6,239	149.2%	4	1	4	300.0%
Total Members	33,089	27,544	24,470	-11.2%	28,082	23,059	20,373	-11.6%	8	8	8	0.0%
Family Size	1.8	1.7	1.7	-1.8%	1.8	1.7	1.7	-1.7%	2.7	2.7	2.7	0.0%
Financial Summary												
Gross Cost	$138,077,453	$116,590,277	$23,737,814	-79.6%	$106,593,460	$87,356,314	$17,971,228	-79.4%	$55,484	$42,591	$7,763	-81.8%
Client Paid	$104,706,277	$88,479,381	$14,697,249	-83.4%	$80,561,976	$66,125,338	$11,380,069	-82.8%	$38,304	$30,890	$3,655	-88.2%
Employee Paid	$33,371,175	$28,110,896	$9,040,565	-67.8%	$26,031,484	$21,230,976	$6,591,159	-69.0%	$17,181	$11,702	$4,108	-64.9%
Client Paid-PEPY	$5,527	$5,391	$3,963	-26.5%	$5,189	$4,960	$3,796	-23.5%	$12,768	$10,297	$4,873	-52.7%
Client Paid-PMPY	$3,164	$3,212	$2,403	-25.2%	$2,869	$2,868	$2,234	-22.1%	$4,788	$3,861	$1,828	-52.7%
Client Paid-PEPM	$461	$449	$330	-26.5%	$432	$413	$316	-23.5%	$1,064	$858	$406	-52.7%
Client Paid-PMPM	$264	$268	$200	-25.4%	$239	$239	$186	-22.2%	$399	$322	$152	-52.8%
High Cost Claimants (HCC's) > $100k												
# of HCC's	160	126	18		115	94	14		0	0	0	
HCC's / 1,000	4.8	4.6	0.7		4.1	4.1	0.7		0.0	0.0	0.0	
Avg HCC Paid	$251,190	$238,643	$145,790	-38.9%	$262,921	$233,021	$153,037	-34.3%	$0	$0	$0	0.0%
HCC's % of Plan Paid	38.4%	34.0%	17.9%	-47.4%	37.5%	33.1%	18.8%	-43.2%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,153	$995	$558	-43.9%	$1,028	$895	$538	-39.9%	$0	$0	$0	0.0%
Facility Outpatient	$939	$1,074	$980	-8.8%	$821	$930	$886	-4.7%	$3,554	$2,208	$1,774	-19.7%
Physician	$1,011	$1,143	$865	-24.3%	$964	$1,043	$811	-22.2%	$1,200	$1,653	$53	-96.8%
Other	$62	$0	$0	0.0%	$56	$0	$0	0.0%	$34	$0	$0	0.0%
Total	$3,164	$3,212	$2,403	-25.2%	$2,869	$2,868	$2,234	-22.1%	$4,788	$3,861	$1,828	-52.7%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY22**	**PY23**	**1Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**1Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	2,981	2,711	2,506	-7.5%	433	366	333	-9.0%	
Spouses	776	624	644	3.2%	62	16	39	153.8%	
Children	729	715	553	-22.7%	18	46	14	-69.7%	
Total Members	4,486	4,049	3,703	-8.6%	514	427	386	-9.7%	
Family Size	1.5	1.5	1.5	-0.7%	1.2	1.2	1.2	-0.9%	1.6
Financial Summary									
Gross Cost	$27,879,066	$25,102,026	$5,116,537	-79.6%	$3,549,442	$4,089,345	$642,286	-84.3%	
Client Paid	$21,491,378	$19,194,786	$3,032,619	-84.2%	$2,614,619	$3,128,367	$280,905	-91.0%	
Employee Paid	$6,387,688	$5,907,239	$2,083,917	-64.7%	$934,823	$960,978	$361,382	-62.4%	
Client Paid-PEPY	$7,210	$7,082	$4,840	-31.7%	$6,033	$8,557	$3,378	-60.5%	$6,642
Client Paid-PMPY	$4,791	$4,740	$3,276	-30.9%	$5,091	$7,321	$2,911	-60.2%	$4,116
Client Paid-PEPM	$601	$590	$403	-31.7%	$503	$713	$281	-60.6%	$553
Client Paid-PMPM	$399	$395	$273	-30.9%	$424	$610	$243	-60.2%	$343
High Cost Claimants (HCC's) > $100k									
# of HCC's	44	31	4		5	5	0		
HCC's / 1,000	9.8	7.7	1.1		9.7	11.7	0.0		
Avg HCC Paid	$199,873	$213,853	$120,422	-43.7%	$231,987	$307,109	$0	-100.0%	
HCC's % of Plan Paid	40.9%	34.5%	15.9%	-53.9%	44.4%	49.1%	0.0%	-100.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,808	$1,250	$725	-42.0%	$2,262	$4,005	$59	-98.5%	$1,190
Facility Outpatient	$1,612	$1,838	$1,388	-24.5%	$1,488	$1,591	$1,989	25.0%	$1,376
Physician	$1,280	$1,652	$1,163	-29.6%	$1,227	$1,724	$863	-49.9%	$1,466
Other	$91	$0	$0	0.0%	$115	$0	$0	0.0%	$84
Total	$4,791	$4,740	$3,276	-30.9%	$5,091	$7,321	$2,911	-60.2%	$4,116
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 4,247,464	$ 849,667	$ 34,622	$ 5,131,753	$ 3,262,334	$ 612,876	$ 168,827	$ 4,044,036	-21.2%
Outpatient	$ 7,798,910	$ 1,646,356	$ 262,930	$ 9,708,196	$ 8,117,736	$ 1,816,531	$ 434,385	$ 10,368,652	6.8%
Total - Medical	**$ 12,046,374**	**$ 2,496,023**	**$ 297,552**	**$ 14,839,949**	**$ 11,380,069**	**$ 2,429,407**	**$ 603,212**	**$ 14,412,689**	**-2.9%**

Net Paid Claims - Per Participant per Month	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 296	$ 375	$ 174	$ 302	$ 316	$ 413	$ 370	$ 331	9.7%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 113,698	$ 260,769	$ 374,467	$ -	$ 2,503	$ 10,933	$ 13,435	-96.4%
Outpatient	$ 2,557	$ 116,539	$ 140,860	$ 259,955	$ 3,655	$ 139,384	$ 128,086	$ 271,125	4.3%
Total - Medical	**$ 2,557**	**$ 230,237**	**$ 401,629**	**$ 634,422**	**$ 3,655**	**$ 141,886**	**$ 139,019**	**$ 284,560**	**-55.1%**

Net Paid Claims - Per Participant per Month	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 284	$ 606	$ 514	$ 542	$ 406	$ 561	$ 187	$ 283	-47.8%

Paid Claims by Claim Type – Total Participants

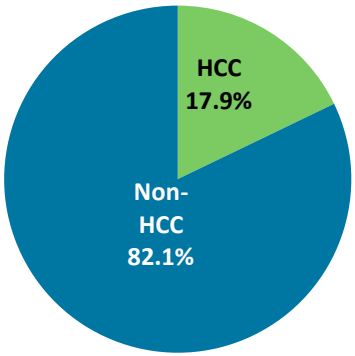
Net Paid Claims - Total Total Participants	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 4,247,464	$ 963,365	$ 295,391	$ 5,506,220	$ 3,262,334	$ 615,379	$ 179,759	$ 4,057,472	-26.3%
Outpatient	$ 7,801,466	$ 1,762,895	$ 403,790	$ 9,968,152	$ 8,121,391	$ 1,955,915	$ 562,471	$ 10,639,777	6.7%
Total - Medical	**$ 12,048,930**	**$ 2,726,260**	**$ 699,181**	**$ 15,474,372**	**$ 11,383,724**	**$ 2,571,294**	**$ 742,231**	**$ 14,697,249**	**-5.0%**

Net Paid Claims - Per Participant per Month	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 296	$ 388	$ 281	$ 308	$ 316	$ 419	$ 313	$ 330	7.2%

Cost Distribution – Medical Claims

1Q23							1Q24					
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
17	0.1%	$3,480,327	22.5%	$106,738	1.2%	$100,000.01 Plus	17	0.1%	$2,624,212	17.9%	$101,641	1.1%
28	0.1%	$1,861,863	12.0%	$168,221	1.8%	$50,000.01-$100,000.00	31	0.1%	$2,194,155	14.9%	$161,742	1.8%
61	0.2%	$2,118,895	13.7%	$380,394	4.1%	$25,000.01-$50,000.00	60	0.2%	$2,155,899	14.7%	$307,842	3.4%
159	0.6%	$2,580,710	16.7%	$798,374	8.6%	$10,000.01-$25,000.00	166	0.7%	$2,696,044	18.3%	$835,784	9.2%
227	0.8%	$1,600,463	10.3%	$881,354	9.5%	$5,000.01-$10,000.00	196	0.8%	$1,338,419	9.1%	$755,669	8.4%
318	1.1%	$1,147,137	7.4%	$864,049	9.3%	$2,500.01-$5,000.00	318	1.3%	$1,141,352	7.8%	$880,578	9.7%
7,163	25.3%	$2,684,976	17.4%	$3,807,661	41.1%	$0.01-$2,500.00	5,798	23.7%	$2,547,168	17.3%	$3,605,954	39.9%
6,373	22.5%	$0	0.0%	$2,261,935	24.4%	$0.00	6,336	25.9%	$0	0.0%	$2,391,356	26.5%
13,942	49.3%	$0	0.0%	$0	0.0%	No Claims	11,548	47.2%	$0	0.0%	$0	0.0%
28,288	**100.0%**	**$15,474,372**	**100.0%**	**$9,268,726**	**100.0%**		**24,470**	**100.0%**	**$14,697,249**	**100.0%**	**$9,040,565**	**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	6	$675,885	25.8%
Cardiac Disorders	15	$303,035	11.5%
Pulmonary Disorders	14	$251,679	9.6%
Renal/Urologic Disorders	6	$196,019	7.5%
Infections	9	$174,698	6.7%
Hematological Disorders	8	$163,110	6.2%
Gastrointestinal Disorders	10	$160,489	6.1%
Endocrine/Metabolic Disorders	9	$152,598	5.8%
Medical/Surgical Complications	2	$119,059	4.5%
Spine-related Disorders	4	$118,709	4.5%
All Other		$308,930	11.8%
Overall	**----**	**$2,624,212**	**100.0%**

Utilization Summary (p. 1 of 2)

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

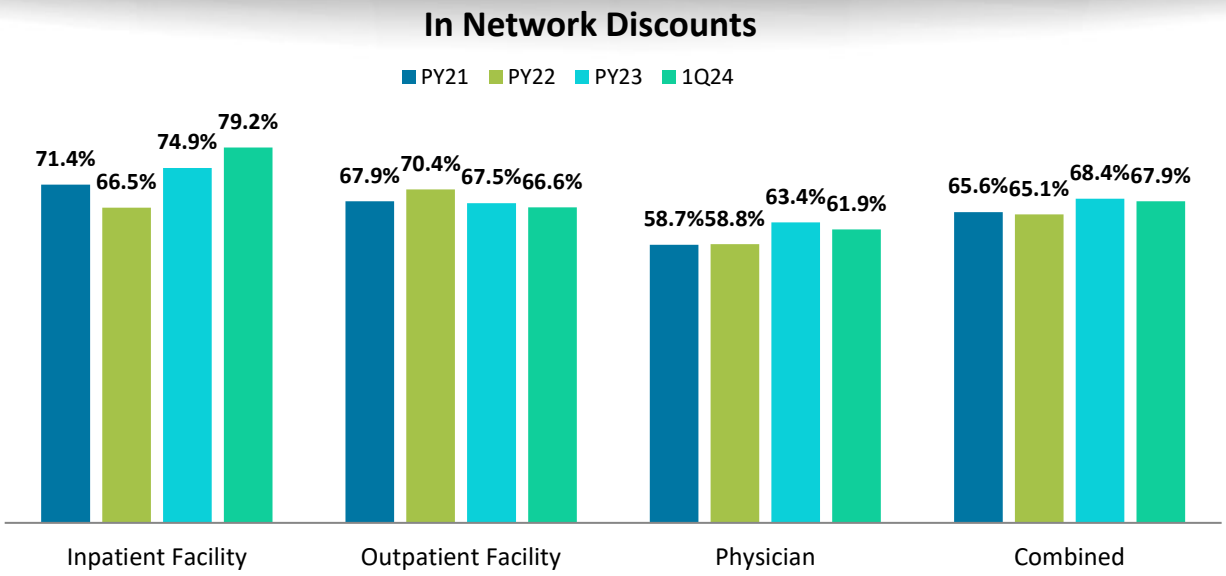
	Total				State Active				Non-State Active			
Summary	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	357	260	196		270	190	145		0	0	0	
# of Bed Days	2,408	1,486	931		1,857	1,102	677		0	0	0	
Paid Per Admit	$32,712	$18,851	$18,385	-2.5%	$33,162	$19,243	$19,248	0.0%	$0	$0	$0	0.0%
Paid Per Day	$4,850	$3,298	$3,871	17.4%	$4,822	$3,318	$4,122	24.2%	$0	$0	$0	0.0%
Admits Per 1,000	42	37	32	-13.5%	37	32	28	-12.5%	0	0	0	0.0%
Days Per 1,000	283	210	152	-27.6%	256	186	133	-28.5%	0	0	0	0.0%
Avg LOS	6.7	5.7	4.8	-15.8%	6.9	5.8	4.7	-19.0%	0	0	0	0.0%
# Admits From ER	217	167	140	-16.2%	149	112	98	-12.5%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	3.7	3.4	3.8	11.8%	3.5	3.1	3.5	12.9%	2.5	1.5	2.5	66.7%
Avg Paid per OV	$64	$61	$56	-8.2%	$67	$63	$55	-12.7%	$45	$0	$21	0.0%
Avg OV Paid per Member	$236	$210	$215	2.4%	$234	$198	$193	-2.5%	$114	$0	$53	0.0%
DX&L Utilization per Member	6.9	9.3	9.2	-1.1%	6.5	8.3	8.6	3.6%	24	4	2	-50.0%
Avg Paid per DX&L	$40	$33	$44	33.3%	$36	$33	$43	30.3%	$6	$0	$887	0.0%
Avg DX&L Paid per Member	$277	$308	$403	30.8%	$236	$274	$374	36.5%	$154	$0	$1,774	0.0%
Emergency Room												
# of Visits	1,229	978	932		1,007	746	737		1	1	0	
Visits Per Member	0.14	0.14	0.15	7.1%	0.14	0.13	0.14	7.7%	0.5	0.50	0.00	-100.0%
Visits Per 1,000	144	138	152	10.1%	139	126	145	15.1%	500	500	0	-100.0%
Avg Paid per Visit	$1,717	$1,717	$2,324	35.4%	$1,776	$1,737	$2,408	38.6%	$209	$2,476	$0	-100.0%
Urgent Care												
# of Visits	2,320	1,652	1,671		2,048	1,435	1,443		1	2	1	
Visits Per Member	0.27	0.23	0.27	17.4%	0.28	0.24	0.28	16.7%	0.50	1.00	0.50	-50.0%
Visits Per 1,000	272	234	273	16.7%	282	242	283	16.9%	500	1,000	500	-50.0%
Avg Paid per Visit	$52	$31	$17	-45.2%	$53	$32	$17	-46.9%	$113	$0	$0	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

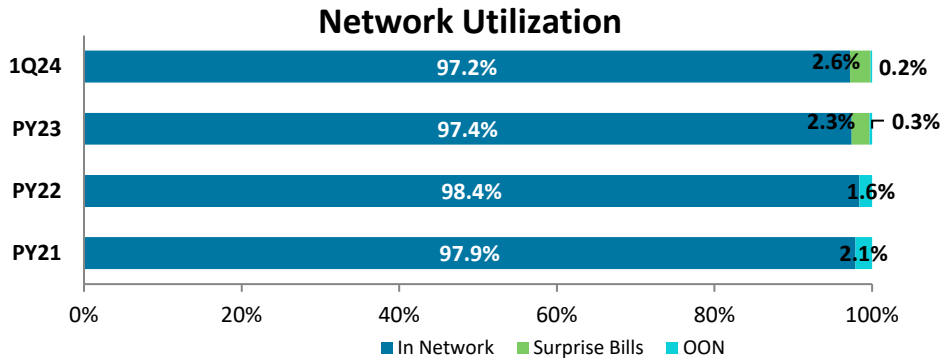
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**Peer Index**
Inpatient Summary									
# of Admits	79	53	39		8	17	12		
# of Bed Days	467	261	206		84	123	48		
Paid Per Admit	$31,731	$16,415	$20,084	22.4%	$27,205	$22,054	$2,440	-88.9%	$16,632
Paid Per Day	$5,368	$3,333	$3,802	14.1%	$2,591	$3,048	$610	-80.0%	$3,217
Admits Per 1,000	70	51	42	-17.6%	59	148	124	-16.2%	76
Days Per 1,000	412	252	223	-11.5%	624	1,073	497	-53.7%	391
Avg LOS	5.9	4.9	5.3	8.2%	10.5	7.2	4.0	-44.4%	5.2
# Admits From ER	63	42	31	-26.2%	5	13	11	-15.4%	
Physician Office									
OV Utilization per Member	4.7	4.7	4.8	2.1%	6.7	7.8	7.9	1.3%	5.0
Avg Paid per OV	$55	$62	$70	12.9%	$17	$18	$25	38.9%	$57
Avg OV Paid per Member	$259	$289	$337	16.6%	$117	$139	$198	42.4%	$286
DX&L Utilization per Member	8.9	13	11.6	-10.8%	9.1	23.3	17.6	-24.5%	10.5
Avg Paid per DX&L	$59	$35	$45	28.6%	$43	$32	$41	28.1%	$50
Avg DX&L Paid per Member	$525	$458	$525	14.6%	$390	$736	$726	-1.4%	$522
Emergency Room									
# of Visits	184	191	162		37	40	33		
Visits Per Member	0.16	0.18	0.17	-5.6%	0.27	0.35	0.34	-2.9%	0.24
Visits Per 1,000	162	184	175	-4.9%	275	349	342	-2.0%	235
Avg Paid per Visit	$1,484	$1,616	$2,247	39.0%	$1,329	$1,826	$831	-54.5%	$943
Urgent Care									
# of Visits	245	195	208		26	20	19		
Visits Per Member	0.22	0.19	0.22	15.8%	0.19	0.17	0.20	17.6%	0.3
Visits Per 1,000	216	188	225	19.7%	193	175	197	12.6%	300
Avg Paid per Visit	$42	$30	$17	-43.3%	$29	$37	$2	-94.6%	$84
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$2,078,092	14.1%	$1,777,721	$267,377	$32,994	$632,337	$1,445,756
Health Status/Encounters	$1,700,044	11.6%	$1,051,305	$219,392	$429,347	$577,919	$1,122,126
Cardiac Disorders	$1,381,951	9.4%	$1,107,157	$234,950	$39,844	$865,641	$516,310
Gastrointestinal Disorders	$1,265,645	8.6%	$948,669	$217,034	$99,941	$497,758	$767,887
Trauma/Accidents	$837,058	5.7%	$600,426	$55,532	$181,100	$400,155	$436,903
Spine-related Disorders	$678,972	4.6%	$601,378	$69,656	$7,938	$430,972	$248,000
Musculoskeletal Disorders	$669,146	4.6%	$503,584	$87,107	$78,456	$199,346	$469,801
Mental Health	$655,174	4.5%	$303,181	$48,901	$303,092	$399,007	$256,168
Infections	$650,578	4.4%	$373,535	$247,769	$29,274	$216,001	$434,577
Renal/Urologic Disorders	$639,798	4.4%	$529,508	$51,133	$59,157	$301,731	$338,067
Neurological Disorders	$621,108	4.2%	$358,519	$134,312	$128,278	$256,137	$364,972
Pulmonary Disorders	$520,904	3.5%	$348,708	$39,042	$133,154	$230,897	$290,007
Eye/ENT Disorders	$365,407	2.5%	$237,457	$82,601	$45,349	$150,476	$214,931
Pregnancy-related Disorders	$357,837	2.4%	$291,256	$18,105	$48,477	$11,471	$346,366
Endocrine/Metabolic Disorders	$349,602	2.4%	$308,130	$34,793	$6,679	$208,184	$141,418
Gynecological/Breast Disorders	$309,099	2.1%	$223,619	$47,598	$37,881	$2,221	$306,878
Medical/Surgical Complications	$295,900	2.0%	$286,744	$6,528	$2,628	$57,425	$238,475
Hematological Disorders	$235,873	1.6%	$88,957	$137,082	$9,834	$140,326	$95,547
Non-malignant Neoplasm	$186,853	1.3%	$152,889	$28,689	$5,275	$34,155	$152,698
Vascular Disorders	$171,756	1.2%	$136,845	$15,593	$19,318	$43,944	$127,812
Diabetes	$147,829	1.0%	$133,399	$5,021	$9,410	$31,255	$116,574
Miscellaneous	$132,630	0.9%	$99,357	$8,768	$24,505	$36,241	$96,389
Medication Related Conditions	$127,587	0.9%	$28,450	$331	$98,806	$1,421	$126,166
Abnormal Lab/Radiology	$87,554	0.6%	$76,817	$6,145	$4,592	$36,094	$51,459
Dermatological Disorders	$86,085	0.6%	$50,723	$11,488	$23,875	$34,964	$51,121
Congenital/Chromosomal Anomalies	$60,077	0.4%	$8,175	$31	$51,871	$9,716	$50,361
External Hazard Exposure	$55,861	0.4%	$2,107	$1,716	$52,038	$52,260	$3,601
Cholesterol Disorders	$22,783	0.2%	$19,849	$2,694	$240	$16,730	$6,053
Allergic Reaction	$5,642	0.0%	$1,866	$270	$3,506	$463	$5,179
Dental Conditions	$274	0.0%	$125	$149	$0	$125	$149
Cause of Morbidity	$128	0.0%	$0	$0	$128	$128	$0
Social Determinants of Health	$0	0.0%	$0	$0	$0	$0	$0
Total	**$14,697,249**	**100.0%**	**$10,650,454**	**$2,079,807**	**$1,966,987**	**$5,875,498**	**$8,821,750**

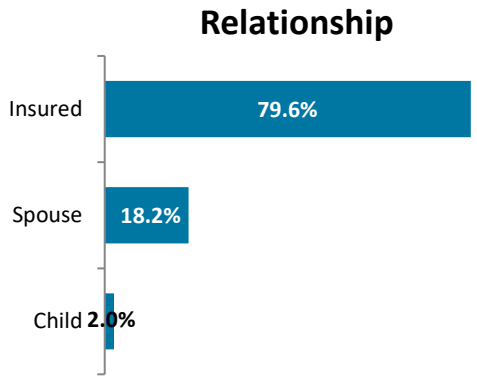
Mental Health Drilldown

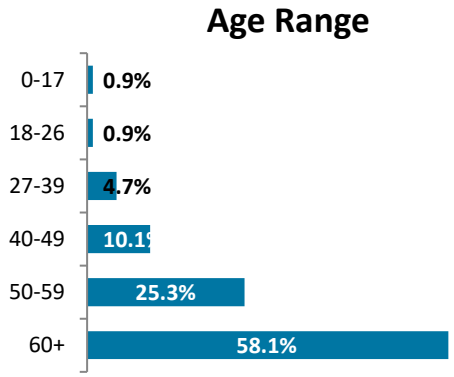
	PY21		PY22		PY23		1Q24	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	1,597	$1,103,414	1,156	$1,279,244	974	$1,005,022	476	$84,104
Developmental Disorders	179	$1,179,402	113	$719,871	106	$1,143,180	56	$152,459
Alcohol Abuse/Dependence	136	$1,288,204	101	$873,612	129	$434,007	45	$228,978
Mental Health Conditions, Other	1,220	$771,034	911	$431,490	774	$383,973	317	$33,494
Mood and Anxiety Disorders	1,920	$638,818	1,486	$406,189	1,263	$370,422	494	$30,622
Bipolar Disorder	315	$464,418	225	$197,224	193	$202,937	112	$32,231
Psychoses	54	$86,357	32	$70,201	35	$108,586	10	$16,210
Eating Disorders	55	$647,596	44	$596,928	34	$112,463	9	$597
Complications of Substance Abuse	42	$202,208	22	$89,081	26	$88,753	12	$19,652
Substance Abuse/Dependence	140	$213,345	86	$540,594	81	$99,940	31	$3,825
Schizophrenia	26	$141,033	25	$110,357	21	$81,413	9	$329
Sexually Related Disorders	68	$90,021	42	$11,305	56	$109,156	19	$38,434
Attention Deficit Disorder	482	$72,965	374	$57,319	369	$42,820	179	$3,661
Sleep Disorders	564	$76,491	371	$46,254	347	$39,783	101	$8,246
Tobacco Use Disorder	126	$8,010	106	$6,184	103	$7,184	24	$760
Personality Disorders	25	$16,690	19	$13,480	8	$1,502	8	$1,571
Total		**$7,000,007**		**$5,449,334**		**$4,231,141**		**$655,174**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	41	124	$964,767	46.4%
Cancers, Other	41	231	$229,013	11.0%
Colon Cancer	25	145	$189,351	9.1%
Breast Cancer	96	433	$149,978	7.2%
Prostate Cancer	50	204	$130,381	6.3%
Lung Cancer	12	65	$96,205	4.6%
Lymphomas	19	105	$59,280	2.9%
Leukemias	18	119	$37,846	1.8%
Thyroid Cancer	17	65	$34,751	1.7%
Cervical/Uterine Cancer	23	82	$33,088	1.6%
Secondary Cancers	24	95	$32,348	1.6%
Kidney Cancer	11	53	$27,922	1.3%
Non-Melanoma Skin Cancers	96	176	$22,931	1.1%
Carcinoma in Situ	26	65	$18,255	0.9%
Pancreatic Cancer	2	52	$15,276	0.7%
Ovarian Cancer	10	58	$14,927	0.7%
Melanoma	14	45	$8,332	0.4%
Brain Cancer	2	3	$5,907	0.3%
Bladder Cancer	12	37	$3,789	0.2%
Myeloma	6	28	$3,746	0.2%
Overall	**----**	**----**	**$2,078,092**	**100.0%**

*Patient and claim counts are unique only within the category

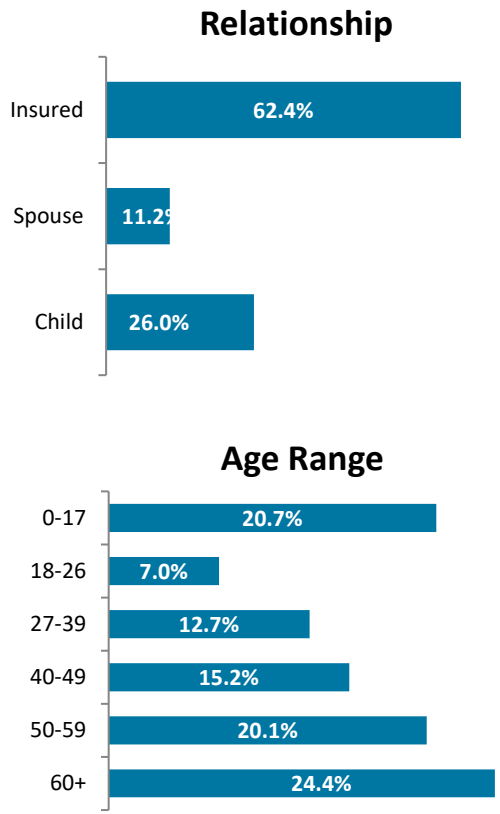




Diagnosis Grouper – Health Status/Encounters

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Screenings	2,080	3,393	$605,337	35.6%
Exams	2,596	4,053	$379,195	22.3%
Prophylactic Measures	956	1,043	$261,994	15.4%
Encounters - Infants/Children	960	1,079	$163,898	9.6%
Counseling	432	1,570	$109,765	6.5%
Aftercare	144	248	$55,004	3.2%
Prosthetics/Devices/Implants	167	376	$41,712	2.5%
Personal History of Condition	241	365	$24,297	1.4%
Family History of Condition	45	66	$20,813	1.2%
Encounter - Procedure	12	22	$12,924	0.8%
Health Status, Other	25	41	$12,288	0.7%
Encounter - Transplant Related	18	42	$6,853	0.4%
Acquired Absence	21	22	$3,582	0.2%
Lifestyle/Situational Issues	27	52	$2,383	0.1%
Patient Non-compliance	1	1	$0	0.0%
Miscellaneous Examinations	4	5	$0	0.0%
Follow-Up Encounters	1	1	$0	0.0%
Overall	**----**	**----**	**$1,700,044**	**100.0%**

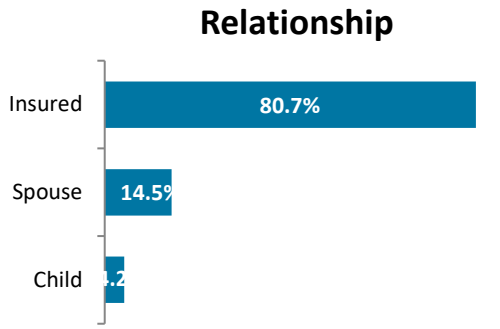
*Patient and claim counts are unique only within the category

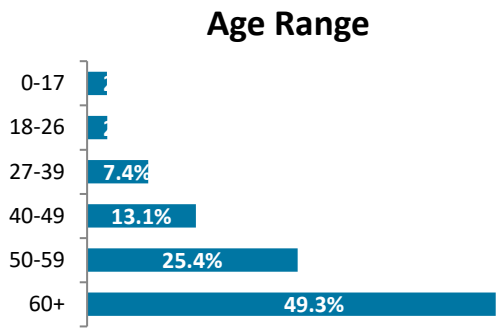


Diagnosis Grouper – Cardiac Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Atrial Fibrillation	105	304	$322,348	23.3%
Chest Pain	321	648	$211,382	15.3%
Myocardial Infarction	17	72	$191,424	13.9%
Congestive Heart Failure	45	135	$164,405	11.9%
Coronary Artery Disease	171	314	$122,924	8.9%
Cardiac Arrhythmias	176	296	$79,143	5.7%
Cardiomyopathy	13	26	$78,691	5.7%
Hypertension	924	1,428	$66,885	4.8%
Cardiac Conditions, Other	181	306	$48,633	3.5%
Pulmonary Embolism	18	68	$37,013	2.7%
Heart Valve Disorders	115	149	$30,057	2.2%
Cardio-Respiratory Arrest	25	66	$22,477	1.6%
Shock	7	24	$6,569	0.5%
Overall	**----**	**----**	**$1,381,951**	**100.0%**

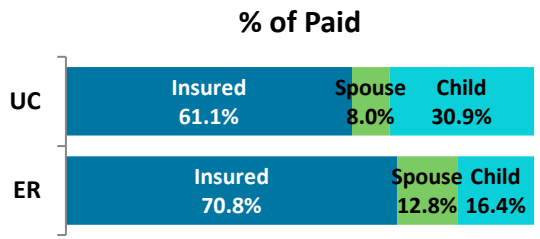
*Patient and claim counts are unique only within the category

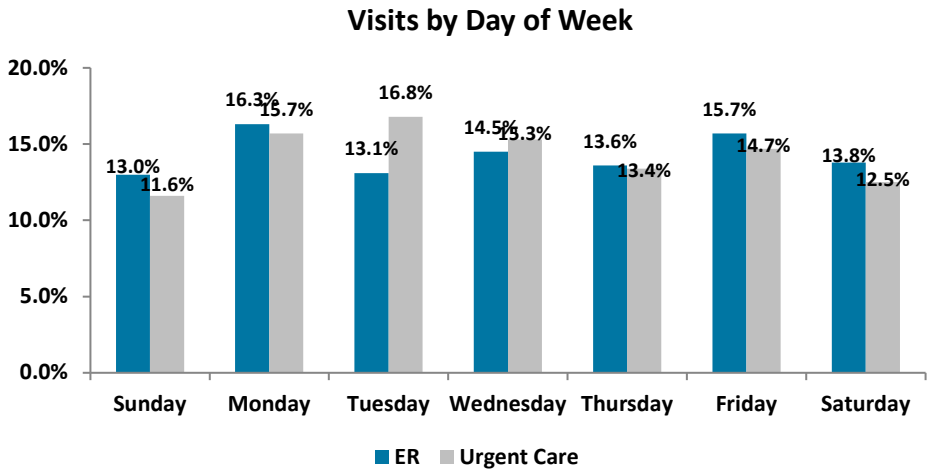




Emergency Room / Urgent Care Summary

	1Q23		1Q24		Peer Index	
	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	978	1,652	932	1,671		
Visits Per Member	0.14	0.23	0.15	0.27	0.22	0.35
Visits/1000 Members	138	234	152	273	221	352
Avg Paid Per Visit	$1,717	$31	$2,324	$17	$968	$135
% with OV*	81.7%	79.2%	82.6%	75.9%		
% Avoidable	11.7%	37.8%	13.7%	35.3%		
Total Member Paid	**$1,507,498**	**$236,520**	**$1,575,804**	**$280,384**		
Total Plan Paid	**$1,679,653**	**$51,999**	**$2,165,879**	**$28,005**		
*looks back 12 months	Annualized	Annualized	Annualized	Annualized		





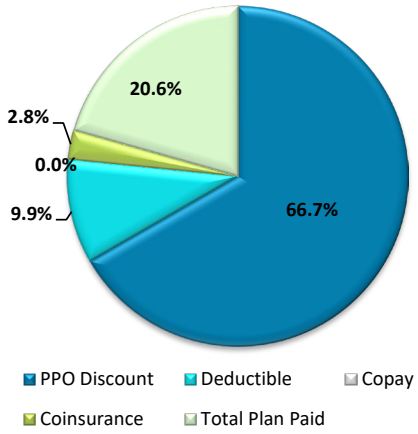
ER / UC Visits by Relationship						
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	593	40	1,060	4,380	1,653	111
Spouse	109	40	157	863	266	97
Child	230	33	454	1,655	684	99
Total	**932**	**38**	**1,671**	**68**	**2,603**	**106**

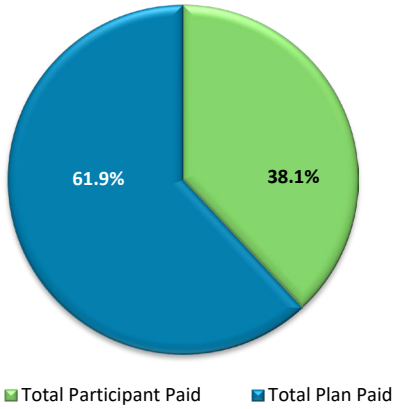
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$73,031,057	$1,641	100.0%
PPO Discount	$47,503,613	$1,067	65.0%
Deductible	$7,060,402	$159	9.7%
Copay	$873	$0	0.0%
Coinsurance	$1,979,290	$44	2.7%
Total Participant Paid	**$9,040,565**	**$203**	**12.4%**
Total Plan Paid	**$14,697,249**	**$330**	**20.1%**

Total Participant Paid - PY23	**$143**
Total Plan Paid - PY23	**$449**





Paid Claims by Age Range – Dental

Dental Paid Claims by Age Group												
	1Q22			1Q23			1Q24			% Change		
Age Range	Dental Plan Paid		Dental PMPM	Dental Plan Paid		Dental PMPM	Dental Plan Paid		Dental PMPM	Dental Plan Paid		Dental PMPM
<1	$	1,507	$ 1	$	1,753	$ 1	$	2,412	$ 2	37.6%		103.0%
1	$	10,899	$ 7	$	12,789	$ 9	$	12,554	$ 10	-1.8%		7.4%
2 - 4	$	102,021	$ 20	$	100,891	$ 21	$	110,644	$ 24	9.7%		12.6%
5 - 9	$	319,163	$ 33	$	271,893	$ 29	$	314,629	$ 35	15.7%		19.9%
10 - 14	$	324,158	$ 28	$	296,169	$ 27	$	334,442	$ 31	12.9%		13.6%
15 - 19	$	394,924	$ 32	$	370,678	$ 30	$	489,200	$ 39	32.0%		29.5%
20 - 24	$	234,582	$ 18	$	206,524	$ 16	$	289,357	$ 22	40.1%		37.4%
25 - 29	$	215,302	$ 23	$	186,386	$ 21	$	203,865	$ 23	9.4%		9.7%
30 - 34	$	287,473	$ 25	$	229,556	$ 21	$	302,026	$ 28	31.6%		32.7%
35 - 39	$	367,720	$ 29	$	287,537	$ 23	$	351,919	$ 29	22.4%		23.9%
40 - 44	$	355,358	$ 28	$	322,871	$ 25	$	405,150	$ 31	25.5%		24.3%
45 - 49	$	386,977	$ 31	$	306,176	$ 25	$	403,519	$ 33	31.8%		30.3%
50 - 54	$	482,828	$ 34	$	403,009	$ 28	$	475,476	$ 33	18.0%		18.0%
55 - 59	$	562,394	$ 38	$	465,071	$ 32	$	547,164	$ 38	17.7%		17.7%
60 - 64	$	691,492	$ 42	$	565,836	$ 35	$	668,212	$ 42	18.1%		21.3%
65+	$	1,805,355	$ 45	$	1,559,384	$ 38	$	1,871,078	$ 46	20.0%		21.9%
Total	**$**	**6,542,153**	**$ 33**	**$**	**5,586,524**	**$ 28**	**$**	**6,781,648**	**$ 35**	**21.4%**		**24.0%**

Dental Paid Claims – State Participants

Dental Paid Claims - Total State Participants	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 3,659,859	$ 514,900	$ 109,193	$ 4,283,953	$ 4,559,231	$ 569,259	$ 142,030	$ 5,270,521	23.0%
Dental Exchange	$ -	$ -	$ 825,911	$ 825,911	$ -	$ -	$ 949,822	$ 949,822	15.0%
Total	**$ 3,659,859**	**$ 514,900**	**$ 935,104**	**$ 5,109,864**	**$ 4,559,231**	**$ 569,259**	**$ 1,091,852**	**$ 6,220,343**	**38.0%**

Dental Paid Claims - Per Participant per Month	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 47	$ 49	$ 50	$ 47	$ 58	$ 56	$ 66	$ 58	22.6%
Dental Exchange	$ -	$ -	$ 48	$ 48	$ -	$ -	$ 54	$ 54	13.7%

Dental Paid Claims – Non-State Participants

Dental Paid Claims - Total Non-State Participants	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 542	$ 20,570	$ 49,276	$ 70,389	$ 1,995	$ 15,032	$ 53,720	$ 70,746	0.5%
Dental Exchange	$ -	$ -	$ 406,272	$ 406,272	$ -	$ -	$ 490,559	$ 490,559	20.7%
Total	**$ 542**	**$ 20,570**	**$ 455,548**	**$ 476,660**	**$ 1,995**	**$ 15,032**	**$ 544,279**	**$ 561,305**	**17.8%**

Dental Paid Claims - Per Participant per Month	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 30	$ 32	$ 39	$ 36	$ 111	$ 33	$ 44	$ 42	15.0%
Dental Exchange	$ -	$ -	$ 40	$ 40	$ -	$ -	$ 50	$ 50	24.6%

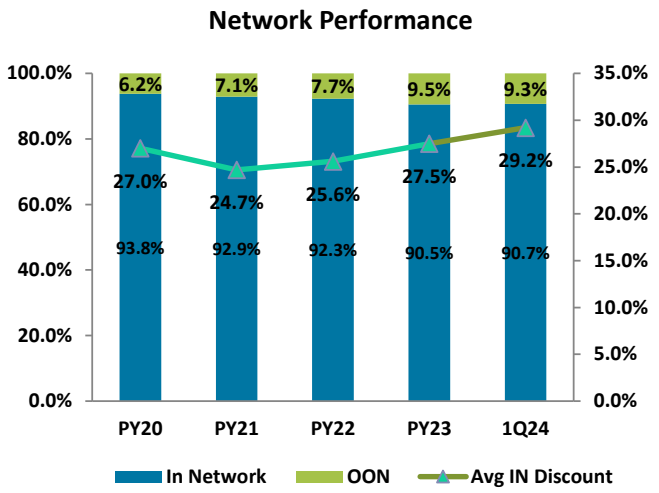
Dental Paid Claims – Total Participants

Dental Paid Claims - Total Total Participants	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 3,660,402	$ 535,471	$ 158,470	$ 4,354,342	$ 4,561,226	$ 584,291	$ 195,750	$ 5,341,267	22.7%
Dental Exchange	$ -	$ -	$ 1,232,183	$ 1,232,183	$ -	$ -	$ 1,440,381	$ 1,440,381	16.9%
Total	**$ 3,660,402**	**$ 535,471**	**$ 1,390,652**	**$ 5,586,524**	**$ 4,561,226**	**$ 584,291**	**$ 1,636,131**	**$ 6,781,648**	**21.4%**

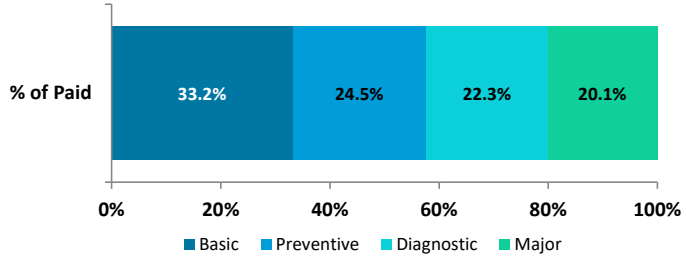
Dental Paid Claims - Per Participant per Month	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Dental	$ 47	$ 48	$ 46	$ 47	$ 58	$ 55	$ 58	$ 58	22.6%
Dental Exchange	$ -	$ -	$ 45	$ 45	$ -	$ -	$ 53	$ 53	17.4%

Dental Claims Analysis

Cost Distribution								
Paid Claims Category	Avg # of Members	% of Members	# Claims	# of Claims	Total Paid	% of Paid	Total EE Paid	% of EE Paid
$1,000.01 Plus	1,457	2.2%	4,368	12.9%	$2,270,617	33.5%	$1,368,437	40.8%
$750.01-$1,000.00	716	1.1%	1,807	5.3%	$621,446	9.2%	$403,648	12.0%
$500.01-$750.00	1,223	1.9%	2,703	8.0%	$757,342	11.2%	$474,494	14.2%
$250.01-$500.00	2,308	3.5%	4,071	12.0%	$806,852	11.9%	$384,019	11.5%
$0.01-$250.00	17,525	26.9%	20,051	59.0%	$2,325,391	34.3%	$663,931	19.8%
$0.00	784	1.2%	972	2.9%	$0	0.0%	$58,166	1.7%
No Claims	41,106	63.1%	0	0.0%	$0	0.0%	$0	0.0%
Total	**65,120**	**100.0%**	**33,972**	**100.0%**	**$6,781,648**	**100.0%**	**$3,352,694**	**100.0%**



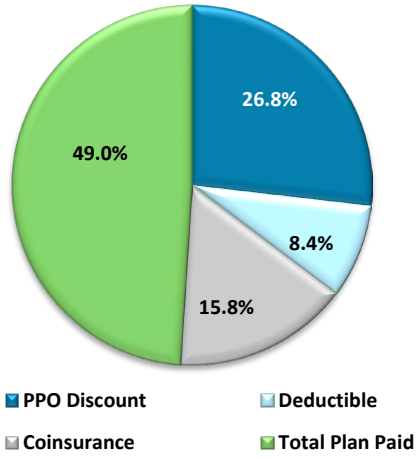
Claim Category	Total Paid	% of Paid
Basic	$2,249,909	33.2%
Preventive	$1,658,291	24.5%
Diagnostic	$1,509,150	22.3%
Major	$1,364,298	20.1%
Total	**$6,781,648**	**100.0%**

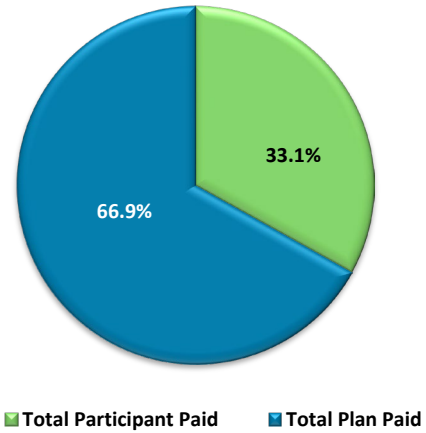


Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$13,846,159	$115	100.0%
PPO Discount	$3,713,412	$31	26.8%
Deductible	$1,169,840	$10	8.4%
Coinsurance	$2,182,854	$18	15.8%
Total Participant Paid	**$3,352,694**	**$28**	**24.2%**
Total Plan Paid	**$6,781,648**	**$56**	**49.0%**

Total Participant Paid - PY23	**$25**
Total Plan Paid - PY23	**$57**





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	936	908	28	96.2%
	<2 asthma related ER Visits in the last 6 months	936	936	0	100.0%
	No asthma related admit in last 12 months	936	934	2	99.8%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	214	207	7	96.7%
	Members with COPD who had an annual spirometry test	214	28	186	13.1%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	4	4	0	100.0%
	No ER Visit for Heart Failure in last 90 days	185	181	4	97.8%
	Follow-up OV within 4 weeks of discharge from HF admission	4	3	1	75.0%
Diabetes	Annual office visit	1,375	1,290	85	93.8%
	Annual dilated eye exam	1,375	502	873	36.5%
	Annual foot exam	1,375	621	754	45.2%
	Annual HbA1c test done	1,375	1,135	240	82.5%
	Diabetes Annual lipid profile	1,375	1,042	333	75.8%
	Annual microalbumin urine screen	1,375	942	433	68.5%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	3,778	3,029	749	80.2%
Hypertension	Annual lipid profile	3,842	2,634	1,208	68.6%
	Annual serum creatinine test	3,769	2,997	772	79.5%
Wellness	Well Child Visit - 15 months	139	134	5	96.4%
	Routine office visit in last 6 months (All Ages)	24,368	14,724	9,644	60.4%
	Colorectal cancer screening ages 45-75 within the appropriate time period	10,229	4,829	5,400	47.2%
	Women age 25-65 with recommended cervical cancer/HPV screening	7,476	5,091	2,385	68.1%
	Males age greater than 49 with PSA test in last 24 months	4,090	2,004	2,086	49.0%
	Routine exam in last 24 months (All Ages)	24,368	20,077	4,291	82.4%
	Women age 40 to 75 with a screening mammogram last 24 months	6,530	3,889	2,641	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**

Chronic Condition	# With Condition	% of Members	Members per 1,000	Admits per 1,000	ER Visits per 1,000	PMPY
Affective Psychosis	169	0.69%	6.91	219.96	488.80	$10,603
Asthma	1,053	4.32%	43.03	130.26	390.79	$13,110
Atrial Fibrillation	275	1.13%	11.24	342.43	550.87	$27,618
Blood Disorders	1,519	6.23%	62.08	252.11	496.00	$21,790
CAD	577	2.36%	23.58	264.76	407.87	$17,884
COPD	211	0.86%	8.62	337.19	436.36	$22,877
Cancer	993	4.07%	40.58	175.18	287.80	$20,996
Chronic Pain	650	2.66%	26.56	147.99	540.48	$15,340
Congestive Heart Failure	185	0.76%	7.56	578.85	734.69	$36,239
Demyelinating Diseases	63	0.26%	2.57	326.09	391.30	$32,983
Depression	1,476	6.05%	60.32	107.52	404.62	$9,799
Diabetes	1,526	6.25%	62.36	118.07	289.80	$12,861
ESRD	34	0.14%	1.39	1,425.74	1,900.99	$34,394
Eating Disorders	76	0.31%	3.11	220.18	275.23	$23,482
HIV/AIDS	32	0.13%	1.31	0.00	125.00	$32,652
Hyperlipidemia	4,678	19.17%	191.18	74.79	213.81	$8,248
Hypertension	3,863	15.83%	157.87	107.82	282.24	$10,555
Immune Disorders	112	0.46%	4.58	450.00	562.50	$43,005
Inflammatory Bowel Disease	85	0.35%	3.47	96.00	624.00	$34,039
Liver Diseases	497	2.04%	20.31	221.28	468.09	$18,460
Morbid Obesity	718	2.94%	29.34	204.48	385.59	$14,617
Osteoarthritis	1,022	4.19%	41.77	117.61	369.04	$12,639
Peripheral Vascular Disease	160	0.66%	6.54	398.23	637.17	$23,425
Rheumatoid Arthritis	141	0.58%	5.76	28.50	313.54	$26,374

*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.

Public Employees' Benefits Program - RX Costs
PY 2024 - Quarter Ending September 30, 2023

Express Scripts

Membership Summary	1Q FY2024 CDHP	1Q FY2023 CDHP	Difference	% Change
			Membership Summary	
Member Count (Membership)	24,365	28,326	(3,961)	-14.0%
Utilizing Member Count (Patients)	11,703	13,847	(2,144)	-15.5%
Percent Utilizing (Utilization)	48.0%	48.9%	(0.01)	-1.7%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	83,031	93,485	(10,454)	-11.2%
Claims per Elig Member per Month (Claims PMPM)	1.14	1.10	0.04	3.6%
Total Claims for Generic (Generic Rx)	72,817	80,707	(7,890.00)	-9.8%
Total Claims for Brand (Brand Rx)	10,214	12,778	(2,564.00)	-20.1%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	315	382	(67.00)	-17.5%
Total Non-Specialty Claims	82,077	92,189	(10,112.00)	-11.0%
Total Specialty Claims	954	1,296	(342.00)	-26.4%
Generic % of Total Claims (GFR)	**87.7%**	**86.3%**	0.01	1.6%
Generic Effective Rate (GCR)	**99.6%**	**99.5%**	0.00	0.0%
Mail Order Claims	23,453	25,153	(1,700.00)	-6.8%
Mail Penetration Rate*	31.8%	30.7%	0.01	1.1%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$10,204,216	$10,652,373	($448,157.00)	-4.2%
Total Generic Gross Cost	$1,027,449	$1,238,257	($210,808.00)	-17.0%
Total Brand Gross Cost	$9,176,768	$9,414,116	($237,348.00)	-2.5%
Total MSB Gross Cost	$139,084	$194,122	($55,038.00)	-28.4%
Total Ingredient Cost	$9,854,938	$10,522,055	($667,117.00)	-6.3%
Total Dispensing Fee	$342,436	$121,570	$220,866.00	181.7%
Total Other (e.g. tax)	$9,843	$8,748	$1,095.00	12.5%
Avg Total Cost per Claim (Gross Cost/Rx)	**$122.90**	**$113.95**	$8.95	7.9%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$14.11	$15.34	($1.23)	-8.0%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$898.45	$736.74	$161.71	21.9%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$441.54	$508.17	($66.63)	-13.1%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$2,535,118**	**$2,891,673**	($356,555.00)	-12.3%
Total Copay	$1,771,104	$1,918,536	($147,432.00)	-7.7%
Total Deductible	$764,014	$973,136	($209,122.00)	-21.5%
Avg Copay per Claim (Copay/Rx)	$21.33	$20.52	$0.81	3.9%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$30.53**	**$30.93**	**($0.40)**	**-1.3%**
Avg Copay for Generic (Copay/Generic Rx)	$7.59	$8.95	($1.36)	-15.2%
Avg Copay for Brand (Copay/Brand Rx)	$194.12	$169.79	$24.33	14.3%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$110.45	$182.09	($71.64)	-39.3%
Net PMPM (Participant Cost PMPM)	**$34.68**	**$34.03**	$0.65	1.9%
Copay % of Total Prescription Cost (Member Cost Share %)	24.8%	27.1%	-2.3%	-8.5%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$7,669,098**	**$7,760,701**	**($91,603.00)**	**-1.2%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$2,975,171	$2,609,897	$365,274.00	14.0%
Total Specialty Drug Cost (Specialty Plan Cost)	$4,693,927	$5,150,803	($456,876.00)	-8.9%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$92.36**	**$83.02**	$9.35	11.3%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$6.52	$6.39	$0.13	2.0%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$704.33	$566.96	$137.37	24.2%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$331.09	$326.08	$5.01	1.5%
Net PMPM (Plan Cost PMPM)	**$104.92**	**$91.33**	**$13.59**	**14.9%**
PMPM without Specialty (Non-Specialty PMPM)	$40.70	$30.71	$4.02	17.3%
PMPM for Specialty Only (Specialty PMPM)	$64.22	$60.61	$3.61	6.0%
Specialty % of Plan Cost	61.2%	66.40%	($0.05)	-7.8%
Rebates Received (Q1 FY2024 actual)	$3,120,343	$2,946,821	$173,521.85	5.9%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$62.23**	**$56.65**	**$5.58**	**9.9%**
PMPM without Specialty (Non-Specialty PMPM)	$20.86	$11.08	$0.92	5.0%
PMPM for Specialty Only (Specialty PMPM)	$41.51	$45.99	($4.48)	-9.7%

Appendix B

Index of Tables
UMR Inc. – LDPPO Utilization Review for PEBP
July 1, 2023 – September 30, 2023

DATASCOPE™

Nevada Public Employees' Benefits Program
Low Deductible Plan
July – September 2023 Incurred,
Paid through November 2023

UMR℠

Overview

- Total Medical Spend for 1Q24 was $16,155,131 with a plan cost per employee per year (PEPY) of $6,850. This is an increase of 10.0% when compared to 1Q23.
  - IP Cost per Admit is $18,128 which is 15.4% lower than 1Q23.
  - ER Cost per Visit is $3,164 which is 18.1% higher than 1Q23.
- Employees shared in 16.1% of the medical cost.
- Inpatient facility costs were 14.8% of the plan spend.
- 94.3% of the Average Membership had paid Medical claims less than $2,500, with 39.8% of those having no claims paid at all during the reporting period.
- 13 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 12.2% of the plan spend. The highest diagnosis category was Cancer, accounting for 44.9% of the high-cost claimant dollars.
- Total spending with in-network providers was 98.2%. The average In Network discount was 66.4%, which is 3.3% higher than the PY23 average discount of 64.3%.

Paid Claims by Age Group

Paid Claims by Age Group																
	1Q23						1Q24						% 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	$ 239,257	$ 539	$ 2,298	$ 5	$ 241,555	$ 544	$ 656,761	$ 1,123	$ 2,462	$ 4	$ 659,223	$ 1,127	172.9%	107.1%
1	$ 109,503	$ 270	$ 2,151	$ 5	$ 111,654	$ 276	$ 101,083	$ 172	$ 1,025	$ 2	$ 102,108	$ 174	-8.5%	-37.1%
2 - 4	$ 171,723	$ 106	$ 13,349	$ 8	$ 185,072	$ 114	$ 246,683	$ 124	$ 6,692	$ 3	$ 253,375	$ 128	36.9%	11.9%
5 - 9	$ 212,419	$ 75	$ 149,243	$ 52	$ 361,662	$ 127	$ 507,114	$ 137	$ 141,159	$ 38	$ 648,273	$ 175	79.2%	37.7%
10 - 14	$ 417,906	$ 136	$ 71,396	$ 23	$ 489,302	$ 159	$ 616,787	$ 153	$ 138,840	$ 34	$ 755,627	$ 187	54.4%	17.8%
15 - 19	$ 420,422	$ 121	$ 116,420	$ 34	$ 536,842	$ 155	$ 670,164	$ 145	$ 152,568	$ 33	$ 822,732	$ 178	53.3%	14.8%
20 - 24	$ 467,917	$ 143	$ 159,612	$ 49	$ 627,529	$ 192	$ 1,063,698	$ 243	$ 182,322	$ 42	$ 1,246,020	$ 284	98.6%	48.0%
25 - 29	$ 449,494	$ 171	$ 213,475	$ 81	$ 662,969	$ 253	$ 860,633	$ 238	$ 400,552	$ 111	$ 1,261,185	$ 349	90.2%	38.0%
30 - 34	$ 757,588	$ 243	$ 222,849	$ 71	$ 980,437	$ 315	$ 1,069,711	$ 248	$ 982,564	$ 228	$ 2,052,275	$ 476	109.3%	51.0%
35 - 39	$ 888,902	$ 249	$ 384,436	$ 108	$ 1,273,338	$ 357	$ 1,499,240	$ 317	$ 615,983	$ 130	$ 2,115,223	$ 447	66.1%	25.3%
40 - 44	$ 815,728	$ 238	$ 679,406	$ 198	$ 1,495,134	$ 436	$ 1,360,542	$ 288	$ 781,718	$ 166	$ 2,142,260	$ 454	43.3%	4.2%
45 - 49	$ 1,371,839	$ 439	$ 407,209	$ 130	$ 1,779,048	$ 569	$ 1,386,228	$ 342	$ 735,430	$ 181	$ 2,121,658	$ 523	19.3%	-8.1%
50 - 54	$ 1,198,087	$ 359	$ 721,285	$ 216	$ 1,919,372	$ 575	$ 1,518,206	$ 331	$ 1,013,087	$ 221	$ 2,531,293	$ 551	31.9%	-4.2%
55 - 59	$ 1,416,144	$ 470	$ 549,971	$ 182	$ 1,966,115	$ 652	$ 1,938,063	$ 473	$ 1,289,264	$ 315	$ 3,227,327	$ 788	64.1%	20.8%
60 - 64	$ 1,368,526	$ 512	$ 846,620	$ 317	$ 2,215,146	$ 829	$ 2,010,876	$ 573	$ 1,085,942	$ 309	$ 3,096,818	$ 882	39.8%	6.4%
65+	$ 493,832	$ 503	$ 253,936	$ 259	$ 747,768	$ 762	$ 649,341	$ 464	$ 357,188	$ 255	$ 1,006,529	$ 720	34.6%	-5.5%
Total	**$ 10,799,288**	**$ 263**	**$ 4,793,655**	**$ 117**	**$ 15,592,943**	**$ 380**	**$ 16,155,131**	**$ 294**	**$ 7,886,797**	**$ 144**	**$ 24,041,928**	**$ 438**	**54.2%**	**15.2%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	3,733	6,935	9,433	36.0%	3,374	6,292	8,600	36.7%	0	1	1	0.0%
Spouses	1,073	1,796	2,357	31.3%	958	1,591	2,096	31.8%	0	1	1	0.0%
Children	2,979	4,936	6,524	32.2%	2,860	4,696	6,221	32.5%	0	0	0	0.0%
Total Members	7,786	13,667	18,314	34.0%	7,192	12,579	16,918	34.5%	1	2	2	0.0%
Family Size	2.1	2.0	1.9	-3.0%	2.1	2.0	2.0	-1.5%	2.0	2.0	2.0	0.0%
Financial Summary												
Gross Cost	$7,837,284	$12,890,174	$19,250,296	49.3%	$6,734,378	$11,286,972	$16,806,721	48.9%	$2,970	$4,583	$8,676	89.3%
Client Paid	$6,255,288	$10,799,288	$16,155,131	49.6%	$5,354,786	$9,454,832	$14,070,609	48.8%	$1,769	$3,623	$6,839	88.8%
Employee Paid	$1,581,996	$2,090,886	$3,095,165	48.0%	$1,379,592	$1,832,140	$2,736,112	49.3%	$1,201	$960	$1,837	91.4%
Client Paid-PEPY	$6,702	$6,229	$6,850	10.0%	$6,348	$6,010	$6,544	8.9%	$7,078	$14,492	$27,354	88.8%
Client Paid-PMPY	$3,214	$3,161	$3,528	11.6%	$2,978	$3,007	$3,327	10.6%	$3,539	$7,246	$13,677	88.8%
Client Paid-PEPM	$559	$519	$571	10.0%	$529	$501	$545	8.8%	$590	$1,208	$2,280	88.7%
Client Paid-PMPM	$268	$263	$294	11.8%	$248	$251	$277	10.4%	$295	$604	$1,140	88.7%
High Cost Claimants (HCC's) > $100k												
# of HCC's	8	8	13	62.5%	7	8	9	12.5%	0	0	0	0.0%
HCC's / 1,000	1.0	0.6	0.7	18.3%	1.0	0.6	0.5	-11.7%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$145,362	$157,873	$150,998	-4.4%	$146,710	$157,873	$147,463	-6.6%	$0	$0	$0	0.0%
HCC's % of Plan Paid	18.6%	11.7%	12.2%	4.3%	19.2%	13.4%	9.4%	-29.6%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$784	$614	$523	-14.8%	$716	$593	$491	-17.2%	$0	$0	$0	0.0%
Facility Outpatient	$822	$1,024	$1,355	32.3%	$750	$955	$1,250	30.9%	$0	$642	$340	-47.0%
Physician	$1,556	$1,523	$1,650	8.3%	$1,462	$1,459	$1,586	8.7%	$3,539	$6,604	$13,337	102.0%
Other	$53	$0	$0	0.0%	$49	$0	$0	0.0%	$0	$0	$0	0.0%
Total	$3,214	$3,161	$3,528	11.6%	$2,978	$3,007	$3,327	10.6%	$3,539	$7,246	$13,677	88.8%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	338	614	801	30.5%	21	27	30	12.3%	
Spouses	104	192	247	28.6%	11	12	13	8.3%	
Children	119	241	302	25.3%	0	0	1	0.0%	
Total Members	561	1,047	1,350	28.9%	32	39	44	13.7%	
Family Size	1.7	1.7	1.7	-1.2%	1.5	1.4	1.5	4.3%	1.6
Financial Summary									
Gross Cost	$1,062,564	$1,567,176	$2,380,191	51.9%	$37,373	$31,442	$54,708	74.0%	
Client Paid	$877,285	$1,318,629	$2,055,224	55.9%	$21,448	$22,203	$22,459	1.2%	
Employee Paid	$185,279	$248,547	$324,967	30.7%	$15,925	$9,239	$32,249	249.1%	
Client Paid-PEPY	$10,382	$8,586	$10,259	19.5%	$4,085	$3,289	$2,962	-9.9%	$6,642
Client Paid-PMPY	$6,255	$5,038	$6,090	20.9%	$2,681	$2,277	$2,026	-11.0%	$4,116
Client Paid-PEPM	$865	$715	$855	19.6%	$340	$274	$247	-9.9%	$553
Client Paid-PMPM	$521	$420	$507	20.7%	$223	$190	$169	-11.1%	$343
High Cost Claimants (HCC's) > $100k									
# of HCC's	1	0	5	0.0%	0	0	0	0.0%	
HCC's / 1,000	1.8	0.0	3.7	0.0%	0.0	0.0	0.0	0.0%	
Avg HCC Paid	$135,928	$0	$127,163	0.0%	$0	$0	$0	0.0%	
HCC's % of Plan Paid	15.5%	0.0%	30.9%	0.0%	0.0%	0.0%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,681	$891	$947	6.3%	$186	$0	$0	0.0%	$1,190
Facility Outpatient	$1,709	$1,862	$2,681	44.0%	$1,295	$726	$959	32.1%	$1,376
Physician	$2,765	$2,285	$2,462	7.7%	$1,159	$1,551	$1,067	-31.2%	$1,466
Other	$100	$0	$0	0.0%	$41	$0	$0	0.0%	$84
Total	$6,255	$5,038	$6,090	20.9%	$2,681	$2,277	$2,026	-11.0%	$4,116
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

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

	Total				State Active				Non-State Active			
Summary	**PY22**	**PY23**	**1Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**1Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**1Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	4,336	7,362	9,433	28.1%	3,926	6,690	8,600	28.6%	1	1	1	0.0%
Spouses	1,172	5,149	2,357	-54.2%	1,042	4,901	2,096	-57.2%	1	0	1	0.0%
Children	3,255	1,857	6,524	251.4%	3,103	1,645	6,221	278.3%	0	1	0	-100.0%
Total Members	8,762	14,368	18,314	27.5%	8,071	13,235	16,918	27.8%	2	2	2	0.0%
Family Size	2.0	2.0	1.9	-0.5%	2.1	2.0	2.0	-0.5%	2.0	2.0	2.0	0.0%
Financial Summary												
Gross Cost	$40,570,436	$64,817,531	$19,250,296	-70.3%	$35,366,785	$56,350,280	$16,806,721	-70.2%	$38,494	$17,911	$8,676	-51.6%
Client Paid	$34,446,692	$55,997,776	$16,155,131	-71.2%	$29,933,591	$48,495,839	$14,070,609	-71.0%	$33,556	$13,953	$6,839	-51.0%
Employee Paid	$6,123,744	$8,819,755	$3,095,165	-64.9%	$5,433,194	$7,854,441	$2,736,112	-65.2%	$4,938	$3,958	$1,837	-53.6%
Client Paid-PEPY	$7,944	$7,606	$6,850	-9.9%	$7,624	$7,249	$6,544	-9.7%	$33,556	$13,953	$27,354	96.0%
Client Paid-PMPY	$3,931	$3,897	$3,528	-9.5%	$3,709	$3,664	$3,327	-9.2%	$16,778	$6,976	$13,677	96.1%
Client Paid-PEPM	$662	$634	$571	-9.9%	$635	$604	$545	-9.8%	$2,796	$1,163	$2,280	96.0%
Client Paid-PMPM	$328	$325	$294	-9.5%	$309	$305	$277	-9.2%	$1,398	$581	$1,140	96.2%
High Cost Claimants (HCC's) > $100k												
# of HCC's	41	54	13	-75.9%	33	43	9	-79.1%	0	0	0	0.0%
HCC's / 1,000	4.7	3.8	0.7	-81.1%	4.1	3.3	0.5	-83.7%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$286,071	$238,672	$150,998	-36.7%	$305,172	$238,047	$147,463	-38.1%	$0	$0	$0	0.0%
HCC's % of Plan Paid	34.0%	23.0%	12.2%	-47.0%	33.6%	21.1%	9.4%	-55.3%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,269	$783	$523	-33.2%	$1,257	$725	$491	-32.3%	$424	$0	$0	0.0%
Facility Outpatient	$1,043	$1,412	$1,355	-4.0%	$933	$1,292	$1,250	-3.3%	$5,152	$1,007	$340	-66.2%
Physician	$1,567	$1,702	$1,650	-3.1%	$1,468	$1,647	$1,586	-3.7%	$9,883	$5,969	$13,337	123.4%
Other	$53	$0	$0	0.0%	$50	$0	$0	0.0%	$1,319	$0	$0	0.0%
Total	$3,931	$3,897	$3,528	-9.5%	$3,709	$3,664	$3,327	-9.2%	$16,778	$6,976	$13,677	96.1%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY22**	**PY23**	**1Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**1Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	388	644	801	24.4%	21	27	30	13.7%	
Spouses	118	248	247	-0.5%	11	0	13	7763.1%	
Children	152	199	302	51.9%	0	13	1	-92.0%	
Total Members	657	1,091	1,350	23.7%	32	39	44	12.7%	
Family Size	1.7	1.7	1.7	-0.6%	1.5	1.5	1.5	-1.4%	1.6
Financial Summary									
Gross Cost	$4,886,927	$8,012,597	$2,380,191	-70.3%	$278,229	$436,743	$54,708	-87.5%	
Client Paid	$4,252,910	$7,107,682	$2,055,224	-71.1%	$226,635	$380,303	$22,459	-94.1%	
Employee Paid	$634,017	$904,915	$324,967	-64.1%	$51,594	$56,440	$32,249	-42.9%	
Client Paid-PEPY	$10,968	$11,032	$10,259	-7.0%	$10,665	$14,261	$2,962	-79.2%	$6,642
Client Paid-PMPY	$6,473	$6,514	$6,090	-6.5%	$7,027	$9,669	$2,026	-79.0%	$4,116
Client Paid-PEPM	$914	$919	$855	-7.0%	$889	$1,188	$247	-79.2%	$553
Client Paid-PMPM	$539	$543	$507	-6.6%	$586	$806	$169	-79.0%	$343
High Cost Claimants (HCC's) > $100k									
# of HCC's	8	11	5	-54.5%	1	1	0	-100.0%	
HCC's / 1,000	12.2	10.1	3.7	-63.3%	31.0	25.4	0.0	-100.0%	
Avg HCC Paid	$193,399	$224,298	$127,163	-43.3%	$111,053	$185,019	$0	-100.0%	
HCC's % of Plan Paid	36.4%	34.7%	30.9%	-11.0%	49.0%	48.7%	0.0%	-100.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,452	$1,476	$947	-35.8%	$675	$1,128	$0	-100.0%	$1,190
Facility Outpatient	$2,262	$2,697	$2,681	-0.6%	$3,333	$6,277	$959	-84.7%	$1,376
Physician	$2,676	$2,342	$2,462	5.1%	$2,969	$2,264	$1,067	-52.9%	$1,466
Other	$83	$0	$0	0.0%	$50	$0	$0	0.0%	$84
Total	$6,473	$6,514	$6,090	-6.5%	$7,027	$9,669	$2,026	-79.0%	$4,116
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 2,224,765	$ 303,966	$ 155	$ 2,528,886	$ 2,656,082	$ 338,949	$ 2,298	$ 2,997,328	18.5%
Outpatient	$ 7,230,067	$ 992,223	$ 22,286	$ 8,244,576	$ 11,414,527	$ 1,659,851	$ 54,126	$ 13,128,505	59.2%
Total - Medical	**$ 9,454,832**	**$ 1,296,189**	**$ 22,440**	**$ 10,773,461**	**$ 14,070,609**	**$ 1,998,800**	**$ 56,424**	**$ 16,125,833**	**49.7%**

Net Paid Claims - Per Participant per Month	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 501	$ 748	$ 202	$ 520	$ 545	$ 895	$ 330	$ 572	9.9%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ -	$ -	$ -	$ -	$ -	$ 369	$ 369	0.0%
Outpatient	$ 3,623	$ 12,497	$ 9,707	$ 25,826	$ 6,839	$ 4,220	$ 17,870	$ 28,929	12.0%
Total - Medical	**$ 3,623**	**$ 12,497**	**$ 9,707**	**$ 25,826**	**$ 6,839**	**$ 4,220**	**$ 18,239**	**$ 29,298**	**13.4%**

Net Paid Claims - Per Participant per Month	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 1,208	$ 278	$ 270	$ 307	$ 2,280	$ 132	$ 309	$ 312	1.4%

Paid Claims by Claim Type – Total Participants

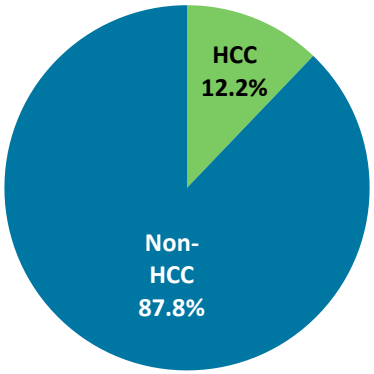
Net Paid Claims - Total Total Participants	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 2,224,765	$ 303,966	$ 155	$ 2,528,886	$ 2,656,082	$ 338,949	$ 2,666	$ 2,997,697	18.5%
Outpatient	$ 7,233,690	$ 1,004,720	$ 31,992	$ 8,270,402	$ 11,421,366	$ 1,664,072	$ 71,996	$ 13,157,434	59.1%
Total - Medical	**$ 9,458,455**	**$ 1,308,686**	**$ 32,147**	**$ 10,799,288**	**$ 14,077,448**	**$ 2,003,020**	**$ 74,663**	**$ 16,155,131**	**49.6%**

Net Paid Claims - Per Participant per Month	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 501	$ 736	$ 219	$ 519	$ 546	$ 884	$ 325	$ 571	10.0%

Cost Distribution – Medical Claims

1Q23							1Q24					
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
8	0.1%	$1,262,986	11.7%	$32,057	1.5%	$100,000.01 Plus	13	0.1%	$1,962,980	12.2%	$53,097	1.7%
22	0.2%	$1,460,575	13.5%	$96,213	4.6%	$50,000.01-$100,000.00	16	0.1%	$1,041,967	6.4%	$53,032	1.7%
29	0.2%	$968,492	9.0%	$106,726	5.1%	$25,000.01-$50,000.00	53	0.3%	$1,833,167	11.3%	$178,051	5.8%
120	0.9%	$1,905,338	17.6%	$320,762	15.3%	$10,000.01-$25,000.00	201	1.1%	$3,118,865	19.3%	$458,448	14.8%
152	1.1%	$1,076,510	10.0%	$225,763	10.8%	$5,000.01-$10,000.00	270	1.5%	$1,903,075	11.8%	$354,356	11.4%
293	2.1%	$1,080,547	10.0%	$302,698	14.5%	$2,500.01-$5,000.00	480	2.6%	$1,724,481	10.7%	$448,226	14.5%
7,047	51.6%	$3,044,840	28.2%	$998,658	47.8%	$0.01-$2,500.00	9,657	52.7%	$4,570,596	28.3%	$1,523,869	49.2%
175	1.3%	$0	0.0%	$8,009	0.4%	$0.00	327	1.8%	$0	0.0%	$26,086	0.8%
5,822	42.6%	$0	0.0%	$0	0.0%	No Claims	7,298	39.8%	$0	0.0%	$0	0.0%
13,667	**100.0%**	**$10,799,288**	**100.0%**	**$2,090,886**	**100.0%**		**18,314**	**100.0%**	**$16,155,131**	**100.0%**	**$3,095,165**	**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	7	$881,665	44.9%
Cardiac Disorders	2	$289,087	14.7%
Pregnancy-related Disorders	2	$267,599	13.6%
Endocrine/Metabolic Disorders	3	$139,562	7.1%
Medical/Surgical Complications	2	$113,911	5.8%
Spine-related Disorders	2	$109,230	5.6%
Trauma/Accidents	3	$107,926	5.5%
Gastrointestinal Disorders	9	$13,587	0.7%
Health Status/Encounters	9	$8,426	0.4%
Eye/ENT Disorders	5	$8,243	0.4%
All Other		$23,745	1.2%
Overall	**----**	**$1,962,980**	**100.0%**

Utilization Summary (p. 1 of 2)

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

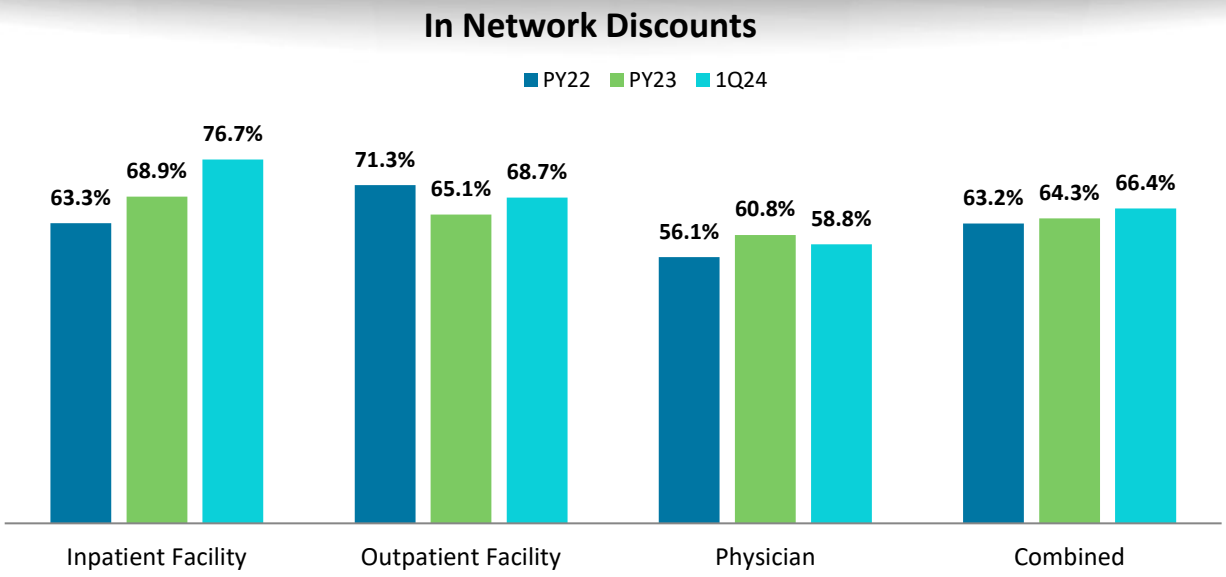
	Total				State Active				Non-State Active			
Summary	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**
Inpatient Facility												
# of Admits	80	114	153		67	103	135		0	0	0	
# of Bed Days	340	529	671		293	476	574		0	0	0	
Paid Per Admit	$28,055	$21,438	$18,128	-15.4%	$27,907	$21,180	$17,897	-15.5%	$0	$0	$0	0.0%
Paid Per Day	$6,601	$4,620	$4,134	-10.5%	$6,381	$4,583	$4,209	-8.2%	$0	$0	$0	0.0%
Admits Per 1,000	41	33	33	0.0%	37	33	32	-3.0%	0	0	0	0.0%
Days Per 1,000	175	155	147	-5.2%	163	151	136	-9.9%	0	0	0	0.0%
Avg LOS	4.3	4.6	4.4	-4.3%	4.4	4.6	4.3	-6.5%	0	0	0	0.0%
# Admits From ER	48	53	76	43.4%	38	46	65	41.3%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	4.6	4.4	5.2	18.2%	4.4	4.3	5.1	18.6%	8.0	10.0	16.0	60.0%
Avg Paid per OV	$134	$117	$119	1.7%	$129	$117	$118	0.9%	$118	$296	$359	21.3%
Avg OV Paid per Member	$613	$519	$613	18.1%	$573	$502	$597	18.9%	$946	$2,960	$5,746	94.1%
DX&L Utilization per Member	8.2	10	10.1	1.0%	7.7	9.5	9.9	4.2%	26	12	22	83.3%
Avg Paid per DX&L	$51	$52	$60	15.4%	$47	$52	$58	11.5%	$68	$169	$219	29.6%
Avg DX&L Paid per Member	$416	$523	$607	16.1%	$362	$492	$570	15.9%	$1,781	$2,025	$4,828	138.4%
Emergency Room												
# of Visits	261	461	729		242	422	676		0	0	0	
Visits Per Member	0.13	0.13	0.16	23.1%	0.13	0.13	0.16	23.1%	0	0	0	0.0%
Visits Per 1,000	134	135	159	17.8%	135	134	160	19.4%	0	0	0	0.0%
Avg Paid per Visit	$2,414	$2,675	$3,164	18.3%	$2,367	$2,732	$3,206	17.3%	$0	$0	$0	0.0%
Urgent Care												
# of Visits	597	1,056	1,525		553	988	1,436		0	0	1	
Visits Per Member	0.31	0.31	0.33	6.5%	0.31	0.31	0.34	9.7%	0.00	0.00	2.00	0.0%
Visits Per 1,000	307	309	333	7.8%	308	314	340	8.3%	0	0	2,000	0.0%
Avg Paid per Visit	$118	$104	$102	-1.9%	$116	$105	$103	-1.9%	$0	$0	$170	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

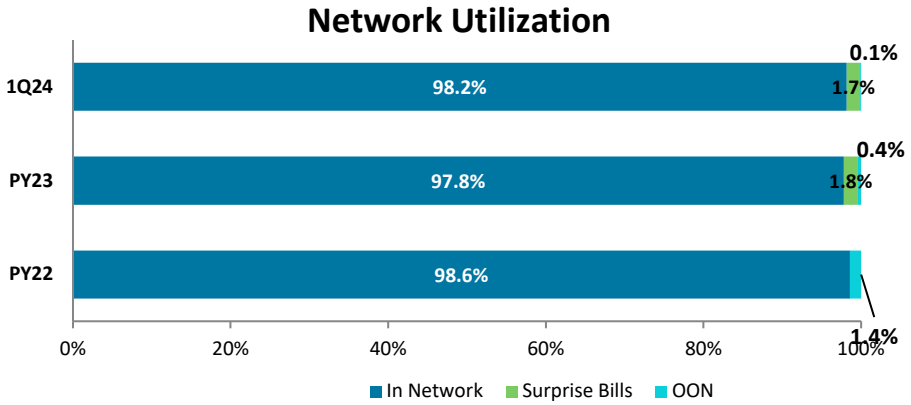
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**Peer Index**
Inpatient Facility									
# of Admits	10	11	17		3	0	1		
# of Bed Days	40	53	94		7	0	3		
Paid Per Admit	$35,139	$23,855	$20,994	-12.0%	$7,768	$0	$669	0.0%	$18,822
Paid Per Day	$8,785	$4,951	$3,797	-23.3%	$3,329	$0	$223	0.0%	$3,265
Admits Per 1,000	71	42	50	19.0%	375	0	90	0.0%	70
Days Per 1,000	285	202	279	38.1%	875	0	271	0.0%	402
Avg LOS	4	4.8	5.5	14.6%	2.3	0.0	3.0	0.0%	5.8
# Admits From ER	8	7	11		2	0	0	0.0%	
Physician Office									
OV Utilization per Member	6.2	6.0	6.3	5.0%	6.1	7.5	6.8	-9.3%	5.4
Avg Paid per OV	$179	$120	$129	7.5%	$102	$83	$77	-7.2%	$96
Avg OV Paid per Member	$1,120	$715	$811	13.4%	$622	$619	$518	-16.3%	$515
DX&L Utilization per Member	13.4	15.7	12.9	-17.8%	9.9	15.9	24.5	54.1%	11.0
Avg Paid per DX&L	$80	$56	$82	46.4%	$75	$56	$41	-26.8%	$50
Avg DX&L Paid per Member	$1,080	$879	$1,055	20.0%	$737	$883	$1,004	13.7%	$543
Emergency Room									
# of Visits	19	38	53		0	1	0		
Visits Per Member	0.14	0.15	0.16	6.7%	0	0.1	0	-100.0%	0.22
Visits Per 1,000	135	145	157	8.3%	0	103	0	-100.0%	221
Avg Paid per Visit	$3,017	$2,073	$2,631	26.9%	$0	$1,726	$0	-100.0%	$968
Urgent Care									
# of Visits	42	67	86		0	1	2		
Visits Per Member	0.30	0.26	0.25	-3.8%	0.00	0.10	0.18	80.0%	0.35
Visits Per 1,000	299	256	255	-0.4%	0	103	180	74.8%	352
Avg Paid per Visit	$150	$101	$86	-14.9%	$0	$52	$72	38.5%	$135
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$1,651,008	10.2%	$960,488	$686,747	$3,773	$727,048	$923,960
Health Status/Encounters	$1,526,263	9.4%	$859,927	$186,239	$480,097	$498,258	$1,028,005
Gastrointestinal Disorders	$1,341,879	8.3%	$908,079	$197,171	$236,628	$534,132	$807,747
Pregnancy-related Disorders	$1,242,698	7.7%	$460,447	$294,291	$487,960	$242,914	$999,784
Cardiac Disorders	$1,201,627	7.4%	$634,438	$189,891	$377,297	$323,417	$878,210
Mental Health	$1,145,336	7.1%	$504,516	$85,084	$555,736	$365,571	$779,765
Trauma/Accidents	$907,143	5.6%	$466,912	$73,173	$367,058	$524,714	$382,429
Neurological Disorders	$855,254	5.3%	$498,645	$151,490	$205,119	$321,359	$533,895
Eye/ENT Disorders	$809,520	5.0%	$415,361	$125,427	$268,733	$384,884	$424,636
Musculoskeletal Disorders	$806,205	5.0%	$638,458	$98,041	$69,705	$306,961	$499,244
Spine-related Disorders	$652,065	4.0%	$537,459	$96,342	$18,264	$226,015	$426,050
Endocrine/Metabolic Disorders	$596,227	3.7%	$495,819	$65,813	$34,595	$104,519	$491,708
Gynecological/Breast Disorders	$592,490	3.7%	$414,469	$122,963	$55,057	$9,183	$583,307
Renal/Urologic Disorders	$494,728	3.1%	$311,034	$93,450	$90,244	$244,713	$250,015
Pulmonary Disorders	$469,208	2.9%	$276,107	$82,085	$111,016	$210,143	$259,065
Infections	$283,380	1.8%	$177,164	$36,973	$69,243	$119,449	$163,931
Non-malignant Neoplasm	$248,051	1.5%	$183,885	$50,231	$13,935	$69,477	$178,574
Miscellaneous	$217,749	1.3%	$128,086	$50,281	$39,382	$94,976	$122,773
Congenital/Chromosomal Anomalies	$200,842	1.2%	$58,199	$45,292	$97,351	$116,286	$84,556
Dermatological Disorders	$190,409	1.2%	$128,016	$23,899	$38,494	$78,070	$112,339
Medical/Surgical Complications	$179,808	1.1%	$63,201	$1,172	$115,434	$117,099	$62,709
Diabetes	$170,689	1.1%	$121,725	$21,363	$27,601	$78,051	$92,638
Abnormal Lab/Radiology	$115,609	0.7%	$92,156	$15,802	$7,651	$39,304	$76,304
Vascular Disorders	$83,460	0.5%	$65,219	$11,269	$6,972	$30,231	$53,229
Hematological Disorders	$53,098	0.3%	$44,596	$4,592	$3,911	$10,474	$42,625
Cholesterol Disorders	$45,362	0.3%	$36,547	$7,353	$1,462	$18,131	$27,231
Medication Related Conditions	$41,651	0.3%	$19,975	$3,373	$18,304	$7,971	$33,680
Allergic Reaction	$17,999	0.1%	$8,543	$1,217	$8,238	$1,916	$16,083
Dental Conditions	$9,186	0.1%	$1,569	$1,834	$5,783	$4,460	$4,726
External Hazard Exposure	$5,898	0.0%	$1,211	$75	$4,613	$5,463	$435
Social Determinants of Health	$289	0.0%	$0	$0	$289	$133	$156
Cause of Morbidity	$0	0.0%	$0	$0	$0	$0	$0
Total	**$16,155,131**	**100.0%**	**$9,512,250**	**$2,822,933**	**$3,819,947**	**$5,815,322**	**$10,339,808**

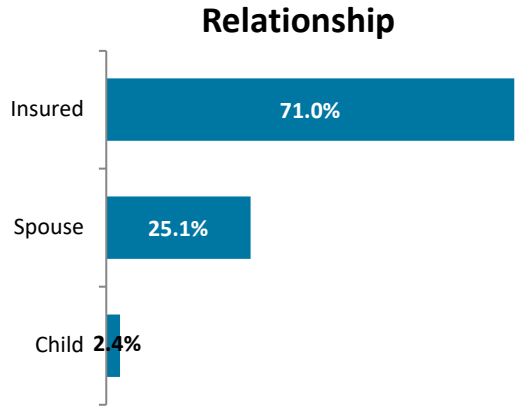
Mental Health Drilldown

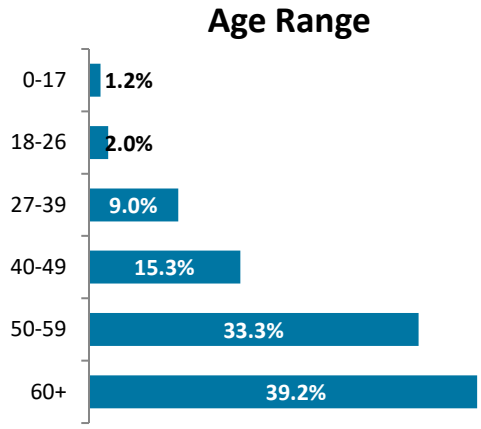
	PY22		PY23		1Q24	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	453	$568,975	883	$898,381	624	$348,188
Mood and Anxiety Disorders	613	$271,735	1,144	$681,784	720	$183,002
Mental Health Conditions, Other	431	$351,519	805	$558,645	533	$179,228
Alcohol Abuse/Dependence	20	$75,926	77	$344,280	35	$74,703
Developmental Disorders	59	$215,640	108	$250,524	66	$114,863
Bipolar Disorder	107	$247,201	189	$253,234	150	$73,723
Attention Deficit Disorder	199	$80,894	414	$132,119	303	$41,650
Eating Disorders	24	$147,776	44	$141,298	23	$44,154
Schizophrenia	4	$2,259	12	$47,488	6	$7,982
Sleep Disorders	124	$26,517	242	$63,421	95	$13,462
Substance Abuse/Dependence	29	$68,285	51	$34,292	30	$8,270
Sexually Related Disorders	28	$8,553	55	$30,340	38	$46,126
Psychoses	6	$10,965	17	$18,602	7	$5,119
Personality Disorders	14	$15,495	17	$12,003	13	$3,518
Tobacco Use Disorder	16	$4,458	54	$3,385	30	$922
Complications of Substance Abuse	6	$27,466	13	$3,466	6	$427
Total		**$2,123,665**		**$3,473,262**		**$1,145,336**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	21	54	$746,767	45.2%
Breast Cancer	52	269	$224,473	13.6%
Prostate Cancer	26	108	$187,072	11.3%
Colon Cancer	10	100	$100,229	6.1%
Cancers, Other	35	127	$79,477	4.8%
Non-Melanoma Skin Cancers	39	72	$77,668	4.7%
Pancreatic Cancer	3	32	$39,385	2.4%
Cervical/Uterine Cancer	9	25	$37,243	2.3%
Carcinoma in Situ	20	52	$36,679	2.2%
Lymphomas	19	95	$31,644	1.9%
Lung Cancer	3	64	$20,856	1.3%
Kidney Cancer	6	15	$19,102	1.2%
Secondary Cancers	13	48	$18,781	1.1%
Thyroid Cancer	24	68	$17,646	1.1%
Brain Cancer	5	27	$5,539	0.3%
Melanoma	8	18	$3,907	0.2%
Ovarian Cancer	3	4	$2,320	0.1%
Leukemias	7	23	$1,971	0.1%
Myeloma	1	2	$249	0.0%
Bladder Cancer	1	1	$0	0.0%
Overall	**----**	**----**	**$1,651,008**	**100.0%**

*Patient and claim counts are unique only within the category

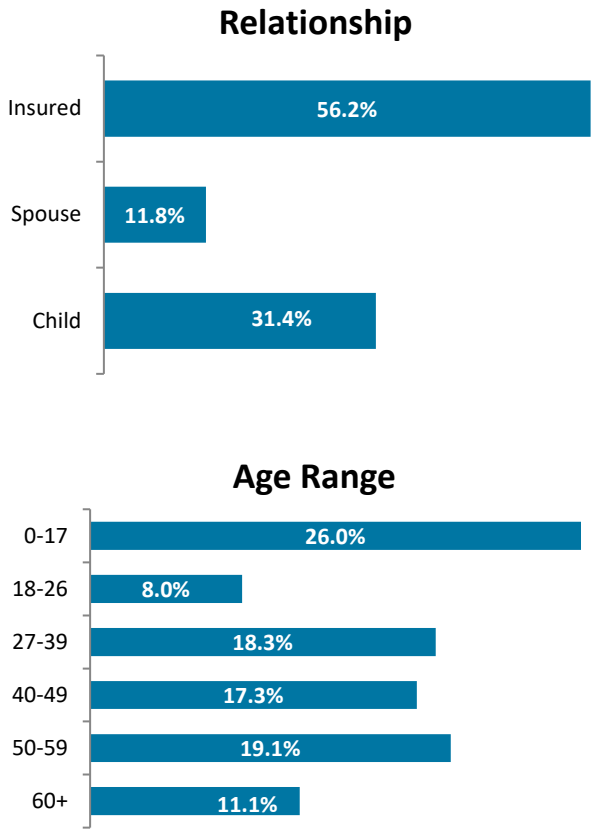




Diagnosis Grouper – Health Status/Encounters

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Screenings	1,705	2,731	$432,902	28.4%
Exams	2,200	3,428	$368,077	24.1%
Prophylactic Measures	991	1,091	$267,355	17.5%
Encounters - Infants/Children	1,067	1,263	$197,490	12.9%
Counseling	460	1,745	$125,503	8.2%
Personal History of Condition	194	296	$35,685	2.3%
Family History of Condition	45	65	$26,058	1.7%
Prosthetics/Devices/Implants	71	183	$20,899	1.4%
Follow-Up Encounters	2	8	$20,711	1.4%
Acquired Absence	14	18	$11,027	0.7%
Aftercare	87	145	$7,554	0.5%
Encounter - Transplant Related	10	45	$5,873	0.4%
Encounter - Procedure	18	18	$3,470	0.2%
Health Status, Other	28	34	$2,232	0.1%
Lifestyle/Situational Issues	15	27	$824	0.1%
Miscellaneous Examinations	8	14	$446	0.0%
Donors	2	2	$157	0.0%
Overall	**----**	**----**	**$1,526,263**	**227.1%**

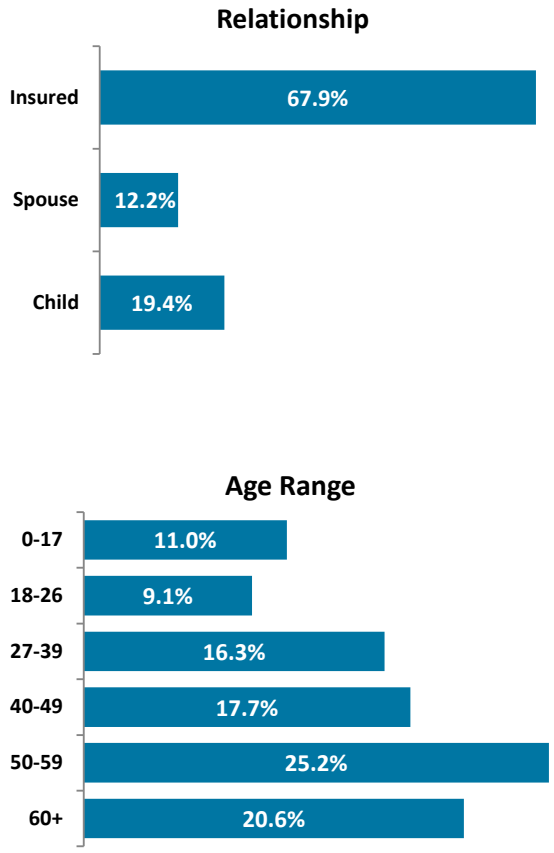
*Patient and claim counts are unique only within the category



Diagnosis Grouper – Gastrointestinal Orders

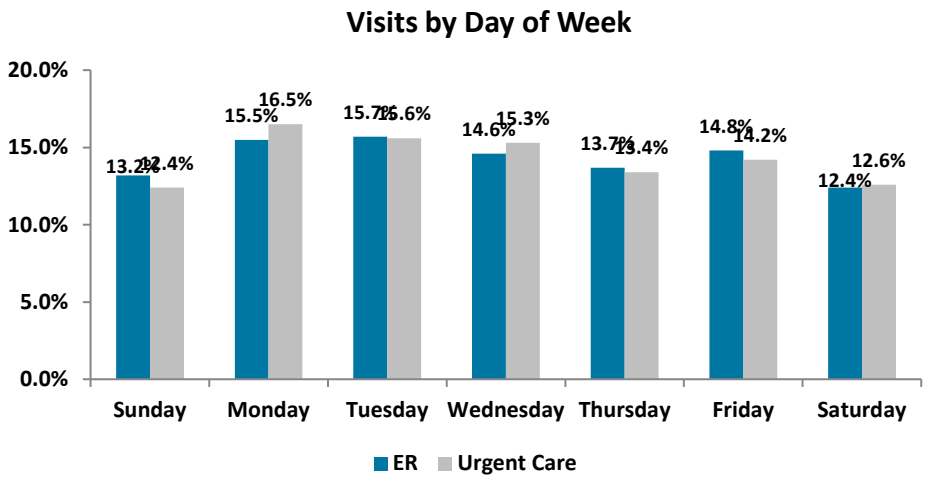
Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Abdominal Disorders	447	877	$333,827	24.9%
GI Disorders, Other	231	406	$277,218	20.7%
Upper GI Disorders	231	401	$159,332	11.9%
GI Symptoms	274	446	$123,451	9.2%
Gallbladder and Biliary Disease	46	149	$117,865	8.8%
Appendicitis	8	48	$69,863	5.2%
Inflammatory Bowel Disease	35	96	$55,110	4.1%
Hernias	36	61	$46,152	3.4%
Liver Diseases	95	144	$38,677	2.9%
Hemorrhoids	53	92	$34,566	2.6%
Diverticulitis	39	65	$26,362	2.0%
Pancreatic Disorders	11	54	$24,062	1.8%
Constipation	71	112	$22,499	1.7%
Peptic Ulcer/Related Disorders	5	7	$6,207	0.5%
Ostomies	10	19	$4,435	0.3%
Esophageal Varices	1	2	$1,142	0.1%
Hepatic Cirrhosis	9	12	$1,110	0.1%
	----	----	$1,341,879	100.0%

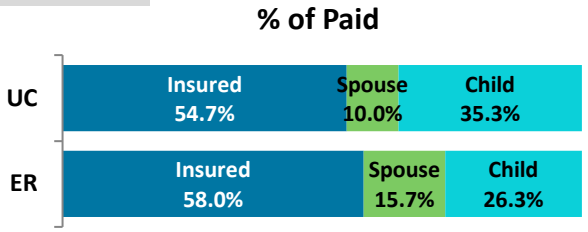
*Patient and claim counts are unique only within the category



Emergency Room / Urgent Care Summary

	1Q23		1Q24		Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	461	1,056	729	1,525		
Visits Per Member	0.13	0.31	0.16	0.33	0.22	0.35
Visits/1000 Members	135	309	159	333	221	352
Avg Paid Per Visit	$2,675	$104	$3,164	$102	$968	$135
% with OV*	75.5%	74.6%	80.1%	77.2%		
% Avoidable	12.6%	37.0%	14.8%	36.8%		
Total Member Paid	**$304,662**	**$76,024**	**$525,868**	**$118,829**		
Total Plan Paid	**$1,233,372**	**$110,092**	**$2,306,737**	**$155,404**		
*looks back 12 months	Annualized	Annualized	Annualized	Annualized		





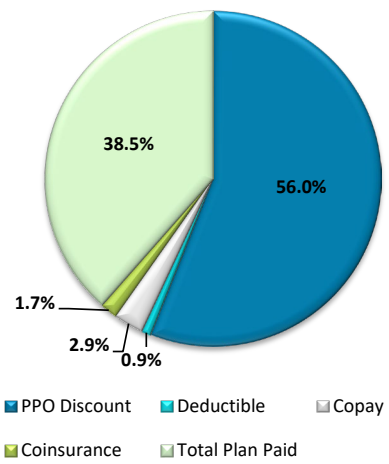
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	384	41	870	92	1,254	133
Spouse	101	44	181	80	282	124
Child	244	37	474	72	718	109
Total	**729**	**40**	**1,525**	**83**	**2,254**	**123**

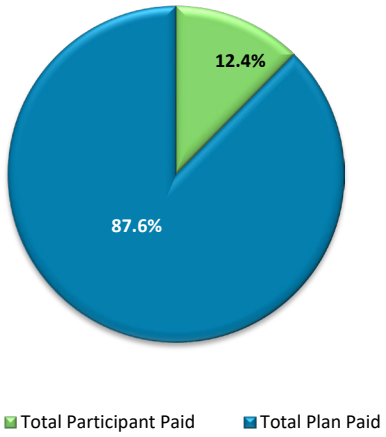
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$57,731,554	$6,107	100.0%
PPO Discount	$38,004,615	$4,020	65.8%
Deductible	$181,065	$19	0.3%
Copay	$1,709,334	$181	3.0%
Coinsurance	$1,204,767	$127	2.1%
Total Participant Paid	**$3,095,165**	**$327**	**5.4%**
Total Plan Paid	**$16,155,131**	**$571**	**28.0%**

Total Participant Paid - PY23	**$213**
Total Plan Paid - PY23	**$634**





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	844	824	20	97.6%
	<2 asthma related ER Visits in the last 6 months	844	843	1	99.9%
	No asthma related admit in last 12 months	844	836	8	99.1%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	79	73	6	92.4%
	Members with COPD who had an annual spirometry test	79	11	68	13.9%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	1	1	0	100.0%
	No ER Visit for Heart Failure in last 90 days	82	80	2	97.6%
	Follow-up OV within 4 weeks of discharge from HF admission	1	1	0	100.0%
Diabetes	Annual office visit	952	930	22	97.7%
	Annual dilated eye exam	952	374	578	39.3%
	Annual foot exam	952	443	509	46.5%
	Annual HbA1c test done	952	801	151	84.1%
	Diabetes Annual lipid profile	952	729	223	76.6%
	Annual microalbumin urine screen	952	688	264	72.3%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	2,371	2,006	365	84.6%
Hypertension	Annual lipid profile	2,143	1,632	511	76.2%
	Annual serum creatinine test	1,956	1,680	276	85.9%
Wellness	Well Child Visit - 15 months	161	145	16	90.1%
	Routine office visit in last 6 months (All Ages)	18,564	12,299	6,265	66.3%
	Colorectal cancer screening ages 45-75 within the appropriate time period	5,879	2,599	3,280	44.2%
	Women age 25-65 with recommended cervical cancer/HPV screening	6,150	3,873	2,277	63.0%
	Males age greater than 49 with PSA test in last 24 months	1,893	942	951	49.8%
	Routine exam in last 24 months (All Ages)	18,564	15,277	3,287	82.3%
	Women age 40 to 75 with a screening mammogram last 24 months	4,327	2,554	1,773	59.0%

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

Chronic Conditions Prevalence

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

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

Chronic Condition	# With Condition	% of Members	Members per 1,000	Admits per 1,000	ER Visits per 1,000	PMPY
Affective Psychosis	190	1.02%	10.38	220.59	595.59	$15,393
Asthma	905	4.87%	49.42	111.80	409.94	$13,555
Atrial Fibrillation	123	0.66%	6.72	202.82	507.04	$14,744
Blood Disorders	957	5.15%	52.26	146.23	416.54	$18,970
CAD	271	1.46%	14.80	236.22	692.91	$24,355
COPD	76	0.41%	4.15	216.22	702.70	$27,940
Cancer	482	2.60%	26.32	34.46	215.36	$26,793
Chronic Pain	464	2.50%	25.34	110.18	477.43	$19,259
Congestive Heart Failure	81	0.44%	4.42	559.32	762.71	$49,244
Demyelinating Diseases	52	0.28%	2.84	77.92	467.53	$61,843
Depression	1,603	8.63%	87.54	129.72	344.14	$12,297
Diabetes	986	5.31%	53.85	97.39	330.28	$17,720
ESRD	14	0.08%	0.76	571.43	0.00	$25,322
Eating Disorders	98	0.53%	5.35	86.02	387.10	$12,246
HIV/AIDS	25	0.13%	1.37	0.00	0.00	$36,218
Hyperlipidemia	2,855	15.37%	155.91	48.38	230.15	$11,041
Hypertension	2,156	11.61%	117.74	86.96	295.65	$12,533
Immune Disorders	106	0.57%	5.79	78.69	393.44	$50,965
Inflammatory Bowel Disease	82	0.44%	4.48	262.01	733.62	$34,122
Liver Diseases	359	1.93%	19.61	214.07	582.76	$18,849
Morbid Obesity	613	3.30%	33.48	153.49	334.88	$17,366
Osteoarthritis	544	2.93%	29.71	69.68	209.03	$12,733
Peripheral Vascular Disease	55	0.30%	3.00	0.00	567.57	$11,619
Rheumatoid Arthritis	119	0.64%	6.50	137.54	171.92	$34,291

*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.

Public Employees' Benefits Program - RX Costs
PY 2024 - Quarter Ending September 30, 2023

Express Scripts

Membership Summary	1Q FY2024 LDPPO	1Q FY2023 LDPPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	18,259	13,619	4,640	34.1%
Utilizing Member Count (Patients)	9,373	7,124	2,249	31.6%
Percent Utilizing (Utilization)	51.3%	52.3%	(0)	-1.9%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	63,609	46,449	17,160	36.9%
Claims per Elig Member per Month (Claims PMPM)	1.16	1.14	0.02	1.8%
Total Claims for Generic (Generic Rx)	54,269	39,337	14,932.00	38.0%
Total Claims for Brand (Brand Rx)	9,340	7,112	2,228.00	31.3%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	370	217	153.00	70.5%
Total Non-Specialty Claims	62,781	45,810	16,971.00	37.0%
Total Specialty Claims	828	639	189.00	29.6%
Generic % of Total Claims (GFR)	**85.3%**	**84.7%**	0.01	0.7%
Generic Effective Rate (GCR)	**99.3%**	**99.5%**	(0.00)	-0.1%
Mail Order Claims	19,378	14,036	5,342.00	38.1%
Mail Penetration Rate*	34.5%	34.5%	-	0.0%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$9,192,157	$5,734,811.00	$3,457,346.00	60.3%
Total Generic Gross Cost	$1,005,248	$815,407.00	$189,841.00	23.3%
Total Brand Gross Cost	$8,186,909	$4,919,405.00	$3,267,504.00	66.4%
Total MSB Gross Cost	$176,029	$91,083.00	$84,946.00	93.3%
Total Ingredient Cost	$8,917,016	$5,673,243.00	$3,243,773.00	57.2%
Total Dispensing Fee	$267,610	$54,773.00	$212,837.00	388.6%
Total Other (e.g. tax)	$7,531	$6,796.00	$735.00	10.8%
Avg Total Cost per Claim (Gross Cost/Rx)	**$144.51**	**$123.46**	$21.05	17.0%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$18.52	$20.73	($2.21)	-10.7%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$876.54	$691.70	$184.84	26.7%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$475.75	$419.74	$56.01	13.3%

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$1,305,360**	**$944,609.00**	$360,751.00	38.2%
Total Copay	$1,305,360	$944,609.00	$360,751.00	38.2%
Total Deductible	$0	$0.00	$0.00	0.0%
Avg Copay per Claim (Copay/Rx)	$20.52	$20.34	$0.19	0.9%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$20.52**	**$20.34**	**$0.19**	**0.9%**
Avg Copay for Generic (Copay/Generic Rx)	$6.57	$6.93	($0.36)	-5.2%
Avg Copay for Brand (Copay/Brand Rx)	$101.56	$94.48	$7.08	7.5%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$28.55	$15.36	$13.19	85.9%
Net PMPM (Participant Cost PMPM)	**$23.83**	**$23.12**	$0.71	3.1%
Copay % of Total Prescription Cost (Member Cost Share %)	14.2%	16.5%	-2.3%	-13.8%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$7,886,797**	**$4,790,203.00**	**$3,096,594.00**	**64.6%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$4,043,471	$2,376,868.00	$1,666,603.00	70.1%
Total Specialty Drug Cost (Specialty Plan Cost)	$3,843,326	$2,413,334.00	$1,429,992.00	59.3%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$123.99**	**$103.13**	$20.86	20.2%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$11.95	$13.80	($1.85)	-13.4%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$774.98	$597.23	$177.75	29.8%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$447.20	$404.38	$42.82	10.6%
Net PMPM (Plan Cost PMPM)	**$143.98**	**$117.24**	**$26.74**	**22.8%**
PMPM for Specialty Only (Specialty PMPM)	$73.82	$58.18	$15.64	26.9%
PMPM without Specialty (Non-Specialty PMPM)	$70.16	$59.07	$11.09	18.8%
Rebates Received (Q1 FY2023 actual)	$2,884,075	$1,696,020	$1,188,054.64	70.0%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$91.33**	**$75.73**	**$15.60**	**20.6%**
PMPM without Specialty (Non-Specialty PMPM)	$47.08	$33.16	$0.92	5.0%
PMPM for Specialty Only (Specialty PMPM)	$44.39	$42.84	$1.55	3.6%

Appendix C

Index of Tables
UMR Inc. – EPO Utilization Review for PEBP
July 1, 2023 – September 30, 2023

DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan
July – September 2023 Incurred,
Paid through November 2023

UMR℠

Overview

- Total Medical Spend for 1Q24 was $7,912,471 with an annualized plan cost per employee per year (PEPY) of $10,044. This is an increase of 19.7% when compared to 1Q23.
  - IP Cost per Admit is $24,343 which is 16.8% higher than 1Q23.
  - ER Cost per Visit is $2,934 which is 3.3% higher than 1Q23.
- Employees shared in 12.4% of the medical cost.
- Inpatient facility costs were 22.3% of the plan spend.
- 92.0% of the Average Membership had paid Medical claims less than $2,500, with 32.2% having no claims paid at all during the reporting period.
- 7 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 12.8% of the plan spend. The highest diagnosis category was Cardiac Disorders, accounting for 21.1% of the high-cost claimant dollars.
- Total spending with in-network providers was 97.3%. The average In Network discount was 57.0%, which is 3.8% higher than the PY23 average discount of 54.9%.

Paid Claims by Age Group

Paid Claims by Age Group																				
	1Q23						1Q24						% 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	$ 131,375	$ 664	$ 64	$ -	$ 131,439	$ 664	$ 232,675	$ 1,337	$ 1,576	$ 9	$ 234,251	$ 1,346	78.2%	102.8%
1	$ 46,956	$ 257	$ 63	$ -	$ 47,019	$ 257	$ 32,483	$ 246	$ 770	$ 6	$ 33,253	$ 252	-29.3%	-2.0%
2 - 4	$ 111,170	$ 173	$ 4,210	$ 7	$ 115,380	$ 180	$ 125,880	$ 219	$ 1,887	$ 3	$ 127,767	$ 222	10.7%	23.2%
5 - 9	$ 78,233	$ 72	$ 21,395	$ 20	$ 99,628	$ 92	$ 94,042	$ 100	$ 8,127	$ 9	$ 102,169	$ 109	2.6%	18.3%
10 - 14	$ 168,716	$ 119	$ 42,112	$ 30	$ 210,828	$ 149	$ 227,312	$ 174	$ 38,590	$ 30	$ 265,902	$ 204	26.1%	36.7%
15 - 19	$ 324,392	$ 187	$ 127,934	$ 74	$ 452,326	$ 260	$ 373,243	$ 253	$ 160,006	$ 109	$ 533,249	$ 362	17.9%	39.2%
20 - 24	$ 454,723	$ 283	$ 63,910	$ 40	$ 518,633	$ 323	$ 295,312	$ 206	$ 48,525	$ 34	$ 343,837	$ 240	-33.7%	-25.8%
25 - 29	$ 193,432	$ 277	$ 80,855	$ 116	$ 274,287	$ 392	$ 156,723	$ 285	$ 104,860	$ 191	$ 261,583	$ 476	-4.6%	21.5%
30 - 34	$ 303,033	$ 329	$ 470,558	$ 511	$ 773,591	$ 840	$ 313,896	$ 438	$ 348,411	$ 486	$ 662,307	$ 924	-14.4%	10.0%
35 - 39	$ 566,498	$ 455	$ 203,362	$ 163	$ 769,860	$ 618	$ 638,109	$ 576	$ 158,282	$ 143	$ 796,391	$ 719	3.4%	16.4%
40 - 44	$ 417,321	$ 316	$ 356,071	$ 270	$ 773,392	$ 586	$ 463,189	$ 390	$ 363,898	$ 306	$ 827,087	$ 696	6.9%	18.8%
45 - 49	$ 491,980	$ 329	$ 311,147	$ 208	$ 803,127	$ 536	$ 561,484	$ 427	$ 510,675	$ 389	$ 1,072,159	$ 816	33.5%	52.2%
50 - 54	$ 917,465	$ 464	$ 496,716	$ 251	$ 1,414,181	$ 715	$ 1,216,006	$ 702	$ 426,946	$ 247	$ 1,642,952	$ 949	16.2%	32.7%
55 - 59	$ 1,125,099	$ 570	$ 634,483	$ 321	$ 1,759,582	$ 891	$ 921,625	$ 531	$ 695,799	$ 401	$ 1,617,424	$ 931	-8.1%	4.5%
60 - 64	$ 1,651,177	$ 723	$ 980,613	$ 430	$ 2,631,790	$ 1,153	$ 1,678,140	$ 811	$ 960,347	$ 464	$ 2,638,487	$ 1,275	0.3%	10.5%
65+	$ 483,035	$ 456	$ 413,817	$ 391	$ 896,852	$ 847	$ 582,352	$ 561	$ 431,705	$ 416	$ 1,014,057	$ 977	13.1%	15.3%
Total	**$ 7,464,605**	**$ 376**	**$ 4,207,311**	**$ 212**	**$ 11,671,916**	**$ 588**	**$ 7,912,471**	**$ 453**	**$ 4,260,404**	**$ 244**	**$ 12,172,875**	**$ 696**	**4.3%**	**18.4%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	4,148	3,558	3,151	-11.4%	3,486	2,964	2,606	-12.1%	3	2	2	0.0%
Spouses	805	702	604	-13.9%	696	599	512	-14.5%	0	0	0	0.0%
Children	2,733	2,356	2,072	-12.0%	2,591	2,199	1,933	-12.1%	0	0	0	0.0%
Total Members	7,686	6,616	5,828	-11.9%	6,773	5,762	5,051	-12.3%	3	2	2	0.0%
Family Size	1.9	1.9	1.9	-2.6%	1.9	1.9	1.9	2.1%	1.0	1.0	1.0	0.0%
Financial Summary												
Gross Cost	$10,594,960	$8,661,931	$9,028,929	4.2%	$9,200,160	$7,137,269	$7,537,190	5.6%	$1,597	$707	$268	-62.1%
Client Paid	$9,211,146	$7,464,605	$7,912,471	6.0%	$8,064,127	$6,165,627	$6,616,623	7.3%	$1,111	$489	$179	-63.4%
Employee Paid	$1,383,814	$1,197,325	$1,116,458	-6.8%	$1,136,033	$971,642	$920,567	-5.3%	$486	$218	$89	-59.2%
Client Paid-PEPY	$8,882	$8,392	$10,044	19.7%	$9,253	$8,322	$10,156	22.0%	$1,333	$978	$359	-63.3%
Client Paid-PMPY	$4,794	$4,513	$5,431	20.3%	$4,763	$4,280	$5,240	22.4%	$1,333	$978	$359	-63.3%
Client Paid-PEPM	$740	$699	$837	19.7%	$771	$693	$846	22.1%	$111	$82	$30	-63.4%
Client Paid-PMPM	$399	$376	$453	20.5%	$397	$357	$437	22.4%	$111	$82	$30	-63.4%
High Cost Claimants (HCC's) > $100k												
# of HCC's	9	6	7	16.7%	9	5	6	20.0%	0	0	0	0.0%
HCC's / 1,000	1.2	0.9	1.2	33.3%	1.3	0.9	1.2	32.2%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$241,208	$150,003	$144,424	-3.7%	$241,208	$131,136	$151,773	15.7%	$0	$0	$0	0.0%
HCC's % of Plan Paid	23.6%	12.1%	12.8%	5.8%	26.9%	10.6%	13.8%	30.2%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,310	$934	$1,210	29.6%	$1,342	$855	$1,142	33.6%	$0	$0	$0	0.0%
Facility Outpatient	$1,133	$1,671	$1,993	19.3%	$1,115	$1,601	$1,967	22.9%	$0	$0	$0	0.0%
Physician	$2,246	$1,907	$2,228	16.8%	$2,213	$1,823	$2,131	16.9%	$1,274	$978	$359	-63.3%
Other	$105	$0	$0	0.0%	$92	$0	$0	0.0%	$59	$0	$0	0.0%
Total	$4,794	$4,513	$5,431	20.3%	$4,763	$4,280	$5,240	22.4%	$1,333	$978	$359	-63.3%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	564	523	488	-6.7%	95	69	55	-20.3%	
Spouses	89	88	81	-8.0%	20	15	11	-25.0%	
Children	132	145	128	-12.0%	10	11	12	5.9%	
Total Members	784	756	697	-7.8%	125	95	78	-17.9%	
Family Size	1.4	1.5	1.4	-4.7%	1.3	1.4	1.4	1.4%	1.6
Financial Summary									
Gross Cost	$1,192,691	$1,390,803	$1,422,269	2.3%	$200,512	$133,151	$69,202	-48.0%	
Client Paid	$990,101	$1,201,580	$1,245,700	3.7%	$155,808	$96,910	$49,970	-48.4%	
Employee Paid	$202,590	$189,224	$176,569	-6.7%	$44,705	$36,241	$19,233	-46.9%	
Client Paid-PEPY	$7,026	$9,184	$10,211	11.2%	$6,560	$5,618	$3,634	-35.3%	$6,297
Client Paid-PMPY	$5,049	$6,355	$7,152	12.5%	$4,986	$4,080	$2,563	-37.2%	$3,879
Client Paid-PEPM	$586	$765	$851	11.2%	$547	$468	$303	-35.3%	$525
Client Paid-PMPM	$421	$530	$596	12.5%	$415	$340	$214	-37.1%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	0	1	1	0.0%	0	0	0	0.0%	
HCC's / 1,000	0.0	1.3	1.4	0.0%	0.0	0.0	0.0	0.0%	
Avg HCC Paid	$0	$244,334	$100,333	0.0%	$0	$0	$0	0.0%	
HCC's % of Plan Paid	0.0%	20.3%	8.1%	0.0%	0.0%	0.0%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$906	$1,649	$1,831	11.0%	$2,136	$66	$82	24.2%	$1,149
Facility Outpatient	$1,317	$2,215	$2,251	1.6%	$950	$1,644	$1,442	-12.3%	$1,333
Physician	$2,636	$2,490	$3,070	23.3%	$1,649	$2,371	$1,038	-56.2%	$1,301
Other	$190	$0	$0	0.0%	$251	$0	$0	0.0%	$96
Total	$5,049	$6,355	$7,152	12.5%	$4,986	$4,080	$2,563	-37.2%	$3,879
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

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

	Total				State Active				Non-State Active			
Summary	**PY22**	**PY23**	**1Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**1Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**1Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	4,021	3,447	3,151	-8.6%	3,370	2,876	2,606	-9.4%	3	2	2	0.0%
Spouses	786	2,297	604	-73.7%	678	2,145	512	-76.1%	0	0	0	0.0%
Children	2,683	676	2,072	206.4%	2,531	580	1,933	233.1%	0	0	0	0.0%
Total Members	7,491	6,421	5,828	-9.2%	6,579	5,601	5,051	-9.8%	3	2	2	0.0%
Family Size	1.9	1.9	1.9	-0.5%	2.0	2.0	1.9	-0.5%	1.0	1.0	1.0	0.0%
Financial Summary												
Gross Cost	$44,187,042	$46,490,212	$9,028,929	-80.6%	$37,820,607	$38,595,575	$7,537,190	-80.5%	$4,744	$4,201	$268	-93.6%
Client Paid	$39,320,787	$42,257,152	$7,912,471	-81.3%	$33,797,612	$35,128,252	$6,616,623	-81.2%	$3,622	$3,335	$179	-94.6%
Employee Paid	$4,866,255	$4,233,060	$1,116,458	-73.6%	$4,022,996	$3,467,323	$920,567	-73.5%	$1,122	$866	$89	-89.7%
Client Paid-PEPY	$9,779	$12,259	$10,044	-18.1%	$10,030	$12,216	$10,156	-16.9%	$1,278	$1,667	$359	-78.5%
Client Paid-PMPY	$5,249	$6,581	$5,431	-17.5%	$5,137	$6,272	$5,240	-16.5%	$1,278	$1,667	$359	-78.5%
Client Paid-PEPM	$815	$1,022	$837	-18.1%	$836	$1,018	$846	-16.9%	$107	$139	$30	-78.4%
Client Paid-PMPM	$437	$548	$453	-17.3%	$428	$523	$437	-16.4%	$107	$139	$30	-78.4%
High Cost Claimants (HCC's) > $100k												
# of HCC's	46	54	7	-87.0%	40	43	6	-86.0%	0	0	0	0.0%
HCC's / 1,000	6.1	8.4	1.2	-85.7%	6.1	7.7	1.2	-84.5%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$237,083	$257,429	$144,424	-43.9%	$246,357	$257,598	$151,773	-41.1%	$0	$0	$0	0.0%
HCC's % of Plan Paid	27.7%	32.9%	12.8%	-61.1%	29.2%	31.5%	13.8%	-56.2%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,432	$1,804	$1,210	-32.9%	$1,437	$1,735	$1,142	-34.2%	$0	$0	$0	0.0%
Facility Outpatient	$1,442	$2,319	$1,993	-14.1%	$1,382	$2,176	$1,967	-9.6%	$27	$158	$0	-100.0%
Physician	$2,259	$2,458	$2,228	-9.4%	$2,209	$2,361	$2,131	-9.7%	$1,142	$1,510	$359	-76.2%
Other	$116	$0	$0	0.0%	$109	$0	$0	0.0%	$109	$0	$0	0.0%
Total	$5,249	$6,581	$5,431	-17.5%	$5,137	$6,272	$5,240	-16.5%	$1,278	$1,667	$359	-78.5%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY22**	**PY23**	**1Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**1Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	564	509	488	-4.0%	85	61	55	-10.0%	
Spouses	90	139	81	-41.8%	19	13	11	-15.4%	
Children	142	83	128	54.1%	10	13	12	-10.0%	
Total Members	796	731	697	-4.6%	114	87	78	-10.8%	
Family Size	1.4	1.4	1.4	-0.7%	1.3	1.4	1.4	-0.7%	1.6
Financial Summary									
Gross Cost	$5,794,991	$7,535,647	$1,422,269	-81.1%	$566,699	$354,790	$69,202	-80.5%	
Client Paid	$5,071,309	$6,861,336	$1,245,700	-81.8%	$448,244	$264,230	$49,970	-81.1%	
Employee Paid	$723,682	$674,311	$176,569	-73.8%	$118,455	$90,560	$19,233	-78.8%	
Client Paid-PEPY	$8,998	$13,493	$10,211	-24.3%	$5,279	$4,326	$3,634	-16.0%	$6,642
Client Paid-PMPY	$6,373	$9,392	$7,152	-23.9%	$3,946	$3,023	$2,563	-15.2%	$4,116
Client Paid-PEPM	$750	$1,124	$851	-24.3%	$440	$360	$303	-15.8%	$553
Client Paid-PMPM	$531	$783	$596	-23.9%	$329	$252	$214	-15.1%	$343
High Cost Claimants (HCC's) > $100k									
# of HCC's	8	12	1	-91.7%	0	0	0	0.0%	
HCC's / 1,000	10.1	16.4	1.4	-91.2%	0.0	0.0	0.0	0.0%	
Avg HCC Paid	$131,446	$235,373	$100,333	-57.4%	$0	$0	$0	0.0%	
HCC's % of Plan Paid	20.7%	41.2%	8.1%	-80.5%	0.0%	0.0%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,443	$2,534	$1,831	-27.7%	$1,101	$183	$82	-55.2%	$1,190
Facility Outpatient	$2,015	$3,585	$2,251	-37.2%	$940	$1,007	$1,442	43.2%	$1,376
Physician	$2,742	$3,273	$3,070	-6.2%	$1,800	$1,832	$1,038	-43.3%	$1,466
Other	$174	$0	$0	0.0%	$106	$0	$0	0.0%	$84
Total	$6,373	$9,392	$7,152	-23.9%	$3,946	$3,023	$2,563	-15.2%	$4,116
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 1,602,345	$ 134,167	$ 233,896	$ 1,970,408	$ 1,708,043	$ 319,881	$ 26,211	$ 2,054,134	4.2%
Outpatient	$ 4,563,282	$ 783,384	$ 50,132	$ 5,396,798	$ 4,908,580	$ 849,932	$ 49,676	$ 5,808,188	7.6%
Total - Medical	**$ 6,165,627**	**$ 917,551**	**$ 284,028**	**$ 7,367,206**	**$ 6,616,623**	**$ 1,169,813**	**$ 75,887**	**$ 7,862,322**	**6.7%**

Net Paid Claims - Per Participant per Month	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 693	$ 676	$ 1,340	$ 704	$ 846	$ 930	$ 368	$ 847	20.3%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ -	$ 2,274	$ 2,274	$ -		$ 3,102	$ 3,102	36.5%
Outpatient	$ 489	$ 45,328	$ 49,309	$ 95,126	$ 179	$ 2,835	$ 44,032	$ 47,047	-50.5%
Total - Medical	**$ 489**	**$ 45,328**	**$ 51,582**	**$ 97,399**	**$ 179**	**$ 2,835**	**$ 47,135**	**$ 50,149**	**-48.5%**

Net Paid Claims - Per Participant per Month	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 82	$ 743	$ 353	$ 457	$ 30	$ 94	$ 349	$ 293	-35.9%

Paid Claims by Claim Type – Total

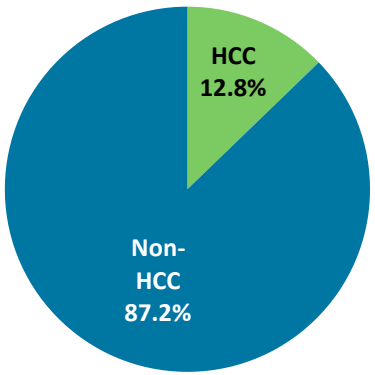
Net Paid Claims - Total Total Participants	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 1,602,345	$ 134,167	$ 236,170	$ 1,972,682	$ 1,708,043	$ 319,881	$ 29,313	$ 2,057,237	4.3%
Outpatient	$ 4,563,771	$ 828,712	$ 99,441	$ 5,491,923	$ 4,908,759	$ 852,767	$ 93,708	$ 5,855,235	6.6%
Total - Medical	**$ 6,166,116**	**$ 962,879**	**$ 335,610**	**$ 7,464,605**	**$ 6,616,802**	**$ 1,172,648**	**$ 123,021**	**$ 7,912,471**	**6.0%**

Net Paid Claims - Per Participant per Month	1Q23				1Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 693	$ 679	$ 937	$ 699	$ 846	$ 910	$ 361	$ 837	19.7%

Cost Distribution – Medical Claims

1Q23							1Q24					
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
6	0.1%	$900,015	12.1%	$20,169	1.7%	$100,000.01 Plus	7	0.1%	$1,010,968	12.8%	$19,557	1.8%
7	0.1%	$448,663	6.0%	$19,423	1.6%	$50,000.01-$100,000.00	14	0.2%	$905,852	11.4%	$38,005	3.4%
35	0.5%	$1,173,213	15.7%	$78,197	6.5%	$25,000.01-$50,000.00	28	0.5%	$1,070,223	13.5%	$66,499	6.0%
107	1.6%	$1,690,361	22.6%	$190,536	15.9%	$10,000.01-$25,000.00	101	1.7%	$1,624,741	20.5%	$151,406	13.6%
108	1.6%	$771,027	10.3%	$131,894	11.0%	$5,000.01-$10,000.00	114	2.0%	$805,004	10.2%	$139,504	12.5%
179	2.7%	$650,865	8.7%	$153,858	12.9%	$2,500.01-$5,000.00	200	3.4%	$700,117	8.8%	$162,250	14.5%
3,716	56.2%	$1,830,462	24.5%	$599,025	50.0%	$0.01-$2,500.00	3,371	57.8%	$1,795,567	22.7%	$536,204	48.0%
183	2.8%	$0	0.0%	$4,224	0.4%	$0.00	118	2.0%	$0	0.0%	$3,032	0.3%
2,276	34.4%	$0	0.0%	$0	0.0%	No Claims	1,875	32.2%	$0	0.0%	$0	0.0%
6,616	**100.0%**	**$7,464,605**	**100.0%**	**$1,197,325**	**100.0%**		**5,828**	**100.0%**	**$7,912,471**	**100.0%**	**$1,116,458**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High-Cost Claimant over $100K

HCC's by Diagnosis Grouper			
Top 10 Diagnosis Groupers	Patients	Total Paid	% Paid
Cardiac Disorders	4	$213,086	21.1%
Hematological Disorders	3	$188,911	18.7%
Cancer	3	$168,251	16.6%
Pregnancy-related Disorders	1	$163,462	16.2%
Neurological Disorders	2	$158,677	15.7%
Health Status/Encounters	7	$56,209	5.6%
Gastrointestinal Disorders	3	$50,408	5.0%
Renal/Urologic Disorders	1	$4,127	0.4%
Miscellaneous	3	$3,132	0.3%
Pulmonary Disorders	3	$1,125	0.1%
All Other		$3,581	0.4%
Overall	**----**	**$1,010,968**	**100.0%**

Utilization Summary (p. 1 of 2)

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

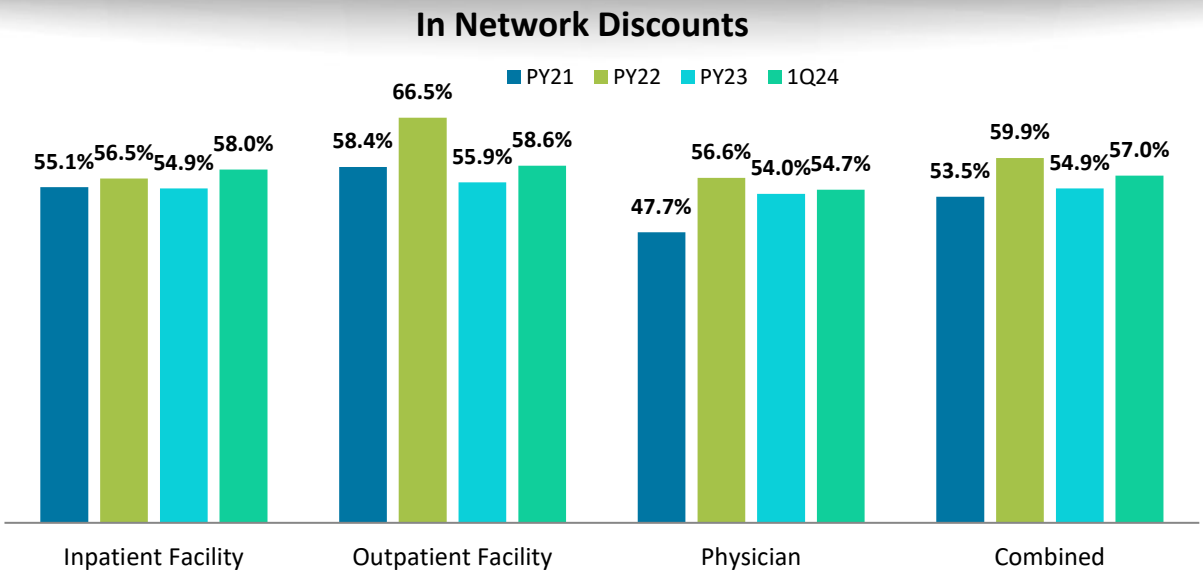
	Total				State Active				Non-State Active			
Summary	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	130	88	82		110	75	67		0	0	0	
# of Bed Days	785	373	316		652	302	261		0	0	0	
Paid Per Admit	$39,810	$20,840	$24,343	16.8%	$41,571	$19,639	$24,250	23.5%	$0	$0	$0	0.0%
Paid Per Day	$6,593	$4,917	$6,317	28.5%	$7,014	$4,877	$6,225	27.6%	$0	$0	$0	0.0%
Admits Per 1,000	68	53	56	5.7%	65	52	53	1.9%	0	0	0	0.0%
Days Per 1,000	409	226	217	-4.0%	385	210	207	-1.4%	0	0	0	0.0%
Avg LOS	6.0	4.2	3.9	-7.1%	5.9	4.0	3.9	-2.5%	0.0	0.0	0.0	0.0%
# Admits From ER	68	38	41	7.9%	55	32	30	-6.3%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	5.5	5	6.0	20.0%	5.3	4.8	5.9	22.9%	6.0	6.0	2.0	-66.7%
Avg Paid per OV	$153	$149	$152	2.0%	$153	$156	$149	-4.5%	$172	$139	$173	24.5%
Avg OV Paid per Member	$840	$744	$915	23.0%	$813	$750	$877	16.9%	$1,033	$835	$346	-58.6%
DX&L Utilization per Member	8.8	13	11.5	-11.5%	8.5	12.2	11.1	-9.0%	1.2	26	20	-23.1%
Avg Paid per DX&L	$48	$53	$67	26.4%	$50	$55	$67	21.8%	$41	$2	$1	-50.0%
Avg DX&L Paid per Member	$424	$686	$768	12.0%	$425	$675	$746	10.5%	$50	$49	$13	-73.5%
Emergency Room												
# of Visits	345	276	277		297	234	245		0	0	0	
Visits Per Member	0.18	0.17	0.19	11.8%	0.18	0.16	0.19	18.8%	0.00	0.00	0.00	0.0%
Visits Per 1,000	180	167	190	13.8%	175	162	194	19.8%	0	0	0	0.0%
Avg Paid per Visit	$1,902	$2,841	$2,934	3.3%	$1,880	$2,903	$2,982	2.7%	$0	$0	$0	0.0%
Urgent Care												
# of Visits	758	547	577		697	481	510		0	0	0	
Visits Per Member	0.39	0.33	0.40	21.2%	0.41	0.33	0.40	21.2%	0.00	0.00	0.00	0.0%
Visits Per 1,000	395	331	396	19.6%	412	334	404	21.0%	0	0	0	0.0%
Avg Paid per Visit	$149	$121	$132	9.1%	$151	$121	$135	11.6%	$0	$0	$0	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

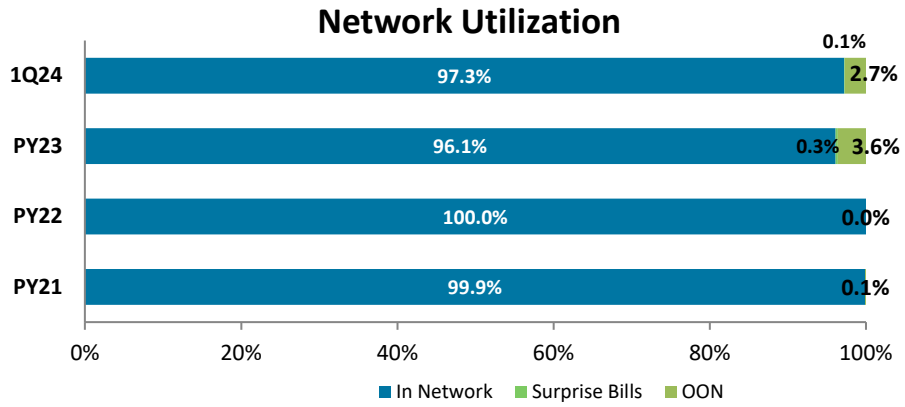
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**1Q22**	**1Q23**	**1Q24**	**Variance to Prior Year**	**Peer Index**
Inpatient Summary									
# of Admits	15	12	12		5	1	3		
# of Bed Days	103	67	45		30	4	10		
Paid Per Admit	$31,995	$29,940	$28,989	-3.2%	$24,510	$1,725	$7,842	354.6%	$16,632
Paid Per Day	$4,660	$5,362	$7,730	44.2%	$4,085	$431	$2,352	445.7%	$3,217
Admits Per 1,000	76	63	69	9.5%	160	42	154	266.7%	76
Days Per 1,000	525	354	258	-27.1%	960	168	513	205.4%	391
Avg LOS	6.9	5.6	3.8	-32.1%	6.0	4.0	3.3	-17.5%	5.2
# Admits From ER	10	6	9	50.0%	3	0	2	0.0%	
Physician Office									
OV Utilization per Member	6.9	6.1	7.1	16.4%	6.4	6.5	5.4	-16.9%	5.0
Avg Paid per OV	$159	$121	$177	46.3%	$114	$60	$61	1.7%	$57
Avg OV Paid per Member	$1,090	$742	$1,258	69.5%	$723	$387	$334	-13.7%	$286
DX&L Utilization per Member	11.6	18.2	15.3	-15.9%	11.2	18.7	6.9	-63.1%	10.5
Avg Paid per DX&L	$37	$43	$63	46.5%	$32	$32	$65	103.1%	$50
Avg DX&L Paid per Member	$424	$786	$965	22.8%	$358	$597	$451	-24.5%	$522
Emergency Room									
# of Visits	41	38	32		7	4	0		
Visits Per Member	0.21	0.20	0.18	-10.0%	0.22	0.17	0.00	-100.0%	0.24
Visits Per 1,000	209	201	184	-8.5%	224	168	0	-100.0%	235
Avg Paid per Visit	$2,338	$2,600	$2,563	-1.4%	$294	$1,484	$0	-100.0%	$943
Urgent Care									
# of Visits	52	59	57		9	7	10		
Visits Per Member	0.27	0.31	0.33	6.5%	0.29	0.29	0.51	75.9%	0.3
Visits Per 1,000	265	312	327	4.8%	288	295	513	73.9%	300
Avg Paid per Visit	$140	$125	$120	-4.0%	$40	$73	$49	-32.9%	$84
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$718,068	9.1%	$441,165	$193,306	$83,597	$302,721	$415,347
Health Status/Encounters	$672,129	8.5%	$417,286	$78,042	$176,802	$261,141	$410,989
Musculoskeletal Disorders	$596,953	7.5%	$510,212	$39,806	$46,935	$290,273	$306,679
Gastrointestinal Disorders	$579,387	7.3%	$281,642	$218,017	$79,728	$199,628	$379,759
Pregnancy-related Disorders	$559,601	7.1%	$301,297	$27,947	$230,357	$171,420	$388,181
Trauma/Accidents	$523,313	6.6%	$354,818	$26,339	$142,156	$283,963	$239,350
Mental Health	$517,716	6.5%	$222,506	$53,384	$241,826	$134,745	$382,971
Neurological Disorders	$505,547	6.4%	$399,898	$76,245	$29,404	$120,460	$385,087
Cardiac Disorders	$490,105	6.2%	$267,860	$211,302	$10,943	$211,616	$278,489
Eye/ENT Disorders	$342,672	4.3%	$217,812	$26,970	$97,891	$144,183	$198,489
Pulmonary Disorders	$308,266	3.9%	$246,001	$29,815	$32,450	$96,313	$211,954
Spine-related Disorders	$279,228	3.5%	$221,634	$50,234	$7,360	$60,787	$218,442
Renal/Urologic Disorders	$275,403	3.5%	$204,453	$13,568	$57,382	$148,367	$127,036
Endocrine/Metabolic Disorders	$265,872	3.4%	$244,756	$15,502	$5,614	$148,871	$117,001
Hematological Disorders	$248,300	3.1%	$224,629	$3,489	$20,183	$192,553	$55,748
Gynecological/Breast Disorders	$201,510	2.5%	$114,244	$71,967	$15,298	$2,919	$198,591
Medical/Surgical Complications	$165,656	2.1%	$155,395	$7,202	$3,059	$99,325	$66,332
Diabetes	$139,397	1.8%	$74,058	$21,210	$44,129	$64,346	$75,051
Non-malignant Neoplasm	$96,682	1.2%	$82,144	$12,028	$2,509	$18,644	$78,037
Infections	$94,823	1.2%	$50,337	$19,687	$24,800	$38,011	$56,812
Dermatological Disorders	$89,461	1.1%	$54,894	$19,063	$15,504	$34,448	$55,013
Miscellaneous	$83,385	1.1%	$44,179	$18,488	$20,718	$32,795	$50,590
Abnormal Lab/Radiology	$58,941	0.7%	$48,600	$7,964	$2,376	$24,041	$34,899
Vascular Disorders	$43,079	0.5%	$27,723	$15,310	$45	$5,559	$37,520
Cholesterol Disorders	$26,922	0.3%	$24,043	$2,516	$363	$12,502	$14,420
Allergic Reaction	$9,017	0.1%	$1,867	$257	$6,893	$7,552	$1,465
Congenital/Chromosomal Anomalies	$8,995	0.1%	$2,926	$0	$6,069	$4,955	$4,040
External Hazard Exposure	$6,057	0.1%	$3,970	$0	$2,087	$5,816	$240
Medication Related Conditions	$4,297	0.1%	$3,075	$929	$293	$1,827	$2,470
Dental Conditions	$1,616	0.0%	$1,246	$0	$369	$462	$1,153
Social Determinants of Health	$73	0.0%	$73	$0	$0	$0	$73
Total	**$7,912,471**	**100.0%**	**$5,244,744**	**$1,260,587**	**$1,407,140**	**$3,120,243**	**$4,792,228**

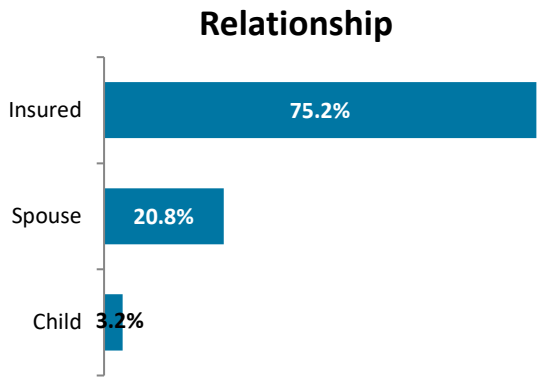
Mental Health Drilldown

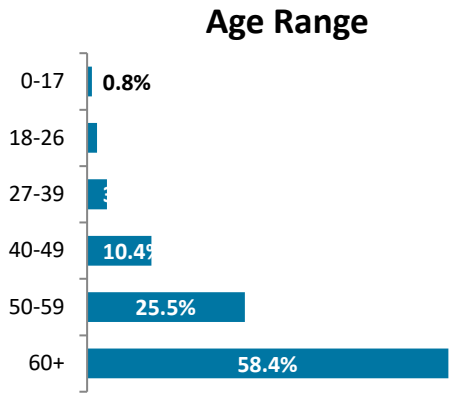
	PY21		PY22		PY23		1Q24	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Mood and Anxiety Disorders	711	$655,375	636	$361,898	591	$339,214	264	$140,350
Mental Health Conditions, Other	609	$876,606	458	$367,897	394	$287,517	174	$110,632
Depression	625	$833,183	505	$720,907	454	$529,695	235	$99,331
Bipolar Disorder	127	$261,349	107	$171,696	109	$84,620	54	$41,832
Developmental Disorders	65	$155,300	58	$89,043	47	$93,123	26	$35,513
Alcohol Abuse/Dependence	43	$163,692	37	$110,736	30	$167,010	16	$32,513
Sexually Related Disorders	27	$81,154	27	$85,457	26	$8,339	11	$15,502
Attention Deficit Disorder	180	$98,736	179	$76,754	202	$61,595	96	$13,270
Substance Abuse/Dependence	57	$45,039	39	$14,853	35	$72,695	11	$6,844
Psychoses	7	$55,219	6	$9,762	9	$6,025	3	$6,139
Sleep Disorders	187	$38,478	148	$43,716	141	$25,583	37	$5,013
Complications of Substance Abuse	14	$63,661	8	$12,407	7	$9,434	6	$4,719
Eating Disorders	24	$370,761	23	$51,995	19	$32,076	8	$2,934
Schizophrenia	9	$10,631	6	$2,286	9	$13,689	3	$1,905
Tobacco Use Disorder	38	$4,775	36	$4,114	42	$3,344	13	$927
Personality Disorders	14	$20,064	17	$47,043	15	$7,832	3	$292
Total		**$3,734,023**		**$2,170,566**		**$1,741,788**		**$517,716**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	9	30	$243,663	33.9%
Cancers, Other	14	74	$121,069	16.9%
Pancreatic Cancer	4	46	$86,331	12.0%
Kidney Cancer	4	18	$62,021	8.6%
Colon Cancer	4	24	$34,254	4.8%
Breast Cancer	24	74	$31,349	4.4%
Melanoma	8	51	$31,282	4.4%
Secondary Cancers	4	26	$26,544	3.7%
Brain Cancer	2	24	$22,123	3.1%
Prostate Cancer	12	65	$19,191	2.7%
Non-Melanoma Skin Cancers	23	40	$12,215	1.7%
Ovarian Cancer	3	14	$8,000	1.1%
Leukemias	5	16	$7,275	1.0%
Lung Cancer	4	14	$4,863	0.7%
Carcinoma in Situ	12	22	$2,901	0.4%
Lymphomas	4	10	$2,397	0.3%
Thyroid Cancer	9	16	$1,944	0.3%
Cervical/Uterine Cancer	3	4	$493	0.1%
Myeloma	1	1	$152	0.0%
Overall	**----**	**----**	**$718,068**	**100.0%**

*Patient and claim counts are unique only within the category

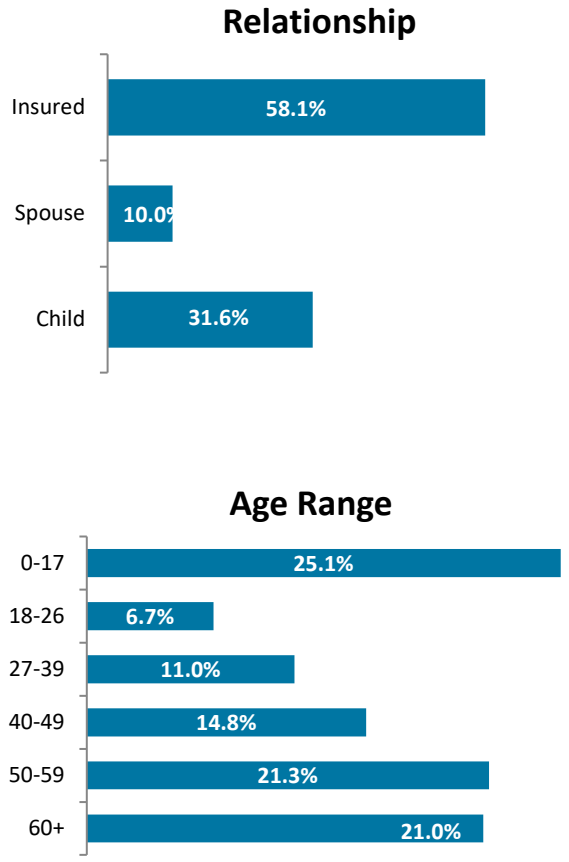




Diagnosis Grouper – Health Status/Encounters

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Screenings	516	886	$181,078	26.9%
Exams	746	1,077	$158,199	23.5%
Prophylactic Measures	433	467	$106,696	15.9%
Encounters - Infants/Children	346	375	$75,115	11.2%
Prosthetics/Devices/Implants	51	113	$69,801	10.4%
Counseling	109	406	$29,561	4.4%
Personal History of Condition	90	121	$28,849	4.3%
Aftercare	31	57	$10,728	1.6%
Acquired Absence	4	4	$5,979	0.9%
Family History of Condition	18	24	$2,301	0.3%
Encounter - Procedure	5	5	$1,984	0.3%
Encounter - Transplant Related	5	11	$963	0.1%
Lifestyle/Situational Issues	6	17	$870	0.1%
Miscellaneous Examinations	2	2	$5	0.0%
Health Status, Other	3	3	$0	0.0%
Donors	2	3	$0	0.0%
Overall	**----**	**----**	**$672,129**	**100.0%**

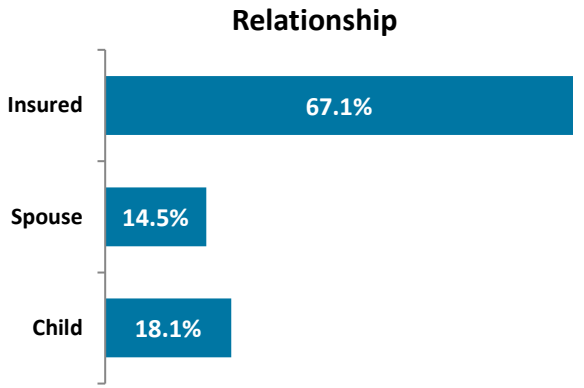
*Patient and claim counts are unique only within the category

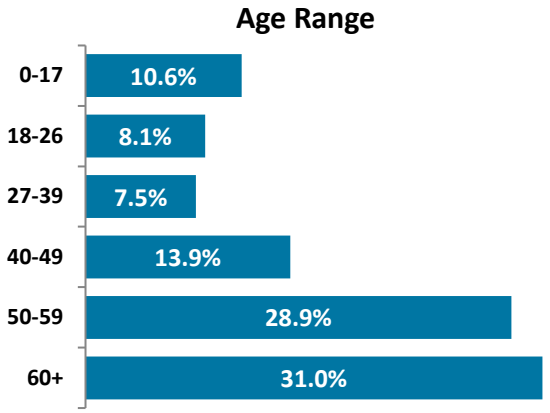


Diagnosis Grouper – Musculoskeletal Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Osteoarthritis	99	256	$182,927	30.6%
Joint Pain	299	800	$165,338	27.7%
Shoulder Problems	37	160	$77,159	12.9%
Limb Pain and Myalgia	179	317	$47,865	8.0%
Musculoskeletal Disorders, Other	147	236	$43,592	7.3%
Foot Problems	32	44	$27,014	4.5%
Joint Derangement	19	51	$23,685	4.0%
Rheumatoid Arthritis	43	90	$12,999	2.2%
Joint Disorders, Other	29	51	$10,783	1.8%
Connective Tissue Disorders	18	35	$3,464	0.6%
Arthropathies, Other	10	17	$1,556	0.3%
Musculoskeletal Deformities, Other	4	5	$326	0.1%
Stress Fractures	2	9	$245	0.0%
	----	----	$596,953	100.0%

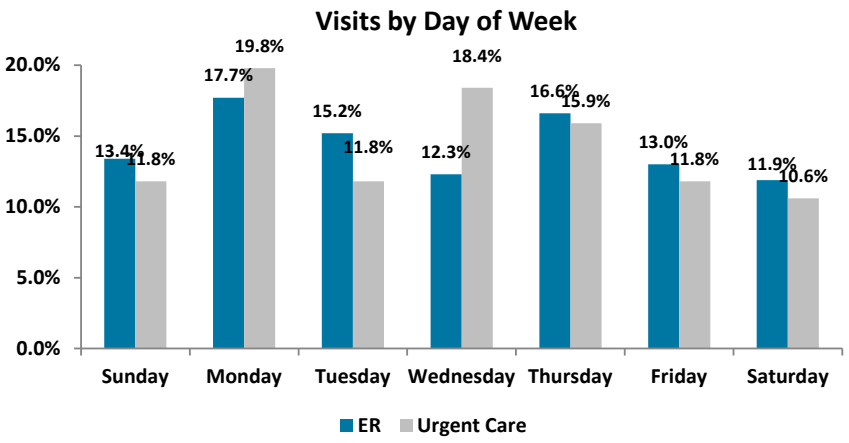
*Patient and claim counts are unique only within the category

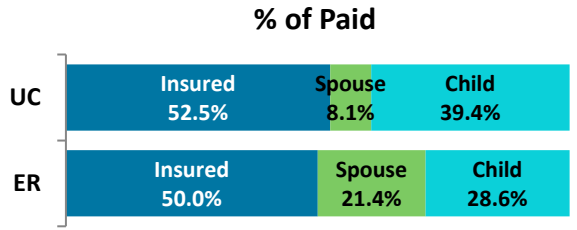




Emergency Room / Urgent Care Summary

	1Q23		1Q24		Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	276	547	277	577		
Visits Per Member	0.17	0.33	0.19	0.40	0.22	0.35
Visits/1000 Members	167	331	190	396	221	352
Avg Paid Per Visit	$2,841	$121	$2,934	$132	$968	$135
% with OV*	92.4%	86.5%	89.5%	88.4%		
% Avoidable	10.1%	34.7%	13.4%	38.0%		
Total Member Paid	**$157,582**	**$25,627**	**$163,023**	**$28,691**		
Total Plan Paid	**$784,080**	**$66,048**	**$812,662**	**$76,390**		
*looks back 12 months	Annualized	Annualized	Annualized	Annualized		





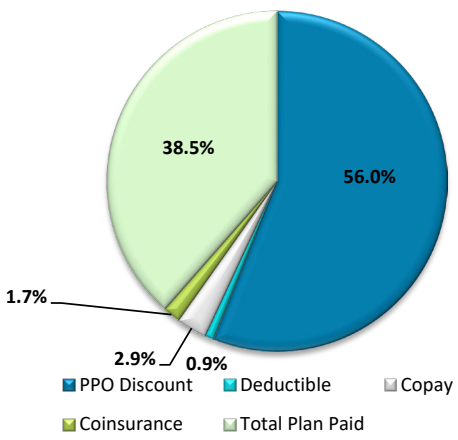
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	147	47	310	98	457	145
Spouse	38	65	51	88	89	153
Child	92	44	216	103	308	147
Total	**277**	**48**	**577**	**99**	**854**	**147**

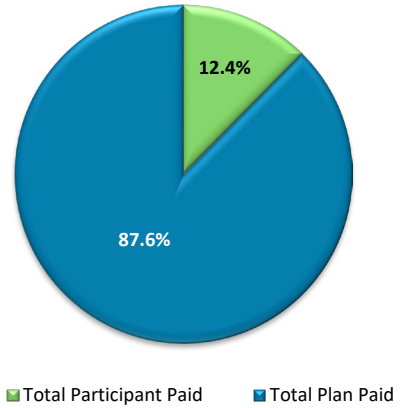
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$20,839,314	$2,205	100.0%
PPO Discount	$11,512,934	$1,218	55.2%
Deductible	$178,853	$19	0.9%
Copay	$598,130	$63	2.9%
Coinsurance	$339,475	$36	1.6%
Total Participant Paid	**$1,116,458**	**$118**	**5.4%**
Total Plan Paid	**$7,912,471**	**$837**	**38.0%**

Total Participant Paid - PY23	**$102**
Total Plan Paid - PY23	**$1,022**





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	394	390	4	99.0%
	<2 asthma related ER Visits in the last 6 months	394	393	1	99.7%
	No asthma related admit in last 12 months	394	390	4	99.0%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	69	63	6	91.3%
	Members with COPD who had an annual spirometry test	69	10	59	14.5%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	1	1	0	100.0%
	No ER Visit for Heart Failure in last 90 days	55	55	0	100.0%
	Follow-up OV within 4 weeks of discharge from HF admission	1	1	0	100.0%
Diabetes	Annual office visit	505	499	6	98.8%
	Annual dilated eye exam	505	263	242	52.1%
	Annual foot exam	505	231	274	45.7%
	Annual HbA1c test done	505	457	48	90.5%
	Diabetes Annual lipid profile	505	404	101	80.0%
	Annual microalbumin urine screen	505	384	121	76.0%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	1,099	885	214	80.5%
Hypertension	Annual lipid profile	1,087	790	297	72.7%
	Annual serum creatinine test	1,065	903	162	84.8%
Wellness	Well Child Visit - 15 months	47	47	0	100.0%
	Routine office visit in last 6 months (All Ages)	5,806	4,328	1,478	74.5%
	Colorectal cancer screening ages 45-75 within the appropriate time period	2,539	1,380	1,159	54.4%
	Women age 25-65 with recommended cervical cancer/HPV screening	1,733	1,343	390	77.5%
	Males age greater than 49 with PSA test in last 24 months	943	532	411	56.4%
	Routine exam in last 24 months (All Ages)	5,806	5,370	436	92.5%
	Women age 40 to 75 with a screening mammogram last 24 months	1,658	1,143	515	68.9%

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	92	1.58%	15.79	314.61	584.27	$19,000
Asthma	439	7.56%	75.33	140.52	477.75	$19,423
Atrial Fibrillation	71	1.22%	12.18	229.67	459.33	$26,114
Blood Disorders	478	8.23%	82.02	272.73	501.47	$29,479
CAD	160	2.75%	27.46	261.44	470.59	$24,767
COPD	68	1.17%	11.67	482.41	844.22	$30,239
Cancer	276	4.75%	47.36	239.10	239.10	$32,694
Chronic Pain	377	6.49%	64.69	143.65	497.24	$20,871
Congestive Heart Failure	55	0.95%	9.44	296.30	814.81	$38,637
Demyelinating Diseases	18	0.31%	3.09	444.44	666.67	$68,767
Depression	699	12.03%	119.95	171.43	390.15	$15,083
Diabetes	538	9.26%	92.32	97.74	240.60	$19,930
ESRD	11	0.19%	1.89	375.00	750.00	$40,529
Eating Disorders	35	0.60%	6.01	606.06	727.27	$24,660
HIV/AIDS	8	0.14%	1.37	0.00	1,043.48	$29,512
Hyperlipidemia	1,384	23.83%	237.49	74.24	204.90	$14,931
Hypertension	1,088	18.73%	186.70	90.03	303.84	$16,819
Immune Disorders	49	0.84%	8.41	345.32	604.32	$52,915
Inflammatory Bowel Disease	35	0.60%	6.01	466.02	466.02	$48,124
Liver Diseases	160	2.75%	27.46	259.74	337.66	$29,478
Morbid Obesity	323	5.56%	55.43	128.48	282.66	$20,603
Osteoarthritis	334	5.75%	57.31	160.99	346.75	$22,267
Peripheral Vascular Disease	38	0.65%	6.52	110.09	550.46	$23,225
Rheumatoid Arthritis	67	1.15%	11.50	60.61	303.03	$34,063

*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.

Public Employees' Benefits Program - RX Costs
PY 2024 - Quarter Ending September 30, 2023

Express Scripts

Membership Summary	1Q FY2024 EPO	1Q FY2023 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	5,825	6,644	(819)	-12.3%
Utilizing Member Count (Patients)	3,492	4,121	(629)	-15.3%
Percent Utilizing (Utilization)	59.9%	62.0%	(0)	-3.3%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	31,089	34,533	(3,444)	-10.0%
Claims per Elig Member per Month (Claims PMPM)	1.78	1.73	0.05	2.9%
Total Claims for Generic (Generic Rx)	26,673	29,539	(2,866.00)	-9.7%
Total Claims for Brand (Brand Rx)	4,416	4,994	(578.00)	-11.6%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	187	165	22.00	13.3%
Total Non-Specialty Claims	30,698	33,993	(3,295.00)	-9.7%
Total Specialty Claims	391	540	(149.00)	-27.6%
Generic % of Total Claims (GFR)	**85.8%**	**85.5%**	0.00	0.3%
Generic Effective Rate (GCR)	**99.3%**	**99.4%**	(0.00)	-0.1%
Mail Order Claims	9,359	9,019	340.00	3.8%
Mail Penetration Rate*	32.9%	28.8%	0.04	4.1%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$4,927,524	$5,004,464	($76,940.00)	-1.5%
Total Generic Gross Cost	$442,768	$564,761	($121,993.00)	-21.6%
Total Brand Gross Cost	$4,484,755	$4,439,703	$45,052.00	1.0%
Total MSB Gross Cost	$102,466	$103,025	($559.00)	-0.5%
Total Ingredient Cost	$4,796,842	$4,971,495	($174,653.00)	-3.5%
Total Dispensing Fee	$125,926	$28,963	$96,963.00	334.8%
Total Other (e.g. tax)	$4,755	$4,006	$749.00	18.7%
Avg Total Cost per Claim (Gross Cost/Rx)	**$158.50**	**$144.92**	$13.58	9.4%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$16.60	$19.12	($2.52)	-13.2%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$1,015.57	$889.01	$126.56	14.2%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$547.95	$624.40	($76.45)	-12.2%

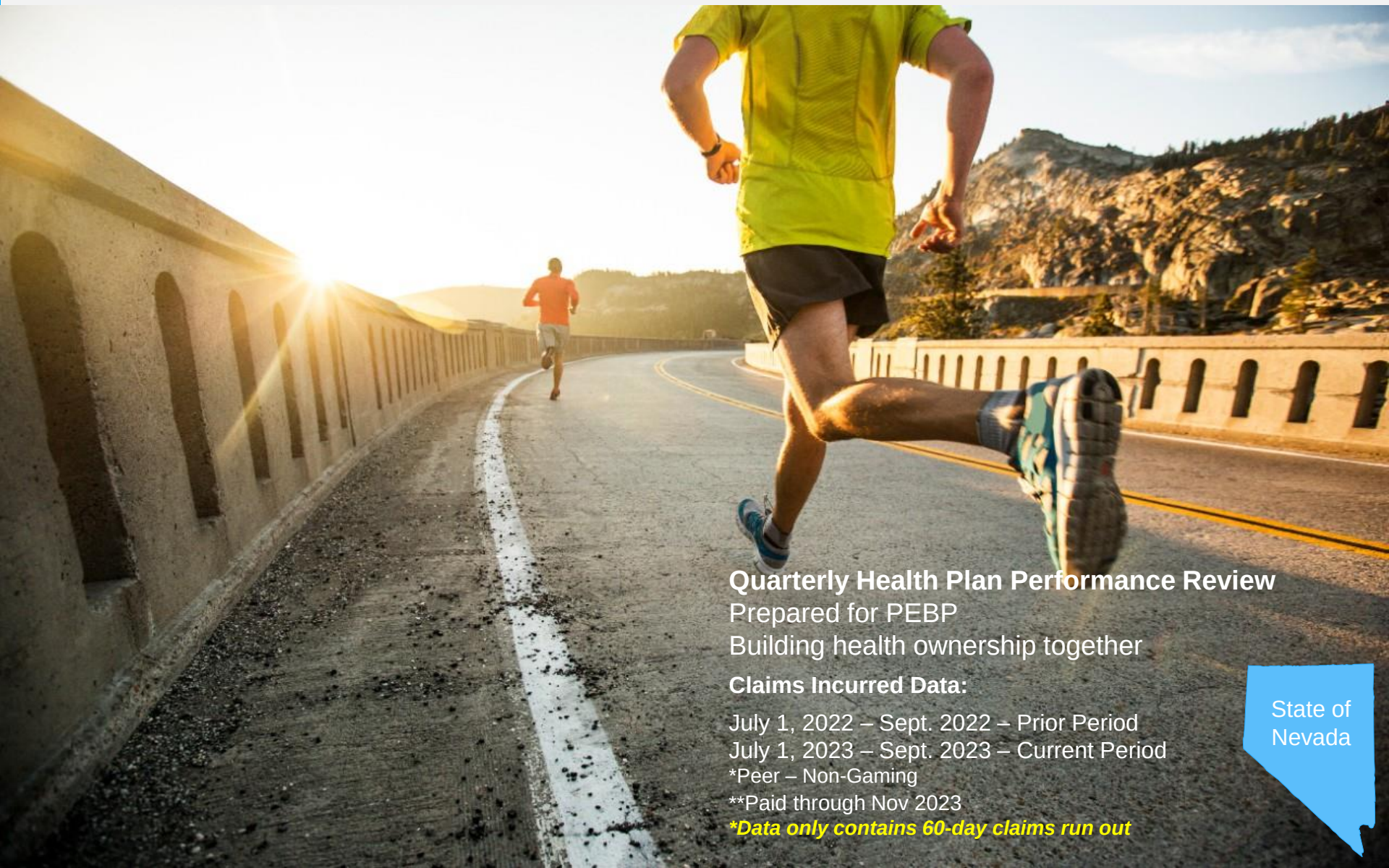
Member Cost Summary			Member Cost Summary	
Total Member Cost	**$667,120**	**$802,085**	($134,965.00)	-16.8%
Total Copay	$665,406	$800,007	($134,601.00)	-16.8%
Total Deductible	$1,714	$2,078	($364.00)	0.0%
Avg Copay per Claim (Copay/Rx)	$21.40	$23.17	($1.76)	-7.6%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$21.46**	**$23.23**	**($1.77)**	**-7.6%**
Avg Copay for Generic (Copay/Generic Rx)	$6.90	$6.99	($0.09)	-1.3%
Avg Copay for Brand (Copay/Brand Rx)	$109.37	$119.24	($9.87)	-8.3%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$85.19	$69.35	$15.84	22.8%
Net PMPM (Participant Cost PMPM)	**$38.18**	**$40.24**	($2.07)	-5.1%
Copay % of Total Prescription Cost (Member Cost Share %)	13.5%	16.0%	-2.5%	-15.5%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$4,260,404**	**$4,202,380**	**$58,024.00**	**1.4%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$1,966,606	$1,903,717	$62,889.00	3.3%
Total Specialty Drug Cost (Specialty Plan Cost)	$2,293,797	$2,298,663	($4,866.00)	-0.2%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$137.04**	**$121.69**	$15.35	12.6%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$9.70	$12.12	($2.42)	-20.0%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$906.20	$769.77	$136.43	17.7%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$462.75	$555.05	($92.30)	-16.6%
Net PMPM (Plan Cost PMPM)	**$243.80**	**$210.84**	**$32.96**	**15.6%**
PMPM for Specialty Only (Specialty PMPM)	$112.54	$95.51	$17.03	17.8%
PMPM without Specialty (Non-Specialty PMPM)	$131.26	$115.33	$15.93	13.8%
Rebates Received (Q1 FY2023 actual)	$1,483,247	$1,428,608	$54,639.04	3.8%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$158.92**	**$139.16**	**$19.76**	**14.2%**
PMPM without Specialty (Non-Specialty PMPM)	$68.65	$53.03	$0.92	5.0%
PMPM for Specialty Only (Specialty PMPM)	$91.83	$86.63	$5.20	6.0%

Appendix D

Index of Tables
Health Plan of Nevada –Utilization Review for PEBP
July 1, 2023 – September 30, 2023

Power Of Partnership.



Quarterly Health Plan Performance Review

Prepared for PEBP

Building health ownership together

Claims Incurred Data:

July 1, 2022 – Sept. 2022 – Prior Period

July 1, 2023 – Sept. 2023 – Current Period

*Peer – Non-Gaming

**Paid through Nov 2023

Data only contains 60-day claims run out

State of Nevada

Executive Summary

Spend and Utilization

Executive Summary Utilization & Spend

UnitedHealthcare

Population

- -4.6% decrease for employees
- -4.9% decrease for members

Medical Paid PMPM

- 7.0% increase in overall medical paid from prior period
- -6.4% decrease in non-Catastrophic spend
- -52.4% decrease in Catastrophic spend

High-Cost Claimants

- 15 HCC in 1Q23, flat from prior period
- % of HCC spend saw a small decrease of -0.4%
- Avg. Paid per case increased 1.3%

Emergency Room

- ER Visits Per 1,000 members decreased -2.2%
- Avg. paid per ER Visit increased 11.1%

Urgent Care

- Urgent Care visits per 1,000 members decreased by -18.1%
- Avg. paid per Urgent care visit increased 6.2%

Rx Drivers

- Rx Net Paid PMPM increased 14.3%
- Specialty Spend decreased -1.8%
- Specialty Rx driving 39.1% of total Rx Spend

Overall Medical / Rx

- Total Medical/Rx increased 9.4% on PMPM basis

Executive Summary Utilization & Spend

UnitedHealthcare®

Claims Paid by Age Group														
	July - Sept. 2022 Q1						July - Sept. 2023 Q1						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	$50,372	$291	$342	$2	$50,714	$293	$172,592	$1,259	$100	$1	$172,692	$1,260	240.5%	-63.1%
01	$57,734	$348	$937	$6	$58,671	$354	$34,119	$231	$1,333	$9	$35,452	$240	-33.7%	59.5%
02-04	$152,751	$259	$2,151	$4	$154,901	$263	$113,352	$229	$4,481	$9	$117,833	$238	-11.5%	148.6%
05-09	$314,294	$285	$15,128	$14	$329,422	$299	$230,998	$239	$14,880	$15	$245,878	$255	-16.1%	12.3%
10-14	$253,076	$180	$89,110	$64	$342,186	$244	$243,662	$178	$50,498	$37	$294,160	$215	-1.2%	-41.8%
15-19	$353,616	$222	$60,543	$38	$414,159	$260	$239,036	$154	$78,642	$51	$317,678	$205	-30.5%	33.5%
20-24	$210,093	$149	$53,382	$38	$263,475	$187	$322,667	$221	$32,376	$22	$355,042	$243	48.1%	-41.5%
25-29	$308,298	$328	$85,391	$91	$393,689	$419	$420,739	$557	$52,476	$69	$473,215	$626	69.6%	-23.6%
30-34	$288,573	$265	$136,741	$126	$425,314	$391	$288,123	$314	$148,617	$162	$436,740	$476	18.4%	28.9%
35-39	$465,059	$361	$266,074	$207	$731,133	$568	$277,845	$233	$331,842	$279	$609,687	$512	-35.4%	34.9%
40-44	$559,239	$404	$193,006	$139	$752,245	$544	$695,573	$542	$182,917	$143	$878,490	$685	34.1%	2.2%
45-49	$523,582	$311	$269,605	$160	$793,187	$471	$624,429	$384	$327,043	$201	$951,472	$585	23.5%	25.6%
50-54	$753,291	$397	$620,374	$327	$1,373,664	$724	$590,443	$316	$544,297	$292	$1,134,740	$608	-20.4%	-10.9%
55-59	$862,035	$466	$572,455	$309	$1,434,490	$775	$738,527	$399	$748,627	$404	$1,487,155	$803	-14.4%	30.7%
60-64	$900,087	$500	$541,337	$301	$1,441,424	$800	$849,711	$470	$553,041	$306	$1,402,752	$776	-5.9%	1.8%
65+	$626,105	$500	$399,898	$320	$1,026,002	$820	$950,611	$771	$522,751	$424	$1,473,363	$1,195	54.1%	32.7%
Total	$6,678,203	$340	$3,306,474	$169	$9,984,677	$509	$6,792,427	$364	$3,593,922	$193	$10,386,349	$557	4.0%	9.4%

Financial Summary

Financial and Demographic (*July 2023 thru Sept 2023 Q1*)												
	Total				State Active				Retiree (State/Non-State)			
Summary	Thru 1Q21	Thru 1Q22	Thru 1Q23	▲	Thru 2Q21	Thru 2Q22	Thru 2Q23	▲	Thru 2Q21	Thru 2Q22	Thru 2Q23	▲
Avg. # Employees	3,832	3,704	3,535	-4.6%	3,357	3,261	3,087	-5.3%	475	443	448	1.0%
Avg. # Members	6,747	6,539	6,218	-4.9%	6,126	5,938	5,604	-5.6%	622	601	614	2.2%
Ratio	1.8	1.8	1.8	-0.4%	1.8	1.8	1.8	-0.3%	1.3	1.4	1.4	1.2%
Financial												
Medical Paid	$8,581,489	$6,678,203	$6,792,427	1.7%	$7,193,469	$6,006,787	$5,690,912	-5.3%	$1,388,020	$671,416	$1,101,515	64.1%
Member Paid	$540,079	$482,423	$576,357	19.5%	$407,513	$376,047	$448,519	19.3%	$132,566	$106,376	$127,838	20.2%
Net Paid PEPY	$8,957	$7,211	$7,686	6.6%	$8,564	$7,358	$7,365	0.1%	$11,735	$6,131	$9,901	61.5%
Net Paid PMPY	$5,087	$4,085	$4,370	7.0%	$4,693	$4,041	$4,057	0.4%	$8,973	$4,525	$7,223	59.6%
Net Paid PEPM	$746	$601	$640	6.6%	$714	$613	$614	0.1%	$978	$511	$825	61.5%
Net Paid PMPM	$424	$340	$364	7.0%	$391	$337	$338	0.4%	$748	$377	$602	59.6%
High Cost Claimants												
# of HCC's > $50k	19	15	15	0.0%	13	13	11	-15.4%	6	2	4	100.0%
Avg. paid per claimant	$154,101	$93,656	$94,919	1.3%	$171,174	$93,036	$86,584	-6.9%	$117,109	$97,687	$117,838	20.6%
HCC % of Spend	34.1%	21.0%	21.0%	-0.4%	31.0%	20.2%	16.8%	-16.9%	50.3%	28.8%	42.5%	47.8%
Spend by Location (PMPY)												
Inpatient	$1,932	$956	$1,371	43.4%	$1,720	$1,012	$1,180	16.6%	$4,021	$1,439	$3,561	147.5%
Outpatient	$1,204	$1,176	$1,029	-12.5%	$1,148	$1,119	$828	-26.1%	$1,755	$993	$1,509	52.0%
Professional	$1,975	$1,959	$1,992	1.7%	$1,829	$1,317	$1,277	-3.1%	$3,416	$2,094	$2,336	11.6%
Total	$5,111	$4,090	$4,392	7.4%	$4,697	$4,046	$4,062	0.4%	$9,193	$4,526	$7,407	63.7%

Paid Claims by Claim Type

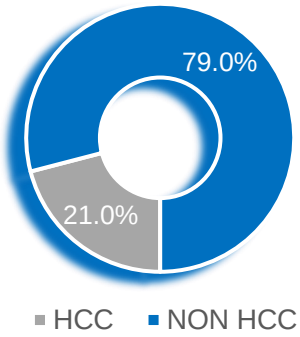
Net Paid Claims - Total									
Total Participants									
	July - Sept. 2022 Q1				July - Sept. 2023 Q1				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical									
InPatient	$1,229,112	$54,276	$278,760	$1,562,147	$1,398,634	$211,341	$520,959	$2,130,934	36.4%
OutPatient	$4,579,686	$197,107	$339,263	$5,116,056	$4,118,669	$130,419	$412,405	$4,661,493	-8.9%
Total - Medical	$5,808,797	$251,383	$618,023	$6,678,203	$5,517,303	$341,760	$933,364	$6,792,427	1.7%

Net Paid Claims - Total									
Total Participants									
	July - Sept. 2022 Q1				July - Sept. 2023 Q1				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical PMPM	$323	$672	$1,653	$340	$324	$918	$757	$364	7.0%

Cost Distribution – Medical Claims > $50K

July - Sept. 1Q22							July - Sept 1Q23					
# 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
3	0.0%	$425,508	6.4%	$175,724	41.3%	> $100k	3	0.0%	$501,870	7.4%	$114,691	22.9%
6	0.1%	$588,556	8.8%	$525,333	89.3%	$50k- $100k	8	0.1%	$579,925	8.5%	$272,231	46.9%
16	0.2%	$522,646	7.8%	$350,800	67.1%	$25k - $50k	25	0.4%	$923,010	13.6%	$449,698	48.7%
69	1.1%	$1,292,331	19.4%	$875,152	67.7%	$10k - $25k	64	1.0%	$1,083,496	16.0%	$694,587	64.1%
99	1.5%	$800,858	12.0%	$564,221	70.5%	$5k - $10k	126	2.0%	$883,927	13.0%	$535,232	60.6%

% Paid Attributed to Catastrophic Cases



HCC > $50k - AHRQ Chapter Conditions - Thru 1Q23			
Top 5 AHRQ Category conditions	# of Patients	Total Paid	% of Med Paid
Diseases of the circulatory system	5	$484,525	7.1%
Neoplasms	4	$249,446	3.7%
Diseases of the nervous system and sense organs	1	$245,025	3.6%
Complications of pregnancy; childbirth	2	$226,197	3.3%
Injury and poisoning	1	$126,659	1.9%

Utilization Summary

UnitedHealthcare

Utilization Summary	Total			State Active			Retiree State/Non-State		
	July - Sept. 1Q22	July - Sept. 1Q23	▲	July - Sept. 1Q22	July - Sept. 1Q23	▲	July - Sept. 1Q22	July - Sept. 1Q23	▲
Inpatient									
# of Admits	76	109	43.2%	68	85	25.0%	8	24	198.4%
# of Bedays	348	592	70.2%	320	439	37.2%	27	152	459.6%
Avg. Paid per Admit	$20,607	$19,533	-5.2%	$19,735	$18,932	-4.1%	$28,022	$21,676	-22.6%
Avg. Paid per Day	$4,530	$3,614	-20.2%	$4,212	$3,682	-12.6%	$8,284	$3,417	-58.8%
Admits Per K	46.7	70.4	50.6%	46.1	61.0	32.4%	53.6	156.4	192.1%
Days Per K	212.6	380.6	79.0%	215.8	313.6	45.3%	181.2	992.3	447.7%
ALOS	4.5	5.4	18.8%	4.7	5.1	9.7%	5.5	5.9	7.3%
Admits from ER	39	43	10.3%	34	32	-5.9%	5	11	120.0%
Physician Office Visits									
Per Member Per Year	2.4	2.2	-5.7%	2.3	2.2	-5.3%	2.8	2.5	-9.9%
Paid Per Visit	$153	$151	-1.7%	$158	$156	-1.1%	$115	$107	-7.2%
Net Paid PMPM	$30	$28	-7.3%	$31	$29	-6.3%	$27	$22	-16.4%
Emergency Room									
# of Visits	199	185	-7.0%	183	169	-7.7%	16	16	0.0%
Visits Per K	121.7	119.0	-2.2%	123.3	120.6	-2.1%	106.5	104.3	-2.1%
Avg Paid Per Visit	$2,589	$2,876	11.1%	$2,687	$2,944	9.6%	$1,478	$2,161	46.2%
Urgent Care									
# of Visits	2,518	1,960	-22.2%	2,259	1,777	-21.3%	259	183	-29.3%
Visits Per K	1540.4	1260.9	-18.1%	1521.7	1268.3	-16.7%	1724.8	1192.8	-30.8%
Avg Paid Per Visit	$115	$122	6.2%	$86	$92	6.1%	$87	$76	-13.1%

**Not Representative of all utilization*

**Data based on medical spend only*

Diagnosis Grouper Summary – Top 25

UnitedHealthcare®

Top 25 AHRQ Category	Total Paid	% Paid	Insured	Spouse	Dependent	Male	Female	Unassigned
Other nervous system disorders	$250,351	4.6%	$17,817	$230,226	$2,309	$17,633	$232,718	$0
Other nutritional; endocrine; and metabolic disorders	$190,823	3.5%	$89,354	$70,812	$30,657	$32,006	$158,817	$0
Spondylosis; intervertebral disc disorders	$167,776	3.1%	$77,135	$90,516	$126	$117,462	$50,315	$0
Transient cerebral ischemia	$165,742	3.1%	$27	$165,715		$165,742		$0
Heart valve disorders	$163,529	3.0%	$110,646	$52,883	$0	$163,302	$228	$0
Acute cerebrovascular disease	$144,030	2.7%	$142,039	$1,991		$73,688	$70,342	$0
Liveborn	$142,647	2.6%			$142,647	$141,021	$1,625	$0
Osteoarthritis	$136,662	2.5%	$121,159	$15,503	$0	$65,722	$70,940	$0
Disorders usually diagnosed in infancy childhood	$130,538	2.4%	$0		$130,538	$100,582	$29,957	$0
Intracranial injury	$125,646	2.3%	$125,646		$0	$122,690	$2,956	$0
Diabetes mellitus with complications	$107,578	2.0%	$87,717	$14,334	$5,527	$69,962	$37,616	$0
Mood disorders	$104,208	1.9%	$41,049	$5,875	$57,285	$30,111	$74,097	$0
Multiple sclerosis	$100,492	1.9%	$100,492				$100,492	$0
Other screening for suspected conditions	$91,568	1.7%	$74,055	$16,587	$926	$35,900	$55,668	$0
Diabetes or abnormal glucose complicating pregnancy	$91,427	1.7%	$9,904	$81,523			$91,427	$0
Biliary tract disease	$83,398	1.5%	$59,735	$5,632	$18,032	$9,012	$74,387	$0
Cardiac dysrhythmias	$82,369	1.5%	$75,237	$7,132	$0	$64,999	$17,370	$0
Cardiac and circulatory congenital anomalies	$79,280	1.5%	$3,132	$0	$76,148	$3,877	$75,403	$0
Cancer of esophagus	$74,609	1.4%		$74,609		$74,609		$0
Nonspecific chest pain	$73,110	1.4%	$54,341	$18,769	$0	$36,325	$36,785	$0
Urinary tract infections	$67,118	1.2%	$57,875	$5,811	$3,431	$1,918	$65,200	$0
Sprains and strains	$66,189	1.2%	$25,540	$4,803	$35,845	$45,391	$20,798	$0
Viral infection	$66,140	1.2%	$61,123	$348	$4,669	$16,068	$50,072	$0
Complications of surgical procedures or medical care	$63,840	1.2%	$40,253	$23,587	$0	$354	$63,485	$0
Cancer of breast	$61,117	1.1%	$23,542	$37,575			$61,117	$0

**Not Representative of all utilization*

**Data based on medical spend only*

Mental Health Drilldown

Top 10 Mental Health				
AHRQ Category Description	July - Sept. 1Q22		July - Sept. 1Q23	
	Patients	Total Paid	Patients	Total Paid
Disorders usually diagnosed in infancy childhood or adolescence	22	$132,849	28	$130,538
Mood disorders	280	$97,079	215	$104,208
Anxiety disorders	238	$40,819	230	$57,654
Adjustment disorders	72	$11,819	90	$23,239
Suicide and intentional self-inflicted injury	4	$5,454	6	$22,280
Attention-deficit conduct and disruptive behavior disorders	78	$6,889	100	$12,775
Schizophrenia and other psychotic disorders	4	$15,216	8	$9,336
Alcohol-related disorders	7	$7,037	12	$5,480
Miscellaneous mental health disorders	19	$7,502	22	$4,075
Delirium dementia and amnestic and other cognitive disorders	2	$215	5	$4,003

**Not Representative of all utilization*

**Data based on medical spend only*

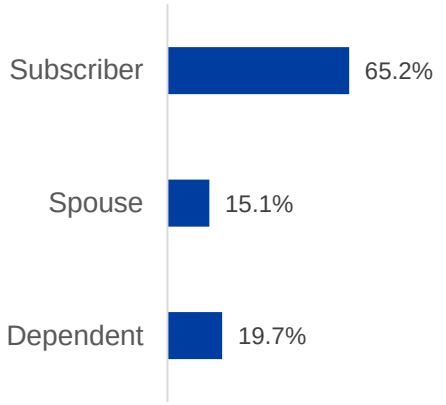
Respiratory Disorders

UnitedHealthcare

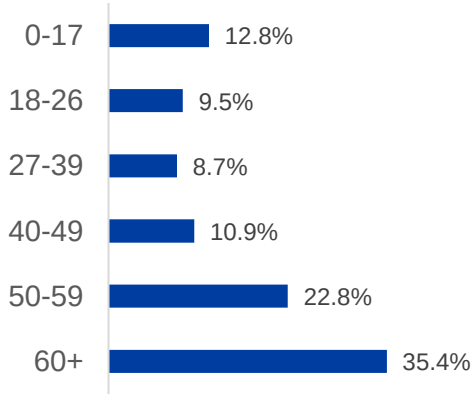
Top 10 Respiratory Disorders				
AHRQ Category Description	Patients	Claims	Total Paid	% Paid
Other upper respiratory infections	222	267	$35,520	26.9%
Other upper respiratory disease	151	324	$30,888	23.4%
Asthma	97	132	$26,166	19.8%
Other lower respiratory disease	131	194	$19,468	14.8%
Pneumonia (except that caused by tuberculosis or std)	6	39	$4,201	3.2%
Acute and chronic tonsillitis	14	19	$3,862	2.9%
Aspiration pneumonitis; food/vomitus	1	2	$3,797	2.9%
Pleurisy; pneumothorax; pulmonary collapse	11	41	$2,926	2.2%
Chronic obstructive pulmonary disease	36	61	$2,315	1.8%
Respiratory failure; insufficiency; arrest (adult)	9	17	$1,904	1.4%

**Not Representative of all utilization*

Spend by Relationship



Spend by Age Range



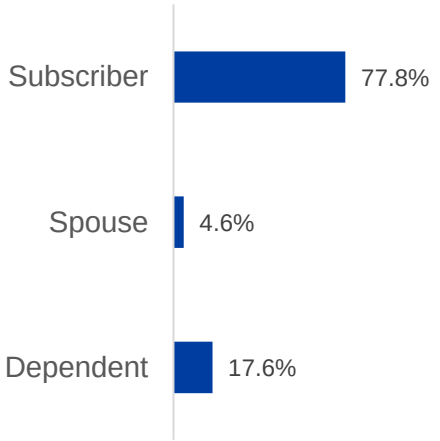
Infections

Top 10 Infectious and Parasitic Diseases				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Viral infection	118	169	$66,140	57.5%
Septicemia (except in labor)	5	8	$24,936	21.7%
Immunizations and screening	204	301	$20,488	17.8%
Bacterial infection; unspecified site	12	14	$1,637	1.4%
STD (not HIV or hepatitis)	5	8	$650	0.6%
Hepatitis	5	7	$428	0.4%
HIV infection	14	33	$326	0.3%
Mycoses	45	53	$235	0.2%
Other infections; including parasitic	6	9	$134	0.1%
Tuberculosis	1	3	$0	0.0%

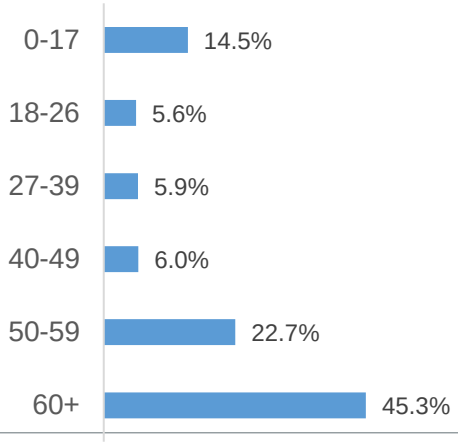
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



Spend by Age Range



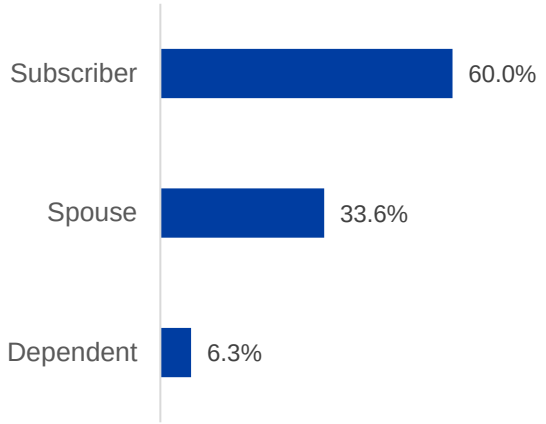
Pregnancy Related Disorders

Top 10 Complications of Pregnancy				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Polyhydramnios and other problems of amniotic cavity	3	9	$108,249	25.9%
Complications of birth; puerperium affecting management	10	18	$51,719	12.4%
Other complications of pregnancy	35	115	$51,204	12.3%
Other pregnancy and delivery including normal	45	114	$32,176	7.7%
Umbilical cord complication	3	3	$30,964	7.4%
Malposition; malpresentation	4	5	$26,918	6.4%
Contraceptive and procreative management	82	141	$22,251	5.3%
Diabetes/Abnormal glucose complicating pregnancy	7	16	$15,205	3.6%
Previous C-section	2	6	$14,169	3.4%
Hemorrhage during pregnancy; abruptio placenta	8	25	$7,082	1.7%

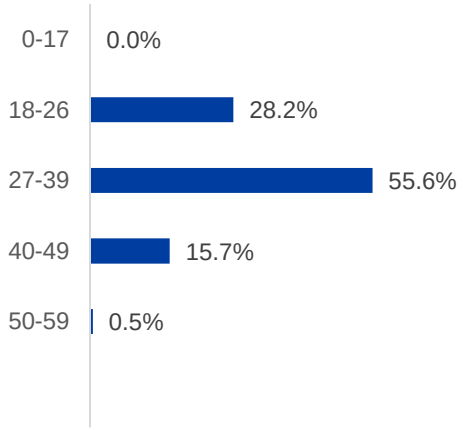
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



Spend by Age Range



Emergency Room and Urgent Care

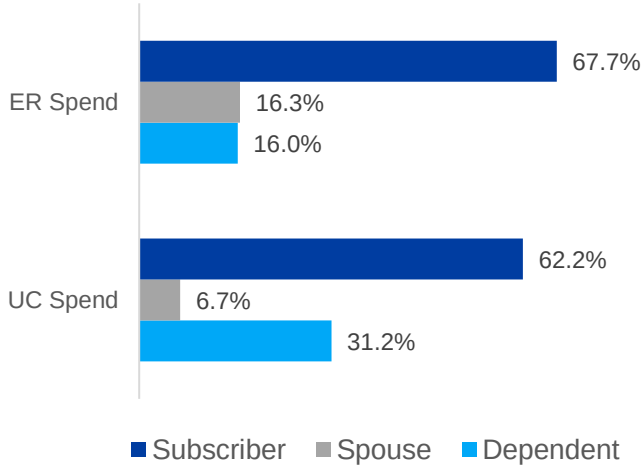
	July - Sept. 1Q22		July - Sept. 1Q23		Peer	
Metric	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
# of Visits	199	943	185	926		
Visits Per Member	0.03	0.48	0.03	0.54	0.08	0.14
Visits Per K	121.7	576.9	119.0	595.7	89.6	385.3
Avg. Paid Per Visit	$2,589	$112	$2,876.16	$121	$2,607	$118

**Not Representative of all utilization*

**Data based on medical spend only*

Emergency Room and Urgent Care Visits by Relationships - 1Q23				
Relationship	ER Visits	ER Per K	UC Visits	UC Per K
Member	113	72.7	582	374.4
Spouse	38	24.4	95	61.1
Dependent	34	21.9	249	160.2
Total	185	119.0	926	595.7

ER / UC Spend by Relationship



Clinical Conditions by Medical Spend

UnitedHealthcare®

Top 15 Common Condition	# of Members	% of Members	Members Per K	PMPM
Mental Disorders	452	7.3%	72.7	$14.44
Intervertebral Disc Disorders	285	4.6%	45.8	$8.99
Diabetes with complications	254	4.1%	40.8	$3.28
Hypertension	240	3.9%	38.6	$5.77
Breast Cancer	39	0.6%	6.3	$0.61
Diabetes without complications	180	2.9%	28.9	$3.41
Asthma	97	1.6%	15.6	$0.28
Prostate Cancer	17	0.3%	2.7	$0.47
Congestive Heart Failure (CHF)	26	0.4%	4.2	$2.30
Chronic Renal Failure	34	0.5%	5.5	$1.40
Acute Myocardial Infarction	2	0.0%	0.3	$0.43
Colon Cancer	3	0.0%	0.5	$0.12
Coronary Atherosclerosis	49	0.8%	7.9	$0.06
COPD	36	0.6%	5.8	$1.14
Cervical Cancer	13	0.2%	2.1	$0.84

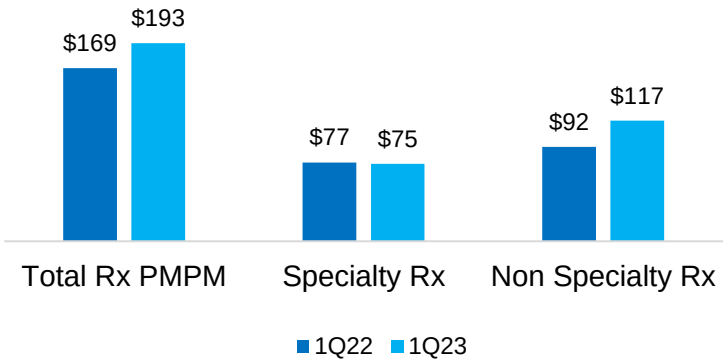
**Not Representative of all utilization*

**Data based on medical spend only*

Pharmacy Drivers

	July - Sept. 1Q22	July - Sept. 1Q23	Δ
Enrolled Members	6,539	6,218	-4.9%
Average Prescriptions PMPY	16.5	16.9	2.0%
Formulary Rate	90.5%	87.7%	-3.1%
Generic Use Rate	84.4%	84.4%	0.0%
Generic Substitution Rate	98.2%	98.2%	0.0%
Avg Net Paid per Prescription	$122	$137	12.1%
Net Paid PMPM	$169	$193	14.3%

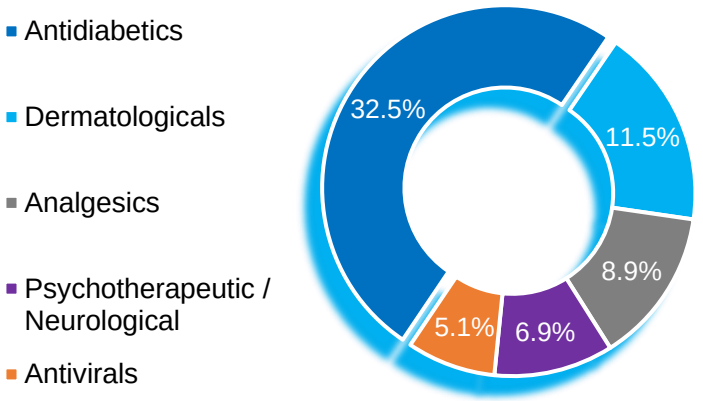
Total Rx Spend by Benefit and Type



Pharmacy Performance

- Rx spend increased of **14.3%**, (**$24 PMPM**) from prior period
- Avg. paid per Script increased **21.1%** (**$15 PMPM**) year over year
- Specialty Rx spend driving **39.1%** of Rx Spend
- Specialty Rx spend remained relatively flat from prior period
  Specialty Rx Drivers:
  Ozempic (Antidiabetic) Spend up **52.6%**
  Jardiance (Antidiabetic) Spend up **25.0%**
- Tier 1 Rx drove **75.3%** of total claim volume, but only accounts for **11.1%** of overall Rx Spend

Top 5 Therapeutic Classes by Spend



4.3

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

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

4.3.1 Q1 UMR – Obesity Care Management Program

4.3.2 Q1 UMR – Diabetes Care Management Program

4.3.3 Q1 Sierra Healthcare Options – Utilization and Large Case Management

4.3.4 Q1 Sierra Healthcare Option and UnitedHealthcare Plus Network – PPO Network

4.3.5 Q1 UnitedHealthcare – Basic Life Insurance

4.3.6 Q1 Express Scripts – Summary Report

4.3.7 Q1 Express Scripts – Utilization Report

4.3.8 Q1 2nd MD – Utilization Report

4.3.9 Doctor on Demand 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 September 30, 2023:

4.3.1 Q1 UMR – Obesity Care Management Program

DATASCOPE™

Obesity Care Management Report

Nevada Public Employees' Benefits Program

July – September 2023 Incurred,

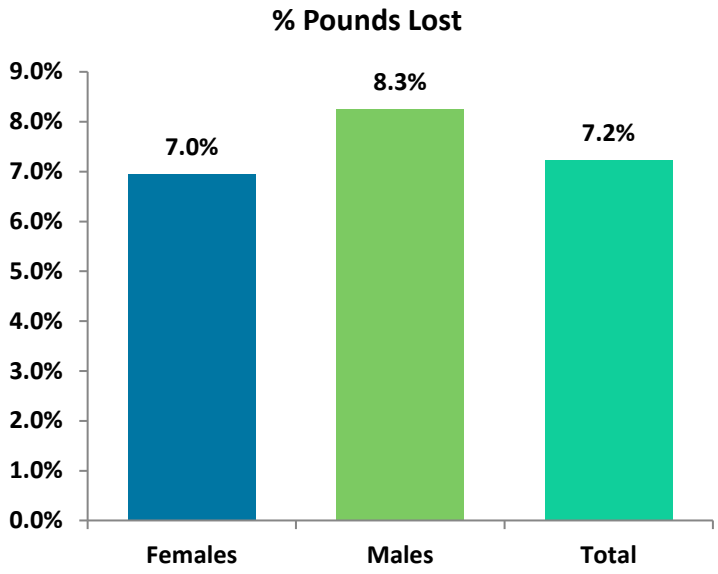
Paid through November 30, 2023

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

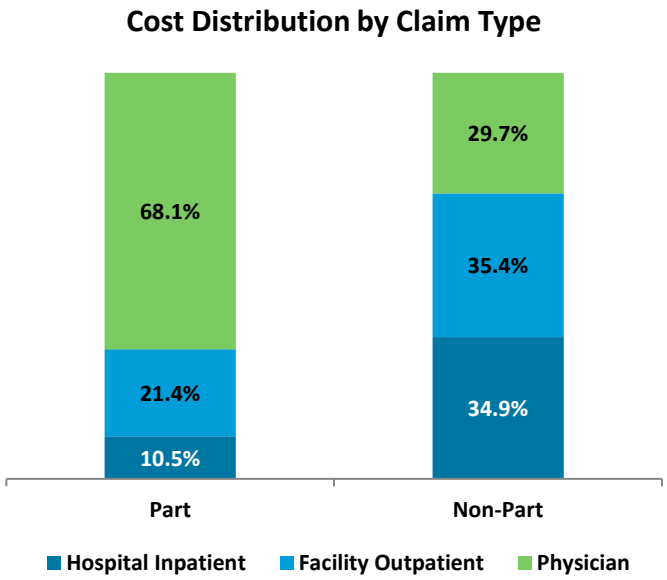
1Q24			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	244	51	295
Average # Lbs. Lost	15.3	21.2	16.3
Total # Lbs. Lost	3,737.7	1,082.8	4,820.5
% Lbs. Lost	7.0%	8.3%	7.2%
Average Cost/ Member	$4,999	$3,577	$4,753



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	266	1,296	-79.5%
Avg # Members	291	1,554	-81.3%
Member/Employee Ratio	1.1	1.2	-8.3%
Financial Summary			
Gross Cost	$444,999	$5,470,004	
Client Paid	$342,943	$4,399,919	
Employee Paid	$102,056	$1,070,084	
Client Paid-PEPY	$5,164	$13,583	-62.0%
Client Paid-PMPY	$4,709	$11,325	-58.4%
Client Paid-PEPM	$430	$1,132	-62.0%
Client Paid-PMPM	$392	$944	-58.5%
High Cost Claimants (HCC's) > $100k			
# of HCC's	0	6	
HCC's / 1,000	0.0	3.9	0.0%
Avg HCC Paid	$0	$170,968	0.0%
HCC's % of Plan Paid	0.0%	23.3%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$494	$3,948	-87.5%
Facility Outpatient	$1,009	$4,014	-74.9%
Physician	$3,206	$3,363	-4.7%
Total	$4,709	$11,325	-58.4%
	Annualized	Annualized	



Obesity Care Management – Utilization Summary

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	3	65	
# of Bed Days	8	471	
Paid Per Admit	$9,557	$24,200	-60.5%
Paid Per Day	$3,584	$3,340	7.3%
Admits Per 1,000	41	167	-75.4%
Days Per 1,000	110	1,212	-90.9%
Avg LOS	2.7	7.2	-62.5%
# of Admits From ER	2	32	-93.8%
Physician Office			
OV Utilization per Member	17.9	10.5	70.5%
Avg Paid per OV	$115	$91	26.4%
Avg OV Paid per Member	$2,057	$955	115.4%
DX&L Utilization per Member	16.9	28.0	-39.6%
Avg Paid per DX&L	$32	$67	-52.2%
Avg DX&L Paid per Member	$548	$1,875	-70.8%
Emergency Room			
# of Visits	17	130	
Visits Per Member	0.23	0.33	-30.3%
Visits Per 1,000	233	335	-30.4%
Avg Paid per Visit	$2,980	$3,651	-18.4%
Urgent Care			
# of Visits	44	188	
Visits Per Member	0.6	0.48	25.0%
Visits Per 1,000	604	484	24.8%
Avg Paid per Visit	$59	$84	-29.8%
	Annualized	Annualized	

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

4.3.2

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

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

4.3.1 Q1 UMR – Obesity Care Management Program

4.3.2 Q1 UMR – Diabetes Care Management Program

DATASCOPE™

Diabetes Care Management Report

Nevada Public Employees' Benefits Program

July – September 2023 Incurred,

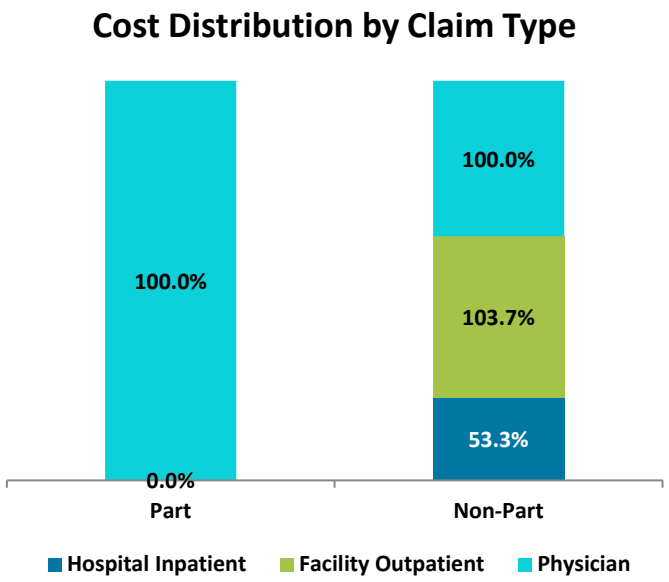
Paid through November 30, 2023

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	4	2,416	-99.8%
Avg # Members	5	3,028	-99.8%
Member/Employee Ratio	1.3	1.3	0.0%
Financial Summary			
Gross Cost	$3,213	$7,523,845	
Client Paid	$1,088	$5,716,834	
Employee Paid	$2,126	$1,807,010	
Client Paid-PEPY	$1,088	$9,466	-88.5%
Client Paid-PMPY	$870	$7,552	-88.5%
Client Paid-PEPM	$91	$789	-88.5%
Client Paid-PMPM	$73	$629	-88.4%
High Cost Claimants (HCC's) > $100k			
# of HCC's	0	6	
HCC's / 1,000	0.0	2.0	0.0%
Avg HCC Paid	$0	$185,735	-100.0%
HCC's % of Plan Paid	0.0%	19.5%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$0	$1,567	-100.0%
Facility Outpatient	$0	$3,047	-100.0%
Physician	$870	$2,938	-70.4%
Total	$870	$2,938	-70.4%
	Annualized	Annualized	



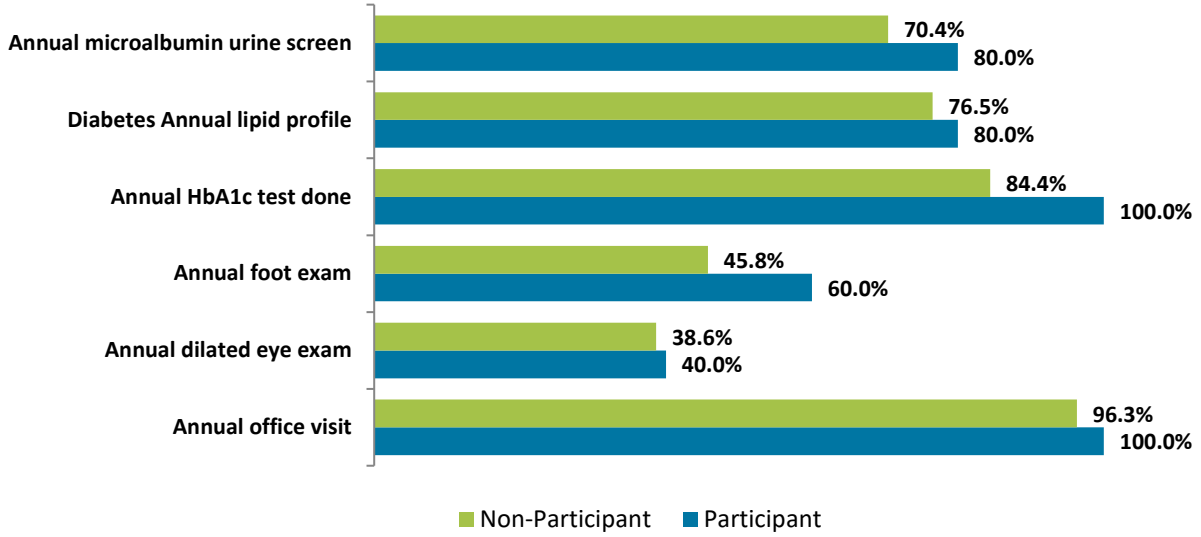
Diabetes Care Management – Utilization Summary

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

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	0	82	
# of Bed Days	0	405	
Paid Per Admit	$0	$16,650	-100.0%
Paid Per Day	$0	$3,371	-100.0%
Admits Per 1,000	0	108	-100.0%
Days Per 1,000	0	535	-100.0%
Avg LOS	0	4.9	-100.0%
# of Admits From ER	0	58	-100.0%
Physician Office			
OV Utilization per Member	4.8	8.7	-44.8%
Avg Paid per OV	$58	$93	-37.6%
Avg OV Paid per Member	$279	$816	-65.8%
DX&L Utilization per Member	16.8	25.0	-32.8%
Avg Paid per DX&L	$12	$57	-78.9%
Avg DX&L Paid per Member	$205	$1,422	-85.6%
Emergency Room			
# of Visits	0	219	
Visits Per Member	0.00	0.29	-100.0%
Visits Per 1,000	0	289	-100.0%
Avg Paid per Visit	$0	$3,261	-100.0%
Urgent Care			
# of Visits	0	291	
Visits Per Member	0.00	0.38	-100.0%
Visits Per 1,000	0	384	-100.0%
Avg Paid per Visit	$0	$71	-100.0%
	Annualized	Annualized	

Quality Metrics

		Participant				Non-Participant			
Condition	Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric
Diabetes	Annual office visit	5	5	0	100.0%	2,730	2,629	101	96.3%
	Annual dilated eye exam	5	2	3	40.0%	2,730	1,055	1,675	38.6%
	Annual foot exam	5	3	2	60.0%	2,730	1,249	1,481	45.8%
	Annual HbA1c test done	5	5	0	100.0%	2,730	2,305	425	84.4%
	Diabetes Annual lipid profile	5	4	1	80.0%	2,730	2,089	641	76.5%
	Annual microalbumin urine screen	5	4	1	80.0%	2,730	1,923	807	70.4%



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 September 30, 2023:

4.3.1 Q1 UMR – Obesity Care Management Program

4.3.2 Q1 UMR – Diabetes Care Management Program

4.3.3 Q1 Sierra Healthcare Options - Utilization and Large Case Management

Excutive Summary

Metrics	Jul-23	Aug-23	Sep-23	Average
Enrollment	48,617	48,786	48,973	**48,792**

Inpatient All - LTACH, AIR, SNF, and OOA

Month	Jul-23	Aug-23	Sep-23	Total	Average
Total Discharges	135	165	136	**436**	**145**
Total Discharges LOS	810	780	589	**2,179**	**726**
Average LOS	6.0	4.7	4.3	**5.0**	**5.0**

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

Inpatient Hospital Acute Only

Month	Jul-23	Aug-23	Sep-23	Total	Average
Total Discharges	90	103	70	**263**	**88**
Total Discharges LOS	358	446	296	**1,100**	**367**
Average LOS	4.0	4.3	4.2	**4.2**	**4.2**

Beddays by Facility Type

Metrics			Beddays		
Facility Type	**Jul-23**	**Aug-23**	**Sep-23**	**Total**	**Average**
Hospital	358	448	296	**1,102**	**367**
Hospital Rehabilitation	10	0	0	**10**	**10**
Skilled Nursing	63	44	17	**124**	**41**
Out of Area	381	290	282	**953**	**318**

Metrics			Beddays per K	
Facility Type	**Jul-23**	**Aug-23**	**Sep-23**	**Total**
Hospital	88.4	110.2	72.5	**90.3**
Hospital Rehabilitation	2.5	0.0	0.0	**0.8**
Skilled Nursing	15.6	10.8	4.2	**10.2**
Out of Area	94.0	71.3	69.1	**78.1**

Admits by Facility Type

Metrics			Admits		
Facility Type	**Jul-23**	**Aug-23**	**Sep-23**	**Total**	**Average**
Hospital	83	107	65	**255**	**85**
Hospital Rehabilitation	1	0	0	**1**	**1**
Skilled Nursing	3	4	1	**8**	**3**
Out of Area	44	53	70	**167**	**56**

Excutive Summary

Metrics	Admits per K			
Facility Type	**Jul-23**	**Aug-23**	**Sep-23**	**Total**
Hospital	20.5	26.3	15.9	**20.9**
Hospital Rehabilitation	0.2	0.0	0.0	**0.1**
Skilled Nursing	0.7	1.0	0.2	**0.7**
Out of Area	10.9	13.0	17.2	**13.7**

Readmits by Facility Type

Metrics	Readmits				
Facility Type	**Jul-23**	**Aug-23**	**Sep-23**	**Total**	**Average**
Hospital	12	7	8	**27**	**9**
Hospital Rehabilitation	0	0	0	**0**	**0**
Skilled Nursing	0	0	0	**0**	**0**
Out of Area	1	3	6	**10**	**3**

Average Length of Stay by Facility

Facility Type	Metrics	Average LOS			
	Facility Name	**Jul-23**	**Aug-23**	**Sep-23**	**Total**
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	3.3	3.8	6.7	**4.4**
	HENDERSON HOSPITAL	3.8	4.3	2.0	**3.9**
	MOUNTAIN VIEW HOSPITAL	1.8	3.2	5.5	**3.3**
	NORTH VISTA HOSPITAL	1.0	4.0	0.0	**1.7**
	RENOWN REGIONAL MEDICAL CENTER	3.7	4.0	3.7	**3.8**
	SOUTHERN HILLS HOSPITAL	1.8	6.0	16.0	**5.2**
	SPRING VALLEY HOSPITAL	1.3	2.7	2.0	**2.0**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	2.0	0.0	0.0	**5.0**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	4.5	4.0	3.5	**4.1**
	SUMMERLIN HOSPITAL MEDICAL CTR	6.0	13.7	6.5	**7.5**
	SUNRISE HOSPITAL	8.0	7.8	5.5	**6.8**
	UNIVERSITY MEDICAL CENTER SO NV	14.0	2.3	2.2	**3.4**
	VALLEY HOSPITAL MEDICAL CTR	0.0	1.0	3.7	**2.8**
	Total	**4.0**	**4.3**	**4.2**	**4.2**
Hospital Rehabilitation	ENCOMPASS HEALTH HOSPITAL OF HENDERSON	10.0	0.0	0.0	**10.0**
	Total	**10.0**	**0.0**	**0.0**	**10.0**
Skilled Nursing	HARMON HOSPITAL	0.0	6.0	0.0	**6.0**
	SAGE CREEK POST ACUTE	33.0	16.5	0.0	**16.5**
	SANDSTONE SPRING VALLEY LLC	0.0	2.5	0.0	**26.0**
	TRELLIS CENTENNIAL	0.0	0.0	0.0	**0.0**
	Total	**31.5**	**8.8**	**17.0**	**15.5**

Excutive Summary

Average Length of Stay by Facility

Facility Type	Metrics	Average LOS			
	Facility Name	Jul-23	Aug-23	Sep-23	Total
Out of Area	Out of Area	9.0	5.1	4.2	**5.8**
	Total	**9.0**	**5.1**	**4.2**	**5.8**

Beddays by Facility

Facility Type	Metrics	Beddays				
	Facility Name	Jul-23	Aug-23	Sep-23	Total	Average
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	10	23	20	**53**	**18**
	HENDERSON HOSPITAL	19	35	2	**56**	**19**
	MOUNTAIN VIEW HOSPITAL	9	29	22	**60**	**20**
	NORTH VISTA HOSPITAL	1	4	0	**5**	**3**
	RENOWN REGIONAL MEDICAL CENTER	172	192	126	**490**	**163**
	SOUTHERN HILLS HOSPITAL	7	24	16	**47**	**16**
	SPRING VALLEY HOSPITAL	4	8	2	**14**	**5**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	2	8	0	**10**	**5**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	45	40	14	**99**	**33**
	SUMMERLIN HOSPITAL MEDICAL CTR	48	41	39	**128**	**43**
	SUNRISE HOSPITAL	24	31	33	**88**	**29**
	UNIVERSITY MEDICAL CENTER SO NV	14	10	11	**35**	**12**
	VALLEY HOSPITAL MEDICAL CTR	3	3	11	**17**	**6**
	Total	**358**	**448**	**296**	**1,102**	**0**
Hospital Rehabilitation	ENCOMPASS HEALTH HOSPITAL OF HENDERSON	10	0	0	**10**	**10**
	Total	**10**	**0**	**0**	**10**	**0**
Skilled Nursing	HARMON HOSPITAL	0	6	0	**6**	**6**
	SAGE CREEK POST ACUTE	33	33	0	**66**	**33**
	SANDSTONE SPRING VALLEY LLC	30	5	17	**52**	**17**
	TRELLIS CENTENNIAL	0	0	0	**0**	**0**
	Total	**63**	**44**	**17**	**124**	**0**
Out of Area	Out of Area	381	290	282	**953**	**318**
	Total	**381**	**290**	**282**	**953**	**0**

Admits by Facility

Facility Type	Metrics	Admits				
	Facility Name	Jul-23	Aug-23	Sep-23	Total	Average
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	3	5	4	**12**	**4**
	HENDERSON HOSPITAL	4	9	1	**14**	**5**

Excutive Summary

Admits by Facility

Facility Type	Metrics	Admits				
	Facility Name	Jul-23	Aug-23	Sep-23	Total	Average
Hospital	MOUNTAIN VIEW HOSPITAL	3	7	7	**17**	**6**
	NORTH VISTA HOSPITAL	1	2	0	**3**	**1**
	RENOWN REGIONAL MEDICAL CENTER	41	52	27	**120**	**40**
	SOUTHERN HILLS HOSPITAL	3	4	2	**9**	**3**
	SPRING VALLEY HOSPITAL	3	3	1	**7**	**2**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	1	1	0	**2**	**1**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	10	9	5	**24**	**8**
	SUMMERLIN HOSPITAL MEDICAL CTR	8	4	5	**17**	**6**
	SUNRISE HOSPITAL	3	4	6	**13**	**4**
	UNIVERSITY MEDICAL CENTER SO NV	2	5	4	**11**	**4**
	VALLEY HOSPITAL MEDICAL CTR	1	2	3	**6**	**2**
	Total	**83**	**107**	**65**	**255**	**0**
Hospital Rehabilitation	ENCOMPASS HEALTH HOSPITAL OF HENDERSON	1	0	0	**1**	**1**
	Total	**1**	**0**	**0**	**1**	**0**
Skilled Nursing	HARMON HOSPITAL	0	1	0	**1**	**1**
	SAGE CREEK POST ACUTE	2	2	0	**4**	**1**
	SANDSTONE SPRING VALLEY LLC	1	1	1	**3**	**1**
	TRELLIS CENTENNIAL	0	0	0	**0**	**0**
	Total	**3**	**4**	**1**	**8**	**0**
Out of Area	Out of Area	44	53	70	**167**	**56**
	Total	**44**	**53**	**70**	**167**	**0**

Readmits by Facility

Facility Type	Metrics	Readmits				
	Facility Name	Jul-23	Aug-23	Sep-23	Total	Average
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	0	0	0	**0**	**0**
	HENDERSON HOSPITAL	1	0	0	**1**	**0**
	MOUNTAIN VIEW HOSPITAL	0	2	3	**5**	**2**
	NORTH VISTA HOSPITAL	0	0	0	**0**	**0**
	RENOWN REGIONAL MEDICAL CENTER	6	3	4	**13**	**4**
	SOUTHERN HILLS HOSPITAL	0	0	0	**0**	**0**
	SPRING VALLEY HOSPITAL	0	0	0	**0**	**0**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	0	0	0	**0**	**0**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	2	2	0	**4**	**1**
	SUMMERLIN HOSPITAL MEDICAL CTR	1	0	1	**2**	**1**

Excutive Summary

Readmits by Facility

Facility Type	Metrics	Readmits				
	Facility Name	**Jul-23**	**Aug-23**	**Sep-23**	**Total**	**Average**
Hospital	SUNRISE HOSPITAL	1	0	0	**1**	**0**
	UNIVERSITY MEDICAL CENTER SO NV	0	0	0	**0**	**0**
	VALLEY HOSPITAL MEDICAL CTR	1	0	0	**1**	**0**
	Total	**12**	**7**	**8**	**27**	**0**
Out of Area	Out of Area	1	3	6	**10**	**3**
	Total	**1**	**3**	**6**	**10**	**0**

Readmits by Facility

Facility Type	Metrics	Readmit Rate				
	Facility Name	**Jul-23**	**Aug-23**	**Sep-23**	**Total**	**Average**
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	HENDERSON HOSPITAL	25.0%	0.0%	0.0%	**7.1%**	**7.1%**
	MOUNTAIN VIEW HOSPITAL	0.0%	28.6%	42.9%	**29.4%**	**29.4%**
	NORTH VISTA HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	RENOWN REGIONAL MEDICAL CENTER	14.6%	5.8%	14.8%	**10.8%**	**10.8%**
	SOUTHERN HILLS HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	SPRING VALLEY HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	20.0%	22.2%	0.0%	**16.7%**	**16.7%**
	SUMMERLIN HOSPITAL MEDICAL CTR	12.5%	0.0%	20.0%	**11.8%**	**11.8%**
	SUNRISE HOSPITAL	33.3%	0.0%	0.0%	**7.7%**	**7.7%**
	UNIVERSITY MEDICAL CENTER SO NV	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	VALLEY HOSPITAL MEDICAL CTR	100.0%	0.0%	0.0%	**16.7%**	**16.7%**
	Total	**14.5%**	**6.5%**	**12.3%**	**10.6%**	**0.0%**
Out of Area	Out of Area	2.3%	5.7%	8.6%	**6.0%**	**6.0%**
	Total	**2.3%**	**5.7%**	**8.6%**	**6.0%**	**0.0%**

Utilization Summary

Outpatient Case Management					
Month	**Jul-23**	**Aug-23**	**Sep-23**	**YTD**	**Average**
New Cases	166	199	160	**525**	**175**
Accepted	115	131	113	**359**	**120**
Acceptance Rate	69.3%	65.8%	70.6%	**68.4%**	**68.4%**
Average Duration (closed only)	11.0	10.8	9.3	**10.4**	**10.4**

Inpatient Case Management					
Month	**Jul-23**	**Aug-23**	**Sep-23**	**YTD**	**Average**
Open End of Month	25	25	23	**73**	**24**
Cases opened in the month	131	164	136	**431**	**144**
Cases closed in the month	135	165	136	**436**	**145**
Denied Days	49	5	3	**57**	**19**
Average LOS	6.0	4.7	4.3	**5.0**	**5.0**
NICU Open at End of Month	1	2	0	**3**	**1**
NICU Cases opened in the month	1	5	2	**8**	**3**
NICU Cases closed in the month	1	5	4	**10**	**3**
NICU Average Legth of Stay	25.0	14.2	0.8	**9.9**	**9.9**

Authorizations					
Month	**Jul-23**	**Aug-23**	**Sep-23**	**YTD**	**Average**
Total services reviewed	2,777	3,149	2,997	**8,923**	**2,974**
Services Approved	2,654	2,996	2,843	**8,493**	**2,831**
Approval Rate	95.6%	95.1%	94.9%	**95.2%**	**95.2%**
Services Denied	123	153	154	**430**	**143**
Denied Charges	$43,694	$82,333	$42,686	**$168,712**	**$56,237**
Denial Rate	4%	5%	5%	**5%**	**5%**

Denial Reason					
Month	**Jul-23**	**Aug-23**	**Sep-23**	**YTD**	**Average**
Denial Reason	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**
Not medically necessary	123	153	154	**430**	**143**

Utilization Summary

Turn Around Time					
Month	**Jul-23**	**Aug-23**	**Sep-23**	**YTD**	**Average**
2 or fewer days	575	661	610	**1,846**	**615**
2 or fewer Pct	61.0%	60.6%	60.0%	**60.5%**	**60.5%**
5 or fewer days	637	679	667	**1,983**	**661**
5 or fewer Pct	67.6%	62.2%	65.6%	**65.0%**	**65.0%**
15 or fewer Days	902	1,045	988	**2,935**	**978**
15 or fewer Pct	95.8%	95.8%	97.2%	**96.3%**	**96.3%**
Over 15 days	40	46	28	**114**	**38**
Over 15 days Pct	4.2%	4.2%	2.8%	**3.7%**	**3.7%**

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

Stat					
Month	**Jul-23**	**Aug-23**	**Sep-23**	**YTD**	**Average**
Stat Request	775	746	763	**2,284**	**761**

Appeals					
Month	**Jul-23**	**Aug-23**	**Sep-23**	**YTD**	**Average**
Appeals 1st Level	3	1	2	**6.00**	**2.00**
Appeals 2nd Level	0	0	0	**0.00**	**0.00**
Appeals 3rd Level	0	0	0	**0.00**	**0.00**
Appeals Overturned	0	0	0	**0.00**	**0.00**
Appeals Upheld	2	1	3	**6.00**	**2.00**

Utilization Summary

Retro Reviews

Month	Jul-23	Aug-23	Sep-23	YTD	Average
Retros	0	2	11	**13**	**4**

Telephone Advise Nurse

Metrics

Outcome description	Jul-23	Aug-23	Sep-23	YTD	Average
Call 911	0	1	1	**2**	**1**
ER	15	10	9	**34**	**11**
Information or Advice Only	1	3	4	**8**	**3**
Other	17	9	18	**44**	**15**
PCP	9	9	5	**23**	**8**
Self-Care/Home Care	2	5	4	**11**	**4**
Urgent Care	15	19	14	**48**	**16**

Bedday Summary

Acute only

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

Month	Jul-23	Aug-23	Sep-23	YTD
Membership	48,617	48,786	48,973	**48,792**
Beddays per K	143.2	146.8	135.3	**141.7**
Admits per K	30.1	37.9	32.6	**33.5**
Average LOS	4.4	3.9	4.2	**4.2**
Readmits per K	3.2	2.5	3.4	**3.0**
Readmit Rate	10.7%	6.5%	10.5%	**9.0%**

SHO

Month	Jul-23	Aug-23	Sep-23	YTD
Beddays per K	166.1	188.5	187.5	**180.7**
Admits per K	33.2	38.5	36.5	**36.1**
Average LOS	4.9	5.2	4.7	**4.9**
Readmits per K	2.6	2.5	3.2	**2.8**
Readmit Rate	7.9%	6.5%	8.8%	**7.7%**

SHL PPO

Month	Jul-23	Aug-23	Sep-23	YTD
Beddays per K	139.8	161.1	111.3	**137.4**
Admits per K	36.2	43.6	35.6	**38.4**
Average LOS	4.7	5.9	4.0	**4.9**
Reamits per K	3.3	4.6	2.0	**3.3**
Readmit Rate	9.2%	10.5%	5.5%	**8.6%**

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

4.3.4

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

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

- 4.3.1 Q1 UMR – Obesity Care Management Program
- 4.3.2 Q1 UMR – Diabetes Care Management Program
- 4.3.3 Q1 Sierra Healthcare Options – Utilization and Large Case Management
- **4.3.4 Q1 Sierra Healthcare Options and United Healthcare Plus Network – PPO Network**

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

Network Repricing Turnaround Time - UMR		
PEBP PG Target	Returned 97% in 3 Days	Returned 99% in 5 days
Q1 Results	98%	100%
Q2 Results		
Q3 Results		
Q4 Results		

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

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 September 30, 2023:

- 4.3.1 Q1 UMR – Obesity Care Management Program
- 4.3.2 Q1 UMR – Diabetes Care Management Program
- 4.3.3 Q1 Sierra Healthcare Options – Utilization and Large Case Management
- 4.3.4 Q1 Sierra Healthcare Options and United Healthcare Plus Network – PPO Network
- **4.3.5 Q1 United Healthcare – Basic Life Insurance**

370074 State of Nevada Public Employees' Benefits Program

Life Performance Guarantees

Service	Metric	Measurement	How Measured	Fee at Risk	Owner	Due to internal account management team by	Results Details (Q1)	Guarantee Achieved?
Client Implementation	Enrollment materials	Enrollment materials completed/shipped within agreed upon timeframe	Implementation Tracking	.3% of premium	Emily Doehr	8/1/2022	N/A	Yes
	Draft certificate issued	30 days from receipt of set up information	Implementation Tracking	.3% of premium	Emily Doehr	8/1/2022	N/A	Yes
	System Readiness	Systems ready for claims/customer service within the following days from receipt of complete set up information: · 45 days list billed groups (excludes EDI) · 30 days for self billed groups	Implementation Tracking	.3% of premium	Emily Doehr	8/1/2022	N/A	Yes
Claim Processing	Life Claims - Timeliness of claim payment	97% of claims processed within 10 days of receipt of complete information	Claim Turn Around Reports	.3% of premium	Geoff Crain	12/15/2023	99.0%	Yes
	Complete Life Claim – Decision	97% of claims approved and payment issues, or claims denied and letter mailed in five business days following receipt of all information necessary to make a claim decision.	Quarterly claim decision report	.3% of premium	Geoff Crain	12/15/2023	87.0%	No
	Life Claims - Accuracy of claim payment	98% of claims processed accurately	Internal Claims Audit	.3% of premium	Geoff Crain	12/15/2023	94.0%	No
Employer Reporting	Accurate reporting provided 45 days after the end of the quarter	Claim reporting sent out to employer	Reporting Send Date	.3% of premium	Account managment			
Claim Customer Service *	Average speed of answer	80% in less than 30 seconds	Call Center Statistics	.3% of premium		12/15/2023	85.0%	Yes
	Abandonment Rate	<5% abandonment rate	Call Center Statistics	.3% of premium		12/15/2023	1.7%	Yes
Account Management	Client Satisfaction	UHCSB performs satisfactory ongoing, day-to-day account management in the opinion of the client's HR and/or benefits staff.	Based on average score of 5 out of 10 on the standard client loyalty survey.	.3% of premium	Account managment			
			Total at Risk	**The lesser of 3% or $50,000**				

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 September 30, 2023:

- 4.3.1 Q1 UMR – Obesity Care Management Program
- 4.3.2 Q1 UMR – Diabetes Care Management Program
- 4.3.3 Q1 Sierra Healthcare Options -Utilization and Large Case Management
- 4.3.4 Q1 Sierra Healthcare Options and United Healthcare Plus Network – PPO Network
- 4.3.5 Q1 United Healthcare – Basic Life Insurance
- **4.3.6 Q1 Express Scripts – Summary Report**

Nevada PEBP

Q1 FY2024

Prepared by Client Analytics

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

12.15.23

**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.*

Hello PEBP Team,

This is the Q1 FY24 Summary File for the three State of Nevada PEBP plans (CDHP, EPO, and PPO). The summary contains Trend breakouts for each plan (Utilization, Unit Cost, and Cost Share). Along with the most notable changes of drugs within the top moving indications. Each plan breakout has a peer comparison of Trend. The file concludes with several Key Statistics of the three plans in aggregate.

CDHP Overall Trend Summaries:

CDHP Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$62.41**	
Utilization	$2.72	4.4%
Unit Cost	($1.53)	(2.5%)
Member Share	($0.01)	(0.0%)
Total Change in Plan Cost Net PMPM	**$1.17**	**1.9%**
Previous Period - Plan Cost Net PMPM	**$61.24**	

Top moving indications and most notable drug changes within the indications are as follows:

- **Cancer**: Previous ranked 2nd, currently ranked 7th by Plan Cost Net.
  - Plan Cost Net ↓ $239k (-22.5%) to current $822k.
  - Plan Cost Net PMPM ↓ $1.25 (-10.0%) to current $11.24.
  - Patient Count ↑ 3 to current count of 165.
  - Adjusted Rxs ↓ 2 to current count of 461.

- **Notable Drug Changes within Indication:**
  - **Lenalidomide (Generic for Revlimid)**
    - Top ranking drug for cancer indication by Plan Cost Net.
    - Plan Cost Net: New, current $113k.
    - Plan Cost Net PMPM: New, current $1.54.
    - Patient Count: New, current count of 3.
    - Adjusted Rxs: New, current count of 9.
  - **Onureg**
    - Currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net: New, current $95k.
    - Plan Cost Net PMPM: New, current $1.30.
    - Patient Count: New, current count of 1.
    - Adjusted Rxs: New, current count of 4.
  - **Revlimid**
    - Previous ranked 1st, currently ranked 9th by Plan Cost Net.

        - Plan Cost Net ↓ $167k (-82.8%) to current $35k.
        - Plan Cost Net PMPM ↓ $1.90 (-80.0%) to current $.47.
        - Patient Count ↓ 2 to current count of 2.
        - Adjusted Rxs ↓ 10 to current count of 3.

- **Ophthalmic Conditions**: Previous ranked 13th, currently ranked 7th.
    - Plan Cost Net ↑ $113k (115.3%) to current $210k.
    - Plan Cost Net PMPM ↑ $1.73 (115.3%) to current $2.88.
    - Patient Count ↓ 8 to current count of 145.
    - Adjusted Rxs ↑ 26 to current count of 246.

- **Notable Drug Changes within Indication:**

    - **Tepezza**
        - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
        - Plan Cost Net ↑ $96k (165.8%) to current $153k.
        - Plan Cost Net PMPM ↑ $1.42 (209%) to current $2.10.
        - Patient Count remains at 1.
        - Adjusted Rxs ↑ 2 to current count of 3.
    - **Eylea**
        - Previous ranked 2nd, currently ranked 2nd by Plan Cost Net.
        - Plan Cost Net ↑ $27k (98.8%) to current $55k.
        - Plan Cost Net PMPM ↑ $.43 (131.1%) to current $.75.
        - Patient Count ↑ 4 to current 12.
        - Adjusted Rxs ↑ 15 to current count of 30.

    - **Other drug changes in this indication were not notable.**

- **Neuromyelitis Optica Spectrum Disorder**: New, currently ranked 10th
    - Plan Cost Net: New, current $130k.
    - Plan Cost Net PMPM: New, current $1.77.
    - Patient Count: New, current count of 1.
    - Adjusted Rxs: New, current count of 6.

- **Notable Drug Changes within Indication:**

    - **Uplizna**
        - New, currently ranked 1st by Plan Cost Net.
        - Plan Cost Net: New, current $130k.
        - Plan Cost Net PMPM: New, current $1.77.
        - Patient Count: New, current count of 1.
        - Adjusted Rxs: New, current count of 6.

    - **No other drugs utilized within this indication.**

Peer Comparison:

- Peer: ESI CDH Program
- PEBP CDHP is outperforming the peer.
- Peer experienced Plan Cost Net PMPM of $83.14 compared to CDHP PEBP of $62.41.
- Peer experienced Trend of 9.9%, compared to CDHP PEBP Trend of 1.9%

EPO Overall Trend Summaries:

EPO Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$160.53**	
Utilization	$5.10	3.5%
Unit Cost	$3.05	2.1%
Member Share	$4.87	3.3%
Total Change in Plan Cost Net PMPM	**$13.02**	**8.8%**
Previous Period - Plan Cost Net PMPM	**$147.51**	

Top moving indications and most notable drug changes within the indications are as follows:

- **Endocrine Disorders**: Previous ranked 3rd, currently ranked 2nd.
  - Plan Cost Net ↑ $82k (25.6%) to current $402k.
  - Plan Cost Net PMPM ↑ $6.94 (43.2%) to current $22.98.
  - Patient Count ↓ 5 to current count of 20.
  - Adjusted Rxs ↓ 13 to current count of 53.

- **Notable Drug Changes within Indication:**

  - **Korlym**
    - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $102k (35.8%) to current $386k.
    - Plan Cost Net PMPM ↑ $7.82 (54.9%) to current $22.08.
    - Patient Count ↑ 1 to current count of 2.
    - Adjusted Rxs ↑ 3 to current count of 7.
  - **Somatuline Depot**
    - Previous ranked 2nd, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net ↓ $13k (-49.5%) to current $13k.
    - Plan Cost Net PMPM ↓ $.56 (-42.4%) to current $.76.
    - Patient Count ↑ 1 to current count of 2.
    - Adjusted Rxs ↓ 12 to current count of 2.

  - **Other drug changes in this indication were not notable.**

- **Narcolepsy**: Previous ranked 21st, currently ranked 7th.
  - Plan Cost Net ↑ $45k (125.4%) to current $81k.
  - Plan Cost Net PMPM ↑ $2.82 (157%) to current $4.62.
  - Patient Count ↑ 1 to current count of 2.
  - Adjusted Rxs ↑ 4 to current count of 7.

- **Notable Drug Changes within Indication:**

  - **Sodium Oxybate**
    - New, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net: New, current $11k.
    - Plan Cost Net PMPM: New, current $2.62.
    - Patient Count: New, current count of 1
    - Adjusted Rxs: New, current count of 4
  - **Wakix**
    - New, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net: New, current $12k.
    - Plan Cost Net PMPM: New, current $2.01.
    - Patient Count: New, current 1.
    - Adjusted Rxs: New, current count of 3.

  - **No other drugs utilized within this indication.**

- **Ophthalmic Conditions**: Previous ranked 10th, currently ranked 20th.
  - Plan Cost Net ↓ $50k (-66.8%) to current $25k.
  - Plan Cost Net PMPM ↓ $2.32 (-62.2%) to current $1.41.
  - Patient Count ↓ 11 to current count of 41.
  - Adjusted Rxs ↑ 26 to current count of 246.

- **Notable Drug Changes within Indication:**

  - **Oxervate**
    - Previous ranked 1st, currently no utilization.
    - Plan Cost Net ↓ $53k (-100%) to current $0.
    - Plan Cost Net PMPM ↓ $2.64 (-100%) to current $0.
    - Patient Count ↓ 1 to current count of 0.
    - Adjusted Rxs ↑ 15 to current count of 30.

  - **Other drug changes in this indication were not notable.**

Peer Comparison:

- Government – West Region/SaveOn (custom peer created for PEBP EPO plan)
- The peer is outperforming PEBP EPO.
- Peer experienced Plan Cost Net PMPM of $99.80 compared to PEBP EPO of $147.51
- Peer experienced Trend of 6.2%, compared to PEBP EPO of 8.8%

PPO Overall Trend Summaries:

PPO Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$91.51**	
Utilization	$2.20	2.7%
Unit Cost	$6.41	7.9%
Member Share	$1.85	2.3%
Total Change in Plan Cost Net PMPM	**$10.47**	**12.9%**
Previous Period - Plan Cost Net PMPM	**$81.04**	

Top moving indications and most notable drug changes within the indications are as follows:

- **Inflammatory Conditions**: Previous ranked 1st, currently ranked 1st.
  - Plan Cost Net ↑ $405k (58.6%) to current $1.1m.
  - Plan Cost Net PMPM ↑ $3.09 (18.3%) to current $20.03.
  - Patient Count ↑ 62 to current count of 189.
  - Adjusted Rxs ↑ 205 to current count of 616.

- **Notable Drug Changes within Indication:**

  - **Humira (CF) Pen**
    - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $75k (32.4%) to current $307k.
    - Plan Cost Net PMPM ↓ $.07 (-1.2%) to current $5.61.
    - Patient Count ↑ 7 to current count of 27.
    - Adjusted Rxs ↑ 19 to current count of 73.
  - **Stelara**
    - Previous ranked 4th, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net ↑ $102k (224.7%) to current $147k.
    - Plan Cost Net PMPM ↑ $1.58 (142.2%) to current $2.68.
    - Patient Count ↑ 5 to current count of 10.
    - Adjusted Rxs ↑ 14 to current count of 30.
  - **Rinvoq**
    - Previous ranked 11th, currently ranked 4th by Plan Cost Net.
    - Plan Cost Net ↑ $71k (587.2%) to current $83k.
    - Plan Cost Net PMPM ↑ $1.22 (412.6%) to current $1.51.
    - Patient Count ↑ 6 to current count of 8.
    - Adjusted Rxs ↑ 20 to current count of 24.

- **Diabetes**: Previous ranked 2nd, currently ranked 2nd.
  - Plan Cost Net ↑ $329k (80.7%) to current $737k.
  - Plan Cost Net PMPM ↑ $3.47 (34.8%) to current $13.45.
  - Patient Count ↑ 365 to current count of 1,009.

- Adjusted Rxs ↑ 2,018 to current count of 5,454.

- **Notable Drug Changes within Indication:**

  - **Ozempic**
    - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $120k (112%) to current $227k.
    - Plan Cost Net PMPM ↑ $1.52 (58.1%) to current $4.14.
    - Patient Count ↑ 98 to current count of 193.
    - Adjusted Rxs ↑ 318 to current count of 577.
  - **Mounjaro**
    - Previous ranked 11th, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net ↑ $126k (1,940.6%%) to current $133k.
    - Plan Cost Net PMPM ↑ $2.26 (1,422%) to current $2.42.
    - Patient Count ↑ 96 to current count of 103.
    - Adjusted Rxs ↑ 301 to current count of 314.
  - **Rybelsus**
    - Previous ranked 6th, currently ranked 5th by Plan Cost Net.
    - Plan Cost Net ↓ $21k (160.2%) to current $33k.
    - Plan Cost Net PMPM ↑ $.29 (94.1%) to current $.61.
    - Patient Count ↑ 16 to current count of 26.
    - Adjusted Rxs ↑ 52 to current count of 85.

- **Ophthalmic Conditions**: Previous ranked 22nd, currently ranked 6th.
  - Plan Cost Net ↑ $265k (716.5%) to current $302k.
  - Plan Cost Net PMPM ↑ $4.61 (509.0%) to current $5.52.
  - Patient Count ↑ 39 to current count of 110.
  - Adjusted Rxs ↑ 97 to current count of 232.

- **Notable Drug Changes within Indication:**

  - **Tepezza**
    - New, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net: New, current $247k.
    - Plan Cost Net PMPM: New, current $4.51.
    - Patient Count: New, current count of 1.
    - Adjusted Rxs: New, current count of 4.

  - **Other drug changes in this indication were not notable.**

Peer Comparison:

- Government – West Region/SaveOn (custom peer created for PEBP PPO plan)
- PEBP PPO is outperforming the peer in Plan Cost Net, however PEBP PPO experienced a higher Trend.
- PEBP PPO experienced Plan Cost Net PMPM of $91.51 compared to peer of $99.80.
- Peer experienced Trend of 6.2%, compared to PEBP PPO of 12.9%.

Total Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$85.14**	
Utilization	$2.30	2.9%
Unit Cost	$1.73	2.2%
Member Share	$2.52	3.2%
Total Change in Plan Cost Net PMPM	**$6.55**	**8.3%**
Previous Period - Plan Cost Net PMPM	**$78.59**	

Summary of Total – Overall the main driver of Trend was Specialty Utilization driven by an increase of 14.4% in Specialty patients. This resulted in an 18.8% increase in Specialty Days of Therapy.

Trend was mitigated by increased rebates of 40.6%. This produced a negative Unit Cost Trend of (-13.3%) on Specialty drugs and reduced NonSpecialty Unit Cost Trend to 1.5%, combined is 2.2%.

Member Cost contributed to Trend on both Specialty and NonSpecialty drugs. This is due to increased Utilization on Specialty drugs and Drug Mix on NonSpecialty drugs. Primary driven by utilization of more expensive brand drugs.

Key Statistics:

Nevada PEBP Total			
Description	Q1 FY23	Q1 FY24	Change
Average Members per Month	48,446	48,586	-0.3%
Number of Unique patients	24,546	25,166	-2.5%
Members Utilizing the Benefit	50.7%	51.8%	-1.1
Gross Cost/Adjusted Rx	$136.86	$122.29	11.9%
Plan Spend	$19,816,299	$21,395,922	18.3%
Rebates (estimated)	$7,442,446	$5,292,515	40.6%
Plan Cost Net	$12,373,853	$11,454,879	8.0%
Plan Cost Net PMPM	$85.14	$78.59	8.3%
Non-Specialty Plan Cost Net PMPM	$36.49	$33.88	7.7%
Specialty Plan Cost Net PMPM	$48.65	$44.71	8.8%
Generic Fill Rate	86.5%	85.7%	0.8
90 Day Utilization	61.4%	61.8%	-0.4
Retail - Maintenance 90 Utilization	28.4%	30.6%	-2.1
Home Delivery Utilization	32.9%	31.2%	1.7
Member Cost Net %	26.7%	28.9%	-2.2

END OF REPORT

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 September 30, 2023:

- 4.3.1 Q1 UMR – Obesity Care Management Program
- 4.3.2 Q1 UMR – Diabetes Care Management Program
- 4.3.3 Q1 Sierra Healthcare Options – Utilization and Large Case Management
- 4.3.4 Q1 Sierra Healthcare Options and United Healthcare Plus Network – PPO Network
- 4.3.5 Q1 United Healthcare – Basic Life Insurance
- 4.3.6 Q1 Express Scripts – Summary Report
- **4.3.7 Q1 Express Scripts – Utilization Report**

Nevada PEBP Q1 FY24 Report

7/1/2023 – 9/30/2023

Report Includes:

- CDHP Comparison Data from Q1 FY23 to Q1 FY24
- EPO Comparison Data from Q1 FY23 to Q1 FY24
- PPO Comparison Data from Q1 FY23 to Q1 FY24
- CDHP, EPO, PPO Breakout Data from Q1 FY23 to Q1 FY24
- Summary Comparison Data from Q1 FY24
- Key Metric Breakout Data from Q1 FY24

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)
12/15/24

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN
+ Q1 FY24 vs Q1 FY23

Membership Summary	Q1 FY 2024	Q1 FY 2023	Change
Member Count (Membership)	48,446	48,586	-0.3%
Utilizing Member Count (Patients)	24,546	25,166	-2.5%
Percent Utilizing (Utilization)	50.7%	51.8%	-1.1

Claim Summary	Q1 FY 2024	Q1 FY 2023	Change
Net Claims (Total Adjusted Rx's)	177,729	174,967	1.6%
Claims per Elig Member per Month (Claims PMPM)	1.22	1.20	1.9%
Total Claims for Generic (Generic ARx)	153,759	150,005	2.5%
Total Claims for Brand (Brand ARx)	23,970	24,962	-4.0%
Total Claims for Multisource Brand Claims (MSB ARx)	872	764	14.1%
Total Non-Specialty Claims	175,556	173,120	1.4%
Total Specialty Claims	2,173	1,847	17.7%
Generic % of Total Claims (GFR)	**86.5%**	**85.7%**	**0.8**
Generic Effective Rate (GCR)	99.4%	99.5%	-0.1
Mail Order Claims	52,190	48,209	8.3%
Mail Penetration Rate*	32.9%	31.2%	1.7

Claims Cost Summary	Q1 FY 2024	Q1 FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$24,323,897**	**$21,395,922**	**13.7%**
Total Generic Gross Cost	$2,475,465	$2,709,598	-8.6%
Total Brand Gross Cost	$21,848,432	$18,686,325	16.9%
Total MSB Gross Cost	$417,579	$381,411	9.5%
Total Ingredient Cost	$23,568,796	$20,696,378	13.9%
Total Dispensing Fee	$735,972	$679,994	8.2%
Total Other (e.g. tax)	$19,129	$19,551	-2.2%
Avg Total Cost per Claim (Gross Cost/ARx)	**$136.86**	**$122.29**	**11.9%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$16.10	$18.06	-10.9%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$911.49	$748.59	21.8%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$478.88	$499.23	-4.1%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN
+ Q1 FY24 vs Q1 FY23

Member Cost Summary	Q1 FY 2024	Q1 FY 2023	Change
Total Member Cost Share	**$4,507,598**	**$4,648,528**	**-3.0%**
Generic Cost Share	$1,093,287	$1,205,465	-9.3%
Brand Cost Share	$3,414,310	$3,443,064	-0.8%
MSB Cost Share	$61,286	$84,247	-27.3%
Total Copay	$3,741,870	$3,672,194	1.9%
Total Deductible	$765,728	$976,335	-21.6%
Avg Copay per Claim (Member Cost Share/ARx)	**$25.36**	**$26.57**	**-4.5%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$7.11	$8.04	-11.5%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$142.44	$137.93	3.3%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$70.28	$110.27	-36.3%
Copay % of Total Prescription Cost (Member Cost Share %)	**18.5%**	**21.7%**	**-3.2**

Plan Cost Summary	Q1 FY 2024	Q1 FY 2023	Change
Total Plan Cost (Plan Cost)	**$19,816,299**	**$16,747,394**	**18.3%**
Generic Plan Cost	$1,382,178	$1,504,133	-8.1%
Brand Plan Cost	$18,434,121	$15,243,261	20.9%
MSB Plan Cost	$356,293	$297,164	19.9%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$8,985,248	$7,874,103	14.1%
Total Specialty Drug Cost (Specialty Plan Cost)	$10,831,051	$8,873,291	22.1%
Avg Plan Cost per Claim (Plan Cost/ARx)	$111.50	$95.72	16.5%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$8.99	$10.03	-10.4%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$769.05	$610.66	25.9%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$408.59	$388.96	5.0%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$51.18	$45.48	12.5%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$4,984.38	$4,804.16	3.8%
Plan Cost PMPM	**$136.35**	**$114.90**	**18.7%**
Non-Specialty Plan Cost PMPM	$61.82	$54.02	14.4%
Specialty Plan Cost PMPM	$74.52	$60.88	22.4%
Specialty % of Plan Cost	54.7%	53.0%	1.7
Net Plan Cost PMPM (factoring Rebates)	**$85.14**	**$78.59**	**8.3%**
Non-Specialty Plan Cost PMPM	$36.49	$33.88	7.7%
Specialty Plan Cost PMPM	$48.65	$44.71	8.8%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN

+ Q1 FY24 vs Q1 FY23

Membership Summary	Q1 FY 2024	Q1 FY 2023	Change
Member Count (Membership)	24,365	28,326	-14.0%
Utilizing Member Count (Patients)	11,703	13,902	-15.8%
Percent Utilizing (Utilization)	48.0%	49.1%	-1.1

Claim Summary	Q1 FY 2024	Q1 FY 2023	Change
Net Claims (Total Adjusted Rx's)	83,031	93,746	-11.4%
Claims per Elig Member per Month (Claims PMPM)	1.14	1.10	3.0%
Total Claims for Generic (Generic ARx)	72,817	80,924	-10.0%
Total Claims for Brand (Brand ARx)	10,214	12,822	-20.3%
Total Claims for Multisource Brand Claims (MSB ARx)	315	382	-17.5%
Total Non-Specialty Claims	82,077	92,793	-11.5%
Total Specialty Claims	954	953	0.1%
Generic % of Total Claims (GFR)	**87.7%**	**86.3%**	**1.4**
Generic Effective Rate (GCR)	99.6%	99.5%	0.1
Mail Order Claims	23,453	25,149	-6.7%
Mail Penetration Rate*	31.8%	30.6%	1.2

Claims Cost Summary	Q1 FY 2024	Q1 FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$10,204,216**	**$10,623,820**	**-3.9%**
Total Generic Gross Cost	$1,027,449	$1,291,483	-20.4%
Total Brand Gross Cost	$9,176,768	$9,332,336	-1.7%
Total MSB Gross Cost	$139,084	$195,871	-29.0%
Total Ingredient Cost	$9,854,938	$10,250,397	-3.9%
Total Dispensing Fee	$342,436	$364,675	-6.1%
Total Other (e.g. tax)	$6,843	$8,748	-21.8%
Avg Total Cost per Claim (Gross Cost/ARx)	**$122.90**	**$113.33**	**8.4%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$14.11	$15.96	-11.6%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$898.45	$727.84	23.4%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$441.54	$512.75	-13.9%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN

+ Q1 FY24 vs Q1 FY23

Member Cost Summary	Q1 FY 2024	Q1 FY 2023	Change
Total Member Cost Share	**$2,535,118**	**$2,893,147**	**-12.4%**
Generic Cost Share	$552,403	$724,309	-23.7%
Brand Cost Share	$1,982,715	$2,168,838	-8.6%
MSB Cost Share	$34,790	$69,472	-49.9%
Total Copay	$1,771,104	$1,918,890	-7.7%
Total Deductible	$764,014	$974,257	-21.6%
Avg Copay per Claim (Member Cost Share/ARx)	**$30.53**	**$30.86**	**-1.1%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$7.59	$8.95	-15.2%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$194.12	$169.15	14.8%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$110.45	$181.86	-39.3%
Copay % of Total Prescription Cost (Member Cost Share %)	**24.8%**	**27.2%**	**-2.4**

Plan Cost Summary	Q1 FY 2024	Q1 FY 2023	Change
Total Plan Cost (Plan Cost)	**$7,669,098**	**$7,730,673**	**-0.8%**
Generic Plan Cost	$475,045	$567,175	-16.2%
Brand Plan Cost	$7,194,053	$7,163,498	0.4%
MSB Plan Cost	$104,294	$126,399	-17.5%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$2,975,171	$3,144,721	-5.4%
Total Specialty Drug Cost (Specialty Plan Cost)	$4,693,927	$4,585,952	2.4%
Avg Plan Cost per Claim (Plan Cost/ARx)	$92.36	$82.46	12.0%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$6.52	$7.01	-6.9%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$704.33	$558.69	26.1%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$331.09	$330.89	0.1%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$36.25	$33.89	7.0%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$4,920.26	$4,812.12	2.2%
Plan Cost PMPM	**$104.92**	**$90.97**	**15.3%**
Non-Specialty Plan Cost PMPM	$40.70	$37.01	10.0%
Specialty Plan Cost PMPM	$64.22	$53.97	19.0%
Specialty % of Plan Cost	61.2%	59.3%	1.9
Net Plan Cost PMPM (factoring Rebates)	**$62.37**	**$61.24**	**1.8%**
Non-Specialty Plan Cost PMPM	$20.86	$21.20	-1.6%
Specialty Plan Cost PMPM	$41.51	$40.04	3.7%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ Q1 FY24 vs Q1 FY23

Membership Summary	Q1 FY 2024	Q1 FY 2023	Change
Member Count (Membership)	5,825	6,644	-12.3%
Utilizing Member Count (Patients)	3,492	4,124	-15.3%
Percent Utilizing (Utilization)	59.9%	62.1%	-2.2

Claim Summary	Q1 FY 2024	Q1 FY 2023	Change
Net Claims (Total Adjusted Rx's)	31,089	34,568	-10.1%
Claims per Elig Member per Month (Claims PMPM)	1.78	1.73	2.6%
Total Claims for Generic (Generic ARx)	26,673	29,572	-9.8%
Total Claims for Brand (Brand ARx)	4,416	4,996	-11.6%
Total Claims for Multisource Brand Claims (MSB ARx)	187	165	13.3%
Total Non-Specialty Claims	30,698	34,139	-10.1%
Total Specialty Claims	391	429	-8.9%
Generic % of Total Claims (GFR)	**85.8%**	**85.5%**	**0.3**
Generic Effective Rate (GCR)	99.3%	99.4%	-0.1
Mail Order Claims	9,359	9,024	3.7%
Mail Penetration Rate*	32.9%	28.8%	4.1

Claims Cost Summary	Q1 FY 2024	Q1 FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$4,927,524**	**$5,013,397**	**-1.7%**
Total Generic Gross Cost	$442,768	$578,494	-23.5%
Total Brand Gross Cost	$4,484,755	$4,434,903	1.1%
Total MSB Gross Cost	$102,466	$92,781	10.4%
Total Ingredient Cost	$4,796,842	$4,879,463	-1.7%
Total Dispensing Fee	$125,926	$129,928	-3.1%
Total Other (e.g. tax)	$4,755	$4,006	18.7%
Avg Total Cost per Claim (Gross Cost/ARx)	**$158.50**	**$145.03**	**9.3%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$16.60	$19.56	-15.1%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$1,015.57	$887.69	14.4%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$547.95	$562.31	-2.6%

Express Scripts
By EVERNORTH
Confidential Information

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ Q1 FY24 vs Q1 FY23

Member Cost Summary	Q1 FY 2024	Q1 FY 2023	Change
Total Member Cost Share	**$667,120**	**$806,053**	**-17.2%**
Generic Cost Share	$184,133	$206,839	-11.0%
Brand Cost Share	$482,987	$599,214	-19.4%
MSB Cost Share	$15,931	$11,442	39.2%
Total Copay	$665,406	$803,975	-17.2%
Total Deductible	$1,714	$2,078	-17.5%
Avg Copay per Claim (Member Cost Share/ARx)	**$21.46**	**$23.32**	**-8.0%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.90	$6.99	-1.3%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$109.37	$119.94	-8.8%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$85.19	$69.35	22.8%
Copay % of Total Prescription Cost (Member Cost Share %)	**13.5%**	**16.1%**	**-2.6**

Plan Cost Summary	Q1 FY 2024	Q1 FY 2023	Change
Total Plan Cost (Plan Cost)	**$4,260,404**	**$4,207,344**	**1.3%**
Generic Plan Cost	$258,635	$371,655	-30.4%
Brand Plan Cost	$4,001,768	$3,835,689	4.3%
MSB Plan Cost	$86,535	$81,338	6.4%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$1,966,606	$2,079,326	-5.4%
Total Specialty Drug Cost (Specialty Plan Cost)	$2,293,797	$2,128,018	7.8%
Avg Plan Cost per Claim (Plan Cost/ARx)	$137.04	$121.71	12.6%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$9.70	$12.57	-22.8%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$906.20	$767.75	18.0%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$462.75	$492.96	-6.1%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$64.06	$60.91	5.2%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$5,866.49	$4,960.42	18.3%
Plan Cost PMPM	**$243.80**	**$211.08**	**15.5%**
Non-Specialty Plan Cost PMPM	$112.54	$104.32	7.9%
Specialty Plan Cost PMPM	$131.26	$106.76	22.9%
Specialty % of Plan Cost	53.8%	50.6%	3.2
Net Plan Cost PMPM (factoring Rebates)	**$160.48**	**$147.50**	**8.8%**
Non-Specialty Plan Cost PMPM	$68.65	$67.35	1.9%
Specialty Plan Cost PMPM	$91.83	$80.15	14.6%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN

+ Q1 FY24 vs Q1 FY23

Membership Summary	Q1 FY 2024	Q1 FY 2023	Change
Member Count (Membership)	18,259	13,619	34.1%
Utilizing Member Count (Patients)	9,373	7,170	30.7%
Percent Utilizing (Utilization)	51.3%	52.6%	-1.3

Claim Summary	Q1 FY 2024	Q1 FY 2023	Change
Net Claims (Total Adjusted Rx's)	63,609	46,653	36.3%
Claims per Elig Member per Month (Claims PMPM)	1.16	1.14	1.7%
Total Claims for Generic (Generic ARx)	54,269	39,509	37.4%
Total Claims for Brand (Brand ARx)	9,340	7,144	30.7%
Total Claims for Multisource Brand Claims (MSB ARx)	370	217	70.5%
Total Non-Specialty Claims	62,781	46,188	35.9%
Total Specialty Claims	828	465	78.1%
Generic % of Total Claims (GFR)	**85.3%**	**84.7%**	**0.6**
Generic Effective Rate (GCR)	99.3%	99.5%	-0.1
Mail Order Claims	19,378	14,036	38.1%
Mail Penetration Rate*	34.5%	34.4%	0.1

Claims Cost Summary	Q1 FY 2024	Q1 FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$9,192,157**	**$5,758,706**	**59.6%**
Total Generic Gross Cost	$1,005,248	$839,620	19.7%
Total Brand Gross Cost	$8,186,909	$4,919,085	66.4%
Total MSB Gross Cost	$176,029	$92,759	89.8%
Total Ingredient Cost	$8,917,016	$5,566,518	60.2%
Total Dispensing Fee	$267,610	$185,391	44.3%
Total Other (e.g. tax)	$7,531	$6,797	10.8%
Avg Total Cost per Claim (Gross Cost/ARx)	**$144.51**	**$123.44**	**17.1%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$18.52	$21.25	-12.8%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$876.54	$688.56	27.3%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$475.75	$427.46	11.3%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN

+ Q1 FY24 vs Q1 FY23

Member Cost Summary	Q1 FY 2024	Q1 FY 2023	Change
Total Member Cost Share	**$1,305,360**	**$949,329**	**37.5%**
Generic Cost Share	$356,751	$274,317	30.1%
Brand Cost Share	$948,609	$675,012	40.5%
MSB Cost Share	$10,565	$3,333	217.0%
Total Copay	$1,305,360	$949,329	37.5%
Total Deductible	$0	$0	0.0%
Avg Copay per Claim (Member Cost Share/ARx)	**$20.52**	**$20.35**	**0.8%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.57	$6.94	-5.3%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$101.56	$94.49	7.5%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$28.55	$15.36	85.9%
Copay % of Total Prescription Cost (Member Cost Share %)	**14.2%**	**16.5%**	**-2.3**

Plan Cost Summary	Q1 FY 2024	Q1 FY 2023	Change
Total Plan Cost (Plan Cost)	**$7,886,797**	**$4,809,377**	**64.0%**
Generic Plan Cost	$648,497	$565,303	14.7%
Brand Plan Cost	$7,238,300	$4,244,074	70.6%
MSB Plan Cost	$165,465	$89,426	85.0%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$4,043,471	$2,650,055	52.6%
Total Specialty Drug Cost (Specialty Plan Cost)	$3,843,326	$2,159,321	78.0%
Avg Plan Cost per Claim (Plan Cost/ARx)	$123.99	$103.09	20.3%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$11.95	$14.31	-16.5%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$774.98	$594.08	30.5%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$447.20	$412.10	8.5%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$64.41	$57.38	12.3%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$4,641.70	$4,643.70	0.0%
Plan Cost PMPM	**$143.98**	**$117.71**	**22.3%**
Non-Specialty Plan Cost PMPM	$73.82	$64.86	13.8%
Specialty Plan Cost PMPM	$70.16	$52.85	32.8%
Specialty % of Plan Cost	48.7%	44.9%	3.8
Net Plan Cost PMPM (factoring Rebates)	**$91.48**	**$81.03**	**12.9%**
Non-Specialty Plan Cost PMPM	$47.08	$43.90	7.2%
Specialty Plan Cost PMPM	$44.39	$37.13	19.6%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO, CDHP, & PPO PLAN

+ Q1 FY24 vs Q1 FY23

Membership Summary	Total	EPO	CDHP	PPO
Member Count (Membership)	48,446	5,825	24,365	18,259
Utilizing Member Count (Patients)	24,546	3,492	11,703	9,373
Percent Utilizing (Utilization)	50.7%	59.9%	48.0%	51.3%

Claim Summary	Total	EPO	CDHP	PPO
Net Claims (Total Rx's)	177,729	31,089	83,031	63,609
Claims per Elig Member per Month (Claims PMPM)	1.22	1.78	1.14	1.16
Total Claims for Generic (Generic Rx)	153,759	26,673	72,817	54,269
Total Claims for Brand (Brand Rx)	23,970	4,416	10,214	9,340
Total Claims for Multisource Brand Claims (MSB Rx)	872	187	315	370
Total Non-Specialty Claims	175,556	30,698	82,077	62,781
Total Specialty Claims	2,173	391	954	828
Generic % of Total Claims (GFR)	**86.5%**	**85.8%**	**87.7%**	**85.3%**
Generic Effective Rate (GCR)	99.4%	99.3%	99.6%	99.3%
Mail Order Claims	52,190	9,359	23,453	19,378
Mail Penetration Rate*	32.9%	32.9%	31.8%	34.5%

Claims Cost Summary	Total	EPO	CDHP	PPO
Total Prescription Cost (Total Gross Cost)	**$24,323,897**	**$4,927,524**	**$10,204,216**	**$9,192,157**
Total Generic Gross Cost	$2,475,465	$442,768	$1,027,449	$1,005,248
Total Brand Gross Cost	$21,848,432	$4,484,755	$9,176,768	$8,186,909
Total MSB Gross Cost	$417,579	$102,466	$139,084	$176,029
Total Ingredient Cost	$23,568,796	$4,796,842	$9,854,938	$8,917,016
Total Dispensing Fee	$468,362	$125,926	$342,436	$267,610
Total Other (e.g. tax)	$19,129	$4,755	$6,843	$7,531
Avg Total Cost per Claim (Gross Cost/Rx)	**$136.86**	**$158.50**	**$122.90**	**$144.51**
Avg Total Cost for Generic (Generic Gross Cost/Generic Rx)	$16.10	$16.60	$14.11	$18.52
Avg Total Cost for Brand (Brand Gross Cost/Brand Rx)	$911.49	$1,015.57	$898.45	$876.54
Avg Total Cost for MSB (MSB Gross Cost/MSB Rx)	$478.88	$547.95	$441.54	$475.75

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO, CDHP, & PPO PLAN

+ Q1 FY24 vs Q1 FY23

Member Cost Summary	Total	EPO	CDHP	PPO
Total Member Cost Share	**$4,507,598**	**$667,120**	**$2,535,118**	**$1,305,360**
Generic Cost Share	$1,093,287	$184,133	$552,403	$356,751
Brand Cost Share	$3,414,310	$482,987	$1,982,715	$948,609
MSB Cost Share	$61,286	$15,931	$34,790	$10,565
Total Copay	$3,741,870	$665,406	$1,771,104	$1,305,360
Total Deductible	$765,728	$1,714	$764,014	$0
Avg Copay per Claim (Member Cost Share/Rx)	**$25.36**	**$21.46**	**$30.53**	**$20.52**
Avg Copay for Generic (Generic Member Cost Share/Generic Rx)	$7.11	$6.90	$7.59	$6.57
Avg Copay for Brand (Brand Member Cost Share/Brand Rx)	$142.44	$109.37	$194.12	$101.56
Avg Copay for MSB (MSB Member Cost Share/MSB Rx)	$70.28	$85.19	$110.45	$28.55
Copay % of Total Prescription Cost (Member Cost Share %)	**18.5%**	**13.5%**	**24.8%**	**14.2%**

Plan Cost Summary	Total	EPO	CDHP	PPO
Total Plan Cost (Plan Cost)	**$19,816,299**	**$4,260,404**	**$7,669,098**	**$7,886,797**
Generic Plan Cost	$1,382,178	$258,635	$475,045	$648,497
Brand Plan Cost	$18,434,121	$4,001,768	$7,194,053	$7,238,300
MSB Plan Cost	$356,293	$86,535	$104,294	$165,465
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$8,985,248	$1,966,606	$2,975,171	$4,043,471
Total Specialty Drug Cost (Specialty Plan Cost)	$10,831,051	$2,293,797	$4,693,927	$3,843,326
Avg Plan Cost per Claim (Plan Cost/Rx)	$111.50	$137.04	$92.36	$123.99
Avg Plan Cost for Generic (Generic Plan Cost/Generic Rx)	$8.99	$9.70	$6.52	$11.95
Avg Plan Cost for Brand (Brand Plan Cost/Brand Rx)	$769.05	$906.20	$704.33	$774.98
Avg Plan Cost for MSB (MSB Plan Cost/MSB Rx)	$408.59	$462.75	$331.09	$447.20
Avg Non-Specialty Plan Cost per Claim (Plan Cost/Rx)	$51.18	$64.06	$36.25	$64.41
Avg Specialty Plan Cost per Claim (Plan Cost/Rx)	$4,984.38	$5,866.49	$4,920.26	$4,641.70
Plan Cost PMPM	**$136.35**	**$243.80**	**$104.92**	**$143.98**
Non-Specialty Plan Cost PMPM	$61.82	$112.54	$40.70	$73.82
Specialty Plan Cost PMPM	$74.52	$131.26	$64.22	$70.16
Specialty % of Plan Cost	54.7%	53.8%	61.2%	48.7%
Net Plan Cost PMPM (factoring Rebates)	**$85.14**	**$160.48**	**$62.37**	**$91.48**
Non-Specialty Net Plan Cost PMPM	$36.49	$68.65	$20.86	$47.08
Specialty Net Plan Cost PMPM	$48.65	$91.83	$41.51	$44.39

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN

+ Q1 FY24 vs Q1 FY23

State of Nevada PEBP Q1 FY2024				
Description	Grand Total	EPO	CDHP	PPO
Avg Members per Month	48,446	5,825	24,365	18,259
Pct Members Utilizing Benefit	50.7%	59.9%	48.0%	51.3%
Total Plan Cost	$ 19,816,299	$ 4,260,404	$ 7,669,098	$ 7,886,797
Total Days	4,691,859	842,525	2,186,559	1,662,775
Total Adjusted Rxs	177,729	31,089	83,031	63,609
Plan Cost PMPM	$ 136.35	$ 243.80	$ 104.92	$ 143.98
Plan Cost Net PMPM	$ 85.14	$ 160.48	$ 62.37	$ 91.48
Plan Cost/Day	$ 4.22	$ 5.06	$ 3.51	$ 4.74
Plan Cost per Adjusted Rx	$ 111.50	$ 137.04	$ 92.36	$ 123.99
Nbr Rxs PMPM	1.22	1.78	1.14	1.16
Generic Fill Rate	86.5%	85.8%	87.7%	85.3%
Home Delivery Utilization	32.9%	32.9%	31.8%	34.5%
Member Cost %	18.5%	13.5%	24.8%	14.2%
Specialty Percent of Plan Cost	54.7%	53.8%	61.2%	48.7%
Specialty Plan Cost PMPM	$ 74.52	$ 131.26	$ 64.22	$ 70.16
Formulary Compliance Rate	99.4%	99.2%	99.5%	99.3%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN

+ Q1 FY24 vs Q1 FY23

State of Nevada PEBP Q1 FY2024 - Grand Total					
Description	Grand Total	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	48,446	42,165	5,762	12	512
Pct Members Utilizing Benefit	50.7%	48.0%	68.2%	58.3%	82.8%
Total Plan Cost	$ 19,816,299	$ 15,628,064	$ 3,650,876	$ 76,939	$ 460,420
Total Days	4,691,859	3,479,113	1,055,470	2,676	154,600
Total Adjusted Rxs	177,729	133,642	38,413	101	5,573
Plan Cost PMPM	$ 136.35	$ 123.55	$ 211.20	$ 2,137.18	$ 299.75
Plan Cost Net PMPM	$ 85.14	$ 77.89	$ 127.57	$ 1,798.54	$ 163.53
Plan Cost/Day	$ 4.22	$ 4.49	$ 3.46	$ 28.75	$ 2.98
Plan Cost per Adjusted Rx	$ 111.50	$ 116.94	$ 95.04	$ 761.77	$ 82.62
Nbr Rxs PMPM	1.22	1.06	2.22	2.81	3.63
Generic Fill Rate	86.5%	86.1%	87.7%	88.1%	87.4%
Home Delivery Utilization	32.9%	30.7%	39.7%	94.2%	37.2%
Member Cost %	18.5%	17.9%	20.8%	29.5%	20.9%
Specialty Percent of Plan Cost	54.7%	55.5%	51.6%	95.4%	43.2%
Specialty Plan Cost PMPM	$ 74.52	$ 68.58	$ 108.96	$ 2,037.83	$ 129.45
Formulary Compliance Rate	99.4%	99.4%	99.5%	100.0%	99.4%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN

+ Q1 FY24 vs Q1 FY23

State of Nevada PEBP Q1 FY2024 - CDHP					
Description	CDHP	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	24,365	20,257	3,711	8	389
Pct Members Utilizing Benefit	48.0%	44.1%	66.0%	50.0%	83.0%
Total Plan Cost	$ 7,669,098	$ 5,332,477	$ 1,967,246	$ 53,333	$ 316,042
Total Days	2,186,559	1,435,080	629,701	704	121,074
Total Adjusted Rxs	83,031	55,630	23,011	28	4,362
Plan Cost PMPM	$ 104.92	$ 87.75	$ 176.70	$ 2,222.22	$ 270.82
Plan Cost Net PMPM	$ 62.37	$ 52.28	$ 106.10	$ 1,960.19	$ 131.39
Plan Cost/Day	$ 3.51	$ 3.72	$ 3.12	$ 75.76	$ 2.61
Plan Cost per Adjusted Rx	$ 92.36	$ 95.86	$ 85.49	$ 1,904.76	$ 72.45
Nbr Rxs PMPM	1.14	0.92	2.07	1.17	3.74
Generic Fill Rate	87.7%	87.4%	88.6%	85.7%	86.9%
Home Delivery Utilization	31.8%	28.1%	39.0%	94.2%	37.9%
Member Cost %	24.8%	25.1%	24.3%	30.0%	23.0%
Specialty Percent of Plan Cost	61.2%	62.6%	60.4%	99.6%	37.1%
Specialty Plan Cost PMPM	$ 64.22	$ 54.89	$ 106.69	$ 2,212.83	$ 100.36
Formulary Compliance Rate	99.5%	99.5%	99.6%	100.0%	99.5%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ Q1 FY24 vs Q1 FY23

State of Nevada PEBP Q1 FY2024 - EPO					
Description	EPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	5,825	5,046	699	2	78
Pct Members Utilizing Benefit	59.9%	57.5%	76.4%	50.0%	78.2%
Total Plan Cost	$ 4,260,404	$ 3,382,504	$ 803,225	$ 3,090	$ 71,585
Total Days	842,525	642,012	178,921	1,260	20,332
Total Adjusted Rxs	31,089	23,908	6,401	42	738
Plan Cost PMPM	$ 243.80	$ 223.44	$ 383.04	$ 515.00	$ 305.92
Plan Cost Net PMPM	$ 160.48	$ 146.77	$ 254.53	$ 230.05	$ 202.57
Plan Cost/Day	$ 5.06	$ 5.27	$ 4.49	$ 2.45	$ 3.52
Plan Cost per Adjusted Rx	$ 137.04	$ 141.48	$ 125.48	$ 73.57	$ 97.00
Nbr Rxs PMPM	1.78	1.58	3.05	7.00	3.63
Generic Fill Rate	85.8%	85.4%	86.8%	85.7%	89.2%
Home Delivery Utilization	32.9%	32.3%	34.1%	100.0%	36.6%
Member Cost %	13.5%	12.6%	16.8%	10.8%	18.4%
Specialty Percent of Plan Cost	53.8%	55.4%	47.2%	0.0%	58.5%
Specialty Plan Cost PMPM	$ 131.26	$ 123.72	$ 180.78	$ -	$ 178.88
Formulary Compliance Rate	99.2%	99.2%	99.3%	100.0%	98.8%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN

+ Q1 FY24 vs Q1 FY23

State of Nevada PEBP Q1 FY2024 - PPO					
Description	PPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	18,259	16,861	1,352	2	44
Pct Members Utilizing Benefit	51.3%	49.8%	69.9%	100.0%	90.9%
Total Plan Cost	$ 7,886,797	$ 6,913,083	$ 880,405	$ 20,515	$ 72,794
Total Days	1,662,775	1,402,021	246,848	712	13,194
Total Adjusted Rxs	63,609	54,104	9,001	31	473
Plan Cost PMPM	$ 143.98	$ 136.67	$ 217.06	$ 3,419.20	$ 551.47
Plan Cost Net PMPM	$ 91.48	$ 88.05	$ 120.88	$ 2,720.44	$ 382.16
Plan Cost/Day	$ 4.74	$ 4.93	$ 3.57	$ 28.81	$ 5.52
Plan Cost per Adjusted Rx	$ 123.99	$ 127.77	$ 97.81	$ 661.78	$ 153.90
Nbr Rxs PMPM	1.16	1.07	2.22	5.17	3.58
Generic Fill Rate	85.3%	85.2%	85.9%	93.5%	89.4%
Home Delivery Utilization	34.5%	32.5%	45.4%	84.0%	31.3%
Member Cost %	14.2%	14.0%	15.6%	30.4%	13.3%
Specialty Percent of Plan Cost	48.7%	50.1%	36.0%	98.7%	54.8%
Specialty Plan Cost PMPM	$ 70.16	$ 68.53	$ 78.05	$ 3,375.68	$ 302.04
Formulary Compliance Rate	99.3%	99.2%	99.2%	100.0%	100.0%

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 September 30, 2023:

- 4.3.1 Q1 UMR – Obesity Care Management Program
- 4.3.2 Q1 UMR – Diabetes Care Management Program
- 4.3.3 Q1 Sierra Healthcare Options – Utilization and Large Case Management
- 4.3.4 Q1 Sierra Healthcare Options and United Healthcare Plus Network – PPO Network
- 4.3.5 Q1 United Healthcare – Basic Life Insurance
- 4.3.6 Q1 Express Scripts – Summary Report
- 4.3.7 Q1 Express Scripts – Utilization Report
- **4.3.8 Q1 2nd MD – Utilization Report**

2nd.MD
Specializing in Medical Certainty

State of Nevada PEBP

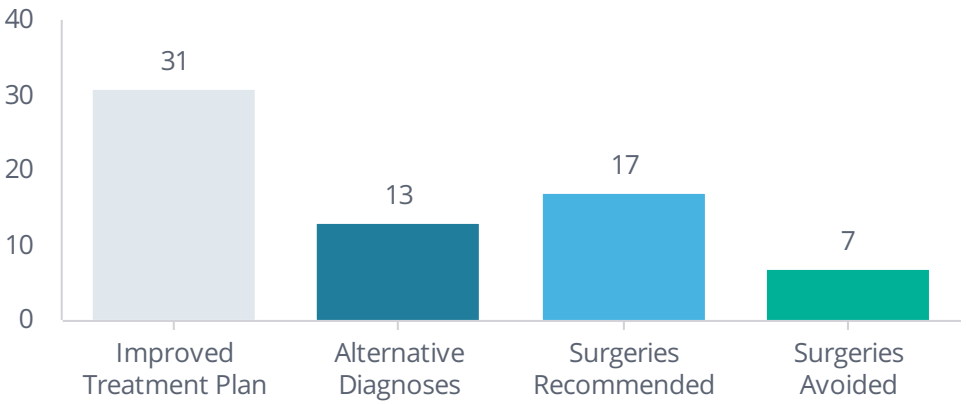
Utilization Report for Q3

EXECUTIVE SUMMARY

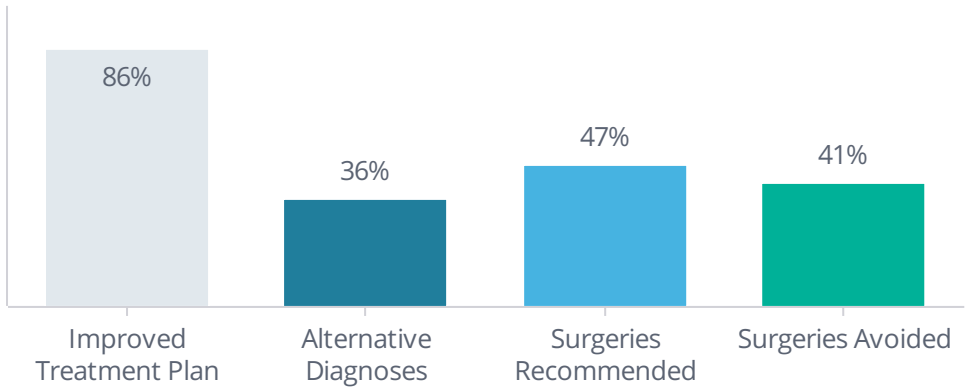
Covered Households	Utilization	Completed Consults	Personalized Local Support	Specialty Care Navigation
22,660	1.01%	36	19	1
Prior Period **27.101**	Prior Period **0.65%**	Prior Period **22**	Prior Period **18**	Prior Period **4**

Activations	Net Promoter Score	Turnaround Time	Total Cost Savings	Savings Per Surgery A...	Savings Per Case
48	89	1.44	$365,929	$48,944	$10,165
Prior Period **170**	Prior Period **88**	Prior Period **2.66**	Prior Period **$116.502**	Prior Period **$17.094**	Prior Period **$5.296**

Clinical Outcomes



Clinical Outcomes Percentage



PROACTIVE OUTREACH PROGRAM

Non-Proactive Outreach Cost Savings Per Case

$9,243

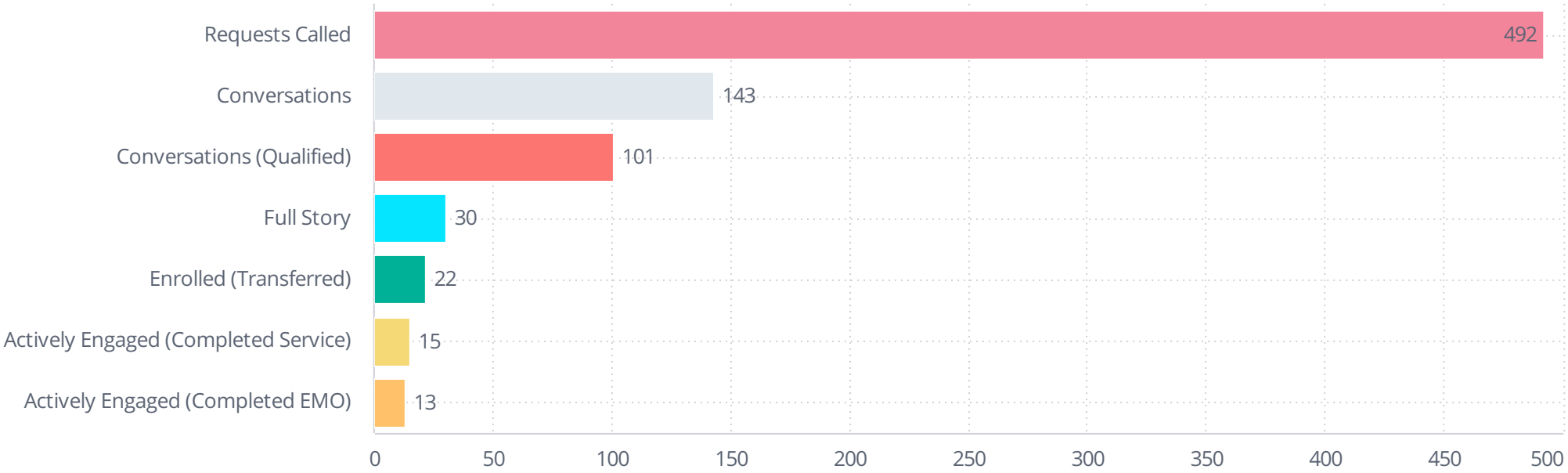
Prior Period **$5.674**

Proactive Outreach Cost Savings Per Case

$10,739

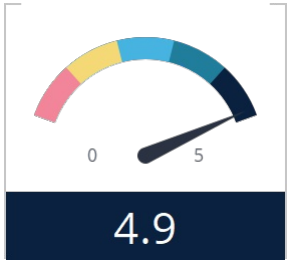
Past Period **$3.665**

Proactive Outreach Engagement

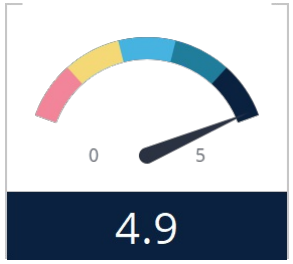


ADDITIONAL INSIGHTS

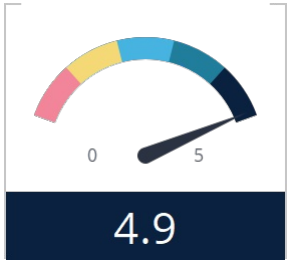
Doctor Care Survey Rating



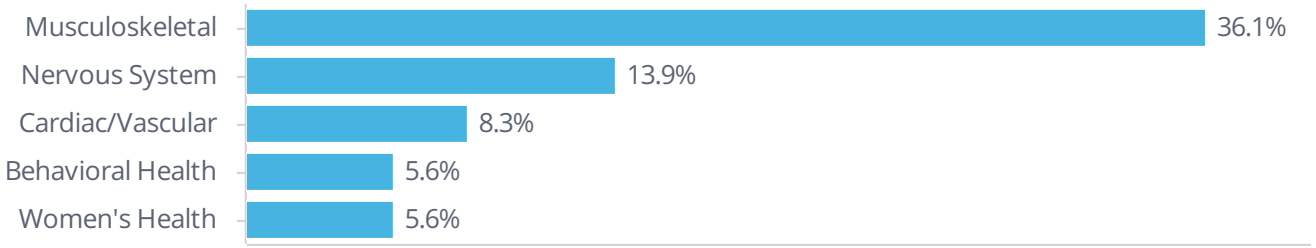
Doctor Expertise Survey Rating



Customer Care Survey Rating



Top Major Diagnostic Categories



Unique Major Diagnostic Categories Served

14

Completed Member Survey

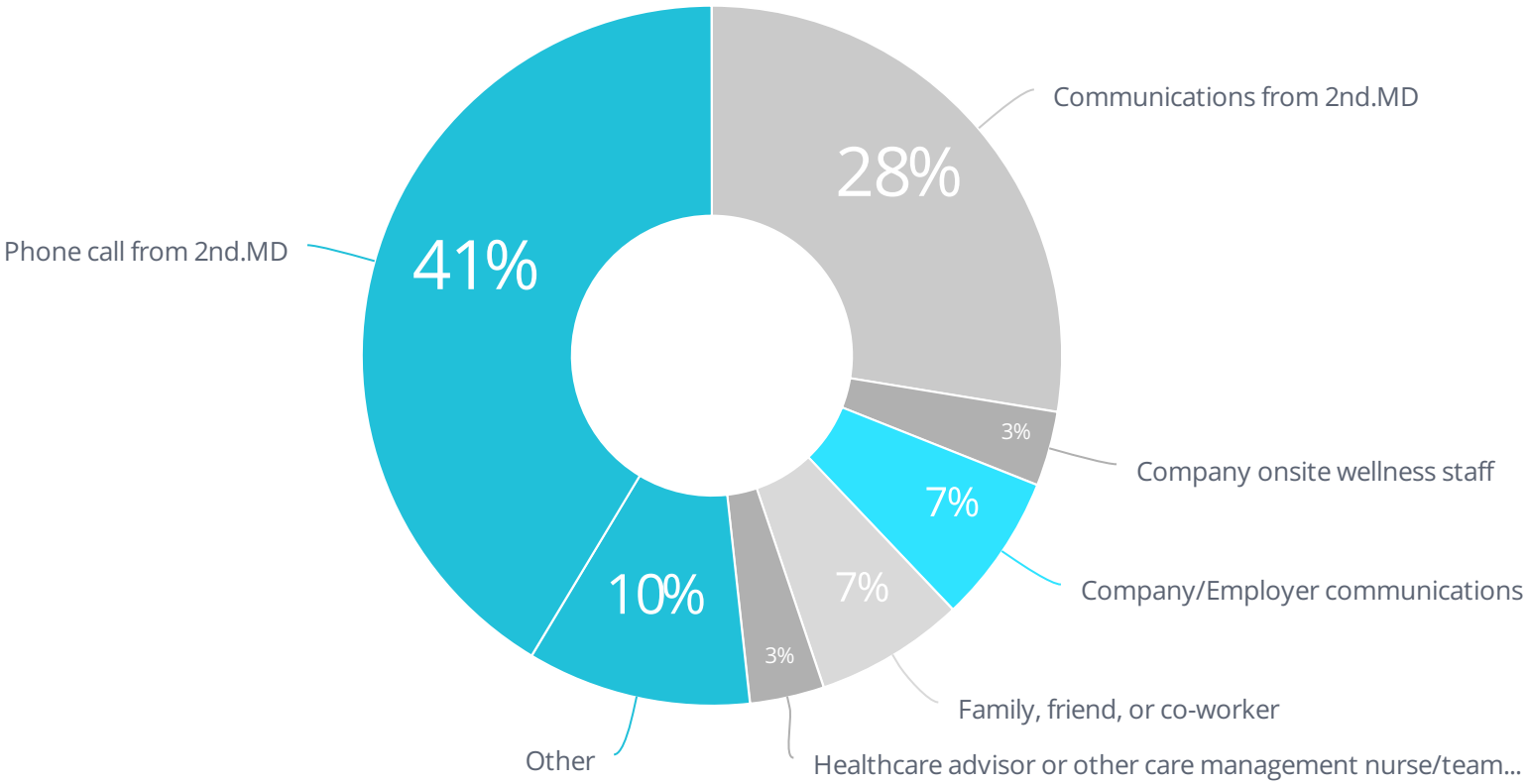
78%

Benefit Satisfaction

97%

SURVEY RESPONDENTS
who said access to 2nd.MD increased their appreciation of their employer's benefits

Member Survey Data: What Reminded Members of 2nd.MD



Definitions

Alternative Diagnosis: The 2nd.MD specialist observed an element of the medical record or patient history that indicates an alternative diagnosis may be more appropriate. Specialist may recommend additional evaluations to confirm or rule out the alternative diagnosis.

Avoided Surgery: The 2nd.MD specialist suggested an alternative treatment plan and member avoided surgery.

Improved Treatment Plan: The member was provided alternative interventions to consider with the risks, benefits, and alternatives articulated so that the member can make a more informed decision.

Consults: Total 2nd.MD Expert Consults. (One completed consult includes member intake, records collection, specialist matching, live conversation with the expert specialist and delivery of a consult summary)

Personalized Local Support: 2nd.MD will provide the member with support and education, which may include recommendations of a local, in-network specialist, if requested by the Member. 2nd.MD will use Member's location and specific case needs to locate a specialist for the member's needs.

Specialty Care Navigation: helps members navigate the complexities of managing their health and achieve better health outcomes. Based on the expertise of our Care Team nurses, it includes education, high-touch coaching, referrals, and network steerage. SCN is available for all specialty conditions, as well as for members who are symptomatic or unsure of where to go for initial diagnostic work-up and treatment. Upon completion of these services, members receive a written summary of all discussion points and any recommended activities, along with a letter to share with their treating physician.

Activations: Number of employees within an eligible population who have actively registered with 2nd.MD's platform (created a username and password). Registered users are typically a good measure of employee engagement and awareness of program and typically goes up year over year as clients communicate.

EOC COST SAVINGS METHODOLOGY

2nd.MD uses an episode of care (EOC) based cost savings methodology that looks at the difference between what the members' local provider recommended to what the member decides to proceed with after their 2nd.MD virtual consultation with an elite specialist. We use various tools to price out these procedures and use averages consistent to the Zip code where the member resides.

We include all cases, even those in which the expert opinion resulted in a cost increase or no savings. Our methodology has been reviewed and accepted by several actuaries at national consulting firms and by health plans who are using our service for their fully insured book of business. We are currently undergoing validation by an independent third party.

The following example describes how we calculate savings. A treating physician recommended lumbar spinal fusion for a 35-year-old male accountant. After video consultation with our elite specialist, the member pursues physical therapy.

Local Provider Recommendation Episodic Care Costs:
MD Visit - $229
Imaging/Tests - $292
Surgical Procedure - $71,672
Medications - $600
Physical Therapy - $793
Follow-Up MD Visits - $260

Net Cost of Procedure Pathway: $73,846

2nd.MD Specialist Recommendation Costs:
Physical Therapy - $1,200
Net Difference Between Local Provider Recommendation and 2nd.MD Specialist:
Recommendation: $73,846 - $1,200 = $72,646.
CPT codes: 22630, 22612
Return on Investment Calculation:
$6,530 Avg. Savings Per Consult/ $ Cost Per Consult = 3.4

4.3.9

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

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

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- 4.3.5 Q1 United Healthcare – Basic Life Insurance
- 4.3.6 Q1 Express Scripts – Summary Report
- 4.3.7 Q1 Express Scripts – Utilization Report
- 4.3.8 Q1 2nd MD – Utilization Report
- **4.3.9 Doctor on Demand Utilization Report**

Virtual Care Engagement Monthly Report

UMR – STATE OF NEVADA

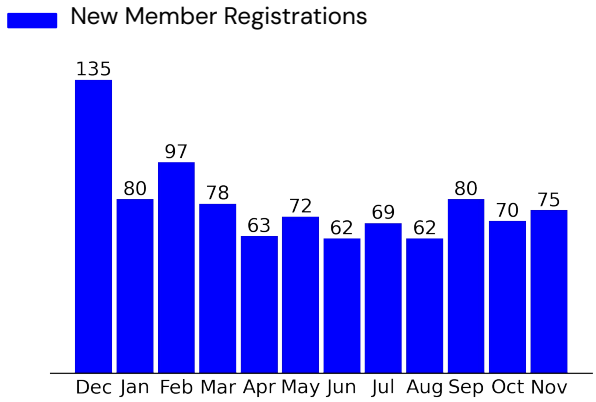
Reporting Period: 11/01/23 to 12/01/23

Member Engagement

74	281	348
Registrations This Month	Unique Visitors This Month	Total Visits This month

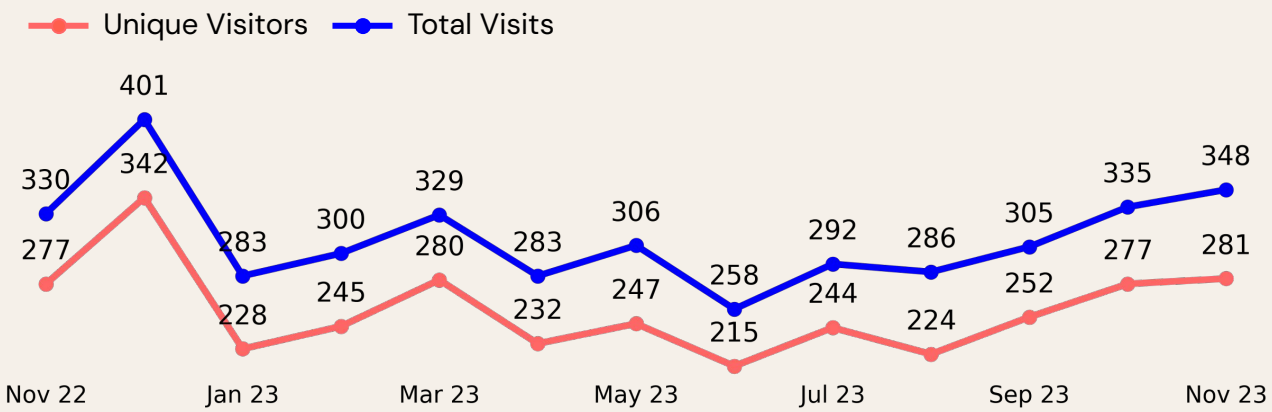
This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement 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	**3,092** Registrations Lifetime to date	Registration Rate Lifetime to date
Employee Covered Lives	**807** Registrations Year to Date	Registration Rate Year to Date

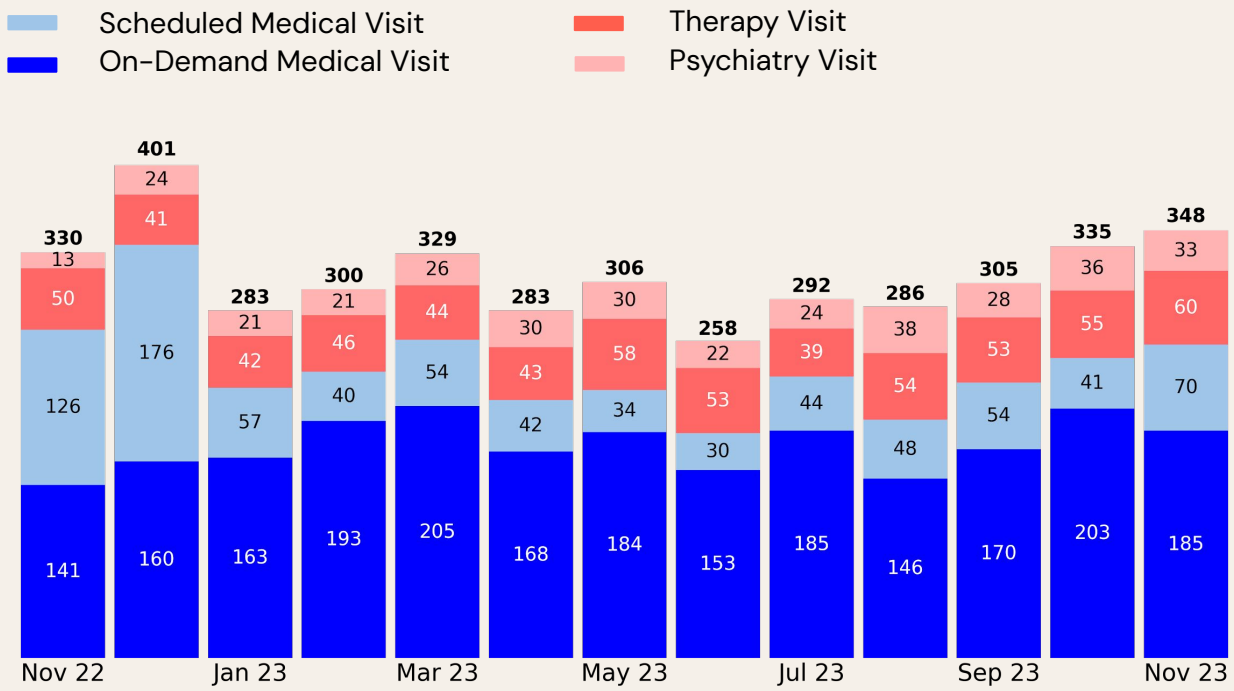
Visits Last 12 Months



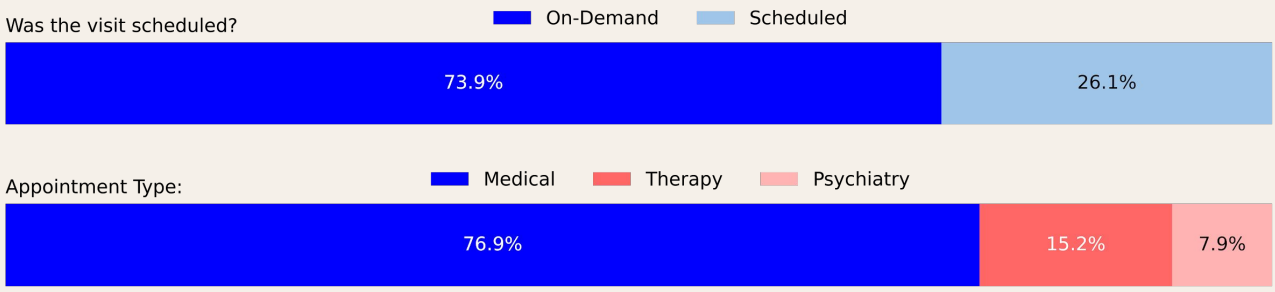
5,031 Visits Lifetime to date	**2,304** Unique Visitors Lifetime to date	**2.2** Average Visits Per Visitor Lifetime to date	Engagement Rate Lifetime to date (Visitors/Lives)	
3,325 Visits Year to Date	**1,669** Unique Visitors Year to Date	**2.0** Average Visits Per Visitor Year to Date	Engagement Rate Year to Date (Visitors/Lives)	

Member Engagement

Medical & Behavioral Health Visits (Rolling 12 Months)



Member Demand by Visit Type Life to Date



Most Popular Day for Visits Life to Date

Monday

Most Popular Time for Visits Life to Date

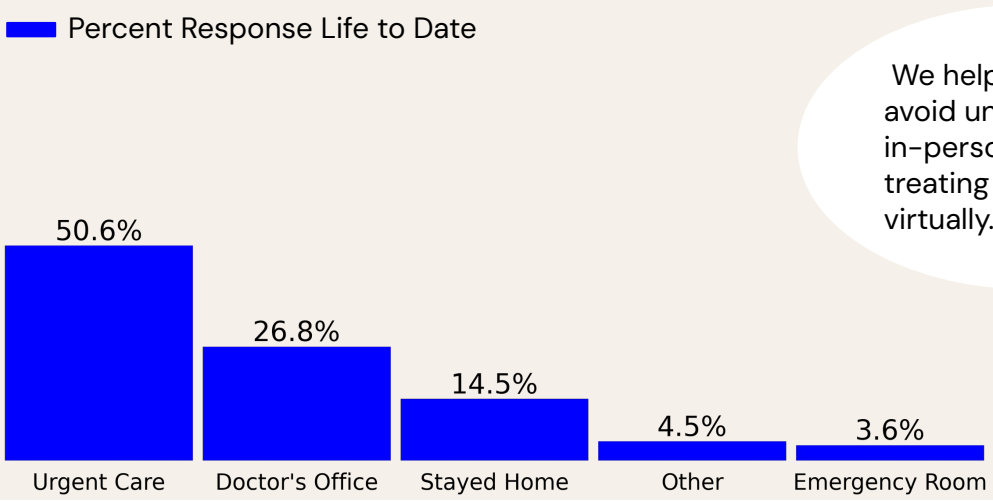
10AM - Noon

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

Member Access

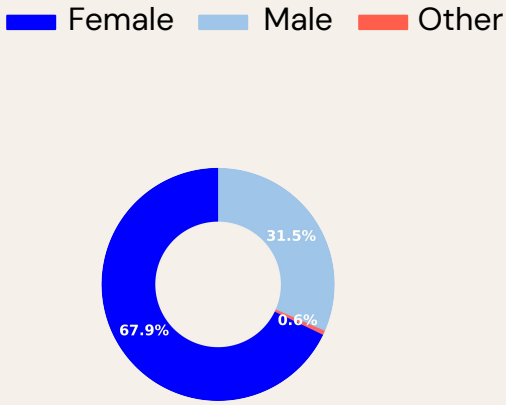
This section highlights our impact on increasing members' access to appropriate medical and behavioral health care, and their satisfaction with our services. We improve access to care by seeing members after hours (when brick & mortar providers are closed) and by making it easier to visit with a provider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

Without Included Health, where would you have gone?

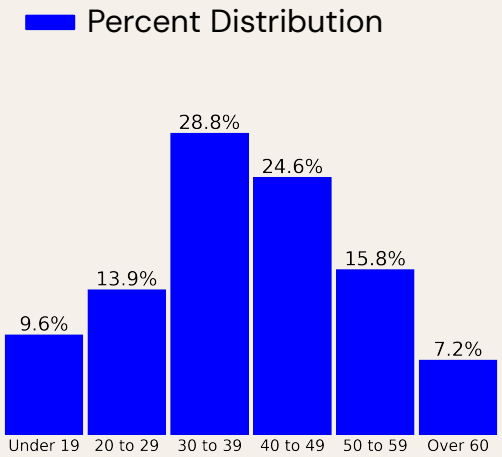


We help members avoid unnecessary in-person visits by treating their needs virtually.

Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	This Month	Life to Date
Average Member Rating	4.97 / 5 (N = 227)	4.96 / 5 (N = 3,607)
Average Wait Time for On-Demand Medical Appointments	14.78 min	14.65 min
Average Days to Scheduled Appointment	4.6 days	4.2 days

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 Life to Date
Congestion / sinus p..	125	1,465
Cough	90	1,202
Fatigue / weakness	75	1,096
Headache	80	1,057
Sore throat	72	988
Difficulty sleeping	47	912
Nasal discharge	66	765
Fever	31	562
Difficulty / pain sw..	24	504
Ear pain	44	497

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits This Month	Visits Life to Date
Other upper respiratory infections	95	1,039
Anxiety disorders	61	813
Mood disorders	44	597
Urinary tract infections	11	431
Administrative/social admission	19	299
COVID-19	23	286
Adjustment disorders	22	239
Inflammation; infection of eye (except that c..	15	225
Cough, unspecified	18	218
Other upper respiratory disease	7	190

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

391	68.6%	64	3.8%
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 Life to Date
benzonatate	37	446
prednisone	22	313
nitrofurantoin monoh..	8	266
amoxicillin/potassiu..	25	264
albuterol	21	255
ipratropium nasal	17	224
nirmatrelvir/ritonavir	18	164
fluticasone nasal	7	152
methylprednisolone	7	139
amoxicillin	3	136

Top Labs	Count This Month	Count Life to Date
Urinalysis, Complete..	5	63
Comprehensive Metabo..	6	58
CBC+diff	5	53
Lipid Panel	6	45
TSH with Reflex to F..	4	42
Hemoglobin A1c	4	35
Chlamydia/GC, Urine	2	33
Urine Culture, Routine		30
Vitamin D	4	27
HIV-1/2 Ag/Ab, 4th G..	2	24

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.

4.4

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

4.4 Acceptance of the annual PEBP Appeals and Complaints Summary for submission to the Nevada Division of Insurance and Department of Health and Human Services

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

January 26, 2024

RICHARD WHITLEY, MS
DIRECTOR OF DHHS
OFFICE OF CONSUMER HEALTH ASSISTANCE
400 W KING ST STE 300
CARSON CITY NV 89703

Re: Public Employees' Benefits Program (PEBP) Appeals and Complaints
Summary Report Calendar Year 2023

Dear Mr. Whitley:

In accordance with NRS 695G.310, PEBP presents to the Office of Consumer Health Assistance, under the Aging and Disability Services Division of the Department of Health & Human Services, its annual Appeals and Complaints Summary Report for Calendar Year 2023.

Specifically, the name of the employee(s) responsible for appeals, descriptions of notification procedures, and an explanation of rights are set forth below, followed by a narrative summary of the attached appeals and complaints log. A graph showing the number of appeals and complaints resolved in Calendar Years 2017 through 2023 has been included for historical comparison purposes.

Pursuant to NRS 695G.200, the "name and title of the employee[s] responsible for the system for resolving complaints" are:

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

Additionally, pursuant to NRS 695G.200, a description of the system for resolving appeals and to notify an insured of the decision regarding their appeal and a "copy of the explanation of rights and procedures" provided to insureds:

PEBP has contracted with UMR located in Las Vegas, Nevada, to provide third-party administration services for PEBP's self-funded plans: the Consumer Driven Health Plan (CDHP), Low Deductible PPO (LD-PPO), and the Exclusive Provider Organization (EPO). As PEBP's claims administrator, UMR receives claims from physicians, dentists, psychiatrists, laboratories, and other providers. UMR reviews the claims and processes them in accordance with provisions in the applicable plan year PEBP Master Plan Document. Included at the bottom of every

explanation of benefits (EOB) notice sent by UMR to participants is a statement that describes the first level of appeal available to a participant:

> **What if I have questions about this claims decision?**
> If you have any questions about this explanation of benefits, please call the toll-free number on your ID Card.
>
> **What if I don't agree with this claim decision?**
> If your claims has been denied in whole or in part, you may file an appeal by sending a written request and pertinent information (eg: office notes, lab results, operative notes/reports, and medical history) within 180 days from the date of this notice, or the period otherwise established by your plan. Be sure to also check your benefits booklet for information about claim determination and your plan's specific appeal process.
>
> **How do I file an appeal?**
> If you are not satisfied with this decision, either you or your authorized representative can start the appeal process by sending a written request to:
>
> Claims Appeal Unit
> P.O. Box 30546
> Salt Lake City, UT 84130-0546
>
> Or the member can submit an appeal electronically through the UMR appeals portal. Please log into UMR.COM and click on submit an appeal/or as otherwise set out in your benefit plan book within 180 days of receipt of this explanation of benefits (unless a longer term is permitted by your plan). Please note that if you choose to designate an authorized representative, you must make this designation to us in writing.
>
> **Your rights and other resources**
> If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party after exhausting the internal appeal process. You must make the request within 4 months or within the period as specified in your plan documents. Contact us at the phone number on your ID card to find out how to start an external review.

The written request for appeal is either mailed to the address listed on the EOB or electronically filed through the member's UMR portal. The Third-Party Administrator's (UMR) decision on the Level 1 Claim Appeal is mailed to the PEBP participant in writing. If the TPA approves the appeal, they reprocess the related claim(s). If the TPA denies the Level 1 Claim Appeal, the denial letter to the participant includes instructions on how to proceed to a Level 2 Claim Appeal, if the participant deems necessary.

Level 2 Claim Appeals are adjudicated by PEBP, and decisions are sent to participants in writing. If the Level 2 Claim Appeal is denied, the denial letter to the participant may include instructions on how to proceed to an External Review. External Reviews are managed by the Nevada Office of Consumer Health Assistance (OCHA):

> If you are not satisfied with this decision, you may have the right to request a separate external review. This means you have the right to have the claim determination reviewed by an independent health care professional.
>
> To file an external review, you must contact the Nevada Governor's Office for Consumer Health Assistance (GOVCHA) and file your request for an external review within 4 months after the date of receipt if this letter. A standard external review request form is available in the PEBP website at www.pebp.state.nv.us or the GOVHA website at http://dhhs.nv.gov/Programs/CHA.
>
> Office for Consumer Health Assistance
> 3320 W. Sahara Ave, Suite 100
> Las Vegas, NV 89102
> Phone: (702) 486 -3587, (888) 333-1597
> Website:
> https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/

The claim appeal process described in PEBP's Master Plan Document complies with the requirements of the Patient Protection and Affordable Care Act of 2010 (PPACA) and Chapter NRS 695G of the Nevada Revised Statutes. Forms for completing the various levels of review are available by accessing their E-PEBP Portal at https://pebp.nv.gov/ or by calling the PEBP office.

Summary Narrative

The Complaints and Claim Appeals Summary Report for calendar year 2023 lists 36 Level 2 Claim Appeals, 13 External Reviews, and 79 Complaints totaling 128 resolved. Complaints are categorized by vendor and complaint type. This compares to 5 external reviews, 22 Level 2 Claim Appeals, and 79 complaints totaling 106 resolved in 2022.

When compared to 2022, the 2023 Appeals and Complaints have increased overall for external reviews, Level 2 Claim Appeals, and complaints. Members who exercise their right to an External Review saw roughly 70% of decisions upholding either the Utilization Management or Claims determination. Meanwhile, the increase in Level 2 Claim Appeals saw approximately 58% of appeals upheld by PEBP.

Of the complaints resolved in 2023, 32% were directed at UMR, 20% were directed at Express Scripts, 13% were directed at VIA Benefits. UMR experienced 25 complaints, mostly focused on claims processing and claims payments. Express Scripts (ESI) experienced an increase in complaints with 16 in 2023 compared to 11 in 2022. The majority of ESI complaints centered on the price of prescriptions. Willis Towers Watson's VIA Benefits experienced a decrease to 10

complaints in 2023 compared to 11 complaints in 2023, with most complaints relating to customer service.

The number of complaints for PEBP and other vendors, such as Corestream, Health Plan of Nevada, HSA Bank, Network, etc. experienced an increase in 2023, from 25 overall complaints in 2022 up to 28 for 2023. Most of these complaints (13) are related to PEBP for administration and eligibility determinations.

Sincerely,

Tim Lindley
Quality Control Officer
Public Employees' Benefits Program
775-684-7000

Enclosure(s): Appeal and Complaint report (3 pages)

JOE LOMBARDO
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
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CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

January 26, 2024

SCOTT KIPPER
NEVADA DIVISION OF INSURANCE
1818 E. COLLEGE PARKWAY, SUITE 103
CARSON CITY, NV 89706

Re: Public Employees' Benefits Program (PEBP) Complaints Summary Report Calendar Year 2023.

Dear Commissioner Kipper:

In accordance with NAC 287.750, PEBP presents to the Nevada Division of Insurance, under the Department of Business and Industry, its annual Complaints Summary Report for Calendar Year 2023. Specifically, the name of the employee(s) responsible for appeals, descriptions of notification procedures, and an explanation of rights are set forth below, followed by a narrative summary of the attached complaints log.

Pursuant to NAC 287.750(1)(a), the "name and title of the employee[s] responsible for the system for resolving complaints" are:

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

Additionally, pursuant to NAC 287.750, below is a "description of the procedure used to notify an insured of the decision regarding his or her complaint" provided to insureds:

A complaint may be made to the PEBP by any participant, provider, vendor, etc., regarding any PEBP process or service. It is recognized that complaints may be in person, over the phone, by e-mail, or other method of communication. Complaints must be in writing for appropriate consideration.

1. The Compliance Division staff member will respond to the participant either by mail, e-mail, or phone within 2 business days to acknowledge receipt of the complaint. Generally, complaints will be acknowledged in the same method as submitted to PEBP.
2. The Compliance Division staff will log the Complaint for tracking and reporting purposes with the pertinent details of the complaint. The Compliance Division staff review complaint documents to determine a response.
3. If the complaint is addressed to QCO, or the PEBP, the Compliance Division staff will draft a response and review with the QCO for approval prior to mailing.

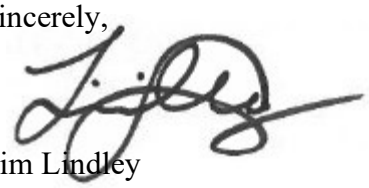
4. The Compliance Division staff will respond to the participant with determination of complaint findings within 7 business days. In the event further time is needed to completely research and review the complaint, the Compliance Division staff will contact the member as needed to provide status updates.
5. A final complaint response, including signed written response from the Compliance Division, are mailed to the member.
6. For PEBP Operational purposes, the Compliance Division staff may note the participant's account in the current PEBP internal Client Relations Management Tool and will not include participant's Personal Health Information (PHI).

Summary Narrative

The Complaints Summary Report for calendar year 2023 lists 79 Complaints resolved. Complaints are categorized by vendor and complaint type. This compares to 79 complaints resolved in 2022. Of the complaints resolved in 2023, 32% were directed at UMR, 20% were directed at Express Scripts, 13% were directed at VIA Benefits. UMR experienced 25 complaints, mostly focused on claims processing and claims payments. Express Scripts (ESI) experienced an increase in complaints with 16 in 2023 compared to 11 in 2022. The majority of ESI complaints centered on the price of prescriptions. Willis Towers Watson's VIA Benefits experienced a decrease to 10 complaints in 2023 compared to 11 complaints in 2023, with most complaints relating to customer service.

The number of complaints for PEBP and other vendors, such as Corestream, Health Plan of Nevada, HSA Bank, Network, etc. experienced an increase in 2023, from 25 overall complaints in 2022 up to 28 for 2023. Most of these complaints (13) are related to PEBP for administration and eligibility determinations.

Sincerely,



Tim Lindley
Quality Control Officer
Public Employees' Benefits Program
775-684-7000

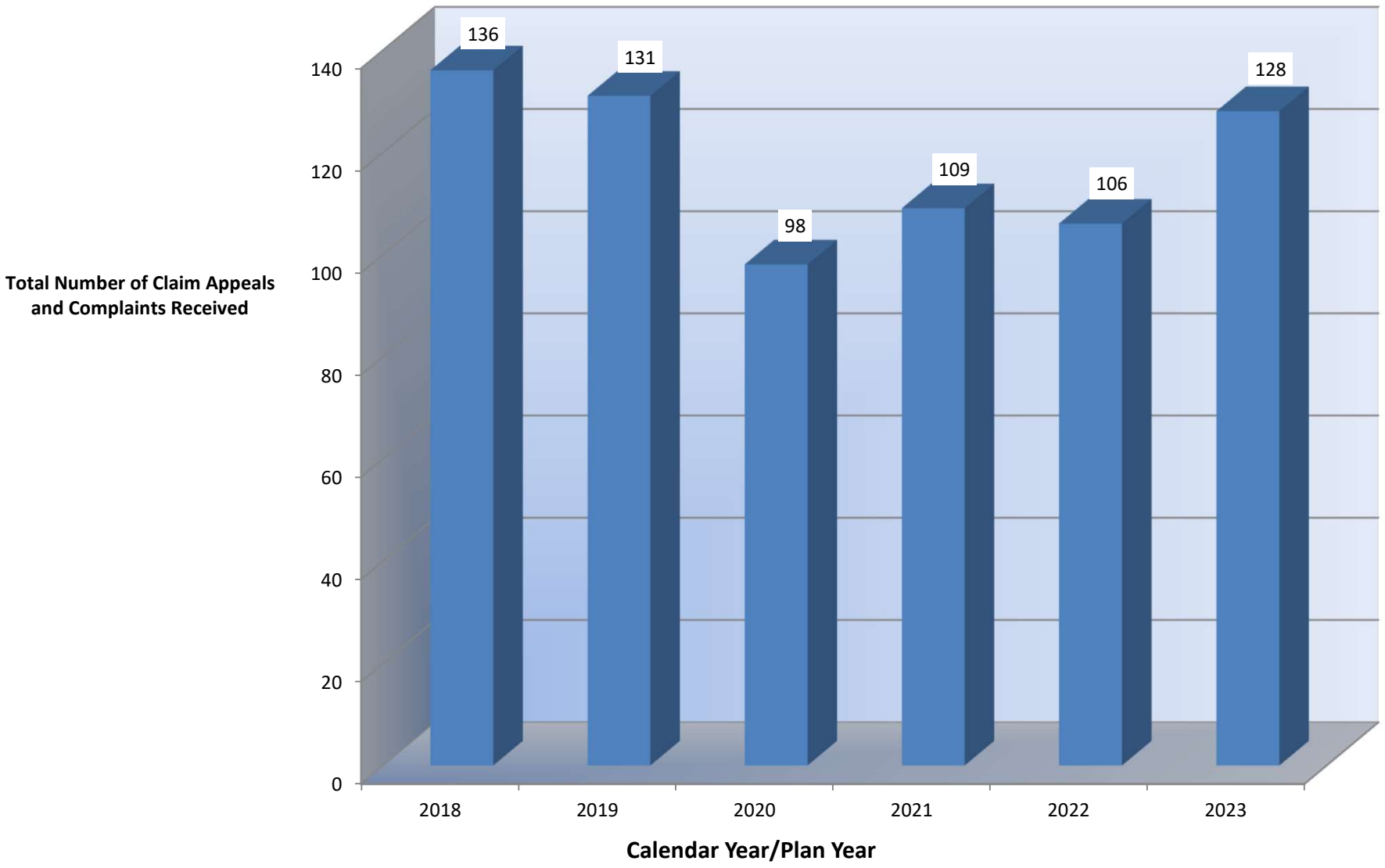
Enclosure(s): Complaint report (1 page)

Level 2 Claim Appeals														
Plan and Appeal Outcome	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Year Totals**	**% of Total**
CDHP-PPO	**3**	**1**	**1**			**5**	**1**		**2**	**2**	**1**	**1**	**17**	**47%**
Addt'l Docs Req.	1					4							5	
Overturned										1	1		2	
Untimely									1				1	
Upheld	2	1	1			1	1		1	1		1	9	
Exclusive Provider (EPO)	**2**					**2**	**1**		**1**	**1**	**1**		**8**	**22%**
Addt'l Docs Req.	2												2	
Overturned						1			1	1			3	
Upheld						1	1				1		3	
Low Deductible-PPO	**1**	**1**	**2**		**1**		**1**	**1**	**1**	**1**	**2**		**11**	**31%**
Overturned								1		1			2	
Upheld	1	1	2		1		1		1		2		9	
Year Totals	**6**	**2**	**3**	**0**	**1**	**7**	**3**	**1**	**4**	**4**	**4**	**1**	**36**	**100%**

External Review Appeals														
Plan and Appeal Outcome	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Year Totals**	**% of Total**
CDHP-PPO	**1**			**2**			**2**		**2**		**1**		**8**	**62%**
Overturned	1						1		1				3	
Upheld				2			1		1		1		5	
HMO						**1**							**1**	**8%**
Upheld						1							1	
Low Deductible-PPO				**1**		**1**				**2**			**4**	**31%**
Overturned										1			1	
Upheld				1		1				1			3	
Year Totals	**1**	**0**	**0**	**3**	**0**	**2**	**2**	**0**	**2**	**2**	**1**	**0**	**13**	**100%**

Complaints														
Vendor and Complaint Type	**01/2023**	**02/2023**	**03/2023**	**04/2023**	**05/2023**	**06/2023**	**07/2023**	**08/2023**	**09/2023**	**10/2023**	**11/2023**	**12/2023**	**Grand Total**	**% of Total**
Corestream							**2**	**1**			**1**		**4**	**5%**
Administration							1						1	
Claim Processing								1					1	
Voluntary Benefits/Products							1				1		2	
ExpressScripts		**1**	**3**	**2**	**1**	**2**	**3**		**1**	**1**	**2**		**16**	**20%**
Administration											1		1	
Claim Price Payment Dispute			2										2	
Customer Service									1		1		2	
Enrollment & Eligibility							1						1	
Network Provider Access				1		1							2	
Prescription		1			1		1						3	
Prescription Pricing			1			1	1			1			4	
Prior Authorization				1									1	
Health Plan of NV						**1**							**1**	**1%**
Administration						1							1	
HealthSCOPE Benefits				**1**	**1**								**2**	**3%**
Administration				1									1	
Claim Price Payment Dispute					1								1	
HSA Bank	**1**				**1**	**3**		**1**				**1**	**7**	**9%**
Administration												1	1	
Claim Denial					1								1	
Claim Processing						1							1	
HSA/HRA/FSA	1					2		1					4	
Network-UHC Choice Plus/SHO/BHO								**1**					**1**	**1%**
Voluntary Benefits/Products								1					1	
Public Employees' Benefits Program		**1**		**1**	**1**	**1**	**1**	**2**	**3**	**1**	**1**	**1**	**13**	**16%**
Administration								2	2	1		1	6	
Enrollment & Eligibility		1		1			1		1				4	
HSA/HRA/FSA											1		1	
Network Provider Access					1								1	
Voluntary Benefits/Products						1							1	
UMR	**1**	**1**	**6**	**2**	**2**	**4**	**3**	**1**	**2**	**1**	**2**		**25**	**32%**
Administration	1	1	1										3	
Carrier Issues			3										3	
Claim Denial					2	1							3	
Claim Price Payment Dispute			1	1		1	1				1		5	
Claim Processing						2	2	1	2	1	1		9	
HSA/HRA/FSA			1										1	
Plan Design				1									1	
VIA Benefits (Willis Towers Watson, O	**1**	**1**		**1**			**1**			**2**	**1**	**3**	**10**	**13%**
Administration											1		1	
Claim Processing										1			1	
Customer Service										1		3	4	
HSA/HRA/FSA	1			1			1						3	
Network Provider Access		1											1	
Grand Total	**3**	**4**	**9**	**7**	**6**	**11**	**10**	**6**	**6**	**5**	**7**	**5**	**79**	**100%**

PEBP Complaints and Appeals History Comparison
2017 - 2023



5.

5. Presentation and possible action on the status and approval of PEBP contracts, contract amendments and solicitations. With respect to a new proposed contract with Carrum Health to maintain a network of National Centers of Excellence, the Board previously reviewed the results of the evaluation of proposals for the contract in closed session pursuant to NRS 287.04345(4) in its December 7, 2023, meeting. To the extent that additional consideration of the proposed contract requires the Board's discussion of confidential material related to the contract prior to any Notice of Award being issued, see NRS 333.335(7), such portion of this meeting may be conducted in closed session pursuant to NRS 287.04345(4). All action on contracts will occur in open session pursuant to NRS 287.04345(5). (Michelle Weyland, Chief Financial Officer) (**For Possible Action**)

JOE LOMBARDO
Governor

STATE OF NEVADA
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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: January 26, 2024

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 December 31, 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	$ 103,972,553.61	$ 88,121,294.39
Diversified Dental Services Inc.	Dental PPO	23810	7/1/2021	6/30/2026	$ 1,601,613.00	$ 767,410.12	$ 834,202.88
Lifeworks	Benefits Management System	25935	5/10/2022	12/31/2026	$ 6,145,600.00	$ 2,498,277.00	$ 3,647,323.00
Express Scripts, Inc.	Pharmacy Benefit Manager	25582	5/10/2022	6/30/2026	$ 332,109,496.00	$ 117,576,375.31	$ 214,533,120.69
*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	$ 5,593,424.35	$ 7,230,823.65
Brown & Brown of Massachusetts	Health Plan Auditor	24030	4/13/2021	6/30/2027	$ 1,581,662.00	$ 504,023.00	$ 1,077,639.00
Segal Company, Inc.	Consulting Services	25557	7/1/2022	6/30/2027	$ 4,285,410.00	$ 1,040,760.00	$ 3,244,650.00
HAT LTD, DBA Manpower	Temporary Employment	23928	1/1/2023	12/31/2023	$ 189,500.00	$ 153,289.57	$ 36,210.43
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

*Willis Towers Watson (VIA) As of July 1, 2019 Willis Towers Watson no longer charges PEBP an administrative fee.

5.2 New Contracts

Centers of Excellence – Travel Concierge. pending discussion and action resulting from closed session

5.3 Contract Amendment Ratifications

No contract amendments.

5.4 Contract Solicitation Ratifications

No Contract Solicitation Ratifications.

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	Carrum Health	Mar. 2024

Recommendation

Approve the contract for Carrum Health - Centers of Excellence – Travel Concierge.

6.

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

JOE LOMBARDO
Governor

STATE OF NEVADA
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CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

☐ Action Item

☒ Information Only

Date: January 26, 2024

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

The IRBC met on January 16, 2024, in Las Vegas. Both Michelle Weyland, CFO and I attended in person to present the reports on the recently approved plan design changes and plan year 2023 utilization. Representatives from the Segal team were also present to respond to specific questions regarding the Mental Health Parity and Addiction Equity Act and the most recent Other Post Employment Benefits (OPEB) reports. The committee inquired about potential rate increases over the coming plan years and what if any discussions PEBP has had regarding plan design for Plan Years 2026 and 2027.

UMR/VIA BENEFITS CUSTOMER SERVICE UTILIZATION

At the September 28, 2023, meeting, PEBP staff reported that we had been able to coordinate with both UMR and Via Benefits to have a representative available to provide in person assistance for our members. Members can contact UMR and Via directly to schedule an appointment either in Carson City or in Las Vegas. As of this report it appears that PEBP members are not availing themselves of this opportunity. Below is a table depicting the results of those meetings.

Month	Number of Appointments UMR	Number of Appointments Via Benefits
September 2023	0	1 No Show
October 2023	0	N/A
November 2023	0	N/A
December 2023	0	2 scheduled, 1 No Show

Due to a lack of utilization, we may consider reducing the availability from monthly to either every other month or quarterly dependent upon interest and utilization.

Contact information is being provided again so that members may schedule an in-person meeting with a representative from either UMR and/or Via Benefits (see below).

UMR
If members have questions about claims, UMR's Field Account Manager for PEBP will be available to PEBP members in Northern and Southern Nevada on a rotating basis at either the PEBP office or the UMR campus. Generally, the availability will be Wednesdays and Thursdays with one day for appointments and the other for walk-ins; however, this is subject to change based on utilization. Members should contact UMR directly to schedule a meeting with the UMR representative at (888) 763-8232 or through the UMR chat function on the members individual UMR account:

PEBP office in Carson City:
3427 Goni Road, Suite 109
Carson City, NV 89706

UMR Campus in Las Vegas:
2716 N Tenaya Way,
Las Vegas, NV 89128

VIA Benefits
VIA benefits will have on-site assistance at the PEBP office in Carson City approximately every other month. Members can call for HRA Onsite Assistance Appointments at 1-844-266-1395. This number is also available on our website under Plan Contacts. Additionally, members can schedule a call through their Via Benefit website at https://my.viabenefits.com/pebp.

STAFFING

There have been no changes to PEBP staffing levels in recent weeks – the vacancy rate remains at approximately 21%. PEBP continues to work with the Division of Human Resource Management to fill vacant positions.

7.

7. Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Third-Party Administrator, UMR, for FY2024 Q1 covering the period of July 1, 2023 – September 30, 2023.
(Tim Lindley, Quality Control Officer)
(**For Possible Action**)

7.1 UMR Remediation Plan

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employee's Benefit Program Plans

Administered by UMR Insurance Company

Audit Period: July 1, 2023 – September 30, 2023
Audit Number 1.FY24.Q1

Presented to

State of Nevada Public Employee's Benefit Program

January 26, 2024

CLAIM TECHNOLOGIES INCORPORATED

Proprietary and Confidential

TABLE OF CONTENTS

EXECUTIVE SUMMARY

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

Scope

CTI performed an audit for the period of July 1, 2023 through September 30, 2023 (quarter 1 (Q1) for Fiscal Year (FY) 2024). The population of claims and amount paid during the audit period reported by UMR Benefits:

Medical and Dental	
Total Paid Amount	$54,932,316
Total Number of Claims Paid/Denied/Adjusted	217,995

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

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

Auditor's Opinion

Based on these findings, and in our opinion:

1. UMR's Financial Accuracy, Overall Accuracy and Claim Turnaround Time did not meet the service objective and a penalty is owed (breakdown in summary below).
2. CTI recommends UMR should:
   - Review the financial errors identified in 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 did not meet the claims processing measurements for PEBP in Q1 FY2024 and a penalty is owed. Reported administrative fees for the quarter totaled $1,326,302.50.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy (p.12)	99.4%	Not Met – 97.5%	1.5%	$19,894.54
Overall Accuracy (p. 13)	98.0%	Not Met – 96.0%	1.0%	$13,263.03
Claim Turnaround Time (p. 14)	92% in 14 Days 99% in 30 Days	Met – 92.8% Not Met – 95.9%	NA 1.0%	$0.00 $13,263.03
		Total Penalty	3.5%	$46,420.60

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of UMR Insurance Company's (UMR) administration of the State of Nevada Public Employee's Benefit 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.

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 Q1 FY2024 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	93.1%	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	90.3%	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%	1.1%	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%	93.8%	Not Met
1.8	**Open Inquiry Closure:** addresses the time taken in hours and/or days by CSRs at the administrator's service facility to close open inquiries placed by participants of PEBP to the facility.	90.00% 48 Hours 98.00% 5 Business Days	94.7% 95.3%	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%	95.5%	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	85%	Not 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%	NA	Reported Annually
1.13	**Account Management – Plan will guarantee that the services provided by the TPA's team during the guarantee period will be satisfactory to PEBP. Areas of satisfaction will include:**			
	Knowledge/Capabilities – Account representative demonstrates competence in getting issues and problems resolved.	Agree	5	Met

	Metric	Service Objective	Actual	Met/ Not 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.).			
	Professionalism – Demonstrates objectivity and empathy with customer problems.			
	Flexibility – Ability to meet client-specific needs.			
	Participation in periodic meetings – Attendance at all required client meetings or conference calls.			
	Guarantee measured with staff responses to internal questionnaire. A scale from 1 to 5 will be used to measure performance, where 1 means 'very dissatisfied' and 5 means 'very satisfied'; and 2 through 4 are defined, respectively.			
	Periodic program reports will be provided and presented with recommended actions. Standard program reports, within 30 days to quarter-end. Year-end activity report, within 45 days of program year end.			
	Open Enrollment Support: Accurate materials will be provided at least 60 days prior to the open enrollment period starting on April 1 each year. Representative will be available, if requested, for up to 5 employee benefit fairs.			
	Service Objective (out of a score of 5 on internal questionnaire):	350		
1.14	**Eligibility Processing:** Confirm daily and weekly eligibility and enrollment within specified business days of the receipt of the eligibility information, given that information is complete and accurate.	98.00% 2 Business Days	100%	Met
1.15	**Data Reporting:** Offeror will provide PEBP with 100% of the applicable reports (within 10 business days for standard reports and within 10 business days of Plan year-end for Annual Reports and Regulatory documents).	100% 10 Business Days	100%	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	No new subcontractors	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	No issues	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	98% 100%	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%	98.3%	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	100%	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%	No new subcontractors	Met

	Metric	Service Objective	Actual	Met/ Not 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 complaints	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%	99.96%	Met
UTILIZATION MANAGEMENT/CASE MANAGEMENT – SERVICES AND PERFORMANCE GUARANTEES				
3.1	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within calendar 10 days of end of reporting period or event as determined by PEBP.	100% 10 Calendar Days	100%	Met
3.2	**Notification of potential high expense cases. High expense case is defined as a single claim or treatment plan expected to exceed $100,000.00.** Designated PEBP staff will be notified within 5 business days of the UM/CM vendors initial notification of the requested Service.	100% 5 Business Days	100%	Met
3.3	**Pre-Certification Requests:** Precertification requests from healthcare providers shall be completed in accordance with URAC/NCQA standards and turn-around timeframes; completed Pre-certifications shall be communicated to PEBP's Third Party Administrator using an approved method e.g., electronically, within 5 business days of UM completing Precertification determination.	98.00% 5 Business Days	NA	Reported Annually
3.4	**Concurrent Hospital Reviews:** Concurrent hospital reviews shall be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated to the provider using an approved method e.g., electronically within 2 business days of determination decision.	98.00% 2 Business Days	NA	Reported Annually
3.5	**Retrospective Hospital Reviews:** Retrospective reviews must be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated using an approved method e.g., electronically within 5 business days of determination decision.	98.00% 5 Business Days	NA	Reported Annually
3.8	**Hospital Discharge Planning:** CM will contact or attempt to contact 95% of patients discharged from any facility within 3 business days of notification of discharge with clinical coaching and discharge planning assistance.	95.00% 3 Business Days	NA	Reported Annually
3.9	**Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	95.00%	NA	Reported Annually
3.10	**Utilization Management for Medical Necessity and Center of Excellence Usage:** UM review to determine medical necessity in accordance with the MPDs. Services to be performed at a Center of Excellence to be managed through the Case Management process.	98.00%	NA	Reported Annually
3.11	**Return On Investment (ROI) Guarantee – Utilization Management/Case Management:** 2:1 Savings to Fees for Utilization Management/Case Management.	100%	NA	Reported Annually
3.12	**Disclosure of Subcontractors:** All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor.	100% 60 Calendar Days	No new subcontractors	Met

	Metric	Service Objective	Actual	Met/ Not Met
	Implementation will not be in effect until PEBP has provided written authorization.			
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	No changes	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.

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 with an identification number (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				
33	$78.90	Agree.	Procedural deficiency and overpayments remain. UMR paid duplicate charges. CTI notes QID 33 was corrected on 10/27/23; and QID 37 was corrected on 12/20/23. Both overpayments adjusted.	☐ M ☒ S
34	$137.28			☒ M ☐ S
35	$508.68			☒ M ☐ S
36	$38.00			☐ M ☒ S
37	$205.54			☒ M ☐ S
Plan Exclusions				
Massage Therapy				
49	$119.07	Agree. Massage Therapy code 97124 is an excluded service on the plan.	Procedural deficiency and overpayment remain. Massage therapy, procedure 97124, is excluded per pages 100 and 102 of the CDHP plan document.	☒ M ☐ S
Potential Fraud, Waste, and Abuse				
Repeated Genetic Testing				
45	$1,662.42	Agree. At the time this claim was processed there was no authorization on file for code 81420.	Procedural deficiency and overpayment remain. The service authorized was for procedure 81420 which paid $1,062.67 for services rendered on 7/5/23. The procedure code for repeat genetic testing (81479) should have been denied.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Copay Application				
Specialist				
16	$18.23	Agree. There should be a $40.00 copay applied to this claim for services by a specialist.	Procedural deficiency and overpayment remain. The $40.00 specialist copay should have applied instead of the $20.00 PCP copay. Claim paid $18.23 after COB savings applied, should have paid $0.00.	☒ M ☐ S
18	($25.41)		Procedural deficiency and underpayment remain. A $40.00 copay should have applied instead of the deductible.	☒ M ☐ S
Diagnostic Mammography				
14	($122.73)	Agree. Diagnostic mammograms are subject to a $40.00 copay.	Procedural deficiency and overpayment remain. The EPO plan had a $40.00 copay for diagnostic mammography, deductible and coinsurance were applied in error.	☒ M ☐ S
15	($39.99)			☒ M ☐ S
17	($80.13)			☒ M ☐ S
PPO Provider Without Discount				
28	$13,467.20	Agree. This claim was allowed at billed charges in error. Pricing for the claim has been completed. This claim was adjusted on 11-3-2023 and results in a $13,467.20 overpayment.	Procedural deficiency and overpayment remain. This in-network PPO provider was paid without a discount.	☒ M ☐ S
Preventive Services				
Denied				
6	($375.00)	Agree. PEBP does not require annual COB investigations.	Procedural deficiency and underpayment remain. The claimant was the employee; PEBP does not require UMR to send annual COB questionnaires, and no indication was presented indicating the member had other insurance. This preventive claim should have been allowed.	☐ M ☒ S

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 $439,011.21. The claims sampled and reviewed revealed $9,512.18 in underpayments and $7,968.32 in overpayments. This reflects a weighted Financial Accuracy rate of 97.50% over the stratified sample. This is a decrease in performance from the prior period. Detail is provided in the following table, Random Sample Findings Detail Report.

UMR did not meet the Performance Guarantee for PEBP in Q1 FY2024 of 99.40% for this measure. The penalty owed is 1.5% of the administrative fees of $1,326,302.50 or $19,894.54.

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 8 incorrectly paid claims and 192 correctly paid claims. This is a decrease 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	3	5	96.0%

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 decreased from the prior period. UMR did not meet the Performance Guarantee for PEBP in Q1 FY2024 of 98.0% for this measure. The penalty owed is 1.0% of the administrative fees of $1,326,302.50 or $13,263.04. Detail is provided in the table below, Random Sample Findings Detail Report.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
192	2	6	96.0%

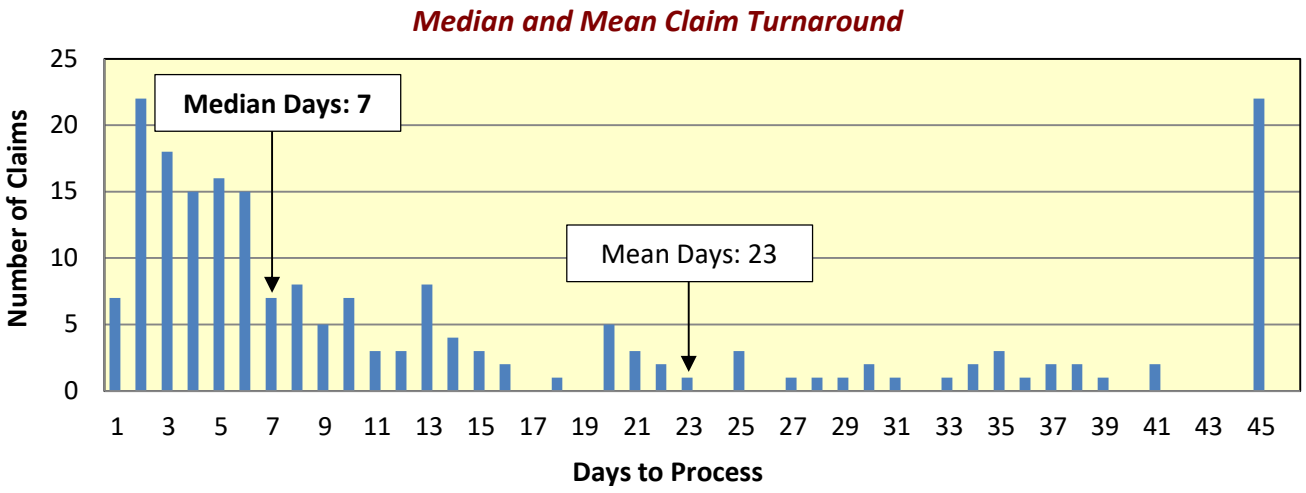
Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Denied Eligible Expense				
1076	($6,771.55)	Agree. The Customer First Representative (CFR) updated the COB status in the CPS processing system to reflect Medicare Primary in error. This caused the claim to deny for a MEOB. This claim has since been adjusted on 12-12-2023 with a payment of $6,771.55 to the provider	Procedural error and underpayment remain. Eligible expenses were denied on this claim for a Medicare EOB. The member was in an active group and the file stated this member had Medicare as secondary.	☒ M ☐ S
PPO Discount				
1061	($2,727.51)	Agree. The SHO allowed amount for this claim is $24,501.27. UMR allowed $21,773.76 in error. This claim was adjusted on 11-29-2023 to allow the SHO contract case rate $24,501.27 with an additional payment made of $2727.51.	Procedural error and underpayment remain. An incorrect PPO discount was applied to the sampled claim.	☒ M ☐ S
1112	$7,476.55	Agree. UMR agrees there is an error with the processing of this claim. An incorrect allowable amount was used to process this claim.	Procedural error and overpayment remain. An incorrect PPO discount was applied to the sampled claim.	☒ M ☐ S
1129	$239.76	Agree. An incorrect allowable was applied to this claim during processing.	Procedural error and overpayment remain. The pricing documentation provided by UMR states the correct	☒ M ☐ S

Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
			allowed amount for the sample claim was $17,779.90. The allowed amount processed on the claim was $18,019.66.	
Coinsurance Error				
1131	$144.61	Agree. Outpatient surgery copay $500 should apply to this claim. This results in a $144.61 overpayment. This claim will be adjusted at the completion of the audit.	Procedural error and overpayment remain. Per page 39 of the plan document, there should have been a $500.00 copay applied to these in-network hospital surgery services followed by no coinsurance.	☒ M ☐ S
2012	$23.40	Agree. Coinsurance should have been applied to the service. This resulted in an overpayment of $23.40. UMR will adjust the claim at the completion of the audit.	Procedural error and overpayment remain. The coinsurance applied should have been $23.40 and it was $0.00. Per page 12 of the plan document, periapical x-rays should be allowed under the Basic Services benefit.	☐ M ☒ S
2014	($13.12)	Agree. Incorrect coinsurance was applied to the claim. This resulted in an overpayment of $13.12. UMR will adjust the claim at the completion of the audit.	Procedural error and underpayment remain. There was incorrect coinsurance on this claim. The coinsurance applied should have been $3.28 and it was $16.40.	☒ M ☐ S
Deductible Error				
2023	$84.00	Agree. Deductible should have been taken on the service. This resulted in an overpayment of $84.00. UMR will adjust the claim at the completion of the audit.	Procedural error and overpayment remain. The deductible applied should have been $84.00 and it was $0.00. The sample claim full mouth series should have applied Basic Services according to page 13 of the plan document. The member had not met the plan year individual or family deductible.	☐ 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.



UMR did not meet the Performance Guarantee for PEBP in Q1 FY2024 of 92% processed within 14 days but did meet 99% processed within 30 days. This performance did not improve from the prior period. The penalty owed for this Performance Guarantee is 1.0% of the administrative fees of $1,326,302.50 or $13,263.04.

Additional Observations

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

Audit Number	Observation
1015	UMR stated a general health panel, code 80050, was not on the Health Care Reform preventive coverage list payable without patient cost share. However, page 60 of the CDHP plan document states a general health panel should be paid as preventive. CTI recommends PEBP update the plan documents to align with UMR's stated procedure.

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. CTI's screening indicated there were no sanctioned providers that received payment from UMR during the audit period.

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 95.80% 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 payor 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 payor.

PTP Edits Reports

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

Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary			Primary Description	Secondary Description	Line	Amount CMS
Code	Mod	Code	Mod	Mod Use			Count	Would Deny
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	21	$14,034
					Standards of medical/surgical practice			
70496		70450		YES	CT ANGIOGRAPHY HEAD	CT HEAD/BRAIN W/O DYE	3	$4,430
					Misuse of Column Two code with Column One code			
58662		58350		YES	LAPAROSCOPY EXCISE LESIONS	REOPEN FALLOPIAN TUBE	1	$2,406
					Standards of medical/surgical practice			
97162	GP	64448		YES	PHYSICAL THERAPY EVALUATION MOD COMPLEX 30	femoral nerve, continuous infusion by cath	1	$2,309
					Misuse of Column Two code with Column One code			
90853		90832		YES	GROUP PSYCHOTHERAPY	Psytx pt&/family 30 minutes	3	$1,936
					CPT Manual or CMS manual coding instruction			
74177		96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	7	$1,729
					Standards of medical/surgical practice			
93975		76700		YES	VASCULAR STUDY	US EXAM ABDOM COMPLETE	1	$1,692
					Misuse of Column Two code with Column One code			
70551	TC	70544	TC	YES	Mri brain stem w/o dye	MR ANGIOGRAPHY HEAD W/O DYE	1	$1,586
					Misuse of Column Two code with Column One code			
96374		G0463		YES	THER/PROPH/DIAG INJ IV PUSH	Hospital outpatient clinic visit for assessm	1	$1,237
					Standards of medical/surgical practice			
99213		99212		YES	Office/outpatient visit for E&M of estab patient, 2	Office/outpatient visit for E&M of estab pat	17	$1,201
					Misuse of Column Two code with Column One code			
						Top 10 TOTAL	**56**	**$32,561**
						GRAND TOTAL	**253**	**$70,034**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary			Primary Description	Secondary Description	Line	Amount CMS
Code	Mod	Code	Mod	Mod Use			Count	Would Deny
92609	GN	92507	GN	YES	USE OF SPEECH DEVICE SERVICE	SPEECH/HEARING THERAPY	26	$2,817
					Misuse of Column Two code with Column One code			
01480	AA	64447	51	YES	ANESTH LOWER LEG BONE SURG	femoral nerve, including imaging guidance	2	$1,545
					Standard preparation/monitoring services for anesthesia			
19342	50	19370	99	YES	Insertion or replacement of breast implant on sep	Revision of peri-implant capsule, breast,inc	1	$837
					Misuse of Column Two code with Column One code			
84481		84480		NO	FREE ASSAY (FT-3)	ASSAY TRIIODOTHYRONINE (T3)	22	$428
					More extensive procedure			
33477		93317	26	YES	Transcatheter pulmonary valve implantation, per	ECHO TRANSESOPHAGEAL	1	$272
					Misuse of Column Two code with Column One code			
93975	26	76700	26	YES	VASCULAR STUDY	US EXAM ABDOM COMPLETE	1	$226
					Misuse of Column Two code with Column One code			
11104		99215	5	YES	PUNCH BIOPSY SKIN SINGLE LESION	Office/outpatient visit for E&M of estab pat	1	$223
					CPT Manual or CMS manual coding instruction			
84439		84436		NO	ASSAY OF FREE THYROXINE	ASSAY OF TOTAL THYROXINE	23	$217
					More extensive procedure			
G6015		77321		NO	Intensity modulated treatment delivery, single or	SPECIAL TELETX PORT PLAN	1	$204
					Misuse of Column Two code with Column One code			
90460		99392	5	YES	IM ADMIN 1ST/ONLY COMPONENT	PREV VISIT EST AGE 1-4	1	$193
					CPT Manual or CMS manual coding instruction			
						Top 10 TOTAL	**79**	**$6,962**
						GRAND TOTAL	**136**	**$9,447**

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
99292	8	CRITICAL CARE ADDL 30 MIN	1	$5,610
		Rationale: Clinical: Data		
31295	1	Nasal/sinus endoscopy, surgical, w dilation (balloon dila	6	$5,331
		Rationale: CMS Policy		
96133	7	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR	3	$5,040
		Rationale: Nature of Service/Procedure		
19364	1	with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)	1	$2,602
		Rationale: Nature of Service/Procedure		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	3	$2,528
		Rationale: Clinical: CMS Workgroup		
19318	1	Breast reduction	1	$1,878
		Rationale: CMS Policy		
30140	1	RESECT INFERIOR TURBINATE	7	$1,711
		Rationale: CMS Policy		
64905	1	NERVE PEDICLE TRANSFER	1	$1,225
		Rationale: Clinical: Data		
97153	32	ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN	2	$1,176
		Rationale: Clinical: Society Comment		
31276	1	SINUS ENDOSCOPY SURGICAL	1	$1,021
		Rationale: CMS Policy		
		Top 10 TOTAL	**26**	**$28,123**
		GRAND TOTAL	**56**	**$33,561**

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
E2402	1	NEG PRESS WOUND THERAPY PUMP	4	$11,842
		Rationale: Code Descriptor / CPT Instruction		
V2520	2	CONTACT LENS HYDROPHILIC	15	$990
		Rationale: Anatomic Consideration		
B4035	1	ENTERAL FEED SUPP PUMP PER D	5	$747
		Rationale: Code Descriptor / CPT Instruction		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	12	$677
		Rationale: Nature of Equipment		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	6	$440
		Rationale: Anatomic Consideration		
V2020	1	VISION SVCS FRAMES PURCHASES	4	$414
		Rationale: Clinical: Data		
V2522	2	CNTCT LENS HYDROPHIL BIFOCL	3	$220
		Rationale: Anatomic Consideration		
A7030	1	CPAP FULL FACE MASK	1	$208
		Rationale: Published Contractor Policy		
B4034	1	ENTER FEED SUPKIT SYR BY DAY	3	$194
		Rationale: Code Descriptor / CPT Instruction		
A7046	1	REPL WATER CHAMBER, PAP DEV	3	$155
		Rationale: Published Contractor Policy		
		Top 10 TOTAL	**56**	**$15,888**
		GRAND TOTAL	**63**	**$16,100**

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.

Audit Period 7/1/2023 - 9/30/2023							
Provider Id	Surgeries with 'CMS Defined' Prohibited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period	
	Surgeries without E/M Procedures during Prohibited Global Fee		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes without Modifier 24, 25, or 57	
	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
880459017	0	$0	1	100.0%	$129	2	$138
854064968	0	$0	1	100.0%	$30	0	$0
852202580	0	$0	1	100.0%	$141	0	$0
844822939	0	$0	1	100.0%	$30	0	$0
840404253	0	$0	1	100.0%	$127	0	$0
510566371	0	$0	1	100.0%	$115	0	$0
462843588	0	$0	1	100.0%	$160	0	$0
462812080	0	$0	1	100.0%	$103	0	$0
452698394	2	$1,319	1	33.3%	$660	0	$0
275302424	0	$0	1	100.0%	$201	0	$0
Top 10	**2**	**$1,319**	**10**	**83.3%**	**$1,695**	**2**	**$138**
Overall Total	**22**	**$5,913**	**28**	**56.0%**	**$5,008**	**2**	**$138**

CONCLUSION

UMR did not meet the performance metrics for financial accuracy, overall accuracy or claim turnaround in the first quarter of FY2024. A penalty of $46,420.60, or 3% of the administration fees for the quarter, is owed.

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.

115 West Wausau Ave
Wausau, WI 54401

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

December 22, 2023

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q1Y24 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID- 33 – Claim [redacted]6660 was adjusted and denied on 10-27-2023 as a duplicate to previously processed claim [redacted]5132. The payment error is $0.00 as there was no payment made.

Line 1 - Payment Information					Adjust Service
001	Deductible	.00	Total Amount Paid		.00
	Full Pay	.00	Withhold		.00
	Partial Pay	.00	CDH		.00
	% Paid	00	Tax Amount		
	Prov Go Out Rate	.00			

Claim Control #	[redacted]	Billed Amount	333.00		Release Date	08/31/23
Begin Date	08/22/23	Ineligible 1	.00	000	Draft Sub	0002
End Date	08/22/23	Ineligible 2	284.89	908	Provider	[redacted]
CPT Code	99214	Ineligible 3	48.11	858	Refer Prov	0000000

QID 34 – Claim [redacted]3047 was adjusted and denied on 12-20-2023 as a duplicate to previously processed claim [redacted]5372. This results in a $137.28 payment error.
QID 35 – Claim [redacted]2828 was adjusted and denied on 12-20-2023 as a duplicate to previously processed claim [redacted]7215. This results in a $508.68 payment error.
QID 37 – Claim [redacted]3569 was adjusted and denied on 12-202-023 as a duplicate to previously processed claim [redacted]4708. This results in a $0.00 payment error as there was no payment made.

Line 1 - Payment Information					Adjust Service
002	Deductible	205.54	Total Amount Paid		.00
	Full Pay	.00	Withhold		.00
	Partial Pay	.00	CDH		.00
	% Paid	00	Tax Amount		
	Prov Go Out Rate	.00			

Claim Control #	[redacted]	Billed Amount	635.67		Release Date	09/07/23
Begin Date	08/07/23	Ineligible 1	430.13	908	Draft Sub	0002
End Date	08/07/23	Ineligible 2	.00	000	Provider	[redacted]
CPT Code	99215	Ineligible 3	.00	000	Refer Prov	0000000

QID 36 – Claim [redacted]9264 was adjusted and denied on 12/19/2023 as a duplicate to previously processed claim [redacted]5758. This results in a $96.00 payment error.

Plan Exclusions – Massage Therapy
QID 49 - After further review, UMR agrees with this finding. Massage Therapy code 97124 is an excluded service on the plan. This claim will be adjusted and results in a $119.07 overpayment.

Potential Fraud, Waste, and Abuse – Repeated Genetic Testing
QID 45 – After further review, UMR agrees with this finding. At the time this claim was processed there was no authorization on file for code 81420. This claim was adjusted on 12-20-2023 and results in a $1662.42 overpayment.

Copay Application
PCP
QID 11- UMR disagrees with this finding. The provider specialty for this claim is OB GYN. This is a specialist and correctly applied a $50.00 copay.
Specialist
QID 16 – UMR agrees with this finding. A $40.00 copay was not applied this claim. This claim was adjusted on 12-20-2023 and results in a $0.00 payment error as the balance after Medicare remains the same.
QID 18 – UMR agrees with this finding. A $40.00 copay was not applied to this claim. This claim was adjusted on 11-3-2023 and results in a $25.41 underpayment.
Diagnostic Mammography
UMR agrees with these findings. The claims should have applied a $40.00 copay for diagnostic mammogram.
QID 14 – This claim was adjusted on 12-20-2023 and results in $36.54 underpayment.
QID 15 - This claim was adjusted on 11-14-2023 and results in a $39.99 underpayment.
QID 17 - This claim was adjusted on 11-14-2023 and results in a $80.13 underpayment.

PPO Provider without Discount
QID 28 – UMR agrees with this finding. This claim was allowed without pricing. The claim was adjusted on 11-3-2023 and results in a $13, 467.20 overpayment.

Preventive Services – Denied
QID 6 - After further review, UMR agrees with this finding. PEBP does not require annual COB investigations. This claim was adjusted on 12-20-2023 and results in a $375.00 underpayment.

Random Sample Findings

Denied Eligible Expenses
Sample 1076 – UMR agrees to a procedure error on this claim. The Customer First Representative (CFR) updated the COB status in the CPS processing system to reflect Medicare Primary in error. This caused the claim to deny for a MEOB. This claim has since been adjusted on 12-12-2023 with a payment of $6771.55 to the provider.

PPO Discount
Sample 1061 – [redacted]**8046 -** UMR agrees with this finding. An incorrect allowable was applied to this claim during processing. This claim was adjusted on 11-29-2023 to apply the correct SHO contract case rate. This results in a $2727.51 underpayment.

Sample 1112 – [redacted]**4982** - UMR agrees with this finding. An incorrect allowable was applied to this claim during processing. This claim was adjusted on 12-19-2023 to apply the correct SHO contract case rate. This results in a $7476.55 overpayment.
Sample 1129 – [redacted]**6220 –** UMR agrees with this finding. An incorrect allowable was applied to this claim during processing. This claim will be adjusted. This results in a $239.76 overpayment.

Coinsurance Error
Sample 1131 – UMR agrees with this finding. This outpatient surgery claim was processed with an incorrect POS. For this reason, the copay did not apply per the plan benefits and was allowed at 80%. This claim was adjusted on 12-20-2023 and results in a $144.61 overpayment.
Sample 2012 - UMR agrees with this finding. An incorrect coinsurance applied to this claim. This claim will be adjusted and results in a $23.40 overpayment. UMR is investigating the root cause.
Sample 2014 - UMR agrees with this finding. An incorrect coinsurance applied to this claim. This claim will be adjusted and results in a $13.12 underpayment. UMR is investigating the root cause.

Deductible Error
Sample 2023 – UMR agrees with this finding. This claim should have applied to the deductible. This claim will be adjusted and results in a $84.00 overpayment. UMR is investigating the root cause.

MUE – Page 19 and 20 - As a commercial payer, we do not only adhere to CMS or NCCI guidelines, but rather we also consider AMA interpretation and the interpretation of the Nationally recognized sources such as the various specialty societies and associations. If the AMA or one of these other sources have a different guideline or interpretation, that will be applied within our editing as a commercial payer instead of NCCI.

UMR is dedicated to improving the overall experience for the State of Nevada PEBP members and will continue to work diligently on addressing any issues highlighted by this review. Coaching and ongoing training is held with our dedicated processors. We continue to meet with the staff daily to go over quality reports, identifying trending errors, initiating refresher training for skill gaps, and using this data to improve the overall quality of the staff.
If you have any questions or concerns regarding our responses, please feel free to contact me at 715-841-7262.

Sincerely,

Julie Frahm
Sr. 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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7.1

7. Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Third-Party Administrator, UMR, for FY2024 Q1 covering the period of July 1, 2023 – September 30, 2023.
(Tim Lindley, Quality Control Officer)
(**For Possible Action**)

7.1 UMR Remediation Plan

UMR Remediation Plan

State of Nevada Public Employees' Benefit Program (PEBP)

Administered by UMR

Remediation Response Period:

July 1, 2022 – September 30, 2023

Presented to:

State of Nevada Public Employees' Benefit Program (PEBP)

January 26, 2024

Proprietary and Confidential

Table of Contents

Executive Summary

This Remediation Plan will play an integral role in managing and achieving PEBP's expectations and UMR's Performance Guarantees for the near future.

UMR has met the Performance Guarantees for Utilization Management/Case Management for the last three quarters. We also met the Performance Guarantees for Network Administration in Q1 2024. This is the standard UMR is committed to achieve for Claims Administration Performance Guarantees.

Included with this strategic Remediation Plan you will find goals and objectives that UMR leadership and staff have implemented. These steps will ensure that we bring the remaining eight Performance Guarantees outlined in this remediation plan in compliance with the agreed upon standards. More frequent status reports will be provided to PEBP staff monthly.

In addition to the legacy HealthSCOPE Benefits (HSB) staff who have worked on the PEBP account for 13 years, we continue to add additional resources in the areas of claims administration and customer care. The legacy HSB staff are directly involved in day-to-day operations and their historical knowledge is instrumental to our success. Additionally, we have increased internal audits on the PEBP account for process improvement opportunities.

For Plan Year 2023 we processed 530,438 claims for a total billed amount of over $1,082,468,170 for 9,228 unique providers and 43,665 unique participants. Additionally, we managed over 86,000 participant calls with a call satisfaction rate of 97.4%.

Access to health care in UMR's network across the state of Nevada for PEBP employees and their families has been stable and consistent since PEBP became a UMR client on July 1, 2022. In fact, we have added more providers to our networks since July 1, 2022, than the number of providers that have left the network for various reasons. Provider terminations are generally due to retirement, providers leaving the community, provider group acquisitions, etc. UMR is not aware of any provider terminations related to service issues.

Through our various networks, medical management, and payment integrity services, UMR has helped the PEBP plan achieve an estimated savings of over $872,000,000 for Plan Year 2023. These estimated savings not only saved the taxpayer funded PEBP plan but also directly saved money for PEBP participants, retirees, and their families.

UMR (including legacy HealthSCOPE Benefits) staff and PEBP have partnered to service State of Nevada participants, retirees, and their families for over a decade. We are fully committed to meet our mutual goals under the UMR brand.

Detailed Objectives

CLAIMS OPERATIONS

Our goal is to meet or exceed Performance Guarantees going forward. The section below will outline our plan for continuous improvement until we meet the requirements of the contract specific to the following areas: Financial and Overall Accuracy, Claim Turnaround Time, and Claim Adjustment Time.

1.1 Financial Accuracy and 1.2 Overall Accuracy

The objective is to improve Financial and Overall accuracy results to meet or exceed the required metrics. Leadership is focused on using errors identified through internal and Claims Technologies (CTI) audits to guide training efforts with analysts. Additional daily monitoring of internal UMR accuracy results began mid-January, will provide timely remediation at the claim analyst level. In addition, internal UMR daily audits have been implemented to identify duplicate claims. The planned result being to minimize or eliminate repetitive errors at their beginning stages.

Training sessions pertaining to “refresher subjects” and repetitive errors identified through our internal daily monitoring will be held weekly.

Targeted areas of review will be complex specialized claims, claim pricing scenarios and duplicate claim review.

Results will be measured monthly with an expectation of continuous improvement until we meet the requirements of the contract for financial and overall accuracy to meet Performance Guarantees.

1.3 Claim Turnround Time

The objective is to reduce turnaround time to meet or exceed required metrics. Based on average manual claim receipts of 25,000 per month, we increased our dedicated claim analysts from 14 to 20. We added additional support to assist with managing inventory and improve claim turnaround time. With these changes we were able to meet the Q1 Plan Year 2024 for the 14 days turnaround Performance Guarantee.

Daily monitoring of the claim analysts productivity and availability is conducted by the Claims Director to ensure individual analyst metrics are achieved. This process began January 2, 2024.

As a result of these improvements, we expect to see continuous improvement in turnaround time metrics until we meet the requirements of the contract.

1.4 Claim Adjustment Time

The objective is to improve Claim Adjustment Turnaround Time to meet or exceed required metrics. Leadership will distribute adjustment assignments daily to analysts as priority and implement check-ins at the 72-hour mark to ensure adjustments are managed timely.

Results will be measured monthly with an expectation of continuous improvement until we meet the requirements of the contract.

CUSTOMER CARE

Our goal is to meet or exceed Performance Guarantees going forward. This section below will outline our plan for continuous improvement until we meet the requirements of the contract specific to the following areas: First Call Resolution, Open Inquiry Closure, Quality Audit Scores, and Callback Performance.

1.7 First Call Resolution

In July 2022, during the transition from HealthSCOPE Benefits (HSB) to UMR, call staffing levels increased from 18 call agents to 22 agents. In August 2023, the call staff was increased from 22 to 27 agents and then again in November 2023, the call staff was increased from 27 to 31 agents. The increase in staffing was implemented to support the Performance Guarantee for calls answered within 30 seconds, which has been consistently met since reaching a level of 31 call staff.

The increase to 31 call agents along with 2 dedicated claims analysts, will support the steady improvement of first call resolution toward consistently meeting quarterly Performance Guarantees.

1.8 Open Inquiry Closure

As indicated under 1.7, call staffing has steadily increased over the past 18 months. We currently have 31 call agents assigned to PEBP account. The increase in call agents along with 2 dedicated claims analysts has helped to consistently meet the 90% within 48 hours goal and steadily improve on the 98% within 5 business days goal toward meeting quarterly Performance Guarantees.

1.9 CSR Audit or Quality Scores

In January 2024 we increased the call audits from 120 to 180 calls per month. The additional call audits, along with an increase of supervisor reviews of live calls, will give UMR a larger sampling to help identify areas and individuals that may be struggling. Quality results are reviewed during biweekly team meetings and our weekly one on ones with call agents. Coaching and training are also performed as needed. The increased reviews and heightened awareness will improve the overall quality scores and give more consistency month over month to meet quarterly Performance Guarantee.

1.10 CSR Callback Performance

Additional reporting was implemented January 2024 to identify outstanding callbacks. This internal report is used to monitor and resolve any calls within 24 hours. There is also some redundancy built into the monitoring through multiple leaders to ensure no days are missed which will enable us to meet Performance Guarantees.

PPO PRICING ERRORS

Summary of action items taken and discussed within the Remediation Plan.

- Increase of claim audits from 400 per month to 600 per month to eliminate pricing errors and to improve accuracy and efficiency.
- Network Repricing Unit (NRU) to complete back-end reporting for quality improvement.
- Network team will collaborate in our internal weekly management meetings.
- Continued collaboration between internal team to improve overall Performance.

Objective:

Our objective is to reduce and eliminate pricing errors and to improve accuracy and efficiency in network administration. We have conducted a thorough analysis of pricing errors and identified gaps in the process.

We will conduct coaching and additional training sessions to help staff thoroughly understand the internal workflow process. These sessions will also focus on the importance of accuracy and attention to detail. We will review and streamline the processes for network pricing to make it more efficient. This will include review of increasing our ability to systematically price claims, provide clear procedural guidelines and training materials for staff, and utilize our efforts for continuous monitoring and improvement. Continuing education sessions on the handling of claims will take place collaboratively with the UMR Network team and Claim Operations.

UMR will increase internal audits from 400 to 600 on a monthly basis immediately to ensure claims process accurately. It is important to increase the population of audited claims on a weekly basis, this will help to identify and address any ongoing issues and ensure that discounts apply correctly. In addition to audits, it is also important to implement additional back-end audit production reports. These reports will generate on claims that require manual pricing from the network team which will identify any discrepancies and allow for prompt action. UMR Network Team has started running back-end audit reports to review accuracy.

We will regularly monitor the progress of the Remediation Plan and track the reduction in pricing errors. This will identify any ongoing issues and allow for timely action. Any identified issues or concerns will be addressed promptly. We will share the progress internally with UMR Leadership and highlight any improvements. There will be open communication with the UMR Network Team, Account Management and Claim Operations about the Remediation Plan progress. This will help manage expectations and build trust in the accuracy of claim administration as well as provide an opportunity for feedback and suggestions for improvement. We will accomplish this through weekly internal meetings.

We understand pricing errors have a significant impact on the accuracy and efficiency of claim administration. By following this Remediation Plan, we aim to reduce and eliminate these errors, leading to improved customer satisfaction and increased productivity. Regular monitoring and continuous improvement will be key to the success of this plan.

Conclusion

UMR holds our partnership with State of Nevada Public Employees' Benefit Plan (PEBP) with the upmost importance. UMR's objectives and goals are in alignment with PEBP and it is our commitment to improve and meet all Performance Guarantees.

The forty-two (42) PEBP Performance Guarantees reported either quarterly or annually are the largest number of Performance Guarantees, and the most stringent, that UMR has for our entire book of business. We agreed to these standards, and as agreed upon in our contract, we have paid $531,507.56 in Performance Guarantee penalties.

UMR leadership and staff are committed to meeting the challenge to bring the remaining 8 Performance Guarantees outlined in this remediation plan in compliance with the standards. When comparing the average miss for the 8 Performance Guarantees from Q1 2023 to Q1 2024, we have improved the average miss from 4.4% to 2.4%, or an improvement of 46%.

In addition to the steps outlined in this Remediation Plan, UMR will also submit a monthly Performance Guarantee report to PEBP beginning mid-February. Our goal is to document our efforts and meet the standards established in this Remediation Plan.

UMR appreciates the ongoing partnership with PEBP to work together to provide high-level service to the State employees, retirees, their families, and the provider community.

Appendix

Book of Business Provider Add/Term Counts

Total Provider Count (Facility, Ancillary Professional) – UHC Choice Plus Network (SOUTH)

As of July 1, 2022	7,052
Terms 7/1/22 – 12/18/23	2,024
Adds 7/1/22 – 12/18/23	2,915
Net as of 12/18/23	7,943

Total Provider Count (Facility, Ancillary Professional) – UHC Choice Plus Network (NORTH)

As of July 1, 2022	4,429
Terms 7/1/22 – 12/18/23	1,356
Adds 7/1/22 – 12/18/23	1,649
Net as of 12/18/23	4,722

Total Provider Count (Facility, Ancillary Professional) – SHO/BHO (SOUTH)

As of July 1, 2022	11,600
Terms 7/1/22 – 12/31/23	3,056
Adds 7/1/22 – 12/31/23	2,994
Net as of 12/31/23	11,538

Total Provider Count (Facility, Ancillary Professional) – SHO/BHO (NORTH)

As of July 1, 2022	3,762
Terms 7/1/22 – 12/31/23	912
Adds 7/1/22 – 12/31/23	937
Net as of 12/31/23	3,787

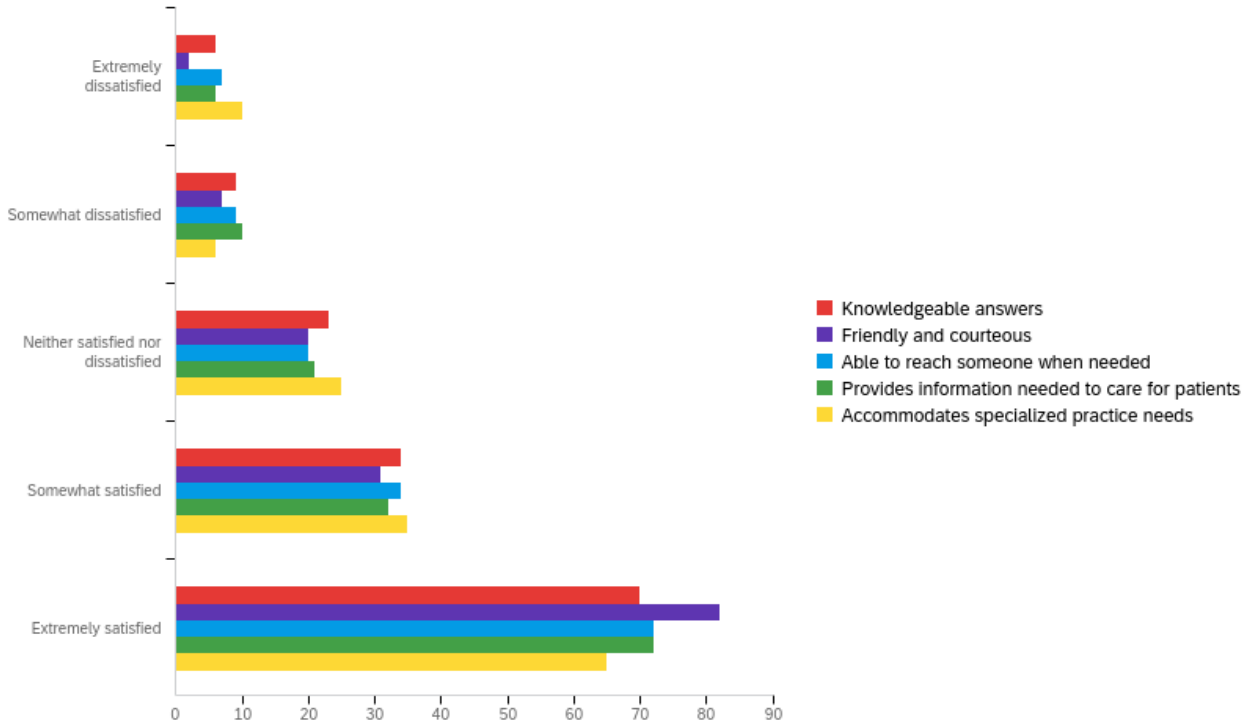
*Terminations are for reasons such as retirement, providers leaving the community, provider group acquisitions, etc.

NV PUBLIC EMPLOYEES BENEFITS PROGRAM
Medical Plans Claims & Call
Utilization Process Period 7/1/2022 6/30/2023

How many claims have we processed?	530,438
Total Dollar amount billed?	$1,082,468,170
Total Dollar amount paid?	$169,265,027

Quarter	Calls Received	Surveys Answered	Positive Answers	Survey Score
1st Quarter	22,478	445	434	97.5%
2nd Quarter	17,395	359	349	97.2%
3rd Quarter	22,867	435	431	99.1%
4th Quarter	23,677	422	403	95.5%
Total	86,417	1,661	1,617	97.4%

Provider Satisfaction Survey



8.

8. Acceptance of Mental Health Parity and Addiction Equity Act Report including possible action on, but not limited to, the following items (Celestena Glover, Executive Officer) (Information/Discussion)

8.1 Mental Health Parity and Addiction Equity Act Executive Summary

8.1

8. Acceptance of Mental Health Parity and Addiction Equity Act Report including possible action on, but not limited to, the following items (Celestena Glover, Executive Officer) (Information/Discussion)

8.1 Mental Health Parity and Addiction Equity Act Executive Summary

Segal

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Memorandum

To: Celestena Glover, Executive Officer
Nevada Public Employees' Benefits Program (PEBP)

From: Richard Ward, FSA, FCA, MAAA

Amy Dunn, JD, MHA

Date: January 19, 2024

Re: Executive Summary and Recommendations for Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

Executive Summary

Segal was retained to review the Nevada Public Employees' Benefits Program's (PEBP) benefits under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). We have prepared this memorandum to assist PEBP in reviewing possible Plan Document language revisions that may be considered for purposes of consistency with the MHPAEA and related regulations.

For purposes of this memo, we reviewed the Nonquantitative Treatment Limitations (NQTLs) in the Plan Documents downloaded from PEBP's website June 2, 2023 for the July 1, 2023 – June 30, 2024 Plan Year for the Consumer Driven Health Plan (CDHP), Low Deductible PPO Plan (LD PPO) and the Exclusive Provider Organization Plan (EPO).

Throughout this memo, we use the acronyms "Med/Surg" to refer to medical and surgical, and MH/SUD to refer to mental health and substance use disorder benefits.

Key Findings

In addition to the plan design changes approved in December 2023 to the LD PPO and EPO plans, our recommendations generally include the following actions:

- Modify or remove certain exclusions/limitations
- Clarify certain day limits or visit limits
- Clarify certain benefit descriptions
- Reassign certain benefit classifications
- Other considerations

The following provisions, as written in the Plan Document(s), merit reconsideration for compliance with MHPAEA:

Modify or remove certain exclusions/limitations

Exclusion for Attention Deficit Disorder

The Plan Documents exclude benefits for “attention deficit disorders (with or without hyperactivity, except when the services are for diagnosis, the prescription of medication as prescribed by a physician or other health care practitioner, or when accompanied by a treatment plan as submitted to the Plan or its designee) or the treatment is related to the management of ADD/ ADHD without prescription drugs and is approved by the Plan”. This may present issues under MHPAEA as there appear to be restrictions on care for this specific diagnosis that are not applied to any medical diagnosis. Also, if a plan provides MH or SUD benefits in any one classification, it must provide treatment in all classifications in which Med/Surg benefits are provided. As PEBP is covering prescription medications for treatment of attention deficit disorder, it must provide coverage for all six benefit classifications that are prescribed under the regulations.

Recommendation

Remove exclusion for attention deficit disorders.

Exclusion for Hypnosis and Hypnotherapy

The Plan Documents include an exclusion for hypnosis and hypnotherapy. This exclusion appears only under the behavioral health exclusions and there is not a similar exclusion under medical.

Recommendation

Move this exclusion under the general exclusions; so it is clear it applies equally to MH/SUD and Med/Surg if that is consistent with administrative operation.

Exclusion for Marriage, Couples and/or Sex Counseling

The Plan Documents include an exclusion for marriage, couples and/or sex counseling. While marriage, couples and/or sex counseling is not required to be covered, many plans have added a clarification to similar exclusions noting that the exclusion will not limit mental health treatment for an otherwise covered mental health condition for each family member (such as a spouse receiving individual covered mental health services from a marriage counselor for a diagnosis of depression). We also note that an exclusion for “sex counseling” could be interpreted as an exclusion aimed at gender dysphoria and PEBP should clarify the intent.

Recommendation

Clarify that the exclusion for marriage/couples counseling will not limit individual mental health counseling for an otherwise covered mental health condition.

As sex counseling could be interpreted as an exclusion aimed at gender dysphoria, PEBP may want to clarify intent for exclusion for “sex counseling” or remove the exclusion.

Exclusion for Cognitive Therapy

The Plan Documents exclude coverage for cognitive therapy unless it is related to “short-term services necessitated by a catastrophic neurological event to restore functioning for activities of daily living”.

Cognitive therapy is a common form of therapy for MH/SUD. It is unclear how this exclusion may be applied and whether it excludes benefits for otherwise covered MH conditions.

Recommendation

Revise the Plan Documents to add an exception to this exclusion for medically necessary treatment of a MH/SUD condition.

Exclusion for Sleep Disorders

The Plan Documents cover medical treatment for sleep disorders. However, there is an exclusion for “cognitive behavior therapy for sleep disorders“. Allowing medical treatment of sleep disorders while excluding cognitive therapy raises compliance concerns under MHPAEA because cognitive therapy is a form of therapy for MH/SUD.

Recommendation

Add an exception for medically necessary treatment of a MH/SUD condition.

Exclusion for Milieu Therapy

The Plan Documents include an exclusion for milieu therapy. This could exclude treatment for an otherwise covered MH/SUD condition and raise compliance concerns under MHPAEA. Although milieu therapy may also be done on an outpatient basis, it is treatment for behavioral health and is not used for medical indications.

Recommendation

Confirm if this exclusion is intended to deny benefits for residential treatment that is otherwise covered throughout the Plan Document. If consistent with administrative practice, add a clarification to the exclusion “unless the care is otherwise medically necessary”.

Exclusion for Food Addictions

The Plan Documents include an exclusion for food addictions. PEBP should review how this exclusion is applied in operation. Plans are permitted under MHPAEA to have a complete exclusion of all benefits that treat a particular MH/SUD condition. However, Federal enforcement generally tends to raise questions about plan provisions that may exclude medically necessary treatment for eating disorders.

Recommendation

PEBP should consider removing the exclusion for food addictions as it may run afoul of MHPAEA which considers an eating disorder to be a mental health diagnosis and subject to MHPAEA. If the exclusion is maintained, PEBP will need to confirm that it is excluded in all six benefit classifications in the regulations (including prescription drugs).

Exclusion for weight management

The Plan Documents include an exclusion for weight management as follows:

> Expenses for medical or surgical treatment of severe underweight, including (but not limited to) high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of anorexia, bulimia, or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height, and body frame based on weight tables generally used by physicians to determine normal body weight.

There is no requirement under MHPAEA to provide coverage for specific diagnoses (such as severe underweight) as long as it is being excluded in all six categories. However, MHPAEA considers eating disorders to be a mental health diagnosis and therefore, subject to MHPAEA. The Plan Documents do include an exception for anorexia, bulimia, or acute starvation.

Recommendation

PEBP may want to remove the list of specific diagnoses (as it is not all-inclusive) and reference "medically necessary treatment of an eating disorder".

Speech Therapy

The CDHP Schedule of Medical Benefits includes benefits for speech therapy for an injury, or sickness that is other than a learning or mental disorder. Limiting speech therapy for a mental health diagnosis may present problems under MHPAEA as speech therapy is commonly used for the treatment of MH conditions, notably autism. As the limitation is only present in the CDHP Plan and not the LD PPO or EPO, it is possible it was inadvertently maintained.

Recommendation

Remove the limitation for speech therapy for a mental disorder.

Alternative/Complimentary Health Care Exclusions

The Plan Documents exclude coverage for chelation therapy except as may be medically necessary for treatment of acute arsenic, gold, mercury, or lead poisoning and for diseases due to clearly demonstrated excess of copper or iron. While it would be appropriate to exclude chelation therapy for all conditions, it raises MHPAEA compliance concerns to allow it only for certain medical diagnoses as it can be prescribed for the diagnosis of autism and ADHD.

Recommendation

Add an exception for medically necessary treatment of a mental health diagnosis.

Exclusion for Vitamin B-12 injections

The Plan Documents exclude vitamin B-12 injections "except for pernicious anemia, other specified megaloblastic anemias not elsewhere classified, anemias due to disorders of glutathione metabolism, post-surgery care or other b-complex deficiencies), antihemophilic factors including tissue plasminogen activator (TPA), acne preparations, and laxatives (unless otherwise specified in the Schedule of Medical Benefits". Allowing B12-injections for certain medical diagnoses while not allowing for any mental health diagnoses (such as anxiety and depression) could present issues under MHPAEA.

Recommendation

Revise the exclusion to make an exception for a MH/SUD condition.

Clarify certain day limits or visit limits

Speech, occupational, and physical therapy visits

The EPO and LD PPO Plans limit coverage for Rehabilitation and Habilitation Facilities to 60 days per Plan year (for physical, occupational and speech therapies). Since visit limits and day limits do not appear to apply to substantially all Med/Surg benefits, it would not be permissible for a visit limit to be imposed with respect to any services provided in this classification for the treatment of a MH/SUD condition.

The Plans require precertification for habilitative and rehabilitative therapy visits (physical, speech, occupational) exceeding 90 combined visits per Plan Year.

The CDHP Plan, LD PPO Plan and the EPO Plan further outline available habilitative and rehabilitative benefits. However, the CDHP Plan and the LD PPO Plan describe the requirement for prior authorization for visits exceeding the combined therapy maximum and specifically state "(limit not applied to therapy treating a behavioral health condition)."

Recommendation

We recommend adding an exception to the EPO and LD PPO Plans in the Rehabilitation and Habilitation Facilities row to clarify that the 60 days per Plan year (for physical, occupational and speech therapies) does not apply to treatment of mental health or substance use disorder.

PEBP may also want to consider adding a consistent exception throughout all three of the documents (wherever habilitative and rehabilitative benefits are described with a limit) to state "Visit limits will not apply to Medically Necessary treatment of mental health or substance use disorder".

Clarify certain benefit descriptions

Case Management

The Plan Documents describe a case management program. We note that this is a voluntary program. However, the plan language does not clearly indicate that case management is available for MH/SUD conditions though it also does not state that it is excluded.

Recommendation

Revise the plan language to make clear that a disability resulting from a mental health or substance use diagnosis will be covered under the case management program.

Rehabilitation Therapy (Inpatient or Outpatient)

The Plan Documents exclude coverage for speech therapy for "conditions of psychoneurotic origin". The language is unclear if this excludes treatment for autism or other MH conditions.

Recommendation

If “conditions of psychoneurotic origin” includes autism or other MH conditions, it should be removed.

Exclusion for Sexual Dysfunction

The Plan Documents include the following located within the exclusion section: “Except as otherwise provided in the Summary of Medical Benefits and Schedule of Medical Benefits, drugs, medicines, procedures, services, and supplies to correct or enhance erectile function, enhance sensitivity or for sexual dysfunction (organic or inorganic), inadequacy, or enhancement, including penile implants and prosthetics, injections, and durable medical equipment”. However, under the family planning benefits in the Schedule of Benefits for the CDHP plan, it states “procedures related to sexual dysfunction may be covered”. Additionally, under the LD PPO and EPO plans, the Plan Documents state “Medical or surgical treatment for sexual dysfunction: There are some limits on sexual dysfunction drugs such as Viagra or Muse and are subject to the Plan Year Deductible.”

If a plan provides MH or SUD benefits in any one classification, it must provide treatment in all classifications in which Med/Surg benefits are provided. This means that if the plan is covering procedures related to sexual dysfunction, it may be required to provide coverage for all six benefit classifications that are prescribed under the regulations (including prescription drugs).

Recommendation

PEBP should clarify coverage and plan language for services and drugs related to sexual dysfunction within the CDHP, LD PPO and EPO plans consistent with MHPAEA.

Enteral Formulas and Special Food Products

The Plan Documents allow enteral formulas and special food products for a person with inherited metabolic disease up to a maximum benefit of $2,500 per Plan Year. There is no similar coverage available for a mental health condition, such as an eating disorder. Allowing coverage for special food products with respect to medical condition, but not if needed with respect to otherwise covered MH condition, such as an eating disorder raises MHPAEA compliance concerns.

Recommendation

Allow enteral feedings for a MH diagnosis without the $2,500 annual maximum per plan year (as plans are not able to impose a dollar limit on a MH/SUD diagnosis).

Reassign certain benefit classifications

Partial Hospitalization

The Plan Documents specifically list partial hospitalization as an “inpatient” benefit under the preauthorization requirements of the plan. The comparative analysis also assigns outpatient partial hospitalization as an inpatient benefit.

Recommendation

Partial hospitalization should be reassigned as an outpatient benefit and referenced accordingly throughout the Plan Document and the comparative analysis received from Sierra Healthcare Options (SHO).

Other Considerations

Treatment plan required for treatment of autism

The Plan Documents state that any treatment of autism spectrum disorders must be identified in a treatment plan. In addition, the CDHP Plan states that "treatment must have a physician's order, include a treatment, and discharge plan". The plan terms are written as required under state law.

Requiring a treatment plan (in addition to a physician's order and discharge plan on the CDHP Plan) for behavioral health services when there is no similar requirement for medical services raises MHPAEA compliance concerns. The DOL Warning Signs on mental health parity specifically mentions this as problematic when no similar handling is required for Med/Surg treatment.

Recommendation

The Plan should coordinate with the administrator and State regulators and/or the Department of Health and Human Services (HHS) regarding questions related to appropriate coordination of related but distinct State/Federal requirements related to autism, a MH benefit subject to MHPAEA.

ABA Therapy

The comparative analysis from SHO addressing prior authorization shows ABA therapy as a medical benefit.

Recommendation

Restrictions related to treatment of autism are being reviewed by the Federal Departments under MHPAEA and raising heightened scrutiny in the Federal audit context. The comparative analysis received from SHO states "NOTE: Applied Behavioral Analysis (ABA) is a medical benefit per Nevada statute." As a federal auditor may not agree with this approach, SHO will need to have a comparative analysis available that assigns ABA therapy as a MH benefit.

As with all our work involving the analysis of a law and its application to specific facts, the State should rely on Legal Counsel for authoritative advice.

Conclusion

The adoption of these recommendations is expected to have a negligible impact on plan expenses in aggregate.

If additional discussion would be helpful to clarify our comments and recommendations, or if we can be assistance in seeking any clarifications regarding plan administration, please let us know and we would be glad to meet, discuss and assist as needed.

9.

9. Discussion and possible action on potential plan design changes for Plan Year 2025 (July 1, 2024 to June 30, 2025) (Celestena Glover, Executive Officer) (**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: January 26, 2024

Item Number: 9

Title: Proposed Plan Design Changes for Plan Year 2025

SUMMARY

This report provides options for the Plan Year 2025 plan design changes beginning July 1, 2024.

BACKGROUND

At the December 2023 PEBP Board Meeting recommendations were discussed for potential plan design changes. All were approved except the UMR Prescription Copay Maximizer. Since that time additional reviews of the plan design and the requirement to comply with the provisions of the Mental Health Parity and Addiction Equity Act resulted in additional recommendations for plan design and benefit changes.

REPORT

PLAN DESIGN CHANGES

UMR Prescription Copay Maximizer

This recommendation was brought to the board in our December 2023 board meeting. This is a voluntary program that provides copay assistance to members via a coupon program. During that discussion the Board asked staff to renegotiate the terms for further consideration. An agreement has been reached with UMR, however, since the negotiated rate is confidential that specific information has been provided to the Board under separate cover.

> The "UMR Prescription Copay Maximizer Benefit" is a voluntary program that provides copay assistance to members via a coupon program. A UMR patient advocate will conduct outreach to members and introduce the UMR Prescription Copay Maximizer Program.

Mental Health Parity and Addiction Equity Act (MHPAEA)

Segal's Non-Qualitative Treatment Analysis has revealed the need for updates to bring PEBP plans in compliance with the MHPAEA. The majority of which are clarification to plan document language rather than plan design changes. However, to ensure no potential plan design changes are missed in the approval process PEBP staff included this item as a general plan design change. Details were provided in Segal's report provided in agenda item 8.

Elimination of Prior Authorization Requirements for Certain Services

Ambulatory Surgery Centers

The Utilization Management Company, SHO, reports outpatient and physician surgery performed at ambulatory surgical centers (ASC) cost significantly less to the member and the Plan. By removing prior authorizations for services performed at an ASC, there will be steerage to In-Network facilities and will reduce PEBP member's administrative barriers to services. If services are not performed at an In-Network ASC, the prior authorization requirement will apply.

Dialysis

SHO reported to PEBP that requiring a prior authorization for dialysis is redundant when performed at an In-Network facility. It is recommended to remove Dialysis from requiring a prior authorization.

GSA Rates for Travel Benefits

During the 2022 biennial compliance review, it was determined that travel reimbursements were subject to cost share and reimbursements in excess of IRS limitations were subject to federal tax assessments. At that time PEBP did not have the ability to report taxable income to the IRS, therefore travel benefit rates were reduced.

UMR has reported they are able to issue payment for travel reimbursements without utilizing cost-share. Due to this, PEBP will be able to manually report taxable income to the IRS and the members.

This change will allow reimbursement for meals, travel, and lodging for the member and one companion. This benefit would apply to these specific medically approved services:

- Bariatric
- Hip/Knee
- Organ/Tissue Transplant
- Abortion

RECOMMENDATIONS

1. Approve UMR's Prescription Copay Maximizer Program at the proposed terms.

2. Approve the required changes to bring all plans in compliance with the Mental Health Parity and Addiction Equity Act.

3. Approve removing prior authorization requirements for services provided at In-Network Ambulatory Surgery Centers by In-Network providers.

4. Approve removing prior authorization requirements for dialysis.

5. Approve the use of GSA rates for reimbursement of allowed travel expenses, for medically approved services to include reporting to the IRS.

10.

10. Discussion and possible action on recommended changes and updates to the Master Plan Documents for Plan Year 2025 (July 1, 2024 to June 30, 2025)
(Tim Lindley, Quality Control Officer)
(**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: January 26, 2024

Item Number: 10

Title: Proposed Changes to the Plan Year 2025 Master Plan Documents (MPDs)

SUMMARY

This report will go over the benefit changes and updates to the Master Plan Documents (MPD) and Summary of Benefits and Coverage for plan year 2025:

- Consumer Driven Health Plan Master Plan Document and Summary of Benefits and Coverage
- Low Deductible PPO Master Plan Document and Summary of Benefits and Coverage
- Exclusive Provider Organization Master Plan Document and Summary of Benefits and Coverage
- Dental Plan and Life Insurance Master Plan Document
- Health Reimbursement Arrangement Summary Plan Document
- Flexible Spending Account Master Plan Document
- Enrollment & Eligibility Master Plan Document
- Medicare Health Reimbursement Arrangement Master Plan Document
- Health and Welfare Wrap for Actives
- Health and Welfare Wrap for Retirees
- Section 125 Master Plan Document

Due to file size, to see red-lined changes please visit https://pebp.nv.gov/Meetings/current-board-meetings/ for digital, PDF copies of plan documents.

BACKGROUND

Throughout the plan year, several intricacies in the plan document verbiage are identified through various methods. Examples include a member notifying PEBP, an audit review, vendor inquiry, etc.

PEBP staff and its vendor partners, reviewed Master Plan Documents, Summary Plan Documents, and Summary of Benefits and Coverages. The proposed changes stem from input received from subject matter experts – some changes being simply housekeeping efforts, while others are regulatory and compliance matters.

REPORT

The lists and tables below will review housekeeping changes, Board approved changes, changes required per the Mental Health Parity and Addiction Equity Act, No Surprises Act, Plan Design changes, and other changes deemed necessary for board approval.

"HOUSEKEEPING" CHANGES

There were several updates and changes implemented across plan documents. These include the following list of changes:

- Formatting.
- Removal of PEBP-specific one-time funding information for Health Savings Accounts and Health Reimbursement Arrangements.
- Updates to limitations per IRS requirements.
    - This includes increased Health Savings Account contribution limitations, the deductible floor the high-deductible health plan, and any other mandatory required changes.
- Plan year timeframe updated to 07/01/2024 through 06/30/2025.
- Updating the plan documents to reference PEBP's current web address: https://pebp.nv.gov/
- Required amendments to the plan documents throughout Plan Year 2024 were applied to the plan documents accordingly. Amendments incurred during Plan Year 2024:
    - Added language from bills passed in the 2023 Legislative Session.
    - Health Savings Account contribution limitations per IRS.
    - Under the Utilization Management section for "Impatient Admissions" – Remove "All" and "Same-day surgeries." Refer to the Outpatient and Physician Surgery category for outpatient and same-day surgery prior authorization requirements.
    - Preventative Services updated to align with USPSTF guidelines, NRS, and remove mammogram limitation language.
    - For Durable Medical Equipment, clarified listed examples.
    - Added NRS for Continuity of Coverage under the No Surprises Act.
    - For Pharmacy Benefits, added information for Diabetes Care Value.

    - For limitations and exclusions, added NRS citations and clarified limits for corrective appliances to "not medically necessary."
    - Updated contact information for Office of Consumer Health Assistance.
    - Updated Coordination of Benefits language to coincide with the Health and Welfare Wrap Plan Documents
- Updated Key Terms and Definitions to include NRS citations for Medically Necessary, Step Therapy, and Medical Management Techniques.
- Updated references to Nevada Revised Statute (NRS) or Nevada Administrative Code throughout documents:
    - Health benefits covered under NRS were cited in the MPD next to appropriate benefit language and hyperlinked to the legislative website.

Note: As bills from the 2023 Legislative Session are codified, the plan document may be updated mid-year to cite the appropriate statutory chapter.

BOARD REVIEWED AND PLAN DESIGN CHANGES

There are some changes the Board has already approved that are identified here. This includes other plan benefit changes that are contingent on the Board's approval in the prior agenda item.

#	Change Type	Proposed Change	Justification	Section
1	Reduction	Updated deductible as required for Health Savings Account to $1,600 for single tier coverage and $3,200 for spouse, children, and family tiers	Board approved on December 7, 2023	Consumer Driven Health Plan Master Plan Document
2	Enhancement	For Specialty Drugs part of the SaveOnSP program, the coinsurance applies (CDHP - 20%, PPO 30%, EPO 20%). For Specialty Drugs not part of the SaveOnSP program, the respective coinsurance applies with a copay limitation $100 minimum and a maximum of $250.	Board approved on December 7, 2023	Prescription Drug Benefit

#	Change Type	Proposed Change	Justification	Section
3	Enhancement	Under the Plans Prescription Drug Benefit, this will be added: UMR offers a Medical Pharmacy Coupon Program: For drugs administered in an inpatient setting, there is a "UMR Prescription Copay Maximizer Benefit" where a member may receive cost-share assistance. A UMR patient advocate will conduct outreach to members and introduce the UMR Prescription Copay Maximizer Program. The member can voluntarily enroll in to qualifying copay assistance programs. This may help the member with their cost-share for certain drugs. Please contact UMR for additional information or assistance.	UMR prescription Coupon Program	Prescription Drug Benefit
4	Enhancement	Reinstate Travel Benefit to allow for reimbursement up to GSA rates, with specifics documented in Exhibit A.	The TPA reports they are able to issue payment for travel reimbursements without cost-share. Due to this, PEBP will be able to manually report taxable income to the IRS and to member.	Schedule/Summary of Benefits

#	Change Type	Proposed Change	Justification	Section
5	Enhancement	For services requiring precertification's Outpatient and Physician Surgery: Added "When outpatient and physician surgery is performed at an In-Network, contracted ambulatory surgical center (ASC) by an In-Network, contracted physician, prior authorizations is not required. However, when services are not performed at an In-Network, contracted ASC, procedures will require prior authorization. This is commonly referred to as Site of Service. Examples of services that require prior authorization include, but are not limited to: [with list provided]"	The UM company reports that when outpatient and physician surgery is performed at an In-Network, contracted ambulatory surgical center (ASC) by an In-Network, contracted physician, the Plan and member receive significant savings. Adding this removes administrative barriers to services and assists with steerage.	Utilization Management
6	Removal	For services requiring precertification's Outpatient and Physician Continuing Care Services: Removed "Dialysis"	The UM company reports that this is redundant when performed at an In-Network facility.	Utilization Management

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT CHANGES

These changes are made in response to the Non-Qualitative Limitation analysis under the Mental Health Parity and Addiction Equity Act performed by the Actuary.

#	Change Type	Proposed Change	Justification	Section
7	Clarification	For Behavioral (Mental) Health Services, clarified sex counseling between individuals, so as not to exclude gender dysphoria.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
8	Clarification	For Behavioral (Mental) Health Services, separated hypnosis and hypnotherapy from Behavioral (Mental) Health Services exclusion to its own section.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
9	Clarification	For Weight Management, updated eating disorder and adjusted anorexia and bulimia as examples.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
10	Clarification	Moved "Hypnosis and Hypnotherapy" from "Behavioral Health Care Exclusions" to its own.	This should be a general plan exclusion and is moved to comply with MHPAEA's Non-Quantitative Treatment Limitation analysis.	Benefit Limitations and Exclusions
11	Clarification	Separated hypnosis and hypnotherapy to its own exclusion	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
12	Enhancement	For Alternative/Complimentary Health Care, added exception for chelation therapy for treatment of mental health.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions

#	Change Type	Proposed Change	Justification	Section
13	Enhancement	For Behavioral (Mental) Health Services, removed exclusion for attention deficit disorders.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
14	Enhancement	For Drugs, Medicines, Nutrition or Devices Exclusion, allowed exception to B-12 for Mental Health or Substance Abuse.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
15	Enhancement	For Other Benefit Exclusions, added exception for Mental Health and or Substance Abuse.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
16	Enhancement	For Other Benefit Exclusions, as related to milieu therapy inserted exception for Mental Health or Substance Abuse.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
17	Enhancement	For Other Benefit Exclusions, removed exceptions for sexual dysfunction.	For compliance with MHPAEA NQTL findings. This could be discriminatory when treating gender dysphoria or other mental health condition. This update will apply benefit based on medical necessity.	Benefit Limitations and Exclusions
18	Enhancement	For Other Benefit Exclusions, the exclusion for food addictions does apply when for Mental Health or Substance Use per MHPAEA.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
19	Enhancement	For Rehabilitation Therapy (Inpatient or Outpatient), removed exclusion for condition of psychoneurotic origin; allowed exception for cognitive therapy.	Psychoneurotic origin is related mental health conditions and added enhancement for compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions

#	Change Type	Proposed Change	Justification	Section
20	Enhancement	Under Other Benefit Exclusions, removed the exclusion for "Except as otherwise provided in the Summary of Medical Benefits and Schedule of Medical Benefits, drugs, medicines, procedures, services, and supplies to correct or enhance erectile function, enhance sensitivity or for sexual dysfunction (organic or inorganic), inadequacy, or enhancement, including penile implants and prosthetics, injections, and durable medical equipment."	PEBP currently covers drugs when there is a prior authorization. This also may exclude treatments of gender dysphoria.	Benefit Limitations and Exclusions
21	Removal	For Cosmetic and Gender Dysphoria, removed references to "no coverage for travel costs"	Travel benefits are specifically and narrowly addressed. Removed for compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
22	Update	The word "Medical" was removed from various headings such as Exclusions Under the Medical Plan, Summary of Medical Benefits, etc.	For compliance with MHPAEA NQTL findings. PEBP coverages include non-medical benefits, such as mental health and substance use disorder.	Benefit Limitations and Exclusions
23	Enhancement	For Speech Therapy, remove exclusion for mental health	For compliance with MHPAEA NQTL findings.	Consumer Driven Health Plan
24	Enhancement	For Autism Spectrum Disorders, removed duplication of NRS 695G.1645.	For compliance with MHPAEA NQTL findings	Schedule/Summary of Benefits

#	Change Type	Proposed Change	Justification	Section
25	Enhancement	For Enteral Formulas and Special Food Products, included treatment for MH/SUD and removed $2,500 dollar maximum for MH/SUD	For compliance with MHPAEA NQTL findings.	Schedule/Summary of Benefits
26	Enhancement	For Habilitative and Rehabilitative Therapy, the visit limit of 90 visits between types of therapy per plan year will exclude Mental Health and Substance Use.	For compliance with MHPAEA NQTL findings.	Schedule/Summary of Benefits
27	Clarification	Under "Case Management" clarified that "Case management is a voluntary process administered by the UM company for PEBP benefits, including but not limited to, medical, behavioral health, mental health, substance use disorder, etc." Also, removed "medical" from "medical professionals"	For compliance with MHPAEA NQTL findings	Utilization Management
28	Clarification	Under Case Management, added "Case management is also available for a disability resulting from a mental health or substance use disorder diagnosis."	Language suggested per MHPAEA NQTL findings	Utilization Management
29	Clarification	Under Services Requiring Precertification: moved "partial residential programs" from "Inpatient" to "Outpatient"	For compliance with MHPAEA NQTL findings.	Utilization Management
30	Enhancement	For Habilitative and Rehabilitative Therapy, the visit limit of 90 visits between types of therapy per plan year will exclude Mental Health and Substance Use.	For compliance with MHPAEA NQTL findings.	Utilization Management

NO SURPRISES ACT CHANGES

During a review of the Master Plan Documents, some changes were noted to be required for compliance with the No Surprises Act.

#	Change Type	Proposed Change	Justification	Section
31	Clarification	Under Provider Network, clarified that there is an exception for emergency care.	Emergency care is subject to the No Surprises Act.	Description of In-Network and Out-of-Network
32	Clarification	Under Provider Network, included verbiage for how the Directories of Network Providers is maintained.	Provider network notification and maintenance is subject to the No Surprises Act.	Description of In-Network and Out-of-Network
33	Clarification	Under Provider Network, updated language to include PEBP leases a network of preferred providers (PPO) through a contract with a vendor who maintains such a network" and "The provider network is subject to change.	PEBP does not have direct contracts with Providers.	Description of In-Network and Out-of-Network
34	Removal	Under Provider Network: Removed "You are responsible for verifying a provider's network status prior to receiving services, even when you are referred by another In-Network provider."	This is redundant and technical change to comply with potential NSA findings.	Description of In-Network and Out-of-Network

OTHER CHANGES FOR MASTER PLAN DOCUMENTS

Listed are the plan document updates recommended for clarification, changes, updates, and additions to the plan documents.

#	Change Type	Proposed Change	Justification	Section
35	Clarification	Added exclusion for "Taxes: Sales taxes, unless specifically covered in the Plan. See also CMS Publication 15-1, The Provider Reimbursement Manual – Part 1, Chapter 21, Section 2122.2.G."	As a government entity, PEBP is exempt from sales taxes. This is also addressed by CMS that sales taxes are not reimbursable.	Benefit Limitations and Exclusions
36	Clarification	For Cosmetic Services and Surgery and Gender Dysphoria, removed reference to no reimbursement for travel costs.	This is redundant as travel costs are narrowly construed to the specific benefits preapproved by the Board, and could be construed as targeting a benefit for exclusion.	Benefit Limitations and Exclusions
37	Clarification	For various exclusions, paragraph format was converted to a bullet point or list format.	This will reduce the run-on sentences which will make the language easier to read and understand.	Benefit Limitations and Exclusions
38	Clarification	Under Preventative Services, added "This plan is an IRS qualified High Deductible Health Plan and is required to comply with Section 223 of the Internal Revenue Code. Section 223 addresses preventative care benefits permitted to be provided by a high-deductible health plan not subject to cost-share.	As a high-deductible health plan, PEBP is required to follow IRS guidelines to maintain an HSA qualifying plan	Consumer Driven Health Plan Master Plan Document
39	Clarification	In HSA and HRA sections, addressed reference and link to IRS Publication 969, which provides further information.	The IRS Publication 969 addresses Health Savings Accounts.	Consumer Driven Health Plan Master Plan Document

#	Change Type	Proposed Change	Justification	Section
40	Clarification	Updated Corrective Appliances by breaking out Hearing aids to its own section.	Cleans up benefit language and aligns with the layout in other plan documents	Consumer Driven Health Plan Master Plan Document
41	Update	Under Highlights of the Plan, the bullet point was updated to include reference to prescription.	Lead Insurance Counsel review of plan document language	Consumer Driven Health Plan Master Plan Document
42	Clarification	For some instances where deductible, copayment/copay, and/or coinsurance is listed, this is replaced with "Cost-Share" which is defined in plan document.	Some plan documents refer to deductible or copays when they are not applicable for the respective document. "Cost-share" satisfies the plan intent.	Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization
43	Clarification	Moved the list of preventative services from a table to the body of the benefits and limitations. Removed duplicate items listed that are already in the body of the benefits and limitations.	The list of preventative services in the table was demonstrated as examples and directs readers to the websites of organizations governing preventative services. This move puts the language for the list and organizational information next to each other.	Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization

#	Change Type	Proposed Change	Justification	Section
44	Update	In the Introduction, updated paragraph to "The Plan and this document are intended to comply with the Nevada Revised Statutes (NRS) Chapter 287, and the Nevada Administrative Code (NAC) 287, and all other applicable provisions of Nevada Law. Additionally, PEBP intends to incorporate herein by reference and to comply with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA)."	Lead Insurance Counsel review of plan document language	Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization
45	Update	For instances where the document references "Exclusion" sections, this was updated to "Benefit Limitations and Exclusions."	To match renamed section of document	Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization
46	Update	For instances where the document references "Appeals Procedure" sections, this was updated to "Appeals."	To match renamed section of document	Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization
47	Update	Under Deductibles, an incomplete paragraph was noted and updated to end with "and other out of pocket costs."	Lead Insurance Counsel review of plan document language	Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization

#	Change Type	Proposed Change	Justification	Section
48	Update	Under Provider Network, updated paragraph for continued medical treatment to "Pursuant to NRS 695G.164, if a member is receiving medical treatment from a provider whose In-Network status changes during the course of treatment, the member may continue to receive treatment with that provider at In-Network rates under certain circumstances. See more detailed explanation in PPO Network Health Care Provider Services section."	Lead Insurance Counsel review of plan document language	Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization
49	Clarification	For basic life insurance coverage, added "Basic Life Insurance claim payouts are subject to resolution of any outstanding financial responsibilities (premiums or Health Reimbursement Arrangement funds) with PEBP or its vendors."	Member accounts have to be current with PEBP and vendors for premiums or HRA overpayments; otherwise, the claim may not be eligible for basic life insurance.	Dental Plan and Basic Life Insurance
50	Update	Added verbiage for Coordination of Benefits.	This adds some information for Coordination of Benefits to the reader and directs the reader to the Health and Welfare Wrap document for specific details.	Dental Plan and Basic Life Insurance
51	Clarification	Under Eligible Medical Expenses, added that when an individual changes from employee/retiree to dependent or vice versa, accumulators follow the individual.	There was some confusion on what happens to an individual's accumulators when they change status on a PEBP plan. Per TPA and Actuary, this is industry standard to have spent	Eligible Medical Expenses

#	Change Type	Proposed Change	Justification	Section
			dollars follow the individual during the plan year.	
52	Added	Added section for "Eligibility for Member of the Senate and Assembly."	This helps clarify that members of the legislature are not "employees" per NRS 287.045.	Enrollment & Eligibility MPD
53	Added	Added verbiage for Elected Officials throughout.	Elected Officials are not employees; however, are eligible for benefits.	Enrollment & Eligibility MPD
54	Added	After the Enrollment & Eligibility Events Quick Reference Table, added section for Examples of Timelines.	Per NRS 287.245 and IRS Section 125 rules, changes are prospective from date of notification. This example table clarifies impact of notification and retiree coverage issues.	Enrollment & Eligibility MPD
55	Added	For the Enrollment & Eligibility Events Quick Reference Table under "Permanent Guardianship of a Child to Age 19:" added "Coverage for other dependent(s) is effective on the first day of the month concurrent with or following notification."	Per NRS 287.245 and IRS Section 125 rules, changes are prospective from notification with limited exceptions.	Enrollment & Eligibility MPD

#	Change Type	Proposed Change	Justification	Section
56	Clarification	For the Enrollment & Eligibility Events Quick Reference Table under "Marriage or the establishment of Domestic Partnership:" Added "Participant shall enroll in coverage to add dependents."	Dependent coverage requires the primary participant to be enrolled.	Enrollment & Eligibility MPD
57	Clarification	For the Enrollment & Eligibility Events Quick Reference Table under "Newborn Child" and "Adoption of a Child or Placement for Adoption of a Child:" Added "Participant shall enroll in coverage to cover the newborn."	Dependent coverage requires the primary participant to be enrolled.	Enrollment & Eligibility MPD
58	Clarification	For the Enrollment & Eligibility Events Quick Reference Table under "Survivor of Police/ Firefighter killed in the line of Duty :" Added citation and "Eligible dependents may join the plan."	NRS Citation and allowance for adding qualified dependents.	Enrollment & Eligibility MPD
59	Clarification	For the Enrollment & Eligibility Events Quick Reference Table: Combined sections for "Employee or Retiree Death" and "Dependent Death"	These sections have the same requirements.	Enrollment & Eligibility MPD
60	Clarification	For the Enrollment & Eligibility Master Plan Document references to "Qualified Medical Child Support Order:" Included references to court orders. Added section for Court Orders	Court Orders can be valid orders per Department of Labor instructions on QMCSOs.	Enrollment & Eligibility MPD

#	Change Type	Proposed Change	Justification	Section
61	Clarification	For the Enrollment & Eligibility Master Plan Document, references which include "spouse/domestic partner, or other dependents" are updated to "eligible dependents."	Dependents are already defined to mean "dependent child(ren), spouse or domestic partner."	Enrollment & Eligibility MPD
62	Clarification	Under "Declining Active Employee Coverage:" Updated paragraph to bullet points and specified participant must furnish proof of other coverage. Additionally, included loss of PEBP benefits, including basic life insurance.	Per HIPAA, marriage is a Qualifying Life Event to add dependent to a plan. In order to remove the participant, we need proof of other coverage.	Enrollment & Eligibility MPD
63	Clarification	Under "Medicare Part B Premium Credit," added "Eligibility for the Medicare Part B Premium credit is subject to NRS 287.046."	Per NRS 287.046, retirees hired after 01/01/2012 do not receive Medicare Part B Premium Credit or other retiree benefits.	Enrollment & Eligibility MPD
64	Clarification	Under "When Coverage Begins," added "Retiree Coverage Information" and table reflecting coverage timelines for retirees	Demonstrate the enrollment requirements for retirees to maintain continuous coverage.	Enrollment & Eligibility MPD
65	Update	For the Enrollment & Eligibility Events Quick Reference Table under "Adoption of a Child or Placement for Adoption of a Child:" updated required supporting documents section.	This will align the quick reference table with the "Eligibility for Dependents" section in the Enrollment & Eligibility Master Plan Document.	Enrollment & Eligibility MPD
66	Update	For the Enrollment & Eligibility Events Quick Reference Table under "Notification Period:" updated language to refer to "within 60 days of the event date."	This section of the table had instances where language was different; however, meant the same thing. The update simplifies this.	Enrollment & Eligibility MPD

#	Change Type	Proposed Change	Justification	Section
67	Update	In the Enrollment & Eligibility Master Plan Document's Enrollment & Eligibility Events Quick Reference Table: removed erroneous bullet points, adjusted formatting for table.	The quick reference table was not uniform throughout.	Enrollment & Eligibility MPD
68	Clarification	Added introductory verbiage to FSA MPD: "There are three types of flexible spending accounts: A Health Care FSA, Limited-Purpose FSA, and Dependent Care FSA."	This introduction provides clarity for the reader.	Flexible Spending Account Master Plan Document
69	Clarification	For Introduction, added "PEBP's FSA benefits are subject to IRS Publication 969."	The IRS Publication 969 addresses Flexible Spending Account.	Flexible Spending Account Master Plan Document
70	Update	Updated FSA rollover and contribution limitations.	IRS released updated figures for Flexible Spending Accounts	Flexible Spending Account Master Plan Document
71	Added	Under "Miscellaneous" added information regarding reinstated employees.	Clarify HRA reinstatement to coincide with CDHP MPD where the HRA section addressed reinstated employees and their HRA funds.	Health Reimbursement Arrangement SPD
72	Clarification	For general information about HRA, added "HRA funds must be used on a prospective basis from the date of funding."	Members have tried to use HRA funds for claims prior to the HRA being established.	Health Reimbursement Arrangement SPD
73	Clarification	For Introduction, added "PEBP's HRA benefits are subject to IRS Publication 969."	The IRS Publication 969 addresses Health Reimbursement Arrangements.	Health Reimbursement Arrangement SPD

#	Change Type	Proposed Change	Justification	Section
74	Reduction	Remove PEBP-funded supplemental $300 Health Reimbursement Arrangement or Health Savings Account funding and related verbiage.	Voted on in December 5, 2022, Board Meeting, this benefit was for plan year 2024. This does not impact the Legislature's appropriated HSA/HRA funding.	Health Reimbursement Arrangement SPD, Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization
75	Clarification	For Cost-Sharing, added "Cost-Share" to the definition.	These words are used interchangeably.	Key Terms and Definitions
76	Update	For Durable Medical Equipment, updated definition layout and cited CMS.	Plan documents originally copied the definition from CMS; however, CMS has updated their definition of Durable Medical Equipment.	Key Terms and Definitions
77	Update	Update definition of Primary Care Physician to include Primary Care Doctor and definition under NRS 695G.060.	The definition originally had listed examples for providers. The citation to NRS enhances the definition.	Key Terms and Definitions
78	Clarification	Under Outpatient Rehabilitation and Habilitative Therapy Services it was clarified that "Outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) and is subject to cost-share for each therapy type."	This is a benefit clarification that was reported to Quality Control by auditors and the TPA due to confusing language. The plan language was found to be conflicting. This language clarifies the confusing language.	Low Deductible PPO and Exclusive Provider Organization
79	Clarification	Under Vision Care Services: clarified the exam is for preventative, screening exams. Clarified PEBP does not maintain a network specific to vision care.	This is in the CDHP, but not clarified in the LD or EPO plans.	Low Deductible PPO and Exclusive Provider Organization

#	Change Type	Proposed Change	Justification	Section
80	Clarification	"Outpatient Short-Term Rehabilitation Services" section heading updated to "Outpatient Rehabilitation and Habilitative Therapy Services"	This will match the benefit description section within the plan document.	Low Deductible PPO and Exclusive Provider Organization
81	Clarification	Under "Schedule of Medical Benefits" for "Durable Medical Equipment": updated section to refer the reader to the definition of DME	This helps align with the CDHP plan, which refers reader to Key Terms and Definitions.	Low Deductible PPO and Exclusive Provider Organization
82	Clarification	Under Other Medical Services, moved benefit description from Summary of Benefits to Schedule of Benefits	The plan design was in the improper location.	Low Deductible PPO and Exclusive Provider Organization
83	Change	Amend the term "Low Deductible" from the "Low Deductible PPO." The new name would officially be the "PPO Plan" with references to the "Low Deductible PPO" plan acceptable throughout the next plan year.	This plan currently has no In-Network deductible. Calling the plan a Low Deductible plan can be a misnomer and cause member confusion. Plan documents would be updated accordingly.	Low Deductible PPO Master Plan Document
84	Update	Update the plan language that references a legislative session to the appropriate NRS or NAC citation when available.	When bills from the 82nd legislative session are updated on the legislative website, the plan documents will be updated accordingly.	PEBP MPDs and SPDs as applicable.
85	Clarification	Correction for what preventative laboratory services are: removed "general health panel" and adjusted the examples to say "etc."	CTI noted this language is actually a service that is not a preventative service. Plan language caused confusion when the intent was to	Schedule/Summary of Benefits

#	Change Type	Proposed Change	Justification	Section
			demonstrate examples of a preventative laboratory service.	
86	Update	Update Clinical Trials to "Coverage for certain treatment received as part of a clinical trial or study for treatment of cancer or chronic fatigue syndrome will be provided subject to the requirements and limitations set forth in NRS 695G.173."	Lead Insurance Counsel review of plan document language	Schedule/Summary of Benefits
87	Added	For services requiring precertification's Inpatient Admissions: Added ""Bariatric/weight loss surgeries at Centers of Excellence and adjustments to lap bands after the first 12 months post-surgery."	The UM company reports that most procedures are in inpatient setting. Therefore, it is being added to the inpatient section.	Utilization Management
88	Added	For services requiring precertification's Inpatient Admissions: Added "Surgeries to treat Gender Dysphoria"	The UM company reports that most procedures are in inpatient setting. Therefore, it is being added to the inpatient section.	Utilization Management
89	Clarification	For Emergency Air Ambulance: Added reference to the No Surprises Act.	Emergency Air Ambulance has additional details in the Schedule of Medical Benefits.	Utilization Management

#	Change Type	Proposed Change	Justification	Section
90	Clarification	For How to request pre certification: Removed "Your or your" for who must call the UM company and changed to "Your provider…"	The UM company reports that Preauthorization's require sufficient medical records and supporting documentation that only Providers have; otherwise, the PA will deny, causing member abrasion. In the event a provider is unwilling to submit preauthorizations, the member can go to PEBP's Quality Control for assistance.	Utilization Management
91	Clarification	For Second Opinion: Added reference to PEBP's recommended second opinion provider, 2nd MD.	PEBP has a preferred Second Opinion Service listed in the Schedule of Medical Benefits.	Utilization Management
92	Clarification	For services requiring precertification's Inpatient Admissions: Clarified “Acute observation” was “Acute inpatient or observation.”	UM company recommendation.	Utilization Management
93	Clarification	For services requiring precertification's Inpatient Admissions: Removed "all" from "Transplant including pre-transplant related services	UM company recommendation.	Utilization Management

RECOMMENDATION

Approve PEBP Staff's proposed travel benefit language in the attached Exhibit A.

Approve PEBP Staff's proposed language for UMR's Prescription Copay Maximizer Program in the attached Exhibit B

Approve the proposed changes for the Master Plan Documents for Plan Year 2025:

- Consumer Driven Health Plan Master Plan Document and Summary of Benefits and Coverage
- Low Deductible PPO Master Plan Document and Summary of Benefits and Coverage
- Exclusive Provider Organization Master Plan Document and Summary of Benefits and Coverage
- Dental Plan and Life Insurance Master Plan Document
- Health Reimbursement Arrangement Summary Plan Document
- Flexible Spending Account Master Plan Document
- Enrollment & Eligibility Master Plan Document
- Medicare Health Reimbursement Arrangement Master Plan Document
- Health and Welfare Wrap for Actives
- Health and Welfare Wrap for Retirees
- Section 125 Master Plan Document

EXHIBIT A

Travel Benefit Explanations and Limitations

This Plan allows for the reimbursement of certain travel and lodging accommodation expenses consistent with Section 213(d) of the Internal Revenue Code and IRS Publication 502 for qualified medical expenses for the member and one additional person (travel companion). Travel expenses are covered when incurred in conjunction with the member's:

- Transplant or bariatric surgery.
  - This does not include pre-surgery appointments such as evaluations, testing, counseling, etc.
- Hip and knee total joint replacement surgery performed at an approved exclusive Nevada hospital/ ambulatory surgery facility when prior authorized by the utilization management company
  - This includes pre-surgery evaluations and
  - For one year after surgery for follow-up visits as required by the patient's surgeon; and
- Travel expenses related to an organ or tissue transplant or bariatric surgery scheduled or performed at a facility or other provider type that is not a Center of Excellence as determined by the Plan Administrator or its designee will not be covered.
  - Travel expenses related to an inpatient or outpatient surgery that is not determined to be a preferred hospital/ambulatory surgical facility by the UM company will not be covered. There are no exceptions.
- Travel for a participant located in a State with more restrictive access to abortion than Nevada, *see* NRS 422.250, to the nearest care center for abortion services covered under this Plan.

The plan reimburses for travel up to one year after services for follow-up visits as required by the patient's provider/surgeon. Travel expenses incurred on or after one year are not eligible for reimbursement.

If the travel companion has their own separate PEBP plan, travel expense reimbursement will not apply to the companion.

PEBP does not provide advance payment for travel expenses.

The Plan will reimburse up to the GSA rate for lodging, travel, meals, or actual expenses, whichever is less.

Pre-approval for travel expenses:

- Travel expenses must be pre-approved by PEBP or its designee
  - If the member is unable to obtain pre-approval because the organ or tissue transplant required immediate travel, the member may submit travel costs to PEBP or its designee after the transplant surgery.

Pre-approval will provide an estimation of your travel reimbursement based on GSA rates. A Travel Pre-Authorization form is available at pebp.nv.gov.

Submitting Travel Reimbursement form and receipts:

- Requests for travel expense reimbursement must be submitted to PEBP using the Travel Reimbursement form available at pebp.nv.gov.
- Travel Reimbursement forms and receipts must be submitted within 12 months of the date of the service.
    - The form must be completed, including the start and end times, destination, and purpose of trip
    - Must include original itemized receipts identifying the name(s) of the person(s) incurring the expense. If the travel includes a commercial airline flight, an itinerary attached for meal justification.

Reimbursement of eligible travel expenses, including any relating to a travel companion, will be payable to the primary participant.

Reimbursement will be based on actual expenses incurred and the actual number of days and travel times and may differ from the pre-approval estimation. The lessor of GSA rates or actual expenses will be used.

Meals will be reimbursed in accordance with the meals and incidental expense (M&IE) allowance. Receipts are not required for the M&IE allowance. Participants should refer to the GSA's website http://gsa.gov and the link "Per Diem Rates" for the most current rates.

Eligible Travel Expenses include:

This Plan follows the travel expense reimbursement guidelines established in Section 213(d) of the Internal Revenue Code, IRS Publication 502, and under the GSA rates based on region or locality.

- Method of transportation including personal car, airline, rental car, bus, taxi, etc. The least expensive method of transportation must be used.
    - Flight expenses for commercial air (regular coach rate).
    - Mileage reimbursement for personal vehicle (GSA non-medical mileage rate).
- Travel meals (for patient and travel companion only).
    - Reimbursement for meals while traveling will apply the GSA rate for the travel day for the first and last day of travel.
- Lodging accommodations (GSA rate)
    - For transplants, some Centers of Excellence facilities may have on-site or affiliated lodging services.
        - For required lodging, the plan will pay the lesser of the affiliated lodging or GSA rates, subject to verification of availability.

Travel expenses are not subject to cost-share (Deductible, copay, and/or Out-of-Pocket Maximum). Therefore, PEBP will issue appropriate reporting forms (form 1099, W2, etc.) for federal tax reporting purposes. You may be liable for taxes and must consult your tax professional for further assistance.

Excluded travel expenses:
The following are specifically excluded from reimbursement under any circumstances (other expenses not included below may be denied if they are not preapproved):

- Alcoholic beverages.
- Car maintenance.
- Vehicle insurance.
- Flight insurance.
- Cards, stationery, stamps.
- Clothing.
- Dry cleaning.
- Entertainment (cable televisions, books, magazines, movie rentals).
- Flowers.
- Household products.
- Household utilities, including cell phone charges, house cleaner, baby-sitter, or day care services.
- Kennel fees.
- Laundry services.
- Security deposits.
- Toiletries.
- Travel expenses related to a facility or provider that is not a certified Center of Excellence, exclusive hospital/ambulatory surgical facility, or outpatient infusion facility; and
- Travel expenses incurred on or after one year following services are not eligible for reimbursement.

EXHIBIT B

To be added in the plan documents under the prescription drug benefit:

UMR offers a Medical Pharmacy Coupon Program: For drugs administered in an inpatient setting, there is a "UMR Prescription Copay Maximizer Benefit" where a member may receive cost-share assistance. A UMR patient advocate will conduct outreach to members and introduce the UMR Prescription Copay Maximizer Program. The member can voluntarily enroll in to qualifying copay assistance programs. This may help the member with their cost-share for certain drugs. Please contact UMR for additional information or assistance.

11.

11. Public Comment