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

JOY GRIMMER
Board Chair

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program
Date and Time of Meeting:	July 25, 2024 9:00 a.m.
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/SWKoWgvh8Kw

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

To listen to and view the PEBP Board Meeting please click on the YouTube Link located in "Video Conferencing" field above.

There are two agenda items designated for public comment. If you wish to provide verbal public comment during those agenda items, please follow the instructions below:

Option #1 **Join the webinar as an attendee** https://us06web.zoom.us/j/84665529164

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: 846 6552 9164 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 in person or 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. (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

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

   4.1 Approval of Action Minutes from the May 23, 2024 PEBP Board Meeting.

   4.2 Receipt of quarterly staff reports for the period ending March 31, 2024:

   4.2.1 Q3 Budget Report

   4.2.2 Q3 Utilization Report

   4.2.3 Contract Status Report

   4.3 Receipt of quarterly vendor reports for the period ending March 31, 2024:

   4.3.1 Q3 UMR – Obesity Care Management

   4.3.2 Q3 UMR – Diabetes Care Management

   4.3.3 Q3 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network

   4.3.4 Q3 UnitedHealthcare – Basic Life Insurance

   4.3.5 Q3 Express Scripts – Summary Report

   4.3.6 Q3 Express Scripts – Utilization Report

4.3.7 UMR – Performance Guarantee Report

4.3.8 Doctor on Demand – Engagement Report

4.3.9 Real Appeal – Utilization Report

4.4 Revised PEBP Language Access Plan per NRS 232.0081

4.5 Self Insurance Internal Service Fund Financial Statement

4.6 State Retirees' Health & Welfare Benefits Fund Financial Statement

5. Election of Board Vice-Chair pursuant to Nevada Administrative Code (NAC) 287.172. Eligible candidates are Bepsy Strasburg, Michelle Kelley, Jim Barnes, Janell Woodward and Jennifer McClendon. (Joy Grimmer, Board Chair) (**For Possible Action**)
6. Executive Officer Report. (Celestena Glover, Executive Officer) (Information/Discussion)
7. Overview of Current Plan Options. (Richard Ward, Segal) (Information/Discussion)
8. Discussion regarding the framework for development of the Agency Budget Request for the 2026-2027 Biennium. (Celestena Glover, Executive Officer) (**For Possible Action**)
9. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR for the period of January 1, 2024 – March 31, 2024. (Joni Amato, Claim Technologies Incorporated) (**For Possible Action**)
10. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by Express Scripts for the period of July 1, 2022 – June 30, 2023. (Joni Amato, Claim Technologies Incorporated) (**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, NV 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 (Joy Grimmer, Board Chair) (**All items for possible action**)

4.1 Approval of Action Minutes from the May 23, 2024 PEBP Board Meeting

4.2 Receipt of quarterly staff reports for the period ending March 31, 2024:

- 4.2.1 Q3 Budget Report
- 4.2.2 Q3 Utilization Report
- 4.2.3 Contract Status Report

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2024:

- 4.3.1 Q3 UMR – Obesity Care Management
- 4.3.2 Q3 UMR – Diabetes Care Management
- 4.3.3 Q3 Sierra HealthCare Options and UnitedHealthcare Plus Network – PPO Network
- 4.3.4 Q3 UnitedHealthcare – Basic Life Insurance
- 4.3.5 Q3 Express Scripts – Summary Report
- 4.3.6 Q2 Express Scripts – Utilization Report
- 4.3.7 UMR – Performance Guarantee Report
- 4.3.8 Doctor on Demand – Engagement Report
- 4.3.9 Real Appeal – Utilization Report

4.4 Revised PEBP Language Access Plan per NRS 232.0081

4.5 Self Insurance Internal Service Fund Financial Statement

4.6 State Retirees' Health & Welfare Benefits Fund Financial Statement

4.1

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.1 Approval of Action Minutes from the May 23, 2024 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)
May 23, 2024

MEMBERS PRESENT	Mr. Jack Robb, Board Chair
IN PERSON:	Ms. Michelle Kelley, Vice Chair Dr. Jennifer McClendon, Member Ms. April Caughron, Member Mr. Jim Barnes, Member Ms. Janell Woodward, Member Ms. Betsy Aiello, Member Ms. Leslie Bittleston, Member Ms. Stacie Weeks, Member
MEMBERS EXCUSED:	Ms. Bepsy Strasburg, 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 Ms. Brandee Mooneyhan, Lead Insurance Counsel Ms. Jessica Crane, Executive Assistant
OTHER PRESENTERS:	Richard Ward, Segal Joni Amato, CTI Helmut Braun, UMR Nathan Meier, UMR Rhonda Huckaby, UMR Jesse Stockwell, UMR

1. Open Meeting; Roll Call

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

2. Public Comment

    - Bill Welch – Member

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

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

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

    4.1 Approval of Action Minutes from the March 28, 2024 PEBP Board Meeting.

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

    4.2.1 Q2 Utilization Report

    4.3 Receipt of quarterly vendor reports for the period ending December 31, 2023 and March 31, 2024:

    4.3.1 Q2 UMR – Obesity Care Management

    4.3.2 Q2 UMR – Diabetes Care Management

    4.3.3 Q2 UMR – Performance Guarantee Report

    4.3.4 Q2 Sierra Healthcare Options – Utilization and Large Case Management

    4.3.5 Q2 Express Scripts – Summary Report

    4.3.6 Q2 Express Scripts – Utilization Report

    4.3.7 Q3 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report

    4.3.8 Q3 Amplifon Performance Report

    4.3.9 Doctor on Demand Engagement Report

    4.3.10 Real Appeal – Utilization Report

    4.4. Fiscal Year 2024 Other Post-Employment Benefits (OPEB) valuation prepared by Segal in conformance with the Governmental Accounting Standards Board (GASB) requirements.

BOARD ACTION ON ITEM 4
MOTION: Motion to accept consent items 4.1, 4.2, 4.4 and all items in 4.3, except 4.3.2.
BY: Vice Chair Michelle Kelley
SECOND: Member Leslie Bittleston
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 4.3.2
MOTION: Motion to approve 4.3.2.
BY: Member Betsy Aiello
SECOND: Vice Chair Michelle Kelley
VOTE: Unanimous, the motion carried

5. Discussion and possible action regarding proposed amendments to Chapter 287 of the Nevada Administrative Code as set forth in LCB File No. R047-24 to include review of any public comments and possible adoption of proposed amendments. (Celestena Glover, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 5
MOTION: Motion to adopt the regulation as workshop and pass through the LCB.
BY: Vice Chair Michelle Kelley
SECOND: Member Leslie Bittleston
VOTE: Unanimous, the motion carried

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 Q2 covering the period of October 1, 2023 – December 31, 2023. (Celestena Glover, Executive Officer) (**For Possible Action**)

    7.1 UMR Remediation Plan

BOARD ACTION ON ITEM 7
MOTION: Motion to accept the Audit Report for Q2 from CTI.
BY: Vice Chair Michelle Kelley
SECOND: Member Betsy Aiello
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 7.1
MOTION: Motion to accept UMR's remediation plan.
BY: Vice Chair Michelle Kelley
SECOND: Member Leslie Bittleston
VOTE: Unanimous; the motion carried

8. Discussion and possible action on Pharmacy Benefit Manager Market Check. (Richard Ward, Segal) (**For Possible Action**)

BOARD ACTION ON ITEM 8
MOTION: Motion to accept the new pricing captured through the market check by Segal.
BY: Vice Chair Michelle Kelley
SECOND: Member Stacie Weeks
VOTE: Unanimous; the motion carried

9. Segal presentation on Medicare Exchanges. (Richard Ward, Segal) (Information/Discussion)

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

BOARD ACTION ON ITEM 10
MOTION: Motion to accept the Express Scripts contract 25582 amendment number two, incorporate the plan year 2024 market check, and move forward with the RFP.
BY: Vice Chair Michelle Kelley
SECOND: Member Janell Woodward
VOTE: Unanimous, the motion carried

11. Public Comment

- Terri Laird – RPEN

12. Adjournment

- Board Chair Robb adjourned the meeting at 11:26 a.m.

4.2

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.1 Approval of Action Minutes from the May 23, 2024 PEBP Board Meetings

4.2 Receipt of quarterly staff reports for the period ending March 31, 2024

4.2.1

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.2 Receipt of quarterly staff reports for the period ending March 31, 2024:

4.2.1 Q3 Budget Report

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Executive Officer

JOY GRIMMER
Board Chair

AGENDA ITEM

[X] Action Item

[ ] Information Only

Date: July 25, 2024

Item Number: 4.2.1

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of March 31, 2024 to include:

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

Budget Account 1338 – Operational Budget – Shown below is a summary of the operational budget account status as of March 31, 2024, with comparisons to the same period in Fiscal Year 2023. The budget status is reported on a cash basis and does not include incurred expenses and income owed to the fund.

The budget status report reflects actual income of $323.4 million as of March 31, 2024, compared to 291.4 million as of March 31, 2023, or an increase of 11.0%. Total expenses for the period have increased by 22.2 million or 7.2% for the same period.

The budget status report shows Realized Funding Available (cash) at $113.3 million. This compares to $131.6 million for the same period of last year. The table below reflects the actual revenues and expenditures for the period.

Operational Budget 1338

	FISCAL YEAR 2024			FISCAL YEAR 2023		
	Actual as of 3/31/2024	Work Program	Percent	Actual as of 3/31/2023	Fiscal Year 2023 Close	Percent
Beginning Cash	120,714,437	120,714,437	100%	148,854,786	148,854,786	100%
Premium Income	286,894,528	419,156,515	68%	262,901,773	357,314,410	74%
All Other Income	36,532,369	38,079,991	96%	28,498,338	36,548,418	78%
Total Income	323,426,897	457,236,506	71%	291,400,111	393,862,827	74%
Personnel Services	1,881,318	2,938,164	64%	1,593,968	2,320,130	69%
Operating - Other than Personnel	1,993,266	3,084,368	65%	2,416,223	3,400,154	71%
Insurance Program Expenses	326,805,745	459,496,779	71%	304,299,377	415,155,444	73%
All Other Expenses	124,009	187,157	66%	297,896	1,127,449	26%
Total Expenses	330,804,338	465,706,468	71%	308,607,464	422,003,177	73%
Change in Cash	(7,377,441)	(8,469,962)		(17,207,353)	(28,140,349)	
REALIZED FUNDING AVAILABLE	113,336,996	112,244,475	101%	131,647,433	120,714,437	109%
Incurred But Not Reported Liability	(52,874,000)	(52,874,000)		(51,030,000)	(51,030,000)	
Catastrophic Reserve	(41,762,000)	(41,762,000)		(38,426,000)	(38,426,000)	
HRA Reserve	(20,600,889)	(20,600,889)		(22,800,889)	(22,800,889)	
NET REALIZED FUNDING AVAILABLE	(1,899,893)	(2,992,414)		19,390,544	8,457,548	

Current Budget Projections

The following table represents projections for FY 2024. The projection reflects total income to be more than budgeted by 1.9% ($588.7 million vs $578.0 million), total expenditures are projected to be less than budgeted by 3.9% ($443.4 million vs $461.6 million); total reserves are projected to be more than budgeted by 24.9% ($145.3 million vs $116.4 million).

State Subsidies are projected to be less than the budgeted amount by $23.7 million (7.4%), Non-State Subsidies are projected to be more than budgeted by $8.2 million (40.9%), and Premium Income is projected to be more than budgeted by $23.1 million (29.3%). The overall increase in budgeted revenue is $10.8 million due to an increase in participant premiums because of actual enrollment compared to budgeted enrollment and a change in the mix of plan and tiers. The mix of participants is as follows:

- 0.35% fewer state actives,
- 3.82% fewer state non-Medicare retirees,
- 12.96% more non-state actives,
- 5.48% fewer non-state, non-Medicare retirees
- 1.80% fewer state Medicare retirees, and
- 3.92% fewer non-state Medicare retirees

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 3/31/24**	**Projected**	**Difference**	
Carryforward	120,714,437	120,714,437	120,714,437	0	0.0%
State Subsidies	319,982,387	221,131,381	296,306,883	(23,675,504)	-7.4%
Non-State Subsidies	20,164,091	14,978,108	28,401,994	8,237,903	40.9%
Premium	79,010,037	50,785,039	102,159,847	23,149,810	29.3%
Appropriations	11,816,381	11,816,381	11,816,381	0	1.9%
All Other	26,263,610	24,715,988	29,323,830	3,060,220	11.7%
Total	577,950,943	444,141,334	588,723,372	10,772,429	1.9%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 3/31/24**	**Projected**	**Difference**	
Operating	6,052,184	3,998,593	6,031,315	20,869	0.3%
State Insurance Costs	398,440,131	293,064,081	387,913,765	10,526,366	2.6%
Non-State Insurance Costs	7,657,002	4,907,466	7,824,432	(167,430)	-2.2%
Medicare Retiree Insurance Costs	49,429,501	28,834,198	41,645,227	7,784,274	15.7%
Total Insurance Costs	455,526,634	326,805,745	437,383,423	18,143,211	4.0%
Total Expenses	461,578,818	330,804,338	443,414,738	18,164,080	3.9%
Restricted Reserves	115,236,889	115,236,889	122,353,521	(7,116,632)	-6.2%
Differential Cash Available	1,135,236	(1,899,893)	22,955,113	(21,819,877)	-1922.1%
Total Reserves	116,372,125	113,336,996	145,308,634	(28,936,509)	-24.9%
Total of Expenses and Reserves	577,950,943	444,141,334	588,723,372	(10,772,429)	-1.9%

Expenses for Fiscal Year 2024 are projected to be $18.2 million (3.9%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be less than budgeted by $.02 million (0.3%). Employee and Retiree insurances costs are projected to be less than budgeted by $18.1 million (4.0%) when taken in total (see table above for specific information).

Recommendations

None.

4.2.2

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.2 Receipt of quarterly staff reports for the period ending March 31, 2024:

4.2.1 Q3 Budget Report

4.2.2 Q3 Utilization Report

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Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: July 25, 2024

Item Number: 4.2.2

Title: Self-Funded CDHP, LDPPO, and EPO Plan Utilization Report for the period ending March 31, 2024

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the PY 2024 period ending March 31, 2024. Included are:

- Executive Summary – provides a utilization overview.
- UMR Inc. CDHP Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- UMR Inc. LDPPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- UMR Inc. EPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- Express Scripts Utilization Report – provides details supporting the prescription drug information included in the Executive Summary.
- Health Plan of Nevada Utilization – see Appendix D for Q3 Plan Year 2023 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q3 of Plan Year 2024 compared to Q3 of Plan Year 2023 is summarized below.

- Population:
  - 10.3% decrease for primary participants
  - 12.4% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 2.8% increase for primary participants
  - 5.0% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 96 High-Cost Claimants accounting for 33.2% of the total plan paid for Q3 of Plan Year 2024
  - 26.1% increase in High-Cost Claimants per 1,000 members
  - 19.3% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cancer ($5.4 million) – 27.4% of paid claims
  - Neurological Disorders ($2.2 million) – 11.2% of paid claims
  - Cardia Disorders ($2.2 million) – 11.0% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased 3.4%
  - Average paid per ER visit increased 6.7%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased 10.1%
  - Average paid per Urgent Care visit decreased 6.7% (from $45 to $42)
- Network Utilization:
  - 97.4% of claims are from In-Network providers (the same as Q3 of PY2023)
  - Q3 of Plan Year 2024 In-Network discounts stayed the same as PY 2023 at 68.4%

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 10.5%
    - Total Gross Claims Costs decreased 0.4% ($0.1 million)
    - Average Total Cost per Claim increased 11.2%
      - From $115.05 to $127.97
  - Member:
    - Total Member Cost decreased 4.3%
    - Average Participant Share per Claim increased 7.0%
    - Net Member PMPM increased 9.7%
      - From $30.58 to $33.54
  - Plan
    - Total Plan Cost increased 0.7%

        - Average Plan Share per Claim increased 12.5%
        - Net Plan PMPM increased 15.4%
            - From $100.53 to $116.00
        - Net Plan PMPM factoring rebates increased 14.0%
            - From $65.97 to $75.20

LOW DEDUCTIBLE PPO PLAN (LDPPO)

The Low Deductible PPO Plan (LDPPO) experience for Q3 of Plan Year 2024 compared to Q3 of Plan Year 2023 is summarized below.

- Population:
    - 35.5% increase for primary participants
    - 33.5% increase for primary participants plus dependents (members)
- Medical Cost:
    - 8.3% increase for primary participants
    - 10.0% increase for primary participants plus dependents (members)
- High-Cost Claims:
    - There were 55 High-Cost Claimants accounting for 21.9% of the total plan paid for Q3 of Plan Year 2024
    - 4.3% decrease in High-Cost Claimants per 1,000 members
    - 5.2% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
    - Cancer ($3.6 million) – 27.4% of paid claims
    - Neurological Disorders ($2.7 million) – 21.0% of paid claims
    - Cardiac Disorders ($1.6 million) – 12.5% of paid claims
- Emergency Room:
    - ER visits per 1,000 members increased 11.0%
    - Average paid per ER visit increased 1.6%
- Urgent Care:
    - Urgent Care visits per 1,000 members increased by 1.4%
    - Average paid per Urgent Care visit increased 8.1% (from $99 to $107)
- Network Utilization:
    - 97.8% of claims are from In-Network providers (the same as Q3 of PY 2023)
    - Q3 of Plan Year 2024 In-Network discounts increased 1.0% over PY 2023

- Prescription Drug Utilization:
    - Overall:
        - Total Net Claims increased 36.2%
        - Total Gross Claims Costs increased 66.9% ($12.1million)
        - Average Total Cost per Claim increased 22.5%
            - From $120.20 to $147.28
    - Member:
        - Total Member Cost increased 56.8%
        - Average Participant Share per Claim increased 15.1%

        - Net Member PMPM increased 17.4%
            - From $23.18 to $27.21
    - Plan
        - Total Plan Cost increased 68.8%
        - Average Plan Share per Claim increased 24.0%
        - Net Plan PMPM increased 26.4%
            - From $119.56 to $151.11
        - Net Plan PMPM factoring rebates increased 27.5%
            - From $78.59 to $100.17

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q3 of Plan Year 2024 compared to Q3 of Plan Year 2023 is summarized below.

- Population:
    - 10.6% decrease for primary participants
    - 11.0% decrease for primary participants plus dependents (members)
- Medical Cost:
    - 4.2% increase for primary participants
    - 4.5 increase for primary participants plus dependents (members)
- High-Cost Claims:
    - There were 46 High-Cost Claimants accounting for 32.3% of the total plan paid for Q3 of Plan Year 2024
    - 23.1% increase in High-Cost Claimants per 1,000 members
    - 15.4% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
    - Cancer ($2.5 million) – 26.7% of paid claims
    - Cardiac Disorders ($1.3 million) – 13.9% of paid claims
    - Infections ($0.1 million) – 9.8% of paid claims
- Emergency Room:
    - ER visits per 1,000 members increased by 5.9%
    - Average paid per ER visit increased by 9.0%
- Urgent Care:
    - Urgent Care visits per 1,000 members increased by 7.8%
    - Average paid per Urgent Care visit increased 4.7%
- Network Utilization:
    - 96.2% of claims are from In-Network providers
    - In-Network utilization increased 0.1% over PY 2023
    - In-Network discounts increased 1.3% over PY 2023

- Prescription Drug Utilization:
    - Overall:
        - Total Net Claims decreased 7.3%
        - Total Gross Claims Costs increased 2.3% ($0.3 million)
        - Average Total Cost per Claim increased 10.3%

        - From $145.79 to $160.86
    - Member:
        - Total Member Cost decreased 4.6%
        - Average Participant Share per Claim increased 2.9%
        - Net Member PMPM increased 7.5%
            - From $40.97 to $44.06
    - Plan
        - Total Plan Cost increased 3.7%
        - Average Plan Share per Claim increased 11.8%
        - Net Plan PMPM increased 16.8%
            - From $214.11 to $250.06
        - Net Plan PMPM factoring rebates increased 16.8%
            - From $139.74 to $163.19

DENTAL PLAN

The Dental Plan experience for Q3 of Plan Year 2024 is summarized below.

- Dental Cost:
    - Total of $19,905,370 paid for Dental claims
        - Basic claims account for 34.0% ($6.8million)
        - Preventive claims account for 25.1% ($5.0 million)
        - Diagnostic claims account for 22.5% ($4.5 million)
        - Major claims account for 18.3 ($3.7 million)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of HRA account balances as of March 31, 2024.

HRA Account Balances as of Mar. 31, 2024			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	17,679	0.00	0.00
$.01 - $500.00	35,636	8,875,776.60	249.07
$500.01 - $1,000	3,120	2,105,246.36	674.76
$1,000.01 - $1,500	1,039	1,252,242.03	1,205.24
$1,500.01 - $2,000	500	865,102.22	1,730.20
$2,000.01 - $2,500	297	669,271.49	2,253.44
$2,500.01 - $3,000	232	638,709.62	2,753.06
$3,000.01 - $3,500	142	459,398.64	3,235.20
$3,500.01 - $4,000	182	681,551.72	3,744.79
$4,000.01 - $4,500	132	558,951.85	4,234.48
$4,500.01 - $5,000	106	504,971.61	4,763.88
$5,000.01 +	**664**	**5,651,038.56**	**8,510.60**
Total	**59,729**	**$ 22,262,261**	**$ 373**

CONCLUSION

The information in this report provides plan experience for the Consumer Driven Health Plan (CDHP), Low Deductible PPO Plan (LDPPO) and the PEBP Premier Plan (EPO) through the third quarter of Plan Year 2024. The CDHP total plan paid decreased 8.0% over the same time for Plan Year 2023; however, on a PEPY basis the plan experienced an increase of 2.6%. The LDPPO total plan paid increased 8.3% over Q3 of Plan Year 2023. The EPO total plan paid decreased 6.9% over Q3 of Plan Year 2023. For HMO utilization and cost data please see the report provided in Appendix D.

Appendix A

Index of Tables
UMR Inc. – CDHP Utilization Review for PEBP
January 1, 2024 – March 31, 2024

DATASCOPE™

Nevada Public Employees' Benefits Program
HDHP Plan
July 2023 – March 2024 Incurred,
Paid through May 2024

UMR℠

Overview

- Total Medical Spend for 3Q24 was $59,215,710 of which 75.3% was spent in the State Active population. When compared to 3Q23, this reflected a decrease of 8.0% in plan spend, with State Actives having a decrease of 3.9%.
  - When compared to 3Q22, 3Q24 decreased 18.2%, with State Actives having a decrease of 16.7%.
- On a PEPY basis, 3Q24 reflected an increase of 2.6% when compared to 3Q23. The largest group, State Actives, had a 7.2% increase when compared to the 3Q23 PEPY%.
  - When compared to 3Q22, 3Q24 increased 5.6%, with State Actives increasing 8.8%.
- 88.6% of the Average Membership had paid Medical claims less than $2,500, with 24.8% having no claims paid at all during the reporting period.
- There were 96 high-cost Claimants (HCC's) over $100K, that accounted for 33.2% of the total spend. HCCs accounted for 34.3% of total spend during 3Q23, with 87 members hitting the $100K threshold. The largest diagnosis grouper was Cancer accounting for 27.4% of high-cost claimant dollars.
- IP Paid per Admit was $28,380 which is an increase of 5.1% compared to 3Q23.
- ER Paid per Visit is $2,435, which is an increase of 6.7% compared to 3Q23.
- 97.4% of all Medical spend dollars were to In Network providers. The average In Network discount was 68.2%, which is comparable to the PY23 average discount of 68.4%.

Paid Claims by Age Group

Paid Claims by Age Group																
	3Q23						3Q24						% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 4,636,463	$ 3,161	$ 33,929	$ 23	$4,670,392	$ 3,184	$ 1,563,904	$ 1,401	$ 513	$ 0	$ 1,564,417	$ 1,402	-66.5%	-56.0%
1	$ 295,269	$ 158	$ 17,144	$ 9	$312,413	$ 168	$ 276,597	$ 233	$ 70,754	$ 60	$ 347,351	$ 292	11.2%	74.4%
2 - 4	$ 622,175	$ 109	$ 124,473	$ 22	$746,648	$ 131	$ 471,851	$ 98	$ 122,783	$ 26	$ 594,634	$ 124	-20.4%	-5.4%
5 - 9	$ 985,888	$ 79	$ 200,278	$ 16	$1,186,166	$ 95	$ 1,008,953	$ 100	$ 228,275	$ 23	$ 1,237,228	$ 123	4.3%	29.6%
10 - 14	$ 1,275,224	$ 86	$ 238,634	$ 16	$1,513,858	$ 102	$ 1,286,841	$ 103	$ 419,140	$ 34	$ 1,705,981	$ 137	12.7%	34.1%
15 - 19	$ 3,588,200	$ 219	$ 555,472	$ 34	$4,143,672	$ 253	$ 3,403,709	$ 232	$ 395,864	$ 27	$ 3,799,573	$ 259	-8.3%	2.3%
20 - 24	$ 2,479,557	$ 123	$ 914,832	$ 45	$3,394,389	$ 168	$ 2,324,750	$ 133	$ 1,112,413	$ 64	$ 3,437,163	$ 197	1.3%	17.0%
25 - 29	$ 2,726,306	$ 198	$ 717,660	$ 52	$3,443,966	$ 251	$ 1,854,300	$ 158	$ 342,572	$ 29	$ 2,196,872	$ 188	-36.2%	-25.1%
30 - 34	$ 4,203,153	$ 249	$ 750,398	$ 45	$4,953,551	$ 294	$ 3,263,468	$ 225	$ 670,643	$ 46	$ 3,934,111	$ 272	-20.6%	-7.5%
35 - 39	$ 2,672,843	$ 146	$ 1,236,947	$ 67	$3,909,790	$ 213	$ 3,752,657	$ 234	$ 1,115,372	$ 69	$ 4,868,029	$ 303	24.5%	42.4%
40 - 44	$ 3,331,268	$ 172	$ 1,607,018	$ 83	$4,938,286	$ 255	$ 3,210,536	$ 184	$ 1,487,190	$ 85	$ 4,697,726	$ 269	-4.9%	5.4%
45 - 49	$ 3,803,016	$ 206	$ 1,677,703	$ 91	$5,480,719	$ 297	$ 3,816,553	$ 234	$ 2,047,721	$ 126	$ 5,864,274	$ 360	7.0%	20.9%
50 - 54	$ 6,754,006	$ 322	$ 2,982,170	$ 142	$9,736,176	$ 463	$ 6,177,774	$ 332	$ 3,259,624	$ 175	$ 9,437,398	$ 507	-3.1%	9.3%
55 - 59	$ 7,948,416	$ 343	$ 4,172,614	$ 180	$12,121,030	$ 523	$ 7,701,246	$ 382	$ 3,119,372	$ 155	$ 10,820,618	$ 536	-10.7%	2.5%
60 - 64	$ 12,907,547	$ 472	$ 5,434,512	$ 199	$18,342,059	$ 670	$ 12,482,979	$ 507	$ 5,693,097	$ 231	$ 18,176,076	$ 738	-0.9%	10.1%
65+	$ 6,136,737	$ 339	$ 4,422,523	$ 244	$10,559,260	$ 583	$ 6,619,593	$ 387	$ 5,178,284	$ 303	$ 11,797,877	$ 689	11.7%	18.2%
Total	**$ 64,366,069**	**$ 258**	**$ 25,086,307**	**$ 101**	**$ 89,452,376**	**$ 359**	**$ 59,215,710**	**$ 271**	**$ 25,263,617**	**$ 116**	**$ 84,479,327**	**$ 387**	**-5.6%**	**7.8%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	19,061	16,465	14,764	-10.3%	15,625	13,359	11,974	-10.4%	3	3	3	14.7%
Spouses	4,030	3,298	2,782	-15.7%	3,188	2,527	2,115	-16.3%	1	1	1	-22.0%
Children	10,289	7,948	6,721	-15.4%	9,534	7,301	6,159	-15.6%	4	4	3	-27.8%
Total Members	33,380	27,711	24,267	-12.4%	28,347	23,187	20,248	-12.7%	8	8	7	-11.1%
Family Size	1.8	1.7	1.6	-3.5%	1.8	1.7	1.7	-0.6%	2.7	2.7	2.1	-23.7%
Financial Summary												
Gross Cost	$99,158,042	$86,994,559	$80,818,684	-7.1%	$76,691,001	$65,464,986	$62,788,584	-4.1%	$49,469	$34,301	$67,783	97.6%
Client Paid	$72,363,670	$64,366,069	$59,215,710	-8.0%	$55,885,730	$48,458,781	$46,580,031	-3.9%	$33,462	$23,704	$51,943	119.1%
Employee Paid	$26,794,372	$22,628,491	$21,602,974	-4.5%	$20,805,272	$17,006,205	$16,208,553	-4.7%	$16,008	$10,596	$15,840	49.5%
Client Paid-PEPY	$5,062	$5,212	$5,348	2.6%	$4,769	$4,837	$5,187	7.2%	$14,872	$10,535	$20,107	90.9%
Client Paid-PMPY	$2,890	$3,097	$3,254	5.1%	$2,629	$2,787	$3,067	10.0%	$5,577	$3,951	$9,739	146.5%
Client Paid-PEPM	$422	$434	$446	2.8%	$397	$403	$432	7.2%	$1,239	$878	$1,676	90.9%
Client Paid-PMPM	$241	$258	$271	5.0%	$219	$232	$256	10.3%	$465	$329	$812	146.8%
High Cost Claimants (HCC's) > $100k												
# of HCC's	117	87	96	10.3%	81	63	75	19.0%	0	0	0	0.0%
HCC's / 1,000	3.5	3.1	4.0	26.1%	2.9	2.7	3.7	36.0%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$218,227	$253,617	$204,586	-19.3%	$235,740	$256,535	$213,880	-16.6%	$0	$0	$0	0.0%
HCC's % of Plan Paid	35.3%	34.3%	33.2%	-3.2%	34.2%	33.4%	34.4%	3.0%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,041	$1,049	$947	-9.7%	$923	$956	$932	-2.5%	$0	$0	$0	0.0%
Facility Outpatient	$867	$1,000	$1,110	11.0%	$768	$869	$1,022	17.6%	$4,236	$2,164	$8,110	274.8%
Physician	$930	$1,049	$1,197	14.1%	$890	$962	$1,114	15.8%	$1,306	$1,786	$1,629	0.0%
Other	$52	$0	$0	0.0%	$48	$0	$0	0.0%	$35	$0	$0	0.0%
Total	$2,890	$3,097	$3,254	5.1%	$2,629	$2,787	$3,067	10.0%	$5,577	$3,951	$9,739	146.5%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	2,991	2,732	2,464	-9.8%	442	371	323	-13.1%	
Spouses	777	722	630	-12.8%	64	48	37	-24.0%	
Children	733	626	545	-13.0%	18	16	14	-14.9%	
Total Members	4,502	4,081	3,639	-10.8%	523	436	373	-14.4%	
Family Size	1.5	1.5	1.5	-1.3%	1.2	1.2	1.2	-3.3%	1.6
Financial Summary									
Gross Cost	$20,279,351	$18,225,283	$16,199,279	-11.1%	$2,138,221	$3,269,990	$1,763,038	-46.1%	
Client Paid	$15,085,396	$13,455,139	$11,575,357	-14.0%	$1,359,082	$2,428,444	$1,008,379	-58.5%	
Employee Paid	$5,193,955	$4,770,144	$4,623,922	-3.1%	$779,138	$841,546	$754,659	-10.3%	
Client Paid-PEPY	$6,724	$6,567	$6,265	-4.6%	$4,104	$8,722	$4,168	-52.2%	$6,258
Client Paid-PMPY	$4,468	$4,397	$4,242	-3.5%	$3,464	$7,430	$3,603	-51.5%	$3,830
Client Paid-PEPM	$560	$547	$522	-4.6%	$342	$727	$347	-52.3%	$521
Client Paid-PMPM	$372	$366	$353	-3.6%	$289	$619	$300	-51.5%	$319
High Cost Claimants (HCC's) > $100k									
# of HCC's	34	25	22	-12.0%	3	3	1	-66.7%	
HCC's / 1,000	7.6	6.1	6.1	-1.3%	5.7	6.9	2.7	-61.0%	
Avg HCC Paid	$175,686	$188,781	$163,603	-13.3%	$154,760	$394,479	$0	-100.0%	
HCC's % of Plan Paid	39.6%	35.1%	31.1%	-11.4%	34.2%	48.7%	0.0%	-100.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,787	$1,246	$1,038	-16.7%	$1,032	$4,134	$912	-77.9%	$1,044
Facility Outpatient	$1,442	$1,670	$1,559	-6.6%	$1,258	$1,695	$1,367	-19.4%	$1,310
Physician	$1,160	$1,480	$1,644	11.1%	$1,097	$1,601	$1,325	-17.2%	$1,404
Other	$79	$0	$0	0.0%	$76	$0	$0	0.0%	$72
Total	$4,468	$4,397	$4,242	-3.5%	$3,464	$7,430	$3,603	-51.5%	$3,830
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

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

	Total				State Active				Non-State Active			
Summary	**PY22**	**PY23**	**3Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**3Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**3Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	18,943	16,411	14,764	-10.0%	15,526	13,332	11,974	-10.2%	3	3	3	14.7%
Spouses	3,974	7,866	2,782	-64.6%	3,134	7,223	2,115	-70.7%	1	4	1	-80.5%
Children	10,172	3,266	6,721	105.8%	9,421	2,504	6,159	146.0%	4	1	3	189.0%
Total Members	33,089	27,544	24,267	-11.9%	28,082	23,059	20,248	-12.2%	8	8	7	-11.1%
Family Size	1.8	1.7	1.6	-2.4%	1.8	1.7	1.7	-2.3%	2.7	2.7	2.1	-22.8%
Financial Summary												
Gross Cost	$138,077,453	$116,590,277	$80,818,684	-30.7%	$106,593,460	$87,356,314	$62,788,584	-28.1%	$55,484	$42,591	$67,783	59.1%
Client Paid	$104,706,277	$88,479,381	$59,215,710	-33.1%	$80,561,976	$66,125,338	$46,580,031	-29.6%	$38,304	$30,890	$51,943	68.2%
Employee Paid	$33,371,175	$28,110,896	$21,602,974	-23.2%	$26,031,484	$21,230,976	$16,208,553	-23.7%	$17,181	$11,702	$15,840	35.4%
Client Paid-PEPY	$5,527	$5,391	$5,348	-0.8%	$5,189	$4,960	$5,187	4.6%	$12,768	$10,297	$20,107	95.3%
Client Paid-PMPY	$3,164	$3,212	$3,254	1.3%	$2,869	$2,868	$3,067	6.9%	$4,788	$3,861	$9,739	152.2%
Client Paid-PEPM	$461	$449	$446	-0.7%	$432	$413	$432	4.6%	$1,064	$858	$1,676	95.3%
Client Paid-PMPM	$264	$268	$271	1.1%	$239	$239	$256	7.1%	$399	$322	$812	152.2%
High Cost Claimants (HCC's) > $100k												
# of HCC's	160	126	96		115	94	75		0	0	0	
HCC's / 1,000	4.8	4.6	4.0		4.1	4.1	3.7		0.0	0.0	0.0	
Avg HCC Paid	$251,190	$238,643	$204,586	-14.3%	$262,921	$233,021	$213,880	-8.2%	$0	$0	$0	0.0%
HCC's % of Plan Paid	38.4%	34.0%	33.2%	-2.4%	37.5%	33.1%	34.4%	3.9%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,153	$995	$947	-4.8%	$1,028	$895	$932	4.1%	$0	$0	$0	0.0%
Facility Outpatient	$939	$1,074	$1,110	3.4%	$821	$930	$1,022	9.9%	$3,554	$2,208	$8,110	267.3%
Physician	$1,011	$1,143	$1,197	4.7%	$964	$1,043	$1,114	6.8%	$1,200	$1,653	$1,629	-1.5%
Other	$62	$0	$0	0.0%	$56	$0	$0	0.0%	$34	$0	$0	0.0%
Total	$3,164	$3,212	$3,254	1.3%	$2,869	$2,868	$3,067	6.9%	$4,788	$3,861	$9,739	152.2%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY22**	**PY23**	**3Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**3Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	2,981	2,711	2,464	-9.1%	433	366	323	-11.8%	
Spouses	776	624	630	0.9%	62	16	37	136.6%	
Children	729	715	545	-23.8%	18	46	14	-70.0%	
Total Members	4,486	4,049	3,639	-10.1%	514	427	373	-12.7%	
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	$16,199,279	-35.5%	$3,549,442	$4,089,345	$1,763,038	-56.9%	
Client Paid	$21,491,378	$19,194,786	$11,575,357	-39.7%	$2,614,619	$3,128,367	$1,008,379	-67.8%	
Employee Paid	$6,387,688	$5,907,239	$4,623,922	-21.7%	$934,823	$960,978	$754,659	-21.5%	
Client Paid-PEPY	$7,210	$7,082	$6,265	-11.5%	$6,033	$8,557	$4,168	-51.3%	$6,258
Client Paid-PMPY	$4,791	$4,740	$4,242	-10.5%	$5,091	$7,321	$3,603	-50.8%	$3,830
Client Paid-PEPM	$601	$590	$522	-11.5%	$503	$713	$347	-51.3%	$521
Client Paid-PMPM	$399	$395	$353	-10.6%	$424	$610	$300	-50.8%	$319
High Cost Claimants (HCC's) > $100k									
# of HCC's	44	31	22		5	5	1		
HCC's / 1,000	9.8	7.7	6.1		9.7	11.7	2.7		
Avg HCC Paid	$199,873	$213,853	$163,603	-23.5%	$231,987	$307,109	$0	-100.0%	
HCC's % of Plan Paid	40.9%	34.5%	31.1%	-9.9%	44.4%	49.1%	0.0%	-100.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,808	$1,250	$1,038	-17.0%	$2,262	$4,005	$912	-77.2%	$1,044
Facility Outpatient	$1,612	$1,838	$1,559	-15.2%	$1,488	$1,591	$1,367	-14.1%	$1,310
Physician	$1,280	$1,652	$1,644	-0.5%	$1,227	$1,724	$1,325	-23.1%	$1,404
Other	$91	$0	$0	0.0%	$115	$0	$0	0.0%	$72
Total	$4,791	$4,740	$4,242	-10.5%	$5,091	$7,321	$3,603	-50.8%	$3,830
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 19,003,003	$ 3,794,559	$ 393,683	$ 23,191,246	$ 16,142,735	$ 2,760,560	$ 419,659	$ 19,322,953	-16.7%
Outpatient	$ 29,455,778	$ 8,187,369	$ 1,079,528	$ 38,722,675	$ 30,437,296	$ 6,574,387	$ 1,820,751	$ 38,832,435	0.3%
Total - Medical	**$ 48,458,781**	**$ 11,981,929**	**$ 1,473,211**	**$ 61,913,921**	**$ 46,580,031**	**$ 9,334,947**	**$ 2,240,410**	**$ 58,155,388**	**-6.1%**

Net Paid Claims - Per Participant per Month	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 403	$ 612	$ 295	$ 427	$ 432	$ 538	$ 464	$ 448	4.8%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 361,518	$ 1,082,334	$ 1,443,852		$ 62,617	$ 227,061	$ 289,678	-79.9%
Outpatient	$ 23,704	$ 580,477	$ 404,115	$ 1,008,296	$ 51,943	$ 308,831	$ 409,870	$ 770,644	-23.6%
Total - Medical	**$ 23,704**	**$ 941,995**	**$ 1,486,449**	**$ 2,452,148**	**$ 51,943**	**$ 371,448**	**$ 636,931**	**$ 1,060,322**	**-56.8%**

Net Paid Claims - Per Participant per Month	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 878	$ 898	$ 649	$ 728	$ 1,678	$ 538	$ 288	$ 361	-50.4%

Paid Claims by Claim Type – Total Participants

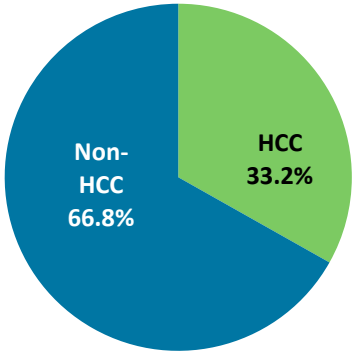
Net Paid Claims - Total Total Participants	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 19,003,003	$ 4,156,077	$ 1,476,017	$ 24,635,097	$ 16,142,735	$ 2,823,176	$ 646,720	$ 19,612,631	-20.4%
Outpatient	$ 29,479,482	$ 8,767,846	$ 1,483,643	$ 39,730,971	$ 30,489,240	$ 6,883,219	$ 2,230,621	$ 39,603,079	-0.3%
Total - Medical	**$ 48,482,486**	**$ 12,923,923**	**$ 2,959,660**	**$ 64,366,068**	**$ 46,631,974**	**$ 9,706,395**	**$ 2,877,341**	**$ 59,215,710**	**-8.0%**

Net Paid Claims - Per Participant per Month	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 403	$ 626	$ 406	$ 434	$ 433	$ 538	$ 409	$ 446	2.6%

Cost Distribution – Medical Claims

3Q23							3Q24					
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
81	0.3%	$22,061,710	34.3%	$539,659	2.4%	$100,000.01 Plus	87	0.4%	$19,640,253	33.2%	$546,479	2.5%
107	0.4%	$8,068,065	12.5%	$677,496	3.0%	$50,000.01-$100,000.00	112	0.5%	$8,231,480	13.9%	$631,841	2.9%
235	0.8%	$8,528,547	13.3%	$1,286,496	5.7%	$25,000.01-$50,000.00	199	0.8%	$7,092,638	12.0%	$1,106,455	5.1%
561	2.0%	$9,156,663	14.2%	$2,859,035	12.6%	$10,000.01-$25,000.00	523	2.2%	$8,567,756	14.5%	$2,576,288	11.9%
766	2.8%	$5,558,687	8.6%	$2,596,454	11.5%	$5,000.01-$10,000.00	759	3.1%	$5,494,080	9.3%	$2,720,252	12.6%
1,093	3.9%	$4,026,747	6.3%	$2,719,630	12.0%	$2,500.01-$5,000.00	1,090	4.5%	$3,973,663	6.7%	$2,813,934	13.0%
12,940	46.7%	$6,965,649	10.8%	$9,658,452	42.7%	$0.01-$2,500.00	10,423	43.0%	$6,215,840	10.5%	$8,834,118	40.9%
4,925	17.8%	$0	0.0%	$2,291,268	10.1%	$0.00	5,053	20.8%	$0	0.0%	$2,373,608	11.0%
7,004	25.3%	$0	0.0%	$0	0.0%	No Claims	6,020	24.8%	$0	0.0%	$0	0.0%
27,711	**100.0%**	**$64,366,069**	**100.0%**	**$22,628,491**	**100.0%**		**24,267**	**100.0%**	**$59,215,710**	**100.0%**	**$21,602,974**	**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	38	$5,388,807	27.4%
Neurological Disorders	61	$2,201,796	11.2%
Cardiac Disorders	72	$2,163,301	11.0%
Hematological Disorders	40	$1,138,384	5.8%
Gastrointestinal Disorders	58	$1,120,790	5.7%
Pregnancy-related Disorders	6	$1,004,848	5.1%
Infections	35	$924,906	4.7%
Medical/Surgical Complications	26	$764,840	3.9%
Pulmonary Disorders	61	$719,545	3.7%
Endocrine/Metabolic Disorders	46	$580,738	3.0%
All Other		$3,632,298	18.5%
Overall	**----**	**$19,640,253**	**100.0%**

Utilization Summary (p. 1 of 2)

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

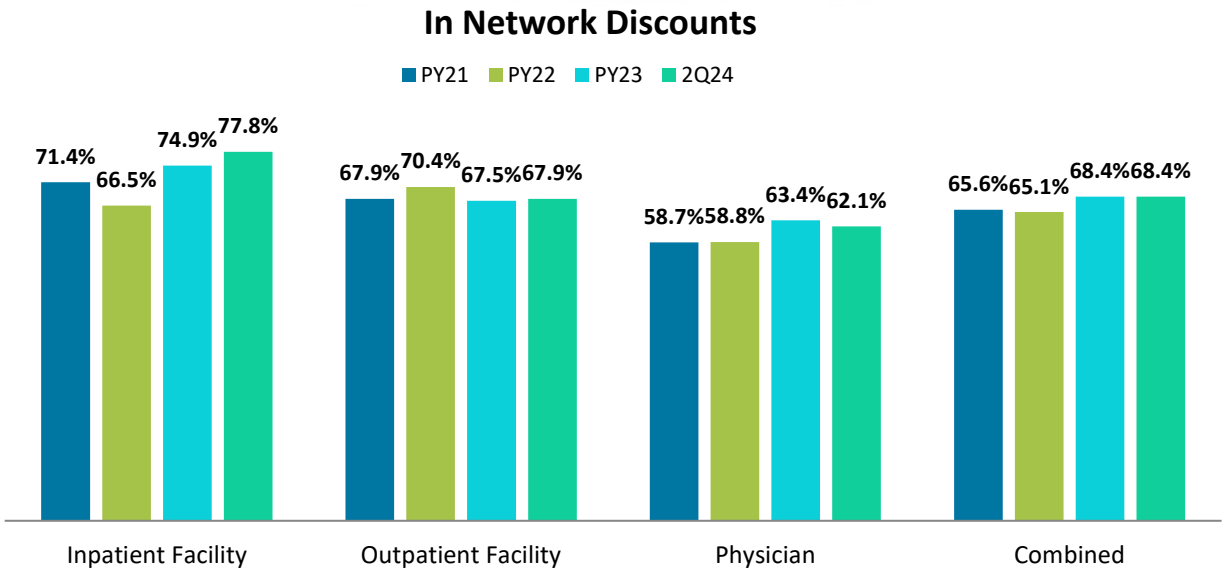
	Total				State Active				Non-State Active			
Summary	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	1,036	820	708		758	612	538		0	0	0	
# of Bed Days	7,071	4,956	4,076		5,152	3,665	2,977		0	0	0	
Paid Per Admit	$36,824	$27,014	$28,380	5.1%	$38,349	$27,718	$30,519	10.1%	$0	$0	$0	0.0%
Paid Per Day	$5,395	$4,470	$4,930	10.3%	$5,642	$4,628	$5,515	19.2%	$0	$0	$0	0.0%
Admits Per 1,000	41	39	39	0.0%	36	35	35	0.0%	0	0	0	0.0%
Days Per 1,000	282	238	224	-5.9%	242	211	196	-7.1%	0	0	0	0.0%
Avg LOS	6.8	6	5.8	-3.3%	6.8	6	5.5	-8.3%	0	0	0	0.0%
# Admits From ER	572	475	460	-3.2%	376	328	335	2.1%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	3.7	3.7	4	8.1%	3.5	3.4	3.7	8.8%	3.7	3.2	3.4	6.2%
Avg Paid per OV	$77	$80	$80	0.0%	$79	$76	$76	0.0%	$79	$71	$113	0.0%
Avg OV Paid per Member	$286	$293	$319	8.9%	$276	$256	$280	9.4%	$290	$224	$382	0.0%
DX&L Utilization per Member	7.2	9.2	9.4	2.2%	6.8	8.4	8.8	4.8%	15.5	6.2	8.3	33.9%
Avg Paid per DX&L	$50	$46	$48	4.3%	$47	$43	$47	9.3%	$204	$92	$276	0.0%
Avg DX&L Paid per Member	$366	$423	$457	8.0%	$322	$366	$419	14.5%	$3,161	$566	$2,280	0.0%
Emergency Room												
# of Visits	3,691	3,088	2,808		3,077	2,461	2,269		4	3	5	
Visits Per Member	0.15	0.15	0.15	0.0%	0.14	0.14	0.15	7.1%	0.67	0.50	0.94	88.0%
Visits Per 1,000	147	149	154	3.4%	145	142	149	4.9%	667	500	938	87.6%
Avg Paid per Visit	$1,918	$2,283	$2,435	6.7%	$1,948	$2,379	$2,548	7.1%	$1,117	$4,167	$4,474	7.4%
Urgent Care												
# of Visits	6,732	5,566	5,373		5,944	4,920	4,692		5	3	2	
Visits Per Member	0.27	0.27	0.30	11.1%	0.28	0.28	0.31	10.7%	0.83	0.50	0.38	-24.0%
Visits Per 1,000	269	268	295	10.1%	280	283	309	9.2%	833	500	375	-25.0%
Avg Paid per Visit	$66	$45	$42	-6.7%	$66	$45	$42	-6.7%	$106	$42	$130	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

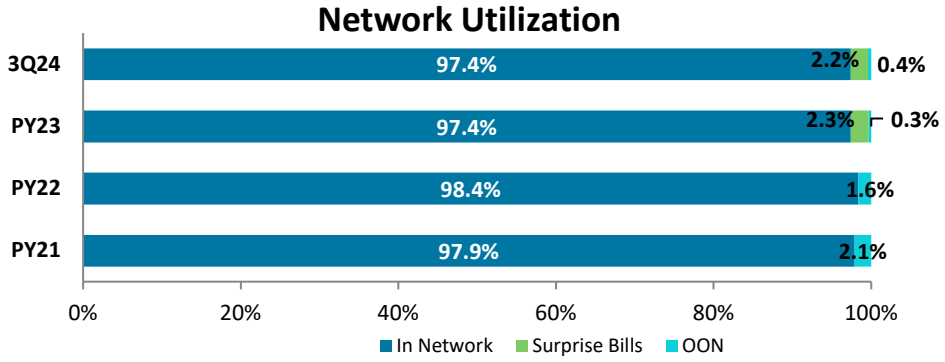
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**Peer Index**
Inpatient Summary									
# of Admits	238	165	137		40	43	33		
# of Bed Days	1,697	966	951		222	325	148		
Paid Per Admit	$34,238	$25,474	$24,479	-3.9%	$23,317	$22,909	$9,714	-57.6%	$19,305
Paid Per Day	$4,802	$4,351	$3,526	-19.0%	$4,201	$3,031	$2,166	-28.5%	$3,615
Admits Per 1,000	70	54	50	-7.4%	102	132	118	-10.6%	64
Days Per 1,000	503	316	348	10.1%	566	994	529	-46.8%	342
Avg LOS	7.1	5.9	6.9	16.9%	5.6	7.6	4.5	-40.8%	5.3
# Admits From ER	168	118	100	-15.3%	28	29	25	-13.8%	
Physician Office									
OV Utilization per Member	4.9	4.9	5.0	2.0%	6.6	7.5	8.1	8.0%	5.2
Avg Paid per OV	$73	$102	$108	5.9%	$34	$37	$34	-8.1%	$97
Avg OV Paid per Member	$355	$503	$542	7.8%	$227	$279	$274	-1.8%	$502
DX&L Utilization per Member	9.7	12.8	12	-6.3%	9.5	19.7	17.9	-9.1%	9.0
Avg Paid per DX&L	$63	$56	$53	-5.4%	$52	$35	$41	17.1%	$46
Avg DX&L Paid per Member	$618	$719	$639	-11.1%	$499	$692	$736	6.4%	$412
Emergency Room									
# of Visits	530	523	435		80	101	99		
Visits Per Member	0.16	0.17	0.16	-5.9%	0.20	0.31	0.35	12.9%	0.23
Visits Per 1,000	157	171	159	-7.0%	204	309	354	14.6%	228
Avg Paid per Visit	$1,821	$1,987	$2,204	10.9%	$1,441	$1,441	$752	-47.8%	$1,035
Urgent Care									
# of Visits	718	573	608		65	70	71		
Visits Per Member	0.21	0.19	0.22	15.8%	0.17	0.21	0.25	19.0%	0.38
Visits Per 1,000	213	187	223	19.3%	166	214	254	18.7%	379
Avg Paid per Visit	$62	$48	$40	-16.7%	$38	$37	$49	32.4%	$132
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$7,880,005	13.3%	$6,008,739	$1,815,274	$55,992	$3,241,030	$4,638,975
Cardiac Disorders	$5,191,621	8.8%	$3,389,147	$1,133,325	$669,149	$3,256,760	$1,934,861
Health Status/Encounters	$5,098,056	8.6%	$3,335,388	$698,934	$1,063,735	$1,896,985	$3,201,071
Gastrointestinal Disorders	$4,758,837	8.0%	$3,362,979	$566,530	$829,328	$1,734,849	$3,023,988
Neurological Disorders	$4,294,794	7.3%	$2,023,092	$590,391	$1,681,311	$1,003,819	$3,290,976
Pregnancy-related Disorders	$3,130,099	5.3%	$1,418,791	$334,284	$1,377,024	$697,194	$2,432,905
Trauma/Accidents	$3,087,896	5.2%	$1,965,959	$323,674	$798,263	$1,262,372	$1,825,524
Musculoskeletal Disorders	$2,722,239	4.6%	$2,142,590	$357,128	$222,520	$961,559	$1,760,679
Mental Health	$2,573,848	4.3%	$1,008,680	$258,866	$1,306,301	$1,262,326	$1,311,521
Spine-related Disorders	$2,238,038	3.8%	$1,830,831	$280,493	$126,714	$1,028,657	$1,209,382
Infections	$2,146,428	3.6%	$1,730,065	$262,983	$153,380	$981,431	$1,164,998
Pulmonary Disorders	$1,996,950	3.4%	$1,236,772	$245,716	$514,461	$1,034,195	$962,754
Eye/ENT Disorders	$1,996,820	3.4%	$1,341,827	$351,535	$303,458	$889,926	$1,106,894
Renal/Urologic Disorders	$1,873,221	3.2%	$1,420,326	$193,036	$259,859	$863,754	$1,009,467
Endocrine/Metabolic Disorders	$1,535,968	2.6%	$1,316,519	$172,536	$46,914	$832,989	$702,980
Hematological Disorders	$1,457,901	2.5%	$692,653	$734,444	$30,803	$1,000,020	$457,881
Gynecological/Breast Disorders	$1,270,032	2.1%	$910,178	$258,523	$101,331	$25,431	$1,244,601
Non-malignant Neoplasm	$1,182,133	2.0%	$1,059,876	$84,737	$37,520	$451,369	$730,764
Medical/Surgical Complications	$1,181,950	2.0%	$957,044	$115,166	$109,739	$180,961	$1,000,988
Dermatological Disorders	$693,835	1.2%	$433,702	$166,888	$93,245	$304,336	$389,500
Diabetes	$603,194	1.0%	$450,197	$37,439	$115,559	$239,323	$363,872
Miscellaneous	$596,728	1.0%	$452,346	$67,640	$76,742	$179,442	$417,285
Vascular Disorders	$514,296	0.9%	$383,510	$39,567	$91,219	$193,627	$320,669
Abnormal Lab/Radiology	$392,065	0.7%	$298,376	$80,618	$13,071	$138,706	$253,359
Congenital/Chromosomal Anomalies	$381,558	0.6%	$71,630	$139,149	$170,779	$86,740	$294,818
Medication Related Conditions	$198,544	0.3%	$57,590	$7,639	$133,315	$19,574	$178,971
External Hazard Exposure	$95,283	0.2%	$4,746	$2,466	$88,071	$88,737	$6,546
Cholesterol Disorders	$81,319	0.1%	$67,460	$12,177	$1,681	$48,321	$32,998
Dental Conditions	$21,443	0.0%	$14,590	$263	$6,590	$11,700	$9,743
Allergic Reaction	$20,361	0.0%	$9,187	$916	$10,258	$8,904	$11,457
Cause of Morbidity	$241	0.0%	$0	$0	$241	$241	$0
Social Determinants of Health	$6	0.0%	$6	$0	$0	$0	$6
Total	**$59,215,710**	**100.0%**	**$39,394,799**	**$9,332,336**	**$10,488,575**	**$23,925,277**	**$35,290,434**

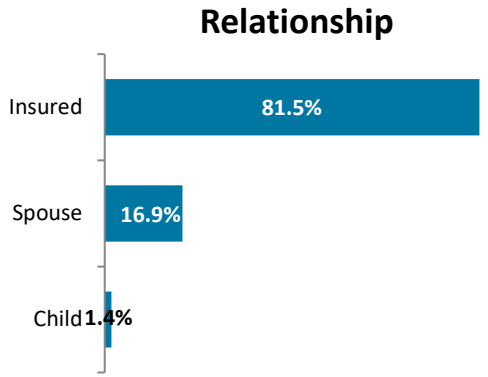
Mental Health Drilldown

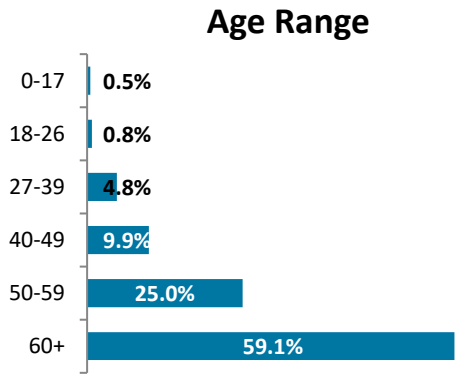
	PY21		PY22		PY23		3Q24	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Developmental Disorders	179	$1,179,402	113	$719,871	106	$1,143,180	95	$659,222
Alcohol Abuse/Dependence	136	$1,288,204	101	$873,612	129	$434,007	98	$533,809
Depression	1,597	$1,103,414	1,156	$1,279,244	974	$1,005,022	844	$455,172
Mood and Anxiety Disorders	1,920	$638,818	1,486	$406,189	1,263	$370,422	1,025	$292,028
Mental Health Conditions, Other	1,220	$771,034	911	$431,490	774	$383,973	658	$216,730
Eating Disorders	55	$647,596	44	$596,928	34	$112,463	24	$79,085
Bipolar Disorder	315	$464,418	225	$197,224	193	$202,937	185	$69,127
Sexually Related Disorders	68	$90,021	42	$11,305	56	$109,156	44	$59,836
Substance Abuse/Dependence	140	$213,345	86	$540,594	81	$99,940	58	$45,337
Complications of Substance Abuse	42	$202,208	22	$89,081	26	$88,753	24	$38,860
Schizophrenia	26	$141,033	25	$110,357	21	$81,413	16	$32,132
Attention Deficit Disorder	482	$72,965	374	$57,319	369	$42,820	332	$31,699
Psychoses	54	$86,357	32	$70,201	35	$108,586	21	$27,609
Sleep Disorders	564	$76,491	371	$46,254	347	$39,783	254	$23,913
Personality Disorders	25	$16,690	19	$13,480	8	$1,502	14	$5,664
Tobacco Use Disorder	126	$8,010	106	$6,184	103	$7,184	89	$3,626
Total		**$7,000,007**		**$5,449,334**		**$4,231,141**		**$2,573,848**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	63	379	$2,776,154	4.7%
Cancers, Other	77	824	$1,443,812	2.4%
Breast Cancer	151	1,431	$847,886	1.4%
Secondary Cancers	44	365	$600,782	1.0%
Prostate Cancer	92	567	$443,364	0.7%
Colon Cancer	38	452	$355,189	0.6%
Carcinoma in Situ	77	262	$204,487	0.3%
Lung Cancer	19	166	$179,684	0.3%
Cervical/Uterine Cancer	42	276	$131,252	0.2%
Lymphomas	29	336	$127,040	0.2%
Melanoma	35	139	$114,225	0.2%
Thyroid Cancer	35	175	$113,777	0.2%
Leukemias	23	317	$110,480	0.2%
Ovarian Cancer	19	173	$103,110	0.2%
Non-Melanoma Skin Cancers	206	519	$98,769	0.2%
Myeloma	10	199	$82,877	0.1%
Kidney Cancer	19	178	$63,491	0.1%
Brain Cancer	4	13	$39,616	0.1%
Pancreatic Cancer	4	108	$30,454	0.1%
Bladder Cancer	15	79	$13,555	0.0%
Overall	**----**	**----**	**$7,880,005**	**100.0%**

*Patient and claim counts are unique only within the category

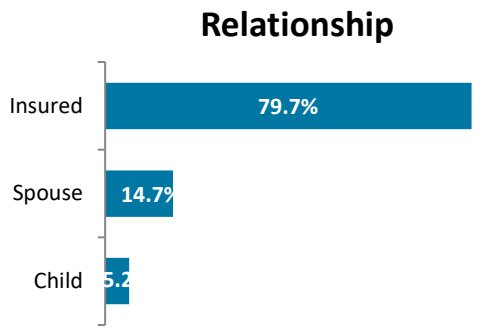


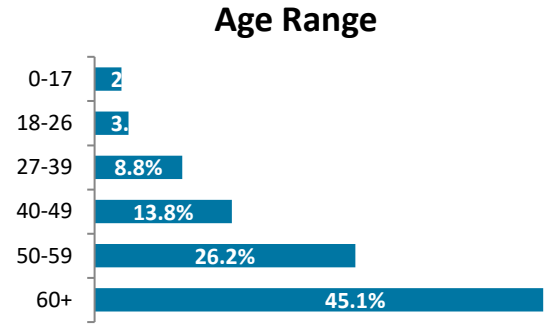


Diagnosis Grouper – Cardiac Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Coronary Artery Disease	388	991	$811,674	1.4%
Myocardial Infarction	40	229	$772,588	1.3%
Heart Valve Disorders	263	424	$731,347	1.2%
Atrial Fibrillation	193	868	$725,777	1.2%
Chest Pain	863	1,999	$652,320	1.1%
Congestive Heart Failure	121	374	$433,170	0.7%
Hypertension	2,191	4,656	$335,406	0.6%
Pulmonary Embolism	34	191	$246,805	0.4%
Cardiac Arrhythmias	475	1,009	$182,677	0.3%
Cardiac Conditions, Other	446	898	$151,953	0.3%
Cardiomyopathy	31	69	$91,982	0.2%
Cardio-Respiratory Arrest	55	164	$46,758	0.1%
Shock	11	36	$8,500	0.0%
Ventricular Fibrillation	4	4	$666	0.0%
Overall	**----**	**----**	**$5,191,621**	**100.0%**

*Patient and claim counts are unique only within the category

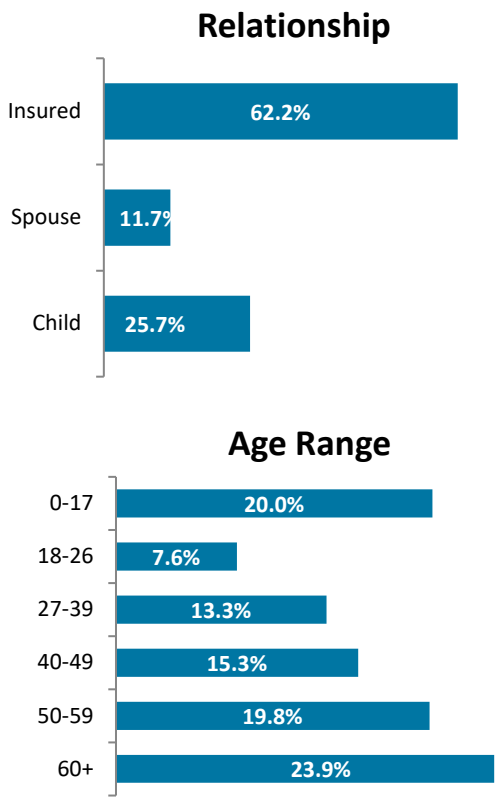




Diagnosis Grouper – Health Status/Encounters

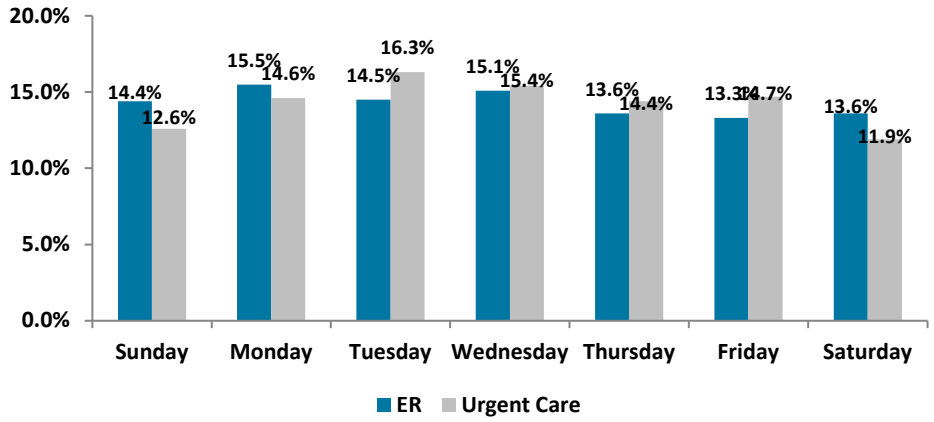
Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Screenings	5,208	10,021	$1,830,361	3.1%
Exams	6,561	11,826	$1,217,082	2.1%
Prophylactic Measures	2,838	3,601	$686,735	1.2%
Encounters - Infants/Children	2,004	2,853	$405,217	0.7%
Aftercare	331	798	$243,430	0.4%
Prosthetics/Devices/Implants	348	1,136	$197,925	0.3%
Counseling	612	2,239	$144,306	0.2%
Personal History of Condition	697	1,149	$118,777	0.2%
Acquired Absence	55	92	$104,528	0.2%
Family History of Condition	130	196	$75,553	0.1%
Encounter - Transplant Related	34	165	$24,752	0.0%
Encounter - Procedure	40	62	$22,260	0.0%
Health Status, Other	84	132	$14,153	0.0%
Lifestyle/Situational Issues	77	140	$6,275	0.0%
Follow-Up Encounters	8	17	$6,011	0.0%
Miscellaneous Examinations	18	32	$526	0.0%
Donors	2	2	$113	0.0%
Blood Type	1	2	$51	0.0%
Patient Non-compliance	1	1	$0	0.0%
Overall	**----**	**----**	**$5,098,056**	**8.5%**

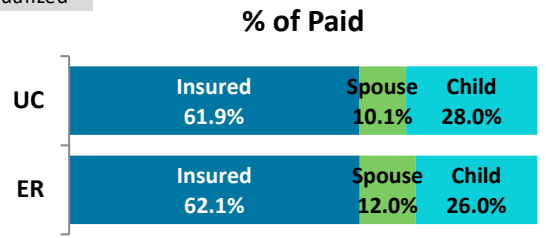
*Patient and claim counts are unique only within the category



Emergency Room / Urgent Care Summary

	3Q23		3Q24		Peer Index	
	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	3,088	5,566	2,808	5,373		
Visits Per Member	0.15	0.27	0.15	0.30	0.23	0.38
Visits/1000 Members	149	268	154	296	228	379
Avg Paid Per Visit	$2,283	$45	$2,435	$42	$1,085	$132
% with OV*	80.7%	78.5%	81.8%	77.7%		
% Avoidable	16.1%	41.4%	15.5%	39.8%		
Total Member Paid	**$3,940,686**	**$708,013**	**$3,807,678**	**$775,264**		
Total Plan Paid	**$7,051,027**	**$250,789**	**$6,837,899**	**$225,700**		
*looks back 12 months	Annualized	Annualized	Annualized	Annualized		





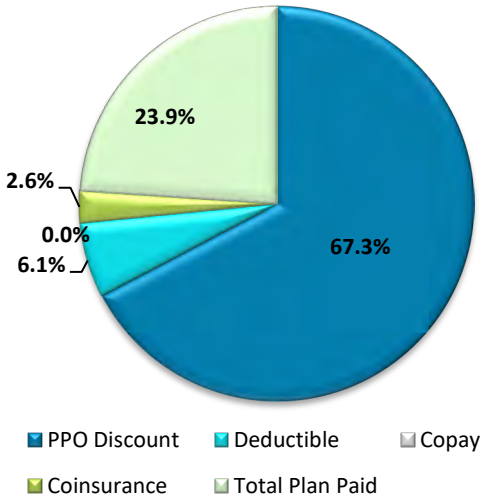
ER / UC Visits by Relationship						
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	1,743	118	3,324	4,380	5,067	343
Spouse	337	121	542	863	879	316
Child	728	108	1,507	1,655	2,235	333
Total	**2,808**	**116**	**5,373**	**221**	**8,181**	**337**

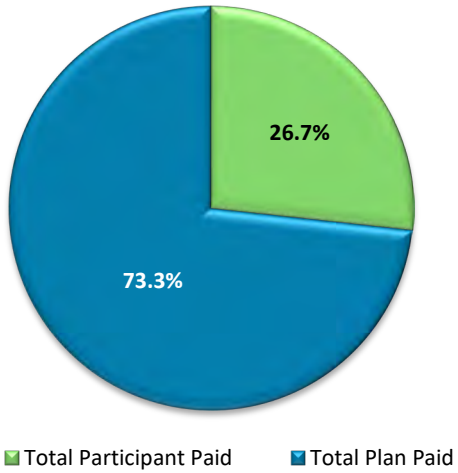
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$256,362,971	$1,929	100.0%
PPO Discount	$166,454,402	$1,253	64.9%
Deductible	$15,167,712	$114	5.9%
Copay	$243	$0	0.0%
Coinsurance	$6,435,019	$48	2.5%
Total Participant Paid	**$21,602,974**	**$163**	**8.4%**
Total Plan Paid	**$59,215,710**	**$446**	**23.1%**

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





Paid Claims by Age Range – Dental

Dental Paid Claims by Age Group												
	3Q22		3Q23		3Q24		% Change	
Age Range	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM
<1	$ 8,125	$ 2	$ 6,193	$ 1	$ 7,417	$ 3	19.8%	93.6%
1	$ 38,589	$ 8	$ 37,555	$ 9	$ 37,179	$ 12	-1.0%	29.9%
2 - 4	$ 304,460	$ 20	$ 297,020	$ 21	$ 314,053	$ 28	5.7%	33.7%
5 - 9	$ 942,227	$ 32	$ 868,316	$ 29	$ 908,404	$ 41	4.6%	39.4%
10 - 14	$ 951,380	$ 28	$ 953,784	$ 27	$ 991,833	$ 37	4.0%	35.5%
15 - 19	$ 1,076,080	$ 29	$ 1,072,350	$ 29	$ 1,348,925	$ 43	25.8%	50.1%
20 - 24	$ 678,238	$ 17	$ 650,075	$ 17	$ 808,561	$ 25	24.4%	47.5%
25 - 29	$ 646,038	$ 23	$ 555,431	$ 21	$ 669,214	$ 30	20.5%	43.9%
30 - 34	$ 857,552	$ 25	$ 724,862	$ 22	$ 846,314	$ 32	16.8%	43.5%
35 - 39	$ 1,038,679	$ 27	$ 919,981	$ 24	$ 1,051,516	$ 34	14.3%	40.6%
40 - 44	$ 1,025,864	$ 27	$ 995,763	$ 26	$ 1,173,151	$ 36	17.8%	39.4%
45 - 49	$ 1,080,130	$ 29	$ 989,198	$ 26	$ 1,194,426	$ 39	20.7%	46.5%
50 - 54	$ 1,343,834	$ 31	$ 1,263,941	$ 29	$ 1,411,371	$ 40	11.7%	36.2%
55 - 59	$ 1,519,728	$ 34	$ 1,414,266	$ 33	$ 1,626,915	$ 46	15.0%	39.0%
60 - 64	$ 1,934,543	$ 39	$ 1,717,029	$ 36	$ 1,916,045	$ 50	11.6%	36.8%
65+	$ 5,085,544	$ 42	$ 4,764,184	$ 40	$ 5,600,045	$ 56	17.5%	41.4%
Total	**$18,531,011**	**$ 31**	**$17,229,950**	**$ 29**	**$ 19,905,369**	**$ 41**	**15.5%**	**40.9%**

Dental Paid Claims – State Participants

Dental Paid Claims - Total State Participants	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 11,370,567	$ 1,583,426	$ 342,505	$ 13,296,498	$ 13,233,287	$ 1,655,906	$ 428,524	$ 15,317,718	15.2%
Dental Exchange	$ -	$ -	$ 2,453,723	$ 2,453,723	$ -	$ -	$ 2,906,269	$ 2,906,269	18.4%
Total	**$ 11,370,567**	**$ 1,583,426**	**$ 2,796,228**	**$ 15,750,221**	**$ 13,233,287**	**$ 1,655,906**	**$ 3,334,793**	**$ 18,223,986**	**33.6%**

Dental Paid Claims - Per Participant per Month	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 49	$ 51	$ 53	$ 49	$ 55	$ 55	$ 67	$ 56	13.4%
Dental Exchange	$ -	$ -	$ 47	$ 47	$ -	$ -	$ 55	$ 55	17.2%

Dental Paid Claims – Non-State Participants

Dental Paid Claims - Total Non-State Participants	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 3,120	$ 69,024	$ 156,068	$ 228,212	$ 2,645	$ 48,368	$ 167,561	$ 218,574	-4.2%
Dental Exchange	$ -	$ -	$ 1,251,517	$ 1,251,517	$ -	$ -	$ 1,462,810	$ 1,462,810	16.9%
Total	**$ 3,120**	**$ 69,024**	**$ 1,407,586**	**$ 1,479,729**	**$ 2,645**	**$ 48,368**	**$ 1,630,370**	**$ 1,681,383**	**13.6%**

Dental Paid Claims - Per Participant per Month	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 58	$ 39	$ 42	$ 41	$ 44	$ 39	$ 46	$ 44	8.0%
Dental Exchange	$ -	$ -	$ 41	$ 41	$ -	$ -	$ 50	$ 50	21.1%

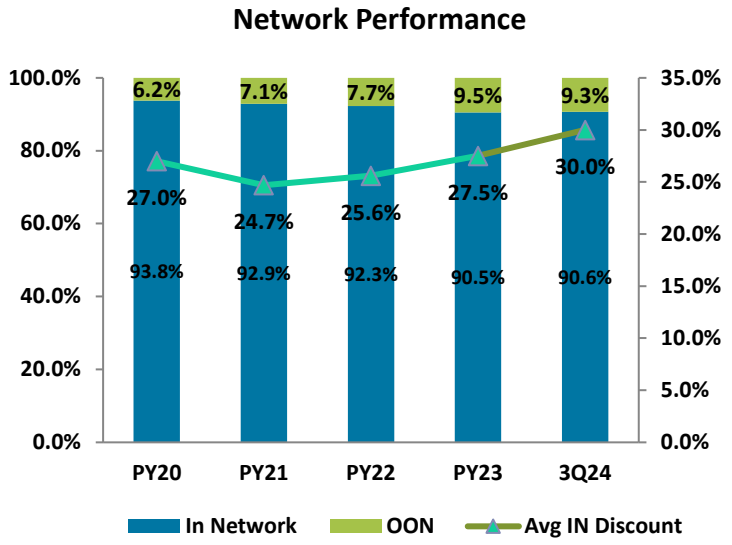
Dental Paid Claims – Total Participants

Dental Paid Claims - Total Total Participants	2Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 11,373,687	$ 1,652,449	$ 498,574	$ 13,524,710	$ 13,235,932	$ 1,704,274	$ 596,085	$ 15,536,292	14.9%
Dental Exchange	$ -	$ -	$ 3,705,240	$ 3,705,240	$ -	$ -	$ 4,369,078	$ 4,369,078	17.9%
Total	**$ 11,373,687**	**$ 1,652,449**	**$ 4,203,814**	**$ 17,229,950**	**$ 13,235,932**	**$ 1,704,274**	**$ 4,965,163**	**$ 19,905,370**	**15.5%**

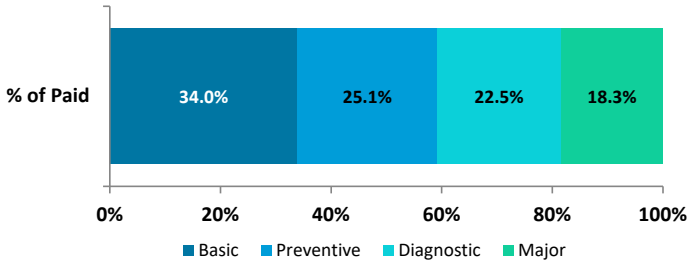
Dental Paid Claims - Per Participant per Month	2Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Dental	$ 49	$ 50	$ 49	$ 49	$ 55	$ 54	$ 59	$ 55	13.3%
Dental Exchange	$ -	$ -	$ 45	$ 45	$ -	$ -	$ 54	$ 54	18.6%

Dental Claims Analysis

Cost Distribution								
Paid Claims Category	Avg # of Members	% of Members	# Claims	# of Claims	Total Paid	% of Paid	Total EE Paid	% of EE Paid
$1,000.01 Plus	4,239	7.9%	24,979	24.2%	$8,735,269	43.9%	$4,947,830	56.1%
$750.01-$1,000.00	1,726	3.2%	7,808	7.6%	$1,861,722	9.4%	$980,839	11.1%
$500.01-$750.00	2,820	5.3%	11,319	11.0%	$2,166,022	10.9%	$966,844	11.0%
$250.01-$500.00	9,764	18.3%	31,043	30.1%	$4,253,051	21.4%	$1,008,394	11.4%
$0.01-$250.00	14,499	27.1%	27,189	26.3%	$2,889,307	14.5%	$880,300	10.0%
$0.00	432	0.8%	954	0.9%	$0	0.0%	$33,074	0.4%
No Claims	19,994	37.4%	0	0.0%	$0	0.0%	$0	0.0%
Total	**53,473**	**100.0%**	**103,292**	**100.0%**	**$19,905,370**	**100.0%**	**$8,817,279**	**100.0%**



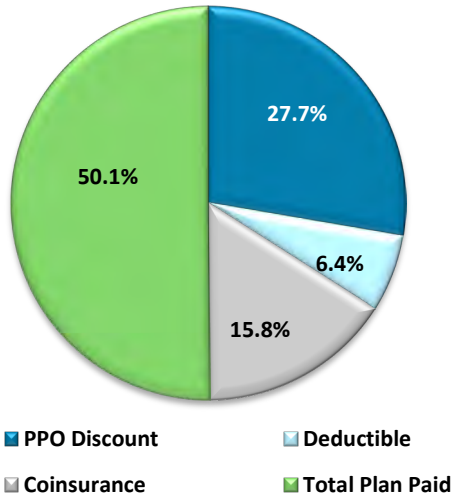
Claim Category	Total Paid	% of Paid
Basic	$6,768,878	34.0%
Preventive	$5,001,042	25.1%
Diagnostic	$4,484,244	22.5%
Major	$3,651,205	18.3%
Total	**$19,905,370**	**100.0%**

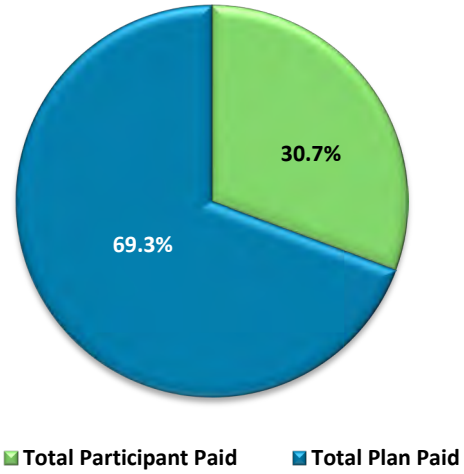


Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$39,843,717	$134	100.0%
PPO Discount	$10,987,468	$37	27.6%
Deductible	$2,524,988	$9	6.3%
Coinsurance	$6,292,292	$21	15.8%
Total Participant Paid	**$8,817,279**	**$30**	**22.1%**
Total Plan Paid	**$19,905,370**	**$67**	**50.0%**

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	1,005	976	29	97.1%
	Two or more asthma related ER Visits in the last 6 months	1,005	3	1,002	0.3%
	Asthma related admit in last 12 months	1,005	8	997	0.8%
Chronic Obstructive Pulmonary Disease	Exacerbations in last 12 months	229	8	221	3.5%
	Members with COPD who had an annual spirometry test	229	38	191	16.6%
Congestive Heart Failure	Re-admission to hospital with Heart Failure diagnosis within 30 days following a HF inpat	8	0	8	0.0%
	ER Visit for Heart Failure in last 90 days	196	7	189	3.6%
	Follow-up OV within 4 weeks of discharge from HF admission	8	5	3	62.5%
Diabetes	Annual office visit	1,406	1,341	65	95.4%
	Annual dilated eye exam	1,406	485	921	34.5%
	Annual foot exam	1,406	638	768	45.4%
	Annual HbA1c test done	1,406	1,165	241	82.9%
	Diabetes Annual lipid profile	1,406	1,091	315	77.6%
	Annual microalbumin urine screen	1,406	959	447	68.2%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	4,060	3,266	794	80.4%
Hypertension	Hypertension Annual lipid profile	3,963	2,746	1,217	69.3%
	Annual serum creatinine test	3,876	3,099	777	80.0%
Wellness	Well Child Visit - 15 months	112	106	6	94.6%
	Routine office visit in last 6 months (All Ages)	24,015	14,391	9,624	59.9%
	Colorectal cancer screening ages 45-75 within the appropriate time period	10,060	4,960	5,100	49.3%
	Women age 25-65 with recommended cervical cancer/HPV screening	7,301	5,001	2,300	68.5%
	Males age greater than 49 with PSA test in last 24 months	4,046	1,988	2,058	49.1%
	Routine exam in last 24 months (All Ages)	24,015	19,790	4,225	82.4%
	Women age 40 to 75 with a screening mammogram last 24 months	6,406	3,897	2,509	60.8%

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

Chronic Conditions Prevalence

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

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

Chronic Condition	# With Condition	% of Members	Members per 1,000	Admits per 1,000	ER Visits per 1,000	PMPY
Affective Psychosis	177	0.74%	7.29	195.92	579.59	$11,450
Asthma	1,139	4.74%	46.94	134.00	448.34	$14,771
Atrial Fibrillation	287	1.19%	11.83	367.55	546.36	$28,450
Blood Disorders	1,676	6.97%	69.07	252.79	444.35	$22,030
CAD	600	2.49%	24.73	270.01	408.60	$24,479
COPD	226	0.94%	9.31	352.37	561.17	$24,916
Cancer	984	4.09%	40.55	202.54	250.98	$26,762
Chronic Pain	710	2.95%	29.26	172.66	530.62	$17,855
Congestive Heart Failure	195	0.81%	8.04	627.55	864.80	$44,608
Demyelinating Diseases	61	0.25%	2.51	296.02	432.64	$52,019
Depression	1,599	6.65%	65.89	124.84	413.07	$11,366
Diabetes	1,578	6.56%	65.03	135.53	283.55	$15,353
ESRD	30	0.12%	1.24	1,129.41	1,270.59	$43,127
Eating Disorders	89	0.37%	3.67	219.18	566.21	$17,614
HIV/AIDS	33	0.14%	1.36	41.24	247.42	$42,942
Hyperlipidemia	5,021	20.88%	206.91	80.67	217.53	$9,527
Hypertension	3,993	16.60%	164.55	116.18	299.05	$11,900
Immune Disorders	135	0.56%	5.56	392.73	480.00	$46,478
Inflammatory Bowel Disease	94	0.39%	3.87	134.83	524.34	$33,785
Liver Diseases	552	2.30%	22.75	289.32	484.00	$20,825
Morbid Obesity	824	3.43%	33.96	199.38	379.36	$16,461
Osteoarthritis	1,121	4.66%	46.20	116.62	366.89	$13,729
Peripheral Vascular Disease	166	0.69%	6.84	368.96	571.01	$22,343
Rheumatoid Arthritis	144	0.60%	5.93	87.31	388.04	$28,149

*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 - Through Quarter Ending March 31, 2024

Express Scripts

	1Q-3Q FY2024 CDHP	1Q-3Q FY2023 CDHP	Difference	% Change
Membership Summary			**Membership Summary**	
Member Count (Membership)	24,197	27,720	(3,523)	-12.7%
Utilizing Member Count (Patients)	16,420	19,723	(3,303)	-16.7%
Percent Utilizing (Utilization)	67.9%	71.2%	(0.03)	-4.6%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	254,470	284,290	(29,820)	-10.5%
Claims per Elig Member per Month (Claims PMPM)	1.17	1.14	0.03	2.6%
Total Claims for Generic (Generic Rx)	222,058	243,426	(21,368.00)	-8.8%
Total Claims for Brand (Brand Rx)	32,412	40,864	(8,452.00)	-20.7%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	921	1,130	(209.00)	-18.5%
Total Non-Specialty Claims	251,565	280,345	(28,780.00)	-10.3%
Total Specialty Claims	2,905	3,945	(1,040.00)	-26.4%
Generic % of Total Claims (GFR)	**87.3%**	**85.6%**	0.02	1.9%
Generic Effective Rate (GCR)	**99.6%**	**99.5%**	0.00	0.0%
Mail Order Claims	69,807	79,194	(9,387.00)	-11.9%
Mail Penetration Rate*	31.2%	32.0%	(0.01)	-0.8%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$32,565,038	$32,708,629	($143,591.00)	-0.4%
Total Generic Gross Cost	$3,324,684	$3,738,579	($413,895.00)	-11.1%
Total Brand Gross Cost	$29,240,354	$28,970,050	$270,304.00	0.9%
Total MSB Gross Cost	$402,567	$629,317	($226,750.00)	-36.0%
Total Ingredient Cost	$31,451,608	$32,225,558	($773,950.00)	-2.4%
Total Dispensing Fee	$1,091,671	$447,194	$644,477.00	144.1%
Total Other (e.g. tax)	$21,758	$35,878	($14,120.00)	-39.4%
Avg Total Cost per Claim (Gross Cost/Rx)	**$127.97**	**$115.05**	$12.92	11.2%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$15.36	$15.36	$0.00	0.0%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$902.15	$708.94	$193.21	27.3%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$437.10	$556.92	($119.82)	-21.5%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$7,303,881**	**$7,629,342**	($325,461.00)	-4.3%
Total Copay	$5,894,999	$6,005,466	($110,467.00)	-1.8%
Total Deductible	$1,408,882	$1,623,877	($214,995.00)	-13.2%
Avg Copay per Claim (Copay/Rx)	$23.17	$21.12	$2.04	9.7%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$28.70**	**$26.84**	**$1.87**	**7.0%**
Avg Copay for Generic (Copay/Generic Rx)	$6.79	$6.85	($0.06)	-0.9%
Avg Copay for Brand (Copay/Brand Rx)	$178.81	$145.87	$32.94	22.6%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$115.32	$162.88	($47.56)	-29.2%
Net PMPM (Participant Cost PMPM)	**$33.54**	**$30.58**	$2.96	9.7%
Copay % of Total Prescription Cost (Member Cost Share %)	22.4%	23.3%	-0.9%	-3.8%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$25,261,156**	**$25,079,287**	**$181,869.00**	**0.7%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$10,589,174	$9,098,426	$1,490,748.00	16.4%
Total Specialty Drug Cost (Specialty Plan Cost)	$14,671,982	$15,980,860	($1,308,878.00)	-8.2%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$99.27**	**$88.22**	$11.05	12.5%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$8.18	$8.50	($0.32)	-3.8%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$723.34	$563.06	$160.28	28.5%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$321.77	$1,394.03	($1,072.26)	-76.9%
Net PMPM (Plan Cost PMPM)	**$116.00**	**$100.53**	**$15.47**	**15.4%**
PMPM without Specialty (Non-Specialty PMPM)	$42.09	$36.47	$4.02	17.3%
PMPM for Specialty Only (Specialty PMPM)	$67.37	$64.06	$3.31	5.2%
Specialty % of Plan Cost	58.1%	63.70%	($0.06)	-8.8%
Rebates Received (Q1-Q3 FY2023 actual)	$8,885,059	$8,622,319	$262,740.45	3.0%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$75.20**	**$65.97**	**$9.23**	**14.0%**
PMPM without Specialty (Non-Specialty PMPM)	$29.36	$15.36	$0.92	5.0%
PMPM for Specialty Only (Specialty PMPM)	$45.03	$50.00	($4.97)	-9.9%

Appendix B

Index of Tables
UMR Inc. – LDPPO Utilization Review for PEBP
January 1, 2024 – March 31, 2024

DATASCOPE™

Nevada Public Employees' Benefits Program
Low Deductible Plan
July 2023 – March 2024 Incurred,
Paid through May 2024

UMR℠

Overview

- Total Medical Spend for 3Q24 was $59,634,480 with a plan cost per employee per year (PEPY) of $8,122. This is an increase of 8.3% when compared to 3Q23.
  - IP Cost per Admit is $24,045 which is 4.4% lower than 3Q23.
  - ER Cost per Visit is $3,216 which is 1.6% higher than 3Q23.
- Employees shared in 13.8% of the medical cost.
- Inpatient facility costs were 17.7% of the plan spend.
- 80.9% of the Average Membership had paid Medical claims less than $2,500, with 18.3% of those having no claims paid at all during the reporting period.
- 55 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 21.9% of the plan spend. The highest diagnosis category was Cancer, accounting for 27.4% of the high-cost claimant dollars.
- Total spending with in-network providers was 97.8%. The average In Network discount was 65.3%, which is 1.6% higher than the PY23 average discount of 64.3%.

Paid Claims by Age Group

Paid Claims by Age Group																		
	3Q23						3Q24						% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 1,518,680	$ 1,096	$ 32,133	$ 23	$ 1,550,813	$ 1,119	$ 5,035,887	$ 2,826	$ 17,316	$ 10	$ 5,053,203	$ 2,836	225.8%	153.4%
1	$ 316,887	$ 241	$ 6,767	$ 5	$ 323,654	$ 246	$ 415,641	$ 236	$ 3,937	$ 2	$ 419,578	$ 238	29.6%	-3.4%
2 - 4	$ 827,960	$ 171	$ 36,202	$ 7	$ 864,162	$ 178	$ 809,899	$ 134	$ 30,447	$ 5	$ 840,346	$ 139	-2.8%	-22.1%
5 - 9	$ 722,944	$ 83	$ 408,937	$ 47	$ 1,131,881	$ 130	$ 1,460,746	$ 129	$ 426,311	$ 38	$ 1,887,057	$ 166	66.7%	28.1%
10 - 14	$ 1,122,395	$ 119	$ 254,200	$ 27	$ 1,376,595	$ 146	$ 1,793,459	$ 146	$ 338,219	$ 28	$ 2,131,678	$ 174	54.9%	19.1%
15 - 19	$ 1,829,743	$ 169	$ 384,266	$ 36	$ 2,214,009	$ 205	$ 2,278,243	$ 158	$ 593,537	$ 41	$ 2,871,780	$ 200	29.7%	-2.6%
20 - 24	$ 1,888,855	$ 184	$ 569,764	$ 56	$ 2,458,619	$ 240	$ 3,118,432	$ 230	$ 847,449	$ 63	$ 3,965,881	$ 293	61.3%	22.1%
25 - 29	$ 1,739,117	$ 214	$ 830,260	$ 102	$ 2,569,377	$ 316	$ 3,025,067	$ 265	$ 1,366,486	$ 120	$ 4,391,553	$ 385	70.9%	21.9%
30 - 34	$ 2,973,992	$ 304	$ 786,743	$ 80	$ 3,760,735	$ 385	$ 3,760,089	$ 281	$ 2,635,813	$ 197	$ 6,395,902	$ 479	70.1%	24.4%
35 - 39	$ 3,032,290	$ 272	$ 1,056,147	$ 95	$ 4,088,437	$ 367	$ 4,709,587	$ 322	$ 1,950,402	$ 134	$ 6,659,989	$ 456	62.9%	24.3%
40 - 44	$ 3,483,133	$ 324	$ 1,560,761	$ 145	$ 5,043,894	$ 469	$ 4,906,438	$ 335	$ 2,390,429	$ 163	$ 7,296,867	$ 498	44.7%	6.3%
45 - 49	$ 3,701,372	$ 386	$ 1,613,085	$ 168	$ 5,314,457	$ 554	$ 4,045,687	$ 320	$ 2,602,582	$ 206	$ 6,648,269	$ 526	25.1%	-5.0%
50 - 54	$ 4,438,374	$ 427	$ 2,139,231	$ 206	$ 6,577,605	$ 632	$ 6,087,595	$ 428	$ 3,750,769	$ 264	$ 9,838,364	$ 692	49.6%	9.5%
55 - 59	$ 4,890,498	$ 524	$ 1,967,460	$ 211	$ 6,857,958	$ 735	$ 7,160,443	$ 568	$ 3,449,739	$ 274	$ 10,610,182	$ 841	54.7%	14.5%
60 - 64	$ 6,626,446	$ 801	$ 2,764,763	$ 334	$ 9,391,209	$ 1,135	$ 7,528,723	$ 691	$ 3,790,938	$ 348	$ 11,319,661	$ 1,039	20.5%	-8.5%
65+	$ 1,529,135	$ 487	$ 775,753	$ 247	$ 2,304,888	$ 734	$ 3,498,544	$ 805	$ 1,444,090	$ 332	$ 4,942,634	$ 1,137	114.4%	54.9%
Total	**$ 40,641,821**	**$ 319**	**$ 15,186,469**	**$ 119**	**$ 55,828,290**	**$ 439**	**$ 59,634,480**	**$ 351**	**$ 25,638,464**	**$ 151**	**$ 85,272,944**	**$ 502**	**52.7%**	**14.5%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	4,175	7,226	9,790	35.5%	3,780	6,561	8,946	36.3%	1	1	1	22.0%
Spouses	1,146	1,836	2,407	31.1%	1,020	1,626	2,139	31.6%	1	1	1	22.0%
Children	3,172	5,088	6,688	31.4%	3,030	4,841	6,378	31.8%	0	0	0	0.0%
Total Members	8,493	14,150	18,884	33.5%	7,830	13,028	17,463	34.0%	2	2	2	22.0%
Family Size	2.0	2.0	1.9	-3.5%	2.1	2.0	2.0	-2.5%	2.0	2.0	2.0	0.0%
Financial Summary												
Gross Cost	$29,751,991	$47,147,759	$69,176,993	46.7%	$25,837,154	$40,990,958	$60,632,684	47.9%	$31,539	$12,127	$25,046	106.5%
Client Paid	$25,158,456	$40,641,821	$59,634,480	46.7%	$21,781,871	$35,216,533	$52,089,402	47.9%	$26,601	$9,284	$20,541	121.3%
Employee Paid	$4,593,536	$6,505,938	$9,542,513	46.7%	$4,055,283	$5,774,424	$8,543,282	48.0%	$4,938	$2,842	$4,505	58.5%
Client Paid-PEPY	$8,034	$7,500	$8,122	8.3%	$7,683	$7,156	$7,764	8.5%	$35,468	$12,379	$22,408	81.0%
Client Paid-PMPY	$3,949	$3,830	$4,211	9.9%	$3,709	$3,604	$3,977	10.3%	$17,734	$6,190	$11,204	81.0%
Client Paid-PEPM	$669	$625	$677	8.3%	$640	$596	$647	8.6%	$2,956	$1,032	$1,867	80.9%
Client Paid-PMPM	$329	$319	$351	10.0%	$309	$300	$331	10.3%	$1,478	$516	$934	81.0%
High Cost Claimants (HCC's) > $100k												
# of HCC's	33	43	55	27.9%	27	34	42	23.5%	0	0	0	0.0%
HCC's / 1,000	3.9	3.0	2.9	-4.3%	3.5	2.6	2.4	-7.7%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$263,630	$218,375	$237,773	8.9%	$273,797	$225,632	$246,902	9.4%	$0	$0	$0	0.0%
HCC's % of Plan Paid	34.6%	23.1%	21.9%	-5.2%	33.9%	21.8%	19.9%	-8.7%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,330	$822	$745	-9.4%	$1,299	$769	$708	-7.9%	$566	$0	$0	0.0%
Facility Outpatient	$1,023	$1,366	$1,666	22.0%	$915	$1,252	$1,534	22.5%	$6,869	$584	$560	-4.1%
Physician	$1,545	$1,642	$1,800	9.6%	$1,447	$1,582	$1,736	9.7%	$10,299	$5,606	$10,644	89.9%
Other	$52	$0	$0	0.0%	$49	$0	$0	0.0%	$0	$0	$0	0.0%
Total	$3,949	$3,830	$4,211	9.9%	$3,709	$3,604	$3,977	10.3%	$17,734	$6,190	$11,204	81.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	374	637	814	27.8%	21	27	29	9.3%	
Spouses	114	197	254	28.8%	11	12	13	1.9%	
Children	142	246	308	25.0%	0	0	1	0.0%	
Total Members	630	1,080	1,376	27.4%	32	39	43	10.0%	
Family Size	1.7	1.7	1.7	-0.6%	1.5	1.5	1.5	-2.7%	1.6
Financial Summary									
Gross Cost	$3,641,943	$5,851,517	$8,243,113	40.9%	$241,355	$293,157	$276,149	-5.8%	
Client Paid	$3,152,224	$5,156,304	$7,309,799	41.8%	$197,759	$259,699	$214,737	-17.3%	
Employee Paid	$489,719	$695,213	$933,314	34.2%	$43,596	$33,458	$61,412	83.5%	
Client Paid-PEPY	$11,248	$10,800	$11,975	10.9%	$12,490	$12,985	$9,761	-24.8%	$6,258
Client Paid-PMPY	$6,669	$6,364	$7,083	11.3%	$8,211	$8,879	$6,676	-24.8%	$3,830
Client Paid-PEPM	$937	$900	$998	10.9%	$1,041	$1,082	$813	-24.9%	$521
Client Paid-PMPM	$556	$530	$590	11.3%	$684	$740	$556	-24.9%	$319
High Cost Claimants (HCC's) > $100k									
# of HCC's	6	9	13	0.0%	1	1	1	0.0%	
HCC's / 1,000	9.5	8.3	9.5	0.0%	31.1	25.6	23.3	0.0%	
Avg HCC Paid	$199,468	$179,387	$199,858	0.0%	$110,440	$104,131	$109,461	0.0%	
HCC's % of Plan Paid	38.0%	31.3%	35.5%	0.0%	55.8%	40.1%	51.0%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,743	$1,435	$1,137	-20.8%	$901	$1,517	$3,292	0.0%	$1,044
Facility Outpatient	$2,188	$2,600	$3,346	28.7%	$4,088	$5,214	$1,834	-64.8%	$1,310
Physician	$2,649	$2,330	$2,599	11.5%	$3,174	$2,148	$1,550	-27.8%	$1,404
Other	$89	$0	$0	0.0%	$48	$0	$0	0.0%	$72
Total	$6,669	$6,364	$7,083	11.3%	$8,211	$8,879	$6,676	-24.8%	$3,830
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

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

	Total				State Active				Non-State Active			
Summary	**PY22**	**PY23**	**3Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**3Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**3Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	4,336	7,362	9,790	33.0%	3,926	6,690	8,946	33.7%	1	1	1	22.0%
Spouses	1,172	5,149	2,407	-53.3%	1,042	4,901	2,139	-56.4%	1	0	1	0.0%
Children	3,255	1,857	6,688	260.2%	3,103	1,645	6,378	287.8%	0	1	0	-100.0%
Total Members	8,762	14,368	18,884	31.4%	8,071	13,235	17,463	31.9%	2	2	2	22.0%
Family Size	2.0	2.0	1.9	-1.0%	2.1	2.0	2.0	-1.5%	2.0	2.0	2.0	0.0%
Financial Summary												
Gross Cost	$40,570,436	$64,817,531	$69,176,993	6.7%	$35,366,785	$56,350,280	$60,632,684	7.6%	$38,494	$17,911	$25,046	39.8%
Client Paid	$34,446,692	$55,997,776	$59,634,480	6.5%	$29,933,591	$48,495,839	$52,089,402	7.4%	$33,556	$13,953	$20,541	47.2%
Employee Paid	$6,123,744	$8,819,755	$9,542,513	8.2%	$5,433,194	$7,854,441	$8,543,282	8.8%	$4,938	$3,958	$4,505	13.8%
Client Paid-PEPY	$7,944	$7,606	$8,122	6.8%	$7,624	$7,249	$7,764	7.1%	$33,556	$13,953	$22,408	60.6%
Client Paid-PMPY	$3,931	$3,897	$4,211	8.1%	$3,709	$3,664	$3,977	8.5%	$16,778	$6,976	$11,204	60.6%
Client Paid-PEPM	$662	$634	$677	6.8%	$635	$604	$647	7.1%	$2,796	$1,163	$1,867	60.5%
Client Paid-PMPM	$328	$325	$351	8.0%	$309	$305	$331	8.5%	$1,398	$581	$934	60.8%
High Cost Claimants (HCC's) > $100k												
# of HCC's	41	54	55	1.9%	33	43	42	-2.3%	0	0	0	0.0%
HCC's / 1,000	4.7	3.8	2.9	-22.6%	4.1	3.3	2.4	-25.8%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$286,071	$238,672	$237,773	-0.4%	$305,172	$238,047	$246,902	3.7%	$0	$0	$0	0.0%
HCC's % of Plan Paid	34.0%	23.0%	21.9%	-4.8%	33.6%	21.1%	19.9%	-5.7%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,269	$783	$745	-4.9%	$1,257	$725	$708	-2.3%	$424	$0	$0	0.0%
Facility Outpatient	$1,043	$1,412	$1,666	18.0%	$933	$1,292	$1,534	18.7%	$5,152	$1,007	$560	-44.4%
Physician	$1,567	$1,702	$1,800	5.8%	$1,468	$1,647	$1,736	5.4%	$9,883	$5,969	$10,644	78.3%
Other	$53	$0	$0	0.0%	$50	$0	$0	0.0%	$1,319	$0	$0	0.0%
Total	$3,931	$3,897	$4,211	8.1%	$3,709	$3,664	$3,977	8.5%	$16,778	$6,976	$11,204	60.6%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY22**	**PY23**	**3Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**3Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	388	644	814	26.3%	21	27	29	10.0%	
Spouses	118	248	254	2.3%	11	0	13	7439.0%	
Children	152	199	308	55.2%	0	13	1	-92.0%	
Total Members	657	1,091	1,376	26.1%	32	39	43	9.1%	
Family Size	1.7	1.7	1.7	0.0%	1.5	1.5	1.5	-1.4%	1.6
Financial Summary									
Gross Cost	$4,886,927	$8,012,597	$8,243,113	2.9%	$278,229	$436,743	$276,149	-36.8%	
Client Paid	$4,252,910	$7,107,682	$7,309,799	2.8%	$226,635	$380,303	$214,737	-43.5%	
Employee Paid	$634,017	$904,915	$933,314	3.1%	$51,594	$56,440	$61,412	8.8%	
Client Paid-PEPY	$10,968	$11,032	$11,975	8.5%	$10,665	$14,261	$9,761	-31.6%	$6,258
Client Paid-PMPY	$6,473	$6,514	$7,083	8.7%	$7,027	$9,669	$6,676	-31.0%	$3,830
Client Paid-PEPM	$914	$919	$998	8.6%	$889	$1,188	$813	-31.6%	$521
Client Paid-PMPM	$539	$543	$590	8.7%	$586	$806	$556	-31.0%	$319
High Cost Claimants (HCC's) > $100k									
# of HCC's	8	11	13	18.2%	1	1	1	0.0%	
HCC's / 1,000	12.2	10.1	9.5	-6.3%	31.0	25.4	23.3	-8.3%	
Avg HCC Paid	$193,399	$224,298	$199,858	-10.9%	$111,053	$185,019	$109,461	-40.8%	
HCC's % of Plan Paid	36.4%	34.7%	35.5%	2.3%	49.0%	48.7%	51.0%	4.7%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,452	$1,476	$1,137	-23.0%	$675	$1,128	$3,292	191.8%	$1,044
Facility Outpatient	$2,262	$2,697	$3,346	24.1%	$3,333	$6,277	$1,834	-70.8%	$1,310
Physician	$2,676	$2,342	$2,599	11.0%	$2,969	$2,264	$1,550	-31.5%	$1,404
Other	$83	$0	$0	0.0%	$50	$0	$0	0.0%	$72
Total	$6,473	$6,514	$7,083	8.7%	$7,027	$9,669	$6,676	-31.0%	$3,830
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 8,889,971	$ 1,283,201	$ 10,531	$ 10,183,702	$ 11,138,342	$ 1,276,158	$ 12,066	$ 12,426,565	22.0%
Outpatient	$ 26,326,563	$ 3,708,372	$ 154,199	$ 30,189,135	$ 40,951,061	$ 5,751,932	$ 269,644	$ 46,972,636	55.6%
Total - Medical	**$ 35,216,533**	**$ 4,991,574**	**$ 164,730**	**$ 40,372,837**	**$ 52,089,402**	**$ 7,028,090**	**$ 281,709**	**$ 59,399,202**	**47.1%**

Net Paid Claims - Per Participant per Month	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 596	$ 932	$ 443	$ 623	$ 647	$ 1,036	$ 523	$ 676	8.5%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 47,476	$ 564	$ 48,040			$ 106,760	$ 106,760	0.0%
Outpatient	$ 9,284	$ 88,780	$ 122,879	$ 220,943	$ 20,541	$ 13,963	$ 94,014	$ 128,518	-41.8%
Total - Medical	**$ 9,284**	**$ 136,256**	**$ 123,444**	**$ 268,984**	**$ 20,541**	**$ 13,963**	**$ 200,774**	**$ 235,278**	**-12.5%**

Net Paid Claims - Per Participant per Month	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 1,032	$ 1,117	$ 1,046	$ 1,080	$ 1,871	$ 157	$ 1,148	$ 856	-20.8%

Paid Claims by Claim Type – Total Participants

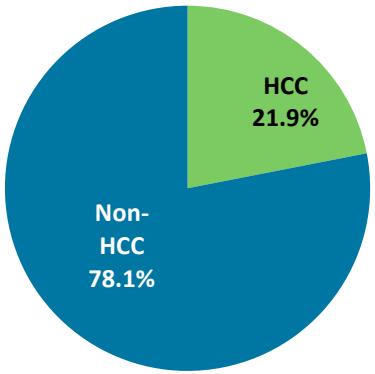
Net Paid Claims - Total Total Participants	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 8,889,971	$ 1,330,677	$ 11,095	$ 10,231,743	$ 11,138,342	$ 1,276,158	$ 118,826	$ 12,533,325	22.5%
Outpatient	$ 26,335,847	$ 3,797,152	$ 277,079	$ 30,410,078	$ 40,971,602	$ 5,765,895	$ 363,658	$ 47,101,154	54.9%
Total - Medical	**$ 35,225,818**	**$ 5,127,829**	**$ 288,174**	**$ 40,641,821**	**$ 52,109,944**	**$ 7,042,053**	**$ 482,484**	**$ 59,634,480**	**46.7%**

Net Paid Claims - Per Participant per Month	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 596	$ 936	$ 588	$ 625	$ 647	$ 1,024	$ 676	$ 677	8.3%

Cost Distribution – Medical Claims

3Q23							3Q24					
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
39	0.3%	$9,291,746	22.9%	$164,028	2.5%	$100,000.01 Plus	48	0.3%	$13,077,515	21.9%	$254,161	2.7%
52	0.4%	$4,157,579	10.2%	$222,857	3.4%	$50,000.01-$100,000.00	78	0.4%	$6,095,461	10.2%	$326,641	3.4%
132	0.9%	$4,738,511	11.7%	$472,032	7.3%	$25,000.01-$50,000.00	232	1.2%	$8,218,126	13.8%	$829,241	8.7%
468	3.3%	$7,607,951	18.7%	$1,281,956	19.7%	$10,000.01-$25,000.00	655	3.5%	$10,529,096	17.7%	$1,756,368	18.4%
600	4.2%	$4,426,192	10.9%	$1,069,593	16.4%	$5,000.01-$10,000.00	942	5.0%	$6,957,836	11.7%	$1,566,752	16.4%
1,061	7.5%	$3,927,204	9.7%	$1,132,702	17.4%	$2,500.01-$5,000.00	1,647	8.7%	$6,062,154	10.2%	$1,750,465	18.3%
9,004	63.6%	$6,492,638	16.0%	$2,157,654	33.2%	$0.01-$2,500.00	11,633	61.6%	$8,694,292	14.6%	$3,038,434	31.8%
103	0.7%	$0	0.0%	$5,115	0.1%	$0.00	190	1.0%	$0	0.0%	$20,451	0.2%
2,690	19.0%	$0	0.0%	$0	0.0%	No Claims	3,458	18.3%	$0	0.0%	$0	0.0%
14,150	**100.0%**	**$40,641,821**	**100.0%**	**$65,005,938**	**100.0%**		**18,884**	**100.0%**	**$59,634,480**	**100.0%**	**$9,542,513**	**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	19	$3,585,306	27.4%
Neurological Disorders	24	$2,743,588	21.0%
Cardiac Disorders	28	$1,640,496	12.5%
Pregnancy-related Disorders	11	$1,348,086	10.3%
Endocrine/Metabolic Disorders	20	$572,943	4.4%
Pulmonary Disorders	30	$407,383	3.1%
Mental Health	14	$349,385	2.7%
Renal/Urologic Disorders	16	$342,525	2.6%
Spine-related Disorders	12	$264,366	2.0%
Medication Related Conditions	9	$261,407	2.0%
All Other		$1,562,031	11.9%
Overall	**----**	**$13,077,515**	**100.0%**

Utilization Summary (p. 1 of 2)

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

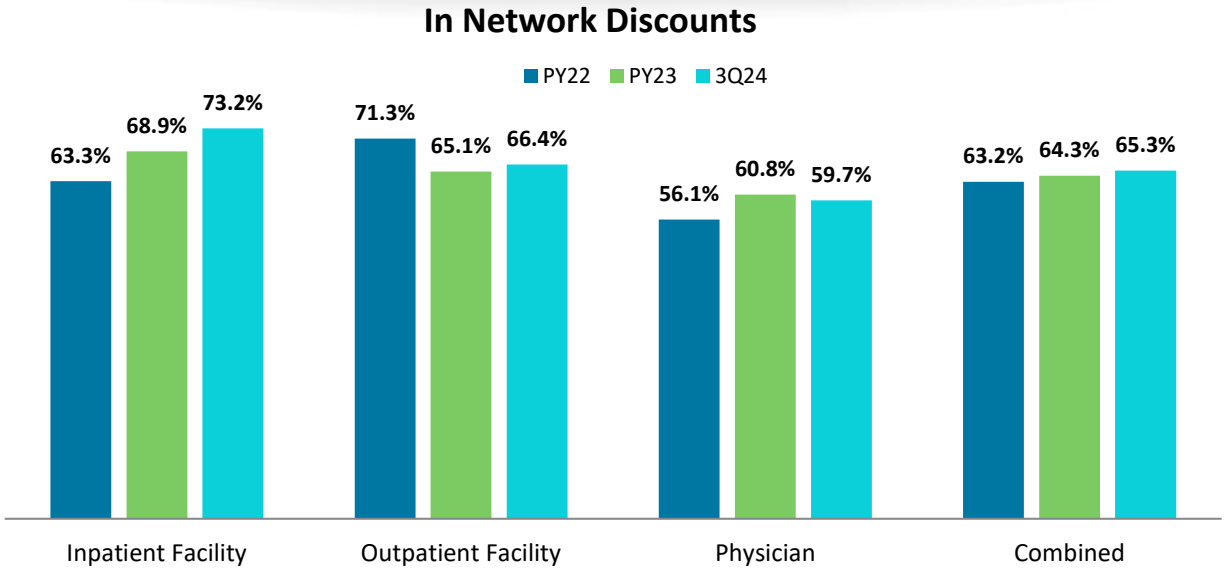
	Total				State Active				Non-State Active			
Summary	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**
Inpatient Facility												
# of Admits	239	411	531		206	370	486		1	0	0	
# of Bed Days	1,294	1,781	2,834		1,181	1,585	2,487		1	0	0	
Paid Per Admit	$44,229	$25,147	$24,045	-4.4%	$45,460	$24,333	$23,352	-4.0%	$2,303	$0	$0	0.0%
Paid Per Day	$8,169	$5,803	$4,505	-22.4%	$7,930	$5,680	$4,563	-19.7%	$2,303	$0	$0	0.0%
Admits Per 1,000	38	39	37	-5.1%	35	38	37	-2.6%	667	0	0	0.0%
Days Per 1,000	203	168	200	19.0%	201	162	190	17.3%	667	0	0	0.0%
Avg LOS	5.4	4.3	5.3	23.3%	5.7	4.3	5.1	18.6%	1	0	0	0.0%
# Admits From ER	120	205	282	37.6%	99	179	254	41.9%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	4.6	4.9	5.5	12.2%	4.5	4.8	5.4	12.5%	14.7	12.7	9.3	-26.8%
Avg Paid per OV	$126	$116	$120	3.4%	$120	$116	$119	2.6%	$299	$295	$560	89.8%
Avg OV Paid per Member	$586	$571	$657	15.1%	$539	$553	$640	15.7%	$4,385	$3,740	$5,197	39.0%
DX&L Utilization per Member	8.1	10.1	10.5	4.0%	7.7	9.7	10.2	5.2%	29.3	25.3	22.4	-11.5%
Avg Paid per DX&L	$51	$58	$65	12.1%	$48	$57	$62	8.8%	$97	$57	$155	171.9%
Avg DX&L Paid per Member	$408	$589	$684	16.1%	$368	$552	$633	14.7%	$2,845	$1,452	$3,463	138.5%
Emergency Room												
# of Visits	850	1,536	2,284		788	1,406	2,109		1	0	0	
Visits Per Member	0.13	0.14	0.16	14.3%	0.13	0.14	0.16	14.3%	0.67	0	0	0.0%
Visits Per 1,000	133	145	161	11.0%	134	144	161	11.8%	667	0	0	0.0%
Avg Paid per Visit	$2,490	$3,164	$3,216	1.6%	$2,466	$3,192	$3,197	0.2%	$4,222	$0	$0	0.0%
Urgent Care												
# of Visits	1,972	3,925	5,309		1,847	3,719	5,006		0	2	2	
Visits Per Member	0.31	0.37	0.37	0.0%	0.31	0.38	0.38	0.0%	0.00	1.33	1.09	0.0%
Visits Per 1,000	310	370	375	1.4%	315	381	382	0.3%	0	1,333	1,091	0.0%
Avg Paid per Visit	$118	$99	$107	8.1%	$117	$98	$107	9.2%	$0	$154	$170	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

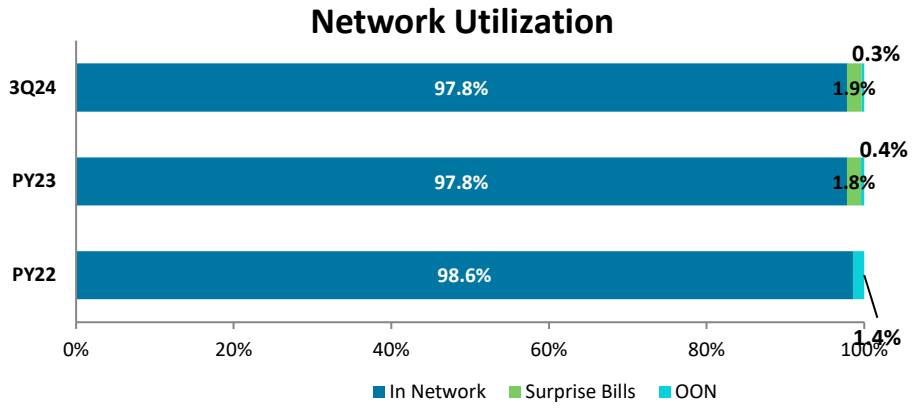
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**Peer Index**
Inpatient Facility									
# of Admits	25	40	43		7	1	2		
# of Bed Days	91	193	332		21	3	15		
Paid Per Admit	$41,443	$32,111	$31,212	-2.8%	$23,928	$47,476	$38,294	0.0%	$19,305
Paid Per Day	$11,385	$6,655	$4,043	-39.2%	$7,976	$15,825	$5,106	0.0%	$3,615
Admits Per 1,000	53	49	42	-14.3%	291	34	62	0.0%	64
Days Per 1,000	193	238	322	35.3%	872	103	466	0.0%	342
Avg LOS	3.6	4.8	7.7	60.4%	3.0	3.0	7.5	0.0%	5.3
# Admits From ER	17	26	27		4	0	1	0.0%	
Physician Office									
OV Utilization per Member	6.2	6.5	6.7	3.1%	6.9	7.8	8.5	9.0%	5.2
Avg Paid per OV	$185	$120	$131	9.2%	$100	$87	$79	-9.2%	$97
Avg OV Paid per Member	$1,153	$775	$875	12.9%	$694	$683	$669	-2.0%	$502
DX&L Utilization per Member	12.5	15.1	14.4	-4.6%	13	17.6	20.1	14.2%	9.0
Avg Paid per DX&L	$69	$67	$92	37.3%	$85	$68	$43	-36.8%	$46
Avg DX&L Paid per Member	$857	$1,012	$1,323	30.7%	$1,103	$1,197	$857	-28.4%	$412
Emergency Room									
# of Visits	60	126	166		1	4	9		
Visits Per Member	0.13	0.16	0.16	0.0%	0.04	0.14	0.28	100.0%	0.23
Visits Per 1,000	127	156	161	3.2%	42	137	280	104.4%	228
Avg Paid per Visit	$2,785	$2,921	$3,331	14.0%	$1,827	$1,034	$5,431	425.2%	$1,035
Urgent Care									
# of Visits	123	200	297		2	4	4		
Visits Per Member	0.26	0.25	0.29	16.0%	0.08	0.14	0.12	-14.3%	0.38
Visits Per 1,000	260	247	288	16.6%	83	137	124	-9.5%	379
Avg Paid per Visit	$139	$102	$103	1.0%	$70	$69	$51	-26.1%	$132
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





Inc Jul23-Mar24, Pd through May24

Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$5,371,620	9.0%	$3,288,108	$2,076,353	$7,159	$2,341,921	$3,029,699
Gastrointestinal Disorders	$5,011,415	8.4%	$3,263,979	$951,819	$795,617	$1,916,267	$3,095,148
Neurological Disorders	$4,909,825	8.2%	$1,786,204	$468,381	$2,655,240	$3,038,668	$1,871,158
Health Status/Encounters	$4,788,271	8.0%	$2,665,080	$729,989	$1,393,202	$1,530,237	$3,258,034
Cardiac Disorders	$4,649,983	7.8%	$3,037,761	$912,908	$699,313	$1,454,766	$3,195,217
Pregnancy-related Disorders	$4,615,365	7.7%	$1,703,749	$901,832	$2,009,784	$1,085,394	$3,529,971
Mental Health	$4,300,530	7.2%	$2,003,577	$368,887	$1,928,066	$1,398,802	$2,901,728
Musculoskeletal Disorders	$3,341,400	5.6%	$2,243,411	$660,562	$437,428	$1,314,035	$2,027,365
Trauma/Accidents	$2,868,062	4.8%	$1,429,753	$354,207	$1,084,102	$1,462,470	$1,405,591
Eye/ENT Disorders	$2,852,307	4.8%	$1,538,256	$406,859	$907,192	$1,294,872	$1,557,435
Gynecological/Breast Disorders	$2,167,054	3.6%	$1,412,009	$492,081	$262,964	$66,790	$2,100,265
Spine-related Disorders	$2,126,133	3.6%	$1,530,608	$475,171	$120,354	$866,788	$1,259,345
Pulmonary Disorders	$2,059,856	3.5%	$1,010,857	$358,351	$690,648	$1,079,065	$980,791
Endocrine/Metabolic Disorders	$1,986,542	3.3%	$1,672,779	$204,401	$109,361	$472,569	$1,513,973
Renal/Urologic Disorders	$1,816,666	3.0%	$1,240,414	$308,367	$267,886	$1,003,032	$813,635
Infections	$1,116,420	1.9%	$666,584	$178,310	$271,526	$477,818	$638,601
Non-malignant Neoplasm	$881,732	1.5%	$659,218	$127,750	$94,765	$173,047	$708,686
Dermatological Disorders	$667,654	1.1%	$376,874	$144,235	$146,546	$280,012	$387,642
Miscellaneous	$641,501	1.1%	$369,741	$121,393	$150,367	$272,557	$368,944
Medical/Surgical Complications	$593,490	1.0%	$326,472	$93,069	$173,949	$364,746	$228,744
Diabetes	$533,201	0.9%	$356,781	$89,745	$86,675	$236,884	$296,317
Abnormal Lab/Radiology	$485,945	0.8%	$370,764	$85,352	$29,830	$175,871	$310,075
Vascular Disorders	$480,082	0.8%	$435,025	$34,381	$10,676	$211,238	$268,844
Congenital/Chromosomal Anomalies	$399,081	0.7%	$115,006	$50,303	$233,772	$180,052	$219,029
Medication Related Conditions	$396,216	0.7%	$66,390	$268,000	$61,826	$33,485	$362,731
Hematological Disorders	$252,990	0.4%	$221,080	$17,710	$14,200	$56,496	$196,494
Cholesterol Disorders	$152,988	0.3%	$119,827	$29,047	$4,114	$68,245	$84,743
Allergic Reaction	$73,028	0.1%	$29,372	$5,561	$38,095	$15,646	$57,381
Dental Conditions	$70,953	0.1%	$45,765	$8,481	$16,707	$8,152	$62,801
External Hazard Exposure	$22,781	0.0%	$14,518	$196	$8,068	$16,843	$5,938
Cause of Morbidity	$773	0.0%	$0	$109	$664	$109	$664
Social Determinants of Health	$616	0.0%	$0	$139	$477	$133	$483
Total	**$59,634,480**	**100.0%**	**$33,999,962**	**$10,923,947**	**$14,710,571**	**$22,897,007**	**$36,737,473**

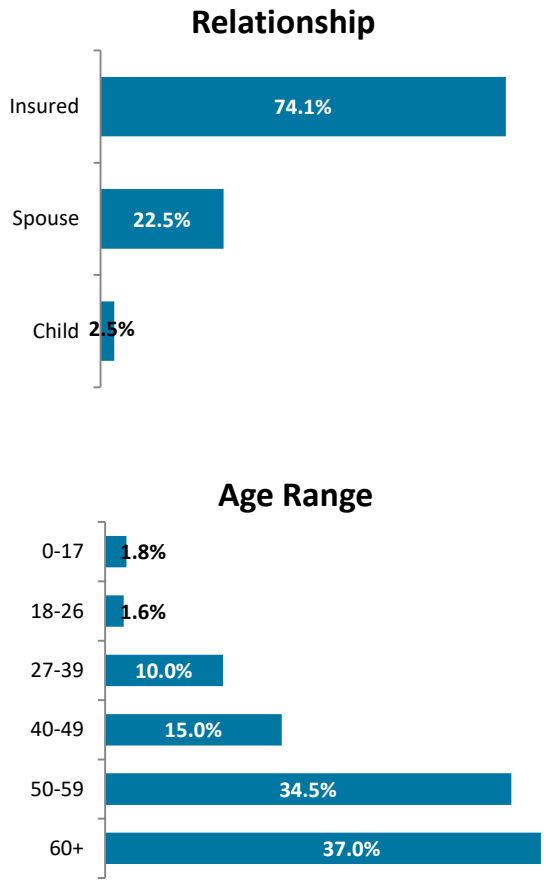
Mental Health Drilldown

	PY22		PY23		3Q24	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	453	$568,975	883	$898,381	1,112	$1,301,323
Mood and Anxiety Disorders	613	$271,735	1,144	$681,784	1,447	$688,313
Mental Health Conditions, Other	431	$351,519	805	$558,645	1,045	$637,171
Developmental Disorders	59	$215,640	108	$250,524	138	$490,124
Alcohol Abuse/Dependence	20	$75,926	77	$344,280	71	$306,826
Bipolar Disorder	107	$247,201	189	$253,234	241	$214,351
Attention Deficit Disorder	199	$80,894	414	$132,119	575	$157,386
Eating Disorders	24	$147,776	44	$141,298	47	$150,971
Sexually Related Disorders	28	$8,553	55	$30,340	68	$149,659
Schizophrenia	4	$2,259	12	$47,488	12	$75,705
Substance Abuse/Dependence	29	$68,285	51	$34,292	50	$43,603
Sleep Disorders	124	$26,517	242	$63,421	257	$40,033
Psychoses	6	$10,965	17	$18,602	10	$14,084
Complications of Substance Abuse	6	$27,466	13	$3,466	14	$14,021
Personality Disorders	14	$15,495	17	$12,003	23	$12,299
Tobacco Use Disorder	16	$4,458	54	$3,385	85	$4,661
Total		**$2,123,665**		**$3,473,262**		**$4,300,530**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	33	171	$2,052,005	3.4%
Breast Cancer	94	905	$862,456	1.4%
Colon Cancer	16	326	$526,115	0.9%
Cancers, Other	61	411	$388,085	0.7%
Prostate Cancer	44	294	$289,055	0.5%
Pancreatic Cancer	3	73	$261,986	0.4%
Secondary Cancers	26	190	$189,381	0.3%
Lymphomas	27	269	$165,082	0.3%
Non-Melanoma Skin Cancers	98	220	$141,197	0.2%
Kidney Cancer	9	43	$95,417	0.2%
Lung Cancer	6	178	$81,918	0.1%
Carcinoma in Situ	38	135	$73,659	0.1%
Thyroid Cancer	34	189	$66,180	0.1%
Leukemias	10	95	$64,759	0.1%
Cervical/Uterine Cancer	13	71	$54,980	0.1%
Melanoma	17	67	$23,444	0.0%
Brain Cancer	6	95	$23,071	0.0%
Myeloma	4	16	$5,162	0.0%
Ovarian Cancer	4	14	$5,057	0.0%
Bladder Cancer	2	5	$2,610	0.0%
Overall	**----**	**----**	**$5,371,620**	**100.0%**

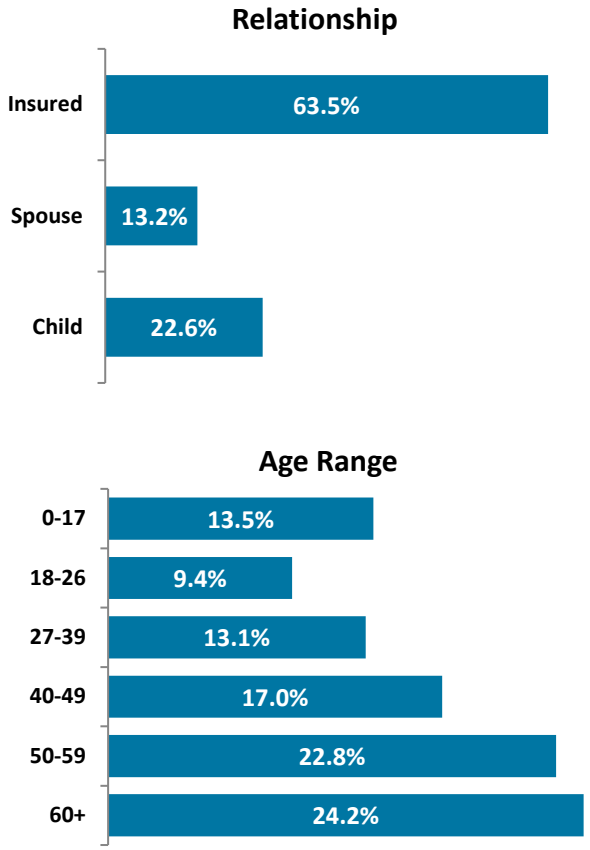
*Patient and claim counts are unique only within the category



Diagnosis Grouper – Gastrointestinal Orders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Abdominal Disorders	1,173	2,770	$955,277	1.6%
GI Disorders, Other	667	1,449	$763,775	1.3%
Gallbladder and Biliary Disease	135	599	$740,786	1.2%
Upper GI Disorders	600	1,345	$564,293	0.9%
GI Symptoms	796	1,568	$436,515	0.7%
Hernias	124	302	$332,995	0.6%
Appendicitis	22	150	$238,543	0.4%
Inflammatory Bowel Disease	74	368	$235,778	0.4%
Constipation	218	406	$139,339	0.2%
Diverticulitis	106	227	$109,049	0.2%
Pancreatic Disorders	33	153	$108,118	0.2%
Liver Diseases	226	426	$88,955	0.1%
Hepatic Cirrhosis	17	50	$81,379	0.1%
Hemorrhoids	151	263	$76,189	0.1%
Peptic Ulcer/Related Disorders	17	26	$70,756	0.1%
Ostomies	20	104	$41,388	0.1%
Esophageal Varices	4	17	$28,280	0.0%
	----	----	$5,011,415	8.2%

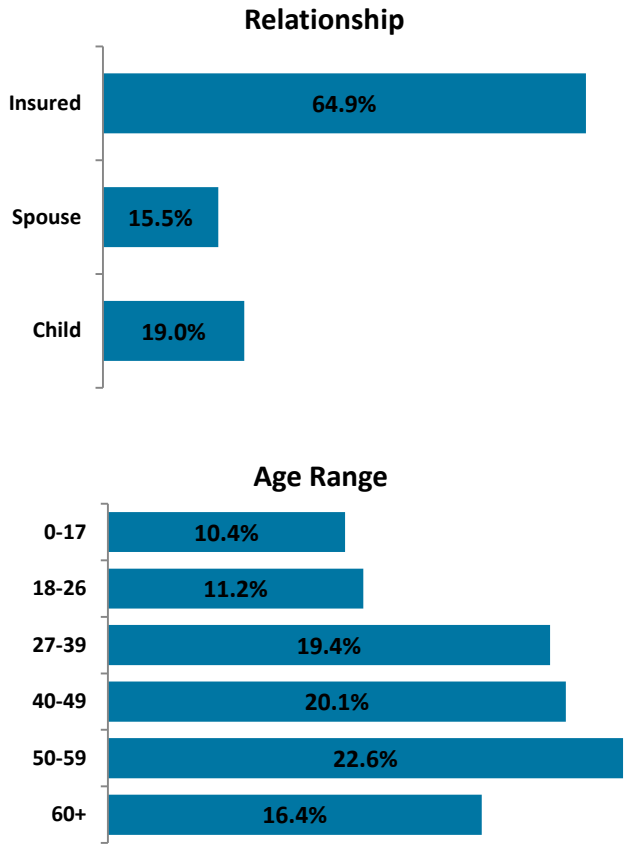
*Patient and claim counts are unique only within the category



Diagnosis Grouper – Neurological Disorders

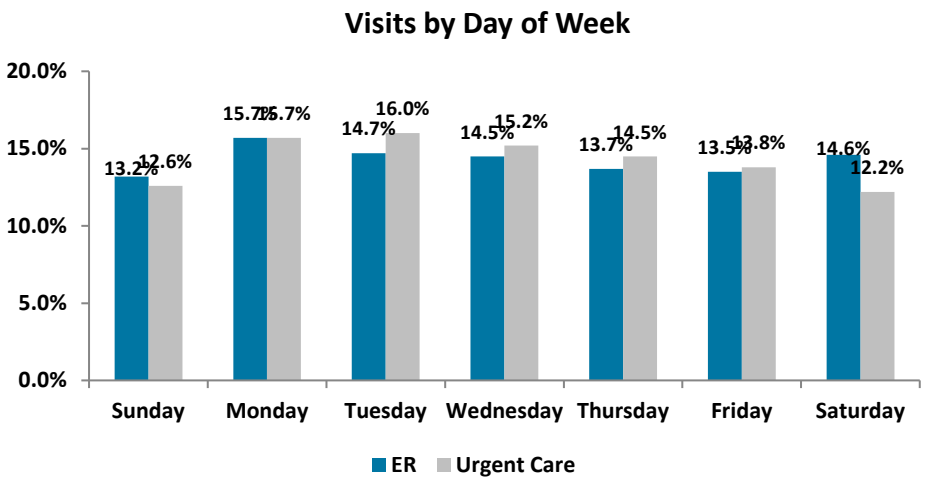
Diagnosis Category	Patients	Claims	Total Paid	% Paid
Spinal/Cerebellar Conditions	69	237	$2,392,653	4.0%
Multiple Sclerosis	52	209	$614,384	1.0%
Migraines	376	958	$354,799	0.6%
Coma and Altered Consciousness	346	800	$292,361	0.5%
Headaches	380	715	$242,052	0.4%
Seizure Disorders	106	377	$235,676	0.4%
Stroke	75	220	$150,302	0.3%
Pain Disorders	342	602	$124,576	0.2%
Carpal Tunnel Syndrome	77	183	$80,949	0.1%
Central Nervous System Conditions, Other	108	222	$79,654	0.1%
Neurological Disorders, Other	198	650	$77,782	0.1%
Cerebral Hemorrhage	11	58	$65,738	0.1%
Cerebrovascular Disorders	30	59	$59,799	0.1%
Neuropathies	128	303	$45,563	0.1%
Effects of Cerebrovascular Accident	10	15	$26,884	0.0%
Paralytic Syndromes	14	39	$16,457	0.0%
Parkinson's Disease	12	46	$13,103	0.0%
Dementias	20	50	$11,665	0.0%
Non-infectious Encephalomyelitis	14	39	$8,393	0.0%
Cerebral Palsy	11	30	$7,601	0.0%
Nerve Root and Plexus Disorders	11	43	$5,178	0.0%
Alzheimers Disease	4	10	$3,618	0.0%
Myasthenia Gravis	3	8	$640	0.0%
	----	----	$4,909,825	100.0%

*Patient and claim counts are unique only within the category

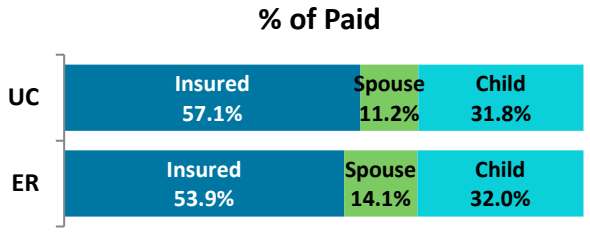


Emergency Room / Urgent Care Summary

	3Q23		3Q24		Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	1,536	3,925	2,284	5,309		
Visits Per Member	0.14	0.37	0.16	0.37	0.23	0.38
Visits/1000 Members	145	370	159	370	228	379
Avg Paid Per Visit	$3,164	$99	$3,216	$107	$1,085	$132
% with OV*	80.6%	75.2%	82.4%	80.1%		
% Avoidable	14.8%	43.2%	16.4%	40.1%		
Total Member Paid	**$1,045,041**	**$286,090**	**$1,574,322**	**$409,012**		
Total Plan Paid	**$4,860,123**	**$386,704**	**$7,344,922**	**$566,853**		
*looks back 12 months	Annualized	Annualized	Annualized	Annualized		



ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	1,231	126	3,034	310	4,265	436
Spouse	321	133	597	248	918	381
Child	732	109	1,678	251	2,410	360
Total	**2,284**	**121**	**5,309**	**281**	**7,593**	**402**

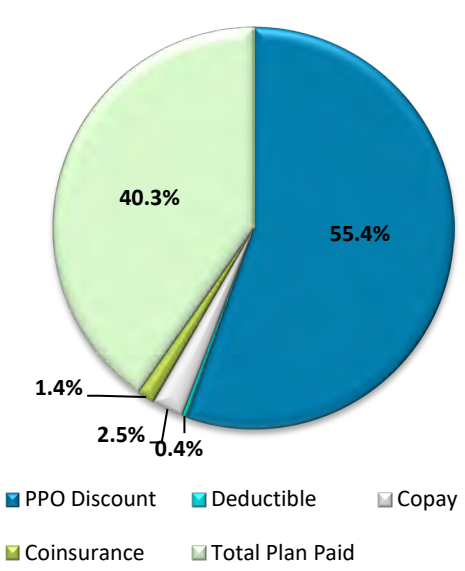


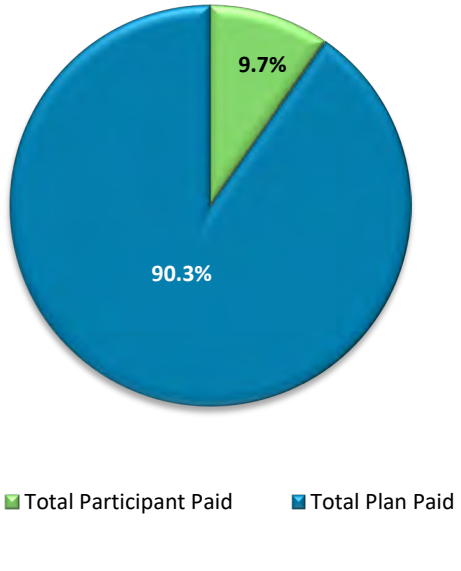
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$201,672,436	$7,206	100.0%
PPO Discount	$130,519,485	$4,664	64.7%
Deductible	$428,450	$15	0.2%
Copay	$5,410,489	$193	2.7%
Coinsurance	$3,703,575	$132	1.8%
Total Participant Paid	**$9,542,513**	**$341**	**4.7%**
Total Plan Paid	**$59,634,480**	**$677**	**29.6%**

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	1,024	1,012	12	98.8%
	<2 asthma related ER Visits in the last 6 months	1,024	1	1,023	0.1%
	Asthma related admit in last 12 months	1,024	6	1,018	0.6%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	96	6	90	6.3%
	Members with COPD who had an annual spirometry test	96	14	82	14.6%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	4	0	4	0.0%
	No ER Visit for Heart Failure in last 90 days	84	3	81	3.6%
	Follow-up OV within 4 weeks of discharge from HF admission	4	1	3	25.0%
Diabetes	Annual office visit	1,132	1,086	46	95.9%
	Annual dilated eye exam	1,132	413	719	36.5%
	Annual foot exam	1,132	550	582	48.6%
	Annual HbA1c test done	1,132	967	165	85.4%
	Diabetes Annual lipid profile	1,132	884	248	78.1%
	Annual microalbumin urine screen	1,132	803	329	70.9%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	2,861	2,439	422	85.2%
Hypertension	Annual lipid profile	2,473	1,919	554	77.6%
	Annual serum creatinine test	2,196	1,880	316	85.6%
Wellness	Well Child Visit - 15 months	173	153	20	88.4%
	Routine office visit in last 6 months (All Ages)	19,797	13,259	6,538	67.0%
	Colorectal cancer screening ages 45-75 within the appropriate time period	6,278	2,936	3,342	46.8%
	Women age 25-65 with recommended cervical cancer/HPV screening	6,551	4,237	2,314	64.7%
	Males age greater than 49 with PSA test in last 24 months	2,033	1,036	997	51.0%
	Routine exam in last 24 months (All Ages)	19,797	16,637	3,160	84.0%
	Women age 40 to 75 with a screening mammogram last 24 months	4,601	2,842	1,759	61.8%

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

Chronic Conditions Prevalence

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

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

Chronic Condition	# With Condition	% of Members	Members per 1,000	Admits per 1,000	ER Visits per 1,000	PMPY
Affective Psychosis	232	1.17%	12.29	186.98	367.28	$14,215
Asthma	1,099	5.55%	58.20	117.30	385.62	$13,822
Atrial Fibrillation	149	0.75%	7.89	212.12	515.15	$28,054
Blood Disorders	1,141	5.76%	60.42	209.55	468.08	$24,115
CAD	326	1.65%	17.26	259.76	510.24	$28,999
COPD	93	0.47%	4.92	320.22	589.89	$34,587
Cancer	534	2.70%	28.28	89.18	281.47	$30,578
Chronic Pain	571	2.88%	30.24	116.11	488.75	$19,148
Congestive Heart Failure	82	0.41%	4.34	640.00	622.22	$68,153
Demyelinating Diseases	60	0.30%	3.18	101.05	429.47	$51,811
Depression	1,945	9.82%	103.00	115.54	331.01	$11,995
Diabetes	1,175	5.93%	62.22	86.81	320.43	$18,602
ESRD	17	0.09%	0.90	1,551.72	517.24	$86,856
Eating Disorders	122	0.62%	6.46	197.18	464.79	$17,182
HIV/AIDS	24	0.12%	1.27	61.22	122.45	$39,950
Hyperlipidemia	3,417	17.25%	180.94	56.40	224.75	$11,594
Hypertension	2,494	12.59%	132.07	84.95	277.55	$14,192
Immune Disorders	123	0.62%	6.51	205.85	629.67	$44,800
Inflammatory Bowel Disease	101	0.51%	5.35	180.90	497.49	$35,303
Liver Diseases	434	2.19%	22.98	170.98	446.64	$19,116
Morbid Obesity	744	3.76%	39.40	101.35	320.27	$14,631
Osteoarthritis	651	3.29%	34.47	76.37	277.72	$18,206
Peripheral Vascular Disease	80	0.40%	4.24	290.66	415.22	$29,187
Rheumatoid Arthritis	135	0.68%	7.15	121.88	354.57	$34,477

*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 - Through Quarter Ending March 31, 2024

Express Scripts

	1Q-3Q FY2024 LDPPO	1Q-3Q FY2023 LDPPO	Difference	% Change
Membership Summary			**Membership Summary**	
Member Count (Membership)	18,852	14,114	4,738	33.6%
Utilizing Member Count (Patients)	14,049	10,992	3,057	27.8%
Percent Utilizing (Utilization)	74.5%	77.9%	(0)	-4.3%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	205,430	150,839	54,591	36.2%
Claims per Elig Member per Month (Claims PMPM)	1.21	1.19	0.02	1.7%
Total Claims for Generic (Generic Rx)	175,530	126,915	48,615.00	38.3%
Total Claims for Brand (Brand Rx)	29,900	23,924	5,976.00	25.0%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	1,110	791	319.00	40.3%
Total Non-Specialty Claims	202,881	148,712	54,169.00	36.4%
Total Specialty Claims	2,549	2,127	422.00	19.8%
Generic % of Total Claims (GFR)	**85.4%**	**84.1%**	0.01	1.6%
Generic Effective Rate (GCR)	**99.4%**	**99.4%**	(0.00)	0.0%
Mail Order Claims	59,172	46,900	12,272.00	26.2%
Mail Penetration Rate*	33.0%	36.0%	(0.03)	-3.0%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$30,255,099	$18,130,993	$12,124,106.00	66.9%
Total Generic Gross Cost	$3,452,025	$2,397,534	$1,054,491.00	44.0%
Total Brand Gross Cost	$26,803,074	$15,733,460	$11,069,614.00	70.4%
Total MSB Gross Cost	$519,461	$385,529	$133,932.00	34.7%
Total Ingredient Cost	$29,361,766	$17,877,625	$11,484,141.00	64.2%
Total Dispensing Fee	$869,084	$227,143	$641,941.00	282.6%
Total Other (e.g. tax)	$24,249	$26,225	($1,976.00)	-7.5%
Avg Total Cost per Claim (Gross Cost/Rx)	**$147.28**	**$120.20**	$27.08	22.5%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$19.67	$18.89	$0.78	4.1%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$896.42	$657.64	$238.78	36.3%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$467.98	$487.39	($19.41)	-4.0%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$4,615,853**	**$2,944,180**	$1,671,673.00	56.8%
Total Copay	$4,615,853	$2,944,180	$1,671,673.00	56.8%
Total Deductible	$0	$0	$0.00	0.0%
Avg Copay per Claim (Copay/Rx)	$22.47	$19.52	$2.95	15.1%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$22.47**	**$19.52**	**$2.95**	**15.1%**
Avg Copay for Generic (Copay/Generic Rx)	$6.72	$6.30	$0.42	6.7%
Avg Copay for Brand (Copay/Brand Rx)	$114.90	$89.65	$25.25	28.2%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$36.36	$26.74	$9.62	36.0%
Net PMPM (Participant Cost PMPM)	**$27.21**	**$23.18**	$4.03	17.4%
Copay % of Total Prescription Cost (Member Cost Share %)	15.3%	16.2%	-1.0%	-6.0%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$25,639,246**	**$15,186,813**	**$10,452,433.00**	**68.8%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$13,460,060	$7,646,094	$5,813,966.00	76.0%
Total Specialty Drug Cost (Specialty Plan Cost)	$12,179,186	$7,540,719	$4,638,467.00	61.5%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$124.81**	**$100.68**	$24.13	24.0%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$12.94	$12.59	$0.35	2.8%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$781.52	$567.99	$213.53	37.6%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$431.62	$460.66	($29.04)	-6.3%
Net PMPM (Plan Cost PMPM)	**$151.11**	**$119.56**	**$31.56**	**26.4%**
PMPM without Specialty (Non-Specialty PMPM)	$79.33	$60.19	$19.14	31.8%
PMPM for Specialty Only (Specialty PMPM)	$71.78	$59.36	$12.42	20.9%
Rebates Received (Q1-Q3FY2023 actual)	$8,643,702	$5,203,910	$3,439,792.25	66.1%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$100.17**	**$78.59**	**$21.58**	**27.5%**
PMPM without Specialty (Non-Specialty PMPM)	$53.22	$34.20	$0.92	5.0%
PMPM for Specialty Only (Specialty PMPM)	$45.97	$43.75	$2.22	5.1%

Appendix C

Index of Tables
UMR Inc. – EPO Utilization Review for PEBP
January 1, 2024 – March 31, 2024

DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan
July 2023 – March 2024 Incurred,
Paid through May 2024

UMR℠

Overview

- Total Medical Spend for 3Q24 was $29,185,074 with an annualized plan cost per employee per year (PEPY) of $12,514. This is a decrease of 6.9% when compared to 3Q23.
  - IP Cost per Admit is $34,179 which is 5.3% lower than 3Q23.
  - ER Cost per Visit is $3,235 which is 9.0% higher than 3Q23.
- Employees shared in 9.7% of the medical cost.
- Inpatient facility costs were 25.0% of the plan spend.
- 73.2% of the Average Membership had paid Medical claims less than $2,500, with 11.9% having no claims paid at all during the reporting period.
- 46 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 32.3% of the plan spend. The highest diagnosis category was Cancer, accounting for 26.7% of the high-cost claimant dollars.
- Total spending with in-network providers was 96.6%. The average In Network discount was 56.8%, which is 3.5% higher than the PY23 average discount of 54.9%.

Paid Claims by Age Group

Paid Claims by Age Group																
	3Q23						3Q24						% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 2,379,872	$ 3,724	$ 13,867	$ 22	$ 2,393,739	$ 3,151	$ 704,268	$ 1,565	$ 3,909	$ 9	$ 708,177	$ 1,574	-70.4%	-50.1%
1	$ 227,152	$ 428	$ 622	$ 1	$ 227,774	$ 332	$ 192,521	$ 419	$ 2,276	$ 5	$ 194,797	$ 424	-14.5%	27.8%
2 - 4	$ 420,955	$ 227	$ 11,697	$ 6	$ 432,652	$ 228	$ 362,619	$ 220	$ 8,400	$ 5	$ 371,019	$ 225	-14.2%	-1.0%
5 - 9	$ 280,221	$ 88	$ 58,186	$ 18	$ 338,407	$ 105	$ 342,571	$ 120	$ 39,478	$ 14	$ 382,049	$ 133	12.9%	27.1%
10 - 14	$ 671,772	$ 159	$ 114,048	$ 27	$ 785,820	$ 157	$ 1,154,924	$ 302	$ 114,571	$ 30	$ 1,269,495	$ 332	61.6%	110.9%
15 - 19	$ 1,053,568	$ 207	$ 442,665	$ 87	$ 1,496,233	$ 250	$ 1,115,642	$ 255	$ 507,806	$ 116	$ 1,623,448	$ 370	8.5%	48.0%
20 - 24	$ 1,002,478	$ 212	$ 168,786	$ 36	$ 1,171,264	$ 253	$ 799,337	$ 185	$ 162,260	$ 38	$ 961,597	$ 223	-17.9%	-11.8%
25 - 29	$ 870,027	$ 439	$ 207,726	$ 105	$ 1,077,753	$ 386	$ 584,112	$ 365	$ 281,181	$ 176	$ 865,293	$ 540	-19.7%	39.9%
30 - 34	$ 1,122,946	$ 422	$ 1,177,122	$ 442	$ 2,300,068	$ 877	$ 977,518	$ 464	$ 1,024,894	$ 487	$ 2,002,412	$ 951	-12.9%	8.4%
35 - 39	$ 2,625,510	$ 720	$ 649,214	$ 178	$ 3,274,724	$ 736	$ 1,928,256	$ 593	$ 506,083	$ 156	$ 2,434,339	$ 749	-25.7%	1.8%
40 - 44	$ 2,270,331	$ 584	$ 1,163,597	$ 299	$ 3,433,928	$ 849	$ 1,474,509	$ 413	$ 1,145,395	$ 321	$ 2,619,904	$ 733	-23.7%	-13.6%
45 - 49	$ 1,846,880	$ 424	$ 958,636	$ 220	$ 2,805,516	$ 575	$ 3,047,334	$ 780	$ 1,480,961	$ 379	$ 4,528,295	$ 1,159	61.4%	101.6%
50 - 54	$ 3,853,217	$ 652	$ 1,570,454	$ 266	$ 5,423,671	$ 799	$ 3,055,897	$ 602	$ 1,238,798	$ 244	$ 4,294,695	$ 846	-20.8%	5.9%
55 - 59	$ 4,104,232	$ 707	$ 1,918,213	$ 330	$ 6,022,445	$ 1,018	$ 4,129,411	$ 790	$ 2,208,144	$ 422	$ 6,337,555	$ 1,212	5.2%	19.0%
60 - 64	$ 6,368,155	$ 957	$ 2,769,661	$ 416	$ 9,137,816	$ 1,262	$ 6,612,255	$ 1,092	$ 2,905,119	$ 480	$ 9,517,374	$ 1,571	4.2%	24.5%
65+	$ 2,256,983	$ 714	$ 1,307,445	$ 414	$ 3,564,428	$ 1,026	$ 2,703,898	$ 858	$ 1,350,473	$ 429	$ 4,054,371	$ 1,287	13.7%	25.4%
Total	**$ 31,354,299**	**$ 538**	**$ 12,531,941**	**$ 215**	**$ 43,886,240**	**$ 684**	**$ 29,185,074**	**$ 562**	**$ 12,979,748**	**$ 250**	**$ 42,164,822**	**$ 813**	**-3.9%**	**18.8%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	4,058	3,479	3,110	-10.6%	3,403	2,903	2,569	-11.5%	3	2	2	0.0%
Spouses	793	687	603	-12.1%	684	589	513	-12.8%	0	0	0	0.0%
Children	2,698	2,315	2,052	-11.3%	2,549	2,162	1,912	-11.5%	0	0	0	0.0%
Total Members	7,549	6,481	5,765	-11.0%	6,635	5,653	4,994	-11.6%	3	2	2	0.0%
Family Size	1.9	1.9	1.9	-2.6%	2.0	2.0	1.9	-3.0%	1.0	1.0	1.0	0.0%
Financial Summary												
Gross Cost	$32,474,418	$34,617,679	$32,328,577	-6.6%	$27,933,037	$28,755,420	$27,454,652	-4.5%	$4,170	$3,859	$3,897	1.0%
Client Paid	$28,738,168	$31,354,299	$29,185,074	-6.9%	$24,842,309	$26,085,488	$24,872,107	-4.7%	$3,120	$3,050	$3,049	0.0%
Employee Paid	$3,736,250	$3,263,380	$3,143,503	-3.7%	$3,090,728	$2,669,933	$2,582,545	-3.3%	$1,050	$810	$848	4.7%
Client Paid-PEPY	$9,443	$12,015	$12,514	4.2%	$9,734	$11,982	$12,907	7.7%	$1,337	$2,033	$2,033	0.0%
Client Paid-PMPY	$5,076	$6,451	$6,749	4.6%	$4,992	$6,153	$6,640	7.9%	$1,337	$2,033	$2,033	0.0%
Client Paid-PEPM	$787	$1,001	$1,043	4.2%	$811	$998	$1,076	7.8%	$111	$169	$169	0.0%
Client Paid-PMPM	$423	$538	$562	4.5%	$416	$513	$553	7.8%	$111	$169	$169	0.0%
High Cost Claimants (HCC's) > $100k												
# of HCC's	35	42	46	9.5%	30	33	39	18.2%	0	0	0	0.0%
HCC's / 1,000	4.6	6.5	8.0	23.1%	4.5	5.8	7.8	33.7%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$224,770	$242,425	$205,165	-15.4%	$238,978	$246,809	$211,322	-14.4%	$0	$0	$0	0.0%
HCC's % of Plan Paid	27.4%	32.5%	32.3%	-0.6%	28.9%	31.2%	33.1%	6.1%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,409	$1,910	$1,686	-11.7%	$1,425	$1,787	$1,779	-0.4%	$0	$0	$0	0.0%
Facility Outpatient	$1,331	$2,168	$2,533	16.8%	$1,282	$2,065	$2,459	19.1%	$33	$210	$286	0.0%
Physician	$2,232	$2,373	$2,530	6.6%	$2,188	$2,301	$2,402	4.4%	$1,172	$1,823	$1,746	-4.2%
Other	$103	$0	$0	0.0%	$97	$0	$0	0.0%	$132	$0	$0	0.0%
Total	$5,076	$6,451	$6,749	4.6%	$4,992	$6,153	$6,640	7.9%	$1,337	$2,033	$2,033	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	564	511	487	-4.6%	88	63	51	-19.0%	
Spouses	90	84	80	-4.5%	19	14	10	-29.1%	
Children	139	140	129	-8.3%	10	13	12	-6.6%	
Total Members	794	736	696	-5.4%	117	90	73	-19.3%	
Family Size	1.4	1.4	1.4	-0.7%	1.3	1.4	1.4	1.4%	1.6
Financial Summary									
Gross Cost	$4,047,960	$5,579,441	$4,517,192	-19.0%	$489,251	$278,958	$352,836	26.5%	
Client Paid	$3,504,302	$5,063,279	$4,017,549	-20.7%	$388,437	$202,482	$292,369	44.4%	
Employee Paid	$543,658	$516,162	$499,643	-3.2%	$100,814	$76,476	$60,467	-20.9%	
Client Paid-PEPY	$8,281	$13,200	$10,992	-16.7%	$5,900	$4,278	$7,644	78.7%	$6,258
Client Paid-PMPY	$5,888	$9,174	$7,693	-16.1%	$4,418	$2,992	$5,365	79.3%	$3,830
Client Paid-PEPM	$690	$1,100	$916	-16.7%	$492	$356	$637	78.9%	$521
Client Paid-PMPM	$491	$764	$641	-16.1%	$368	$249	$447	79.5%	$319
High Cost Claimants (HCC's) > $100k									
# of HCC's	6	10	8	0.0%	0	0	1	0.0%	
HCC's / 1,000	7.6	13.6	11.5	0.0%	0.0	0.0	13.8	0.0%	
Avg HCC Paid	$116,268	$203,715	$132,918	0.0%	$0	$0	$132,680	0.0%	
HCC's % of Plan Paid	19.9%	40.2%	26.5%	0.0%	0.0%	0.0%	45.4%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,280	$3,065	$1,075	-64.9%	$1,403	$213	$1,229	477.0%	$1,044
Facility Outpatient	$1,794	$3,091	$3,251	5.2%	$1,047	$1,150	$823	-28.4%	$1,310
Physician	$2,667	$3,018	$3,367	11.6%	$1,839	$1,629	$3,312	103.3%	$1,404
Other	$147	$0	$0	0.0%	$129	$0	$0	0.0%	$72
Total	$5,888	$9,174	$7,693	-16.1%	$4,418	$2,992	$5,365	79.3%	$3,830
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

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

	Total				State Active				Non-State Active			
Summary	**PY22**	**PY23**	**3Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**3Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**3Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	4,021	3,447	3,110	-9.8%	3,370	2,876	2,569	-10.7%	3	2	2	0.0%
Spouses	786	2,297	603	-73.7%	678	2,145	513	-76.1%	0	0	0	0.0%
Children	2,683	676	2,052	203.4%	2,531	580	1,912	229.5%	0	0	0	0.0%
Total Members	7,491	6,421	5,765	-10.2%	6,579	5,601	4,994	-10.8%	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	$32,328,577	-30.5%	$37,820,607	$38,595,575	$27,454,652	-28.9%	$4,744	$4,201	$3,897	-7.2%
Client Paid	$39,320,787	$42,257,152	$29,185,074	-30.9%	$33,797,612	$35,128,252	$24,872,107	-29.2%	$3,622	$3,335	$3,049	-8.6%
Employee Paid	$4,866,255	$4,233,060	$3,143,503	-25.7%	$4,022,996	$3,467,323	$2,582,545	-25.5%	$1,122	$866	$848	-2.1%
Client Paid-PEPY	$9,779	$12,259	$12,514	2.1%	$10,030	$12,216	$12,907	5.7%	$1,278	$1,667	$2,033	22.0%
Client Paid-PMPY	$5,249	$6,581	$6,749	2.6%	$5,137	$6,272	$6,640	5.9%	$1,278	$1,667	$2,033	22.0%
Client Paid-PEPM	$815	$1,022	$1,043	2.1%	$836	$1,018	$1,076	5.7%	$107	$139	$169	21.6%
Client Paid-PMPM	$437	$548	$562	2.6%	$428	$523	$553	5.7%	$107	$139	$169	21.6%
High Cost Claimants (HCC's) > $100k												
# of HCC's	46	54	46	-14.8%	40	43	39	-9.3%	0	0	0	0.0%
HCC's / 1,000	6.1	8.4	8.0	-5.1%	6.1	7.7	7.8	1.7%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$237,083	$257,429	$205,165	-20.3%	$246,357	$257,598	$211,322	-18.0%	$0	$0	$0	0.0%
HCC's % of Plan Paid	27.7%	32.9%	32.3%	-1.8%	29.2%	31.5%	33.1%	5.1%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,432	$1,804	$1,686	-6.5%	$1,437	$1,735	$1,779	2.5%	$0	$0	$0	0.0%
Facility Outpatient	$1,442	$2,319	$2,533	9.2%	$1,382	$2,176	$2,459	13.0%	$27	$158	$286	81.0%
Physician	$2,259	$2,458	$2,530	2.9%	$2,209	$2,361	$2,402	1.7%	$1,142	$1,510	$1,746	15.6%
Other	$116	$0	$0	0.0%	$109	$0	$0	0.0%	$109	$0	$0	0.0%
Total	$5,249	$6,581	$6,749	2.6%	$5,137	$6,272	$6,640	5.9%	$1,278	$1,667	$2,033	22.0%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY22**	**PY23**	**3Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**3Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	564	509	487	-4.2%	85	61	51	-16.5%	
Spouses	90	139	80	-42.3%	19	13	10	-23.1%	
Children	142	83	129	55.3%	10	13	12	-12.5%	
Total Members	796	731	696	-4.7%	114	87	73	-16.9%	
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	$4,517,192	-40.1%	$566,699	$354,790	$352,836	-0.6%	
Client Paid	$5,071,309	$6,861,336	$4,017,549	-41.4%	$448,244	$264,230	$292,369	10.6%	
Employee Paid	$723,682	$674,311	$499,643	-25.9%	$118,455	$90,560	$60,467	-33.2%	
Client Paid-PEPY	$8,998	$13,493	$10,992	-18.5%	$5,279	$4,326	$7,644	76.7%	$6,258
Client Paid-PMPY	$6,373	$9,392	$7,693	-18.1%	$3,946	$3,023	$5,365	77.5%	$3,830
Client Paid-PEPM	$750	$1,124	$916	-18.5%	$440	$360	$637	76.9%	$521
Client Paid-PMPM	$531	$783	$641	-18.1%	$329	$252	$447	77.4%	$319
High Cost Claimants (HCC's) > $100k									
# of HCC's	8	12	8	-33.3%	0	0	1	0.0%	
HCC's / 1,000	10.1	16.4	11.5	-30.1%	0.0	0.0	13.8	0.0%	
Avg HCC Paid	$131,446	$235,373	$132,918	-43.5%	$0	$0	$132,680	0.0%	
HCC's % of Plan Paid	20.7%	41.2%	26.5%	-35.7%	0.0%	0.0%	45.4%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,443	$2,534	$1,075	-57.6%	$1,101	$183	$1,229	571.6%	$1,044
Facility Outpatient	$2,015	$3,585	$3,251	-9.3%	$940	$1,007	$823	-18.3%	$1,310
Physician	$2,742	$3,273	$3,367	2.9%	$1,800	$1,832	$3,312	80.8%	$1,404
Other	$174	$0	$0	0.0%	$106	$0	$0	0.0%	$72
Total	$6,373	$9,392	$7,693	-18.1%	$3,946	$3,023	$5,365	77.5%	$3,830
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 9,033,701	$ 1,090,193	$ 798,039	$ 10,921,934	$ 7,578,449	$ 571,116	$ 51,762	$ 8,201,327	-24.9%
Outpatient	$ 17,051,786	$ 2,918,420	$ 256,627	$ 20,226,833	$ 17,293,658	$ 3,088,718	$ 305,953	$ 20,688,329	2.3%
Total - Medical	**$ 26,085,488**	**$ 4,008,613**	**$ 1,054,666**	**$ 31,148,767**	**$ 24,872,107**	**$ 3,659,834**	**$ 357,715**	**$ 28,889,656**	**-7.3%**

Net Paid Claims - Per Participant per Month	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 998	$ 1,005	$ 1,715	$ 1,014	$ 1,076	$ 977	$ 560	$ 1,050	3.6%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 14,081	$ 3,066	$ 17,147			$74,973.71	$ 74,974	337.2%
Outpatient	$ 3,050	$ 68,241	$ 117,094	$ 188,385	$ 3,049	$ 14,648	$202,746.81	$ 220,444	17.0%
Total - Medical	**$ 3,050**	**$ 82,323**	**$ 120,159**	**$ 205,532**	**$ 3,049**	**$ 14,648**	**$ 277,721**	**$ 295,418**	**43.7%**

Net Paid Claims - Per Participant per Month	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 169	$ 601	$ 279	$ 351	$ 169	$ 222	$ 707	$ 619	76.4%

Paid Claims by Claim Type – Total

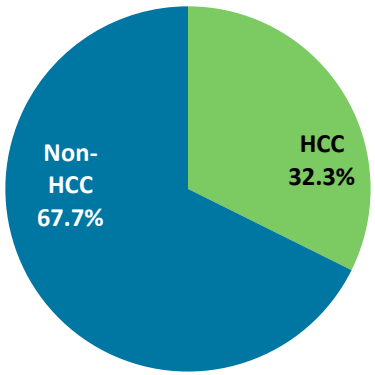
Net Paid Claims - Total Total Participants	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 9,033,701	$ 1,104,274	$ 801,105	$ 10,939,081	$ 7,578,449	$ 571,116	$ 126,736	$ 8,276,301	-24.3%
Outpatient	$ 17,054,836	$ 2,986,662	$ 373,720	$ 20,415,218	$ 17,296,707	$ 3,103,366	$ 508,700	$ 20,908,773	2.4%
Total - Medical	**$ 26,088,537**	**$ 4,090,936**	**$ 1,174,826**	**$ 31,354,299**	**$ 24,875,156**	**$ 3,674,482**	**$ 635,436**	**$ 29,185,074**	**-6.9%**

Net Paid Claims - Per Participant per Month	3Q23				3Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 998	$ 992	$ 1,123	$ 1,001	$ 1,075	$ 964	$ 616	$ 1,043	4.1%

Cost Distribution – Medical Claims

3Q23							3Q24					
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
39	0.6%	$10,181,843	32.5%	$159,612	4.9%	$100,000.01 Plus	41	0.7%	$9,437,599	32.3%	$176,339	5.6%
42	0.7%	$2,968,710	9.5%	$139,181	4.3%	$50,000.01-$100,000.00	42	0.7%	$3,005,403	10.3%	$154,597	4.9%
149	2.3%	$5,198,545	16.6%	$384,316	11.8%	$25,000.01-$50,000.00	115	2.0%	$4,154,888	14.2%	$311,352	9.9%
299	4.6%	$4,798,981	15.3%	$554,771	17.0%	$10,000.01-$25,000.00	271	4.7%	$4,384,171	15.0%	$524,092	16.7%
370	5.7%	$2,694,737	8.6%	$518,302	15.9%	$5,000.01-$10,000.00	419	7.3%	$2,964,477	10.2%	$598,133	19.0%
600	9.3%	$2,235,486	7.1%	$531,489	16.3%	$2,500.01-$5,000.00	656	11.4%	$2,390,697	8.2%	$560,680	17.8%
4,031	62.2%	$3,275,996	10.4%	$974,103	29.8%	$0.01-$2,500.00	3,491	60.5%	$2,847,839	9.8%	$817,707	26.0%
76	1.2%	$0	0.0%	$1,605	0.0%	$0.00	46	0.8%	$0	0.0%	$602	0.0%
875	13.5%	$0	0.0%	$0	0.0%	No Claims	685	11.9%	$0	0.0%	$0	0.0%
6,481	**100.0%**	**$31,354,299**	**100.0%**	**$3,263,380**	**100.0%**		**5,765**	**100.0%**	**$29,185,074**	**100.0%**	**$3,143,503**	**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	19	$2,517,429	26.7%
Cardiac Disorders	33	$1,311,041	13.9%
Infections	18	$922,013	9.8%
Medical/Surgical Complications	9	$706,680	7.5%
Hematological Disorders	13	$633,570	6.7%
Gastrointestinal Disorders	22	$523,375	5.5%
Neurological Disorders	22	$473,232	5.0%
Pregnancy-related Disorders	3	$419,934	4.4%
Renal/Urologic Disorders	17	$370,117	3.9%
Endocrine/Metabolic Disorders	19	$292,593	3.1%
All Other		$1,267,615	13.4%
Overall	**----**	**$9,437,599**	**100.0%**

Utilization Summary (p. 1 of 2)

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

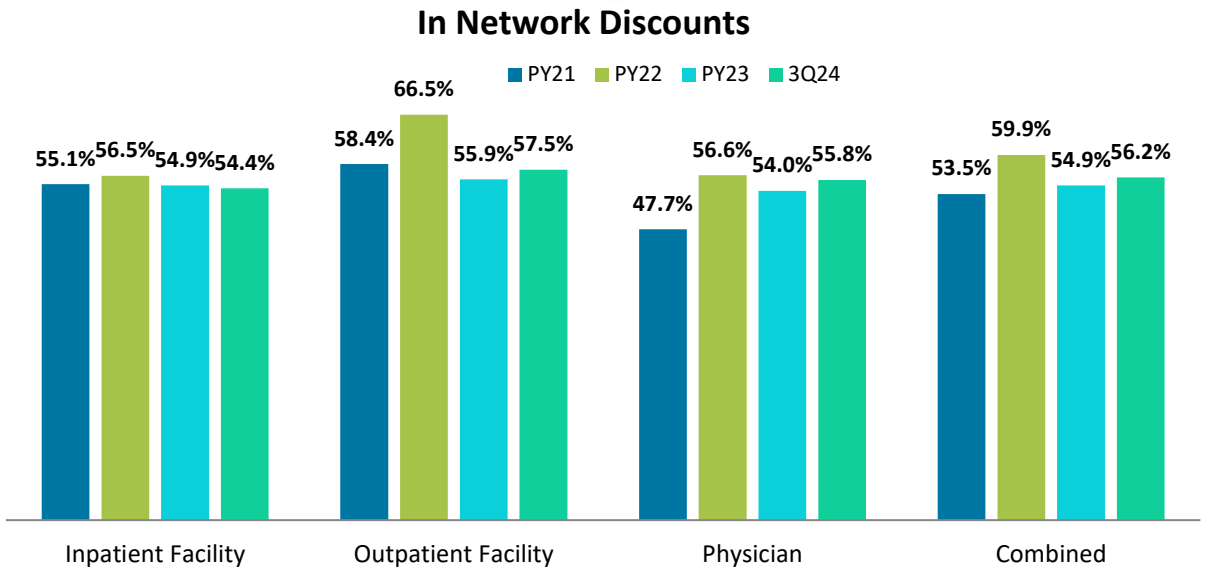
	Total				State Active				Non-State Active			
Summary	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	312	293	264		269	240	221		0	0	0	
# of Bed Days	1,857	1,444	1,410		1,577	1,103	1,167		0	0	0	
Paid Per Admit	$35,747	$36,091	$34,179	-5.3%	$36,815	$35,866	$36,878	2.8%	$0	$0	$0	0.0%
Paid Per Day	$6,006	$7,323	$6,399	-12.6%	$6,280	$7,804	$6,984	-10.5%	$0	$0	$0	0.0%
Admits Per 1,000	55	60	61	1.7%	54	57	59	3.5%	0	0	0	0.0%
Days Per 1,000	328	297	326	9.8%	317	260	312	20.0%	0	0	0	0.0%
Avg LOS	6.0	4.9	5.3	8.2%	5.9	4.6	5.3	15.2%	0.0	0.0	0.0	0.0%
# Admits From ER	158	133	146	9.8%	129	103	120	16.5%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	5.6	5.5	6.3	14.5%	5.4	5.3	6.2	17.0%	5.6	6.0	6.0	0.0%
Avg Paid per OV	$152	$158	$156	-1.3%	$153	$163	$151	-7.4%	$158	$132	$153	15.9%
Avg OV Paid per Member	$853	$863	$986	14.3%	$829	$866	$932	7.6%	$881	$793	$917	15.6%
DX&L Utilization per Member	9.6	11.4	11.9	4.4%	9.2	10.9	11.3	3.7%	4.7	29.3	16.7	-43.0%
Avg Paid per DX&L	$56	$70	$82	17.1%	$57	$73	$82	12.3%	$40	$17	$32	88.2%
Avg DX&L Paid per Member	$540	$806	$976	21.1%	$524	$794	$924	16.4%	$189	$513	$541	5.5%
Emergency Room												
# of Visits	1,021	897	848		877	763	751		0	0	0	
Visits Per Member	0.18	0.18	0.20	11.1%	0.18	0.18	0.20	11.1%	0.00	0.00	0.00	0.0%
Visits Per 1,000	180	185	196	5.9%	176	180	200	11.1%	0	0	0	0.0%
Avg Paid per Visit	$2,080	$2,969	$3,235	9.0%	$2,057	$3,026	$3,254	7.5%	$0	$0	$0	0.0%
Urgent Care												
# of Visits	2,343	2,046	1,964		2,121	1,838	1,763		0	0	0	
Visits Per Member	0.41	0.42	0.45	7.1%	0.43	0.43	0.47	9.3%	0.00	0.00	0.00	0.0%
Visits Per 1,000	414	421	454	7.8%	426	434	471	8.5%	0	0	0	0.0%
Avg Paid per Visit	$151	$128	$134	4.7%	$153	$130	$136	4.6%	$0	$0	$0	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

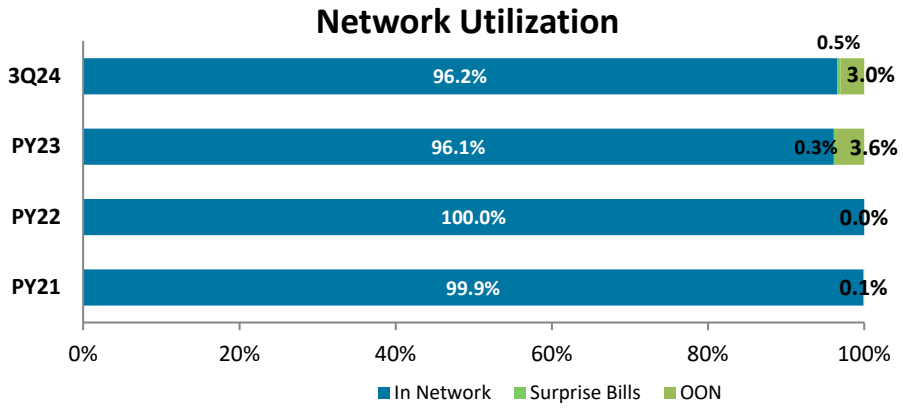
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**3Q22**	**3Q23**	**3Q24**	**Variance to Prior Year**	**Peer Index**
Inpatient Summary									
# of Admits	35	51	36		8	2	7		
# of Bed Days	215	334	226		65	7	17		
Paid Per Admit	$31,922	$38,220	$19,164	-49.9%	$16,574	$8,773	$26,178	198.4%	$19,305
Paid Per Day	$5,197	$5,836	$3,053	-47.7%	$2,040	$2,507	$10,779	330.0%	$3,615
Admits Per 1,000	59	92	69	-25.0%	91	30	128	326.7%	64
Days Per 1,000	361	605	433	-28.4%	739	103	312	202.9%	342
Avg LOS	6.1	6.5	6.3	-3.1%	8.1	3.5	2.4	-31.4%	5.3
# Admits From ER	24	29	21	-27.6%	5	1	5	0.0%	
Physician Office									
OV Utilization per Member	6.9	6.6	7.4	12.1%	7.1	6.5	6.2	-4.6%	5.2
Avg Paid per OV	$153	$134	$194	44.8%	$117	$73	$58	-20.5%	$97
Avg OV Paid per Member	$1,059	$883	$1,434	62.4%	$826	$473	$360	-23.9%	$502
DX&L Utilization per Member	13.3	15.6	16.2	3.8%	9.9	13.1	10.6	-19.1%	9.0
Avg Paid per DX&L	$52	$60	$87	45.0%	$49	$37	$39	5.4%	$46
Avg DX&L Paid per Member	$684	$941	$1,404	49.2%	$481	$480	$409	-14.8%	$412
Emergency Room									
# of Visits	125	113	95		19	21	2		
Visits Per Member	0.21	0.20	0.18	-10.0%	0.22	0.31	0.04	-87.1%	0.23
Visits Per 1,000	210	205	182	-11.2%	216	310	37	-88.1%	228
Avg Paid per Visit	$2,428	$2,933	$3,145	7.2%	$825	$1,092	$291	-73.4%	$1,035
Urgent Care									
# of Visits	193	187	180		29	21	21		
Visits Per Member	0.32	0.34	0.34	0.0%	0.33	0.31	0.39	25.8%	0.38
Visits Per 1,000	324	339	345	1.8%	330	310	385	24.2%	379
Avg Paid per Visit	$148	$121	$122	0.8%	$63	$62	$54	-12.9%	$132
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$3,217,162	11.0%	$1,958,425	$796,459	$462,278	$1,525,262	$1,691,900
Cardiac Disorders	$2,317,536	7.9%	$1,435,719	$837,957	$43,861	$1,230,425	$1,087,110
Gastrointestinal Disorders	$2,147,866	7.4%	$1,342,451	$534,706	$270,710	$898,318	$1,249,548
Musculoskeletal Disorders	$1,826,802	6.3%	$1,387,204	$321,236	$118,363	$779,613	$1,047,189
Health Status/Encounters	$1,824,417	6.3%	$1,120,563	$229,603	$474,252	$669,383	$1,155,034
Mental Health	$1,692,434	5.8%	$666,887	$266,456	$759,091	$482,862	$1,209,572
Neurological Disorders	$1,489,329	5.1%	$1,033,076	$279,026	$177,226	$361,215	$1,128,114
Trauma/Accidents	$1,421,341	4.9%	$951,069	$142,796	$327,475	$768,318	$653,023
Pregnancy-related Disorders	$1,394,249	4.8%	$707,108	$58,862	$628,279	$360,478	$1,033,771
Infections	$1,393,134	4.8%	$1,044,261	$258,967	$89,906	$750,319	$642,815
Pulmonary Disorders	$1,236,345	4.2%	$833,906	$154,392	$248,047	$404,720	$831,625
Eye/ENT Disorders	$1,201,898	4.1%	$760,580	$116,871	$324,447	$494,061	$707,837
Spine-related Disorders	$1,045,766	3.6%	$876,171	$145,099	$24,496	$373,197	$672,569
Renal/Urologic Disorders	$960,870	3.3%	$783,805	$31,967	$145,098	$457,545	$503,324
Medical/Surgical Complications	$926,073	3.2%	$898,007	$9,800	$18,266	$167,572	$758,501
Endocrine/Metabolic Disorders	$921,365	3.2%	$822,568	$74,098	$24,699	$341,984	$579,381
Hematological Disorders	$778,318	2.7%	$621,864	$16,711	$139,743	$649,748	$128,570
Gynecological/Breast Disorders	$748,260	2.6%	$558,092	$108,339	$81,830	$7,580	$740,680
Non-malignant Neoplasm	$723,309	2.5%	$548,959	$46,389	$127,960	$263,273	$460,036
Diabetes	$542,994	1.9%	$282,295	$171,061	$89,637	$372,694	$170,300
Dermatological Disorders	$343,251	1.2%	$233,254	$44,870	$65,127	$171,427	$171,824
Vascular Disorders	$262,754	0.9%	$215,512	$46,741	$501	$162,508	$100,245
Miscellaneous	$255,570	0.9%	$130,631	$44,714	$80,225	$105,622	$149,948
Abnormal Lab/Radiology	$235,441	0.8%	$179,991	$47,971	$7,479	$94,609	$140,832
Cholesterol Disorders	$87,323	0.3%	$76,610	$8,794	$1,920	$40,651	$46,673
Congenital/Chromosomal Anomalies	$80,443	0.3%	$13,425	$1,070	$65,948	$66,138	$14,305
Medication Related Conditions	$64,951	0.2%	$30,939	$3,959	$30,053	$32,899	$32,051
Allergic Reaction	$21,738	0.1%	$4,417	$401	$16,919	$11,134	$10,604
Dental Conditions	$11,943	0.0%	$5,297	$299	$6,348	$6,040	$5,904
External Hazard Exposure	$9,792	0.0%	$6,332	$0	$3,460	$6,990	$2,802
Social Determinants of Health	$2,400	0.0%	$73	$0	$2,327	$0	$2,400
Total	**$29,185,074**	**0.0%**	**$19,529,493**	**$4,799,611**	**$4,855,971**	**$12,056,585**	**$17,128,489**

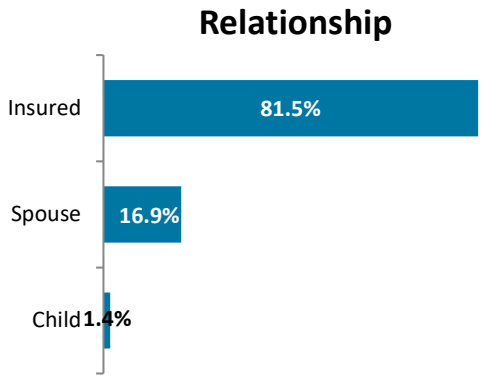
Mental Health Drilldown

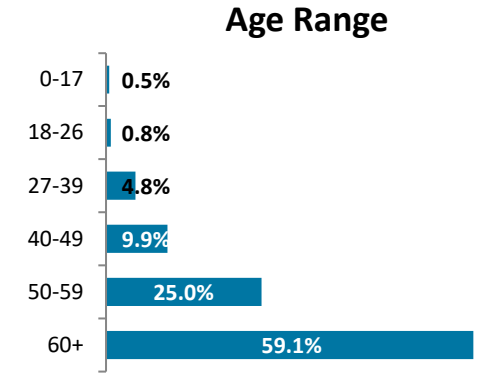
	PY21		PY22		PY23		3Q24	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	625	$833,183	505	$720,907	454	$529,695	380	$422,433
Mood and Anxiety Disorders	711	$655,375	636	$361,898	591	$339,214	454	$345,927
Mental Health Conditions, Other	609	$876,606	458	$367,897	394	$287,517	310	$301,996
Alcohol Abuse/Dependence	43	$163,692	37	$110,736	30	$167,010	37	$171,646
Developmental Disorders	65	$155,300	58	$89,043	47	$93,123	41	$142,376
Bipolar Disorder	127	$261,349	107	$171,696	109	$84,620	81	$87,455
Attention Deficit Disorder	180	$98,736	179	$76,754	202	$61,595	171	$56,100
Complications of Substance Abuse	14	$63,661	8	$12,407	7	$9,434	8	$43,933
Substance Abuse/Dependence	57	$45,039	39	$14,853	35	$72,695	18	$38,840
Psychoses	7	$55,219	6	$9,762	9	$6,025	6	$24,160
Sexually Related Disorders	27	$81,154	27	$85,457	26	$8,339	17	$20,473
Sleep Disorders	187	$38,478	148	$43,716	141	$25,583	102	$20,262
Eating Disorders	24	$370,761	23	$51,995	19	$32,076	15	$7,149
Schizophrenia	9	$10,631	6	$2,286	9	$13,689	7	$5,511
Tobacco Use Disorder	38	$4,775	36	$4,114	42	$3,344	35	$3,477
Personality Disorders	14	$20,064	17	$47,043	15	$7,832	4	$697
Total		**$3,734,023**		**$2,170,566**		**$1,741,788**		**$1,692,434**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	63	379	$2,776,154	4.7%
Cancers, Other	77	824	$1,443,812	2.4%
Breast Cancer	151	1,431	$847,886	1.4%
Secondary Cancers	44	365	$600,782	1.0%
Prostate Cancer	92	567	$443,364	0.7%
Colon Cancer	38	452	$355,189	0.6%
Carcinoma in Situ	77	262	$204,487	0.3%
Lung Cancer	19	166	$179,684	0.3%
Cervical/Uterine Cancer	42	276	$131,252	0.2%
Lymphomas	29	336	$127,040	0.2%
Melanoma	35	139	$114,225	0.2%
Thyroid Cancer	35	175	$113,777	0.2%
Leukemias	23	317	$110,480	0.2%
Ovarian Cancer	19	173	$103,110	0.2%
Non-Melanoma Skin Cancers	206	519	$98,769	0.2%
Myeloma	10	199	$82,877	0.1%
Kidney Cancer	19	178	$63,491	0.1%
Brain Cancer	4	13	$39,616	0.1%
Pancreatic Cancer	4	108	$30,454	0.1%
Bladder Cancer	15	79	$13,555	0.0%
Overall	**----**	**----**	**$7,880,005**	**100.0%**

*Patient and claim counts are unique only within the category

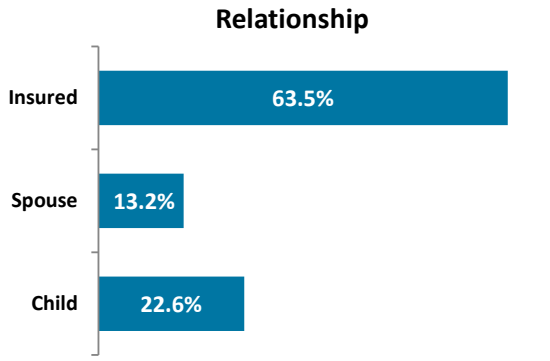


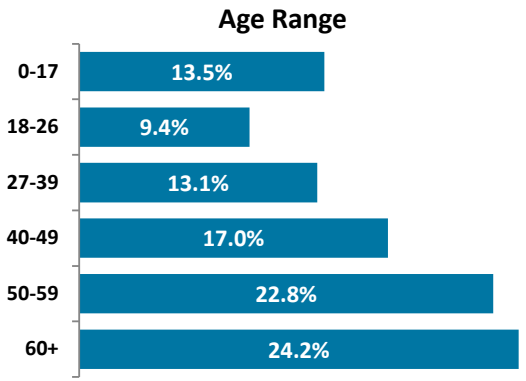


Diagnosis Grouper – Gastrointestinal Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Abdominal Disorders	348	872	$449,587	1.5%
GI Disorders, Other	210	609	$357,069	1.2%
Inflammatory Bowel Disease	43	121	$175,764	0.6%
Diverticulitis	49	140	$163,946	0.6%
Gallbladder and Biliary Disease	34	128	$152,156	0.5%
GI Symptoms	251	465	$134,848	0.5%
Appendicitis	7	41	$133,994	0.5%
Upper GI Disorders	190	406	$132,838	0.5%
Liver Diseases	87	204	$115,740	0.4%
Hernias	37	90	$103,364	0.4%
Hepatic Cirrhosis	10	18	$66,354	0.2%
Pancreatic Disorders	9	38	$62,511	0.2%
Constipation	72	112	$36,681	0.1%
Ostomies	8	41	$28,109	0.1%
Hemorrhoids	32	62	$19,909	0.1%
Peptic Ulcer/Related Disorders	8	9	$14,998	0.1%
	----	----	$2,147,866	7.5%

*Patient and claim counts are unique only within the category

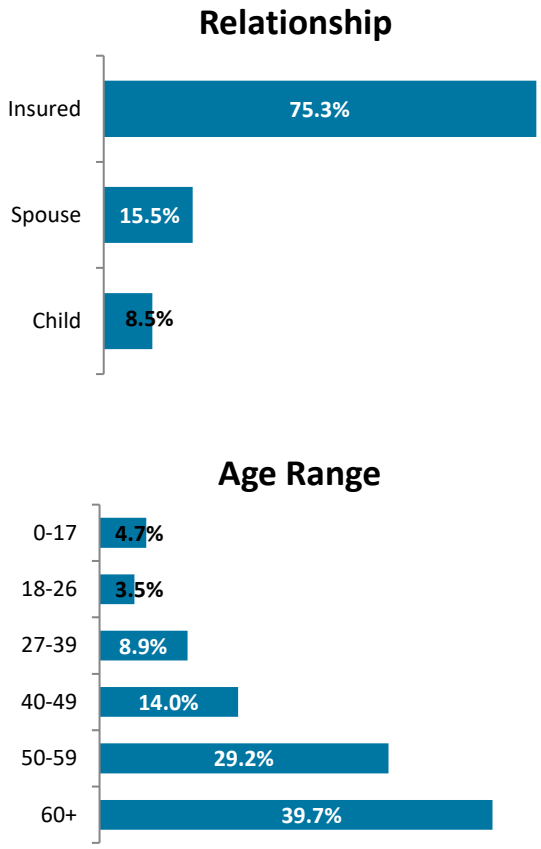




Diagnosis Grouper – Cardiac Disorders

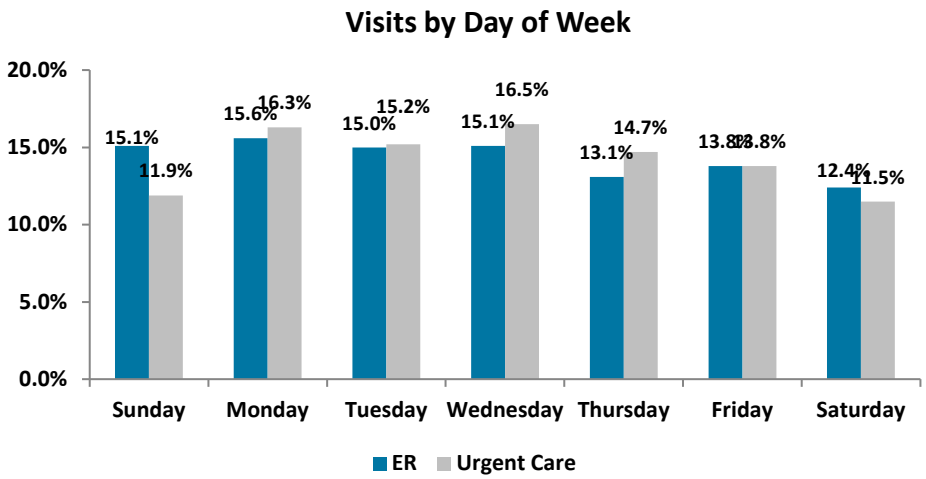
Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Atrial Fibrillation	53	339	$868,107	3.0%
Myocardial Infarction	9	51	$405,987	1.4%
Chest Pain	193	461	$234,974	0.8%
Heart Valve Disorders	53	137	$203,450	0.7%
Hypertension	514	1,007	$141,226	0.5%
Congestive Heart Failure	40	210	$114,319	0.4%
Cardiac Arrhythmias	146	296	$108,508	0.4%
Cardiac Conditions, Other	131	267	$75,890	0.3%
Coronary Artery Disease	77	150	$55,216	0.2%
Pulmonary Embolism	13	41	$44,730	0.2%
Shock	6	14	$28,865	0.1%
Cardio-Respiratory Arrest	23	61	$18,911	0.1%
Cardiomyopathy	14	31	$17,352	0.1%
Overall	**----**	**----**	**$2,317,536**	**100.0%**

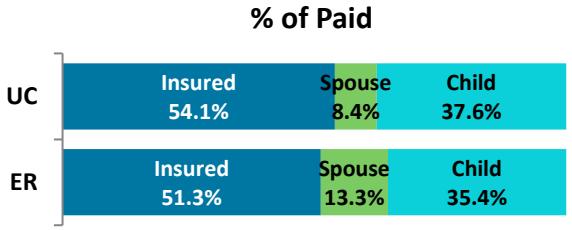
*Patient and claim counts are unique only within the category



Emergency Room / Urgent Care Summary

	3Q23		3Q24		Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	897	2,046	848	1,964		
Visits Per Member	0.18	0.42	0.20	0.46	0.23	0.38
Visits/1000 Members	185	421	197	456	228	379
Avg Paid Per Visit	$2,969	$128	$3,235	$134	$1,085	$132
% with OV*	89.9%	88.9%	89.5%	88.2%		
% Avoidable	14.5%	43.2%	13.4%	41.0%		
Total Member Paid	**$498,378**	**$97,039**	**$478,153**	**$966,675**		
Total Plan Paid	**$2,662,933**	**$262,221**	**$2,743,407**	**$263,145**		
*looks back 12 months	Annualized	Annualized	Annualized	Annualized		





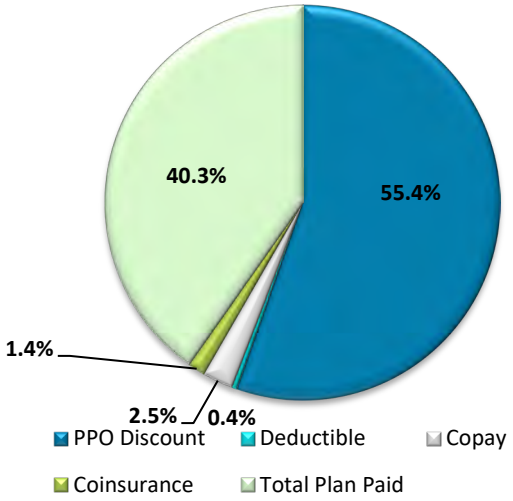
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	435	140	1,062	342	1,497	481
Spouse	113	187	164	272	277	459
Child	300	146	738	360	1,038	506
Total	**848**	**147**	**1,964**	**341**	**2,812**	**488**

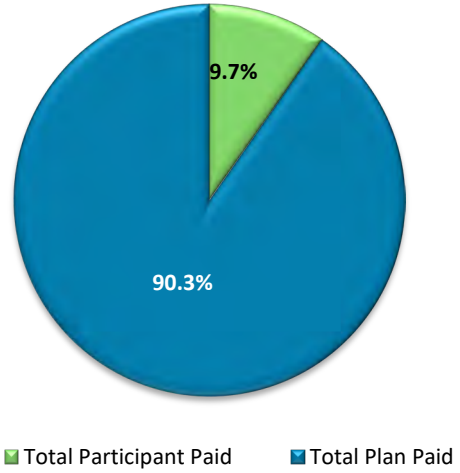
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$73,826,254	$2,638	100.0%
PPO Discount	$40,167,762	$1,435	54.4%
Deductible	$306,533	$11	0.4%
Copay	$1,799,540	$64	2.4%
Coinsurance	$1,037,431	$37	1.4%
Total Participant Paid	**$3,143,504**	**$112**	**4.3%**
Total Plan Paid	**$29,185,074**	**$1,043**	**39.5%**

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	446	439	7	98.4%
	<2 asthma related ER Visits in the last 6 months	446	1	445	0.2%
	Asthma related admit in last 12 months	446	6	440	1.3%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	73	4	69	5.5%
	Members with COPD who had an annual spirometry test	73	13	60	17.8%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	3	0	3	0.0%
	No ER Visit for Heart Failure in last 90 days	56	3	53	5.4%
	Follow-up OV within 4 weeks of discharge from HF admission	3	2	1	66.7%
Diabetes	Annual office visit	527	516	11	97.9%
	Annual dilated eye exam	527	254	273	48.2%
	Annual foot exam	527	255	272	48.4%
	Annual HbA1c test done	527	475	52	90.1%
	Diabetes Annual lipid profile	527	424	103	80.5%
	Annual microalbumin urine screen	527	392	135	74.4%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	1,210	960	250	79.3%
Hypertension	Annual lipid profile	1,125	825	300	73.3%
	Annual serum creatinine test	1,106	941	165	85.1%
Wellness	Well Child Visit - 15 months	51	50	1	98.0%
	Routine office visit in last 6 months (All Ages)	5,671	4,313	1,358	76.1%
	Colorectal cancer screening ages 45-75 within the appropriate time period	2,462	1,413	1,049	57.4%
	Women age 25-65 with recommended cervical cancer/HPV screening	1,655	1,310	345	79.2%
	Males age greater than 49 with PSA test in last 24 months	924	532	392	57.6%
	Routine exam in last 24 months (All Ages)	5,671	5,281	390	93.1%
	Women age 40 to 75 with a screening mammogram last 24 months	1,621	1,139	482	70.3%

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

Chronic Conditions Prevalence

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

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

Chronic Condition	# With Condition	% of Members	Members per 1,000	Admits per 1,000	ER Visits per 1,000	PMPY
Affective Psychosis	98	1.73%	17.00	246.38	449.28	$21,485
Asthma	492	8.67%	85.34	147.19	467.53	$19,294
Atrial Fibrillation	69	1.22%	11.97	260.43	480.80	$42,762
Blood Disorders	514	9.06%	89.15	298.92	454.13	$34,103
CAD	166	2.93%	28.79	261.06	435.10	$32,134
COPD	71	1.25%	12.31	541.81	702.34	$45,989
Cancer	291	5.13%	50.47	240.00	240.00	$36,130
Chronic Pain	403	7.10%	69.90	186.59	508.54	$25,432
Congestive Heart Failure	56	0.99%	9.71	611.97	745.01	$41,157
Demyelinating Diseases	20	0.35%	3.47	338.98	474.58	$38,504
Depression	766	13.50%	132.86	158.27	410.74	$16,726
Diabetes	563	9.92%	97.65	126.11	259.63	$26,699
ESRD	8	0.14%	1.39	1,217.39	521.74	$85,865
Eating Disorders	43	0.76%	7.46	566.37	1,026.55	$34,861
HIV/AIDS	8	0.14%	1.39	0.00	333.33	$31,511
Hyperlipidemia	1,504	26.50%	260.86	91.08	207.25	$18,418
Hypertension	1,131	19.93%	196.17	132.58	292.17	$20,502
Immune Disorders	48	0.85%	8.33	387.10	506.20	$63,424
Inflammatory Bowel Disease	43	0.76%	7.46	633.43	527.86	$57,091
Liver Diseases	180	3.17%	31.22	344.06	604.20	$35,331
Morbid Obesity	348	6.13%	60.36	175.87	327.20	$24,528
Osteoarthritis	350	6.17%	60.71	152.16	386.57	$21,535
Peripheral Vascular Disease	47	0.83%	8.15	160.43	417.11	$38,504
Rheumatoid Arthritis	64	1.13%	11.10	151.62	281.59	$35,663

*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 - Through Quarter Ending March 31, 2024

Express Scripts

Membership Summary	1Q-3Q FY2024 EPO	1Q-3Q FY2023 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	5,767	6,498	(731)	-11.2%
Utilizing Member Count (Patients)	4,508	5,300	(792)	-14.9%
Percent Utilizing (Utilization)	78.2%	81.6%	(0)	-4.2%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	94,902	102,323	(7,421)	-7.3%
Claims per Elig Member per Month (Claims PMPM)	1.83	1.75	0.08	4.6%
Total Claims for Generic (Generic Rx)	81,545	87,084	(5,539.00)	-6.4%
Total Claims for Brand (Brand Rx)	13,357	15,239	(1,882.00)	-12.3%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	515	500	15.00	3.0%
Total Non-Specialty Claims	93,757	100,666	(6,909.00)	-6.9%
Total Specialty Claims	1,145	1,657	(512.00)	-30.9%
Generic % of Total Claims (GFR)	**85.9%**	**85.1%**	0.01	1.0%
Generic Effective Rate (GCR)	**99.4%**	**99.4%**	(0.00)	-0.1%
Mail Order Claims	27,959	28,562	(603.00)	-2.1%
Mail Penetration Rate*	32.4%	31.0%	0.01	1.4%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$15,265,936	$14,917,970	$347,966.00	2.3%
Total Generic Gross Cost	$1,434,234	$1,577,469	($143,235.00)	-9.1%
Total Brand Gross Cost	$13,831,701	$13,340,501	$491,200.00	3.7%
Total MSB Gross Cost	$300,275	$296,707	$3,568.00	1.2%
Total Ingredient Cost	$14,862,685	$14,784,656	$78,029.00	0.5%
Total Dispensing Fee	$390,394	$118,673	$271,721.00	229.0%
Total Other (e.g. tax)	$12,856	$14,642	($1,786.00)	-12.2%
Avg Total Cost per Claim (Gross Cost/Rx)	**$160.86**	**$145.79**	$15.07	10.3%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$17.59	$18.11	($0.52)	-2.9%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$1,035.54	$875.42	$160.12	18.3%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$583.06	$593.41	($10.35)	-1.7%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$2,287,037**	**$2,396,124**	($109,087.00)	-4.6%
Total Copay	$2,285,109	$2,393,649	($108,540.00)	-4.5%
Total Deductible	$1,929	$2,474	($545.00)	0.0%
Avg Copay per Claim (Copay/Rx)	$24.08	$23.39	$0.69	2.9%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$24.10**	**$23.42**	**$0.68**	**2.9%**
Avg Copay for Generic (Copay/Generic Rx)	$6.88	$6.67	$0.21	3.1%
Avg Copay for Brand (Copay/Brand Rx)	$129.21	$119.12	$10.09	8.5%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$69.20	$70.83	($1.63)	-2.3%
Net PMPM (Participant Cost PMPM)	**$44.06**	**$40.97**	$3.09	7.5%
Copay % of Total Prescription Cost (Member Cost Share %)	15.0%	16.1%	-1.1%	-6.7%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$12,978,898**	**$12,521,847**	**$457,051.00**	**3.7%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$6,236,188	$5,711,902	$524,286.00	9.2%
Total Specialty Drug Cost (Specialty Plan Cost)	$6,742,711	$6,809,944	($67,233.00)	-1.0%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$136.76**	**$122.38**	$14.39	11.8%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$10.71	$11.44	($0.73)	-6.4%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$906.33	$756.30	$150.03	19.8%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$513.86	$522.59	($8.73)	-1.7%
Net PMPM (Plan Cost PMPM)	**$250.06**	**$214.11**	**$35.95**	**16.8%**
PMPM without Specialty (Non-Specialty PMPM)	$120.15	$97.67	$22.48	23.0%
PMPM for Specialty Only (Specialty PMPM)	$129.91	$116.45	$13.46	11.6%
Rebates Received (Q1-Q3 FY2023 actual)	$4,508,679	$4,349,325	$159,354.09	3.7%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$163.19**	**$139.74**	**$23.45**	**16.8%**
PMPM without Specialty (Non-Specialty PMPM)	$76.00	$54.31	$0.92	5.0%
PMPM for Specialty Only (Specialty PMPM)	$92.00	$89.06	$2.94	3.3%

Appendix D

Index of Tables
Health Plan of Nevada –Utilization Review for PEBP
January 1, 2024 – March 31, 2024

Power Of Partnership.

Quarterly Health Plan Performance Review

Prepared for PEBP

Building health ownership together

Claims Incurred Data:

July 1, 2022 – March. 2023 Q3– Prior Period

July 1, 2023 – March 2024 Q3– Current Period

*Paid through May 2024

**Peer – Non-Gaming*

Data only contains 60-day claims run out

State of Nevada

Executive Summary

Spend and Utilization

Executive Summary Utilization & Spend

UnitedHealthcare

Population

- -2.7% decrease for employees
- -3.2% decrease for members

Medical Paid PMPM

- 1.3% increase in overall medical paid from prior period
- 4.7% increase in non-Catastrophic spend
- -13.1% decrease in Catastrophic spend

High-Cost Claimants

- 53 HCC in 2Q23, -7.0% decrease from prior period
- % of HCC spend saw a small decrease of -14.4%
- Avg. Paid per case increased -13.1%

Emergency Room

- ER Visits Per 1,000 members slight increased .07%
- Avg. paid per ER Visit increased 19.4%

Urgent Care

- Urgent Care visits per 1,000 members increased by 2.6%
- Avg. paid per Urgent care visit increased 8.0%

Rx Drivers

- Rx Net Paid PMPM increased 5.8%
- Specialty Spend decreased -10.2%
- Specialty Rx driving 37.3% of total Rx Spend

Overall Medical / Rx

- Total Medical/Rx increased 2.8% on PMPM basis

Executive Summary Utilization & Spend

UnitedHealthcare®

Claims Paid by Age Group														
	July 2022 - March 2023 Q3						July 2023 - March 2024 Q3						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	$302,798	$605	$1,396	$3	$304,195	$608	$442,661	$1,230	$1,201	$3	$443,862	$1,233	45.9%	19.5%
01	$248,133	$541	$3,745	$8	$251,879	$550	$140,495	$314	$2,180	$5	$142,674	$319	-41.9%	-40.3%
02-04	$552,113	$322	$14,526	$8	$566,639	$331	$470,586	$326	$12,198	$8	$482,783	$334	1.1%	-0.4%
05-09	$668,756	$207	$52,714	$16	$721,470	$223	$553,295	$192	$59,967	$21	$613,262	$213	-7.0%	27.9%
10-14	$705,238	$172	$268,489	$65	$973,728	$237	$680,661	$170	$124,503	$31	$805,164	$201	-1.0%	-52.4%
15-19	$845,954	$179	$165,010	$35	$1,010,964	$214	$872,765	$187	$209,478	$45	$1,082,243	$232	4.7%	28.8%
20-24	$602,588	$145	$156,344	$38	$758,932	$183	$892,162	$205	$79,314	$18	$971,476	$224	41.3%	-51.6%
25-29	$1,110,968	$424	$267,600	$102	$1,378,568	$526	$1,009,992	$432	$153,411	$66	$1,163,404	$497	1.7%	-35.8%
30-34	$1,048,375	$337	$438,069	$141	$1,486,444	$478	$858,348	$314	$403,574	$147	$1,261,923	$461	-7.0%	4.7%
35-39	$1,194,240	$319	$708,303	$189	$1,902,542	$509	$1,224,666	$345	$909,584	$256	$2,134,250	$601	7.9%	35.2%
40-44	$1,291,342	$322	$590,612	$147	$1,881,953	$470	$1,721,338	$455	$482,667	$127	$2,204,005	$582	41.0%	-13.5%
45-49	$1,850,677	$367	$829,975	$164	$2,680,652	$531	$1,728,110	$358	$1,178,238	$244	$2,906,348	$602	-2.4%	48.4%
50-54	$2,673,946	$473	$1,817,348	$321	$4,491,294	$794	$1,722,540	$308	$1,567,466	$280	$3,290,006	$589	-34.8%	-12.7%
55-59	$2,311,115	$422	$1,758,379	$321	$4,069,493	$742	$2,111,989	$376	$2,028,152	$361	$4,140,141	$737	-10.8%	12.6%
60-64	$3,052,616	$574	$1,754,917	$330	$4,807,533	$905	$2,869,576	$534	$1,560,315	$290	$4,429,891	$824	-7.0%	-12.1%
65+	$2,024,250	$538	$1,202,041	$319	$3,226,291	$857	$2,781,230	$732	$1,494,698	$393	$4,275,928	$1,125	36.1%	23.1%
Total	$20,483,110	$355	$10,029,468	$174	$30,512,578	$529	$20,080,415	$360	$10,266,944	$184	$30,347,359	$544	-0.5%	2.8%

Financial Summary

Financial and Demographic (*July 2023 thru March 2024 Q3*)

	Total				State Active				Retire	
ru 3Q22	Thru 3Q23	Thru 3Q24	▲	Thru 3Q22	Thru 3Q23	Thru 3Q24	▲	Thru 3Q22	Th
3,793	3,636	3,539	-2.7%	3,322	3,212	3,099	-3.5%	471	
6,695	6,403	6,196	-3.2%	6,075	5,829	5,593	-4.0%	620	
1.8	1.8	1.8	-0.6%	1.8	1.8	1.8	-0.6%	1.3	
,188,250	$20,483,110	$20,080,415	-2.0%	$26,993,296	$18,274,176	$17,080,513	-6.5%	$4,194,954	$2
,087,757	$1,394,423	$1,693,072	21.4%	$1,468,124	$1,042,020	$1,246,829	19.7%	$619,633	
$10,962	$7,511	$7,565	0.7%	$10,823	$7,578	$7,334	-3.2%	$11,948	
$6,211	$4,265	$4,321	1.3%	$5,919	$4,175	$4,064	-2.7%	$9,081	
$914	$626	$630	0.7%	$902	$632	$611	-3.2%	$996	
$518	$355	$360	1.3%	$493	$348	$339	-2.7%	$757	
75	57	53	-7.0%	60	51	40	-21.6%	15	
221,758	$117,404	$108,048	-8.0%	$237,436	$115,925	$106,865	-7.8%	$159,045	$
52.9%	32.7%	28.4%	-13.1%	52.5%	32.4%	25.0%	-22.8%	55.1%	
$2,907	$1,123	$1,195	6.5%	$2,725	$1,295	$1,122	-13.3%	$4,694	
$1,149	$1,232	$1,111	-9.9%	$1,115	$1,111	$932	-16.1%	$1,369	
$2,155	$1,910	$2,015	5.5%	$2,084	$1,306	$1,297	-0.6%	$2,965	
$6,211	$4,265	$4,321	1.3%	$5,924	$4,180	$4,072	-2.6%	$9,028	

Paid Claims by Claim Type

UnitedHealthcare®

Net Paid Claims - Total Total Participants	July - March 2023 Q3				July - March 2024 Q3				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical									
InPatient	$4,376,828	$119,560	$895,073	$5,391,461	$3,954,823	$331,945	$1,268,189	$5,554,957	3.0%
OutPatient	$13,300,930	$661,541	$1,129,178	$15,091,649	$12,569,785	$442,509	$1,513,164	$14,525,458	-3.8%
Total - Medical	$17,677,759	$781,101	$2,024,250	$20,483,110	$16,524,608	$774,454	$2,781,353	$20,080,415	-2.0%

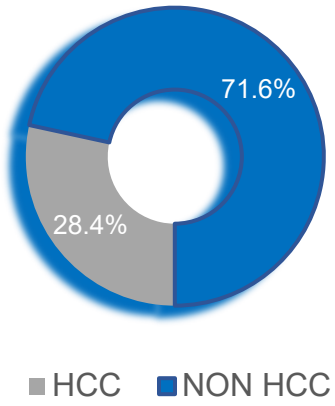
Net Paid Claims - Total Total Participants	July - March 2023 Q3				July - March 2024 Q3				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical PMPM	$335	$693	$1,795	$355	$325	$678	$732	$360	1.3%

Cost Distribution – Medical Claims > $50K

UnitedHealthcare

July - March 2023 Q3					July - March 2024			
Total Paid	% of Paid	Subscriber Paid	% of Subscribers paid	Paid Claims	# of Members	% of Population	Total Paid	% of Paid
1,517,931	7.4%	$750,657	49.5%	> $100k	6	0.1%	$975,449	4.9%
2,146,677	10.5%	$1,537,324	71.6%	$50k- $100k	17	0.3%	$1,332,139	6.6%
1,982,851	9.7%	$1,448,813	73.1%	$25k - $50k	73	1.2%	$2,776,249	13.8%
3,517,886	17.2%	$2,425,483	68.9%	$10k - $25k	179	2.9%	$3,714,569	18.5%
2,358,896	11.5%	$1,678,147	71.1%	$5k - $10k	294	4.7%	$2,564,899	12.8%

% Paid Attributed to Catastrophic Cases



HCC > $50k - AHRQ Chapter Conditions - Thru March 2024 Q3

Condition	# of Patients	Total Paid	% of Med Paid
Diseases of the circulatory system	12	$1,104,754	5.5%
Neoplasms	11	$989,876	4.9%
Complications of pregnancy	4	$663,180	3.3%
Injury and poisoning	4	$483,994	2.4%
Diseases of the digestive system	3	$471,965	2.3%

Utilization Summary

UnitedHealthcare

Utilization Summary	Total			State Active			Retiree State/Non-State		
	July - March 3Q23	July - March 3Q24	▲	July - March 3Q23	July - March 3Q24	▲	July - March 3Q23	July - March 3Q24	▲
Inpatient									
# of Admits	265	310	17.1%	242	253	4.6%	23	57	147.4%
# of Bedays	1,513	1,767	16.8%	1,410	1,279	-9.3%	103	488	375.4%
Avg. Paid per Admit	$20,468	$18,044	-11.8%	$20,552	$17,691	-13.9%	$19,592	$19,604	0.1%
Avg. Paid per Day	$3,583	$3,166	-11.6%	$3,523	$3,497	-0.7%	$4,410	$2,296	-47.9%
Admits Per K	55.2	66.7	21.0%	55.3	60.3	9.0%	53.6	126.4	136.0%
Days Per K	315.1	380.3	20.7%	322.6	305.0	-5.5%	238.0	1,079.3	353.4%
ALOS	5.7	5.7	-0.2%	5.8	5.1	-13.3%	5.5	5.9	7.3%
Admits from ER	135	150	11.1%	119	119	0.0%	16	31	93.8%
Physician Office Visits									
Per Member Per Year	2.3	2.3	-2.2%	2.3	2.2	-1.5%	2.7	2.5	-8.3%
Paid Per Visit	$149	$152	2.3%	$154	$158	2.8%	$107	$105	-2.1%
Net Paid PMPM	$29	$29	0.1%	$29	$30	1.2%	$24	$22	-10.2%
Emergency Room									
# of Visits	585	570	-2.6%	532	520	-2.3%	53	50	-5.7%
Visits Per K	121.8	122.7	0.7%	121.7	124.0	1.9%	123.0	110.7	-10.0%
Avg Paid Per Visit	$2,573	$3,072	19.4%	$2,625	$3,114	18.7%	$2,057	$2,635	28.1%
Urgent Care									
# of Visits	3,036	3,014	-0.7%	2,755	2,706	-1.8%	281	308	9.6%
Visits Per K	632.2	648.6	2.6%	630.2	645.1	2.4%	652.2	681.8	4.5%
Avg Paid Per Visit	$119	$126	5.6%	$92	$93	1.0%	$80	$91	13.3%

**Not Representative of all utilization*

**Data based on medical spend only*

Diagnosis Grouper Summary – Top 25

UnitedHealthcare®

Top 25 AHRQ Category	Total Paid	% Paid	Insured	Spouse	Dependent	Male	Female	Unassigned
Other nutritional; endocrine; and metabolic disorders	$605,989	3.8%	$386,071	$183,783	$36,135	$81,162	$524,826	$0
Spondylosis; intervertebral disc disorders; other back proble	$515,532	3.3%	$392,281	$105,967	$17,284	$231,917	$283,615	$0
Other nervous system disorders	$439,560	2.8%	$138,174	$290,407	$10,979	$77,356	$362,204	$0
Disorders usually diagnosed in infancy childhood or adolesc	$438,942	2.8%	$0	$0	$438,942	$347,157	$91,784	$0
Cancer of breast	$425,478	2.7%	$286,058	$139,421	$0	$0	$425,478	$0
Osteoarthritis	$418,442	2.6%	$374,433	$44,009	$0	$142,173	$276,269	$0
Diabetes mellitus with complications	$345,230	2.2%	$268,957	$54,591	$21,682	$203,596	$141,634	$0
Mood disorders	$314,829	2.0%	$134,434	$20,475	$159,921	$58,693	$256,136	$0
Septicemia (except in labor)	$283,392	1.8%	$174,237	$109,133	$23	$61,215	$222,177	$0
Liveborn	$281,834	1.8%	$0	$0	$281,834	$272,994	$8,840	$0
Coronary atherosclerosis and other heart disease	$271,262	1.7%	$69,335	$201,928	$0	$231,306	$39,956	$0
Other screening for suspected conditions (not mental disor	$261,866	1.7%	$212,193	$44,637	$5,036	$87,951	$173,915	$0
Cancer of esophagus	$237,601	1.5%	$0	$237,601	$0	$237,601	$0	$0
Noninfectious gastroenteritis	$233,692	1.5%	$52,137	$173,021	$8,534	$196,696	$36,996	$0
Peri-; endo-; and myocarditis; cardiomyopathy (except that	$233,331	1.5%	$233,331	$0	$0	$202,303	$31,027	$0
Nonspecific chest pain	$230,509	1.5%	$140,020	$74,627	$15,862	$119,865	$110,644	$0
Cardiac dysrhythmias	$218,176	1.4%	$188,154	$24,896	$5,126	$115,768	$102,407	$0
Acute cerebrovascular disease	$206,423	1.3%	$172,213	$33,818	$392	$147,748	$58,675	$0
Abdominal pain	$199,514	1.3%	$143,591	$24,171	$31,751	$65,434	$134,079	$0
Multiple sclerosis	$190,055	1.2%	$190,055	$0	$0	$0	$190,055	$0
Medical examination/evaluation	$187,213	1.2%	$40,618	$7,271	$139,324	$80,564	$106,649	$0
Anxiety disorders	$187,173	1.2%	$110,480	$20,502	$56,191	$49,373	$137,800	$0
Other complications of pregnancy	$184,779	1.2%	$128,017	$30,295	$26,466	$0	$184,779	$0
Other female genital disorders	$181,660	1.1%	$168,194	$10,536	$2,931	$0	$181,660	$0
Urinary tract infections	$180,643	1.1%	$92,070	$56,769	$31,804	$66,399	$114,244	$0

**Not Representative of all utilization*

**Data based on medical spend only*

Mental Health Drilldown

UnitedHealthcare®

Top 10 Mental Health				
AHRQ Category Description	July - March 3Q23		July - March 2Q24	
	Patients	Total Paid	Patients	Total Paid
Disorders usually diagnosed in infancy childhood	39	$372,816	43	$438,942
Mood disorders	412	$285,852	372	$314,829
Anxiety disorders	391	$157,998	408	$187,173
Alcohol-related disorders	14	$14,664	29	$114,243
Adjustment disorders	129	$50,308	148	$70,169
Attention-deficit conduct and disruptive behavior disorders	132	$26,639	152	$41,989
Suicide and intentional self-inflicted injury	13	$21,932	9	$26,700
Schizophrenia and other psychotic disorders	12	$21,323	14	$24,571
Miscellaneous mental health disorders	44	$36,028	52	$9,826
Substance-related disorders	32	$49,038	32	$9,815

**Not Representative of all utilization*

**Data based on medical spend only*

Respiratory Disorders

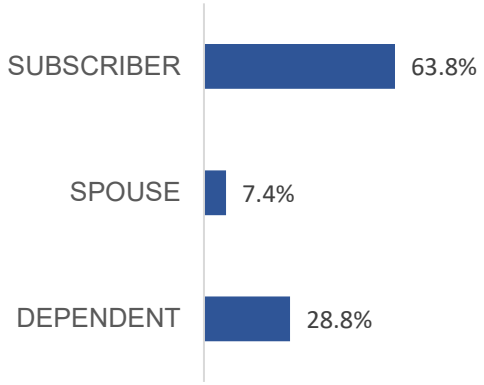
UnitedHealthcare

Top 10 Respiratory Disorders				
AHRQ Category Description	Patients	Claims	Total Paid	% Paid
Other upper respiratory infections	865	1,194	$141,939	20.8%
Other upper respiratory disease	398	1,079	$124,485	18.3%
Other lower respiratory disease	474	800	$104,752	15.4%
Asthma	252	472	$104,687	15.4%
Pneumonia (except that caused by tuberculosis or std)	32	99	$92,444	13.6%
Pleurisy; pneumothorax; pulmonary collapse	32	117	$38,058	5.6%
Acute and chronic tonsillitis	46	74	$22,657	3.3%
Influenza	80	90	$21,159	3.1%
Respiratory failure; insufficiency; arrest (adult)	22	59	$11,852	1.7%
Chronic obstructive pulmonary disease and bronchiectasis	110	224	$9,966	1.5%

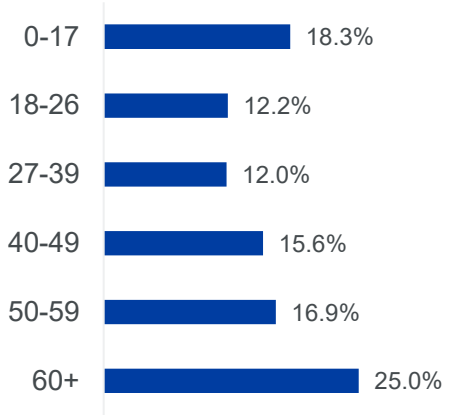
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



Spend by Age Range



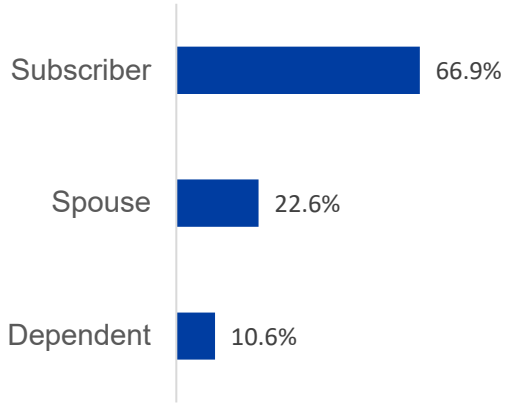
Infections

Top 10 Infectious and Parasitic Diseases				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Septicemia (except in labor)	23	69	$283,392	56.8%
Viral infection	350	512	$151,203	30.3%
Immunizations and screening for infectious disease	531	838	$54,195	10.9%
Mycoses	101	138	$5,346	1.1%
HIV infection	22	116	$1,340	0.3%
Hepatitis	13	42	$1,174	0.2%
Sexually transmitted infections (not HIV)	11	21	$858	0.2%
Bacterial infection; unspecified site	19	23	$813	0.2%
Tuberculosis	4	14	$483	0.1%
Other infections; including parasitic	12	15	$154	0.0%

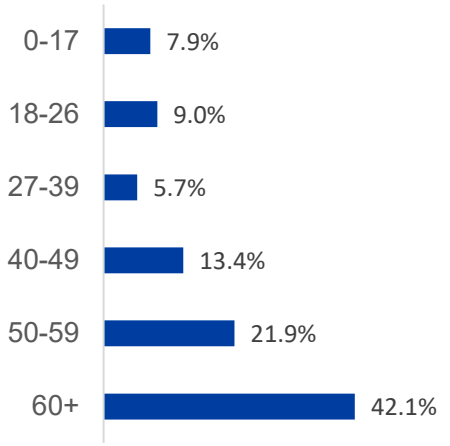
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



Spend by Age Range



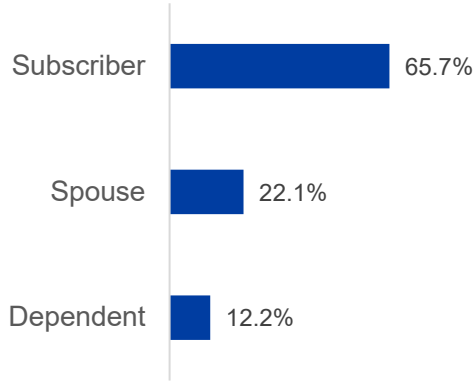
Pregnancy Related Disorders

Top 10 Complications of Pregnancy				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Other complications of pregnancy	60	320	$184,779	21.4%
Hypertension complicating pregnancy;	15	92	$108,041	12.5%
Polyhydramnios and other problems of amniotic cavity	12	33	$97,950	11.3%
Diabetes or abnormal glucose tolerance complicating pregnancy	13	99	$93,254	10.8%
Previous C-section	4	14	$64,168	7.4%
Other pregnancy and delivery including normal	77	300	$61,809	7.2%
Other complications of birth	25	43	$54,711	6.3%
Contraceptive and procreative management	161	313	$49,849	5.8%
Fetal distress and abnormal forces of labor	7	15	$40,240	4.7%
Malposition; malpresentation	2	5	$33,964	3.9%

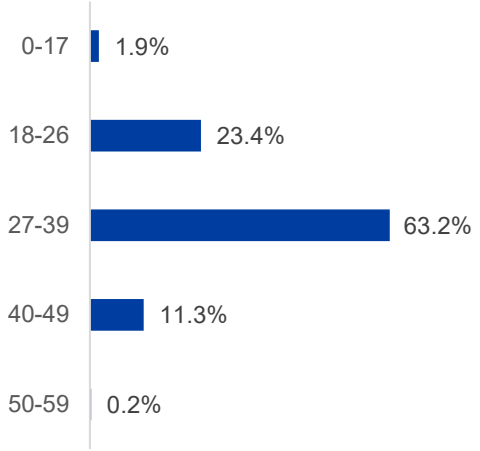
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



Spend by Age Range



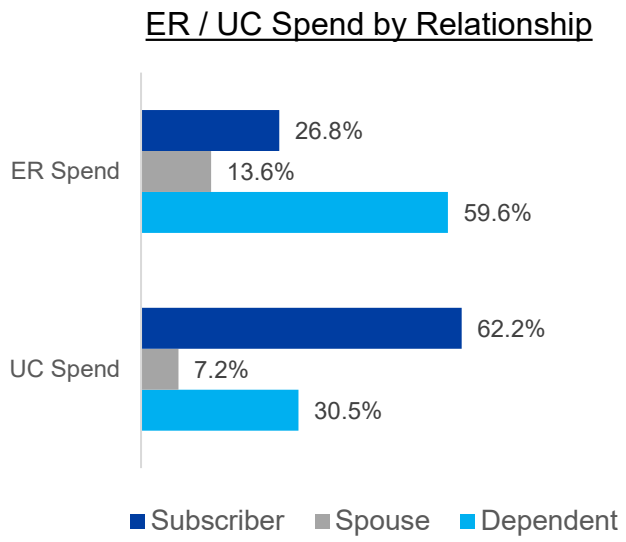
Emergency Room and Urgent Care

Metric	July - March 3Q23		July - March 3Q24		Peer	
	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
# of Visits	585	3,036	570	3,014		
Visits Per Member	0.09	0.47	0.09	0.49	0.089	0.02
Visits Per K	121.8	632.2	122.7	648.6	90.1	387.1
Avg. Paid Per Visit	$2,573	$112	$3,072.22	$121	$2,619	$117

**Not Representative of all utilization*

**Data based on medical spend only*

Emergency Room and Urgent Care Visits by Relationships - 3Q24				
Relationship	ER Visits	ER Per K	UC Visits	UC Per K
Member	173	37.2	1,916	412.3
Spouse	81	17.4	289	62.2
Dependent	316	68.0	809	174.1
Total	570	122.7	3,014	648.6



Clinical Conditions by Medical Spend

UnitedHealthcare

Top 15 Common Condition	# of Members	% of Members	Members Per K	PMPM
Mental Disorders	745	12.0%	120.2	$16.63
Intervertebral Disc Disorders	544	8.8%	87.8	$9.25
Diabetes with complications	66	1.1%	10.7	$7.63
Breast Cancer	437	7.1%	70.5	$6.19
Hypertension	98	1.6%	15.8	$4.17
Coronary Atherosclerosis	585	9.4%	94.4	$4.86
Diabetes without complications	436	7.0%	70.4	$0.57
Asthma	250	4.0%	40.4	$1.76
Prostate Cancer	8	0.1%	1.3	$1.88
Acute Myocardial Infarction	24	0.4%	3.9	$2.04
Chronic Renal Failure	49	0.8%	7.9	$0.33
Congestive Heart Failure (CHF)	72	1.2%	11.6	$0.94
Colon Cancer	4	0.1%	0.6	$0.18
COPD	109	1.8%	17.6	$0.05
Cervical Cancer	34	0.5%	5.5	$0.65

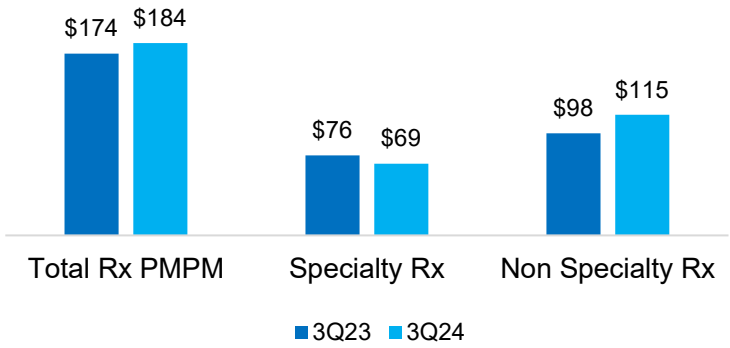
**Not Representative of all utilization*

**Data based on medical spend only*

Pharmacy Drivers

	July - March 3Q23	July - March 3Q24	Δ
Enrolled Members	6,403	6,196	-3.2%
Average Prescriptions PMPY	17.0	17.2	1.2%
Formulary Rate	89.8%	87.9%	-2.1%
Generic Use Rate	84.7%	85.2%	0.6%
Generic Substitution Rate	98.3%	98.3%	0.0%
Avg Net Paid per Prescription	$123	$129	4.5%
Net Paid PMPM	$174	$184	5.8%

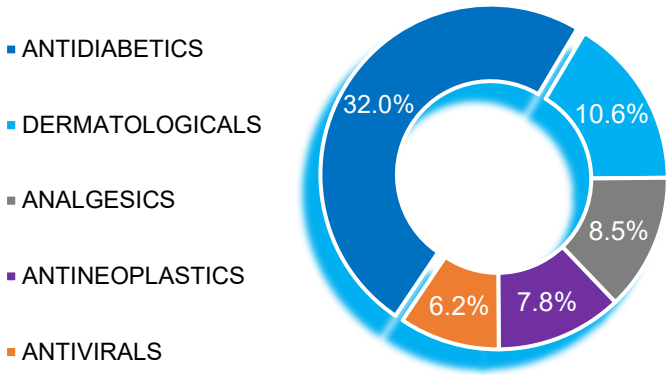
Total Rx Spend by Benefit and Type



Pharmacy Performance

- Rx spend increased of **5.8%**, (**$10 PMPM**) from prior period
- Avg. paid per Script increased **4.5%** (**$6 PMPM**) year over year
- Specialty Rx spend driving **37.3%** of Rx Spend
- Specialty Rx spend decreased **-10.2%** from prior period
  Specialty Rx Drivers:
  Ozempic (Antidiabetic) Spend up **44.1%**
  Jardiance (Antidiabetic) Spend up **17.3%**
- Tier 1 Rx drove **75.4%** of total claim volume, but only accounts for **9.6%** of overall Rx Spend

Top 5 Therapeutic Classes by Spend



4.2.3

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.2 Receipt of quarterly staff reports for the period ending March 31, 2024:

4.2.1 Q3 Budget Report

4.2.2 Q3 Utilization Report

4.2.3 Contract Status Report

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

JOY GRIMMER
Board Chair

AGENDA ITEM

[X] Action Item

[ ] Information Only

Date: July 25, 2024

Item Number: 4.2.3

Title: Contract Status Report

Summary

This report addresses the status of PEBP contracts to include:

1. Contract Overview
2. New Contracts for approval
3. Contract Amendments for approval
4. Contract Solicitations for approval
5. Status of Current Solicitations

10.1 Contracts Overview

Below is a listing of the active PEBP contracts as of June 30, 2024.

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	$ 61,875.00	$ 324,625.00
Health Plan of Nevada Inc	Southern Nevada HMO	23802	7/1/2021	6/30/2025	$ 192,093,848.00	$ 126,398,967.30	$ 65,694,880.70
Diversified Dental Services Inc.	Dental PPO	23810	7/1/2021	6/30/2026	$ 1,601,613.00	$ 952,288.67	$ 649,324.33
Lifeworks/Telus Health	Benefits Management System	25935	5/10/2022	12/31/2026	$ 6,145,600.00	$ 3,107,170.58	$ 3,038,429.42
Express Scripts, Inc.	Pharmacy Benefit Manager	25582	5/10/2022	6/30/2026	$ 332,109,496.00	$ 171,625,600.02	$ 160,483,895.98
*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	$ 8,596,317.13	$ 4,227,930.87
Brown & Brown of Massachusetts	Health Plan Auditor	24030	4/13/2021	6/30/2027	$ 1,581,662.00	$ 559,695.00	$ 1,021,967.00
Segal Company, Inc.	Consulting Services	25557	7/1/2022	6/30/2027	$ 4,285,410.00	$ 1,486,710.00	$ 2,798,700.00
Capitol Reporters	Court Reporting	27029	2/1/2023	6/30/2025	$ 31,932.00	$ 9,018.00	$ 22,914.00
Carrum Health	Centers of Excellence	28745	2/12/2024	6/30/2028	$ 4,000,000.00	$ -	$ 4,000,000.00
Carrum Health	Oncology Concierge	29053	5/14/2024	6/30/2028	$ 1,490,000.00	$ -	$ 1,490,000.00
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.

Recommendation

No action necessary

10.2 New Contracts

NO NEW CONTRACTS

Recommendation

No action necessary

10.3 Contract Amendment Ratifications

NO NEW CONTRACT AMENDMENTS

Recommendation

No action necessary.

10.4 Contract Solicitation Ratifications

PEBP does not currently have any contract solicitations for ratification.

10.5 Status of Current Solicitations

The chart below provides information on the status of PEBP's in-progress solicitations:

Service	Anticipated/ Actual RFP release date	Anticipated/ Actual NOI	Winning Vendor	Anticipated Board Approval
HMO Vendor	08/2024	10/2024	TBA	11/2024
Medicare Exchange Vendor	09/2024	11/2024	TBA	11/2024

4.3

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2024:

4.3.1 Q3 UMR – Obesity Care Management

4.3.2 Q3 UMR – Diabetes Care Management

4.3.3 Q3 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network

4.3.4 Q3 UnitedHealthcare – Basic Life Insurance

4.3.5 Q3 Express Scripts – Summary Report

4.3.6 Q3 Express Scripts – Utilization Report

4.3.7 UMR – Performance Guarantee Report

4.3.8 Doctor on Demand – Engagement Report

4.3.9 Real Appeal – Utilization Report

4.3.1

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2024:

4.3.1 Q3 UMR – Obesity Care Management

DATASCOPE™

Obesity Care Management Report

Nevada Public Employees' Benefits Program

July 2023 – March 2024 Incurred,

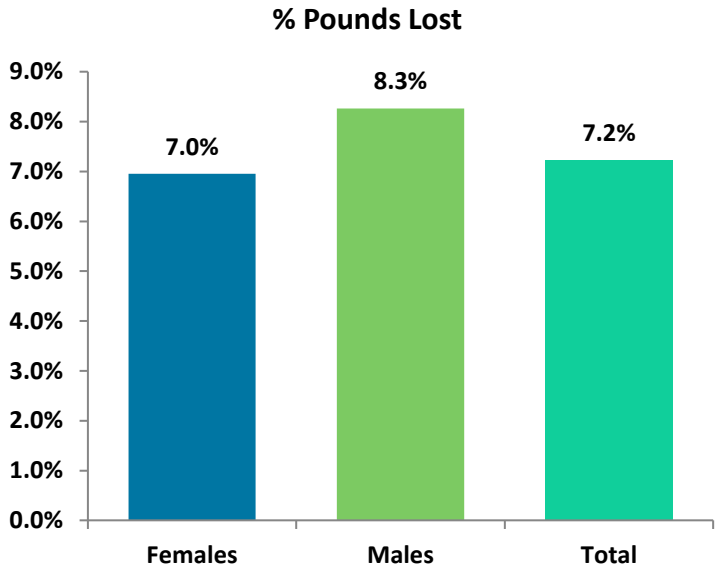
Paid through May 31, 2024

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

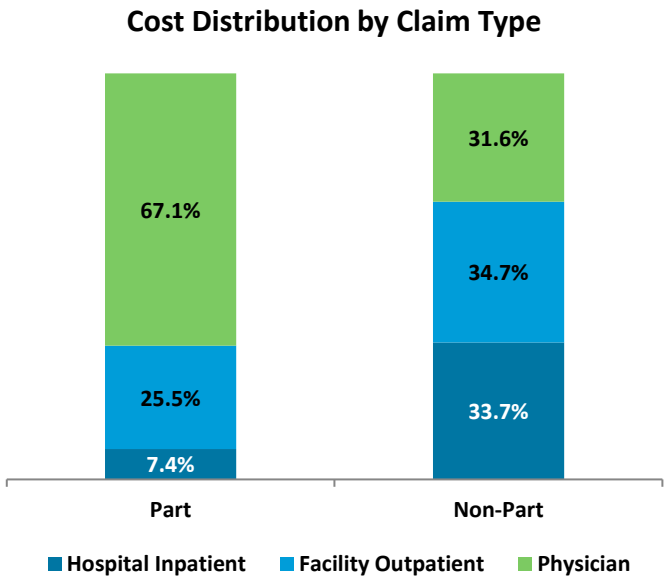
3Q24			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	235	48	283
Average # Lbs. Lost	15.4	23.2	16.7
Total # Lbs. Lost	3,612.2	1,112.8	4,725.0
% Lbs. Lost	7.0%	8.3%	7.2%
Average Cost/ Member	$5,238	$4,071	$5,040



Obesity Care Management – Financial Summary

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	259	1,498	-82.7%
Avg # Members	282	1,792	-84.3%
Member/Employee Ratio	1.1	1.2	-9.2%
Financial Summary			
Gross Cost	$1,313,560	$18,408,137	
Client Paid	$1,037,100	$15,811,161	
Employee Paid	$276,460	$2,596,976	
Client Paid-PEPY	$5,337	$14,073	-62.1%
Client Paid-PMPY	$4,902	$11,767	-58.3%
Client Paid-PEPM	$445	$1,173	-62.1%
Client Paid-PMPM	$408	$981	-58.4%
High Cost Claimants (HCC's) > $100k			
# of HCC's	0	20	
HCC's / 1,000	0.0	11.2	0.0%
Avg HCC Paid	$0	$244,982	0.0%
HCC's % of Plan Paid	0.0%	31.0%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$364	$3,965	-90.8%
Facility Outpatient	$1,248	$4,080	-69.4%
Physician	$3,290	$3,722	-11.6%
Total	$4,902	$11,767	-58.3%
	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



Obesity Care Management – Utilization Summary

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

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	9	196	
# of Bed Days	21	1,356	
Paid Per Admit	$10,679	$31,542	-66.1%
Paid Per Day	$4,577	$4,559	0.4%
Admits Per 1,000	43	146	-70.5%
Days Per 1,000	99	1,009	-90.2%
Avg LOS	2.3	6.9	-66.7%
# of Admits From ER	4	112	-96.4%
Physician Office			
OV Utilization per Member	18.6	10.3	80.6%
Avg Paid per OV	$113	$106	6.6%
Avg OV Paid per Member	$2,113	$1,092	93.5%
DX&L Utilization per Member	18.0	25.5	-29.4%
Avg Paid per DX&L	$41	$72	-43.1%
Avg DX&L Paid per Member	$739	$1,828	-59.6%
Emergency Room			
# of Visits	47	457	
Visits Per Member	0.22	0.34	-35.3%
Visits Per 1,000	222	340	-34.7%
Avg Paid per Visit	$3,386	$3,423	-1.1%
Urgent Care			
# of Visits	117	721	
Visits Per Member	0.55	0.54	1.9%
Visits Per 1,000	553	537	3.0%
Avg Paid per Visit	$88	$105	-16.2%
	Annualized	Annualized	

4.3.2

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2024:

4.3.1 Q3 UMR – Obesity Care Management

4.3.2 Q3 UMR – Diabetes Care Management

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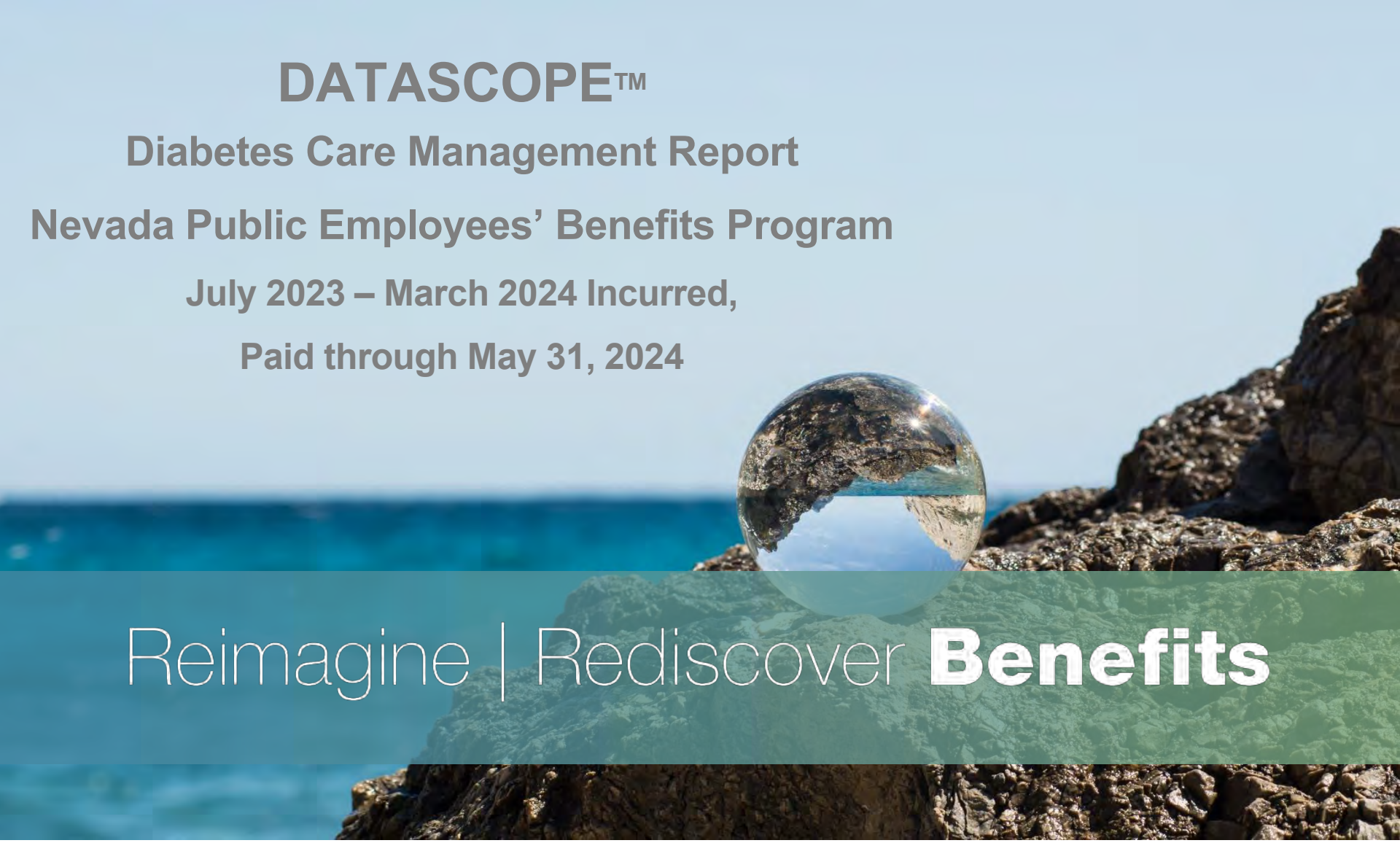
Diabetes Care Management Report

Nevada Public Employees' Benefits Program

July 2023 – March 2024 Incurred,

Paid through May 31, 2024

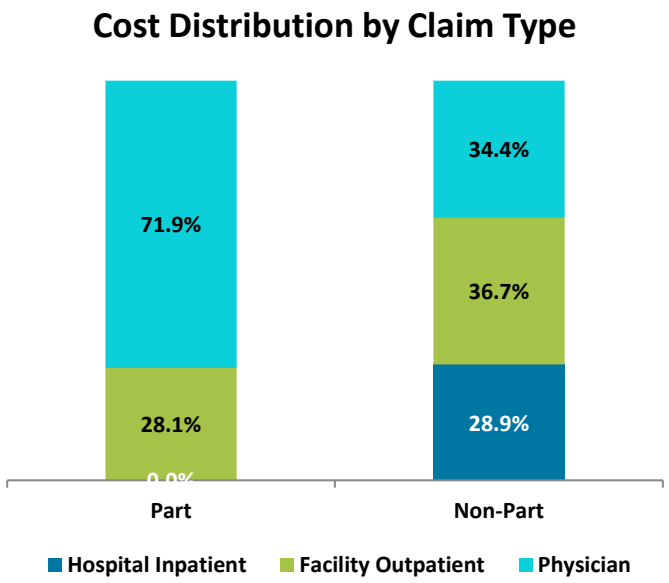


UMR℠

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	3	2,582	-99.9%
Avg # Members	5	3,233	-99.8%
Member/Employee Ratio	1.7	1.3	33.6%
Financial Summary			
Gross Cost	$12,306	$28,996,342	
Client Paid	$6,031	$24,646,239	
Employee Paid	$6,275	$4,350,103	
Client Paid-PEPY	$2,680	$12,726	-78.9%
Client Paid-PMPY	$1,608	$10,164	-84.2%
Client Paid-PEPM	$223	$1,060	-79.0%
Client Paid-PMPM	$134	$847	-84.2%
High Cost Claimants (HCC's) > $100k			
# of HCC's	0	42	
HCC's / 1,000	0.0	13.0	0.0%
Avg HCC Paid	$0	$212,956	-100.0%
HCC's % of Plan Paid	0.0%	36.3%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$0	$2,942	-100.0%
Facility Outpatient	$452	$3,726	-87.9%
Physician	$1,156	$3,495	-66.9%
Total	$1,608	$10,164	-84.2%
	Annualized	Annualized	



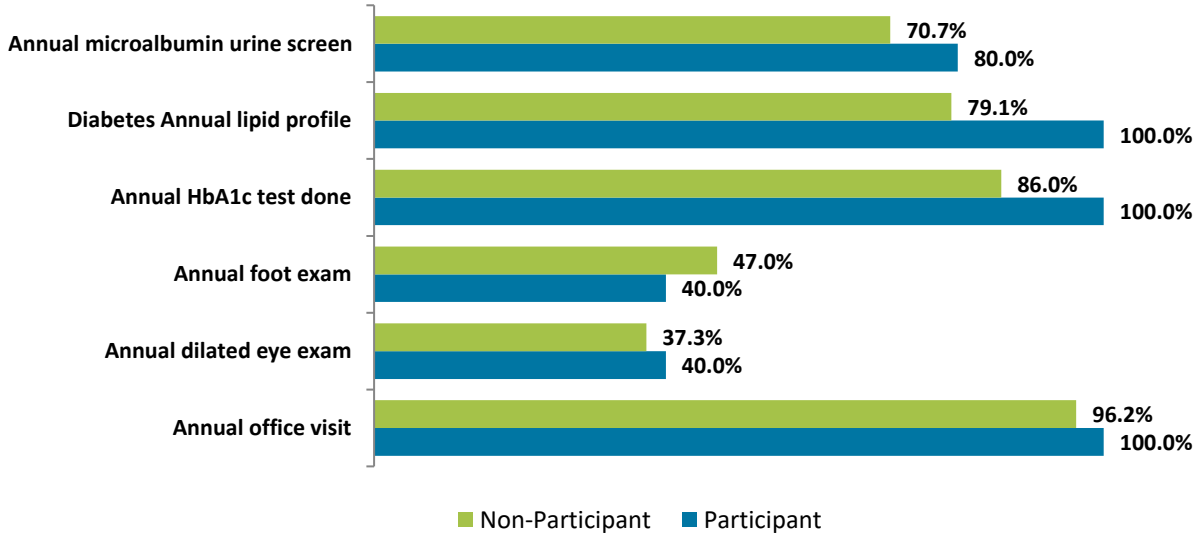
Diabetes Care Management – Utilization Summary

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

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	0	272	
# of Bed Days	0	1,709	
Paid Per Admit	$0	$30,953	-100.0%
Paid Per Day	$0	$4,926	-100.0%
Admits Per 1,000	0	112	-100.0%
Days Per 1,000	0	705	-100.0%
Avg LOS	0	6.3	-100.0%
# of Admits From ER	0	200	-100.0%
Physician Office			
OV Utilization per Member	6.9	8.9	-22.5%
Avg Paid per OV	$115	$115	0.0%
Avg OV Paid per Member	$798	$1,020	-21.8%
DX&L Utilization per Member	29.3	24.7	18.6%
Avg Paid per DX&L	$26	$63	-58.7%
Avg DX&L Paid per Member	$752	$1,558	-51.7%
Emergency Room			
# of Visits	0	688	
Visits Per Member	0.00	0.28	-100.0%
Visits Per 1,000	0	284	-100.0%
Avg Paid per Visit	$0	$3,210	-100.0%
Urgent Care			
# of Visits	0	1019	
Visits Per Member	0.00	0.42	-100.0%
Visits Per 1,000	0	420	-100.0%
Avg Paid per Visit	$0	$93	-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%	3,004	2,891	113	96.2%
	Annual dilated eye exam	5	2	3	40.0%	3,004	1,121	1,883	37.3%
	Annual foot exam	5	2	3	40.0%	3,004	1,412	1,592	47.0%
	Annual HbA1c test done	5	5	0	100.0%	3,004	2,582	422	86.0%
	Diabetes Annual lipid profile	5	5	0	100.0%	3,004	2,377	627	79.1%
	Annual microalbumin urine screen	5	4	1	80.0%	3,004	2,125	879	70.7%



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

4.3.3

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2024:

4.3.1 Q3 UMR – Obesity Care Management

4.3.2 Q3 UMR – Diabetes Care Management

4.3.3 Q3 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network

Network Repricing Quality - UMR		
PEBP PG Target	97%	
Q1 Results	98.3%	
Q2 Results	97.9%	
Q3 Results	97.3%	
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	99.5%	99.5%
Q3 Results	99.5%	99.5%
Q4 Results		

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

4.3.4

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2024:

4.3.1 Q3 UMR – Obesity Care Management

4.3.2 Q3 UMR – Diabetes Care Management

4.3.3 Q3 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network

4.3.4 Q3 UnitedHealthcare – Basic Life Insurance

370074 State of Nevada Public Employees' Benefits Program
Life Performance Gurantees

Service	Metric	Measurement	How Measured	Fee At Risk	Owner	Due to internal account management team by	Results	Guarantee Currently Met?
Client Implementation	Enrollment materials	Enrollment materials completed/shipped within agreed upon timeframe	Implementation Tracking	.3% of premium			N/A	Yes
	Draft certificate issued	30 days from receipt of set up information	Implementation Tracking	.3% of premium			N/A	Yes
	System Readiness	Systems ready for claims/customer service within the following days from receipt of complete set up information - 45 days list billed groups (excludes EDI) - 30 days for self billed groups	Implementation Tracking	.3% of premium			N/A	Yes
Claim Processing	Life Claims - Timeliness of claim payment	97% of claims processed within 10 days of receipt of complete information	Claim Turn Around Reports	.3% of premium	Karen Bogdan	6/14/2024	98.4%	Yes
	Complete Life Claim – Decision	97% of claims approved and payment issued, or claims denied and letter mailed in five business days following receipt of all information necessary to make a claim decision.	Internal Claims Audit	.3% of premium	Karen Bogdan	6/14/2024	75.6%	No
	Life Claims - Accuracy of claim payment	98% of claims processed accurately	Internal Claims Audit	.3% of premium	Karen Bogdan	6/14/2024	100.0%	Yes
Employer Reporting	Accurate reporting provided 45 days after the end of the quarter	Claim reporting sent out to employer	Claim Turn Around Reports	.3% of premium	Account Management			
Claim Customer Service *	Average speed of answer	80% in less than 30 seconds	Call Center Statistics	.3% of premium	Karen Bogdan	6/14/2024	31	No
	Abandonment Rate	<5% abandonment rate	Call Center Statistics	.3% of premium	Karen Bogdan	6/14/2024	1.8%	Yes
Account Management	Client Satisfaction	UHCSB performs satisfactory ongoing, day-to-day account management in the opiniion of the client's HR and/or benefits staff.	Claim Turn Around Reports	.3% of premium	Account Management			
			Total at Risk	**The lesser of 3% or $50,000**				

4.3.5

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2024:

- 4.3.1 Q3 UMR – Obesity Care Management
- 4.3.2 Q3 UMR – Diabetes Care Management
- 4.3.3 Q3 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network
- 4.3.4 Q3 UnitedHealthcare – Basic Life Insurance
- **4.3.5 Q3 Express Scripts – Summary Report**

Nevada PEBP

Q3 FY2024

Prepared by Client Analytics

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

6/04/2024

**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 Q3 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	**$74.39**	
Utilization	$2.28	3.3%
Unit Cost	$3.51	5.1%
Member Share	($0.37)	(0.5%)
Total Change in Plan Cost Net PMPM	**$5.41**	**7.8%**
Previous Period - Plan Cost Net PMPM	**$68.98**	

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

- **Cancer**: Previous ranked 2nd, currently ranked 2nd by Plan Cost Net.
  - Plan Cost Net ↓ $711k (22.3%) to current $2.5m.
  - Plan Cost Net PMPM ↓ $1.40 (11.0%) to current $11.40.
  - Patient Count ↓ 5 to current count of 224.
  - Adjusted Rxs ↓ 66 to current count of 1,419.

- **Notable Drug Changes within Indication:**

  - **Revlimid:**
    - Previous ranked 1st, currently ranked 8th by Plan Cost Net.
    - Plan Cost Net ↓ $354k (75.9%) to current $113k.
    - Plan Cost Net PMPM ↓ $1.35 (72.3%) to current $.52.
    - Patient Count ↓ 2 to current count of 2.
    - Adjusted Rxs ↓ 19 to current count of 10.

  - **Ibrance:**
    - Previous ranked 2nd, currently ranked 6th by Plan Cost Net.
    - Plan Cost Net ↓ $277k (70.5%) to current $116k.
    - Plan Cost Net PMPM ↓ $1.04 (66.2%) to current $.53.
    - Patient Count ↓ 2 to current count of 2.
    - Adjusted Rxs ↓ 24 to current count of 8.

- **Lenalidomide (Generic for Revlimid):**
  - Previous ranked 12th, currently ranked 1st by Plan Cost Net.
  - Plan Cost Net ↑ $188k (177.8%) to current $294k.
  - Plan Cost Net PMPM ↑ $.93 (218.2%) to current $1.35.
  - Patient Count: Remains at 3.
  - Adjusted Rxs ↑ 15 to current count of 23.

- **Vaccinations**: Previous ranked 5th, currently ranked 5th by Plan Cost Net.
  - Plan Cost Net ↑ $387k (54.8%) to current $1.1m.
  - Plan Cost Net PMPM ↑ $2.19 (77.3%) to current $5.01.
  - Patient Count ↓ 1,889 to current count of 5,135.
  - Adjusted Rxs ↓ 2,459 to current count of 9,677.

- **Notable Drug Changes within Indication:**

  - **Comirnaty 2023-2024 (COVID):**
    - New, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net: New, current $264k.
    - Plan Cost Net PMPM: New, current $1.21.
    - Patient Count: New, current count of 1,846.
    - Adjusted Rxs: New, current count of 1,861.

  - **Spikevax 2023-2024 (COVID):**
    - New, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net: New, current $198k.
    - Plan Cost Net PMPM: New, current $.91.
    - Patient Count: New, current count of 1,303.
    - Adjusted Rxs: New, current count of 1,306.

  - **Arexvy (RSV):**
    - New, currently ranked 3rd by Plan Cost Net.
    - Plan Cost Net: New, current $156k.
    - Plan Cost Net PMPM: New, current $.71.
    - Patient Count: New, current count of 576.
    - Adjusted Rxs: New, current count of 576.

- **Ophthalmic Conditions**: Previous ranked 21st, currently ranked 7th by Plan Cost Net.
  - Plan Cost Net ↑ $472k (261.7%) to current $652k.
  - Plan Cost Net PMPM ↑ $2.27 (314.3%) to current $2.99.
  - Patient Count ↓ 29 to current count of 285.
  - Adjusted Rxs ↑ 11 to current count of 669.

- **Notable Drug Changes within Indication:**

  - **Tepezza:**
    - Previous ranked 2nd, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $396k (686.5%) to current $453k.
    - Plan Cost Net PMPM ↑ $1.85 (801.0%) to current $2.08.
    - Patient Count: Remains at 1.
    - Adjusted Rxs ↑ 7 to current count of 8.

  - **Eylea:**
    - Previous ranked 1st, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net ↑ $54k (78.1%) to current $123k.
    - Plan Cost Net PMPM ↑ $.29 (104.0%) to current $.56.
    - Patient Count ↑ 2 to current count of 13.
    - Adjusted Rxs ↑ 32 to current count of 71.

  - **Oxervate:**
    - New, currently ranked 3rd by Plan Cost Net.
    - Plan Cost Net: New, current $57k.
    - Plan Cost Net PMPM: New, current $.26.
    - Patient Count: New, current count of 1.
    - Adjusted Rxs: New, current count of 3.

Peer Comparison:

- Peer: ESI CDH Program
- PEBP CDHP is outperforming the peer.
- Peer experienced Plan Cost Net PMPM of $79.59 compared to CDHP PEBP of $74.39.
- Peer experienced Trend of 12.0%, compared to CDHP PEBP Trend of 7.8%.

EPO Overall Trend Summaries:

EPO Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$167.99**	
Utilization	$7.87	5.3%
Unit Cost	$9.11	6.1%
Member Share	$1.67	1.1%
Total Change in Plan Cost Net PMPM	**$18.66**	**12.5%**
Previous Period - Plan Cost Net PMPM	**$149.33**	

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

- **Inflammatory Conditions**: Previous ranked 1st, currently ranked 1st by Plan Cost Net.
  - Plan Cost Net ↓ $138k (7.4%) to current $1.7m.
  - Plan Cost Net PMPM ↑ $1.39 (4.3%) to current $33.28.
  - Patient Count ↓ 13 to current count of 134.
  - Adjusted Rxs ↓ 43 to current count of 1,085.

- **Notable Drug Changes within Indication:**

  - **Humira (CF) Pen:**
    - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↓ $225k (27.7%) to current $588k.
    - Plan Cost Net PMPM ↓ $2.58 (18.6%) to current $11.32.
    - Patient Count ↓ 3 to current count of 22.
    - Adjusted Rxs ↓ 15 to current count of 172.

  - **Tavneos:**
    - New, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net: New, current $182k.
    - Plan Cost Net PMPM: New, current $3.51.
    - Patient Count: New, current count of 2.
    - Adjusted Rxs: New, current count of 14.

  - **Skyrizi Pen:**
    - Previous ranked 2nd, currently ranked 3rd by Plan Cost Net.
    - Plan Cost Net ↓ $40k (24.7%) to current $122k.
    - Plan Cost Net PMPM ↓ $.42 (15.1%) to current $2.35.
    - Patient Count ↓ 1 to current count of 5.
    - Adjusted Rxs ↓ 16 to current count of 37.

- **Diabetes**: Previous ranked 2nd, currently ranked 2nd by Plan Cost Net.
  - Plan Cost Net ↑ $135k (11.5%) to current $1.3m.
  - Plan Cost Net PMPM ↑ $5.16 (25.6%) to current $25.31.
  - Patient Count ↓ 14 to current count of 608.
  - Adjusted Rxs ↓ 32 to current count of 8,503.

- **Notable Drug Changes within Indication:**

    - **Ozempic:**
        - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
        - Plan Cost Net ↑ $108k (37.8%) to current $393k.
        - Plan Cost Net PMPM ↑ $2.69 (55.2%) to current $7.57.
        - Patient Count ↑ 10 to current count of 131.
        - Adjusted Rxs ↑ 198 to current count of 870.

    - **Mounjaro:**
        - Previous ranked 4th, currently ranked 2nd by Plan Cost Net.
        - Plan Cost Net ↑ $139k (136.2%) to current $241k.
        - Plan Cost Net PMPM ↑ $2.90 (166.1%) to current $4.64.
        - Patient Count ↑ 29 to current count of 79.
        - Adjusted Rxs ↑ 259 to current count of 480.

    - **Trulicity:**
        - Previous ranked 2nd, currently ranked 3rd by Plan Cost Net.
        - Plan Cost Net ↓ $53k (27.4%) to current $140k.
        - Plan Cost Net PMPM ↓ $.60 (18.2%) to current $2.70.
        - Patient Count ↓ 17 to current count of 53.
        - Adjusted Rxs ↓ 149 to current count of 327.

- **Endocrine Disorders**: Previous ranked 3rd, currently ranked 3rd by Plan Cost Net.
    - Plan Cost Net ↑ $245k (29.4%) to current $1.1m.
    - Plan Cost Net PMPM ↑ $6.52 (45.8%) to current $20.76.
    - Patient Count ↓ 6 to current count of 27.
    - Adjusted Rxs ↓ 3 to current count of 166.

- **Notable Drug Changes within Indication:**

    - **Korlym:**
        - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
        - Plan Cost Net ↑ $233k (30.1%) to current $1m.
        - Plan Cost Net PMPM ↑ $6.16 (46.6%) to current $19.38.
        - Patient Count: Remains at 2.
        - Adjusted Rxs ↑ 6 to current count of 17.

    - **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 $104.56 compared to PEBP EPO of $167.99
- Peer experienced Trend of 9.8%, compared to PEBP EPO of 12.5%

PPO Overall Trend Summaries:

PPO Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$99.19**	
Utilization	$2.23	2.7%
Unit Cost	$13.95	16.9%
Member Share	$0.63	0.8%
Total Change in Plan Cost Net PMPM	**$16.80**	**20.4%**
Previous Period - Plan Cost Net PMPM	**$82.39**	

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

- **Inflammatory Conditions**: Previous ranked 1st, currently ranked 1st by Plan Cost Net.
  - Plan Cost Net ↑ $1.1m (54.4%) to current $3.2m.
  - Plan Cost Net PMPM ↑ $2.52 (15.6%) to current $18.68.
  - Patient Count ↑ 74 to current count of 256.
  - Adjusted Rxs ↑ 580 to current count of 1,914.

- **Notable Drug Changes within Indication:**

  - **Humira (CF) Pen:**
    - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $143k (23.0%) to current $765k.
    - Plan Cost Net PMPM ↓ $.39 (7.9%) to current $4.51.
    - Patient Count ↑ 7 to current count of 35.
    - Adjusted Rxs ↑ 80 to current count of 241.

  - **Stelara:**
    - Previous ranked 3rd, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net ↑ $243k (128.9%) to current $432k.
    - Plan Cost Net PMPM ↑ $1.06 (71.4%) to current $2.55.
    - Patient Count ↑ 5 to current count of 13.
    - Adjusted Rxs ↑ 40 to current count of 96.

- **Rinvoq:**
  - Previous ranked 8th, currently ranked 5th by Plan Cost Net.
  - Plan Cost Net ↑ $162k (187.6%) to current $248k.
  - Plan Cost Net PMPM ↑ $.78 (115.3%) to current $1.46.
  - Patient Count ↑ 8 to current count of 12.
  - Adjusted Rxs ↑ 57 to current count of 82.

- **Diabetes**: Previous ranked 2nd, currently ranked 2nd by Plan Cost Net.
  - Plan Cost Net ↑ $1.3m (91.3%) to current $2.6m.
  - Plan Cost Net PMPM ↑ $4.67 (43.2%) to current $15.46.
  - Patient Count ↑ 507 to current count of 1,410.
  - Adjusted Rxs ↑ 6,185 to current count of 17,185.

- **Notable Drug Changes within Indication:**

  - **Ozempic:**
    - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $421k (118.9%) to current $775k.
    - Plan Cost Net PMPM ↑ $1.78 (63.9%) to current $4.57.
    - Patient Count ↑ 120 to current count of 285.
    - Adjusted Rxs ↑ 863 to current count of 1,730.

  - **Mounjaro:**
    - Previous ranked 4th, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net ↑ $504k (494.3%) to current $605k.
    - Plan Cost Net PMPM ↑ $2.77 (344.9%) to current $3.57.
    - Patient Count ↑ 134 to current count of 197.
    - Adjusted Rxs ↑ 990 to current count of 1,212.

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

- **Enzyme Deficiencies**: Previous ranked 6th, currently ranked 4th by Plan Cost Net.
  - Plan Cost Net ↑ $771k (197.5%) to current $1.2m.
  - Plan Cost Net PMPM ↑ $3.77 (122.7%) to current $6.84.
  - Patient Count ↑ 3 to current count of 6.
  - Adjusted Rxs ↑ 22 to current count of 37.

- **Notable Drug Changes within Indication:**

  - **Nexviazyme:**
    - Previous ranked 3rd, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $540k (1112.9%) to current $588k.
    - Plan Cost Net PMPM ↑ $3.08 (808.1%) to current $3.47.
    - Patient Count: Remains at 1.
    - Adjusted Rxs ↑ 8 to current count of 9.

  - **Galafold:**
    - New, currently ranked 3rd by Plan Cost Net.
    - Plan Cost Net: New, current $147k.
    - Plan Cost Net PMPM: New, current $.87.
    - Patient Count: New, current count of 1.
    - Adjusted Rxs: New, current count of 5.

  - **Palnziq:**
    - New, currently ranked 4th by Plan Cost Net.
    - Plan Cost Net: New, current $111k.
    - Plan Cost Net PMPM: New, current $.66.
    - Patient Count: New, current count of 1.
    - Adjusted Rxs: New, current count of 8.

Peer Comparison:

- Government – West Region/SaveOn (custom peer created for PEBP PPO plan)
- The PEBP PPO is outperforming the peer in Plan Cost Net PMPM, however peer experienced lower trend.
- Peer experienced Plan Cost Net PMPM of $104.56 compared to PEBP PPO of $99.19.
- Peer experienced Trend of 9.8%, compared to PEBP PPO of 20.4%.

Total Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$95.03**	
Utilization	$2.34	2.8%
Unit Cost	$7.83	9.4%
Member Share	$1.16	1.4%
Total Change in Plan Cost Net PMPM	**$11.32**	**13.5%**
Previous Period - Plan Cost Net PMPM	**$83.71**	

Summary of Total – Overall the main driver of Trend was Specialty Utilization driven by an increase of 9.5% in Specialty patients. This resulted in a 16.9% increase in Specialty Days of Therapy.

Overall Trend was mitigated by increased rebates of 37.5%. This produced a negative Unit Cost Trend of (4.0%) on Specialty drugs and reduced Non-Specialty Unit Cost Trend to 10.0%, combined Unit Cost Trend is 9.4%.

Member Cost contributed to Trend on Non-Specialty drugs and was flat on Specialty drugs. This is due to Drug Mix on Non-Specialty drugs, which was primary driven by utilization of more expensive brand drugs.

Key Statistics:

Nevada PEBP Total			
Description	Q3 FY24	Q3 FY23	Change
Average Members per Month	48,814	48,328	1.0%
Number of Unique patients	34,916	36,034	-3.1%
Members Utilizing the Benefit	71.5%	74.6%	-3.0
Gross Cost/Adjusted Rx	$100.86	$91.68	10.0%
Plan Spend	$63,879,300	$52,503,413	21.7%
Rebates (estimated)	$22,129,313	$16,094,911	37.5%
Plan Cost Net	$41,749,987	$36,408,502	14.7%
Plan Cost Net PMPM	$95.03	$83.71	13.5%
Non-Specialty Plan Cost Net PMPM	$44.09	$38.11	15.7%
Specialty Plan Cost Net PMPM	$50.94	$45.60	11.7%
Generic Fill Rate	86.4%	85.1%	1.2
90 Day Utilization	60.4%	61.7%	-1.3
Retail - Maintenance 90 Utilization	28.3%	28.8%	-0.5
Home Delivery Utilization	32.1%	32.8%	-0.7
Member Cost Net %	25.4%	26.3%	-0.9

END OF REPORT

4.3.6

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2024:

- 4.3.1 Q3 UMR – Obesity Care Management
- 4.3.2 Q3 UMR – Diabetes Care Management
- 4.3.3 Q3 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network
- 4.3.4 Q3 UnitedHealthcare – Basic Life Insurance
- 4.3.5 Q3 Express Scripts – Summary Report
- **4.3.6 Q3 Express Scripts – Utilization Report**

Nevada PEBP Q3 FY24 Report

7/1/2023 – 3/31/2024

Report Includes:

- CDHP Comparison Data from Q3 FY23 to Q3 FY24
- EPO Comparison Data from Q3 FY23 to Q3 FY24
- PPO Comparison Data from Q3 FY23 to Q3 FY24
- CDHP, EPO, PPO Breakout Data from Q3 FY23 to Q3 FY24
- Summary Comparison Data from Q3 FY24
- Key Metric Breakout Data from Q3 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)
6/04/24

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN
+ Q3 FY24 vs Q3 FY23

Membership Summary	Q3 FY 2024	Q3 FY 2023	Change
Member Count (Membership)	48,814	48,328	1.0%
Utilizing Member Count (Patients)	34,916	36,034	-3.1%
Percent Utilizing (Utilization)	71.5%	74.6%	-3.1

Claim Summary	Q3 FY 2024	Q3 FY 2023	Change
Net Claims (Total Adjusted Rx's)	554,802	538,845	3.0%
Claims per Elig Member per Month (Claims PMPM)	1.26	1.24	1.9%
Total Claims for Generic (Generic ARx)	479,133	458,650	4.5%
Total Claims for Brand (Brand ARx)	75,669	80,195	-5.6%
Total Claims for Multisource Brand Claims (MSB ARx)	2,546	2,423	5.1%
Total Non-Specialty Claims	548,203	533,116	2.8%
Total Specialty Claims	6,599	5,729	15.2%
Generic % of Total Claims (GFR)	**86.4%**	**85.1%**	**1.3**
Generic Effective Rate (GCR)	99.5%	99.5%	0.0
Mail Order Claims	156,938	154,658	1.5%
Mail Penetration Rate*	32.1%	32.8%	-0.7

Claims Cost Summary	Q3 FY 2024	Q3 FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$78,086,072**	**$65,494,155**	**19.2%**
Total Generic Gross Cost	$8,210,943	$7,811,056	5.1%
Total Brand Gross Cost	$69,875,129	$57,683,100	21.1%
Total MSB Gross Cost	$1,222,304	$1,309,102	-6.6%
Total Ingredient Cost	$75,676,059	$63,279,365	19.6%
Total Dispensing Fee	$2,351,149	$2,138,045	10.0%
Total Other (e.g. tax)	$58,864	$76,746	-23.3%
Avg Total Cost per Claim (Gross Cost/ARx)	**$140.75**	**$121.55**	**15.8%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$17.14	$17.03	0.6%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$923.43	$719.29	28.4%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$480.09	$540.28	-11.1%

Express Scripts
By EVERNORTH
Confidential Information

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN

+ Q3 FY24 vs Q3 FY23

Member Cost Summary	Q3 FY 2024	Q3 FY 2023	Change
Total Member Cost Share	**$14,206,772**	**$12,990,742**	**9.4%**
Generic Cost Share	$3,249,948	$3,057,097	6.3%
Brand Cost Share	$10,956,824	$9,933,645	10.3%
MSB Cost Share	$182,213	$240,726	-24.3%
Total Copay	$12,795,961	$11,360,016	12.6%
Total Deductible	$1,410,811	$1,630,726	-13.5%
Avg Copay per Claim (Member Cost Share/ARx)	**$25.61**	**$24.11**	**6.2%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.78	$6.67	1.8%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$144.80	$123.87	16.9%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$71.57	$99.35	-28.0%
Copay % of Total Prescription Cost (Member Cost Share %)	**18.2%**	**19.8%**	**-1.6**

Plan Cost Summary	Q3 FY 2024	Q3 FY 2023	Change
Total Plan Cost (Plan Cost)	**$63,879,300**	**$52,503,413**	**21.7%**
Generic Plan Cost	$4,960,995	$4,753,958	4.4%
Brand Plan Cost	$58,918,305	$47,749,454	23.4%
MSB Plan Cost	$1,040,090	$1,068,376	-2.6%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$30,285,422	$25,795,287	17.4%
Total Specialty Drug Cost (Specialty Plan Cost)	$33,593,879	$26,708,126	25.8%
Avg Plan Cost per Claim (Plan Cost/ARx)	$115.14	$97.44	18.2%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$10.35	$10.37	-0.1%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$778.63	$595.42	30.8%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$408.52	$440.93	-7.4%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$55.24	$48.39	14.2%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$5,090.75	$4,661.92	9.2%
Plan Cost PMPM	**$145.40**	**$120.71**	**20.5%**
Non-Specialty Plan Cost PMPM	$68.94	$59.31	16.2%
Specialty Plan Cost PMPM	$76.47	$61.40	24.5%
Specialty % of Plan Cost	52.6%	50.9%	1.7
Net Plan Cost PMPM (factoring Rebates)	**$95.03**	**$83.71**	**13.5%**
Non-Specialty Plan Cost PMPM	$44.09	$38.11	15.7%
Specialty Plan Cost PMPM	$50.94	$45.60	11.7%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN

+ Q3 FY24 vs Q3 FY23

Membership Summary	Q3 FY 2024	Q3 FY 2023	Change
Member Count (Membership)	24,197	27,720	-12.7%
Utilizing Member Count (Patients)	16,420	19,800	-17.1%
Percent Utilizing (Utilization)	67.9%	71.4%	-3.5

Claim Summary	Q3 FY 2024	Q3 FY 2023	Change
Net Claims (Total Adjusted Rx's)	254,470	285,096	-10.7%
Claims per Elig Member per Month (Claims PMPM)	1.17	1.14	2.3%
Total Claims for Generic (Generic ARx)	222,058	244,153	-9.0%
Total Claims for Brand (Brand ARx)	32,412	40,943	-20.8%
Total Claims for Multisource Brand Claims (MSB ARx)	921	1,131	-18.6%
Total Non-Specialty Claims	251,565	282,186	-10.9%
Total Specialty Claims	2,905	2,910	-0.2%
Generic % of Total Claims (GFR)	**87.3%**	**85.6%**	**1.7**
Generic Effective Rate (GCR)	99.6%	99.5%	0.0
Mail Order Claims	69,807	79,193	-11.9%
Mail Penetration Rate*	31.2%	31.9%	-0.7

Claims Cost Summary	Q3 FY 2024	Q3 FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$32,565,038**	**$32,496,133**	**0.2%**
Total Generic Gross Cost	$3,324,684	$3,846,786	-13.6%
Total Brand Gross Cost	$29,240,354	$28,649,347	2.1%
Total MSB Gross Cost	$402,567	$636,697	-36.8%
Total Ingredient Cost	$31,451,608	$31,327,047	0.4%
Total Dispensing Fee	$1,091,671	$1,133,208	-3.7%
Total Other (e.g. tax)	$21,758	$35,878	-39.4%
Avg Total Cost per Claim (Gross Cost/ARx)	**$127.97**	**$113.98**	**12.3%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$14.97	$15.76	-5.0%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$902.15	$699.74	28.9%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$437.10	$562.95	-22.4%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN
+ Q3 FY24 vs Q3 FY23

Member Cost Summary	Q3 FY 2024	Q3 FY 2023	Change
Total Member Cost Share	**$7,303,881**	**$7,633,929**	**-4.3%**
Generic Cost Share	$1,508,430	$1,673,415	-9.9%
Brand Cost Share	$5,795,451	$5,960,514	-2.8%
MSB Cost Share	$106,214	$184,123	-42.3%
Total Copay	$5,894,999	$6,005,678	-1.8%
Total Deductible	$1,408,882	$1,628,252	-13.5%
Avg Copay per Claim (Member Cost Share/ARx)	**$28.70**	**$26.78**	**7.2%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.79	$6.85	-0.9%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$178.81	$145.58	22.8%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$115.32	$162.80	-29.2%
Copay % of Total Prescription Cost (Member Cost Share %)	**22.4%**	**23.5%**	**-1.1**

Plan Cost Summary	Q3 FY 2024	Q3 FY 2023	Change
Total Plan Cost (Plan Cost)	**$25,261,156**	**$24,862,204**	**1.6%**
Generic Plan Cost	$1,816,253	$2,173,371	-16.4%
Brand Plan Cost	$23,444,903	$22,688,833	3.3%
MSB Plan Cost	$296,353	$452,575	-34.5%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$10,589,174	$10,946,413	-3.3%
Total Specialty Drug Cost (Specialty Plan Cost)	$14,671,982	$13,915,791	5.4%
Avg Plan Cost per Claim (Plan Cost/ARx)	$99.27	$87.21	13.8%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$8.18	$8.90	-8.1%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$723.34	$554.16	30.5%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$321.77	$400.15	-19.6%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$42.09	$38.79	8.5%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$5,050.60	$4,782.06	5.6%
Plan Cost PMPM	**$116.00**	**$99.66**	**16.4%**
Non-Specialty Plan Cost PMPM	$48.62	$43.88	10.8%
Specialty Plan Cost PMPM	$67.37	$55.78	20.8%
Specialty % of Plan Cost	58.1%	56.0%	2.1
Net Plan Cost PMPM (factoring Rebates)	**$74.39**	**$68.98**	**7.8%**
Non-Specialty Plan Cost PMPM	$29.36	$26.87	9.3%
Specialty Plan Cost PMPM	$45.03	$42.11	6.9%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ Q3 FY24 vs Q3 FY23

Membership Summary	Q3 FY 2024	Q3 FY 2023	Change
Member Count (Membership)	5,767	6,498	-11.2%
Utilizing Member Count (Patients)	4,508	5,307	-15.1%
Percent Utilizing (Utilization)	78.2%	81.7%	-3.5

Claim Summary	Q3 FY 2024	Q3 FY 2023	Change
Net Claims (Total Adjusted Rx's)	94,902	102,425	-7.3%
Claims per Elig Member per Month (Claims PMPM)	1.83	1.75	4.4%
Total Claims for Generic (Generic ARx)	81,545	87,170	-6.5%
Total Claims for Brand (Brand ARx)	13,357	15,255	-12.4%
Total Claims for Multisource Brand Claims (MSB ARx)	515	500	3.0%
Total Non-Specialty Claims	93,757	101,165	-7.3%
Total Specialty Claims	1,145	1,260	-9.1%
Generic % of Total Claims (GFR)	**85.9%**	**85.1%**	**0.8**
Generic Effective Rate (GCR)	99.4%	99.4%	-0.1
Mail Order Claims	27,959	28,564	-2.1%
Mail Penetration Rate*	32.4%	31.0%	1.5

Claims Cost Summary	Q3 FY 2024	Q3 FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$15,265,936**	**$14,872,507**	**2.6%**
Total Generic Gross Cost	$1,434,234	$1,551,425	-7.6%
Total Brand Gross Cost	$13,831,701	$13,321,082	3.8%
Total MSB Gross Cost	$300,275	$284,565	5.5%
Total Ingredient Cost	$14,862,685	$14,460,263	2.8%
Total Dispensing Fee	$390,394	$397,601	-1.8%
Total Other (e.g. tax)	$12,856	$14,642	-12.2%
Avg Total Cost per Claim (Gross Cost/ARx)	**$160.86**	**$145.20**	**10.8%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$17.59	$17.80	-1.2%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$1,035.54	$873.23	18.6%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$583.06	$569.13	2.4%

Express Scripts
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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ Q3 FY24 vs Q3 FY23

Member Cost Summary	Q3 FY 2024	Q3 FY 2023	Change
Total Member Cost Share	**$2,287,037**	**$2,401,682**	**-4.8%**
Generic Cost Share	$561,158	$581,222	-3.5%
Brand Cost Share	$1,725,880	$1,820,459	-5.2%
MSB Cost Share	$35,639	$35,414	0.6%
Total Copay	$2,285,109	$2,399,207	-4.8%
Total Deductible	$1,929	$2,474	-22.1%
Avg Copay per Claim (Member Cost Share/ARx)	**$24.10**	**$23.45**	**2.8%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.88	$6.67	3.2%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$129.21	$119.34	8.3%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$69.20	$70.83	-2.3%
Copay % of Total Prescription Cost (Member Cost Share %)	**15.0%**	**16.1%**	**-1.1**

Plan Cost Summary	Q3 FY 2024	Q3 FY 2023	Change
Total Plan Cost (Plan Cost)	**$12,978,898**	**$12,470,826**	**4.1%**
Generic Plan Cost	$873,077	$970,203	-10.0%
Brand Plan Cost	$12,105,821	$11,500,623	5.3%
MSB Plan Cost	$264,637	$249,151	6.2%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$6,236,188	$6,252,963	-0.3%
Total Specialty Drug Cost (Specialty Plan Cost)	$6,742,711	$6,217,863	8.4%
Avg Plan Cost per Claim (Plan Cost/ARx)	$136.76	$121.76	12.3%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$10.71	$11.13	-3.8%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$906.33	$753.89	20.2%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$513.86	$498.30	3.1%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$66.51	$61.81	7.6%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$5,888.83	$4,934.81	19.3%
Plan Cost PMPM	**$250.06**	**$213.24**	**17.3%**
Non-Specialty Plan Cost PMPM	$120.15	$106.92	12.4%
Specialty Plan Cost PMPM	$129.91	$106.32	22.2%
Specialty % of Plan Cost	52.0%	49.9%	2.1
Net Plan Cost PMPM (factoring Rebates)	**$167.99**	**$149.33**	**12.5%**
Non-Specialty Plan Cost PMPM	$76.00	$69.36	9.6%
Specialty Plan Cost PMPM	$92.00	$79.97	15.0%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN

+ Q3 FY24 vs Q3 FY23

Membership Summary	Q3 FY 2024	Q3 FY 2023	Change
Member Count (Membership)	18,852	14,114	33.6%
Utilizing Member Count (Patients)	14,049	11,038	27.3%
Percent Utilizing (Utilization)	74.5%	78.2%	-3.7

Claim Summary	Q3 FY 2024	Q3 FY 2023	Change
Net Claims (Total Adjusted Rx's)	205,430	151,324	35.8%
Claims per Elig Member per Month (Claims PMPM)	1.21	1.19	1.6%
Total Claims for Generic (Generic ARx)	175,530	127,327	37.9%
Total Claims for Brand (Brand ARx)	29,900	23,997	24.6%
Total Claims for Multisource Brand Claims (MSB ARx)	1,110	792	40.2%
Total Non-Specialty Claims	202,881	149,765	35.5%
Total Specialty Claims	2,549	1,559	63.5%
Generic % of Total Claims (GFR)	**85.4%**	**84.1%**	**1.3**
Generic Effective Rate (GCR)	99.4%	99.4%	0.0
Mail Order Claims	59,172	46,901	26.2%
Mail Penetration Rate*	33.0%	35.9%	-2.9

Claims Cost Summary	Q3 FY 2024	Q3 FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$30,255,099**	**$18,125,515**	**66.9%**
Total Generic Gross Cost	$3,452,025	$2,412,844	43.1%
Total Brand Gross Cost	$26,803,074	$15,712,671	70.6%
Total MSB Gross Cost	$519,461	$387,840	33.9%
Total Ingredient Cost	$29,361,766	$17,492,054	67.9%
Total Dispensing Fee	$869,084	$607,236	43.1%
Total Other (e.g. tax)	$24,249	$26,225	-7.5%
Avg Total Cost per Claim (Gross Cost/ARx)	**$147.28**	**$119.78**	**23.0%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$19.67	$18.95	3.8%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$896.42	$654.78	36.9%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$467.98	$489.70	-4.4%

Express Scripts
By EVERNORTH
Confidential Information

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN

+ Q3 FY24 vs Q3 FY23

Member Cost Summary	Q3 FY 2024	Q3 FY 2023	Change
Total Member Cost Share	**$4,615,853**	**$2,955,131**	**56.2%**
Generic Cost Share	$1,180,360	$802,460	47.1%
Brand Cost Share	$3,435,493	$2,152,672	59.6%
MSB Cost Share	$40,361	$21,189	90.5%
Total Copay	$4,615,853	$2,955,131	56.2%
Total Deductible	$0	$0	NA
Avg Copay per Claim (Member Cost Share/ARx)	**$22.47**	**$19.53**	**15.1%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.72	$6.30	6.7%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$114.90	$89.71	28.1%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$36.36	$26.75	35.9%
Copay % of Total Prescription Cost (Member Cost Share %)	**15.3%**	**16.3%**	**-1.0**

Plan Cost Summary	Q3 FY 2024	Q3 FY 2023	Change
Total Plan Cost (Plan Cost)	**$25,639,246**	**$15,170,384**	**69.0%**
Generic Plan Cost	$2,271,665	$1,610,384	41.1%
Brand Plan Cost	$23,367,581	$13,559,999	72.3%
MSB Plan Cost	$479,100	$366,651	30.7%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$13,460,060	$8,595,912	56.6%
Total Specialty Drug Cost (Specialty Plan Cost)	$12,179,186	$6,574,472	85.2%
Avg Plan Cost per Claim (Plan Cost/ARx)	$124.81	$100.25	24.5%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$12.94	$12.65	2.3%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$781.52	$565.07	38.3%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$431.62	$462.94	-6.8%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$66.34	$57.40	15.6%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$4,778.03	$4,217.11	13.3%
Plan Cost PMPM	**$151.11**	**$119.43**	**26.5%**
Non-Specialty Plan Cost PMPM	$79.33	$67.67	17.2%
Specialty Plan Cost PMPM	$71.78	$51.76	38.7%
Specialty % of Plan Cost	47.5%	43.3%	4.2
Net Plan Cost PMPM (factoring Rebates)	**$99.19**	**$82.39**	**20.4%**
Non-Specialty Plan Cost PMPM	$53.22	$45.79	16.2%
Specialty Plan Cost PMPM	$45.97	$36.61	25.6%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO, CDHP, & PPO PLAN

+ Q3 FY24 vs Q3 FY23

Membership Summary	Total	EPO	CDHP	PPO
Member Count (Membership)	48,814	5,767	24,197	18,852
Utilizing Member Count (Patients)	34,916	4,508	16,420	14,049
Percent Utilizing (Utilization)	71.5%	78.2%	67.9%	74.5%

Claim Summary	Total	EPO	CDHP	PPO
Net Claims (Total Rx's)	554,802	94,902	254,470	205,430
Claims per Elig Member per Month (Claims PMPM)	1.26	1.83	1.17	1.21
Total Claims for Generic (Generic Rx)	479,133	81,545	222,058	175,530
Total Claims for Brand (Brand Rx)	75,669	13,357	32,412	29,900
Total Claims for Multisource Brand Claims (MSB Rx)	2,546	515	921	1,110
Total Non-Specialty Claims	548,203	93,757	251,565	202,881
Total Specialty Claims	6,599	1,145	2,905	2,549
Generic % of Total Claims (GFR)	**86.4%**	**85.9%**	**87.3%**	**85.4%**
Generic Effective Rate (GCR)	99.5%	99.4%	99.6%	99.4%
Mail Order Claims	156,938	27,959	69,807	59,172
Mail Penetration Rate*	32.1%	32.4%	31.2%	33.0%

Claims Cost Summary	Total	EPO	CDHP	PPO
Total Prescription Cost (Total Gross Cost)	**$78,086,072**	**$15,265,936**	**$32,565,038**	**$30,255,099**
Total Generic Gross Cost	$8,210,943	$1,434,234	$3,324,684	$3,452,025
Total Brand Gross Cost	$69,875,129	$13,831,701	$29,240,354	$26,803,074
Total MSB Gross Cost	$1,222,304	$300,275	$402,567	$519,461
Total Ingredient Cost	$75,676,059	$14,862,685	$31,451,608	$29,361,766
Total Dispensing Fee	$1,482,066	$390,394	$1,091,671	$869,084
Total Other (e.g. tax)	$58,864	$12,856	$21,758	$24,249
Avg Total Cost per Claim (Gross Cost/Rx)	**$140.75**	**$160.86**	**$127.97**	**$147.28**
Avg Total Cost for Generic (Generic Gross Cost/Generic Rx)	$17.14	$17.59	$14.97	$19.67
Avg Total Cost for Brand (Brand Gross Cost/Brand Rx)	$923.43	$1,035.54	$902.15	$896.42
Avg Total Cost for MSB (MSB Gross Cost/MSB Rx)	$480.09	$583.06	$437.10	$467.98

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO, CDHP, & PPO PLAN

+ Q3 FY24 vs Q3 FY23

Member Cost Summary	Total	EPO	CDHP	PPO
Total Member Cost Share	**$14,206,772**	**$2,287,037**	**$7,303,881**	**$4,615,853**
Generic Cost Share	$3,249,948	$561,158	$1,508,430	$1,180,360
Brand Cost Share	$10,956,824	$1,725,880	$5,795,451	$3,435,493
MSB Cost Share	$182,213	$35,639	$106,214	$40,361
Total Copay	$12,795,961	$2,285,109	$5,894,999	$4,615,853
Total Deductible	$1,410,811	$1,929	$1,408,882	$0
Avg Copay per Claim (Member Cost Share/Rx)	**$25.61**	**$24.10**	**$28.70**	**$22.47**
Avg Copay for Generic (Generic Member Cost Share/Generic Rx)	$6.78	$6.88	$6.79	$6.72
Avg Copay for Brand (Brand Member Cost Share/Brand Rx)	$144.80	$129.21	$178.81	$114.90
Avg Copay for MSB (MSB Member Cost Share/MSB Rx)	$71.57	$69.20	$115.32	$36.36
Copay % of Total Prescription Cost (Member Cost Share %)	**18.2%**	**15.0%**	**22.4%**	**15.3%**

Plan Cost Summary	Total	EPO	CDHP	PPO
Total Plan Cost (Plan Cost)	**$63,879,300**	**$12,978,898**	**$25,261,156**	**$25,639,246**
Generic Plan Cost	$4,960,995	$873,077	$1,816,253	$2,271,665
Brand Plan Cost	$58,918,305	$12,105,821	$23,444,903	$23,367,581
MSB Plan Cost	$1,040,090	$264,637	$296,353	$479,100
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$30,285,422	$6,236,188	$10,589,174	$13,460,060
Total Specialty Drug Cost (Specialty Plan Cost)	$33,593,879	$6,742,711	$14,671,982	$12,179,186
Avg Plan Cost per Claim (Plan Cost/Rx)	$115.14	$136.76	$99.27	$124.81
Avg Plan Cost for Generic (Generic Plan Cost/Generic Rx)	$10.35	$10.71	$8.18	$12.94
Avg Plan Cost for Brand (Brand Plan Cost/Brand Rx)	$778.63	$906.33	$723.34	$781.52
Avg Plan Cost for MSB (MSB Plan Cost/MSB Rx)	$408.52	$513.86	$321.77	$431.62
Avg Non-Specialty Plan Cost per Claim (Plan Cost/Rx)	$55.24	$66.51	$42.09	$66.34
Avg Specialty Plan Cost per Claim (Plan Cost/Rx)	$5,090.75	$5,888.83	$5,050.60	$4,778.03
Plan Cost PMPM	**$145.40**	**$250.06**	**$116.00**	**$151.11**
Non-Specialty Plan Cost PMPM	$68.94	$120.15	$48.62	$79.33
Specialty Plan Cost PMPM	$76.47	$129.91	$67.37	$71.78
Specialty % of Plan Cost	52.6%	52.0%	58.1%	47.5%
Net Plan Cost PMPM (factoring Rebates)	**$95.03**	**$167.99**	**$74.39**	**$99.19**
Non-Specialty Net Plan Cost PMPM	$44.09	$76.00	$29.36	$53.22
Specialty Net Plan Cost PMPM	$50.94	$92.00	$45.03	$45.97

Express Scripts

By EVERNORTH

Confidential Information

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN

+ Q3 FY24 vs Q3 FY23

State of Nevada PEBP Q1 - Q3 FY2024				
Description	Grand Total	EPO	CDHP	PPO
Avg Members per Month	48,814	5,767	24,197	18,852
Pct Members Utilizing Benefit	71.5%	78.2%	67.9%	74.5%
Total Plan Cost	$ 63,879,300	$ 12,978,898	$ 25,261,156	$ 25,639,246
Total Days	14,478,573	2,550,719	6,629,951	5,297,903
Total Adjusted Rxs	554,802	94,902	254,470	205,430
Plan Cost PMPM	$ 145.40	$ 250.06	$ 116.00	$ 151.11
Plan Cost Net PMPM	$ 95.03	$ 167.99	$ 74.39	$ 99.19
Plan Cost/Day	$ 4.41	$ 5.09	$ 3.81	$ 4.84
Plan Cost per Adjusted Rx	$ 115.14	$ 136.76	$ 99.27	$ 124.81
Nbr Rxs PMPM	1.26	1.83	1.17	1.21
Generic Fill Rate	86.4%	85.9%	87.3%	85.4%
Home Delivery Utilization	32.1%	32.4%	31.2%	33.0%
Member Cost %	18.2%	15.0%	22.4%	15.3%
Specialty Percent of Plan Cost	52.6%	52.0%	58.1%	47.5%
Specialty Plan Cost PMPM	$ 76.47	$ 129.91	$ 67.37	$ 71.78
Formulary Compliance Rate	99.4%	99.3%	99.6%	99.3%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN
+ Q3 FY24 vs Q3 FY23

State of Nevada PEBP Q1 - Q3 FY2024 - Grand Total					
Description	Grand Total	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	48,814	42,585	5,729	12	491
Pct Members Utilizing Benefit	71.5%	70.1%	84.0%	75.0%	94.3%
Total Plan Cost	$ 63,879,300	$ 49,879,872	$ 12,332,270	$ 271,391	$ 1,395,767
Total Days	14,478,573	10,794,775	3,221,129	6,786	455,883
Total Adjusted Rxs	554,802	419,965	118,104	253	16,480
Plan Cost PMPM	$ 145.40	$ 130.14	$ 239.18	$ 2,512.88	$ 315.86
Plan Cost Net PMPM	$ 95.03	$ 85.60	$ 153.35	$ 2,232.47	$ 179.42
Plan Cost/Day	$ 4.41	$ 4.62	$ 3.83	$ 39.99	$ 3.06
Plan Cost per Adjusted Rx	$ 115.14	$ 118.77	$ 104.42	$ 1,072.69	$ 84.69
Nbr Rxs PMPM	1.26	1.10	2.29	2.34	3.73
Generic Fill Rate	86.4%	86.1%	87.3%	85.4%	87.3%
Home Delivery Utilization	32.1%	29.8%	38.9%	93.2%	36.9%
Member Cost %	18.2%	17.9%	19.4%	22.1%	18.4%
Specialty Percent of Plan Cost	52.6%	52.9%	51.9%	95.6%	41.0%
Specialty Plan Cost PMPM	$ 76.47	$ 68.78	$ 124.12	$ 2,402.89	$ 129.40
Formulary Compliance Rate	99.4%	99.4%	99.6%	100.0%	99.6%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN
+ Q3 FY24 vs Q3 FY23

State of Nevada PEBP Q1 - Q3 FY2024 - CDHP					
Description	CDHP	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	24,197	20,163	3,651	8	375
Pct Members Utilizing Benefit	67.9%	65.3%	81.1%	62.5%	94.7%
Total Plan Cost	$ 25,261,156	$ 17,341,053	$ 6,791,023	$ 149,764	$ 979,316
Total Days	6,629,951	4,373,493	1,898,328	1,945	356,185
Total Adjusted Rxs	254,470	171,895	69,609	77	12,889
Plan Cost PMPM	$ 116.00	$ 95.56	$ 206.67	$ 2,340.07	$ 290.17
Plan Cost Net PMPM	$ 74.39	$ 61.05	$ 136.29	$ 2,241.81	$ 148.22
Plan Cost/Day	$ 3.81	$ 3.97	$ 3.58	$ 77.00	$ 2.75
Plan Cost per Adjusted Rx	$ 99.27	$ 100.88	$ 97.56	$ 1,944.99	$ 75.98
Nbr Rxs PMPM	1.17	0.95	2.12	1.07	3.82
Generic Fill Rate	87.3%	86.9%	88.2%	88.3%	86.7%
Home Delivery Utilization	31.2%	27.7%	38.2%	96.2%	37.4%
Member Cost %	22.4%	23.0%	21.2%	26.2%	19.6%
Specialty Percent of Plan Cost	58.1%	58.3%	59.8%	99.6%	36.6%
Specialty Plan Cost PMPM	$ 67.37	$ 55.67	$ 123.64	$ 2,331.37	$ 106.06
Formulary Compliance Rate	99.6%	99.6%	99.7%	100.0%	99.7%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN
+ Q3 FY24 vs Q3 FY23

State of Nevada PEBP Q1 - Q3 FY2024 - EPO					
Description	EPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	5,767	4,994	698	2	73
Pct Members Utilizing Benefit	78.2%	76.7%	93.6%	50.0%	89.0%
Total Plan Cost	$ 12,978,898	$ 10,035,315	$ 2,729,934	$ 9,751	$ 203,898
Total Days	2,550,719	1,939,211	549,134	2,512	59,862
Total Adjusted Rxs	94,902	72,789	19,877	86	2,150
Plan Cost PMPM	$ 250.06	$ 223.27	$ 434.56	$ 609.44	$ 310.35
Plan Cost Net PMPM	$ 167.99	$ 149.43	$ 294.55	$ 288.87	$ 225.11
Plan Cost/Day	$ 5.09	$ 5.17	$ 4.97	$ 3.88	$ 3.41
Plan Cost per Adjusted Rx	$ 136.76	$ 137.87	$ 137.34	$ 113.38	$ 94.84
Nbr Rxs PMPM	1.83	1.62	3.16	4.78	3.73
Generic Fill Rate	85.9%	85.8%	86.0%	77.9%	89.2%
Home Delivery Utilization	32.4%	31.5%	35.2%	99.5%	36.7%
Member Cost %	15.0%	14.2%	17.6%	8.1%	17.7%
Specialty Percent of Plan Cost	52.0%	52.8%	49.6%	0.0%	46.5%
Specialty Plan Cost PMPM	$ 129.91	$ 117.80	$ 215.41	$ -	$ 144.47
Formulary Compliance Rate	99.3%	99.2%	99.5%	100.0%	99.0%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN
+ Q3 FY24 vs Q3 FY23

State of Nevada PEBP Q1 - Q3 FY2024 - PPO					
Description	PPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	18,852	17,427	1,379	2	43
Pct Members Utilizing Benefit	74.5%	73.8%	87.3%	150.0%	100.0%
Total Plan Cost	$ 25,639,246	$ 22,503,504	$ 2,811,313	$ 111,876	$ 212,553
Total Days	5,297,903	4,482,071	773,667	2,329	39,836
Total Adjusted Rxs	205,430	175,281	28,618	90	1,441
Plan Cost PMPM	$ 151.11	$ 143.48	$ 226.52	$ 6,215.32	$ 549.23
Plan Cost Net PMPM	$ 99.19	$ 95.73	$ 127.14	$ 5,167.18	$ 373.92
Plan Cost/Day	$ 4.84	$ 5.02	$ 3.63	$ 48.04	$ 5.34
Plan Cost per Adjusted Rx	$ 124.81	$ 128.39	$ 98.24	$ 1,243.06	$ 147.50
Nbr Rxs PMPM	1.21	1.12	2.31	5.00	3.72
Generic Fill Rate	85.4%	85.3%	85.9%	90.0%	89.8%
Home Delivery Utilization	33.0%	31.2%	43.4%	83.8%	32.9%
Member Cost %	15.3%	15.1%	16.5%	17.1%	13.1%
Specialty Percent of Plan Cost	47.5%	48.7%	35.0%	98.6%	56.0%
Specialty Plan Cost PMPM	$ 71.78	$ 69.92	$ 79.25	$ 6,128.01	$ 307.37
Formulary Compliance Rate	99.3%	99.3%	99.4%	100.0%	100.0%

4.3.7

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2024:

- 4.3.1 Q3 UMR – Obesity Care Management
- 4.3.2 Q3 UMR – Diabetes Care Management
- 4.3.3 Q3 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network
- 4.3.4 Q3 UnitedHealthcare – Basic Life Insurance
- 4.3.5 Q3 Express Scripts – Summary Report
- 4.3.6 Q3 Express Scripts – Utilization Report
- **4.3.7 UMR – Performance Guarantee Report**

PERFORMANCE GUARANTEE REPORT
NV PUBLIC EMPLOYEES BENEFITS PROGRAM
FOR MONTH ENDING: 5/2024
PLAN YEAR: JUL-JUN

Current Month

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	91.2%	-0.8%
Claim TAT in 20 Business Days	99.0%	99.4%	0.4%
Abandonment Rate	3.0%	0.6%	2.4%
Calls Answered Within Service Level	85.0%	92.2%	7.2%
CSR Callback	90.0%	100.0%	10.0%
Call Resolution	95.0%	96.2%	1.2%
Adjustment Turnaround in 5 Days Rate	95.0%	96.5%	1.5%
Customer Service Quality Rate	97.0%	97.9%	0.9%
Open Issue Resolution 2 Days Rate	90.0%	98.4%	8.4%
Open Issue Resolution 5 Days Rate	98.0%	99.5%	1.5%

Current Quarter to Date

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	92.6%	0.6%
Claim TAT in 20 Business Days	99.0%	99.4%	0.4%
Abandonment Rate	3.0%	0.6%	2.4%
Calls Answered Within Service Level	85.0%	92.9%	7.9%
CSR Callback	90%	100.0%	10.0%
Call Resolution	95.0%	96.0%	1.0%
Adjustment Turnaround in 5 Days Rate	95.0%	97.6%	2.6%
Customer Service Quality Rate	97.0%	97.2%	0.2%
Open Issue Resolution 2 Days Rate	90.0%	98.3%	8.3%
Open Issue Resolution 5 Days Rate	98.0%	99.6%	1.6%

Current Year to Date

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	93.5%	1.5%
Claim TAT in 20 Business Days	99.0%	95.9%	-3.1%
Abandonment Rate	3.0%	0.6%	2.4%
Calls Answered Within Service Level	85.0%	93.4%	8.4%
CSR Callback	90.0%	100.00	10.00
Call Resolution	95.0%	93.7%	-1.3%
Adjustment Turnaround in 5 Days Rate	95.0%	94.6%	-0.4%
Customer Service Quality Rate	97.0%	96.8%	-0.2%
Open Issue Resolution 2 Days Rate	90.0%	96.3%	6.3%
Open Issue Resolution 5 Days Rate	98.0%	97.1%	-0.9%

PERFORMANCE GUARANTEE REPORT
NV PUBLIC EMPLOYEES BENEFITS PROGRAM
FOR MONTH ENDING: 6/2024
PLAN YEAR: JUL-JUN

Current Month

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	94.9%	2.9%
Claim TAT in 20 Business Days	99.0%	99.7%	0.7%
Abandonment Rate	3.0%	0.5%	2.5%
Calls Answered Within Service Level	85.0%	92.6%	7.6%
CSR Callback	90.0%	100.0%	10.0%
Call Resolution	95.0%	97.2%	2.2%
Adjustment Turnaround in 5 Days Rate	95.0%	98.4%	3.4%
Customer Service Quality Rate	97.0%	98.4%	1.4%
Open Issue Resolution 2 Days Rate	90.0%	98.7%	8.7%
Open Issue Resolution 5 Days Rate	98.0%	99.7%	1.7%

Current Quarter to Date

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	93.3%	1.3%
Claim TAT in 20 Business Days	99.0%	99.5%	0.5%
Abandonment Rate	3.0%	0.6%	2.4%
Calls Answered Within Service Level	85.0%	92.8%	7.8%
CSR Callback	90%	100.0%	10.0%
Call Resolution	95.0%	96.3%	1.3%
Adjustment Turnaround in 5 Days Rate	95.0%	97.8%	2.8%
Customer Service Quality Rate	97.0%	97.5%	0.5%
Open Issue Resolution 2 Days Rate	90.0%	98.4%	8.4%
Open Issue Resolution 5 Days Rate	98.0%	99.6%	1.6%

Current Year to Date

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	93.6%	1.6%
Claim TAT in 20 Business Days	99.0%	96.2%	-2.8%
Abandonment Rate	3.0%	0.6%	2.4%
Calls Answered Within Service Level	85.0%	93.4%	8.4%
CSR Callback	90.0%	100.00	10.00
Call Resolution	95.0%	93.9%	-1.1%
Adjustment Turnaround in 5 Days Rate	95.0%	94.9%	-0.1%
Customer Service Quality Rate	97.0%	97.0%	0.0%
Open Issue Resolution 2 Days Rate	90.0%	96.4%	6.4%
Open Issue Resolution 5 Days Rate	98.0%	97.2%	-0.8%

4.3.8

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2024:

- 4.3.1 Q3 UMR – Obesity Care Management
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- 4.3.4 Q3 UnitedHealthcare – Basic Life Insurance
- 4.3.5 Q3 Express Scripts – Summary Report
- 4.3.6 Q3 Express Scripts – Utilization Report
- 4.3.7 UMR – Performance Guarantee Report
- **4.3.8 Doctor on Demand – Engagement Report**

Included HEALTH

dr. on demand by Included Health

Virtual Care Engagement Monthly Report

UMR - STATE OF NEVADA

Reporting Period:

04/01/24 to 05/01/24

Member Engagement

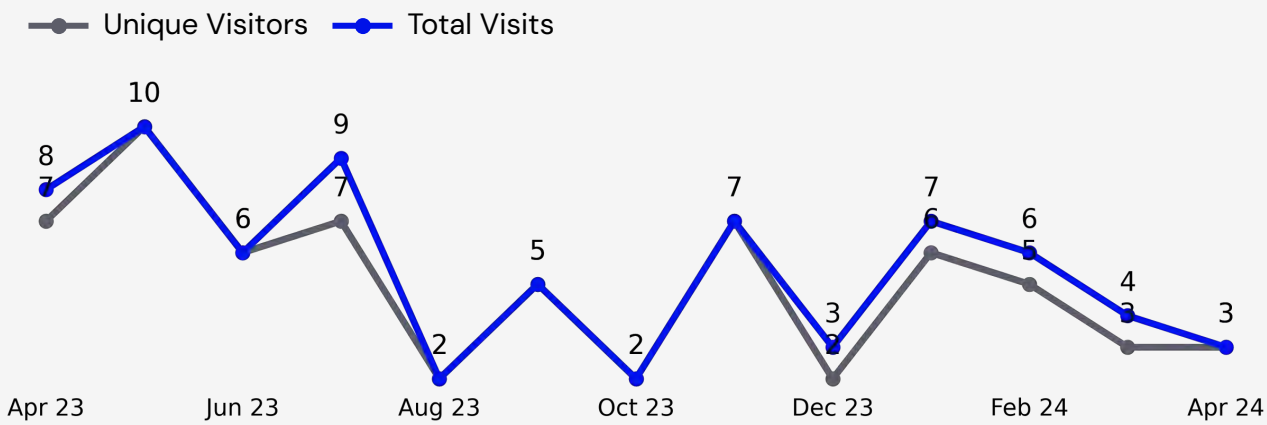
81	3	3
Registrations This Month	Unique Visitors This Month	Total Visits This month

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 (Year to Date)

-	3,757	-
Total Covered Lives	Registrations Lifetime to date	Registration Rate Lifetime to date
-	316	-
Employee Covered Lives	Registrations Year to Date	Registration Rate Year to Date

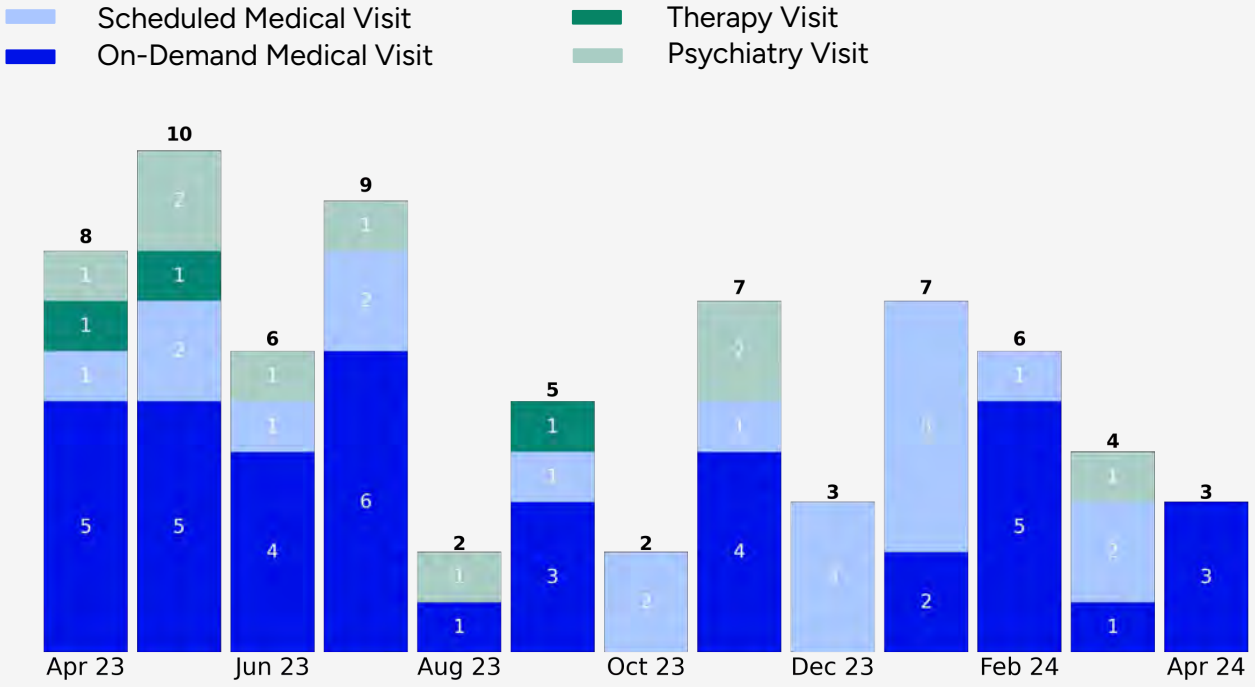
Visits Last 12 Months



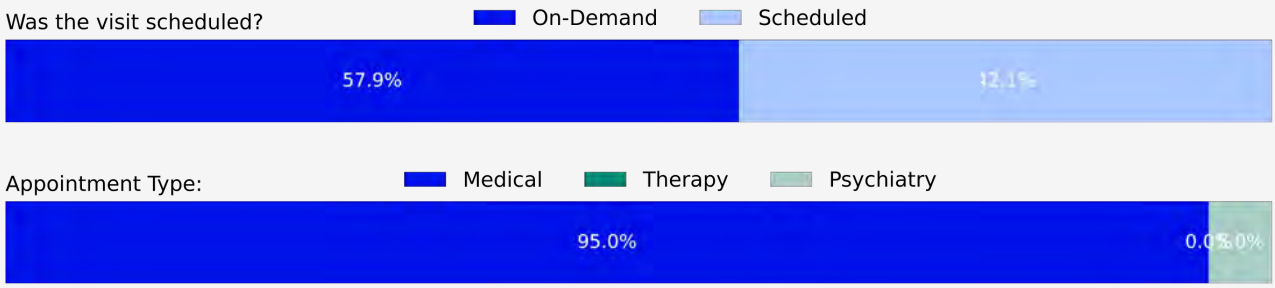
181	68	2.7	-
Visits Lifetime to Date	Unique Visitors Lifetime to Date	Average Visits Per Visitor Lifetime to Date	Engagement Rate Lifetime to Date (Visitors/Lives)
20	14	1.4	-
Visits Year to Date	Unique Visitors Year to Date	Average Visits Per Visitor Year to Date	Engagement Rate Year to Date (Visitors/Lives)

Member Engagement

Medical & Behavioral Health Visits (Rolling 12 Months)



Member Demand by Visit Type Year to Date



Most Popular Day for Visits Year to Date

Friday

Most Popular Time for Visits Year to Date

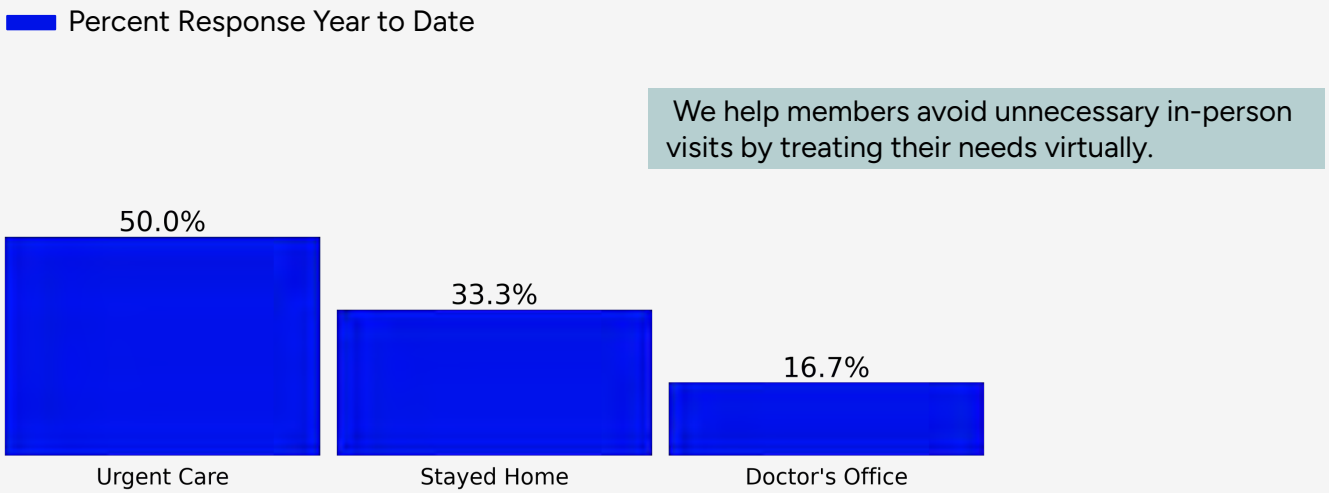
Noon - 2PM

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

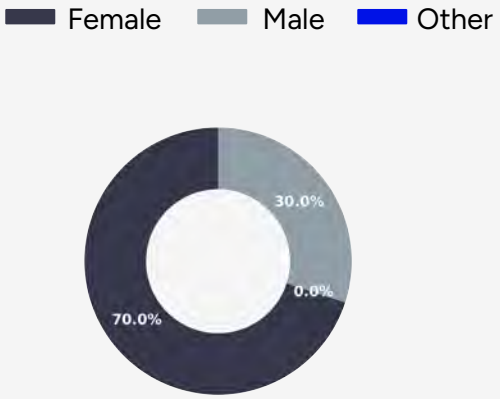
Member Access

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.

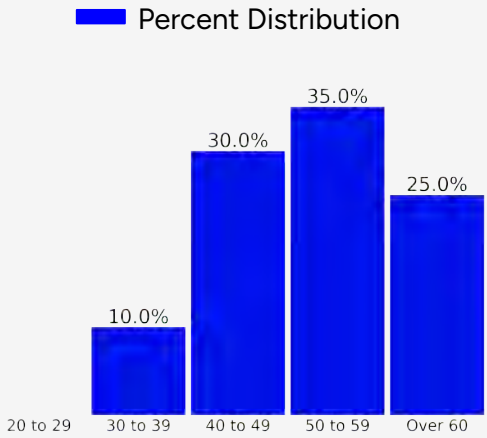
Without Included Health, where would you have gone?



Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	This Month	Year to Date
Average Member Rating	5.0 / 5 (N = 3)	5.0 / 5 (N = 14)
Median Wait Time for On-Demand Medical Appointments	2 min	2 min

Member Clinical Needs

This section highlights the range of clinical conditions that we treat through virtual care services. The program addresses comprehensive 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 Year to Date
Nasal discharge	2	7
Headache	2	7
Congestion / sinus problem	2	7
Sore throat	1	4
Ear pain	1	2
Sputum / productive cough / phlegm	1	4
Cough	1	7
Night sweats	1	1
Difficulty sleeping	1	7
Mood changes	0	4

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits This Month	Visits Year to Date
Other upper respiratory infections	2	8
Cough, unspecified	1	2
Other ear and sense organ disorders	1	1
Anxiety disorders	0	2
Administrative/social admission	0	1
Immunizations and screening for infectious di..	0	0
Nausea and vomiting	0	0
Abdominal pain	0	0
Disorders of teeth and jaw	0	0
Acute candidiasis of vulva and vagina	0	1

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

6	75.0%	0	5.0%
Prescriptions This Month	of visits resulted in a prescription order Year to Date	Lab Orders This Month	of visits resulted in a lab order Year to Date

Top Prescriptions and Testing Orders

Top Prescriptions	Count This Month	Count Year to Date
benzonatate	1	2
naproxen	1	1
ipratropium nasal	1	1
albuterol	1	2
prednisone	1	2
amoxicillin/potassiu..	1	1
citalopram	0	1
atorvastatin	0	0
clindamycin	0	1
erythromycin ophthal..	0	1

Top Labs	Count This Month	Count Year to Date
RPR w/ Reflex	0	0
Urine Culture, Routine	0	0
Chlamydia/GC, Urine	0	0
HSV 2, IgG w/ Reflex	0	0
Trichomonas Vaginali..	0	0
Urinalysis, Complete..	0	1
Insulin	0	0
Lipid Panel	0	0
Hepatitis Panel	0	0
HIV-1/2 Ag/Ab, 4th G..	0	0

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 digitally accept the Included Health TOS. 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.

Included HEALTH

dr. on demand by Included Health

Virtual Care Engagement Monthly Report

UMR - STATE OF NEVADA

Reporting Period:

05/01/24 to 06/01/24

Member Engagement

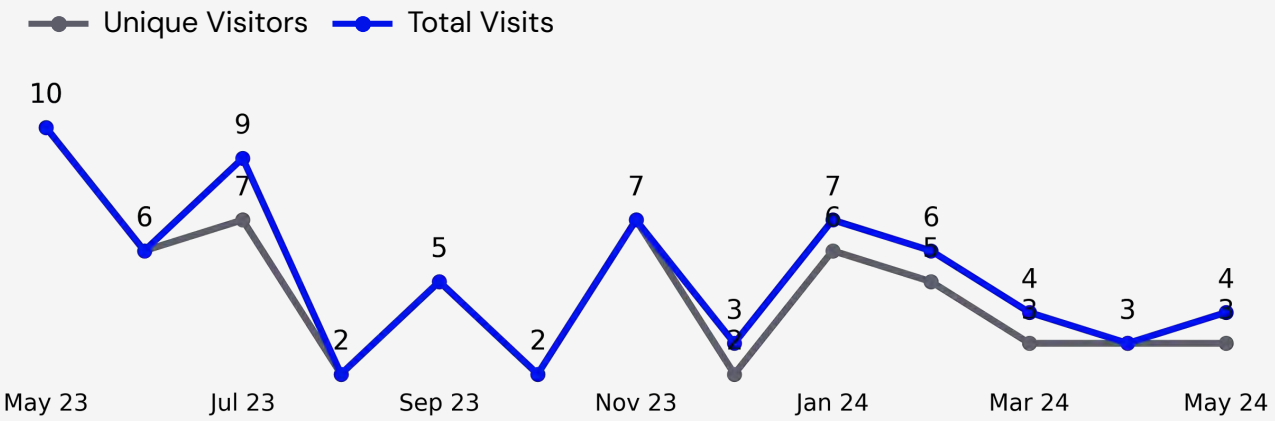
95	3	4
Registrations This Month	Unique Visitors This Month	Total Visits This month

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 (Year to Date)

-	3,888	-
Total Covered Lives	Registrations Lifetime to date	Registration Rate Lifetime to date
-	416	-
Employee Covered Lives	Registrations Year to Date	Registration Rate Year to Date

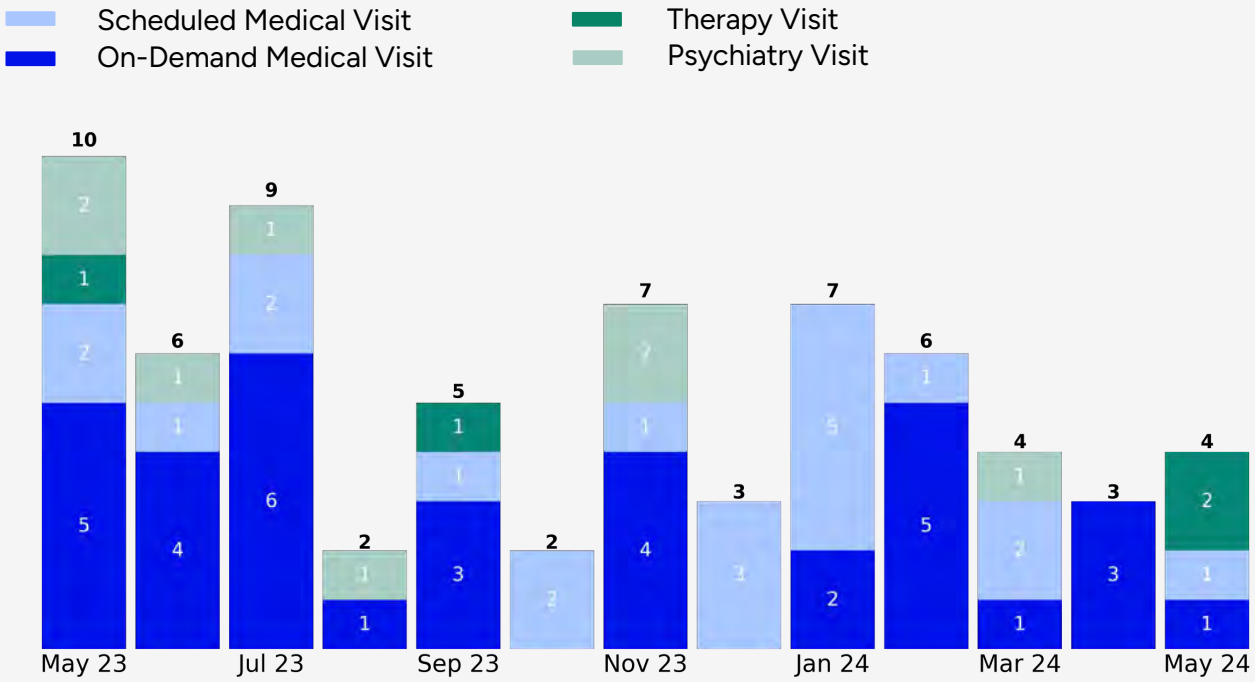
Visits Last 12 Months



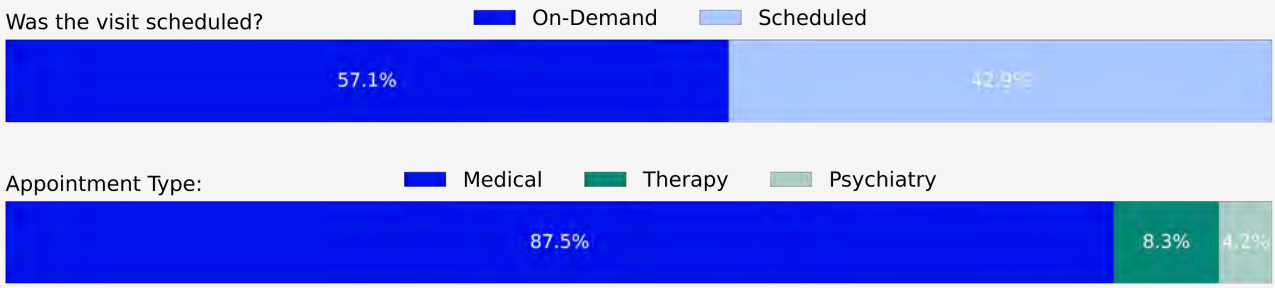
185	68	2.7	-
Visits Lifetime to Date	Unique Visitors Lifetime to Date	Average Visits Per Visitor Lifetime to Date	Engagement Rate Lifetime to Date (Visitors/Lives)
24	15	1.6	-
Visits Year to Date	Unique Visitors Year to Date	Average Visits Per Visitor Year to Date	Engagement Rate Year to Date (Visitors/Lives)

Member Engagement

Medical & Behavioral Health Visits (Rolling 12 Months)



Member Demand by Visit Type Year to Date



Most Popular Day for Visits Year to Date

Friday

Most Popular Time for Visits Year to Date

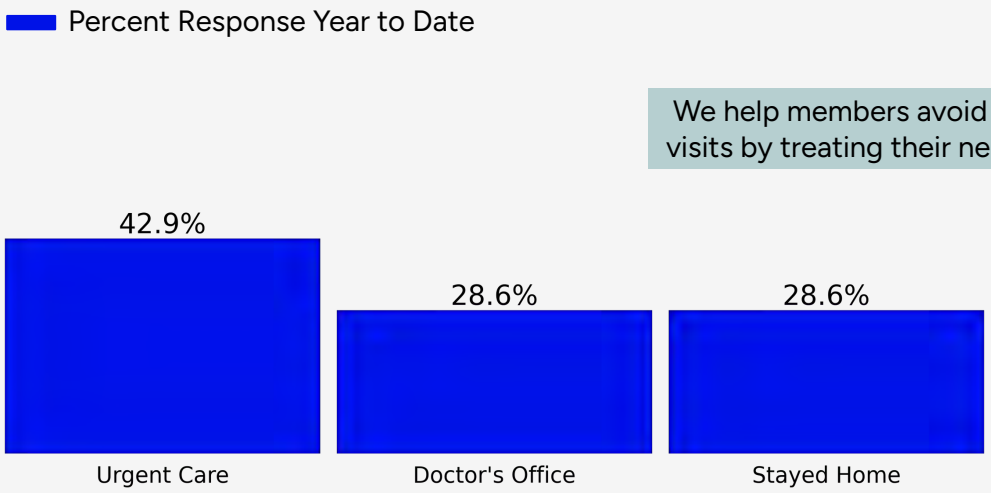
Noon - 2PM

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

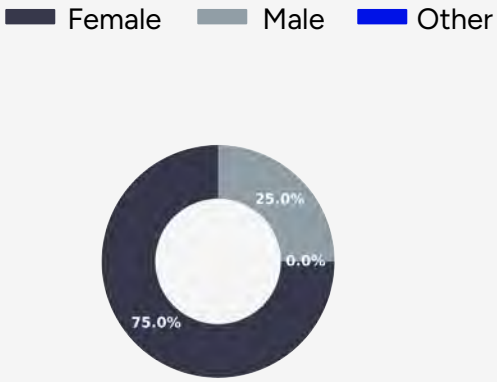
Member Access

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.

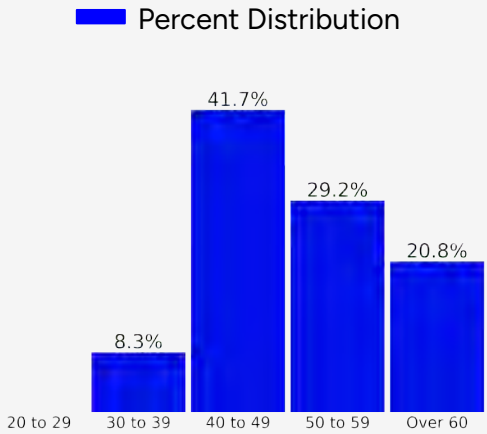
Without Included Health, where would you have gone?



Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	This Month	Year to Date
Average Member Rating	5.0 / 5 (N = 4)	5.0 / 5 (N = 18)
Median Wait Time for On-Demand Medical Appointments	30 min	3 min

Member Clinical Needs

This section highlights the range of clinical conditions that we treat through virtual care services. The program addresses comprehensive 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 Year to Date
Headache	1	8
Life transition or traumatic event	1	1
Nasal discharge	1	8
Shortness of breath	1	2
Anxiety / stress / worry	1	1
Congestion / sinus problem	1	8
Guilt / grief / loss	1	1
Trouble sleeping	1	1
Mood changes	0	4
Irregular periods	0	0

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits This Month	Visits Year to Date
Adjustment disorders	2	2
Anxiety disorders	1	3
Other upper respiratory infections	1	9
Other upper respiratory disease	1	3
Administrative/social admission	1	2
Other lower respiratory disease	1	3
Cough, unspecified	0	2
Viral infection	0	0
Disorders of teeth and jaw	0	0
Acute bronchitis	0	0

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

4	70.8%	0	4.2%
Prescriptions This Month	of visits resulted in a prescription order Year to Date	Lab Orders This Month	of visits resulted in a lab order Year to Date

Top Prescriptions and Testing Orders

Top Prescriptions	Count This Month	Count Year to Date
albuterol sulfate	1	1
methylprednisolone	1	1
benzonatate	1	3
citalopram hydrobrom..	1	1
amoxicillin/potassiu..	0	1
doxycycline hyclate	0	0
escitalopram	0	0
polymyxin b sulfate/..	0	0
fluticasone nasal	0	0
amlodipine besylate	0	0

Top Labs	Count This Month	Count Year to Date
Chlamydia/GC, Urine	0	0
Lipid Panel	0	0
Basic Metabolic Panel	0	0
RPR w/ Reflex	0	0
HSV 2, IgG w/ Reflex	0	0
Trichomonas Vaginali..	0	0
Hepatitis Panel	0	0
Comprehensive Metabo..	0	0
Urinalysis, Complete..	0	1
HIV-1/2 Ag/Ab, 4th G..	0	0

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

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4.3.9

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2024:

- 4.3.1 Q3 UMR – Obesity Care Management
- 4.3.2 Q3 UMR – Diabetes Care Management
- 4.3.3 Q3 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network
- 4.3.4 Q3 UnitedHealthcare – Basic Life Insurance
- 4.3.5 Q3 Express Scripts – Summary Report
- 4.3.6 Q3 Express Scripts – Utilization Report
- 4.3.7 UMR – Performance Guarantee Report
- 4.3.8 Doctor on Demand – Engagement Report
- **4.3.9 Real Appeal – Utilization Report**

Optum

Real Appeal

State of Nevada

Data through May 2024

Dashboard Report

1,292
Enrollment
Members enrolled since program inception

85%
At-Risk
Members with BMI > 30, or BMI between 25 to 29.99 and a qualifying comorbidity

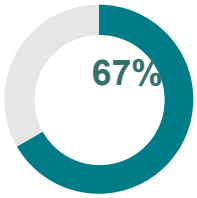
692
Engagement
Members attending one or more coaching sessions

233
Currently Engaged
Members actively engaged due to logging activity within the last six weeks

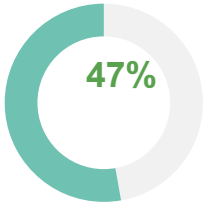
Member Satisfaction Rating
4.81

At-Risk Attendance

4+ Sessions Attended



9+ Sessions Attended



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

At-Risk Weight Loss

33%
5%+ Weight Loss
Attended 4+ Sessions In Program 16+ Weeks

5.7
Average lbs. Loss
(per member)
Attended 4+ Sessions In Program 16+ Weeks

507
Members Reporting Weight Loss

4,558
Total Pounds Lost

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

Optum | Real Appeal

Dashboard Report

1,292
Enrollment
Members enrolled since program inception

85%
At-Risk
Members with BMI > 30, or BMI between 25 to 29.99 and a qualifying comorbidity

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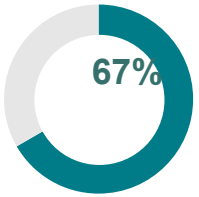
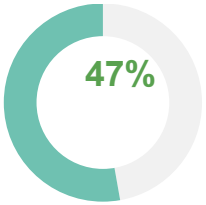
At-Risk Attendance

4+ Sessions Attended

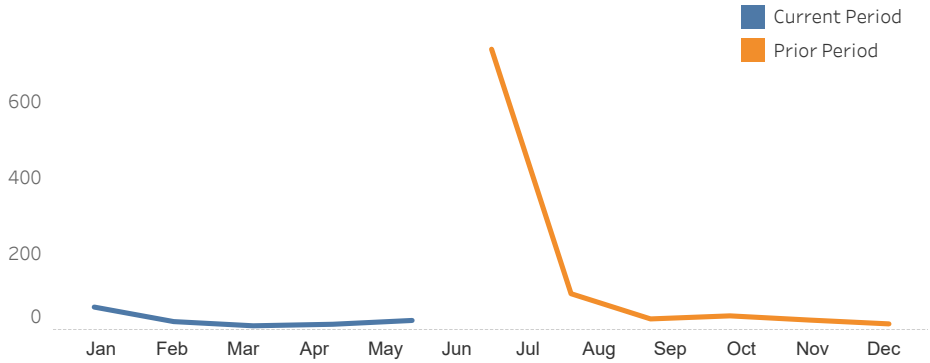


9+ Sessions Attended



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

At-Risk Enrollment



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Current Period	62	24	13	17	27							
Prior Period							737	97	31	39	28	18

At-Risk Weight Loss

33%
5%+ Weight Loss
Attended 4+ Sessions In Program 16+ Weeks

5.7
Average lbs. Loss
(per member)
Attended 4+ Sessions In Program 16+ Weeks

507
Members Reporting Weight Loss

4,558
Total Pounds Lost

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

	2023	2024
Enrolled	**1,125**	**167**
Disqualified	**41**	**6**

Disqualification Criteria:

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

Optum | Real Appeal

Enrollment Summary

1,292
Enrollment
Members enrolled since program inception

1,093
At-Risk
Members with BMI>30, or BMI between 25 - 29.9 and a qualifying comorbidity

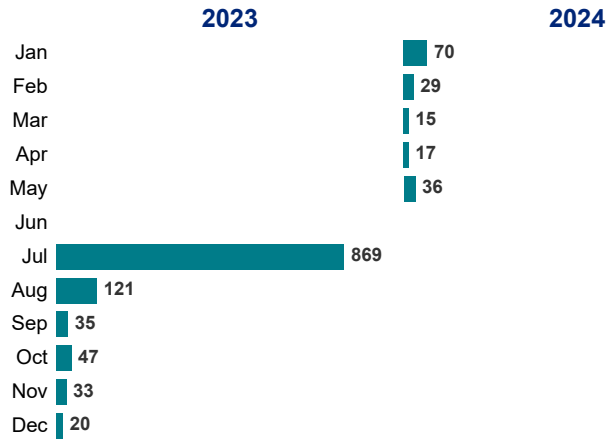
0
Re-Enrolled
Members who completed the programs and enrolled for another period

233
Currently Engaged
Members actively engaged due to logging activity within the last six weeks

Enrollments by Year

Grand Total	2023	2024
1,292	1,125	167

Enrollments by Month



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

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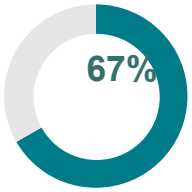
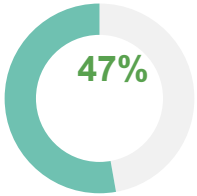
At-Risk Class Progression & Session Engagement

4+ Sessions Attended



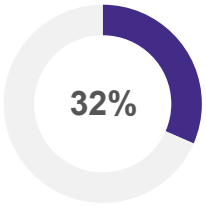
458

9+ Sessions Attended



316

16+ Sessions Attended



207

Real Appeal Expectations

70% Will Attend 4+ Sessions

50% Will Attend 9+ Sessions

30% Will Attend 16+ Sessions

Currently in Week / Session Engagement

	1+ Attended	4+	Attended 4+	9+	Attended 9+	16+	Attended 16+	26+	Attended 26+
1 - 3 Weeks	5	0	0%	0	0%	0	0%	0	0%
4 - 8 Weeks	18	9	50%	0	0%	0	0%	0	0%
9 - 15 Weeks	13	8	62%	6	46%	0	0%	0	0%
16 - 25 Weeks	56	37	66%	24	43%	15	27%	0	0%
26 - 52 Weeks	600	404	67%	286	48%	192	32%	96	16%
Grand Total	692	458	67%	316	47%	207	32%	96	16%

Optum | Real Appeal

At-Risk Outcomes

507
Members with Weight Loss

4,558
Pounds Lost

2.7%
Average Weight Loss
Members began 16+ weeks ago & attended 4+ sessions

3.2% Book of Business

33%
4+ Attended Sessions with 5%+ Loss
Real Appeal Expectations 33% with 5%+ Loss

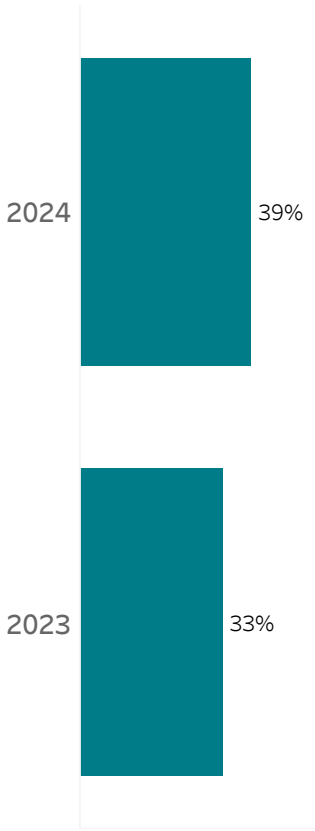
Your Results

	All Weeks 1+ Attended	Began 16+ Weeks Ago 1+	4+	9+
1+ Attended	692	656	441	310
3%+ Loss	34%	35%	46%	53%
5%+ Loss	18%	19%	25%	31%
Total Weight Loss *	3,051	2,815	2,525	1,808
Avg. Start lbs.	215.6	214.7	213.9	213.3
Avg. lbs. Loss	4.4	4.3	5.7	5.8
Avg. % lbs. Loss	2.0%	2.0%	2.7%	2.7%

Real Appeal Book of Business

	All Weeks 1+ Attended	Began 16+ Weeks Ago 1+	4+	9+
3%+ Loss	36%	37%	44%	50%
5%+ Loss	22%	22%	27%	33%
Avg. Start lbs.	218.6	218.6	218.1	217.6
Avg. lbs. Loss	5.7	5.8	7.1	8.2
Avg. % lbs. Loss	2.6%	2.6%	3.2%	3.8%

At-Risk 5%+ Weight Loss



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

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Enrollee Characteristics & Outcomes

BMI

** 23-24.9	25-29.9	>=30
90 7%	370 29%	832 64%

Medical Need

At-Risk	Not At-Risk
1,093 85%	199 15%

Gender

Female	Male
1,077 83%	215 17%

Plan Member Type

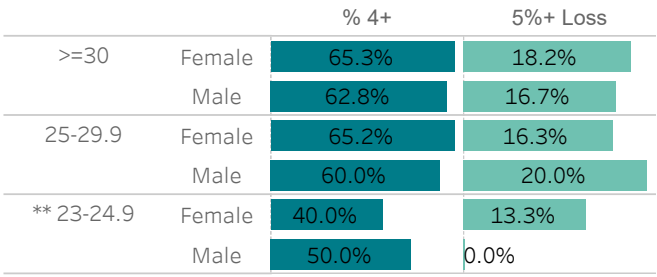
Employee	Spouse/Other
1,225 95%	67 5%

Age Range

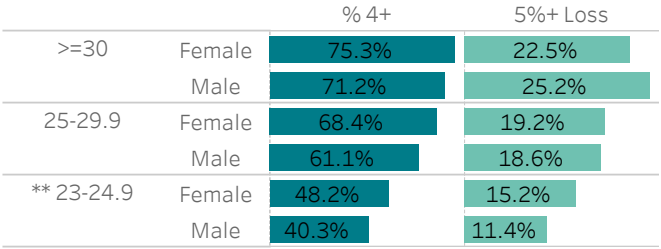
18-29	30-39	40-49	50-64	65-69	70+
81 6%	303 23%	346 27%	505 39%	45 3%	12 1%

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

Attendance & Weight Loss



Book of Business Attendance & Weight Loss



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Member Satisfaction

Member Satisfaction Rating

4.81

Book of Business 4.82

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

Total Ratings
Classroom Experience

3,058

Optum | Real Appeal

Registration & Enrollment

Relationship

	Relationship	Grand Total	2023	2024
Registered	Employee	**1,268**	1,099	169
	Spouse/Other	**71**	67	4
Disqualified	Employee	**43**	37	6
	Spouse/Other	**4**	4	0
Enrolled	Employee	**1,225**	1,062	163
	Spouse/Other	**67**	63	4
At-Risk	Employee	**1,036**	896	140
	Spouse/Other	**57**	54	3
Not At-Risk	Employee	**189**	166	23
	Spouse/Other	**10**	9	1
Re-Enrolled	Employee	**0**	0	0
	Spouse/Other	**0**	0	0

Month

	Total	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Registered	**1,339**	901	126	37	48	33	21	72	30	15	18	38
Disqualified	**47**	32	5	2	1	0	1	2	1	0	1	2
Enrolled	**1,292**	869	121	35	47	33	20	70	29	15	17	36
At-Risk	**1,093**	737	97	31	39	28	18	62	24	13	17	27
Not At-Risk	**199**	132	24	4	8	5	2	8	5	2	0	9
Re-Enrolled	**0**	0	0	0	0	0	0	0	0	0	0	0

Appendix

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

At-Risk Measurements

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

Outcomes

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

Optum | Real Appeal

4.4

4. Consent Agenda (Joy Grimmer, Board Chair)
(**All Items for Possible Action**)

4.4 Revised PEBP Language Access Plan per NRS 232.0081

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

JOY GRIMMER
Board Chair

AGENDA ITEM

[X] Action Item

[ ] Information Only

Date: July 25, 2024

Item Number: 4.4

Title: Revised Language Access Plan

SUMMARY

This report explains the revised Language Access Plan (LAP).

BACKGROUND

Pursuant to NRS 232.0081, all executive branch agencies must biennially revise their LAPs. Revised LAPs are due to the Governor's Office for New Americans by August 1, 2024. PEBP issued its first LAP in 2022, and the proposed revisions substantially reformat and streamline the LAP's contents.

REPORT

As set forth in the revised LAP, most PEBP members are proficient in English. In the last seven years, PEBP has received no requests that any plan document be translated into a language other than English. Accordingly, PEBP has not preemptively translated any of its plan documents. However, PEBP does provide to all members a notice of non-discrimination, which sets forth in numerous languages how to obtain information about PEBP's services in those languages. Additionally, PEBP is familiar with the resources developed by the Purchasing Division to purchase translation services and will use them if they become necessary to serve PEBP's members.

JOE LOMBARDO
Governor

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CELESTENA GLOVER
Executive Officer

JOY GRIMMER
Board Chair

Language Access Plan

Introduction

Nevada Revised Statutes (NRS) 232.0081 requires the Nevada Public Employees' Benefits Program (PEBP) have a Language Access Plan (LAP) to ensure that persons with Limited English Proficiency (LEP) have access to oral and written communication in their preferred language at a literacy level and format they can understand, and the degree to which PEBP meets those needs.

General Policy

PEBP recognizes its obligation to provide to persons with LEP meaningful and timely access to its services, including its online member portal, communication with PEBP staff and member-facing vendors, new hire education, plan documents, and notices.

PEBP's Language Access Coordination is the responsibility of:

Quality Control and Compliance Unit
3427 Goni Road, Suite 109
Carson City, NV 89706
775-684-7000

Profile of Persons Served by PEBP

PEBP is a Nevada state entity established pursuant to Chapter 287 of the NRS that administers a program offering medical, prescription drug, dental, and basic life insurance benefits to eligible participants. Eligible participants primarily include officers, employees, and retirees of the State of Nevada and other certain non-state local governmental agencies and the dependents of such individuals. *See* NRS Chapter 287.

Because PEBP participants are generally state and local government employees, participants are typically English proficient. PEBP does not collect information related to the race/ethnicity, preferred or primary language, language proficiency, literacy, or refugee status of its members. While many of PEBP's services are available electronically, virtually all documents may be provided in writing upon request.

If PEBP were to seek such information about its members, it would request pertinent and available

demographic information from the Division of Human Resources Management and other agency partners, such as the Nevada System of Higher Education. If PEBP were to begin collecting such information directly from its members, it would require revision of numerous forms and system enhancements through the appropriate vendor to populate, store, and report such data.

PEBP Language Access Services and Procedures

PEBP currently provides a notice of non-discrimination that includes information about how to access PEBP's services in numerous languages, including Spanish, Tagalog, Chinese, Korean, Vietnamese, Amharic, Thai, Japanese, Arabic, Russian, French, Persian, Samoan, and German: https://pebp.nv.gov/Plans/mandatory-notices/. Upon request for translation, including for captions or sign language, PEBP contacts a contracted vendor identified on the Department of Administration's Purchasing Division Statewide Contracts for Translation and Interpretation services to fulfill such requests. There have been no such requests in the last seven years.

Community Outreach and Engagement

In addition to the language access resources set forth in its non-discrimination notice, as described above, PEBP has notified agency representatives, who deal directly with PEBP members, of its language access services.

Implementing Language Access Services to Staff

PEBP encourages staff to access several helpful cultural competency resources provided by the "Think Cultural Health" website, sponsored by the Office of Minority Health of the United States Department of Health and Human Services:

- *Guide to Providing Effective Communication and Language Assistance Services*, available at https://thinkculturalhealth.hhs.gov/education/communication-guide
- *A Primer on Communication and Language Assistance* (video presentation), available at: https://thinkculturalhealth.hhs.gov/resources/presentations/7/a-primer-on-communication-and-language-assistance
- "How-to" guides, available at https://thinkculturalhealth.hhs.gov/resources/library:

    - *Communication styles*
    - *Combating implicit bias and stereotypes*
    - *How to better understand different social identities*
    - *CLAS, cultural competency, and cultural humility*

Obtaining Request for Language Services

The Member Services Unit (MSU) shall take requests for language services in the following manner.

1. Provide the member the Non-Discrimination Notice containing information in numerous languages besides English and determine the client's preferred language;
2. Note the member's preferred language in the member's account; and
3. Notify the Quality Control and Compliance Unit so that appropriate interpretation and/or translation services may be arranged.

Accessing Appropriate Oral Language Services

The preferred method to serve LEP members is by having multilingual staff who can communicate with members orally, and to provide translations of vital documents. In the absence of these staff resources, staff are authorized to:

1. Utilize translation applications, such as Google Translate, to triage the initial interaction and proceed to the next step.
2. Seek professional interpretation and translation services from an appropriate vendor, with the assistance of the Quality Control and Compliance Unit.

Accessing Appropriate Written Language Services

According to PEBP's stated policy on the determination of "vital" documents, the following procedures shall be followed to access qualified written language services. This applies both to written information intended for broad distribution as well as written communications between PEBP and individual clients.

1. Identify the LEP client's preferred language by utilizing the non-discrimination notice as a template for assistance.
2. Inform the members that the documents shall be provided in their preferred written language.
3. Utilize online translation applications, such as Google Translate, to triage the initial interaction and proceed to the next step.
4. PEBP Quality Control and Compliance Unit will seek appropriate professional interpretation and translation services from an appropriate vendor, on an expedited basis, if necessary.
5. Once any translation is completed, PEBP staff will call the PEBP member and arrange delivery of the document by mail or email.

Language Services Quality Assurance:

The qualifications of those providing oral language or written translation services are documented in the Department of Administration's Purchasing Division Statewide Contracts for Translation and Interpretation. Any dissatisfaction with such services shall be relayed to the Purchasing Division.

Staff Training Policies and Procedures

PEBP ensures that its staff are familiar with its language access plan.

Evaluation/Recommendation for PEBP's Language Access Plan

This language access plan shall be reviewed every two years or sooner when deemed necessary.

Processes for Monitoring and Evaluation

The responsibility for monitoring and evaluating the language access plan lies with the Quality Control and Compliance Unit and is subject to approval by the PEBP Board.

PEBP's Quality Control and Compliance Unit shall track all access requests from members and vendors. In

the past seven years, there have been no requests for translation services; therefore, PEBP does not currently analyze performance measures based on translation services.

LAP Considerations/Possible Revisions

PEBP is monitoring potential statewide implementation of translation software to provide a baseline for any members with LEP to initially access plan documents, subject to further professional translation, if necessary. If such software is implemented or available, and cost-effective, PEBP may seek funding to purchase any appropriate license/s.

Budgetary Implications

PEBP has identified vital documents required for members to use its services and those required by state and federal law. Those documents are:

1. Enrollment and Eligibility Master Plan Document
2. Consumer Driven Health Plan Master Plan Document
3. Low Deductible Plan Master Plan Document
4. Exclusive Provider Organization Plan Master Plan Document
5. Dental and Basic Life Insurance Master Plan Document
6. Health Reimbursement Arrangement Summary Plan Description
7. Flexible Spending Accounts Master Plan Document
8. Carrum Health: Centers of Excellence Wrap Plan Document
9. Active Employee Health and Welfare Wrap Plan Document
10. Retiree Employee Health and Welfare Wrap Plan Document
11. Section 125: Health and Welfare Benefits Plan Document
12. Notices to members
13. Forms for members to participate in PEBP

Combined, these documents contain more than 342,000 words. The estimated costs to translate these documents, by language, utilizing the State's contracted translations vendors is noted below.

Vendor Number	Spanish	Chinese (Mandarin & Cantonese), Arabic, Russian, Farsi, Vietnamese, Swahili, Somali, Korean, French, Portuguese, German, Italian	Bosnian-Serbo Croatian, Bulgarian, Czech, Danish, Dutch, Finnish, Flemish, Greek, Hungarian, Norwegian, Polish, Romanian, Slovak, Slovenian, Swedish, Turkish, Ukrainian	All other languages (includes Tagalog)
99SWC- NV22-11678	$0.12/word	$0.15 / word	$0.18 / word	$0.21 / word
99SWE- NV22-11691	$0.09/word	$0.16 / word	$0.16 / word	$0.16 / word
99SWC-NV-11693	$0.09/word	$0.14 / word	$0.15 / word	$0.20 / word
Highest Estimated Cost	**$41,040**	**$54,720**	**$61,560**	**$71,820**

The top three languages spoken in Nevada after English are Spanish, Tagalog, and Chinese[1]. To translate some or all the vital documents into those languages would cost PEBP up to **$167,580 per year,** based on the estimates on the above chart. Expedited translations are noted to have significantly higher cost per word.

As no members have requested translation of the vital documents in the past seven years, it appears that members with limited English proficiency constitute less than 5% of PEBP's eligible population. Accordingly, these documents have not been preemptively translated. In the event PEBP requires translation of these documents, the cost would be included in PEBPs annual budget.

For PEBP to track members who are indigenous, a refugee, or with LEP, the enrollment and eligibility system will require a system enhancement. According to the vendor, this would cost approximately **$35,000** ($15,000 for the identification of LEP and $20,000 for the identification of indigenous or refugee).

Additionally, PEBP may request an enhancement to the enrollment and eligibility system to display the online member portal in other languages. The vendor indicates that translation to Spanish only will cost approximately **$300,000**.

[1] https://www.guinncenter.org/articles/the-2020-census-in-nevada-snapshot-7

4.5

4. Consent Agenda (Joy Grimmer, Board Chair) (**All Items for Possible Action**)

4.5 Self Insurance Internal Service Fund Financial Statement

Financial Statements
June 30, 2023 and 2022

State of Nevada

Self Insurance
Internal Service Fund
Public Employees' Benefits Program

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Table of Contents
June 30, 2023 and 2022

EideBailly

CPAs & BUSINESS ADVISORS

Independent Auditor's Report

To the Board of the
Public Employees' Benefits Program
Carson City, Nevada

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of the Self Insurance Internal Service Fund of the State of Nevada, as of and for the year ended June 30, 2023, and the related notes to the financial statements, as listed in the table of contents.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the financial position of the Self Insurance Internal Service Fund of the State of Nevada, as of June 30, 2023, and the changes in its financial position and cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States *(Government Auditing Standards)*. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the State of Nevada, and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Emphasis of a Matter

As discussed in Note 1, the financial statements present only the Self Insurance Internal Service Fund, and do not purport to, and do not, present fairly the financial position of the State of Nevada, as of June 30, 2023 and 2022, the changes in its financial position, or, where applicable, its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Correction of an Error

The financial statements of the Self Insurance Internal Service Fund of the State of Nevada as of and for the year ended June 30, 2022 were audited by other auditors, whose report dated February 22, 2023, contained an unmodified opinion on those statements.

As discussed in Note 13 to the financial statements, certain errors occurred related to the classification of cash flow activities that were previously reported for the year ended June 30, 2022. This error resulted in a restatement of cash flow activities as of June 30, 2022. Our opinion is not modified with respect to this matter.

As part of our audit of the 2023 financial statements, we also audited the adjustments described in Note 13 that were applied to restate the 2022 financial statements. In our opinion, such adjustments were appropriate and have been properly applied. We were not engaged to audit, review or apply any procedures to the 2022 financial statements of the Self Insurance Internal Service Fund of the State of Nevada other than with respect to the adjustments and, accordingly, we do not express an opinion or any other form of assurance on the 2022 financial statements as a whole.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and Government Auditing Standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the State of Nevada's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the schedule of the Fund's proportionate share of the net pension liability on page 35, the schedule of the Fund's contributions – pension on page 36, schedule of the Fund's proportionate share of the net OPEB liability on page 37, and the schedule of the Fund's contributions – OPEB on page 38 be presented to supplement the basic financial statements. Such information is the responsibility of management and although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with GAAS, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Management has omitted the management's discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements is not affected by this missing information.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated July 11, 2024 on our consideration of the Self Insurance Internal Service Fund of the State of Nevada's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Self Insurance Internal Service Fund of the State of Nevada's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Self Insurance Internal Service Fund of the State of Nevada's internal control over financial reporting and compliance.

Eide Bailly LLP

Reno, Nevada
July 11, 2024

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Statements of Net Position
June 30, 2023 and 2022

	2023	2022
Assets		
Current Assets		
Cash and cash equivalents	$ 128,251,217	$ 140,185,989
Prepaid insurance	7,975	14
Receivables		
Accounts receivable, net	3,922,217	13,772,307
Intergovernmental receivable	928,279	2,240,641
Due from other State of Nevada funds	1,811,555	2,842,560
Due from State of Nevada Retiree Health and Welfare fund	34,416,623	25,046,900
Due from Nevada System of Higher Education	38	1,105,541
Total current assets	169,337,904	185,193,952
Capital Assets		
Equipment	137,064	154,663
Right to use leased assets	2,239,384	-
Less accumulated depreciation and amortization	(244,429)	(144,356)
Total capital assets, net	2,132,019	10,307
Total assets	171,469,923	185,204,259
Deferred Outflows of Resources		
Pension related amounts	1,354,022	1,312,782
OPEB related amounts	89,230	125,886
Total deferred outflows of resources	1,443,252	1,438,668

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Statements of Net Position
June 30, 2023 and 2022

Liabilities and Net Position	2023	2022
Current Liabilities		
Bank overdraft	$ 1,207,902	$ 3,413,547
Accounts payable	1,699,175	1,301,408
Accrued payroll and related benefits	131,257	102,946
Due to other State of Nevada funds	29,624	46,105
Unearned revenue	9,664,653	5,435,806
Current maturities of compensated absences	115,928	158,007
Current maturities of lease liabilities	171,712	-
Current maturities of net OPEB liability	34,009	-
Reserve for losses	80,174,935	79,492,071
Total current liabilities	93,229,195	89,949,890
Noncurrent Liabilities		
Compensated absences, net of current maturities	54,656	70,554
Lease liabilities, net of current maturities	2,018,932	-
Net OPEB liability, net of current maturities	1,154,935	1,395,724
Net pension liability	4,034,515	2,265,928
Total noncurrent liabilities	7,263,038	3,732,206
Total liabilities	100,492,233	93,682,096
Deferred Inflows of Resources		
Pension related amounts	183,925	1,916,469
OPEB related amounts	139,064	56,929
Total deferred inflows of resources	322,989	1,973,398
Net Position		
Net investment in capital assets	(58,625)	10,307
Restricted for future claims and related expenses	72,156,578	90,977,126
Total net position	$ 72,097,953	$ 90,987,433

See Notes to Financial Statements

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Statements of Revenues, Expenses and Changes in Net Position
Years Ended June 30, 2023 and 2022

	2023	2022
Operating Revenues		
Insurance premiums	$ 365,997,765	$ 359,639,820
Other	36,650	21,183
Total operating revenues	366,034,415	359,661,003
Operating Expenses		
Salaries and benefits	2,161,003	2,024,758
Operating	4,418,205	5,082,430
Claims expense	326,861,514	304,752,973
Depreciation/amortization	129,590	3,237
Insurance premiums and contractual obligations	60,410,337	58,244,946
Total operating expenses	393,980,649	370,108,344
Operating Income (Loss)	(27,946,234)	(10,447,341)
Nonoperating Revenues (Expenses)		
Payments from other State of Nevada funds	6,038,836	16,516,757
Payments to other State of Nevada funds	(727,330)	-
Interest expense	(33,196)	-
Gain (loss) on disposal of assets	(3,267)	-
Investment income (expense)	210,751	(4,702,251)
Interest Income	3,570,960	1,020,748
Total nonoperating revenues	9,056,754	12,835,254
Change in Net Position	(18,889,480)	2,387,913
Net Position, Beginning of Year	90,987,433	88,599,520
Net Position, End of Year	$ 72,097,953	$ 90,987,433

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Statements of Cash Flows
Years Ended June 30, 2023 and 2022

	2023	2022 As Restated
Operating Activities		
Receipts from customers and users	$ 95,398,987	$ 83,785,517
Receipts from services to State of Nevada funds	146,453,391	137,655,066
Receipts from State of Nevada component units	131,524,828	118,793,080
Payments to suppliers, other governments and beneficiaries	(392,105,185)	(370,592,136)
Payments to employees	(2,283,855)	(2,384,959)
Payments for services to other State of Nevada funds	(717,846)	(659,985)
Net cash used for operating activities	(21,729,680)	(33,403,417)
Noncapital Financing Activities		
Receipts from other State of Nevada funds	7,988,836	18,786,311
Payments to other State of Nevada funds	(743,811)	-
Net cash from noncapital financing activities	7,245,025	18,786,311
Capital and Related Financing Activities		
Purchase of capital assets	(15,185)	(2,906)
Principal paid on leases	(48,740)	-
Interest paid on leases	(33,196)	-
Net cash used for capital and related financing activities	(97,121)	(2,906)
Investing Activities		
Interest, dividends and gains (losses)	2,647,004	(3,902,979)
Net Decrease in Cash and Cash Equivalents	(11,934,772)	(18,522,991)
Cash and Cash Equivalents, Beginning of Year	140,185,989	158,708,980
Cash and Cash Equivalents, End of Year	$ 128,251,217	$ 140,185,989

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Statements of Cash Flows
Years Ended June 30, 2023 and 2022

	2023	2022 As Restated
Reconciliation of Operating Income (Loss) to Net Cash used for Operating Activities		
Operating income	$ (27,946,234)	$ (10,447,341)
Adjustments to reconcile operating income to net cash from (used for) operating activities		
Depreciation	129,590	3,237
Changes in assets and liabilities		
Decrease (increase) in receivables	11,162,452	(3,328,523)
Decrease (increase) in due from State of Nevada funds, retiree health and welfare and system of higher ed	(8,048,508)	(18,051,129)
Decrease (increase) in prepaid expenses	(7,961)	3,505
Decrease (increase) in deferred outflows of resources	(4,584)	(715,589)
Increase (decrease) in payables and accruals	(1,154,680)	(3,195,962)
Increase (decrease) in unearned revenue	4,228,847	1,952,312
Increase (decrease) in net pension liability	1,768,587	(1,271,523)
Increase (decrease) in net OPEB liability	(206,780)	(9,905)
Increase (decrease) in deferred inflows of resources	(1,650,409)	1,657,501
Total adjustments	6,216,554	(22,956,076)
Net Cash used for Operating Activities	$ (21,729,680)	$ (33,403,417)
Noncash Investment, Capital and Financing Activities		
Leases incurred for right to use assets	$ 2,239,384	$ -

Note 1 - Summary of Significant Accounting Policies

The financial statements of the Self Insurance Internal Service Fund (the Fund), Public Employees' Benefits Program (PEBP) of the State of Nevada (the State) have been prepared in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP) as applied to governmental units. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. A summary of the Fund's significant accounting policies applied in the preparation of the accompanying financial statements is presented below.

Plan Description

The Fund was created in 1983 by the Nevada Legislature to administer group health, life and disability insurance for covered employees, both active and retired, of the State, and certain other participating public employers within the State. All public employers in the State are eligible to participate in the activities of the Fund and currently, in addition to the State, there were four public employers participating at June 30, 2023 and 2022. whose employees are covered under the plan. Additionally, all retirees of public employers contracted with PEBP to provide coverage to their employees are eligible to join the program subsequent to their retirement. Public employers are required to subsidize their retirees who participate in the plan in the same manner the State subsidizes its retirees. Currently, the State, the Nevada System of Higher Education and 165 public employers within the State are billed for retiree subsidies. The Fund provides medical, dental, vision, long-term disability, mental health, substance abuse, and life insurance benefits. The Fund is overseen by PEBP's Board. The board is composed of eleven members, ten members appointed by the governor, and the director of the State's Department of Administration or their designee.

The Fund is self-insured for medical, dental, vision, mental health and substance abuse benefits and also offers fully insured HMO products. Life insurance benefits are fully insured by outside carriers. For the self-insured benefits, rate-setting policies have been established after consultation with an actuary. The participating public employers, with the exception of the State, are not subject to supplemental assessment in the event of deficiencies.

PEBP has instituted a Consumer Driven Health Plan (CDHP) with Health Savings Account (HSA) and Health Reimbursement Account (HRA) components. The HSA component is designed for eligible active employee's where the HRA component is for retirees and surviving spouses, domestic partners and certain employees enrolled in the CDHP.

PEBP has also implemented an individual market Medicare exchange where retirees eligible for Medicare purchase individual coverage on the private market with an HRA component to reimburse retirees for insurance premiums and other out of pocket expenses.

In addition, PEBP has implemented an Exclusive Provider Organization (EPO) plan. The plan is self-insured.

Reporting Entity

Governmental accounting and financial reporting principles require that basic financial statements be presented for governmental entities which present financial statements in accordance with accounting principles generally accepted in the United States of America. The accompanying financial statements are not intended to present the combined financial activities of the State taken as a whole, but are intended only to present the financial position, results of operations, and cash flows of the Fund.

Fund Accounting

The operations of the Fund, a proprietary fund (internal service fund), are accounted for by a separate set of self-balancing accounts that comprise its assets, liabilities, net position, revenues, and expenses. The Fund is used to account for the services provided to the employees and retirees of the State and other governmental units under the programs administered by management.

Basis of Accounting

The Fund maintains its accounting records on the accrual basis of accounting. Under this method, revenues are recognized at the time they are earned and expenses are recognized when the related liabilities are incurred regardless of the timing of cash flows. The Fund is reported using the economic resources measurement focus. The revenues derived from current operations are generally intended to provide those resources necessary to maintain continued delivery of such services in the future. Net positions greater or lesser than those required to support ongoing operations are moderated by adjustments of future charge rates appropriate to accomplish the long-term cost recovery objectives of the Fund.

Internal Service Funds distinguish operating revenues and expenses from nonoperating items. Operating revenues and expenses result from providing services in connection with providing group health, life and disability insurance. Operating expenses include the cost of services, administrative expenses and depreciation on capital assets. All revenues and expenses not meeting this definition are reported as nonoperating revenues and expenses.

Cash with State Treasurer

For the purpose of presentation in the Fund's financial statements and the statements of cash flows, cash equivalents are short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash and (b) so near to maturity that they present insignificant risk of changes in value due to changing interest rates. Such amounts include the State's general portfolio (Treasurer's Pool). Cash with State Treasurer functions as a demand deposit account.

Receivables, Due from other State of Nevada Funds, Fiduciary Funds, and Component Units

Receivables as well as the due from other State of Nevada funds, State of Nevada Retiree Health and Welfare Fund, and Nevada System of Higher Education comprise of insurance premiums due as of June 30 that have not yet been remitted, interest distributions from the Treasurer's Pool, various rebates, or other miscellaneous items such as approved transfers from other State of Nevada Funds that have not yet occurred. The fund evaluates the collectability of these balances based on historical factors and known conditions. An allowance for doubtful accounts is created, if the historical factors and known conditions create doubt on the potential collectability. Amounts on the statements of net position are shown net of an allowance, if applicable. Additional detail of these balances is presented in Note 4 to the financial statements.

The third party administrator that processes claims payments on behalf of the Fund has identified overpayments in the amount of $2,435,716 and $3,192,254 as of June 30, 2023 and 2022, respectively. Overpayments are followed up on every 30 days until recovery is made. These amounts have not been accrued as a receivable on the statement of net position but are recorded as a reduction to claims expense in the period in which recovery is received. Collection attempts cease when the overpayment is greater than four years old.

Unearned Revenue

The Fund administers an additional pass-through budget account, the Active Employee Group Insurance Subsidy (AEGIS) budget account. This budget account is utilized for recording the payments made by the State and participating employers and received by the Fund on behalf of active employees. Agencies contribute a fixed dollar amount per employee into this budget account. However, insurance premiums are earned in accordance with the PEBP approved rate for insurance coverage for the plan and tier to which each employee belonged. The difference between cash contributions from AEGIS and premiums earned resulted in a surplus of contributions over premiums of $9,664,653 and $5,248,361 for the years ended June 30, 2023 and 2022, respectively. These amounts were allocated among all state entities that paid the AEGIS subsidy proportionate to their size and were included in the subsequent year's budget.

Capital Assets

Capital assets are recorded at cost and consist of assets with an initial, individual cost of more than $5,000 and an estimated useful life in excess of one year. Capital assets are depreciated on a straight-line basis over estimated useful lives of three to ten years. The cost of repairs and maintenance that do not materially extend the life of an asset are not capitalized.

Right to use leased assets are recognized at the lease commencement date and represent the Fund's right to use an underlying asset for the lease term. Right to use leased assets are measured at the initial value of the lease liability plus any payments made to the lessor before commencement of the lease term, less any lease incentives received from the lessor at or before the commencement of the lease term, plus any initial direct costs necessary to place the lease asset into service. Right to use leased assets are amortized over the shorter of the lease term or useful life of the underlying asset using the straight-line method. The amortization period for the Fund's right to use assets ranges from 5 – 12 years.

Estimated Claims

The Fund contracted a provider of consulting and actuarial services to estimate its liability for incurred but not reported claims, claims reported but not yet paid and administrative expenses expected to be incurred in conjunction with processing incurred but not reported claims as of June 30, 2023 and 2022, respectively. This liability is estimated by the actuary based on industry trends and claims lag information reported by the third-party administrator. Such liabilities are necessarily based on estimates, and, while management believes the amount is adequate, the ultimate liability may be in excess of, or less than, the amounts provided. The methods for making such estimates and for establishing the resulting liability are reviewed on an annual basis and any adjustments are currently reflected in net income from operations.

Included in the estimated claims is the liability for the unused portion of the HRA component of the CDHP and the Medicare exchange. The liabilities are provided by each third-party administrator.

Compensated Absences

A liability for compensated absences relating to services already rendered and that are not contingent on a specified event is accrued as employees earn the rights to the benefits. Compensated absences relating to future services or that are contingent on a specified event will be accounted for in the period those services are rendered or those events take place. Annual and sick leave benefits not used as earned accumulate to be carried over to the next year, except that annual leave in excess of 240 hours (30 days) per employee is forfeited each December 31.

Accumulated annual leave and compensatory time are payable upon termination, retirement, or death. Unused sick leave may be partially compensated at that time according to formulas established by the Department of Administration. The Fund reports accrued compensated absences as a liability.

Lease Liability

Lease liabilities represent the Fund's obligation to make lease payments arising from the lease. Lease liabilities are recognized at the lease commencement date based on the present value of future lease payments expected to be made during the lease term. The present value of lease payments is discounted based on a borrowing rate determined by the Fund.

Pensions

For purposes of measuring the net pension liability and deferred outflows/inflows of resources related to pensions, and pension expense, information about the fiduciary net position of the Public Employees' Retirement System of Nevada (PERS) plan and additions to/deductions from the plan's fiduciary net position have been determined on the same basis as they are reported by PERS. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Post-Employment Benefits Other Than Pensions (OPEB)

For purposes of measuring the net OPEB liability, deferred outflows/inflows of resources related to OPEB and OPEB expense, information about the fiduciary net position of the State Retirees' Health and Welfare Benefits Fund and additions to/deductions fiduciary net position have been determined on the same basis as they are reported by the State Retirees' Health and Welfare Benefits Fund. For this purpose, benefit payments are recognized when due and payable in accordance with the benefit terms.

Deferred Outflows/Inflows of Resources

In addition to assets, the statements of net position include a separate section for deferred outflows of resources. This financial statement element represents a consumption of net assets that applies to a future period(s) and so will not be recognized as an outflow of resources (expense) until that time. The Fund reflects deferred outflows of resources in the statements of net position for items related to pensions and other postemployment benefits.

In addition to liabilities, the statements of net position include a separate section for deferred inflows of resources. This separate financial statement element represents an acquisition of net assets that applies to future period(s) and will not be recognized as an inflow of resources (revenue) until that time. The Fund reflects deferred inflows of resources in the statements of net position for items related to pensions and other postemployment benefits.

Net Position

In proprietary fund financial statements, equity is classified as net position and displayed in three components:

- Net Investment in Capital Assets – Consists of capital assets, net of accumulated depreciation/amortization and reduced by outstanding balances of any bonds, notes, leases, or other borrowings that are attributable to the acquisition, construction or improvement of those assets.
- Restricted Net Position – Consists of equity with constraints placed on their use either by (1) external groups such as creditors, grantors, contributors, or laws and regulations of other governments; (2) law through constitutional provisions of enabling legislation.
- Unrestricted Net Position – All other equity that does not meet the definition of net investment in capital assets or restricted net position.

Management of the Fund has determined that all net position, other than net investment in capital assets, should be classified as restricted net position, due to legal restrictions placed on the use of funds.

Operating and Nonoperating Revenues and Expenses

Revenues and expenses are classified as operating if they result from providing services and producing and delivering goods. They also include other events that are not defined as capital and related financing, noncapital financing, or investing activities. Contracts representing an exchange transaction are considered operating revenues.

Revenues and expenses are classified as nonoperating if they result from capital and related financing, noncapital financing or investing activities. Appropriations received to finance operating deficits are classified as noncapital financing activities; therefore, they are reported as nonoperating revenues. Contracts representing nonexchange receipts are treated as nonoperating revenues.

The Fund has transactions with other funds within the State of Nevada. Accordingly, transactions for which services are provided (insurance premiums) or goods received (operating costs) are classified as operating revenues or expenses; whereas, transactions with other State of Nevada funds classified as nonoperating are related to financing and investing activities within the State.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Reclassifications

A reclassification of intergovernmental receivables to due from other State of Nevada funds was performed for the year ended June 30, 2022 to conform with the current year presentation.

Implementation of GASB Statement No. 96

As of July 1, 2022, the Fund adopted GASB Statement No. 96, *Subscription-Based Information Technology Arrangements* (SBITA). The implementation of this standard establishes that a SBITA results in a right-to-use subscription asset – an intangible asset – and a corresponding liability. The standard provides the capitalization criteria for outlays other than subscription payments, including implementation costs of a SBITA. There was no effect on beginning net position due to the implementation of this standard.

Note 2 - Stewardship and Compliance

Compliance with Nevada Revised Statutes (NRS) and the Nevada Administrative Code (NAC)

The Fund conformed to all significant statutory constraints on its financial administration during the year.

Note 3 - Cash and Cash with Treasurer

	2023	2022
Bank overdraft		
Overdraft accounts	$ (1,207,902)	$ (3,413,547)
Cash with State Treasurer		
State Treasurer's Investment Pool	132,290,093	144,435,616
Unrealized gains and losses	(4,038,876)	(4,249,627)
Total cash with State Treasurer	128,251,217	140,185,989
Total cash and deposits	$ 127,043,315	$ 136,772,442

The Fund has three checking accounts at June 30, 2023 and 2022. These accounts contain $360,903 and $639,140 (of the total overdraft accounts balances above) in stale outstanding checks for the years ended June 30, 2023 and 2022, respectively. The controlled disbursement account is presented as a liability on the statement of net position and is funded only when checks are presented for payment. The negative balance represents outstanding checks issued that have not been presented for payment. In accordance with NRS 353.140, the Fund honors outstanding stale warrants presented for payment within six years from the date of origination. For insurance and collateral purposes, the account is commingled with all of the cash accounts of the State. All cash and cash with Treasurer are recorded at fair value.

NRS directs the Office of the State Treasurer to deposit funds into any state, or national bank, credit union or savings and loan association covered by federal depository insurance. For those deposits over and above the federal depository insurance maximum balance, sufficient collateral must be held by the financial institution to protect the state of Nevada against loss. The pooled collateral for the deposits program maintains a 102% pledge collateral for all public deposits.

NRS 355.140 details the types of securities in which the State may invest. In general, authorized investments include: certificates of deposit, asset-backed securities, bankers' acceptances and commercial paper, collateralized mortgage obligations, corporate notes, money market funds whose policies meet the criteria set forth in the statute, United States treasury securities and specific securities implicitly guaranteed by the federal government. Additionally, the State may invest in limited types of repurchase agreements; however, statutes generally prohibit the State from entering into reverse-repurchase agreements.

Note 4 - Receivables

Receivable balances are disaggregated by type and presented separately in the financial statements. Additional disaggregation by purpose is shown below.

Receivable balances, including intergovernmental and State of Nevada related funds and entities were as follows at June 30, 2023:

	Accounts Receivable	Intergovernmental	State of Nevada Funds	Retiree Health and Welfare	NV System of Higher Education
Premiums	$ 3,922,217	$ 67,347	$ 11,918	$ 34,416,623	$ 38
Interest	-	-	1,799,637	-	-
Rebates	-	860,932	-	-	-
Other	-	-	-	-	-
	$ 3,922,217	$ 928,279	$ 1,811,555	$ 34,416,623	$ 38

Receivable balances, including intergovernmental and State of Nevada related funds and entities were as follows at June 30, 2022:

	Accounts Receivable	Intergovernmental	State of Nevada Funds	Retiree Health and Welfare	NV System of Higher Education
Premiums	$ 13,942,555	$ 1,898,048	$ 227,630	$ 25,046,900	$ 1,105,541
Interest	-	-	664,930	-	-
Rebates	-	342,593	-	-	-
Other	-	-	1,950,000	-	-
Allowance	(170,248)	-	-	-	-
	$ 13,772,307	$ 2,240,641	$ 2,842,560	$ 25,046,900	$ 1,105,541

Note 5 - Capital Assets

The following schedule summarizes the changes in capital assets for the year ended June 30, 2023:

	Balance July 1, 2022	Additions	Deletions	Balance June 30, 2023
Capital assets being depreciated				
Equipment	$ 154,663	$ 15,185	$ (32,784)	$ 137,064
Less accumulated depreciation	(144,356)	(4,527)	29,517	(119,366)
Capital assets being depreciated, net	10,307	10,658	(3,267)	17,698
Right to use leased assets being amortized				
Building	-	2,206,084	-	2,206,084
Equipment	-	33,300	-	33,300
Less accumulated amortization				
Building	-	(100,276)	-	(100,276)
Equipment	-	(24,787)	-	(24,787)
Right of use leased assets, net	-	2,114,321	-	2,114,321
Total capital assets, net	$ 10,307	$ 2,124,979	$ (3,267)	$ 2,132,019

The following schedule summarizes the changes in capital assets for the year ended June 30, 2022:

	Balance July 1, 2021	Additions	Deletions	Balance June 30, 2022
Capital assets being depreciated				
Equipment	$ 268,533	$ 2,906	$ (116,776)	$ 154,663
Less accumulated depreciation	(257,895)	(3,237)	116,776	(144,356)
Total capital assets, net	$ 10,638	$ (331)	$ -	$ 10,307

Note 6 - Leases

Key estimates and judgments related to leases include how the Fund determines (1) the discount rate it uses to discount the expected lease payments to present value, (2) lease term, and (3) lease payments. The Fund uses the interest rate charged by the lessor as the discount rate. When the interest rate charged by the lessor is not provided, the Fund generally uses the incremental borrowing rate for borrowings of a like nature. The lease term includes the noncancellable period of the lease plus any options to extend that are reasonably certain of being exercised. Lease payments included in the measurement of the lease liability are composed of fixed payments or fixed in substance payments as well as any purchase option prices that the Fund is reasonably certain of exercising. Variable payments, if applicable, based on usage or future events are not included in the measurement. The Fund monitors changes in circumstances that would require a remeasurement of its lease and will remeasure any lease asset and liability if certain changes occur that are expected to significantly affect the amount of the lease liability. Right to use leased assets are reported along with other capital assets.

The Fund has entered into various agreements to lease office equipment and a building with initial terms ranging from 5 to 12 years. The various leases will terminate by December 2033. At June 30, 2023 and 2022, the Fund recognized right to use assets of $2,239,384 and $0, respectively. At June 30, 2023 and 2022, the Fund recognized lease liabilities of $2,190,644 and $0, respectively. The Fund recognized amortization expense of $125,063 and $0 for the years ended June 30, 2023 and 2022, respectively. The Fund recognized interest expense of $33,196 and $0 for the years ended June 30, 2023 and 2022, respectively.

Changes in long-term lease liabilities during the year ended June 30, 2023, are as follows:

	Balance July 1, 2022	Additions	Deletions	Balance June 30, 2023	Due Within One Year
Leases	$ -	$ 2,239,384	$ (48,740)	$ 2,190,644	$ 171,712

Remaining principal and interest payments on leases are as follows:

Year Ending June 30,	Principal	Interest
2024	$ 171,712	$ 62,183
2025	176,242	57,027
2026	186,282	51,545
2027	196,558	45,827
2028	207,016	39,729
2029 - 2033	1,130,219	100,528
2034	122,615	460
	$ 2,190,644	$ 357,299

Note 7 - Compensated Absences

The following schedule summarizes the changes in compensated absences for the year ended June 30, 2023:

	Balance July 1, 2022	Additions	Deletions	Balance June 30, 2023	Due Within One Year
Compensated absences	$ 228,561	$ 102,219	$ 160,196	$ 170,584	$ 115,928

The following schedule summarizes the changes in compensated absences for the year ended June 30, 2022:

	Balance July 1, 2021	Additions	Deletions	Balance June 30, 2022	Due Within One Year
Compensated absences	$ 250,584	$ 127,384	$ 149,407	$ 228,561	$ 158,007

Note 8 - Defined Benefit Pension Plans

Plan Description

The Fund contributes to the PERS. PERS administers a cost-sharing, multiple-employer, defined benefit public employees' retirement system which includes both regular and police/fire members. PERS was established by the Nevada Legislature in 1947, effective July 1, 1948. PERS is administered to provide a reasonable base income to qualified employees who have been employed by a public employer and whose earning capacities have been removed or substantially impaired by age or disability.

Benefits Provided

Benefits, as required by NRS, are determined by the number of years of accredited service at time of retirement and the member's highest average compensation in any 36 consecutive months with special provisions for members entering PERS on or after January 1, 2010 and July 1, 2015. Benefit payments to which participants or their beneficiaries may be entitled under the plan include pension benefits, disability benefits, and survivor benefits.

Monthly benefit allowances for members are computed at 2.5 percent of average compensation for each accredited year of service prior to July 1, 2001. For service earned on or after July 1, 2001, this multiplier is 2.67% of average compensation. For members entering PERS on or after January 1, 2010, there is a 2.50% service time factor. Regular members entering PERS on or after July 1, 2015, have a 2.25% multiplier for all years of service. PERS offers several alternatives to the unmodified service retirement allowance which, in general, allow the retired employee to accept a reduced service retirement allowance payable monthly during his or her lifetime and various optional monthly payments to a named beneficiary after his or her death.

Post-retirement increases are provided by authority of NRS 286.575 – 286.579.

Vesting

Regular members entering PERS prior to January 1, 2010 are eligible for retirement at age 65 with 5 years of service, at age 60 with 10 years of service, or at any age with 30 years of service. Regular members entering PERS on or after January 1, 2010, are eligible for retirement at age 65 with 5 years of service, or age 62 with 10 years of service, or any age with 30 years of service. Regular members entering PERS on or after July 1, 2015 are eligible for retirement at age 65 with 5 years of service, or age 62 with 10 years of service, or at 55 with 30 years of service, or at any age with 33 1/3 years of service.

The normal ceiling limitation on monthly benefits allowances is 75% of average compensation. However, a member who has an effective date of membership before July 1, 1985, is entitled to a benefit of up to 90% of average compensation. Both Regular and Police/Fire members become fully vested as to benefits upon completion of five years of service.

Contributions

The authority for establishing and amending the obligation to make contributions and member contribution rates, is set by statute. New hires, in agencies which did not elect the Employer-Pay Contribution (EPC) plan prior to July 1, 1983, have the option of selecting one of two contribution plans. One plan provides for matching employee and employer contributions, while the other plan provides for employer-pay contributions only. Under the matching Employee/Employer Contribution plan a member may, upon termination of service for which contribution is required, withdraw employee contributions which have been credited to their account. All membership rights and active service credit in the System are canceled upon withdrawal of contributions from the member's account. If EPC was selected, the member cannot convert to the Employee/Employer Contribution plan.

PERS' basic funding policy provides for periodic contributions at a level pattern of cost as a percentage of salary throughout an employee's working lifetime in order to accumulate sufficient assets to pay benefits when due.

PERS receives an actuarial valuation on an annual basis indicating the contribution rates required to fund PERS on an actuarial reserve basis. Contributions actually made are in accordance with the required rates established by the Nevada Legislature. These statutory rates are increased/decreased pursuant to NRS 286.421 and 286.450.

The actuary funding method used is the entry age actuarial cost method. It is intended to meet the funding objective and result in a relatively level long-term contributions requirement as a percentage of salary.

For the fiscal years ended June 30, 2023 and 2022, the Statutory Employer/Employee matching rate for Regular members was 15.50%. The Employer-Pay Contribution (EPC) rate was 29.75% for Regular members for the fiscal years ended June 30, 2023 and 2022.

The Fund's contributions to PERS for the years ended June 30, 2023 and 2022 were $229,841 and $246,551, respectively, equal to the required contributions for the year.

PERS Investment Policy

PERS' policies which determine the investment portfolio target asset allocation are established by the PERS Board. The asset allocation is reviewed annually and is designed to meet the future risk and return needs of PERS.

The following was the PERS Board adopted policy target asset allocation as of June 30, 2022:

Asset Class	Target Allocation	Long-Term Geometric Expected Real Rate of Return*
U.S. stocks	42%	5.50%
International stocks	18%	5.50%
U.S. bonds	28%	0.75%
Private markets	12%	6.65%

As of June 30, 2022, PERS' long-term inflation assumption was 2.50%.

Net Pension Liability

At June 30, 2023 and 2022, the Fund reported a liability for its proportionate share of the net pension liability of $4,034,515 and $2,265,928, respectively. The net pension liability was measured as of June 30, 2022 and 2021, respectively, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of those dates. The Fund's proportion of the net pension liability was based on the Fund's share of contributions to the PERS pension plan relative to the total contributions of all participating PERS employers. At June 30, 2022, the Fund's proportion was 0.0224% which was a decrease of .0021% from the proportion of 0.0245% at June 30, 2021, which was a decrease of .0009% from its proportion measured as of June 30, 2020.

Pension Liability Discount Rate Sensitivity

The following presents the net pension liability of the Fund as of June 30, 2023, calculated using the discount rate of 7.25%, as well as what the Fund's net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (6.25%) or 1-percentage-point higher (8.25%) than the current discount rate:

	1% Decrease in Discount Rate (6.25%)	Discount Rate (7.25%)	1% Decrease in Discount Rate (8.25%)
Net pension liability	$ 6,194,299	$ 4,034,515	$ 2,252,368

The following presents the net pension liability of the Fund as of June 30, 2022, calculated using the discount rate of 7.25%, as well as what the Fund's net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (6.25%) or 1-percentage-point higher (8.25%) than the current discount rate:

	1% Decrease in Discount Rate (6.25%)	Discount Rate (7.25%)	1% Decrease in Discount Rate (8.25%)
Net pension liability	$ 4,511,389	$ 2,265,928	$ 413,606

Pension Plan Fiduciary Net Position

Detailed information about the pension plan's fiduciary net position is available in the PERS Annual Comprehensive Financial Report, available on the PERS website.

Actuarial Assumptions

The Fund's net pension liability was measured as of June 30, 2022 and June 30, 2021, respectively, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of those dates. The total pension liability was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation rate	2.50%
Payroll growth	3.50%
Investment rate of return/discount rate	7.25%
Productivity pay increase	0.50%
Projected salary increases	Regular: 4.20% to 9.10%, depending on service Police/Fire: 4.60% to 14.50%, depending on service Rates include inflation and productivity increases
Consumer price index	2.50%
Other assumptions	Same as those used in the June 30, 2022 and 2021 funding actuarial valuation

Mortality rates for healthy regular members and contingent beneficiaries were based on Pub-2010 General Healthy Retiree Amount-Weighted Above-Median Mortality Table with rates increased by 30% for males and 15% for females. For ages before age 40, mortality rates are based on Pub-2010 General Employee Amount-Weighted Above-Median Mortality Tables. For ages 40 through 50, the rates were smoothed between the above tables. Mortality rates for heathy police/fire members were based on Pub-2010 Safety Healthy Retiree Amount-Weighted Above-Median Mortality Table with rates increased by 30% for males and 5% for females. For ages before age 35, mortality rates are based on Pub-2010 Safety Employee Amount-Weighted Above-Median Mortality Table. For ages 35 through 45, the rates were smoothed between the above tables.

Mortality rates for disabled regular members were based on Pub-2010 Non-Safety Disabled Retiree Amount-Weighted Mortality Table with rates increased by 20% for males and 15% for females. Mortality rates for disabled police/fire members were based on Pub-2010 Safety Disabled Retiree Amount-Weighted Mortality Table with rates increased by 30% for males and 10% for females.

Mortality rates for current beneficiaries were based on Pub-2010 Contingent Survivor Amount-Weighted Above-Median Mortality Table with rates increased by 15% for males and 30% for females. For ages before age 35, mortality rates are based on Pub-2010 General Employee Amount-Weighted Above-Median Mortality Table. For ages 35 through 45, the rates were smoothed between the above tables.

Mortality rates for pre-retirement regular members were based on Pub-2010 General Employee Amount-Weighted Above-Median Mortality Table. Morality rates for pre-retirement police/fire members were based on Pub-2010 Safety Employee Amount-Weighted Above-Median Mortality Table.

The mortality tables were projected generationally with the two-dimensional mortality improvement scale MP-2020.

Actuarial assumptions used in the June 30, 2022 and 2021 valuation were based on the results of the experience study for the period July 1, 2016 through June 30, 2020.

The discount rate used to measure the total pension liability was 7.25% as of June 30, 2022 and 2021. The projection of cash flows used to determine the discount rate assumed that plan contributions will be made in amounts consistent with statutory provisions and recognizing the plan's current funding policy and cost-sharing mechanism between employers and members. For this purpose, all contributions that are intended to fund benefits for all plan members and their beneficiaries are included, except the projected contributions that are intended to fund the service costs for future plan members and their beneficiaries are not included.

Based on those assumptions, the pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability as of June 30, 2022 and 2021.

Changes in Assumptions

There were no changes in assumptions from June 30, 2021 to June 30, 2022 valuations.

PERS reflects the following changes in assumptions from June 30, 2020 to June 30, 2021:

- The inflation rate decreased from 2.75% to 2.50%
- Payroll growth decreased from 5.00% to 3.50%
- Investment rate of return decreased from 7.50% to 7.25%
- Projected salary increases declined from 4.25% to 9.15% to 4.20% to 9.10% for Regular members

- The consumer price index decreased from 2.75% to 2.50%
- Mortality rates were changed from Headcount-Weighted RP-2014 Tables to Pub-2010 Mortality Tables
- Future mortality improvement was changed from 6 years to the Generational Projection Scale MP-2020

Pension Expense, Deferred Outflows of Resources, and Deferred Inflows of Resources Related to Pensions

For the years ended June 30, 2023 and 2022, the Fund recognized pension expense (income) of 223,895 and ($76,693), respectively.

At June 30, 2023 and 2022, the Fund reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	2023		2022	
	Deferred Outflows of Resources	Deferred Inflows of Resources	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 522,403	$ 2,882	$ 250,996	$ 15,947
Change of assumptions	518,262	-	752,327	-
Net difference between projects and actual earnings on investments	49,224	-	-	1,848,925
Changes in proportion and differences between actual contributions and proportionate share of contributions	34,292	181,043	62,908	51,597
System contributions subsequent to the measurement date	229,841	-	246,551	-
	$ 1,354,022	$ 183,925	$ 1,312,782	$ 1,916,469

The $229,841 and 246,551 reported as deferred outflows of resources related to pensions, resulting from the Fund's contributions subsequent to the measurement date, will be recognized as a reduction of the net pension liability in the year ended June 30, 2024 and 2023, respectively.

The average of the expected remaining service lives of all employees that are provided with pensions through PERS (active and inactive employees) is 5.70 years and 6.14 years for the measurement period ending June 30, 2022 and 2021, respectively.

Other estimated amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions, excluding contributions subsequent to the measurement date, will be recognized in pension expense as follows:

Year Ending June 30,	
2024	$ 138,062
2025	130,261
2026	110,324
2027	510,329
2028	51,280
	$ 940,256

Additional Information

Additional information supporting the Schedule of Employer Allocations and the Schedule of Pension Amounts by Employer is located in the PERS Annual Comprehensive Financial Report (ACFR) available on the PERS website at www.nvpers.org under Quick Links – Publications.

Note 9 - Other Post Employment Retirement Benefits

Plan Description

Officers and employees of the State of Nevada and of certain other participating local governmental agencies within the State of Nevada are provided with OPEB through the Nevada Public Employees' Benefits Program (PEBP), a multiple-employer cost-sharing defined postemployment benefit plan. The program is administered by the PEBP board, which consists of ten members appointed by the governor as well as the director of the State's Department of Administration or their designee. NRS 287.023 provides officers and employees eligible to be covered by any group insurance, plan of benefits or medical and hospital service established pursuant to NRS 287 the option upon retirement to cancel or continue any such coverage. The cost to administer the program is financed through the contributions and investment earnings of the plan. NRS 287.043 grants the PEBP Board the authority to establish and amend the benefit terms of the program. The Fund operationally administers the program. However, the Fund does not accumulate the resources of the eligible retirees for purposes of calculating the plan's fiduciary net position. The plan's fiduciary net position is accumulated and accounted for in the State of Nevada Retiree Health and Welfare Benefits Fund, which issues separate publicly available financial statements that may be obtained from Public Employees' Benefits Program, 901 South Stewart Street, Suite 1001, Carson City, NV 89701.

Benefits Provided

Benefits are provided to eligible retirees and their dependents through the payment of subsidies from the State of Nevada Retiree Health and Welfare Benefits Fund. The base subsidy rates are set by PEBP and approved by the Legislature and vary depending on the number of dependents and the medical plan selected. These subsidy rates are subtracted from the premium to arrive at the participant premium. The years of service subsidy rates are then used to adjust the participant premium based on the years of service. The current subsidy rates can be found on the PEBP website at www.pebp.state.nv.us. Benefits include health, prescription drug, dental and life insurance coverage. As required by statute, the subsidy is determined by the number of years of service at the time of retirement and the individual's initial date of hire. Officers and employees hired after December 31, 2011 are not eligible to receive subsidies to reduce premiums. The following individuals and their dependents are eligible to receive subsidies from the State of Nevada Retiree Health and Welfare Benefits Fund pursuant to NRS 287.023 and NRS 287.046:

Any PEBP covered retiree with State service whose last employer was the State or a participating local government entity and who:

- Has at least five years of public service and who was initially hired by the State prior to January 1, 2010; or
- Has at least 15 years of public service and who was initially hired by the State on or after January 1, 2010, but before January 1, 2012; or
- Has at least five years of public service, who has a disability and who was initially hired by the State on or after January 1, 2010, but before January 1, 2012; or
- Any PEBP covered retirees with State service whose last employer was not the State or a participating local government entity and who has been continuously covered under PEBP as a retiree since November 30, 2008.

State service is defined as employment with any State agency, the Nevada System of Higher Education and any State Board or Commission.

Contributions

The State of Nevada Retiree Health and Welfare Benefits Fund was established in 2007 by the Nevada Legislature as an irrevocable trust fund to account for the financial assets designated to offset the portion of current and future costs of health and welfare benefits paid on behalf of State retirees (NRS 287.0436).

Contributions are paid by the participating state agencies through an assessment of actual payroll paid by each State agency through the Retired Employee Group Insurance assessment (REGI). REGI was 2.18% and 2.17% of actual payroll for the years ended June 30, 2023 and 2022, respectively. Benefits are paid to the Self Insurance Internal Service Fund as necessary to offset retiree premiums pursuant to NRS 287.046. Administrative costs are absorbed by the Self Insurance Internal Service Fund.

Contributions recognized as part of OPEB expense were $34,009 and $35,622 for the years ended June 30, 2023 and 2022, respectively.

OPEB Liabilities, OPEB Expenses, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to OPEB

At June 30, 2023 and 2022, the Fund reported a net OPEB liability of $1,188,944 and $1,395,724, respectively, for its proportionate share of the collective net OPEB liability. The collective net OPEB liability was measured as of June 30, 2022 and 2021, respectively, and the total OPEB liability used to calculate the collective net OPEB liability was determined by an actuarial measurement as of those dates. The Fund's proportion of the collective net OPEB liability was based on the Fund's contributions to the OPEB plan relative to the contributions of all participating entities. At June 30, 2022, the Fund's proportion was 0.0824% which was a decrease of .0082% from the proportion of 0.0906% at June 30, 2021, which was a decrease of .0032% from its proportion measured as of June 30, 2020.

For the years ended June 30, 2023 and 2022, the Fund recognized OPEB expense of $70,386 and $119,971, respectively. At June 30, 2023 and 2022, the Fund reported deferred outflows of resources and deferred inflows of resources related to OPEB for the following sources:

	2023		2022	
	Deferred Outflows of Resources	Deferred Inflows of Resources	Deferred Outflows of Resources	Deferred Inflows of Resources
Changes of assumptions	$ 43,384	$ 98,984	$ 90,264	$ 6,048
Differences between expected and actual experience	-	40,080	-	50,881
Fund contributions subsequent to measurement date	45,846	-	35,622	-
	$ 89,230	$ 139,064	$ 125,886	$ 56,929

$45,846 and $35,622 reported as deferred outflows of resources related to OPEB resulting in the Fund's contractually required contribution subsequent to the measurement date will be recognized as a reduction of the net OPEB liability in the year ended June 30, 2024 and 2023, respectively.

Other amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized in OPEB expense (expense offset) as follows:

Year Ending June 30,	
2024	$ (28,241)
2025	(30,929)
2026	(36,464)
2027	(46)
	$ (95,680)

Actuarial Assumptions

The total OPEB liability as of June 30, 2022 and 2021 was determined by actuarial valuation using the following actuarial assumptions:

Measurement date	June 30, 2022	June 30, 2021
Valuation date	June 30, 2022	July 1, 2020
Inflation	2.50%	2.50%
Salary increases	4.20% to 9.10%, for regular members and 4.60% to 14.50% for police/ fire members, varying by service, including inflation	2.75%, for regular members and police/fire members
Investment rate of return	2.50%	2.50%
Healthcare cost trend rates	For medical prescription drug benefits, the current amount is 4.80% increase then 7.25% graded down 0.25% to ultimate 4.50% over eleven years. For dental benefits 4.00% For Part B Reimbursement, the trend rate is 0.00% effective July 1, 2023 and 2024, respectively, then 4.50% thereafter.	For medical prescription drug benefits, the current amount is 6.25% and decreases to 4.50% long-term trend rate after six years. For dental benefits and Part B premiums the trend rate is 4.00% and 4.50% respectively.

Post-retirement Mortality Rates

Healthy: Regular Members – Pub-2010 General Healthy Retiree Headcount-Weighted Above-Median Mortality Table with rates increased by 30% for males and 15% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020. Police/Fire Members – Pub-2010 Safety Healthy Retiree Headcount-Weighted Above-Median Morality Table with rates increased by 30% for males and 5% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020 (MP-2019 utilized in the July 1, 2020 actuarial valuation).

Disabled: Regular Members – Pub-2010 Non-Safety Disabled Retiree Headcount-Weighted Mortality Table with rates increased by 20% for males and 15% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020. Police/Fire Members – Pub-2010 Safety Disabled Retiree Headcount-Weighted Mortality Table with rates increased by 30% for males and 10% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020 (MP-2019 utilized in the July 1, 2020 actuarial valuation).

Beneficiaries: Regular and Police/Fire Current Beneficiaries in Pay Status – Pub-2010 Contingent Survivor Headcount-Weighted Above-Median Mortality Table with rates increased by 15% for males and 30% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020 (MP-2019 utilized in the July 1, 2020 actuarial valuation).

Pre-retirement Mortality Rates

Regular Members – Pub-2010 General Employee Headcount-Weighted Above-Median Mortality Table, projected generationally with the two-dimensional mortality improvement scale MP-2020 (MP-2019 utilized in the July 1, 2020 actuarial valuation. Police/Fire Members – Pub-2010 Safety Employee Headcount-Weighted Above-Median Mortality table, projected with the two-dimensional morality improvement scale MP-2020 (MP-2019 utilized in the July 1, 2020 actuarial valuation).

Discount Rate

The discount rate used to measure the total OPEB liability was 3.54% and 2.16% for fiscal years ended June 30, 2023 and 2022, respectively. As the Fund is funded on a pay-as-you-go basis, the discount rate is based on the Bond Buyer 20-Bond General Obligation Index rate.

Experience

The actuarial assumptions used in the June 30, 2022 valuation were based on the results of the 2020 actuarial experience study for the Public Employees' Retirement System of the State of Nevada dated September 10, 2021.

The actuarial assumptions used in the July 1, 2020 valuation were based on the results of an actuarial experience study for the period July 1, 2017 to June 30, 2018. As a result of the 2018 actuarial experience study, the expectation of life after disability was adjusted in the January 1, 2018 actuarial valuation to more closely reflect actual experience.

Significant Changes in Assumptions

The following were the significant changes between the June 30, 2022 and July 1, 2020 valuations:.

- Discount rate changed from 2.16% to 3.54%
- Healthcare cost trend rates were changed from 6.25% - 4.50% to 7.25% - 4.50%
- Part B reimbursement was adjusted from 4.50% to 4.00%
- Salary increases were updated from 2.75% to 4.20% – 9.10% for Regular members
- Salary increases were updated from 2.75% to 4.60% - 14.50% for Police/Fire members

Sensitivity of the Fund's Proportionate Share of the Net OPEB Liability to Changes in the Discount Rate

The following presents the Fund's proportionate share of the net OPEB liability, as well as what the Fund's proportionate share of the net OPEB liability would be if it were calculated using a discount rate that is 1-percentage point lower (2.54%) or 1-percentage-point higher (4.54%) than the current discount rate.

	1% Decrease in Discount Rate 2.54%	Discount Rate 3.54%	1% Increase in Discount Rate 4.54%
Net OPEB liability, June 30, 2023	$ 1,307,411	$ 1,188,944	$ 1,086,379

	1% Decrease in Discount Rate 1.16%	Discount Rate 2.16%	1% Increase in Discount Rate 3.16%
Net OPEB liability, June 30, 2022	$ 1,545,405	$ 1,395,724	$ 1,355,835

Sensitivity of the Fund's Proportionate Share of the Net OPEB Liability to Changes in the Healthcare Cost Trend Rates

The following presents the Fund's proportionate share of the net OPEB liability, as well as what the Fund's proportionate share of the net OPEB liability would be if it were calculated using healthcare cost trend rates (as previously disclosed) that are 1-percentage point lower or 1-percentage-point higher than the current healthcare cost trend rates.

	1% Decrease in Healthcare Cost Trend Rates	Healthcare Cost Trend	1% Increase in Healthcare Cost Trend Rates
Net OPEB liability, June 30, 2023	$ 1,131,462	$ 1,188,944	$ 1,254,766
Net OPEB liability, June 30, 2022	$ 1,273,533	$ 1,395,724	$ 1,499,186

OPEB Plan Fiduciary Net Position

Detailed information about the OPEB plan's fiduciary net position is available in the separately issued State of Nevada Retiree Health and Welfare Benefits Fund available on the PEBP website at www.pebp.nv.gov under Resources, Fiscal & Utilization Reports.

Note 10 - Commitments

The Fund is committed to the following contracts or policies after June 30, 2023:

Contractor	Contract Rate	Expiration Date
Segal Company, Inc	Hourly rate	06/30/2027
Brown & Brown of Massachusetts	Varies by audit	06/30/2027
Diversified Dental Services	Per participant per month	06/30/2026
Express Scripts	Per participant per month admin fee, claims costs	
United Healthcare	Varies	06/30/2026
UMR Inc.	Varies by service	06/30/2028
Segal Company	Hourly rate	06/30/2027
Health Plan of Nevada	Per participant premium by tier	06/30/2025
Lifeworks	Per participant per month fee for services rendered	12/31/2026

The above contracts include varying termination provisions that allow termination without cause with notice required between 30 and 180 days prior to the date of termination.

Note 11 - Risk Management

Estimated Claims Liabilities

The management of the Fund establishes claims liabilities based on estimates of the ultimate cost of claims (including future claim adjustment expenses) that have been reported but not settled, and of claims that have been incurred but not reported and the unused portion of the HRA liability. Because actual claims costs depend on such complex factors as inflation, changes in doctrines of legal liability and damage awards, the process used in computing claims liabilities does not necessarily result in an exact amount. Typically, after consultation with an actuary, claims liabilities are recomputed annually using a variety of actuarial and statistical techniques to produce current estimates that reflect recent settlements, claim frequency and other economic and social factors. A provision for inflation in the calculation of estimated future claims costs is implicit in the calculation, because reliance is placed both on actual historical data that reflect past inflation and on other factors that are considered to be appropriate modifiers of past experience. Adjustments to claims liabilities are charged or credited to expense in the periods in which claims are made.

Unpaid Claims Liabilities

As discussed above, management established a liability for both reported and unreported insured events, which includes estimates of both future payments of losses and related claim adjustment expenses. The following presents changes in those aggregate liabilities for the Fund during the past two years.

	2023	2022
Reserve for claims balance		
Beginning balance	$ 51,030,000	$ 52,286,000
Claims and changes in estimates	998,373,645	277,858,690
Claims payments	(996,529,645)	(279,114,690)
Ending balance reserve for claims balance	52,874,000	51,030,000
HRA liability		
Beginning of balance	28,462,071	31,298,731
Incurred	49,821,983	34,243,392
Paid	(50,983,119)	(37,080,052)
Ending balance HRA liability	27,300,935	28,462,071
Ending balance	$ 80,174,935	$ 79,492,071

These unpaid claims liabilities are all for the self-funded medical, dental, vision and prescription drug benefits and the CDHP and Medicare exchange HRAs.

Note 12 - Contingencies

Contingent Liabilities

In accordance with NRS 353.140, the Fund honors outstanding stale warrants presented for payment within six years from the date of origination. Management has estimated the total amount of outstanding stale warrants less than six years old to be $360,903 and $639,140 as of June 30, 2023 and 2022, respectively. Management has assessed that it is not probable that these warrants will be presented for payment during the statutory time frame. However, these warrants will continue to be recorded as a liability as after the statutory six year period the funds will be turned over to the State Treasurer as unclaimed property.

The State of Nevada, the Fund, its officers or its employees are parties to a number of lawsuits which may indirectly or directly affect the Fund. The litigation potentially affecting the Fund has been evaluated and has either been evaluated as minimal risk of loss due to an unfavorable outcome or due to other various facts and circumstances. No potential losses have been evaluated as probable and thus no liability has been recorded.

Note 13 - Correction of Error

During the year ended June 30, 2023, an error was discovered in the classification of certain cash flow activities. Accordingly, the Statement of Cash Flows for the year ended June 30, 2022 was adjusted as follows:

	June 30, 2022, As Originally Reported	Adjustment	June 30, 2022, As Restated
Operating Activities			
Receipts from customers and users	$ 257,500,729	$(173,715,212)	$ 83,785,517
Receipts from services to State of Nevada funds	-	137,655,066	137,655,066
Receipts from State of Nevada component units	97,511,041	21,282,039	118,793,080
Payments to suppliers, other governments and beneficiaries	(371,959,715)	1,367,579	(370,592,136)
Change in due from other funds related to operations	(12,992,658)	12,992,658	-
Payments to employees	(1,669,370)	(715,589)	(2,384,959)
Payments for services to other State of Nevada funds	-	(659,985)	(659,985)
Net cash used for operating activities	(31,609,973)	(1,793,444)	(33,403,417)
Noncapital Financing Activities			
Grants received	16,771,391	(16,771,391)	-
Receipts from other State of Nevada funds	-	18,786,311	18,786,311
Net cash from noncapital financing activities	16,771,391	2,014,920	18,786,311
Capital and Related Financing Activities			
Purchase of capital assets	-	(2,906)	(2,906)
Investing Activities			
Interest, dividends and gains (losses)	1,017,842	(4,920,821)	(3,902,979)
Net Decrease in Cash and Cash Equivalents	(13,820,740)	(4,702,251)	(18,522,991)
Cash and Cash Equivalents, Beginning of Year	158,256,356	452,624	158,708,980
Cash and Cash Equivalents, End of Year	$ 144,435,616	$ (4,249,627)	$ 140,185,989

	June 30, 2022, As Originally Reported	Adjustment	June 30, 2022, As Restated
Reconciliation of Operating Income (Loss) to Net Cash used for Operating Activities			
Operating income	$ (10,447,341)	$ -	$ (10,447,341)
Adjustments to reconcile operating income to net cash from (used for) operating activities			
Depreciation	3,237	-	3,237
Allowance for doubtful accounts	(107,470)	107,470	-
Changes in assets and liabilities			
Decrease (increase) in receivables	(6,494,075)	3,165,552	(3,328,523)
Decrease (increase) in due from other State of Nevada funds	(12,992,658)	12,992,658	-
Decrease (increase) in due from State of Nevada funds, retiree health and welfare and system of higher ed	-	(18,051,129)	(18,051,129)
Decrease (increase) in prepaid expenses	3,505	-	3,505
Decrease (increase) in deferred outflows of resources	(715,589)	-	(715,589)
Increase (decrease) in payables and accruals	(3,187,967)	(7,995)	(3,195,962)
Increase (decrease) in unearned revenue	1,952,312	-	1,952,312
Increase (decrease) in net pension liability	(1,271,523)	-	(1,271,523)
Increase (decrease) in net OPEB liability	(9,905)	-	(9,905)
Increase (decrease) in deferred inflows of resources	1,657,501	-	1,657,501
Total adjustments	(21,162,632)	(1,793,444)	(22,956,076)
Net Cash used for Operating Activities	$ (31,609,973)	$ (1,793,444)	$ (33,403,417)
Noncash Investment, Capital and Financing Activities			
Change in fair value of investments	$ (4,249,627)	$ 4,249,627	$ -

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Schedule of the Fund's Proportionate Share of the Net Pension Liability
Last Ten Fiscal Years* (Unaudited)

	2022	2021	2020	2019	2018	2017	2016	2015	2014
Fund's portion of the net pension liability	0.0224%	0.0245%	0.0254%	0.0281%	0.0260%	0.0253%	0.0270%	0.0262%	0.0254%
Fund's proportionate share of the net pension liability	$ 4,034,515	$ 2,265,928	$ 3,537,451	$ 3,833,649	$ 3,547,239	$ 3,361,917	$ 3,633,788	$ 3,003,622	$ 2,681,426
Fund's covered payroll	$ 1,629,320	$ 1,594,419	$ 1,532,510	$ 1,684,981	$ 1,509,506	$ 1,374,657	$ 1,333,326	$ 1,344,932	$ 1,451,686
Fund's proportional share of the net pension liability as a percentage of its covered payroll	247.62%	142.12%	230.83%	227.52%	234.99%	244.56%	272.54%	223.33%	184.71%
Plan Fiduciary Net Position as a percentage of the total pension liability	75.12%	86.51%	77.04%	76.46%	75.24%	74.42%	72.23%	75.13%	76.31%

*GASB Statement No. 68 requires ten years of information to be presented in this table. Until ten years of data is compiled, the Fund will present information only for those years for which information is available.

Notes to Schedules:

	2021 through 2022	2020 through 2017	2016 through 2014
Inflation rate	2.50%	2.75%	3.50%
Payroll growth	3.50%	5.00%	5.00%
Investment rate of return/ discount rate	7.25%	7.50%	8.00%
Productivity pay increase	0.50%	0.50%	0.75%
Projected salary increases			
Regular**	4.20% to 9.10%	4.25% to 9.15%	4.60% to 9.75%
Police/Fire**	4.60% to 14.50%	4.55% to 13.90%	5.25% to 14.50%
Consumer price index	2.50%	2.75%	3.50%
Mortality rates			
Healthy***	Pub- 2010 General and Safety Healthy Retiree and Employee	Headcount-Weighted RP-2014 Healthy	RP-2000 Combined Healthy Mortality Table
Disabled	Pub- 2010 Non-Safety and Safety Disabled Retiree Amount-Weighted	Headcount-Weighted RP-2014 Disabled	RP-2000 Disabled Retiree Mortality Table
Current beneficiaries***	Pub- 2010 Contingent Survivor and General Employee	Headcount-Weighted RP-2014 Healthy	N/A
Post-retirement***	Pub- 2010 General and Safety Employee	Headcount-Weighted RP-2014 Employee	N/A
Future mortality improvement	Generational Projection Scale MP-2020	6 years	

** Depending on service. Rates include inflation and productivity increases.
*** Amount-weighted Above-Median.

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Schedule of the Fund's Contributions - Pension
Last Ten Fiscal Years* (Unaudited)

	2023	2022	2021	2020	2019	2018	2017	2016	2015
Contractually Required Contribution	$ 229,841	$ 246,551	$ 260,407	$ 267,388	$ 270,930	$ 241,784	$ 220,384	$ 228,943	$ 281,658
Contributions in Relation to the Contractually Required Contribution	(229,841)	(246,551)	(260,407)	(267,388)	(270,930)	(241,784)	(220,384)	(228,943)	(281,658)
Contribution Deficiency (Excess)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fund's covered payroll	$ 1,538,420	$ 1,629,320	$ 1,594,419	$ 1,532,510	$ 1,684,981	$ 1,509,506	$ 1,374,657	$ 1,333,326	$ 1,344,932
Contributions as a Percentage of Covered Payroll	14.94%	15.13%	16.33%	17.45%	16.08%	16.02%	16.03%	17.17%	20.94%

*GASB Statement No. 68 requires ten years of information to be presented in this table. Until ten years of data is compiled, the Fund will present information only for those years for which information is available

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Schedule of the Fund's Proportionate Share of the OPEB Liability
Last Ten Fiscal Years* (Unaudited)

	2022	2021	2020	2019	2018	2017
Fund's portion of the net OPEB liability	0.0824%	0.0906%	0.0938%	0.0934%	0.1070%	0.1029%
Fund's proportionate share of the net OPEB liability	1,188,943	1,395,724	1,405,629	1,301,204	1,417,507	1,339,747
Fund's covered payroll	1,641,567	1,594,419	1,532,510	1,684,981	1,509,506	1,374,657
Fund's proportionate share of the net OPEB liability as a percentage of its covered payroll	72.43%	87.54%	91.72%	77.22%	93.91%	97.46%
Plan Fiduciary Net Position as a Percentage of the Total OPEB Liability	-1.41%	-0.65%	-0.38%	0.02%	0.12%	0.11%

*GASB Statement No. 75 requires ten years of information to be presented in this table. Until ten years of data is compiled, the Fund will present information only for those years for which information is available.

	2022	2021	2020	2019	2018	2017
Valuation Date	June 30, 2022	July 1, 2020	July 1, 2020	June 30, 2018	June 30, 2018	January 1, 2018
Actuarial Cost Method	Entry Age Normal	Entry Age Normal	Entry Age Normal	Entry Age Normal	Entry Age Normal	Entry Age Normal
Amortization Method	Level % of Pay	Level % of Pay	Level % of Pay	Level % of Pay	Level % of Pay	Level % of Pay
Amortization Period	25-year	25-year	25-year	25-year	25-year	25-year
Asset Valuation Method	Market Value	Market Value	Market Value	Market Value	Market Value	Market Value
Inflation Rate	2.50%	2.50%	2.50%	2.50%	2.50%	2.75%
Discount Rate	3.54%	2.16%	2.21%	3.51%	3.87%	3.58%
Healthcare Cost Trend Rates						
Medical prescription drug	7.25% - 4.50%	6.25% - 4.50%	6.25% - 4.50%	6.50% - 4.50%	6.50% - 4.50%	6.50% - 5.00%
Dental	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%
Part B Reimbursement	27.17% effective 7/1/24 then 4.00%	4.50%	4.50%	4.50%	4.50%	4.50%
Salary Increases						
Regular Members	4.20% - 9.10%	2.75%	2.75%	1.00% - 10.65%	1.00% - 10.65%	1.00% - 10.65%
Police/Fire Members	4.60% - 14.50%	2.75%	2.75%	1.00% - 10.65%	1.00% - 10.65%	1.00% - 10.65%
Investment Rate of Return	2.50%	2.50%	2.50%	2.50%	2.50%	2.75%
Retirement Age	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service
Mortality						
Healthy						
Regular Members	Pub-2010 General Health	Pub-2010 General Health	Pub-2010 General Health	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014
Police/Fire Members	Pub-2010 Safety Health	Pub-2010 Safety Health	Pub-2010 Safety Health	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014
Disabled						
Regular Members	Pub-2010 Non-Safety Disabled	Pub-2010 Non-Safety Disabled	Pub-2010 Non-Safety Disabled	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014
Police/Fire Members	Pub-2010 Safety Disabled	Pub-2010 Safety Disabled	Pub-2010 Safety Disabled	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014
Beneficiaries	Pub-2010 Contingent Survivor	Pub-2010 Contingent Survivor	Pub-2010 Contingent Survivor	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014
Mortality Improvement	MP-2020	MP-2019	MP-2019	MP-2016	MP-2016	MP-2016

Plan Changes: No significant plan changes

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Schedule of Fund's Contributions - OPEB
Last Ten Fiscal Years* (Unaudited)

	2023	2022	2021	2020	2019	2018
Contractually Required Contribution	$ 34,009	$ 35,622	$ 37,136	$ 41,705	$ 44,268	$ 39,801
Contributions	(34,009)	(35,622)	(37,136)	(41,705)	(44,268)	(39,801)
Contribution Deficiency (Excess)	$ -	$ -	$ -	$ -	$ -	$ -
Fund's covered payroll	$ 1,560,046	$ 1,641,567	$ 1,573,559	$ 1,782,265	$ 1,891,795	$ 1,693,660
Contributions as a Percentage of Covered Payroll	2.18%	2.17%	2.36%	2.34%	2.34%	2.35%

*GASB Statement No. 75 requires ten years of information to be presented in this table. Until ten years of data is compiled, the Fund will present information only for those years for which information is available.

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CPAs & BUSINESS ADVISORS

Independent Auditors' Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

To the Board of the
Public Employees' Benefits Program
Carson City, Nevada

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*), the financial statements the Self Insurance Internal Service Fund of the State of Nevada, as of and for the year ended June 30, 2023, and the related notes to the financial statements, which collectively comprise the Self Insurance Internal Service Fund of the State of Nevada's basic financial statements and have issued our report thereon dated July 11, 2024.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Self Insurance Internal Service Fund of the State of Nevada's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Self Insurance Internal Service Fund of the State of Nevada's internal control. Accordingly, we do not express an opinion on the effectiveness of the Self Insurance Internal Service Fund of the State of Nevada's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that have not been identified. We identified a certain deficiency in internal control, described in the accompanying Schedule of Findings and responses as item 2023-001 that we consider to be a material weakness.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Self Insurance Internal Service Fund of the State of Nevada's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Self Insurance Internal Service Fund of the State of Nevada's Response to Finding

Government Auditing Standards requires the auditor to perform limited procedures on the Self Insurance Internal Service Fund of the State of Nevada's response to the finding identified in our audit and described in the accompanying Schedule of Findings and Responses. The Self Insurance Internal Service Fund of the State of Nevada's response was not subjected to the other auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the response.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Self Insurance Internal Service Fund of the State of Nevada's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Self Insurance Internal Service Fund of the State of Nevada's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Eide Bailly LLP

Reno, Nevada
July 11, 2024

2023-001 Financial Statement Preparation, Statement of Cash Flows, and Communication with Controller's Office
Material Weakness

Criteria: Management is responsible for establishing and maintaining an effective system of internal control over financial reporting. One of the key components of an effective system of internal control over financial reporting is the preparation of full disclosure financial statements that do not require adjustment as part of the audit process.

Condition: Management prepares internal use financial statements. However, management required the assistance of the external audit firm to prepare the audited financial statements and related note disclosures. Although the preparation of financial statements as a part of the audit engagement is not unusual, it may result in financial statements and related information included in financial statement disclosures not being available for management purposes as timely as it would be if prepared by the Fund's personnel.

In addition, corrections and adjustments were required related to the Fund's presentation of cash flow activities in the prior year financial statements.

Lastly, transactions were recorded by the Controller's Office that were not effectively monitored by the Fund. Several transactions were posted in the prior year that were not reflected in the prior year financial statements and required adjustment in the current year. Moreover, adjustments were required for the Fund's right to use leased asset and lease liability.

Cause: Accounting personnel do not have the current resources of time necessary to prepare the financial statements in accordance with generally accepted accounting principles. As a result, the Fund chose to contract with Eide Bailly, LLP to the prepare its financial statements.

In addition, the Fund did not have adequate internal controls to ensure the cash flow activity was presented appropriately in accordance with U.S. GAAP nor adequate communication with the Controller's Office to ensure all transactions were properly monitored and recorded.

Effect: The internal interim financial information prepared by the Fund may not comply with generally accepted accounting principles. Also, the statement of cash flows was restated for the year ended June 30, 2022. Lastly, the right to use leased asset and related lease liability were understated by approximately $1.5 million and prior year transactions of approximately $1,700,000 were adjusted through the current year.

Recommendation: We recommend the Fund allocate the resources necessary to enable the preparation of the financial statements in accordance with generally accepted accounting principles, enhance internal controls to ensure the cash flow activities are appropriately disclosed and presented, and enhance communication with the Controller's Office to ensure all transactions are monitored and properly recorded.

Views of Responsible Officials: Management partially agrees with this finding.

4.6

4. Consent Agenda (Joy Grimmer, Board Chair)
(**All Items for Possible Action**)

4.6 State Retirees' Health & Welfare Benefits Fund Financial Statement

Financial Statements
June 30, 2023

State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program, a fiduciary component unit of the State of Nevada

State of Nevada
State Retirees' Health & Welfare Benefits Fund
Public Employees' Benefits Program
Table of Contents
June 30, 2023

EideBailly

CPAs & BUSINESS ADVISORS

Independent Auditor's Report

To the Board of the
Public Employees' Benefits Program
Carson City, Nevada

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of the State Retirees' Health & Welfare Benefits Fund (the Fund), Public Employees' Benefits Program, a fiduciary component unit of the State of Nevada, as of and for the year ended June 30, 2023, and the related notes to the financial statements, which collectively comprise the Fund's basic financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the financial position of the Fund, as of June 30, 2023, and the changes in its financial position for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States (*Government Auditing Standards*). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Fund and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Correction of Error

The financial statements of the Fund as of and for the year ended June 30, 2022 were audited by other auditors, whose report dated February 22, 2023, contained an unmodified opinion on those statements.

As discussed in Note 6 to the financial statements, the Fund corrected errors related to the classification of net position. This error resulted in a restatement of the net position classification as of June 30, 2022. Our opinion is not modified with respect to this matter.

As part of our audit of the 2023 financial statements, we also audited the adjustment described in Note 6 that was applied to restate the 2022 financial statements. In our opinion, such adjustment is appropriate and has been properly applied. We were not engaged to audit, review or apply any procedures to the 2022 financial statements of the Fund other than with respect to the adjustment and, accordingly, we do not express an opinion or any other form of assurance on the 2022 financial statements as a whole.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Fund's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the State's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Fund's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the schedule of changes in net OPEB liability and related ratios, the schedule of contributions, and the schedule of investment returns be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with GAAS, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Management has omitted the management's discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements is not affected by this missing information.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated May 1, 2024, on our consideration of the Fund's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness the Fund's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Fund's internal control over financial reporting and compliance.

Eide Bailly LLP

Reno, Nevada
May 1, 2024

State of Nevada
State Retirees' Health & Welfare Benefits Fund
Public Employees' Benefits Program
Statements of Fiduciary Net Position
June 30, 2023 and 2022

	2023	2022 As Restated
Assets		
Cash with State Treasurer	$ 2,199,374	$ 3,491,998
Intergovernmental receivable	23,940	20,584
Due from other State of Nevada funds	137,891	107,288
Due from State of Nevada component units	1,526,308	1,334,319
Total assets	3,887,513	4,954,189
Liabilities and Net Position		
Current Liabilities		
Due to State of Nevada Self Insurance Fund	34,414,831	25,046,900
Net Position		
Unrestricted (deficit)	$ (30,527,318)	$ (20,092,711)

See Notes to Financial Statements

State of Nevada
State Retirees' Health & Welfare Benefits Fund
Public Employees' Benefits Program
Statements of Changes in Fiduciary Net Position
Years Ended June 30, 2023 and 2022

	2023	2022
Additions		
Contributions		
Employer contributions	$ 41,136,140	$ 39,621,208
Treasurer's pool income (loss)		
Interest and dividends	102,658	19,046
Net appreciation (depreciation) in fair value of treasurer's pool	37,344	(111,936)
Total net treasurer's pool income (loss)	140,002	(92,890)
Total additions	41,276,142	39,528,318
Deductions		
Benefit payments	51,710,749	49,653,201
Change in Net Position	(10,434,607)	(10,124,883)
Net Position (Deficit), Beginning of Year	(20,092,711)	(9,967,828)
Net Position (Deficit), End of Year	$ (30,527,318)	$ (20,092,711)

Note 1 - Summary of Significant Accounting Policies

Reporting Entity, Purpose, and Plan Administration

The State Retirees' Health and Welfare Benefits Fund (the Fund), Public Employees Benefits Program (PEBP) of the State of Nevada (the State) was created in 2007 by the Nevada Legislature to account for the financial assets designated to offset the portion of current and future costs of health and welfare benefits paid on behalf of the State retirees. The Fund is a multiple employer cost-sharing defined postemployment benefit plan run by the PEBP Board. The Fund provides benefits other than pensions to eligible retirees and their dependents through the payment of subsidies to PEBP which administers a group health and life insurance program.

The Fund is governed by the PEBP Board of Trustees which consists of ten members who are appointed by the Governor of the State. Each appointee represents a specific class of public employees and retirees including the Nevada System of Higher Education, retired public employees, State employees, and local government employees. Additionally, two members must have substantial and demonstrated experience in risk management, health care administration, or employee benefits programs. One member must be employed in a managerial capacity for the State Department of Administration. These requirements are all in accordance with Nevada Revised Statute (NRS) 287.041.

The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. GASB standards have set forth certain component unit criteria, in part, as follows to consider:

- If the State of Nevada appoints a voting majority of the PEBP board and either has financial burden (legally or assumed) to make contributions to the Fund or if the State of Nevada may impose its will on the Fund.
- If the State of Nevada does not appoint a voting majority of the PEBP board and has both a financial burden (legally or assumed) to make contributions to the Fund and the Fund is fiscally dependent on the State of Nevada.

The Governor appoints the majority of the PEBP board, and the State of Nevada has the financial burden to make contributions to the Fund. The assets of the Fund belong to the officers, employees, and retirees of the State of Nevada in aggregate. Neither the State of Nevada nor the governing body of any county, school district, municipal corporation, political subdivision, public corporation, or other local governmental agency of the State of Nevada, nor any single officer, employee or retiree of any such entity has any right to the assets in the Fund. Therefore, due to the above factors, the Fund is considered a fiduciary component unit of the State of Nevada.

Basis of Accounting

The financial statements of the Fund have been prepared in conformity with accounting principles accepted in the United States of America (U.S. GAAP) as applied to governmental units. The accompanying financial statements of the Fund have been prepared using the accrual basis of accounting and the economic resources measurement focus.

Cash with State Treasurer

Monies being held by the Fund that are not required to pay current benefits are invested in either the Retirement Benefits Investment Fund established pursuant to NRS 355.220 or are held in the State of Nevada's general portfolio (Treasurer's Pool) pursuant to NRS 226.110 as approved in the legislatively approved budget. Cash with State Treasurer functions as a demand deposit account.

Contributions and Receivables

Employer contributions are recognized when due based on the assessment on actual payroll. Employer contributions are received from other state agencies.

The receivable balances are reported in three classifications: intergovernmental, other State of Nevada funds, and State of Nevada component units. Intergovernmental receivables are amounts outstanding from state agencies, such as state boards and commissions. Other State of Nevada funds are amounts outstanding from governmental and proprietary funds within the State of Nevada. State of Nevada component unit receivables are amounts outstanding from the Nevada System of Higher Education. The Fund has not established an allowance for uncollectible amounts based on prior experience and known factors with respect to the employers.

The Fund does not receive member contributions.

Benefits and Payables

Benefits and refunds are recognized when due and payable in accordance with the terms of the plan. Benefits are administered by the State of Nevada Self Insurance Fund, an internal service fund of the State of Nevada. Therefore, all benefit liabilities are recognized as due to the Self Insurance Fund.

Net Position

Net position is restricted for postemployment benefits other than pension as described in NRS 287.04362. As more fully described in Note 5 to the financial statements, the Fund has a deficit net position as of June 30, 2023 and 2022, respectively, which requires presentation as an unrestricted (deficit) within the Statements of Fiduciary Net Position to be in accordance with U.S. GAAP.

Use of Estimates

The preparation of financial statements is in conformity with accounting principles accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the financial statements and notes. Actual results could differ from those estimates.

Note 2 - Plan Description and Contribution and Benefits Provided

The Fund was created in 2007 by the Nevada Legislature to account for the financial assets designated to offset the portion of current and future costs of health and welfare benefits paid on behalf of the State retirees. The Fund is a multiple employer cost-sharing defined postemployment benefit plan run by the PEBP Board. The Fund provides benefits other than pensions to eligible retirees and their dependents through the payment of subsidies to PEBP which administers a group health and life insurance program.

Contributions to the Fund are paid by the participating state agencies through an assessment of actual payroll paid by each State agency through the Retired Employee Group Insurance assessment (REGI). REGI is set by the Governor's Finance Office based on an amount provided by the Legislature each biennium in session law. REGI was 2.18% and 2.17% of actual payroll for the years ended June 30, 2023 and 2022, respectively. Benefits are paid to the PEBP Self Insurance Trust Fund as necessary to offset retiree premiums pursuant to NRS 287.046. Administrative costs of the Fund are absorbed by the State of Nevada Self Insurance Trust Fund.

Pursuant to NRS 287.023 and NRS 287.046, the following individuals and their dependents are eligible to receive benefits from the Fund:

Any PEBP covered retiree with state service whose last employer was the State and who:

- Has at least five years of public service and who was initially hired by the State prior to January 1, 2010; or
- Has at least 15 years of public service and who was initially hired by the State on or after January 1, 2010, but before January 1, 2012; or
- Has at least five years of public service, who has a disability and who was initially hired by the State on or after January 1, 2010, but before January 1, 2012; or
- Any PEBP covered retirees with state service whose last employer was not the State or a participating local government entity and who has been continuously covered under PEBP as a retiree since November 30, 2008.

State service is defined as employment with any Nevada State agency, the Nevada System of Higher Education and any State Board or Commission.

Pursuant to NRS 287.0425, the Executive Officer reports information regarding the Fund annually to the Governor's Finance Office and the Nevada Legislature. The Fund is governed by NRS 287.0436 through NRS 287.04364.

State active employee and retiree enrollment and inactive members consisted of the following as of the actuarial valuation date of June 30, 2022 rolled forward to a measurement date of June 30, 2023:

Active Plan members*	28,015
Inactive Plan members or beneficiaries currently receiving benefit**	12,692
Inactive Plan members entitled to but Not Yet Receiving Benefit Payments	18,495
Total Plan members	59,202

*Active counts reflect those hired prior to January 1, 2012
**Inactive counts include terminated vested participants and reflect State retirees only.

State participating employers consisted of the following as of the actuarial valuation date:

Total participating employers	24

Note 3 - Net OPEB Liability

The projections of the net OPEB liability are based on the substantive plan (the plan as understood by the employer and plan members) and includes the types of benefits provided at the time of each valuation and the historical pattern of sharing of benefit costs between the employer and plan members to that point. The projection of the net OPEB liability does not explicitly incorporate the potential effects of legal or contractual funding limitations on the pattern of cost-sharing between the employer and plan members in the future. The actuarial methods and assumptions used include techniques that are designed to reduce the effects of short-term volatility in actuarial estimated liabilities and the actuarial value of assets, consistent with the long-term perspective of the calculations. However, the preparation of any estimate of future post-employment costs requires consideration of a broad array of complex social and economic events. Future changes in the healthcare reform, changes in reimbursement methodology, the emergence of new and expensive medical procedures and prescription drug options, changes in the investment rate of return and other matters increase the level of uncertainty of such estimates. As such, the estimate of postemployment program costs contains considerable uncertainty and variability, and actual experience may vary significantly by the current estimated net OPEB liability.

Net OPEB Liability of the State

The components of the net OPEB liability of the State at June 30, 2023 and 2022 were as follows (in thousands):

	2023	2022
Total OPEB liability	$ 1,427,444	$ 1,422,115
Plan fiduciary net position	(30,527)	(20,093)
Net OPEB liability	$ 1,457,971	$ 1,442,208
Plan fiduciary net position as a percentage of total OPEB liability	-2.14%	-1.41%

Actuarial Assumptions

The total OPEB liability was determined by an actuarial valuation as of June 30, 2022, using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.50%
Salary increases	4.20% to 9.10%, for regular members and 4.60% to 14.50% for Police/Fire members, varying by service, including inflation
Investment rate of return	2.50%
Healthcare cost trend rates	For medical prescription drug benefits, the current amount is 4.80% increase effective July 1, 2023, then 7.25% graded down 0.25% to ultimate 4.50% over eleven years. For dental benefits 4.00%. For Part B Reimbursement, the trend rate is 0.00% and 27.17%, effective July 1, 2023 and 2024, respectively, the 4.50%.

Postretirement Mortality Rates

Healthy: Regular Members – Pub-2010 General Healthy Retiree Headcount-Weighted Above-Median Mortality Table with rates increased by 30% for males and 15% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020. Police/Fire Members – Pub-2010 Safety Healthy Retiree Headcount-Weighted Above-Median Morality Table with rates increased by 30% for males and 5% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020.

Disabled: Regular Members – Pub-2010 Non-Safety Disabled Retiree Headcount-Weighted Mortality Table with rates increased by 20% for males and 15% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020. Police/Fire Members – Pub-2010 Safety Disabled Retiree Headcount-Weighted Mortality Table with rates increased by 30% for males and 10% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020.

Beneficiaries: Regular and Police/Fire Current Beneficiaries in Pay Status – Pub-2010 Contingent Survivor Headcount-Weighted Above-Median Mortality Table with rates increased by 15% for males and 30% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020.

The actuarial assumptions used in the June 30, 2022 valuation were based on the results of the 2020 actuarial experience study for the Public Employees' Retirement System of the State of Nevada dated September 10, 2021.

Preretirement Mortality Rates

Regular Members: Pub-2010 General Employee Headcount-Weighted Above-Median Mortality Table, projected generationally with the two-dimensional mortality improvement scale MP-2020.

Police/Fire Members: Pub-2010 Safety Employee Headcount-Weighted Above-Median Mortality table, projected with the two-dimensional morality improvement scale MP-2020.

Discount Rate

The discount rate used to measure the total OPEB liability was 3.65% and 3.54% for fiscal years ended June 30, 2023 and 2022, respectively. As the Fund is funded on a pay-as-you-go basis, the discount rate is based on the Bond Buyer 20-Bond General Obligation Index rate.

Sensitivity of the Net OPEB Liability to Changes in the Discount Rate

The following presents the net OPEB liability of the State, as well as what the State's net OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower or 1-percentage-point higher than the current discount rate (in thousands):

	1% Decrease (2.65%)	Discount Rate (3.65%)	1% Increase (4.65%)
Net OPEB liability, June 30, 2023	$ 1,599,174	$ 1,457,971	$ 1,335,499

	1% Decrease (2.54%)	Discount Rate (3.54%)	1% Increase (4.54%)
Net OPEB liability, June 30, 2022	$ 1,585,911	$ 1,442,208	$ 1,317,795

Sensitivity of the Net OPEB Liability to Changes in the Healthcare Cost Trend Rates

The following presents the net OPEB liability of the State, as well as what the State's liability would be if it were using healthcare cost trend rates that are 1-percentage-point lower or 1-percentage-point higher than the current healthcare cost trend rates (in thousands):

	1% Decrease	Healthcare Cost Trend Rates	1% Increase
Net OPEB liability, June 30, 2023	$ 1,382,572	$ 1,457,971	$ 1,544,492

	1% Decrease	Healthcare Cost Trend Rates	1% Increase
Net OPEB liability, June 30, 2022	$ 1,372,482	$ 1,442,208	$ 1,522,051

Note 4 - Cash and Deposits with the State Treasurer

The NRS directs the Office of the State Treasurer to deposit funds into any state, or national bank, credit union or savings and loan association covered by federal depository insurance. For those deposits over and above the federal depository insurance maximum balance, sufficient collateral must be held by the financial institution to protect the State against loss. The pooled collateral for deposits program maintains a 102% pledge collateral for all public deposits. The Fund is a participant in the investment pool maintained by the Treasurer of the State. The investment pool is not registered with the Securities and Exchange Commission as an investment company. The State has not provided or obtained any legally binding guarantees during the period to support the value of the shares. The Fund receives a pro-rated share of the earnings from its participation in the investment pool based on daily cash balances. Due to the nature of the investment pool, it is not possible to separately identify any specific investment as being that of the Fund. Instead, the Fund owns a proportionate share of each investment, based on the Fund's participating percentage in the investment pool. The cash (due on demand) with State Treasurer balance as of June 30, were as follows (expressed in thousands):

	2023	2022
Cash		
Cash with State Treasurer		
State Treasurer's Investment Pool	$ 2,268	$ 3,598
Unrealized gains and losses	(69)	(106)
Total cash with State Treasurer	$ 2,199	$ 3,492

Rate of Return

For the years ended June 30, 2023 and 2022, the annual money-weighted rate of return on investment, net of investment expenses was 0.63% and 0.17%, respectively. The money-weighted rate of return expresses investment performance, net of investment expense, adjusted for the changing amounts actually invested.

Note 5 - Net Position

Net position is normally restricted for postemployment benefits other than pension; however, the net position of the Fund is in a deficit position. The deficit increased by $10,434,607 to a total deficit of $30,527,318 as of June 30, 2023. Management of the Fund is actively working on a plan to improve the Fund's net position. A rebalancing of the REGI Assessment was approved during the 2023 legislative session. The REGI assessment is calculated and collected as a percentage of gross salaries. The Governor recommended REGI assessments for the upcoming biennium of 3.11% for Fiscal Year 2024 and 3.18% for Fiscal Year 2025. This is an increase from the 2.18% approved for Fiscal Year 2023 and is related to the Governor's recommendation to revise the methodology by which the REGI assessment is determined. This is an increase of over 42% in the REGI assessment and is expected to gradually decrease the deficit over the next couple of fiscal years. Management of the Fund is committed to ongoing monitoring of benefit costs, expected payroll, and the REGI assessment rates to better present the Fund's net position and financial health.

Note 6 - Correction of Error

During the year ended June 30, 2023, an error was discovered in the classification of net position. The Fund has a deficit net position rather than a restricted net position. Accordingly, the Statement of Fiduciary Net Position for the year ended June 30, 2022, was adjusted as follows:

	June 30, 2022, As Originally Reported	Adjustment	June 30, 2022, As Restated
Net Position			
Restricted for other postemployment benefits	$ (20,092,711)	$ 20,092,711	$ -
Unrestricted (deficit)	-	(20,092,711)	(20,092,711)
Total Net Position	$ (20,092,711)	$ -	$ (20,092,711)

Note 7 - Commitment and Contingencies

The State of Nevada, the Fund, its officers or its employees are parties to a number of lawsuits which may indirectly or directly affect the Fund. The litigation potentially affecting the Fund has been evaluated and has either been evaluated as minimal risk of loss due to an unfavorable outcome or due to other various facts and circumstances. No potential losses have been evaluated as probable and thus no liability has been recorded.

State of Nevada
State Retirees' Health & Welfare Benefits Fund
Public Employees' Benefits Program
Schedule of Changes in Net OPEB Liability and Related Ratios (in thousands)
Last Ten Fiscal Years*

	Fiscal Year Ended June 30,							
	2023	2022	2021	2020	2019	2018	2017	2016
Total OPEB Liability								
Service cost	$ 46,424	$ 52,675	$ 55,710	$ 53,039	$ 51,349	$ 51,882	$ 59,309	$ 49,794
Interest cost	50,768	33,718	33,853	49,915	52,488	47,795	39,469	45,361
Changes of benefit terms	-	38,605	-	-	-	-	-	-
Differences between expected and actual experiences	(7,880)	(19,316)	(2,313)	(72,984)	(31,485)	-	-	-
Changes of assumptions	(14,550)	(159,738)	(938)	124,245	37,971	(36,851)	(102,300)	123,519
Gross benefit payments	(69,433)	(64,012)	(44,188)	(49,969)	(42,490)	(39,710)	(38,069)	(35,932)
Net Change in Total OPEB Liability	5,329	(118,068)	42,124	104,246	67,833	23,116	(41,591)	182,742
Total OPEB liability, beginning of year	1,422,115	1,540,183	1,498,059	1,393,813	1,325,980	1,302,864	1,344,455	1,161,713
Total OPEB liability, end of year	1,427,444	1,422,115	1,540,183	1,498,059	1,393,813	1,325,980	1,302,864	1,344,455
Plan Fiduciary Net Position								
Contributions								
Employer	41,136	39,621	39,564	43,882	40,943	39,669	38,049	32,213
Net investment income	140	(93)	308	205	181	162	164	55
Gross benefit payments	(51,711)	(49,653)	(44,188)	(49,969)	(42,490)	(39,710)	(38,069)	(35,932)
Net Change in Plan Fiduciary Net Position	(10,435)	(10,125)	(4,316)	(5,882)	(1,366)	121	144	(3,664)
Plan Fiduciary Net Position, Beginning of Year	(20,092)	(9,967)	(5,651)	231	1,597	1,476	1,332	4,996
Plan Fiduciary Net Position, End of Year	(30,527)	(20,092)	(9,967)	(5,651)	231	1,597	1,476	1,332
State's Net OPEB Liability	$ 1,457,971	$ 1,442,207	$ 1,550,150	$ 1,503,710	$ 1,393,582	$ 1,324,383	$ 1,301,388	$ 1,343,123
Plan Fiduciary Net Position as a Percentage of Total OPEB Liability	-2.14%	-1.41%	-0.65%	-0.38%	0.02%	0.12%	0.11%	0.10%
Covered Payroll	$ 1,886,972	$ 1,825,853	$ 1,676,441	$ 1,875,299	$ 1,749,658	$ 1,688,043	$ 1,612,246	$ 1,627,517
State's Net OPEB Liability as a Percentage of Covered Payroll	77.27%	78.99%	92.47%	80.19%	79.65%	78.46%	80.72%	82.53%

*GASB Statement No. 74 requires ten years of information to be presented in this table. Until ten years of data is compiled, the Fund will present information only for those years for which information is available.

State of Nevada
State Retirees' Health & Welfare Benefits Fund
Public Employees' Benefits Program
Schedule of Contributions (in thousands)
Last Ten Fiscal Years*

	Fiscal Year Ended June 30,							
	2023	2022	2021	2020	2019	2018	2017	2016
Contractually Required Contribution	$ 41,136	$ 39,621	$ 39,564	$ 43,882	$ 40,942	$ 39,669	$ 38,049	$ 32,213
Contributions Made in Relation to the Contractually Required Contribution	41,136	39,621	39,564	43,882	40,942	39,669	38,049	32,213
Contribution Deficiency (Excess)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Covered Payroll	$ 1,886,972	$ 1,825,853	$ 1,676,441	$ 1,875,299	$ 1,749,658	$ 1,688,043	$ 1,612,246	$ 1,512,347
Contributions as a Percentage of Covered Payroll	2.18%	2.17%	2.36%	2.34%	2.34%	2.35%	2.36%	2.13%

*GASB Statement No. 74 requires ten years of information to be presented in this table. Until ten years of data is compiled, the Fund will present information only for those years for which information is available.

Notes to Schedules:

	2023	2022	2021	2020	2019	2018	2017	2016
Valuation Date	June 30, 2022	June 30, 2022	July 1, 2020	July 1, 2020	June 30, 2018	June 30, 2018	January 1, 2018	January 1, 2018
Actuarial Cost Method	Entry Age Normal	Entry Age Normal	Entry Age Normal	Entry Age Normal	Entry Age Normal	Entry Age Normal	Entry Age Normal	Entry Age Normal
Amortization Method	Level % of Pay	Level % of Pay	Level % of Pay	Level % of Pay	Level % of Pay	Level % of Pay	Level % of Pay	Level % of Pay
Amortization Period	25-year	25-year	25-year	25-year	25-year	25-year	25-year	25-year
Asset Valuation Method	Market Value	Market Value	Market Value	Market Value	Market Value	Market Value	Market Value	Market Value
Inflation Rate	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.75%	2.75%
Discount Rate	3.65%	3.54%	2.16%	2.21%	3.51%	3.87%	3.58%	3.58%
Healthcare Cost Trend Rates								
Medical prescription drug	7.25% - 4.50%	7.25% - 4.50%	6.25% - 4.50%	6.25% - 4.50%	6.50% - 4.50%	6.50% - 4.50%	6.50% - 5.00%	6.50% - 5.00%
Dental	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%
Part B Reimbursement	27.17% effective 7/1/2024 then 4.00%	27.17% effective 7/1/2024 then 4.00%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%
Salary Increases								
Regular Members	4.20% - 9.10%	4.20% - 9.10%	2.75%	2.75%	1.00% - 10.65%	1.00% - 10.65%	1.00% - 10.65%	1.00% - 10.65%
Police/Fire Members	4.60% - 14.50%	4.60% - 14.50%	2.75%	2.75%	1.00% - 10.65%	1.00% - 10.65%	1.00% - 10.65%	1.00% - 10.65%
Investment Rate of Return	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.75%	2.75%
Retirement Age	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service	Varies by Age and Service
Mortality								
Healthy								
Regular Members	Pub-2010 General Health	Pub-2010 General Health	Pub-2010 General Health	Pub-2010 General Health	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014
Police/Fire Members	Pub-2010 Safety Health	Pub-2010 Safety Health	Pub-2010 Safety Health	Pub-2010 Safety Health	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014
Disabled								
Regular Members	Pub-2010 Non-Safety Disabled	Pub-2010 Non-Safety Disabled	Pub-2010 Non-Safety Disabled	Pub-2010 Non-Safety Disabled	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014
Police/Fire Members	Pub-2010 Safety Disabled	Pub-2010 Safety Disabled	Pub-2010 Safety Disabled	Pub-2010 Safety Disabled	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014
Beneficiaries	Pub-2010 Contingent Survivor	Pub-2010 Contingent Survivor	Pub-2010 Contingent Survivor	Pub-2010 Contingent Survivor	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014	RP-2000 Projected to 2014
Mortality Improvement	MP-2020	MP-2020	MP-2019	MP-2019	MP-2016	MP-2016	MP-2016	MP-2016

Plan Changes: No significant plan changes

State of Nevada
State Retirees' Health & Welfare Benefits Fund
Public Employees' Benefits Program
Schedule of Investment Returns
Last Ten Fiscal Years*

	Fiscal Year Ended June 30,							
	2023	2022	2021	2020	2019	2018	2017	2016
Annual money-weighted rate of return, net of investment expense**	0.63%	0.17%	0.15%	0.48%	0.55%	***	***	***

*GASB Statement No. 74 requires ten years of information to be presented in this table. Until ten years of data is compiled, the Fund will present information only for those years for which information is available.

**The annual money-weighted rate of return includes cash held by the State Treasurer and related earnings.

***Information for 2018 - 2016 is not available.

EideBailly

CPAs & BUSINESS ADVISORS

Independent Auditors' Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

To the Board of the
Public Employees' Benefits Program
Carson City, Nevada

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*), the financial statements the State Retirees' Health & Welfare Benefits Fund (the Fund), Public Employees' Benefits Program, a fiduciary component unit of the State of Nevada, as of and for the year ended June 30, 2023, and the related notes to the financial statements, which collectively comprise Fund's basic financial statements, and have issued our report thereon dated May 1, 2024.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Fund internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Fund's internal control. Accordingly, we do not express an opinion on the effectiveness of the Fund's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that have not been identified. We identified a certain deficiency in internal control, described in the accompanying Schedule of Findings and Responses as item 2023-001 that we consider to be a material weakness.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Fund's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Fund's Response to Finding

Government Auditing Standards requires the auditor to perform limited procedures on the Fund's response to the finding identified in our audit and described in the accompanying Schedule of Findings and Responses. The Fund's response was not subjected to the other auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the response.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Fund's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Fund's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Reno, Nevada
May 1, 2024

2023-001 Financial Statement Preparation and GASB Standards
Material Weakness

Criteria: Management is responsible for establishing and maintaining an effective system of internal control over financial reporting. One of the key components of an effective system of internal control over financial reporting is the preparation of full disclosure financial statements that do not require adjustment as part of the audit process.

Condition: Management prepares internal use financial statements. However, management required the assistance of the external audit firm to prepare the audited financial statements and related note disclosures. Although the preparation of financial statements as a part of the audit engagement is not unusual, it may result in financial statements and related information included in financial statement disclosures not being available for management purposes as timely as it would be if prepared by the Fund's personnel.

In addition, corrections and adjustments were required related to the Fund's net position and other postemployment benefits (OPEB) liability. Prior to correction, the Fund's disclosures with respect to OPEB related amounts were presented in accordance with Governmental Accounting Standards Board (GASB) Statement No. 75 *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*, which is the required presentation for participating employers. However, the Fund should have presented OPEB related amounts in accordance with GASB Statement No. 74 *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*.

Cause: Accounting personnel do not have the current resources of time necessary to prepare the financial statements in accordance with generally accepted accounting principles. As a result, the Fund chose to contract with Eide Bailly, LLP to the prepare its financial statements. In addition, the Fund did not have adequate internal controls to ensure the net position, net OPEB liabilities, and required supplementary information were disclosed or presented appropriately in accordance with U.S. GAAP.

Effect: The Fund's net OPEB liability note disclosure and the required supplementary information reported the net OPEB liability a year in arrears; however, the net OPEB liability should be measured as of the Fund's most recent fiscal year. This resulted in correcting:

- the net OPEB liabilities disclosures for fiscal years 2023 and 2022.
- the schedule of changes in the net OPEB liability and related ratios for all years presented.

In addition, the schedule of contributions was updated to appropriately reflect the contractually required contribution amounts and the contributions made in relation to the contractually required contributions for all years presented, as well as the covered payroll in which the required contributions are calculated.

Moreover, the schedule of investment returns was not previously included, but was added to disclose the annual money-weighted rate of return, net of investment expense for all years presented in accordance with GASB 74.

Lastly, the net position was restated to properly classify the net position as a deficit rather than restricted net position.

Recommendation: We recommend the Fund allocate the resources necessary to enable the preparation of the financial statements in accordance with generally accepted accounting principles and enhance internal controls to ensure the net position, net OPEB liabilities, and required supplementary information are appropriately disclosed and presented.

Views of Responsible Officials: Management partially agrees.

5.

5. Election of Board Vice-Chair pursuant to Nevada Administrative Code (NAC) 287.172. Eligible candidates are Bepsy Strasburg, Michelle Kelley, Jim Barnes, Janell Woodward and Jennifer McClendon. (Joy Grimmer, Board Chair) (**For Possible Action**)

6.

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

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

JOY GRIMMER
Board Chair

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: July 25, 2024

Item Number: 6

Title: Executive Officer Report

SUMMARY

This report provides the Board, PEBP members and other stakeholders with information on the overall activities of PEBP.

REPORT

OPEN ENROLLMENT UPDATE

PEBP's annual open enrollment was held beginning on May 1, 2024, and ending May 31, 2024. Approximately 6,079 members made open enrollment selections which is consistent with the number of previous years activity. PEBP took a total of 4,719 calls to assist members with questions and/or issues with open enrollment and password resets. The chart below provides the final enrollment numbers by plan. Enrollment in the LDPPO continues to increase year over year.

Plan Enrollment as of 7/1/2024 – Total Lives Covered

Plan	PY2023 Enrollment	Current PY2024 Enrollment	Current elections for PY2025
CDHP	26,875	23,944	22,677
LD	14,911	20,098	22,427
EPO	6,221	5,600	5,284
HMO	6,246	6,129	6,035
Dental	10,440	10,309	10,128
Declined	2,496	2,643	2,609

STRATEGIC PLANNING MEETING UPDATE

PEBP will be holding the next strategic planning meeting on October 1st and 2nd, 2024, at the Casino Fandango. Included will be PEBP staff, vendors and 3 to 4 PEBP Board members. As stated in the May 23, 2024, Board meeting we will discuss where we are today, the direction we would like to take PEBP and the future of PEBP plan offerings. The results of that meeting will be brought to the Board for review and consideration at the November/December meeting.

STAFFING

I am happy to announce that Leslie Bittleston, former PEBP Board member, has accepted the position of Quality Control Officer. She started in her new role on Tuesday, July 9, 2024. In addition, 2 new staff have been hired in the Member Services Unit. Their start date is July 22, 2024. This will bring PEBP's vacancy rate down to 11.8 percent.

7.

7. Overview of Current Plan Options. (Richard Ward, Segal) (Information/Discussion)

Nevada Public Employees' Benefits Program

Overview of Current Plan Options

July 25, 2024

Segal

Current Plan Designs and Premiums

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

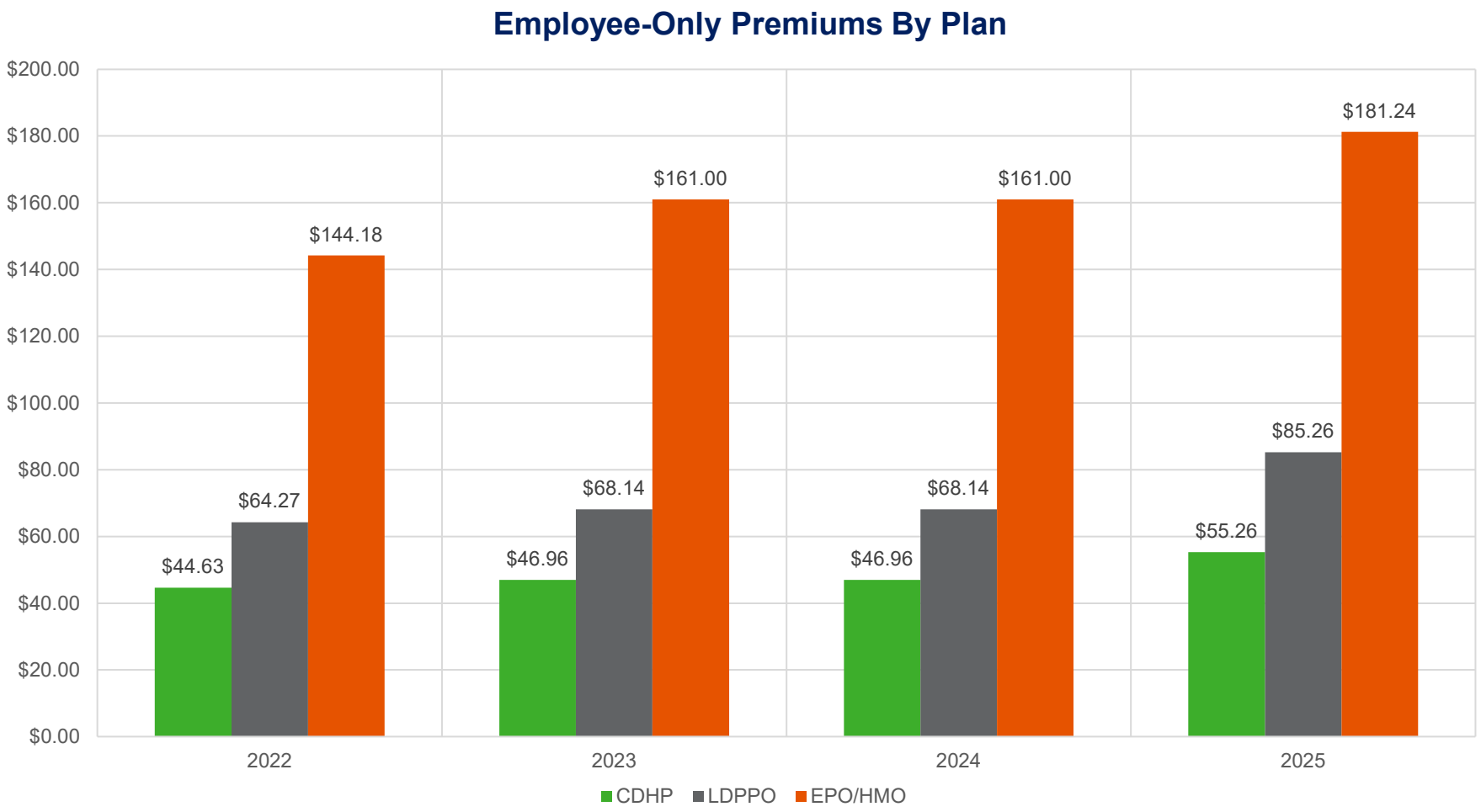
	Consumer Driven Health Plan (CDHP)	Low Deductible (LDPPO)	Premier Plan (EPO)	Health Plan of Nevada (HMO)
Actuarial Value*	76.7%	85.2%	88.3%	91.4%
Service Area	Global	Global	Northern Nevada	Southern Nevada
Annual Deductible (medical and prescription combined)	$1,600 Individual $3,200 Family $3,200 Individual Family Member Deductible	$0	$100 Individual $200 Family $100 Individual Family Member Deductible	N/A With exception of Tier 4 prescription drug coverage
Medical Coinsurance	20% after deductible	20% after deductible	20% after deductible	N/A
Out-of-Pocket Maximum	$4,000 Individual $8,000 Family	$4,000 Individual $8,000 Family	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family
Primary Care/ Specialist Office Visit	20% after deductible	$30/ $50 copay per visit	$20/ $40 copay per visit	$25/ $40 ($25 with referral) copay per visit
Urgent Care Visit	20% after deductible	$80 copay per visit	$50 copay per visit	$50 copay per visit
Emergency Room Visit	20% after deductible	$750 copay per visit	$600 copay per visit	$600 copay per visit
In-Patient Hospital	20% after deductible	20% after deductible	$600 copay per visit	$600 copay per visit
Outpatient Surgery	20% after deductible	$500 copay per visit	$350 copay per visit	Ambulatory Facility $50 copay Hospital $350 copay
Rx 30-days**	20% / 20% / 100% / 20%	$10 / $40 / $75 / 30% (mail only)	$10 / $40 / $75 / 20% (mail only)	$10 / $40 / $75 / 20%***
Employee Only Premium	$55.26	$85.26	$181.24	$181.24

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

Segal

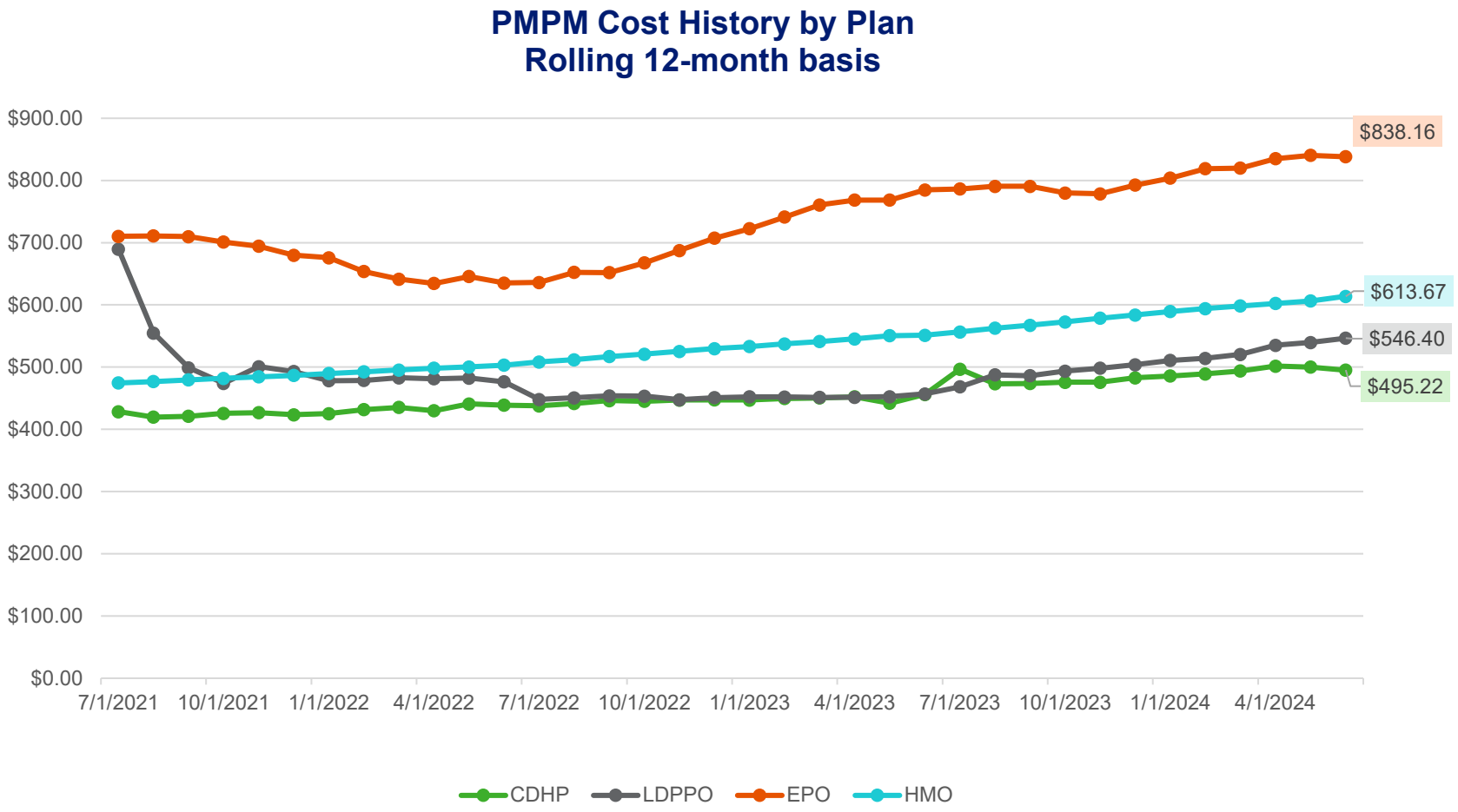
Historical Employee-Only Premiums

EPO/HMO premiums are ~2x the LDPPO premiums and ~3x the CDHP premiums



Historical PMPMs

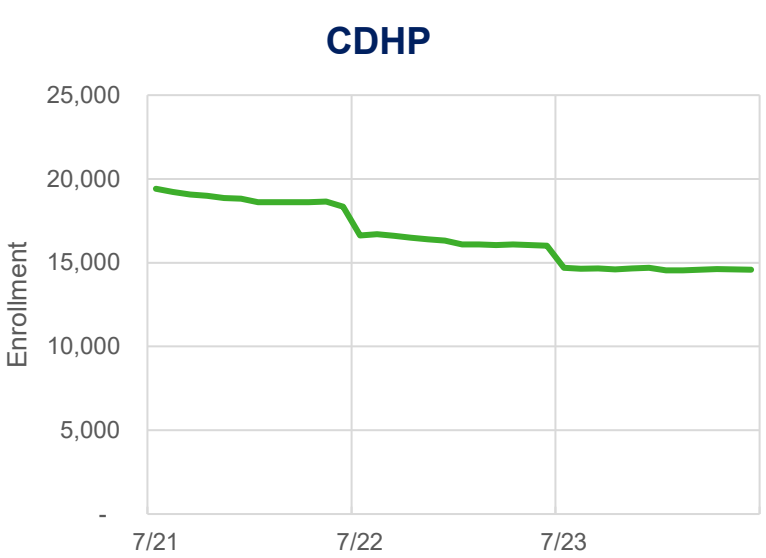
- **HMO premiums are higher than total costs for the EPO**
- **CDHP is the lowest cost plan on a PMPM basis**

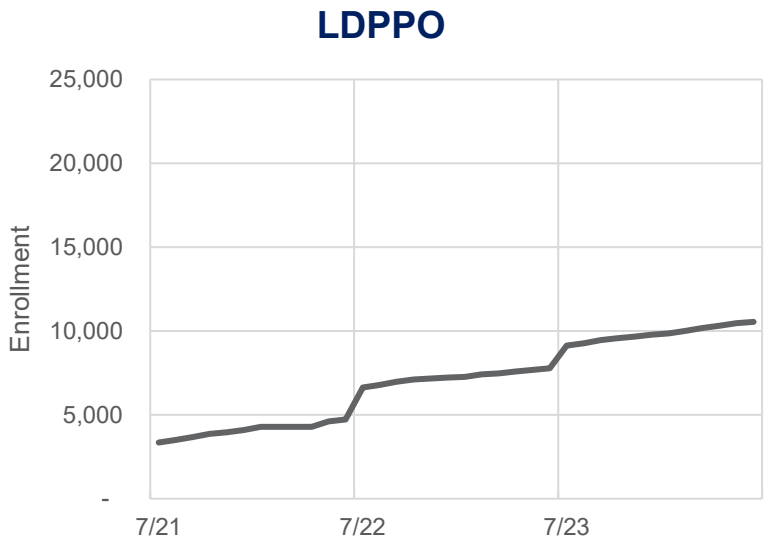


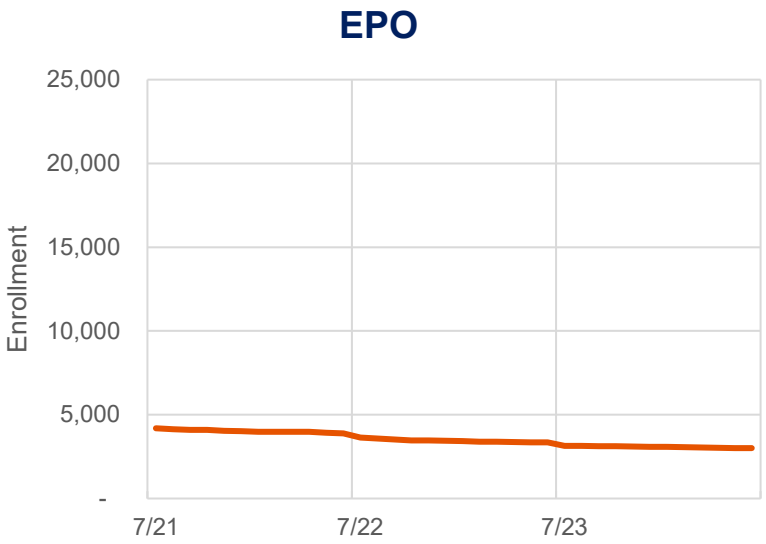
1. Self-insured plan costs include medical and Rx claims net of rebates, ASO fees, HRA claims and HSA funding.
2. Fully insured HMO costs include premiums and HRA claims.
3. Prior to 7/1/2023, only the CDHP plan included HSA funding and HRA claims. In PY2024, all participants in all four plans received additional HRA funding.

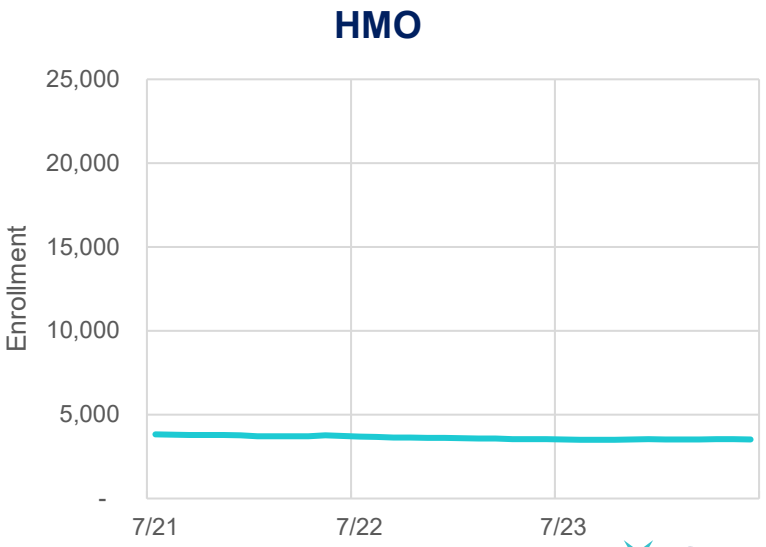
Migration to the LDPPO

Members are migrating to the LDPPO from both the EPO/HMO and the CDHP



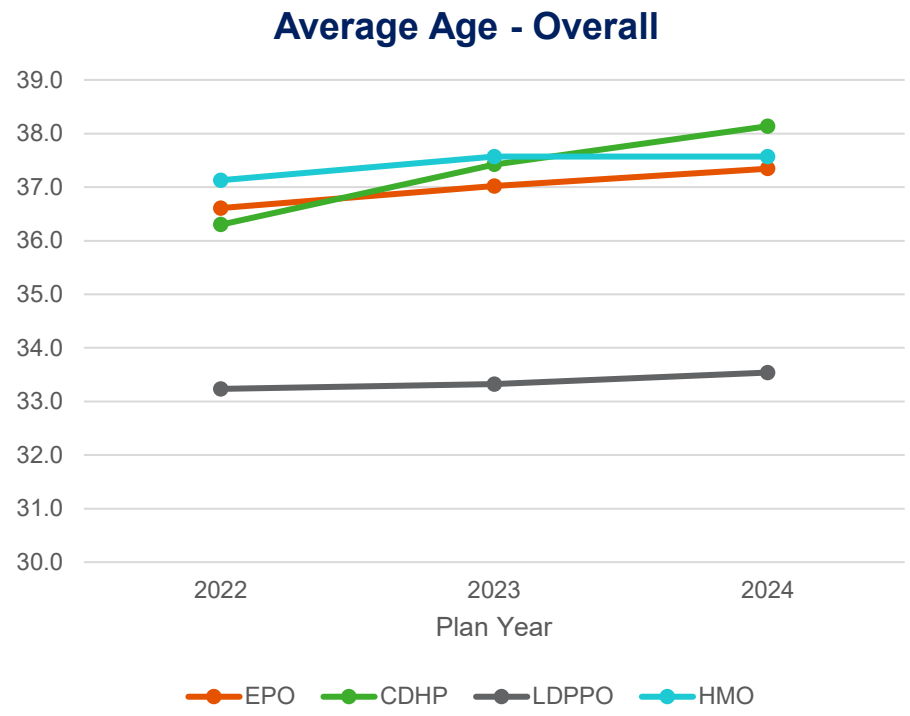


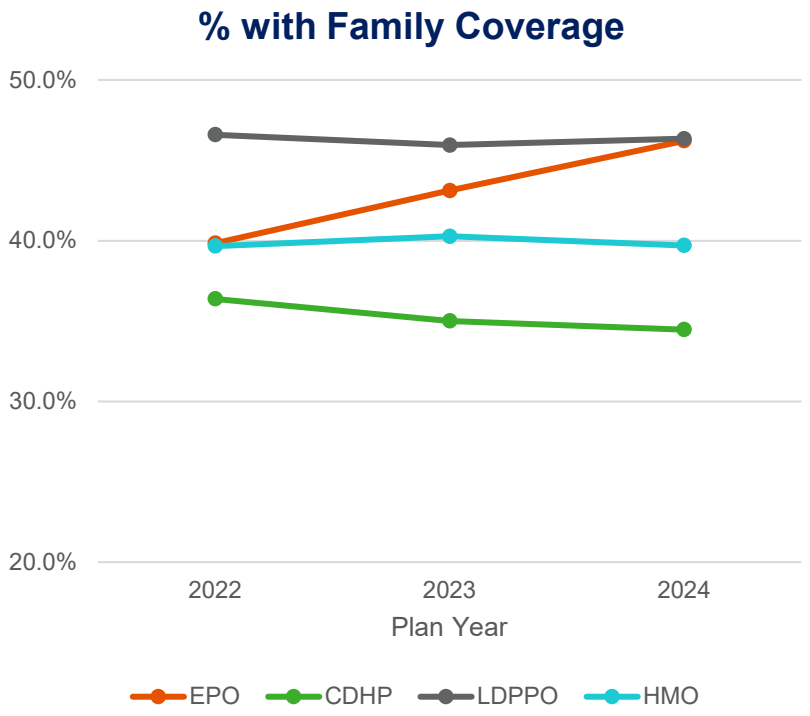




Demographics

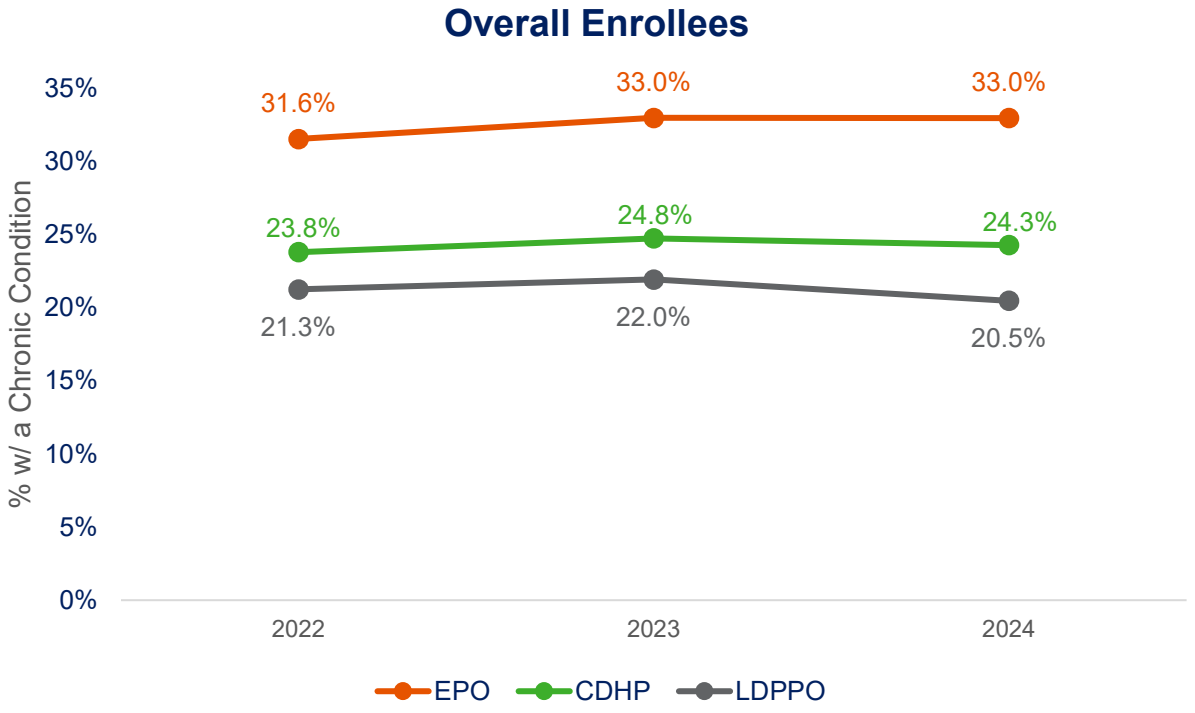
- **Higher ages and larger family sizes contribute to health risk**
- **LDPPO has the youngest membership and the highest rate of family coverage**
- **EPO mix is trending towards families. This suggests single EEs are driving the migration out of the EPO**





Chronic Conditions[1]

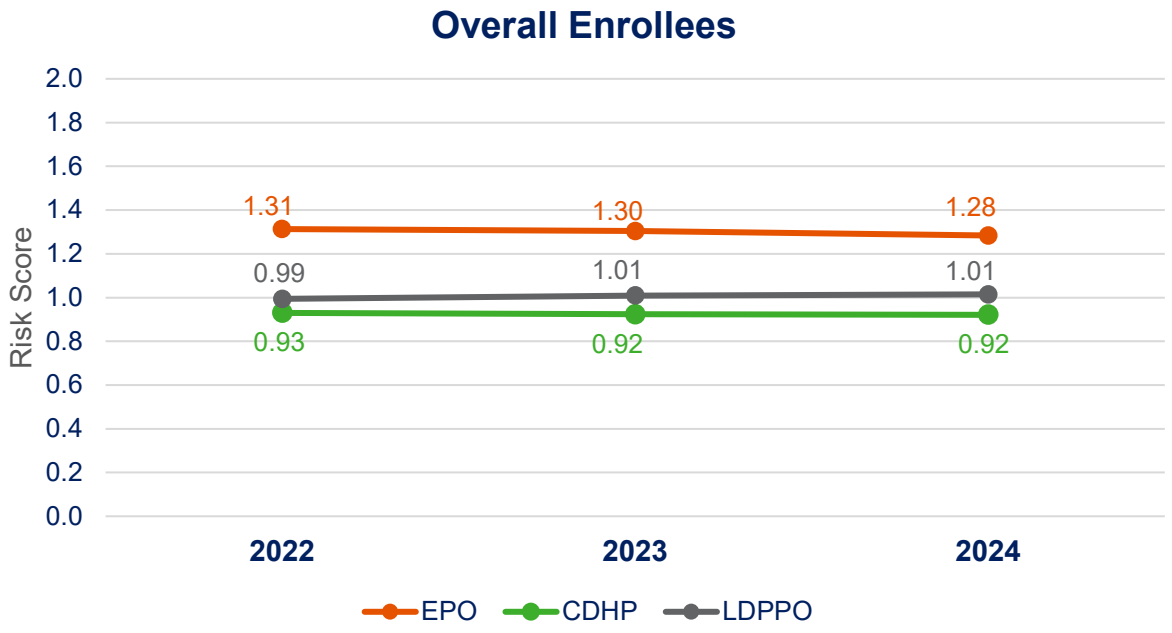
- **Higher prevalence of chronic conditions leads to higher health risk**
- **The EPO has a highest prevalence of chronic conditions**
- **The LDPPO has the lowest prevalence of chronic conditions**



[1] *Chronic conditions include asthma, COPD, CAD, CHF, diabetes, hypertension.*

Health Risk[1]

- **Health risk is determined by analyzing claims data and developing a risk factor for each member based on utilization, health conditions, preventive services and demographics**
- **EPO membership has significantly higher health risk**
- **CDHP has lowest risk**



[1] The risk score is developed from the Clinical Classifications Software Refined (CCSR) risk model developed by the Agency for Healthcare Research and Quality (AHRQ).

Plan Efficiency

- **Plan Efficiency is a metric that measures health risk management**
- **Efficiency normalizes for differences in plan design and member risk**
- **Lower adjusted PMPMs indicate better risk management**
- **The LDPPO is the most efficient plan, and the EPO is the least efficient plan**

	CDHP	LDPPO	EPO
PMPM (a)	$440.45	$527.19	$818.20
AV (b)	76.7%	85.2%	88.3%
Risk Score* (c)	0.92	1.01	1.28
Efficiency** (d) = (a÷b)÷c	$700.98	$632.24	$739.45

** Risk scores are normalized for the average risk score each plan year.*

*** Allowed amount per unit of risk.*

Questions

8.

8. Discussion regarding the framework for development of the Agency Budget Request for the 2026-2027 Biennium. (Celestena Glover, Executive Officer) (**For Possible Action**)

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

JOY GRIMMER
Board Chair

AGENDA ITEM

[X] Action Item

[ ] Information Only

Date: July 25, 2024

Item Number: 8

Title: PEBP Agency Request Budget 2025-2027 Biennium

SUMMARY

This report provides updates on budget direction and proposed budget recommendations for PEBP's Agency Request Fiscal Year 2026/2027 Budget submission.

REPORT

BACKGROUND

NRS 353.150 - NRS 353.246, also known as the State Budget Act, outlines the biennial budget process. Pursuant to Assembly Bill 346, NRS 353.211 and 353.230 were amended to include language for the definition of "adjusted base budget" as the amount appropriated or authorized to support ongoing expenditures budgeted to the agency by the Legislature for the second year of the current biennium, as adjusted for removal of one-time costs. Previously "adjusted base budget" was actual expenditures of the even numbered year of the current biennium less any one-time costs.

In accordance with the State Budget Act, all agencies must complete the data entry of their 2025-2027 Agency Request Budget into the Nevada Executive Budgeting System (NEBS) by 4:00PM on Friday, August 30, 2024. This is a statutory deadline (NRS 353.210) which cannot be changed or extended.

BUDGET DIRECTION

During the statewide budget kickoff meeting in March, agencies were given direction to build their FY26/27 agency request budget using two times the FY25 cap as adjusted. Cap is the 2nd

year of the biennium which is a change from previous years. With this direction PEBP is building a "flat" budget; however, maintenance decision units will be allowed for caseload growth (projected enrollment of active and retired employees) and agency specific inflation (trend and experience which will affect the overall rates set for each plan and tier offered by PEBP) as approved by the Budget Division. As in past years PEBP is collaborating with our actuary vendor Segal to forecast the FY26/27 budget needs based on the current plan designs utilizing trend and experience both within PEBP as well as with similar plans across the Segal book of business.

AGENCY SPECIFIC INFLATION

PEBP's primary concern is sufficient funding through employer contributions to mitigate potential increases to employee premiums without reducing benefits within the plan offerings. The last two years of claims experience indicates the PEBP will need to request an increase in funding to fund expected claims expenses. This translates to higher premiums and subsidies for all tiers and plans. Staff will work with the Governors Finance Office and the appropriate money committees to educate individuals on the needs of PEBP and the importance of its services to our members. In addition, restoration of the basic life insurance cut in previous years was funded through a general fund appropriation. As part of the benefit offering, it is important to maintain consistent basic life insurance benefits. This will be considered in our agency request budget and request for increased funding.

BUDGET ENHANCEMENTS

Budget enhancements requested by state agencies must meet the Governor's 3-Year Plan Policy Matrix.

1. Education and Workforce
2. Economic growth and business development
3. Health and wellness
4. Public safety and infrastructure
5. Government support services
6. Rural and natural resources

PEBP currently has no recommendations for major budget enhancements but will be requesting new equipment and software to add TEAMS and ZOOM meeting capabilities to the PEBP conference room in the executive suite to enable accessibility for joint meetings with agencies in multiple locations.

RECOMMENDATIONS

Approve the submission of PEBP's agency request budget based on existing plan benefit design and 2) include the enhancement request for new equipment and software to enhance meeting capabilities within the PEBP conference room.

9.

9. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR Benefits for the period of January 1, 2024 – March 31, 2024. (Joni Amato, Claim Technologies Incorporated) (**For Possible Action**)

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefits Program Plans
Administered by UMR Insurance Company

Audit Period: January 1, 2024 – March 31, 2024
Audit Number 1.FY24.Q3

Presented to

State of Nevada Public Employees' Benefits Program

July 25, 2024

CLAIM TECHNOLOGIES INCORPORATED

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EXECUTIVE SUMMARY

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

Scope

CTI performed an audit for the period of January 1, 2024 through March 31, 2024 (quarter 3 (Q3) 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	$70,303,130
Total Number of Claims Paid/Denied/Adjusted	222,754

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 and Claim Turnaround Time within 30 days did not meet the service objective and a penalty is owed (breakdown in summary below). Overall Accuracy and Claim Turnaround Time within 14 days met the service objective.
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 financial accuracy and claim turnaround within 30 days measurements for PEBP in Q3 FY2024 and a penalty is owed. Reported administrative fees for the quarter totaled $1,351,734.20.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy (p. 12)	99.4%	Not Met – 98.47%	1.5%	$20,276.01
Overall Accuracy (p. 13)	98.0%	Met – 98.5%	NA	$0.00
Claim Turnaround Time (p. 14)	92% in 14 Days	Met – 94.0%	NA	$0.00
	99% in 30 Days	Not Met – 98.5%	1.0%	$13,517.34
		Total Penalty	2.5%	$33,586.70

AUDIT OBJECTIVES

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

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

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

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

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

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 Q3 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	94.30%	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	92.20%	Met
1.6	**Call Abandonment Rate:** total number of participant and provider calls abandoned, divided by the total number of calls received by the facility's customer service telephone system.	3.00%	0.50%	Met
1.7	**First Call Resolution Rate:** the percentage of telephone inquiries completely resolved within a 'window period' of time. A call is considered 'resolved' when the same participant or a family member under the same subscriber ID has not contacted the administrator's customer service facility again regarding the same issue within 60 calendar days of the initial call.	95.00%	95.80%	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	98.00% 99.20%	Met 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%	97.00%	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	100%	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
	Responsiveness – All calls returned within at most 24 hours; along with an alternate person identified who can assist with service issues when account representative is unavailable.			
	Ability to meet deadlines – Supplying all requested materials accurately and in a timely manner, along with all necessary documentation (i.e., enrollment kits, rate confirmations, plan performance work plans, group contracts, ZIP code file, etc.).			

	Metric	Service Objective	Actual	Met/ Not Met
	Professionalism – Demonstrates objectivity and empathy with customer problems.			
	Flexibility – Ability to meet client-specific needs.			
	Participation in periodic meetings – Attendance at all required client meetings or conference calls.			
	Guarantee measured with staff responses to internal questionnaire. A scale from 1 to 5 will be used to measure performance, where 1 means 'very dissatisfied' and 5 means 'very satisfied'; and 2 through 4 are defined, respectively.			
	Periodic program reports will be provided and presented with recommended actions. Standard program reports, within 30 days to quarter-end. Year-end activity report, within 45 days of program year end.			
	Open Enrollment Support: Accurate materials will be provided at least 60 days prior to the open enrollment period starting on April 1 each year. Representative will be available, if requested, for up to 5 employee benefit fairs.			
	Service Objective (out of a score of 5 on internal questionnaire):	350		
1.14	**Eligibility Processing:** Confirm daily and weekly eligibility and enrollment within specified business days of the receipt of the eligibility information, given that information is complete and accurate.	98.00% 2 Business Days	100%	Met
1.15	**Data Reporting:** Offeror will provide PEBP with 100% of the applicable reports (within 10 business days for standard reports and within 10 business days of Plan year-end for Annual Reports and Regulatory documents).	100% 10 Business Days	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	99.00% 99.50%	Met Met
2.2	**EDI Claims Re-Pricing Accuracy:** At least 97% of claims re-priced by the PPO Network must be accurate and must not cause a claim adjustment by PEBP's TPA.	97.00%	97.80%	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
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%	100%	Met

	Metric	Service Objective	Actual	Met/ Not Met
UTILIZATION MANAGEMENT/CASE MANAGEMENT – SERVICES AND PERFORMANCE GUARANTEES				
3.1	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within calendar 10 days of end of reporting period or event as determined by PEBP.	100% 10 Calendar Days	100%	Met
3.2	**Notification of potential high expense cases. High expense case is defined as a single claim or treatment plan expected to exceed $100,000.00.** Designated PEBP staff will be notified within 5 business days of the UM/CM vendors initial notification of the requested Service.	100% 5 Business Days	100%	Met
3.3	**Pre-Certification Requests:** Precertification requests from healthcare providers shall be completed in accordance with URAC/NCQA standards and turn-around timeframes; completed Pre-certifications shall be communicated to PEBP's Third Party Administrator using an approved method e.g., electronically, within 5 business days of UM completing Precertification determination.	98.00% 5 Business Days	NA	Reported Annually
3.4	**Concurrent Hospital Reviews:** Concurrent hospital reviews shall be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated to the provider using an approved method e.g., electronically within 2 business days of determination decision.	98.00% 2 Business Days	NA	Reported Annually
3.5	**Retrospective Hospital Reviews:** Retrospective reviews must be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated using an approved method e.g., electronically within 5 business days of determination decision.	98.00% 5 Business Days	NA	Reported Annually
3.8	**Hospital Discharge Planning:** CM will contact or attempt to contact 95% of patients discharged from any facility within 3 business days of notification of discharge with clinical coaching and discharge planning assistance.	95.00% 3 Business Days	NA	Reported Annually
3.9	**Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	95.00%	NA	Reported Annually
3.10	**Utilization Management for Medical Necessity and Center of Excellence Usage:** UM review to determine medical necessity in accordance with the MPDs. Services to be performed at a Center of Excellence to be managed through the Case Management process.	98.00%	NA	Reported Annually
3.11	**Return On Investment (ROI) Guarantee – Utilization Management/Case Management:** 2:1 Savings to Fees for Utilization Management/Case Management.	100%	NA	Reported Annually
3.12	**Disclosure of Subcontractors:** All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	No new subcontractors	Met
3.13	**Unauthorized Transfer of PEBP Data:** All PEBP PHI or PII data will be stored, processed, and maintained solely on currently designated servers and storage devices identified in this contract. Any changes to those designated systems during the life of this agreement shall be reported to PEBP at least 60 calendar days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	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 or 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				
39	$20.70	Agree.	Procedural deficiencies and overpayments remain. UMR paid duplicate charges.	☒ M ☐ S
40	$72.86			☒ M ☐ S
42	$52.00			☐ M ☒ S
43	$400.00			☐ M ☒ S
44	$79.00			☐ M ☒ S
45	$52.00			☐ M ☒ S
46	$188.92			☒ M ☐ S
47	$52.00			☐ M ☒ S
48	$534.40			☐ M ☒ S
Plan Exclusions				
Potential Cosmetic Procedure				
36	$1,955.00	Agree. Claims are reviewed based on services billed. Procedure and Diagnosis selections are coded in the UMR system to identify these claims. These types of claims require prior authorization from the UM Vendor. This claim is paid in error.	Procedural deficiency and overpayment remain. Payment for potential cosmetic service (procedure 19318) was not authorized.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Inappropriate Use of Modifier 26/TC				
33	$11.84	Disagree. Services billed by laboratory for professional component of a service or procedure and has also prepared a written interpretation and report based on the modifier billed on this claim.	Procedural deficiency and overpayment remain. There was not a separate reimbursable professional component for this automated lab test. The full reimbursement for 80053 was made to Memorial University Medical Center on 11/30/23.	☐ M ☒ S
Copay Application				
Diagnostic Mammogram				
10	($3.31)	Agree. A $40 copay should have applied between codes 77066 and G0279, with coinsurance being applied on procedure 76642. The claim will be adjusted.	Procedural deficiency and underpayment remain. The diagnostic mammogram should have paid at 100% of allowable after application of $40.00 copay, $43.31 coinsurance was applied in error.	☒ M ☐ S
Fraud, Waste and Abuse				
Durable Medical Equipment (DME) Allowance				
21	$445.31	Agree. UMR reviewed this claim post payment. UM approved the enteral feeding/supplies under case id xxxx80064. UM approved the enteral feeding/supplies under case id xxxx80064. This claim was allowed without the out of network pricing. The correct allowable is $ 349.37. The plan should pay $ 174.69, we paid $620.00, which resulted in overpayment of $445.31.	Procedural deficiency and overpayment remain. The incorrect allowable was processed for this DME claim.	☒ M ☐ S
Specialty Medications (Non Hospital)				
23	$1,114.30	Agree. Prior authorization was approved for these services. The correct allowable for code J0585 is $7.00 per unit. The provider billed 1 unit. $7.00 x 80% = $5.60. This claim will be adjusted and is overpaid $1114.30.	Procedural deficiency and overpayment remain. The incorrect allowable was calculated for specialty drug J0585.	☒ M ☐ S
24	$2,519.05	Agree. Prior authorization was approved for these services. The correct allowable for code J1602 is $40.78 per unit. The provider billed 150 units. $6,117.45 at 100%. This claim will be adjusted and is overpaid $2,519.05.	Procedural deficiency and overpayment remain. The incorrect allowable was calculated for specialty drug J1602.	☒ M ☐ S
High Dollar Payments to Employees				
26	$7,333.58	Agree. This claim was paid in error to the member. Stop payment was completed. UMR will reissue payment to the provider. Member has Medicare Part B. Medicare denied as not covered.	Procedural deficiency and overpayment remain. Payment should have been made to the provider but was issued to the member in error.	☒ M ☐ S
UCR Assistant Surgeon				
27	$5,322.06	Agree. Allowance should have been 140% of Medicare = $237.08. Claim adjusted 05/07/24 – overpaid $5,322.06. Customer First Representative did not route the claim for out of network pricing.	Procedural deficiency and overpayment remain The incorrect out of network pricing was calculated for this procedure.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Cardiovascular Genetic Testing				
30	$4,524.60	Agree. The claim was allowed in error. No prior authorization was done. Claim was paid in error and overpaid. An adjustment will be made, and overpayment requested.	Procedural deficiencies and overpayments remain. Services were paid without the required prior authorization.	☐ M ☒ S
31	$4,659.22			☒ M ☐ S

Additional Observations

During the Targeted 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.

QID Number	Observation
2, 3, 4	UMR did not use the Procedure to Procedure CMS NCCI edits that disallow payments for procedures that cannot be billed together. UMR stated it is working on system enhancements to allow for historical UHC claim editing, which is targeted for 2025.

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 $2,385,161.61. The claims sampled and reviewed revealed $100.00 in underpayments and $54,099.89 in overpayments. This reflects a weighted Financial Accuracy rate of 98.47% over the stratified sample. This is a decrease in performance from the prior period. Detail is provided on the following page in the Random Sample Findings Detail Report table.

UMR did not meet the Performance Guarantee for PEBP in Q3 FY2024 of 99.40% for this measure. The penalty owed is 1.5% of the administrative fees of $1,351,734.20 or $20,276.01.

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 3 incorrectly paid claims and 197 correctly paid claims. This is an increase in performance from the prior period. Detail is provided below, Random Sample Findings Detail Report.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	1	2	98.50%

Overall Accuracy

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

UMR met the Performance Guarantee for PEBP in Q3 FY2024 of 98.0% for this measure, performance increased from the prior period. Detail is provided in the table below, Random Sample Findings Detail Report.

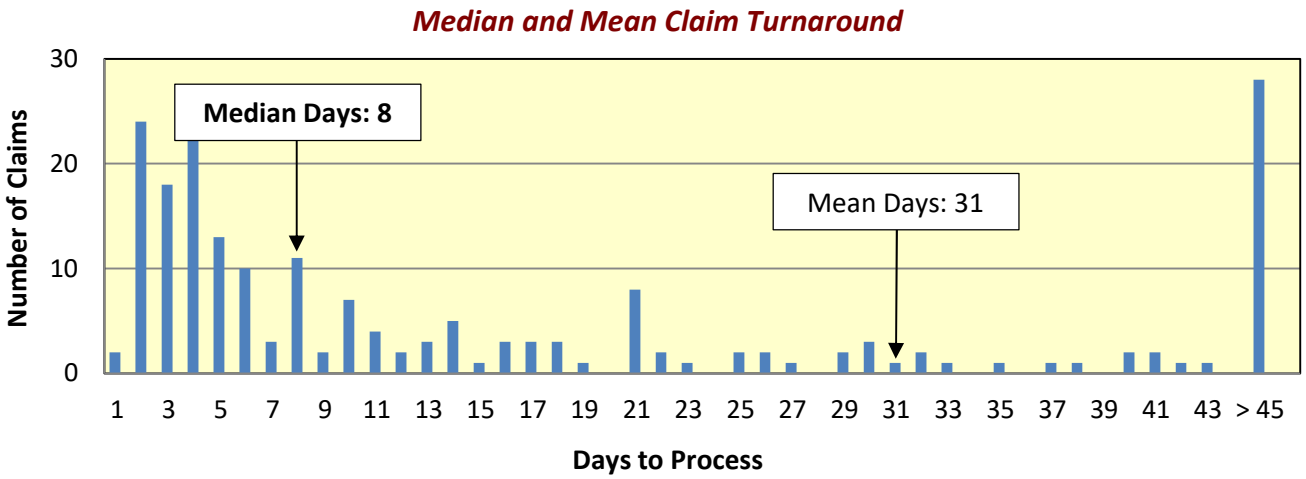
Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
197	1	2	98.50%

Random Sample Findings Detail Report				
Audit No.	(Under)/ Over Paid	UMR Response	CTI Conclusion	Manual or System
PPO Discount Error				
1048	$49.89	Agree. The pricing analyst transposed the allowable amount on the contract. H0015 allowable is $170.00. This claim was adjusted on 5/15/24 and results in a $49.89 overpayment.	Procedural error and overpayment remain. An incorrect PPO discount was applied. The allowable amount was $186.63, and it should have been $170.00 for each of three dates of service.	☒ M ☐ S
1114	$54,050.00	Agree. Claim was allowed at billed charge in error. The correct allowable is $4,299.00. This results in a $54,050 overpayment. The claim adjusted on 5/22/24 requesting provider refund.	Procedural error and overpayment remain. An incorrect PPO discount was applied. The allowable amount was $68,949, and it should have been $4,299.00.	☒ M ☐ S
Denied Eligible Expense				
1126	($100.00)	Agree. vision hardware was denied in error and should have been covered. This results in a $100 underpayment. Claim was adjusted on 5/10/24 issuing an additional payment of $100.	Procedural error and underpayment remain. The vision hardware was denied in error and should have been covered.	☐ 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 Q3 FY2024 of 99% processed within 30 days but did meet 92% processed within 14 days. This performance did improve from the prior period, but a penalty is still due. The penalty owed for this Performance Guarantee is 1.0% of the administrative fees of $1,351,734.20 or $13,517.20.

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 No.	Observation
1032	The sample claim was an adjustment with a corrected provider allowed amount. The original claim paid on 8/10/23 with an incorrect allowed amount of $76.00. UMR provider contract effective 7/1/23 was loaded on 1/24/24. The update was completed in UMR's system on 2/9/24. The sample claim was adjusted to allow the updated rate of $110.00. UMR should explain why it took over seven months to load the correct contract rates and provide confirmation all other claims paid for PEBP members using the incorrect contract have been adjusted.
2031	The plan document did not reflect coverage for crowns on a primary tooth. The sample claim allowed coverage on four primary tooth crowns and paid $610.00 in benefits under UMR's standard logic. PEBP should review to ensure payment for a crown on primary teeth is an intended benefit.

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

PEBP's members under age 65 had utilization of network or secondary network medical providers at 97.1% of all allowed charges and 95.9% of all claims.

Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$3,571,886.98	$2,975,696.86	45.4%	$3,085,378.97
Non-Facility	$32,083,057.34	$37,952,089.76	54.2%	$23,958,786.81
Facility Inpatient	$19,188,512.10	$46,763,240.17	70.9%	$18,115,090.87
Facility Outpatient	$28,388,787.96	$52,354,669.95	64.8%	$23,306,139.54
Total	**$83,232,244.38**	**$140,045,696.74**	**62.7%**	**$68,465,396.19**

Sanctioned Provider Identification

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

Scope

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

Report

We screened 100% of non-facility claims against OIG's LEIE and found no providers on the sanctioned list 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.

We analyzed the payments to determine if they were compliant. To demonstrate full compliance with PPACA's requirements, the analysis 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.

Report

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 98.96% 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.

Procedure to Procedure Edits								
PEBP - UMR								
Based on Paid Dates 1/1/2024 through 3/31/2024								
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	18	$11,590
					Standards of medical/surgical practice			
19318	50	15200	50	YES	Breast reduction	SKIN FULL GRAFT TRUNK	1	$5,826
					Standards of medical/surgical practice			
19342	50	19380	50	YES	Insertion or replacement of breast implant on sep	Revision of reconstructed breast(eg,signific	1	$5,560
					More extensive procedure			
70496	TC	96374		YES	CT ANGIOGRAPHY HEAD	THER/PROPH/DIAG INJ IV PUSH	5	$4,437
					Standards of medical/surgical practice			
94626		94625		YES	Physician services for outpatient pulmonary reha	Physician services for outpatient pulmonar	10	$3,125
					Mutually exclusive procedures			
76819	TC	59025		YES	FETAL BIOPHYS PROFIL W/O NST	FETAL NON-STRESS TEST	3	$2,777
					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	$2,721
					Misuse of Column Two code with Column One code			
99285		99284		YES	Emergency department visit for E&M of patient re	Emergency department visit for E&M of pati	1	$2,697
					Misuse of Column Two code with Column One code			
90853		90832		YES	GROUP PSYCHOTHERAPY	Psytx pt&/family 30 minutes	4	$2,397
					CPT Manual or CMS manual coding instruction			
94640		99285		YES	AIRWAY INHALATION TREATMENT	Emergency department visit for E&M of pati	1	$2,195
					CPT Manual or CMS manual coding instruction			
						Top 10 TOTAL	**45**	**$43,327**
						GRAND TOTAL	**327**	**$100,183**

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
54640	99	54512	50	YES	Orchiopexy, inguinal or scrotal approach	EXCISE LESION TESTIS	1	$2,108
					Standards of medical/surgical practice			
92609	GN	92507	GN	YES	USE OF SPEECH DEVICE SERVICE	SPEECH/HEARING THERAPY	12	$1,261
					Misuse of Column Two code with Column One code			
19370	50	11970	50	YES	Revision of peri-implant capsule, breast,includin	Replacement of tissue expander with perma	1	$441
					More extensive procedure			
00580	AA	93312	26	YES	ANESTH HEART/LUNG TRANSPLNT	ECHO TRANSESOPHAGEAL	1	$413
					Standard preparation/monitoring services for anesthesia			
88360	26	88341	26	YES	TUMOR IMMUNOHISTOCHEM/MANUAL	Immunohistochemistry or immunocytochen	3	$409
					CPT Manual or CMS manual coding instruction			
90460		99392	5	YES	IM ADMIN 1ST/ONLY COMPONENT	PREV VISIT EST AGE 1-4	2	$386
					CPT Manual or CMS manual coding instruction			
98941		97140	GP	YES	Chiropract manj 3-4 regions	Manual therapy 1/> regions	16	$335
					Standards of medical/surgical practice			
29880	51	29876	51	YES	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$305
					Standards of medical/surgical practice			
00562	AA	93312	26	YES	ANESTH HRT SURG W/PMP AGE 1+	ECHO TRANSESOPHAGEAL	1	$281
					Standard preparation/monitoring services for anesthesia			
84481		84480		NO	FREE ASSAY (FT-3)	ASSAY TRIIODOTHYRONINE (T3)	14	$272
					More extensive procedure			
						Top 10 TOTAL	**52**	**$6,212**
						GRAND TOTAL	**125**	**$8,546**

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
97154	18	GROUP ADAPTIVE BHV TX BY PROTOCOL TECH EA 15 MIN	20	$9,257
		Rationale: Clinical: CMS Workgroup		
31295	1	Nasal/sinus endoscopy, surgical, w dilation (balloon dila	3	$8,360
		Rationale: CMS Policy		
88332	13	PATH CONSULT INTRAOP ADDL	1	$3,764
		Rationale: Clinical: Data		
32667	3	THORACOSCOPY W/W RESECT ADDL	2	$3,546
		Rationale: Clinical: Data		
96133	7	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR	1	$1,568
		Rationale: Nature of Service/Procedure		
90837	2	Psytx pt&/family 60 minutes	2	$1,450
		Rationale: Clinical: CMS Workgroup		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	3	$1,343
		Rationale: Clinical: CMS Workgroup		
54640	1	Orchiopexy, inguinal or scrotal approach	1	$945
		Rationale: CMS Policy		
86255	5	FLUORESCENT ANTIBODY SCREEN	1	$807
		Rationale: Clinical: Data		
30140	1	RESECT INFERIOR TURBINATE	3	$573
		Rationale: CMS Policy		
		Top 10 TOTAL	**37**	**$31,613**
		GRAND TOTAL	**63**	**$35,097**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, or non-facility)				
Procedure	Service Unit	Procedure Description	Line count	Amount CMS
A4238	1	Adju cgm supply allowance	15	$16,219
		Rationale: CMS Policy		
A4239	1	Non-adju cgm supply allow	7	$4,776
		Rationale: Nature of Equipment		
B4035	1	ENTERAL FEED SUPP PUMP PER D	4	$1,810
		Rationale: Code Descriptor / CPT Instruction		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	7	$550
		Rationale: Anatomic Consideration		
V2520	2	CONTACT LENS HYDROPHILIC	8	$500
		Rationale: Anatomic Consideration		
L2830	2	SOFT INTERFACE ABOVE KNEE SE	2	$270
		Rationale: Anatomic Consideration		
V2020	1	VISION SVCS FRAMES PURCHASES	2	$220
		Rationale: Clinical: Data		
V2100	2	LENS SPHER SINGLE PLANO 4.00	4	$220
		Rationale: Clinical: Data		
V2510	2	CNTCT GAS PERMEABLE SPHERICL	2	$220
		Rationale: Anatomic Consideration		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	5	$127
		Rationale: Nature of Equipment		
		Top 10 TOTAL	**56**	**$24,912**
		GRAND TOTAL	**65**	**$25,230**

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.

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 with Modifier 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
880133501	20	$6,985	6	23.1%	$1,444	5	$741	2	$289
880459167	0	$0	1	100.0%	$125	1	$77	0	$0
880335489	0	$0	1	100.0%	$125	1	$179	0	$0
880236758	3	$650	3	50.0%	$534	3	$289	0	$0
863930553	0	$0	1	100.0%	$30	1	$32	0	$0
813253496	1	$191	2	66.7%	$382	2	$287	0	$0
452698394	2	$1,319	2	50.0%	$1,319	2	$306	0	$0
270773333	2	$255	1	33.3%	$127	1	$166	0	$0
263303591	2	$753	1	33.3%	$172	1	$123	0	$0
223951517	0	$0	1	100.0%	$30	1	$20	0	$0
Top 10	**30**	**$10,152**	**19**	**38.8%**	**$4,289**	**18**	**$2,222**	**2**	**$289**
Overall Total	**34**	**$10,642**	**22**	**39.3%**	**$4,689**	**21**	**$2,489**	**2**	**$289**

CONCLUSION

UMR did not meet the performance metrics for financial accuracy and claim turnaround within 30 days; however, they did meet the performance metrics for overall accuracy and claim turnaround within 14 days in the third quarter of FY2024. A penalty of $33,586.70 or 2.5% of the administration fees for the quarter, is owed.

We consider it a privilege to have worked for, and with, 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

June 19, 2024

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q3Y24 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID 39 and 40 – Claim 23350436609 is a duplicate to previously processed claim 23341347680. This results in a $20.70 overpayment. UMR has requested an overpayment for this claim. Sample selection 39 and 40 are for the same claim.

QID 42 – Claim 24061361134 was adjusted and denied on 5/7/2024 as a duplicate to previously processed claim 24075434038. This results in a $31.20 overpayment.

QID 43 – Claim 24016002922 was adjusted and denied on 5/7/2024 as a duplicate to previously processed claim 23206159133. This results in a $400.00 overpayment.

QID 44 – Claim 24016012796 was adjusted and denied on 5/7/2024 as a duplicate to previously processed claim 23227000700. This results in a $79.00 overpayment.

QID 45 – Claim 24095258614 was adjusted and denied on 5/7/2024 as a duplicate to previously processed claim 24066347772. This results in a $52.00 overpayment.

QID 46 – Claim 23165421857was adjusted and denied on 5/7/2024 as a duplicate to previously processed claim 23132152998. This results in a $188.92 overpayment. UMR has requested an overpayment for this claim.

QID 47 – Claim 24075258313 was adjusted and denied on 5/7/2024 as a duplicate to previously processed claim 24066347757. This results in a $52.00 overpayment.

QID 48 – Claim 24079003472 was adjusted and denied on 5/7/2024 as a duplicate to previously processed claim 24058700591. This results in a $534.40 overpayment.

Plan Exclusions – Potential Cosmetic Procedure

QID 36 – UMR agrees with this finding. This service was not authorized prior to payment and should have been denied. This results in a $3107.50 overpayment. This claim was adjusted on 6-18-2024.

Plan Exclusions - Inappropriate Use of Modifier 26/TC

QID 33 – UMR disagrees with this finding. Services billed by laboratory for professional component of a service or procedure and has also prepared a written interpretation and report based on the modifier billed on this claim.

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

Copay Application - DX Mammography/Chiro

QID 10 – UMR agrees with this finding. The benefit is to apply a $40.00 copayment for diagnostic mammograms. This claim was adjusted on 6/5/2024 and results in a $43.31 overpayment.

Fraud, Waste and Abuse – DME

QID 21 – UMR agrees with this finding. UM approved the enteral feeing/supplies under cases management. This claim was allowed without the out of network pricing that should apply to this claim. This results in a $445.31 overpayment. This claim was adjusted on 6-18-2024.

Fraud, Waste and Abuse – Specialty Medications (Non-Hospital)

QID 23 – UMR agrees with this finding. An incorrect allowable for code J0585 was applied to this claim. This results in a $1114.30 overpayment. This claim was adjusted on 6-18-2024.

QID 24 - UMR agrees with this finding. An incorrect allowable for code J1602 was applied to this claim. This results in a $2519.05 overpayment. This claim will be adjusted at the completion of this audit.

Fraud, Waste and Abuse – High Dollar Payments to Employees

QID 26 – UMR agrees with this finding. This claim was paid to the member in error. A stop payment was completed, and UMR reissued payment to the provider on 5/5/2024.

Fraud, Waste and Abuse – UCR Assistant Surgeon

QID 27 – UMR agrees with this finding. This claim should have been allowed at 140% of Medicare. This claim was adjusted on 5/7/2024 and results in a $5322.06 overpayment.

Fraud, Waste and Abuse – Cardiovascular Genetic Testing

QID 30 – UMR agrees with this finding. This service was not authorized prior to payment and should have been denied. This results in a $4524.60 overpayment. This claim was adjusted on 6-18-2024.

QID 31 – UMR agrees with this finding. This service was not authorized prior to payment and should have been denied. This results in a $5716.78 overpayment. This claim was adjusted on 6-18-2024.

Additional Observations:

QID 2, 3, 4 - UMR currently does not subscribe to historical iCES editing, therefore the claim repriced correctly based on the current editing software in place. UMR is in the process of a system enhancement to allow for historical UHC claim editing, and this is targeted for 2025.

QID 17 – For certain high -cost specialty drugs administered under the medical plan (i.e., certain gene therapy drugs), United Healthcare may negotiate with the provider. When the claim was originally processed, network pricing was applied based on the billed revenue code for drug charges rather than the negotiated rate for the specific gene therapy drug. UHC Network team verified an agreement was on file and the claim was adjudicated per the single case agreement.

Random Sample Findings

PPO Discount Error

Sample 1039 – 24039138722 UMR disagrees with this finding. This claim is processed correctly with the most current Medicare Allowable Rate that was in our system at the time this claim was processed. This claim will be adjusted at the completion of the audit.

Sample 1048 – UMR agrees with this finding. The allowable amount on the contract was transposed. This is a manual error and results in a $49.89 overpayment. This claim was adjusted on 5-15-2024.

UMR

Sample 1114 – UMR agrees with is finding. This claim was allowed at billed charges with an incorrect discount amount. This was a manual processor error and results in a $54,050 overpayment. The claim was adjusted on 5-22-2024.

Deductible Error

Sample 1084 – UMR disagrees with this finding. Per the plan benefits, Ology claims are to be paid INN when referred by a participating physician. The referring provider on the claim is a PPO provider. This claim is processed correctly at 80%.

Denied Eligible Expense

Sample 1076 – UMR disagrees with this error. The claim was reviewed by Advanced Claim Review, to deny for global billing of modifiers TC and 26. Claim adjustment is the result of a provider dispute, original determination over-turned, and claim adjusted 3/1/2024 with network pricing provided.

Sample 1126 – UMR agrees with this finding. Vision hardware is a covered expense on the plan. This results in a $100 underpayment. This claim was adjusted on 5-10-2024.

Additional Observations:

Sample 1032 – UMR received a retro contract effective 1/7/2023. This was received on 1-24-2024 and updated in our system on 2-9-2024. The claim was adjusted on 3-18-2024 with the updated rates.

Sample 1122 – UMR disagrees with this finding. Enrollment and monthly documentation is required from the provider for the Obesity Care Management program. There is a process in place to identify the lab claims related to the enrollment in this program for retrospective review and reconsideration of affected claims. The claim was adjusted on 1-31-024.

Sample 2031 – UMR's standard logic for code D2929 is covered under basic services.

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

100 Court Avenue – Suite 306 • Des Moines, IA 50309
(515) 244-7322 • claimtechnologies.com

10.

10. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by Express Scripts for the period of July 1, 2022 – June 30, 2023. (Joni Amato, Claim Technologies Incorporated) (**For Possible Action**)

Prescription Benefit Management Audit

ANNUAL FINDINGS REPORT

State of Nevada Public Employee Benefit Program Plans

Administered by Express Scripts

Audit Period: July 1, 2022 – June 30, 2023
Audit Number 3. FY2023

Presented to

State of Nevada Public Employee Benefit Program

Prepared by

PillarRx
Consulting

Subcontractor to

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

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EXECUTIVE SUMMARY

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

Scope

PillarRx performed an audit of ESI's administration of PEBP's pharmacy plan for the period of July 1, 2022, through June 30, 2023 (FY2023). The population of claims and amount paid during the audit period reported by ESI:

Pharmacy	
Number of Prescriptions Paid	463,240
Net Plan Paid	$71,383,983.76

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

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

Auditor's Findings

PillarRx has the following opinion/recommendations based on the FY2023 audit of ESI:

- ESI should complete a re-reconciliation of Pricing and Fees at the conclusion of the audit for the confirmed errors found. PEBP should ensure this is complete and variance is reimbursed.
- PillarRx recommends PEBP follow up with ESI to obtain reimbursement for penalty payments due PEBP for FY2023.
- ESI should provide an action plan to ensure performance guarantee will be met moving forward.
- For the minimum rebate guarantees, PillarRx recommends PEBP work with ESI on the contract interpretation differences and request the additional rebate money be paid to PEBP.

FY2023 Audit Findings	
Pricing and Fees Reconciliation	$405,789.61 additional owed to PEBP
SLA Performance Guarantees	Missed targets for nine performance standards additional $763,195.48 owed to PEBP (see detail below)
Minimum Rebate Reconciliation	$5,154,762.98 additional owed to PEBP

Performance Guarantees FY 2023 (Missed Targets)		
Service Performance Standard	Penalty	Met/Not Met
Member Satisfaction with Retail, Mail Order, and Specialty Program (p. 14)	$60,363.79	Not Met
Dispensing Timeliness – 2 Business Days (p. 14)	$128,771.89	Not Met
Dispensing Timeliness – 4 Business Days (p. 14)	$128,771.89	Not Met
Speed of Answer – Member (p. 14)	$29,486.12	Not Met
Abandonment Rate – Member (p. 14)	$29,486.12	Not Met
First Call Resolution (p. 14)	$128,771.89	Not Met
Prior Approvals (p. 14)	$128,771.89	Not Met
ID Card Turnaround – Maintenance (p. 15)	$128,771.89	Not Met

AUDIT OBJECTIVES

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

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

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

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

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

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

PRICING AND FEES AUDIT

Objective

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

Scope

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

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

Methodology

Contract Document Review

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

Claim Validation

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

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

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

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

Pricing and Fees Analysis

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

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

prescription was dispensed. ESI used MediSpan as well as First Data Bank for generic or brand drug classification.

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

Findings

Pricing Findings

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

Dispensing Fee Findings

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

As shown in the following table, the dispensing fee analysis identified fees were not in alignment based on the contract for FY2023.

Note: *In the following chart, a* ***negative*** *variance indicates a higher than contracted dispensing fee collected. A* ***positive*** *variance indicates a lower than contracted dispensing fee collected. Only negative variances have been included in the Total as outlined in contract guidelines.*

Dispensing Fees (7/1/2022 – 6/30/2023)					
Component Description*	**Contracted Dispensing Fee**	**Number of Claims**	**Total Actual Dispensing Fee**	**Total Contracted Dispensing Fee**	**Total Overage/ (Shortfall)**
Retail Brand (1-83 DS)**	$0.35	42,530	$199,238.94	$14,885.50	($184,353.44)
Retail Brand (84-90 DS) **	$0.00	5,695	$31.70	$0.00	($31.70)
Retail Generic (1-83 DS)**	$0.35	264,508	$109,232.75	$92,577.80	($16,654.95)
Retail Generic (84-90 DS)**	$0.00	42,194	$157.26	$0.00	($157.26)
Mail Brand	$16.03	14,286	$141,669.76	$229,004.58	$87,334.82
Mail Generic	$16.03	61,437	$996,710.67	$984,835.11	($11,875.56)
Specialty Accredo Brand	$170.00	5,117	$852,056.95	$869,890.00	$17,833.05
Specialty Accredo Generic	$170.00	356	$54,195.71	$60,520.00	$6,324.29
TOTAL		**436,123**	**$2,353,293.74**	**$2,251,712.99**	**($213,072.91)**

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

*** DS= Days' Supply*

RECONCILIATION OF PRICING GUARANTEES

Objective

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

Scope

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

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

Methodology

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

Findings

The following tables demonstrate our findings relative to pricing guarantees.

***Note:** In the following chart, only underperformances have been included in the total as outlined in contract guidelines.*

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

Discounts FY2023								
Component Description*	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Difference in Rate (Contracted vs Actual)	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/ (Shortfall)	
Retail Brand (1-83 DS)**	42,530	22.50%	22.52%	+.02%	$11,847,836.11	$11,844,654.34	$3,181.77	>
Retail Brand (84-90 DS)**	5,695	27.53%	25.54%	-1.99%	$7,499,718.70	$7,705,419.74	($205,701.04)	<
Retail Generic (1-83 DS)**	264,508	85.60%	86.35%	+0.75%	$4,449,389.79	$4,217,150.85	$232,238.94	>
Retail Generic (84-90 DS)**	42,194	88.15%	88.50%	+0.35%	$2,117,496.86	$2,055,410.34	$62,086.52	>
Mail Brand	14,286	21.20%	20.04%	-1.16%	$11,703,294.78	$11,875,387.51	($172,092.73)	<
Mail Generic	61,437	94.95%	92.36%	-2.59%	$1,120,486.17	$1,695,199.14	($574,712.97)	<
Specialty Accredo Brand	5,117	85.00%	68.37%	-16.63%	$416,082.71	$877,250.66	($461,167.95)	<
Specialty Accredo Generic	356	21.30%	20.83%	- 0.47%	$39,179,975.95	$39,415,804.12	($235,828.17)	<
			TOTAL	**- 21.72%**	**$78,334,281.07**	**$79,686,276.70**	**($1,649,502.86)**	<

**Compound, Over the Counter, Retail Usual and Customary, Vaccines, Subscriber, and Coordination of Benefits claims were excluded from contract guarantees, PillarRx reviewed claims for reasonableness and found no outliers. The aggregate total for each standard is calculated separately (retail, mail, and specialty) and then combined to determine the total over or underperformance.*

*** DS= Days' Supply*

PillarRx found that ESI incorrectly excluded 21,756 vaccine and nine specialty brand claims that should have been included in the guarantees. PillarRx also found that ESI incorrectly included three claims in the mail guarantee that should have instead been included in specialty. ESI confirmed these errors and agreed to re-reconcile at the conclusion of the audit.

In summary, when aggregating the pricing guarantee discounts with the dispensing fee outcome, ESI self-reported a total underperformance of ($1,456,379.24). However, PillarRx found an additional underperformance due the client in the amount of $405,789.61. See chart below for breakout.

	PillarRx Combined Discounts and Dispensing Fee Guarantees	ESI Combined Discounts and Dispensing Fee Guarantee Reconciliation
Discounts	($1,649,502.85)	($1,416,877.32)
Dispensing Fees	($213,072.91)	($39,501.92)
Price Assured Shared Savings	$73,581.36	$73,174.45
FY2023	($1,788,994.40)	($1,383,204.79)

ESI has agreed to the additional underperformance error and will work with PEBP to make the appropriate payments.

BENEFIT PAYMENT ACCURACY REVIEW

Objective

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

Scope

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

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

Methodology

After receiving the plan documentation from PEBP and ESI including member cost share, accumulators and coverage rules, and summary plan descriptions and/or plan documents, PillarRx programmed PEBP's plan design in AccuCAST. Each claim was then readjudicated and exceptions were identified. The exceptions were aggregated by category and our benefit analysts reviewed each category.

Exceptions that could not be explained were submitted to ESI for review. When adequate documentation was provided to support that exceptions were adjudicated correctly, AccuCAST was reset to represent the revised plan parameters and the claims were electronically readjudicated to ensure consistency.

Findings

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

Member Cost Share

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

Member Cost Share (7/1/2022 – 6/30/2023)	
Total Claims	**Cost Share Collected**
463,240	$17,240,707.38

PillarRx submitted 246 claims based on 8 different observations to ESI that represented potential exceptions to the member cost share requirements for FY2023. After review of the supporting documentation and explanations provided by ESI, PillarRx was able to confirm that claims were processing correctly. A description of each observation and responses can be found below.

Observation 1 – Glucose Monitors not applying $0 Cost Share.
ESI Response – Per supporting documentation, CDHP PEBP Master Plan, members are only allowed one $0 blood glucose monitor per plan year.

PillarRx agrees, nothing additional required.

Observation 2 – ACA medication applying cost share greater than $0.
ESI Response – Bowel Prep- ESI noted that per "Attachment F -BAC Addendums" and "Preventive Set up Form BAC Addendum" Bowel Prep products follow an age restriction of adults >49 and <76 years of age. The age requirement changes to 45 - 75 years of age on 1/1/2023.

ACA Contraceptives Statins- ESI noted that these drug were targeted by the RRA program, and the member had exceeded their retail refill allotment prior to the processing of this claim. The member was appropriately charged the RRA copay as RRA takes precedence over HCR copay waivers.

PillarRx agrees, nothing additional required.

Observation 3 – $20 copay not applying for Generic Mail Order claims.
ESI Response – ESI noted these were adjustment claims. State of Nevada executed a new contract with ESI effective 7/1/2022. This was a very unique Agreement with Mail Order and Accredo acquisition cost billing. ESI is to bill State of Nevada as close to ESI's acquisition costs as possible. Pricing was submitted to be full Pass-through at the Carrier Level. It was not detected until February 2023 that some pricing for State of Nevada was at the Contract Id level. Therefore, Smart90 Pass-Through pricing and Mail Order/Accredo pricing was not using Carrier Level. The Pricing team has included a step in their process to review existing pricing to prevent any negative effects on new contractual pricing due to outdated pricing setups. The client was reimbursed on 7/26/2023. Please note impact related to this issue would have been discussed and shared with the client at the time the adjustment was completed.

PillarRx agrees but recommends confirmation from PEBP that they received the appropriate adjustment.

Observation 4 – Mail Preferred Brand claims applying greater than $80 copay at ESI Pharmacies.
ESI Response – ESI noted these claims were adjustment claims. State of Nevada executed a new contract with ESI effective 7/1/2022. This was a very unique Agreement with Mail Order and Accredo acquisition cost billing. ESI is to bill State of Nevada as close to ESI's acquisition costs as possible. Pricing was submitted to be full Pass-through at the Carrier Level. It was not detected until February, 2023 that some pricing for State of Nevada was at the Contract Id level. Therefore, Smart90 Pass-Through pricing and Mail Order/Accredo pricing was not using Carrier Level. The Pricing team has included a step in their process to review existing pricing to prevent any negative effects on new contractual pricing due to outdated pricing setups. The client was reimbursed on 7/26/2023. Please note impact related to this issue would have been discussed and shared with the client at the time the adjustment was completed.

PillarRx agrees but recommends confirmation from PEBP that they received the appropriate adjustment.

Observation 5 – Generic Meds applying a $0 cost share at Mail Order.
ESI Response – ESI noted these claims were adjustment claims. State of Nevada executed a new contract with ESI effective 7/1/2022. This was a very unique Agreement with Mail Order and Accredo acquisition cost billing. ESI is to bill State of Nevada as close to ESI's acquisition costs as possible. Pricing was submitted to be full Pass-through at the Carrier Level. It was not detected until February, 2023 that some pricing for State of Nevada was at the

Contract Id level. Therefore, Smart90 Pass-Through pricing and Mail Order/Accredo pricing was not using Carrier Level. The Pricing team has included a step in their process to review existing pricing to prevent any negative effects on new contractual pricing due to outdated pricing setups. The client was reimbursed on 7/26/2023. Please note impact related to this issue would have been discussed and shared with the client at the time the adjustment was completed.

PillarRx agrees but recommends confirmation from PEBP that they received the appropriate adjustment.

Observation 6 – Mail Preferred Brand claims applying $0 cost share at Mail Order.

ESI Response – ESI noted these claims were adjustment claims. State of Nevada executed a new contract with ESI effective 7/1/2022. This was a very unique Agreement with Mail Order and Accredo acquisition cost billing. ESI is to bill State of Nevada as close to ESI's acquisition costs as possible. Pricing was submitted to be full Pass-through at the Carrier Level. It was not detected until February, 2023 that some pricing for State of Nevada was at the Contract Id level. Therefore, Smart90 Pass-Through pricing and Mail Order/Accredo pricing was not using Carrier Level. The Pricing team has included a step in their process to review existing pricing to prevent any negative effects on new contractual pricing due to outdated pricing setups. The client was reimbursed on 7/26/2023. Please note impact related to this issue would have been discussed and shared with the client at the time the adjustment was completed.

PillarRx agrees but recommends confirmation from PEBP that they received the appropriate adjustment.

Exclusions

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

Observation 7 – Claims processing with no PA on file.

ESI Response – ESI notes that the pharmacy submitted this claim with an 'SCC_1' of '13'. This is an emergency override submission clarification code (SCC) which caused the claim to pay without a UM Review. Please see the 'SCC_1' field for support. Claims that process with an emergency override are excluded from clinical rules processing.

PillarRx Follow Up Response – Please provide supporting documentation showing that claims that are processed with an emergency override of 13 are excluded from clinical rule processing and that that is the standard practice and intent of the pharmacy benefit.

ESI Response 2 – Please see the attached email titled "[EXTERNAL] RE: BDR 57-71". The client was aware and acknowledged that "The Emergency Access to Benefits claims processing capability ensures access to pharmacy benefits for members during an emergency. It would not provide members any exception to the benefit design. For example, if a CDHP member needs an early fill of their maintenance medication during a declared natural disaster, this added benefit allows that individual the ability to obtain that medication. If that medication has an expired PA and a PA case is not yet completed, this emergency access benefit will bypass that so that the member can get their meds. If that CDHP individual has not satisfied their DED, they will still be subject to paying 100% in that DED phase of the benefit."

PillarRx agrees no Issue - Per the [EXTERNAL] RE: BDR 57-71 email provided, claims that process with an emergency override are excluded from clinical rules processing.

Administration of Age Rules

Age rules specify that a participant must be within a specific age group for a specific medication to be covered. Sample claims including review of age rules were included and reviewed in Observation 2 for bowel prep medications.

PillarRx found no issues, nothing additional required.

Administration of Quantity Limits

Quantity limits are included in plans to ensure safety and appropriate utilization. PillarRx noted that based on the language in the drug coverage documents provided by ESI, claims were adjudicated within plan parameters.

Observation 8 – Claims exceeding the max quantities allowed per plan.

- Erectile dysfunction drugs exceeding max quantity of 8 in 30 days or 24 units in 90 days.
- Nizoral 2% shampoo to be dispensed at max quantity of 120mL in 21 days or 360mL in 63 days.

ESI Response – ESI noted that the pharmacy submitted this claim with an 'SCC_1' of '13'. This is an emergency override submission clarification code (SCC) which caused the claim to pay without a UM Review. Please see the 'SCC_1' field for support. Claims that process with an emergency override are excluded from clinical rules processing.

PillarRx Follow Up Response – Please provide supporting documentation showing that claims that are processed with an emergency override of 13 are excluded from clinical rule processing and that that is the standard practice and intent of the pharmacy benefit.

ESI Response 2 – Please see the attached email titled "RE: BDR 57-71" and "[EXTERNAL] RE: BDR 57-71". Nevada PEBP has the following in place today for Emergency Access to Benefits: Option 1: allowing the benefit to automatically use this benefit without action from myself to activate it in time of a declared disaster. However, this option is limited to a set amount of fills per a period of time. They are set up to allow 1 additional fill every 365 days. This fill will bypass all edits: refill too soon, refills not allowed, PA required, step therapy requirements, dose edits (but does not apply to maximum daily dose high dose rejects).

PillarRx agrees No issue. Per the [EXTERNAL] RE: BDR 57-71 email provided, claims that process with an emergency override are excluded from clinical rules processing.

PERFORMANCE GUARANTEE REVIEW

Objective

The objectives of PillarRx's Performance Guarantee Assessment is to verify ESI's internal quality control measures critical to minimizing financial loss meet the States contractual requirements and are in full compliance with all applicable laws, regulations, and industry standards.

Findings

PillarRx reviewed the annual performance guarantee documentation provided by ESI for reporting period, July 2022 through June 2023, and summarized the findings in the chart below. Overall, ESI met most of the expectations for the contracted standards.

	Guarantee and Metric	Penalty	Met/ Not Met
1	**Implementation Guarantee Benefit Set Up:** Measured by vendor's ability to complete all key functions in an accurate and timely manner according to the detailed work plan. Must achieve an average of 4 or better on a scale of 1 to 5.	Year 1 – $5.00/member	Met
2	**Implementation Guarantee ID Card Production and Mailing:** within five (5) business days.	Year 1 – $5.00/member	Met
3	**Implementation Guarantee Open Enrollment Support:** provide support for open enrollment meetings.	Year 1 – $5.00/member	Met
4	**Implementation Guarantee Pre-Implementation Audit:** Guarantees that the pre-implementation audit will be completed, including follow up test claims at least 15 days prior to effective date.	$30,000 per implementation audit	Met
5	**Overall, Client Satisfaction with Service:** ESI will initiate quarterly customer service reviews, with PEBP staff and call center staff to analyze member questions and trends to improve member and client satisfaction. Measured and reported annually.	$300,000	Met
6	**Pharmacy Access Rate:** At least 97% of participants shall reside within 1.5 miles of a network pharmacy for Urban areas, within 3 miles for Suburban areas and within 10 miles for Rural areas. Measured and reported annually.	1% Annual Administrative Fees	Met
7	**Network Stability:** There will not be greater than 5% total net loss of pharmacies in the broadest network. Measured and reported annually.	1% Annual Administrative Fees	Met
8	**Account Management Action Log:** Designated members of client's staff will complete an annual report card to evaluate vendor account team, or the overall service performance. PBM shall be responsible for survey design, data collection, analysis and all costs associated with conducting the surveys. Measured and reported annually.	1% Annual Administrative Fees	Met
9	**Account Management Open Issue Log:** Account team will maintain an open issues log and share it with client on at least a monthly basis.	2% Quarterly Administrative Fees	Met
10	**Account Management Responsiveness:** Respond to client within 2 business days: Service warranty within 5 business days.	2% Quarterly Administrative Fees	Met
11	**Account Management Team Continuity:** Account team will not change over the duration of the contract term except for promotion or termination of employment, unless mutually agreed by client and PBM. Target 100%	2% Quarterly Administrative Fees	Met
12	**Annual Benefit Plan Review:** Vendor will conduct an annual benefit plan review by November 15th.	1% Annual Administrative Fees	Met
13	**Timeliness of Standard Performance:** Monthly – within 15 business days of the end of billing cycle. Quarterly – within 30 business days of the end of billing cycle.	2% Quarterly Administrative Fees	Met
14	**Timeliness of Billing Reports:** Vendor will mail billing reports, providing client with detailed claim activity within 5 business days.	2% Quarterly Administrative Fees	Met
15	**Timeliness of Management Reports:** Standard quarterly management reports shall be available within 45 calendar days.	2% Quarterly Administrative Fees	Met

	Guarantee and Metric	Penalty	Met/ Not Met
16	**Fraud, Waste and Abuse Reporting:** Vendor will provide quarterly reports to client addressing potential fraud, waste, and abuse within 30 calendar days.	2% Quarterly Administrative Fees	Met
17	**Claims Compliance Format:** Vendor will guarantee that 99% of the prescription drug claims submitted on behalf of eligible participant will be submitted in a HIPAA-compliant format.	2% Quarterly Administrative Fees	Met
18	**Claims Processing Accuracy:** Based on vendor's internal quality review for retail, mail order, and specialty claims. Target 99.99%	2% Quarterly Administrative Fees	Met
19	**Eligibility Processing Accuracy:** Vendor guarantees that 100% of usable, error-free eligibility files received by organization will be loaded without error.	2% Quarterly Administrative Fees	Met
20	**Eligibility Updates:** 2 Business days	2% Quarterly Administrative Fees	Met
21	**Retail Direct Reimbursement Claims Timeliness of Processing and Response:** 5 business days.	2% Quarterly Administrative Fees	Met
22	**Mail Order Turnaround Time for Prescription Drugs Requiring no Intervention:** 100% dispensed within 2 Business Days	2% Quarterly Administrative Fees $128,771.89	**Not Met-** **Q1 - 94%** **Q2 - 94%** **Q3 - 90%** **Q4 - 91%**
23	**Mail Order Turnaround Time for Prescription Drugs Requiring Administrative/ Clinical Intervention:** 100% dispensed within 4 Business Days	2% Quarterly Administrative Fees $128,771.89	**Not Met-** **Q1 - 97%** **Q2 - 97%** **Q3 - 97%** **Q4 - 97%**
24	**Mail Order Dispensing Accuracy:** 99.99%	2% Quarterly Administrative Fees	Met
25	**Average Speed of Answer:** 100% of calls will be answered by a live voice within an average of 25 seconds or less.	2% Quarterly Administrative Fees $29,486.12	**Not Met** Q1- 6.1 Q2 - 17.7 **Q3 - 107.8** Q4 - 4.4
26	**Phone Abandonment Rate:** 2% or less will be abandoned before the call is answered by CSR.	2% Quarterly Administrative Fees $29,486.12	**Not Met** Q1 - 0.3% Q2 - 0.7% **Q3 - 6.1%** Q4 - 0.2%
27	**First Call Resolution:** At least 98% of all calls will be resolved at first point of contact.	2% Quarterly Administrative Fees $128,771.89	**Not Met-** **Q1 - 97%** **Q2 - 97%** **Q3 - 97%** **Q4 - 96%**
28	**Prior Approvals:** PBM will respond to requests for prior approval for specific drugs following receipt of all required information in no more than 2 Business Days.	2% Quarterly Administrative Fees $128,771.89	**Not Met** ***Not Measured All 4 Quarters***
29	**Plan Administration Turnaround Time:** Vendor guarantees that client's standard plan design changes will be implemented within 10 calendar days.	2% Quarterly Administrative Fees	Met
30	**Member Satisfaction with Retail, Mail Order, and Specialty Program:** At least 95% satisfaction.	2% Quarterly Administrative Fees	Not Met **Q1 - 90%** **Q2 - 89%** ***Quarters 3 and 4 Not Measured***

	Guarantee and Metric	Penalty	Met/ Not Met
31	**ID Card Mailing:** Vendor will issue at least 99% of all new member ID cards within four business days and 100% within seven business days following your receipt and update of a processable eligibility tape or transmission identifying the applicable eligible participant(s).	2% Quarterly Administrative Fees $128,771.89	**Not Met** ***Not Measured All 4 Quarters***
32	**Written Inquiry (Paper or Electronic mail response time):** 100% within 5 Business days or 98% within 7 Business days.	2% Quarterly Administrative Fees	Met
33	**Performance Guarantee Reporting:** Vendor guarantees to provide reporting to the client within 45 calendar days of the end of the measurement period.	2% Quarterly Administrative Fees	Met

The penalties shown in the table above, *Performance Guarantees FY 2023 (Missed Targets*), have been calculated based on the total admin fees reported by ESI for FY 2023. Please see table below for breakout.

Total Admin Fees FY2023		
Quarter	**Amount**	**Calculated 2%**
1	$1,065,334.43	$21,306.69
2	$1,952,855.04	$39,057.10
3	$1,474,306.11	$29,486.12
4	$1,946,098.91	$38,921.98
Total FY 2023	$6,438,594.59	$128,771.89

REBATE REVIEW

Objective

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

Scope

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

Methodology

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

Findings

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

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

Rebate Calculations FY2023		
Component Description	**Number of Claims**	**Total Minimum Contract Rebate**
Brand 1-83 Days' Supply	18,071	$4,698,460.00
Brand 84-90 Days' Supply	5,752	$4,486,560.00
Specialty Accredo	4,736	$10,467,410.00
Specialty	645	$331,188.00
Mail Brand	8,784	$6,851,520.00
TOTAL	**37,988**	**$26,835,138.00**

ESI Rebate Payments FY 2023		
Allocation Period	**Payment Date**	**Total Amount**
FY23 Q1: 7/1/22 - 9/30/22	11/28/2022	$6,071,449.81
FY23 Q2: 10/1/22 - 12/31/22	2/27/2023	$6,284,649.96
FY23 Q3: 1/1/23 - 3/31/23	5/26/2023	$5,819,454.30
FY23 Q4: 4/1/23 - 6/30/23	8/30/2023	$3,504,820.95
	TOTAL	**$21,680,375.02**

ESI's rebate amount is less than PillarRx's calculated rebate amount. PillarRx's Rebate Review showed, based on the minimum rebates stipulated within the contract between PEBP and ESI, that ESI did not meet the minimum rebates owed. PillarRx found a variance of ($5,154,762.98) which is owed to PEBP. Please see below for a summary of the differences.

PillarRx found a discrepancy of 21,879 claims.

- 20,346 claims had a lower rebate amount than expected.
- Six claims were expected to be included with the ESI specialty but were included in the general retail/mail categories.
- Two claims were expected to be included within the mail specialty bucket, not retail.
- 69 claims were expected to be included in rebates but were not found on the rebate reconciliation provided by ESI.
- 1,456 claims were non-preferred brand claims that were included in rebates.

PillarRx and ESI disagree on ESI's response to the minimum rebate differences and recommends PEBP and ESI discuss the discrepancies. PillarRx and ESI have different interpretations of the contract language. ESI states the guaranteed amount provided in the contract is prorated based on the days' supply of the claim, yet there is no methodology included, nor does it state this in the contract. Additionally, per PEBP ESI contract Attachment DD – Fee Schedule, non-preferred brand claims should be included in the minimum rebate guarantees, yet ESI stated they should be excluded.

Upon review of the rebate amount difference and contract methodology, PEBP agrees with PillarRx and requests ESI to provide the specific contract details that states prorating of the rebate dollars is correct.

RECOMMENDATIONS

PillarRx has the following opinion/recommendations based on the FY2023 audit of ESI:

1. ESI should complete the re-reconciliation of the Pricing and Fees at the conclusion of the audit for the confirmed errors found. PEBP should ensure this is completed and any variance reimbursed.
2. For the performance guarantee standards not met, PEBP should follow up with ESI to obtain reimbursement for penalty payments due for FY2023.
3. ESI should provide an action plan to ensure performance guarantees are met.
4. For the minimum rebate guarantee, PEBP should work with ESI on the contract interpretation differences and request any additional rebate money be paid to PEBP.

APPENDIX – PBM RESPONSE TO DRAFT REPORT

May 9, 2024

Shaidikia DeVaughn
PillarRx Consulting
shaidikia.devaughn@pillarrx.com

RE: State of Nevada Specific Findings DRAFT Report FY 2023

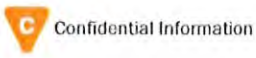
Dear Shaidikia DeVaughn:

Please find enclosed ESI's responses to the pharmacy audit report received on 4/8/2024 that was performed on behalf of Nevada Public Employees Benefit Program for the audit period 7/1/2022 - 6/30/2023. ESI has provided responses as well as excerpts from the PillarRx report to provide context.

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

Sincerely,

Marcia Corredor
Client Audit Senior Advisor



PRICING AND FEES AUDIT

Pricing and Fees Audit Objective

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

Pricing and Fees Audit Scope

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

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

Pricing and Fees Audit Methodology

Contract Document Review

PillarRx requested and received from PEBP and ESI each contract, amendments, formulary drug lists, and reconciliation documents.

Claim Validation

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

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

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

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

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

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

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

Pricing and Fees Audit Findings

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

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

As shown in the following table, the dispensing fee analysis identified fees were not in alignment based on the contract for FY2023.

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

Dispensing Fees (7/1/2022 – 6/30/2023)					
Component Description*	Contracted Dispensing Fee	Number of Claims	Total Actual Dispensing Fee	Total Contracted Dispensing Fee	Total Overage/ (Shortfall)

Retail Brand (1-83DS)	$0.35	42,530	$199,238.94	$14,885.50	($184,353.44)
Retail Brand (84-90 DS)	$0.00	5,695	$31.70	$0.00	($31.70)
Retail Generic (1-83 DS)	$0.35	264,508	$109,232.75	$92,577.80	($16,654.95)
Retail Generic (84-90 DS)	$0.00	42,194	$157.26	$0.00	($157.26)
Mail Brand	$16.03	14,286	$141,669.76	$229,004.58	$87,334.82
Mail Generic	$16.03	61,437	$996,710.67	$984,835.11	($11,875.56)
Specialty Accredo Brand	$170.00	5,117	$852,056.95	$869,890.00	$17,833.05
Specialty Accredo Generic	$170.00	356	$54,195.71	$60,520.00	$6,324.29
	TOTAL	**436,123**	**$2,353,293.74**	**$2,251,712.99**	**($213,072.91)**

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

ESI Response – Pricing and Fees Audit Findings

ESI acknowledges this was provided for informational purposes only.

RECONCILIATION OF PRICING GUARANTEES

Reconciliation of Pricing Guarantees Objective

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

Reconciliation of Pricing Guarantees Scope

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

- AWP discounts applied for each drug against third party pricing sources;
- MAC allowance for generic;

- Specialty drug allowance; and
- Dispensing fees.

Reconciliation of Pricing Guarantees Methodology

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

Reconciliation of Pricing Guarantees Findings

The following tables demonstrate our findings relative to pricing guarantees.

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

Discounts FY2023

Component Description*	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Difference in Rate (Contracted vs Actual)	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/ (Shortfall)	
Retail Brand (1-83 DS)	42,530	22.50%	22.52%	+.02%	$11,847,836.11	$11,844,654.34	$3,181.77	>
Retail Brand (84-90 DS)	5,695	27.53%	25.54%	-1.99%	$7,499,718.70	$7,705,419.74	($205,701.04)	<
Retail Generic (1-83 DS)	264,508	85.60%	86.35%	+0.75%	$4,449,389.79	$4,217,150.85	$232,238.94	>
Retail Generic (84-90 DS)	42,194	88.15%	88.50%	+0.35%	$2,117,496.86	$2,055,410.34	$62,086.52	>
Mail Brand	14,286	21.20%	20.04%	-1.16%	$11,703,294.78	$11,875,387.51	($172,092.73)	<
Mail Generic	61,437	94.95%	92.36%	-2.59%	$1,120,486.17	$1,695,199.14	($574,712.97)	<
Specialty Accredo Brand	5,117	85.00%	68.37%	-16.63%	$416,082.71	$877,250.66	($461,167.95)	<
Specialty Accredo Generic	356	21.30%	20.83%	- 0.47%	$39,179,975.95	$39,415,804.12	($235,828.17)	<
			TOTAL	- 21.72%	$78,334,281.07	$79,686,276.70	($1,649,502.85)	<

**Compound, Over the Counter, Retail Usual and Customary, Vaccines, Subscriber, and Coordination of Benefits claims were excluded from contract guarantees, PillarRx reviewed claims for reasonableness and found no outliers. The aggregate total for each standard is calculated separately (retail, mail, and specialty) and then combined to determine the total over or underperformance.*

PillarRx found that ESI incorrectly excluded 21,756 vaccine and 9 specialty brand claims that should have been included in the guarantees. PillarRx also found that ESI incorrectly included 3

claims in the mail guarantee where they should have been included in specialty instead. ESI has confirmed these errors and have agreed to re-reconcile at the conclusion of this audit.

In summary, when aggregating the pricing guarantee discounts with the dispensing fee outcome, ESI's self-reported a total underperformance of ($1,456,379.24). However, PillarRx found an additional underperformance due to the client in the amount of $405,789.61. See chart below for breakout.

	PillarRx Combined Discounts and Dispensing Fee Guarantees	ESI Combined Discounts and Dispensing Fee Guarantee Reconciliation
Discounts	($1,649,502.85)	($1,416,877.32)
Dispensing Fees	($213,072.91)	($39,501.92)
Price Assured Shared Savings	$73,581.36	$73,174.45
FY2023	($1,788,994.40)	($1,383,204.79)

ESI Response – Reconciliation of Pricing Guarantees:

ESI agrees vaccine and specialty claims were incorrectly excluded and has begun re-reconciling the guarantees to determine the financial impact

BENEFIT PAYMENT ACCURACY REVIEW

Benefit Payment Accuracy Review Objective

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

Benefit Payment Accuracy Review Scope

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

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

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

Benefit Payment Accuracy Review Methodology

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

Benefit Payment Accuracy Review Findings

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

Member Cost Share

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

Member Cost Share (7/1/2022 – 6/30/2023)	
Total Claims	**Cost Share Collected**
463,240	$17,240,707.38

PillarRx submitted 246 claims based on 8 different scenarios to ESI that represented potential exceptions to the member cost share requirements for FY2023. After review of the supporting documentation and explanations provided by ESI, PillarRx was able to confirm that claims were processing correctly. A description of each observation and responses can be found below.

Scenario 1- Glucose Monitors not applying $0 Cost Share.

ESI Response- Per supporting documentation, CDHP PEBP Master Plan, members are only allowed one $0 blood glucose monitor per plan year.

PillarRx agrees, nothing additional required.

ESI Response- Scenario 1

ESI acknowledges that Glucose Monitors adjudicated correctly.

Scenario 2- ACA medication applying cost share greater than $0.

ESI Response-

Bowel Prep- ESI noted that per "Attachment F -BAC Addendums" and "Preventive Set up Form BAC Addendum" Bowel Prep products follow an age restriction of adults >49 and <76 years of age. The age requirement changes to 45 - 75 years of age on 1/1/2023.

ACA Contraceptives Statins- ESI noted that these drug were targeted by the RRA program, and the member had exceeded their retail refill allotment prior to the processing of this claim. The member was appropriately charged the RRA copay as RRA takes precedence over HCR copay waivers.

PillarRx agrees, nothing additional required.

ESI Response- Scenario 2

ESI acknowledges that ACA medications adjudicated correctly.

Scenario 3 – $20 copay not applying for Generic Mail Order claims.

ESI Response- ESI noted these were adjustment claims. State of Nevada executed a new contract with ESI effective 7/1/2022. This was a very unique Agreement with Mail Order and Accredo acquisition cost billing. ESI is to bill State of Nevada as close to ESI's acquisition costs as possible. Pricing was submitted to be full Pass-through at the Carrier Level. It was not detected until February, 2023 that some pricing for State of Nevada was at the Contract Id level. Therefore, Smart90 Pass-Through pricing and Mail Order/Accredo pricing was not using Carrier Level. The Pricing team has included a step in their process to review existing pricing to prevent any negative effects on new contractual pricing due to outdated pricing setups. The client was reimbursed on 7/26/2023. Please note impact related to this issue would have been discussed and shared with the client at the time the adjustment was completed.

PillarRx agrees but recommends confirmation from PEBP that they received the appropriate adjustment.

ESI Response- Scenario 3

ESI acknowledges PillarRx's observation and the Account Team is available to discuss should the client wish to do so.

Scenario 4- Mail Preferred Brand claims applying greater than $80 copay at ESI Pharmacies.

ESI Response- ESI noted these claims were adjustment claims. State of Nevada executed a new contract with ESI effective 7/1/2022. This was a very unique Agreement with Mail Order and Accredo acquisition cost billing. ESI is to bill State of Nevada as close to ESI's acquisition costs as possible. Pricing was submitted to be full Pass-through at the Carrier Level. It was not detected until February, 2023 that some pricing for State of Nevada was at the Contract Id level. Therefore, Smart90 Pass-Through pricing and Mail Order/Accredo pricing was not using Carrier Level. The Pricing team has included a step in their process to review existing pricing to prevent any negative effects on new contractual pricing due to outdated pricing setups. The client was reimbursed on 7/26/2023. Please note impact related to this issue would have been discussed and shared with the client at the time the adjustment was completed.

PillarRx agrees but recommends confirmation from PEBP that they received the appropriate adjustment.

ESI Response- Scenario 4

ESI acknowledges PillarRx's observation and the Account Team is available to discuss should the client wish to do so.

Scenario 5- Generic Meds applying a $0 cost share at Mail Order.

ESI Response- ESI noted these claims were adjustment claims. State of Nevada executed a new contract with ESI effective 7/1/2022. This was a very unique Agreement with Mail Order and Accredo acquisition cost billing. ESI is to bill State of Nevada as close to ESI's acquisition costs as possible. Pricing was submitted to be full Pass-through at the Carrier Level. It was not detected until February, 2023 that some pricing for State of Nevada was at the Contract Id level. Therefore, Smart90 Pass-Through pricing and Mail Order/Accredo pricing was not using Carrier Level. The Pricing team has included a step in their process to review existing pricing to prevent any negative effects on new contractual pricing due to outdated pricing setups. The client was reimbursed on 7/26/2023. Please note impact related to this issue would have been discussed and shared with the client at the time the adjustment was completed.

PillarRx agrees but recommends confirmation from PEBP that they received the appropriate adjustment.

ESI Response- Scenario 5

ESI acknowledges PillarRx's observation and the Account Team is available to discuss should the client wish to do so.

Scenario 6- Mail Preferred Brand claims applying $0 cost share at Mail Order.

ESI Response- ESI noted these claims were adjustment claims. State of Nevada executed a new contract with ESI effective 7/1/2022. This was a very unique Agreement with Mail Order and Accredo acquisition cost billing. ESI is to bill State of Nevada as close to ESI's acquisition costs as possible. Pricing was submitted to be full Pass-through at the Carrier Level. It was not detected until February, 2023 that some pricing for State of Nevada was at the Contract Id level. Therefore, Smart90 Pass-Through pricing and Mail Order/Accredo pricing was not using Carrier Level. The Pricing team has included a step in their process to review existing pricing to prevent any negative effects on new contractual pricing due to outdated pricing setups. The client was reimbursed on

7/26/2023. Please note impact related to this issue would have been discussed and shared with the client at the time the adjustment was completed.

PillarRx agrees but recommends confirmation from PEBP that they received the appropriate adjustment.

ESI Response- Scenario 6

ESI acknowledges PillarRx's observation and the Account Team is available to discuss should the client wish to do so.

Exclusions

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

Scenario 7- Claims processing with no PA on file.

ESI Response- ESI notes that the pharmacy submitted this claim with an 'SCC_1' of '13'. This is an emergency override submission clarification code (SCC) which caused the claim to pay without a UM Review. Please see the 'SCC_1' field for support. Claims that process with an emergency override are excluded from clinical rules processing.

PillarRx Follow Up Response- Please provide supporting documentation showing that claims that are processed with an emergency override of 13 are excluded from clinical rule processing and that that is the standard practice and intent of the pharmacy benefit.

ESI Response 2- Please see the attached email titled "[EXTERNAL] RE: BDR 57-71". The client was aware and acknowledged that "The Emergency Access to Benefits claims processing capability ensures access to pharmacy benefits for members during an emergency. It would not provide members any exception to the benefit design. For example, if a CDHP member needs an early fill of their maintenance medication during a declared natural disaster, this added benefit allows that individual the ability to obtain that medication. If that medication has an expired PA and a PA case is not yet completed, this emergency access benefit will bypass that so that the member

can get their meds. If that CDHP individual has not satisfied their DED, they will still be subject to paying 100% in that DED phase of the benefit."

PillarRx Response 2-

PillarRx agrees no Issue - Per the [EXTERNAL] RE: BDR 57-71 email provided, claims that process with an emergency override are excluded from clinical rules processing.

ESI Response- Scenario 7

ESI acknowledges that the emergency access to benefits was applied as the client intended.

Administration of Age Rules

Age rules specify that a participant must be within a specific age group for a specific medication to be covered. Sample claims including review of age rules were included and reviewed in Scenario 2 for bowel prep medications.

PillarRx found no issues, nothing additional required.

ESI Response- Administration of Age Rules

ESI acknowledges that all clinical rules were applied as the client intended.

Administration of Quantity Limits
Quantity limits are included in plans to ensure safety and appropriate utilization. PillarRx noted that based on the language in the drug coverage documents provided by ESI, claims were adjudicated within plan parameters.

Scenario 8- Claims exceeding the max quantities allowed per plan.

- Erectile dysfunction drugs exceeding max quantity of 8 in 30 days or 24 units in 90 days.
- Nizoral 2% shampoo to be dispensed at a max quantity of 120mL in 21 days or 360mL in 63 days.
-

ESI Response- ESI noted that the pharmacy submitted this claim with an 'SCC_1' of '13'. This is an emergency override submission clarification code (SCC) which caused the claim to pay without a UM Review. Please see the 'SCC_1' field for support. Claims that process with an emergency override are excluded from clinical rules processing.

PillarRx Response- Please provide supporting documentation showing that claims that are processed with an emergency override of 13 are excluded from clinical rule processing and that that is the standard practice and intent of the pharmacy benefit.

ESI Response 2- Please see the attached email titled "RE: BDR 57-71" and "[EXTERNAL] RE: BDR 57-71". Nevada PEBP has the following in place today for Emergency Access to Benefits: Option 1: allowing the benefit to automatically use this benefit without action from myself to activate it in time of a declared disaster. However, this option is limited to a set amount of fills per a period of time. They are set up to allow 1 additional fill every 365 days. This fill will bypass all edits: refill too soon, refills not allowed, PA required, step therapy requirements, dose edits (but does not apply to maximum daily dose high dose rejects).

PillarRx Response 2 - PillarRx agrees No issue. Per the [EXTERNAL] RE: BDR 57-71 email provided, claims that process with an emergency override are excluded from clinical rules processing.

ESI Response-Scenario 8

ESI acknowledges that the emergency access to benefits was applied as the client intended.

PERFORMANCE GUARANTEE REVIEW

Performance Guarantee Assessment Objective

The objective of PillarRx's Performance Guarantee Assessment is to verify that Express Scripts (ESI's) internal quality control measures critical to minimizing financial loss, meet the States contractual requirements and are in full compliance with all applicable laws, regulations, and industry standards.

Performance Guarantee Assessment

PillarRx reviewed the annual performance guarantee documentation provided by ESI for reporting period, July 2022 through June 2023, and summarized the findings in the chart below. Overall, ESI met most of the expectations for the contracted standards.

Performance Guarantees FY 2023 (Missed Targets)		
Service Performance Standard	**Penalty**	**Met/Not Met**
Overall, Client Satisfaction with Service	$300,000.00	Not Met
Dispensing Timeliness – 2 Business Days	2% Quarterly Administrative Fees	Not Met
Dispensing Timeliness – 4 Business Days	2% Quarterly Administrative Fees	Not Met
Mail Order Dispensing Accuracy	2% Quarterly Administrative Fees	Not Met
Speed of Answer-Member	2% Quarterly Administrative Fees	Not Met
Abandonment Rate (Member)	2% Quarterly Administrative Fees	Not Met
First Call Resolution	2% Quarterly Administrative Fees	Not Met

Prior Approvals	2% Quarterly Administrative Fees	Not Met
ID Card Turnaround-Maintenance	2% Quarterly Administrative Fees	Not Met

Please see Exhibit 1. SoNV Performance Guarantees FY2023 Full Summary for a complete summary of the Performance Guarantees.

ESI has reviewed the initial summary and provided supporting statements for their acceptance of missing a guarantee or why the guarantee should be considered met or not applicable. Per the executed contract #25582, Attachment CC-Performance Guarantees, PillarRx concludes that ESI did not meet the contracted target for the following standards:

5 - Ongoing Service- Overall Client Satisfaction with Service: *Member Satisfaction (95% satisfaction) measured quarterly - 1Q (90%) and 2Q (89%) Not Met; not surveyed in 3Q or 4Q.* ESI confirmed there was a systematic issue with the member satisfaction, so members were not surveyed – and this guarantee is consider missed. **Penalty to be paid is $300,000.**

ESI Response –

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

22 - Ongoing Service- Mail Order Turnaround Time for Prescription Drugs Requiring No Intervention: Dispensing Timeliness (*100% within 2 business days*) measured quarterly - Not Met 1Q (94%), 2Q (94%), 3Q (90%), 4Q (91%), and Annual (92%). ESI has reviewed and confirmed this guarantee has been missed for all four quarters. **Penalty to be paid is 2% of 1**

Quarter Administrative Fees, 2 Quarter Administrative Fees, 3 Quarter Administrative Fees, and 4 Quarter Administrative Fees.

ESI Response –

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

23 – Ongoing Service- Mail Order Turnaround Time for Prescription Drugs Requiring Administrative/Clinical Intervention: Dispensing Timeliness (*100% within 4 business days*) measured quarterly - Not Met 1Q (97%), 2Q (97%), 3Q (97%), 4Q (97%), and Annual (97%). ESI has reviewed and confirmed this guarantee has been missed for all four quarters. **Penalty to be paid is 2% of 1 Quarter Administrative Fees, 2 Quarter Administrative Fees, 3 Quarter Administrative Fees, and 4 Quarter Administrative Fees.**

ESI Response –

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

25 - Ongoing Service- Phone Average Speed of Answer:
Speed of Answer- Member (*100% of calls answered by live voice within average of 25 seconds or less*) measured quarterly - Met Q1 (6.1 secs), Met Q2 (17.7 secs), Missed Q3 (107.8 seconds), Met Q4 (4.4 secs) and Annual (31.3 secs). ESI confirmed they did not meet the guarantee for 3Q. **Penalty to be paid is 2% of 3rd Quarter Administrative Fees.**
Speed of Answer- Member (*inbound call answered within average of 30 seconds or less*) measured quarterly - Met Q1 (6.1 secs), Met Q2 (17.7 secs), Missed Q3 (107.8 seconds), Met Q4 (4.4 secs) and Annual (31.3 secs). ESI confirmed they did not meet the guarantee for 3Q. **Penalty to be paid is 2% of 3rd Quarter Administrative Fees.**

ESI Response –

ESI agrees that both Speed of answer metrics were missed for Q3 and a penalty is applicable. The State of Nevada Public Employee Benefit Program's (PEBP's) pharmacy plan will provide ESI with a payment request upon completion of the audit which has not yet been received. ESI notes the penalty is based on the admin fees for the year.

26 – Ongoing Service- Phone Abandonment: Abandonment Rate (%)-Member (*2% of less calls will be abandoned)* measured quarterly- Met Q1 (0.3%), Met Q2 (0.7%), Missed Q3 (6.1%), Met Q4 (0.2%), Annual (1.7%). ESI has reviewed and has stated this target has been met. PillarRx disagrees as 3Q is over 2% at 6.1%. **Penalty to be paid is 2% of 3rd Quarter Administrative Fees.**

ESI Response –

ESI agrees that the Abandonment Rate metric was missed for Q3 and a penalty is applicable. The State of Nevada Public Employee Benefit Program's (PEBP's) pharmacy plan will provide ESI with a payment request upon completion of the audit which has not yet been received. ESI notes the penalty is based on the admin fees for the year.

27 - Ongoing Service – First Call Resolution: First Call Resolution Rate (*at least 98% of calls resolved at first point of contact*) measured quarterly - Not Met 1Q (97%), Not Met 2Q (97%), Not Met 3Q (97%), Not Met 4Q (96%), Annual (97%). ESI has reviewed and confirmed this guarantee has been missed for all four quarters. **Penalty to be paid is 2% of 1 Quarter Administrative Fees, 2 Quarter Administrative Fees, 3 Quarter Administrative Fees, and 4 Quarter Administrative Fees.**

ESI Response –

ESI agrees that the First Call Resolution Rate metric was missed and a penalty is applicable. The State of Nevada Public Employee Benefit Program's (PEBP's) pharmacy plan will provide ESI with a payment request upon completion of the audit which has not yet been received. ESI notes the penalty is based on the admin fees for the year.

28 - Ongoing Service- Prior Approvals: Prior Authorization Turnaround (Business) (*review and respond to requests no more than 2 business days once clinical is received*) measured quarterly - No % guarantee noted to assess if the guarantee was met or not. ESI has reviewed and

confirmed the contract language does not include a percentage, so the assumption is 100%, therefore this guarantee has missed the target. **Penalty to be paid is 2% of 1 Quarter Administrative Fees, 2 Quarter Administrative Fees, 3 Quarter Administrative Fees, and 4 Quarter Administrative Fees.**

ESI Response –

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

31- Ongoing Service- ID Card Mailing: ID Card Turnaround- Maintenance (*issue 99% of all new member ID cards within 4 business days and 100% within 7 business days*) measured quarterly – There was no scoring provided. ESI responded there was no activity recorded, either the client provides their own or they were digital cards. PillarRx continues to call this performance guarantee out in error as ESI was not able to provide confirmation that all new member ID cards were issued within the agreed to timeframes. **Penalty to be paid is 2% of 1 Quarter Administrative Fees, 2 Quarter Administrative Fees, 3 Quarter Administrative Fees, and 4 Quarter Administrative Fees.**

ESI Response –

ESI disagrees and maintains responded there was no activity recorded, either the client provides their own or they were digital cards.

REBATE REVIEW

Rebate Audit Objective

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

Rebate Review Scope

PillarRx's Rebate Review assessed whether the minimum per claim rebates listed within the PEBP's contract with ESI were met. The review assessed whether there were any differences between

the rebates contractually agreed upon between the PEBP and ESI and the rebate amounts that were actually paid to the PEBP.

Rebate Review Methodology

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

Rebate Review Findings

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

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

Rebate Calculations FY2023		
Component Description	**Number of Claims**	**Total Minimum Contract Rebate**
Brand 1-83 DS	18,071	$4,698,460.00
Brand 84-90 DS	5,752	$4,486,560.00
Specialty Accredo	4,731	$10,458,220.00
Specialty	645	$331,188.00
Mail Brand	8,784	$6,851,520.00
TOTAL	**37,988**	**$26,835,138.00**

ESI Rebate Payments FY 2023		
Allocation Period	**Payment Date**	**Total Amount**
FY23 Q1: 7/1/22-9/30/22	11/28/2022	$6,071,449.81
FY23 Q2: 10/1/22-12/31/22	2/27/2023	$6,284,649.96
FY23 Q3: 1/1/23-3/31/23	5/26/2023	$5,819,454.30
FY23 Q4: 4/1/23-6/30/23	8/30/2023	$7,487,665.34
	TOTAL	**$21,680,375.02**

ESI's rebate amount is less than PillarRx's calculated rebate amount. PillarRx's Rebate Review shows, based on the minimum rebates stipulated within the contract between PEBP and ESI, that ESI did not meet the minimum rebates owed. PillarRx found a variance of ($4,490,938.93) which is owed to PEBP. Please see below for a summary of the differences.

PillarRx found a discrepancy of 21,879 claims.

- 20,346 claims had a lower rebate amount than expected.

ESI Response –

ESI maintains the client's Specialty Retail and Specialty ESI Mail per rx rates are based on a 30 day average supply, the Non-Specialty Retail Low day supply is based on a 83 day average supply, and Non-Specialty high day supply per rx rates are based on a 90 day average supply. All of these average day supplies for these categories are supported by the client's agreement. The actual per rx rate for claims that are eligible for these categories are pro-rated if their actual days' supply is lower than the stated average day supply for the category.

- 6 claims were expected to be included with the ESI specialty but have been included in the general retail/mail categories.

ESI Response –

ESI maintains the products in question were not considered specialty on the claims date of service and were therefore appropriately included in the non-specialty guarantees. Please refer to the specialty list provided at the start of the audit for support.

- 2 claims expected to be included within the mail specialty bucket, not retail.

ESI Response –

ESI maintains the products in question were not considered specialty on the claims date of service and were therefore appropriately included in the non-specialty guarantees. Please refer to the specialty list provided at the start of the audit for support.

- 69 claims expected to be included in rebates but were not found on the rebate reconciliation provided by ESI.

ESI Response –

ESI maintains the Rebate guarantee is reconciled based on how the claim is billed to the client. When a MSB drug is dispensed with a DAW of 0 (no selection made), 3 (pharmacist notes dispense as written), 4 (generic not in stock), DAW of 5 (house generic), DAW of 6 (override), or DAW of 9 (Other) the member is charged the generic copay and the client receives the lower of logic pricing, which includes the MAC (generic) price. Additionally, when a MSB is dispensed with a DAW code of 1 or 2, the brand was requested by the prescriber or patient respectively. In these situations the member is responsible for the difference in cost between the brand and generic and the client is charged only for the MAC (generic) price. As these claims were billed to the client as a generic drug, they were appropriately not included in the rebate guarantee.

1,456 claims are non-preferred brand claims that were included in rebates.

ESI Response –

ESI maintains the Rebate guarantee in Exhibit A-3 spells out two requirements for claims to be eligible – first, the claims must adhere to the ESI National Preferred Formulary (this is the reference in the "Formulary" tab of the table), and the claims must also be for Brand Drugs. The NPF exclusion targets products that were excluded from the National Preferred Formulary. Non formulary products would still be included in the rebate guarantee, however, products that are specifically excluded from the National Preferred Formulary are not eligible for inclusion in the rebate guarantee as they do not adhere to the guidelines of the Formulary drug condition.

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

This document has been prepared in good faith on the basis of information provided to Claim Technologies Incorporated, without any independent verification. If the data, information, and observations received are inaccurate or incomplete, our review, analysis, and conclusions may likewise be inaccurate or incomplete. Our conclusions and recommendations are developed after careful analysis and reflect our best professional judgment.

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

PART OF THE BROWN & BROWN TEAM

100 Court Avenue – Suite 306 • Des Moines, IA 50309
(515) 244-7322 • claimtechnologies.com

11.

11. Public Comment

12.

12. Adjournment