



Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY

PUBLIC EMPLOYEES' BENEFITS PROGRAM

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Carson City, Nevada 89706
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Stacie Weeks
Director



Theresa Carsten
Executive Officer

MEETING NOTICE AND AGENDA – Amended 5-19-26

Name of Organization: Public Employees' Benefits Program

Date and Time of Meeting: May 21, 2026, 9:00 a.m.

Physical Meeting Location: 3427 Goni Road, Suite 117, Carson City, NV 89706

Video Conferencing: **This meeting will also be available by means of a remote technology system pursuant to NRS 241.023 using video- and tele-conference. Instructions for both are below. This meeting can be viewed live over the internet on the PEBP YouTube Channel at <https://www.youtube.com/live/eaUiX7IWNp4>**

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/89342623148>
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: 893 4262 3148 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@nvha.nv.gov

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. At the discretion of the chair, the time for each individual to make comment, as well as the aggregate time for public comment, may be reasonably limited. Any such limitations will be announced at the beginning of the comment period. Additional comment periods, subject to similar limitations as announced by the chair, may be allowed on individual agenda items at the discretion of the chair. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the Board. 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 or who wish to make comments not subject to a potential time limit may submit their public comment in writing by uploading a document to the [Public Comment Upload Form](#) located under [Contact Us](#) on the PEBP website, <https://www.pebp.nv.gov/>, no later than two business days prior to the meeting. **If you need ADA accommodation, please let us know by 4:00 pm two days before the board meeting so that we may make appropriate arrangements.** 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. (Gabriel Lither, Deputy Attorney General) (Information/Discussion)
4. Approval of Action Minutes from the March 19, 2026 PEBP Board Meeting. (Jim Wells, Board Chair) (**For Possible Action**)
5. Discussion and acceptance of Eide Bailly's audited financial statement: Self Insurance Internal Service Fund. (Kurt Schlicker, Eide Bailly) (**For Possible Action**)
6. Presentation on HIPAA. (Brandee Mooneyhan, Lead Insurance Counsel) (Information/Discussion)
7. Presentation on Ethics in Government. (Nevada Commission on Ethics) (Information/Discussion)
8. Presentation on Program Overview. (Debbie Donaldson, Segal) (**For Possible Action**)
 - 8.1 GLP-1 Utilization
 - 8.2 Obesity and Weight Management

9. Review and discussion of Express Scripts, Inc. programs. (Amy Donohue, ESI)
(For Possible Action)
 - 9.1 Pharmacy Benefit Manager Programs
 - 9.2 Hinge Health
10. Review and discussion of UMR programs. (UMR) **(For Possible Action)**
 - 10.1 Obesity Care and Diabetes Care Management
 - 10.2 2ndMD
 - 10.3 Real Appeal
 - 10.4 Doctor on Demand
11. Review and discussion of Carrum Health programs. (Alex Brochu, Carrum Health)
(For Possible Action)
 - 11.1 Knee, Hip, Shoulder, Spine, Heart
 - 11.2 Weight Loss Surgeries
 - 11.3 Cancer Care
12. Executive Officer Report. (Nik Proper, Operations Officer on behalf of Theresa Carsten, Executive Officer) (Information/Discussion)
13. Contract Status Report. (Brandee Mooneyhan, Lead Insurance Counsel) **(For Possible Action)**
 - 13.1 Contract Overview
 - 13.2 New Contracts
 - 13.3 Contract Amendments
 - 13.4 Status of Current Solicitations
14. SFY26 Q3 Budget Report (Monica McJoy, Chief Financial Officer) (Information/Discussion)
15. 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.
16. Adjournment.

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at <https://www.pebp.nv.gov/meetings-events/current-board-meetings/> (under the Board Meeting date referenced above). For additional information 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://www.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://www.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 e-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. (Gabriel Lither, Deputy Attorney General) (Information/Discussion)

4.

4. Approval of Action Minutes from the March 19, 2026 PEBP Board Meeting. (Jim Wells, Board Chair) **(For Possible Action)**

**STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING**

Video/Telephonic Open Meeting
Carson City

ACTION MINUTES (Subject to Board Approval)

March 19, 2026

**MEMBERS PRESENT
IN PERSON:**

Mr. Jim Wells, Board Chair
Ms. Blaine Harper, Member
Mr. Tom Zumtobel, Member
Mr. Jim Barnes, Member
Ms. Keiko Duncan, Member
Mr. Christopher Viton, Member
Ms. Laura Rich, Member
Dr. Jennifer McClendon, Member

MEMBERS EXCUSED:

Ms. Joy Grimmer, Vice Chair

FOR THE BOARD:

Mr. Jose Rivera, Deputy Attorney General

FOR STAFF:

Ms. Theresa Carsten, Executive Officer
Mr. Nik Proper, Operations Officer
Ms. Brandee Mooneyhan, Lead Insurance Counsel
Ms. Monica McJoy, Chief Financial Officer
Ms. Jessica Crane, Executive Assistant

OTHER PRESENTERS:

Deborah Doaldson – Segal, Amy McClendon – Segal, Joan Marie Operario – UCH, Sabrina Semaan – UHC, Amy Daily – ESI

1. Open Meeting; Roll Call.
 - Board Chair Wells opened the meeting at 9:00 a.m.
2. Public Comment.
 - Kevin Salls, Member
 - April Corino, Retiree
 - Kent Ervin, NV Faculty Alliance
 - Tess Opferman, AFSCME
 - Susan Mowers, Member
 - Paul Lunkwitz, Retiree
 - Doug Unger, NV Faculty Alliance
 - Gabriel Mortensen, Member
 - Jason Stinehour, Member
 - Marie Bledsoe, Member
 - Janell Woodward, Member
 - Terri Laird, RPEN
 - Cassie Charles, AFSCME
 - Tracie Barnthouse, Member
 - Ashley Hogan, Member
 - Brittne Caldwell, Member
 - Velisity Barker, Member
 - Chelsea Coggin, Member
 - Beth Jacobsen, Member
3. PEBP Board disclosures for applicable Board meeting agenda items. (Jose Rivera, Deputy Attorney General) (Information/Discussion)
4. Approval of Action Minutes from the January 20, 2026 and February 24, 2026 PEBP Board Meetings. (Jim Wells, Board Chair) (**For Possible Action**)

BOARD ACTION ON ITEM 4

MOTION: Motion to approve action minutes

BY: Member, Jim Barnes

SECOND: Member, Tom Zumtobel

VOTE: Unanimous, the motion carried

5. Discussion and possible action regarding possible plan design changes in conjunction with rate setting scenarios and approving Plan Year 2027 rates for State and Non- State employees, retirees, and their dependents for the Consumer Driven Health Plan (CDHP), Low Deductible Plan (LD), Exclusive Provider Organization Plan (EPO), and Health Maintenance Organization Plan (HMO). (Deborah Donaldson, Segal and Theresa Carsten, Executive Officer) (**For Possible Action**)

Public Comment.

- Kent Ervin, NV Faculty Alliance
- Cassie Charles, AFSCME
- Susan Mowers, Member
- Jesse Mosley, Member
- Doug Unger, NV Faculty Alliance

- Katrina Aldridge, Member
- Rachel Rosenberg, Member
- John Doe, Member
- Ali Anderson, Member

BOARD ACTION ON ITEM 5

MOTION: Motion to adopt scenario 3C.

BY: Member, Jim Barnes

SECOND: Member, Blaine Harper

VOTE: Ayes – 3
Nays – 4. The motion failed

BOARD ACTION ON ITEM 5

MOTION: Motion to keep the benefit changes approved in December and adopt scenario 1C for the CDHP & LD PPO and 1B for the EPO & HMO.

BY: Member, Keiko Duncan

SECOND: Member, Laura Rich

VOTE: Ayes – 4
Nays – 3. The motion carried

BOARD ACTION ON ITEM 5

MOTION: Motion to move \$20 per month per active employee from the AEGIS account and \$50 per month per employee from the REGI account to offset shortfalls to rebuild reserves for 2027.

BY: Member, Laura Rich

SECOND: Member, Keiko Duncan

VOTE: Unanimous, the motion carried

BOARD ACTION ON ITEM 5

MOTION: Motion to cap the deductions for retirees at the amount that active employees pay for like coverage and implement the change in Plan Year 2028.

BY: Member, Laura Rich

SECOND: Member, Keiko Duncan

VOTE: Ayes – 2
Nays – 5. The motion failed

6. Discussion and possible action on shortening the Open Enrollment period for Plan Year 2027. (Theresa Carsten, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 6

MOTION: No action taken.

7. Executive Officer Report. (Theresa Carsten, Executive Officer) (Information/Discussion)
8. Contract Status Report. (Brandee Mooneyhan, Lead Insurance Counsel) (Information/Discussion)
 - 8.1 Contract Overview
 - 8.2 New Contracts
 - 8.3 Contract Amendments
 - 8.4 Status of Current Solicitations

9. SFY 26 Q2 Budget Report. (Monica McJoy, Chief Financial Officer) (Information/Discussion)
10. Q2 Sierra Healthcare Options – Utilization and Large Case Management.
(Joan Operario and Kelly Hall, UnitedHealthcare) (Information/Discussion)
11. Q2 Express Scripts – Utilization and Summary Reports.
(Amy Donohue & Amy Daily, Express Scripts) (Information/Discussion)
12. Vendor Reports for the period ending December 31, 2025. (Information/Discussion)
 - 12.1 Q2 UMR – Obesity and Diabetes Care Management
 - 12.2 Q2 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network
 - 12.3 Q2 UnitedHealthcare Basic Life Insurance
 - 12.4 Q2 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report
 - 12.5 Q2 CDHP Performance Review
 - 12.6 Q2 LD PPO Performance Review
 - 12.7 Q2 EPO Performance Review
 - 12.8 Q2 HPN Performance Review
 - 12.9 Q2 Dental Performance Review
 - 12.10 Q2 Doctor on Demand Engagement Report
 - 12.11 Q2 Real Appeal Performance Report
13. 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.
 - Kent Ervin, NV Faculty Alliance
 - Terri Laird, RPEN
14. Adjournment.

BOARD ACTION ON ITEM 14

MOTION: Motion to adjourn at 2:30 p.m.

BY: Member, Jim Barnes

SECOND: Member, Laura Rich

VOTE: Unanimous, the motion carried

Kent Ervin, K-E-N-T E-R-V-I-N, Nevada Faculty Alliance

I request that my comments be entered into the official record per the Open Meeting Law.

Where to start?

In December, we were told the budget would restore mandatory reserves this year. In January, there is a fiscal crisis and PEBP will not have funds to pay all claims within a few years. In February, that was worse by \$56 million because the actuary had been using wrong numbers since last Spring. Today's budget report shows revenues are meeting expenses so far this year, good news. Board members have been told the legislative budget is wrong. How and why? Before making any rate decisions, the Board must receive credible explanations. How can rates be set with ever-changing numbers?

Today's rate proposals were not posted in time for written comments. We've been struggling to analyze the report issued Tuesday morning. Board members are likely struggling to understand also. That alone is a reason to defer any action on rates.

If you do move ahead, there are nine scenarios in the packet. The Board Chair has verbally committed to a 3-year phase-in, option C. In round numbers, option C will increase PEBP's cash reserves from \$60 million to \$80 million in FY2027 toward the \$120 million actuarial target. Given the one-third/two-thirds split in employee vs state revenue overall, that's really the entire employee share in one year. Questions: What is the breakdown of the total rates between ongoing healthcare expense versus replenishing reserves? What would employee premiums be if we had started the year with full reserves? The new actuary should be able to answer. Option D should be to keep the reserve deficit from getting worse and fixing the problem in the 2027 session. That's worth consideration at a special meeting.

The other choice is whether to maintain the increases in out-of-pocket maximums that were approved in December with bad information. The \$1000 to \$2000 increases on the high-deductible and low-deductible plans will hurt most low-income employees who need significant healthcare to remain productive in their jobs. Option 3C is the least-bad of the nine scenarios. Option 1C does not change premiums much vs 3C and is just not worth it when employees are being asked to come up with \$10s of millions to fix a deficit not of their making. The juice is not worth the squeeze. It's insult on top of injury.

Please defer action to receive better information and options.

Thank you.

Dr. Kent M. Ervin

(Past) Past President

Nevada Faculty Alliance

5.

5. Discussion and acceptance of Eide Bailly's audited financial statement: Self Insurance Internal Service Fund. (Kurt Schlicker, Eide Bailly) **(For Possible Action)**



April 29, 2026

To the Public Employees' Benefits Program Board
Self Insurance Internal Service Fund
Carson City, Nevada

We have audited the financial statements of the Self Insurance Internal Service Fund (the Fund), Public Employees' Benefits Program, of the State of Nevada (the State), as of and for the year ended June 30, 2024, and have issued our report thereon dated April 29, 2026. Professional standards require that we advise you of the following matters relating to our audit.

Our Responsibility in Relation to the Financial Statement Audit under Generally Accepted Auditing Standards and *Government Auditing Standards*

As communicated in our letter dated July 21, 2025, our responsibility, as described by professional standards, is to form and express an opinion about whether the financial statements that have been prepared by management with your oversight are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your respective responsibilities.

Our responsibility, as prescribed by professional standards, is to plan and perform our audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement. An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control over financial reporting. Accordingly, as part of our audit, we considered the internal control of the Fund solely for the purpose of determining our audit procedures and not to provide any assurance concerning such internal control.

We are also responsible for communicating significant matters related to the audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

We have provided our comments regarding a material weakness over financial reporting identified during our audit in our Independent Auditor's 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* dated April 29, 2026, and in the Schedule of Findings and Responses.

Planned Scope and Timing of the Audit

We conducted our audit consistent with the planned scope we previously communicated to you. There were significant delays in the receipt of the trial balance, which is partially prepared by management of the Fund and partially prepared by the State of Nevada Controller's Office. The Fund and the Controller's Office cooperate to produce a final trial balance for the audit. The trial balance was not received until December 2025, which delayed the completion of our audit procedures.

Compliance with All Ethics Requirements Regarding Independence

The engagement team, others in our firm, as appropriate, our firm, and other firms utilized in the engagement, if applicable, have complied with all relevant ethical requirements regarding independence.

Qualitative Aspects of the Entity's Significant Accounting Practices

Significant Accounting Policies

Management has the responsibility to select and use appropriate accounting policies. A summary of the significant accounting policies adopted by the Fund is included in Note 1 to the financial statements. There have been no initial selection of accounting policies and no changes in significant accounting policies or their application during 2024. No matters have come to our attention that would require us, under professional standards, to inform you about (1) the methods used to account for significant unusual transactions and (2) the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

Accounting Estimates and Related Disclosures

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's current judgments. Those judgments are normally based on knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ markedly from management's current judgments.

The most sensitive accounting estimates affecting the financial statements are management's estimate of the net pension liability, net OPEB liability, and self insurance reserves (incurred but not reported and HRA liability).

- Management's estimate of the net pension liability is based on a third-party actuarial valuation. The actuarial valuation is based on the employee information submitted by the Fund. We evaluated the key factors and assumptions used to develop the pension liability in determining that it is reasonable in relation to the financial statements taken as a whole.
- Management's estimate of other post-employment benefit liability is based on a third-party actuarial valuation. We evaluated the key factors and assumptions used to develop the other post-employment benefit liability in determining that it is reasonable in relation to the financial statements taken as a whole.

- Management's estimate of self insurance reserves is based on a third-party actuarial valuation. We evaluated the key factors and assumptions used to develop the self insurance reserves liabilities in determining that they are reasonable in relation to the financial statements taken as a whole.

Financial Statement Disclosures

Certain financial statement disclosures involve significant judgment and are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the Fund's financial statements relate to:

- The net pension liability in Note 8 to the financial statements provides information on the assumptions made and inputs used to determine the net pension liability.
- The net OPEB liability in Note 9 to the financial statements provides information on the assumptions made and inputs used to determine the net OPEB liability.
- Risk management in Note 11 to the financial statements provides information on estimated claim liabilities.

Significant Difficulties Encountered during the Audit

We encountered no significant difficulties in dealing with management relating to the performance of the audit.

Uncorrected and Corrected Misstatements

For purposes of this communication, professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that we believe are trivial, and communicate them to the appropriate level of management. Further, professional standards require us to also communicate the effect of uncorrected misstatements related to prior periods on the relevant classes of transactions, account balances or disclosures, and the financial statements as a whole. Uncorrected misstatements or matters underlying those uncorrected misstatements could potentially cause future-period financial statements to be materially misstated, even though the uncorrected misstatements are immaterial to the financial statements currently under audit.

The following misstatements that we identified as a result of our audit procedures were brought to the attention of, and corrected by, management:

- Adjustment for an overstatement of revenue and expense of \$2,493,233.
- Adjustment for an overstatement of accounts payable and expense of \$2,300,117.

There were no uncorrected misstatements identified as a result of our audit procedures.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a matter, whether or not resolved to our satisfaction, concerning a financial accounting, reporting, or auditing matter, which could be significant to the Fund's financial statements or the auditor's report. No such disagreements arose during the course of the audit.

Circumstances that Affect the Form and Content of the Auditor's Report

For purposes of this letter, professional standards require that we communicate any circumstances that affect the form and content of our auditor's report. We made the following modifications to our auditor's report:

Required Supplementary Information

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.

Representations Requested from Management

We have requested certain written representations from management which are included in the management representation letter dated April 29, 2026.

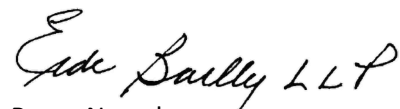
Management's Consultations with Other Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters. Management informed us that, and to our knowledge, there were no consultations with other accountants regarding auditing and accounting matters.

Other Significant Matters, Findings, or Issues

In the normal course of our professional association with the Fund, we generally discuss a variety of matters, including the application of accounting principles and auditing standards, significant events or transactions that occurred during the year, operating and regulatory conditions affecting the entity, and operational plans and strategies that may affect the risks of material misstatement. None of the matters discussed resulted in a condition to our retention as the Fund's auditors.

This report is intended solely for the information and use of the Public Employees' Benefits Program Board, and management of the Fund and is not intended to be, and should not be, used by anyone other than these specified parties.



Reno, Nevada

Financial Statements
For the Years Ended June 30, 2024 and 2023
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, 2024 and 2023

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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 (the Fund), Public Employees' Benefits Program, of the State of Nevada, as of and for the years ended June 30, 2024 and 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 Fund of the State of Nevada, as of June 30, 2024 and 2023, and the changes in its financial position and cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinions

We conducted our audits 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 opinions.

Emphasis of a Matter

As discussed in Note 1, the financial statements present only the Fund, and do not purport to, and do not, present fairly the financial position of the State of Nevada, as of June 30, 2024 and 2023, 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.

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, the schedule of the Fund's contributions – pension, schedule of the Fund's proportionate share of the net OPEB liability, and the schedule of the Fund's contributions – OPEB 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 opinions on the basic financial statements are 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 April 29, 2026 on our consideration of the 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 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 Fund of the State of Nevada’s internal control over financial reporting and compliance.

A handwritten signature in cursive script that reads "Eide Bailly LLP".

Reno, Nevada
April 29, 2026

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Statements of Net Position
June 30, 2024 and 2023

	2024	2023
Assets		
Current Assets		
Cash and cash equivalents	\$ 107,698,133	\$ 128,251,217
Prepaid insurance	10,740	7,975
Receivables		
Accounts receivable, net	11,067,048	3,922,217
Intergovernmental receivable	875,118	928,279
Due from other State of Nevada funds	1,662,663	1,813,347
Due from State of Nevada Retiree Health and Welfare fund	16,813,187	34,414,831
Due from Nevada System of Higher Education	699	38
Total current assets	138,127,588	169,337,904
Capital Assets		
Equipment	137,064	137,064
Right to use leased assets	2,254,145	2,239,384
Less accumulated depreciation and amortization	(433,888)	(244,429)
Total capital assets, net	1,957,321	2,132,019
Total assets	140,084,909	171,469,923
Deferred Outflows of Resources		
Pension related amounts	1,143,165	1,354,022
OPEB related amounts	90,807	89,230
Total deferred outflows of resources	1,233,972	1,443,252

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Statements of Net Position
June 30, 2024 and 2023

	2024	2023
Liabilities and Net Position		
Current Liabilities		
Bank overdraft	\$ 1,422,964	\$ 1,207,902
Accounts payable	1,227,840	1,699,174
Accrued payroll and related benefits	147,202	131,257
Due to other State of Nevada funds	1,212,958	29,624
Unearned revenue	11,638,428	9,664,653
Current maturities of compensated absences	163,931	115,928
Current maturities of lease liabilities	184,828	171,712
Current maturities of net OPEB liability	58,104	34,009
Reserve for claims liability	90,099,752	80,174,935
Total current liabilities	106,156,007	93,229,194
Noncurrent Liabilities		
Compensated absences, net of current maturities	95,186	54,656
Lease liabilities, net of current maturities	1,871,575	2,018,932
Net OPEB liability, net of current maturities	1,189,732	1,154,935
Net pension liability	3,610,068	4,034,515
Total noncurrent liabilities	6,766,561	7,263,038
Total liabilities	112,922,568	100,492,232
Deferred Inflows of Resources		
Pension related amounts	266,988	183,925
OPEB related amounts	103,138	139,064
Total deferred inflows of resources	370,126	322,989
Net Position		
Net investment in capital assets	(99,082)	(58,625)
Restricted for future claims and related expenses	28,125,269	72,156,578
Total net position	\$ 28,026,187	\$ 72,097,953

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, 2024 and 2023

	2024	2023
Operating Revenues		
Insurance premiums	\$ 371,114,418	\$ 365,997,765
Other	11,640	36,650
Total operating revenues	371,126,058	366,034,415
Operating Expenses		
Salaries and benefits	2,699,433	2,161,003
Operating	2,748,105	4,418,205
Claims expense	366,557,041	326,861,514
Depreciation/amortization	214,060	129,590
Insurance premiums and contractual obligations	61,841,197	60,410,337
Total operating expenses	434,059,836	393,980,649
Operating Loss	(62,933,778)	(27,946,234)
Nonoperating Revenues (Expenses)		
Payments from other State of Nevada funds	11,727,499	6,038,836
Payments to other State of Nevada funds	-	(727,330)
Interest expense	(63,095)	(33,196)
Gain (loss) on disposal of assets	(4,996)	(3,267)
Investment income (expense)	1,959,104	210,751
Interest Income	5,243,500	3,570,960
Total nonoperating revenues	18,862,012	9,056,754
Change in Net Position	(44,071,766)	(18,889,480)
Net Position, Beginning of Year	72,097,953	90,987,433
Net Position, End of Year	\$ 28,026,187	\$ 72,097,953

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Statements of Cash Flows
Years Ended June 30, 2024 and 2023

	2024	2023
Operating Activities		
Receipts from customers and users	\$ 81,494,279	\$ 95,398,987
Receipts from services to State of Nevada funds	145,939,598	146,453,391
Receipts from State of Nevada component units	156,458,699	131,524,828
Payments to suppliers, other governments and beneficiaries	(421,185,831)	(392,105,185)
Payments to employees	(2,704,093)	(2,283,855)
Payments for services to other State of Nevada funds	(294,733)	(717,846)
Net cash used for operating activities	(40,292,081)	(21,729,680)
Noncapital Financing Activities		
Receipts from other State of Nevada funds	11,727,499	7,988,836
Payments to other State of Nevada funds	-	(743,811)
Net cash from noncapital financing activities	11,727,499	7,245,025
Capital and Related Financing Activities		
Purchase of capital assets	-	(15,185)
Principal paid on leases	(178,599)	(48,740)
Interest paid on leases	(63,095)	(33,196)
Net cash used for capital and related financing activities	(241,694)	(97,121)
Investing Activities		
Interest, dividends and gains (losses)	8,253,192	2,647,004
Net Decrease in Cash and Cash Equivalents	(20,553,084)	(11,934,772)
Cash and Cash Equivalents, Beginning of Year	128,251,217	140,185,989
Cash and Cash Equivalents, End of Year	\$ 107,698,133	\$ 128,251,217

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Statements of Cash Flows
Years Ended June 30, 2024 and 2023

	2024	2023
Reconciliation of Operating Loss to Net Cash used for Operating Activities		
Operating loss	\$ (62,933,778)	\$ (27,946,234)
Adjustments to reconcile operating loss to net cash used for operating activities		
Depreciation	214,060	129,590
Changes in assets and liabilities		
Decrease (increase) in receivables	(7,091,670)	11,162,452
Decrease (increase) in due from State of Nevada funds, retiree health and welfare and system of higher ed	16,701,079	(8,048,508)
Decrease (increase) in prepaid expenses	(2,765)	(7,961)
Decrease (increase) in deferred outflows of resources	209,280	(4,584)
Increase (decrease) in payables and accruals	9,773,022	(1,154,680)
Increase (decrease) in unearned revenue	1,973,775	4,228,847
Increase (decrease) in due to State of Nevada funds	1,183,334	-
Increase (decrease) in net pension liability	(424,447)	1,768,587
Increase (decrease) in net OPEB liability	58,892	(206,780)
Increase (decrease) in deferred inflows of resources	47,137	(1,650,409)
Total adjustments	22,641,697	6,216,554
Net Cash used for Operating Activities	\$ (40,292,081)	\$ (21,729,680)
Noncash Investment, Capital and Financing Activities		
Leases incurred for right to use assets	\$ 44,358	\$ 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, 2024 and 2023 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.

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 \$11,638,428 and \$9,644,653 for the years ended June 30, 2024 and 2023, 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 Reserves for Claims Liability

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, 2024 and 2023, 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

Certain amounts for receivables due from other funds presented in the Statement of Net Position as of June 30, 2023 have been reclassified to be more consistent with presentation as of June 30, 2024.

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.

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Notes to Financial Statements
June 30, 2024 and 2023

Note 3 - Cash and Cash with Treasurer

	2024	2023
Bank overdraft		
Overdraft accounts	\$ (1,422,964)	\$ (1,207,902)
Cash with State Treasurer		
State Treasurer's Investment Pool	109,777,905	132,290,093
Unrealized gains and losses	(2,079,772)	(4,038,876)
Total cash with State Treasurer	107,698,133	128,251,217
Total cash and deposits	\$ 106,275,169	\$ 127,043,315

The Fund has three checking accounts at June 30, 2024 and 2023. These accounts contain \$254,225 and \$360,903 (of the total overdraft accounts balances above) in stale outstanding checks for the years ended June 30, 2024 and 2023, 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.

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Notes to Financial Statements
June 30, 2024 and 2023

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, 2024:

	<u>Accounts Receivable</u>	<u>Intergovernmental</u>	<u>State of Nevada Funds</u>	<u>Retiree Health and Welfare</u>	<u>NV System of Higher Education</u>
Premiums	\$ 11,067,048	\$ 103,451	\$ -	\$ 16,813,187	\$ 699
Interest	-	-	1,662,663	-	-
Rebates	-	771,667	-	-	-
	<u>\$ 11,067,048</u>	<u>\$ 875,118</u>	<u>\$ 1,662,663</u>	<u>\$ 16,813,187</u>	<u>\$ 699</u>

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

	<u>Accounts Receivable</u>	<u>Intergovernmental</u>	<u>State of Nevada Funds</u>	<u>Retiree Health and Welfare</u>	<u>NV System of Higher Education</u>
Premiums	\$ 3,922,217	\$ 67,347	\$ 13,710	\$ 34,414,831	\$ 38
Interest	-	-	1,799,637	-	-
Rebates	-	860,932	-	-	-
	<u>\$ 3,922,217</u>	<u>\$ 928,279</u>	<u>\$ 1,813,347</u>	<u>\$ 34,414,831</u>	<u>\$ 38</u>

State of Nevada
Self Insurance Internal Service Fund
Public Employees' Benefits Program
Notes to Financial Statements
June 30, 2024 and 2023

Note 5 - Capital Assets

The following schedule summarizes the changes in capital assets for the year ended June 30, 2024:

	Balance July 1, 2023	Additions	Deletions	Balance June 30, 2024
Capital assets being depreciated				
Equipment	\$ 137,064	\$ -	\$ -	\$ 137,064
Less accumulated depreciation	(119,366)	(5,432)	-	(124,798)
Capital assets being depreciated, net	17,698	(5,432)	-	12,266
Right to use leased assets being amortized				
Building	2,206,084	-	-	2,206,084
Equipment	33,300	44,358	(29,597)	48,061
Less accumulated amortization				
Building	(100,276)	(200,553)	-	(300,829)
Equipment	(24,787)	(8,075)	24,601	(8,261)
Right of use leased assets, net	2,114,321	(164,270)	(4,996)	1,945,055
Total capital assets, net	<u>\$ 2,132,019</u>	<u>\$ (169,702)</u>	<u>\$ (4,996)</u>	<u>\$ 1,957,321</u>

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	<u>\$ 10,307</u>	<u>\$ 2,124,979</u>	<u>\$ (3,267)</u>	<u>\$ 2,132,019</u>

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, 2024 and 2023, the Fund recognized right to use assets of \$2,254,145 and \$2,239,384, respectively. At June 30, 2024 and 2023, the Fund recognized lease liabilities of \$2,056,403 and \$2,190,644, respectively. The Fund recognized amortization expense of \$208,628 and \$125,063 for the years ended June 30, 2024 and 2023, respectively. The Fund recognized interest expense of \$63,095 and \$33,196 for the years ended June 30, 2024 and 2023, respectively.

Changes in long-term lease liabilities during the year ended June 30, 2024, are as follows:

	<u>Balance July 1, 2023</u>	<u>Additions</u>	<u>Deletions</u>	<u>Balance June 30, 2024</u>	<u>Due Within One Year</u>
Leases	\$ 2,190,644	\$ 44,358	\$ (178,599)	\$ 2,056,403	\$ 184,828

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

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

State of Nevada
Self Insurance Internal Service Fund
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June 30, 2024 and 2023

Remaining principal and interest payments on leases are as follows:

<u>Year Ending June 30,</u>	<u>Principal</u>	<u>Interest</u>
2025	\$ 184,828	\$ 56,975
2026	195,129	51,516
2027	205,674	45,823
2028	216,409	39,855
2029	214,235	33,473
2030-2034	1,040,128	67,239
	<u>\$ 2,056,403</u>	<u>\$ 294,881</u>

Note 7 - Compensated Absences

The following schedule summarizes the changes in compensated absences for the year ended June 30, 2024:

	<u>Balance July 1, 2023</u>	<u>Additions</u>	<u>Deletions</u>	<u>Balance June 30, 2024</u>	<u>Due Within One Year</u>
Compensated absences	\$ 170,584	\$ 204,393	\$ 115,860	\$ 259,117	\$ 163,931

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

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

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, 2024 and 2023, the Statutory Employer/Employee matching rate for Regular members was 17.50% and 15.50%, respectively. The Employer-Pay Contribution (EPC) rate was 33.50% and 29.75%, respectively, for Regular members for the fiscal years ended June 30, 2024 and 2023.

The Fund's contributions to PERS for the years ended June 30, 2024 and 2023 were \$317,957 and \$229,841, 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, 2023:

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, 2023, PERS' long-term inflation assumption was 2.50%.

Net Pension Liability

At June 30, 2024 and 2023, the Fund reported a liability for its proportionate share of the net pension liability of \$3,610,068 and \$4,034,515, respectively. The net pension liability was measured as of June 30, 2023 and 2022, 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, 2023, the Fund's proportion was 0.0198% which was a decrease of 0.0026% from the proportion of 0.0224% at June 30, 2022, which was a decrease of 0.0021% from its proportion measured as of June 30, 2021.

Pension Liability Discount Rate Sensitivity

The following presents the net pension liability of the Fund as of June 30, 2024, 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	<u>\$ 5,617,796</u>	<u>\$ 3,610,068</u>	<u>\$ 1,953,103</u>

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	<u>\$ 6,194,299</u>	<u>\$ 4,034,515</u>	<u>\$ 2,252,368</u>

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, 2023 and June 30, 2022, 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, 2023 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 healthy 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. Mortality 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, 2023 and 2022 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, 2023 and 2022. 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, 2023 and 2022.

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Changes in Assumptions

There were no changes in assumptions from June 30, 2022 to June 30, 2023 valuations or from June 30, 2021 to June 30, 2022 valuations.

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

For the years ended June 30, 2024 and 2023, the Fund recognized pension expense (income) of \$186,550 and \$223,895 respectively.

At June 30, 2024 and 2023, the Fund reported deferred outflows of resources and deferred inflows of resources State of Nevada related to pensions from the following sources:

	2024		2023	
	Deferred Outflows of Resources	Deferred Inflows of Resources	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	\$ 470,550	\$ -	\$ 522,403	\$ 2,882
Change of assumptions	338,332	-	518,262	-
Net difference between projects and actual earnings on investments	-	33,790	49,224	-
Changes in proportion and differences between actual contributions and proportionate share of contributions	16,326	233,198	34,292	181,043
System contributions subsequent to the measurement date	317,957	-	229,841	-
	<u>\$ 1,143,165</u>	<u>\$ 266,988</u>	<u>\$ 1,354,022</u>	<u>\$ 183,925</u>

The \$317,957 and \$229,841 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, 2025 and 2024, respectively.

The average of the expected remaining service lives of all employees that are provided with pensions through PERS (active and inactive employees) is 5.63 years and 5.70 years for the measurement period ending June 30, 2023 and 2022, respectively.

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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,		
2025	\$	76,785
2026		59,007
2027		412,809
2028		7,111
2029		2,508
	\$	558,220

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 3.11% and 2.18% of actual payroll for the years ended June 30, 2024 and 2023, 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.

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Contributions recognized as part of OPEB expense were \$58,104 and \$34,009 for the years ended June 30, 2024 and 2023, respectively.

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

At June 30, 2024 and 2023, the Fund reported a net OPEB liability of \$1,247,836 and \$1,188,944, respectively, for its proportionate share of the collective net OPEB liability. The collective net OPEB liability was measured as of June 30, 2023 and 2022, 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, 2023, the Fund's proportion was 0.0856% which was an increase of .0032% from the proportion of 0.0824% at June 30, 2022, which was a decrease of .0082% from its proportion measured as of June 30, 2021.

For the years ended June 30, 2024 and 2023, the Fund recognized OPEB expense of \$36,838 and \$70,386, respectively. At June 30, 2024 and 2023, the Fund reported deferred outflows of resources and deferred inflows of resources related to OPEB for the following sources:

	2024		2023	
	Deferred Outflows of Resources	Deferred Inflows of Resources	Deferred Outflows of Resources	Deferred Inflows of Resources
Changes of assumptions	\$ 17,537	\$ 78,298	\$ 43,384	\$ 98,984
Differences between expected and actual experience	-	24,840	-	40,080
Fund contributions subsequent to measurement date	73,270	-	45,846	-
	<u>\$ 90,807</u>	<u>\$ 103,138</u>	<u>\$ 89,230</u>	<u>\$ 139,064</u>

The \$73,270 and \$45,846 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, 2025 and 2024, respectively.

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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,		
2025	\$	(35,760)
2026		(41,506)
2027		(3,700)
2028		(3,652)
2029		(983)
		\$ (85,601)

Actuarial Assumptions

The total OPEB liability as of June 30, 2023 and 2022 was determined by actuarial valuation using the following actuarial assumptions:

Measurement date	June 30, 2023	June 30, 2022
Valuation date	June 30, 2022	June 30, 2022
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	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%	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% and 27.17%, effective July and 2024, respectively, then 4.50% thereafter.	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% and 27.17%, effective Jul and 2024, respectively, then 4.50% thereafter.

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 mortality 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 3.65% and 3.54% for fiscal years ended June 30, 2024 and 2023, 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.

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

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Since a new valuation was not performed for the year ended June 30, 2024, the only change in assumption was the change in discount rate from 3.54% to 3.65%

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 (2.65% for year ending June 30, 2024 and 2.54% for year ending June 30, 2023) or 1-percentage-point higher (4.65% for year ending June 30, 2024 and 4.54% for year ending June 30, 2023) than the current discount rate.

	1% Decrease in Discount Rate 2.65%	Discount Rate 3.65%	1% Increase in Discount Rate 4.65%
Net OPEB liability, June 30, 2024	\$ 1,368,621	\$ 1,247,836	\$ 1,142,960
	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

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, 2024	\$ 1,183,247	\$ 1,247,836	\$ 1,321,823
Net OPEB liability, June 30, 2023	\$ 1,131,462	\$ 1,188,944	\$ 1,254,766

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, 2024:

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 Reserves for 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.

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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.

	2024	2023
Reserve for claims liability		
Beginning balance	\$ 80,174,935	\$ 79,492,071
Claims and changes in estimates	366,557,041	326,861,514
Claims payments	(356,632,224)	(326,178,650)
Ending reserves for claims liability	\$ 90,099,752	\$ 80,174,935

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 \$254,224 and \$360,903 as of June 30, 2024 and 2023, 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.

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Schedule of the Fund's Proportionate Share of the Net Pension Liability
Last Ten Fiscal Years (Unaudited)

	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014
Fund's portion of the net pension liability	0.0198%	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	\$ 3,610,068	\$ 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	\$ 1,538,420	\$ 1,629,320	\$ 1,594,419	\$ 1,532,510	\$ 1,684,981	\$ 1,509,506	\$ 1,374,657	\$ 1,333,326	\$ 1,344,932	\$ 1,451,686
Fund's proportional share of the net pension liability as a percentage of its covered payroll	234.66%	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	76.16%	75.12%	86.51%	77.04%	76.46%	75.24%	74.42%	72.23%	75.13%	76.31%

Notes to Schedules:

	2021 through 2023	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)

	<u>2024</u>	<u>2023</u>	<u>2022</u>	<u>2021</u>	<u>2020</u>	<u>2019</u>	<u>2018</u>	<u>2017</u>	<u>2016</u>
Contractually Required Contribution	\$ 317,957	\$ 229,841	\$ 246,551	\$ 260,407	\$ 267,388	\$ 270,930	\$ 241,784	\$ 220,384	\$ 228,943
Contributions in Relation to the Contractually Required Contribution	<u>(317,957)</u>	<u>(229,841)</u>	<u>(246,551)</u>	<u>(260,407)</u>	<u>(267,388)</u>	<u>(270,930)</u>	<u>(241,784)</u>	<u>(220,384)</u>	<u>(228,943)</u>
Contribution Deficiency (Excess)	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>
Fund's covered payroll	\$ 1,887,340	\$ 1,538,420	\$ 1,629,320	\$ 1,594,419	\$ 1,532,510	\$ 1,684,981	\$ 1,509,506	\$ 1,374,657	\$ 1,333,326
Contributions as a Percentage of Covered Payroll	16.85%	14.94%	15.13%	16.33%	17.45%	16.08%	16.02%	16.03%	17.17%

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)

	2023	2022	2021	2020	2019	2018	2017
Fund's portion of the net OPEB liability	0.0856%	0.0824%	0.0906%	0.0938%	0.0934%	0.1070%	0.1029%
Fund's proportionate share of the net OPEB liability	1,247,836	1,188,944	1,395,724	1,405,629	1,301,204	1,417,507	1,339,747
Fund's covered payroll	1,560,046	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	79.99%	72.43%	87.54%	91.72%	77.22%	93.91%	97.46%
Plan Fiduciary Net Position as a Percentage of the Total OPEB Liability	-2.14%	-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.

	2023	2022	2021	2020	2019	2018	2017
Valuation Date	June 30, 2023	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	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
Amortization Period	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
Inflation Rate	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.75%
Discount Rate	3.65%	3.54%	2.16%	2.21%	3.51%	3.87%	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%
Dental	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%
Part B Reimbursement	27.17% effective 7/1/24 then 4.00%	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%	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%	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%	2.50%	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	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
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
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
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
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
Mortality Improvement	MP-2020	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)

	2024	2023	2022	2021	2020	2019	2018
Contractually Required Contribution	\$ 58,104	\$ 34,009	\$ 35,622	\$ 37,136	\$ 41,705	\$ 44,268	\$ 39,801
Contributions	<u>(58,104)</u>	<u>(34,009)</u>	<u>(35,622)</u>	<u>(37,136)</u>	<u>(41,705)</u>	<u>(44,268)</u>	<u>(39,801)</u>
Contribution Deficiency (Excess)	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>
Fund's covered payroll	\$ 1,868,296	\$ 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	3.11%	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.



**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 (the Fund), Public Employees' Benefits Program, of the State of Nevada, as of and for the year ended June 30, 2024, and the related notes to the financial statements, which collectively comprise the Fund of the State of Nevada's basic financial statements and have issued our report thereon dated April 29, 2026.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the 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 Fund of the State of Nevada's internal control. Accordingly, we do not express an opinion on the effectiveness of the 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 2024-001 that we consider to be a material weakness.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Fund 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 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 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 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 Fund of the State of Nevada's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.



Reno, Nevada
April 29, 2026

**2024-001 Financial Statement Preparation
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, adjustments were required related to the Fund's financial statements.

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 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, revenues and expenses were overstated by \$2,493,233 and accounts payable and expense were overstated by \$2,300,117 prior to adjustment for amounts recorded in the wrong fiscal 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 all transactions are monitored and properly recorded.

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

6.

6. Presentation on HIPAA. (Brandee Mooneyhan, Lead Insurance Counsel) (Information/Discussion)



HIPAA Overview

May 21, 2026

WHAT IS HIPAA?

Health Insurance Portability and Accountability Act

- **42 U.S.C. § 1320d et seq.**
- **45 C.F.R. Parts 160 and 164**

PEBP is a “Covered Entity” Subject to HIPAA

Covered entities:

- Health plans (includes group health plans that pay the cost of medical care);
- Health clearinghouses;
- Health care providers who transmit health information in electronic form

(45 C.F.R. § 160.103)

PEBP Board and HIPAA

May learn protected health information in carrying out Board duties

Awareness of PEBP policies for staff who frequently deal with PHI

Focus: Privacy Rule

Prohibits unauthorized disclosure of protected health information (PHI)

- PHI is *individually identifiable health information* held or transmitted by a covered entity in any form or media (i.e., electronic, paper, verbal) that relates to:
 - Past, present, or future physical or mental health or condition,
 - Provision of health care, or
 - Past, present, or future payment for health care,
and that identifies the person (or could reasonably be used to identify the person), such as name, address, birth date, Social Security Number.
- For example: claim information, EOBs, enrollment info

(45 C.F.R. Part 160 and Part 164, Subparts A and E)

Permitted Uses and Disclosures

(not all inclusive)

Treatment, payment, and health care operations

When required by law

Public Health Activities

KEY: Minimum Necessary

Security Rule

Protects electronic PHI

- Administrative policies
 - Ex.: Personnel screening, access management, training
- Physical access controls
 - Ex.: Work station access, passwords
- Technical security measures
 - Backup, when to encrypt

(45 C.F.R. Part 160 and Part 164, Subparts A and C)

Examples of PEBP safeguards

- Key card access to areas where PHI may be
- Visitor procedures
- Passwords
- Shredding
- Login monitoring
- Anti-virus/anti-malware software
- Encrypted computer files
- Locked drawers and file cabinets
- Use of secure transfer sites

Examples of PEBP safeguards cont'd

- Designated privacy officer/contact person
- Complaint procedure
- Biennial compliance assessment includes review of HIPAA compliance
- Staff HIPAA training (initial and annual), with records maintained
- Provide Notice of Privacy Practices to plan participants (recently updated)

Breach Notification Rule

In event of data breach, covered entity must notify affected individuals and relevant authorities

(45 C.F.R. §§ 164.400-.414)

HITECH

Health Information Technology for Economic and Clinical Health Act

Enacted 2009 (13 years after HIPAA)

Promoted adoption of electronic health records

Strengthened HIPAA compliance requirements

- Extended HIPAA requirement to business associates of covered entities
- Tougher penalties for violating HIPAA

Business Associates

- Most of PEBP's vendors are business associates subject to HIPAA requirements
- Business associate agreements setting forth HIPAA requirements are part of contracts

Risks of noncompliance

Civil: Monetary penalties, corrective action plans

Criminal: For intentional breach of PHI, fines and imprisonment

(HIPAA Enforcement Rule: 45 C.F.R. Part 160, Subparts C, D, and E)

Anthem settlement

- Cyber-attackers gained access to databases through phishing emails sent to Anthem subsidiary
 - “At least one employee responded to the malicious email and opened the door”
- In approximately two months, cyber-attackers stole ePHI or almost 79 million persons
 - Names, social security numbers, medical ID numbers, addresses, DOBs, email addresses, and employment information
- Anthem reported breach to U.S. Department of Health and Human Services Office for Civil Rights (OCR)
- Anthem faced investigations by most state attorneys general, class action lawsuit, and enforcement action by OCR
- While maintaining that it did not violate the law and that no evidence supported that any of the stolen information was used to commit fraud or identity theft, Anthem agreed to pay \$16 million to OCR and take substantial corrective action to settle enforcement matter

Cadia Healthcare Facilities settlement

- 2025 settlement with OCR for potential HIPAA violations
- Complaint asserted that Cadia impermissibly disclosed patient's name, photo, and information pertaining to patient's conditions, treatment, and recovery as a “success story” on website
 - Failed to obtain HIPAA authorization form before doing so
 - OCR investigation showed similar pattern for 150 patients
- Failed to comply with Breach Notification Rule by failing to inform affected persons
- Agreed to corrective action plan and \$182,000 penalty

Questions/discussion?

7.

7. Presentation on Ethics in Government. (Nevada Commission on Ethics)
(Information/Discussion)



ETHICS LAW BASICS

PEBP BOARD



ROADMAP

- Why Ethics Matters
- Barriers to Compliance
- What We Do
- Who and What is Covered
- Key Areas of the Law
 - Improper Benefits
 - Disclosure & Abstention
 - Cooling Off
- Resources & Contacts



WHY AN ETHICS LAW?

- Watergate Scandal Triggered Enactment of Government Ethics Laws
 - Federal Ethics in Government Act (1978)
 - Nevada Ethics Law (1975)



STAY ON THE PATH



“A public office is a public trust and shall be held for the sole benefit of the people”

NRS 281A.020

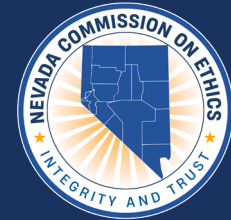


WHY DOES ETHICS MATTER?

Dissolves Trust in
Government

Undermines Efforts of Public
Servants

Government for the People



BARRIERS TO ETHICAL CONDUCT IN PUBLIC SERVICE

- Lack of awareness of ethics laws and best practices
- Limited knowledge about where to find ethics resources
- Contradiction between normative practices in private sector and public sector ethics laws and best practices
- Pressure from supervisors, vendors, legislators, and more
- Societal pressures





MAJOR FUNCTIONS OF THE COMMISSION



Education and Outreach
about Nevada's Ethics Law



Provide Advisory Opinions to
public officers and
employees about Nevada's
Ethics Law



Receive and process
Complaints alleging
violations of Nevada's Ethics
Law

Prevention

Enforcement



THE NEVADA COMMISSION ON ETHICS – NRS 281A

Commissioners are prohibited from:

- Serving more than two consecutive, 4-year terms
- Holding another public office
- Being actively involved in the work of any political party or campaign
- Lobbying

*Make-up of the Commission:

- No more than 4 members can be from the same political party or reside in the same county.
- 2 must be a Nevada Licensed attorney.
- 4 Commissioner appointments must be former public officers/employees.



WHAT FALLS UNDER THE JURISDICTION OF THE ETHICS COMMISSION?

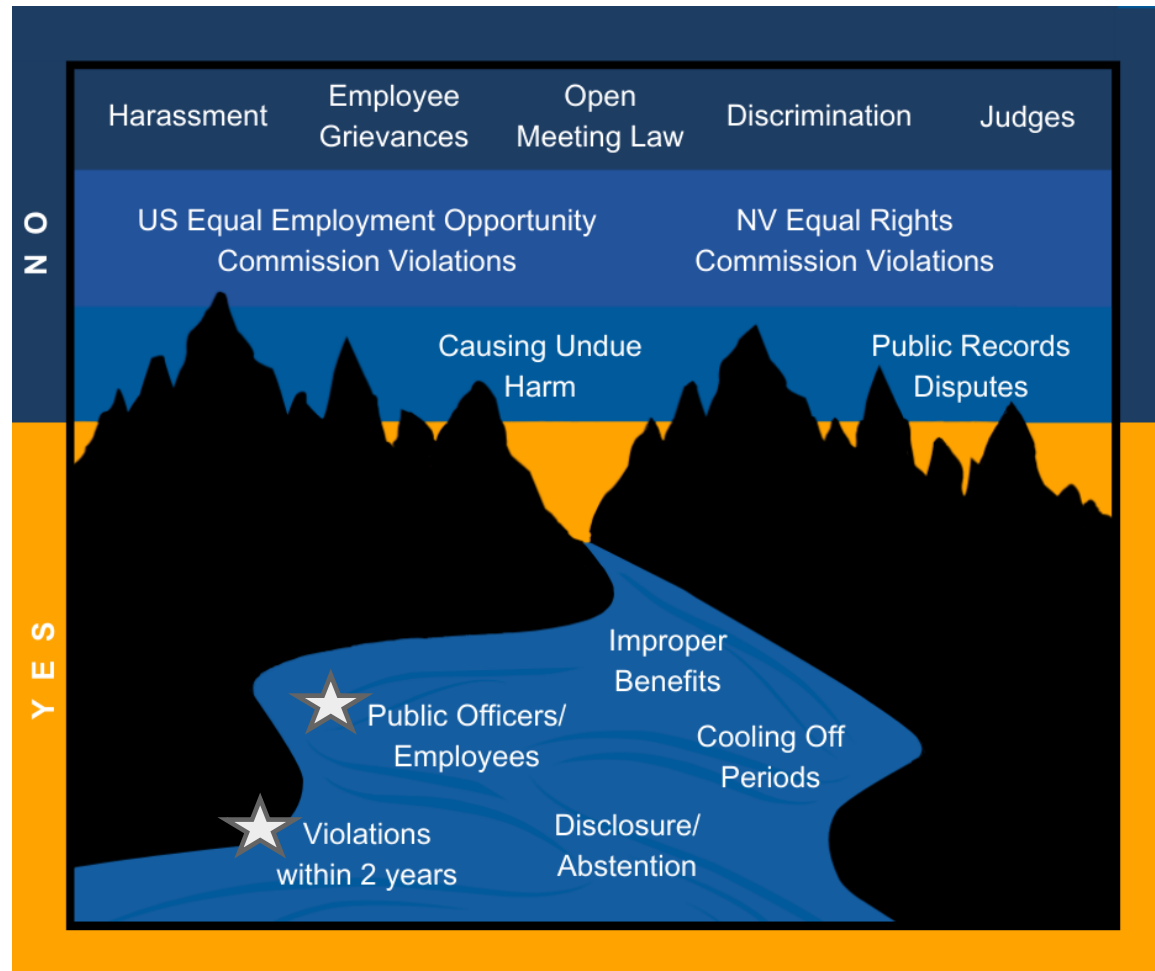


Image developed by the Nevada Commission on Ethics using Canva™.



COMMITMENT IN A PRIVATE CAPACITY - NRS 281A.065



Spouse / Domestic Partner



Member of Household



3rd Degree of
Consanguinity / Affinity



Employer



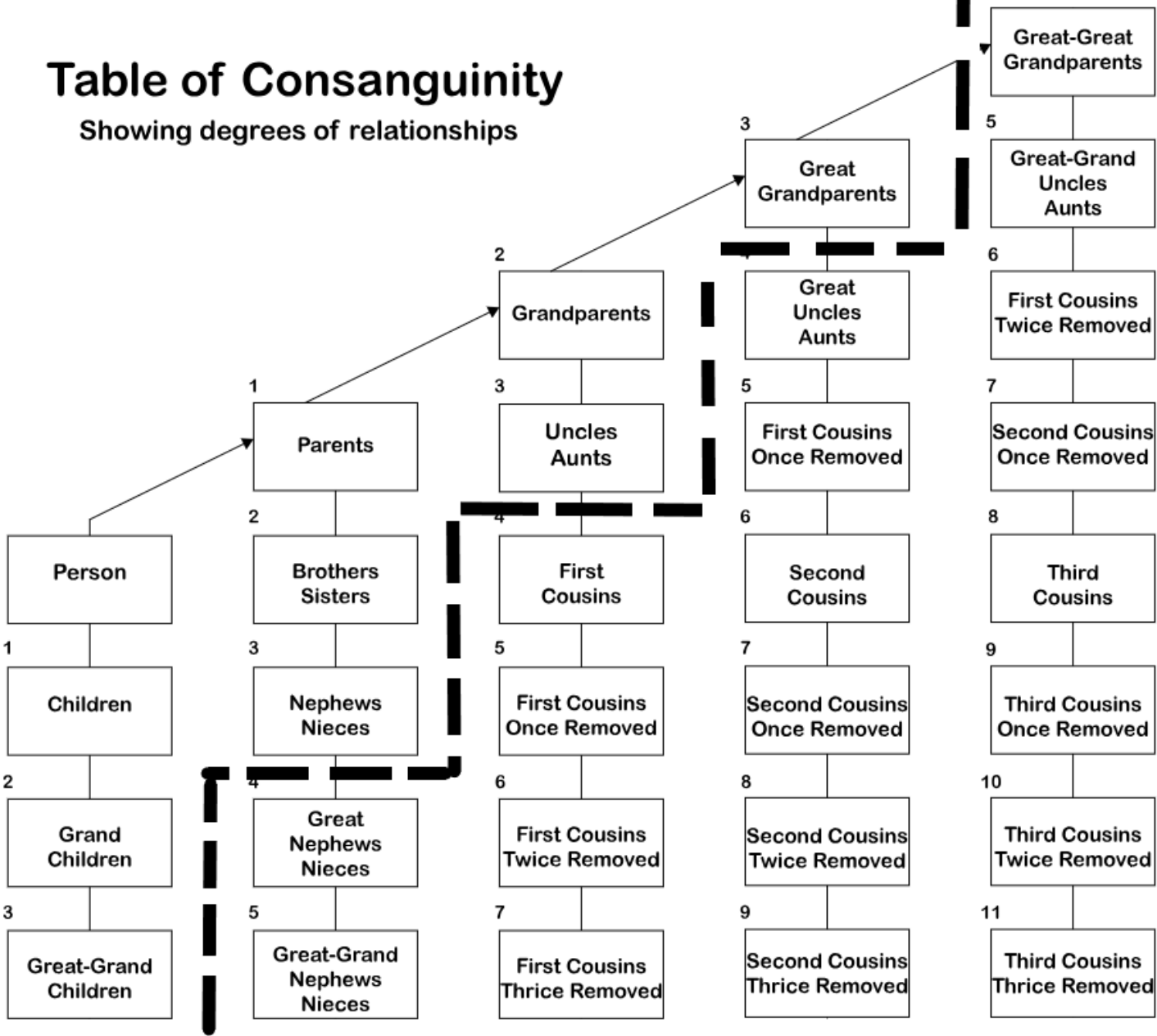
Substantial and Continuing
Business Relationship



Substantially Similar

Table of Consanguinity

Showing degrees of relationships





COMMITMENT IN A PRIVATE CAPACITY - NRS 281A.065



Spouse / Domestic Partner



Member of Household



3rd Degree of
Consanguinity / Affinity



Employer



Substantial and Continuing
Business Relationship



Substantially Similar



3 MAIN AREAS OF THE ETHICS LAW



IMPROPER BENEFIT – GOVERNMENT RESOURCES



Use Government Position



Benefit/Gift/Loan for Themselves or
Someone They Have a Private Commitment



Potential Ethics Violation



IMPROPER BENEFIT - GIFTS

- No gifts, services, favors, or engagements that “tend improperly to influence a reasonable person to depart from the faithful and impartial discharge of duties” NRS 281A.400(1)

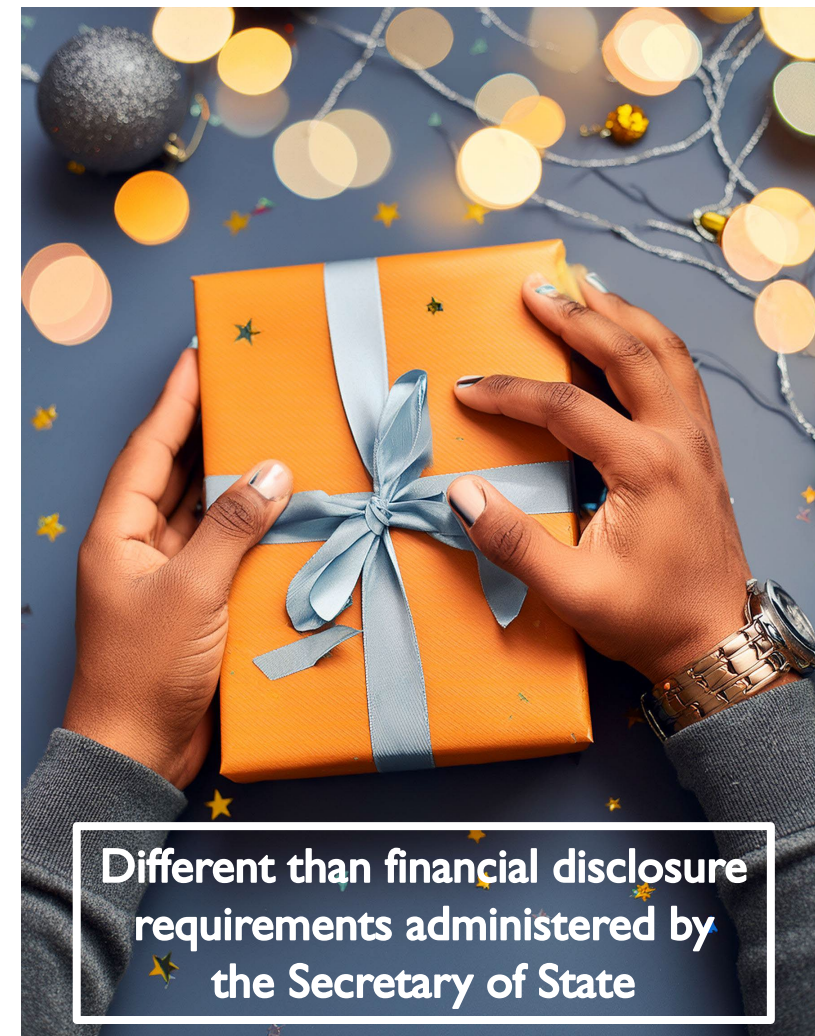
Facts to Consider

1. Accept or seek out the gift?
2. Value of the Gift
3. Nexus between the “gifter” and “giftee’s” decision

In re City of Reno (Advisory) – theater tickets

In re McClinton (Complaint) – hockey tickets

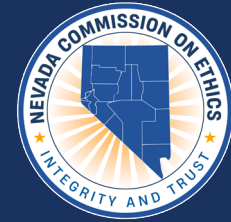
In re Lopez (Complaint) – coach purse



Different than financial disclosure requirements administered by the Secretary of State

IMPROPER BENEFIT – GOVERNMENT RESOURCES

- Unwarranted privileges, preferences, exemptions or advantages using position (NRS 281A.400(2))
- Negotiating a contract with self or for others with current agency (NRS 281A.400(3))
- Contracting with government (NRS 281A.430)
- No salary or compensation from private source for performance of public duties NRS 281.400(4)
- Benefit to self or other using influence over a subordinate (NRS 281A.400(9))
- Honorarium for speaking (NRS 281A.510)



IMPROPER BENEFIT – GOVERNMENT RESOURCES



- Use of government time, property, equipment, or other facility to benefit a significant personal or pecuniary interest. NRS 281A.400(7)

In re Pamintuan (Complaint) – state email/time

In re Hall (Complaint) – county credit card



IMPROPER BENEFIT – GOVERNMENT RESOURCES

Limited Use Exception (Property, Equipment, Facility) NRS 281A.400(7)(a)

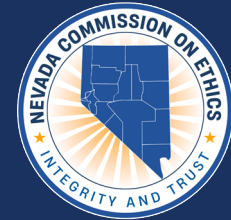
Properly authorized by policy allowing the use or if use is result of an emergency

Use does not interfere with performance of public officer/employee's public duties

Cost of value related to the use is nominal

Does not create the appearance of impropriety

**All 4 conditions must
be met together**



IMPROPER BENEFIT – USE OF INFORMATION



- Use of non-public information to benefit self or others (NRS 281A.400(5))
- Suppression of government report to benefit self or others (NRS 281A.400(6))

DISCLOSURE & ABSTENTION



“Government ought to be outside and not inside...Everybody knows that corruption thrives in secret places, and avoids public places, and we believe it a fair presumption that secrecy means impropriety”

President Woodrow Wilson

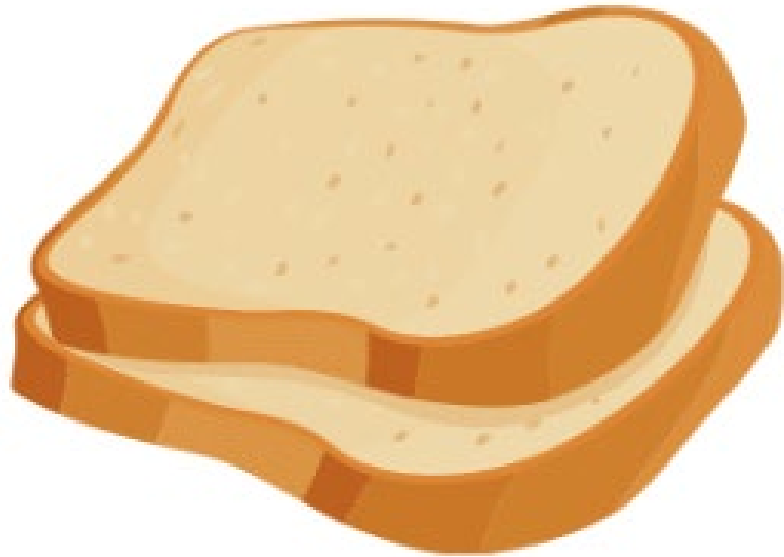
DISCLOSURE & ABSTENTION

Before approving, voting, or acting on a matter when

- Gift or loan accepted
- Significant pecuniary interest
- Reasonably affected by commitment in private capacity
- Former lobbying

NRS 281A.420

QUALITY DISCLOSURE



- “Sufficient to inform the public of the potential effect of the action or abstention upon the person or interest”

AND

- “Made at the time the matter is considered”

In re Gibson, et al (Complaint) – FI ticket disclosure

DISCLOSURE & ABSTENTION

- A Public Officer shall not vote upon or advocate for the passage or failure of a matter
- A Public Officer shall not make decisions or act upon
 - If Independence of judgment of a reasonable person affected by
 - own pecuniary (\$) interest,
 - commitment in a private capacity,
 - gift or loan



DISCLOSURE & ABSTENTION



Presumption in NRS 281A.420



- Favors participation
- Abstention required in clear cases where the public officer's situation is materially affected
- Presumed permissible if no greater benefit/detriment to officer than to anyone else affected by the matter

Case by Case Basis
Item by Item Basis

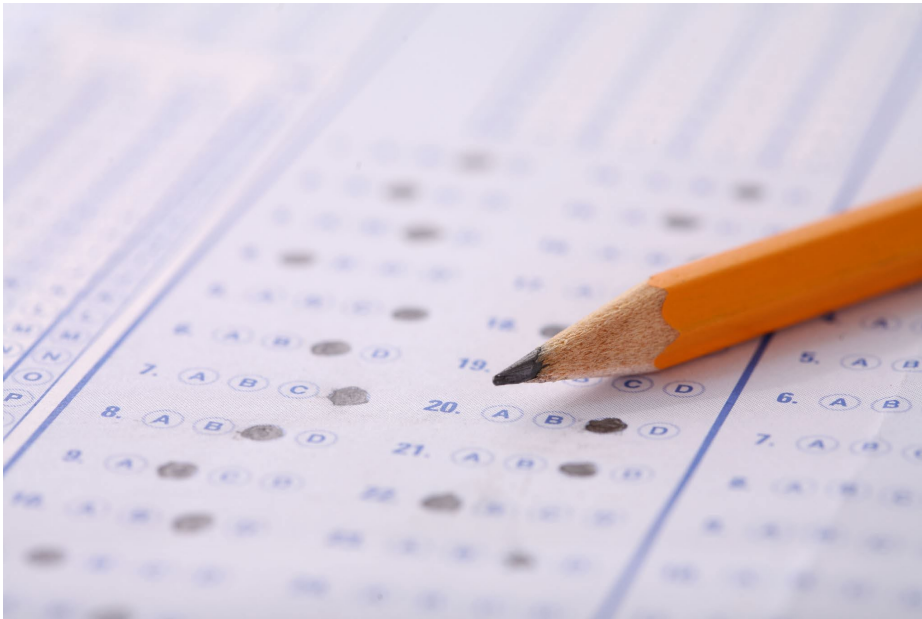
In re Ancho (Advisory) – retired public employee

DISCLOSURE & ABSTENTION



Test Cases

- Medical Benefits
 - Board is considering increasing costs that her nephew, as a public employee, will have to pay for benefits
- Vendor Selection
 - Picking a vendor and your friend from high school works for the vendor





COOLING
OFF

COOLING OFF

- One-year cooling off period to seek or accept employment
 - Vendors of the agency
 - Private regulated business/industry (State Only)
- Private counseling or lobbying former agency

NRS 281A.410 and .550



Relief can be granted

1. Contract awarded exceeded \$25,000;
2. Awarded in the 12-months before you left
3. You could have affected or influenced who was awarded the contract.



RESOLUTION EXAMPLES

Willful

Civil Penalties Up to \$5k, \$10k, or \$25k
Petition to Removal a Public Officer

Non-Willful

Ethics Training
Mandated Apology
Admonishment
Payback Financial Benefit
Conditions on Future Behavior

No Violation

Letter of Caution/Instruction



TIPS AND BEST PRACTICES



1. Maintain a list of individuals or entities to which you have a “commitment in a private capacity”
2. Familiarize yourself on your local/agency policies.
3. Be proactive to identify potential conflicts of interest as early as possible
4. If you are unsure, it is better to disclose than not disclose.
5. Consult with legal counsel who can search prior opinions
6. Request an advisory opinion

ASKING FOR HELP



- Timing
- Fear of being perceived as unethical for asking
- Commission is required to protect confidential information
- Whistleblower protections
- Asking your agency attorney first protects you
- We won't open a complaint if you ask for help
- It benefits others when you request opinion

ETHICS RESOURCES



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CONTACT INFO



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Nevada Commission on Ethics

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Special thanks to Susan Willeke of the Ohio Ethics Commission for media clips



FEEDBACK

8.

8. Presentation on Program Overview. (Debbie Donaldson, Segal)

(For Possible Action)

8.1 GLP-1 Utilization

8.2 Obesity and Weight Management



Nevada Public Employees' Benefits Program

Condition & Program Overview – Obesity & Diabetes

May 21, 2026



| Agenda

Population Overview

GLP-1 Utilization Condition-

Specific Programs Appendix

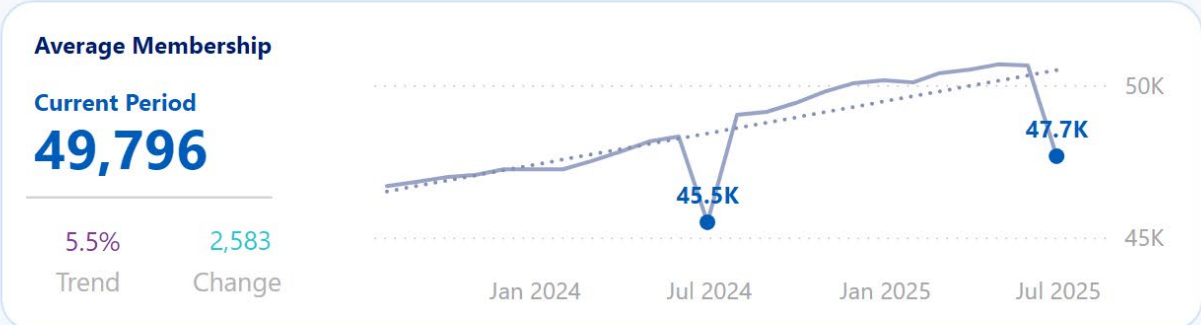
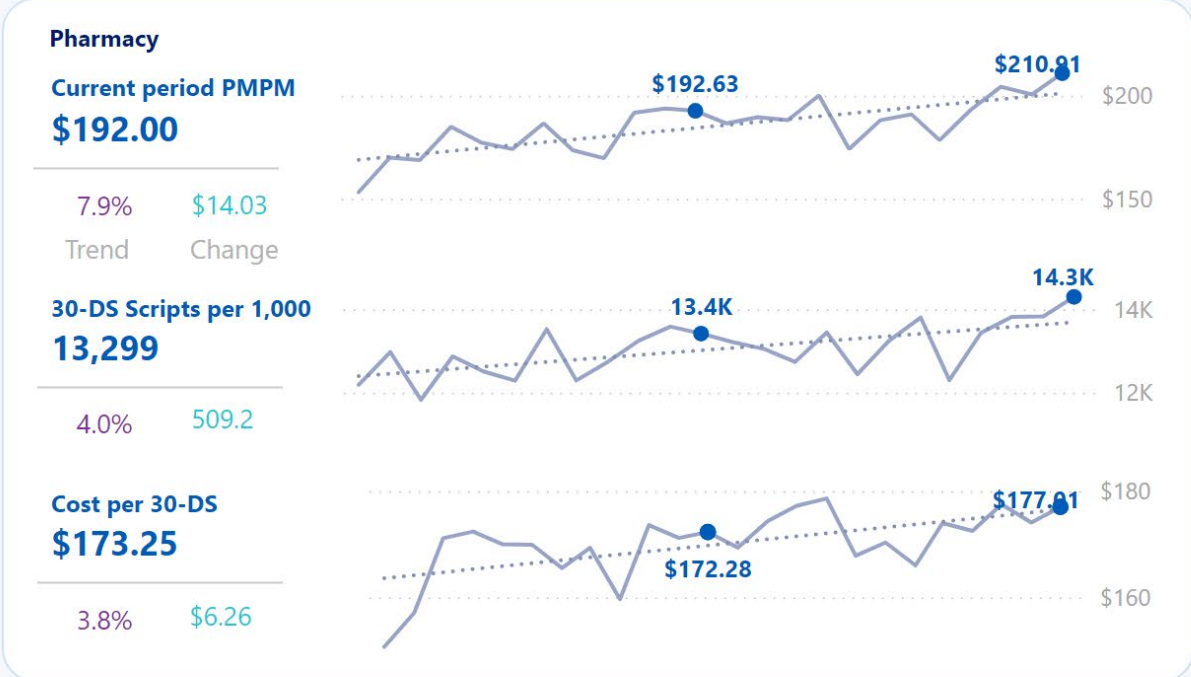
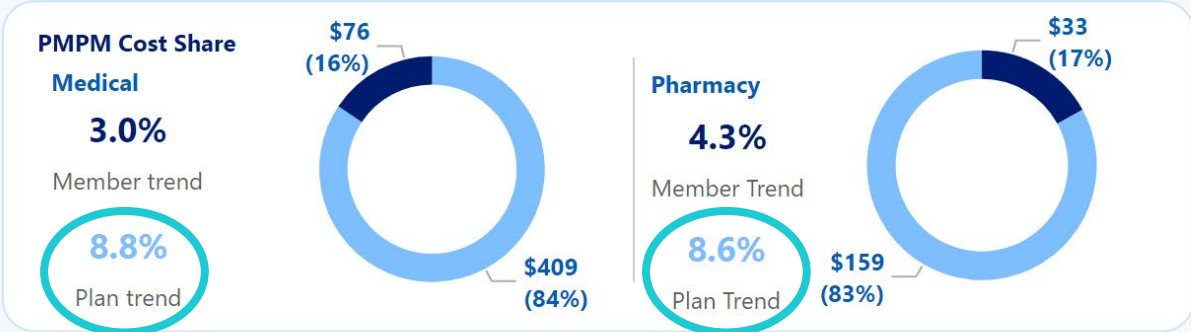
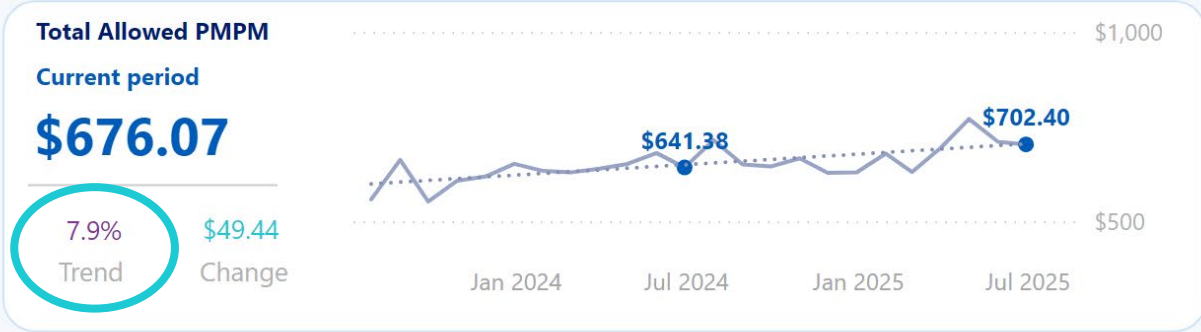
| Population Overview

Analysis Overview

- The following slides provide an overview of PEBP costs and utilization, drivers of trend, chronic conditions, and potential gaps in care
- Segal reviewed medical and pharmacy data provided by PEBP vendors and stored in our Segal Health Analysis of Plan Experience (SHAPE) data warehouse with claims paid through February 28, 2026
 - Current Year: July 1, 2024, through June 30, 2025 (Incurred)
 - Previous Year: July 1, 2023, through June 30, 2024 (Incurred)
- Allowed amounts include both the plan paid portion and member out-of-pocket cost
- Includes active employees and non-Medicare retirees and their dependents
- Benchmarks represent state and other public sector plans
- Detailed reports by plan can be found in the Appendix
 - Self-insured plans included CDHP, LDPPO and EPO

Executive Summary

- Medical trend largely driven by increased outpatient services, followed by professional services
 - Moderate inpatient trend with reductions in inpatient surgery and rehabilitation
 - Offset by a larger increase in outpatient surgery and Emergency Room (ER) visits
 - Opportunity to focus on ER utilization, the largest driver of outpatient trends
- Pharmacy trend driven by increased higher-cost brand and specialty drug utilization
 - Top spend is for diabetic GLP-1s which also represent the highest year over year cost increase
 - Specialty drugs represent 54% of allowed costs but only 2.2% of scripts
 - Trends partially offset by a reduction in Humira utilization due to biosimilar migration
- 53% of the membership with 1+ and 7% having 4+ chronic conditions
- Care Gap Compliance: Opportunity for improvement
 - Cancer, asthma and hyperlipidemia compliance is improving but remains below benchmark
 - Coronary artery disease (CAD) and some diabetes compliance has declined and remains below benchmark



- Note: Member and plan PMPM amounts may not sum to total PMPM figures due to rounding.
- Medical PMPM trend was 7.9% across all plans (actives and retirees), within Segal's benchmark range of 7-10%. Low trend for inpatient costs help to offset larger increases in outpatient and professional services.
- Pharmacy PMPM increased 7.9% to \$192.00, driven by both higher utilization (+4.0% scripts per 1,000) and rising unit costs (+3.8% cost per 30-day supply (DS)), representing a meaningful contribution to overall plan cost growth.

Total Allowed \$
\$289.3M
 13.8%

Allowed PMPM 📅
\$484.07
 7.9%

% Med Utilizers 👥
81.5%
 0.7% pp

% Utilizers - IP 🏠
3.7%
 0.3% pp

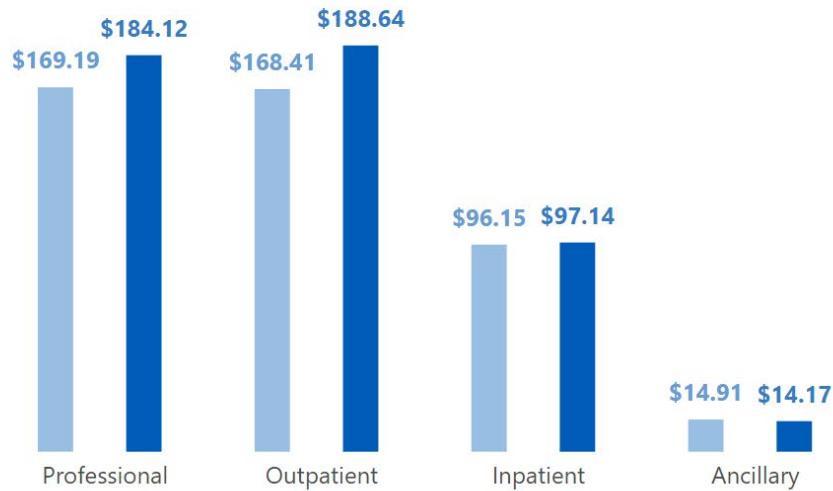
% Utilizers - ER 🏥
11.7%
 0.8% pp

% Utilizers - UC 📶
21.8%
 1.0% pp

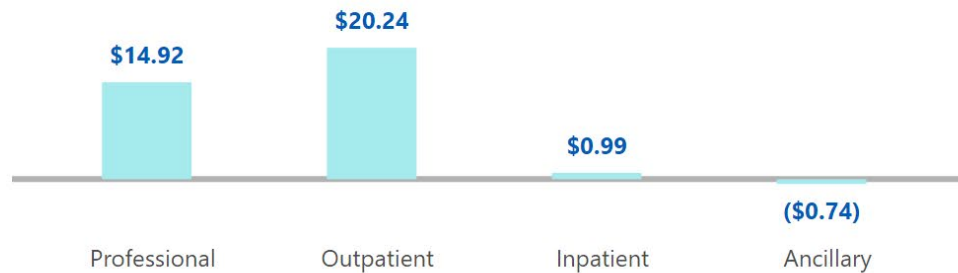
% Utilizers - E&M 👤
73.7%
 1.2% pp

Allowed PMPM by major service category

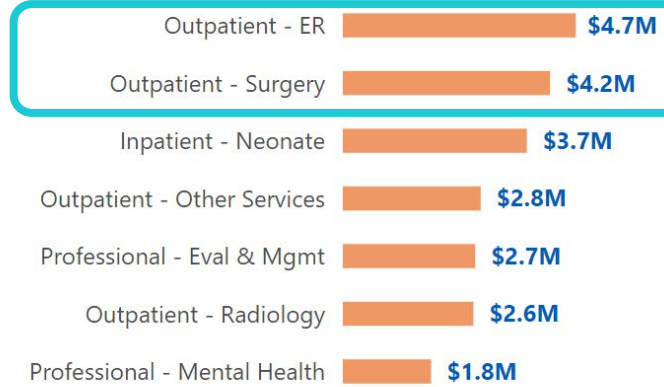
● Prior Period ● Current Period



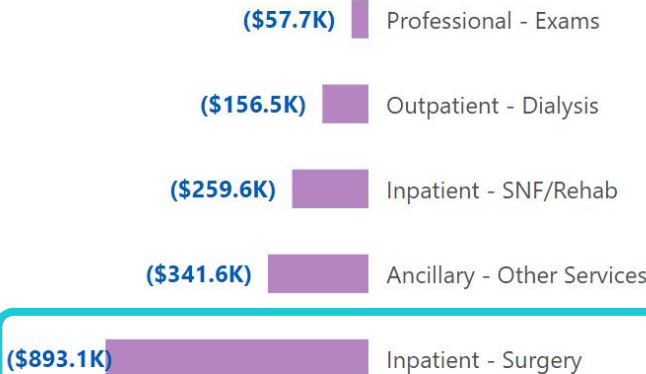
Change



Top 7 spend changes by major + minor service Increases



Decreases



Encounters per 1,000

Subcategory	Current Period	Period Over Period Delta
E&M	3,526	193
Urgent Care	371	17
ER	179	11
Inpatient	52	3

- Medical costs increased across professional, outpatient, and inpatient services. Inpatient costs rose very modestly due to lower surgery and SNF/rehab costs.
- Though inpatient costs held steady, this is largely due to a sharp decrease on the CDHP plan. The LDPPPO plan saw high inpatient trend (31.2%).
- The two major outpatient cost drivers were ER and surgery (particularly for musculoskeletal and heart conditions).
- Higher professional costs for evaluation/management and mental health suggest improved engagement..

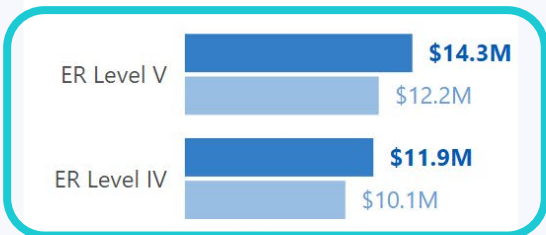
View by **ER**

Other Detail

Total Allowed \$31.9M 17.3%	Allowed PMPM \$53.37 11.2%	Utilizers 6,581 658	Visits per 1,000 179.2 6.7%	Allowed per Visit \$3,573 4.2%	% Total Med Allowed 11.0% 0.3% pp
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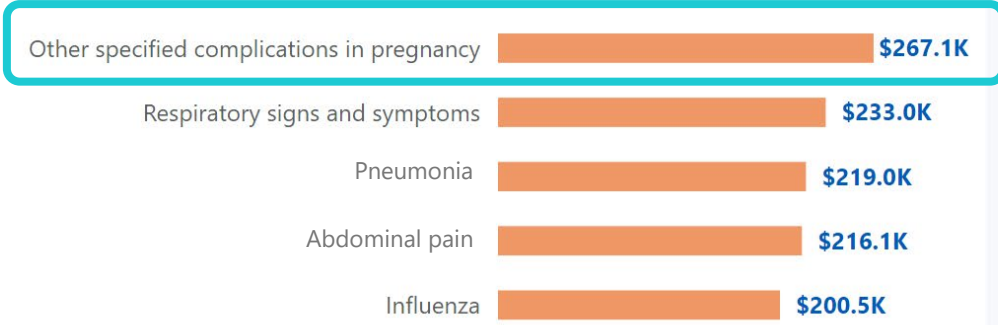
Allowed by service category

● Current Period ● Prior Period

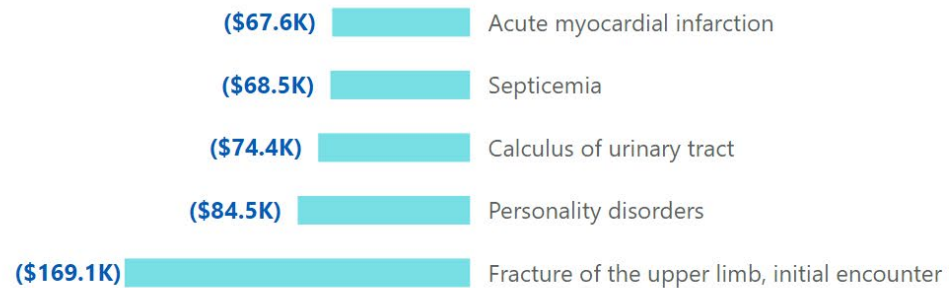


Top 5 spend changes by diagnostic category - Allowed change period over period

Increases



Decreases



Detail by **Rendering Provider - Source**

Rendering Provider - Source	Medical Allowed	Encounters	Allowed Per Encounter
REOWN REGIONAL MED	\$4,486,410.95	1,082	\$4,146.41
CARSON TAHOE REGIONAL HEALTHCA	\$3,616,585.20	1,406	\$2,572.25
HENDERSON HOSPITAL	\$1,908,393.53	472	\$4,043.21
REOWN SOUTH MEADO	\$1,889,209.55	485	\$3,895.28
NORTHERN NV HOSP	\$1,887,407.85	493	\$3,828.41
ST ROSE DOMINICAN	\$1,782,153.21	303	\$5,881.69

- ER costs rose by 11.2% on a PMPM basis, driven more by utilization (+6.7%) than by unit costs (+4.2%).
- Costs rose the most for high-severity ER encounters (levels IV and V), indicating that members are generally reserving ERs for true emergencies.
- There were more ER visits for pregnancy complications, which – though emergent – may indicate gaps in prenatal care access and adherence.

Major Chronic Conditions

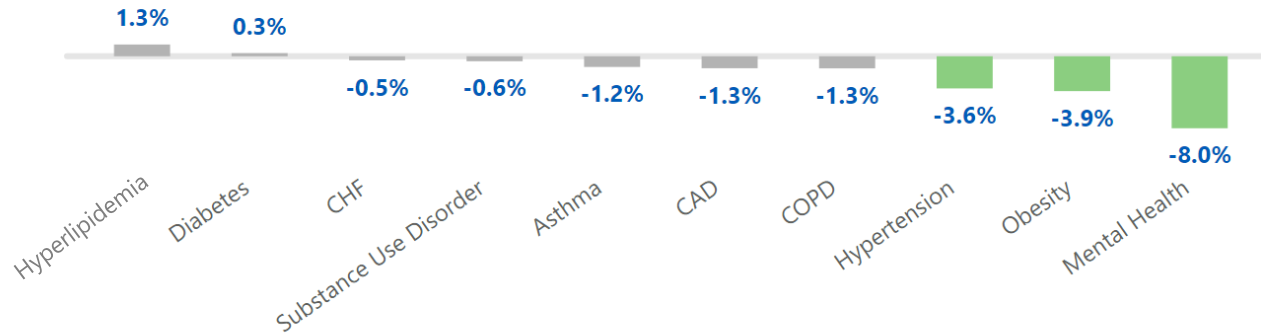
Benchmark Type

Public Sector ▼

Members
25,131
2K

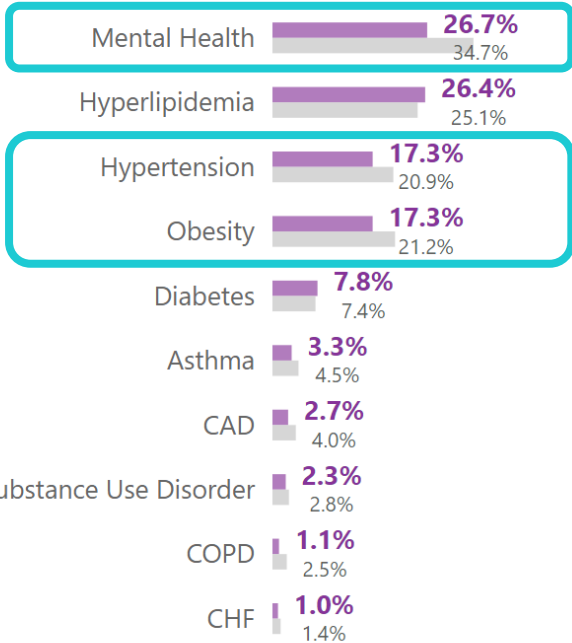
Prevalence
52.7%
1.9% pp

Prevalence Variation from Benchmark



Chronic Conditions Prevalence - hover for age band dist.

● Current Prevalence ● Benchmark



Chronic Condition	Members	Member Change	Prevalence Change	Avg Total Conditions	Med PMPM	Rx PMPM
Mental Health	12,750	1305 ↑	1.6% ↑	2.1	\$796	\$298
Hyperlipidemia	12,585	996 ↑	0.9% ↓	2.6	\$755	\$400
Hypertension	8,256	481 ↑	0.2% ↑	3.0	\$1,010	\$476
Obesity	8,255	772 ↑	0.9% ↑	2.8	\$826	\$362
Diabetes	3,710	387 ↑	0.5% ↑	3.5	\$996	\$773
Asthma	1,581	90 ↑	0.0% ↑	2.8	\$802	\$544
CAD	1,291	135 ↑	0.2% ↑	4.0	\$1,887	\$661
Substance Use Disorder	1,095	119 ↑	0.2% ↑	3.0	\$1,202	\$312
COPD	538	31 ↑	0.0% ↑	3.4	\$1,906	\$936
CHF	454	34 ↑	0.0% ↑	4.5	\$3,035	\$914

- 53% of the population has one or more of the ten conditions listed, though prevalence compares favorably to norms for most conditions.
- Mental health is the most common condition and the fastest-growing. Programs should address mental health as a growing area of clinical risk, especially as it can make managing physical conditions more difficult..

Care Gap Compliance

Benchmark Type Public Sector

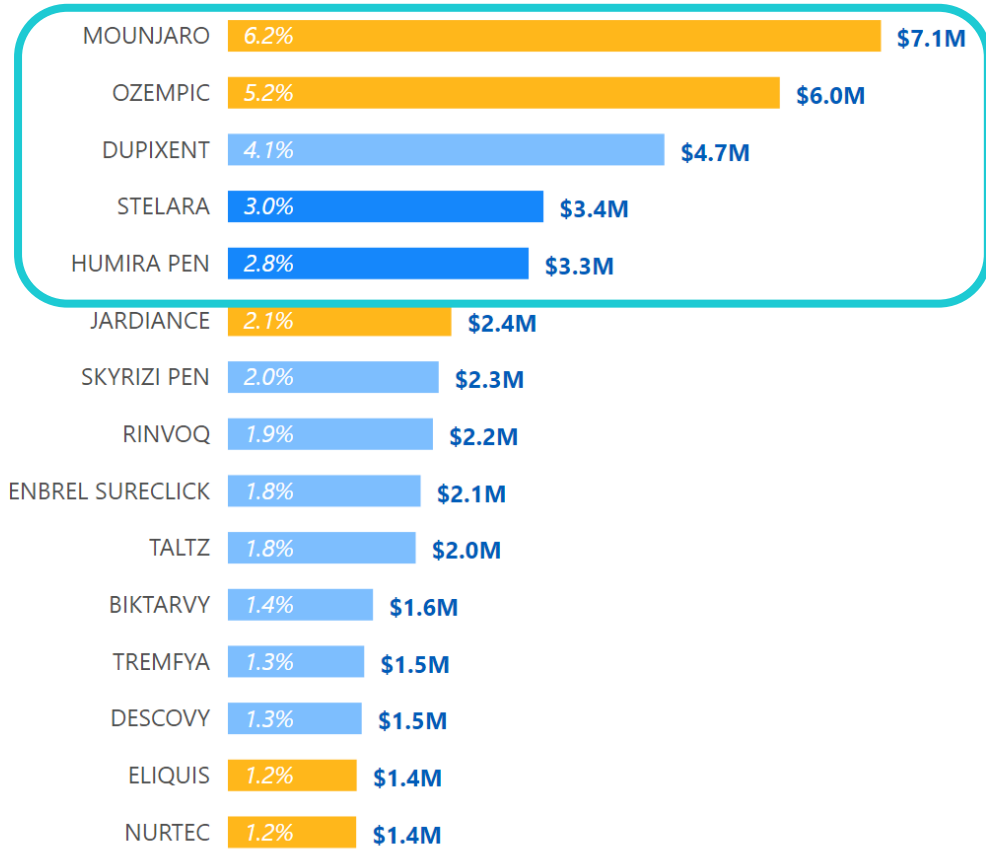
Description	Current	Previous	Change	Benchmark	Variation	
Asthma						
Patient(s) with inhaled corticosteroids or leukotriene inhibitors in the last 12	83.2%	83.0%	0.1% ↑	84.1%	-0.9% ↓	Improving but Not Beating Benchmark
CAD						
Patient(s) currently taking a statin	64.6%	66.2%	-1.6% ↓	69.2%	-4.6% ↓	Declining and Not Beating Benchmark
Patient(s) currently taking an ACE-inhibitor	18.4%	21.5%	-3.2% ↓	21.5%	-3.2% ↓	Declining and Not Beating Benchmark
COPD						
Patients with spirometry testing within the last 12 months	21.7%	22.5%	-0.7% ↓	19.9%	1.9% ↑	Declining but Beating Benchmark
Diabetes						
Patient(s) that had an annual screening test for diabetic nephropathy	63.0%	62.1%	0.9% ↑	63.6%	-0.6% ↓	Improving but Not Beating Benchmark
Patient(s) that had an annual screening test for diabetic retinopathy	29.5%	32.0%	-2.5% ↓	33.5%	-4.0% ↓	Declining and Not Beating Benchmark
Patient(s) that had at least 1 hemoglobin A1C tests in last 12 reported months	85.8%	83.2%	2.6% ↑	84.4%	1.4% ↑	Improving and Beating Benchmark
Hyperlipidemia						
Patient(s) with a LDL cholesterol test in last 12 reported months	76.5%	76.2%	0.3% ↑	77.7%	-1.2% ↓	Improving but Not Beating Benchmark
Preventive Screening						
Breast Cancer	64.3%	61.4%	2.8% ↑	71.8%	-7.5% ↓	Improving but Not Beating Benchmark
Cervical Cancer	53.3%	51.8%	1.5% ↑	60.1%	-6.8% ↓	Improving but Not Beating Benchmark
Colorectal Cancer	50.3%	45.6%	4.6% ↑	56.9%	-6.6% ↓	Improving but Not Beating Benchmark
Prostate Cancer	48.0%	45.8%	2.2% ↑	56.0%	-8.0% ↓	Improving but Not Beating Benchmark

- Only two out of twelve care quality metrics are above the public sector norm, though most are improving, which is an encouraging trend.
- Special attention should be paid to continuing to boost cancer screening rates, which have risen in the past year but still lag the benchmark.

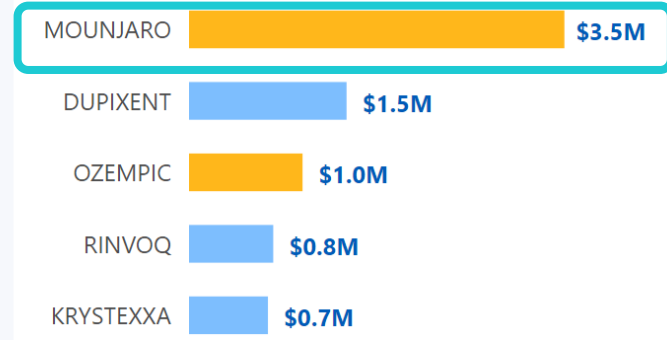
Total Allowed \$114.7M 13.8%	30-DS Rx per 1,000 13,299 4.0%	Allowed PMPM \$192.00 7.9%	Cost per 30-DS \$173.25 3.8%	Generic Fill Rate 87.0% 0.5% pp	Utilizers 38,193 1,775	% Utilizing Rx 67.6% 0.7% pp
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Top 15 Drugs - Pharmacy Allowed (% of Total Pharmacy Allowed) *

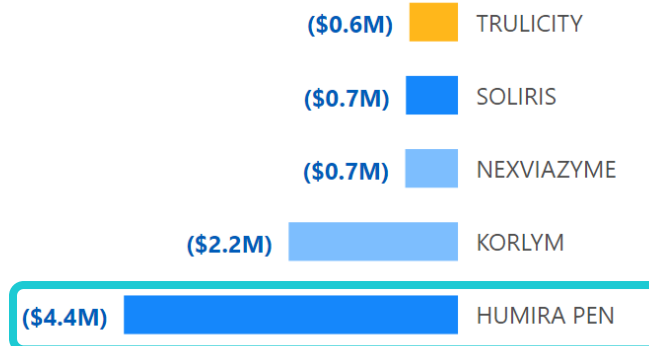
● NS ● S ● S - Bio Available



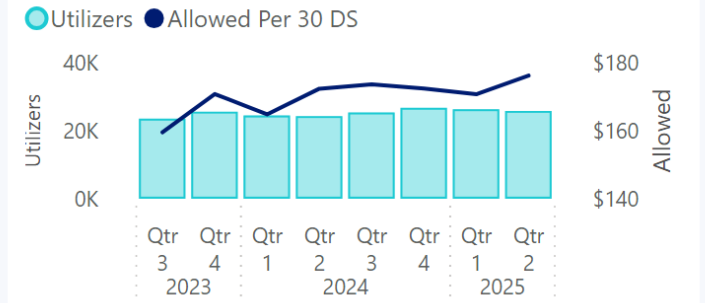
Top 5 spend changes by drug - Allowed change Increases



Decreases



Cost vs. Utilization



- Pharmacy costs increased meaningfully, with PMPM rising 7.9% and utilization growing 4.0% on a scripts per 1,000 basis, with the LDPPO and CDHP showing the strongest growth and the EPO trending more moderately.
- GLP-1s and specialty drugs remained the primary cost drivers, with Mounjaro (+\$3.5M), Dupixent (+\$1.5M), and Ozempic (+\$1.0M) leading spend increases across all plans combined.
- Humira costs fell sharply by \$4.4M, though it remains the fifth-costliest drug, indicating biosimilar savings. Biosimilars are a continued area of opportunity for savings. Stelara, a similar autoimmune product for which biosimilars are newly available, was the fourth-costliest at \$3.4M.

Total Allowed \$93.8M 11.7%	30-DS RX per 1,000 3,029 7.0%	Allowed PMPM \$156.90 5.9%	Cost per 30-DS \$621.62 -1.0%	Generic Fill Rate 55.7% -0.7% pp	Utilizers 22,734 1K	% Total Rx Cost 81.7% -1.5%
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Rank	Disease Indication	Previous Rank	Rank Change	Current Rx PMPM	PMPM Change	Current Utilizers	Utilizer Change	% Total Rx	Generic Fill Rate
1	Diabetes	1	0	\$36.53	\$1.15 ↑	4,158	439 ↑	19.0%	46.8%
2	Autoimmune Disease	2	0	\$22.82	(\$4.33) ↓	422	21 ↑	11.9%	19.1%
3	Psoriasis	3	0	\$18.84	\$3.02 ↑	229	36 ↑	9.8%	9.6%
4	Oncology	4	0	\$13.53	\$0.83 ↑	682	71 ↑	7.0%	84.8%
5	Skin Disorders	5	0	\$10.43	\$2.72 ↑	5,673	624 ↑	5.4%	85.4%
6	Viral Infections/HIV AIDS	7	1 ↑	\$7.84	\$1.50 ↑	290	63 ↑	4.1%	29.8%
7	Asthma/COPD	6	-1 ↓	\$7.60	\$0.53 ↑	6,078	553 ↑	4.0%	85.1%
8	Vaccines/Immunizing Agents	8	0	\$6.50	\$0.47 ↑	9,556	-561 ↓	3.4%	0.0%
9	Migraine	11	2 ↑	\$5.91	\$0.93 ↑	1,341	120 ↑	3.1%	51.1%
10	Multiple Sclerosis/Neuromuscular Disorders	12	2 ↑	\$5.90	\$0.99 ↑	50	1 ↑	3.1%	32.1%
11	Rare Disorders	9	-2 ↓	\$5.78	(\$0.14) ↓	156	37 ↑	3.0%	74.4%
12	Blood Disorders	10	-2 ↓	\$5.46	(\$0.03) ↓	1,019	114 ↑	2.8%	41.2%
13	ADHD/Narcolepsy	13	0	\$3.88	\$0.09 ↑	2,206	341 ↑	2.0%	93.1%
14	Mental Health/Neurological Disorders	16	2 ↑	\$3.00	\$0.79 ↑	1,151	91 ↑	1.6%	86.0%
15	Diabetic Supplies/Monitoring	14	-1 ↓	\$2.88	\$0.24 ↑	852	67 ↑	1.5%	0.0%

- These fifteen disease indications accounted for 81.7% of total Rx costs. The top five indications are unchanged, led by diabetes and autoimmune disease at \$36.53 and \$22.82, respectively, though autoimmune disease costs did fall due to less spend on Humira.
- Meanwhile, psoriasis PMPM rose due to greater Dupixent spend. This category should be closely monitored to ensure that utilization is well managed and that lower-cost alternatives are in use wherever possible. Stelara (which can treat psoriasis) currently has the largest potential for biosimilar migration.

Observations by Plan

- LDPPO experienced the most significant cost growth of all plans, with total allowed PMPM rising 12.6% to \$699.84
 - Driven by broad-based medical trend, particularly inpatient surgery, ER, and neonatal services
 - Saw both higher utilization and a meaningful membership influx (+21.8%) introducing younger cohorts that may shift costs due to a different demographic risk
- EPO carries the highest per-member cost burden at \$1,055.71 PMPM
 - Driven by the highest chronic condition prevalence (65.2%) and an aging and declining (-10.1%) membership base
 - Medical costs rose 8.0% PMPM despite a drop in overall allowed costs
- CDHP demonstrated the most stable cost experience (+3.5% total allowed PMPM)
 - Inpatient costs declined materially (-20.6%), partially offset by outpatient cost pressure
 - Ongoing membership decline (-4.5%) warrants monitoring as it may mask underlying per-member cost acceleration
- Non-Medicare PMPM costs are nearly 70% higher than for Actives; however, they make up only 9% of self-funded population

| GLP-1 Utilization

GLP-1 Overview

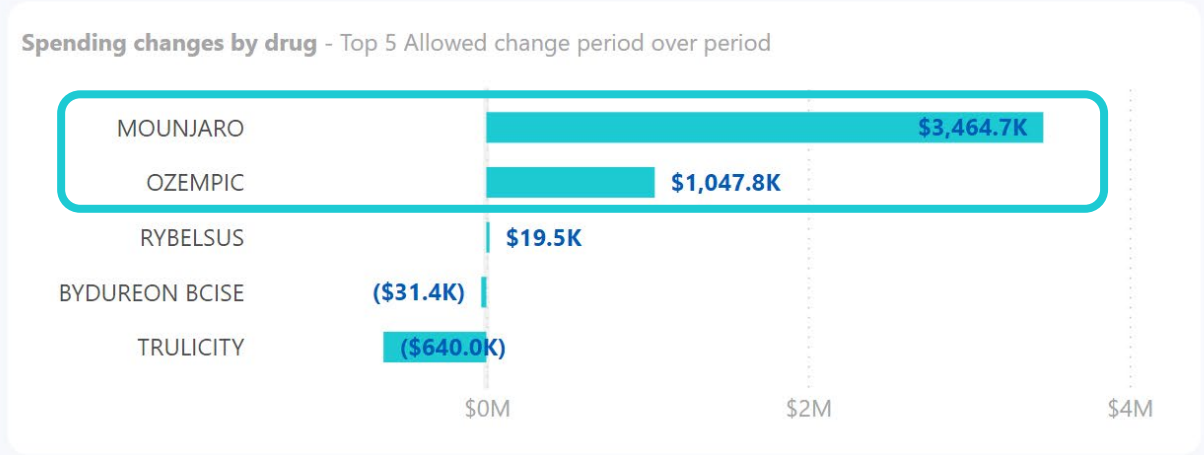
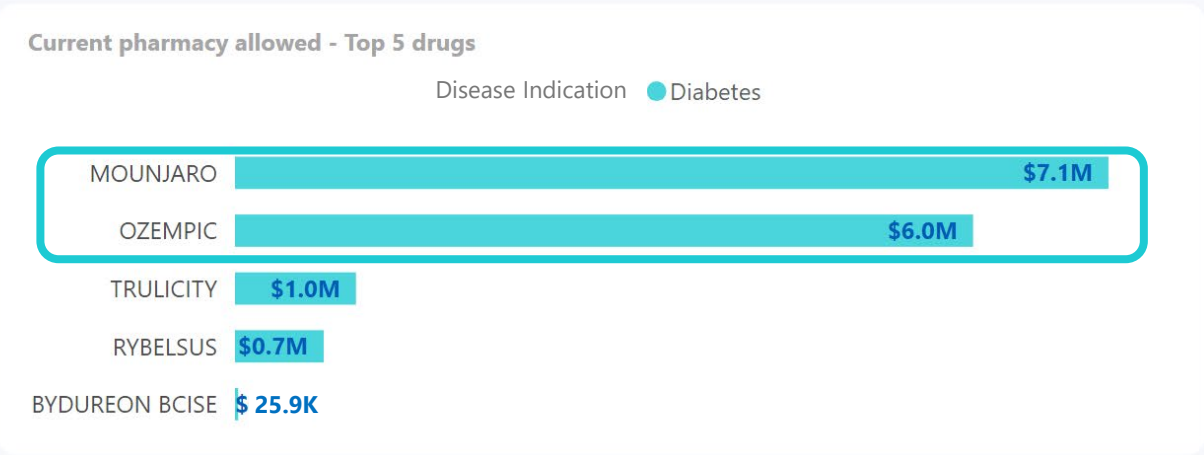
- GLP-1s have been on the market since the early 2000's
 - Used for the treatment of diabetes and obesity
 - Utilization increased significantly mid-2022 with the popularity of Ozempic
- \$3.8M cost increase for GLP-1s (\$11M in PY2024 compared to \$14.8M in PY2025)
 - 18% increase in utilizers in PY2025 from PY2024
 - 52% of GLP-1 utilizers enrolled in the LDPPO Plan; 33% in the CDHP Plan, 15% in the EPO Plan
 - Off-label use (GLP-1 utilization by members without a diabetes diagnosis) seems controlled with under 4% of all users

40% (1,798 members)
of enrolled PEBP diabetic
members utilize GLP-1's



\$14.8M
GLP-1 spend in
PY2025

Total Allowed \$14.8M 34.8%	30-DS RX per 1,000 303 21.6%	Allowed PMPM \$24.83 27.8%	Cost per 30-DS \$982.64 5.2%	Generic Fill Rate 0.1% 0.1% pp	Utilizers 1,798 273
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- Though GLP-1s continue to exert significant cost pressure, the rate of cost increases may be moderating. Between fiscal years 2023 and 2024, utilization rose 26.1%, compared to 21.6% between fiscal years 2024 and 2025.
- About 40% of diabetics currently enrolled use GLP-1s, with similar rates across plans. Potential off-label use by non-diabetics is well controlled at under 4% of all users.

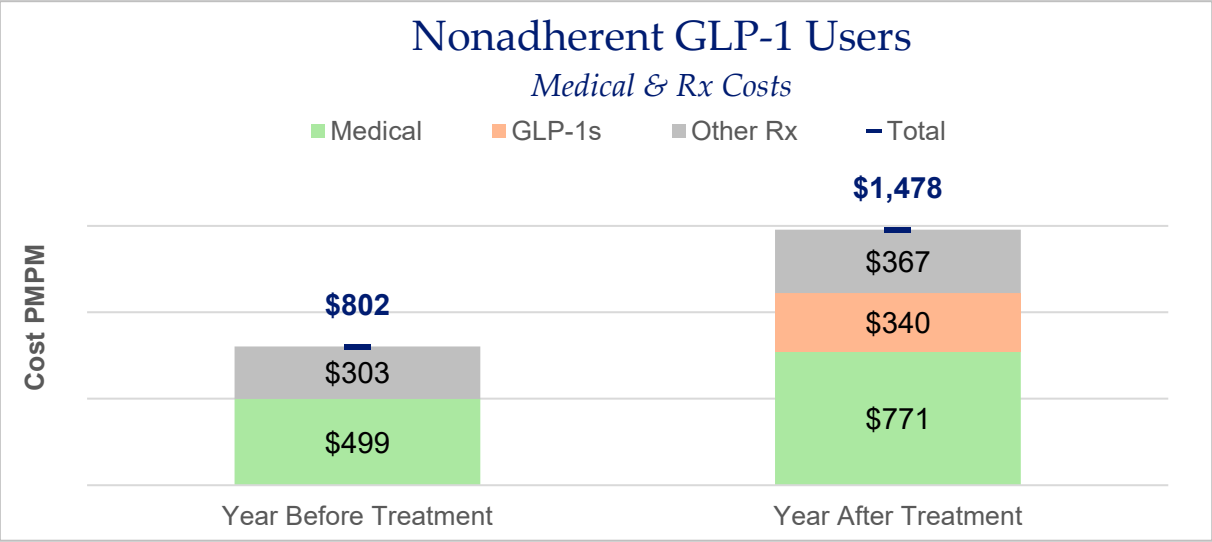
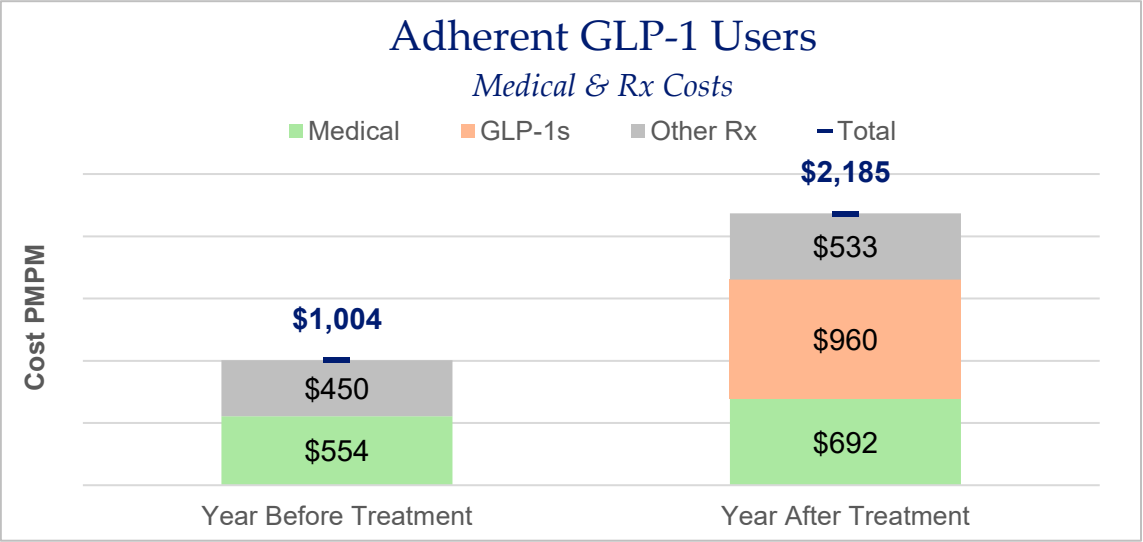
GLP-1 Adherence Results*

- Adherence* for GLP-1 medications is approximately 50-60% over all plans
 - Members who were not adherent in the first year of therapy exhibited nearly a 30-percentage point increase in medical costs*
 - Adherent GLP-1 users exhibited reduction in emergency room and urgent care spend
 - It is typical to have higher professional costs in the first year taking GLP-1s given additional engagement with PCPs, endocrinologists, etc.
- While GLP-1s have some clinical benefit and medical cost saving after 24 months, to date, there has not been enough medical expense savings to offset the high cost of GLP-1 medications

*Analyzed members who initiated GLP-1 usage in CY2023-CY2024 using medical claims paid through March 2026. Adherence defined as members that filled scripts to cover at least 80% of days in a year.



Cost Impact – Adherent vs. Non-Adherent



Adherent Observations

- Adherent GLP-1 users (n = 750) experienced a **9.8% reduction in outpatient costs**, reflecting declines in spend for emergency room (\$63 vs. \$34 PMPM) and urgent care (\$8 vs. \$6 PMPM) but an increase in professional costs including evaluation and labs (\$192 vs. \$243 PMPM).
- Total medical costs for adherent members increased from **\$554 PMPM** at baseline (12 months pre-initiation) to **\$692 PMPM** in the first year of therapy (i.e., measurement), **representing a 25% increase**.
- Total cost of care (medical and drug, gross rebates) increased by **118%**, primarily driven by the **high cost of GLP-1s which contributed an additional \$960 PMPM**.

Non-Adherent Observations

- Nonadherent (n = 618) members experienced **increased medical costs across inpatient, outpatient, and professional settings**.
- Overall had **22% higher inpatient costs** after treatment compared to adherent users (\$252 vs. \$206 for adherent PMPM).
- Outpatient cost increases were driven by **63% higher emergency room** spend (\$94 vs. \$153 PMPM) and **73% higher surgery** (\$36 vs. \$61 PMPM).
- Overall medical costs for nonadherent GLP-1 users rose from **\$499 PMPM** at baseline (12 months pre-initiation) to **\$771 PMPM** in the first year of therapy (i.e., measurement), reflecting a **54% increase**.
- Total cost of care (medical and drug, gross of rebates) increased by **84%** in the first year of therapy initiation, which **included GLP-1 cost of \$340 PMPM**.

| Condition-Specific Programs

Overview of Programs

- **Diabetes Care Management (DCM)**

- Eligible: CDHP participants and covered dependents; must meet BMI eligibility requirement
- Description: Voluntary “opt-in” program that provides, but it not limited to, the ability to purchase diabetes related medications, such as insulin, at a copy and not be subject to deductible or coinsurance

- **Obesity Care Management (OCM)**

- Eligible: CDHP, LDPPO, and EPO participants and covered dependents
- Description: Voluntary “opt-in” program that provides, but is not limited to, medically supervised weight loss program, nutritional counseling, weight-loss medications

- **Real Appeal**

- Eligible: CDHP, LDPPO, EPO and HMO participants and covered dependents; must meet BMI eligibility requirement
- Description: Online weight management program focused on building healthier habits; offers virtual group sessions, fitness, food and weight trackers and food and weight scales

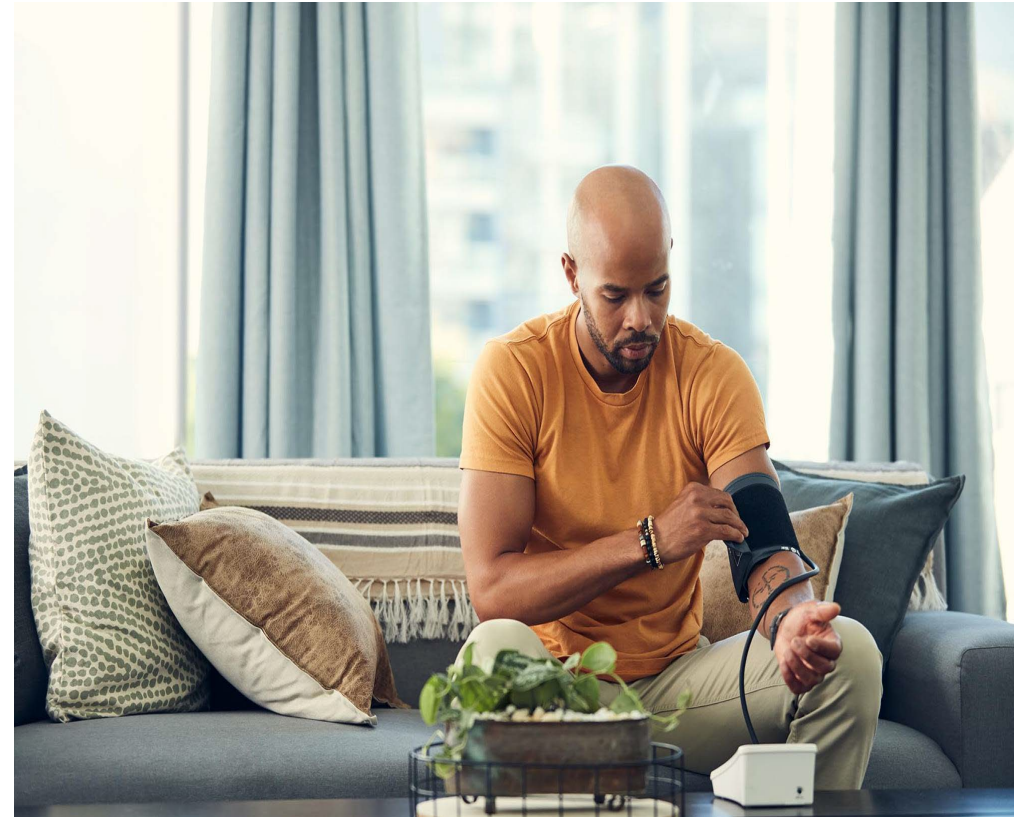
- **Nevada Business Group on Health Pilot Program (NVBGH)**

- Eligible: PEBP participants identified as Type 2 diabetic or Pre-Diabetic
- Description: Lifestyle change pilot program focused offered to Type 2 diabetics and Pre-Diabetic; in person and virtual options

* Disease Management Program available to HMO participants not evaluated due to lack of data availability.

Summary of Programs

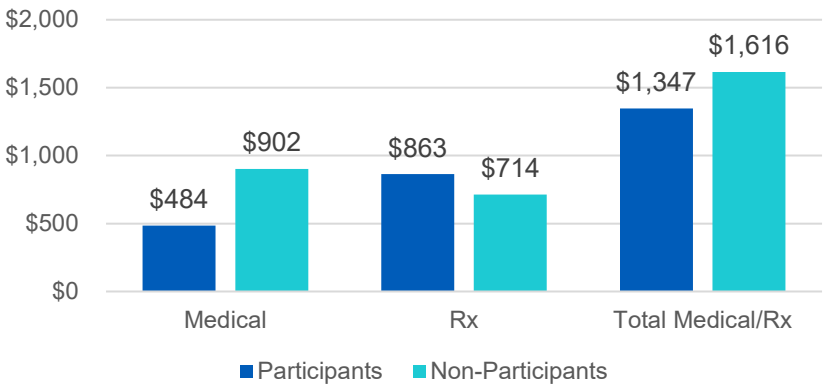
- Low engagement across all programs evaluated
- Of those participating:
 - Average of 2-3 chronic conditions
 - Lower inpatient admissions & emergency room utilization
 - Increased utilization on lower-level care settings such as physical exams and urgent care



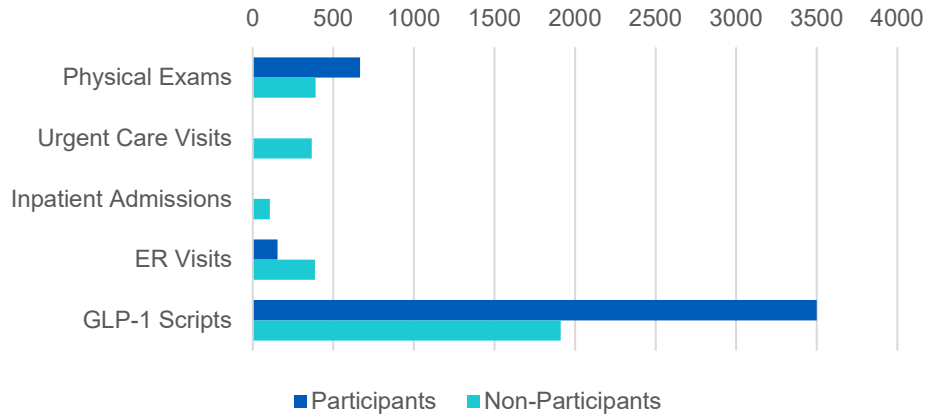
Overall, the industry is moving towards whole-person health versus programs specific to certain conditions

Diabetes Care Management Program*

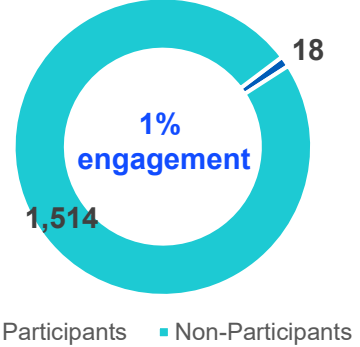
Cost Differential
Allowed PMPM



Utilization Per 1,000



Participation



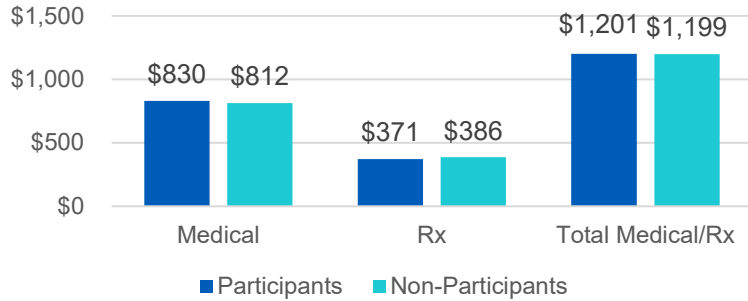
Metric*	Participants	Non-Participants
Avg. Total Risk Score	11.0	13.9
Avg, # Conditions	2.9	3.5
A1 Screening	100%	85%
Retinopathy Screening	72%	64%
Nephropathy Screening	28%	24%
LDL Cholesterol Screening	100%	79%

*Based on medical and Rx claims incurred in CY2025 and paid through February 2026. Given small participation size, results are not credible and could vary significantly year to year.

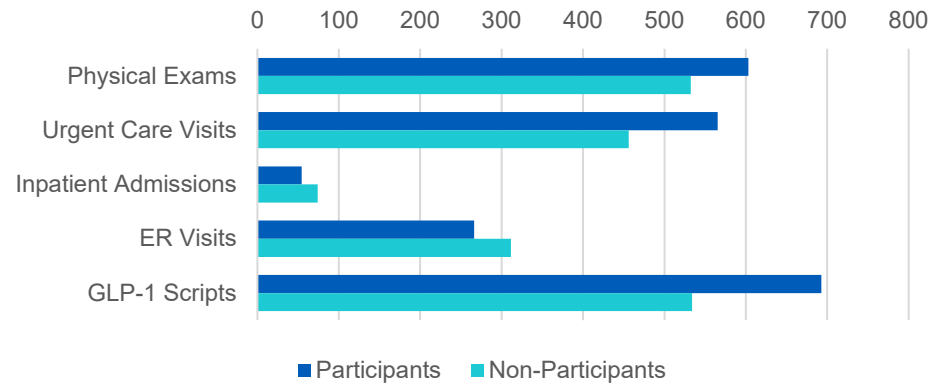
- Program developed by PEBP and offered only to CDHP participants
 - Included as a part of the base administrative fee
 - Low engagement
 - Those who participate are doing so largely to access medications prior to meeting CDHP deductible
- For the small sample of participants:
 - Medical costs for Program participants are lower, and Rx costs are higher than for non-participants
- Additional opportunity to communicate program to those on CDHP to lower member out-of-pocket costs and potentially better manage conditions

Obesity Care Management Program*

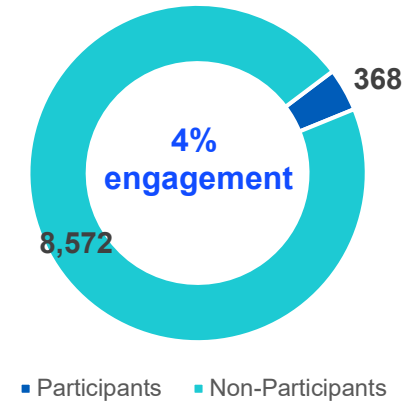
Cost Differential
Allowed PMPM



Utilization Per 1,000



Participation



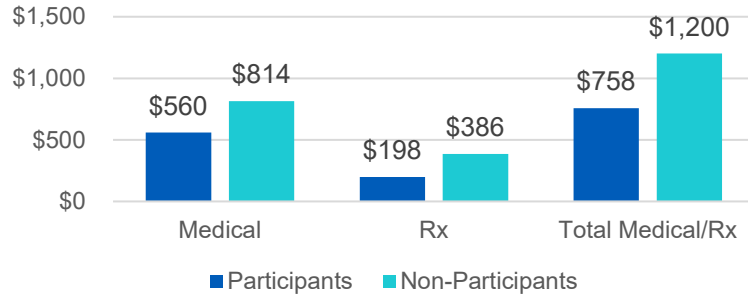
Metric*	Participants	Non-Participants
Avg. Total Risk Score	13.2	12.0
Avg, # Conditions	2.0	1.8
Diabetics		
A1c Screening	85%	87%
Retinopathy Screening	38%	65%
Nephropathy Screening	23%	30%
Hyperlipidemia		
Total Cholesterol	87%	80%
Hypertension		
Annual Physical	100%	97%

- Program was developed by PEBP and included in base administrative fee
- Higher participation than the other programs evaluated, but still low engagement (4%)
- Engaged members have higher risk scores and average more conditions, but overall costs are similar between participants and non-participants
 - Less inpatient admissions and ER visits and more spend for lower cost settings such as physical exams and urgent care visits
- Opportunity to improve compliance rates for participants for certain types of screenings such as A1c, retinopathy, and nephropathy

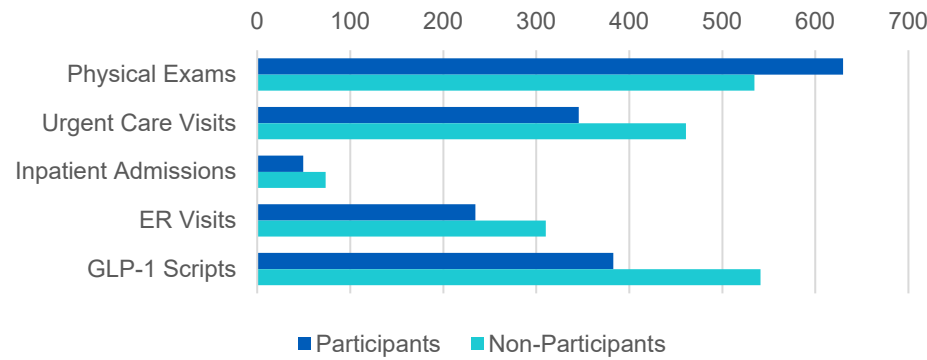
*Based on medical and Rx claims incurred in CY2025 and paid through February 2026. Given small participation size, results are not credible and could vary significantly year to year.

Real Appeal

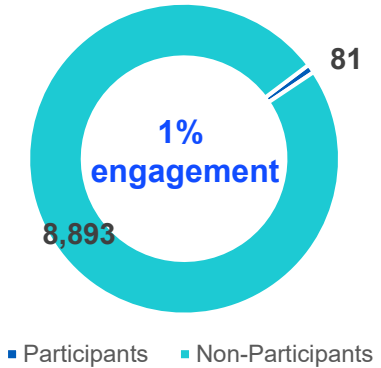
Cost Differential
Allowed PMPM



Utilization Per 1,000



Participation



Metric	Participants	Non-Participants
Avg. Total Risk Score	11.7	12.0
Avg. # Conditions	2.0	2.8
Diabetics		
A1 Screening	94%	87%
Retinopathy Screening	59%	63%
Nephropathy Screening	24%	29%
Hyperlipidemia		
LDL Cholesterol Screening	94%	81%
Total Cholesterol	83%	81%
Hypertension		
Annual Physical	100%	97%

- No administrative fee but charges flow through medical claims
 - Average claim cost is \$799 per 52-week program, which includes one-time fee when participant completes the assessment and registers for the program
 - Max of 12 sessions are submitted but member can attend unlimited sessions - only charged for a session if member is on track for 5% weight loss
- Engagement represents a small portion (1%) of those who are eligible
- Engaged members have lower inpatient admissions, ER and urgent care visits and GLP-1 scripts
- Higher compliance with certain diagnostic screenings

*Based on medical and Rx claims incurred in CY2025 and paid through February 2026. Given small participation size, results are not credible and could vary significantly year to year.

Nevada Business Group on Health

- Pilot program offered at no cost to PEBP
- National Diabetes Prevention Program
 - Evidence-based lifestyle change program for preventing Type 2 diabetes
 - Year-long program; weekly sessions for 6-months and shift to monthly
 - Meet with trained lifestyle coach and small group of others making lifestyle changes
- Diabetes Self-Management Education and Support Programs
 - Evidence-based educational program to reduce symptoms and improve quality of life
 - 6-week group program for those with Type 2 diabetes with 2.5 hour weekly sessions
- Locations
 - Sanford Center for Aging
 - Offers virtual or in-person sessions in Reno / Sparks area
 - 44 participants; however, unable to match reliably to claims data
 - Dignity Health St. Rose Dominican
 - Offers virtual or in-person sessions in Las Vegas / Henderson Valley area
 - Participation data not tracked

Thank You

Disclaimers

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- The projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, changes in medical innovation/FDA approvals, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases.

| Appendix

| Reporting by Plan

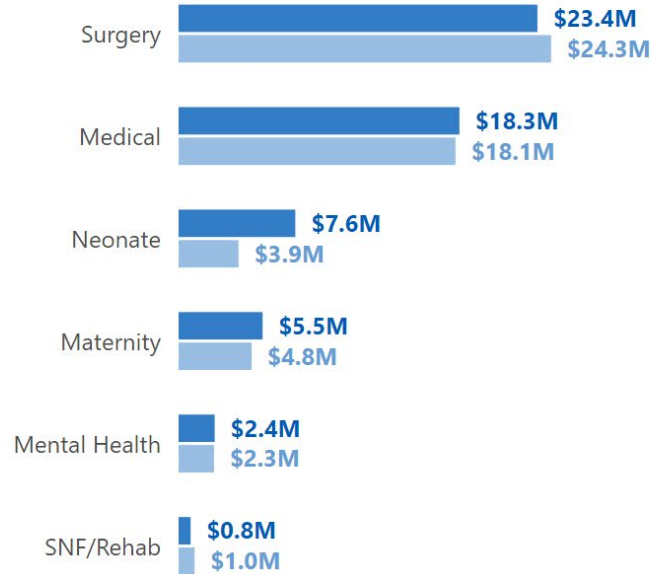
1. **All Enrollees – Actives and Non-Medicare**
2. LDPPO Plan – Actives and Non-Medicare
3. CDHP Plan – Actives and Non-Medicare
4. EPO Plan – Actives and Non-Medicare

Data was reviewed for reasonableness but not audited for accuracy



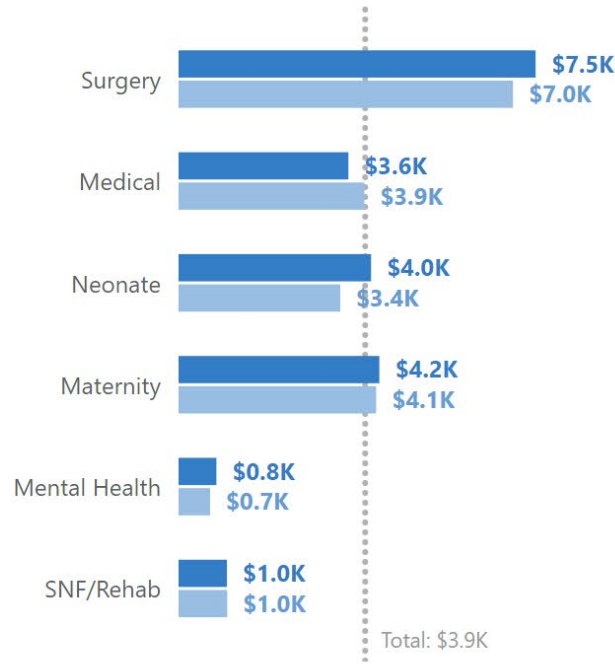
Allowed by service category

● Current Period ● Prior Period



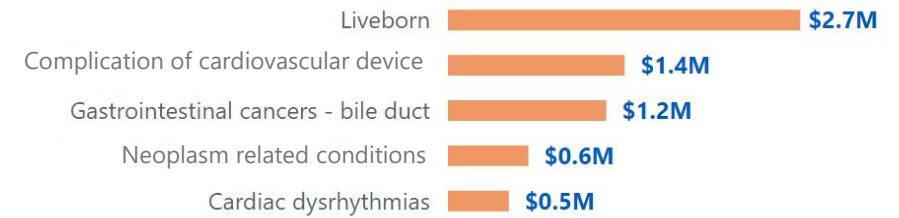
Average Allowed Per Day

● Current Period ● Prior Period

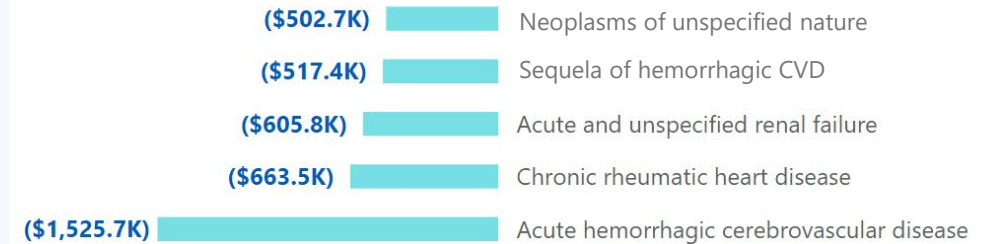


Top 5 spend changes by diagnostic category

Increases



Decreases



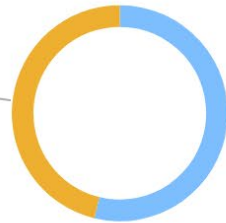
- Though generally stable across all enrollees, inpatient costs rose for neonatal and maternity services, where costs climbed by 94.9% and 14.6%, respectively.
- Average allowed costs for maternity services were stable, indicating that increased costs here were due to generally higher rates of pregnancy and childbirth this year, which is supported by the large increase in liveborn claims (+\$2.7 million).
- However, the increase in neonatal claims was driven primarily by episode severity and a higher cost per encounter (\$34,655, up 47.8%). Some neonatal cases were due to standard single and multiple births, but there were some large claims for serious complications (e.g., bacterial sepsis, respiratory issues).

Current Pharmacy Allowed

Specialty allowed trend

9.0%

\$53.0M (46.2%)



\$61.7M (53.8%)

Non-specialty allowed trend

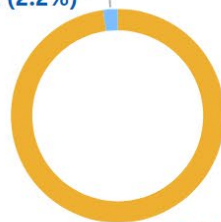
20.0%

Prescriptions

Specialty scripts trend

17.9%

10.8K (2.2%)



485.2K (97.8%)

Non-specialty script trend

9.4%

Average Cost per 30 day supply

Specialty average cost trend

-8.6%

\$5,279.51

Specialty
Non-Specialty

\$81.50

Non-specialty average cost trend

9.5%

Allowed PMPM Trends

Specialty allowed PMPM

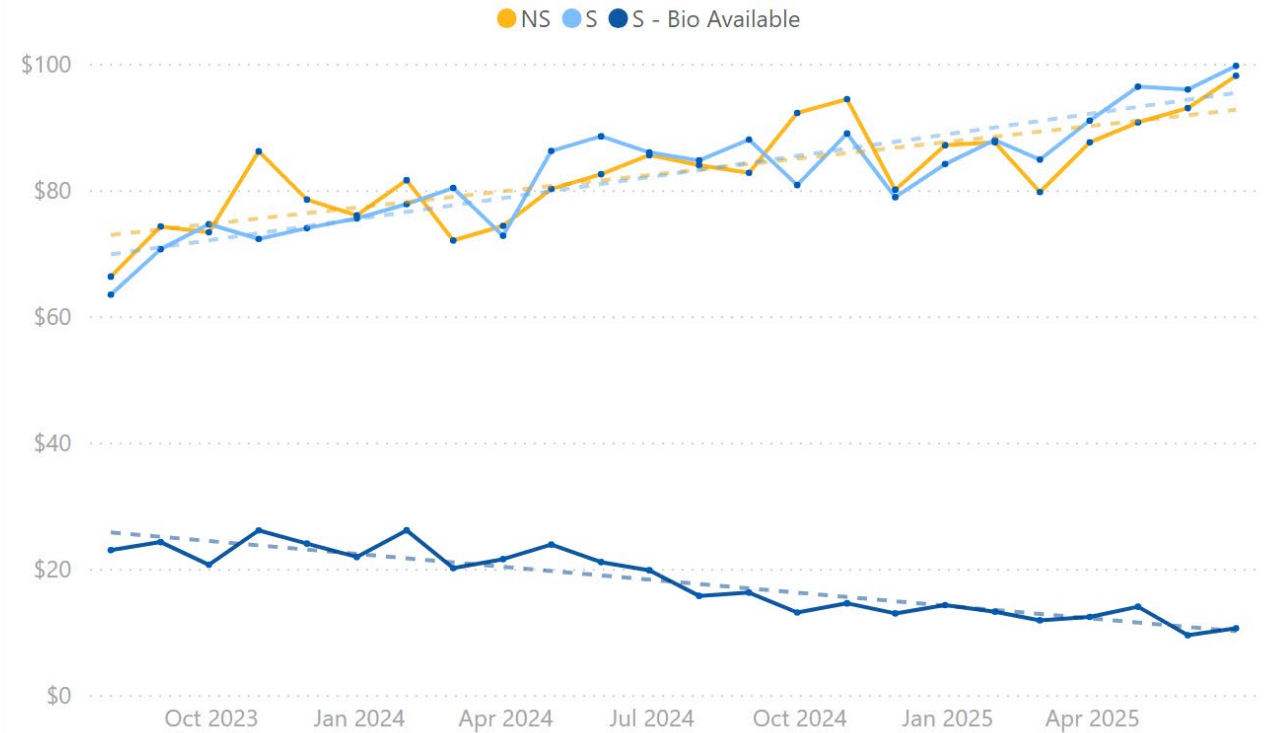
\$103.27

3.3%

Non-specialty allowed PMPM

\$88.73

13.7%

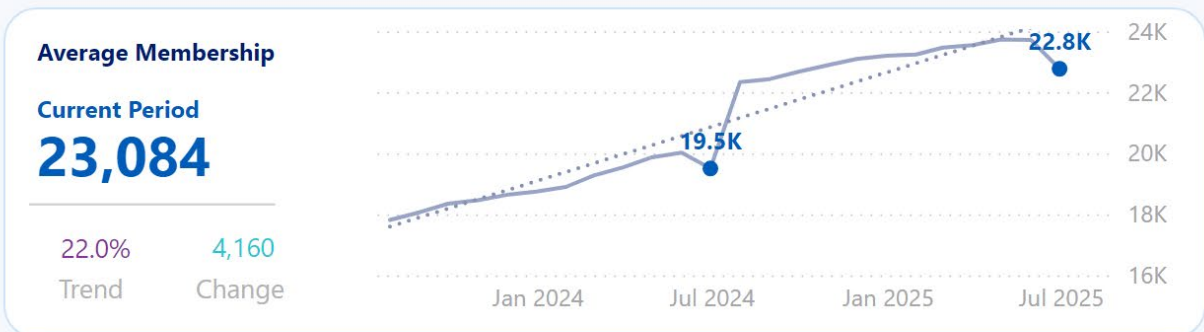
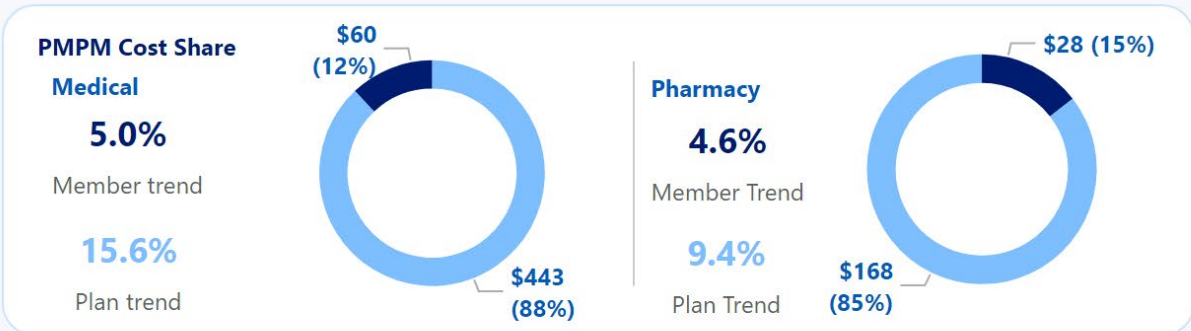


- Pharmacy cost trend was pronounced across both specialty and non-specialty products, with non-specialty PMPM increasing 13.7% and specialty PMPM rising 3.3%. Note that specialty indicators are based on a list maintained by Segal, which may not align exactly with that of ESI or other vendors.
- Specialty average cost per 30-day supply declined 8.6% to \$5,279.51 despite higher script volume, suggesting favorable drug mix is helping to contain unit cost increases — though with biosimilars available for high-cost agents like Humira and Stelara, further savings opportunities remain.

| Reporting by Plan

1. All Enrollees – Actives and Non-Medicare
- 2. LDPPPO Plan – Actives and Non-Medicare**
3. CDHP Plan – Actives and Non-Medicare
4. EPO Plan – Actives and Non-Medicare

Data was reviewed for reasonableness but not audited for accuracy



- Note: Member and plan PMPM amounts may not sum to total PMPM figures due to rounding.
- Allowed PMPM increased 12.6% (+\$78.28) to \$699.84, driven primarily by medical cost growth (+14.2%), and by pharmacy's increase of 8.7%.
- Medical allowed PMPM rose 14.2% to \$503.70, with increases observed across all major service categories, driven by inpatient and outpatient services.
- Pharmacy PMPM increased 8.7% to \$196.14, driven by both higher utilization and rising unit costs, contributing meaningfully to overall plan cost growth.

Total Allowed \$
\$139.5M
 39.3%

Allowed PMPM 📅
\$503.70
 14.2%

% Med Utilizers 👥
86.3%
 1.0% pp

% Utilizers - IP 🏠
4.0%
 0.6% pp

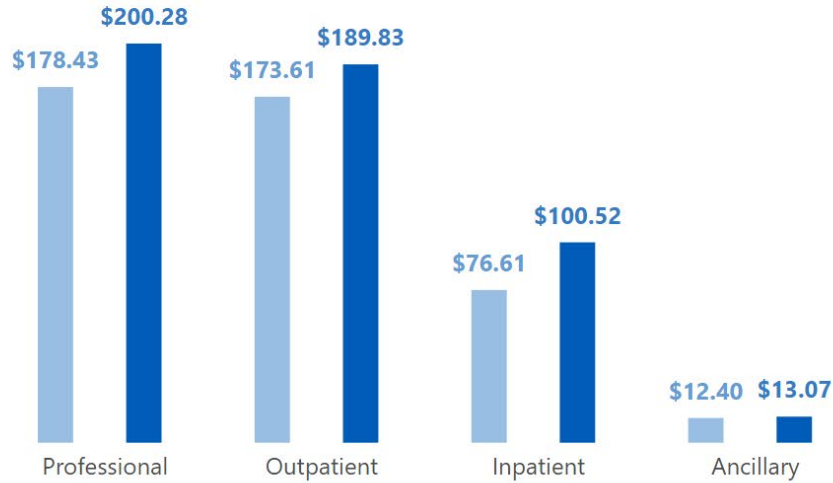
% Utilizers - ER 🏥
11.8%
 1.1% pp

% Utilizers - UC 📈
23.2%
 0.9% pp

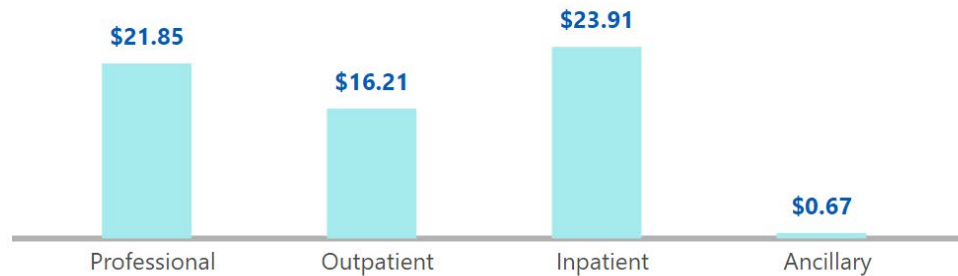
% Utilizers - E&M 👤
78.0%
 1.5% pp

Allowed PMPM by major service category

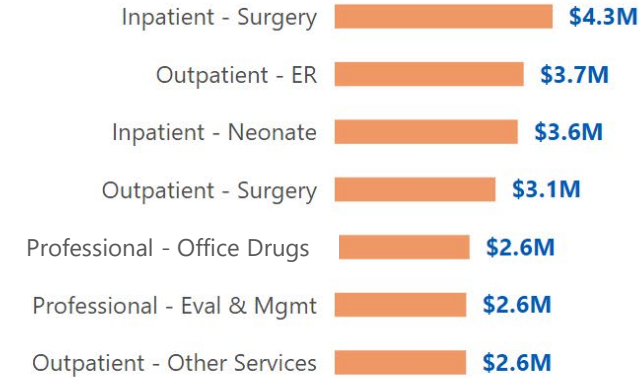
● Prior Period ● Current Period



Change



Top 7 spend changes by major + minor service Increases



Decreases

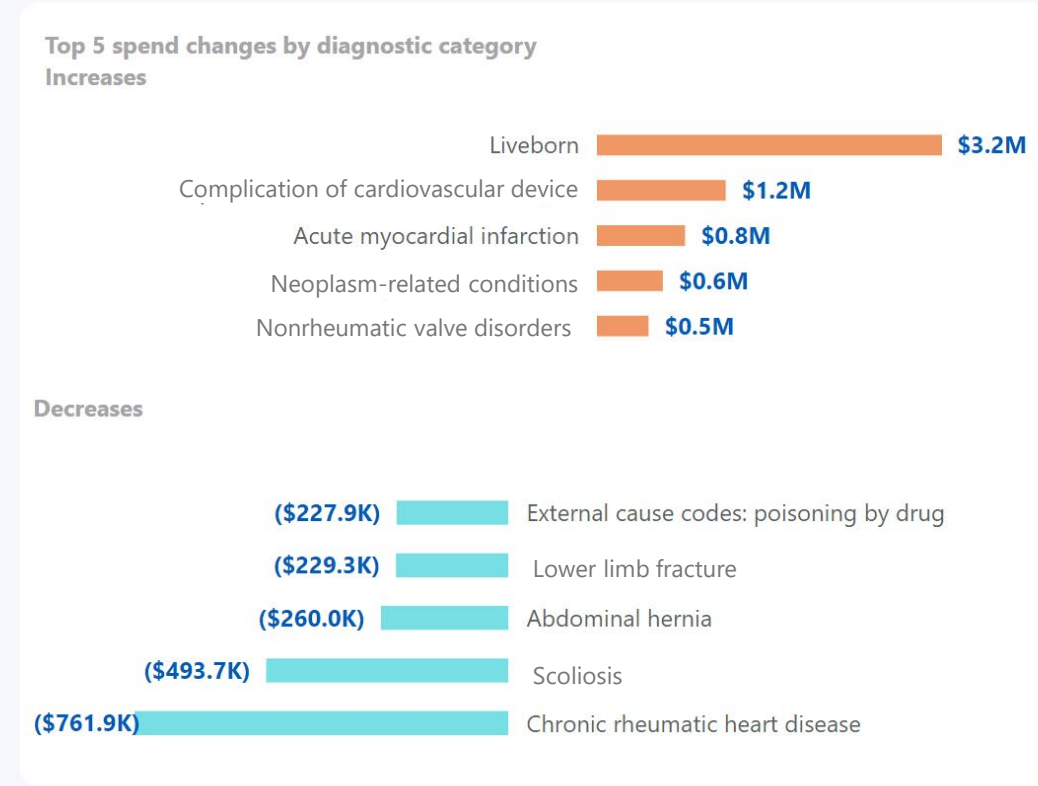
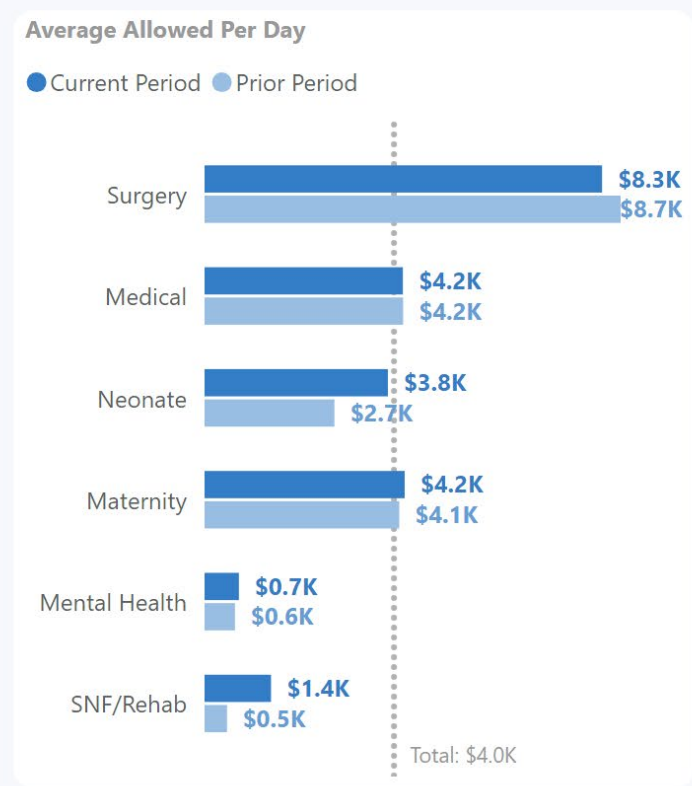
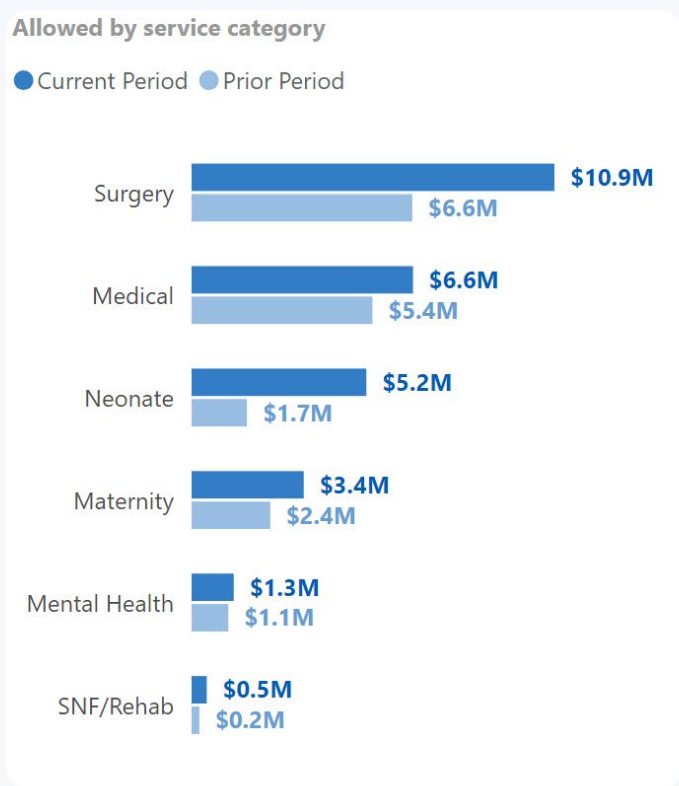


Encounters per 1,000

Subcategory	Current Period	Period Over Period Delta
E&M	3,835	183
Urgent Care	395	11
ER	182	13
Inpatient	57	10

- Cost growth was broad-based, as PMPM increased across all major service categories, with inpatient services showing the largest increase (+\$23.91 PMPM, or 31.2%).
- Inpatient and outpatient services were among the largest contributors to medical spend growth, driven by higher surgical and ER-related costs.
- In the current period, 11.8% of LDPPO members visited the ER at least once, up 1.1 percentage points from the prior year. Outpatient ER costs increased by \$3.7M over the prior year and represented the second largest spend driver for the period.

Total Allowed \$27.8M 60.1%	Allowed PMPM \$100.52 31.2%	Utilizers 1,060 294	Admissions per 1,000 56.9 21.8%	Allowed per Admission \$21,208 7.8%	Average LOS (Days) 5.3 -12.1%	% Total Med Allowed 20.0% 2.6% pp
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- Inpatient costs increased materially, with total allowed reaching \$27.8M. Higher utilization was a key driver, as admissions increased 21.8% and inpatient utilizers increased by nearly 300 during the period.
- Unit costs also contributed, with allowed cost per admission increasing 7.8% to \$21.2K, despite a 12.1% decrease in average length of stay.
- Surgical and medical admissions were the primary cost drivers, with notable increases associated with live births and cardiovascular-related diagnoses.
- Neonatal costs rose sharply, mainly driven by normal liveborn claims. This is partially due to the overall increase in enrollment, especially in members aged 30-44.

View by **ER**

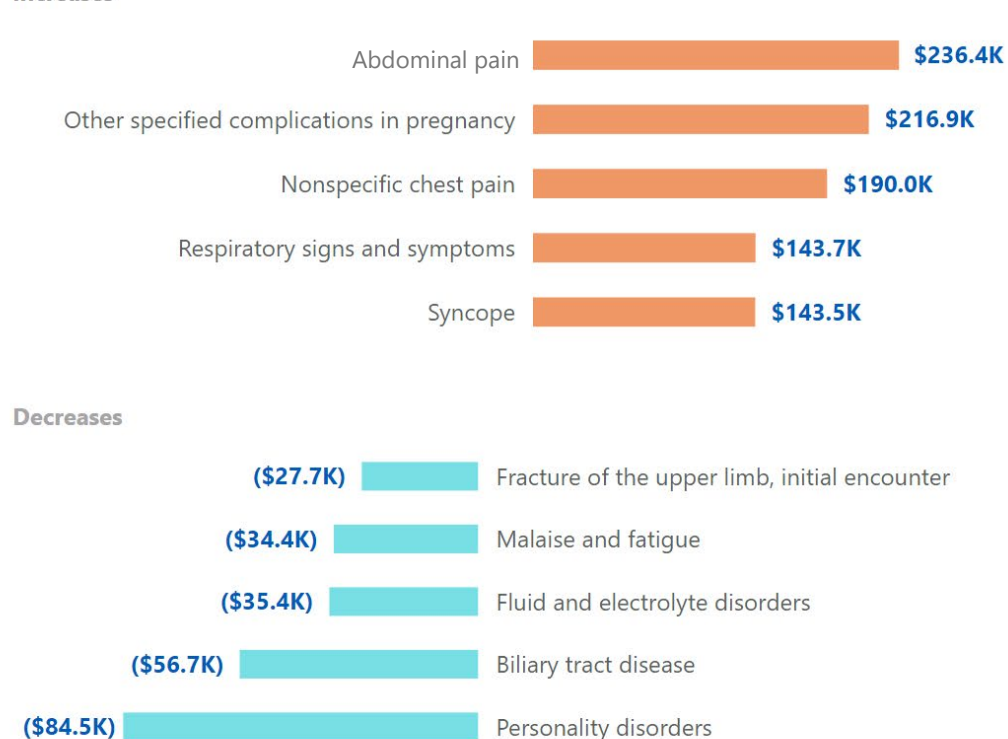
Total Allowed \$14.8M 33.2%	Allowed PMPM \$53.54 9.2%	Utilizers 3,136 719	Visits per 1,000 182.4 7.8%	Allowed per Visit \$3,523 1.3%	% Total Med Allowed 10.6% -0.5% pp
---	---	---	---	--	--

Allowed by service category

● Current Period ● Prior Period



Top 5 spend changes by diagnostic category - Allowed change period over period



Detail by **Rendering Provider - Source**

Rendering Provider - Source	Medical Allowed	Encounters	Allowed Per Encounter
RENOWN REGIONAL MED	\$2,162,360.26	515	\$4,198.76
CARSON TAHOE REGIONAL HEALTHCA	\$1,667,769.53	679	\$2,456.21
HENDERSON HOSPITAL	\$942,793.34	240	\$3,928.31
RENOWN SOUTH MEADO	\$883,071.97	231	\$3,822.82
ST ROSE DOMINICAN SIENA	\$871,319.53	149	\$5,847.78

- ER utilization increased with visits rising to 182.4 per 1,000 contributing to the 9.2% increase in PMPM.
- Higher acuity ER services continued to drive spend, with Level V and Level IV visits representing the largest portions of ER allowed costs.
- Allowed cost per ER visit increased modestly to \$3.5K (+1.3%), indicating that cost growth was driven more by utilization than cost inflation.

Major Chronic Conditions

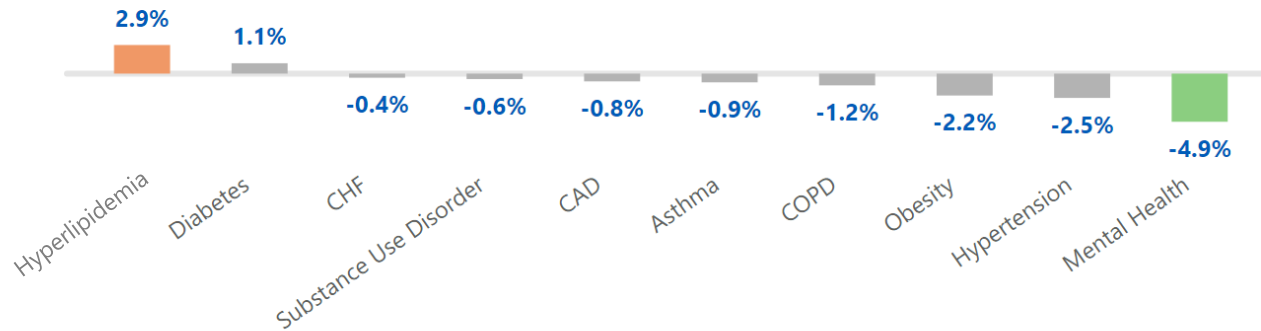
Benchmark Type

Public Sector

Members
12,259
2K

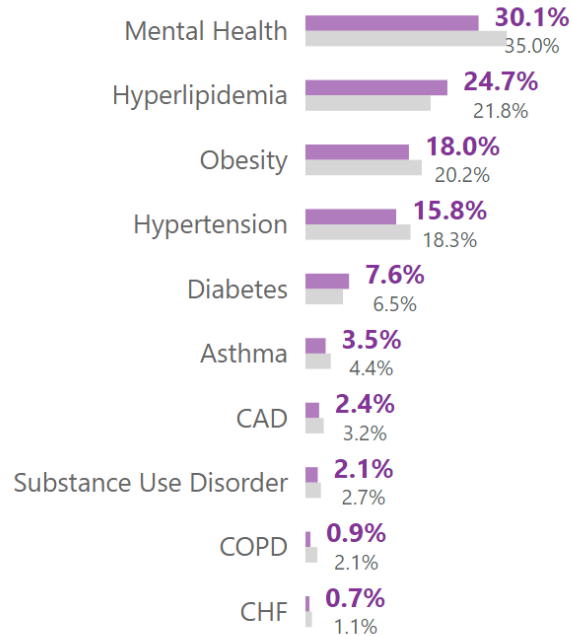
Prevalence
53.9%
3.4% pp

Prevalence Variation from Benchmark



Chronic Conditions Prevalence - hover for age band dist.

● Current Prevalence ● Benchmark



- Mental health, hyperlipidemia, and obesity were the most prevalent chronic conditions, and each saw a large increase in prevalence this year.
- Relative to Segal's Public Sector benchmark, prevalence was higher for hyperlipidemia and diabetes, while obesity, asthma, and cardiac conditions were below benchmark levels.
- Members with chronic conditions exhibited multiple comorbidities and materially higher PMPM costs.

Chronic Condition	Members	Member Change	Prevalence Change	Avg Total Conditions	Med PMPM	Rx PMPM
Mental Health	6,850	1446 ↑	2.4% ↑	2.0	\$803	\$294
Hyperlipidemia	5,616	1174 ↑	1.9% ↑	2.6	\$738	\$396
Obesity	4,093	828 ↑	1.2% ↑	2.7	\$780	\$347
Hypertension	3,590	698 ↑	0.9% ↑	3.0	\$987	\$470
Diabetes	1,725	405 ↑	0.8% ↑	3.4	\$896	\$795
Asthma	799	156 ↑	0.2% ↑	2.7	\$787	\$489
CAD	541	121 ↑	0.2% ↑	4.0	\$2,102	\$652
Substance Use Disorder	486	121 ↑	0.3% ↑	3.0	\$1,136	\$397
COPD	196	43 ↑	0.1% ↑	3.4	\$1,645	\$1,020
CHF	159	32 ↑	0.0% ↑	4.5	\$3,127	\$789

Care Gap Compliance

Benchmark Type

Public Sector

Description	Current	Previous	Change	Benchmark	Variation	
Asthma						
Patient(s) with inhaled corticosteroids or leukotriene inhibitors in the last 12	83.4%	84.0%	-0.6% ↓	84.2%	-0.9% ↓	Declining and Not Beating Benchmark
CAD						
Patient(s) currently taking a statin	61.2%	61.4%	-0.2% ↓	67.2%	-6.0% ↓	Declining and Not Beating Benchmark
Patient(s) currently taking an ACE-inhibitor	15.5%	20.0%	-4.5% ↓	20.7%	-5.1% ↓	Declining and Not Beating Benchmark
COPD						
Patients with spirometry testing within the last 12 months	25.0%	22.9%	2.1% ↑	19.5%	5.5% ↑	Improving and Beating Benchmark
Diabetes						
Patient(s) that had an annual screening test for diabetic nephropathy	62.4%	61.2%	1.2% ↑	62.3%	0.1% ↑	Improving and Beating Benchmark
Patient(s) that had an annual screening test for diabetic retinopathy	29.1%	30.9%	-1.8% ↓	31.6%	-2.5% ↓	Declining and Not Beating Benchmark
Patient(s) that had at least 1 hemoglobin A1C tests in last 12 reported months	85.7%	82.4%	3.3% ↑	83.4%	2.3% ↑	Improving and Beating Benchmark
Hyperlipidemia						
Patient(s) with a LDL cholesterol test in last 12 reported months	78.3%	78.2%	0.1% ↑	77.3%	1.0% ↑	Improving and Beating Benchmark
Preventive Screening						
Breast Cancer	64.8%	60.8%	4.0% ↑	71.2%	-6.4% ↓	Improving but Not Beating Benchmark
Cervical Cancer	52.4%	49.2%	3.2% ↑	59.8%	-7.4% ↓	Improving but Not Beating Benchmark
Colorectal Cancer	47.4%	42.2%	5.2% ↑	55.5%	-8.1% ↓	Improving but Not Beating Benchmark
Prostate Cancer	49.7%	46.8%	2.9% ↑	55.5%	-5.8% ↓	Improving but Not Beating Benchmark

- Overall, diabetes care metrics are above or near norm, though cardiovascular care is both declining and below norm.
- All four preventive cancer screenings are below norm, though rates did increase over the prior year.

Total Allowed \$
\$54.3M
 32.5%

30-DS Rx per 1,000 Rx
13,203
 4.6%

Allowed PMPM 📅
\$196.14
 8.7%

Cost per 30-DS 📄
\$178.26
 3.9%

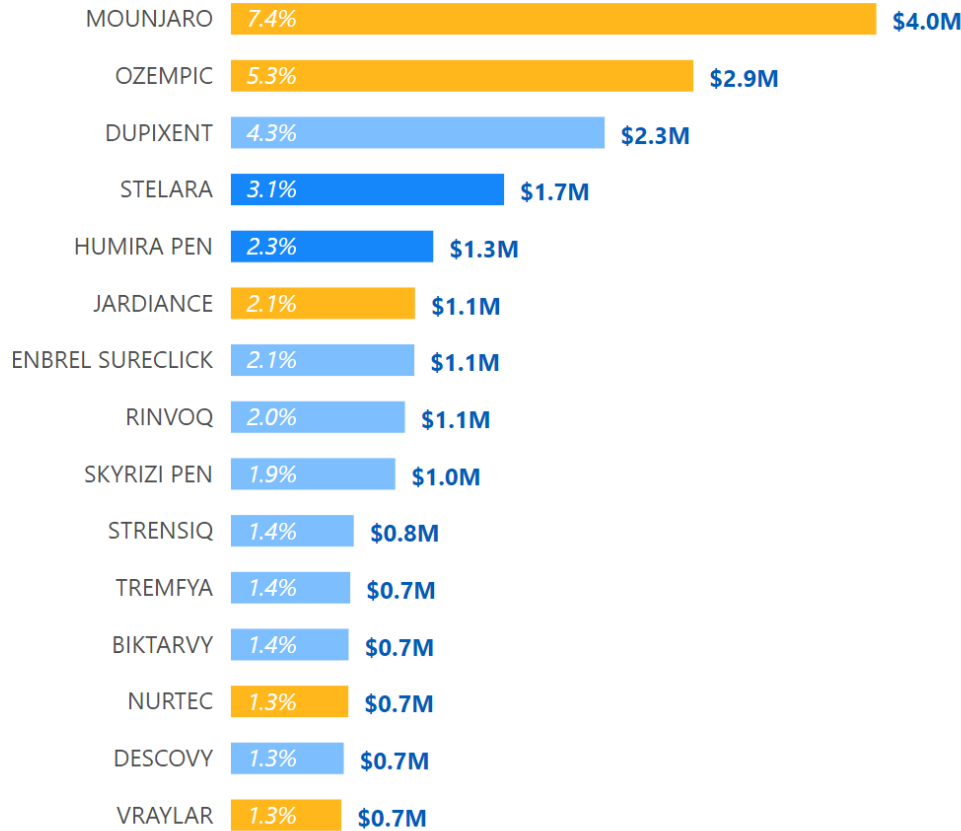
Generic Fill Rate 📈
86.8%
 0.7% pp

Utilizers 👥
18,605
 2,882

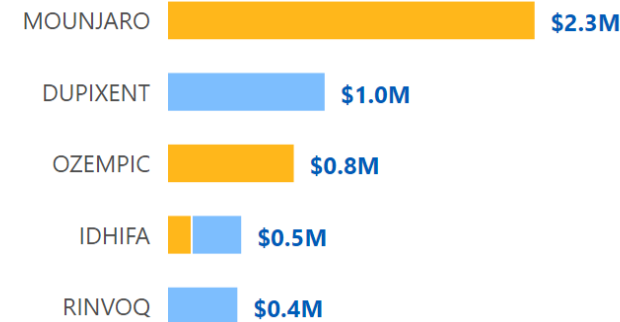
% Utilizing Rx 👤
70.1%
 0.4% pp

Top 15 Drugs - Pharmacy Allowed (% of Total Pharmacy Allowed) *

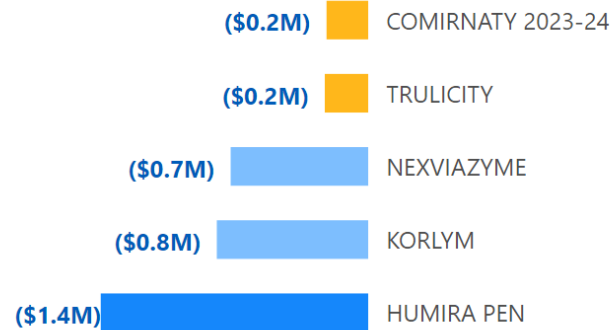
● NS ● S ● S - Bio Available



Top 5 spend changes by drug - Allowed change Increases

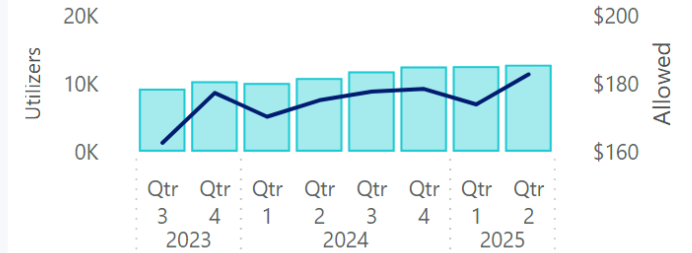


Decreases



Cost vs. Utilization

● Utilizers ● Allowed Per 30 DS



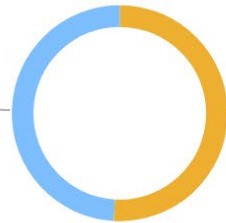
- Utilization increased 4.6% on a scripts per 1,000 basis, with PMPM rising 8.7% to \$196.14, indicating that cost growth was driven by both higher utilization and unit cost increases.
- Cost per 30-day supply increased 3.9% to \$178.26, while the generic fill rate remained high at 86.8%, helping to mitigate overall pharmacy cost growth.
- High-cost GLP-1 and specialty drugs were the primary spend drivers, with Mounjaro (+\$2.3M), Dupixent (+\$1.0M), and Ozempic (+\$0.8M) leading increases, partially offset by declines in Humira Pen (-\$1.4M) and other specialty agents.

Current Pharmacy Allowed

Specialty allowed trend

25.6%

\$26.7M (49.1%)



\$27.7M (50.9%)

Non-specialty allowed trend

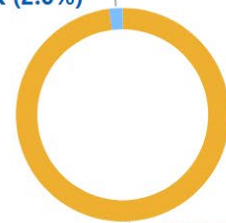
40.0%

Prescriptions

Specialty scripts trend

38.6%

4.7K (2.0%)



227.4K (98.0%)

Non-specialty script trend

27.5%

Average Cost per 30 day supply

Specialty average cost trend

-9.6%



Non-specialty average cost trend

9.9%

\$92.30

Allowed PMPM Trends

Specialty allowed PMPM

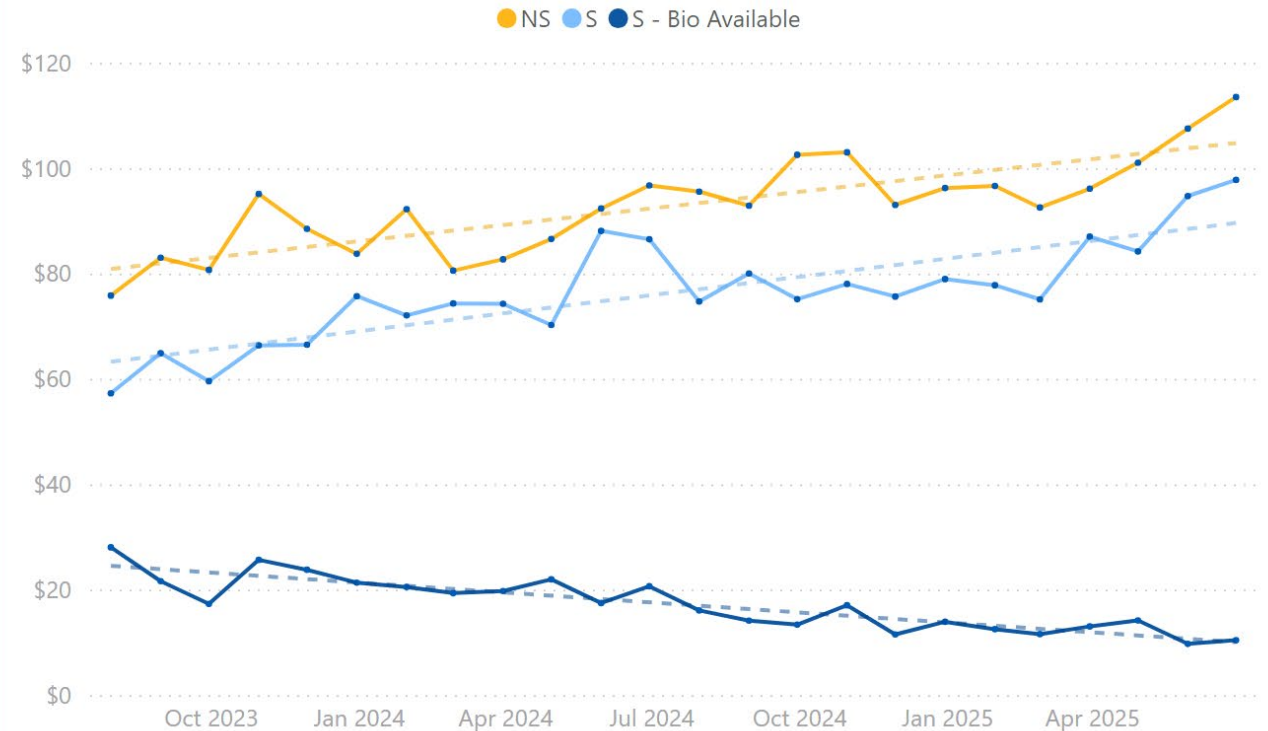
\$96.28

3.0%

Non-specialty allowed PMPM

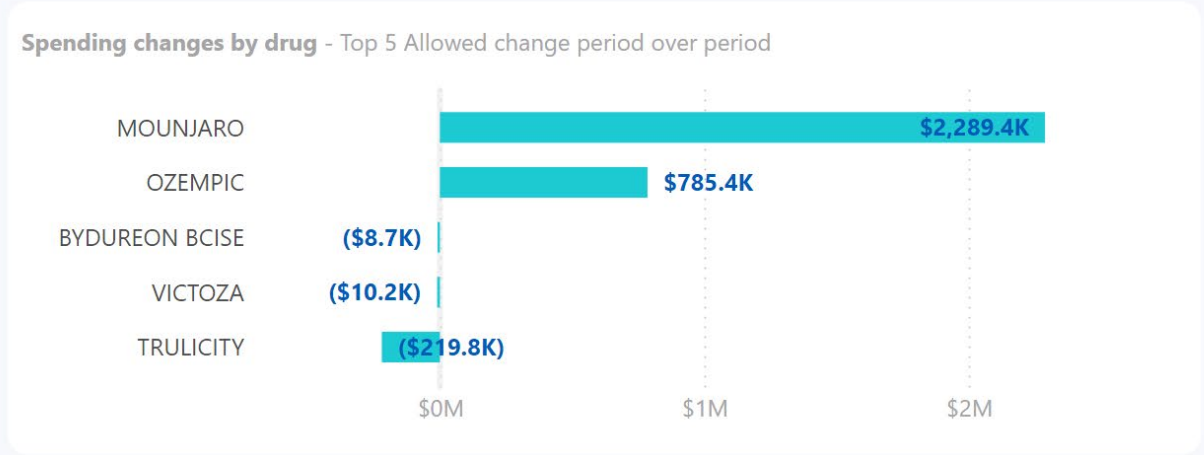
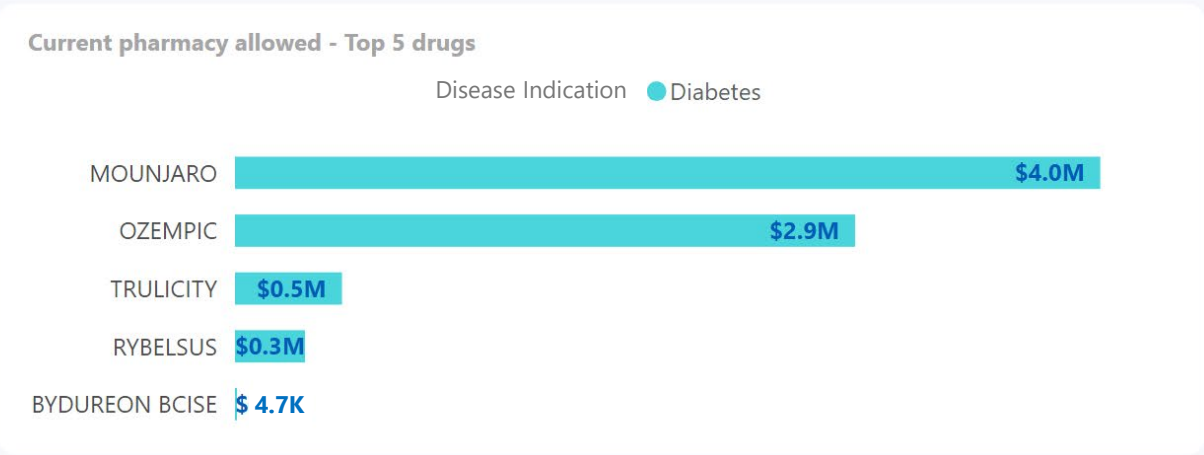
\$99.85

14.8%



- Note: specialty and non-specialty allowed and PMPM amounts may not sum up to the total pharmacy allowed and PMPM due to rounding.
- Specialty drugs accounted for 49.1% of total pharmacy allowed, while representing only 2.0% of total prescriptions.
- Both specialty and non-specialty PMPM increased, with non-specialty rising 14.8% and specialty increasing 3.0%, driven primarily by significant script volume growth in both categories. Average cost per 30-day supply declined for specialty drugs (-9.6%) but increased for non-specialty drugs (+9.9%).

Total Allowed \$7.7M 60.1%	30-DS RX per 1,000 337 24.4%	Allowed PMPM \$27.91 31.2%	Cost per 30-DS \$994.89 5.4%	Generic Fill Rate 0.1% 0.1% pp	Utilizers 893 220
--	--	--	--	--	---------------------------------------



- GLP-1 medications accounted for \$7.7M in allowed costs (14.2% of total pharmacy), with allowed PMPM increasing 31.2% to \$27.91 during the period.
- Utilization increased meaningfully, with 30-day prescriptions per 1,000 rising 24.4% and total utilizers reaching 893 members.
- GLP-1 therapies remain expensive, with an average cost per 30-day supply of \$994.89, and spending increases concentrated among Mounjaro and Ozempic.

Total Allowed \$44.8M 31.0%	30-DS RX per 1,000 3,179 7.7%	Allowed PMPM \$161.81 7.4%	Cost per 30-DS \$610.75 -0.3%	Generic Fill Rate 57.1% -0.8% pp	Utilizers 11,154 2K	% Total Rx Cost 82.5% -1.0%
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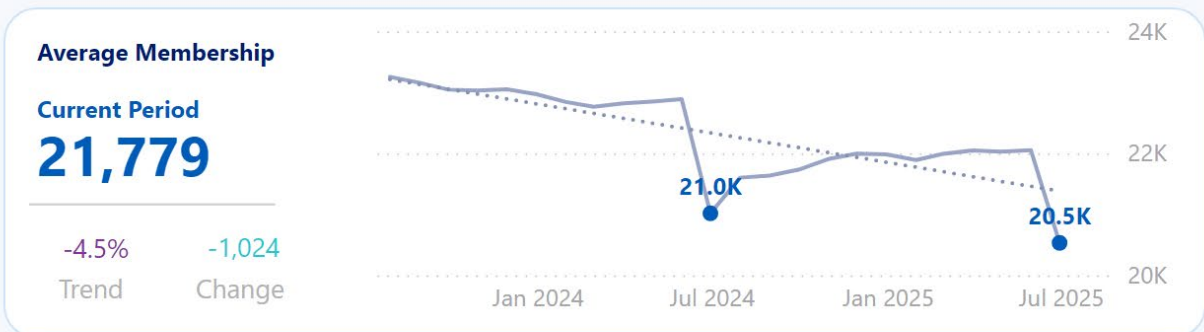
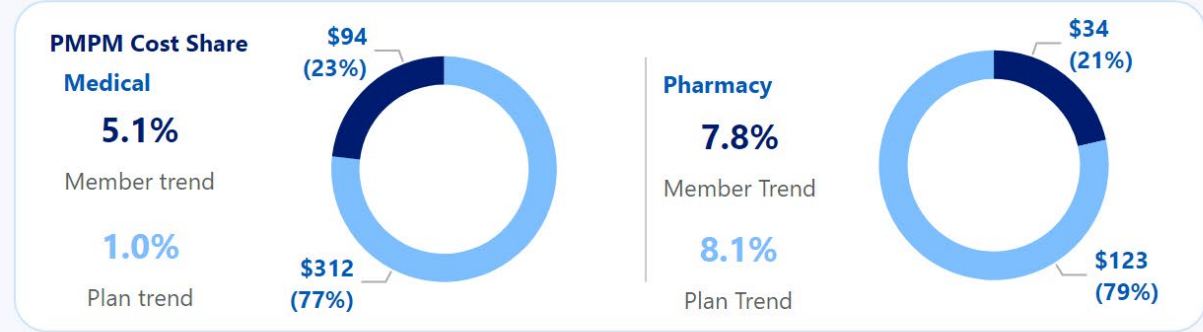
Rank	Disease Indication	Previous Rank	Rank Change	Current Rx PMPM	PMPM Change	Current Utilizers	Utilizer Change	% Total Rx	Generic Fill Rate
1	Diabetes	1	0	\$39.33	\$2.86 ↑	1,996	419 ↑	20.1%	44.4%
2	Autoimmune Disease	2	0	\$23.10	(\$3.17) ↓	213	38 ↑	11.8%	18.7%
3	Psoriasis	3	0	\$17.56	\$0.79 ↑	119	28 ↑	9.0%	16.1%
4	Skin Disorders	6	2 ↑	\$11.32	\$3.02 ↑	2,915	603 ↑	5.8%	85.5%
5	Rare Disorders	4	-1 ↓	\$11.21	(\$0.10) ↓	86	31 ↑	5.7%	63.3%
6	Oncology	5	-1 ↓	\$10.93	\$1.07 ↑	317	78 ↑	5.6%	86.2%
7	Viral Infections/HIV AIDS	8	1 ↑	\$7.75	\$1.52 ↑	146	52 ↑	4.0%	30.6%
8	Asthma/COPD	7	-1 ↓	\$7.32	\$0.73 ↑	3,070	733 ↑	3.7%	85.5%
9	Migraine	9	0	\$6.58	\$0.55 ↑	728	150 ↑	3.4%	51.5%
10	Multiple Sclerosis/Neuromuscular Disorders	10	0	\$6.15	\$0.66 ↑	28	5 ↑	3.1%	33.3%
11	Vaccines/Immunizing Agents	11	0	\$5.00	\$0.81 ↑	4,363	355 ↑	2.5%	0.0%
12	Mental Health/Neurological Disorders	15	3 ↑	\$4.35	\$1.33 ↑	604	121 ↑	2.2%	81.7%
13	ADHD/Narcolepsy	13	0	\$3.96	\$0.52 ↑	1,293	314 ↑	2.0%	93.1%
14	Blood Disorders	12	-2 ↓	\$3.92	\$0.31 ↑	459	117 ↑	2.0%	40.3%
15	Diabetic Supplies/Monitoring	14	-1 ↓	\$3.32	\$0.25 ↑	430	104 ↑	1.7%	0.0%

- Diabetes remained the largest pharmacy cost driver at \$39.33 PMPM; autoimmune disease and psoriasis also contributed meaningfully to overall spend.
- Overall pharmacy costs by indication grew meaningfully, with allowed PMPM rising 7.4% and scripts per 1,000 increasing 7.7%, as PMPM increases were broad-based across the majority of the top 15 indications.
- Mental Health/Neurological Disorders jumped three ranks to #12 (+\$1.33 PMPM, +121 utilizers), reflecting a growing behavioral health utilization on the pharmacy side.

| Reporting by Plan

1. All Enrollees – Actives and Non-Medicare
2. LDPPO Plan – Actives and Non-Medicare
- 3. CDHP Plan – Actives and Non-Medicare**
4. EPO Plan – Actives and Non-Medicare

Data was reviewed for reasonableness but not audited for accuracy



- Total Allowed PMPM increased 3.5% (+\$19.23) to \$562.55, driven by modest medical cost growth (+1.9%) and a meaningful pharmacy contribution (+8.0% PMPM) to overall plan trend.
- Pharmacy PMPM increased 8.0% to \$156.72, driven by both higher utilization (+3.1% scripts per 1,000) and rising unit costs (+4.7% cost per 30-DS).
- Membership in higher-risk demographics declined, with a decrease in female and older enrollees, contributing to slower overall cost growth versus other plans.

Total Allowed \$
\$106.1M
 -2.7%

Allowed PMPM 📅
\$405.83
 1.9%

% Med Utilizers 👥
76.5%
 -0.2% pp

% Utilizers - IP 🏠
3.1%
 -0.0% pp

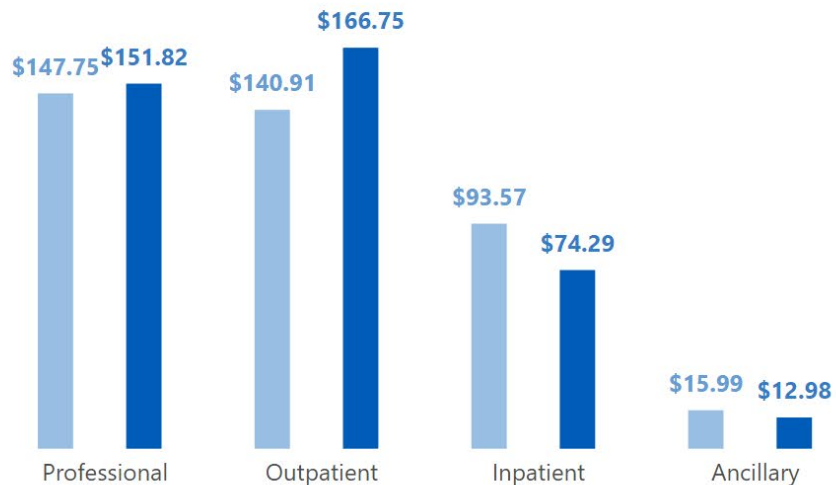
% Utilizers - ER 🏥
11.0%
 0.7% pp

% Utilizers - UC ⚡
18.9%
 0.7% pp

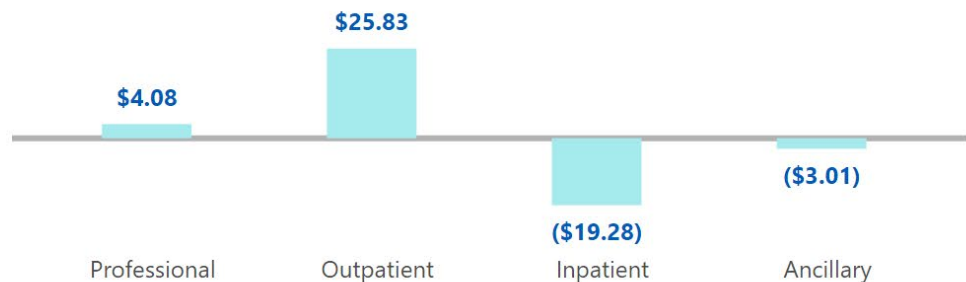
% Utilizers - E&M 👤
68.3%
 0.3% pp

Allowed PMPM by major service category

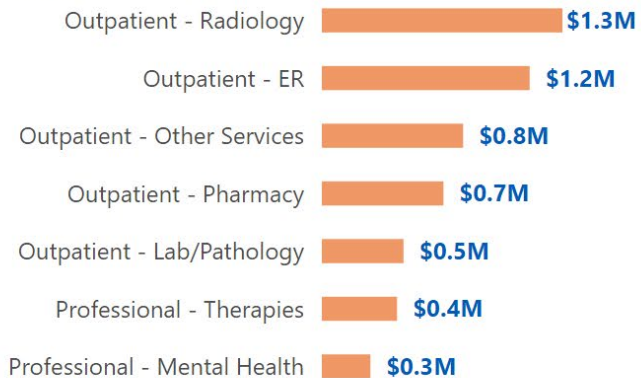
● Prior Period ● Current Period



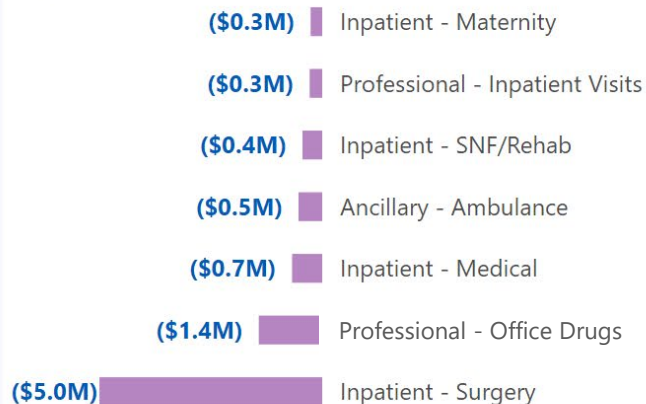
Change



Top 7 spend changes by major + minor service Increases



Decreases

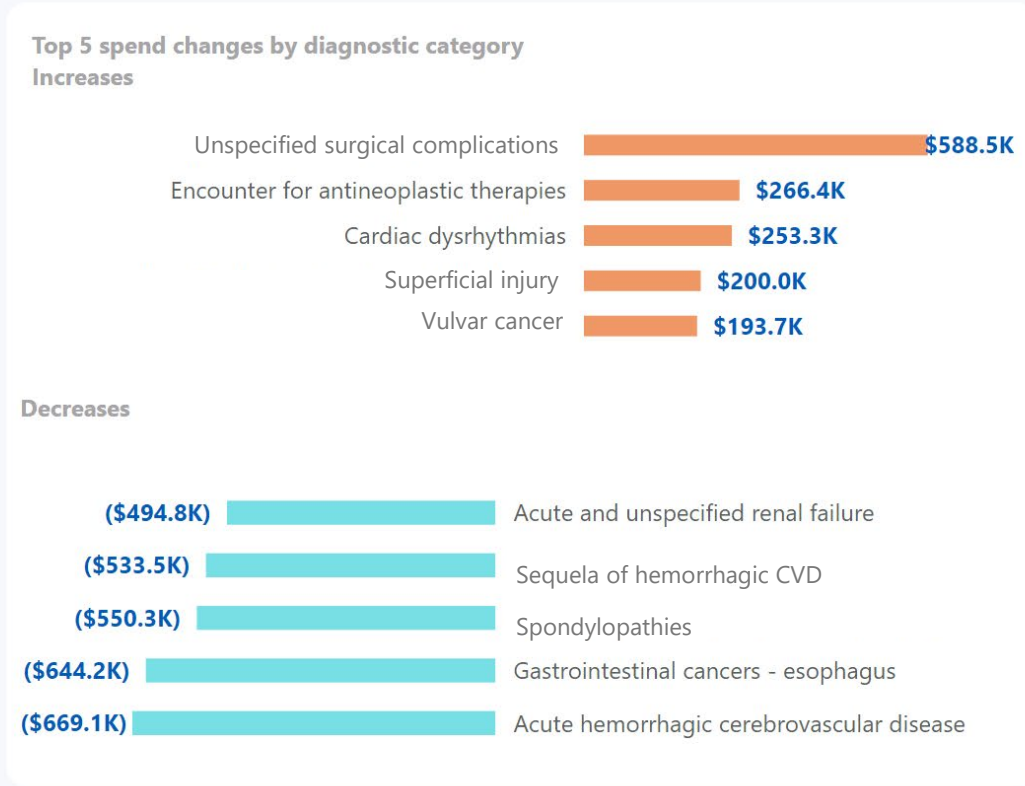
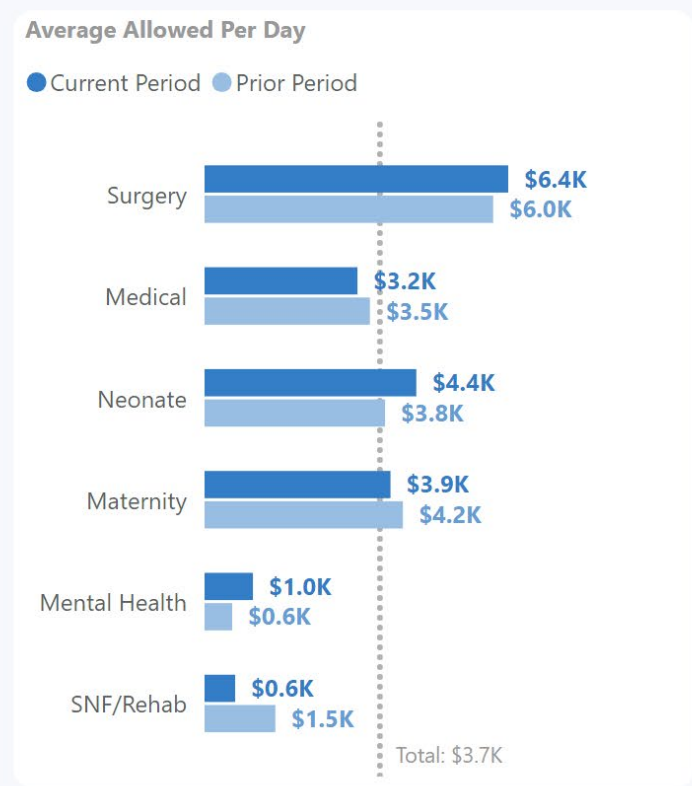
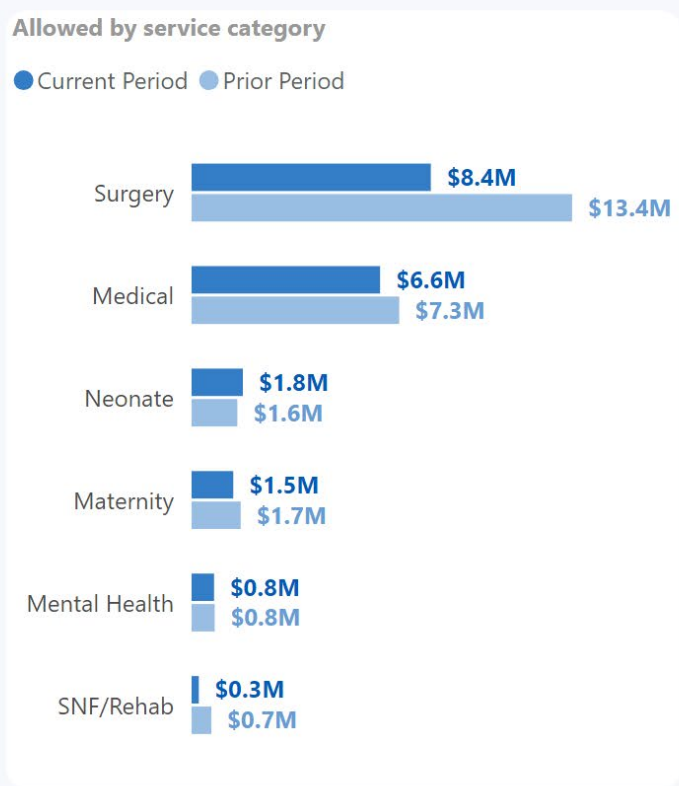


Encounters per 1,000

Subcategory	Current Period	Period Over Period Delta
E&M	2,990	119
Urgent Care	318	13
ER	173	15
Inpatient	44	-3

- The large increase in outpatient costs was led by radiology and ER. Costs rose especially for radiation oncology. There may be an opportunity to collaborate with vendors around cancer care management to ensure patients are on the best course of treatment for them.
- Inpatient costs declined (-\$19.28 PMPM), driven largely by a \$5.0M reduction in Inpatient surgery and lower acuity SNF/Rehab spend. This may reflect favorable case mix shifts and migration of members out of the CDHP, which will redistribute condition risk to the other plans. The age bands where enrollment dropped the most were 0-9 and 60-64.

Total Allowed \$19.4M -24.2%	Allowed PMPM \$74.29 -20.6%	Utilizers 764 -48	Admissions per 1,000 43.7 -5.5%	Allowed per Admission \$20,393 -16.0%	Average LOS (Days) 5.6 -16.0%	% Total Med Allowed 18.3% -5.2% pp
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- Inpatient costs declined significantly, with total allowed dropping 24.2% to \$19.4M, driven by reductions across all key metrics including admissions per 1,000 (-5.5%), cost per admission (-16.0%), and average length of stay (-16.0%) — a broad-based improvement consistent with the overall membership decline in the CDHP.
- Surgical inpatient spend fell sharply from \$13.4M to \$8.4M; this is a continued pattern from the prior year driven by non-recurring high-cost events and/or migration. This service category can be volatile and may rebound.
- SNF/Rehab costs per day dropped materially, which, when combined with shorter average LOS, was driven by non-recurring acute events.

View by **ER**

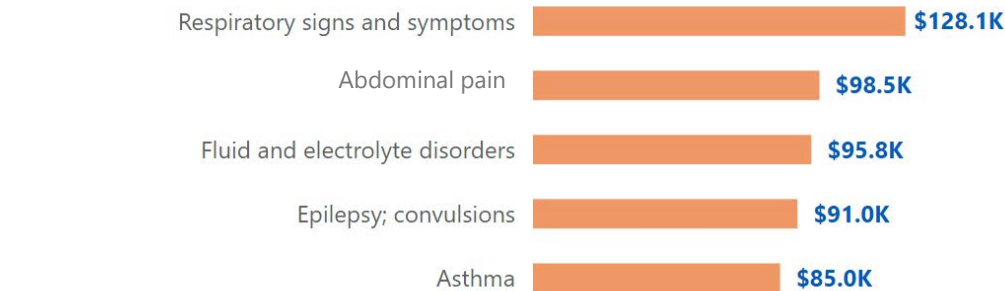
Total Allowed \$13.6M 9.3%	Allowed PMPM \$52.03 14.4%	Utilizers 2,720 24	Visits per 1,000 172.6 9.4%	Allowed per Visit \$3,617 4.5%	% Total Med Allowed 12.8% 1.4% pp
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Allowed by service category

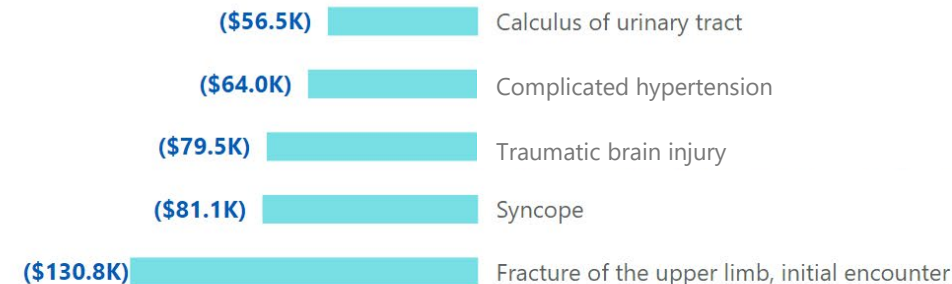
● Current Period ● Prior Period



Top 5 spend changes by diagnostic category - Allowed change period over period



Decreases



Detail by **Rendering Provider - Source**

Rendering Provider - Source	Medical Allowed	Encounters	Allowed Per Encounter
RENOWN REGIONAL MED	\$1,400,582.85	323	\$4,336.17
CARSON TAHOE REGIONAL HEALTHCA	\$1,138,518.97	452	\$2,518.85
HENDERSON HOSPITAL	\$959,329.19	232	\$4,135.04
ST ROSE DOMINICAN SIENA	\$910,833.68	155	\$5,876.35

- ER utilization increased, especially among higher severity levels, indicating generally appropriate use.
- Allowed cost per ER visit increased moderately, indicating that ER cost growth was driven primarily by higher utilization rather than unit cost inflation.
- There may be an opportunity to mitigate use for members with respiratory conditions, e.g., through ensuring appropriate inhaler use and proactive disease management.

Major Chronic Conditions

Benchmark Type

Public Sector

Members

10,018

-83

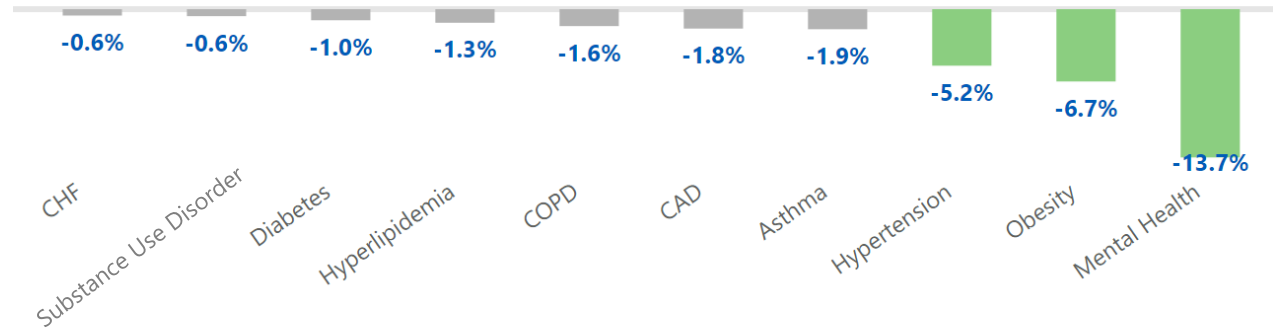

Prevalence

48.8%

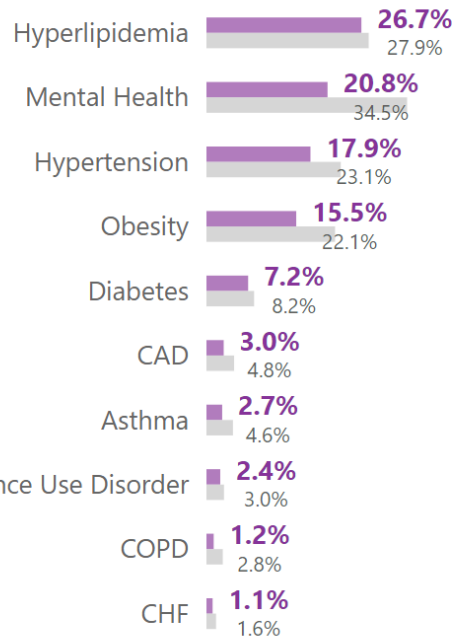
0.7% pp



Prevalence Variation from Benchmark



Chronic Conditions Prevalence - *hover for age band dist.*

● Current Prevalence ● Benchmark


Chronic Condition	Members	Member Change	Prevalence Change	Avg Total Conditions	Med PMPM	Rx PMPM
Hyperlipidemia	5,474	-46 ↓	0.4% ↑	2.6	\$683	\$358
Mental Health	4,278	29 ↑	0.6% ↑	2.2	\$719	\$250
Hypertension	3,674	-102 ↓	-0.1% ↓	3.0	\$918	\$423
Obesity	3,172	60 ↑	0.6% ↑	2.8	\$774	\$324
Diabetes	1,472	13 ↑	0.2% ↑	3.5	\$971	\$678
CAD	609	39 ↑	0.3% ↑	3.9	\$1,755	\$651
Asthma	555	-21 ↓	-0.0% ↓	2.8	\$772	\$528
Substance Use Disorder	487	20 ↑	0.1% ↑	3.0	\$1,237	\$202
COPD	255	-15 ↓	-0.0% ↓	3.4	\$1,552	\$830
CHF	217	0 ↑	0.0% ↑	4.4	\$2,476	\$927

- Mental health, hyperlipidemia, and hypertension were the most prevalent chronic conditions within the CDHP population.
- Relative to Segal's Public Sector benchmark, prevalence was lower for all major chronic conditions, including diabetes, hypertension, obesity, and cardiac conditions.
- Mental health prevalence was meaningfully below benchmark (-13.7%), despite being one of the most common conditions. Though it is increasing, lower prevalence can sometimes indicate barriers to accessing treatment.

Care Gap Compliance

Benchmark Type

Public Sector

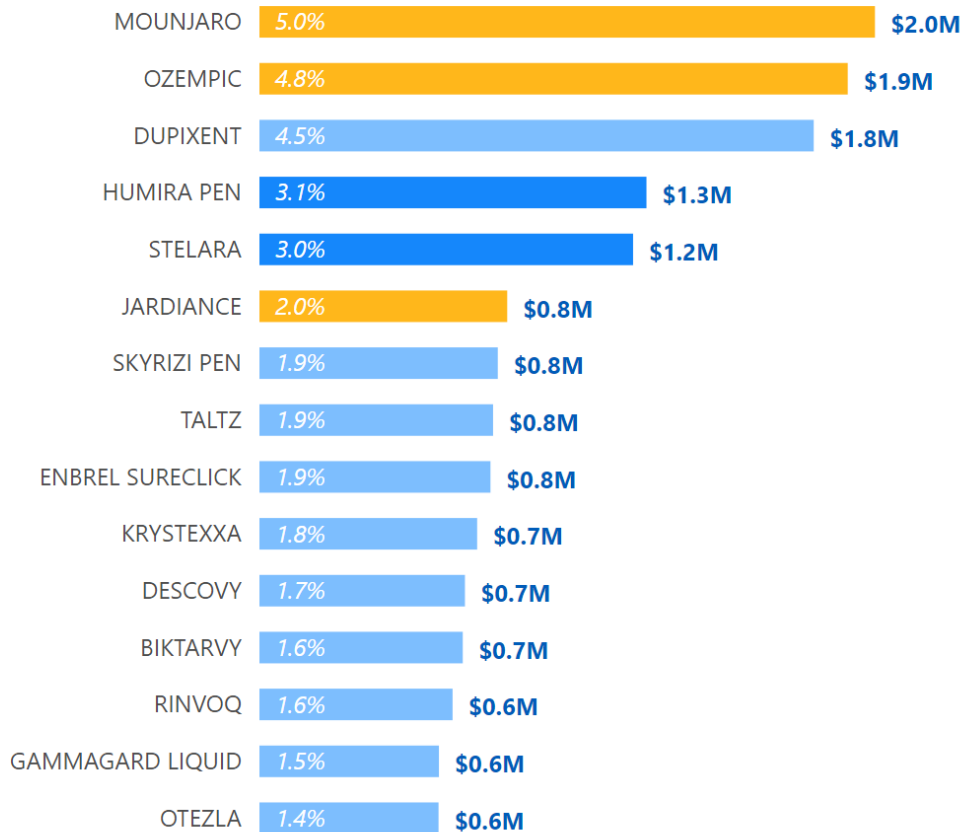
Description	Current	Previous	Change	Benchmark	Variation	
Asthma						
Patient(s) with inhaled corticosteroids or leukotriene inhibitors in the last 12	84.0%	81.9%	2.0% ↑	83.6%	0.4% ↑	Improving and Beating Benchmark
CAD						
Patient(s) currently taking a statin	65.4%	68.4%	-3.1% ↓	70.3%	-5.0% ↓	Declining and Not Beating Benchmark
Patient(s) currently taking an ACE-inhibitor	18.9%	20.5%	-1.6% ↓	22.1%	-3.2% ↓	Declining and Not Beating Benchmark
COPD						
Patients with spirometry testing within the last 12 months	18.0%	20.4%	-2.3% ↓	19.9%	-1.9% ↓	Declining and Not Beating Benchmark
Diabetes						
Patient(s) that had an annual screening test for diabetic nephropathy	63.6%	62.5%	1.1% ↑	64.6%	-1.0% ↓	Improving but Not Beating Benchmark
Patient(s) that had an annual screening test for diabetic retinopathy	26.0%	28.1%	-2.1% ↓	35.2%	-9.2% ↓	Declining and Not Beating Benchmark
Patient(s) that had at least 1 hemoglobin A1C tests in last 12 reported months	85.1%	82.0%	3.1% ↑	85.1%	-0.0% ↓	Improving but Not Beating Benchmark
Hyperlipidemia						
Patient(s) with a LDL cholesterol test in last 12 reported months	75.7%	75.2%	0.5% ↑	77.8%	-2.1% ↓	Improving but Not Beating Benchmark
Preventive Screening						
Breast Cancer	61.8%	59.8%	2.0% ↑	72.2%	-10.4% ↓	Improving but Not Beating Benchmark
Cervical Cancer	52.6%	52.5%	0.1% ↑	60.3%	-7.7% ↓	Improving but Not Beating Benchmark
Colorectal Cancer	50.9%	46.2%	4.6% ↑	57.7%	-6.8% ↓	Improving but Not Beating Benchmark
Prostate Cancer	45.4%	44.5%	0.9% ↑	56.3%	-10.9% ↓	Improving but Not Beating Benchmark

- Care gap compliance is the lowest for CDHP enrollees out of all plans. Only a single measure (asthma medication) is above norm.
- Most metrics are increasing, which is an encouraging sign, though remain below norm – in some cases (e.g., breast cancer) substantially so.

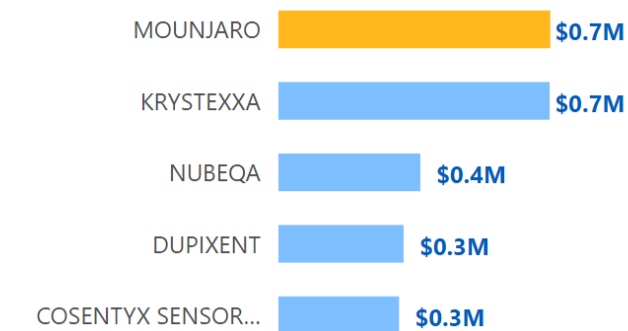
Total Allowed \$41.0M 3.2%	30-DS Rx per 1,000 11,664 3.1%	Allowed PMPM \$156.72 8.0%	Cost per 30-DS \$161.23 4.7%	Generic Fill Rate 87.2% 0.5% pp	Utilizers 15,746 -910	% Utilizing Rx 63.6% -0.2% pp
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Top 15 Drugs - Pharmacy Allowed (% of Total Pharmacy Allowed) *

● NS ● S ● S - Bio Available



Top 5 spend changes by drug - Allowed change Increases

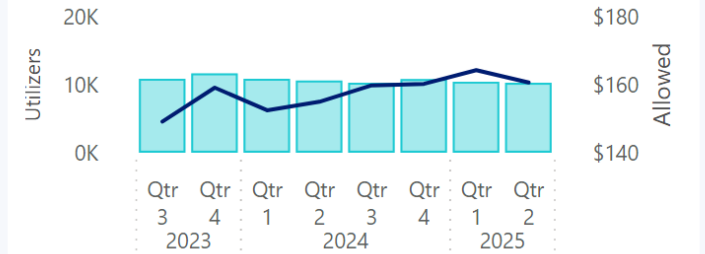


Decreases



Cost vs. Utilization

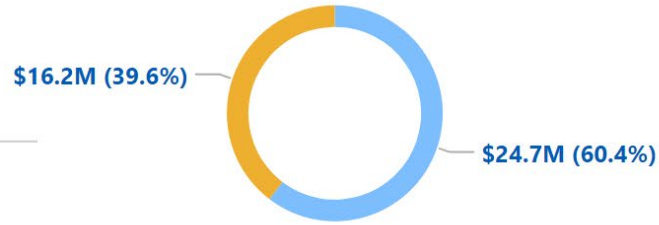
● Utilizers ● Allowed Per 30 DS



- Total pharmacy allowed increased 3.2% to \$41.0M, with allowed PMPM rising 8.0% to \$156.72, reflecting growth in both utilization (+3.1% scripts per 1,000) and unit costs (+4.7% cost per 30-DS).
- Pharmacy utilization increased, with 30-day prescriptions per 1,000 rising 3.1%, while the high generic fill rate of 87.2% helped partially mitigate overall cost growth.
- GLP-1 medications and high-cost specialty drugs drove spend increases, with Mounjaro (+\$0.7M) and Krystexxa (+\$0.7M) leading gains, partially offset by a meaningful decline in Humira Pen (-\$1.9M).

Current Pharmacy Allowed

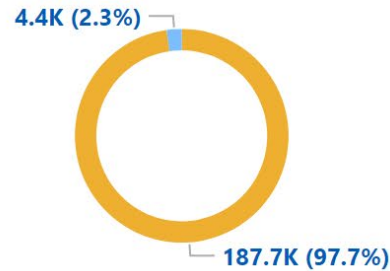
Specialty allowed trend
2.4%



Non-specialty allowed trend
4.3%

Prescriptions

Specialty scripts trend
6.7%



Non-specialty script trend
-2.3%

Average Cost per 30 day supply

Specialty average cost trend
-4.5%



Non-specialty average cost trend
6.1%

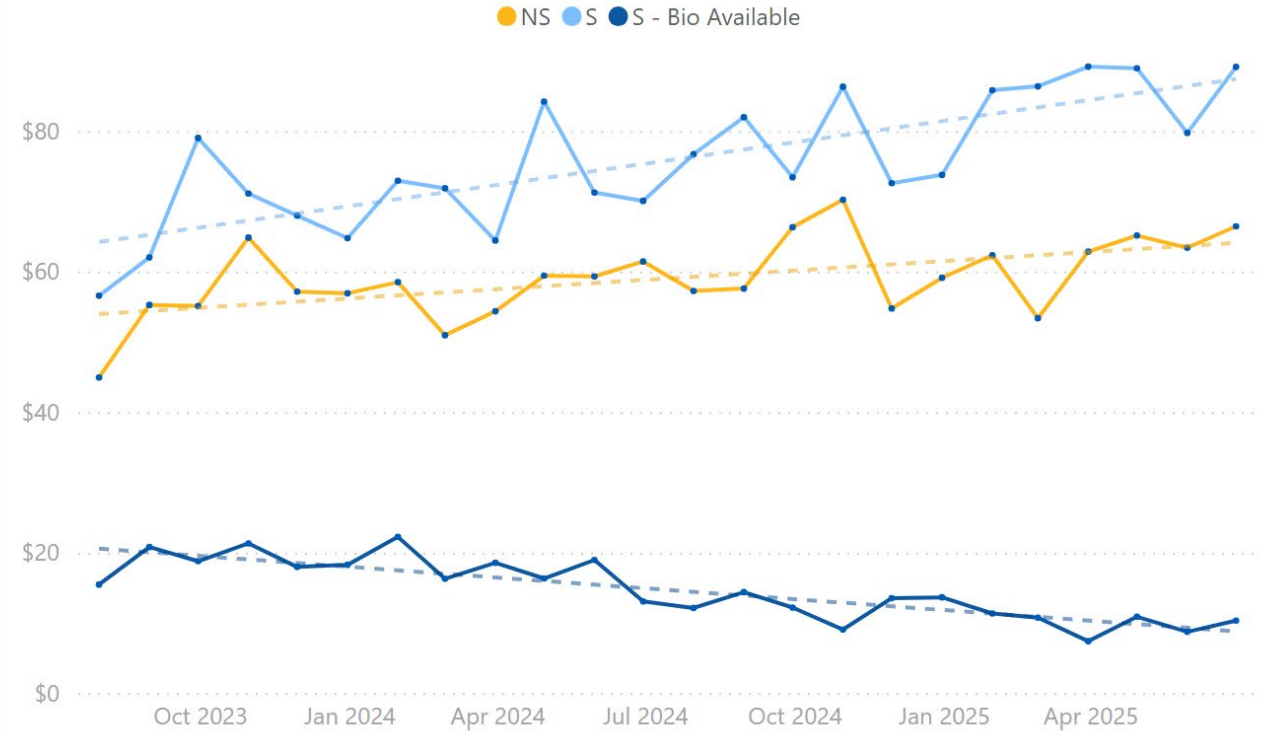
Allowed PMPM Trends

Specialty allowed PMPM
\$94.59

7.2%

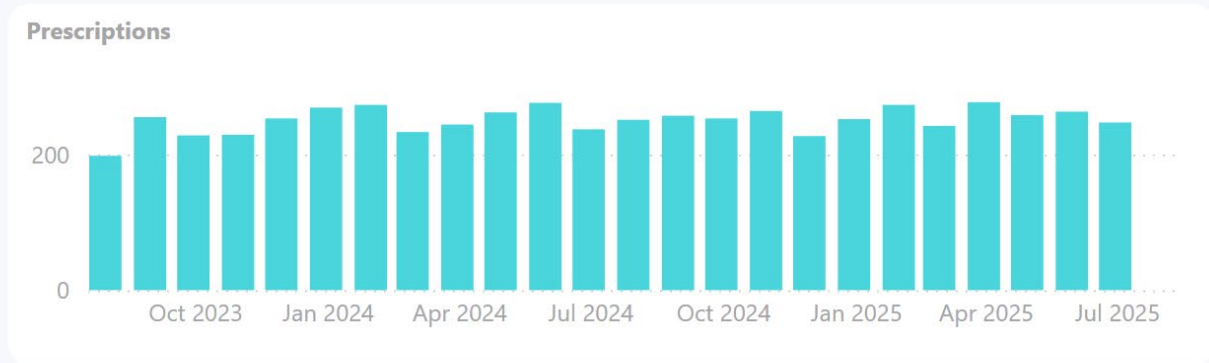
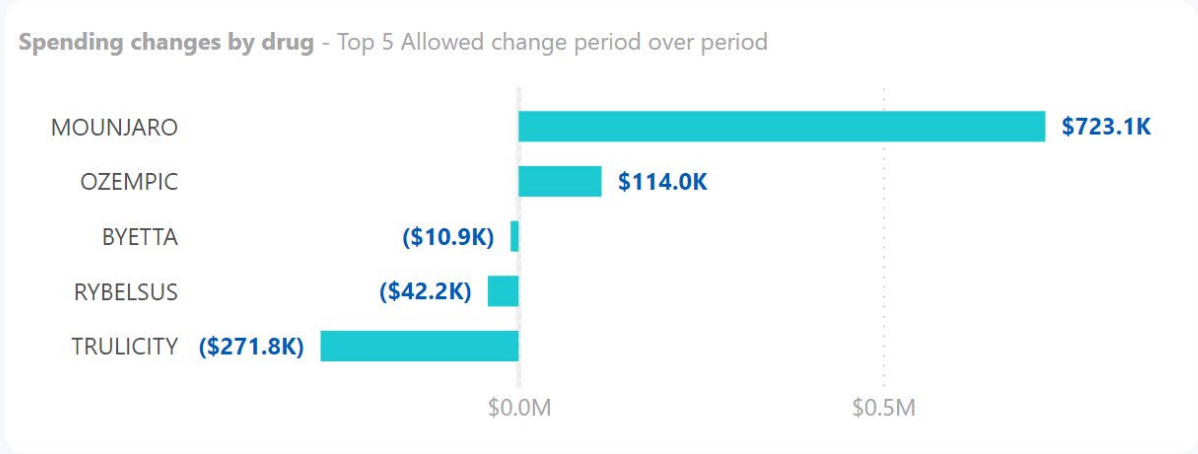
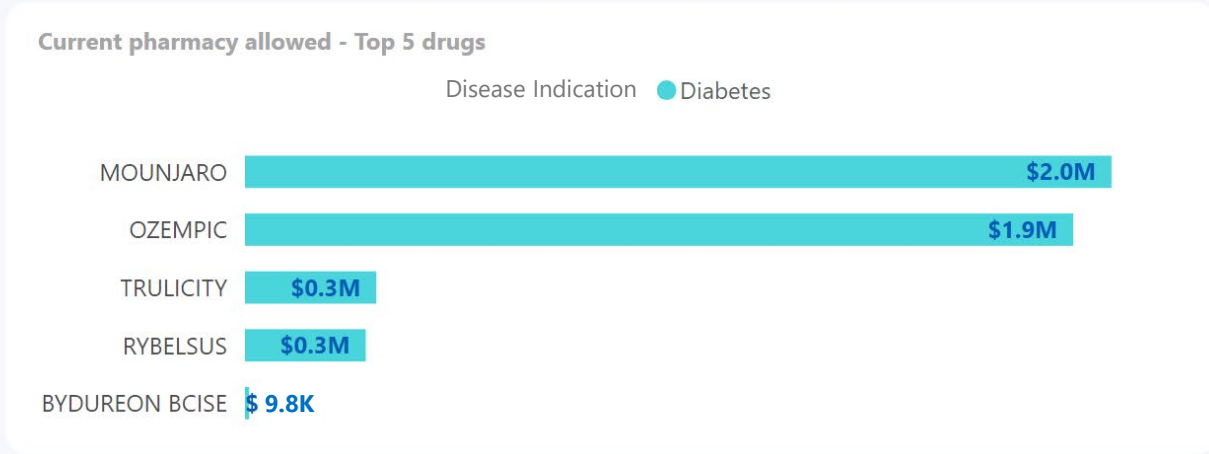
Non-specialty allowed PMPM
\$62.12

9.2%



- Note: specialty and non-specialty allowed and PMPM amounts may not sum up to the total pharmacy allowed and PMPM due to rounding.
- Both specialty and non-specialty PMPM increased, with specialty rising 7.2% (+6.7% scripts) and non-specialty increasing 9.2% despite lower utilization (-2.3%).
- Specialty average cost per 30-day supply declined (-4.5% to \$5,341.90) while non-specialty increased (+6.1% to \$65.10), indicating favorable selection in the specialty tier.

Total Allowed \$4.6M 12.2%	30-DS RX per 1,000 219 12.5%	Allowed PMPM \$17.58 17.5%	Cost per 30-DS \$964.92 4.4%	Generic Fill Rate 0.1% 0.1% pp	Utilizers 641 33
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- GLP-1 allowed PMPM increased 17.5% to \$17.58, driven primarily by higher utilization (up 12.5%) rather than by unit cost (up 4.4%). However, the large decrease in the overall CDHP population may cause the utilization increase to appear higher.
- Utilization increased, with 30-day prescriptions per 1,000 rising 12.5% and total utilizers increasing to 641 members during the period.
- GLP-1 therapies remained high-cost, with an average cost per 30-day supply of \$964.92 and spending concentrated primarily in Mounjaro and Ozempic.

Total Allowed \$34.4M 4.6%	30-DS RX per 1,000 2,688 5.2%	Allowed PMPM \$131.51 9.5%	Cost per 30-DS \$587.21 4.1%	Generic Fill Rate 60.2% -1.5% pp	Utilizers 9,338 -678	% Total Rx Cost 83.9% 1.1%
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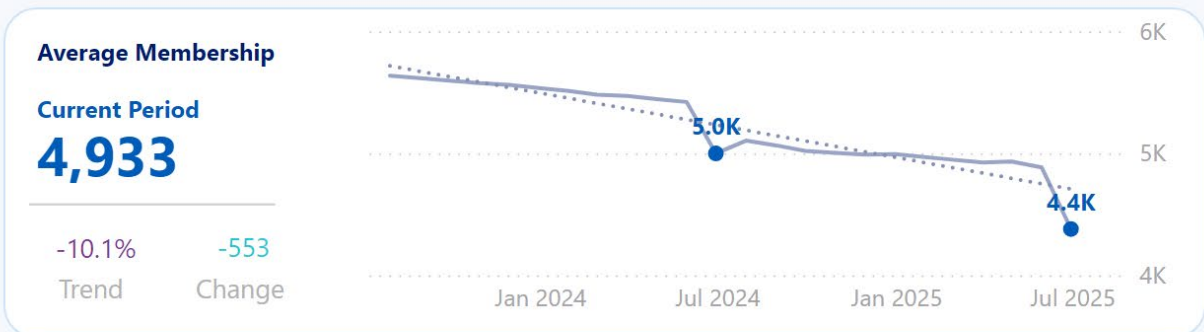
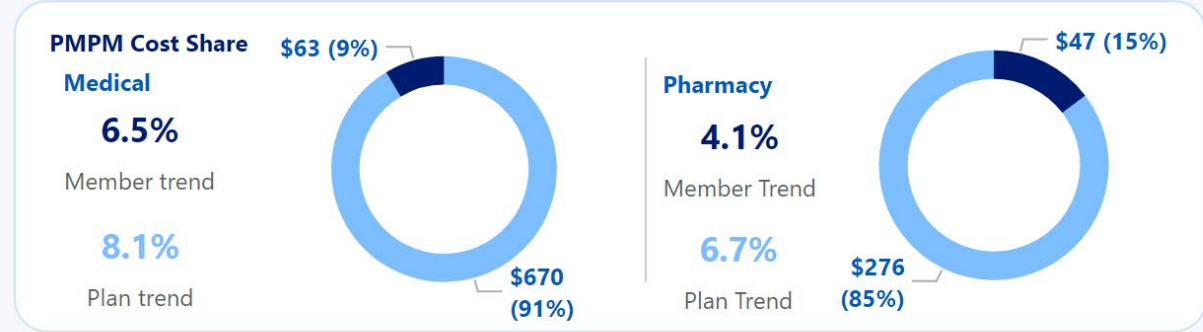
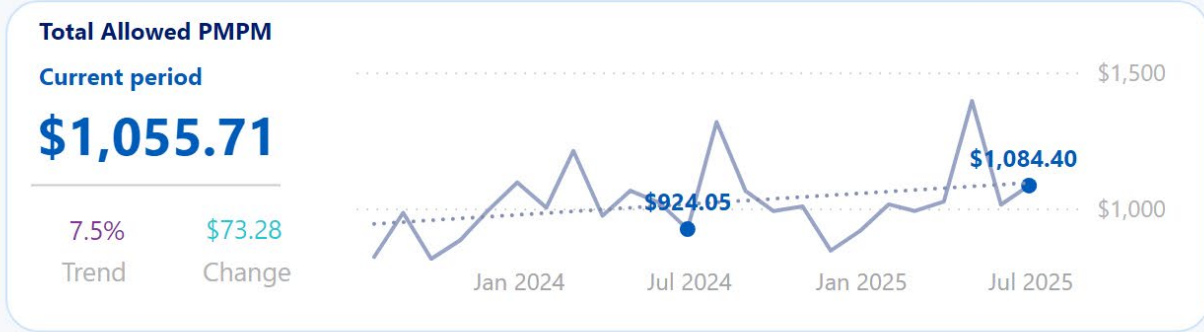
Rank	Disease Indication	Previous Rank	Rank Change	Current Rx PMPM	PMPM Change	Current Utilizers	Utilizer Change	% Total Rx	Generic Fill Rate
1	Diabetes	1	0	\$27.09	\$2.02 ↑	1,622	27 ↑	17.3%	50.6%
2	Autoimmune Disease	2	0	\$18.61	(\$3.86) ↓	139	-12 ↓	11.9%	20.2%
3	Psoriasis	4	1 ↑	\$16.54	\$4.21 ↑	76	2 ↑	10.6%	4.6%
4	Oncology	3	-1 ↓	\$15.96	\$0.74 ↑	270	-1 ↓	10.2%	82.2%
5	Skin Disorders	6	1 ↑	\$8.63	\$1.61 ↑	2,099	25 ↑	5.5%	84.8%
6	Viral Infections/HIV AIDS	7	1 ↑	\$8.20	\$1.54 ↑	121	10 ↑	5.2%	27.1%
7	Vaccines/Immunizing Agents	5	-2 ↓	\$7.50	\$0.18 ↑	4,093	-748 ↓	4.8%	0.0%
8	Asthma/COPD	8	0	\$6.48	\$0.52 ↑	2,233	-146 ↓	4.1%	86.3%
9	Multiple Sclerosis/Neuromuscular Disorders	9	0	\$4.75	\$0.37 ↑	16	-3 ↓	3.0%	21.2%
10	Blood Disorders	10	0	\$3.53	\$0.24 ↑	410	1 ↑	2.3%	43.6%
11	Migraine	12	1 ↑	\$3.42	\$0.64 ↑	414	1 ↑	2.2%	53.8%
12	Cardiovascular/Heart Disease	11	-1 ↓	\$3.24	\$0.18 ↑	164	-4 ↓	2.1%	75.2%
13	Gout	50	37 ↑	\$2.84	\$2.76 ↑	289	-22 ↓	1.8%	99.0%
14	ADHD/Narcolepsy	13	-1 ↓	\$2.71	\$0.11 ↑	638	31 ↑	1.7%	94.6%
15	Seizure Disorder	15	0	\$2.02	\$0.15 ↑	1,271	32 ↑	1.3%	97.6%

- The top 15 disease indications accounted for \$34.4M in allowed costs, representing 83.9% of total pharmacy spend, highlighting a high concentration of pharmacy costs across a limited number of conditions.
- Diabetes remained the largest pharmacy cost driver, accounting for 17.3% of total Rx spend, with PMPM increasing modestly and relatively stable user counts.
- Psoriasis and Gout spending increased the most due to more spend for Cosentyx and Krystexxa; these conditions are generally treated with specialty medications.

| Reporting by Plan

1. All Enrollees – Actives and Non-Medicare
2. LDPPO Plan – Actives and Non-Medicare
3. CDHP Plan – Actives and Non-Medicare
- 4. EPO Plan – Actives and Non-Medicare**

Data was reviewed for reasonableness but not audited for accuracy



- Medical allowed PMPM rose 8.0% to \$732.50, reflecting higher medical utilization and unit costs, and accounting for nearly 70% of total allowed PMPM.
- Pharmacy allowed PMPM increased 6.3% to \$323.21, driven by higher utilization (+6.5% scripts per 1,000) while cost per 30-day supply remained essentially flat (-0.1%), indicating utilization as the primary pharmacy cost driver.
- Average membership declined 10.1% (-553 members), with losses spread across nearly all age bands but particularly among older members (60-64: -71).

Total Allowed \$
\$43.4M
 -2.9%

Allowed PMPM 📅
\$732.50
 8.0%

% Med Utilizers 👥
90.7%
 -0.1% pp

% Utilizers - IP 🏠
4.9%
 0.4% pp

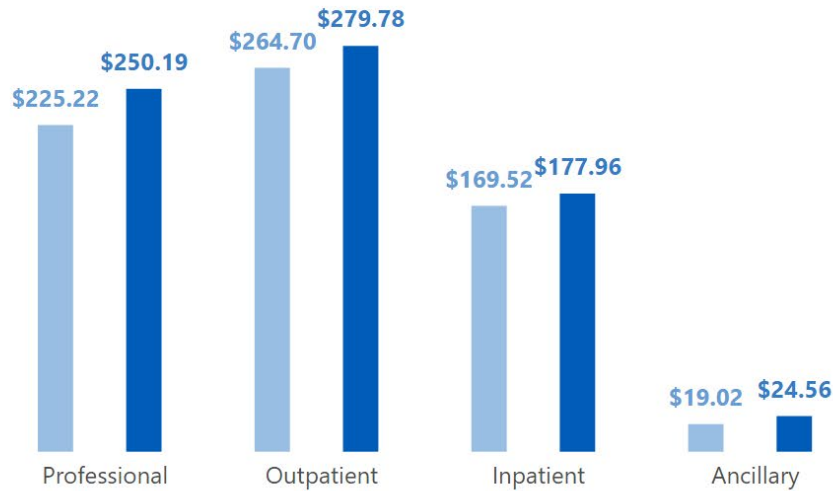
% Utilizers - ER 🏥
13.7%
 -0.1% pp

% Utilizers - UC 📶
28.4%
 1.7% pp

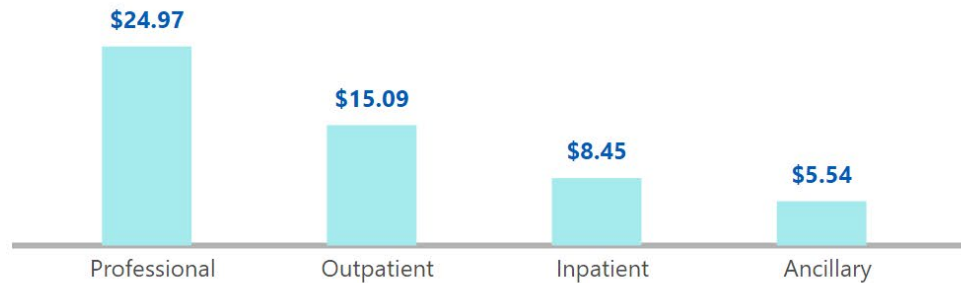
% Utilizers - E&M 👤
83.7%
 0.2% pp

Allowed PMPM by major service category

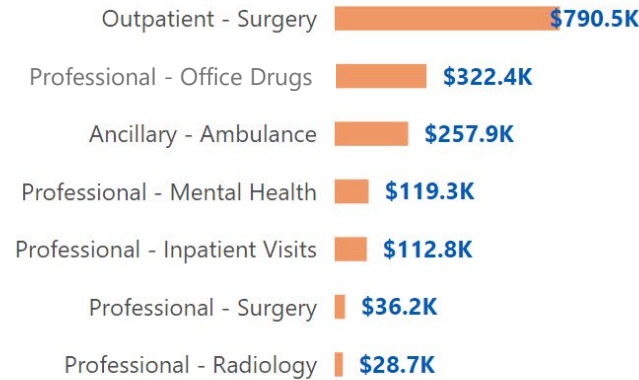
● Prior Period ● Current Period



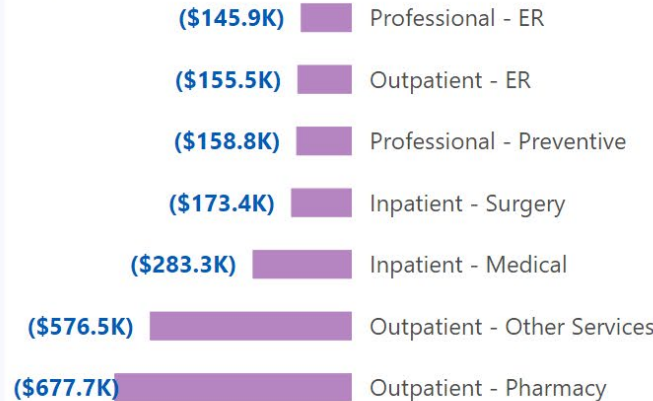
Change



Top 7 spend changes by major + minor service Increases



Decreases



Encounters per 1,000

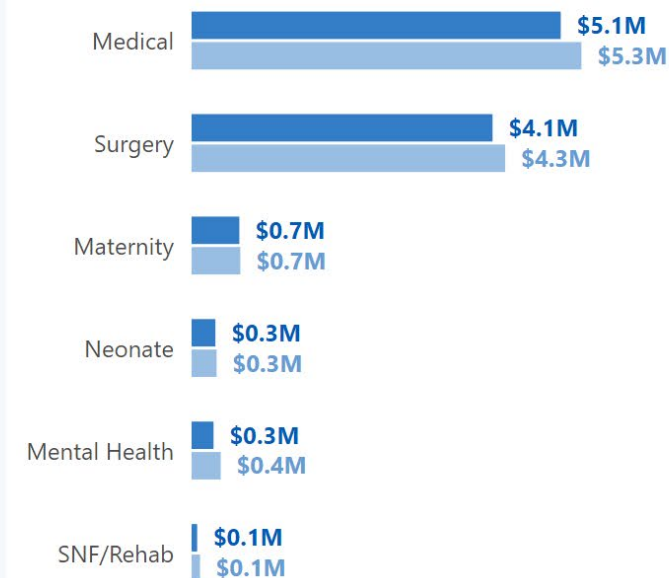
Subcategory	Current Period	Period Over Period Delta
E&M	4,446	295
Urgent Care	499	41
ER	194	-12
Inpatient	65	-2

- Medical allowed PMPM increased to \$732.50, the highest across all three plans, with cost growth across all major service categories, despite a slight decline in total allowed (-2.9%) driven by membership losses.
- Cost growth was led by professional (+\$24.97 PMPM) and outpatient care (+\$15.09 PMPM), with outpatient surgery and office drugs among the top services by cost change.
- ER utilization declined modestly while urgent care utilization rose to 28.4% of membership, the highest rate across all plans. This suggests that members are redirecting some care to lower-acuity settings.



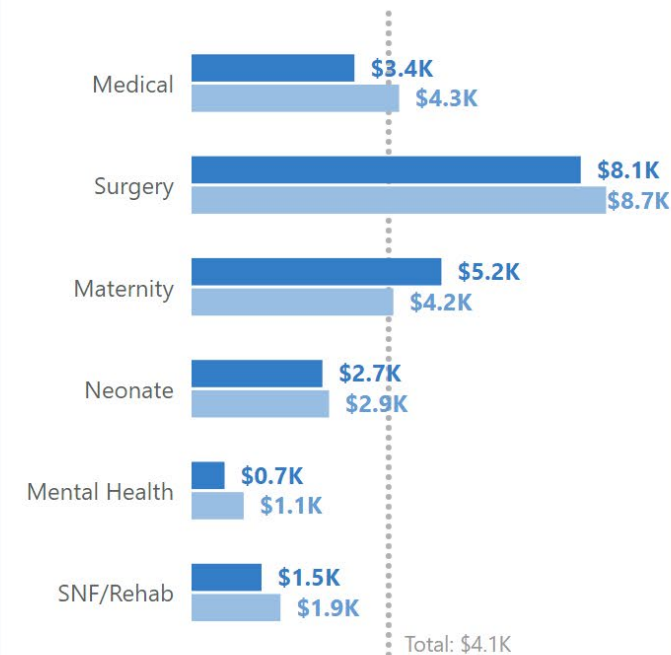
Allowed by service category

● Current Period ● Prior Period

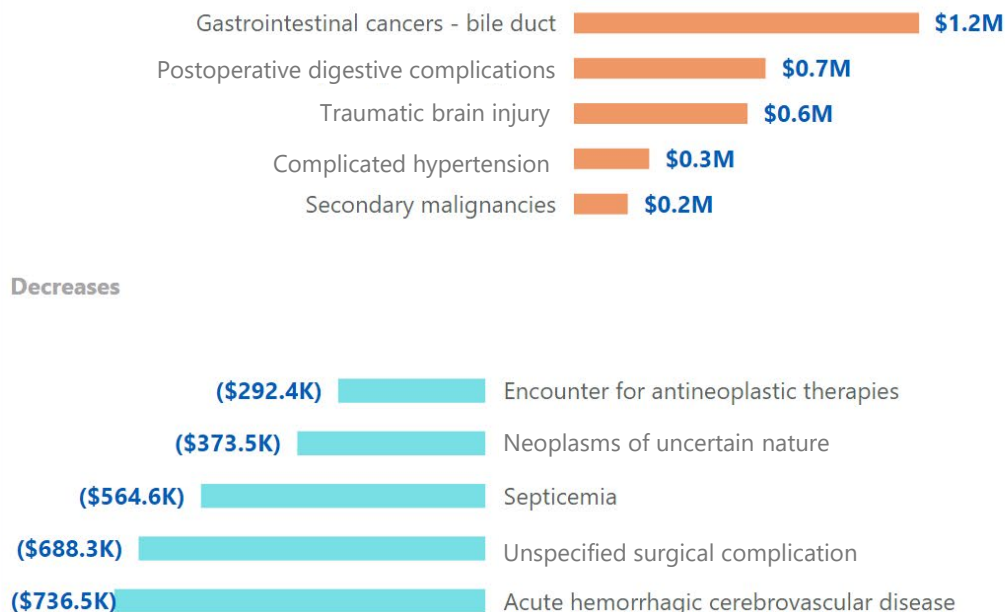


Average Allowed Per Day

● Current Period ● Prior Period



Top 5 spend changes by diagnostic category



- Inpatient PMPM increased 5.0%, driven primarily by higher cost per admission (\$33,023) and a significantly longer average length of stay (8.0 days), pointing to a more complex inpatient case mix period-over-period.
- Gastrointestinal cancers and postprocedural complications were the top inpatient spend drivers, alongside traumatic brain injury, suggesting a shift in acuity toward oncology and complex surgical cases consistent with the larger share of older enrollees (55+) in the EPO population.
- Maternity cost per day increased notably (\$1.0K), accompanied by a slight decline in surgical case volume.

View by ER

Total Allowed \$
\$3.5M
 -4.3%

Allowed PMPM 📅
\$58.48
 6.4%

Utilizers 👥
733
 -89

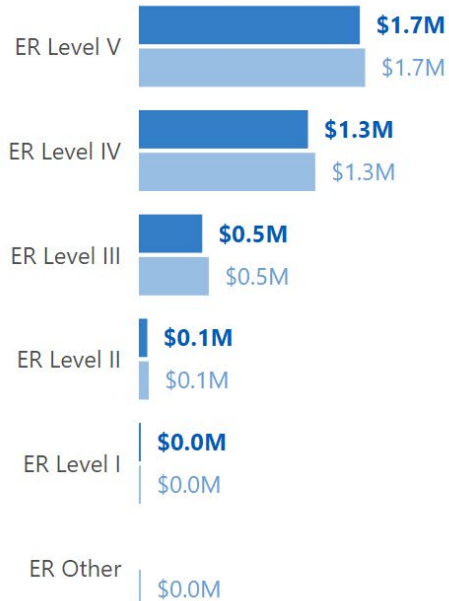
Visits per 1,000 🏠
194.2
 -5.9%

Allowed per Visit 👤
\$3,613
 13.1%

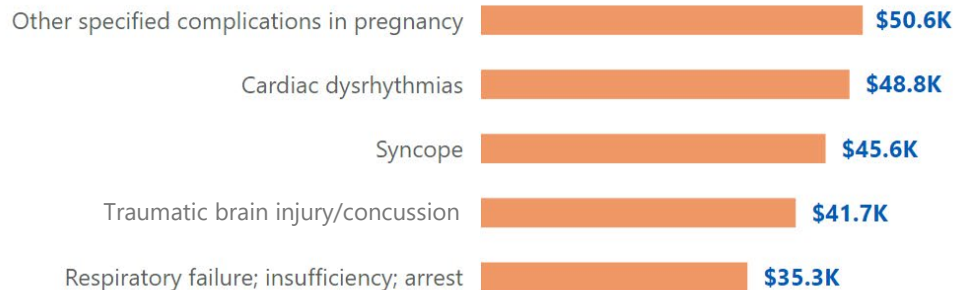
% Total Med Allowed 📄
8.0%
 -0.1% pp

Allowed by service category

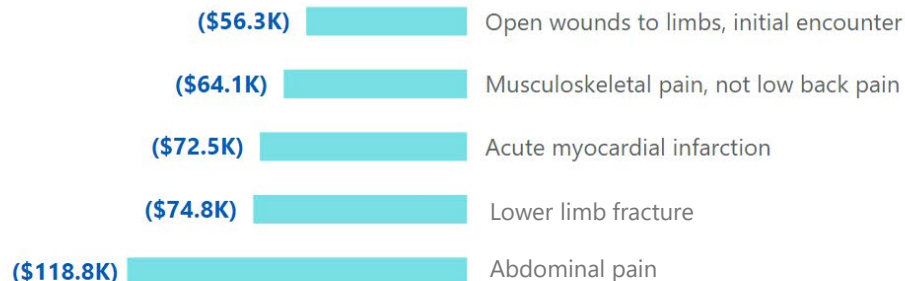
● Current Period ● Prior Period



Top 5 spend changes by diagnostic category - Allowed change period over period
 Increases



Decreases



Detail by Rendering Provider - Source

Rendering Provider - Source	Medical Allowed	Encounters	Allowed Per Encounter
RENOWN REGIONAL MED	\$923,467.84	246	\$3,753.93
CARSON TAHOE REGIONAL HEALTHCA	\$810,296.70	277	\$2,925.26
RENOWN SOUTH MEADO	\$481,341.82	116	\$4,149.50
NORTHERN NV HOSP	\$392,144.25	99	\$3,961.05
CARSON VALLEY MED CENTER	\$153,063.40	38	\$4,027.98

- Pregnancy complications, cardiac dysrhythmias, and syncope were the top ER spend drivers, collectively reflecting a case mix shift toward more serious presentations rather than routine or avoidable ER use.
- TBI/concussion and respiratory failure also contributed to spend increases, further supporting the observation that higher clinical acuity is driving EPO ER costs.

Major Chronic Conditions

Benchmark Type

Public Sector

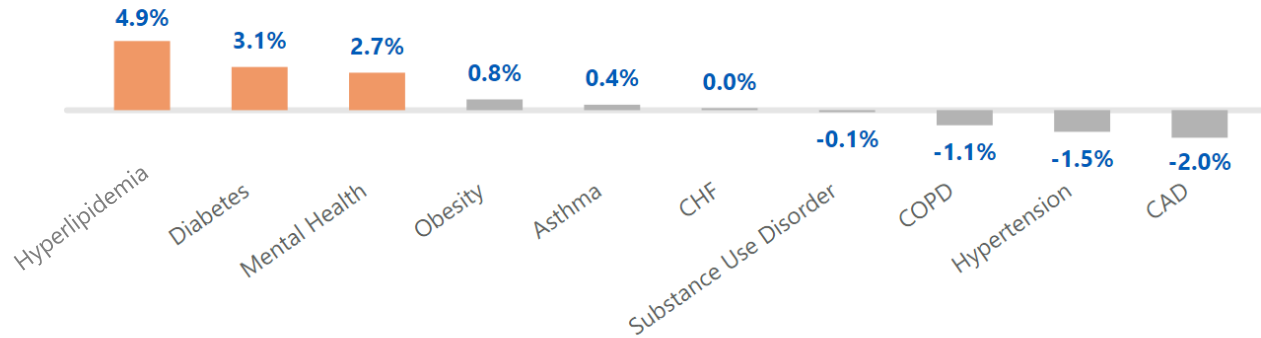
Members
2,854
-320



Prevalence
65.2%
1.7% pp

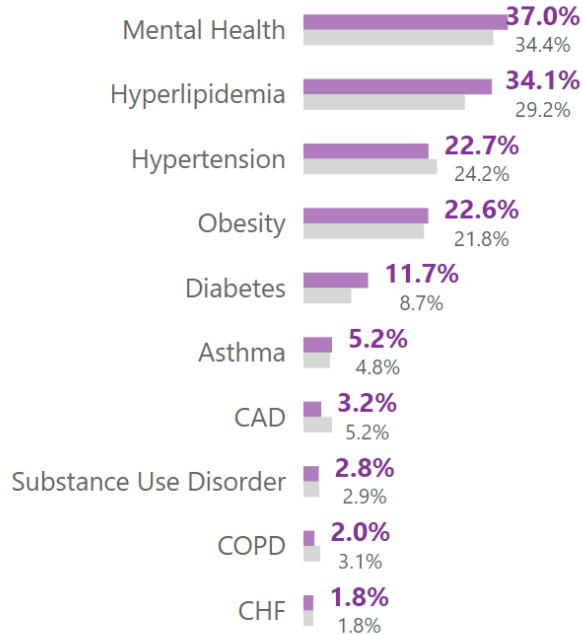


Prevalence Variation from Benchmark



Chronic Conditions Prevalence - hover for age band dist.

● Current Prevalence ● Benchmark



Chronic Condition	Members	Member Change	Prevalence Change	Avg Total Conditions	Med PMPM	Rx PMPM
Mental Health	1,622	-170 ↓	1.2% ↑	2.3	\$963	\$437
Hyperlipidemia	1,495	-132 ↓	1.6% ↑	2.9	\$1,083	\$573
Hypertension	992	-115 ↓	0.5% ↑	3.3	\$1,428	\$698
Obesity	990	-116 ↓	0.5% ↑	3.0	\$1,177	\$547
Diabetes	513	-31 ↓	0.8% ↑	3.8	\$1,396	\$970
Asthma	227	-45 ↓	-0.3% ↓	2.9	\$926	\$780
CAD	141	-25 ↓	-0.1% ↓	4.3	\$1,641	\$739
Substance Use Disorder	122	-22 ↓	-0.1% ↓	3.4	\$1,319	\$418
COPD	87	3 ↑	0.3% ↑	3.7	\$3,529	\$1,057
CHF	78	2 ↑	0.3% ↑	4.6	\$4,392	\$1,130

- Overall chronic condition prevalence was 65.2%, indicating a relatively high chronic burden within the EPO population, with many members having multiple chronic conditions.
- Mental health, hyperlipidemia, and hypertension were most prevalent, with mental health affecting over one-third of members.
- Relative to Segal's Public Sector benchmark, prevalence was higher for hyperlipidemia, diabetes, and mental health, while other conditions were near or below benchmark.

Care Gap Compliance

Benchmark Type

Public Sector

Description	Current	Previous	Change	Benchmark	Variation	
Asthma						
Patient(s) with inhaled corticosteroids or leukotriene inhibitors in the last 12	80.6%	83.1%	-2.5% ↓	84.8%	-4.2% ↓	Declining and Not Beating Benchmark
CAD						
Patient(s) currently taking a statin	74.5%	70.5%	4.0% ↑	71.5%	2.9% ↑	Improving and Beating Benchmark
Patient(s) currently taking an ACE-inhibitor	27.0%	28.9%	-2.0% ↓	22.3%	4.6% ↑	Declining but Beating Benchmark
COPD						
Patients with spirometry testing within the last 12 months	25.3%	28.6%	-3.3% ↓	20.4%	4.9% ↑	Declining but Beating Benchmark
Diabetes						
Patient(s) that had an annual screening test for diabetic nephropathy	63.2%	62.9%	0.3% ↑	64.9%	-1.8% ↓	Improving but Not Beating Benchmark
Patient(s) that had an annual screening test for diabetic retinopathy	40.7%	44.9%	-4.1% ↓	35.0%	5.7% ↑	Declining but Beating Benchmark
Patient(s) that had at least 1 hemoglobin A1C tests in last 12 reported months	87.9%	88.2%	-0.3% ↓	85.3%	2.6% ↑	Declining but Beating Benchmark
Hyperlipidemia						
Patient(s) with a LDL cholesterol test in last 12 reported months	72.6%	74.4%	-1.8% ↓	78.3%	-5.7% ↓	Declining and Not Beating Benchmark
Preventive Screening						
Breast Cancer	72.6%	70.0%	2.7% ↑	72.9%	-0.3% ↓	Improving but Not Beating Benchmark
Cervical Cancer	61.8%	59.9%	1.9% ↑	60.9%	0.9% ↑	Improving and Beating Benchmark
Colorectal Cancer	58.2%	52.7%	5.4% ↑	58.5%	-0.3% ↓	Improving but Not Beating Benchmark
Prostate Cancer	53.8%	49.1%	4.7% ↑	56.2%	-2.4% ↓	Improving but Not Beating Benchmark

- Half of the twelve clinical quality metrics are above benchmark, which indicates good condition management given the high disease burden of this group.

Total Allowed \$
\$19.1M
 -4.4%

30-DS Rx per 1,000 Rx
20,550
 6.5%

Allowed PMPM Calendar
\$323.21
 6.3%

Cost per 30-DS Calculator
\$188.73
 -0.1%

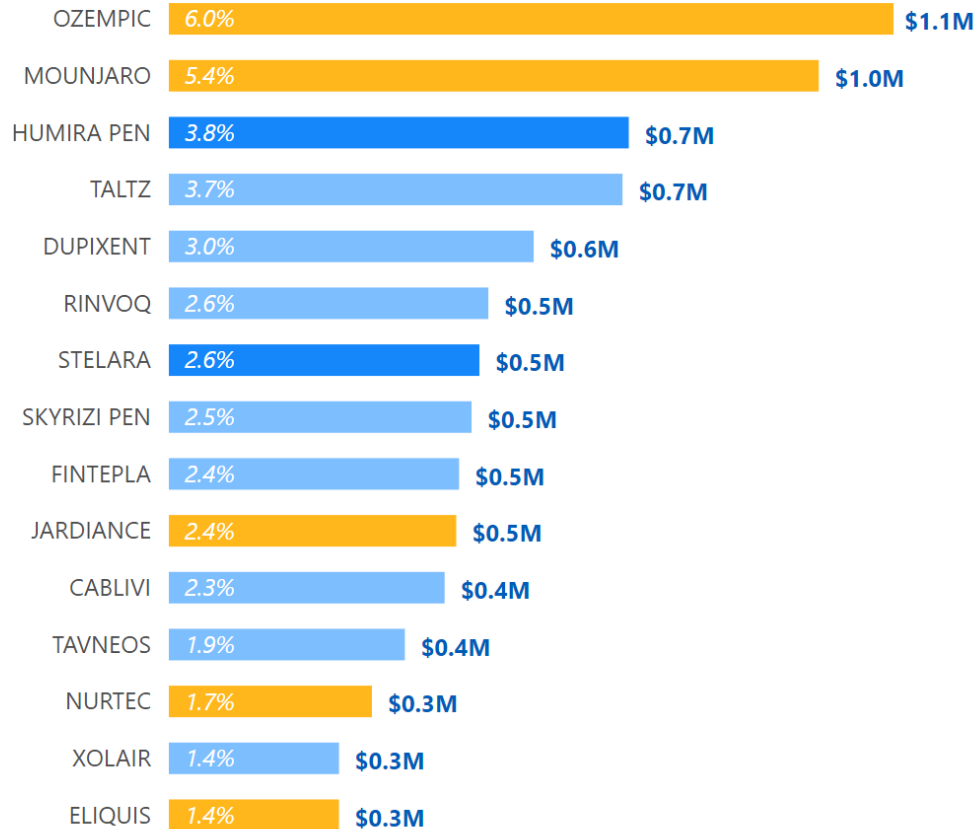
Generic Fill Rate Heart Rate
86.9%
 0.3% pp

Utilizers People
4,238
 -369

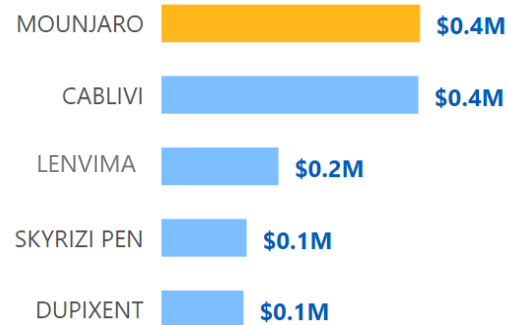
% Utilizing Rx Person with Rx
79.0%
 1.9% pp

Top 15 Drugs - Pharmacy Allowed (% of Total Pharmacy Allowed) *

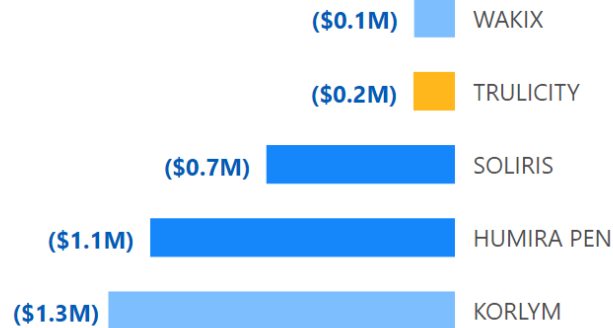
● NS ● S ● S - Bio Available



Top 5 spend changes by drug - Allowed change Increases

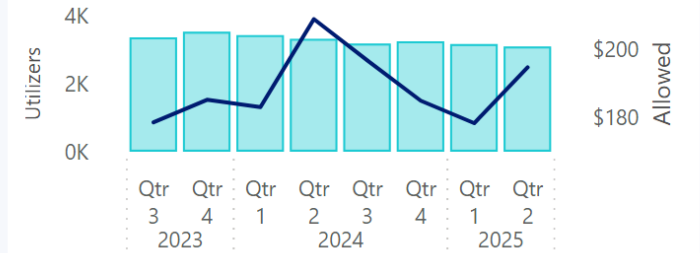


Decreases



Cost vs. Utilization

● Utilizers ● Allowed Per 30 DS



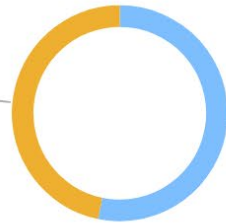
- Total pharmacy allowed declined 4.4% to \$19.1M, reflecting lower overall spend driven by declining membership, while allowed PMPM increased 6.3%.
- Pharmacy utilization increased 6.5% on a scripts per 1,000 basis, while cost per 30-day supply remained essentially flat (-0.1%), indicating utilization as the primary driver of PMPM growth.
- GLP-1s were the costliest drugs for EPO enrollees, together representing over 13% of total pharmacy allowed. High-cost specialty drugs further concentrated spend among a small number of medications, despite a strong generic fill rate elsewhere.

Current Pharmacy Allowed

Specialty allowed trend

-9.1%

\$8.9M (46.8%)



\$10.2M (53.2%)

Non-specialty allowed trend

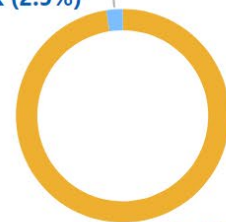
1.6%

Prescriptions

Specialty scripts trend

3.0%

1.7K (2.5%)



68.2K (97.5%)

Non-specialty script trend

-5.5%

Average Cost per 30 day supply

Specialty average cost trend

-15.1%

\$5,291.41

Specialty
Non-Specialty

\$89.98

Non-specialty average cost trend

6.3%

Allowed PMPM Trends

Specialty allowed PMPM

\$172.04

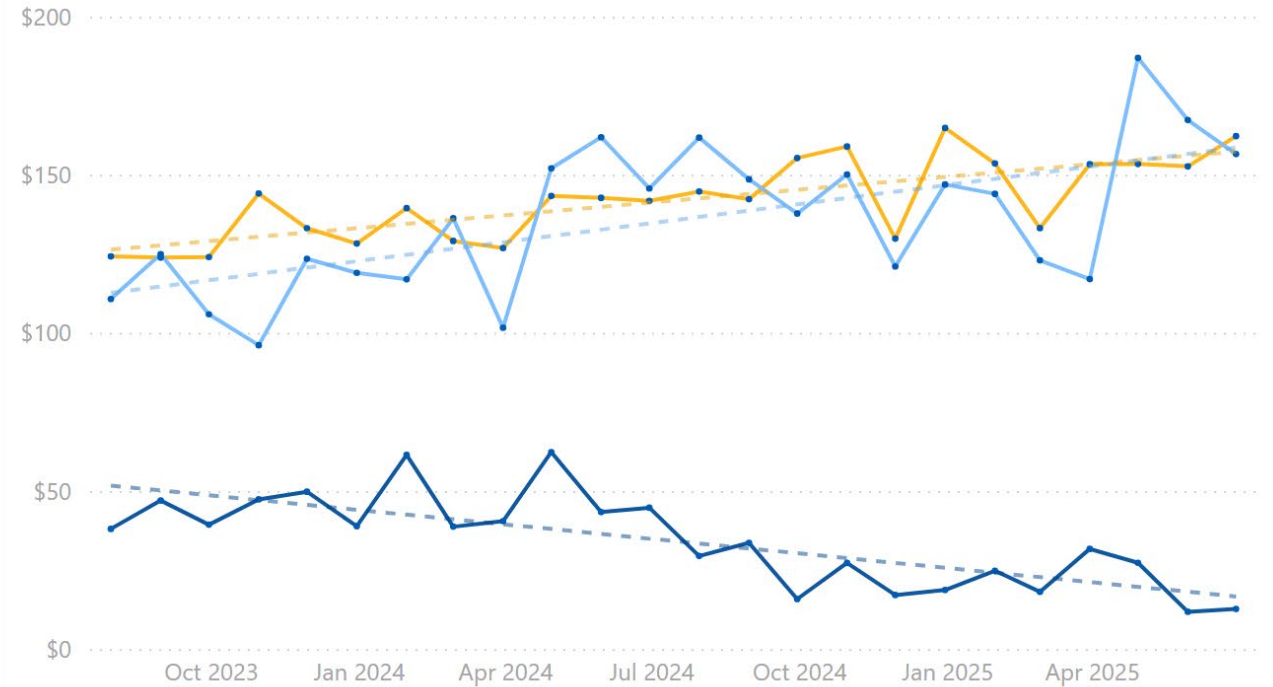
1.1%

Non-specialty allowed PMPM

\$151.17

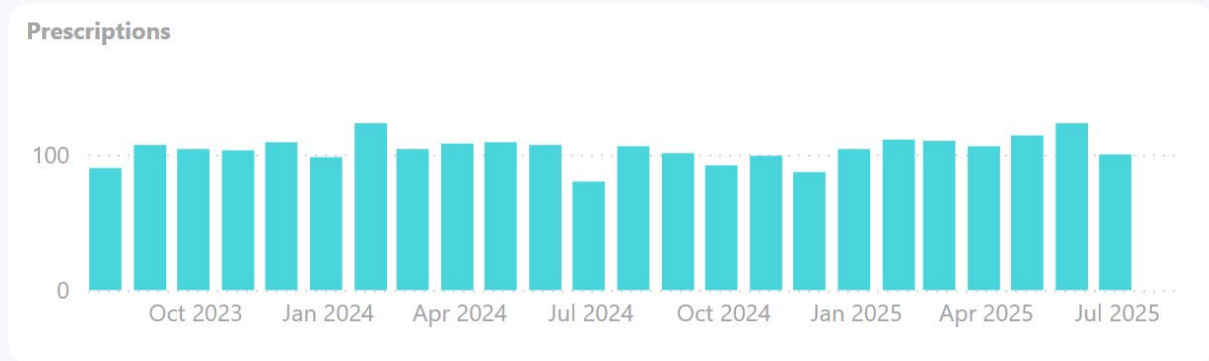
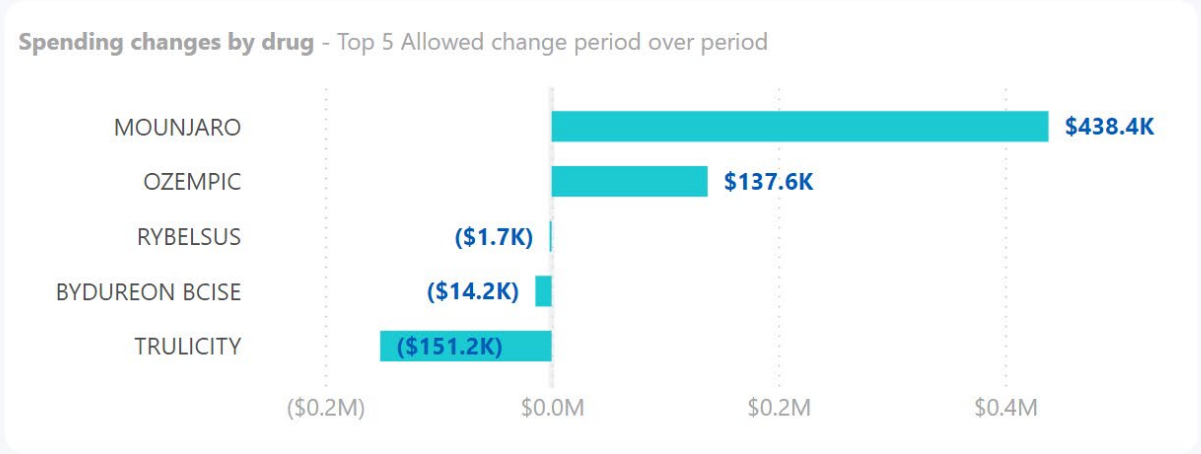
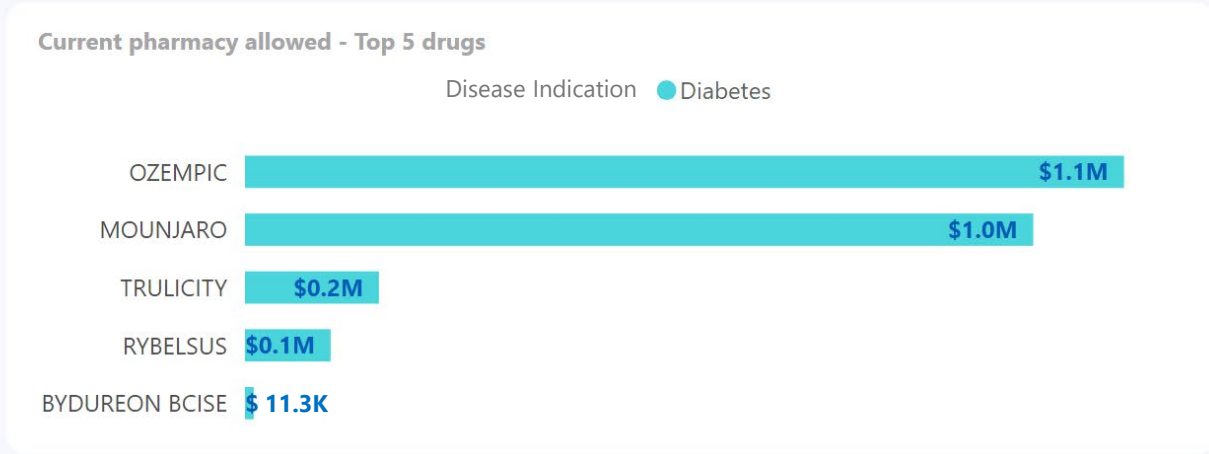
12.9%

● NS ● S ● S - Bio Available




- Specialty drugs accounted for 53.2% of total pharmacy allowed costs while representing only 2.5% of prescriptions.
- Specialty pharmacy performance increased moderately, with allowed PMPM increasing 1.1% and average cost per 30-day supply decreasing 15.1% during the period.
- Non-specialty PMPM increased 12.9%, driven by higher unit costs (+6.3%) despite a decline in prescription utilization (-5.5%).


Total Allowed \$2.5M 19.5%	30-DS RX per 1,000 511 26.9%	Allowed PMPM \$41.69 32.9%	Cost per 30-DS \$978.74 4.7%	Generic Fill Rate 0.0% 0.0% pp	Utilizers 279 13
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- GLP-1 allowed PMPM increased 32.9% to \$41.69 — the highest across all three plans — driven as in other groups mainly by higher utilization rather than unit costs. Though cost per 30-days did increase, the change was modest compared to that of utilization (4.7% vs. 26.9%).
- Mounjaro and Ozempic account for over 80% of total GLP-1 spend, as prescribing continues to shift toward newer agents and away from older drugs like Trulicity.

Total Allowed 
\$16.0M
 -7.1%


30-DS RX per 1,000 
5,626
 7.1%

Allowed PMPM 
\$270.16
 3.4%

Cost per 30-DS 
\$576.23
 -3.5%

Generic Fill Rate 
60.5%
 -0.1% pp

Utilizers 
2,831
 -257

% Total Rx Cost 
83.6%
 -2.4%

Rank	Disease Indication	Previous Rank	Rank Change	Current Rx PMPM	PMPM Change	Current Utilizers	Utilizer Change	% Total Rx	Generic Fill Rate
1	Diabetes	1	0	\$64.02	(\$10.23) ↓	587	-23 ↓	19.8%	43.3%
2	Autoimmune Disease	2	0	\$40.08	(\$9.55) ↓	77	-5 ↓	12.4%	17.6%
3	Psoriasis	3	0	\$35.05	\$7.90 ↑	34	3 ↑	10.8%	3.4%
4	Blood Disorders	4	0	\$21.15	(\$0.01) ↓	152	-9 ↓	6.5%	36.5%
5	Oncology	6	1 ↑	\$14.99	\$2.94 ↑	97	-11 ↓	4.6%	87.8%
6	Skin Disorders	9	3 ↑	\$14.05	\$5.58 ↑	658	-21 ↓	4.3%	86.6%
7	Asthma/COPD	5	-2 ↓	\$13.73	\$0.46 ↑	782	-55 ↓	4.2%	80.5%
8	Migraine	7	-1 ↓	\$13.71	\$3.21 ↑	209	-38 ↓	4.2%	45.2%
9	Seizure Disorder	10	1 ↑	\$11.04	\$2.99 ↑	487	-38 ↓	3.4%	96.9%
10	Multiple Sclerosis/Neuromuscular Disorders	13	3 ↑	\$9.80	\$4.75 ↑		1 ↑	3.0%	44.6%
11	Vaccines/Immunizing Agents	11	0	\$8.87	\$1.93 ↑	1,062	-182 ↓	2.7%	0.0%
12	ADHD/Narcolepsy	8	-4 ↓	\$8.63	(\$1.27) ↓	316	2 ↑	2.7%	90.3%
13	Viral Infections/HIV AIDS	14	1 ↑	\$5.45	\$0.57 ↑	24	2 ↑	1.7%	42.8%
14	Mental Health/Neurological Disorders	12	-2 ↓	\$4.89	(\$0.61) ↓	175	-14 ↓	1.5%	84.8%
15	Diabetic Supplies/Monitoring	15	0	\$4.70	\$0.10 ↑	112	-12 ↓	1.5%	0.0%

- The top 15 disease indications accounted for \$16.0M in allowed costs and 83.6% of total pharmacy spend.
- Diabetes remained the largest pharmacy cost driver at nearly 20% of total pharmacy spend, despite a decline in PMPM (-\$10.23) and fewer utilizers during the period.
- PMPM increases were broad-based across the majority of indications, with Psoriasis (+\$7.90), Skin Disorders (+\$5.58), and Multiple Sclerosis (+\$4.75) among the largest contributors, partially offset by declines in Diabetes and Autoimmune Disease.

A Word About Privacy

- Data presented has been “de-identified”, which means it does not contain names or SSNs, etc.
- Specific medical conditions are identified.
- If the plan administrator knows the identity of individuals with a specific condition, that information is considered PHI.
- PHI is subject to the HIPAA Privacy Rule’s protections, which means it must be kept confidential and cannot be used for any reason other than health plan administration (e.g., using it for employment purposes, or by other benefit plans, is prohibited).



GLP-1 Experience Monitoring

Methodology and Limitations

- A review of experience for members utilizing Glucagon-like-peptide-1 (GLP-1) prescription drugs was performed to monitor user adherence and drug efficacy.
 - Members enrolled in Medicare are excluded from the analysis
- The cost impact analysis includes members who initiated GLP-1 therapy between January 2023 and December 2024.
 - Medical claims data through March 2026 was included. December 2024 was used as the cutoff to ensure users had at least 12 months of experience with a GLP-1 and three months of claims runout.
 - Members must have been enrolled for at least 6 months prior to GLP-1 initiation and at least 12 months after initiation.
- Certain claims unrelated to GLP-1 utilization were excluded from the cost impact analysis.
- GLP-1 medications often have target doses for effectiveness; this is not accounted for in medication adherence, which only considers receipt of drug treatment.
- We have provided a list of medical claims detail by service category for adherent and nonadherent members separately.



GLP-1 Analysis – Methodology & Limitations

- Medication adherence is measured based on the proportion of days covered (PDC) methodology, which is the standard used by the Pharmacy Quality Alliance and Medicare. PDC accounts for the total days of therapy available to an individual (days covered) within a standardized window. For members receiving refills prior to the end of a previous prescription, days are “shifted” to account for this overlap. For example, a member filling a 28-day supply of Ozempic on Jan 1, 2023 and again on Jan 25, 2023 would have 4 days of overlap since the first prescription would end on Jan 28, 2023. Therefore, the second prescription is “shifted” to begin on Jan 29, 2023 and end on Feb 25, 2023. In this scenario, 56 days would be counted for the member.
 - If a member begins a GLP-1 medication, but later fills a different GLP-1 medication, days are not shifted if an overlap occurs, but instead the remaining days on the first prescription are not counted. Ex: Member fills a 28-day supply of Ozempic on Jan 1, 2023 and a 28-day supply of Mounjaro on Jan 25, 2023. Ozempic’s days counted are Jan 1 – 24 and Mounjaro’s days counted are Jan 25, 2023 through Feb 21, 2023. In this scenario, only 52 days would be counted for the member.
 - PDC is typically calculated within a specific time period, typically a calendar year. Here, we calculated PDC starting with the date of a member’s first prescription and through 1 year. Any days supply after the end of 1 year are not counted, which caps a PDC value at 100%. For example, if a member’s first fill is Jan 1, 2023 then the last day counted would be Dec 31, 2023 (1 year since the first prescription). If the member fills an 84-day supply on Dec 30, 2023, then only 2 days (Dec 30 and 31) are included in the calculation.
 - An illustrative exhibit on how PDC was calculated is included in the Appendix.
- Members with a PDC of 80% or greater are considered “adherent” and less than 80% considered “non-adherent”.
- All exhibits reviewing adherence requiring members to be enrolled for at least 12 months following GLP-1 therapy initiation, which limited the exhibits to users who initiated therapy by December 2024. Additionally, we’ve only included participants who initiated therapy on or after January 2023.

Condition-Specific Program Analysis

- Segal requested participation lists from the various programs from UMR and Nevada Business Group on Health
- Participants were then matched to the claims in the SHAPE data warehouse with claims paid through February 28, 2026
 - Current Year: July 1, 2024 through June 30, 2025 (Incurred)
 - Previous Year (Multi-Year Analysis): July 1, 2023 through June 30, 2024 (Incurred)
- To get the eligible population, we applied our standard logic to identifying those with either diabetes or obesity
- While some participant sample sizes were small, observations were summarized on each slide
- Overall, the industry is moving towards whole-person health versus programs specific to certain conditions

9.

9. Review and discussion of Express Scripts, Inc. Programs.

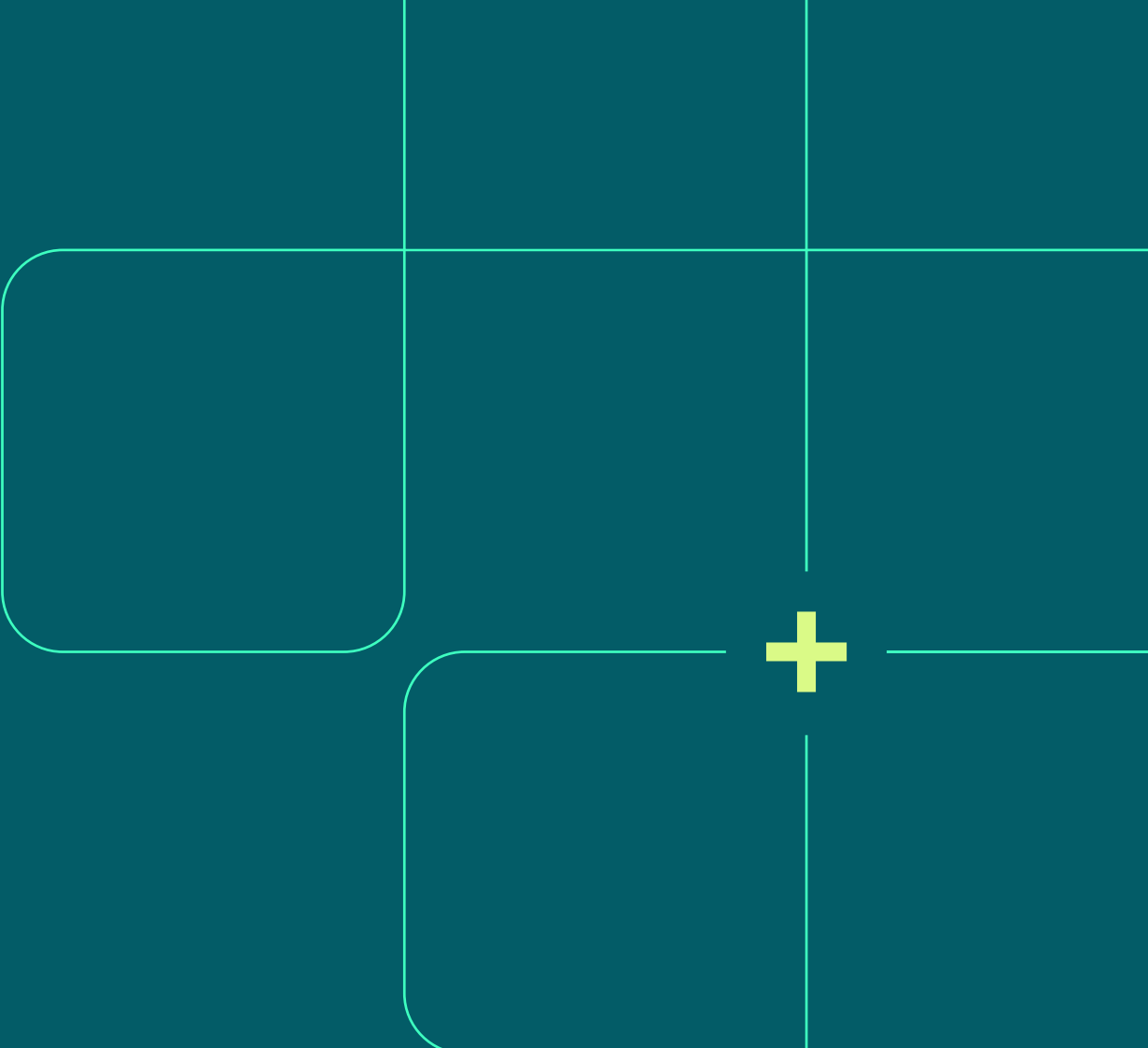
(Amy Donohue, ESI) (**For Possible Action**)

9.1 Pharmacy Benefit Manager Programs

9.2 Hinge Health

Nevada Public Employees Benefit Program

Prescription Benefit Recommendations and Current Program Savings



EncircleRx | Diabetes GLP-1 Savings Guarantee Option

ESTIMATED DIABETES SAVINGS WITH ENCIRCLE RX

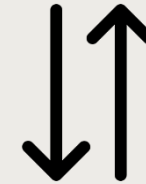
Program Levers

- + Diabetes Diagnosis with medical data.
- + Increased GLP-1 monitoring & fraud protection

\$0.25 PMPM
Program Cost



\$8.85 PMPM Spend
(2026 Estimate)



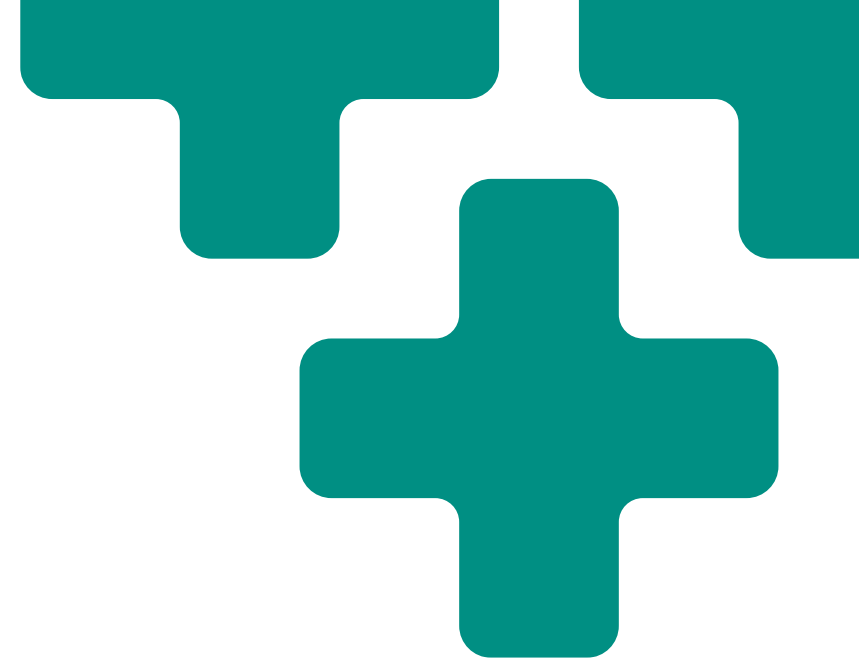
\$8.39 PMPM
Plan Cost Net PMPM Spend +
Program Fees

3:1
Savings Guarantee

Improving clinical and financial outcomes

No one can predict when a member will be diagnosed with a costly, complex chronic condition and new expensive therapies are coming to market at a new, rapid pace. However, plan sponsors can prepare to manage these costs while taking a clinically effective approach.

- + **We ensure clinically appropriate use of medications for approved conditions** with prior authorizations
- + **We drive use of clinically effective first-line medications first** with step therapy
- + **We align dispensing quantity with FDA-approved dosage guidelines** with drug quantity management



Recommended Utilization Management Option

Package	Price PMPM	Estimated Annual Net Plan Cost Savings*	Estimated Net Plan Cost Savings PMPM	Estimated Member Impact
Unlimited	\$0.27	\$967,756	\$1.54	1,298

- + **Active Management Prior Authorization List**
- + **Cost Watch Prior Authorization List**
- + **Optional Prior Authorization List**

**Based on 52,325 lives
 Current program fees total \$1.20 pmpm – new package price replaces existing fees.
 Savings estimates are net of program cost assumes no continuation of therapy
 Implementation may require an adjustment to rebate guarantee.*

SUPPLEMENTAL

Current Program Descriptions and Savings

April 1, 2025 – March 31, 2026

PROGRAM	ABOUT	PLAN SAVINGS
Advanced Utilization Management	Control pharmacy spend by proactively managing medication use through tools like prior authorization, step therapy, and quantity limits to ensure safe, effective, and appropriate treatment.	\$17.5M
Hinge Health	Digital musculoskeletal (MSK) care solution that helps members manage joint and muscle conditions (e.g., back, knee, hip, shoulder pain) through virtual care.	\$1.7M
Medical Channel Management	Select specialty drugs are moved from the medical benefit to the pharmacy benefit access rebates and consistent utilization management.	TBD
National Preferred Formulary	Member choice while reducing pharmacy spend. The formulary includes nearly all generics and a wide range of brand-name drugs, excluding select high-cost products that do not provide additional clinical value.	\$7.2M
SafeGuard	Care Value and protection program to manage utilization, improve outcomes, and guard against price increases. This program helps drive appropriate therapy while controlling overall pharmacy spend.	\$3.1M
SaveonSP	Copay assistance program to reduce specialty drug costs, by maximizing available manufacturer funding to save the plan and members dollars.	\$2.8M
Smart90 Savings	Channel management program that requires members to fill a 90-day supply of maintenance medications at select retail pharmacies or mail order with improved pricing to improve adherence and reduce overall pharmacy costs.	\$2.1M

10.

10. Review and discussion of UMR programs. (UMR)

(For Possible Action)

10.1 Obesity Care and Diabetes Care Management

10.2 2ndMD

10.3 Real Appeal

10.4 Doctor on Demand



State of Nevada Public Employees' Benefits Program

May 2026 Board Meeting

Overview of current programs and ecosystem



Obesity Care Management Program

Customized disease management solution developed for PEBP



Diabetes Care Management Program

Customized disease management solution developed for PEBP



Real Appeal

Weight management solution (UMR program)



Diabetes (DSMP) Program

Administered by Nevada Health Partners



Diabetic Care Value Program

Administered by Express Scripts



Doctor on Demand

Telehealth services (UMR program)



2nd MD

Second opinion (UMR program)



Integrated case management

Prior authorization, Inpatient Case Management, Outpatient Case Management, Access Center, Transplant Case Management, Total Population Health



Payment Integrity

(UMR program)



Medical Rx Advisor

Effective July 1st (UMR program)



Hinge Health

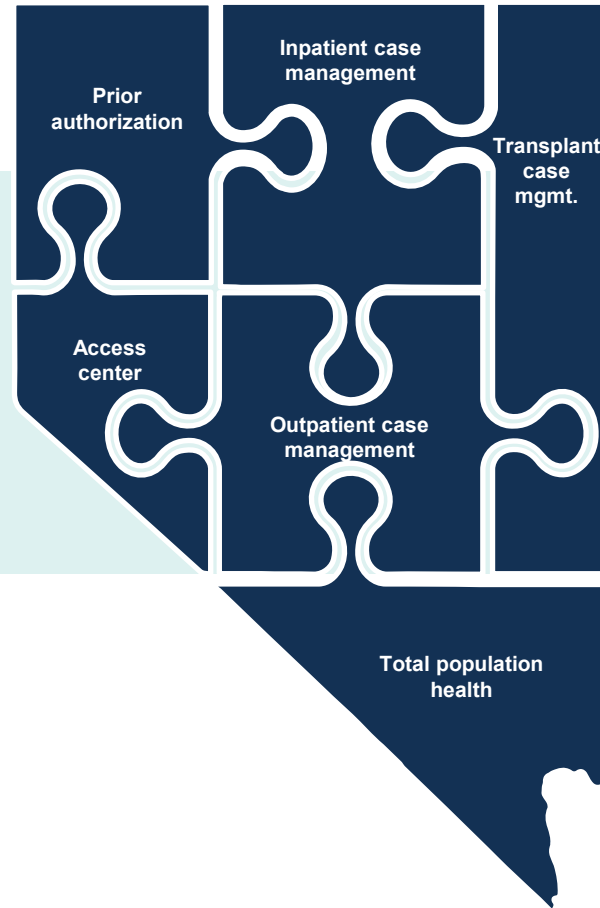
Digital health program designed to treat and prevent MSK pain (ESI direct agreement)



Carrum Health

Cancer Concierge Program, COEs for orthopedic, cardiac surgery, bariatric surgery

Engagement through integrated clinical solutions



Inpatient care management	Complex case management	NICU	Social worker
<ul style="list-style-type: none"> • Ensure patients receive quality medical care in the most appropriate setting and refer to appropriate quality outpatient programs. • Provide case management coverage seven days per week with weekend staff onsite at high census hospitals • Patient assessment of all major domains using evidence-based criteria (physical, functional, financial and psychosocial) • Develop individualized discharge plans that involve all stakeholders including the patient and caregiver goals for successful transitions of care • Implement discharge plan involving health care resources across the continuum and maximize members benefits within their plan guidelines • Monitor and report variances that may challenge timely quality 	<ul style="list-style-type: none"> • Complex Case Management (CCM) Team provides coordination of care and services to members who have experienced a critical event or diagnosis that requires the extensive use of resources. • The case manager works in collaboration with members, providers and key stakeholders in coordinating healthcare services and referrals. • Encourage self-management of care • Increase customer satisfaction to support Net Promoter Score (NPS) • Decrease admissions and readmissions for all lines of business • Single point of contact for complex patients • Increase engagement with PCPs and members 	<ul style="list-style-type: none"> • NICU is managed locally with no delegations to NRS • NICU RNs provide case management which includes level of care bed day coding to ensure appropriate length of stay • Perform onsite visits (one day per week / assigned hospitals) • Provide resource information and coordinate discharge planning • Arrange delivery of DME and services that include, but not limited to: <ul style="list-style-type: none"> – Private duty nursing – Home health visits 	<ul style="list-style-type: none"> • Provides services to members for any diagnosis that may benefit from the following • Financial needs: disability resource information; utility assistance/rental assistance; emergency assistance; employment resources; co-pay/prescription assistance program • Housing needs: emergency shelter resources; weatherization/home modification resources; transitional housing resources • Food needs: food assistance resources; food pantry resources • Other needs: domestic violence assistance resources; infant supply resources; caregiver resources; clothing resources; cancer/disease specific resources; legal resources; veteran's resources

SHO Case Management Dashboard

Activity Summary & Participation by Program (7/1/2025 – 3/31/2026)



Utilization Management	SHO Utilization Management		SHO Utilization Management \$ Savings	
		<u>FY</u>		<u>FY</u>
	➤ Services Reviewed	37,523	➤ Services Avoided	994
	➤ % Cases Completed Within 5 Days	66.0%	➤ Denial Rate	2.6%
			➤ Savings From Avoided Services & Site of Service Review	\$902,575

Case Management	Outpatient Case Management		Inpatient Case Management	
		<u>FY</u>		<u>FY</u>
	➤ Outpatient Cases Open	2,276	➤ IP Cases Opened	1,474
	➤ Outpatient Cases Managed	1,373	➤ Saved IP Bed Days	506
	➤ Acceptance Rate	60.3%	➤ Savings From Avoided Bed Days	\$2,940,936

Telephone Advice Nurse	TAN Utilization	
		<u>FY</u>
	➤ Total Calls	392
	➤ Top Call Outcomes:	
	PCP	77
	Self-Care/Home Care	26
	Urgent Care	87
	ER Diversions	190
	Call 911/ER	17
	➤ Total Savings (ER Diversions):	\$590,139

Combined Activity		<u>FY</u>	All Programs
▶	Avoided Service and SOS Savings		
▶	IP Savings	\$2.94M	
▶	ER Diversion	\$590K	
Total Savings:		\$4.43M	
Savings PEPM		\$16.50	
Savings PMPM		\$9.37	



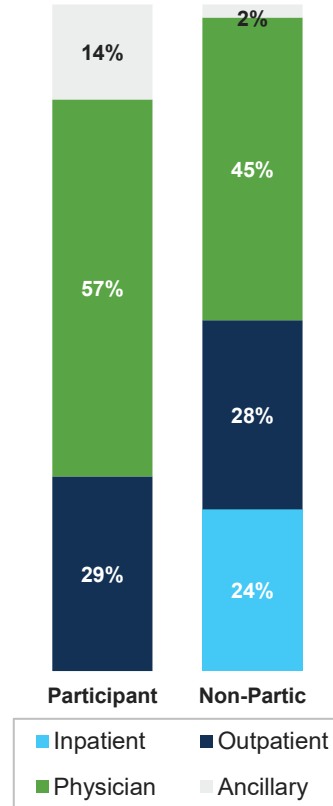
Diabetes Care Management

Financial & utilization summary

Financial summary

Financial measure	Participants	Non-partic.	Variance
Average enrollment			
Employees	13	2,788	-99.5%
Tot. Members	18	3,470	-99.5%
Emp to total ratio	1.4	1.2	11.2%
Financial summary			
Allowed	\$51,310	\$28,142,302	-99.8%
Plan paid	\$32,581	\$22,024,358	-99.9%
Member Paid (OOP)	\$18,729	\$4,157,281	-99.5%
Paid PEPY*	\$3,339	\$10,523	-68.3%
Paid PMPY*	\$2,411	\$8,455	-71.5%
Paid PEPM	\$278	\$877	-68.3%
Paid PMPM	\$201	\$705	-71.5%
High-cost claimants (Med paid \$100,000+)			
# of HCCs	0	32	-100.0%
HCCs per 1000	0.0	9.2	-100.0%
Paid per HCC	\$0	\$183,398	-
HCC paid % of tot	0.0%	26.6%	-26.6 pts
Cost distribution by claim type (Paid PMPY*)			
Inpatient	\$0	\$2,051	-100.0%
Outpatient	\$704	\$2,399	-70.7%
Physician	\$1,364	\$3,840	-64.5%
Ancillary	\$344	\$165	108.3%

Cost distribution by claim type



Utilization summary

Utilization measure	Participants	Non-partic.	Variance
Inpatient admissions			
# of admits	0	201	-100.0%
# of admit days	0	1,095	-100.0%
paid per admit	\$0	\$31,510	-
paid per admit day	\$0	\$5,784	-
Admits per 1000	0.0	77.2	-100.0%
Average LOS	0.0	5.4	-
Emergency room visits			
# of ER visits	1	796	-99.9%
~ % resulting in admit	0.0%	17.5%	-17.5 pts
ER visits per patient	1.0	1.5	-32.3%
ER visits per 1000	74.0	305.6	-75.8%
Paid per ER visit	\$3,218	\$3,351	-4.0%
Urgent care visits			
# Of UC visits	2	900	-99.8%
UC visits per patient	1.0	1.5	-32.7%
UC visits per 1000	148.0	345.5	-57.2%
Paid per UC visit	\$104	\$99	5.0%
Office visits			
Off visits per patient	3.1	6.0	-48.2%
Paid per office visit	\$57	\$91	-37.3%
Office visits paid PMPY	\$224	\$677	-67.0%
Services			
Radiology svcs per 1000	1,406.1	7,010.7	-79.9%
Radiology paid PMPY	\$243	\$627	-61.3%
Lab services per 1000	15,171.3	19,898.4	-23.8%
Labs paid PMPY	\$151	\$418	-63.9%

* Annualized

Non-participants are defined as members identified with diabetes in the prior 12 months (4/1/2025 - 3/31/2026), but who are not enrolled in the Diabetes Care Management program

Claims date range: service dates 7/1/2025 - 3/31/2026, Paid through 3/31/2026

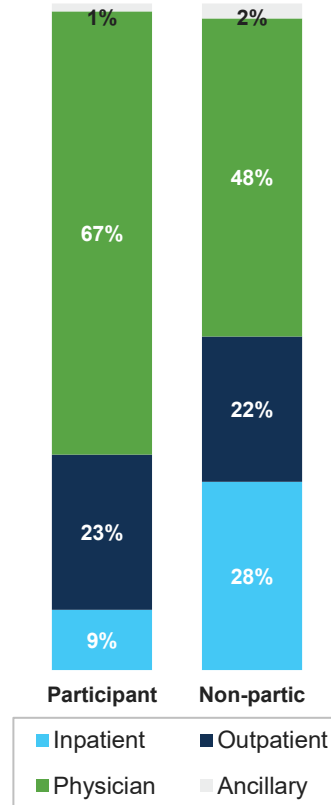
Obesity Care Management

Financial & utilization summary

Financial summary

Financial measure	Participants	Non-Partic.	Variance
Average enrollment			
Employees	295	521	-43.4%
Tot. members	334	607	-45.0%
Emp to total ratio	1.1	1.2	-2.8%
Financial summary			
Allowed	\$1,969,880	\$5,738,544	-65.7%
Plan paid	\$1,520,778	\$4,917,976	-69.1%
Member paid (OOP)	\$273,793	\$787,739	-65.2%
Paid PEPY*	\$6,867	\$12,575	-45.4%
Paid PMPY*	\$6,065	\$10,793	-43.8%
Paid PEPM	\$572	\$1,048	-45.4%
Paid PMPM	\$505	\$899	-43.8%
High-cost claimants (med paid \$100,000+)			
# Of HCCs	1	5	-80.0%
Hccs per 1000	3.0	8.2	-63.7%
Paid per HCC	\$159,786	\$309,029	-48.3%
HCC paid % of tot	10.5%	31.4%	-20.9 pts
Cost distribution by claim type (paid PMPY*)			
Inpatient	\$547	\$3,050	-82.1%
Outpatient	\$1,412	\$2,352	-40.0%
Physician	\$4,034	\$5,148	-21.6%
Ancillary	\$72	\$242	-70.2%

Cost distribution by claim type



Utilization summary

Utilization measure	Participants	Non-partic.	Variance
Inpatient admissions			
# of admits	10	47	-78.7%
# of admit days	41	303	-86.5%
Paid per admit	\$16,201	\$34,765	-53.4%
Paid per admit day	\$3,951	\$5,393	-26.7%
Admits per 1000	39.9	103.1	-61.3%
Average LOS	4.1	6.4	-36.4%
Emergency room visits			
# of ER visits	47	152	-69.1%
~ % Resulting in admit	10.6%	14.5%	-3.8 pts
ER visits per patient	1.3	1.5	-13.1%
ER visits per 1000	187.5	333.6	-43.8%
Paid per ER visit	\$4,075	\$3,235	26.0%
Urgent care visits			
# Of UC visits	108	195	-44.6%
UC visits per patient	1.4	1.5	-2.5%
UC visits per 1000	430.7	427.9	0.7%
Paid per UC visit	\$110	\$103	6.0%
Office visits			
Off visits per patient	14.6	6.7	119.2%
Paid per office visit	\$123	\$94	31.0%
Office visits paid PMPY	\$2,386	\$801	197.8%
Services			
Radiology svcs per 1000	5,767.2	5,817.9	-0.9%
Radiology paid PMPY	\$376	\$707	-46.8%
Lab services per 1000	17,325.5	21,364.3	-18.9%
Labs paid PMPY	\$311	\$496	-37.3%

* Annualized

Non-participants are defined as members identified with a morbid obesity condition in the prior 12 months (4/1/2025 - 3/31/2026), but who are not enrolled in the Obesity Care Management program

Claims Date Range: Service Dates 7/1/2025 - 3/31/2026, Paid through 3/31/2026

Real Appeal

Real Appeal is the virtual lifestyle program focused on weight loss through proper nutrition and exercise.

The program is available to all employees enrolled in the medical plan, plus covered spouses and dependents. Participants must be 18 or over, with a body mass index (BMI) of 23 or higher.

Real Appeal is a pay-for-performance program committed to helping people take small steps for larger, long-term results. The model combines live online group sessions, regular accountability, easy access to the desktop or mobile app, and personalized messaging to support participants with all the tools necessary for sustained behavior change.

Real Appeal uses highly interactive virtual coaching to drive small behavior changes. The program is designed to support participants who are overweight or simply wanting to lose weight.



Real Appeal Dashboard

Data through December 2025



2nd MD – Second Opinions



2nd.MD is a market leader in second opinions, offering members virtual consultations with a national network of specialists across all adult and pediatric specialties.

- ✓ Access to trained specialists
- ✓ Independent expert advice before major health events or decisions
- ✓ Specialized team offering personalized member support
- ✓ Comprehensive digital tools across all medical and behavioral health conditions
- ✓ 2nd.MD provides virtual second opinions with outcomes rooted in this solution approach: helping decrease medical and Rx cost trend
- ✓ Data-driven outreach to help identify and impact members in their time of need with virtual second opinions delivered within days, not weeks
- ✓ Independent review: unbiased second opinions from a national network of specialists

2nd MD – Executive Summary

2nd.MD July 2025 -March 2026

Providing convenient virtual access to experts



82
Net Promoter Score

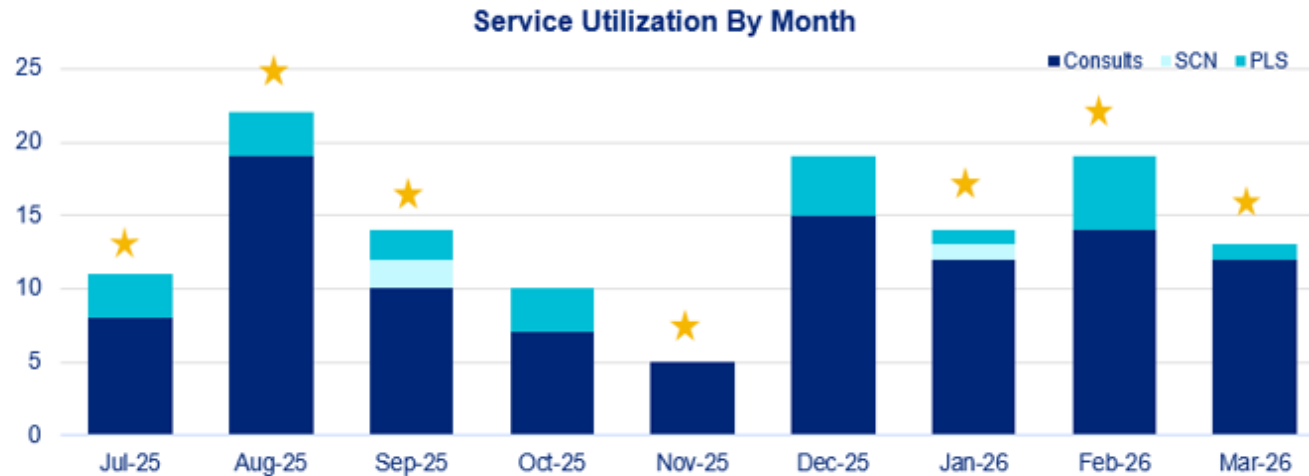
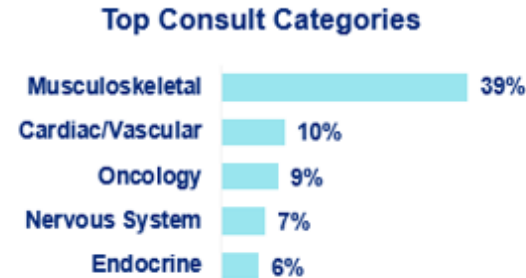
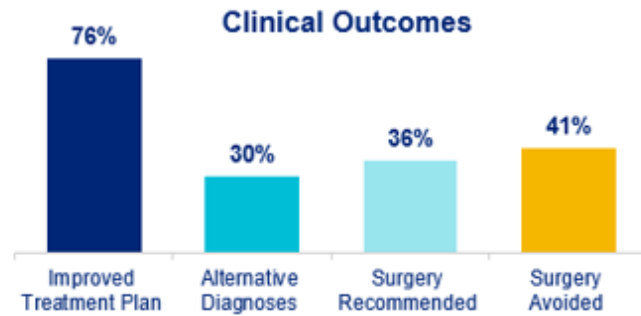
214
Activations

0.68%
Utilization

102
Completed Consults

26
Personalized Local Support (PLS)

3
Specialty Care Navigation (SCN)



★ 2nd.MD Communication



\$426,638
Total Cost Savings

\$21,213
Avg. Savings Per Surgery Avoided

\$4,183
Avg. Savings Per Consult

"It was evident the specialist reviewed all medical records provided. Extremely knowledgeable and thorough with explanations. Very courteous and professional."

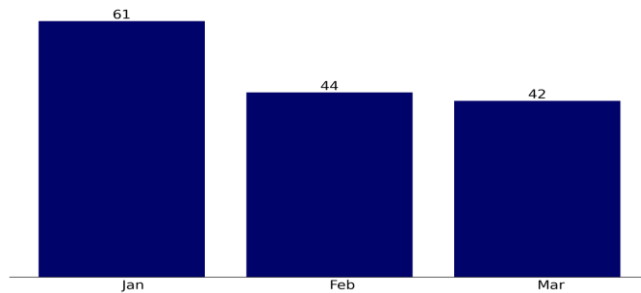
– SON PEBP Member

Doctor on Demand Engagement

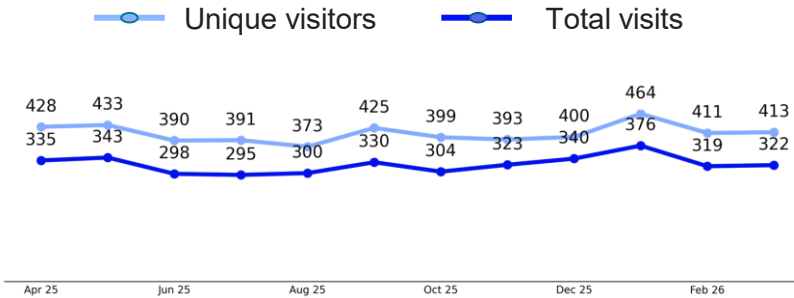


42 Registrations in March 2026	322 Unique visitors in March 2026	413 Total visits in March 2026
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New registrations (year to date)



Visits last 12 months



14,173 Registrations Lifetime to date	29% Registration rate Lifetime to date*
147 Registrations Year to date	0.3 Registration rate Year to date*

*Based on 48,935 covered lives

84% of Medical and Psychiatry visits resulted in a prescription order - YTD

2% of Medical visits resulted in a lab order - YTD

28,982 visits Lifetime to date	8,490 unique visitors Lifetime to date	3.4 Avg visits per visitor Lifetime to date	17% Engagement rate (visitors/lives) Lifetime to date
1,288 visits YTD	810 unique visitors YTD	1.6 Avg visits per visitor YTD	2% Engagement rate (visitors/lives) YTD



Plan Performance Observations and Proposed Solutions

	<p>PEBP's medical trend continues to track below benchmark norms.</p>		<p>Behavioral Health – Neurodevelopmental Disorders – new enhanced ABA program in place.</p>
	<p>98.2% of all medical spend dollars were to In Network providers.</p>		<p>MedicalRx Advisor estimated to save ~\$1M annually</p>
	<p>\$13.8M in savings in 2025 from our Payment Integrity Program which identifies potential fraud, waste and abuse</p>		<p>Health Activation Index (HAI) measures decision making across metrics including various services, like preventive, ER, imaging, network, as well as Evidence Based Medicine metrics captured in claim utilization.</p>
	<p>Emergency room utilization has increased across all three medical plans. We are partnering with Doctor on Demand to develop an ER avoidance flyer for distribution and the PEBP website.</p>		<p>Medicine on the Move is our mobile clinic initiative created to improve access to preventive care for employees. The clinic travels throughout Nevada, focusing on communities with limited transportation access. This model could be an effective solution for PEBP, particularly in rural areas.</p>

11.

- 11. Review and discussion of Carrum Health programs.
(Alex Brochu, Carrum Health) (**For Possible Action**)
 - 11.1 Knee, Hip, Shoulder, Spine, Heart
 - 11.2 Weight Loss Surgeries
 - 11.3 Cancer Care

State of Nevada: May Board Meeting



May 2026

CONFIDENTIAL

Agenda

- 01** Carrum Overview
- 02** Executive Summary
- 03** Engagement Results
- 04** Expansion Opportunities
- 05** Plan Design Changes



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Your Carrum Team



Alex Brochu
Client Success Manager



Kathryn Laughlin
Director, Client Success



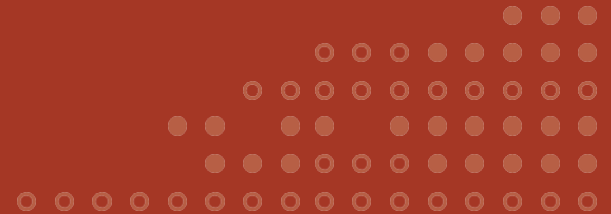
Alex Wynne
Sr. Director, Commercial Partnerships



Alyssa Ferrera
Client Success Associate

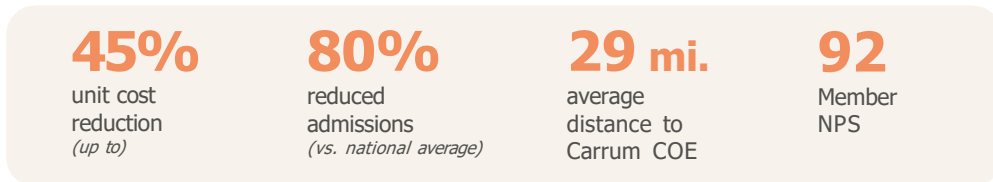
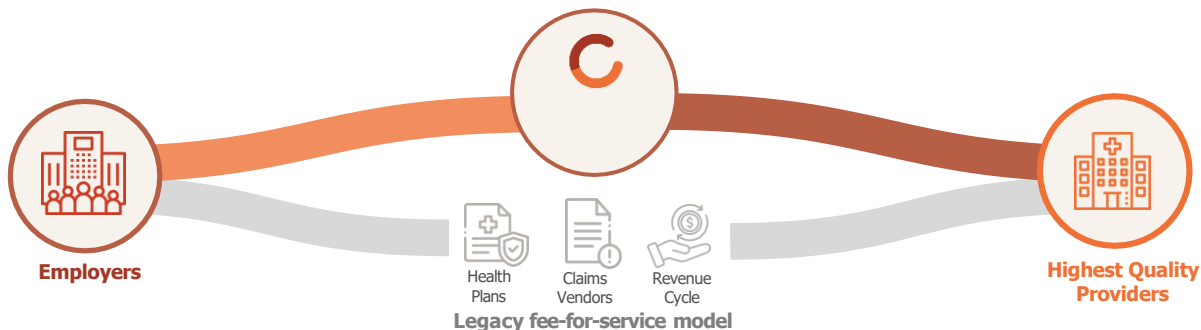
01

Carrum Overview



One-stop solution for premier specialty care

Connecting your members to the highest quality, most appropriate care.



CONFIDENTIAL

True value-based care model

All-inclusive prospective bundles with provider-held warranties



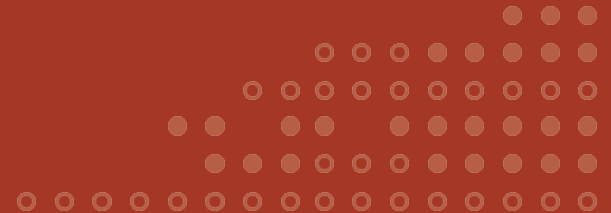
*Unique to
Carrum*

*Unique to
Carrum*

- 1 Aligns provider incentives
- 2 Accountability throughout entire patient journey
- 3 Patients get the best care pathway

02

Executive Summary



PEBP Partnership Executive Summary: 7/1/24 - 5/15/26

RESULTS

2,208

Registrations

109

Completed Consults and
Surgeries

87

PEBP NPS Score

12.1%

Conversion Rate

8.4%

Utilization Rate

1.4%

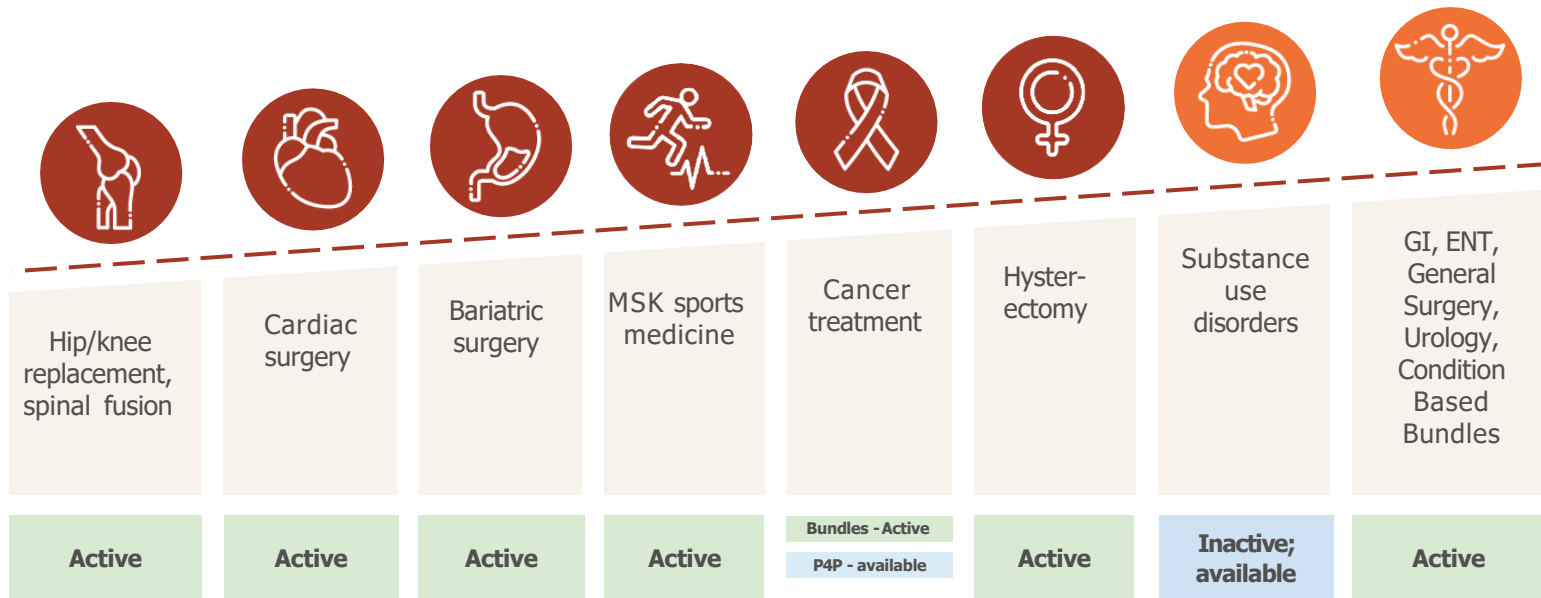
Complication Rate

"Lily has been so super fantastic to work with! I felt like I could tell her anything and we became friends... Truly, she is an asset, and **I couldn't have made it through without her**. She laughed with me, got mad with me and for me, she cried with me and listened to all of my blubbering stories of divine signs showing me I was being seen! She was calm when I wasn't and allowed me the time to vent and peacefully put it away.

Thank you to Lily for being my soundboard, my therapist, my advocate and most of all, for being that calm, cool, and collected voice on the other end of the phone cheering me on. She is amazing and **I'd love to have a pocket full of Lily's!**"

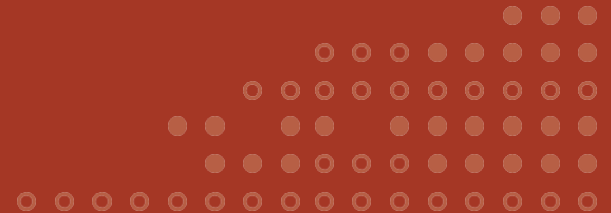
Cancer patient
City of Hope

Pushing the envelope in bundled payments



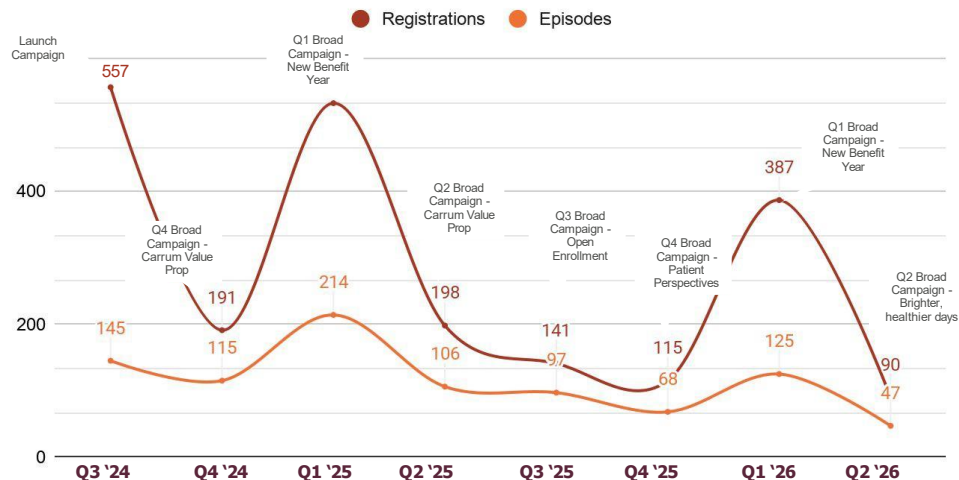
03

Engagement Results



Broad Member Campaign Insights

Registrations & Episodes - Broad Campaign Deployments



29.6%

Avg. Open Rate Across Lifetime Broad Campaigns

In line with Carrum's Voluntary BoB

15.2%

Avg. Click-Through Rate Across Lifetime Broad Campaigns

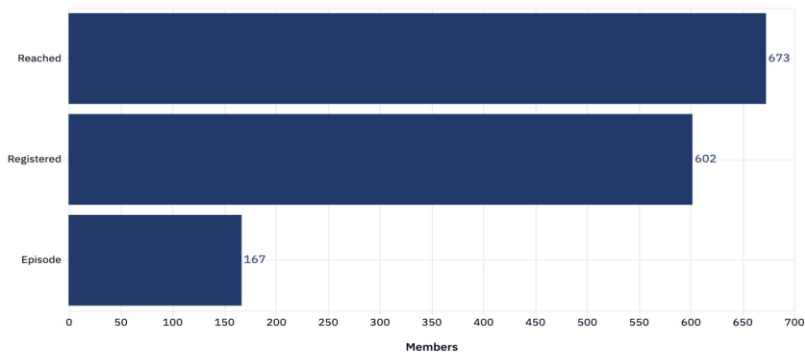
4.6x higher compared to Carrum's Voluntary BoB



- **Utilization:** Reg→Episode conversion is rising structurally as cohorts mature. Members who registered earlier in the program now have time to convert to surgical episodes, and they're doing so at industry-leading rates.
- **Campaign Performance:** Roughly 6 in 10 PEBP registrations happened within 24 hours of a broad-email click, highlighting the role broad-email outreach continues to play in driving member engagement. Broad email campaigns contributed to ~1,531 registrations (✓69.2% of total registrations), while open and click-through rates have remained consistent across quarters since launch.
- **Top 5 Service Line Categories:** Bariatric, MSK, Oncology, Gynecology, Cardiac

Automated Program Performance Highlights

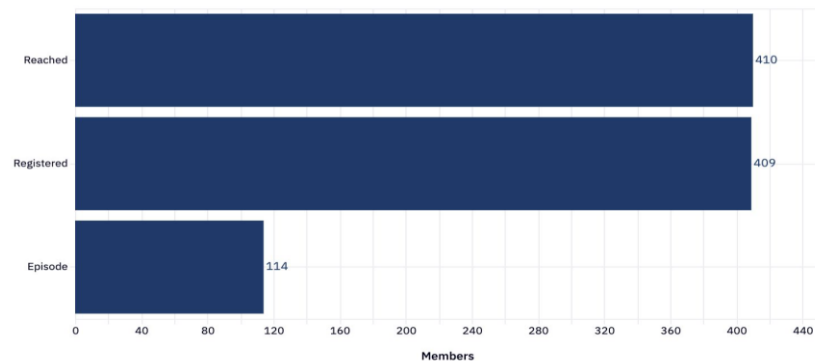
Geo-Targeting



Key Takeaways

- **Communications drive action:** Nearly 9 in 10 geo recipients (89.4%) registered with Carrum, reinforcing that localized, relevant messaging resonates strongly.
- **Bariatric, MSK and Oncology are top drivers:** Each service line accounts for 16–20% of geo episodes, indicating broad engagement across service lines.

New Member Awareness



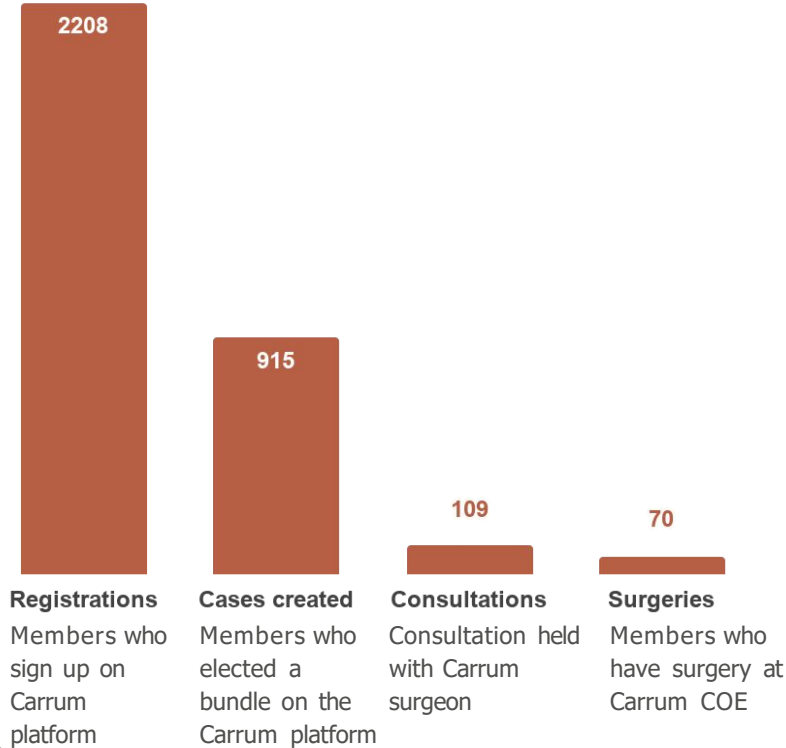
Key Takeaways

- **Near-perfect registration follow-through:** Effectively every new hire (409 of 410) who received the welcome email went on to register with Carrum.
- **~28% reached-to-episode conversion:** 410 new hires reached, 114 went on to create an episode of care.

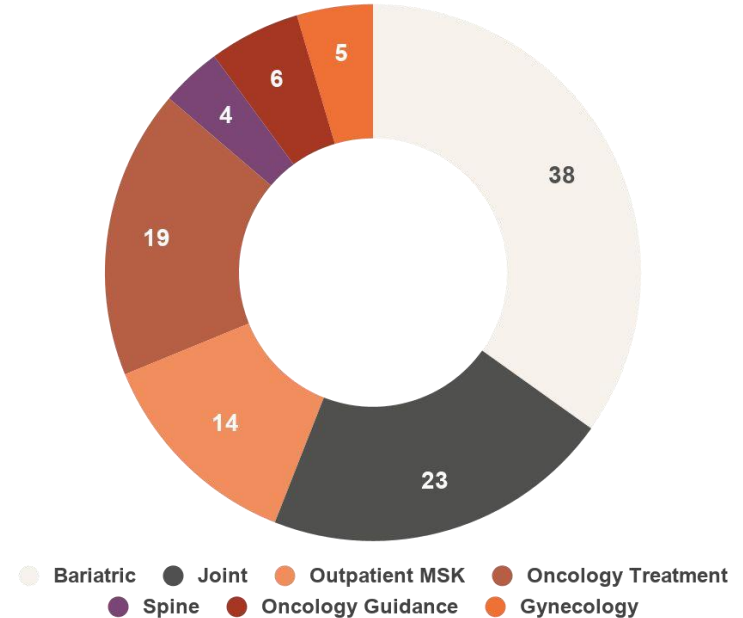
PEBP Member Engagement

Date range 7/1/24 - 5/15/26

MEMBER ENGAGEMENT



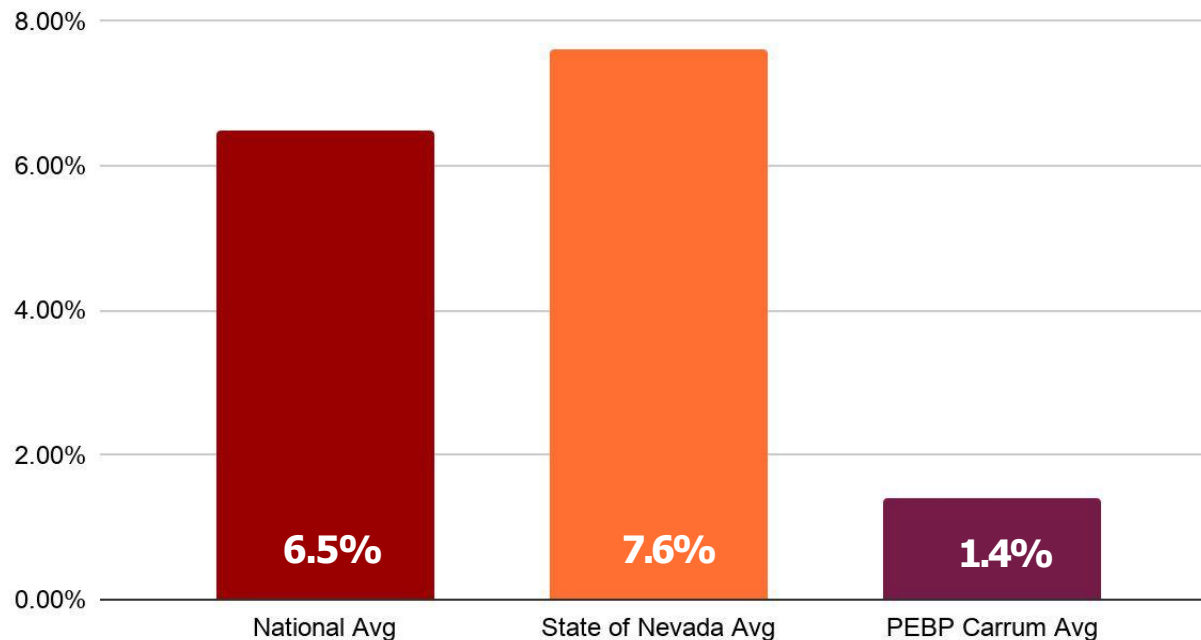
CONSULT & SURGERY TYPES



Surgeon-level evaluation for PEBP

Carrum provides high quality care to PEBP members

Claims Based Complication Rate



**Based on Carrum's set of available Medicare + Commercial claims data*



PEBP patient experiences at Carrum COEs

“

My experience at North Vista Hospital was truly amazing. The team was highly skilled, and the operation ran like a well-oiled machine. Everyone made me feel safe and cared for throughout the process. Both the surgeon and anesthesiologist took their time to speak with me, answer all my questions, and ensure I was comfortable.

After the surgery, the nursing team was nothing short of exceptional.

The center of excellence and the overall experience with my surgeon exceeded all expectations.

Bariatric

North Vista Hospital

“

The experience with my surgeon, his amazing staff, and the hospital was all top notch.

This [experience] was way better than I ever imagined!

Bariatric

North Vista Hospital

“

I can't thank Dr Crovetti and his team enough for excellent treatment and caring throughout my process.

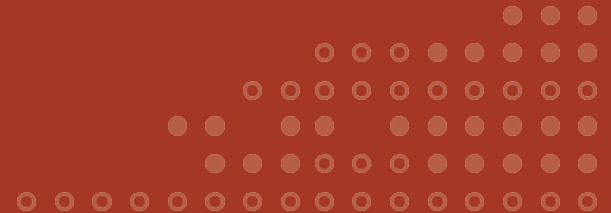
I felt very well treated in my most painful moments, and trustful and confident of the job that he had done in my hip and his team. What an excellent team!!! Bravo to them, great job and well done!
Definitely highly recommend.

Hip replacement

Crovetti Orthopaedics & Sports Medicine

04

Expansion Opportunities



What is unique about Carrum's Cancer Treatment program?

CENTERS OF EXCELLENCE NETWORK

Ultra-curated network of the highest quality providers and facilities

- **50+ quality metrics evaluated:** focus on evidence-based guideline compliance and pathways, appropriateness of care & treatment-related readmissions
- Includes both NCI-designated centers and community oncology centers

VALUE~~BASED~~ BASED PAYMENTS (✓ Providers bear risk)

All providers contracted and incentivized to provide high-quality, cost-effective care

- **Treatment Bundles:** All-in rate for a treatment episode, including cost of therapeutics and related complications
- **NEW: Pay for Performance:** 10% penalty if quality and patient satisfaction criteria not met for non-bundled treatments

Holistic treatment coverage for all cancer types

Expert review and treatment planning

Diagnostic review and treatment plan development

- In-person assessment: review of medical records/pathology
- Additional testing as needed
- Evidence-based treatment planning

Treatment

All modalities covered regardless of tumor type / stage

- Excision surgery
- Chemotherapy
- Radiation
- Related imaging, labs
- Symptom management
- Palliative care

Wraparound services

Representative “whole-person” care at Carrum COEs

- Nutrition
- Behavioral health
- Integrative medicine
- Caregiver support
- Survivorship support



Support throughout from dedicated Oncology-Trained Nurses

30M[✓] U.S. Employees

Currently struggle with substance use disorders

1ⁱⁿ 6

U.S. working
adults 18[✓]

40%

Severe / moderate
need
comprehensive
treatment







Sources:

1. [Substance Abuse and Mental Health Services Administration \(SAMHSA\) annual 2024 survey](#)
2. [U.S. Census Bureau, Employment status of the civilian population by sex and age.](#); U.S. Bureau of Labor Statistics, 9.25



Substance Use Treatment

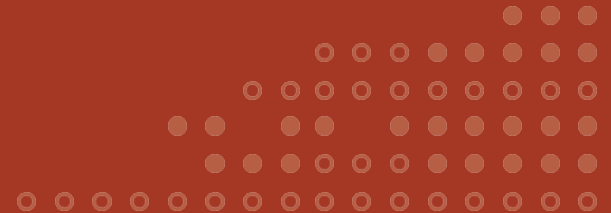
Comprehensive value-based care treatment

- 
Highest-quality treatment options
 End to end for successful outcomes and recovery
- 
Rapid access to a nationwide network
 Referrals in 24 hours, treatment commences within 36
- 
Pre-negotiated rates and VBC for savings
 Bundled pricing reduces costs up to 30% vs market price
- 
Dedicated clinical navigators
 White glove guidance and ecosystem integration

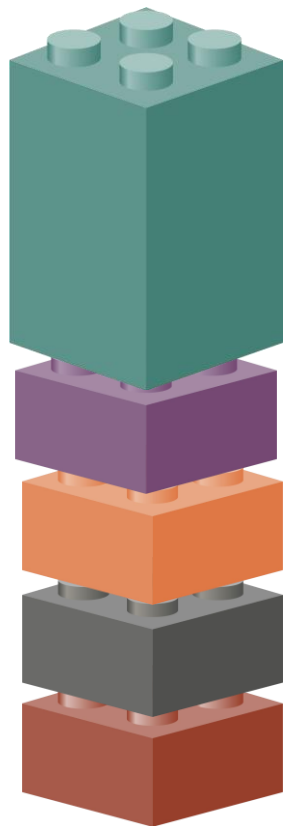
Alcohol + Opioids + Cannabis + Stimulants + Sedatives

05

Plan Design Changes



Combine all elements to maximize engagement



Plan Design

✓(Carum Best Practice)
4X utilization

Broad and Precision Marketing

Ecosystem Referrals

\$0 patient cost share

Access

Part of
PEBP's
program
to date

Greatly improve cost savings



91%
of PEBP members live
within 50 miles of a
Carrum COE

only impacts

6 out of
1,000
members



delivers

Up to ^{*}
4x
cost savings and
member usage



*Estimated cost savings; may vary by client

Transitioning to VoluntaryFlex—Customer case study

BACKGROUND

Major U.S. airline

- 16K employees (concentrations in FL, NY, and Boston)
- Carrum Health partner since 2023

CHALLENGES

Experienced high claims costs, with majority of employees in the Northeast.

- Second opinion services unsuccessful in the past
- Groups are collectively bargained; would like broad network access

SOLUTION

Transitioned to 1 VoluntaryFlex service line to start: bariatrics

	YEAR ONE	YEAR TWO <i>with VFlex</i>	
BARIATRICS UTILIZATION	9%	93%	↑ 620%
BARIATRIC SURGERIES <i>through Carrum</i>	3	31	↑ 930%
TOTAL SAVINGS	\$382 _K ¹	\$962 _K ²	↑ 152%

ADDITIONAL WINS:

- Strong member NPS of 84 in year 2, even with VoluntaryFlex
- Maintained surgery avoidance rate of 25%



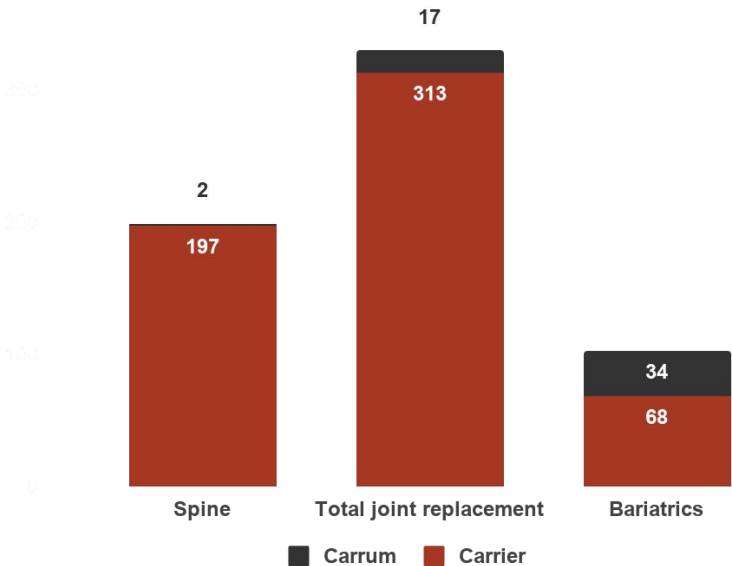
¹Breakdown Year 1: \$31K bundle savings; \$351K surgery avoidance

²Breakdown year 2: \$352K bundle savings; \$610K surgery avoidance

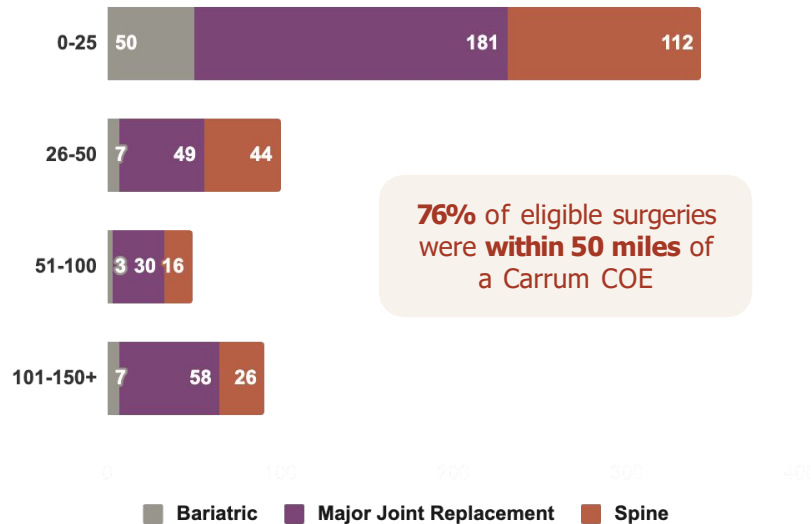
Opportunity for increased utilization

Date range 7/1/24 - 5/15/26

CARRUM ELIGIBLE SURGERIES^X



ELIGIBLE MEMBERS' DISTANCE TO COE



76% of eligible surgeries were **within 50 miles** of a Carrum COE



^XBased on State of Nevada claims data

Carrum as the preferred provider for select procedures

- Positioned as an approach to containing premium increases
- Opportunity to increase plan savings
- Steerage already in place for total joint and spine procedures through UMR Utilization Management
- No disruption to member experience as it exists today
- Members are most likely getting care outside of the benefit at Carrum COE's today
- Empathetic exceptions process



PEBP patient experience with Carrum care team

“

I am beyond grateful for the exceptional service I received from Hannah, an integral part of Carrum's health care concierge team. From the very beginning, she made the entire process of arranging my gastric sleeve surgery seamless and stress-free. Hannah provided expert recommendations for top-tier surgeons, and **I truly believe I was paired with the best.** The surgeon's skill and precision were evident, and **the entire experience was far better than I could have imagined.** **Bariatric**

North Vista Hospital

“

Hannah was wonderful! She isn't allowed to take time off and leave me with anyone else. 😊

Bariatric

North Vista Hospital

“

Jordan was my perfect agent who held my hand and walked me all the way through this process in a easy and clear way. **She made me feel confident and trustful in my process** of my hip replacement. She always responded timely to all my questions and also asked me if I had concerns so she could clarify my concerns. She had a great attitude and paid attention to details. She was very patient all the way through this process. I will speak highly about how kind and respectful a person that Jordan is. She was simply an angel through this process!! **Thank you from the bottom of my heart Jordan!**

Hip replacement

Crovetti Orthopaedics & Sports
Medicine

Thank you

We can provide dedicated, in-depth sessions on our quality evaluation methodology, savings methodology, or geo-access methodology upon request.

Alex Brochu

abrochu@carrumhealth.com

12.

12. Executive Officer Report. (Nik Proper, Operations Officer on behalf of Theresa Carsten, Executive Officer) (Information/Discussion)



NEVADA HEALTH AUTHORITY
PUBLIC EMPLOYEES' BENEFITS PROGRAM

3427 Goni Road, Suite 109
Carson City, Nevada 89706

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Stacie Weeks
Director



Nik Proper
Interim Executive Officer

Joe Lombardo
Governor

AGENDA ITEM

Action Item

Information Only

Date: May 21, 2026

Item Number: 12

Title: Executive Officer Report

SUMMARY

This report provides the Board, PEBP members and other stakeholders with information on agency operations.

REPORT

State and Local Government Benefits Association Conference

The Executive Officer attended the SALGBA conference in Rhode Island the week of May 4, 2026, and learned of possible organizations that have implemented diabetes, cancer, and heart health programs to address cost drivers in their states. She is currently working with Segal to review PEBP data to determine if any of these ideas would be cost effective by incorporating similar solutions to address population health concerns with PEBP membership. She hopes to provide additional information to the board during our strategic planning discussions.

Joint Interim Standing Committee on Government Affairs

On May 7, 2026, Operations Officer, Nik Proper, Chief Financial Officer, Monica McJoy, and Director of the Nevada Health Authority, Stacie Weeks presented on PEBP's rate setting process, as well as audit findings pertaining to the status of PEBP's budget, and the reasons for the rate adjustments in PY 2027.

Joint Interim Standing Committee on Commerce and Labor

Today, the Executive Officer is presenting with Director Stacie Weeks on PEBP's program status, audit findings, and reasons for the rate adjustments made for PY 2027, and will also stand for questions related to the PEBP presentation presented by the American Federation of State, County and Municipal Employees on health care quality and costs for state employees should the committee have questions for PEBP at that time.

13.

13. Contract Status Report. (Brandee Mooneyhan, Lead Insurance Counsel) (**For Possible Action**)

13.1 Contract Overview

13.2 New Contracts

13.3 Contract Amendments

13.4 Status of Current Solicitations



NEVADA HEALTH AUTHORITY PUBLIC EMPLOYEES' BENEFITS PROGRAM

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Stacie Weeks
Director



Theresa Carsten
Executive Officer

Joe Lombardo
Governor

AGENDA ITEM

Action Item

Information Only

Date: May 21, 2026

Item Number: 13

Title: Contract Status Report

Summary

This report addresses the status of PEBP's contracts, including an overview of current contracts, potential new contracts, contract amendments, and the status of current solicitations.

8.1 Contracts Overview

PEBP Active Contracts Summary			
VENDOR	SERVICE	EFFECTIVE DATE	EXPIRATION DATE
Brown & Brown/Claims Technologies	Health Plan Auditor	04/13/2021	06/30/2027
Carrum Health	Centers of Excellence	02/12/2024	06/30/2028
Carrum Health	Oncology Concierge	05/14/2024	06/30/2028
Diversified Dental Services	Dental PPO	07/01/2021	06/30/2027
Eide Bailly	Financial Auditor	07/11/2023	12/31/2026
Express Scripts	Pharmacy Benefit Manager	07/01/2025	06/30/2026
Health Plan of Nevada	Southern Nevada HMO	07/01/2025	06/30/2030
HSA Bank	HSA/HRA Account Manager	07/01/2022	06/30/2028
Lifeworks/TELUS Health	Benefits Management System	05/10/2022	12/31/2026
Segal Company	Consulting Services	07/01/2022	06/30/2027
United Healthcare Insurance	Group Basic Life Insurance	07/01/2022	06/30/2028
UMR, Inc.	TPA & Other Services	07/01/2022	06/30/2028 ¹
Willis Towers Watson (Via Benefits)	Medicare Exchange	07/01/2025	06/30/2030

¹ While PEBP is not a party to the network agreement between its third-party administrator, UMR, Inc., and Carson Tahoe Health (CTH), please note that UMR and CTH have agreed to extend their agreement, thereby keeping CTH in the UMR network, though June 30, 2027. Because ensuring its members' access to CTH services is a top priority, PEBP will continue to monitor this contractual relationship and apprise the Board of developments.

Update on contracts set to expire in 2026:

- Financial Auditor: PEBP staff and Eide Bailly have discussed a potential extension of their contract for the auditing of PEBP's financial statements. PEBP is seeking State Purchasing's approval to pursue such an extension and, if approved, anticipates presenting an extension for the Board's consideration at its July meeting.

- Pharmacy Benefit Manager: An amendment extending the contract until June 2028 is presented below for Board consideration.

- Benefits Management System: PEBP and NVHA staff meet weekly with the vendor chosen during the RFP process and anticipate presenting results of the RFP process at the July Board meeting.

No action necessary.

8.2 New Contracts

There are no new contracts for the Board's consideration.

No action necessary.

8.3 Contract Amendments

Express Scripts - Pharmacy Benefit Management: Terms of a two-year extension of PEBP's contract with Express Scripts have been negotiated with the assistance of subject matter experts at NVHA. If the Board approves the amendment, it will be considered by the Board of Examiners at its June meeting, so that the new terms will take effect on July 1, 2026.

Recommendation: Approve the amendment extending PEBP's contract with Express Scripts until June 30, 2028.

8.4 Current Solicitations

Benefits Management System: As noted above, PEBP continues to work on negotiations with the vendor chosen during the RFP process, including incorporation of Nevada Health Authority contract management goals, and anticipates presenting the results to the Board at its July meeting.

Other solicitations: PEBP and NVHA staff are working on developing Requests for Proposal (RFPs) for contracts set to expire in 2027: health plan auditing services, providing a dental network, and consulting services. Staff will update the Board on the progress of these RFPs at future meetings.

No action necessary.

CETS #:	25582
Solicitation #:	95PEBP-S1711

AMENDMENT # 4

TO CONTRACT FOR SERVICES OF INDEPENDENT CONTRACTOR

Between the State of Nevada
Acting By and Through Its

Agency Name:	Public Employees' Benefits Program
Address:	3427 Goni Road, Suite 109
City, State, Zip Code:	Carson City, NV 89706
Contact:	Rochelle Russum, Administrative Services Officer II
Phone:	(775) 684-7009
Email:	rlrussum@nvha.nv.gov

Contractor Name:	Express Scripts, Inc
Address:	One Express Way
City, State, Zip Code:	St. Louis, Missouri 63121
Contact:	Roger Holland
Phone:	949-499-2042
Email:	roger_holland@express-scripts.com

1. **AMENDMENTS.** For and in consideration of mutual promises and other valuable consideration, all provisions of the original Contract resulting from Request for Proposal #95PEBP-S1711 and dated 05/10/2022, and all prior amendments thereto, attached hereto as Exhibit A, remain in full force and effect with the exception of the following:

A. Provide a brief explanation for contract amendment.

This is the fourth amendment to the original contract. This amendment: (1) extends the expiration date of the contract to June 30, 2028; and (2) increases the contract maximum from \$387,109,496.00 to \$624,988,284.00.

B. Current Contract Language:

3. **CONTRACT TERM.** This Contract shall be effective as noted below, unless sooner terminated by either party as specified in *Section 10, Contract Termination*. Contract is subject to Board of Examiners' approval.

Effective from:	July 1, 2022	To:	June 30, 2026
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4. **INCORPORATED DOCUMENTS.** The parties agree that this contract, inclusive of the following attachments, specifically describes the scope of work. This Contract incorporates the following attachments in descending order of constructive precedence:

ATTACHMENT AA:	NEGOTIATED ITEMS
ATTACHMENT BB:	INSURANCE SCHEDULE

CETS #:	25582
Solicitation #:	95PEBP-S1711

ATTACHMENT CC:	PERFORMANCE GUARANTEES
ATTACHMENT DD:	FEE SCHEDULE (CONFIDENTIAL) EFFECTIVE 07/01/2023
ATTACHMENT EE:	BUSINESS ASSOCIATE ADDENDUM
ATTACHMENT FF:	STATE SOLICITATION OR RFP #95PEBP-S1711 AND AMENDMENT(S)
ATTACHMENT GG:	VENDOR PROPOSAL #95PEBP-VQ10761
ATTACHMENT HH:	STATE SOLICITATION OR RFP #95PEBP-S1711 AND CONFIDENTIAL VENDOR PROPOSAL
ATTACHMENT II:	EXPRESS SCRIPTS' REBATE RECONCILIATION METHODOLOGY
ATTACHMENT JJ	2024 PEBP PREVENTIVE MEDICATIONS LIST
ATTACHMENT KK	2024 PBM PRICING SUPPLEMENT
ATTACHMENT LL	PBM AGREEMENT SERVICE ADDENDUM REGARDING HINGE HEALTH (CONFIDENTIAL)
ATTACHMENT MM	2025 PBM PRICING SUPPLEMENT (CONFIDENTIAL)

5. CONSIDERATION. The parties agree that Contractor will provide the services specified in *Section 5, Incorporated Documents* at a cost as noted below:

Basis for Payment:	Attachment DD – Fee Schedule
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Total Contract Not to Exceed:	\$387,109,496.00
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The State does not agree to reimburse Contractor for expenses unless otherwise specified in the incorporated attachments. Any intervening end to a biennial appropriation period shall be deemed an automatic renewal (not changing the overall Contract term) or a termination as the result of legislative appropriation may require.

C. Amended Contract Language:

3. CONTRACT TERM. This Contract shall be effective as noted below, unless sooner terminated by either party as specified in *Section 10, Contract Termination*. Contract is subject to Board of Examiners' approval.

Effective from:	July 1, 2022	To:	June 30, 2028
-----------------	--------------	-----	---------------

4. INCORPORATED DOCUMENTS. The parties agree that this contract, inclusive of the following attachments, specifically describes the scope of work. This Contract incorporates the following attachments in descending order of constructive precedence:

ATTACHMENT AA:	NEGOTIATED ITEMS
ATTACHMENT BB:	INSURANCE SCHEDULE
ATTACHMENT CC:	PERFORMANCE GUARANTEES

CETS #:	25582
Solicitation #:	95PEBP-S1711

ATTACHMENT DD:	FEE SCHEDULE (CONFIDENTIAL) EFFECTIVE 07/01/2023
ATTACHMENT EE:	BUSINESS ASSOCIATE ADDENDUM
ATTACHMENT FF:	STATE SOLICITATION OR RFP #95PEBP-S1711 AND AMENDMENT(S)
ATTACHMENT GG:	VENDOR PROPOSAL #95PEBP-VQ10761
ATTACHMENT HH:	STATE SOLICITATION OR RFP #95PEBP-S1711 AND CONFIDENTIAL VENDOR PROPOSAL
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ATTACHMENT JJ	2024 PEBP PREVENTIVE MEDICATIONS LIST
ATTACHMENT KK	2024 PBM PRICING SUPPLEMENT
ATTACHMENT LL	PBM AGREEMENT SERVICE ADDENDUM REGARDING HINGE HEALTH (CONFIDENTIAL)
ATTACHMENT MM	2025 PRICING SUPPLEMENT (CONFIDENTIAL)
ATTACHMENT NN	UPDATED PRICING TERMS AND PHARMACY PROGRAM FEES (EFFECTIVE JULY 1, 2026) (CONFIDENTIAL)

Any provision, term or condition of an Attachment that contradicts the terms of this Contract, or that would change the obligation of the State under this Contract, shall be void and unenforceable.

5. CONSIDERATION. The parties agree that Contractor will provide the services specified in *Section 5, Incorporated Documents* at a cost as noted below:

Basis for Payment:	Attachment DD – Fee Schedule (and incorporating the Updated Pricing Terms and Pharmacy Program Fees (Effective July 1, 2026) set forth in Attachment NN)
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Total Contract Not to Exceed:	\$624,988,284.00
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The State does not agree to reimburse Contractor for expenses unless otherwise specified in the incorporated attachments. Any intervening end to a biennial appropriation period shall be deemed an automatic renewal (not changing the overall Contract term) or a termination as the result of legislative appropriation may require.

6. INCORPORATED DOCUMENTS. Exhibit A (original Contract, Amendment #1, Amendment #2, and Amendment #3) is attached hereto, incorporated by reference herein and made a part of this amended contract.

7. REQUIRED APPROVAL. This amendment to the original Contract shall not become effective until and unless approved by the Nevada State Board of Examiners.

14.

14. SFY26 Q3 Budget Report. (Monica McJoy, Chief Financial Officer)
(Information/Discussion)



**NEVADA HEALTH AUTHORITY
PUBLIC EMPLOYEES' BENEFITS PROGRAM**

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Stacie Weeks
Director

Nik Proper
Interim Executive Officer

Joe Lombardo
Governor

AGENDA ITEM

Action Item

Information Only

Date: May 21, 2026

Item Number: 14

Title: Chief Financial Officer Budget Report

FY 26 Budget Projections

BUDGETED & PROJECTED INCOME (BUDGET ACCOUNT 1338)					
Description	Budget	Actual as of 3/31/26	Total Projected to Collect	Difference	% Remaining
Funds Carried Forward from Prior Year	66,888,128	66,888,128	66,888,128	-	
State Subsidies	440,038,912	277,026,492	375,313,506	(64,725,406)	-14.7%
Non-State Subsidies	22,214,260	14,016,190	19,124,647	(3,089,613)	-13.9%
State Premium Income	110,047,197	62,288,181	92,663,320	(17,383,877)	-15.8%
Non-State Premium Income	5,015,705	2,047,191	2,735,625	(2,280,080)	-45.5%
All Other Income	45,957,505	30,537,473	46,288,508	331,003	0.7%
Total Income	690,161,707	452,803,655	603,013,734	(87,147,973)	-12.6%

BUDGETED & PROJECTED EXPENSES (BUDGET ACCOUNT 1338)					
Description	Budget	Actual as of 3/31/26	Total Projected to Spend	Difference	
Operating	7,521,240	4,411,733	6,330,188	1,191,052	15.8%
State Insurance Costs	504,507,236	366,482,561	460,792,049	43,715,187	8.7%
Non-State Ins. Costs	7,716,969	4,814,226	7,476,188	240,781	3.1%
Medicare Retiree Ins. Costs	49,113,283	29,141,576	43,240,092	5,873,191	12.0%
Total Insurance Costs	561,337,488	400,438,363	511,508,329	49,829,159	8.9%
Total Expenses	568,858,728	404,850,096	517,838,517	51,020,211	9.0%

Total Budgeted Revenue	603,013,734
Less Total Projected Expenditures	(517,838,517)
Balance Remaining	85,175,217
Less Actuary Estimated Reserves	(121,302,979)
Over/Under Reserves	(36,127,762)

15.

15. Public Comment.

16.

16. Adjournment.