Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY

PUBLIC EMPLOYEES' BENEFITS PROGRAM

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NVHA.NV.GOV
PEBP.NV.GOV

Stacie Weeks
Director

Theresa Carsten
Executive Officer

# MEETING NOTICE AND AGENDA – Amended 9/28/26

| | |
|---|---|
| Name of Organization: | Public Employees' Benefits Program |
| Date and Time of Meeting: | October 2, 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/CXGRcwNzUtg** |

**To submit written public comment, please upload your document to the Public Comment Upload Form located under Meetings and Events 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/85830573823**
**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: 858 3057 3823 then press #. When prompted for a Participant ID, please enter #.**

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

**To resolve any issues related to dialing in to provide public comment for this meeting, please call (775) 684-7020 or email jcrane@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 Meetings and Events 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. (Jose Rivera, Deputy Attorney General) (Information/Discussion)

4. Approval of Action Minutes from the August 20, 2026 Board Meeting. (Jim Wells, Board Chair) (**For Possible Action**)

5. Executive Officer Report. (Theresa Carsten, Executive Officer) (Information/Discussion)

6. PEBP Options Report. (Stacie Weeks, NVHA Director, and Milliman staff) (Information/Discussion)

7. Strategic Planning Decisions. (PEBP Board) (**For Possible Action)**
   7.1 Disease Management and Care Coordination
   7.2 Pharmacy Benefits
   7.3 Contracting Procedures

8. Discussion and possible action regarding plan design and the State Subsidization Policy and any necessary amendments to PEBP's Board and Agency Duties, Polices and Procedures. (Debbie Donaldson, Segal) (**For Possible Action**).

9. Contract Status Report. (Shannan Canfield, Quality Control Officer) (**For Possible Action**)
   9.1 Contract Overview
   9.2 New Contracts
   9.3 Contract Amendments
   9.4 Status of Current Solicitations

10. PY24 Claims Technology Incorporated audit findings for State of Nevada Public Employees' Benefits Program administered by Express Scripts. (Joni Amato, CTI) (**For Possible Action**)

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

12. Adjournment.

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at https://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. (Jose Rivera, Deputy Attorney General) (Information/Discussion)

# 4.

4. Approval of Action Minutes from the August 20, 2026 Board Meeting. (Jim Wells, Board Chair)
**(For Possible Action)**

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

Video/Telephonic Open Meeting
Carson City

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**ACTION MINUTES (Subject to Board Approval)**
August 20, 2026

| | |
|---|---|
| **MEMBERS PRESENT IN PERSON:** | Mr. Jim Wells, Board Chair<br>Dr. Keiko Duncan, Vice Chair<br>Mr. Jim Barnes, Member<br>Ms. Laura Rich, Member<br>Mr. Chris Viton, Member<br>Mr. Tom Zumtobel, Member |
| **MEMBERS PRESENT VIA TELECONFERENCE:** | Dr. Paul Davis, Member |
| **MEMBERS EXCUSED:** | Dr. Jennifer McClendon, Member<br>Dr. Blaine Harper, Member<br>Ms. Joy Grimmer, Member |
| **FOR THE BOARD:** | Ms. Brandee Mooneyhan, Lead Insurance Counsel |
| **FOR STAFF:** | Ms. Theresa Carsten, Executive Officer<br>Mr. Nik Proper, Operations Officer<br>Ms. Brandee Mooneyhan, Lead Insurance Counsel<br>Ms. Monica McJoy, Chief Financial Officer<br>Ms. Shannan Canfield, Quality Control Officer<br>Ms. Jessica Crane, Executive Assistant |
| **OTHER PRESENTERS:** | Debbie Donaldson, Segal<br>Amy Daily, Express Scripts<br>Joni Amato, Claim Technologies, Inc<br>Jennifer Spencer, UMR<br>Chris Garcia, Willis Towers Watson/VIA Benefits |

1. Open Meeting; Roll Call.
    - Board Chair Wells opened the meeting at 9:01 a.m.

2. Public Comment.
    - Kent Ervin, RPEN
    - Doug Unger, UNLV Advisory Committee
    - Tess Opferman, AFSCME

3. PEBP Board disclosures for applicable Board meeting agenda items. (Brandee Mooneyhan, Lead Insurance Counsel) (Information/Discussion)

4. Approval of Action Minutes from the July 23, 2026 Strategic Planning Meeting. (Jim Wells, Board Chair) (**For Possible Action)**

**BOARD ACTION ON ITEM 4**
**MOTION:** Motion to approve action minutes.
**BY:** Member, Jim Barnes
**SECOND:** Member, Laura Rich
**VOTE:** Unanimous, the motion carried

5. Executive Officer Report. (Theresa Carsten, Executive Officer) (Information/Discussion)

6. Q4 Budget Report. (Monica McJoy, Chief Financial Officer) (Information/Discussion)

7. Discussion and possible action regarding framework for submission of Agency Budget Request for the 2028-2029 biennium. (Monica McJoy, Chief Financial Officer and Theresa Carsten, Executive Officer) (**For Possible Action**)
   Topics addressed will include, but not be limited to:
   A. Administrative Enhancements;
   B. State Subsidization Policy;
   C. Other items requested by the Board; and
   D. Any Necessary Amendment to PEBP's Board and Agency Duties, Polices and Procedures Resulting from the discussion

**BOARD ACTION ON ITEM 7A**
**MOTION:** Motion to approve administrative enhancements.
**BY:** Vice Chair, Keiko Duncan
**SECOND:** Member, Laura Rich
**VOTE:** Unanimous, the motion carried

8. Report Concerning Costs for Retired State Employees to Obtain Coverage through PEBP Under Medicare and Not Under Medicare for Transmittal to Interim Finance Committee Pursuant to NRS 297.04347. (Brandee Mooneyhan, Lead Insurance Counsel, and Debbie Donaldson, Segal) (**For Possible Action**)

**BOARD ACTION ON ITEM 8**
**MOTION:** Motion to approve report and transmit it to IFC.
**BY:** Member, Laura Rich
**SECOND:** Member, Chris Viton
**VOTE:** Unanimous, the motion carried.

9. Pharmacy Benefit Manager Rebate Changes. (Amy Donahue and Amy Daily, ESI) (Information/Discussion)
   9.1 Impact of Rebate Changes to the Biennial Budget and Premiums (Debbie Donaldson, Segal) (Information/Discussion)

10. NVHA Statewide Purchasing Delegation. (Theresa Carsten, Executive Officer) (**For Possible Action**)
    10.1 Pharmacy Benefit Manager
    10.2 Dental Benefit Network/Manager
    10.3 Actuarial Services

**BOARD ACTION ON ITEM 10**
**MOTION:** Motion to approve delegation to Nevada Health Authority.
**BY:** Member, Tom Zumtobel
**SECOND:** Member, Chris Viton
**VOTE:** Unanimous, the motion carried

11. Contract Status Report. (Brandee Mooneyhan, Lead Insurance Counsel) (**For Possible Action**)
    11.1 Contract Overview
    11.2 New Contracts
    11.3 Contract Amendments
    11.4 Status of Current Solicitations

**BOARD ACTION ON ITEM 11**
**MOTION:** Motion to approve the extension for PEBP's diversified dental contract with Diversified Dental until June 30th, 2028, the contract with Brown and Brown/Claim technologies until June 30th, 2028 and the contract with HSA Bank our HSA HRA account management services until June 30th, 2032, and approve the amendment to the existing contract with Eide Bailey until December 31st, 2030.
**BY:** Member, Keiko Duncan
**SECOND:** Member, Chris Viton
**VOTE:** Unanimous, the motion carried

12. Q2 & Q3 Claims Technology Incorporated audit findings for State of Nevada Public Employees' Benefits Program administered by UMR. (Joni Amato, CTI) (**For Possible Action**)

**BOARD ACTION ON ITEM 12**
**MOTION:** Motion to accept quarter 2 and quarter 3 Claims Technology Incorporated audit findings and assess the calculated penalties of $51,569.38 for Q2 and $36,988.57 for Q3 .
**BY:** Member, Jim Barnes
**SECOND:** Member,
**VOTE:** Ayes: 5
Nayes: 1
The motion carried.

13. Q3 WTW's Individual Marketplace (VIA Benefits) Enrollment & Performance Report. (Chris Garcia, Willis Towers Watson/VIA) (Information/Discussion)

14. Receipt of quarterly vendor reports for the period ending March 31, 2026. (Information/Discussion)
    - 14.1 Q3 UMR – Obesity & Diabetes Care Management
    - 14.2 Q3 Sierra Healthcare Options & UnitedHealthcare Plus Network – PPO Network
    - 14.3 Q3 Sierra Healthcare Options – Utilization and Large Case Management
    - 14.4 Q3 UnitedHealthcare – Basic Life Insurance
    - 14.5 Q3 Express Scripts – Utilization Report
    - 14.6 Q3 Express Scripts – Summary Report
    - 14.7 Q3 CDHP Performance Report
    - 14.8 Q3 LD PPO Performance Report
    - 14.9 Q3 EPO Performance Report
    - 14.10 Q3 HPN Performance Report
    - 14.11 Q3 Dental Performance Review
    - 14.12 Q3 Doctor on Demand Engagement Report

15. Public Comment.
    - Kent Ervin, RPEN
    - Doug Unger, UNLV Advisory Committee

16. Adjournment.

**BOARD ACTION ON ITEM 16**
**MOTION:** Motion to adjourn at 1:08 p.m.
**BY:** Member, Laura Rich
**SECOND:** Vice Chair, Keiko Duncan
**VOTE:** Unanimous, the motion carried

Items to bring back:
- Segal: Budget gaps from agenda item 6. Active and retiree subsidization policy options (7 total)
- ESI: Transparency agreement between ESI and FTC
- UMR/CTI: UMR corrective action plan, fiscal effect of system errors
- Willis Towers Watson: Average number of retirees that do and don't pass Medigap underwriting.

# 5.

5. Executive Officer Report. (Theresa Carsten, Executive Officer) (Information/Discussion)

NEVADA HEALTH AUTHORITY

# Public Employees' Benefit Program Executive Officer Board Report

**Theresa Carsten**

Executive Officer, PEBP

October 2, 2026

# Agenda

**Purpose**: One sentence describing the goal of this presentation and what the audience will take away.

| | |
|---|---|
| 1 | **Plan Year 2027 Available Cash on Hand** |
| 2 | **Staff Reorganization** |

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# Financial Snapshot of Cash on Hand PY 2027

## Our costs could outpace our cashflow.

- Starting Cash: $ 52.5M
- Revenue: $ 65.3M
- Medical/Rx Claims: $129.9M
- AEGIS transfer 8/31: $1,184,920 and

  REGI transfer 8/31: $ 1,271,100

  - **Approximately $12.6M dollars** of additional AEGIS/REGI revenue will be transferred in 27 to offset the $30M shortfall based off of projected enrollment for the year.

| | 2027 Cash As of 9.10.26 | |
|---|---|---|
| A | Revenue and Balance Forward | 117.9M |
| | * AEGIS/REGI Transfer | (2.4M) |
| B | RX Rebates | 13.6M |
| C | Medical/RX claims | 129.9M |
| D | Available cash | 1.6M |

*Aegis/Regi transfer is part of the total Revenue and Balance Forward amount.

Formula: (A+B)-C=D

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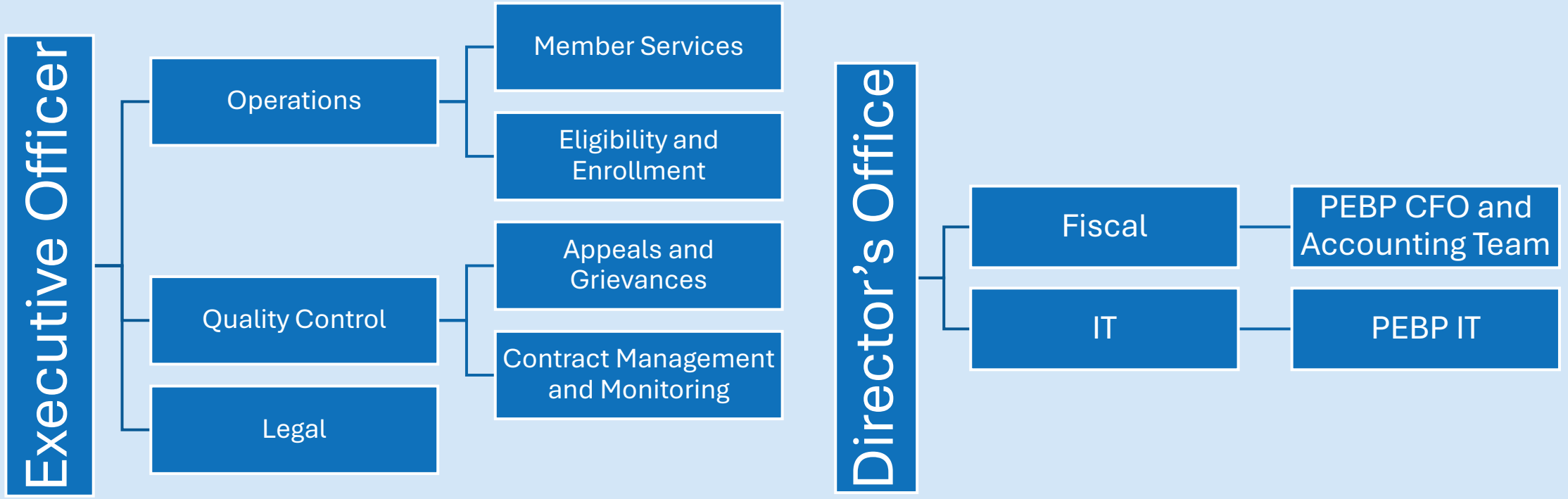
**Key Takeaway: This snapshot includes the AEGIS and REGI transfers voted on by the board in March 2026.**

# Staff Reorganization

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**PEBP Recruitments: Operations Officer, Management Analyst II, and Administrative Assistant.**

# Thank You

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# 6.

6. PEBP Options Report. (Stacie Weeks, NVHA Director and Milliman Staff) (Information/Discussion)

# State of Nevada Public Employees' Benefits Program (PEBP)

## Program Assessment – Key Findings and Opportunities

**October 2, 2026**

Milliman
Solutions for a world at risk™

## Table of Contents

# Executive Summary

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# Executive Summary

## Strengths

PEBP is generally competitive in access and benefit richness

## Pressure Points

Cost and utilization is uneven across plans and member cohorts

## Near-Term Opportunities

Provider reimbursement represents the clearest opportunity for true plan savings

## Tradeoffs

Opportunities to better align with benchmarks exist that generate savings, but primarily through cost shifting to members

# Potential Action Items

Considerations based on key findings to promote long-term PEBP sustainability

| INITIATIVE | PRIORITY LEVEL | POTENTIAL SAVINGS | TRADEOFFS | EFFECTIVE DATE |
|---|---|---|---|---|
| **TPA / Carrier Procurement** | High | **$$ to $$$**<br>If more favorable network discounts, utilization management, and / or HMO options proposed compared to current vendors | Administrative effort (procurement and implementation); some member disruption if new vendors implemented | PY 2029 |
| **Direct Contracts** | High | **$ to $$** | No direct member impact; additional administrative effort | PY 2028 / 2029 |
| **Replace or Eliminate EPO / HMO** | High | **$ to $$**<br>Depending on replacement options and / or migration from elimination | Potential member disruption, but plans represent small portion of overall population | PY 2029 (aligned with TPA procurement) |
| **PEBP / Market-Wide Reimbursement Caps** | Medium | **$$$** | Provider pushback and potential legislative hurdles | PY 2030+ |
| **Split Risk Pools (Active / Retiree)**<br>▪ Separate rating while maintaining retiree PEBP access | Medium | Minimal for State overall<br>Potentially meaningful for active staff depending on subsidy reallocations | Potential reduced cost for actives, increased cost for retirees (depends on premium contribution strategy) | PY 2028 |
| **Plan Design Adjustments** | Low | **$ to $$**<br>Based on historical claims, results will depend on selected options | Cost shift from plan to members; potential enrollment attrition | PY 2028 |
| **Dependent Subsidy Reallocations** | Low | **$ to $$**<br>Depending on selected subsidies and enrollment shifts | Cost shift from employees without dependents to employees with dependents; potential enrollment attrition | PY 2028 |

# Background and Assessment Process

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# Background

- The Nevada Health Authority (NVHA) engaged Milliman to provide strategic and actuarial support to improve the Public Employees' Benefits Program's (PEBP's) performance with respect to access to care and cost containment
- This includes a broad assessment of the current state of the program, evaluating PEBP's strengths and weaknesses with respect to financial sustainability and accessibility, as well as a summary of options to improve these elements and recommended paths forward
- This presentation summarizes key findings and potential near-term action items, focused on the following areas of PEBP's medical and prescription drug benefits
  - Program structure and benchmarking
  - Financial performance and utilization analysis
  - Network adequacy and efficiency

# Assessment Process

What we reviewed to arrive at key findings and identify opportunities

# PEBP at a Glance

Program structure and enrollment breakdown

## Northern Nevada

**UMR**
Self-funded medical administration

**UHC Choice Plus network**
CDHP | LDPPO | EPO

## Southern Nevada

**UMR**
Self-funded medical administration

**HPN**
Fully insured HMO (medical + Rx)

**Sierra Care Options network**
CDHP | LDPPO

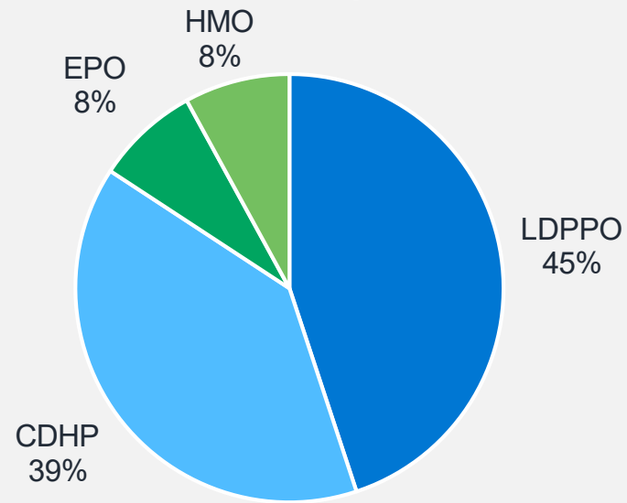
**PHARMACY ADMINISTRATION**

**Express Scripts (ESI)**
PBM for CDHP, LDPPO, and EPO

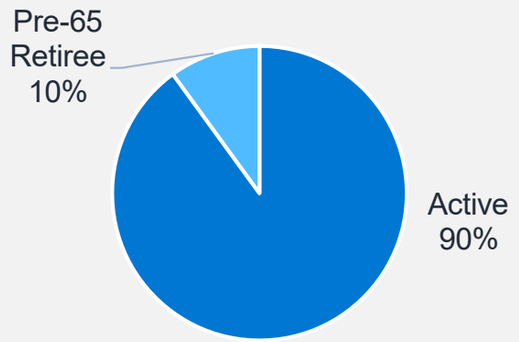
**GEOGRAPHIC FOOTPRINT***

**North ~50% | South ~50%**

**Membership by Plan***




**Membership by Status***




*PY 2026 average enrollment through April 2026; cohort figures are for UMR plans where noted.

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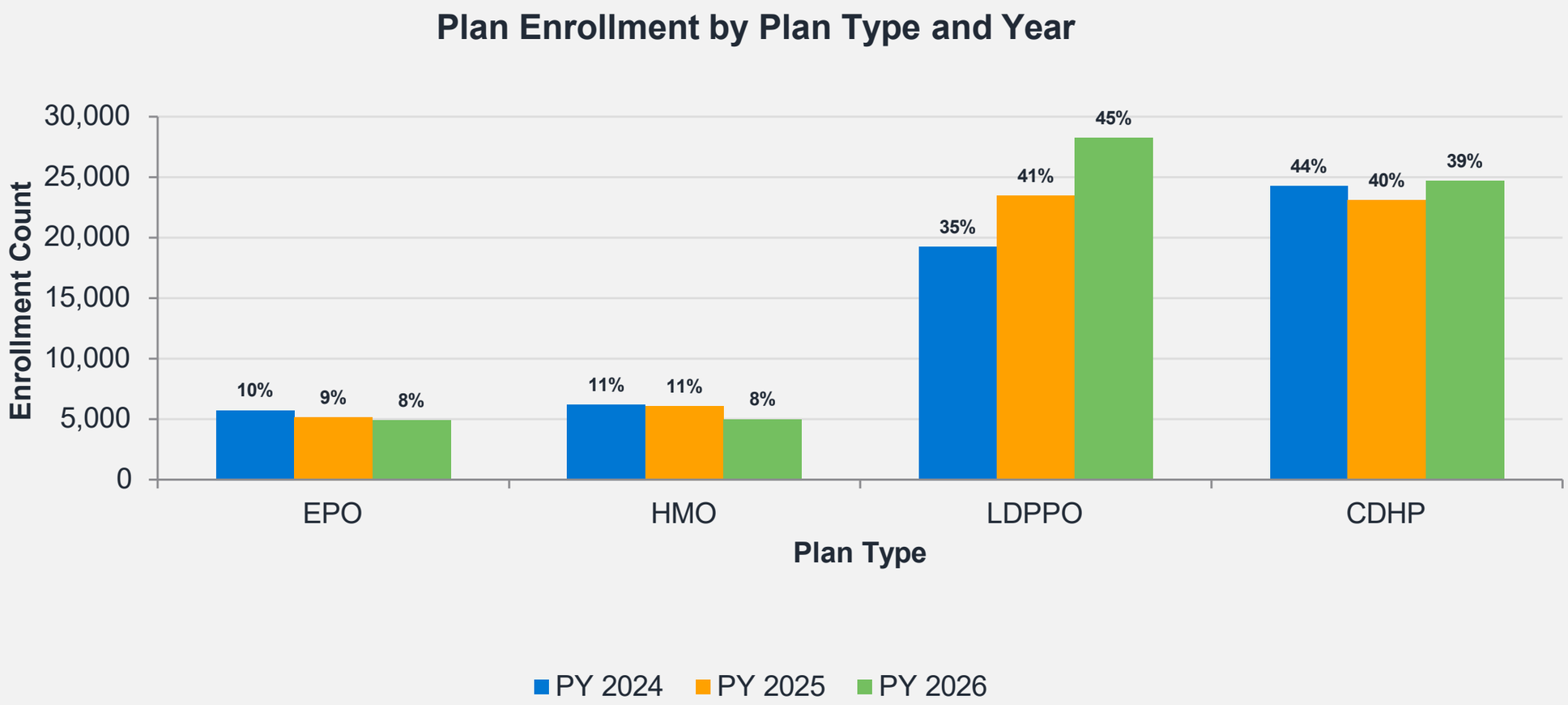
# PEBP at a Glance

Year-over-year enrollment by plan, PY 2024 through PY 2026



# PEBP at a Glance

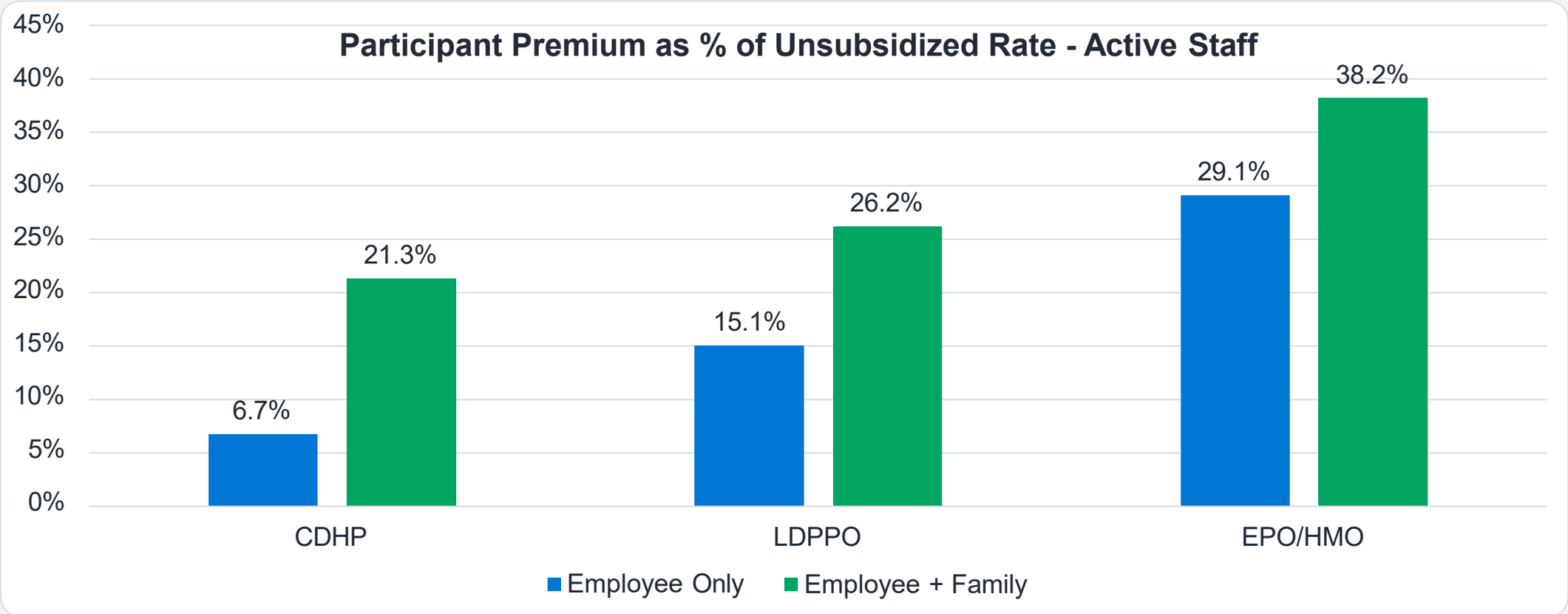
PY 2027 Plan Options

## MEDICAL EXPENSE OVERVIEW (IN-NETWORK)

| MEDICAL PLAN DESIGN FEATURES | CONSUMER DRIVEN HEALTH PLAN (PPO) | LOW DEDUCTIBLE PLAN (PPO) | EXCLUSIVE PROVIDER ORGANIZATION PLAN (EPO) | HEALTH PLAN OF NEVADA (HMO) |
|---|---|---|---|---|
| **Service Areas** In-Network | Global | Global | Northern Nevada | Southern Nevada |
| **Annual Deductible** (medical and prescription combined) | $1,700 Individual<br>$3,400 Family | $300 Individual<br>$600 Family | $100 Individual<br>$200 Family | N/A with exception of Tier 4 prescription drug coverage (see prescription overview) |
| **Out-of-Pocket Maximum** | $5,000 Individual<br>$10,000 Family / $5,000 Individual Family Member | $5,000 Individual<br>$10,000 Family / $5,000 Individual Family Member | $4,000 Individual<br>$8,000 Family / $4,000 Individual Family Member OOPM | $5,000 Individual<br>$10,000 Family / 5,000 Individual Family Member |
| **HSA/HRA PEBP Contribution** (Prorated after 7/1) | Base $700 + $200 each for dependent (up to three) | N/A | N/A | N/A |
| **Medical Coinsurance** | 20% after Deductible | 20% after Deductible | 20% after Deductible | N/A |
| **Primary Care Office Visit** | 20% after Deductible | $30 Copay | $20 Copay | $25 Copay |
| **Specialist Visit** (No Referral Required) | 20% after Deductible | $50 Copay | $40 Copay | $25 Copay *with* a referral<br>$40 Copay *without* a referral |
| **Urgent Care Visit** | 20% after Deductible | $80 Copay | $50 Copay | $50 Copay |
| **ER Visit** | 20% after Deductible | $750 Copay | $600 Copay | $600 Copay |

# Participant Premium Contributions

Active staff contributions as a percentage of unsubsidized premium rates – PY 2027



# Key Findings

## Program Structure and Benchmarking

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= Richer (i.e., more generous) than government benchmark

= Leaner (i.e., less generous) than government benchmark

# In-Network Plan Design Benchmarking – State / National

Several components richer than benchmark, along with some deviations for ER copay

| In-Network | State of Nevada | | Benchmark - PPO Plans | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | LD (PPO) | | National - All | | Nevada | | Government Organization | | Large Employers (5,000+) | |
| | Single | Family | Single | Family | Single | Family | Single | Family | Single | Family |
| Deductible | $300 | $600 | $1,500 | $3,000 | $1,000 | $2,000 | $1,000 | $2,000 | $1,000 | $2,000 |
| OOP Maximum | $5,000 | $10,000 | $5,000 | $10,000 | $5,500 | $11,000 | $4,500 | $9,000 | $4,750 | $9,500 |
| | | | | | | | | | | |
| Emergency Room | $750 | | $300 | | $350 | | $250 | | $225 | |
| Urgent Care | $80 | | $75 | | $75 | | $50 | | $40 | |

| In-Network | State of Nevada | | Benchmark - HDHP Plans | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | CDHP (PPO) | | National - All | | Nevada | | Government Organization | | Large Employers (5,000+) | |
| | Single | Family | Single | Family | Single | Family | Single | Family | Single | Family |
| Deductible | $1,700 | $3,400 | $3,300 | $6,600 | $3,250 | $6,500 | $3,300 | $6,600 | $3,000 | $6,000 |
| OOP Maximum | $5,000 | $10,000 | $6,000 | $12,000 | $5,500 | $11,000 | $4,500 | $9,000 | $5,250 | $10,500 |
| | | | | | | | | | | |
| Emergency Room | Ded; 20% | | Ded; 20% | | Ded; 20% | | Ded; 0% | | Ded; 20% | |
| HSA Funding (single) | $700 | | $780 | | $1,560 | | $800 | | $1,600 | |

| In-Network | State of Nevada | | | | Benchmark - EPO/HMO Plans | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | EPO | | HPN (HMO) | | National - All | | Nevada | | Government Organization | | Large Employers (5,000+) | |
| | Single | Family | Single | Family | Single | Family | Single | Family | Single | Family | Single | Family |
| Deductible | $100 | $200 | N/A | N/A | $1,000 | $2,000 | $0 | $0 | $1,000 | $2,000 | $1,000 | $2,000 |
| OOP Maximum | $4,000 | $8,000 | $5,000 | $10,000 | $5,500 | $11,000 | $4,000 | $8,000 | $5,000 | $10,000 | $4,000 | $8,000 |
| | | | | | | | | | | | | |
| Coinsurance | 20% | | N/A | | 0% | | 0% | | 0% | | 20% | |
| Emergency Room | $600 | | $600 | | $350 | | $200 | | $150 | | $150 | |
| **Retail Rx** | | | | | | | | | | | | |
| Non-Preferred Brand | $75 | | $75 | | $70 | | $60 | | $50 | | $50 | |

- **Deductible** is significantly richer than benchmarks for each plan type
- **Coinsurance, Office Visits, and Pharmacy Copays** are generally in line with benchmarks, except:
  - EPO coinsurance is leaner than benchmarks
  - HMO/EPO non-preferred brand Rx copays are leaner than benchmarks
- **Emergency Room** copay is much leaner than benchmarks (2 to 3 times other comparator groups) – we assume this is intentional to drive more efficient plan utilization
- **Urgent Care Copays** are also leaner than benchmarks for the LDPPO

**Other benefits generally in line with benchmarks**

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Source: State of Nevada Employee Benefits Website, Milliman HCR Benefit Survey
Benchmark family tier assumes 2x single tiers and mail-order assumes 2x retail.

# Plan Structure Benchmarking

Level of choice offered for PEBP-sponsored plans (excludes Medicare exchange)

PEBP offers two statewide PPO plan options with two other regional plans specific to northern and southern Nevada

1. LD PPO
2. CDHP
3. EPO
4. HMO

} Northern / Southern

## PEBP vs. Milliman State & National Benchmarks

- Between **25% and 40%** of employers in our benchmark data offer one plan
- Between **45% and 50%** offer two or three options for employees to choose from
  - **75%** of government plans offer one to two plans
- **40% to 55%** of employers in our benchmark data offer a PPO plan, while **25% to 40%** offer an HDHP
  - **~50%** of government plans offer a PPO, while nearly **40%** offer a HDHP
  - **~10%** of government plans offer an HMO, while other benchmarks cuts are between **16% and 32%**

## PEBP vs. State Employee Plan Benchmarks

| | | |
|---|---|---|
| # Plan Options | **3** | vs. ~1-2 avg (76% of plans) |
| Plan AV Range | **87–92%** | vs. 80-90% typical range |

Milliman

Source: Milliman HCR Benefit Survey (2025 data) and Georgetown University Center on Health Insurance Reforms Data (2022).

# Local Comparator Benchmarking

Key observations comparing PEBP to local municipalities

**Local comparators include:**

1. Washoe County
2. Carson City
3. Clark County
4. Clark County School District
5. City of Las Vegas

## PEBP vs. Local Benchmarks

- Local comparators offer between **two** and **five** plans for employees to choose from
  - Two options: Carson City, Clark County, Clark County School District (Teachers Trust)
  - Three options: Washoe County, Clark County School District (Support Professionals)
  - Five options: City of Las Vegas
- **Four of the five** comparators partner with UMR / HPN for plan administration / network access
  - Carson City partners with Prominence
  - Of those that partner with UMR / HPN, all leverage Sierra Care Options network for at least one plan in Southern NV
- All offer at least one broad PPO plan
- Two offer HDHPs
- Four offer at least one EPO/HMO/POS option
- Three offer at least one plan with a tiered network to steer utilization to preferred providers

## Premium Contributions

Premium contribution information was available for four of the five* comparators

- Three have 100% subsidized employee only coverage
  - City of Las Vegas, Carson City, and Washoe County
  - CCSD Teachers Trust employee contribution < 5% of premium
- Dependent subsidies range from 25% to 60% of premium
  - Carson City, Washoe County do not exceed 50% dependent subsidies
  - CCSD Teachers Trust dependent tier contributions < 40% of premium

*All except Clark County and CCSD Support Professionals (CCSD Teachers Trust information was available).
Dependent subsidy as a percentage of premium not available for City of Las Vegas.

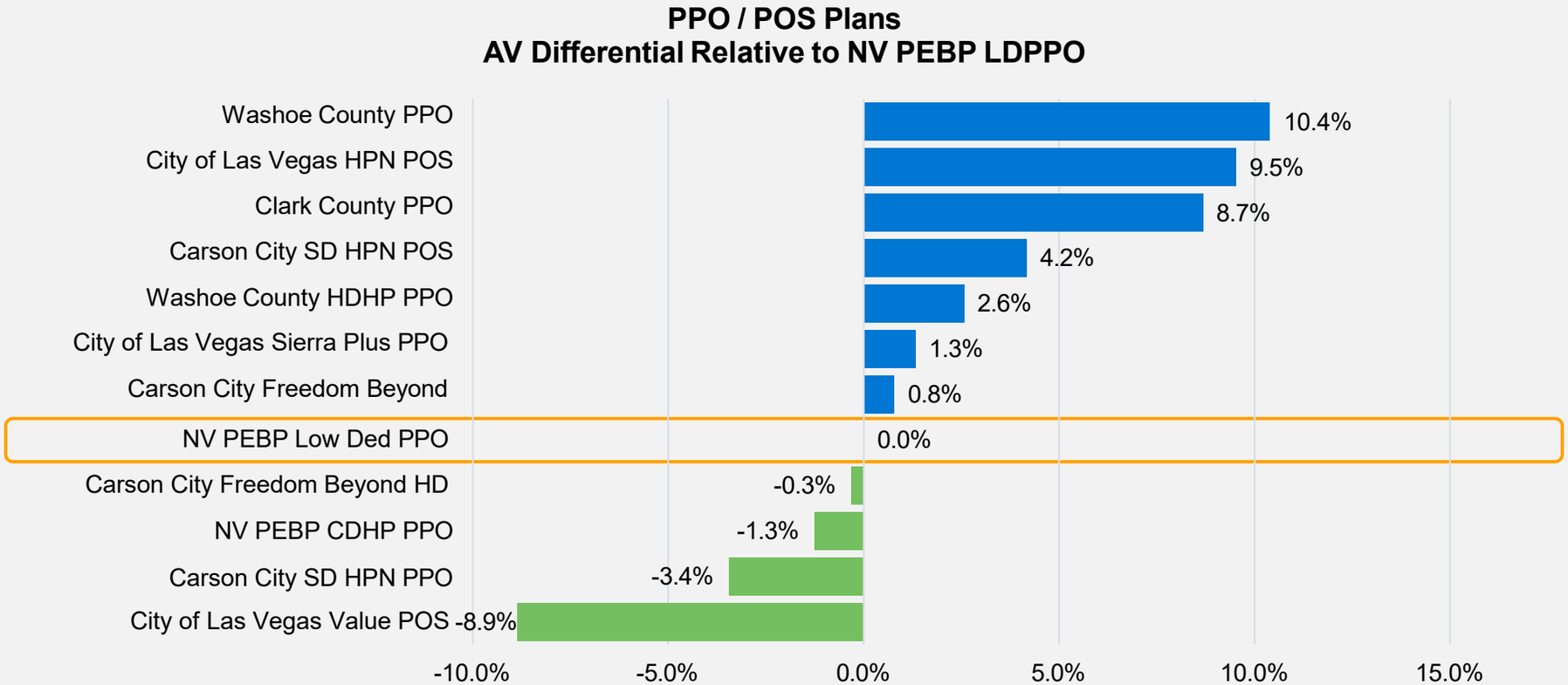
**Retiree Coverage**

- Information was available for Washoe County, Clark County, and Clark County School District
- Non-Medicare retirees generally eligible for the same plan options as actives, but with higher premium rates / contributions (rates appear to be set distinctly from actives, i.e., separate risk pools)

# PEBP vs. Local Comparators

Actuarial value differentials – PPO/POS plans

**Actuarial values include impact of employer HSA funding, where applicable / where information was available (including PEBP CDHP)**




**Plans with a <u>negative differential</u> compared to the PEBP LDPPO are leaner (i.e., benefits are less generous / member cost sharing is generally higher); plans with a <u>positive differential</u> are richer (i.e., benefits are more generous / member cost sharing is generally lower).**

**Differentials are calculated as the actuarial value for each respective plan minus the actuarial value for the PEBP LDPPO.**

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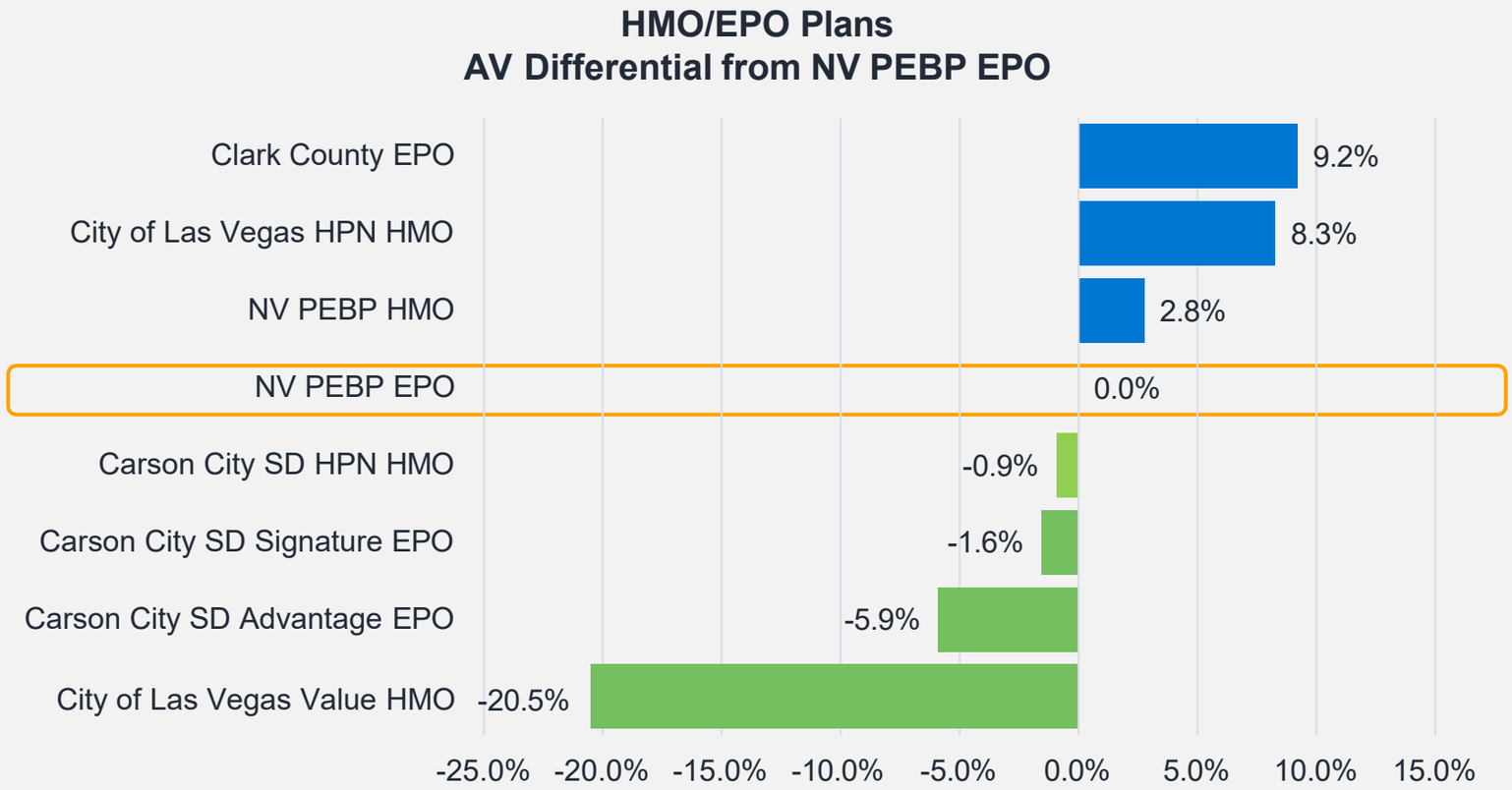
Note: plans with tiered networks assume 75% Tier 1 utilization.
Plans with no explicit specialty Rx cost sharing information assume 30% coinsurance.

# PEBP vs. Local Comparators

Actuarial value differentials – HMO/EPO plans




**Plans with a <u>negative differential</u> compared to the PEBP EPO are leaner (i.e., benefits are less generous / member cost sharing is generally higher); plans with a <u>positive differential</u> are richer (i.e., benefits are more generous / member cost sharing is generally lower).**

**Differentials are calculated as the actuarial value for each respective plan minus the actuarial value for the PEBP EPO.**

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Note: plans with tiered networks assume 75% Tier 1 utilization.
Plans with no explicit specialty Rx cost sharing information assume 30% coinsurance.

# Benchmarking – Key Takeaways and Opportunities Identified

## Key Takeaways

- PEBP plans are competitive compared to national benchmarks across industries / employer sizes
- Some PEBP design components are more generous (and a few are slightly less generous)
- PEBP offers more choice than other state employee health plans on average and have higher actuarial values (i.e., plans are more generous)
- PEBP plans are generally in line with local comparators, with some components slightly less generous
  - Many local comparator plans include tiered networks to steer utilization towards narrow / more efficient provider networks
- PEBP premium subsidies deviate from local comparators
  - Several local comparators have little to no premium requirement for employees covering only themselves and much higher requirements for employees covering dependents

## Opportunities Identified

- PEBP could consider:
  - Reducing the number of plans offered
  - Introducing tiered networks with differentiated cost sharing
  - Splitting active and retiree risk pools to be rated separately
  - Reallocating premium subsidies to reduce cost sharing for employees / increase for dependents
  - Increase deductibles across plan types
- These changes could potentially drive overall plan savings and promote more efficient plan utilization

# Key Findings

## Financial Performance and Utilization Analysis

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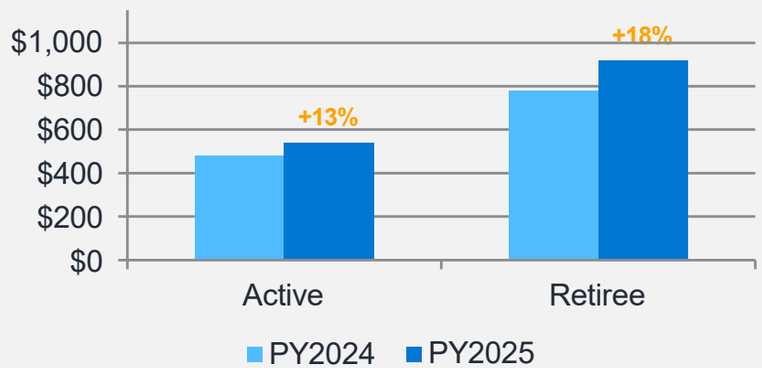
# Financial Performance by Plan and Status

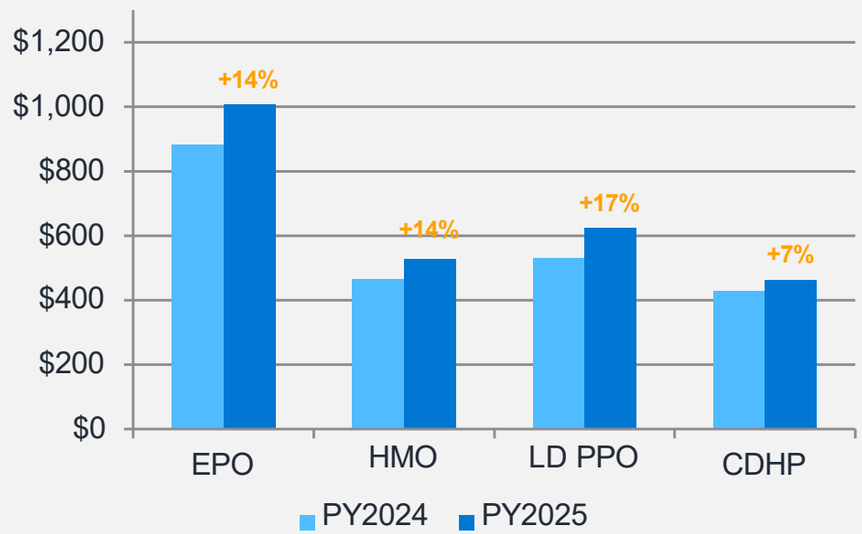
PY 2024 and PY 2025 costs PMPM by plan option and active / retiree status

## PMPM by Status




- Non-Medicare retiree costs PMPM increased at a higher rate compared to actives from PY 2024 to PY 2025
- Retiree claims PMPM were ~62% higher than actives in PY 2024 and ~70% higher than actives in PY 2025

## PMPM by Plan




- PMPM costs are lowest on the CDHP and highest on the EPO
  - EPO costs are higher than all other plans by a significant margin
- The CDHP also experienced the lowest actual year-over-year trend rate from PY 2024 to PY 2025

# Utilization Benchmarks by Plan – LDPPO

PEBP plan costs PMPM compared to Milliman benchmarks based on utilization rates and average cost per service

| | NORTHERN NEVADA | | | SOUTHERN NEVADA | | |
|---|---|---|---|---|---|---|
| | BENCHMARK | PEBP | % DIFFERENCE | BENCHMARK | PEBP | % DIFFERENCE |
| **Inpatient Facility** | $64.45 | $103.97 | 61.3% | $31.30 | $77.19 | 146.6% |
| **Outpatient Facility** | $164.46 | $204.24 | 24.2% | $88.09 | $104.88 | 19.0% |
| **Professional** | $127.38 | $182.85 | 43.6% | $104.96 | $150.68 | 43.6% |
| **Other** | $14.74 | $11.45 | -22.3% | $14.17 | $7.03 | -50.4% |
| **Pharmacy** | $128.27 | $182.91 | 42.6% | $120.84 | $164.24 | 35.9% |
| **Total** | **$499.29** | **$685.42** | **37.3%** | **$359.36** | **$504.02** | **40.3%** |

- High inpatient costs PMPM in both Northern and Southern Nevada appear to be driven by high unit costs (i.e., cost per service).
- High outpatient costs PMPM in Northern Nevada appear to be driven by high utilization rates. Unit costs are largely below benchmarks.
- Professional costs PMPM may be above benchmarks due to the mix of services obtained by PEBP members compared to benchmarks. There is wide variation in unit cost and utilization rates compared to benchmarks across specific service types.



Based on PEBP PY 2025 experience. Milliman benchmarks calibrated to PEBP demographics, plan design, geography, and average provider discounts.

# Utilization Benchmarks by Plan – CDHP

PEBP plan costs PMPM compared to Milliman benchmarks based on utilization rates and average cost per service

| | NORTHERN NEVADA | | | SOUTHERN NEVADA | | |
|---|---|---|---|---|---|---|
| | BENCHMARK | PEBP | % DIFFERENCE | BENCHMARK | PEBP | % DIFFERENCE |
| **Inpatient Facility** | $59.89 | $82.30 | 37.4% | $28.33 | $76.04 | 168.4% |
| **Outpatient Facility** | $161.03 | $147.42 | -8.5% | $84.85 | $91.15 | 7.4% |
| **Professional** | $120.33 | $93.19 | -22.6% | $96.98 | $105.39 | 8.7% |
| **Other** | $11.60 | $11.25 | -3.0% | $10.93 | $5.97 | -45.4% |
| **Pharmacy** | $133.61 | $134.69 | 0.8% | $121.95 | $134.91 | 10.6% |
| **Total** | $486.46 | $468.85 | -3.6% | $343.04 | $413.47 | 20.5% |

**Northern Nevada**

- PMPM costs in the North were slightly better than benchmarks.
- High inpatient costs PMPM appear to be driven by high unit costs.
- Outpatient costs PMPM are below benchmarks, which appear to be driven by below benchmark utilization rates.
- Professional costs PMPM are also below benchmarks, driven by low unit cost and utilization rates.

**Southern Nevada**

- Costs PMPM are above benchmarks for most service categories.
- Professional costs PMPM exceed benchmarks, despite unit costs and utilization for most services generally falling below benchmark levels. This difference may reflect a service mix that differs from the mix represented in the benchmark data.



Based on PEBP PY 2025 experience. Milliman benchmarks calibrated to PEBP demographics, plan design, geography, and average provider discounts.

# Utilization Benchmarks by Plan – EPO/HMO

PEBP plan costs PMPM compared to Milliman benchmarks based on utilization rates and average cost per service

| | NORTHERN NEVADA – EPO | | | SOUTHERN NEVADA – HMO | | |
|---|---|---|---|---|---|---|
| | BENCHMARK | PEBP | % DIFFERENCE | BENCHMARK | PEBP | % DIFFERENCE |
| **Inpatient Facility** | $66.47 | $223.59 | 236.3% | $33.47 | $118.46 | 254.0% |
| **Outpatient Facility** | $172.06 | $240.36 | 39.7% | $96.77 | $79.38 | -18.0% |
| **Professional** | $132.10 | $222.68 | 68.6% | $114.27 | $97.22 | -14.9% |
| **Other** | $15.20 | $20.23 | 33.1% | $12.91 | $16.84 | 30.5% |
| **Pharmacy** | $147.02 | $301.57 | 105.1% | $138.19 | $215.39 | 55.9% |
| **Total** | $532.85 | $1,008.42 | 89.3% | $395.61 | $527.30 | 33.3% |

**EPO**

- Costs PMPM are well above benchmarks across all service categories, which appears to be driven by:
  - High inpatient unit costs
  - High outpatient utilization rates
  - Overall difference in service category mix vs. benchmarks
- High inpatient costs PMPM appear to be driven by high unit costs (i.e., cost per service).

**HMO**

- PEBP costs for the HMO may not be as directly comparable to benchmarks given the capitated structure for certain services on the HMO.
- In general, costs PMPM are above benchmarks for most service categories.

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Based on PEBP PY 2025 experience. Milliman benchmarks calibrated to PEBP demographics, plan design, geography, and average provider discounts.

# Financial Performance and Utilization Review – Key Takeaways and Opportunities Identified

## Key Takeaways

- PEBP costs PMPM are higher than benchmarks for all plans in both Northern and Southern Nevada, except the CDHP in Northern Nevada.
- Inpatient costs PMPM are significantly higher than benchmarks across all plans / geographies.
  - This appears to be driven by high unit costs (i.e., cost per inpatient day) rather than high utilization rates (i.e., number of inpatient days).
  - This could imply provider reimbursement rates are less competitive than the market, or that members are utilizing providers with higher average costs per service compared to market norms.

## Opportunities Identified

- PEBP could consider:
  - Increasing member cost sharing via plan design to drive more efficient utilization.
  - Pursuing more competitive provider reimbursement rates.
  - Adjusting / eliminating underperforming plan options.
  - Implementing tiered provider networks with benefit differentials to drive utilization at more efficient providers.

# Key Findings

## Network Adequacy and Efficiency

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# Network Discount / Disruption Analysis

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# Traditional Network Discount / Disruption Analysis

Comparing UMR to other major national carriers and third-party administrators

**Background**

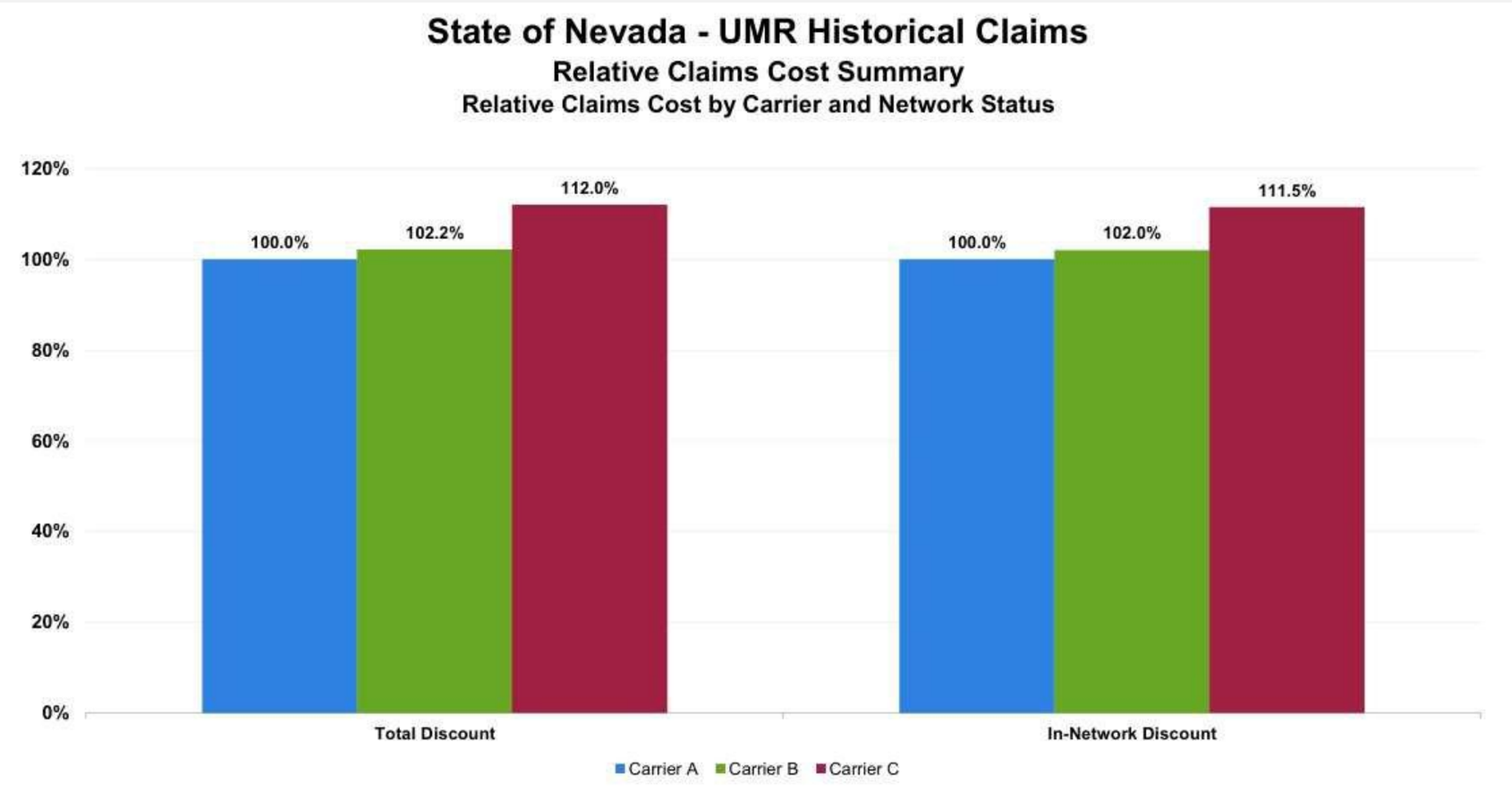
Milliman completed a medical network analysis and disruption comparison for PEBP to determine the expected relative claims cost based on providers / services utilized by PEBP members for medical claims paid between January 1, 2025 and December 31, 2025. We repriced PEBP claims based on each carrier's book of business discounts aggregated using the Uniform Data Specification (UDS) requirements based on 3-digit zip code discounts.

**Important Notes**

- Data use agreements between Milliman and carriers submitting UDS data limit what information can be attributed back to carriers.
  - Results from this analysis are blinded by carrier because of these limits.
  - Results can be used to assess how many carriers offer competitive discounts and robust provider networks based on current PEBP utilization.
- One major national carrier with a presence in Nevada declined to participate in this analysis.
  - The carrier indicated it would provide a discount analysis as part of an RFP response, should PEBP elect to conduct a medical TPA RFP in the future.
- This analysis focused on historical PEBP claims incurred under the UMR plans, repriced to each carrier's broad PPO network in Nevada.

# Traditional Network Discount / Disruption Analysis

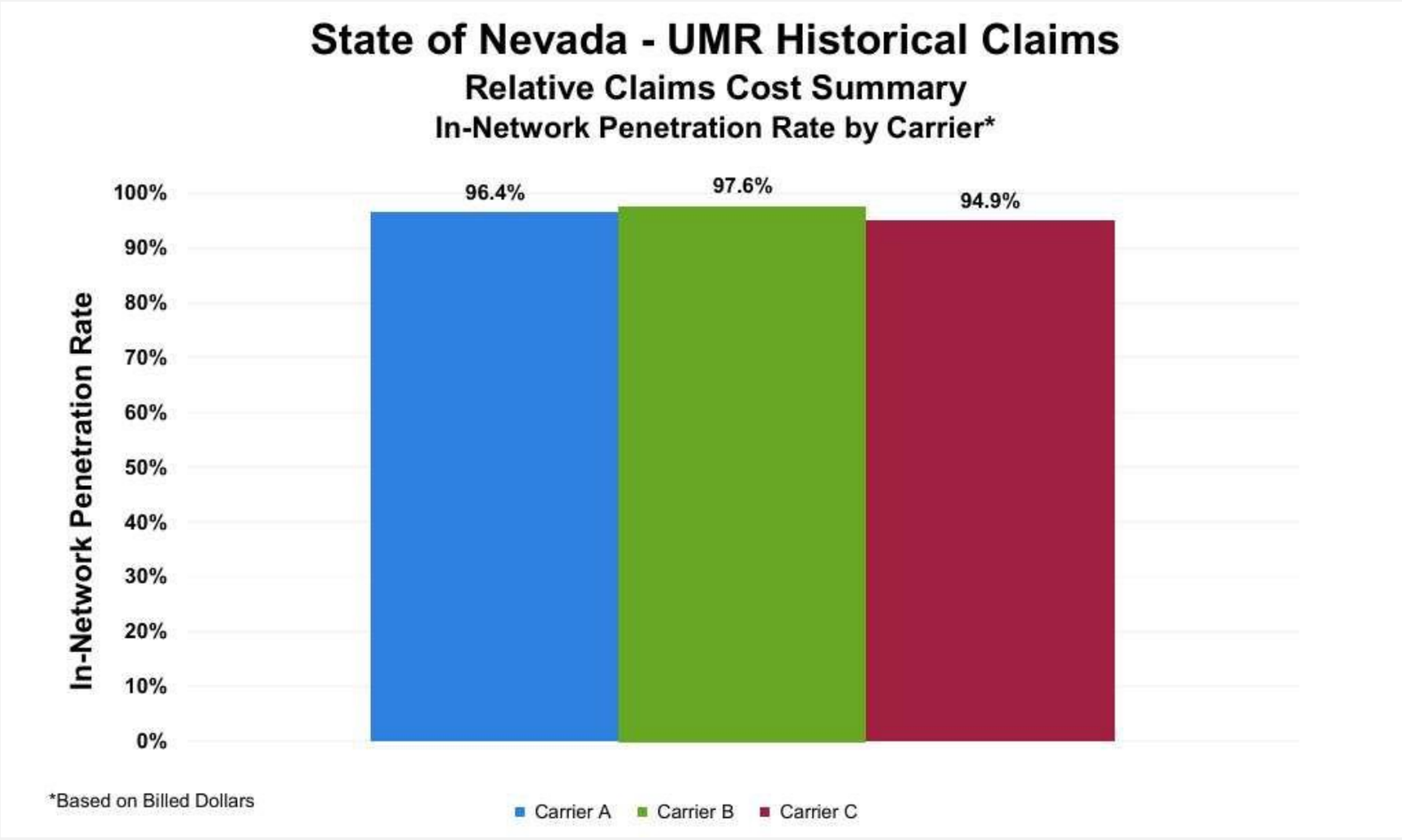
Results – discount relativity by carrier




- **Carriers A and B have relatively close discounts overall**
- **Carrier C's discounts are less competitive relative to Carriers A and B**

# Traditional Network Discount / Disruption Analysis

Results – in-network penetration by carrier




- **Carrier B has the highest percentage of providers in-network currently utilized by PEBP members**

# Price Transparency Analysis

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# Price Transparency Analysis – Background

- The Hospital Price Transparency (HPT) and Transparency in Coverage (TiC) federal requirements enacted in the last few years have made a vast amount of proprietary data publicly available for the first time.
- The Centers for Medicare and Medicaid Services (CMS) published a Final Rule in 2019 requiring hospitals to publish machine-readable files (MRF) of their negotiated payment rates starting January 1, 2021.
- Additionally, in 2020, the U.S. Department of Health and Human Services, Department of the Treasury, and Department of Labor collectively released the Transparency in Coverage Final Rules, requiring group health plans and health insurance issuers to publish certain information about the prices of healthcare services.
- Milliman Transparent leverages foundational data from Turquoise Health, which aggregates the publicly available data resulting from the regulations outlined above and enriches the data using Milliman's vast claims and contracting experience to improve data quality and usability. Milliman Transparent incorporates proprietary utilization profiles and standardized pricing to create case-mix-weighted percent of Medicare relativities that enable fair contract comparisons.

# Price Transparency Analysis – PEBP Analysis

- In order to assess the strength of PEBP's existing TPA and health plan provider contracts, we reviewed several different cuts of data from Milliman Transparent. Broadly, we evaluated statewide data for Nevada. We then narrowed our focus to specific hospitals and health plans / TPAs that PEBP already uses and / or that may be relevant for benchmarking purposes. We grouped PY 2025 incurred claims by National Provider Identifier (NPI) to determine the top hospitals / hospital systems utilized by PEBP members based on total paid claims (combined across service categories – inpatient, outpatient, and professional). This yielded the following list of top providers:
  - Renown Regional Medical Center
  - Carson Tahoe Regional Medical Center
  - Renown South Meadows Medical Center
  - Dignity Health – St. Rose Dominican Hospitals – Siena Campus
  - Sunrise Hospital and Medical Center
  - Summerlin Hospital Medical Center
  - Carson Valley Health Hospital
  - Mountainview Hospital
  - University Medical Center
  - Centennial Hills Hospital Medical Center
- Outpatient spend generally represents a larger proportion of spend at these hospital systems compared to inpatient spend, but inpatient spend is still significant. Notably, outpatient spend is particularly high as a percentage of total spend at Renown and Carson Tahoe.

When evaluating the market at large, we focused on comparing provider reimbursement rates at PEBP's top hospitals for the following health plans / networks:

- Anthem PPO
- United Healthcare Choice Plus
- United Healthcare Options (includes Sierra Care Options)
- Hometown HMO

Health Plan Nevada data was not well populated in the HPT or TiC datasets. Information for many providers was available for Aetna and Cigna, but we did not focus on these given their overall presence in the Nevada commercial market.

# Payer (TiC) Transparency Data

## Inpatient / Outpatient Overview

**Percent of Expected Color Coding**

- Greater than 75%
- Between 75% to 50%
- Between 50% to 25%
- Less than 25%

**GVRU Medicare**

**Market Data Summary**

| Provider Name | Beds | Anthem Anthem PPO FIP | Anthem Anthem PPO FOP | United UHC Choice Plus FIP | United UHC Choice Plus FOP | United UHC Options FIP | United UHC Options FOP |
|---|---|---|---|---|---|---|---|
| Renown Regional Medical Center | 509 | 354% | 291% | 319% | 254% | 319% | 254% |
| Carson Tahoe Regional Medical Center | 211 | 248% | 343% | n/a | n/a | n/a | n/a |
| Renown South Meadows Medical Center | 138 | 361% | 324% | 252% | 258% | 252% | 258% |
| Dignity Health - St. Rose Dominican Hospitals - Siena Campus | 326 | 274% | 458% | 441% | 225% | n/a | n/a |
| Sunrise Hospital And Medical Center | 718 | 550% | 315% | 194% | 164% | n/a | n/a |
| Summerlin Hospital Medical Center | 391 | 280% | 287% | 211% | 166% | 211% | 166% |
| Carson Valley Health Hospital | 23 | 201% | 392% | 156% | n/a | 156% | n/a |
| Mountainview Hospital | 417 | 565% | 315% | 192% | 163% | n/a | n/a |
| University Medical Center | 514 | 397% | 413% | 174% | 136% | 174% | 136% |
| Centennial Hills Hospital Medical Center | 326 | 280% | 287% | 211% | 166% | 211% | 166% |

- Providers above reflect top providers in terms of total paid claims (combined for PY 2024, PY 2025, and PY 2026 through April)
- The colored circle next to each percentage represents to “Percent of Expected” or how complete the payer posted transparency data is
- The actual percentage represents the “GRVU Medicare Percentage” or a normalized cost relativity based on a commercial population
- Anthem’s facility inpatient (FIP) data shows high degree of completeness while United’s are less complete, making comparisons more challenging, although the posted payer data would appear to indicate United generally has more favorable rates than Anthem
- UHC is posting the same rates for its Options network as for its Choice Plus network; however, in Nevada, United offers a Sierra Care network for which United is not posting complete data – the hospital-posted data does include Sierra-specific rate information
- We were not able to assess any reliable payer data for Hometown and Health Plan of Nevada



*Please refer to pages 44-47 for additional information, caveats, and limitations about price transparency data summaries*

# Hospital (HPT) Transparency Data

## Inpatient / Outpatient Overview

**Percent of Expected Color Coding**
- Greater than 75%
- Between 75% to 50%
- Between 50% to 25%
- Less than 25%

**GVRU Medicare**

**Market Data Summary**

| Provider Name | Beds | Anthem Anthem PPO FIP | Anthem Anthem PPO FOP | United UHC Choice Plus FIP | United UHC Choice Plus FOP | Hometown Hometown HMO FIP | Hometown Hometown HMO FOP |
|---|---|---|---|---|---|---|---|
| Renown Regional Medical Center | 509 | 354% | 216% | n/a | 490% | 160% | 397% |
| Carson Tahoe Regional Medical Center | 211 | 239% | 464% | 80% | 428% | 244% | 289% |
| Renown South Meadows Medical Center | 138 | 360% | 223% | 220% | 436% | 121% | 681% |
| Dignity Health - St. Rose Dominican Hospitals - Siena Campus | 326 | 242% | 380% | 427% | 780% | n/a | n/a |
| Sunrise Hospital And Medical Center | 718 | 270% | 287% | 164% | 270% | 184% | 532% |
| Summerlin Hospital Medical Center | 391 | 280% | 255% | 219% | 374% | n/a | n/a |
| Carson Valley Health Hospital | 23 | 545% | 441% | 241% | 469% | n/a | n/a |
| Mountainview Hospital | 417 | 270% | 287% | 182% | 277% | 184% | 536% |
| University Medical Center | 514 | 134% | 226% | 126% | 224% | 201% | 372% |
| Centennial Hills Hospital Medical Center | 326 | 280% | 255% | 219% | 374% | n/a | n/a |

- HPT data aligns with TiC data in some cases, but differs in many as well and network names can be difficult to interpret in some cases
- Hometown appears competitive at select facilities on the FIP side, while the FOP data is less robust / reliable, but does appear to have the lowest percent of charge contracts at Renown Regional Medical Center
- In the HPT data, it appears as though the United broad network has higher outpatient rates than other networks (e.g., Sierra appears more favorable at Carson Tahoe and Hometown and Anthem appear more favorable at Renown)
- In the HPT data, we can often see two Sierra rates, an Options PPO and a Health Plan of Nevada HMO, where the latter is more favorable
- University Medical Center posted what appear to be custom rates for many employer-sponsored plans, including those in the Gaming industry and local unions; rates are generally consistent across plans and in line with United's rates



*Please refer to pages 44-47 for additional information, caveats, and limitations about price transparency data summaries*

# Network Adequacy and Efficiency – Key Takeaways and Opportunities Identified

## Key Takeaways

- The traditional network discount analysis shows two national carriers that have average discounts within a few percentage points of each other. One additional carrier did not respond to our RFI. There could be competitive network discounts available with limited disruption with other TPAs / carriers.
- Transparency data indicates UHC Choice Plus network may not reflect best-in-market rates at all hospitals, particularly for outpatient services. We performed a deeper review of transparency data at Carson Tahoe and Renown, where PEBP has significant claim spend:
  - Carson Tahoe
    - UHC Choice Plus generally appears competitive on inpatient
    - Anthem's rates appear more competitive for select outpatient service categories
    - UHC Options network (which we understand includes Sierra Care Options) appears more competitive than UHC Choice Plus for outpatient reimbursements overall
  - Renown
    - UHC Choice Plus may not be optimal for outpatient services
    - Anthem PPO and Hometown HMO networks appear more favorable compared to UHC Choice Plus

## Opportunities Identified

- PEBP could consider:
  - Conduct TPA / carrier procurement, including tiered network options, alternative HMO options, and performance guarantees on network discounts / provider reimbursement rates
  - Pursuing more competitive provider reimbursement rates via direct contracts with select providers
  - Evaluate market-wide reimbursement caps / reference-based pricing strategy for select services or on a broad basis
    - Could be done as a second phase after direct contract pursuit, or if direct contracts are not viable
    - To be explored as part of broader NVHA cross-program initiatives
    - Leverage Transparency data for this evaluation

# Next Steps

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# Next Steps

**NVHA / PEBP Decisions**

Select initiatives to advance / evaluate further

**Start legal / actuarial review of active / retiree risk pool separation**

**Develop TPA / carrier RFP**

**Evaluate plan design / dependent subsidy adjustments**

**Start direct contracting discussions with select providers**

# Q&A

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# Caveats, Limitations on Use, and Additional Information

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# Caveats and Limitations on Use

We are consulting actuaries and pharmacy benefit consultants with Milliman. Andrew Timcheck is a member of the American Academy of Actuaries and meets the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

This information has been prepared for the internal use of the Nevada Health Authority (NVHA). No portion may be provided to, or relied upon by, any other party without Milliman's prior written consent.

This information is intended to highlight observations and opportunities related to the State's employee health plan (PEBP). This information may not be appropriate, and should not be used, for other purposes.

Milliman has developed certain models to estimate the values included in this deliverable. The intent of the models was to summarize PEBP actuarial values relative to local comparator plans, assess PEBP provider network strength and opportunities, and assess PEBP pharmacy benefit utilization and opportunities. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

We developed these observations and considerations based on information provided by NVHA, PEBP, UMR, HPN, and Segal. Some information contained within is from the Milliman Transparent product. This information is based on a large historical nationwide healthcare dataset proprietary to Milliman, as well as publicly available price transparency data collected by Turquoise Health, enriched by Milliman analytics. Estimates based or derived from this data and supporting files are dependent upon data from Milliman Transparent.

In preparation of our analysis, we relied upon the accuracy of data or information provided to us. We have not audited this information, although we have reviewed it for reasonableness. If the underlying data or information is inaccurate or incomplete, the results presented in this report may likewise be inaccurate or incomplete.

# Cost and Utilization Benchmarking – Additional Information

- 2025 Milliman *Health Cost Guidelines™ (HCGs)* for average managed care as benchmark basis
  - Nationwide detailed claims and enrollment data represent over 100 million commercially insured lives

- Further, the *HCGs* were calibrated to Northern Nevada or Southern Nevada for:
  - Region and plan combination
  - Demographics
  - 2025 plan year PEBP approximated service discounts (medical and pharmacy)

- Plans by region were then compared to these calibrated benchmarks

# Network Discount / Disruption Analysis

Caveats and Limitations

State of Nevada historical claims data provided by UMR and Health Plan of Nevada was the basis for the reimbursement analysis and provider disruption comparison. We did not audit the historical data set or verify the accuracy of the data but did review the data for reasonableness.

We relied on the UDS data provided to us by Carrier A, Carrier B, and Carrier C. We did not audit their results; however, we did review the results for reasonableness. We also compared their results against internal resources to perform additional checks.

Discount data reflects allowed charges and allowed-to-billed discount levels achieved by the various vendors. Any differences in the timing of the claims information between the vendor data and the State of Nevada data could result in differences from the results presented in this letter.

The provider discounts used in our analysis were provided from the carriers and based on their overall book of business. Each of these providers could have different discounts. If the distribution of providers in the State of Nevada data differs from the distribution in the vendors' data, then results could be affected. Similarly, the distribution of services within the hospital categories could differ between State of Nevada historical data and book-of-business, which could also affect results.

Determination of in vs. out of network providers for each carrier is based primarily on the disruption analysis provided to us by the carriers.

Discount data is not a forecast of projected claim cost for State of Nevada. Milliman makes no guarantee of the impact of the actual financial results in this reimbursement analysis. There are a number of factors, many of which are discussed in this report, which could cause actual financial results to vary from the results presented in this letter.

# Price Transparency Analysis

Background and key information regarding how to interpret results

- The price transparency data in this presentation is from Milliman Transparent, Milliman's price transparency analytics product. Milliman Transparent takes raw price data from Turquoise Health and layers on additional enhancements to make it more actionable for analytics and comparisons.
- In order to allow for fair, reliable, and defensible comparisons across payers and providers, we aggregate code-level prices from hospital transparency (HPT) and payer transparency (TiC) data into a normalized, comparable benchmark called Percent of GRVU Medicare. This benchmark is an approximation of nationwide Medicare relativities for a commercial population based on Milliman's Global Relative Value Units (GRVUs).
- Neither the hospital nor payer dataset includes any utilization or service mix information to allow for aggregations of the code-level data. In order to create actionable insights from the data, we develop utilization profiles specific to line of business (e.g., group commercial) and provider type (e.g., short-term acute care hospital) using commercial claims data from Milliman's research databases of over 80 million commercial lives to allow for aggregations of the code-level transparency data into meaningful service categories.
- Claims data obtained from PEBP was utilized to help determine which geographic markets, providers, and payers were most relevant for this analysis.
  - Please note we do not use PEBP's utilization to create PEBP-specific code-level service mix aggregations due to concerns with credibility, though we do evaluate how PEBP's utilization affects the analysis.

# Price Transparency Analysis

Interpreting results – assessing reliability and credibility of comparisons

- Additionally, Milliman has developed metrics to quantify the quality and reliability of the data and our Percent of GRVU Medicare reference values. **The most important metric is our Percent of Expected value**:
  - Percent of Expected: Estimates the total Relative Value Units (RVUs) associated with the transparency data that pass all quality checks relative to the total RVUs we would expect for the given provider type and line of business (LOB). This metric helps quantify the comprehensiveness and reliability of the posted transparency data (i.e., how much is available compared to what we would expect).
  - Although we always recommend analyzing the results and underlying data for reasonability, we believe the following metrics provide a guideline for interpretation of results:
    - Percent of Expected greater than 75%: Highly reliable
    - Percent of Expected between 50% and 75%: Generally reliable; consider additional investigation
    - Percent of Expected between 25% and 50%: Moderately reliable; recommend additional investigation
    - Percent of Expected less than 25%: Generally unreliable; recommend code-level investigation

Understanding the reliability of the comparisons is critical when making assessments. We do not recommend accepting results without considering the reliability and credibility of the data.

# Price Transparency Analysis

Interpreting results – Transparency data vs. claims data

- The analysis presented herein is intended to use the publicly available price transparency data to compare costs across various third-party administrators (TPAs), networks, and providers
- One of the limitations of the publicly posted price transparency data is that it does not capture all of the nuances associated with an adjudicated healthcare claim, for example:
  - Some claims are subject to payment terms and adjustments not reflected in the posted rates including outlier claims / stop-loss provisions
  - Some types of services are coded / priced as a bundle or set of services receiving one payment and bundling is not always clear in the posted rates
  - Some TPAs contract differently than others / report prices differently than others

# Price Transparency Analysis

Interpreting results – guidelines to consider

- The “Percent of Expected” metric is critical to evaluate when analyzing results, **however:**
  - Even when Percent of Expected is high, it’s important to evaluate the reasonability of results
  - Even when Percent of Expected is low, there could be meaningful results, for example:
    - Often percent of charge reporting (i.e., when negotiated rates are developed as a discount off of billed charges), has a low Percent of Expected value, but it’s possible to understand comparisons when multiple payers have a percent of charge contract with a provider, and vice versa
    - There is an opportunity to review code-level negotiated detail for top codes

- When results from the payer and hospital data are aligned, we have far more confidence in results
- When results from the payer and hospital are not aligned, consider reviewing claims data to validate which data source more closely aligns with how your claims are adjudicated
  - These discrepancies offer opportunities to communicate with your TPA to understand inconsistencies

# 7.

7. Strategic Planning Decisions. (PEBP Board)
   (**For Possible Action**)
   7.1 Disease Management and Care Coordination
   7.2 Pharmacy Benefits
   7.3 Contracting Procedures

# 8.

8. Discussion and possible action regarding plan design and the State Subsidization Policy and any necessary amendments to PEBP's Board and Agency Duties, Policies and Procedures. (Debbie Donaldson, Segal) (**For Possible Action**)

Segal

Nevada Public Employees' Benefits Program

# Plan Design and Subsidy Considerations

October 2, 2026

# Agenda

- Current State
- Plan Design
- Tier Analysis
- Subsidy Analysis
- Combined Scenario

# Current State

# Current Financial State

- FY26 PEBP ending cash balance = $52.6M
- IBNR as of June 30, 2026 = $63M
- Board voted in March 2026 to phase-in full rates: Anticipated $32M need in additional funding, not included in PY27 AEGIS/REGI funding allocation
  - PY27 projected to be $32M - $36M
- Projected PY27 cash balance = $16M
  - Data through July 2026
  - Assuming an additional $13M to offset a portion of the phase-in
  - Reflecting IBNR reserve results in -$47M

# PY2027 Plan Designs

| | CDHP | LDPPO | EPO | HMO |
|---|---|---|---|---|
| Actuarial Value | 78% | 83% | 89% | 91% |
| Service Area | Global | Global | Northern Nevada | Southern Nevada |
| HSA/HRA Contribution | $700 PEPY<br>+$200 per dep (max 3) | N/A | N/A | N/A |
| Annual Deductible | $1,700 Individual<br>$3,400 Family<br>$3,400 Individual Family Member Deductible | $300 Individual<br>$600 Family | $100 Individual<br>$200 Family<br>$100 Individual Family Member Deductible | N/A With exception of Tier 4 prescription drug coverage |
| Medical Coinsurance | 20% after deductible | 20% after deductible | 20% after deductible | N/A |
| Out-of-Pocket Maximum | $5,000 Individual<br>$10,000 Family | $5,000 Individual<br>$10,000 Family | $4,000 Individual<br>$8,000 Family | $5,000 Individual<br>$10,000 Family |
| Primary Care/<br>Specialist Office Visit | 20% after deductible | $30/ $50<br>copay per visit | $20/ $40<br>copay per visit | $25/ $40<br>($25 with referral)<br>copay per visit |
| Urgent Care Visit | 20% after deductible | $80 copay per visit | $50 copay per visit | $50 copay per visit |
| Emergency Room Visit | 20% after deductible | $750 copay per visit | $600 copay per visit | $600 copay per visit |
| In-Patient Hospital | 20% after deductible | 20% after deductible | $600 copay per visit | $600 copay per visit |
| Outpatient Surgery | 20% after deductible | $500 copay per visit | $350 copay per visit | Ambulatory Facility<br>$50 copay Hospital<br>$350 copay |
| PY2027 Employee Only Premium | $55.26 | $160.18 | $381.24 | $381.24 |

# Enrollment Change as of July 2026

## Plan Migration During Open Enrollment PY 2027 – Actives and Non-Medicare Retirees

| | | July 2026 Plan Election | | | | | |
|---|---|---|---|---|---|---|---|
| May 2026 Plan Election | | CDHP | LDPPO | EPO | Dropped | Total | May 2026 Share |
| | CDHP | 12,027 | 357 | 5 | 691 | 13,080 | 45.4% |
| | LDDPO | 1,151 | 11,733 | 12 | 606 | 13,502 | 46.8% |
| | EPO | 54 | 474 | 1,654 | 72 | 2,254 | 7.8% |
| | New Plan Enrollees | 709 | 995 | 18 | | 1,722 | |
| | Total | 13,941 | 13,559 | 1,689 | 1,369 | 30,558 | |
| | July 2026 Share | 47.8% | 46.5% | 5.8% | | | |

- CHDP Plan:
  - July enrollment share increased 2.4 percentage points to 47.8% from May 2026
  - 3% (357) moved to LDPPO
- LDPPO Plan
  - July enrollment share stayed roughly the same (a 0.3 percentage point decrease)
  - 9% (1,151) moved to CDHP
- EPO Plan
  - July enrollment share decreased 2 percentage points
  - 21% (474) moved to LDPPO, 2% (54) moved to CDHP
- More EPO members moved to LDPPO and less into CDHP than expected; it also depends on who moved as well.
- Less LDPPO members moved to CDHP than expected, again depends on who does and does not move.

# PY2026 Medical/Rx Plan Performance

- Total expenses exceeded medical/Rx revenue by $14.6M

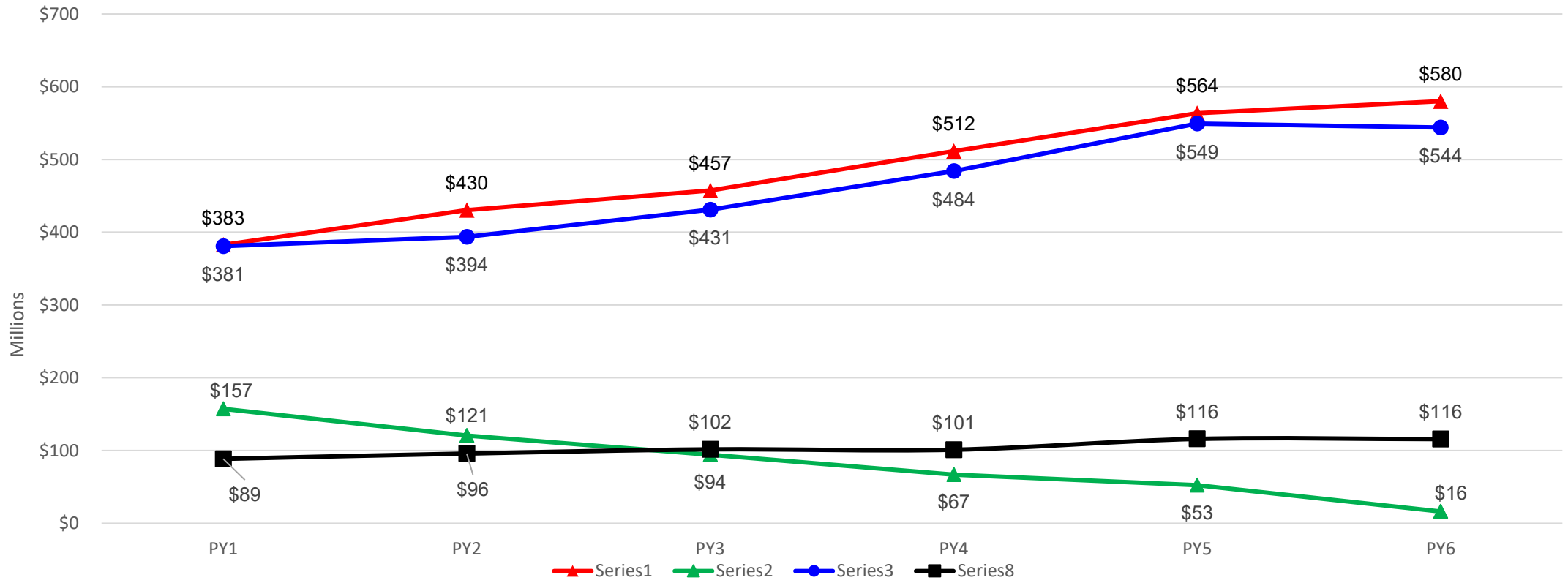
| | CDHP | LDPPO | EPO/HMO | Dental | Medicare HRA | Total |
|---|---|---|---|---|---|---|
| Total Revenue* | $176,046,991 | $179,927,657 | $87,638,887 | $30,767,700 | $33,612,164 | $507,993,400 |
| Total Expenses** | $154,136,600 | $202,554,900 | $102,383,700 | $29,939,700 | $33,612,164 | $522,627,064 |
| Net | $21,910,391 | ($22,627,243) | ($14,744,813) | $828,000 | $0 | ($14,633,664) |
| Avg. Enrollment | 13,772 | 13,450 | 5,634 | 41,873 | 12,936 | 32,856[1] |
| Revenue PEPM*** | $1,065 | $1,115 | $1,296 | $61 | $217 | $1,288 |
| Expense PEPM | $933 | $1,255 | $1,514 | $60 | $217 | $1,326 |
| Net PEPM Difference | $133 | ($140) | ($218) | $2 | $0 | ($37) |

* State funding, employee and retiree premium contributions (excludes contributions to dental, life and general PEBP administration costs and revenue received in PY2026 attributable to prior plan years).
** Paid claim costs, fully insured HMO premiums, HSA contributions, HRA claims (including supplemental) and administrative costs, net of prescription drug rebates
*** Per Employee Per Month
[1] Represents total Medica/Rx plan enrollment

# Reserves

- Leading up to FY2024, reserves were actively spent down
  - Plan changes, premium subsidies and supplemental HRAs
- Trend increase accelerated at the same time
- FY26 increase in AEGIS/REGI used to reduce employee premiums, partially used in FY27 for the premium phase-in

| | FY24 | FY25 | FY26 | FY27 |
|---|---|---|---|---|
| AEGIS | $730 | $759 | $991 | $943 |
| REGI | $515 | $545 | $650 | $700 |




[1]Catastrophic Reserve set at 50 days of claims for PY2024 and earlier; 45 days of claims for PY2025 and later.
[2] Assets and IBNR estimated for FY2027.

# Plan Design and other Financial Considerations

# Plan Design Scenarios

- Option A – Eliminate EPO/HMO; enhance plan design for LDPPO = $8M PY28 projected savings
- Option B – Change HMO to self-funded (EPO) option = $7M PY28 projected savings
- Option C – De-couple active and retirees = $19M PY28 projected reduction in active rates, $20M PY28 increase in retiree rates

# Plan Design Considerations – Option A

## Eliminate EPO/HMO, enhance LDPPO plan design

- Increased Actuarial Value in LDPPO by one percentage point (83% to 84%)
- Assume most members remaining in EPO plan would migrate to LDPPO
- Update specialty Rx benefit for CDHP and LDPPO
- Update CDHP deductible to comply with IRS requirements
- Majority of savings is associated with move to a self-funded arrangement

**Projected PY28 Total Med/Rx Savings = $8M**

# PY28 Plan Design Considerations – Option A

| Medical | CDHP | LDPPO Current | LDPPO - Proposed |
|---|---|---|---|
| Actuarial Value (Medical + Rx) | 78% | 83% | 84% |
| Service Area | Global | Global | Global |
| HSA/HRA Contribution | $700 PEPY<br>+$200 per dep (max 3) | N/A | N/A |
| Annual Deductible | $1,750 Individual<br>$3,500 Family<br>$3,500 Individual Family Member Deductible | $300 Individual<br>$600 Family | $500 Individual<br>$1,000 Family |
| Medical Coinsurance | 20% after deductible | 20% after deductible | 20% after deductible |
| Out-of-Pocket Maximum | $5,000 Individual<br>$10,000 Family | $5,000 Individual<br>$10,000 Family | $4,000 Individual<br>$8,000 Family |
| Primary Care/ Specialist Office Visit | 20% after deductible | $30/ $50<br>copay per visit | $25/ $40<br>copay per visit |
| Urgent Care Visit | 20% after deductible | $80 copay per visit | $50 copay per visit |
| Emergency Room Visit | 20% after deductible | $750 copay per visit | $600 copay per visit |
| In-Patient Hospital | 20% after deductible | 20% after deductible | 20% after deductible |
| Outpatient Surgery | 20% after deductible | $500 copay per visit | $400 copay per visit |
| **Rx** | | | |
| Preferred Generic (30d/90d) | 20% after deductible | $10 (30-day) /$20 (90-day retail and mail) | $10 (30-day) /$20 (90-day retail and mail) |
| Preferred Brand | 20% after deductible | $40 (30-day)/ $80 (90-day retail and mail) | $40 (30-day)/ $80 (90-day retail and mail) |
| Non-Formulary | 100% member paid | $75 (30-day) /$150 (90-day retail and mail) | $100 (30-day) /$200 (90-day retail and mail) |
| Specialty (30 day) | 30% after deductible; for drugs not on SaveOnSP ($75 min / $150Max) | 30% after deductible; for drugs not on SaveOnSP ($100 min / $250Max) | 30% after deductible; for drugs not on SaveOnSP ($75 min / $150Max) |

# Plan Design Considerations – Option B

## Change HMO to self-funded

- Change HMO to self-funded option, plan design = EPO
- CDHP deductible change to comply with IRS requirements
- Rx specialty change on CDHP and LDPPO (page 12)

Projected PY28 Total Med/Rx Savings = $7M

# Plan Design Considerations – Option C

## Actives and Retirees De-Coupled

Based on projections for PY2028, if actives and retirees were rated separately based on their own experience

| Population | Projected Budget Rate Impact | Projected PY 2028 Budget Impact |
|---|---|---|
| Actives | 4% reduction | - $19M |
| Retirees | 27% increase | + $20M |

# Tier Analysis

# Coverage Tier Analysis

| | Current Tier Ratios | Ratios Based on 5yr Claims Analysis | Suggested updated Tier Ratios |
|---|---|---|---|
| Employee (EE) | 1.000 | 1.000 | 1.000 |
| EE + Spouse/DP | 2.000 | 2.204 | 2.200 |
| EE + Child(ren) | 1.375 | 1.448 | 1.450 |
| EE + Family | 2.375 | 2.651 | 2.650 |

- **Changes to tier ratios will not change overall costs**
- **Changes will reduce unintended subsidies between employees and dependents**

| Tier | PY27 CDHP Rates | Illustrative PY27 LDPPO with updated Tier Ratios | $ Change | PY27 LDPPO Rates | Illustrative PY27 LDPPO with updated Tier Ratios | $ Change |
|---|---|---|---|---|---|---|
| Employee (EE) | $55 | $46 | ($9) | $160 | $139 | ($21) |
| EE + Spouse/DP | $314 | $334 | $20 | $521 | $565 | $44 |
| EE + Child(ren) | $152 | $154 | $2 | $296 | $299 | $3 |
| EE + Family | $411 | $441 | $30 | $657 | $724 | $67 |

# Subsidy Analysis

# Subsidy Analysis – Current State

- AEGIS and REGI Base Subsidy is consistent across plans and is based on CDHP rates
  - AEGIS: Employee = **93.5%** of CDHP total EE only rate
  - AEGIS: Dependents = **68.5%** of dependent portion of total CDHP rate
  - REGI: Retiree = **70%** of CDHP total retiree only rate
  - REGI: Dependents = **45%** of dependent portion of total CDHP rate
- When reviewing Base Subsidy as a percentage of total rates, the following percentages apply:

| State Actives | CDHP | LDPPO | EPO |
|---|---|---|---|
| Employee (EE) | 93.5% | 69.8% | 55.1% |
| EE + Spouse/DP | 81.1% | 60.5% | 47.6% |
| EE + Child(ren) | 86.8% | 64.7% | 51.0% |
| EE + Family | 79.1% | 59.0% | 46.5% |

| State Retirees | CDHP | LDPPO | EPO |
|---|---|---|---|
| Retiree (Ret) | 70.0% | 52.2% | 41.1% |
| Ret + Spouse/DP | 57.6% | 42.9% | 33.8% |
| Ret + Child(ren) | 63.2% | 47.1% | 37.1% |
| Ret + Family | 55.6% | 41.4% | 32.6% |

Based on initial PY 2028 budget projections

# Subsidy Scenarios

- Scenario 1 – Return AEGIS and REGI Base Subsidies to historical levels = **PY28 projected savings of $6M**
- Scenario 2 – AEGIS Base Subsidy set so CDHP employee only premium = $0, dependent subsidy changes, no change for REGI = **$0 PY28 projected savings**
- Scenario 3 – AEGIS Base Subsidy percentage varies by plan, no change for REGI = **PY28 projected savings of $1M**
- Scenario 4 – Reduce AEGIS spousal Base Subsidy 5%, reduce REGI Base Subsidy = **PY28 projected savings of $8M**
- Scenario 5 – Only REGI Base Subsidy for retirees, no change to AEGIS Base Subsidy = **PY28 projected savings of $9M**

# Subsidy Scenario 1 – Historical Levels

- Return Base Subsidy to historical levels:
  - AEGIS: **93%** for employee and **68%** for dependents
  - REGI: **64%** for retirees and **39%** for dependents

Projected PY28 PEBP Med/Rx Savings = $6M

- $2M for AEGIS
- $4M for REGI

# Subsidy Scenario 1 – Historical Levels Premium

| | Plan Year 2027 Participant Premium | | | Illustrative Participant Premium | | | Difference | | |
|---|---|---|---|---|---|---|---|---|---|
| **State Active Employees** | **CDHP** | **LDPPO** | **EPO/HMO** | **CDHP** | **LDPPO** | **EPO/HMO** | **CDHP** | **LDPPO** | **EPO/HMO** |
| Employee Only | $55 | $160 | $381 | $60 | $165 | $386 | $5 | $5 | $5 |
| Employee + Spouse | $314 | $521 | $962 | $327 | $535 | $976 | $13 | $13 | $13 |
| Employee + Child(ren) | $152 | $296 | $599 | $160 | $304 | $607 | $8 | $8 | $8 |
| Employee + Family | $411 | $657 | $1,180 | $428 | $673 | $1,197 | $17 | $17 | $17 |

| | Plan Year 2027 Participant Premium | | | Illustrative Participant Premium | | | Difference | | |
|---|---|---|---|---|---|---|---|---|---|
| **State Retirees** | **CDHP** | **LDPPO** | **EPO/HMO** | **CDHP** | **LDPPO** | **EPO/HMO** | **CDHP** | **LDPPO** | **EPO/HMO** |
| Retiree only | $278 | $373 | $589 | $326 | $421 | $637 | $48 | $48 | $48 |
| Retiree + Spouse | $703 | $892 | $1,324 | $852 | $1,042 | $1,474 | $149 | $149 | $149 |
| Retiree + Child(ren) | $437 | $568 | $865 | $525 | $655 | $952 | $88 | $88 | $88 |
| Retiree + Family | $862 | $1,087 | $1,600 | $1,048 | $1,273 | $1,786 | $186 | $186 | $186 |

- Actual premiums paid by retirees depend on years of service, retirement date, and enrollment in Medicare B
- Maximum subsidy is $262.50 for 20+ years of service and $145.30 for Medicare Part B for a total of $407.80 per month

# Subsidy Scenario 2 – $0 EE CDHP Premium

- Set AEGIS Base Subsidy such that the resulting employee premium for CDHP is $0
  - May result in additional migration into the CDHP
  - Higher increases for tiers covering spouses
- Resulting AEGIS Base Subsidy rates are **100.0%** for employee and **47.4%** for dependents

**Projected PY28 PEBP Med/Rx Savings = $0 (net neutral)**

| | Plan Year 2027 Participant Premium | | | Illustrative Participant Premium | | | Difference | | |
|---|---|---|---|---|---|---|---|---|---|
| **State Active Employees** | **CDHP** | **LDPPO** | **EPO/HMO** | **CDHP** | **LDPPO** | **EPO/HMO** | **CDHP** | **LDPPO** | **EPO/HMO** |
| Employee Only | $55 | $160 | $381 | $0 | $105 | $326 | ($55) | ($55) | ($55) |
| Employee + Spouse | $314 | $521 | $962 | $433 | $641 | $1,081 | $119 | $119 | $119 |
| Employee + Child(ren) | $152 | $296 | $599 | $162 | $306 | $609 | $10 | $10 | $10 |
| Employee + Family | $411 | $657 | $1,180 | $596 | $841 | $1,365 | $185 | $185 | $185 |

# Subsidy Scenario 3 – Subsidy Varies by Plan

- AEGIS Base Subsidy will vary by plan:
  - Employee: **95%** for CDHP, **75%** for LDPPO, **65%** for EPO/HMO
  - Dependent: **40%** for all plans

**Projected PY28 PEBP Med/Rx Savings = $1M**

| | Plan Year 2027 Participant Premium | | | Illustrative Participant Premium | | | Difference | | |
|---|---|---|---|---|---|---|---|---|---|
| **State Active Employees** | **CDHP** | **LDPPO** | **EPO/HMO** | **CDHP** | **LDPPO** | **EPO/HMO** | **CDHP** | **LDPPO** | **EPO/HMO** |
| Employee Only | $55 | $160 | $381 | $44 | $129 | $297 | ($12) | ($31) | ($84) |
| Employee + Spouse | $314 | $521 | $962 | $536 | $627 | $916 | $222 | $105 | ($46) |
| Employee + Child(ren) | $152 | $296 | $599 | $228 | $316 | $529 | $76 | $20 | ($70) |
| Employee + Family | $411 | $657 | $1,180 | $721 | $813 | $1,148 | $310 | $156 | ($32) |

# Subsidy Scenario 4 – Reduce Spousal and Retiree Subsidy

- AEGIS:  No Change to employee and children Base Subsidy, reduce the spousal Base Subsidy 5%
  - No change to Employee Only and Employee + Child(ren) tiers
  - Resulting subsidy rates are **93.5%** for employee, **63.5%** for spouses, and **68.5%** for children
- REGI: Reduce retiree Base Subsidy to **64%** and spouse Base Subsidy to **29%**

Estimated PY28 PEBP Med/Rx Savings = $8M

- $3M for AEGIS
- $5M for REGI

# Subsidy Scenario 4 – Reduce Spousal and Retiree Subsidy Premium

| | Plan Year 2027 Participant Premium | | | Illustrative Participant Premium | | | Difference | | |
|---|---|---|---|---|---|---|---|---|---|
| **State Active Employees** | **CDHP** | **LDPPO** | **EPO/HMO** | **CDHP** | **LDPPO** | **EPO/HMO** | **CDHP** | **LDPPO** | **EPO/HMO** |
| Employee Only | $55 | $160 | $381 | $55 | $160 | $381 | $0 | $0 | $0 |
| Employee + Spouse | $314 | $521 | $962 | $359 | $566 | $1,007 | $45 | $45 | $45 |
| Employee + Child(ren) | $152 | $296 | $599 | $152 | $296 | $599 | $0 | $0 | $0 |
| Employee + Family | $411 | $657 | $1,180 | $456 | $702 | $1,225 | $45 | $45 | $45 |

| | Plan Year 2027 Participant Premium | | | Illustrative Participant Premium | | | Difference | | |
|---|---|---|---|---|---|---|---|---|---|
| **State Retirees** | **CDHP** | **LDPPO** | **EPO/HMO** | **CDHP** | **LDPPO** | **EPO/HMO** | **CDHP** | **LDPPO** | **EPO/HMO** |
| Retiree only | $278 | $373 | $589 | $326 | $421 | $637 | $48 | $48 | $48 |
| Retiree + Spouse | $703 | $892 | $1,324 | $932 | $1,121 | $1,553 | $229 | $229 | $229 |
| Retiree + Child(ren) | $437 | $568 | $865 | $554 | $685 | $982 | $117 | $117 | $117 |
| Retiree + Family | $862 | $1,087 | $1,600 | $1,158 | $1,383 | $1,896 | $296 | $296 | $296 |

- Actual premiums paid by retirees depend on years of service, retirement date, and enrollment in Medicare B
- Maximum subsidy is $262.50 for 20+ years of service and $145.30 for Medicare Part B for a total of $407.80 per month

# Subsidy Scenario 5 – REGI Retiree Only Subsidy

- Return REGI subsidy for retirees to historical levels **64.0%** and **0%** for dependents

**Estimated PY28 PEBP Med/Rx Savings = $9M**

| | Plan Year 2027 Participant Premium | | | Illustrative Participant Premium | | | Difference | | |
|---|---|---|---|---|---|---|---|---|---|
| **State Retirees** | **CDHP** | **LDPPO** | **EPO/HMO** | **CDHP** | **LDPPO** | **EPO/HMO** | **CDHP** | **LDPPO** | **EPO/HMO** |
| Retiree only | $278 | $373 | $589 | $326 | $421 | $637 | $48 | $48 | $48 |
| Retiree + Spouse | $703 | $892 | $1,324 | $1,163 | $1,353 | $1,785 | $461 | $461 | $461 |
| Retiree + Child(ren) | $437 | $568 | $865 | $640 | $770 | $1,067 | $203 | $203 | $203 |
| Retiree + Family | $862 | $1,087 | $1,600 | $1,477 | $1,702 | $2,215 | $615 | $615 | $615 |

- Actual premiums paid by retirees depend on years of service, retirement date, and enrollment in Medicare B
- Maximum subsidy is $262.50 for 20+ years of service and $145.30 for Medicare Part B for a total of $407.80 per month

# Combined Scenario

# Combined Plan Design and Subsidy Scenario

- Eliminate EPO/HMO
- Implement specialty medical and Rx design changes on LDPPO and CDHP
- Return AEGIS subsidy for actives to historical levels **93%** for employee and **68%** for dependents
- Return REGI subsidy for retirees to historical levels **64%** for retiree and **39%** for dependents

Estimated PY28 Total Med/Rx Savings = $14M

# 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.

# 9.

9. Contract Status Report. (Shannan Canfield, Quality Control Officer) (**For Possible Action**)
   9.1 Contract Overview
   9.2 New Contracts
   9.3 Contract Amendments
   9.4 Status of Current Solicitations

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Governor

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# AGENDA ITEM

[X] Action Item
[ ] Information Only

**Date:** October 2, 2026
**Item Number:** 9
**Title:** Contract Status Report

## Status of PEBP Contracts

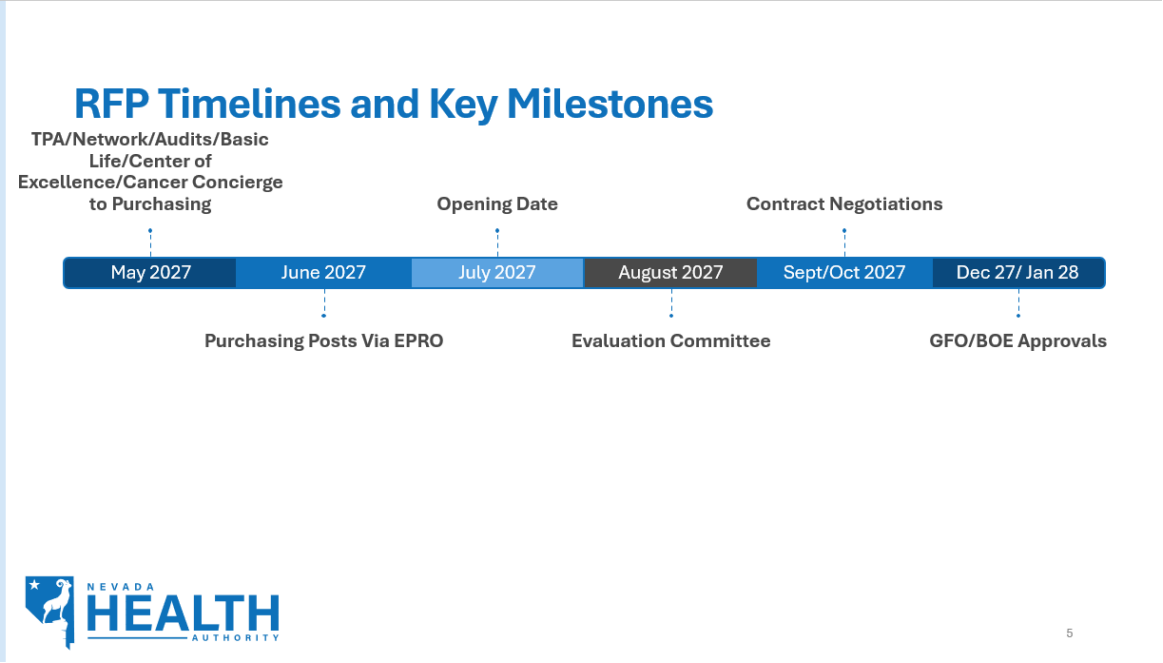
| Contracts Summary Including Above Strategies | | | |
|---|---|---|---|
| **SERVICE** | **CURRENT VENDOR** | **CURRENT EXPIRATION DATE** | **ANTICIPATED EXPIRATION DATE** |
| Actuarial/Consulting Services | Segal Company | 06/30/2027 | 06/30/2027 + assumed by NVHA |
| Benefits Management System | Lifeworks/TELUS Health | 12/31/2026 | 12/31/2026. Currently in the process of negotiating with the vendor for an additional four-year term. |
| Centers of Excellence | Carrum Health | 06/30/2028 | 06/30/2028 |
| Dental PPO | Diversified Dental Services | 06/30/2027 | 06/30/2028 + assumed by NVHA |
| Financial Auditor | Eide Bailly | 12/31/2026 | 12/31/2030 |
| Group Basic Life Insurance | United Healthcare Insurance | 06/30/2028 | 06/30/2028 |
| Health Plan Auditor | Brown & Brown/Claims Technologies | 06/30/2027 | 06/30/2028 |
| HSA/HRA Account Management | HSA Bank | 06/30/2028 | 06/30/2032 |
| Medical PPO | UMR, Inc. | 06/30/2028 | 06/30/2028 |
| Medicare Exchange | Willis Towers Watson (Via Benefits) | 06/30/2030 | 06/30/2030 |
| Oncology Concierge | Carrum Health | 06/30/2028 | 06/30/2028 |
| Pharmacy Benefit Manager | Express Scripts | 06/30/2028 | 06/30/2032 + assumed by NVHA |
| Southern Nevada HMO | Health Plan of Nevada | 06/30/2030 | 06/30/2030 |
| Third-Party Claims Administration | UMR, Inc. | 06/30/2028 | 06/30/2028 |
| Utilization/Case Management | UMR, Inc. | 06/30/2028 | 06/30/2028 |

**Recommendation:**

We recommend that PEBP fully consolidate its procurement functions within the Nevada Health Authority (NVHA). Centralizing procurement processes and decisions under NVHA will significantly reduce administrative burden, eliminate duplicative efforts across agencies, and create a more efficient and unified process for managing vendor relationships and RFP development.

By aligning with NVHA's statewide procurement structure, PEBP can leverage the State's combined purchasing power to negotiate more competitive contracts, strengthen vendor oversight, and ensure that procurement decisions support long-term cost stability for both public employees and the State. This strategic alignment will enhance consistency across contracts, enable more effective monitoring of vendor performance, and support a coordinated approach to purchasing across Nevada's health programs.

Overall, delegating procurement responsibilities to PEBP staff and NVHA administration is a practical and fiscally responsible strategy that will enhance PEBP's ability to secure high-quality services, improve operational efficiency, and safeguard the long-term sustainability of the program.



# 10.

10. PY24 Claims Technology Incorporated audit findings for State of Nevada Public Employees' Benefits Program administered by Express Scripts. (Joni Amato, CTI) (**For Possible Action**)

**Prescription Benefit Management Audit**

# ANNUAL FINDINGS REPORT

**State of Nevada Pharmacy Plan(s)**

**Administered by Express Scripts**

**Audit Period: July 1, 2023 – June 30, 2024**

**Presented to**

**State of Nevada Public Employee Benefit Program**

**Prepared by**

PillarRx Consulting

CUSTOMIZED PHARMACY SOLUTIONS

**Subcontractor to**

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

*Proprietary and Confidential*

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# EXECUTUVE SUMMARY

This ***Specific Findings Report*** contains detailed information, findings, and conclusions the PillarRx Consulting, LLC's (PillarRx) audit team has drawn from our Prescription Benefit Management Audit of Express Scripts' (ESI's) administration of State of Nevada Public Employee Benefit Program's (PEBP's) pharmacy plan.

## Scope

PillarRx performed an audit of ESI's administration of PEBP's pharmacy plan for the period of July 1, 2023, through June 30, 2024 (FY2024). The claims population and amount paid during the audit period reported by ESI:

| Pharmacy | |
|---|---|
| **Number of Prescriptions Paid** | 484,411 |
| **Net Plan Paid** | $88,195,345.55 |

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

1. Pricing and Fees Audit
2. Reconciliation of Pricing Guarantees
3. Benefit Payment Accuracy Review
4. Rebate Review
5. Performance Guarantee Review

## Auditor's Findings

PillarRx has the following opinion/recommendations based on the FY2024 audit of ESI:

- ESI should complete a re-reconciliation of Pricing and Fees at the conclusion of the audit for the confirmed errors found. PEBP should ensure this is complete and variance is reimbursed.
- PillarRx recommends PEBP follow up with ESI to obtain reimbursement for penalty payments due PEBP for FY2024.
- ESI should provide an action plan to ensure performance guarantee will be met moving forward.
- For the minimum rebate guarantees, ESI should complete a re-reconciliation at the conclusion of the audit for the confirmed errors found. PEBP should ensure this is complete and variance is reimbursed.

| | |
|---|---|
| **Pricing and Fees Reconciliation** | No additional money is owed to PEBP. |
| **SLA Performance Guarantees** | Missed targets for nine performance standards additional PillarRx calculated $529,865.31 owed to PEBP (see detail below). ESI calculated a penalty of $936,557.08. |
| **Minimum Rebate Reconciliation** | No additional money is owed to PEBP. |

| Performance Guarantees FY 2024 (Missed Targets) | | | |
|---|---|---|---|
| **Service Performance Standard** | **PillarRx Calculated Penalty** | **ESI Penalty** | **Met/Not Met** |
| **Ongoing Service – Network Access (p. 16)** | $46,925.35 | $78,311.77<br>$9,574.35 | Not Met |
| **Retail Direct Reimbursement Timeliness (p. 17)** | $20,767.61 | $34,044.83 | Not Met |
| **Mail Order Turnaround (Clean RXs) (p. 17)** | $93,850.70 | $34,044.83<br>$57,307.52<br>$38,746.13<br>$26,525.07 | Not Met |
| **Mail Order Turnaround (Protocol RXs) (p. 17)** | $93,850.70 | $34,044.83 | Not Met |

| | | | |
|---|---|---|---|
| | | $57,307.52<br>$38,746.13<br>$19,148.71 | |
| **Phone Avg Speed of Answer (p. 17)** | $46,455.32 | $38,746.13<br>$26,525.07<br>$19,148.71 | Not Met |
| **Phone Abandonment Rate (p. 17)** | $19,546.62 | $38,746.13 | Not Met |
| **First Call Resolution (p. 17)** | $93,850.70 | $34,044.83<br>$57,307.52<br>$38,746.13<br>$26,525.07<br>$19,148.71 | Not Met |
| **Prior Approvals (p. 17)** | $20,767.61 | $34,044.83 | Not Met |
| **Member Satisfaction (p. 18)** | $93,850.70 | $34,044.83<br>$57,307.52<br>$38,746.13<br>$26,525.07<br>$19,148.71 | Not Met |

## AUDIT OBJECTIVES

This ***Specific Findings Report*** contains detailed information, findings, and conclusions the PillarRx Consulting, LLC (PillarRx) audit team has drawn from its Prescription Benefit Management Audit of Express Scripts (ESI) administration of State of Nevada's (PEBP) pharmacy plan. This report is provided to PEBP and ESI, the pharmacy benefit manager (PBM). Text designated as *ESI Responses* and presented in blue reflects verbatim excerpts from the PBM's official response.

The findings in this report are based on data and information ESI and PEBP provided to PillarRx, and the report's validity relies upon the accuracy and completeness of that information.

The audit was planned and performed to obtain a reasonable assurance that prescription drug claims were adjudicated according to the terms of the contract between ESI and PEBP as well as client approved benefit descriptions (summary plan descriptions, plan documents or other communications).

PillarRx is a firm specializing in audit and control of pharmacy benefit plan administration. The statements made by PillarRx in this report relate narrowly and specifically to the overall efficacy of ESI's policies, processes, and systems relative to PEBP's paid claims during the audit period.

While performing the audit, PillarRx complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

The objectives of the PillarRx audit of ESI's pharmacy benefit management were to:

- verify claims were processed in accordance with the pricing terms specified in the contract between PEBP and ESI.
- verify claims adjudicated according to plan provisions.
- validate rebate calculations based on PEBP's actual rebate payments.
- validate ESI met contractually approved performance guarantees.

## Audit Scope

PillarRx's audit encompassed the contract(s) in force and the pharmacy benefit claims administered by ESI for the audit period of July 1, 2023 – June 30, 2024 for PEBP. The population of claims and the total net plan paid (total payment, less member copayment) during the audit period was:

| | Number of Prescriptions Paid | Net Plan Paid |
|---|---|---|
| **July 1, 2023 – June 30, 2024** | 484,411 | $88,195,345.55 |

The audit included the following components.

1. **Pricing and Fees Audit**
2. **Reconciliation of Pricing Guarantees**
3. **Benefit Payment Accuracy Review**
4. **Rebate Review**
5. **Performance Guarantees Review**

Key findings for each component can be found in the following sections of this report. All work papers and system documentation in support of any finding will be provided to PEBP upon request.

# PRICING AND FEES AUDIT

## Objective

The Pricing and Fees Audit verified claims were processed in compliance with the discounts and fees specified in ESI's contract with PEBP.

## Scope

After verification of the electronic claim data provided by ESI, PillarRx systematically repriced 100% of prescription drug claims paid during the audit period to determine whether:

- discounts were applied correctly based on the PBM contract.
- pharmacy dispensing fees were applied correctly.

## Methodology

### Contract Document Review

PillarRx requested and received from PEBP and ESI all contracts, amendments, formulary drug lists, and reconciliation documents.

### Claim Validation

PillarRx mapped and validated the raw claims data provided by ESI to our standard layout. Raw claims data represented the successive pharmacy claim transactions that included both paid and reversed claims and was critical to our understanding of ESI's processing and adjudication rules. Once mapped, the data was reconciled against control totals and put through a rigorous process referred to at PillarRx as data forensics – or the verification of claim data by assessing appropriate patterns and relationships. The resulting data forensics included comparing the mapped data to verify:

- Prior authorizations (PA)
- Rejections
- Reversals
- National Provider Identifier (NPI)
- National Drug Code (NDC)

### Pricing and Fees Analysis

The analysis of pricing and fees included 100% electronic comparison of the pharmacy guarantees for all brand, generic, and specialty drugs, or products.

For this audit of ESI, the ingredient cost allowance was determined using the AWP from the Medi-Span® Drug Database or the pharmacy's usual and customary (U&C) listed on the claim for the date each prescription was dispensed.

PillarRx also electronically verified dispensing fees for each drug type, distribution channel, and service fees (e.g., compound drug service fees) were charged in accordance with ESI's contract.

### Findings

#### *Pricing Findings*

The pricing discounts are the amounts contractually agreed upon by PEBP and ESI as the amounts to be calculated for the ingredient cost of a prescription.

As shown in the following table, the overall ingredient costs charged was an under performance by ESI which represents a plan liability to PEBP's prescription drug plan.

ESI did not apply all adjudication methods for determining the correct allowance for prescriptions drugs by type and distribution method during the audit period. The following tables demonstrate our findings relative to pricing guarantees.

| Key | Over Performance *> Greater Than Contracted Rates* | Acceptable Performance *— Same as Contracted Rates* | Under-Performance *< Less Than Contracted Rates* |
|---|---|---|---|

| Discounts (7/1/2023 6/30/2024) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Component Description*** | **Number of Claims** | **Contracted Discount Rate** | **Actual Discount Rate** | **Contracted Claim Ingredient Cost** | **Actual Claim Ingredient Cost** | **Variance Total Overage/ (Shortfall) **** | |
| Retail Brand 1-83 DS | 33,247 | 22.55% | 23.67% | $15,249,563.57 | $15,029,040.53 | $220,523.04 | > |
| Retail Brand 84+ DS | 6,182 | 27.66% | 27.78% | $8,857,343.70 | $8,842,397.75 | $14,945.95 | > |
| Retail Generic 1-83 DS | 286,531 | 85.65% | 86.33% | $4,869,515.62 | $4,637,683.71 | $231,831.91 | > |
| Retail Generic 84+ DS | 53,708 | 88.20% | 88.47% | $2,236,898.21 | $2,186,641.47 | $50,256.74 | > |
| Mail Brand | 8,998 | 21.25% | 21.27% | $12,897,662.68 | $12,894,940.44 | $2,722.24 | > |
| Mail Generic | 61,190 | 95.00% | 93.15% | $1,128,925.76 | $1,547,295.23 | ($418,369.47) | < |
| Specialty Brand | 5,259 | 21.40% | 21.03% | $42,274,218.96 | $42,472,728.70 | ($198,509.74) | < |
| Specialty Generic | 513 | 86.00% | 70.17% | $503,779.74 | $1,073,575.07 | ($569,795.33) | < |
| | | | **TOTAL** | **$88,017,908.24** | **$88,684,302.90** | **($1,186,674.54)** | **<** |

**Compounds, bulk chemicals, powders, COB claims, subrogation claims, prescriptions filled at VA hospitals, 340b pricing, client-owned pharmacies if not a participating pharmacy, out of network paper claims, 100% member cost share program claims, claims from entities eligible for federal supply schedule prices, discount card claims, no bill no remit, onsite pharmacy utilization, out of network claims, paper/member submitted claims, tribal pharmacy claims (excluded from 84-90 days' supply claims). DS equals Days' Supply.*

*** Variance Total Overage/(Shortfall) Total is based upon the under-performing components only.*

In summary, PillarRx's analysis shows an aggregate under performance of discount guarantees in the amount of $1,186,674.54. The differences found were:

- PillarRx accepted that COVID anti-viral products were to be excluded from the pricing guarantees even without contract documentation. COVID anti-viral products are a common exclusion found across all PBM's; ESI will discuss directly with the PEBP if there are any concerns.

  ***ESI Response:*** This client was enrolled in ESI's COVID Antiviral program in early 2022. A notification would have been sent to the Client informing this of the enrollment as well as noting that these products would be excluded from all pricing and rebate guarantees. ESI is unable to locate this notification that was sent to the Client. ESI's Account team is available to discuss with the Client should questions remain.

  ***ESI Draft Response:*** ESI maintains its stance that This client was enrolled in ESI's COVID Antiviral program in early 2022. A notification would have been sent to the Client informing this of the enrollment as well as noting that these products would be excluded from all pricing and rebate guarantees. ESI is unable to locate this notification that was sent to the Client. ESI's Account team is available to discuss with the Client should questions remain.

***ESI Update 4/30/2026:*** This exclusion is not explicitly listed in the contract, and this was a book of business exclusion utilized at the time by ESI due to the federal emergency order, still in place during this period. (See attached exhibit for email correspondence)

- PillarRx disagrees with 60 claims that were incorrectly classified as a Brand or Generic medication. Per 5.3. All-In Guarantees. Notwithstanding anything herein to the contrary: (i) a Prescription Drug Claim that processes as a brand at adjudication shall be reconciled as part of the brand guarantees; and (ii) a Prescription Drug Claim that processes as a generic at the time of adjudication shall be reconciled as part of the generic guarantee. Based on the language stated, the guarantee is based on how the claims were processed and not how the claim was billed to the client.

  ***ESI Response:*** ESI maintains this claim was appropriately reconciled in the generic guarantee. Section 5.3 states that 'The application of brand and generic pricing below may be subject to certain "dispensed as written" (DAW) protocols and Sponsor or Plan defined plan design and coverage policies for adjudication and Member Copayment purposes.' Per this language, multi-source brand drugs with a DAW code of 0, 3, 4, 5, 6, or 9 adjudicate at the generic billed cost to the Client therefore they are appropriately reconciled in the generic guarantees.

  ***ESI Draft Response:*** ESI maintains these claims were appropriately reconciled in the generic guarantee. Section 5.3 states that 'The application of brand and generic pricing below may be subject to certain "dispensed as written" (DAW) protocols and Sponsor or Plan defined plan design and coverage policies for adjudication and Member Copayment purposes.' Per this language, multi-source brand drugs with a DAW code of 0, 3, 4, 5, 6, or 9 adjudicate at the generic billed cost to the Client therefore they are appropriately reconciled in the generic guarantees. ESI's Account team is available to discuss with the Client should questions remain.

**Dispensing Fee Findings**

The dispensing fee was the amount contractually agreed upon by PEBP and ESI as the amount paid by the plan to the pharmacy for dispensing a prescription.

As shown in the following table, the dispensing fee analysis identified fees were overcharged by ESI for July 1, 2023 – June 30, 2024, which represents a liability to PEBP prescription drug plan. ***Note:*** *In the following chart, a negative variance indicates a higher than contracted dispensing fee collected. A positive variance indicates a lower than contracted dispensing fee collected.*

| Dispensing Fees (7/1/2023 6/30/2024) | | | | | |
|---|---|---|---|---|---|
| **Component Description*** | **Contracted Dispensing Fee** | **Number of Claims** | **Total Actual Dispensing Fee** | **Total Contracted Dispensing Fee** | **Total Overage/ (Shortfall)**** |
| Retail Brand 1-83 DS | $0.35 | 33,247 | $12,860.61 | $11,636.45 | ($1,224.16) |
| Retail Brand 84+ DS | $0.00 | 6,182 | $36.64 | $0.00 | ($36.64) |
| Retail Generic 1-83 DS | $0.35 | 286,531 | $110,633.96 | $100,285.85 | ($10,348.11) |
| Retail Generic 84+ DS | $0.00 | 53,708 | $540.89 | $0.00 | ($540.89) |
| Mail Brand | $16.93 | 8,998 | $183,615.72 | $152,336.14 | ($31,279.58) |
| Mail Generic | $16.93 | 61,190 | $1,033,957.10 | $1,035,946.70 | $1,989.60 |
| Specialty Brand | $180.00 | 5,259 | $942,691.39 | $946,620.00 | $3,928.61 |
| Specialty Generic | $180.00 | 513 | $75,823.14 | $92,340.00 | $16,516.86 |
| | | | **TOTAL** | **$2,339,165.14** | **($43,429.38)** |

**Compounds, bulk chemicals, powders, COB claims, subrogation claims, prescriptions filled at VA hospitals, 340b pricing, client-owned pharmacies if not a participating pharmacy, out of network paper claims, 100% member cost share program claims, claims from entities eligible for federal supply schedule prices, discount card claims, no bill no remit, onsite pharmacy utilization, out of network claims, paper/member submitted claims, tribal pharmacy claims (excluded from 84-90 days' supply claims). DS equals Days' Supply.*

*** Variance Total Overage/(Shortfall) Total is based upon the under-performing components only.*

In summary, PillarRx's analysis shows an aggregate over collection in dispensing fees of $43,429.38, which is in alignment with what was reported by ESI.

***ESI Draft Response:*** ESI maintains that the Dispensing Fee guarantees were reconciled accurately. Please note that no dispensing fee discrepancy samples were provided to ESI to respond to.

# RECONCILIATION OF PRICING GUARANTEES

## Objective

The Reconciliation of Pricing Guarantees determined if the discount savings and other price controls with guaranteed performance levels in PEBP's contract with ESI were met, and if not met, that accurate credit or payment was made to PEBP within the timeframe specified in the contract.

## Scope

Using the terms of PEBP's contract with ESI, we accumulated all prescription claims by type and distribution method for the period specified in the contract and balanced the total discount savings against the specified minimum discount guarantees. Similarly, all other performance guarantees were mapped against the actual prescription claims adjudicated during the prescribed contract periods for performance guarantees. This reconciliation included the following contractual guarantees:

- Average Wholesale Price (AWP) discounts applied for all drugs against third party pricing sources;
- Maximum Allowable Cost (MAC) allowance for generic;
- specialty drug allowance; and
- dispensing fees.

## Methodology

PillarRx used its proprietary AccuCAST® system to electronically compile total discount savings by drug type and distribution method (also known as silo) and compare them to the contract guarantees in the ESI contract. If ESI's performance fell short of any guarantees, we validated that ESI recognized the shortfall and credited or paid the difference to PEBP on a timely basis.

## Findings

When aggregating the discounts with the dispensing fee outcomes, ESI's self-reported calculated reconciliation paid out appropriately. See the following chart for breakout. No further action is necessary.

| | **Combined Discounts and Dispensing Fee Guarantees** | |
|---|---|---|
| | **PillarRx** | **ESI Reconciliation** |
| **July 1, 2023 – June 30, 2024** | Discounts: ($1,186,674.54)<br>Dispensing Fees: ($43,429.38)<br>Price Assured Savings: $70,522.16<br>**Combined: ($1,159,581.76)** | Discounts: ($1,248,292.61)<br>Dispensing Fees: ($51,487.07)<br>Price Assured Savings: $70,694.41<br>**Combined: ($1,230,085.27)** |

There is no additional money due to the client. Client was paid $1,230,085.27 via EFT on 10/1/2024.

***ESI Draft Response***: ESI agrees that the self-reported calculated reconciliation paid out appropriately and in accordance with the contractual requirements. ESI agrees no further action is necessary and no additional monies are due to the Client.

# BENEFIT PAYMENT ACCURACY

## Objective

The objectives of the Benefit Payment Accuracy Review were to verify correct adjudication of plan design provisions and quantify potential opportunities for recovery and/or cost savings.

## Scope

PillarRx created an exact model of the benefit plan parameters of PEBP's pharmacy plan in AccuCAST and systematically re-adjudicated 100% of paid prescription drugs. Benefit plan parameters analyzed included, but were not limited to:

- Copayments/Coinsurance
- Drug Exclusions
- Prior Authorizations (PA)
- Age/Gender Rules
- Day Supply Maximums
- Quantity Limits

Exceptions that were identified, but could not be explained by PillarRx's benefit analysts, were provided to ESI for explanation. When adequate documentation was provided to support exceptions were adjudicated correctly, AccuCAST was reset to represent the revised plan parameters and the claims were electronically re-adjudicated again to ensure consistency.

## Methodology

After receiving the plan documentation from PEBP and ESI, including copayment and coverage rules and summary plan descriptions and/or plan documents, PillarRx programmed PEBP's plan design in AccuCAST. We adjudicated each claim and identified any exceptions. We then aggregated the exceptions by category and our benefit analysts reviewed each category. Exceptions that could not be explained were submitted to ESI for review.

PillarRx then provided a sample of 181 claims in the identified exception categories to ESI for review and response. The audit results presented are based upon those responses. ESI's responses can be made available upon request.

## Findings

### Copayments/Coinsurace

Copayments represented the dollar amount required to be paid by the member when a prescription drug was purchased. Our observations and conclusions relative to copayment are shown in the following chart.

| Copayments | |
|---|---|
| **Total Claims** | **Copays Collected** |
| 484,411 | $18,878,494.49 |

PillarRx submitted 181 sample claims based on five separate observations to ESI that represented potential exceptions to the copayment requirements. ESI provided adequate explanation and documentation for each category of exception, which allowed PillarRx to conclude all copayments were applied correctly.

PillarRx agrees with ESI's responses and copays adjudicated according to plan design specifications.

***ESI Draft Response:*** ESI acknowledges that PillarRx agrees with ESI's responses and that copays were adjudicated according to plan design specifications.

**Drug Exclusions/Prior Authorizations**

Exclusions specify the drugs and products that a plan would not cover unless there was a PA on file. Based on documentation provided by ESI, PillarRx created excluded drug and PA drug listings and re-adjudicated the claims for these non-covered and prior authorized medications. The claim data and documentation provided by ESI allowed PillarRx to confirm that drug exclusions and prior authorizations were administered correctly.

***ESI Draft Response:*** ESI acknowledges that PillarRx agrees with ESI's responses and that drug exclusions and prior authorizations were administered correctly.

**Age/Gender Rules**

Age rules specify that a participant must be within a given age group and/or gender for a specific medication to be covered. PillarRx noted no issues related to age rules.

***ESI Draft Response:*** ESI acknowledges that PillarRx noted no issues related to age rules.

**Quantity Limits/Day Supply Maximums**

Quantity limits and/or day supply maximums were included in the plan to ensure safety and appropriate utilization. PillarRx noted that based on the language in the drug coverage documents provided by ESI, claims were adjudicating within the parameters.

***ESI Draft Response:*** ESI acknowledges that PillarRx noted that claims adjudicated within the quantity limits and day supply maximums according to plan design.

# REBATE REVIEW

## Objective

The Rebate Review provided confirmation ESI reimbursed PEBP the minimum amount per brand claim as outlined in the contract.

## Scope

PillarRx reviewed the rebate reports provided by ESI and assessed these based on the minimum per claim rebates listed within the contract with PEBP. The rebate review identified any differences between the rebates contractually agreed upon between PEBP and ESI, and the rebate amounts actually paid to PEBP.

## Methodology

PillarRx identified all brand claims per distribution channel and calculated the minimum rebate amount owed to PEBP based upon the contract terms. These amounts were then reconciled against rebate reports provided by the PBM and assessed to determine whether ESI appropriately reimbursed PEBP.

## Findings

PillarRx has previously found that differences can occur in the rebate amounts billed to manufacturers by a PBM and the rebate amount calculated by PillarRx for an individual health plan. The primary reason for these differences lies in the common practice by PBMs of submitting rebate-eligible claims to a manufacturer for a PBM's book of business rather than for each individual client's plan. This typically works to the advantage of all plans, as the amount of rebates paid by the manufacturer will be based on a larger pool of claims. The PBM then pays rebates to each plan separately based on the plan's claims.

| Rebate Calculations | | |
|---|---|---|
| **Component Description** | **Number of Claims** | **Total Rebate** |
| Retail Brand 1-83 DS | 19,243 | $5,483,292.85 |
| Retail Brand 84+ DS | 5,871 | $5,018,824.35 |
| Retail Specialty | 431 | $968,026.00 |
| Mail Brand | 8,744 | $7,474,808.40 |
| Mail Specialty | 4,937 | $11,088,502.00 |
| **TOTAL** | **39,226** | **$30,033,453.60** |

PillarRx's Rebate Review shows, based on the minimum rebates stipulated within the contract with PEBP, ESI met and exceeded the minimum rebates owed of $30,033,453.60. ESI paid out a total of **$31,055,486.45** in rebates to PEBP – a difference of $1,022,032.85 in PEBP's favor.

PillarRx concludes that ESI processed and paid rebates to PEBP in compliance with its contract with the exception of the following observations. It is PillarRx's view that there is no financial impact with these findings because ESI paid more than PillarRx's calculated amount due.

- Non-Preferred Formulary (NPF) claims need to be manually reviewed one at a time for verification to prove inclusion or exclusion from rebates. PillarRx accepts most as NPF except Cimzia and Entyvio which are listed on the Formulary. (The formulary report is a PDF by name and not in a usable audit requested file layout and all claims are received with the formulary flag = Y).

PillarRx recommends that ESI correct the claim extract for a more accurate formulary indicator and requests future audits have a full formulary file in excel by GPI and NDC.

***ESI Draft Response:*** ESI will work to improve its upfront files and processes to make auditor review more efficient. ESI notes all upfront documentation was provided for PillarRx to effectively conduct their analysis, however, ESI acknowledges PillarRx's recommendation related to future process improvements. Please note non formulary products are still included in the rebate guarantee. The National Preferred Formulary contains a list of products that are explicitly excluded from the formulary. Only those products that are on that NPF exclusion list are excluded from the rebate guarantee as they do not adhere to the terms of the National Preferred Formulary. The terms of the formulary being that products excluded will not be covered.

- PillarRx found two claims incorrectly classified as retail when they should have been mail order.

  ***ESI Response:*** ESI agrees the claim in question was reconciled incorrectly and ESI will re-reconcile at the conclusion of the audit.

  ***ESI Draft Response:*** ESI agrees the claims in question were incorrectly reconciled and is working on re-reconciling to correct this issue and determine any potential reimbursement. While ESI does agree to the error, ESI does not agree to the alleged financial impact noted. ESI will need to reconcile all eligible claims to confirm any potential impact. Please note Pillar Rx's alleged impact may not take into account that the claims in question may be excluded for other reasons.

  ***ESI 4/30/2026 Update:*** Confirming these are set to be reconciled and paid on the May rebate payment for PEBP.

- PillarRx found 16 Specialty claims filled at Express Scripts Pharmacy that did not have a rebate.

  ***ESI Response:*** ESI agrees the claim was reconciled incorrectly and ESI will re-reconcile at the conclusion of the audit.

  ***ESI Draft Response:*** ESI agrees the claims in question were incorrectly reconciled and is working on re-reconciling to correct this issue and determine any potential reimbursement. While ESI does agree to the error, ESI does not agree to the alleged financial impact noted. ESI will need to reconcile all eligible claims to confirm any potential impact. Please note Pillar Rx's alleged impact may not take into account that the claims in question may be excluded for other reasons.

  ***ESI 4/30/2026 Update:*** Confirming that 16 claims that the audit team advised that were reviewed will be paid on the May rebate payment for PEBP.

# PERFORMANCE GUARANTEE REVIEW

## Objective

The objective of PillarRx's Performance Guarantee Review was to verify ESI met contractual service level guarantees outlined in the client/PBM contract.

## Methodology

PillarRx reviewed all service level guarantee summaries and detail reports provided by the PBM. If service levels were not met, PillarRx provided recommendations for process improvements or detail any money that may be owed back to the client based upon contractual penalties if service levels were not met.

## Findings

| # | Service Performance Standard | Guarantee | Method of Measurement | Penalty | Met / Not-Met | Penalty Amount | Auditor Recommendations |
|---|---|---|---|---|---|---|---|
| 1 | Implementation Guarantee – Benefit Set Up | Load, test, release plan benefit coding within 6 weeks | Vendor's ability to complete all key functions accurately | $5.00 per member | N/A | – | Not reported |
| 2 | Implementation Guarantee – ID Card Mailing | Produce/distribute ID cards within 5 business days | Same as above | $5.00 per member | N/A | – | Not reported |
| 3 | Implementation Guarantee – Open Enrollment | Provide support for open enrollment meetings | Same as above | $5.00 per member | N/A | – | Not reported |
| 4 | Implementation Guarantee – Pre-Implementation Audit | Complete audit 15 days prior to effective date | Same as above | $30,000 per audit | N/A | – | Not reported |
| 5 | Ongoing Service – Overall Client Satisfaction | PEBP satisfaction; quarterly reviews | Measured annually | $300,000 | Met | – | – |
| 6 | Ongoing Service – Network Access | 97% access within defined miles | Measured annually | 1% Admin Fees | Not Met (Q1–Q4: 93%) | $46,925.35 | Expand rural network or mail-order |
| 7 | Ongoing Service – Network Stability | ≤ 5% net loss of pharmacies | Measured annually | 1% Admin Fees | Met | – | – |
| 8 | Ongoing Service – Overall Account Satisfaction | ≥ 4.0 on scale of 1–5 | Annual survey | 1% Admin Fees | Met | – | – |
| 9 | Ongoing Service – Open Issue Log | 100% monthly log | Quarterly | 2% Admin Fees | Met | – | – |
| 10 | Account Management Responsiveness | Respond within 2 business days | Quarterly | 2% Admin Fees | Met | – | – |
| 11 | Account Management Team Continuity | 100% continuity | Quarterly | 2% Admin Fees | Met | – | – |
| 12 | Annual Benefit Plan Review | By Nov 15 | Annually | 1% Admin Fees | Met | – | – |

| # | Service Performance Standard | Guarantee | Method of Measurement | Penalty | Met / Not-Met | Penalty Amount | Auditor Recommendations |
|---|---|---|---|---|---|---|---|
| 13 | Timeliness of Standard Reports | Monthly: 15 days; Quarterly: 30 days | Quarterly | 2% Admin Fees | Met | – | – |
| 14 | Timeliness of Billing Reports | 5 business days | Quarterly | 2% Admin Fees | Met | – | – |
| 15 | Timeliness of Management Reports | 45 calendar days | Quarterly | 2% Admin Fees | Met | – | – |
| 16 | Fraud, Waste, and Abuse Reporting | 30 calendar days | Quarterly | 2% Admin Fees | Met | – | – |
| 17 | Claims Compliance Format | 99% HIPAA-compliant | Quarterly | 2% Admin Fees | Met | – | – |
| 18 | Claims Processing Accuracy | 99.99% | Quarterly | 2% Admin Fees | Met | – | – |
| 19 | Eligibility Processing Accuracy | 100% | Quarterly | 2% Admin Fees | Met | – | – |
| 20 | Eligibility Updates | 2 business days | Quarterly | 2% Admin Fees | Met | – | – |
| 21 | Retail Direct Reimbursement Timeliness | 5 business days | Quarterly | 2% Admin Fees | Not Met (Q1–97%) | $20,767.61 | Review workflows; set alerts |
| 22 | Mail Order Turnaround (Clean RXs) | 2 business days | Quarterly | 2% Admin Fees | Not Met (Q1–Q4: 85–92%) | $93,850.70 | Investigate delays; automate |
| 23 | Mail Order Turnaround (Protocol RXs) | 4 business days | Quarterly | 2% Admin Fees | Not Met (Q1–Q4: 92–95%) | $93,850.70 | Investigate delays; automate |
| 24 | Mail Order Dispensing Accuracy | 99.996% | Quarterly | 2% Admin Fees | Met | – | – |
| 25 | Phone Avg Speed of Answer | ≤ 25 sec | Quarterly | 2% Admin Fees | Not Met (Q3–79.9; Q4–39.8) | $46,455.32 | Train reps; adjust staffing |
| 26 | Phone Abandonment Rate | ≤ 2% | Quarterly | 2% Admin Fees | Not Met (Q3–3.6%) | $19,546.62 | Train reps; adjust staffing |
| 27 | First Call Resolution | 98% | Quarterly | 2% Admin Fees | Not Met (Q1–Q4: 96–97%) | $93,850.70 | Train reps; monitor metrics |
| 28 | Prior Approvals | 2 business days | Quarterly | 2% Admin Fees | Not Met (Q1–94%) | $20,767.61 | Review workflows; set alerts |
| 29 | Plan Admin Turnaround | 10 calendar days | Quarterly | 2% Admin Fees | Met | – | – |
| 30 | Member Satisfaction | 95% | Quarterly | 2% Admin Fees | Not Met (Q1–Q4: 87–93%) | $93,850.70 | Analyze feedback; improve service |
| 31 | ID Card Mailing | 99% | Quarterly | 2% Admin Fees | N/A | – | – |

| # | Service Performance Standard | Guarantee | Method of Measurement | Penalty | Met / Not-Met | Penalty Amount | Auditor Recommendations |
|---|---|---|---|---|---|---|---|
| 32 | Written Inquiry Response | 100%–5 days; 98%–7 days | Quarterly | 2% Admin Fees | Met | – | – |
| 33 | Performance Guarantee Reporting | 45 calendar days | Quarterly | 2% Admin Fees | Met | – | – |
| | | | | | | **Total Penalty** | **$529,865.31** |

PillarRx reviewed the performance guarantee documents provided by ESI. Overall, ESI did not meet expectations for the contracted standards. For the performance guarantee standards that were not met, PillarRx would recommend ESI provide details for all actions to be implemented to ensure the performance guarantee will be met moving forward.

***ESI Draft Response:*** ESI agrees that for any performance guarantees missed a penalty is applicable. The State of Nevada Public Employee Benefit Program's (PEBP's) pharmacy plan will provide ESI with a payment request upon completion of the audit which has not yet been received. ESI notes the penalty is based on the admin fees for the year.

The penalties shown in the table above, *Performance Guarantees FY 2023 (Missed Targets*), have been calculated based on the total admin fees reported by ESI for FY 2023. Please see table below for breakout:

| Total Admin Fees FY2023 | | |
|---|---|---|
| **Quarter** | **Amount** | **Calculated 2%** |
| **1** | $1,065,334.43 | $21,306.69 |
| **2** | $1,952,855.04 | $39,057.10 |
| **3** | $1,474,306.11 | $29,486.12 |
| **4** | $1,946,098.91 | $38,921.98 |
| **Total FY 2023** | $6,438,594.59 | $128,771.89 |

***ESI 4/30/2026 Update:*** There were two payments we made for this period -one payment was made in September 2024 and the other was made in October 2024. Reporting for missed performance guarantees attached. Total amount paid payment 1 $876,912.96 and payment 2 $105,317.90. We are reporting more paid than Pillar on missed PGs.

- Network/Pharmacy Access – Pillar reporting and ESI reporting $78,311.77 (7.23-6.24) + $9574.35 (7.23-6.24)
- Retail Direct Reimbursement Timeliness/Direct Claim Turnaround – Pillar reporting $20,767.61 and ESI reporting $34,044.83 (7.23-9.23)
- Mail Order Turnaround – Pillar reporting $93,850.70 and ESI reporting - $34,044.83 (7.23-9.23) + $57,307.52 (10.23-12.23) + $38,746.13 (1.24-3.24) + $26,525.07 (4.24-6.24) + 19,148.71 (4.24-6.24)
- Mail Order Turnaround (Protocols) – Pillar reporting $93,850.70 and ESI reporting - $19,148.71 (4.24-6.24) + 34,044.83 (7.23-9.23) + 57,307.52 (10.23-12.23) +$38,746.13 (1.24-3.24) +$26,525.07 (4.24-6.24)
- Phone Ave Speed – Pillar reporting $46,455.32 and ESI Reporting $38,746.13 (1.24-3.24) + $26,525.07 (4.24-6.24) +$19,148.71 (4.24-6.24)

- Phone Abandonment Rate – Pillar reporting $19,546.62 and ESI Reporting $38,746.13 (1.24-3.24)
- First Call Resolution – Pillar reporting $93,850.70 and ESI Reporting $34,044.83 (7.23-9.23) + $57,307.52 (10.23-12.23) + 38,746.13 (1.24-3.24) + $26,525.17 (4.24-6.24) + $19,148.71 (4.24-6.24)
- Prior Authorization – Pillar reporting $20,767.61 and ESI Reporting $34,044.83 (7.23-9.23)
- Member Satisfaction – Pillar reporting $93,850.70 and ESI Reporting $34,044.83 (7.23-9.23) + $57,307.52 (10.23-12.23) +$38,746.13 (1.24-3.24) + $26,525.07 (4.24-6.24) + $19,148.71 (4.24-6.24)

## CONCLUSION

We consider it a privilege to have worked for, and with, your staff and PBM.  Thank you again for choosing PillarRx.

## EXHIBITS

Accompanying this report are the exhibits listed below. These exhibits provide data and/or detailed information upon which the findings and recommendations discussed in this report are based.

**Caution: These exhibits may contain Protected Health Information (PHI) and may be subject to protection under Federal law, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).**

1. COVID email May 20, 2022
2. 47787_30_PerformanceGtee_Jul23toJun24
3. 47787_25_PerformancePenalty_Jul23toJun24
4. 47787_25_PerformancePenalty_Jul23toJun24_1

*This document has been prepared in good faith based on information provided to PillarRx Consulting, without any independent verification. If the data, information, and observations received are inaccurate or incomplete, our review, analysis, and conclusions may likewise be inaccurate or incomplete. Our conclusions and recommendations are developed after careful analysis and reflect our best professional judgment.*

*This document is the proprietary work product of PillarRx Consulting and is provided for your internal use only. No further use or distribution to any third party is authorized without PillarRx Consulting's prior written consent.*

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

**Julie Weissmann**

**From:** Langeland, Nancy (VIR) <nancy_langeland@express-scripts.com>
**Sent:** Friday, May 20, 2022 8:23 AM
**To:** Laura Rich
**Cc:** Williams, Amy R; Zeyaee, Harris A
**Subject:** Update requested: Provide a $0 patient copay with the COVID-19 Oral Antiviral Therapeutics Program - Carrier 7787


Good morning Laura -

To meet the federal government's expectations of providing COVID-19 therapeutics to patients at no cost, we are updating the COVID-19 Oral Antiviral Therapeutics Program to cover FDA-approved oral antiviral medications at a $0 patient copay.

## Take action to meet federal expectations

**We are strongly recommending that enrolled clients align their copay setup to provide patients with a $0 copay.** This change is not required; however, we urge clients to opt in to this update to ensure their population can obtain these therapies at no cost.

The federal government is now aware that some patients are paying out-of-pocket copays for these therapies, and they are beginning to reach out to organizations directly to emphasize the importance of providing these therapies at no cost.

## Delivering on your plan and population's needs: coverage for COVID-19 therapies

This program is designed to deliver optimal support to your plan and your population as you continue to navigate the ongoing pandemic and its costs. This has been achieved by:

- providing access to COVID-19 oral antiviral medications, which currently include Pfizer's pill, Paxlovid™, and Merck's monlupiravir, which have been added to the formulary.
- providing access to the broadest retail pharmacy network offered by Express Scripts® PBM.
- delivering a $0 ingredient cost while funded by the Federal government.
- passing through the dispensing fee from the pharmacy.

## Opt in by June 10, 2022

**If you plan to align your offering with this update, please fill out the brief form here by June 10, 2022.**

The change will go into effect as soon as operationally possible following your submission. By opting your plan into this update, the dispensing fee will shift from the patient to your plan. If you would like to make this change after June 10, you can do so by contacting me directly.

Thank you,

Nancy Langeland
Senior Account Executive | Express Scripts
☎Direct: 201.452.0416
nancy_langeland@express-scripts.com

**NEVADA PEBP**
**Carrier 7787**

# Performance Guarantee Report

**Client Name: 47787 - NEVADA PUBLIC EMPLOY PEBP**

**Reporting Period: Jul23 to Jun24**

| Performance Guarantee | Guarantee Language | Q1 | Q2 | Q3 | Q4 | YTD |
|---|---|---|---|---|---|---|
| Dispensing Timeliness | 100% dispensed within 2 business days (not an average). This guarantee is measured in business days from the date the prescription drug claim is received by the vendor (either via paper, phone, fax or Internet) to the date it is shipped. Measured and Reported Quarterly | 92% | 92% | 91% | 85% | 90% |
| Dispensing Timeliness | 100% dispensed within 4 business days (not an average). This guarantee is measured in business days from the date the prescription drug claim is received by the vendor (either via paper, phone, fax or Internet) to the date it is shipped. Measured and Reported Quarterly | 95% | 95% | 93% | 92% | 94% |
| Direct Claim Turnaround | At least 100% of Retail direct reimbursement claims processed for payment or rejected and responded to within five (5) business days (not an average). Measured and Reported Quarterly | 97% | 100% | 100% | 100% | 99% |
| Eligibility | Vendor will process any processable maintenance eligibility transactions received in a mutually agreed upon format within two (2) business days of receipt (if received before 12:00 p.m. E.T. on any business day). Measured and Reported Quarterly | Met | Met | Met | Met | Met |
| ID Card Turnaround - Maintenance | You will issue at least 99% of all new member ID cards within four business days and 100% within seven business days following your receipt and update of a processable eligibility tape or transmission identifying the applicable Eligible Participant(s). Measured and Reported Quarterly | | | | | |
| Claims Adjudication Accuracy Rate | Based on vendor s internal quality review for Retail, Mail Order, and Spacialty claims. Calculated as all claims audited and found to be without adjudication error of any kind (i.e. any claim processing inaccuracy that results in an incorrect charge to the client or its plan Members), divided by all claims audited. Measured and Reported Quarterly 99.99% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| Pharmacy Access Rate - rural | At least 97% of participants shall reside within 1.5 miles of a network pharmacy for Urban areas, within 3 miles for Suburban areas and within 10 miles for Rural areas. Measured and Reported Annually | 93% | 93% | 93% | 93% | 93% |
| Pharmacy Access Rate - suburban | At least 97% of participants shall reside within 1.5 miles of a network pharmacy for Urban areas, within 3 miles for Suburban areas and within 10 miles for Rural areas. Measured and Reported Annually | 100% | 100% | 100% | 100% | 100% |
| Pharmacy Access Rate - urban | At least 97% of participants shall reside within 1.5 miles of a network pharmacy for Urban areas, within 3 miles for Suburban areas and within 10 miles for Rural areas. Measured and Reported Annually | 100% | 100% | 100% | 100% | 100% |




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# Performance Guarantee Report

**Client Name: 47787 - NEVADA PUBLIC EMPLOY PEBP**

**Reporting Period: Jul23 to Jun24**

| Performance Guarantee | Guarantee Language | Q1 | Q2 | Q3 | Q4 | YTD |
|---|---|---|---|---|---|---|
| Speed of Answer - Member | 100% of calls will be answered by a live voice within an average of 25 seconds or less. The amount of time that elapses between the time a call is received into a member service queue to the time the phone is answered by a Customer Service Representative (CSR). Measurement excludes calls routed to IVR. Measured and Reported Quarterly | 4.1 | 4.3 | 79.9 | 39.8 | 31.7 |
| Speed of Answer - Member | Inbound calls to the PBM's toll-free customer service lines shall be answered within an average time of thirty (30) seconds or less. Measurement excludes calls routed to an IVR. Measured and Reported Quarterly | 4.1 | 4.3 | 79.9 | 39.8 | 31.7 |
| Speed of Answer - Member | 100% of calls will be answered by a live voice within an average of 25 seconds or less. The amount of time that elapses between the time a call is received into a member service queue to the time the phone is answered by a Customer Service Representative (CSR). Measurement excludes calls routed to IVR. Measured and Reported Quarterly | 4.1 | 4.3 | 79.9 | 39.8 | 31.7 |
| Speed of Answer - Member | Inbound calls to the PBM's toll-free customer service lines shall be answered within an average time of thirty (30) seconds or less. Measurement excludes calls routed to an IVR. Measured and Reported Quarterly | 4.1 | 4.3 | 79.9 | 39.8 | 31.7 |
| Abandonment Rate (%) - Member | 2% or less of calls will be abandoned (i.e. caller hangs up) before call is answered by CSR. Calculated as the number of calls that are not answered divided by the number of calls received. Measurement excludes calls routed to IVR and includes calls abandoned within the first 20 seconds. Measured and Reported Quarterly | 0.2% | 0.2% | 3.6% | 1.5% | 1.4% |
| Acct Mgmt Action Log | The account team will maintain an open issues log and share it with Client on at least a monthly basis. The account team will be available to meet with Client on a weekly basis to discuss the status report. Measured and Reported Quarterly | Met | Met | Met | Met | Met |
| Acct Mgmt Inquiry Turnaround | Account team will respond to Client requests within 2 Business Days and when applicable provide any requested modeling turnaround time within the 2 Business Days. Any issues requiring service warranty escalation and review will be submitted for analysis in the service warranty process within 5 Business Days. Measured and Reported Quarterly | Met | Met | Met | Met | Met |
| Acct Mgmt Staff Changes | The account team (including the strategic account executive, account manager, and clinical account manager) will not change over the duration of the contract term except for promotion or termination of employment, unless mutually agreed to by Client and you. Measured and Reported Quarterly | Met | Met | Met | Met | Met |
| AM Standard Rpt Delivery | Standard quarterly management reports shall be available within 45 calendar days after the end of each contract quarter. Measured and Reported Quarterly | Met | Met | Met | Met | Met |




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# Performance Guarantee Report

**Client Name: 47787 - NEVADA PUBLIC EMPLOY PEBP**

**Reporting Period: Jul23 to Jun24**

| Performance Guarantee | Guarantee Language | Q1 | Q2 | Q3 | Q4 | YTD |
|---|---|---|---|---|---|---|
| **Annual Benefit Review** | Vendor will maintain a documented quality control and pre- implementation document and provide it to Client for review and approval at least 15 days prior to implementation of any benefit or program change. Vendor will conduct an annual benefit plan review by November 15 to coincide with Client s plan implementation of benefit plan modifications. If such reviews identify any systems set in error by Vendor, then Vendor will reconcile such errors on a dollar for dollar basis, and shall pay the Client s penalty amount at risk. Measured and Reported Annually | | | | | **Met** |
| **Reporting Timeliness - Trend Central Reporting Suite** | Vendor will make available online their Standard Financial Performance Package Report within fifteen (15) business days of the end of the billing cycled that includes the last calendar day of the reporting month, for monthly reports, and thirty (30) business days of the end of the billing cycle that includes the last calendar day of the reporting quarter for quarterly reports. Measured and Reported Quarterly | **Met** | **Met** | **Met** | **Met** | **Met** |
| **Reporting Timeliness - Performance Guarantee Report** | Vendor guarantees it will provide reporting to the Client demonstrating compliance to these performance guarantees within 45 calendar days of the end of the measurement period and any penalties due will be credited within 75 calendar days of the end of the measurement period. Measured and Reported Quarterly | **Met** | **Met** | **Met** | **Met** | **Met** |
| **Payment Timeliness - Annual Performance Guarantee Penalty** | Vendor guarantees it will provide reporting to the Client demonstrating compliance to these performance guarantees within 45 calendar days of the end of the measurement period and any penalties due will be credited within 75 calendar days of the end of the measurement period. Measured and Reported Quarterly | | | | | |
| **Reporting Timeliness - Billing** | Vendor will mail Billing Reports, providing Client with detailed claim activity, within five (5) business days of the end of each claim cycle report period. Measured and Reported Quarterly | **Met** | **Met** | **Met** | **Met** | **Met** |
| **Reporting Timeliness - Fraud Waste & Abuse Reports** | Vendor will provide quarterly reports to Client addressing potential fraud, waste, and abuse within 30 days of the end of the quarter and your staff will conduct quarterly meetings to review these reports. Quarterly reports will be at a mutually acceptable time. Measured and Reported Quarterly | **Met** | **Met** | **Met** | **Met** | **Met** |
| **Member Satisfaction** | Ongoing Service - Member Satisfaction With Retail, Mail Order & Specialty Program. At least 95% satisfaction. Measured as the number of satisfied to highly satisfied survey ratings divided by the total number of survey responses. Survey tool and survey methodology will be mutually agreed upon by vendor and Client. Measured and Reported Quarterly | **87%** | **90%** | **93%** | **93%** | **90%** |




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# Performance Guarantee Report

**Client Name: 47787 - NEVADA PUBLIC EMPLOY PEBP**

**Reporting Period: Jul23 to Jun24**

| Performance Guarantee | Guarantee Language | Q1 | Q2 | Q3 | Q4 | YTD |
|---|---|---|---|---|---|---|
| **Account Management Satisfaction** | Designated Members of Client's staff will complete an annual report card to evaluate vendor account team, or the overall service performance. Guarantee will be measured using a mutually agreed upon survey and tool. Scorings can be pass/fail or based on a rating such as: 5 = Outstanding 4 = Commendable 3 = Satisfactory 2 = Needs improvement 1 = Unacceptable The account team is typically scored on: Technical knowledge Accessibility and Responsiveness Interpersonal Skills Communication Skills Overall Performance Vendor s overall service may be scored on such dimensions as: - Proactiveness in communication of issues and recommendations - Timeliness and accuracy of reports - Responsiveness to day to day needs - Adequacy of staffing and training - Ability to meet performance standards PBM shall be responsible for survey design, data collection, analysis and all costs associated with conducting the surveys. Measured and Reported Annually | | | | | **Met** |
| **ESI Satisfaction Rate** | If, at any time, Express Scripts? performance is not satisfactory in PEBP's judgment, PEBP agrees to notify Express Scripts and the parties shall work together in good faith to resolve any such issues. PEBP will make best effort to provide appropriate and timely notification to Express Scripts of such issues. In addition, ESI will initiate quarterly customer service reviews, with PEBP staff and call center staff, where we will analyze member questions and trends and determine how we can, in partnership continue to push to improve member and client satisfaction. Measured and Reported Annually | | | | | **Met** |
| **Dispensing Accuracy Rate** | Dispensing Accuracy Rate means (i) the number of all Mail Order prescriptions dispensed in a contract quarter less the number of those prescriptions dispensed in such contract quarter which are reported and verified as having been dispensed with the incorrect drug, strength, dosage form, patient name, directions, packing non-conformance, or address causing medication to be delivered incorrectly divided by (ii) the number of all Mail Order prescriptions dispensed in such contract quarter. Measured and Reported Quarterly 99.996% | **100.000%** | **100.000%** | **100.000%** | **100.000%** | **100.000%** |
| **Written Inquiry Turnaround** | 98% within five business days (not an average) and 100% within seven business days (not an average). Response time for all written inquiries will be based on the number of calendar days subtracting the date received by vendor from the date the response was sent. Measured and Reported Quarterly | **100%** | **100%** | **100%** | **100%** | **100%** |
| **Written Inquiry Turnaround** | 98% within five business days (not an average) and 100% within seven business days (not an average). Response time for all written inquiries will be based on the number of calendar days subtracting the date received by vendor from the date the response was sent. Measured and Reported Quarterly | **100%** | **100%** | **100%** | **100%** | **100%** |
| **First Call Resolution Rate** | At least 98% of all calls will be resolved at first point of contact. Calculated as the total calls to vendor minus total number of unresolved calls divided by the total number of calls received. Measurement excludes calls routed to IVR. Measured and Reported Quarterly | **97%** | **97%** | **96%** | **96%** | **96%** |




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# Performance Guarantee Report

**Client Name: 47787 - NEVADA PUBLIC EMPLOY PEBP**

**Reporting Period: Jul23 to Jun24**

| Performance Guarantee | Guarantee Language | Q1 | Q2 | Q3 | Q4 | YTD |
|---|---|---|---|---|---|---|
| **Accuracy of Eligiblity Files** | Vendor guarantees that 100% of usable, error-free eligibility files received by your organization will be loaded without error. This will be measured as the number of eligibility files audited and found to be processed and loaded without error divided by the total number of eligibility files received. Measured and Reported Quarterly | **Met** | **Met** | **Met** | **Met** | **Met** |
| **HIPAA Claim Compliance** | Vendor will guarantee that 99% of the prescription drug claims submitted on behalf of eligible participant will be submitted in a HIPAA-compliant format. Measured and Reported Quarterly | **Met** | **Met** | **Met** | **Met** | **Met** |
| **Network Pharmacy Decline Rate** | You guarantee that there will not be greater than 5% total net loss of pharmacies in your broadest network for the duration of the contract provided that pharmacies remain in business, are not involved in fraudulent activities, or perform any actions that warrant removal from the network. Total net loss will be calculated as the total network pharmacies at the beginning of the contract term plus all new network pharmacies added during the life of the contract, less any network pharmacies terminated during the life of the contract (except for the termination conditions noted) divided by the total network pharmacies at the start of the contract term. This guarantee does not apply to Client requested pharmacy network changes for removal of pharmacies from the network. Measured and Reported Annually | **Met** | **Met** | **Met** | **Met** | **Met** |
| **Prior Authorization Turnaround (Business)** | You will promptly review and respond to requests for prior approval for specific drugs following receipt of all required information, but in any case will respond in no more than 2 business days (no average) once all clinical information is received. Measured and Reported Quarterly | **94%** | **100%** | **100%** | **100%** | **98%** |
| **Benefit Design Change Turnaround** | Vendor guarantees that Client s standard Plan design changes will be implemented within 10 calendar days. Complex Plan design changes, will be implemented by a mutually agreed upon date. Measured and Reported Quarterly | **Met** | **Met** | **Met** | **Met** | **Met** |
| **Benefit Design Change Turnaround** | Vendor guarantees that Client s standard Plan design changes will be implemented within 10 calendar days. Complex Plan design changes, will be implemented by a mutually agreed upon date. Measured and Reported Quarterly | **Met** | **Met** | **Met** | **Met** | **Met** |




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## Penalty Summary Report

**Contract Year: Jul 2023 - Jun 2024**

**Client Name : 47787 - NEVADA PUBLIC EMPLOY PEBP**

**Contract Language**

| |
|---|
| Nonprotocol Dispensing Timeliness |
| 100% dispensed within 2 business days (not an average). This guarantee is measured in business days from the date the prescription drug claim is received by the vendor (either via paper, phone, fax or Internet) to the date it is shipped. Measured and Reported Quarterly |
| Protocol Dispensing Timeliness |
| 100% dispensed within 4 business days (not an average). This guarantee is measured in business days from the date the prescription drug claim is received by the vendor (either via paper, phone, fax or Internet) to the date it is shipped. Measured and Reported Quarterly |
| Direct Claim Turnaround |
| At least 100% of Retail direct reimbursement claims processed for payment or rejected and responded to within five (5) business days (not an average). Measured and Reported Quarterly |
| Pharmacy Access |
| At least 97% of participants shall reside within 1.5 miles of a network pharmacy for Urban areas, within 3 miles for Suburban areas and within 10 miles for Rural areas. Measured and Reported Annually |
| Speed of Answer |
| 100% of calls will be answered by a live voice within an average of 25 seconds or less. The amount of time that elapses between the time a call is received into a member service queue to the time the phone is answered by a Customer Service Representative (CSR). Measurement excludes calls routed to IVR. Measured and Reported Quarterly |
| Abandonment Rate |
| 2% or less of calls will be abandoned (i.e. caller hangs up) before call is answered by CSR. Calculated as the number of calls that are not answered divided by the number of calls received. Measurement excludes calls routed to IVR and includes calls abandoned within the first 20 seconds. Measured and Reported Quarterly |
| Member Satisfaction |
| Ongoing Service - Member Satisfaction With Retail, Mail Order & Specialty Program. At least 95% satisfaction. Measured as the number of satisfied to highly satisfied survey ratings divided by the total number of survey responses. Survey tool and survey methodology will be mutually agreed upon by vendor and Client. Measured and Reported Quarterly |
| First Call Resolution Rate |
| At least 98% of all calls will be resolved at first point of contact. Calculated as the total calls to vendor minus total number of unresolved calls divided by the total number of calls received. Measurement excludes calls routed to IVR. Measured and Reported Quarterly |
| Prior Auth Turnaround |
| You will promptly review and respond to requests for prior approval for specific drugs following receipt of all required information, but in any case will respond in no more than 2 business days (no average) once all clinical information is received. Measured and Reported Quarterly |

| Guarantee | Target | Period | Actual | Penalty Type | Penalty | Total Penalty |
|---|---|---|---|---|---|---|
| Nonprotocol Dispensing Timeliness | 100% | 07/23-09/23 | 92% | 2% of Quarterly Admin Fees | $34,044.83 | $34,044.83 |
| Nonprotocol Dispensing Timeliness | 100% | 10/23-12/23 | 92% | 2% of Quarterly Admin Fees | $57,307.52 | $57,307.52 |
| Nonprotocol Dispensing Timeliness | 100% | 01/24-03/24 | 91% | 2% of Quarterly Admin Fees | $38,746.13 | $38,746.13 |
| Nonprotocol Dispensing Timeliness | 100% | 04/24-06/24 | 85% | 2% of Quarterly Admin Fees | $26,525.07 | $26,525.07 |
| Protocol Dispensing Timeliness | 100% | 07/23-09/23 | 95% | 2% of Quarterly Admin Fees | $34,044.83 | $34,044.83 |
| Protocol Dispensing Timeliness | 100% | 10/23-12/23 | 95% | 2% of Quarterly Admin Fees | $57,307.52 | $57,307.52 |
| Protocol Dispensing Timeliness | 100% | 01/24-03/24 | 93% | 2% of Quarterly Admin Fees | $38,746.13 | $38,746.13 |
| Protocol Dispensing Timeliness | 100% | 04/24-06/24 | 92% | 2% of Quarterly Admin Fees | $26,525.07 | $26,525.07 |
| Direct Claim Turnaround | 100% | 07/23-09/23 | 97% | 2% of Quarterly Admin Fees | $34,044.83 | $34,044.83 |
| Pharmacy Access | 97% | 07/23-06/24 | 93% | 1% of Annual Admin Fees | $78,311.77 | $78,311.77 |
| Speed of Answer | 25 seconds | 01/24-03/24 | 79.9 | 2% of Quarterly Admin Fees | $38,746.13 | $38,746.13 |
| Speed of Answer | 25 seconds | 04/24-06/24 | 39.8 | 2% of Quarterly Admin Fees | $26,525.07 | $26,525.07 |
| Abandonment Rate | 2.0% | 01/24-03/24 | 3.6% | 2% of Quarterly Admin Fees | $38,746.13 | $38,746.13 |
| Member Satisfaction | 95% | 07/23-09/23 | 87% | 2% of Quarterly Admin Fees | $34,044.83 | $34,044.83 |
| Member Satisfaction | 95% | 10/23-12/23 | 90% | 2% of Quarterly Admin Fees | $57,307.52 | $57,307.52 |
| Member Satisfaction | 95% | 01/24-03/24 | 93% | 2% of Quarterly Admin Fees | $38,746.13 | $38,746.13 |
| Member Satisfaction | 95% | 04/24-06/24 | 93% | 2% of Quarterly Admin Fees | $26,525.07 | $26,525.07 |
| First Call Resolution Rate | 98% | 07/23-09/23 | 97% | 2% of Quarterly Admin Fees | $34,044.83 | $34,044.83 |
| First Call Resolution Rate | 98% | 10/23-12/23 | 97% | 2% of Quarterly Admin Fees | $57,307.52 | $57,307.52 |
| First Call Resolution Rate | 98% | 01/24-03/24 | 96% | 2% of Quarterly Admin Fees | $38,746.13 | $38,746.13 |
| First Call Resolution Rate | 98% | 04/24-06/24 | 96% | 2% of Quarterly Admin Fees | $26,525.07 | $26,525.07 |
| Prior Auth Turnaround | 100% | 07/23-09/23 | 94% | 2% of Quarterly Admin Fees | $34,044.83 | $34,044.83 |
| | | | | **Total Due to Client** | | **$876,912.96** |

| | |
|---|---|
| **Total Q1 Admin Fees** | **$1,702,241.49** |
| **Total Q2 Admin Fees** | **$2,865,375.93** |
| **Total Q3 Admin Fees** | **$1,937,306.44** |
| **Total Q4 Admin Fees** | **$1,326,253.34** |
| **Total Admin Fees** | **$7,831,177.20** |





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**Contract Language**

| |
|---|
| Nonprotocol Dispensing Timeliness |
| 100% dispensed within 2 business days (not an average). This guarantee is measured in business days from the date the prescription drug claim is received by the vendor (either via paper, phone, fax or Internet) to the date it is shipped. Measured and Reported Quarterly |
| Protocol Dispensing Timeliness |
| 100% dispensed within 4 business days (not an average). This guarantee is measured in business days from the date the prescription drug claim is received by the vendor (either via paper, phone, fax or Internet) to the date it is shipped. Measured and Reported Quarterly |
| Pharmacy Access |
| At least 97% of participants shall reside within 1.5 miles of a network pharmacy for Urban areas, within 3 miles for Suburban areas and within 10 miles for Rural areas. Measured and Reported Annually |
| Speed of Answer |
| 100% of calls will be answered by a live voice within an average of 25 seconds or less. The amount of time that elapses between the time a call is received into a member service queue to the time the phone is answered by a Customer Service Representative (CSR). Measurement excludes calls routed to IVR. Measured and Reported Quarterly |
| Member Satisfaction |
| Ongoing Service - Member Satisfaction With Retail, Mail Order & Specialty Program. At least 95% satisfaction. Measured as the number of satisfied to highly satisfied survey ratings divided by the total number of survey responses. Survey tool and survey methodology will be mutually agreed upon by vendor and Client. Measured and Reported Quarterly |
| First Call Resolution Rate |
| At least 98% of all calls will be resolved at first point of contact. Calculated as the total calls to vendor minus total number of unresolved calls divided by the total number of calls received. Measurement excludes calls routed to IVR. Measured and Reported Quarterly |

| Guarantee | Target | Period | Actual | Penalty Type | Penalty | Total Penalty |
|---|---|---|---|---|---|---|
| Nonprotocol Dispensing Timeliness | 100% | 04/24-06/24 | 85% | 2% of Quarterly Admin Fees | $19,148.71 | $19,148.71 |
| Protocol Dispensing Timeliness | 100% | 04/24-06/24 | 92% | 2% of Quarterly Admin Fees | $19,148.71 | $19,148.71 |
| Pharmacy Access | 97% | 07/23-06/24 | 93% | 1% of Annual Admin Fees | $9,574.35 | $9,574.35 |
| Speed of Answer | 25 seconds | 04/24-06/24 | 39.8 | 2% of Quarterly Admin Fees | $19,148.71 | $19,148.71 |
| Member Satisfaction | 95% | 04/24-06/24 | 93% | 2% of Quarterly Admin Fees | $19,148.71 | $19,148.71 |
| First Call Resolution Rate | 98% | 04/24-06/24 | 96% | 2% of Quarterly Admin Fees | $19,148.71 | $19,148.71 |

| | |
|---|---|
| **Revised Q4 Admin Fees** | **$957,435.34** |
| **Revised FY Admin Fees** | **$957,435.34** |





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# 11.

11. Public Comment.

# 12.

12. Adjournment.