JOE LOMBARDO
Governor

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

CELESTENA GLOVER
Executive Officer

JOY GRIMMER
Board Chair

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program
Date and Time of Meeting:	November 21, 2024 9:00 a.m.
Video Conferencing:	This meeting will be available by means of a remote technology system pursuant to NRS 241.023 using video- and tele-conference. Instructions for both options are below. This meeting can be viewed live over the Internet on the PEBP YouTube channel at https://youtube.com/live/6g7JA3iZoCM

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

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

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

Option #1 **Join the webinar as an attendee** https://us06web.zoom.us/j/87948344752

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: 879 4834 4752 then press #. When prompted for a Participant ID, please enter #.**

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

To resolve any issues related to dialing in to provide public comment for this meeting, please call (775) 684-7016 or email jcrane@peb.nv.gov

Meeting materials can be accessed here: https://pebp.nv.gov/Meetings/current-board-meetings/

AGENDA

1. Open Meeting; Roll Call.

2. Public Comment.
   Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda as an item on which action may be taken. Public comments to the Board will be taken under advisement but will not be answered during the meeting. Comments may be limited to three minutes per person at the discretion of the chairperson. Additional three-minute comment periods may be allowed on individual agenda items at the discretion of the chairperson. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the Board. The total time allotted to public comment may be limited to one hour at the discretion of the chairperson. As noted above, members of the public may make public comment by using the call-in number provided above. Persons unable to attend the meeting in person or by telephone and persons whose comments may extend past the three-minute time limit may submit their public comment in writing by uploading your document to the *Public Comment Upload Form* located under *Contact Us* on the PEBP website, *https://pebp.nv.gov*, no later than two business days prior to the meeting. If you need ADA accommodation, please let us know in advance. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

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

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

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

   4.1 Approval of Action Minutes from the September 26, 2024 PEBP Board Meeting.

   4.2 Receipt of quarterly staff reports for the period ending June 30 and September 30, 2024:

   4.2.1 Q4 Utilization Report

   4.2.2 Q1 Budget Report

   4.2.3 Contract Status Report

   4.3 Receipt of quarterly vendor reports for the period ending June 30, 2024:

   4.3.1 Q4 Express Scripts – Summary Report

   4.3.2 Q4 Express Scripts – Utilization Report

   4.3.3 2nd MD – Annual Review Report

5. Executive Officer Report. (Celestena Glover, Executive Officer) (Information/Discussion)
6. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR for the period of April 1, 2024 – June 30, 2024. (Joni Amato, Claim Technologies Incorporated) (**For Possible Action**)
7. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by VIA Benefits for the period of July 1, 2023 – June 30, 2024. (Joni Amato, Claim Technologies Incorporated) (**For Possible Action**)
8. Health Savings Bank Investment Discussion. (Celestena Glover, Executive Officer) (Information/Discussion) (No written report.)
9. Discussion and possible action regarding Carson Tahoe Health's expressed intent to leave the United Health Network effective May 30, 2025. (Celestena Glover, Executive Officer) (**For Possible Action**)
10. Acceptance of Biennial Compliance Report. (Leslie Bittleston, Quality Control Officer) (**For Possible Action**)
11. Public Comment.

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

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at https://pebp.nv.gov/Meetings/current-board-meetings/ (under the Board Meeting date referenced above). Contact Jessica Crane at PEBP, 3427 Goni Rd, Suite 109, Carson City, NV 89706 (775) 684-7020 or (800) 326-5496
An item raised during a report or public comment may be discussed but may not be deliberated or acted upon unless it is on the agenda as an action item.
All times are approximate. The Board reserves the right to take items in a different order or to combine two or more agenda items for consideration to accomplish business in the most efficient manner. The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time.
We are pleased to make reasonable efforts to assist and accommodate persons with physical disabilities who wish to participate in the meeting. If special arrangements for the meeting are necessary, please notify the PEBP in writing, at 3427 Goni Rd, Suite 109, Carson City, NV 89706, or call Jessica Crane at (775) 684-7020 or (800) 326-5496, as soon as possible so that reasonable efforts can be made to accommodate the request.
Copies of both the PEBP Meeting Action Minutes and Meeting Transcripts, if such transcripts are prepared, are available for inspection, at no charge, at the PEBP Office, 3427 Goni Rd, Suite 109, Carson City, NV 89706 or on the PEBP website at https://pebp.nv.gov. For additional information, contact Jessica Crane at (775) 684-7020 or (800) 326-5496.
Notice of this meeting was posted on or before 9:00 a.m. on the third working day before the meeting on the PEBP website at https://pebp.nv.gov, at the office of the public body and to the public notice website for meetings at https://notice.nv.gov. In addition, the agenda was mailed to groups and individuals as requested.

1.

1. Open Meeting; Roll Call.

2.

2. Public Comment.

3.

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

4.

4. Consent Agenda. (Joy Grimmer, Board Chair) (**All items for possible action**)

4.1 Approval of Action Minutes from the September 26, 2024 PEBP Board Meeting.

4.2 Receipt of quarterly staff reports for the period ending June 30 and September 30, 2024:

- 4.2.1 Q4 Utilization Report
- 4.2.2 Q1 Budget Report
- 4.2.3 Contract Status Report

4.3 Receipt of quarterly vendor reports for the period ending June 30, 2024:

- 4.3.1 Q4 Express Scripts – Summary Report
- 4.3.2 Q4 Express Scripts – Utilization Report
- 4.3.3 2nd MD – Annual Review Report

4.1

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

4.1 Approval of Action Minutes from the September 26, 2024 PEBP Board Meeting.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

3427 Goni Road, Suite 117
Carson City, NV 89706

ACTION MINUTES (Subject to Board Approval)
September 26, 2024

MEMBERS PRESENT	Ms. Joy Grimmer, Board Chair
IN PERSON:	Dr. Jennifer McClendon, Member Mr. Jim Barnes, Member Ms. Janell Woodward, Member Ms. Michelle Kelley, Member Ms. Bepsy Strasburg, Member
MEMBERS EXCUSED:	Ms. Stacie Weeks
FOR THE BOARD:	Ms. Radhika Kunnel, Deputy Attorney General
FOR STAFF:	Ms. Celestena Glover, Executive Officer Mr. Nik Proper, Operations Officer Ms. Michelle Weyland, Chief Financial Officer Ms. Brandee Mooneyhan, Lead Insurance Counsel Ms. Leslie Bittleston, Quality Control Officer Ms. Jessica Crane, Executive Assistant
OTHER PRESENTERS:	Richard Ward, Segal

1. Open Meeting; Roll Call

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

2. Public Comment
    - Kent Ervin – NV Faculty Alliance
    - Tess Opferman – AFSCME
    - Lisa Partee – PEBP Member
    - Shelley Shannon – PEBP Member
    - Deborah Arteaga – PEBP Member
    - Doug Unger – NV Faculty Alliance
    - David Cooper – PEBP Member
    - Monica Rosales – PEBP Member
    - Stacy Fernandes – PEBP Member
    - Timothy Hoft – PEBP Member
    - Laura Naumann – PEBP Member
    - Kelly Osborne – PEBP Member

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

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

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

    4.1 Approval of Action Minutes from the July 25, 2024 PEBP Board Meeting.

    4.2 Receipt of quarterly staff reports for the period ending June 30, 2024:

    4.2.1 Q4 Budget Report

    4.2.2 Contract Status Report

    4.3 Receipt of quarterly vendor reports for the period ending June 30, 2024:

    4.3.1 Q4 UMR – Obesity Care Management

    4.3.2 Q4 UMR – Diabetes Care Management

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

    4.3.4 Q4 UnitedHealthcare – Basic Life Insurance

4.3.5 Q4 UMR Performance Guarantee Report

4.3.6 Q4 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report

4.3.7 Amplifon Performance Report

BOARD ACTION ON ITEM 4
MOTION: Motion to accept consent agenda items except 4.1.
BY: Member Michelle Kelley
SECOND: Member Bepsy Strasburg
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 4.1
MOTION: Motion to accept the minutes as written.
BY: Member Janell Woodward
SECOND: Member Bepsy Strasburg
VOTE: Ayes - 4, the motion carried
Abstained - Michelle Kelley

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

6. Plan Design Report. (Celestena Glover, Executive Officer and Segal) (**For Possible Action**)

BOARD ACTION ON ITEM 6
MOTION: Motion to approve the proposed increase to the HSA and HRA to $700 for the primary participant and $200 for each dependent up to $600 for those enrolled in CDHP. Also motion to maintain life insurance benefits at $25,000 for employees and $12,500 for retirees.
BY: Member Michelle Kelly
SECOND: Member Bepsy Strasburg
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 6
MOTION: Motion to table the transition to the LD PPO to a standard PPO plan and also the elimination of the EPO and the HMO plans for the November Meeting.
BY: Member Bepsy Strasburg
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

7. Public Comment

- Lisa Partee – PEBP Member
- Kent Ervin – NV Faculty Alliance
- Kelly Osborne – PEBP Member
- Debbie Arteaga – PEBP Members
- Amelia Davis – PEBP Member
- David Kelsey – PEBP Member

- Terri Laird – RPEN
- David Cooper – PEBP Member
- Mary Mkrtchyan
- Laura Naumann

8. Adjournment
    - Board Chair Grimmer adjourned the meeting at 11:59 a.m.

4.2

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

4.1 Approval of Action Minutes from the September 26, 2024 PEBP Board Meeting.

4.2 Receipt of quarterly staff reports for the period ending June 30 and September 30, 2024.

4.2.1

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

4.2 Receipt of quarterly staff reports for the period ending June 30 and September 30, 2024:

4.2.1 Q4 Utilization Report

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CELESTENA GLOVER
Executive Officer

JOY GRIMMER
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: November 21, 2024

Item Number: 4.2.1

Title: Self-Funded CDHP, LDPPO, and EPO Plan Utilization Report for the period ending June 30, 2024

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

- Executive Summary – provides a utilization overview.
- UMR Inc. CDHP Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- UMR Inc. LDPPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- UMR Inc. EPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- Express Scripts Utilization Report – provides details supporting the prescription drug information included in the Executive Summary.
- Health Plan of Nevada Utilization – see Appendix D for Q4 Plan Year 2023 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q4 of Plan Year 2024 compared to Q4 of Plan Year 2023 is summarized below.

- Population:
  - 10.0% decrease for primary participants
  - 12.0% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 6.5% increase for primary participants
  - 8.9% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 127 High-Cost Claimants accounting for 33.6% of the total plan paid for Plan Year 2024
  - 13.0% increase in High-Cost Claimants per 1,000 members
  - 6.1% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cancer ($7.5 million) – 26.2% of paid claims
  - Neurological Disorders ($3.3 million) – 11.6% of paid claims
  - Cardia Disorders ($2.5 million) – 9.0% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased 5.2%
  - Average paid per ER visit increased 5.8%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased 13.4%
  - Average paid per Urgent Care visit decreased 2.0% (from $50 to $51)
- Network Utilization:
  - 97.3% of claims are from In-Network providers
  - In-Network utilization decreased 0.1% over PY 2023
  - In-Network discounts increased 0.2% over PY 2023

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 9.4%
    - Total Gross Claims Costs increased 1.3% ($0.6 million)
    - Average Total Cost per Claim increased 11.8%
      - From $115.56 to $129.22
  - Member:
    - Total Member Cost decreased 4.1%
    - Average Participant Share per Claim increased 5.8%
    - Net Member PMPM increased 9.3%
      - From $29.83 to $32.61
  - Plan
    - Total Plan Cost increased 2.9%

        - Average Plan Share per Claim increased 13.6%
        - Net Plan PMPM increased 17.3%
            - From $101.62 to $119.24
        - Net Plan PMPM factoring rebates increased 0.9%
            - From $70.60 to $71.23

LOW DEDUCTIBLE PPO PLAN (LDPPO)

The Low Deductible PPO Plan (LDPPO) experience for Q4 of Plan Year 2024 compared to Q4 of Plan Year 2023 is summarized below.

- Population:
    - 35.6% increase for primary participants
    - 33.7% increase for primary participants plus dependents (members)
- Medical Cost:
    - 10.2% increase for primary participants
    - 11.8% increase for primary participants plus dependents (members)
- High-Cost Claims:
    - There were 91 High-Cost Claimants accounting for 24.2% of the total plan paid for Plan Year 2024
    - 26.1% increase in High-Cost Claimants per 1,000 members
    - 6.8% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
    - Cancer ($5.2 million) – 25.7% of paid claims
    - Neurological Disorders ($3.1 million) – 15.3% of paid claims
    - Cardiac Disorders ($2.5 million) – 12.2% of paid claims
- Emergency Room:
    - ER visits per 1,000 members increased 12.2%
    - Average paid per ER visit increased 5.2%
- Urgent Care:
    - Urgent Care visits per 1,000 members increased by 2.2%
    - Average paid per Urgent Care visit increased 9.2% (from $98 to $107)
- Network Utilization:
    - 97.8% of claims are from In-Network providers
    - In-Network utilization stayed the same compared to PY 2023
    - In-Network discounts increased 1.4% over PY 2023

- Prescription Drug Utilization:
    - Overall:
        - Total Net Claims increased 37.3%
        - Total Gross Claims Costs increased 66.8% ($16.8 million)
        - Average Total Cost per Claim increased 21.5%
            - From $123.14 to $149.56

    - Member:
        - Total Member Cost increased 52.6%
        - Average Participant Share per Claim increased 11.1%

        - Net Member PMPM increased 14.0%
            - From $23.96 to $27.32
    - Plan
        - Total Plan Cost increased 69.9%
        - Average Plan Share per Claim increased 23.5%
        - Net Plan PMPM increased 26.7%
            - From $122.00 to $154.55
        - Net Plan PMPM factoring rebates increased 13.5%
            - From $88.39 to $100.35

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q4 of Plan Year 2024 compared to Q4 of Plan Year 2023 is summarized below.

- Population:
    - 10.4% decrease for primary participants
    - 10.8% decrease for primary participants plus dependents (members)
- Medical Cost:
    - 6.0% increase for primary participants
    - 6.5 increase for primary participants plus dependents (members)
- High-Cost Claims:
    - There were 60 High-Cost Claimants accounting for 35.9% of the total plan paid for Plan Year 2024
    - 24.6% increase in High-Cost Claimants per 1,000 members
    - 6.6% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
    - Cancer ($3.2million) – 5.1% of paid claims
    - Cardiac Disorders ($2.1 million) – 3.4% of paid claims
    - Neurological Disorders ($1.2 million) – 1.9% of paid claims
- Emergency Room:
    - ER visits per 1,000 members increased by 9.1%
    - Average paid per ER visit increased by 5.1%
- Urgent Care:
    - Urgent Care visits per 1,000 members increased by 8.2%
    - Average paid per Urgent Care visit increased 4.7%
- Network Utilization:
    - 96.4% of claims are from In-Network providers
    - In-Network utilization increased 0.3% over PY 2023
    - In-Network discounts increased 1.8% over PY 2023

- Prescription Drug Utilization:
    - Overall:
        - Total Net Claims decreased 6.3%
        - Total Gross Claims Costs increased 5.1% ($1.0 million)
        - Average Total Cost per Claim increased 12.2%

        - From $149.01 to $167.25
    - Member:
        - Total Member Cost decreased 4.8%
        - Average Participant Share per Claim increased 1.6%
        - Net Member PMPM increased 6.9%
            - From $42.30 to $45.23
    - Plan
        - Total Plan Cost increased 7.1%
        - Average Plan Share per Claim increased 14.3%
        - Net Plan PMPM increased 20.3%
            - From $217.75 to $261.91
        - Net Plan PMPM factoring rebates increased 15.7%
            - From $144.64 to $167.33

DENTAL PLAN

The Dental Plan experience for Q4 of Plan Year 2024 is summarized below.

- Dental Cost:
    - Total of $26,841,134 paid for Dental claims
        - Basic claims account for 34.5% ($9.2 million)
        - Preventive claims account for 25.1% ($6.7 million)
        - Diagnostic claims account for 22.8% ($6.1 million)
        - Major claims account for 17.7 ($4.7 million)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of HRA account balances as of June 30, 2024.

HRA Account Balances as of June 30, 2024			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	13,802	0.00	0.00
$.01 - $500.00	33,357	7,535,577.49	225.91
$500.01 - $1,000	1,986	1,361,491.54	685.54
$1,000.01 - $1,500	771	932,170.74	1,209.04
$1,500.01 - $2,000	381	656,133.86	1,722.14
$2,000.01 - $2,500	227	514,164.09	2,265.04
$2,500.01 - $3,000	183	502,162.75	2,744.06
$3,000.01 - $3,500	102	327,703.50	3,212.78
$3,500.01 - $4,000	146	546,216.08	3,741.21
$4,000.01 - $4,500	109	461,388.61	4,232.92
$4,500.01 - $5,000	92	438,435.77	4,765.61
$5,000.01 +	**576**	**4,907,058.24**	**8,519.20**
Total	**51,732**	**$ 18,182,503**	**$ 351.47**

CONCLUSION

The information in this report provides plan experience for the Consumer Driven Health Plan (CDHP), Low Deductible PPO Plan (LDPPO) and the PEBP Premier Plan (EPO) for Plan Year 2024.

- The CDHP total plan paid decreased 4.6% over the same time for Plan Year 2023; however, on a PEPY basis the plan experienced an increase of 6.5%.
- The LDPPO total plan paid increased 49.4% over Plan Year 2023. This increase is in part attributed to the increase in enrollment (33.7%) in the LDPPO plan over the previous plan year. However, on a PEPY basis the plan experienced an increase of 10.2%.
- The EPO total plan paid decreased 5.0% over Plan Year 2023. However, on a PEPY basis the plan experienced an increase of 6.0%.

The HMO utilization and cost data can be found in the report provided in Appendix D.

Appendix A

Index of Tables
UMR Inc. – CDHP Utilization Review for PEBP
July 1, 2023 – June 30, 2024

DATASCOPE™

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

UMR℠

Overview

- Total Medical Spend for PY24 was $84,813,752 of which 77.8% was spent in the State Active population. When compared to PY23, this reflected a decrease of 4.1% in plan spend.
  - When compared to PY22, PY24 decreased 19.0%, with State Actives having a decrease of 18.1%.
- On a PEPY basis, PY24 reflected an increase of 6.5% when compared to PY23. The largest group, State Actives, had a 10.7% increase when compared to the PY23 PEPY%.
  - When compared to PY22, PY24 increased 3.8%, with State Actives increasing 5.9%.
- 83.7% of the Average Membership had paid Medical claims less than $2,500, with 19.9% having no claims paid at all during the reporting period.
- There were 127 high-cost Claimants (HCC's) over $100K, that accounted for 33.6% of the total spend. HCCs accounted for 34.0% of total spend during PY23, with 126 members hitting the $100K threshold. The largest diagnosis grouper was Cancer accounting for 26.2% of high-cost claimant dollars.
- IP Paid per Admit was $28,516 which is an increase of 7.8% compared to PY23.
- ER Paid per Visit is $2,535, which is an increase of 5.8% compared to PY23.
- 97.3% of all Medical spend dollars were to In Network providers. The average In Network discount was 68.6%, which is comparable to the PY23 average discount of 68.4%.

Paid Claims by Age Group

Paid Claims by Age Group																
	PY23						PY24						% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 5,181,350	$ 2,699	$ 34,144	$ 18	$5,215,494	$ 2,716	$ 2,426,666	$ 1,630	$ 599	$ -	$ 2,427,265	$ 1,630	-53.5%	-40.0%
1	$ 486,016	$ 205	$ 36,705	$ 15	$522,721	$ 220	$ 357,511	$ 231	$ 78,174	$ 51	$ 435,685	$ 282	-16.7%	28.2%
2 - 4	$ 891,648	$ 119	$ 170,272	$ 23	$1,061,920	$ 141	$ 676,906	$ 107	$ 126,916	$ 20	$ 803,821	$ 127	-24.3%	-10.0%
5 - 9	$ 1,356,073	$ 82	$ 299,717	$ 18	$1,655,790	$ 101	$ 1,540,966	$ 115	$ 350,867	$ 26	$ 1,891,833	$ 142	14.3%	41.0%
10 - 14	$ 1,731,650	$ 88	$ 340,380	$ 17	$2,072,030	$ 106	$ 1,675,565	$ 101	$ 544,430	$ 33	$ 2,219,994	$ 133	7.1%	25.9%
15 - 19	$ 4,387,437	$ 202	$ 690,093	$ 32	$5,077,530	$ 233	$ 4,784,493	$ 245	$ 539,583	$ 28	$ 5,324,076	$ 273	4.9%	17.0%
20 - 24	$ 3,477,004	$ 130	$ 1,251,232	$ 47	$4,728,236	$ 176	$ 3,308,963	$ 142	$ 1,647,261	$ 71	$ 4,956,223	$ 212	4.8%	20.4%
25 - 29	$ 3,595,795	$ 197	$ 896,458	$ 49	$4,492,253	$ 247	$ 2,292,827	$ 146	$ 498,661	$ 32	$ 2,791,488	$ 178	-37.9%	-27.8%
30 - 34	$ 5,254,060	$ 235	$ 961,196	$ 43	$6,215,256	$ 278	$ 4,831,833	$ 250	$ 921,364	$ 48	$ 5,753,197	$ 298	-7.4%	7.0%
35 - 39	$ 4,105,925	$ 168	$ 1,669,207	$ 68	$5,775,132	$ 237	$ 5,317,308	$ 248	$ 1,507,122	$ 70	$ 6,824,430	$ 319	18.2%	34.7%
40 - 44	$ 4,561,901	$ 177	$ 2,219,537	$ 86	$6,781,438	$ 263	$ 4,560,380	$ 196	$ 2,040,212	$ 87	$ 6,600,592	$ 283	-2.7%	7.6%
45 - 49	$ 5,337,965	$ 219	$ 2,254,193	$ 92	$7,592,158	$ 311	$ 5,542,233	$ 255	$ 2,789,262	$ 128	$ 8,331,494	$ 383	9.7%	23.1%
50 - 54	$ 9,184,369	$ 330	$ 4,070,171	$ 146	$13,254,540	$ 476	$ 8,601,476	$ 347	$ 4,496,659	$ 181	$ 13,098,135	$ 528	-1.2%	10.9%
55 - 59	$ 11,486,435	$ 373	$ 5,271,340	$ 171	$16,757,775	$ 544	$ 10,865,390	$ 405	$ 4,354,135	$ 162	$ 15,219,525	$ 568	-9.2%	4.3%
60 - 64	$ 17,740,796	$ 490	$ 7,298,136	$ 202	$25,038,932	$ 692	$ 18,518,608	$ 569	$ 7,798,993	$ 240	$ 26,317,601	$ 809	5.1%	17.0%
65+	$ 9,700,956	$ 402	$ 6,103,938	$ 253	$15,804,894	$ 655	$ 9,512,627	$ 415	$ 6,864,300	$ 300	$ 16,376,927	$ 715	3.6%	9.2%
Total	**$ 88,479,381**	**$ 268**	**$ 33,566,719**	**$ 102**	**$ 122,046,100**	**$ 369**	**$ 84,813,751**	**$ 292**	**$ 34,558,538**	**$ 119**	**$ 119,372,289**	**$ 410**	**-2.2%**	**11.2%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**
Average Enrollment												
Employees	18,943	16,411	14,777	-10.0%	15,526	13,332	12,013	-9.9%	3	3	4	19.3%
Spouses	3,974	7,866	2,766	-64.8%	3,134	7,223	2,107	-70.8%	1	4	1	-85.5%
Children	10,172	3,266	6,695	105.0%	9,421	2,504	6,137	145.1%	4	1	2	142.0%
Total Members	33,089	27,544	24,238	-12.0%	28,082	23,059	20,257	-12.1%	8	8	7	-17.8%
Family Size	1.8	1.7	1.6	-2.4%	1.8	1.7	1.7	-2.3%	2.7	2.7	1.8	-31.1%
Financial Summary												
Gross Cost	$138,077,453	$116,590,277	$111,641,277	-4.2%	$106,593,460	$87,356,314	$86,271,523	-1.2%	$55,484	$42,591	$84,703	98.9%
Client Paid	$104,706,277	$88,479,381	$84,813,752	-4.1%	$80,561,976	$66,125,338	$65,990,251	-0.2%	$38,304	$30,890	$68,857	122.9%
Employee Paid	$33,371,175	$28,110,896	$26,827,525	-4.6%	$26,031,484	$21,230,976	$20,281,272	-4.5%	$17,181	$11,702	$15,845	35.4%
Client Paid-PEPY	$5,527	$5,391	$5,739	6.5%	$5,189	$4,960	$5,493	10.7%	$12,768	$10,297	$19,216	86.6%
Client Paid-PMPY	$3,164	$3,212	$3,499	8.9%	$2,869	$2,868	$3,258	13.6%	$4,788	$3,861	$10,459	170.9%
Client Paid-PEPM	$461	$449	$478	6.5%	$432	$413	$458	10.9%	$1,064	$858	$1,601	86.6%
Client Paid-PMPM	$264	$268	$292	9.0%	$239	$239	$271	13.4%	$399	$322	$872	170.8%
High Cost Claimants (HCC's) > $100k												
# of HCC's	160	126	127		115	94	98		0	0	0	
HCC's / 1,000	4.8	4.6	5.2		4.1	4.1	4.8		0.0	0.0	0.0	
Avg HCC Paid	$251,190	$238,643	$224,115	-6.1%	$262,921	$233,021	$232,920	0.0%	$0	$0	$0	0.0%
HCC's % of Plan Paid	38.4%	34.0%	33.6%	-1.2%	37.5%	33.1%	34.6%	4.5%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,153	$995	$975	-2.0%	$1,028	$895	$950	6.1%	$0	$0	$0	0.0%
Facility Outpatient	$939	$1,074	$1,217	13.3%	$821	$930	$1,092	17.4%	$3,554	$2,208	$9,003	307.7%
Physician	$1,011	$1,143	$1,307	14.3%	$964	$1,043	$1,216	16.6%	$1,200	$1,653	$1,456	-11.9%
Other	$62	$0	$0	0.0%	$56	$0	$0	0.0%	$34	$0	$0	0.0%
Total	$3,164	$3,212	$3,499	8.9%	$2,869	$2,868	$3,258	13.6%	$4,788	$3,861	$10,459	170.9%

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	2,981	2,711	2,443	-9.9%	433	366	318	-13.0%	
Spouses	776	624	622	-0.3%	62	16	36	130.6%	
Children	729	715	542	-24.2%	18	46	14	-70.6%	
Total Members	4,486	4,049	3,607	-10.9%	514	427	367	-14.0%	
Family Size	1.5	1.5	1.5	-0.7%	1.2	1.2	1.2	-0.9%	1.6
Financial Summary									
Gross Cost	$27,879,066	$25,102,026	$23,033,994	-8.2%	$3,549,442	$4,089,345	$2,251,057	-45.0%	
Client Paid	$21,491,378	$19,194,786	$17,411,511	-9.3%	$2,614,619	$3,128,367	$1,343,132	-57.1%	
Employee Paid	$6,387,688	$5,907,239	$5,622,483	-4.8%	$934,823	$960,978	$907,925	-5.5%	
Client Paid-PEPY	$7,210	$7,082	$7,129	0.7%	$6,033	$8,557	$4,224	-50.6%	$6,258
Client Paid-PMPY	$4,791	$4,740	$4,827	1.8%	$5,091	$7,321	$3,656	-50.1%	$3,830
Client Paid-PEPM	$601	$590	$594	0.7%	$503	$713	$352	-50.6%	$521
Client Paid-PMPM	$399	$395	$402	1.8%	$424	$610	$305	-50.0%	$319
High Cost Claimants (HCC's) > $100k									
# of HCC's	44	31	32		5	5	1		
HCC's / 1,000	9.8	7.7	8.9		9.7	11.7	2.7		
Avg HCC Paid	$199,873	$213,853	$176,136	-17.6%	$231,987	$307,109	$0	-100.0%	
HCC's % of Plan Paid	40.9%	34.5%	32.4%	-6.1%	44.4%	49.1%	0.0%	-100.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,808	$1,250	$1,134	-9.3%	$2,262	$4,005	$813	-79.7%	$1,044
Facility Outpatient	$1,612	$1,838	$1,886	2.6%	$1,488	$1,591	$1,395	-12.3%	$1,310
Physician	$1,280	$1,652	$1,807	9.4%	$1,227	$1,724	$1,448	-16.0%	$1,404
Other	$91	$0	$0	0.0%	$115	$0	$0	0.0%	$72
Total	$4,791	$4,740	$4,827	1.8%	$5,091	$7,321	$3,656	-50.1%	$3,830

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 23,807,910	$ 4,876,554	$ 672,073	$ 29,356,537	$ 22,021,830	$ 3,852,892	$ 722,538	$ 26,597,261	-9.4%
Outpatient	$ 42,317,427	$ 11,764,006	$ 1,882,153	$ 55,963,587	$ 43,968,421	$ 10,265,462	$ 2,570,619	$ 56,804,501	1.5%
Total - Medical	**$ 66,125,338**	**$ 16,640,560**	**$ 2,554,226**	**$ 85,320,124**	**$ 65,990,251**	**$ 14,118,354**	**$ 3,293,157**	**$ 83,401,762**	**-2.2%**

Net Paid Claims - Per Participant per Month	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 413	$ 643	$ 384	$ 443	$ 458	$ 616	$ 514	$ 481	8.5%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 398,052	$ 1,415,160	$ 1,813,211		$ 105,406	$ 231,995	$ 337,401	-81.4%
Outpatient	$ 30,890	$ 664,301	$ 650,855	$ 1,346,046	$ 68,857	$ 404,932	$ 600,799	$ 1,074,588	-20.2%
Total - Medical	**$ 30,890**	**$ 1,062,353**	**$ 2,066,014**	**$ 3,159,257**	**$ 68,857**	**$ 510,338**	**$ 832,794**	**$ 1,411,989**	**-55.3%**

Net Paid Claims - Per Participant per Month	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 858	$ 790	$ 679	$ 714	$ 1,603	$ 586	$ 283	$ 366	-48.8%

Paid Claims by Claim Type – Total Participants

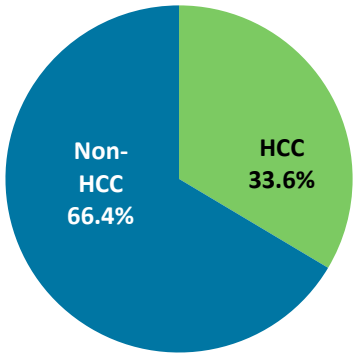
Net Paid Claims - Total Total Participants	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 23,807,910	$ 5,274,606	$ 2,087,232	$ 31,169,749	$ 22,021,830	$ 3,958,298	$ 954,534	$ 26,934,662	-13.6%
Outpatient	$ 42,348,317	$ 12,428,307	$ 2,533,008	$ 57,309,632	$ 44,037,278	$ 10,670,394	$ 3,171,417	$ 57,879,089	1.0%
Total - Medical	**$ 66,156,227**	**$ 17,702,913**	**$ 4,620,240**	**$ 88,479,381**	**$ 66,059,108**	**$ 14,628,692**	**$ 4,125,951**	**$ 84,813,752**	**-4.1%**

Net Paid Claims - Per Participant per Month	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 413	$ 650	$ 477	$ 449	$ 458	$ 615	$ 441	$ 478	6.5%

Cost Distribution – Medical Claims

PY23							PY24					
Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid	Paid Claims Category	Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
113	0.4%	$29,935,819	33.8%	$832,847	3.0%	$100,000.01 Plus	114	0.5%	$28,462,543	33.6%	$717,479	2.7%
156	0.6%	$11,675,364	13.2%	$965,047	3.4%	$50,000.01-$100,000.00	162	0.7%	$11,767,487	13.9%	$952,499	3.6%
316	1.1%	$11,600,473	13.1%	$1,730,194	6.2%	$25,000.01-$50,000.00	300	1.2%	$10,855,249	12.8%	$1,563,755	5.8%
792	2.9%	$13,059,289	14.8%	$3,895,107	13.9%	$10,000.01-$25,000.00	782	3.2%	$12,836,348	15.1%	$3,810,241	14.2%
1,101	4.0%	$8,145,730	9.2%	$3,683,619	13.1%	$5,000.01-$10,000.00	1,043	4.3%	$7,709,653	9.1%	$3,686,005	13.7%
1,510	5.5%	$5,660,247	6.4%	$3,680,595	13.1%	$2,500.01-$5,000.00	1,545	6.4%	$5,738,039	6.8%	$3,836,075	14.3%
13,927	50.6%	$8,402,458	9.5%	$11,274,699	40.1%	$0.01-$2,500.00	11,254	46.4%	$7,444,434	8.8%	$10,127,813	37.8%
4,043	14.7%	$0	0.0%	$2,048,788	7.3%	$0.00	4,211	17.4%	$0	0.0%	$2,133,659	8.0%
5,586	20.3%	$0	0.0%	$0	0.0%	No Claims	4,826	19.9%	$0	0.0%	$0	0.0%
27,544	**100.0%**	**$88,479,381**	**100.0%**	**$28,110,896**	**100.0%**		**24,238**	**100.0%**	**$84,813,752**	**100.0%**	**$26,827,525**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High-Cost Claimant over $100K

HCC's by Diagnosis Grouper			
Top 10 Diagnosis Groupers	**Patients**	**Total Paid**	**% Paid**
Cancer	49	$7,462,468	26.2%
Neurological Disorders	83	$3,315,053	11.6%
Cardiac Disorders	93	$2,552,381	9.0%
Pregnancy-related Disorders	9	$1,730,774	6.1%
Infections	50	$1,553,534	5.5%
Gastrointestinal Disorders	78	$1,514,133	5.3%
Medical/Surgical Complications	32	$1,238,346	4.4%
Hematological Disorders	48	$1,177,368	4.1%
Renal/Urologic Disorders	50	$992,731	3.5%
Pulmonary Disorders	75	$970,543	3.4%
All Other		$5,955,210	20.9%
Overall	**----**	**$28,462,543**	**100.0%**

Utilization Summary (p. 1 of 2)

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

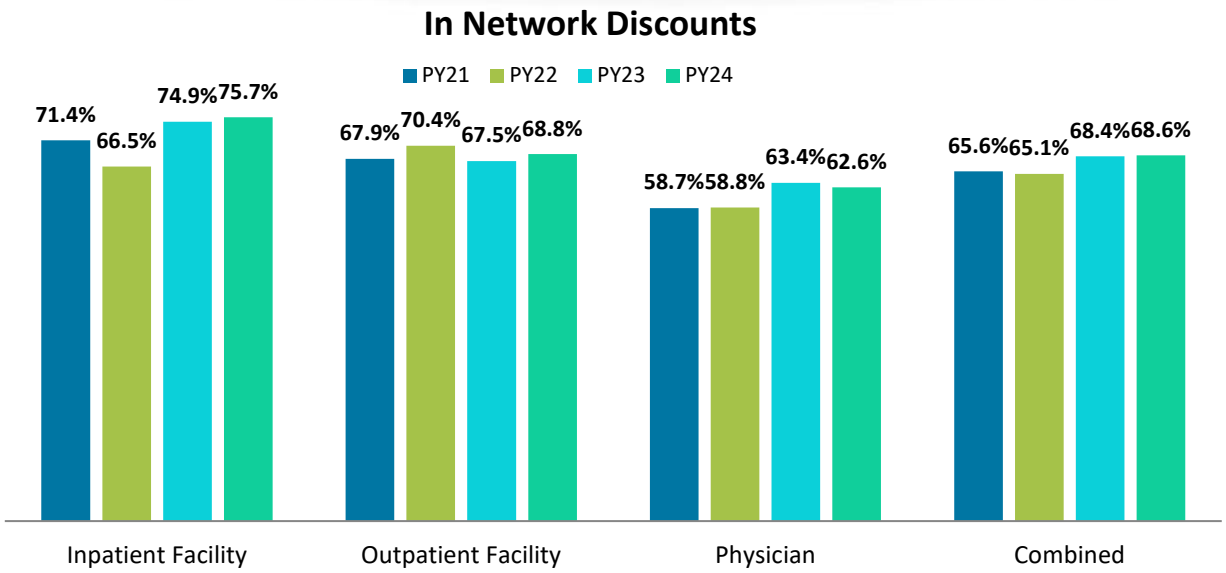
	Total				State Active			
Summary	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**
Inpatient Summary								
# of Admits	1,357	1,072	986		997	797	743	
# of Bed Days	8,861	6,155	5,652		6,471	4,533	4,250	
Paid Per Admit	$33,963	$26,453	$28,516	7.8%	$35,180	$26,882	$30,787	14.5%
Paid Per Day	$5,201	$4,607	$4,975	8.0%	$5,420	$4,726	$5,382	13.9%
Admits Per 1,000	41	39	41	5.1%	36	35	37	5.7%
Days Per 1,000	268	223	233	4.5%	230	197	210	6.6%
Avg LOS	6.5	5.7	5.7	0.0%	6.5	5.7	5.7	0.0%
# of Admits From ER	780	613	635	3.6%	516	419	460	9.8%
Physician Office								
OV Utilization per Member	3.8	3.8	4.1	7.9%	3.5	3.5	3.8	8.6%
Avg Paid per OV	$82	$86	$87	1.2%	$84	$82	$84	2.4%
Avg OV Paid per Member	$312	$324	$355	9.6%	$297	$284	$320	12.7%
DX&L Utilization per Member	7.4	9.4	9.8	4.3%	6.9	8.6	9.1	5.8%
Avg Paid per DX&L	$54	$48	$52	8.3%	$50	$46	$51	10.9%
Avg DX&L Paid per Member	$402	$457	$511	11.8%	$348	$398	$464	16.6%
Emergency Room								
# of Visits	4,877	4,216	3,865		4,039	3,339	3,153	
Visits Per Member	0.15	0.15	0.16	6.7%	0.14	0.14	0.16	14.3%
Visits Per 1,000	147	153	161	5.2%	144	145	156	7.6%
Avg Paid per Visit	$2,011	$2,396	$2,535	5.8%	$2,053	$2,508	$2,619	4.4%
Urgent Care								
# of Visits	8,823	7,180	7,179		7,756	6,318	6,230	
Visits Per Member	0.27	0.26	0.30	15.4%	0.28	0.27	0.31	14.8%
Visits Per 1,000	267	261	296	13.4%	276	274	308	12.4%
Avg Paid per Visit	$70	$50	$51	2.0%	$70	$50	$51	2.0%

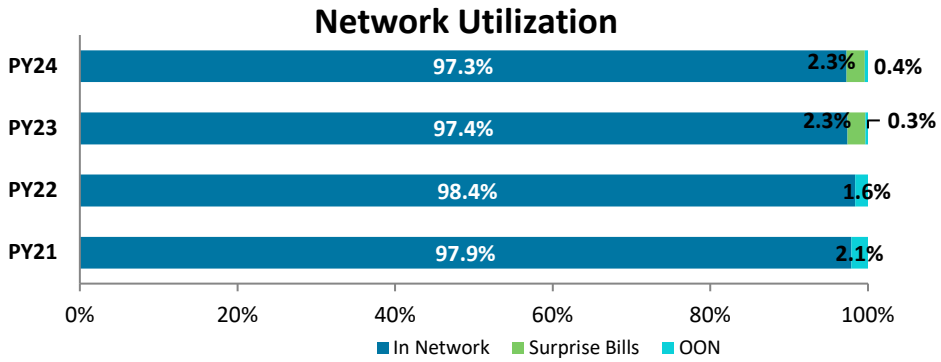
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**Peer Index**
Inpatient Summary									
# of Admits	302	222	199		58	53	44		
# of Bed Days	2,000	1,253	1,203		390	369	199		
Paid Per Admit	$30,487	$25,483	$24,460	-4.0%	$31,145	$24,071	$8,519	-64.6%	$19,305
Paid Per Day	$4,603	$4,515	$4,046	-10.4%	$4,632	$3,457	$1,884	-45.5%	$3,615
Admits Per 1,000	67	55	55	0.0%	113	124	120	-3.2%	64
Days Per 1,000	446	309	334	8.1%	759	863	542	-37.2%	342
Avg LOS	6.6	5.6	6	7.1%	6.7	7.0	4.5	-35.7%	5.3
# of Admits From ER	222	156	143	-8.3%	42	38	32	-15.8%	
Physician Office									
OV Utilization per Member	5.0	5.1	5.2	2.0%	6.8	7.7	8.3	7.8%	5.2
Avg Paid per OV	$82	$109	$107	-1.8%	$39	$41	$38	-7.3%	$97
Avg OV Paid per Member	$410	$557	$557	0.0%	$268	$313	$314	0.3%	$502
DX&L Utilization per Member	9.9	13	12.6	-3.1%	9.6	19.4	18.3	-5.7%	9.0
Avg Paid per DX&L	$72	$58	$59	1.7%	$58	$39	$42	7.7%	$46
Avg DX&L Paid per Member	$717	$762	$740	-2.9%	$557	$754	$778	3.2%	$412
Emergency Room									
# of Visits	725	725	582		108	148	123		
Visits Per Member	0.16	0.18	0.16	-11.1%	0.21	0.35	0.33	-5.7%	0.23
Visits Per 1,000	162	179	161	-10.1%	210	346	335	-3.2%	228
Avg Paid per Visit	$1,856	$2,125	$2,424	14.1%	$1,520	$1,165	$768	-34.1%	$1,035
Urgent Care									
# of Visits	980	770	847		82	85	98		
Visits Per Member	0.22	0.19	0.23	21.1%	0.16	0.20	0.27	35.0%	0.38
Visits Per 1,000	218	190	235	23.7%	160	199	267	34.2%	379
Avg Paid per Visit	$71	$53	$48	-9.4%	$39	$47	$53	12.8%	$132

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$10,652,139	12.6%	$8,163,093	$2,426,419	$62,626	$4,494,888	$6,157,251
Cardiac Disorders	$6,934,310	8.2%	$4,892,896	$1,323,290	$718,123	$4,260,384	$2,673,926
Gastrointestinal Disorders	$6,897,237	8.1%	$5,051,815	$811,145	$1,034,276	$2,747,935	$4,149,302
Health Status/Encounters	$6,864,506	8.1%	$4,508,864	$965,298	$1,390,344	$2,479,554	$4,384,951
Neurological Disorders	$6,316,554	7.4%	$2,928,305	$927,366	$2,460,882	$1,446,871	$4,869,683
Trauma/Accidents	$4,697,673	5.5%	$2,955,241	$412,607	$1,329,826	$2,240,564	$2,457,110
Pregnancy-related Disorders	$4,526,499	5.3%	$1,829,996	$457,067	$2,239,436	$1,376,564	$3,149,934
Musculoskeletal Disorders	$4,450,108	5.2%	$3,385,444	$689,739	$374,925	$1,612,883	$2,837,225
Mental Health	$3,624,664	4.3%	$1,408,243	$354,328	$1,862,093	$1,738,847	$1,885,817
Spine-related Disorders	$3,461,496	4.1%	$2,865,964	$448,383	$147,149	$1,620,096	$1,841,400
Renal/Urologic Disorders	$3,069,907	3.6%	$2,408,154	$341,480	$320,273	$1,460,652	$1,609,255
Infections	$3,016,757	3.6%	$2,462,651	$374,224	$179,882	$1,690,023	$1,326,733
Pulmonary Disorders	$2,885,550	3.4%	$1,692,347	$523,071	$670,131	$1,452,221	$1,433,329
Eye/ENT Disorders	$2,839,891	3.3%	$1,928,311	$445,125	$466,456	$1,272,765	$1,567,126
Endocrine/Metabolic Disorders	$2,348,811	2.8%	$2,036,622	$244,863	$67,327	$1,232,938	$1,115,873
Medical/Surgical Complications	$1,834,519	2.2%	$1,471,847	$232,826	$129,846	$653,070	$1,181,449
Gynecological/Breast Disorders	$1,801,433	2.1%	$1,326,352	$302,118	$172,962	$35,779	$1,765,653
Hematological Disorders	$1,666,989	2.0%	$850,130	$762,695	$54,165	$1,059,010	$607,979
Non-malignant Neoplasm	$1,474,188	1.7%	$1,332,642	$101,775	$39,771	$521,478	$952,710
Diabetes	$1,130,044	1.3%	$757,315	$68,016	$304,713	$406,635	$723,409
Dermatological Disorders	$1,097,967	1.3%	$711,298	$237,820	$148,848	$478,341	$619,626
Miscellaneous	$877,429	1.0%	$653,395	$113,772	$110,263	$296,699	$580,730
Vascular Disorders	$687,666	0.8%	$537,179	$53,186	$97,301	$312,749	$374,917
Abnormal Lab/Radiology	$597,161	0.7%	$471,279	$107,807	$18,074	$233,325	$363,835
Congenital/Chromosomal Anomalies	$492,723	0.6%	$118,576	$140,409	$233,738	$132,403	$360,320
Medication Related Conditions	$226,049	0.3%	$79,068	$10,671	$136,311	$34,249	$191,800
Cholesterol Disorders	$148,274	0.2%	$122,729	$23,004	$2,542	$89,055	$59,220
External Hazard Exposure	$103,120	0.1%	$9,005	$2,670	$91,444	$89,092	$14,028
Dental Conditions	$44,720	0.1%	$35,350	$777	$8,594	$18,476	$26,244
Allergic Reaction	$44,633	0.1%	$24,717	$1,275	$18,641	$12,066	$32,567
Social Determinants of Health	$494	0.0%	$254	$239	$0	$462	$31
Cause of Morbidity	$241	0.0%	$0	$0	$241	$241	$0
Total	**$84,813,752**	**100.0%**	**$57,019,082**	**$12,903,466**	**$14,891,203**	**$35,500,316**	**$49,313,436**

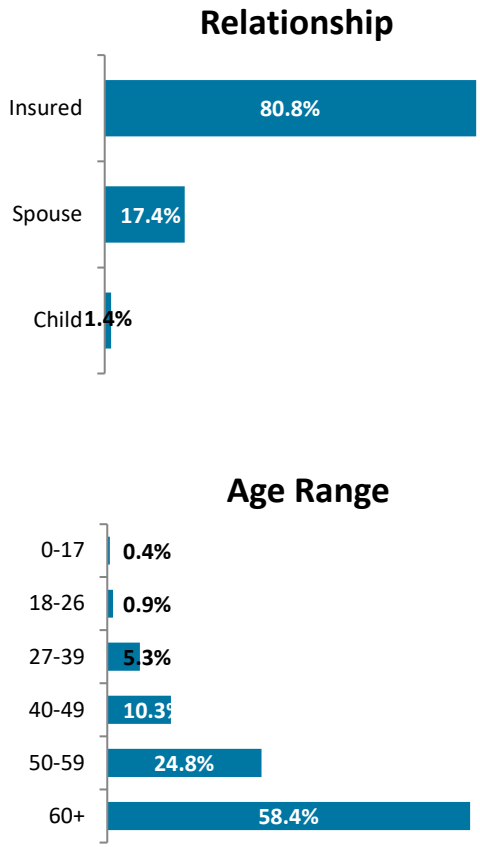
Mental Health Drilldown

	PY21		PY22		PY23		PY24	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Developmental Disorders	179	$1,179,402	113	$719,871	106	$1,143,180	106	$981,565
Alcohol Abuse/Dependence	136	$1,288,204	101	$873,612	129	$434,007	116	$663,138
Depression	1,597	$1,103,414	1,156	$1,279,244	974	$1,005,022	1,028	$668,747
Mood and Anxiety Disorders	1,920	$638,818	1,486	$406,189	1,263	$370,422	1,265	$428,733
Mental Health Conditions, Other	1,220	$771,034	911	$431,490	774	$383,973	822	$344,251
Eating Disorders	55	$647,596	44	$596,928	34	$112,463	30	$85,934
Bipolar Disorder	315	$464,418	225	$197,224	193	$202,937	226	$107,812
Sexually Related Disorders	68	$90,021	42	$11,305	56	$109,156	59	$68,016
Substance Abuse/Dependence	140	$213,345	86	$540,594	81	$99,940	74	$57,201
Complications of Substance Abuse	42	$202,208	22	$89,081	26	$88,753	30	$42,685
Schizophrenia	26	$141,033	25	$110,357	21	$81,413	20	$40,164
Attention Deficit Disorder	482	$72,965	374	$57,319	369	$42,820	383	$50,697
Psychoses	54	$86,357	32	$70,201	35	$108,586	30	$35,096
Sleep Disorders	564	$76,491	371	$46,254	347	$39,783	321	$32,656
Personality Disorders	25	$16,690	19	$13,480	8	$1,502	16	$8,339
Tobacco Use Disorder	126	$8,010	106	$6,184	103	$7,184	115	$9,630
Total		**$7,000,007**		**$5,449,334**		**$4,231,141**		**$3,624,664**

Diagnosis Grouper – Cancer

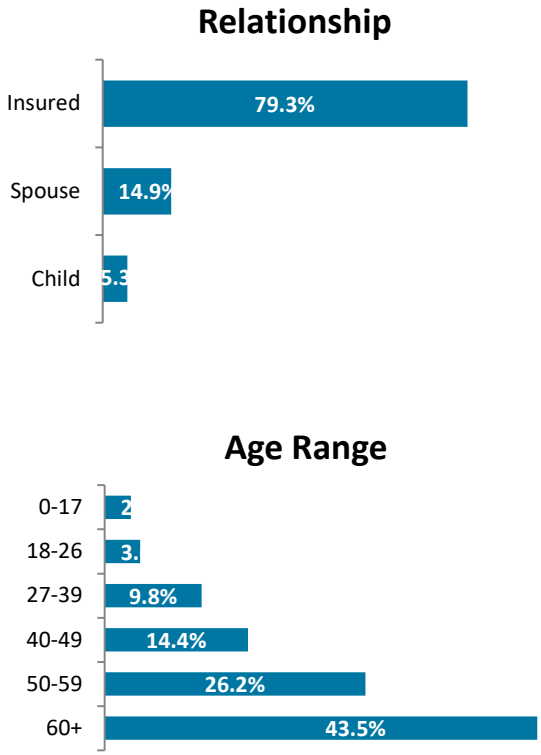
Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	78	522	$3,834,939	4.5%
Cancers, Other	99	1,177	$1,712,287	2.0%
Breast Cancer	170	1,846	$1,196,078	1.4%
Secondary Cancers	54	449	$671,937	0.8%
Prostate Cancer	104	832	$615,942	0.7%
Colon Cancer	42	671	$425,097	0.5%
Lung Cancer	25	254	$322,033	0.4%
Cervical/Uterine Cancer	47	378	$246,020	0.3%
Melanoma	45	202	$219,247	0.3%
Myeloma	11	292	$217,841	0.3%
Carcinoma in Situ	102	333	$217,709	0.3%
Ovarian Cancer	22	242	$170,995	0.2%
Myeloproliferative Neoplasms	55	560	$162,287	0.2%
Lymphomas	36	445	$147,482	0.2%
Non-Melanoma Skin Cancers	259	683	$146,389	0.2%
Thyroid Cancer	39	230	$132,938	0.2%
Kidney Cancer	20	285	$74,807	0.1%
Pancreatic Cancer	5	146	$54,578	0.1%
Brain Cancer	5	18	$49,844	0.1%
Bladder Cancer	17	120	$33,690	0.0%
Overall	**----**	**----**	**$10,652,139**	**12.8%**

*Patient and claim counts are unique only within the category



Diagnosis Grouper – Cardiac Disorders

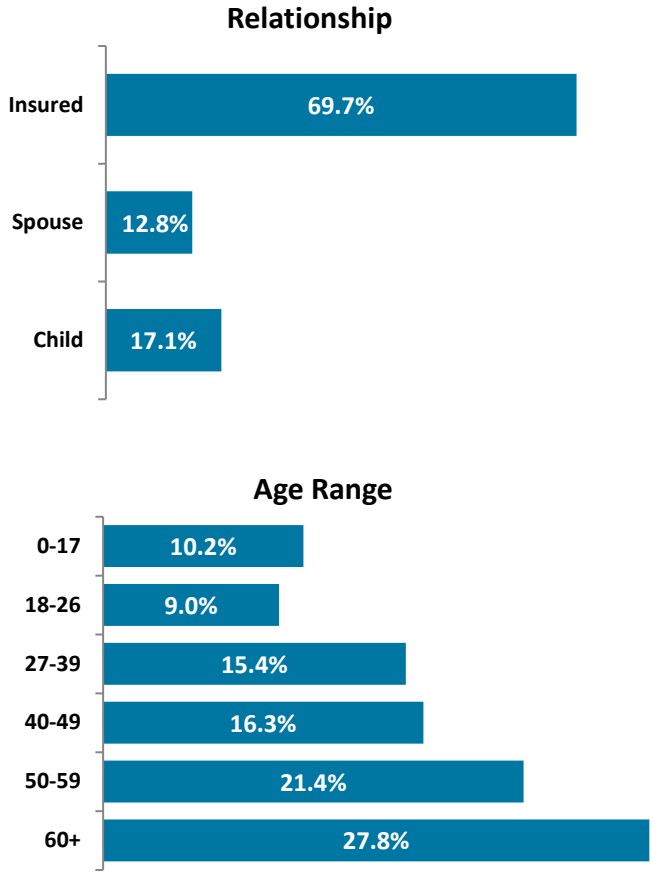
Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Coronary Artery Disease	456	1,347	$1,197,492	1.4%
Chest Pain	1142	2,763	$927,376	1.1%
Myocardial Infarction	47	291	$919,005	1.1%
Atrial Fibrillation	227	1,175	$865,694	1.0%
Heart Valve Disorders	353	569	$775,157	0.9%
Congestive Heart Failure	151	541	$539,152	0.6%
Hypertension	2,678	6,487	$507,971	0.6%
Pulmonary Embolism	44	272	$427,292	0.5%
Cardiac Arrhythmias	631	1,399	$317,704	0.4%
Cardiac Conditions, Other	586	1,220	$234,533	0.3%
Cardiomyopathy	44	120	$109,081	0.1%
Cardio-Respiratory Arrest	80	240	$103,596	0.1%
Shock	15	46	$9,590	0.0%
Ventricular Fibrillation	4	4	$666	0.0%
Overall	**----**	**----**	**$6,934,310**	**8.1%**



Diagnosis Grouper – Gastrointestinal Disorders

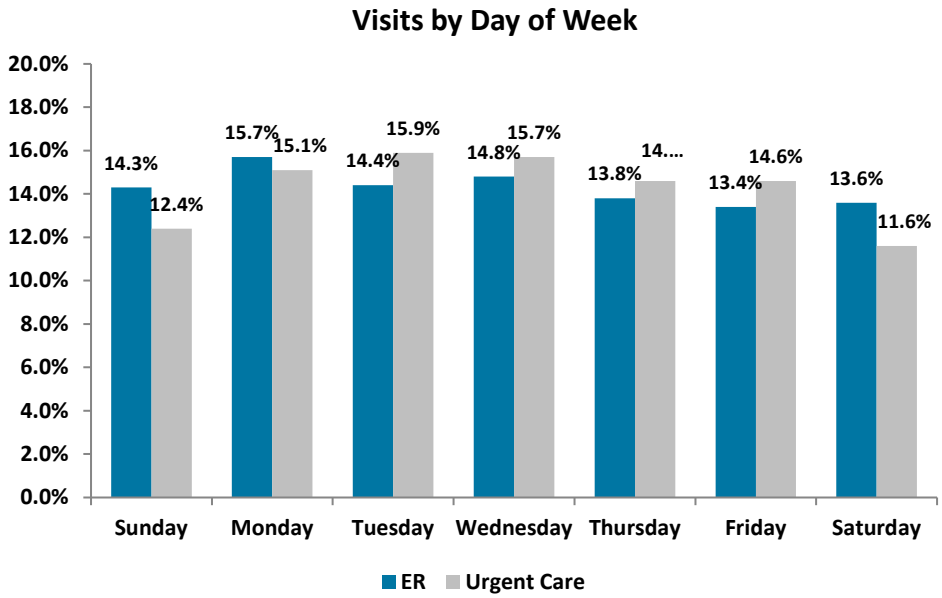
Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Abdominal Disorders	1,570	4,054	$1,142,845	1.3%
GI Disorders, Other	899	2,178	$883,891	1.0%
Hernias	250	794	$718,748	0.8%
Gallbladder and Biliary Disease	175	730	$680,040	0.8%
Upper GI Disorders	816	2,068	$583,585	0.7%
GI Symptoms	1,074	2,353	$565,033	0.7%
Inflammatory Bowel Disease	75	403	$433,858	0.5%
Diverticulitis	168	405	$323,896	0.4%
Pancreatic Disorders	60	318	$299,791	0.4%
Hepatic Cirrhosis	31	196	$278,702	0.3%
Liver Diseases	348	678	$276,156	0.3%
Appendicitis	38	274	$230,596	0.3%
Ostomies	38	355	$169,853	0.2%
Constipation	238	401	$139,815	0.2%
Hemorrhoids	166	301	$101,968	0.1%
Peptic Ulcer/Related Disorders	38	57	$54,574	0.1%
Esophageal Varices	6	17	$13,886	0.0%
	----	----	$6,897,237	8.1%

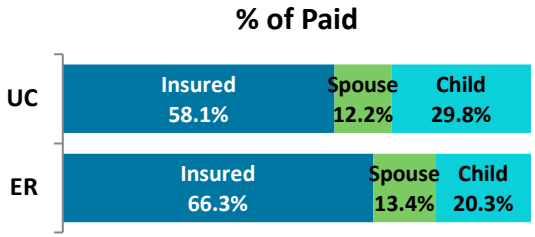
*Patient and claim counts are unique only within the category



Emergency Room / Urgent Care Summary

	PY23		PY24		Peer Index	
	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	4,216	7,180	3,865	7,179		
Visits Per Member	0.15	0.26	0.16	0.30	0.23	0.38
Visits/1000 Members	153	261	161	296	228	379
Avg Paid Per Visit	$2,409	$50	$2,535	$51	$1,085	$132
% with OV*	81.0%	78.0%	81.3%	78.2%		
% Avoidable	15.7%	41.2%	15.2%	40.1%		
Total Member Paid	**$4,955,181**	**$863,690**	**$4,775,880**	**$962,886**		
Total Plan Paid	**$10,157,383**	**$360,133**	**$9,796,429**	**$363,481**		





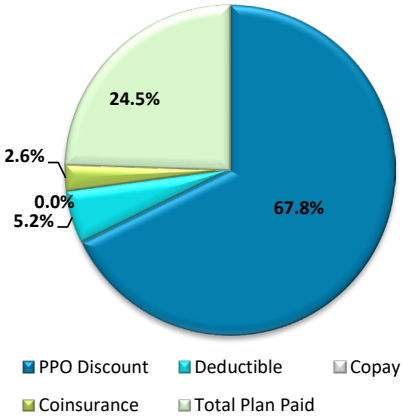
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	2,432	165	4,470	4,380	6,902	467
Spouse	447	162	797	863	1,244	450
Child	986	147	1,972	1,655	2,958	442
Total	**3,865**	**161**	**7,239**	**296**	**11,104**	**458**

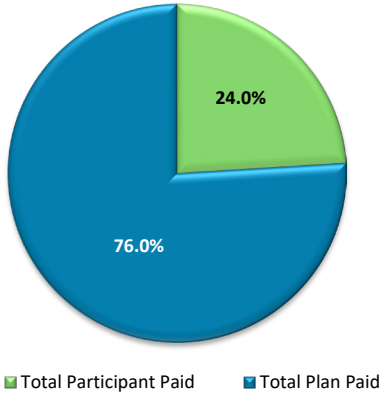
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$361,185,004	$2,037	100.0%
PPO Discount	$234,828,622	$1,324	65.0%
Deductible	$17,923,620	$101	5.0%
Copay	$368	$0	0.0%
Coinsurance	$8,903,537	$50	2.5%
Total Participant Paid	**$26,827,525**	**$151**	**7.4%**
Total Plan Paid	**$84,813,752**	**$478**	**23.5%**

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





Paid Claims by Age Range – Dental

Dental Paid Claims by Age Group												
	PY22		PY23		PY24		% Change	
Age Range	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM
<1	$ 10,139	$ 2	$ 8,515	$ 2	$ 10,999	$ 3	29.2%	40.2%
1	$ 50,347	$ 10	$ 50,274	$ 11	$ 51,004	$ 12	1.5%	8.3%
2 - 4	$ 411,560	$ 24	$ 404,140	$ 25	$ 422,480	$ 26	4.5%	4.8%
5 - 9	$ 1,237,486	$ 37	$ 1,175,803	$ 37	$ 1,236,105	$ 40	5.1%	6.1%
10 - 14	$ 1,279,857	$ 33	$ 1,295,455	$ 35	$ 1,325,552	$ 35	2.3%	1.9%
15 - 19	$ 1,442,554	$ 34	$ 1,493,927	$ 35	$ 1,827,562	$ 42	22.3%	18.4%
20 - 24	$ 919,674	$ 20	$ 879,120	$ 20	$ 1,079,634	$ 24	22.8%	21.3%
25 - 29	$ 868,582	$ 27	$ 753,936	$ 25	$ 924,119	$ 30	22.6%	18.5%
30 - 34	$ 1,140,186	$ 30	$ 996,206	$ 27	$ 1,159,253	$ 31	16.4%	13.9%
35 - 39	$ 1,360,917	$ 31	$ 1,229,651	$ 29	$ 1,429,221	$ 33	16.2%	14.0%
40 - 44	$ 1,405,195	$ 32	$ 1,382,499	$ 32	$ 1,585,061	$ 35	14.7%	10.1%
45 - 49	$ 1,465,920	$ 34	$ 1,368,193	$ 32	$ 1,603,746	$ 37	17.2%	15.6%
50 - 54	$ 1,750,235	$ 36	$ 1,731,395	$ 35	$ 1,916,051	$ 38	10.7%	8.7%
55 - 59	$ 2,018,842	$ 39	$ 1,922,113	$ 38	$ 2,152,139	$ 43	12.0%	12.0%
60 - 64	$ 2,535,229	$ 45	$ 2,332,023	$ 43	$ 2,551,166	$ 48	9.4%	10.7%
65+	$ 6,661,475	$ 48	$ 6,546,559	$ 47	$ 7,567,042	$ 55	15.6%	16.0%
Total	**$24,558,198**	**$ 36**	**$23,569,810**	**$ 35**	**$ 26,841,134**	**$ 40**	**13.9%**	**12.9%**

Dental Paid Claims – State Participants

Dental Paid Claims - Total State Participants	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 15,543,626	$ 2,149,425	$ 476,404	$ 18,169,456	$ 17,855,023	$ 2,203,968	$ 576,177	$ 20,635,168	13.6%
Dental Exchange			$ 3,365,799	$ 3,365,799	$ -	$ -	$ 3,906,600	$ 3,906,600	16.1%
Total	**$ 15,543,626**	**$ 2,149,425**	**$ 3,842,204**	**$ 21,535,255**	**$ 17,855,023**	**$ 2,203,968**	**$ 4,482,776**	**$ 24,541,767**	**29.6%**

Dental Paid Claims - Per Participant per Month	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 50	$ 52	$ 56	$ 50	$ 55	$ 55	$ 67	$ 56	11.2%
Dental Exchange	$ -	$ -	$ 49	$ 49	$ -	$ -	$ 56	$ 56	15.0%

Dental Paid Claims – Non-State Participants

Dental Paid Claims - Total Non-State Participants	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 3,733	$ 97,091	$ 207,244	$ 308,068	$ 2,945	$ 66,992	$ 230,008	$ 299,945	-2.6%
Dental Exchange			$ 1,726,487	$ 1,726,487	$ -	$ -	$ 1,999,422	$ 1,999,422	15.8%
Total	**$ 3,733**	**$ 97,091**	**$ 1,933,731**	**$ 2,034,555**	**$ 2,945**	**$ 66,992**	**$ 2,229,430**	**$ 2,299,367**	**13.0%**

Dental Paid Claims - Per Participant per Month	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 52	$ 43	$ 42	$ 42	$ 8	$ 43	$ 48	$ 44	5.0%
Dental Exchange	$ -	$ -	$ 43	$ 43	$ -	$ -	$ 52	$ 52	20.2%

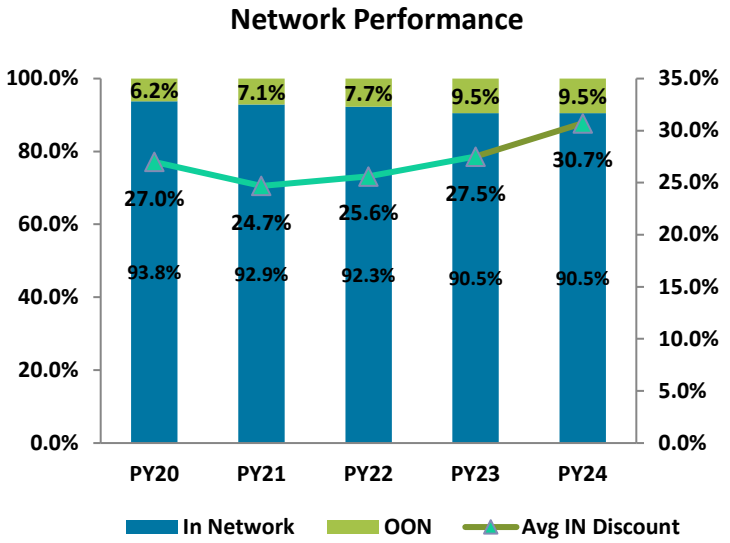
Dental Paid Claims – Total Participants

Dental Paid Claims - Total Total Participants	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 15,547,359	$ 2,246,517	$ 683,648	$ 18,477,524	$ 17,857,969	$ 2,270,960	$ 806,184	$ 20,935,113	13.3%
Dental Exchange	$ -	$ -	$ 5,092,287	$ 5,092,287	$ -	$ -	$ 5,906,022	$ 5,906,022	16.0%
Total	**$ 15,547,359**	**$ 2,246,517**	**$ 5,775,935**	**$ 23,569,810**	**$ 17,857,969**	**$ 2,270,960**	**$ 6,712,206**	**$ 26,841,134**	**13.9%**

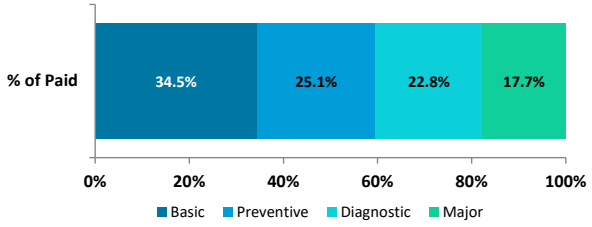
Dental Paid Claims - Per Participant per Month	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Dental	$ 50	$ 51	$ 51	$ 50	$ 55	$ 55	$ 60	$ 56	11.1%
Dental Exchange	$ -	$ -	$ 46	$ 46	$ -	$ -	$ 54	$ 54	16.9%

Dental Claims Analysis

Cost Distribution								
Paid Claims Category	Avg # of Members	% of Members	# Claims	# of Claims	Total Paid	% of Paid	Total EE Paid	% of EE Paid
$1,000.01 Plus	6,526	11.6%	42,150	30.1%	$13,145,136	49.0%	$7,124,864	62.2%
$750.01-$1,000.00	2,471	4.4%	12,298	8.8%	$2,569,190	9.6%	$1,183,329	10.3%
$500.01-$750.00	4,596	8.2%	20,430	14.6%	$3,348,266	12.5%	$1,132,624	9.9%
$250.01-$500.00	13,392	23.8%	44,142	31.5%	$5,760,781	21.5%	$1,276,003	11.1%
$0.01-$250.00	9,890	17.6%	20,074	14.3%	$2,017,761	7.5%	$709,952	6.2%
$0.00	415	0.7%	1,035	0.7%	$0	0.0%	$30,179	0.3%
No Claims	18,952	33.7%	0	0.0%	$0	0.0%	$0	0.0%
Total	**56,241**	**100.0%**	**140,129**	**100.0%**	**$26,841,134**	**100.0%**	**$11,456,952**	**100.0%**



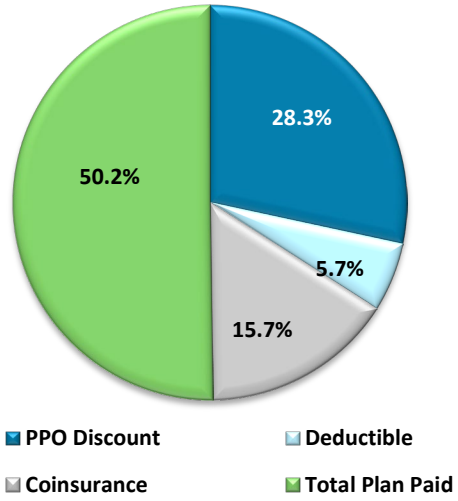
Claim Category	Total Paid	% of Paid
Basic	$9,247,280	34.5%
Preventive	$6,735,048	25.1%
Diagnostic	$6,114,860	22.8%
Major	$4,743,946	17.7%
Total	**$26,841,134**	**100.0%**

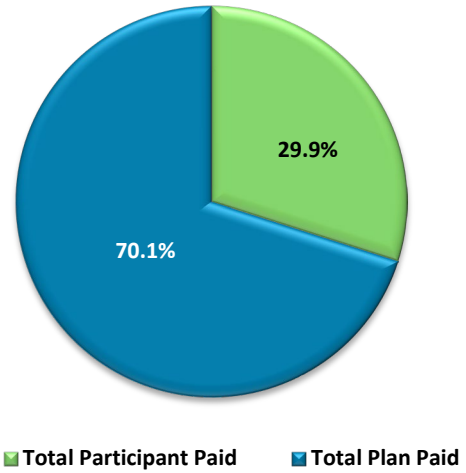


Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$53,673,718	$129	100.0%
PPO Discount	$15,150,527	$36	28.2%
Deductible	$3,038,876	$7	5.7%
Coinsurance	$8,418,076	$20	15.7%
Total Participant Paid	**$11,456,952**	**$28**	**21.3%**
Total Plan Paid	**$26,841,134**	**$64**	**50.0%**

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





Quality Metrics

Condition	Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric
Asthma	Asthma and a routine provider visit in the last 12 months	1,005	979	26	97.1%
	Two or more asthma related ER Visits in the last 6 months	1,005	2	1,003	0.3%
	Asthma related admit in last 12 months	1,005	7	998	0.8%
Chronic Obstructive Pulmonary Disease	Exacerbations in last 12 months	228	7	221	3.5%
	Members with COPD who had an annual spirometry test	228	39	189	16.6%
Congestive Heart Failure	Re-admission to hospital with Heart Failure diagnosis within 30 days following a HF inpat	10	0	10	0.0%
	ER Visit for Heart Failure in last 90 days	212	12	200	3.6%
	Follow-up OV within 4 weeks of discharge from HF admission	10	9	1	62.5%
Diabetes	Annual office visit	1,468	1,383	85	94.2%
	Annual dilated eye exam	1,468	505	963	34.5%
	Annual foot exam	1,468	671	797	45.4%
	Annual HbA1c test done	1,468	1,245	223	82.9%
	Diabetes Annual lipid profile	1,468	1,140	328	77.6%
	Annual microalbumin urine screen	1,468	1,022	446	68.2%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	4,169	3,352	817	80.4%
Hypertension	Hypertension Annual lipid profile	3,986	2,765	1,221	69.3%
	Annual serum creatinine test	3,877	3,101	776	80.0%
Wellness	Well Child Visit - 15 months	109	104	5	95.4%
	Routine office visit in last 6 months (All Ages)	24,108	14,600	9,508	60.6%
	Colorectal cancer screening ages 45-75 within the appropriate time period	10,008	5,053	4,955	50.5%
	Women age 25-65 with recommended cervical cancer/HPV screening	7,328	5,002	2,326	68.3%
	Males age greater than 49 with PSA test in last 24 months	4,031	2,013	2,018	49.9%
	Routine exam in last 24 months (All Ages)	24,108	19,831	4,277	82.3%
	Women age 40 to 75 with a screening mammogram last 24 months	6,389	3,921	2,468	61.4%

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

Chronic Conditions Prevalence

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

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

Chronic Condition	# With Condition	% of Members	Members per 1,000	Admits per 1,000	ER Visits per 1,000	PMPY
Affective Psychosis	191	0.79%	7.88	193.94	587.88	$12,034
Asthma	1,147	4.75%	47.32	129.51	462.82	$15,937
Atrial Fibrillation	290	1.20%	11.96	413.66	534.63	$30,588
Blood Disorders	1,725	7.15%	71.17	266.98	463.56	$22,141
CAD	617	2.56%	25.46	270.07	446.51	$25,252
COPD	225	0.93%	9.28	355.85	538.71	$28,138
Cancer	1,028	4.26%	42.41	219.51	276.05	$25,974
Chronic Pain	744	3.08%	30.70	179.74	551.83	$19,403
Congestive Heart Failure	210	0.87%	8.66	650.44	865.41	$39,890
Demyelinating Diseases	60	0.25%	2.48	243.83	452.83	$52,752
Depression	1,675	6.94%	69.11	132.64	445.34	$12,577
Diabetes	1,642	6.80%	67.74	141.31	295.89	$15,818
ESRD	30	0.12%	1.24	1,250.81	1,328.99	$57,572
Eating Disorders	91	0.38%	3.75	268.24	621.18	$19,662
HIV/AIDS	37	0.15%	1.53	88.24	323.53	$43,585
Hyperlipidemia	5,148	21.32%	212.39	82.86	228.18	$9,777
Hypertension	4,020	16.65%	165.86	123.91	318.58	$12,016
Immune Disorders	136	0.56%	5.61	385.77	476.06	$50,105
Inflammatory Bowel Disease	95	0.39%	3.92	143.51	507.82	$34,692
Liver Diseases	583	2.41%	24.05	302.72	520.69	$19,946
Morbid Obesity	870	3.60%	35.89	201.06	402.12	$16,623
Osteoarthritis	1,140	4.72%	47.03	119.89	381.65	$15,152
Peripheral Vascular Disease	176	0.73%	7.26	337.38	588.75	$19,802
Rheumatoid Arthritis	149	0.62%	6.15	79.14	395.68	$30,511

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

Data Includes Medical and Pharmacy
Based on 24 months incurred dates

Methodology

- Average member counts were weighted by the number of months each member had on the plan.
- Claims were pulled based upon the date paid.
- Claims were categorized based upon four groups:
  - Inpatient Facility
  - Outpatient Facility
  - Physician
  - Other (Other includes any medical reimbursements or durable medical equipment.)
- Inpatient analysis was done by identifying facility claims where a room and board charge was submitted and paid. Claims were then rolled up for the entire admission and categorized by the diagnosis code that held the highest paid amount. (Hospice and skilled nursing facility claims were excluded)
- Outpatient claims were flagged by an in-or-outpatient indicator being present on the claim that identified it as taking place at an outpatient facility.
- Physician claims were identified when the vendor type indicator was flagged as a professional charge.
  - These claims were in some cases segregated further to differentiate primary care physicians and specialists.
  - Office visits were identified by the presence of evaluation and management or consultation codes.
- Emergency room and urgent care episodes should be considered subcategories of physician and outpatient facility.
  - Emergency Room visits are identified by facility claims with a revenue code of 450-455, 457-459.
  - Urgent Care visits are identified by facility claims with a revenue code of 456 or physician claims with a place of service of “Urgent Care”.
  - Outpatient claims (including facility and physician) are then rolled up for the day of service and summarized as an ER/UC visit.
  - If a member has an emergency room visit on the same day as an urgent care visit, all claims are grouped into one episode and counted as an emergency room visit.
  - If a member was admitted into the hospital through the ER, the member will not show an ER visit. ER claims are bundled with the inpatient stay.

Appendix B

Index of Tables
UMR Inc. – LDPPO Utilization Review for PEBP
July 1, 2023 – June 30, 2024

DATASCOPE™

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

UMR℠

Overview

- Total Medical Spend for PY24 was $83,671,713 with a plan cost per employee per year (PEPY) of $8,381. This is an increase of 10.2% when compared to PY23.
  - IP Cost per Admit is $24,743 which is 1.1% higher than PY23.
  - ER Cost per Visit is $3,289 which is 5.2% higher than PY23.
- Employees shared in 13.3% of the medical cost.
- Inpatient facility costs were 20.1% of the plan spend.
- 74.9% of the Average Membership had paid Medical claims less than $2,500, with 13.8% of those having no claims paid at all during the reporting period.
- 91 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 24.2% of the plan spend. The highest diagnosis category was Cancer, accounting for 25.7% of the high-cost claimant dollars.
- Total spending with in-network providers was 97.8%. The average In Network discount was 65.7%, which is 2.2% higher than the PY23 average discount of 64.3%.

Paid Claims by Age Group

Paid Claims by Age Group																		
	PY23						PY24						% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 2,501,778	$ 1,345	$ 32,538	$ 17	$ 2,534,316	$ 1,363	$ 5,873,049	$ 2,438	$ 21,608	$ 9	$ 5,894,657	$ 2,447	132.6%	79.6%
1	$ 504,661	$ 279	$ 9,018	$ 5	$ 513,679	$ 283	$ 725,917	$ 300	$ 5,780	$ 2	$ 731,697	$ 302	42.4%	6.5%
2 - 4	$ 1,075,154	$ 167	$ 44,756	$ 7	$ 1,119,910	$ 174	$ 1,221,076	$ 149	$ 39,843	$ 5	$ 1,260,919	$ 153	12.6%	-12.3%
5 - 9	$ 1,037,022	$ 88	$ 510,021	$ 43	$ 1,547,043	$ 131	$ 1,938,022	$ 126	$ 612,277	$ 40	$ 2,550,299	$ 166	64.8%	26.6%
10 - 14	$ 1,613,381	$ 127	$ 339,379	$ 27	$ 1,952,760	$ 154	$ 2,385,670	$ 144	$ 444,775	$ 27	$ 2,830,445	$ 171	44.9%	11.2%
15 - 19	$ 2,490,501	$ 170	$ 529,723	$ 36	$ 3,020,224	$ 207	$ 3,500,078	$ 180	$ 833,803	$ 43	$ 4,333,880	$ 223	43.5%	7.9%
20 - 24	$ 2,780,617	$ 200	$ 738,589	$ 53	$ 3,519,206	$ 253	$ 4,261,497	$ 233	$ 1,234,084	$ 67	$ 5,495,581	$ 300	56.2%	18.5%
25 - 29	$ 2,528,215	$ 226	$ 1,176,813	$ 105	$ 3,705,028	$ 331	$ 4,297,532	$ 275	$ 1,872,936	$ 120	$ 6,170,468	$ 395	66.5%	19.2%
30 - 34	$ 3,957,289	$ 299	$ 1,404,659	$ 106	$ 5,361,948	$ 405	$ 5,278,283	$ 289	$ 3,392,460	$ 186	$ 8,670,743	$ 475	61.7%	17.4%
35 - 39	$ 4,229,494	$ 282	$ 1,497,515	$ 100	$ 5,727,009	$ 381	$ 6,401,843	$ 323	$ 2,960,313	$ 149	$ 9,362,156	$ 472	63.5%	23.8%
40 - 44	$ 4,705,186	$ 320	$ 2,080,302	$ 142	$ 6,785,488	$ 462	$ 6,954,167	$ 350	$ 3,344,676	$ 168	$ 10,298,843	$ 518	51.8%	12.2%
45 - 49	$ 4,940,717	$ 383	$ 2,240,868	$ 174	$ 7,181,585	$ 556	$ 5,933,745	$ 346	$ 3,713,379	$ 217	$ 9,647,124	$ 563	34.3%	1.2%
50 - 54	$ 5,958,170	$ 422	$ 2,958,706	$ 209	$ 8,916,876	$ 631	$ 8,587,672	$ 446	$ 5,379,646	$ 279	$ 13,967,319	$ 725	56.6%	14.8%
55 - 59	$ 6,680,393	$ 527	$ 2,758,808	$ 218	$ 9,439,201	$ 744	$ 9,990,828	$ 585	$ 4,611,103	$ 270	$ 14,601,931	$ 855	54.7%	14.9%
60 - 64	$ 8,807,144	$ 790	$ 3,625,065	$ 325	$ 12,432,209	$ 1,115	$ 10,957,617	$ 744	$ 5,076,252	$ 344	$ 16,033,869	$ 1,088	29.0%	-2.4%
65+	$ 2,188,054	$ 511	$ 1,051,053	$ 245	$ 3,239,107	$ 756	$ 5,364,717	$ 911	$ 2,057,554	$ 349	$ 7,422,270	$ 1,261	129.1%	66.8%
Total	**$ 55,997,776**	**$ 325**	**$ 20,997,812**	**$ 122**	**$ 76,995,588**	**$ 447**	**$ 83,671,713**	**$ 363**	**$ 35,600,489**	**$ 154**	**$ 119,272,202**	**$ 518**	**54.9%**	**15.9%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**
Average Enrollment												
Employees	4,336	7,362	9,984	35.6%	3,926	6,690	9,134	36.5%	1	1	1	25.0%
Spouses	1,172	5,149	2,435	-52.7%	1,042	4,901	2,166	-55.8%	1	0	1	0.0%
Children	3,255	1,857	6,786	265.5%	3,103	1,645	6,475	293.7%	0	1	0	-100.0%
Total Members	8,762	14,368	19,205	33.7%	8,071	13,235	17,775	34.3%	2	2	3	25.0%
Family Size	2.0	2.0	1.9	-1.5%	2.1	2.0	2.0	-1.5%	2.0	2.0	2.0	0.0%
Financial Summary												
Gross Cost	$40,570,436	$64,817,531	$96,559,363	49.0%	$35,366,785	$56,350,280	$84,790,434	50.5%	$38,494	$17,911	$35,717	99.4%
Client Paid	$34,446,692	$55,997,776	$83,671,713	49.4%	$29,933,591	$48,495,839	$73,198,110	50.9%	$33,556	$13,953	$28,750	106.0%
Employee Paid	$6,123,744	$8,819,755	$12,887,650	46.1%	$5,433,194	$7,854,441	$11,592,324	47.6%	$4,938	$3,958	$6,966	76.0%
Client Paid-PEPY	$7,944	$7,606	$8,381	10.2%	$7,624	$7,249	$8,013	10.5%	$33,556	$13,953	$23,000	64.8%
Client Paid-PMPY	$3,931	$3,897	$4,357	11.8%	$3,709	$3,664	$4,118	12.4%	$16,778	$6,976	$11,500	64.9%
Client Paid-PEPM	$662	$634	$698	10.1%	$635	$604	$668	10.6%	$2,796	$1,163	$1,917	64.8%
Client Paid-PMPM	$328	$325	$363	11.7%	$309	$305	$343	12.5%	$1,398	$581	$958	64.9%
High Cost Claimants (HCC's) > $100k												
# of HCC's	41	54	91	68.5%	33	43	75	74.4%	0	0	0	0.0%
HCC's / 1,000	4.7	3.8	4.7	26.1%	4.1	3.3	4.2	29.8%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$286,071	$238,672	$222,339	-6.8%	$305,172	$238,047	$217,806	-8.5%	$0	$0	$0	0.0%
HCC's % of Plan Paid	34.0%	23.0%	24.2%	5.2%	33.6%	21.1%	22.3%	5.7%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,269	$783	$778	-0.6%	$1,257	$725	$758	4.6%	$424	$0	$0	0.0%
Facility Outpatient	$1,043	$1,412	$1,708	21.0%	$933	$1,292	$1,558	20.6%	$5,152	$1,007	$1,281	27.2%
Physician	$1,567	$1,702	$1,871	9.9%	$1,468	$1,647	$1,802	9.4%	$9,883	$5,969	$10,219	71.2%
Other	$53	$0	$0	0.0%	$50	$0	$0	0.0%	$1,319	$0	$0	0.0%
Total	$3,931	$3,897	$4,357	11.8%	$3,709	$3,664	$4,118	12.4%	$16,778	$6,976	$11,500	64.9%

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	388	644	820	27.3%	21	27	28	6.6%	
Spouses	118	248	256	3.1%	11	0	12	7252.9%	
Children	152	199	310	55.9%	0	13	1	-92.0%	
Total Members	657	1,091	1,386	27.0%	32	39	42	5.9%	
Family Size	1.7	1.7	1.7	0.0%	1.5	1.5	1.5	-0.7%	1.6
Financial Summary									
Gross Cost	$4,886,927	$8,012,597	$11,406,410	42.4%	$278,229	$436,743	$326,803	-25.2%	
Client Paid	$4,252,910	$7,107,682	$10,192,079	43.4%	$226,635	$380,303	$252,774	-33.5%	
Employee Paid	$634,017	$904,915	$1,214,330	34.2%	$51,594	$56,440	$74,029	31.2%	
Client Paid-PEPY	$10,968	$11,032	$12,429	12.7%	$10,665	$14,261	$8,895	-37.6%	$6,258
Client Paid-PMPY	$6,473	$6,514	$7,355	12.9%	$7,027	$9,669	$6,067	-37.3%	$3,830
Client Paid-PEPM	$914	$919	$1,036	12.7%	$889	$1,188	$741	-37.6%	$521
Client Paid-PMPM	$539	$543	$613	12.9%	$586	$806	$506	-37.2%	$319
High Cost Claimants (HCC's) > $100k									
# of HCC's	8	11	17	54.5%	1	1	1	0.0%	
HCC's / 1,000	12.2	10.1	12.3	21.7%	31.0	25.4	24.0	-5.6%	
Avg HCC Paid	$193,399	$224,298	$222,814	-0.7%	$111,053	$185,019	$109,572	-40.8%	
HCC's % of Plan Paid	36.4%	34.7%	37.2%	7.2%	49.0%	48.7%	43.3%	-11.1%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,452	$1,476	$985	-33.3%	$675	$1,128	$2,544	125.5%	$1,044
Facility Outpatient	$2,262	$2,697	$3,626	34.4%	$3,333	$6,277	$1,721	-72.6%	$1,310
Physician	$2,676	$2,342	$2,744	17.2%	$2,969	$2,264	$1,802	-20.4%	$1,404
Other	$83	$0	$0	0.0%	$50	$0	$0	0.0%	$72
Total	$6,473	$6,514	$7,355	12.9%	$7,027	$9,669	$6,067	-37.3%	$3,830

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 11,601,072	$ 1,731,651	$ 34,322	$ 13,367,044	$ 16,054,962	$ 1,625,676	$ 69,021	$ 17,749,659	32.8%
Outpatient	$ 36,894,767	$ 5,134,903	$ 206,807	$ 42,236,477	$ 57,143,147	$ 8,126,721	$ 370,661	$ 65,640,530	55.4%
Total - Medical	**$ 48,495,839**	**$ 6,866,553**	**$ 241,129**	**$ 55,603,521**	**$ 73,198,110**	**$ 9,752,397**	**$ 439,682**	**$ 83,390,189**	**50.0%**

Net Paid Claims - Per Participant per Month	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 604	$ 952	$ 467	$ 632	$ 668	$ 1,071	$ 598	$ 698	10.5%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 48,492	$ 564	$ 49,056			$ 106,871	$ 106,871	0.0%
Outpatient	$ 13,953	$ 114,559	$ 216,688	$ 345,200	$ 28,750	$ 36,286	$ 109,617	$ 174,653	-49.4%
Total - Medical	**$ 13,953**	**$ 163,051**	**$ 217,252**	**$ 394,256**	**$ 28,750**	**$ 36,286**	**$ 216,488**	**$ 281,525**	**-28.6%**

Net Paid Claims - Per Participant per Month	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 1,163	$ 1,052	$ 1,317	$ 1,188	$ 1,917	$ 324	$ 946	$ 791	-33.4%

Paid Claims by Claim Type – Total Participants

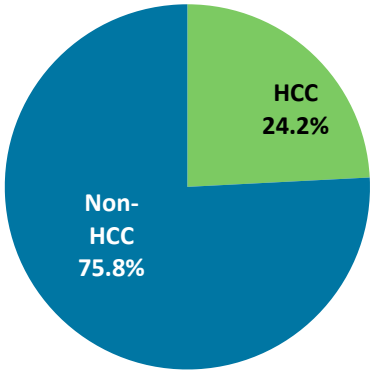
Net Paid Claims - Total Total Participants	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 11,601,072	$ 1,780,142	$ 34,886	$ 13,416,100	$ 16,054,962	$ 1,625,676	$ 175,892	$ 17,856,530	33.1%
Outpatient	$ 36,908,720	$ 5,249,462	$ 423,495	$ 42,581,676	$ 57,171,898	$ 8,163,007	$ 480,279	$ 65,815,183	54.6%
Total - Medical	**$ 48,509,792**	**$ 7,029,604**	**$ 458,381**	**$ 55,997,776**	**$ 73,226,860**	**$ 9,788,683**	**$ 656,171**	**$ 83,671,713**	**49.4%**

Net Paid Claims - Per Participant per Month	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 604	$ 954	$ 673	$ 634	$ 668	$ 1,062	$ 681	$ 698	10.2%

Cost Distribution – Medical Claims

PY23							PY24					
Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid	Paid Claims Category	Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
47	0.3%	$12,789,533	22.8%	$211,287	2.4%	$100,000.01 Plus	80	0.4%	$20,232,451	24.2%	$386,848	3.0%
81	0.6%	$6,325,231	11.3%	$361,408	4.1%	$50,000.01-$100,000.00	121	0.6%	$9,054,493	10.8%	$492,196	3.8%
198	1.4%	$7,156,895	12.8%	$756,235	8.6%	$25,000.01-$50,000.00	317	1.6%	$11,545,111	13.8%	$1,180,426	9.2%
638	4.4%	$10,590,927	18.9%	$1,838,747	20.8%	$10,000.01-$25,000.00	932	4.9%	$15,393,947	18.4%	$2,734,238	21.2%
830	5.8%	$6,225,819	11.1%	$1,559,993	17.7%	$5,000.01-$10,000.00	1,333	6.9%	$9,890,548	11.8%	$2,304,274	17.9%
1,454	10.1%	$5,554,427	9.9%	$1,625,903	18.4%	$2,500.01-$5,000.00	2,025	10.5%	$7,684,735	9.2%	$2,263,524	17.6%
8,922	62.1%	$7,354,945	13.1%	$2,460,696	27.9%	$0.01-$2,500.00	11,570	60.2%	$9,870,428	11.8%	$3,505,812	27.2%
90	0.6%	$0	0.0%	$5,487	0.1%	$0.00	176	0.9%	$0	0.0%	$20,332	0.2%
2,108	14.7%	$0	0.0%	$0	0.0%	No Claims	2,652	13.8%	$0	0.0%	$0	0.0%
14,368	**100.0%**	**$55,997,776**	**100.0%**	**$8,819,755**	**100.0%**		**19,205**	**100.0%**	**$83,671,713**	**100.0%**	**$12,887,650**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High-Cost Claimant over $100K

HCC's by Diagnosis Grouper			
Top 10 Diagnosis Groupers	**Patients**	**Total Paid**	**% Paid**
Cancer	37	$5,204,938	25.7%
Neurological Disorders	49	$3,087,572	15.3%
Cardiac Disorders	55	$2,471,722	12.2%
Pregnancy-related Disorders	14	$1,703,646	8.4%
Gastrointestinal Disorders	59	$1,066,454	5.3%
Pulmonary Disorders	56	$989,945	4.9%
Endocrine/Metabolic Disorders	36	$946,564	4.7%
Trauma/Accidents	26	$685,725	3.4%
Spine-related Disorders	24	$633,138	3.1%
Renal/Urologic Disorders	32	$480,006	2.4%
All Other		$2,963,175	14.6%
Overall	**----**	**$20,232,885**	**100.0%**

Utilization Summary (p. 1 of 2)

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

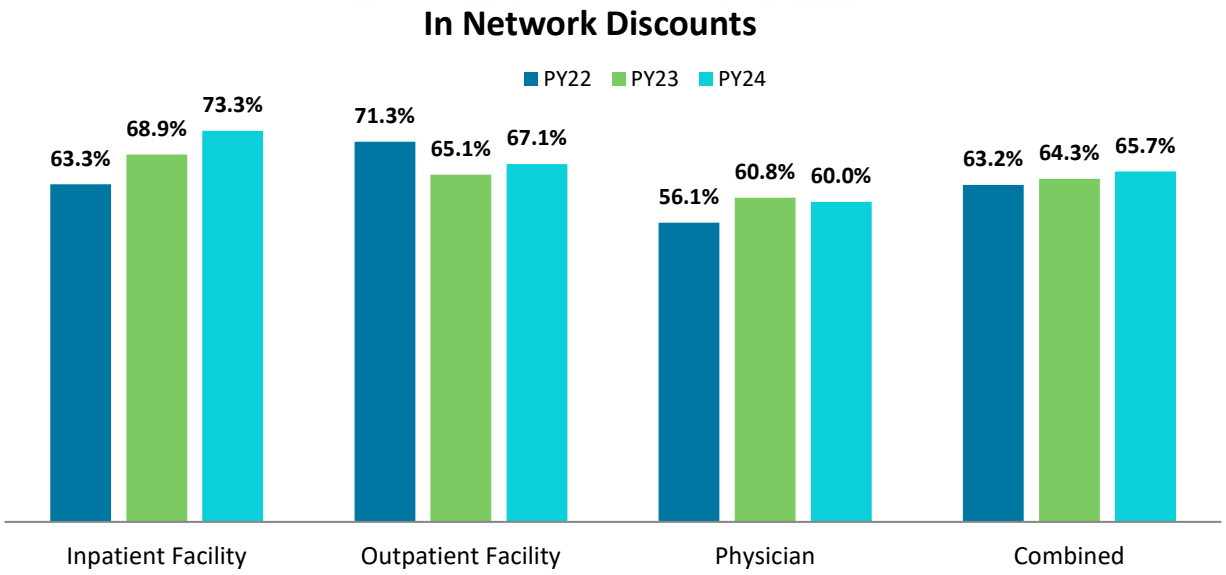
	Total				State Active				Non-State Active			
Summary	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**
Inpatient Facility												
# of Admits	318	551	739		275	498	685		1	0	0	
# of Bed Days	1,769	2,359	3,784		1,628	2,125	3,395		1	0	0	
Paid Per Admit	$37,589	$24,480	$24,743	1.1%	$38,947	$23,382	$24,070	2.9%	$2,303	$0	$0	0.0%
Paid Per Day	$6,757	$5,718	$4,832	-15.5%	$6,579	$5,480	$4,857	-11.4%	$2,303	$0	$0	0.0%
Admits Per 1,000	36	38	38	0.0%	34	38	39	2.6%	500	0	0	0.0%
Days Per 1,000	202	164	197	20.1%	202	161	191	18.6%	500	0	0	0.0%
Avg LOS	5.6	4.3	5.1	18.6%	5.9	4.3	5	16.3%	1	0	0	0.0%
# Admits From ER	164	266	399	50.0%	136	231	365	58.0%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	4.7	5.1	5.6	9.8%	4.6	5	5.5	10.0%	13.0	13.5	10.0	-25.9%
Avg Paid per OV	$124	$118	$121	2.5%	$120	$118	$120	1.7%	$335	$320	$490	53.1%
Avg OV Paid per Member	$589	$601	$681	13.3%	$549	$583	$662	13.6%	$4,351	$4,315	$4,902	13.6%
DX&L Utilization per Member	8.1	10.3	10.8	4.9%	7.8	9.9	10.5	6.1%	27.5	30	28.8	-4.0%
Avg Paid per DX&L	$51	$60	$66	10.0%	$49	$59	$63	6.8%	$94	$54	$110	103.7%
Avg DX&L Paid per Member	$419	$618	$710	14.9%	$382	$583	$657	12.7%	$2,574	$1,628	$3,167	94.5%
Emergency Room												
# of Visits	1,170	2,129	3,192		1,090	1,957	2,950		1	0	1	
Visits Per Member	0.13	0.15	0.17	13.3%	0.14	0.15	0.17	13.3%	0.5	0	0.4	0.0%
Visits Per 1,000	134	148	166	12.2%	135	148	166	12.2%	500	0	400	0.0%
Avg Paid per Visit	$2,440	$3,126	$3,289	5.2%	$2,425	$3,152	$3,251	3.1%	$5,209	$0	$1,817	0.0%
Urgent Care												
# of Visits	2,734	5,111	7,164		2,578	4,843	6,754		0	3	2	
Visits Per Member	0.31	0.36	0.36	0.0%	0.32	0.37	0.38	2.7%	0.00	1.50	0.80	-46.7%
Visits Per 1,000	312	356	364	2.2%	319	366	380	3.8%	0	1,500	800	-46.7%
Avg Paid per Visit	$120	$98	$107	9.2%	$119	$98	$107	9.2%	$0	$159	$170	6.9%

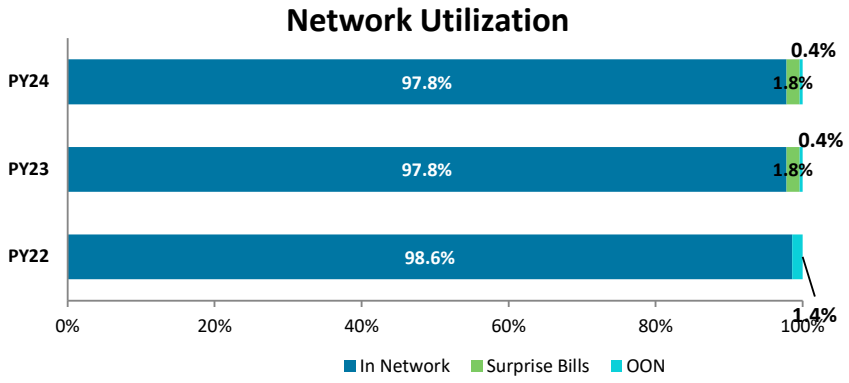
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**Peer Index**
Inpatient Facility									
# of Admits	35	52	52		7	1	2		
# of Bed Days	119	231	374		21	3	15		
Paid Per Admit	$33,826	$34,536	$33,079	-4.2%	$8,120	$48,492	$38,349	-20.9%	$19,305
Paid Per Day	$9,949	$7,774	$4,599	-40.8%	$2,707	$16,164	$5,113	-68.4%	$3,615
Admits Per 1,000	53	48	38	-20.8%	217	25	48	92.0%	64
Days Per 1,000	181	212	270	27.4%	651	76	360	373.7%	342
Avg LOS	3.4	4.4	7.2	63.6%	3.0	3.0	7.5	150.0%	5.3
# Admits From ER	24	35	33	-5.7%	4	0	1	0.0%	
Physician Office									
OV Utilization per Member	6.4	6.7	6.8	1.5%	7.5	8.1	9.1	12.3%	5.2
Avg Paid per OV	$166	$120	$132	10.0%	$96	$89	$98	10.1%	$97
Avg OV Paid per Member	$1,059	$802	$904	12.7%	$721	$719	$898	24.9%	$502
DX&L Utilization per Member	12.5	14.9	14.6	-2.0%	12.3	19.9	22	10.6%	9.0
Avg Paid per DX&L	$67	$69	$95	37.7%	$78	$68	$43	-36.8%	$46
Avg DX&L Paid per Member	$835	$1,020	$1,382	35.5%	$954	$1,361	$957	-29.7%	$412
Emergency Room									
# of Visits	78	166	228		1	6	13		
Visits Per Member	0.12	0.15	0.16	6.7%	0.03	0.15	0.31	106.7%	0.23
Visits Per 1,000	119	152	165	8.6%	31	153	312	103.9%	228
Avg Paid per Visit	$2,622	$2,895	$3,719	28.5%	$1,827	$961	$4,509	369.2%	$1,035
Urgent Care									
# of Visits	154	254	402		2	11	6		
Visits Per Member	0.23	0.23	0.29	26.1%	0.06	0.28	0.14	-50.0%	0.38
Visits Per 1,000	234	233	290	24.5%	62	280	144	-48.6%	379
Avg Paid per Visit	$143	$100	$104	4.0%	$70	$64	$38	-40.6%	$132

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Gastrointestinal Disorders	$7,319,784	8.7%	$4,829,374	$1,288,460	$1,201,950	$2,619,808	$4,699,976
Cancer	$7,006,433	8.4%	$4,614,687	$2,383,071	$8,675	$3,107,425	$3,899,009
Health Status/Encounters	$6,505,125	7.8%	$3,636,811	$970,316	$1,897,998	$2,033,403	$4,471,722
Cardiac Disorders	$6,353,152	7.6%	$3,880,285	$1,713,094	$759,772	$2,531,207	$3,821,944
Mental Health	$6,297,625	7.5%	$2,914,634	$503,918	$2,879,072	$2,226,247	$4,071,377
Pregnancy-related Disorders	$6,229,241	7.4%	$2,368,342	$1,156,732	$2,704,166	$1,363,977	$4,865,264
Neurological Disorders	$6,068,107	7.3%	$2,593,265	$644,881	$2,829,961	$3,330,687	$2,737,420
Musculoskeletal Disorders	$4,752,155	5.7%	$3,242,813	$953,193	$556,148	$1,860,483	$2,891,671
Trauma/Accidents	$4,218,886	5.0%	$2,161,808	$454,697	$1,602,382	$2,345,196	$1,873,690
Eye/ENT Disorders	$4,011,254	4.8%	$2,190,510	$597,871	$1,222,873	$1,708,644	$2,302,610
Spine-related Disorders	$3,277,548	3.9%	$2,422,354	$693,659	$161,535	$1,474,454	$1,803,094
Pulmonary Disorders	$3,264,008	3.9%	$1,412,739	$829,949	$1,021,320	$1,954,003	$1,310,004
Gynecological/Breast Disorders	$3,064,664	3.7%	$2,089,128	$613,650	$361,886	$102,019	$2,962,645
Endocrine/Metabolic Disorders	$3,027,136	3.6%	$2,522,860	$306,292	$197,985	$876,295	$2,150,841
Renal/Urologic Disorders	$2,535,448	3.0%	$1,716,869	$477,544	$341,035	$1,359,220	$1,176,229
Infections	$1,789,633	2.1%	$1,040,012	$366,243	$383,378	$914,297	$875,336
Non-malignant Neoplasm	$1,226,926	1.5%	$931,560	$191,640	$103,726	$225,153	$1,001,773
Miscellaneous	$927,004	1.1%	$532,871	$176,920	$217,213	$374,079	$552,925
Dermatological Disorders	$917,802	1.1%	$512,439	$200,890	$204,473	$363,494	$554,308
Diabetes	$816,338	1.0%	$533,853	$119,448	$163,036	$394,879	$421,459
Medical/Surgical Complications	$737,885	0.9%	$439,975	$128,827	$169,083	$382,267	$355,618
Abnormal Lab/Radiology	$701,081	0.8%	$541,093	$117,592	$42,395	$250,687	$450,395
Vascular Disorders	$643,847	0.8%	$542,911	$85,861	$15,076	$265,446	$378,401
Congenital/Chromosomal Anomalies	$617,906	0.7%	$188,512	$50,506	$378,888	$277,554	$340,352
Medication Related Conditions	$438,262	0.5%	$86,834	$278,636	$72,792	$42,214	$396,047
Hematological Disorders	$435,753	0.5%	$350,413	$40,903	$44,436	$142,121	$293,632
Cholesterol Disorders	$228,261	0.3%	$180,996	$41,796	$5,469	$105,541	$122,720
Dental Conditions	$126,259	0.2%	$89,029	$12,080	$25,151	$24,758	$101,501
Allergic Reaction	$102,770	0.1%	$39,003	$11,397	$52,371	$21,829	$80,941
External Hazard Exposure	$29,652	0.0%	$18,599	$999	$10,054	$20,381	$9,272
Social Determinants of Health	$886	0.0%	$270	$139	$477	$133	$752
Cause of Morbidity	$882	0.0%	$109	$109	$664	$109	$773
Total	**$83,671,713**	**100.0%**	**$48,624,959**	**$15,411,314**	**$19,635,441**	**$32,698,011**	**$50,973,703**

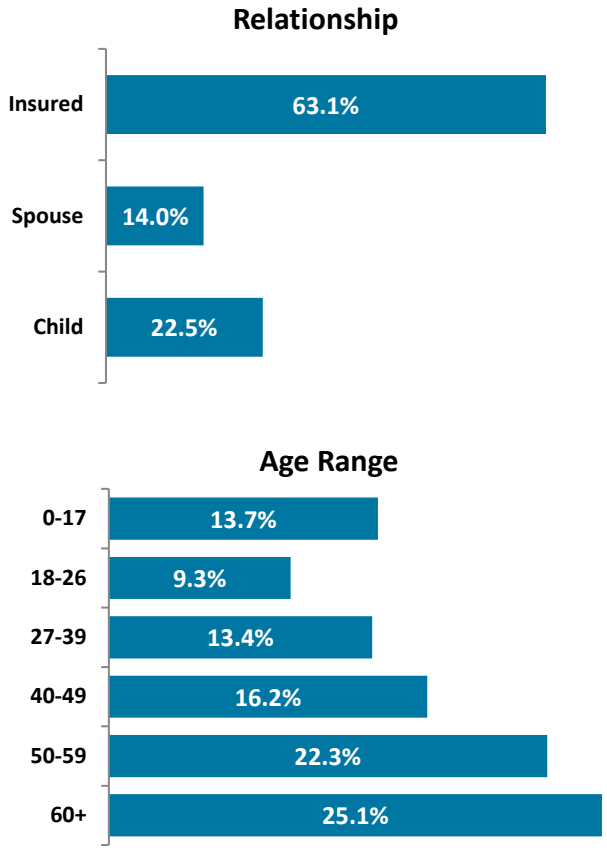
Mental Health Drilldown

	PY22		PY23		PY24	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	453	$568,975	883	$898,381	1,358	$1,739,453
Mood and Anxiety Disorders	613	$271,735	1,144	$681,784	1,753	$1,013,421
Mental Health Conditions, Other	431	$351,519	805	$558,645	1,271	$933,549
Developmental Disorders	59	$215,640	108	$250,524	163	$852,020
Alcohol Abuse/Dependence	20	$75,926	77	$344,280	104	$417,809
Bipolar Disorder	107	$247,201	189	$253,234	282	$266,830
Attention Deficit Disorder	199	$80,894	414	$132,119	692	$236,319
Eating Disorders	24	$147,776	44	$141,298	62	$250,458
Sexually Related Disorders	28	$8,553	55	$30,340	78	$218,527
Schizophrenia	4	$2,259	12	$47,488	14	$164,945
Substance Abuse/Dependence	29	$68,285	51	$34,292	64	$53,163
Sleep Disorders	124	$26,517	242	$63,421	344	$62,221
Psychoses	6	$10,965	17	$18,602	15	$46,121
Complications of Substance Abuse	6	$27,466	13	$3,466	20	$15,687
Personality Disorders	14	$15,495	17	$12,003	36	$19,676
Tobacco Use Disorder	16	$4,458	54	$3,385	105	$7,425
Total		**$2,123,665**		**$3,473,262**		**$6,297,625**

Diagnosis Grouper – Gastrointestinal Orders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Abdominal Disorders	1,555	3,833	$1,331,137	1.6%
GI Disorders, Other	870	2,041	$1,046,475	1.3%
Gallbladder and Biliary Disease	169	779	$1,041,635	1.2%
Hernias	172	475	$853,191	1.0%
Upper GI Disorders	759	1,838	$702,125	0.8%
GI Symptoms	1,105	2,214	$664,318	0.8%
Inflammatory Bowel Disease	88	490	$344,397	0.4%
Appendicitis	30	199	$307,030	0.4%
Constipation	300	576	$198,722	0.2%
Pancreatic Disorders	45	197	$150,262	0.2%
Diverticulitis	133	283	$137,877	0.2%
Hemorrhoids	196	367	$127,549	0.2%
Liver Diseases	323	608	$120,261	0.1%
Ostomies	22	148	$97,896	0.1%
Hepatic Cirrhosis	22	77	$89,525	0.1%
Peptic Ulcer/Related Disorders	26	43	$78,111	0.1%
Esophageal Varices	4	19	$29,271	0.0%
	----	----	$7,319,784	8.7%

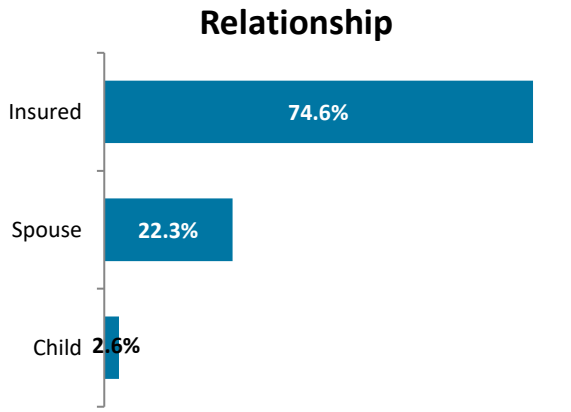
*Patient and claim counts are unique only within the category

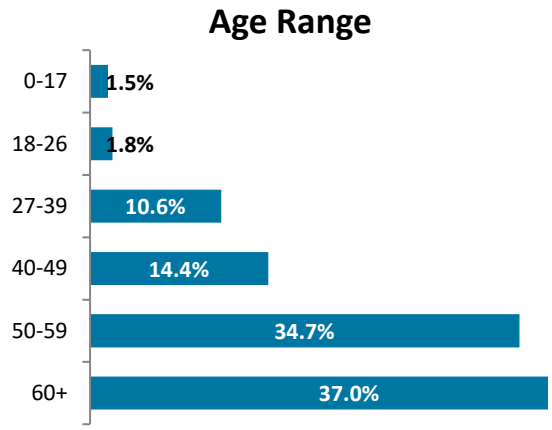


Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	41	234	$2,405,495	2.9%
Breast Cancer	107	1,254	$1,236,262	1.5%
Colon Cancer	16	480	$644,274	0.8%
Cancers, Other	76	561	$470,348	0.6%
Prostate Cancer	50	384	$382,898	0.5%
Lymphomas	30	341	$378,954	0.5%
Secondary Cancers	33	275	$331,299	0.4%
Pancreatic Cancer	4	88	$278,427	0.3%
Non-Melanoma Skin Cancers	135	363	$191,005	0.2%
Carcinoma in Situ	49	188	$107,885	0.1%
Myeloproliferative Neoplasms	26	275	$103,976	0.1%
Kidney Cancer	12	52	$97,823	0.1%
Thyroid Cancer	41	247	$94,849	0.1%
Lung Cancer	8	205	$86,512	0.1%
Melanoma	24	106	$76,139	0.1%
Cervical/Uterine Cancer	15	101	$74,701	0.1%
Brain Cancer	6	119	$27,002	0.0%
Ovarian Cancer	5	21	$8,678	0.0%
Myeloma	4	17	$5,316	0.0%
Bladder Cancer	4	16	$4,591	0.0%
Overall	**----**	**----**	**$7,006,433**	**8.4%**

*Patient and claim counts are unique only within the category

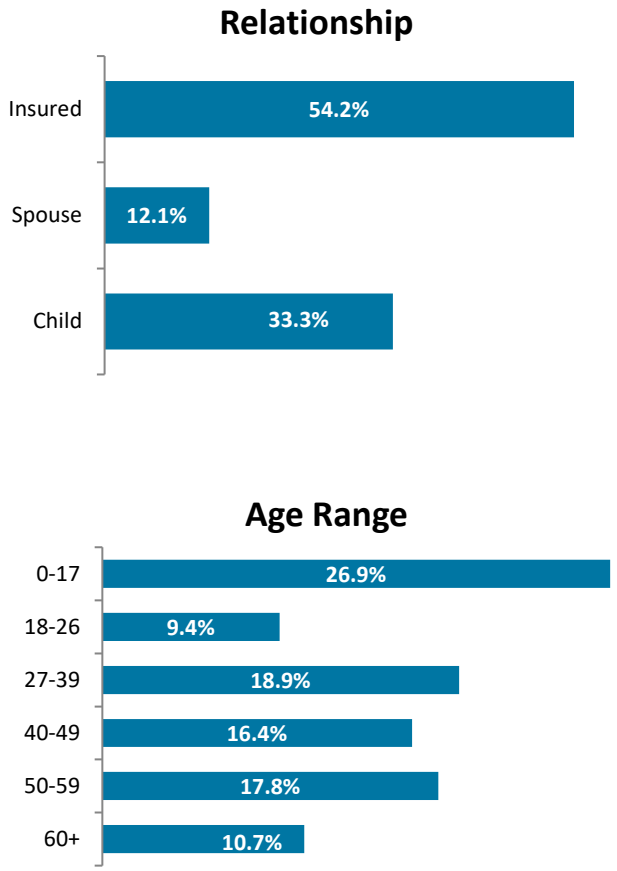




Diagnosis Grouper – Health Status/Encounters

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Screenings	5,708	11,831	$2,019,915	2.4%
Exams	7,369	14,422	$1,610,875	1.9%
Prophylactic Measures	3,578	4,884	$1,073,093	1.3%
Encounters - Infants/Children	3,019	4,793	$728,280	0.9%
Personal History of Condition	753	1,255	$225,217	0.3%
Counseling	738	2,781	$198,033	0.2%
Prosthetics/Devices/Implants	230	853	$187,678	0.2%
Aftercare	311	533	$153,426	0.2%
Family History of Condition	216	316	$148,883	0.2%
Acquired Absence	57	105	$44,523	0.1%
Encounter - Procedure	69	82	$38,060	0.0%
Encounter - Transplant Related	22	187	$37,319	0.0%
Follow-Up Encounters	3	17	$25,795	0.0%
Health Status, Other	97	133	$6,247	0.0%
Lifestyle/Situational Issues	74	115	$5,713	0.0%
Miscellaneous Examinations	30	51	$1,775	0.0%
Donors	4	4	$224	0.0%
Blood Type	2	2	$68	0.0%
Overall	**----**	**----**	**$6,505,057**	**7.8%**

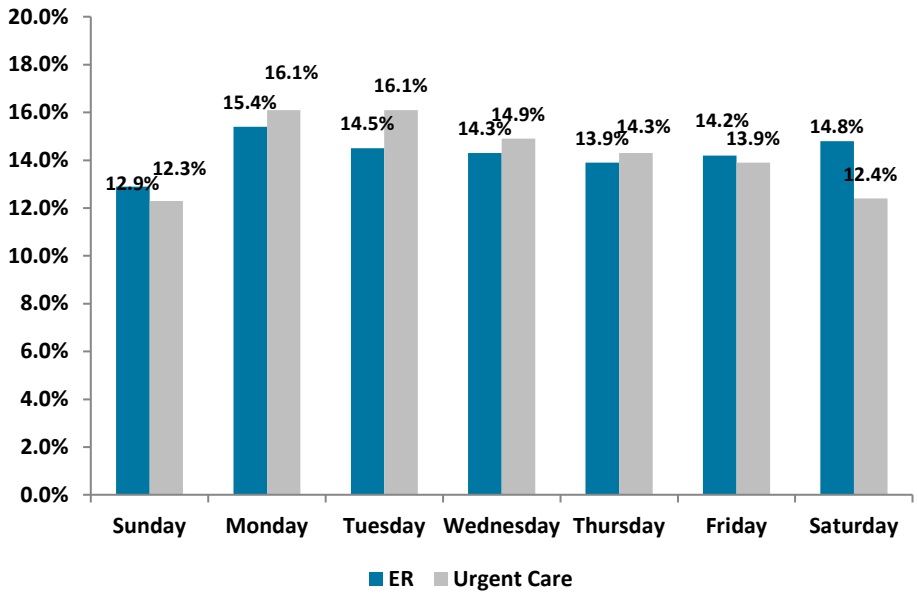
*Patient and claim counts are unique only within the category



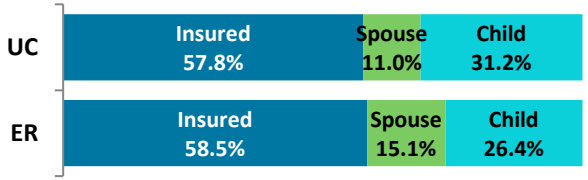
Emergency Room / Urgent Care Summary

	PY23		PY24		Peer Index	
ER/Urgent Care	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	2,129	5,111	3,192	7,164		
Visits Per Member	0.15	0.36	0.16	0.36	0.23	0.38
Visits/1000 Members	148	356	162	364	228	379
Avg Paid Per Visit	$3,126	$98	$3,289	$107	$1,085	$132
% with OV*	82.2%	76.7%	82.5%	80.1%		
% Avoidable	15.4%	43.2%	15.9%	40.2%		
Total Member Paid	**$1,416,716**	**$374,175**	**$2,141,898**	**$547,817**		
Total Plan Paid	**$6,655,359**	**$501,260**	**$10,499,937**	**$767,959**		

Visits by Day of Week



% of Paid



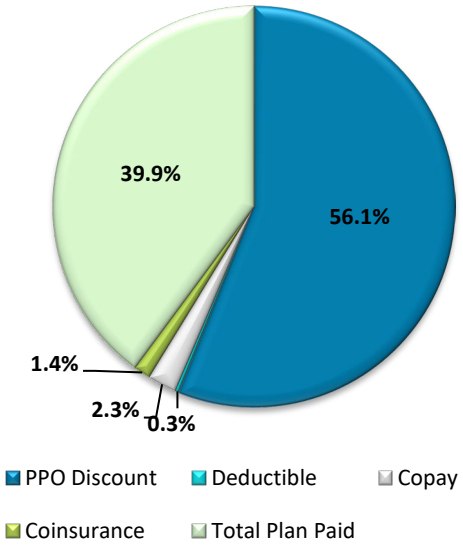
ER / UC Visits by Relationship						
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	1,692	169	4,126	413	5,818	583
Spouse	433	178	786	323	1,219	501
Child	1,067	157	2,252	332	3,319	489
Total	**3,192**	**166**	**7,164**	**364**	**10,356**	**539**

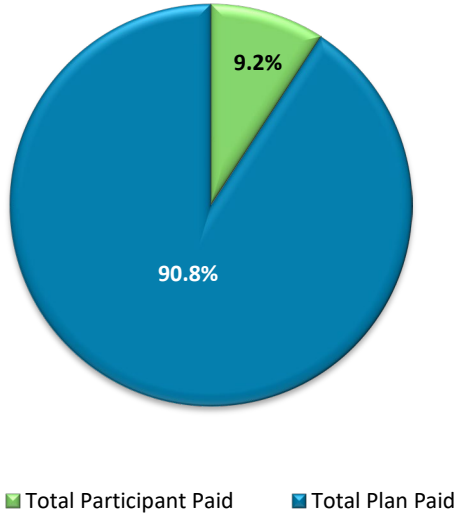
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$284,665,206	$7,681	100.0%
PPO Discount	$185,537,052	$5,006	65.2%
Deductible	$583,636	$16	0.2%
Copay	$7,298,615	$197	2.6%
Coinsurance	$5,005,400	$135	1.8%
Total Participant Paid	**$12,887,650**	**$348**	**4.5%**
Total Plan Paid	**$83,671,713**	**$698**	**29.4%**

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





Quality Metrics

Condition	Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric
Asthma	Asthma and a routine provider visit in the last 12 months	1,078	1,056	22	98.0%
	<2 asthma related ER Visits in the last 6 months	1,078	2	1,076	0.2%
	Asthma related admit in last 12 months	1,078	4	1,074	0.4%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	100	7	93	7.0%
	Members with COPD who had an annual spirometry test	100	16	84	16.0%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	6	0	6	0.0%
	No ER Visit for Heart Failure in last 90 days	89	4	85	4.5%
	Follow-up OV within 4 weeks of discharge from HF admission	6	5	1	83.3%
Diabetes	Annual office visit	1,197	1,124	73	93.9%
	Annual dilated eye exam	1,197	433	764	36.2%
	Annual foot exam	1,197	607	590	50.7%
	Annual HbA1c test done	1,197	1,050	147	87.7%
	Diabetes Annual lipid profile	1,197	980	217	81.9%
	Annual microalbumin urine screen	1,197	855	342	71.4%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	3,058	2,615	443	85.5%
Hypertension	Annual lipid profile	2,566	2,011	555	78.4%
	Annual serum creatinine test	2,282	1,967	315	86.2%
Wellness	Well Child Visit - 15 months	182	159	23	87.4%
	Routine office visit in last 6 months (All Ages)	20,344	13,817	6,527	67.9%
	Colorectal cancer screening ages 45-75 within the appropriate time period	6,451	3,118	3,333	48.3%
	Women age 25-65 with recommended cervical cancer/HPV screening	6,752	4,414	2,338	65.4%
	Males age greater than 49 with PSA test in last 24 months	2,082	1,094	988	52.5%
	Routine exam in last 24 months (All Ages)	20,344	17,229	3,115	84.7%
	Women age 40 to 75 with a screening mammogram last 24 months	4,726	2,967	1,759	62.8%

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

Chronic Conditions Prevalence

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

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

Chronic Condition	# With Condition	% of Members	Members per 1,000	Admits per 1,000	ER Visits per 1,000	PMPY
Affective Psychosis	246	1.21%	12.81	183.47	500.83	$15,594
Asthma	1,156	5.68%	60.19	110.95	397.23	$14,157
Atrial Fibrillation	149	0.73%	7.76	247.10	509.65	$30,141
Blood Disorders	1,223	6.01%	63.68	222.11	496.02	$24,955
CAD	337	1.66%	17.55	284.79	488.72	$30,541
COPD	97	0.48%	5.05	376.96	678.53	$36,748
Cancer	595	2.92%	30.98	110.68	297.84	$30,494
Chronic Pain	635	3.12%	33.06	116.43	496.77	$19,714
Congestive Heart Failure	87	0.43%	4.53	649.72	543.65	$67,124
Demyelinating Diseases	60	0.29%	3.12	94.64	473.19	$53,907
Depression	2,103	10.33%	109.50	112.84	344.21	$12,559
Diabetes	1,247	6.13%	64.93	97.98	325.37	$19,427
ESRD	19	0.09%	0.99	1,466.67	600.00	$94,127
Eating Disorders	133	0.65%	6.93	272.25	607.33	$20,769
HIV/AIDS	26	0.13%	1.35	41.38	124.14	$39,434
Hyperlipidemia	3,642	17.90%	189.64	58.87	226.83	$12,028
Hypertension	2,587	12.71%	134.70	90.36	289.66	$14,743
Immune Disorders	131	0.64%	6.82	232.92	633.54	$47,136
Inflammatory Bowel Disease	99	0.49%	5.15	200.99	579.31	$33,852
Liver Diseases	480	2.36%	24.99	184.34	473.65	$21,200
Morbid Obesity	826	4.06%	43.01	113.41	334.49	$15,920
Osteoarthritis	670	3.29%	34.89	84.98	308.06	$19,080
Peripheral Vascular Disease	88	0.43%	4.58	280.79	458.13	$30,126
Rheumatoid Arthritis	138	0.68%	7.19	140.01	345.92	$37,103

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

Data Includes Medical and Pharmacy
Based on 24 months incurred dates

Methodology

- Average member counts were weighted by the number of months each member had on the plan.
- Claims were pulled based upon the date paid.
- Claims were categorized based upon four groups:
  - Inpatient Facility
  - Outpatient Facility
  - Physician
  - Other (Other includes any medical reimbursements or durable medical equipment.)
- Inpatient analysis was done by identifying facility claims where a room and board charge was submitted and paid. Claims were then rolled up for the entire admission and categorized by the diagnosis code that held the highest paid amount. (Hospice and skilled nursing facility claims were excluded)
- Outpatient claims were flagged by an in-or-outpatient indicator being present on the claim that identified it as taking place at an outpatient facility.
- Physician claims were identified when the vendor type indicator was flagged as a professional charge.
  - These claims were in some cases segregated further to differentiate primary care physicians and specialists.
  - Office visits were identified by the presence of evaluation and management or consultation codes.
- Emergency room and urgent care episodes should be considered subcategories of physician and outpatient facility.
  - Emergency Room visits are identified by facility claims with a revenue code of 450-455, 457-459.
  - Urgent Care visits are identified by facility claims with a revenue code of 456 or physician claims with a place of service of “Urgent Care”.
  - Outpatient claims (including facility and physician) are then rolled up for the day of service and summarized as an ER/UC visit.
  - If a member has an emergency room visit on the same day as an urgent care visit, all claims are grouped into one episode and counted as an emergency room visit.
  - If a member was admitted into the hospital through the ER, the member will not show an ER visit. ER claims are bundled with the inpatient stay.

Appendix C

Index of Tables
UMR Inc. – EPO Utilization Review for PEBP
July 1, 2023 – June 30, 2024

DATASCOPE™

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

UMR℠

Overview

- Total Medical Spend for PY24 was $40,123,645 with an annualized plan cost per employee per year (PEPY) of $12,992. This is an increase of 6.0% when compared to PY23.
  - IP Cost per Admit is $38,944 which is 10.5% higher than PY23.
  - ER Cost per Visit is $3,246 which is 5.1% higher than PY23.
- Employees shared in 9.2% of the medical cost.
- Inpatient facility costs were 27.1% of the plan spend.
- 64.4% of the Average Membership had paid Medical claims less than $2,500, with 8.6% having no claims paid at all during the reporting period.
- 60 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 35.9% of the plan spend. The highest diagnosis category was Cancer, accounting for 17.5% of the high-cost claimant dollars.
- Total spending with in-network providers was 96.4%. The average In Network discount was 56.7%, which is 3.2% higher than the PY23 average discount of 54.9%.

Paid Claims by Age Group

Paid Claims by Age Group																
	PY23						PY24						% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 2,371,577	$ 2,823	$ 16,074	$ 19	$ 2,387,651	$ 2,842	$ 809,300	$ 1,405	$ 4,521	$ 8	$ 813,821	$ 1,413	-65.9%	-50.3%
1	$ 276,620	$ 397	$ 1,567	$ 2	$ 278,187	$ 400	$ 245,893	$ 397	$ 3,891	$ 6	$ 249,784	$ 404	-10.2%	1.1%
2 - 4	$ 709,797	$ 291	$ 15,497	$ 6	$ 725,294	$ 298	$ 430,299	$ 203	$ 10,814	$ 5	$ 441,113	$ 208	-39.2%	-30.1%
5 - 9	$ 372,847	$ 89	$ 68,943	$ 16	$ 441,790	$ 105	$ 474,618	$ 123	$ 51,360	$ 13	$ 525,978	$ 136	19.1%	28.9%
10 - 14	$ 1,002,695	$ 178	$ 154,711	$ 27	$ 1,157,406	$ 206	$ 1,645,584	$ 326	$ 144,219	$ 29	$ 1,789,803	$ 355	54.6%	72.6%
15 - 19	$ 1,773,288	$ 264	$ 646,020	$ 96	$ 2,419,308	$ 361	$ 1,661,409	$ 288	$ 695,685	$ 120	$ 2,357,094	$ 408	-2.6%	13.1%
20 - 24	$ 1,394,464	$ 222	$ 228,294	$ 36	$ 1,622,758	$ 258	$ 1,056,838	$ 183	$ 273,944	$ 47	$ 1,330,782	$ 231	-18.0%	-10.5%
25 - 29	$ 1,192,563	$ 460	$ 282,774	$ 109	$ 1,475,337	$ 569	$ 823,703	$ 397	$ 349,260	$ 168	$ 1,172,963	$ 566	-20.5%	-0.6%
30 - 34	$ 1,499,139	$ 432	$ 1,514,655	$ 437	$ 3,013,794	$ 869	$ 1,323,443	$ 471	$ 1,410,824	$ 502	$ 2,734,267	$ 972	-9.3%	11.8%
35 - 39	$ 3,337,786	$ 692	$ 841,512	$ 174	$ 4,179,298	$ 866	$ 2,468,606	$ 579	$ 652,567	$ 153	$ 3,121,174	$ 733	-25.3%	-15.4%
40 - 44	$ 2,992,652	$ 580	$ 1,539,679	$ 298	$ 4,532,331	$ 878	$ 1,953,885	$ 412	$ 1,634,374	$ 345	$ 3,588,259	$ 757	-20.8%	-13.8%
45 - 49	$ 2,464,377	$ 431	$ 1,465,368	$ 256	$ 3,929,745	$ 687	$ 5,244,744	$ 1,018	$ 2,144,514	$ 416	$ 7,389,258	$ 1,435	88.0%	109.0%
50 - 54	$ 5,159,525	$ 662	$ 2,069,596	$ 266	$ 7,229,121	$ 928	$ 4,013,100	$ 599	$ 1,730,567	$ 258	$ 5,743,667	$ 858	-20.5%	-7.6%
55 - 59	$ 5,756,991	$ 751	$ 2,528,164	$ 330	$ 8,285,155	$ 1,080	$ 5,557,019	$ 795	$ 3,025,787	$ 433	$ 8,582,806	$ 1,228	3.6%	13.7%
60 - 64	$ 8,456,113	$ 961	$ 3,714,588	$ 422	$ 12,170,701	$ 1,384	$ 8,625,026	$ 1,078	$ 4,005,552	$ 501	$ 12,630,578	$ 1,579	3.8%	14.1%
65+	$ 3,496,720	$ 825	$ 1,732,013	$ 409	$ 5,228,733	$ 1,234	$ 3,790,176	$ 896	$ 1,872,019	$ 443	$ 5,662,195	$ 1,339	8.3%	8.5%
Total	**$ 42,257,152**	**$ 548**	**$ 16,819,453**	**$ 218**	**$ 59,076,605**	**$ 766**	**$ 40,123,645**	**$ 584**	**$ 18,009,898**	**$ 262**	**$ 58,133,543**	**$ 846**	**-1.6%**	**10.5%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**
Average Enrollment												
Employees	4,021	3,447	3,088	-10.4%	3,370	2,876	2,551	-11.3%	3	2	2	0.0%
Spouses	786	2,297	601	-73.9%	678	2,145	511	-76.2%	0	0	0	0.0%
Children	2,683	676	2,039	201.4%	2,531	580	1,898	227.1%	0	0	0	0.0%
Total Members	7,491	6,421	5,727	-10.8%	6,579	5,601	4,960	-11.4%	3	2	2	0.0%
Family Size	1.9	1.9	1.9	-0.5%	2.0	2.0	1.9	-0.5%	1.0	1.0	1.0	0.0%
Financial Summary												
Gross Cost	$44,187,042	$46,490,212	$44,180,571	-5.0%	$37,820,607	$38,595,575	$37,530,175	-2.8%	$4,744	$4,201	$5,536	31.8%
Client Paid	$39,320,787	$42,257,152	$40,123,645	-5.0%	$33,797,612	$35,128,252	$34,185,883	-2.7%	$3,622	$3,335	$4,101	23.0%
Employee Paid	$4,866,255	$4,233,060	$4,056,926	-4.2%	$4,022,996	$3,467,323	$3,344,293	-3.5%	$1,122	$866	$1,434	65.6%
Client Paid-PEPY	$9,779	$12,259	$12,992	6.0%	$10,030	$12,216	$13,399	9.7%	$1,278	$1,667	$2,051	23.0%
Client Paid-PMPY	$5,249	$6,581	$7,006	6.5%	$5,137	$6,272	$6,893	9.9%	$1,278	$1,667	$2,051	23.0%
Client Paid-PEPM	$815	$1,022	$1,083	6.0%	$836	$1,018	$1,117	9.7%	$107	$139	$171	23.0%
Client Paid-PMPM	$437	$548	$584	6.6%	$428	$523	$574	9.8%	$107	$139	$171	23.0%
High Cost Claimants (HCC's) > $100k												
# of HCC's	46	54	60	11.1%	40	43	49	14.0%	0	0	0	0.0%
HCC's / 1,000	6.1	8.4	10.5	24.6%	6.1	7.7	9.9	28.6%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$237,083	$257,429	$240,344	-6.6%	$246,357	$257,598	$253,764	-1.5%	$0	$0	$0	0.0%
HCC's % of Plan Paid	27.7%	32.9%	35.9%	9.1%	29.2%	31.5%	36.4%	15.6%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,432	$1,804	$1,898	5.2%	$1,437	$1,735	$2,006	15.6%	$0	$0	$0	0.0%
Facility Outpatient	$1,442	$2,319	$2,540	9.5%	$1,382	$2,176	$2,453	12.7%	$27	$158	$232	46.8%
Physician	$2,259	$2,458	$2,567	4.4%	$2,209	$2,361	$2,434	3.1%	$1,142	$1,510	$1,819	20.5%
Other	$116	$0	$0	0.0%	$109	$0	$0	0.0%	$109	$0	$0	0.0%
Total	$5,249	$6,581	$7,006	6.5%	$5,137	$6,272	$6,893	9.9%	$1,278	$1,667	$2,051	23.0%

Financial Summary (p. 2 of 2)

	Total				State Retirees				Non-State Retirees				
Summary	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment													
Employees	4,021	3,447	3,088	-10.4%	564	509	485	-4.6%	85	61	50	-18.5%	
Spouses	786	2,297	601	-73.9%	90	139	80	-42.4%	19	13	10	-25.0%	
Children	2,683	676	2,039	201.4%	142	83	129	56.0%	10	13	12	-13.7%	
Total Members	7,491	6,421	5,727	-10.8%	796	731	695	-4.9%	114	87	71	-18.8%	
Family Size	1.9	1.9	1.9	-0.5%	1.4	1.4	1.4	-0.7%	1.3	1.4	1.4	0.0%	1.6
Financial Summary													
Gross Cost	$44,187,042	$46,490,212	$44,180,571	-5.0%	$5,794,991	$7,535,647	$6,248,719	-17.1%	$566,699	$354,790	$396,140	11.7%	
Client Paid	$39,320,787	$42,257,152	$40,123,645	-5.0%	$5,071,309	$6,861,336	$5,611,766	-18.2%	$448,244	$264,230	$321,895	21.8%	
Employee Paid	$4,866,255	$4,233,060	$4,056,926	-4.2%	$723,682	$674,311	$636,953	-5.5%	$118,455	$90,560	$74,245	-18.0%	
Client Paid-PEPY	$9,779	$12,259	$12,992	6.0%	$8,998	$13,493	$11,565	-14.3%	$5,279	$4,326	$6,470	49.6%	$6,258
Client Paid-PMPY	$5,249	$6,581	$7,006	6.5%	$6,373	$9,392	$8,078	-14.0%	$3,946	$3,023	$4,534	50.0%	$3,830
Client Paid-PEPM	$815	$1,022	$1,083	6.0%	$750	$1,124	$964	-14.2%	$440	$360	$539	49.7%	$521
Client Paid-PMPM	$437	$548	$584	6.6%	$531	$783	$673	-14.0%	$329	$252	$378	50.0%	$319
High Cost Claimants (HCC's) > $100k													
# of HCC's	46	54	60	11.1%	8	12	12	0.0%	0	0	1	0.0%	
HCC's / 1,000	6.1	8.4	10.5	24.6%	10.1	16.4	17.3	5.1%	0.0	0.0	14.1	0.0%	
Avg HCC Paid	$237,083	$257,429	$240,344	-6.6%	$131,446	$235,373	$154,460	-34.4%	$0	$0	$132,680	0.0%	
HCC's % of Plan Paid	27.7%	32.9%	35.9%	9.1%	20.7%	41.2%	33.0%	-19.9%	0.0%	0.0%	41.2%	0.0%	
Cost Distribution by Claim Type (PMPY)													
Facility Inpatient	$1,432	$1,804	$1,898	5.2%	$1,443	$2,534	$1,236	-51.2%	$1,101	$183	$946	416.9%	$1,044
Facility Outpatient	$1,442	$2,319	$2,540	9.5%	$2,015	$3,585	$3,353	-6.5%	$940	$1,007	$725	-28.0%	$1,310
Physician	$2,259	$2,458	$2,567	4.4%	$2,742	$3,273	$3,490	6.6%	$1,800	$1,832	$2,863	56.3%	$1,404
Other	$116	$0	$0	0.0%	$174	$0	$0	0.0%	$106	$0	$0	0.0%	$72
Total	$5,249	$6,581	$7,006	6.5%	$6,373	$9,392	$8,078	-14.0%	$3,946	$3,023	$4,534	50.0%	$3,830

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 11,494,351	$ 1,267,256	$ 801,113	$ 13,562,720	$ 11,225,240	$ 670,423	$ 265,574	$ 12,161,237	-10.3%
Outpatient	$ 23,633,901	$ 4,467,417	$ 325,550	$ 28,426,868	$ 22,960,643	$ 4,236,086	$ 439,683	$ 27,636,412	-2.8%
Total - Medical	**$ 35,128,252**	**$ 5,734,673**	**$ 1,126,663**	**$ 41,989,588**	**$ 34,185,883**	**$ 4,906,509**	**$ 705,257**	**$ 39,797,649**	**-5.2%**

Net Paid Claims - Per Participant per Month	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 1,018	$ 1,085	$ 1,382	$ 1,034	$ 1,117	$ 986	$ 831	$ 1,092	5.6%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 14,081	$ 4,746	$ 18,827			$ 75,134	$ 75,134	299.1%
Outpatient	$ 3,335	$ 78,421	$ 166,982	$ 248,738	$ 4,101	$ 17,355	$ 229,406	$ 250,862	0.9%
Total - Medical	**$ 3,335**	**$ 92,502**	**$ 171,728**	**$ 267,565**	**$ 4,101**	**$ 17,355**	**$ 304,540**	**$ 325,996**	**21.8%**

Net Paid Claims - Per Participant per Month	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 139	$ 554	$ 303	$ 353	$ 171	$ 223	$ 587	$ 525	48.5%

Paid Claims by Claim Type – Total

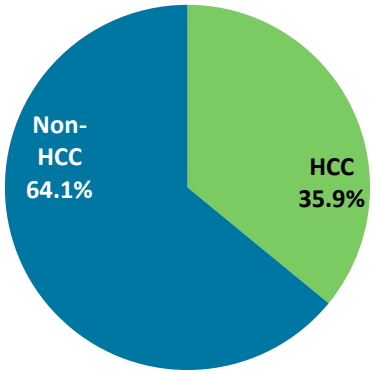
Net Paid Claims - Total Total Participants	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 11,494,351	$ 1,281,337	$ 805,859	$ 13,581,547	$ 11,225,240	$ 670,423	$ 340,707	$ 12,236,371	-9.9%
Outpatient	$ 23,637,236	$ 4,545,838	$ 492,532	$ 28,675,605	$ 22,964,744	$ 4,253,441	$ 669,089	$ 27,887,274	-2.7%
Total - Medical	**$ 35,131,586**	**$ 5,827,175**	**$ 1,298,391**	**$ 42,257,152**	**$ 34,189,984**	**$ 4,923,864**	**$ 1,009,797**	**$ 40,123,645**	**-5.0%**

Net Paid Claims - Per Participant per Month	PY23				PY24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 1,017	$ 1,068	$ 940	$ 1,022	$ 1,116	$ 975	$ 738	$ 1,083	6.0%

Cost Distribution – Medical Claims

PY23							PY24					
Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid	Paid Claims Category	Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
50	0.8%	$13,901,178	32.9%	$215,964	5.1%	$100,000.01 Plus	53	0.9%	$14,420,643	35.9%	$242,182	6.0%
67	1.0%	$4,962,218	11.7%	$231,401	5.5%	$50,000.01-$100,000.00	59	1.0%	$4,239,158	10.6%	$227,027	5.6%
199	3.1%	$6,991,359	16.5%	$548,257	13.0%	$25,000.01-$50,000.00	144	2.5%	$5,267,173	13.1%	$398,010	9.8%
386	6.0%	$6,197,687	14.7%	$770,272	18.2%	$10,000.01-$25,000.00	386	6.7%	$6,205,352	15.5%	$829,173	20.4%
536	8.4%	$3,908,538	9.2%	$774,562	18.3%	$5,000.01-$10,000.00	561	9.8%	$4,087,086	10.2%	$834,889	20.6%
774	12.0%	$2,905,516	6.9%	$707,442	16.7%	$2,500.01-$5,000.00	831	14.5%	$3,067,378	7.6%	$723,694	17.8%
3,713	57.8%	$3,390,658	8.0%	$984,390	23.3%	$0.01-$2,500.00	3,162	55.2%	$2,836,855	7.1%	$801,301	19.8%
60	0.9%	$0	0.0%	$772	0.0%	$0.00	37	0.6%	$0	0.0%	$651	0.0%
636	9.9%	$0	0.0%	$0	0.0%	No Claims	494	8.6%	$0	0.0%	$0	0.0%
6,421	**100.0%**	**$42,257,152**	**100.0%**	**$4,233,060**	**100.0%**		**5,727**	**100.0%**	**$40,123,645**	**100.0%**	**$4,056,926**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High-Cost Claimant over $100K

HCC's by Diagnosis Grouper			
Top 10 Diagnosis Groupers	**Patients**	**Total Paid**	**% Paid**
Cancer	21	$3,227,056	5.1%
Cardiac Disorders	45	$2,149,774	3.4%
Neurological Disorders	33	$1,212,130	1.9%
Gastrointestinal Disorders	33	$1,166,917	1.8%
Infections	24	$1,121,572	1.8%
Medical/Surgical Complications	13	$1,022,444	1.6%
Hematological Disorders	22	$823,989	1.3%
Non-malignant Neoplasm	16	$754,124	1.2%
Renal/Urologic Disorders	24	$461,187	0.7%
Pregnancy-related Disorders	3	$437,329	0.7%
All Other		$2,044,122	14.2%
Overall	**----**	**$14,420,643**	**33.7%**

Utilization Summary (p. 1 of 2)

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

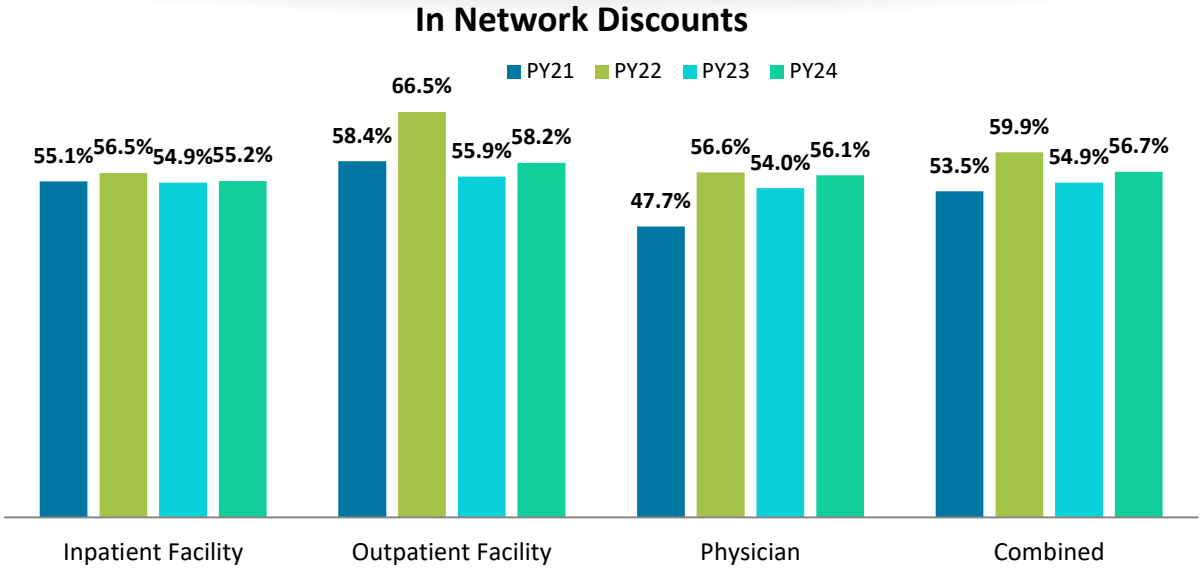
	Total				State Active				Non-State Active			
Summary	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	397	381	332		344	318	280		0	0	0	
# of Bed Days	2,419	1,912	2,080		2,081	1,540	1,782		0	0	0	
Paid Per Admit	$34,699	$35,238	$38,944	10.5%	$35,114	$35,521	$41,624	17.2%	$0	$0	$0	0.0%
Paid Per Day	$5,695	$7,022	$6,216	-11.5%	$5,805	$7,335	$6,540	-10.8%	$0	$0	$0	0.0%
Admits Per 1,000	53	59	58	-1.7%	52	57	56	-1.8%	0	0	0	0.0%
Days Per 1,000	323	298	363	21.8%	316	275	359	30.5%	0	0	0	0.0%
Avg LOS	6.1	5.0	6.3	26.0%	6.0	4.8	6.4	33.3%	0.0	0.0	0.0	0.0%
# Admits From the ER	205	176	181	2.8%	167	141	147	4.3%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	5.7	5.6	6.4	14.3%	5.5	5.5	6.2	12.7%	5.3	5.0	5.5	10.0%
Avg Paid per OV	$151	$162	$156	-3.7%	$152	$165	$151	-8.5%	$169	$129	$159	23.3%
Avg OV Paid per Member	$860	$915	$1,001	9.4%	$840	$902	$946	4.9%	$894	$645	$876	35.8%
DX&L Utilization per Member	9.6	11.7	12.2	4.3%	9.2	11.1	11.5	3.6%	5.6	22	16	-27.3%
Avg Paid per DX&L	$59	$70	$81	15.7%	$60	$71	$81	14.1%	$29	$17	$29	70.6%
Avg DX&L Paid per Member	$569	$819	$986	20.4%	$551	$787	$935	18.8%	$165	$385	$467	21.3%
Emergency Room												
# of Visits	1,327	1,196	1,150		1,139	1,009	1,001		0	0	1	
Visits Per Member	0.18	0.19	0.20	5.3%	0.17	0.18	0.20	11.1%	0.00	0.00	0.50	0.0%
Visits Per 1,000	177	186	203	9.1%	173	180	202	12.2%	0	0	500	0.0%
Avg Paid per Visit	$2,003	$3,089	$3,246	5.1%	$1,972	$3,169	$3,292	3.9%	$0	$0	$369	0.0%
Urgent Care												
# of Visits	3,025	2,649	2,563		2,733	2,395	2,303		0	0	0	
Visits Per Member	0.40	0.41	0.45	9.8%	0.42	0.43	0.46	7.0%	0.00	0.00	0.00	0.0%
Visits Per 1,000	404	413	447	8.2%	415	428	464	8.4%	0	0	0	0.0%
Avg Paid per Visit	$153	$129	$135	4.7%	$155	$130	$137	5.4%	$0	$0	$0	0.0%

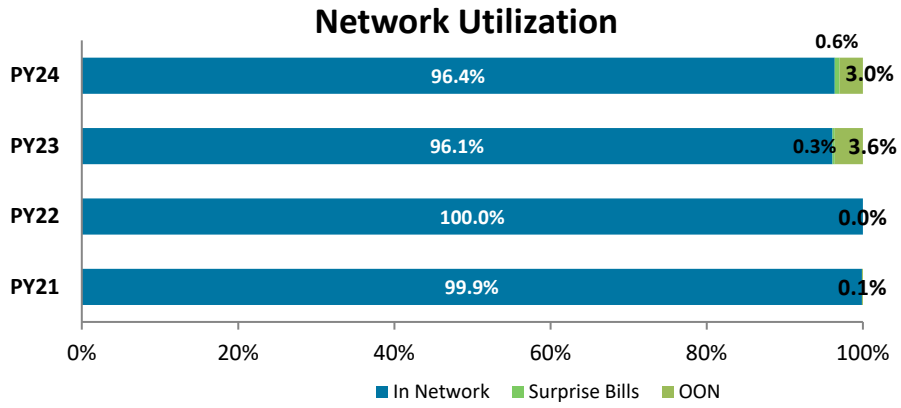
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**PY22**	**PY23**	**PY24**	**Variance to Prior Year**	**Peer Index**
Inpatient Summary									
# of Admits	45	60	45		8	3	7		
# of Bed Days	273	364	281		65	8	17		
Paid Per Admit	$34,743	$35,179	$24,236	-31.1%	$16,574	$6,422	$26,278	309.2%	$19,305
Paid Per Day	$5,727	$5,799	$3,881	-33.1%	$2,040	$2,408	$10,820	349.3%	$3,615
Admits Per 1,000	57	82	65	-20.7%	70	34	99	191.2%	64
Days Per 1,000	343	498	405	-18.7%	572	92	239	159.8%	342
Avg LOS	6.1	6.1	6.2	1.6%	8.1	2.7	2.4	-11.1%	5.3
# Admits From the ER	32	33	29	-12.1%	6	2	5	150.0%	
Physician Office									
OV Utilization per Member	7.1	6.8	7.7	13.2%	6.8	6.5	6.2	-4.6%	5.2
Avg Paid per OV	$147	$157	$190	21.0%	$112	$77	$66	-14.3%	$97
Avg OV Paid per Member	$1,036	$1,069	$1,455	36.1%	$763	$502	$405	-19.3%	$502
DX&L Utilization per Member	13.4	16.2	16.9	4.3%	9.2	12.8	10.5	-18.0%	9.0
Avg Paid per DX&L	$55	$69	$83	20.3%	$48	$35	$39	11.4%	$46
Avg DX&L Paid per Member	$738	$1,114	$1,408	26.4%	$441	$449	$411	-8.5%	$412
Emergency Room									
# of Visits	168	162	141		20	25	7		
Visits Per Member	0.21	0.22	0.20	-9.1%	0.18	0.29	0.10	-65.5%	0.23
Visits Per 1,000	211	222	203	-8.6%	176	286	99	-65.4%	228
Avg Paid per Visit	$2,357	$2,890	$3,090	6.9%	$775	$1,155	$269	-76.7%	$1,035
Urgent Care									
# of Visits	258	227	235		34	27	25		
Visits Per Member	0.32	0.31	0.34	9.7%	0.30	0.31	0.35	12.9%	0.38
Visits Per 1,000	324	311	338	8.7%	299	309	352	13.9%	379
Avg Paid per Visit	$147	$124	$123	-0.8%	$64	$59	$53	-10.2%	$132

Provider Network Summary





Diagnosis Grouper Summary

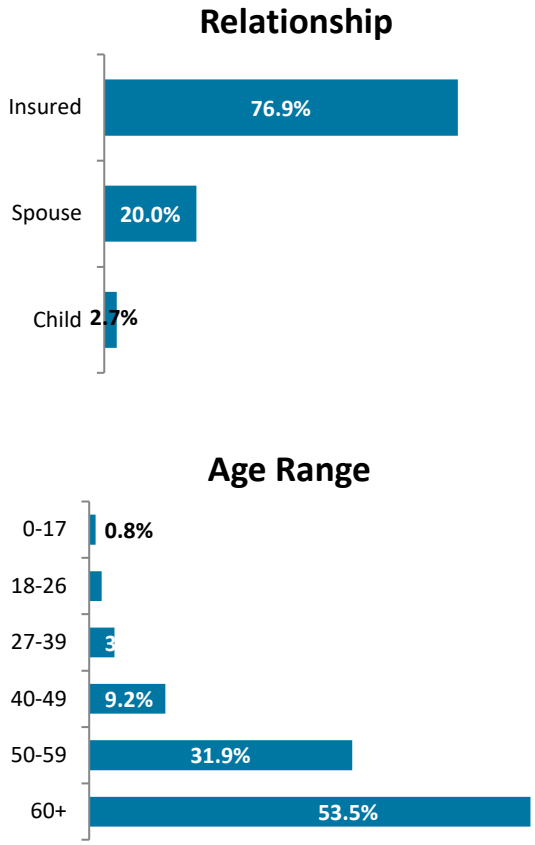
Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$4,118,121	10.3%	$2,608,941	$966,188	$542,993	$1,963,219	$2,154,902
Cardiac Disorders	$3,335,077	8.3%	$2,172,278	$1,093,994	$68,805	$1,668,285	$1,666,792
Gastrointestinal Disorders	$3,253,155	8.1%	$2,245,704	$652,992	$354,460	$1,129,179	$2,123,976
Neurological Disorders	$2,579,799	6.4%	$1,959,191	$370,391	$250,216	$507,683	$2,072,116
Health Status/Encounters	$2,452,681	6.1%	$1,438,319	$312,731	$701,631	$888,173	$1,564,508
Musculoskeletal Disorders	$2,390,218	6.0%	$1,769,400	$436,501	$184,316	$982,842	$1,407,376
Mental Health	$2,284,472	5.7%	$925,525	$347,887	$1,011,060	$649,203	$1,635,269
Trauma/Accidents	$1,993,943	5.0%	$1,297,805	$206,369	$489,769	$947,985	$1,045,959
Infections	$1,722,497	4.3%	$1,286,352	$320,557	$115,588	$819,382	$903,114
Pregnancy-related Disorders	$1,616,970	4.0%	$786,039	$129,844	$701,088	$386,832	$1,230,138
Eye/ENT Disorders	$1,601,593	4.0%	$1,007,225	$157,964	$436,404	$716,197	$885,396
Pulmonary Disorders	$1,554,425	3.9%	$1,042,580	$229,976	$281,869	$537,511	$1,016,913
Spine-related Disorders	$1,426,733	3.6%	$1,222,166	$168,680	$35,886	$565,665	$861,068
Renal/Urologic Disorders	$1,366,755	3.4%	$1,121,363	$57,396	$187,997	$638,649	$728,106
Medical/Surgical Complications	$1,269,835	3.2%	$1,240,204	$10,830	$18,802	$185,987	$1,083,849
Non-malignant Neoplasm	$1,253,452	3.1%	$733,657	$75,090	$444,705	$357,379	$896,073
Endocrine/Metabolic Disorders	$1,228,413	3.1%	$1,077,913	$120,449	$30,051	$477,211	$751,202
Hematological Disorders	$1,000,585	2.5%	$840,670	$19,216	$140,698	$841,118	$159,467
Gynecological/Breast Disorders	$943,082	2.4%	$706,362	$137,016	$99,705	$14,562	$928,520
Diabetes	$699,567	1.7%	$407,726	$190,658	$101,184	$483,345	$216,223
Dermatological Disorders	$465,569	1.2%	$325,426	$54,809	$85,335	$226,190	$239,379
Vascular Disorders	$412,535	1.0%	$306,319	$98,506	$7,711	$218,474	$194,061
Miscellaneous	$337,839	0.8%	$176,418	$67,748	$93,673	$132,625	$205,214
Abnormal Lab/Radiology	$329,916	0.8%	$248,552	$72,644	$8,721	$135,514	$194,402
Congenital/Chromosomal Anomalies	$233,934	0.6%	$46,385	$1,334	$186,215	$162,462	$71,472
Cholesterol Disorders	$117,874	0.3%	$104,170	$11,418	$2,285	$53,754	$64,120
Medication Related Conditions	$71,123	0.2%	$36,216	$4,732	$30,176	$34,092	$37,031
Allergic Reaction	$29,404	0.1%	$10,134	$647	$18,624	$17,056	$12,349
Dental Conditions	$18,285	0.0%	$9,063	$299	$8,924	$8,807	$9,478
External Hazard Exposure	$11,079	0.0%	$6,622	$997	$3,460	$8,107	$2,971
Social Determinants of Health	$4,713	0.0%	$73	$0	$4,640	$0	$4,713
Total	**$40,123,645**	**0.0%**	**$27,158,795**	**$6,317,862**	**$6,646,987**	**$15,757,490**	**$24,366,154**

Mental Health Drilldown

	PY21		PY22		PY23		3Q24	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	625	$833,183	505	$720,907	454	$529,695	440	$549,750
Mood and Anxiety Disorders	711	$655,375	636	$361,898	591	$339,214	550	$443,958
Mental Health Conditions, Other	609	$876,606	458	$367,897	394	$287,517	380	$420,632
Alcohol Abuse/Dependence	43	$163,692	37	$110,736	30	$167,010	40	$242,494
Developmental Disorders	65	$155,300	58	$89,043	47	$93,123	51	$182,621
Bipolar Disorder	127	$261,349	107	$171,696	109	$84,620	90	$106,484
Attention Deficit Disorder	180	$98,736	179	$76,754	202	$61,595	208	$83,367
Complications of Substance Abuse	14	$63,661	8	$12,407	7	$9,434	8	$43,933
Substance Abuse/Dependence	57	$45,039	39	$14,853	35	$72,695	21	$39,956
Psychoses	7	$55,219	6	$9,762	9	$6,025	10	$26,854
Sexually Related Disorders	27	$81,154	27	$85,457	26	$8,339	22	$44,125
Sleep Disorders	187	$38,478	148	$43,716	141	$25,583	135	$26,914
Eating Disorders	24	$370,761	23	$51,995	19	$32,076	18	$59,888
Schizophrenia	9	$10,631	6	$2,286	9	$13,689	7	$6,957
Tobacco Use Disorder	38	$4,775	36	$4,114	42	$3,344	40	$4,572
Personality Disorders	14	$20,064	17	$47,043	15	$7,832	7	$1,966
Total		**$3,734,023**		**$2,170,566**		**$1,741,788**		**$2,284,472**

Diagnosis Grouper – Cancer

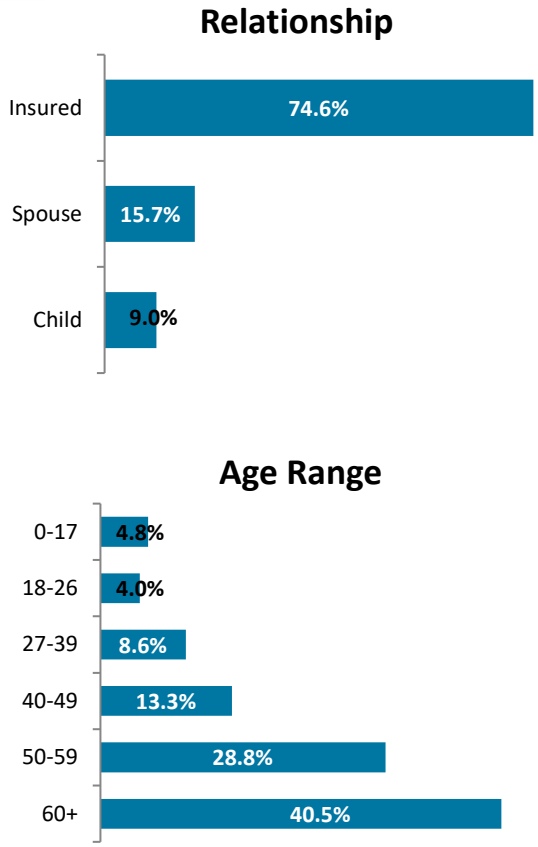
Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	19	142	$1,705,625	4.3%
Cancers, Other	35	229	$422,013	1.1%
Breast Cancer	46	562	$304,064	0.8%
Kidney Cancer	7	60	$287,520	0.7%
Lung Cancer	4	138	$225,484	0.6%
Pancreatic Cancer	4	141	$164,959	0.4%
Colon Cancer	9	93	$161,799	0.4%
Prostate Cancer	23	279	$138,207	0.3%
Secondary Cancers	15	80	$135,435	0.3%
Lymphomas	14	177	$125,557	0.3%
Brain Cancer	3	54	$115,645	0.3%
Melanoma	14	154	$77,019	0.2%
Myeloproliferative Neoplasms	10	140	$58,722	0.1%
Carcinoma in Situ	28	148	$55,082	0.1%
Non-Melanoma Skin Cancers	63	170	$54,382	0.1%
Cervical/Uterine Cancer	7	23	$53,255	0.1%
Ovarian Cancer	5	39	$29,124	0.1%
Thyroid Cancer	13	34	$4,079	0.0%
Myeloma	1	1	$152	0.0%
Overall	**----**	**----**	**$4,118,121**	**10.2%**



Diagnosis Grouper – Cardiac Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Atrial Fibrillation	56	417	$906,562	2.3%
Myocardial Infarction	13	90	$560,653	1.4%
Congestive Heart Failure	45	288	$409,251	1.0%
Heart Valve Disorders	70	170	$381,978	1.0%
Chest Pain	253	651	$339,964	0.8%
Hypertension	614	1,376	$210,635	0.5%
Coronary Artery Disease	100	235	$158,743	0.4%
Cardiac Arrhythmias	197	428	$132,501	0.3%
Cardiac Conditions, Other	175	376	$112,166	0.3%
Pulmonary Embolism	14	64	$47,959	0.1%
Shock	7	15	$29,540	0.1%
Cardiomyopathy	16	50	$23,856	0.1%
Cardio-Respiratory Arrest	25	69	$19,404	0.0%
Overall	**----**	**----**	**$3,335,077**	**8.3%**

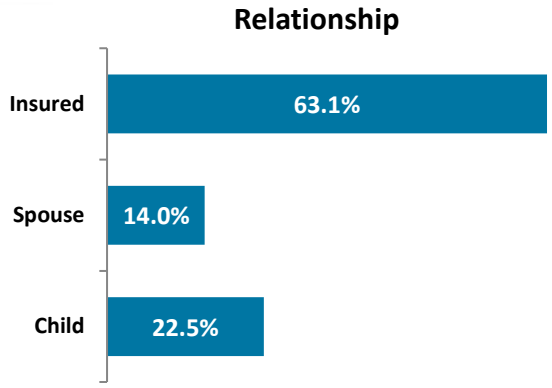
*Patient and claim counts are unique only within the category

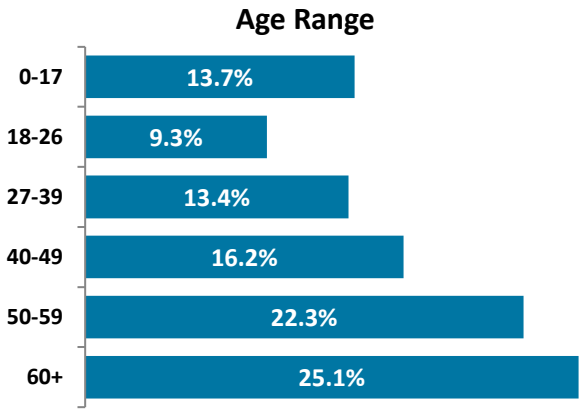


Diagnosis Grouper – Gastrointestinal Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Upper GI Disorders	254	587	$690,553	1.7%
Abdominal Disorders	467	1,209	$586,980	1.5%
GI Disorders, Other	273	758	$451,237	1.1%
Inflammatory Bowel Disease	51	158	$226,922	0.6%
Gallbladder and Biliary Disease	49	162	$198,890	0.5%
Hernias	61	161	$194,407	0.5%
GI Symptoms	326	640	$192,012	0.5%
Diverticulitis	59	155	$178,358	0.4%
Appendicitis	11	65	$145,865	0.4%
Liver Diseases	115	256	$128,940	0.3%
Hepatic Cirrhosis	13	26	$68,247	0.2%
Pancreatic Disorders	10	40	$63,054	0.2%
Constipation	86	150	$48,880	0.1%
Ostomies	9	52	$29,507	0.1%
Peptic Ulcer/Related Disorders	9	18	$28,722	0.1%
Hemorrhoids	35	70	$20,581	0.1%
	----	----	$3,253,155	8.3%

*Patient and claim counts are unique only within the category

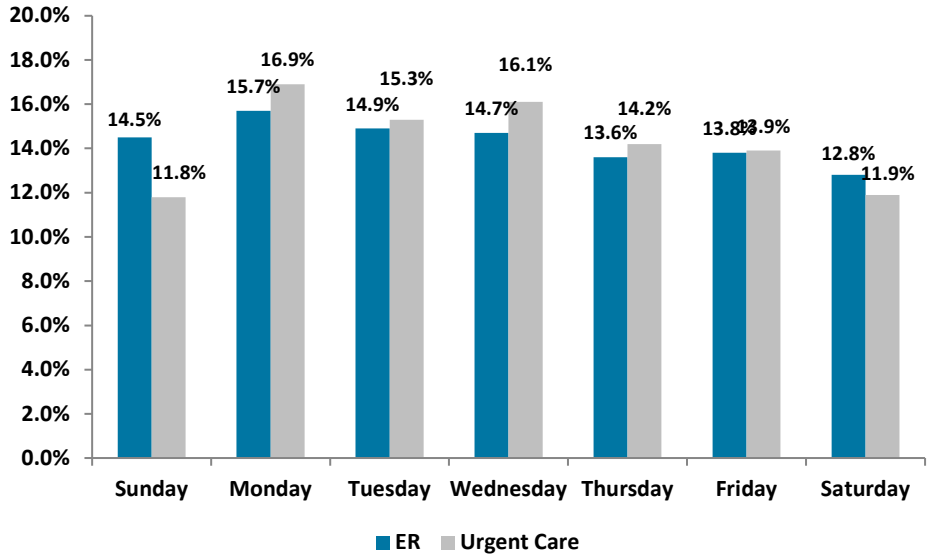




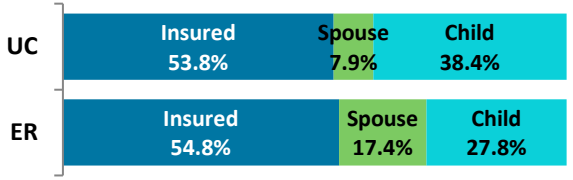
Emergency Room / Urgent Care Summary

	PY23		PY24		Peer Index	
ER/Urgent Care	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	1,196	2,649	1,150	2,563		
Visits Per Member	0.19	0.41	0.20	0.45	0.23	0.38
Visits/1000 Members	186	413	203	452	228	379
Avg Paid Per Visit	$3,089	$129	$3,246	$135	$1,085	$132
% with OV*	90.1%	88.4%	89.6%	88.4%		
% Avoidable	14.4%	42.2%	13.4%	41.1%		
Total Member Paid	**$666,263**	**$125,900**	**$630,542**	**$124,796**		
Total Plan Paid	**$3,694,614**	**$341,493**	**$3,733,282**	**$346,751**		

Visits by Day of Week



% of Paid



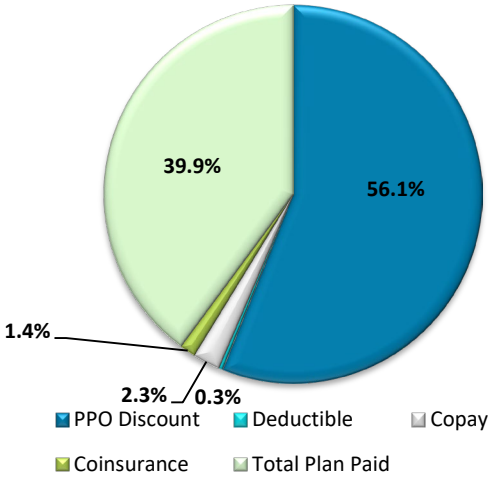
ER / UC Visits by Relationship						
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	610	198	1,404	455	2,014	652
Spouse	151	251	217	361	368	612
Child	389	191	942	462	1,331	653
Total	**1,150**	**203**	**2,563**	**447**	**3,713**	**648**

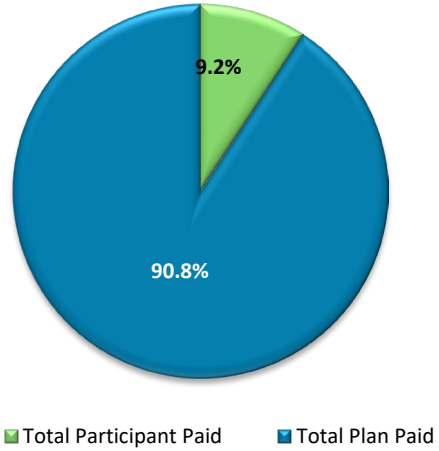
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$102,632,283	$2,769	100.0%
PPO Discount	$56,413,348	$1,522	55.0%
Deductible	$339,544	$9	0.3%
Copay	$2,352,628	$63	2.3%
Coinsurance	$1,364,755	$37	1.3%
Total Participant Paid	**$4,056,927**	**$109**	**4.0%**
Total Plan Paid	**$40,123,645**	**$1,083**	**39.1%**

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





Quality Metrics

Condition	Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric
Asthma	Asthma and a routine provider visit in the last 12 months	437	429	8	98.2%
	<2 asthma related ER Visits in the last 6 months	437	2	435	0.5%
	Asthma related admit in last 12 months	437	5	432	1.1%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	75	4	71	5.3%
	Members with COPD who had an annual spirometry test	75	16	59	21.3%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	4	0	4	0.0%
	No ER Visit for Heart Failure in last 90 days	60	1	59	1.7%
	Follow-up OV within 4 weeks of discharge from HF admission	4	4	0	100.0%
Diabetes	Annual office visit	529	499	30	94.3%
	Annual dilated eye exam	529	269	260	50.9%
	Annual foot exam	529	250	279	47.3%
	Annual HbA1c test done	529	478	51	90.4%
	Diabetes Annual lipid profile	529	429	100	81.1%
	Annual microalbumin urine screen	529	378	151	71.5%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	1,227	980	247	79.9%
Hypertension	Annual lipid profile	1,123	807	316	71.9%
	Annual serum creatinine test	1,098	927	171	84.4%
Wellness	Well Child Visit - 15 months	53	52	1	98.1%
	Routine office visit in last 6 months (All Ages)	5,577	4,216	1,361	75.6%
	Colorectal cancer screening ages 45-75 within the appropriate time period	2,445	1,431	1,014	58.5%
	Women age 25-65 with recommended cervical cancer/HPV screening	1,614	1,291	323	80.0%
	Males age greater than 49 with PSA test in last 24 months	918	548	370	59.7%
	Routine exam in last 24 months (All Ages)	5,577	5,200	377	93.2%
	Women age 40 to 75 with a screening mammogram last 24 months	1,599	1,151	448	72.0%

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

Chronic Conditions Prevalence

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

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

Chronic Condition	# With Condition	% of Members	Members per 1,000	Admits per 1,000	ER Visits per 1,000	PMPY
Affective Psychosis	93	1.67%	16.24	275.86	505.75	$21,486
Asthma	482	8.64%	84.16	142.41	456.15	$20,667
Atrial Fibrillation	68	1.22%	11.87	235.91	440.37	$52,527
Blood Disorders	508	9.10%	88.70	279.96	467.36	$36,423
CAD	172	3.08%	30.03	271.07	462.81	$33,280
COPD	74	1.33%	12.92	459.18	658.16	$41,271
Cancer	298	5.34%	52.03	239.31	289.48	$33,755
Chronic Pain	434	7.78%	75.78	156.29	503.31	$26,123
Congestive Heart Failure	59	1.06%	10.30	511.48	727.87	$52,520
Demyelinating Diseases	19	0.34%	3.32	266.67	480.00	$40,604
Depression	765	13.71%	133.57	151.55	415.30	$16,638
Diabetes	569	10.20%	99.35	115.62	257.34	$27,599
ESRD	7	0.13%	1.22	1,076.92	461.54	$96,774
Eating Disorders	44	0.79%	7.68	676.06	957.75	$38,088
HIV/AIDS	8	0.14%	1.40	0.00	275.86	$34,740
Hyperlipidemia	1,537	27.54%	268.36	87.13	227.24	$19,206
Hypertension	1,131	20.27%	197.47	122.13	300.19	$21,931
Immune Disorders	51	0.91%	8.90	372.26	481.75	$59,419
Inflammatory Bowel Disease	45	0.81%	7.86	715.23	423.84	$58,936
Liver Diseases	184	3.30%	32.13	319.32	619.48	$37,706
Morbid Obesity	352	6.31%	61.46	162.25	336.97	$25,828
Osteoarthritis	361	6.47%	63.03	141.73	428.35	$22,085
Peripheral Vascular Disease	47	0.84%	8.21	193.94	460.61	$37,432
Rheumatoid Arthritis	64	1.15%	11.17	116.50	266.30	$38,379

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

Data Includes Medical and Pharmacy
Based on 24 months incurred dates

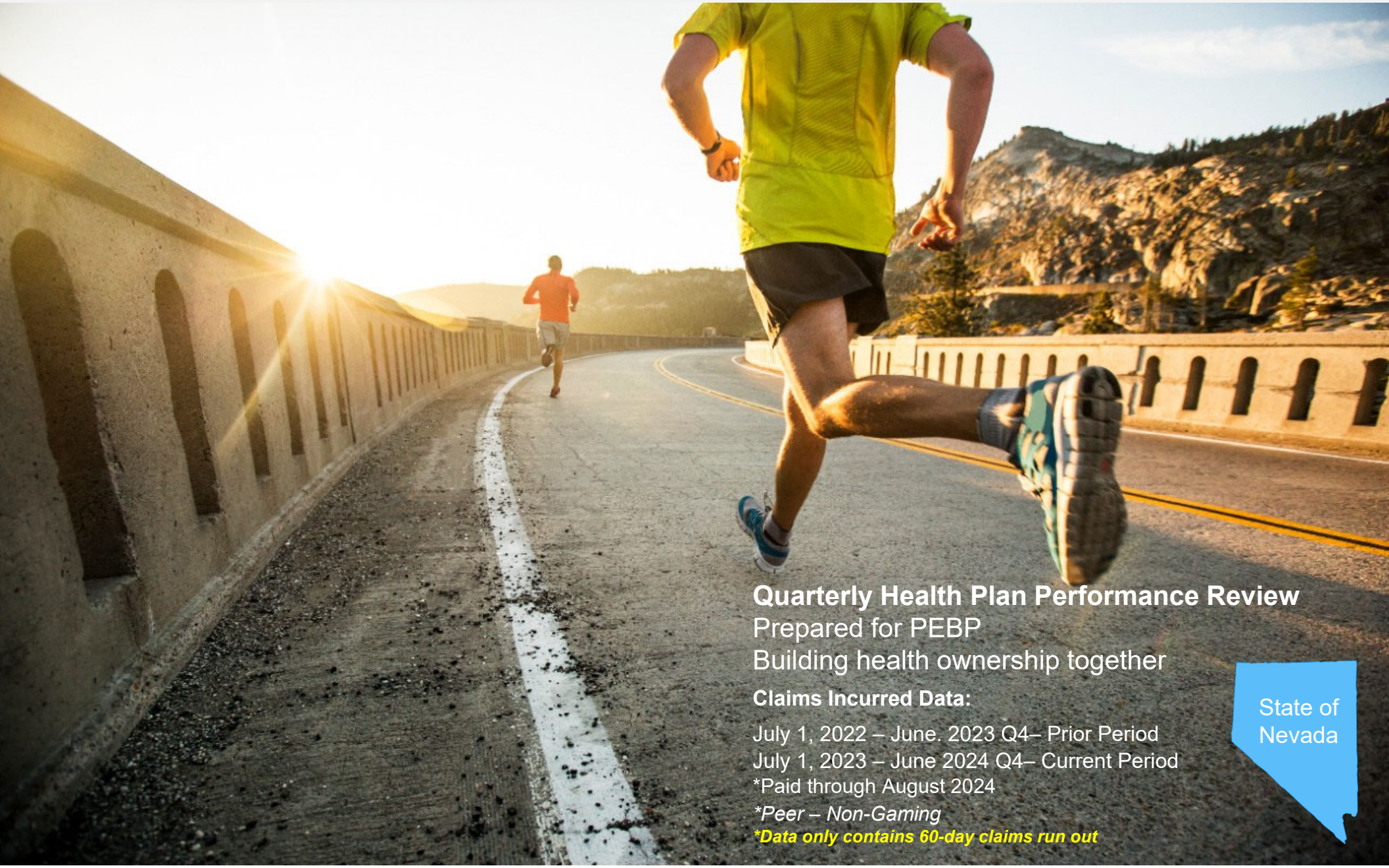
Methodology

- Average member counts were weighted by the number of months each member had on the plan.
- Claims were pulled based upon the date paid.
- Claims were categorized based upon four groups:
  - Inpatient Facility
  - Outpatient Facility
  - Physician
  - Other (Other includes any medical reimbursements or durable medical equipment.)
- Inpatient analysis was done by identifying facility claims where a room and board charge was submitted and paid. Claims were then rolled up for the entire admission and categorized by the diagnosis code that held the highest paid amount. (Hospice and skilled nursing facility claims were excluded)
- Outpatient claims were flagged by an in-or-outpatient indicator being present on the claim that identified it as taking place at an outpatient facility.
- Physician claims were identified when the vendor type indicator was flagged as a professional charge.
  - These claims were in some cases segregated further to differentiate primary care physicians and specialists.
  - Office visits were identified by the presence of evaluation and management or consultation codes.
- Emergency room and urgent care episodes should be considered subcategories of physician and outpatient facility.
  - Emergency Room visits are identified by facility claims with a revenue code of 450-455, 457-459.
  - Urgent Care visits are identified by facility claims with a revenue code of 456 or physician claims with a place of service of “Urgent Care”.
  - Outpatient claims (including facility and physician) are then rolled up for the day of service and summarized as an ER/UC visit.
  - If a member has an emergency room visit on the same day as an urgent care visit, all claims are grouped into one episode and counted as an emergency room visit.
  - If a member was admitted into the hospital through the ER, the member will not show an ER visit. ER claims are bundled with the inpatient stay.

Appendix D

Index of Tables
Health Plan of Nevada –Utilization Review for PEBP
July 1, 2023 – June 30, 2024

Power Of Partnership.



Quarterly Health Plan Performance Review
Prepared for PEBP
Building health ownership together

Claims Incurred Data:

July 1, 2022 – June. 2023 Q4– Prior Period
July 1, 2023 – June 2024 Q4– Current Period
*Paid through August 2024
**Peer – Non-Gaming*
Data only contains 60-day claims run out

State of Nevada

Executive Summary

Spend and Utilization

Executive Summary Utilization & Spend

UnitedHealthcare®

Population

- -2.1% decrease for employees
- -3.0% decrease for members

Medical Paid PMPM

- 2.9% increase in overall medical paid from prior period
- -1.0% decrease in non-Catastrophic spend
- -4.6% decrease in Catastrophic spend

High-Cost Claimants

- 72 HCC in 4Q24, remained flat year over year
- % of HCC spend saw a small decrease of -4.6%
- Avg. Paid per case increased -4.0%

Emergency Room

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

Urgent Care

- Urgent Care visits per 1,000 members increased by 6.9% from prior period
- Avg. paid per Urgent care visit increased 7.2%

Rx Drivers

- Rx Net Paid PMPM increased 4.9%
- Specialty Spend decreased -8.2%
- Specialty Rx driving 38.3% of total Rx Spend

Overall Medical / Rx

- Total Medical/Rx increased 3.4% on PMPM basis

Executive Summary Utilization & Spend

UnitedHealthcare®

Claims Paid by Age Group														
	July 2022 - June 2023 Q4						July 2023 - June 2024 Q4						Change	
Age Band	Medical Net Paid	Medical PMPM	Rx Net Paid	Rx PMPM	Med/Rx Net Paid	Med/Rx PMPM	Medical Net Paid	Medical PMPM	Rx Net Paid	Rx PMPM	Med/Rx Net Paid	Med/Rx PMPM	Med/Rx Net Paid	Med/Rx Net PMPM
<1	$788,891	$1,241	$1,522	$2	$790,414	$1,243	$671,816	$1,426	$1,234	$3	$673,050	$1,429	-14.8%	9.4%
01	$282,152	$456	$4,649	$8	$286,801	$463	$153,776	$273	$2,599	$5	$156,375	$277	-40.1%	-38.6%
02-04	$670,730	$296	$23,092	$10	$693,821	$307	$905,248	$469	$13,400	$7	$918,648	$476	58.2%	-32.0%
05-09	$857,789	$201	$70,318	$16	$928,107	$217	$738,384	$194	$73,234	$19	$811,618	$213	-3.5%	16.7%
10-14	$964,404	$177	$333,868	$61	$1,298,272	$238	$1,045,564	$197	$164,830	$31	$1,210,394	$228	11.2%	-49.3%
15-19	$1,076,434	$171	$235,767	$38	$1,312,201	$209	$1,157,165	$186	$255,704	$41	$1,412,869	$228	8.9%	9.9%
20-24	$804,656	$145	$197,695	$36	$1,002,351	$180	$1,166,838	$202	$109,309	$19	$1,276,147	$221	40.0%	-46.6%
25-29	$1,301,541	$384	$358,057	$106	$1,659,598	$490	$1,237,863	$391	$201,108	$63	$1,438,972	$454	1.8%	-39.9%
30-34	$1,263,084	$309	$570,543	$139	$1,833,627	$448	$1,156,613	$318	$523,013	$144	$1,679,626	$461	2.9%	3.0%
35-39	$1,509,372	$304	$986,824	$199	$2,496,196	$503	$1,577,339	$337	$1,185,312	$253	$2,762,651	$590	10.9%	27.5%
40-44	$1,755,462	$333	$738,558	$140	$2,494,019	$473	$2,208,540	$438	$755,409	$150	$2,963,949	$588	31.7%	7.0%
45-49	$2,463,327	$368	$1,140,464	$170	$3,603,791	$539	$2,186,661	$342	$1,604,663	$251	$3,791,324	$593	-7.1%	47.3%
50-54	$3,437,043	$457	$2,381,027	$317	$5,818,070	$774	$2,352,080	$315	$2,190,201	$294	$4,542,281	$609	-31.0%	-7.3%
55-59	$2,883,608	$395	$2,444,750	$335	$5,328,357	$730	$2,787,421	$374	$2,672,050	$359	$5,459,471	$733	-5.2%	7.1%
60-64	$4,432,279	$626	$2,398,260	$339	$6,830,539	$964	$3,909,024	$547	$2,076,672	$291	$5,985,695	$838	-12.5%	-14.1%
65+	$2,616,559	$521	$1,719,704	$343	$4,336,263	$864	$3,802,032	$749	$1,936,656	$381	$5,738,688	$1,130	43.6%	11.3%
Total	$27,107,331	$355	$13,605,097	$178	$40,712,428	$533	$27,056,365	$365	$13,765,391	$186	$40,821,757	$551	0.3%	3.4%

Financial Summary

UnitedHealthcare®

Financial and Demographic (*July 2023 thru June 2024 Q4*)												
	Total				State Active				Retiree (State/Non-State)			
Summary	Thru 4Q22	Thru 4Q23	Thru 4Q24	▲	Thru 4Q22	Thru 4Q23	Thru 4Q24	▲	Thru 4Q22	Thru 4Q23	Thru 4Q24	▲
Avg. # Employees	3,780	3,618	3,541	-2.1%	3,312	3,199	3,107	-2.9%	468	419	435	3.8%
Avg. # Members	6,672	6,370	6,176	-3.0%	6,053	5,804	5,582	-3.8%	619	566	595	5.1%
Ratio	1.8	1.8	1.7	-0.9%	1.8	1.8	1.8	-1.0%	1.3	1.4	1.4	1.2%
Financial												
Medical Paid	$38,424,993	$27,107,331	$27,056,365	-0.2%	$34,120,354	$24,546,189	$23,971,719	-2.3%	$4,304,639	$2,561,142	$3,084,646	20.4%
Member Paid	$2,701,033	$1,936,984	$2,262,369	16.8%	$1,910,804	$1,368,233	$1,650,867	20.7%	$790,229	$568,751	$611,501	7.5%
Net Paid PEPY	$10,165	$7,493	$7,640	2.0%	$10,104	$7,491	$7,517	0.3%	$10,594	$7,511	$8,523	13.5%
Net Paid PMPY	$5,759	$4,256	$4,381	2.9%	$5,529	$4,129	$4,184	1.3%	$8,017	$5,559	$6,231	12.1%
Net Paid PEPM	$847	$624	$637	2.0%	$842	$624	$626	0.3%	$883	$626	$710	13.5%
Net Paid PMPM	$480	$355	$365	2.9%	$461	$344	$349	1.3%	$668	$463	$519	12.1%
High Cost Claimants												
# of HCC's > $50k	95	72	72	0.0%	78	63	55	-12.7%	17	9	17	88.9%
Avg. paid per claiman	$206,470	$125,920	$120,857	-4.0%	$217,010	$122,929	$125,370	2.0%	$158,113	$146,858	$106,258	-27.6%
HCC % of Spend	50.6%	33.4%	31.9%	-4.6%	50.2%	32.3%	29.4%	-9.1%	52.8%	42.0%	47.5%	13.1%
Spend by Location (PMPY)												
Inpatient	$2,489	$1,151	$1,292	12.3%	$2,350	$1,312	$1,277	-2.7%	$3,853	$1,295	$2,225	71.8%
Outpatient	$1,152	$1,223	$1,092	-10.7%	$1,155	$1,095	$931	-15.0%	$1,244	$2,086	$1,468	-29.7%
Professional	$2,118	$1,882	$1,996	6.1%	$2,132	$1,288	$1,300	0.9%	$2,880	$2,141	$2,485	16.1%
Total	$5,760	$4,256	$4,381	2.9%	$5,637	$4,229	$4,295	1.5%	$7,976	$5,522	$6,177	11.9%

Paid Claims by Claim Type

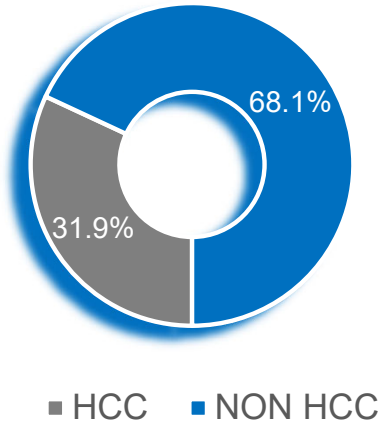
Net Paid Claims - Total									
Total Participants									
	July - June 2023 Q4				July - June 2024 Q4				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical									
InPatient	$5,963,422	$184,893	$1,181,290	$7,329,605	$5,762,331	$332,833	$1,887,106	$7,982,269	8.9%
OutPatient	$17,517,208	$825,249	$1,435,268	$19,777,726	$16,599,199	$559,871	$1,915,026	$19,074,096	-3.6%
Total - Medical	$23,480,630	$1,010,143	$2,616,559	$27,107,331	$22,361,529	$892,703	$3,802,132	$27,056,365	-0.2%

Net Paid Claims - Total									
Total Participants									
	July - June 2023 Q4				July - June 2024 Q4				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical PMPM	$336	$672	$1,742	$355	$331	$580	$749	$365	2.9%

Cost Distribution – Medical Claims > $50K

July - June 2023 Q3							July - June 2024 Q4					
# of Members	% of Population	Total Paid	% of Paid	Subscriber Paid	% of Subscribers paid	Paid Claims	# of Members	% of Population	Total Paid	% of Paid	Subscriber Paid	% of Subscribers paid
11	0.2%	$2,044,279	7.5%	$750,657	36.7%	> $100k	13	0.2%	$2,102,950	7.8%	$295,552	14.1%
26	0.4%	$2,823,456	10.4%	$1,537,324	54.4%	$50k- $100k	24	0.4%	$1,845,299	6.8%	$494,560	26.8%
68	1.1%	$2,574,035	9.5%	$1,448,813	56.3%	$25k - $50k	76	1.2%	$3,038,497	11.2%	$1,922,247	63.3%
224	3.5%	$4,756,931	17.5%	$2,425,483	51.0%	$10k - $25k	226	3.7%	$4,978,289	18.4%	$2,394,032	48.1%
344	5.4%	$3,098,287	11.4%	$1,678,147	54.2%	$5k - $10k	394	6.4%	$3,462,432	12.8%	$1,576,111	45.5%

% Paid Attributed to Catastrophic Cases



HCC > $50k - AHRQ Chapter Conditions - Thru June 2024 Q4			
Condition	# of Patients	Total Paid	% of Med Paid
Neoplasms	13	$1,619,187	5.9%
Diseases of the circulatory system	17	$1,614,138	5.9%
Diseases of the digestive system	4	$945,069	3.5%
Injury and poisoning	5	$802,246	2.9%
Infectious and parasitic diseases	5	$736,368	2.7%

Utilization Summary

UnitedHealthcare®

Utilization Summary									
	Total			State Active			Retiree State/Non-State		
	July - June 4Q23	July - June 4Q24	▲	July - June 4Q23	July - June 4Q24	▲	July - June 4Q23	July - June 4Q24	▲
Inpatient									
# of Admits	365	409	12.0%	326	336	3.0%	39	73	86.5%
# of Bedays	2,137	2,446	14.4%	1,882	1,826	-3.0%	255	620	142.7%
Avg. Paid per Admit	$20,205	$19,880	-1.6%	$20,338	$20,263	-0.4%	$19,098	$18,118	-5.1%
Avg. Paid per Day	$3,450	$3,321	-3.7%	$3,522	$3,725	5.8%	$2,925	$2,132	-27.1%
Admits Per K	57.3	66.2	15.5%	56.1	60.1	7.1%	69.1	122.7	77.5%
Days Per K	335.5	396.0	18.0%	324.2	327.1	0.9%	451.3	1,042.8	131.1%
ALOS	5.9	6.0	2.2%	5.8	5.4	-5.8%	5.5	5.9	7.3%
Admits from ER	187	199	6.4%	164	160	-2.4%	23	39	69.6%
Physician Office Visits									
Per Member Per Year	1.8	1.7	-2.4%	1.7	1.7	-1.8%	2.1	1.9	-8.4%
Paid Per Visit	$149	$152	2.3%	$154	$158	2.8%	$107	$105	-2.1%
Net Paid PMPM	$22	$22	-0.1%	$22	$22	0.9%	$19	$17	-10.4%
Emergency Room									
# of Visits	737	764	3.7%	669	694	3.7%	68	70	2.9%
Visits Per K	115.7	123.7	6.9%	115.3	124.3	7.9%	120.1	117.7	-2.0%
Avg Paid Per Visit	$2,634	$3,019	14.6%	$2,693	$3,084	14.5%	$2,048	$2,370	15.7%
Urgent Care									
# of Visits	4,011	3,973	-0.9%	3,617	3,573	-1.2%	394	400	1.5%
Visits Per K	629.7	643.3	2.2%	623.2	640.1	2.7%	696.1	672.7	-3.4%
Avg Paid Per Visit	$117	$126	7.2%	$91	$93	2.8%	$79	$88	11.3%

**Not Representative of all utilization*

**Data based on medical spend only*

Diagnosis Grouper Summary – Top 25

UnitedHealthcare®

*Current Period

Top 25 AHRQ Category	Total Paid	% Paid	Insured	Spouse	Dependent	Male	Female	Unassigned
Septicemia (except in labor)	$746,539	3.5%	$418,813	$322,517	$5,209	$506,276	$240,263	$0
Other nutritional; endocrine; and metabolic disorders	$675,566	3.2%	$447,426	$188,028	$40,112	$105,019	$570,547	$0
Spondylosis; intervertebral disc disorders;	$616,798	2.9%	$471,558	$128,894	$16,346	$271,043	$345,755	$0
Disorders usually diagnosed in infancy childhood	$576,584	2.7%	$66		$576,518	$458,365	$118,219	$0
Cancer of breast	$547,990	2.6%	$354,149	$193,841			$547,990	$0
Other nervous system disorders	$487,758	2.3%	$175,046	$298,777	$13,935	$100,264	$387,494	$0
Liveborn	$473,120	2.2%			$473,120	$459,173	$13,947	$0
Diabetes mellitus with complications	$436,743	2.0%	$313,174	$65,529	$58,040	$236,796	$199,947	$0
Osteoarthritis	$429,711	2.0%	$388,365	$41,346	$0	$167,264	$262,447	$0
Mood disorders	$405,220	1.9%	$174,171	$28,150	$202,900	$96,611	$308,610	$0
Other screening for suspected conditions	$368,647	1.7%	$299,721	$60,577	$8,348	$128,544	$240,103	$0
Coronary atherosclerosis and other heart disease	$338,488	1.6%	$149,292	$189,195		$298,426	$40,061	$0
Burns	$336,179	1.6%	$0		$336,179	$787	$335,392	$0
Acute cerebrovascular disease	$319,663	1.5%	$286,898	$32,395	$370	$180,928	$138,735	$0
Cardiac dysrhythmias	$297,370	1.4%	$216,377	$76,069	$4,925	$129,882	$167,488	$0
Nonspecific chest pain	$290,965	1.4%	$193,554	$77,978	$19,433	$160,183	$130,782	$0
Cancer of esophagus	$279,728	1.3%		$279,728		$279,728		$0
Anxiety disorders	$257,371	1.2%	$162,457	$26,189	$68,726	$69,670	$187,702	$0
Heart valve disorders	$255,373	1.2%	$102,610	$44,385	$108,378	$247,669	$7,704	$0
Viral infection	$254,936	1.2%	$128,400	$96,823	$29,713	$41,751	$213,186	$0
Abdominal pain	$251,425	1.2%	$172,718	$27,720	$50,987	$83,561	$167,865	$0
Peri-; endo-; and myocarditis; cardiomyopathy	$248,304	1.2%	$248,304	$0	$0	$186,496	$61,808	$0
Medical examination/evaluation	$242,108	1.1%	$54,480	$9,252	$178,376	$103,409	$138,699	$0
Hypertension complicating pregnancy;	$237,205	1.1%	$190,890	$8,704	$37,611		$237,205	$0
Complications of surgical procedures or medical care	$235,104	1.1%	$63,002	$125,711	$46,390	$139,303	$95,801	$0

*Not Representative of all utilization

*Data based on medical spend only

Mental Health Drilldown

UnitedHealthcare®

*Current Period

Top 10 Mental Health				
AHRQ Category Description	July - June 4Q23		July - June 4Q24	
	Patients	Total Paid	Patients	Total Paid
Disorders usually diagnosed in infancy childhood	47	$495,808	52	$576,584
Mood disorders	482	$394,957	445	$405,220
Anxiety disorders	469	$209,847	496	$257,371
Alcohol-related disorders	18	$20,807	33	$114,446
Adjustment disorders	151	$74,032	183	$92,964
Attention-deficit conduct and disruptive behavior disorders	157	$37,439	175	$52,892
Suicide and intentional self-inflicted injury	19	$36,388	14	$47,129
Schizophrenia and other psychotic disorders	17	$30,616	16	$37,003
Substance-related disorders	39	$54,026	49	$24,593
Miscellaneous mental health disorders	62	$41,644	72	$14,935

*Not Representative of all utilization

*Data based on medical spend only

Respiratory Disorders

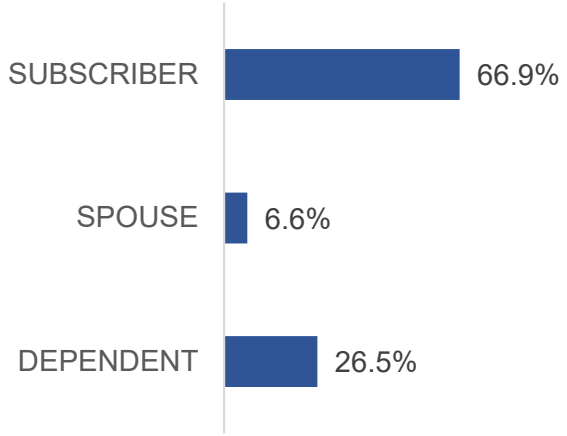
*Current Period

Top 10 Respiratory Disorders				
AHRQ Category Description	Patients	Claims	Total Paid	% Paid
Other upper respiratory infections	1,085	1,559	$209,414	23.2%
Other upper respiratory disease	523	1,522	$160,698	17.8%
Asthma	294	591	$135,752	15.0%
Other lower respiratory disease	587	1,044	$125,309	13.9%
Pneumonia (except that caused by tuberculosis or std)	47	144	$93,240	10.3%
Respiratory failure; insufficiency; arrest (adult)	26	112	$54,357	6.0%
Pleurisy; pneumothorax; pulmonary collapse	38	142	$43,753	4.9%
Acute and chronic tonsillitis	57	100	$37,841	4.2%
Influenza	83	93	$19,966	2.2%
Chronic obstructive pulmonary disease and bronchiectasis	136	282	$10,335	1.1%

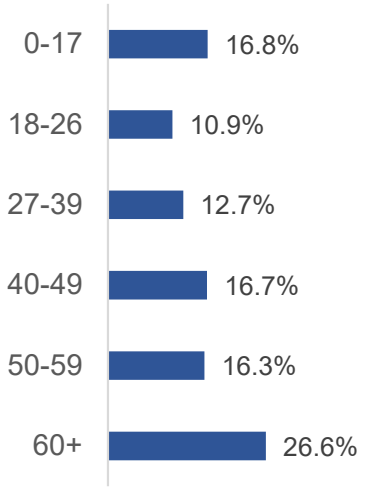
*Not Representative of all utilization

*Data based on medical spend only

Spend by Relationship



Spend by Age Range



Infections

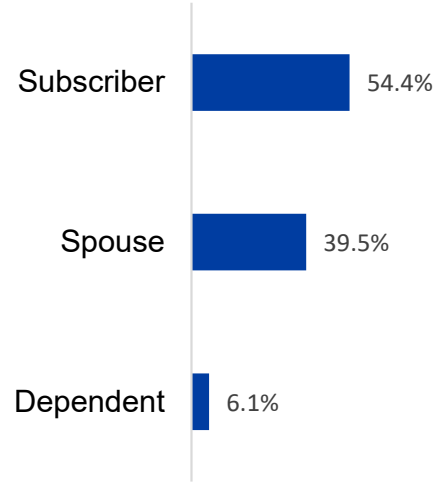
*Current Period

Top 10 Infectious and Parasitic Diseases				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Septicemia (except in labor)	35	99	$746,539	67.6%
Viral infection	416	622	$254,936	23.1%
Immunizations and screening for infectious disease	664	1,118	$74,602	6.8%
Bacterial infection; unspecified site	24	36	$14,393	1.3%
Mycoses	137	191	$7,916	0.7%
Hepatitis	14	72	$3,326	0.3%
HIV infection	24	150	$1,624	0.1%
Sexually transmitted infections (not HIV)	14	25	$819	0.1%
Tuberculosis	6	18	$681	0.1%
Other infections; including parasitic	15	22	$153	0.0%

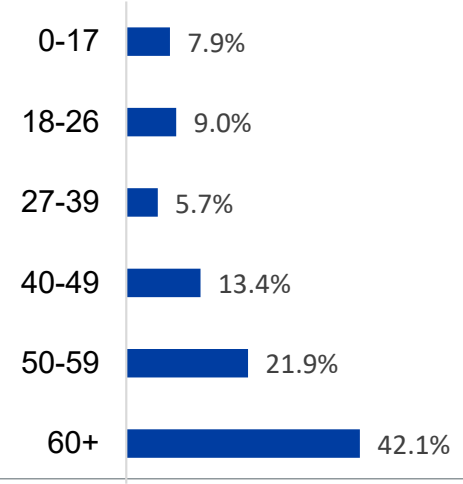
*Not Representative of all utilization

*Data based on medical spend only

Spend by Relationship



Spend by Age Range



Pregnancy Related Disorders

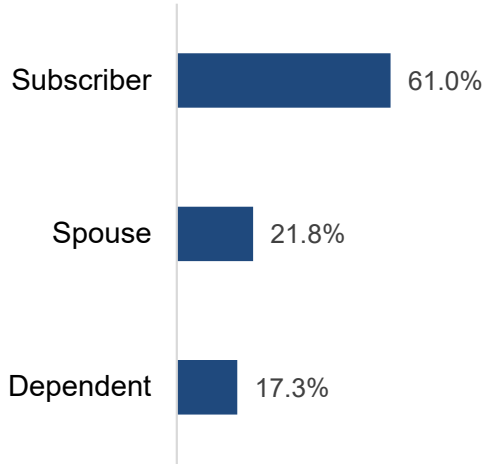
*Current Period

Top 10 Complications of Pregnancy				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Hypertension complicating pregnancy; childbirth and the puerperium	18	148	$237,205	19.0%
Other complications of pregnancy	78	420	$230,023	18.4%
Polyhydramnios and other problems of amniotic cavity	17	40	$115,338	9.2%
Diabetes or abnormal glucose tolerance complicating pregnancy; childl	13	118	$110,664	8.9%
Previous C-section	8	30	$96,175	7.7%
Other pregnancy and delivery including normal	94	424	$92,946	7.4%
Other complications of birth; puerperium affecting management of moth	30	67	$75,298	6.0%
Contraceptive and procreative management	198	410	$73,765	5.9%
Malposition; malpresentation	4	12	$51,942	4.2%
Fetal distress and abnormal forces of labor	8	16	$41,864	3.4%

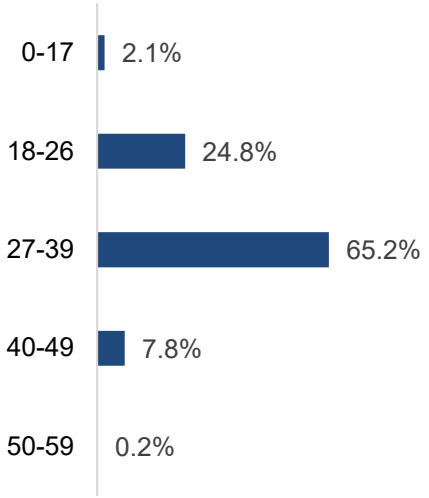
*Not Representative of all utilization

*Data based on medical spend only

Spend by Relationship



Spend by Age Range



Emergency Room and Urgent Care

Metric	July - June 4Q23		July - June 4Q24		Peer	
	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
# of Visits	737	4,011	764	3,973		
Visits Per Member	0.12	0.63	0.12	0.64	0.9	0.51
Visits Per K	115.7	629.7	123.7	643.3	97.4	522.1
Avg. Paid Per Visit	$2,634	$112	$3,018.84	$121	$2,742	$124

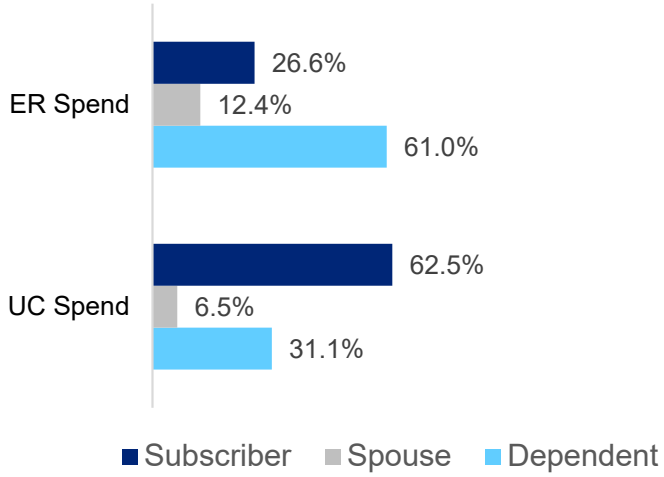
**Not Representative of all utilization*

**Data based on medical spend only*

**Current Period*

Emergency Room and Urgent Care Visits by Relationships - 4Q24				
Relationship	ER Visits	ER Per K	UC Visits	UC Per K
Member	232	37.6	2,565	415.3
Spouse	97	15.7	372	60.2
Dependent	435	70.4	1,036	167.7
Total	764	123.7	3,973	643.3

ER / UC Spend by Relationship



Clinical Conditions by Medical Spend

UnitedHealthcare®

*Current Period

Top 15 Common Condition	# of Members	% of Members	Members Per K	PMPM
Mental Disorders	904	11.0%	109.8	$16.48
Intervertebral Disc Disorders	669	8.1%	81.2	$8.32
Breast Cancer	69	0.8%	8.4	$7.39
Diabetes with complications	494	6.0%	60.0	$5.89
Coronary Atherosclerosis	121	1.5%	14.7	$3.90
Hypertension	707	8.6%	85.9	$4.57
Diabetes without complications	554	6.7%	67.3	$0.62
Asthma	290	3.5%	35.2	$1.41
Acute Myocardial Infarction	11	0.1%	1.3	$1.83
Prostate Cancer	27	0.3%	3.3	$2.00
Congestive Heart Failure (CHF)	53	0.6%	6.4	$0.78
Chronic Renal Failure	82	1.0%	10.0	$0.24
Colon Cancer	4	0.0%	0.5	$0.14
COPD	135	1.6%	16.4	$0.05
Cervical Cancer	41	0.5%	5.0	$0.69

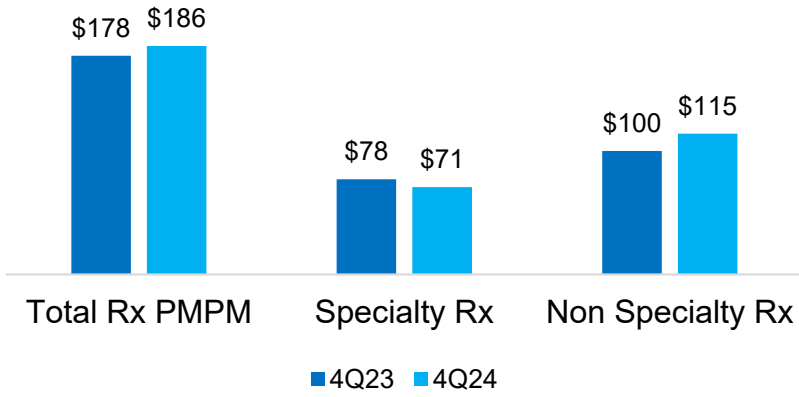
*Not Representative of all utilization

*Data based on medical spend only

Pharmacy Drivers

	July - June 4Q23	July - June 4Q23	Δ
Enrolled Members	6,370	6,176	-3.0%
Average Prescriptions PMPY	16.9	17.2	2.0%
Formulary Rate	89.8%	88.6%	-1.4%
Generic Use Rate	85.1%	85.8%	0.9%
Generic Substitution Rate	98.3%	98.4%	0.1%
Avg Net Paid per Prescription	$127	$130	2.3%
Net Paid PMPM	$178	$186	4.3%

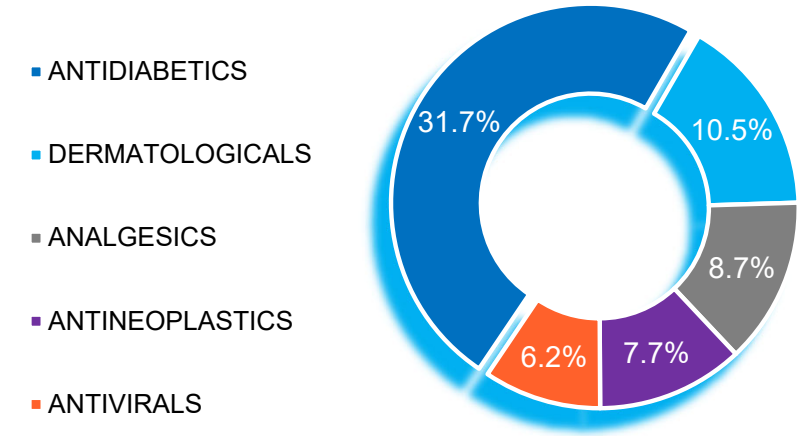
Total Rx Spend by Benefit and Type



Pharmacy Performance

- Rx spend increased of **4.3%**, (**$8 PMPM**) from prior period
- Avg. paid per Script increased **2.3%** (**$3 PMPM**) year over year
- Specialty Rx spend driving **38.3%** of Rx Spend
- Specialty Rx spend decreased **-8.2%** from prior period
  Specialty Rx Drivers:
  Ozempic (Antidiabetic) Accounts for **7.9%** of total Rx Spend
  Jardiance (Antidiabetic) Accounts for **6.3%** of total Rx Spend
- Tier 1 Rx drove **75.8%** of total claim volume, but only accounts for **8.5%** of overall Rx Spend

Top 5 Therapeutic Classes by Spend



4.2.2

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

4.2 Receipt of quarterly staff reports for the period ending June 30 and September 30, 2024:

4.2.1 Q4 Utilization Report

4.2.2 Q1 Budget Report

JOE LOMBARDO
Governor

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

CELESTENA GLOVER
Executive Officer

JOY GRIMMER
Board Chair

AGENDA ITEM

[X] Action Item

[ ] Information Only

Date: November 21, 2024

Item Number: 4.2.2

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of September 30, 2024, fiscal year end, to include:

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

Budget Account 1338 – Operational Budget – Shown below is a summary of the operational budget account status as of September 30, 2024, with comparisons to the same period in Fiscal Year 2024. The budget status is reported on a cash basis and does not include incurred expenses and income owed to the fund.

The budget status report reflects actual income of $128 million as of September 30, 2024, compared to $84.3 million as of September 30, 2023, or an increase of 51.8%. Total expenses for the period have increased by $3.4 million or 3.2% for the same period.

The budget status report shows Realized Funding Available (cash) at $112.7 million. This compares to $98.8 million for the same period of last year. The table below reflects the actual revenues and expenditures for the period.

Operational Budget 1338

	FISCAL YEAR 2025			FISCAL YEAR 2024		
	Actual as of 9/30/2024	Work Program	Percent	Actual as of 9/30/2023	Fiscal Year 2024 Close	Percent
Beginning Cash	94,373,969	94,373,969	100%	120,714,437	120,714,437	100%
Premium Income	107,099,019	433,139,318	25%	68,969,560	400,716,314	17%
All Other Income	20,873,108	24,983,809	84%	15,321,623	34,220,617	45%
Total Income	127,972,127	458,123,127	28%	84,291,183	434,936,931	19%
Personnel Services	714,211	3,020,415	24%	466,237	2,722,805	17%
Operating - Other than Personnel	430,300	3,095,546	14%	535,391	2,825,959	19%
Insurance Program Expenses	108,417,702	481,360,913	23%	105,168,351	455,467,372	23%
All Other Expenses	66,818	214,039	31%	39,316	172,381	23%
Total Expenses	109,629,031	487,690,913	22%	106,209,295	461,188,517	23%
Change in Cash	18,343,095	(29,567,786)		(21,918,112)	(26,251,586)	
REALIZED FUNDING AVAILABLE	112,717,064	64,806,183	174%	98,796,325	94,373,969	105%
Incurred But Not Reported Liability	(39,999,273)	(39,999,273)		(52,874,000)	(52,874,000)	
Catastrophic Reserve	(33,892,991)	(33,892,991)		(38,212,000)	(38,212,000)	
HRA Reserve	(14,864,089)	(14,864,089)		(20,600,889)	(20,600,889)	
NET REALIZED FUNDING AVAILABLE	23,960,711	(23,950,170)		(12,890,564)	(17,312,920)	

Current Budget Projections

The following table represents projections for FY 2025. The projection reflects total income to be more than budgeted by 3.0% ($581.1 million vs $564.3 million), total expenditures are projected to be less than budgeted by 8.1% ($ 437.1 million vs $ 475.7 million); and total reserves are projected to be more than budgeted by 62.3% ($ 144.0 million vs $88.8 million).

State Subsidies are projected to be more than the budgeted amount by $13.7 million (4.1%), Non-State Subsidies are projected to be less than budgeted by $2.2 million (10.6%), and Premium Income is projected to be less than budgeted by $11.4 million (13.8%). The overall increase in budgeted revenue is due in part to an increase in state subsidies because of actual state active enrollment compared to budgeted enrollment and a change in the mix of plan and tiers. The mix of participants is as follows:

- 2.35% more state actives,
- 6.50% less state non-Medicare retirees,
- 22.22% more non-state actives,
- 12.92% less non-state, non-Medicare retirees
- 4.59% less state Medicare retirees, and
- 6.77% less non-state Medicare retirees

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 9/30/24**	**Projected**	**Difference**	
Carryforward	94,373,969	94,373,969	94,373,969	0	0.0%
State Subsidies	330,044,762	82,968,505	343,695,171	13,650,409	4.1%
Non-State Subsidies	20,452,623	4,721,144	18,292,001	(2,160,622)	-10.6%
Premium	82,641,933	19,409,369	71,234,940	(11,406,993)	-13.8%
COVID Funds	0	0	0	0	66.7%
Appropriations	11,816,381	11,816,381	11,816,381	0	3.0%
All Other	24,983,809	10,863,458	41,650,062	16,666,253	66.7%
Total	564,313,477	224,152,827	581,062,524	16,749,047	3.0%

Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 9/30/24**	**Projected**	**Difference**	
Operating	6,330,000	1,211,330	6,440,476	(110,476)	-1.7%
State Insurance Costs	408,589,808	109,227,092	384,099,747	24,490,061	6.0%
Non-State Insurance Costs	10,009,650	652,205	3,474,015	6,535,635	65.3%
Medicare Retiree Insurance Costs	50,809,373	8,548,054	43,036,866	7,772,507	15.3%
Total Insurance Costs	469,408,831	118,427,352	430,610,628	38,798,203	8.3%
Total Expenses	475,738,831	119,638,681	437,051,104	38,687,727	8.1%
Restricted Reserves	88,756,353	88,756,353	103,091,071	(14,334,718)	-16.2%
Differential Cash Available	0	15,757,792	40,920,349	(40,920,349)	
Total Reserves	88,756,353	104,514,145	144,011,420	(55,255,067)	-62.3%
Total of Expenses and Reserves	564,495,184	224,152,827	581,062,524	(16,567,340)	-2.9%

Expenses for Fiscal Year 2025 are projected to be $38.7 million (8.1%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be more than budgeted by $0.1 million (1.7%). Employee and Retiree insurances costs are projected to be less than budgeted by $38.8 million (8.3%) when taken in total (see table above for specific information).

Recommendations

None.

4.2.3

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

4.2 Receipt of quarterly staff reports for the period ending June 30 and September 30, 2024:

4.2.1 Q4 Utilization Report

4.2.2 Q1 Budget Report

4.2.3 Contract Status Report

JOE LOMBARDO
Governor

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

JOY GRIMMER
Board Chair

AGENDA ITEM

[X] Action Item

[ ] Information Only

Date: November 21, 2024

Item Number: 4.2.3

Title: Contract Status Report

Summary

This report addresses the status of PEBP contracts to include:

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

1. Contracts Overview

Below is a listing of the active PEBP contracts as of October 31, 2024.

PEBP Active Contracts Summary

Vendor	Service	Contract #	Effective Date	Termination Date	Contract Max	Current Expenditures	Amount Remaining
Eide Bailly	Financial Auditor	27703	7/11/2023	12/31/2026	$ 386,500.00	$ 127,500.00	$ 259,000.00
Health Plan of Nevada Inc	Southern Nevada HMO	23802	7/1/2021	6/30/2025	$ 192,093,848.00	$ 142,844,177.44	$ 49,249,670.56
Diversified Dental Services Inc.	Dental PPO	23810	7/1/2021	6/30/2026	$ 1,601,613.00	$ 1,033,902.45	$ 567,710.55
Lifeworks/Telus Health	Benefits Management System	25935	5/10/2022	12/31/2026	$ 6,145,600.00	$ 3,376,896.08	$ 2,768,703.92
Express Scripts, Inc.	Pharmacy Benefit Manager	25582	5/10/2022	6/30/2026	$ 332,109,496.00	$ 203,955,914.60	$ 128,153,581.40
*Willis Towers Watson (VIA)	*Medicare Exchange	16468	7/1/2015	6/30/2025	$ 1,546,000.00	$ 1,233,741.92	$ 312,258.08
United Healthcare Insurance	Group Basic Life Insurance	25607	7/1/2022	6/30/2026	$ 12,824,248.00	$ 9,911,441.45	$ 2,912,806.55
Brown & Brown of Massachusetts	Health Plan Auditor	24030	4/13/2021	6/30/2027	$ 1,581,662.00	$ 618,404.00	$ 963,258.00
Segal Company, Inc.	Consulting Services	25557	7/1/2022	6/30/2027	$ 4,285,410.00	$ 1,711,375.00	$ 2,574,035.00
Capitol Reporters	Court Reporting	27029	2/1/2023	6/30/2025	$ 31,932.00	$ 11,550.00	$ 20,382.00
Carrum Health	Centers of Excellence	28745	2/12/2024	6/30/2028	$ 4,000,000.00	$ 92,206.52	$ 3,907,793.48
Carrum Health	Oncology Concierge	29053	5/14/2024	6/30/2028	$ 1,490,000.00	$ 40,000.00	$ 1,450,000.00
UMR, Inc.	TPA and Other Services	25155	7/1/2022	6/30/2028	$ 65,413,106.00	$ 9,345,082.04	$ 56,068,023.96

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

Recommendation

No action necessary

2. New Contracts

NO NEW CONTRACTS

Recommendation

No action necessary

3. Contract Amendment Ratifications

NO NEW CONTRACT AMENDMENTS

Recommendation

No action necessary.

4. Contract Solicitation Ratifications

PEBP does not currently have any contract solicitations for ratification.

5. Status of Current Solicitations

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

Service	Anticipated/ Actual RFP release date	Anticipated/ Actual NOI	Winning Vendor	Anticipated Board Approval
HMO Vendor	08/23/2024	10/2024	TBA	11/2024
Medicare Exchange Vendor	11/15/2024	12/2024	TBA	01/2025

4.3

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

4.3 Receipt of quarterly vendor reports for the period ending June 30, 2024:

4.3.1 Q4 Express Scripts – Summary Report

4.3.2 Q4 Express Scripts – Utilization Report

4.3.3 2nd MD – Annual Review Report

4.3.1

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

4.3 Receipt of quarterly vendor reports for the period ending June 30, 2024:

4.3.1 Q4 Express Scripts – Summary Report

Nevada PEBP

FY2024

Prepared by Client Analytics

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

9/13/2024

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

Hello PEBP Team,

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

CDHP Overall Trend Summaries:

CDHP Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$77.25**	
Utilization	$2.79	4.0%
Unit Cost	$3.88	5.5%
Member Share	$0.04	0.1%
Total Change in Plan Cost Net PMPM	**$6.71**	**9.5%**
Previous Period - Plan Cost Net PMPM	**$70.54**	

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

- **Cancer**: Previous ranked 2nd, currently ranked 2nd by Plan Cost Net.
  - Plan Cost Net ↓ $768k (18.4%) to current $3.4m.
  - Plan Cost Net PMPM ↓ $.88 (7.0%) to current $11.76.
  - Patient Count ↓ 3 to current count of 246.
  - Adjusted Rxs ↓ 113 to current count of 1,881.

- **Notable Drug Changes within Indication:**

  - **Revlimid:**
    - Previous ranked 1st, currently ranked 9th by Plan Cost Net.
    - Plan Cost Net ↓ $379k (71.0%) to current $155k.
    - Plan Cost Net PMPM ↓ $1.08 (66.9%) to current $.53.
    - Patient Count ↓ 2 to current count of 2.
    - Adjusted Rxs ↓ 20 to current count of 13.

  - **Brukinsa:**
    - Previous ranked 25th, currently ranked 4th by Plan Cost Net.
    - Plan Cost Net ↑ $218k (2147.0%) to current $228k.
    - Plan Cost Net PMPM ↑ $.75 (2462.0%) to current $.79.
    - Patient Count ↑ 1 to current count of 2.
    - Adjusted Rxs ↑ 18 to current count of 19.

- **Unureg:**
  - Previous ranked 14th, currently ranked 2nd by Plan Cost Net.
  - Plan Cost Net ↑ $210k (175.6%) to current $330k.
  - Plan Cost Net PMPM ↑ $.78 (214.2%) to current $1.14.
  - Patient Count: Remains at 1.
  - Adjusted Rxs ↑ 8 to current count of 15.

- **Lenalidomide (Generic for Revlimid):**
  - Previous ranked 8th, currently ranked 1st by Plan Cost Net.
  - Plan Cost Net ↑ $149k (67.2%) to current $372k.
  - Plan Cost Net PMPM ↑ $.61 (90.6%) to current $1.28.
  - Patient Count: Remains at 3.
  - Adjusted Rxs ↑ 12 to current count of 29.

- **Vaccinations**: Previous ranked 7th, currently ranked 5th by Plan Cost Net.
  - Plan Cost Net ↑ $393k (50.1%) to current $1.2m.
  - Plan Cost Net PMPM ↑ $1.69 (71.2%) to current $4.06.
  - Patient Count ↓ 1,956 to current count of 5,273.
  - Adjusted Rxs ↓ 2,623 to current count of 10,214.

- **Notable Drug Changes within Indication:**

  - **Comirnaty 2023-2024 (COVID):**
    - New, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net: New, current $275k.
    - Plan Cost Net PMPM: New, current $.95.
    - Patient Count: New, current count of 1,884.
    - Adjusted Rxs: New, current count of 1,929.

  - **Spikevax 2023-2024 (COVID):**
    - New, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net: New, current $206k.
    - Plan Cost Net PMPM: New, current $.71.
    - Patient Count: New, current count of 1,329.
    - Adjusted Rxs: New, current count of 1,354.

  - **Arexvy (RSV):**
    - New, currently ranked 3rd by Plan Cost Net.
    - Plan Cost Net: New, current $160k.
    - Plan Cost Net PMPM: New, current $.55.
    - Patient Count: New, current count of 591.
    - Adjusted Rxs: New, current count of 590.

- **Ophthalmic Conditions**: Previous ranked 21st, currently ranked 9th by Plan Cost Net.
  - Plan Cost Net ↑ $498k (210.4%) to current $735k.
  - Plan Cost Net PMPM ↑ $1.82 (253.9%) to current $2.54.
  - Patient Count ↓ 35 to current count of 365.
  - Adjusted Rxs ↑ 26 to current count of 942.

- **Notable Drug Changes within Indication:**

  - **Tepezza:**
    - Previous ranked 2nd, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $396k (686.5%) to current $453k.
    - Plan Cost Net PMPM ↑ $1.39 (796.8%) to current $1.56.
    - Patient Count: Remains at 1.
    - Adjusted Rxs ↑ 7 to current count of 8.

  - **Eylea:**
    - Previous ranked 1st, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net ↑ $58k (55.3%) to current $163k.
    - Plan Cost Net PMPM ↑ $.24 (77.0%) to current $.56.
    - Patient Count ↑ 5 to current count of 17.
    - Adjusted Rxs ↑ 39 to current count of 98.

  - **Oxervate:**
    - New, currently ranked 3rd by Plan Cost Net.
    - Plan Cost Net: New, current $76k.
    - Plan Cost Net PMPM: New, current $.26.
    - Patient Count: New, current count of 1.
    - Adjusted Rxs: New, current count of 4.

Peer Comparison:

- Peer: ESI CDH Program
- PEBP CDHP is outperforming the peer.
- Peer experienced Plan Cost Net PMPM of $80.91 compared to CDHP PEBP of $77.25.
- Peer experienced Trend of 11.6%, compared to CDHP PEBP Trend of 9.5%.

EPO Overall Trend Summaries:

EPO Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$178.45**	
Utilization	$8.79	5.7%
Unit Cost	$13.44	8.8%
Member Share	$3.23	2.1%
Total Change in Plan Cost Net PMPM	**$25.46**	**16.6%**
Previous Period - Plan Cost Net PMPM	**$152.99**	

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

- **Diabetes**: Previous ranked 2nd, currently ranked 2nd by Plan Cost Net.
  - Plan Cost Net ↑ $246k (15.7%) to current $1.8m.
  - Plan Cost Net PMPM ↑ $6.07 (30.0%) to current $26.28.
  - Patient Count ↓ 25 to current count of 647.
  - Adjusted Rxs ↑ 104 to current count of 11,514.

- **Notable Drug Changes within Indication:**

  - **Ozempic:**
    - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $161k (40.5%) to current $560k.
    - Plan Cost Net PMPM ↑ $2.89 (57.8%) to current $8.15.
    - Patient Count ↑ 15 to current count of 157.
    - Adjusted Rxs ↑ 298 to current count of 1,230.

  - **Mounjaro:**
    - Previous ranked 3rd, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net ↑ $177k (111.5%) to current $335k.
    - Plan Cost Net PMPM ↑ $2.82 (137.6%) to current $4.87.
    - Patient Count ↑ 32 to current count of 91.
    - Adjusted Rxs ↑ 325 to current count of 664.

  - **Trulicity:**
    - Previous ranked 2nd, currently ranked 3rd by Plan Cost Net.
    - Plan Cost Net ↓ $80k (32.0%) to current $171k.
    - Plan Cost Net PMPM ↓ $.77 (23.6%) to current $2.49.
    - Patient Count ↓ 18 to current count of 53.
    - Adjusted Rxs ↓ 206 to current count of 401.

- **Endocrine Disorders**: Previous ranked 3rd, currently ranked 3rd by Plan Cost Net.
    - Plan Cost Net ↑ $230k (19.0%) to current $1.4m.
    - Plan Cost Net PMPM ↑ $5.28 (33.7%) to current $20.94.
    - Patient Count ↓ 6 to current count of 31.
    - Adjusted Rxs ↓ 4 to current count of 234.

- **Notable Drug Changes within Indication:**

    - **Korlym:**
        - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
        - Plan Cost Net ↑ $201k (17.8%) to current $1.3m.
        - Plan Cost Net PMPM ↑ $4.73 (32.4%) to current $19.35.
        - Patient Count: Remains at 2.
        - Adjusted Rxs ↑ 6 to current count of 23.

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

- **Gout**: Previous ranked 44th, currently ranked 16th by Plan Cost Net.
    - Plan Cost Net ↑ $160k (888.1%) to current $178k.
    - Plan Cost Net PMPM ↑ $2.36 (1010.0%) to current $2.59.
    - Patient Count ↓ 9 to current count of 127.
    - Adjusted Rxs ↓ 5 to current count of 1,096.

- **Notable Drug Changes within Indication:**

    - **Krystexxa:**
        - New, currently ranked 1st by Plan Cost Net.
        - Plan Cost Net: New, current $162k.
        - Plan Cost Net PMPM: New, current $2.35
        - Patient Count: New, current count of 2.
        - Adjusted Rxs: New, current count of 4.

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

Peer Comparison:

- Government – West Region/SaveOn (custom peer created for PEBP EPO plan)
- The peer is outperforming PEBP EPO.
- Peer experienced Plan Cost Net PMPM of $106.99 compared to PEBP EPO of $178.45
- Peer experienced Trend of 11.5%, compared to PEBP EPO of 16.6%

PPO Overall Trend Summaries:

PPO Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$103.31**	
Utilization	$2.75	3.3%
Unit Cost	$14.74	17.5%
Member Share	$1.67	2.0%
Total Change in Plan Cost Net PMPM	**$19.16**	**22.8%**
Previous Period - Plan Cost Net PMPM	**$84.15**	

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

- **Inflammatory Conditions**: Previous ranked 1st, currently ranked 1st by Plan Cost Net.
  - Plan Cost Net ↑ $1.5m (54.3%) to current $4.3m.
  - Plan Cost Net PMPM ↑ $2.47 (15.3%) to current $18.69.
  - Patient Count ↑ 77 to current count of 279.
  - Adjusted Rxs ↑ 717 to current count of 2,576.

- **Notable Drug Changes within Indication:**

  - **Stelara:**
    - Previous ranked 3rd, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net ↑ $316k (113.9%) to current $593k.
    - Plan Cost Net PMPM ↑ $.96 (59.8%) to current $2.57.
    - Patient Count ↑ 5 to current count of 14.
    - Adjusted Rxs ↑ 49 to current count of 131.

  - **Skyrizi Pen:**
    - Previous ranked 4th, currently ranked 3rd by Plan Cost Net.
    - Plan Cost Net ↑ $161k (75.1%) to current $376k.
    - Plan Cost Net PMPM ↑ $.38 (30.9%) to current $1.63.
    - Patient Count ↑ 3 to current count of 13.
    - Adjusted Rxs ↑ 40 to current count of 110.

  - **Rinvoq:**
    - Previous ranked 7th, currently ranked 5th by Plan Cost Net.
    - Plan Cost Net ↑ $239k (196.6%) to current $360k.
    - Plan Cost Net PMPM ↑ $.86 (121.6%) to current $1.56.
    - Patient Count ↑ 11 to current count of 16.
    - Adjusted Rxs ↑ 75 to current count of 115.

- **Diabetes**: Previous ranked 2nd, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net ↑ $1.7m (89.6%) to current $3.7m.
    - Plan Cost Net PMPM ↑ $4.73 (41.6%) to current $16.08.
    - Patient Count ↑ 530 to current count of 1,582.
    - Adjusted Rxs ↑ 8,439 to current count of 23,829.

- **Notable Drug Changes within Indication:**

    - **Ozempic:**
        - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
        - Plan Cost Net ↑ $582k (109.8%) to current $1.1m.
        - Plan Cost Net PMPM ↑ $1.75 (56.8%) to current $4.83.
        - Patient Count ↑ 148 to current count of 355.
        - Adjusted Rxs ↑ 1,211 to current count of 2,491.

    - **Mounjaro:**
        - Previous ranked 3rd, currently ranked 2nd by Plan Cost Net.
        - Plan Cost Net ↑ $697k (350.1%) to current $896k.
        - Plan Cost Net PMPM ↑ $2.73 (350.1%) to current $3.89.
        - Patient Count ↑ 143 to current count of 236.
        - Adjusted Rxs ↑ 1,356 to current count of 1,780.

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

- **Enzyme Deficiencies**: Previous ranked 6th, currently ranked 4th by Plan Cost Net.
    - Plan Cost Net ↑ $1m (158.2%) to current $1.7m.
    - Plan Cost Net PMPM ↑ $3.46 (92.9%) to current $7.18.
    - Patient Count ↑ 3 to current count of 7.
    - Adjusted Rxs ↑ 29 to current count of 52.

- **Notable Drug Changes within Indication:**

    - **Nexviazyme:**
        - Previous ranked 2nd, currently ranked 1st by Plan Cost Net.
        - Plan Cost Net ↑ $608k (313.4%) to current $803k.
        - Plan Cost Net PMPM ↑ $2.36 (208.9%) to current $3.49.
        - Patient Count: Remains at 1.
        - Adjusted Rxs ↑ 8 to current count of 12.

- **Galafold:**
  - New, currently ranked 3rd by Plan Cost Net.
  - Plan Cost Net: New, current $237k.
  - Plan Cost Net PMPM: New, current $1.03.
  - Patient Count: New, current count of 1.
  - Adjusted Rxs: New, current count of 8.

- **Palnziq:**
  - Previous ranked 4th, currently ranked 4th by Plan Cost Net.
  - Plan Cost Net ↑ $131k (1059.1%) to current $144k.
  - Plan Cost Net PMPM ↑ $.55 (766.0%) to current $.62.
  - Patient Count: Remains at 1.
  - Adjusted Rxs ↑ 9 to current count of 10.

Peer Comparison:

- Government – West Region/SaveOn (custom peer created for PEBP PPO plan)
- PEBP PPO is outperforming the peer.
- Peer experienced Plan Cost Net PMPM of $106.99 compared to PEBP PPO of $103.31
- Peer experienced Trend of 11.5%, compared to PEBP PPO of 22.8%

Total Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$99.27**	
Utilization	$2.89	3.4%
Unit Cost	$8.94	10.4%
Member Share	$1.86	2.2%
Total Change in Plan Cost Net PMPM	**$13.69**	**16.0%**
Previous Period - Plan Cost Net PMPM	**$85.58**	

Summary of Total – Overall the main driver of Trend was Specialty Utilization driven by an increase of 11.5% in Specialty patients. This resulted in a 18.7% increase in Specialty Days of Therapy.

Overall Trend was mitigated by increased rebates of 36.0%. This produced a negative Unit Cost Trend of (4.0%) on Specialty drugs and reduced Non-Specialty Unit Cost Trend to 11.8%, combined Unit Cost Trend is 10.4%.

Member Cost contributed to Trend on both Non-Specialty and Specialty drugs: NSP 3.1%, SP 1.4%. This is due to Drug Mix on Non-Specialty drugs, which was primary driven by utilization of more expensive brand drugs.

Key Statistics:

Nevada PEBP Total			
Description	FY24	FY23	Change
Average Members per Month	49,065	48,303	1.6%
Number of Unique patients	37,636	38,417	-2.0%
Members Utilizing the Benefit	76.7%	79.5%	-2.8
Gross Cost/Adjusted Rx	$103.50	$93.38	10.8%
Plan Spend	$88,157,729	$71,454,594	23.4%
Rebates (estimated)	$29,710,201	$21,849,300	36.0%
Plan Cost Net	$58,447,528	$49,605,295	17.8%
Plan Cost Net PMPM	$99.27	$85.58	16.0%
Non-Specialty Plan Cost Net PMPM	$45.91	$38.87	18.1%
Specialty Plan Cost Net PMPM	$53.36	$46.71	14.2%
Generic Fill Rate	87.0%	85.9%	1.0
90 Day Utilization	60.3%	61.5%	-1.2
Retail - Maintenance 90 Utilization	28.7%	28.6%	0.1
Home Delivery Utilization	31.6%	33.0%	-1.4
Member Cost Net %	24.4%	25.8%	-1.4

END OF REPORT

4.3.2

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

4.3 Receipt of quarterly vendor reports for the period ending June 30, 2024:

4.3.1 Q4 Express Scripts – Summary Report

4.3.2 Q4 Express Scripts – Utilization Report

Nevada PEBP FY24 Report

7/1/2023 – 6/30/2024

Report Includes:

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

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

PREPARED BY CLIENT ANALYTICS
Cynthia Eaton (Cynthia.eaton@express-scripts.com)
9/13/24

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN

+ FY24 vs FY23

Membership Summary	FY 2024	FY 2023	Change
Member Count (Membership)	49,065	48,303	1.6%
Utilizing Member Count (Patients)	37,636	38,417	-2.0%
Percent Utilizing (Utilization)	76.7%	79.5%	-2.8

Claim Summary	FY 2024	FY 2023	Change
Net Claims (Total Adjusted Rx's)	746,853	715,955	4.3%
Claims per Elig Member per Month (Claims PMPM)	1.27	1.24	2.7%
Total Claims for Generic (Generic ARx)	649,591	615,235	5.6%
Total Claims for Brand (Brand ARx)	97,262	100,720	-3.4%
Total Claims for Multisource Brand Claims (MSB ARx)	3,169	3,243	-2.3%
Total Non-Specialty Claims	737,808	708,178	4.2%
Total Specialty Claims	9,045	7,777	16.3%
Generic % of Total Claims (GFR)	**87.0%**	**85.9%**	**1.0**
Generic Effective Rate (GCR)	99.5%	99.5%	0.0
Mail Order Claims	209,789	208,522	0.6%
Mail Penetration Rate*	31.6%	33.0%	-1.4

Claims Cost Summary	FY 2024	FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$107,007,335**	**$88,706,897**	**20.6%**
Total Generic Gross Cost	$11,202,461	$10,287,463	8.9%
Total Brand Gross Cost	$95,804,875	$78,419,434	22.2%
Total MSB Gross Cost	$1,833,053	$1,799,701	1.9%
Total Ingredient Cost	$103,921,159	$85,844,240	21.1%
Total Dispensing Fee	$3,005,678	$2,765,356	8.7%
Total Other (e.g. tax)	$80,498	$97,301	-17.3%
Avg Total Cost per Claim (Gross Cost/ARx)	**$143.28**	**$123.90**	**15.6%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$17.25	$16.72	3.1%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$985.02	$778.59	26.5%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$578.43	$554.95	4.2%

Express Scripts By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN

+ FY24 vs FY23

Member Cost Summary	FY 2024	FY 2023	Change
Total Member Cost Share	**$18,849,606**	**$17,252,302**	**9.3%**
Generic Cost Share	$4,290,369	$3,938,966	8.9%
Brand Cost Share	$14,559,238	$13,313,336	9.4%
MSB Cost Share	$238,097	$326,899	-27.2%
Total Copay	$17,237,956	$15,430,999	11.7%
Total Deductible	$1,611,650	$1,821,304	-11.5%
Avg Copay per Claim (Member Cost Share/ARx)	**$25.24**	**$24.10**	**4.7%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.60	$6.40	3.2%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$149.69	$132.18	13.2%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$75.13	$100.80	-25.5%
Copay % of Total Prescription Cost (Member Cost Share %)	**17.6%**	**19.4%**	**-1.8**

Plan Cost Summary	FY 2024	FY 2023	Change
Total Plan Cost (Plan Cost)	**$88,157,729**	**$71,454,594**	**23.4%**
Generic Plan Cost	$6,912,092	$6,348,496	8.9%
Brand Plan Cost	$81,245,637	$65,106,098	24.8%
MSB Plan Cost	$1,594,956	$1,472,802	8.3%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$41,810,194	$35,018,889	19.4%
Total Specialty Drug Cost (Specialty Plan Cost)	$46,347,535	$36,435,706	27.2%
Avg Plan Cost per Claim (Plan Cost/ARx)	$118.04	$99.80	18.3%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$10.64	$10.32	3.1%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$835.33	$646.41	29.2%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$503.30	$454.15	10.8%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$56.67	$49.45	14.6%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$5,124.11	$4,685.06	9.4%
Plan Cost PMPM	**$149.73**	**$123.27**	**21.5%**
Non-Specialty Plan Cost PMPM	$71.01	$60.42	17.5%
Specialty Plan Cost PMPM	$78.72	$62.86	25.2%
Specialty % of Plan Cost	52.6%	51.0%	1.6
Net Plan Cost PMPM (factoring Rebates)	**$99.27**	**$85.58**	**16.0%**
Non-Specialty Plan Cost PMPM	$45.91	$38.87	18.1%
Specialty Plan Cost PMPM	$53.36	$46.71	14.2%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN

+ FY24 vs FY23

Membership Summary	FY 2024	FY 2023	Change
Member Count (Membership)	24,149	27,535	-12.3%
Utilizing Member Count (Patients)	17,575	21,017	-16.4%
Percent Utilizing (Utilization)	72.8%	76.3%	-3.6

Claim Summary	FY 2024	FY 2023	Change
Net Claims (Total Adjusted Rx's)	340,521	376,677	-9.6%
Claims per Elig Member per Month (Claims PMPM)	1.18	1.14	3.1%
Total Claims for Generic (Generic ARx)	299,405	325,987	-8.2%
Total Claims for Brand (Brand ARx)	41,116	50,690	-18.9%
Total Claims for Multisource Brand Claims (MSB ARx)	1,117	1,493	-25.2%
Total Non-Specialty Claims	336,537	372,744	-9.7%
Total Specialty Claims	3,984	3,933	1.3%
Generic % of Total Claims (GFR)	**87.9%**	**86.5%**	**1.4**
Generic Effective Rate (GCR)	99.6%	99.5%	0.1
Mail Order Claims	92,626	105,990	-12.6%
Mail Penetration Rate*	30.7%	32.0%	-1.3

Claims Cost Summary	FY 2024	FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$44,003,462**	**$43,484,642**	**1.2%**
Total Generic Gross Cost	$4,531,341	$5,089,899	-11.0%
Total Brand Gross Cost	$39,472,121	$38,394,743	2.8%
Total MSB Gross Cost	$523,824	$817,422	-35.9%
Total Ingredient Cost	$42,593,561	$41,986,449	1.4%
Total Dispensing Fee	$1,380,824	$1,453,215	-5.0%
Total Other (e.g. tax)	$29,076	$44,979	-35.4%
Avg Total Cost per Claim (Gross Cost/ARx)	**$129.22**	**$115.44**	**11.9%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$15.13	$15.61	-3.1%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$960.02	$757.44	26.7%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$468.96	$547.50	-14.3%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

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+ CDHP PLAN

+ FY24 vs FY23

Member Cost Summary	FY 2024	FY 2023	Change
Total Member Cost Share	**$9,448,736**	**$9,854,969**	**-4.1%**
Generic Cost Share	$1,928,505	$2,082,443	-7.4%
Brand Cost Share	$7,520,231	$7,772,526	-3.2%
MSB Cost Share	$134,398	$227,843	-41.0%
Total Copay	$7,839,056	$8,036,153	-2.5%
Total Deductible	$1,609,680	$1,818,817	-11.5%
Avg Copay per Claim (Member Cost Share/ARx)	**$27.75**	**$26.16**	**6.1%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.44	$6.39	0.8%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$182.90	$153.33	19.3%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$120.32	$152.61	-21.2%
Copay % of Total Prescription Cost (Member Cost Share %)	**21.5%**	**22.7%**	**-1.2**

Plan Cost Summary	FY 2024	FY 2023	Change
Total Plan Cost (Plan Cost)	**$34,554,726**	**$33,629,673**	**2.8%**
Generic Plan Cost	$2,602,836	$3,007,456	-13.5%
Brand Plan Cost	$31,951,890	$30,622,217	4.3%
MSB Plan Cost	$389,426	$589,578	-33.9%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$14,723,453	$14,934,338	-1.4%
Total Specialty Drug Cost (Specialty Plan Cost)	$19,831,273	$18,695,335	6.1%
Avg Plan Cost per Claim (Plan Cost/ARx)	$101.48	$89.28	13.7%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$8.69	$9.23	-5.8%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$777.12	$604.11	28.6%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$348.64	$394.89	-11.7%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$43.75	$40.07	9.2%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$4,977.73	$4,753.45	4.7%
Plan Cost PMPM	**$119.24**	**$101.78**	**17.2%**
Non-Specialty Plan Cost PMPM	$50.81	$45.20	12.4%
Specialty Plan Cost PMPM	$68.43	$56.58	20.9%
Specialty % of Plan Cost	57.4%	55.6%	1.8
Net Plan Cost PMPM (factoring Rebates)	**$77.25**	**$70.54**	**9.5%**
Non-Specialty Plan Cost PMPM	$31.36	$27.96	12.2%
Specialty Plan Cost PMPM	$45.89	$42.58	7.8%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ FY24 vs FY23

Membership Summary	FY 2024	FY 2023	Change
Member Count (Membership)	5,730	6,437	-11.0%
Utilizing Member Count (Patients)	4,735	5,546	-14.6%
Percent Utilizing (Utilization)	82.6%	86.2%	-3.5

Claim Summary	FY 2024	FY 2023	Change
Net Claims (Total Adjusted Rx's)	126,270	134,884	-6.4%
Claims per Elig Member per Month (Claims PMPM)	1.84	1.75	5.2%
Total Claims for Generic (Generic ARx)	108,916	115,470	-5.7%
Total Claims for Brand (Brand ARx)	17,354	19,414	-10.6%
Total Claims for Multisource Brand Claims (MSB ARx)	644	666	-3.3%
Total Non-Specialty Claims	124,671	133,202	-6.4%
Total Specialty Claims	1,599	1,682	-4.9%
Generic % of Total Claims (GFR)	**86.3%**	**85.6%**	**0.6**
Generic Effective Rate (GCR)	99.4%	99.4%	0.0
Mail Order Claims	37,164	38,666	-3.9%
Mail Penetration Rate*	32.3%	31.6%	0.7

Claims Cost Summary	FY 2024	FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$21,118,865**	**$20,089,644**	**5.1%**
Total Generic Gross Cost	$1,921,950	$1,995,532	-3.7%
Total Brand Gross Cost	$19,196,915	$18,094,112	6.1%
Total MSB Gross Cost	$473,029	$402,866	17.4%
Total Ingredient Cost	$20,595,503	$19,554,173	5.3%
Total Dispensing Fee	$505,904	$516,518	-2.1%
Total Other (e.g. tax)	$17,458	$18,954	-7.9%
Avg Total Cost per Claim (Gross Cost/ARx)	**$167.25**	**$148.94**	**12.3%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$17.65	$17.28	2.1%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$1,106.20	$932.01	18.7%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$734.52	$604.90	21.4%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ FY24 vs FY23

Member Cost Summary	FY 2024	FY 2023	Change
Total Member Cost Share	**$3,109,910**	**$3,268,246**	**-4.8%**
Generic Cost Share	$748,686	$767,716	-2.5%
Brand Cost Share	$2,361,224	$2,500,531	-5.6%
MSB Cost Share	$50,090	$56,010	-10.6%
Total Copay	$3,107,939	$3,265,760	-4.8%
Total Deductible	$1,971	$2,487	-20.8%
Avg Copay per Claim (Member Cost Share/ARx)	**$24.63**	**$24.23**	**1.6%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.87	$6.65	3.4%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$136.06	$128.80	5.6%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$77.78	$84.10	-7.5%
Copay % of Total Prescription Cost (Member Cost Share %)	**14.7%**	**16.3%**	**-1.5**

Plan Cost Summary	FY 2024	FY 2023	Change
Total Plan Cost (Plan Cost)	**$18,008,955**	**$16,821,398**	**7.1%**
Generic Plan Cost	$1,173,264	$1,227,817	-4.4%
Brand Plan Cost	$16,835,691	$15,593,581	8.0%
MSB Plan Cost	$422,939	$346,856	21.9%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$8,482,448	$8,293,300	2.3%
Total Specialty Drug Cost (Specialty Plan Cost)	$9,526,508	$8,528,097	11.7%
Avg Plan Cost per Claim (Plan Cost/ARx)	$142.62	$124.71	14.4%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$10.77	$10.63	1.3%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$970.13	$803.21	20.8%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$656.74	$520.80	26.1%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$68.04	$62.26	9.3%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$5,957.79	$5,070.21	17.5%
Plan Cost PMPM	**$261.91**	**$217.77**	**20.3%**
Non-Specialty Plan Cost PMPM	$123.36	$107.36	14.9%
Specialty Plan Cost PMPM	$138.55	$110.40	25.5%
Specialty % of Plan Cost	52.9%	50.7%	2.2
Net Plan Cost PMPM (factoring Rebates)	**$178.45**	**$152.99**	**16.6%**
Non-Specialty Plan Cost PMPM	$78.63	$69.35	13.4%
Specialty Plan Cost PMPM	$99.81	$83.64	19.3%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN

+ FY24 vs FY23

Membership Summary	FY 2024	FY 2023	Change
Member Count (Membership)	19,192	14,339	33.8%
Utilizing Member Count (Patients)	15,413	12,019	28.2%
Percent Utilizing (Utilization)	80.3%	83.8%	-3.5

Claim Summary	FY 2024	FY 2023	Change
Net Claims (Total Adjusted Rx's)	280,062	204,394	37.0%
Claims per Elig Member per Month (Claims PMPM)	1.22	1.19	2.4%
Total Claims for Generic (Generic ARx)	241,270	173,778	38.8%
Total Claims for Brand (Brand ARx)	38,792	30,616	26.7%
Total Claims for Multisource Brand Claims (MSB ARx)	1,408	1,084	29.9%
Total Non-Specialty Claims	276,600	202,232	36.8%
Total Specialty Claims	3,462	2,162	60.1%
Generic % of Total Claims (GFR)	**86.1%**	**85.0%**	**1.1**
Generic Effective Rate (GCR)	99.4%	99.4%	0.0
Mail Order Claims	79,999	63,866	25.3%
Mail Penetration Rate*	32.5%	35.8%	-3.3

Claims Cost Summary	FY 2024	FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$41,885,009**	**$25,132,611**	**66.7%**
Total Generic Gross Cost	$4,749,170	$3,202,031	48.3%
Total Brand Gross Cost	$37,135,839	$21,930,579	69.3%
Total MSB Gross Cost	$836,201	$579,414	44.3%
Total Ingredient Cost	$40,732,095	$24,303,619	67.6%
Total Dispensing Fee	$1,118,949	$795,623	40.6%
Total Other (e.g. tax)	$33,965	$33,369	1.8%
Avg Total Cost per Claim (Gross Cost/ARx)	**$149.56**	**$122.96**	**21.6%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$19.68	$18.43	6.8%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$957.31	$716.31	33.6%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$593.89	$534.51	11.1%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN

+ FY24 vs FY23

Member Cost Summary	FY 2024	FY 2023	Change
Total Member Cost Share	**$6,290,961**	**$4,129,087**	**52.4%**
Generic Cost Share	$1,613,178	$1,088,808	48.2%
Brand Cost Share	$4,677,783	$3,040,279	53.9%
MSB Cost Share	$53,610	$43,046	24.5%
Total Copay	$6,290,961	$4,129,087	52.4%
Total Deductible	$0	$0	NA
Avg Copay per Claim (Member Cost Share/ARx)	**$22.46**	**$20.20**	**11.2%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.69	$6.27	6.7%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$120.59	$99.30	21.4%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$38.07	$39.71	-4.1%
Copay % of Total Prescription Cost (Member Cost Share %)	**15.0%**	**16.4%**	**-1.4**

Plan Cost Summary	FY 2024	FY 2023	Change
Total Plan Cost (Plan Cost)	**$35,594,048**	**$21,003,524**	**69.5%**
Generic Plan Cost	$3,135,992	$2,113,224	48.4%
Brand Plan Cost	$32,458,056	$18,890,300	71.8%
MSB Plan Cost	$782,591	$536,368	45.9%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$18,604,293	$11,791,250	57.8%
Total Specialty Drug Cost (Specialty Plan Cost)	$16,989,755	$9,212,274	84.4%
Avg Plan Cost per Claim (Plan Cost/ARx)	$127.09	$102.76	23.7%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$13.00	$12.16	6.9%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$836.72	$617.01	35.6%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$555.82	$494.80	12.3%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$67.26	$58.31	15.4%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$4,907.50	$4,261.00	15.2%
Plan Cost PMPM	**$154.55**	**$122.07**	**26.6%**
Non-Specialty Plan Cost PMPM	$80.78	$68.53	17.9%
Specialty Plan Cost PMPM	$73.77	$53.54	37.8%
Specialty % of Plan Cost	47.7%	43.9%	3.9
Net Plan Cost PMPM (factoring Rebates)	**$103.31**	**$84.15**	**22.8%**
Non-Specialty Plan Cost PMPM	$54.44	$46.14	18.0%
Specialty Plan Cost PMPM	$48.87	$38.02	28.5%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO, CDHP, & PPO PLAN

+ FY24 vs FY23

Membership Summary	Total	EPO	CDHP	PPO
Member Count (Membership)	49,065	5,730	24,149	19,192
Utilizing Member Count (Patients)	37,636	4,735	17,575	15,413
Percent Utilizing (Utilization)	76.7%	82.6%	72.8%	80.3%

Claim Summary	Total	EPO	CDHP	PPO
Net Claims (Total Rx's)	746,853	126,270	340,521	280,062
Claims per Elig Member per Month (Claims PMPM)	1.27	1.84	1.18	1.22
Total Claims for Generic (Generic Rx)	649,591	108,916	299,405	241,270
Total Claims for Brand (Brand Rx)	97,262	17,354	41,116	38,792
Total Claims for Multisource Brand Claims (MSB Rx)	3,169	644	1,117	1,408
Total Non-Specialty Claims	737,808	124,671	336,537	276,600
Total Specialty Claims	9,045	1,599	3,984	3,462
Generic % of Total Claims (GFR)	**87.0%**	**86.3%**	**87.9%**	**86.1%**
Generic Effective Rate (GCR)	99.5%	99.4%	99.6%	99.4%
Mail Order Claims	209,789	37,164	92,626	79,999
Mail Penetration Rate*	31.6%	32.3%	30.7%	32.5%

Claims Cost Summary	Total	EPO	CDHP	PPO
Total Prescription Cost (Total Gross Cost)	**$107,007,335**	**$21,118,865**	**$44,003,462**	**$41,885,009**
Total Generic Gross Cost	$11,202,461	$1,921,950	$4,531,341	$4,749,170
Total Brand Gross Cost	$95,804,875	$19,196,915	$39,472,121	$37,135,839
Total MSB Gross Cost	$1,833,053	$473,029	$523,824	$836,201
Total Ingredient Cost	$103,921,159	$20,595,503	$42,593,561	$40,732,095
Total Dispensing Fee	$1,886,729	$505,904	$1,380,824	$1,118,949
Total Other (e.g. tax)	$80,498	$17,458	$29,076	$33,965
Avg Total Cost per Claim (Gross Cost/Rx)	**$143.28**	**$167.25**	**$129.22**	**$149.56**
Avg Total Cost for Generic (Generic Gross Cost/Generic Rx)	$17.25	$17.65	$15.13	$19.68
Avg Total Cost for Brand (Brand Gross Cost/Brand Rx)	$985.02	$1,106.20	$960.02	$957.31
Avg Total Cost for MSB (MSB Gross Cost/MSB Rx)	$578.43	$734.52	$468.96	$593.89

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO, CDHP, & PPO PLAN

+ FY24 vs FY23

Member Cost Summary	Total	EPO	CDHP	PPO
Total Member Cost Share	**$18,849,606**	**$3,109,910**	**$9,448,736**	**$6,290,961**
Generic Cost Share	$4,290,369	$748,686	$1,928,505	$1,613,178
Brand Cost Share	$14,559,238	$2,361,224	$7,520,231	$4,677,783
MSB Cost Share	$238,097	$50,090	$134,398	$53,610
Total Copay	$17,237,956	$3,107,939	$7,839,056	$6,290,961
Total Deductible	$1,611,650	$1,971	$1,609,680	$0
Avg Copay per Claim (Member Cost Share/Rx)	**$25.24**	**$24.63**	**$27.75**	**$22.46**
Avg Copay for Generic (Generic Member Cost Share/Generic Rx)	$6.60	$6.87	$6.44	$6.69
Avg Copay for Brand (Brand Member Cost Share/Brand Rx)	$149.69	$136.06	$182.90	$120.59
Avg Copay for MSB (MSB Member Cost Share/MSB Rx)	$75.13	$77.78	$120.32	$38.07
Copay % of Total Prescription Cost (Member Cost Share %)	**17.6%**	**14.7%**	**21.5%**	**15.0%**

Plan Cost Summary	Total	EPO	CDHP	PPO
Total Plan Cost (Plan Cost)	**$88,157,729**	**$18,008,955**	**$34,554,726**	**$35,594,048**
Generic Plan Cost	$6,912,092	$1,173,264	$2,602,836	$3,135,992
Brand Plan Cost	$81,245,637	$16,835,691	$31,951,890	$32,458,056
MSB Plan Cost	$1,594,956	$422,939	$389,426	$782,591
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$41,810,194	$8,482,448	$14,723,453	$18,604,293
Total Specialty Drug Cost (Specialty Plan Cost)	$46,347,535	$9,526,508	$19,831,273	$16,989,755
Avg Plan Cost per Claim (Plan Cost/Rx)	$118.04	$142.62	$101.48	$127.09
Avg Plan Cost for Generic (Generic Plan Cost/Generic Rx)	$10.64	$10.77	$8.69	$13.00
Avg Plan Cost for Brand (Brand Plan Cost/Brand Rx)	$835.33	$970.13	$777.12	$836.72
Avg Plan Cost for MSB (MSB Plan Cost/MSB Rx)	$503.30	$656.74	$348.64	$555.82
Avg Non-Specialty Plan Cost per Claim (Plan Cost/Rx)	$56.67	$68.04	$43.75	$67.26
Avg Specialty Plan Cost per Claim (Plan Cost/Rx)	$5,124.11	$5,957.79	$4,977.73	$4,907.50
Plan Cost PMPM	**$149.73**	**$261.91**	**$119.24**	**$154.55**
Non-Specialty Plan Cost PMPM	$71.01	$123.36	$50.81	$80.78
Specialty Plan Cost PMPM	$78.72	$138.55	$68.43	$73.77
Specialty % of Plan Cost	52.6%	52.9%	57.4%	47.7%
Net Plan Cost PMPM (factoring Rebates)	**$99.27**	**$178.45**	**$77.25**	**$103.31**
Non-Specialty Net Plan Cost PMPM	$45.91	$78.63	$31.36	$54.44
Specialty Net Plan Cost PMPM	$53.36	$99.81	$45.89	$48.87

Express Scripts
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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN
+ FY24 vs FY23

State of Nevada PEBP FY2024				
Description	Grand Total	EPO	CDHP	PPO
Avg Members per Month	49,065	5,730	24,149	19,192
Pct Members Utilizing Benefit	76.7%	82.6%	72.8%	80.3%
Total Plan Cost	$ 88,157,729	$ 18,008,955	$ 34,554,726	$ 35,594,048
Total Days	19,647,902	3,409,284	8,947,514	7,291,104
Total Adjusted Rxs	746,853	126,270	340,521	280,062
Plan Cost PMPM	$ 149.73	$ 261.91	$ 119.24	$ 154.55
Plan Cost Net PMPM	$ 99.27	$ 178.45	$ 77.25	$ 103.31
Plan Cost/Day	$ 4.49	$ 5.28	$ 3.86	$ 4.88
Plan Cost per Adjusted Rx	$ 118.04	$ 142.62	$ 101.48	$ 127.09
Nbr Rxs PMPM	1.27	1.84	1.18	1.22
Generic Fill Rate	87.0%	86.3%	87.9%	86.1%
Home Delivery Utilization	31.6%	32.3%	30.7%	32.5%
Member Cost %	17.6%	14.7%	21.5%	15.0%
Specialty Percent of Plan Cost	52.6%	52.9%	57.4%	47.7%
Specialty Plan Cost PMPM	$ 78.72	$ 138.55	$ 68.43	$ 73.77
Formulary Compliance Rate	99.5%	99.3%	99.7%	99.3%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN
+ FY24 vs FY23

State of Nevada PEBP FY2024 - Grand Total					
Description	Grand Total	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	49,065	42,873	5,705	11	482
Pct Members Utilizing Benefit	76.7%	75.5%	88.5%	90.9%	97.5%
Total Plan Cost	$ 88,157,729	$ 69,070,336	$ 16,997,355	$ 276,750	$ 1,813,287
Total Days	19,647,902	14,705,145	4,332,070	8,565	602,122
Total Adjusted Rxs	746,853	566,919	157,898	318	21,718
Plan Cost PMPM	$ 149.73	$ 134.25	$ 248.28	$ 2,096.59	$ 313.50
Plan Cost Net PMPM	$ 99.27	$ 87.64	$ 156.68	$ 1,847.08	$ 165.41
Plan Cost/Day	$ 4.49	$ 4.70	$ 3.92	$ 32.31	$ 3.01
Plan Cost per Adjusted Rx	$ 118.04	$ 121.83	$ 107.65	$ 870.28	$ 83.49
Nbr Rxs PMPM	1.27	1.10	2.31	2.41	3.75
Generic Fill Rate	87.0%	86.7%	87.8%	86.2%	87.9%
Home Delivery Utilization	31.6%	29.4%	38.4%	89.8%	36.4%
Member Cost %	17.6%	17.4%	18.5%	21.9%	17.0%
Specialty Percent of Plan Cost	52.6%	52.9%	52.1%	93.8%	38.7%
Specialty Plan Cost PMPM	$ 78.72	$ 71.02	$ 129.25	$ 1,966.00	$ 121.47
Formulary Compliance Rate	99.5%	99.4%	99.6%	100.0%	99.6%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN
+ FY24 vs FY23

State of Nevada PEBP FY2024 - CDHP					
Description	CDHP	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	24,149	20,155	3,618	10	369
Pct Members Utilizing Benefit	72.8%	70.5%	85.9%	50.0%	97.6%
Total Plan Cost	$ 34,554,726	$ 23,847,934	$ 9,264,292	$ 149,764	$ 1,292,735
Total Days	8,947,514	5,928,965	2,543,557	1,945	473,047
Total Adjusted Rxs	340,521	230,585	92,756	77	17,103
Plan Cost PMPM	$ 119.24	$ 98.60	$ 213.38	$ 1,872.06	$ 291.95
Plan Cost Net PMPM	$ 77.25	$ 61.74	$ 136.51	$ 1,787.83	$ 136.06
Plan Cost/Day	$ 3.86	$ 4.02	$ 3.64	$ 77.00	$ 2.73
Plan Cost per Adjusted Rx	$ 101.48	$ 103.42	$ 99.88	$ 1,944.99	$ 75.59
Nbr Rxs PMPM	1.18	0.95	2.14	0.64	3.86
Generic Fill Rate	87.9%	87.6%	88.7%	88.3%	87.4%
Home Delivery Utilization	30.7%	27.2%	37.7%	96.2%	36.6%
Member Cost %	21.5%	22.1%	20.2%	26.2%	18.2%
Specialty Percent of Plan Cost	57.4%	57.7%	58.9%	99.6%	35.8%
Specialty Plan Cost PMPM	$ 68.43	$ 56.89	$ 125.74	$ 1,865.10	$ 104.52
Formulary Compliance Rate	99.7%	99.6%	99.7%	100.0%	99.7%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN
+ FY24 vs FY23

State of Nevada PEBP FY2024 - EPO					
Description	EPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	5,730	4,961	696	2	71
Pct Members Utilizing Benefit	82.6%	81.5%	97.1%	100.0%	93.0%
Total Plan Cost	$ 18,008,955	$ 13,813,801	$ 3,932,983	$ 14,080	$ 248,092
Total Days	3,409,284	2,591,306	738,247	3,246	76,485
Total Adjusted Rxs	126,270	96,824	26,606	112	2,728
Plan Cost PMPM	$ 261.91	$ 232.04	$ 470.90	$ 703.99	$ 291.19
Plan Cost Net PMPM	$ 178.45	$ 154.32	$ 321.99	$ 404.79	$ 194.55
Plan Cost/Day	$ 5.28	$ 5.33	$ 5.33	$ 4.34	$ 3.24
Plan Cost per Adjusted Rx	$ 142.62	$ 142.67	$ 147.82	$ 125.71	$ 90.94
Nbr Rxs PMPM	1.84	1.63	3.19	4.67	3.75
Generic Fill Rate	86.3%	86.2%	86.3%	77.7%	89.4%
Home Delivery Utilization	32.3%	31.2%	35.3%	99.0%	37.1%
Member Cost %	14.7%	14.2%	16.5%	7.4%	16.3%
Specialty Percent of Plan Cost	52.9%	53.3%	52.5%	0.0%	40.5%
Specialty Plan Cost PMPM	$ 138.55	$ 123.66	$ 247.17	$ -	$ 117.95
Formulary Compliance Rate	99.3%	99.2%	99.5%	100.0%	99.0%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN
+ FY24 vs FY23

State of Nevada PEBP FY2024 - PPO					
Description	PPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	19,192	17,757	1,391	3	42
Pct Members Utilizing Benefit	80.3%	79.8%	91.5%	100.0%	104.8%
Total Plan Cost	$ 35,594,048	$ 31,408,601	$ 3,800,081	$ 112,906	$ 272,460
Total Days	7,291,104	6,184,874	1,050,266	3,374	52,590
Total Adjusted Rxs	280,062	239,510	38,536	129	1,887
Plan Cost PMPM	$ 154.55	$ 147.40	$ 227.66	$ 3,136.27	$ 540.60
Plan Cost Net PMPM	$ 103.31	$ 98.41	$ 126.42	$ 2,574.77	$ 373.95
Plan Cost/Day	$ 4.88	$ 5.08	$ 3.62	$ 33.46	$ 5.18
Plan Cost per Adjusted Rx	$ 127.09	$ 131.14	$ 98.61	$ 875.24	$ 144.39
Nbr Rxs PMPM	1.22	1.12	2.31	3.58	3.74
Generic Fill Rate	86.1%	86.1%	86.5%	92.2%	90.4%
Home Delivery Utilization	32.5%	30.7%	42.4%	77.2%	33.4%
Member Cost %	15.0%	14.9%	16.3%	17.0%	11.4%
Specialty Percent of Plan Cost	47.7%	49.1%	34.9%	97.7%	51.1%
Specialty Plan Cost PMPM	$ 73.77	$ 72.34	$ 79.40	$ 3,064.00	$ 276.32
Formulary Compliance Rate	99.3%	99.3%	99.4%	100.0%	100.0%

4.3.3

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

4.3 Receipt of quarterly vendor reports for the period ending June 30, 2024:

- 4.3.1 Q4 Express Scripts – Summary Report
- 4.3.2 Q4 Express Scripts – Utilization Report
- **4.3.3 2nd MD Annual Review Report**

2nd.MD
Specializing in Medical Certainty

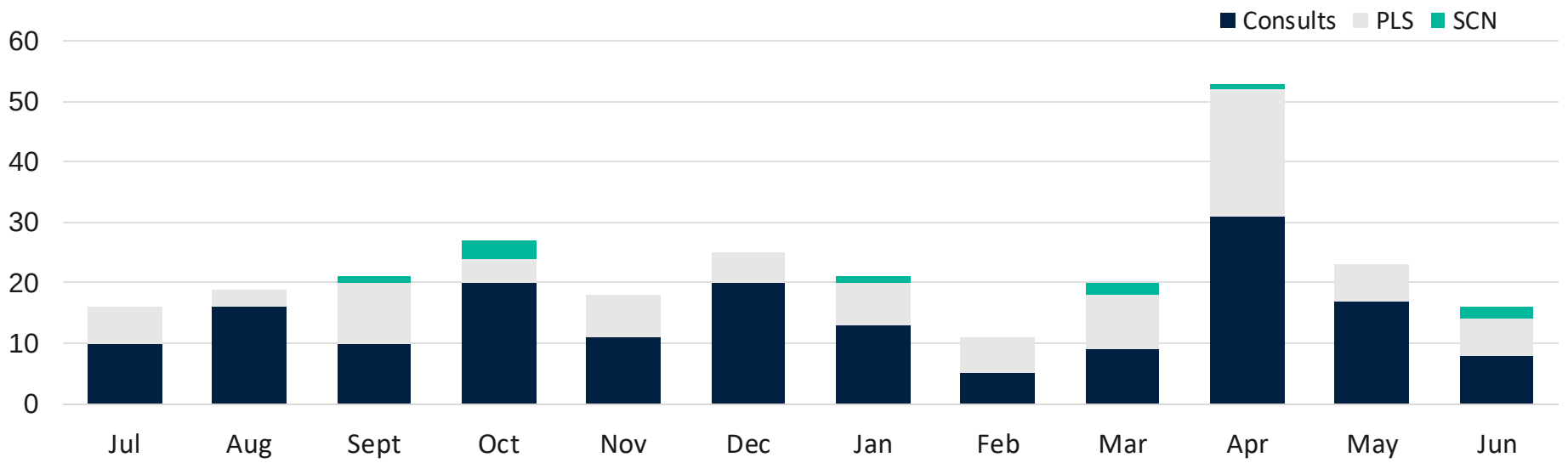
STATE OF NEVADA

Annual Review
June 2023-July 2024

2023-2024 EXECUTIVE SUMMARY

Covered Households	Activations	Service Utilization	Completed Consults	Personalized Local Support (PLS)	Specialty Care Navigation (SCN)
23,180	**367**	**1.16%**	**170**	**90**	**10**
Prior Period 25,645	Prior Period 419	Prior Period 0.82%	Prior Period 123	Prior Period 72	Prior Period 16

SERVICES COMPLETED BY MONTH



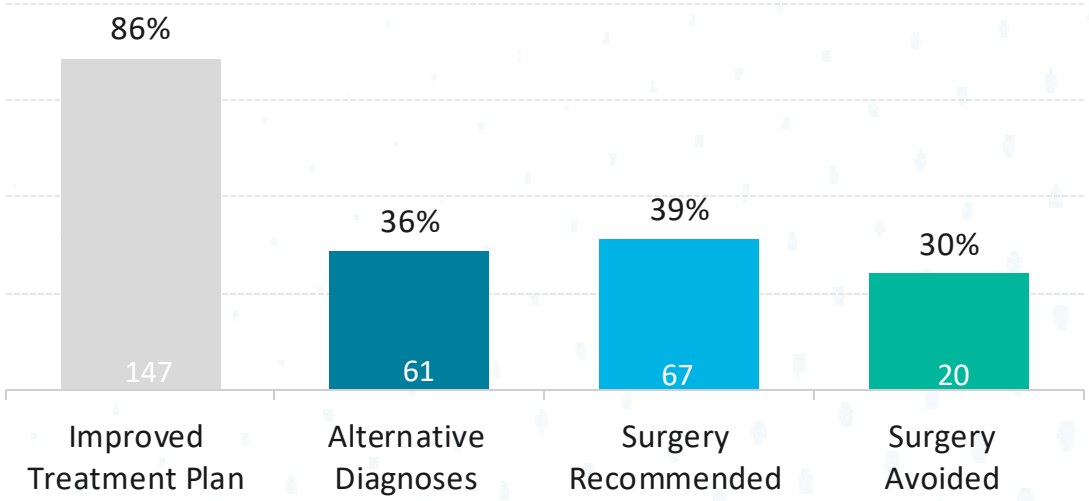
"This is a wonderful service. I feel it will be very useful in helping me to navigate the medical issues I'm experiencing."

-SON Member

COST SAVINGS & CLINICAL IMPACT

Total Cost Savings	Savings Per Surgery	Savings Per Case
$908,102	**$35,346**	**$5,342**
Prior Period $926,735	Prior Period $25,721	Prior Period $7,534

CLINICAL OUTCOMES



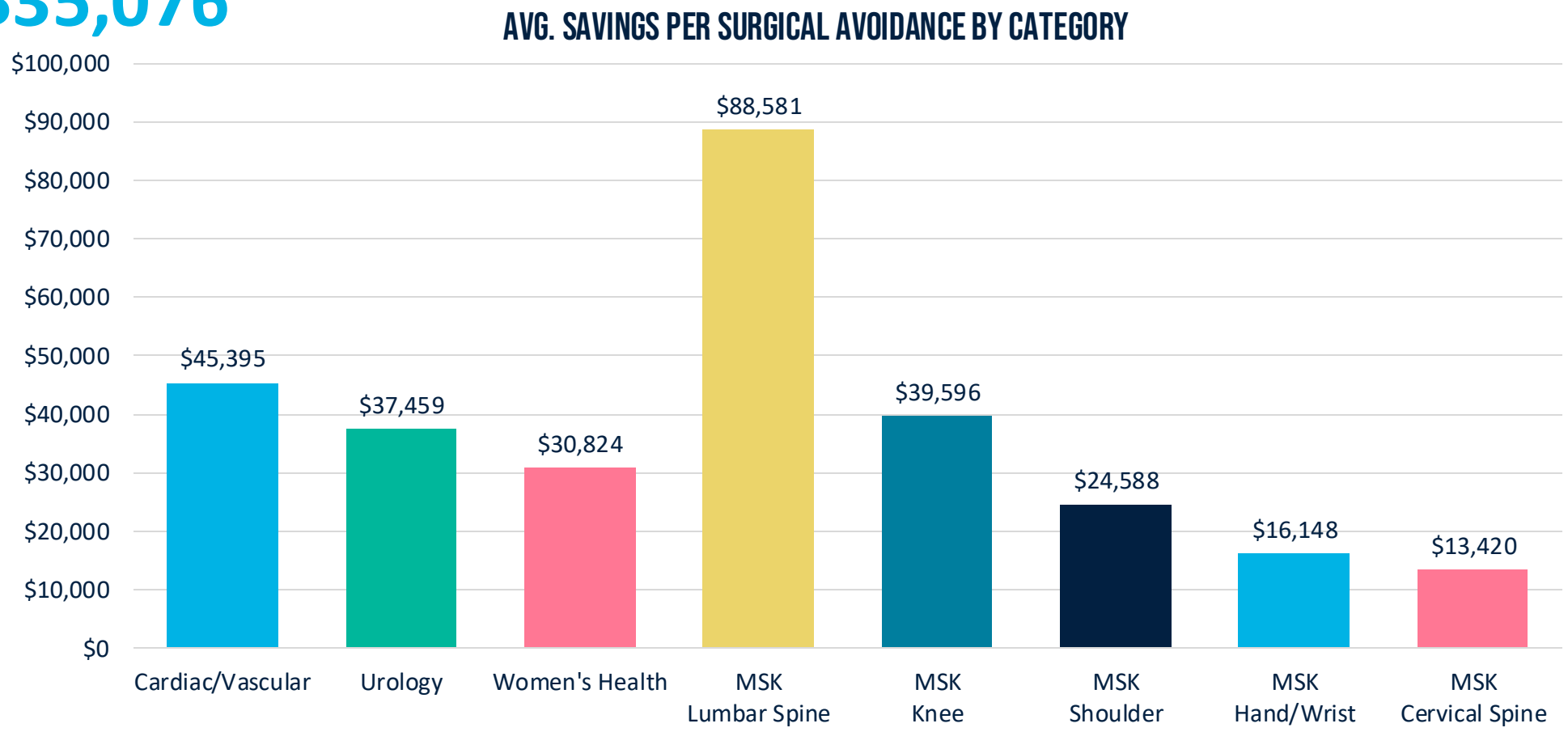
Highlights:

- Total cost savings generated by 2nd.MD services in 2023/2024 was $**908,102**, with a **2.5:1 ROI**, and a net savings of **$544,982**
- SONs savings per case was $5,342 in 2023/204, compared to 2nd.MD's UHC book of business of $5,884.
- 39% of SON's members completing a consult in 2023 had surgery recommended by their Local Provider; 31% of those resulted in the surgery being avoided or changed, driving **$701,534** in savings.

SAVINGS PER SURGICAL AVOIDANCE

Average savings per surgical avoidance was

$35,076



MAJOR DIAGNOSTIC CATEGORIES

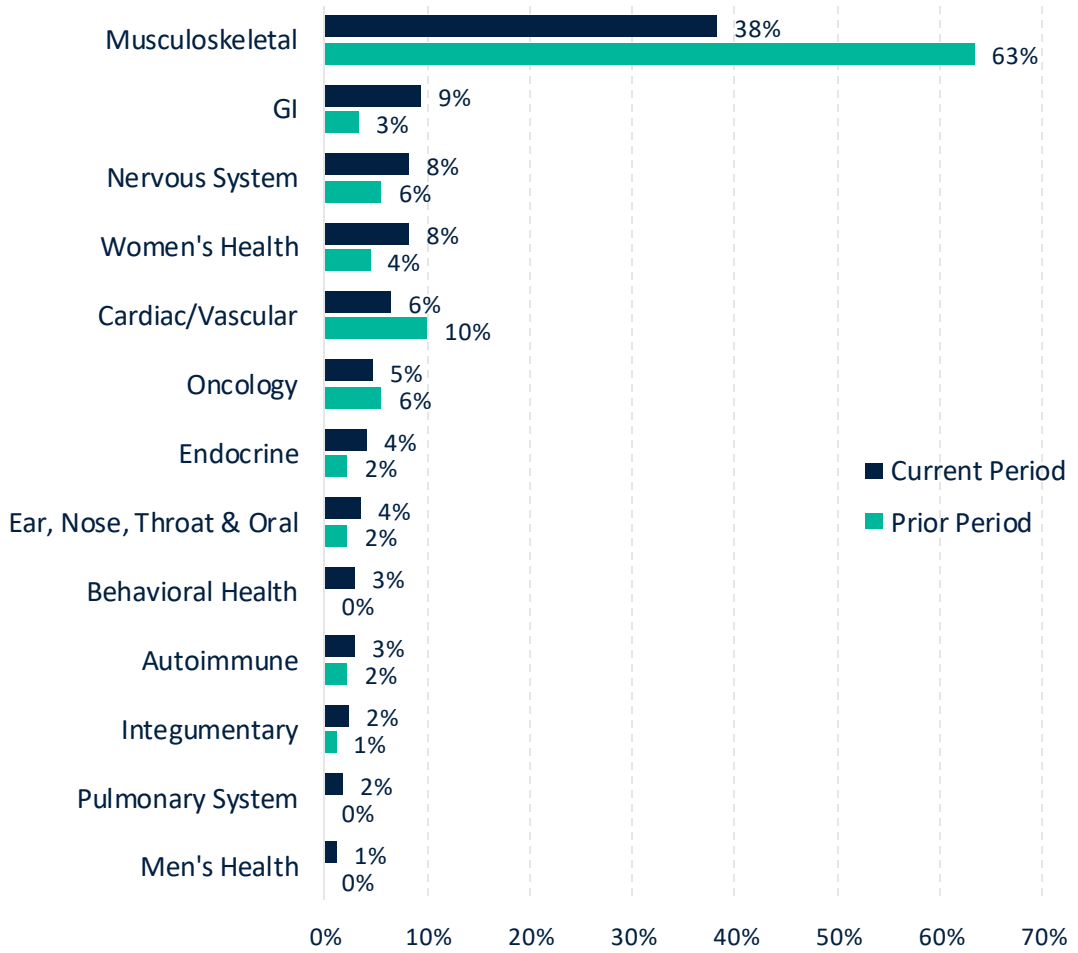
Highlights:

- Musculoskeletal is the leading diagnostic category at 38.2%, just below 2nd.MD's UHC book-of-business at 46%
- GI follows at 9.4%, slightly above 2nd.MD's UHC book-of-business at 7.6%
- Nervous System 8.2%
- Behavioral health 2.9%

"[The 2nd.MD Specialist] is very thorough, knowledgeable and caring! I plan to use him again in the future for I trust his diagnosis of my condition and suggestions."

-SON Member

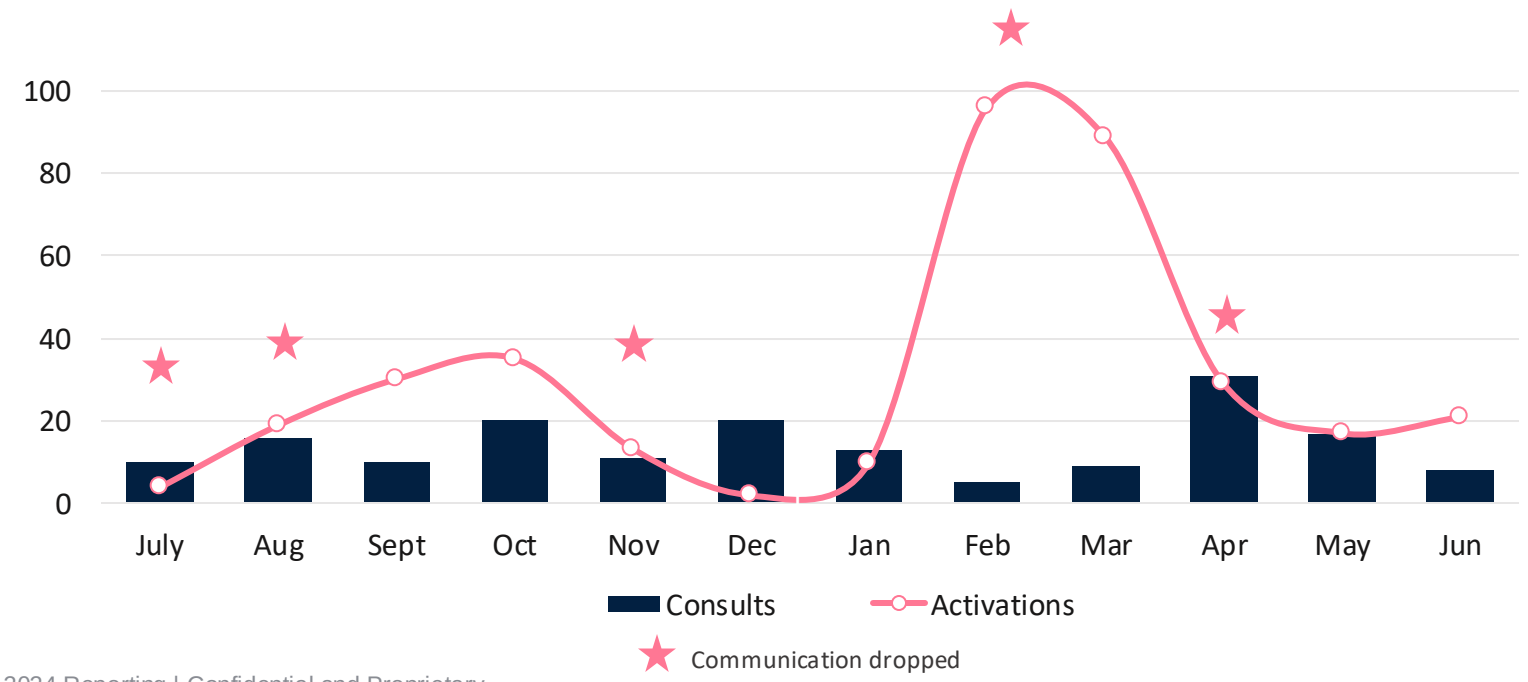
MAJOR DIAGNOSTIC CATEGORIES SERVICED



ENGAGEMENT

- State of Nevada has opted into all 2nd.MD campaigns, including the activation sweepstakes, helping push engagement levels that are above BoB.
- Activations drive awareness and remind members of our service when they may need 2nd.MD support down the road

COMPLETED CONSULTS AND ACTIVATIONS BY MONTH



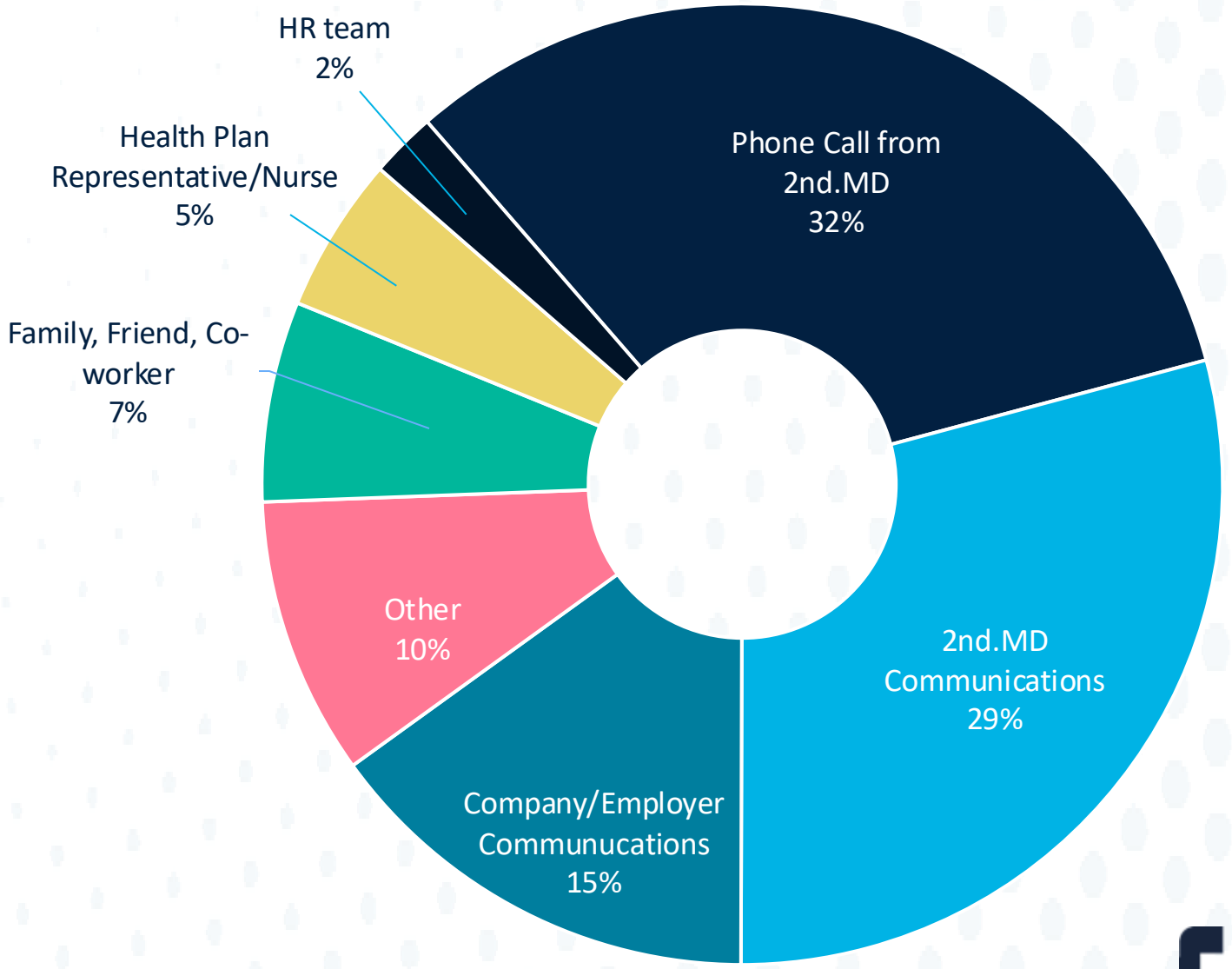
2023 GENERAL AWARENESS CAMPAIGNS

Campaign	Opt-in/out	Modality
GA2 23’ (July)	✓	Email
GA3 23’ (Aug)	✓	Email
GA4 23’ (Nov)	✓	Email
GA1 24’ (Feb)	✓	Email
GA2 24’ (Apr)	✓	Email

CONSULT ENGAGEMENT DRIVERS

Phone call from 2nd.MD acted as the main driver for consult engagement (32%) in 2023-2024.

2nd.MD communications also contributed significantly to utilization (29%).



Data is pulled from the member satisfaction survey and is self-reported

MEMBER SATISFACTION

93% of members who completed the survey said access to 2nd.MD increases their appreciation of State of Nevada's benefits

Completed Member Survey	Benefit Satisfaction	Turnaround Time	Net Promoter Score
79%	93%	1.86	92
	Prior Period 95%	Prior Period 2.36	Prior Period 91

Doctor Care Survey Rating	Doctor Expertise Survey Rating	Customer Care Survey Rating
		
4.9	4.9	4.9

"I thought the [The 2nd.MD Specialist] was truly knowledgeable and had insights that I hadn't been given to me before by other doctors. I appreciated that he was taking notes for me, and I didn't have to worry about anything other than paying attention and getting my questions answered. I thought he had good advice and the things he suggested is reasonable to follow."

STATE OF NEVADA MEMBER CASE STUDY

The member is a female dependent in her late 40's who has a history of breast cancer and now reports pain in the lower right quadrant of her abdomen. After ultrasound imaging showed an enlarged uterus, her local provider diagnosed her with adenomyosis and recommends a total hysterectomy surgery. The member called 2nd.MD for an expert medical opinion to discuss her diagnosis, the proposed surgery, and any alternative options to consider.

The member met with our board-certified specialist in Obstetrics and Gynecology who reviewed the member's clinical records. The specialist educated the member that her lack of pelvic pain and menstrual cramps is not indicative of her diagnosis. The specialist proposed the member's abdominal pain could be musculoskeletal spasms causing nerve compression and suggested the member try pelvic floor therapy and muscle relaxers for pain relief. If conservative options do not help and her symptoms increase and if surgery is warranted in the future, she educated the member not to remove her ovaries so she can naturally go through menopause.

Upon follow up the member expressed satisfaction with the consultation and reported plans to cancel surgery and pursue pelvic floor therapy.

- Total Cost Savings: **$26,599**
- Surgery/Procedure Avoided
- Recovery Days Avoided: **90**
- Consultation with a board-certified OB/GYN Specialist
- NPS Score: 10

"The consult went really well. [The 2nd.MD Specialist] had a lot of information to share and spent a lot of time with us talking about different factors and answered all of our questions."

ENGAGEMENT UPDATES

ENGAGEMENT TACTICS

STRATEGY:

- Drive awareness and inform members on the value of our service and how simple it is to complete a second opinion through 2nd.MD
- Encourage account activation and motivate members to complete a consult

CLIENT ENGAGEMENT TACTICS:

- Utilize 2nd.MD's robust communications suite via *Brandfolder for internal promotion:
  - **2nd.MD Engagement Playbook:** engagement best practices and content
  - **Supplemental Materials:** pre-written content, images, flyers, QR codes
  - **Condition Specific Flyers:** Oncology, MSK, GI, Women's Health, Mental Health, etc.

**Bookmark the Brandfolder link; 2nd.MD adds new materials as they're available*

2ND.MD BRAND REFRESH

2nd.MD
Specializing in Medical Certainty

2nd.MD

Brand Refresh Objectives:

- Simplified, yet updated branding includes a new logo, color palette, and imagery
- Communications will continue to focus on creating awareness and engagement
- Updated campaigns will focus on real people, convey seriousness, explain the service, and have a strong call-to-action

Timing:

- New branding will be in place (website, app, and communications) early 2025
- New flyers and other materials will be available for OE and onsite events
- New launch campaign creatives will be available for review in the coming months

REFERRAL PARTNER UPDATES

Vendor Name	Short Description	Eligibility	Contact Info (Phone/URL)
Ex: 2nd.MD	*A second opinion and health education service that can help you make more informed decisions, provide you with treatment options, and improve alignment with you and your doctor. Provided at no cost to you when enrolled in one of the United Healthcare medical plans. 2nd.MD connects you with board-certified, leading doctors across the country for an expert second opinion via video or phone. The 2nd.MD Care Team coordinates all the details, so you can focus on one thing – getting the best care possible.*	*Employees and eligible dependents*	*https://www.2nd.md/activate 1.866.269.3534*
Ex. Diabetes Vendor			
Ex. MSK Vendor			
Ex. COE Vendor			

APPENDIX

HOUSE CALLS WEBINARS

Topic	Date
How Second Opinions Can Improve Your Treatment Plan and Quality of Life	January 18
Exploring Heart Disease and Treatment Options	February 15
Reducing Pain From Joint, Bone and Muscle Conditions	March 21
Trust Your Gut: Learning More About Celiac Disease, IBS, GERD and More	April 18
Exploring Mental Health Conditions and Treatment Options	May 16
Understanding Men's Health: Prostate Cancer, Erectile Dysfunction and More	June 20
Navigating Cancer: Finding the Right Treatment Plan for You and Your Family	August 15
Understanding Women's Health: Fibroids, Endometriosis, Menopause and More	**September 19**
Exploring Joint, Bone and Muscle Conditions and Treatment Options	**October 10**
How To Decide if Surgery Is Right for You	**December 19**

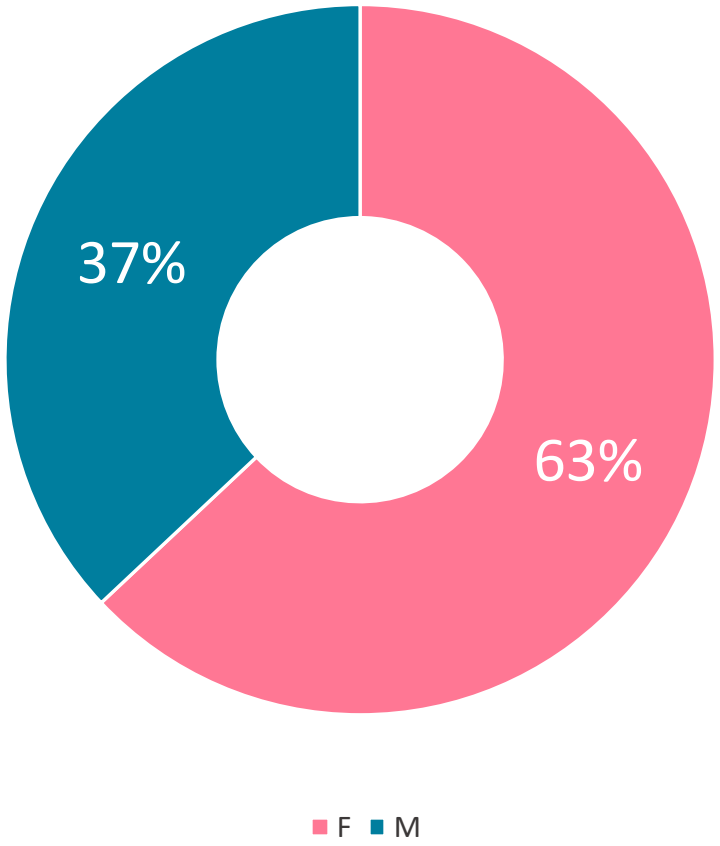
Schedule and topics subject to change based on current events.

Webinar Details:

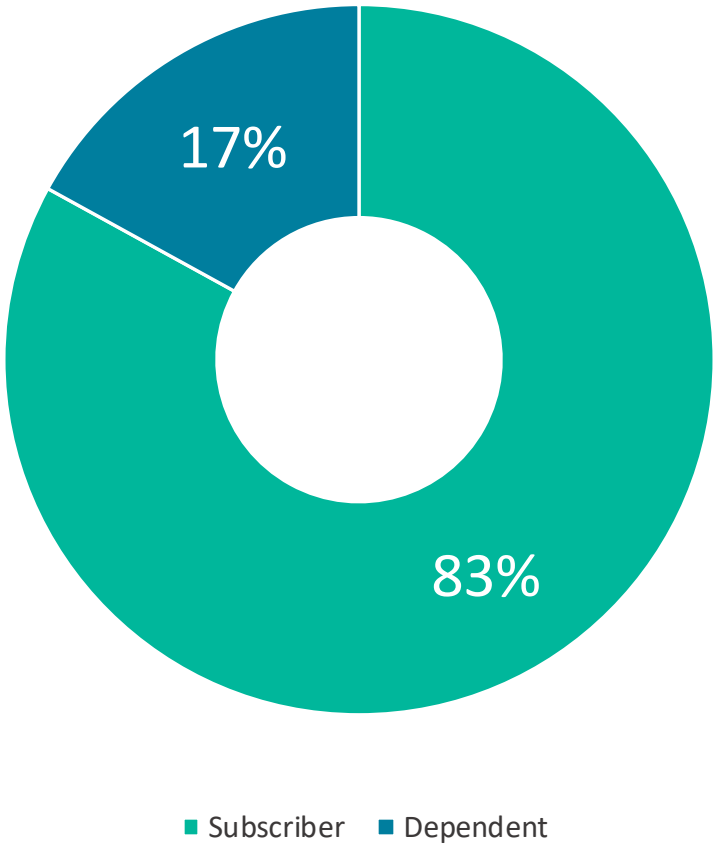
- Webinars are public and can be promoted to full population
- All webinars are recorded and available for on-demand viewing
- Visit 2nd.md/webinars to review past and upcoming webinars
- A quarterly awareness email will be sent to customer contacts with upcoming House Calls Webinars info.

ADDITIONAL DEMOGRAPHIC INFORMATION

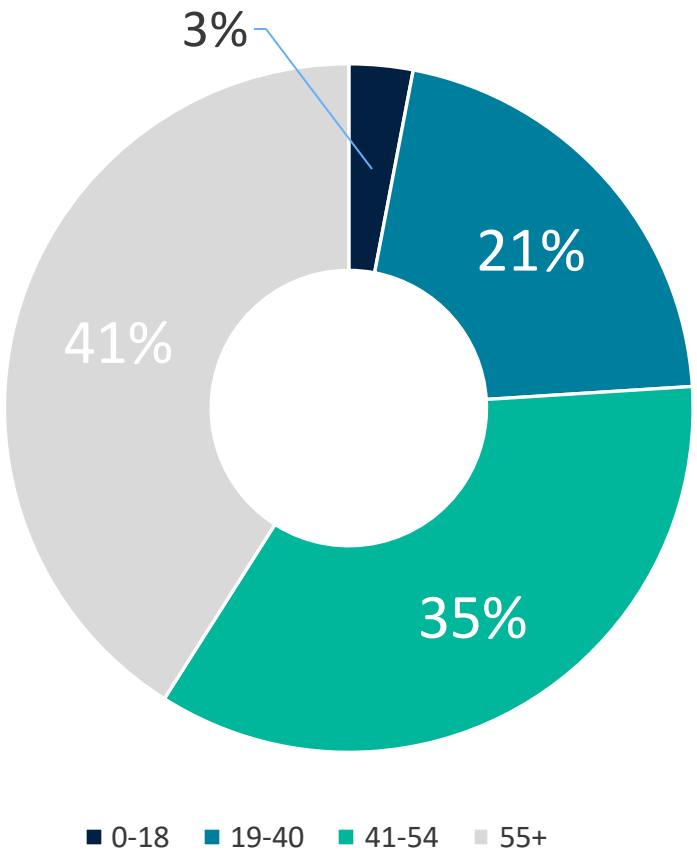
CONSULTS BY GENDER



CONSULTS BY MEMBER TYPE



CONSULTS BY AGE GROUP



JANUARY – JUNE 2024 BENCHMARKING

Utilization: 2nd.MD's UHC book-of-business average is .76%

Clinical Outcomes:

- Alternative Diagnosis: 27%
- Improved Treatment Plan: 81%
- Avoided Surgeries: 33%

Average savings/consult: $6,433

Percentage of members who report 2nd.MD increased their appreciation of their company's benefits: 94%

NPS: 86

DEFINITIONS

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

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

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

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

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

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

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

EOC COST SAVINGS METHODOLOGY

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

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

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

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

Net Cost of Procedure Pathway: $73,846

2nd.MD Specialist Recommendation Costs:
Physical Therapy - $1,200

Net Difference Between Local Provider Recommendation and 2nd.MD Specialist:
Recommendation: $73,846 - $1,200 = $72,646.
CPT codes: 22630, 22612

Return on Investment Calculation:
$6,530 Avg. Savings Per Consult/ $1,940 Cost Per Consult = 3.4

2nd.MD also uses two additional methodologies for cases where a confirmed misdiagnoses has occurred and for behavioral health cases. For more information about these methodologies, we're happy to provide our full cost savings policy.

5.

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

JOE LOMBARDO
Governor

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

CELESTENA GLOVER
Executive Officer

JOY GRIMMER
Board Chair

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: November 21, 2024

Item Number: 5

Title: Executive Officer Report

SUMMARY

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

REPORT

INTERIM RETIREMENT AND BENEFITS COMMITTEE

IRBC has been scheduled for December 17, 2024, in Las Vegas (agenda pending). In accordance with NRS 287.0425, PEBP will be presenting information relating to Plan Year 2024 and 2025. The fiscal year 2024 Financial Statements and OPEB reports will not be available prior to the scheduled meeting but will be delivered as soon as they become available.

STRATEGIC PLANNING MEETING

The strategic planning meeting was held October 1st and 2nd of this year. The attendees included PEBP Executive staff, Board Members Weeks and Kelly along with vendors UMR, Express Scripts and Segal. A number of presentations were given and ideas discussed regarding programs currently offered and what might be offered in the future. The consensus being that any new programs/benefits should be considered for Plan Year 2027 (July 1, 2026 – June 30, 2027), to allow sufficient time for research, Request for Proposal (RFP) and implementations as needed. In addition, there was a lot of discussion around what may happen in the upcoming legislative session which could result in plan design changes. Areas of focus and consideration are:

- Wellness plan – address concerns for different ages and populations across PEBP membership. Should provide members access to keep their health in check (focus on prevention vs managing current conditions) and show value. Participation should be voluntary and offer incentives. PEBP staff will research options for this program with

the end goal of developing an RFP. This information will be brought back to the PEBP Board at a later date for further consideration and approval.

- Legislative action – monitor for bills requiring health plans to provide coverage for either, medical, mental health or pharmacy benefits not currently provided in existing PEBP plans. Board meetings will be scheduled to provide updates as needed during the 2025 session.

PEBP BUDGET PRESENTATION

PEBP staff provided a presentation to the Governor's Office, Governor's Finance Office and the Legislative Council Bureau on September 30, 2024. There were no major concerns or questions posed at this presentation.

MEDICARE OPEN ENROLLMENT

Open enrollment for Medicare has begun and will continue through December 7, 2024. This is a reminder that PEBP members on the Medicare Exchange (Via) or transitioning to Medicare must enroll in a plan through Via Benefits. Failure to do so will result in the loss of their Health Reimbursement Arrangement (HRA) and life insurance benefits.

EPO/HMO DISCUSSION

The agenda was originally intended to include an item for discussion regarding the viability of continuing the HMO/EPO with final discussion and action by the board. Because the related materials were not available in time to allow the board sufficient time to review it is now scheduled to be heard during the January 2025 board meeting.

6.

6. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR for the period of April 1, 2024 – June 30, 2024. (Joni Amato, Claim Technologies Incorporated) (**For Possible Action**)

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT and Annual Operational Review

State of Nevada Public Employees' Benefits Program Plans

Administered by UMR Insurance Company

Audit Period: April 1, 2024 – June 30, 2024
Audit Number 1.FY24.Q4

Presented to

State of Nevada Public Employees' Benefits Program

November 21, 2024

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

TABLE OF CONTENTS

EXECUTIVE SUMMARY

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

Scope

CTI performed an audit for the period of April 1, 2024 through June 30, 2024 (quarter 4 (Q4) for Fiscal Year (FY) 2024). The population of claims and amount paid during the audit period reported by UMR Benefits:

Medical and Dental	
Total Paid Amount	$70,620,439
Total Number of Claims Paid/Denied/Adjusted	228,502

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

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

Auditor's Opinion

Based on these findings, and in our opinion:

1. UMR's Financial Accuracy and Overall Accuracy performance decreased in Q4 FY2024, both performance guarantees were not met, and a 2.5% penalty is owed. Claim turnaround time performance increased in Q4 and no penalty is owed.
2. CTI Recommends UMR should:
    - Review the financial errors identified in our random sample audit and determine if system changes or claim processor training could help reduce or eliminate errors of a similar nature in the future.
    - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings.
    - Where appropriate, verify claim processor coaching, feedback, and retraining has occurred because most errors were manually processed.

Summary of UMR's Guarantee Measurements

Based on CTI's Random Sample Audit results, UMR did not meet the Financial Accuracy and Overall Accuracy measurements and penalties are owed. It did, however, meet the Claim Turnaround Time measurements for PEBP in Q4 FY2024. Reported administrative fees for the quarter totaled $1,372,307.36.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy (p. 15)	99.4%	Not Met – 96.41%	1.5%	$20,584.61
Overall Accuracy (p. 16)	98.0%	Not Met – 97.5%	1.0%	$13,723.07
Claim Turnaround Time (p. 17)	92% in 14 Days 99% in 30 Days	Met – 93.3% Met – 99.5%	NA NA	$0 $0
		Total Penalty	2.5%	$34,307.68

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of UMR Insurance Company's (UMR) administration of the State of Nevada Public Employees' Benefits Program (PEBP) plans. We provide this report to PEBP, the plan sponsor, and UMR, the claim administrator. A copy of UMR's response to these findings can be found in the Appendix of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by PEBP and UMR. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain reasonable assurance claims were adjudicated according to the terms of the contract between UMR and PEBP.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems UMR used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

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

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

ANNUAL OPERATIONAL REVIEW

Objective

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

Scope

The scope of the Operational Review included:

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

Methodology

CTI used an Operational Review Questionnaire to gather information from UMR. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting a Systems and Organization Controls (SOC) audit of a service administrator. We modified that tool to elicit information specific to the administration of your plans.

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

Findings

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

- UMR indicated it maintained levels and types of insurance reasonable and customary for a health services organization with comparable size and market presence.
- UMR was audited by Baker Tilly for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report. Under SOC 1, the administrator was required to provide a description of its system and controls, which the service auditor validated. CTI received a copy of the report for the period of January 1, 2023 to December 31, 2023. A bridge letter dated July 8, 2024 was also provided noting no material changes were made to internal controls.
- UMR stated it had incorporated all CMS National Correct Coding Initiative edits into its unbundling software.
- High dollar claims billed over $25,000 did not auto adjudicate and were processed by the large dollar claim team. Checks exceeding $100,000 were handled by the internal review team and those exceeding $250,000 were reviewed by an operations senior vice president.
- UMR batched provider payments and issued payments to providers twice weekly for PEBP claim payments.
- UMR reported it honored assignment of benefits for non-network providers which allowed non-network providers to receive payment directly from UMR versus having to pay the member who would then have to pay the non-network provider. This is a best practice.
- UMR had adequately documented training, workflow, procedures, and systems.
- UMR received daily eligibility files; all changes, additions, and terminations were processed daily by UMR.
- Verification of initial or continued coordination of benefits (COB) by UMR was not required by PEBP. When UMR was the secondary payor, it would never pay more than its total allowable amount. UMR reported COB savings of $5,031,092 for the PEBP plans for FY2024.
- UMR reported 94.4% of claims were received electronically during the audit period and 75.05% of claims received were auto adjudicated. These were increases from the prior year.
- UMR reported it had a $100.00 minimum dollar threshold to recoup an overpayment and could automatically recoup a refund from the next payment made to the same provider. No minimum dollar threshold was imposed when recovered via auto recoupment. UMR reported it used vendors to perform overpayment recovery. No fee was charged back to PEBP for recoveries from Optum Payment Recovery Services. A 20% fee was charged back to PEBP for credit balance recoveries through Optum. An overpayment recovery report was not provided to CTI for FY2024.
- UMR used the OnBase appeal tracking system. UMR leadership monitored tracking daily to ensure timely responses to member appeals. UMR provided a member appeal tracking report to CTI for FY2024. It showed 203 appeals received; 149 appeals upheld the original determination and 54 were overturned. Sixteen appeals took more than 20 days to resolve.

- UMR created system edits, developed review procedures, and provided special training to its claim professionals to help identify potential fraudulent situations. UMR reported 2,642 new potential fraud, waste, and abuse cases opened in FY2024 with 241 closed.
- UMR stated it used state websites and the Office of Inspector General's List of Excluded Individuals/Entities to identify sanctioned providers. CTI identified two providers on the LEIE that were paid by UMR during FY2024.
- UMR reported it received 99.1% of PEBP's eligible charges from in-network providers. To help drive additional provider savings, UMR participated in programs such as Cancer Resource Programs and Centers of Excellence.
- UMR put policies and procedures in place to comply with the Transparency in Coverage Act (No Surprises Billing) effective January 1, 2022. UMR reported 16 appeals and 34 inquiries received for allowances made for out-of-network services. Seven appeals and ten inquiries were overturned.
- UMR's parent company, UnitedHealthcare's privacy office, developed and implemented HIPAA compliance training. All new employees were required to complete HIPAA training and all employees were required to complete the training annually. UMR reported no breeches during the audit period.

QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with UMR. The results for Q4 FY2024 follow.

	Metric	Service Objective	Actual	Met/ Not Met
CLAIMS ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
1.4	**Claim Adjustment Processing Time:** measured from the time a prior claim submission requiring an adjustment is identified through the date the claim adjustment is processed by service facility personnel.	95.00% 7 Calendar/ 5 Business Days	97.8%	Met
1.5	**Telephone Service Factor:** Defined as the percentage of Client telephone inquiries answered by facility Customer Service Representatives (CSRs) within 30 seconds. Measured from the time caller completes the prompts of the automated telephone system to the time the caller reaches a CSR.	85.00% Calls answered within 30 seconds	92.8%	Met
1.6	**Call Abandonment Rate:** total number of participant and provider calls abandoned, divided by the total number of calls received by the facility's customer service telephone system.	3.00%	0.6%	Met
1.7	**First Call Resolution Rate:** percentage of telephone inquiries completely resolved within a 'window period' of time. A call is considered 'resolved' when the same participant or a family member under the same subscriber ID has not contacted the administrator's customer service facility again regarding the same issue within 60 calendar days of the initial call.	95.00%	96.3%	Met
1.8	**Open Inquiry Closure:** addresses the time taken in hours and/or days by CSRs at the administrator's service facility to close open inquiries placed by participants of PEBP to the facility.	90.00% 48 Hours 98.00% 5 Business Days	98.4% 99.6%	Met Met
1.9	**CSR Audit, or Quality Scores:** determined by the process used to evaluate the effectiveness and accuracy of participant telephone call handling at the administrator's customer service facility.	97.00%	97.5%	Met
1.10	**CSR Callback Performance:** measured from the CSR commitment data in hours and/or days to the time the actual callback was placed to the participant.	90.00% Within 24 Hours	100%	Met
1.11	**Participant Email Response Performance:** measured from the time an email is received by the administrator's response team to the time in hours or days to the time the actual email response is sent to the participant.	90.00% Within 8 Hours 95.00% Within 24 Hours	100% 100%	Met Met
1.12	**Member Satisfaction:** At least 95%-member satisfaction with the services. Measured as the number of satisfied to highly satisfied survey ratings divided by the total number of survey responses. Survey tool and survey methodology to be mutually agreed upon by Offeror and PEBP.	95.0%	95.63%	Met
1.13	**Account Management – Plan will guarantee that the services provided by the TPA's team during the guarantee period will be satisfactory to PEBP. Areas of satisfaction will include:**			
	Knowledge/Capabilities – Account representative demonstrates competence in getting issues and problems resolved.	Agree	5	Met
	Responsiveness – All calls returned within at most 24 hours; along with an alternate person identified who can assist with service issues when account representative is unavailable.			
	Ability to meet deadlines – Supplying all requested materials accurately and in a timely manner, along with all necessary documentation (i.e., enrollment kits, rate confirmations, plan performance work plans, group contracts, ZIP code file, etc.).			
	Professionalism – Demonstrates objectivity and empathy with customer problems.			
	Flexibility – Ability to meet client-specific needs.			

	Metric	Service Objective	Actual	Met/ Not Met
	Participation in periodic meetings – Attendance at all required client meetings or conference calls.			
	Guarantee measured with staff responses to internal questionnaire. A scale from 1 to 5 will be used to measure performance, where 1 means 'very dissatisfied' and 5 means 'very satisfied'; and 2 through 4 are defined, respectively.			
	Periodic program reports will be provided and presented with recommended actions. Standard program reports, within 30 days to quarter-end. Year-end activity report, within 45 days of program year end.			
	Open Enrollment Support: Accurate materials will be provided at least 60 days prior to the open enrollment period starting on April 1 each year. Representative will be available, if requested, for up to 5 employee benefit fairs.			
	Service Objective (out of a score of 5 on internal questionnaire):	350		
1.14	**Eligibility Processing:** Confirm daily and weekly eligibility and enrollment within specified business days of the receipt of the eligibility information, given that information is complete and accurate.	98.00% 2 Business Days	94.19% 81 days met/ 86 total days	Not Met
1.15	**Data Reporting:** Offeror will provide PEBP with 100% of the applicable reports (within 10 business days for standard reports and within 10 business days of Plan year-end for Annual Reports and Regulatory documents).	100% 10 Business Days	100%	Met
1.17	**ID Card Production and Distribution**	100% 10 Business Days	100%	Met
1.18	**Disclosure of Subcontractors:** Offeror will provide the identity of the subcontractors who have access to PEBP member PHI. Provide identity of subcontractors who have access to PHI within 30 calendar days of the subcontractors' gaining access.	100% 30 Calendar Days	No New Subcontractors	Met
1.19	**PHI:** Offeror will store PEBP member PHI data on designated servers. Must remove PEBP member PHI within 3 business days after offeror knows or should have known using commercially reasonable efforts that such PHI is not store on a designated server.	100% 30 Business Days	No Issues	Met
NETWORK ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
2.1	**EDI Claims Re-Pricing Turnaround Time:** At least 97% of medical claims covered under the PEBP Medical PPO Network must be electronically re-priced within business 3 days and 99% within business 5 days.	97.00% 3 Business Days 99.00% 5 Business Days	99.5% 99.5%	Met Met
2.2	**EDI Claims Re-Pricing Accuracy:** At least 97% of claims re-priced by the PPO Network must be accurate and must not cause a claim adjustment by PEBP's TPA.	97.00%	99.5%	Met
2.3	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within business 10 days of end of reporting period or event as determined by PEBP.	100% 10 Business Days	100%	Met
2.4	**Subcontractor Disclosure:** 100% of all subcontractors used by vendor are disclosed prior to any work done on behalf of PEBP. Business Associate Agreements completed by all subcontractors.	100%	No New Subcontractors	Met
2.5	**Provider Directory:** Best efforts to resolve 100% of complaints within 10 business days. Provider Directory issue resolution log maintained by Vendor and periodically reviewed with PEBP.	100% 10 Business Days	No Issues	Met
2.6	**Website:** A website hosting a reasonably accurate and updated Provider directory must be available and accessible on all major browsers 99% of time.	99.00%	99.99%	Met

	Metric	Service Objective	Actual	Met/ Not Met
UTILIZATION MANAGEMENT/CASE MANAGEMENT – SERVICES AND PERFORMANCE GUARANTEES				
3.1	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within calendar 10 days of end of reporting period or event as determined by PEBP.	100% 10 Calendar Days	100%	Met
3.2	**Notification of potential high expense cases. High expense case is defined as a single claim or treatment plan expected to exceed $100,000.00.** Designated PEBP staff will be notified within 5 business days of the UM/CM vendors initial notification of the requested Service.	100% 5 Business Days	100%	Met
3.3	**Pre-Certification Requests:** Precertification requests from healthcare providers shall be completed in accordance with URAC/NCQA standards and turn-around timeframes; completed Pre-certifications shall be communicated to PEBP's Third Party Administrator using an approved method e.g., electronically, within 5 business days of UM completing Precertification determination.	98.00% 5 Business Days	99.99%	Met
3.4	**Concurrent Hospital Reviews:** Concurrent hospital reviews shall be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated to the provider using an approved method e.g., electronically within 2 business days of determination decision.	98.00% 2 Business Days	100%	Met
3.5	**Retrospective Hospital Reviews:** Retrospective reviews must be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated using an approved method e.g., electronically within 5 business days of determination decision.	98.00% 5 Business Days	100%	Met
3.8	**Hospital Discharge Planning:** CM will contact or attempt to contact 95% of patients discharged from any facility within 3 business days of notification of discharge with clinical coaching and discharge planning assistance.	95.00% 3 Business Days	98.11%	Met
3.9	**Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	95.00%	95.00%	Met
3.10	**Utilization Management for Medical Necessity and Center of Excellence Usage:** UM review to determine medical necessity in accordance with the MPDs. Services to be performed at a Center of Excellence to be managed through the Case Management process.	98.00%	100%	Met
3.11	**Return On Investment (ROI) Guarantee – Utilization Management/ Case Management:** 2:1 Savings to Fees for Utilization Management/Case Management.	100%	100%	Met
3.12	**Disclosure of Subcontractors:** All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	No New Subcontractors	Met
3.13	**Unauthorized Transfer of PEBP Data:** All PEBP PHI or PII data will be stored, processed, and maintained solely on currently designated servers and storage devices identified in this contract. Any changes to those designated systems during the life of this agreement shall be reported to PEBP at least 60 calendar days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	No Issues	Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS®) software identified and quantified potential claim administration payment errors. PEBP and UMR should discuss any verified under- or overpayments to determine the appropriate actions to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by UMR during the audit period for both medical and dental claims. The accuracy and completeness of UMR's data directly impacted the screening categories we completed and the integrity of our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Patient cost share
- Fraud, waste, and abuse
- Timely filing
- Coordination of benefits
- Large claim review

Methodology

We used ESAS to analyze claim payment and eligibility maintenance accuracy as well as any opportunities for system and process improvement. Using the data file provided by UMR, we readjudicated each line on every claim the plan paid or denied during the audit period against plan benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into UMR's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters Set*** – We used your plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated your claim data, reconciled it against control totals, and checked it for reasonableness.
- ***Electronic Screening*** – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. Note using ESAS could lead to false positives if there was incomplete claim data. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we did not extrapolate results. We selected 50 cases and sent your administrator a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched UMR's administration.

- ***Audit of Administrator Response and Documentation*** – We reviewed and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.
- ***Eligibility Verification of Every Claim by Date of Service*** – We used ESAS to compare service dates against the eligibility periods provided to us by the eligibility vendor TELUS Health to look for claims paid for ineligible members.

Findings

We are confident in the accuracy of our ESAS results. It should be noted that dollar amounts associated with the results represent potential payment errors and process improvement opportunities. To substantiate the findings, CTI would have to perform additional testing to provide the basis for remedial action planning or reimbursement.

Categories for Process Improvement

The ESAS Findings Detail Report shows by category the line items where exceptions were noted. PEBP should work with its TPA, UMR, to examine areas of concern. A CTI auditor reviewed UMR's responses and supporting documentation. The administrator responses shown in the ESAS Detail Findings Report on the following pages were copied directly from UMR's reply to audit findings. **It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so PEBP can discuss how to reduce errors and re-work in the future with UMR.**

For each potential error, we sent an ESAS Questionnaire (QID) to UMR for written response. After review of the response and any additional information provided, CTI confirmed the potential for process improvement.

Manually adjudicated claims were processed by an individual claim processor. Auto-adjudicated claims were paid by the system with no manual intervention.

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
44	$114.40	Agree.	Procedural deficiency and overpayments remain. UMR paid duplicate charges.	☐ M ☒ S
46	$44.00			☐ M ☒ S
47	$13.06			☒ M ☐ S
50	$79.00			☐ M ☒ S
Plan Exclusions				
Dental, Prosthodontics				
37	$2,484.50	Agree. Non-accident-related dental crown procedures are excluded on the medical plan. This claim should have been denied under the medical plan.	Procedural deficiency and overpayment remain. Per page 93 of the master plan document (MPD), the plan excluded non-accident-related dental expenses.	☒ M ☐ S
Potential Fraud, Waste, and Abuse				
Durable Medical Equipment Over Medicare Allowance				
26	$867.64	Agree. Services billed are medically necessary and appropriate for treatment billed. However, claim was manually entered and paid at billed charges without discount applied.	Procedural deficiency and overpayment remain. The provider discount was not applied to the claim in error.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Specialty Medication (Non-Hospital)				
28	$5,113.92	Agree. Specialty medication claims are pended to the CFR processor for review. Authorization is on file. CPT J0585 was priced incorrectly. The allowed amount is $2,739.60.	Procedural deficiency and overpayment remain. The correct provider discount amount was not applied.	☒ M ☐ S
Cardiovascular Genetic Testing				
36	$3,750.00	Agree. This claim should have been denied due to the UM Vendor denial. This claim will be adjusted accordingly requesting $3,750.00 reimbursement.	Procedural deficiency and overpayment remain. Claim should have denied as the required prior authorization was not obtained.	☒ M ☐ S
Copay Application				
Diagnostic Mammography				
12	$3.45	Agree. Per the plan Diagnostic Mammography does have a copay. This results in a $40.00 overpayment. This claim will be adjusted at the completion of the audit.	Procedural deficiency and overpayment remain. Page 32 of the MPD specifically states diagnostic mammography has a $40 copayment. No copay was taken for this date of service (office visit, facility or professional).	☒ M ☐ S
PPO Provider Without Discount				
25	$8,293.00	Agree. This is a SHO provider. The correct allowable is $2,879.84 This is a processor error for not applying appropriate discount. This claim was adjusted on 8/8/24 and is overpaid $8,293.00.	Procedural deficiency and overpayment remain. The provider discount was not applied to the claim in error.	☒ M ☐ S
Preventive Services				
With Copay Applied				
3	($40.00)	Agree. This claim should be allowed at 100%. The claim was adjusted on 7/22/24. This results in a $40.00 underpayment.	Procedural deficiency and underpayment remain. Charge should have paid at 100% of allowed amount under preventive.	☒ M ☐ S

Additional Observations

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

QID Number	Observation
14	To align the plan language with intent, CTI recommends adding language to the EPO MPD to waive the Diagnostic Mammography $40.00 copay when performed for a non-diagnostic reason; for example, when performed after a biopsy to document marker placement.
34	The sampled claim, with a date of service of April 26, 2024, was for procedure code 81479 (Tier 2 - Unlisted Molecular Pathology) genetic testing code. CTI notes a public records release by the U.S. Attorney's Office, District of South Carolina, in July 2019 found the provider of service entered into a Civil settlement regarding false claims act allegations of genetic cancer screening tests. According to the National Health Care Anti-Fraud Association, cardiovascular genetic testing codes have a high-risk of provider abuse, specifically when genetic testing codes are billed by laboratories without a corresponding office visit claim by a physician or other medical provider on the same day as genetic testing procedures, as found on the sampled claim.

QID Number	Observation
	CTI recommends UMR review all genetic testing claims and payments to this provider for medical necessity, including requests for medical records. In addition, CTI recommends UMR have a formal written policy regarding authorization for cardiovascular genetic testing codes. Finally, CTI recommends this provider be referred to UMR's SIU for potential fraud, waste, and abuse review.

Annual Eligibility Verification

CTI electronically compared dates of service for FY2024 Q1 through Q4 and PEBP's electronic eligibility file from TELUS Health. The screening revealed that some services were paid during the audit period for potentially ineligible claimants. The output was provided to TELUS Health for its review and comment. At this time, potentially overpaid amounts have been flagged into one of the following categories:

Employee Eligibility Screening Subcategory	Amount Paid
No Identification Match to Any Eligible Employee	$27,937
Payments Prior to Effective Date	$4,882
Payments During Gaps in Coverage	$86
After Termination Date of Employee's Coverage	$2,031
Subtotal	$34,936
Dependent Eligibility Screening Subcategory	**Amount Paid**
No Identification Match to Any Eligible Employee	$2,485
Payments Prior to Effective Date	$680
Payments During Gaps in Coverage	$2,747
After Termination Date of Employee's Coverage	$37,486
Subtotal	$43,399
COMBINED TOTAL*	**$78,334**

**CTI notes that 0.11% of the PEBP's total medical expense processed by UMR was identified as paid for members who may not have been eligible for coverage. These results are normal compared to the less than 0.5% CTI generally reports.*

RANDOM SAMPLE AUDIT

Objectives

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

Scope

CTI's statistically valid Random Sample Audit included a stratified random sample of 200 paid or denied claims. UMR's performance was measured using the following key performance indicators:

- Financial Accuracy
- Claims Payment Accuracy
- Overall Accuracy

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

Methodology

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

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information UMR had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so PEBP can discuss how to reduce errors and re-work in the future with UMR.**

CTI communicated with UMR in writing about any errors or observations using system-generated response forms. We sent UMR a preliminary report for its review and written response. We considered UMR's written response, as found in the Appendix, when producing our final reports. Note that the administrator responses have been copied directly from UMR's reply.

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The total paid in the 200-claim audit sample was $1,988,229.15. The claims sampled and reviewed revealed $708.30 in underpayments and $7,983.25 in overpayments. This reflects a weighted Financial Accuracy rate of 96.41% over the stratified sample. This is a decrease in performance from the prior periods. Detail is provided in the following table, Random Sample Findings Detail Report.

UMR did not meet the Performance Guarantee for PEBP in Q4 FY2024 of 99.40% for this measure. The penalty owed is 1.5% of the administrative fees of $1,372,307.36 or $20,584.61.

Claims Payment Accuracy

CTI defines Claims Payment Accuracy as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 5 incorrectly paid claims and 195 correctly paid claims. This is a decrease in performance from the prior period. Detail is provided in the table below.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	1	4	97.50%

Overall Accuracy

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

Performance decreased from the prior period. UMR did not meet the Performance Guarantee for PEBP in Q4 FY2024 of 98.0% for this measure. The penalty owed is 1% of the administrative fees of $1,372,307.36 or $13,723.07. Detail is provided in the table below.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
195	0	5	97.50%

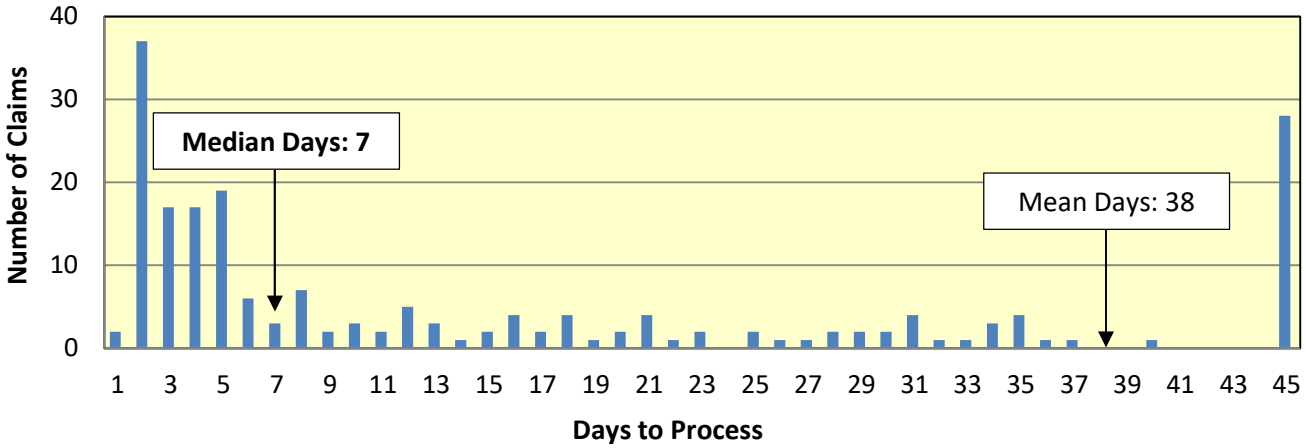
Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
PPO Discount				
1045	($708.30)	Agree. This claim was considered with incorrect pricing and was reconsidered with correct pricing on 7/30/24.	Procedural error and underpayment remain. An incorrect PPO discount was applied to the sampled claim.	☒ M ☐ S
1071	$3,868.25	Agree. This claim was allowed in full with no discount applied. The claim has been adjusted.	Procedural errors and overpayments remain. An incorrect PPO discount was applied to the sampled claim.	☒ M ☐ S
1113	$19.00	Agree. Claim was overpaid by $19.00 for code S9379.		☒ M ☐ S
Non-Compliance with Pre-certification Requirements				
1042	$3,596.00	Agree. This is a manual processing error for not obtaining discount and authorization. The rate for E0676 is $2697.00. UMR will pursue a retro authorization with DME UM Vendor as this is over $1000.00.	Procedural error and overpayment remain. No documentation of precertification was required for DME exceeding $1,000.	☒ M ☐ S
Copay Calculation Error				
1125	$500.00	Agree. A $500 copay should have applied to this claim. The original allowable was $2520 x 80% = $2016.00. The new allowable is $2020.00 x 100% (OOP met) = $2020.00. The claim was adjusted on 9-30-2024 and results in a $4.00 underpayment.	Procedural error and overpayment remain. There was an incorrect copay on this claim. Per page 42 of the MPD, "TMJ Surgical Services (including surgical services)" had a $500 copay, and the sample claim did not apply a copay. The MPD specifically excludes surgical services from the office visit copay section; "Office Based Services (excluding surgical services)".	☒ M ☐ S

Claim Turnaround

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents just a few claims with extended turnaround time from distorting the true performance picture.

Median and Mean Claim Turnaround



UMR met the Performance Guarantees for PEBP in Q4 FY2024 of 92% processed within 14 days and 99% processed within 30 days. This performance increased from the prior periods.

Additional Observations

During the random sample audit, our auditor observed the following procedures or situations that may not have caused an error but may impact future claims or overall quality of service.

Audit Number	Observation
1008 and 1012	An incorrect copay of $40 was originally applied to these claims. UMR identified the errors prior to provision of claim data to CTI; the sampled claims were adjusted to apply correct copay of $20.
2007	CTI notes the denial reason on the explanation of benefits was not specific stating the service was denied because the member had met their annual dental maximum. Instead, it stated "Maximum has been met for this type of service - see Schedule of Benefits".
2011	Procedure Code D0393, treatment simulation using 3D image volume, was allowed at 100% as a preventive service and paid $304.00. UMR had historically coded it as preventive instead of a basic service, PEBP should verify this is the plan's intent.

DATA ANALYTICS

Medical Findings

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

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

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

Network Provider Utilization and Discount Savings

The Network Provider Utilization and Discount Savings report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in a consistent manner across CTI's book of business will allow for more meaningful comparisons to be made.

Scope

CTI compared submitted charges to allowable charges for claims paid during the audit period.

The review was divided into three subsets:

- In-network
- Out-of-network
- Secondary networks

Each of these subsets was further delineated into four subgroups:

- Ancillary services – such as durable medical equipment
- Non-facility services – such as an office visit
- Facility inpatient – such as services received at a hospital
- Facility outpatient – such as services received at a surgical center

Report

PEBP's members under age 65 had utilization of network or secondary network medical providers at 96.3% of all allowed charges and 96.1% of all claims.

Total of All Claims		
Claim Type	**Provider Discount**	
Ancillary	$3,683,547.72	46.8%
Non-Facility	$39,044,038.29	54.3%
Facility Inpatient	$45,008,175.36	69.7%
Facility Outpatient	$51,937,672.10	67.2%
Total	**$139,673,433.47**	**63.0%**

Sanctioned Provider Identification

The Sanctioned Provider Identification report identifies services rendered by providers on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). OIG's LEIE provides information to the healthcare industry, patients, and the public about individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

Scope

CTI received and converted an electronic data file containing every PEBP claim processed by UMR during the audit period. The claims screened included medical (not including prescription drug) and dental claims paid or denied during the audit period. Through electronic screening, we identified claims in the data that were non-facility claims, i.e., claims submitted by providers of service other than hospitals, nursing, or skilled care facilities, or durable medical equipment suppliers. These claims predominantly include physician and other medical professional claims.

Report

We screened 100% of non-facility claims against the OIG's LEIE and identified the following providers as sanctioned. CTI's screening indicated the providers received payment from UMR during the audit period.

NPI	Exclusion Date	Reinstatement Date	Exclusion Type	Provider Name	Claim Count	Total Charged	Total Allowed	Total Paid
1104912278	20191219	N/A	1128a4	SHELBY,JAMES,S,DDS	1	$291	$253	$245
1699741041	20200120	N/A	1128a4	LI,SHOUPING,MD	5	$931	$499	$235
				Totals	**6**	**$1,222**	**$752**	**$480**

PPACA Preventive Services Coverage Compliance

The Preventive Services Coverage Compliance report confirms that the administrator processed preventive services as required by PPACA and as regulated by the Department of Health and Human Services (HHS). The federal PPACA mandate for health plans (unless grandfathered) requires that certain preventive services, if performed by a network provider, must be covered at 100% without copayment, coinsurance, or deductible. CTI's review analyzed in-network preventive care services to determine if UMR paid services in compliance with PPACA guidelines.

Scope

CTI's review included each in-network service we believe should be categorized as preventive and paid at 100%. The guidance provided by HHS for the definition of preventive services is somewhat vague, leaving it up to individual health plans to define its own system edits. In addition to the U.S. Preventive Services Task Force recommendations, CTI researched best practices of major health plan administrators to develop a compliance review we believe reflects the industry's most comprehensive overview of procedures to be paid at 100%. CTI's review did not include services:

- performed by an out-of-network provider;
- adjusted or paid more than once (duplicate payments) during the audit period; or
- for which PPACA requirements suggest a frequency limitation such as one per year.

CTI's data analytics parameters relied upon the published recommendations from the sources HHS used to create the list of preventive services for which it has mandated coverage.

Reports

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

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

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

CTI's analysis also found that 93.99% of the procedure codes identified as preventive services were paid by UMR at 100% when provided in-network. This total is net of claims denied as a duplicate of a preventive claim paid in a prior period.

NCCI Editing Compliance

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

Scope

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

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

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

PTP Edits Reports

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

Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary			Primary Description	Secondary Description	Line Count	Amount CMS Would Deny
Code	Mod	Code	Mod	Mod Use				
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	12	$8,168
					Standards of medical/surgical practice			
80053		80048		NO	COMPREHEN METABOLIC PANEL	METABOLIC PANEL TOTAL CA	8	$2,505
					CPT Manual or CMS manual coding instruction			
93005		15772		YES	ELECTROCARDIOGRAM TRACING	Grafting autologous fat harvstd by liposctn	1	$2,196
					Misuse of Column Two code with Column One code			
70491	TC	96374		YES	CT SOFT TISSUE NECK W/DYE	THER/PROPH/DIAG INJ IV PUSH	2	$1,957
					Standards of medical/surgical practice			
70553	TC	70544	TC	YES	Mri brain stem w/o & w/dye	MR ANGIOGRAPHY HEAD W/O DYE	1	$1,874
					Misuse of Column Two code with Column One code			
92950		93005		YES	HEART/LUNG RESUSCITATION CPR	ELECTROCARDIOGRAM TRACING	2	$1,698
					Standards of medical/surgical practice			
92526	GN	97530	GP	YES	ORAL FUNCTION THERAPY	THERAPEUTIC ACTIVITIES	7	$1,603
					Misuse of Column Two code with Column One code			
46922		64430	50	YES	EXCISION OF ANAL LESION(S)	Injection(s), anesthetic agent(s) and/or ster	1	$1,560
					Standards of medical/surgical practice			
22856		95939	TC	YES	CERV ARTIFIC DISKECTOMY	C MOTOR EVOKED UPR&LWR LIMBS	1	$1,543
					Misuse of Column Two code with Column One code			
70496	TC	96374		YES	CT ANGIOGRAPHY HEAD	THER/PROPH/DIAG INJ IV PUSH	2	$1,535
					Standards of medical/surgical practice			
						Top 10 TOTAL	**37**	**$24,640**
						GRAND TOTAL	**368**	**$96,011**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary			Primary Description	Secondary Description	Line Count	Amount CMS Would Deny
Code	Mod	Code	Mod	Mod Use				
90837		97803		NO	Psytx pt&/family 60 minutes	MED NUTRITION INDIV SUBSEQ	4	$640
					Misuse of Column Two code with Column One code			
92609	GN	92507	GN	YES	USE OF SPEECH DEVICE SERVICE	SPEECH/HEARING THERAPY	10	$608
					Misuse of Column Two code with Column One code			
31500		99291		YES	INSERT EMERGENCY AIRWAY	CRITICAL CARE FIRST HOUR	1	$470
					CPT Manual or CMS manual coding instruction			
93975		76700		YES	VASCULAR STUDY	US EXAM ABDOM COMPLETE	1	$405
					Misuse of Column Two code with Column One code			
52000		51703	51	NO	CYSTOSCOPY	INSERT BLADDER CATH COMPLEX	1	$338
					CPT Manual or CMS manual coding instruction			
88344	26	88342	26	YES	Immunohistochemistry or immunocytochemistry,	IMMUNOHISTOCHEMISTRY	2	$274
					CPT Manual or CMS manual coding instruction			
84481		84480		NO	FREE ASSAY (FT-3)	ASSAY TRIIODOTHYRONINE (T3)	13	$253
					More extensive procedure			
90471		99214	5	YES	IMMUNIZATION ADMIN	OFFICE/OUTPATIENT VISIT FOR E&M ESTAB P	1	$193
					CPT Manual or CMS manual coding instruction			
84439		84436		NO	ASSAY OF FREE THYROXINE	ASSAY OF TOTAL THYROXINE	19	$179
					More extensive procedure			
93015		99223		YES	CARDIOVASCULAR STRESS TEST	Initial hospital inpatient or observation ca	1	$178
					Misuse of Column Two code with Column One code			
						Top 10 TOTAL	**53**	**$3,538**
						GRAND TOTAL	**105**	**$5,120**

MUE Reports

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

CTI's MUE analyses are grouped into three separate reports, outpatient hospital, non-facility, and ancillary. Of note: the outpatient hospital screening had no results.

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Amount CMS Would Deny
97154	18	GROUP ADAPTIVE BHV TX BY PROTOCOL TECH EA 15 MIN	43	$21,017
		Rationale: Clinical: CMS Workgroup		
J9332	600	Inj efgartigimod 2mg	6	$11,545
		Rationale: Prescribing Information		
31295	1	Nasal/sinus endoscopy, surgical, w dilation (balloon dila	5	$10,362
		Rationale: CMS Policy		
95999	1	NEUROLOGICAL PROCEDURE	6	$6,253
		Rationale: Clinical: CMS Workgroup		
96133	7	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR	2	$3,136
		Rationale: Nature of Service/Procedure		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	3	$2,081
		Rationale: Clinical: CMS Workgroup		
88341	13	Immunohistochemistry or immunocytochemistry, per spe	2	$1,252
		Rationale: Clinical: Data		
30140	1	RESECT INFERIOR TURBINATE	6	$1,220
		Rationale: CMS Policy		
68720	1	CREATE TEAR SAC DRAIN	1	$1,120
		Rationale: CMS Policy		
86317	6	IMMUNOASSAY INFECTIOUS AGENT	3	$732
		Rationale: Clinical: CMS Workgroup		
		Top 10 TOTAL	**77**	**$58,718**
		GRAND TOTAL	**119**	**$63,686**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, or non-facility)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Amount CMS Would Deny
A4239	1	Non-adju cgm supply allow	6	$2,720
		Rationale: Nature of Equipment		
A4238	1	Adju cgm supply allowance	1	$1,081
		Rationale: CMS Policy		
V2522	2	CNTCT LENS HYDROPHIL BIFOCL	4	$564
		Rationale: Anatomic Consideration		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	4	$383
		Rationale: Nature of Equipment		
V2520	2	CONTACT LENS HYDROPHILIC	4	$330
		Rationale: Anatomic Consideration		
B4035	1	ENTERAL FEED SUPP PUMP PER D	2	$206
		Rationale: Code Descriptor / CPT Instruction		
V2510	2	CNTCT GAS PERMEABLE SPHERICL	1	$110
		Rationale: Anatomic Consideration		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	1	$110
		Rationale: Anatomic Consideration		
A7046	1	REPL WATER CHAMBER, PAP DEV	2	$109
		Rationale: Published Contractor Policy		
V2104	2	SPHEROCYLINDR 4.00D/2.12-4D	2	$60
		Rationale: Anatomic Consideration		
		Top 10 TOTAL	**27**	**$5,673**
		GRAND TOTAL	**30**	**$5,718**

Global Surgery Prohibited Fee Period Analysis

CMS created the definition of global surgical package to make payments for services provided by a surgeon before, during, and after procedures. The objective of CTI's Global Surgery Prohibited Fee Period Analysis is to compare paid surgical claims to Medicare's payment guidelines and identify instances of unbundling and improper use of evaluation and management (E/M) coding.

Scope

The scope of the Global Surgery Prohibited Fee Period Analysis is surgery charges provided in any setting, including inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. Claims for surgeon visits in intensive care or critical care units are also included in the global surgical package. CTI's analysis encompasses the three types of procedures with global surgical packages: simple, minor, and major. Each type has specific global periods including simple – one day, minor – ten days, and major – ninety days.

CMS allows providers to bill for an E/M service after surgery if the patient's condition required a significant, separately identifiable E/M service beyond the usual pre-operative and post-operative care. When this occurs, the provider can add a modifier 24, 25, or 57 to the E/M service procedure code that alerts the administrator special payment circumstances may exist. The administrator must also submit supporting documentation with the claim.

Report

The following report provides a summary of:

- top 10 providers with and without E/M charges during prohibited periods and associated charges;
- analysis of same providers' surgeries with modifier 24, 25, or 57 when Medicare would have required supporting documentation before payment; and
- analysis of the same providers' surgeries without modifier 24, 25, or 57 when Medicare would have denied payment.

Payment of unbundled, post-surgical E/M services during the global fee period increases the cost of a claim. While there are no universally accepted guidelines for global surgery fee periods with 24, 25, or 57 modifiers, some states and groups mandate providers accept assignment of benefits on those claims. This mitigates the financial impact of unbundling and improper coding. When we discuss the findings, we will help PEBP identify strategies to monitor and eliminate unbundling within PEBP's plan.

Audit Period 4/1/2024 - 6/30/2024									
	Surgeries with 'CMS Defined' Prohibited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period			
	Surgeries without E/M Procedures during Prohibited Global Fee		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes with Modifier 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
Provider ID	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
880115812	0	$0	1	100.0%	$149	1	$92	1	$92
880383202	2	$1,319	3	60.0%	$1,562	2	$185	1	$92
853977236	0	$0	1	100.0%	$138	1	$124	0	$0
843370496	0	$0	1	100.0%	$93	1	$83	0	$0
464920174	0	$0	1	100.0%	$90	1	$73	0	$0
460577493	0	$0	1	100.0%	$434	1	$134	0	$0
452698394	2	$505	1	33.3%	$660	1	$268	0	$0
270028866	0	$0	1	100.0%	$276	1	$190	0	$0
264836128	2	$181	1	33.3%	$151	1	$89	0	$0
260076062	0	$0	2	100.0%	$457	2	$279	0	$0
Top 10	**6**	**$2,005**	**13**	**68.4%**	**$4,008**	**12**	**$1,517**	**2**	**$184**
Overall Total	**40**	**$11,849**	**29**	**42.0%**	**$6,461**	**28**	**$3,395**	**2**	**$184**

FY2024 REVIEW AND RECOMMENDATIONS

The table below presents a summary of UMR's performance against the FY2024 quarterly metrics based on CTI's random sample audit results. Results shown in red represent where UMR missed the metric.

Measure	Guarantee	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Financial Accuracy	**99.4%**	97.5%	99.89%	98.47%	96.41%
Overall Accuracy	**98.0%**	96.0%	97.5%	98.5%	97.5%
Claim Turnaround Time	**92% in 14 Days**	92.8%	93.9%	94.0%	93.3%
	99% in 30 Days	95.9%	96.9%	98.5%	99.5%

CTI has the following recommendations that represent recurring issues identified in the FY2024 quarterly audits:

1. UMR should review each of the financial errors identified in our FY2024 random sample audits and determine if system changes or additional claim processor training could help reduce or eliminate errors of a similar nature in the future. It should focus specifically on steps necessary to improve Financial Accuracy.
2. UMR should conduct a focused analysis of the errors identified through ESAS to determine if overpayment recovery and/or system improvements are possible and to reduce or eliminate similar errors going forward. For the issues identified by ESAS, CTI can prepare claim detail for UMR to use in its analysis.
3. PEBP should review the results of the eligibility screening and perform causal analysis to identify workflow and/or system improvements to reduce or eliminate paying claims on ineligible claimants.
4. UMR should review its procedures for excluding claim payments from sanctioned providers that appear on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE).

CONCLUSION

UMR met the performance metrics for claim turnaround 92% within 14 days for all four quarters of FY2024 and 99% within 30 days in quarter 4. UMR did not meet the performance metrics for financial accuracy and overall accuracy in three out of four quarters in FY2024.

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

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

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

115 West Wausau Ave
Wausau, WI 54401

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

October 3, 2024

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q4Y24 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID 44 – Claim [redacted] is a duplicate to previously processed claim [redacted]. This results in a $114.40 overpayment.

QID 46 – Dental claim [redacted] is a duplicate to previously processed claim [redacted]. This results in a $44.00 overpayment.

QID 47 – Claim [redacted] is a duplicate to previously processed claim [redacted]. The claim was adjusted on 8-27-2024 and results in a $13.06 overpayment.

QID 50 – Claim [redacted] is a duplicate to previously processed claim [redacted]. This results in a $79.00 overpayment.

Plan Exclusions – Dental, Prosthodontics

QID 37 – UMR agrees with this finding. Non-accident-related dental crown procedures are excluded on the medical plan. This claim was allowed in error. This results in $2484.50 overpayment. An adjustment will be considered at the completion of the audit.

Potential Fraud, Waste and Abuse – DME

QID 26 – UMR agrees with this finding. This claim was considered at billed charges, with no discount applied. The claim was adjusted on 9-12-2024 and results in a $867.64 overpayment.

Fraud, Waste and Abuse – Specialty Medications (Non-Hospital)

QID 28 – UMR agrees with this finding. CPT J0585 was priced incorrectly allowing $9132.00. The correct allowable is $2739.60. This results in a $5113.92 overpayment. An adjustment will be considered at the completion of the audit.

Fraud, Waste and Abuse – Cardiovascular Genetic Testing

QID 36 – UMR agrees with this finding. There is a UM Vendor denial for this claim and therefore should have been denied. The claim was adjusted on 10-1-2024 and results in a $3750.00 overpayment.

715-841-7262 www.UMR.com Julie.Frahm@UMR.com

Copay Application - DX Mammography

QID 12 – After further review, UMR agrees with this finding. Per the plan Diagnostic Mammography does have a copay. This results in a $40.00 overpayment. This claim will be adjusted at the completion of the audit.

QID 14 – UMR disagrees with this finding. Per the plan benefit, a copay does not apply to this outpatient hospital claim due to the ology benefit.

Timely Filing

QID 6 – UMR disagrees with this finding. UMR managed the reprocessing of this claim appropriately. HSB initially processed as out of network. UMR was notified this is a participating provider and followed policy and procedures to correct the claim per the plan benefits. An exception from PEBP is not required as the claim was initially processed timely.

PPO Provider Without Discount

QID 25 – UMR agrees with this finding. The SHO discount was not applied to this claim at the time of processing. This is a manual processing error. The claim was adjusted on 8-8-2024 and results in a $8293.00 overpayment.

Preventive Services – with Copay Applied

QID 3 – UMR agrees with this finding. This claim should have allowed at 100% per the preventive benefits with no copay. The claim was adjusted on 7-22-2024 and results in a $40.00 underpayment.

Additional Observation:

QID 34 – Provider for this claim has been referred to UMR's SIU team for review.

Random Sample Findings

PPO Discount

Sample 1045 – UMR agrees with this finding. This claim was considered with incorrect pricing. The claim was adjusted on 7-30-2024 and results in a $708.30 underpayment.

Sample 1071 – UMR agrees with this error. This claim was considered at billed charges, with no discount applied. The claim was adjusted on 8-13-2024 and results in a $3868.25 overpayment.

Sample 1113 – UMR agrees with this finding. CPT S9379 was considered at billed charges, with no discount applied. The allowable is $66.00. The claim was adjusted on 9-6-2024 and results in a $19.00 overpayment.

Sample 1129 – UMR disagrees with this error. The provider of service submitted a corrected claim. Total billed charges changed to $3795.46. Corrected claim and pricing are attached.

Non-Compliance with Pre-Certification Requirements

Sample 1042 – UMR agrees with this finding. Authorization was not on file at the time this claim was processed. This is a manual processing error. This results in a $3596.00 overpayment. UMR will pursue a retro authorization with the DME UM Vendor.

Copay Calculation Error

Sample 1125 – After further review, UMR agrees with this finding. A $500 copay should have applied to this claim. The original allowable was $2520 x 80% = $2016.00. The new allowable is $2020.00 x 100% (OOP met) = $2020.00. The claim was adjusted on 9-30-2024 and results in a $4.00 underpayment.

Denied Eligible Expense

Sample 2027 – UMR disagrees with this finding. At the time of services, 2-26-2024, this member had dental coverage primary through United Healthcare. This claim was processed as secondary by UMR utilizing the EOB from UHC. CPT 00270 for bitewings, billed charge $52.00 - $30.00 provider negotiated discount. UHC allowed and paid $22.00. There was no balance for UMR to make a payment. The member notified UMR on 4-8-2024 there is no other insurance. UMR updated this member file accordingly. This is why at the time of audit, the members file notes there is No Other Insurance. Claim Image and OI EOB are attached.

Additional Observations:

Sample 1008 and 1012 - A copay application error was identified by the UMR Claims Team. An adjustment project was completed on 6-26-2024.

Sample 2007 – The denial reason code on the explanation of benefits is UMRs standard when the maximum has been met.

Sample 2011 – D0393 is considered a diagnostic service on the UMR platform, we pay it at 100% for in-network and 80% for out of network.

UMR is dedicated to improving the overall experience for the State of Nevada PEBP members and will continue to work diligently on addressing any issues highlighted by this review. Coaching and ongoing training is held with our dedicated processors. We continue to meet with the staff daily to go over quality reports, identifying trending errors, initiating refresher training for skill gaps, and using this data to improve the overall quality of the staff.

If you have any questions or concerns regarding our responses, please feel free to contact me at 715-841-7262.

Sincerely,

Julie Frahm
Sr. UMR External Audit Coordinator

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

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7.

7. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by VIA Benefits for the period of July 1, 2023 – June 30, 2024. (Joni Amato, Claim Technologies Incorporated) (**For Possible Action**)

Claim Administration Audit

HEALTH REIMBURSEMENT ARRANGEMENT

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

Administered by Via Benefits from Willis Towers Watson

Audit Period: July 1, 2023 through June 30, 2024
Plan Year 2024

Presented to

State of Nevada Public Employees' Benefits Program

November 21, 2024

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

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EXECUTIVE SUMMARY

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

Scope

CTI performed an audit of Via Benefits' administration of the PEBP HRA for the period of July 1, 2023 through June 30, 2024 (plan year 2024). The population of claims and amount paid during the audit period was taken from the paid claim file provided by Via Benefits.

Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$18,931,372
Total Number of Claims Paid/Denied/Adjusted	191,726

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

- Operational Review
- Random Sample Audit
- Eligibility Verification

Auditor's Opinion

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

1. Via Benefits again improved service to PEBP's members and exceeded all performance guarantees for FY2024.
2. Although Via Benefits provided good service to PEBP's members, CTI recommends the following area for improvement:
    - Provide claim processors with coaching on the errors identified during the audit.

Summary of Via Benefits Guarantee Measurements

Based on CTI's Random Sample Audit results, Via Benefits met all three of the annual metrics for PEBP in plan year 2024.

FY 2024 Annual Metrics	Guarantee	Met/Not Met	Penalty
Claim Financial Precision	98%	Met–99.00%	$0
Claim Processing Payment Precision	98%	Met 99.00%	$0
Claim Processing Turnaround Time	Average 2 business days	Met – 0.44 days	$0
		Total Penalty	$0

AUDIT OBJECTIVES

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

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by PEBP and Via Benefits. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain reasonable assurance claims were adjudicated according to the terms of the contract between Via Benefits and PEBP.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems Via Benefits used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

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

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

OPERATIONAL REVIEW

Objectives

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

Scope

The scope of our review included:

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

Methodology

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

Findings

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

- Via Benefits indicated it maintained levels and types of insurance reasonable and customary for a health services organization with comparable size and market presence.
- Willis Towers Watson (WTW), parent company of Via Benefits, reported that it had been audited by KPMG LLP, for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report and provided CTI a copy of the report.

- The business continuity plan provided by Via Benefits included two approaches to data protection: 1) continuous off-site replication to a second, geographically distant location and, 2) the use of daily backups of files and databases.
- Via Benefits indicated no claim processing functions, member services, or provider services were outsourced.
- Refunds and return checks were forwarded to PEBP to deposit to PEBP's bank account.
- Via Benefits indicated PEBP provided the allocation amount for which participants were eligible. Effective May 31, 2021, PEBP implemented an $8,000 cap on the available balance.
- Via Benefits indicated loss of HRA eligibility was the biggest reason for a claim overpayment. Via Benefits did not provide an HRA overpayment report for FY2024.
- Customer service operations were available via phone Monday through Friday from 5:00 AM to 4:00 PM PST.
- The member online portal allowed claim submission, check claim status, check participant balances, supporting documents submittal, and viewing of historical information.
- Via Benefits communicated with account holders via mail or email. It provided digital newsletters approximately every two months, a one-time enrollment guide mailing when a participant aged into Medicare, and a one-time HRA welcome packet mailing upon initial qualification.
- Via Benefits reported it used secure system passwords and system authorization, as well as separation of duties for system security. It also limited access to eligibility maintenance and claim adjudication.
- Via Benefits' internal system control document provided a thorough overview including detail on data entry logic, duplicate logic, and overpayment logic as examples.
- Web-based security and compliance training was provided to Via Benefits staff within 90 days after hire and then annually thereafter.
- Via Benefits reported there were no privacy or security breaches identified during the audit period.

Performance Guarantee Validation

As part of CTI's audit of PEBP, we reviewed the Performance Guarantees included in its contract with Via Benefits. The self-reported results for plan year 2024 follow.

Metric and Service Objective	Actual	Met/ Not Met
Reports Annual Review: Reports provided within 15 days.	All reports delivered within 15 days	Met
HRA Web Services Annual Review: 99% availability of web services for benefit information and HRA information exclusive of scheduled maintenance.	99.98%	Met
Customer Service Abandon Rate Annual Review: The percentage of incoming calls abandoned by participants be 5% or less.	2.37%	Met
Customer Service Speed to Answer Quarter Review: Incoming telephone calls answered in less than or equal to: Ninety seconds in Q1 PY 2024 Five minutes in Q2 PY 2024 Two minutes in Q3 PY 2024 Ninety seconds in Q4 PY 2024	 Q1 PY 2024 – 0:10 Q2 PY 2024 – 1:28 Q3 PY 2024 – 0:26 Q4 PY 2024 – 0:10	Met
Customer Satisfaction Quarter Review: At least 80% of participants surveyed will be satisfied with services.	Q1 PY 2024 – 92.31% Q2 PY 2024 – 87.47% Q3 PY 2024 – 92.12% Q4 PY 2024 – 90.48%	Met
Disclosure of Subcontractors Per Violation: additional subcontractors shall not be engaged, unless at least 60 days prior notice to the engagement of a new subcontractor.	100%	Met
Unauthorize Transfer of Data Per Violation: All data will be stored, processed, and maintained on designated servers. Any changes must have 60 days notification.	100%	Met

RANDOM SAMPLE AUDIT

Objective

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

Scope

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

- Claim Financial Precision
- Claim Processing Payment Precision

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

Methodology

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

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

Findings

CTI defines claim financial precision as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample. Claim processing payment precision is defined as the total number of payments made correctly without a payment or nonpayment error compared to the total number of payments issued. The sampled claims were selected from the PEBP HRA claims processed during the 2024 plan year.

Via Benefits did meet the performance guarantees for claim financial precision, claim processing payment precision, and claim turnaround time.

Note: A summary of each finding follows the chart below.

Performance Measure	Claims Sampled		Sampled Claims with Errors		Results
	Claims	Dollars Paid	Claims	Dollars Paid	
Claim Financial Precision	200	$18,509.50	2	$184.70	99.00%
Claim Processing Payment Precision	200		2		99.00%
Claim Turnaround Time	Average 2 business days				0.44 days

Random Sample Findings Detail Report			
Audit Number	**Over/(Under) Paid**	**Via Benefits Response**	**CTI's Conclusion**
Duplicate Payment			
1017	$174.70	Agree.	Procedural error and overpayment remain. The claim was a duplicate payment.
Paid Ineligible Procedure			
1007	$10.00	Agree.	Procedural error and overpayment remain. An ineligible charge on the claim submission was paid.

Additional Observations

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

Audit Number	Observation
1011, 1092, 1122	Via Benefits' protocol is to process claims as one payment for multiple receipts. Best practice is to separate individual claims to identify and prevent duplicate payments. In the samples cited, multiple receipts were combined into one claim.

ELIGIBILITY VERIFICATION

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

Description	Claim Lines	Members	*Paid Amount
Member Not on File	326	27	$42,871.38
Incurred After Member Benefit End Date	201	71	$26,095.24
TOTALS	**527**	**98**	**$68,966.62**

**CTI notes that 0.36% of PEBP's total medical spend processed by Via Benefits was identified as paid for members who may not have been eligible for coverage. These results are within the norm of less than 0.5% CTI generally reports.*

PLAN YEAR 2024 RECOMMENDATIONS

CTI has the following recommendations based on the findings of the Plan Year 2024 audit of Via Benefits:

1. Via Benefits should coach its claims processors on errors identified during the audit including:
    - Duplicate payments
    - Payment of ineligible expenses

CONCLUSION

Via Benefits met the performance metrics for claim financial precision, claim processing payment precision, and claim turnaround time for FY2024.

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

APPENDIX – ADMINISTRATOR RESPONSE TO INITIAL REPORT

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

October 10, 2024

State of Nevada Public Employees Benefits Program:

On behalf of Willis Towers Watson (WTW) regarding the draft report of the Audit of the State of Nevada Public Employees' Benefits Program Health Savings Account and Health Reimbursement Arrangement for the period of July 2023-June 2024 please see our response to the report and the auditors recommendations below:

Observation:

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

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

Required Information:

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

Expenses must be fore the same person (participant or dependent)

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

Guidance:

Common documentation that can be used to club expenses:

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

- EOB
- Invoice
- Statement
- Ledger

Claim Entry Instructions:

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

Recommendations:

1. Via Benefits should coach its claims processors on errors identified during the audit including:
   - Duplicate payments
   - Payment of ineligible expenses

WTW Response:

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

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

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

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8.

8. Health Savings Bank Investment Discussion.
   (Celestena Glover, Executive Officer)
   (Information/Discussion)
   (No written report.)

9.

9. Discussion and possible action regarding Carson Tahoe Health's expressed intent to leave the United Health Network effective May 30, 2025.
(Celestena Glover, Executive Officer)
(**For Possible Action**)

JOE LOMBARDO
Governor

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

CELESTENA GLOVER
Executive Officer

JOY GRIMMER
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: November 21, 2024

Item Number: 9

Title: Carson Tahoe Health

SUMMARY

This report provides options for the Board's consideration regarding Carson Tahoe Health (CTH). CTH has expressed their intent to not renew the contract with United Health Care at the expiration of the current contract which expires on May 30, 2025. The result is that should an alternative not be found CTH (facilities and providers) will no longer be in-network for PEBP members.

REPORT

DISCUSSION OF POTENTIAL OPTIONS

This agenda item presents an opportunity for the PEBP Board to voice their concerns and ask questions of both CTH and UMR to assist the board in making a decision regarding the path forward. Potential options have been discussed as follows:

- Take no action at this time, potentially resulting in Carson Tahoe Health (facilities and providers) becoming an out-of-network provider.
    - As a part of this option the PEBP Board could request CTH and UMR to continue working toward a suitable agreement between the parties with direction for the final agreement negotiated no later than the January 23, 2025, PEBP Board meeting.

The following were suggested by Carson Tahoe Health:

- Enter into a direct contract with Carson Tahoe Health final terms to be negotiated.

- Enter into a contract with Nevada Business Group on Health/Nevada Health Partners (NBGH/NHP) to provide a second network that will provide access to Carson Tahoe Health as an in-network provider (final terms to be negotiated).

CTH's suggestions will require PEBP to begin the formal contract solicitation process ensuring that PEBP is in compliance with the provisions of NRS 333.

CONSIDERATIONS

Taking no action may result in a major provider in the Carson City area becoming an out-of-network provider. PEBP members utilizing their services will be subjected to higher out-of-pocket costs.

Emergent and urgent care would continue to be covered as in-network service.

Pursuing a direct contract or second network may come at higher costs through administrative fees or claims costs or both and require PEBP staff to field additional calls to answer questions resulting from confusion that may occur from having a secondary network or separate contract with CTH.

Entering into a direct contract or engaging a second network may also incentivize other providers to seek direct contracts with PEBP. PEBP does not have the staff or expertise to administer multiple provider contracts.

CONCLUSIONS

PEBP staff will continue to explore any avenues available including options the Board would like staff to analyze not previously discussed in this report. Should the Board opt to begin the formal solicitation process PEBP staff will work with the Purchasing Division to release an RFP for the required services.

Note: The time required to write, release, evaluate, negotiate the terms of a new contract and the implementation of a new vendors is extensive. This could result in CTH becoming an out-of-network provider for 6 months or more at the end of the current plan year and the beginning of plan year 2026.

Ultimately the best course of action would be for the parties to come to an agreement that is favorable for all especially PEBP members.

RECOMMENDATION

Provide PEBP staff with direction as to how the Board wishes to proceed.

10.

10. Acceptance of Biennial Compliance Report. (Leslie Bittleston, Quality Control Officer) (**For Possible Action**)

Public Employees' Benefits Program

Biennial Compliance Review

Executive Summary

November 2024

Segal

Section 1. Introduction

NRS 287.0425(2)(b) requires an independent biennial review of Public Employees' Benefits Program ("PEBP"), to determine whether the Program complies with federal and state laws relating to taxes and employee benefits. At the request of the Public Employees' Benefits Program ("PEBP"), Segal performed a review of certain plan documents and administration processes provided by PEBP to enable PEBP to comply with applicable federal and state laws. Segal worked with PEBP to confirm the scope of review, and identify the applicable State statutes subject to review.

Our compliance review is based on documents received, statutes, and regulations as existing and in effect for PEBP's July 1, 2024—June 30, 2025 plan year ("PY 2025"). We requested from PEBP staff members certain documents and answers to specific questions relevant to PEBP. We did not attempt to verify actual administration of PEBP through sampling techniques, discussions with third party vendors/administrators, or otherwise. In addition, we did not perform any claim audits related to PEBP, or consider issues related to payroll practices, workers' compensation, unemployment compensation, classification of employees, or other non-benefits-related aspects of any federal or state law.

Although we identified certain compliance issues relating to PEBP, our report should not be relied upon to identify all possible weaknesses in internal controls, errors, irregularities, or illegal acts, or to identify all possible violations of the Nevada Revised Statutes ("NRS"), Nevada Administrative Code ("NAC"), the Internal Revenue Code (the "Code"), Public Health Service Act ("PHSA"), the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (in relevant part as made applicable through the PHSA), Internal Revenue Service ("IRS"), regulations, or other technical pronouncements as we did not perform a transactional operational compliance review of PEBP. We interpreted compliance requirements in a manner we believe to be reasonable. However, we cannot guarantee that government agencies, courts, or participants will agree with our interpretation, or that PEBP would be in compliance with all applicable laws, regulations, rules, or other governmental pronouncements if PEBP implemented all of our recommendations.

This report outlines the results of Segal's review and summarizes our findings and recommendations to address certain document compliance issues that we have identified as a result of our compliance review. Any consulting advice we provide is intended to assist PEBP in determining how best to comply with applicable requirements relating to PEBP's compliance with federal and state laws. Nevertheless, Segal does not engage in the practice of law, and the consulting advice we provide is not, and is not intended to be, legal advice. Accordingly, this report should be reviewed with PEBP's legal counsel.

Section 2. Summary of Findings

The following summary highlights key findings from the biennial review. As Federal and State benefits laws are continually changing, the review noted some areas which PEBP should update to enhance its compliance with Federal and State requirements. Below are some areas identified for PEBP's consideration.

Federal Findings

Notices

Segal reviewed PEBP's compliance with Federal notices required by the ACA, COBRA, HIPAA, No Surprises Act, and other Federal regulations. Based on the review of plan documents and responses, Segal recommends updating the ACA Marketplace Notice, the Surprise Billing Notice, and the Qualified Child Support Medical Order Notice. PEBP should also consider adopting the practice of distributing a new hire packet with mandatory notices in addition to annual distribution of notices, or update its new member letter to more clearly identify the availability and location of these notices.

Benefit Consistencies

During review, certain inconsistencies between plan documents were identified. PEBP should review its pediatric vision benefit schedule of benefits, physician references throughout the document, and DCFSA eligibility definition and clarify and/or update these sections as necessary.

HIPAA Privacy Protections

The Department of Health and Human Services (HHS) recently issued a final rule that strengthens privacy protections for Protected Health Information (PHI) related to lawful reproductive healthcare. The rule requires covered entities, including group health plans, to modify privacy policies and procedures and prepare new Notices of Privacy Practices reflecting the changes. PEBP should review the new regulations and make updates to its policies, procedures, and Notice of Privacy Practices. PEBP should also ensure the HIPAA Privacy Notice is provided upon enrollment in the plan. The effective date is June 25, 2024, with a general compliance deadline of December 23, 2024. Privacy notices must be updated by February 16, 2026.

Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008

In 2023, PEBP implemented plan changes to comply with the proposed MHPAEA rules published on August 3, 2023. On September 23, 2024, the final rules for MHPAEA were published. The rules contain additional definitions, call for coverage of core treatments for covered mental health and substance use conditions, and require collection and review of data outcomes. Additional guidance is forthcoming, related to outcomes data collection and evaluation, as well as an updated self-compliance tool. PEBP should continue to evaluate the final rules and determine the impact on future MHPAEA compliance efforts.

Section 2. Summary of Findings (Continued)

State Findings

NRS 287.04335 directs that compliance with certain provisions in NRS and NAC is required to provide health insurance through a plan of self-insurance. Segal worked with PEBP to confirm the scope of review, and identify the applicable State statutes subject to review. NRS 287.04335 was amended in the 2023 Nevada Legislature, and made several changes applicable to PEBP.

PEBP should review the benefit requirements and new updates, and make updates to the Master Plan Documents (MPDs) as necessary. PEBP should also confirm with UMR that it is administering the benefits according to the amendments made to NRS 287.04335.

The following statutes were identified as areas PEBP should clarify:

- **Telehealth -** PEBP should clarify how out-of-network coverage is paid on the Low Deductible plan and whether this complies with the State mandate for telehealth coverage to mirror in person coverage.
- **Human immunodeficiency virus and hepatitis C -** PEBP should clarify the Plan provides for testing and other services for hepatitis C and HIV. PEBP should also clarify coverage for drugs used for prevention of HIV.
- **Coverage for testing, treatment and prevention of sexually transmitted diseases -** PEBP should update the MPDs to clarify all coverage mandated for testing, treatment, and prevention of sexually transmitted diseases is included. PEBP should also remove the exclusion for condoms. PEBP should confirm with UMR that coverage is provided according to State law.
- **Substance Use and Opioid Disorder Drugs -** PEBP should amend the MPDs to clarify the Plan provides benefits for substance use disorder for all drugs approved by FDA to support safe withdrawal from substance use disorder, including, without limitation lofexidine. PEBP should clarify that the Plan does not subject these benefits to medical management techniques, other than step therapy.
- **Mandates for certain wellness benefits -** PEBP should clarify that it covers hormone replacement therapy.
- **Emergency Prescription coverage during emergency or disaster declaration -** PEBP should consider adding language explaining procedure to obtain emergency prescription coverage during emergency or disaster declaration, and the geographic limitations as applicable.

Public Employees' Benefits Program

Biennial Compliance Review

November 2024

Segal

Table of Content

Section 1. Introduction

NRS 287.0425(2)(b) requires an independent biennial review of Public Employees' Benefits Program ("PEBP"), to determine whether the Program complies with federal and state laws relating to taxes and employee benefits. At the request of the Public Employees' Benefits Program ("PEBP"), Segal performed a review of certain plan documents and administration processes provided by PEBP to enable PEBP to comply with applicable federal and state laws. Segal worked with PEBP to confirm the scope of review and identify the applicable State statutes subject to review.

Our compliance review is based on documents received, statutes, and regulations as existing and in effect for PEBP's July 1, 2024—June 30, 2025 plan year ("PY 2025"). We requested from PEBP staff members certain documents and answers to specific questions relevant to PEBP. We did not attempt to verify actual administration of PEBP through sampling techniques, discussions with third party vendors/administrators, or otherwise. In addition, we did not perform any claim audits related to PEBP, or consider issues related to payroll practices, workers' compensation, unemployment compensation, classification of employees, or other non-benefits-related aspects of any federal or state law.

Although we identified certain compliance issues relating to PEBP, our report should not be relied upon to identify all possible weaknesses in internal controls, errors, irregularities, or illegal acts, or to identify all possible violations of the Nevada Revised Statutes ("NRS"), Nevada Administrative Code ("NAC"), the Internal Revenue Code (the "Code"), Public Health Service Act ("PHSA"), the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (in relevant part as made applicable through the PHSA), Internal Revenue Service ("IRS"), regulations, or other technical pronouncements as we did not perform a transactional operational compliance review of PEBP. We interpreted compliance requirements in a manner we believe to be reasonable. However, we cannot guarantee that government agencies, courts, or participants will agree with our interpretation, or that PEBP would be in compliance with all applicable laws, regulations, rules, or other governmental pronouncements if PEBP implemented all of our recommendations.

This report outlines the results of Segal's review and summarizes our findings and recommendations to address certain document compliance issues that we have identified as a result of our compliance review. Any consulting advice we provide is intended to assist PEBP in determining how best to comply with applicable requirements relating to PEBP's compliance with federal and state laws. Nevertheless, Segal does not engage in the practice of law, and the consulting advice we provide is not, and is not intended to be, legal advice. Accordingly, this report should be reviewed with PEBP's legal counsel.

Section 2. Summary of Findings

The following highlights key findings. Please reference Section 3, Section 4, Section 5 and Appendices A and B for detailed information and recommended actions.

Federal Findings

Notices

Segal reviewed PEBP's compliance with Federal notices required by the ACA, COBRA, HIPAA, No Surprises Act, and other Federal regulations. Based on the review of plan documents and responses, Segal identified notices that PEBP should revise in order to comply with best practices. PEBP should also consider adopting the practice of distributing a new hire packet with mandatory notices in addition to annual distribution of notices.

Benefit Consistencies

During review, certain inconsistencies between plan documents were identified. PEBP should review its pediatric vision benefit schedule of benefits, physician references throughout the document, and DCFSA eligibility definition and clarify and/or update these sections as necessary.

HIPAA Privacy Protections

The Department of Health and Human Services (HHS) recently issued a final rule that strengthens privacy protections for Protected Health Information (PHI) related to lawful reproductive healthcare. The rule requires covered entities, including group health plans, to modify privacy policies and procedures and prepare new Notices of Privacy Practices reflecting the changes. PEBP should ensure the HIPAA Privacy Notice is provided upon enrollment in the plan.

Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008

In 2023, PEBP implemented plan changes to comply with the proposed MHPAEA rules published on August 3, 2023. On September 23, 2024, the final rules for MHPAEA were published. The rules contain additional definitions, call for coverage of core treatments for covered mental health and substance use conditions, and require collection and review of data outcomes. Additional guidance is forthcoming, related to outcomes data collection and evaluation, as well as an updated self-compliance tool. PEBP should continue to evaluate the final rules and determine the impact on future MHPAEA compliance efforts.

State Findings

NRS 287.04335 directs that compliance with certain provisions in NRS and NAC is required to provide health insurance through a plan of self-insurance. Segal worked with PEBP to confirm the scope of review and identify the applicable State statutes subject to review. NRS 287.04335 was amended in the 2023 Nevada Legislature and made several changes applicable to PEBP.

PEBP should review the benefit requirements and new updates and make updates to the Master Plan Documents (MPDs) as necessary. PEBP should also confirm with UMR that it is administering the benefits according to the amendments made to NRS 287.04335.

Section 3. Federal Notices

Summary

Segal reviewed PEBP's compliance with Federal notices required by ACA, COBRA, HIPAA, No Surprises Act, and other Federal regulations.

- **Notice of Coverage Options in the ACA Marketplace**

  While this notice is an employer and not a PEBP requirement, PEBP provides this notice on its website. PEBP should ensure the notice is updated according to the new model notice released by HHS in 2024. Employers are required to distribute this notice within 14 days of date of hire. While PEBP is not the employer, PEBP may want to consider adding this notice into a new hire packet as discussed below.

- **Disclosure Notice Regarding Patient Protections Against Surprise Billing**

  PEBP posts this notice on its website under mandatory notices. PEBP should update this notice to the most current surprise billing model notice.

- **Qualified Medical Child Support Notice**

  PEBP describes the Qualified Medical Child Support Order (QMCSO) in its MPDs. PEBP should consider amending language in the MPDs to clarify that a copy of the QMCSO procedures are provided free of charge.

- **Notices for newly hired employees**

  In its review, Segal could not confirm whether PEBP provides certain notices upon initial enrollment. PEBP provides a new member welcome letter which contains a link to the PEBP website, where all plan documents, forms, and notices are contained. PEBP should consider a New Enrollee notice packet in addition to the annual notice packet, containing notices required to be distributed upon initial enrollment (ie: HIPAA special enrollment notice, HIPAA notice of privacy practices, CHIPRA, marketplace notice.) Alternatively, PEBP should consider amending its new member welcome letter to more clearly identify the location of any required initial notices.

Section 4. HIPAA Privacy Protections

Summary

The Department of Health and Human Services (HHS) recently issued a final rule that strengthens privacy protections for Protected Health Information (PHI) related to lawful reproductive healthcare. The rule requires covered entities, including group health plans, to modify privacy policies and procedures and prepare new Notices of Privacy Practices reflecting the changes. PEBP should ensure the HIPAA Privacy Notice is provided upon enrollment in the plan.

- **Restrictions on use of PHI:** The final rule restricts covered entities (such as health plans healthcare clearinghouses or healthcare providers) and business associates from using or disclosing an individual's PHI for the purpose of conducting a criminal, civil or administrative investigation into or to impose criminal, civil or administrative liability on any person for the mere act of seeking, obtaining, providing or facilitating lawful reproductive healthcare. The final rule also restricts them from using PHI to identify any person for the purpose of conducting such investigation or imposing such liability.
- **Required Attestation:** When covered entities and business associates receive a request for PHI potentially related to reproductive healthcare, the final rule requires them obtain a signed written attestation from the person requesting the PHI that the use or disclosure is not for a prohibited purpose.
- **Revisions to Notices of Privacy Practices:** Covered entities must also amend Notices of Privacy Practices to include descriptions of the types of uses and disclosures prohibited under the final rule in sufficient detail for an individual to understand the rule. The final rule also requires revisions to Notices of Privacy Practices to address requirements under the Part 2 Rule for the Confidentiality of Substance Use Disorder Patient Records, published on February 16, 2024.

Effective Date: The effective date is June 25, 2024, with a general compliance deadline of December 23, 2024. Privacy notices must be updated by February 16, 2026.

Section 5. State Statute Review

Summary

NRS 287.04335 directs that compliance with certain provisions in NRS and NAC is required to provide health insurance through a plan of self-insurance. NRS 287.04335 was amended in the 2023 Nevada Legislature and made several changes applicable to PEBP. PEBP should review the benefit requirements and new updates and make updates to the Master Plan Documents (MPDs) as necessary. The following statutes were identified as areas PEBP may wish to clarify.

- **Telehealth**

NRS 695G.162 mandates that a plan must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means. PEBP's MPDs for the Low Deductible plan is unclear on whether the Plan provides telehealth coverage out-of-network. PEBP should clarify how out-of-network coverage is paid, and whether this complies with the State mandate.

- **Human immunodeficiency virus and hepatitis C**

NRS 695G.1705 mandates coverage for laboratory testing that is necessary for therapy that uses a drug to prevent the acquisition of human immunodeficiency virus (HIV) and any service to test for, prevent, or treat HIV or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist. PEBP should clarify the Plan provides for testing and other services for hepatitis C and HIV. Currently the MPDs state the Plan cover hepatitis C drugs. PEBP should also clarify coverage for drugs used for prevention of HIV.

- **Coverage for testing, treatment, and prevention of sexually transmitted diseases**

NRS 695G.1707 mandates that plans include coverage for testing for, treatment of and prevention of sexually transmitted diseases. The statute also mandates unrestricted coverage of condoms for insureds who are 13 years of age or older. NRS 695G.1714 mandates plans provide coverage for examination of person who is pregnant for certain diseases. The MPDs state the Plans provide for "counseling of sexually transmitted diseases" and ACA mandated preventive care services. The MPDs also contain an exclusion for condoms. These statutes above appear to mandate coverage above what the ACA preventive services mandate. PEBP should update the MPDs to clarify all coverage mandated by NRS 695G.1707 and NRS 695G.1714 is included. PEBP should also remove the exclusion for condoms. PEBP should confirm with UMR that coverage is provided according to the referenced State statutes.

- **Substance Use and Opioid Disorder Drugs**

  NRS 695G.1719 requires that plans shall include in the plan coverage for: (a) All drugs approved by the United States Food and Drug Administration to support safe withdrawal from substance use disorder, including, without limitation, lofexidine. (b) All drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone. The statute further requires that these drugs are not subjected to medication management techniques, other than step therapy. PEBP should amend the MPDs to clarify the Plan provides benefits for substance use disorder for all drugs approved by FDA to support safe withdrawal from substance use disorder, including, without limitation lofexidine. PEBP should clarify that the Plan does not subject these benefits to medical management techniques, other than step therapy.

- **Mandates for certain wellness benefits**

  NRS 695G. 1717 mandates coverage for certain wellness benefits, including hormone replacement therapy. PEBP should clarify that it covers hormone replacement therapy.

- **Emergency Prescription coverage during emergency or disaster declaration**

  NRS 695G.1635 mandates emergency prescription coverage during emergency or disaster declaration. PEBP should consider adding language explaining procedure to obtain emergency prescription coverage during emergency or disaster declaration, and the geographic limitations to this benefit.

Appendix A. Summary of Findings – Federal

1. IRS Requirements

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Form W-2	Employers must report the cost of health coverage and Dependent Care Assistance Program and Health Flexible Spending Arrangement (FSA) benefits on an annual Form W-2, along with other information.	PEBP's Eligibility and Enrollment vendor TELUS Health/Lifeworks sends the necessary data for reporting on individual employee W-2s to the applicable state employers. PEBP has stated that neither PEBP nor Central Payroll have any concerns. No concerns noted during review.	None.	

2. ACA (Patient Protection and Affordable Care Act) Requirements

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Summary of Benefits and Coverage	Plans must provide a Summary of Benefits and Coverage (SBC) that accurately summarize key features of the plan, such as covered benefits, cost-sharing provisions and coverage limitations.	PY2025 SBCs provided: • PY2025 CDHP SBC Employee Family • PY2025 EPO SBC Individual Family • PY2025 Health Plan of Nevada HMO SBC • PY2025 LD PPO SBC Employee Family SBCs are posted on the PEBP website. SBCs are referenced in the annual Benefits Guide with a statement that the SBCs "are available by logging on to your E-PEBP Portal at www.pebp.state.nv.us or by calling PEBP and requesting a copy be mailed to you." No concerns with PEBPs distribution of SBCs noted.	None.	
Patient-Centered Outcomes Research Institute (PCORI) Fee	Plans and insurers pay fees to fund PCORI, which funds evidence-based research projects with the goal to advance quality of care. Fee is filed with IRS on Form 720. Payment is due 7/31 of calendar year immediately following last day of plan year to which fees apply. Applies through plan years ending before 10/01/29.	PEBP states it has paid its PCORI fee for 2023 and will pay PCORI fees for 2024 in the fourth quarter of PY 2025, when they are due. PEBP states that Health Plan of Nevada pays the PCORI fee for the HMO plan. PEBP is in compliance with PCORI fee.	None.	
Coverage for children up to age 26	Health plans that provide coverage of dependent children must make coverage available for adult children up to age 26, regardless of the child's	Per the Eligibility MPD, Dependent children are covered through the end of the month in which they turn 26.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	student or marital status. Coverage must be provided through the end of the month in which the child turns 26 to meet employer penalty rules. The age 26 mandate requirements do not apply to children who are outside the scope of the definition in Internal Revenue Code section 152(f)(1).	With respect to coverage beyond the required children, foster children are not eligible for dependent coverage. Unmarried children under age 19 who are under a legal permanent guardianship may be enrolled as a dependent. To continue coverage after age 19 (to age 26), the child must be unmarried and either reside with the participant or be enrolled as a full-time student at an accredited institution and satisfy certain conditions 1. Is eligible to be claimed as a dependent on the federal income tax return of the participant or his spouse/domestic partner for the preceding calendar year; and 2. Dependent is a grandchild, brother, sister, stepbrother, step-sister, or descendent of such relative. 3. Children covered under legal guardianship are not eligible to continue benefits under the provision of a disabled dependent. No concerns noted with PEBPs coverage of dependent children.		
90-Day Waiting Period Rule	Plans must cover employees within 90 days of the date on which an employee is otherwise eligible.	Eligibility MPD states new hire employees are eligible for coverage on the first day of the month concurrent with or following the date of hire.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		PEBP is in compliance with the 90-day waiting period rule.		
No Rescission	Plans may not rescind coverage retroactively (with limited exceptions).	MPD discusses no retroactive rescission with limited exceptions. No concerns noted.	None.	
Preexisting Condition Exclusions	Plans may not have preexisting condition exclusions or limitations. Hidden preexisting conditions are also prohibited.	The Health & Welfare Wrap MPD states that PPACA group market (insurance) reforms that apply to all grandfathered and non-grandfathered group health plan Benefit Options under the Plan that are not exempt or excepted benefits under Section 2791 of the PHSA, including prohibition of preexisting condition exclusions under PHSA 2704. No pre-existing conditions were discovered during review.	None.	
No annual or lifetime dollar limits on Essential Health Benefits (EHBs)	Plans may not impose an annual or lifetime dollar limitation on EHBs. Plans may adopt a benchmark that excludes a benefit from EHB and have dollar limit on those benefits. One of the EHBs categories include pediatric vision services.	It does not appear that the PEBP plan imposes annual or lifetime dollar limitations on EHBs in the medical plan. However, the vision benefit within the medical plan includes a $100 limit for exams. This should be reviewed against the vision exam benefit as offered for children up to age 19. Additionally, the LD PPO MPD includes glasses benefit without distinction to age. The SBC states eyeglasses for children are not covered. This inconsistency needs to be clarified between the MPD and SBC and confirmed that the benefit complies with EHB rules.	Action Required: Review MPDs and SBCs for pediatric vision benefit offering for consistency and EHB.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		PEBP removed the dental maximum benefit for children up to age 19 in 2023.		
Preventive Care	Non-grandfathered group health plans must provide certain specified preventive health services without cost sharing.	Per the MPD: Preventive Care/Wellness Benefits are covered 100% in-network not subject to the deductible.	None.	
Cost-Sharing Rules Out-of-Pocket Maximums	Non-grandfathered plans must have limits on out-of-pocket cost sharing. The cost sharing limits only apply to a plan's essential health benefits (EHB). 2025 limits: $9,200 for an individual plan and $18,400 for a family plan before marketplace subsidies; maximum deductible is the same as the out-of-pocket maximum.	Per the MPD: 2024-2025 OOP maximums: Low PPO - $4,000/$8,000 (in-network) EPO - $5,000/$10,000 (in-network) See below for CDHP out-of-pocket maximums	None.	
Clinical Trials	Non-grandfathered plans must cover routine patient costs for items and services furnished in connection with participation in an approved clinical trial for cancer or other life-threatening conditions.	Per the MPD – "Coverage for certain treatment received as part of a clinical trial or study for treatment of cancer or chronic fatigue syndrome will be provided subject to the requirements and limitations set forth in NRS 695G.173" The MPD sets out preauthorization requirements for clinical trials and defines approved clinical trials. No concerns noted.	None.	
Provider Nondiscrimination	Plans cannot discriminate against a health care provider acting within the scope of his or her license.	The Active Health and Welfare Wrap MPD has reference to provider non-discrimination under PHSA 2706 in the Compliance with Federal Group	Action Recommended: PEBP to review physician references in MPD and revise to Health Care Practitioner if appropriate.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		Health Plan Benefits and Coverage Mandates section. Additionally, the definition of Health Care Practitioner includes a "physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, master's prepared audiologist, optometrist, optician for vision Plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice."		
Excepted Benefits	Excepted benefits are exempt from numerous provisions in the Affordable Care Act (ACA), including its market reforms (e.g., restrictions on annual limits, age 26 rule, first-dollar preventive care), the research effectiveness (PCORI) fee, the requirement to provide a Uniform Summary of Benefits and Coverage (SBC), and the requirement to report the cost of the benefits on the employee's W-2. Additionally, "excepted"	PEBP removed the lifetime maximum for dependents to age 19.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	benefits are exempt from the HIPAA portability rules.			
Employer Shared Responsibility Penalty I.R.C. Sections 4980H(a) and 4980H(b).	Employer responsible for counting hours and determining who is a full-time employee eligible for coverage. Medical coverage offered must meet minimum value standard and be affordable (monthly contribution amount for employee-only coverage in the lowest cost plan is below Federal Poverty Line) Employers classified as applicable large employers (ALEs) generally those with 50 or more full-time employees and full-time equivalent employees—may face excise tax penalties if they do not offer health coverage or do not offer coverage that meets certain minimum value and affordability standards.	Employees working 80 hours a month (NAC 287.150) or an average of at least 130 hours per month as defined by the IRS are defined as full-time. The employers may have received the Employer Shared Responsibility Payment notice from the IRS. No concerns identified.	None.	
Minimum Value	Coverage must meet minimum value standard (60 percent)	SBCs state the plans meet minimum value.	None.	
Affordability	Employer-offered coverage is considered affordable for an employee if the employee's required premium contribution (if any) is no more than 9.5% of that employee's household income (indexed annually) (9.12% for 2023, and 8.39% for 2024). For this test, look at the employee's cost of enrolling in the least expensive self-only coverage offered by the employer that provides minimum value, even if the employee	PEBP uses the state of Nevada minimum wage for affordability. (Rate of Pay). Nevada minimum wage: $12.00 regardless of whether employer provides qualifying health coverage ($12.00 x 130 hours) = 1,560 $1560 x 8.39% = $130.88 The lowest cost employee only contributions per month is $55.26 for the CDHP PPO plan.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	elects more expensive coverage or coverage that does not provide minimum value. For the rate of pay safe harbor, for an hourly employee, the employer uses an assumed rate of 130 hours per calendar month multiplied by an hourly employee's rate of pay, regardless of whether the employee actually works more or less than 130 hours during a calendar month. An offer of coverage to a non-hourly employee is treated as affordable for a calendar month if the employee's required contribution for the calendar month for the lowest-cost self-only coverage that provides minimum value does not exceed 9.5% (as indexed) of the employee's monthly salary, as of the first day of the coverage period (instead of 130 multiplied by the hourly rate of pay); provided that if the monthly salary is reduced, including due to a reduction in work hours, the safe harbor is not available.	PEBP meets the affordability standard.		
Form 1095-B and Form 1094-B	Group health plans as well as employers that are not large employers, that offer self-insured minimum essential coverage must provide participants with Form 1095-B, documenting enrollment in plan coverage, and file all such forms with IRS (along with Form 1094-B transmittal). Forms for the	PEBP works with central payroll and specific 1095 software. PEBP sends out the 1095-B and 1094-B forms when necessary, and files with the IRS. This is administered in house using 1099 Pro. No concerns reported.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	previous reporting year are generally due to participants by 3/1 and filed with IRS by 3/31 if filed electronically (by 2/28 for paper filing). Employers filing more than 250 reporting forms are required to file electronically. Employers can use IRS Form 8809 for an automatic 30-day extension.			
Form 1095-C and Form 1094-C	Large employers (50 or more full-time employees, including equivalents), must provide full-time employees with Form 1095-C, documenting offer of coverage, and file all such forms with IRS (along with Form 1094-C transmittal). Forms for the previous reporting year are generally due to employees by 3/1 and filed with IRS by 3/31 if filed electronically (or 2/28 for paper filing). Employers filing more than 250 reporting forms are required to file electronically. Employers use IRS Form 8809 for an automatic 30-day extension of time.	PEBP works with central payroll and specific 1095 software. PEBP sends out the 1095-C and 1094-C forms, and files with the IRS. This is administered in house using 1099 Pro. No concerns reported.	None.	
Notice of Choice of Providers (Patient Protection)	Group health plans that require a designation of a primary care provider (PCP) must provide the following disclosure: notice of the right to choose a PCP, pediatrician, or ob/gyn in SPD or other descriptions of benefits. Effective for plan years beginning on and after January 1, 2022, the No Surprises Act recodified the patient protections	The Plan does not require a designation of a primary care physician.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	regarding choice of health care professional and extended to grandfathered health plans.			
Notice of Coverage Options in the ACA Marketplace	Employer subject to the Fair Labor Standards Act required to provide new employees within 14 days of hire with notice about health insurance marketplaces, their options for health coverage, and information about premium tax credits, regardless of the employee's plan enrollment status or of part-time or full-time status. Note – this is an employer requirement, not a health plan requirement.	Included within the link here: Mandatory Notices (pebp.nv.gov/plans/mandatory-notices The website includes the 2022 version of the Marketplace notice. A new model notice was released early 2024.	Action Required: This is an employer requirement, however PEBP does include this notice on its website. PEBP should ensure the notice is updated according to the new model notice released by HHS in 2024.	
Notice of Grandfathered Status	A grandfathered plan must include a statement to that effect in any and all materials describing benefits under the plan.	N/A. The plan is not grandfathered.	N/A.	
Notice of Rescission	Advance written notice of retroactive termination of coverage due to fraud or intentional misrepresentation of material facts by participant must be provided to the participant at least 30 days before coverage may be retroactively terminated.	The MPD defines rescission, and the Plan has not rescinded coverage retroactively.	None.	
Section 1557 Notice (or Statement) of Nondiscrimination with Taglines	ACA §1557 prohibits discrimination on the basis of race, color, national origin, disability, age, and sex in health plans that receive federal financial assistance or are administered by HHS such as Medicare Part D. Covered entities must provide	MPD includes Section 1557 Notice. While pending litigation enjoined the application of Section 1557, we recommend inclusion of the notice while awaiting future guidance.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	participants/beneficiaries with a notice conveying information about §1557 nondiscrimination requirements in significant publications, communications, websites, and physical locations. The final rule was published in the federal register on May 6, 2024, with a general effective date of July 5, 2024. The final rule reinstated the application of 1557 and the tagline requirement to all covered entities.			

3. COBRA

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Initial or General Rights Notice	Provides basic information regarding COBRA and the rights and responsibilities of qualified beneficiaries to ensure they have the information they need before the occurrence of a qualifying event.	General notice provided. Notice is mailed to all new enrollees by eligibility unit.	None.	
COBRA Continuation Coverage Election Notice	Plans must send notices to qualified beneficiaries after a qualifying event. Employers have to alert the COBRA administrator within 30 days of terminating a worker. Once the COBRA\ administrator is notified, it has 14 days to send a notice to qualified beneficiary(ies). However, if the employer administers COBRA, the deadline to send the notice is 14 days.	Election notice provided.	None.	
Notice of Unavailability of COBRA	Individuals who have sent the plan a qualifying event notice must be notified about why COBRA is not available. The notice must be provided within 14 days after the plan administrator is notified of the qualifying event.	Notice of Unavailability provided. PEBP stated it provides this notice as required.	None.	
Notice of Termination of COBRA	Qualified beneficiaries must be notified about early termination of COBRA. The notice is required as soon as practicable after the plan's determination that COBRA can be terminated prior to the applicable 18-, 36-, or 29-month period.	Notice of Termination example provided. PEBP states it provides this notice as required.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Notice of Insufficient Payment of COBRA Premium	Qualified beneficiaries must be notified that a COBRA payment was less than the correct amount required before terminating COBRA. Plan must provide a reasonable period to cure the deficiency before terminating COBRA. A 30-day grace period is considered to be a reasonable period.	Notice of Late payment provided. PEBP states it provides this notice as required. A premium payment shortfall is insignificant if it is less than or equal to the lesser of (a) $50; or (b) 10% of the COBRA premium required by the plan. Payment of such an amount will be deemed to satisfy the COBRA payment requirement unless the plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency.	None.	

4. Health Insurance Portability and Accountability Act (HIPAA)

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
HIPAA Notice of Special Enrollment Rights	HIPAA requires group health plans to provide notice of special enrollment opportunities outside of the plans' regular enrollment periods in the following situations: • A loss of eligibility for other health coverage. • Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP); • The acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption; and • Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP. Notice must be provided on or before the date the participant is offered the opportunity to enroll in the plan.	Provided in Enrollment and Eligibility MPD under "HIPAA Special Enrollment Notice" and within Annual Notices. The Annual Notices were emailed to all Active and Retired PEBP members July 17, 2024.	Action Required: PEBP should ensure the HIPAA notice of Special Enrollment Rights is provided upon enrollment in the plan. See discussion in Section 3 above.	
HIPAA Prohibition Against Discrimination on account of Health Factor	HIPAA also prohibits discrimination against employees and their dependents based on any health factors they may have, including prior medical conditions, previous claims experience, and genetic information. Cannot be denied eligibility or ongoing eligibility to enroll in the plan because of a health factor; Cannot be charged a greater amount for	Active Health and Welfare Wrap MPD states PPACA group market (insurance) reforms that apply to all grandfathered and non-grandfathered group health plan Benefit Options under the Plan that are not exempt or excepted benefits under Section 2791 of the PHSA including: • Prohibiting discrimination against Participants and beneficiaries based on a	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	coverage than an individual in a similar situation on account of any health factor.	health factor under PHSA 2705.		
Wellness Incentives	Plans that provide wellness incentives must meet 5-factor test, including 30 percent test and reasonable accommodations standards.	N/A. PEBP does not have a wellness program.	None.	
Plan Sponsor Certification of Group Health Plan HIPAA Compliance	HIPAA requires plan sponsor to certify understanding of and compliance with certain HIPAA requirements before the plan may disclose PHI to the plan sponsor or its authorized representatives.	Section 7.2 of the Section 125 H&W Benefits Plan Document. "HIPAA Privacy and Security of Protected Health Information". "The Plan Sponsor certifies that this Article incorporates the provisions set forth in 45 CFR 164.504(f)(2)(ii) and the Plan Sponsor agrees to such provisions in accordance with 45 CFR Section 164.504(f)(2)(ii)"	None.	
HIPAA Notice of Privacy Practices (NPP)	A notice to participants describing their rights, plan's legal duties with respect to Protected Health Information (PHI) and the plan's uses and disclosures of PHI must be included on the plan's website and provided upon enrollment. In general, any material revision to the notice must be provided within 60 days of the revisions. If a plan posts the revision on its website by the revision's effective date, then individual notices can be sent at the time of the next annual mailing. The notice must also be provided upon request. The Department of Health and Human Services (HHS) recently	The Privacy Notice – Disclosure and Access to Medical Information is located on the PEBP website (Mandatory Notices (state.nv.us) The Privacy notice was last updated July 2021.	Action Required: PEBP should ensure the new HIPAA Notice of Privacy Practices complies with the new rule by February 2026. PEBP should ensure the privacy notice is provided upon enrollment. See discussion in Section 3 above.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	issued a final rule that strengthens privacy protections for Protected Health Information (PHI) related to lawful reproductive healthcare. The rule requires covered entities, including group health plans, to modify privacy policies and procedures and prepare new Notices of Privacy Practices reflecting the changes.			
HIPAA Notice of Privacy Practices Reminder	Covered individuals must be notified at least once every three years of the availability of the NPP. Not required if the NPP is provided annually.	The Privacy Notice – Disclosure and Access to Medical Information is located on the PEBP website (Mandatory Notices (state.nv.us). The reminder notice is included in the Annual Notices were emailed to all Active and Retired PEBP members July 17, 2024.	None.	
HIPAA Privacy Policy and Procedures	A covered entity must develop and implement written privacy policies and procedures that are consistent with the HIPAA Privacy Rule. The Department of Health and Human Services (HHS) recently issued a final rule that strengthens privacy protections for Protected Health Information (PHI) related to lawful reproductive healthcare. The rule requires covered entities, including group health plans, to modify privacy policies and procedures and prepare new Notices of Privacy Practices reflecting the changes.	Privacy and Security of Protected Health Information (PHI) policy – updated 08/20/2021	Action Required: PEBP should review HIPAA Privacy policies and procedures ensure they comply with the new rule.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
HIPAA Security Policy and Procedures	A covered entity must adopt reasonable and appropriate policies and procedures to comply with the provisions of the Security Rule.	Privacy and Security of Protected Health Information (PHI) policy – updated 08/20/2021	None.	
HIPAA Security Risk Analysis	HIPAA Security Rule requires covered entities to perform risk analysis as part of their security management processes, risk analysis should be an ongoing process, in which a covered entity regularly reviews its records to track access to e-PHI and detect security incidents, periodically evaluates the effectiveness of security measures put in place, and regularly reevaluates potential risks to e-PHI.	PEBP has conducted a security risk assessment through the use of the Security Risk Assessment Tool as provided through healthit.gov on September 11, 2024.	Action Recommended: PEBP should supplement this assessment with an additional review addressing issues such as how information is identified as PHI, when is PHI encrypted or destroyed for purposes of rendering it secure under the HITECH Act, and providing details about items such as reporting events, training, and how the plan assures business associate contracts are in place.	
HIPAA Training	A covered entity must train all workforce members on its privacy and security policies and procedures, including the new rules regarding reproductive healthcare.	HIPAA Privacy and Data Security Training – conducted annually. PEBP keeps training attestations.	Action Required: PEBP should review HIPAA training materials and update for new provisions for reproductive healthcare.	
Breach of Unsecured PHI	Plan must file notice with HHS (and prominent media outlets) within 60 days of discovery if the breach affects 500 or more individuals. Plan must file annually with HHS if the breach affects fewer than 500 individuals, no later than 60 days after the end of calendar year.	Privacy and Security of Protected Health Information (PHI) policy – updated 8/20/2021. PEBP confirmed no breaches of PHI within this review period.	None.	
Business Associate Agreements (BAA)	A BAA is a required agreement between the covered entity (i.e.,	PEBP should continue to inventory current BAAs.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	the plan) and a vendor, TPA, or individual that performs functions or activities on behalf of, or provides a service to, the plan that involves access to Protected Health Information (PHI) under the plan.			

5. Medicare

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Medicare Part D Notices	Participants and beneficiaries eligible for Part D must be notified in writing, before October 15 each year, whether a plan's prescription drug coverage is, on average, at least as good as standard coverage under Medicare Part D.	PEBP mailed and emailed the Medicare Part D notices July 2024.	None.	
Creditable Coverage Disclosure to CMS	Provide written disclosure to CMS stating whether the plan's prescription drug coverage is, on average, at least as good as standard Medicare Part D coverage is due 60 days after beginning of the plan year (generally March 1 for a calendar year plan). Plan must also provide within 30 days of the plan's termination of drug coverage or change in creditable status of the plan. No penalty.	PEBP submits on CMS website every year. PEBP confirmed submission for PY 2024 and PY 2025.	None.	
Retiree Drug Subsidy Application	RDS application (along with retiree list and attestation) is due at least 90 days prior to the start of the plan year (typically October 3 for a calendar year plan, unless extended for 30 days until November 2). Reconciliation must be completed within 15 months after the end of the applicable plan year, unless 30-day extension.	The RDS is performed annually by PEBP. Data files are downloaded from TELUS and requested from ESI and HPN and reconciled with each other, then the reporting is completed on the CMS website and payment is requested.	None.	
Medicare Secondary Payer (MSP) Data Reporting	Plans (including HRAs with annual benefit levels of $5,000 or more as of the beginning of	Both UMR and ESI confirm they follow Section 111 guidelines	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	the plan year) must report to CMS medical and prescription drug coverage (since 2020) information about participants and beneficiaries who are also Medicare enrollees. Plans should be registered with CMS and reporting electronically on a quarterly basis.			

6. Transparency – No Surprises Act

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Disclosure Notice Regarding Patient Protections Against Surprise Billing	Effective for plan years beginning on or after January 1, 2022, Section 104 of the No Surprises Act requires group health plans and health insurance issuers offering group or individual health insurance coverage to make publicly available, post on a public website of the plan or issuer and include on each explanation of benefits for an item or service with respect to which the requirements of the No Surprises Act apply.	PEBP has posted this notice on its website. PEBP is using the 2022 version of notice.	Action Required: PEBP should update notice to most current balance billing notice.	
Notice of Right to Continue Care	Under the No Surprises Act, beginning January 1, 2022, group health plans must notify each individual who is a "continuing care patient" at the time of a provider or facility network contract termination and permit the individual to continue transitional care from the provider or facility at in-network rates.	UMR confirmed that provider termination notices are sent to members. Patients under care are allowed to elect to continue benefits under the plan, with the treating provider and under the same terms and conditions for a period of 90 days (from date of notice) or earlier with the ending of continuing care from the provider. UMR's continuing care patient notice was provided.	None.	
Group Health Plan Transparency Rule for Public Disclosure (Machine-Readable Files)	Effective 1/1/2022. non-grandfathered plans must post on public website the following information online using three machine-readable files, which must be updated monthly: 4. In-network rates 5. Out-of-network allowed amounts and	Provided on website: https://pebp.state.nv.us/plans/mandatory-notices/ including the link to the machine-readable files provided by URL: https://transparency-in-coverage.uhc.com/	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	6. Prescription drug negotiated rates Enforcement delayed until future rulemaking for prescription drug negotiated rate file.			
Insurance Identification Cards	For plan years beginning on and after 1/1/2022, Plans must include plan deductibles, out-of-pocket (OOP) maximums and consumer assistance contact information (phone number and website) in clear writing on any physical or electronic plan or insurance identification card.	PEBP has confirmed that UMR has updated the identification cards.	None.	
Prescription Drug Reporting (RxDC Report)	Under Section 204 (of Title II, Division BB) of the Consolidated Appropriations Act, 2021 (CAA), insurance companies and employer-based health plans must submit information about prescription drugs and health care spending.	PEBP response: ESI sends out an email to clients in Q1 to initiate the process of collecting data elements needed for the file submission on behalf of our clients who want ESI to be the reporting entity on their behalf. Once the file is sent, a confirmation email goes to the client. The file itself cannot be shared since this is an aggregated file that is sent. Files are sent annually. PEBP should continue to coordinate with its medical and PBM vendors to confirm filing status.	None.	
Gag Clause Attestation	Group health plans and health insurance issuers may not enter into an agreement with a provider, network, TPA or other service provider that would directly or indirectly restrict the plan or issuer from providing provider-specific cost or quality information to referring providers, the plan sponsor,	PEBP has stated they have worked with vendors for submission and will submit the new attestation by the required date.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	participants/ beneficiaries (or people eligible for coverage under the plan). Plans must provide by 12/31 an annual attestation to the government that they are in compliance with this section.			
No Surprises Act: Emergency Services	Effective for plan years beginning 1/1/2022, Plans must cover emergency services at non-participating facility, services/items provided by non-participating provider at a participating facility, or non-participating provider air ambulance services with the same participant cost-sharing whether the services are from a participating or non-participating provider or facility. Providers and facilities are banned from balance billing.	Per nv.doi.gov: The new federal Surprise Billing law covers everything protected under current Nevada state law and more. In situations where the state has stricter statutes to protect consumers, or rules in place determining the rate of compensation due to the out-of-network providers, the federal law defers to the state law. This would be the case for out-of-network providers that were previously in-network within the last 24 months. In this situation Nevada law specifies the formula for computing the rate of compensation. PEBP has included language in its MPD to highlight when balance billing is not permitted under the No Surprises Act.	None.	
Group Health Plan Transparency Rule (Internet-Based Price Comparison Tool)	For plan years beginning on or after 1/1/2023, for 500 items and services (on or after 1/1/2024 for all covered items and services) non-grandfathered plans must provide cost-sharing information and rate information that is accurate at the time of the request to participants on a searchable, internet-based, self-service tool; and must provide a notice when the tool is used.	PEBP Response: UnitedHealth Group is committed to compliance with the laws and regulations applicable to its businesses. This includes requirements of the Consolidated Appropriations Act (CAA), Transparency in Coverage Rule and No Surprises Act. When participants log into their account on the UMR portal, they are able to access cost-sharing/price tool. It is not public facing and does require the member to be in their account.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		UMR is not aware of any concerns that have been reported regarding this tool to PEBP or UMR.		

7. Families First Coronavirus Response Act ("FFCRA")

as amended by the Coronavirus Aid, Relief, and Economic Security Act ("CARES ACT") and IRS Notices 2020-29, 2020-33, 2021-15

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
OTC Medical Product reimbursable.	OTC Medications and Menstrual Care Products qualifying medical expenses after 12/31/2019. No amendment needed if plan simply refers to expenses allowed under Code Section (Section 213(d)).	Per the MPD, effective January 1, 2020, "individuals may use HSAs, FSAs, and HRAs to purchase over-the-counter medicines without a prescription, and to purchase menstrual care products."	None.	
Preventive Services	CARES Act requires non-grandfathered group health plans and issuers to cover preventive services — once available — without cost sharing upon the recommendation from the United States Preventive Services Task Force (USPSTF) or the Centers for Disease Control and Prevention (CDC).	Per the MPD, the "Plan will cover qualifying items, services, or immunizations intended to prevent or mitigate COVID-19 (qualifying coronavirus preventive services) without imposing cost sharing. To be covered, the services must be either (i) an evidenced-based item or service that has a "A" or "B" rating in the current recommendations from the United States Preventive Services Task Force, or (ii) an immunization with a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	None.	
Telehealth and Health Savings Accounts (HSAs)	CARES Act provides a temporary safe harbor allowing high-deductible health plans (HDHPs) to cover telehealth and other remote care services before participants have met	The CDHP MPD highlights the plan will pay for telehealth services after the deductible is met, however provides a copay list for Doctors on Demand services before the deductible is	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	their deductibles. The act also provides that having telehealth coverage outside of an HDHP will not make an individual ineligible for HSA contributions. This expansion of permissible telehealth for individuals with HDHPs and HSAs applies to all types of care, not just COVID-19 care. These changes took effect March 27, 2020, but only apply for plan years beginning on or before December 31, 2021. For calendar-year plans the temporary changes expire December. 31, 2021, but are renewed for the period April 1, 2022 – December 31, 2022. 2023 CAA extended this safe harbor through December 31, 2024.	met. The Plan pays 80% after the deductible is met.		

8. Other Laws Affecting Group Health Plans

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Age Discrimination in Employment Act of 1967	The Older Workers Benefit Protection Act of 1990 (OWBPA) amended the ADEA to specifically prohibit employers from denying benefits to older employees. Only in limited circumstances (e.g., life insurance), an employer may be permitted to reduce benefits based on age, as long as the cost of providing the reduced benefits to older workers is the same as the cost of providing benefits to younger workers. Employers are permitted to coordinate retiree health benefit plans with eligibility for Medicare or a comparable state-sponsored health benefit.	PEBP does not reduce benefits based on age.	None.	
Americans with Disabilities Act of 1990, as amended ("ADA")	Under the ADA, workers with disabilities must have equal access to all benefits and privileges of employment that are available to similarly situated employees without disabilities. Prohibits exclusion from participation or denial of benefits in "services, programs or activities of a public entity." Website accessibility is a current litigation risk under the ADA.	Per the Health and Welfare Active MPD - To the extent applicable, the Plan shall comply with the Americans with Disability Act (ADA), including the requirement that any condition that substantially limits a major life activity will be considered a disability, even if the individual can offset or compensate for the disability with the mitigating measures such as hearing aids or artificial limbs. Website pages regarding ADA accessibility: Americans With Disabilities Act (adahelp.anv.gov)	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		Accessibility Information (adahelp.nv.gov)		
Family and Medical Leave Act of 1993 ("FMLA")	Employers must continue an employee's insurance coverage under the company's group health plan during FMLA leave, just as if the employee had worked continuously rather than out on leave. The employer may require employees on FMLA leave to pay their share of premium payments in any of the following ways: (1) Due at the same time as it would be made if by payroll deduction; (2) Due on the same schedule as payments are made under COBRA; (3) Prepaid pursuant to a cafeteria plan at the employee's option; (4) Using employer's existing rules for payment by employees on leave without pay provided that such rules do not require payment prior to the commencement of the leave of the premiums that will become due during a period of unpaid FMLA leave or payment of higher premiums than if the employee had continued to work instead of taking leave; or, (5) Another system voluntarily agreed to between the employer and the employee, which may include prepayment of premiums (e.g., through increased payroll deductions when the need for the FMLA leave is foreseeable).	Per the Eligibility and Enrollment MPD: "During FMLA leave, the employer must maintain the employee's health coverage under any employer group health plan on the same terms as if the employee had continued to work, regardless of whether the employee is on paid or unpaid leave." Per the Active Wrap plan document: "If a Participant fails to pay Participant Contributions during a Leave of Absence and the Plan Administrator in its discretion continues coverage under any Component Benefit in effect during such Leave of Absence, any unpaid Participant Contributions during such period will be collected in arrears through payroll deductions through the Cafeteria Plan, or as otherwise directed by the Plan Administrator upon the Participant's return to employment with the Employer or expiration of the Participant's Leave of Absence, as applicable."	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Genetic Information Nondiscrimination Act of 2008 ("GINA")	• Group health plans cannot adjust premiums or contribution amounts for a plan, or a group of similarly situated individuals under the plan, based on genetic information of one or more individuals in the group. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.) • Prohibits plans and issuers from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. A plan or issuer may request the results of a genetic test to determine payment of a claim for benefits, but only the minimum amount of information necessary in order to determine payment. Also, a research exception. • Prohibits plans from collecting genetic information (including family medical history) from an individual prior to or in connection with enrollment in the plan, or at any time for underwriting purposes.	Per the Active Wrap plan document: "Genetic Information Non-discrimination Act of 2008 (GINA). The Plan shall comply with the Genetic Information Non-discrimination Act of 2008 (GINA) to the extent applicable including Title I (regarding genetic nondiscrimination in group health plans) and Title II (regarding genetic nondiscrimination in employment). Under GINA, the Plan shall not base enrollment decisions, premium costs, or Participant contributions on genetic information. The Plan shall not require that individuals undergo genetic testing. PEBP is prevented from conditioning hiring or firing decisions based on genetic information. Lastly, GINA will extend medical privacy and confidentiality rules to the disclosure of genetic information. Currently, PEBP and the State of Nevada do not use genetic information regarding either employment or the determination of benefits."	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	Plans and issuers are generally prohibited from offering rewards in return for the provision of genetic information, including family medical history information collected as part of a Health Risk Assessment.			
Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART Act")	Heart Act allows – but doesn't require — a health FSA to permit reservists called to active duty for 180 days or more to withdraw all or a portion of any unused money (notwithstanding the normal "use it or lose it" rule). The distribution of these funds must be made during the period from the date of call-up until the last day the benefits could normally be reimbursed for the plan year.	Per the FSA MPD: "Under the Heroes Earnings Assistance & Relief Tax Act of 2008, employees called to active military duty for a period of at least six months can receive a taxable distribution of the HCFSA funds to avoid forfeiture."	None.	
Newborns' and Mothers' Health Protection Act	Plans may not restrict hospital stays in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a caesarean delivery.	Per the MPD: "Hospital length of stay for childbirth: This Plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a health care practitioner to obtain authorization from the Plan or its UM Company for prescribing a length of stay not more than those periods. However, federal law generally does not prohibit the mother's or newborn's attending health care practitioner, after consulting with	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable)."		
Pregnancy Discrimination Act ("PDA")	Any health insurance provided by an employer must cover and reimburse expenses for pregnancy related conditions on the same basis as expenses for other medical conditions. Insurance coverage for expenses arising from abortion is not required, except where the life of the mother is endangered, or medical complications arise from an abortion. The amounts payable by the insurance provider can be limited only to the same extent as costs for other conditions. No additional or larger deductible can be imposed.	Per the CDHP MPD: "Prenatal and delivery is covered for a female employee or spouse only. For covered dependent children, only prenatal coverage is provided for maternity, except for complications of pregnancy for the dependent child." LD PPO and EPO both state "Medically necessary maternity services for pregnant participants are covered, including prenatal and postpartum care, related delivery room and ancillary services and newborn care." "Elective termination of pregnancy is covered only when the attending physician certifies that the mother's health would be endangered if the fetus were carried to term."	None.	
Title VII of the Civil Rights Act of 1964	Supreme Court held in *Bostock v. Clayton County* (2020) that Title VII of the Civil Rights Act of 1964 protects transgender, gay and lesbian employees (and prospective employees) from workplace discrimination based on sex. Bostock. This protective authority of Title VII generally extends to employer-sponsored healthcare benefits.	PEBP revised the Plan Year 2023 MPD to reflect enhancements in plan design for gender dysphoria treatment. Plan year 2025 MPD reflects these changes.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	Supreme Court held in *Newport News Shipbuilding Co. v. EEOC* (1983) that Title VII requires equally comprehensive coverage to both male and female employees, mandating that employer-provided health plans may not discriminate on sex-based characteristics (e.g., employer-provided health plans must cover pregnancy, childbirth and related medical conditions).			
Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")	• Reemployed service members are entitled to the seniority and all rights and benefits based on seniority that they would have attained with reasonable certainty had they remained continuously employed. • During a period of service, the employees must be treated as if they are on a leave of absence and are entitled to participate in any rights and benefits not based on seniority that are available to employees on comparable. nonmilitary leaves of absence, whether paid or unpaid. If there is a variation in benefits among different types of nonmilitary leaves of absence, the service member is entitled to the most favorable treatment so long as the nonmilitary leave is comparable. • Service member entitled to benefits that become	Per the Enrollment and Eligibility MPD: "Employees who go into active military service for up to 31 days can continue their health care coverage during that leave period if they continue to pay their contributions for that coverage during the period of that leave. State employees who go into active military service for 31 days or more are eligible to enroll in health care coverage provided by the military the day the employee is activated for military duty. This coverage is also available to dependents. The employee is also eligible to purchase continued health care coverage through PEBP for up to 24 months in a manner like the provisions of COBRA. When the employee returns from military leave within the required reemployment period, there will be an immediate reinstatement of PEBP-sponsored medical coverage with no waiting period.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	effective during their service and that are provided to similarly situated employees on furlough or leave of absence. Service members may be required to pay the employee cost, if any, of any funded benefit to the extent that other employees on leave of absence are so required.	Questions regarding entitlement to this leave and to the continuation of health care coverage should be referred to PEBP. Questions regarding reemployment rights should be addressed with the employer."		
Women's Health and Cancer Rights Act	Plans that cover mastectomies must cover certain reconstructive surgery and services.	Per the MPD: "This Plan complies with the Women's Health and Cancer Rights Act of 1998 (WHCRA) Breast reconstructive surgery and the internal or external prosthetic devices are covered for members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the physician and the member. For any covered individual who is receiving mastectomy-related benefits, coverage will be provided for: • All stages of reconstruction of the breast on which the mastectomy has been performed. • Surgery and reconstruction of the other breast to produce a symmetrical appearance; and • External prostheses that are needed before or during reconstruction; and	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		Treatment of physical complications of all stages of the mastectomy, including lymphedema (fluid build-up in the arm and chest on the side of the surgery). Treatment of leaking breast implant is covered when the breast implant surgery was performed for reconstructive services following a partial or complete mastectomy as mandated by the Women's Health and Cancer Rights Act."		

9. Certain Required Notices

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Women's Health and Cancer Rights Act (WHCRA) Notice	Plans must provide a description of benefits under WHCRA both upon enrollment and annually thereafter.	PEBP's Annual Notices document includes Women's Health and Cancer Rights Act. The Annual Notices were emailed to all Active and Retired PEBP members July 2024. WHCRA language is included in the MPDs.	None.	
Children's Health Insurance Program Reauthorization Act (CHIPRA) Notice	Employers in states with Medicaid or CHIP premium assistance programs must annually notify employees of these opportunities by the first day of the plan year. Frequently provided in open enrolment materials. Model notice updated 7/31/2024. https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra	PEBP's Annual Notices document includes CHIP Notice– Medicaid and Children's Health Insurance. The Annual Notices were emailed to all Active and Retired PEBP members July 2024.	None.	
Section 125 Cafeteria Plan	While there is no reporting or disclosure requirement for the Section 125 plan, employers typically make the plan document available to employees on a website or upon request.	The PEBP Section 125 Health and Welfare Plan Document is accessible on the PEBP website.	None.	
Change in Status Events	Employers typically make information available in the SPD about mid-year change in status events, including forms for changing enrollment elections.	The PEBP Section 125 Health and Welfare Plan Document includes a section of the mid-year change events and is accessible on the PEBP website.	None.	
Wellness Program Notice of Reasonable Alternative	Plans must disclose availability of a reasonable alternative standard to qualify for the wellness program's reward in all plan materials that describe health-contingent wellness programs. Also, must provide contact information for obtaining the alternative standard	PEBP does not have a wellness program.	N/A.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	and a statement that recommendations of an individual's personal physician will be accommodated The information must be included in the SPD, enrollment materials and other materials discussing wellness.			
Wellness Notice (required by EEOC)	If wellness program includes disability-related inquiries, genetic information, or medical examinations, the plan sponsor must provide participants with a notice describing what medical information will be obtained, how it will be used and how it will be protected from improper disclosure. Programs that permit spouses to participate must provide similar notice and obtain the spouse's authorization if genetic information is being requested. Notice must be provided before the participant is asked to answer disability-related questions or undergo a medical exam.	PEBP does not have a wellness program.	N/A.	
Newborns' and Mothers' Notice	Plans must provide notice describing requirements for minimum length of hospital stay in connection with childbirth required within SPD time frame.	PEBP's Annual Notices document includes Newborns' and Mothers' Health Protection Act; and is referenced within the MPD. The Annual Notices were emailed to all Active and Retired PEBP members July 2024.	None.	
Michelle's Law Notice	Only if coverage provided based on student status (age 26 or older), plans must provide notice regarding ability to extend coverage for post-secondary students on medical leave.	Per the Active Employee Wrap Plan Document: "Michelle's Law. The Plan shall comply with Michelle's Law to the extent it applies to Dependent Child(ren)'s eligibility for health coverage conditioned on maintaining full-time student status as	None. .	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		described in the Master Plan Document for the PEBP Enrollment and Eligibility. Should Michelle's Law apply and a Dependent Child takes a medically necessary leave of absence for a serious illness or injury that causes loss of full-time student status, the Plan shall not terminate his or her coverage before the date that is the earlier of: (1) one year after the first day of the medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the PEBP. A written certification stating that the Dependent Child is suffering from a serious illness or injury and that the leave of absence is medically necessary must be provided by a treating physician of the Dependent Child to PEBP for eligibility and coverage to continue."		
Qualified Medical Child Support Notice	Plans must acknowledge receipt of medical child support order and notify participants that its QMCSO procedures for determining whether the order is qualified are available free of charge. Within a reasonable time after its receipt, the plan must also issue notice of whether the order is qualified.	The Plan shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO) as set forth in the MPD for the PEBP Enrollment and Eligibility. Qualified Medical Child Support Orders (QMCSO): QMCSOs are state court orders requiring a parent to provide medical support to a	Action Required: PEBP should amend the following language to the MPD "You and the affected child will be notified if an order is received, *and a copy of the procedures is available free of charge upon request*."	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		child often because of legal separation or divorce. A QMCSO may require the Plan to make coverage available to your child even though, for income tax or Plan purposes, the child is not your dependent. To qualify, a medical support order must be a judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which: o Specifies your last known name and address and the child's last known name and address. o Describes the type of coverage to be provided, or how the type of coverage will be determined. o States the period to which it applies; and o Specifies each plan to which it applies. The QMCSO cannot require the Plan to cover any type or form of benefit that they do not currently cover. The Plan must pay benefits directly to the child, or to the child's custodial parent or legal guardian, consistent with the terms of the order and Plan provisions. You and the affected child will be notified if an order is received.		

10. Cafeteria Plan, FSAs, HSA/HDHPs, HRAs

CAFETERIA PLAN

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Plan year requirement	A cafeteria plan year must continue for 12 consecutive months, as established by the plan document. A plan year of less than 12 months is only allowed for a valid business purpose, e.g., first plan year, last plan year.	Plan year is defined as the 12-month period beginning each July 1st and ending each June 30th.	None.	
Written plan document	Section 125 requires a written plan document. While there is no reporting or disclosure requirement, employers typically make the plan document available to employees on a website or upon request.	PEBP has a written Section 125 Health and Welfare Benefits Plan Document.	None.	
Salary reduction agreement	Required for participant to pay for benefits on a pre-tax basis	Defined and referenced throughout Section 125 plan document.	None.	
Annual participation and contribution elections generally must be irrevocable for the plan year	Exceptions: • contributions to HSAs • status or cost/coverage changes as adopted under the plan. • To comply with HIPAA special enrollment rights • To comply with a judgment, decree, or order to provide coverage for a dependent child in connection with a change in marital status or custody	Permitted mid-year events referenced in Status Change Elections; Special Enrollment; Other Election Changes section of the Section 125 plan document.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	• To reflect a change in entitlement to Medicare or Medicaid • The Family and Medical Leave Act grants employees on FMLA leave the right to revoke or change an existing election for accident or health plan coverage. Limited exception for administrative error: Although the election change regulations do not address mistakes, based on the informal IRS "doctrine of mistake" an election may be corrected when there is "clear and convincing evidence" a mistake has been made. For example, if an employee with no eligible dependents makes a dependent care election, rather than a health FSA election, there is clearly an error. If there is evidence that an individual has made a mistake in an election, or that the employer has made an administrative mistake in recording that election, then the election can be undone, even retroactively, to correct the mistake.			
Participants limited to current or former employees	Individuals who are self-employed, such as sole proprietors or partners in a partnership, and individuals who	Active Legislators pay 100% of their own contributions after tax. There are no subsidies.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	are 2% shareholders in an S corporation, are not employees for this purpose. Though only employees may participate, spouses and dependents may benefit from the plan.			
Paid Time Off (PTO)	A cafeteria plan can offer elective PTO (i.e., PTO that can be purchased or sold under the cafeteria plan) as a permitted taxable benefit, including through the application of flex-credits.	N/A. The cafeteria plan does not offer PTO that can be purchased or sold.	N/A.	
Non-elective Employer Contributions (flex credits)	The employer may make contributions on behalf of participants to be used for non-taxable qualified benefits. The contribution amount (or maximum) must be specified in the cafeteria plan document, as either a fixed amount or a percentage of compensation. Participants can allocate these employer contributions among different qualified and/or taxable benefits offered through the plan.	No flex credits.	N/A.	

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Maximum annual employee contribution election	For 2024: $3,200	The limit for calendar year 2024 is $3,200 for the medical FSA or the Limited Purpose FSA.	None.	
Employer contribution	An employer may match up to $500, regardless of whether or not the employee contributes to	No employer contributions to health FSA.	N/A.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	a health FSA themselves. Above $500, employers may only make a dollar-for-dollar match to the employee's contribution. But see rules for Excepted Benefit FSA below.			
Uniform coverage rule	The full amount of reimbursement available under a health FSA (less amounts previously reimbursed for the plan year) must be available throughout the plan year. This rule does not apply to DCFSA.	Per the FSA MPD: "You may be paid the full amount of your claim or the balance of your annual election, whichever is less, whenever you file a qualifying claim. Payment under the medical FSA is not limited to the amount in your account at the time of your claim. Your monthly contributions will continue for the remainder of the Plan Year."	None.	
Grace period (optional)	Cannot have both a grace period and a carryover Allows costs to be incurred up to 2½ months after the end of the plan year.	The Plan does not permit a grace period.	N/A	
Carryover (optional)	Cannot have both a grace period and a carryover Maximum carryover amount indexed to 20 percent of the annual maximum election. For 2024 ($610); For 2025 ($640). Not applicable to DCFSA.	The Health Care FSA and Limited Purpose FSA permit a carryover of up to $640.	None	
Run-out period (optional)	A predetermined amount of time (generally set by the employer) that allows reimbursement after the plan year ends. Most run-out periods are 90 days, starting the day after the plan year ends.	Per the FSA MPD - Claims for expenses incurred during the Plan Year must be submitted to the TPA by October 31st following the end of the Plan Year.	None.	
Significant cost or coverage changes	Does not apply to an election change with respect to a health	FSA MPD confirms this does not apply to the health FSA or	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	FSA (or on account of a change in cost or coverage under a health FSA).	limited purposes states the change applies when the cost charged to employee for a benefits package option significantly increases or decreases.		
Qualified medical expenses	Qualified medical expenses are those specified in the plan that are paid for care as described in Section 213 (d) of the Internal Revenue Code that are not otherwise reimbursed. See Pub. 502. Expenses incurred after December 31, 2019, for over-the-counter medicine (whether or not prescribed) and menstrual care products are considered medical care and are considered a covered expense.	Per the FSA MPD - Qualifying expenses are those expenses which are incurred by the taxpayer or their eligible dependents during the Plan Year for medical care as defined in Section 213(d) of the Internal Revenue Code, excluding all insurance premiums and long-term care expenses.	None.	
Substantiation	An independent third party must substantiate medical expenses paid or reimbursed from a health FSA. Substantiation for health care expenses includes: information describing the service or product; the date of service or sale; and the amount of the expense.	Section in FSA MPD "When Do I Have to Turn in Paperwork" discusses substantiation.	None.	
Limited Purpose Health FSA (LPFSA)	Qualified medical expenses are limited to eligible dental and vision costs.	The LPFSA is set up to reimburse only eligible FSA dental and vision expenses.	None.	
Excepted Benefit FSA	Employer contributions should not exceed $500 per plan year for a health care FSA to maintain excepted benefit status, which avoids making it subject to certain ACA and HIPAA requirements.	No employer contributions to health FSA.	N/A.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Integration with HSA	Employees with an HSA can only have a Limited Purpose FSA.	Per MPD - IRS provisions do permit enrollment in both an HSA and a LPFSA as LPFSA reimbursement is restricted to only vision and dental expenses.	None.	
COBRA Special Exception (not required to offer COBRA to qualified beneficiaries who have "Overspent" their FSA amounts)	An employer determines whether a participant has "overspent" or "underspent" his or her health FSA account by looking at: (1) the participant's maximum benefit for the plan year; (2) the amount of reimbursable claims submitted to the FSA for the plan year before the qualifying event; and (3) the maximum amount that the employer is permitted to charge for COBRA coverage under the health FSA for the remainder of the plan year.	Per the MPD – "COBRA FSA benefits will end on the earlier of: • You cease paying the monthly administration fee. • Your remaining FSA balance is depleted; or, • At the end of the applicable Plan Year." "If COBRA is elected, it will be available only for the remainder of the applicable Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA."	None.	
COBRA Premium	IRS regulations indicate that the maximum COBRA premium for FSA coverage is based on the annual coverage amount under the FSA, which includes both employee and employer contributions (and any carryover).	PEBP does not charge a COBRA premium for the health FSA.	None.	

DEPENDENT CARE FSA

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Eligibility	both parents working one spouse not working: generally, can qualify if (i) Job-related: the spending must	Per the FSA MPD: "Dependent Care FSA. To qualify for this account, both you and your spouse must be	Action Required: PEBP should clarify if the DCFSA is only open to employees enrolled in the	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	enable participant and spouse to work or look for a new job and (ii) Earned income: Spouse must make money through employment during the year to exceed the DCFSA contribution spouse disabled: can use a DCFSA when only one parent is working, when one spouse is physically or mentally incapable of self-care or disabled (person is physically or mentally incapable of performing regular job duties) fulltime student: parent is working when the other is a full-time student attending classes at an authorized school. IRS rules define when they impute earned income during the month. Full-time definition: enrolled in classes for at least five calendar months, with enough credit hours to exceed the school-defined part-time definition Authorized intuitions: high schools, colleges, universities, plus technical, trades, and mechanical schools Unauthorized institutions: correspondence classes and internet-based online learning programs	gainfully employed (unless you are a single parent). If your spouse is a full-time student, actively looking for full-time employment, or disabled, you may also qualify if you meet strict IRS eligibility guidelines. The Dependent Care FSA covers expenses if you claim the person being cared for as a dependent on your income tax return and the person is either: • Younger than 13; or • Physically or mentally incapable of self-care and regularly spends at least eight hours a day in your household. Regularly does not mean daily, but frequently, on a regular basis. A DCFSA is an option for active employees covered under the PEBP Consumer Driven Health Plan (CDHP), HMO, or EPO Plan that allows you to pay for dependent care expenses and lower your taxable income."	PEBP CDHP, HMO or EPO plans.	
Qualifying Individuals	A qualifying individual(s) who is: • A qualifying child who has not attained age 13; or	Per the FSA MPD: "Day care expenses are limited to care for children under age 13, for whom you have more than 50% custody, or for a spouse or	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	• A dependent of the taxpayer who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the taxpayer for more than ½ of the tax year; or • The spouse of the taxpayer, if the spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the taxpayer for more than one-half of the tax year.	dependent who is physically or mentally incapable of caring for himself or herself and who lives in your home at least 8 hours each day. The expenses may not be paid to a child of yours who is under the age of 19 at the end of the year in which the expenses are incurred or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent."		
Annual Contribution Limits	$5,000 a year for individuals or married couples filing jointly, or $2,500 for a married person filing separately.	DCFSA is limited to $5,000 for single taxpayers and $2,500 for married individuals filing separately.	None.	
Use-it-or-lose-it	Under the "use or lose" rule, costs payable under all three types of FSAs are required to be incurred during the plan year (except for grace period)	Per the FSA MPD: "If you have funds remaining in your DCFSA account at the end of the year, that amount will be forfeited by you as required by federal regulations."	None.	
Grace Period (optional)	Allows costs to be incurred up to 2½ months after the end of the plan year.	There is no grace period.	N/A.	
Run-Out Period (optional)	A predetermined amount of time (generally set by the employer) that allows reimbursement after the plan year ends. Most run-out periods are 90 days, starting the day after the plan year ends.	Per the FSA MPD, all claims must be filed by October 31st following the end of the Plan Year.	None.	
Qualifying Expenses	As set forth in the plan, payment for provision of services, which if paid for by the employee would	Per the FSA MPD: "Expenses necessary for you to be gainfully employed:	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	be considered, employment related expenses under I.R.C. § 21(b)(2). DCFSA-eligible expenses (i.e., expenses paid to enable the taxpayer to be gainfully employed) while the taxpayer is gainfully employed or is in active search for gainful employment. Expenses paid for household services and services for the care of a qualifying individual with respect to the taxpayer, but only if the expenses are incurred to enable the taxpayer to be gainfully employed. Expenses paid for household services performed in connection with the care of a qualifying individual. Expenses paid for the performance in and around the taxpayer's home of ordinary and usual services necessary to the maintenance of a household Expenses paid for services provided for the primary purpose of a qualifying individual's well-being and protection, including expenses for benefits which are incident to and inseparably a part of the qualifying care services. Expenses paid for services provided in dependent care centers that provide care for more than six individuals and are compensated in fees, payments, or grants for	• Expenses paid to a dependent care center. • Expenses paid to a "babysitter". • Expenses paid for care of a dependent under age 13. • Expenses paid for care of a dependent who is physically or mentally incapable of caring for herself or himself."		

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	providing services for any of the individuals.			
Payments to Related Persons	No amount paid or incurred during the taxable year of an employee by an employer in providing dependent care assistance to such employee shall be excluded from income (a) if such amount was paid or incurred to an individual—(1) with respect to whom, for such taxable year, a deduction is allowable under section 151(c) (relating to personal exemptions for dependents) to such employee or the spouse of such employee, or (2) who is a child of such employee (within the meaning of section 152(f)(1)) under the age of 19 at the close of such taxable year.	Per the FSA MPD: "The expenses may not be paid to a child of yours who is under the age of 19 at the end of the year in which the expenses are incurred or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent."	None.	
Substantiation Requirements	Receipts must include specific information to prove that the payment was for qualified expenses. Specifically, the receipt must note: Recipient's Name—the name of the person who received the service Provider's Name—the name, address, and taxpayer identification number of the person performing the services are included on the return to which the exclusion relates, or if such person is a 501(3)€ organization; the name and address of such person are	Per the FSA MPD "The TPA will review your claim, and if approved will reimburse you. Claim reimbursements are issued within one business day of the receipt of your claim up to the amount that you have on deposit in your account. If your claim exceeds your available funds, the difference will be recorded and paid as funds become available from your payroll contributions. You must submit a completed claim form along with copies of invoices or statements to serve as proof that you have incurred a qualified expense to receive payment. Statements are	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	included on the return to which the exclusion relates Date of Service—the date when services were provided Type of Service—a detailed description of the service provided Cost—the amount paid for the service	required to be from the provider/store stating the date of service/purchase, a description of services/products, the expense amount, the name of the service provider/store and the person for whom the service was provided."		
DCFSA required notification	Employers must provide reasonable notification to employees of the availability of the program. Each employee must be furnished, on or before Jan. 31, a written statement showing the amounts paid or expenses incurred under the DCFSA during the previous calendar year. This requirement is usually met by reporting the amounts on the employee's Form W-2.	PEBP's Eligibility and Enrollment vendor Lifeworks sends the necessary data for reporting on individual employee W-2s to the applicable state employers.	None.	

Additional FSA Rules

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Cannot transfer funds between the two accounts	Cannot transfer funds between the Health FSA and the DCFSA.	PEBP's funds cannot be transferred between the Health FSA and the DCFSA.	None.	

Debit Cards

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Card limit	The use of the card is limited to the maximum dollar amount of	PEBP's debit card is limited to the maximum dollar amount of	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	coverage available in the employee's health FSA or HRA.	coverage available in the employee's health FSA or HRA.	.	
Where can be used for health expenses	The card can only be used at merchants and service providers that have merchant category codes related to health care, such as physicians, pharmacies, dentists, vision care offices, hospitals, and other medical care providers.	Per the FSA MPD: "Per IRS regulations, the FSA debit card can only be used at health care providers (based upon the Merchant Category Code) and at stores that have implemented an Inventory Information Approval System (IIAS)."	None.	
Substantiation rules	Flexible Spending Account (FSA) claims paid with a debit card must include the required substantiation, containing all of the information normally required for a claim submitted for reimbursement through means such as an online portal or mobile app. Expenses must be substantiated by an independent third party with the following information: name of the individual receiving the eligible service or purchasing the eligible item. date(s) the service was provided, or item was purchased (start and end dates if applicable). description of the service provided, or product purchased (e.g., prescription, copay, office visit, glasses, daycare). name of the service provider or merchant where the item was purchased; and	Per the FSA MPD: "Debit card transactions can be accepted by the FSA administrator without any follow up if the merchant is an acceptable merchant type such as a physician's office or hospital and at least one of four other criteria are met. Transactions are electronically substantiated if: The dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment or any combination of any known co-pays up to five times the highest known co-pay, for the employer-sponsored medical, vision or dental plan that participant has elected. • The expense is a recurring expense that matches expenses previously approved as to amount, provider, and time period (e.g., for an employee who pays a monthly fee for	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	claim amount (dollar amount spent for the service or item). In addition, the Health FSA sponsor may coordinate with an individual's insurance provider to use information provided in an explanation of benefits to substantiate a debit card charge without requiring more information.	orthodontia at the same provider for the same amount); or • The merchant maintains a compliant Inventory Information Approval System (IIAS) for over-the-counter supplies and prescription medication (this system is allowable only if the merchant approves only qualifying items; all other purchased items must be paid for in a split tender transaction.) "		
Auto-substantiation	Exception for expenses from certain providers (e.g., pharmacies) that can be auto substantiated by the Merchant Category Code (MCC) of the provider's debit card machine and when the item or service is identified by an Inventory Information Approval System (IIAS). Automatic substantiation is allowed at merchants that have an IIAS in place to ensure that cards are used only for eligible health-related expenses.	Per the FSA MPD: "Per IRS regulations, the FSA debit card can only be used at health care providers (based upon the Merchant Category Code) and at stores that have implemented an Inventory Information Approval System (IIAS)."	None.	
Prohibition against self-substantiation	Section 105 and § 125 require the substantiation of all medical expenses as a precondition of payment or reimbursement. "Self-substantiation" or "self-certification" of an expense by an employee-participant does not constitute the required substantiation.	Per the FSA MPD: "All claims for Benefits offered through the Plan's Code §125 cafeteria plan feature must be substantiated by information provided by an independent third party in accordance with applicable regulations before benefits may be paid."	None.	
Use of Debit Card for DCFSA	An employer may use a payment card program to	PEBP uses the debit card for DCFSA.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	provide benefits under its DCFSA. However, dependent care expenses may not be reimbursed before the expenses are incurred. For this purpose, dependent care expenses are treated as having been incurred when the dependent care services are provided, not when the expenses are formally billed, charged for, or paid by the participant. Thus, if a dependent care provider requires payment before the dependent care services are provided, those expenses cannot be reimbursed at the time of payment, even through the use of a payment card program.	Per the MPD: "Dependent care expenses are incurred when the day care is provided. You must receive the dependent care services before you file a claim for those services."		

HSA/HDHP

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Only employees enrolled in a HDHP can enroll in the HSA		Per the CDHP MPD, "Employees may not establish or contribute to a Health Savings Account if any of the following apply: The employee is covered under other medical insurance coverage unless that medical insurance coverage: (1) is also a High Deductible Health Plan as defined by the IRS; (2) covers a specific disease state (such as cancer insurance); or (3) only reimburses expenses after the Deductible is met."	None.	
Annual limits	HSA Contribution Limit: 2024 2025	Per the MPD:	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	Self-only $4,150 $4,300 Family $8,300 $8,550 HSA Catch-up Contributions: Age 55 + $1,000 $1,000 HDHP Minimum Deductible: Self-only $1,600 $1,650 Embedded $3,200 $3,300 Family $3,200 $3,300 HDHP Maximum Out-of-pocket Expense Limit (deductibles, copayments, and other amounts, but not premiums) Self-only $8,050 $8,300 Family $16,100 $16,600	2024 HSA contribution: $4,150 / $8,300 HSA Catch Up Contribution: $1,000 HDHP Min. Ded. $1,600/$3,200 (ind./family) HDHP – OOP Max (in-network) $4,000/$6,850/$8,000 (ind/family member/family)		
Funds can rollover indefinitely	HSAs have no use-it-or-lose-it provision. Any funds still in the plan at the end of the year can be rolled over indefinitely.	CDHP MPD: HSAs are employee-owned accounts, meaning the funds in the HSA remain with the employee and carry over from one year to the next.	None.	
FSA carryover/grace period conflict	A participant who has FSA carryover amount who wants to switch to an HDHP with HSA for the next plan year is prohibited from contributing to the HSA for the entire plan year. Or if they have funds remaining in the health FSA and there is a grace period, contributions would be prohibited to an HSA during the grace period. Two ways to resolve the carryover issue are (1) to move the FSA funds to a limited purpose health FSA (dental and vision only) or (2) to allow the participant to decline the	Per the FSA MPD: "the FSA carryover will make you ineligible for the PEBP health savings account. To be eligible for the PEBP health savings account you may either elect to decline the carryover prior to the next Plan Year or switch your enrollment to the Limited Purpose FSA and carry over the unused funds to your new account."	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	carryover and waive the funds prior to the end of the FSA plan year (it is not generally permissible to decline a grace period, however). Employers may allow participants to choose whether to convert a carryover amount to a limited purpose health FSA, but a health FSA having a grace period is generally not permitted to offer each participant that choice (but may impose a mandatory conversion for all participants).			

HRAs

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Permitted Contributions	Employer contributions only	Per FSA MPD: Active HRA: Participants cannot contribute to a CDHP HRA. If the annual funds in the CDHP HRA are exhausted, neither PEBP nor the participant will contribute any additional funds. Per Medicare Exchange HRA MPD: The HRA is funded solely by the Plan Administrator	None.	
Integrated HRA	Must be integrated with employer group health plan that meets the ACA's market reform requirements. HRAs so	Per the Active Wrap Plan Doc: "Health Reimbursement Arrangement is intended to be	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	integrated are deemed to comply with those requirements.	integrated for purposes of PPACA and related guidance."		
Retiree-Only HRA	Terminated/Retired employees only (limited to less than 2 active employees) Can reimburse their Medicare Part A, Part B and Part D premiums. Not subject to ACA market reforms but must satisfy: Reporting of minimum essential coverage (6055 reporting generally only for pre-Medicare retirees and dependents) and PCOR fee. For purposes of nondiscrimination testing, a key employee includes a retiree who was a key employee when he or she retired.	Per the Medicare HRA MPD: The HRA is provided to eligible retirees enrolled in a Medicare Plan through Via Benefits or who have Tricare for Life, and Medicare Parts A and B.	None.	
COBRA	Eligibility	Integrated HRA: can elect COBRA for HRA only if COBRA is elected for group health plan. COBRA is offered for the HRA.	None.	
COBRA	Premium	At the beginning of each plan year, the employer should calculate a reasonable premium for the HRA, both for single and family coverage. The IRS has defined two methods for determining the COBRA premium: the actuarial method and the past-cost method. PEBP does not charge an additional COBRA premium.	None.	
Coordination with Health FSA	While an employee can have both an HRA and an FSA at the same time, the same expense	Health Scope Benefits has confirmed that the participant signs an attestation including that the expenses are not	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	cannot be reimbursed from both accounts. The IRS states that special coordination rules should be implemented to determine whether the HRA or FSA should be used first. As a general rule, the HRA funds must be used first prior to the FSA. IRS Notice 2002-45.	eligible for reimbursement under any other health plan. The FSA and HRA SPDs state that if an employee has coverage under both the Health FSA and HRA, claims should be submitted to the health FSA first until that account is exhausted.		

Appendix B. Summary of Findings – State

STATE LAW	Description	Findings	Action Required	PEBP Response
Eligibility and Participation: Definition of "Dependent", "Participant" and "Domestic Partner" NAC 287.035 NAC 287.311 NAC 287.312 NAC 287.313 NRS 689B.035	• Dependent: defined. • Dependents: Enrollment and disenrollment. • Dependents: Eligibility of child of participant, spouse, or domestic partner. • Responsibility for final determinations concerning eligibility. • Required provision in certain policies concerning termination of coverage on dependent child.	MPD defines dependent child, domestic partner, and outlines eligibility. MPD defines participant and eligibility. MPD provides for provisions concerning termination of coverage of dependent children.	None.	
Eligibility and Participation: Definition of "Full-Time Employment" and Eligibility Waiting Periods NRS 287.045 NAC 287.150 NAC 287.313	• Persons eligible to participate in Program; receipt of notice of eligibility; automatic enrollment; limited affiliation period. • "Full-time employment" interpreted. Responsibility for final determinations concerning eligibility.	MPD outlines eligibility, full-time employment.	None.	
Eligibility and Participation: Retirees NAC 287.530 NAC 287.540 NAC 287.542 NAC 287.544 NAC 287.546 NAC 287.548 NRS 287.023 NRS 287.047	• Coverage of retired person, spouse, domestic partner or surviving dependent. • Coverage of participating employee of State who reenrolls upon retirement or total disability, coverage of nonparticipating employee of State. • Coverage of participating employee of local	MPD outlines retiree eligibility and enrollment process.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	governmental agency who retires on or before September 1, 2008 and reenrolls upon retirement or total disability. • Coverage of nonparticipating employee of local governmental agency who retires on or before September 1, 2008 and enrolls upon retirement or total disability. • Coverage of participating employee of local governmental agency who retires after September 1, 2008 and reenrolls upon retirement or total disability. • Coverage of nonparticipating employee of local governmental agency who retires after September 1, 2008. • Option of retired officer or employee or dependent to cancel or continue group insurance, plan of benefits, medical and hospital service or coverage under Public Employees' Benefits Program; notice of selection of option; payment of costs for coverage. • Retention by certain retired state officers and employees of membership in and dependents' coverage under Program.			
Eligibility and Participation: Seasonal Employees and	Retention by certain short-term state employees of membership	PEBP states that the employers report employee eligibility.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
Employees on a Biennial Plan NRS 287.0467	in and dependents' coverage under Program.			
Eligibility and Participation: Individual as Both Employee and Dependent NAC 287.520	Coverage of person qualified as both employee and dependent; change of status from employee to dependent.	Per the MPD: • Any spouse or domestic partner that is eligible for coverage as both a primary participant and a dependent shall be enrolled as a primary participant. • A child that is eligible as both a primary participant and a dependent may enroll as a primary participant or continue coverage as a dependent of a PEBP participant until age 26 years.	None.	
Eligibility and Participation: Surviving Spouse/ Dependents NAC 287.530 NRS 287.0475 NRS 287.0477	• Coverage of retired person, spouse, domestic partner or surviving dependent. • Reinstatement of insurance by retired public officer or employee or surviving spouse. Option of surviving spouse or child of police officer, firefighter or volunteer firefighter killed in line of duty to join or continue coverage under Public Employees' Benefits Program; notification; payment of costs for coverage; duration of eligibility.	MPD outlines surviving spouse/dependents eligibility. MPD highlights that the surviving spouse and any surviving child of a police officer or firefighter who was employed by a participating public agency and who was killed in the line of duty may join or continue coverage under PEBP if the police officer or firefighter was eligible to participate on the date of the death of the police officer or firefighter. If the surviving dependent elects to join or discontinue coverage under the PEBP pursuant to this section, the dependent or legal guardian of the dependent must notify the participating public agency that employed the police officer or firefighter in writing within 60 days after the date of	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
		death of the police officer or firefighter.		
Eligibility and Participation: Coverage of Newly Born and Adopted Children NRS 689B.033	Certain policies covering family members required to include certain coverage for insured's newly born and adopted children and children placed with insured for adoption.	Per the MPD, newborn dependent child(ren) of a PEBP participant will automatically be covered under a PEBP medical Plan option from the date of birth to 31 days following the date of birth (referred to as the initial coverage period) NRS 689B.033. If the newborn is covered under more than one health insurance plan, the PEBP Plan reserves the right to coordinate benefits as stated in the Coordination of Benefits section of the PEBP Consumer Driven Health Plan, Low Deductible PPO Plan, and EPO Plan or HMO Evidence of Coverage Certificate (as applicable).	None.	
Eligibility and Participation: Orientation Program NAC 287.314 NAC 287.317	• Provision of information about Program to participants, representatives of participating public agencies and employees of Program. Participating public agency to notify Program of appointment of persons eligible to participate in Program or of termination of appointment; enrollment.	PEBP provides enrollment materials; notices and MPDs to eligible participants.	None.	
Eligibility and Participation: Terminating Interlocal Contract and Withdrawing from Program NAC 287.320	• Withdrawal from Program: Procedure; termination of coverage; limitation on reentry; eligibility of certain officers and employees after exclusion of group; liability of Program.	PEBP reports there are no opt-out plans maintained by local government agencies.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
Eligibility and Participation: Opt-out Plan Administration NAC 287.371 NAC 287.376	• Eligibility of officer or employee to join opt-out plan; ineligibility of officer or employee to continue participation in opt-out plan. Participation in Program by certain persons eligible for coverage under or participating in opt-out plan prohibited; exceptions.	PEBP reports there are no opt-out plans maintained by local government agencies.	None.	
Benefits Coverage NRS 287.0433 NRS 287.04062 NRS 695G.160 NRS 287.0485	• Power to establish plan of life, accident or health insurance; reinsurance; power to use list of preferred prescription drugs developed by Department of Health and Human Services and obtain prescription drugs through certain purchasing agreements. • "Program Fund" defined. • Written criteria concerning coverage of health care services and standards for quality of health care services. No inherent right to certain benefits.	No exceptions noted. Per the MPD no officer, employee, or retiree of the State has any inherent right to benefits provided under PEBP.	None.	
Benefits Coverage: Reinstatement of Coverage by Retired Public Officer, Employee or Surviving Spouse NRS 287.0205 NRS 287.0475	Reinstatement of insurance by retired public officer or employee or surviving spouse.	Per NRS 287.0475, a retired public officer or employee of the State, NSHE, a participating local government, or the surviving spouse thereof, may reinstate insurance during the open enrollment period if the retired public officer or employee did not have more than one period during which he	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
		or she was not covered under the PEBP Plan on or after October 1, 2011, or on or after the date of his or her retirement, whichever is later. Meaning, the above individuals will only have one opportunity to rejoin a PEBP Plan following retirement. In accordance with NRS 287.0475, a retired public officer or employee who retired from a nonparticipating local governmental agency or the surviving spouse thereof, may reinstate insurance during the open enrollment period through the Medicare Exchange or under the Public Employees' Benefits Program if eligible, if the retired public officer or employee (1) did not have more than one period during which he or she was not covered by insurance under the Program on or after October 1, 2011; (2) was enrolled in the Program as a retiree on November 30, 2008; and (3) is enrolled in Medicare Parts A and B at the time of the request for reinstatement. To enroll as a late enrollee, contact PEBP between April 15th and May 15th to request the retiree late enrollment form. All reinstatement applications are subject to the provisions of the Plan. Approved enrollment for reinstated retirees will become effective July 1st. Reinstated retirees are not eligible for basic life insurance coverage through the PEBP.		

STATE LAW	Description	Findings	Action Required	PEBP Response
		Requests for reinstatement must be completed through the submission of the required forms to the PEBP office not later than 31 days before the commencement of the plan year.		
Benefits Coverage: Oral Chemotherapy Parity NRS 695G.167 NRS 287.04335	• Plan covering treatment of cancer through use of chemotherapy: Prohibited acts related to orally administered chemotherapy. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs indicate that the health plans cover orally administered chemotherapy.	None.	
Benefits: Coverage: Services Provided Through Telehealth NRS 695G.162 NRS 287.04335	• Required provision concerning coverage for services provided through telehealth to same extent and in same amount as though provided in person or by other means; exception; prohibited acts. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	NRS 695G.152 requires plans to cover telehealth services to the same extent as though provided in person and by other means. The MPDs reflect that telemedicine is covered by Doctors on Demand, and alternatively, telemedicine is available from in-network providers is covered on the same basis as in-person services. The review cannot confirm from the LD plan language whether telehealth is covered out of network. The CDHP MPD reflects that telemedicine is covered at 80% in network, or 50% out of network, after the deductible has been met.	Action Required: PEBP should clarify whether telehealth services are provided out of network in the same manner as out of network in person coverage on the LD plan.	
Benefits: Coverage: Continued Medical Treatment	• Required provision in certain plans concerning coverage	MPDs reflect continuation of coverage provisions.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
NRS 695G.164 NRS 287.04335	for continued medical treatment; exceptions; regulations. Compliance with certain provisions required to provide health insurance through plan of self-insurance.			
Benefits Coverage: Autism Spectrum Disorders NRS 695G.1645 NRS 287.04335	• Required provision in plan for group coverage concerning coverage for autism spectrum disorders for certain persons, prohibited acts. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs reflect autism coverage with the same copay, deductible, and coinsurance provisions as other medical services covered by the plan	None.	
Benefits Coverage: Medically Necessary Emergency Services NRS 695G.170 NRS 287.04335	• Required provision concerning coverage for medically necessary emergency services at any hospital, prohibited acts. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs do not require precertification for medically necessary emergency services provided at any hospital.	None.	
Benefits Coverage: Submission to step therapy protocol NRS 695G.1702 NRS 287.04335	Plan covering prescription drugs: Submission to step therapy protocol for drug to treat psychiatric condition prohibited in certain circumstances.	MPDs provide that prescription drugs that are prescribed to treat psychiatric condition are not subject to medical management techniques, such as step therapy	None.	
Benefits Coverage: Biomarker testing NRS 695G.1703 NRS 287.04335	• Required provision concerning coverage for biomarker testing for diagnosis, treatment, management and monitoring of cancer in certain circumstances; establishment of process to request	MPDs provide for biomarker testing, and provide for 24-hour urgent prior authorization limit, and 72 hour prior authorization limit.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	exception or appeal denial of coverage; time for responding to request for prior authorization.			
Benefits Coverage: Hepatitis C and HIV NRS 695G.1705 NRS 287.04335	Required provision concerning coverage for drugs, laboratory testing and certain services related to human immunodeficiency virus and hepatitis C; reimbursement of certain providers of health care for certain services; prohibited acts	NRS 695G.1705 requires coverage for any service to test for, prevent, or treat human immunodeficiency virus or hepatitis C. MPDs provide coverage for hepatitis C drugs, however, are silent on treatment or testing services for hepatitis C or human immunodeficiency virus.	Action Required: PEBP should clarify the Plan provides for testing and other services for hepatitis C and HIV. PEBP should clarify coverage for drugs used for prevention of HIV.	
Benefits Coverage: Sexually Transmitted Diseases NRS 695G.1707 NRS 287.04335	Required provision concerning coverage for testing, treatment and prevention of sexually transmitted diseases; required provision concerning coverage for condoms for certain insureds. .	NRS 695G.1707 appears to mandate coverage for more than what is on the ACA preventive service requirements. The Statute also mandates unrestricted coverage of condoms for insureds who are 13 years or older. MPD states the Plans provide for "counseling for sexually transmitted diseases" • Evidence-based items or services that have an "A" or "B" Recommendation by the United States Preventive Services Task Force (USPSTF) and Section 2713(a)(5)) of the 2015 Consolidated Appropriations Act. • With respect to women, such additional preventive care and screenings not described	Action Required: PEBP should update the MPDs to include all coverage mandated by NRS 695G.1707. PEBP should remove the exclusion for condoms.	

STATE LAW	Description	Findings	Action Required	PEBP Response
		under this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. MPDs provide an exclusion for condoms.		
Benefits Coverage: BRCA gene NRS 695G.1712 NRS 287.04335	Required provision concerning coverage for screening, genetic counseling and testing related to BRCA gene in certain circumstances.	MPDs provide for coverage for: Genetic Testing, including o BRCA o Biomarker testing for the diagnosis, treatment, appropriate management, and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence.	None.	
Benefits Coverage: Prohibition on Pre-Existing Conditions NRS 695G.155 NRS 287.04335	Managed care organization required to offer and issue plan regardless of health status of persons; prohibited acts; authority to include wellness program in plan that offers discounts based on health status under certain circumstances.	No pre-existing issues noted. MPD provides for domestic violence exceptions for any exclusions. MPDs do not list a wellness program.	None.	
Benefits Coverage: Required Provision Concerning Coverage for Human Papillomavirus Vaccine NRS 695G.171 NRS 287.04335	• Required provision concerning coverage for certain tests and vaccines relating to human papillomavirus, prohibited acts. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs provide coverage for HPV testing and vaccine.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
Benefits Coverage: Treatment Received as Part of a Clinical Trial or Study NRS 695G.173 NRS 287.04335	• Required provision concerning coverage for certain treatment received as part of clinical trial or study for treatment of cancer or chronic fatigue syndrome; authority of managed care organization to require certain information; immunity from liability. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs provide coverage for Experimental and/or Investigational Services as provided under NRS 695G.173.	None.	
Benefits Coverage: Required Provisions for Prescription Drugs Irregularly Dispensed for Synchronization of Chronic Medications NRS 695G.1665 NRS 287.04335	• Required provision in plan covering prescription drugs concerning coverage for prescription drugs irregularly dispensed for purpose of synchronization of chronic medications; prohibited acts; exception. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs provide provision concerning coverage for prescription drugs irregularly dispensed for the synchronization of chronic medications	None.	
Benefits Coverage: Required Provisions for Early Refills of Topical Ophthalmic Products NRS 695G.172 NRS 287.04335	• Plan covering prescription drugs: Denial of coverage prohibited for early refills of otherwise covered topical ophthalmic products. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs provide required provision concerning coverage for early refills of topical ophthalmic products.	None.	
Benefits Coverage: Required Provisions for Coverage for Prostate Cancer Screening NRS 695G.177	• Required provision in plans covering treatment of prostate cancer concerning	MPDs provide this benefit is covered as preventive care service.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
NRS 287.04335	coverage for prostate cancer screening; prohibited acts. Compliance with certain provisions required to provide health insurance through plan of self-insurance.			
Benefits Coverage: Claims Involving Intoxication NRS 695G.405 NRS 287.04335	• Managed care organization prohibited from denying coverage solely because applicant or insured was intoxicated or under the influence of controlled substance, exceptions. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPD provide that plans exclude a claim that involves an injury to which a contributing cause was the insured's commission of or attempt to commit a felony, except if as a result of a medical or behavioral health condition. This exclusion is permissible under NRS 695G.405.	None.	
Benefits Coverage: Sickle Cell Anemia Treatment NRS 695G.174 NRS 287.04335	• Required provision concerning coverage for management and treatment of sickle cell disease and its variants; plan covering prescription drugs required to provide coverage for medically necessary prescription drugs to treat sickle cell disease and its variants. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs provide for coverage for sickle cell disease. MPDs provide for coverage for prescription drugs to treat sickle cell disease.	None.	
Benefits Coverage: Gestational Maternity Care NRS 695G.1716 NRS 287.04335	• Health care plan covering maternity care: Prohibited acts by managed care organization if insured is acting as gestational carrier; child deemed child of	Per the MPD - "Medically necessary maternity services for pregnant participants are covered."	Action Recommended: While the review did not note any exclusions, the LD Plan appears to have a gestational carrier definition, while the other plans do not. PEBP should clarify in the other plans the use	

STATE LAW	Description	Findings	Action Required	PEBP Response
	intended parent for purposes of plan. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	No exclusions for gestational carriers noted.	of the gestational carrier definition. .	
Benefits Coverage: Claims NRS 689B.255 NRS 287.04335	• Claims relating to health insurance coverage: Approval or denial; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements; imposition of administrative fine or suspension or revocation of certificate of registration for failure to comply. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	No exceptions noted.	None.	
Benefits Coverage: Electronic Health Information NRS 439.581 to NRS 439.597 NRS 287.04335	• Certification for health information exchange required; disciplinary action for failure to comply with law; administrative fine for operating without certification; regulations • Limitations on use, release or publication of certain information; penalty for unauthorized access to electronic health record or health information exchange; establishment of complaint system. • Patient not required to participate in health	PEBP provided a copy of its PHI security procedures. Additionally, PEBP provided that PEBP staff, with exception of the Executive Officer and Quality Control (QC) staff, do not handle EHRs. PEBPs Executive Officer and QC I staff have access to vendor portals such as UMR and ESI in order to review claims for level 2 appeals. The claims data does not include diagnosis or medical notes; rather, it includes the providers name, the billed amount, and the CPT code for the procedure. In addition,	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	information exchange; notification to patient of breach of confidentiality of electronic health records or health information exchange; patient access to electronic health records. • Electronic health records, electronic signatures and electronically transmitted or retrieved health information deemed to comply with certain writing and signature requirements; information maintained or transmitted in electronic health record or retrieved by a health information exchange deemed to comply with certain confidentiality requirements; exception. Electronic transmission of health information: Exemption from state law concerning privacy or confidentiality of certain health information; ability of person to opt out of electronic disclosure of certain health information.	members may provide QC staff with copies of prior authorizations and appeal decision letter with health information as component of a compliant or an appeal. Lastly QC staff facilitate the External Review Process. As with complaints/appeals, QC staff may receive copies of prior authorizations, medical records, etc as a component of an external review. Health records are sent and received securely between PEBP and their various vendors.		
Contract Provisions: Vision Care NRS 686A.135 NRS 287.04335	Vision care: Prohibited provisions in contract between insurer and provider; insurer required to provide list of reimbursement rates to provider before entering contract; insurer required to disclose in policy pecuniary interest in supplier or provider; prohibited advertisements by insurer related to coverage; provider required to disclose pecuniary interest in supplier; use of in-	This section sets out certain prohibited contract provisions between insurers and providers. PEBP should operate due diligence in ensuring its vendors comply with contract prohibitions mandated by NRS 686A.135.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	network source or supplier not prohibited.			
Contract Provisions: Medicare Supplemental Policies NRS 687B.352 NRS 287.04335	Open enrollment period for Medicare supplemental policies required; prohibited acts; notice; treatment of Medicare supplemental policies purchased during open enrollment period for purposes relating to payment of commissions.	PEBP does not offer Medicare supplemental coverage. This section is not applicable.	None.	
Contract Provisions: Mental Health and Substance Abuse Payments NRS 687B.409 NRS 287.04335	Payments to out-of-network providers for treatment of mental health or alcohol or substance use disorder, assignment of benefits.	This section outlines certain mandates as to payments to out of network mental health and substance use providers. PEBP should continue its due diligence to ensure vendors are following NRS 687B.409 procedures for payments to out-of-network mental health and substance use disorder providers.	None.	
Contract Provisions: Dental Care NRS 687B.723 NRS 287.04335	Claim for dental care: Health carrier or administrator of health benefit plan prohibited from denying claim for which prior authorization has been granted; exceptions.	PEBP has not encountered any concerns regarding denial of claims after prior authorization was granted.	None.	
Claims: Dental Care NRS 687B.725 NRS 287.04335	Claim for dental care: Requirements and limitations related to recovery of overpayments.	No concerns noted. PEBP should continue its due diligence to ensure vendors are following overpayment procedures mandated by NRS 687B.725	None.	
Benefits Coverage: Inherited Metabolic Disease NRS 695C.1723 NRS 287.04335	Required provision concerning coverage for treatment of certain inherited metabolic diseases.	"Documentation to substantiate the presence of an inherited metabolic disease, including documentation that the product purchased is a special food	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
		product or enteral formula, may be required before the Plan will reimburse for costs associated with special food products or enteral formulas." – parity? MPD states there is coverage for enteral formulas for treatment of inherited metabolic diseases, with a $2,500 annual limit.		
Benefits Coverage: Authorization of Recommended and Covered Services NRS 695G.150 NRS 287.04335	Authorization of recommended and covered health care services required.	Per the MPD's, "The utilization management (UM) company is staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer utilization review services. The review includes a process to determine the medical necessity, appropriateness, location, and cost effectiveness of health care services. Depending on the service, a review may occur before, during, or after the services are rendered, including, but not limited to precertification/pre-authorization; concurrent and/or continued stay review; discharge planning; retrospective review; and case management." The Plans appear to comply with NRS 695G.150's requirements.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
Benefits Coverage: Prescription Coverage during Emergency Declaration NRS 695G.1635 NRS 287.04335	Plan covering prescription drugs: Required actions by managed care organization related to acquisition of prescription drugs for certain insureds residing in area for which emergency or disaster has been declared.	MPDs do not appear to contain language explaining coverage during emergency or disaster declaration. PEBP may already be providing coverage as required, however may wish to clarify procedures to obtain emergency prescription coverage, and limitations to this benefit.	Action Required: PEBP should consider adding language to the MPDs explaining procedure to obtain emergency prescription coverage during emergency or disaster declaration, and the geographic limitations to this benefit.	
Benefits Coverage: Step Therapy Cancer Protocols NRS 695G.1675 NRS 287.04335	Plan covering prescription drug for treatment of cancer or cancer symptom that is part of step therapy protocol: Managed care organization required to allow insured or attending practitioner to apply for exemption from step therapy protocol in certain circumstances; procedure for applying for and granting exemption.	Per MPD: "The Plan also complies with step therapy for treatment of cancer or cancer symptom that is part of step therapy protocol per NRS 695G.1675" The MPD does not provide for step therapy exemption procedures.	Action Recommended: While the MPD indicates that the Plan complies with this statute, PEBP should clarify step therapy exemption procedures in the MPD.	
Benefits Coverage: Examination of pregnant person for certain diseases NRS 695G.1714 NRS 287.04335	Required provision concerning coverage for examination of person who is pregnant for certain diseases.	The MPD's provide that the Plan provides for "Counseling for sexually transmitted infections (STI), HIV counseling and testing" as part of the preventive/wellness care services. The MPDs provide that the Plan covers ACA services for OB/GYN visits. The MPDs do not specifically specify whether testing for diseases referenced in NRS 695G.1714 are covered as part of maternity coverage.	Action Recommended: The Plan should clarify it provides coverage for testing for diseases references in NRS 695G.1714 during as part of maternity coverage, without prior authorization required.	

STATE LAW	Description	Findings	Action Required	PEBP Response
Benefits Coverage: Contraception and related health services NRS 695G.1715 NRS 287.04335	Required provision concerning coverage for drug or device for contraception and related health services; prohibited acts; exceptions.	MPDs provide coverage for tubal ligations. MPDs state "This Plan covers FDA approved contraceptive methods, including contraceptive injection or the insertion of a device at a hospital immediately after an insured gives birth, sterilization procedures, and patient education and counseling for women with reproductive capacity. The FDA requires the services to be "prescribed" by a physician even for over-the-counter methods. This Plan complies with the coverage requirements for contraception and related health services set forth in NRS 695G.1715."	None.	
Benefits Coverage: Drugs related to Substance and opioid use disorder NRS 695G.1719 NRS 287.04335	Required provision concerning coverage for certain drugs and services related to substance use disorder and opioid use disorder; reimbursement of pharmacists and pharmacies for certain services; prohibited acts.	MPDs state "The Plan provides benefits for substance use disorder including coverage for all drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone." The MPDs do not provide language for benefits for safe withdrawal from substance use disorder, including lofexidine.	Action Required: PEBP should amend the MPDs to clarify the Plan provides benefits for substance use disorder for all drugs approved by FDA to support safe withdrawal from substance use disorder, including, without limitation lofexidine. PEBP should clarify that the Plan does not subject these benefits to medical management techniques, other than step therapy.	
Benefits Coverage: Gender Dysphoria NRS 695G.1718	• Required provision concerning coverage for medically necessary treatment of conditions	MPDs state: "This Plan provides benefits to individuals seeking medically necessary services for the treatment of gender	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
NRS 695G.415 NRS 287.04335	relating to gender dysphoria and gender incongruence; restriction on refusal to cover certain treatments; authority of managed care organization to prescribe requirements for covering surgical treatments for minors; determination of medical necessity. • Managed care organization prohibited from discriminating against person with respect to participation or coverage on basis of gender identity or expression.	dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license." PEBP provides the coverage mandated by this statute.		
Benefits Coverage: Preventive and Wellness services, tests, and screenings NRS 695G.1717 NRS 287.04335	Required provision concerning coverage for certain services, screenings and tests relating to wellness, prohibited acts.	MPDs provide for the following coverage: • Breastfeeding support, supplies, and counseling • Screening for interpersonal and domestic violence • Counseling for sexually transmitted infections (STI), HIV counseling and testing • Screening for gestational diabetes • Prenatal care • Routine gynecologic examination (one per Plan Year), including annual cytologic screening test (Pap smear) for women 18 years of age or older, pelvic examination, urinalysis, and breast examination. • Evidence-based items or services that have an "A" or "B" Recommendation by	Action Required: PEBP should clarify it covers hormone replacement therapy.	

STATE LAW	Description	Findings	Action Required	PEBP Response
		the United States Preventive Services Task Force (USPSTF) and Section 2713(a)(5)) of the 2015 Consolidated Appropriations Act. • With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services guidelines including the American Academy of Pediatrics Bright Futures guidelines; and • With respect to women, such additional preventive care and screenings not described under this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. • Smoking/tobacco cessation • Vaccinations such as shingles, HPV, Flu, pneumonia, Herpes Zoster, TDAP (tetanus, diphtheria, and pertussis -whooping cough)		

STATE LAW	Description	Findings	Action Required	PEBP Response
		This list incorporates most of the requirements under this statute. However, the MPDs are silent on coverage of hormone replacement therapy.		
Required provision concerning coverage for management and treatment of sickle cell disease and its variants NRS 695G.174 NRS 287.04335	Required provision concerning coverage for management and treatment of sickle cell disease and its variants; plan covering prescription drugs required to provide coverage for medically necessary prescription drugs to treat sickle cell disease and its variants.	MPDs provide that the plans cover "Medically necessary prescription drugs to treat sickle cell disease and its variants pursuant to the provisions of NRS 695G.174." and sickle cell disease on an outpatient basis. PEBP in compliance with State law.	None.	
Plan covering anatomical gifts, organ transplants or treatments or services related to organ transplants NRS 695G.176 NRS 287.04335	Plan covering anatomical gifts, organ transplants or treatments or services related to organ transplants: Prohibited acts by managed care organization if insured is person with disability.	No issues noted.	None.	
Benefits Coverage: Prescription Drug Coverage NRS 287.0433	Power to establish plan of life, accident or health insurance; reinsurance; power to use list of preferred prescription drugs developed by Department of Health and Human Services and obtain prescription drugs through certain purchasing agreements.	No exceptions noted.	None.	
Funding Requirements: Payment of Premiums NAC 287.420 NRS 287.04385 NRS 287.044	• Employer may agree with employee to defer compensation, investment of withheld money. • Action by Program to recover delinquent payments, penalties or late fees, statute of limitations. • Payment of premiums or contributions to Program;	NAC 287.420 provides penalties to be assessed in the event of nonpayment by the participating public agency. PEBP provided its procedures for billing and collection of payments of non-state entities. No concerns were noted in review of billing and collection procedures.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	coverage of dependents; allocation of money paid to Program; establishment of Active Employee Group Insurance Subsidy Account.			
Funding Requirements: Direct Payment of Premiums for Retirees, LOAs Without Pay and LOAs due to Work Injury NAC 287.430 NAC 287.440 NAC 287.450 NAC 287.460 NRS 287.046 NRS 287.0439 NRS 287.0445	• Direct payment of premiums or contributions: Date due; cancellation of coverage. • Payment of premiums or contributions by retired officers and employees. • Employees on leave without pay: Conditions for payment of premiums or contributions by participating public agency; continuation of or eligibility for coverage or insurance; coverage and insurance upon return to full-time employment. • Officers and employees on leave because of injuries in course of employment: Payment of premiums or contributions; reports of change in status; coverage of dependents upon return to work. • Office of Finance to establish assessment to pay portion of premiums or contributions for participating retirees with state service; amounts assessed to be deposited in Retirees' Fund; adjustments to portion paid to Program by Retirees' Fund. • Participating public agency required to furnish certain notice and information to	A State agency that employs an individual who is on LWOP (other than FMLA leave) shall NOT pay any amount of the cost of premium or contributions for group insurance for that employee, unless the employee receives a minimum compensation of 80 hours in the month. An employee who is on approved LWOP may pay the full cost of premiums for their coverage and insurance to PEBP. An employee on LWOP is not eligible for coverage as a dependent of another PEBP covered participant.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	Board and make records available for inspection; reimbursement of Program for premiums or contributions if agency fails to notify Program of change in status of employee. • Payment of premiums or contributions for state officer or employee injured in course of employment while member of Program.			
Funding Requirements: Procedures Regarding Handling Over/ Underpayments of Premiums NAC 287.470	• Overpayment or underpayment of premiums or contributions. • Powers and duties.	PEBP has confirmed it has over and underpayment procedures in place, including assessments of underpayment penalties. No concerns noted.	None.	
Subrogation to Rights of Officer, Employee or Dependent NRS 287.0465	Board subrogated to rights of member; lien upon proceeds of recovery from person liable for illness or injury.	The Active Wrap Plan Document highlights the subrogation rights.	None.	
Claims and Appeals Procedures NRS 287.608 NAC 287.610 NAC 287.620 NAC 287.660 NAC 287.670 NAC 287.680 NAC 287.690 NRS 287.695 NRS 287.04335 NRS 689B.255	Coverage of person qualified as both employee and dependent; change of status from employee to dependent. • Period for submission. • Assumption regarding availability of benefits under Medicare; coordination under Medicare. • Notification of adverse determination; grounds for appeal. • Appeal of adverse determination: Requirements; duties of Appeals Manager.	The Active Wrap Plan Document and medical MPDs outline the claims and appeals procedures. No concerns noted with claims and appeals procedures as written.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	• Appeal of decision of Appeals Manager: Requirements; duties of Executive Officer or designee. • Request for external review. • Request for expedited review by Claims Administrator • Compliance with certain provisions required to provide health insurance through plan of self-insurance. Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements; imposition of administrative fine or suspension or revocation of certificate of authority for failure to comply.			
Claims and Appeals Procedures: Complaint System; Notice Requirements to Insured NAC 287.750 NRS 695G.200 NRS 695G.220 NRS 695G.230 NRS 287.04335	• System for resolving complaints of insureds: Requirements for approval and annual report. • Establishment; approval; requirements; assistance for persons filing complaints; examination. • Annual report; managed care organization required to maintain records of and report complaints concerning something other than health care services. • Written notice required by carrier to insured explaining rights of insureds regarding	PEBP has confirmed they have a complaint resolution system to the Division of Insurance as noted in NAC 287.750.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	decision to deny coverage; written notice to insured when health carrier denies coverage of health care service. Compliance with certain provisions required to provide health insurance through plan of self-insurance.			
Claims and Appeals Procedures: Notice to Insured; Expedited Review Process NRS 695G.210 NRS 695G.230 NRS 287.04335	• Review board; appeal; right to expedited review of complaint; notice to insured. • Written notice required by carrier to insured explaining rights of insureds regarding decision to deny coverage; written notice to insured when health carrier denies coverage of health care service. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	No exceptions noted.	None.	
Claims and Appeals Procedures: External Review Process NRS 695G.241 NRS 695G.300 NRS 695G.310 NRS 287.04335	• Circumstances under which adverse determination may be subject to external review; exceptions. • Submission of complaint of covered person to independent review organization. • Annual report; requirements. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	No exceptions noted.	None.	
PEBP Board Authority and Duties NRS 287.04062	• "Program Fund" defined. • Powers and duties.	No exceptions noted.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
NRS 287.043 NRS 287.0487 NRS 287.04335 NRS 287.0434	• Participant in Program may seek assistance from Office for Consumer Health Assistance regarding coverage. • Compliance with certain provisions required to provide health insurance through plan of self-insurance. Power to use assets, contract for services and charge and collect certain fees and payments. [Effective through December 31, 2025.]			
Taxable compensation reduction NRS 287.245	Employer may agree with employee to reduce taxable compensation; federal requirements prerequisite for operation of program; powers of Board of the Public Employees' Benefits Program.	No exceptions noted.	None.	
Local governmental agency may contract with Public Employees' Benefits Program NRS 287.025	Local governmental agency may contract with Public Employees' Benefits Program or other local governmental agency or participate as member of nonprofit cooperative association or corporation for group insurance, related medical services or health-related information.	PEBP confirmed several agencies contract with PEBP.	None.	

11.

11. Public Comment.

12.

12. Adjournment.