JOE LOMBARDO
Governor

CELESTENA GLOVER
Executive Officer

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

JACK ROBB
Board Chair

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program
Date and Time of Meeting:	May 23, 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://www.youtube.com/live/a_H2oD-p1nQ

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/85476934123

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: 854 7693 4123 then press #. When prompted for a Participant ID, please enter #.**

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

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

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

AGENDA

1. Open Meeting; Roll Call.

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

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

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

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

   - 4.1 Approval of Action Minutes from the March 28, 2024 PEBP Board Meeting.
   - 4.2 Receipt of quarterly staff reports for the period ending December 31, 2023:
     - 4.2.1 Q2 Utilization Report
   - 4.3 Receipt of quarterly vendor reports for the period ending December 31, 2023 and March 31, 2024:
     - 4.3.1 Q2 UMR – Obesity Care Management
     - 4.3.2 Q2 UMR – Diabetes Care Management
     - 4.3.3 Q2 UMR – Performance Guarantee Report
     - 4.3.4 Q2 Sierra Healthcare Options – Utilization and Large Case Management
     - 4.3.5 Q2 Express Scripts – Summary Report
     - 4.3.6 Q2 Express Scripts – Utilization Report
     - 4.3.7 Q3 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report

4.3.8 Q3 Amplifon Performance Report

4.3.9 Doctor on Demand Engagement Report

4.3.10 Real Appeal – Utilization Report

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

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

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

7. Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Third-Party Administrator, UMR, for FY2024 Q2 covering the period of October 1, 2023 – December 31, 2023. (Celestena Glover, Executive Officer) (**For Possible Action**)

   7.1 UMR Remediation Plan

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

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

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

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 (Jack Robb, Board Chair) (**All items for possible action**)

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

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

4.2.1 Q2 Utilization Report

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

4.3.1 Q2 UMR – Obesity Care Management

4.3.2 Q2 UMR – Diabetes Care Management

4.3.3 Q2 UMR – Performance Guarantee Report

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4.1

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

4.1 Approval of Action Minutes from the March 28, 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)
March 28, 2024

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

1. Open Meeting; Roll Call

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

2. Public Comment
    - Kent Ervin – Nevada Faculty Alliance
    - Leanne Boner Welch – Member
    - Bill Welch – Member
    - Margaret Kelly Osborne – Member
    - Doug Unger – Nevada Faculty Alliance
    - Patty Antonucci – Member
    - Michael Hallmeier – Member
    - Tess Opferman – AFSCME
    - Teri Laird - RPEN

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

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

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

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

    4.2 Receipt of quarterly Staff Reports for the period ending December 31, 2023

    4.2.1 Q2 Budget Report

    4.3 Receipt of quarterly vendor reports for the period ending December 31, 2023

    4.3.1 Q2 Sierra Healthcare Options and UnitedHealthcare Plus Network – PPO Network

    4.3.2 Q2 UnitedHealthcare – Basic Life Insurance

    4.3.3 Q2 Express Scripts – Summary Report

BOARD ACTION ON ITEM 4
MOTION: Motion to approve agenda items.
BY: Member Bepsy Strasburg
SECOND: Member Jennifer McClendon
VOTE: Unanimous; the motion carried

5. Discussion and possible action regarding a proposed contract with Carrum Health – Oncology Concierge to maintain a network of National Centers of Excellence. A portion of this item may be conducted in closed session to allow review of the results of the evaluation of proposals for the contract, in accordance with NRS 287.04345(4). Any action on the contract will occur in open session, in accordance with NRS 287.04345(5). (Michelle Weyland, Chief Financial Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 5
MOTION: Motion to approve the proposed contract with Carrum Health as presented.
BY: Vice Chair Michelle Kelley
SECOND: Member Leslie Bittleston
VOTE: Unanimous, the motion carried

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

6.1 Wrap Document – Centers of Excellence Benefit

7. Discussion and possible action to include approving Plan Year 2025 Rates for State and Non – State employees, retirees, and their dependents for the Consumer Driven Health Plan (CDHP), Low Deductible Plan (LD), Exclusive Provider Organization Plan (EPO), and Health Maintenance Organization Plan (HMO) (Celestena Glover, Executive Officer) (**For Possible Action**)

A. Plan Year 2025 Rates Table
B. Plan Year 2025 Comparison Table

7.1 Segal PY24 Trend Report

BOARD ACTION ON ITEM 7
MOTION: Motion to accept option number 3 as presented by staff, 50% premium mitigation option.
BY: Member Leslie Bittleston
SECOND: Vice Chair Michelle Kelley
VOTE: Unanimous; the motion carried

8. Discussion and Possible action of UMR's Medical RX Coupon Program (Celestena Glover, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 8
MOTION: Motion to accept Director Glover's recommendation to not go with the Medical RX Coupon Program and to relook at it down the road.
BY: Member Janell Woodward
SECOND: Member Bepsy Strasburg
VOTE: Unanimous; the motion carried

9. Appeals Process (Celestena Glover, Executive Officer) (Information/Discussion)

10. Public Comment

- Kent Ervin – Nevada Faculty Alliance
- Doug Unger – Nevada Faculty Alliance

11. Adjournment

- Board Chair Robb adjourned the meeting at 12:15 p.m.

4.2

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

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

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

4.2.1

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

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

4.2.1 Q2 Utilization Report

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CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: May 23, 2024

Item Number: 4.2.1

Title: Self-Funded CDHP, LDPPO, and EPO Plan Utilization Report for the period ending December 31, 2023

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the PY 2024 period ending December 31, 2023. Included are:

- Executive Summary – provides a utilization overview.
- UMR Inc. CDHP Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- UMR Inc. LDPPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- UMR Inc. EPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- Express Scripts Utilization Report – provides details supporting the prescription drug information included in the Executive Summary.
- Health Plan of Nevada Utilization – see Appendix D for Q2 Plan Year 2024 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q2 of Plan Year 2024 compared to Q2 of Plan Year 2023 is summarized below.

- Population:
  - 10.7% decrease for primary participants
  - 12.8% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 1.8% decrease for primary participants
  - 0.4% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 40 High-Cost Claimants accounting for 21.7% of the total plan paid for Q2 of Plan Year 2024
  - 0.6% decrease in High-Cost Claimants per 1,000 members
  - 31.1% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cancer ($2.2 million) – 30.4% of paid claims
  - Neurological Disorders ($0.7 million) – 9.9% of paid claims
  - Cardiac Disorders ($0.6million) – 8.9% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased by 9.9%
  - Average paid per ER visit increased by 10.8%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased 5.1%
  - Average paid per Urgent Care visit decreased 20.5% (decrease from $39 to $31)
- Network Utilization:
  - 97.0% of claims are from In-Network providers
  - Q2 of Plan Year 2024 In-Network utilization decreased 0.4% over PY 2023
  - Q2 of Plan Year 2024 In-Network discounts remained at 68.4 as in PY 2023

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 11.6%
    - Total Gross Claims Costs increased 0.1% ($0.3 million)
    - Average Total Cost per Claim increased 13.0%
      - From $111.27 to $125.69
  - Member:
    - Total Member Cost decreased 5.7%
    - Average Participant Share per Claim increased 6.6%
    - Net Member PMPM increased 8.7%
      - From $30.14 to $32.76

- Plan
  - Total Plan Cost increase 1.6%
  - Average Plan Share per Claim increased 14.7%
  - Net Plan PMPM increased 17.1%
    - From $97.90 to $114.66
  - Net Plan PMPM factoring rebates increased 52.4%
    - From $62.93 to $$95.90
    -

LOW DEDUCTIBLE PPO PLAN (LDPPO)

The Low Deductible PPO Plan (LDPPO) experience for Q2 of Plan Year 2024 compared to Q2 of Plan Year 2023 is summarized below.

- Population:
  - 35.4% increase for primary participants
  - 33.3% increase for primary participants plus dependents (members)
- Medical Cost:
  - 14.0% increase for primary participants
  - 15.7% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 34 High-Cost Claimants accounting for 19.7% of the total plan paid for Q2 of Plan Year 2024
  - 41.9% increase in High-Cost Claimants per 1,000 members
  - 8.4% decrease in average cost of High-Cost Claimant paid.
- Top three highest cost clinical classifications include:
  - Cancer ($2.0 million) – 27.3% of paid claims
  - Cardiac Disorders ($1.2 million) – 16.5% of paid claims
  - Pregancy-related Disorders ($1.1 million) – 15.2% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased 20.3%
  - Average paid per ER visit decreased 1.7%
- Urgent Care:
  - Urgent Care visits per 1,000 members decreased by 0.8%
  - Average paid per Urgent Care visit increased 3.0% (decrease from $101 to $104)
- Network Utilization:
  - 98.3% of claims are from In-Network providers
  - Q2 of Plan Year 2024 In-Network utilization increased 0.5% over PY 2023
  - Q2 of Plan Year 2024 In-Network discounts increased 0.8% over PY 2023

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims increased 34.8%
    - Total Gross Claims Costs increased 65.9% ($7.8 million)
    - Average Total Cost per Claim increased 23.1%
      - From $118.37to $145.70

- Member:
  - Total Member Cost increased 51.2%
  - Average Participant Share per Claim increased 12.2%
  - Net Member PMPM increased 13.3%
    - From $21.59 to $24.45
- Plan
  - Total Plan Cost increased 68.5%
  - Average Plan Share per Claim increased 25.0%
  - Net Plan PMPM increased 26.3%
    - From $120.36 to $152.00
  - Net Plan PMPM factoring rebates increased 72.3%
    - From $79.92 to $137.67

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q2 of Plan Year 2024 compared to Q2 of Plan Year 2023 is summarized below.

- Population:
  - 10.9% decrease for primary participants
  - 11.3% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 7.5% increase for primary participants
  - 8.1% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 25 High-Cost Claimants accounting for 24.6% of the total plan paid for Q2 Plan Year 2024
  - 17.4% increase in High-Cost Claimants per 1,000 members
  - 19.3% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cancer ($1.2 million) – 26.4% of paid claims
  - Infections ($0.7 million) – 15.3% of paid claims
  - Cardiac Disorders ($0.6 million) – 13.9% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased 8.5%
  - Average paid per ER visit increased by 12.8%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased 10.3%
  - Average paid per Urgent Care visit increased 5.6%
- Network Utilization:
  - 96.6% of claims are from In-Network providers
  - Q2 of Plan Year 2024 In-Network utilization increased 0.5% over PY 2023
  - Q2 of Plan Year 2024 In-Network discounts increased 0.9% over PY 2023

- Prescription Drug Utilization:
  - Overall:

        - Total Net Claims decreased 8.9%
        - Total Gross Claims Costs increased 1.7% ($ 0.2 million)
        - Average Total Cost per Claim increased 11.7%
            - From $142.12 to $158.71
    - Member:
        - Total Member Cost decreased 9.3%
        - Average Participant Share per Claim decreased 0.4%
        - Net Member PMPM increased 2.6%
            - From $37.33 to $38.29
    - Plan
        - Total Plan Cost increased 3.6%
        - Average Plan Share per Claim increased 13.8%
        - Net Plan PMPM increased 17.2%
            - From $213.70 to $250.51
        - Net Plan PMPM factoring rebates increased 25.4%
            - From $134.77 to $169.05

DENTAL PLAN

The Dental Plan experience for Q2 of Plan Year 2024 is summarized below.

- Dental Cost:
    - Total of $13,219,088 paid for Dental claims.
        - Preventative claims account for 24.6% ($3.3 million)
        - Basic claims account for 33.7% ($4.5 million)
        - Major claims account for 19.8% ($2.6 million)
        - Diagnostic claims account for 21.9% ($2.9 million)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of CDHP HRA account balances as of December 31, 2023.

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

HRA Account Balances as of Dec. 31, 2023			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	14,331	0.00	0.00
$.01 - $500.00	35,046	9,506,880.62	271.27
$500.01 - $1,000	3,341	2,255,413.80	675.07
$1,000.01 - $1,500	1,086	1,309,077.61	1,205.41
$1,500.01 - $2,000	520	897,394.16	1,725.76
$2,000.01 - $2,500	311	703,212.68	2,261.13
$2,500.01 - $3,000	233	642,119.65	2,755.88
$3,000.01 - $3,500	153	493,117.79	3,222.99
$3,500.01 - $4,000	190	709,796.34	3,735.77
$4,000.01 - $4,500	139	589,217.67	4,238.98
$4,500.01 - $5,000	107	510,327.02	4,769.41
$5,000.01 +	**676**	**5,749,510.34**	**224,591.36**
Total	**56,133**	**$ 23,366,068**	**$ 416**

CONCLUSION

The information in this report provides plan experience for the Consumer Driven Health Plan (CDHP), Low Deductible PPO Plan (LDPPO) and the PEBP Premier Plan (EPO) through the second quarter of Plan Year 2024. The total medical spend for the CDHP was $49.5 million of which the plan paid $33.5 million or a decrease of 12.3% over the same time for Plan Year 2023. The total medical spend for the LDPPO was $43.3 million of which the plan paid $37.0 million or an increase of 54.3% over Q2 of Plan Year 2023. The total medical spend for the EPO was $19.8 million of which the plan paid $17.7 million or a decrease of 4.1% over Q2 of Plan Year 2023. For HMO utilization and cost data please see the report provided in Appendix D.

Appendix A

Index of Tables
UMR Inc. – CDHP Utilization Review for PEBP
July 1, 2023 – December 31, 2023

DATASCOPE™

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

UMR℠

Overview

- Total Medical Spend for 2Q24 was $33,464,827 of which 77.9% was spent in the State Active population. When compared to 2Q23, this reflected a decrease of 12.3% in plan spend, with State Actives having a decrease of 10.7%.
  - When compared to 2Q22, 2Q24 decreased 24.5%, with State Actives having a decrease of 23.6%.
- On a PEPY basis, 2Q24 reflected a decrease of 1.8% when compared to 2Q23. The largest group, State Actives, was right in line with the 2Q23 PEPY%.
  - When compared to 2Q22, 2Q24 decreased 2.1%, with State Actives decreasing .4%.
- 92.8% of the Average Membership had paid Medical claims less than $2,500, with 32.5% having no claims paid at all during the reporting period.
- There were 40 high-cost Claimants (HCC's) over $100K, that accounted for 21.7% of the total spend. HCCs accounted for 31.8% of total spend during 2Q23, with 46 members hitting the $100K threshold. The largest diagnosis grouper was Cancer accounting for 30.4% of high-cost claimant dollars.
- IP Paid per Admit was $20,864 which is a decrease of 17.7% compared to 2Q23.
- ER Paid per Visit is $2,316, which is an increase of 10.8% compared to 2Q23.
- 97.0% of all Medical spend dollars were to In Network providers. The average In Network discount was 68.4%, which is equal to the PY23 average discount of 68.4%.

Paid Claims by Age Group

Paid Claims by Age Group																
	2Q23						2Q24						% 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	$ 3,470,181	$ 3,343	$ 14,085	$ 14	$3,484,266	$ 3,357	$ 363,189	$ 496	$ 194	$ 0	$ 363,383	$ 496	-89.6%	-85.2%
1	$ 174,061	$ 134	$ 1,800	$ 1	$175,861	$ 136	$ 191,331	$ 229	$ 55,766	$ 67	$ 247,097	$ 296	40.5%	118.3%
2 - 4	$ 346,615	$ 90	$ 89,301	$ 23	$435,916	$ 113	$ 290,723	$ 90	$ 67,111	$ 21	$ 357,834	$ 111	-17.9%	-1.7%
5 - 9	$ 668,479	$ 79	$ 131,232	$ 15	$799,711	$ 94	$ 653,810	$ 96	$ 159,963	$ 24	$ 813,773	$ 120	1.8%	27.5%
10 - 14	$ 720,821	$ 72	$ 155,167	$ 16	$875,988	$ 88	$ 852,063	$ 102	$ 309,078	$ 37	$ 1,161,141	$ 139	32.6%	58.2%
15 - 19	$ 2,396,355	$ 217	$ 384,782	$ 35	$2,781,137	$ 252	$ 1,216,268	$ 123	$ 253,633	$ 26	$ 1,469,901	$ 149	-47.1%	-41.0%
20 - 24	$ 1,472,721	$ 109	$ 501,925	$ 37	$1,974,646	$ 146	$ 1,475,015	$ 126	$ 853,532	$ 73	$ 2,328,547	$ 199	17.9%	36.1%
25 - 29	$ 1,435,151	$ 155	$ 510,509	$ 55	$1,945,660	$ 210	$ 1,057,088	$ 134	$ 218,724	$ 28	$ 1,275,812	$ 162	-34.4%	-22.7%
30 - 34	$ 2,691,308	$ 236	$ 518,871	$ 46	$3,210,179	$ 282	$ 1,834,514	$ 189	$ 429,312	$ 44	$ 2,263,826	$ 233	-29.5%	-17.2%
35 - 39	$ 1,285,040	$ 104	$ 834,785	$ 68	$2,119,825	$ 172	$ 2,183,365	$ 204	$ 724,258	$ 68	$ 2,907,623	$ 272	37.2%	58.2%
40 - 44	$ 1,965,468	$ 151	$ 1,023,455	$ 79	$2,988,923	$ 230	$ 1,939,012	$ 166	$ 973,762	$ 83	$ 2,912,774	$ 249	-2.5%	8.5%
45 - 49	$ 2,175,094	$ 177	$ 1,154,443	$ 94	$3,329,537	$ 270	$ 2,146,981	$ 198	$ 1,342,442	$ 124	$ 3,489,423	$ 322	4.8%	19.0%
50 - 54	$ 4,020,905	$ 285	$ 1,881,357	$ 133	$5,902,262	$ 419	$ 3,598,631	$ 290	$ 2,180,135	$ 176	$ 5,778,766	$ 465	-2.1%	11.1%
55 - 59	$ 4,795,542	$ 308	$ 2,757,859	$ 177	$7,553,401	$ 486	$ 4,416,214	$ 326	$ 2,030,603	$ 150	$ 6,446,817	$ 475	-14.7%	-2.1%
60 - 64	$ 7,146,628	$ 389	$ 3,569,646	$ 194	$10,716,274	$ 583	$ 7,172,190	$ 434	$ 3,629,795	$ 220	$ 10,801,985	$ 653	0.8%	12.1%
65+	$ 3,384,807	$ 279	$ 2,923,753	$ 241	$6,308,560	$ 520	$ 4,074,431	$ 358	$ 3,488,142	$ 306	$ 7,562,573	$ 664	19.9%	27.6%
Total	**$ 38,149,177**	**$ 228**	**$ 16,452,971**	**$ 98**	**$ 54,602,148**	**$ 326**	**$ 33,464,827**	**$ 229**	**$ 16,716,452**	**$ 114**	**$ 50,181,279**	**$ 343**	**-8.1%**	**5.4%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	19,199	16,565	14,801	-10.7%	15,753	13,433	11,986	-10.8%	3	3	4	16.7%
Spouses	4,089	3,335	2,805	-15.9%	3,246	2,554	2,130	-16.6%	1	1	1	0.0%
Children	10,413	8,044	6,760	-16.0%	9,656	7,397	6,194	-16.3%	4	4	4	-12.5%
Total Members	33,701	27,944	24,365	-12.8%	28,655	23,384	20,310	-13.1%	8	8	8	0.0%
Family Size	1.8	1.7	1.7	-2.1%	1.8	1.7	1.7	-0.6%	2.7	2.7	2.3	-15.2%
Financial Summary												
Gross Cost	$63,975,609	$54,222,932	$49,473,997	-8.8%	$49,236,488	$41,211,985	$37,898,786	-8.0%	$21,822	$29,248	$21,774	-25.6%
Client Paid	$44,327,868	$38,149,177	$33,464,827	-12.3%	$34,143,038	$29,210,832	$26,075,515	-10.7%	$12,232	$19,651	$12,870	-34.5%
Employee Paid	$19,647,740	$16,073,754	$16,009,170	-0.4%	$15,093,450	$12,001,153	$11,823,272	-1.5%	$9,589	$9,597	$8,903	-7.2%
Client Paid-PEPY	$4,618	$4,606	$4,522	-1.8%	$4,335	$4,349	$4,351	0.0%	$8,155	$13,101	$4,142	-68.4%
Client Paid-PMPY	$2,631	$2,731	$2,747	0.6%	$2,383	$2,498	$2,568	2.8%	$3,058	$4,913	$3,574	-27.3%
Client Paid-PEPM	$385	$384	$377	-1.8%	$361	$362	$363	0.3%	$680	$1,092	$345	-68.4%
Client Paid-PMPM	$219	$228	$229	0.4%	$199	$208	$214	2.9%	$255	$409	$298	-27.1%
High Cost Claimants (HCC's) > $100k												
# of HCC's	68	46	40	-13.0%	50	35	34	-2.9%	0	0	0	0.0%
HCC's / 1,000	2.0	1.7	1.6	-0.6%	1.7	1.5	1.7	11.3%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$190,516	$263,874	$181,855	-31.1%	$197,233	$271,047	$178,848	-34.0%	$0	$0	$0	0.0%
HCC's % of Plan Paid	29.2%	31.8%	21.7%	-31.8%	28.9%	32.5%	23.3%	-28.3%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$924	$981	$684	-30.3%	$816	$899	$663	-26.3%	$0	$0	$0	0.0%
Facility Outpatient	$799	$851	$1,037	21.9%	$691	$767	$951	24.0%	$2,389	$2,937	$2,367	-19.4%
Physician	$863	$899	$1,025	14.0%	$834	$832	$954	14.7%	$646	$1,975	$851	0.0%
Other	$46	$0	$0	0.0%	$42	$0	$0	0.0%	$23	$0	$0	0.0%
Total	$2,631	$2,731	$2,747	0.6%	$2,383	$2,498	$2,568	2.8%	$3,058	$4,913	$3,218	-34.5%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	2,996	2,750	2,483	-9.7%	448	379	328	-13.5%	
Spouses	777	729	636	-12.8%	65	51	38	-24.9%	
Children	735	627	549	-12.4%	18	17	14	-15.2%	
Total Members	4,508	4,105	3,667	-10.7%	531	447	380	-14.9%	
Family Size	1.5	1.5	1.5	-1.3%	1.2	1.2	1.2	-3.3%	1.6
Financial Summary									
Gross Cost	$13,239,264	$10,973,139	$10,274,227	-6.4%	$1,478,034	$2,008,560	$1,279,210	-36.3%	
Client Paid	$9,296,905	$7,549,558	$6,697,118	-11.3%	$875,694	$1,369,136	$679,324	-50.4%	
Employee Paid	$3,942,360	$3,423,581	$3,577,109	4.5%	$602,341	$639,424	$599,886	-6.2%	
Client Paid-PEPY	$6,206	$5,492	$5,395	-1.8%	$3,912	$7,222	$4,142	-42.6%	$6,258
Client Paid-PMPY	$4,125	$3,679	$3,652	-0.7%	$3,300	$6,133	$3,574	-41.7%	$3,830
Client Paid-PEPM	$517	$458	$450	-1.7%	$326	$602	$345	-42.7%	$521
Client Paid-PMPM	$344	$307	$304	-1.0%	$275	$511	$298	-41.7%	$319
High Cost Claimants (HCC's) > $100k									
# of HCC's	17	9	7	-22.2%	1	3	0	-100.0%	
HCC's / 1,000	3.8	2.2	1.9	-12.8%	1.9	6.7	0.0	-100.0%	
Avg HCC Paid	$167,653	$216,838	$170,481	-21.4%	$243,333	$233,344	$0	-100.0%	
HCC's % of Plan Paid	30.7%	25.8%	17.8%	-31.0%	27.8%	51.1%	0.0%	-100.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,603	$1,183	$782	-33.9%	$956	$3,405	$898	-73.6%	$1,044
Facility Outpatient	$1,422	$1,264	$1,458	15.3%	$1,289	$1,383	$1,545	11.7%	$1,310
Physician	$1,033	$1,231	$1,412	14.7%	$984	$1,344	$1,130	-15.9%	$1,404
Other	$67	$0	$0	0.0%	$72	$0	$0	0.0%	$72
Total	$4,125	$3,679	$3,652	-0.7%	$3,300	$6,133	$3,574	-41.7%	$3,830
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

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

	Total				State Active				Non-State Active			
Summary	**PY22**	**PY23**	**2Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**2Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**2Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	18,943	16,411	14,801	-9.8%	15,526	13,332	11,986	-10.1%	3	3	4	16.7%
Spouses	3,974	7,866	2,805	-64.3%	3,134	7,223	2,130	-70.5%	1	4	1	-75.0%
Children	10,172	3,266	6,760	107.0%	9,421	2,504	6,194	147.4%	4	1	4	250.0%
Total Members	33,089	27,544	24,365	-11.5%	28,082	23,059	20,310	-11.9%	8	8	8	0.0%
Family Size	1.8	1.7	1.7	-1.8%	1.8	1.7	1.7	-2.3%	2.7	2.7	2.3	-14.2%
Financial Summary												
Gross Cost	$138,077,453	$116,590,277	$49,473,997	-57.6%	$106,593,460	$87,356,314	$37,898,786	-56.6%	$55,484	$42,591	$21,774	-48.9%
Client Paid	$104,706,277	$88,479,381	$33,464,827	-62.2%	$80,561,976	$66,125,338	$26,075,515	-60.6%	$38,304	$30,890	$12,870	-58.3%
Employee Paid	$33,371,175	$28,110,896	$16,009,170	-43.0%	$26,031,484	$21,230,976	$11,823,272	-44.3%	$17,181	$11,702	$8,903	-23.9%
Client Paid-PEPY	$5,527	$5,391	$4,522	-16.1%	$5,189	$4,960	$4,351	-12.3%	$12,768	$10,297	$4,142	-59.8%
Client Paid-PMPY	$3,164	$3,212	$2,747	-14.5%	$2,869	$2,868	$2,568	-10.5%	$4,788	$3,861	$3,574	-7.4%
Client Paid-PEPM	$461	$449	$377	-16.0%	$432	$413	$363	-12.1%	$1,064	$858	$345	-59.8%
Client Paid-PMPM	$264	$268	$229	-14.6%	$239	$239	$214	-10.5%	$399	$322	$298	-7.5%
High Cost Claimants (HCC's) > $100k												
# of HCC's	160	126	40		115	94	34		0	0	0	
HCC's / 1,000	4.8	4.6	1.6		4.1	4.1	1.7		0.0	0.0	0.0	
Avg HCC Paid	$251,190	$238,643	$181,855	-23.8%	$262,921	$233,021	$178,848	-23.2%	$0	$0	$0	0.0%
HCC's % of Plan Paid	38.4%	34.0%	21.7%	-36.2%	37.5%	33.1%	23.3%	-29.6%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,153	$995	$684	-31.3%	$1,028	$895	$663	-25.9%	$0	$0	$0	0.0%
Facility Outpatient	$939	$1,074	$1,037	-3.4%	$821	$930	$951	2.3%	$3,554	$2,208	$2,367	7.2%
Physician	$1,011	$1,143	$1,025	-10.3%	$964	$1,043	$954	-8.5%	$1,200	$1,653	$851	-48.5%
Other	$62	$0	$0	0.0%	$56	$0	$0	0.0%	$34	$0	$0	0.0%
Total	$3,164	$3,212	$2,747	-14.5%	$2,869	$2,868	$2,568	-10.5%	$4,788	$3,861	$3,218	-16.7%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY22**	**PY23**	**2Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**2Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	2,981	2,711	2,483	-8.4%	433	366	328	-10.3%	
Spouses	776	624	636	1.9%	62	16	38	146.3%	
Children	729	715	549	-23.2%	18	46	14	-69.7%	
Total Members	4,486	4,049	3,667	-9.4%	514	427	380	-11.0%	
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	$10,274,227	-59.1%	$3,549,442	$4,089,345	$1,279,210	-68.7%	
Client Paid	$21,491,378	$19,194,786	$6,697,118	-65.1%	$2,614,619	$3,128,367	$679,324	-78.3%	
Employee Paid	$6,387,688	$5,907,239	$3,577,109	-39.4%	$934,823	$960,978	$599,886	-37.6%	
Client Paid-PEPY	$7,210	$7,082	$5,395	-23.8%	$6,033	$8,557	$4,142	-51.6%	$6,258
Client Paid-PMPY	$4,791	$4,740	$3,652	-23.0%	$5,091	$7,321	$3,574	-51.2%	$3,830
Client Paid-PEPM	$601	$590	$450	-23.7%	$503	$713	$345	-51.6%	$521
Client Paid-PMPM	$399	$395	$304	-23.0%	$424	$610	$298	-51.1%	$319
High Cost Claimants (HCC's) > $100k									
# of HCC's	44	31	7		5	5	0		
HCC's / 1,000	9.8	7.7	1.9		9.7	11.7	0.0		
Avg HCC Paid	$199,873	$213,853	$170,481	-20.3%	$231,987	$307,109	$0	-100.0%	
HCC's % of Plan Paid	40.9%	34.5%	17.8%	-48.4%	44.4%	49.1%	0.0%	-100.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,808	$1,250	$782	-37.4%	$2,262	$4,005	$898	-77.6%	$1,044
Facility Outpatient	$1,612	$1,838	$1,458	-20.7%	$1,488	$1,591	$1,545	-2.9%	$1,310
Physician	$1,280	$1,652	$1,412	-14.5%	$1,227	$1,724	$1,130	-34.5%	$1,404
Other	$91	$0	$0	0.0%	$115	$0	$0	0.0%	$72
Total	$4,791	$4,740	$3,652	-23.0%	$5,091	$7,321	$3,574	-51.2%	$3,830
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 12,054,589	$ 201,931	$ 2,457,895	$ 14,714,415	$ 7,847,100	$ 1,510,553	$ 172,351	$ 9,530,004	-35.2%
Outpatient	$ 17,156,243	$ 582,669	$ 4,307,062	$ 22,045,975	$ 18,228,415	$ 3,920,624	$ 1,093,590	$ 23,242,629	5.4%
Total - Medical	**$ 29,210,832**	**$ 784,601**	**$ 6,764,958**	**$ 36,760,390**	**$ 26,075,515**	**$ 5,431,178**	**$ 1,265,940**	**$ 32,772,633**	**-10.8%**

Net Paid Claims - Per Participant per Month	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 362	$ 60	$ 2,016	$ 379	$ 363	$ 465	$ 392	$ 377	-0.3%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 307,550	$ 528,292	$ 835,842	$ -	$ 46,918	$ 144,082	$ 191,000	-77.1%
Outpatient	$ 19,651	$ 297,967	$ 235,327	$ 552,945	$ 12,870	$ 241,337	$ 246,987	$ 501,195	-9.4%
Total - Medical	**$ 19,651**	**$ 605,517**	**$ 763,619**	**$ 1,388,787**	**$ 12,870**	**$ 288,255**	**$ 391,069**	**$ 692,194**	**-50.2%**

Net Paid Claims - Per Participant per Month	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 1,092	$ 832	$ 494	$ 606	$ 613	$ 591	$ 264	$ 348	-42.5%

Paid Claims by Claim Type – Total Participants

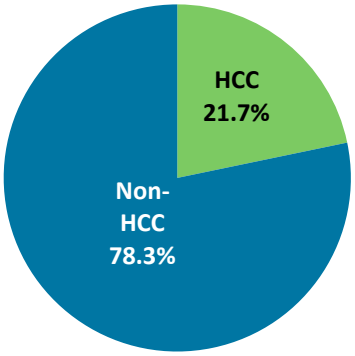
Net Paid Claims - Total Total Participants	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 12,054,589	$ 509,481	$ 2,986,187	$ 15,550,258	$ 7,847,100	$ 1,557,471	$ 316,432	$ 9,721,003	-37.5%
Outpatient	$ 17,175,894	$ 880,636	$ 4,542,389	$ 22,598,920	$ 18,241,285	$ 4,161,961	$ 1,340,577	$ 23,743,823	5.1%
Total - Medical	**$ 29,230,483**	**$ 1,390,117**	**$ 7,528,577**	**$ 38,149,176**	**$ 26,088,385**	**$ 5,719,432**	**$ 1,657,009**	**$ 33,464,827**	**-12.3%**

Net Paid Claims - Per Participant per Month	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 363	$ 100	$ 1,536	$ 384	$ 363	$ 470	$ 352	$ 377	-1.8%

Cost Distribution – Medical Claims

2Q23							2Q24					
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
44	0.2%	$12,138,215	31.8%	$255,290	1.6%	$100,000.01 Plus	37	0.2%	$7,274,195	21.7%	$219,567	1.4%
62	0.2%	$4,801,280	12.6%	$340,002	2.1%	$50,000.01-$100,000.00	79	0.3%	$5,564,706	16.6%	$458,382	2.9%
140	0.5%	$5,076,275	13.3%	$846,964	5.3%	$25,000.01-$50,000.00	130	0.5%	$4,645,229	13.9%	$744,755	4.7%
343	1.2%	$5,474,220	14.3%	$1,710,395	10.6%	$10,000.01-$25,000.00	334	1.4%	$5,421,852	16.2%	$1,678,264	10.5%
446	1.6%	$3,208,248	8.4%	$1,644,691	10.2%	$5,000.01-$10,000.00	490	2.0%	$3,518,018	10.5%	$1,771,361	11.1%
662	2.4%	$2,431,970	6.4%	$1,710,878	10.6%	$2,500.01-$5,000.00	689	2.8%	$2,504,712	7.5%	$1,839,057	11.5%
10,973	39.3%	$5,018,970	13.2%	$7,076,094	44.0%	$0.01-$2,500.00	8,815	36.2%	$4,536,115	13.6%	$6,760,879	42.2%
5,954	21.3%	$0	0.0%	$2,489,439	15.5%	$0.00	5,861	24.1%	$0	0.0%	$2,536,906	15.8%
9,319	33.3%	$0	0.0%	$0	0.0%	No Claims	7,931	32.5%	$0	0.0%	$0	0.0%
27,942	**100.0%**	**$38,149,177**	**100.0%**	**$16,073,754**	**100.0%**		**24,365**	**100.0%**	**$33,464,827**	**100.0%**	**$16,009,170**	**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	16	$2,209,720	30.4%
Neurological Disorders	25	$717,895	9.9%
Cardiac Disorders	30	$648,228	8.9%
Infections	18	$532,252	7.3%
Gastrointestinal Disorders	25	$496,338	6.8%
Hematological Disorders	16	$441,309	6.1%
Pulmonary Disorders	26	$351,238	4.8%
Non-malignant Neoplasm	5	$299,523	4.1%
Endocrine/Metabolic Disorders	15	$286,483	3.9%
Renal/Urologic Disorders	13	$275,175	3.8%
All Other		$1,016,034	14.0%
Overall	**----**	**$7,274,195**	**100.0%**

Utilization Summary (p. 1 of 2)

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

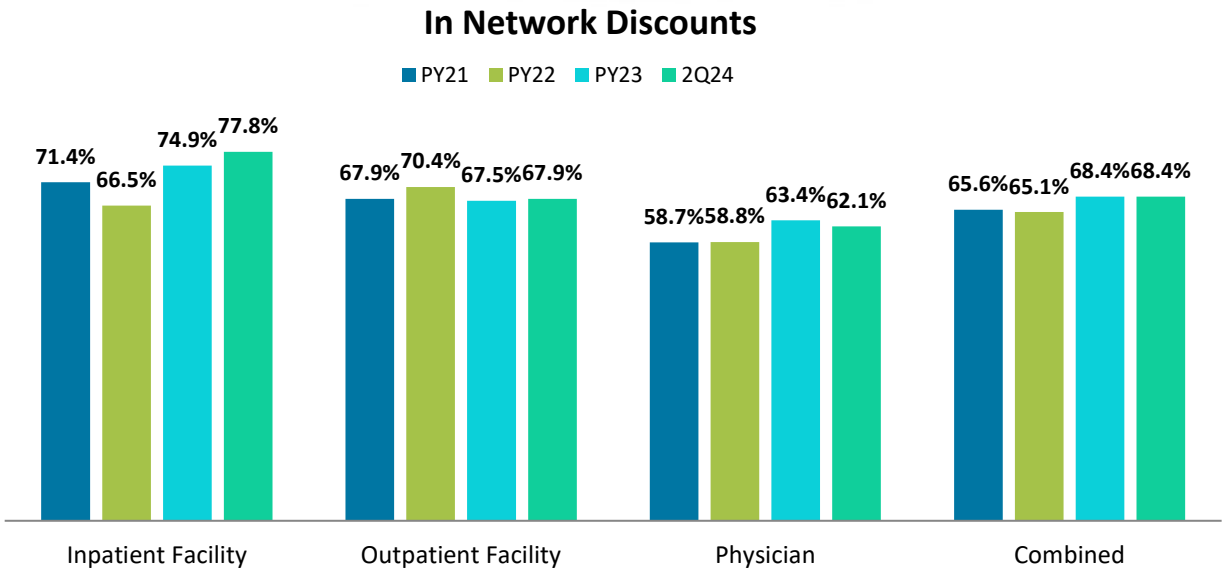
	Total				State Active				Non-State Active			
Summary	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	699	525	456		513	379	348		0	0	0	
# of Bed Days	4,347	3,283	2,338		3,269	2,403	1,670		0	0	0	
Paid Per Admit	$30,798	$25,366	$20,864	-17.7%	$31,757	$25,842	$21,746	-15.9%	$0	$0	$0	0.0%
Paid Per Day	$4,952	$4,056	$4,069	0.3%	$4,984	$4,076	$4,532	11.2%	$0	$0	$0	0.0%
Admits Per 1,000	41	38	37	-2.6%	36	32	34	6.3%	0	0	0	0.0%
Days Per 1,000	258	235	192	-18.3%	228	206	164	-20.4%	0	0	0	0.0%
Avg LOS	6.2	6.3	5.1	-19.0%	6.4	6.3	4.8	-23.8%	0	0	0	0.0%
# Admits From ER	393	309	313	1.3%	261	205	232	13.2%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	3.7	3.5	3.9	11.4%	3.5	3.2	3.6	12.5%	3.5	3.0	2.8	-6.7%
Avg Paid per OV	$71	$71	$68	-4.2%	$74	$69	$66	-4.3%	$48	$49	$118	0.0%
Avg OV Paid per Member	$262	$246	$263	6.9%	$256	$222	$236	6.3%	$166	$148	$324	0.0%
DX&L Utilization per Member	7.2	8.7	9.3	6.9%	6.8	7.9	8.7	10.1%	14.5	5	5.3	6.0%
Avg Paid per DX&L	$45	$41	$46	12.2%	$41	$40	$45	12.5%	$41	$97	$299	0.0%
Avg DX&L Paid per Member	$322	$358	$428	19.6%	$282	$318	$395	24.2%	$594	$483	$1,569	0.0%
Emergency Room												
# of Visits	2,520	1,985	1,901		2,102	1,587	1,536		3	3	1	
Visits Per Member	0.15	0.14	0.16	14.3%	0.15	0.14	0.15	7.1%	0.75	0.75	0.25	-66.7%
Visits Per 1,000	150	142	156	9.9%	147	136	151	11.0%	750	750	250	-66.7%
Avg Paid per Visit	$1,835	$2,091	$2,316	10.8%	$1,847	$2,116	$2,430	14.8%	$1,489	$4,167	$6,492	55.8%
Urgent Care												
# of Visits	4,606	3,821	3,502		4,072	3,389	3,034		2	2	2	
Visits Per Member	0.27	0.27	0.29	7.4%	0.28	0.29	0.30	3.4%	0.50	0.50	0.50	0.0%
Visits Per 1,000	273	273	287	5.1%	284	290	299	3.1%	500	500	500	0.0%
Avg Paid per Visit	$63	$39	$31	-20.5%	$63	$39	$32	-17.9%	$102	$0	$130	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

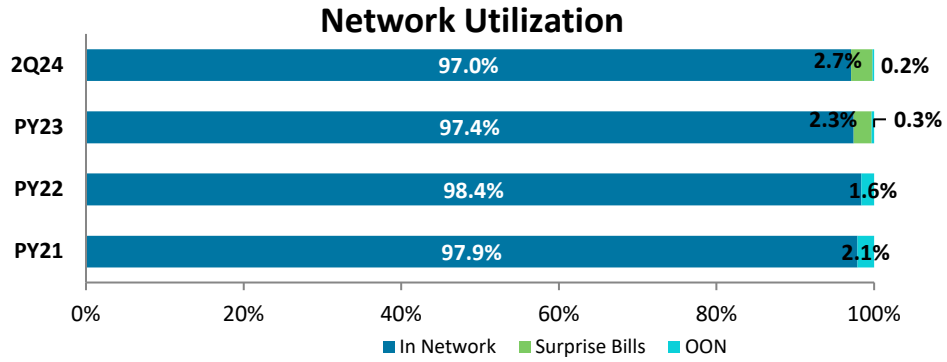
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**Peer Index**
Inpatient Summary									
# of Admits	166	113	85		20	33	23		
# of Bed Days	954	654	565		124	226	103		
Paid Per Admit	$29,106	$23,741	$20,301	-14.5%	$20,260	$25,460	$9,596	-62.3%	$19,305
Paid Per Day	$5,065	$4,102	$3,054	-25.5%	$3,268	$3,718	$2,143	-42.4%	$3,615
Admits Per 1,000	74	55	46	-16.4%	75	148	121	-18.2%	64
Days Per 1,000	423	319	308	-3.4%	467	1,012	542	-46.4%	342
Avg LOS	5.7	5.8	6.6	13.8%	6.2	6.8	4.5	-33.8%	5.3
# Admits From ER	122	82	62	-24.4%	10	22	19	-13.6%	
Physician Office									
OV Utilization per Member	4.8	4.7	4.9	4.3%	6.6	7.3	7.8	6.8%	5.2
Avg Paid per OV	$64	$83	$85	2.4%	$26	$25	$28	12.0%	$97
Avg OV Paid per Member	$308	$390	$418	7.2%	$173	$183	$217	18.6%	$502
DX&L Utilization per Member	9.6	11.9	11.8	-0.8%	9.7	18.9	17.6	-6.9%	9.0
Avg Paid per DX&L	$58	$46	$49	6.5%	$47	$37	$41	10.8%	$46
Avg DX&L Paid per Member	$560	$550	$580	5.5%	$456	$700	$715	2.1%	$412
Emergency Room									
# of Visits	358	336	306		57	59	58		
Visits Per Member	0.16	0.16	0.17	6.3%	0.21	0.26	0.31	19.2%	0.23
Visits Per 1,000	159	164	167	1.8%	215	264	305	15.5%	228
Avg Paid per Visit	$1,795	$1,993	$2,043	2.5%	$1,677	$1,865	$681	-63.5%	$1,035
Urgent Care									
# of Visits	479	382	423		53	48	43		
Visits Per Member	0.21	0.19	0.23	21.1%	0.20	0.22	0.23	4.5%	0.38
Visits Per 1,000	213	186	231	24.2%	200	215	226	5.1%	379
Avg Paid per Visit	$60	$40	$28	-30.0%	$39	$27	$12	-55.6%	$132
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$4,507,602	13.5%	$3,794,796	$660,612	$52,195	$1,502,328	$3,005,274
Health Status/Encounters	$3,258,521	9.7%	$2,047,908	$439,424	$771,189	$1,133,537	$2,124,984
Gastrointestinal Disorders	$2,769,240	8.3%	$1,982,950	$387,663	$398,627	$902,238	$1,867,003
Cardiac Disorders	$2,736,168	8.2%	$1,911,082	$740,468	$84,618	$1,676,612	$1,059,556
Neurological Disorders	$2,157,480	6.4%	$1,223,771	$229,060	$704,648	$696,024	$1,461,456
Trauma/Accidents	$1,721,113	5.1%	$1,085,447	$162,290	$473,375	$825,131	$895,981
Musculoskeletal Disorders	$1,620,150	4.8%	$1,288,207	$191,358	$140,585	$510,759	$1,109,392
Infections	$1,452,660	4.3%	$1,194,916	$188,378	$69,366	$645,901	$806,759
Mental Health	$1,444,130	4.3%	$572,612	$161,912	$709,605	$743,335	$700,795
Spine-related Disorders	$1,424,716	4.3%	$1,172,383	$199,953	$52,381	$746,531	$678,185
Renal/Urologic Disorders	$1,305,065	3.9%	$974,356	$122,037	$208,672	$627,838	$677,227
Pulmonary Disorders	$1,204,975	3.6%	$778,703	$125,420	$300,852	$577,139	$627,836
Pregnancy-related Disorders	$1,125,948	3.4%	$754,908	$136,782	$234,258	$68,879	$1,057,069
Eye/ENT Disorders	$1,108,283	3.3%	$690,685	$233,134	$184,464	$400,126	$708,158
Endocrine/Metabolic Disorders	$741,721	2.2%	$654,116	$80,437	$7,167	$389,217	$352,504
Gynecological/Breast Disorders	$733,894	2.2%	$553,536	$113,478	$66,880	$16,910	$716,985
Medical/Surgical Complications	$686,638	2.1%	$559,483	$94,350	$32,805	$166,453	$520,185
Non-malignant Neoplasm	$677,525	2.0%	$592,977	$55,535	$29,013	$357,881	$319,644
Hematological Disorders	$651,881	1.9%	$203,968	$421,600	$26,313	$438,415	$213,466
Diabetes	$402,119	1.2%	$299,192	$18,819	$84,108	$127,182	$274,938
Dermatological Disorders	$358,435	1.1%	$228,928	$65,344	$64,164	$161,146	$197,289
Vascular Disorders	$338,754	1.0%	$227,457	$30,945	$80,352	$136,284	$202,471
Miscellaneous	$297,856	0.9%	$210,515	$33,680	$53,661	$125,145	$172,711
Medication Related Conditions	$238,476	0.7%	$81,517	$22,975	$133,984	$26,297	$212,179
Abnormal Lab/Radiology	$230,948	0.7%	$199,988	$22,034	$8,926	$93,514	$137,434
Congenital/Chromosomal Anomalies	$111,482	0.3%	$32,153	$420	$78,909	$44,251	$67,231
External Hazard Exposure	$92,248	0.3%	$2,561	$2,297	$87,390	$87,890	$4,358
Cholesterol Disorders	$46,189	0.1%	$39,839	$5,927	$423	$29,859	$16,329
Allergic Reaction	$12,638	0.0%	$5,367	$718	$6,554	$3,857	$8,782
Dental Conditions	$7,724	0.0%	$4,308	$263	$3,153	$4,995	$2,729
Cause of Morbidity	$241	0.0%	$0	$0	$241	$241	$0
Social Determinants of Health	$6	0.0%	$6	$0	$0	$0	$6
Total	**$33,464,827**	**100.0%**	**$23,368,635**	**$4,947,314**	**$5,148,877**	**$13,265,914**	**$20,198,913**

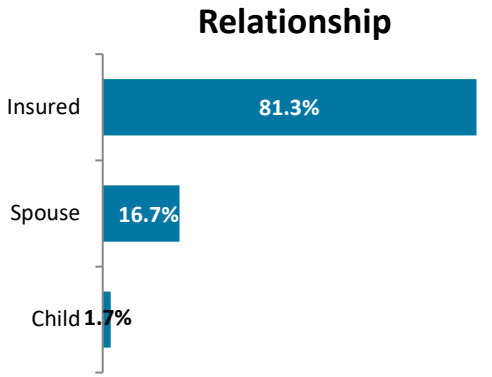
Mental Health Drilldown

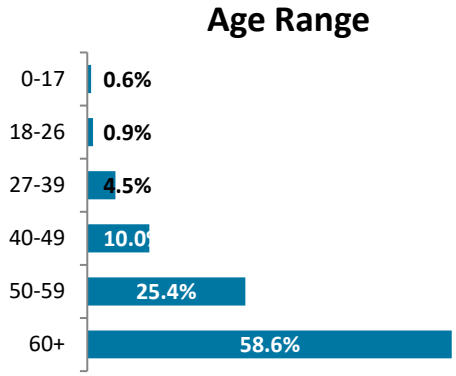
	PY21		PY22		PY23		2Q24	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Alcohol Abuse/Dependence	136	$1,288,204	101	$873,612	129	$434,007	75	$354,518
Developmental Disorders	179	$1,179,402	113	$719,871	106	$1,143,180	71	$347,777
Depression	1,597	$1,103,414	1,156	$1,279,244	974	$1,005,022	685	$268,724
Mood and Anxiety Disorders	1,920	$638,818	1,486	$406,189	1,263	$370,422	787	$118,833
Mental Health Conditions, Other	1,220	$771,034	911	$431,490	774	$383,973	490	$101,689
Bipolar Disorder	315	$464,418	225	$197,224	193	$202,937	147	$50,912
Eating Disorders	55	$647,596	44	$596,928	34	$112,463	15	$46,310
Sexually Related Disorders	68	$90,021	42	$11,305	56	$109,156	33	$42,372
Complications of Substance Abuse	42	$202,208	22	$89,081	26	$88,753	19	$26,607
Psychoses	54	$86,357	32	$70,201	35	$108,586	17	$23,396
Substance Abuse/Dependence	140	$213,345	86	$540,594	81	$99,940	45	$15,487
Sleep Disorders	564	$76,491	371	$46,254	347	$39,783	163	$15,408
Attention Deficit Disorder	482	$72,965	374	$57,319	369	$42,820	268	$15,357
Schizophrenia	26	$141,033	25	$110,357	21	$81,413	12	$11,108
Personality Disorders	25	$16,690	19	$13,480	8	$1,502	12	$3,706
Tobacco Use Disorder	126	$8,010	106	$6,184	103	$7,184	55	$1,925
Total		**$7,000,007**		**$5,449,334**		**$4,231,141**		**$1,444,130**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	56	236	$1,832,115	40.6%
Cancers, Other	62	508	$539,212	12.0%
Breast Cancer	131	875	$439,927	9.8%
Secondary Cancers	38	265	$337,869	7.5%
Colon Cancer	32	259	$274,842	6.1%
Prostate Cancer	78	400	$208,573	4.6%
Lung Cancer	16	122	$143,050	3.2%
Carcinoma in Situ	50	169	$92,396	2.0%
Lymphomas	25	198	$86,476	1.9%
Ovarian Cancer	15	122	$83,037	1.8%
Cervical/Uterine Cancer	37	161	$81,439	1.8%
Thyroid Cancer	29	119	$75,057	1.7%
Leukemias	21	215	$64,693	1.4%
Non-Melanoma Skin Cancers	154	362	$61,409	1.4%
Kidney Cancer	17	115	$55,964	1.2%
Myeloma	9	93	$41,185	0.9%
Pancreatic Cancer	2	96	$29,287	0.6%
Melanoma	24	90	$27,341	0.6%
Brain Cancer	4	9	$24,449	0.5%
Bladder Cancer	15	65	$9,281	0.2%
Overall	**----**	**----**	**$4,507,602**	**100.0%**

*Patient and claim counts are unique only within the category

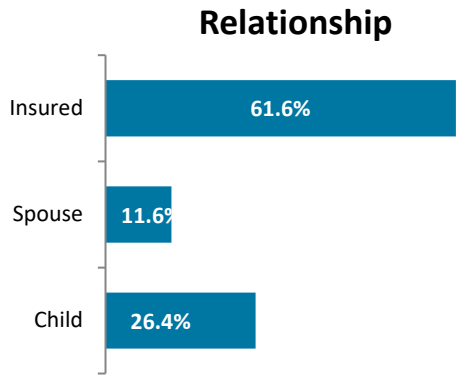


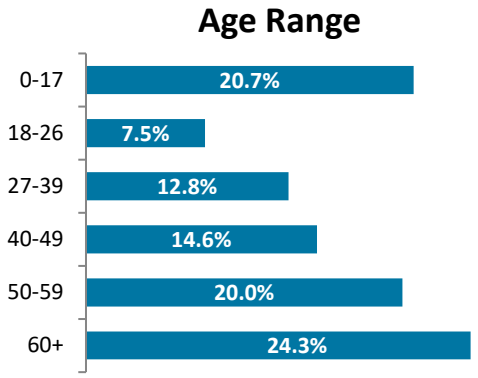


Diagnosis Grouper – Health Status/Encounters

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Screenings	3,741	6,601	$1,177,592	36.1%
Exams	4,602	7,795	$753,810	23.1%
Prophylactic Measures	2,324	2,792	$510,155	15.7%
Encounters - Infants/Children	1,554	1,986	$291,659	9.0%
Aftercare	238	525	$140,046	4.3%
Counseling	536	2,035	$132,631	4.1%
Prosthetics/Devices/Implants	273	749	$64,847	2.0%
Personal History of Condition	455	727	$61,541	1.9%
Family History of Condition	86	126	$40,754	1.3%
Acquired Absence	43	68	$30,465	0.9%
Encounter - Transplant Related	26	101	$18,968	0.6%
Encounter - Procedure	28	45	$17,974	0.6%
Health Status, Other	51	85	$13,349	0.4%
Lifestyle/Situational Issues	52	102	$4,292	0.1%
Miscellaneous Examinations	13	19	$274	0.0%
Donors	1	1	$113	0.0%
Blood Type	1	2	$51	0.0%
Patient Non-compliance	1	1	$0	0.0%
Follow-Up Encounters	1	2	$0	0.0%
Overall	**----**	**----**	**$3,258,521**	**100.0%**

*Patient and claim counts are unique only within the category

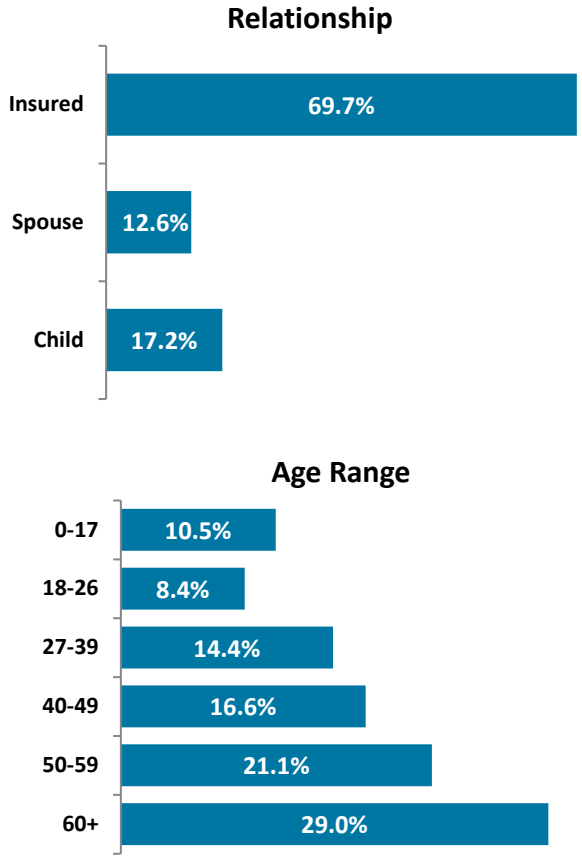




Diagnosis Grouper – Gastrointestinal Disorders

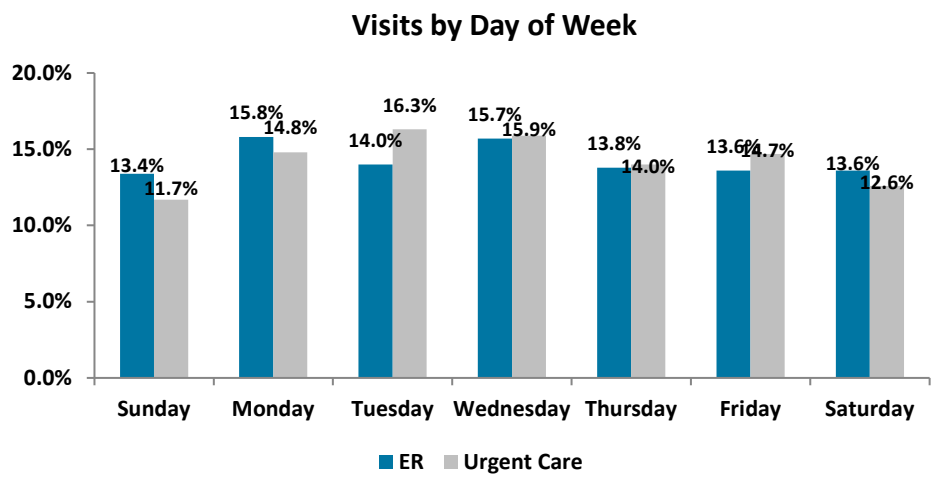
Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Abdominal Disorders	848	1,949	$435,958	15.7%
Hernias	139	422	$412,353	14.9%
GI Disorders, Other	429	961	$386,915	14.0%
GI Symptoms	532	1,091	$234,642	8.5%
Upper GI Disorders	447	925	$224,099	8.1%
Gallbladder and Biliary Disease	90	314	$213,885	7.7%
Appendicitis	28	176	$139,843	5.0%
Inflammatory Bowel Disease	56	194	$131,530	4.7%
Pancreatic Disorders	29	150	$120,096	4.3%
Hepatic Cirrhosis	21	79	$105,762	3.8%
Diverticulitis	84	187	$98,619	3.6%
Liver Diseases	172	294	$94,436	3.4%
Constipation	121	192	$81,346	2.9%
Hemorrhoids	84	144	$47,488	1.7%
Ostomies	25	152	$34,389	1.2%
Peptic Ulcer/Related Disorders	16	22	$6,496	0.2%
Esophageal Varices	4	9	$1,383	0.0%
	----	----	$2,769,240	100.0%

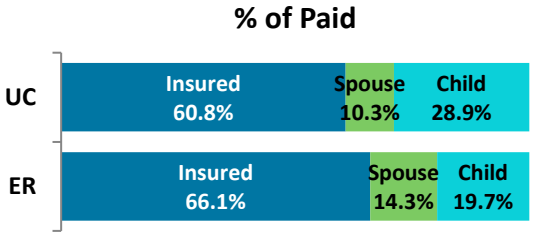
*Patient and claim counts are unique only within the category



Emergency Room / Urgent Care Summary

	2Q23		2Q24		Peer Index	
	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	1,985	3,821	1,901	3,502		
Visits Per Member	0.14	0.27	0.16	0.29	0.23	0.38
Visits/1000 Members	142	273	156	287	228	379
Avg Paid Per Visit	$2,091	$39	$2,316	$31	$1,085	$132
% with OV*	80.2%	78.5%	83.0%	77.6%		
% Avoidable	15.1%	40.2%	14.8%	38.3%		
Total Member Paid	**$2,812,684**	**$522,853**	**$2,802,309**	**$538,359**		
Total Plan Paid	**$4,126,032**	**$149,367**	**$4,403,297**	**$109,878**		
*looks back 12 months	Annualized	Annualized	Annualized	Annualized		





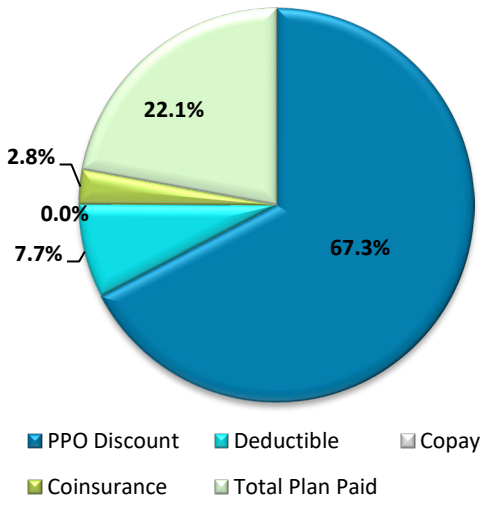
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	1,180	80	2,192	4,380	3,372	228
Spouse	231	85	970	863	1,201	443
Child	490	72	340	1,655	830	121
Total	**1,901**	**78**	**3,502**	**144**	**5,403**	**222**

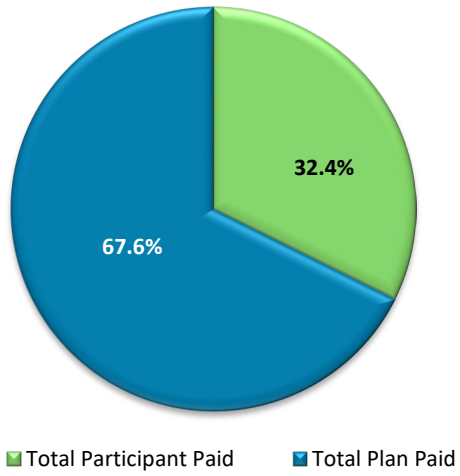
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$157,459,129	$1,773	100.0%
PPO Discount	$102,051,463	$1,149	64.8%
Deductible	$11,723,087	$132	7.4%
Copay	$223	$0	0.0%
Coinsurance	$4,285,860	$48	2.7%
Total Participant Paid	**$16,009,170**	**$180**	**10.2%**
Total Plan Paid	**$33,464,827**	**$377**	**21.3%**

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





Paid Claims by Age Range – Dental

Dental Paid Claims by Age Group												
	2Q22		2Q23		2Q24		% Change	
Age Range	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM
<1	$ 4,624	$ 2	$ 3,677	$ 1	$ 4,733	$ 2	28.7%	48.3%
1	$ 24,384	$ 8	$ 25,586	$ 9	$ 24,078	$ 9	-5.9%	2.9%
2 - 4	$ 197,775	$ 19	$ 196,205	$ 21	$ 209,307	$ 22	6.7%	8.9%
5 - 9	$ 615,077	$ 32	$ 544,872	$ 29	$ 590,519	$ 33	8.4%	11.6%
10 - 14	$ 632,173	$ 28	$ 597,828	$ 27	$ 643,970	$ 30	7.7%	8.0%
15 - 19	$ 758,700	$ 31	$ 711,743	$ 29	$ 895,557	$ 35	25.8%	22.7%
20 - 24	$ 461,202	$ 18	$ 442,530	$ 17	$ 537,029	$ 20	21.4%	20.5%
25 - 29	$ 434,828	$ 23	$ 372,460	$ 21	$ 427,153	$ 24	14.7%	13.2%
30 - 34	$ 568,428	$ 25	$ 477,840	$ 22	$ 565,469	$ 26	18.3%	18.4%
35 - 39	$ 714,163	$ 28	$ 600,599	$ 24	$ 706,257	$ 28	17.6%	16.5%
40 - 44	$ 694,624	$ 28	$ 659,885	$ 26	$ 778,984	$ 30	18.0%	14.2%
45 - 49	$ 726,434	$ 29	$ 661,311	$ 26	$ 801,755	$ 32	21.2%	21.2%
50 - 54	$ 919,786	$ 32	$ 833,773	$ 29	$ 926,052	$ 32	11.1%	10.0%
55 - 59	$ 1,035,663	$ 35	$ 957,492	$ 33	$ 1,105,227	$ 38	15.4%	16.0%
60 - 64	$ 1,313,464	$ 40	$ 1,162,161	$ 36	$ 1,278,537	$ 41	10.0%	11.8%
65+	$ 3,423,389	$ 42	$ 3,238,556	$ 40	$ 3,724,461	$ 46	15.0%	15.3%
Total	**$12,524,714**	**$ 31**	**$11,486,516**	**$ 29**	**$ 13,219,088**	**$ 34**	**15.1%**	**15.3%**

Dental Paid Claims – State Participants

Dental Paid Claims - Total State Participants	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 7,540,918	$ 1,042,467	$ 222,772	$ 8,806,158	$ 9,209,301	$ 785,078	$ 190,961	$ 10,185,340	15.7%
Dental Exchange	$ -	$ -	$ 1,666,037	$ 1,666,037	$ -	$ -	$ 1,915,468	$ 1,915,468	15.0%
Total	**$ 7,540,918**	**$ 1,042,467**	**$ 1,888,809**	**$ 10,472,194**	**$ 9,209,301**	**$ 785,078**	**$ 2,106,429**	**$ 12,100,808**	**30.6%**

Dental Paid Claims - Per Participant per Month	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 48	$ 50	$ 52	$ 49	$ 58	$ 39	$ 45	$ 56	14.4%
Dental Exchange	$ -	$ -	$ 48	$ 48	$ -	$ -	$ 55	$ 55	13.6%

Dental Paid Claims – Non-State Participants

Dental Paid Claims - Total Non-State Participants	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 2,321	$ 45,795	$ 107,321	$ 155,437	$ 11,563	$ 32,571	$ 97,366	$ 141,499	-9.0%
Dental Exchange	$ -	$ -	$ 858,884	$ 858,884	$ -	$ -	$ 976,782	$ 976,782	13.7%
Total	**$ 2,321**	**$ 45,795**	**$ 966,205**	**$ 1,014,321**	**$ 11,563**	**$ 32,571**	**$ 1,074,147**	**$ 1,118,281**	**10.2%**

Dental Paid Claims - Per Participant per Month	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 64	$ 37	$ 43	$ 41	$ 296	$ 38	$ 40	$ 42	3.0%
Dental Exchange	$ -	$ -	$ 42	$ 42	$ -	$ -	$ 50	$ 50	17.4%

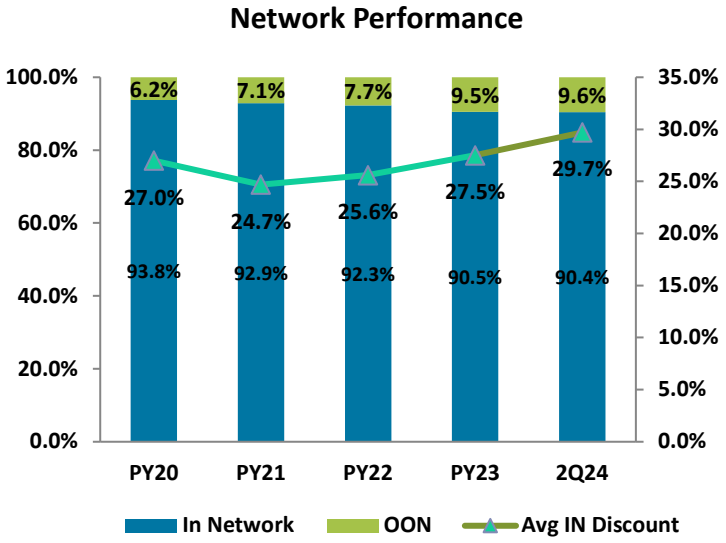
Dental Paid Claims – Total Participants

Dental Paid Claims - Total Total Participants	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 7,543,240	$ 1,088,262	$ 330,093	$ 8,961,594	$ 9,220,864	$ 817,648	$ 288,327	$ 10,326,839	15.2%
Dental Exchange	$ -	$ -	$ 2,524,921	$ 2,524,921	$ -	$ -	$ 2,892,249	$ 2,892,249	14.5%
Total	**$ 7,543,240**	**$ 1,088,262**	**$ 2,855,014**	**$ 11,486,515**	**$ 9,220,864**	**$ 817,648**	**$ 3,180,576**	**$ 13,219,088**	**15.1%**

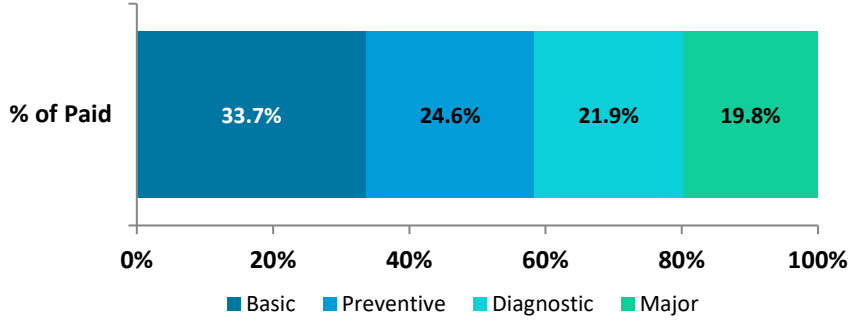
Dental Paid Claims - Per Participant per Month	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Dental	$ 48	$ 49	$ 49	$ 48	$ 58	$ 39	$ 43	$ 55	14.3%
Dental Exchange	$ -	$ -	$ 46	$ 46	$ -	$ -	$ 53	$ 53	15.0%

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	3,202	4.9%	12,798	19.1%	$5,234,024	39.6%	$3,122,895	50.0%
$750.01-$1,000.00	1,388	2.1%	4,288	6.4%	$1,214,790	9.2%	$731,656	11.7%
$500.01-$750.00	2,146	3.3%	5,854	8.7%	$1,342,922	10.2%	$752,913	12.1%
$250.01-$500.00	5,891	9.0%	12,898	19.2%	$2,022,635	15.3%	$662,513	10.6%
$0.01-$250.00	22,777	34.9%	30,276	45.1%	$3,404,717	25.8%	$925,572	14.8%
$0.00	686	1.1%	996	1.5%	$0	0.0%	$47,599	0.8%
No Claims	29,153	44.7%	0	0.0%	$0	0.0%	$0	0.0%
Total	**65,243**	**100.0%**	**67,110**	**100.0%**	**$13,219,088**	**100.0%**	**$6,243,148**	**100.0%**



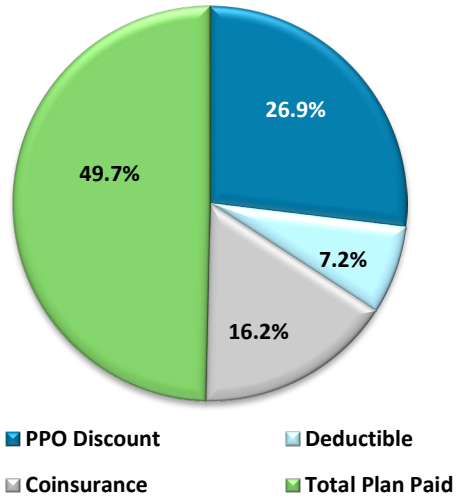
Claim Category	Total Paid	% of Paid
Basic	$4,457,088	33.7%
Preventive	$3,257,124	24.6%
Diagnostic	$2,889,420	21.9%
Major	$2,615,456	19.8%
Total	**$13,219,088**	**100.0%**

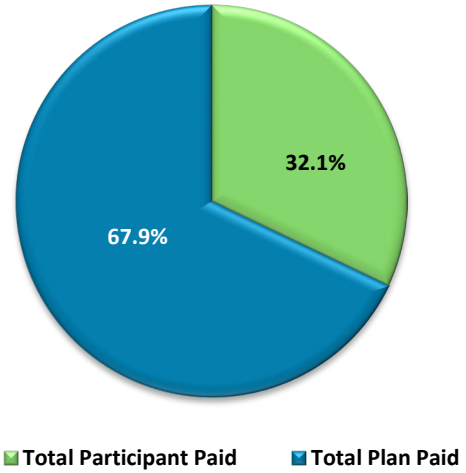


Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$26,669,192	$111	100.0%
PPO Discount	$7,160,982	$30	26.9%
Deductible	$1,925,442	$8	7.2%
Coinsurance	$4,317,706	$18	16.2%
Total Participant Paid	**$6,243,148**	**$26**	**23.4%**
Total Plan Paid	**$13,219,088**	**$55**	**49.6%**

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	1,000	975	25	97.5%
	<2 asthma related ER Visits in the last 6 months	1,000	1	999	0.1%
	No asthma related admit in last 12 months	1,000	5	995	0.5%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	234	9	225	3.8%
	Members with COPD who had an annual spirometry test	234	32	202	13.7%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	8	0	8	0.0%
	No ER Visit for Heart Failure in last 90 days	199	6	193	3.0%
	Follow-up OV within 4 weeks of discharge from HF admission	8	5	3	62.5%
Diabetes	Annual office visit	1,384	1,281	103	92.6%
	Annual dilated eye exam	1,384	499	885	36.1%
	Annual foot exam	1,384	631	753	45.6%
	Annual HbA1c test done	1,384	1,154	230	83.4%
	Diabetes Annual lipid profile	1,384	1,068	316	77.2%
	Annual microalbumin urine screen	1,384	940	444	67.9%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	3,981	3,173	808	79.7%
Hypertension	Annual lipid profile	3,893	2,652	1,241	68.1%
	Annual serum creatinine test	3,809	3,007	802	78.9%
Wellness	Well Child Visit - 15 months	933	528	405	56.6%
	Routine office visit in last 6 months (All Ages)	5,735	5,332	403	93.0%
	Colorectal cancer screening ages 45-75 within the appropriate time period	1,645	1,142	503	69.4%
	Women age 25-65 with recommended cervical cancer/HPV screening	1,703	1,336	367	78.4%
	Males age greater than 49 with PSA test in last 24 months	24,219	14,604	9,615	60.3%
	Routine exam in last 24 months (All Ages)	7,419	5,041	2,378	67.9%
	Women age 40 to 75 with a screening mammogram last 24 months	10,178	4,898	5,280	48.1%

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	175	0.72%	7.18	285.62	772.28	$18,806
Asthma	1,128	4.65%	46.30	133.67	658.51	$16,003
Atrial Fibrillation	285	1.18%	11.70	336.93	654.40	$34,359
Blood Disorders	1,625	6.70%	66.69	315.09	641.72	$33,500
CAD	596	2.46%	24.46	318.74	589.10	$30,912
COPD	231	0.95%	9.48	384.22	797.40	$33,598
Cancer	984	4.06%	40.39	229.83	344.31	$40,262
Chronic Pain	683	2.82%	28.03	194.01	716.09	$24,278
Congestive Heart Failure	198	0.82%	8.13	678.92	875.14	$57,415
Demyelinating Diseases	62	0.26%	2.54	154.06	423.51	$61,691
Depression	1,574	6.49%	64.60	156.33	482.07	$14,334
Diabetes	1,545	6.37%	63.41	143.85	393.68	$19,450
ESRD	36	0.15%	1.48	1,005.32	1,090.73	$123,351
Eating Disorders	78	0.32%	3.20	272.88	725.41	$23,410
HIV/AIDS	34	0.14%	1.40	121.13	405.80	$44,802
Hyperlipidemia	4,914	20.26%	201.68	96.11	303.98	$14,153
Hypertension	3,921	16.17%	160.93	118.54	391.44	$15,635
Immune Disorders	130	0.54%	5.34	436.58	635.75	$72,162
Inflammatory Bowel Disease	92	0.38%	3.78	198.22	462.77	$48,730
Liver Diseases	520	2.14%	21.34	294.66	707.13	$31,530
Morbid Obesity	760	3.13%	31.19	205.24	534.03	$19,940
Osteoarthritis	1,070	4.41%	43.91	142.68	440.05	$21,606
Peripheral Vascular Disease	167	0.69%	6.85	349.85	600.89	$33,028
Rheumatoid Arthritis	142	0.59%	5.83	135.02	448.80	$35,088

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

Data Includes Medical and Pharmacy
Based on 24 months incurred dates

Methodology

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

Public Employees' Benefits Program - RX Costs
PY 2024 - Through Quarter Ending December 31, 2023

Express Scripts

Membership Summary	1Q-2Q FY2024 CDHP	1Q-2Q FY2023 CDHP	Difference	% Change
			Membership Summary	
Member Count (Membership)	24,297	28,010	(3,713)	-13.3%
Utilizing Member Count (Patients)	14,819	18,037	(3,218)	-17.8%
Percent Utilizing (Utilization)	61.0%	64.4%	(0.03)	-5.3%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	170,990	193,380	(22,390)	-11.6%
Claims per Elig Member per Month (Claims PMPM)	1.17	1.15	0.02	1.7%
Total Claims for Generic (Generic Rx)	147,083	163,487	(16,404.00)	-10.0%
Total Claims for Brand (Brand Rx)	23,907	29,893	(5,986.00)	-20.0%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	754	769	(15.00)	-2.0%
Total Non-Specialty Claims	169,049	190,774	(21,725.00)	-11.4%
Total Specialty Claims	1,941	2,606	(665.00)	-25.5%
Generic % of Total Claims (GFR)	**86.0%**	**84.5%**	0.01	1.7%
Generic Effective Rate (GCR)	**99.5%**	**99.5%**	(0.00)	0.0%
Mail Order Claims	46,573	51,531	(4,958.00)	-9.6%
Mail Penetration Rate*	31.4%	31.1%	0.00	0.3%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$21,492,348	$21,518,275	($25,927.00)	-0.1%
Total Generic Gross Cost	$2,170,769	$2,494,885	($324,116.00)	-13.0%
Total Brand Gross Cost	$19,321,579	$19,023,390	$298,189.00	1.6%
Total MSB Gross Cost	$322,777	$441,855	($119,078.00)	-26.9%
Total Ingredient Cost	$20,692,082	$21,173,079	($480,997.00)	-2.3%
Total Dispensing Fee	$786,385	$323,875	$462,510.00	142.8%
Total Other (e.g. tax)	$13,880	$21,320	($7,440.00)	-34.9%
Avg Total Cost per Claim (Gross Cost/Rx)	**$125.69**	**$111.27**	$14.42	13.0%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$14.76	$15.26	($0.50)	-3.3%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$808.20	$636.38	$171.82	27.0%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$428.09	$574.58	($146.49)	-25.5%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$4,776,329**	**$5,065,371**	($289,042.00)	-5.7%
Total Copay	$3,630,113	$3,685,708	($55,595.00)	-1.5%
Total Deductible	$1,146,216	$1,379,663	($233,447.00)	-16.9%
Avg Copay per Claim (Copay/Rx)	$27.93	$19.06	$8.87	46.5%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$27.93**	**$26.19**	**$1.74**	**6.6%**
Avg Copay for Generic (Copay/Generic Rx)	$7.17	$7.64	($0.47)	-6.2%
Avg Copay for Brand (Copay/Brand Rx)	$155.67	$127.69	$27.98	21.9%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$98.33	$174.98	($76.65)	-43.8%
Net PMPM (Participant Cost PMPM)	**$32.76**	**$30.14**	$2.62	8.7%
Copay % of Total Prescription Cost (Member Cost Share %)	22.2%	23.5%	-1.3%	-5.6%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$16,716,019**	**$16,452,903**	**$263,116.00**	**1.6%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$6,877,440	$5,830,693	$1,046,747.00	18.0%
Total Specialty Drug Cost (Specialty Plan Cost)	$9,838,579	$10,622,210	($783,631.00)	-7.4%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$97.76**	**$85.08**	$12.68	14.9%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$7.59	$7.62	($0.03)	-0.4%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$652.53	$508.69	$143.84	28.3%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$329.76	$399.60	($69.84)	-17.5%
Net PMPM (Plan Cost PMPM)	**$114.66**	**$97.90**	**$16.77**	**17.1%**
PMPM without Specialty (Non-Specialty PMPM)	$47.18	$34.69	$4.02	17.3%
PMPM for Specialty Only (Specialty PMPM)	$67.49	$63.20	$4.29	6.8%
Specialty % of Plan Cost	58.9%	64.6%	($0.06)	-8.8%
Rebates Received (Q1-Q2 FY2024 actual)	$2,734,938	$5,876,725	($3,141,786.94)	-53.5%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$95.90**	**$62.93**	**$32.97**	**52.4%**
PMPM without Specialty (Non-Specialty PMPM)	$27.76	$14.27	$0.92	5.0%
PMPM for Specialty Only (Specialty PMPM)	$45.63	$48.87	($3.24)	-6.6%

Appendix B

Index of Tables
UMR Inc. – LDPPO Utilization Review for PEBP
July 1, 2023 – December 31, 2023

DATASCOPE™

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

UMR℠

Overview

- Total Medical Spend for 2Q24 was $36,980422 with a plan cost per employee per year (PEPY) of $7,706. This is an increase of 14.0% when compared to 2Q23.
  - IP Cost per Admit is $23,559 which is 1.0% higher than 2Q23.
  - ER Cost per Visit is $3,125 which is 1.7% lower than 2Q23.
- Employees shared in 14.5% of the medical cost.
- Inpatient facility costs were 17.7% of the plan spend.
- 87.6% of the Average Membership had paid Medical claims less than $2,500, with 25.1% of those having no claims paid at all during the reporting period.
- 34 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 19.7% of the plan spend. The highest diagnosis category was Cancer, accounting for 27.3% of the high-cost claimant dollars.
- Total spending with in-network providers was 98.3%. The average In Network discount was 65.1%, which is 1.2% higher than the PY23 average discount of 64.3%.

Paid Claims by Age Group

Paid Claims by Age Group																
	2Q23						2Q24						% 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	$ 952,206	$ 1,037	$ 12,813	$ 14	$ 965,019	$ 1,051	$ 2,801,418	$ 2,394	$ 3,784	$ 3	$ 2,805,202	$ 2,398	190.7%	128.1%
1	$ 200,437	$ 235	$ 4,730	$ 6	$ 205,167	$ 241	$ 238,701	$ 206	$ 2,062	$ 2	$ 240,763	$ 208	17.3%	-13.7%
2 - 4	$ 519,289	$ 159	$ 24,713	$ 8	$ 544,002	$ 167	$ 506,184	$ 126	$ 23,240	$ 6	$ 529,424	$ 132	-2.7%	-20.9%
5 - 9	$ 461,813	$ 80	$ 291,974	$ 51	$ 753,787	$ 131	$ 1,003,724	$ 135	$ 298,836	$ 40	$ 1,302,560	$ 175	72.8%	33.6%
10 - 14	$ 840,770	$ 135	$ 164,248	$ 26	$ 1,005,018	$ 161	$ 1,150,756	$ 142	$ 243,615	$ 30	$ 1,394,371	$ 172	38.7%	6.9%
15 - 19	$ 1,017,142	$ 144	$ 252,305	$ 36	$ 1,269,447	$ 179	$ 1,450,433	$ 154	$ 377,061	$ 40	$ 1,827,494	$ 194	44.0%	8.4%
20 - 24	$ 1,074,808	$ 160	$ 356,576	$ 53	$ 1,431,384	$ 213	$ 1,847,112	$ 207	$ 477,139	$ 54	$ 2,324,251	$ 261	62.4%	22.4%
25 - 29	$ 894,828	$ 168	$ 500,318	$ 94	$ 1,395,146	$ 262	$ 1,938,318	$ 260	$ 899,762	$ 121	$ 2,838,080	$ 381	103.4%	45.0%
30 - 34	$ 1,698,193	$ 266	$ 468,856	$ 73	$ 2,167,049	$ 339	$ 2,394,013	$ 273	$ 1,893,236	$ 216	$ 4,287,249	$ 489	97.8%	44.4%
35 - 39	$ 1,949,915	$ 267	$ 718,780	$ 98	$ 2,668,695	$ 365	$ 2,984,988	$ 312	$ 1,316,943	$ 138	$ 4,301,931	$ 450	61.2%	23.2%
40 - 44	$ 2,008,733	$ 286	$ 1,134,778	$ 162	$ 3,143,511	$ 448	$ 2,943,297	$ 308	$ 1,577,528	$ 165	$ 4,520,825	$ 473	43.8%	5.6%
45 - 49	$ 2,542,958	$ 401	$ 1,026,465	$ 162	$ 3,569,423	$ 563	$ 2,657,480	$ 321	$ 1,686,994	$ 204	$ 4,344,474	$ 525	21.7%	-6.7%
50 - 54	$ 2,872,067	$ 423	$ 1,435,335	$ 211	$ 4,307,402	$ 634	$ 3,588,380	$ 384	$ 2,347,289	$ 251	$ 5,935,669	$ 636	37.8%	0.3%
55 - 59	$ 2,848,976	$ 468	$ 1,251,320	$ 205	$ 4,100,296	$ 673	$ 4,499,551	$ 543	$ 2,430,893	$ 294	$ 6,930,444	$ 837	69.0%	24.3%
60 - 64	$ 3,233,417	$ 594	$ 1,923,145	$ 353	$ 5,156,562	$ 948	$ 4,681,416	$ 658	$ 2,505,809	$ 352	$ 7,187,225	$ 1,011	39.4%	6.7%
65+	$ 843,930	$ 412	$ 471,496	$ 230	$ 1,315,426	$ 643	$ 2,294,651	$ 805	$ 830,919	$ 292	$ 3,125,570	$ 1,097	137.6%	70.6%
Total	**$ 23,959,484**	**$ 287**	**$ 10,037,853**	**$ 120**	**$ 33,997,337**	**$ 407**	**$ 36,980,422**	**$ 332**	**$ 16,915,110**	**$ 152**	**$ 53,895,532**	**$ 484**	**58.5%**	**18.9%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	3,075	7,088	9,598	35.4%	3,595	6,433	8,760	36.2%	0	1	1	0.0%
Spouses	1,113	1,817	2,372	30.6%	992	1,608	2,107	31.0%	0	1	1	0.0%
Children	3,974	5,025	6,594	31.2%	2,945	4,782	6,287	31.5%	0	0	0	0.0%
Total Members	8,161	13,930	18,564	33.3%	7,531	12,824	17,153	33.8%	1	2	2	0.0%
Family Size	2.1	2.0	1.9	-3.5%	2.1	2.0	2.0	-2.0%	2.0	2.0	2.0	0.0%
Financial Summary												
Gross Cost	$19,582,093	$28,044,415	$43,255,350	54.2%	$16,875,837	$24,386,794	$37,942,282	55.6%	$20,089	$9,392	$16,700	77.8%
Client Paid	$16,486,768	$23,959,484	$36,980,422	54.3%	$14,156,779	$20,789,498	$32,352,329	55.6%	$16,221	$7,316	$13,253	81.2%
Employee Paid	$3,095,325	$4,084,930	$6,274,928	53.6%	$2,719,057	$3,597,296	$5,589,952	55.4%	$3,869	$2,077	$3,447	66.0%
Client Paid-PEPY	$8,298	$6,759	$7,706	14.0%	$7,876	$6,462	$7,387	14.3%	$32,442	$14,632	$26,507	81.2%
Client Paid-PMPY	$4,040	$3,440	$3,984	15.8%	$3,759	$3,242	$3,772	16.3%	$16,221	$7,316	$13,253	81.2%
Client Paid-PEPM	$692	$563	$642	14.0%	$656	$539	$616	14.3%	$2,703	$1,219	$2,209	81.2%
Client Paid-PMPM	$337	$287	$332	15.7%	$313	$270	$314	16.3%	$1,352	$610	$1,104	81.0%
High Cost Claimants (HCC's) > $100k												
# of HCC's	23	18	34	88.9%	18	14	28	100.0%	0	0	0	0.0%
HCC's / 1,000	2.8	1.3	1.8	41.9%	2.4	1.1	1.6	49.5%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$265,379	$233,855	$214,258	-8.4%	$283,321	$248,746	$213,081	-14.3%	$0	$0	$0	0.0%
HCC's % of Plan Paid	37.0%	17.6%	19.7%	11.9%	36.0%	16.8%	18.4%	9.5%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,461	$683	$707	3.5%	$1,401	$619	$672	8.6%	$0	$0	$0	0.0%
Facility Outpatient	$970	$1,194	$1,561	30.7%	$861	$1,112	$1,442	29.7%	$5,328	$491	$1,027	109.2%
Physician	$1,557	$1,563	$1,716	9.8%	$1,447	$1,512	$1,658	9.7%	$10,893	$6,825	$12,226	79.1%
Other	$52	$0	$0	0.0%	$51	$0	$0	0.0%	$0	$0	$0	0.0%
Total	$4,040	$3,440	$3,984	15.8%	$3,759	$3,242	$3,772	16.3%	$16,221	$7,316	$13,253	81.2%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	357	627	808	28.7%	21	27	30	11.8%	
Spouses	109	195	252	28.9%	11	12	13	6.9%	
Children	130	243	306	25.7%	0	0	1	0.0%	
Total Members	596	1,066	1,365	28.1%	32	39	44	12.4%	
Family Size	1.7	1.7	1.7	-0.6%	1.5	1.4	1.5	4.3%	1.6
Financial Summary									
Gross Cost	$2,523,590	$3,554,103	$5,136,556	44.5%	$162,576	$94,126	$159,812	69.8%	
Client Paid	$2,184,001	$3,088,200	$4,504,317	45.9%	$129,767	$74,470	$110,522	48.4%	
Employee Paid	$339,589	$465,903	$632,239	35.7%	$32,809	$19,656	$49,290	150.8%	
Client Paid-PEPY	$12,241	$9,845	$11,156	13.3%	$12,261	$5,551	$7,368	32.7%	$6,258
Client Paid-PMPY	$7,329	$5,795	$6,601	13.9%	$8,068	$3,835	$5,043	31.5%	$3,830
Client Paid-PEPM	$1,020	$820	$930	13.4%	$1,022	$463	$614	32.6%	$521
Client Paid-PMPM	$611	$483	$550	13.9%	$672	$320	$420	31.3%	$319
High Cost Claimants (HCC's) > $100k									
# of HCC's	6	4	7	0.0%	0	0	0	0.0%	
HCC's / 1,000	10.1	3.8	5.1	0.0%	0.0	0.0	0.0	0.0%	
Avg HCC Paid	$167,323	$181,739	$188,359	0.0%	$0	$0	$0	0.0%	
HCC's % of Plan Paid	46.0%	23.5%	29.3%	0.0%	0.0%	0.0%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$2,281	$1,469	$1,119	-23.8%	$552	$324	$1,414	0.0%	$1,044
Facility Outpatient	$2,141	$2,179	$3,035	39.3%	$4,599	$1,368	$2,159	57.8%	$1,310
Physician	$2,842	$2,147	$2,446	13.9%	$2,852	$2,143	$1,470	-31.4%	$1,404
Other	$65	$0	$0	0.0%	$65	$0	$0	0.0%	$72
Total	$7,329	$5,795	$6,601	13.9%	$8,068	$3,835	$5,043	31.5%	$3,830
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

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

	Total				State Active				Non-State Active			
Summary	**PY22**	**PY23**	**2Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**2Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**2Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	4,336	7,362	9,598	30.4%	3,926	6,690	8,760	30.9%	1	1	1	0.0%
Spouses	1,172	5,149	2,372	-53.9%	1,042	4,901	2,107	-57.0%	1	0	1	0.0%
Children	3,255	1,857	6,594	255.1%	3,103	1,645	6,287	282.3%	0	1	0	-100.0%
Total Members	8,762	14,368	18,564	29.2%	8,071	13,235	17,153	29.6%	2	2	2	0.0%
Family Size	2.0	2.0	1.9	-1.0%	2.1	2.0	2.0	-1.0%	2.0	2.0	2.0	0.0%
Financial Summary												
Gross Cost	$40,570,436	$64,817,531	$43,255,350	-33.3%	$35,366,785	$56,350,280	$37,942,282	-32.7%	$38,494	$17,911	$16,700	-6.8%
Client Paid	$34,446,692	$55,997,776	$36,980,422	-34.0%	$29,933,591	$48,495,839	$32,352,329	-33.3%	$33,556	$13,953	$13,253	-5.0%
Employee Paid	$6,123,744	$8,819,755	$6,274,928	-28.9%	$5,433,194	$7,854,441	$5,589,952	-28.8%	$4,938	$3,958	$3,447	-12.9%
Client Paid-PEPY	$7,944	$7,606	$7,706	1.3%	$7,624	$7,249	$7,387	1.9%	$33,556	$13,953	$26,507	90.0%
Client Paid-PMPY	$3,931	$3,897	$3,984	2.2%	$3,709	$3,664	$3,772	2.9%	$16,778	$6,976	$13,253	90.0%
Client Paid-PEPM	$662	$634	$642	1.3%	$635	$604	$616	2.0%	$2,796	$1,163	$2,209	89.9%
Client Paid-PMPM	$328	$325	$332	2.2%	$309	$305	$314	3.0%	$1,398	$581	$1,104	90.0%
High Cost Claimants (HCC's) > $100k												
# of HCC's	41	54	34	-37.0%	33	43	28	-34.9%	0	0	0	0.0%
HCC's / 1,000	4.7	3.8	1.8	-51.3%	4.1	3.3	1.6	-49.8%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$286,071	$238,672	$214,258	-10.2%	$305,172	$238,047	$213,081	-10.5%	$0	$0	$0	0.0%
HCC's % of Plan Paid	34.0%	23.0%	19.7%	-14.3%	33.6%	21.1%	18.4%	-12.8%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,269	$783	$707	-9.7%	$1,257	$725	$672	-7.3%	$424	$0	$0	0.0%
Facility Outpatient	$1,043	$1,412	$1,561	10.6%	$933	$1,292	$1,442	11.6%	$5,152	$1,007	$1,027	2.0%
Physician	$1,567	$1,702	$1,716	0.8%	$1,468	$1,647	$1,658	0.7%	$9,883	$5,969	$12,226	104.8%
Other	$53	$0	$0	0.0%	$50	$0	$0	0.0%	$1,319	$0	$0	0.0%
Total	$3,931	$3,897	$3,984	2.2%	$3,709	$3,664	$3,772	2.9%	$16,778	$6,976	$13,253	90.0%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY22**	**PY23**	**2Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**2Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	388	644	808	25.3%	21	27	30	12.5%	
Spouses	118	248	252	1.3%	11	0	13	7601.1%	
Children	152	199	306	54.0%	0	13	1	-92.0%	
Total Members	657	1,091	1,365	25.1%	32	39	44	11.4%	
Family Size	1.7	1.7	1.7	0.0%	1.5	1.5	1.5	-1.4%	1.6
Financial Summary									
Gross Cost	$4,886,927	$8,012,597	$5,136,556	-35.9%	$278,229	$436,743	$159,812	-63.4%	
Client Paid	$4,252,910	$7,107,682	$4,504,317	-36.6%	$226,635	$380,303	$110,522	-70.9%	
Employee Paid	$634,017	$904,915	$632,239	-30.1%	$51,594	$56,440	$49,290	-12.7%	
Client Paid-PEPY	$10,968	$11,032	$11,156	1.1%	$10,665	$14,261	$7,368	-48.3%	$6,258
Client Paid-PMPY	$6,473	$6,514	$6,601	1.3%	$7,027	$9,669	$5,043	-47.8%	$3,830
Client Paid-PEPM	$914	$919	$930	1.2%	$889	$1,188	$614	-48.3%	$521
Client Paid-PMPM	$539	$543	$550	1.3%	$586	$806	$420	-47.9%	$319
High Cost Claimants (HCC's) > $100k									
# of HCC's	8	11	7	-36.4%	1	1	0	-100.0%	
HCC's / 1,000	12.2	10.1	5.1	-49.1%	31.0	25.4	0.0	-100.0%	
Avg HCC Paid	$193,399	$224,298	$188,359	-16.0%	$111,053	$185,019	$0	-100.0%	
HCC's % of Plan Paid	36.4%	34.7%	29.3%	-15.6%	49.0%	48.7%	0.0%	-100.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,452	$1,476	$1,119	-24.2%	$675	$1,128	$1,414	25.4%	$1,044
Facility Outpatient	$2,262	$2,697	$3,035	12.5%	$3,333	$6,277	$2,159	-65.6%	$1,310
Physician	$2,676	$2,342	$2,446	4.4%	$2,969	$2,264	$1,470	-35.1%	$1,404
Other	$83	$0	$0	0.0%	$50	$0	$0	0.0%	$72
Total	$6,473	$6,514	$6,601	1.3%	$7,027	$9,669	$5,043	-47.8%	$3,830
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 4,809,745	$ 4,304	$ 874,647	$ 5,688,696	$ 7,038,357	$ 807,761	$ 10,049	$ 7,856,168	38.1%
Outpatient	$ 15,979,754	$ 50,099	$ 2,159,150	$ 18,189,003	$ 25,313,972	$ 3,477,125	$ 209,381	$ 29,000,479	59.4%
Total - Medical	**$ 20,789,498**	**$ 54,403**	**$ 3,033,797**	**$ 23,877,699**	**$ 32,352,329**	**$ 4,284,886**	**$ 219,431**	**$ 36,856,646**	**54.4%**

Net Paid Claims - Per Participant per Month	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 539	$ 15	$ 12,855	$ 564	$ 616	$ 953	$ 627	$ 642	13.9%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 6,740	$ 564	$ 7,304			$ 31,856	$ 31,856	0.0%
Outpatient	$ 7,316	$ 47,465	$ 19,700	$ 74,481	$ 13,253	$ 5,742	$ 72,924	$ 91,919	23.4%
Total - Medical	**$ 7,316**	**$ 54,205**	**$ 20,265**	**$ 81,786**	**$ 13,253**	**$ 5,742**	**$ 104,780**	**$ 123,775**	**51.3%**

Net Paid Claims - Per Participant per Month	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 1,219	$ 630	$ 270	$ 490	$ 2,209	$ 93	$ 888	$ 665	35.9%

Paid Claims by Claim Type – Total Participants

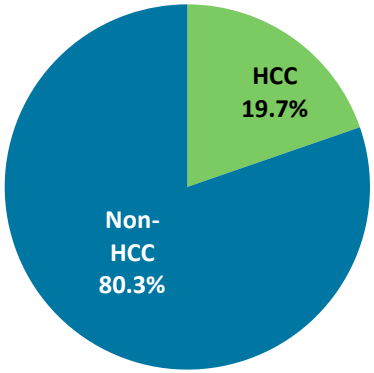
Net Paid Claims - Total Total Participants	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 4,809,745	$ 11,044	$ 875,211	$ 5,696,000	$ 7,038,357	$ 807,761	$ 41,906	$ 7,888,024	38.5%
Outpatient	$ 15,987,070	$ 97,564	$ 2,178,850	$ 18,263,484	$ 25,327,225	$ 3,482,867	$ 282,305	$ 29,092,398	59.3%
Total - Medical	**$ 20,796,814**	**$ 108,608**	**$ 3,054,062**	**$ 23,959,484**	**$ 32,365,583**	**$ 4,290,628**	**$ 324,211**	**$ 36,980,422**	**54.3%**

Net Paid Claims - Per Participant per Month	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 539	$ 30	$ 9,820	$ 563	$ 616	$ 942	$ 693	$ 642	14.0%

Cost Distribution – Medical Claims

2Q23							2Q24					
Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid	Paid Claims Category	Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
17	0.1%	$4,209,398	17.6%	$72,124	1.8%	$100,000.01 Plus	28	0.2%	$7,193,404	19.5%	$124,977	2.0%
41	0.3%	$3,128,054	13.1%	$174,984	4.3%	$50,000.01-$100,000.00	48	0.3%	$3,330,110	9.0%	$200,409	3.2%
67	0.5%	$2,366,111	9.9%	$246,522	6.0%	$25,000.01-$50,000.00	118	0.6%	$4,074,450	11.0%	$408,795	6.5%
269	1.9%	$4,293,330	17.9%	$710,874	17.4%	$10,000.01-$25,000.00	431	2.3%	$6,890,528	18.6%	$1,089,431	17.4%
356	2.6%	$2,549,174	10.6%	$571,665	14.0%	$5,000.01-$10,000.00	614	3.3%	$4,499,679	12.2%	$926,383	14.8%
624	4.5%	$2,315,355	9.7%	$636,009	15.6%	$2,500.01-$5,000.00	1,048	5.6%	$3,773,638	10.2%	$1,032,085	16.4%
8,683	62.3%	$5,098,063	21.3%	$1,667,131	40.8%	$0.01-$2,500.00	11,368	61.2%	$7,218,612	19.5%	$2,468,508	39.3%
121	0.9%	$0	0.0%	$5,623	0.1%	$0.00	240	1.3%	$0	0.0%	$24,339	0.4%
3,754	27.0%	$0	0.0%	$0	0.0%	No Claims	4,668	25.1%	$0	0.0%	$0	0.0%
13,931	**100.0%**	**$23,959,484**	**100.0%**	**$4,084,930**	**100.0%**		**18,564**	**100.0%**	**$36,980,422**	**100.0%**	**$6,274,928**	**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	12	$1,992,176	27.3%
Cardiac Disorders	9	$1,205,259	16.5%
Pregnancy-related Disorders	8	$1,106,565	15.2%
Neurological Disorders	14	$1,090,100	15.0%
Endocrine/Metabolic Disorders	8	$307,105	4.2%
Pulmonary Disorders	16	$280,636	3.9%
Medication Related Conditions	3	$259,129	3.6%
Spine-related Disorders	8	$245,949	3.4%
Gastrointestinal Disorders	18	$140,755	1.9%
Medical/Surgical Complications	5	$121,716	1.7%
All Other		$535,395	7.3%
Overall	**----**	**$7,284,785**	**100.0%**

Utilization Summary (p. 1 of 2)

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

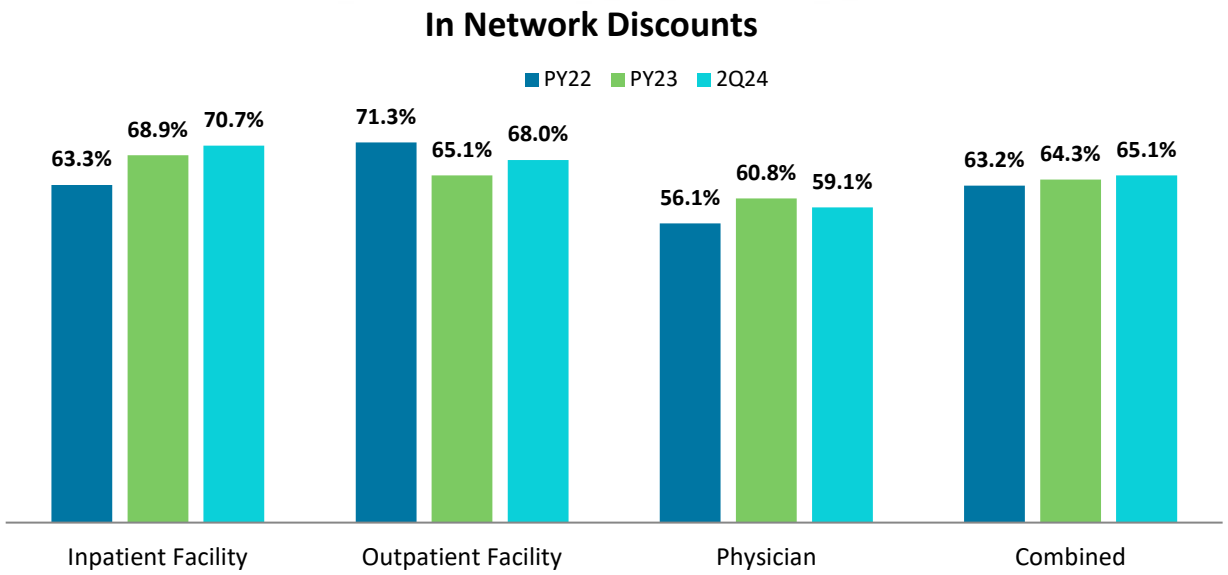
	Total				State Active				Non-State Active			
Summary	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**
Inpatient Facility												
# of Admits	157	239	333		132	215	303		0	0	0	
# of Bed Days	779	1,039	1,667		694	940	1,486		0	0	0	
Paid Per Admit	$36,610	$23,315	$23,559	1.0%	$36,703	$21,956	$23,124	5.3%	$0	$0	$0	0.0%
Paid Per Day	$7,378	$5,363	$4,706	-12.3%	$6,981	$5,022	$4,715	-6.1%	$0	$0	$0	0.0%
Admits Per 1,000	38	34	36	5.9%	35	34	35	2.9%	0	0	0	0.0%
Days Per 1,000	191	149	180	20.8%	184	147	173	17.7%	0	0	0	0.0%
Avg LOS	5	4.3	5	16.3%	5.3	4.4	4.9	11.4%	0	0	0	0.0%
# Admits From ER	79	111	169	52.3%	63	97	151	55.7%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	4.6	4.5	5.3	17.8%	4.5	4.4	5.2	18.2%	11.0	12.0	12.0	0.0%
Avg Paid per OV	$133	$116	$120	3.4%	$124	$115	$119	3.5%	$228	$340	$492	44.7%
Avg OV Paid per Member	$616	$525	$637	21.3%	$560	$508	$619	21.9%	$2,513	$4,076	$5,903	44.8%
DX&L Utilization per Member	8.1	9.5	10.4	9.5%	7.7	9.1	10	9.9%	33	30	22	-26.7%
Avg Paid per DX&L	$48	$59	$65	10.2%	$45	$58	$63	8.6%	$111	$63	$150	138.1%
Avg DX&L Paid per Member	$387	$562	$679	20.8%	$345	$523	$628	20.1%	$3,658	$1,876	$3,303	76.1%
Emergency Room												
# of Visits	532	958	1,544		496	878	1,427		0	0	0	
Visits Per Member	0.13	0.14	0.17	21.4%	0.13	0.14	0.17	21.4%	0	0	0	0.0%
Visits Per 1,000	130	138	166	20.3%	132	137	166	21.2%	0	0	0	0.0%
Avg Paid per Visit	$2,338	$3,179	$3,125	-1.7%	$2,302	$3,204	$3,121	-2.6%	$0	$0	$0	0.0%
Urgent Care												
# of Visits	1,270	2,596	3,435		1,188	2,465	3,246		0	1	2	
Visits Per Member	0.31	0.37	0.37	0.0%	0.32	0.38	0.38	0.0%	0.00	1.00	2.00	0.0%
Visits Per 1,000	311	373	370	-0.8%	315	384	378	-1.6%	0	1,000	2,000	0.0%
Avg Paid per Visit	$119	$101	$104	3.0%	$118	$101	$105	4.0%	$0	$170	$170	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

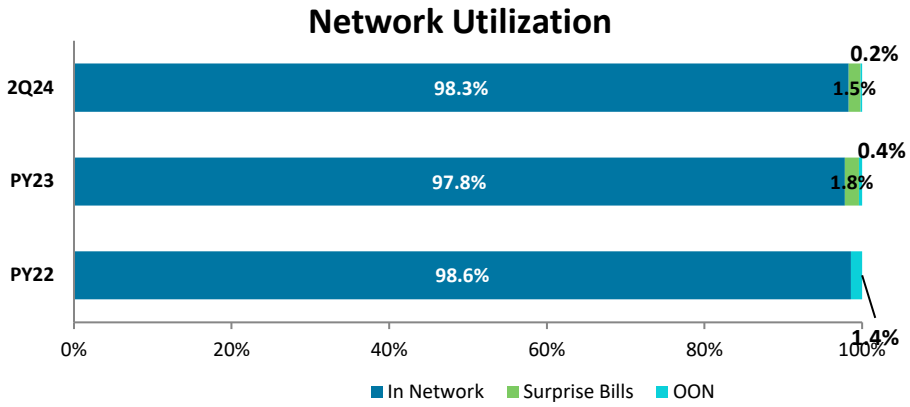
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**Peer Index**
Inpatient Facility									
# of Admits	20	23	28		5	1	2		
# of Bed Days	71	96	166		14	3	15		
Paid Per Admit	$43,865	$36,656	$29,894	-18.4%	$5,130	$8,577	$786	0.0%	$19,305
Paid Per Day	$12,356	$8,782	$5,042	-42.6%	$1,832	$2,859	$105	0.0%	$3,615
Admits Per 1,000	67	43	41	-4.7%	311	52	91	0.0%	64
Days Per 1,000	238	180	243	35.0%	870	155	684	0.0%	342
Avg LOS	3.6	4.2	5.9	40.5%	2.8	3.0	7.5	0.0%	5.3
# Admits From ER	14	14	17		2	0	1	0.0%	
Physician Office									
OV Utilization per Member	6.3	6.1	6.6	8.2%	6.2	7.5	7.8	4.0%	5.2
Avg Paid per OV	$209	$118	$129	9.3%	$108	$83	$77	-7.2%	$97
Avg OV Paid per Member	$1,318	$719	$847	17.8%	$671	$625	$601	-3.8%	$502
DX&L Utilization per Member	13	14.2	14	-1.4%	14.4	17	24.6	44.7%	9.0
Avg Paid per DX&L	$67	$72	$93	29.2%	$77	$45	$38	-15.6%	$46
Avg DX&L Paid per Member	$875	$1,018	$1,306	28.3%	$1,107	$763	$932	22.1%	$412
Emergency Room									
# of Visits	35	77	113		1	3	4		
Visits Per Member	0.12	0.14	0.17	21.4%	0.06	0.15	0.18	20.0%	0.23
Visits Per 1,000	117	144	166	15.3%	62	155	183	18.1%	228
Avg Paid per Visit	$2,860	$2,961	$2,935	-0.9%	$1,827	$1,260	$9,740	673.0%	$1,035
Urgent Care									
# of Visits	80	129	184		2	1	3		
Visits Per Member	0.27	0.24	0.27	12.5%	0.12	0.05	0.14	180.0%	0.38
Visits Per 1,000	268	242	270	11.6%	124	52	137	163.5%	379
Avg Paid per Visit	$146	$101	$102	1.0%	$70	$52	$68	30.8%	$132
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$3,245,740	8.8%	$1,757,762	$1,483,467	$4,512	$1,414,837	$1,830,903
Health Status/Encounters	$3,179,689	8.6%	$1,796,283	$435,168	$948,238	$1,062,658	$2,117,031
Gastrointestinal Disorders	$3,139,405	8.5%	$2,062,759	$618,653	$457,994	$1,267,876	$1,871,530
Cardiac Disorders	$3,138,960	8.5%	$2,253,334	$425,563	$460,062	$707,981	$2,430,978
Pregnancy-related Disorders	$3,136,131	8.5%	$1,078,448	$576,845	$1,480,838	$731,771	$2,404,360
Neurological Disorders	$2,566,534	6.9%	$1,188,910	$283,152	$1,094,472	$1,321,244	$1,245,290
Mental Health	$2,549,000	6.9%	$1,138,235	$224,958	$1,185,807	$823,009	$1,725,992
Musculoskeletal Disorders	$2,106,645	5.7%	$1,362,397	$443,428	$300,819	$862,987	$1,243,658
Trauma/Accidents	$1,754,348	4.7%	$879,303	$213,252	$661,792	$873,727	$880,620
Eye/ENT Disorders	$1,750,968	4.7%	$982,332	$240,478	$528,159	$763,719	$987,249
Spine-related Disorders	$1,400,349	3.8%	$985,751	$314,240	$100,358	$567,309	$833,040
Gynecological/Breast Disorders	$1,355,362	3.7%	$865,171	$305,316	$184,875	$43,615	$1,311,747
Pulmonary Disorders	$1,258,453	3.4%	$591,068	$197,823	$469,562	$620,996	$637,457
Endocrine/Metabolic Disorders	$1,150,324	3.1%	$1,001,002	$107,689	$41,633	$157,398	$992,926
Renal/Urologic Disorders	$1,059,521	2.9%	$665,402	$215,938	$178,182	$537,878	$521,644
Infections	$597,093	1.6%	$318,139	$96,502	$182,453	$244,305	$352,788
Non-malignant Neoplasm	$529,110	1.4%	$393,566	$96,459	$39,085	$126,793	$402,318
Miscellaneous	$422,001	1.1%	$248,508	$75,066	$98,426	$192,054	$229,947
Medical/Surgical Complications	$396,465	1.1%	$258,470	$6,755	$131,241	$250,464	$146,001
Medication Related Conditions	$379,273	1.0%	$54,884	$275,482	$48,907	$52,420	$326,852
Dermatological Disorders	$372,594	1.0%	$244,731	$60,218	$67,645	$152,037	$220,556
Diabetes	$344,790	0.9%	$234,641	$44,890	$65,258	$155,716	$189,074
Congenital/Chromosomal Anomalies	$298,009	0.8%	$100,172	$47,621	$150,215	$154,297	$143,712
Abnormal Lab/Radiology	$288,467	0.8%	$232,044	$35,610	$20,813	$102,440	$186,027
Vascular Disorders	$231,889	0.6%	$201,528	$20,346	$10,015	$85,817	$146,073
Hematological Disorders	$165,625	0.4%	$148,549	$8,572	$8,503	$33,798	$131,827
Cholesterol Disorders	$91,989	0.2%	$74,268	$14,905	$2,816	$39,596	$52,394
Allergic Reaction	$34,412	0.1%	$12,851	$3,038	$18,523	$6,083	$28,329
Dental Conditions	$29,504	0.1%	$12,200	$2,874	$14,429	$7,630	$21,873
External Hazard Exposure	$7,344	0.0%	$1,966	$196	$5,182	$6,362	$982
Social Determinants of Health	$429	0.0%	$0	$139	$289	$133	$295
Cause of Morbidity	$0	0.0%	$0	$0	$0	$0	$0
Total	**$36,980,422**	**100.0%**	**$21,144,673**	**$6,874,646**	**$8,961,103**	**$13,366,949**	**$23,613,473**

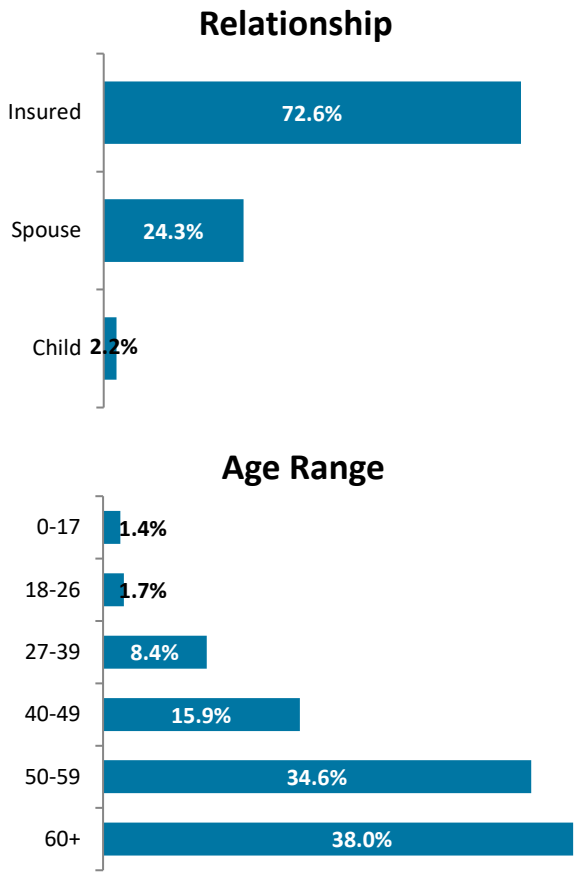
Mental Health Drilldown

	PY22		PY23		2Q24	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	453	$568,975	883	$898,381	890	$764,613
Mood and Anxiety Disorders	613	$271,735	1,144	$681,784	1,102	$419,620
Mental Health Conditions, Other	431	$351,519	805	$558,645	776	$402,811
Developmental Disorders	59	$215,640	108	$250,524	103	$294,434
Alcohol Abuse/Dependence	20	$75,926	77	$344,280	51	$177,031
Bipolar Disorder	107	$247,201	189	$253,234	191	$144,819
Sexually Related Disorders	28	$8,553	55	$30,340	58	$110,751
Attention Deficit Disorder	199	$80,894	414	$132,119	444	$95,850
Eating Disorders	24	$147,776	44	$141,298	30	$69,354
Sleep Disorders	124	$26,517	242	$63,421	180	$24,959
Substance Abuse/Dependence	29	$68,285	51	$34,292	41	$17,193
Schizophrenia	4	$2,259	12	$47,488	7	$9,922
Personality Disorders	14	$15,495	17	$12,003	20	$8,061
Psychoses	6	$10,965	17	$18,602	7	$5,119
Tobacco Use Disorder	16	$4,458	54	$3,385	60	$2,859
Complications of Substance Abuse	6	$27,466	13	$3,466	9	$1,604
Total		**$2,123,665**		**$3,473,262**		**$2,549,000**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	26	105	$1,302,577	40.1%
Breast Cancer	79	560	$482,160	14.9%
Colon Cancer	14	210	$334,500	10.3%
Prostate Cancer	37	218	$252,164	7.8%
Cancers, Other	44	268	$201,487	6.2%
Non-Melanoma Skin Cancers	75	147	$107,017	3.3%
Secondary Cancers	21	108	$100,389	3.1%
Pancreatic Cancer	3	60	$84,383	2.6%
Lung Cancer	5	155	$78,967	2.4%
Lymphomas	24	196	$78,231	2.4%
Carcinoma in Situ	30	87	$52,951	1.6%
Kidney Cancer	9	30	$45,069	1.4%
Cervical/Uterine Cancer	12	43	$43,108	1.3%
Thyroid Cancer	30	128	$26,842	0.8%
Leukemias	8	50	$24,618	0.8%
Brain Cancer	6	62	$14,302	0.4%
Melanoma	10	31	$6,566	0.2%
Myeloma	3	10	$4,042	0.1%
Ovarian Cancer	4	9	$3,759	0.1%
Bladder Cancer	2	5	$2,610	0.1%
Overall	**----**	**----**	**$3,245,740**	**100.0%**

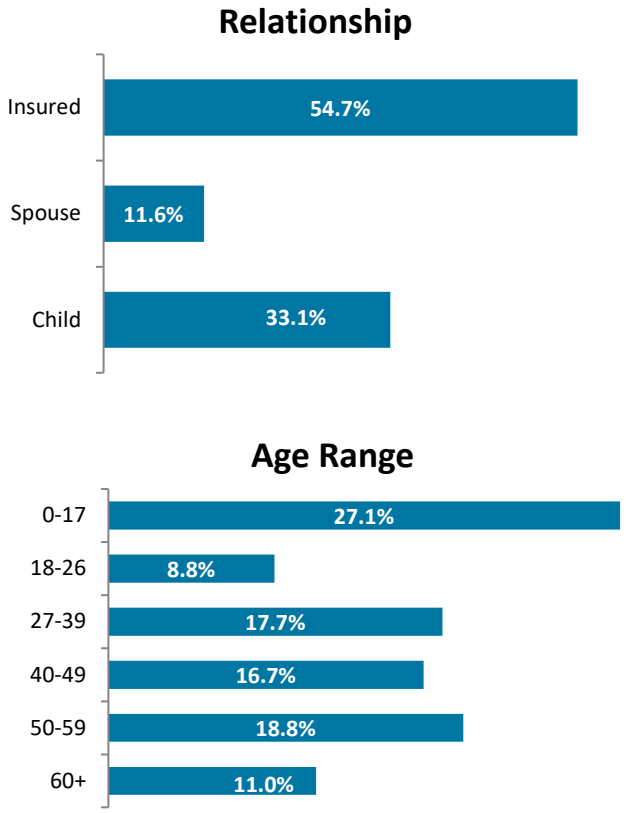
*Patient and claim counts are unique only within the category



Diagnosis Grouper – Health Status/Encounters

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Screenings	3,134	5,571	$920,318	28.9%
Exams	3,956	6,759	$734,805	23.1%
Prophylactic Measures	2,546	3,102	$579,592	18.2%
Encounters - Infants/Children	1,770	2,392	$367,756	11.6%
Counseling	550	2,170	$154,387	4.9%
Prosthetics/Devices/Implants	133	347	$107,655	3.4%
Personal History of Condition	362	589	$104,258	3.3%
Family History of Condition	97	142	$69,953	2.2%
Aftercare	156	261	$67,584	2.1%
Follow-Up Encounters	2	11	$23,205	0.7%
Acquired Absence	28	40	$16,396	0.5%
Encounter - Procedure	36	38	$15,414	0.5%
Encounter - Transplant Related	16	88	$12,793	0.4%
Health Status, Other	48	73	$2,756	0.1%
Lifestyle/Situational Issues	30	48	$2,078	0.1%
Miscellaneous Examinations	14	25	$714	0.0%
Blood Type	1	1	$24	0.0%
Donors	2	2	$0	0.0%
Overall	**----**	**----**	**$3,179,689**	**100.0%**

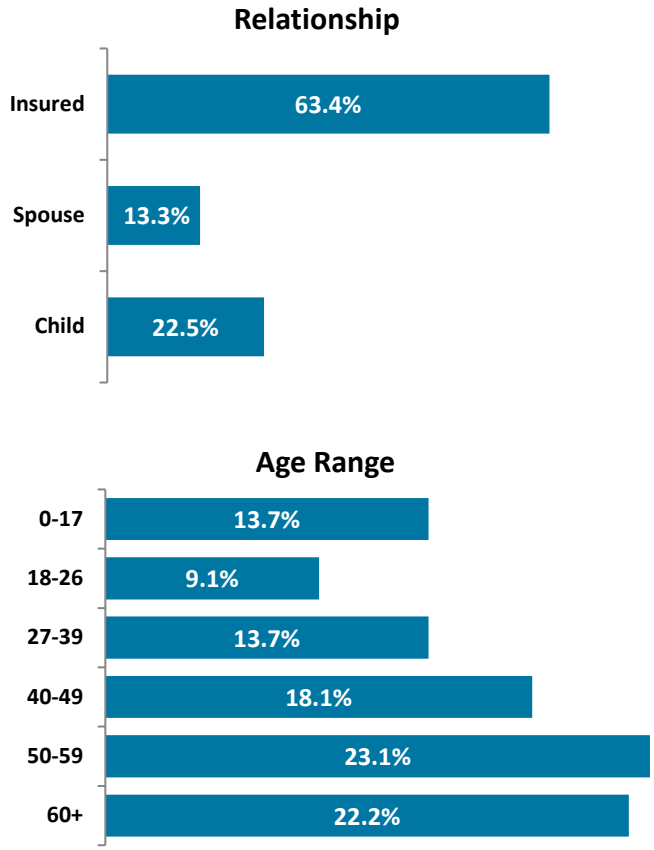
*Patient and claim counts are unique only within the category



Diagnosis Grouper – Gastrointestinal Orders

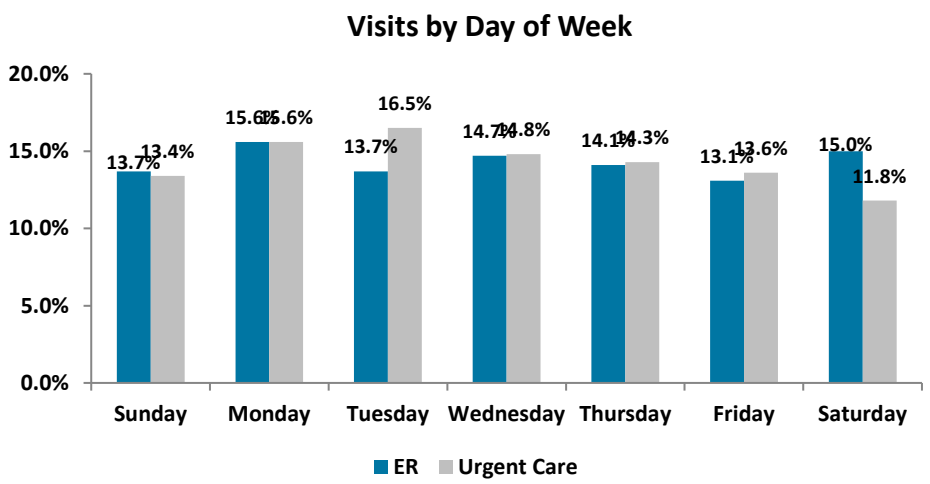
Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Abdominal Disorders	800	1,788	$646,847	20.6%
GI Disorders, Other	457	898	$542,488	17.3%
Gallbladder and Biliary Disease	94	429	$471,473	15.0%
Upper GI Disorders	406	819	$309,896	9.9%
GI Symptoms	547	982	$293,558	9.4%
Hernias	67	149	$162,588	5.2%
Inflammatory Bowel Disease	63	240	$151,132	4.8%
Appendicitis	11	77	$145,680	4.6%
Diverticulitis	76	180	$80,820	2.6%
Constipation	145	254	$74,835	2.4%
Liver Diseases	162	280	$67,199	2.1%
Peptic Ulcer/Related Disorders	7	10	$65,382	2.1%
Hemorrhoids	101	176	$49,955	1.6%
Pancreatic Disorders	20	87	$34,759	1.1%
Ostomies	16	64	$32,761	1.0%
Hepatic Cirrhosis	16	31	$6,344	0.2%
Esophageal Varices	2	8	$3,689	0.1%
	----	----	$3,139,405	100.0%

*Patient and claim counts are unique only within the category

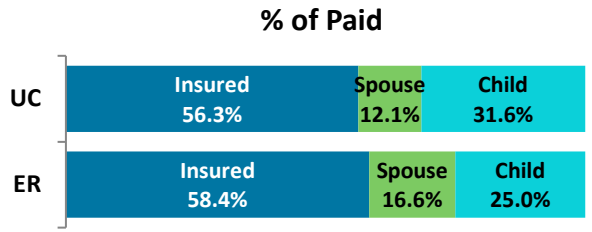


Emergency Room / Urgent Care Summary

	2Q23		2Q24		Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	958	2,596	1,544	3,435		
Visits Per Member	0.14	0.37	0.17	0.37	0.23	0.38
Visits/1000 Members	138	373	166	370	228	379
Avg Paid Per Visit	$3,179	$101	$3,125	$104	$1,085	$132
% with OV*	78.9%	75.5%	81.0%	79.4%		
% Avoidable	14.3%	41.4%	16.2%	38.0%		
Total Member Paid	**$665,547**	**$189,724**	**$1,089,671**	**$265,822**		
Total Plan Paid	**$3,045,918**	**$262,539**	**$4,824,504**	**$358,842**		
*looks back 12 months	Annualized	Annualized	Annualized	Annualized		



ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	836	87	1,938	202	2,774	289
Spouse	215	94	407	178	622	272
Child	493	74	1,090	163	1,583	237
Total	**1,544**	**83**	**3,435**	**185**	**4,979**	**268**

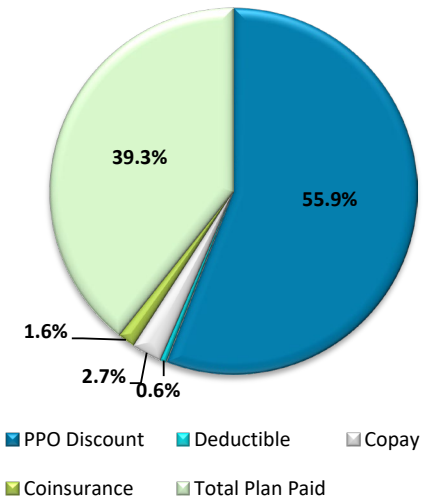


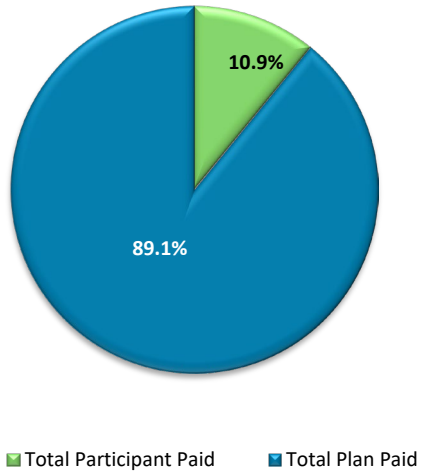
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$124,970,410	$6,649	100.0%
PPO Discount	$80,604,840	$4,288	64.5%
Deductible	$306,763	$16	0.2%
Copay	$3,566,868	$190	2.9%
Coinsurance	$2,401,297	$128	1.9%
Total Participant Paid	**$6,274,927**	**$334**	**5.0%**
Total Plan Paid	**$36,980,422**	**$642**	**29.6%**

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





Quality Metrics

Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric
Asthma and a routine provider visit in the last 12 months	945	929	16	98.3%
<2 asthma related ER Visits in the last 6 months	945	0	945	0.0%
No asthma related admit in last 12 months	945	6	939	0.6%
No exacerbations in last 12 months	81	6	75	7.4%
Members with COPD who had an annual spirometry test	81	10	71	12.3%
No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	1	0	1	0.0%
No ER Visit for Heart Failure in last 90 days	83	0	83	0.0%
Follow-up OV within 4 weeks of discharge from HF admission	1	1	0	100.0%
Annual office visit	1,043	1,013	30	97.1%
Annual dilated eye exam	1,043	390	653	37.4%
Annual foot exam	1,043	502	541	48.1%
Annual HbA1c test done	1,043	876	167	84.0%
Diabetes Annual lipid profile	1,043	804	239	77.1%
Annual microalbumin urine screen	1,043	747	296	71.6%
Hyperlipidemia Annual lipid profile	2,656	2,244	412	84.5%
Annual lipid profile	2,318	1,782	536	76.9%
Annual serum creatinine test	2,068	1,775	293	85.8%
Well Child Visit - 15 months	161	148	13	91.9%
Routine office visit in last 6 months (All Ages)	18,956	12,776	6,180	67.4%
Colorectal cancer screening ages 45-75 within the appropriate time period	6,040	2,747	3,293	45.5%
Women age 25-65 with recommended cervical cancer/HPV screening	6,311	4,038	2,273	64.0%
Males age greater than 49 with PSA test in last 24 months	1,947	979	968	50.3%
Routine exam in last 24 months (All Ages)	18,956	15,890	3,066	83.8%
Women age 40 to 75 with a screening mammogram last 24 months	4,423	2,682	1,741	60.6%

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

Chronic Conditions Prevalence

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

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

Chronic Condition	# With Condition	% of Members	Members per 1,000	Admits per 1,000	ER Visits per 1,000	PMPY
Affective Psychosis	207	1.09%	11.15	285.62	772.28	$18,806
Asthma	1,008	5.32%	54.30	133.67	658.51	$16,003
Atrial Fibrillation	136	0.72%	7.33	336.93	654.40	$34,359
Blood Disorders	1,057	5.57%	56.94	315.09	641.72	$33,500
CAD	301	1.59%	16.21	318.74	589.10	$30,912
COPD	78	0.41%	4.20	384.22	797.40	$33,598
Cancer	502	2.65%	27.04	229.83	344.31	$40,262
Chronic Pain	535	2.82%	28.82	194.01	716.09	$24,278
Congestive Heart Failure	81	0.43%	4.36	678.92	875.14	$57,415
Demyelinating Diseases	55	0.29%	2.96	154.06	423.51	$61,691
Depression	1,815	9.57%	97.77	156.33	482.07	$14,334
Diabetes	1,081	5.70%	58.23	143.85	393.68	$19,450
ESRD	17	0.09%	0.92	1,005.32	1,090.73	$123,351
Eating Disorders	105	0.55%	5.66	272.88	725.41	$23,410
HIV/AIDS	24	0.13%	1.29	121.13	405.80	$44,802
Hyperlipidemia	3,179	16.77%	171.25	96.11	303.98	$14,153
Hypertension	2,339	12.34%	126.00	118.54	391.44	$15,635
Immune Disorders	117	0.62%	6.30	436.58	635.75	$72,162
Inflammatory Bowel Disease	95	0.50%	5.12	198.22	462.77	$48,730
Liver Diseases	409	2.16%	22.03	294.66	707.13	$31,530
Morbid Obesity	686	3.62%	36.95	205.24	534.03	$19,940
Osteoarthritis	606	3.20%	32.64	142.68	440.05	$21,606
Peripheral Vascular Disease	67	0.35%	3.61	349.85	600.89	$33,028
Rheumatoid Arthritis	123	0.65%	6.63	135.02	448.80	$35,088

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

Data Includes Medical and Pharmacy
Based on 24 months incurred dates

Methodology

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

Public Employees' Benefits Program - RX Costs
PY 2024 - Through Quarter Ending December 31, 2023

Express Scripts

Membership Summary	1Q-2Q FY2024 LDPPO	1Q-2Q FY2023 LDPPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	18,549	13,900	4,649	33.4%
Utilizing Member Count (Patients)	12,302	9,685	2,617	27.0%
Percent Utilizing (Utilization)	66.3%	69.7%	(0)	-4.8%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	134,780	100,013	34,767	34.8%
Claims per Elig Member per Month (Claims PMPM)	1.21	1.20	0.01	0.8%
Total Claims for Generic (Generic Rx)	113,404	83,074	30,330.00	36.5%
Total Claims for Brand (Brand Rx)	21,376	16,939	4,437.00	26.2%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	823	506	317.00	62.6%
Total Non-Specialty Claims	133,098	98,690	34,408.00	34.9%
Total Specialty Claims	1,682	1,323	359.00	27.1%
Generic % of Total Claims (GFR)	**84.1%**	**83.1%**	0.01	1.3%
Generic Effective Rate (GCR)	**99.3%**	**99.4%**	(0.00)	-0.1%
Mail Order Claims	388,934	29,609	359,325.00	1213.6%
Mail Penetration Rate*	33.5%	34.8%	(0.01)	-1.3%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$19,637,591	$11,838,596	$7,798,995.00	65.9%
Total Generic Gross Cost	$2,257,816	$1,641,190	$616,626.00	37.6%
Total Brand Gross Cost	$17,379,775	$10,197,406	$7,182,369.00	70.4%
Total MSB Gross Cost	$375,742	$221,796	$153,946.00	69.4%
Total Ingredient Cost	$19,003,397	$11,663,636	$7,339,761.00	62.9%
Total Dispensing Fee	$618,608	$158,542	$460,066.00	290.2%
Total Other (e.g. tax)	$15,587	$16,417	($830.00)	-5.1%
Avg Total Cost per Claim (Gross Cost/Rx)	**$145.70**	**$118.37**	$27.33	23.1%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$19.91	$19.76	$0.15	0.8%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$813.05	$602.01	$211.04	35.1%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$456.55	$438.33	$18.22	4.2%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$2,721,339**	**$1,800,382**	$920,957.00	51.2%
Total Copay	$2,721,339	$1,800,382	$920,957.00	51.2%
Total Deductible	$0	$0	$0.00	0.0%
Avg Copay per Claim (Copay/Rx)	$20.19	$18.00	$2.19	12.2%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$20.19**	**$18.00**	**$2.19**	**12.2%**
Avg Copay for Generic (Copay/Generic Rx)	$6.71	$6.60	$0.11	1.7%
Avg Copay for Brand (Copay/Brand Rx)	$91.69	$73.90	$17.79	24.1%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$30.62	$14.93	$15.69	105.1%
Net PMPM (Participant Cost PMPM)	**$24.45**	**$21.59**	$2.86	13.3%
Copay % of Total Prescription Cost (Member Cost Share %)	13.9%	15.2%	-1.3%	-8.9%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$16,916,252**	**$10,038,214**	**$6,878,038.00**	**68.5%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$8,740,916	$4,997,512	$3,743,404.00	74.9%
Total Specialty Drug Cost (Specialty Plan Cost)	$8,175,336	$5,040,702	$3,134,634.00	62.2%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$125.51**	**$100.37**	$25.14	25.0%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$13.20	$13.15	$0.05	0.4%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$721.36	$528.10	$193.26	36.6%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$425.93	$423.41	$2.52	0.6%
Net PMPM (Plan Cost PMPM)	**$152.00**	**$120.36**	**$31.63**	**26.3%**
PMPM without Specialty (Non-Specialty PMPM)	$78.54	$59.92	$18.62	31.1%
PMPM for Specialty Only (Specialty PMPM)	$73.46	$60.44	$13.02	21.5%
Rebates Received (Q1-Q2 FY2024 actual)	$1,594,679	$3,373,251	($1,778,571.88)	-52.7%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$137.67**	**$79.92**	**$57.75**	**72.3%**
PMPM without Specialty (Non-Specialty PMPM)	$34.67	$34.67	$0.00	0.0%
PMPM for Specialty Only (Specialty PMPM)	$44.75	$44.75	$0.00	0.0%

Appendix C

Index of Tables
UMR Inc. – EPO Utilization Review for PEBP
July 1, 2023 – December 31, 2023

DATASCOPE™

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

UMR℠

Overview

- Total Medical Spend for 2Q24 was $17,689,075 with an annualized plan cost per employee per year (PEPY) of $11,293. This is an increase of 7.6% when compared to 2Q23.
  - IP Cost per Admit is $28,768 which is 26.2% lower than 2Q23.
  - ER Cost per Visit is $3,178 which is 12.8% higher than 2Q23.
- Employees shared in 10.9% of the medical cost.
- Inpatient facility costs were 22.4% of the plan spend.
- 82.5% of the Average Membership had paid Medical claims less than $2,500, with 18.5% having no claims paid at all during the reporting period.
- 25 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 24.6% of the plan spend. The highest diagnosis category was Cancer, accounting for 26.4% of the high-cost claimant dollars.
- Total spending with in-network providers was 96.6%. The average In Network discount was 56.8%, which is 3.5% higher than the PY23 average discount of 54.9%.

Paid Claims by Age Group

Paid Claims by Age Group																
	2Q23						2Q24						% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 1,303,974	$ 3,150	$ 482	$ 1	$ 1,304,456	$ 3,151	$ 460,733	$ 1,449	$ 3,151	$ 10	$ 463,884	$ 1,459	-64.4%	-53.7%
1	$ 117,093	$ 331	$ 444	$ 1	$ 117,537	$ 332	$ 99,941	$ 347	$ 1,597	$ 6	$ 101,538	$ 353	-13.6%	6.2%
2 - 4	$ 278,943	$ 221	$ 7,836	$ 6	$ 286,779	$ 228	$ 219,933	$ 195	$ 5,195	$ 5	$ 225,128	$ 200	-21.5%	-12.3%
5 - 9	$ 182,513	$ 85	$ 43,015	$ 20	$ 225,528	$ 105	$ 195,929	$ 104	$ 28,525	$ 15	$ 224,454	$ 119	-0.5%	13.1%
10 - 14	$ 373,107	$ 132	$ 70,752	$ 25	$ 443,859	$ 157	$ 443,755	$ 172	$ 73,803	$ 29	$ 517,558	$ 201	16.6%	27.7%
15 - 19	$ 586,215	$ 171	$ 272,470	$ 79	$ 858,685	$ 250	$ 814,488	$ 276	$ 319,301	$ 108	$ 1,133,789	$ 385	32.0%	53.8%
20 - 24	$ 683,903	$ 216	$ 116,004	$ 37	$ 799,907	$ 253	$ 551,210	$ 193	$ 105,245	$ 37	$ 656,455	$ 230	-17.9%	-9.1%
25 - 29	$ 376,254	$ 277	$ 147,145	$ 109	$ 523,399	$ 386	$ 411,259	$ 375	$ 197,051	$ 179	$ 608,310	$ 554	16.2%	43.5%
30 - 34	$ 772,250	$ 425	$ 821,679	$ 452	$ 1,593,929	$ 877	$ 593,642	$ 423	$ 726,005	$ 517	$ 1,319,647	$ 940	-17.2%	7.2%
35 - 39	$ 1,365,816	$ 555	$ 444,333	$ 181	$ 1,810,149	$ 736	$ 1,168,191	$ 532	$ 348,835	$ 159	$ 1,517,026	$ 691	-16.2%	-6.1%
40 - 44	$ 1,455,516	$ 559	$ 754,980	$ 290	$ 2,210,496	$ 849	$ 972,085	$ 409	$ 773,428	$ 326	$ 1,745,513	$ 735	-21.0%	-13.5%
45 - 49	$ 1,094,520	$ 372	$ 599,433	$ 203	$ 1,693,953	$ 575	$ 1,345,654	$ 511	$ 965,902	$ 367	$ 2,311,556	$ 878	36.5%	52.6%
50 - 54	$ 2,136,084	$ 537	$ 1,040,649	$ 262	$ 3,176,733	$ 799	$ 2,173,318	$ 635	$ 855,527	$ 250	$ 3,028,845	$ 886	-4.7%	10.9%
55 - 59	$ 2,652,993	$ 678	$ 1,330,969	$ 340	$ 3,983,962	$ 1,018	$ 2,285,018	$ 655	$ 1,476,425	$ 424	$ 3,761,443	$ 1,079	-5.6%	6.0%
60 - 64	$ 3,767,595	$ 839	$ 1,894,677	$ 422	$ 5,662,272	$ 1,262	$ 4,432,817	$ 1,082	$ 1,943,878	$ 474	$ 6,376,695	$ 1,556	12.6%	23.3%
65+	$ 1,296,743	$ 616	$ 864,926	$ 411	$ 2,161,669	$ 1,026	$ 1,521,102	$ 728	$ 889,303	$ 426	$ 2,410,405	$ 1,154	11.5%	12.5%
Total	**$ 18,443,519**	**$ 470**	**$ 8,409,793**	**$ 214**	**$ 26,853,312**	**$ 684**	**$ 17,689,075**	**$ 508**	**$ 8,713,171**	**$ 250**	**$ 26,402,246**	**$ 759**	**-1.7%**	**10.9%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	4,100	3,515	3,133	-10.9%	3,440	2,932	2,589	-11.7%	3	12	2	-83.3%
Spouses	799	695	604	-13.1%	689	594	513	-13.7%	0	0	0	0.0%
Children	2,709	2,331	2,062	-11.5%	2,563	2,176	1,922	-11.7%	0	0	0	0.0%
Total Members	7,607	6,541	5,799	-11.3%	6,692	5,703	5,024	-11.9%	3	12	2	-83.3%
Family Size	1.9	1.9	1.9	-2.6%	2.0	1.9	1.9	2.1%	1.0	1.0	1.0	0.0%
Financial Summary												
Gross Cost	$22,421,549	$20,580,358	$19,848,431	-3.6%	$19,253,441	$17,206,132	$16,691,145	-3.0%	$3,180	$1,987	$2,826	42.2%
Client Paid	$19,784,855	$18,443,519	$17,689,075	-4.1%	$17,081,090	$15,460,924	$14,923,635	-3.5%	$2,330	$1,551	$2,234	44.0%
Employee Paid	$2,636,694	$2,136,839	$2,159,356	1.1%	$2,172,351	$1,745,208	$1,767,510	1.3%	$850	$436	$592	35.8%
Client Paid-PEPY	$9,652	$10,495	$11,293	7.6%	$9,930	$10,546	$11,528	9.3%	$1,471	$1,551	$2,234	44.0%
Client Paid-PMPY	$5,202	$5,640	$6,101	8.2%	$5,105	$5,422	$5,941	9.6%	$1,471	$1,551	$2,234	44.0%
Client Paid-PEPM	$804	$875	$941	7.5%	$828	$879	$961	9.3%	$123	$129	$186	44.2%
Client Paid-PMPM	$433	$470	$508	8.1%	$425	$452	$495	9.5%	$123	$129	$186	44.2%
High Cost Claimants (HCC's) > $100k												
# of HCC's	26	24	25	4.2%	23	20	22	10.0%	0	0	0	0.0%
HCC's / 1,000	3.4	3.7	4.3	17.4%	3.4	3.5	4.4	24.8%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$211,967	$215,676	$174,149	-19.3%	$224,122	$215,064	$176,823	-17.8%	$0	$0	$0	0.0%
HCC's % of Plan Paid	27.9%	28.1%	24.6%	-12.5%	30.2%	27.8%	26.1%	-6.1%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,511	$1,734	$1,369	-21.0%	$1,500	$1,682	$1,393	-17.2%	$0	$0	$0	0.0%
Facility Outpatient	$1,294	$1,882	$2,362	25.5%	$1,261	$1,784	$2,278	27.7%	$49	$242	$370	0.0%
Physician	$2,291	$2,024	$2,370	17.1%	$2,247	$1,957	$2,270	16.0%	$1,314	$1,309	$1,864	42.4%
Other	$106	$0	$0	0.0%	$97	$0	$0	0.0%	$108	$0	$0	0.0%
Total	$5,202	$5,640	$6,101	8.2%	$5,105	$5,422	$5,941	9.6%	$1,471	$1,551	$2,234	44.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	565	515	489	-5.1%	91	66	53	-19.3%	
Spouses	89	86	81	-6.4%	20	15	11	-29.2%	
Children	136	142	128	-10.1%	10	13	12	-4.0%	
Total Members	791	743	697	-6.2%	121	93	76	-18.8%	
Family Size	1.4	1.4	1.4	-0.7%	1.3	1.4	1.4	1.4%	1.6
Financial Summary									
Gross Cost	$2,777,883	$3,166,544	$3,002,209	-5.2%	$387,046	$205,696	$152,250	-26.0%	
Client Paid	$2,394,965	$2,829,500	$2,650,199	-6.3%	$306,470	$151,543	$113,007	-25.4%	
Employee Paid	$382,918	$337,043	$352,010	4.4%	$80,576	$54,153	$39,243	-27.5%	
Client Paid-PEPY	$8,475	$10,988	$10,850	-1.3%	$6,723	$4,616	$4,264	-7.6%	$6,258
Client Paid-PMPY	$6,059	$7,615	$7,606	-0.1%	$5,059	$3,259	$2,994	-8.1%	$3,830
Client Paid-PEPM	$706	$916	$904	-1.3%	$560	$385	$355	-7.8%	$521
Client Paid-PMPM	$505	$635	$634	-0.2%	$422	$272	$249	-8.5%	$319
High Cost Claimants (HCC's) > $100k									
# of HCC's	4	4	4	0.0%	0	0	0	0.0%	
HCC's / 1,000	5.1	5.4	5.7	0.0%	0.0	0.0	0.0	0.0%	
Avg HCC Paid	$89,083	$218,734	$115,905	0.0%	$0	$0	$0	0.0%	
HCC's % of Plan Paid	14.9%	30.9%	17.5%	0.0%	0.0%	0.0%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,536	$2,313	$1,275	-44.9%	$2,008	$310	$728	134.8%	$1,044
Facility Outpatient	$1,618	$2,717	$3,114	14.6%	$1,064	$1,256	$1,083	-13.8%	$1,310
Physician	$2,735	$2,585	$3,217	24.4%	$1,811	$1,692	$1,182	-30.1%	$1,404
Other	$171	$0	$0	0.0%	$176	$0	$0	0.0%	$72
Total	$6,059	$7,615	$7,606	-0.1%	$5,059	$3,259	$2,994	-8.1%	$3,830
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

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

	Total				State Active				Non-State Active			
Summary	**PY22**	**PY23**	**2Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**2Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**2Q24**	**Variance to Prior Year**
Average Enrollment												
Employees	4,021	3,447	3,133	-9.1%	3,370	2,876	2,589	-10.0%	3	2	2	0.0%
Spouses	786	2,297	604	-73.7%	678	2,145	513	-76.1%	0	0	0	0.0%
Children	2,683	676	2,062	204.8%	2,531	580	1,922	231.2%	0	0	0	0.0%
Total Members	7,491	6,421	5,799	-9.7%	6,579	5,601	5,024	-10.3%	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	$19,848,431	-57.3%	$37,820,607	$38,595,575	$16,691,145	-56.8%	$4,744	$4,201	$2,826	-32.7%
Client Paid	$39,320,787	$42,257,152	$17,689,075	-58.1%	$33,797,612	$35,128,252	$14,923,635	-57.5%	$3,622	$3,335	$2,234	-33.0%
Employee Paid	$4,866,255	$4,233,060	$2,159,356	-49.0%	$4,022,996	$3,467,323	$1,767,510	-49.0%	$1,122	$866	$592	-31.6%
Client Paid-PEPY	$9,779	$12,259	$11,293	-7.9%	$10,030	$12,216	$11,528	-5.6%	$1,278	$1,667	$2,234	34.0%
Client Paid-PMPY	$5,249	$6,581	$6,101	-7.3%	$5,137	$6,272	$5,941	-5.3%	$1,278	$1,667	$2,234	34.0%
Client Paid-PEPM	$815	$1,022	$941	-7.9%	$836	$1,018	$961	-5.6%	$107	$139	$186	33.8%
Client Paid-PMPM	$437	$548	$508	-7.3%	$428	$523	$495	-5.4%	$107	$139	$186	33.8%
High Cost Claimants (HCC's) > $100k												
# of HCC's	46	54	25	-53.7%	40	43	22	-48.8%	0	0	0	0.0%
HCC's / 1,000	6.1	8.4	4.3	-48.8%	6.1	7.7	4.4	-43.0%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$237,083	$257,429	$174,149	-32.4%	$246,357	$257,598	$176,823	-31.4%	$0	$0	$0	0.0%
HCC's % of Plan Paid	27.7%	32.9%	24.6%	-25.2%	29.2%	31.5%	26.1%	-17.1%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,432	$1,804	$1,369	-24.1%	$1,437	$1,735	$1,393	-19.7%	$0	$0	$0	0.0%
Facility Outpatient	$1,442	$2,319	$2,362	1.9%	$1,382	$2,176	$2,278	4.7%	$27	$158	$370	134.2%
Physician	$2,259	$2,458	$2,370	-3.6%	$2,209	$2,361	$2,270	-3.9%	$1,142	$1,510	$1,864	23.4%
Other	$116	$0	$0	0.0%	$109	$0	$0	0.0%	$109	$0	$0	0.0%
Total	$5,249	$6,581	$6,101	-7.3%	$5,137	$6,272	$5,941	-5.3%	$1,278	$1,667	$2,234	34.0%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY22**	**PY23**	**2Q24**	**Variance to Prior Year**	**PY22**	**PY23**	**2Q24**	**Variance to Prior Year**	**Peer Index**
Average Enrollment									
Employees	564	509	489	-3.9%	85	61	53	-13.2%	
Spouses	90	139	81	-42.2%	19	13	11	-19.2%	
Children	142	83	128	54.3%	10	13	12	-10.0%	
Total Members	796	731	697	-4.6%	114	87	76	-13.6%	
Family Size	1.4	1.4	1.4	-0.7%	1.3	1.4	1.4	-0.7%	1.6
Financial Summary									
Gross Cost	$5,794,991	$7,535,647	$3,002,209	-60.2%	$566,699	$354,790	$152,250	-57.1%	
Client Paid	$5,071,309	$6,861,336	$2,650,199	-61.4%	$448,244	$264,230	$113,007	-57.2%	
Employee Paid	$723,682	$674,311	$352,010	-47.8%	$118,455	$90,560	$39,243	-56.7%	
Client Paid-PEPY	$8,998	$13,493	$10,850	-19.6%	$5,279	$4,326	$4,264	-1.4%	$6,258
Client Paid-PMPY	$6,373	$9,392	$7,606	-19.0%	$3,946	$3,023	$2,994	-1.0%	$3,830
Client Paid-PEPM	$750	$1,124	$904	-19.6%	$440	$360	$355	-1.4%	$521
Client Paid-PMPM	$531	$783	$634	-19.0%	$329	$252	$249	-1.2%	$319
High Cost Claimants (HCC's) > $100k									
# of HCC's	8	12	4	-66.7%	0	0	0	0.0%	
HCC's / 1,000	10.1	16.4	5.7	-65.1%	0.0	0.0	0.0	0.0%	
Avg HCC Paid	$131,446	$235,373	$115,905	-50.8%	$0	$0	$0	0.0%	
HCC's % of Plan Paid	20.7%	41.2%	17.5%	-57.5%	0.0%	0.0%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,443	$2,534	$1,275	-49.7%	$1,101	$183	$728	297.8%	$1,044
Facility Outpatient	$2,015	$3,585	$3,114	-13.1%	$940	$1,007	$1,083	7.5%	$1,310
Physician	$2,742	$3,273	$3,217	-1.7%	$1,800	$1,832	$1,182	-35.5%	$1,404
Other	$174	$0	$0	0.0%	$106	$0	$0	0.0%	$72
Total	$6,373	$9,392	$7,606	-19.0%	$3,946	$3,023	$2,994	-1.0%	$3,830
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 5,586,527	$ 463,550	$ 518,318	$ 6,568,395	$ 4,042,195	$ 446,592	$ 48,797	$ 4,537,584	-30.9%
Outpatient	$ 9,874,397	$ 159,110	$ 1,688,522	$ 11,722,029	$ 10,881,440	$ 2,003,136	$ 151,673	$ 13,036,250	11.2%
Total - Medical	**$ 15,460,924**	**$ 622,660**	**$ 2,206,840**	**$ 18,290,424**	**$ 14,923,635**	**$ 2,449,728**	**$ 200,470**	**$ 17,573,834**	**-3.9%**

Net Paid Claims - Per Participant per Month	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 879	$ 233	$ 5,305	$ 884	$ 961	$ 975	$ 478	$ 952	7.6%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 14,081	$ 2,403	$ 16,484	$ -		$ 31,328	$ 31,328	90.0%
Outpatient	$ 1,551	$ 55,496	$ 79,563	$ 136,610	$ 2,234	$ 13,144	$ 68,535	$ 83,913	-38.6%
Total - Medical	**$ 1,551**	**$ 69,577**	**$ 81,966**	**$ 153,094**	**$ 2,234**	**$ 13,144**	**$ 99,862**	**$ 115,241**	**-24.7%**

Net Paid Claims - Per Participant per Month	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 129	$ 689	$ 280	$ 377	$ 186	$ 258	$ 374	$ 349	-7.4%

Paid Claims by Claim Type – Total

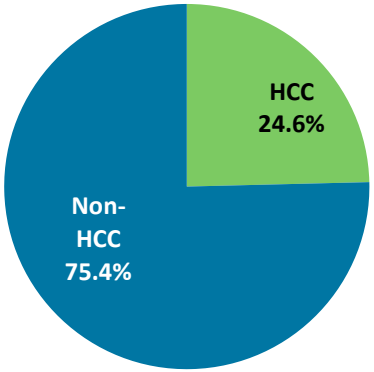
Net Paid Claims - Total Total Participants	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 5,586,527	$ 477,631	$ 520,722	$ 6,584,880	$ 4,042,195	$ 446,592	$ 80,125	$ 4,568,912	-30.6%
Outpatient	$ 9,875,948	$ 214,606	$ 1,768,085	$ 11,858,639	$ 10,883,675	$ 2,016,281	$ 220,208	$ 13,120,163	10.6%
Total - Medical	**$ 15,462,475**	**$ 692,237**	**$ 2,288,807**	**$ 18,443,519**	**$ 14,925,869**	**$ 2,462,873**	**$ 300,333**	**$ 17,689,075**	**-4.1%**

Net Paid Claims - Per Participant per Month	2Q23				2Q24				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 878	$ 249	$ 3,228	$ 875	$ 960	$ 961	$ 438	$ 941	7.6%

Cost Distribution – Medical Claims

2Q23							2Q24					
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
22	0.3%	$5,176,214	28.1%	$68,514	3.2%	$100,000.01 Plus	24	0.4%	$4,353,726	24.6%	$93,132	4.3%
21	0.3%	$1,396,775	7.6%	$66,125	3.1%	$50,000.01-$100,000.00	24	0.4%	$1,753,136	9.9%	$79,124	3.7%
79	1.2%	$2,702,541	14.7%	$167,270	7.8%	$25,000.01-$50,000.00	62	1.1%	$2,299,592	13.0%	$161,889	7.5%
211	3.2%	$3,507,644	19.0%	$375,402	17.6%	$10,000.01-$25,000.00	209	3.6%	$3,386,104	19.1%	$363,206	16.8%
211	3.2%	$1,524,074	8.3%	$270,107	12.6%	$5,000.01-$10,000.00	228	3.9%	$1,635,817	9.2%	$313,949	14.5%
364	5.6%	$1,317,297	7.1%	$305,730	14.3%	$2,500.01-$5,000.00	466	8.0%	$1,685,778	9.5%	$398,092	18.4%
4,232	64.7%	$2,818,973	15.3%	$881,235	41.2%	$0.01-$2,500.00	3,650	62.9%	$2,574,922	14.6%	$748,396	34.7%
122	1.9%	$0	0.0%	$2,455	0.1%	$0.00	64	1.1%	$0	0.0%	$1,568	0.1%
1,279	19.6%	$0	0.0%	$0	0.0%	No Claims	1,071	18.5%	$0	0.0%	$0	0.0%
6,541	**100.0%**	**$18,443,519**	**100.0%**	**$2,136,839**	**100.0%**		**5,799**	**100.0%**	**$17,689,075**	**100.0%**	**$2,159,356**	**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	12	$1,150,547	26.4%
Infections	6	$665,869	15.3%
Cardiac Disorders	15	$605,173	13.9%
Neurological Disorders	12	$350,057	8.0%
Pregnancy-related Disorders	2	$303,076	7.0%
Hematological Disorders	8	$292,132	6.7%
Gastrointestinal Disorders	9	$229,913	5.3%
Renal/Urologic Disorders	6	$196,986	4.5%
Diabetes	3	$145,698	3.3%
Trauma/Accidents	10	$137,020	3.1%
All Other		$277,257	6.4%
Overall	**----**	**$4,353,726**	**100.0%**

Utilization Summary (p. 1 of 2)

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

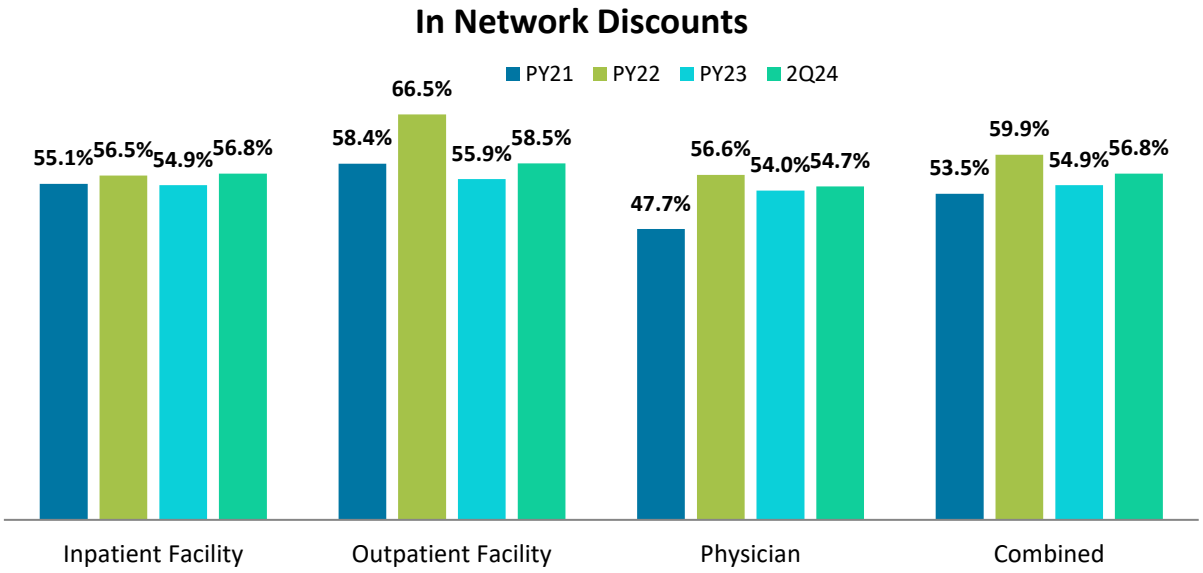
	Total				State Active				Non-State Active			
Summary	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	225	172	164		192	143	136		0	0	0	
# of Bed Days	1,311	926	836		1,093	763	693		0	0	0	
Paid Per Admit	$36,860	$38,964	$28,768	-26.2%	$37,853	$37,904	$30,391	-19.8%	$0	$0	$0	0.0%
Paid Per Day	$6,326	$7,237	$5,644	-22.0%	$6,649	$7,104	$5,964	-16.0%	$0	$0	$0	0.0%
Admits Per 1,000	59	53	57	7.5%	57	50	54	8.0%	0	0	0	0.0%
Days Per 1,000	345	283	288	1.8%	327	268	276	3.0%	0	0	0	0.0%
Avg LOS	5.8	5.4	5.1	-5.6%	5.7	5.3	5.1	-3.8%	0.0	0.0	0.0	0.0%
# Admits From ER	116	78	94	20.5%	94	63	77	22.2%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	5.6	5.1	6.1	19.6%	5.4	4.9	6.0	22.4%	6.3	7.0	5.0	-28.6%
Avg Paid per OV	$155	$150	$155	3.3%	$155	$157	$151	-3.8%	$164	$112	$205	83.0%
Avg OV Paid per Member	$866	$768	$953	24.1%	$836	$775	$901	16.3%	$1,039	$786	$1,025	30.4%
DX&L Utilization per Member	9.6	10.5	11.6	10.5%	9.1	10	11	10.0%	3.8	32	18	-43.8%
Avg Paid per DX&L	$54	$69	$79	14.5%	$56	$72	$78	8.3%	$33	$12	$42	250.0%
Avg DX&L Paid per Member	$521	$729	$913	25.2%	$513	$723	$865	19.6%	$126	$396	$753	90.2%
Emergency Room												
# of Visits	696	579	557		595	496	498		0	0	0	
Visits Per Member	0.18	0.18	0.19	5.6%	0.18	0.17	0.20	17.6%	0.00	0.00	0.00	0.0%
Visits Per 1,000	183	177	192	8.5%	178	174	198	13.8%	0	0	0	0.0%
Avg Paid per Visit	$1,992	$2,818	$3,178	12.8%	$1,982	$2,837	$3,212	13.2%	$0	$0	$0	0.0%
Urgent Care												
# of Visits	1,530	1,297	1,271		1,387	1,157	1,131		0	0	0	
Visits Per Member	0.40	0.40	0.44	10.0%	0.41	0.41	0.45	9.8%	0.00	0.00	0.00	0.0%
Visits Per 1,000	402	397	438	10.3%	415	406	450	10.8%	0	0	0	0.0%
Avg Paid per Visit	$156	$126	$133	5.6%	$158	$127	$135	6.3%	$0	$0	$0	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

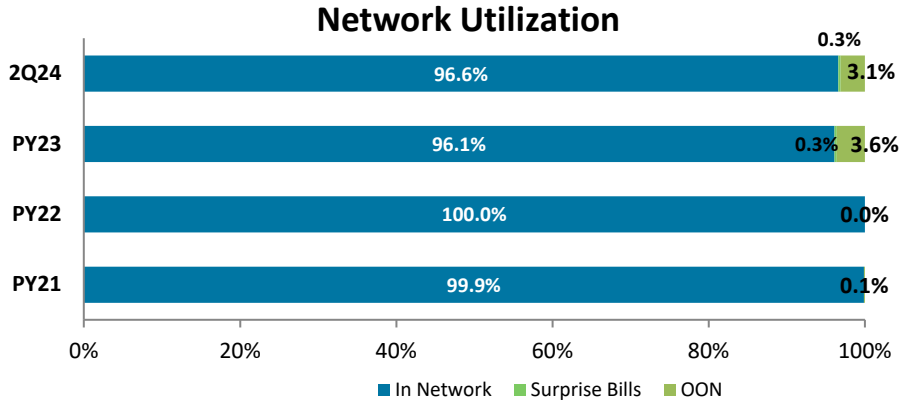
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**2Q22**	**2Q23**	**2Q24**	**Variance to Prior Year**	**Peer Index**
Inpatient Summary									
# of Admits	25	27	24		8	2	4		
# of Bed Days	153	156	131		65	7	12		
Paid Per Admit	$35,722	$46,841	$22,176	-52.7%	$16,574	$8,442	$13,149	55.8%	$19,305
Paid Per Day	$5,837	$8,107	$4,063	-49.9%	$2,040	$2,412	$4,383	81.7%	$3,615
Admits Per 1,000	63	73	69	-5.5%	132	43	106	146.5%	64
Days Per 1,000	387	420	376	-10.5%	1,073	151	318	110.6%	342
Avg LOS	6.1	5.8	5.5	-5.2%	8.1	3.5	3.0	-14.3%	5.3
# Admits From ER	17	14	15	7.1%	5	1	2	0.0%	
Physician Office									
OV Utilization per Member	6.9	6.2	7.4	19.4%	7.0	6.3	6.2	-1.6%	5.2
Avg Paid per OV	$163	$122	$188	54.1%	$117	$65	$55	-15.4%	$97
Avg OV Paid per Member	$1,123	$755	$1,390	84.1%	$817	$410	$337	-17.8%	$502
DX&L Utilization per Member	13.2	14.5	16	10.3%	11.5	12.6	9.7	-23.0%	9.0
Avg Paid per DX&L	$44	$55	$82	49.1%	$47	$41	$47	14.6%	$46
Avg DX&L Paid per Member	$583	$802	$1,314	63.8%	$538	$514	$461	-10.3%	$412
Emergency Room									
# of Visits	84	72	57		17	11	2		
Visits Per Member	0.21	0.19	0.16	-15.8%	0.28	0.24	0.05	-79.2%	0.23
Visits Per 1,000	213	194	164	-15.5%	281	237	53	-77.6%	228
Avg Paid per Visit	$2,301	$2,967	$2,987	0.7%	$817	$983	$291	-70.4%	$1,035
Urgent Care									
# of Visits	122	125	126		21	15	14		
Visits Per Member	0.31	0.34	0.36	5.9%	0.35	0.32	0.37	15.6%	0.38
Visits Per 1,000	309	336	362	7.7%	347	323	371	14.9%	379
Avg Paid per Visit	$151	$123	$118	-4.1%	$62	$57	$39	-31.6%	$132
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





Inc Jul-Dec23, Pd through Feb24

Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$1,656,973	9.4%	$1,030,928	$475,790	$150,255	$738,107	$918,866
Gastrointestinal Disorders	$1,410,261	8.0%	$829,497	$376,623	$204,140	$654,667	$755,594
Cardiac Disorders	$1,346,268	7.6%	$860,277	$466,380	$19,612	$682,768	$663,500
Health Status/Encounters	$1,229,590	7.0%	$744,393	$148,133	$337,065	$473,866	$755,724
Musculoskeletal Disorders	$1,211,235	6.8%	$952,762	$175,274	$83,199	$523,265	$687,970
Trauma/Accidents	$1,206,422	6.8%	$856,826	$110,266	$239,329	$679,928	$526,494
Mental Health	$1,048,165	5.9%	$453,663	$102,331	$492,171	$308,756	$739,409
Neurological Disorders	$1,020,326	5.8%	$722,036	$174,429	$123,860	$199,914	$820,412
Pregnancy-related Disorders	$928,382	5.2%	$485,009	$33,398	$409,975	$323,483	$604,898
Infections	$898,595	5.1%	$745,993	$110,252	$42,351	$430,115	$468,480
Spine-related Disorders	$734,816	4.2%	$623,561	$98,799	$12,456	$291,954	$442,862
Eye/ENT Disorders	$717,827	4.1%	$447,141	$68,324	$202,362	$307,979	$409,848
Renal/Urologic Disorders	$666,987	3.8%	$536,213	$20,953	$109,821	$262,032	$404,955
Pulmonary Disorders	$652,978	3.7%	$479,657	$78,848	$94,473	$214,407	$438,571
Gynecological/Breast Disorders	$441,415	2.5%	$309,242	$87,479	$44,693	$3,885	$437,530
Diabetes	$403,526	2.3%	$173,214	$154,229	$76,084	$280,526	$123,000
Hematological Disorders	$388,463	2.2%	$336,206	$12,992	$39,266	$303,247	$85,217
Endocrine/Metabolic Disorders	$343,812	1.9%	$303,732	$31,033	$9,047	$109,147	$234,665
Non-malignant Neoplasm	$329,766	1.9%	$294,668	$25,868	$9,229	$59,417	$270,349
Medical/Surgical Complications	$257,030	1.5%	$235,921	$11,998	$9,111	$127,512	$129,518
Dermatological Disorders	$199,865	1.1%	$120,076	$33,211	$46,578	$86,770	$113,095
Miscellaneous	$162,124	0.9%	$88,580	$30,674	$42,870	$67,061	$95,064
Abnormal Lab/Radiology	$151,698	0.9%	$121,007	$24,740	$5,950	$67,299	$84,399
Vascular Disorders	$120,570	0.7%	$89,550	$30,974	$45	$49,839	$70,731
Cholesterol Disorders	$49,985	0.3%	$43,500	$5,923	$562	$22,902	$27,083
Congenital/Chromosomal Anomalies	$46,570	0.3%	$5,926	$1,068	$39,576	$38,234	$8,336
Medication Related Conditions	$29,572	0.2%	$19,437	$3,493	$6,642	$6,857	$22,714
Allergic Reaction	$17,048	0.1%	$3,084	$345	$13,620	$9,966	$7,082
Dental Conditions	$8,727	0.0%	$7,113	$0	$1,615	$5,912	$2,816
External Hazard Exposure	$7,680	0.0%	$5,225	$0	$2,455	$6,844	$836
Social Determinants of Health	$2,400	0.0%	$73	$0	$2,327	$0	$2,400
Total	**$17,689,075**	**100.0%**	**$11,924,509**	**$2,893,827**	**$2,870,738**	**$7,336,658**	**$10,352,416**

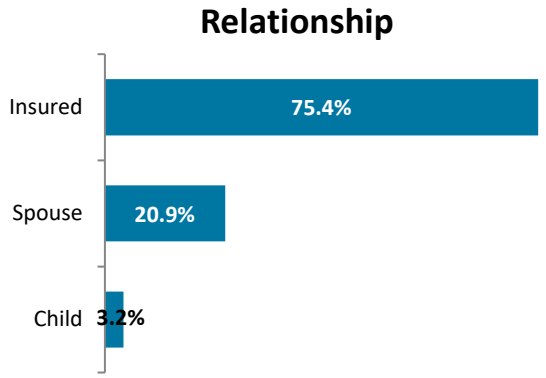
Mental Health Drilldown

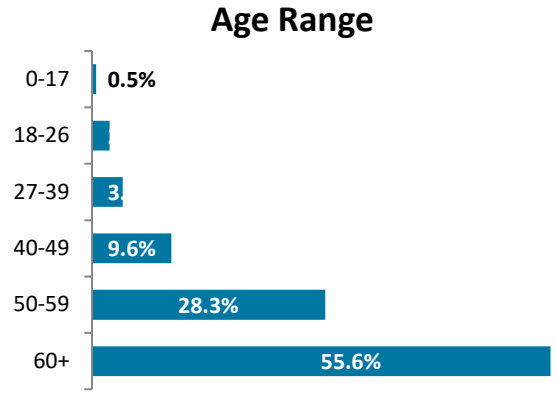
	PY21		PY22		PY23		2Q24	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	625	$833,183	505	$720,907	454	$529,695	311	$269,918
Mood and Anxiety Disorders	711	$655,375	636	$361,898	591	$339,214	363	$230,353
Mental Health Conditions, Other	609	$876,606	458	$367,897	394	$287,517	251	$195,704
Developmental Disorders	65	$155,300	58	$89,043	47	$93,123	34	$70,400
Alcohol Abuse/Dependence	43	$163,692	37	$110,736	30	$167,010	24	$64,185
Bipolar Disorder	127	$261,349	107	$171,696	109	$84,620	69	$63,962
Complications of Substance Abuse	14	$63,661	8	$12,407	7	$9,434	7	$41,414
Attention Deficit Disorder	180	$98,736	179	$76,754	202	$61,595	144	$33,915
Psychoses	7	$55,219	6	$9,762	9	$6,025	6	$22,830
Sexually Related Disorders	27	$81,154	27	$85,457	26	$8,339	14	$18,321
Sleep Disorders	187	$38,478	148	$43,716	141	$25,583	71	$15,507
Substance Abuse/Dependence	57	$45,039	39	$14,853	35	$72,695	15	$10,904
Eating Disorders	24	$370,761	23	$51,995	19	$32,076	11	$5,225
Schizophrenia	9	$10,631	6	$2,286	9	$13,689	4	$2,539
Tobacco Use Disorder	38	$4,775	36	$4,114	42	$3,344	26	$2,437
Personality Disorders	14	$20,064	17	$47,043	15	$7,832	4	$551
Total		**$3,734,023**		**$2,170,566**		**$1,741,788**		**$1,048,165**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	15	61	$670,849	40.5%
Breast Cancer	39	209	$158,945	9.6%
Kidney Cancer	5	34	$149,816	9.0%
Pancreatic Cancer	4	89	$137,244	8.3%
Cancers, Other	22	131	$137,109	8.3%
Lung Cancer	4	115	$93,268	5.6%
Cervical/Uterine Cancer	4	16	$49,869	3.0%
Prostate Cancer	18	118	$42,588	2.6%
Melanoma	11	85	$42,558	2.6%
Colon Cancer	6	34	$35,984	2.2%
Secondary Cancers	7	34	$32,772	2.0%
Carcinoma in Situ	16	58	$26,888	1.6%
Brain Cancer	2	33	$24,968	1.5%
Non-Melanoma Skin Cancers	38	84	$22,052	1.3%
Leukemias	7	41	$14,201	0.9%
Ovarian Cancer	4	21	$9,233	0.6%
Lymphomas	9	25	$5,944	0.4%
Thyroid Cancer	11	24	$2,531	0.2%
Myeloma	1	1	$152	0.0%
Overall	**----**	**----**	**$1,656,973**	**100.0%**

*Patient and claim counts are unique only within the category

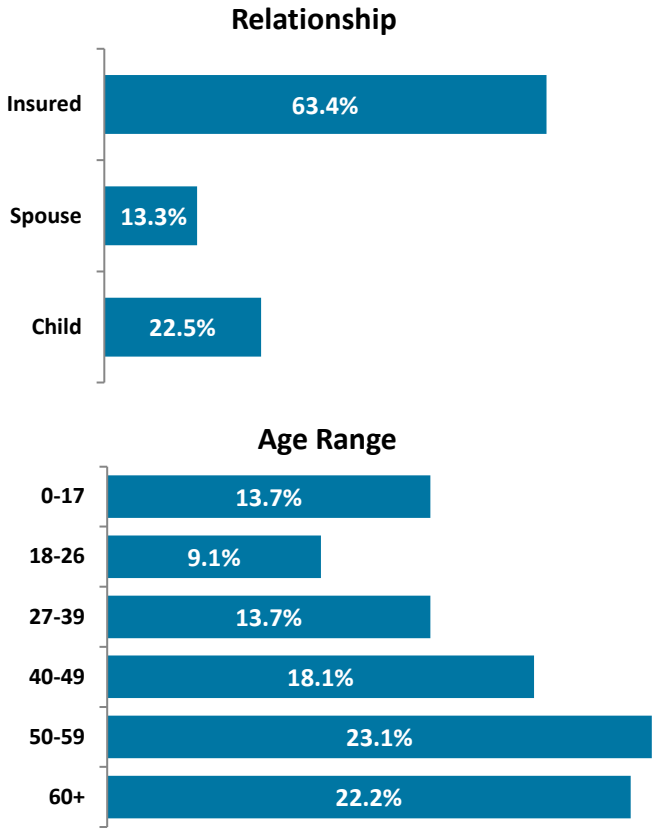




Diagnosis Grouper – Gastrointestinal Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Abdominal Disorders	257	562	$299,438	21.2%
GI Disorders, Other	137	312	$264,635	18.8%
Diverticulitis	38	99	$125,989	8.9%
Inflammatory Bowel Disease	25	73	$114,893	8.1%
Appendicitis	5	30	$114,715	8.1%
Gallbladder and Biliary Disease	26	92	$99,525	7.1%
GI Symptoms	177	290	$82,631	5.9%
Liver Diseases	64	120	$74,702	5.3%
Upper GI Disorders	126	248	$71,640	5.1%
Hernias	21	51	$58,595	4.2%
Hepatic Cirrhosis	9	15	$35,788	2.5%
Pancreatic Disorders	5	27	$32,309	2.3%
Constipation	46	74	$26,175	1.9%
Hemorrhoids	24	36	$6,663	0.5%
Ostomies	8	19	$1,637	0.1%
Peptic Ulcer/Related Disorders	4	4	$925	0.1%
	----	----	$1,410,261	100.0%

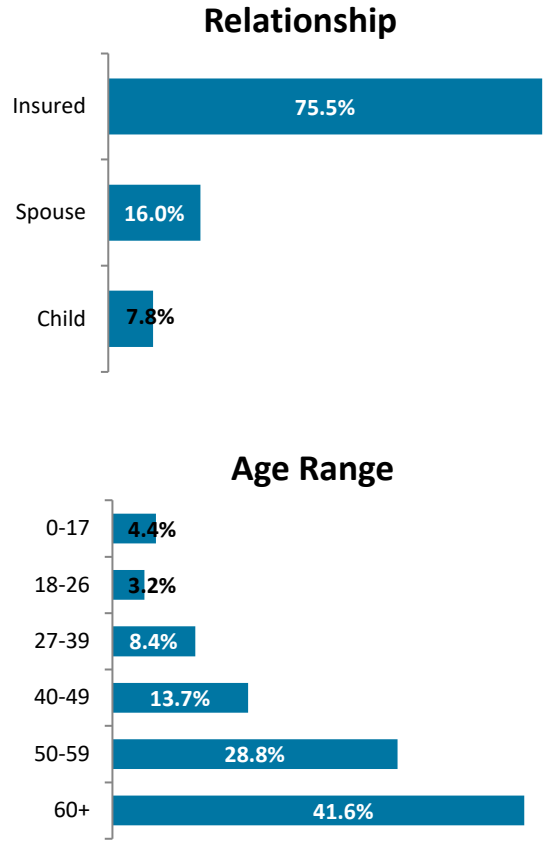
*Patient and claim counts are unique only within the category



Diagnosis Grouper – Cardiac Disorders

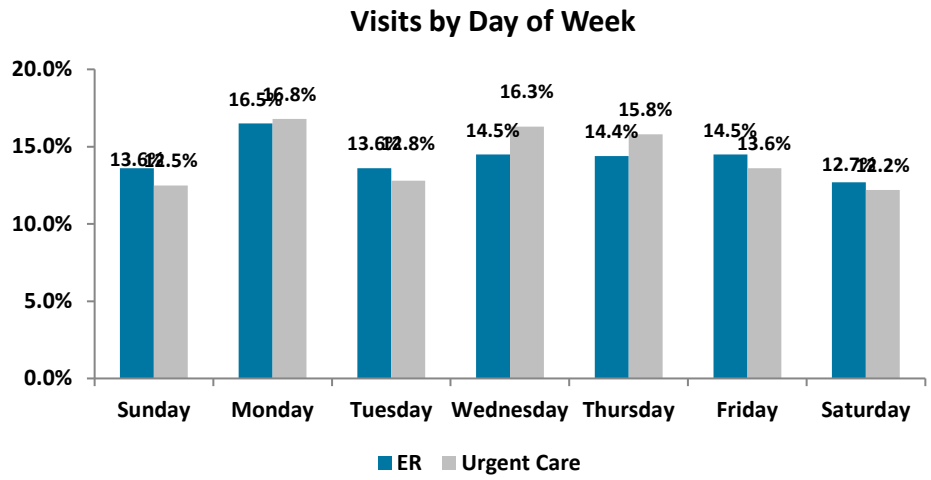
Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Atrial Fibrillation	40	227	$492,960	36.6%
Myocardial Infarction	6	46	$198,133	14.7%
Chest Pain	120	271	$140,221	10.4%
Heart Valve Disorders	34	89	$121,987	9.1%
Congestive Heart Failure	27	145	$82,495	6.1%
Hypertension	389	645	$77,616	5.8%
Cardiac Arrhythmias	104	182	$58,369	4.3%
Cardiac Conditions, Other	81	165	$45,912	3.4%
Pulmonary Embolism	11	32	$43,859	3.3%
Coronary Artery Disease	62	107	$42,759	3.2%
Shock	3	11	$27,511	2.0%
Cardio-Respiratory Arrest	16	37	$8,579	0.6%
Cardiomyopathy	10	15	$5,866	0.4%
Overall	**----**	**----**	**$1,346,268**	**100.0%**

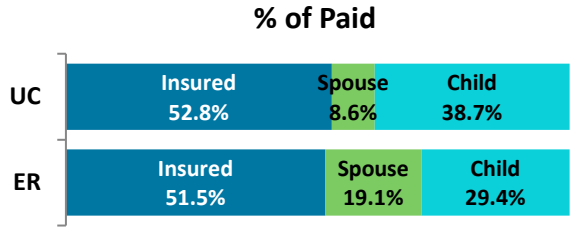
*Patient and claim counts are unique only within the category



Emergency Room / Urgent Care Summary

	2Q23		2Q24		Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	579	1,297	557	1,271		
Visits Per Member	0.18	0.40	0.19	0.44	0.23	0.38
Visits/1000 Members	177	397	192	438	228	379
Avg Paid Per Visit	$2,818	$126	$3,178	$133	$1,085	$132
% with OV*	91.3%	87.7%	89.4%	88.4%		
% Avoidable	15.3%	38.4%	13.8%	39.9%		
Total Member Paid	**$323,841**	**$60,981**	**$323,920**	**$63,040**		
Total Plan Paid	**$1,629,881**	**$163,516**	**$1,770,309**	**$168,622**		
*looks back 12 months	Annualized	Annualized	Annualized	Annualized		





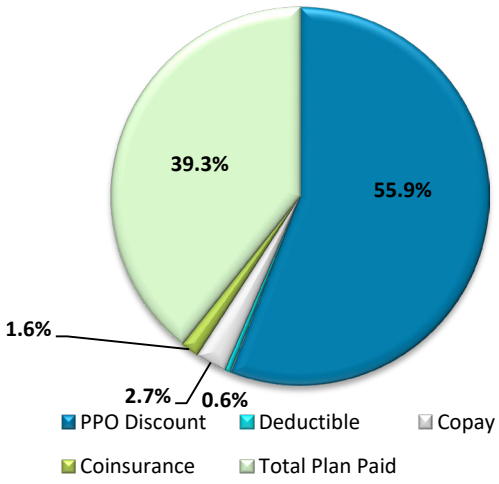
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	282	90	688	220	970	310
Spouse	76	131	115	198	191	329
Child	199	95	468	224	667	320
Total	**557**	**96**	**1,271**	**219**	**1,828**	**315**

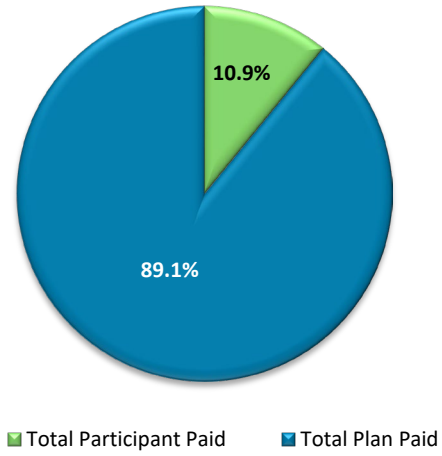
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$46,074,223	$2,451	100.0%
PPO Discount	$25,170,758	$1,339	54.6%
Deductible	$257,906	$14	0.6%
Copay	$1,200,257	$64	2.6%
Coinsurance	$701,193	$37	1.5%
Total Participant Paid	**$2,159,356**	**$115**	**4.7%**
Total Plan Paid	**$17,689,075**	**$941**	**38.4%**

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





Quality Metrics

Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric
Asthma and a routine provider visit in the last 12 months	429	421	8	98.1%
<2 asthma related ER Visits in the last 6 months	429	0	429	0.0%
No asthma related admit in last 12 months	429	3	426	0.7%
No exacerbations in last 12 months	71	4	67	5.6%
Members with COPD who had an annual spirometry test	71	11	60	15.5%
No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	1	0	1	0.0%
No ER Visit for Heart Failure in last 90 days	53	1	52	1.9%
Follow-up OV within 4 weeks of discharge from HF admission	1	1	0	100.0%
Annual office visit	519	507	12	97.7%
Annual dilated eye exam	519	254	265	48.9%
Annual foot exam	519	251	268	48.4%
Annual HbA1c test done	519	462	57	89.0%
Diabetes Annual lipid profile	519	417	102	80.3%
Annual microalbumin urine screen	519	382	137	73.6%
Hyperlipidemia Annual lipid profile	1,151	911	240	79.1%
Annual lipid profile	1,113	804	309	72.2%
Annual serum creatinine test	1,091	925	166	84.8%
Well Child Visit - 15 months	49	49	0	100.0%
Routine office visit in last 6 months (All Ages)	5,735	4,289	1,446	74.8%
Colorectal cancer screening ages 45-75 within the appropriate time period	2,512	1,389	1,123	55.3%
Women age 25-65 with recommended cervical cancer/HPV screening	1,703	1,336	367	78.4%
Males age greater than 49 with PSA test in last 24 months	933	528	405	56.6%
Routine exam in last 24 months (All Ages)	5,735	5,332	403	93.0%
Women age 40 to 75 with a screening mammogram last 24 months	1,645	1,142	503	69.4%

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

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

Data Includes Medical and Pharmacy
Based on 24 months incurred dates

Methodology

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

Public Employees' Benefits Program - RX Costs
PY 2024 - Through Quarter Ending December 31, 2023

Express Scripts

Membership Summary	1Q-2Q FY2024 EPO	1Q-2Q FY2023 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	5,797	6,559	(762)	-11.6%
Utilizing Member Count (Patients)	4,161	4,944	(783)	-15.8%
Percent Utilizing (Utilization)	71.8%	75.4%	(0)	-4.8%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	63,291	69,510	(6,219)	-8.9%
Claims per Elig Member per Month (Claims PMPM)	1.82	1.77	0.05	2.8%
Total Claims for Generic (Generic Rx)	53,768	58,771	(5,003.00)	-8.5%
Total Claims for Brand (Brand Rx)	9,523	10,739	(1,216.00)	-11.3%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	413	326	87.00	26.7%
Total Non-Specialty Claims	62,523	68,402	(5,879.00)	-8.6%
Total Specialty Claims	768	1,108	(340.00)	-30.7%
Generic % of Total Claims (GFR)	**85.0%**	**84.6%**	0.00	0.5%
Generic Effective Rate (GCR)	**99.2%**	**99.4%**	(0.00)	-0.2%
Mail Order Claims	18,689	18,173	516.00	2.8%
Mail Penetration Rate*	32.7%	29.3%	0.03	3.4%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$10,045,058	$9,878,987	$166,071.00	1.7%
Total Generic Gross Cost	$933,816	$1,102,017	($168,201.00)	-15.3%
Total Brand Gross Cost	$9,111,242	$8,776,970	$334,272.00	3.8%
Total MSB Gross Cost	$223,146	$207,200	$15,946.00	7.7%
Total Ingredient Cost	$9,763,024	$9,794,585	($31,561.00)	-0.3%
Total Dispensing Fee	$273,452	$75,843	$197,609.00	260.6%
Total Other (e.g. tax)	$8,581	$8,559	$22.00	0.3%
Avg Total Cost per Claim (Gross Cost/Rx)	**$158.71**	**$142.12**	$16.59	11.7%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$17.37	$18.75	($1.38)	-7.4%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$956.76	$817.30	$139.46	17.1%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$540.31	$635.58	($95.27)	-15.0%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$1,331,951**	**$1,469,205**	($137,254.00)	-9.3%
Total Copay	$1,330,062	$1,466,995	($136,933.00)	-9.3%
Total Deductible	$1,889	$2,210	($321.00)	0.0%
Avg Copay per Claim (Copay/Rx)	$21.04	$21.10	($0.06)	-0.3%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$21.04**	**$21.14**	**($0.09)**	**-0.4%**
Avg Copay for Generic (Copay/Generic Rx)	$6.84	$6.79	$0.05	0.7%
Avg Copay for Brand (Copay/Brand Rx)	$101.25	$99.66	$1.59	1.6%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$52.63	$75.43	($22.80)	-30.2%
Net PMPM (Participant Cost PMPM)	**$38.29**	**$37.33**	$0.96	2.6%
Copay % of Total Prescription Cost (Member Cost Share %)	13.3%	14.9%	-1.6%	-10.8%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$8,713,107**	**$8,409,782**	**$303,325.00**	**3.6%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$4,140,543	$3,759,704	$380,839.00	10.1%
Total Specialty Drug Cost (Specialty Plan Cost)	$4,572,564	$4,650,079	($77,515.00)	-1.7%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$137.67**	**$120.99**	$16.68	13.8%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$10.53	$11.96	($1.43)	-12.0%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$855.51	$717.64	$137.87	19.2%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$487.68	$560.15	($72.47)	-12.9%
Net PMPM (Plan Cost PMPM)	**$250.51**	**$213.70**	**$36.81**	**17.2%**
PMPM without Specialty (Non-Specialty PMPM)	$119.04	$95.54	$23.50	24.6%
PMPM for Specialty Only (Specialty PMPM)	$131.46	$118.16	$13.30	11.3%
Rebates Received (Q1 FY2024 actual)	$2,833,099	$3,106,125	($273,026.09)	-8.8%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$169.05**	**$134.77**	**$34.29**	**25.4%**
PMPM without Specialty (Non-Specialty PMPM)	$75.05	$53.53	$21.52	40.2%
PMPM for Specialty Only (Specialty PMPM)	$92.97	$88.90	$4.07	4.6%

Appendix D

Index of Tables
Health Plan of Nevada –Utilization Review for PEBP
July 1, 2023 – December 31, 2023

Power Of Partnership.

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

Claims Incurred Data:

July 1, 2022 – Dec. 2022 – Prior Period
July 1, 2023 – Dec. 2023 – Current Period
*Peer – Non-Gaming
**Paid through March 2024

State of Nevada

Executive Summary

Spend and Utilization

Executive Summary Utilization & Spend

UnitedHealthcare

Population

- -3.4% decrease for employees
- -3.9% decrease for members

Medical Paid PMPM

- -.5% decrease in overall medical paid from prior period
- 3.4% increase in non-Catastrophic spend
- -9.1% decrease in Catastrophic spend

High-Cost Claimants

- 34 HCC in 2Q23, flat from prior period
- % of HCC spend saw a small decrease of -9.4%
- Avg. Paid per case increased -12.8%

Emergency Room

- ER Visits Per 1,000 members decreased -8.7%
- Avg. paid per ER Visit increased 19.1%

Urgent Care

- Urgent Care visits per 1,000 members decreased by -1.3%
- Avg. paid per Urgent care visit increased 4.8%

Rx Drivers

- Rx Net Paid PMPM increased 10.5%
- Specialty Spend decreased -17.1%
- Specialty Rx driving 37.7% of total Rx Spend

Overall Medical / Rx

- Total Medical/Rx increased 3.1% on PMPM basis

Executive Summary Utilization & Spend

UnitedHealthcare®

Claims Paid by Age Group														
	July - Dec. 2022 Q1						July - Dec 2023 Q1						Change	
Age Band	Medical Net Paid	Medical PMPM	Rx Net Paid	Rx PMPM	Med/Rx Net Paid	Med/Rx PMPM	Medical Net Paid	Medical PMPM	Rx Net Paid	Rx PMPM	Med/Rx Net Paid	Med/Rx PMPM	Med/Rx Net Paid	Med/Rx Net PMPM
<1	$256,229	$756	$1,086	$3	$257,315	$759	$290,068	$1,131	$896	$3	$290,964	$1,135	13.1%	9.0%
01	$200,439	$654	$2,631	$9	$203,069	$663	$89,932	$304	$1,948	$7	$91,880	$310	-53.6%	-23.4%
02-04	$336,416	$289	$8,512	$7	$344,927	$296	$259,197	$267	$9,240	$10	$268,437	$276	-7.8%	30.0%
05-09	$499,568	$229	$33,012	$15	$532,580	$244	$378,725	$196	$33,250	$17	$411,975	$214	-14.2%	14.0%
10-14	$528,937	$192	$184,464	$67	$713,401	$259	$457,878	$170	$93,057	$35	$550,935	$205	-11.4%	-48.4%
15-19	$627,833	$198	$106,741	$34	$734,574	$231	$583,069	$187	$155,738	$50	$738,807	$237	-5.3%	48.8%
20-24	$417,437	$150	$106,253	$38	$523,689	$188	$601,553	$208	$62,015	$21	$663,568	$229	38.4%	-43.9%
25-29	$613,268	$341	$189,243	$105	$802,511	$446	$685,575	$443	$111,206	$72	$796,781	$514	29.9%	-31.7%
30-34	$778,591	$370	$271,106	$129	$1,049,696	$499	$636,503	$350	$281,969	$155	$918,472	$506	-5.4%	20.4%
35-39	$846,103	$335	$531,234	$210	$1,377,337	$545	$592,764	$248	$656,698	$275	$1,249,462	$524	-25.8%	30.9%
40-44	$883,755	$327	$415,338	$154	$1,299,093	$480	$1,142,527	$449	$331,735	$130	$1,474,263	$579	37.4%	-15.1%
45-49	$1,200,479	$354	$508,972	$150	$1,709,451	$504	$1,191,037	$368	$702,104	$217	$1,893,141	$584	3.8%	44.3%
50-54	$1,657,246	$437	$1,212,836	$320	$2,870,082	$757	$1,135,862	$304	$1,087,464	$291	$2,223,326	$595	-30.5%	-9.0%
55-59	$1,661,587	$453	$1,134,788	$309	$2,796,376	$762	$1,548,130	$415	$1,361,709	$365	$2,909,839	$780	-8.4%	17.9%
60-64	$1,870,219	$525	$1,138,988	$320	$3,009,207	$844	$1,809,242	$502	$1,092,091	$303	$2,901,332	$805	-4.3%	-5.2%
65+	$1,277,782	$508	$755,719	$300	$2,033,501	$808	$1,663,694	$664	$1,031,550	$412	$2,695,244	$1,076	30.7%	37.1%
Total	$13,655,888	$352	$6,600,922	$170	$20,256,811	$523	$13,065,756	$351	$7,012,669	$188	$20,078,425	$539	-0.9%	3.1%

Financial Summary

Financial and Demographic (*July 2023 thru Dec 2023 Q2*)												
	Total				State Active				Retiree (State/Non-State)			
Summary	Thru 2Q21	Thru 2Q22	Thru 2Q23	▲	Thru 2Q21	Thru 2Q22	Thru 2Q23	▲	Thru 2Q21	Thru 2Q22	Thru 2Q23	▲
Avg. # Employees	3,815	3,666	3,540	-3.4%	3,342	3,233	3,095	-4.3%	472	433	445	2.9%
Avg. # Members	6,730	6,461	6,212	-3.9%	6,112	5,875	5,602	-4.6%	618	586	610	4.1%
Ratio	1.8	1.8	1.8	-0.5%	1.8	1.8	1.8	-0.4%	1.3	1.4	1.4	1.2%
Financial												
Medical Paid	$22,269,875	$13,655,888	$13,065,756	-4.3%	$19,729,431	$12,426,807	$11,035,603	-11.2%	$2,540,444	$1,229,082	$2,030,153	65.2%
Member Paid	$1,391,413	$953,762	$1,055,158	10.6%	$1,054,375	$724,645	$799,275	10.3%	$337,038	$229,118	$255,883	11.7%
Net Paid PEPY	$11,675	$7,450	$7,381	-0.9%	$11,796	$7,675	$7,117	-7.3%	$10,818	$5,771	$9,216	59.7%
Net Paid PMPY	$6,618	$4,227	$4,206	-0.5%	$6,451	$4,224	$3,932	-6.9%	$8,271	$4,259	$6,723	57.8%
Net Paid PEPM	$973	$621	$615	-0.9%	$983	$640	$593	-7.3%	$902	$481	$768	59.7%
Net Paid PMPM	$551	$352	$351	-0.5%	$538	$352	$328	-6.9%	$689	$355	$560	57.8%
High Cost Claimants												
# of HCC's > $50k	46	34	34	0.0%	36	32	23	-28.1%	10	2	11	450.0%
Avg. paid per claimant	$260,233	$109,760	$95,672	-12.8%	$298,059	$109,823	$98,331	-10.5%	$124,058	$108,762	$90,110	-17.1%
HCC % of Spend	53.5%	27.3%	24.9%	-9.1%	54.4%	28.3%	20.5%	-27.6%	47.2%	17.4%	48.0%	175.4%
Spend by Location (PMPY)												
Inpatient	$3,393	$1,121	$1,151	2.7%	$3,362	$1,276	$1,031	-19.2%	$3,701	$1,055	$2,698	155.7%
Outpatient	$1,144	$1,181	$1,073	-9.2%	$1,095	$1,128	$893	-20.8%	$1,627	$1,143	$1,500	31.3%
Professional	$2,081	$1,925	$1,982	3.0%	$1,999	$1,321	$1,253	-5.2%	$3,054	$2,061	$2,529	22.7%
Total	$6,618	$4,227	$4,206	-0.5%	$6,456	$4,230	$3,940	-6.9%	$8,382	$4,259	$6,727	57.9%

Paid Claims by Claim Type

UnitedHealthcare

Net Paid Claims - Total Total Participants									
	July - Dec 2022 Q2				July - Dec 2023 Q2				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical									
InPatient	$3,020,633	$82,666	$517,650	$3,620,949	$2,611,089	$260,696	$704,630	$3,576,414	-1.2%
OutPatient	$8,889,293	$404,813	$740,832	$10,034,938	$8,280,345	$271,618	$937,380	$9,489,342	-5.4%
Total - Medical	$11,909,927	$487,479	$1,258,482	$13,655,888	$10,891,433	$532,313	$1,642,009	$13,065,756	-4.3%

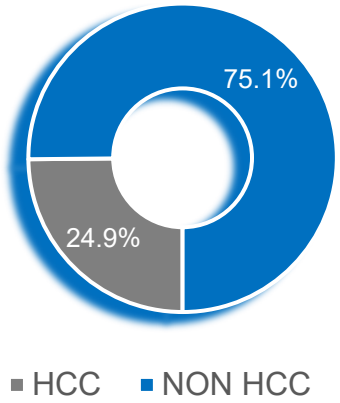
Net Paid Claims - Total Total Participants									
	July - Dec 2022 Q2				July - Dec 2023 Q2				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical PMPM	$335	$656	$1,694	$352	$320	$708	$655	$351	-0.5%

Cost Distribution – Medical Claims > $50K

UnitedHealthcare

July - Dec 2Q22							July - Dec 2Q23					
# 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
7	0.1%	$1,081,869	7.9%	$601,829	55.6%	> $100k	4	0.1%	$630,759	4.8%	$102,843	16.3%
11	0.2%	$1,103,299	8.1%	$736,269	66.7%	$50k- $100k	12	0.2%	$912,484	7.0%	$306,920	33.6%
264	4.1%	$1,193,867	8.7%	$808,799	67.7%	$25k - $50k	276	4.4%	$1,260,687	9.6%	$831,921	66.0%
34	0.5%	$1,227,846	9.0%	$970,038	79.0%	$10k - $25k	197	3.2%	$1,603,756	12.3%	$992,146	61.9%
200	3.1%	$1,708,895	12.5%	$1,182,950	69.2%	$5k - $10k	45	0.7%	$1,687,899	12.9%	$1,120,857	66.4%

% Paid Attributed to Catastrophic Cases



HCC > $50k - AHRQ Chapter Conditions - Thru 2Q23			
Complications of pregnancy;	# of Patients	Total Paid	% of Med Paid
Diseases of the circulatory system	4	$360,969	2.8%
Diseases of the nervous system	1	$252,881	1.9%
Neoplasms	4	$248,344	1.9%
Complications of pregnancy;	3	$239,180	1.8%
Diseases of the digestive system	2	$177,975	1.4%

Utilization Summary

UnitedHealthcare

Utilization Summary	Total			State Active			Retiree State/Non-State		
	July - Dec 2Q22	July - Dec 2Q23	▲	July - Dec 2Q22	July - Dec 2Q23	▲	July - Dec 2Q22	July - Dec 2Q23	▲
Inpatient									
# of Admits	176	203	15.3%	161	164	2.1%	15	39	156.7%
# of Bedays	961	1,127	17.2%	900	789	-12.3%	61	337	450.3%
Avg. Paid per Admit	$20,750	$17,987	-13.3%	$20,711	$17,023	-17.8%	$21,174	$22,082	4.3%
Avg. Paid per Day	$3,789	$3,233	-14.7%	$3,693	$3,534	-4.3%	$5,199	$2,529	-51.4%
Admits Per K	54.3	65.2	20.0%	54.6	58.5	7.1%	51.3	126.6	146.7%
Days Per K	297.6	362.7	21.9%	306.4	281.8	-8.0%	209.1	1,105.7	428.8%
ALOS	5.5	5.6	1.6%	5.6	4.8	-14.1%	5.5	5.9	7.3%
Admits from ER	86	96	11.6%	76	77	1.3%	10	19	90.0%
Physician Office Visits									
Per Member Per Year	2.3	2.2	-3.5%	2.3	2.2	-2.9%	2.7	2.5	-9.5%
Paid Per Visit	$148	$152	2.5%	$153	$158	2.9%	$106	$105	-0.9%
Net Paid PMPM	$29	$28	-1.1%	$29	$29	-0.2%	$24	$21	-10.3%
Emergency Room									
# of Visits	416	380	-8.7%	383	350	-8.6%	33	30	-9.1%
Visits Per K	128.8	122.3	-5.0%	130.4	124.9	-4.2%	112.6	98.4	-12.6%
Avg Paid Per Visit	$2,486	$2,959	19.1%	$2,551	$3,033	18.9%	$1,726	$2,098	21.6%
Urgent Care									
# of Visits	2,039	2,012	-1.3%	1,845	1,800	-2.4%	194	212	9.3%
Visits Per K	631.1	647.7	2.6%	628.1	642.6	2.3%	661.9	695.1	5.0%
Avg Paid Per Visit	$119	$125	4.8%	$92	$92	0.0%	$75	$90	19.9%

**Not Representative of all utilization*

**Data based on medical spend only*

Diagnosis Grouper Summary – Top 25

UnitedHealthcare®

Top 25 AHRQ Category	Total Paid	% Paid	Insured	Spouse	Dependent	Male	Female	Unassigned
Other nervous system disorders	$325,940	3.2%	$72,302	$250,012	$3,626	$66,802	$259,138	$0
Other nutritional; endocrine; and metabolic disorders	$307,137	3.0%	$134,976	$137,925	$34,236	$68,004	$239,133	$0
Spondylosis; intervertebral disc disorders	$299,611	2.9%	$207,579	$89,910	$2,122	$142,638	$156,973	$0
Disorders usually diagnosed in infancy childhood	$266,786	2.6%	$0		$266,786	$201,896	$64,890	$0
Osteoarthritis	$259,613	2.5%	$245,062	$14,551	$0	$107,321	$152,292	$0
Diabetes mellitus with complications	$238,923	2.3%	$178,505	$44,865	$15,554	$135,089	$103,834	$0
Mood disorders	$226,842	2.2%	$94,635	$12,759	$119,448	$45,318	$181,525	$0
Cancer of breast	$205,097	2.0%	$117,711	$87,386			$205,097	$0
Cancer of esophagus	$192,935	1.9%		$192,935		$192,935		$0
Liveborn	$181,551	1.8%			$181,551	$172,512	$9,039	$0
Acute cerebrovascular disease	$177,667	1.7%	$175,336	$1,902	$429	$118,258	$59,409	$0
Transient cerebral ischemia	$161,044	1.6%	$8,040	$153,004		$153,613	$7,431	$0
Other gastrointestinal disorders	$158,151	1.5%	$41,655	$103,951	$12,545	$136,945	$21,205	$0
Other screening for suspected conditions	$156,807	1.5%	$121,185	$31,775	$3,846	$53,242	$103,564	$0
Nonspecific chest pain	$155,688	1.5%	$79,425	$73,761	$2,503	$97,642	$58,046	$0
Other female genital disorders	$150,515	1.5%	$143,631	$4,693	$2,191		$150,515	$0
Urinary tract infections	$146,814	1.4%	$67,302	$56,125	$23,387	$70,394	$76,420	$0
Heart valve disorders	$140,322	1.4%	$94,605	$45,716	$0	$140,107	$214	$0
Abdominal pain	$139,711	1.4%	$101,685	$10,091	$27,934	$36,653	$103,057	$0
Cardiac dysrhythmias	$131,945	1.3%	$119,326	$9,125	$3,495	$75,510	$56,435	$0
Coronary atherosclerosis and other heart disease	$128,073	1.3%	$56,303	$71,769		$101,312	$26,761	$0
Regional enteritis and ulcerative colitis	$127,388	1.2%	$27,506	$2,547	$97,335	$99,060	$28,328	$0
Residual codes; unclassified	$122,188	1.2%	$101,174	$10,616	$10,397	$41,839	$80,348	$0
Anxiety disorders	$120,779	1.2%	$66,515	$12,924	$41,340	$33,256	$87,524	$0
Hypertension with complications / secondary hypertension	$120,766	1.2%	$95,727	$25,039		$96,723	$24,043	$0

**Not Representative of all utilization*

**Data based on medical spend only*

Mental Health Drilldown

UnitedHealthcare®

Top 10 Mental Health				
AHRQ Category Description	July - Dec 2Q22		July - Dec 2Q23	
	Patients	Total Paid	Patients	Total Paid
Disorders usually diagnosed in infancy childhood or adolescence	29	$254,668	37	$266,786
Mood disorders	356	$223,095	293	$226,842
Anxiety disorders	308	$113,077	316	$120,779
Alcohol-related disorders	9	$13,880	22	$70,549
Adjustment disorders	103	$28,074	111	$45,299
Suicide and intentional self-inflicted injury	9	$17,838	9	$27,343
Attention-deficit conduct and disruptive behavior disorders	111	$19,380	124	$26,669
Schizophrenia and other psychotic disorders	8	$16,946	12	$13,719
Miscellaneous mental health disorders	33	$33,422	38	$7,574
Substance-related disorders	21	$26,923	21	$4,281

**Not Representative of all utilization*

**Data based on medical spend only*

Respiratory Disorders

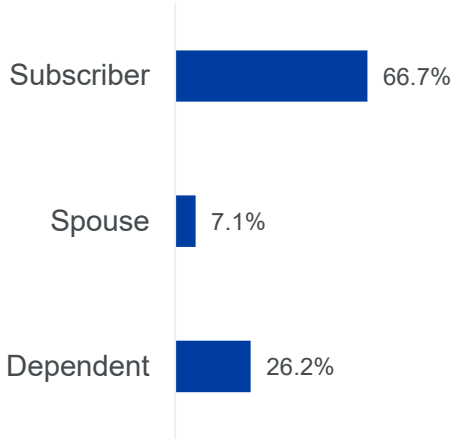
UnitedHealthcare

Top 10 Respiratory Disorders				
AHRQ Category Description	Patients	Claims	Total Paid	% Paid
Pneumonia	22	79	$89,277	18.9%
Other upper respiratory infections	568	726	$88,693	18.8%
Other upper respiratory disease	267	669	$83,310	17.6%
Other lower respiratory disease	314	527	$65,982	14.0%
Asthma	175	293	$63,043	13.4%
Pleurisy; pneumothorax; pulmonary collapse	26	76	$40,384	8.6%
Influenza	38	45	$13,646	2.9%
Acute and chronic tonsillitis	25	40	$8,366	1.8%
Chronic obstructive pulmonary disease and bronchiectasis	75	149	$7,722	1.6%
Respiratory failure; insufficiency; arrest (adult)	16	44	$5,466	1.2%

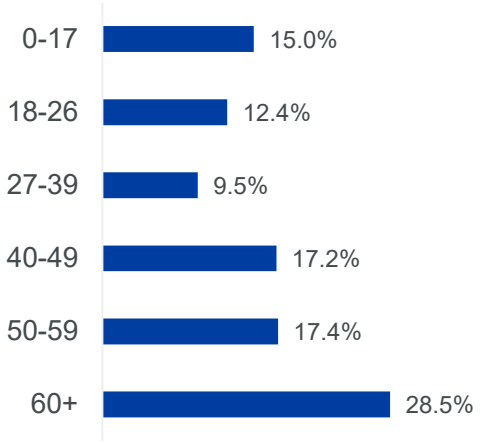
*Not Representative of all utilization

*Data based on medical spend only

Spend by Relationship



Spend by Age Range



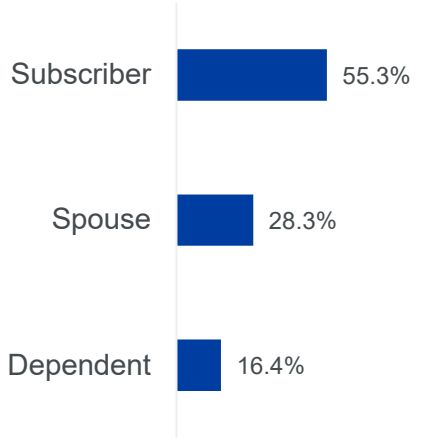
Infections

Top 10 Infectious and Parasitic Diseases				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Septicemia (except in labor)	13	41	$108,632	44.4%
Viral infection	254	372	$91,625	37.5%
Immunizations	395	589	$38,379	15.7%
Mycoses	77	99	$2,298	0.9%
HIV infection	22	80	$1,156	0.5%
Bacterial infection; unspecified site	16	20	$830	0.3%
Hepatitis	11	29	$729	0.3%
Sexually transmitted infections	8	16	$638	0.3%
Other infections; including parasitic	9	12	$158	0.1%
Tuberculosis	1	6	$0	0.0%

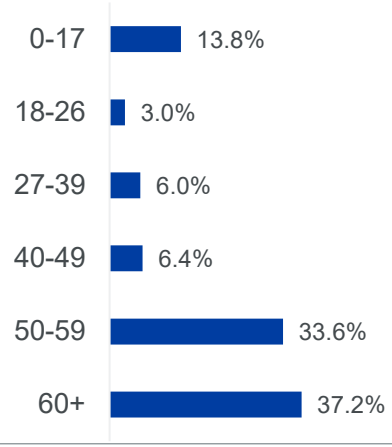
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



Spend by Age Range



Pregnancy Related Disorders

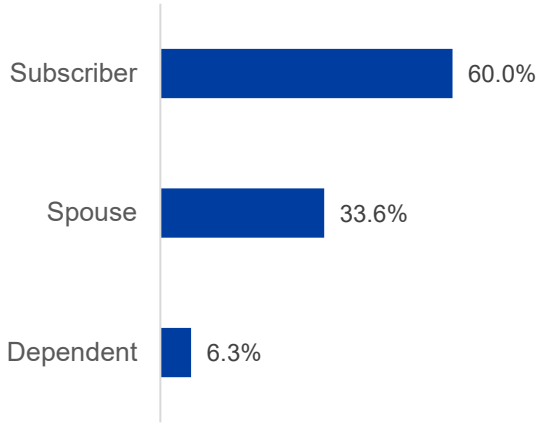
UnitedHealthcare

Top 10 Complications of Pregnancy				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Diabetes or abnormal glucose tolerance complicating pregnancy	6	50	$91,427	21.9%
Fetal distress and abnormal forces of labor	5	13	$44,897	10.8%
Hypertension complicating pregnancy; childbirth and the puerperium	4	15	$43,392	10.4%
Malposition; malpresentation	2	4	$40,887	9.8%
Other complications of pregnancy	32	105	$39,927	9.6%
Previous C-section	2	8	$30,942	7.4%
Polyhydramnios and other problems of amniotic cavity	3	13	$30,627	7.3%
Contraceptive and procreative management	72	122	$27,743	6.6%
Prolonged pregnancy	3	11	$25,923	6.2%
Other pregnancy and delivery including normal	38	96	$18,014	4.3%

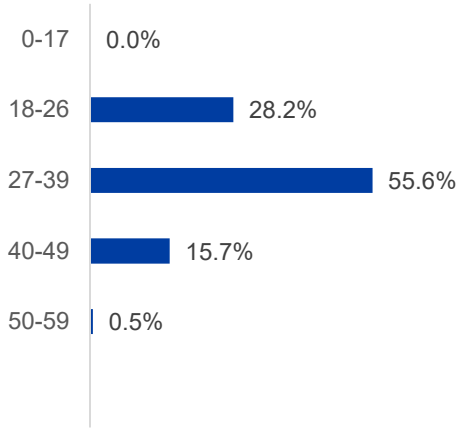
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



Spend by Age Range



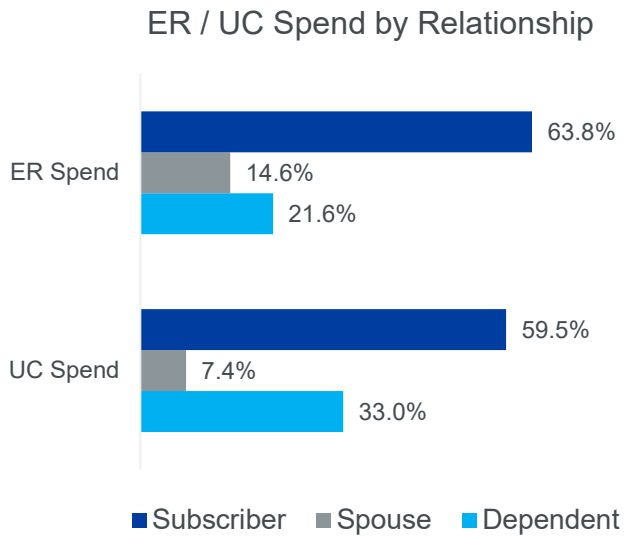
Emergency Room and Urgent Care

	July - Dec 2Q22		July - Dec 2Q23		Peer	
Metric	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
# of Visits	416	2,039	380	2,012		
Visits Per Member	0.06	0.32	0.06	0.32	0.09	0.014
Visits Per K	128.8	631.1	122.3	647.7	89.3	384.9
Avg. Paid Per Visit	$2,486	$112	$2,959.33	$121	$2,605	$116

**Not Representative of all utilization*

**Data based on medical spend only*

Emergency Room and Urgent Care Visits by Relationships - 2Q23				
Relationship	ER Visits	ER Per K	UC Visits	UC Per K
Member	219	70.5	1,275	410.5
Spouse	62	20.0	197	63.4
Dependent	99	31.9	540	173.8
Total	380	122.3	2,012	647.7



Clinical Conditions by Medical Spend

UnitedHealthcare®

Top 15 Common Condition	# of Members	% of Members	Members Per K	PMPM
Mental Disorders	591	9.5%	95.1	$15.68
Intervertebral Disc Disorders	425	6.8%	68.4	$8.04
Diabetes with complications	360	5.8%	57.9	$5.50
Breast Cancer	63	1.0%	10.1	$6.41
Hypertension	429	6.9%	69.1	$3.44
Coronary Atherosclerosis	78	1.3%	12.6	$0.71
Diabetes without complications	297	4.8%	47.8	$4.35
Asthma	175	2.8%	28.2	$1.09
Prostate Cancer	22	0.4%	3.5	$1.69
Acute Myocardial Infarction	5	0.1%	0.8	$1.98
Chronic Renal Failure	56	0.9%	9.0	$0.51
Congestive Heart Failure (CHF)	35	0.6%	5.6	$1.37
Colon Cancer	3	0.0%	0.5	$0.21
COPD	75	1.2%	12.1	$0.05
Cervical Cancer	26	0.4%	4.2	$0.67

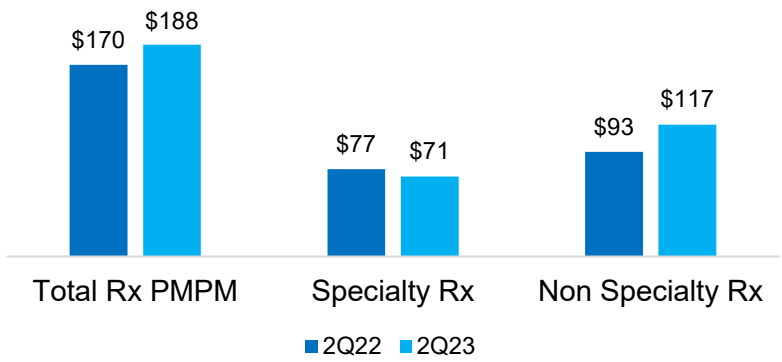
**Not Representative of all utilization*

**Data based on medical spend only*

Pharmacy Drivers

	July - Dec 2Q22	July - Dec 2Q23	Δ
Enrolled Members	6,461	6,212	-3.9%
Average Prescriptions PMPY	17.1	17.3	1.0%
Formulary Rate	89.7%	86.9%	-3.2%
Generic Use Rate	83.9%	84.0%	0.2%
Generic Substitution Rate	98.3%	98.1%	-0.2%
Avg Net Paid per Prescription	$119	$131	9.4%
Net Paid PMPM	$170	$188	10.5%

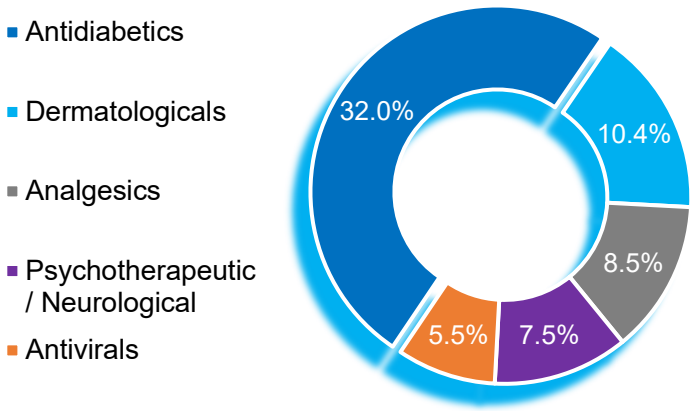
Total Rx Spend by Benefit and Type



Pharmacy Performance

- Rx spend increased of **10.5%**, (**$18 PMPM**) from prior period
- Avg. paid per Script increased **9.4%** (**$11 PMPM**) year over year
- Specialty Rx spend driving **37.7%** of Rx Spend
- Specialty Rx spend decreased **-17.08%** from prior period
  Specialty Rx Drivers:
  Ozempic (Antidiabetic) Spend up **45.2%**
  Jardiance (Antidiabetic) Spend up **18.1%**
- Tier 1 Rx drove **74.8%** of total claim volume, but only accounts for **10.8%** of overall Rx Spend

Top 5 Therapeutic Classes by Spend



4.3

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

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

4.3.1 Q2 UMR – Obesity Care Management

4.3.2 Q2 UMR – Diabetes Care Management

4.3.3 Q2 UMR – Performance Guarantee Report

4.3.4 Q2 Sierra Healthcare Options – Utilization and Large Case Management

4.3.5 Q2 Express Scripts – Summary Report

4.3.6 Q2 Express Scripts – Utilization Report

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

4.3.8 Q3 Amplifon Performance Report

4.3.9 Doctor on Demand Engagement Report

4.3.10 Real Appeal – Utilization Report

4.3.1

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

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

4.3.1 Q2 UMR – Obesity Care Management

DATASCOPE™

Obesity Care Management Report

Nevada Public Employees' Benefits Program

July – December 2023 Incurred,

Paid through February 29, 2023

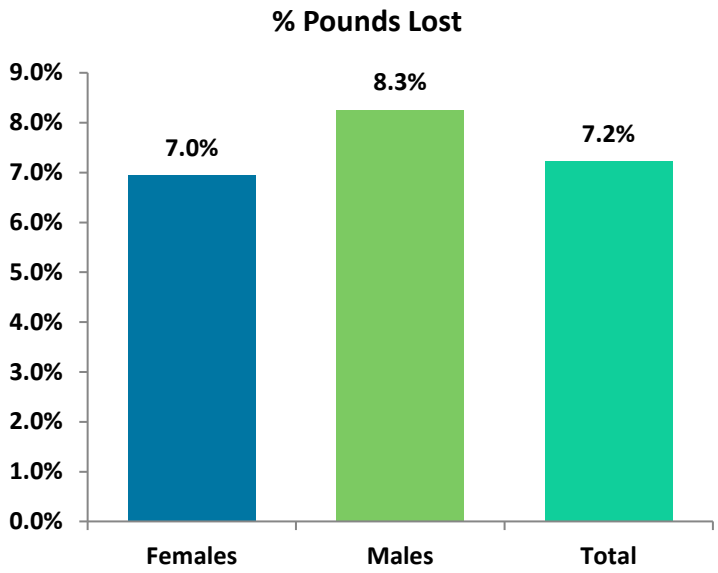
Reimagine | Rediscover **Benefits**

UMR℠

Obesity Care Management Overview

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

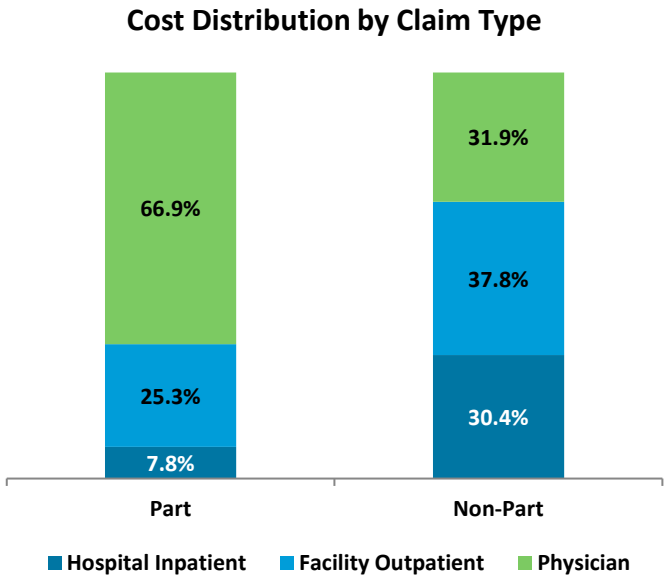
2Q24			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	246	50	296
Average # Lbs. Lost	13.9	20.8	15.1
Total # Lbs. Lost	3,425.1	1,041.2	4,466.3
% Lbs. Lost	7.0%	8.3%	7.2%
Average Cost/ Member	$5,538	$4,451	$5,354



Obesity Care Management – Financial Summary

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

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	271	1,398	-80.6%
Avg # Members	294	1,673	-82.4%
Member/Employee Ratio	1.1	1.2	-10.0%
Financial Summary			
Gross Cost	$974,742	$11,074,274	
Client Paid	$770,045	$9,161,544	
Employee Paid	$204,697	$1,912,730	
Client Paid-PEPY	$5,683	$13,107	-56.6%
Client Paid-PMPY	$5,241	$10,956	-52.2%
Client Paid-PEPM	$474	$1,092	-56.6%
Client Paid-PMPM	$437	$913	-52.1%
High Cost Claimants (HCC's) > $100k			
# of HCC's	0	8	
HCC's / 1,000	0.0	4.8	0.0%
Avg HCC Paid	$0	$193,908	0.0%
HCC's % of Plan Paid	0.0%	16.9%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$408	$3,326	-87.7%
Facility Outpatient	$1,327	$4,138	-67.9%
Physician	$3,507	$3,491	0.5%
Total	$5,241	$10,956	-52.2%
	Annualized	Annualized	



Obesity Care Management – Utilization Summary

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	6	129	
# of Bed Days	15	851	
Paid Per Admit	$9,965	$26,272	-62.1%
Paid Per Day	$3,986	$3,983	0.1%
Admits Per 1,000	41	154	-73.4%
Days Per 1,000	102	1,018	-90.0%
Avg LOS	2.5	6.6	-62.1%
# of Admits From ER	4	72	-94.4%
Physician Office			
OV Utilization per Member	19.4	10.3	88.3%
Avg Paid per OV	$115	$100	15.0%
Avg OV Paid per Member	$2,238	$1,026	118.1%
DX&L Utilization per Member	18.0	26.4	-31.8%
Avg Paid per DX&L	$41	$71	-42.3%
Avg DX&L Paid per Member	$735	$1,870	-60.7%
Emergency Room			
# of Visits	35	293	
Visits Per Member	0.24	0.35	-31.4%
Visits Per 1,000	238	350	-32.0%
Avg Paid per Visit	$3,456	$3,381	2.2%
Urgent Care			
# of Visits	83	441	
Visits Per Member	0.56	0.53	5.7%
Visits Per 1,000	565	529	6.8%
Avg Paid per Visit	$78	$97	-19.6%
	Annualized	Annualized	

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

4.3.2

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

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

4.3.1 Q2 UMR – Obesity Care Management

4.3.2 Q2 UMR – Diabetes Care Management

DATASCOPE™

Diabetes Care Management Report

Nevada Public Employees' Benefits Program

July – December 2023 Incurred,

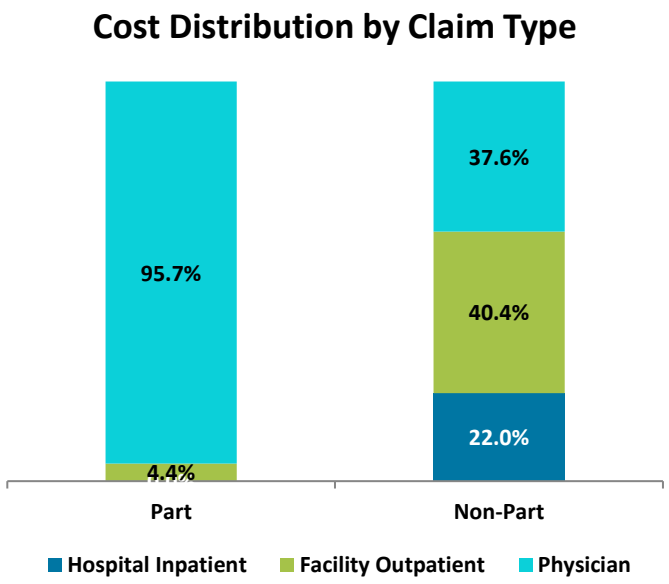
Paid through February 29, 2023

UMR℠

Diabetes Care Management – Financial Summary

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

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	5	2,502	-99.8%
Avg # Members	7	3,135	-99.8%
Member/Employee Ratio	1.4	1.3	12.0%
Financial Summary			
Gross Cost	$7,815	$17,156,945	
Client Paid	$2,881	$13,874,722	
Employee Paid	$4,934	$3,282,223	
Client Paid-PEPY	$1,152	$11,092	-89.6%
Client Paid-PMPY	$823	$8,851	-90.7%
Client Paid-PEPM	$96	$924	-89.6%
Client Paid-PMPM	$69	$738	-90.7%
High Cost Claimants (HCC's) > $100k			
# of HCC's	0	17	
HCC's / 1,000	0.0	5.4	0.0%
Avg HCC Paid	$0	$203,345	-100.0%
HCC's % of Plan Paid	0.0%	24.9%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$0	$1,950	-100.0%
Facility Outpatient	$36	$3,574	-99.0%
Physician	$788	$3,327	-76.3%
Total	$823	$8,851	-90.7%
	Annualized	Annualized	



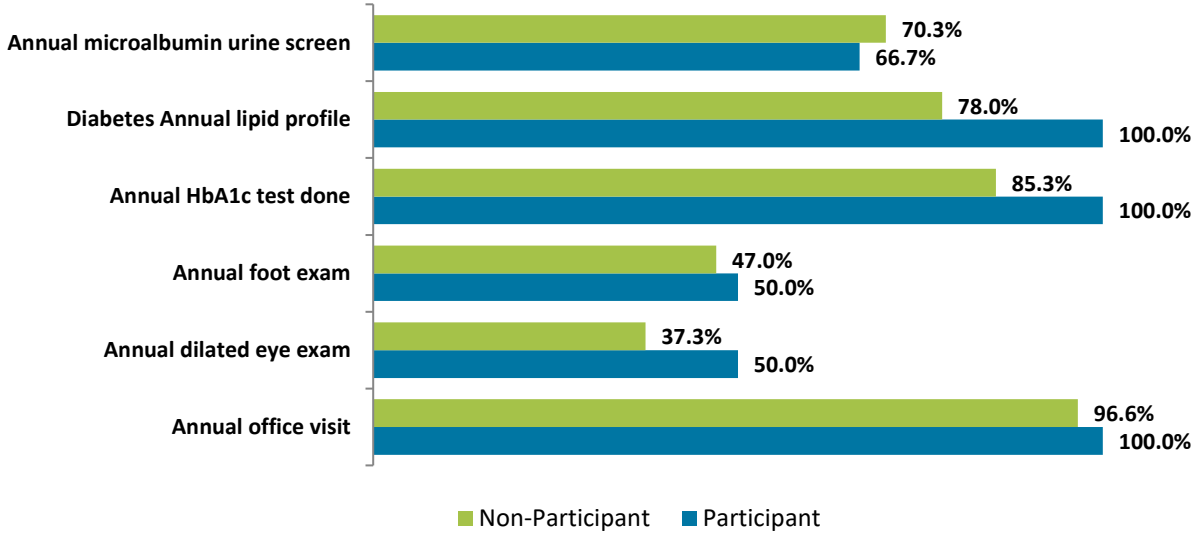
Diabetes Care Management – Utilization Summary

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

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	0	172	
# of Bed Days	0	988	
Paid Per Admit	$0	$23,499	-100.0%
Paid Per Day	$0	$4,091	-100.0%
Admits Per 1,000	0	110	-100.0%
Days Per 1,000	0	630	-100.0%
Avg LOS	0	5.7	-100.0%
# of Admits From ER	0	120	-100.0%
Physician Office			
OV Utilization per Member	4.4	8.8	-50.0%
Avg Paid per OV	$104	$107	-2.8%
Avg OV Paid per Member	$456	$949	-51.9%
DX&L Utilization per Member	9	24.5	-63.3%
Avg Paid per DX&L	$58	$59	-1.7%
Avg DX&L Paid per Member	$521	$1,454	-64.2%
Emergency Room			
# of Visits	0	448	
Visits Per Member	0.00	0.29	-100.0%
Visits Per 1,000	0	286	-100.0%
Avg Paid per Visit	$0	$3,160	-100.0%
Urgent Care			
# of Visits	0	658	
Visits Per Member	0.00	0.42	-100.0%
Visits Per 1,000	0	420	-100.0%
Avg Paid per Visit	$0	$81	-100.0%
	Annualized	Annualized	

Quality Metrics

		Participant				Non-Participant			
Condition	Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric
Diabetes	Annual office visit	6	6	0	100.0%	2,872	2,774	98	96.6%
	Annual dilated eye exam	6	3	3	50.0%	2,872	1,072	1,800	37.3%
	Annual foot exam	6	3	3	50.0%	2,872	1,350	1,522	47.0%
	Annual HbA1c test done	6	6	0	100.0%	2,872	2,451	421	85.3%
	Diabetes Annual lipid profile	6	6	0	100.0%	2,872	2,239	633	78.0%
	Annual microalbumin urine screen	6	4	2	66.7%	2,872	2,018	854	70.3%



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

4.3.3

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

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

4.3.1 Q2 UMR – Obesity Care Management

4.3.2 Q2 UMR – Diabetes Care Management

4.3.3 Q2 UMR – Performance Guarantee Report

PERFORMANCE GUARANTEE REPORT
NV PUBLIC EMPLOYEES BENEFITS PROGRAM
FOR MONTH ENDING: 3/2024
PLAN YEAR: JUL-JUN

Current Month

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	95.0%	3.0%
Claim TAT in 20 Business Days	99.0%	99.0%	0.0%
Abandonment Rate	3.0%	0.7%	2.3%
Calls Answered Within Service Level	85.0%	89.6%	4.6%
CSR Callback	90.0%	100.0%	10.0%
Call Resolution	95.0%	95.8%	0.8%
Adjustment Turnaround in 5 Days Rate	95.0%	97.8%	2.8%
Customer Service Quality Rate	97.0%	97.2%	0.2%
Open Issue Resolution 2 Days Rate	90.0%	98.3%	8.3%
Open Issue Resolution 5 Days Rate	98.0%	99.4%	1.4%

Current Quarter to Date

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	94.0%	2.0%
Claim TAT in 20 Business Days	99.0%	98.5%	-0.5%
Abandonment Rate	3.0%	0.5%	2.5%
Calls Answered Within Service Level	85.0%	92.2%	7.2%
CSR Callback	90%	100.0%	10.0%
Call Resolution	95.0%	95.8%	0.8%
Adjustment Turnaround in 5 Days Rate	95.0%	94.3%	-0.7%
Customer Service Quality Rate	97.0%	97.0%	0.0%
Open Issue Resolution 2 Days Rate	90.0%	98.0%	8.0%
Open Issue Resolution 5 Days Rate	98.0%	99.2%	1.2%

Current Year to Date

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	93.7%	1.7%
Claim TAT in 20 Business Days	99.0%	95.0%	-4.0%
Abandonment Rate	3.0%	0.6%	2.4%
Calls Answered Within Service Level	85.0%	93.5%	8.5%
CSR Callback	90.0%	100.00	10.00
Call Resolution	95.0%	93.3%	-1.7%
Adjustment Turnaround in 5 Days Rate	95.0%	93.9%	-1.1%
Customer Service Quality Rate	97.0%	96.6%	-0.4%
Open Issue Resolution 2 Days Rate	90.0%	95.9%	5.9%
Open Issue Resolution 5 Days Rate	98.0%	96.6%	-1.4%

4.3.4

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

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

- 4.3.1 Q2 UMR – Obesity Care Management
- 4.3.2 Q2 UMR – Diabetes Care Management
- 4.3.3 Q2 UMR – Performance Guarantee Report
- **4.3.4 Q2 Sierra Healthcare Options – Utilization and Large Case Management**

SHO-PUBLIC EMPLOYEES BENEFIT

2023 Performance Review

Excutive Summary

Metrics	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Average
Enrollment	48,645	48,816	49,008	49,039	49,228	49,249	**48,997**

Inpatient All - LTACH, AIR, SNF, and OOA

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Total	Average
Total Discharges	135	166	136	129	161	151	**878**	**146**
Total Discharges LOS	810	786	589	670	850	794	**4,499**	**750**
Average LOS	6.0	4.7	4.3	5.2	5.3	5.3	**5.1**	**5.1**

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

Inpatient Hospital Acute Only

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Total	Average
Total Discharges	90	104	70	78	97	86	**525**	**88**
Total Discharges LOS	358	452	296	428	572	465	**2,571**	**429**
Average LOS	4.0	4.3	4.2	5.5	5.9	5.4	**4.9**	**4.9**

Beddays by Facility Type

Metrics							Beddays	
Facility Type	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Total**	**Average**
Hospital	358	454	296	430	572	465	**2,575**	**429**
Hospital Rehabilitation	10	0	0	0	9	55	**74**	**25**
Skilled Nursing	63	44	17	85	31	13	**253**	**42**
Out of Area	381	290	282	157	345	261	**1,716**	**286**

Metrics							Beddays per K
Facility Type	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Total**
Hospital	88.3	111.6	72.5	105.2	139.4	113.3	**105.1**
Hospital Rehabilitation	2.5	0.0	0.0	0.0	2.2	13.4	**3.0**
Skilled Nursing	15.5	10.8	4.2	20.8	7.6	3.2	**10.3**
Out of Area	94.0	71.3	69.1	38.4	84.1	63.6	**70.0**

Admits by Facility Type

Metrics							Admits	
Facility Type	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Total**	**Average**
Hospital	83	108	65	85	97	84	**522**	**87**
Hospital Rehabilitation	1	0	0	0	1	3	**5**	**2**
Skilled Nursing	3	4	1	3	2	1	**14**	**2**
Out of Area	44	53	70	50	59	62	**338**	**56**

Excutive Summary

Metrics	Admits per K						
Facility Type	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Total**
Hospital	20.5	26.5	15.9	20.8	23.6	20.5	**21.3**
Hospital Rehabilitation	0.2	0.0	0.0	0.0	0.2	0.7	**0.2**
Skilled Nursing	0.7	1.0	0.2	0.7	0.5	0.2	**0.6**
Out of Area	10.9	13.0	17.1	12.2	14.4	15.1	**13.8**

Readmits by Facility Type

Metrics	Readmits							
Facility Type	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Total**	**Average**
Hospital	12	7	8	5	8	7	**47**	**8**
Hospital Rehabilitation	0	0	0	0	0	0	**0**	**0**
Skilled Nursing	0	0	0	0	0	0	**0**	**0**
Out of Area	1	3	6	3	9	5	**27**	**5**

Average Length of Stay by Facility

Facility Type	Metrics	Average LOS						
	Facility Name	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Total**
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	3.3	3.8	6.7	3.0	2.7	2.8	**3.5**
	DIGNITY ST ROSE - FLAMINGO HOSPITAL	0.0	0.0	0.0	2.0	0.0	0.0	**2.0**
	HENDERSON HOSPITAL	3.8	4.4	2.0	2.8	6.3	7.4	**4.7**
	MOUNTAIN VIEW HOSPITAL	1.8	3.2	5.5	3.9	5.8	5.3	**4.0**
	NORTH VISTA HOSPITAL	1.0	4.0	0.0	0.0	1.0	0.0	**1.3**
	RENOWN REGIONAL MEDICAL CENTER	3.7	4.0	3.7	7.1	6.9	6.4	**5.3**
	SOUTHERN HILLS HOSPITAL	1.8	6.0	16.0	5.8	3.0	6.7	**5.4**
	SPRING VALLEY HOSPITAL	1.3	2.7	2.0	8.0	8.0	4.3	**4.4**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	2.0	0.0	0.0	0.0	4.3	2.0	**4.1**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	4.5	4.0	3.5	3.7	2.3	3.8	**3.7**
	SUMMERLIN HOSPITAL MEDICAL CTR	6.0	13.7	6.5	3.1	13.0	1.6	**5.9**
	SUNRISE HOSPITAL	8.0	7.8	5.5	7.0	9.3	1.8	**6.0**
	UNIVERSITY MEDICAL CENTER SO NV	14.0	2.3	2.2	5.5	3.0	6.5	**4.2**
	VALLEY HOSPITAL MEDICAL CTR	0.0	1.0	3.7	0.0	10.5	21.0	**7.6**
	Total	**4.0**	**4.3**	**4.2**	**5.5**	**5.9**	**5.4**	**4.9**
Hospital Rehabilitation	ENCOMPASS HEALTH HOSPITAL OF DESERT CANYON	0.0	0.0	0.0	0.0	0.0	0.0	**9.0**
	ENCOMPASS HEALTH HOSPITAL OF HENDERSON	10.0	0.0	0.0	0.0	0.0	2.0	**6.0**
	PAM SPECIALTY HOSPITAL OF LAS VEGAS	0.0	0.0	0.0	0.0	0.0	53.0	**53.0**
	Total	**10.0**	**0.0**	**0.0**	**0.0**	**0.0**	**18.3**	**18.5**

Excutive Summary

Average Length of Stay by Facility

Facility Type	Metrics	Average LOS						
	Facility Name	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Total
Skilled Nursing	HARMON HOSPITAL	0.0	6.0	0.0	0.0	0.0	0.0	**6.0**
	SAGE CREEK POST ACUTE	33.0	16.5	0.0	0.0	0.0	0.0	**16.5**
	SANDSTONE SPRING VALLEY LLC	0.0	2.5	0.0	85.0	2.7	13.0	**22.6**
	TRELLIS CENTENNIAL	0.0	0.0	0.0	0.0	0.0	0.0	**11.5**
	Total	**31.5**	**8.8**	**17.0**	**85.0**	**10.3**	**6.5**	**18.1**
Out of Area	Out of Area	9.0	5.1	4.2	3.1	3.9	4.4	**4.8**
	Total	**9.0**	**5.1**	**4.2**	**3.1**	**3.9**	**4.4**	**4.8**

Beddays by Facility

Facility Type	Metrics	Beddays							
	Facility Name	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Total	Average
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	10	23	20	12	16	17	**98**	**16**
	DIGNITY ST ROSE - FLAMINGO HOSPITAL	0	0	0	2	0	0	**2**	**2**
	HENDERSON HOSPITAL	19	41	2	13	19	37	**131**	**22**
	MOUNTAIN VIEW HOSPITAL	9	29	22	27	29	21	**137**	**23**
	NORTH VISTA HOSPITAL	1	4	0	0	3	0	**8**	**3**
	RENOWN REGIONAL MEDICAL CENTER	172	192	126	247	319	236	**1,292**	**215**
	SOUTHERN HILLS HOSPITAL	7	24	16	35	12	40	**134**	**22**
	SPRING VALLEY HOSPITAL	4	8	2	8	32	17	**71**	**12**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	2	8	0	0	17	2	**29**	**7**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	45	40	14	37	16	15	**167**	**28**
	SUMMERLIN HOSPITAL MEDICAL CTR	48	41	39	22	39	11	**200**	**33**
	SUNRISE HOSPITAL	24	31	33	7	28	9	**132**	**22**
	UNIVERSITY MEDICAL CENTER SO NV	14	10	11	11	21	39	**106**	**18**
	VALLEY HOSPITAL MEDICAL CTR	3	3	11	9	21	21	**68**	**11**
	Total	**358**	**454**	**296**	**430**	**572**	**465**	**2,575**	**0**
Hospital Rehabilitation	ENCOMPASS HEALTH HOSPITAL OF DESERT CANYON	0	0	0	0	9	0	**9**	**9**
	ENCOMPASS HEALTH HOSPITAL OF HENDERSON	10	0	0	0	0	2	**12**	**6**
	PAM SPECIALTY HOSPITAL OF LAS VEGAS	0	0	0	0	0	53	**53**	**53**
	Total	**10**	**0**	**0**	**0**	**9**	**55**	**74**	**0**
Skilled Nursing	HARMON HOSPITAL	0	6	0	0	0	0	**6**	**6**
	SAGE CREEK POST ACUTE	33	33	0	0	0	0	**66**	**33**
	SANDSTONE SPRING VALLEY LLC	30	5	17	85	8	13	**158**	**26**

Excutive Summary

Beddays by Facility

Facility Type	Metrics	Beddays							
	Facility Name	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Total	Average
Skilled Nursing	TRELLIS CENTENNIAL	0	0	0	0	23	0	**23**	**23**
	Total	**63**	**44**	**17**	**85**	**31**	**13**	**253**	**0**
Out of Area	Out of Area	381	290	282	157	345	261	**1,716**	**286**
	Total	**381**	**290**	**282**	**157**	**345**	**261**	**1,716**	**0**

Admits by Facility

Facility Type	Metrics	Admits							
	Facility Name	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Total	Average
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	3	5	4	4	6	5	**27**	**5**
	DIGNITY ST ROSE - FLAMINGO HOSPITAL	0	0	0	1	0	0	**1**	**1**
	HENDERSON HOSPITAL	4	10	1	5	3	7	**30**	**5**
	MOUNTAIN VIEW HOSPITAL	3	7	7	6	4	4	**31**	**5**
	NORTH VISTA HOSPITAL	1	2	0	0	3	0	**6**	**2**
	RENOWN REGIONAL MEDICAL CENTER	41	52	27	40	47	35	**242**	**40**
	SOUTHERN HILLS HOSPITAL	3	4	2	6	4	6	**25**	**4**
	SPRING VALLEY HOSPITAL	3	3	1	2	4	4	**17**	**3**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	1	1	0	0	4	1	**7**	**1**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	10	9	5	10	6	4	**44**	**7**
	SUMMERLIN HOSPITAL MEDICAL CTR	8	4	5	7	4	5	**33**	**6**
	SUNRISE HOSPITAL	3	4	6	1	4	4	**22**	**4**
	UNIVERSITY MEDICAL CENTER SO NV	2	5	4	2	7	7	**27**	**5**
	VALLEY HOSPITAL MEDICAL CTR	1	2	3	1	1	2	**10**	**2**
	Total	**83**	**108**	**65**	**85**	**97**	**84**	**522**	**0**
Hospital Rehabilitation	ENCOMPASS HEALTH HOSPITAL OF DESERT CANYON	0	0	0	0	1	0	**1**	**1**
	ENCOMPASS HEALTH HOSPITAL OF HENDERSON	1	0	0	0	0	1	**2**	**1**
	PAM SPECIALTY HOSPITAL OF LAS VEGAS	0	0	0	0	0	2	**2**	**2**
	Total	**1**	**0**	**0**	**0**	**1**	**3**	**5**	**0**
Skilled Nursing	HARMON HOSPITAL	0	1	0	0	0	0	**1**	**1**
	SAGE CREEK POST ACUTE	2	2	0	0	0	0	**4**	**1**
	SANDSTONE SPRING VALLEY LLC	1	1	1	3	1	1	**8**	**1**
	TRELLIS CENTENNIAL	0	0	0	0	1	0	**1**	**0**
	Total	**3**	**4**	**1**	**3**	**2**	**1**	**14**	**0**
Out of Area	Out of Area	44	53	70	50	59	62	**338**	**56**
	Total	**44**	**53**	**70**	**50**	**59**	**62**	**338**	**0**

Excutive Summary

Readmits by Facility

Facility Type	Metrics	Readmits							
	Facility Name	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Total**	**Average**
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	0	0	0	0	0	0	**0**	**0**
	DIGNITY ST ROSE - FLAMINGO HOSPITAL	0	0	0	0	0	0	**0**	**0**
	HENDERSON HOSPITAL	1	0	0	0	0	1	**2**	**0**
	MOUNTAIN VIEW HOSPITAL	0	2	3	1	0	0	**6**	**1**
	NORTH VISTA HOSPITAL	0	0	0	0	0	0	**0**	**0**
	RENOWN REGIONAL MEDICAL CENTER	6	3	4	3	5	2	**23**	**4**
	SOUTHERN HILLS HOSPITAL	0	0	0	0	0	2	**2**	**0**
	SPRING VALLEY HOSPITAL	0	0	0	0	1	0	**1**	**0**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	0	0	0	0	0	0	**0**	**0**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	2	2	0	0	0	0	**4**	**1**
	SUMMERLIN HOSPITAL MEDICAL CTR	1	0	1	0	0	0	**2**	**0**
	SUNRISE HOSPITAL	1	0	0	0	1	1	**3**	**1**
	UNIVERSITY MEDICAL CENTER SO NV	0	0	0	1	1	1	**3**	**1**
	VALLEY HOSPITAL MEDICAL CTR	1	0	0	0	0	0	**1**	**0**
	Total	**12**	**7**	**8**	**5**	**8**	**7**	**47**	**0**
Out of Area	Out of Area	1	3	6	3	9	5	**27**	**5**
	Total	**1**	**3**	**6**	**3**	**9**	**5**	**27**	**0**

Readmits by Facility

Facility Type	Metrics	Readmit Rate							
	Facility Name	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Total**	**Average**
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	DIGNITY ST ROSE - FLAMINGO HOSPITAL	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	HENDERSON HOSPITAL	25.0%	0.0%	0.0%	0.0%	0.0%	14.3%	**6.7%**	**6.7%**
	MOUNTAIN VIEW HOSPITAL	0.0%	28.6%	42.9%	16.7%	0.0%	0.0%	**19.4%**	**19.4%**
	NORTH VISTA HOSPITAL	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	RENOWN REGIONAL MEDICAL CENTER	14.6%	5.8%	14.8%	7.5%	10.6%	5.7%	**9.5%**	**9.5%**
	SOUTHERN HILLS HOSPITAL	0.0%	0.0%	0.0%	0.0%	0.0%	33.3%	**8.0%**	**8.0%**
	SPRING VALLEY HOSPITAL	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	**5.9%**	**5.9%**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	20.0%	22.2%	0.0%	0.0%	0.0%	0.0%	**9.1%**	**9.1%**
	SUMMERLIN HOSPITAL MEDICAL CTR	12.5%	0.0%	20.0%	0.0%	0.0%	0.0%	**6.1%**	**6.1%**
	SUNRISE HOSPITAL	33.3%	0.0%	0.0%	0.0%	25.0%	25.0%	**13.6%**	**13.6%**
	UNIVERSITY MEDICAL CENTER SO NV	0.0%	0.0%	0.0%	50.0%	14.3%	14.3%	**11.1%**	**11.1%**

Excutive Summary

Facility Type	Readmits by Facility							
	Metrics	Readmit Rate						
	Facility Name	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Total	Average
Hospital	VALLEY HOSPITAL MEDICAL CTR	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**10.0%**	**10.0%**
	Total	**14.5%**	**6.5%**	**12.3%**	**5.9%**	**8.2%**	**8.3%**	**9.0%**	**0.0%**
Out of Area	Out of Area	2.3%	5.7%	8.6%	6.0%	15.3%	8.1%	**8.0%**	**8.0%**
	Total	**2.3%**	**5.7%**	**8.6%**	**6.0%**	**15.3%**	**8.1%**	**8.0%**	**0.0%**

Utilization Summary

Outpatient Case Management

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD	Average
New Cases	166	199	160	268	390	263	**1,446**	**241**
Accepted	115	131	113	176	242	188	**965**	**161**
Acceptance Rate	69.3%	65.8%	70.6%	65.7%	62.1%	71.5%	**66.7%**	**66.7%**
Average Duration (closed only)	14.0	13.8	12.4	13.2	11.3	7.4	**11.6**	**11.6**

Inpatient Case Management

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD	Average
Open End of Month	25	25	23	37	28	26	**164**	**27**
Cases opened in the month	131	165	136	138	159	150	**879**	**147**
Cases closed in the month	135	166	136	129	161	151	**878**	**146**
Denied Days	49	5	3	3	4	5	**69**	**12**
Average LOS	6.0	4.7	4.3	5.2	5.3	5.3	**5.1**	**5.1**
NICU Open at End of Month	1	2	0	3	3	1	**10**	**2**
NICU Cases opened in the month	1	5	2	6	4	1	**19**	**3**
NICU Cases closed in the month	1	5	4	3	4	1	**18**	**3**
NICU Average Legth of Stay	25.0	14.2	0.8	12.0	36.3	28.0	**17.1**	**17.1**

Authorizations

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD	Average
Total services reviewed	2,779	3,159	3,003	3,631	3,503	3,151	**19,226**	**3,204**
Services Approved	2,660	3,006	2,849	3,473	3,368	3,076	**18,432**	**3,072**
Approval Rate	95.7%	95.2%	94.9%	95.6%	96.1%	97.6%	**95.9%**	**95.9%**
Services Denied	119	153	154	158	135	75	**794**	**132**
Denied Charges	$41,588	$82,333	$42,686	$82,231	$48,238	$392,955	**$690,030**	**$115,005**
Denial Rate	4%	5%	5%	4%	4%	2%	**4%**	**4%**

Denial Reason

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD	Average
Denial Reason	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**	**Denied**
Not medically necessary	119	153	154	158	135	75	**794**	**132**

Utilization Summary

Turn Around Time

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD	Average
2 or fewer days	576	661	613	841	863	821	**4,375**	**729**
2 or fewer Pct	61.0%	60.6%	60.2%	65.6%	64.3%	67.0%	**63.4%**	**63.4%**
5 or fewer days	638	679	670	897	902	859	**4,645**	**774**
5 or fewer Pct	67.6%	62.2%	65.8%	70.0%	67.2%	70.1%	**67.3%**	**67.3%**
15 or fewer Days	904	1,044	991	1,269	1,320	1,208	**6,736**	**1,123**
15 or fewer Pct	95.8%	95.7%	97.3%	99.0%	98.3%	98.5%	**97.6%**	**97.6%**
Over 15 days	40	47	28	13	23	18	**169**	**28**
Over 15 days Pct	4.2%	4.3%	2.7%	1.0%	1.7%	1.5%	**2.4%**	**2.4%**

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

Stat

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD	Average
Stat Request	779	746	768	929	870	875	**4,967**	**828**

Appeals

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD	Average
Appeals 1st Level	3	1	2	1	4	3	**14.00**	**2.33**
Appeals 2nd Level	0	0	0	0	0	0	**0.00**	**0.00**
Appeals 3rd Level	0	0	0	0	0	0	**0.00**	**0.00**
Appeals Overturned	0	0	0	1	0	1	**2.00**	**0.33**
Appeals Upheld	2	1	3	1	4	2	**13.00**	**2.17**

Utilization Summary

Retro Reviews

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD	Average
Retros	0	2	11	25	20	1	**59**	**10**

Telephone Advise Nurse

Metrics

Outcome description	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD	Average
Call 911	0	1	1	3	0	1	**6**	**2**
ER	15	10	9	5	4	6	**49**	**8**
Information or Advice Only	1	3	4	5	3	4	**20**	**3**
Other	17	9	18	15	17	18	**94**	**16**
PCP	9	9	5	7	11	12	**53**	**9**
Self-Care/Home Care	2	5	4	3	4	6	**24**	**4**
Urgent Care	15	18	14	16	9	11	**83**	**14**

Bedday Summary

Acute only

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

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD
Membership	48,645	48,816	49,008	49,039	49,228	49,249	**48,997**
Beddays per K	143.1	148.2	135.2	142.7	199.6	189.6	**159.8**
Admits per K	30.1	38.1	32.6	32.8	38.0	36.1	**34.6**
Average LOS	4.4	3.9	4.2	4.6	5.2	5.3	**4.6**
Readmits per K	3.2	2.5	3.4	2.0	4.1	2.9	**3.0**
Readmit Rate	10.7%	6.5%	10.5%	6.0%	10.9%	8.1%	**8.7%**

SHO

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD
Beddays per K	173.3	197.8	201.8	197.3	220.1	188.5	**196.4**
Admits per K	34.6	40.7	38.5	38.1	39.8	38.9	**38.4**
Average LOS	4.9	5.1	5.2	5.0	5.3	4.8	**5.1**
Readmits per K	2.8	2.7	3.5	2.6	4.5	2.7	**3.1**
Readmit Rate	8.1%	6.6%	9.1%	6.9%	11.4%	6.9%	**8.2%**

SHL PPO

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD
Beddays per K	144.2	163.0	118.9	144.3	138.1	154.8	**143.9**
Admits per K	38.0	44.2	36.2	44.9	40.9	40.2	**40.7**
Average LOS	4.6	5.9	4.1	3.5	4.9	4.2	**4.5**
Reamits per K	3.3	4.4	2.0	3.7	2.8	3.0	**3.2**
Readmit Rate	8.7%	9.9%	5.4%	8.2%	6.9%	7.6%	**7.9%**

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

4.3.5

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

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

- 4.3.1 Q2 UMR – Obesity Care Management
- 4.3.2 Q2 UMR – Diabetes Care Management
- 4.3.3 Q2 UMR – Performance Guarantee Report
- 4.3.4 Q2 Sierra Healthcare Options – Utilization and Large Case Management
- **4.3.5 Q2 Express Scripts – Summary Report**

Nevada PEBP

Q2 FY2024

Prepared by Client Analytics

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

3/15/2024

**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 Q2 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	**$73.39**	
Utilization	$2.15	3.2%
Unit Cost	$3.83	5.7%
Member Share	$0.12	0.2%
Total Change in Plan Cost Net PMPM	**$6.10**	**9.1%**
Previous Period - Plan Cost Net PMPM	**$67.29**	

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 ↓ $539k (-24.1%) to current $1.7m.
  - Plan Cost Net PMPM ↓ $1.66 (-12.5%) to current $11.66.
  - Patient Count ↓ 4 to current count of 196.
  - Adjusted Rxs ↓73 to current count of 922.

- **Notable Drug Changes within Indication:**

  - **Lenalidomide (Generic for Revlimid)**
    - Previous ranked 15th, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $203k (785.5%) to current $229k.
    - Plan Cost Net PMPM ↑ $1.42 (920.8%) to current $1.57.
    - Patient Count ↑ 2 to current count of 3.
    - Adjusted Rxs ↑ 16 to current count of 18.

  - **Ibrance**
    - Previous ranked 2nd, currently ranked 4th by Plan Cost Net.
    - Plan Cost Net ↓ $176k (-60.2%) to current $116k.
    - Plan Cost Net PMPM ↓ $.94 (-54.2%) to current $.80.
    - Patient Count ↓ 2 to current count of 2.
    - Adjusted Rxs ↓ 14 to current count of 8.

  - **Revlimid**
    - Previous ranked 1st, currently ranked 9th by Plan Cost Net.
    - Plan Cost Net ↓ $284k (-77.8%) to current $81k.
    - Plan Cost Net PMPM ↓ $1.62 (-74.4%) to current $.55.
    - Patient Count ↓ 2 to current count of 2.
    - Adjusted Rxs ↓ 16 to current count of 7.

- **Ophthalmic Conditions:**
  - Previous ranked 20th, currently ranked 6th by Plan Cost Net.
  - Plan Cost Net ↑ $385k (311.4%) to current $508k.
  - Plan Cost Net PMPM ↑ $2.75 (374.3%) to current $3.49.
  - Patient Count ↑ 17 to current count of 218.
  - Adjusted Rxs ↑ 6 to current count of 449.

- **Notable Drug Changes within Indication:**

  - **Tepezza**
    - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $350k (608%) to current $58k.
    - Plan Cost Net PMPM ↑ $2.46 (716.2%) to current $2.80.
    - Patient Count: Remains at 1.
    - Adjusted Rxs ↑ 6 to current count of 7.

  - **Eylea**
    - Previous ranked 2nd, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net ↑ $56k (148.3%) to current $94k.
    - Plan Cost Net PMPM ↑ $.42 (186.2%) to current $.64.
    - Patient Count ↑ 3 to current count of 13.
    - Adjusted Rxs ↑ 30 to current count of 53.

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

- **Vaccinations**:
  - Previous ranked 5th, currently ranked 4th by Plan Cost Net.
  - Plan Cost Net ↑ $335k (54.1%) to current $953k.
  - Plan Cost Net PMPM ↑ $2.86 (77.6%) to current $6.54.
  - Patient Count ↓ 1,852 to current count of 4,814.
  - Adjusted Rxs ↓ 2,418 to current count of 8,770.

- **Notable Drug Changes within Indication:**

  - **Comirnaty 2023-2024 (COVID)**:
    - New, currently ranked 1st.
    - Plan Cost Net: New, current $239k.
    - Plan Cost Net PMPM: New, current $1.64.
    - Patient Count: New, current count of 1,701.
    - Adjusted Rxs: New, current count of 1,697.

  - **Spikevax 2023-2024 (COVID)**:
    - New, currently ranked 2nd.
    - Plan Cost Net: New, current $179k.
    - Plan Cost Net PMPM: New, current $1.23.
    - Patient Count: New, current count of 1,193.
    - Adjusted Rxs: New, current count of 1,189.

  - **Arexvy (RSV)**:
    - New, currently ranked 3rd.
    - Plan Cost Net: New, current $132k.

- Plan Cost Net PMPM: New, current $.91.
- Patient Count: New, current count of 493.
- Adjusted Rxs: New, current count of 490.

Peer Comparison:

- Peer: ESI CDH Program
- PEBP CDHP is outperforming the peer.
- Peer experienced Plan Cost Net PMPM of $89.92 compared to CDHP PEBP of $73.39.
- Peer experienced Trend of 13.0%, compared to CDHP PEBP Trend of 9.1%

EPO Overall Trend Summaries:

EPO Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$168.02**	
Utilization	$6.11	4.1%
Unit Cost	$9.58	6.4%
Member Share	$2.99	2.0%
Total Change in Plan Cost Net PMPM	**$18.68**	**12.5%**
Previous Period - Plan Cost Net PMPM	**$149.33**	

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

- **Endocrine Disorders**:
  - Previous ranked 3rd, currently ranked 3rd by Plan Cost Net.
  - Plan Cost Net ↑ $190k (34.3%) to current $742k.
  - Plan Cost Net PMPM ↑ $7.29 (52.0%) to current $21.33.
  - Patient Count ↓ 3 to current count of 25.
  - Adjusted Rxs ↓ 14 to current count of 107.

- **Notable Drug Changes within Indication:**

  - **Korlym:**
    - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $201k (40.2%) to current $702k.
    - Plan Cost Net PMPM ↑ $7.46 (40.2%) to current $20.19.
    - Patient Count ↑ 1 to current count of 2.
    - Adjusted Rxs ↑ 5 to current count of 12.

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

- **Vaccinations**:
  - Previous ranked 5th, currently ranked 11th by Plan Cost Net.
  - Plan Cost Net ↑ $97k (73.1%) to current $231k.
  - Plan Cost Net PMPM ↑ $3.25 (95.9%) to current $6.63.
  - Patient Count ↓ 303 to current count of 1,201.
  - Adjusted Rxs ↓ 347 to current count of 2,158.

- **Notable Drug Changes within Indication:**

    - **Comirnaty 2023-2024 (COVID)**:
        - New, currently ranked 1st.
        - Plan Cost Net: New, current $60k.
        - Plan Cost Net PMPM: New, current $1.73.
        - Patient Count: New, current count of 423.
        - Adjusted Rxs: New, current count of 423.

    - **Spikevax 2023-2024 (COVID)**:
        - New, currently ranked 2nd.
        - Plan Cost Net: New, current $46k.
        - Plan Cost Net PMPM: New, current $1.31.
        - Patient Count: New, current count of 305.
        - Adjusted Rxs: New, current count of 305.

    - **Arexvy (RSV)**:
        - New, currently ranked 3rd.
        - Plan Cost Net: New, current $29k.
        - Plan Cost Net PMPM: New, current $.82.
        - Patient Count: New, current count of 105.
        - Adjusted Rxs: New, current count of 105.

- **Skin Conditions**:
    - Previous ranked 7th, currently ranked 14th by Plan Cost Net.
    - Plan Cost Net ↓ $73k (-39.3%) to current $113k.
    - Plan Cost Net PMPM ↓ $1.48 (-31.3%) to current $3.26.
    - Patient Count ↓ 47 to current count of 287.
    - Adjusted Rxs ↓ 111 to current count of 455.

- **Notable Drug Changes within Indication:**

    - **Dupixent Pen:**
        - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
        - Plan Cost Net ↓ $31k (-26.4%) to current $86k.
        - Plan Cost Net PMPM ↓ $.49 (-16.7%) to current $2.46.
        - Patient Count ↓ 1 to current count of 9.
        - Adjusted Rxs ↓ 12 to current count of 40.

    - **Dupixent Syringe:**
        - Previous ranked 2nd, currently ranked 2nd by Plan Cost Net.
        - Plan Cost Net ↓ $22k (-61.7%) to current $14k.
        - Plan Cost Net PMPM ↓ $.51 (-56.7%) to current $.39.
        - Patient Count ↓ 1 to current count of 2.
        - Adjusted Rxs ↓ 9 to current count of 7.

    - **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 $107.75 compared to PEBP EPO of $168.02
- Peer experienced Trend of 10.3%, compared to PEBP EPO of 12.5%

PPO Overall Trend Summaries:

PPO Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$100.05**	
Utilization	$1.87	2.2%
Unit Cost	$13.10	15.6%
Member Share	$1.10	1.3%
Total Change in Plan Cost Net PMPM	**$16.07**	**19.1%**
Previous Period - Plan Cost Net PMPM	**$83.98**	

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 ↑ $826k (54.9%) to current $2.3m.
  - Plan Cost Net PMPM ↑ $2.90 (16.1%) to current $20.93.
  - Patient Count ↑ 59 to current count of 222.
  - Adjusted Rxs ↑ 404 to current count of 1,264.

  - **Humira(CF) Pen:**
    - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $162k (34.0%) to current $639k.
    - Plan Cost Net PMPM ↑ $.02 (0.4%) to current $5.74.
    - Patient Count ↑ 7 to current count of 31.
    - Adjusted Rxs ↑ 54 to current count of 163.

  - **Stelara:**
    - Previous ranked 3rd, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net ↑ $169k (124.7%) to current $304k.
    - Plan Cost Net PMPM ↑ $1.11 (2.73%) to current $2.73.
    - Patient Count ↑ 5 to current count of 11.
    - Adjusted Rxs ↑ 27 to current count of 62.

  - **Rinvoq:**
    - Previous ranked 10th, currently ranked 5th by Plan Cost Net.
    - Plan Cost Net ↑ $113k (211.1%) to current $167k.
    - Plan Cost Net PMPM ↑ $0.86 (133.1%) to current $1.50.
    - Patient Count ↑ 8 to current count of 11.
    - Adjusted Rxs ↑ 37 to current count of 52.

- **Diabetes**:
  - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
  - Plan Cost Net ↑ $750k (84.4%) to current $1.6m.
  - Plan Cost Net PMPM ↑ $4.07 (38.2%) to current $14.71.
  - Patient Count ↑ 441 to current count of 1,222.
  - Adjusted Rxs ↑ 4,010 to current count of 11,098.

  - **Ozempic:**
    - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net ↑ $263k (118.8%) to current $485k.
    - Plan Cost Net PMPM ↑ $1.70 (63.9%) to current $4.35.
    - Patient Count ↑ 116 to current count of 240.
    - Adjusted Rxs ↑ 572 to current count of 1,107.

  - **Mounjaro:**
    - Previous ranked 5th, currently ranked 2nd by Plan Cost Net.
    - Plan Cost Net ↑ $311k (776.5%) to current $351k.
    - Plan Cost Net PMPM ↑ $2.67 (556.9%) to current $3.15.
    - Patient Count ↑ 105 to current count of 145.
    - Adjusted Rxs ↑ 648 to current count of 730.

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

- **Enzyme Deficiencies**:
  - Previous ranked 1st, currently ranked 1st by Plan Cost Net.
  - Plan Cost Net ↑ $529k (228.3%) to current $761k.
  - Plan Cost Net PMPM ↑ $4.06 (146.0%) to current $6.84.
  - Patient Count ↑ 3 to current count of 5.
  - Adjusted Rxs ↑ 13 to current count of 22.

- **Notable Drug Changes within Indication:**

  - **Nexviazyme:**
    - New, currently ranked 1st by Plan Cost Net.
    - Plan Cost Net: New, current $417k.
    - Plan Cost Net PMPM: New, current $3.74.
    - Patient Count: New, current count of 1.
    - Adjusted Rxs: New, current count of 6.

  - **Palynziq:**
    - New, currently ranked 3rd by Plan Cost Net.
    - Plan Cost Net: New, current $73k.
    - Plan Cost Net PMPM: New, current $0.65.
    - Patient Count: New, current count of 1.
    - Adjusted Rxs: New, current count of 5.

  - **Galafold:**
    - New, currently ranked 4th by Plan Cost Net.
    - Plan Cost Net: New, current $58k.
    - Plan Cost Net PMPM: New, current $0.52.

- Patient Count: New, current count of 1.
- Adjusted Rxs: New, current count of 2.

Peer Comparison:

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

Total Overall Trend		% Change
Current Period - Plan Cost Net PMPM	**$94.84**	
Utilization	$1.98	2.4%
Unit Cost	$7.82	9.4%
Member Share	$1.86	2.2%
Total Change in Plan Cost Net PMPM	**$11.66**	**14.0%**
Previous Period - Plan Cost Net PMPM	**$83.18**	

Summary of Total – Overall the main driver of Trend was Specialty Utilization driven by an increase of 15% in Specialty patients. This resulted in an 17.6% increase in Specialty Days of Therapy.

Trend was mitigated by increased rebates of 38.1%. This produced a negative Unit Cost Trend of (-5.5%) on Specialty drugs and reduced NonSpecialty Unit Cost Trend to 9.7%, combined is 9.4%.

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

Key Statistics:

Nevada PEBP Total			
Description	Q2 FY24	Q2 FY23	Change
Average Members per Month	48,640	48,466	0.4%
Number of Unique patients	31,239	32,695	-4.5%
Members Utilizing the Benefit	64.2%	67.5%	-3.2
Gross Cost/Adjusted Rx	$138.66	$118.67	16.8%
Plan Spend	$42,345,378	$34,810,187	21.6%
Rebates (estimated)	$14,667,722	$10,620,859	38.1%
Plan Cost Net	$27,677,656	$24,189,328	14.4%
Plan Cost Net PMPM	$94.84	$83.18	14.0%
Non-Specialty Plan Cost Net PMPM	$42.82	$36.85	16.2%
Specialty Plan Cost Net PMPM	$52.02	$46.34	12.3%
Generic Fill Rate	85.1%	84.1%	1.0
90 Day Utilization	60.8%	61.7%	-0.9
Retail - Maintenance 90 Utilization	28.4%	30.0%	-1.6
Home Delivery Utilization	32.4%	31.7%	0.7
Member Cost Net %	24.2%	25.7%	-1.5

END OF REPORT

4.3.6

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

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

- 4.3.1 Q2 UMR – Obesity Care Management
- 4.3.2 Q2 UMR – Diabetes Care Management
- 4.3.3 Q2 UMR – Performance Guarantee Report
- 4.3.4 Q2 Sierra Healthcare Options – Utilization and Large Case Management
- 4.3.5 Q2 Express Scripts – Summary Report
- **4.3.6 Q2 Express Scripts – Utilization Report**

Nevada PEBP Q1 FY24 Report

7/1/2023 – 12/31/2023

Report Includes:

- CDHP Comparison Data from Q2 FY23 to Q2 FY24
- EPO Comparison Data from Q2 FY23 to Q2 FY24
- PPO Comparison Data from Q2 FY23 to Q2 FY24
- CDHP, EPO, PPO Breakout Data from Q2 FY23 to Q2 FY24
- Summary Comparison Data from Q2 FY24
- Key Metric Breakout Data from Q2 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)
3/15/24

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN

+ Q2 FY24 vs Q2 FY23

Membership Summary	Q2 FY 2024	Q2 FY 2023	Change
Member Count (Membership)	48,640	48,466	0.4%
Utilizing Member Count (Patients)	31,239	32,695	-4.5%
Percent Utilizing (Utilization)	64.2%	67.5%	-3.2

Claim Summary	Q2 FY 2024	Q2 FY 2023	Change
Net Claims (Total Adjusted Rx's)	369,061	363,725	1.5%
Claims per Elig Member per Month (Claims PMPM)	1.26	1.25	1.1%
Total Claims for Generic (Generic ARx)	314,255	306,021	2.7%
Total Claims for Brand (Brand ARx)	54,806	57,704	-5.0%
Total Claims for Multisource Brand Claims (MSB ARx)	1,990	1,601	24.3%
Total Non-Specialty Claims	364,670	359,974	1.3%
Total Specialty Claims	4,391	3,751	17.1%
Generic % of Total Claims (GFR)	**85.1%**	**84.1%**	**1.0**
Generic Effective Rate (GCR)	99.4%	99.5%	-0.1
Mail Order Claims	104,196	99,313	4.9%
Mail Penetration Rate*	32.4%	31.7%	0.7

Claims Cost Summary	Q2 FY 2024	Q2 FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$51,174,997**	**$43,163,579**	**18.6%**
Total Generic Gross Cost	$5,362,401	$5,352,108	0.2%
Total Brand Gross Cost	$45,812,596	$37,811,471	21.2%
Total MSB Gross Cost	$921,665	$867,609	6.2%
Total Ingredient Cost	$49,458,504	$41,589,334	18.9%
Total Dispensing Fee	$1,678,445	$1,527,949	9.8%
Total Other (e.g. tax)	$38,049	$46,296	-17.8%
Avg Total Cost per Claim (Gross Cost/ARx)	**$138.66**	**$118.67**	**16.8%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$17.06	$17.49	-2.4%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$835.90	$655.27	27.6%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$463.15	$541.92	-14.5%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN

+ Q2 FY24 vs Q2 FY23

Member Cost Summary	Q2 FY 2024	Q2 FY 2023	Change
Total Member Cost Share	**$8,829,619**	**$8,353,392**	**5.7%**
Generic Cost Share	$2,183,710	$2,202,344	-0.8%
Brand Cost Share	$6,645,909	$6,151,048	8.0%
MSB Cost Share	$121,078	$166,702	-27.4%
Total Copay	$7,681,515	$6,966,342	10.3%
Total Deductible	$1,148,104	$1,387,050	-17.2%
Avg Copay per Claim (Member Cost Share/ARx)	**$23.92**	**$22.97**	**4.2%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.95	$7.20	-3.4%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$121.26	$106.60	13.8%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$60.84	$104.12	-41.6%
Copay % of Total Prescription Cost (Member Cost Share %)	**17.3%**	**19.4%**	**-2.1**

Plan Cost Summary	Q2 FY 2024	Q2 FY 2023	Change
Total Plan Cost (Plan Cost)	**$42,345,378**	**$34,810,187**	**21.6%**
Generic Plan Cost	$3,178,691	$3,149,764	0.9%
Brand Plan Cost	$39,166,687	$31,660,423	23.7%
MSB Plan Cost	$800,588	$700,907	14.2%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$19,758,899	$16,686,030	18.4%
Total Specialty Drug Cost (Specialty Plan Cost)	$22,586,479	$18,124,157	24.6%
Avg Plan Cost per Claim (Plan Cost/ARx)	$114.74	$95.70	19.9%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$10.12	$10.29	-1.7%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$714.64	$548.67	30.3%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$402.31	$437.79	-8.1%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$54.18	$46.35	16.9%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$5,143.81	$4,831.82	6.5%
Plan Cost PMPM	**$145.10**	**$119.71**	**21.2%**
Non-Specialty Plan Cost PMPM	$67.70	$57.38	18.0%
Specialty Plan Cost PMPM	$77.39	$62.33	24.2%
Specialty % of Plan Cost	53.3%	52.1%	1.3
Net Plan Cost PMPM (factoring Rebates)	**$94.84**	**$83.18**	**14.0%**
Non-Specialty Plan Cost PMPM	$42.82	$36.85	16.2%
Specialty Plan Cost PMPM	$52.02	$46.34	12.3%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN

+ Q2 FY24 vs Q2 FY23

Membership Summary	Q2 FY 2024	Q2 FY 2023	Change
Member Count (Membership)	24,297	28,010	-13.3%
Utilizing Member Count (Patients)	14,819	18,093	-18.1%
Percent Utilizing (Utilization)	61.0%	64.6%	-3.6

Claim Summary	Q2 FY 2024	Q2 FY 2023	Change
Net Claims (Total Adjusted Rx's)	170,990	193,821	-11.8%
Claims per Elig Member per Month (Claims PMPM)	1.17	1.15	1.7%
Total Claims for Generic (Generic ARx)	147,083	163,868	-10.2%
Total Claims for Brand (Brand ARx)	23,907	29,953	-20.2%
Total Claims for Multisource Brand Claims (MSB ARx)	754	769	-2.0%
Total Non-Specialty Claims	169,049	191,901	-11.9%
Total Specialty Claims	1,941	1,920	1.1%
Generic % of Total Claims (GFR)	**86.0%**	**84.5%**	**1.5**
Generic Effective Rate (GCR)	99.5%	99.5%	(0.0)
Mail Order Claims	46,573	51,531	-9.6%
Mail Penetration Rate*	31.4%	31.0%	0.3

Claims Cost Summary	Q2 FY 2024	Q2 FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$21,492,348**	**$21,461,228**	**0.1%**
Total Generic Gross Cost	$2,170,769	$2,594,347	-16.3%
Total Brand Gross Cost	$19,321,579	$18,866,881	2.4%
Total MSB Gross Cost	$322,777	$447,412	-27.9%
Total Ingredient Cost	$20,692,082	$20,621,615	0.3%
Total Dispensing Fee	$786,385	$818,293	-3.9%
Total Other (e.g. tax)	$13,880	$21,320	-34.9%
Avg Total Cost per Claim (Gross Cost/ARx)	**$125.69**	**$110.73**	**13.5%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$14.76	$15.83	-6.8%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$808.20	$629.88	28.3%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$428.09	$581.81	-26.4%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN

+ Q2 FY24 vs Q2 FY23

Member Cost Summary	Q2 FY 2024	Q2 FY 2023	Change
Total Member Cost Share	**$4,776,329**	**$5,074,756**	**-5.9%**
Generic Cost Share	$1,054,669	$1,252,187	-15.8%
Brand Cost Share	$3,721,660	$3,822,569	-2.6%
MSB Cost Share	$74,141	$134,559	-44.9%
Total Copay	$3,630,113	$3,689,916	-1.6%
Total Deductible	$1,146,216	$1,384,840	-17.2%
Avg Copay per Claim (Member Cost Share/ARx)	**$27.93**	**$26.18**	**6.7%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$7.17	$7.64	-6.2%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$155.67	$127.62	22.0%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$98.33	$174.98	-43.8%
Copay % of Total Prescription Cost (Member Cost Share %)	**22.2%**	**23.6%**	**-1.4**

Plan Cost Summary	Q2 FY 2024	Q2 FY 2023	Change
Total Plan Cost (Plan Cost)	**$16,716,019**	**$16,386,472**	**2.0%**
Generic Plan Cost	$1,116,100	$1,342,160	-16.8%
Brand Plan Cost	$15,599,919	$15,044,312	3.7%
MSB Plan Cost	$248,636	$312,853	-20.5%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$6,877,440	$6,997,252	-1.7%
Total Specialty Drug Cost (Specialty Plan Cost)	$9,838,579	$9,389,220	4.8%
Avg Plan Cost per Claim (Plan Cost/ARx)	$97.76	$84.54	15.6%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$7.59	$8.19	-7.4%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$652.53	$502.26	29.9%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$329.76	$406.83	-18.9%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$40.68	$36.46	11.6%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$5,068.82	$4,890.22	3.7%
Plan Cost PMPM	**$114.66**	**$97.50**	**17.6%**
Non-Specialty Plan Cost PMPM	$47.18	$41.64	13.3%
Specialty Plan Cost PMPM	$67.49	$55.87	20.8%
Specialty % of Plan Cost	58.9%	57.3%	1.6
Net Plan Cost PMPM (factoring Rebates)	**$73.39**	**$67.29**	**9.1%**
Non-Specialty Plan Cost PMPM	$27.76	$25.16	10.3%
Specialty Plan Cost PMPM	$45.63	$42.13	8.3%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ Q2 FY24 vs Q2 FY23

Membership Summary	Q2 FY 2024	Q2 FY 2023	Change
Member Count (Membership)	5,797	6,559	-11.6%
Utilizing Member Count (Patients)	4,161	4,948	-15.9%
Percent Utilizing (Utilization)	71.8%	75.4%	-3.7

Claim Summary	Q2 FY 2024	Q2 FY 2023	Change
Net Claims (Total Adjusted Rx's)	63,291	69,558	-9.0%
Claims per Elig Member per Month (Claims PMPM)	1.82	1.77	3.0%
Total Claims for Generic (Generic ARx)	53,768	58,812	-8.6%
Total Claims for Brand (Brand ARx)	9,523	10,746	-11.4%
Total Claims for Multisource Brand Claims (MSB ARx)	413	326	26.7%
Total Non-Specialty Claims	62,523	68,700	-9.0%
Total Specialty Claims	768	858	-10.5%
Generic % of Total Claims (GFR)	**85.0%**	**84.6%**	**0.4**
Generic Effective Rate (GCR)	99.2%	99.4%	-0.2
Mail Order Claims	18,689	18,173	2.8%
Mail Penetration Rate*	32.7%	29.3%	3.4

Claims Cost Summary	Q2 FY 2024	Q2 FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$10,045,058**	**$9,846,897**	**2.0%**
Total Generic Gross Cost	$933,816	$1,092,103	-14.5%
Total Brand Gross Cost	$9,111,242	$8,754,795	4.1%
Total MSB Gross Cost	$223,146	$193,921	15.1%
Total Ingredient Cost	$9,763,024	$9,559,049	2.1%
Total Dispensing Fee	$273,452	$279,289	-2.1%
Total Other (e.g. tax)	$8,581	$8,559	0.3%
Avg Total Cost per Claim (Gross Cost/ARx)	**$158.71**	**$141.56**	**12.1%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$17.37	$18.57	-6.5%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$956.76	$814.70	17.4%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$540.31	$594.85	-9.2%

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN

+ Q2 FY24 vs Q2 FY23

Member Cost Summary	Q2 FY 2024	Q2 FY 2023	Change
Total Member Cost Share	**$1,331,951**	**$1,470,033**	**-9.4%**
Generic Cost Share	$367,712	$399,198	-7.9%
Brand Cost Share	$964,238	$1,070,834	-10.0%
MSB Cost Share	$21,734	$24,589	-11.6%
Total Copay	$1,330,062	$1,467,823	-9.4%
Total Deductible	$1,889	$2,210	-14.5%
Avg Copay per Claim (Member Cost Share/ARx)	**$21.04**	**$21.13**	**-0.4%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.84	$6.79	0.8%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$101.25	$99.65	1.6%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$52.63	$75.43	-30.2%
Copay % of Total Prescription Cost (Member Cost Share %)	**13.3%**	**14.9%**	**-1.7**

Plan Cost Summary	Q2 FY 2024	Q2 FY 2023	Change
Total Plan Cost (Plan Cost)	**$8,713,107**	**$8,376,865**	**4.0%**
Generic Plan Cost	$566,104	$692,904	-18.3%
Brand Plan Cost	$8,147,004	$7,683,960	6.0%
MSB Plan Cost	$201,412	$169,332	18.9%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$4,140,543	$4,119,692	0.5%
Total Specialty Drug Cost (Specialty Plan Cost)	$4,572,564	$4,257,173	7.4%
Avg Plan Cost per Claim (Plan Cost/ARx)	$137.67	$120.43	14.3%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$10.53	$11.78	-10.6%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$855.51	$715.05	19.6%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$487.68	$519.42	-6.1%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$66.22	$59.97	10.4%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$5,953.86	$4,961.74	20.0%
Plan Cost PMPM	**$250.51**	**$212.86**	**17.7%**
Non-Specialty Plan Cost PMPM	$119.04	$104.68	13.7%
Specialty Plan Cost PMPM	$131.46	$108.18	21.5%
Specialty % of Plan Cost	52.5%	50.8%	1.7
Net Plan Cost PMPM (factoring Rebates)	**$168.02**	**$149.33**	**12.5%**
Non-Specialty Plan Cost PMPM	$75.05	$68.40	9.7%
Specialty Plan Cost PMPM	$92.97	$80.94	14.9%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN

+ Q2 FY24 vs Q2 FY23

Membership Summary	Q2 FY 2024	Q2 FY 2023	Change
Member Count (Membership)	18,549	13,900	33.4%
Utilizing Member Count (Patients)	12,302	9,717	26.6%
Percent Utilizing (Utilization)	66.3%	69.9%	-3.6

Claim Summary	Q2 FY 2024	Q2 FY 2023	Change
Net Claims (Total Adjusted Rx's)	134,780	100,346	34.3%
Claims per Elig Member per Month (Claims PMPM)	1.21	1.20	0.7%
Total Claims for Generic (Generic ARx)	113,404	83,341	36.1%
Total Claims for Brand (Brand ARx)	21,376	17,005	25.7%
Total Claims for Multisource Brand Claims (MSB ARx)	823	506	62.6%
Total Non-Specialty Claims	133,098	99,373	33.9%
Total Specialty Claims	1,682	973	72.9%
Generic % of Total Claims (GFR)	**84.1%**	**83.1%**	**1.1**
Generic Effective Rate (GCR)	99.3%	99.4%	-0.1
Mail Order Claims	38,934	29,609	31.5%
Mail Penetration Rate*	33.5%	34.7%	(1.2)

Claims Cost Summary	Q2 FY 2024	Q2 FY 2023	Change
Total Prescription Cost (Total Gross Cost)	**$19,637,591**	**$11,855,454**	**65.6%**
Total Generic Gross Cost	$2,257,816	$1,665,659	35.6%
Total Brand Gross Cost	$17,379,775	$10,189,795	70.6%
Total MSB Gross Cost	$375,742	$226,275	66.1%
Total Ingredient Cost	$19,003,397	$11,408,670	66.6%
Total Dispensing Fee	$618,607	$430,366	43.7%
Total Other (e.g. tax)	$15,587	$16,417	-5.1%
Avg Total Cost per Claim (Gross Cost/ARx)	**$145.70**	**$118.15**	**23.3%**
Avg Total Cost for Generic (Generic Gross Cost/Generic ARx)	$19.91	$19.99	-0.4%
Avg Total Cost for Brand (Brand Gross Cost/Brand ARx)	$813.05	$599.22	35.7%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$456.55	$447.18	2.1%

Express Scripts
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STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN

+ Q2 FY24 vs Q2 FY23

Member Cost Summary	Q2 FY 2024	Q2 FY 2023	Change
Total Member Cost Share	**$2,721,339**	**$1,808,603**	**50.5%**
Generic Cost Share	$761,329	$550,958	38.2%
Brand Cost Share	$1,960,011	$1,257,645	55.8%
MSB Cost Share	$25,202	$7,553	233.7%
Total Copay	$2,721,339	$1,808,603	50.5%
Total Deductible	$0	$0	NA
Avg Copay per Claim (Member Cost Share/ARx)	**$20.19**	**$18.02**	**12.0%**
Avg Copay for Generic (Generic Member Cost Share/Generic ARx)	$6.71	$6.61	1.6%
Avg Copay for Brand (Brand Member Cost Share/Brand ARx)	$91.69	$73.96	24.0%
Avg Copay for MSB (MSB Member Cost Share/MSB ARx)	$30.62	$14.93	105.1%
Copay % of Total Prescription Cost (Member Cost Share %)	**13.9%**	**15.3%**	**-1.4**

Plan Cost Summary	Q2 FY 2024	Q2 FY 2023	Change
Total Plan Cost (Plan Cost)	**$16,916,252**	**$10,046,851**	**68.4%**
Generic Plan Cost	$1,496,488	$1,114,700	34.3%
Brand Plan Cost	$15,419,764	$8,932,150	72.6%
MSB Plan Cost	$350,540	$218,722	60.3%
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$8,740,916	$5,569,086	57.0%
Total Specialty Drug Cost (Specialty Plan Cost)	$8,175,336	$4,477,765	82.6%
Avg Plan Cost per Claim (Plan Cost/ARx)	$125.51	$100.12	25.4%
Avg Plan Cost for Generic (Generic Plan Cost/Generic ARx)	$13.20	$13.38	-1.3%
Avg Plan Cost for Brand (Brand Plan Cost/Brand ARx)	$721.36	$525.27	37.3%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$425.93	$432.26	-1.5%
Avg Non-Specialty Plan Cost per Claim (Plan Cost/ARx)	$65.67	$56.04	17.2%
Avg Specialty Plan Cost per Claim (Plan Cost/ARx)	$4,860.49	$4,602.02	5.6%
Plan Cost PMPM	**$152.00**	**$120.47**	**26.2%**
Non-Specialty Plan Cost PMPM	$78.54	$66.78	17.6%
Specialty Plan Cost PMPM	$73.46	$53.69	36.8%
Specialty % of Plan Cost	48.3%	44.6%	3.8
Net Plan Cost PMPM (factoring Rebates)	**$100.05**	**$83.98**	**19.1%**
Non-Specialty Plan Cost PMPM	$52.46	$45.50	15.3%
Specialty Plan Cost PMPM	$47.59	$38.48	23.7%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO, CDHP, & PPO PLAN

+ Q2 FY24 vs Q2 FY23

Membership Summary	Total	EPO	CDHP	PPO
Member Count (Membership)	48,640	5,797	24,297	18,549
Utilizing Member Count (Patients)	31,239	4,161	14,819	12,302
Percent Utilizing (Utilization)	64.2%	71.8%	61.0%	66.3%

Claim Summary	Total	EPO	CDHP	PPO
Net Claims (Total Rx's)	369,061	63,291	170,990	134,780
Claims per Elig Member per Month (Claims PMPM)	1.26	1.82	1.17	1.21
Total Claims for Generic (Generic Rx)	314,255	53,768	147,083	113,404
Total Claims for Brand (Brand Rx)	54,806	9,523	23,907	21,376
Total Claims for Multisource Brand Claims (MSB Rx)	1,990	413	754	823
Total Non-Specialty Claims	364,670	62,523	169,049	133,098
Total Specialty Claims	4,391	768	1,941	1,682
Generic % of Total Claims (GFR)	**85.1%**	**85.0%**	**86.0%**	**84.1%**
Generic Effective Rate (GCR)	99.4%	99.2%	99.5%	99.3%
Mail Order Claims	104,196	18,689	46,573	38,934
Mail Penetration Rate*	32.4%	32.7%	31.4%	33.5%

Claims Cost Summary	Total	EPO	CDHP	PPO
Total Prescription Cost (Total Gross Cost)	**$51,174,997**	**$10,045,058**	**$21,492,348**	**$19,637,591**
Total Generic Gross Cost	$5,362,401	$933,816	$2,170,769	$2,257,816
Total Brand Gross Cost	$45,812,596	$9,111,242	$19,321,579	$17,379,775
Total MSB Gross Cost	$921,665	$223,146	$322,777	$375,742
Total Ingredient Cost	$49,458,504	$9,763,024	$20,692,082	$19,003,397
Total Dispensing Fee	$1,059,838	$273,452	$786,385	$618,607
Total Other (e.g. tax)	$38,049	$8,581	$13,880	$15,587
Avg Total Cost per Claim (Gross Cost/Rx)	**$138.66**	**$158.71**	**$125.69**	**$145.70**
Avg Total Cost for Generic (Generic Gross Cost/Generic Rx)	$17.06	$17.37	$14.76	$19.91
Avg Total Cost for Brand (Brand Gross Cost/Brand Rx)	$835.90	$956.76	$808.20	$813.05
Avg Total Cost for MSB (MSB Gross Cost/MSB Rx)	$463.15	$540.31	$428.09	$456.55

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO, CDHP, & PPO PLAN

+ Q2 FY24 vs Q2 FY23

Member Cost Summary	Total	EPO	CDHP	PPO
Total Member Cost Share	**$8,829,619**	**$1,331,951**	**$4,776,329**	**$2,721,339**
Generic Cost Share	$2,183,710	$367,712	$1,054,669	$761,329
Brand Cost Share	$6,645,909	$964,238	$3,721,660	$1,960,011
MSB Cost Share	$121,078	$21,734	$74,141	$25,202
Total Copay	$7,681,515	$1,330,062	$3,630,113	$2,721,339
Total Deductible	$1,148,104	$1,889	$1,146,216	$0
Avg Copay per Claim (Member Cost Share/Rx)	**$23.92**	**$21.04**	**$27.93**	**$20.19**
Avg Copay for Generic (Generic Member Cost Share/Generic Rx)	$6.95	$6.84	$7.17	$6.71
Avg Copay for Brand (Brand Member Cost Share/Brand Rx)	$121.26	$101.25	$155.67	$91.69
Avg Copay for MSB (MSB Member Cost Share/MSB Rx)	$60.84	$52.63	$98.33	$30.62
Copay % of Total Prescription Cost (Member Cost Share %)	**17.3%**	**13.3%**	**22.2%**	**13.9%**

Plan Cost Summary	Total	EPO	CDHP	PPO
Total Plan Cost (Plan Cost)	**$42,345,378**	**$8,713,107**	**$16,716,019**	**$16,916,252**
Generic Plan Cost	$3,178,691	$566,104	$1,116,100	$1,496,488
Brand Plan Cost	$39,166,687	$8,147,004	$15,599,919	$15,419,764
MSB Plan Cost	$800,588	$201,412	$248,636	$350,540
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$19,758,899	$4,140,543	$6,877,440	$8,740,916
Total Specialty Drug Cost (Specialty Plan Cost)	$22,586,479	$4,572,564	$9,838,579	$8,175,336
Avg Plan Cost per Claim (Plan Cost/Rx)	$114.74	$137.67	$97.76	$125.51
Avg Plan Cost for Generic (Generic Plan Cost/Generic Rx)	$10.12	$10.53	$7.59	$13.20
Avg Plan Cost for Brand (Brand Plan Cost/Brand Rx)	$714.64	$855.51	$652.53	$721.36
Avg Plan Cost for MSB (MSB Plan Cost/MSB Rx)	$402.31	$487.68	$329.76	$425.93
Avg Non-Specialty Plan Cost per Claim (Plan Cost/Rx)	$54.18	$66.22	$40.68	$65.67
Avg Specialty Plan Cost per Claim (Plan Cost/Rx)	$5,143.81	$5,953.86	$5,068.82	$4,860.49
Plan Cost PMPM	**$145.10**	**$250.51**	**$114.66**	**$152.00**
Non-Specialty Plan Cost PMPM	$67.70	$119.04	$47.18	$78.54
Specialty Plan Cost PMPM	$77.39	$131.46	$67.49	$73.46
Specialty % of Plan Cost	53.3%	52.5%	58.9%	48.3%
Net Plan Cost PMPM (factoring Rebates)	**$94.84**	**$168.02**	**$73.39**	**$100.05**
Non-Specialty Net Plan Cost PMPM	$42.82	$75.05	$27.76	$52.46
Specialty Net Plan Cost PMPM	$52.02	$92.97	$45.63	$47.59

Express Scripts
By EVERNORTH

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN

+ Q2 FY24 vs Q2 FY23

State of Nevada PEBP Q2 FY2024 - FY2024				
Description	Grand Total	EPO	CDHP	PPO
Avg Members per Month	48,640	5,797	24,297	18,549
Pct Members Utilizing Benefit	64.2%	71.8%	61.0%	66.3%
Total Plan Cost	$ 42,345,378	$ 8,713,107	$ 16,716,019	$ 16,916,252
Total Days	9,531,769	1,691,004	4,404,292	3,436,473
Total Adjusted Rxs	369,061	63,291	170,990	134,780
Plan Cost PMPM	$ 145.10	$ 250.51	$ 114.66	$ 152.00
Plan Cost Net PMPM	$ 94.84	$ 168.02	$ 73.39	$ 100.05
Plan Cost/Day	$ 4.44	$ 5.15	$ 3.80	$ 4.92
Plan Cost per Adjusted Rx	$ 114.74	$ 137.67	$ 97.76	$ 125.51
Nbr Rxs PMPM	1.26	1.82	1.17	1.21
Generic Fill Rate	85.1%	85.0%	86.0%	84.1%
Home Delivery Utilization	32.4%	32.7%	31.4%	33.5%
Member Cost %	17.3%	13.3%	22.2%	13.9%
Specialty Percent of Plan Cost	53.3%	52.5%	58.9%	48.3%
Specialty Plan Cost PMPM	$ 77.39	$ 131.46	$ 67.49	$ 73.46
Formulary Compliance Rate	99.4%	99.3%	99.6%	99.2%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ TOTAL PLAN
+ Q2 FY24 vs Q2 FY23

State of Nevada PEBP Q2 FY2024 - Grand Total					
Description	Grand Total	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	48,640	42,383	5,744	12	503
Pct Members Utilizing Benefit	64.2%	62.2%	78.3%	58.3%	90.9%
Total Plan Cost	$ 42,345,378	$ 33,238,455	$ 7,940,993	$ 217,391	$ 948,539
Total Days	9,531,769	7,084,152	2,134,154	4,423	309,040
Total Adjusted Rxs	369,061	278,745	78,899	166	11,251
Plan Cost PMPM	$ 145.10	$ 130.71	$ 230.41	$ 3,019.32	$ 314.29
Plan Cost Net PMPM	$ 94.84	$ 86.15	$ 146.03	$ 2,709.79	$ 179.24
Plan Cost/Day	$ 4.44	$ 4.69	$ 3.72	$ 49.15	$ 3.07
Plan Cost per Adjusted Rx	$ 114.74	$ 119.24	$ 100.65	$ 1,309.58	$ 84.31
Nbr Rxs PMPM	1.26	1.10	2.29	2.31	3.73
Generic Fill Rate	85.1%	84.7%	86.4%	84.3%	86.7%
Home Delivery Utilization	32.4%	30.1%	39.1%	93.3%	37.0%
Member Cost %	17.3%	16.8%	19.1%	20.3%	18.3%
Specialty Percent of Plan Cost	53.3%	53.9%	51.1%	96.4%	42.1%
Specialty Plan Cost PMPM	$ 77.39	$ 70.46	$ 117.81	$ 2,911.50	$ 132.33
Formulary Compliance Rate	99.4%	99.4%	99.5%	100.0%	99.5%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ CDHP PLAN

+ Q2 FY24 vs Q2 FY23

State of Nevada PEBP Q2 FY2024 - CDHP					
Description	CDHP	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	24,297	20,228	3,679	8	383
Pct Members Utilizing Benefit	61.0%	58.0%	75.6%	50.0%	91.1%
Total Plan Cost	$ 16,716,019	$ 11,619,979	$ 4,311,558	$ 131,901	$ 652,581
Total Days	4,404,292	2,896,810	1,264,866	1,412	241,204
Total Adjusted Rxs	170,990	115,342	46,803	55	8,790
Plan Cost PMPM	$ 114.66	$ 95.74	$ 195.32	$ 2,747.94	$ 283.98
Plan Cost Net PMPM	$ 73.39	$ 61.34	$ 126.50	$ 2,616.93	$ 146.10
Plan Cost/Day	$ 3.80	$ 4.01	$ 3.41	$ 93.41	$ 2.71
Plan Cost per Adjusted Rx	$ 97.76	$ 100.74	$ 92.12	$ 2,398.21	$ 74.24
Nbr Rxs PMPM	1.17	0.95	2.12	1.15	3.83
Generic Fill Rate	86.0%	85.5%	87.3%	85.5%	86.1%
Home Delivery Utilization	31.4%	27.7%	38.3%	95.9%	37.6%
Member Cost %	22.2%	22.6%	21.3%	25.7%	19.9%
Specialty Percent of Plan Cost	58.9%	59.5%	59.4%	99.7%	36.3%
Specialty Plan Cost PMPM	$ 67.49	$ 56.94	$ 115.97	$ 2,739.69	$ 103.07
Formulary Compliance Rate	99.6%	99.6%	99.6%	100.0%	99.6%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ EPO PLAN
+ Q2 FY24 vs Q2 FY23

State of Nevada PEBP Q2 FY2024 - EPO					
Description	EPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	5,797	5,021	698	2	76
Pct Members Utilizing Benefit	71.8%	69.8%	87.5%	50.0%	85.5%
Total Plan Cost	$ 8,713,107	$ 6,824,521	$ 1,735,305	$ 6,150	$ 147,131
Total Days	1,691,004	1,284,263	363,960	1,710	41,071
Total Adjusted Rxs	63,291	48,488	13,265	57	1,481
Plan Cost PMPM	$ 250.51	$ 226.53	$ 414.35	$ 615.02	$ 322.66
Plan Cost Net PMPM	$ 168.02	$ 151.73	$ 278.90	$ 273.08	$ 224.13
Plan Cost/Day	$ 5.15	$ 5.31	$ 4.77	$ 3.60	$ 3.58
Plan Cost per Adjusted Rx	$ 137.67	$ 140.75	$ 130.82	$ 107.90	$ 99.35
Nbr Rxs PMPM	1.82	1.61	3.17	4.75	3.73
Generic Fill Rate	85.0%	84.7%	85.5%	78.9%	88.6%
Home Delivery Utilization	32.7%	31.9%	34.7%	100.0%	36.7%
Member Cost %	13.3%	12.2%	16.7%	8.5%	17.7%
Specialty Percent of Plan Cost	52.5%	53.8%	47.6%	0.0%	50.3%
Specialty Plan Cost PMPM	$ 131.46	$ 121.90	$ 197.32	$ -	$ 162.19
Formulary Compliance Rate	99.3%	99.2%	99.5%	100.0%	98.8%

STATE OF NEVADA PEBP:

PRESCRIPTION DRUG UTILIZATION

+ PPO PLAN
+ Q2 FY24 vs Q2 FY23

State of Nevada PEBP Q2 FY2024 - PPO					
Description	PPO	State Actives	State Retirees	Non-State Actives	Non-State Retirees
Avg Members per Month	18,549	17,135	1,367	2	44
Pct Members Utilizing Benefit	66.3%	65.2%	81.3%	100.0%	97.7%
Total Plan Cost	$ 16,916,252	$ 14,793,955	$ 1,894,130	$ 79,339	$ 148,827
Total Days	3,436,473	2,903,079	505,328	1,301	26,765
Total Adjusted Rxs	134,780	114,915	18,831	54	980
Plan Cost PMPM	$ 152.00	$ 143.90	$ 230.94	$ 6,611.62	$ 563.74
Plan Cost Net PMPM	$ 100.05	$ 96.22	$ 130.76	$ 5,563.49	$ 390.18
Plan Cost/Day	$ 4.92	$ 5.10	$ 3.75	$ 60.98	$ 5.56
Plan Cost per Adjusted Rx	$ 125.51	$ 128.74	$ 100.59	$ 1,469.25	$ 151.86
Nbr Rxs PMPM	1.21	1.12	2.30	4.50	3.71
Generic Fill Rate	84.1%	84.0%	84.8%	88.9%	88.9%
Home Delivery Utilization	33.5%	31.6%	44.3%	81.8%	31.9%
Member Cost %	13.9%	13.7%	15.8%	10.3%	11.1%
Specialty Percent of Plan Cost	48.3%	49.6%	35.6%	98.5%	59.5%
Specialty Plan Cost PMPM	$ 73.46	$ 71.34	$ 82.15	$ 6,510.23	$ 335.38
Formulary Compliance Rate	99.2%	99.2%	99.3%	100.0%	100.0%

4.3.7

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

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

- 4.3.1 Q2 UMR – Obesity Care Management
- 4.3.2 Q2 UMR – Diabetes Care Management
- 4.3.3 Q2 UMR – Performance Guarantee Report
- 4.3.4 Q2 Sierra Healthcare Options – Utilization and Large Case Management
- 4.3.5 Q2 Express Scripts – Summary Report
- 4.3.6 Q2 Express Scripts – Utilization Report
- **4.3.7 Q3 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report**

Public Employees Benefit Program

Quarterly Update –3rd Quarter Plan Year 2024

WTW's Individual Marketplace (Via Benefits)

April 26, 2024

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2024

Executive Summary

Plan Enrollment:

- At the end of FY Q3 2024, PEBP's total enrollment into Medicare policies through WTW's Individual Marketplace increased slightly to 11,344. Since inception, 123 carriers have been selected by PEBP's retirees with current enrollment in 2,145 different plans.
- Medicare Supplement (MS) plan selection remained consistent at 85% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 6,057 and 1,688 enrollees respectively. The average monthly premium cost for MS plans remained consistent at $146.
- The percentage of Medicare Advantage (MA or MAPD) plans selected remained consistent at 15%. Top MA carriers include Aetna with 624 individual plan selections and Humana with 338 individual plan selections. The average monthly premium cost to PEBP participants decreased slightly to $9.

Customer Satisfaction:

- In Q3 2024, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 4.7 out of 5.0 based on 32 surveys returned.
- For Q3 2024, the average satisfaction score for Service Calls was 4.2 out of 5.0 based on 301 surveys returned.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.2 out of 5.0 for Q3 2024.

Health Reimbursement Arrangement:

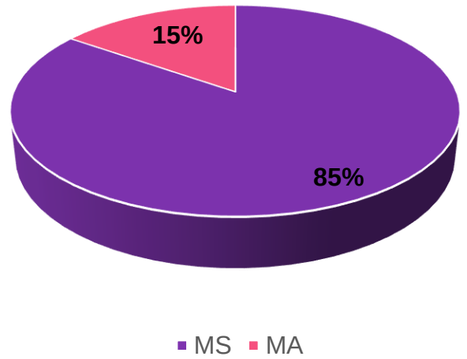
- At the end of Q3 2024 there were 13,302 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 124,721 claims processed in Q3, with 82.1% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 102,452 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q3 was $8,377,503.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 3/31/2024		Previous Qtr.
Total enrolled through individual marketplace	11,344	11,328
Number of carriers**	123	123
Number of plans**	2,145	2,128

Plan Type Selection Through 3/31/2024		Previous Qtr.
Medicare Advantage (MA, MAPD)	1,735	1,688
Medicare Supplement (MS)	9,626	9,662

Medical Enrollment



"The percentage of Medicare Advantage plans selected by PEBP's retiree population is now slightly below the average for WTW's Book of Business.

Plan Type	Number Enrolled	Average Premium
Medicare Supplement (MS)	9,626	$149
Medicare Advantage (MA,MAPD)	1,735	$4 / $18
Part D drug coverage	6,631	$26
Dental coverage	847	$34
Vision coverage	1,624	$11

** Reflects total carriers and plans that PEBP participants have enrolled in nationwide, since inception.

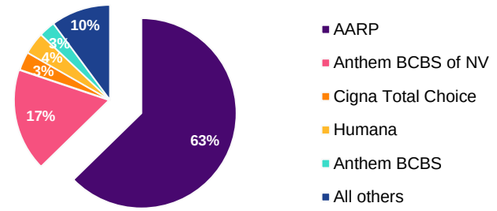
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2024

Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,057
Anthem BCBS of NV	1,688
Humana	364
Cigna Total Choice	303
Anthem BCBS	270

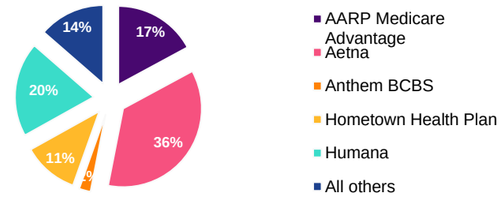
Medicare Supplement Carrier Choice



Cost Data For MS Plans	Cost
Minimum	$22
Average	$146
Median	$140
Maximum	$481

Top Medicare Advantage Plans	Total
Aetna	624
Humana	338
AARP	297
Hometown Health Plan	199
Anthem BCBS	41

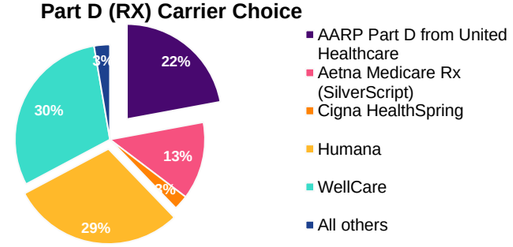
Medicare Advantage Carrier Choice



Cost Data For MA Plans	Cost
Minimum	$0
Average	$8
Median	$0
Maximum	$194

Top Medicare Part D (RX)	Total
WellCare	1,995
Humana	1,951
AARP Part D from United Healthcare	1,464
Aetna Medicare Rx (SilverScript)	878
Cigna HealthSpring	165

Part D (RX) Carrier Choice



Cost Data For Part D (RX)	Cost
Minimum	$0
Average	$22
Median	$16
Maximum	$121

The Public Employees Benefit Program Executive Dashboard

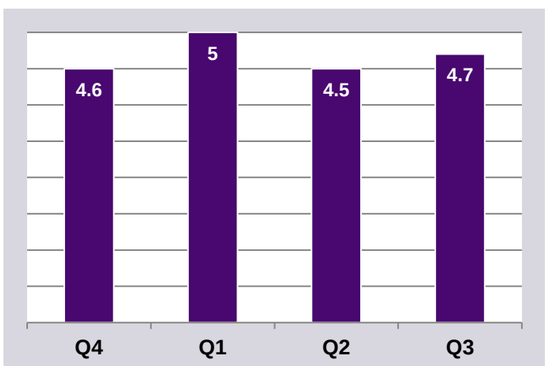
Quarterly Update – 3rd Quarter Plan Year 2024

Customer Service – Voice of the Customer (VoC)

Individual Marketplace conducts phone and email surveys of all participant transactions. Each survey contains approximately 12-16 questions. Responses are scanned by IBM Mindshare Analytics which expose trends within an hour, alerting Individual Marketplace of issues and allowing for real-time feedback and adjustments

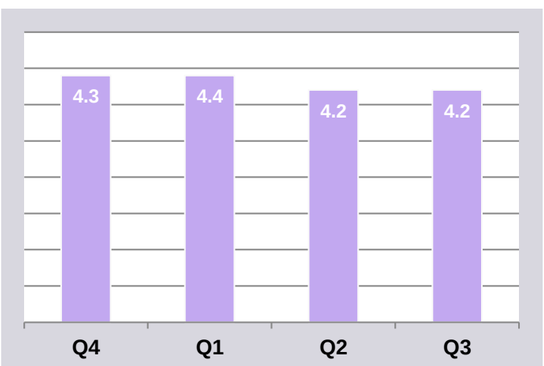
Q3 Enrollment Satisfaction

CSAT score	Count	%
5	24	75%
4	7	22%
3	1	3%
2	0	0%
1	0	0%
	32	**100%**



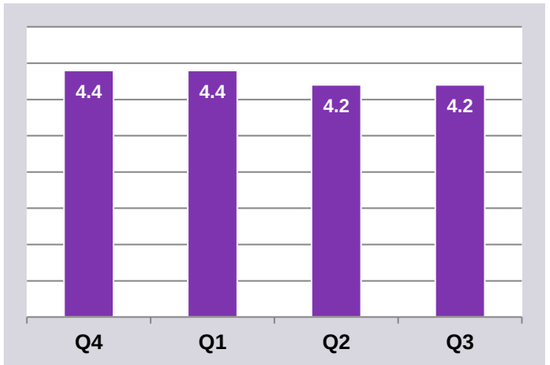
Q3 Service Satisfaction

CSAT score	Count	%
5	185	61%
4	42	14%
3	35	12%
2	14	5%
1	25	8%
	301	**100%**



Q3 Enrollment & Service Combined

CSAT score	Count	%
5	209	63%
4	49	15%
3	36	11%
2	14	4%
1	25	8%
	333	**100%**

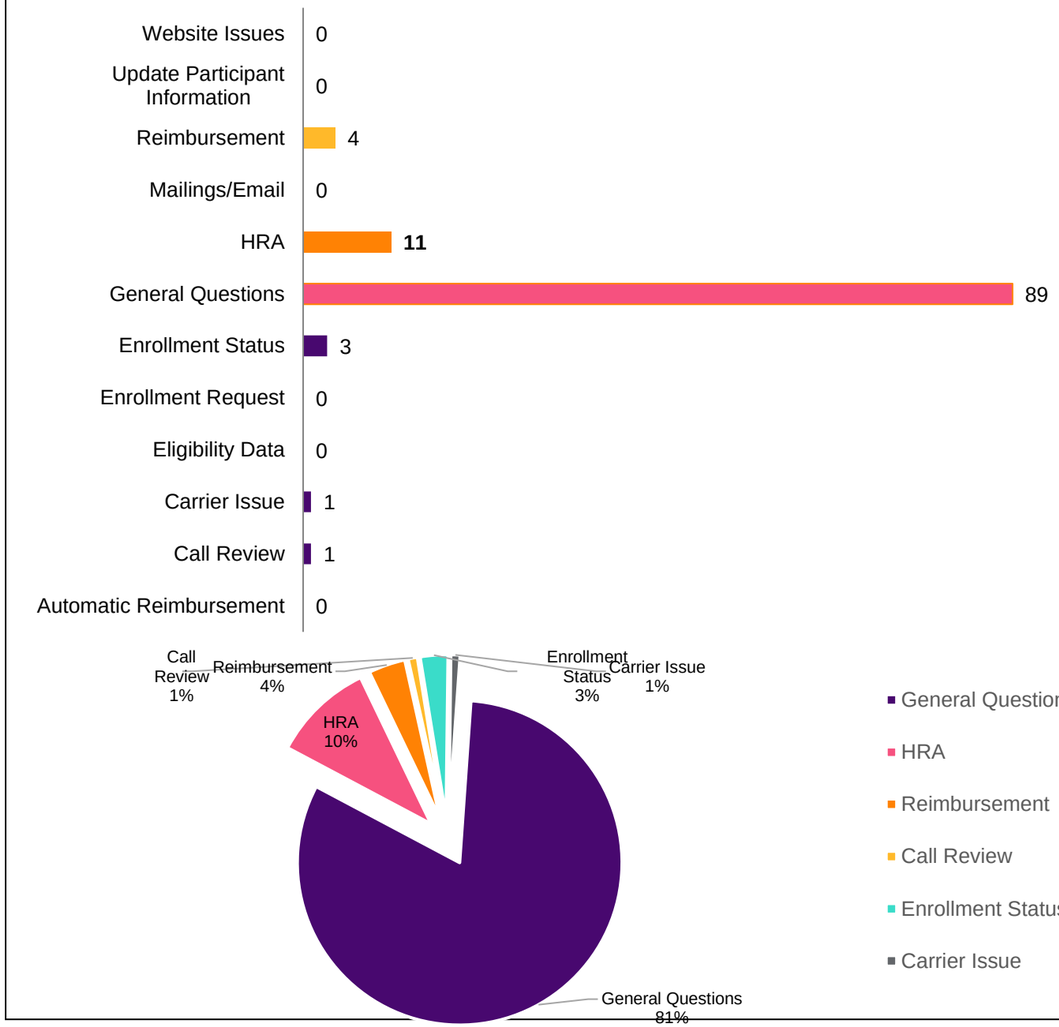


The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2024

Customer Service – Issues Log Resolution

Each quarter a certain number of participant inquiries are received by both PEBP and WTW that require escalation to Individual Marketplace Issues Log. Items on the Issues Log are carefully evaluated and continuously monitored by seasoned WTW staff until resolution is reached. The total number of inquiries reviewed during Q1-PY24 is 92 and are associated with the following categories:



Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	13,302
Number of payments	48,230
Accounts with no balance	7,996
Claims paid amount	$8,377,504

Claims By Source	Total
A/R file	102,452
Mail	9,909
Web	9,142
Mobile App	3,218

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2024

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.40 Days	Yes
Claim Financial Precision	≥ 98%	99.52%	Yes
Reports	≤ 15 business days	Met	Yes
HRA Web Services	≥ 99%	99.99%	Yes
Benefits Administration Customer Service Avg. Speed to Answer	≤ 2 min. in Q1 ≤ 90 sec in Q4 and Q4 ≤ 5 minutes in Q4 Note - Quarters listed are based on calendar year.	25 Seconds	Yes
Benefits Administration Customer Service Abandonment Rate Annual	≤ 5%	3.47%	Yes
Customer Satisfaction	≥ 80%	88.29%	Yes
Disclosure of Subcontractors	100%	100%	Yes
Unauthorized Transfer of PEBP Data	100%	100%	Yes

*Please note that the performance guarantees are ultimately measured based on the annual audit period.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update - 3rd Quarter Plan Year 2024

Operations Report

Spring Retiree Meetings:

WTW and Nevada PEBP held successful virtual retiree meetings on March 26 and 27, with a live attendance option at the PEBP offices in Carson City. The meetings are designed to help age-in participants get educated on the transition to Medicare as well as assist those who are already enrolled through Via Benefits. Links for participants to register for the meetings were available on the main page of our Nevada PEBP specific Website at https://my.viabenefits.com/PEBP

Meeting Date/Time	Meeting Type	Webinar Attendees
March 26 – 11:30 am PT	Pre-Medicare/Ageing into Medicare	166
March 26 – 2:00 pm PT	Already enrolled in Medicare/HRA	45
March 27 – 9:30 am PT	Already enrolled in Medicare/HRA	36
March 27 - 12:00 pm PT	Pre-Medicare/Ageing into Medicare	82

HRA Available Balance Cap of $8,000:

Effective May 31, 2024, we will process the annual $8,000 HRA Available Balance Cap reduction on accounts with a balance of more then $8,000. Nevada PEBP is planning on sending communications related to this Cap to participants with balances of $7,000 or greater as they are expected to be the ones who will potentially be impacted by the Cap this year. The goal of the communication is to remind participants to submit claims against their balance to reduce it below the $8,000 threshold so they do not lose any of their HRA balance. Once funds are removed because they are over the $8,000 cap, they cannot be added back.

Communications:

Below is information on communications that were mailed or will be coming up.

- Spring Balance Reminder
  - This communication is mailed to participants who have not had any payment activity in their HRA in the prior 90 days. It is designed to remind them of their HRA balance so they can take action and submit new claims for reimbursement from their account. The Balance Reminder for the spring was mailed in mid-February and was staggered over 2 weeks.

VIA BENEFITS

Via Benefits
PO Box 12345
City Name, PA 67890-1234
Electronic Service Requested

Balance Reminder

Identifier: 17555630, H2555912
GROUP NAME, LLC

John Sample
1234 Street Name
Any Town, OH 12345
United States

10/10/2021

You have a total available balance of $1,560.00 in your reimbursement account that you can use for eligible expenses. The table below shows the available balance from each account and plan year.

Account Balance Breakdown

Account	Plan Year	Available Balance
HRA	2018	$140.00
HRA	2019	$220.00
HRA	2020	$1,200.00
Total Available Balance: $1,560.00		

We're here to assist you

If you have questions, please call Via Benefits at 1-800-888-8888 (TTY: 711), Monday through Friday 9:00 a.m. to 8:00 p.m. Time Zone.

Sincerely,

Via Benefits

Get Informed Faster | Get instant updates via email. Update your notification settings at viabenefitsurl.com.

4.3.8

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

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

- 4.3.1 Q2 UMR – Obesity Care Management
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- 4.3.6 Q2 Express Scripts – Utilization Report
- 4.3.7 Q3 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report
- **4.3.8 Q3 Amplifon Performance Report**

amplifon Hearing Health Care

Performance Report

Nevada Public Employees' Benefit Program
January 1st through March 31st, 2024

Amplifon Updates

AMPLIFON CONTINUES GROWING RAPIDLY

We now work with 50+ health and insurance partners. In just 24 months, we've doubled our Medicare Advantage business, doubled our Medicare Supplement business, and doubled our commercial client business

CONCIERGE-LEVEL SERVICE EXCELLENCE

Amplifon continues to focus on exceptional member service through our focus on education and engagement, our hearing-dedicated Patient Care Advocates, and enhancements to our member journey via virtual tools

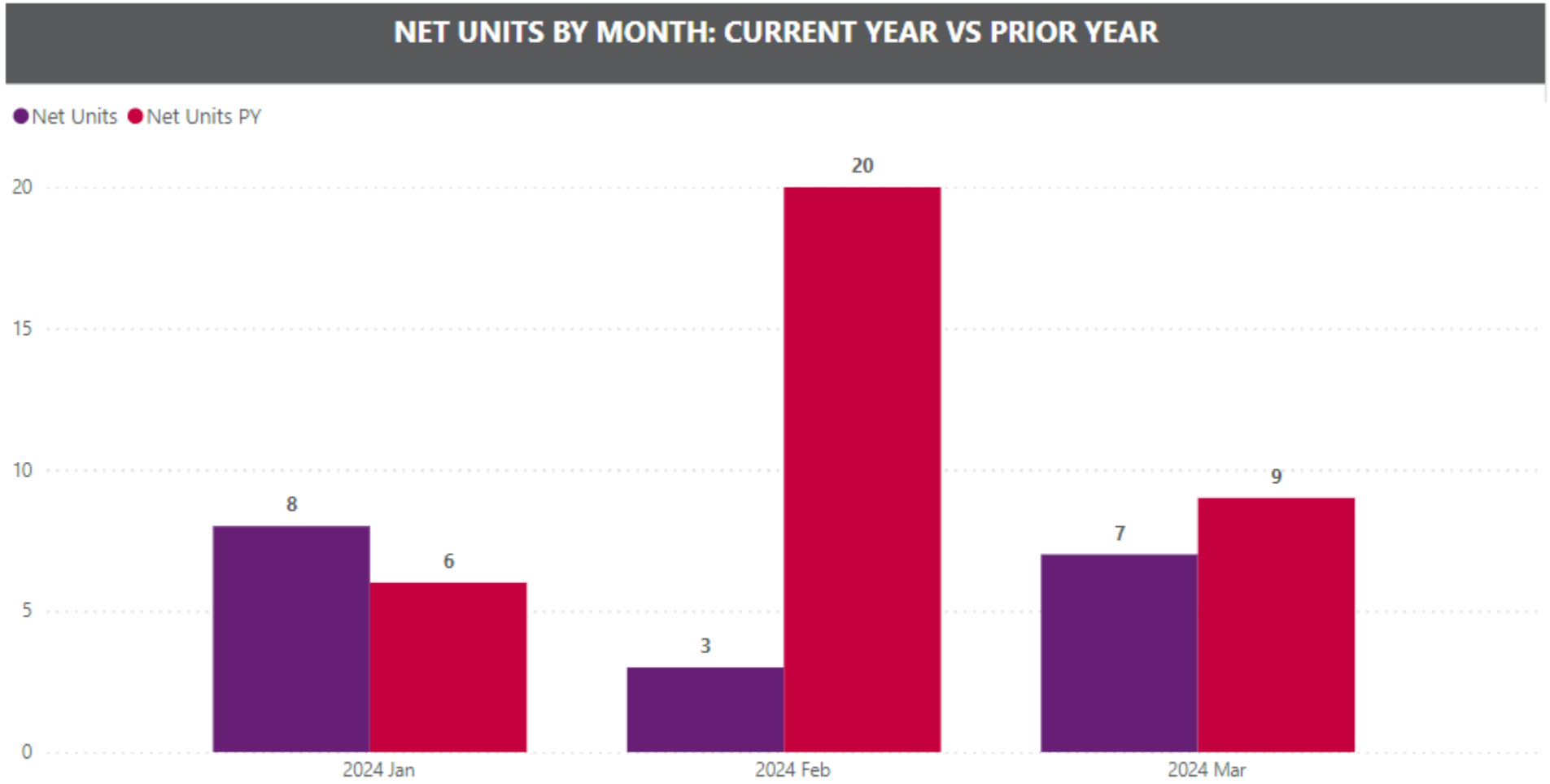
A FOCUS ON NETWORK ACCESS

Amplifon continues to expand our network and will soon exceed 6,000 nationwide locations. We remain the only hearing health administrator with Miracle-Ear® locations in network

UNIFORM PROVIDER REIMBURSEMENT

Amplifon continues to be the only hearing health administrator with a universal provider reimbursement focused on quality of care vs. a graded reimbursement that rewards providers for selling more expensive HAs

Hearing Aid Purchases



MEMBERS SERVED

10

19 -47.37%

PY %YOY

HEARING AIDS DISPENSED

18

35 -48.57%

PY %YOY

RETURN RATE

5.88 %

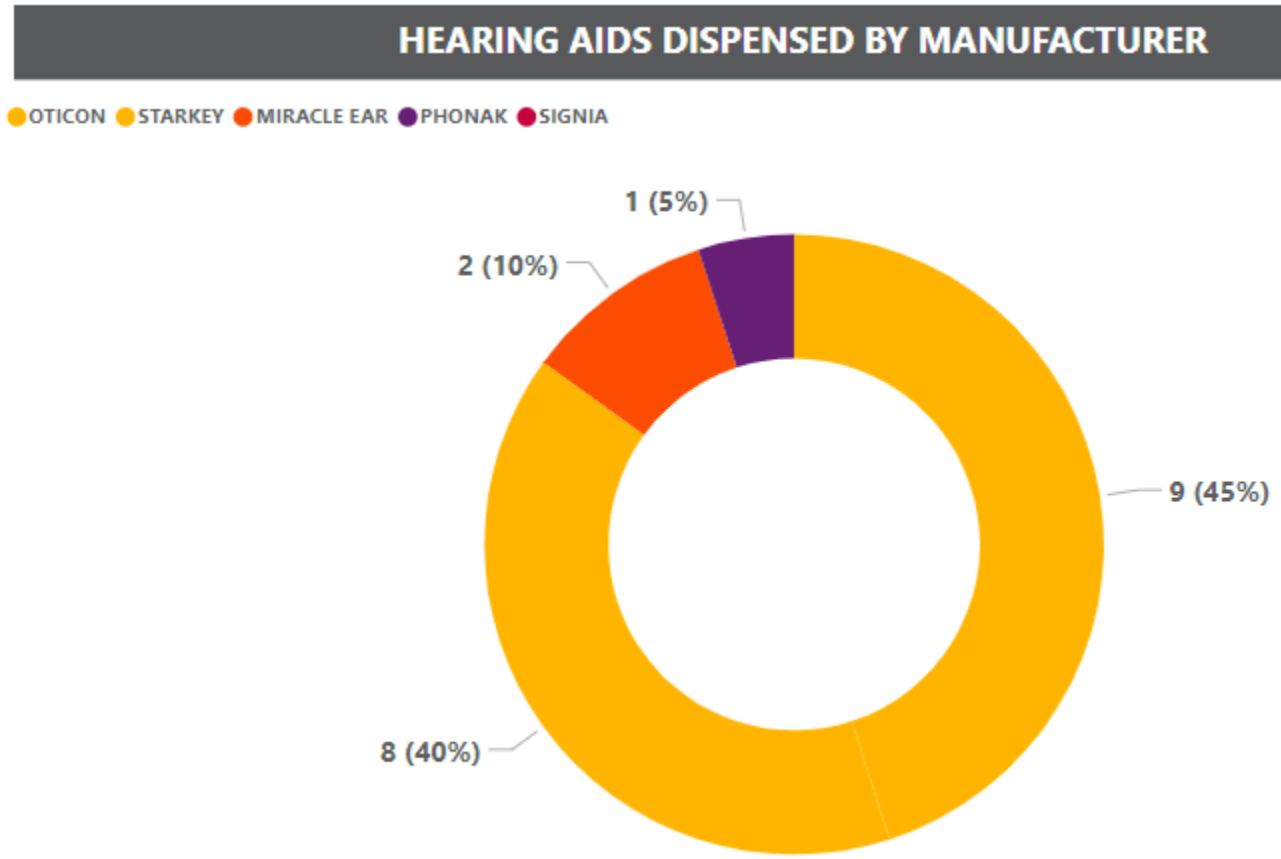
(Blank) (Blank)

PY %YOY

Why do members return hearing aids?

Typically, members return hearing aids due to issues with comfort. For example, a member may feel they want an invisible in-the-ear-canal model but realize it's uncomfortable. They may request to return their hearing aids and switch to an over-the-ear model.

Hearing Aids Dispensed by Manufacturer



THE IMPORTANCE OF CHOICE

Since Amplifon is the only major hearing administrator not owned by a manufacturer, our program is designed to provide your members substantial member choice.

Why is choice of hearing aids important?

- Most providers do not offer all manufacturers. Most only offer 1 to 2 brands of hearing aids
- For members who may already wear hearing aids, they often prefer not to switch manufacturers because they are comfortable with their existing brand
- Some models by manufacturers may be better suited for different lifestyle, technology and hearing healthcare needs

What do providers think?

In a recent Amplifon survey, 90% of providers indicated they prefer having the option to dispense the hearing aid brand and model best suited for the members' lifestyle, technology and hearing needs.

Hearing Aids Dispensed by Technology Tier

UNDERSTANDING TECHNOLOGY TIERS

PREMIER
For **dynamic** lifestyles. Typically includes: 20+ frequency channels, beam forming, wind/echo reduction, impulse noise reduction, and binaural processing

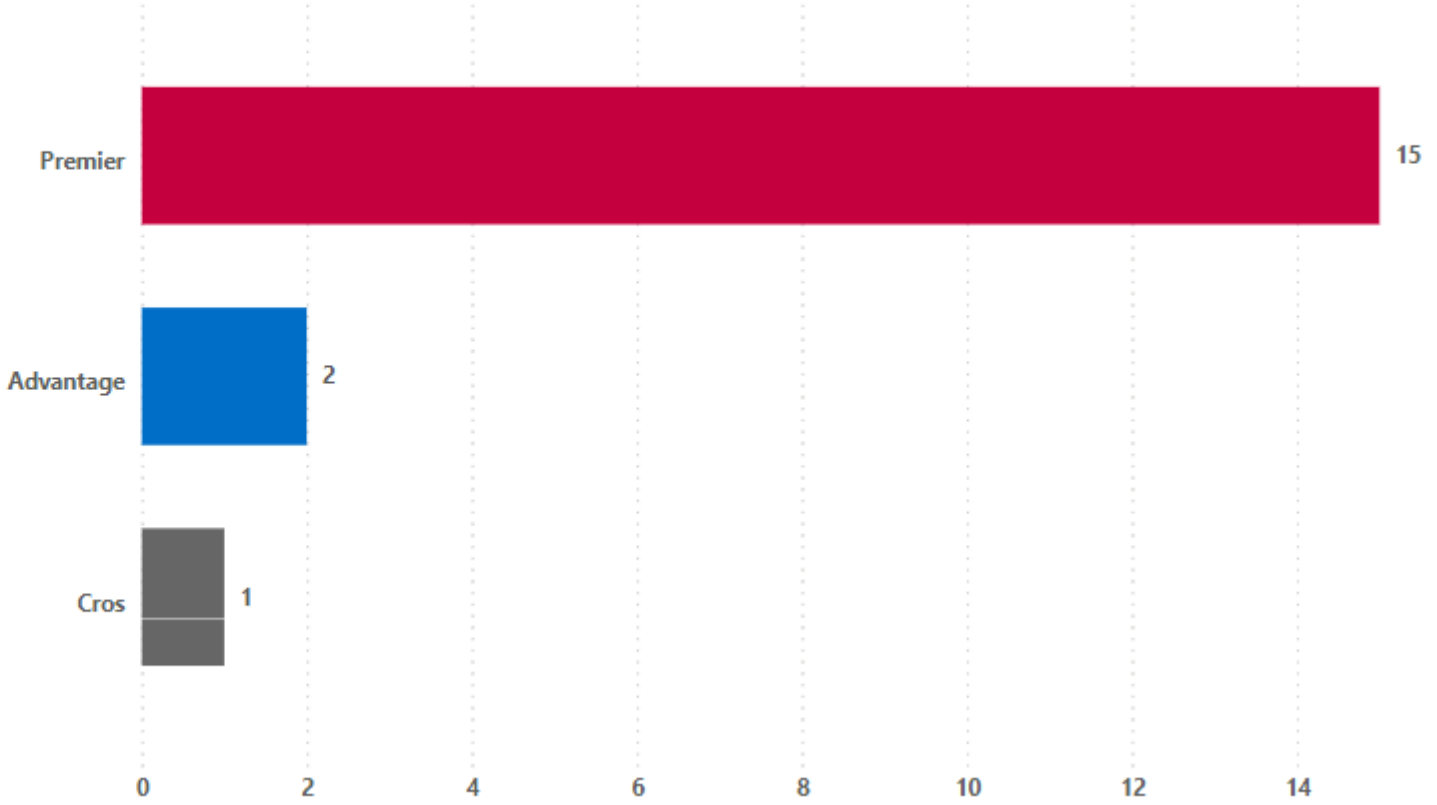
SIGNATURE
For **very active** lifestyles. Typically include: 16 frequency channels, beam forming (limited), wind/echo reduction, impulse noise reducing and binaural processing

ADVANTAGE
For **moderately active** lifestyles. Typically include: 12 frequency channels without other features listed above

PLUS AND BASIC
For **casual or quiet** lifestyles. Typically includes 8 or fewer frequency channels without other features listed above

CROS
A **specialized** hearing aid whose microphone picks from the "poor side" and sends it via wireless connection into a conventional hearing aid on your better ear

HEARING AIDS DISPENSED BY TECHNOLOGY TIER



75%

Percent of Your Members Purchased Rechargeable Hearing Aids
What's the primary difference between disposable and rechargeable hearing aid batteries? Rechargeable hearing aids eliminate the time, stress, and cost of dealing with disposable batteries. Take note: two digital hearing aids eat up an average of 300 (or more!) batteries in a 3-year span.

Savings Analysis

$103,145 =

TOTAL SAVINGS YEAR TO DATE

We're on our way to another successful year. Think of the impact you're making on your members quality of life!

	HAs PURCHASED	AVR MSRP	AVR MBR COST	TOTAL SAVINGS
Premier	15	$8,671	$2,195	$97,140
Advantage	2	$3,520	$1,495	$4,050
Cros	1	$3,850	$1,895	$1,955

Average MSRP Per Aid

$7,831

$5,955 31.5%

PY %YOY

Average Cost Per Aid

$2,101

$2,206 -4.80%

PY %YOY

Total Cost of Aids Purchased

$38K

$77.23K -51.04%

PY %YOY

Average Cost Per Purchase

$3,738

$4,197 -10.94...

PY %YOY

Network Access

Member Utilization: Top Counties

COUNTY	STATE	UTILIZATION YTD	PRIOR YEAR
CARSON CITY	NV	9	4
CLARK	NV	1	4
WASHOE	NV	0	8

Member Utilization: Top Providers

PROVIDER	UTILIZATION YTD	PRIOR YEAR
Hearing Care Of Carson City Ltd	5	2
Sierra Nevada Hearing Aid Center	4	2
LeMay Hearing & Balance	1	1
Miracle Ear	1	2
Silver State Hearing and Balance	-1	4

The Importance of a Uniform Provider Reimbursement Schedule

Rewarding providers with larger dispensing fees (right) leads to unnecessary upselling and greater expense.

FACT: Amplifon is the only hearing health administrator with a universal provider reimbursement rate.

FOCUS: QUALITY OF CARE

Amplifon	
Premier	$$
Signature	$$
Advance	$$
Plus	$$
Basic	$$

Competitors	
Premier	$$$$$
Signature	$$$$ ⬆
Advance	$$$ ⬆
Plus	$$ ⬆
Basic	$ ⬆

FOCUS: MAXIMIZING PROVIDER ROI

Thank you!

4.3.9

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

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

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- 4.3.6 Q2 Express Scripts – Utilization Report
- 4.3.7 Q3 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report
- 4.3.8 Q3 Amplifon Performance Report
- **4.3.9 Doctor on Demand Engagement Report**

Virtual Care Engagement Monthly Report

UMR - STATE OF NEVADA

Reporting Period:

01/01/24 to 02/01/24

Member Engagement

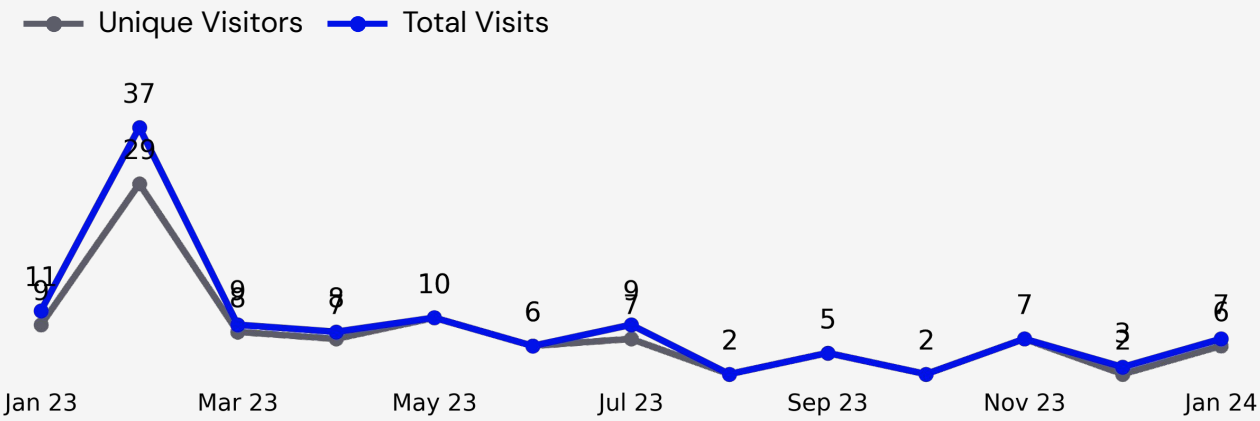
98	6	7
Registrations This Month	Unique Visitors This Month	Total Visits This month

This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement is key to program success; changes in engagement can result from marketing initiatives or seasonality (e.g. cold and flu).

New Registrations (Last 12 Months)

-	3,439	-
Total Covered Lives	Registrations Lifetime to date	Registration Rate Lifetime to date
-	98	-
Employee Covered Lives	Registrations Year to Date	Registration Rate Year to Date

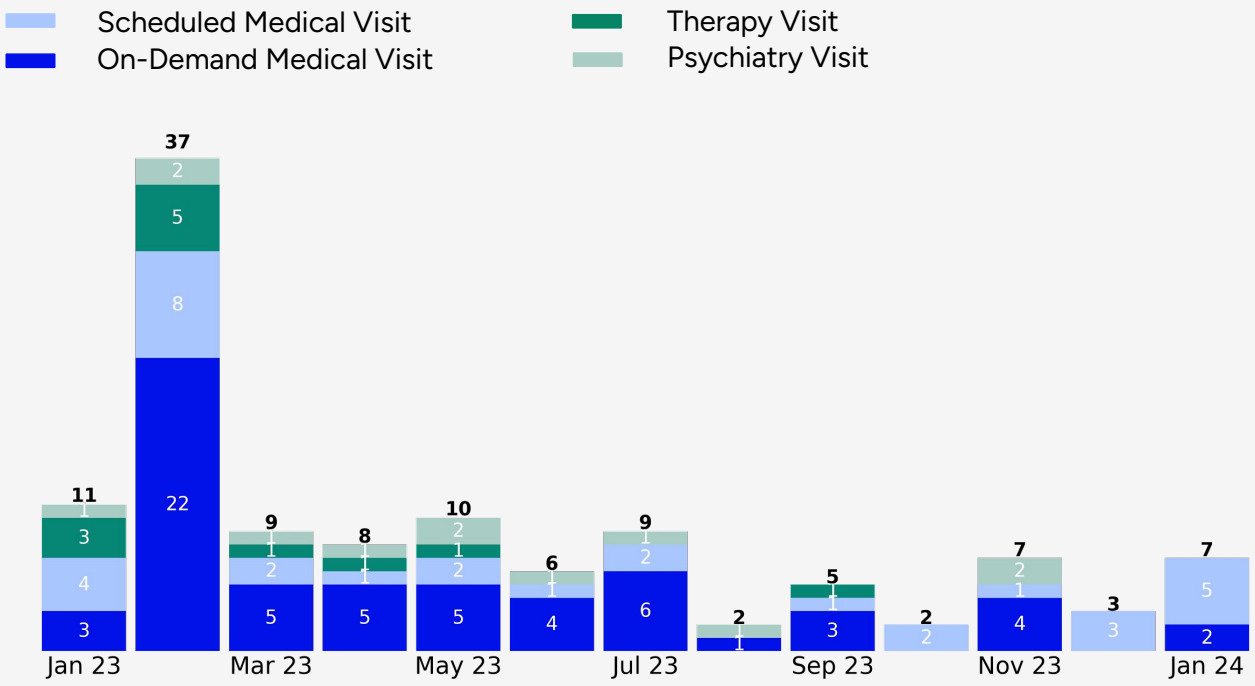
Visits Last 12 Months



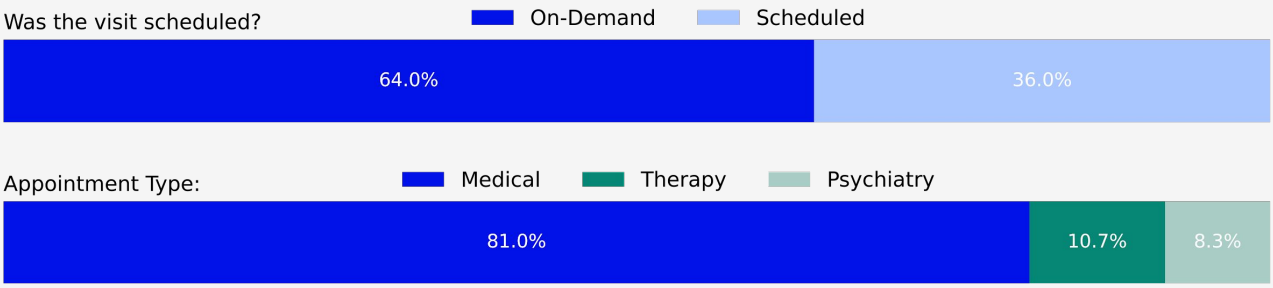
168	67	2.5	-
Visits Lifetime to Date	Unique Visitors Lifetime to Date	Average Visits Per Visitor Lifetime to Date	Engagement Rate Lifetime to Date (Visitors/Lives)
7	6	1.2	-
Visits Year to Date	Unique Visitors Year to Date	Average Visits Per Visitor Year to Date	Engagement Rate Year to Date (Visitors/Lives)

Member Engagement

Medical & Behavioral Health Visits (Rolling 12 Months)



Member Demand by Visit Type Life to Date



Most Popular Day for Visits Life to Date

Tuesday

Most Popular Time for Visits Life to Date

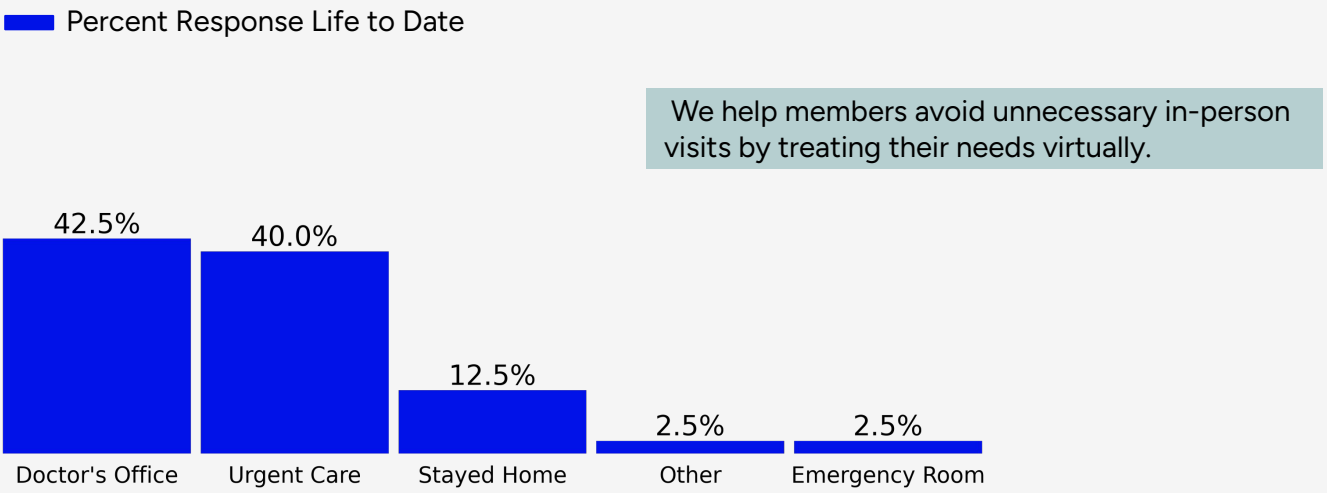
8AM - 10AM

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

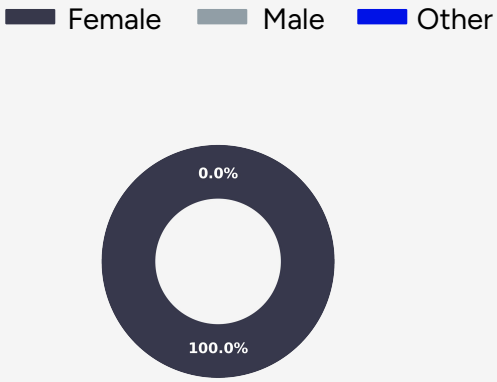
Member Access

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

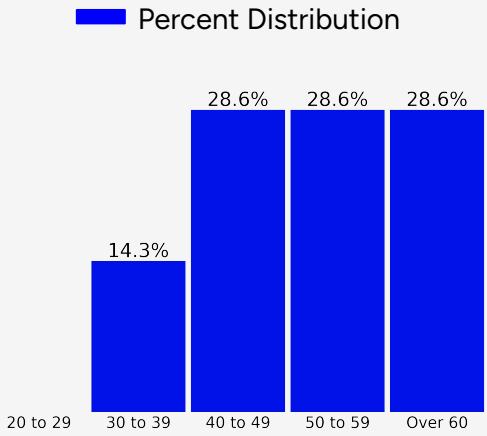
Without Included Health, where would you have gone?



Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	This Month	Life to Date
Average Member Rating	5.0 / 5 (N = 4)	4.98 / 5 (N = 124)
Average Wait Time for On-Demand Medical Appointments	1.81 min	13.33 min

Member Clinical Needs

This section highlights the range of clinical conditions that we treat through virtual care services. The program addresses comprehensive physical and behavioral health needs, and chronic and acute conditions. Examining the top needs of your population can inform more targeted clinical interventions and programs.

Member Reported Symptoms

Top 10 Symptoms

Symptom	Visits This Month	Visits Life to Date
Congestion / sinus p..	3	50
Headache	1	42
Cough	4	42
Nasal discharge	3	37
Difficulty sleeping	2	35
Fatigue / weakness	2	31
Sore throat	1	28
Frequent urination	1	20
Loss of appetite	-	17
Sputum / productive ..	1	17

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits This Month	Visits Life to Date
Anxiety disorders	1	35
Other upper respiratory infections	3	35
Urinary tract infections	1	18
Mood disorders	-	18
Administrative/social admission	1	17
COVID-19	-	14
Cough, unspecified	1	8
Inflammation; infection of eye (except that c..	-	7
Nausea and vomiting	-	6
Acute bronchitis	-	6

Clinical Service Delivery

Our clinical team can provide a wide range of clinical services to help address members' needs. Our team has a focus on prescribing and labs to ensure our efficacy meets or exceeds that of in-person care through connections with pharmacy benefits and top lab networks.

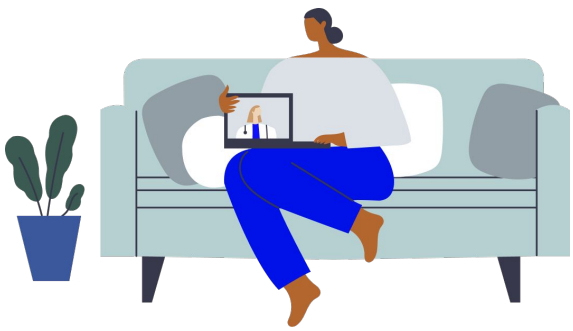
Prescriptions and Testing Summary

8	78.0%	1	4.8%
Prescriptions This Month	of visits resulted in a prescription order Lifetime to Date	Lab Orders This Month	of visits resulted in a lab order Lifetime to Date

Top Prescriptions and Testing Orders

Top Prescriptions	Count This Month	Count Life to Date
benzonatate	1	19
prednisone	1	13
nitrofurantoin monoh..	1	12
sertraline	-	9
albuterol	1	9
amoxicillin/potassiu..	-	8
fluticasone nasal	-	8
nirmatrelvir/ritonavir	-	8
doxycycline hyclate	-	7
azelastine nasal	1	7

Top Labs	Count This Month	Count Life to Date
Urine Culture, Routine	-	3
Urinalysis, Complete..	1	3
RPR w/ Reflex	-	2
Hepatitis Panel	-	2
Chlamydia/GC, Urine	-	2
HIV-1/2 Ag/Ab, 4th G..	-	2
Comprehensive Metabo..	-	1
Lipid Panel	-	1
Trichomonas Vaginali..	-	1
Basic Metabolic Panel	-	1



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

Data Dictionary

Metric	Definition
Behavioral Health Visit	Behavioral Health visits refer to scheduled appointments with our multidisciplinary team of therapists, psychologists, and psychiatrists. Our integrated Behavioral Health solution delivers highly-accessible, virtual-first therapy and psychiatry to members to address every member need from subclinical to clinical. Therapy visits are 25 or 50 minutes in length depending on the patient's needs. Initial Psychiatry visits are 45 minutes in length and all follow up psychiatry visits are 15 minutes in length.
Covered Lives	Total count of member lives (employees and dependents) eligible for Included Health services.
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Engagement Rate	Total number of unique visitors as a percentage of eligible lives.
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ICD-10 Code and Description	Describes the top international classification of diseases for diagnoses, symptoms, and procedures recorded by our clinicians as a result of the visit.
Member Rating	Average visitor rating of 1-5 stars submitted upon visit completion.
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Reported Age and Gender	Describes the patient's age and gender category as provided by the member's insurance carrier or reported by the patient. Note, these demographics describe the patient, not the visitor.
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Virtual Care Engagement Monthly Report

UMR - STATE OF NEVADA

Reporting Period:

02/01/24 to 03/01/24

Member Engagement

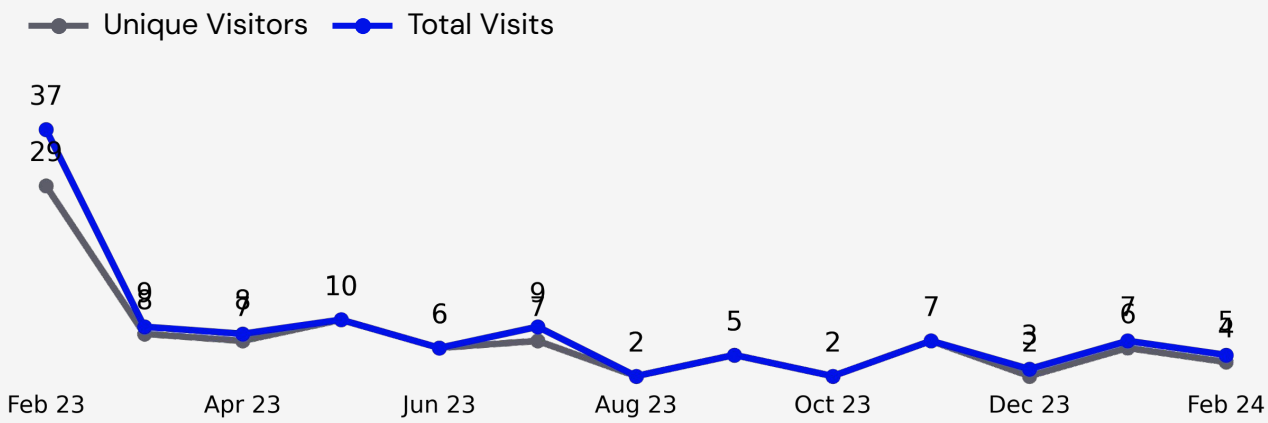
66	4	5
Registrations This Month	Unique Visitors This Month	Total Visits This month

This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement is key to program success; changes in engagement can result from marketing initiatives or seasonality (e.g. cold and flu).

New Registrations (Year to Date)

-	3,542	-
Total Covered Lives	Registrations Lifetime to date	Registration Rate Lifetime to date
-	165	-
Employee Covered Lives	Registrations Year to Date	Registration Rate Year to Date

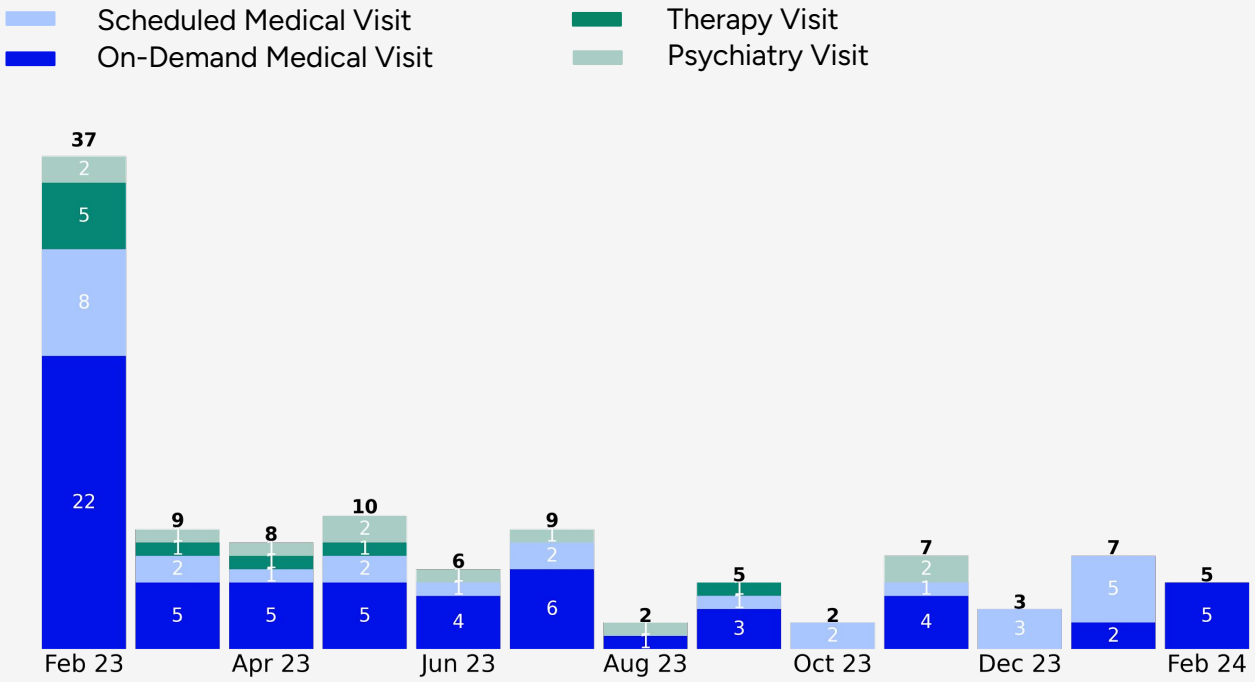
Visits Last 12 Months



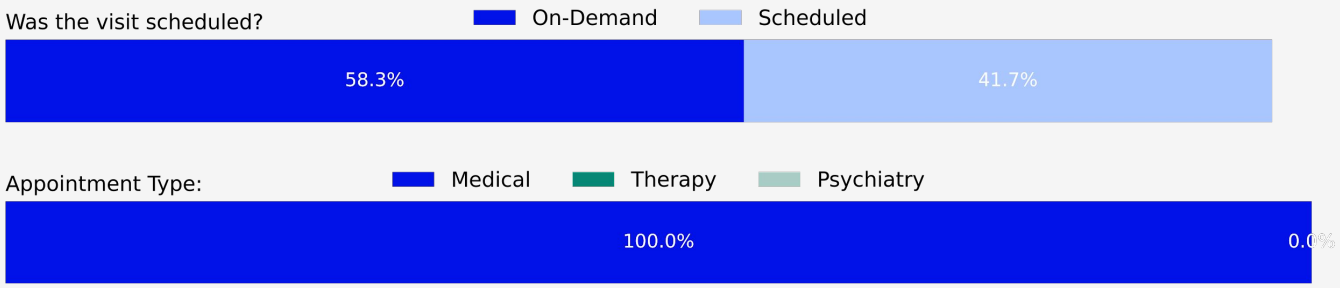
173	67	2.6	-
Visits Lifetime to Date	Unique Visitors Lifetime to Date	Average Visits Per Visitor Lifetime to Date	Engagement Rate Lifetime to Date (Visitors/Lives)
12	10	1.2	-
Visits Year to Date	Unique Visitors Year to Date	Average Visits Per Visitor Year to Date	Engagement Rate Year to Date (Visitors/Lives)

Member Engagement

Medical & Behavioral Health Visits (Rolling 12 Months)



Member Demand by Visit Type Year to Date



Most Popular Day for Visits Year to Date

Friday

Most Popular Time for Visits Year to Date

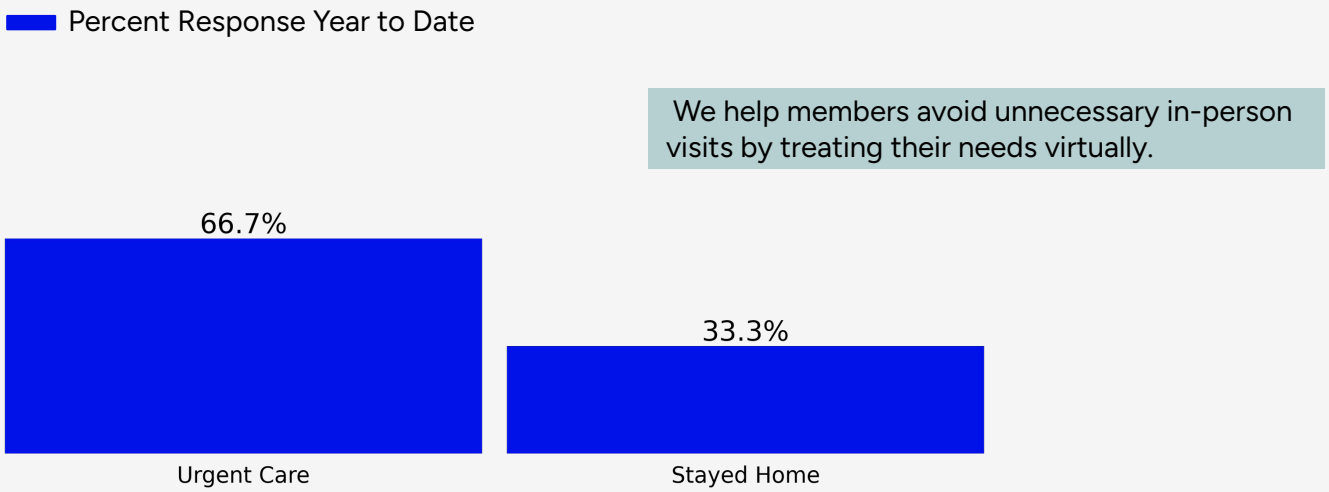
10AM - Noon

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

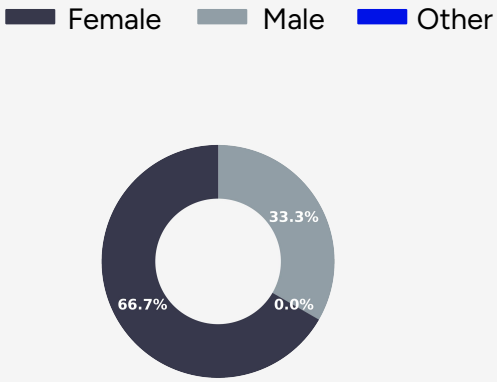
Member Access

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

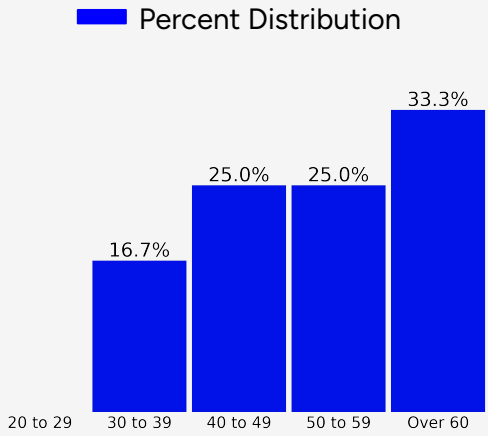
Without Included Health, where would you have gone?



Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	This Month	Year to Date
Average Member Rating	5.0 / 5 (N = 5)	5.0 / 5 (N = 9)
Average Wait Time for On-Demand Medical Appointments	5.88 min	4.71 min

Member Clinical Needs

This section highlights the range of clinical conditions that we treat through virtual care services. The program addresses comprehensive physical and behavioral health needs, and chronic and acute conditions. Examining the top needs of your population can inform more targeted clinical interventions and programs.

Member Reported Symptoms

Top 10 Symptoms

Symptom	Visits This Month	Visits Year to Date
Difficulty sleeping	3	5
Headache	3	4
Muscle pain	2	2
Mood changes	2	3
Eye redness / discharge	2	3
Cough	2	6
Chest pressure / pain	2	3
Dizzy / lightheaded	2	3
Sputum / productive cough / phlegm	2	3
Loss of appetite	2	2

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits This Month	Visits Year to Date
Other upper respiratory infections	1	4
Inflammation; infection of eye (except that c..	1	1
Urinary tract infections	1	2
Other lower respiratory disease	1	2
Headache, unspecified	1	1
Fever of unknown origin	-	-
Anxiety disorders	-	1
Abdominal pain	-	-
Administrative/social admission	-	1
Other nutritional; endocrine; and metabolic d..	-	-

Clinical Service Delivery

Our clinical team can provide a wide range of clinical services to help address members' needs. Our team has a focus on prescribing and labs to ensure our efficacy meets or exceeds that of in-person care through connections with pharmacy benefits and top lab networks.

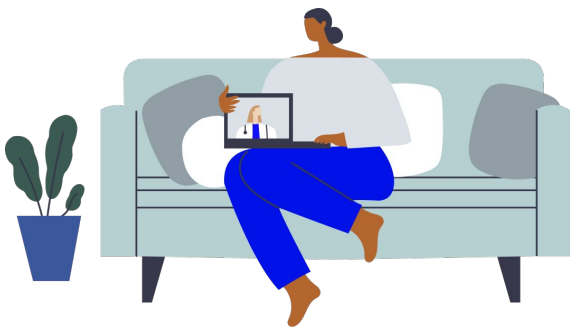
Prescriptions and Testing Summary

4	78.0%	-	4.6%
Prescriptions This Month	of visits resulted in a prescription order Lifetime to Date	Lab Orders This Month	of visits resulted in a lab order Lifetime to Date

Top Prescriptions and Testing Orders

Top Prescriptions	Count This Month	Count Year to Date
erythromycin ophthal..	1	1
cephalexin	1	1
doxycycline monohydr..	1	1
sumatriptan	1	1
scopolamine	-	-
benzonatate	-	1
metoclopramide	-	-
amlodipine besylate	-	-
atenolol	-	-
azithromycin	-	-

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



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Included HEALTH

dr+ on demand by Included Health

Virtual Care Engagement Monthly Report

UMR - STATE OF NEVADA

Reporting Period:

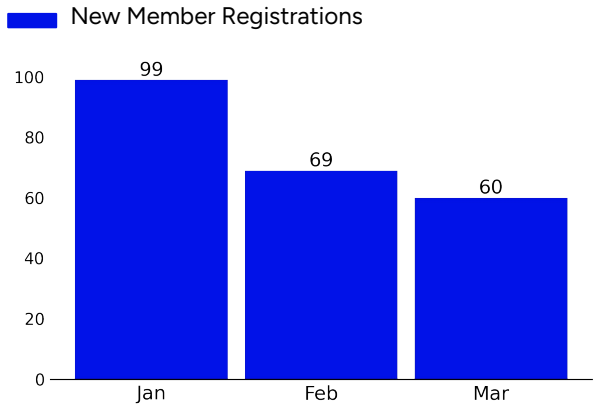
03/01/24 to 04/01/24

Member Engagement

60	3	4
Registrations This Month	Unique Visitors This Month	Total Visits This month

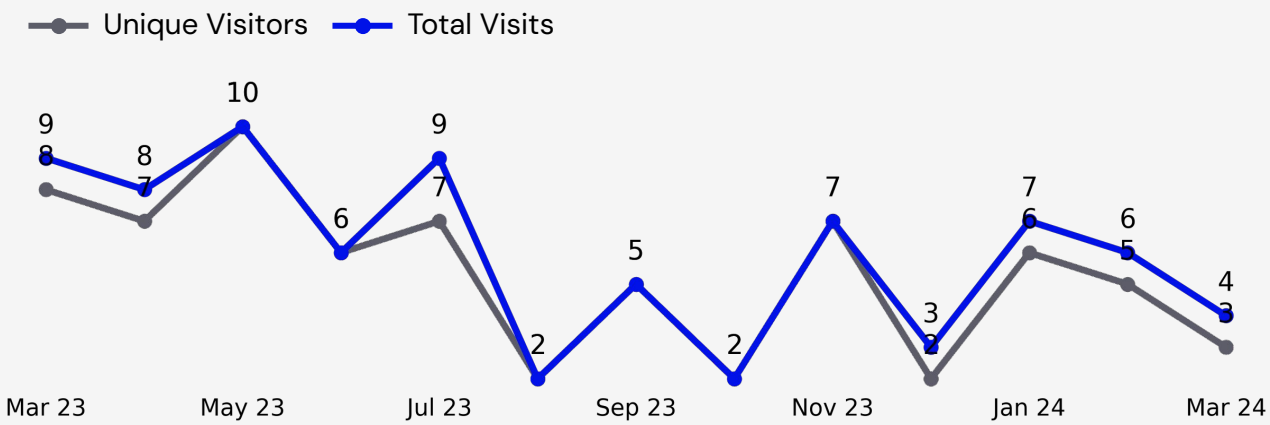
This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement is key to program success; changes in engagement can result from marketing initiatives or seasonality (e.g. cold and flu).

New Registrations (Year to Date)



-	3,625	-
Total Covered Lives	Registrations Lifetime to date	Registration Rate Lifetime to date
-	228	-
Employee Covered Lives	Registrations Year to Date	Registration Rate Year to Date

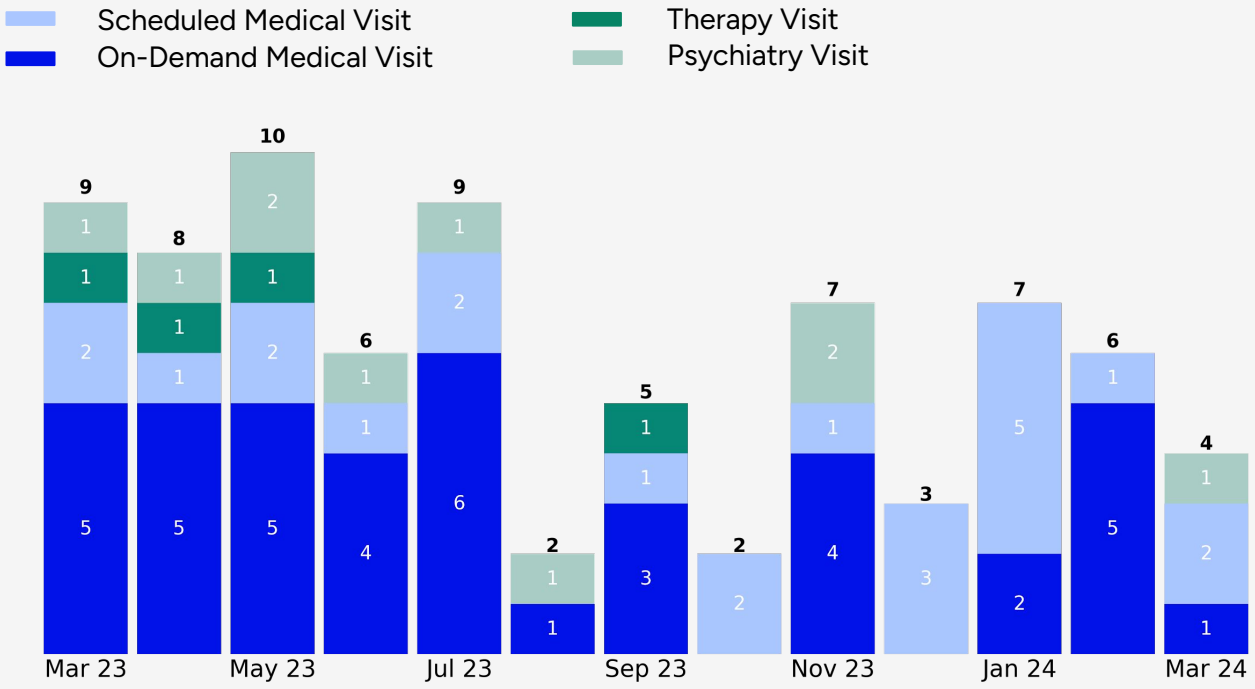
Visits Last 12 Months



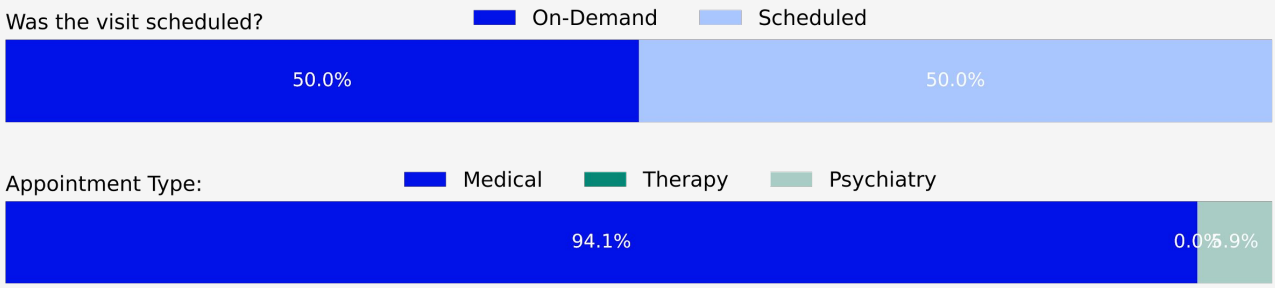
178	67	2.7	-
Visits Lifetime to Date	Unique Visitors Lifetime to Date	Average Visits Per Visitor Lifetime to Date	Engagement Rate Lifetime to Date (Visitors/Lives)
17	11	1.5	-
Visits Year to Date	Unique Visitors Year to Date	Average Visits Per Visitor Year to Date	Engagement Rate Year to Date (Visitors/Lives)

Member Engagement

Medical & Behavioral Health Visits (Rolling 12 Months)



Member Demand by Visit Type Year to Date



Most Popular Day for Visits Year to Date

Friday

Most Popular Time for Visits Year to Date

Noon - 2PM

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

Member Access

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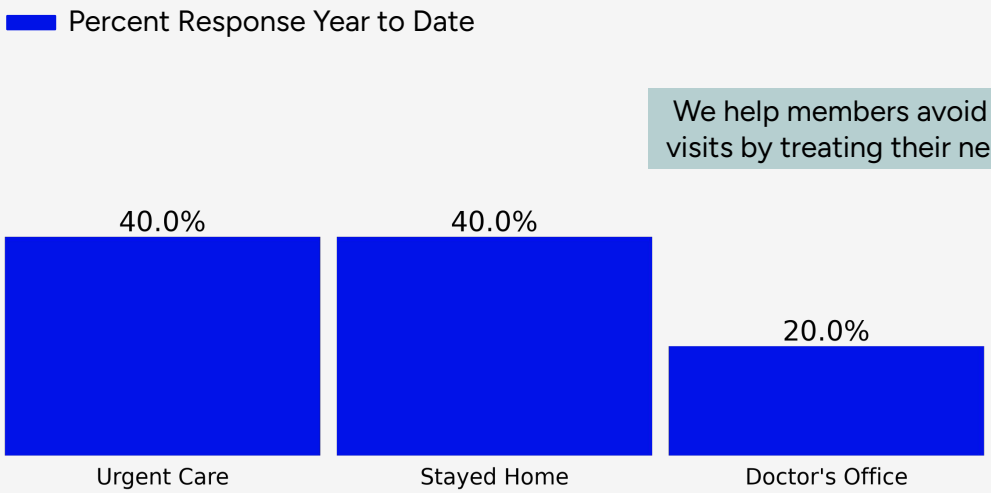
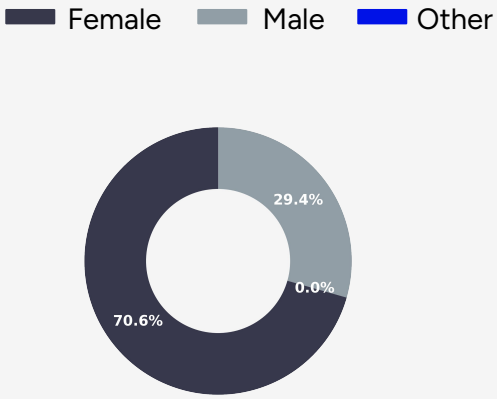
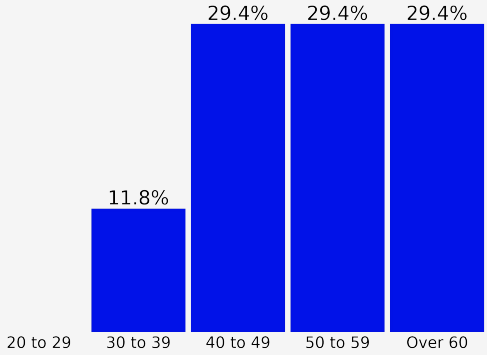


Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	This Month	Year to Date
Average Member Rating	5.0 / 5 (N = 2)	5.0 / 5 (N = 11)
Average Wait Time for On-Demand Medical Appointments	9.5 min	5.31 min

Member Clinical Needs

This section highlights the range of clinical conditions that we treat through virtual care services. The program addresses comprehensive physical and behavioral health needs, and chronic and acute conditions. Examining the top needs of your population can inform more targeted clinical interventions and programs.

Member Reported Symptoms

Top 10 Symptoms

Symptom	Visits This Month	Visits Year to Date
Headache	1	5
Nasal discharge	1	5
Congestion / sinus problem	1	5
Frequent urination	1	3
Discomfort / burning with urination	1	3
Fatigue / weakness	1	4
Mood changes	1	4
Blood in urine	1	1
Eye redness / discharge	1	4
Difficulty sleeping	1	6

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits This Month	Visits Year to Date
Mood disorders	1	1
Acute candidiasis of vulva and vagina	1	1
Other upper respiratory infections	1	6
Anxiety disorders	1	2
Asthma	1	1
Urinary tract infections	1	3
Other lower respiratory disease	0	2
Other upper respiratory disease	0	2
Other gastrointestinal disorders	0	0
Otitis media and related conditions	0	0

Clinical Service Delivery

Our clinical team can provide a wide range of clinical services to help address members' needs. Our team has a focus on prescribing and labs to ensure our efficacy meets or exceeds that of in-person care through connections with pharmacy benefits and top lab networks.

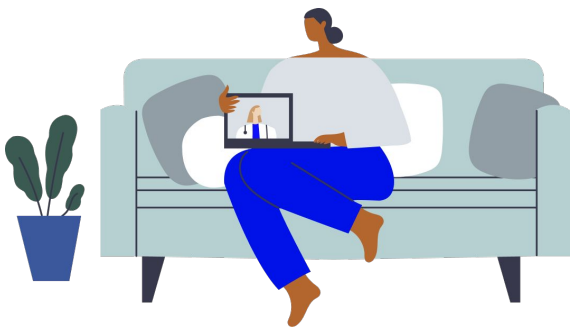
Prescriptions and Testing Summary

2	70.6%	0	5.9%
Prescriptions This Month	of visits resulted in a prescription order Year to Date	Lab Orders This Month	of visits resulted in a lab order Year to Date

Top Prescriptions and Testing Orders

Top Prescriptions	Count This Month	Count Year to Date
clindamycin	1	1
sertraline	1	1
colchicine	0	0
metronidazole	0	0
ofloxacin ophthalmic	0	0
tirzepatide	0	0
ubrogepant	0	0
ofloxacin	0	0
salicylic acid	0	0
doxycycline monohydr..	0	1

Top Labs	Count This Month	Count Year to Date
Trichomonas Vaginali..	0	0
HSV 2, IgG w/ Reflex	0	0
Comprehensive Metabo..	0	0
RPR w/ Reflex	0	0
Insulin	0	0
Hepatitis Panel	0	0
Lipid Panel	0	0
Urine Culture, Routine	0	0
Chlamydia/GC, Urine	0	0
Urinalysis, Complete..	0	1



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Covered Lives	Total count of member lives (employees and dependents) eligible for Included Health services.
Employee Lives	Total count of employee lives eligible for Included Health services.
Engagement Rate	Total number of unique visitors as a percentage of eligible lives.
Medical Visit	Medical visits refer to on-demand and/or scheduled encounters with our multidisciplinary team of clinicians. **Urgent Care:** Our Everyday & Urgent Care solution offers accessible video-first care for acute needs. Our multidisciplinary team of employed clinicians provide 24/7 care on demand or by appointment to improve access to care and deliver a better care experience. Providers are cross-trained in behavioral health, primary dermatology, and geriatric medicine, to treat a wide range of everyday & urgent care and behavioral health needs including cold, flu, UTIs, sinus infections, along with anxiety and depression **Virtual Primary Care -** With Primary Care, we provide 24/7 care across the full continuum of member needs, including physical - acute, preventive and chronic - and behavioral for engaged members.
ICD-10 Code and Description	Describes the top international classification of diseases for diagnoses, symptoms, and procedures recorded by our clinicians as a result of the visit.
Member Rating	Average visitor rating of 1-5 stars submitted upon visit completion.
Patient Reported Symptoms	Describes the top symptoms selected by the patient during visit intake. A patient may select more than one symptom per visit.
Registration	A member is considered "registered" when they digitally accept the Included Health TOS. Registration rate is the total number of individuals registered as a percentage of eligible lives.
Reported Age and Gender	Describes the patient's age and gender category as provided by the member's insurance carrier or reported by the patient. Note, these demographics describe the patient, not the visitor.
Visit	A visit describes a member's encounter with an Included Health provider. Visits can be classified as: Medical or Behavioral (Therapy, Psychiatry)
Visitors	A member that initiates a visit with Included Health. Unique visitor counts is determined by the member that initiates the visit, not the patient seen by the provider. For example: A patient that initiates a visit for herself and a separate visit for her child is counted as one unique visitor.

4.3.10

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

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

- 4.3.1 Q2 UMR – Obesity Care Management
- 4.3.2 Q2 UMR – Diabetes Care Management
- 4.3.3 Q2 UMR – Performance Guarantee Report
- 4.3.4 Q2 Sierra Healthcare Options – Utilization and Large Case Management
- 4.3.5 Q2 Express Scripts – Summary Report
- 4.3.6 Q2 Express Scripts – Utilization Report
- 4.3.7 Q3 WTW's Individual Marketplace (VIA Benefits) Enrollment and Performance Report
- 4.3.8 Q3 Amplifon Performance Report
- 4.3.9 Doctor on Demand Engagement Report
- **4.3.10 Real Appeal – Utilization Report**

Real Appeal

State of Nevada

Data through January 2024

Dashboard Report

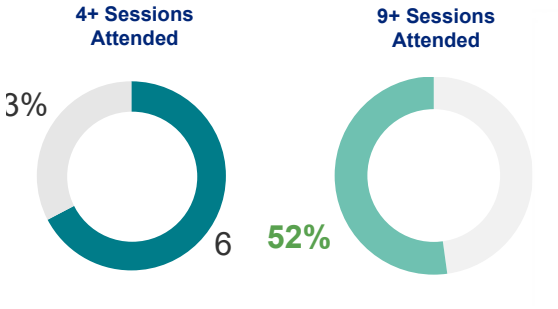
1,124
Enrollment
Members enrolled since program inception

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

610
Engagement
Members attending one or more coaching sessions

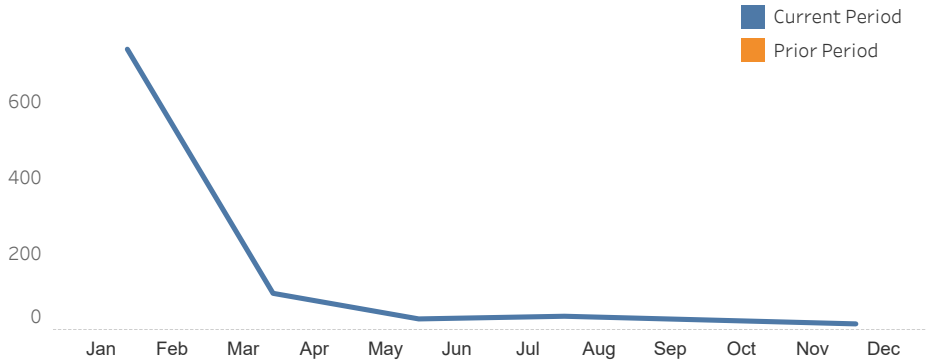
385
Currently Engaged
Members actively engaged due to logging activity within the last six weeks

At-Risk Attendance



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

At-Risk Enrollment



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Current Period							737	98	31	38	28	18
Prior Period												

At-Risk Weight Loss

32%
5%+ Weight Loss
Attended 4+ Sessions In Program 16+ Weeks

4.1
Average lbs. Loss
(per member)
Attended 4+ Sessions In Program 16+ Weeks

447
Members Reporting Weight Loss

3,322
Total Pounds Lost

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

	2022	2023
Enrolled		**1,124**
Disqualified		**41**

Disqualification Criteria:

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

Optum Real Appeal

Enrollment Summary

1,124
Enrollment
Members enrolled since program inception

950
At-Risk
Members with BMI>30, or BMI between 25 - 29.9 and a qualifying comorbidity

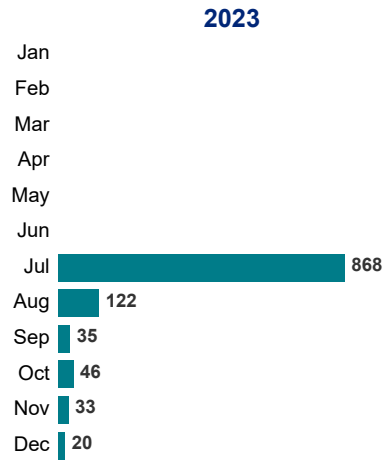
0
Re-Enrolled
Members who completed the programs and enrolled for another period

385
Currently Engaged
Members actively engaged due to logging activity within the last six weeks

Enrollments by Year

Grand Total	2023
1,124	1,124

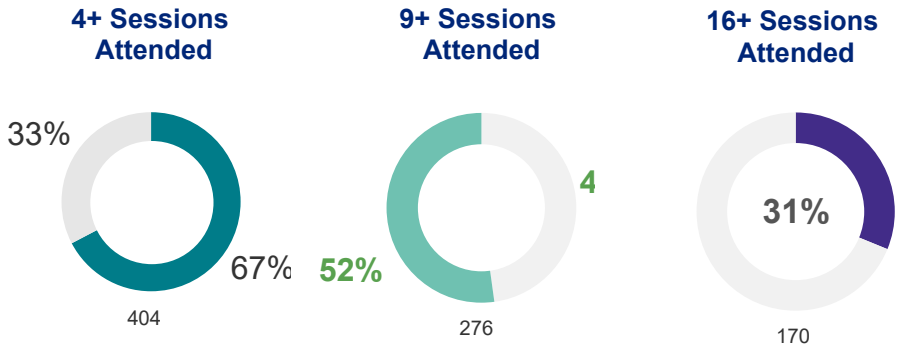
Enrollments by Month



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

Optum | Real Appeal

At-Risk Class Progression & Session Engagement



Real Appeal Expectations

70% Will Attend 4+ Sessions

50% Will Attend 9+ Sessions

30% Will Attend 16+ Sessions

Currently in Week / Session Engagement

	1+ Attended	4+	Attended 4+	9+	Attended 9+	16+	Attended 16+	26+	Attended 26+
1 - 3 Weeks	10	0	0%	0	0%	0	0%	0	0%
4 - 8 Weeks	23	15	65%	0	0%	0	0%	0	0%
9 - 15 Weeks	32	23	72%	12	38%	0	0%	0	0%
16 - 25 Weeks	541	362	67%	260	48%	166	31%	0	0%
26 - 52 Weeks	4	4	100%	4	100%	4	100%	4	100%
Grand Total	610	404	67%	276	48%	170	31%	4	100%

Optum | Real Appeal

At-Risk Outcomes

447
Members with Weight Loss

3,322
Pounds Lost

1.9%
Average Weight Loss
Members began 16+ weeks ago & attended 4+ sessions

3.3% Book of Business

32%
4+ Attended Sessions with 5%+ Loss
Real Appeal Expectations 33% with 5%+ Loss

Your Results

	All Weeks 1+ Attended	Began 16+ Weeks Ago 1+	4+	9+
1+ Attended	610	545	366	264
3%+ Loss	33%	34%	45%	52%
5%+ Loss	18%	19%	25%	30%
Total Weight Loss *	1,798	1,766	1,496	1,144
Avg. Start lbs.	214.6	214.9	214.3	214.0
Avg. lbs. Loss	2.9	3.2	4.1	4.3
Avg. % lbs. Loss	1.4%	1.5%	1.9%	2.0%

At-Risk 5%+ Weight Loss

Real Appeal Book of Business

	All Weeks 1+ Attended	Began 16+ Weeks Ago 1+	4+	9+
3%+ Loss	36%	37%	45%	50%
5%+ Loss	22%	22%	28%	33%
Avg. Start lbs.	218.7	218.7	218.1	217.6
Avg. lbs. Loss	5.7	5.8	7.1	8.2
Avg. % lbs. Loss	2.6%	2.7%	3.3%	3.8%

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

Optum | Real Appeal

Enrollee Characteristics & Outcomes

BMI

** 23-24.9	25-29.9	>=30
85 8%	319 28%	720 64%

Medical Need

At-Risk	Not At-Risk
950 85%	174 15%

Gender

Female	Male
938 83%	186 17%

Plan Member Type

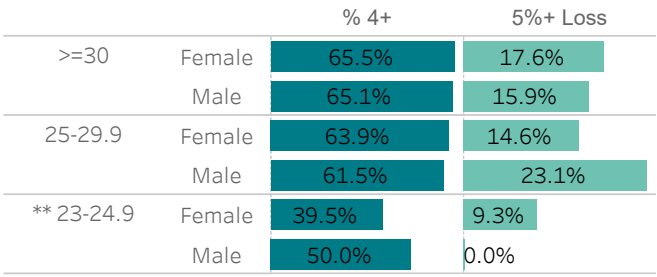
Employee	Spouse/Other
1,061 94%	63 6%

Age Range

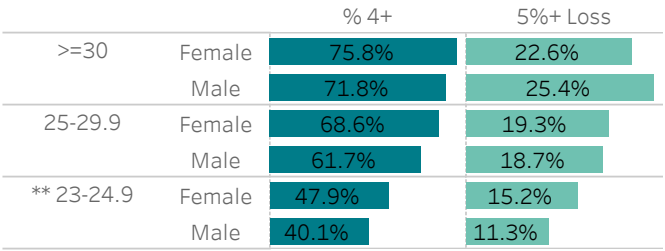
18-29	30-39	40-49	50-64	65-69	70+
75 7%	266 24%	294 26%	446 40%	33 3%	10 1%

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

Attendance & Weight Loss



Book of Business Attendance & Weight Loss



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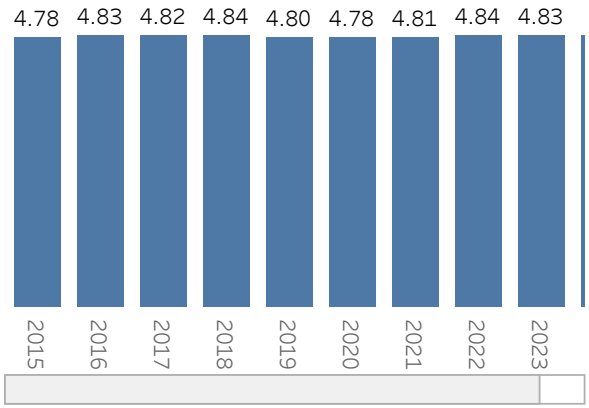
Member Satisfaction

Member Satisfaction Rating

4.82

Book of Business 4.82

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



Total Ratings
Classroom Experience

5,062,278

Optum | Real Appeal

Registration & Enrollment

Relationship

	Relationship	Grand Total	2023
Registered	Employee	**1,098**	1,098
	Spouse/Other	**67**	67
Disqualified	Employee	**37**	37
	Spouse/Other	**4**	4
Enrolled	Employee	**1,061**	1,061
	Spouse/Other	**63**	63
At-Risk	Employee	**896**	896
	Spouse/Other	**54**	54
Not At-Risk	Employee	**165**	165
	Spouse/Other	**9**	9
Re-Enrolled	Employee	**0**	0
	Spouse/Other	**0**	0

Month

	Total	Jul	Aug	Sep	Oct	Nov	Dec
Registered	**1,165**	900	127	37	47	33	21
Disqualified	**41**	32	5	2	1	0	1
Enrolled	**1,124**	868	122	35	46	33	20
At-Risk	**950**	737	98	31	38	28	18
Not At-Risk	**174**	131	24	4	8	5	2
Re-Enrolled	**0**	0	0	0	0	0	0

Optum | Real Appeal

Appendix

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

At-Risk Measurements

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

Outcomes

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

Optum | Real Appeal

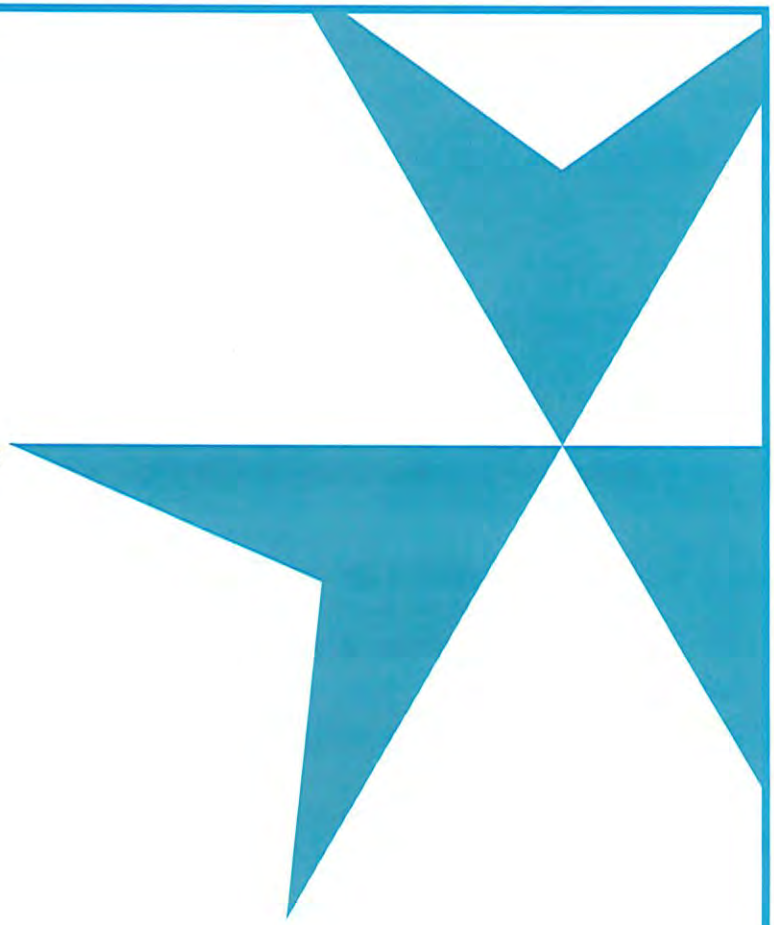
4.4

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

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

State of Nevada
Retiree Health and Life Insurance Plan

Governmental Accounting Standards Board (GASB) Statement 74 Actuarial Valuation and Review of Other Postemployment Benefits (OPEB) measured as of June 30, 2023



Segal

Segal

500 North Brand Boulevard, Suite 1400
Glendale, CA 91203-3338
segalco.com

April 29, 2024

Board of Trustees
State of Nevada Public Employees' Benefits Program
3427 Goni Rd, Suite #109
Carson City, NV 89706

Dear Board Members:

We are pleased to submit this Actuarial Valuation and Review of Other Postemployment Benefits (OPEB) measured as of June 30, 2023 under Governmental Accounting Standards Board Statement No. 74. The report summarizes the actuarial data used in the valuation, discloses the Net OPEB Liability (NOL), and analyzes the preceding year's experience. The actuarial calculations were completed under the supervision of Daniel J. Rhodes, FSA, FCA, MAAA and Mehdi Riazi, FSA, FCA, EA. MAAA.

The measurements shown in this actuarial valuation may not be applicable for other purposes. Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: plan experience differing from that anticipated by the economic or demographic assumptions; changes in economic or demographic assumptions; and changes in plan provisions or applicable law.

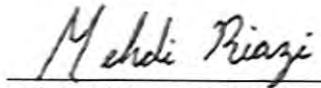
The actuarial valuation has been completed in accordance with generally accepted actuarial principles and practices for the exclusive use and benefit of the Board, based upon information provided by the staff of the Plan and the Plan's other service providers. To the best of our knowledge, the information supplied in this actuarial valuation is complete and accurate. Further, in our opinion, the assumptions used in this valuation and described in Section 3, Exhibit 2 are reasonably related to the experience of and the expectations for the Plan. The actuarial projections are based on these assumptions and the plan of benefits as summarized in Section 3, Exhibit 3.

Segal makes no representation or warranty as to the future status of the Plan and does not guarantee any particular result. This document does not constitute legal, tax, accounting or investment advice or create or imply a fiduciary relationship. The Board is encouraged to discuss any issues raised in this report with the Plan's legal, tax and other advisors before taking, or refraining from taking, any action.

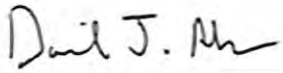
Sincerely,

Segal

Richard Ward, FSA, FCA, MAAA
Senior Vice President



Mehdi Riazi, FSA, FCA, EA, MAAA
Vice President & Consulting Actuary



Daniel J. Rhodes, FSA, FCA, MAAA
Senior Vice President & Consulting Actuary

Table of Contents

Section 1: Actuarial Valuation Summary

Purpose and basis

This report presents the results of our actuarial valuation of the State of Nevada's (the "State") Public Employees Benefits Program (PEBP) Retiree Health and Life Insurance Plan as of June 30, 2023, required by Governmental Accounting Standards Board (GASB) Statement No. 74, *Financial Reporting for Postemployment Benefit Plans Other than Pension Plans.* The actuarial computations made are for purposes of fulfilling plan accounting requirements. Determinations for purposes other than meeting financial accounting requirements may be significantly different from the results reported here. This valuation is based on:

- The benefit provisions of the State of Nevada PEBP Retiree Health and Life Insurance Plan, as administered by Nevada PEBP;
- The characteristics of covered active members, terminated vested members, and retired members and beneficiaries as of June 30, 2023, provided by Nevada PEBP and Nevada Public Employees' Retirement System (PERS);
- The assets of the Plan as of June 30, 2023, provided by Nevada PEBP;
- Health care trends and other medical related assumptions; and
- Other (non-health) actuarial assumptions, regarding employee terminations, retirement, death, disability, etc. based on the State of Nevada PERS Actuarial Experience Study as of June 30, 2020, dated September 10, 2021.

Because the 2025 Final CY 2025 Part D Redesign Program Instructions were released by the Centers for Medicare and Medicaid Services (CMS) several months after the June 30, 2023 measurement date, the trend rate assumptions do not reflect the generally higher anticipated cost due to the implementation of the provisions found in the Inflation Reduction Act of 2022.

Section 1: Actuarial Valuation Summary
Highlights of the valuation

Accounting and Financial Reporting

- The Net OPEB Liability (NOL) as of June 30, 2023 was $1,457,970,965, an increase of $15,763,231 or 1.1%, from the June 30, 2022 NOL of $1,442,207,734. The NOL was expected to increase due to normal plan operations. The increase was less than expected, mainly due to the change in the discount rate from 3.54% to 3.65%. The change in the discount rate decreased the NOL by $14,550,157.

Funding (pay-as-you-go)

- It is our understanding that Nevada PEBP funds OPEB Plan benefits on a pay-as-you-go basis. Under GASB Statement No. 74, if the State were to begin funding OPEB benefits, it would be able to take advantage of a higher discount rate than what is being currently used, which would result in a lower reported liability.

Related Items

- At the request of the PEBP, we are including two additional metrics to assist the State with its bond offering discussions. These additional items are not required disclosures under GASB Statement No. 74. The Actuarially Determined Contribution (ADC) provided below is not based on a formally adopted funding policy nor is it meant to represent a measure of accountability for the State of Nevada. The ADC was determined in a manner consistent with GASB's OPEB reporting framework prior to Statements Nos. 74 and 75.
  a. The Present Value of Benefits (PVB) as of June 30, 2023 was $1,829,699,020. This PVB was based on the same data, methods, and actuarial assumptions as the June 30, 2023 TOL, including a 3.65% discount rate.
  b. The ADC for Fiscal Year Ending 2024 was $133,395,931. This hypothetical ADC consists of the plan's service cost plus a payment towards a 25-year, level-dollar amortization of the NOL. The ADC was developed using the same data, methods, and actuarial assumptions, including a 3.65% discount rate, as those used to develop the June 30, 2023 NOL.

Summary of key valuation results

Valuation Result	Current	Prior
Measurement Date	June 30, 2023	June 30, 2022
Disclosure elements for fiscal year ending June 30:		
• Total OPEB Liability	$1,427,443,647	$1,422,115,023
• Plan Fiduciary Net Position (Assets)	(30,527,318)	(20,092,711)
• Net OPEB Liability	1,457,970,965	1,442,207,734
• Plan Fiduciary Net Position as a percentage of Total OPEB Liability	(2.14)%	(1.41)%
• Service Cost at Beginning of Year	46,423,873	52,675,056
• Total Payroll	2,372,044,778	2,277,677,722
Key assumptions as of June 30:		
• Discount rate	3.65%	3.54%
• Inflation rate	2.50%	2.50%

Important information about actuarial valuations

An actuarial valuation is a budgeting tool with respect to defining future uncertain obligations of a postretirement health plan. As such, it will never forecast the precise future stream of benefit payments. It is an estimated forecast – the actual cost of the plan will be determined by the benefits and expenses paid, not by the actuarial valuation.

In order to prepare a valuation, Segal relies on a number of input items. These include:

Input Item	Description
Plan of benefits	Plan provisions define the rules that will be used to determine benefit payments, and those rules, or the interpretation of them, may change over time. Even where they appear precise, outside factors may change how they operate. For example, a plan may provide health benefits to post-65 retirees that coordinates with Medicare. If so, changes in the Medicare law or administration may change the plan's costs without any change in the terms of the plan itself. It is important for the State to keep Segal informed with respect to plan provisions and administrative procedures, and to review the plan summary included in our report to confirm that Segal has correctly interpreted the plan of benefits.
Participant data	An actuarial valuation for a plan is based on data provided to the actuary by the plan. Segal does not audit such data for completeness or accuracy, other than reviewing it for obvious inconsistencies compared to prior data and other information that appears unreasonable. It is not necessary to have perfect data for an actuarial valuation: the valuation is an estimated forecast, not a prediction. The uncertainties in other factors are such that even perfect data does not produce a "perfect" result. Notwithstanding the above, it is important for Segal to receive the best possible data and to be informed about any known incomplete or inaccurate data.
Assets	The valuation is based on the market value of assets as of the valuation date, as provided by the State.
Actuarial assumptions	In preparing an actuarial valuation, Segal starts by developing a forecast of the benefits to be paid to existing plan participants for the rest of their lives and the lives of their beneficiaries. To determine the future costs of benefits, Segal collects claims, premiums, and enrollment data in order to establish a baseline cost for the valuation measurement, and then develops short- and long-term health care cost trend rates to project increases in costs in future years. This forecast also requires actuarial assumptions as to the probability of death, disability, withdrawal, and retirement of each participant for each year, as well as forecasts of the plan's benefits for each of those events. The forecasted benefits are then discounted to a present value, typically based on an estimate of the rate of return that will be achieved on the plan's assets or, if there are no assets, a rate of return based on a yield or index rate for 20-year, tax-exempt general obligation municipal bonds with an average rating of AA/Aa or higher (or equivalent quality on another rating scale). All of these factors are uncertain and unknowable. Thus, there will be a range of reasonable assumptions, and the results may vary materially based on which assumptions the actuary selects within that range. That is, there is no right answer (except with hindsight). It is important for any user of an actuarial valuation to understand and accept this constraint. The actuarial model necessarily uses approximations and estimates that may lead to significant changes in our results but will have no impact on the actual cost of the plan. In addition, the actuarial assumptions may change over time, and while this can have a significant impact on the reported results, it does not mean that the previous assumptions or results were unreasonable or wrong.

Section 1: Actuarial Valuation Summary

The user of Segal's actuarial valuation (or other actuarial calculations) should keep the following in mind:

- The actuarial valuation is prepared for use by the Nevada PEBP. It includes information for compliance with accounting standards and for the plan's auditor. Segal is not responsible for the use or misuse of its report, particularly by any other party.
- If the State is aware of any event or trend that was not considered in this valuation that may materially change the results of the valuation, Segal should be advised, so that we can evaluate it.
- An actuarial valuation is a measurement at a specific date – it is not a prediction of a plan's future financial condition. Accordingly, Segal did not perform an analysis of the potential range of financial measurements, except where otherwise noted. The actual long-term cost of the plan will be determined by the actual benefits and expenses paid and the actual investment experience of the plan.
- Sections of this report include actuarial results that are not rounded, but that does not imply precision.
- Critical events for a plan include, but are not limited to, decisions about changes in benefits and contributions. The basis for such decisions needs to consider many factors such as the risk of changes in plan enrollment, emerging claims experience, health care trend, and investment losses, not just the current valuation results.
- Segal does not provide investment, legal, accounting, or tax advice and is not acting as a fiduciary to the Plan. This valuation is based on Segal's understanding of applicable guidance in these areas and of the Plan's provisions, but they may be subject to alternative interpretations. The State should look to their other advisors for expertise in these areas.
- While Segal maintains extensive quality assurance procedures, an actuarial valuation involves complex computer models and numerous inputs. In the event that an inaccuracy is discovered after presentation of Segal's valuation, Segal may revise that valuation or make an appropriate adjustment in the next valuation.
- Segal's report shall be deemed to be final and accepted by the State upon delivery and review. The State should notify Segal immediately of any questions or concerns about the final content.

April 29, 2024

Actuarial Certification

This is to certify that Segal has conducted an actuarial valuation of certain benefit obligations of State of Nevada Retiree Health and Life Insurance Plan's other postemployment benefit programs as of June 30, 2023, in accordance with generally accepted actuarial principles and practices. The actuarial calculations presented in this report have been made on a basis consistent with our understanding of GASB Statement 74 for the determination of the liability for postemployment benefits other than pensions.

The actuarial valuation is based on the plan of benefits verified by the PEBP and reliance on participant, premium, claims and expense data provided by the Employer or from vendors employed by the PEBP. Segal does not audit the data provided. The accuracy and comprehensiveness of the data is the responsibility of those supplying the data. Segal, however, does review the data for reasonableness and consistency.

The actuarial computations made are for purposes of fulfilling plan accounting requirements. Determinations for purposes other than meeting financial accounting requirements may be significantly different from the results reported here. Accordingly, additional determinations may be needed for other purposes, such as judging benefit security at termination of the plan, or determining short-term cash flow requirements.

Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: retiree group benefits program experience or rates of return on assets differing from that anticipated by the assumptions; changes in assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period); and changes in retiree group benefits program provisions or applicable law. Retiree group benefits models necessarily rely on the use of approximations and estimates, and are sensitive to changes in these approximations and estimates. Small variations in these approximations and estimates may lead to significant changes in actuarial measurements. The scope of the assignment did not include performing an analysis of the potential change of such future measurements except where noted.

To the best of our knowledge, this report is complete and accurate and in our opinion presents the information necessary to comply with GASB Statement 74 with respect to the benefit obligations addressed. The signing actuaries are members of the Society of Actuaries, the American Academy of Actuaries, and other professional actuarial organizations and collectively meet the "General Qualification Standards for Statements of Actuarial Opinions" to render the actuarial opinion contained herein.

Mehdi Riazi

Mehdi Riazi, FSA, FCA, EA, MAAA
Vice President & Consulting Actuary
Certifying Liability Calculations

Daniel J. Rhodes

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Section 2: GASB 74 Information

General information about the OPEB plan

Plan administration. The Public Employees' Benefits Program (PEBP) of the State of Nevada administers the OPEB plan - a multiple-employer, cost-sharing OPEB plan that is used to provide OPEB for permanent full-time employees of the State.

Plan membership. At June 30, 2022, the State's OPEB plan membership consisted of the following:

Membership	Medical
Retired members or beneficiaries currently receiving benefits[1]	12,692
Vested terminated members entitled to but not yet receiving benefits[2]	18,495
Active members	28,015
Total	**59,202**

Benefits provided. Non-Medicare retirees are eligible for medical and prescription drug benefits via four separate health plan options. Premiums for non-Medicare retirees vary based on date of hire, date of retirement, and years of service.

Medicare retirees are eligible for medical and prescription drug benefits through the Exchange. Medicare retirees hired before January 1, 2012 are eligible for a monthly Exchange HRA contribution of $195 if retired prior to January 1, 1994, or $13 per year of service, up to a maximum of 20 years of service if retired on or after January 1, 1994. Medicare retirees hired between January 1, 2010 and December 31, 2011 require 15 years of service to qualify for an HRA contribution.

[1] Retiree and Beneficiary counts only include State participants.
[2] Vested Terminated counts include Non-State participants. The Nevada PERS census data, determined as the best source for vested terminated participants, does not differentiate between State and non-State participants. The participation assumption for vested terminated members has been adjusted downward to reflect only future State retirees from this group.

Section 2: GASB 74 Information

Benefits provided (continued). Retirees and spouses who are over the age of 65 can maintain their healthcare coverage on a non-Exchange plan until the younger spouse reaches the age of 65. In addition, retirees over the age of 65 who are not eligible for free Part A coverage are allowed to stay on a non-Exchange health plan. In these situations, the retiree contribution for a retired member who is over the age of 65 is reduced by the Part B premium credit. The Part B reimbursement is not provided to spouses who are over the age of 65. Enrollment in Medicare Part B is required for retirees who are over the age of 65. Retirees over the age of 65 who are eligible for free Medicare Part A are required to enroll in Medicare Part A and a health plan offered by the Medicare Exchange.

Duration of coverage. Until both the retiree and spouse become Medicare-eligible, whereupon they will move to the Exchange. Certain retirees over age 65 are not eligible for Medicare Part A. Lifetime benefits are provided to members hired prior to January 1, 2012. Medicare retirees hired between January 1, 2010 and December 31, 2011 require 15 years of service to qualify for an HRA contribution.

Dependent coverage. Benefits are available for dependents. However, beneficiaries and spouses do not receive any Exchange benefits. Couples can remain on a non-Medicare plan until the younger spouse reaches age 65. A member who is older than 65 and has a spouse who is younger than 65 is required to enroll in Medicare. The plan will pay secondary to Medicare and will reimburse the member $135.10 towards the Medicare Part B premium. Surviving spouses of retirees, and surviving spouses of active employees who had at least 10 years of service, are allowed to maintain their health coverage to age 65 but are required to pay the full blended premiums. Surviving spouses and children of Police/Fire employees killed in the line of duty are allowed to join or continue the plan, and their full premium is paid by the employer.

Life insurance. Any retiree with retiree health insurance coverage, either through the CDHP PPO, LD PPO, EPO, HMO, or Medicare Exchange is provided a basic life insurance benefit of $12,500 free of charge. Retirees can purchase additional coverage at their own expense.

Retiree contributions. Retiree and spouse contribution rates are periodically reset by the PEBP. The monthly contributions shown below were effective from July 1, 2022 through June 30, 2023. Employees hired on or after January 1, 2012, or hired between January 1, 2010 and January 1, 2012 with less than 15 years of service, as well as all surviving spouses, are required to pay the plan's overall blended premium rates for coverage.

	CDHP PPO	LD PPO	HMO/EPO
Retiree	$241.26	$262.44	$355.30
Retiree + Spouse	588.96	631.34	817.06
Surviving Spouse	670.83	691.98	779.47

Retiree contributions (continued). Service-based adjustments are applied to the CDHP PPO, LD PPO, EPO, and HMO premiums as follows. These service-based adjustments do not apply to spouses, surviving spouses, or employees hired on or after January 1, 2012.

Years of Service	Change in Premium ($)
5	+373.50
6	+336.15
7	+298.80
8	+261.45
9	+224.10
10	+186.75
11	+149.40
12	+112.05
13	+74.70
14	+37.35
15	0
16	-37.35
17	-74.70
18	-112.05
19	-149.40
20+	-186.75

Net OPEB liability

Components of the Net OPEB Liability	Current	Prior
Measurement Date	June 30, 2023	June 30, 2022
Total OPEB Liability	$1,427,443,647	$1,422,115,023
Plan Fiduciary Net Position	(30,527,318)	(20,092,711)
Net OPEB Liability	1,457,970,965	1,442,207,734
Plan Fiduciary Net Position as a percentage of the Total OPEB Liability	(2.14)%	(1.41)%

The Net OPEB Liability was measured as of June 30, 2023 and 2022. Plan Fiduciary Net Position (plan assets) was valued as of the measurement dates and the Total OPEB Liability was determined from actuarial valuations using data as of June 30, 2022.

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Actuarial assumptions. The Total OPEB Liability was measured by an actuarial valuation as of June 30, 2022 using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified. The Total OPEB Liability as of June 30, 2023 was developed using standard actuarial roll-forward techniques.

Assumption Type	Assumption
Inflation	2.50%
Salary increases	4.20% to 9.10%, for Regular members and 4.60% to 14.50% for Police/Fire members, varying by service, including inflation
Discount rate	3.65%
Healthcare cost trend rates	
Medical/Prescription Drug	4.80% increase effective July 1, 2023, then 7.25% graded down 0.25% to ultimate 4.50% over 11 years.
Retiree premiums	First year trend rates were based on actual increases effective July 1, 2023. Afterwards, premium increases were expected to be in-line with the underlying medical and prescription drug claims trend assumption.
Dental	4.00%
Administrative costs	3.00%
Part B reimbursement	0% and 27.17%, effective July 1, 2023 and 2024, respectively, then 4.50%
Demographic assumptions	The demographic assumptions which are not unique to the OPEB valuation were based on the 2020 Actuarial Experience Study conducted for the Public Employees' Retirement System of the State of Nevada, dated September 10, 2021. For details, please see Section 3, Exhibit 2.

Determination of discount rate and investment rates of return

Since the State funds this Plan on a pay-as-you-go-basis, GASB requires the discount rate be based on a yield or index rate for 20-year, tax-exempt general obligation municipal bonds with an average rating of AA/Aa or higher (or equivalent quality on another rating scale). To comply with this requirement, the discount rate is based on an index of 20-year, tax-exempt general obligation bonds. Specifically, the chosen rate is 3.65%, the Bond Buyer 20-Bond GO Index rate published closest to, but not later than, the measurement date of June 30, 2023.

Sensitivity

The following presents the NOL as well as what the NOL would be if it were calculated using a discount rate that is 1-percentage-point lower (2.65%) or 1-percentage-point higher (4.65%) than the current rate. Also, shown is the NOL as if it were calculated using healthcare cost trend rates that were 1-percentage-point lower or 1-percentage-point higher than the current healthcare trend rates.

Item	1% Decrease (2.65%)	Current Discount Rate (3.65%)	1% Increase (4.65%)
Net OPEB Liability (Asset)	$1,599,173,891	$1,457,970,965	$1,335,498,630

Item	1% Decrease in Health Care Cost Trend Rates	Current Health Care Cost Trend Rates	1% Increase in Health Care Cost Trend Rates
Net OPEB Liability (Asset)	$1,382,571,885	$1,457,970,965	$1,544,492,010

Schedule of changes in Net OPEB Liability – Last two fiscal years

	Current	Prior
Measurement Date	June 30, 2023	June 30, 2022
Total OPEB Liability		
Service cost	$46,423,873	$52,675,056
Interest	50,767,999	33,718,089
Change of benefit terms	0	38,605,492
Differences between expected and actual experience	(7,880,015)	(19,315,612)
Changes of assumptions	(14,550,157)	(159,738,443)
Benefit payments, including refunds of member contributions	(69,433,076)	(64,012,286)
Net change in Total OPEB Liability	**$5,328,624**	**$(118,067,704)**
Total OPEB Liability – beginning	1,422,115,023	1,540,182,727
Total OPEB Liability – ending	**$1,427,443,647**	**$1,422,115,023**
Plan Fiduciary Net Position		
Contributions – employer[1]	$58,858,467	$53,980,293
Contributions – employee	0	0
Net investment income	140,002	(92,890)
Benefit payments, including refunds of member contributions	(69,433,076)	(64,012,286)
Administrative expense	0	0
Other	0	0
Net change in Plan Fiduciary Net Position	**$(10,434,607)**	**$(10,124,883)**
Plan Fiduciary Net Position – beginning	(20,092,711)	(9,967,828)
Plan Fiduciary Net Position – ending	**$(30,527,318)**	**$(20,092,711)**

[1] For the measurement periods ending June 30, 2023 and June 30, 2022,
(1) benefit payments were calculated using actual underlying claims, premiums, and HRA benefits, net of retiree contributions, and
(2) employer contributions reflect contributions to the retiree health benefits trust plus contributions related to benefits that were not reimbursed by the retiree health benefits trust.

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	Current	Prior
Net OPEB Liability		
Net OPEB Liability – ending	$1,457,970,965	$1,442,207,734
Plan Fiduciary Net Position as a percentage of the Total OPEB Liability	(2.14)%	(1.41)%
Covered payroll	$2,372,044,778	$2,277,677,722
Plan Net OPEB Liability as percentage of covered payroll	61.46%	63.32%

Notes to Schedule:

- Benefit changes: None.
- Changes of assumptions: The discount rate increased from 3.54% to 3.65%. This change lowered the TOL.

Statement of Fiduciary Net Position

	Amounts as of June 30, 2023
Assets	
• Cash with Treasurer	$2,199,374
Receivables	
• Intergovernmental Receivable	23,940
• Due From Other Funds	137,891
• Due From Component, Units, Net	1,526,308
• Total receivables	$1,688,139
Total Assets	**$3,887,513**
Liabilities	
Payables	
• Due to Other Funds	34,414,831
Total liabilities	**$34,414,831**
Net position restricted for OPEB	**$(30,527,318)**

Section 3: Supporting Information

Exhibit 1: Summary of Participant Data

As of June 30, 2022

Number of retirees	12,319
Average age of retirees	69.86
Number of spouses	2,354
Average age of spouses	67.28
Number of surviving spouses	373
Average age of surviving spouses	76.61
Number inactive vested[1]	18,495
Average age of inactive vested	49.15
Number of actives[2]	28,015
Average age of actives	45.04
Average service	8.74

[1] Based on discussions with the State, we agreed to use the June 30, 2022 Nevada PERS census data for vested terminated participants. Only vested terminated employees who were younger than age 65 as of the valuation date were included. The PERS database was the best source of data available for vested terminated participants. However, we were not able to determine which vested terminated PERS participants were State employees. As a result, the participation assumption for current vested terminated participants was adjusted downward to reflect the fact that the census data includes State and Non-State vested terminated participants.

[2] Of the 28,015 active employees, 18,198 were hired on or after January 1, 2012.

Exhibit 2: Actuarial Assumptions and Actuarial Cost Method

Data:

Detailed census data, premium data and claim experience, and summary plan descriptions for OPEB were provided by Nevada PEBP.

Actuarial Cost Method:

Entry Age Normal level percent of pay

Asset Valuation Method:

Market Value

Measurement Date:

June 30, 2023

Actuarial Valuation Date:

June 30, 2022

Roll Forward Techniques:

The Total OPEB Liability as of June 30, 2023 was based on the results in the Actuarial Valuation and Review of Other Postemployment Benefits as of June 30, 2022 in accordance with GASB No. 75, dated August 1, 2023, by Segal, adjusted forward using standard actuarial techniques and also adjusted for changes in assumptions.

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Discount Rate:

3.65%, based on bond index as of June 30, 2023

Inflation Rate:

2.50%

Investment Return Assumption:

2.50%, same as Inflation Rate assumption

Demographic and Salary Assumptions:

The demographic and salary increase assumptions that are common to the PERS pension valuation were based on the 2020 Actuarial Experience Study for the Public Employees' Retirement System of the State of Nevada dated September 10, 2021.

The demographic assumptions that are unique to the GASB 74 valuation (such as enrollment elections, dependent coverage assumptions, and relative ages of spouses) are based on the plan's experience and are reviewed every full valuation.

Salary Increases (%):

Inflation: 2.50% plus

Productivity pay increases: 0.50% plus

Merit and promotion salary increases:

Years of Service	Regular	Police/Fire
0 – 1	6.10	11.50
1 – 2	5.00	8.20
2 – 3	4.40	5.80
3 – 4	4.00	5.20
4 – 5	3.70	4.90
5 – 6	3.40	4.70
6 – 7	3.30	4.40
7 – 8	3.20	4.20
8 – 9	3.00	4.00
9 – 10	2.80	3.90
10 – 11	2.60	3.50
11 – 12	2.30	2.80
12 – 13	2.10	2.20
13 – 14	1.90	2.00
14 – 15	1.80	1.90
15 – 16	1.70	1.70
16 – 17	1.60	1.70
17 – 18	1.50	1.70
18 – 19	1.40	1.70
19 – 20	1.30	1.70
20 & Over	1.20	1.60

Future salary increases are assumed to occur at the beginning of the year.

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Mortality Rates:

Healthy Preretirement:

- **Regular Members:** Pub-2010 General Employee Headcount-Weighted Above-Median Mortality Table (separate tables for males and females), projected generationally with the two-dimensional mortality improvement scale MP-2020.
- **Police/Fire Members:** Pub-2010 Safety Employee Headcount-Weighted Above-Median Mortality Table (separate tables for males and females), projected generationally with the two-dimensional mortality improvement scale MP-2020.

Healthy Postretirement:

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

Disabled Postretirement:

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

Beneficiaries:

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

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Termination Rates (%) before Retirement:

Years of Service	Regular	Police/Fire
0 – 1	15.75	14.50
1 – 2	12.75	8.25
2 – 3	10.25	6.50
3 – 4	8.25	5.50
4 – 5	7.50	4.50
5 – 6	6.50	4.25
6 – 7	5.75	3.25
7 – 8	5.25	2.50
8 – 9	4.75	2.50
9 – 10	4.50	1.90
10 – 11	4.25	1.40
11 – 12	3.25	1.25
12 – 13	3.00	1.00
13 – 14	2.75	0.90
14 – 15	2.25	0.80
15 – 16	2.25	0.70
16 – 17	2.25	0.60
17 – 18	2.00	0.50
18 – 19	1.75	0.40
19 – 20	1.75	0.30
20 – 21	1.75	0.30
21 – 22	1.75	0.30
22 – 23	1.75	0.30
23 – 24	1.75	0.30
24 – 25	1.50	0.30
25 & Over	1.50	0.30

No termination is assumed after a member reaches the earliest retirement age.

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Disability Rates (%):

Age	Regular	Police/Fire
22	0.01	0.00
27	0.03	0.06
32	0.04	0.16
37	0.10	0.32
42	0.20	0.50
47	0.30	0.80
52	0.55	0.70
57	0.70	0.50
62	0.30	0.30
65 & Over	0.00	0.00

Disability rates are applied only for members with:

- 5 to 30 years of service for Regular members with a date of membership before July 1, 2015,
- Less than 33 1/3 years of service for Regular members with a date of membership on or after July 1, 2015,
- Less than 25 years of service for Police/Fire members with a date of membership before January 1, 2010, or
- Less than 30 years of service for Police/Fire members with a date of membership on or after January 1, 2010.

Actives' Retirement Rates (%):

Regular members with an effective date of membership before January 1, 2010:

Age	5 – 9 Years of Service	10 – 19 Years of Service	20 – 24 Years of Service	25 – 27 Years of Service	28 – 29 Years of Service	30 & Over Years of Service
45	0.00	0.10	0.10	0.50	20.00	20.00
46	0.00	0.20	0.20	1.00	20.00	20.00
47	0.00	0.30	0.30	1.50	20.00	20.00
48	0.00	0.40	0.40	2.00	20.00	20.00
49	0.00	0.50	0.50	2.00	20.00	20.00
50	0.20	0.60	0.70	2.00	20.00	20.00
51	0.30	0.70	1.00	2.00	20.00	20.00
52	0.40	0.80	1.20	3.00	20.00	20.00
53	0.50	1.00	1.50	3.00	20.00	20.00
54	0.60	1.20	2.00	3.00	20.00	20.00
55	0.80	1.50	3.00	3.00	20.00	20.00
56	1.00	2.00	3.50	4.00	20.00	20.00
57	1.50	2.50	4.00	7.00	20.00	20.00
58	2.00	3.00	5.00	7.00	20.00	20.00
59	2.50	4.00	7.00	11.00	20.00	20.00
60	5.00	11.00	18.00	25.00	21.00	21.00
61	6.00	10.00	15.00	20.00	21.00	21.00
62	7.00	11.00	16.00	20.00	20.00	20.00
63	8.00	11.00	16.00	20.00	20.00	20.00
64	9.00	11.00	16.00	20.00	20.00	20.00
65	18.00	19.00	22.00	22.00	25.00	25.00
66	18.00	19.00	22.00	22.00	25.00	25.00
67	18.00	19.00	22.00	22.00	25.00	25.00
68	18.00	19.00	22.00	22.00	25.00	25.00
69	18.00	19.00	22.00	22.00	25.00	25.00
70	20.00	20.00	25.00	30.00	30.00	30.00
71	20.00	20.00	25.00	30.00	30.00	30.00
72	20.00	20.00	25.00	30.00	30.00	30.00
73	20.00	20.00	25.00	30.00	30.00	30.00
74	20.00	20.00	25.00	30.00	30.00	30.00
75 & Over	100.00	100.00	100.00	100.00	100.00	100.00

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Regular members with an effective date of membership on or after January 1, 2010 and before July 1, 2015:

Age	5 – 9 Years of Service	10 – 19 Years of Service	20 – 24 Years of Service	25 – 27 Years of Service	28 – 29 Years of Service	30 & Over Years of Service
45	0.00	0.00	0.00	0.00	20.00	20.00
46	0.00	0.00	0.00	0.00	20.00	20.00
47	0.00	0.00	0.00	0.00	20.00	20.00
48	0.00	0.00	0.00	0.00	20.00	20.00
49	0.00	0.00	0.00	0.00	20.00	20.00
50	0.00	0.00	0.00	0.00	20.00	20.00
51	0.00	0.00	0.00	0.00	20.00	20.00
52	0.00	0.40	0.70	1.70	20.00	20.00
53	0.00	0.60	0.90	1.80	20.00	20.00
54	0.00	0.80	1.30	1.90	20.00	20.00
55	0.20	1.00	2.00	2.00	20.00	20.00
56	0.40	1.40	2.50	2.90	20.00	20.00
57	0.60	1.90	3.00	5.20	20.00	20.00
58	0.80	2.30	3.90	5.40	20.00	20.00
59	1.00	3.20	5.60	8.80	20.00	20.00
60	2.00	4.00	6.00	10.00	21.00	21.00
61	3.50	6.00	10.00	15.00	21.00	21.00
62	4.00	10.30	15.00	18.70	20.00	20.00
63	5.00	10.30	15.00	18.70	20.00	20.00
64	7.00	10.30	15.00	18.70	20.00	20.00
65	17.00	17.80	20.60	20.60	25.00	25.00
66	17.00	17.80	20.60	20.60	25.00	25.00
67	17.00	17.80	20.60	20.60	25.00	25.00
68	17.00	17.80	20.60	20.60	25.00	25.00
69	17.00	17.80	20.60	20.60	25.00	25.00
70	19.00	18.70	23.40	28.10	30.00	30.00
71	19.00	18.70	23.40	28.10	30.00	30.00
72	19.00	18.70	23.40	28.10	30.00	30.00
73	19.00	18.70	23.40	28.10	30.00	30.00
74	19.00	18.70	23.40	28.10	30.00	30.00
75 & Over	100.00	100.00	100.00	100.00	100.00	100.00

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Regular members with an effective date of membership on or after July 1, 2015:

Age	5 – 9 Years of Service	10 – 19 Years of Service	20 – 24 Years of Service	25 – 29 Years of Service	30 – 33.3 Years of Service	33.3 & Over Years of Service
45	0.00	0.00	0.00	0.00	7.20	20.00
46	0.00	0.00	0.00	0.00	8.30	20.00
47	0.00	0.00	0.00	0.00	9.40	20.00
48	0.00	0.00	0.00	0.00	10.40	20.00
49	0.00	0.00	0.00	0.00	11.50	20.00
50	0.00	0.00	0.00	0.00	12.60	20.00
51	0.00	0.00	0.00	0.00	13.70	20.00
52	0.00	0.40	0.60	1.50	14.80	20.00
53	0.00	0.50	0.80	1.60	15.80	20.00
54	0.00	0.70	1.20	1.70	16.90	20.00
55	0.20	0.90	1.80	1.80	18.00	20.00
56	0.40	1.30	2.30	2.60	18.00	20.00
57	0.50	1.70	2.70	4.70	18.00	20.00
58	0.70	2.10	3.50	4.90	18.00	20.00
59	0.90	2.90	5.00	7.90	18.00	20.00
60	1.80	3.60	5.40	9.00	18.90	21.00
61	3.20	5.40	9.00	13.50	18.90	21.00
62	3.60	9.30	13.50	16.80	18.00	20.00
63	4.50	9.30	13.50	16.80	18.00	20.00
64	6.30	9.30	13.50	16.80	18.00	20.00
65	15.30	16.00	18.50	18.50	22.50	25.00
66	15.30	16.00	18.50	18.50	22.50	25.00
67	15.30	16.00	18.50	18.50	22.50	25.00
68	15.30	16.00	18.50	18.50	22.50	25.00
69	15.30	16.00	18.50	18.50	22.50	25.00
70	17.10	16.80	21.10	25.30	27.00	30.00
71	17.10	16.80	21.10	25.30	27.00	30.00
72	17.10	16.80	21.10	25.30	27.00	30.00
73	17.10	16.80	21.10	25.30	27.00	30.00
74	17.10	16.80	21.10	25.30	27.00	30.00
75 & Over	100.00	100.00	100.00	100.00	100.00	100.00

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Police/Fire members with an effective date of membership before January 1, 2010:

Age	5 – 9 Years of Service	10 – 19 Years of Service	20 – 22 Years of Service	23 – 24 Years of Service	25 – 29 Years of Service	30 & Over Years of Service
40	0.00	0.10	0.00	0.00	0.00	0.00
41	0.00	0.20	0.00	20.00	20.00	0.00
42	0.00	0.30	1.00	20.00	20.00	0.00
43	0.00	0.40	2.00	20.00	20.00	0.00
44	0.00	0.50	3.00	20.00	20.00	0.00
45	0.00	0.70	3.50	20.00	20.00	20.00
46	0.00	0.90	4.00	20.00	20.00	20.00
47	0.00	1.10	4.50	20.00	20.00	20.00
48	0.00	1.30	5.00	20.00	20.00	20.00
49	0.00	1.50	6.50	20.00	20.00	20.00
50	1.50	4.50	16.00	23.00	23.00	23.00
51	1.50	4.50	13.00	23.00	23.00	23.00
52	1.50	5.00	13.00	23.00	23.00	23.00
53	1.50	6.00	13.00	23.00	23.00	23.00
54	1.50	7.00	13.00	23.00	23.00	23.00
55	4.50	11.00	18.00	25.00	25.00	25.00
56	4.50	11.00	18.00	25.00	25.00	25.00
57	4.50	11.00	18.00	25.00	25.00	25.00
58	4.50	11.00	18.00	25.00	25.00	25.00
59	4.50	11.00	18.00	25.00	25.00	25.00
60	5.00	18.00	26.00	35.00	35.00	35.00
61	6.00	18.00	26.00	35.00	35.00	35.00
62	7.00	18.00	26.00	35.00	35.00	35.00
63	8.00	18.00	26.00	35.00	35.00	35.00
64	9.00	18.00	26.00	35.00	35.00	35.00
65	20.00	25.00	40.00	50.00	50.00	50.00
66	20.00	25.00	40.00	50.00	50.00	50.00
67	20.00	25.00	40.00	50.00	50.00	50.00
68	20.00	25.00	40.00	50.00	50.00	50.00
69	20.00	25.00	40.00	50.00	50.00	50.00
70 & Over	100.00	100.00	100.00	100.00	100.00	100.00

Section 3: Supporting Information

Police/Fire members with an effective date of membership on or after January 1, 2010 and before July 1, 2015:

Age	5 – 9 Years of Service	10 – 19 Years of Service	20 – 24 Years of Service	25 – 27 Years of Service	28 – 29 Years of Service	30 & Over Years of Service
40	0.00	0.00	0.00	0.00	0.00	0.00
41	0.00	0.00	0.00	0.00	0.00	0.00
42	0.00	0.00	0.70	0.00	0.00	0.00
43	0.00	0.00	1.50	10.90	20.00	0.00
44	0.00	0.00	2.40	12.00	20.00	0.00
45	0.00	0.00	2.90	13.10	20.00	20.00
46	0.00	0.00	3.40	14.20	20.00	20.00
47	0.00	0.00	3.90	15.40	20.00	20.00
48	0.00	0.00	4.50	16.50	20.00	20.00
49	0.00	0.00	6.00	17.60	20.00	20.00
50	0.00	2.10	15.00	21.50	23.00	23.00
51	0.00	2.30	12.20	21.50	23.00	23.00
52	0.00	2.80	12.20	21.50	23.00	23.00
53	0.00	3.50	12.20	21.50	23.00	23.00
54	0.00	4.40	12.20	21.50	23.00	23.00
55	2.80	7.20	16.90	23.40	25.00	25.00
56	3.00	7.80	16.90	23.40	25.00	25.00
57	3.20	8.40	16.90	23.40	25.00	25.00
58	3.40	9.10	16.90	23.40	25.00	25.00
59	3.50	9.70	16.90	23.40	25.00	25.00
60	4.10	16.90	24.30	32.80	35.00	35.00
61	5.10	16.90	24.30	32.80	35.00	35.00
62	6.10	16.90	24.30	32.80	35.00	35.00
63	7.20	16.90	24.30	32.80	35.00	35.00
64	8.30	16.90	24.30	32.80	35.00	35.00
65	18.70	23.40	37.50	46.80	50.00	50.00
66	18.70	23.40	37.50	46.80	50.00	50.00
67	18.70	23.40	37.50	46.80	50.00	50.00
68	18.70	23.40	37.50	46.80	50.00	50.00
69	18.70	23.40	37.50	46.80	50.00	50.00
70 & Over	100.00	100.00	100.00	100.00	100.00	100.00

Section 3: Supporting Information

Police/Fire members with an effective date of membership on or after July 1, 2015:

Age	5 – 9 Years of Service	10 – 19 Years of Service	20 – 24 Years of Service	25 – 29 Years of Service	30 & Over Years of Service
40	0.00	0.00	0.00	0.00	0.00
41	0.00	0.00	0.00	0.00	0.00
42	0.00	0.00	0.70	0.00	0.00
43	0.00	0.00	1.50	10.90	0.00
44	0.00	0.00	2.40	12.00	0.00
45	0.00	0.00	2.90	13.10	20.00
46	0.00	0.00	3.40	14.20	20.00
47	0.00	0.00	3.90	15.40	20.00
48	0.00	0.00	4.50	16.50	20.00
49	0.00	0.00	6.00	17.60	20.00
50	0.00	2.10	15.00	21.50	23.00
51	0.00	2.30	12.20	21.50	23.00
52	0.00	2.80	12.20	21.50	23.00
53	0.00	3.50	12.20	21.50	23.00
54	0.00	4.40	12.20	21.50	23.00
55	2.80	7.20	16.90	23.40	25.00
56	3.00	7.80	16.90	23.40	25.00
57	3.20	8.40	16.90	23.40	25.00
58	3.40	9.10	16.90	23.40	25.00
59	3.50	9.70	16.90	23.40	25.00
60	4.10	16.90	24.30	32.80	35.00
61	5.10	16.90	24.30	32.80	35.00
62	6.10	16.90	24.30	32.80	35.00
63	7.20	16.90	24.30	32.80	35.00
64	8.30	16.90	24.30	32.80	35.00
65	18.70	23.40	37.50	46.80	50.00
66	18.70	23.40	37.50	46.80	50.00
67	18.70	23.40	37.50	46.80	50.00
68	18.70	23.40	37.50	46.80	50.00
69	18.70	23.40	37.50	46.80	50.00
70 & Over	100.00	100.00	100.00	100.00	100.00

Vested Terminated Retirement Rates:

Inactive vested participants with less than 10 years of service are assumed to retire at age 65. Those with 10 or more years of service are assumed to retire at age 60.

Higher Education Retirement Rates:

For Higher Education employees, the assumed rates of retirement are the same as those used for Regular employees, except no rates of retirement are assumed unless the member has at least 5 years of service and is at least 60 years old.

Unknown Data for Participants:

Same as those exhibited by members with similar known characteristics. If not specified, members are assumed to be male. Active participants with unknown dates of hire were assumed to enter at age 36.

Participants with unknown Regular or Police/Fire indicators were assumed to be General employees. Participants with unknown State or Non-State indicators were assumed to be State employees.

Section 3: Supporting Information

Participation and Coverage Election:

90% of active employees with active healthcare coverage.

60% of actives without active coverage and future vested terminated employees.

35% for future retirees who would be required to pay the full "un-subsidized" rates for coverage.

35% for eligible surviving spouses of active employees. Surviving spouses of retirees are assumed to continue coverage after the retiree's death.

5% of current vested terminated employees. The census data provided for current vested terminated participants as of the valuation date was from the PERS and Judges pension valuations. This census data for current vested terminated participants includes many participants who are in the pension plans, but who were never participants in the retiree healthcare plan. In other words, they worked for employers who are not participating in the State's retiree healthcare plan. The participation assumption of 5% reflects the fact that the census data includes participants who we know will not be eligible for the State's retiree healthcare benefits at retirement.

All current and future retirees are assumed to be eligible for Medicare at age 65.

Dental coverage is assumed for all participants on the non-Exchange health plans. No separate dental participation assumption is needed for retirees who are on the Medicare Exchange because the maximum HRA benefit is valued for each retiree.

Life insurance coverage is provided to all retirees who have healthcare coverage, either through the Exchange or non-Exchange health plans. Reinstated retirees do not receive the $12,500 basic life insurance benefit.

Dependents:

Demographic data was available for spouses of current retirees. For future retirees, male participants were assumed to be three years older than their spouses and female participants were assumed to be two years younger than their spouses. Of those actives who elect to continue their health coverage at retirement, 30% of males and 15% of females were assumed to have an eligible spouse who also opts for health coverage at that time.

Section 3: Supporting Information

Per Capita Cost Development:

Per-capita claims costs for the self-insured CDHP PPO, LD PPO, and EPO were based on retiree claims experience furnished by PEBP for periods July 1, 2020 through June 30, 2022. Claims were developed on an incurred basis and were adjusted for plan changes and renegotiated pharmacy contracts. The historical claims were trended forward to the valuation year using a 5.0% assumption for medical costs and a 10.0% assumption for prescription drug costs. Per-capita costs for the fully-insured HMO were based on the premiums charged by the insurer, effective July 1, 2022, and the demographics of the active employees and retirees who elected the HMO. A weighted average set of per capita costs was developed based on the enrollment in each of the plan options. Actuarial factors were used to estimate individual costs by age in accordance with ASOP 6, and to reflect Medicare offsets for those participants who are eligible for Medicare.

Per-capita claims costs for the self-insured dental plan were based on retiree claims experience furnished by PEBP for periods July 1, 2020 through June 30, 2022. Dental claims were developed on an incurred basis and include administrative expenses. The historical claims were trended forward to the valuation year using a 4.0% assumption.

Per Capita Health Costs:

The annual per capital dental claims cost for the plan year 2022/2023 was estimated to be $379.

2022/2023 medical and prescription drug claims costs, excluding assumed expenses, are shown in the table below for retirees and for spouses at selected ages. These costs are net of deductibles and other benefit plan cost sharing provisions. The blended claims estimates shown below were used for all current and future retirees, regardless of their current health plan election, and were based on the health plan distribution of current retirees. Post-65 claims costs apply to Medicare-eligible retirees that are not in an Exchange plan.

Medical and Prescription Drug Claims

Age	Male	Female
50	$8,633	$9,116
55	9,742	9,895
60	11,216	10,727
64	13,631	11,646
65	4,800	3,987
70	5,391	4,460
75	5,955	4,689
80	6,236	5,005
85+	6,530	5,342

CDHP PPO - HRA Contributions:

An annual HRA contribution of $382 was added to projected incurred medical and prescription drug claims costs. The $382 dollar benefit equals the $600 annual HRA benefit for retirees who elect the CDHP PPO multiplied by the assumed percentage of retirees choosing the CDHP PPO (i.e., 63.7%). The HRA contribution associated with the CDHP PPO was not assumed to increase.

Health Care Cost Trend Rates (%):

Health care trend measures the anticipated overall rate at which health plan costs are expected to increase in future years. The rates shown below are "net" and are applied to the net per capita costs shown above. The trend shown for a particular plan year is the rate that is applied to that year's cost to yield the next year's projected cost. The PEBP Part B premium reimbursement is assumed to be reset to the prevailing Part B premium in plan year 2024/2025.

Increase Effective July 1,	Medical/ Prescription Drug	Dental	Admin	Part B Reimbursements
2023	4.80	4.00	3.00	0.00
2024	7.25	4.00	3.00	27.17
2025	7.00	4.00	3.00	4.50
2026	6.75	4.00	3.00	4.50
2027	6.50	4.00	3.00	4.50
2028	6.25	4.00	3.00	4.50
2029	6.00	4.00	3.00	4.50
2030	5.75	4.00	3.00	4.50
2031	5.50	4.00	3.00	4.50
2032	5.25	4.00	3.00	4.50
2033	5.00	4.00	3.00	4.50
2034	4.75	4.00	3.00	4.50
2035 & Later	4.50	4.00	3.00	4.50

The trend rate assumptions were developed using Segal's internal guidelines, which are established each year using data sources such as the Segal Health Trend Survey, internal client results, trends from other published surveys prepared by the S&P Dow Jones Indices, consulting firms and brokers, and CPI statistics published by the Bureau of Labor Statistics.

Retiree Contribution Increase Rate:

First year trend rates for retiree contributions were based on known changes effective July 1, 2023. Retiree contributions are modeled using:

1. the overall blended premiums
2. the base explicit subsidy, and
3. the service-based explicit subsidies.

The first-year trends for these components were -2.10% for the overall blended premiums, -3.50% for the base explicit subsidy, and 2.62% for the service-based explicit subsidies. After the first year, retiree contributions were assumed to follow the Medical/Prescription Drug trend.

Administrative Expenses:

An administrative expense of $283 per participant increasing at 3.0% per year was added to projected incurred claim costs in developing the benefit obligations. The expense was based on actual medical and prescription drug administrative expenses paid for the periods July 1, 2021 through June 30, 2022.

Health Care Reform:

This valuation does not reflect the potential impact of any future changes due to prior or pending legislations. Because the 2025 Final CY 2025 Part D Redesign Program Instructions were released by the Centers for Medicare and Medicaid Services (CMS) several months after the June 30, 2023 measurement date, the trend rate assumptions do not reflect the anticipated impact of the Inflation Reduction Act of 2022 on the plan's 2025 Medicare plan premiums.

Plan Design:

Development of plan liabilities was based on the substantive plan of benefits in effect as described in Exhibit 3.

Section 3: Supporting Information

Models:

Segal accounting results are based on proprietary actuarial modeling software. The accounting valuation models generate a comprehensive set of liability and cost calculations that are presented to meet accounting standards and client requirements. Our Actuarial Technology and Systems unit, comprising both actuaries and programmers, is responsible for the initial development and maintenance of these models. The models have a modular structure that allows for a high degree of accuracy, flexibility and user control. The client team programs the assumptions and the plan provisions, validates the models, and reviews test lives and results, under the supervision of the responsible actuary.

Our claims costs assumptions are based on proprietary modeling software as well as models that were developed by others. These models generate per capita claims cost calculations that are used in our valuation software. Our Health Technical Services Unit, comprised of actuaries and programmers, is responsible for the initial development and maintenance of our health models. They are also responsible for testing models that we purchase from other vendors for reasonableness. The client team inputs the paid claims, enrollments, plan provisions and assumptions into these models and reviews the results for reasonableness, under the supervision of the responsible actuary.

Assumption Changes:

The discount rate increased from 3.54% to 3.65%. This change lowered the TOL.

Exhibit 3: Summary of Plan

This exhibit summarizes the major benefit provisions as included in the valuation. To the best of our knowledge, the summary represents the substantive plans as of the measurement date. It is not intended to be, nor should it be interpreted as, a complete statement of all benefit provisions.

Eligibility:

Members are not required to be active immediately prior to retirement to be eligible for benefits. Members must be receiving a PERS, LRS, JRS, or RPA pension.

Service Retirement for members with an effective date of membership before January 1, 2010:

- Regular: Age 65 with five years of service, or age 60 with ten years of service, or 30 years of service.
- P&F: Age 65 with 5 years of service, or age 55 with ten years of Police/Fire service, or age 50 with 20 years of Police/Fire service, or 25 years of Police/Fire service.

Service Retirement for members with an effective date of membership on or after January 1, 2010:

- Regular: Age 65 with five years of service, or age 62 with ten years of service, or 30 years of service.
- P&F: Age 65 with 5 years of service, or age 60 with ten years of Police/Fire service, or age 50 with 20 years of Police/Fire service, or 30 years of Police/Fire service.

Service Retirement for Regular members with an effective date of membership before July 1, 2015:

- Age 65 with five years of service, or age 62 with ten years of service, or age 55 with 30 years of service, or any age with 33 1/3 years of service.

Early Retirement: Five years of service.

Disability: Five years of service and totally unable to perform current job or any comparable job for which the member is qualified by training and experience, because of injury or illness of a permanent nature, provided the member is in the employ of a participating employer at the time of application for disability retirement.

Members hired before January 1, 2010 are eligible to receive a base non-Medicare subsidy, as well as service-based non-Medicare and Medicare Exchange subsidies.

Members hired on or after January 1, 2012 are not eligible for any of the explicit subsidies mentioned above. However, they are eligible for non-Medicare coverage by paying the plan's overall blended premiums.

Members hired on or after January 1, 2010 and before January 1, 2012 must have 15 years of service in order to be eligible for the plan's explicit subsidies, unless they retire through the disability retirement.

Benefit Types:

Non-Medicare retirees are eligible for medical and prescription drug benefits via four separate health plan options. Premiums for non-Medicare retirees vary based on date of hire, date of retirement, and years of service. Medicare retirees are eligible for medical and prescription drug benefits through the Exchange. Medicare retirees hired before January 1, 2012 are eligible for a monthly Exchange HRA contribution of $195 if retired prior to January 1, 1994, or $13 per year of service, up to a maximum of 20 years of service if retired on or after January 1, 1994.

Retirees and spouses who are over the age of 65 can maintain their healthcare coverage on a non-Exchange plan until the younger spouse reaches the age of 65. In addition, retirees over the age of 65 who are not eligible for free Part A coverage are allowed to stay on a non-Exchange health plan. In these situations, the retiree contribution for a retired member who is over the age of 65 is reduced by the Part B premium credit. The Part B reimbursement is not provided to spouses who are over the age of 65. Enrollment in Medicare Part B is required for retirees who are over the age of 65. Retirees over the age of 65 who are eligible for free Medicare Part A are required to enroll in Medicare Part A and a health plan offered by the Medicare Exchange.

Duration of Coverage:

Until both the retiree and spouse become Medicare-eligible, whereupon they will move to the Exchange. Certain retirees over age 65 are not eligible for Medicare Part A. Lifetime benefits are provided to members hired prior to January 1, 2012.

Dependent Coverage:

Benefits are available for dependents. However, beneficiaries and spouses do not receive any Exchange benefits. Couples can remain on a non-Medicare plan until the younger spouse reaches age 65. A member who is older than 65 and has a spouse who is younger than 65 is required to enroll in Medicare. The plan will pay secondary to Medicare and will reimburse the member $135.10 for the Medicare Part B premium. Surviving spouses of retirees, and surviving spouses of active employees who had at least 10 years of service, are allowed to maintain their health coverage to age 65, but are required to pay the full blended premiums. Surviving spouses and children of Police/Fire employees killed in the line of duty are allowed to join or continue the plan, and their full premium is paid by the employer.

Life Insurance:

Any retiree with retiree health insurance coverage, either through the CDHP PPO, LD PPO, EPO, HMO or Medicare Exchange is provided a basic life insurance benefit of $12,500 free of charge. Retirees can purchase additional coverage at their own expense.

Dental Contribution:

Dental coverage is included with health benefits (no separate dental premium) for participants that have not moved to the Exchange. Dental coverage is available to retirees who are on the Medicare Exchange, but the dental premiums are separate from the medical premiums. The plan year 2022/23 monthly dental premium for State retirees who are enrolled in the Medicare Exchange was $47.61. Exchange retirees have the option of using their HRA funds towards dental premiums.

Part B Reimbursement:

Retirees who are over the age of 65 and continue to have health care coverage on the CDHP PPO, LD PPO, EPO, or HMO are required to enroll in Medicare Part B. In addition to the base explicit subsidy and the service-based explicit subsidies, these retirees also received a monthly Part B premium credit/reimbursement of $135.50 in plan year 2022/23. Spouses and surviving spouses are not eligible for the Part B reimbursement.

Section 3: Supporting Information

Retiree Contributions:

Retiree and spouse contribution rates are periodically reset by the PEBP. The monthly contributions shown below were effective from July 1, 2022 through June 30, 2023. Employees hired on or after January 1, 2012, or hired between January 1, 2010 and January 1, 2012 with less than 15 years of service, as well as all surviving spouses, are required to pay the plan's overall blended premium rates for coverage.

	CDHP PPO	LD PPO	EPO/ HMO
Retiree	$241.26	$262.44	$355.30
Retiree + Spouse	588.96	631.34	817.06
Surviving Spouse	670.83	691.98	779.47
Base Explicit Subsidy Retiree	429.57	429.54	424.17
Base Explicit Subsidy Spouse	317.64	317.61	312.24

Service-based adjustments are applied to the CDHP PPO, LD PPO, EPO, and HMO premiums as follows. These service-based adjustments do not apply to spouses, surviving spouses, or employees hired on or after January 1, 2012.

Years of Service	Change in Premium ($)	Years of Service	Change in Premium ($)
5	+373.50	13	+74.70
6	+336.15	14	+37.35
7	+298.80	15	0
8	+261.45	16	-37.35
9	+224.10	17	-74.70
10	+186.75	18	-112.05
11	+149.40	19	-149.40
12	+112.05	20+	-186.75

Section 3: Supporting Information

Plan Changes

None.

Appendix A: Definition of Terms

Definitions of certain terms as they are used in Statement 74. The terms may have different meanings in other contexts.

Term	Definition
Actuarially Determined Contribution:	A target or recommended contribution to an OPEB plan for the reporting period based on the most recent measurement available.
Assumptions or Actuarial Assumptions:	The estimates on which the cost of the Plan is calculated including: a. Investment return — the rate of investment yield that the Plan will earn over the long-term future; b. Mortality rates — the death rates of employees and retirees; life expectancy is based on these rates; c. Retirement rates — the rate or probability of retirement at a given age; d. Turnover rates — the rates at which employees of various ages are expected to leave employment for reasons other than death, disability, or retirement.
Covered Payroll:	The payroll of the employees that are provided OPEB benefits
Discount Rate:	The single rate of return, that when applied to all projected benefit payments results in an actuarial present value that is the sum of the following: a. the actuarial present value of projected benefit payments projected to be funded by plan assets using a long term rate of return, and b. the actuarial present value of projected benefit payments that are not included in (1) using a yield or index rate for 20 year tax exempt general obligation municipal bonds with an average rating of AA/Aa or higher
Entry Age Actuarial Cost Method:	An actuarial cost method where the present value of the projected benefits for an individual is allocated on a level basis over the earnings or service of the individual between entry age and assumed exit age
Healthcare Cost Trend Rates:	The rate of change in per capita health costs over time
Net OPEB Liability:	The Total OPEB Liability less the Plan Fiduciary Net Position
Plan Fiduciary Net Position:	Market Value of Assets
Real Rate of Return:	The rate of return on an investment after removing inflation
Service Cost:	The amount of contributions required to fund the benefit allocated to the current year of service.
Total OPEB Liability:	The portion of the actuarial present value of projected benefit payments that is attributed to past periods of employee service in conformity with the requirements of Statement No. 74.
Valuation Date:	The date at which the actuarial valuation is performed

Appendix B: Accounting Requirements

The Governmental Accounting Standards Board (GASB) issued Statement Number 74 – Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans, and Statement Number 75 – Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions. Under these statements, all state and local government entities that provide other post-employment benefits are required to report the cost of these benefits on their financial statements. The accounting standards supplement cash accounting, under which the expense for postemployment benefits is equal to benefit and administrative costs paid on behalf of retirees and their dependents (i.e., a pay-as-you-go basis).

The statements cover postemployment benefits of medical, prescription drugs, dental, vision and life insurance coverage for retirees; long-term care coverage, life insurance and death benefits that are *not* offered as part of a pension plan; and long-term disability insurance for employees. The benefits valued in this report are limited to those described in Exhibit 3 of Section 3, which are based on those provided under the terms of the substantive plan in effect at the time of the valuation and on the pattern of sharing costs between the employer and plan members. The projection of benefits is not limited by legal or contractual limits on funding the plan unless those limits clearly translate into benefit limits on the substantive plan being valued.

The new standards prescribe an accrual-basis accounting requirement, thereby recognizing the employer cost of postemployment benefits over an employee's career. The standards also prescribe a consistent accounting requirement for both pension and non-pension benefits.

The total cost of providing postemployment benefits is projected, taking into account assumptions about demographics, turnover, mortality, disability, retirement, health care trends, and other actuarial assumptions. These assumptions are summarized in Exhibit 2 of Section 3. This amount is then discounted to determine the Total OPEB Liability. The Net OPEB Liability (NOL) is the difference between the Total OPEB Liability and market value of assets in the Plan, called the Plan Fiduciary Net Position.

Once the NOL is determined, the Annual OPEB Expense is determined as the change in NOL from the prior year with deferred recognition of certain elements. In addition, Required Supplementary Information (RSI) must be reported, including historical information about the Net OPEB Liability and the contributions made to the Plan. Appendix A of Section 3 contains a definition of terms.

The calculation of an accounting obligation does not, in and of itself, imply that there is any legal liability to provide the benefits valued, nor is there any implication that the Employer is required to implement a funding policy to satisfy the projected expense.

Actuarial calculations reflect a long-term perspective, and the methods and assumptions use techniques designed to reduce short-term volatility in accrued liabilities and the actuarial value of assets, if any.

Actuarial valuations involve estimates of the value of reported amounts and assumptions about the probability of events far into the future, and the actuarially determined amounts are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future.

5837235v4/16664.011

5.

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

PROPOSED REGULATION OF THE BOARD OF THE

PUBLIC EMPLOYEES' BENEFITS PROGRAM

LCB File No. R047-24

March 25, 2024

EXPLANATION – Matter in ***italics*** is new; matter in brackets **[~~omitted material~~]** is material to be omitted.

AUTHORITY: §§ 1 and 2, NRS 287.043; § 3, NRS 287.0415, 287.043 and 287.045.

A REGULATION relating to public employees; revising provisions relating to the Board of the Public Employees' Benefits Program; repealing certain regulations relating to Board meetings; eliminating certain provisions relating to enrollment in benefits and coverage; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the Board of the Public Employees' Benefits Program to establish and carry out the Public Employees' Benefits Program relating to insurance and benefits for participants. (NRS 287.043) Existing law further requires the: (1) Governor to designate one of the members of the Board to serve as the Chair; and (2) Board to meet quarterly and at other times upon the call of the Chair. (NRS 287.0415) Existing regulations require the Board to elect from its members a Vice Chair at the first meeting of each plan year. (NAC 287.172). **Section 1** of this regulation reorganizes certain provisions of existing regulations relating to the Chair, Vice Chair and motions for consideration. **Section 3** of this regulation eliminates certain requirements and provisions relating to Board meetings, enrollment in the Program and coverage for a person or a retired participant returning to work in certain circumstances. **Section 2** of this regulation makes a conforming change to remove a reference to a section repealed by **section 3**.

Section 1. NAC 287.172 is hereby amended to read as follows:

1. ***The Chair shall:***

(a) Determine the agenda of a meeting of the Board; and

(b) Preside over the meetings of the Board.

2. At the first meeting of each plan year, the Board will elect from its members a Vice Chair

~~1.~~

~~2. The Vice Chair~~] ***who*** shall serve as the Chair in the absence of the Chair.

3. Any member of the Board may submit to the Executive Officer, or in the absence of the Executive Officer, the Operations Officer of the Program, a request for a matter to be placed on the agenda of a meeting of the Board.

4. Any motion made by a member of the Board requires a second to the motion for consideration of the motion by the Board.

Sec. 2. NAC 287.311 is hereby amended to read as follows:

1. Except as otherwise provided in NAC 287.312, a participant who desires or is required to enroll or disenroll a person in the Program as a dependent as a result of a life event that qualifies the participant to amend his or her coverage outside the period of open enrollment must, within 60 days after the date on which the dependent becomes eligible to participate or loses his or her eligibility to participate in the Program:

(a) Execute a declaration of enrollment electronically through the Internet website of the Board ~~[or by submitting a form prescribed by the Program pursuant to NAC 287.318,]~~ under penalty of perjury and subject to the provisions of NRS 686A.290 and 686A.291.

(b) Submit copies of any supporting documentation required to establish or terminate the dependent's eligibility to participate in the Program as a dependent as requested by the Program.

2. Except as otherwise provided in subsections 3 and 4, if a participant fails to enroll or disenroll a person in the Program as a dependent within 60 days after the date on which the dependent becomes eligible to participate or loses his or her eligibility to participate in the Program, the participant may not enroll or disenroll the person in the Program as a dependent until the next period of open enrollment.

3. The Program will enroll a person as a dependent of a participant in accordance with an order to obtain health insurance for his or her child pursuant to NRS 31A.350.

4. The Program will disenroll a person as a dependent of a participant on the date on which the dependent becomes deceased.

Sec. 3. NAC 287.170, 287.174, 287.176, 287.178, 287.3125, 287.318, 287.319, 287.510 and 287.515 are hereby repealed.

TEXT OF REPEALED SECTIONS

287.170 Chair: Duty; voting. (NRS 287.043)

1. The Chair shall preside over the meetings of the Board.

2. Unless the Chair is required to abstain from voting or is otherwise disqualified from participating in a matter before the Board:

(a) If the Chair does not vote on the matter, it will be presumed that the Chair voted with the prevailing majority of members of the Board who voted on the matter.

(b) The Chair shall vote in the case of a tie.

287.174 Meetings: Agenda. (NRS 287.043)

1. The Chair shall determine the agenda of a meeting of the Board.

2. Any member of the Board may submit to the Executive Officer, or in his or her absence, the Operations Officer of the Program appointed pursuant to NRS 287.0426, a request for a matter to be placed on the agenda of a meeting of the Board.

287.176 Meetings: Approval of actions; motions; rules of conduct. (NRS 287.043)

1. All action by the Board must be approved by a majority of the members of the Board who are present at the meeting. A tie vote constitutes a rejection of the question or matter before the Board.

2. Any motion made by a member of the Board requires a second to the motion for consideration of the motion by the Board.

3. *Robert's Rules of Order* govern the general conduct of meetings of the Board.

287.178 Meetings: Minutes; transcript. (NRS 287.0415, 287.043)

1. The minutes of each meeting of the Board must be distributed to each member of the Board.

2. A transcript of a meeting posted to the Internet website of the Board pursuant to NRS 287.0415 will remain posted on the Internet website of the Board for at least 6 months after posting. During the period in which the transcript of the meeting is posted on the Internet website of the Board, a person may request a hard copy of the transcript.

3. The Board may charge the person a fee for the transcript that does not exceed the actual cost of the Board to provide the copy of the transcript.

287.3125 Dependents: Terms and conditions of certain changes. (NRS 287.043) Except during a period of open enrollment, the right to change coverage or insurance for a dependent or to add or change dependents is governed by the terms and conditions of any applicable plan, insurance policy or law.

287.318 Enrollment forms: Required information. (NRS 287.043) Enrollment forms that are submitted to the Program must include, without limitation:

1. The name, address, social security number, if any, and signature of the person who is enrolling in the Program; and

2. The name and social security number, if any, of any dependent that the person chooses to cover under the Program.

287.319 Notification of change of address by participant to Program. (NRS 287.043) A participant shall notify the Program within 30 days after a change of address of the participant.

287.510 Coverage of persons returning to work with previous employer within 1 year after leaving employment. (NRS 287.043, 287.045) If a person other than a retired officer or employee returns to work for a participating public agency with which the person was previously employed within 1 year after leaving employment:

1. The person may select any coverage and insurance offered to participants in the Program at the time that the person returns to work; and

2. Coverage and insurance for the person is effective:

(a) If the effective date of reemployment is on the first day of a month, on the effective date of reemployment; or

(b) If the effective date of reemployment is not on the first day of a month, on the first day of the month immediately following the effective date of reemployment.

287.515 Coverage of retired participants upon reemployment with participating public agency. (NRS 287.043, 287.045)

1. Except as otherwise provided in this section, a person who participates in the Program as a retired officer or employee and who returns to full-time employment with a participating public agency is eligible to participate in the Program as an active officer or employee:

(a) If the effective date of reemployment is on the first day of a month, on the effective date of reemployment; or

(b) If the effective date of reemployment is not on the first day of a month, on the first day of the month immediately following the effective date of reemployment.

2. If a person who participates in the Program as a retired justice or judge accepts reemployment as a justice of the Supreme Court or district judge pursuant to NRS 1A.370, the person is eligible to participate in the Program as an active justice or judge, as applicable:

(a) If the effective date of reemployment is on the first day of a month, on the effective date of reemployment; or

(b) If the effective date of reemployment is not on the first day of a month, on the first day of the month immediately following the effective date of reemployment.

3. Except as otherwise required by federal law, a retired officer or employee who returns to full-time employment with a participating public agency to fill a position which has been designated as a position for which there is a critical labor shortage pursuant to NRS 286.523 and who continues to receive allowances under the retirement system of which he or she is a member is eligible to participate in the Program in the same manner as he or she participated before returning to full-time employment. Except for a retired officer or employee who was enrolled in the Program on November 30, 2008, and continues his or her participation in the Program, coverage of a retired officer or employee who returns to full-time employment with a participating local governmental agency pursuant to this subsection terminates on the date on which the participating local governmental agency terminates its participation in the Program.

4. A retired officer or employee who returns to full-time employment with a participating state agency to fill a position which has been designated as a position for which there is a critical

labor shortage pursuant to NRS 286.523 and who discontinues receiving allowances under the retirement system of which he or she is a member is eligible to participate in the Program as an active officer or employee:

(a) If the effective date of reemployment is on the first day of a month, on the effective date of reemployment; or

(b) If the effective date of reemployment is not on the first day of a month, on the first day of the month immediately following the effective date of reemployment.

5. A retired officer or employee who returns to full-time employment with a participating local governmental agency to fill a position which has been designated as a position for which there is a critical labor shortage pursuant to NRS 286.523 and who discontinues receiving allowances under the retirement system of which he or she is a member is eligible to participate in the Program as an active officer or employee:

(a) If the effective date of reemployment is on the first day of a month, on the effective date of reemployment; or

(b) If the effective date of reemployment is not on the first day of a month, on the first day of the month immediately following the effective date of reemployment.

➥ Except for a retired officer or employee who was enrolled in the Program on November 30, 2008, and continues his or her participation in the Program, coverage of a retired officer or employee pursuant to this subsection terminates on the date on which the participating local governmental agency with which the retired officer or employee returns to full-time employment terminates its participation in the Program.

JOE LOMBARDO
Governor

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

CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

NOTICE OF REGULATION WORKSHOP AND AGENDA

Name of Organization:	Public Employees' Benefits Program
Date and Time of Meeting:	March 6, 2024 1:30 p.m.
Place of Meeting:	3427 Goni Rd Ste. 117 Carson City, NV 89706
Video Conferencing:	This meeting will be available by means of a remote technology system pursuant to NRS 241.023 using video- and tele-conference. Instructions for both options are below. This meeting can be viewed live over the Internet on the PEBP YouTube channel at https://youtube.com/live/uos4y110wtE

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/83045640999**
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: 830 4564 0999 then press #. When prompted for a Participant ID, please enter #.**

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

To resolve any issues related to dialing in to provide public comment for this meeting, please call (775) 684-7020 or email jcrane@peb.nv.gov

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

AGENDA

1. Call to Order; Introductions

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 Public Employees' Benefits Program (PEBP) 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 PEBP Executive Officer. The total time allotted to public comment may be limited to one hour at the discretion of the PEBP Executive Officer. As noted above, members of the public may make public comment in person or 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 a document to the *Public Comment Upload Form* located under *Contact Us* on the PEBP website, https://pebp.nv.gov, no later than two business days prior to the meeting. Persons making public comment need to state and spell their name for the record at the beginning of their comment.

3. Presentation and Discussion of Proposed Amendments to Chapter 287 of the Nevada Administrative Code, to include Solicitation of Comments from Interested Persons (Tim Lindley, Quality Control Officer) (Information/Discussion)

   The proposed amendments:
   - Consolidate essential procedures of the PEBP Board into a single regulation, specifically, a revised version of NAC 287.172; and
   - Repeal:
     - NAC 287.170;
     - NAC 287.174;
     - NAC 287.176;
     - NAC 287.178;
     - NAC 287.3125;
     - NAC 287.318;
     - NAC 287.319;
     - NAC 287.510; and
     - NAC 287.515.

4. 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 PEBP Executive Officer. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

5. Adjournment

The supporting material to this agenda is available, at no charge, on the PEBP website at https://pebp.nv.gov/Meetings/current-board-meetings/ (under the 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
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.
Notice of this meeting was posted on or before 9:00 a.m. at least 15 days before the meeting at the following locations: PUBLIC EMPLOYEES' BENEFITS PROGRAM, 3427 Goni Road, Suite 109, Carson City; NEVADA STATE LIBRARY, ARCHIVES & PUBLIC RECORDS, 100 North Stewart St., Carson City; OFFICE OF THE NEVADA ATTORNEY GENERAL, 100 North Carson Street, Carson City; OFFICE OF THE NEVADA ATTORNEY GENERAL, 555 East Washinton Avenue, Suite 3900, Las Vegas; and posted on the PEBP website at https://pebp.nv.gov; on the Nevada Public Notice Website at https://notice.nv.gov; and on the Nevada Legislature's "Administrative Regulation Notices Meetings and Workshops Page" at https://leg.state.nv.us. In addition, the agenda was mailed to groups and individuals as requested.

JOE LOMBARDO
Governor

STATE OF NEVADA
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www.pebp.state.nv.us

CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

REGULATION WORKSHOP ON NAC 287

Held in the Board Room at the office of the Public Employees' Benefits Program
3427 Goni Rd, Ste 117, Carson City, NV 89706

and video conferenced via YouTube

Wednesday March 6, 2024 – 1:30 p.m.

Staff Present
Celestena Glover, Executive Officer
Nik Proper, Operations Officer
Brandee Mooneyhan, Lead Insurance Counsel

MINUTES

Agenda Item 1:
CALL TO ORDER AND INTRODUCTIONS

The meeting was called to order by Celestena Glover, Executive Officer at 1:30pm. Mrs. Glover stated that this was the time and place for the regulation workshop for NAC 287. She introduced Nik Proper, Operations Officer and Brandee Mooneyhan, In House Legal Counsel.

Agenda Item 2:
PUBLIC COMMENT

Erin Lynch

Agenda Item 3:
PRESENTATION AND DISCUSSION OF PROPOSED REGULATION NAC 287

Mrs. Glover stated that PEBP is eliminating duplicate language that was in the regulation and consolidating where it makes most sense. The amendments are available in the workshop agenda.

Agenda Item 4:
QUESTION AND ANSWER PERIOD FOR PROPOSED REGULATION NAC 287

Mrs. Glover stated that this was the period that members of the public could ask questions about the proposed regulation changes. There were no questions.

Agenda Item 5:
PUBLIC COMMENT

No public comment.

Agenda Item 6:
ADJOURNMENT

Mrs. Glover adjourned the meeting at 1:36pm.

JOE LOMBARDO
Governor

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CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

NOTICE OF INTENT TO ACT UPON A REGULATION AND HEARING AGENDA

Notice of Hearing on the Adoption of Permanent Regulations
of the Nevada Public Employees' Benefits Program

LCB File No. R047-24

Please note that the Nevada Public Employees' Benefits Program will conduct a public hearing to receive comments from all interested persons regarding the adoption of proposed permanent regulations amending Chapter 287 of the Nevada Administrative Code (NAC). Members of the public may attend and participate as follows:

Name of Organization:	Public Employees' Benefits Program
Date and Time of Hearing:	May 9, 2024 1:30 p.m.
Place of Hearing:	3427 Goni Rd Ste. 117 Carson City, NV 89706
Video Conferencing:	This meeting will be available by means of a remote technology system pursuant to NRS 241.023 using video- and tele-conference. Instructions for both options are below. This meeting can be viewed live over the Internet on the PEBP YouTube channel at https://www.youtube.com/watch?v=DGoLKPYlRWc

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 9 a.m. on May 9, 2024.

To listen to and view the hearing, 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/84173651663**
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: 841 7365 1663 then press #. When prompted for a Participant ID, please enter #.**

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

To resolve any issues related to dialing in to provide public comment for this meeting, please call (775) 684-7020 or email jcrane@peb.nv.gov

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

INFORMATIONAL STATEMENT

The following information is provided pursuant to the requirements of NRS 233B.0603:

1. The need for and purpose of the proposed regulation or amendment.

In accordance with Executive Order 2023-003, which, in part, required executive agencies to review their regulations and recommend regulations that could be removed from the Nevada Administrative Code, the Board of the Public Employees' Benefits Program (PEBP) proposed consolidation of essential Board procedures into a single regulation and the repeal of several regulations whose provisions were otherwise addressed in statute or more appropriately addressed in agency documents.

2. If the proposed regulation is a temporary regulation, the terms or the substance of the proposed regulation to be adopted, amended, or repealed, or a description of the subjects and issues involved.

The proposed regulation is not a temporary regulation.

3. If the proposed regulation is a permanent regulation, a statement explaining how to obtain the approved or revised text of the proposed regulation prepared by the Legislative Counsel pursuant to NRS 233B.063.

The text of the proposed regulation is attached to this notice. Additionally, copies of this Notice and the proposed regulation are available at PEBP's office at 3427 Goni Road, Suite 109, Carson City, Nevada 89706, for inspecting and copying by members of the public during business hours, and on PEBP's website, https://pebp.nv.gov/. This Notice and the text of the proposed regulation is also available in the State of Nevada Register of Administrative Regulations, which is prepared and published monthly by the Legislative Counsel Bureau pursuant to NRS 233B.0653, and available on the Internet at: https://www.leg.state.nv.us/register/. Copies of this Notice and the proposed regulation will also be mailed or emailed to members of the public at no charge upon request to jcrane@peb.nv.gov or 775-684-7020. Requests should specify LCB File No. R047-24.

4. The estimated economic effect of the regulation on the business which it is to regulate and on the public, stated separately; and each including (a) both adverse and beneficial effects; and (2) both immediate and long-term effects.

- **Adverse/beneficial economic effects and immediate/long-term effects on regulated business:**

The proposed regulation does not regulate a business, rather, it addresses the procedures of PEBP and the meetings of its Board. Accordingly, PEBP anticipates no immediate or long-term effects, either adverse or beneficial, on any business.

- **Adverse/beneficial economic effects and immediate/long-term effects on public:**

PEBP anticipates no immediate or long-term economic effects, either adverse or beneficial, on the public from the proposed regulation.

5. The methods used by the agency in determining the impact on a small business.

PEBP prepared a letter explaining the proposed amendments and requested input as to whether the proposed amendments had a direct and significant burden upon small businesses or directly restrict the formation, operation, or expansion of small businesses within Nevada. The letter was posted on PEBP's website and also sent to the Nevada State Medical Association, Capitol Reporters, the Las Vegas Metro Chamber of Commerce, the Reno Sparks Chamber of Commerce, and the Rural Nevada Development Corporation. To date, PEBP has received no responses indicating that the proposed regulations will affect small businesses.

6. The estimated cost to the agency for enforcement of the proposed regulation.

The proposed regulations do not contemplate "enforcement" other than complying with the meeting procedures consolidated into a single new regulation. Carrying out these provisions will not result in an increased cost to PEBP.

7. A description of and citation to any regulations of other state or local governmental agencies which the proposed regulation overlaps or duplicates and a statement explaining why the duplication or overlapping is necessary. If the proposed regulation overlaps or duplicates a federal regulation, the notice must include the name of the regulating federal agency.

To PEBP's knowledge, the proposed regulations do not overlap or duplicate the regulations of other state or local governmental agencies or any federal regulations.

8. If the regulation is required pursuant to federal law, a citation and description of the federal law.

The proposed regulations are not required pursuant to federal law.

9. If the regulation includes provisions which are more stringent than a federal regulation that regulates the same activity, a summary of such provisions.

To PEBP's knowledge, the proposed regulations are not duplicative or more stringent than any federal regulation.

10. Whether the proposed regulation establishes a new fee or increases an existing fee.

The proposed regulation does not establish a new fee or increase an existing fee.

Persons wishing to comment upon PEBP's potential adoption of the proposed regulation may appear at the scheduled public hearing or may address their comments, data, views, or arguments, in written form, to: Jessica Crane, Public Employees' Benefits Program, 3427 Goni Road Suite 109, Carson City, Nevada 89706 or by uploading a document to the *Public Comment Upload Form* located under *Contact Us* on the PEBP website, https://pebp.nv.gov. Written submissions must be received on or before 9 a.m. on May 9, 2024.

If no person who is directly affected by the proposed action appears to request time to make an oral presentation, the Nevada Public Employees' Benefits Program may proceed immediately to act upon any written submissions.

Upon adoption of any regulation, the agency, if requested to do so by an interested person, either before adoption or within 30 days thereafter, shall issue a concise statement of the principal reasons for and against its adoption and incorporate therein its reason for overruling the consideration urged against its adoption.

HEARING AGENDA

1. Call to Order; Introductions

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 Public Employees' Benefits Program (PEBP) 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 PEBP Executive Officer or her designee. The total time allotted to public comment may be limited to one hour at the discretion of the PEBP Executive Officer or her designee. 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 a document to the *Public Comment Upload Form* located under *Contact Us* on the PEBP website, https://pebp.nv.gov, no later than 9 a.m. on the day of the meeting. Persons making public comment need to state and spell their name for the record at the beginning of their comment.

3. Public Hearing on LCB File No. R047-24 (Celestena Glover, Executive Officer) (Information/Discussion)

   Public comment regarding LCB File No. R047-24 is welcomed. Any written comments received by 9 a.m. on May 9, 2024, will be read into the record.

4. 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 PEBP Executive Officer or her designee. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

5. Adjournment

The supporting material to this agenda is available, at no charge, on the PEBP website at https://pebp.nv.gov/Meetings/current-board-meetings/ (under the hearing date referenced above). Contact Jessica Crane at PEBP, 3427 Goni Rd, Suite 109, Carson City NV 89706 (775) 684-7020 or (800) 326-5496.
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Notice of this meeting was posted at least 30 days before the meeting at the following locations: PUBLIC EMPLOYEES' BENEFITS PROGRAM, 3427 Goni Road, Suite 109, Carson City and posted on the PEBP website at https://pebp.nv.gov; on the Nevada Public Notice Website at https://notice.nv.gov; and on the Nevada Legislature's "Administrative Regulation Notices Meetings and Workshops Page" at https://leg.state.nv.us. In addition, the agenda was mailed to groups and individuals as requested.

PROPOSED REGULATION OF THE BOARD OF THE

PUBLIC EMPLOYEES' BENEFITS PROGRAM

LCB File No. R047-24

March 25, 2024

EXPLANATION – Matter in ***italics*** is new; matter in brackets **[~~omitted material~~]** is material to be omitted.

AUTHORITY: §§ 1 and 2, NRS 287.043; § 3, NRS 287.0415, 287.043 and 287.045.

A REGULATION relating to public employees; revising provisions relating to the Board of the Public Employees' Benefits Program; repealing certain regulations relating to Board meetings; eliminating certain provisions relating to enrollment in benefits and coverage; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the Board of the Public Employees' Benefits Program to establish and carry out the Public Employees' Benefits Program relating to insurance and benefits for participants. (NRS 287.043) Existing law further requires the: (1) Governor to designate one of the members of the Board to serve as the Chair; and (2) Board to meet quarterly and at other times upon the call of the Chair. (NRS 287.0415) Existing regulations require the Board to elect from its members a Vice Chair at the first meeting of each plan year. (NAC 287.172). **Section 1** of this regulation reorganizes certain provisions of existing regulations relating to the Chair, Vice Chair and motions for consideration. **Section 3** of this regulation eliminates certain requirements and provisions relating to Board meetings, enrollment in the Program and coverage for a person or a retired participant returning to work in certain circumstances. **Section 2** of this regulation makes a conforming change to remove a reference to a section repealed by **section 3**.

Section 1. NAC 287.172 is hereby amended to read as follows:

1. ***The Chair shall:***

(a) Determine the agenda of a meeting of the Board; and

(b) Preside over the meetings of the Board.

2. At the first meeting of each plan year, the Board will elect from its members a Vice Chair

~~1.~~

~~2. The Vice Chair~~] ***who*** shall serve as the Chair in the absence of the Chair.

3. Any member of the Board may submit to the Executive Officer, or in the absence of the Executive Officer, the Operations Officer of the Program, a request for a matter to be placed on the agenda of a meeting of the Board.

4. Any motion made by a member of the Board requires a second to the motion for consideration of the motion by the Board.

Sec. 2. NAC 287.311 is hereby amended to read as follows:

1. Except as otherwise provided in NAC 287.312, a participant who desires or is required to enroll or disenroll a person in the Program as a dependent as a result of a life event that qualifies the participant to amend his or her coverage outside the period of open enrollment must, within 60 days after the date on which the dependent becomes eligible to participate or loses his or her eligibility to participate in the Program:

(a) Execute a declaration of enrollment electronically through the Internet website of the Board ~~[or by submitting a form prescribed by the Program pursuant to NAC 287.318,]~~ under penalty of perjury and subject to the provisions of NRS 686A.290 and 686A.291.

(b) Submit copies of any supporting documentation required to establish or terminate the dependent's eligibility to participate in the Program as a dependent as requested by the Program.

2. Except as otherwise provided in subsections 3 and 4, if a participant fails to enroll or disenroll a person in the Program as a dependent within 60 days after the date on which the dependent becomes eligible to participate or loses his or her eligibility to participate in the Program, the participant may not enroll or disenroll the person in the Program as a dependent until the next period of open enrollment.

3. The Program will enroll a person as a dependent of a participant in accordance with an order to obtain health insurance for his or her child pursuant to NRS 31A.350.

4. The Program will disenroll a person as a dependent of a participant on the date on which the dependent becomes deceased.

Sec. 3. NAC 287.170, 287.174, 287.176, 287.178, 287.3125, 287.318, 287.319, 287.510 and 287.515 are hereby repealed.

TEXT OF REPEALED SECTIONS

287.170 Chair: Duty; voting. (NRS 287.043)

1. The Chair shall preside over the meetings of the Board.

2. Unless the Chair is required to abstain from voting or is otherwise disqualified from participating in a matter before the Board:

(a) If the Chair does not vote on the matter, it will be presumed that the Chair voted with the prevailing majority of members of the Board who voted on the matter.

(b) The Chair shall vote in the case of a tie.

287.174 Meetings: Agenda. (NRS 287.043)

1. The Chair shall determine the agenda of a meeting of the Board.

2. Any member of the Board may submit to the Executive Officer, or in his or her absence, the Operations Officer of the Program appointed pursuant to NRS 287.0426, a request for a matter to be placed on the agenda of a meeting of the Board.

287.176 Meetings: Approval of actions; motions; rules of conduct. (NRS 287.043)

1. All action by the Board must be approved by a majority of the members of the Board who are present at the meeting. A tie vote constitutes a rejection of the question or matter before the Board.

2. Any motion made by a member of the Board requires a second to the motion for consideration of the motion by the Board.

3. *Robert's Rules of Order* govern the general conduct of meetings of the Board.

287.178 Meetings: Minutes; transcript. (NRS 287.0415, 287.043)

1. The minutes of each meeting of the Board must be distributed to each member of the Board.

2. A transcript of a meeting posted to the Internet website of the Board pursuant to NRS 287.0415 will remain posted on the Internet website of the Board for at least 6 months after posting. During the period in which the transcript of the meeting is posted on the Internet website of the Board, a person may request a hard copy of the transcript.

3. The Board may charge the person a fee for the transcript that does not exceed the actual cost of the Board to provide the copy of the transcript.

287.3125 Dependents: Terms and conditions of certain changes. (NRS 287.043) Except during a period of open enrollment, the right to change coverage or insurance for a dependent or to add or change dependents is governed by the terms and conditions of any applicable plan, insurance policy or law.

287.318 Enrollment forms: Required information. (NRS 287.043) Enrollment forms that are submitted to the Program must include, without limitation:

1. The name, address, social security number, if any, and signature of the person who is enrolling in the Program; and

2. The name and social security number, if any, of any dependent that the person chooses to cover under the Program.

287.319 Notification of change of address by participant to Program. (NRS 287.043) A participant shall notify the Program within 30 days after a change of address of the participant.

287.510 Coverage of persons returning to work with previous employer within 1 year after leaving employment. (NRS 287.043, 287.045) If a person other than a retired officer or employee returns to work for a participating public agency with which the person was previously employed within 1 year after leaving employment:

1. The person may select any coverage and insurance offered to participants in the Program at the time that the person returns to work; and

2. Coverage and insurance for the person is effective:

(a) If the effective date of reemployment is on the first day of a month, on the effective date of reemployment; or

(b) If the effective date of reemployment is not on the first day of a month, on the first day of the month immediately following the effective date of reemployment.

287.515 Coverage of retired participants upon reemployment with participating public agency. (NRS 287.043, 287.045)

1. Except as otherwise provided in this section, a person who participates in the Program as a retired officer or employee and who returns to full-time employment with a participating public agency is eligible to participate in the Program as an active officer or employee:

(a) If the effective date of reemployment is on the first day of a month, on the effective date of reemployment; or

(b) If the effective date of reemployment is not on the first day of a month, on the first day of the month immediately following the effective date of reemployment.

2. If a person who participates in the Program as a retired justice or judge accepts reemployment as a justice of the Supreme Court or district judge pursuant to NRS 1A.370, the person is eligible to participate in the Program as an active justice or judge, as applicable:

(a) If the effective date of reemployment is on the first day of a month, on the effective date of reemployment; or

(b) If the effective date of reemployment is not on the first day of a month, on the first day of the month immediately following the effective date of reemployment.

3. Except as otherwise required by federal law, a retired officer or employee who returns to full-time employment with a participating public agency to fill a position which has been designated as a position for which there is a critical labor shortage pursuant to NRS 286.523 and who continues to receive allowances under the retirement system of which he or she is a member is eligible to participate in the Program in the same manner as he or she participated before returning to full-time employment. Except for a retired officer or employee who was enrolled in the Program on November 30, 2008, and continues his or her participation in the Program, coverage of a retired officer or employee who returns to full-time employment with a participating local governmental agency pursuant to this subsection terminates on the date on which the participating local governmental agency terminates its participation in the Program.

4. A retired officer or employee who returns to full-time employment with a participating state agency to fill a position which has been designated as a position for which there is a critical

labor shortage pursuant to NRS 286.523 and who discontinues receiving allowances under the retirement system of which he or she is a member is eligible to participate in the Program as an active officer or employee:

(a) If the effective date of reemployment is on the first day of a month, on the effective date of reemployment; or

(b) If the effective date of reemployment is not on the first day of a month, on the first day of the month immediately following the effective date of reemployment.

5. A retired officer or employee who returns to full-time employment with a participating local governmental agency to fill a position which has been designated as a position for which there is a critical labor shortage pursuant to NRS 286.523 and who discontinues receiving allowances under the retirement system of which he or she is a member is eligible to participate in the Program as an active officer or employee:

(a) If the effective date of reemployment is on the first day of a month, on the effective date of reemployment; or

(b) If the effective date of reemployment is not on the first day of a month, on the first day of the month immediately following the effective date of reemployment.

➥ Except for a retired officer or employee who was enrolled in the Program on November 30, 2008, and continues his or her participation in the Program, coverage of a retired officer or employee pursuant to this subsection terminates on the date on which the participating local governmental agency with which the retired officer or employee returns to full-time employment terminates its participation in the Program.

JOE LOMBARDO
Governor

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PUBLIC EMPLOYEES' BENEFITS PROGRAM
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CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

REGULATION WORKSHOP ON LCB FILE NO. R047-24

Held in the Board Room at the office of the Public Employees' Benefits Program
3427 Goni Rd, Ste 117, Carson City, NV 89706

and video conferenced via YouTube

Thursday May 9, 2024 – 1:30 p.m.

Staff Present
Celestena Glover, Executive Officer
Nik Proper, Operations Officer
Brandee Mooneyhan, Lead Insurance Counsel

MINUTES

Agenda Item 1:
CALL TO ORDER AND INTRODUCTIONS

The meeting was called to order by Celestena Glover, Executive Officer at 1:30pm. Mrs. Glover stated that this was the hearing on the regulation changes proposed in the workshop completed in March 2024. She introduced Nik Proper, Operations Officer and Brandee Mooneyhan, Legal Counsel for PEBP.

Agenda Item 2:
PUBLIC COMMENT

None

Agenda Item 3:
PUBLIC HEARING ON LCB FILE NO. R047-24

Mrs. Glover stated this is the public hearing for LCB file No. R047-24 which is the file number assigned to the regulation change that PEBP proposed in accordance with Executive Order from 2023-003. The order directed state agencies to submit ten proposed regulation changes. PEBP reviewed the appropriate sections of NAC 287 and recommended changes to the PEBP Board in March 2023. The Board reviewed and approved those changes. A workshop was conducted on March 6, 2024 to discuss the changes. For this hearing, one public comment relevant to PEBP was received, but it was not relevant to the regulation changes.

Agenda Item 4:
QUESTION AND ANSWER PERIOD FOR LCB FILE NO. R047-24

Mrs. Glover stated that this was the period that members of the public could ask questions about the proposed regulation changes. There were no questions.

Agenda Item 5:
PUBLIC COMMENT

No public comment.

Agenda Item 6:
ADJOURNMENT

Mrs. Glover adjourned the meeting at 1:36pm.

May 7, 2024

PEBP Board
PEBP Executive Officer Celestina Glover
3427 Goni Road, STE 109
Carson City, NV 89706

RE: Public Comments 5/9/2024 Meeting

I was a member of the PEBP Board when the Board adopted the SaveOnSP program.

I am writing regarding the declaration in the Master Plan Designs (MPD) that "**copayment assistance for specialty drugs will not apply toward your deductible and Out-of-pocket Maximum**" and to indicate that I believe the master plan designs incorrectly state the intent of the Board and may create issues because of the way the language in the MPD's have been written. This letter provides background on the adoption of the SaveOnSP program, why the MPD language is wrong, and suggested changes to the language in the MPD.

At the time the SaveOnSP program was adopted, the Board did not vote to disallow copay assistance for specialty drugs in totality. The purpose of using the SaveOnSP program was to allow PEBP participants to access these specialty drugs at no cost to them, while maximizing the amount of copay assistance to the plan to offset that benefit. The intent was to disallow <u>direct</u> copay assistance from pharmaceutical companies from applying to accumulators.

As explained when the SaveOnSP program was presented, the PEBP plan became the beneficiary of any pharmaceutical copay assistance, and the plan participant paid $0 for the medication. The copay assistance collected by the SaveOnSP program would not apply to the deductible or out of pocket maximum because the plan participant received the medication with no out-of-pocket cost. This left the accumulators in place and the participant would be responsible for all other medical costs that would generally apply to the deductible and out of pocket maximum.

The reason for this change was the pharmaceutical copay assistance was usually GREATER than the out-of-pocket maximum incurred by the member, therefore the actual cost to the plan was less by offering this plan in this manner.

During the March 31, 2020 Board meeting where the SaveOnSP program was approved, there was discussion about patient assistance programs <u>for non SaveOnSP medications</u>. The information provided to the Board was that patient assistance programs could still apply. In other words, patient assistance could apply to the deductibles and copays for drugs not on the SaveOnSP program.

The transcript statement on page 91 on that March 31, 2020 date reads:

MS. DALY: So that's on slide seven and there would be and there are some members that are on a specialty drug with co-pay assistance that are not a part of Save-On. So some of the members will not be participating in Save-On again because of the targeted list. But if they are using the co-pay assistance programs they can continue to do that. Those dollars will not go away and our specialty pharmacy will continue to encourage members to sign up for those dollars if they are available.

COPAYMENT ASSISTANCE

There are many kinds of copayment assistance including direct and indirect. Some indirect patient assistance providers are funded in part by pharmaceutical companies, but users must apply to receive them. This type of assistance is indirect copayment assistance. It's not a coupon anyone can use.

Some of these indirect patient assistant programs include funding from the National Organization for Rare Disorders (NORD) and MedMonk. These programs are indirect patient assistance programs which generally have qualification requirements (need based, or other criteria). These are not direct pharmaceutical coupons but is specifically approved funding placed into an account on behalf of a patient that can be accessed by a specialty pharmacy to cover the bills for certain specialty drugs.

Direct copayment assistance is more in the line of pharmaceutical coupons or direct to consumer incentives or payments that come directly from manufacturers.

When a member participates in the SaveOnSP program, they enroll into it and the plan follows a specific method to capture the copayment assistance for the benefit of the plan. There is a specific agreement between the PEBP plan and the enrolled participant.

There are several patient assistance programs that assist plan members with the costs of drugs that are NOT on the SaveOnSP program.

Absent a specific agreement for the plan to capture the copayment assistance on behalf of a participant, how can the plan possibly take non-direct copay assistance used to pay a medical bill on behalf of participant without applying it to the amount owed by the participant?

The way the PEBP Board has structured the language in the SPD, a participant could qualify for $20,000 in patient assistance funding from NORD because of financial need, and as this indirect copay assistance was applied to the bills from the specialty pharmacy, the plan would simply take the money without giving credit to the bills the participant is responsible for paying, leaving the participant to pay the bills for the specialty drugs again.

This practice, in my opinion, violates the intent of the Board when the SaveOnSP plan was adopted. I also believe that the application of disallowing non-direct copay assistance from applying toward a deductible or OOP for specialty drugs that are not part of the SaveOnSP program would be arbitrary and capricious and perhaps unlawful. Certainly, such a practice would violate the affordable care act.

I request that PEBP and the PEBP Board clarify/change the currently overbroad statement in the master plan design from:

"copayment assistance for specialty drugs will not apply toward your deductible and Out-of-pocket Maximum"

To read:

"copayment assistance for specialty drugs that are part of the SaveOnSP program will not apply toward your deductible or Out-of-pocket Maximum. Direct copayment assistance from pharmaceutical companies such as discounts or coupons will not apply toward your deductible or Out-of-pocket Maximum. Indirect copayment assistance will apply toward your copays, deductible and Out-of-pocket Maximum."

A change such as this would align with the intent of the Board that adopted the SaveOnSP program, would clarify to Accredo and UMR when to allow or disallow copayment assistance from applying to accumulators, and would not create an issue for the plan or plan members when indirect copayment assistance is applied when non-SaveOnSP specialty medications are provided by Accredo.

I request that this be clarified in writing before the end of Open Enrollment as it makes a difference on the choices participants make.

Please feel free to reach out to me with any questions.

Sincerely,

[redacted]

6.

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

JOE LOMBARDO
Governor

CELESTENA GLOVER
Executive Officer

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JACK ROBB
Board Chair

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: May 23, 2024

Item Number: 6

Title: Executive Officer Report

SUMMARY

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

REPORT

OPEN ENROLLMENT

PEBP's annual open enrollment began on May 1, 2024, and will continue through May 31, 2024. As in past years, information was provided to members through the 4th Quarter newsletter, emailed to those members with email addresses within PEBP's system and via a statewide email sent to employees. The open enrollment communications included information about webinars to be held April 30, 2024, through May 2, 2024. The webinars provided members with the opportunity to ask questions and to become familiar with the open enrollment process. As of (5/14/24) there have been 1151 events in progress, and 2285 open enrollment events completed. This is on track as last year there were 1221 in progress, and 2143 completed events by 5/12/23.

Plan Enrollment as of 5/14/24 – Total Lives Covered

Plan	PY2023 Enrollment	Current PY2024 Enrollment	Current elections for PY2025
CDHP	26,875	23,944	23,849
LD	14,911	20,098	20,917
EPO	6,221	5,600	5,509
HMO	6,246	6,129	6,091
Dental	10,440	10,309	10,306
Declined	2,496	2,643	2,644

STRATEGIC PLANNING MEETING

PEBP will be holding the next strategic planning meeting in October of this year. Included will be PEBP staff, vendors and 3 to 4 PEBP Board members. We will discuss where we are today, the direction we would like to take PEBP and the future of PEBP plan offerings. The results of that meeting will be brought to the Board for review and consideration at the November/December meeting.

SALGBA

I attended the SALGBA conference held in April 2024 along with Vice Chair Kelley. During that conference there was a lot of discussion around wellness programs and pharmacy spend. My takeaway from that event is that GLP1s for weight loss drugs remain a hot topic although, many plans still do not cover these drugs as they are very expensive. In addition, we learned that most of the local and state governments attending the conference do include a wellness program as part of their benefit offerings. In the past PEBP offered a wellness program however, it was eliminated due to pressure from certain members and the legislature. It is time to discuss the potential for offering a wellness program to PEBP members in the future. This will be discussed during the strategic planning meeting to develop some ideas for what that may look like and the timing of that offering should it be approved by the PEBP Board.

7.

7. Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Third-Party Administrator, UMR, for FY2024 Q2 covering the period of October 1, 2023 – December 31, 2023. (Celestena Glover, Executive Officer) (**For Possible Action**)

    7.1 UMR Remediation Plan

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefits Program Plans
Administered by United Medical Resources

Audit Period: October 1, 2023 – December 31, 2023
Audit Number 1.FY24.Q2

Presented to

State of Nevada Public Employees' Benefits Program

May 23, 2024

CLAIM TECHNOLOGIES INCORPORATED

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 United Medical Resources' (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 October 1, 2023 through December 31, 2023 (quarter 2 (Q2) 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	$53,920,419
Total Number of Claims Paid/Denied/Adjusted	210,866

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

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

Auditor's Opinion

Based on these findings, and in our opinion:

1. UMR's Financial Accuracy and Claim Turnaround Time within 14 days met the service objective. Overall Accuracy and Claim Turnaround Time within 30 days did not meet the service objective and a penalty is owed (breakdown in summary below).
2. CTI recommends UMR should:
   - Review the financial errors identified in our random sample audit and determine if system changes or claim processor training could help reduce or eliminate errors of a similar nature in the future.
   - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings.
   - Where appropriate, verify claim processor coaching, feedback, and retraining has occurred because most errors were manually processed.

Summary of UMR's Guarantee Measurements

Based on CTI's Random Sample Audit results, UMR did not meet the overall accuracy and claim turnaround within 30 days measurements for PEBP in Q2 FY2024 and a penalty is owed. Reported administrative fees for the quarter totaled $1,292,524.65.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy (p. 11)	99.4%	Met – 99.89%	NA	$0.00
Overall Accuracy (p. 12)	98.0%	Not Met – 97.5%	1.0%	$12,925.25
Claim Turnaround Time (p. 14)	92% in 14 Days 99% in 30 Days	Met – 93.9% Not Met – 96.6%	NA 1.0%	$0.00 $12,925.25
		Total Penalty	2.0%	$25,850.50

AUDIT OBJECTIVES

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

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

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

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

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

QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with UMR. The results for Q2 FY2024 follow.

	Metric	Service Objective	Actual	Met/ Not Met
CLAIMS ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
1.4	**Claim Adjustment Processing Time:** measured from the time a prior claim submission requiring an adjustment is identified through the date the claim adjustment is processed by service facility personnel.	95.00% 7 Calendar/ 5 Business Days	94.50%	Not Met
1.5	**Telephone Service Factor:** Defined as the percentage of the Client telephone inquiries answered by facility Customer Service Representatives (CSRs) within 30 seconds. Measured from the time the caller completes the prompts of the automated telephone system to the time the caller reaches a CSR.	85.00% Calls answered within 30 seconds	97.80%	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%	0.10%	Met
1.7	**First Call Resolution Rate:** the percentage of telephone inquiries completely resolved within a 'window period' of time. A call is considered 'resolved' when the same participant or a family member under the same subscriber ID has not contacted the administrator's customer service facility again regarding the same issue within 60 calendar days of the initial call.	95.00%	91.00%	Not Met
1.8	**Open Inquiry Closure:** addresses the time taken in hours and/or days by CSRs at the administrator's service facility to close open inquiries placed by participants of PEBP to the facility.	90.00% 48 Hours 98.00% 5 Business Days	95.20% 95.50%	Met Not Met
1.9	**CSR Audit, or Quality Scores:** determined by the process used to evaluate the effectiveness and accuracy of participant telephone call handling at the administrator's customer service facility.	97.00%	96.80%	Not Met
1.10	**CSR Callback Performance:** measured from the CSR commitment data in hours and/or days to the time the actual callback was placed to the participant.	90.00% Within 24 Hours	76.92%	Not Met
1.11	**Participant Email Response Performance:** measured from the time an email is received by the administrator's response team to the time in hours or days to the time the actual email response is sent to the participant.	90.00% Within 8 Hours 95.00% Within 24 Hours	100% 100%	Met Met
1.12	**Member Satisfaction:** At least 95%-member satisfaction with the services. Measured as the number of satisfied to highly satisfied survey ratings divided by the total number of survey responses. Survey tool and survey methodology to be mutually agreed upon by Offeror and PEBP.	95.0%	NA	Reported Annually
1.13	**Account Management – Plan will guarantee that the services provided by the TPA's team during the guarantee period will be satisfactory to PEBP. Areas of satisfaction will include:**			
	Knowledge/Capabilities – Account representative demonstrates competence in getting issues and problems resolved.	Agree	5	Met
	Responsiveness – All calls returned within at most 24 hours; along with an alternate person identified who can assist with service issues when account representative is unavailable.			
	Ability to meet deadlines – Supplying all requested materials accurately and in a timely manner, along with all necessary documentation (i.e., enrollment kits, rate confirmations, plan performance work plans, group contracts, ZIP code file, etc.).			

	Metric	Service Objective	Actual	Met/ Not Met
	Professionalism – Demonstrates objectivity and empathy with customer problems.			
	Flexibility – Ability to meet client-specific needs.			
	Participation in periodic meetings – Attendance at all required client meetings or conference calls.			
	Guarantee measured with staff responses to internal questionnaire. A scale from 1 to 5 will be used to measure performance, where 1 means 'very dissatisfied' and 5 means 'very satisfied'; and 2 through 4 are defined, respectively.			
	Periodic program reports will be provided and presented with recommended actions. Standard program reports, within 30 days to quarter-end. Year-end activity report, within 45 days of program year end.			
	Open Enrollment Support: Accurate materials will be provided at least 60 days prior to the open enrollment period starting on April 1 each year. Representative will be available, if requested, for up to 5 employee benefit fairs.			
	Service Objective (out of a score of 5 on internal questionnaire):	350		
1.14	**Eligibility Processing:** Confirm daily and weekly eligibility and enrollment within specified business days of the receipt of the eligibility information, given that information is complete and accurate.	98.00% 2 Business Days	100%	Met
1.15	**Data Reporting:** Offeror will provide PEBP with 100% of the applicable reports (within 10 business days for standard reports and within 10 business days of Plan year-end for Annual Reports and Regulatory documents).	100% 10 Business Days	100%	Met
1.17	**ID Card Production and Distribution**	100% 10 Business Days	100%	Met
1.18	**Disclosure of Subcontractors:** Offeror will provide the identity of the subcontractors who have access to PEBP member PHI. Provide identity of subcontractors who have access to PHI within 30 calendar days of the subcontractors' gaining access.	100% 30 Calendar Days	No new subcontractors	Met
1.19	**PHI:** Offeror will store PEBP member PHI data on designated servers. Must remove PEBP member PHI within 3 business days after offeror knows or should have known using commercially reasonable efforts that such PHI is not store on a designated server.	100% 30 Business Days	No issues	Met
NETWORK ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
2.1	**EDI Claims Re-Pricing Turnaround Time:** At least 97% of medical claims covered under the PEBP Medical PPO Network must be electronically re-priced within business 3 days and 99% within business 5 days.	97.00% 3 Business Days 99.00% 5 Business Days	99.50% 99.50%	Met Met
2.2	**EDI Claims Re-Pricing Accuracy:** At least 97% of claims re-priced by the PPO Network must be accurate and must not cause a claim adjustment by PEBP's TPA.	97.00%	97.90%	Met
2.3	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within business 10 days of end of reporting period or event as determined by PEBP.	100% 10 Business Days	100%	Met
2.4	**Subcontractor Disclosure:** 100% of all subcontractors used by vendor are disclosed prior to any work done on behalf of PEBP. Business Associate Agreements completed by all subcontractors.	100%	No new subcontractors	Met
2.5	**Provider Directory:** Best efforts to resolve 100% of complaints within 10 business days. Provider Directory issue resolution log maintained by Vendor and periodically reviewed with PEBP.	100% 10 Business Days	0 complaints	Met
2.6	**Website:** A website hosting a reasonably accurate and updated Provider directory must be available and accessible on all major browsers 99% of time.	99.00%	99.97%	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	92.30%	Not Met
3.3	**Pre-Certification Requests:** Precertification requests from healthcare providers shall be completed in accordance with URAC/NCQA standards and turn-around timeframes; completed Pre-certifications shall be communicated to PEBP's Third Party Administrator using an approved method e.g., electronically, within 5 business days of UM completing Precertification determination.	98.00% 5 Business Days	NA	Reported Annually
3.4	**Concurrent Hospital Reviews:** Concurrent hospital reviews shall be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated to the provider using an approved method e.g., electronically within 2 business days of determination decision.	98.00% 2 Business Days	NA	Reported Annually
3.5	**Retrospective Hospital Reviews:** Retrospective reviews must be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated using an approved method e.g., electronically within 5 business days of determination decision.	98.00% 5 Business Days	NA	Reported Annually
3.8	**Hospital Discharge Planning:** CM will contact or attempt to contact 95% of patients discharged from any facility within 3 business days of notification of discharge with clinical coaching and discharge planning assistance.	95.00% 3 Business Days	NA	Reported Annually
3.9	**Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	95.00%	NA	Reported Annually
3.10	**Utilization Management for Medical Necessity and Center of Excellence Usage:** UM review to determine medical necessity in accordance with the MPDs. Services to be performed at a Center of Excellence to be managed through the Case Management process.	98.00%	NA	Reported Annually
3.11	**Return On Investment (ROI) Guarantee – Utilization Management/Case Management:** 2:1 Savings to Fees for Utilization Management/Case Management.	100%	NA	Reported Annually
3.12	**Disclosure of Subcontractors:** All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	No new subcontractors	Met
3.13	**Unauthorized Transfer of PEBP Data:** All PEBP PHI or PII data will be stored, processed, and maintained solely on currently designated servers and storage devices identified in this contract. Any changes to those designated systems during the life of this agreement shall be reported to PEBP at least 60 calendar days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	No changes	Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

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

Scope

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

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

Methodology

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

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

- ***Audit of Administrator Response and Documentation*** – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.

Findings

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

Categories for Process Improvement

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

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

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

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
40	$12.80	Agree.	Procedural deficiency and overpayments remain. UMR paid duplicate charges.	☐ M ☒ S
41	$1,089.00			☒ M ☐ S
42	$167.07			☒ M ☐ S
43	$35.00			☒ M ☐ S
44	$491.00			☐ M ☒ S
45	$16.78			☒ M ☐ S
46	$18.68			☒ M ☐ S
47	$2,160.00			☒ M ☐ S
Plan Exclusions				
Service Not Authorized				
27	$1,256.53	Agree. Review of these types of claims are based on procedure and diagnosis selections coded in the UMR system to pend for review. No authorization on file for services rendered.	Procedural deficiency and overpayment remain. Services were not authorized and should have been denied.	☒ M ☐ S
38	$617.51	Agree. CPT code 15839 was approved by UM vendor for medical necessity. This claim was not allowed appropriately based on the review and allowed amount. CPT	Procedural deficiency and overpayment remain. Payment for cosmetic services (procedure 15830) was not authorized.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**(Under)/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		15830 should be denied, and CPT 15839 allowed amount is $1059.77. This results in a $617.51 overpayment.		
Copay Application				
Outpatient Surgery				
14	$174.70	Agree. This claim did not apply the $350.00 copay for outpatient surgery. This results in a $174.70 overpayment.	Procedural deficiency and overpayment remain. The claim included outpatient surgery and a $350.00 copay was not applied.	☒ M ☐ S
PPO Provider Without Discount				
24	$2,419.20	Agree. The provider was participating at the time services were rendered. Claim was a reconsideration, and the service was paid with no discount in error.	Procedural deficiency and overpayment remain. Provider discount not applied.	☒ M ☐ S
Preventive Services				
Denied				
3	($177.73)	Agree. Preventive service was denied in error. This claim was adjusted on 2/9/24. This results in a $177.73 underpayment.	Procedural deficiency and underpayment remain. The preventive service was denied in error.	☒ M ☒ S

Additional Observations

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

QID Number	Observation
13	The EPO plan has a $40.00 copay for diagnostic mammography; however, deductible and coinsurance were applied on this claim in error. The claim was processed on 10/27/23 and applied $46.03 to the deductible and $43.39 in coinsurance. The claim was corrected on 11/17/23 and applied the $40.00 copay. Because the error was identified through UMR's internal QA process and corrected prior to the audit data being pulled and submitted to CTI, no error has been assessed.

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 $1,613,655.34. The claims sampled and reviewed revealed $158.50 in underpayments and $358.40 in overpayments. This reflects a weighted Financial Accuracy rate of 99.89% over the stratified sample. This is an increase in performance from the prior period. Detail is provided on the following page in the Random Sample Findings Detail Report table.

UMR met the Performance Guarantee for PEBP in Q2 FY2024 of 99.40% for this measure.

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 an improvement in performance from the prior period. Detail is provided in the table below, Random Sample Findings Detail Report.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	3	2	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.

UMR did not meet the Performance Guarantee for PEBP in Q2 FY2024 of 98.0% for this measure; however, performance did increase from the prior period. The penalty owed is 1.0% of the administrative fees of $1,292,524.65 or $12,925.25. Detail is provided in the table below, Random Sample Findings Detail Report.

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

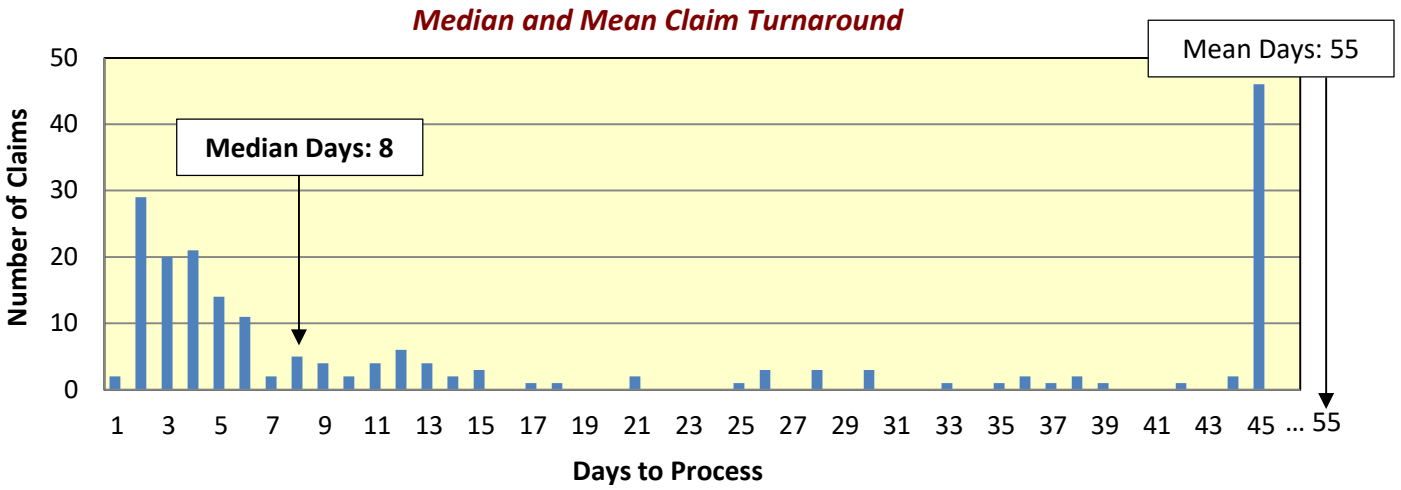
Random Sample Findings Detail Report				
Audit No.	**(Under) / Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
PPO Discount Error				
1001	$4.00	Agree. Billed charges are to be used if the maximum allowed is greater than billed. This claim was adjusted on 3/11/24 and results in a $4.00 underpayment.	Procedural error and overpayment identified. An incorrect PPO discount was applied to the claim. The discount amount was processed on the third line of the claim as -$20.00 resulting in an incorrect coinsurance calculation. The allowed amount was $20.00 more than charged amount.	☒ M ☐ S
1092	($75.48)	Agree. An incorrect discount amount was entered for rev code 305. The billed amount is $150.96 - $75.48 (discount) = $75.48. This results in a $75.48 underpayment.	Procedural error and underpayment remain. The discount amount was $18,524.58, and it should have been $18,600.06.	☒ M ☐ S
1093	$354.40	Agree. UHC network pricing for this claim allows $308.00. The claim was initially processed allowing billed charges. The claim was adjusted on 2/6/24 allowing the $308.00 at 80%. This results in $354.40 overpayment.	Procedural error and overpayment remain. An incorrect PPO discount was applied. The discount amount was $0.00, and it should have been $443.00.	☒ M ☐ S

Deductible Error				
1033	($5.30)	Agree. Procedure 81025 should be allowed as preventive with no cost share when performed in conjunction with contraceptive management. Claim adjusted on 3/11/24 and results in a $5.30 underpayment.	Procedural error and underpayment identified. This contraceptive management pregnancy test should have paid at 100%. The visit was for removal and reinsertion of IUD, the pregnancy test was performed in conjunction with the preventive contraceptive service. The deductible applied should have been $0.00 and it was $5.30.	☒ M ☐ S
Copay Calculation Error				
1025	($77.72)	Agree. Pre-admission testing on 7/6/23 should not have a separate copayment applied. These services should be allowed at deductible then coinsurance. This claim has been adjusted and results in a $77.72 underpayment.	Procedural error and underpayment remain. There was an incorrect copay on this claim. The copay should have been $350.00, and it was $700.00. Deductible and coinsurance should have applied to pre-admission testing.	☒ M ☐ S

Claim Turnaround

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

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



UMR did not meet the Performance Guarantee for PEBP in Q2 FY2024 of 99% processed within 30 days but did meet 92% processed within 14 days. This performance did not improve from the prior period. The penalty owed for this Performance Guarantee is 1.0% of the administrative fees of $1,292,524.65 or $12,925.25.

Additional Observations

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

Audit No.	Observation
2004, 2024, 2027, 2035, 2044	CTI notes page 14 of the dental MPD states "Crown, including crown build up" is covered under Major Services payable at 50%. PEBP and UMR previously agreed to use the UMR standard when determining coverage level; and D2950 (crown build up) falls under the Basic Services under the UMR standard, payable at 80% under the plan. This conflicts with the MPD language. CTI recommends PEBP consider updating the dental MPD for crown build ups to align with the plan 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

We were unable to calculate provider discounts for PEBP because UMR did not provide the data in their electronic claim data file.

Sanctioned Provider Identification

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

Scope

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

Report

We screened 100% of non-facility claims against OIG's LEIE and identified the following provider as sanctioned. CTI's screening indicated the provider 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	3	$1,661	$1,661	$898
				Totals	**3**	**$1,661**	**$1,661**	**$898**

According to the OIG, James Shelby was excluded on December 19, 2019 with for a felony-controlled substance conviction.

PPACA Preventive Services Coverage Compliance

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

Scope

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

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

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

Reports

We analyzed the payments to determine if they were compliant. To demonstrate full compliance with PPACA's requirements, the analysis should show 100% of services performed by network providers were paid and that no deductible, coinsurance, or copayment was applied.

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

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 99.43% 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. This is an improvement from the prior period.

NCCI Editing Compliance

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

Scope

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

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

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

PTP Edits Reports

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

Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary		Mod	Primary Description	Secondary Description	Line	Amount CMS
Code	Mod	Code	Mod	Use			Count	Would Deny
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	20	$12,514
					Standards of medical/surgical practice			
93351		93306		YES	STRESS TTE COMPLETE	TTE W/DOPPLER COMPLETE	1	$4,842
					HCPCS/CPT procedure code definition			
93453		75710		YES	R&L HRT CATH W/VENTRICLGRPHY	ARTERY X-RAYS ARM/LEG	1	$3,737
					Misuse of Column Two code with Column One code			
70496	TC	96374		YES	CT ANGIOGRAPHY HEAD	THER/PROPH/DIAG INJ IV PUSH	3	$2,893
					Standards of medical/surgical practice			
12002		64450		YES	Rpr s/n/ax/gen/trnk2.6-7.5cm	Injection(s), anesthetic agent(s) and/or ster	1	$2,471
					Anesthesia service included in surgical procedure			
71275	TC	96374		YES	CT ANGIOGRAPHY CHEST	THER/PROPH/DIAG INJ IV PUSH	3	$1,961
					Standards of medical/surgical practice			
90471		99282		YES	IMMUNIZATION ADMIN	Emergency department visit for evaluation &	2	$1,812
					CPT Manual or CMS manual coding instruction			
99285		99284		YES	Emergency department visit for E&M of patient re	Emergency department visit for E&M of pati	1	$1,796
					Misuse of Column Two code with Column One code			
96374		96372		YES	THER/PROPH/DIAG INJ IV PUSH	THER/PROPH/DIAG INJ SC/IM	5	$1,770
					CPT Manual or CMS manual coding instruction			
99284		99283		YES	Emergency department visit for E&M of patient re	Emergency department visit for E&M of pati	2	$1,591
					Misuse of Column Two code with Column One code			
						Top 10 TOTAL	**39**	**$35,386**
						GRAND TOTAL	**251**	**$71,783**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary		Mod	Primary Description	Secondary Description	Line	Amount CMS
Code	Mod	Code	Mod	Use			Count	Would Deny
92609	GN	92507	GN	YES	USE OF SPEECH DEVICE SERVICE	SPEECH/HEARING THERAPY	17	$1,842
					Misuse of Column Two code with Column One code			
34710		37236	99	YES	Delayed placement of distal or proximal extensio	Transcatheter placement of an intravascula	2	$900
					Misuse of Column Two code with Column One code			
93975		76700		YES	VASCULAR STUDY	US EXAM ABDOM COMPLETE	1	$553
					Misuse of Column Two code with Column One code			
99233		99232		NO	Subsequent hospital inpatient or observation car	Subsequent hospital inpatient or observatio	5	$428
					HCPCS/CPT procedure code definition			
84481		84480		NO	FREE ASSAY (FT-3)	ASSAY TRIIODOTHYRONINE (T3)	20	$389
					More extensive procedure			
63047	AS	63042	AS	YES	Remove spine lamina 1 lmbr	LAMINOTOMY SINGLE LUMBAR	1	$364
					HCPCS/CPT procedure code definition			
99238		99232		NO	Hospital inpatient or observation, discharge day	Subsequent hospital inpatient or observatio	4	$300
					CPT Manual or CMS manual coding instruction			
92133		92134		NO	CMPTR OPHTH IMG OPTIC NERVE	CPTR OPHTH DX IMG POST SEGMT	2	$252
					CPT Manual or CMS manual coding instruction			
97012	GP	97140	GP	YES	MECHANICAL TRACTION THERAPY	Manual therapy 1/> regions	11	$234
					Mutually exclusive procedures			
99222		99232		NO	Initial hospital inpatient or observation care, per	Subsequent hospital inpatient or observatio	1	$207
					HCPCS/CPT procedure code definition			
						Top 10 TOTAL	**64**	**$5,468**
						GRAND TOTAL	**154**	**$8,173**

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-Fa+A9:E57cility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Amount CMS Would Deny
31295	1	Nasal/sinus endoscopy, surgical, w dilation (balloon dila	7	$12,076
		Rationale: CMS Policy		
86255	5	FLUORESCENT ANTIBODY SCREEN	2	$5,053
		Rationale: Clinical: Data		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	4	$2,991
		Rationale: Clinical: CMS Workgroup		
19357	1	Tissue expander placement in breast reconstruction, incl	1	$1,837
		Rationale: CMS Policy		
88307	8	TISSUE EXAM BY PATHOLOGIST	1	$1,714
		Rationale: Clinical: Data		
30140	1	RESECT INFERIOR TURBINATE	7	$1,343
		Rationale: CMS Policy		
97153	32	ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN	5	$1,243
		Rationale: Clinical: Society Comment		
31254	1	REVISION OF ETHMOID SINUS	3	$1,079
		Rationale: CMS Policy		
37236	1	Transcatheter placement of an intravascular stent	2	$900
		Rationale: Code Descriptor / CPT Instruction		
J2248	150	MICAFUNGIN SODIUM INJECTION	1	$736
		Rationale: Prescribing Information		
		Top 10 TOTAL	**33**	**$28,971**
		GRAND TOTAL	**65**	**$32,215**

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
A4238	1	Adju cgm supply allowance	2	$2,221
		Rationale: CMS Policy		
E2402	1	NEG PRESS WOUND THERAPY PUMP	1	$1,940
		Rationale: Code Descriptor / CPT Instruction		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	12	$980
		Rationale: Anatomic Consideration		
K0553	1	THER CGM SUPPLY ALLOWANCE	1	$975
		Rationale: Code Descriptor / CPT Instruction		
V2520	2	CONTACT LENS HYDROPHILIC	8	$768
		Rationale: Anatomic Consideration		
B4035	1	ENTERAL FEED SUPP PUMP PER D	2	$368
		Rationale: Code Descriptor / CPT Instruction		
V2523	2	CNTCT LENS HYDROPHIL EXTEND	4	$330
		Rationale: Anatomic Consideration		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	8	$290
		Rationale: Nature of Equipment		
B4224	1	PARENTERAL ADMINISTRATION KI	1	$210
		Rationale: Code Descriptor / CPT Instruction		
B4034	1	ENTER FEED SUPKIT SYR BY DAY	3	$179
		Rationale: Code Descriptor / CPT Instruction		
		Top 10 TOTAL	**42**	**$8,261**
		GRAND TOTAL	**49**	**$8,621**

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 10/1/2023 - 12/31/2023							
	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 Periods		Surgery with E/M Charge during Prohibited Global Fee Periods			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
860800150	0	$0	1	100.0%	$7,067	1	$218
880341656	3	$2,458	1	25.0%	$1,317	1	$107
840404253	2	$287	1	33.3%	$161	0	$0
832310783	0	$0	1	100.0%	$388	0	$0
823819185	0	$0	1	100.0%	$106	0	$0
510566371	0	$0	1	100.0%	$115	0	$0
472242077	0	$0	2	100.0%	$1,022	0	$0
460227855	0	$0	1	100.0%	$341	0	$0
263303591	0	$0	1	100.0%	$191	0	$0
263147146	8	$1,291	1	11.1%	$155	0	$0
Top 10	**13**	**$4,037**	**11**	**45.8%**	**$10,862**	**2**	**$325**
Overall Total	**53**	**$17,495**	**26**	**32.9%**	**$14,027**	**2**	**$325**

CONCLUSION

UMR met the performance metrics for financial accuracy and claim turnaround within 14 days; however, they did not meet the performance metrics for overall accuracy and claim turnaround within 30 days in the second quarter of FY2024. A penalty of $25,925.25 or 2.0% of the administration fees for the quarter, is owed.

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

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

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

115 West Wausau Ave
Wausau, WI 54401

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

March 12, 2024

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q2Y24 audit draft report. The following is our response to the draft report completed by CTI.

ESAS Targeted Sample Analysis

Duplicate Payments

QID 40 – Claim 23312448209 was adjusted prior to the audit and denied on 2/1/2024 as a duplicate to previously processed claim 23295183056. This results in a $24.00 overpayment.
QID 41 – Claim 23300253043 was adjusted and denied on 3/8/2024 as duplicate to previously processed claim 23311148319. This results in a $1089.00 overpayment.
QID 42 – Claim 23312703283 was adjusted and denied on3/8/2024 as a duplicate to previously processed claim 23285394058. This results in a $167.07 overpayment.
QID 43 – Claim 23317237027 was adjusted and denied on 3/8//2024 as a duplicate to previously processed claim 23317237023. This results in a $35.00 payment error.
QID 44 – Claim 23344700314 was adjusted prior to the and denied on 1/31/2024 as a duplicate to previously processed claim 23334000010. This results in a $494.00 payment error.
QID 45 – Claim 23283517764 was adjusted and denied on 3/8/2024 as a duplicate to previously processed claim 23279139859. This results in a $16.78 payment error.
QID 46 – Claim 23325129892 was adjusted prior to the audit and denied on 12-14-2023 as a duplicate to previously processed claim 23319222708. This results in a $18.68 payment error.
QID 47 – Claim 23310163243 was adjusted and denied on 3/8/2024 as a duplicate to previously processed claim 23273192815. This results in a $2160.00 payment error.

Plan Exclusions

QID 27 – UMR agrees with this finding. This service was not authorized prior to payment and should have been denied. This claim was adjusted on 3/7/2024 and results in a $1256.53 overpayment.
QID 38 – UMR agrees with this finding. Based on the review of Medical Necessity for Procedure Code 15839 this claim was not allowed appropriately. This claim was adjusted on 3/8/2024 and results in a $442.26 underpayment.

Copay Application - DX Mammography/Chiro

QID 13 – UMR disagrees with this finding. The benefit is to apply a $40.00 copayment for diagnostic mammograms. This was identified prior to this audit and corrected. UMR adjusted this claim on 11-17-2023.

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

QID 14 - UMR agrees with this finding. The benefit is to apply a $350.00 copayment for outpatient surgery. A copayment was not applied in error. This claim was adjusted on 3/8/2024 and results in a $174.70 overpayment.
QID 15 – UMR disagrees with this finding. Procedure 97112, DOS 8-2-2024 a copayment was applied to a previously processed claim. A second copayment would not apply to the sample claim for the same procedure and DOS.

PPO Provider without Discount
QID 24 – UMR agrees with this finding. The provider was participating at the time of services. Network pricing for CPT code 73700 was not applied in error. This claim has been adjusted and results in a $2419.20 overpayment.

Preventive Services – Denied
QID 3 – UMR agrees with this finding. Preventive service was denied in error. This claim was adjusted on 2/9/2024 and results in a $177.73 underpayment.

Random Sample Findings

PPO Discount
Sample 1001 – After further review, UMR agrees with this finding. Billed charges are to be used if the maximum allowed is greater than billed. This claim was adjusted on 3/11/2024 and results in a $4.00 underpayment.
Sample 1055 – UMR disagrees with this finding. This claim was initially processed correctly based on the provider status of out-of-network. The provider submitted an appeal and UHC Choice Plus updated this provider to participating and provided UMR with updated pricing for this claim. This claim was identified and adjusted on 11/18/2023 prior to the audit.
Sample 1092 – UMR agrees with this finding. An incorrect discount amount was entered on Rev code 305 at the time of processing. This claim was adjusted on 3/11/2024 and results in a $75.48 underpayment.
Sample 1093 – UMR agrees with this finding. This claim was allowed at billed charges in error. This claim was adjusted on 2/6/2024 to apply the network discount. This results in a $354.40 overpayment.

Coinsurance Error
Sample 2004, 2024, 2027, 2035, 2044 - UMR disagrees with these findings. UMR considers ADA code D2950 as a basic service as this service is a type of filling material and used to restore a tooth. This procedure is done prior to a crown placement.

Deductible Error
Sample 1033 – After further review, UMR agrees with this finding. Procedure 81025 should be allowed as preventive with no cost share when performed in conjunction with contraceptive management. This claim was adjusted on 3/11/2024 and results in a $5.30 underpayment.

Copay Calculation Error
Sample 1025 – UMR agrees with this finding. A separate $350.00 copay should not have applied to the pre-admission testing. This claim was adjusted on 2-14-2024 and results in a $77.72 underpayment.

Non-Compliance with Pre-Certification Requirements

Sample 1040 – UMR disagrees with this error. Per MPD (pages 29-30) Partial Hospitalization and Intensive Outpatient Therapy require prior authorization from UM vendor. This claim is not for intensive outpatient treatment or partial hospitalization.

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

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

Sincerely,

Julie Frahm
Sr. UMR External Audit Coordinator

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

CLAIM TECHNOLOGIES INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309

(515) 244-7322 • claimtechnologies.com

7.1

7. Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Third-Party Administrator, UMR, for FY2024 Q2 covering the period of October 1, 2023 – December 31, 2023. (Celestena Glover, Executive Officer) (**For Possible Action**)

7.1 UMR Remediation Plan

PERFORMANCE GUARANTEE REPORT
NV PUBLIC EMPLOYEES BENEFITS PROGRAM
FOR MONTH ENDING: 1/2024
PLAN YEAR: JUL-JUN

Current Month

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	92.0%	0.0%
Claim TAT in 20 Business Days	99.0%	97.1%	-1.9%
Abandonment Rate	3.0%	0.2%	2.8%
Calls Answered Within Service Level	85.0%	96.1%	11.1%
Call Resolution	95.0%	95.3%	0.3%
Adjustment Turnaround in 5 Days Rate	95.0%	89.5%	-5.5%
Customer Service Quality Rate	97.0%	96.9%	-0.1%
CSR Callback	90.0%	100.0%	10.0%
Open Issue Resolution 2 Days Rate	90.0%	97.2%	7.2%
Open Issue Resolution 5 Days Rate	98.0%	98.7%	0.7%

Current Quarter to Date

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	92.0%	0.0%
Claim TAT in 20 Business Days	99.0%	97.1%	-1.9%
Abandonment Rate	3.0%	0.2%	2.8%
Calls Answered Within Service Level	85.0%	96.1%	11.1%
Call Resolution	95.0%	95.3%	0.3%
Adjustment Turnaround in 5 Days Rate	95.0%	89.5%	-5.5%
Customer Service Quality Rate	97.0%	96.9%	-0.1%
CSR Callback	90.0%	100.0%	10.0%
Open Issue Resolution 2 Days Rate	90.0%	97.2%	7.2%
Open Issue Resolution 5 Days Rate	98.0%	98.7%	0.7%

Current Year to Date

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	93.4%	1.4%
Claim TAT in 20 Business Days	99.0%	93.8%	-5.2%
Abandonment Rate	3.0%	0.6%	2.4%
Calls Answered Within Service Level	85.0%	94.3%	9.3%
Call Resolution	95.0%	92.8%	-2.2%
Adjustment Turnaround in 5 Days Rate	95.0%	93.1%	-1.9%
Customer Service Quality Rate	97.0%	96.3%	-0.7%
CSR Callback	90.0%	100.0%	10.0%
Open Issue Resolution 2 Days Rate	90.0%	95.2%	5.2%
Open Issue Resolution 5 Days Rate	98.0%	95.8%	-2.2%

PERFORMANCE GUARANTEE REPORT
NV PUBLIC EMPLOYEES BENEFITS PROGRAM
FOR MONTH ENDING: 2/2024
PLAN YEAR: JUL-JUN

Current Month

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	95.0%	3.0%
Claim TAT in 20 Business Days	99.0%	99.4%	0.4%
Abandonment Rate	3.0%	0.8%	2.2%
Calls Answered Within Service Level	85.0%	88.4%	3.4%
CSR Callback	90.0%	100.0%	10.0%
Call Resolution	95.0%	96.2%	1.2%
Adjustment Turnaround in 5 Days Rate	95.0%	92.3%	-2.7%
Customer Service Quality Rate	97.0%	96.8%	-0.2%
Open Issue Resolution 2 Days Rate	90.0%	98.5%	8.5%
Open Issue Resolution 5 Days Rate	98.0%	99.6%	1.6%

Current Quarter to Date

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	93.5%	1.5%
Claim TAT in 20 Business Days	99.0%	98.3%	-0.7%
Abandonment Rate	3.0%	0.4%	2.6%
Calls Answered Within Service Level	85.0%	93.2%	8.2%
CSR Callback	90%	100.0%	10.0%
Call Resolution	95.0%	95.7%	0.7%
Adjustment Turnaround in 5 Days Rate	95.0%	91.2%	-3.8%
Customer Service Quality Rate	97.0%	96.9%	-0.1%
Open Issue Resolution 2 Days Rate	90.0%	97.8%	7.8%
Open Issue Resolution 5 Days Rate	98.0%	99.1%	1.1%

Current Year to Date

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	93.6%	1.6%
Claim TAT in 20 Business Days	99.0%	94.5%	-4.5%
Abandonment Rate	3.0%	0.6%	2.4%
Calls Answered Within Service Level	85.0%	93.8%	8.8%
CSR Callback	90.0%	100.00	10.00
Call Resolution	95.0%	93.0%	-2.0%
Adjustment Turnaround in 5 Days Rate	95.0%	93.0%	-2.0%
Customer Service Quality Rate	97.0%	96.4%	-0.6%
Open Issue Resolution 2 Days Rate	90.0%	95.6%	5.6%
Open Issue Resolution 5 Days Rate	98.0%	96.3%	-1.7%

PERFORMANCE GUARANTEE REPORT
NV PUBLIC EMPLOYEES BENEFITS PROGRAM
FOR MONTH ENDING: 3/2024
PLAN YEAR: JUL-JUN

Current Month

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	95.0%	3.0%
Claim TAT in 20 Business Days	99.0%	99.0%	0.0%
Abandonment Rate	3.0%	0.7%	2.3%
Calls Answered Within Service Level	85.0%	89.6%	4.6%
CSR Callback	90.0%	100.0%	10.0%
Call Resolution	95.0%	95.8%	0.8%
Adjustment Turnaround in 5 Days Rate	95.0%	97.8%	2.8%
Customer Service Quality Rate	97.0%	97.2%	0.2%
Open Issue Resolution 2 Days Rate	90.0%	98.3%	8.3%
Open Issue Resolution 5 Days Rate	98.0%	99.4%	1.4%

Current Quarter to Date

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	94.0%	2.0%
Claim TAT in 20 Business Days	99.0%	98.5%	-0.5%
Abandonment Rate	3.0%	0.5%	2.5%
Calls Answered Within Service Level	85.0%	92.2%	7.2%
CSR Callback	90%	100.0%	10.0%
Call Resolution	95.0%	95.8%	0.8%
Adjustment Turnaround in 5 Days Rate	95.0%	94.3%	-0.7%
Customer Service Quality Rate	97.0%	97.0%	0.0%
Open Issue Resolution 2 Days Rate	90.0%	98.0%	8.0%
Open Issue Resolution 5 Days Rate	98.0%	99.2%	1.2%

Current Year to Date

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	93.7%	1.7%
Claim TAT in 20 Business Days	99.0%	95.0%	-4.0%
Abandonment Rate	3.0%	0.6%	2.4%
Calls Answered Within Service Level	85.0%	93.5%	8.5%
CSR Callback	90.0%	100.00	10.00
Call Resolution	95.0%	93.3%	-1.7%
Adjustment Turnaround in 5 Days Rate	95.0%	93.9%	-1.1%
Customer Service Quality Rate	97.0%	96.6%	-0.4%
Open Issue Resolution 2 Days Rate	90.0%	95.9%	5.9%
Open Issue Resolution 5 Days Rate	98.0%	96.6%	-1.4%

PERFORMANCE GUARANTEE REPORT
NV PUBLIC EMPLOYEES BENEFITS PROGRAM
FOR MONTH ENDING: 4/2024
PLAN YEAR: JUL-JUN

Current Month

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	94.0%	2.0%
Claim TAT in 20 Business Days	99.0%	99.4%	0.4%
Abandonment Rate	3.0%	0.6%	2.4%
Calls Answered Within Service Level	85.0%	93.6%	8.6%
CSR Callback	90.0%	100.0%	10.0%
Call Resolution	95.0%	95.7%	0.7%
Adjustment Turnaround in 5 Days Rate	95.0%	98.2%	3.2%
Customer Service Quality Rate	97.0%	95.9%	-1.1%
Open Issue Resolution 2 Days Rate	90.0%	98.1%	8.1%
Open Issue Resolution 5 Days Rate	98.0%	99.6%	1.6%

Current Quarter to Date

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	94.0%	2.0%
Claim TAT in 20 Business Days	99.0%	99.4%	0.4%
Abandonment Rate	3.0%	0.6%	2.4%
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Call Resolution	95.0%	95.7%	0.7%
Adjustment Turnaround in 5 Days Rate	95.0%	98.2%	3.2%
Customer Service Quality Rate	97.0%	95.9%	-1.1%
Open Issue Resolution 2 Days Rate	90.0%	98.1%	8.1%
Open Issue Resolution 5 Days Rate	98.0%	99.6%	1.6%

Current Year to Date

Performance Standard	Target	Actual	Current Variance
Claims TAT in 10 Business Days	92.0%	93.8%	1.8%
Claim TAT in 20 Business Days	99.0%	95.5%	-3.5%
Abandonment Rate	3.0%	0.6%	2.4%
Calls Answered Within Service Level	85.0%	93.5%	8.5%
CSR Callback	90.0%	100.00	10.00
Call Resolution	95.0%	93.4%	-1.6%
Adjustment Turnaround in 5 Days Rate	95.0%	94.5%	-0.5%
Customer Service Quality Rate	97.0%	96.4%	-0.6%
Open Issue Resolution 2 Days Rate	90.0%	96.1%	6.1%
Open Issue Resolution 5 Days Rate	98.0%	96.9%	-1.1%

8.

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

Richard Ward, FSA, FCA, MAAA
RWard@Segalco.com
T:818-956-6714
M:619-710-9952

Memorandum

To: Celestena Glover, Executive Officer

From: Richard Ward, FSA, FCA, MAAA
Senior Vice President

Date: March 14, 2024

Re: State of Nevada PEBP – PBM Market Check for Plan Year 2025 – Express Scripts - Update

This memo is an update to the January 31, 2024 memo for the State of Nevada PEBP – 2024 PBM Market Check.

Segal conducted an analysis of the State of Nevada Public Employees' Benefits Program's (PEBP's) Pharmacy Benefit Manager (PBM) pricing contract. PEBP is currently in the second year of a five-year contract with their PBM, Express Scripts, Inc. (ESI). PEBP retained Segal to assess the competitiveness of their pricing contract through a PBM market check.

Segal reviewed PEBP's pharmacy claims data and PBM pricing contracts and compared to several other PBM pricing contracts that Segal has negotiated on behalf of other clients. These comparative clients represent other large public sector clients who have renegotiated their contract with their PBM in the past 12 months. We reviewed pricing offers from ESI clients as well as clients with other competitive PBMs.

In order to preserve the confidentiality of the comparative client pricing contract rates, we have taken the overall average for each pricing component across each comparative client.

After our initial review of PEBP's current pricing contracts we determined that the pricing is less competitive than what the market can currently offer. We presented our original results to PEBP on February 9, 2024 and thereafter communicated with ESI that the market check results were showing that the pricing was noncompetitive.

This memo provides an update to the January 31, 2024 letter based on our conversations with PEBP and ESI. This memo also contains a summary of the PEBP current pricing contracts, the market competitive benchmarks, the ESI renewal offer, Segal observations, analysis, and recommendations for PEBP to consider.

This analysis provides benchmark expectations for available pricing improvements along with the actual pricing improvements. These negotiated improvements are the true indication of the opportunity available to PEBP in the absence of issuing an RFP. Any difference between the negotiated pricing the terms and the market available benchmarks can be attributed to the RFP and bidding process.

Summary

The table below shows the estimated costs to PEBP under the current contract terms compared to the average market competitive benchmarks and ESI renewal offer. Segal reviewed PEBP pharmacy claims data from the period October 1, 2022 through September 30, 2023 and projected forward to the next Contract Year of July 1, 2024 through June 30, 2025. Based on our review of the current contracts and the updated data, we estimate that the ESI renewal offer could yield pricing improvements as outlined below:

- July 1, 2024 through June 30, 2025 - Estimated pricing improvements of up to roughly 3.9% or $2.2M.

PEBP could realize these pricing improvements by obtaining a pricing contract similar to the market competitive benchmark in a competitive bid scenario.

Table 1 below shows the July 1, 2024 through June 30, 2025 estimated costs under the PEBP current contract and those under the market competitive benchmark, which we consider representative of terms that could be obtained in a new contract under a competitive bid scenario.

Table 1 - July 1, 2024 - June 30, 2025

PEBP	Incumbent	ESI Renewal	Market Benchmark Average
Gross Prescription Drug Spend	$105,589,500	$105,589,500	$109,505,233
(+) Admin Fees	$1,701,000	$1,701,000	$543,633
(-) Member Cost Share	$18,626,400	$18,626,400	$18,626,400
(-) Rebates	$31,491,400	$33,696,400	$38,064,400
Total Net Cost	**$57,172,700**	**$54,967,700**	**$53,358,067**
% Difference from Baseline		-3.9%	-6.7%
$ Difference from Baseline		($2,205,000)	($3,814,633)

Vaccines

Vaccines continue to be an evolving coverage category and ESI has proposed an increase the maximum pharmacy administrative fee that will be passed back to PEBP. Currently, PEBP pays the full administrative fee charged by a participating pharmacy to a maximum. Due to changes in Federal subsidies for COVID, and other vaccines, retail pharmacies have increased their administrative fee and the proposed increase in the cap ($5.00 per vaccine) is intended to keep pace.

No other aspects of vaccine pricing will be affected. Table 2 shows the impacted elements of the vaccine program's pricing.

Table 2 – Changes in Vaccine Administrative Fee Cap

	Participating Pharmacy INFLUENZA	Participating Pharmacy COVID19	Participating Pharmacy ALL OTHER VACCINES	Member Submitted Vaccine Claims (excluding foreign claims)
Pharmacy Vaccine Administration Fee[1]	Capped at $20 per Vaccine claim (currently $15)	Capped at $40 per Vaccine claim (currently $35)	Capped at $25 per Vaccine Claim (currently $20)	Submitted amount

[1]Vaccine Administration Fee subject to change based on market conditions upon ninety (90) days advanced notice.

The estimated impact of this change is a $65,000 increase to Plan Year 2025 expenses.

Observations and Next Steps

As seen in Table 1, the market competitive benchmarks that are comparable to PEBP's design could yield about 6.7% in pricing improvements.

ESI provided a renewal offer which Segal evaluated and estimated it could provide PEBP 3.9% (or $2.2M) in pricing improvements over the current contract for the next Contract Year. These pricing improvements came in the form of improved rebate minimum guarantees, which is in-line with how we have seen recent pricing renewals in the market. The ESI renewal offer is stronger than the current contract terms but not as strong as our market check average benchmarks. However, we feel that this offer is competitive, reasonable, and foregoes the need to perform a PBM RFP since the possible residual pricing improvements from the market benchmarks is minimal.

Table 3 outlines PEBP's current pricing rates compared to the market competitive benchmark contracts. Cells highlighted in red are pricing metrics in which PEBP's current pricing are below or less competitive than the benchmark range. Cells highlighted in green are pricing metrics in which PEBP's current pricing is above or more competitive than the benchmark range. Cells highlighted in orange are pricing metrics in which PEBP's current pricing is within the benchmark range, but Segal believes there is room for improvement in PEBP's rates. Cells with no highlighting are competitive within the range of the market benchmarks. Please note that because PBM pricing contracts are analyzed and underwritten in the aggregate, having individual pricing metrics within the range of the benchmark average does not imply that the entire pricing contract is competitive.

We feel that the biggest room for improvement in PEBP's contract is through improved rebate minimum guarantees. PEBP has acquisition-like pricing through ESI and the AWP discounts and dispensing fees are competitive in the aggregate. However, the rebates are lagging to what we have seen in recently negotiated PBM contracts.

ESI improved in minimum guaranteed rebates, which are highlighted in blue in the ESI renewal column. We feel that the rebate improvements provided by ESI make the renewal offer competitive.

Table 3 - Current Pricing Terms and Benchmark Ranges

PEBP	Current Contract 7/1/2024 - 6/30/2025	ESI Renewal 7/1/2024 - 6/30/2025	Benchmark Range
Retail 30			
Brand Discount	22.60%	22.60%	19.00% - 20.35%
Generic Discount	85.70%	85.70%	85.45% - 86.60%
Dispensing Fee	$0.35	$0.35	$0.40 - $0.65
Retail 90			
Brand Discount	27.72%	27.72%	21.90% - 24.10%
Generic Discount	88.25%	88.25%	87.15% - 89.60%
Dispensing Fee	$0.00	$0.00	$0.00 - $0.50
Mail Order			
Brand Discount	21.30%	21.30%	22.25% - 24.35%
Generic Discount	95.05%	95.05%	87.15% - 90.10%
Dispensing Fee	$17.88	$17.88	$0.00 - $0.10
Specialty Retail			
Brand Discount	22.60%	22.60%	20.90% - 21.60%
Generic Discount	85.70%	85.70%	20.90% - 21.60%
Dispensing Fee	$0.35	$0.35	$0.00 - $0.65
Specialty Mail Order			
Brand Discount	21.50%	21.50%	20.90% - 21.60%
Generic Discount	87.00%	87.00%	20.90% - 21.60%
Dispensing Fee	$180.00	$180.00	$0.00 - $0.10
Limited Distribution Drugs			
Brand Discount	21.50%	21.50%	15.90% - 21.35%
Generic Discount	87.00%	87.00%	15.90% - 21.35%
Dispensing Fee	$0.35	$0.35	$0.00 - $0.65
Rebates (per Brand)			
Retail 30	$306.80	$315.00	$305.00 - $390.00
Retail 90	$920.40	$945.00	$755.00 - $1,059.00
Mail Order	$920.40	$945.00	$910.00 - $1,059.00
Specialty Retail	$2,246.00	$2,900.00	$2,765.00 - $4,230.00
Specialty Mail Order	$2,630.00	$2,900.00	$2,765.00 - $4,230.00
Limited Distribution Drugs	$2,630.00	$2,900.00	$2,765.00 - $4,230.00

ESI provided updated, and improved, financial guarantees for the remainder of the contract term. While these terms improve the value of the contract for PEBP, it would be premature to compare these terms with other contracts at this point in time. It is anticipated that PEBP will conduct an annual market check and we will review the updated terms for Plan Year 2026 at this time next year. This does position the current ESI contract more competitively for that analysis than would have previously been the case. These improved terms are focused on the rebate guarantees and are shown in Table 4.

Table 4 – Rebate Guarantees Plan Years 2026 - 2028

Rebates (per Brand)	Current	Proposed	Improvement
Plan Year 2026			
Retail 30	$326.30	$335.00	$8.70
Retail 90	$978.90	$1,005.00	$26.10
Mail Order	$978.90	$1,005.00	$26.10
Specialty at Retail	$2,246.00	$3,265.00	$1,019.00
Specialty at Mail	$2,997.00	$3,265.00	$268.00
Plan Year 2027			
Retail 30	$349.30	$360.00	$10.70
Retail 90	$1,047.90	$1,080.00	$32.10
Mail Order	$1,047.90	$1,080.00	$32.10
Specialty at Retail	$2,246.00	$3,605.00	$1,359.00
Specialty at Mail	$3,335.00	$3,605.00	$270.00
Plan Year 2028			
Retail 30	$359.10	$370.00	$10.90
Retail 90	$1,077.30	$1,110.00	$32.70
Mail Order	$1,077.30	$1,110.00	$32.70
Specialty at Retail	$2,246.00	$3,925.00	$1,679.00
Specialty at Mail	$3,532.00	$3,925.00	$393.00

Based on our review of the improved financial guarantees, we would recommend accepting ESI's proposal and execute a contract amendment with the updated pricing for the July 1, 2024 through June 30, 2028 Contract Years, with the continued understanding that PEBP can exercise an annual market check review. Segal can review the draft amendment and pursue further negotiations as needed.

We look forward to discussing these results with you at your convenience. Please feel free to reach out at any time with any questions or concerns you may have.

Richard Ward, FSA, FCA, MAAA
Senior Vice President

cc: Michelle Weyland, Chief Financial Officer, PEBP
Amy Cohen, Segal
Scott McEachern, Segal
Kautook Vyas, Segal

9.

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

Board Meeting

Nevada Public Employees' Benefits Program

Medicare Exchanges Overview

May 23, 2024

Segal

Medicare Exchange Market

Overview

Private Exchanges provide access to the individual Medicare marketplace

Medicare Supplement ("Medigap") Plans

Covers Medicare A/B deductibles and the coinsurance. Different options provide additional benefits

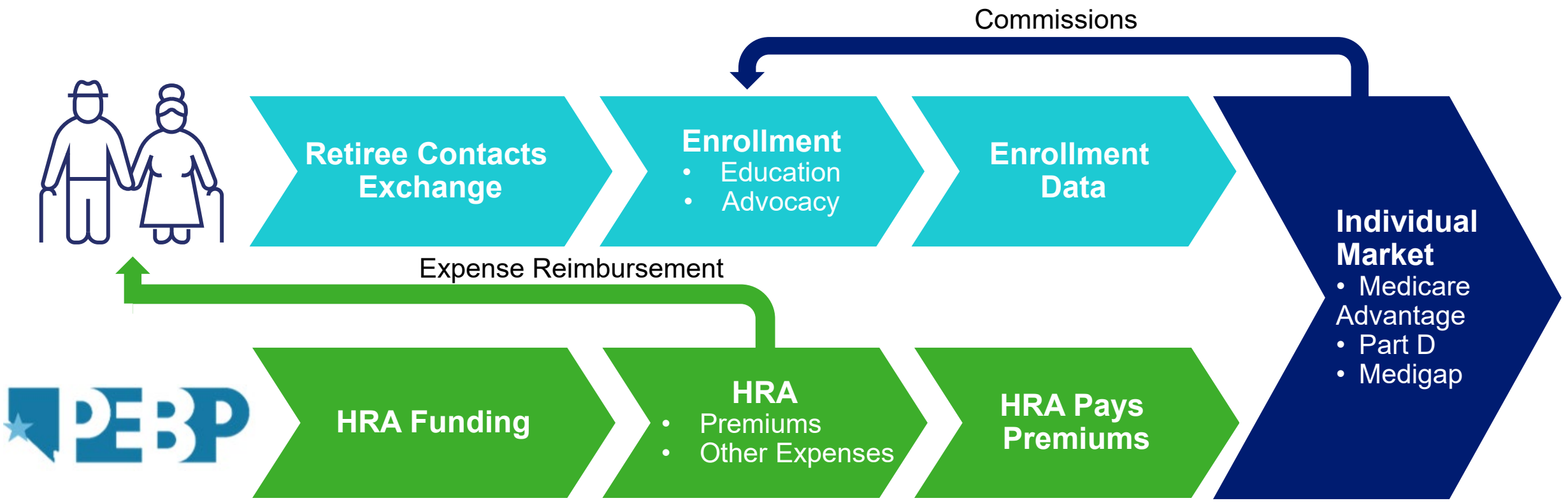
Medicare Advantage Plans

Replaces Medicare parts A and B with an HMO-like plan for (historically) very little additional premium.

Medicare Prescription Drug Plans (PDPs)

Basic Medicare does not cover prescription drugs, Medicare Part D plans do.

How Exchanges Work



Considerations Specific to Medicare Exchanges

Exchanges Contract with Carriers
- PEBP has no input
- Plans Change
- Service Areas Change

Individual Enrollment
- Geography
- Age
- Health status
- Rx use

HRA Funds Premiums/OOP Expenses

Costs Vary for Retirees
- Age
- Gender
- Geographic location

Exchange Holds Broker of Record

Commissions Fund Exchange Services
- Fixed By Carrier
- Can Vary By Exchange Due To Different Carrier Mix

Contracts are Usually on a "Zero Dollar" Basis

Challenging to Move Existing Retirees to New Exchange
- Medicare non-solicitation rules
- Commission duration

Medicare Exchange Market

Key Players and Differentiators

Key differentiators

- Strength of advocacy services
- Level of customer assistance for non-enrollment questions
- Relationship with advocates (geographic focus/single point of contact focus)
- Metrics (e.g., call wait times, satisfaction)
- Level of outsourcing
- Communications Support
- Minimum group size requirements
- Experience/book of business
- Plan and carrier availability

Key players:

- Via (WTW)
- Alight
- Aptia (Mercer)
- Conduent
- Aetna (w/ eHealth)
- Anthem
- Humana (w/ Via)
- UHC
- Select Quote
- AmWINS

We anticipate that the list of vendors and differentiators will continue to evolve over time.

Medicare Market

Legislative and Regulatory Changes

There have been a number of legislative and regulatory changes impacting Medicare Advantage and Part D plans.

- **Medicare Advantage:** CMS continues to adjust how Federal subsidies are calculated for Medicare Advantage Plans, resulting in a continued reduction in Medicare Advantage Subsidies (Medical)
- **Part D Plans**: Inflation Reduction Act
  - $35 cap on member costs for insulin products (2024)
  - $2,000 Out-of-Pocket Limit for Rx (2024)
  - Redesign of Basic Part D, resulting in reduction in total Part D subsidies (2025)
  - CMS negotiating pricing for high-cost medications (2026+)

These changes are increasing premiums and/or leading to tighter access or reduced benefits

Exchange Implementation Timeline

RFP and Implementation - Sample

- **Award in Fall/Winter 2024**
- Project Steps:
  - Vendor RFP
  - Vendor Selection

- **Middle 2025**
- Project Steps:
  - Announcement Letter
  - Retiree Meetings
  - Welcome Kit / Enrollment Guide

Benefits Live: January 1, 2026

- **Early 2025**
- Project Steps:
  - Kick-off meeting
  - Setup and Meetings
    - Eligibility
    - Banking
    - HRA Funding
  - Testing
  - Benefit Advisor Training

- **Enrollment October – December**
- Project Steps:
  - Retiree meetings with Benefit Advisor
  - Plan election/enrollment
  - Broker of Records set-up

Going Forward: One or Two Exchanges

New Exchange: attempt to transition

- Goal: current and future retirees use new exchange
- Can tie HRA allocation to using new Exchange
- Commissions follow Broker of Record (BOR)
- BOR may not follow retiree to new Exchange

1

2

New Exchange: future retirees only

- Based on Date of Retirement
- Commissions for prior Exchange may sunset and not support required service level
- Two vendors to manage and communicate

Thank You

10.

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

JOE LOMBARDO
Governor

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

CELESTENA GLOVER
Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: May 23, 2024

Item Number: 10

Title: Contract Status Report

Summary

This report addresses the status of PEBP contracts to include:

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

10.1 Contracts Overview

Below is a listing of the active PEBP contracts as of March 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	$ 61,875.00	$ 324,625.00
Health Plan of Nevada Inc	Southern Nevada HMO	23802	7/1/2021	6/30/2025	$ 192,093,848.00	$ 115,349,493.73	$ 76,744,354.27
Diversified Dental Services Inc.	Dental PPO	23810	7/1/2021	6/30/2026	$ 1,601,613.00	$ 872,337.67	$ 729,275.33
Lifeworks/Telus Health	Benefits Management System	25935	5/10/2022	12/31/2026	$ 6,145,600.00	$ 2,843,686.24	$ 3,301,913.76
Express Scripts, Inc.	Pharmacy Benefit Manager	25582	5/10/2022	6/30/2026	$ 332,109,496.00	$ 154,274,175.23	$ 177,835,320.77
*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	$ 7,295,725.01	$ 5,528,522.99
Brown & Brown of Massachusetts	Health Plan Auditor	24030	4/13/2021	6/30/2027	$ 1,581,662.00	$ 531,859.00	$ 1,049,803.00
Segal Company, Inc.	Consulting Services	25557	7/1/2022	6/30/2027	$ 4,285,410.00	$ 1,350,620.00	$ 2,934,790.00
Capitol Reporters	Court Reporting	27029	2/1/2023	6/30/2025	$ 31,932.00	$ 9,018.00	$ 22,914.00
Carrum Health	Centers of Excellence	28745	2/12/2024	6/30/2028	$ 4,000,000.00	$ -	$ 4,000,000.00
Carrum Health	Oncology Concierge	29053	5/14/2024	6/30/2028	$ 1,490,000.00	$ -	$ 1,490,000.00
UMR, Inc.	TPA and Other Services	25155	7/1/2022	6/30/2028	$ 65,413,106.00	$ 9,345,082.04	$ 56,068,023.96

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

10.2 New Contracts

No new contracts

10.3 Contract Amendment Ratifications

Express Scripts, Inc. – Contract 25582 – Amendment #2 – Incorporation of Plan Year 2024 Market Check.

10.4 Contract Solicitation Ratifications

No Contract Solicitation Ratifications.

10.5 Status of Current Solicitations

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

Service	Anticipated RFP release date*	Anticipated/ Actual NOI	Winning Vendor	Anticipated Board Approval
Medicare Exchange	Fall 2024	TBA	TBA	TBA
Health Maintenance Organization	Fall 2024	TBA	TBA	TBA

*Pending Board Approval of RFP.

Recommendation

Approve Amendment 2 for Contract 25582 – Express Scripts, Inc.
Approve the pending Request for Proposals for the Medicare Exchange and Health Maintenance Organization.

CONTRACT SUMMARY

(This form must accompany all contracts submitted to the Board of Examiners (BOE) for review and approval)

I. DESCRIPTION OF CONTRACT

1. Contract Number: **25582**

Amendment Number: **2**

Legal Entity Name: EXPRESS SCRIPTS, INC.

Agency Name: **PUBLIC EMPLOYEES' BENEFITS PROGRAM**

Contractor Name: **EXPRESS SCRIPTS, INC.**

Agency Code: **950**

Address: **ONE EXPRESS WAY**

Appropriation Unit: **1338 - All Categories**

Is budget authority available?: **Yes**

City/State/Zip **SAINT LOUIS, MO 63121-1824**

If "No" please explain: Not Applicable

Contact/Phone: 949/499-2042

Vendor No.: T29037510

NV Business ID: NV20151712630

To what State Fiscal Year(s) will the contract be charged? **2023-2026**

What is the source of funds that will be used to pay the contractor? Indicate the percentage of each funding source if the contractor will be paid by multiple funding sources.

General Funds	0.00 %		Fees	0.00 %
Federal Funds	0.00 %		Bonds	0.00 %
Highway Funds	0.00 %	X	Other funding	**100.00 % State Subsidy and Participant Premium**

2. Contract start date:

a. Effective upon Board of Examiner's approval? **No** or b. other effective date **07/01/2022**

Anticipated BOE meeting date null/null

Retroactive? **No**

If "Yes", please explain

Not Applicable

3. Previously Approved Termination Date: **06/30/2026**

Contract term: **4 years**

4. Type of contract: **Contract**

Contract description: **PBM**

5. Purpose of contract:

This is the second amendment to the original contract for Pharmacy Benefit Manager Services. This amendment incorporates the 2024 Nevada Public Employees&#65533; Benefit Program Preventive Medications List, Express Scripts&#65533; Rebate Reconciliation Methodology change, and the Plan Year 2024 ESI Market Check pricing adjustments.

6. CONTRACT AMENDMENT

		Trans $	Info Accum $	Action Accum $	Agenda
1.	The max amount of the original contract:	$332,109,496.00	$332,109,496.00	$332,109,496.00	Yes - Action
	a. Amendment 1:	$0.00	$0.00	$0.00	No
2.	Amount of current amendment (#2):	$0.00	$0.00	$0.00	No
3.	New maximum contract amount:	$332,109,496.00			

II. JUSTIFICATION

7. What conditions require that this work be done?

Pharmacy Benefits are a key component to the core benefits offered by PEBP.

8. Explain why State employees in your agency or other State agencies are not able to do this work:

The State of Nevada does not administer prescription drug benefits.

9. Were quotes or proposals solicited? Yes
   Was the solicitation (RFP) done by the Purchasing Division? Yes
   a. List the names of vendors that were solicited to submit proposals (include at least three):

   b. Soliciation Waiver: **Not Applicable**
   c. Why was this contractor chosen in preference to other?
   RFP#95PEBPOS1711
   d. Last bid date: Anticipated re-bid date:

10. a. Does the contract contain any IT components? No
    b. Is the contract part of an IT investment project over $50,000? No

III. OTHER INFORMATION

11. Is there an Indirect Cost Rate or Percentage Paid to the Contractor?
    No If "Yes", please provide the Indirect Cost Rate or Percentage Paid to the Contractor
    Not Applicable
12. a. Is the contractor a current employee of the State of Nevada or will the contracted services be performed by a current employee of the State of Nevada?
    No
    b. Was the contractor formerly employed by the State of Nevada within the last 24 months or will the contracted services be performed by someone formerly employed by the State of Nevada within the last 24 months?
    No
    c. Is the contractor employed by any of Nevada's political subdivisions or by any other government?
    No If "Yes", please explain
    Not Applicable
13. Has the contractor ever been engaged under contract by any State agency?
    Yes If "Yes", specify when and for which agency and indicate if the quality of service provided to the identified agency has been verified as satisfactory:
    Current PBM for PEBP.
14. Is the contractor currently involved in litigation with the State of Nevada?
    No If "Yes", please provide details of the litigation and facts supporting approval of the contract:
    Not Applicable
15. The contractor is registered with the Nevada Secretary of State's Office as a:
    Nevada Corporation
16. a. Is the Contractor Name the same as the legal Entity Name?
    Yes
17. a. Does the contractor have a current Nevada State Business License (SBL)?
    Yes
18. a. Is the legal entity active and in good standing with the Nevada Secretary of State's Office?
    Yes
19. Agency Field Contract Monitor:
20. Contract Status:
    Contract Approvals:

Approval Level	User	Signature Date
Budget Account Approval	mweyland	03/27/2024 16:39:38 PM
Division Approval	mweyland	03/27/2024 16:39:47 PM

CETS #:	
Solicitation #:	**95PEBP-S1711**

AMENDMENT # 2

TO CONTRACT FOR SERVICES OF INDEPENDENT CONTRACTOR

Between the State of Nevada
Acting By and Through Its

Agency Name:	**Public Employees' Benefits Program**
Address:	**3427 Goni Road, Suite 109**
City, State, Zip Code:	**Carson City, NV 89706**
Contact:	**Michelle Weyland**
Phone:	**775-684-7020**
Fax:	**775-684-7028**
Email:	**mweyland@peb.nv.gov**

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

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

   A. **Provide a brief explanation for contract amendment.**

   This is the second amendment to the original contract. This amendment incorporates the 2024 Nevada Public Employees' Benefit Program Preventive Medications List, Express Scripts' Rebate Reconciliation Methodology change, and the Plan Year 2024 ESI Market Check pricing adjustments.

   B. **Current Contract Language:**

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

ATTACHMENT AA:	NEGOTIATED ITEMS
ATTACHMENT BB:	INSURANCE SCHEDULE
ATTACHMENT CC:	PERFORMANCE GUARANTEES
ATTACHMENT DD:	FEE SCHEDULE (CONFIDENTIAL) Effective 7/1/2023

CETS #:	
Solicitation #:	95PEBP-S1711

ATTACHMENT EE:	BUSINESS ASSOCIATE ADDENDUM
ATTACHMENT FF:	STATE SOLICITATION OR RFP # 95PEBP-S1711 and AMENDMENT(S)
ATTACHMENT GG:	VENDOR PROPOSAL #95PEBP-VQ10761
ATTACHMENT HH:	STATE SOLICITATION OR RFP #95PEBP-S1711 and CONFIDENTIAL VENDOR PROPOSAL

C. **Amended Contract Language:**

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

ATTACHMENT AA:	NEGOTIATED ITEMS
ATTACHMENT BB:	INSURANCE SCHEDULE
ATTACHMENT CC:	PERFORMANCE GUARANTEES
ATTACHMENT DD:	FEE SCHEDULE (CONFIDENTIAL) Effective 7/1/2023
ATTACHMENT EE:	BUSINESS ASSOCIATE ADDENDUM
ATTACHMENT FF:	STATE SOLICITATION OR RFP # 95PEBP-S1711 and AMENDMENT(S)
ATTACHMENT GG:	VENDOR PROPOSAL #95PEBP-VQ10761
ATTACHMENT HH:	STATE SOLICITATION OR RFP #95PEBP-S1711 and CONFIDENTIAL VENDOR PROPOSAL
ATTACHMENT II:	EXPRESS SCRIPTS' REBATE RECONCILIATION METHODOLOGY
ATTACHMENT JJ:	2024 PEBP PREVENTIVE MEDICATIONS LIST
ATTACHMENT KK:	2024 PBM PRICING SUPPLEMENT

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

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

CETS #:	
Solicitation #:	**95PEBP-S1711**

IN WITNESS WHEREOF, the parties hereto have caused this amendment to the original contract to be signed and intend to be legally bound thereby.

DocuSigned by:
Jim Engler
11795BFA0F3749F...

05/11/2024 | 7:16 AM EDT

VP, Account Management

Independent Contractor's Signature — Date — Independent Contractor's Title

State of Nevada Authorized Signature — Date — Title

State of Nevada Authorized Signature — Date — Title

State of Nevada Authorized Signature — Date — Title

APPROVED BY BOARD OF EXAMINERS

Signature – Board of Examiners

On: _____
Date

Approved as to form by:

On: _____

Deputy Attorney General for Attorney General — Date

CETS #:	**25582**
Solicitation #:	**95PEBP-S1711**

AMENDMENT # 1

Between the State of Nevada
Acting by and Through Its

Public Employees' Benefits Program
901 S. Stewart Street, Suite 1001
Carson City, NV, 89701
Contact: Michelle Weyland
Phone: (775) 684-7020 Fax: (775) 684-7028
Email: mweyland@peb.nv.gov

and

Express Scripts, Inc.
One Express Way
St. Louis, Missouri 63121
Contact: Roger Holland
Phone: (949) 499-2042
Email: roger_holland@express-scripts.com

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

   A. This is the first amendment to the original contract for Pharmacy Benefit Manager services. This amendment updates Attachment DD – Fee Schedule (Confidential).

   B. **Current Contract Language:**

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

ATTACHMENT AA:	NEGOTIATED ITEMS
ATTACHMENT BB:	INSURANCE SCHEDULE
ATTACHMENT CC:	PERFORMANCE GUARANTEES
ATTACHMENT DD:	FEE SCHEDULE (CONFIDENTIAL)
ATTACHMENT EE:	BUSINESS ASSOCIATE ADDENDUM
ATTACHMENT FF:	STATE SOLICITATION OR RFP # 95PEBP-S1711 and AMENDMENT(S)
ATTACHMENT GG:	VENDOR PROPOSAL #95PEBP-VQ10761
ATTACHMENT HH:	STATE SOLICITATION OR RFP #95PEBP-S1711 and CONFIDENTIAL VENDOR PROPOSAL

CETS #:	**25582**
Solicitation #:	**95PEBP-S1711**

C. **Amended Contract Language:**

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

ATTACHMENT AA:	NEGOTIATED ITEMS
ATTACHMENT BB:	INSURANCE SCHEDULE
ATTACHMENT CC:	PERFORMANCE GUARANTEES
ATTACHMENT DD:	FEE SCHEDULE (CONFIDENTIAL) Effective 7/1/2023
ATTACHMENT EE:	BUSINESS ASSOCIATE ADDENDUM
ATTACHMENT FF:	STATE SOLICITATION OR RFP # 95PEBP-S1711 and AMENDMENT(S)
ATTACHMENT GG:	VENDOR PROPOSAL #95PEBP-VQ10761
ATTACHMENT HH:	STATE SOLICITATION OR RFP #95PEBP-S1711 and CONFIDENTIAL VENDOR PROPOSAL

CETS #:	25582
SoJicitation #:	95PEBP-S1711

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

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

IN WITNESS WHEREOF, the parties hereto have caused this amendment to the original contract to be signed and intend to be legally bound thereby.

DocuSigned by:
Jim Engler

05/15/2023 | 5:15 PM EDT VP, Account Management

Independent Contractor's Signature | Date | Independent Contractor's Title

Laura Rich 5/19/23

Laura Rich | Date

PEBP Executive Officer
Title

APPROVED BY BOARD OF EXAMINERS

Signature - Board of Examiners

On: _____
Date

Approved as to form by:

[redacted]D
Deputy Attorney General
Attorney General for

On: 7/03/23
Date

Revised: August 2019

A PROPOSAL TO PROVIDE

PHARMACY BENEFIT MANAGEMENT SERVICES

STATE OF NEVADA

EFFECTIVE 7/1/2023

APRIL 27, 2023

EXHIBIT A

PRICING TERMS AND PHARMACY PROGRAM FEES

Exhibit A-1
Billing, Payment, and Miscellaneous Pricing Terms

Exhibit A-2
Claims Reimbursement Rates

Exhibit A-3
Manufacturer Payments

Exhibit A-4
Administrative Services and Clinical Program Fees

Exhibit A-1

Term, Billing, Payment, and Miscellaneous Pricing Terms

1. TERM. This Agreement will commence as of July 1, 2022 and will continue for a period of four (4) years ("Initial Term"). The Initial Term plus any renewal terms will be known as the Term ("Term"). Thereafter, at Sponsors discretion, this Agreement may be renewed for an additional two (2) years, subject to the right of termination as otherwise provided herein.

2. BILLING AND PAYMENT.

   a. Billing. ESI will invoice Sponsor: [redacted]

   b. Payment. [redacted]

3. PHARMACY MANAGEMENT FUND ("PMF").

   a. [redacted]

   b. [redacted]

   c. [redacted]

   d. [redacted]

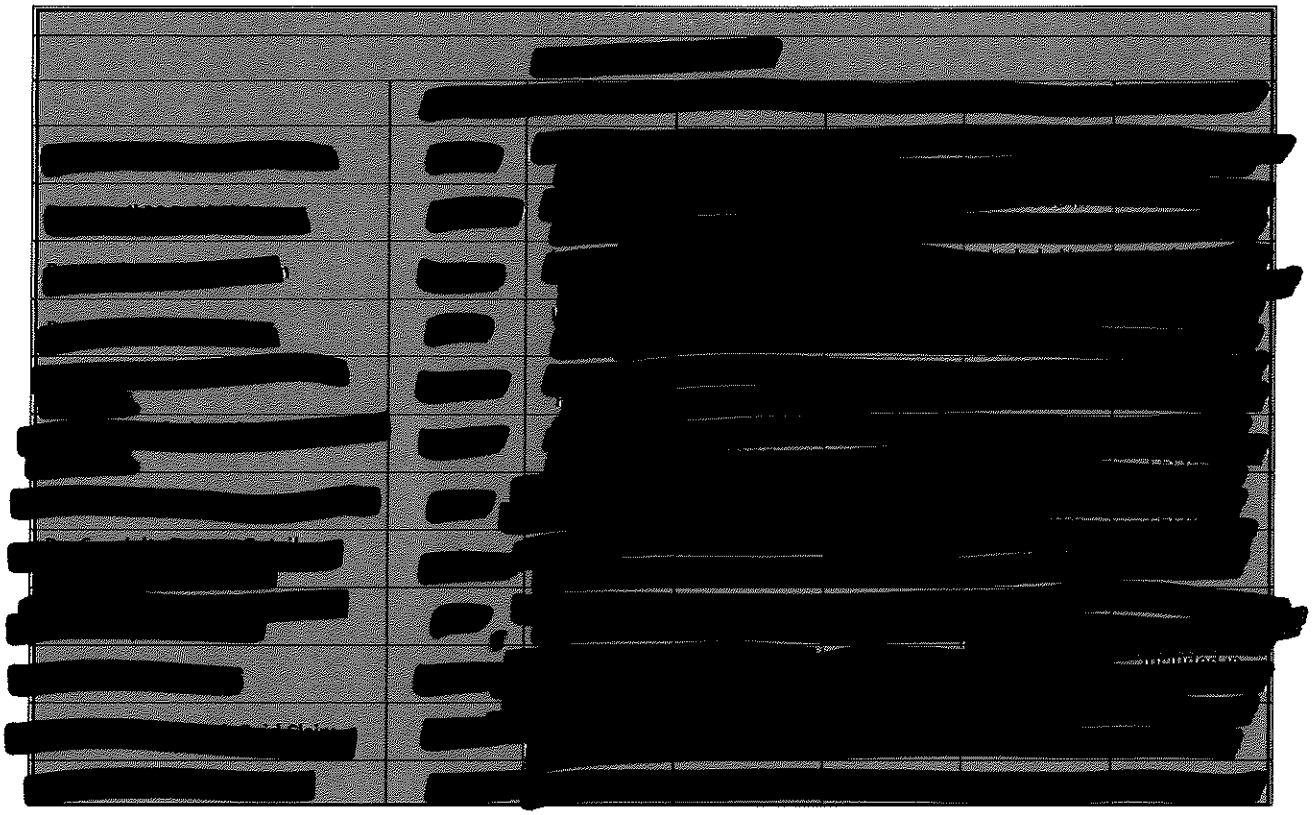
Exhibit A-2

Claims Reimbursement Rates

Sponsor will pay to ESI for each Prescription Drug Claim dispensed or processed pursuant to the terms of this Agreement. Sales or excise tax or other governmental surcharge, if any, will be the responsibility of Sponsor.

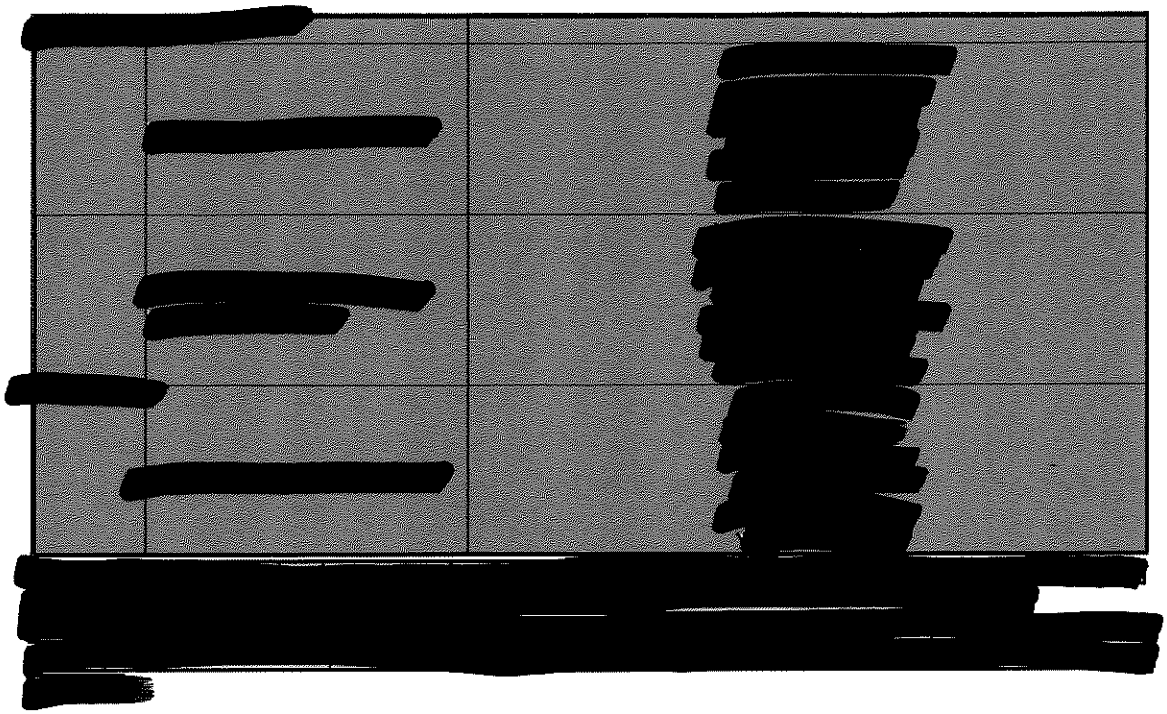
1. BASE ADMINISTRATIVE FEES.

1.1. Sponsor will pay ESI the following base Administrative Fees on all claims processed by ESI under this Agreement. These shall be in addition to any other Administrative Fees set forth in this Agreement.



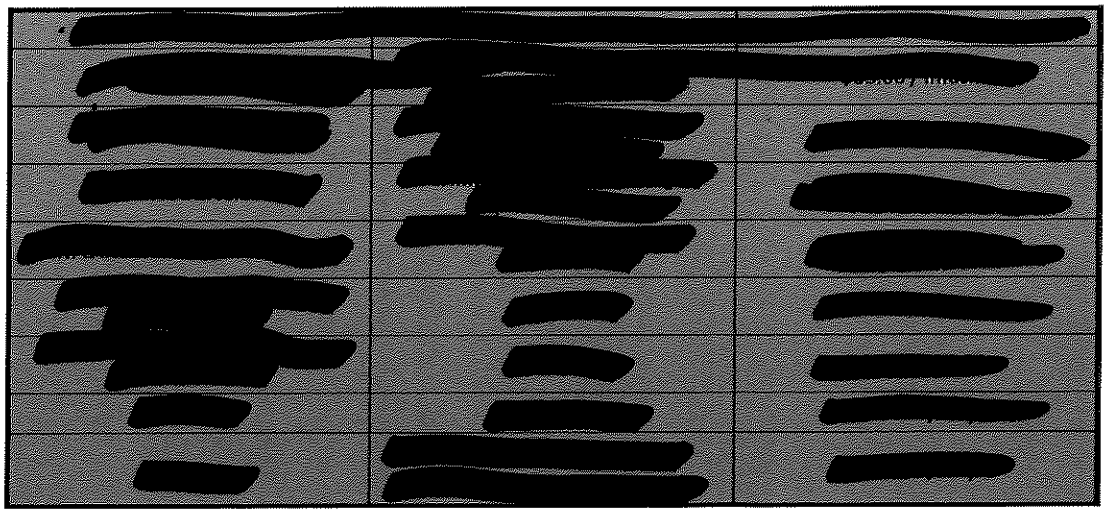
2. PARTICIPATING PHARMACY AND ESI MAIL PHARMACY AVERAGE AGGREGATE ANNUAL INGREDIENT COST AND DISPENSING FEE GUARANTEES (DOES NOT APPLY TO MAIL SPECIALTY PRODUCTS).

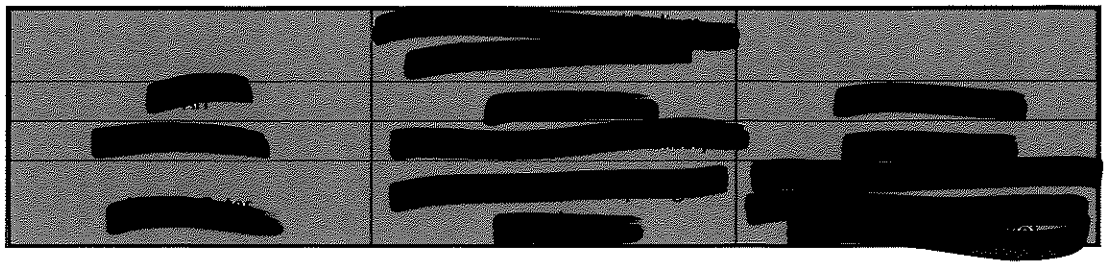
2.1. **Participating Pharmacy Commercial Ingredient Cost and Dispensing Fees**



3.2.

3.3. ASES. For Specialty Products needing an additional charge to cover costs of all ASES required to administer the Specialty Products, ESI or ESI Specialty Pharmacy will bill, at ESI's option, either the Sponsor's medical plan or the Sponsor directly at the following standard per diem and nursing fee rates set forth below, maintained and updated by ESI from time to time. If ESI elects to bill Sponsor's medical plan for ASES, Sponsor will work with ESI to coordinate the invoicing and payment of ASES through Sponsor's medical plan. If Sponsor's medical plan will not cover the cost of ASES billed through ESI or ESI Specialty Pharmacy, Sponsor shall be responsible for the costs of all ASES. Unless otherwise set forth in an agreement directly between ESI Specialty Pharmacy and Sponsor or a Plan, if a Specialty Product dispensed or ASES provided by ESI Specialty Pharmacy is billed to Sponsor or a Plan directly by ESI Specialty Pharmacy instead of being processed through ESI, Sponsor or Plan will timely pay ESI Specialty Pharmacy for such claim pursuant to the rates below and within thirty (30) days of Sponsor's, Plan's, or its designee's, receipt of such electronic or paper claim from ESI Specialty Pharmacy. ESI Specialty Pharmacy shall have 360 days from the date of service to submit such electronic or paper claim.



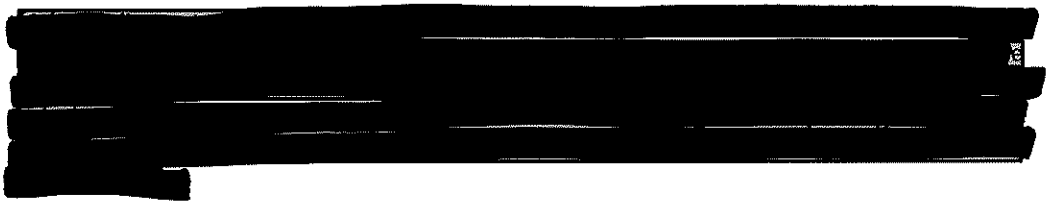


4. COMPOUND DRUG PRICING.

	ALL YEARS
Compounds (not listed elsewhere)	Pass-Through

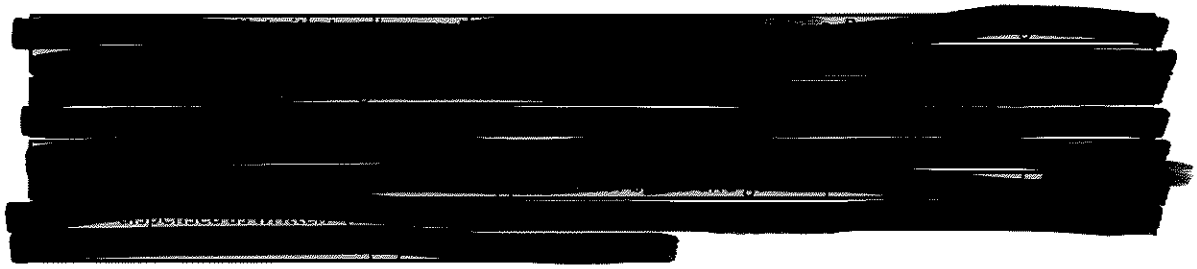
5. GENERAL PRICING TERMS. The following terms are applicable to all pricing terms set forth in this Agreement.

5.1. Calculation of Ingredient Cost Guarantees. ESI will guarantee an average aggregate annual discounts to Sponsor to be calculated as follows:

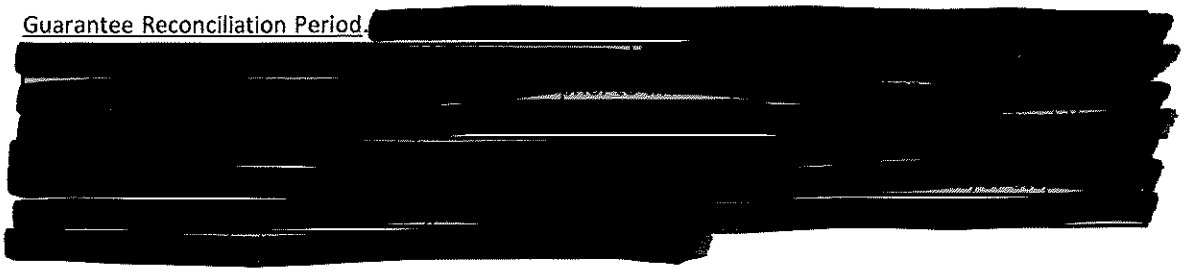


5.2. Calculation of Dispensing Fee Guarantees. ESI will guarantee an average aggregate annual per Prescription Drug Claim dispensing fee to Sponsor to be calculated as follows:

5.3.



5.4. Guarantee Reconciliation Period.



[redacted]

6. VACCINE CLAIMS (NO VACCINE CLAIMS WILL BE INCLUDED IN ANY MANUFACTURER PAYMENT GUARANTEE SET FORTH IN THE AGREEMENT).

6.1. General Terms applicable to Vaccine Claims

a. "Vaccine Claim" means a claim for a Covered Drug which is a vaccine.

b. "Vaccine Vendor Transaction Fee" means the data interchange fee that ESI is charged by its third party vendor to convert Vaccine Claims submitted electronically by physicians to NCPDP 5.1 format in order for ESI to process the claim.

c. [redacted]

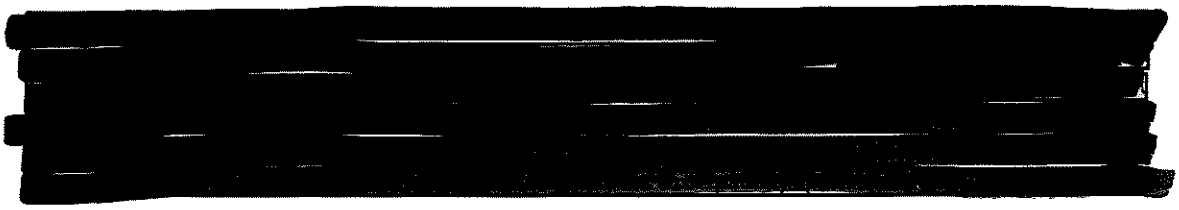
d. [redacted]

e. [redacted]

f. [redacted]

6.2. Commercial (Including Medicaid and Exchange, if applicable)

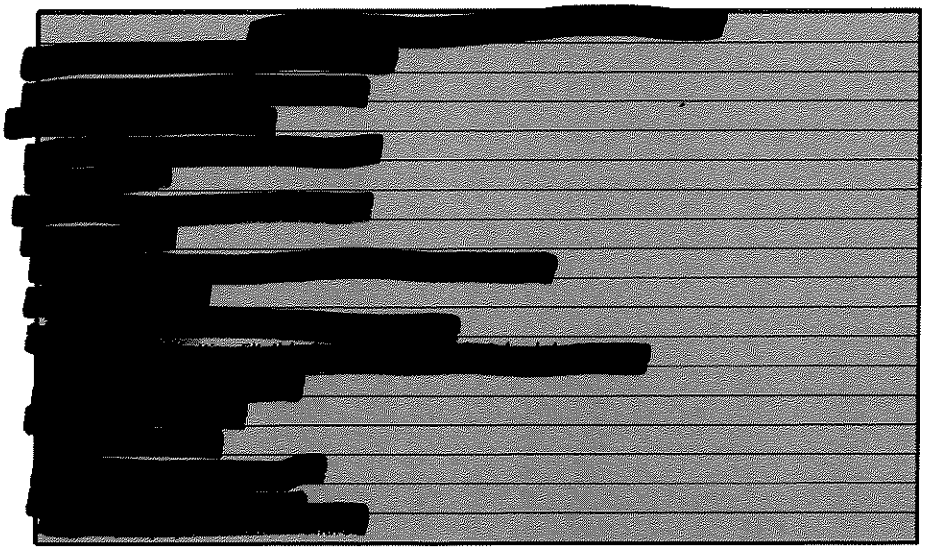
[redacted]



3 CONDITIONS (APPLIES TO ALL MANUFACTURER PAYMENTS)

3.1 ESI contracts for Manufacturer Payments on its own behalf and for its own benefit, and not on behalf of Sponsor. Accordingly, ESI retains all right, title and interest to any and all actual Manufacturer Payments received. ESI will pay Sponsor amounts equal to the Manufacturer Payment amounts allocated to Sponsor, as specified above, from ESI's general assets (neither Sponsor, its Members, nor Sponsor's plan retains any beneficial or proprietary interest in ESI's general assets). Sponsor acknowledges and agrees that neither it, its Members, nor its Plan will have a right to interest on, or the time value of, any Manufacturer Payment payments received by ESI during the collection period or moneys payable under this Section. No amounts for Manufacturer Payments will be paid until this Agreement is executed by Sponsor. ESI will have the right to apply Sponsor's allocated Manufacturer Payment amounts to unpaid Fees.

3.2 Guarantee Exclusions: The following are not eligible for guaranteed Manufacturer Payment amounts (if any):



3.3 Sponsor acknowledges that it may be eligible for Manufacturer Payment amounts under this Agreement only so long as Sponsor, its affiliates, or its agents do not contract directly or indirectly with anyone else for discounts, utilization limits, rebates or other financial incentives on pharmaceutical products or formulary programs for claims processed by ESI pursuant to the Agreement, without the prior written consent of ESI. In the event that Sponsor negotiates or arranges for Manufacturer Payments or similar discounts for any Covered Drugs

hereunder, but without limiting ESI's right to other remedies, ESI may immediately withhold any Manufacturer Payments amounts earned but not yet paid to Sponsor. To the extent Sponsor knowingly negotiates and/or contracts for discounts or rebates on claims for Covered Drugs without prior written approval of ESI, such activity will be deemed to be a material breach of this Agreement, entitling ESI to suspend payment of Manufacturer Payments, amounts hereunder and to renegotiate the terms and conditions of this Agreement.

3.4 [redacted]

3.5 Under its Rebate program, ESI may implement ESI's Formulary management programs and controls, which may include, among other things, cost containment initiatives, and communications with Members, Participating Pharmacies, and/or physicians. ESI reserves the right to modify or replace such programs from time to time. Guaranteed Manufacturer Payment amounts, if any, set forth herein, are conditioned on adherence to various Formulary management controls, benefit design requirements, claims volume, and other factors stated in the applicable rebate agreements, as communicated by ESI to Sponsor from time to time. If any government action, change in law or regulation, change in the interpretation of any law or regulation, or any action by a pharmaceutical manufacturer has an adverse effect on the availability of Manufacturer Payments, then ESI may make an adjustment to the Manufacturer Payment terms and guaranteed Manufacturer Payment amounts, if any, hereunder.

3.6 Manufacturer Payment amounts paid to Sponsor pursuant to this Agreement are intended to be treated as "discounts" pursuant to the federal anti-kickback statute set forth at 42 U.S.C. §1320a-7b and implementing regulations. Sponsor is obligated if requested by the Secretary of the United States Department of Health and Human Services, or as otherwise required by applicable law, to report the Manufacturer Payment amounts and to provide a copy of this notice. ESI will refrain from doing anything that would impede Sponsor from meeting any such obligation.

FINANCIAL DISCLOSURE TO ESI PBM CLIENTS

This disclosure provides an overview of the principal revenue sources of Express Scripts, Inc. and Medco Health Solutions, Inc. (individually and collectively referred to herein as "ESI"), as well as ESI's affiliates. In addition to administrative and dispensing fees paid to ESI by our clients for pharmaceutical benefit management ("PBM") services, ESI and its affiliates derive revenue from other sources, including arrangements with pharmaceutical manufacturers, wholesale distributors, and retail pharmacies. Some of this revenue relates to utilization of prescription drugs by members of the clients receiving PBM services. ESI may pass through certain manufacturer payments to its clients or may retain those payments for itself, depending on the contract terms between ESI and the client.

Relationship with Cigna Corporation. On December 20, 2018, ESI's parent company, Express Scripts Holding Company, was acquired by Cigna Corporation.

Relationship with Evernorth Health, Inc. Evernorth Health, Inc., a wholly-owned subsidiary of Cigna Corporation, is the parent company of ESI.

Network Pharmacies – ESI contracts for its own account with retail pharmacies to dispense prescription drugs to client members. Rates paid by ESI to these pharmacies may differ among networks (e.g., Medicare, Worker's Comp, open and limited), and among pharmacies within a network, and by client arrangements. PBM agreements generally provide that a client pays ESI an ingredient cost, plus dispensing fee, for drug claims. If the rate paid by a client exceeds the rate contracted with a particular pharmacy, ESI will realize a positive margin on the applicable claim. The reverse also may be true, resulting in negative margin for ESI. ESI also enters into pass-through arrangements where the client pays ESI the actual ingredient cost and dispensing fee amount paid by ESI for the particular claim when the claim is adjudicated to the pharmacy. In addition, when ESI receives payment from a client before payment to a pharmacy, ESI retains the benefit of the use of the funds between these payments. ESI may maintain non-client specific aggregate guarantees with pharmacies and may realize positive margin. ESI may charge pharmacies standard transaction fees to access ESI's pharmacy claims systems and for other related administrative purposes. ESI may also maintain certain preferred value or quality networks; pharmacies participating in those networks may pay or receive aggregated payments related to these networks.

Brand/Generic Classifications – Prescription drugs may be classified as either a "brand" or "generic;" however, the reference to a drug by its chemical name does not necessarily mean that the product is recognized as a generic for adjudication, pricing or copay purposes. For the purposes of pharmacy reimbursement, ESI distinguishes brands and generics through a proprietary algorithm ("BGA") that uses certain published elements provided by First DataBank (FDB), a third-party vendor, including price indicators, Generic Indicator, Generic Manufacturer Indicator, Generic Name Drug Indicator, Innovator, Drug Class and abbreviated new drug application (ANDA). The BGA uses these data elements in a hierarchical process to categorize the products as brand or generic. The BGA also has processes to resolve discrepancies and prevent "flipping" between brand and generic status due to price fluctuations and marketplace availability changes. The elements listed above and sources are subject to change based on the availability of the specific fields. Updated summaries of the BGA are available upon request. Brand or generic classification for client reimbursement purposes is either based on the BGA or specific code indicators from Medi-Span, a third-party vendor, or a combination of the two as reflected in the client's specific contract terms. Application of an alternative methodology based on specific client contract terms does not affect ESI's application of its BGA for ESI's other contracts.

Maximum Allowable Cost ("MAC")/Maximum Reimbursement Amount ("MRA") – As part of the administration of the PBM services, ESI maintains a MAC List of drug products identified as requiring pricing management due to the number of manufacturers, utilization and/or pricing volatility. The criteria for inclusion on the MAC List are based on whether the drug has readily available generic product(s), is generally equivalent to a brand drug, is cleared of any negative clinical implications, and has a cost basis that will allow for pricing below brand rates. ESI also maintains MRA price lists for drug products on the MAC List based on current price reference data provided by MediSpan or other nationally recognized pricing sources, market pricing and availability information from generic manufacturers and on-line research of national wholesale drug company files, and client arrangements. Similar to the BGA, the elements listed above and sources are subject to change based on the availability of the specific fields. Updated summaries of the MAC methodology are available upon request.

Manufacturer Programs Formulary Rebates, Associated Administrative Fees, and PBM Service Fees – ESI contracts with manufacturers and/or group purchasing organizations ("GPOs") for its own account to obtain formulary rebates attributable to the utilization of certain drugs and supplies. Formulary rebate amounts received vary based on client specific utilization, the volume of utilization as well as formulary position applicable to the drug or supplies, and adherence to various formulary management controls, benefit design requirements, claims volume, and other similar factors, and in certain instances also may vary based on the product's market-share. ESI pays formulary rebates it receives to a client based on the client's PBM agreement terms and may realize positive margin. In addition, ESI provides administrative services to contracted manufacturers, which include, for example, maintenance and operation of systems and other infrastructure necessary for invoicing and processing rebates, pharmacy discount programs, access to drug utilization data, as allowed by law, for purposes of verifying and evaluating applicable payments, and for other purposes related to the manufacturer's products. ESI receives administrative fees directly from participating manufacturers and indirectly from GPOs. In its capacity as a PBM company, ESI may receive other compensation from manufacturers for the performance of various programs or

services, including, for example, formulary compliance initiatives, clinical services, therapy management services, education services, inflation protection programs, medical benefit management services, cost containment programs, discount programs, and the sale of non-patient identifiable claim information. This compensation is not part of the formulary rebates or associated administrative fees, and ESI may realize positive margin between amounts paid to clients and amounts received. ESI retains the financial benefit of the use of any funds held until payment is made to the client.

Copies of ESI's standard formularies may be reviewed at https://www.controlcenter.com/.

Third Party Offerings - ESI partners with multiple third party vendors to provide clinical programs and other product offerings to clients. ESI may have an ownership interest in certain third party vendors.

ESI Subsidiary Pharmacies – ESI has several licensed pharmacy subsidiaries, including our specialty pharmacies. These entities may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers, wholesale distributors, and other health care providers. These subsidiary pharmacies contract for these arrangements on their own account in support of their various pharmacy operations. Many of these subsidiary arrangements relate to services provided outside of PBM arrangements, and may be entered into irrespective of whether the particular drug is on one of ESI's national formularies. Discounts and fee-for-service payments received by ESI's subsidiary pharmacies are not part of the PBM formulary rebates or associated administrative fees paid to ESI in connection with ESI's PBM formulary rebate programs. However, certain purchase discounts received by ESI's subsidiary pharmacies, whether directly or through ESI, may be considered for formulary purposes if the value of such purchase discounts is used by ESI to supplement the discount on the ingredient cost of the drug to the client based on the client's PBM agreement terms. From time to time, ESI and its affiliates also may pursue and maintain for its own account other supply chain sourcing relationships not described below as beneficial to maximize ESI's drug purchasing capabilities and efficiencies, and ESI or affiliates may realize an overall positive margin with regard to these initiatives.

The following provides additional information regarding examples of ESI subsidiary discount arrangements and fee-for-service arrangements with pharmaceutical manufacturers, and wholesale distributors:

ESI Subsidiary Pharmacy Discount Arrangements – ESI subsidiary pharmacies purchase prescription drug inventories, either from manufacturers or wholesalers, for dispensing to patients. Often, purchase discounts off the acquisition cost of these products are made available by manufacturers and wholesalers in the form of either up-front discounts or retrospective discounts. These purchase discounts, obtained through separate purchase contracts, are not formulary rebates paid in connection with our PBM formulary rebate programs. Drug purchase discounts are based on a pharmacy's inventory needs and, at times, the performance of related patient care services and other performance requirements. When a subsidiary pharmacy dispenses a product from its inventory, the purchase price paid for the dispensed product, including applicable dispensing fees, may be greater or less than that pharmacy's acquisition cost for the product net of purchase discounts. In general, our pharmacies realize an overall positive margin between the net acquisition cost and the amounts paid for the dispensed drugs.

ESI Subsidiary Fee-For-Service Arrangements – One or more of ESI's subsidiaries, including, but not limited to, its subsidiary pharmacies also may receive fee-for-service payments from manufacturers, wholesalers, or other health care providers in conjunction with various programs or services, including, for example, patient assistance programs for indigent patients, dispensing prescription medications to patients enrolled in clinical trials, various therapy adherence and fertility programs, administering FDA compliance requirements related to the drug, 340B contract pharmacy services, product reimbursement support services, and various other clinical or pharmacy programs or services. As a condition to having access to certain products, and sometimes related to certain therapy adherence criteria or FDA requirements, a pharmaceutical manufacturer may require a pharmacy to report selected information to the manufacturer regarding the pharmacy's service levels and other dispensing-related data with respect to patients who receive that manufacturer's product. A portion of the discounts or other fee-for-service payments made available to our pharmacies may represent compensation for such reporting.

Other Manufacturer Arrangements – ESI also maintains other lines of business that may involve discount and service fee relationships with pharmaceutical manufacturers and wholesale distributors. Examples of these businesses include a wholesale distribution business, group purchasing organizations (and related group purchasing organization fees), and a medical benefit management company. Compensation derived through these business arrangements is not considered for PBM formulary placement, and is in addition to other amounts described herein. These service fees are not part of the formulary rebates or associated administrative fees.

Third Party Data Sales – Consistent with any client contract limitations, ESI or its affiliates may sell HIPAA compliant information maintained in their capacity as a PBM, pharmacy, or otherwise to data aggregators, manufacturers, or other third parties on a fee-for-service basis or as a condition of discount eligibility. All such activities are conducted in compliance with applicable patient and pharmacy privacy laws and client contract restrictions.

August 4, 2022

THIS EXHIBIT REPRESENTS ESI'S FINANCIAL POLICIES. ESI MAY PERIODICALLY UPDATE THIS EXHIBIT AND THE FINANCIAL DISCLOSURES CONTAINED HEREIN TO REFLECT CHANGES IN ITS BUSINESS PROCESSES; THE CURRENT FINANCIAL DISCLOSURE IS AVAILABLE UPON REQUEST AND ACCESSIBLE ON HTTPS://WWW.EXPRESS-SCRIPTS.COM/CORPORATE AND HTTPS://WWW.CONTROLCENTER.COM/.

Attachment II

[redacted]

Signed:

[redacted]

EXPRESS SCRIPTS, INC.

By: [signature]

Printed Name: Keith Urich

Title: VP / GM Market Coalitions

Date: August 7, 2023

Submit

PEBP
NEVADA PUBLIC EMPLOYEES BENEFITS PROGRAM

EXPRESS SCRIPTS®

2024 Nevada Public Employees Benefit Program Preventive Medications List

This list provides examples of commonly prescribed preventive medications. It is not an all-inclusive list; however, many examples of the medications are listed in each category.

This list does not indicate coverage. Please check with your plan administrator and/or benefit information materials if you have questions on coverage. Your cost share will be determined by your plan's drug coverage and formulary plan.

Coverage prior to the deductible being met may not be provided for every strength or dosage form of a listed medication.

Please note: When feasible, brand names are shown in capitals in each category. If generic is available, it is listed in lowercase next to the brand name. If only generics are available (for example, brands are no longer available), they will only be listed in lowercase.

ASTHMA/COPD

ADVAIR HFA
AIRDUO DIGIHALER
AIRSUPRA
albuterol HFA
albuterol nebulizer solution
albuterol oral
ANORO ELLIPTA
ARNUITY ELLIPTA
ASMANEX HFA
ASMANEX TWISTHALER
ATROVENT HFA
BREO ELLIPTA
BREZTRI AEROSPHERE
budesonide oral inhalation
COMBIVENT RESPIMAT
cromolyn nebulizer solution
DULERA
FASENRA
formoterol
ipratropium/albuterol nebulizer solution
ipratropium nebulizer solution
LONHALA MAGNAIR
metaproterenol
montelukast
NUCALA
QVAR REDIHALER
roflumilast
SPIRIVA RESPIMAT
STIOLTO RESPIMAT
terbutaline oral
TEZSPIRE

ASTHMA/COPD (continued)

THEO-24
theophylline
TRELEGY ELLIPTA
XOLAIR
YUPELRI
zileuton ER
ZYFLO

BONE DISEASE AND FRACTURES

ATELVIA DR (risedronate DR)
BINOSTO
DUAVEE

CAVITIES

CLINPRO
periomed
sodium fluoride rinse, gel, cream, paste, tabs and drops

COLONOSCOPY PREPARATION*

gavilyte-c
gavilyte-n
sodium, potassium and magnesium sulfates
SUFLAVE
SUTAB

DEPRESSION

citalopram
escitalopram
fluoxetine
fluoxetine DR
fluvoxamine
fluvoxamine ER
sertraline

HEART DISEASE AND STROKE

BLOOD THINNERS

aspirin, 81 mg* & 325 mg
aspirin/dipyridamole ER
BRILINTA
clopidogrel
dabigatran
dipyridamole
DURLAZA ER
ELIQUIS
jantoven
warfarin
XARELTO
ZONTIVITY

(over, please)

Attachment JJ

2024 Nevada Public Employees Benefit Program
Preventive Medications List

CHOLESTEROL LOWERING

HMG-COA REDUCTASE INHIBITORS*

ATORVALIQ
atorvastatin
FLOLIPID suspension
fluvastatin
LIVALO
lovastatin
pravastatin
rosuvastatin
simvastatin
ZYPITAMAG

OTHER CHOLESTEROL LOWERING AGENTS

colesevelam
ezetimibe
ezetimibe/simvastatin
NEXLETOL
NEXLIZET
NIACOR
niacin
ROSZET

HIGH BLOOD PRESSURE (HBP)

ACE INHIBITORS

captopril
fosinopril
moexipril
perindopril
trandolapril

ACE INHIBITORS/DIURETIC COMBINATIONS

captopril/HCTZ
fosinopril/HCTZ

ANGIOTENSIN II RECEPTOR ANTAGONISTS

candesartan
eprosartan
irbesartan
losartan
olmesartan
telmisartan
valsartan

ANGIOTENSIN II RECEPTOR ANTAGONISTS/DIURETIC COMBINATIONS

candesartan/HCTZ
irbesartan/HCTZ
losartan/HCTZ
olmesartan/HCTZ
telmisartan/HCTZ
valsartan/HCTZ

BETA BLOCKERS

acebutolol
betaxolol
bisoprolol
metoprolol succinate ER
nebivolol
pindolol
propranolol
propranolol ER
timolol

BETA BLOCKER/DIURETIC COMBINATIONS

metoprolol/HCTZ
propranolol/HCTZ
TENORETIC (atenolol/chlorthalidone)

CALCIUM CHANNEL BLOCKERS

amlodipine
felodipine ER
isradipine
nicardipine
nifedipine
SULAR ER (nisoldipine ER)
TIAZAC ER (diltiazem ER, tiadylt ER, taztia XT)
verapamil
verapamil ER

DIURETICS

chlorthalidone
DIURIL suspension
hydrochlorothiazide
indapamide
metolazone

OTHER HBP & COMBINATIONS

amlodipine/benazepril
amlodipine/olmesartan
amlodipine/olmesartan/HCTZ
amlodipine/telmisartan
amlodipine/valsartan
amlodipine/valsartan/HCTZ
Blood pressure monitors
PRESTALIA
trandolapril/verapamil ER)

MALARIA

ARAKODA
chloroquine
mefloquine

MISC ANTIVIRALS

APRETUDE*
BEYFORTUS
DESCOVY*
emtricitabine/ tenofovir disoproxil fumarate (TDF) 200mg/300mg*
PREVYMIS
SYNAGIS

OBESITY

benzphetamine
diethylpropion
diethylpropion ER
phendimetrazine
phendimetrazine ER

SMOKING-CESSATION*

bupropion SR 150mg
CHANTIX (varenicline)
NICOTROL
NICOTROL NS

Attachment JJ

2024 Nevada Public Employees Benefit Program
Preventive Medications List

VACCINATION*

Anthrax, BCG, Cholera, COVID-19, Diphtheria, Haemophilus Influenza B, Hepatitis A and B, Human Papillomavirus, Influenza, Japanese Encephalitis, Measles, Meningococcal, Monkey/smallpox, Mumps, Pertussis, Pneumococcal, Poliovirus, Rabies, Respiratory syncytial virus, Rotavirus, Rubella, Shingles, Tetanus, Tick-borne encephalitis, Typhoid, Varicella, Yellow Fever, Zoster

VITAMINS OR MINERALS

Folic acid*
Prenatal vitamins
Pediatric multivitamins with fluoride*

*Please note that some of these medications are also subject to the Affordable Care Act (ACA) and may be covered by your plan at 100%.

Express Scripts manages your prescription benefit for your employer, plan sponsor, or health plan. For specific questions on coverage, please call the phone number on your member ID card or visit our website express-scripts.com.

ATTACHMENT KK

A PROPOSAL TO PROVIDE

PHARMACY BENEFIT MANAGEMENT SERVICES

NEVADA PEBP

2/29/2024

EXHIBIT A

PRICING TERMS AND PHARMACY PROGRAM FEES

Exhibit A-1
Claims Reimbursement Rates

Exhibit A-2
Rebates

Except as expressly provided herein, the terms and conditions of the Agreement between Express Scripts and Sponsor shall remain in full force and effect.

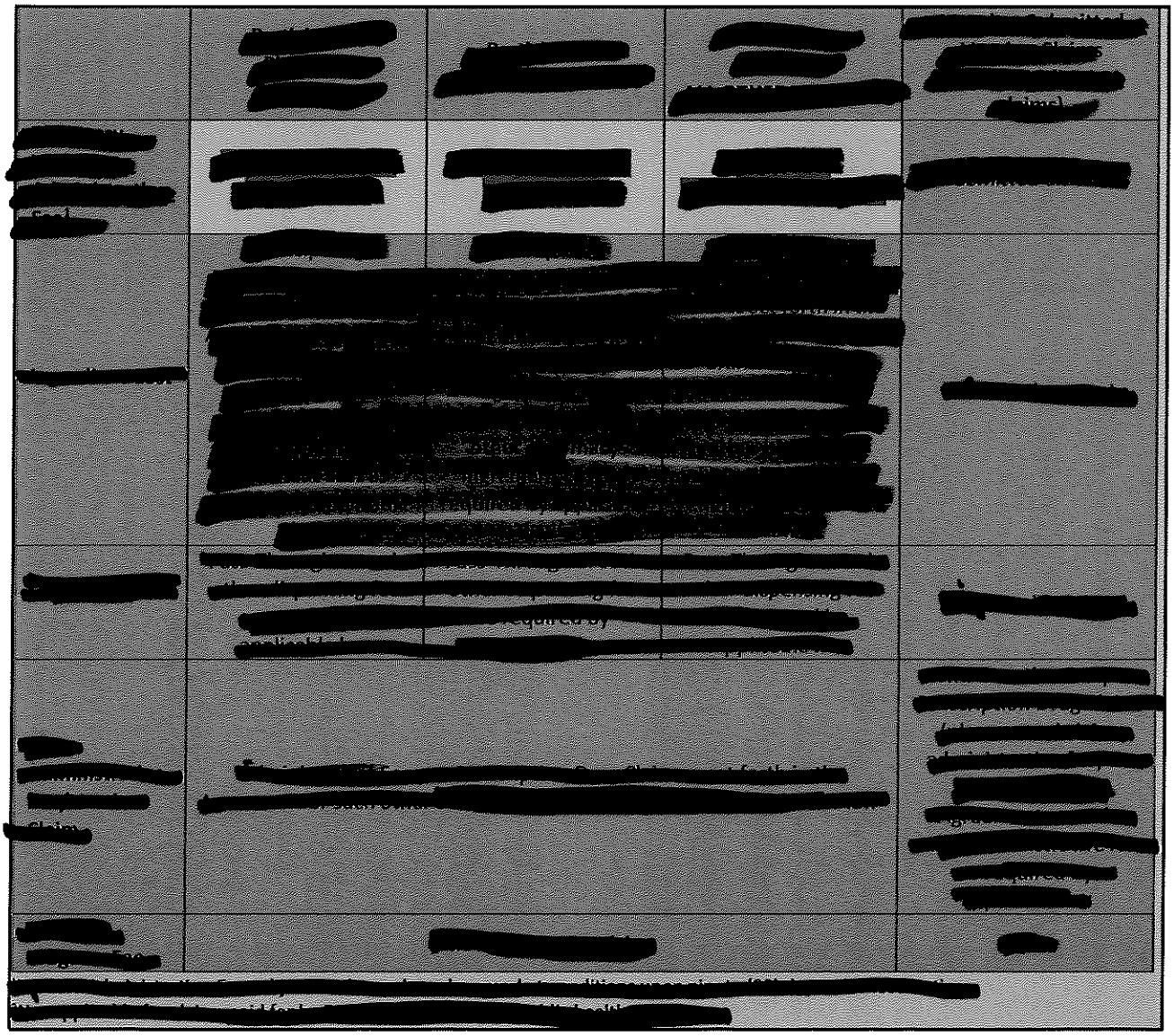
Exhibit A-1

Claims Reimbursement Rates

Sponsor will pay to ESI for each Prescription Drug Claim dispensed or processed pursuant to the terms of this Agreement. Sales or excise tax or other governmental surcharge, if any, will be the responsibility of Sponsor.

2. VACCINE CLAIMS

3.1. Commercial



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Relationship with The Cigna Group. On December 20, 2018, ESI's parent company, Express Scripts Holding Company, was acquired by The Cigna Group.

Relationship with Evernorth Health, Inc. Evernorth Health, Inc., a wholly-owned subsidiary of The Cigna Group, is the parent company of ESI.

Network Pharmacies – ESI contracts for its own account with retail pharmacies to dispense prescription drugs to client members. Rates paid by ESI to these pharmacies may differ among networks (e.g., Medicare, Worker's Comp, open and limited), and among pharmacies within a network, and by client arrangements. PBM agreements generally provide that a client pays ESI an ingredient cost, plus dispensing fee, for drug claims. If the rate paid by a client exceeds the rate contracted with a particular pharmacy, ESI will realize a positive margin on the applicable claim. The reverse also may be true, resulting in negative margin for ESI. ESI also enters into pass-through arrangements where the client pays ESI the actual ingredient cost and dispensing fee amount paid by ESI for the particular claim when the claim is adjudicated to the pharmacy. In addition, when ESI receives payment from a client before payment to a pharmacy, ESI retains the benefit of the use of the funds between these payments. ESI may maintain non-client specific aggregate guarantees with pharmacies and may realize positive margin. ESI may charge pharmacies standard transaction fees to access ESI's pharmacy claims systems and for other related administrative purposes. ESI may also maintain certain preferred value or quality networks; pharmacies participating in those networks may pay or receive aggregated payments related to these networks.

Brand/Generic Classifications – Prescription drugs may be classified as either a "brand" or "generic;" however, the reference to a drug by its chemical name does not necessarily mean that the product is recognized as a generic for adjudication, pricing or copay purposes. For the purposes of pharmacy reimbursement, ESI distinguishes brands and generics through a proprietary algorithm ("BGA") that uses certain published elements provided by First DataBank (FDB), a third-party vendor, including price indicators, Generic Indicator, Generic Manufacturer Indicator, Generic Name Drug Indicator, Innovator, Drug Class and abbreviated new drug application (ANDA). The BGA uses these data elements in a hierarchical process to categorize the products as brand or generic. The BGA also has processes to resolve discrepancies and prevent "flipping" between brand and generic status due to price fluctuations and marketplace availability changes. The elements listed above and sources are subject to change based on the availability of the specific fields. Updated summaries of the BGA are available upon request. Brand or generic classification for client reimbursement purposes is either based on the BGA or specific code indicators from Medi-Span, a third-party vendor, or a combination of the two as reflected in the client's specific contract terms. Application of an alternative methodology based on specific client contract terms does not affect ESI's application of its BGA for ESI's other contracts.

Maximum Allowable Cost ("MAC")/Maximum Reimbursement Amount ("MRA") – As part of the administration of the PBM services, ESI maintains a MAC List of drug products identified as requiring pricing management due to the number of manufacturers, utilization and/or pricing volatility. The criteria for inclusion on the MAC List are based on whether the drug has readily available generic product(s), is generally equivalent to a brand drug, is cleared of any negative clinical implications, and has a cost basis that will allow for pricing below brand rates. ESI also maintains MRA price lists for drug products on the MAC List based on current price reference data provided by MediSpan or other nationally recognized pricing sources, market pricing and availability information from generic manufacturers and on-line research of national wholesale drug company files, and client arrangements. Similar to the BGA, the elements listed above and sources are subject to change based on the availability of the specific fields. Updated summaries of the MAC methodology are available upon request.

Manufacturer Programs Formulary Rebates, Associated Administrative Fees, and PBM Service Fees – ESI contracts with manufacturers and/or group purchasing organizations ("GPOs") for its own account to obtain formulary rebates attributable to the utilization of certain drugs and supplies. Formulary rebate amounts received vary based on client specific utilization, the volume of utilization as well as formulary position applicable to the drug or supplies, and adherence to various formulary management controls, benefit design requirements, claims volume, and other similar factors, and in certain instances also may vary based on the product's market-share. ESI pays formulary rebates it receives to a client based on the client's PBM agreement terms and may realize positive margin. In addition, ESI provides administrative services to contracted manufacturers, which include, for example, maintenance and operation of systems and other infrastructure necessary for invoicing and processing rebates, pharmacy discount programs, access to drug utilization data, as allowed by law, for purposes of verifying and evaluating applicable payments, and for other purposes related to the manufacturer's products. ESI receives administrative fees directly from participating manufacturers and indirectly from GPOs. In its capacity as a PBM company, ESI may receive other compensation from manufacturers for the performance of various programs or services, including, for example, formulary compliance initiatives, clinical services, therapy management services, education services,

inflation protection programs, medical benefit management services, cost containment programs, discount programs, and the sale of non-patient identifiable claim information. This compensation is not part of the formulary rebates or associated administrative fees, and ESI may realize positive margin between amounts paid to clients and amounts received. ESI retains the financial benefit of the use of any funds held until payment is made to the client.

Copies of ESI's standard formularies may be reviewed at https://www.controlcenter.com/.

Third Party Offerings - ESI partners with multiple third party vendors to provide clinical programs and other product offerings to clients. ESI may have an ownership interest in certain third party vendors.

ESI Subsidiary Pharmacies – ESI has several licensed pharmacy subsidiaries, including our specialty pharmacies. These entities may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers, wholesale distributors, and other health care providers. These subsidiary pharmacies contract for these arrangements on their own account in support of their various pharmacy operations. Many of these subsidiary arrangements relate to services provided outside of PBM arrangements, and may be entered into irrespective of whether the particular drug is on one of ESI's national formularies. Discounts and fee-for-service payments received by ESI's subsidiary pharmacies are not part of the PBM formulary rebates or associated administrative fees paid to ESI in connection with ESI's PBM formulary rebate programs. However, certain purchase discounts received by ESI's subsidiary pharmacies, whether directly or through ESI, may be considered for formulary purposes if the value of such purchase discounts is used by ESI to supplement the discount on the ingredient cost of the drug to the client based on the client's PBM agreement terms. From time to time, ESI and its affiliates also may pursue and maintain for its own account other supply chain sourcing relationships not described below as beneficial to maximize ESI's drug purchasing capabilities and efficiencies, and ESI or affiliates may realize an overall positive margin with regard to these initiatives.

The following provides additional information regarding examples of ESI subsidiary discount arrangements and fee-for-service arrangements with pharmaceutical manufacturers, and wholesale distributors:

ESI Subsidiary Pharmacy Discount Arrangements – ESI subsidiary pharmacies purchase prescription drug inventories, either from manufacturers or wholesalers, for dispensing to patients. Often, purchase discounts off the acquisition cost of these products are made available by manufacturers and wholesalers in the form of either up-front discounts or retrospective discounts. These purchase discounts, obtained through separate purchase contracts, are not formulary rebates paid in connection with our PBM formulary rebate programs. Drug purchase discounts are based on a pharmacy's inventory needs and, at times, the performance of related patient care services and other performance requirements. When a subsidiary pharmacy dispenses a product from its inventory, the purchase price paid for the dispensed product, including applicable dispensing fees, may be greater or less than that pharmacy's acquisition cost for the product net of purchase discounts. In general, our pharmacies realize an overall positive margin between the net acquisition cost and the amounts paid for the dispensed drugs.

ESI Subsidiary Fee-For-Service Arrangements – One or more of ESI's subsidiaries, including, but not limited to, its subsidiary pharmacies also may receive fee-for-service payments from manufacturers, wholesalers, or other health care providers in conjunction with various programs or services, including, for example, patient assistance programs for indigent patients, dispensing prescription medications to patients enrolled in clinical trials, various therapy adherence and fertility programs, administering FDA compliance requirements related to the drug, 340B contract pharmacy services, product reimbursement support services, and various other clinical or pharmacy programs or services. As a condition to having access to certain products, and sometimes related to certain therapy adherence criteria or FDA requirements, a pharmaceutical manufacturer may require a pharmacy to report selected information to the manufacturer regarding the pharmacy's service levels and other dispensing-related data with respect to patients who receive that manufacturer's product. A portion of the discounts or other fee-for-service payments made available to our pharmacies may represent compensation for such reporting.

Other Manufacturer Arrangements – ESI also maintains other lines of business that may involve discount and service fee relationships with pharmaceutical manufacturers and wholesale distributors. Examples of these businesses include a wholesale distribution business, group purchasing organizations (and related group purchasing organization fees), and a medical benefit management company. Compensation derived through these business arrangements is not considered for PBM formulary placement, and is in addition to other amounts described herein. These service fees are not part of the formulary rebates or associated administrative fees.

Third Party Data Sales – Consistent with any client contract limitations, ESI or its affiliates may sell HIPAA compliant information maintained in their capacity as a PBM, pharmacy, or otherwise to data aggregators, manufacturers, or other third parties on a fee-for-service basis or as a condition of discount eligibility. All such activities are conducted in compliance with applicable patient and pharmacy privacy laws and client contract restrictions.

November 6, 2023

THIS EXHIBIT REPRESENTS ESI'S FINANCIAL POLICIES. ESI MAY PERIODICALLY UPDATE THIS EXHIBIT AND THE FINANCIAL DISCLOSURES CONTAINED HEREIN TO REFLECT CHANGES IN ITS BUSINESS PROCESSES; THE CURRENT FINANCIAL DISCLOSURE IS AVAILABLE UPON REQUEST AND ACCESSIBLE ON HTTPS://WWW.EXPRESS-SCRIPTS.COM/CORPORATE AND HTTPS://WWW.CONTROLCENTER.COM/.

11.

11. Public Comment

12.

12. Adjournment