State of Nebraska, Department of Administrative Services

Consulting and Actuarial Services

Solicitation Number: 120005 O5

January 6, 2025

Segal

2727 Paces Ferry Road
Suite 1400, Building One
Atlanta, Georgia 30339
segalco.com
T 678.306.3142
pklein@segalco.com

January 6, 2025

Connie Heinrichs and Brook Taylor
Procurement Contract Officer(s)
State of Nebraska, Department of Administrative Services
1526 K Street
Suite 130
Lincoln, NE 68508

RE: Consulting and Actuarial Services to State of Nebraska, Department of Administrative Services

Dear Connie and Brook:

We appreciate the opportunity to present our proposal for Consulting and Actuarial Services to State of Nebraska, Department of Administrative Services (DAS). We trust that this proposal will demonstrate that Segal continues to be the best qualified to provide the requested benefits consulting.

The services defined in the RFP are core services that we provide daily to our clients. In our response, we will clearly demonstrate our philosophy, approach, and ability to meet your needs. We recognize that each client is unique. With this in mind, our approach to any project will be tailored, paying particular attention to nuances of DAS's benefits philosophy and culture. Segal has strived to be a trusted advisor to DAS throughout our nine-year relationship. Our focus has been providing customized consulting recommendations based on your goals, supported with data. We also pride ourselves on our responsiveness given the environment in which decision makers need information in a timely manner.

We strive to continue to be your long-term advisor and will work with DAS in a proactive partnership, advocating on behalf of you and your members. Our Atlanta team has a track record of success and client satisfaction.

As the Account Manager assigned to DAS, I affirm that I am legally authorized to bind Segal.

Our submission is intended to be fully compliant with the specifications of the proposal and be responsive to all questions. We look forward to discussing our proposal response with you in greater detail. Please feel free to contact me directly at 678.306.3142 or pklein@segalco.com.

Sincerely,

Patrick J. Klein, FSA, MAAA
Vice President & Consulting Actuary

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Executive Summary

Segal appreciates the opportunity to submit this proposal to continue providing consulting and actuarial services as described in the State of Nebraska, Department of Administrative Services (DAS) Request for Proposal (RFP).

We have responded to the DAS request for proposal utilizing a narrative approach, detailing every aspect of the scope of services and how Segal is the best qualified to provide these services to DAS.

Understanding your needs

As your consultant since 2016, we understand the challenges you face providing a comprehensive and cost-effective benefits package for your employees and families. Working with our Segal team, you have a partner who understands your needs, based on working closely with your Plan and your team over the past nine years.

Segal's consulting philosophy and overall approach is highlighted by our commitment to our clients. By forming a partnership with our clients, we serve as both advisors and advocates and as a result, we ensure that our consulting services align with your strategic goals. We seek to be innovative and to accommodate the special requirements of each client, rather than merely replicating an approach that worked in another situation.

We understand the DAS is seeking a consultant to provide professional health and welfare consulting and actuarial services for the employee insurance benefits program which includes health, wellness, dental, vision, life, short- and long-term disability, flexible spending accounts, health savings account, and an employee assistance program.

Segal will continue to actively and proactively provide advice and guidance to help you manage your programs, meeting regularly with your team and vendors to ensure all objectives are on track. Staying focused on the long-term goals and objectives, and monitoring performance against those objectives, will provide the best outcomes for DAS.

We will partner with DAS to help prioritize projects, assist you in managing them and provide the technical assistance required for each. Our team is comprised of dedicated consultants, actuaries and analysts who are uniquely qualified to meet these demands.

The Segal team we propose to continue working with you has:

- Historical knowledge of Nebraska, the plan options and premium rates, and the reserve fund position
- All the talent and resources needed – including employee benefit consultants, actuaries, data analysts, pharmacy consultants, clinical consultants (MDs, RNs, and pharmacists), compliance and legal specialists, systems and process experts, and communication experts
- Capacity to work on your account and be available as needed
- Demonstrated experience through an array of client references and similar completed projects

Providing trusted advice that improves lives

The value we deliver to DAS

Our proposal demonstrates how the State will benefit from a continued relationship with Segal because of our:

- **Nebraska historical perspective**: The Segal team that I lead has extensive knowledge of your special circumstances, gained through nine years of continued service. The Plan has undergone many strategic changes over the past decade, and your Segal team has worked closely with the DAS team in implementing the changes. Several notable changes include:

Establishing an incentive-based plan (WellNebraska – Wellness) that creatively meets federal requirements.
Generating a vast menu of potential plan design options that were integrated into a live model to help decision makers balance plan changes with funding requirements.
Adding new sections to the Annual Report to ensure the report stays relevant and fresh.
Providing guidance with various legislation and decision points throughout the National Public Health Emergency associated with COVID-19.
Completing a benchmarking study of your peer states.
Recommending a premium holiday to meet the goal of reducing surplus without lowering rates or enhancing plan designs, to mitigate future financial deficits.
Creating an experience monitoring tool, projecting monthly cash flows that vary with seasonality.
Analyzing the cost and benefits of the Strada Pilot Program as well as other pending legislation that impact the Plan.

- **Looking forward:** Based on our work with the DAS, we have a firm understanding of your internal department structure, plan of benefits and how the healthcare benefits impact the department's human resources objectives – and that institutional knowledge helps guide the future as we navigate an increasingly complicated environment. We also understand the goals of DAS, simply to provide the most cost-effective benefits to your members, providing the best value possible.
- **National resources with local, boutique service**: DAS will continue to have the advantage of being serviced by national experts yet still receive the customized, "hands-on" service of a smaller firm from our local account team in Atlanta. We will also continue to provide complimentary access to firmwide research and expertise to help you in your role, from compliance updates about legislation that affects your plan, to publications and informative webinars to explain benefit developments, to sharing industry data and benchmarking, at no additional cost.
- **Legislative and compliance expertise**: Our in-house Compliance team ensures that you will continue to stay informed and prepared for late-breaking legislation and other issues.
- **Unbiased consulting**: Unlike other firms, we are an independent, private, employee-owned company. We do not have any stake in selling pre-packaged solutions or conflicts of interests from external ownership or affiliations. Our only goal is to continue to support the Plan.

Helping you manage changes

- **Public sector leadership**: Segal has been assisting public plans and employers for more than 70 years. Serving the public sector is the primary focus of your Segal team and is one of the pillars upon which our firm was founded. In addition to active participation and leadership in industry associations and conferences, we issue publications that are specific to the public sector community and typically include survey data of all 50 states. Your team has access to all of the Segal reports and webinars.
- **Competitive pricing**: We offer the customized, hands-on service of a small firm – while being backed by national research and benchmarking capabilities. This structure allows us to be efficient, nimble, and offer our high-value services for a competitive fee.
- **Continuity of service**: Because we are your Plan's current consultant, there would be no service interruption or "ramp-up" time needed. We are also not proposing to change any members of your current team.

We look forward to extending our service relationship with DAS for the next contract and beyond.

Contractual Agreement Form

CONTRACTUAL AGREEMENT FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Contractual Agreement Form, the bidder guarantees compliance with the provisions stated in this solicitation and agrees to the terms and conditions unless otherwise indicated in writing and certifies that bidder is not owned by the Chinese Communist Party.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603, DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Vendors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ NEBRASKA VENDOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Vendor. "Nebraska Vendor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this Solicitation. All vendors who are not a Nebraska Vendor are considered Foreign Vendors under Neb. Rev Stat § 73-603 (c).

_____ I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. § 71-8611 and wish to have preference considered in the award of this contract.

THIS FORM MUST BE SIGNED MANUALLY IN INK OR BY DOCUSIGN

COMPANY:	**The Segal Company (Southeast), Inc. d/b/a Segal**
ADDRESS:	**One Paces West, 2727 Paces Ferry Road, Suite 1400, Atlanta, GA 30339**
PHONE:	**678-306-3142**
EMAIL:	**pklein@segalco.com**
BIDDER NAME & TITLE:	**Patrick Klein, Vice President & Consulting Actuary**
SIGNATURE:	
DATE:	**January 6, 2025**

VENDOR COMMUNICATION WITH THE STATE CONTACT INFORMATION (IF DIFFERENT FROM ABOVE)	
NAME:	**Same as above**
TITLE:	
PHONE:	
EMAIL:	

II. Terms and Conditions

II. TERMS AND CONDITIONS

Bidder should read the Terms and Conditions within this section and must initial either "Accept All Terms and Conditions Within Section as Written" or "Exceptions Taken to Terms and Conditions Within Section as Written" in the table below. If the bidder takes any exceptions, they must provide the following within the "Exceptions" field of the table below (Bidder may provide responses in separate attachment if multiple exceptions are taken):

1. The specific clause, including section reference, to which an exception has been taken;
2. An explanation of why the bidder took exception to the clause; and
3. Provide alternative language to the specific clause within the solicitation response.

By signing the solicitation, bidder agrees to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the solicitation response. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the solicitation response. The State reserves the right to reject solicitation responses that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

Accept All Terms and Conditions Within Section as Written (Initial)	Exceptions Taken to Terms and Conditions Within Section as Written (Initial)	**Exceptions:** (Bidder must note the specific clause, including section reference, to which an exception has been taken, an explanation of why the bidder took exception to the clause, and provide alternative language to the specific clause within the solicitation response.)
	PJK	We take the same exceptions as we did in 2016. Segal currently provides services to DAS. Accordingly, if Segal is determined to be the winning bidder, Segal proposes to continue providing services pursuant to contract terms and conditions that are substantively similar to the previously negotiated contract. Please note that our form contract has changed but we are willing to discuss any changes and tailor the agreement as appropriate under the circumstances.

The bidders should submit with their solicitation response any license, user agreement, service level agreement, or similar documents that the bidder wants incorporated in the Contract. The State will not consider incorporation of any document not submitted with the solicitation response as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

If a conflict or ambiguity arises after the Addendum to Contract Award has been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one (1) Party has a particular clause, then that clause shall control,
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together,
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

A. GENERAL

1. The contract resulting from this Solicitation shall incorporate the following documents:

- **a.** Solicitation, including any attachments and addenda;
- **b.** Questions and Answers;
- **c.** Bidder's properly submitted solicitation response, including any terms and conditions or agreements submitted by the bidder;
- **d.** Addendum to Contract Award (if applicable);and
- **e.** Amendments to the Contract. (if applicable)

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference

over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) Executed Contract and any attached Addenda 3) Addendums to the solicitation and any Questions and Answers, 4) the original solicitation document and any Addenda or attachments, and 5) the Vendor's submitted solicitation response, including any terms and conditions or agreements that are accepted by the State.

Unless otherwise specifically agreed to in writing by the State, the State's standard terms and conditions, as executed by the State, shall always control over any terms and conditions or agreements submitted or included by the Vendor.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B. NOTIFICATION

Bidder and State shall identify the contract manager who shall serve as the point of contact for the executed contract.

Communications regarding the executed contract shall be in writing and shall be deemed to have been given if delivered personally; electronically, return receipt requested; or mailed, return receipt requested. All notices, requests, or communications shall be deemed effective upon receipt.

Either party may change its address for notification purposes by giving notice of the change and setting forth the new address and an effective date.

C. BUYER'S REPRESENTATIVE

The State reserves the right to appoint a Buyer's Representative to manage or assist the Buyer in managing the contract on behalf of the State. The Buyer's Representative will be appointed in writing, and the appointment document will specify the extent of the Buyer's Representative authority and responsibilities. If a Buyer's Representative is appointed, the bidder will be provided a copy of the appointment document and is expected to cooperate accordingly with the Buyer's Representative. The Buyer's Representative has no authority to bind the State to a contract, amendment, addendum, or other change or addition to the contract.

D. GOVERNING LAW (Nonnegotiable)

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. BEGINNING OF WORK & SUSPENSION OF SERVICES

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Vendor. The Vendor will be notified in writing when work may begin.

The State may, at any time and without advance notice, require the Vendor to suspend any or all performance or deliverables provided under this Contract. In the event of such suspension, the Contract Manager or POC, or their designee, will issue a written order to stop work. The written order will specify which activities are to be immediately suspended and the reason(s) for the suspension. Upon receipt of such order, the Vendor shall immediately comply with its terms and take all necessary steps to mitigate and eliminate the incurrence of costs allocable to the work affected by the order during the period of suspension. The suspended performance or deliverables may only resume when the State provides the Vendor with written notice that such performance or deliverables may resume, in whole or in part.

F. AMENDMENT

This Contract may be amended in writing, within scope, upon the agreement of both parties.

G. CHANGE ORDERS OR SUBSTITUTIONS

The State and the Vendor, upon the written agreement, may make changes to the contract within the general scope of the solicitation. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Vendor may not claim forfeiture of the contract by reasons of such changes.

The Vendor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Vendor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Vendor's solicitation response, were foreseeable, or result from difficulties with or failure of the Vendor's solicitation response or performance.

No change shall be implemented by the Vendor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

In the event any good or service is discontinued or replaced upon mutual consent during the contract period or prior to delivery, the State reserves the right to amend the contract to include the alternate product at the same price.

*****Vendor will not substitute any item that has been awarded without prior written approval of SPB*****

H. RECORD OF VENDOR PERFORMANCE

The State may document the vendor's performance, which may include, but is not limited to, the customer service provided by the vendor, the ability of the vendor, the skill of the vendor, and any instance(s) of products or services delivered or performed which fail to meet the terms of the purchase order, contract, and/or specifications. In addition to other remedies and options available to the State, the State may issue one or more notices to the vendor outlining any issues the State has regarding the vendor's performance for a specific contract ("Contract Compliance Request"). The State may also document the Vendor's performance in a report, which may or may not be provided to the vendor ("Contract Non-Compliance Notice"). The Vendor shall respond to any Contract Compliance Request or Contract Non-Compliance Notice in accordance with such notice or request. At the sole discretion of the State, such Contract Compliance Requests and Contract Non-Compliance Notices may be placed in the State's records regarding the vendor and may be considered by the State and held against the vendor in any future contract or award opportunity. The record of vendor performance will be considered in any suspension or debarment action.

I. NOTICE OF POTENTIAL VENDOR BREACH

If Vendor breaches the contract or anticipates breaching the contract, the Vendor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

J. BREACH

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by email, delivery receipt requested; certified mail, return receipt requested; or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time.

The State's failure to make payment shall not be a breach, and the Vendor shall retain all available statutory remedies. (See Indemnity - Self-Insurance and Payment)

K. NON-WAIVER OF BREACH

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

L. SEVERABILITY

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the provision held to be invalid or illegal.

M. INDEMNIFICATION

1. GENERAL

The Vendor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses ~~of every nature~~, including investigation costs and expenses, settlement costs, and reasonable attorney fees and expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, ~~arising out of~~, resulting from, ~~or attributable to~~ the willful misconduct, negligence, error, or omission of the Vendor, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Vendor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The Vendor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims ~~arise out of~~, result from, ~~or are attributable to~~, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Vendor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Vendor prompt notice in writing of the claim. The Vendor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Vendor has indemnified the State, the Vendor shall, at the Vendor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Vendor, and the State may receive the remedies provided under this Solicitation.

3. PERSONNEL

The Vendor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, provided by the Vendor.

4. SELF-INSURANCE

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01. If there is a presumed loss under the provisions of this agreement, Vendor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,239.01 to 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Neb. Rev. Stat. § 81-8,294), Tort (Neb. Rev. Stat. § 81-8,209), and Contract Claim Acts (Neb. Rev. Stat. § 81-8,302), as outlined in state law and accepts liability under this agreement only to the extent provided by law.

5. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

N. ATTORNEY'S FEES

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if ordered by the court, including attorney's fees and costs, if the other Party prevails.

Should Contractor be the prevailing party in such action, the State agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs.

O. ASSIGNMENT, SALE, OR MERGER

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Vendor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Vendor's business. Vendor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Vendor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

P. CONTRACTING WITH OTHER NEBRASKA POLITICAL SUBDIVISIONS OF THE STATE OR ANOTHER STATE

The Vendor may, but shall not be required to, allow agencies, as defined in Neb. Rev. Stat. § 81-145(2), to use this contract. The terms and conditions, including price, of the contract may not be amended. The State shall not be contractually obligated or liable for any contract entered into pursuant to this clause. A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

The Vendor may, but shall not be required to, allow other states, agencies or divisions of other states, or political subdivisions of other states to use this contract. The terms and conditions, including price, of this contract shall apply to any such contract, but may be amended upon mutual consent of the Parties. The State of Nebraska shall not be contractually or otherwise obligated or liable under any contract entered into pursuant to this clause. The State shall be notified if a contract is executed based upon this contract.

Q. FORCE MAJEURE

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event") that was not foreseeable at the time the Contract was executed. The Party so affected shall immediately make a written request for relief to the other Party and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

R. CONFIDENTIALITY

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party ~~immediately~~ as soon as practical of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

S. EARLY TERMINATION

The contract may be terminated as follows:

1. The State and the Vendor, by mutual written agreement, may terminate the contract, in whole or in part, at any time.

2. The State, in its sole discretion, may terminate the contract, in whole or in part, for any reason upon thirty (30) calendar day's written notice shall be delivered by email, delivery receipt requested; certified mail, return receipt requested; or in person with proof of delivery to the Vendor. Such termination shall not relieve the Vendor of warranty or other service obligations incurred under the terms of the contract. In the event of termination, the Vendor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the contract, in whole or in part, immediately for the following reasons:

- **a.** if directed to do so by statute,
- **b.** Vendor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business,
- **c.** a trustee or receiver of the Vendor or of any substantial part of the Vendor's assets has been appointed by a court,
- **d.** fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Vendor, its employees, officers, directors, or shareholders,

e. an involuntary proceeding has been commenced by any Party against the Vendor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Vendor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Vendor has been decreed or adjudged a debtor,

f. a voluntary petition has been filed by the Vendor under any of the chapters of Title 11 of the United States Code,

g. Vendor intentionally discloses confidential information,

h. Vendor has or announces it will discontinue support of the deliverable; and,

i. In the event funding is no longer available.

4. Contractor may terminate this contract upon no less than thirty (30) days' written notice in the event of either (1) the State's failure to pay any undisputed invoices in a timely manner or (2) the State's directing or requiring the Contractor to act in a manner that would violate applicable law or regulation

T. CONTRACT CLOSEOUT

Upon termination of the contract for any reason the Vendor shall within thirty (30) days, unless stated otherwise herein:

1. Transfer all completed or partially completed deliverables to the State,

2. Transfer ownership and title to all completed or partially completed deliverables to the State,

3. Return to the State all information and data unless the Vendor is permitted to keep the information or data by contract or rule of law. Vendor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Vendor's routine back up procedures,

4. Cooperate with any successor Contactor, person, or entity in the assumption of any or all of the obligations of this contract,

5. Cooperate with any successor Contactor, person, or entity with the transfer of information or data related to this contract,

6. Return or vacate any state owned real or personal property; and,

7. Return all data in a mutually acceptable format and manner.

Nothing in this section should be construed to require the Vendor to surrender intellectual property, real or personal property, or information or data owned by the Vendor for which the State has no legal claim.

U. AMERICANS WITH DISABILITIES ACT

Vendor shall comply with all applicable provisions of the Americans with Disabilities Act of 1990 (42 U.S.C. 12131–12134), as amended by the ADA Amendments Act of 2008 (ADA Amendments Act) (Pub.L. 110–325, 122 Stat. 3553 (2008)), which prohibits discrimination on the basis of disability by public entities.

Attachment D

STATE OF NEBRASKA

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT ("Agreement") amends and is made a part of all Services Agreements (as defined below) between _____("Business Associate") and State of Nebraska ("Company") on behalf of the Group Health Plans sponsored by Company (the "Plan"). This Agreement is effective _____ or upon the effective date of the underlying Services Agreement, whichever is later ("Effective Date"). This Agreement supersedes and replaces any prior Business Associate Agreements between the parties.

1. **Definitions**.

a. **Catch-all definitions**. The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Covered Entity, Data Aggregation, Designated Record Set, Disclose or Disclosure, Electronic Protected Health Information, Health Care Operations, Minimum Necessary, Notice of Privacy Practices, Protected Health Information or PHI, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use. Other capitalized terms used but not otherwise defined in this Agreement shall have the meaning ascribed in the HIPAA Rules.

b. **Specific definitions**.

(1) ***"Business Associate"*** shall generally have the same meaning as the term "Business Associate" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean the party identified above as Business Associate.

(2) ***"Business Associate Functions"*** means functions performed by Business Associate on behalf of the Plan in the course of providing or arranging for plan administration services which involve the creation, receipt, maintenance or transmission of PHI by Business Associate or its agents or Subcontractors. It is anticipated that the services provided by Business Associate will be performed as part of the Plan's "health care operations" as defined in the HIPAA Rules.

(3) ***"HIPAA Rules"*** shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended at the time the section is to be applied.

(4) ***"Individual"*** shall generally have the same meaning ascribed in the HIPAA Rules and shall refer only to Individuals who are covered persons under the Plan.

(5) ***"Services Agreements"*** means all agreements whether now in effect or hereafter entered into, between Company and Business Associate for the performance of Business Associate Functions by Business Associate on behalf of the Plan.

2. **Purpose**. The Plan is a Covered Entity under HIPAA. The HIPAA Rules require the Plan to obtain, and Business Associate to provide, satisfactory written contractual assurances before Business Associate may create, receive, maintain, or Disclose PHI to perform Business Associate Functions on behalf of the Plan. This Agreement is entered into to provide the contractual assurances required under the HIPAA Rules.

3. **Obligations of Business Associate**. As an express condition of performing Business Associate Functions, Business Associate agrees to:

a. Not Use or Disclose PHI other than as permitted or required by this Agreement or as otherwise Required by Law.

b. Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to Electronic Protected Health Information, to prevent Use or Disclosure of PHI other than as provided for in this Agreement.

c. Report to the Plan's designated privacy official~~, without unreasonable delay but in no event more than three (3) business days after discovery by Business Associate~~, any Use or Disclosure of PHI not provided for by this Agreement of which Business Associate becomes aware, including any Breach of Unsecured Protected Health Information as required at 45 CFR 164.410, and any Security Incident of which it becomes aware, together with any remedial or mitigating action taken or proposed to be taken with respect thereto. ~~If Business Associate does not have available complete information in satisfaction of 45 CFR 164.410(c) within three (3) business days of discovery of the impermissible Use or Disclosure, Business Associate shall provide all information it has at such time, and immediately update the Plan with additional information as it becomes available through prompt investigation.~~ In the event of Breach of Unsecured Protected Health Information, such report shall be made without unreasonable delay but in no event more than thirty (30) calendar days after discovery by Business Associate, This Agreement serves as Business Associate's notice to the Plan that attempted but unsuccessful Security Incidents regularly occur and that no further notice will be made by Business Associate unless there has been a successful Security Incident or attempts or patterns of attempts that Business Associate determines to be suspicious.

Business Associate shall cooperate with the Plan in mitigating any harmful effects of any impermissible Use or Disclosure. In the case of a Breach ~~as determined to exist in the sole discretion of the Plan which was due to a violation of this Agreement by Business Associate~~, Business Associate shall pay for the reasonable and actual costs of ~~investigation~~, agreed upon mitigation and notification to affected Individuals. As an alternative to Business Associate reimbursing Company and the Plan for the costs of notification, the Plan may elect to have Business Associate directly provide the notifications to Individuals for breaches caused by Business Associate, provided that Company and the Plan shall have final approval of all content of notifications to Individuals.

d. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), ensure that any Subcontractors that create, receive, maintain, or transmit PHI on behalf of Business Associate agree in writing to the same or more stringent restrictions, conditions, and requirements that apply to Business Associate with respect to such information.

e. Within ten (10) business days of request by an Individual or notification by the Plan, make available to the Individual such Individual's PHI maintained by Business Associate in a Designated Record Set in accordance with 45 CFR 164.524. ~~The parties agree that Individuals will be directed to Business Associate to make all requests for access to PHI. Business Associate will provide such access according to its own procedures for such access in accordance with the requirements of 45 CFR 164.524. If the requested PHI is maintained in one or more Designated Record Sets electronically and if the Individual requests an electronic copy of such PHI, Business Associate must provide the Individual with access to PHI in the electronic form and format requested by the Individual, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed to between Business Associate and the Individual. Business Associate shall provide the requested information directly to the Individual, along with a notice to the Individual that a copy of the individual's request has been furnished to the Plan and that the Plan may provide additional information to the Individual in response to the request.~~

If the Individual's request covers records not maintained by Business Associate, Business Associate shall notify the Plan ~~within three (3) days~~ as soon as possible upon receipt of the request. The Plan will be responsible for providing access or otherwise responding directly to the Individual pursuant to the HIPAA Rules with respect to PHI not in the possession of Business Associate or an agent or subcontractor of Business Associate. Business Associate may charge the Individual reasonable fees related to this access, as determined by Business Associate, but only in such amounts as permitted by the HIPAA Rules. The Plan authorizes Business Associate to require payment of such fees from the Individual prior to releasing any records.

f. Business Associate agrees to receive requests for amendment and amend PHI as required by 45 CFR 164.526 on the Plan's behalf for as long as such information is maintained by Business Associate. ~~The parties agree that Individuals will be directed to Business Associate to make all such requests for amendment of PHI. Business Associate will amend such PHI according to its own procedures for such amendment in accordance with the requirements of 45 CFR 164.526.~~ If the Individual's request covers records not maintained by Business Associate, Business Associate shall notify the Plan ~~within three (3) days~~ as soon as possible upon receipt of such request. The Plan will be responsible for amending or otherwise responding directly to the Individual pursuant to the HIPAA Rules with respect to PHI not in the possession of Business Associate or an agent or contractor of Business Associate. Business Associate shall notify the Plan of any amendments made to PHI.

g. Business Associate agrees to process all requests for disclosure accounting by Individuals for as long as such information is maintained by Business Associate. Individuals will be directed to Business Associate to make all such requests. Business Associate will provide the accounting that is required under 45 CFR 164.528 on the Plan's behalf directly to the Individual. Business Associate will provide such accounting according to its own procedures for such accounting in accordance with the requirements of 45 CFR 164.528.

Business Associate shall notify the Plan ~~within three (3) days~~ as soon as possible of any request made by an Individual for a disclosure accounting. The Plan will be responsible for responding directly to the Individual (or the Individual's personal representative) pursuant to 45 CFR 164.528 with respect to disclosures of PHI by persons or entities other than Business Associate or a subcontractor or agent of Business Associate. ~~Business Associate shall provide directly to the Individual the requested accounting of disclosures made by Business Associate or a subcontractor or agent of Business Associate, along with a notice to the Individual that a copy of the Individual's request has been furnished to the Plan and that the Plan may provide additional information to the Individual in response to the request.~~

h. Subject to applicable legal privileges or other legally binding confidentiality obligations, make its internal practices, books and records relating to this Agreement available to the Secretary of HHS , in the time and manner designated by the Secretary and to the Plan upon reasonable notice and during normal business hours for purposes of determining the Plan's and Business Associate's compliance with the HIPAA Rules.

i. So that the Plan may meet its obligations to evaluate requests for restrictions and confidential communications in connection with the disclosure of PHI under 45 CFR 164.522, Business Associate and the Plan agree that, to the extent that communications are within the control of Business Associate, Business Associate will perform these evaluations on behalf of the Plan. Business Associate will evaluate such requests according to its own procedures for such requests, in accordance with the requirements of 45 CFR 164.522, and shall implement such appropriate operational steps as are required by its own procedures. Such evaluation will not relieve the Plan of any additional and independent obligations to evaluate restrictions or implement confidential communications where requested by an Individual. Accordingly, Business Associate will evaluate requests for restrictions and requests for confidential communications, and will respond to these requests as appropriate under Business Associate's procedures. The Plan agrees that it will not agree to such restriction or request that would affect Business Associate without the approval of Business Associate, so that Business Associate can determine whether it can reasonably administer the request.

j. So that the Plan may meet its obligation to evaluate complaints from Individuals regarding their privacy rights or privacy practices of the ~~Plan or~~ Business Associate, the parties agree that Individuals shall be directed to submit any such complaint to Business Associate for review and evaluation. Business Associate will evaluate such complaints according to its own procedures for complaints, and shall implement appropriate operation steps as are required by its own procedures. The Privacy Officer of the Plan shall cooperate with Business Associate in the evaluation of any such complaint. Business Associate shall provide a copy of all complaints to the Plan within three (3) days of receipt by Business Associate. If the complaint appears to involve handling of PHI by the Plan, Plan Sponsor, or other Business Associate of the Plan, Business Associate shall notify the Plan and it shall be the Plan's responsibility to review and evaluate the complaint.

k. Limit the Uses and Disclosures of, or requests for, PHI for purposes described in this Agreement to the Minimum Necessary to perform the required

Business Associate Functions. Business Associate shall comply with any additional requirements for the determination of Minimum Necessary as are required from time to time by the HIPAA Rules, as amended, or through additional guidance published by the Secretary.

l. To the extent Business Associate is expressly obligated under the Services Agreements to carry out one or more of the Plan's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Plan in the performance of such obligation(s).

m. Except for the specific Uses and Disclosures for the Business Associate's own management and administration or to carry out the legal responsibilities of Business Associate, Business Associate shall not Use or Disclose PHI in a manner that would violate the HIPAA Rules if done by the Plan.

4. **Permitted Uses and Disclosures of PHI**. Business Associate shall only Use or Disclose PHI as follows:

a. Business Associate may Use or Disclose PHI as Required by Law. Business Associate agrees to follow the current law covering the use and disclosure of PHI related to substance abuse and reproductive health.

b. Business Associate may Use or Disclose PHI as necessary to carry out Business Associate Functions.

c. Business Associate may Use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

d. Business Associate may Disclose PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided the Disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is Disclosed that the information will remain confidential and be Used or further Disclosed only as Required by Law or for the purposes for which it was Disclosed to the person, and the person notifies Business Associate in writing of any instances of which it is aware in which the confidentiality of the information has been breached or compromised.

e. If specifically identified as a Business Associate Function in the Services Agreements, Business Associate may provide Data Aggregation services relating to the Health Care Operations of Covered Entity.

f. ~~If de-identification is listed as a Business Associate Function in the Services Agreements, or if Business Associate is expressly permitted to de-identify PHI and use data thus de-identified for its own uses in the Services Agreements~~, Business Associate may Use PHI to de-identify the information in accordance with 45 CFR 164.514(a)-(c) ~~Business Associate may use de-identified data only for the purposes specified in the Services Agreements.~~ and may use or disclose information that has been de-identified.

5. **Responsibilities of the Plan**. The Plan agrees to:

a. Notify Business Associate promptly of any restriction on the Use or Disclosure of PHI that the Plan has agreed to or is required to abide by under 45 CFR 164.522, to the extent such restriction may affect Business Associate's Use or Disclosure of PHI.

b. Notify Business Associate of any changes in, or revocation of, the permission by an Individual to Use or Disclose PHI, to the extent that such changes may affect Business Associate's Use or Disclosure of PHI.

c. Provide Business Associate with a copy of any amendment to PHI which is accepted by Covered Entity under 45 CFR 164.526 which Covered Entity believes will apply to PHI maintained by Business Associate in a Designated Record Set.

d. Not request Business Associate to Use or Disclose PHI in any manner that would not be permissible under the HIPAA Rules if done by the Plan, with exception for any Data Aggregation services permitted under Section 4.

6. **Compliance with Electronic Transactions Rule**. If Business Associate conducts in whole or part electronic Transactions (as defined in 45 CFR 160.103) on behalf of Covered Entity for which the Secretary of HHS has established standards, Business Associate will comply, and will require any Subcontractor involved with the conduct of such Transactions to comply, with each applicable requirement of the Electronic Transactions Rule at 45 CFR Parts 160 and 162 and of any operating rules adopted by the Secretary of HHS with respect to Transactions.

7. **Supervening Law**. Upon the enactment of any law or regulation affecting the Use or Disclosure of PHI, or the publication of any decision of a court of the United States or of this state relating to any such law, or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, the parties agree to amend this Agreement in such manner as is necessary to comply with such law or regulation. If the parties are unable to agree on an amendment within thirty (30) days, either party may terminate the Services Agreements on not less than thirty (30) days' written notice to the other.

8. **Liability and Reimbursement**. Each party shall be responsible for the acts and omissions of its own agents, employees and contractors. Notwithstanding the foregoing, and notwithstanding any limitation of liability or disclaimer of damages in the Services Agreements or elsewhere, to the extent that the Secretary determines that Business Associate is acting as an agent of the Plan under the Services Agreements or this Agreement, Business Associate shall ~~indemnify~~ reimburse Company and the Plan for any fines, civil monetary penalties or monetary resolutions incurred by Company or the Plan, ~~plus reasonable attorneys' fees of Company and the Plan, arising out of or relating to the actions or omissions of Business Associate which constitute a breach of this Agreement by Business Associate. This indemnification is in addition to any additional indemnification provided by Business Associate in the Services Agreement~~. resulting from Business Associate's improper use or disclosure of PHI.

9. **Term and Termination**.

a. **Term**. This Agreement shall become effective on the Effective Date and shall continue in effect until all obligations of the parties have been met, including return or destruction of all PHI in Business Associate's possession (or in the possession of Business Associate's agents and Subcontractors), unless sooner terminated as provided herein. It is expressly agreed that the terms and conditions of this Agreement designed to safeguard PHI shall survive expiration or other termination of the Services Agreements and shall continue in effect until Business Associate has performed all obligations under this Agreement and has either returned or destroyed all PHI.

b. **Termination**. Either party may terminate this Agreement if the other violates a material term of the Agreement, provided that the non-breaching party provides the breaching party with no less than 30 days in which to cure such violation prior to termination becoming effective. However, if the non-breaching party reasonably and in good faith determines that the violation is not curable, it may terminate this Agreement immediately upon written notice to the breaching party. Upon termination of this Agreement, the Services Agreement between the parties also shall terminate to the extent that it requires Business Associate to access, use, disclose and/or maintain PHI in order to provide the Services

c. **Business Associate Obligations Upon Termination**. Upon termination of this Agreement for any reason, Business Associate, with respect to PHI received from the Plan, or created, maintained, or received by Business Associate on behalf of the Plan, shall:

(i) Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities or as to which Business Associate reasonably determines such PHI is technically incapable of being returned or destroyed; The Company and the Plan understand that Business Associate's need to maintain portions of the PHI for archival purposes related to memorializing advice provided will render return or destruction infeasible;

(ii) Return to the Plan or, if not provided for in the Services Agreements, destroy the PHI retained under 8.c.(i) that the Business Associate maintains in any form;

(iii) Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic Protected Health Information retained by Business Associate to prevent Use or Disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;

(iv) Not Use or Disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Sections 4.c. and 4.d. which applied prior to termination; and

(v) Return to the Plan or, if not provided for in the Services Agreements, destroy the PHI retained by Business Associate under Section 8.c.(i)

when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities, except where Business Associate reasonably determines such PHI is not technically capable of being returned or destroyed.

10. **Miscellaneous**.

a. **Applicability**. For purposes of this Agreement, and as applicable to the Business Associate Functions of Business Associate under the Services Agreements covered by this Agreement, references to the Plan shall include the named Plan and all other group health plans subject to HIPAA and sponsored by Company that participate in an organized health care arrangement.

b. **Survival**. The respective rights and obligations of Business Associate and the Plan or Company hereunder shall survive termination of this Agreement according to the terms hereof and the obligations imposed on the Plan or Company and Business Associate under the HIPAA Rules.

c. **Interpretation; Amendment**. This Agreement shall be interpreted and applied in a manner consistent with the Plan's and Business Associate's obligations under the HIPAA Rules. All amendments shall be in writing and signed by both parties, except that this Agreement shall attach to additional Services Agreements entered into between the parties in the future without the necessity of amending this Agreement each time. This Agreement is intended to cover the entire Business Associate *relationship* between the parties, as amended, from time to time, through Services Agreements or other means.

d. **Waiver**. A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any right or remedy as to subsequent events.

e. **No Third-Party Beneficiaries**. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and their respective successors or assigns, any rights, remedies or obligations.

f. **Informal Resolution.** If any controversy, dispute, or claim arises between the parties with respect to this Agreement, the parties shall make good faith efforts to resolve such matters informally.

g. **Notices.** All notices to be given pursuant to the terms of this Agreement shall be in writing and shall be sent certified mail, return receipt requested, postage prepaid or by courier service. If to Company or the Plan, the notice shall be sent to such address as Company notifies Business Associate of in writing. If to Business Associate, the notice shall be sent to the Privacy Official, c/o General Counsel, The Segal Group, 333 West 34th Street, New York, New York 10001.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf.

Company: **Business Associate:**

State of Nebraska _____

Signature:_____ Signature:_____

Printed Name:_____ Printed Name:_____

Title:_____ Title:_____

Date Signed: _____ Date Signed: _____

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III. Vendor Duties

III. VENDOR DUTIES

Bidder should read the Vendor Duties within this section and must initial either "Accept All Terms and Conditions Within Section as Written" or "Exceptions Taken to Vendor Duties Within Section as Written" in the table below. If the bidder takes any exceptions, they must provide the following within the "Exceptions" field of the table below (Bidder may provide responses in separate attachment if multiple exceptions are taken):

1. The specific clause, including section reference, to which an exception has been taken;
2. An explanation of why the bidder took exception to the clause; and
3. Provide alternative language to the specific clause within the solicitation response.

By signing the solicitation, bidder agrees to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the solicitation response. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the solicitation response. The State reserves the right to reject solicitation responses that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

Accept All Vendor Duties Within Section as Written (Initial)	Exceptions Taken to Vendor Duties Within Section as Written (Initial)	**Exceptions:** (Bidder must note the specific clause, including section reference, to which an exception has been taken, an explanation of why the bidder took exception to the clause, and provide alternative language to the specific clause within the solicitation response.)
	PJK	We take the same exceptions as we did in 2016. Segal currently provides services to DAS. Accordingly, if Segal is determined to be the winning bidder, Segal proposes to continue providing services pursuant to contract terms and conditions that are substantively similar to the previously negotiated contract. Please note that our form contract has changed but we are willing to discuss any changes and tailor the agreement as appropriate under the circumstances.

A. INDEPENDENT VENDOR / OBLIGATIONS

It is agreed that the Vendor is an independent Vendor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Vendor is solely responsible for fulfilling the contract. The Vendor or the Vendor's representative shall be the sole point of contact regarding all contractual matters.

The Vendor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Vendor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

By-name personnel commitments made in the bidder's solicitation response shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Vendor to the contract shall be employees of the Vendor or a subcontractor and shall be fully qualified to perform the work required herein. Personnel employed by the Vendor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Vendor or the subcontractor respectively.

With respect to its employees, the Vendor agrees to be solely responsible for the following:

1. Any and all pay, benefits, and employment taxes and/or other payroll withholding,
2. Any and all vehicles used by the Vendor's employees, including all insurance required by state law,
3. Damages incurred by Vendor's employees within the scope of their duties under the contract,

4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law,
5. Determining the hours to be worked and the duties to be performed by the Vendor's employees; and,
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Vendor, its officers, agents, or subcontractors or subcontractor's employees).

If the Vendor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the solicitation response. The Vendor shall agree that it will not utilize any subcontractors not specifically included in its solicitation response in the performance of the contract without the prior written authorization of the State. If the Vendor subcontracts any of the work, the Vendor agrees to pay any and all subcontractors in accordance with the Vendor's agreement with the respective subcontractor(s).

The State reserves the right to require the Vendor to reassign or remove from the project any Vendor or subcontractor employee.

Vendor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

The Vendor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.

B. FOREIGN ADVERSARY CONTRACTING PROHIBITION ACT CERTIFICATION (Nonnegotiable)

The Vendor certifies that it is not a scrutinized company as defined under the Foreign Adversary Contracting Prohibition Act, Neb. Rev. Stat. Sec. § 73-903 (5); that it will not subcontract with any scrutinized company for any aspect of performance of the contemplated contract; and that any products or services to be provided do not originate with a scrutinized company.

C. EMPLOYEE WORK ELIGIBILITY STATUS

The Vendor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Vendor is an individual or sole proprietorship, the following applies:

1. The Vendor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at https://das.nebraska.gov/materiel/docs/pdf/Individual%20or%20Sole%20Proprietor%20United%20States%20Attestation%20Form%20English%20and%20Spanish.pdf
2. The completed United States Attestation Form should be submitted with the Solicitation response.
3. If the Vendor indicates on such attestation form that he or she is a qualified alien, the Vendor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Vendor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
4. The Vendor understands and agrees that lawful presence in the United States is required, and the Vendor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. § 4-108.

D. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Nonnegotiable)

The Vendor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Vendors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §§ 48-1101 to 48-1125). The Vendor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Vendor shall insert a similar provision in all Subcontracts for goods and services to be covered by any contract resulting from this Solicitation.

E. COOPERATION WITH OTHER VENDORS

Vendor may be required to work with or in close proximity to other Vendors or individuals that may be working on same or different projects. The Vendor shall agree to cooperate with such other Vendors or individuals and shall not

commit or permit any act which may interfere with the performance of work by any other Vendor or individual. Vendor is not required to compromise Vendor's intellectual property or proprietary information unless expressly required to do so by this contract.

F. DISCOUNTS

Prices quoted shall be inclusive of ALL trade discounts. Cash discount terms of less than thirty (30) days will not be considered as part of the solicitation response. Cash discount periods will be computed from the date of receipt of a properly executed claim voucher or the date of completion of delivery of all items in a satisfactory condition, whichever is later.

G. PRICES

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the Solicitation. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

Prices submitted on the cost sheet, once accepted by the State, shall remain fixed for the first two (2) years of the contract. Any request for a price increase subsequent to the initial two (2) years of the contract shall not exceed four percent (4 %) of the price proposed for the period. Increases shall not be cumulative and will only apply to that period of the contract. The request for a price increase must be submitted in writing to the State Purchasing Bureau a minimum of 120 days prior to the end of the current contract period. Documentation may be required by the State to support the price increase.

The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

The State will be given full proportionate benefit of any decreases for the term of the contract.

H. PERMITS, REGULATIONS, LAWS

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Vendor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Vendor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

I. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Vendor on behalf of the State pursuant to this contract.

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Vendor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

~~The State of Nebraska shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or derived by the Contractor pursuant to this contract.~~

Except to the extent that they incorporate Contractor's proprietary software, know-how, techniques, methodologies and report formats (collectively, "Contractor's Proprietary Information"), all documents, data, and other tangible materials authored or prepared and delivered by Contractor to the State of Nebraska under the terms of this Agreement (collectively, the "Deliverables"), are the sole and exclusive property of the State of Nebraska, once paid for by the State. To the extent Contractor's Proprietary Information is incorporated into such Deliverables, the State of Nebraska shall have a perpetual, nonexclusive, worldwide, royalty-free license to use, copy, and modify Contractor's Proprietary Information as part of the Deliverables internally and for their intended purpose.

J. INSURANCE REQUIREMENTS

The Vendor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Vendor shall not commence work on the contract until the insurance is in place. If Vendor subcontracts any portion of the Contract the Vendor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor,
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Vendor has verified that each subcontractor has the required coverage; or,
3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.

The Vendor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Vendor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Vendor hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within two (2) years of termination or expiration of the contract, the Vendor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and two (2) years following termination or expiration of the contract.

If by the terms of any insurance a mandatory deductible is required, or if the Vendor elects to increase the mandatory deductible amount, the Vendor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

As edited below: Products and Completed Operations are included in the general aggregate. We also have an umbrella of $20M that will cover anything over the $2M aggregate; Segal does Not own any vehicles; Segal does not have the coverage deleted below.

1. **WORKERS' COMPENSATION INSURANCE**

   The Vendor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Vendor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter**. The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**

   The Vendor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Vendor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Vendor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

   The Commercial General Liability Insurance shall be written on an **occurrence basis**, and provide Premises/Operations, Products/Completed Operations, Independent Vendors, Personal Injury, and Contractual Liability coverage. **The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory**. **The COI shall contain the mandatory COI liability waiver language found hereinafter.** The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	~~$2,000,000~~ included in the general aggregate
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$300,000 each occurrence
Contractual	Included
~~XCU Liability (Explosion, Collapse, and Underground Damage)~~	~~Included~~
~~Independent Vendors~~	~~Included~~
Abuse & Molestation	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All ~~Owned~~, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000 per occurrence
PROFESSIONAL LIABILITY	
Professional liability (Medical Malpractice)	Limits consistent with Nebraska Medical Malpractice Cap
Qualification Under Nebraska Excess Fund	
All Other Professional Liability (Errors & Omissions)	$1,000,000 Per Claim / Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$1,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$5,000,000
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

3. EVIDENCE OF COVERAGE

The Vendor shall furnish the Contract Manager, via email, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

RFP 120005 O5

Department of Administrative Services
State Purchasing Bureau
Attn: Brook Taylor
1526 K Street, Suite 130
Lincoln, NE 68508
brook.taylor@nebraska.gov

These certificates or the cover sheet shall reference the solicitation number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Vendor to maintain such insurance, then the Vendor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

4. DEVIATIONS

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Vendor.

K. ANTITRUST

The Vendor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

L. CONFLICT OF INTEREST

By submitting a solicitation response, vendor certifies that no relationship exists between the vendor and any person or entity which either is, or gives the appearance of, a conflict of interest related to this solicitation or project.

Vendor further certifies that vendor will not employ any individual known by vendor to have a conflict of interest nor shall vendor take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its contractual obligations hereunder or which creates an actual or appearance of conflict of interest.

If there is an actual or perceived conflict of interest, vendor shall provide with its solicitation response a full disclosure of the facts describing such actual or perceived conflict of interest and a proposed mitigation plan for consideration. The State will then consider such disclosure and proposed mitigation plan and either approve or reject as part of the overall solicitation response evaluation.

M. ADVERTISING

The Vendor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its goods or services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

N. NEBRASKA TECHNOLOGY ACCESS STANDARDS (Nonnegotiable)

1. The State of Nebraska is committed to ensuring that all information and communication technology (ICT), developed, leased, or owned by the State of Nebraska, affords equivalent access to employees, program participants and members of the public with disabilities, as it affords to employees, program participants and members of the public who are not persons with disabilities.

2. By entering into this Contract, Vendor understands and agrees that if the Vendor is providing a product or service that contains ICT, as defined in subsection 3 below and such ICT is intended to be directly interacted with by the user or is public facing, such ICT must provide equivalent access, or be modified during implementation to afford equivalent access, to employees, program participants, and members of the public who have and who do not have disabilities. The Vendor may comply with this section by complying with Section 508 of the Rehabilitation Act of 1973, as amended, and its implementing standards adopted and promulgated by the U.S. Access Board.

3. ICT means information technology and other equipment, systems, technologies, or processes, for which the principal function is the creation, manipulation, storage, display, receipt, or transmission of electronic data and information, as well as any associated content. Vendor hereby agrees ICT includes computers and peripheral equipment, information kiosks and transaction machines, telecommunications equipment, customer premises equipment, multifunction office machines, software, applications, web sites, videos, and electronic documents. For the purposes of these assurances, ICT does not include ICT that is used exclusively by a Vendor.

O. DISASTER RECOVERY/BACK UP PLAN

The Vendor shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue delivery of goods and services as specified under the specifications in the contract in the event of a disaster.

P. DRUG POLICY

Vendor certifies it maintains a drug free workplace environment to ensure worker safety and workplace integrity. Vendor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

Q. WARRANTY

Despite any clause to the contrary, the Vendor represents and warrants that its services hereunder shall be performed by competent personnel and shall be of professional quality consistent with generally accepted industry standards for the performance of such services and shall comply in all respects with the requirements of this Agreement. For any breach of this warranty, the Vendor shall, for a period of ninety (90) days from performance of the service, perform the services again, at no cost to the State, or if Vendor is unable to perform the services as warranted, Vendor shall reimburse the State all fees paid to Vendor for the unsatisfactory services. The rights and remedies of the parties under this warranty are in addition to any other rights and remedies of the parties provided by law or equity, including, without limitation actual damages, and, as applicable and awarded under the law, to a prevailing party, reasonable attorneys' fees and costs.

R. TIME IS OF THE ESSENCE

Time is of the essence with respect to Vendor's performance and deliverables pursuant to this Contract.

IV. Payment

IV. PAYMENT

Bidder should read the Payment clauses within this section and must initial either "Accept All Terms and Conditions Within Section as Written" or "Exceptions Taken to Payment clauses Within Section as Written" in the table below. If the bidder takes any exceptions, they must provide the following within the "Exceptions" field of the table below (Bidder may provide responses in separate attachment if multiple exceptions are taken):

1. The specific clause, including section reference, to which an exception has been taken;
2. An explanation of why the bidder took exception to the clause; and
3. Provide alternative language to the specific clause within the solicitation response.

By signing the solicitation, bidder agrees to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the solicitation response. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the solicitation response. The State reserves the right to reject solicitation responses that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

Accept All Payment Clauses Within Section as Written (Initial)	Exceptions Taken to Payment Clauses Within Section as Written (Initial)	**Exceptions:** (Bidder must note the specific clause, including section reference, to which an exception has been taken, an explanation of why the bidder took exception to the clause, and provide alternative language to the specific clause within the solicitation response.)
PJK		

A. PROHIBITION AGAINST ADVANCE PAYMENT (Nonnegotiable)

Pursuant to Neb. Rev. Stat. § 81-2403, "[n]o goods or services shall be deemed to be received by an agency until all such goods or services are completely delivered and finally accepted by the agency."

B. TAXES (Nonnegotiable)

The State is not required to pay taxes and assumes no such liability as a result of this Solicitation. The Vendor may request a copy of the Nebraska Department of Revenue, Nebraska Resale or Exempt Sale Certificate for Sales Tax Exemption, Form 13 for their records. Any property tax payable on the Vendor's equipment which may be installed in a state-owned facility is the responsibility of the Vendor.

C. INVOICES

Invoices for payments must be submitted by the Vendor to the agency requesting the services with sufficient detail to support payment. Invoices for payments must be submitted by the Vendor to the agency requesting the services with sufficient detail to support payment. Invoices should be emailed to Department of Administrative Services, Employee Wellness and Benefits at kris.bourke@nebraska.gov and as.employeebenefits@nebraska.gov.

The terms and conditions included in the Vendor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract. **The State shall have forty-five (45) calendar days to pay after a valid and accurate invoice is received by the State.**

D. INSPECTION AND APPROVAL

Final inspection and approval of all work required under the contract shall be performed by the designated State officials.

The State and/or its authorized representatives shall have the right to enter any premises where the Vendor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

E. PAYMENT (Nonnegotiable)

Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. § 81-2403). The State may require the Vendor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any goods and services provided by the Vendor prior to the Effective Date of the contract, and the Vendor hereby waives any claim or cause of action for any such goods or services.

F. LATE PAYMENT (Nonnegotiable)

The Vendor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §§ 81-2401 through 81-2408).

G. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS (Nonnegotiable)

The State's obligation to pay amounts due on the Contract for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Vendor written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Vendor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Vendor be paid for a loss of anticipated profit.

H. RIGHT TO AUDIT (First Paragraph is Nonnegotiable)

The State shall have the right to audit the Vendor's performance of this contract upon a thirty (30) days' written notice. Vendor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. (Neb. Rev. Stat. § 84-304 et seq.) The State may audit, and the Vendor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Vendor shall make the Information available to the State at Vendor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Vendor so elects, the Vendor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Vendor be required to create or maintain documents not kept in the ordinary course of Vendor's business operations, nor will Vendor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to Vendor.

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one-half of one percent (.5%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Vendor, the Vendor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety (90) days of written notice of the claim. The Vendor agrees to correct any material weaknesses or condition found as a result of the audit.

V. C. Business Requirements

1. *The vendor shall provide an Account Management team to oversee the services listed in detail under the Scope of Work. The Account Manager shall be accessible by phone and email. A backup to the Account Manager should also be assigned when the Account Manager is not available.*

Segal has provided an Account Manager, Patrick Klein and a Day-to-Day Contact/Project Manager, Jennifer Slutzky. Their information is under the **Corporate Overview** but here we are providing it again.

The Account Manager for this engagement is **Patrick Klein FSA, MAAA**. Patrick is located in the Atlanta Office and is your primary contact for Segal. He can be reached via email at, pklein@segalco.com, or by phone: office (678) 306-3142 / mobile (470) 279-0232. Patrick has almost 20 years of experience. The majority of his work experience has been spent serving state clients in a lead actuary or account manager role.

The Day-to-Day Contact and Project Manager for this engagement is **Jennifer Slutzky, MPH**. Jennifer has over 25 years of the same experience with large employer group health plans. She is your day-to-day contact for Segal. She can be reached via email at, jslutzky@segalco.com, or by phone: office (678) 306-3120 / mobile (678) 464-4124.

Patrick and Jennifer will continue to work together as an account management team to oversee the services requested under the Scope of Work. They currently provide services to DAS as your lead contacts along with other states that have a similar account management structure, such as Arkansas, Pennsylvania Public School Employees' Retirement System, and Kansas.

As a Senior Vice President and a Principal of Segal, **Ken Vieira FSA, MAAA**, the States' assigned Executive Sponsor, has the ability to deploy personnel on a moment's notice to meet the needs of our clients. This is a key to successfully managing your account. Ken has experience working with the State of Nebraska and is familiar with your actuarial and consulting needs. Patrick and Jennifer will keep him informed and involve him as necessary.

2. *The vendor shall have experience providing benefit consult services to large employers who offer a self-insured employee health plan and wellness program.*

Segal's expertise in the large employer marketplace is focused on flexible funding: participating contracts, experience-rated contracts, minimum premium contracts, and self-insured contracts.

The Atlanta health practice manages 10 state plans and 4 large local municipalities – all offer self-funded medical plans and wellness programs.

Our approach is proactive and strives to prevent or resolve service issues at the root. Rather than serving as an extension of your human resources department in managing routine matters, we demonstrate our value by holding your vendors accountable to prevent administrative and customer service failures. We are your liaison in resolving complex matters and addressing concerns related to employer and employee service, ideally before the matter escalates to an untenable level. As in all matters related to our relationship, we follow issues, projects, requests, and concerns from inception to resolution and keep you informed.

Self-insured employers hire Third Party Administrators (TPAs) to pay and manage medical/ prescription drug / vision and dental claims, interface with a stop-loss carrier, maintain their own or lease provider network and serve as pharmacy benefit manager. Your TPA will either subcontract or perform utilization review, preauthorization and large case management.

Segal will apply our many years of experience in analyzing and working with all types of service delivery platforms to help DAS ensure that you select and utilize the most cost-effective plans with the best service available to DAS' members.

Segal identifies the most advantageous plan or administrator by matching the DAS's needs in order of importance and appropriate weight as defined by you and our partnership to the capabilities of the vendor. This includes the vendor's:

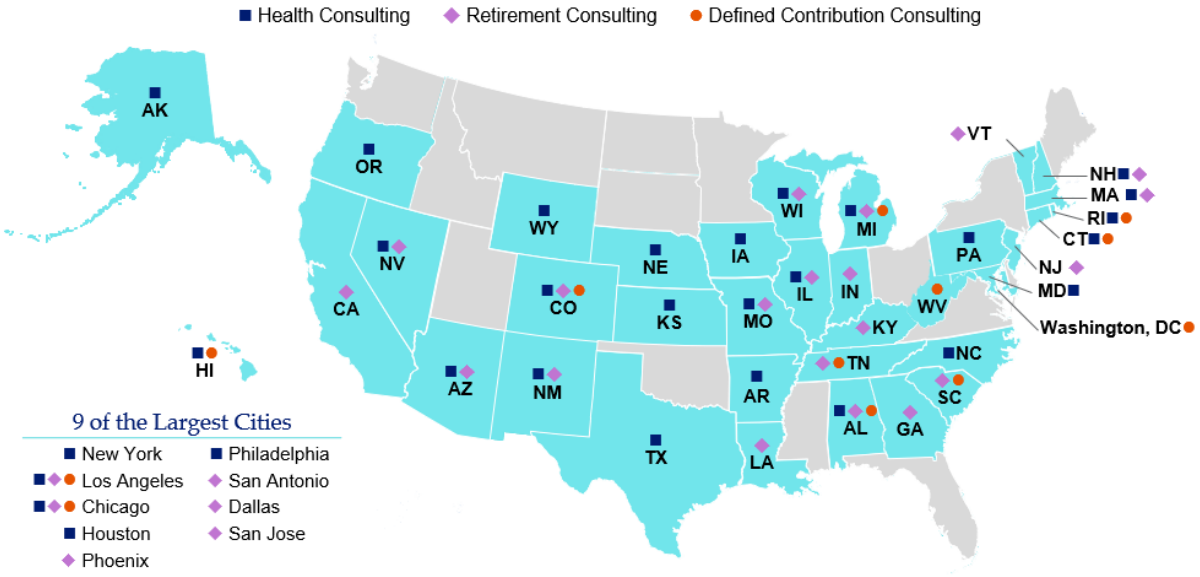
- Specific area of strength and expertise, program capabilities and offerings
- Client and employee service philosophy, flexibility, compliance and financial stability
- Ability to manage claims and/or work with and transfer information to other vendors and contain your exposure to costs and other risks
- Network and other discounts
- Claims payment accuracy, turnaround time, problem resolution, reporting and other information capabilities
- Quality control measures including edits and automation
- On-line tools, dedicated resources and people, and other tools
- Willingness to implement performance standards and guarantee performance
- Ability to demonstrate needed flexibility

Further considerations include employee access and available networks, and employer and employee costs, as well as the vendor's capacity and ability to expand its capabilities consistent with the growth and objectives of the client; the ability to facilitate smooth transitions and implement changes; as well as any other factor as identified by you.

Segal has extensive experience with self-insured clients and routinely performs a bidding process for TPAs and Administrative Services Only (ASO) arrangements. We can customize your procurements to include a variety of alternative funding arrangements.

Self-insured employee state health plan experience

Segal's public sector market team provides health benefit consulting services to more than 250 public sector entities, including 25 states, each of which offers self-funded plan options for employees to choose from. These states are shown in the exhibit below.



We perform health, retirement and/or defined contribution consulting for 35 states, 9 of the largest U.S. cities, 12 California county retirement systems, the District of Columbia, the U.S. Virgin Islands, Puerto Rico and Canada.

Our wellness consulting approach

A health risk appraisal questionnaire, biometric screening, health coaching, disease management, and incentives for participation are often integral ingredients in wellness programs. Increasingly, employers are expanding their view of wellness into a total human well-being perspective. Financial, emotional, spiritual and career well-being accompany physical wellness in most program content.

Our wellness consulting approach generally includes the following elements:

A. **Assess current state**: We identify prevalent health risks and cost drivers from preventable conditions and from better health condition management. We inventory available resources both internal and through your existing vendor relationships. We assess your overall program in light of our Healthy Enterprise Opportunity Analysis (a compendium of over 250 best practices in wellness program design and operation).

B. **Goal setting and strategy development**: We generally work with a committee of individuals to establish a wellness program philosophy, to set goals and then develop a strategy evolving the wellness program effort. This is part of our long-term benefits strategy development process.

C. **Wellness incentive program design**: Given the assessment findings and the strategies developed, we may re-design the wellness qualification requirements and the incentive

structure. We also develop a program implementation process and budget for review and approval. The incentive structures we develop are fully informed by our knowledge of behavioral economics. Designed in the correct manner, incentive structures integrating behavioral economic techniques produce better results at lower cost.

D. **Engagement platform and wellness program delivery**: We will reevaluate our initial assessment and the current state to ensure existing resources are sufficient to engage plan participants, deliver the program content and administer the incentive arrangement or determine whether modifications should be considered. It may be necessary to negotiate service enhancements with existing providers or to find a different partner through an RFP process.

E. **Program evaluation**: Annually, we will evaluate the wellness program by examining program participation, behavior change, population health improvement and outcomes and operating cost. This will give DAS a measure of value on investment.

We will develop a wellness and communications strategy, design a compliant program, implement it and measure it by evaluating vendor reporting and data analytics. We would then refine any program elements that are not meeting expectations. This is a continuous cycle to improve the overall program and results over time.

3. The vendor shall certify they as well as any subcontractors that the vendor utilizes, is in full compliance with HIPAA's regulations protecting the privacy of individually identifiable health information.

Segal certifies that we continue to be in full compliance with HIPAA's regulations protecting the privacy of individually identifiable health information.

In addition, Segal's health plan clients are Covered Entities under the HIPAA Security Rule.

As a HIPAA "business associate" to our health plan clients, Segal implements administrative, physical and technical safeguards designed to protect the confidentiality, integrity and availability of protected health information in electronic form (ePHI). Segal is in compliance with the HIPAA Security Rule and utilizes industry standard technology solutions and best practices to maintain a secure environment for the storage and transmission of ePHI and other confidential data.

Although we do not anticipate any subcontractors on your account, for this contract term, it is standard policy that any subcontractor vendor, working on behalf of Segal, comply with all applicable laws including HIPAA, state laws governing security, and any other federal or state rule or regulation governing vendor's provision of services to the State.

4. The vendor shall agree to sign the State's Business Associate Agreement, see Attachment D.

Segal currently provides services to DAS. Accordingly, if Segal is determined to be the winning bidder, Segal proposes to continue providing services pursuant to contract terms and conditions that are substantively similar to the previously negotiated contract. Please note that our form contract has changed but we are willing to discuss any changes and tailor the agreement as appropriate under the circumstances.

We have provided the State's Business Associate Agreement with modifications, should the State consider these modifications in place of the current BAA.

VI. Solicitation Response Instructions, 1. Corporate Overview

1. CORPORATE OVERVIEW

The Corporate Overview section of the solicitation response should consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

Name of Firm:

The Segal Company (Southeast), Inc. d/b/a Segal

Home (Headquarters) & Office Addresses:

The address of our Segal headquarters located in New York, New York.

333 West 34th Street
New York, NY 10011

DAS will be managed out of our **Atlanta, Georgia** office.

One Paces West
2727 Paces Ferry Road SE
Suite 1400
Atlanta, Georgia 30339

Dates of Incorporation:

The Segal Company (Southeast), Inc.: Incorporated 08/05/1971 (a Georgia corporation)

History and ownership structure

Founded in 1939, Segal is an independent, employee-owned actuarial and benefits consulting firm, headquartered in New York, with more than 1,100 employees in 25 cities and co-working space locations throughout the U.S. and Canada. Members of the Segal family include Segal (benefits specialists); Segal Benz (benefits communication specialists) and Segal Marco (investment solutions specialists). The firm provides the full range of retirement and health actuarial, employee benefits and human resources consulting to public sector, multiemployer and corporate clients.

Segal has been employee owned by its officers since 1978. There are currently 340 employee owners, with no shareholder owning more than 5% of the company. An 11-member Board of Directors sets policy and governs the organization. Implementation of policies, development of strategies and day-to-day operations are the responsibilities of the Chief Executive Officer.

Our teams help a wide range of industries. No matter who you are, we can assist you.

Segal		Segal Benz	Segal Marco Advisors
Administration and Technology Consulting	Health and Welfare Benefits	Benefits Communication	Corporate Governance and Proxy Voting
Benefit Audit Solutions	HR and Benefits Technology	Communication Strategy	Defined Contribution Consulting
Compensation and Career Strategies	Insurance	Personalized Benefit Statements	Discretionary Investment Management
Compliance	Organizational Effectiveness	Surveys and Focus Groups	Intermediary/Advisor Solutions
	Retirement Benefits	Website and Portal Design	Investment Consulting
			OCIO (Outsourced Chief Investment Officer)

Acquisitions over the years included Sibson Consulting (acquired in 2002), Marco Consulting Group (acquired in 2017), Benz Communications (acquired in 2019) and LRWL Inc. (acquired in 2020).

Today we formally operate under one name – Segal – and members of the Segal family include Segal, Segal Benz and Segal Marco.

b. FINANCIAL STATEMENTS

The bidder should provide financial statements applicable to the firm. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that solicitation evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

We have submitted a password protected electronic/uploaded pdf of Segal's most recent audited financial reports and statements. These statements include the name, address, and telephone number of the representative responsible. We request that these are reviewed directly by the State's staff responsible for the evaluation of this information only.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

No pending litigation has ever affected Segal's ability to provide services to its clients or materially affected Segal's financial position or operations.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

We acknowledge the State may elect to use a third-party to conduct credit checks as part of the corporate evaluation.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the solicitation response due date, the bidder should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded bidder(s) will require notification to the State.

Segal is a privately held, employee-owned company, and as such, we do not anticipate any change in ownership or control of our company in the future.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska should be identified.

The State will primarily be serviced out of our Atlanta, Georgia office. Information for that office is below:

One Paces West
2727 Paces Ferry Road SE
Suite 1400
Atlanta, Georgia 30339

This office currently serves as the lead office for DAS along with a number of other state accounts.

The Atlanta office is one of Segal's public sector hubs.

e. RELATIONSHIPS WITH THE STATE

The bidder should describe any dealings with the State over the previous five (5) years. If the organization, its predecessor, or any Party named in the bidder's solicitation response has contracted with the State, the bidder should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

Since 2016, Segal has been the State's current consultant and health actuary for the same scope of services requested in this RFP.

Below is the current contract information:

- The contract number is 73507 Q4

Contract to supply and deliver professional health and welfare consulting services for the employee insurance benefits program which includes health, wellness, dental, vision, life, long term disability, flexible spending accounts, health savings account, and employee assistance program to the State of Nebraska as per the attached specifications for the contract period September 1, 2023 through February 28, 2025 (service contract amendment)

- Original/Bid Document 5297 Z1

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any Party named in the bidder's solicitation response is or was an employee of the State within the past twenty-four (24) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a subcontractor to the bidder, as of the due date for solicitation response submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within

the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this solicitation. If no such relationship exists, so declare.

To our knowledge, no such relationship currently exists or has existed in the past.

g. CONTRACT PERFORMANCE

If the bidder or any proposed subcontractor has had a contract terminated for default during the past five (5) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

We have experienced no termination for default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other Party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's solicitation response accordingly. If no such termination for default has been experienced by the bidder in the past five (5) years, so declare.

We have experienced no termination for default.

If at any time during the past five (5) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

We have experienced no termination for default.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder should provide a summary matrix listing the bidder's previous projects, including at least one (1) other state project, similar to this Solicitation in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the solicitation response.

The bidder should address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Solicitation. These descriptions should include:

a) The time period of the project,

b) The scheduled and actual completion dates,

c) The bidder's responsibilities,

d) For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and

e) Each project description should identify whether the work was performed as the prime Vendor or as a subcontractor. If a bidder performed as the prime Vendor, the description should provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

ii. Bidder and Subcontractor(s) experience should be listed separately. Narrative descriptions submitted for Subcontractors should be specifically identified as subcontractor projects.

iii. The bidder shall have at least five years total of business experience providing comprehensive employee benefit consulting services to large public sector and non-public sector employers with more than 10,000 employees and retirees.

iv. If the work was performed as a subcontractor, the narrative description should identify the same information as requested for the bidders above. In addition, subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a subcontractor.

Segal has extensive experience in providing actuarial and benefits consulting services to public plans and employers. We work with more than 25 state-level health plans across the country. Not only has Segal worked with DAS since 2016 providing the same scope of services listed in this RFP, but your team also works for a number of states throughout the region.

Our State experience

Segal's professional staff includes more than 170 credentialed actuaries firmwide. Our actuaries are Fellows or Associates of the Society of Actuaries and Members of the American Academy of Actuaries. Segal's actuaries work with many state and local government clients on their self-funded health benefit programs. The actuarial team assigned for this engagement has experience with State level plans in Nebraska, Kansas, Missouri, Iowa, Illinois, Wisconsin, North Carolina, Alabama, Maryland, Arkansas, Texas, and others. Additionally, we work with many large cities and counties, some of which approach State level participation.

Governmental entities require an array of specialized expertise, which Segal is committed to providing to meet the evolving needs of public sector clients. Our consulting experience extends not merely to the routine plan design, premium rate renewals, actuarial valuations, and rate setting, but also to the special projects where jurisdictions are exploring new options to meet new challenges. This makes Segal uniquely qualified to provide the services outlined in DAS' RFP.

The following table illustrates our team's experience in providing complex, similar services to other large state clients supported by the Atlanta office and other offices in the East Region.

	AL	CT	IA	IL	KS	MD	MO	NC	NE	NH	PA	RI	TX	WI
Financial Projections	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
IBNR	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Funding Rates/Plan Cost Modeling	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Actuarial Rate Development	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Data Analysis/Trends	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Plan Design Review	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDHP (HSA/HRA)				✓	✓		✓	✓	✓			✓	✓	✓
Narrow Networks		✓				✓		✓	✓				✓	✓
Benchmarking		✓			✓		✓	✓			✓	✓		✓
Medicare Advantage	✓	✓		✓	✓		✓	✓		✓	✓		✓	✓
Medicare Supplement/Wrap	✓	✓	✓	✓	✓	✓		✓		✓	✓			✓
Medicare Part D Consulting	✓	✓		✓	✓	✓	✓	✓		✓	✓		✓	
OPEB Valuation		✓	✓			✓	✓	✓	✓	✓				✓
Legislative Support	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓
Compliance Consulting/ Healthcare Reform	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Wellness Plan Designs & Program Analysis	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓		✓
Contract Negotiations	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Strategic Planning/Migration Strategies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participation in Meetings and Workgroups	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Procurement/Marketing	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Reporting	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Local Governments/Schools	✓	✓		✓	✓	✓		✓			✓		✓	✓
Communications/		✓		✓		✓				✓	✓	✓	✓	
Technology Consulting/ Implementation	✓	✓	✓			✓				✓	✓	✓	✓	✓
Expert Testimony	✓	✓			✓	✓		✓						✓

At Segal, we recognize that each state is unique. Some states, such as Illinois and Wisconsin, have a large number of HMOs that compete in a managed competition style model. Other states, such as Alabama and North Carolina, have a few dominant carriers with a more traditional approach. We have also looked at several alternative models, such as integrating ACOs and Patient Centered Medical Homes, for states such as Texas and Connecticut. All are looking to use their unique local market strengths to best meet their members' needs and improve the sustainability of their programs.

We look forward to continuing to provide DAS a fresh, unbiased approach to your program – integrating your current strengths with our experiences from across the country.

Throughout our response we have additional details on a number of these clients. In this section we have focused on three clients serviced by your proposed team: North Carolina, Missouri, and Wisconsin. Note that Ken has worked for North Carolina for over 20 years.

References & narrative descriptions for consideration by the State and Selection Committee:

Reference 1

North Carolina State Health Plan (NCSHP)

Contact Information:
Charles Sceiford, ASA
Health & Benefit Actuary
3200 Atlantic Avenue
Raleigh, NC 27604
919.814.4412
Charles.Sceiford@nctreasurer.com

Time Period: 2012 - Current

Number of Participants: 740,000

Services Provided:

The NCSHP for Teachers, State Employees and Retirees is one of Segal's largest accounts, covering approximately 740,000 members, with over 130,000 Medicare eligibles. Segal is currently the Plan's Consultant and Actuary and has been in this role since 2012. We provide a broad range of services for NCSHP, including the following projects over the last 12 months:

- Providing ongoing actuarial analyses and financial projections over 5 years
- Calculation of participant and employer rates
- Data mining, warehousing and in-depth utilization claims analysis, including EBD dashboards
- Clinical risk group analysis
- GASB OPEB actuarial valuations
- Quarterly and annual pharmacy benefit manager audits of claims, MAC pricing and discounts, and rebates
- Medicare Part D actuarial attestations
- IBNR analysis and reserve recommendations
- Analysis of return on investment of contracted disease management vendor
- Strategic consulting and planning with the Board of Trustees
- Alternative plan design, including incentives, penalties, and value based features
- HIPAA compliance review and consulting

- ACA program consulting, including the evaluation of the financial and compliance implications of upcoming legislation
- Medicare Advantage, PDP and EGWP consulting
- Review of medical management performance guarantees
- Bundled payment strategies and opportunities
- Network design and pricing
- PBM and TPA Marketing

Segal performed over 90% of the work related to this engagement. Only printing subcontractors for communication materials are/were utilized.

Reference 2

Missouri Consolidated Health Care Plan (MCHCP)

Contact Information:

Stacia G. Fischer
Chief Financial Officer/Deputy Director
832 Weathered Rock Court
P.O. Box 104355
Jefferson City, Missouri 65110
573.526.4062 (o)

Time Period: 2022 - Current

Number of Participants: 86,000

Services Provided:

The Missouri Consolidated Heath Care Plan (MCHCP) covers approximately 86,000 members with a spend of approximately $800M per year. The size and scope of services is very similar to what Segal currently provides to the Nebraska DAS, including: actuarial projections, funding rates, monthly models, quarterly IBNRs, procurements, pharmacy, clinical, Board presentations, etc.

Segal began consulting services for MCHCP in 2023 and they are one of our larger clients implemented over the last 3 years.

Segal performed 100% of the work related to this engagement and no subcontractors were utilized.

State of Wisconsin – Department of Employee Trust Fund (ETF)

Contact Information:

Renee Walk
Programs & Policy Unit Director
4822 Madison Yards Way
Madison, WI 53705-9100
608.261.7254 (t)
Renee.Walk@etf.wi.gov

Time Period: 2014 to Current

Number of Participants: 241,000

Services Provided:

Segal was retained by ETF to perform a full range of services related to the analysis, design, management, and communication of the State's health insurance program for employees and retirees.

We have also been hired to perform actuarial consulting services for ETF, which consist of the following items:

- Provide actuarial consultation and advisory services on any technical, policy or administrative problems arising during the course of operations - by meetings, routine telephone calls and correspondence.
- Make recommendations to the State of Wisconsin Group Insurance Board (GIB) from time to time relative to possible improvements in the financing and benefit structure of the plans (including advice and fiscal estimates on proposed state law changes). Give advice on new developments in the group health insurance industry. Keep the GIB apprised of current trends and progress within the actuarial profession.
- Offer consultation and advisory services regarding the fiscal effect, and policy and administrative issues with implementing new legislation.
- Assist in establishing and maintaining specifications for group health insurance data files whether maintained by the Department or third parties
- Provide advisement on developments in federal legislation and/or regulations regarding financing, benefits, fiduciary responsibility, taxation, disclosure, etc.
- Review self-funded health and pharmacy benefit plans
- Procure and market for dental, data management, TPA, PBM, wellness and Medicare Advantage
- Annual review of alternate plan (HMO/PPO) activity
- Review of Medicare Part D activity

Segal performed 100% of the work related to this engagement and no subcontractors were utilized.

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder should present a detailed description of its proposed approach to the management of the project.

The State prefers the proposed account manager have a minimum of 10 years consulting experience in employee benefits, including a minimum of 5 years consulting experience in governmental benefits or employers with self-insured health plans with more than 10,000 employees enrolled. The State reserves the right to have complete approval rights to the account manager assigned to our account.

Patrick J. Klein, FSA, MAAA is a Vice President in our Atlanta office and will serve as the DAS Account Manager. Patrick supports state-level assignments in the Midwest. He will provide ongoing consultation services to DAS under this contract and serve as a day-to-day point of contact for actuarial work.

Patrick has 18 years of actuarial and consulting experience working with public and private sector plans and employers. Working with both self-insured and fully insured plans, he has specialized expertise in developing employer healthcare strategies for active and retiree benefit programs, new product development, risk profiling, data analytics, vendor selection, employee contributions, wellness, and eligibility provisions to meet client goals and objectives. Patrick is the current Account Manager for the State of Nebraska (DAS), Arkansas and Illinois. He has also provided consulting and actuarial support for Iowa, AL PEEHIP, Kansas, and North Carolina.

Patrick thoughtfully negotiates fully insured renewals for Medicare Advantage, HMO and other insurance products on his clients' behalf, consistently resulting in significant savings. He provides certification of estimated incurred but not reported reserves (IBNR), as well as the claims/premium assumptions used in retiree health valuations. Patrick is adept at building and presenting custom actuarial models used to calculate refined estimates and the sensitivities surrounding those estimates.

In addition to project management and client work, Patrick assists clients with messaging and gaining organizational buy-in to support the recommended strategy. He regularly presents to various committees and governing boards, articulating complex actuarial concepts in easy-to-understand layman's terms.

Many of the services the State is requesting are performed for the above-mentioned State clients which Patrick has/is managing with staff from your Segal Team

Patrick will be responsible for the completion of each service component and deliverable of all work under the scope of this RFP. He will work closely with the leads on each team and has final sign off on all deliverables and/or reports.

We understand the State reserves the right to have complete approval rights to the account manager assigned to your account.

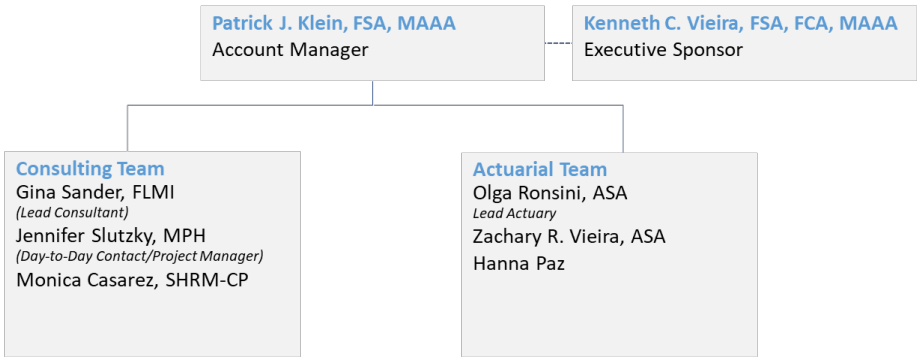
The bidder should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Solicitation. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface, and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

Segal has assembled a senior team of consultants, actuaries, and clinicians who have experience working with state health plans as well as previously served on this State contract and have a deep knowledge of the healthcare delivery systems utilized primarily in Nebraska.

The team will be staffed primarily out of the Atlanta office and will be supported, as needed, by our Regional and National Healthcare Practitioners.

All of the senior team members meet the minimum requirements described in **C. Business Requirements**.

Below is a summary of our proposed State of Nebraska account team and the lines of responsibility on your account:



Subject Matter Experts

Compliance
Elena Lynett, JD

Clinical & Wellness
Sadhna Paralkar, MD, MPH, MBA

Pharmacy
Kautook Vyas, PharmD

Communications
Catharine Hamrick

Data Analytics & Network Analysis
Albert Shaaya, PMP

State of Nebraska proposed team

Key members of your proposed team are summarized on the following pages, highlighting their expertise and role on your account only. We have included detailed resumes of each team member in the Segal Team Resumes section of the proposal.

Below is a brief summary of each member of our team, their role on the account and how their experience would benefit DAS.

Team Member	Title	Role for the State
Patrick J. Klein, FSA, MAAA 678.306.3142 pklein@segalco.com	Vice President	Mr. Klein will be responsible for day-to-day execution of all actuarial projects including the renewal rates and budgeting. He has specialized expertise in employee benefit strategy, vendor negotiation, and cost projections. He has in-depth experience with many public sector large group entities.
Kenneth C. Vieira, FSA, FCA, MAAA 678.306.3154 kvieira@segalco.com	Senior Vice President, East Region Public Sector Market Leader	Mr. Vieira will serve as the executive sponsor for DAS. Ken brings a full complement of actuarial and consulting expertise to his clients. He has extensive experience in strategic consulting, benefit plan design and evaluation, financial forecasting, trend analysis, risk profiling, new product design, plan rating, premium rate development, data analytics, retiree medical, statistical modeling and other medical management programs.
Gina T. Sander, FLMI 678.306.3185 gsander@segalco.com	Vice President and Health Practice Leader	Mrs. Sander will serve as DAS' Lead Consultant. She has extensive experience in strategic consulting, benefit program/plan design and evaluation, financial forecasting, trend analysis, plan rating, premium rate development, data analytics, vendor selection and management and presenting to committees, councils and boards.
Jennifer Slutzky, MPH 678.306.3120 jslutzky@segalco.com	Senior Health Consultant	Mrs. Slutzky will serve as your Day- to Day Project Manager. She has extensive experience in developing, analyzing, and managing public sector procurements for coverages including medical, prescription drug, wellness, and Medicare Advantage. She also assists in vendor selection, contract negotiations, and program implementation, including member-facing communications
Monica Casarez, SHRM-CP 915.731.1476 mcasarez@segalco.com	Associate Consultant	Ms. Casarez will serve as your consultant and provide support to Jennifer and Gina. Monica has more than 19 years of human resource experience in employee benefits, risk management, employee relations, staffing and hiring.
Olga Ronsini, ASA, MAAA 678.306.3141 oronsini@segalco.com	Actuary	Mrs. Ronsini will serve as your Lead Actuary. She performs technical work and review for actuarial valuations, actuarial assumptions studies and related projects.
Zachary Vieira, ASA, MAAA 678.306.3153 zvieira@segalco.com	Associate Health Consultant	Mr. Vieira will serve as your assistant actuary and support Olga. He provides financial analysis and interpretation of healthcare data, including medical,

Team Member	Title	Role for the State
		prescription drug, stop loss, dental, vision, life and disability coverages.
Hanna Paz 678.306.3139 hpaz@segalco.com	Health Benefit Analyst	Ms. Paz helps to assist actuarial teams with data and analysis.
Elena Lynett, JD 202.833.6486 elynett@segalco.com	Senior Vice President	Ms. Lynett will serve as the Compliance specialist on your team. She provides analysis of federal and state law impacting group health plan coverage and is an expert on the Affordable Care Act, Mental Health Parity, Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination and wellness provisions, and Genetic Information Nondiscrimination Act compliance.
Sadhna Paralkar, MD, MPH, MBA 312.984.8520 sparalkar@segalco.com	Senior Vice President and National Medical Director	Ms. Paralkar will serve as your Clinical and Wellness Director. She leads Segal's Medical Management consulting and has specialized expertise in on-site clinics, wellness programs, medical management program design, healthcare informatics and network management strategies to optimize health improvement while containing costs, and evaluation and implementation of disease management and wellness programs.
Kautook Vyas, PharmD 312.984.8587 kvyas@segalco.com	Vice President, Senior Pharmacy Benefits Consultant	Mr. Vyas will serve as your Pharmacy Consultant. He provides consulting services that incorporate advanced data analytics with the latest best-practice guidelines for clinical pharmacy.
Catharine Hamrick 312.984.8607 chamrick@segalbenz.com	Communications	Ms. Hamrick is Vice President, Communications in Segal Benz's Chicago office. Driven by a passion to make a positive difference in employees' lives, Catharine has been an HR communications professional for more than 15 years.
Albert Shaaya 404.276.2089 ashaaya@segalco.com	Senior Health Consultant	Mr. Shaaya will serve as your Data Analytics resource. He has more than 16 years of data analytics and business intelligence experience with a focus on healthcare data management and actuarial support.

The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Solicitation in addition to assessing the experience of specific individuals.

We have included resumes of our key associates with references, and we have included resumes of the full team assigned to the State in ***Appendix 1: Segal Team Resumes***.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

All team member resumes meet the above requirements.

We have provided references for our top team members as they will be performing the majority of the work for the State.

j. SUBCONTRACTORS

If the bidder intends to subcontract any part of its performance hereunder, the bidder should provide:

i. name, address, and telephone number of the subcontractor(s),

ii. specific tasks for each subcontractor(s),

iii. percentage of performance hours intended for each subcontract; and

iv. total percentage of subcontractor(s) performance hours.

Segal does not plan to subcontract any part of the work on this project. Should a need arise to engage a subcontractor during the course of work on the project, we will discuss that need with the State and request written approval from the State prior to engaging the subcontractor or committing to the work.

VI. Solicitation Response Instructions, 2. Technical Response

a. Understanding of the Project Requirements

D. Project Requirements

The vendor will provide the following services:

1. *Strategic consulting services for all health and welfare programs including the State's self-insured medical (including performance guarantee), pharmacy, wellness programs, and collective bargaining;*
    a. *The medical RFP is the only separate cost.*
    b. *The cost to support the State on the remaining contracts must be included in the annual rate.*
2. *Actuarial services for the State's Employee Health Plan;*
3. *Health plan data analytics and reporting (including the OPEB, CAFR and GASB #75 reporting annually);*
4. *Assist with benefit plan requests for proposals (RFP); and*
5. *Legislative and Regulatory Analysis & Education.*

We understand the requirements outlined in this RFP and are fully committed to delivering exceptional service and support for the health benefit programs offered by the Department of Administrative Services (DAS). Our extensive expertise in managing and partnering with State Clients in administering health benefit programs equips us to effectively support DAS, both now and in the future, ensuring the seamless delivery of services and continuous enhancement of program offerings. Segal will demonstrate our ability to provide the State of Nebraska with these services throughout our technical proposal and by answering the questions posed in the Attachment A Matrix.

We at Segal are pleased to submit this proposal to continue to provide professional health and welfare consulting services for the employee insurance benefits program which includes health, wellness, dental, vision, life, long term disability, flexible spending accounts, health savings account, and employee assistance program for the State of Nebraska (DAS).

Segal is prepared to serve as your actuary and health care consultant. Our firm brings to this engagement an established record of experience, hard work, and innovation in helping large public and private sector clients manage their benefits programs. Through our work with a broad array of public sector employers at the state, local and federal government levels, we are experienced with many of the complex issues faced by the State.

DAS' Account Manager is **Patrick J. Klein, FSA, MAAA**. Patrick has 18 years of actuarial and consulting experience working with public and private sector plans and employers. Partick is the current Account Manager for the State of Nebraska (DAS), Arkansas, Illinois and Wisconsin where he is the Lead Actuary. He has also served as team member for Iowa, AL PEEHIP and North Carolina.

DAS' Day-to-Day Contact and Project Manager is **Jennifer Slutzky, MPH**. Jennifer is a Senior Health Consultant based in our Atlanta office. She will provide day-to-day support, general support to the team and has expertise in project management, benchmarking, and vendor procurement and implementation of active and retiree health options, Medicare Advantage and Prescription Drug Plan solutions. Jennifer's recent and current clients include, the State of Nebraska (DAS), Alabama PEEHIP, Alabama State and Local Governments, Kansas State Employee Health Plan, the State of Connecticut, as well as the Pennsylvania Public School Employees' Retirement System.

DAS' Lead Consultant is Gina Sander, FLMI. Gina is a Vice President, Senior Health Consultant, and the Atlanta Health Practice Leader in our Atlanta office. Gina has 35 years of experience as an underwriter, lead consultant, and account manager. She will oversee, supervise, and coordinate all team project efforts for the DAS.

Gina has a strong technical underwriting background and brings a full complement of consulting expertise to her clients. She has extensive experience in strategic consulting, benefit program/plan design and evaluation, financial forecasting, trend analysis, plan rating, premium rate development, data analytics, and vendor selection and management. In addition to DAS, some of Gina's recent and current clients include Fulton County (GA), Metropolitan Rapid Transit Authority (MARTA), Harris County (TX), the State of Iowa, State of Kansas, Missouri Consolidated Health Care Plan, State of Illinois, Texas Teachers' Retirement System, and the Wisconsin Employee Trust Fund.

DAS' Lead Actuary is **Olga Ronsini, ASA**. Olga is an Actuary in Segal's Atlanta office. She performs technical work and review for actuarial valuations, actuarial assumptions studies and related projects, including:

- Retiree medical (OPEB) valuations
- Expense and revenue projections for self-funded health plans
- Estimating IBNR reserves
- Quarterly and monthly reports
- Conducting actuarial attestations in support of retiree drug subsidy applications
- Processing and analyzing health claims data

Olga's current clients are the State of Nebraska, Texas Teachers Retirement System, Missouri Consolidated Health Care Plan, AL PEEHIP, and the State of Maryland.

Our senior management team brings a wealth of knowledge to the engagement. Our team has likely worked for nearly every State in our region at some point in their career, some current. The

team will engage our Subject Matter Experts and other experts as we progress through the engagement.

Our understanding

The State of Nebraska (State) offers comprehensive wellness and health benefits to approximately 27,600 employees, spouses and children. These employees live in all 93 Nebraska counties. The State offers four self-insured medical health plans to 13,300 employees, which includes a wellness health plan (**WellNebraska**) requiring participation , a union negotiated plan (Regular Plan) and a consumer-focused HSA. Dental, vision, FSA, life, LTD and EAP services are also options available for selection.

The State is committed to investing in workforce by providing competitive health benefits. The State administers a high performing health care benefit program with excellent benefits at a low cost. In 2023, the State implemented several changes to the design of its health plans to make medical care more affordable to its members including a decreased copay in their Wellness and Regular plans, elimination of the copay for maternity services in the Wellness plan to further its goal to make the State a premier employer for families, and increased the visit limit on speech, occupational and physical therapy. In addition to implementing these benefit improvements, DAS was also able to keep contribution rate increases below market value for the 2023-2024 plan year in a market where most plan sponsors, including peer States, are reducing benefit values and increasing contributions to keep up with medical and pharmacy inflation. For the 2024-2025 plan year, the State again chose to hold premium rate increases well below expected cost trends. Segal looks forward to the opportunity to continue its work with the State to support an affordable quality benefit package that attracts and retains a best-in-class workforce.

The State's objectives and intended results

The State will continue to manage all employee benefit plans. All aspects of the employee benefit plans are subject to review, and the State understands that all areas of plan management are critical to the program's success.

Based on our experience providing consulting services to other state plans we expect that the State intends for the health benefit plan to accomplish simultaneous goals that may conflict at times, including:

- Provide benefits that are similar to other states;
- Demonstrate that the benefit plan provides value in attracting and retaining well qualified staff;
- Provide cost efficient benefits that contribute to helping the State meet budget goals in other areas; and
- Build fund balance strategically over multiple years to reach reserve target.

For DAS's health data planning and reporting Segal has experience and expertise in assisting state plans with their annual OPEB, CAFR, and GASB 75 reporting. Our team is well-equipped to support DAS in completing these essential reports accurately and on time, ensuring compliance with the latest accounting standards and regulations.

We propose to provide actuarial and related consulting services requested by the State, including:

- Strategic Consulting Services;
- Actuarial Services and Related Reporting;

- Health Plan Analytics and Reporting;
- Benefit Plan Request for Proposals; and
- Legislative and Regulatory Analysis & Education

Our proposed team was designed to encompass all the skills and expertise needed to best meet your needs.

Our approach is unique

Segal is known in the benefits, compensation, and human capital industry for the longevity of our client relationships. With over 2,500 clients across the country, we gain and lose some clients each year. Some of our client relationships span a period of as much as 60 years. In a number of cases, former clients that retained the services of other consultants have returned to us.

Segal's consulting approach, for our large state self-insured health plans, is anchored on its dedication to our corporate values and Segal's mission:

"Providing trusted advice that improves lives"

We are committed to our clients' success. We approach DAS in partnership, with the goal of providing strategic support to allow your program to remain viable for years to come. By forming a partnership with our clients, we serve as both advisors and advocates, and as a result, we ensure that our consulting services align with your strategic goals. Our work will affect the lives of your employees and retirees.

What Our Clients Say About Us

"*Quality people…professional, knowledgeable and diverse.*"
"Their strategy focused the alignment to the vision."
"Thorough analyses."
"Ability to understand underlying strategic issues."
"Partnering with the client to best resolve the issue at hand."
"Tells the truth."

Our consulting approach is client focused, timely and pragmatic and forward thinking. To be current and relevant in our work:

- We strive to **understand our public sector client needs** and are sensitive to their unique environment
- We pride ourselves in **challenging the status quo** and delivering the work related to the basic consulting tasks needed to support complex health plans
- We are unmatched in the consulting industry as **creative and innovative thought leaders** dedicated to developing the right solutions
- We are committed to integrity, professionalism and exceeding expectations.

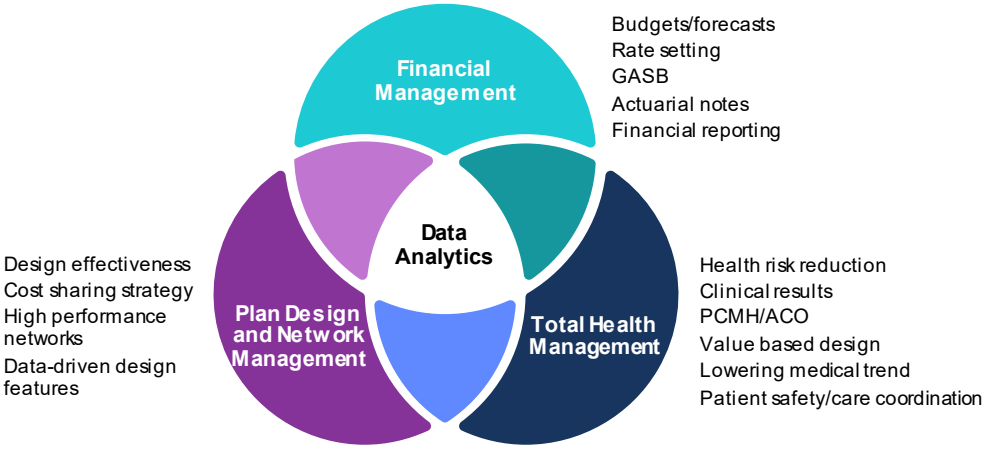
Segal's health consulting model

A key element of our service delivery for DAS will build off of our health consulting model.

The model emphasizes the integration of three pillars:

1. **Financial management**: Aspects of a health plan that are related to budgets, forecasts, rate setting and reporting
2. **Plan and network management**: Advisory services that support design effectiveness, network performance, cost sharing strategies and vendor management
3. **Total health management**: Advisory services that support clinical results, health risk factor reduction strategies, innovative delivery systems (e.g., Patient Centered Medical Home, Accountable Care Organization), digital therapeutics, patient safety and care coordination, and medical trend management

The following diagram illustrates how these consulting pillars fit together for the best outcomes for our clients:



Our consultants understand the interrelationships between each consulting pillar and work together across a wide range of consulting specialties to deliver this integrated consulting model. Each of our clients is at a different place in their development of cutting-edge health benefit programs, and our approach offers wide flexibility in addressing issues at every level. Even when we are retained only for one aspect of the work, we continually think across all these major concerns to help provide our clients the most appropriate advice for their success.

We are committed to working partnerships with our clients that add value and consistently exceed expectations.

Client satisfaction based on the delivery of high quality; client-focused consulting services is the backbone of our business. We place a premium value on our relationships with clients. Segal's commitment to clients is evidenced by the loyalty of our clients, many of whom have maintained long-standing relationships with us spanning over 60 years.

Segal understands the project requirements and has designed your team to ensure continued success.

b. Project development approach

Segal's approach to project development has several facets:

- **We will be an integral part of your organization's HR team,** working closely with you to understand and address your health and benefits communication needs, and to help you meet your communication and behavior change goals.
- **We will engage with DAS as we do with every client – continuously learn as much about your organization, its challenges and needs, objectives and your audiences as possible, before developing any suggested communication strategy or tactics.** We always approach client engagements with open minds and with no preconceived notions about what's needed for your situation. In our eyes, every client is truly unique and deserves to be treated as such.
- **We will make ourselves available when you need us.** We move quickly, change direction nimbly, suggest alternatives when changes in direction are warranted and respond promptly.
- **We will make your job easier.** We understand you have a wide variety of responsibilities outside of health and benefits communications. In that regard, we are your proxy, paying close attention to project development schedules and progress. We will be your eyes and ears as work moves along, alerting you to timing concerns and doing whatever is needed to ensure deadlines are met and quality communications are delivered. We will take on as much of the responsibilities for developing DAS' health and benefits communications as you prefer.

c. Technical requirements

E. SCOPE OF WORK

Explain how the bidder will provide the services below to the State by completing the Requirements Matrix, Attachment A. Responses shall demonstrate experience performing similar services for other State or large employers including accomplishments and other information. Include examples of the bidder's work, when applicable.

1. Strategic Consulting Services

The vendor will provide strategic consulting services for all health and welfare programs listed above in Section V. B. Project Environment. Services include, but not limited to, the following list of services.

a. *Regularly consult with the State on strategy and programs to which help manage the State's self-insured health and wellness plan including plan design, networks, pharmacy benefit program, stop loss, and carriers. Renewal timeline:*

   i. *Plan Year begins: July 1*

   ii. *Governor renewal review: October/November*

   iii. *Final rates & plan design: December/January*

b. *Regularly meet with Employee Wellness and Benefit staff to stay abreast of administrative, programmatic, regulatory, and other issues and opportunities regarding the State's employee benefit programs*

c. *Attend benefit plan vendor meetings as requested to provide input and recommendations.*

d. *Provide on-going monitoring of developments in new benefit strategies.*

e. *Assist in reviews, analysis and recommendations of employee benefits in preparation of labor negotiations and be available to attend onsite preparation meetings as requested. The State has three bi-annual labor unions. Each of the contracts includes a component of employee benefits. Labor negotiations occur every 2 years. (2024 is a bargaining year)*

f. *Train Administrative Services staff on topics including regulatory updates, industry trends, data analysis compliance, and Ad Hoc Training.*

As we currently serve as your health actuarial consultant, Segal will continue to provide the above listed strategic consulting services (a – f), as requested by DAS.

Under ***Attachment A***, where applicable, we have provided a full description of the above services.

2. Actuarial Services & Related Reporting

The vendor shall provide actuarial services for the State's employee health insurance plan and wellness program. The following services and reports shall be prepared as part of this contract:

a. *An annual plan cost analysis and annual calculation of the employer and employee contributions for each of the State's health plans.*

b. *Analyze and recommend the annual Claims Fluctuation Reserve (CFR) level at the end of the plan year. The State currently maintains a CFR at a 90% confidence level.*

c. *Analyze and recommend a projected Incurred But Not Recorded (IBNR) amount at the end of the plan year.*

d. *Help the State prepare a Value on Investment (VOI or ROI) for the State's wellness program each year.*

As we currently serve as your health actuarial consultant, Segal will continue to provide the above listed actuarial services and related reporting (a – d), as requested by DAS.

Under ***Attachment A***, where applicable, we have provided a full description of the above services.

3. Health Plan Analytics and Reporting

The vendor shall provide the State with the following services:

a. *A monthly budget report of the State's health plan performance comparing actual to budgeted costs.*

b. *Pursuant to Nebraska Revised Statute 50-502, the State of Nebraska Health Insurance Plan Annual Report is due in November each year. See Attachment B for the most recent report.*

c. *Health plan reports including cost trending and multi-year forecasting projections as requested by the State.*

d. *Other reporting requirements may include health plan analytical reports, industry surveys, and benefit program performance and gaps.*

As we currently serve as your health actuarial consultant, Segal will continue to provide the above listed health plan analytics and reporting services (a – d), as requested by DAS.

Under ***Attachment A***, where applicable, we have provided a full description of the above services.

4. Benefit Plan Request for Proposals (RFP)

The vendor will assist the State in the preparation and evaluation process for all benefit plan RFP and in accordance with processes established by state statute and the State Purchasing Bureau. Services may include but not limited to develop the technical requirements, assist with questions from potential bidders, provide questions for oral interviews, develop scoring methodology, and conduct cost evaluations.

See Attachment C for the list of Benefit Contracts.

As we currently serve as your health actuarial consultant, Segal will continue to provide benefit plan request for proposals, as requested by DAS.

Under ***Attachment A***, we have provided a full description of the above service.

5. Legislative and Regulatory Analysis & Education

The vendor will assure the State is informed of any regulatory laws and changes which affects the State's employee benefit program. Services include:

a. *Provide guidance, impact analysis and training on all regulatory requirements which affect the State's benefit program. This includes COBRA, ACA, HIPAA, Section 125, IRS, and any other employment laws which affect the State's benefit programs.*

b. *Keep the State informed of pending and final federal and state legislation which may affect the State's employee benefit program.*

c. *Provide guidance and training to the State to assist them with complying with the Affordable Care Act.*

d. *Assist the State with preparing fiscal notes as requested while the Legislature is in session.*

As we currently serve as your health actuarial consultant, Segal will continue to provide the above listed legislative and regulatory analysis and education (a – d), as requested by DAS.

Under ***Attachment A***, where applicable, we have provided a full description of the above services.

F. PERFORM IMPLEMENTATION

As part of the proposal, the bidder shall provide a plan detailing the implementation timeline. The plan shall define responsibilities assigned to the vendor and responsibilities assigned to the State. Implementation must be completed by March 1, 2025.

Your senior account team will be fully engaged during implementation of the new contract.

As we have mentioned earlier in the proposal, Jennifer Slutzky will serve as the day-to-day contact and will work closely with Patrick Klein (Account Manager) and Olga Ronsini (Lead Actuary). With Patrick's knowledge and experience with DAS, and with Jennifer's project management skills as well as her knowledge and experience with DAS, we foresee a smooth contract launch that will not require any ramp-up time.

Segal will continue to have bi-weekly scheduled project calls not only during implementation, but throughout our contract. These calls will include all relevant team members that are working on your account.

Kickoff meeting

For the new contract, we will still request to have a Kickoff meeting with DAS.

This meeting will serve as an opportunity for our respective teams (current and new team members) to meet, clarify questions, understand new and burgeoning objectives, and adjust to the new scope of work to fit the State's needs. The Kickoff meeting will also allow us to establish next steps for ongoing projects and tasks.

We will discuss the role or roles you intend for us to take, under this new contract, and how we can be most effective in supporting and guiding your decisions.

In addition, we will discuss the level and types of reporting desired by the State, under the new contract, and any new expectation of Segal's role in continuing to monitor, produce, analyze and distribute program reports.

Annual service calendar

We will also review with you a draft Annual Service Calendar or Work Plan, including a list of all known and scheduled projects during the year. Based on our discussions, we will then customize the calendar to ensure we are providing the appropriate services and information to you in order to meet your deadlines and the requirements of your decision-making processes.

d. Detailed project work plan

As we have demonstrated in working with DAS for the past eight years, preparing an annual work plan is necessary in any engagement to ensure that both sides manage expectations. We have provided the following example of what Segal anticipates for the initial contract period. Note that we would expect the work plan to be modified in discussions and partnership with DAS to ensure that DAS' needs are met.

Proposed Work Plan Timetable (Every Year)	Timing
Tasks Performed Annually	**Every Year**
Strategy and planning meeting – Segal senior team meets with DAS to strategize on benefit program goals and prepare for the upcoming year.	September-October
Regulations and Compliance advisory – Segal provides ongoing consultation regarding federal (e.g., ACA) and state regulatory requirements that impact DAS' benefits program.	Ongoing
Pharmacy program monitoring – Segal continuously monitors the prescription drug industry and DAS' PBM to keep DAS informed. We analyze trends and cost containment strategies, proposed clinical programs, changes to the formulary, network changes and new to market therapies.	Ongoing
Data compilation – Segal continues to collect monthly data in preparation for semi-annual reporting, rate development and budgeting, and to provide timely customized ad-hoc reports when needed.	Every month
Annual Report – Segal delivers this custom comprehensive report to include a complete analysis of the prior year: utilization summary, member cost sharing, distribution of claimants by claim size, hospital readmission rates, Rx summary (utilization and top drugs by therapeutic class), cost and utilization by disease, clinical quality performance, and changes in utilization and cost by service. We also include a section on any future changes to the program.	November
Monthly Projected vs. Actual – This report provides a financial summary of total annual projected costs by month, comparing actuals to projected. The development of this report is overseen by the Lead Consulting Actuary and certified by his statement of actuarial opinion.	Quarterly
Multi-Year Rate and Budget Projection – This report will include projected rates and increases for the self-funded health. It includes the projected fund balance compared to the reserve target and establishes a strategy to reach the plan's financial goals. The rate development is overseen by the Lead Consulting Actuary and certified by the statement of actuarial opinion.	Initial in October, finalized by March
IBNR reserve – Using our proprietary claims lag analysis tool, combined with our knowledge of claim payment patterns, Segal provides DAS with its estimated IBNR reserve as of June 30. This process is overseen by the Lead Consulting Actuary.	August
Claims Fluctuation Reserve – Segal delivers the CFR memo at the same time as the IBNR so the plan can determine the full reserve target.	August
Review plan documents and SPDs, as needed – Segal's compliance team works closely with the health consultants to ensure these documents accurately represent the benefits programs and meet all regulatory requirements.	March - May

The following projects would likely not be conducted annually; however, Segal recognizes their importance and has included them in the below work plan. As appropriate, pieces of this proposed work plan would integrate with the "Every Year" work plan above.

Proposed Work Plan Timetable (As Needed)	Timing
Tasks Performed Periodically	**As needed**
Best practices and benchmarking – We will conduct a benchmarking study to measure DAS' benefits offerings in comparison to comparable employers, including local entities and other states' benefit plans. This is a great tool in identify best practices in benefit design.	
Vendor audits – Segal will evaluate vendor performance, including but not limited to, claims processing and payment procedures, meeting contracted terms and accurate administration of DAS' plan design. Segal's audit process also includes improvement recommendations.	
Collective bargaining support – Segal will provide recommendations on health plan design options and the modeling of their cost impact, as well as educational presentations to union representatives to facilitate productive discussions between both parties. Segal is very aware of the need for expedited delivery of modeling during this process.	
Review and evaluation of existing employee benefit plans – We focus on information gathering, plan review and benchmarking, objective setting and healthcare strategy development. We also evaluate the appropriateness of alternative financing mechanisms, including employee contributions and the funding of HRA/ HSA/ FSA accounts.	
Vendor RFPs – Segal will work with DAS to develop and analyze any RFPs the State intends to procure, including a medical and prescription drug RFP. Segal will ensure the RFP incorporates all of DAS' wants and concerns for the RFP, including Performance Guarantees. Segal will identify possible Proposers, assist the State in answering Proposer questions, if needed, analyzing RFP responses, supporting vendor selection and contract negotiations. Segal can also support DAS with implementation of the Plan.	
Plan design modeling – Segal will begin our analysis of proposed plan design changes, along with calculating the impact of these benefit modifications. We will perform this modeling during collective bargaining support or as presented throughout the year.	
Vendor management – Segal will work on DAS' behalf to reconcile contract or coverage issues and/or to serve as a representative of DAS in negotiating renewals and contract details with providers.	

e. Deliverables and due dates

Our deliverables and due dates are listed above under **d. Detailed project work plan**.

Attachment A: Requirements Matrix Final

Attachment A
Bidder Requirements Matrix

1.	Describe bidder's understanding of the business requirements in Section V.C.
	Response: See **Section V., C. Business Requirements** for our answers to **1 – 4** starting on page 8.
2.	Describe bidder's understanding of the project requirements in Section V.D.
	Response: See **Section VI. Solicitation Response Instructions, 2. Technical Response, a. Understanding of the Project Requirements** starting on page 27.
3.	Describe the bidder's approach to providing strategic consulting services to the State on all of the benefit programs. Include a summarized listing of services included with the proposal.
	Response: See **Section VI. Solicitation Response Instructions, 2. Technical Response, b. Project Development Approach** starting on page 32.
4.	Describe bidder's process to consult on a self-insured health plan with over 20,000 participants.
	Response: Benefit plan design and consulting are core services of your Segal team. We provide a broad range of services related to plan design and consulting, utilizing a number of tools, benchmarking and best practice databases. The Actuarial and Consulting staff assigned has ample experience working with large clients that exceed 20,000 participants. We will work directly with DAS on all aspects of the program. The assigned State team will devote the time needed to the account, including being available for frequent telephone and on-site consultation with the State. **Patrick J. Klein**, the DAS' Account Manager, has assembled an interdisciplinary team of experts, with each member of the team having unique skills and expertise. Jennifer Slutzky will be the day-to-day point of contact for DAS and Patrick will manage the Segal resources. The majority of your core team members are located in our Atlanta office. However, we may at times draw on resources from other offices in order to bring the right expertise to a particular situation. Every member of your team is committed to be available in person, via phone or email as often as you deem necessary.

Team communication

With an account the size of DAS, managing information flow between project teams and even within a team is vital. Segal has much experience in knowledge management, and this experience will be brought to bear on the State assignment. Elements of this include:

- Creation and utilization of e-mail groups to push information to the teams
- Weekly “open item / status update” meetings
- Written tracking of progress and issues in a “shared document” accessible to the entire team
- Creation of a secure internet portal to house contact information, key deliverables and correspondence

Segal is well-qualified to provide all services to DAS, as outlined in the Scope of Services section of the RFP.

On-going Project Management

At Segal, we closely monitor the workload of each team member to ensure they have capacity to meet our internal performance expectations, and those of our clients. Specifically, we assess staff’s availability to adhere to our high standards for quality work, balanced against the need to meet tight deadlines and be flexible enough to shift gears for the inevitable, unexpected challenges that crop up in the course of client engagements. Prior to being assigned to work on behalf of a client, we assess each team member’s current workload.

We define expectations to our staff for the timing of project deliverables, for each stage of the project, and the amount of time involved. Once we have set the parameters of each project, and assign appropriate staff, we then begin to inform clients of progress one we have started the work. During the project, we will assess client satisfaction with our performance. With that in mind, we have assembled a team of benefit professionals with significant experience working with clients who have needs similar to those faced by the State.

An Account Manager oversees the relationship for each client by monitoring workflow, introducing other advisors as needed, and periodically communicating progress to the client. The Account Manager also solicits client feedback and keeps the client updated on any issues that arise in the industry that may be of interest and have an impact on the client’s programs.

As a Senior Vice President and a Principal of Segal, Ken Vieira, the States’ assigned Executive Sponsor, has the ability to deploy personnel on a moment’s notice to meet the needs of our clients. This is a key to successfully managing your account since many of the deliverables have a one-week turnaround that we are committed to meet.

Developing strategy

Segal will assist with the development of a long-term strategic plan for the State that minimizes costs, maximizes cost savings, and provides comprehensive benefits to the employees of Nebraska. Segal is constantly monitoring and reviewing strategies for our clients to best manage their program.

At the request of DAS, Segal will provide analysis and recommendations regarding potential health care program strategies, fiscal soundness and options for consideration that is consistent with the strategic long-term goals, vision, and objectives established by DAS. Our team of experts will propose and evaluate new programs or benefits and provide you with a complete analysis (financial, legal, administrative, etc.) of the impact of such programs. These strategies typically involve a wide array of expertise, requiring the participation of national health care strategists, a consumerism/wellness expert, a clinician with expertise in wellness and chronic condition management programs, data mining analysts, a pharmacy expert, actuaries, and compliance experts.

Any recommendation will need to be practical, actionable, and consistent with the overall vision of the State. All our strategies are built on an actuarial foundation, where studies and prior experiences help formulate the financial outcome of the recommendation. We will include best practice benchmarks, industry standards, emerging designs, success/failures of similar programs, etc. We review from a number of angles and want to make sure anything recommended has staying power and causes a minimal amount of noise and disruption.

Our recommendation(s) will be supported by the necessary documentation and findings. We will also meet with DAS staff, if requested, to discuss potential risks and the measures that can be taken, and by whom, to minimize these risks. We are also prepared to present such finding to the State.

Plan design for self-funded clients

In this section we will briefly discus some approaches we utilize.

The ultimate goals of plan design are threefold:

- The plan must encourage appropriate utilization by paying for necessary, quality care at a high level and by paying for discretionary care at lower levels.
- The governing plan design must be established in order to assist in meeting the overall cost and financing goals of the plan, as well as maintaining compliance with the DAS's collective bargaining agreements and the rapidly changing legislative environment.
- The plan must be flexible, so it meets the ever-changing needs of members and the current industry trends.

These competing goals can be brought into alignment through strong data management and analysis. The DAS's data should contain the information needed to determine how to encourage appropriate utilization at a cost that is affordable and, more importantly, sustainable.

Effective plan design is the key to providing high-quality, cost-effective healthcare to participants. We have extensive experience in the design and redesign of health benefit

plans. We help clients understand the current and future costs of their benefit programs with the objective of best meeting the needs of participants and the overall management of the plan.

Cost management strategies that address plan design can include:

- **Establishing meaningful cost sharing**, i.e., deductibles, copayments, co-insurance and monthly contribution levels. Nominal copayments do little to discourage wasteful demand for questionable care. However, if the cost sharing is too high, it may deter employees from getting essential care. Examples of how we have helped clients establish meaningful cost sharing have included:
  - Increasing specialist copays to reflect the extraordinary usage of specialists as compared to primary care physicians
  - Recommending a tiered urgent care/emergency room copay to reflect the unnecessary usage of emergency rooms
- **Establishing appropriate cost-sharing differentials among treatment options and settings** so employees are encouraged to seek the most cost-effective courses of treatment and the most efficient providers. Designing differences between network and non-network benefits and the coverage for brand name and generic prescriptions that are significant enough to influence behavior are important. Payment levels between competing therapies and inpatient/outpatient settings also need to differ. Plans with lower out-of-pocket costs for less expensive treatment options can change patients' behavior, benefiting both employees and employers. Recent examples of how Segal has assisted clients in this area include:
  - Redesigning a prescription drug plan to achieve the correct balance between retail and mail-order copays. In this situation, the mail-order copays were initially too low, creating a net-loss to the plan when the mail-order plan was utilized.
  - The variation of fees between the various ambulatory surgery centers exceeded expectations, resulting in higher than expected costs. On behalf of the client, we recently negotiated with the PPO network managers on the allowed fees at various centers for certain common procedures, helping to control costs.
- **Enforcing pre-certification and utilization review rules**: Broad-based, non-specific pre-certification rules that ultimately result in approval of all requests are a waste of time and money. To be most effective, pre-certification rules should be targeted to treatments and services that are subject to overuse or abuse. For instance, some people with minor, acute conditions improperly use narcotic painkillers on an ongoing basis, a potential indication of addiction. Requiring pre-certification can identify these cases and often stop the abuse.
- **Implementing variable copay programs for specialty drugs**: Leveraging the manufacture copay assistance programs so both plan sponsor and patient receive the financial benefit We will review claims to ensure benefits were paid only on behalf of eligible individuals based on the administrator's adjudication system record. Where coverage was retroactively terminated, we will identify if any overpayments exist and report such claims as 'other claim matters' within our report. Our advance questionnaire explores controls related to receipt of eligibility updates, timely processing of electronic updates, and procedures employed when a retroactive termination notice is received.

Segal will discuss your goals and priorities and provide a menu of choices and alternatives for your consideration. We will provide the cost impact associated with each change. Should DAS wish to consider reductions in its plan offerings, in addition to the changes in deductible, co-insurance, out-of-pocket maximums, HSA funding levels, co-payments and/or employee contributions which will influence cost, we will also help predict the enrollment or migration between plan designs options.

Valuing the impact of Plan Changes

Should DAS consider making changes to its benefits plans, Segal will assist in forecasting the effects of those changes. The first step in being able to make supportable forecasts for plan design changes is to establish a benchmark of the value of DAS's current plans. We do that using our Optum CompPricer. This system calculates the relative value of benefits to participants using a large number of factors from the plan design. By calculating relative values of different benefit designs, we can help DAS understand the likely effect of any proposed changes.

The Optum CompPricer calculates the relative value of benefits to participants, using a large number of factors from the plan design. By calculating relative values of different benefit designs, we can help DAS understand the likely effect of such proposed plan changes.

The Optum CompPricer models different deductibles, out-of-pocket maximums, co-payments and changes in provider discounts or utilization to assess the impact of plan changes under a variety of plan management and network platform options. It also has a pharmacy component embedded that models the impact of plan design changes on carved-out prescription drug programs. It can be used to see the effect of implementing out-of-pocket limits on coinsurance plans or how changes in front-end deductibles can reduce bottom-line prescription drug costs. We also have a separate tool for analyzing prescription drug plan design changes that we developed internally called the Rx Omni-Pricer. Rx Omni-Pricer makes use of plan-specific census and utilization information and trends by drug category in order to project the impact of plan changes.

The tool is first calibrated to match the membership's current distribution of geography, age, gender and utilization patterns (by inpatient, outpatient, professional, pharmacy, etc.). This approach enables us to develop the financial impact in a tailored fashion while benchmarking the result(s) against analysis conducted on a national database of claims of more than 20 million individuals.

Vendor management

In addition to this macro approach to health plan management, we also employ a specific process to identify and prioritize strategies which become components of DAS's short- and long-term benefits strategy.

Vendors that demonstrate the best fit for DAS are critical to creating a well-managed health plan. The correct mix of vendors needs to be monitored closely through frequent meetings, measurement of performance guarantees and performance standards, audits and renewal negotiations.

Segal works with virtually all health care insurers, third party administrators, network providers and other service providers nationally and locally. We are not limited to a select group of providers. Rather, we work with all providers available in the market and help our clients to choose the provider that best meets their needs and goals. Over the last few

years, we have conducted numerous statewide procurement processes for these coverages, so we are very familiar with and current on the variability of network access, cost parameters and clinical programs available from these and competing providers.

We will always strive to receive concessions from vendors before implementing changes that will affect employees. Ensuring vendors are effectively managed will ensure employees and employers are paying the lowest cost for the best benefit.

Individual health management

We will work with DAS to establish and improve the components of your wellness or disease management programs. We will keep a close eye on your population's experience to recommend additional disease or condition management programs that may positively impact the participants' risk factors, existing conditions, and the related plan costs.

We have worked with clients that have moved beyond standard first-stage wellness and disease management programs, as well as those taking their first steps. We find that a program's maturity level influences how programs are evaluated, monitored, and improved. Through our Healthy Enterprise research, we understand the relative importance of various initiatives. To that end, we developed a maturity model for a healthy enterprise and conducted research to validate the model. This model informs our consulting approach with each client based on the client's objectives and what we have learned about how different decisions and approaches impact achieving results.

It is critical to review DAS's plan through the three lenses of vendor, plan and individual health plan management and build a benefits strategy to evaluate and then implement any identified initiatives.

In order to demonstrate our knowledge, we have put together a grid summarizing the various ideas that we have worked on with our state clients. Some have been implemented already, others are in the works or just whiteboarding. This is meant to be high level and we would be happy to discuss them in further detail.

State	Innovation/Strategic Initiatives
Alabama	• Developed Pharmacy PBM guarantees on a PMPM basis • Negotiated aggressive MAPD MLR guarantees • IRA Impact model with risk analysis • Active plan management left funding level for nearly 10 years • Mental Health Parity reviews with corrective action plan • Pharmacy pricing impact models, including AAC, NADAC, etc.
Alaska	• Direct hospital contracts • COE network with concierge travel • IRA Impact model with risk analysis • NADAC pricing analysis • Feasibility analysis to admit K-12 Schools into State Plan • Rx rebate audits uncovered substantial shortfalls • Self-insured LTC plan is well funded

Arkansas	• Long term funding policy with "triggers" for experience • Diabetes management program/education • MAPD implementation that reinstated lost pharmacy benefits due to procurement cost savings • PBM fully transparent marketing savings – not from the "big 3"
Arizona	• IRA Impact model with risk analysis • Aggressive MAPD MLR guarantees • Self-insured non-Medicare, resulting in no premium/benefit changes for three years
Colorado	• State of Health integrated wellness program • PBM Reverse auction complete • Managed smooth spend-down of excess reserves • Incorporate narrow network and plan re-design on pre-Medicare retiree health plans
Connecticut	• Innovative weight management program with Flyte, where GLP1s for weight loss only covered only if prescribed by physician in program. • SHAPE warehousing saving millions of dollars annually • Reverse Auction RFP's (medical, pharmacy, dental, MAPD) • PMPM pharmacy guarantees, contract beginning 7/1/24 • Partnership with Segal/HDMS for client access to data warehouse and "front end" reporting
Hawaii	• Innovative combination of insured medical and self-insured Rx to take advantage of unique market dynamics • Fully insured medical has 100% gain-sharing and 0% share in losses • Care management program inventory to compare/assess programs in multiple carrier environment • Benchmarking benefits and employee premiums with other western states
Iowa	• Creative hybrid financial arrangement provides smooth funding • Looking at PBM reverse auction RFP
Illinois	• Local underwriting model– expanded tiers to mitigate group lapse rates • MAPD 5-year guarantee with aggressive MLR guarantees
Kansas	• On-site clinic model • Live financial modeling capabilities for Board • Two medical TPAs to cover state • Point of sale rebates
Massachusetts	• Multi-year EAP procurement and contract negotiation

	• Creative performance guarantees – engagement and access/time-to-care • Troubleshoot vendor engagement strategy • Close gaps in care for evolving needs between the EAP and Health plan benefits
Maryland	• Moving retirees to Medicare exchange platform • Comprehensive communications education for retirees • Annual pharmacy market checks during renewals • PBM reverse auction RFP complete – savings limited due to above • Data management in SHAPE, combining multiple vendors, products, and data sources • Developed performance metrics, allocating incentives for clinical improvements between competing plans • Medical pharmacy analysis with biosimilars
Minnesota	• Re-design of public entity program
Missouri	• RFP partnership with Medicaid for GLP1 purchasing • Public entity risk model for setting each group specific rates • Expanded fertility benefits • Annual pharmacy market checks during renewals
Nebraska	• Creative Integrated wellness plan with participation requirements • Best in class maternity benefits/program • Premium holiday to share surplus without disrupting funding rates • Found no savings from Direct Primary Care Program
New Hampshire	• PBM Reverse auction complete • Incentive program that provides cash rewards to members that opt for care at cost-effective health care providers • Significant savings in moving Medicare retirees to an MA plan and then to an MAPD • Effective contract management through regular RFPs and market checks
New Mexico	• RFPs conducted jointly for multiple state plans • Long-term solvency modeling for retiree health funding and management • Care management program inventory to compare/assess programs in multiple carrier environment • Wellness programs to also address education and behavioral health surrounding weight loss medications • COE partner for certain surgery procedures • Discussing/analyzing NADAC pricing

North Carolina	• Pilot health management program in County with Vera Health • Successful defense of TPA legal dispute, new vendor to be implemented • Using SHAPE population health report to manage programs • Re-design of complete plan using regional system competition and market competition • Removed all caveats from PBM contract to not allow guarantees to be adjusted • Removed GLP1s coverage for weight loss and released an RFI to find a financially sustainable solution
Nevada	• Regional HMO supplemented with self-insured EPO for statewide managed care option • Incentivized Consumer Directed Health Plan option • Medicare Exchange • Managed smooth spend-down of excess reserves
Oregon	• Managed competition renewal model • Sunsetting low performing local MA HMO • Revised reserve policy to better manage premium volatility
Pennsylvania	• Direct Contract with CMS for Medicare Part D • Managed Competition Approach to Medicare Offerings • Virtual Benefit Fair • IRA modelling
Rhode Island	• Targeted reserves policy development • Rate setting methodology development, including considerations for agency budgeting allocations • Award-winning communications campaigns (e.g., “Pick Your Person” beneficiary designation campaign) • Virtual Benefits Fair in place of in-person open enrollment fairs • Introduced choice and re-branded healthcare plan offerings, rolled out new concepts and terms (buy-up options, new plan design features), provided education and decision support, and encouraged independent research and action
Texas	• Developed alternative benefits study/TRS opportunities for Legislature • Redesign of Retiree plan, reducing required contributions for Medicare members while improving benefits • Ranked hospital costs utilizing percent of Medicare • Added primary care focused plan with reduced member/state cost • Eliminated ineffective costly HMO

		• Developed regional rating model with 20 geographic rating areas • Medical pharmacy analysis with site-of-service • Introduced Dental & Vision coverage for retirees
	Wisconsin	• Managed competition model used for negotiations • Local entities utilize underwriting guidelines and have surcharge • Program is regionalized and qualified • Integrated wellness program • Strategic multi-year reserve buy-downs/buy-ups
	Wyoming	• Developed target reserve policy based on other state practices • Cancer and MSK programs implemented to target highest cost categories

5. Describe bidder's process to assist the State in managing a pharmacy benefit program.

Response:

Segal is a qualified pharmacy benefit consultant and will provide insights and resources to aid in the development and analysis of a medical and prescription drug RFP, if the State chooses to have one vendor managing both benefits or a stand-alone PBM RFP if the State chooses the latter. Segal will support the State in the selection of a vendor that will deliver the best overall value to the plan. Segal can assist in determining the vendor that would provide the best value in terms of costs, services, clinical programs and trend management.

Segal has extensive experience in conducting full PBM bid processes for both public and private sector plan sponsors. We are comfortable in being involved in all or part of the procurement process and make a point of adjusting our processes to fit our client's procurement requirements while still maintaining fully objective analysis and quality review.

The next section describes our proposed process for the work we understand our clients typically desire for a PBM bid. The process would be similar for a combined medical and PBM RFP.

The proposed process

Each major step outlined below contains a brief description of the tasks involved and purpose.

Planning meeting

- Clarify plan's objectives for the PBM RFP.
- Discuss any operational or other considerations resulting from plan's current and past PBM vendor experience that need to be incorporated specifically into the content of the RFP.
- Develop and establish selection criteria.
- Review any confidentiality agreements required by the existing PBM related to provision of historical claims data to potential bidders.

- Discuss potential bidders and the current PBM marketplace.
- Establish a project plan with key dates.
- Discuss plan's contractual requirements.
- Discuss plan's procurement process to assure we have a clear understanding of the contractual needs that must be supported through the technical and financial portions of the RFP.
- Begin to gather the necessary information for sending an RFP out to the market.
- Discuss pricing and financial arrangements that will need to be anticipated in the RFP.
- We will also follow-up with meeting notes to document all decisions made.

Develop the RFP

Using our PBM RFP model provisions, Segal will prepare an initial draft of the RFP document. That draft will also take into account the plan's previous RFP for these services, your current RFP formats and content requirements and any new factors identified from our Kickoff meeting. We will then provide the draft RFP to you for review and comments.

Once we receive and discuss your review and comments on the draft RFP, we will modify the draft to incorporate the final understandings.

We will then provide the final RFP version to plan for final procurement processes to release the RFP to the marketplace.

Pre-Bid meeting and bidder Q&A

Segal will assist plan preparing for and participating in the Pre-Bid Meeting, if applicable; we will take notes to ensure all questions and responses are documented; we will track all pre-bid questions and draft responses.

Evaluate bids and produce analysis report

When qualified vendor bids are received by plan and forwarded to Segal, our analysis of each bid will take into consideration at least the following items:

- Technical proposal:
  - Minimum Requirements are met
  - Adherence to Contractual Requirements
  - Specialty Drug Management
  - Network Access
  - Formulary Management & Disruption
  - Utilization Management
  - Mail Order and Web Capabilities
  - Medicare Part D Solutions (if applicable)
  - Account Services
  - Performance Guarantees
- Financial proposal:

- Financial offer
- Comparison of projected costs/savings taking into account:
  - Guaranteed discounts, fees and rebates
  - Formulary drug mix
  - Projected drug trend

Provide comprehensive analysis and bidder evaluation to the plan, discuss the results and select finalists

Once the analysis of the technical and financial bids is completed, we will provide you with a report that will provide both an executive summary of our findings and the detailed results of our analysis. We will schedule a call to review and discuss the results, to clarify the analysis, and to answer any questions. The report we provide will be intended to facilitate plan's decision in selecting finalists.

Manage finalist interviews

We believe on a contract as complex as this and involving so many state dollars it is essential that the selected finalists be allowed to present their capabilities and submit to close questioning about weaknesses in their proposals and/or operational experience. We suggest requiring they bring in the Account Management team that would be responsible for providing services to your account. This will allow you to determine whether they are a good fit with your organization, from a cultural and philosophical standpoint, their commitment to the State, and whether they would be responsive to your needs. Segal will assist the Plan in preparing or reviewing agendas, in developing question sets to be asked of each vendor, and in participation at the interviews as an independent analyst of their representations.

Formulary management and utilization management review and specialty management

The pharmacy market is an ever-expanding and complicated benefit that requires unique expertise and proactive management. Our pharmacy team spends a great amount of time looking at formularies, new to market drugs, patent expirations, specialty distribution channels, limited distribution drugs, copay assistance programs and many other aspects of the market that are always changing.

Segal's pharmacy team is built of clinical experts that keeps a keen eye on formulary management, savings opportunities and new/innovative approaches to cost-containment. Segal will work in collaboration with plan to administer the PBM's formulary offering (or custom formulary) and utilization management package (i.e., Step Therapy, Prior Authorizations, Quantity Limits) to ensure members maintain access to clinically effective medications while ensuring high-cost medications that have limited value to lower cost medications are not being incentivized or adopted in the formulary. The PBMs offer several formulary and utilization management options to their clients, and Segal is well equipped to help plan select the most advantageous offering. Segal's clients have formulary and utilization management options ranging from standard formularies that have a set number of clinical edits on utilization, to custom formularies that select aggressive utilization management based on market trends and the plans own specific utilization.

Segal reviews each of the drugs going on and off the formulary in detail and will provide feedback independent of the PBM for each quarterly and annual review. Analysis of member utilization and market trends also allow Segal pharmacists to identify savings opportunities independently of the Plan's PBM and provide unbiased advice that saves our plan sponsors cost while maintaining high levels of care. Through our claim management system, we monitor drug usage, review new drugs coming to market, provide insight on drugs moving to generics, look for evidence of fraud, waste and abuse, etc.

Segal also offers expertise in addressing the rising cost of specialty drugs- high cost, bio-engineered drugs- used to treat rare and complex conditions. We are experienced with the specialty drug programs and tools available from the major PBMs, including the specialty drug management programs.

Segal's three-step approach to achieving cost savings focuses on plan design, vendor management and individual health management. In addition, we offer an array of services designed to optimize pharmacy benefit management. Segal can help plan manage the cost of prescription drug coverage through a variety of services. We have assisted a number of clients improve the management of their specialty drug utilization with a variety of strategies including the optimization of channel distribution, implementation of prior authorization and other utilization management programs. Many plan sponsors can lower their cost for specialty drugs while at the same time improve the quality of care and service received by plan participants.

Financial guarantees review

Segal has ongoing experience reviewing PBM financial guarantees for many of our clients. We have found it crucial to perform regular financial reviews for PBMs in order to ensure that payers are getting the most for their prescription drug benefit dollars, and in accordance with the PBM contract terms.

Given the constant changes in the PBM industry, such as drug pricing baseline discrepancies (Average Wholesale Price, or AWP, Wholesale Acquisition Cost or WAC), transparent pricing arrangements, and PBM mergers and consolidations, it is more important than ever to closely monitor PBMs and pharmacy benefit plans. Our experience suggests that frequent, independent monitoring of PBM performance, produces the best and most tangible financial results.

PBMs annually reconciles all network discount guarantees off the quoted Average Wholesale Price (AWP) and dispensing fees as well as guaranteed minimum rebates. The PBM will provide its financial performance reconciliation report to the plan typically 90- 120 days after the close of the contract year for the guaranteed discounts and dispensing fees. Rebate guarantees are reconciled typically 90/150/180 days after the year.

Per client request, Segal's National Pharmacy Practice can review these reconciliation reports for reasonableness and compliance in relation to the contract terms. Client or Segal, on client's behalf, can request the PBM's summary reconciliation reports. Segal will then review and confirm that the PBM's self-reported discount and dispensing fee performance reconciliation report was supported by the contractual discounts and dispensing fees. Segal will advise if the reconciliation and dollar values provided in the applicable PBM recovery are appropriate compared to other source documentation such as the plan's history and utilization.

If it is determined that this is not in line with agreement or benchmarks, further options such as a Pharmacy Claims Audit would be recommended. We note that the Annual Pharmacy Guarantee Reconciliation Review is not an independent audit review or validation of the financial performance during the annual contract period. It is a high-level review of the PBM's self-reported financial performance.

6. Describe bidder's process to consult on a wellness program comparable in size to the State's wellness program.

Response:

Changing participant behavior is the cornerstone of any effort to build a "culture of health" in an organization.

To make wellness work, employees and their families must be engaged, empowered and accountable. At most organizations, substantial behavioral and relationship shifts are required for culture change to take hold.

Participants Must:	DAS Must:
Take a more active role in their healthcare and lifestyle choices	Commit to identifying and changing unhealthy practices and processes
Understand the impact of personal lifestyle choices on future health and health costs	Provide the educational resources and tools employees will need to make the best choices
Become educated consumers of wellness, prevention and disease/condition management programs	Track progress
Commit to identifying and changing unhealthy behaviors and developing positive, new habits	Establish a program of ongoing education to drive program results
Manage their healthcare dollars wisely	

A health risk appraisal questionnaire, biometric screening and incentives for participation and Segal's Inventory/Action Plan Phase will move you to the next level to assess the degree to which these and your other wellness efforts impact the health risk factors of your employees and their dependents.

We have extensive experience in helping organizations design and implement wellness communications campaigns, from relatively modest ad hoc efforts to full-blown, multi-year, multi-element programs. The scope of any wellness communications campaign – indeed, any effort to facilitate culture change within an organization – depends on how broad the gap is between current conditions and the desired state, as well as the organization's goals and resources.

Critical elements to affect behavior change include communications and employee engagement. Segal is an expert in both.

Many believe that the only way to change participant behavior is by using penalties. While this form of getting participants' attention is very effective, an equally effective method is the role of "key influencers." A key influencer is someone who is respected and trusted by members. Through active and vocal support of medical management programs, these influencers can be a catalyst for creating a culture of wellness and good health. Therefore, Segal encourages clients to use penalties as a last resort if all other forms of increasing member participation fail.

It is also at this point that you, like most plan sponsors, will want to discuss incentives for encouraging participation in wellness services or for actually changing behavior (stop smoking, lose weight, reduce blood pressure) or incentives for both participation and behavior change. Here, Segal discusses your philosophy and budget constraints as it relates to incentives/rewards or penalties.

Segal understands the need to help you develop a program that assists your participants in making voluntary behavior changes that reduce their health risks and enhance their individual productivity/quality of life. You want to keep healthy people healthy, and have any unhealthy people learn to become healthy.

If necessary, we are prepared to assist you in redesigning a program to reduce the modifiable risk factors that impact your population (such as smoking, obesity, stress/depression, high blood pressure, inactivity/lack of exercise, dyslipidemia, etc.). **Segal is fully prepared to assist you in the redesign of a health promotion program** that emphasizes the four crucial phases:

1. **Communication/awareness** (such as personalized communication, reminders, tools that identify for participants where wellness services already exist in the benefits program, etc.)
2. **Screening and assessment** (including Health Risk Appraisals/Assessment-HRA questionnaires, biometric testing including blood tests, blood pressure, body fat, etc.)
3. **Education** (personalized coaching for individuals with risk factors, group and individual classes, etc.)
4. **Behavior** change systems (including rewards/incentives, worksite modifications, etc.)

How Segal has achieved results

As an industry leader in helping employers create evidenced-based health improvement strategies, Segal has extensive experience helping clients optimize wellness programs. Drawing on decades of research in behavior change science and behavioral economics, combined with practical experience gained from assisting employers across the country, we have determined that the best results can be achieved when organizations help participants progress through a specific pathway to sustained health improvement. The steps in the process include:

- **Forming intentions**: In this phase, participants commit to taking action to improve their health. Intentions might include "I'm going to start eating better," "This year I'm going to get more exercise" or "Next time I'll find a way to avoid that type of stress."
- **Pursuing conscious behaviors**: **I**n this step, individuals actually adopt specific behaviors tied to previously noted intentions. These might include attending a nutrition

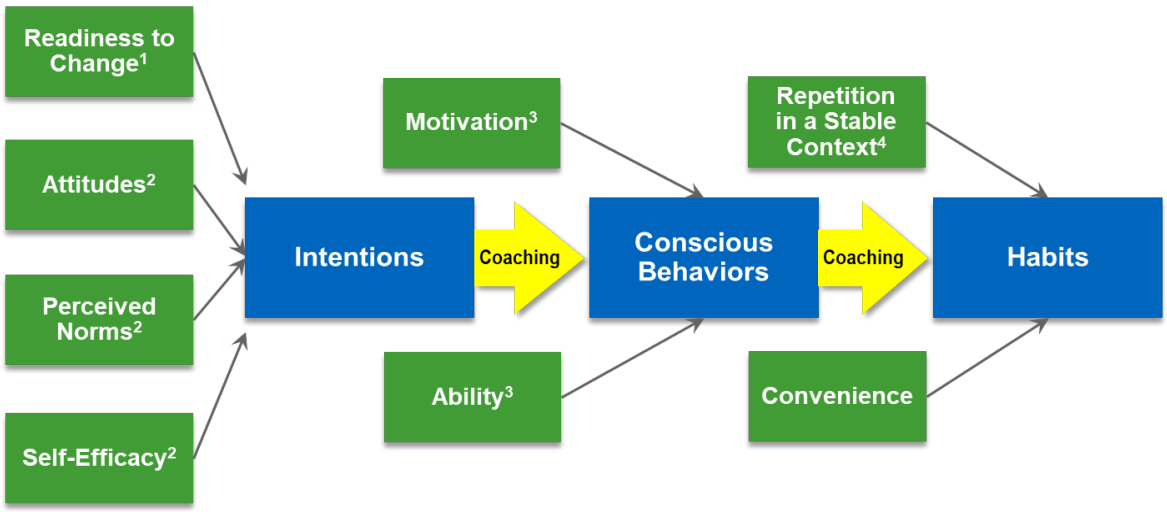
class, joining a walking club or developing a plan with co-workers to reduce certain stress-inducing situations at work.

- **Adopting ongoing habits**: Ongoing habits or daily routines are the lifeblood of sustained behavior change. Once adopted, habits require little or no motivation to sustain (e.g., individuals do not have to motivate themselves to wear a seatbelt each day – they simply click it by habit when getting in car). Moreover, research has shown that when life gets more hectic, people tend to rely even more on habits. For a plethora of reasons, most successful wellness programs are designed to help participants achieve this most critical goal of building long-term healthy habits.

In order to achieve sustained behavior change, it is critical to help participants move through this process of *Intentions* → *Behaviors* → *Habits*. In our view, seeing a participant progress from good intentions to achieving ongoing habits is the ultimate demonstration of true engagement.

The following chart illustrates the model Segal utilizes to help employers move participants from *Intentions* → *Behaviors* → *Habits*, along with the academic research on which our model is built.

Segal's Evidence-Based Framework for Optimizing Wellness Program Impact



Sources:
[1] *Transtheoretical Model* developed by James Prochaska, PhD, Carlo DiClemente, PhD, and John Norcross, PhD
[2] *Theory of Planned Behavior* developed by Icek Ajzen, PhD
[3] *Fogg Behavioral Model* developed by B.J. Fogg, PhD
[4] Research in Habit Formation developed by Wendy Wood, PhD

While we approach each client situation individually, we have found the following five-step process can be useful in helping clients deploy our behavior change model to improve participation and engagement:

1. **Determine program goals**: To help confirm direction and clarify priorities, we assist each client in establishing realistic short and long-term goals for their program. Identifying clear goals upfront helps ensure senior management's support for the

	strategy developed by the organization and allow the organization to speak a common language as we delve further into details of the plan. 2. **Identify potential programs**: To establish an overall framework for the strategy, we assist the organization in identifying specific programs to be explored and potentially implemented, which may include: • Incentives and other nudges to drive employee engagement in specific programs, drawing on Segal's deep expertise in behavioral economics and behavior change science • Tactics to harness employees' own intrinsic motivation to improve their health, helping ensure employees (a) understand the benefits of change, (b) believe they have the ability to change and (c) perceive that others around them are modeling the preferred behaviors • Opportunities to help employees develop new habits to support their physical, emotional and financial well-being (recognizing that habits are a fundamental building block for sustained behavior change) • Low-cost, high-impact environmental changes to help make the healthy choice the easy choice for employees (e.g., where possible, making sure healthy food options are available for employees at their worksite) • Options for cost-effective health coaching/advocacy services to assist employees in overcoming barriers to change and achieving sustained health improvement 3. **Identify required resources**: To help ensure the long-term viability of the strategy, Segal helps the organization detail the resources which will be required to implement specific programs identified in step 2 above. 4. **Establish timeframes for** implementation: Weaving together the programs and resources noted above (from steps 2 and 3 above), we help organizations identify realistic timeframes for implementing various programs. 5. **Creating program metrics**: To enable the organization to monitor the ongoing success of the strategy, we help identify specific metrics that tie program elements (from steps 2, 3 and 4) to overall goals from step 1 above. Drawing on successes we have achieved with other large employers, we find that these often include a combination of financial and outcomes-based measures.
7.	Describe the bidder's process to work with collective bargaining to assist a State government, or large employer similar to the State of Nebraska. Response: Segal is the preeminent benefits consulting firm in the multiemployer market and has extensive experience handling collectively bargained plans. Many of our state clients have groups of collectively bargained employees so we are intimately familiar with the bargaining process and can share our experiences with the State. We currently consult to over 50 collectively bargained health and pension plans across the country. At the beginning of our contract with Nebraska, we attended negotiation meeting and presented ad hoc analyses. Since then, we have supported indirectly as needed. Segal will be available to provide technical advice and assistance during labor negotiations The negotiating process can take many forms. Since strategic initiatives of the State have yet to be developed, providing exact definitions of tasks can be difficult. However, we know that assistance may consist of analyzing and reviewing various scenarios for proposed

plan design changes, developing various rate scenarios, evaluating proposals from the NAPE/AFSCME, attending various negotiation sessions and testifying at the fact finding and interest arbitration proceedings should the issue of medical benefits not be agreed upon during the negotiation proceedings. We are prepared to assist the State in any way requested.

In general, our services in support of the collective bargaining process fall into the following steps:

Develop bargaining proposals

Segal can meet with the State's lead negotiator to provide guidance and support in the development of bargaining strategies. This includes scoping management's proposals to the unions and the unions' demands. Typically, proposals are segmented into economic and non-economic items. Economic items relate to wages and associated pay policies, health benefits, retirement, and pay differentials. Non-economic items relate to work rules, paid time off, and other working conditions. Segal is most cost effective when we are engaged to assist with the development of all benefit related proposals. Our collaborative process includes meeting with negotiating teams and crafting language for each proposal. Our approach draws on internal financial and operating data, input from senior management, and carefully articulates assumptions, methodologies, and costs attributable to each proposal.

Negotiate with union(s), develop contract language

Segal can support direct negotiation with the unions at the bargaining table. This requires a review of union proposals beforehand, as well as any analytical work necessary to supplement the discussions. We anticipate receiving detailed benefit plan design and cost information as key pieces of information among other things. We have found that a data-driven approach to bargaining can be effective as a tool for reaching consensus.

Assess costing implications

Our work typically includes our development of financial implications of union or management proposals. For most economic items (wages, health insurance, retirement, etc.), costing the impact is a vital tool for understanding the ramifications of accepting the proposal. The costing will primarily be based on the census file, other relevant financial and operating data, and is usually segmented by contract year. For example, we will calculate the first-year cost and subsequent costs in each out-year. For some proposals, the first-year cost will be greater than subsequent years (front-loaded) and for other proposals, cost will be back-loaded (more expensive at later years of the contract). Developing the analysis in this manner will assist the State and your constituents in understanding the multi-year financial implication of each proposal, as well as the "steady state" cost for proposals that may have increasing future costs beyond the expiration of the agreement.

Assistance in mediation/arbitration

Your Segal team is available to assist with any impasse process, including the development and presentation of the State's position at any mediations or fact-finding hearings. Since at this time it is difficult to determine the precise level of effort with this phase, our work could include the development of exhibit material, presentations to negotiating committees or hearing boards, and time associated with testimony.

Our team is available to support the negotiations and have resources available for a wide variety of requests.

8. Describe the data analytic tools used to analyze medical and pharmacy claims data. Indicate if the State will have access to any of the data analytic tools.

Response:

Our healthcare consultants use several analytical tools to measure, monitor and predict the costs of health and welfare benefit programs. Segal has also developed a number of pricing tools to help clients assess and report on the full cost of employers' health and welfare programs, including impact of claims experience and recently passed regulations, including those associated with the continuously evolving Affordable Care Act (ACA), the recent Mental Health Parity and Addiction Equity Act (MHPAEA) final rules, and other regulations. These tools are used on behalf of our clients at no additional cost.

We customize our technical resources for your specific needs, ensuring that we provide the high level of quality consulting that our clients expect. We are on the cutting edge of healthcare industry trends and relevant legislation, and we update and revise our tools as needed to provide maximum value to our clients.

Currently, the plan relies on detailed claims analysis from its medical and pharmacy vendor. UHC provides annual and quarterly reports and have produced custom data requests as needed. Segal does have a data warehouse tool available as a contract add-on described below. This would require us to get detailed claims feeds. We have a full team of actuaries, analysts and data scientists to review your data and identify trends, track performance against budgets and expectations and review utilization.

SHAPE data warehousing and predictive modeling tool

SHAPE, Segal's data warehouse and analytics engine, allows you to create sustainable solutions to uncover and manage the root causes of rising healthcare costs and improve population health. Moreover, Segal proactively monitors each client's data searching for trends or anomalies that may result in cost savings opportunities.

SHAPE currently supports approximately 90 clients representing 4 million lives

Key issues we address include:

- Healthcare costs continue to rise and often the root causes of the cost increases are not treated. SHAPE can uncover such untreated conditions, like Musculoskeletal (MSK) issues and infertility, and Segal can advise on how to best address these.
- Fraud and abuse can be difficult to uncover and may lead to significant costs if not identified.
- Clients can have a false sense of security because their vendors provide them with cost reports, but often those reports are not sufficiently comprehensive or applicable as to uncover the true cost drivers
- Clients often want a sense of how they compare to similar plans (e.g., norms).
- Impact of strategic initiatives need to be measured (wellness programs, clinic, value based
  benefits, etc.)
- Vendor accountability: measure vendor performance and manage renewals
- Research suggests that plan sponsors can reduce or avoid future healthcare costs by 5% to 10% annually through the use of data mining technology.

Trigger events:

- Healthcare costs are rising above national averages.
- A spike in prescription drug plan costs is observed.
- Excessive charges are incurred by a providers or facility.
- Abnormal spike in monthly expenses is experienced.
- High utilization in the emergency room is identified.
- There is an increase in the number of high-cost claimants.
- Client frustration over delays and limits to access to their own detailed claims data for future RFPs, audits, independent benchmarking

Differentiators, key features and benefits

- Segal's team of clinicians, data informatics analysts and consultants proactively monitor each client's data searching for trends or anomalies and proactively inform clients if cost savings opportunities are found.
- Segal offers the flexibility to drill into health data to obtain access to the underlying root causes driving costs
- Unlike some competitors, Segal gains unlimited access to historical data allowing for a deeper and richer analysis. If the vendor terminates, historic data is maintained in SHAPE.
- Speed—when data is maintained in SHAPE, there is no need to send separate requests for special studies.

- Segal obtains national best practice information because we can query data across clients, markets and geographies enabling us to make more robust comparisons and analysis.
- The ability to provide a holistic, integrated view of all benefit coverages from financial, clinical and operational performance perspective.

The following recent SHAPE data-driven discoveries inform our consulting advice and provide value to our clients.

What can SHAPE reveal?

Topic	Description
Impact of Wegovy coverage for Part D participants	CMS announced March 22, 2024 that Wegovy is now approved for coverage in Part D plans for adult patients who have established cardiovascular disease, including MI, prior stroke, or peripheral arterial disease, and either obesity or overweight to reduce the risk of cardiovascular death, heart attack and stroke. This policy change could likely lead to expanding access to the drug by commercial plans. In anticipation, a large plan sponsor leveraged SHAPE to quantify the potential impact of this policy change, estimating how many members could become eligible.
Identifying anomaly providers	Using statistical principles regarding the attributes of sets of data, SHAPE flagged the billing practices of a provider as suspicious. Nearly every day the plan was billed on behalf of a me mber for physical therapy treatment on both shoulders (with an average of $55K in treatment annually; $443,381 paid over eight years). Even during the pandemic, the provider billed for treatment. The plan sponsor stopped paying claims and notified the provider they were reviewing historic experience.
Evaluating pharmacy disruptors	As the call for clearer prescription drug pricing has grown, there could be significant shifts in the prescription drug landscape in the coming years, in part due to pharmacy disruption through business models, such as transparent PBMs and pharmacies. One such disruptor is the Mark Cuban Cost Plus Drugs Company, which purports to deliver prescriptions at actual acquisition cost plus a 15% transparent markup and pre-specified, fixed pharmacy labor and shipping fees. Large players are taking note, with both Express Scripts and retail giant CVS announcing their own simpler “cost plus” approaches. However, simple and transparent may not equate to savings and plan sponsors should carefully evaluate all PBM offerings. SHAPE can be used to evaluate Cost Plus and other disruptors and help design and negotiate competitive pricing terms.
Monitoring the impact of gene therapies	Gene therapies have shown immense promise in their ability to treat or prevent genetic disorders and other rare diseases. However, similar to other novel medical treatments, they often come with a hefty price tag. There have been several gene therapies that have already entered the market and the pipeline is strong for the foreseeable future. As such, plan sponsors have faced and will continue to face the difficult decision of determining coverage criteria and the uncertainty around the financial impact o these therapies. SHAPE can be used to help plan sponsors assess the reasonableness of the reinsurance premiums, as well as to give them an idea as to the potential financial impact and value of these therapies.

	Improving PCP engagement	Plan sponsors have the opportunity to both improve population health and reduce costs by encouraging members to maintain a relationship with a primary care physician (PCP). Through SHAPE, Segal is able to identify which members are engaged with a PCP and common characteristics of members who are not engaged. Further, the value of a PCP relationship can be examined by correlating PCP engagement with avoidable emergency room (ER) utilization and identifying which conditions that are treated in the ER may be treated in lower cost settings (e.g., PCP office, urgent care centers, minute clinics, etc.). These lower cost settings often treat members for under $200 per visit whereas the same condition may be treated in the ER for over $2,000 per visit, resulting in significant savings to both members and the Plan.

Please see *Appendix 2* for more information about SHAPE in order to see how SHAPE can benefit DAS.

9. Describe the resources utilized to stay informed of best practices in employee benefits in State Government and other employers similar in size.

Response:

Segal utilized several resources to ensure our team is informed on trending best practices in the employer benefit space. A benefit of the team working primarily with state clients is our exposure to the challenges other State Government plans are experiencing and what potential solutions are working well. It's important that we share this knowledge as we consult with the State of Nebraska Plan.

We routinely benchmark our clients' plans and programs to other comparable entities and will do the same for DAS. Typically, we evaluate and demonstrate how their benefit programs compare to local peers, national published surveys and Segal's book of business. Future benchmarking may occur annually, or bi-annually, based on DAS' needs.

A successful benefit benchmark survey requires selecting the correct comparator organizations, gaining a comprehensive and accurate understanding of both current plans and future initiatives, and applying a rigorous and insightful analysis to the information collected. The key steps of a competitive survey and best practices analysis of health benefits are outlined below.

Identifying comparator organizations

The first step in the survey process is to identify the organizations to be surveyed, and to whose benefit plans the client's plans will be compared and measured. The "comparator" organizations are the organizations against which the client competes – or, more importantly, will compete – in seeking to attract and retain top-level talent. The organizations selected may be:

- In the comparable industry group
- Key employers in the geographic locations where the client has concentrations of employees
- Organizations, including those from different industry groups, whose employees have skill sets or experience that are particularly desirable to the client

The survey process

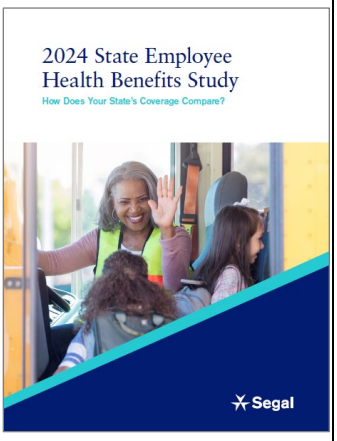
We have several consultants and analysts who regularly manage benchmarking projects for our clients. For our healthcare clients, we typically collect publicly available information posted on the comparators' websites. When information is limited or incomplete, we will contact the comparator directly, to complete the data. Additionally, we include information from one or two nationally published surveys to add regional, national, or market perspective.

Examples of our proprietary surveys and studies we have conducted and external surveys that our firm has access to include:

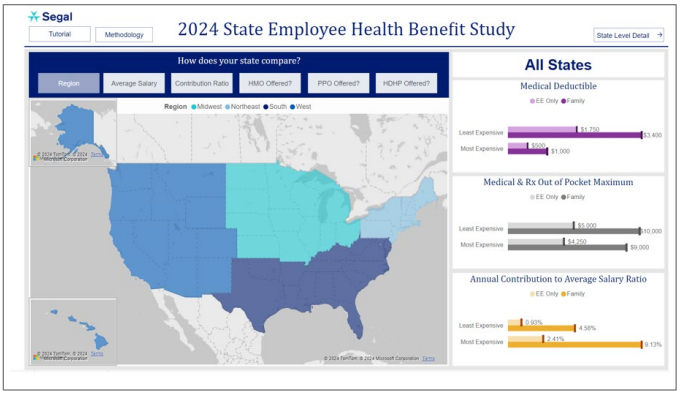
Proprietary surveys

- **SHAPE (**Segal's Health Analysis of Plan Experience) is a comprehensive medical data mining service). This proprietary data warehouse combines data across medical vendors and PBMs and has capability to compare plan to normative benchmarks. Information is used to:
  - Determine the medical conditions and treatments that are driving up healthcare costs which help us develop more targeted and effective cost containment strategies
  - Benchmark cost and utilization patterns of a plan to industry norms and other plan sponsors
  - Determine member out-of-pocket cost burdens relative to other plan sponsors (accurately forecast patient disruption)
  - Assess impact and effectiveness of wellness, disease management and other clinical programs
  - Accurately measure the future saving impact of plan modifications being considered
  - Serve as the tool for plan sponsors and vendors to manage "at risk patients" through predictive modeling
  - Profile cost and quality of highly used hospitals, labs, physicians and other medical care facilities (e.g., build custom, high-performance networks)
  - Serve as an audit tool to validate vendor performance guarantees (e.g., vendors' discounts, generic fill rates, etc.)
  - Investigate fraud, claims coordination and subrogation opportunities
  - Allow clients to centralize all data from multiple vendors in one location
  - This database includes both actives and retirees and can include medical and prescription drug benefits

- **Segal's 2024 *State Employee Health Benefit Study*** presents an overview of plan design and cost-sharing arrangements, based on the health benefit information on the websites of all 50 states in the fourth quarter of 2023 and January 2024. Details on state employee health benefit plans can help state leaders benchmark their programs against those of peer jurisdictions and help inform plan design decisions. Our study covers medical and prescription drug plan design and benefit cost-sharing arrangements offered to full-time active employees for 2023–2024, including the least and most expensive plan options.

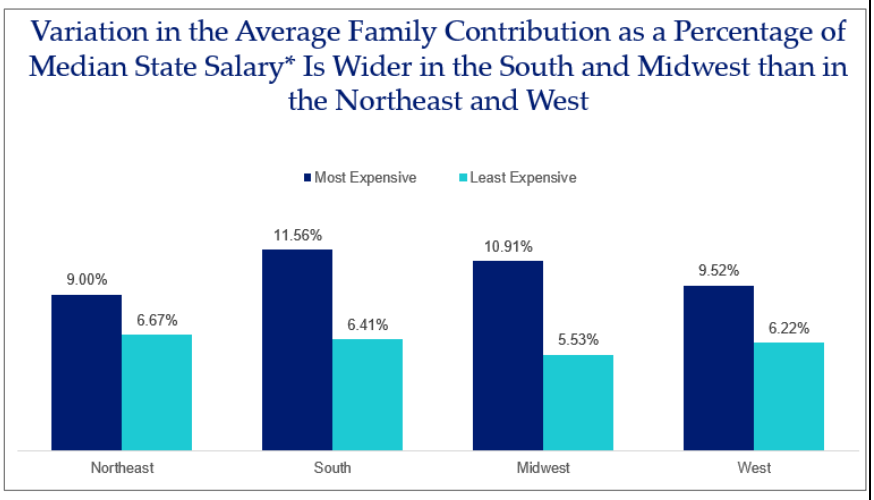


We've also compiled the detailed findings and created a custom interactive online tool, both accessible here, which allows state leaders to compare their state benefits to aggregate data for all states or by region. A summary of the survey report can be found on our website.



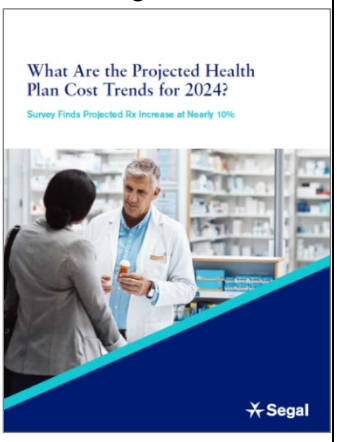
The key findings from the 2024 study are:

- Almost all states (47) give their employees a choice of medical plans.
- Health insurance as a percentage of salary ranges by region and plan type, with employees in the West contributing 0.78 percent of their salary towards coverage for the least expensive plan and employees in the Midwest paying 3.35 percent of their salary for the most expensive plan.
- While deductible levels for high-deductible health plans (HDHP) are much higher than for PPO plan options, including POS plans, by design, the variance of out-of-pocket (OOP) maximums between these plan types is not as significant.



- States are using plan design to manage prescription drug costs by influencing utilization towards more efficient delivery channels and more cost-effective medications

Segal Health Plan Cost Trend Survey: Segal has compiled an annual health plan cost trend survey for the past 27 years. As an example of the 2024 findings:



- The rates of medical plan cost increases for 2024 are forecast to be substantially similar to current levels, suggesting cost increases may have reached a plateau.
- The projected annual cost trend for outpatient prescription drugs is expected to be approaching almost 10 percent, the highest rate of all health benefit cost trend estimates.
- Survey respondents project the per-person cost trend for open-access PPO/POS plans to be 6.8 percent.
- Specialty drug trend is projected to be 14.5 percent. Drivers of projected specialty drug trend are primarily due to utilization of new high-cost specialty drugs replacing lower-cost therapies. Utilization changes account for almost 60 percent of the specialty drug gross cost trend increase before rebates.
- Price inflation is still the primary driver for inpatient hospital, physician and overall Rx trends.
- Diabetes, autoimmune disease and psoriasis have been the top three disease indications for prescription drugs over the past few years. However, over the last two years, anti-obesity medications and drugs to treat migraines showed the greatest growth.
- Trend projections for most dental coverages are expected to reach 4 percent.
- Projected vision trend is 2.8 percent for reasonable and customary (R&C) plans.
- Medical trend projections for Medicare-eligible retirees with Medicare Advantage (MA) PPO plans is forecast to be 4.9 percent.

https://www.segalco.com/consulting-insights/2024-health-plan-cost-trend-survey

Example of prior benchmarking report

For the State of Kansas, Segal has done multiple state benchmarking. The most recent was presented at the February 16, 2024 HCC meeting. The presentation can be found in the meeting materials https://sehp.healthbenefitsprogram.ks.gov/about-us/health-care-commission/hcc-meeting-minutes/categories/b5dceb9c1fb843c0b6029f53b6cf5d52.

Best practices database

Segal operates as a multi-practice consulting firm focusing on public and private organizations in areas as diverse as benefits, compensation, technology and communications. Client projects often involve more than one practice area. We make a point of sharing results and scope of client projects across all our practices and geographic regions to help assure that all Segal consultants and actuaries are aware of developing programs and trends. This guarantees innovative and successful work is always available to future client engagements. Segal has also developed proprietary systems, linked to our intranet, designed to facilitate the sharing of information between consultants, locations, and practices.

In addition, all of our practices conduct annual and sometimes quarterly meetings to share client case studies across our business. Our actuarial practice in particular conducts an

annual meeting that is firm-wide. The purpose of the meeting is to discuss emerging trends, best practices and client experiences for the benefit of all of our practitioners' trends, new services, and new concepts to the account team who would service our account.

Lastly, we have an informal rewards program that recognizes collaboration across our business. The reward program encourages our consultants to bring expertise, ideas, client experiences and relationships to our offices firm wide not just where they sit. In living up to our commitment to providing an outstanding customer experience to our clients and their plan participants, we believe it is critical that our consultants not operate in a silo fashion. This program explicitly encourages them to get out of the silo.

We believe DAS will find Segal's collaborative approach and our sharing of best practices, and new trends, to be a valuable and comfortable fit with the State's goal of maximizing value and utilizing resources effectively.

Emerging actuarial practices

Part of the job of our health and retirement actuaries is to stay abreast of current actuarial trends in the profession. Our actuaries are all accredited under the Society of Actuaries and the American Academy of Actuaries. Actuaries receive newsletters and publications, on a regular basis, from the Society. Academy membership provides Segal's actuaries with a window on the profession's public policy work, helps our actuaries stay on top of emerging issues, enabling them to help prepare your company for the future, allows them to facilitate having a voice in shaping how the actuarial profession maintains its standards and qualifications, facilitate having a voice in shaping how the actuarial profession applies actuarial principles to public policy issues and provides them easy access to a wealth of resources and information from the Academy. All of this benefits the State and DAS.

Many Segal staff are Fellows and Associates of the Society of Actuaries, Members of the American Academy of Actuaries, Fellows and Members of the Conference of Consulting Actuaries, Enrolled Actuaries and Fellows of the Canadian Institute of Actuaries. In addition, several of our firm's senior actuaries have served on committees of the American Academy of Actuaries, the Society of Actuaries, the Conference of Consulting Actuaries and the Actuarial Standards Board and on the Advisory Committee of the Joint Board for the Enrollment of Actuaries.

Because of staff involvement in professional actuarial organizations, Segal has a Director of Actuarial Continuing Education, who arranges a Technical Actuarial Meeting each year, as well as other professional development opportunities, which help actuarial staff meet continuing education requirements.

Plan Structure & Improvement

Using all the various publications, research, experiences and survey information, as part of our ongoing consulting, we will recommend benefit plan design changes where appropriate. Segal evaluates benefit design alternatives in terms of anticipated results and measures them against the State's philosophy and program objectives. We take into account such things as:

- Competitiveness of current benefit plans to prevailing practices;
- Cost effectiveness of the current third-party administrators;
- Appropriateness of certain benefit provisions;

	• Differences in plan design and operation from both the employee and employer points of view; • Projected cost of the model benefit plan as compared to the current arrangement; • Available funding techniques and the appropriateness of each to the State's strategic goals and budget, considering cost, cash-flow and risk features; • Type of service delivery model; and • Performance standards and guarantees that should be included in vendor contracts to administer the plan design change. Based on our analysis, we will make recommendations to the State as to appropriate funding approaches and to the degree to which financial risk should be shifted, retained or shared between the State's and the membership.
10.	Describe bidder's process to perform actuarial services for States or companies of similar size. Response: Segal has a long history of providing actuarial services to public plans and employers. With more than 170 credentialed actuaries across our offices, we provide the following actuarial and consulting services: • Annual rate setting analysis • IBNR and other reserve calculations for self-insured health benefit programs • GASB/OPEB retiree health valuations and modeling of program changes • Provider network analysis, including Pay-for-Performance strategies • RFP/procurements and vendor management • Audits and vendor performance review/measurement • Development of capitation rates • Multi-year budget development • Trend and utilization reporting and analysis • Legislative support and valuation of proposed legislation • Expert witness and subject matter expert testimony and presentations • ACA compliance and related strategic consultation • Pharmacy program consulting • Medicaid and Children's Health Insurance Program consulting and rate certifications • Disability and Paid Time Off design and analysis • Medicare Part D Retiree Drug Subsidy (RDS) calculations and attestations • Valuation of program changes and comparisons of value among different plans • Actuarial attestations on the overall rate structure and cost projections Segal's actuaries work with many state and local government clients on their self-funded health benefit programs. The consulting and actuarial team assigned for the State of Nebraska has experience with State level plans in Nebraska, Alabama, Illinois, Kansas,

	Wisconsin, North Carolina, Iowa, and others. In addition, we work with many large cities and counties, some of which approach State level participation. The actuarial team has a rigorous review process to ensure projections are done accurately. Segal conducts an internal audit each year and the actuarial team staffed on this proposal continuously exceed the company's standards. Segal has served and currently serves as health consultant to hundreds of governmental clients. We clearly meet and exceed the minimum qualifications in of the RFP. The table under **Section V., C. Business Requirements**, illustrates our experience in providing complex, similar services to other large state level clients, in particular the State deliverables and tasks contained in the RFP from our Atlanta office. We have worked with many of the clients for over 10 years and, in the case of Hawaii, for over 50 years.
11.	Provide an example of a premium equivalents report for a self-insured health plan with multiple plans. Response: Premium equivalent development and reporting is included in core services provided to all of Segal's self-funded clients. Below, we discuss our key steps and processes we use for calculating premium equivalents for the State of Nebraska and other large self-insured health clients with multiple plans. **Funding rate development and budget projections** The most important part of projecting the costs of a self-insured benefits program is the proper determination of the per capita costs, commonly called "funding rates" or "premium equivalencies." In short, these are the total expected costs of providing coverage over the coming year, either on a per employee, or per member basis. Multiplying these rates across the anticipated enrollments results in the total costs of providing the benefits, before netting out employee premium contributions. Funding rates typically vary by plan option election (i.e., by HMO or PPO options) as well as by coverage tier election (e.g., Employee Only, Employee+Family, Employee+Spouse). Funding rates are comprised of two main components, expected claims costs and fixed costs. The fixed costs are for expenses for claims processing and administration (ASO fees), medical management, wellness and prevention programs, network access, capitation payments, etc. This is a relatively straightforward process, as these amounts are usually set in the vendor contract, negotiated at renewal, or at vendor selection, and are therefore known amounts. Projecting expected claims costs is less straightforward. The actuary will look to recent experience for the same covered population, trend forward based on expected increases in claims costs and adjust for things such as changes in benefit design, anticipated enrollment shifts (migration and selection), effect of medical management and wellness programs, changes in provider and drug discount levels, anticipated changes in utilization patterns (such as a result of a consumer-focused approach) and so forth. More recently, claims experience has been impacted by COVID-19, with, in addition to the treatment of the disease itself, changes to claim patterns due to increased testing, deferred non-emergent care and the introduction of vaccines and other new pharmaceutical products. During this time, Segal developed a pricing model to incorporate the projected impact of these changes in claim patterns into pricing of future claims. Segal is

continuously monitoring COVID-19 and can track longer-term impact to health plan expense.

Projecting claims costs and funding levels

A classic example of a multiple-option benefit offering to governmental entities is characterized by different plans, regions, tiers and employer types. These arrangements often carry a high degree of adverse selection. Employees will likely choose a plan that best meets their needs, based on the perceived value of the plan versus the perceived cost to the employee. The selection patterns will vary between state regions due to many characteristics, the most common being network adequacy and socioeconomic characteristics.

This is especially true in Nebraska, where there are three separate plans with distinct risk. Our actuaries will properly assess the health and cost risk between the plans and reflect that risk difference correctly in the rates and budget projections.

Segal has a proven process for developing financial forecasts that produce the most accurate and actuarially sound results possible. Our projection is derived from a basic formula used by the industry, then enhanced. The basic steps can be reproduced for any specific group the State would like to track separately. Below we describe the process, data and insight we will use for each of the steps set forth.

Step 1. Confirm project objectives: scope and approach

First, Segal and DAS would prepare a timeframe for draft delivery, final report(s) and any supplemental schedules. It is common to run preliminary results and assumptions by staff at an earlier date to ensure all parties are aligned. We would also discuss the accuracy rate of prior projections and recommend ways to improve upon past methodologies, if warranted.

Additionally, this meeting is imperative for setting strategic direction and ensuring the entire process supports the short and long-term goals of the program. During this meeting, we would also outline the data needs, minimum reserve requirements and any expected changes in funding from DAS from other sources.

We would discuss strategic direction, including targeted funding levels for the end of either the plan-year or the fiscal-year, targeted expense reductions, changes in state funding (such as premium holidays), or any other possible changes or considerations for the coming year(s).

Step 2. Capture experience period (EP) claims

Next, we would capture the EP claims. The claims can be on either a paid or incurred basis. We typically capture the data to develop an incurred rate and then develop an emerging cash flow on a paid basis. Each state has its own unique funding policy, and we will tailor our approach to meet your specific needs and follow established practices.

As the actuary will be receiving and/or developing claim triangles and estimating Incurred But Not Reported (IBNR) claim liabilities, incurred claim estimates will be available. Segal recommends that incurred claims be used for the EP claims. Using incurred claims filters out many payment systems issues and allows the actuary to isolate the impacts due to enrollment changes, plan design changes, changes in contribution strategy, or other

significant events. The claims experience associated with any significant enrollment shift is more appropriately and accurately analyzed using incurred claims for the EP since timing is crucial. Further in our response we discuss our methodology for developing IBNRs. This method is integrated into our financial projections.

In most projection methodologies, the EP claims are converted to a unit measure before application of projection trend. The units are typically referred to as Exposure Units. Employees (also called contracts), members or other measures can be used. Each measure has its pros and cons. Typically, we would use employees, but capture the influence of the relative ratios of single contracts and contracts with dependents. If that ratio changes over time, we would make an adjustment to the revenue required in the Rating Period to account for a different mix of members between the Rating Period and the EP. We would also review the incurred claims for any large claims incurred on a single claimant that might distort the costs per member. Depending on the circumstances, we may use one or two years of experience for the EP claims.

When collecting the data, we would ensure all the reporting groups are appropriately delineated. We understand rates must be developed separately by plan and by tier. Our model will be built accordingly to recognize each unique group. Due to low volume in some of the cells it may be necessary to integrate our credibility model, developed internally by one of our former Health Actuaries.

We would continue to work with DAS if supplemental information is needed but we expect to be able to obtain most of this information for the IBM data aggregation system. Our model requires:

- Enrollment data
- Claims reports and summaries from vendors
- Financial statements of each program
- Vendor reports
- Plan documents including SPDs, communications, etc.
- Strategic plan
- Past actuarial reports or premium rates development work papers

A key step after collecting the data is to review and reconcile between different sources. It is imperative that expense data be consistent with claims data, vendor reports and transactional data available to the staff. This crucial step will help protect against policy decisions being made that are based on projections that, while based on sound methodology, may be developed utilizing data that is not reflective of historical actual experience.

Step 3. Trend EP claims forward to the rating period

The next step is to trend the EP claims forward to the Rating Period. Rating trend is typically viewed as containing three main components: price per service, utilization of services and mix of services. Often the mix of these variables cannot be identified in the data, so it becomes included in one or both of the other components. We will extract some trend data from the IBM system for analysis. Additionally, if there is an expected impact on claims due to changes in technological advances or other external forces which are not explicitly identified in the rating, we will address this impact by increasing or decreasing the rating trend as appropriate.

Financial trend analysis

Provider unit price, utilization and technology are the common influences of healthcare trends. Price is the cost of services (what the provider is paid) and is often measured by the medical component of consumer price index (CPI). CPI is not a perfect measure of prices for a typical employer plan because it includes costs that are not covered (e.g., over-the-counter medications and cosmetic surgery). Provider reimbursements, the key component of price, are measured over time by observing the change in the same service.

Utilization is a very broad measure and can be broken down into more discrete components such as service mix, adverse selection, intensity of services, federal government cost shifting and other external influences on consumer behavior (e.g., potential loss of coverage, financial incentives to refrain utilization, direct to consumer marketing).

Advancement in medical technology is a key contributor to cost increases. Medical research is constantly inventing new drugs, procedures and tests. These new products and services contribute to higher overall utilization, and the higher cost of new technology contributes to higher overall prices. These increases are over and above the price and utilization increases on existing products and services, referenced above. For example, advancements in imaging technology have created new demand for those procedures.

An additional component often overlooked is the "net" trend to DAS. It is common for plans to have a number of fixed cost sharing elements, such as copays, deductibles and out-of-pocket maximums. In these cases, the trend to the plan sponsor (DAS) is leveraged and experiences a higher trend than the overall program. This concept is typically called "deductible leveraging" although it applies to much more than the deductible.

Tracking regional and national trends

Segal has a group that maintains and tracks industry trends and normative data. There are a number of different resources they utilize to monitor and analyze healthcare trends at the state, region and national level. Some of these resources include:

- Segal's National Compliance Office in Washington, DC
- Segal's Public Sector National Practice, which monitors both federal and state benefits-related trends
- Segal's participation in a number of industry groups, including the State and Local Government Benefits Association and the American Benefits Council, wherein we participate in the debate and the analysis of new developments in employee benefits
- Segal's National Health Practice which keeps our consultants – and, in turn, our clients – up to date on developments and emerging trends that may impact benefit plans. Semi-Annually Segal's National Health Practice publishes the Segal Health Care Trend Survey. Our trend figures are based on the projections of the leading actuaries at the major healthcare vendors. This data helps our consultants evaluate health insurance premium renewals and develop self-insured health plan claim projections.
- We also review CPI statistics published by the Bureau of Labor Statistics.

Segal is nationally recognized for the surveys we produce. On an annual basis we produce the Health Plan Cost Trend Survey, and in 2024 we updated the *2024 State Employee*

Health Benefits Study. We recognize that state benefit leaders are increasingly focused on employee health benefit coverage as the cost of coverage continues to outpace overall inflation. These costs have placed budgetary pressure on health plan funding and underscore the need for targeted cost-management strategies.

Setting prospective trend

The actuary, when developing prospective trend, needs to consider several variables: what happened in the past with experience period claims and whether this pattern continued; what is happening currently with trend that can't yet be measured and what will happen in the future (between the time of the evaluation and the end of the Rating Period). All of these variables (i.e., past, present and future) need to be assessed when setting rating trend.

Segal will measure the historical trend in each program, report on cost and utilization trend, and identify explicit, external/internal events that would have triggered a change in cost. In addition, we also will monitor emerging trends in the marketplace to assist in developing our recommended rating trends for each of the programs and groups covered.

Our prospective trend will be broken out by plan, group (active, retirees if applicable) and benefit type (medical, pharmacy, etc.).

Step 4. Determine impact of federal or state regulation or reform

The team will take into consideration the impact of any new regulation at the state or federal level that will impact the financial projections.

Step 5. Tabular adjustments

There are numerous reasons why baseline rates may need to be actuarially adjusted. In general, adjustments may be needed due to factors such as the following:

- Claim backlogs, vendor transitions, computer conversions or enhancements and other causes of altered claims timing
- Changing financial conditions influencing claimant behavior, including layoffs or contribution changes
- Revised benefit plan provisions including changes in deductibles, maximum limits, covered benefits, or the introduction of managed care initiatives
- A change in the demographics or participation of the group caused by such things as the introduction or elimination of health plans or members migrating to the Kentucky Health Benefit Exchange
- Large claims or other distortions and anomalies that may have unique payment patterns
- The deteriorating health status of the group – causes may include aging on a closed or retiree group, or anti-selection from changes in health plans

It is also likely there will be several adjustments to reflect specific changes to the pharmacy program expenditures. The largest components would be due to rebate projections and administrative claims.

Other modifications may be necessary to reflect different circumstances not referenced above. Adjustment techniques will vary, dependent on which modification is used and its impact on the resulting cost. Analysis by medical services, type of health benefit and adjustment for large claims diagnosis and prognosis are all possible refinements, if cost and data considerations support the refinements.

Step 6. Provisions for non-claims expenses

In formulating rates, non-claim expenses for the Rating Period must be added to the Rating Period expected claims to make appropriate provision for all revenue required in the rating period. Non-claim expenses will consist of at least the following:

- Administrative expenses for the claim payment vendors
- Administrative expenses for wellness and medical management programs
- Fulfillment and other non-claim payment expenses not covered above
- Capitation rates (if any)
- Premiums for fully insured options
- DAS's internal expense allocations
- Any surplus management additions or subtractions

Step 7. Develop total plan expenses

Once all the adjustments and factors are developed in the steps listed above, we will calculate a monthly per employee per month (PEPM) cost. This projected cost would be the baseline calculation and would include timing of the benefit provisions, seasonality of health, enrollment mix, movement impact, etc. A companion per member per month (PMPM) can also be developed if that is the more common measurement for DAS.

A similar process will be followed for each component of the projection: medical, pharmacy, administrative, rebates, wellness, etc. We will work through all the various components in our initial meeting during Step 1.

Step 8. Determination of premium equivalent rates

The actuarial team will project the revenue components with great accuracy. This step supports the proposed "rate increase" and variances can result in a potential shortfall over the period. This calculation is fairly straightforward but seems to cause problems for many firms. The basic principle is that once the total expenses are developed you must produce premium rates or funding rates that support these levels.

- Will there be cross subsidies between plans? In many cases a high-cost plan will be subsidized by a lower cost plan that encompasses most of the plan membership. This may be due to the plan being catastrophic in nature, DAS mandates, long term strategies, etc.
- Will there be subsidies between tiers? It is common to have a tier ratio locked in or rolled forward with time. Typically, these rates are not in sync with experience, even if they were re-based at one point of time. Changing these levels may cause winners and losers and the actuary needs to be sensitive to the strategies in place.

- Movement between plans can cause significant adverse selection. This will produce gains or losses that need to be accurately accounted for in the rates. The actuary will use his/her experience and training to reasonably predict this impact.
- How will the contribution strategy impact final enrollment numbers and employer/employee revenue splits? Significant changes in methodology could move a large numbers of plan membership.
- Is there any surplus or deficit that needs to be accounted for in the rate? For example, prior year funding deficiencies would cause our rate to be higher to re-build the reserve.

Note that calculating the experience rates in Step 2 will bring in many assumptions that will need to be revisited in this step. We will discuss our final methodologies and will document them.

When the rates are finished the projected revenue from both the State and Employee will be sufficient to cover program expenditures. A final one-page summary (with details of assumptions as an attachment) will be developed covering the projection period. As premium increase scenarios are developed, we will break out the required revenue by each revenue source.

Step 9. Revenue projections

Projecting anticipated revenue is key to determining the overall fiscal and cash position. This revenue is typically sourced from:

- **Employee/retiree contributions** (unless these are regarded as an offset to expenses, which is not an uncommon practice)
- **Participating employer contributions**, such as DAS agencies, quasi-governmental entities, or local governments (if covered in the Plan). This funding can be defined as a percentage of payroll, a per capita monthly rate (that may vary plan, tier election, etc.) or some combination
- **Federal funds**. Many positions in State government are partially or wholly supported by Federal Funds, which provide matching contributions from the federal government for benefits costs. These may be incorporated into the individual agency budgets, or could be passed directly the state health plan's trust
- **Other sources** include RDS payments (unless deposited into the OPEB Trust), pharmacy rebates, EGWP revenues and subsidies, penalty payments from vendors for performance shortfalls, transfers from other state operated trusts, etc.

In order to determine an accurate revenue projection, it is important to understand how each component is determined and then develop a projection for each factor that determines revenue. For example, if employer contributions are a percentage of payroll, then it is imperative to develop an accurate projection for future salaries. If a per capita method is utilized then the focus will be on forecasting employee/retiree elections for plans, tiers, etc.

Segal will conduct a thorough analysis to make sure the cash position, in conjunction with our projections discussed above, will produce the desired reserve and surplus at the end of the fiscal year.

Step 10. Total budget projections

In order to model the program's cash position, we typically recommend doing projections on a monthly basis first and then view a summary from an annual perspective. Projecting first on a monthly basis enables us to incorporate:

- Invoicing patterns that may vary by month (for example, weekly invoicing may result in 5 invoices one month and 4 the next)
- Quarterly pharmacy rebates
- State or employer revenue that may change on a fiscal year basis that varies from the Plan Year
- Mid-year changes in benefits:
- New laws or mandates that take effect off-cycle
  - Highly utilized drugs that come off patent
  - Changes in vendor administrative practices
  - January 1 plan changes that have a delayed impact on a cash basis (such as changes in annual deductibles)
- Seasonal variations in employment levels
- Other irregular revenue, such as RDS payments, transfers from other State agencies, etc.
- Claims that increase steadily and/or vary with seasonality versus revenue that is more constant

Once the total revenue and expenses are projected by month, we will project the overall cash position for the various programs, based on the assets at the beginning of the projection period and then adjusting based on the monthly projected net gain/loss through the projection period.

This monthly approach will also enable us to identify any mid-year periods where asset levels may fall below reserve targets or even approach a negative balance. Sometime, when asset levels are low, a projection conducted on an annual basis may indicate a sufficient end-of-year balance, but not identify a mid-year trouble spot.

We would continue to work with DAS to best meet your reporting needs.

Step 11. Meeting with DAS

After presentation of the preliminary forecast and numerous exhibits to DAS, Segal (at your direction) would meet with the appropriate representatives to discuss the results to be presented. After appropriate editing and modification by Segal, the final package will be presented to the appropriate parties.

Patrick Klein and Jennifer Slutsky, as well as other team members, have presented to multiple governors, senior executive staff (commissioners, secretaries, etc.), legislative bodies, boards of directors/trustees, as well as their respective staffs. Patrick and Jennifer have also presented to DAS in the past. We commit to providing the support you need in presenting budget projections to the Legislature and other key stakeholders.

	Our analysis will be conducted under the supervision of a Fellow of the Society of Actuaries and comply with all applicable Actuarial Standards of Practice (ASOP). Final results will be independently peer reviewed by the Review Actuary, who will also be a Fellow of the Society of Actuaries. Our deliverable and final report will include: • Rates and the time period(s) for the rates • Assumptions used, such as trend(s), plan elections, etc. and an explanation of how each assumption was developed • A description of our methodology • Documentation of the data utilized and confirmation the data was reviewed and found to be reasonable for the analysis • Description of any adjustments made to the base data for distortions and anomalies • Our conclusions, findings and any recommendations • Detail on the impact of the impact of any Affordable Care Act requirements We will also be available to provide other related consulting and advisory services as needed. Your Account Manager and Lead Actuary have extensive experience in similar engagements and fully understand the nature of the needs of a large state health plan such as DAS.
12.	Explain the approach to analyzing and recommending a CFR level. Provide an example of a CFR report the State would receive. Response: **Calculating claims fluctuation reserves** Segal has developed Medical Claims Fluctuation Reserve factors. The factors: • Are set with an explicit level of safety that will be identified for the State, • Were calculated using a published methodology based on an explicit set of risk, and • Take into account the level of Individual Stop Loss purchased by the State and the credibility of the data that was used in setting the State's expected claim rate. Our typical client that holds these reserves will find that they are adequate to cover fluctuations in claim experience in 90 percent of all years. Segal will identify this level of safety as desired by the State. Generally, Segal also calculates the reserves for safety levels of 95 percent and 99 percent. However, Segal can calculate the reserves based on any percentage level requested by the state. These higher levels of safety (confidence) are more appropriate for clients that prefer to hold larger reserves to increase the level of financial protection that these reserves provide. Three specific risks that lead to claim fluctuations were identified and explicitly included in our calculation model. The three risks are: 1. **Large Claims –** This is the risk of unexpected increases in the number and/or size of claims incurred by individual participants. As the size of the group increases the larger claim are spread over a larger total and this risk becomes less significant. The purchase of individual stop-loss coverage by the plan can significantly reduce the plan's exposure to this risk.

	2. **Client Claims –** This risk relates to overall plan claims experience developing at a variance from the expected cost per participant, due to insufficiently credible claims experience. As the size of the group involved increases, the level of this risk is generally reduced. However, this also depends on the length of the claims experience period that is used to project expected claim levels. 3. **Trend –** This is the risk inherent in a projection that uses a forecast of the overall increase in price and utilization of health care services. This risk is constant for any size of group. Segal will identify and discuss these three risks to the State. The claims fluctuation reserve table provides factors based on three key parameters*:* 1. **The size of the group –** This parameter is based on total number of adult participants instead of number of employees. 2. **The number of years of experience used in setting the projected claims –** This parameter is designed to more accurately determine the reserve based on risk #2 (client claims), above. 3. **The individual stop-loss level (or annual coverage maximum) –** This parameter is designed to more accurately select the reserve based on risk #1 (large claims), above. Segal typically establishes a CFR that is attributed to a percentage of projected claims to ensure stability. The percentage would be re-calculated if there are any major changes to the program such as stop-loss, eligibility, demographics, etc. **We have included a report under Appendix 2.**
13.	Explain the approach to calculating IBNR. Provide an example of IBNR report the State would receive. Response: Segal will estimate the Department's incurred but not reported (IBNR) reserve for the self-funded benefit plans for the State of Nebraska. Segal performs this analysis annually for the majority of our public sector clients and more frequently for some. Our goal is to provide reasonable estimates of future contingent events using the available data, state-of-the-art methodologies, and our professional judgment developed from years of experience making similar estimates. It is also an integral part of our premium rate development process. We will provide an estimate of IBNR liabilities by August 15th for the prior fiscal year that runs from July through June. **Methodology** The unpaid claim liability (UCL), commonly called the incurred but not reported (IBNR) reserve, at a specified date is essentially the estimated claims incurred up to that date less the claims that have been (incurred and) paid to that date. Since the incurred and paid claims are known, the UCL is easily determined once the incurred claims have been estimated. The traditional loss development method uses historical claim payment patterns to develop completion factors that are used to estimate incurred claims. The claims incurred in a given month and paid by the end of the experience period are divided by the

	completion factor to estimate the incurred claims for that month. The UCL for that month is subsequently determined by subtracting the known incurred and paid claims from the estimated incurred claims. The total UCL is merely the sum of all the appropriate monthly UCL estimates. This method is relatively easy to understand and is effective when the historical claim payment patterns are deemed to be stable enough to estimate current/future claim payment patterns and when several months of claim payments (run-out) after the incurred month are available. When the run-out for any month is limited, this month is called immature, and the associated completion factor is significantly less than one. The resulting incurred claim estimate is unstable. Consequently, a secondary method has traditionally been used to estimate the immature months. The secondary method for health claims is often an average of historical incurred claims adjusted for claim trend and enrollment between the historical period and the time of interest. One of the shortcomings of this secondary method is that the available claim payment information for the month being estimated is not used. Another problem is that the line of demarcation between mature months and immature months is as much art as science. The Bornhuetter-Ferguson Method (BFM) addresses both issues by blending the loss development method and the secondary method. The BFM uses the available incurred and paid data and the expected UCL developed from the secondary method to estimate incurred claims. This method generally provides a more stable estimate than the pure loss development method, a more responsive estimate than the secondary method, and a reasonable technique for blending the results of both methods. Segal incorporates any material program/plan changes, seasonality patterns, adjustment for large claims, and considers restated reserves. **We have included a report under Appendix 2.**
14.	Describe bidder's process to calculate VOI on a wellness program. Provide an example of a VOI report. Response: Segal has extensive experience evaluating comprehensive wellness programs, which almost always include retirees (and their dependents) as well as active employees. The State's clinical team has worked together on calculating VOI of state level wellness programs, such as the State of North Carolina and the State of Maryland, described below. Segal regularly works with a variety of employer/plan sponsors including corporate, public sector (city/town, county, state and school districts), and multiemployer union funds to help them implement, evaluate and manage both wellness (also called disease prevention or health promotion) and disease management (DM) programs. Because of the uniqueness of these Wellness and Disease Management Programs, no two plan sponsor projects are ever exactly alike - they are highly customized to you and your unique needs. We at Segal believe that well-designed, diligently implemented and carefully targeted wellness programs can generate substantial VOI — often within five years. Traditionally, a health benefit plan would measure its success by looking solely at total health care costs: the year-to-year cost increases and trend. While measuring these financial factors remains vitally important, evaluating the success of wellness programs within those health benefit plans requires a different approach: the metrics by which wellness programs are measured should capture whether the "population health" is getting better overall.

In the long run, if wellness programs are truly working, they should keep healthy people healthy and reduce modifiable risk factors to slow down the onset and progression of chronic disease, thereby reducing demand for services, which helps to hold down costs. This, in turn, will reduce future health care costs. Because wellness programs alone can do very little to directly impact the unit costs of care, the expectation for instant reduction in overall medical claim costs by instituting wellness programs or expecting wellness programs to "bend the cost curve" immediately, is not realistic.

While it is reasonable for employers to desire a hard dollar return on investment made in wellness programs, they should also track and study the clinical and behavioral progress of the population. The metrics for measuring the performance of wellness programs must capture the value of multiple interventions in delivering various wellness services. The end result could be an estimation of the amount by which clinical interventions were able to control costs by reducing future health care utilization.

For all wellness programs, Segal medical management experts can help employers set clinical goals against which wellness program performance can be monitored and measured. Baselines are established and criteria and targets are customized to each plan's programs and can be drawn from plan-specific performance, national averages and ideal targets. All measures are set to provide a meaningful impact on future direct and indirect cost and quality indicators. Comparing the clinical programs against the established targets is a practical and comprehensive way for employers to assess existing wellness programs. If a plan uses one or more wellness providers, it is important to work with the vendor to set the measures and to implement appropriate performance guarantees for the clinical goals.

To help you track the effectiveness of your wellness programs, Segal has built a tool that defines and takes a snapshot of the most important metrics that need to be monitored. This "dashboard" provides employers with useful information regarding the direction of important cost and clinical outcomes, such as medication compliance, program participation rates, quit rates, and quality and intensity of participant engagement. The metrics can be divided into process metrics and outcome metrics. The outcome metrics are broken down further into three important categories:

1. Clinical improvement
2. Impact on utilization; and,
3. Financial metrics

It's important to work with the wellness vendor to make them understand what metrics are important to track and measure.

Based on the outcome of the overall healthcare and benefits strategy developed with DAS, Segal will work to implement a measurable and effective wellness program that help to reduce costs over the long term. Our approach to this includes using our Well-being Consulting Model. This model combines our health care actuarial expertise with our health benefit, compliance, communications, behavioral economics and behavior change science expertise.

The Well-being Consulting Model consists of two phases:

- **Phase 1**: Measure financial ROI for the current program in place
- **Phase 2**: Discover value enhancement opportunities

Our basic ROI analysis approach is conceptually simple and actuarially sound:

- We identify investments and incremental operating costs from well-being initiatives.
- We forecast health plan, sick leave and short-term disability costs during the "post-implementation period" from "pre-implementation period" baseline costs. This develops an expected cost profile assuming changes were not implemented.
- We control for known effects unrelated to the well-being initiative.
- We avoid using "implied savings" from enhanced worker productivity in our analysis.
- We compare actual post-implementation costs to forecasted expected costs.

Our more complex Value on Investment (VOI) analytic approach adds the population health and workforce productivity metrics.

We offer three levels of additional consulting services designed to enhance the value of a client's well-being initiative — whether the program is well-established or just getting started:

1. Discussion with an expert
2. Professional review of program
3. Professional review of program, benchmarking and strategic planning

Client Need	What Do We Do?
Incentive design and strategy	We design the program qualification requirements, timing and incentive structure using principles of behavioral economics and behavior change science. We model program budget alternatives and perform a regulatory compliance review.
Participation enhancement analysis	We analyze well-being program participation and non-participation by demographic, organizational unit and health status, with the ultimate goal of increasing participation.
Participant experience assessment	We conduct focus groups with participants and non-participants to identify barriers and bridges to engagement and various motivations and perceptions about the culture and physical environment.
Development of balanced scorecards	We develop and populate specific metrics onto "scorecards" that are of interest to various stakeholders.
Well-being vendor reporting and performance enhancement	We participate in the year-end and interim well-being vendor analytic reporting to the client. We advise on improving analytics, engagement, participant satisfaction, outcomes and vendor performance.
Communication planning	We conduct a strategic communication planning session addressing messaging, media, channels and timing. We review existing approaches from a behavioral economics and behavioral change perspective. We assess opportunities for micro-targeting interventions and related content to specific audience groups.
Clinical audits	We audit the performance of disease management and health coaching vendors with clinical experts.
Population well-being assessment	We conduct a comprehensive well-being assessment addressing life satisfaction, emotional well-being, financial wellness, career/job well-being and physical wellness. Individual participant reports provide instant feedback and referrals to applicable resources. Aggregate analytics identify which parts of an organization are thriving, which are not and how that correlates to organizational success.
Well-being program vendor RFP	We help clients define their service requirements, conduct the RFP process, evaluate proposals and negotiate performance standards.

	We include all wellness and incentive strategy development within our annual retainer. All other services are generally special projects for which we will define the scope and determine if any additional cost is necessary to complete it. **We have included a report under Appendix 2.**
15.	Provide an example of the monthly budget report for self-insured health plan. Response: It is vital Segal helps clients understand the short-term and long-term financial health of the plan. Therefore, we provide the State of Nebraska a monthly budget tracker that incorporates the seasonality of the various expenses. However, the multi-year budget projection report is the main tool used to finalize plan design and premium rate decisions each year. Segal has shown the ability to model a vast array of scenarios under tight timelines. **We have included a report under Appendix 2.**
16.	Explain the preparation of a report similar to the State of Nebraska Health Insurance Plan Annual Report. Response: Segal has many resources and tools to the assist with the development of the State's Health Insurance Plan Annual Report. Segal has a multi-disciplined team, with varying disciplines through their staffing and assigned team members. The team consists of actuaries, consultants, data analysts and clinicians who provide a multifaceted analysis of all program operations. Many of the posed team members have worked on other large state clients and their annual reports. They are well aware and have in-depth experience in how to combine all concerted efforts that tie in all areas of the program in order to provide an overall operational picture of the entire program. It's important to convey the key financial and non-financial aspects of the plan. We realize a report of this nature should be easy to understand for all members, most which do not have a background in health insurance. It's also important that the report feels new each year. Segal has drafted the Nebraska Annual Report since 2016 and continually add new relevant sections. The feedback on our reports have been positive.
17.	Provide a sample of a report similar to the State of Nebraska Health Insurance Plan Annual Report. Response: **We have included a report under Appendix 2.**
18.	Provide a list of other reports that are offered including health plan analytic reports. Include examples of the reports. Response: We have included a standard SHAPE dashboard report in ***Appendix 2*** as our example. This is Segal's data analytic tool. We have several other standard reports that are also included in ***Appendix 2***. In general, Segal's approach to large state clients is to customize reports for their specific needs. We rarely use canned reports that are more appropriate for smaller clients.
19.	Describe bidder's process to assist customers similar to the State with RFP. Response: Segal's healthcare consultants utilize several analytical tools to support the RFP process. We customize our vast array of technical resources for your specific needs, ensuring that

	we provide the high level of quality consulting that our clients expect and supporting our client's decision-making process. Segal is on the cutting edge of healthcare industry trends and relevant legislation, and we update and revise our tools, as needed, to provide maximum value to our clients. We have at our disposal several analytical tools and resources to support our engagements as may be appropriate, including: • **Proposal Tech (Electronic RFP Tool)**: This software automates health RFP bidding and analyses processes. The system has the capability to attach necessary data required by a third-party administrator, insurance carrier or vendor in order for them to calculate and provide competitive quotations. Where used as the primary procurement vehicle, this tool allows client access to watch the process unfold and expedites correspondence with vendors as well as revisions to the RFP, as necessary. • **Uniform Data Submission (UDS)**: A work group of multiple consulting firms, UDS provides a collaborative effort to reach consensus on a uniform data format that carriers utilize to transmit discount information on their network arrangements. This data is routinely updated and is used for client specific discount analysis and benchmarking. • **Disruption modeler**: The model is developed to support our analysis of the bidder networks. The results represent the volume of services or claims that would be disrupted as a result of not being in the other carrier's network. • **Performance guarantee standards**: While vendors generally are willing to provide performance guarantees and back them up with specified dollar penalties if they should fail to meet the required standards, many vendors have not been asked to include such guarantees of their performance. The objective is to develop performance guarantees that are meaningful and useful to the client and are measurable. The developed guidelines were prepared to assist Segal staff and the client to accomplish this. • **Industry pricing database**: We have access to all industry standard pricing databases (e.g., Medispan), so we can accurately and independently reprice claims. • **Scoring methodology**: Segal developed a robust scoring methodology that is designed to differentiate proposers' capabilities in a number of areas. This methodology is customizable to each client's priorities for a vendor. • **Predictive modeling**: This tool allows measurement of outcomes, comparison to normalized benchmarks and conducting predictive modeling to align plan design. • **The Optum CompPricer**: We use this health plan rating modeler to support our actuarial work and negotiations with health insurers. This model is often used to independently evaluate the appropriateness of insurance carriers' premium rates for a given client based on their plan design, demographics and other factors. The system can also be used for modeling alternative plan designs, deductibles, copays, etc.

Development and evaluations of RFPs – our approach

DAS can continue to feel confident in our procurement process. Segal assists hundreds of organizations annually with vendor selection, negotiation and management/maintenance. This is a core service our health practice provides our clients for all benefit types:

- Medical, including Medicare Advantage
- Behavioral health
- Pharmacy, including PDP/EGWPs
- Dental
- Vision
- Life insurance
- Wellness
- Disability
- Stop-loss insurance
- Flexible spending accounts
- Voluntary benefits
- Supplemental benefits (Hospital Indemnity, Cancer, Critical Illness, Accident, Long-Term Care, Universal Life, etc.)
- On-site or near-site clinics
- Third Party Administrators

The following is a step-by-step description of the complete procurement process. We are capable of "running the show" and handling all aspects of procurement or providing targeted support on an as-needed basis. We will work with your procurement staff to provide the required level of assistance and ensure the process is compliant with the procurement protocols. Based on the specifications of the RFP, we are prepared to provide RFP/procurement support for your medical, prescription drug, dental, life, short- and long-term disability (both occupational and non-occupational), EAP and any applicable supplemental benefits.

Step 1: Planning meeting

The first step is to develop a detailed RFP (or RFPs) based on your benefit strategy and proposed plan design. We will rely on anticipated experience with DAS, knowledge of the local marketplace, as well as other bid projects and evaluations to develop this RFP. The purpose of the planning meeting will be to:

- Clarify objectives and requirements of the successful bidder(s)
- Develop and establish the selection criteria
- Begin the selection process of appropriate vendors to participate in the RFP
- Update the proposed project timeline with key dates
- Discuss further contractual requirements
- Begin to gather the necessary information for sending an RFP to the market

We will follow up with notes to document the decisions made. Following this meeting, we will prepare a request for detailed claims and benefit plan information needed to support the process.

Step 2: Identify criteria, develop detailed RFP and release

We will prepare a detailed set of technical questions and financial templates for the RFPs, based on the plan designs desired by DAS The RFPs will include:

- Details of the requirements to be met by the vendors. We will include any contract terms that the bidders will be required to agree to as part of their proposal. We will also identify data transmission requirements.
- Instructions for bid submission
- Detailed information about benefit plans. This will include the current plans and any proposed plans. Current plans will be necessary in order for the vendors to interpret historical data properly.
- Summary of demographics and background information on DAS's covered population
- Required mechanism for pricing the plan – insured and/or self-insured
- Any guarantees that might be required upfront
- Detailed list of the services the bidder is expected to perform, including administration, network access, care and disease management, wellness, reporting, administration and communications

Our specifications are prepared by customizing standard materials developed and continually updated by our National Health Practice. These standards help ensure that bid specifications are comprehensive and well organized and reflect the most current benefit and vendor information. Segal has company-standard specifications for all types of health and welfare benefits RFPs.

Specifications include a detailed questionnaire, as well as financial bid forms designed to ensure that information provided is complete and comparable (from one bidder to another). In addition, we will request multiple year contracts and report on the financial soundness of the proposing institutions.

We would submit the RFP to DAS staff for review and comment (and modification, if necessary) prior to distribution. After the RFP has been distributed, we will assist with responding to any inquiries for additional data and clarification.

Identification of the vendor market

With an understanding of your goals and objectives for a particular vendor marketing, Segal will use our extensive market knowledge to help you determine an appropriate target list for initial distribution.

We will also assist in developing the appropriate qualifications and reference requirements to ensure the target market responds and under-qualified firms will find it difficult to "buy

the business" with an aggressive cost proposal, but not have the expertise or support structure required to truly service DAS and the membership. This is especially important, as these procurements are publicly advertised.

Segal is familiar with local and national vendors and maintains a comprehensive directory of carriers, administrators and other vendors related to health and welfare benefit plans. This directory is updated frequently to ensure that company names, offerings and appropriate contacts are current. The RFP process allows us to include a relatively large, comprehensive list of vendors initially, and then to narrow the list before the more comprehensive RFP process has begun. We will also welcome input from DAS regarding vendors to include in the invitation to bid. If the procurement department handles the final release of the RFP and receipt of the vendor proposals, we will suggest vendor contacts to receive notification to help assure that all qualified vendors have a fair opportunity to bid.

We do not have preferred vendor relationships. Instead, we work to find the best vendors to serve a particular client. As a result, we work with every major vendor across the country. With thousands of clients, representing a significant market share, with premiums exceeding $10 billion.

Step 3: Collect proposal and interact with bidders

Interaction with bidders after the proposal is released to the market can be labor-intensive, but is essential to ensuring that proposals are complete, accurate and competitive. We expect to work within purchasing rules and with DAS's Purchasing Department.

- Pre-Bid Conference: Generally, we recommend a "bidders' conference" at which potential proposers may present their questions. We frequently are asked to organize and host such conferences and would do that for DAS, if desired. Questions and answers addressed in the bidders' conference will be documented in writing for subsequent distribution to potential bidders.'
- Q & A: We also recommend a period of time following the bidders' conference in which written questions from potential bidders will be addressed. We require that interaction with bidders be conducted in writing so that we may share questions and answers with all proposers, thereby ensuring a fair, disinterested process.

Step 4: Evaluate proposals

After we collect all of the proposals, we will request supplemental data from the carriers, if necessary, and ensure that all bidders meet minimum qualifications. If any red flags are noticed during this phase, we will provide DAS with updates and analysis points.

We will compare and analyze all responses, focusing on financial issues such as claims processing fees and network access fees (self-funded) and premium rates (fully insured) guarantees. We also will review non-financial, qualitative issues used to identify the relative strengths and weaknesses each organization possesses in its ability to administer the healthcare program.

We will meet with you to review the results of the vendor marketing. Steps in the evaluation should include the following:

- Completeness, accuracy, and thoroughness of the responses
- Competitiveness of the financial quotations
- Network discount analysis
- Pharmacy discount analysis, where applicable
- Pharmacy rebate analysis, where applicable
- Formulary and provider network disruption analysis, where applicable
- Responses to key questions

At the conclusion of this meeting, we should be able to identify the best overall bid. If finalist interviews and solicitation of best and final offers or follow-up negotiations are needed, then we provide assistance in these areas as well.

During this step, we will work with the vendors as permitted by State laws and procurement requirements to resolve any questions or discrepancies in their proposals. The proposal has requested that we act as a technical resource for the evaluators of the RFP responses.

Step 5: Prepare report of findings

The result of our proposal evaluation is a summary report highlighting key findings and presenting the detailed evaluation of components of bidders' financial proposals. Our report will include:

- Detailed summary of pros and cons of each bid
- Scoring, for technical and financial and overall scoring
- Recommended follow-up questions for additional clarification
- Recommendations for finalists, and for topics to be addressed at the finalist stage

At the conclusion of the bidding process, our report will ultimately serve as a complete document of the process, including subsequent events and developments including the Best and Final Offer and negotiation phases.

Step 6: Interviews & finalist process

After finalists have been identified, we will coordinate interviews with each finalist. Interviews are typically one to two hours in length. Working with you, we will facilitate the timing, agenda and logistics. We will attend all meetings and facilitate interaction, when and if required. The interview will allow DAS to verify the finalists' services and capabilities beyond the written word. Segal will work with staff to develop vendor-specific meeting agendas and be available to facilitate such meetings, if requested.

Following finalist interviews (and sometimes before), we ask the vendors to prepare "best and final" offers. This process is usually focused on pricing arrangements, but also includes the following:

- **Performance guarantees**: These include the standard claim and service guarantees. Although from a contracting perspective these are important to have in place, in our experience they are not a driver of performance.
- **Cost, trend and ROI related guarantees**: We have seen a greater willingness for healthcare providers to provide these kinds of guarantees to larger organizations, like DAS. These types of performance guarantees need to be negotiated carefully, as the vendors frequently set a low bar for performance.
- **Implementation credits**: Most of the vendors, in our experience, are open to providing funds for implementation and post-implementation audits.

Following the analysis of the final offers, we will work together to select a winner. We will also conduct any final negotiation that might be required prior to award, working with DAS's Counsel, as appropriate.

Step 7: Award contract

Once a preferred vendor is determined, we will assist DAS in confirming the decision and help coordinate with DAS's Human Resources, Risk Management and Purchasing and Legal departments to acquire needed insurance policies, contracts, clarifications, execution of documents, other required documents and services, as needed.

We will update our summary proposal evaluation report, confirming the final vendor selected, and supplement the material with our interview and site visit notes and the outcomes of finalist negotiations. We will present this report to DAS, as requested, and will be prepared to respond to any questions that may arise. We will also provide support as is necessary, in notifying unsuccessful bidders and other interested parties that a contract has been awarded, summarizing the decision and award processes and assisting DAS in

responding to legal or administrative challenges that may be brought by unsuccessful bidders.

Step 8: Implementation

The last step in the procurement process is implementation. When a new vendor is chosen, a smooth transition from the incumbent to the new vendor is critical.

Segal will continue to work closely with staff and the selected vendor to ensure the target implementation date is met. To achieve this goal, we pay close attention to the following:

- **Data transfers**: We work with the incumbent vendor to ensure that data provided is completely up to date and accurate, and that it transitions fully to the new vendor's systems.
- **Transition of care**: These are often sensitive issues that involve developing approaches that are satisfactory to both vendors and that meet employee needs.
- **Member communication**: We develop communication strategies and tactics that help your members understand the context for the transition, understand what's changing and how changes affect them, present calls to action clearly, simply and logically, and help employees navigate the changes successfully, with the lowest level of disruption possible.
- **Run-out claims**: Segal will negotiate an approach and timeframe that is satisfactory to DAS and to vendor(s).

As the implementation date approaches, Segal will be available to work with all staff and HR professionals and the vendors to address any issues that arise.

RFP cost analysis

Segal will develop a methodology for cost proposal analysis prior to the RFP being released. We will discuss the various methodologies and strategies to ensure the most competitive bid for DAS.

Your Segal team will receive the financial proposals and conduct a detailed price analysis of those bids. We will analyze the quotes over each year of the contract period to reach full comparability in the price quotes. Where a bidder has proposed a price or rate method that does not follow the prescribed methodology or format, we will work with the RFP Coordinator to obtain the quote in the proper format and get clarifications as needed. Where there are differences among bidders in the services covered by the quote, we will analyze those differences and apply factors and assumptions to maintain consistency across all bidders' proposals.

Evaluating the true costs of the program can be challenging when the networks are significantly different. In these cases, we rely on a methodology accepted by a number of actuarial firms.

Determining “true” or “net” costs

Medical and PBM procurements present the most complex cost analyses. Segal will conduct a thorough analysis to make sure the “true cost” or “net cost” is accurately determined. An error in this section can have devastating effect on the financial viability of the program.

Segal uses several approaches to analyze effective discount rates on medical claims. Each approach has some advantages and limitations, so Segal prefers to use a combination of analyses to ensure the most accurate picture of our client's potential costs based on:

- **Claims repricing by proposing vendors**: In this approach, 12 months of claims detail is provided by the current vendor or pulled from your SAS database. Competitors are then asked to reprice the claims so that comparisons between vendors can be made. This approach can be gamed unless your consultant provides detailed direction on how the analysis is to be performed, identifies the appropriate matrix for reporting the results of the repricing, and requires officer sign off by the vendor on a list of criteria under which the repricing was performed. Results are typically presented on a product basis, show in-network utilization and effective discount rate.
- **Review of national claims database**: Segal participates in the Uniform Data Specification task force of health actuaries from all major carriers and consulting firms that have devised a common methodology of evaluating provider discounts that is accepted by most carriers. Most major insurance carriers are represented on this task force. The standardized methodology means that each carrier is submitting information using the same agreed upon definitions of medical terms and same format. This data is routinely updated (twice annually) and can be used for client specific discount analyses by service area. Segal has built a database of provider discounts utilizing detailed inpatient facility, outpatient facility and professional claims data from each carrier’s book of business. Currently Segal uses this database to validate results produced by the discount analyses.
- **Self-reported discounts**: In this approach, vendors are asked to provide the average discount off billed charges by provider type, i.e., primarily specialist care, surgery, in-patient, out-patient, lab, etc. A weighted average discount can be developed for comparison purposes. In this approach, it is critical that the consultant be experienced and knowledgeable about actual discount outcomes so they can evaluate the quality of the data received. Segal does not rely on self-reported discounts but does use them as a "reality-check" to validate our own analyses.

These are the primary methodologies, but we will be customized depending on the procurement type – possibly getting book of business data and marketplace information. We will also use various tools as needed during the analysis and dependent on the RFP; those tools were discussed in our response to Question 5.3.01.

In addition to developing an effective network/provider discount, we will include a number of other elements that impact a vendor’s total projected cost, such as:

- **Administrative fees**: Including its build-up

- **Utilization assumptions**: Depending on the product, there may need to be adjustments to baseline utilization that would impact the cost (pharmacy, wellness, etc.).
- **Enrollment expectation**: With new vendors and plans, there will need to be some migration scenarios.
- **Guarantees**: It will be important to consider the guarantee and their consistency with pricing. This is even more important with a PBM procurement, where pricing is guaranteed dollar for dollar.

Once the total cost is developed, we will score the results, combine with technical and, if desired, make a recommendation. Final decision will reside with DAS.

Our experience with procurements

Procurement assistance is a core service we provide to our State clients. Segal assists hundreds of organizations annually with vendor selection, negotiation, management, and maintenance. Once the design is set, it is imperative to put in place a partner who can best meet your needs. Below is a list of some State clients and the specific procurements we are performing or have performed during the last couple of years.

RFP Services

State	Medical	PBM	Med Adv	Dental	Vision	Life	PHM	STD/LTD	FSA
Alabama	✓	✓	✓				✓		✓
Alaska	✓	✓		✓	✓	✓	✓		✓
Arizona	✓	✓	✓	✓					
Connecticut	✓	✓	✓	✓					
Hawaii	✓	✓	✓	✓	✓				
Illinois	✓	✓	✓				✓		
Kansas	✓	✓		✓	✓	✓	✓		✓
Maryland	✓	✓			✓				✓
Mississippi		✓							
Nebraska	✓	✓							
New Hampshire	✓	✓		✓	✓	✓		✓	✓
New Mexico	✓	✓	✓	✓	✓	✓	✓	✓	
North Carolina	✓	✓	✓				✓		
Pennsylvania	✓	✓		✓	✓	✓			
Rhode Island	✓	✓		✓					
Texas	✓		✓						
Wisconsin	✓	✓	✓	✓			✓		✓

	We look forward to continuing to provide DAS with a fresh, unbiased approach to your program – integrating your current strengths with our experiences from across the country.
20.	Explain how the bidder educates customers of updates and changes to ACA regulations. Indicate resources available specific to ACA. Response: Segal has been at the forefront in reviewing and implementing the requirements relating to healthcare reform since it was first proposed. The federal government and other regulatory entities frequently called on Segal's expertise during the developmental stages of the ACA to understand how the proposed law and regulations would affect group health plans. Segal's active role since before the enactment of the ACA in 2010 uniquely positions us to provide proactive guidance and in-depth analysis -- keeping clients as current as possible on any emerging regulatory or health care reform requirements. Our Health Compliance specialists will be involved in the ongoing work performed, providing input from the compliance perspective. We look deeply into specific areas of ACA compliance to determine how they fit into your overall strategy and how you can address them. In addition, we encourage you to work directly with our Health Compliance specialists whenever a question arises about an issue that can affect your plan. We work with our clients to ensure not only that ACA provisions such as limits on waiting periods and limits on deductibles, co-insurance and co-payments are in place, but that cost impacts and alternatives that may be available to balance budgets also are considered. However, Segal does not provide legal, tax or financial advice. Accordingly, when legal, tax or financial issues arise, we advise clients to supplement the information and observations that we offer by looking to their attorneys or financial advisors for authoritative advice in those areas. Using our ACA health reform compliance assessment tool, we will review the benefit program plan design in light of the ACA's mandates and compliance requirements. Segal's array of ACA services includes, but is not limited to, the following topics: • Shared responsibility penalty: Segal has extensive experience working with corporate and public sector employers, multiemployer funds and other groups, including associations, to minimize applicable large employer (ALE) exposure to the ACA's employer shared responsibility penalty. This includes assisting employers in understanding what coverage is required to be offered, what is meant by minimum value and affordable coverage, counting hours to determine when an employee is full-time, safe harbors and look back periods. We also assist clients with data analysis and filing various government documents, including 1094 and 1095 reporting forms. • Affordability and contributions: Clients generally provide benefit designs aimed at keeping premiums at a low cost. We will look at the impact of ACA compliance in terms of participation, cost and benefit levels, taking into account the ACA's out-of-pocket maximums and affordability requirements. • Maintaining "Grandfathered Plan" status: For clients with grandfathered plans, Segal advises on permissible cost increases and plan changes under the grandfathered plan rules. Segal also assists clients in assessing whether to maintain grandfathered status against the flexibility of making plan changes to have competitive benefit levels and designs. Our analysis will provide recommendations and cost analyses to help the

	client identify key decision and strategy points to determine whether it is better to have more plan design flexibility or maintain grandfathered status for as long as possible. • Excepted benefits: Segal is an expert on various ACA requirements, including benefits excepted from ACA requirements, such as vision, dental and wellness programs. We have experience in reviewing programs to determine whether they must be compliant with the ACA or whether they are outside the scope of the ACA. For those clients that offer or may consider an offer of a Health Reimbursement Arrangement (HRA), we assist in HRA design that is ACA-compliant, including drafting HRA plan documents and employee communications. • Retiree-only plans: There are special rules under the ACA for retiree-only plans. Segal conducts studies to compare how clients currently provide employees with retiree health benefit coverage against an ACA-compliant retiree-only arrangements. The client also should consider whether it should assume the responsibility for providing retiree health coverage under its own plan since alternative Exchange vehicles are available and may offer lower premium costs. In addition, Segal can suggest changes and alternative future approaches to help clients control the ever-growing cost of retiree health benefits. • Expansion of Medicaid: As of January 2024, 40 states and the District of Columbia have adopted Medicaid expansion to provide benefits for a greater range of recipients directly affects a contingent of the persons covered under the CHIP and Medicaid programs. Segal explores this dividing line between employee benefits and recipient benefits to help clients understand the dynamics that drive choice of program. We work with clients to determine more specifically how these participants should be handled and whether state-level benefits require any adjustment in plan philosophy or benefits.
21.	Describe how the bidder stays updated with Federal and State regulations which affect employee benefit programs. Response: Segal's consultants monitor state and federal legislative, regulatory and judicial changes that affect public sector plans. We proactively inform our clients about these changes by publishing articles and facilitating training on the latest compliance issues. Segal provides proactive and responsive compliance advice through our national staff of attorneys focused on the myriad of health and welfare issues including COBRA and HIPAA. **Elena Lynett, JD** will lead this work for DAS, working closely with **Julia Zuckerman, JD** and **Kathy Bakich, JD**. These members of our team have periodically joined our bi-weekly calls with the State of Nebraska when a situation arises. Please see their resumes detailing their extensive expertise and experience. In addition, Segal offers a range of compliance services and publications to help public sector plans navigate the maze of federal, state and local laws and regulations related to benefit plans. These include: • Drafting plan documents, summary plan descriptions, plan enrollment information, administrative forms and participant correspondence and notices • Reviewing documents for compliance with Internal Revenue Code provisions and regulations, internal and external consistency and the provision of clear rules and guidelines for plan operations

	• HIPAA privacy and security assessment, policies and procedures, compliance and training programs • Designing wellness programs to promote healthy lifestyles while complying with strict federal guidelines • Drafting policies and procedures, and conducting training, on a wide range of federally mandated plan provisions, including COBRA, QDROs, USERRA, Cafeteria plans and other laws • Developing individual account health plans to accommodate changing health policy needs of employers, including Health Savings Accounts and Health Reimbursement Arrangements • Helping employers navigate new and confusing rules regarding Medicare, coordination of benefits and the Medicare Part D Retiree Drug Subsidy (RDS) • Helping employers prepare for government audits of health and retirement plans We have extensive experience in preparing comprehensive analyses of federal, state and local legislative and regulatory issues for our public sector clients. These analyses include a wide variety of research projects and reports that we have prepared for boards of trustees of state and local government plans, state legislatures, state commissions and the federal executive and judiciary branches. Our Washington-based staff of health law experts maintain close relationships with government agencies, and this allows them to follow legislative developments and be able to alert clients and respond to questions quickly and efficiently. In addition, Segal's compliance experts wrote and serve as ongoing editors to the Employer's Guide to HIPAA Privacy Requirements (Thompson Publishing Group, Inc.) and serve on the advisory boards of multiple employee benefit publications. We will proactively share our analyses of emerging regulations and legislation through our Alerts and notices. We encourage our clients to contact Segal whenever a question arises about an issue that can affect their plan. However, because Segal does not practice law, if a legal issue arises, you should supplement the information and observations that we offer by consulting with your attorneys for authoritative legal advice.
22.	Describe tools and resources available to help stay compliant with all federal and state regulatory requirements. Response: **Tools and resources Segal uses to stay informed** Staying informed about all developments affecting your plans is essential. Our relationships on behalf of clients with the Internal Revenue Service, U.S. Department of Health and Human Services, Department of Labor and numerous other agencies allow us to not only assist you with compliance and related matters but also disseminate critical information, including “hot-off-the-press” analysis of legislation, in a timely manner. We regularly assess and proactively inform clients about the impacts of federal and state laws and regulations, including Governmental Accounting Standards Board Statement 74/75, COBRA, federal tax provisions, GINA, USERRA, HIPAA, HiTECH, EEO, PPACA (and new proposed legislation from the Biden administration) and IRS section 125 cafeteria plans. We also assist you in identifying any modifications needed to your benefits program to meet compliance standards for all benefits-related legislation.

Segal prepares materials including online *Compliance News* web posts and thought leadership, which are routinely provided to clients, at no additional charge, via e-mail:

- *Compliance News* summarizes important developments affecting retirement plan compliance and health benefit plan compliance, provides a concise description of the legislative or regulatory matter and discussed the possible implications for public sector plans
- Various consulting insights that discuss creative benefit planning options for employers and plan sponsors
- *Trends,* a quarterly publication that captures noteworthy developments of interest to sponsors of public sector health plans
- Complimentary webinars for our clients to discuss current topics of concern and new legal and regulatory requirements

23. Provide two (2) examples of recent training offered to customers.

Response:

Segal conducts frequent webinars for our clients to discuss current topics of concern and new legal and regulatory requirements. These seminars are held as webinars, using Zoom. The presentations, supporting materials and recordings are then made available on our website as an educational resource: segalco.com.

For example, in 2022, Segal was quick to conduct a webinar entitled, "Roe Overturned: What Employers & Plan Sponsors Need to Know." In the most consequential reproductive rights case in generations, the U.S. Supreme Court's decision in Dobbs v. Jackson Women's Health Organization has overturned Roe v. Wade. This decision impacts

employers and plan sponsors, which now have a number of actions to consider. Click here to listen to the replay. Our national compliance and clinical experts explore top employer and plan sponsor concerns including:

- The decision, impact on multi-state entities and potential ERISA preemption
- Required changes and strategic decisions impacting health plans, travel benefits, paid leave, fertility coverage and health reimbursement arrangements
- Pharmaceutical benefits related to pregnancy, such as contraceptives and medication abortion and coordination with pharmacy benefit managers
- Financial security, dependent and education benefits, communication issues and potential disparate impact on workforce diversity

We also conduct webinars highlighting industry trends, such as, "Digital Revolution: Healthcare On-demand" about how digital technology is transforming the way that healthcare is practiced and delivered. The coupling of virtual technologies with remote medicine disrupts the idea that having a regular relationship with a local primary care provider is necessary to manage chronic illness and overall health and well-being. Click here to listen to the replay. In this webinar, you'll:

- Learn which clinical categories are most appropriate for a digital solution
- Gain insight into some of the prominent companies that are emerging in this field
- Learn to identify the best digital therapeutics to match the needs of the population
- Learn how these programs can potentially reduce medical claims and create a healthier workforce

Webinar topics vary widely and have included not only in-depth issues relating to compliance with recent legislation, fiduciary liability and fidelity bonds, cyber liability, employment practices liability, the uniqueness of training fund liability, etc. Guest speakers from the insurance carriers, law firms and other service providers are often included.

Links to the replays of other recent webinars include the following:

Compare Your State Employee Health Benefits With Peers | Segal (segalco.com) 2024

Sponsors of Retiree Health Plans: Ready for 2025? | Segal (segalco.com) 2024

"2023 Mental Health Parity Enforcement Trends in the Face of Regulatory Uncertainty | Segal (segalco.com) 2023

Best Practices for Building Strong Cybersecurity Defenses | Segal (segalco.com) 2023

Proposed MHPAEA Rules and the Challenges They Would Create | Segal (segalco.com) 2023

In addition, we have extensive experience in preparing comprehensive studies and reports on benefits-related topics involving legislative and regulatory issues for many of our clients. We are also available to provide a range of training for clients, developed and customized to your specific needs.

There is no cost for attending a Segal webinar.

	Describe bidder's ability to perform implementation per Section V. F.
24.	Response: Because Segal is the current consultant and actuary for this account, there is no need for a formal start-up implementation plan, although we will continue to advise and support the State moving forward through our lens of experience with the Plan. For the new contract period, we will employ a team approach to implementing and serving DAS. Below is a summary of our process: • **Kickoff meeting**: DAS and Segal teams hold strategic conversations about the environment and trends at DAS and provide our market insights. The session would lay the framework for the upcoming implementation and work to be accomplished and identify short term and long-term strategic goals. We will collaborate with DAS to build a plan for the new contract. • **Communications**: This is another important aspect of our customer service philosophy: – Meetings weekly or bi-weekly with DAS, our team and other subject matter experts (depending on the agenda) will meet with DAS weekly to review open projects and discuss issues and progress. – DAS /Segal coordination: DAS will continue to have unrestricted access to your Segal team. DAS will have direct access to all Segal team members. Every member of your Segal team continues to be committed to be available via phone or email as often as you deem necessary. – Meetings internally: Our team and other subject matter experts meet weekly, ensuring all data and documents have been gathered, identifying any gaps. • **Project plan**: A project plan can be developed with DAS at the onset of our contract and will continue to be modified and updated throughout the course of our contract. **We will work with DAS to ensure we continue to cover all scope items listed in this RFP. This was our current process utilized for our current engagement.**

Form B, Cost Proposal

Per Addendum 1, posted December 18, 2024, we have uploaded the Cost Proposal as a separate file in Sharefile.

Appendix 1: Segal Team Resumes

Patrick J. Klein, FSA, MAAA

Vice President, Atlanta

Project Role: Account Manager

Expertise

Patrick is a Vice President in Segal's Atlanta office with 13 years of actuarial and consulting experience working with public and private sector plans and employers. Working with both self-insured and fully insured plans, he has specialized expertise in developing employer healthcare strategies for active and retiree benefit programs, new product development, risk profiling, data analytics, vendor selection, employee contributions, wellness and eligibility provisions to meet client goals and objectives.

Patrick thoughtfully negotiates fully insured renewals for Medicare Advantage, HMO and other insurance products on his clients' behalf, consistently resulting in significant savings. He provides certification of estimated incurred but not reported reserves (IBNR), as well as the claims/premium assumptions used in retiree health valuations. Patrick is adept at building and presenting custom actuarial models used to calculate refined estimates and the sensitivities surrounding those estimates.

In addition to project management and client work, Patrick assists clients with messaging and gaining organizational buy-in to support the recommended strategy. He regularly presents to various committees and governing boards, articulating complex actuarial concepts in easy-to-understand layman's terms.

Professional background

Prior to Segal, Patrick was a Senior Consultant at Aon Hewitt. There, he served as the lead actuary and performed actuarial analyses for midsized private sector and public sector clients as well as large state health plans.

Education/professional designations

Patrick holds a BS in Actuarial Science from Illinois State University. He is a Fellow of the Society of Actuaries and Member of the American Academy of Actuaries.

References

Ms. Jill Thayer
Chief Legal Council
Arkansas Bureau of Legislative Research
1 Capitol Mall, Fifth Floor
Little Rock, AR 72201
State Capitol Room 315
501.683.0720
thayerj@blr.arkansas.gov

Ms. Renee Walk
Director Strategic Health Policy
Wisconsin Department of Employee Trust Funds
4822 Madison Yards Way
Madison, WI 53705-9100
608.261.7254
Renee.Walk@etf.wi.gov

Ms. Jennifer Flory
Director, State Employee Health Benefits Plan
Kansas Department of Administration
109 SW 9th St., Suite 600
Topeka, KS 66612
Phone: (785) 296-3362
Jennifer.flory@khpa.ks.us

Patrick J. Klein, FSA, MAAA
pklein@segalco.com
678.306.3142
segalco.com

Kenneth C. Vieira, FSA, FCA, MAAA

Senior Vice President, East Region Public Sector Market Leader, Atlanta

Project Role: Executive Sponsor

Expertise

Ken is a Senior Vice President and Consulting Actuary in Segal's Atlanta office with over 25 years of experience as an account manager/account executive, actuary and consultant. He serves as East Region Public Sector Market Leader and is a member of the firm's Public Sector Leadership Group and East Management Team.

Ken brings a full complement of actuarial and consulting expertise to his clients. He has extensive experience in strategic consulting, benefit plan design and evaluation, financial forecasting, trend analysis, risk profiling, new product design, plan rating, premium rate development, data analytics, retiree medical, statistical modeling and other medical management programs.

In addition to his specialty in the governmental sector, Ken has worked with large employers, healthcare providers and health plans. His varied projects have included packaging and pricing medical services, developing claims data reporting, utilizing risk management software, developing HMO rates and renewal support, and developing prospective payment systems.

Professional background

Prior to joining Segal, Ken was the head of the Government Programs Health Practice at a large consulting firm in Atlanta. He has worked extensively with states and other large governmental employers on state health plans, Medicaid programs and a broad range of actuarial issues. With many of these states, Ken served as both the account manager/account executive and actuary and provided a wide array of strategic consulting.

Education/professional designations

Ken received a BS in Software Engineering from Syracuse University. He is a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, a Fellow of the Conference of Consulting Actuaries, and a retired Enrolled Actuary. He is also a licensed Life and Health Insurance Consultant in Georgia, Tennessee, North Carolina and other states.

References

Mr. Charles Sceiford, ASA
Health & Benefit Actuary
3200 Atlantic Avenue
Raleigh, NC 27604
919.814.4412
Charles.Sceiford@nctreasurer.com

Ms. Renee Walk
Director Strategic Health Policy
Wisconsin Department of Employee Trust Funds
4822 Madison Yards Way
Madison, WI 53705-9100
608.261.7254
Renee.Walk@etf.wi.gov

Ms. Jennifer Flory
Director, State Employee Health Benefits Plan
Kansas Department of Administration
109 SW 9th St., Suite 600
Topeka, KS 66612
Phone: (785) 296-3362
Jennifer.flory@khpa.ks.us

Kenneth C. Vieira, FSA, FCA, MAAA
kvieira@segalco.com
678.306.3154
segalco.com

Gina T. Sander, FLMI

Vice President and Health Practice Leader, Atlanta

Project Role: Lead Consultant

Expertise

Gina is a Vice President and the Health Practice Leader in Segal's Atlanta office with over 30 years of experience as an underwriter, consultant and account manager. She is a member of the East Region Health Practice and provides benefits consulting to public sector entities at the federal, state and local levels, as well as large corporate firms.

Gina has a strong technical underwriting background and brings a full complement of consulting expertise to her clients. She has extensive experience in strategic consulting, benefit program/plan design and evaluation, financial forecasting, trend analysis, plan rating, premium rate development, data analytics, vendor selection and management and presenting to committees, councils and boards.

She assists clients with strategic planning, benefit design, procurement and pricing of health and welfare benefits, vendor management, developing customized reports, evaluating the potential financial impact of health legislation and presenting to various committees and governing bodies.

Professional background

Prior to Segal, Gina served as a Senior Consultant at another major consulting firm, specializing in medical, prescription, wellness and other health and welfare benefits. She was responsible for account management, strategic planning, benefit design and modeling, vendor management and cost projections, among other tasks.

Education/professional designations

Gina received a BA in Economics from The University of Georgia. She has earned a Fellowship of Life Management Institute (FLMI) designation and is a licensed Life and Health Insurance Consultant in 21 states.

References

Kansas
Jennifer Flory
Director, State Employee Health Benefits Plan
Kansas Department of Administration
109 SW 9th St., Suite 600
Topeka, KS 66612
Phone: (785) 296-3362
Jennifer.flory@ks.gov

Fulton County, Georgia
Verna Thomas, MHRM, CPM
Employee Benefits Manager
141 Pryor St., S.W., Suite 7001
Atlanta, Georgia 30303
Phone: (404) 612-7639
Verna.Thomas@fultoncountyga.gov

Harris County
Sarah Acosta, MPH, RDN, LD
Director, Benefits & Wellness
1111 Fannin, 6th Floor
Houston, TX 77002
Phone: (713) 274-5492
Sarah.Acosta@harriscountytx.gov

Gina T. Sander, FLMI
gsander@segalco.com
678.306.3158
segalco.com

Jennifer Slutzky

Senior Health Consultant, Atlanta

Project Role: Day-to-Day Contact/ Project Manager

Expertise

Jennifer is a Senior Health Consultant in Segal's Atlanta office with over 25 years of experience in the employee benefits field. She currently consults on and evaluates retiree health options, Medicare Advantage and Prescription Drug (MAPD_Plan solutions and assists with valuating medical management programs and health plan strategies. Jennifer works with clients across Segal's multiemployer, public sector and corporate markets, with a focus on public sector. She has expertise in managing health-related public sector procurements including medical, prescription drug, wellness, onsite clinics and MAPD. She develops, markets and analyzes procurements. She presents results and outcomes to clients and assists them with managing finalist interviews and oral presentations, making vendor selections and advising on contract negotiations. She also has expertise assisting plans with implementation and working with the vendor and client to ensure a seamless onboarding. She performs PBM RFP analyses as well as reviews and assessments of PBM contract terms to determine areas that can be improved to better meet a plan's needs, enhance performance, reduce costs and improve quality. She has also performed RFP analysis for stop-loss, life and AD&D insurance, dental, vision and independent review organization coverages to assist clients in selecting vendors. Jennifer's expertise includes training and development, managed care analysis and assessment, Health Insurance Portability and Accountability Act (HIPAA) privacy and security compliance assessment and MAPD and Pharmacy Benefit Manager (PBM) consulting services.

Professional background

Jennifer has contributed to several company initiatives that provided value for our clients. She designed, managed and served as a coach for the company's health training program curricula for over 250 health practitioners. She also researched various healthcare topics and their relevance to plan sponsors.

Jennifer's past roles at Segal included streamlining Segal's national template of Preferred Provider Organization (PPO) bid specifications, which assisted clients in gathering effective information in order to select the most optimal vendor for their plans. She also developed report templates to facilitate consulting on emerging health issues under the Affordable Care Act (ACA), provided technical and consulting assistance for select client projects and created and updated health benefit benchmarks.

Education/professional designations

Jennifer received a BS degree from Emory University and a Masters of Public Health degree in Health Policy and Management from Emory University's Rollins School of Public Health.

Publications/speeches

Jennifer has contributed to several company surveys and reports, including the *Segal Health Plan Cost Trend Survey*, which captures average forecasted changes in health plans' per capita claims costs for medical, dental, prescription drug and vision coverages before plan changes, and *Trends*, an e-publication that offers a periodic snapshot of newsworthy health coverage developments for plans.

References

State of Connecticut
Josh Wojcik
Director, Health Policy and Benefits Services Division
55 Elm Sreet
Hartford, Connecticut
860 702.3389
joshua.wojcik@ct.gov

State Teachers' Retirement Board
Helen Sullivan
Chief Administrator
165 Capitol Ave, Hartford, CT 06106
959. 867.6313
helen.sullivan@ct.gov

State of Alabama – Local Government Health Insurance Board
David Hilyer
Chief Executive Officer
334-851-6802
P.O. Box 304901
Montgomery, AL 36130
334.851.6802
dhilyer@lghip.org

Jennifer Slutzky
jslutzky@segalco.com
678.306.3120
segalco.com

Olga Ronsini, ASA

Actuary, Atlanta

Project Role: Lead Actuary

Expertise

Olga is an Actuary in Segal's Atlanta office. She performs technical work and review for actuarial valuations, actuarial assumptions studies and related projects, including:

- Retiree medical (OPEB) valuations
- Expense and revenue projections for self-funded health plans
- Estimating IBNR reserves
- Quarterly and monthly reports
- Conducting actuarial attestations in support of retiree drug subsidy applications
- Processing and analyzing health claims data

Professional background

Prior to joining Segal, Olga was a Sales Coordinator at Gallaher Liggett-Ducat, where she provided operational support for a local branch of an international tobacco company.

Education/professional designations

Olga received an MA in Applied Mathematics from Yaroslavl State University (Russia). She is an Associate of the Society of Actuaries (ASA).

References:

Ms. Christina Kuminski
Director, Employee Benefits Division
Maryland Department of Budget and Management
01 W. Preston Street Room 510
Baltimore, MD 21201
410.767.4775
Christina.Kuminski@Maryland.gov

Ms. Diane Scott
Chief Financial Officer
Retirement Systems of Alabama (PEEHIP)
201 South Union Street
Montgomery, Alabama 36104
334.517.7302
diane.scott@rsa-al.gov

Ms. Christy Osentowski
Administrator
Employee Wellness & Benefits Director, Total Rewards
State of Nebraska
1526 K Street, Suite 110
Lincoln, NE 68508
402.471.2832
Christy.Osentowski@nebraska.gov

Olga Ronsini, ASA
oronsini@segalco.com
678.306.3141
segalco.com

Monica Casarez, SHRM-CP

Associate Consultant, Atlanta

Project Role: Consultant

Expertise

Monica is an Associate Consultant in Segal's Atlanta office. She has more than 19 years of human resource experience in employee benefits, risk management, employee relations, staffing and hiring.

Professional background

Before joining Segal, Monica provided benefits consulting to ValoriHR LLC; D&S Community Services, Addison Group; and Cigna, Mindlance Inc. Previously she was a benefits coordinator and manager with the cities of Austin and El Paso.

Education/professional designations

Monica graduated *cum laude* with a Bachelor in Business Administration and Human Resources concentration from the University of Texas at El Paso. She is a Certified Professional and member of the Society for Human Resources Management (SHRM). She is working towards her CEBS designation. Monica is a licensed Life, Accident, Health and HMO agent

Monica Casarez, SHRM-CP
mcasarez@segalco.com
915.731.1476
segalco.com

Zachary Vieira, ASA

Associate Health Consultant, Atlanta

Project Role: Assistant Actuary

Expertise

Zachary is an Associate Health Consultant in Segal's Atlanta office. He provides financial analysis and interpretation of healthcare data, including medical, prescription drug, stop loss, dental, vision, life and disability coverages. He also provides budget projections including pricing of benefit changes for health coverages utilizing experience and manual rating tools, renewal analyses, vendor negotiations, bid specification preparation and analysis of vendor proposals, and assisting consultants with the presentation of data and options to clients.

Professional background

Zachary interned in the Atlanta office for two summers before joining the staff full time in 2018.

Education/professional designations

Zachary graduated *cum laude* from the College of Mathematics and Science at Auburn University with a Bachelor's degree in Applied Mathematics with an option in Actuarial Science. While at Auburn, he was part of the Alpha Delta Lambda National Honor Society, Phi Eta Sigma National Honor Society and Auburn Actuarial Club.

Zachary Vieira
zvieira@segalco.com
678.306.3153
segalco.com

Hanna Paz

Health Benefits Analyst, Atlanta

Project Role:

Expertise

Hanna is a Health Benefits Analyst in Segal's Atlanta office, working with multiemployer and public sector clients. Her work includes analysis and interpretation of healthcare data, including medical, prescription drug, stop loss, dental, vision, life and disability coverages.

Professional background

Prior to joining Segal, Hanna was an Underwriter at a dental carrier for nearly three years, primarily working with corporate and public sector clients.

Education/professional designations

Hanna graduated *cum laude* from the University of Georgia with a BS in Mathematics and a BBA in both Finance and Risk Management with a certification in Actuarial Science.

Hanna Paz
hpaz@segalco.com
678.306.3100
segalco.com

Elena Lynett, JD

Senior Vice President, Washington, DC

Project Role: Compliance

Expertise

Elena is a Senior Vice President in the National Health Compliance Practice Group based in Segal's Washington, DC office and has over 15 years of experience in healthcare regulation and compliance. She provides analysis of federal and state law impacting group health plan coverage and is an expert on the Affordable Care Act, Mental Health Parity, Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination and wellness provisions, and Genetic Information Nondiscrimination Act compliance.

Professional background

Prior to joining Segal, Elena worked as a senior health benefits attorney for the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) developing guidance and providing technical advice and training on the health provisions under Part 7 of ERISA. Prior to her career within the Department of Labor, she conducted a state and federal law compliance project for one of the nation's largest rural health plans. She also worked as a policy assistant for the United Kingdom's National Health Trust where she conducted a project related to compliance with a UK mental health law.

Education/professional designations

Elena received her JD from the Catholic University, Columbus School of Law. She received a Bachelor degree in Health Administration and a minor in Business Administration from the University of Scranton. She is a member of the Bar of the District of Columbia.

Elena was recognized by *Employee Benefits News* as one of the 2022 Excellence in Benefits Award Winners for helping organizations prioritize mental health and substance use support.

Publications/speeches

Elena frequently serves as an expert speaker and was a guest professor for the Georgetown University School of Law. Archives of webcasts and training she provided during her tenure with the Department of Labor are available at www.dol.gov/ebsa.

Elena Lynett, JD
elynett@segalco.com
202.833.6486
segalco.com

Sadhna Paralkar, MD, MPH, MBA

Senior Vice President and National Medical Director, Chicago

Project Role: Clinical and Wellness

Expertise

Sadhna is a Senior Vice President and National Medical Director in Segal's Chicago office with over 20 years of experience. She leads Segal's Medical Management consulting and has specialized expertise in on-site clinics, wellness programs, medical management program design, healthcare informatics and network management strategies to optimize health improvement while containing costs, and evaluation and implementation of disease management and wellness programs.

Professional background

Sadhna's extensive experience in healthcare operations, informatics and consulting includes positions at UnitedHealth Group (UHG) and Ingenix (now Optum Insight), where she provided data centric clinical expertise to clients in the payer, public sector and employer markets. She was responsible for the Care Management ROI model as the Director of Product Development for the Care Management suite of products at Optum.

Prior to joining UHG, Sadhna worked at a *Fortune* 500 company, Navistar, in various capacities for six years. The last position Sadhna held at Navistar was Associate Medical Director, where she was responsible for occupational health and disability, on-site clinics, on-site wellness programs, health benefits plan design and healthcare purchasing.

Education/professional designations

A native of Mumbai (Bombay), India, Sadhna completed her medical internship at L.T.M. General Hospital of University of Bombay, India after she received her baccalaureate degree in Medicine and Surgery from the same institution.

As a licensed family practitioner, some of Sadhna's public health achievements include implementation and evaluation of immunization programs in rural India. She received an MS in Public Health from the University of Illinois at Urbana-Champaign focusing on Health Data Analysis and Epidemiology. The National Institutes of Health funded part of her analytic research on health communications in mass media. Sadhna also received an MBA with a focus on Health Industry Management and Marketing from Northwestern University's Kellogg School of Management.

Sadhna is a member of the American Public Health Association, American College of Occupational and Environmental Medicine, The Institute of Medicine of Chicago, American Association of Physicians from India and Women Business Leaders of the U.S. Health Care Industry Foundation.

Publications/speeches

Sadhna has published several articles on health and productivity in peer-reviewed journals and is a frequent speaker at national conferences concerning healthcare. Past speaking engagements

include the Made in America Conference, the Society of Actuaries conference and the American College of Occupational and Environmental Medicine (ACOEM) conference.

Examples of Sadhna's publications and presentations include:

- "Using Data Analytics to Understand High-Cost Participants," June 2023
- "Understanding Today's High-Cost Participants Through Data Analytics," *Benefits Quarterly* Vol. 39, Second Quarter 2023
- "The Current and Future State of Digital Health," May 2022
- "Reducing Vendor Fatigue and Vetting with Whole-Person Care," Teladoc Forum, July 2021
- "(Re)Making the Case for Wellness During the COVID-19 Pandemic," May 2020
- "Setting Up for Success: Wellness Strategies for Multiemployer Plans," *Benefits Magazine*, December 2017
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Sadhna Paralkar, MD, MPH, MBA
sparalkar@segalco.com
312.984.8520
segalco.com

Kautook Vyas, PharmD

Vice President, Senior Pharmacy Benefits Consultant, Chicago

Project Role: Pharmacy

Expertise

Kautook is a Vice President, Senior Pharmacy Benefits Consultant in Segal's Chicago office with over 15 years of experience in the pharmacy benefits space. He is a member of Segal's National Pharmacy Consulting practice and assists clients in optimizing benefit design and drug mix. He provides consulting services that incorporate advanced data analytics with the latest best-practice guidelines for clinical pharmacy. Kautook's client engagements include Pharmacy Benefit Manager bid procurement, claims auditing and general pharmacy consulting. He has experience working with a wide variety of plan sponsors (including multiemployer, corporate, public sector and coalitions) and the Pharmacy Benefit Managers who service them.

Professional background

Prior to his role as a Pharmacy Consultant, Kautook completed a post-doctoral residency-training program in Pharmacy Benefits Consulting under Segal's National Pharmacy Practice Leader. He has also worked for Astellas Pharmaceuticals in their Scientific Affairs department and has several years of experience working in a community setting for Walgreens Pharmacy.

Education/professional designations

Kautook received both his Doctor of Pharmacy and his BS in Biochemistry from the University of Illinois at Chicago. Kautook is a licensed pharmacist in the state of Illinois, a certified immunizer through the American Pharmacist Association (APhA) and a licensed Life, Accident & Health Producer. Kautook is an active member of the Academy of Managed Care Pharmacy (AMCP).

Publications/speeches

Kautook has spoken on a variety of prescription drug benefits topics at the University of Illinois at Chicago College of Pharmacy where he gives an annual lecture on managed care pharmacy. He also published a study through the Academy of Managed Care Pharmacy titled, "Controlling Fraud and Abuse in the Prescription Drug Benefit with the use of Pharmacy Locks."

Kautook Vyas, PharmD
kvyas@segalco.com
312.984.8587
segalco.com

Catharine Hamrick

Vice President, Communications, Chicago

Project Role: Communications

Expertise

Catharine is Vice President, Communications in Segal Benz's Chicago office. Driven by a passion to make a positive difference in employees' lives, Catharine has been an HR communications professional for more than 15 years.

At Segal Benz, she passes along her expertise to clients in a range of industries, including tech, higher education, public sector and multiemployer benefit funds. Some of her clients include The Walt Disney Company, DuPont, Honeywell, Equity League Benefit Funds and the State of Illinois. Catharine has always been motivated by her belief that benefits have a direct impact on employees' health and wealth. And because of the important role benefits play, it's vital to grab employees' attention and get them engaged with the plans and programs available to them.

Catharine leads our work with online focus groups and is responsible for efforts to grow communications opportunities in the Midwest.

Professional background

Catharine joined Segal Benz after more than 10 years at Alight Solutions (formerly part of Aon Hewitt), which is a human capital and benefits consulting firm that works with more than half of the Fortune 500 companies. As Client Lead for Consumer Experience, she created dynamic strategies focused on getting results, developed total rewards brands designed to get noticed, and delivered high-impact, multi-channel communication campaigns for major corporations. Some of her clients included Allstate, Best Buy, Cintas, McDonald's, Target and United Technologies.

Prior to joining Alight, Catharine was with the American Medical Association (AMA) for nearly a decade. At the AMA, she held various communications roles, capping her career as Vice President of Integrated Brand Marketing.

Education/professional designations

Catharine earned a BA in Political Science from Vanderbilt University and an MA in Government from the University of Notre Dame. She received Segal's One Company Award for 2022, recognizing colleagues who exemplify the attitudes and behaviors of teamwork and collaboration that are inherent in our One Company philosophy.

Catharine Hamrick
chamrick@segalbenz.com
312.984.8607
segalbenz.com

Albert Shaaya

Senior Health Consultant, Atlanta

Project Role: Data Analytics

Expertise

Albert is a Senior Health Consultant in Segal's Atlanta office. He has more than 16 years of data analytics and business intelligence experience with a focus on healthcare data management and actuarial support. Albert has broad experience working in the private sector, with employer funded health plans, as well as the public sector, with State health plans and Medicaid programs.

In his role as a Data Analyst, Albert managed the development of several data warehousing solutions that provide data reporting, data aggregation and model building capabilities to support client needs. In addition to providing technical and analytical solutions, he works closely with clients and data vendors to help establish a secure data transfer of historical and ongoing enrollment and claims type data. The data procurement process also includes data scrubbing and loading, in addition to data profiling and validation.

Albert's main role is to help the firm select the appropriate data management solutions in order to effectively analyze key data elements and help decisionmakers take action to improve plan performance. Additionally, throughout his career, he has managed many client engagements in utilizing data mining software to determine underlying cost drivers, develop strategies for engaging participants in their own care, contain costs and improve patient outcomes.

Albert's current state clients include:

- North Carolina State Health Plan
- State of Wisconsin — Department of Employee Trust Fund
- Alabama Public Education Employees Health Insurance Plan

Professional background

Prior to joining Segal in 2017, Albert worked in data analytics as a Senior Manager for a major consulting firm.

Education/professional designations

Albert received a MS in Information Technology from the American InterContinental University in Atlanta. Albert also holds a BS in Computer Engineering and is a certified Project Management Professional (PMP).

Albert Shaaya
ashaaya@segalco.com
404.276.2089
segalco.com

Appendix 2: Sample Reports

2025 State Employee Health Plan with Dental

With Dental (See Tab 2 for Rates without Dental)

Monthly Premiums (Participants **without** Medicare)

	IYC Health Plan		HDHP	
	Individual	**Family**	**Individual**	**Family**
Aspirus Health Plan	$1,102.64	$2,714.32	$956.80	$2,349.74
Common Ground Healthcare Cooperative	$1,072.82	$2,639.78	$931.16	$2,285.64
Dean Health Plan	$997.18	$2,450.68	$866.10	$2,122.98
Dean Health Plan - Prevea360 East	$1,100.68	$2,709.42	$955.12	$2,345.54
Dean Health Plan - Prevea360 West and Mayo	$1,257.70	$3,101.98	$1,090.16	$2,683.14
GHC of Eau Claire Greater Wisconsin	$1,157.90	$2,852.48	$1,004.32	$2,468.54
GHC of Eau Claire River Region	$1,182.68	$2,914.42	$1,025.64	$2,521.84
GHC-SCW Dane Choice	$942.28	$2,313.42	$818.90	$2,004.98
GHC-SCW Neighbors	$993.62	$2,441.78	$863.04	$2,115.34
HealthPartners Health Plan Southeast	$1,091.86	$2,687.38	$947.54	$2,326.58
HealthPartners Health Plan West	$1,112.60	$2,739.22	$965.36	$2,371.14
Medical Associates Health Plans	$1,022.18	$2,513.18	$887.60	$2,176.74
MercyCare Health Plans	$911.70	$2,236.98	$792.60	$1,939.24
Network Health	$1,080.26	$2,658.38	$937.56	$2,301.64
Quartz Central	$1,105.30	$2,720.98	$959.08	$2,355.44
Quartz UW Health	$963.40	$2,366.22	$837.06	$2,050.38
Quartz West	$1,087.32	$2,676.02	$943.62	$2,316.78
Robin with HealthPartners Health Plan	$1,125.54	$2,771.58	$976.50	$2,398.98
Security Health Plan	$1,135.94	$2,797.58	$985.44	$2,421.34
State Maintenance Plan (SMP) by Dean Health	$1,330.24	$3,283.34	$1,130.36	$2,783.64
	Access Plan		**Access HDHP**	
	Individual	**Family**	**Individual**	**Family**
Access Plan by Dean Health Plan	$1,700.12	$4,208.04	$1,441.06	$3,560.40

2025 Local Traditional Plan with Dental (PO2)

With Dental (See Tab 2 for Rates without Dental)

Monthly Premiums (Participants **without** Medicare)

	Local Traditional Health Plan	
	Individual	**Family**
Aspirus Health Plan	$1,370.02	$3,382.78
Common Ground Healthcare Cooperative	$1,346.08	$3,322.94
Dean Health Plan	$1,171.96	$2,887.64
Dean Health Plan - Prevea360 East	$1,093.46	$2,691.38
Dean Health Plan - Prevea360 West and Mayo Clinic Health System	$1,362.42	$3,363.78
GHC of Eau Claire Greater Wisconsin	$1,451.96	$3,587.64
GHC of Eau Claire River Region	$1,569.52	$3,881.54
GHC-SCW Dane Choice	$939.66	$2,306.88
GHC-SCW Neighbors	$1,088.40	$2,678.74
HealthPartners Health Plan Southeast	$1,437.10	$3,550.48
HealthPartners Health Plan West	$1,443.60	$3,566.74
Medical Associates Health Plans	$997.08	$2,450.44
MercyCare Health Plans	$1,029.26	$2,530.88
Network Health	$1,148.02	$2,827.78
Quartz Central	$1,455.74	$3,597.08
Quartz UW Health	$1,005.74	$2,472.08
Quartz West	$994.74	$2,444.58
Robin with HealthPartners Health Plan	$1,459.94	$3,607.58
Security Health Plan	$1,407.84	$3,477.34
State Maintenance Plan (SMP) by Dean Health	$1,130.64	$2,784.34
	Local Access Plan	
	Individual	**Family**
Access Plan by Dean Health Plan	$1,408.12	$3,478.06

2025 Local Deductible Plan with Dental (PO4)

With Dental (See Tab 2 for Rates without Dental)

Monthly Premiums (Participants **without** Medicare)

	Local Deductible Health Plan	
	Individual	**Family**
Aspirus Health Plan	$1,277.84	$3,152.34
Common Ground Healthcare Cooperative	$1,255.82	$3,097.28
Dean Health Plan	$1,095.62	$2,696.78
Dean Health Plan - Prevea360 East	$1,023.40	$2,516.24
Dean Health Plan - Prevea360 West and Mayo Clinic Health System	$1,270.84	$3,134.84
GHC of Eau Claire Greater Wisconsin	$1,353.22	$3,340.78
GHC of Eau Claire River Region	$1,461.38	$3,611.18
GHC-SCW Dane Choice	$881.90	$2,162.48
GHC-SCW Neighbors	$1,018.76	$2,504.64
HealthPartners Health Plan Southeast	$1,339.56	$3,306.64
HealthPartners Health Plan West	$1,345.54	$3,321.58
Medical Associates Health Plans	$934.74	$2,294.58
MercyCare Health Plans	$964.34	$2,368.58
Network Health	$1,073.60	$2,641.74
Quartz Central	$1,356.70	$3,349.48
Quartz UW Health	$942.70	$2,314.48
Quartz West	$932.58	$2,289.18
Robin with HealthPartners Health Plan	$1,360.56	$3,359.14
Security Health Plan	$1,312.64	$3,239.34
State Maintenance Plan (SMP) by Dean Health	$1,075.90	$2,647.52
	Local Access Plan	
	Individual	**Family**
Access Plan by Dean Health Plan	$1,312.90	$3,240.00

2025 Local Health Plan with Dental (PO6)

With Dental (See Tab 2 for Rates without Dental)

Monthly Premiums (Participants **without** Medicare)

	Local Health Plan	
	Individual	**Family**
Aspirus Health Plan	$1,300.88	$3,209.94
Common Ground Healthcare Cooperative	$1,278.38	$3,153.68
Dean Health Plan	$1,114.70	$2,744.48
Dean Health Plan - Prevea360 East	$1,040.92	$2,560.04
Dean Health Plan - Prevea360 West and Mayo Clinic Health System	$1,293.74	$3,192.08
GHC of Eau Claire Greater Wisconsin	$1,377.90	$3,402.48
GHC of Eau Claire River Region	$1,488.42	$3,678.78
GHC-SCW Dane Choice	$896.34	$2,198.58
GHC-SCW Neighbors	$1,036.16	$2,548.14
HealthPartners Health Plan Southeast	$1,363.94	$3,367.58
HealthPartners Health Plan West	$1,370.04	$3,382.84
Medical Associates Health Plans	$950.32	$2,333.54
MercyCare Health Plans	$980.56	$2,409.14
Network Health	$1,092.20	$2,688.24
Quartz Central	$1,381.46	$3,411.38
Quartz UW Health	$958.46	$2,353.88
Quartz West	$948.12	$2,328.04
Robin with HealthPartners Health Plan	$1,385.40	$3,421.24
Security Health Plan	$1,336.44	$3,298.84
State Maintenance Plan (SMP) by Dean Health	$1,057.64	$2,601.84
	Local Access Plan	
	Individual	**Family**
Access Plan by Dean Health Plan	$1,336.70	$3,299.50

2025 Local High Deductible Health Plan with Dental (PO7)

With Dental (See Tab 2 for Rates without Dental)

Monthly Premiums (Participants **without** Medicare)

	Local High Deductible Health Plan	
	Individual	**Family**
Aspirus Health Plan	$1,121.28	$2,760.92
Common Ground Healthcare Cooperative	$1,101.88	$2,712.42
Dean Health Plan	$960.86	$2,359.88
Dean Health Plan - Prevea360 East	$897.26	$2,200.88
Dean Health Plan - Prevea360 West and Mayo Clinic Health System	$1,115.12	$2,745.52
GHC of Eau Claire Greater Wisconsin	$1,187.66	$2,926.88
GHC of Eau Claire River Region	$1,282.88	$3,164.92
GHC-SCW Dane Choice	$772.68	$1,889.42
GHC-SCW Neighbors	$893.16	$2,190.62
HealthPartners Health Plan Southeast	$1,175.62	$2,896.78
HealthPartners Health Plan West	$1,180.88	$2,909.92
Medical Associates Health Plans	$819.20	$2,005.72
MercyCare Health Plans	$845.26	$2,070.88
Network Health	$941.46	$2,311.38
Quartz Central	$1,190.72	$2,934.52
Quartz UW Health	$826.22	$2,023.28
Quartz West	$817.30	$2,000.98
Robin with HealthPartners Health Plan	$1,194.12	$2,943.02
Security Health Plan	$1,151.92	$2,837.52
State Maintenance Plan (SMP) by Dean Health	$927.42	$2,276.30
	Local Access High Deductible Health Plan	
	Individual	**Family**
Access Plan by Dean Health Plan	$1,152.18	$2,838.20

2025 Local Annuitant Health Plan with Dental (PO8)

With Dental (See Tab 2 for Rates without Dental)

Monthly Premiums (Participants **without** Medicare)

	Local High Deductible Health Plan	
	Individual	**Family**
Aspirus Health Plan	$2,156.46	$5,348.88
Common Ground Healthcare Cooperative	$2,118.42	$5,253.78
Dean Health Plan	$1,841.80	$4,562.24
Dean Health Plan - Prevea360 East	$1,717.12	$4,250.54
Dean Health Plan - Prevea360 West and Mayo Clinic Health System	$2,144.38	$5,318.68
GHC of Eau Claire Greater Wisconsin	$2,286.62	$5,674.28
GHC of Eau Claire River Region	$2,473.40	$6,141.24
GHC-SCW Dane Choice	$1,472.78	$3,639.68
GHC-SCW Neighbors	$1,709.08	$4,230.44
HealthPartners Health Plan Southeast	$2,263.02	$5,615.28
HealthPartners Health Plan West	$2,273.34	$5,641.08
Medical Associates Health Plans	$1,564.00	$3,867.74
MercyCare Health Plans	$1,615.12	$3,995.54
Network Health	$1,803.78	$4,467.18
Quartz Central	$2,292.64	$5,689.34
Quartz UW Health	$1,577.76	$3,902.14
Quartz West	$1,560.28	$3,858.44
Robin with HealthPartners Health Plan	$2,299.30	$5,705.98
Security Health Plan	$2,216.54	$5,499.08
State Maintenance Plan (SMP) by Dean Health	$1,745.38	$4,321.20
	Local Access High Deductible Health Plan	
	Individual	**Family**
Access Plan by Dean Health Plan	$2,217.00	$5,500.24

2025 Local Traditional Plan without Dental (PO12)

Without Dental

Monthly Premiums (Participants **without** Medicare)

	Local Traditional Health Plan	
	Individual	**Family**
Aspirus Health Plan	$1,337.30	$3,300.98
Common Ground Healthcare Cooperative	$1,313.36	$3,241.14
Dean Health Plan	$1,139.24	$2,805.84
Dean Health Plan - Prevea360 East	$1,060.74	$2,609.58
Dean Health Plan - Prevea360 West and Mayo Clinic Health System	$1,329.70	$3,281.98
GHC of Eau Claire Greater Wisconsin	$1,419.24	$3,505.84
GHC of Eau Claire River Region	$1,536.80	$3,799.74
GHC-SCW Dane Choice	$906.94	$2,225.08
GHC-SCW Neighbors	$1,055.68	$2,596.94
HealthPartners Health Plan Southeast	$1,404.38	$3,468.68
HealthPartners Health Plan West	$1,410.88	$3,484.94
Medical Associates Health Plans	$964.36	$2,368.64
MercyCare Health Plans	$996.54	$2,449.08
Network Health	$1,115.30	$2,745.98
Quartz Central	$1,423.02	$3,515.28
Quartz UW Health	$973.02	$2,390.28
Quartz West	$962.02	$2,362.78
Robin with HealthPartners Health Plan	$1,427.22	$3,525.78
Security Health Plan	$1,375.12	$3,395.54
State Maintenance Plan (SMP) by Dean Health	$1,097.92	$2,702.54
	Local Access Plan	
	Individual	**Family**
Access Plan by Dean Health Plan	$1,375.40	$3,396.26

2025 Local Deductible Plan without Dental (PO14)

Without Dental

Monthly Premiums (Participants **without** Medicare)

	Local Deductible Health Plan	
	Individual	**Family**
Aspirus Health Plan	$1,245.12	$3,070.54
Common Ground Healthcare Cooperative	$1,223.10	$3,015.48
Dean Health Plan	$1,062.90	$2,614.98
Dean Health Plan - Prevea360 East	$990.68	$2,434.44
Dean Health Plan - Prevea360 West and Mayo Clinic Health System	$1,238.12	$3,053.04
GHC of Eau Claire Greater Wisconsin	$1,320.50	$3,258.98
GHC of Eau Claire River Region	$1,428.66	$3,529.38
GHC-SCW Dane Choice	$849.18	$2,080.68
GHC-SCW Neighbors	$986.04	$2,422.84
HealthPartners Health Plan Southeast	$1,306.84	$3,224.84
HealthPartners Health Plan West	$1,312.82	$3,239.78
Medical Associates Health Plans	$902.02	$2,212.78
MercyCare Health Plans	$931.62	$2,286.78
Network Health	$1,040.88	$2,559.94
Quartz Central	$1,323.98	$3,267.68
Quartz UW Health	$909.98	$2,232.68
Quartz West	$899.86	$2,207.38
Robin with HealthPartners Health Plan	$1,327.84	$3,277.34
Security Health Plan	$1,279.92	$3,157.54
State Maintenance Plan (SMP) by Dean Health	$1,043.18	$2,565.72
	Local Access Plan	
	Individual	**Family**
Access Plan by Dean Health Plan	$1,280.18	$3,158.20

2025 Local Health Plan without Dental (PO16)

Without Dental

Monthly Premiums (Participants **without** Medicare)

	Local Health Plan	
	Individual	**Family**
Aspirus Health Plan	$1,268.16	$3,128.14
Common Ground Healthcare Cooperative	$1,245.66	$3,071.88
Dean Health Plan	$1,081.98	$2,662.68
Dean Health Plan - Prevea360 East	$1,008.20	$2,478.24
Dean Health Plan - Prevea360 West and Mayo Clinic Health System	$1,261.02	$3,110.28
GHC of Eau Claire Greater Wisconsin	$1,345.18	$3,320.68
GHC of Eau Claire River Region	$1,455.70	$3,596.98
GHC-SCW Dane Choice	$863.62	$2,116.78
GHC-SCW Neighbors	$1,003.44	$2,466.34
HealthPartners Health Plan Southeast	$1,331.22	$3,285.78
HealthPartners Health Plan West	$1,337.32	$3,301.04
Medical Associates Health Plans	$917.60	$2,251.74
MercyCare Health Plans	$947.84	$2,327.34
Network Health	$1,059.48	$2,606.44
Quartz Central	$1,348.74	$3,329.58
Quartz UW Health	$925.74	$2,272.08
Quartz West	$915.40	$2,246.24
Robin with HealthPartners Health Plan	$1,352.68	$3,339.44
Security Health Plan	$1,303.72	$3,217.04
State Maintenance Plan (SMP) by Dean Health	$1,024.92	$2,520.04
	Local Access Plan	
	Individual	**Family**
Access Plan by Dean Health Plan	$1,303.98	$3,217.70

2025 Local High Deductible Health Plan without Dental (PO17)

Without Dental

Monthly Premiums (Participants **without** Medicare)

	Local High Deductible Health Plan	
	Individual	**Family**
Aspirus Health Plan	$1,088.56	$2,679.12
Common Ground Healthcare Cooperative	$1,069.16	$2,630.62
Dean Health Plan	$928.14	$2,278.08
Dean Health Plan - Prevea360 East	$864.54	$2,119.08
Dean Health Plan - Prevea360 West and Mayo Clinic Health System	$1,082.40	$2,663.72
GHC of Eau Claire Greater Wisconsin	$1,154.94	$2,845.08
GHC of Eau Claire River Region	$1,250.16	$3,083.12
GHC-SCW Dane Choice	$739.96	$1,807.62
GHC-SCW Neighbors	$860.44	$2,108.82
HealthPartners Health Plan Southeast	$1,142.90	$2,814.98
HealthPartners Health Plan West	$1,148.16	$2,828.12
Medical Associates Health Plans	$786.48	$1,923.92
MercyCare Health Plans	$812.54	$1,989.08
Network Health	$908.74	$2,229.58
Quartz Central	$1,158.00	$2,852.72
Quartz UW Health	$793.50	$1,941.48
Quartz West	$784.58	$1,919.18
Robin with HealthPartners Health Plan	$1,161.40	$2,861.22
Security Health Plan	$1,119.20	$2,755.72
State Maintenance Plan (SMP) by Dean Health	$894.70	$2,194.50
	Local Access High Deductible Health Plan	
	Individual	**Family**
Access Plan by Dean Health Plan	$1,119.46	$2,756.40

2025 State Employee Health Plan without Dental

Without Dental (See Tab 1 for Rates with Dental)

Monthly Premiums (Participants **without** Medicare)

	IYC Health Plan		HDHP	
	Individual	**Family**	**Individual**	**Family**
Aspirus Health Plan	$1,069.92	$2,632.52	$924.08	$2,267.94
Common Ground Healthcare Cooperative	$1,040.10	$2,557.98	$898.44	$2,203.84
Dean Health Plan	$964.46	$2,368.88	$833.38	$2,041.18
Dean Health Plan - Prevea360 East	$1,067.96	$2,627.62	$922.40	$2,263.74
Dean Health Plan - Prevea360 West and Mayo	$1,224.98	$3,020.18	$1,057.44	$2,601.34
GHC of Eau Claire Greater Wisconsin	$1,125.18	$2,770.68	$971.60	$2,386.74
GHC of Eau Claire River Region	$1,149.96	$2,832.62	$992.92	$2,440.04
GHC-SCW Dane Choice	$909.56	$2,231.62	$786.18	$1,923.18
GHC-SCW Neighbors	$960.90	$2,359.98	$830.32	$2,033.54
HealthPartners Health Plan Southeast	$1,059.14	$2,605.58	$914.82	$2,244.78
HealthPartners Health Plan West	$1,079.88	$2,657.42	$932.64	$2,289.34
Medical Associates Health Plans	$989.46	$2,431.38	$854.88	$2,094.94
MercyCare Health Plans	$878.98	$2,155.18	$759.88	$1,857.44
Network Health	$1,047.54	$2,576.58	$904.84	$2,219.84
Quartz Central	$1,072.58	$2,639.18	$926.36	$2,273.64
Quartz UW Health	$930.68	$2,284.42	$804.34	$1,968.58
Quartz West	$1,054.60	$2,594.22	$910.90	$2,234.98
Robin with HealthPartners Health Plan	$1,092.82	$2,689.78	$943.78	$2,317.18
Security Health Plan	$1,103.22	$2,715.78	$952.72	$2,339.54
State Maintenance Plan (SMP) by Dean Health	$1,297.52	$3,201.54	$1,097.64	$2,701.84
	Access Plan		**Access HDHP**	
	Individual	**Family**	**Individual**	**Family**
Dean Health Insurance	$1,667.40	$4,126.24	$1,408.34	$3,478.60

2025 Local Traditional Plan without Dental (PO2)

Without Dental (See Tab 1 for Rates with Dental)

Monthly Premiums (Participants **without** Medicare)

	Local Traditional Health Plan	
	Individual	**Family**
Aspirus Health Plan	$1,337.30	$3,300.98
Common Ground Healthcare Cooperative	$1,313.36	$3,241.14
Dean Health Plan	$1,139.24	$2,805.84
Dean Health Plan - Prevea360 East	$1,060.74	$2,609.58
Dean Health Plan - Prevea360 West and Mayo Clinic Health System	$1,329.70	$3,281.98
GHC of Eau Claire Greater Wisconsin	$1,419.24	$3,505.84
GHC of Eau Claire River Region	$1,536.80	$3,799.74
GHC-SCW Dane Choice	$906.94	$2,225.08
GHC-SCW Neighbors	$1,055.68	$2,596.94
HealthPartners Health Plan Southeast	$1,404.38	$3,468.68
HealthPartners Health Plan West	$1,410.88	$3,484.94
Medical Associates Health Plans	$964.36	$2,368.64
MercyCare Health Plans	$996.54	$2,449.08
Network Health	$1,115.30	$2,745.98
Quartz Central	$1,423.02	$3,515.28
Quartz UW Health	$973.02	$2,390.28
Quartz West	$962.02	$2,362.78
Robin with HealthPartners Health Plan	$1,427.22	$3,525.78
Security Health Plan	$1,375.12	$3,395.54
State Maintenance Plan (SMP) by Dean Health	$1,097.92	$2,702.54
	Local Access Plan	
	Individual	**Family**
Access Plan by Dean Health Plan	$1,375.40	$3,396.26

2025 Local Deductible Plan without Dental (PO4)

Without Dental (See Tab 1 for Rates with Dental)

Monthly Premiums (Participants **without** Medicare)

	Local Deductible Health Plan	
	Individual	**Family**
Aspirus Health Plan	$1,245.12	$3,070.54
Common Ground Healthcare Cooperative	$1,223.10	$3,015.48
Dean Health Plan	$1,062.90	$2,614.98
Dean Health Plan - Prevea360 East	$990.68	$2,434.44
Dean Health Plan - Prevea360 West and Mayo Clinic Health System	$1,238.12	$3,053.04
GHC of Eau Claire Greater Wisconsin	$1,320.50	$3,258.98
GHC of Eau Claire River Region	$1,428.66	$3,529.38
GHC-SCW Dane Choice	$849.18	$2,080.68
GHC-SCW Neighbors	$986.04	$2,422.84
HealthPartners Health Plan Southeast	$1,306.84	$3,224.84
HealthPartners Health Plan West	$1,312.82	$3,239.78
Medical Associates Health Plans	$902.02	$2,212.78
MercyCare Health Plans	$931.62	$2,286.78
Network Health	$1,040.88	$2,559.94
Quartz Central	$1,323.98	$3,267.68
Quartz UW Health	$909.98	$2,232.68
Quartz West	$899.86	$2,207.38
Robin with HealthPartners Health Plan	$1,327.84	$3,277.34
Security Health Plan	$1,279.92	$3,157.54
State Maintenance Plan (SMP) by Dean Health	$1,043.18	$2,565.72
	Local Access Plan	
	Individual	**Family**
Access Plan by Dean Health Plan	$1,280.18	$3,158.20

2025 Local Health Plan without Dental (PO6)

Without Dental (See Tab 1 for Rates with Dental)

Monthly Premiums (Participants **without** Medicare)

	Local Health Plan	
	Individual	**Family**
Aspirus Health Plan	$1,268.16	$3,128.14
Common Ground Healthcare Cooperative	$1,245.66	$3,071.88
Dean Health Plan	$1,081.98	$2,662.68
Dean Health Plan - Prevea360 East	$1,008.20	$2,478.24
Dean Health Plan - Prevea360 West and Mayo Clinic Health System	$1,261.02	$3,110.28
GHC of Eau Claire Greater Wisconsin	$1,345.18	$3,320.68
GHC of Eau Claire River Region	$1,455.70	$3,596.98
GHC-SCW Dane Choice	$863.62	$2,116.78
GHC-SCW Neighbors	$1,003.44	$2,466.34
HealthPartners Health Plan Southeast	$1,331.22	$3,285.78
HealthPartners Health Plan West	$1,337.32	$3,301.04
Medical Associates Health Plans	$917.60	$2,251.74
MercyCare Health Plans	$947.84	$2,327.34
Network Health	$1,059.48	$2,606.44
Quartz Central	$1,348.74	$3,329.58
Quartz UW Health	$925.74	$2,272.08
Quartz West	$915.40	$2,246.24
Robin with HealthPartners Health Plan	$1,352.68	$3,339.44
Security Health Plan	$1,303.72	$3,217.04
State Maintenance Plan (SMP) by Dean Health	$1,024.92	$2,520.04
	Local Access Plan	
	Individual	**Family**
Access Plan by Dean Health Plan	$1,303.98	$3,217.70

2025 Local High Deductible Health Plan without Dental (PO7)

Without Dental (See Tab 1 for Rates with Dental)

Monthly Premiums (Participants **without** Medicare)

	Local High Deductible Health Plan	
	Individual	**Family**
Aspirus Health Plan	$1,088.56	$2,679.12
Common Ground Healthcare Cooperative	$1,069.16	$2,630.62
Dean Health Plan	$928.14	$2,278.08
Dean Health Plan - Prevea360 East	$864.54	$2,119.08
Dean Health Plan - Prevea360 West and Mayo Clinic Health System	$1,082.40	$2,663.72
GHC of Eau Claire Greater Wisconsin	$1,154.94	$2,845.08
GHC of Eau Claire River Region	$1,250.16	$3,083.12
GHC-SCW Dane Choice	$739.96	$1,807.62
GHC-SCW Neighbors	$860.44	$2,108.82
HealthPartners Health Plan Southeast	$1,142.90	$2,814.98
HealthPartners Health Plan West	$1,148.16	$2,828.12
Medical Associates Health Plans	$786.48	$1,923.92
MercyCare Health Plans	$812.54	$1,989.08
Network Health	$908.74	$2,229.58
Quartz Central	$1,158.00	$2,852.72
Quartz UW Health	$793.50	$1,941.48
Quartz West	$784.58	$1,919.18
Robin with HealthPartners Health Plan	$1,161.40	$2,861.22
Security Health Plan	$1,119.20	$2,755.72
State Maintenance Plan (SMP) by Dean Health	$894.70	$2,194.50
	Local Access High Deductible Health Plan	
	Individual	**Family**
Access Plan by Dean Health Plan	$1,119.46	$2,756.40

2025 Local Annuitant Health Plan without Dental (PO8)

Without Dental (See Tab 1 for Rates with Dental)

Monthly Premiums (Participants **without** Medicare)

	Local High Deductible Health Plan	
	Individual	**Family**
Aspirus Health Plan	$2,123.74	$5,267.08
Common Ground Healthcare Cooperative	$2,085.70	$5,171.98
Dean Health Plan	$1,809.08	$4,480.44
Dean Health Plan - Prevea360 East	$1,684.40	$4,168.74
Dean Health Plan - Prevea360 West and Mayo Clinic Health System	$2,111.66	$5,236.88
GHC of Eau Claire Greater Wisconsin	$2,253.90	$5,592.48
GHC of Eau Claire River Region	$2,440.68	$6,059.44
GHC-SCW Dane Choice	$1,440.06	$3,557.88
GHC-SCW Neighbors	$1,676.36	$4,148.64
HealthPartners Health Plan Southeast	$2,230.30	$5,533.48
HealthPartners Health Plan West	$2,240.62	$5,559.28
Medical Associates Health Plans	$1,531.28	$3,785.94
MercyCare Health Plans	$1,582.40	$3,913.74
Network Health	$1,771.06	$4,385.38
Quartz Central	$2,259.92	$5,607.54
Quartz UW Health	$1,545.04	$3,820.34
Quartz West	$1,527.56	$3,776.64
Robin with HealthPartners Health Plan	$2,266.58	$5,624.18
Security Health Plan	$2,183.82	$5,417.28
State Maintenance Plan (SMP) by Dean Health	$1,712.66	$4,239.40
	Local Access High Deductible Health Plan	
	Individual	**Family**
Access Plan by Dean Health Plan	$2,184.28	$5,418.44

Segal

2727 Paces Ferry Road SE
Building One, Suite 1400
Atlanta, GA 30339-4053
T 678.306.3100
F 678.669.1887
segalco.com

Memorandum

To: Christy Osentowski

From: Patrick Klein, FSA, MAAA

Date: August 2, 2023

Re: Claim Fluctuation Reserve for Self-Insured Medical and Prescription Drug Plans

Summary

The Segal Company has conducted Claim Fluctuation Reserve (CFR) study for the medical and prescription drug plan provided by State of Nebraska (State).

The results were an estimated total claim liability of approximately $251.6 million for plan year ending June 30, 2024 and CFR with 90% confidence level of $19.7 million or 7.8% of claims.

Methodology

CFR was calculated using projected annual claim amount per employee and medical CFR factors. Projected annual claim amount per employee is based on State's claim and census data.

Three specific risks that lead to claim fluctuations were identified and explicitly included in the calculation. The three risks are:

Large Claims – This is the risk of unexpected increases in the number and/or size of claims incurred by individual participants. As the size of the group increases, the larger claims are spread over a larger total and this risk becomes less significant.

Claims – This risk relates to overall plan claims experience developing at a variance from the expected cost per participant, due to insufficiently credible claims experience. As the size of the group involved increases, the level of this risk is generally reduced. However, this also depends on the length of the claims experience period that is used to project expected claim levels.

Trend – This is the risk inherent in a projection that uses a forecast of the overall increase in price and utilization of health care services. This risk is constant for any size of group.

Data and Assumptions

Our calculations were based on budget projections completed for FY 2024. Claims and enrollment data was provided by UHC.

The following annual trends were utilized to trend past claims for purposes of determining the projected, per-capita costs:

- Medical: 4.5%
- Prescription Drugs: 10.0%

Results

According to our calculations, estimated total claim liability for plan year ending June 30, 2024, is $251.6 million. Holding a CFR of $19.7 million or 7.8% of claims will allow State to cover the claims with 90% probability. Holding a larger amount as CFR will increase State's ability to meet claim demand under unfavorable circumstances, while holding a smaller amount will increase probability of running out of funds.

CFR amounts for different confidence intervals are shown below:

Confidence Level	75%	80%	85%	90%	95%	99%
CFR (in millions)	$10.0	$12.7	$15.8	$19.7	$25.6	$37.1
CFR as % of Projected Claims	4.0%	5.0%	6.3%	7.8%	10.2%	14.8%

Please note that CFR is calculated for a single year.

Actuarial certification

I am employed by Segal Consulting. I am a Fellow of the Society of Actuaries and qualified by education and experience to make the statements of actuarial opinion contained herein.

In performing our reserve study, we have relied upon reports and information provided to us. We have not audited this data beyond general tests for reasonableness. The results are our best estimate of claim fluctuation reserve for the plan year 2024. The techniques and methodology used are reasonable, and in accordance with generally accepted actuarial principles and practice.

If you have any questions or concerns, please feel free to call (678) 306-3142.

Patrick Klein, FSA, MAAA
Health Consultant, Vice President

Segal

2727 Paces Ferry Road SE
Building One, Suite 1400
Atlanta, GA 30339-4053
T 678.306.3100
F 678.669.1887
segalco.com

August 2, 2024

Ms. Christy Osentowski
Manager – Employee Wellness & Benefits
Nebraska Department of Administrative Services
1526 K Street, Suite 110
Lincoln, Nebraska 68508

Re: Health Reserve Analysis as of June 30, 2024

Dear Christy:

Please find enclosed our report that provides our determinations of the reserves for medical and prescription drug benefits provided to the employees and covered dependents of State of Nebraska. For this report, we have estimated the reserves for Incurred But Not Paid (IBNP) claims as of June 30, 2024.

We have relied upon data provided by UnitedHealthcare. We accepted this information without audit and have relied upon the source for the accuracy of the data; however, we did review the information for reasonableness and consistency. On the basis of this review, we believe the data and information provided to be sufficiently complete and accurate, and that it is appropriate for the purposes intended.

A detailed report of the data, methodology, assumptions, results, recommendations and conclusions follows.

By signing below, I certify that I am a qualified actuary by education and experience to evaluate health reserves and funding practices. I am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries and certify that all analysis was conducted in accordance with all applicable Actuarial Standards of Practice. All sections of this report are considered an integral part of the actuarial opinion.

Sincerely,

Patrick Klein, FSA, MAAA
Health Consultant, Vice President

State of Nebraska

Actuarial Reserve Study as of June 30, 2024

Medical and Prescription Drug Benefits

August 2024

Segal

State of Nebraska

Table of Contents

Executive Summary

Segal has conducted an actuarial valuation of the incurred, but not paid, claims as of June 30, 2024, for the medical and prescription drug benefits provided by the State of Nebraska to its active and retired employees.

The results in the table below show a projected total necessary reserve of approximately $24.4 million. This figure is composed of an estimated $23.6 million in medical and prescription drug incurred but not paid (IBNP) reserves with an additional margin of 3.5% added for the projected claims runout outstanding as of June 30, 2024. The enrollment numbers are based on the 12-month average member count from July 2023 to June 2024.

Plan	Enrollment (Members)	IBNP[1]	Margin (3.5%)	Total Reserves
Wellness	19,428	$16,930,000	$593,000	$17,523,000
Regular	5,027	$5,409,000	$189,000	$5,598,000
Consumer Focused[2]	3,124	$1,279,000	$45,000	$1,324,000
Total	**27,579**	**$23,618,000**	**$827,000**	**$24,445,000**

[1]Combined IBNP for both medical and prescription drug
[2] Consumer Focused is combined with DPC plans for purposes of this calculation

The next table shows the medical and prescription drug breakdown for each plan. The total is equal to the IBNP for each plan.

Plan	Medical	Prescription Drug	Total
Wellness	$14,510,000	$2,420,000	$16,930,000
Regular	$4,804,000	$605,000	$5,409,000
Consumer Focused[1]	$1,145,000	$134,000	$1,279,000
Total	**$20,459,000**	**$3,159,000**	**$23,618,000**

[1] Consumer Focused is combined with DPC plans for purposes of this calculation

The traditional actuarial loss developmental method, and the Bornhuetter-Fergeson method were the basis of our calculation. The loss development uses historical, paid claims information by incurred date. This method is consistent with reserve calculations within the industry, best reflects the impact on claim payment patterns, and accounts for the cyclical nature of the plans' claims.

The results mentioned above are contingent upon future events. Consequently, actual results will differ from projected results, and these deviations may be material.

Data and Assumptions

We received monthly enrollment and incurred and paid claim data from UnitedHealthcare through June 30, 2024. The following annual trends were utilized to trend past claims for purposes of determining the projected, per-capita costs:

Medical: 4.5%
Prescription Drugs: 10.0%

Methodology

The unpaid claim liability (UCL), also called the incurred but not paid (IBNP) reserve, at a specified date is essentially the estimated claims incurred up to that date less the claims that have been (incurred and) paid to that date. Since the incurred and paid claims are known, the UCL is easily determined once the incurred claims have been estimated.

The traditional loss development method uses historical claim payment patterns to develop completion factors that are used to estimate incurred claims. The claims incurred in a given month and paid by the end of the experience period are divided by the completion factor to estimate the incurred claims for that month. The UCL for that month is subsequently determined by subtracting the known incurred and paid claims from the estimated incurred claims. The total UCL is merely the sum of all the appropriate monthly UCL estimates.

This method is relatively easy to understand and is effective when the historical claim payment patterns are deemed to be stable enough to estimate current/future claim payment patterns and when several months of claim payments (run-out) after the incurred month are available. When the run-out for any month is limited, this month is called immature and the associated completion factor is significantly less than one. The resulting incurred claim estimate is unstable. Consequently, a secondary method has traditionally been used to estimate the immature months.

The secondary method for health claims is often an average of historical incurred claims adjusted for claim trend and enrollment between the historical period and the time of interest. One of the shortcomings of this secondary method is that the available claim payment information for the month being estimated is not used. Another problem is that the line of demarcation between mature months and immature months is as much art as science.

The Bornhuetter-Fergeson Method (BFM) addresses both of these issues by blending the loss development method and the secondary method. The BFM uses the available incurred and paid data and the expected UCL developed from the secondary method to estimate incurred claims. This method generally provides a more stable estimate than the pure loss development method, a more responsive estimate than the secondary method, and a reasonable technique for blending the results of both methods.

Using the BFM with claims paid through June 30, 2024, the resulting UCL for June 30, 2024, was approximately $23.6 million. In addition, an explicit margin for adverse deviation of 3.5%, of claims unpaid as of June 30, 2023, totaling $0.8 million was used.

Actuarial Certification Statement of Opinion

Segal has been retained by State of Nebraska to study the actuarial reserves for incurred but not paid claims as of June 30, 2024, for the medical and pharmacy benefits provided by The State to its active and retired employees. I am employed by Segal. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries and am qualified by education and experience to make the statements of actuarial opinion contained herein.

Our internal proprietary modeling software generates claim lag factors and resulting reserve estimates. Our Health Technical Services unit, comprised of actuaries and programmers, is responsible for the initial development and maintenance of these models. The client team programs the assumptions and the calculation methods, validates the model, and reviews the results under my supervision.

In performing this reserve study, we have relied upon reports and information provided by The State and its vendor. We have not audited this data beyond general tests for reasonableness. The results are our best estimate of incurred but unpaid claims. The techniques and methodology used are reasonable and in accordance with generally accepted actuarial principles and practice.

Patrick Klein, FSA, MAAA
Health Consultant, Vice President

August 2, 2024

Client

Point Solution Program Evaluation

December 2024

Doc#: 10039454

Segal

Point Solution Program Evaluation

Scope of Analysis

- A review of the Point Solution Program (Point Solution) offered to members of the Client (the Fund) was performed to determine the effectiveness of the program.
- Point Solution was implemented in May 2022. Enrollment has increased by an average of 70 members each month since then.
- To ensure adequate experience post-enrollment, the report focuses on participants enrolled from May 2022 through May 2023.
  - Only participants with 12 months of enrollment before and after Point Solution engagement were included in the evaluation. The summary of biometric results include all participants with more than one reading in which we received data for.
  - The month in which a member enrolled in Point Solution was excluded.
  - Members enrolled in Medicare are excluded.
- Medical and prescription drug experience is included in the evaluation. Unless stated otherwise, rebates are not included.
- There were 1,053 non-Medicare members enrolled in Point Solution between May 2022 and May 2023.
  - Only 843 members had at least 12 months of pre- and post-enrollment experience.
- Of the 843 members with the required pre- and post-enrollment experience, propensity score matching and coarsened exact matching (explained on following page) was utilized to match participants to non-participants and to adjust for treatment selection bias.
  - Propensity score matching and coarsened exact matching resulted in 746 program participants (88.5% of 843) matched to 1,747 non-participants.

Point Solution Program Evaluation

Methodology

- Propensity Score Matching, specifically the caliper matching method (<0.01% required), was used to match Point Solution participants to non-participants with similar likelihoods of program engagement using the following variables:
  - Age
  - Total cardiovascular spend during prior year[1]
  - Total medical spend during prior year[1]
  - Total pharmacy spend during prior year[1]
- Exact matching was done on the following variables:
  - Comorbidities (i.e., diabetes, obesity)
  - GLP-1 utilization (3+ scripts required)
  - Gender
  - Status (i.e., active, non-Medicare retiree)
  - Member Type (i.e., employee/retiree, spouse, child)
- Difference-in-difference comparison of participant per member per year (PMPY) cost (i.e., plan paid) increase to matched non-participant PMPY cost (i.e., plan paid) increase used to derive program savings and return on investment (ROI).

[1] *Prior year is 2021 for 2022 enrollees and 2022 for 2023 enrollees*

Point Solution Program Evaluation

Return on Investment (ROI) calculation

$$\textbf{ROI} = \frac{Program\ Savings}{Program\ Fees}$$

- **Program Savings** = (Measurement period costs for participants - Baseline period costs for participants) – (Measurement period costs for non-participants - Baseline period costs for non-participants)
  - Baseline period = Year prior to Point Solution enrollment
  - Measurement period = Year after to Point Solution enrollment (excludes enrollment month)
  - For non-participants, Point Solution enrollment date is based on the enrollment date for the matched participant.
  - Costs include gross medical and prescription drug expenses paid by the Plan. Medical costs are capped at $100,000 per individual. Prescription drug rebates are not included.
- **Program Fees** = $30 per participant per month

Point Solution Program Evaluation

Key Findings

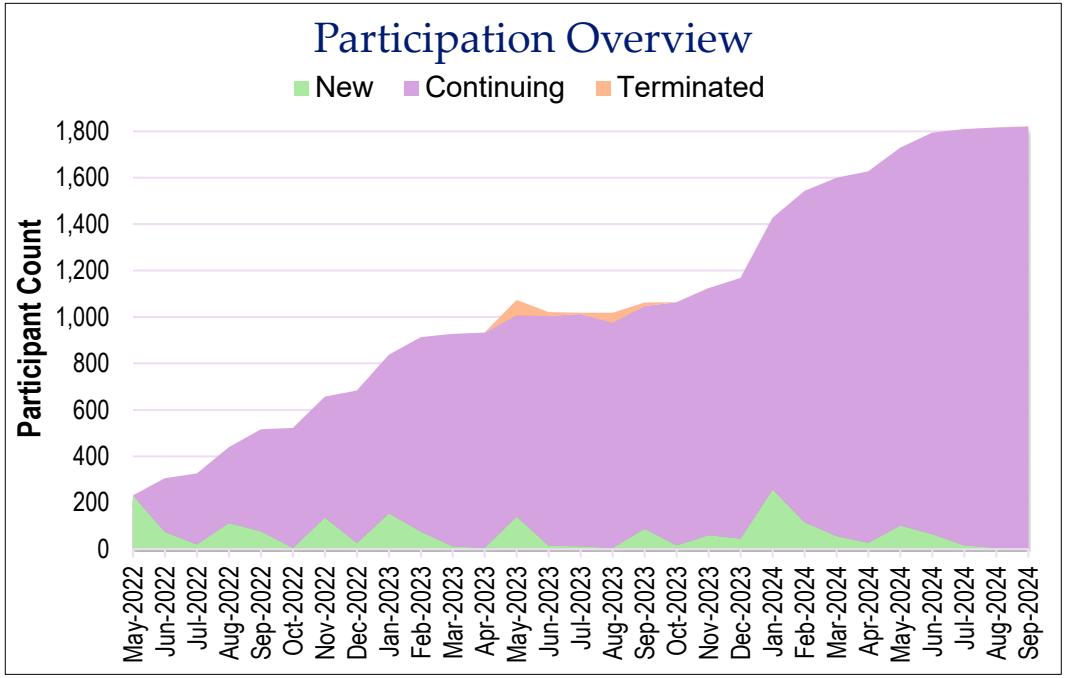
- The Point Solution program is attracting younger members more likely to be male.
- Participation is strong with approximately 20% of hypertensive members enrolling. Further, only 8% of enrollees through September 2024 have disenrolled, which is indicative of high participant satisfaction.
  - According to the data provided to us, there have been no disenrollments since September 2023.
- There are early signs that the program is working as intended, including:
  - Lower medical trend for program participants (-1.5% vs. +24.1%) including lower CVD-related trend (8.2% vs. 56.0%).
  - Increase in CVD-related office visit utilization for program participants (+40.0% vs. +18.7%).
  - Reduction in CVD-related emergency room visits for program participants (-32.0% vs. +50.5%).
  - Lower increase in CVD-related hospital admissions for program participants (+66.7% vs. +96.6%).
- The program appears to be identifying cardiovascular issues (e.g., atrial fibrillation and other cardiac arrhythmias) as there was a noticeable increase in office visits for these conditions in the first year of program enrollment.
- The program appears to be improving medication adherence for participants. Aside from beta blockers, the change in medication adherence following program enrollment was favorable for participants when compared to non-participants.
- Overall, gross medical and prescription drug allowed costs increased by $589 for participants and $2,023 for non-participants. When looking at just Plan costs, the amount paid by the Plan increased by $714 PMPY for matched program participants and $1,978 PMPY for non-participants.
  - Note that the ROI calculation included in this evaluation censors medical claims at $100,000 per individual. The impact of censoring changes the increase in costs for participants to $816 PMPY and to $1,550 PMPY for non-participants.

Point Solution Program Evaluation

Disclaimer

- Segal considers the following evaluation an acceptable methodology in calculating return on investment (ROI) for disease management programs such as Point Solution.
- The evaluation and corresponding results are not to be considered an endorsement of Point Solution by Segal. Although the methodology is validated by Segal and propensity score matching aims to reduce selection bias, there are likely important differences between members who decide to enroll in the program versus those who do not that have not been adjusted for. Examples include:
  - Members are motivated to enroll after a major health event
  - Members who are motivated to improve their condition are more likely to enroll
- Segal relied on data provided by Point Solution and the Fund's other service providers. Segal has not audited the information provided but it has been reviewed for reasonableness. True savings associated with the Point Solution program may be higher or lower than what is shown in this report.

Point Solution Program Evaluation



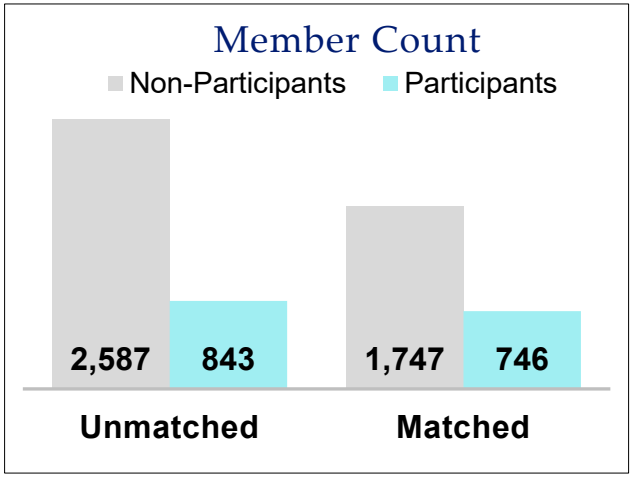
Participant Breakdown Enrolled Between May 2022 and May 2023		
	Count	**% of Hypertensive**
Employees		
Age 29 and Under	69	51%
Age 30-39	166	36%
Age 40-49	151	21%
Age 50-59	232	20%
Age 60+	177	21%
Dependents		
Age 29 and Under	16	5%
Age 30-39	41	24%
Age 40-49	63	16%
Age 50-59	79	12%
Age 60+	59	14%
Total		
All Ages	**1,053**	**20%**

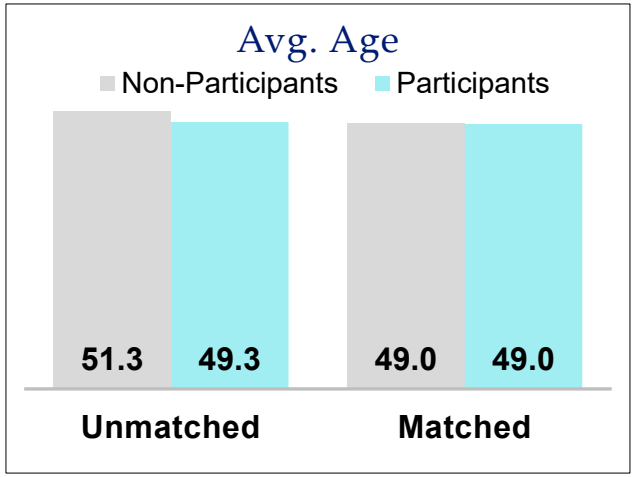
Observations

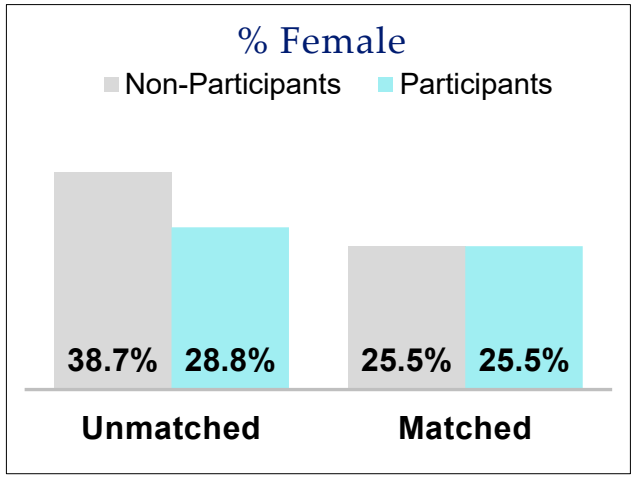
- Since program inception, there have been 2,205 members enrolled in Point Solution as of September 2024. Of these, 248 (11%) were excluded due to Medicare status, 107 (5%) were excluded due to no record of enrollment, and 797 (36%) were excluded due to enrolling after May 2023, leaving 1,053 members included in the evaluation.
  - 168 (8%) members have disenrolled in the Point Solution program. However, disenrolled members are still included in the analysis if they have 12 months of pre- and post-program experience.
- The 1,053 members included in this evaluation represent approximately 20% of all hypertensive members in the Fund.

Point Solution Program Evaluation

Demographics





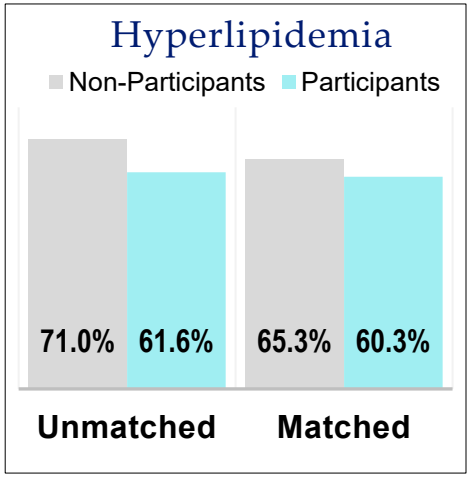


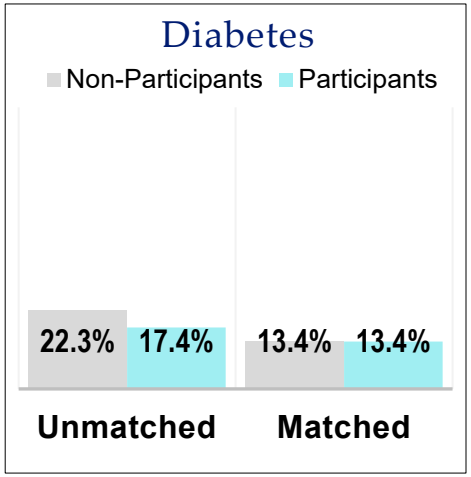
Observations

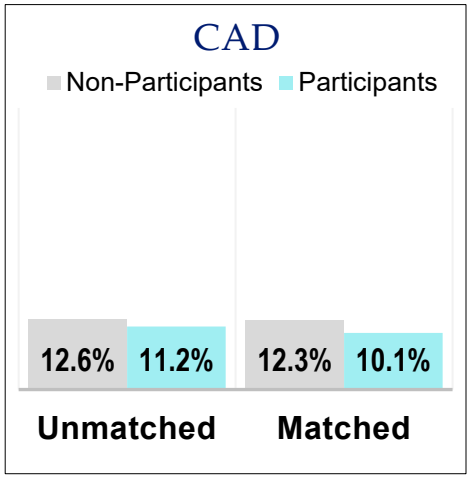
- Of the 1,053 members enrolled during or before May 2023, 843 members had 12 months of experience pre- and post-program engagement.
  - Through propensity score matching and coarsened exact matching, 746 program participants were matched to 1,747 "statistical twin" non-participants.
  - 11.5% of participants and 32.5% of non-participants were removed during the matching process.
- Participants were younger on average than non-participants (49.3 years vs. 51.3 years) and also more likely to be male (28.8% female vs. 38.7% female).
  - The matching process removed the difference in both of these variables.

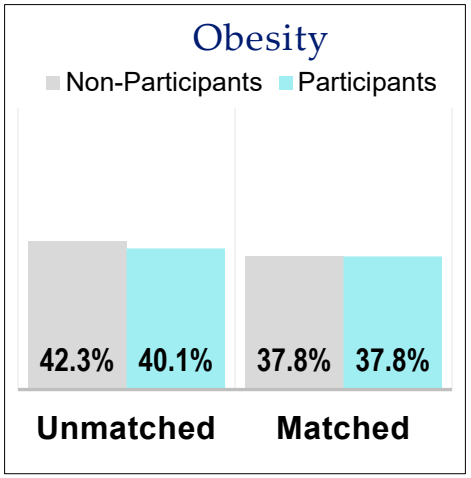
Point Solution Program Evaluation

Comorbidities







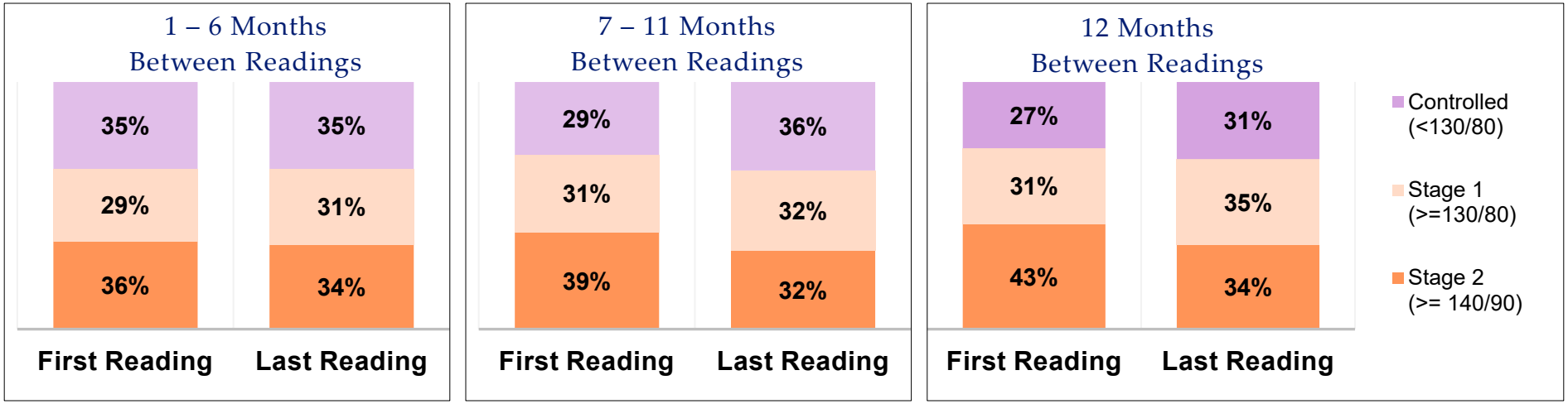


Observations

- Program participants were less likely to have all of the four major chronic conditions listed above.
- The matching process removed the difference between diabetes prevalence and obesity prevalence. However, we were not able to remove the entire difference between hyperlipidemia prevalence and coronary artery disease (CAD) prevalence due to losing too many program participants in the matching process when those variables were included.

Point Solution Program Evaluation

Biometrics: Blood Pressure[1]



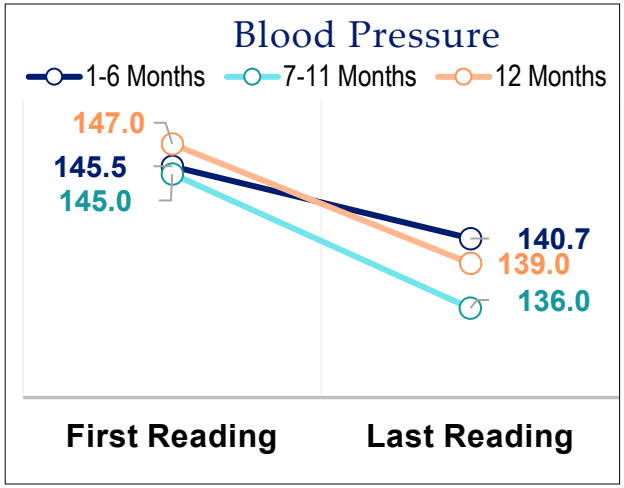
Observations

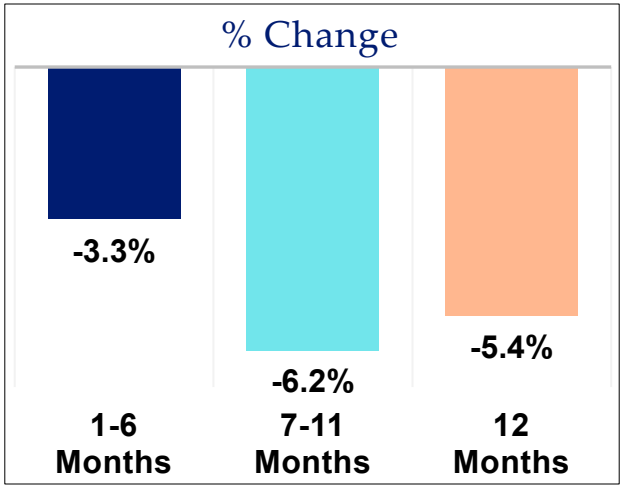
- There were 689 Point Solution participants with 1-6 months between results, 330 Point Solution participants with 7-11 months between results, and 202 Point Solution participants with 12 months between results included in the figures above.
- For participants with 1-6 months between results, 36% had results indicative of having Stage 2 hypertension (i.e., >= 140 systolic or 90 diastolic) during their first reading and 34% had results indicative of having Stage 2 hypertension in the final reading.
- For participants with 7-11 months between results, 39% had results indicative of having Stage 2 hypertension during their first reading and 32% had results indicative of having Stage 2 hypertension in the final reading. Further, 29% of participants had controlled hypertension at first reading versus 36% with controlled hypertension at their last reading.
- For participants with 12 months between results, 43% had results indicative of having Stage 2 hypertension during their first reading and 34% had results indicative of having Stage 2 hypertension in the final reading. Further, 27% of participants had controlled hypertension at first reading versus 31% with controlled hypertension at their last reading.

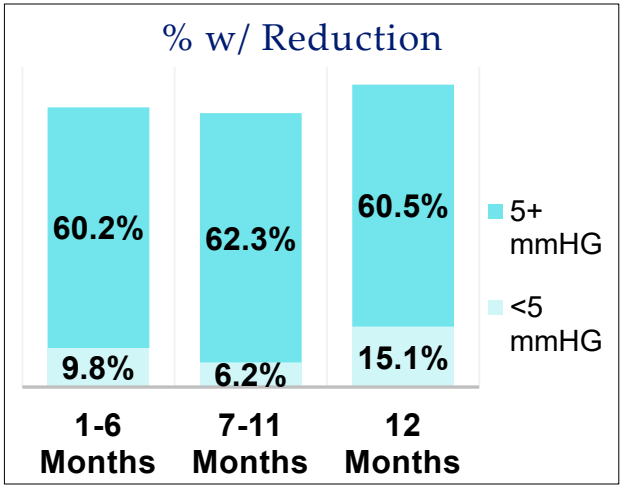
1. https://www.heart.org/en/health-topics/high-blood-pressure/understanding-blood-pressure-readings

Point Solution Program Evaluation

Biometrics: Blood Pressure (Systolic) – Stage 2 Hypertension Only





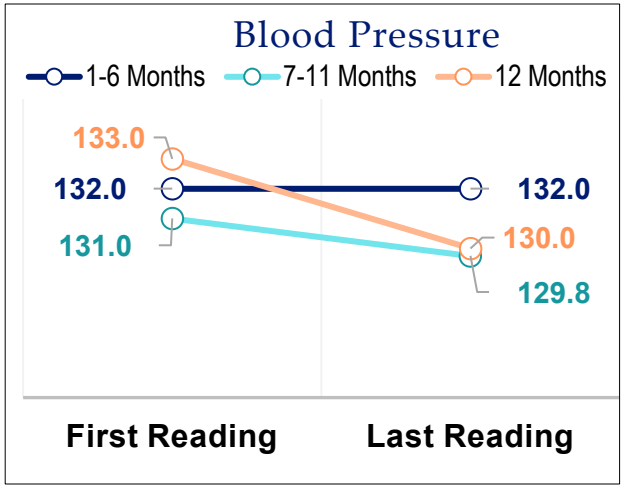


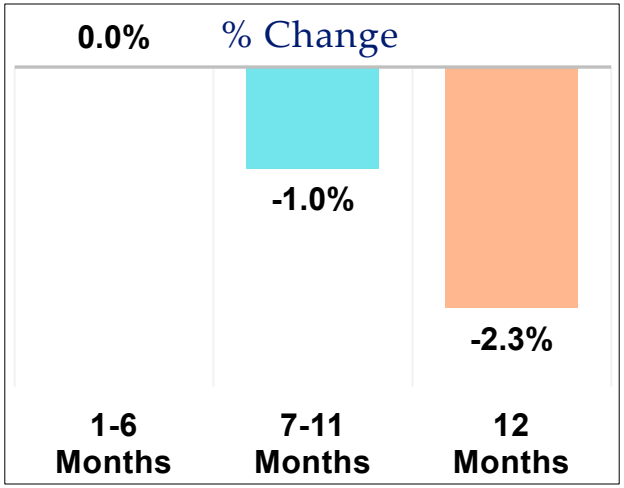
Observations

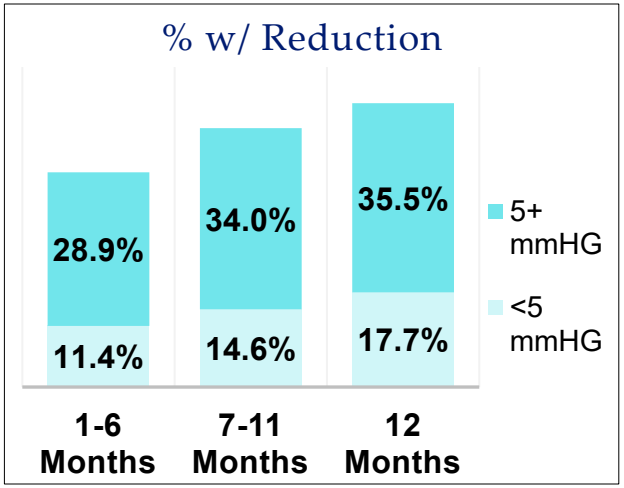
- For Point Solution participants with **Stage 2 Hypertension** based on their first reading, The median systolic blood pressure reading decreased by 4.8 points from the first to last reading for those with 1-6 months between readings, 9.0 points for those with 7-11 months between readings, and 8.0 points for those with 12 months between readings.
- The median % change in systolic blood pressure was -3.3% for those with 1-6 months between readings, -6.2% for those with 7-11 months between results, and -5.4% for those with 12 months between results.
- Over 60% of Stage 2 hypertensive participants experienced a reduction of 5 mmHG or greater in systolic blood pressure between the first and last readings.

Point Solution Program Evaluation

Biometrics: Blood Pressure (Systolic) – Stage 1 Hypertension Only





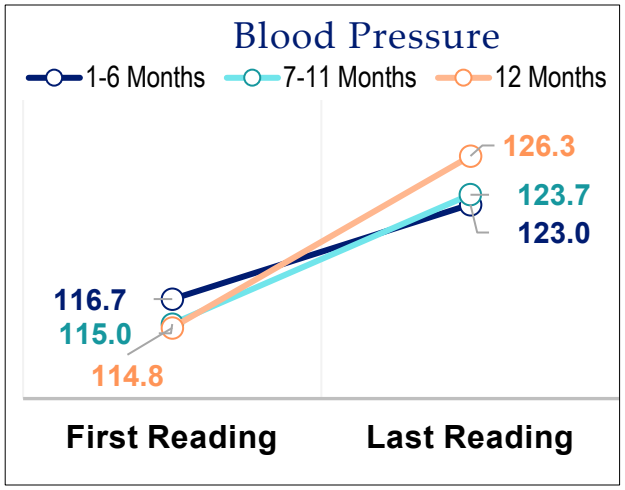


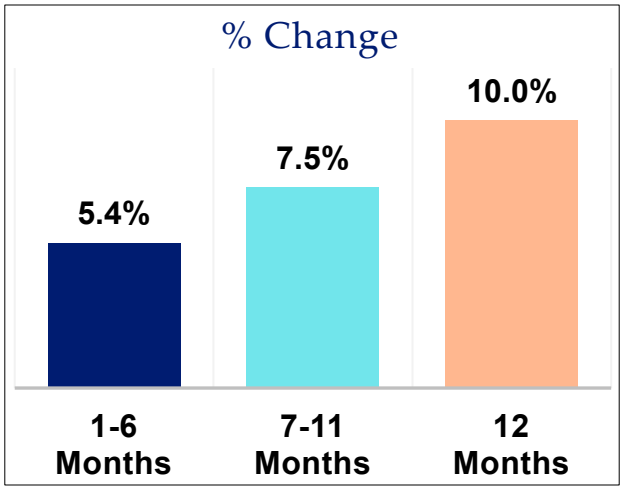
Observations

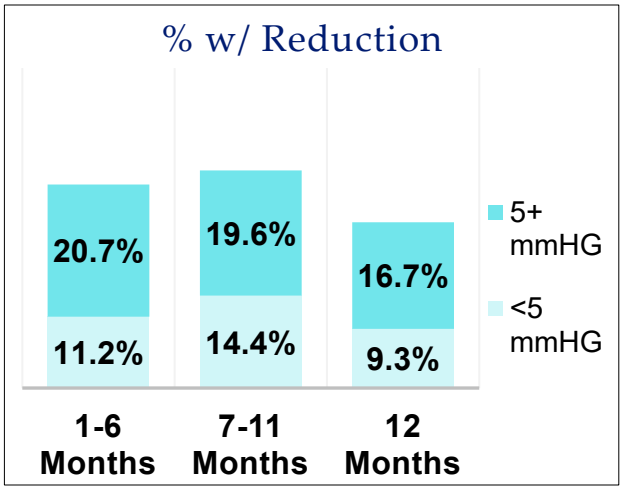
- For Point Solution participants with **Stage 1 Hypertension** based on their first reading, The median systolic blood pressure reading was unchanged from the first to last reading for those with 1-6 months between readings, decreased 1.3 points for those with 7-11 months between readings, and decreased 3.0 points for those with 12 months between readings.
- The median % change in systolic blood pressure was 0.0% for those with 1-6 months between readings, -1.0% for those with 7-11 months between results, and -2.3% for those with 12 months between results.
- 40.3% of participants with 1-6 months between readings, 48.5% of participants with 7-11 months between readings, and 53.2% of participants with 12 months between readings experienced a reduction in systolic blood pressure between the first and last readings.

Point Solution Program Evaluation

Biometrics: Blood Pressure (Systolic) – Controlled Hypertension[1] Only







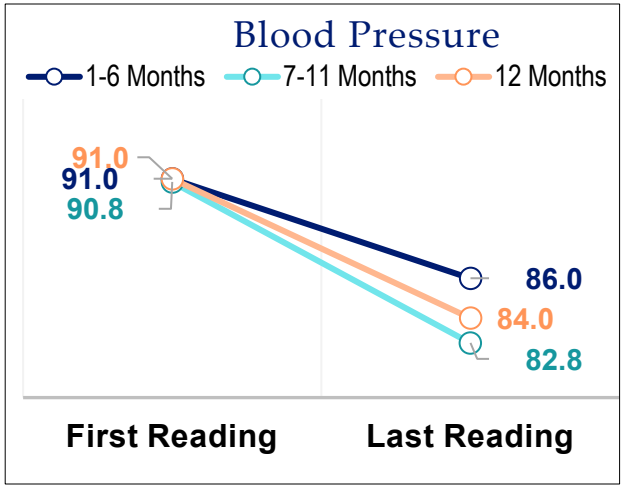
Observations

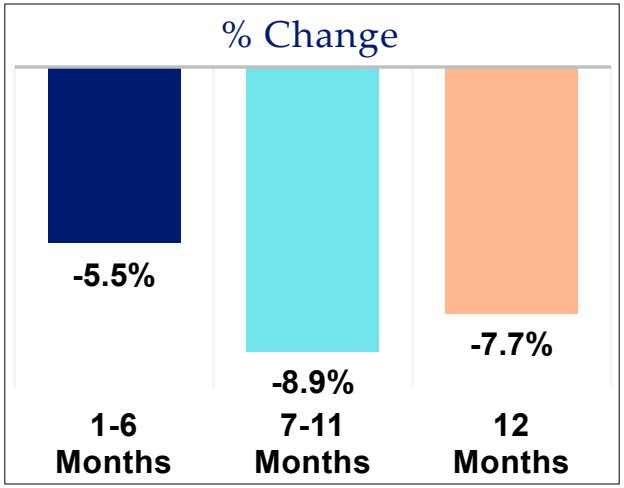
- The charts above summarize systolic blood pressure metrics for Point Solution participants with **Controlled Hypertension[1]** based on their first reading. Note that a reduction in systolic blood pressure may not be the goal for participants with already controlled hypertension. For all time points, the median systolic blood pressure remained controlled on the last reading.
- The median systolic blood pressure reading increased 6.3 points from the first to last reading for those with 1-6 months between readings, increased 8.7 points for those with 7-11 months between readings, and increased 11.5 points for those with 12 months between readings.
- The median % change in systolic blood pressure was 5.4% for those with 1-6 months between readings, 7.5% for those with 7-11 months between results, and 10.0% for those with 12 months between results.
- 31.8% of participants with 1-6 months between readings, 34.0% of participants with 7-11 months between readings, and 25.9% of participants with 12 months between readings experienced a reduction in systolic blood pressure between the first and last readings.

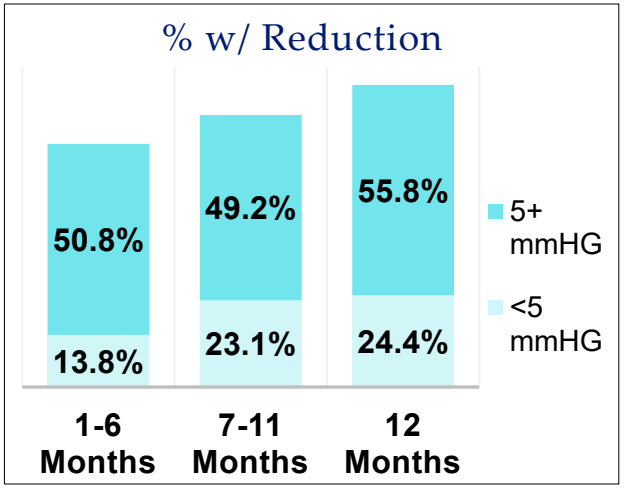
[1] Controlled hypertension includes both elevated hypertension (>=120 / <80) and non-hypertensive (<120 / 80)

Point Solution Program Evaluation

Biometrics: Blood Pressure (Diastolic) – Stage 2 Hypertension Only





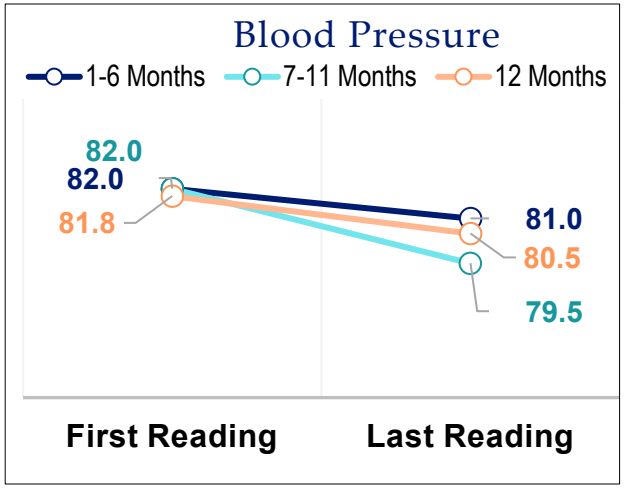


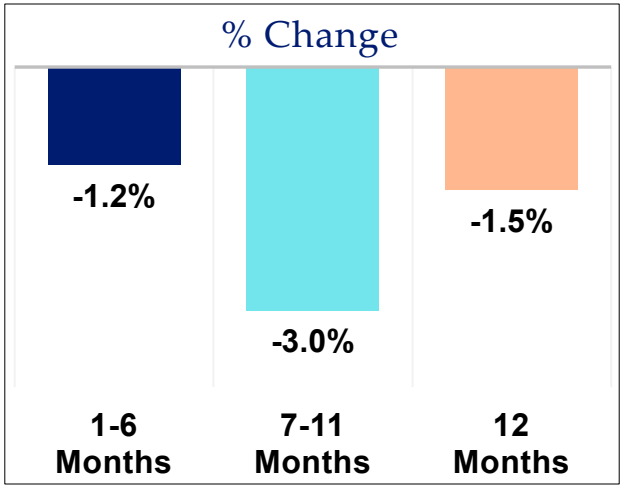
Observations

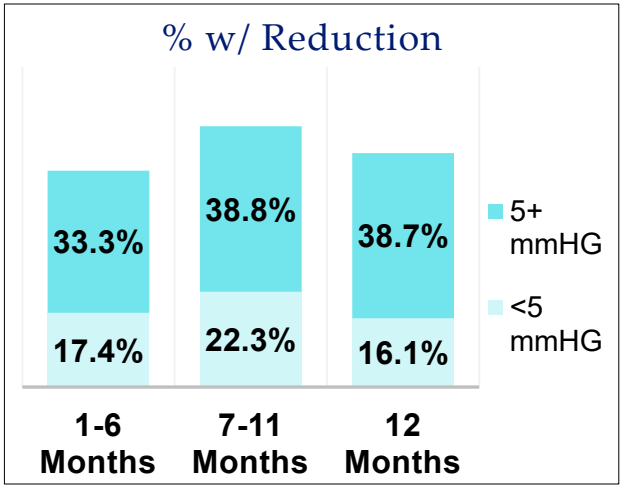
- For Point Solution participants with **Stage 2 Hypertension** based on their first reading, The median diastolic blood pressure reading decreased by 5.0 points from the first to last reading for those with 1-6 months between readings, 8.1 points for those with 7-11 months between readings, and 7.0 points for those with 12 months between readings.
- The median % change in diastolic blood pressure was -5.5% for those with 1-6 months between readings, -8.9% for those with 7-11 months between results, and -7.7% for those with 12 months between results.
- Over 50% of Stage 2 hypertensive participants experienced a reduction of 5 mmHG or greater in diastolic blood pressure between the first and last readings.

Point Solution Program Evaluation

Biometrics: Blood Pressure (Diastolic) – Stage 1 Hypertension Only





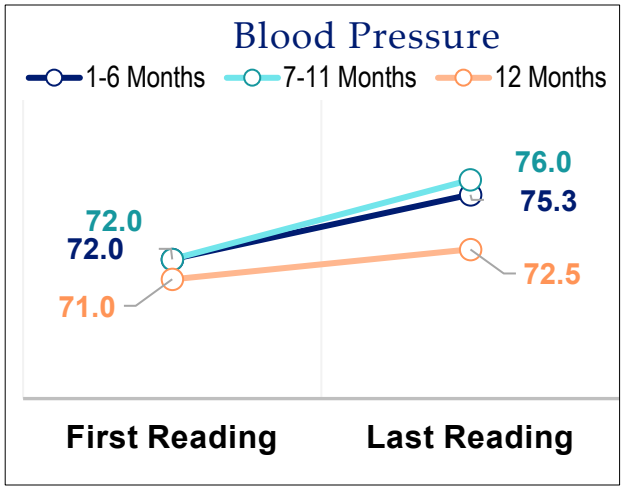


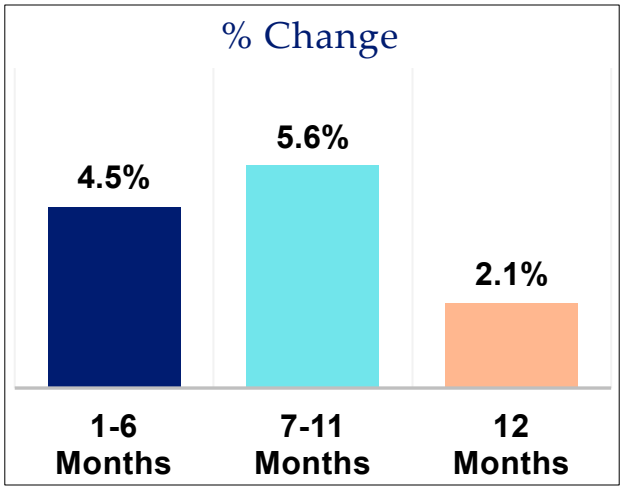
Observations

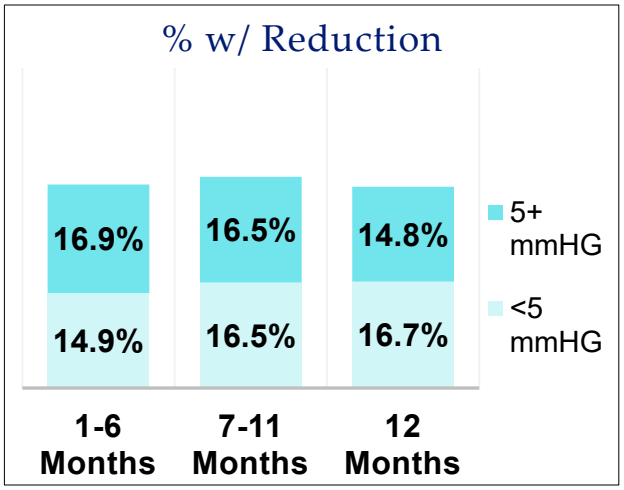
- For Point Solution participants with **Stage 1 Hypertension** based on their first reading, The median diastolic blood pressure reading decreased 1.0 points for those with 1-6 months between readings, decreased 2.5 points for those with 7-11 months between readings, and decreased 1.3 points for those with 12 months between readings.
- The median % change in diastolic blood pressure was -1.2% for those with 1-6 months between readings, -3.0% for those with 7-11 months between results, and -1.5% for those with 12 months between results.
- 50.7% of participants with 1-6 months between readings, 61.2% of participants with 7-11 months between readings, and 54.8% of participants with 12 months between readings experienced a reduction in diastolic blood pressure between the first and last readings.

Point Solution Program Evaluation

Biometrics: Blood Pressure (Diastolic) – Controlled Hypertension[1] Only







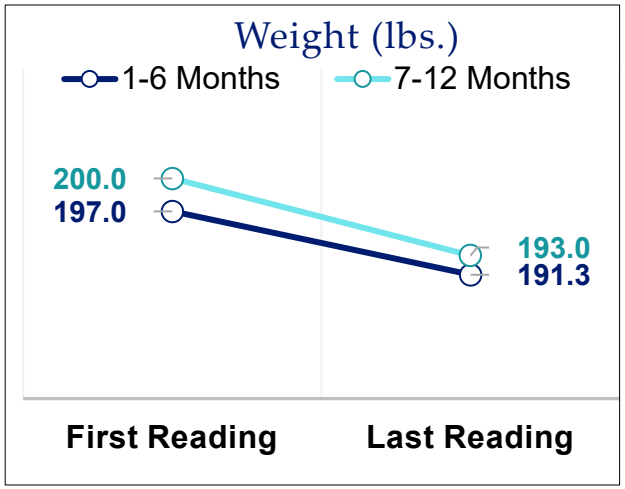
Observations

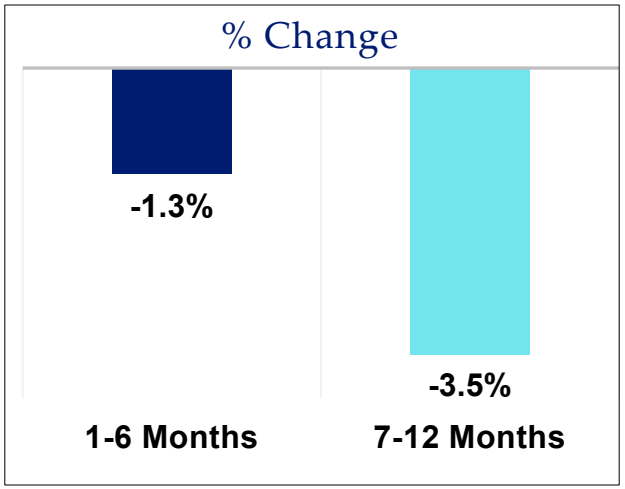
- The charts above summarize diastolic blood pressure metrics for Point Solution participants with **Controlled Hypertension[1]** based on their first reading. Note that a reduction in diastolic blood pressure may not be the goal for participants with already controlled hypertension. For all time points, the median diastolic blood pressure remained controlled on the last reading.
- The median diastolic blood pressure reading increased 3.3 points from the first to last reading for those with 1-6 months between readings, increased 4.0 points for those with 7-11 months between readings, and increased 1.5 points for those with 12 months between readings.
- The median % change in diastolic blood pressure was 4.5% for those with 1-6 months between readings, 5.6% for those with 7-11 months between results, and 2.1% for those with 12 months between results.
- 31.8% of participants with 1-6 months between readings, 33.0% of participants with 7-11 months between readings, and 31.5% of participants with 12 months between readings experienced a reduction in diastolic blood pressure between the first and last readings.

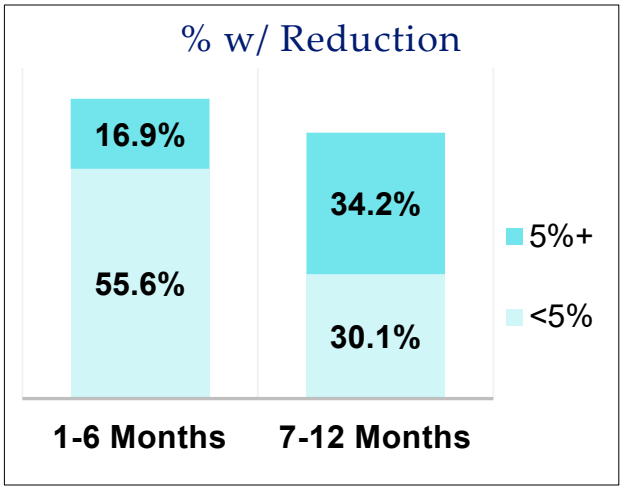
[1] Controlled hypertension includes both elevated hypertension (>=120 / <80) and non-hypertensive (<120 / 80)

Point Solution Program Evaluation

Biometrics: Weight





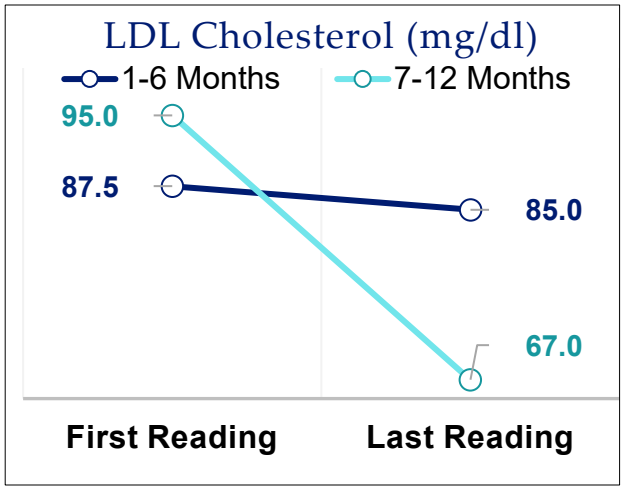


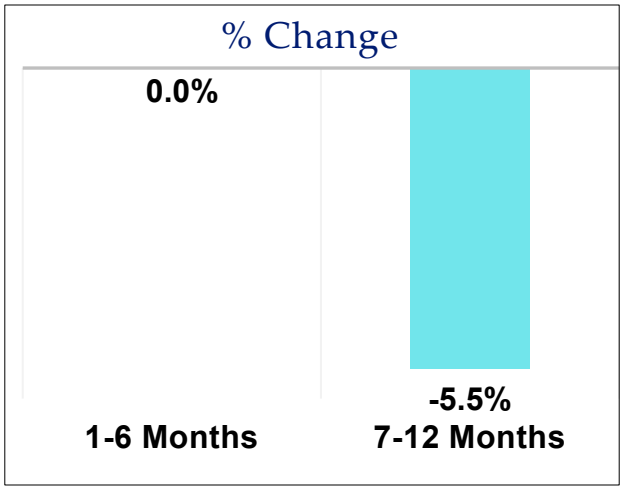
Observations

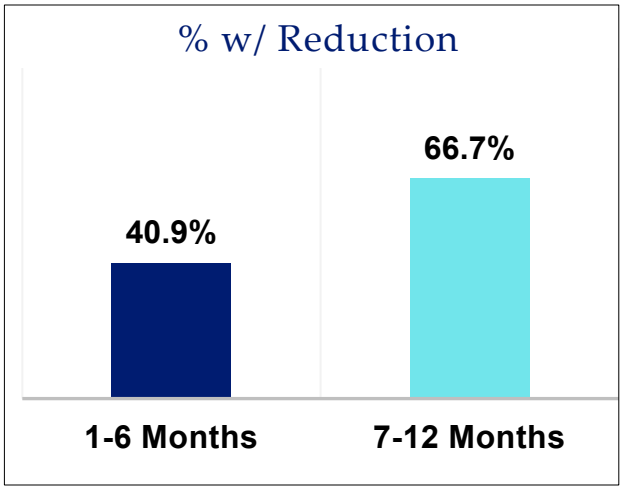
- There were 124 Point Solution participants with 1-6 months between results and 73 Point Solution participants with 7-12 months between results included in the figures above.
- The median weight decreased by 5.7 lbs. from the first to last reading for participants with 1-6 months between results and decreased 7.0 lbs. for participants with 7-12 months between results.
- The median % change in weight decreased 1.3% for those with 1-6 months between results and decreased 3.5% for those with 7-12 months between results.
- 72.6% of participants with 1-6 months between results experienced a reduction in weight between the first and last reading and 64.4% of participants with 7-12 months between readings experienced a reduction in weight.

Point Solution Program Evaluation

Biometrics: LDL Cholesterol





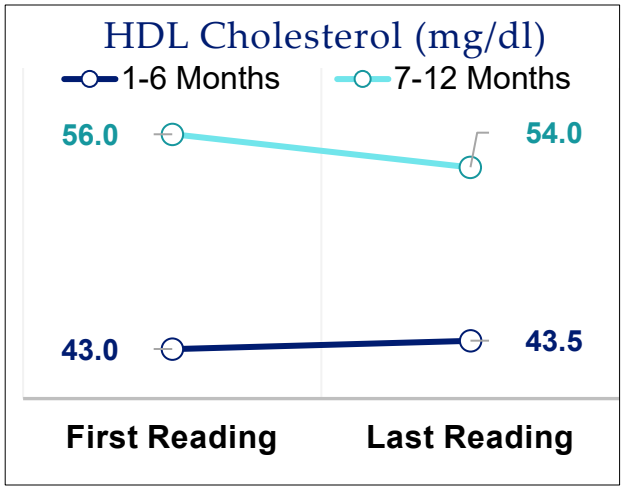


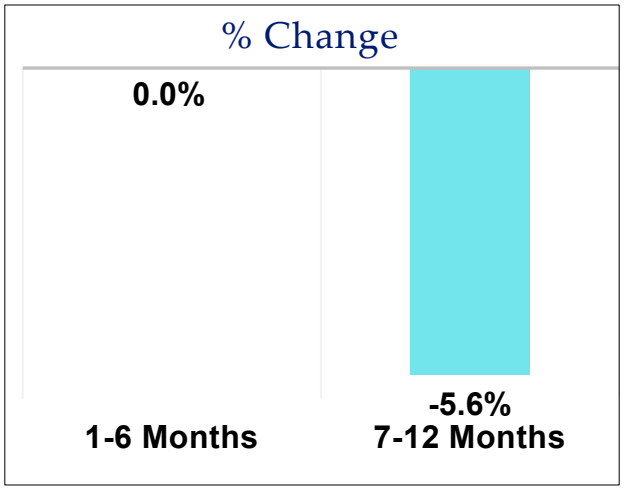
Observations

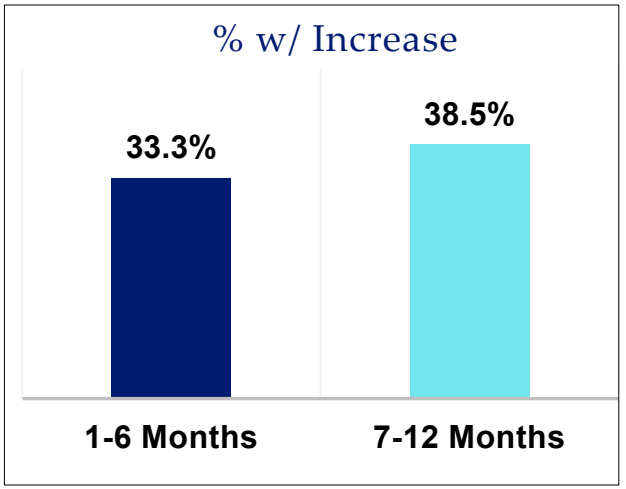
- There were 22 Point Solution participants with 1-6 months between results and 15 Point Solution participants with 7-12 months between results included in the figures above. Note that although we are providing this information, the number of participants is too small to be credible.
- The median LDL cholesterol decreased by 2.5 mg/dl from the first to last reading for participants with 1-6 months between results and decreased 28.0 mg/dl for participants with 7-12 months between results.
- The median % change in LDL cholesterol was 0.0% for those with 1-6 months between results and decreased 5.5% for those with 7-12 months between results.
- 40.9% of participants with 1-6 months between results experienced a reduction in LDL cholesterol between the first and last reading and 66.7% of participants with 7-12 months between readings experienced a reduction in LDL cholesterol.

Point Solution Program Evaluation

Biometrics: HDL Cholesterol





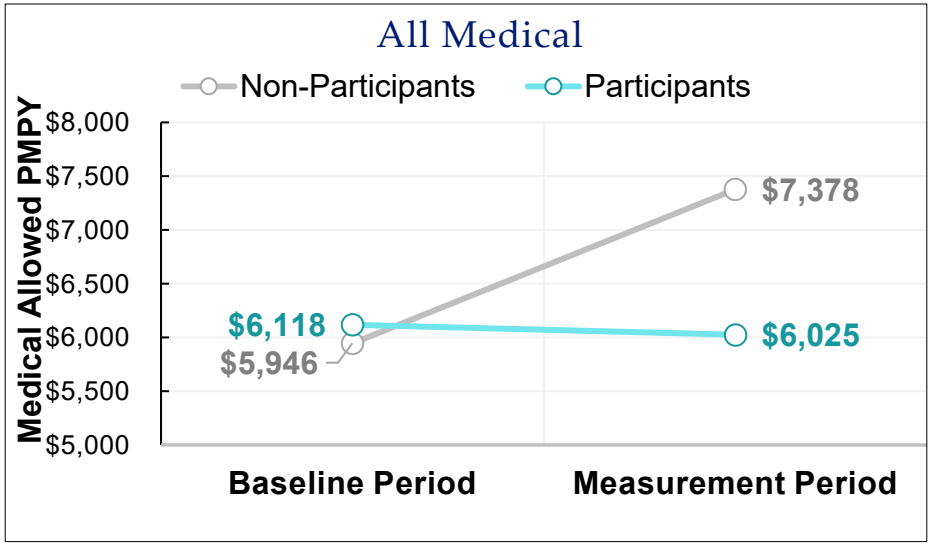


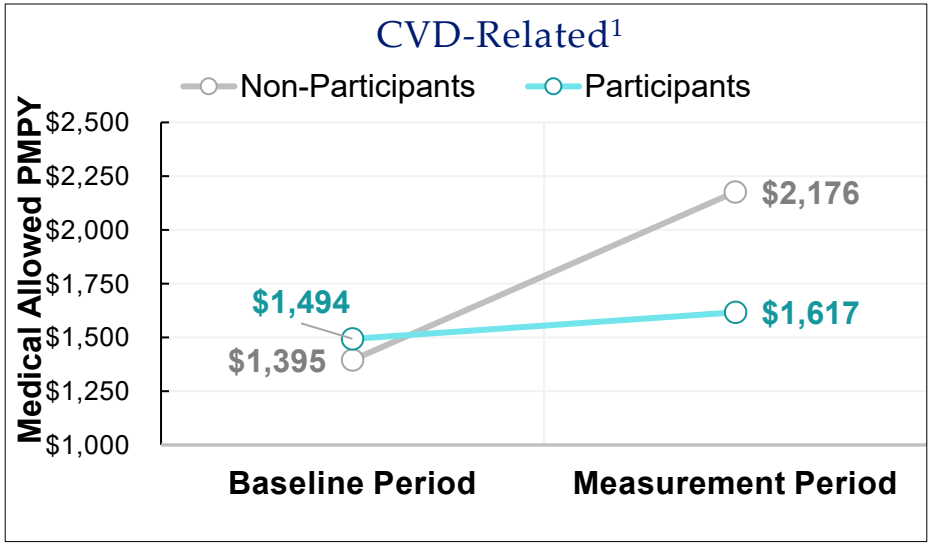
Observations

- There were 24 Point Solution participants with 1-6 months between results and 13 Point Solution participants with 7-12 months between results included in the figures above. Note that although we are providing this information, the number of participants is too small to be credible.
- The median HDL cholesterol increased by 0.5 mg/dl from the first to last reading for participants with 1-6 months between results and decreased 2.0 mg/dl for participants with 7-12 months between results.
- The median % change in HDL cholesterol was 0.0% for those with 1-6 months between results and decreased 5.6% for those with 7-12 months between results.
- 33.3% of participants with 1-6 months between results experienced an increase in HDL cholesterol between the first and last reading and 38.5% of participants with 7-12 months between readings experienced an increase in HDL cholesterol.

Point Solution Program Evaluation

Medical Costs (Matched)





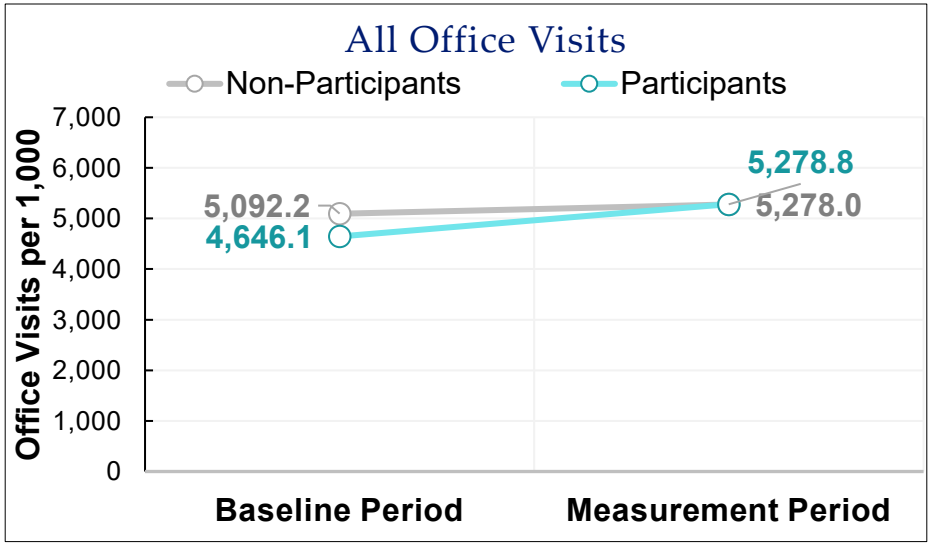
Observations

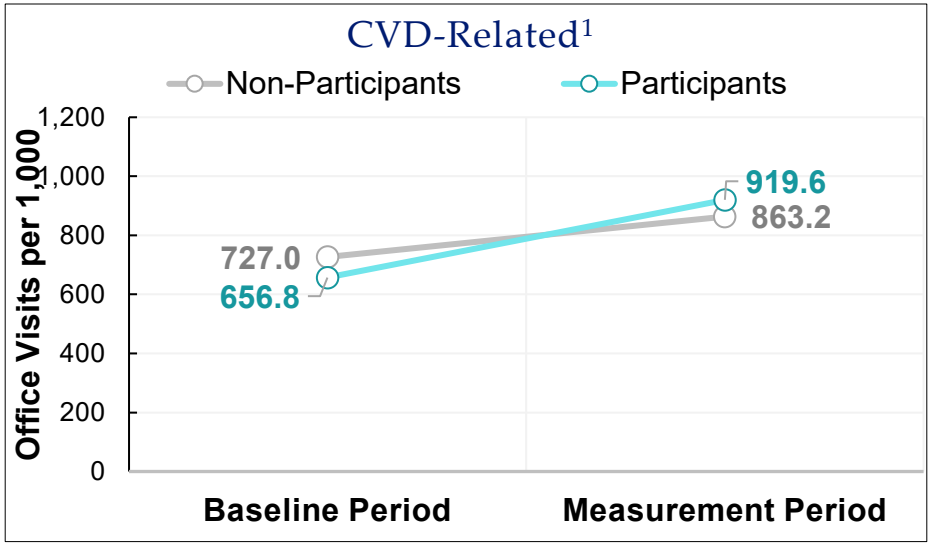
- For matched participants with statistical twins (746 participants and 1,747 non-participants), medical costs decreased from $6,118 to $6,025 per member per year (PMPY) for participants (-1.5%) and increased from $5,946 to $7,378 PMPY for non-participants (+24.1%).
  - The reduction in medical costs were driven by lower costs for aortic aneurysm and dissections, myocardial infarctions, and abdominal pain.
- CVD-related[1] medical costs increased from $1,494 to $1,617 PMPY for participants (+8.2%) and increased from $1,395 to $2,176 PMPY for non-participants (+56.0%).
  - CVD-related medical costs were driven by increases in atrial fibrillation and other cardiac arrhythmias.

[1] CVD-related only includes claims with a cardiovascular-related primary, secondary, or tertiary diagnosis code. Examples include: myocardial infarction, cardiac arrhythmias, heart failure, hypertension, ischemic heart disease, peripheral and visceral vascular disease, and valvular disease.

Point Solution Program Evaluation

Office Visits (Matched)





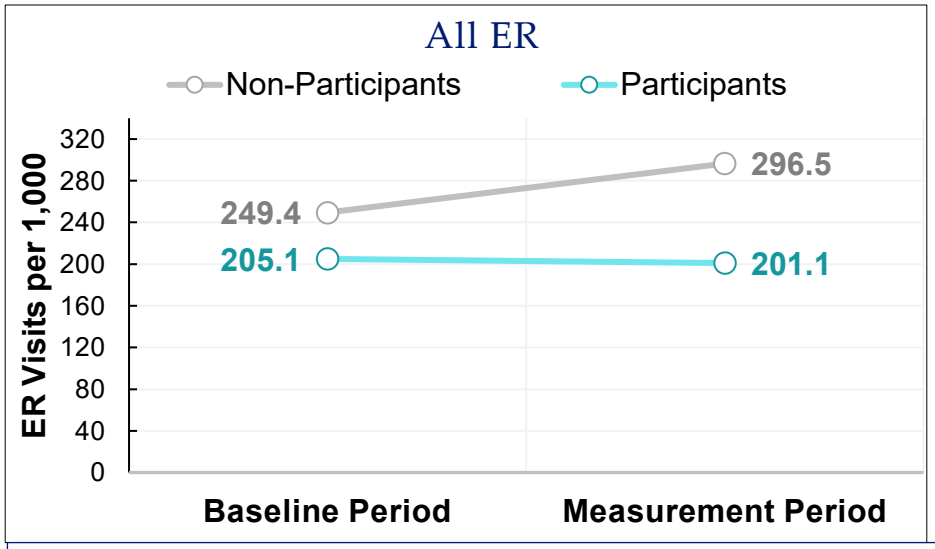
Observations

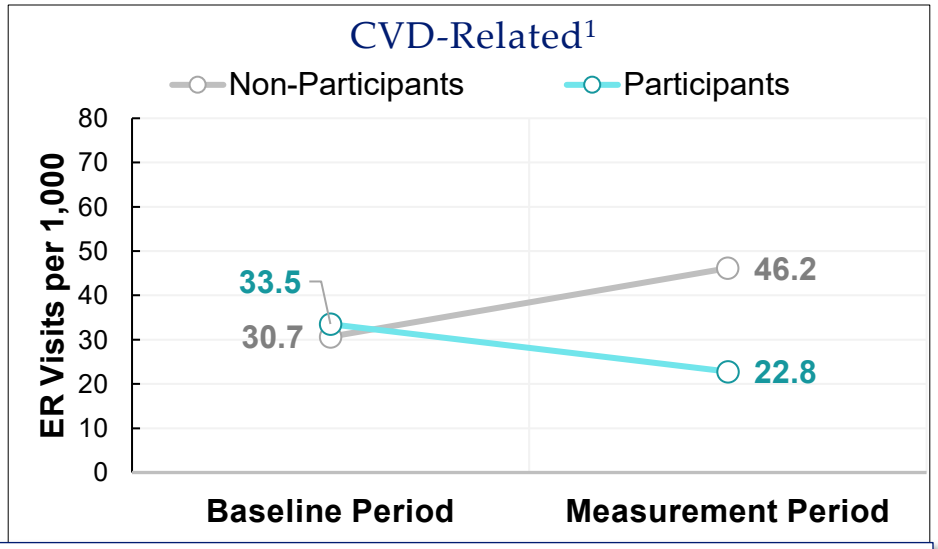
- For matched participants with statistical twins, office visits increased from 4,646.1 to 5,278.8 per 1,000 members for participants (+13.6%) and increased from 5,092.2 to 5,278.0 per 1,000 for non-participants (+3.6%).
  - The increase in office visits was mainly driven by CVD-related treatment, but also obesity and dorsalgia.
- CVD-related[1] office visits increased from 656.8 to 919.6 per 1,000 for participants (+40.0%) and increased from 727.0 to 863.2 per 1,000 for non-participants (+18.7%).
  - The increase in CVD-related office visits was driven by hypertension, cardiomyopathy, and heart failure.

[1] CVD-related only includes claims with a cardiovascular-related primary, secondary, or tertiary diagnosis code. Examples include: myocardial infarction, cardiac arrhythmias, heart failure, hypertension, ischemic heart disease, peripheral and visceral vascular disease, and valvular disease.

Point Solution Program Evaluation

Emergency Room (ER) Visits (Matched)





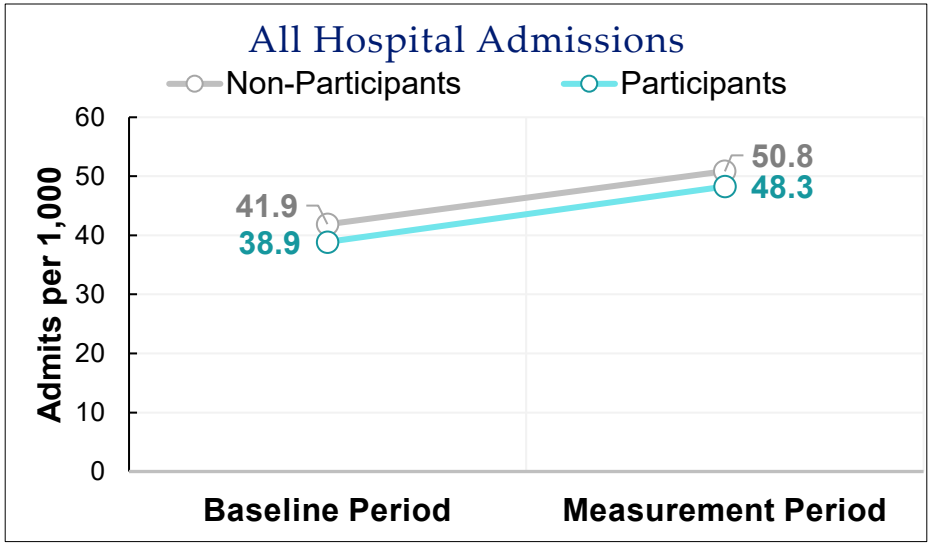
Observations

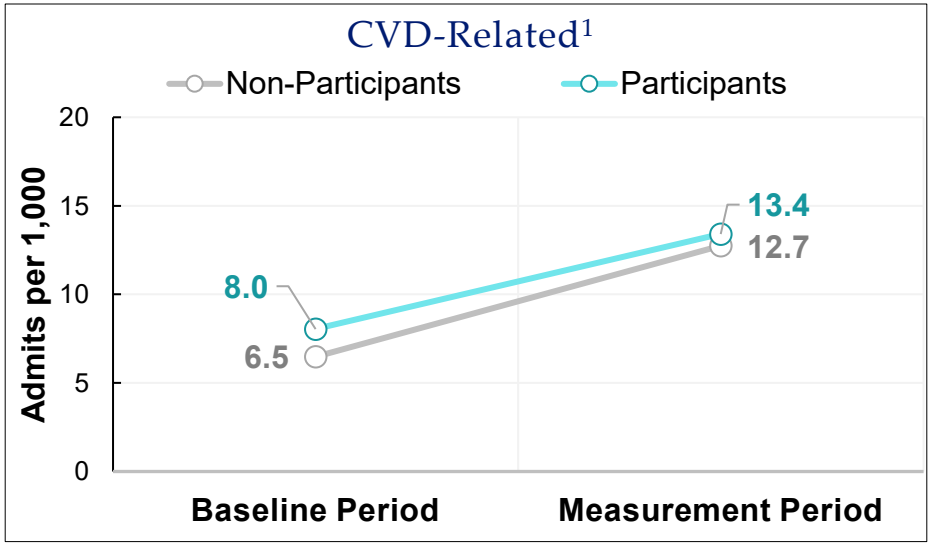
- For matched participants with statistical twins, ER visits decreased from 205.1 to 201.1 per 1,000 members for participants (-2.0%) and increased from 249.4 to 296.5 per 1,000 for non-participants (+18.9%).
  - The reduction in ER visits was driven by fewer visits for COVID-19, dizziness/giddiness, and fluid/electrolyte disorders.
- CVD-related[1] ER visits decreased from 33.5 to 22.8 per 1,000 for participants (-32.0%) and increased from 30.7 to 46.2 per 1,000 for non-participants (+50.5%).
  - The reduction in CVD-related ER visits was driven by fewer visits for myocardial infarctions, hypertension, and hypertensive heart disease.

[1] CVD-related only includes claims with a cardiovascular-related primary, secondary, or tertiary diagnosis code. Examples include: myocardial infarction, cardiac arrhythmias, heart failure, hypertension, ischemic heart disease, peripheral and visceral vascular disease, and valvular disease.

Point Solution Program Evaluation

Hospital Admissions (Matched)





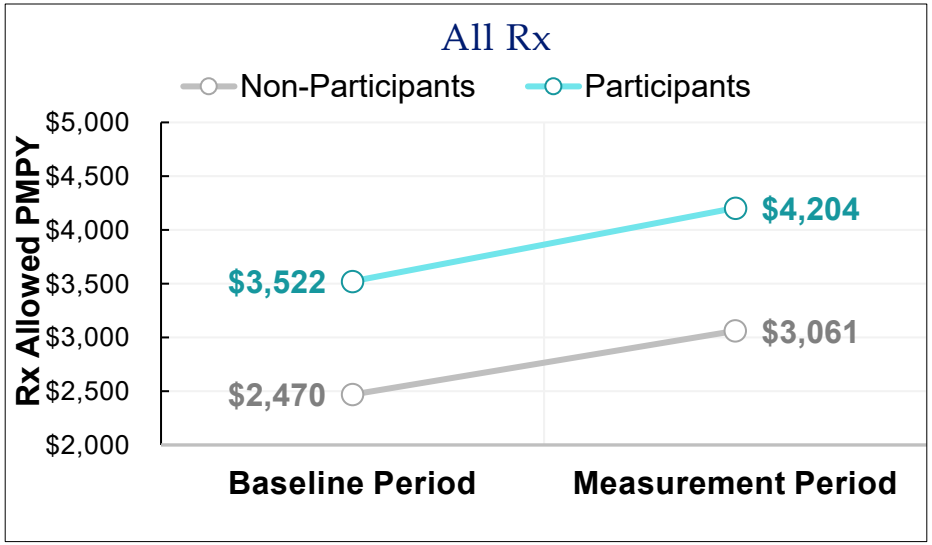
Observations

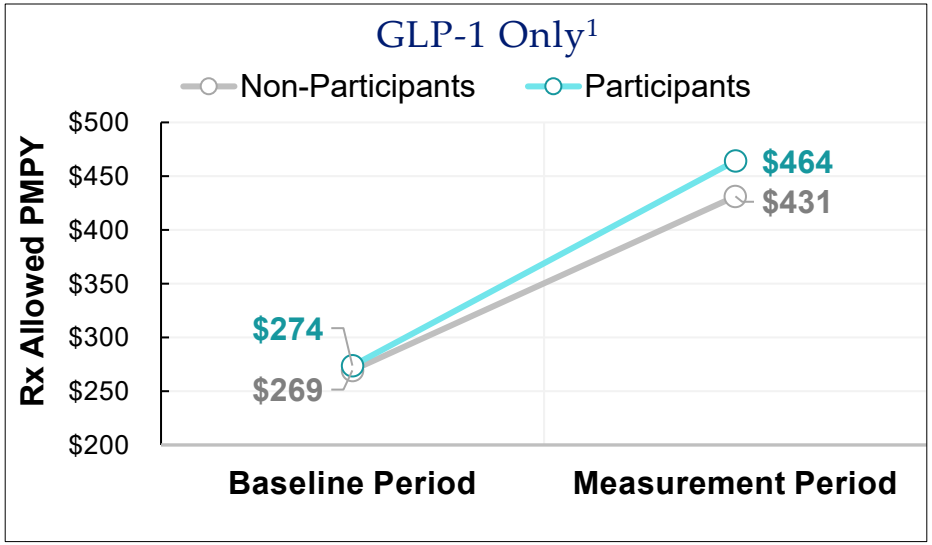
- For matched participants with statistical twins, hospital admissions increased from 38.9 to 48.3 per 1,000 members for participants (+24.1%) and increased from 41.9 to 50.8 per 1,000 for non-participants (+21.4%).
  - The increase in hospital admissions was driven by genitourinary disorders, cancer, and skin infections.
- CVD-related[1] hospital admissions increased from 8.0 to 13.4 per 1,000 for participants (+66.7%) and increased from 6.5 to 12.7 per 1,000 for non-participants (+96.6%).
  - The increase in CVD-related hospital admissions was driven by coronary atherosclerosis, hypertension complicating childbirth, and phlebitis.

[1] CVD-related only includes claims with a cardiovascular-related primary, secondary, or tertiary diagnosis code. Examples include: myocardial infarction, cardiac arrhythmias, heart failure, hypertension, ischemic heart disease, peripheral and visceral vascular disease, and valvular disease.

Point Solution Program Evaluation

Pharmacy (Rx) Costs (Matched)





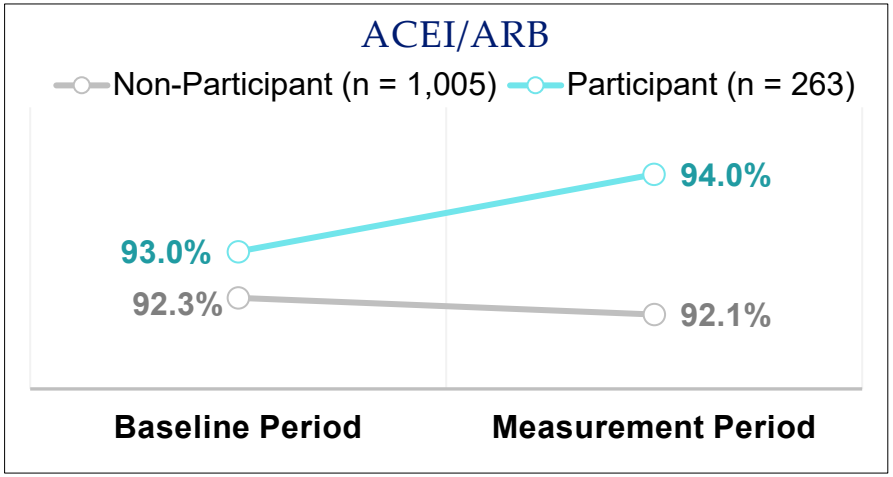
Observations

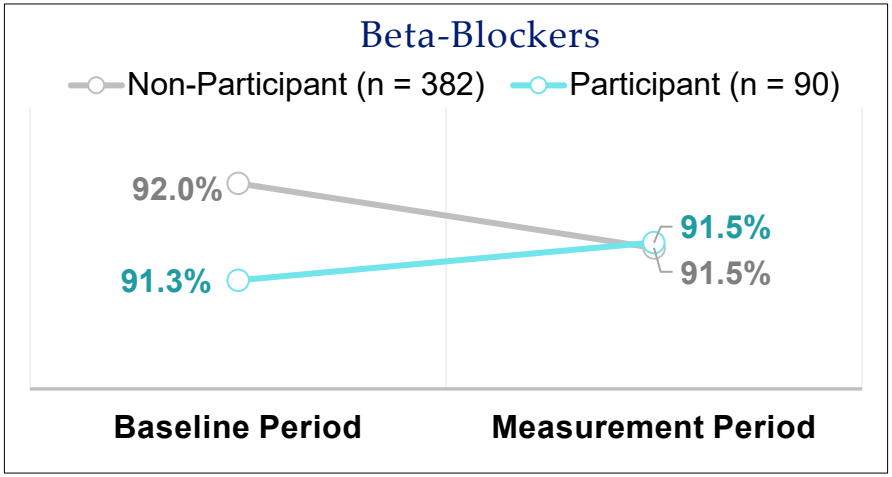
- For matched participants with statistical twins, Rx costs increased from $3,522 to $4,204 PMPY for participants (+19.4%) and increased from $2,470 to $3,061 PMPY for non-participants (+23.9%).
- GLP-1 only[1] Rx costs increased from $274 to $464 PMPY for participants (+69.6%) and increased from $269 to $431 PMPY for non-participants (+60.1%).

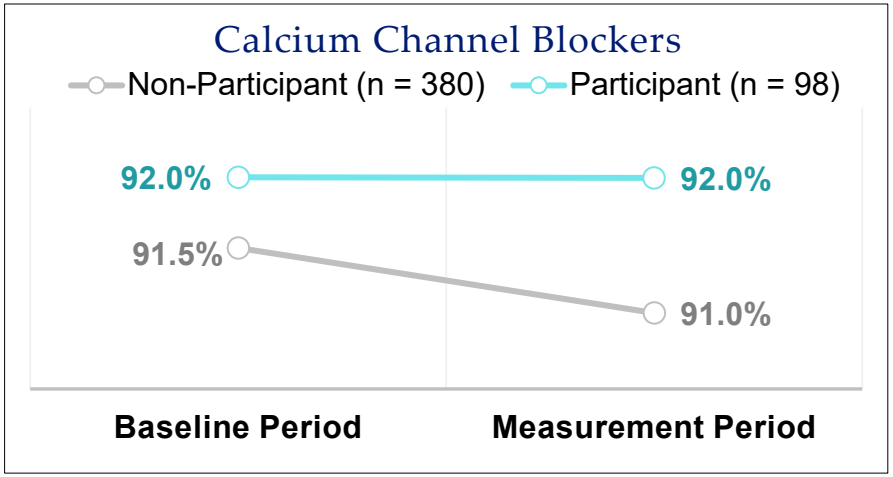
[1] *GLP-1 = Glucagon-like peptide-1 agonists*

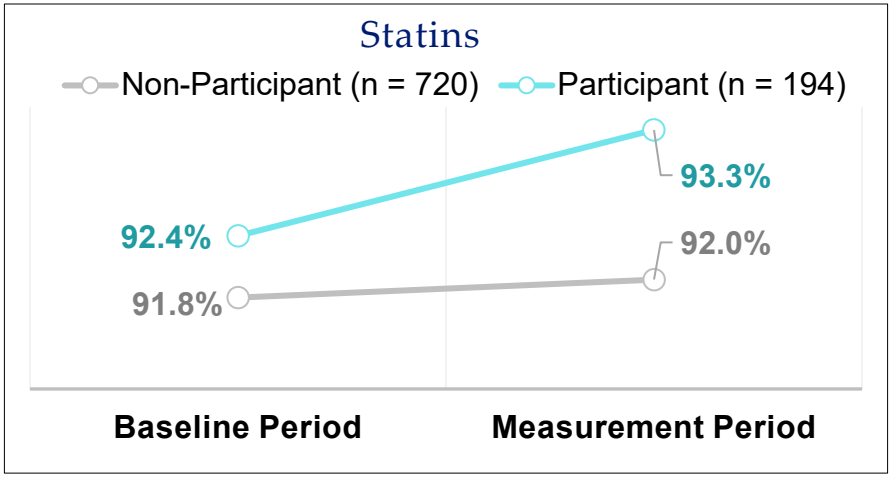
Point Solution Program Evaluation

Medication Adherence – Average Proportion of Days Covered (PDC)







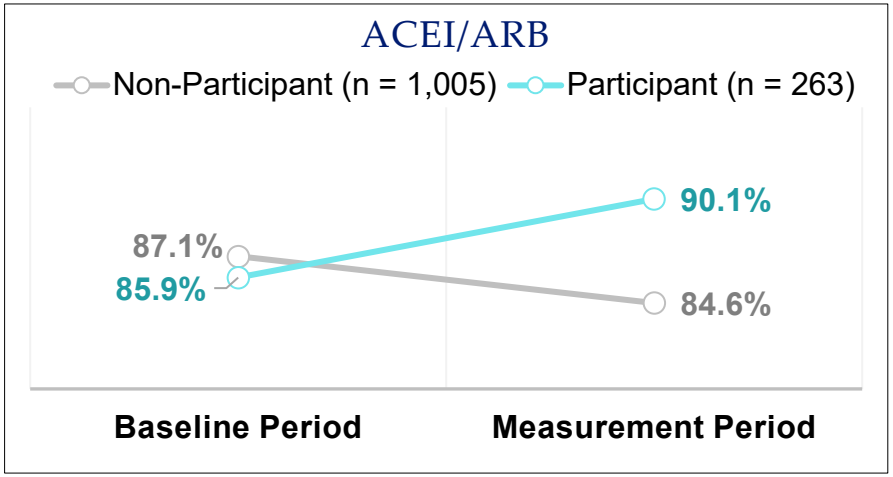


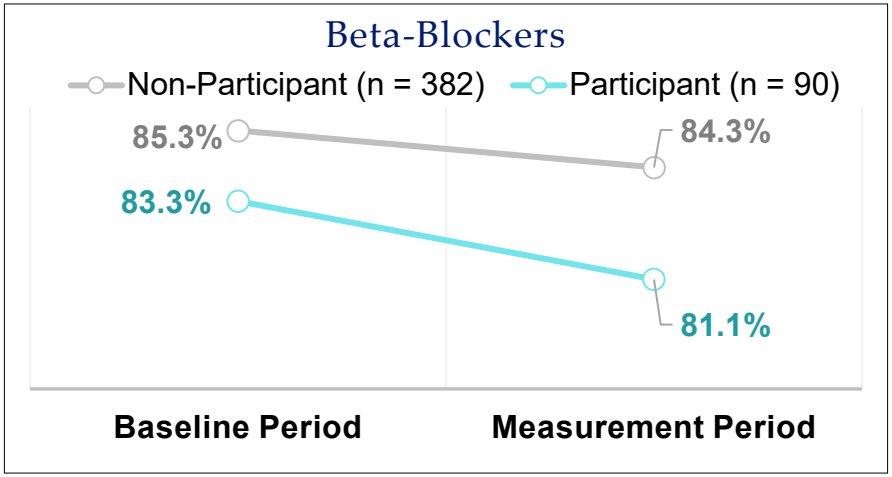
Observations

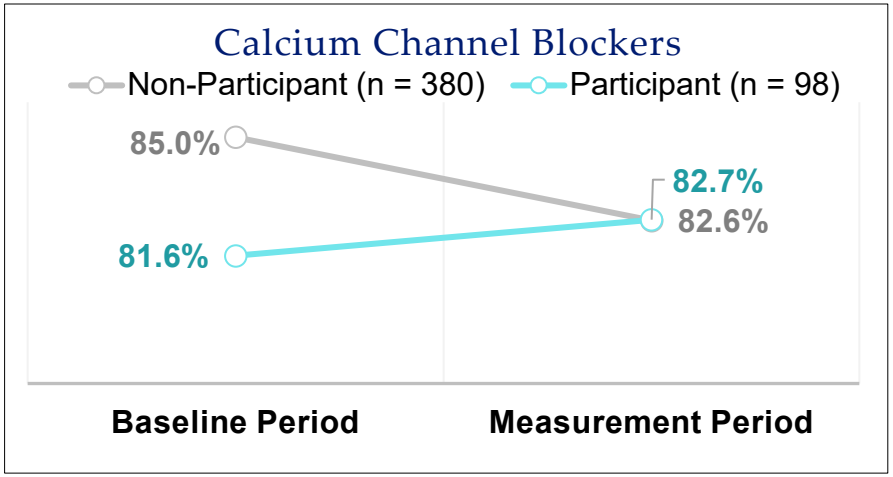
- The average post-year PDC for participants was equal to or exceeded pre-year averages in all four medication categories while 3 of 4 categories decreased slightly for non-participants.

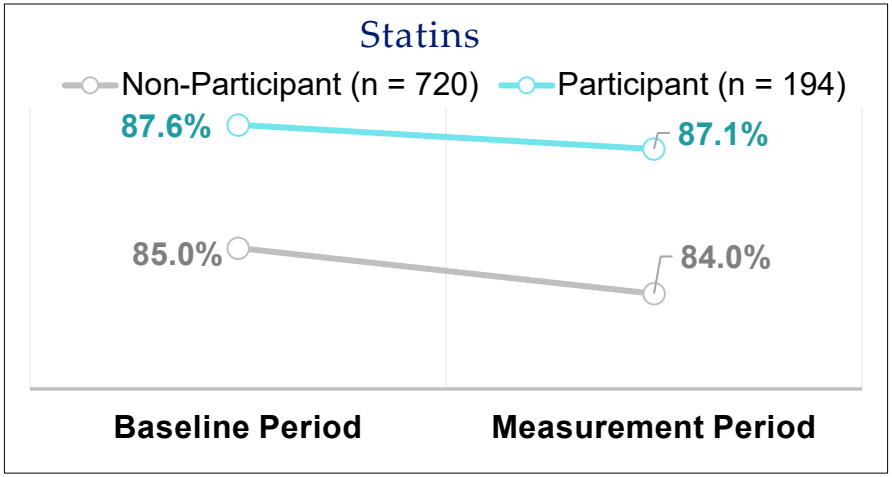
Point Solution Program Evaluation

Medication Adherence – Adherence Rate [% of members with PDC >= 80%]









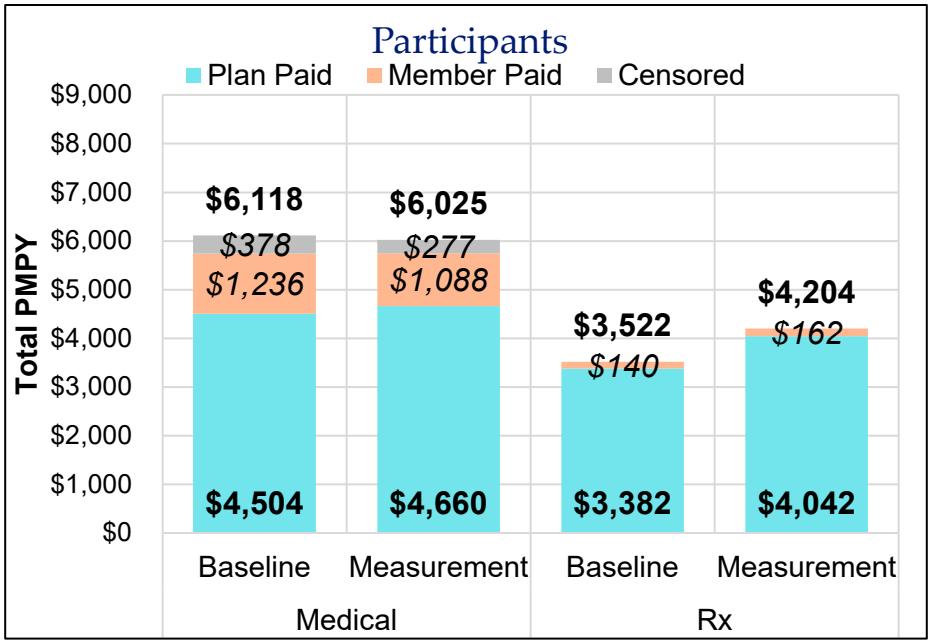
Observations

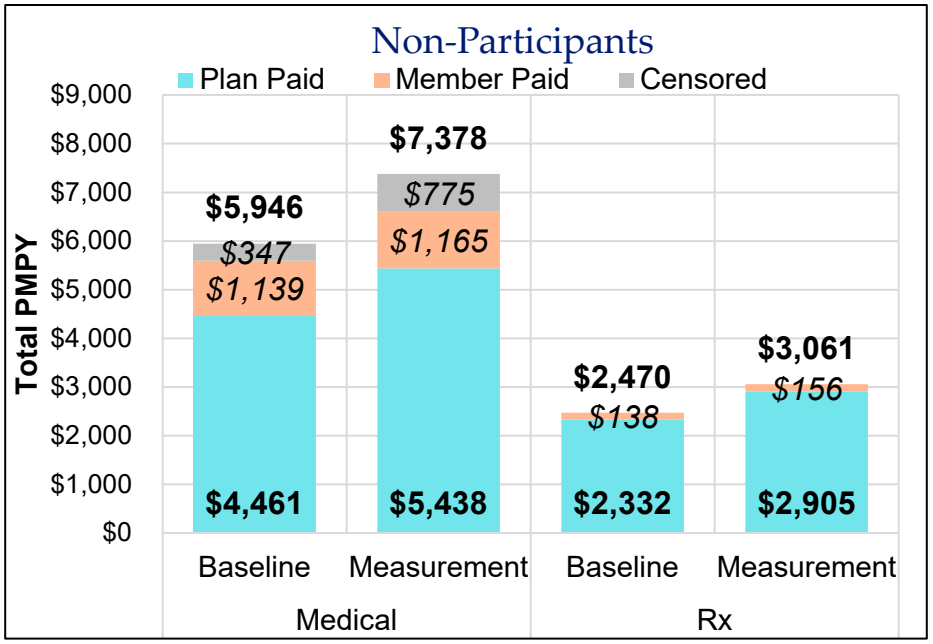
- The % of members adherent[1] to preferred anti-hypertensive therapy (i.e., ACEI/ARB) improved from 85.9% to 90.1% for participants while decreasing from 87.1% to 84.6% for non-participants. A slight improvement was also seen in adherence rates for calcium channel blockers for participants (81.6% to 82.7%) compared to a decrease in non-participants (85.0% to 82.6%)

[1] *Adherence does not account for possible intentional drug discontinuation.*

Point Solution Program Evaluation

Return on Investment (ROI) Calculation – Cost Breakdown



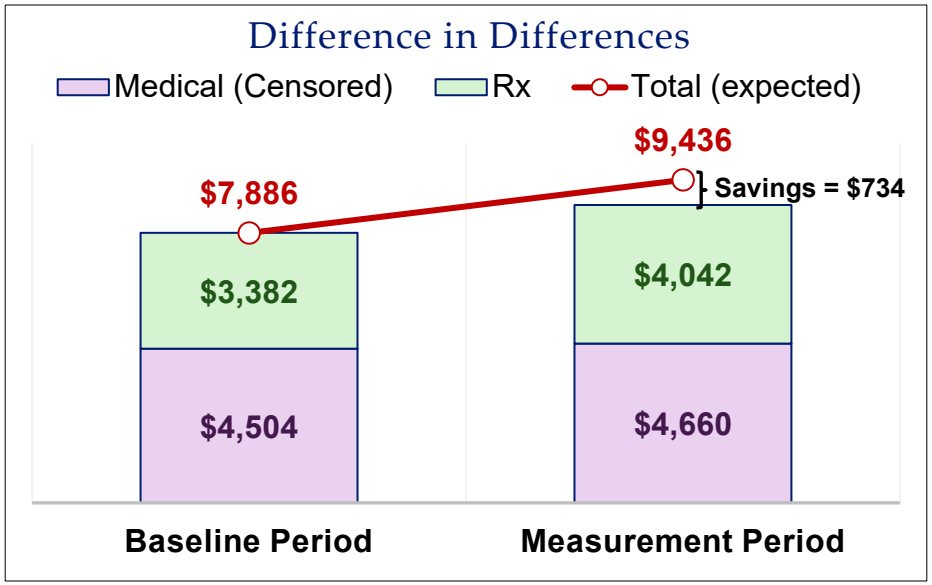


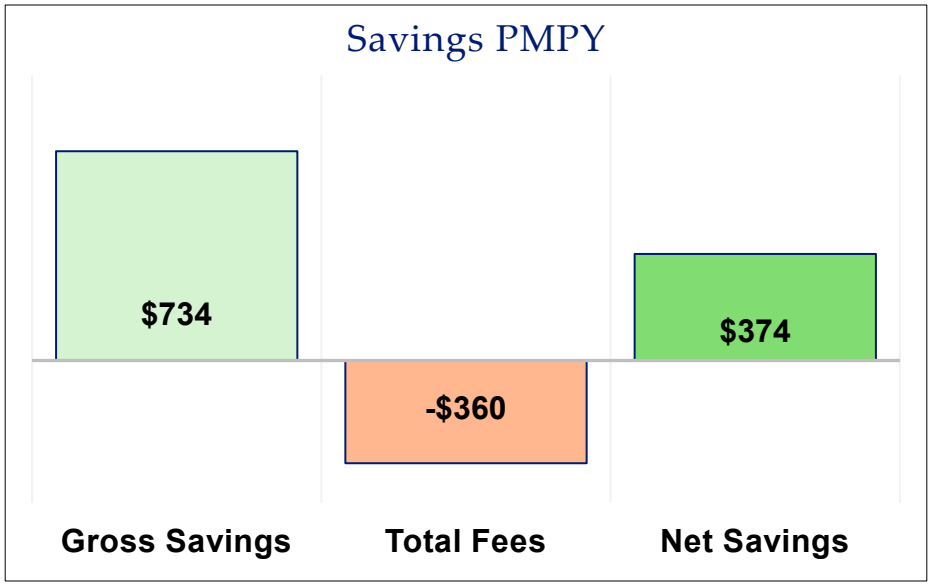
Observations

- The difference in differences approach used to calculate ROI on the following page is based on costs paid by the plan and censors medical claims at $100k per individual (turquoise only). The charts above summarize the overall affect of these components for both participants and non-participants.
  - The total allowed amount (bold number at the top of bars; $6,118, $6,025, etc.) is the number shown on the previous exhibits for both medical and Rx. Total allowed PMPY (medical + Rx) increased $589 for participants versus $2,023 for non-participants.
  - The grey area of the chart is the value of the censored claims above $100k per individual (only applicable to medical).
  - The orange area represents the amount paid by member cost-sharing. Member paid PMPY decreased $125 for participants and increased $45 for non-participants.
  - The turquoise area on the bottom represents the total amount paid by the plan after member cost-sharing and censoring, which is ultimately used in the ROI calculation.

Point Solution Program Evaluation

Return on Investment (ROI) Calculation





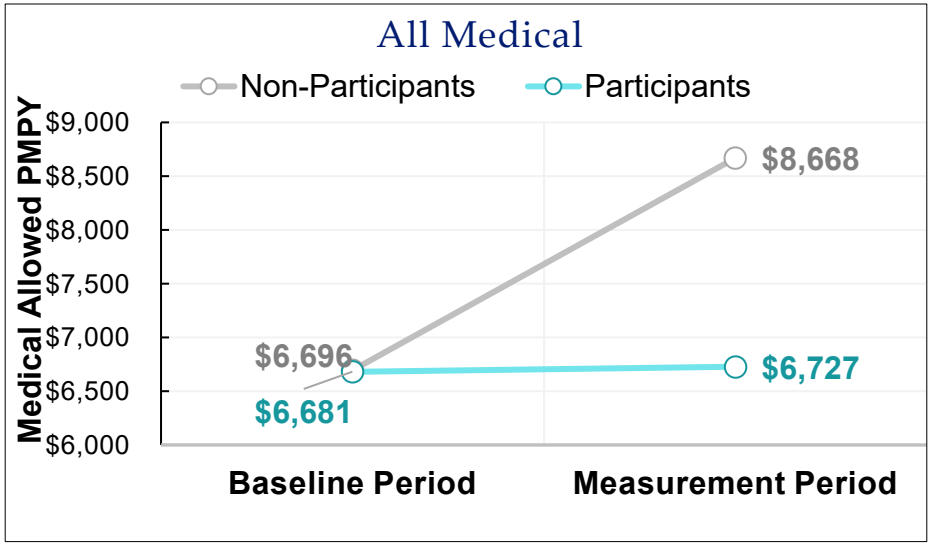
$$\textbf{Return on Investment (ROI)} = \frac{\textbf{Gross Savings PMPY}}{\textbf{Total Fees PMPY}} = \frac{\$734}{\$360} = 2.0$$

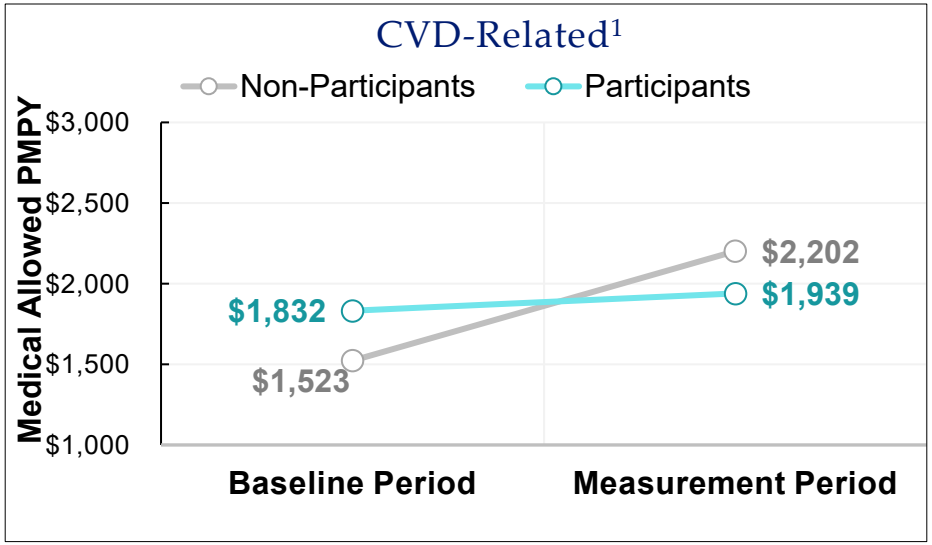
Observations

- The difference in differences approach above censors medical claims at $100k per individual and compares the change in non-participant costs PMPY to the change in participant costs PMPY to derive total expected costs (see previous page for breakdown).
  - Costs represent medical and prescription drug expenses paid by the plan and do not include rebates.
  - Overall healthcare costs (medical censored + Rx) increased $816 PMPY for program participants versus $1,550 PMPY for non-participants, resulting in a savings for program participants of $734 PMPY.

Appendix

Medical Costs (Unmatched)





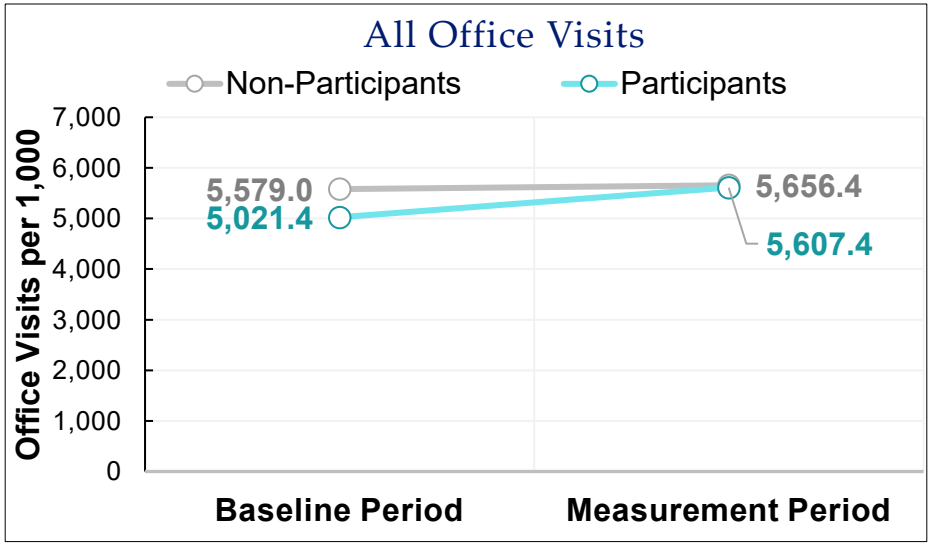
Observations

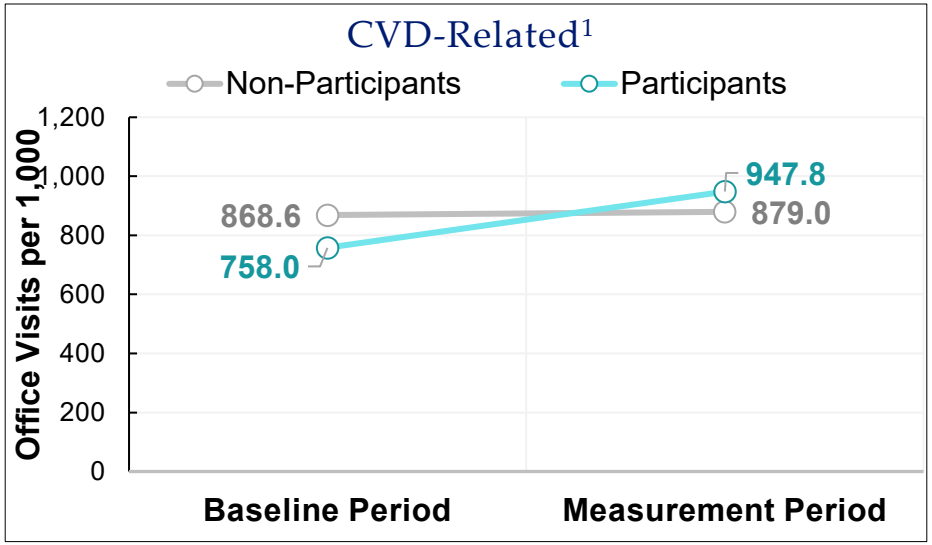
- For all participants prior to matching (843 participants and 2,587 non-participants prior to matching only statistical twins), medical costs increased from $6,681 to $6,727 per member per year (PMPY) for participants (+0.7%) and increased from $6,696 to $8,668 PMPY for non-participants (+29.4%).
- CVD-related[1] medical costs increased from $1,832 to $1,939 PMPY for participants (+5.8%) and increased from $1,523 to $2,202 PMPY for non-participants (+44.5%).

[1] CVD-related only includes claims with a cardiovascular-related primary, secondary, or tertiary diagnosis code. Examples include: myocardial infarction, cardiac arrhythmias, heart failure, hypertension, ischemic heart disease, peripheral and visceral vascular disease, and valvular disease.

Appendix

Office Visits (Unmatched)





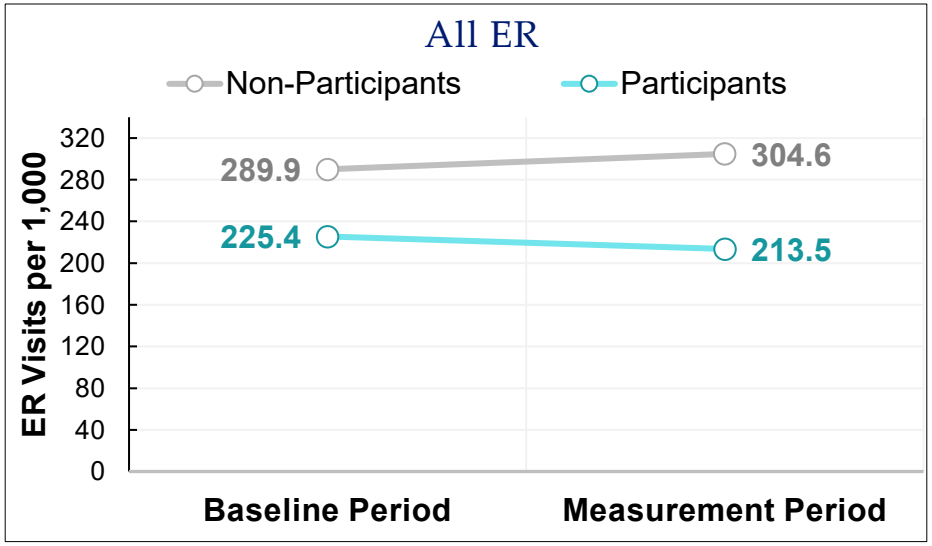
Observations

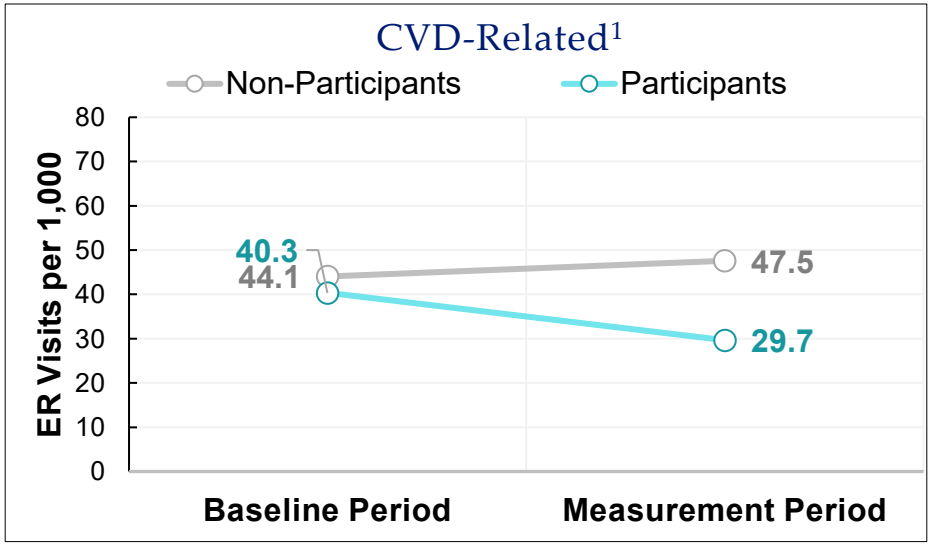
- For all participants prior to matching (i.e. unmatched), office visits increased from 5,021.4 to 5,607.4 per 1,000 members for participants (+11.7%) and increased from 5,579.0 to 5,656.4 per 1,000 for non-participants (+1.4%).
- CVD-related[1] office visits increased from 758.0 to 947.8 per 1,000 for participants (+25.0%) and increased from 868.6 to 879.0 per 1,000 for non-participants (+1.2%).

[1] CVD-related only includes claims with a cardiovascular-related primary, secondary, or tertiary diagnosis code. Examples include: myocardial infarction, cardiac arrhythmias, heart failure, hypertension, ischemic heart disease, peripheral and visceral vascular disease, and valvular disease.

Appendix

Emergency Room (ER) Visits (Unmatched)





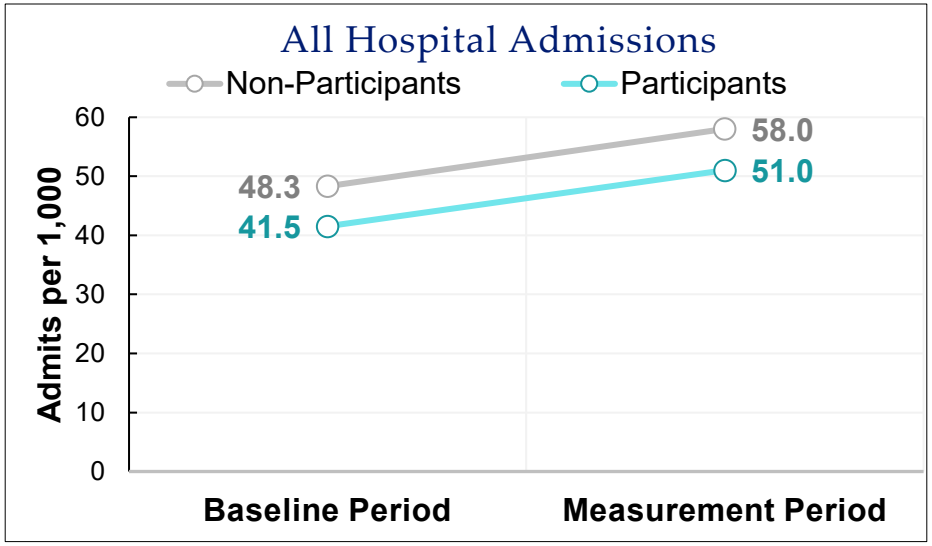
Observations

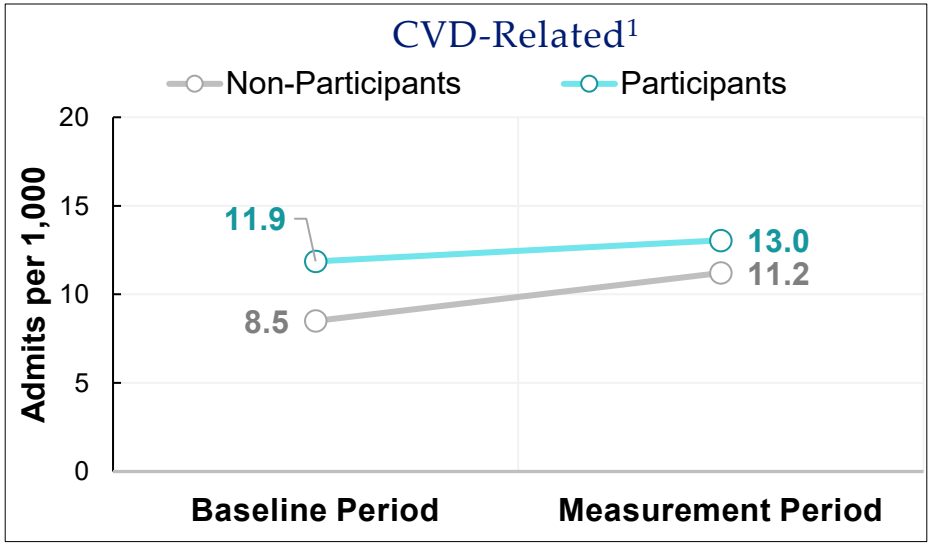
- For all participants prior to matching (i.e. unmatched), ER visits decreased from 225.4 to 213.5 per 1,000 members for participants (-5.3%) and increased from 289.9 to 304.6 per 1,000 for non-participants (+5.1%).
- CVD-related[1] ER visits decreased from 40.3 to 29.7 per 1,000 for participants (-26.5%) and increased from 44.1 to 47.5 per 1,000 for non-participants (+7.9%).

[1] CVD-related only includes claims with a cardiovascular-related primary, secondary, or tertiary diagnosis code. Examples include: myocardial infarction, cardiac arrhythmias, heart failure, hypertension, ischemic heart disease, peripheral and visceral vascular disease, and valvular disease.

Appendix

Hospital Admissions (Unmatched)





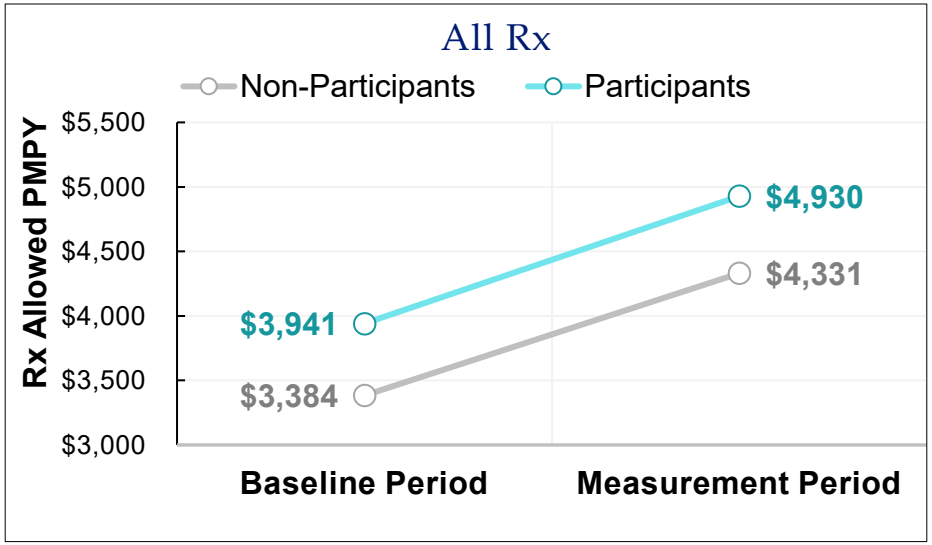
Observations

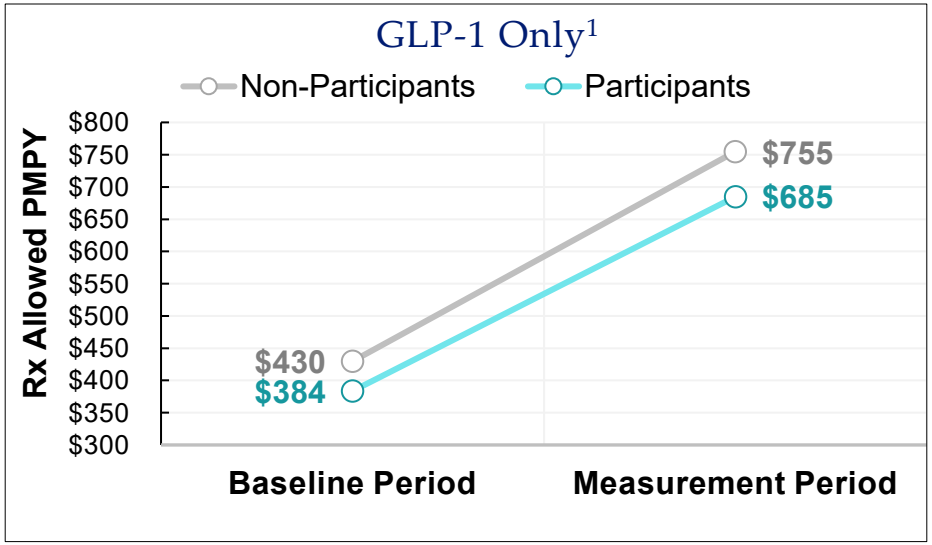
- For all participants prior to matching (i.e. unmatched), hospital admissions increased from 41.5 to 51.0 per 1,000 members for participants (+22.9%) and increased from 48.3 to 58.0 per 1,000 for non-participants (+20.0%).
- CVD-related[1] hospital admissions increased from 11.9 to 13.0 per 1,000 for participants (+10.0%) and increased from 8.5 to 11.2 per 1,000 for non-participants (+31.8%).

[1] CVD-related only includes claims with a cardiovascular-related primary, secondary, or tertiary diagnosis code. Examples include: myocardial infarction, cardiac arrhythmias, heart failure, hypertension, ischemic heart disease, peripheral and visceral vascular disease, and valvular disease.

Appendix

Pharmacy (Rx) Costs (Unmatched)





Observations

- For all participants prior to matching, Rx costs increased from $3,941 to $4,930 PMPY for participants (+25.1%) and increased from $3,384 to $4,331 PMPY for non-participants (+28.0%).
- GLP-1 only[1] Rx costs increased from $383 to $685 PMPY for participants (+78.5%) and increased from $430 to $755 PMPY for non-participants (+75.6%).

[1] *GLP-1 = Glucagon-like peptide-1 agonists*

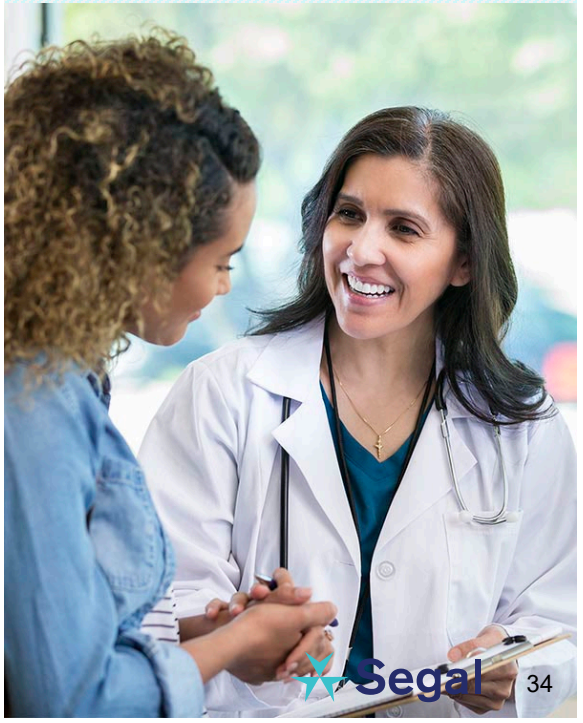
Appendix
Methodology

Medication Adherence

- Medication adherence is a measure of how consistently a patient follows a prescribed medication treatment plan and has been associated with overall lower health expenditures and reduced risks of poor treatment outcomes and reduced and/or delayed development of comorbid conditions.[1]
  - Medication adherence is typically measured by the proportion of days covered (PDC), which calculates the number of days an individual has medication available (days covered) within a specified window (typically calendar year) in a specific group of medications. A member who refills early will have the overlapping days shifted to ensure the PDC does not exceed 100% (see appendix).
    - A member is considered "Adherent" if the PDC is 80% or greater
  - This report has PDC measurements for 4 common medication classes including beta-blockers [BB], calcium channel blockers [CCB], diabetes [DM], renin-angiotensin system antagonists [RASA] (aka "ACEI/ARBs"), and statins. These medications are common treatments for hypertension, cardiovascular disease, and hyperlipidemia.
    - For overall adherence, a member's total days covered across all eligible medication groups is divided by the total days in the period for each group. If a member has 300 days covered of 365 for diabetes and 100 days covered of 120 days for statins, the overall PDC is (300+100) / (365+120) = 82.47% and is "adherent".
- Complete methodology for medication adherence can be found on the Pharmacy Quality Alliance website (https://www.pqaalliance.org/measures-overview)
  - Members included must be 18 years of age at the start of the reporting period
  - Must have 2 or more prescriptions within a medication class prescribed
  - Total days supply for the prescriptions within a class must total at least 91 days
  - Members must have continuous enrollment
  - Limitation: Adherence does not account for possible intentional drug discontinuation

Appendix
A Word About Privacy

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



Kansas State Employees Health Care Commission
2024 Variance Report - Through October
Budget vs. Actual

	Jan-2024			Feb-2024			Mar-2024		
	Initial Budget	Actual	Gain/(Loss)	Initial Budget	Actual	Gain/(Loss)	Initial Budget	Actual	Gain/(Loss)
Revenue									
State ER	35,121,838	35,121,838	-	29,145,973	29,145,973	-	31,265,232	31,344,883	79,651
State EE	6,063,319	6,063,319	-	6,051,048	6,051,048	-	6,622,634	6,567,514	(55,120)
Non-State ER	4,364,382	4,364,382	-	4,325,908	4,325,908	-	4,295,680	4,246,655	(49,025)
Non-State EE	749,369	749,369	-	739,149	739,149	-	722,656	739,314	16,658
Direct Bill	2,663,157	2,663,157	-	2,611,375	2,611,375	-	2,621,281	2,620,835	(446)
COBRA	176,630	176,630	-	128,824	128,824	-	111,004	109,053	(1,951)
Voluntary Benefit	312,485	312,485	-	314,039	314,039	-	332,348	339,019	6,671
Interest/Other	249,049	249,049	-	270,227	270,227	-	278,548	268,500	(10,048)
Administrative Fund	308,509	308,509	-	308,042	308,042	-	270,688	306,095	35,406
Total	**50,008,739**	**50,008,739**	**-**	**43,894,585**	**43,894,585**	**-**	**46,520,071**	**46,541,867**	**21,796**
Expenses									
Medical Claims	28,041,354	28,041,354	-	23,362,081	23,362,081	-	27,523,968	30,487,640	(2,963,673)
Rx Claims	7,975,225	7,975,225	-	6,917,534	6,917,534	-	7,016,285	7,458,001	(441,717)
Dental Claims	2,009,685	2,009,685	-	2,145,289	2,145,289	-	2,742,165	2,585,376	156,789
Health Savings ER	6,414,299	6,414,299	-	1,378,068	1,378,068	-	685,603	704,655	(19,053)
ASO/Premium	3,512,695	3,222,995	289,700	3,574,505	3,284,435	290,069	3,574,810	3,564,905	9,905
Voluntary Benefit	312,485	312,485	-	314,039	314,039	-	332,348	339,019	(6,671)
Onsite Clinic (Marathon)	206,872	206,872	-	183,065	183,065	-	175,830	183,005	(7,175)
Other Contract Fees/Flex	40,762	40,762	-	42,379	42,378.86	-	53,936	42,100	11,836
PCORI	-	-	-	-	-	-	-	-	-
Administrative Fund	431,884	431,884	-	422,909	422,909	-	426,057	447,311	(21,254)
Total	**48,945,260**	**48,655,560**	**289,700**	**38,339,867**	**38,049,798**	**290,069**	**42,531,000**	**45,812,013**	**(3,281,012)**
Net Cash Flow	**1,063,479**	**1,353,179**	**289,700**	**5,554,717**	**5,844,787**	**290,069**	**3,989,071**	**729,854**	**(3,259,216)**
Beginning Balance (Reserve Fund)	58,052,785	58,052,785	-	59,239,640	59,529,339	289,700	64,909,224	65,488,993	579,769
Ending Balance (Reserve Fund)	59,239,640	59,529,339	289,700	64,909,224	65,488,993	579,769	69,053,663	66,360,064	(2,693,599)
Beginning Balance (Administrative Fund)	8,798,683	8,798,683	-	8,675,308	8,675,308	-	8,560,441	8,560,441	-
Ending Balance (Administrative Fund)	8,675,308	8,675,308	-	8,560,441	8,560,441	-	8,405,072	8,419,224	14,152
Beginning Balance (Both Funds)	66,851,469	66,851,469	-	67,914,948	68,204,647	289,700	73,469,665	74,049,434	579,769
Ending Balance (Both Funds)	67,914,948	68,204,647	289,700	73,469,665	74,049,434	579,769	77,458,735	74,779,288	(2,679,447)

Enrollment (Subscriber)	Initial	Updated	Difference	Initial	Updated	Difference	Initial	Updated	Difference
Active	37,848	37,848	-	37,924	37,924	-	38,037	38,037	-
COBRA	133	133	-	120	120	-	103	103	-
Non-Medicare Retiree	387	387	-	377	377	-	385	385	-
Medicare Retiree	7,895	7,895	-	7,876	7,876	-	7,852	7,852	-
Total	46,263	46,263	-	46,297	46,297	-	46,377	46,377	-
Revenue PEPM	1,081	1,081	-	948	948	-	1,003	1,004	0
Expenses PEPM	1,058	1,052	(6)	828	822	(6)	917	988	71

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	Apr-2024			May-2024			Jun-2024		
	Initial Budget	Actual	Gain/(Loss)	Initial Budget	Actual	Gain/(Loss)	Initial Budget	Actual	Gain/(Loss)
Revenue									
State ER	37,703,511	37,777,883	74,372	31,171,042	31,167,879	(3,163)	26,340,049	26,668,481	328,432
State EE	6,622,634	6,615,669	(6,965)	6,622,634	6,585,361	(37,273)	5,499,232	5,574,145	74,913
Non-State ER	4,295,680	4,331,251	35,571	4,295,680	4,377,733	82,053	4,295,680	4,320,906	25,226
Non-State EE	722,656	740,431	17,775	722,656	754,038	31,382	722,656	731,657	9,000
Direct Bill	2,621,281	2,598,383	(22,898)	2,621,281	2,622,638	1,357	2,621,281	2,599,615	(21,666)
COBRA	111,004	108,871	(2,133)	111,004	100,005	(10,998)	111,004	100,025	(10,978)
Voluntary Benefit	332,348	340,325	7,978	332,348	338,163	5,816	332,348	288,496	(43,852)
Interest/Other	278,548	301,244	22,696	488,548	510,309	21,761	488,548	472,150	(16,398)
Administrative Fund	270,688	308,165	37,476	270,688	305,986	35,298	270,688	290,610	19,922
Total	**52,958,350**	**53,122,222**	**163,872**	**46,635,881**	**46,762,113**	**90,934**	**40,681,486**	**41,046,086**	**364,599**
Expenses									
Medical Claims	27,039,926	26,308,025	731,901	32,264,069	32,203,969	60,100	26,322,400	21,900,440	4,421,959
Rx Claims	8,432,459	9,028,246	(595,787)	7,968,435	9,060,681	(1,092,246)	8,320,209	6,186,831	2,133,379
Dental Claims	2,201,828	2,340,822	(138,994)	2,763,454	2,769,804	(6,349)	2,216,216	1,897,823	318,393
Health Savings ER	6,983,405	7,029,621	(46,216)	604,507	789,426	(184,920)	674,439	843,584	(169,145)
ASO/Premium	3,574,810	3,267,930	306,880	3,574,810	4,138,003	(563,193)	3,574,810	3,571,922	2,888
Voluntary Benefit	332,348	340,325	(7,978)	332,348	338,163	(5,816)	332,348	288,496	43,852
Onsite Clinic (Marathon)	175,830	184,642	(8,812)	175,830	180,617	(4,787)	175,830	195,577	(19,747)
Other Contract Fees/Flex	53,936	42,203	11,733	53,936	41,922	12,014	53,936	48,697	5,238
PCORI	-	-	-	-	-	-	-	-	-
Administrative Fund	426,057	419,866	6,192	426,057	411,992	14,065	426,057	450,346	(24,288)
Total	**49,220,599**	**48,961,681**	**258,918**	**48,163,445**	**49,934,577**	**(1,771,132)**	**42,096,244**	**35,383,715**	**6,712,529**
Net Cash Flow	**3,737,751**	**4,160,541**	**422,791**	**(1,527,564)**	**(3,172,464)**	**(1,680,198)**	**(1,414,758)**	**5,662,370**	**7,077,129**
Beginning Balance (Reserve Fund)	69,053,663	66,360,064	(2,693,599)	72,946,783	70,632,307	(2,314,476)	71,574,588	67,565,848	(4,008,739)
Ending Balance (Reserve Fund)	72,946,783	70,632,307	(2,314,476)	71,574,588	67,565,848	(4,008,739)	70,315,199	73,387,954	3,072,755
Beginning Balance (Administrative Fund)	8,405,072	8,419,224	14,152	8,249,703	8,307,523	57,820	8,094,334	8,201,517	107,183
Ending Balance (Administrative Fund)	8,249,703	8,307,523	57,820	8,094,334	8,201,517	107,183	7,938,965	8,041,781	102,816
Beginning Balance (Both Funds)	77,458,735	74,779,288	(2,679,447)	81,196,486	78,939,830	(2,256,656)	79,668,922	75,767,365	(3,901,557)
Ending Balance (Both Funds)	81,196,486	78,939,830	(2,256,656)	79,668,922	75,767,365	(3,901,557)	78,254,164	81,429,736	3,175,572

Enrollment (Subscriber)	**Initial**	**Updated**	**Difference**	**Initial**	**Updated**	**Difference**	**Initial**	**Updated**	**Difference**
Active	38,037	38,011	(26)	38,037	37,928	(109)	38,037	37,950	(87)
COBRA	103	93	(10)	103	93	(10)	103	91	(12)
Non-Medicare Retiree	385	402	17	385	407	22	385	408	23
Medicare Retiree	7,852	7,820	(32)	7,852	7,788	(64)	7,852	7,771	(81)
Total	46,377	46,326	(51)	46,377	46,216	(161)	46,377	46,220	(157)
Revenue PEPM	1,142	1,147	5	1,006	1,012	6	877	888	11
Expenses PEPM	1,061	1,057	(4)	1,039	1,080	42	908	766	(142)

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	Jul-2024			Aug-2024			Sep-2024		
	Initial Budget	Actual	Gain/(Loss)	Initial Budget	Actual	Gain/(Loss)	Initial Budget	Actual	Gain/(Loss)
Revenue									
State ER	34,060,385	33,991,959	(68,426)	27,737,916	28,492,255	754,339	30,211,317	31,412,635	1,201,318
State EE	5,499,232	5,572,653	73,421	5,499,232	5,635,323	136,091	6,060,933	6,288,847	227,914
Non-State ER	4,507,961	4,532,406	24,445	4,507,961	4,546,486	38,525	4,507,961	4,533,610	25,649
Non-State EE	722,656	723,613	956	722,656	742,260	19,604	722,656	743,658	21,002
Direct Bill	2,621,281	2,624,965	3,684	2,621,281	2,609,442	(11,839)	2,621,281	2,621,866	585
COBRA	111,004	96,345	(14,659)	111,004	132,276	21,272	111,004	113,636	2,633
Voluntary Benefit	332,348	288,065	(44,283)	332,348	290,438	(41,909)	332,348	319,455	(12,893)
Interest/Other	480,693	461,064	(19,630)	480,693	479,128	(1,565)	480,693	467,015	(13,678)
Administrative Fund	270,688	285,818	15,130	270,688	288,585	17,897	270,688	305,246	34,557
Total	**48,606,248**	**48,576,887**	**(29,361)**	**42,283,779**	**43,216,194**	**932,415**	**45,318,881**	**46,805,969**	**1,487,087**
Expenses									
Medical Claims	26,363,919	33,717,983	(7,354,063)	34,392,109	36,069,009	(1,676,900)	26,477,574	29,442,183	(2,964,609)
Rx Claims	7,980,608	6,182,002	1,798,606	8,163,646	9,838,979	(1,675,334)	9,265,016	10,216,637	(951,620)
Dental Claims	2,221,682	2,731,846	(510,164)	2,783,951	2,558,684	225,267	2,232,654	2,239,963	(7,309)
Health Savings ER	6,872,219	6,559,594	312,625	471,711	678,195	(206,484)	446,189	914,070	(467,881)
ASO/Premium	3,574,810	3,522,258	52,551	3,574,810	3,528,289	46,520	3,574,810	3,529,773	45,037
Voluntary Benefit	332,348	288,065	44,283	332,348	290,438	41,909	332,348	319,455	12,893
Onsite Clinic (Marathon)	175,830	184,711	(8,881)	175,830	178,249	(2,419)	175,830	178,362	(2,532)
Other Contract Fees/Flex	53,936	40,835	13,100	53,936	40,950	12,986	53,936	41,387	12,549
PCORI	205,000	194,591	10,409	-	-	-	-	-	-
Administrative Fund	426,057	451,034	(24,977)	426,057	474,718	(48,661)	426,057	438,359	(12,302)
Total	**48,206,409**	**53,872,919**	**(5,666,511)**	**50,374,397**	**53,657,513**	**(3,283,116)**	**42,984,413**	**47,320,188**	**(4,335,775)**
Net Cash Flow	**399,839**	**(5,296,033)**	**(5,695,872)**	**(8,090,618)**	**(10,441,319)**	**(2,350,701)**	**2,334,469**	**(514,219)**	**(2,848,688)**
Beginning Balance (Reserve Fund)	70,315,199	73,387,954	3,072,755	70,870,407	68,257,138	(2,613,269)	62,935,159	58,001,952	(4,933,206)
Ending Balance (Reserve Fund)	70,870,407	68,257,138	(2,613,269)	62,935,159	58,001,952	(4,933,206)	65,424,996	57,620,846	(7,804,150)
Beginning Balance (Administrative Fund)	7,938,965	8,041,781	102,816	7,783,596	7,876,565	92,969	7,628,227	7,690,432	62,205
Ending Balance (Administrative Fund)	7,783,596	7,876,565	92,969	7,628,227	7,690,432	62,205	7,472,858	7,557,319	84,460
Beginning Balance (Both Funds)	78,254,164	81,429,736	3,175,572	78,654,003	76,133,703	(2,520,300)	70,563,386	65,692,384	(4,871,002)
Ending Balance (Both Funds)	78,654,003	76,133,703	(2,520,300)	70,563,386	65,692,384	(4,871,002)	72,897,854	65,178,165	(7,719,689)
Enrollment (Subscriber)	**Initial**	**Updated**	**Difference**	**Initial**	**Updated**	**Difference**	**Initial**	**Updated**	**Difference**
Active	38,037	37,709	(328)	38,037	37,823	(214)	38,037	38,165	128
COBRA	103	94	(9)	103	112	9	103	111	8
Non-Medicare Retiree	385	431	46	385	429	44	385	440	55
Medicare Retiree	7,852	7,754	(98)	7,852	7,708	(144)	7,852	7,696	(156)
Total	46,377	45,988	(389)	46,377	46,072	(305)	46,377	46,412	35
Revenue PEPM	1,048	1,056	8	912	938	26	977	1,008	31
Expenses PEPM	1,039	1,171	132	1,086	1,165	78	927	1,020	93

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	Oct-2024			Nov-2024			Dec-2024		
	Initial Budget	Actual	Gain/(Loss)	Initial Budget	Updated Budget	Gain/(Loss)	Initial Budget	Updated Budget	Gain/(Loss)
Revenue									
State ER	36,533,787	37,230,263	696,476	30,211,317	30,489,920	278,602	30,211,317	30,489,920	278,602
State EE	6,060,933	6,221,945	161,012	6,060,933	6,139,133	78,200	6,060,933	6,139,133	78,200
Non-State ER	4,507,961	4,635,868	127,907	4,507,961	4,511,958	3,997	4,507,961	4,511,958	3,997
Non-State EE	722,656	764,148	41,492	722,656	731,253	8,597	722,656	731,253	8,597
Direct Bill	2,621,281	2,612,700	(8,581)	2,621,281	2,621,637	356	2,621,281	2,621,637	356
COBRA	111,004	110,962	(42)	111,004	114,227	3,223	111,004	114,227	3,223
Voluntary Benefit	332,348	316,608	(15,740)	332,348	329,167	(3,181)	332,348	329,167	(3,181)
Interest/Other	480,693	383,486	(97,207)	480,693	438,911	(41,782)	480,693	438,911	(41,782)
Administrative Fund	270,688	304,583	33,895	270,688	272,747	2,059	270,688	272,747	2,059
Total	**51,641,351**	**52,580,562**	**939,212**	**45,318,881**	**45,648,953**	**330,072**	**45,318,881**	**45,648,953**	**330,072**
Expenses									
Medical Claims	28,441,796	27,595,146	846,650	37,886,091	30,764,238	7,121,853	27,678,716	35,389,052	(7,710,336)
Rx Claims	8,890,334	11,841,578	(2,951,244)	10,144,611	11,156,637	(1,012,026)	10,333,605	11,414,859	(1,081,254)
Dental Claims	2,238,160	2,146,069	92,091	2,804,600	2,204,723	599,876	2,249,213	2,780,006	(530,792)
Health Savings ER	6,938,147	6,876,244	61,903	674,895	668,936	5,959	476,371	470,536	5,835
ASO/Premium	3,574,810	3,586,599	(11,789)	3,574,810	3,534,594	40,216	3,574,810	3,534,594	40,216
Voluntary Benefit	332,348	316,608	15,740	332,348	329,167	3,181	332,348	329,167	3,181
Onsite Clinic (Marathon)	175,830	172,067	3,763	175,830	179,020	(3,190)	175,830	179,020	(3,190)
Other Contract Fees/Flex	53,936	42,061	11,875	53,936	51,875	2,061	53,936	51,875	2,061
PCORI	-	-	-	-	-	-	-	-	-
Administrative Fund	426,057	509,042	(82,984)	426,057	426,731	(674)	426,057	427,272	(1,215)
Total	**51,071,417**	**53,085,414**	**(2,013,997)**	**56,073,177**	**49,315,921**	**6,757,256**	**45,300,886**	**54,576,380**	**(9,275,494)**
Net Cash Flow	**569,933**	**(504,852)**	**(1,074,785)**	**(10,754,296)**	**(3,666,968)**	**7,087,328**	**17,996**	**(8,927,427)**	**(8,945,423)**
Beginning Balance (Reserve Fund)	65,424,996	57,620,846	(7,804,150)	66,150,298	57,320,454	(8,829,845)	55,551,371	53,807,469	(1,743,902)
Ending Balance (Reserve Fund)	66,150,298	57,320,454	(8,829,845)	55,551,371	53,807,469	(1,743,902)	55,724,736	45,034,567	(10,690,169)
Beginning Balance (Administrative Fund)	7,472,858	7,557,319	84,460	7,317,489	7,352,860	35,370	7,162,121	7,198,876	36,755
Ending Balance (Administrative Fund)	7,317,489	7,352,860	35,370	7,162,121	7,198,876	36,755	7,006,752	7,044,351	37,599
Beginning Balance (Both Funds)	72,897,854	65,178,165	(7,719,689)	73,467,788	64,673,313	(8,794,474)	62,713,492	61,006,345	(1,707,147)
Ending Balance (Both Funds)	73,467,788	64,673,313	(8,794,474)	62,713,492	61,006,345	(1,707,147)	62,731,487	52,078,918	(10,652,569)
Enrollment (Subscriber)	**Initial**	**Updated**	**Difference**	**Initial**	**Updated**	**Difference**	**Initial**	**Updated**	**Difference**
Active	38,037	38,355	318	38,037	38,355	318	38,037	38,355	318
COBRA	103	107	4	103	107	4	103	107	4
Non-Medicare Retiree	385	446	61	385	446	61	385	446	61
Medicare Retiree	7,852	7,678	(174)	7,852	7,678	(174)	7,852	7,678	(174)
Total	46,377	46,586	209	46,377	46,586	209	46,377	46,586	209
Revenue PEPM	1,114	1,129	15	977	980	3	977	980	3
Expenses PEPM	1,101	1,140	38	1,209	1,059	(150)	977	1,172	195

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	Jan-2024 - Oct-2024			Jan-Dec 2024			
	Initial Budget	Actual	Gain/(Loss)	Initial Budget	Actual/Budget	$ Gain/(Loss)	% Gain/(Loss)
Revenue							
State ER	319,291,051	322,354,050	3,062,998	379,713,686	383,333,889	3,620,203	1.0%
State EE	60,601,830	61,175,824	573,994	72,723,696	73,454,089	730,393	1.0%
Non-State ER	43,904,855	44,215,205	310,350	52,920,777	53,239,122	318,345	0.6%
Non-State EE	7,269,768	7,427,636	157,868	8,715,080	8,890,143	175,063	2.0%
Direct Bill	26,244,782	26,184,977	(59,805)	31,487,345	31,428,252	(59,093)	-0.2%
COBRA	1,193,483	1,176,626	(16,856)	1,415,490	1,405,080	(10,410)	-0.7%
Voluntary Benefit	3,285,305	3,147,093	(138,212)	3,950,000	3,805,426	(144,574)	-3.7%
Interest/Other	3,976,240	3,862,173	(114,067)	4,937,626	4,739,995	(197,631)	-4.0%
Administrative Fund	2,782,057	3,011,638	229,581	3,323,434	3,557,132	233,699	7.0%
Total	**468,549,371**	**472,555,223**	**4,005,852**	**559,187,134**	**563,853,128**	**4,665,995**	**0.8%**
Expenses							
Medical Claims	280,229,195	289,127,830	(8,898,635)	345,794,001	355,281,119	(9,487,118)	-2.7%
Rx Claims	80,929,751	84,705,714	(3,775,963)	101,407,967	107,277,210	(5,869,243)	-5.8%
Dental Claims	23,555,083	23,425,360	129,723	28,608,896	28,410,089	198,807	0.7%
Health Savings ER	31,468,585	32,187,756	(719,171)	32,619,852	33,327,228	(707,376)	-2.2%
ASO/Premium	35,685,677	35,217,110	468,567	42,835,297	42,286,297	549,000	1.3%
Voluntary Benefit	3,285,305	3,147,093	138,212	3,950,000	3,805,426	144,574	3.7%
Onsite Clinic (Marathon)	1,796,576	1,847,166	(50,590)	2,148,236	2,205,206	(56,970)	-2.7%
Other Contract Fees/Flex	514,628	423,297	91,332	622,500	527,047	95,453	15.3%
PCORI	205,000	194,591	10,409	205,000	194,591	10,409	5.1%
Administrative Fund	4,263,251	4,457,461	(194,210)	5,115,366	5,311,465	(196,099)	-3.8%
Total	**461,933,052**	**474,733,378**	**(12,800,326)**	**563,307,115**	**578,625,679**	**(15,318,564)**	**-2.7%**
Net Cash Flow	**6,616,319**	**(2,178,155)**	**(8,794,474)**	**(4,119,981)**	**(14,772,550)**	**(10,652,569)**	
Beginning Balance (Reserve Fund)	58,052,785	58,052,785	-	58,052,785	58,052,785	-	
Ending Balance (Reserve Fund)	66,150,298	57,320,454	(8,829,845)	55,724,736	45,034,567	(10,690,169)	
Beginning Balance (Administrative Fund)	8,798,683	8,798,683	-	8,798,683	8,798,683	-	
Ending Balance (Administrative Fund)	7,317,489	7,352,860	35,370	7,006,752	7,044,351	37,599	
Beginning Balance (Both Funds)	66,851,469	66,851,469	-	66,851,469	66,851,469	-	
Ending Balance (Both Funds)	73,467,788	64,673,313	(8,794,474)	62,731,487	52,078,918	(10,652,569)	

Enrollment (Subscriber)	Initial	Updated	Difference	Initial	Updated	Difference	% Difference
Active	38,007	37,975	(32)	38,012	38,038	27	0.1%
COBRA	108	106	(2)	107	106	(1)	-0.9%
Non-Medicare Retiree	384	411	27	385	417	33	8.5%
Medicare Retiree	7,859	7,784	(75)	7,858	7,766	(91)	-1.2%
Total	46,358	46,276	(82)	46,361	46,327	(33)	-0.1%
Revenue PEPM	1,011	1,021	10	1,005	1,014	9	0.9%
Expenses PEPM	996	1,026	29	1,013	1,041	28	2.8%

DRAFT

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POPULATION RISK REPORT

Actives and Non-Medicare Retirees

August 20, 2024

Doc #: 9989218

Segal

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Background

- Aside from 2023, Segal has prepared a detailed risk study for the State Health Plan (SHP) for the past several years. Consistent with the 2021 and 2022 report, the risk study for this year has been prepared utilizing two different risk models:
  - Clinical Classifications Software Refined (CCSR) developed by the Agency for Healthcare Research and Quality (AHRQ), and
  - SegalRx model developed by health actuaries at Segal.
- The combined risk model provides the following benefits:
  - Provides customizable reports
  - Shows population morbidity changes over time.
  - Provides insights into prescription drug trends
  - Provides a diagnostic tool to assist the SHP in understanding the health of Plan members and the impact of health management and initiatives
- Five years of experience were utilized for the study: calendar year 2019 through calendar year 2023. All experience in this study is shown in the year in which it incurred.
  - Pharmacy rebates are not included in this study.
- Active and non-Medicare retirees and covered dependents are included. Medicare retirees are excluded from the report.
- Note that the 2020 medical risk scores shown throughout this report were artificially low due to underutilization induced by the COVID-19 pandemic.

Objectives

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- Identify the prevalent health risks within the plan's active and non-Medicare retiree population[1] and predict the financial impact of those risks
- Identify emerging health risks
- Understanding the effect of comorbidities and how various chronic conditions interact with each other
- Understanding the effect of mental health disorders and the increased complexity in care management mental health disorders present
- Measure the effectiveness of the wellness programs in improving member health risk over time
- Uncover opportunities for the plan to better control plan cost and improve the health of the covered population
- Measure clinical quality metrics and identify gaps in care
- Quantify health status and underlying drivers of trend
- Proactively identify aberrant utilization patterns
- Improve financial evaluation of program/vendor performance
- Target high risk groups for preventive interventions

[1] See Appendices for more information on the population included in this study.

Understanding Risk Scores

Clinical Classification Software Refined (CCSR) and SegalRx

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- This study utilizes the CCSR risk adjustment model for medical benefits and the SegalRx risk adjustment model for prescription drug benefits. More information regarding both models can be found in the Appendix of this presentation.
- Both models provide risk scores that are to be used as a measure of population health.
  - For the CCSR risk adjustment model, when an individual has an encounter with the healthcare system and is coded with a primary diagnosis code, that code is then mapped to a CCSR category, and a risk score is assigned for that encounter. For a given experience period, all the risk scores for a given individual are added up to produce an overall risk score for that individual's health for that period. Risk scores are only counted once within a given category.
  - For the SegalRx risk adjustment model, when an individual has a drug prescription filled, the National Drug Code (NDC) for that drug is mapped to a SegalRx category and severity level, and a risk score is assigned for that fill. Similar to the CCSR model, all risk scores for that individual during the experience period are added up to provide an overall risk score for that individual. Risk scores are only counted once within a given condition based on the highest severity level.
- Risk scores are shown relative to 2017 for both medical and prescription drugs in order to make it easier to understand morbidity changes over time. Relative risk scores can be read as follows:
  - A risk score of 1.131 in 2023 means that population morbidity has increased by 13.1% since 2017. Said another way, costs are expected to be 13.1% higher in 2023 compared to 2017 before taking into account medical cost inflation.
- It's possible for risk scores to decrease and costs to increase. Risk scores reflect relative morbidity within a population. For example, if overall medical inflation increases by 7% but population morbidity decreases by 3%, costs may still increase by 4%. Additionally, a risk score is just an estimate of healthcare resource utilization. There was a large increase in medical risk scores between 2022 and 2023. However, this was driven in part by members seeking treatment for obesity, likely to gain access to new weight-loss drugs. Although these members received the obesity risk score, there were very few medical costs associated with the majority of these members.

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Key Findings

Section	Key Findings	Recommendations
Medical & Rx Trend Summary (pgs. 17-18)	• Medical trend was 6.7% in 2023 and slightly above Segal's benchmark trend rate. • Prescription drug trend was 17.9% in 2023 and has consistently been higher than Segal's benchmark trend rate.	• Continue to monitor medical trend and evaluate once Aetna has been in place for 12 full months. • Continue to monitor both gross drug trends and prescription drug rebates.
Emerging Trends (pgs. 20-21)	• The top three cost drivers on the medical side are all mental health-related. (neurodevelopmental, anxiety, and trauma) • The top two cost drivers on the pharmacy side are due to GLP-1 medications used to treat diabetes and obesity. However, the Plan removed coverage for anti-obesity GLP-1s in 2024.	• Continue to monitor emerging trend drivers to identify potential intervention strategies, particularly for mental health and cancer. Communication to members about high-quality providers – especially for diagnoses like anxiety and trauma – can reduce the overall cost of these conditions. • Continue to monitor prescription drug trend drivers, particularly as GLP-1 drugs and drugs like Dupixent have expanded disease indications, and continue to aggressively manage the PBM contract, including periodic PBM market checks, to ensure competitive pricing and maximized rebates.

Key Findings

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Section	Key Findings	Recommendations
Population Risk Review (pgs. 23-31)	• Members with multiple chronic conditions (i.e., comorbidities) is both the largest risk group (40% of members) and fastest growing. • The chronic, comorbidities, and malignancies risk groups are the major drivers of both medical and Rx costs. • Non-utilizing members experienced the largest increase in counts year-over-year.	• The Plan should focus on addressing the leading chronic conditions that lead to development of multiple comorbidities: hypertension, hyperlipidemia, and diabetes. • Review non-utilizing members to see what may be driving increases observed and if members are skipping important preventive care.
Chronic Conditions (pgs. 33-35)	• The majority of the main chronic conditions are lifestyle driven and may be mitigated by modifiable risk factors. • 82% of medical expenses and 85% of prescription drug expenses were due to members with one or more of the eight main chronic conditions[1]. • Diabetes is the main chronic condition driving prevalence, medical costs, and prescription drug costs.	• Review availability and appropriateness of disease management programs through Aetna. • Consider implementing a point solution for diabetes and/or hypertension and developing a comprehensive wellness program that incentivizes healthy activities and nutrition. • Add chronic condition-specific communications to website, including testimonials from employees on how they are staying healthy, recipes (e.g., keto-friendly recipes for diabetics), and other wellness information (e.g., important benefits of exercise and spending time outdoors).

[1] Asthma, CAD, CHF, COPD, diabetes, hypertension, mental health, and substance use disorder.

Key Findings

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Section	Key Findings	Recommendations
Cancer (pgs. 37-42)	• Cancer rates are increasing in the Plan and affect about 1.9% of membership. Cancer rates have consistently been about 0.3% higher than the benchmark. • About 25% of all cancer cases are for cancers with preventive screening guidelines, the most prevalent ones being breast and prostate.	• Increasing awareness and providing comprehensive information about the availability and importance of cancer screenings is key to improving compliance rates. • Consider best practice strategies to aid in cancer-prevention education, screening, accurate diagnosis, treatment and support. This can include enhancements with the existing vendor and addition of a cancer care point solution. Aim to improve early detection of cancers, provide second opinions, access to treatment through centers of excellence (COE), treatment guidance, specialized nutritional counseling, and support of virtual and in-home care. • Review cancer care strategies available through Aetna. • Consider offering financial incentives (e.g., gift card, premium discount) to employees who complete all recommended screenings.

Key Findings

Section	Key Findings	Recommendations
Catastrophic Risk Group (pgs. 44-47)	• The catastrophic risk group has grown the fastest historically at 6.8% per year. • Almost 70% of catastrophic members have early intervention opportunities available that may mitigate future catastrophic risk.	• Intervention strategies used to prevent HCCs in individuals with chronic conditions often involve promoting maintenance and preventive care, medication adherence, lifestyle modifications, care coordination, and health education. • Disease management programs that aim to address the main chronic conditions should take a holistic approach to managing members' health as opposed to treating the condition in a silo, including integrating management of mental health conditions. • Discuss with Aetna how high-risk members are identified and managed and consider implementing clinical high-cost claim reviews. These reviews involve in-depth assessments of high-cost claims to identify opportunities to improve care management interventions and coordination of care.

Key Findings

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Section	Key Findings	Recommendations
Diabetes, Cardiovascular Disease, and Obesity (pgs. 49-60)	• Diabetes prevalence increased from 8.9% of the population in 2019 to 11.4% in 2023. 23% of medical expenses and 37% of prescription drug expenses were due to diabetics in 2023. • Diabetics are a main driver of medical and prescription drug trends and are expected to be an important population to manage for the foreseeable future. • Ozempic and Trulicity saw members having medication supplies on-hand of up to 4 times more than potentially needed within the first 2 – 4 weeks of therapy. • Experience through 2023 indicates that there is limited evidence that use of GLP-1 medications results in material improvements on the medical side. However, it may take several years for benefits to manifest and should be monitored periodically.	• Consider adding a point solution that specializes in diabetes management and/or health coaching. Coaches can work one-on-one with members to help them learn more about their condition and how to manage it. • Consider adding digital tools that allow for syncing of personal fitness devices. Members using such tools can join group challenges and explore virtual courses that make managing the condition more engaging for members. • Monitor diabetic GLP-1 spend and utilizers as anti-obesity (AOM) users may shift to diabetic GLP-1s. The Plan should also validate utilization management criteria is functioning to meet its intended goals. • Consider implementing a quantity limit on the first fill and then, a reauthorization criteria for diabetic GLP-1 medications to confirm a positive response to current therapy and/or continued need.

Key Findings

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Section	Key Findings	Recommendations
Diabetes, Cardiovascular Disease, and Obesity (pgs. 49-60)	• Obesity prevalence increased from 30.9% of the population in 2019 to 33.6% in 2023. However, it is likely that prevalence in the population is much greater due to some members not seeking treatment and thus not being identified. • AOM GLP-1 costs nearly equaled that for diabetes in 2023. • Improved AOM GLP-1 persistence and multiple initial prescriptions for new users drove higher sustained costs. • $50.1M (28.7%) of AOM GLP-1 cost was due to with members who may be diabetic • Major adverse cardiovascular event. (MACE) rates (heart attack and stroke) are 15 times higher in ASCVD members with 10+ comorbidities. • The number of members utilizing bariatric surgery decreased from 754 in 2022 to 606 in 2023, likely due to the increased availability of AOM drugs.	• Assess and reevaluate current obesity treatments under the medical benefit and customized programs that includes a range of options for weight loss (e.g., lifestyle weight loss program, bariatric surgery). • Additional studies are underway for diabetic GLP-1s and cardiovascular risk reduction which could reduce MACE rates, disease management programs could ensure high-risk members receive these medications, if appropriate. • GLP-1s are appealing as weight loss medications. However, since the Plan no longer covers this disease indication alone, off-label usage should be closely monitored and prior authorization requirements adjusted if needed. • Consider offering resources and/or discounts to weight-loss and nutritional programs • Monitoring bariatric surgery utilization, cost and quality now that GLP-1s are no longer covered.

Key Findings

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Section	Key Findings	Recommendations
Mental Health (pgs. 62-63)	• Mental health treatment has been a major trend driver for the Plan during the last several years, partly due to increased access to treatment as a result of the pandemic. • Prior to the pandemic in 2019, 21.2% of members had a mental health-related encounter versus 28% of members in 2023, representing a 32% increase. • Mental health costs have increase at an annualized rate of 24%, driven primarily by neurodevelopmental, anxiety, and trauma disorders.	• Prioritizing education and the importance of mental health ensures members feel valued and supported. • Offering clinical navigation services can help ensure members get the right care from the start, reducing unnecessary tests and visits. Navigation services should be able to identify highest-quality providers to reduce the number of counseling sessions used. • The Clear Pricing Project (CPP) should be improving access for members by removing financial barriers and providing in-network care. Review network utilization as the Plan transitions to Aetna as the CPP provider landscape will be changing, and clearly communicate to members about the availability of no-copay Headway providers through this tool. • Ensure that the Aetna network strategy has adequate coverage for mental health and is accessible to members.

Key Findings

Section	Key Findings	Recommendations
Tobacco, Ashma, COPD, and Respiratory Cancer (pgs. 65-67)	• Tobacco use is one of the more significant cost drivers that is also a modifiable risk factor. Tobacco use can lead to several health complications, including COPD and respiratory cancers. • The Plan is one of 11 states that has a tobacco cessation program in place. The incentive for abstaining from for tobacco use is $60 per month, which is the second highest incentive of the 11 states. • The results of the 2023 attestations are: – 5,658 members attested to being tobacco users and also had recent tobacco-related medical claims. These members cost $1,712 PMPM. – 16,227 members attested to not being a tobacco user but had recent tobacco-related medical claims. These members cost $1,490 PMPM. – 65,756 members attested to being a tobacco user but did not have recent tobacco-related medical claims. These members cost $716 PMPM. – 514,103 members attested to not being a tobacco user and did not have any recent tobacco-related medical claims. These members cost $762 PMPM.	• The tobacco cessation program appears to mostly be penalizing members for not filling out the attestation and thus defaulting to being a user. The majority of those attesting to being a user (65,756), did not have any tobacco-related claims and had medical and prescription drug costs that were similar to non-users, suggesting that they do not actually use tobacco. Review the process for filling out the attestation and monitor the results for improvements moving forward. • The $60 incentive is high compared to what other state health plans are doing. Consider lowering the tobacco cessation incentive and adding a wellness incentive. • Respiratory cancer screening compliance appears low. Consider providing communications and/or adding screening requirements alongside the tobacco cessation program to ensure members understand who should be screened and when.

Key Findings

Section	Key Findings	Recommendations
Wilmington Health Pilot (pgs. 69-74)	• The Wilmington Health Pilot was put in place to increase PCP engagement and the quality of care members receive through their PCP. • Based on experience through 2023, utilization of evaluation and management services is high, but there has not been much change for the Wilmington Area than before program implementation. • Risk-adjusted medical costs are lower for Wilmington than the other regions, suggesting this area is managed more efficiently. Risk-adjusted prescription drug costs are slightly higher for Wilmington, although it has improved since the pilot program began. • The Wilmington area has fewer emergency room visits, more preventive visits, and more well-woman visits than the other regions, all positive signs for the pilot program. • The pilot program also aims to improve A1c testing compliance for diabetics. A1c testing compliance was similar in Wilmington prior to program implementation but now is about 3% higher for Wilmington than the other regions.	• The Wilmington Health Pilot is too young to make any firm conclusions at this time. Continue monitoring experience, especially PCP utilization, ER utilization, preventive care utilization, A1c testing compliance, and preventive cancer screening compliance.

Key Findings

Section	Key Findings	Recommendations
Biosimilar Drugs (pgs. 76-78)	• Biologics (originators and biosimilars) account for approximately 35% of plan spend on prescription drugs. • The Plan spent over $130 million on Humira alone in 2023, prior to rebates. • Biosimilar medications are beginning to enter the market, including biosimilars for Humira, which should provide savings opportunities in the coming years.	• As more biosimilars enter the market and the savings opportunity grows, the Plan should consider strategies to incentivize biosimilar utilization. Potential opportunities include: – A tiered plan design that offers lower member costs when taking biosimilars – Updated formularies that include biosimilars as the preferred option – Utilize prior authorization that directs providers and members towards biosimilars if available and appropriate – Implement step therapy so members start with lower-cost biosimilars before becoming eligible for more expensive originator biologics.

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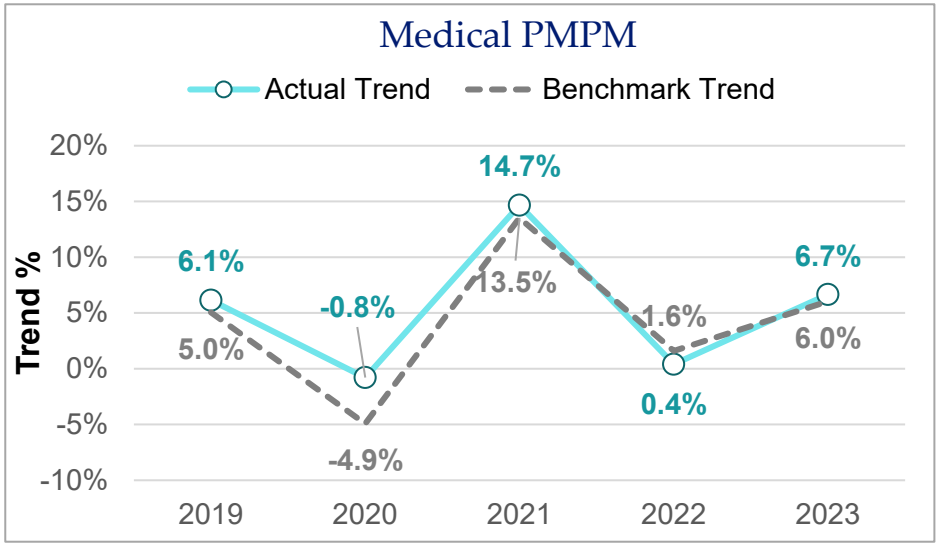
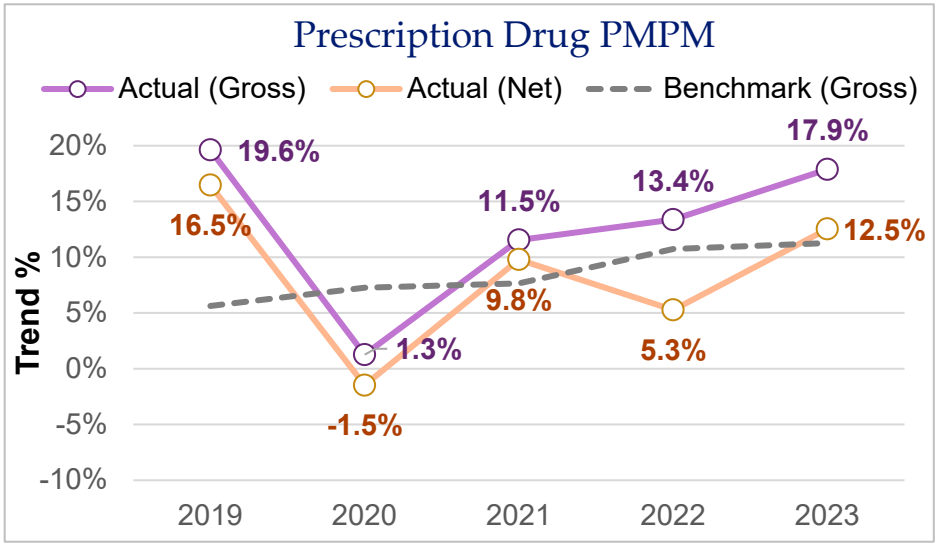
Medical & Rx Trend Summary



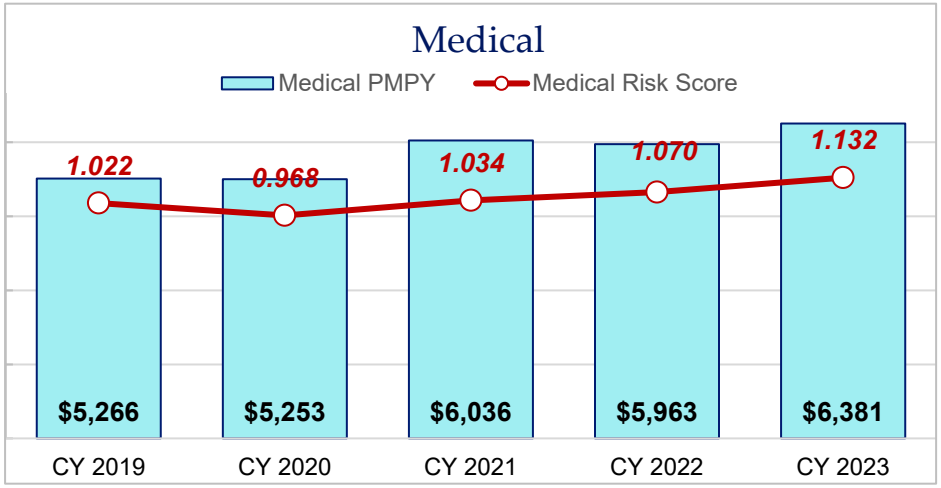


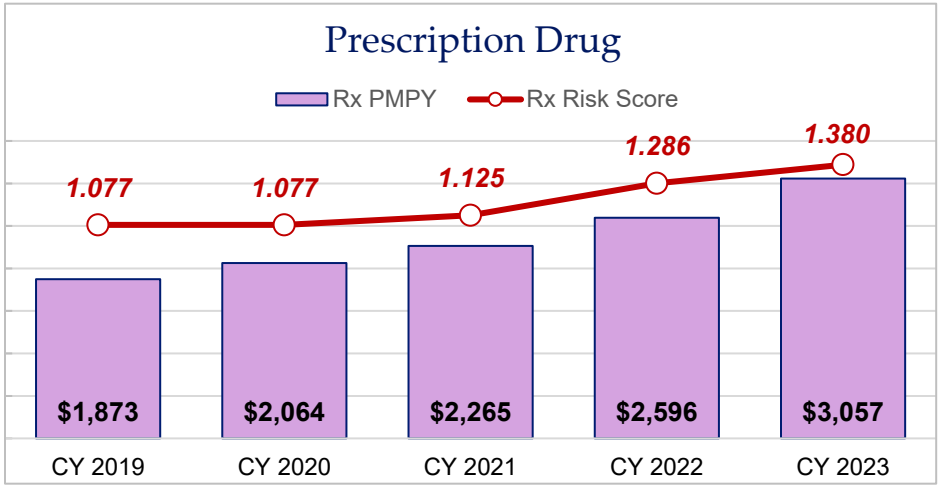
Observations

- The table above summarizes year-over-year (YoY) medical and prescription drug per member per month (PMPM) trends.
  - Trends are based on allowed amounts, which include both the plan paid and member paid amounts.
  - Prescription drug trend is shown on a gross and net (i.e., including rebates) basis.
- Benchmark trend represents the trend from Segal's SHAPE book-of-business. Benchmark trend for prescription drugs is gross of rebates.
- Overall, the Plan is doing well at managing medical expenses. Medical trend for the plan has been slightly higher than the benchmark since 2020.
- The Plan has experienced higher prescription drug trend than the benchmark in every year since 2020. In 2023, prescription drug trend was over 6% higher than the benchmark. However, once rebates are factored in, prescription drug trend in 2023 decreases from 17.9% to 12.5%.

Medical & Rx Trend Summary

Cost and Risk





Observations

- Risk scores for both medical and prescription drug were flat or decreasing during 2020 but have increased every year since then.
  - Medical risk scores decreased as members avoided the doctor during the pandemic and thus received fewer diagnoses than typical.
- Medical risk scores have steadily increased since 2020 and have been driven by diabetes, obesity and mental health disorders (e.g., anxiety, depression).
- Prescription drug risk scores increased significantly between 2021 and 2022 and were driven by medications used to treat diabetes, autoimmune diseases, and obesity. Diabetes and obesity management medications were also the primary driver of costs between 2022 and 2023.
- Summaries of cost and risk by subgroup (e.g., North Carolina Public Schools, Department of Corrections) and by region (e.g., Wilmington Area, Charlotte Area) are provided in the appendices.

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Emerging Trends
Cost Trend Drivers

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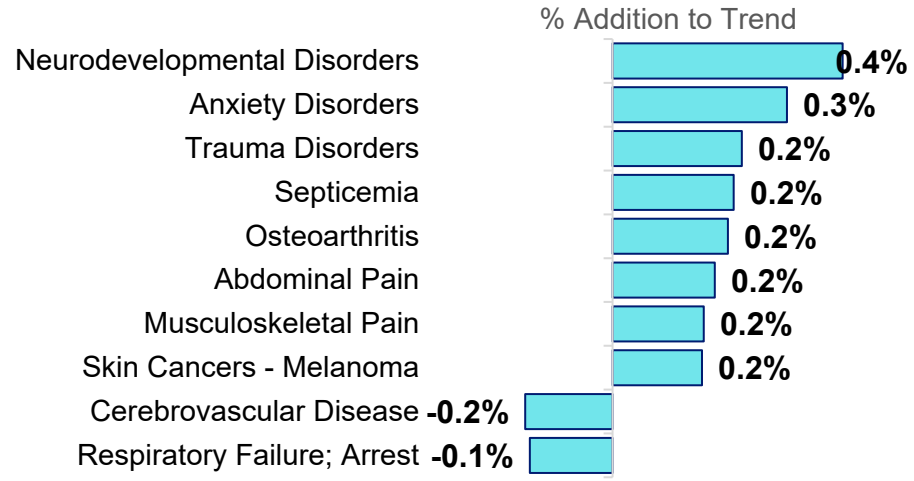
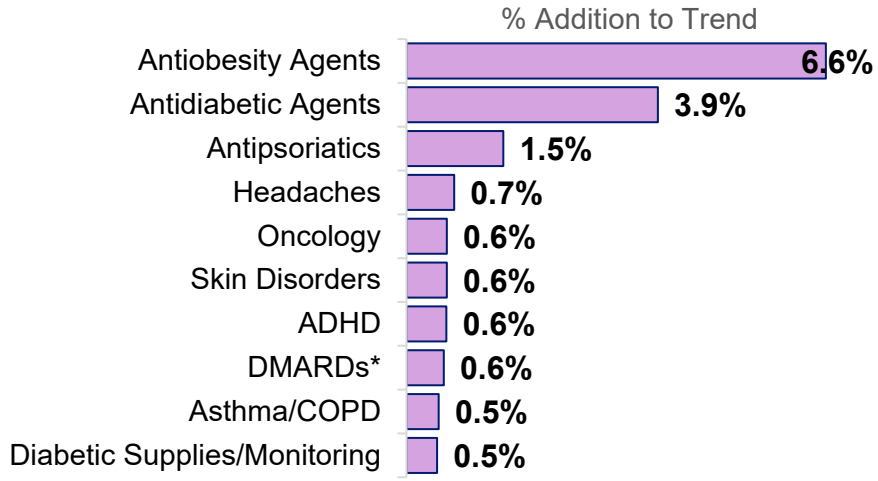
Medical



Prescription Drug



Observations

- One of the main factors driving YOY medical costs have been mental health conditions, including neurodevelopmental disorders (e.g., autism), anxiety disorders, and trauma disorders.
  - Costs for neurodevelopmental disorders increased 46% and alone added 0.4% to trend. Said another way, absent the increase in costs for neurodevelopmental disorder between 2022 and 2023, medical trend would have been 6.3% as opposed to 6.7%.
  - Medical trend has been offset by lower costs for cerebrovascular disease (i.e., strokes) and respiratory failure/arrest. Both strokes and respiratory failure are common complications of unmanaged chronic conditions.
- YoY prescription drug costs have been driven higher mostly due to drugs used to treat diabetes and obesity.
  - Although costs for anti-obesity agents increased 118% and added 6.6% to prescription drug trends in 2023, coverage for these medications has been removed from the Plan and this disease class is not expected to drive trend in the future. However, it is expected that members will transition treatment to the antidiabetic versions of these drugs if eligible, which will increase trend further in that class.

* DMARDs = Disease Modifying Antirheumatic Drugs

Emerging Trends
Prevalence Trend Drivers

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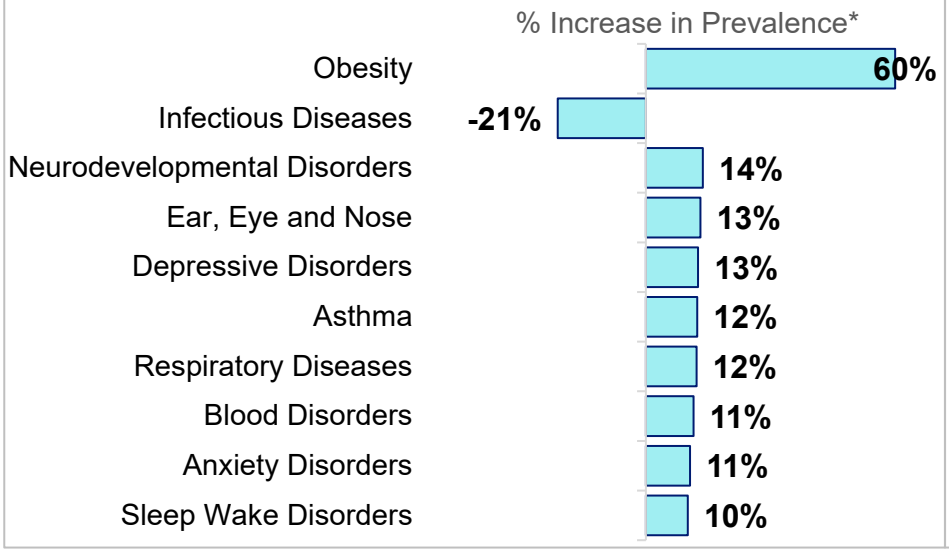
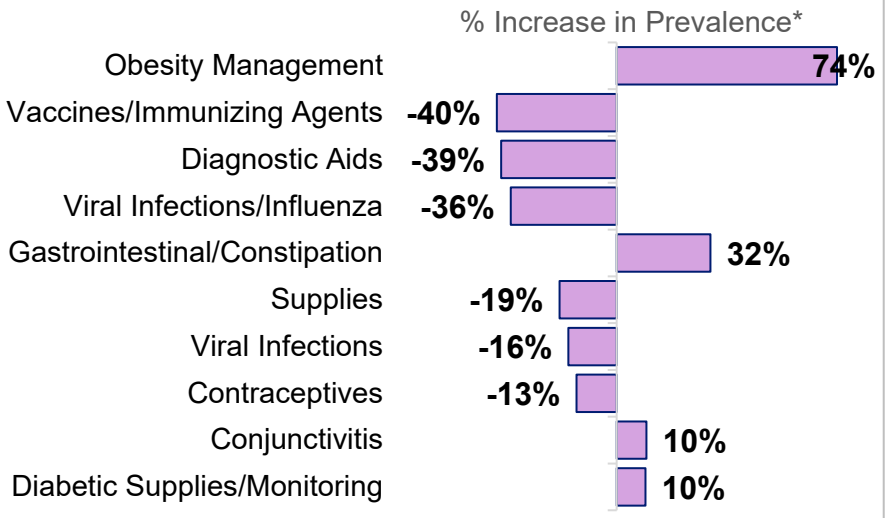
Medical



Prescription Drug



Observations

- 60% more members sought medical treatment for obesity in 2023 versus 2022, likely due to members wanting to get access to new weight-loss medications.
  - Obesity has also been the primary prevalence driver on the pharmacy side with a 74% increase in utilization.
- Four of the top 10 prevalence drivers on the medical side are mental health related (i.e., neurodevelopmental disorders, depressive disorders, anxiety disorders, and sleep wake disorders).
- Along with the mental health conditions, spotlights are provided later in this report for obesity, asthma, and respiratory diseases. Note that obesity and sleep-wake disorders are common comorbidities with diabetes and are included in that section.

* Prevalence = % of members within a given category

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Population Risk Review
Summary

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	CY 2023											
		% of Total		Medical			Prescription Drug			% Change from Prior		
Risk Group	Members	Members	Allowed	Allowed (millions)	PMPY	Risk Score	Allowed (millions)	PMPY	Risk Score	Members	Medical PMPY	Rx PMPY
Non-Utilizers	43,722	8.0%	0.0%	$0.0	$0	0.12	$0.0	$0	0.15	19.9%	0.0%	0.0%
Healthy	98,039	18.0%	3.5%	$110.3	$1,125	0.26	$71.4	$728	0.44	-15.4%	25.8%	32.6%
Minor Acute	46,532	8.5%	2.5%	$96.2	$2,068	0.66	$32.5	$699	0.47	-11.0%	-2.3%	3.9%
Major Acute	24,974	4.6%	3.8%	$165.9	$6,642	1.61	$28.9	$1,156	0.72	12.4%	-13.3%	3.5%
Chronic	104,782	19.2%	13.5%	$513.6	$4,902	1.09	$179.5	$1,713	0.97	0.0%	2.4%	5.9%
Comorbidities	220,062	40.3%	63.2%	$2,002.6	$9,100	1.70	$1,250.5	$5,683	2.44	5.6%	3.5%	14.4%
Malignancies	6,026	1.1%	8.1%	$337.2	$55,954	2.47	$81.7	$13,565	3.12	3.9%	1.8%	5.2%
Catastrophic	1,272	0.2%	5.4%	$254.3	$199,863	9.87	$22.6	$17,781	5.59	13.0%	0.0%	18.3%
Total	**545,410**	**100.0%**	**100.0%**	**$3,480.1**	**$6,381**	**1.13**	**$1,667.2**	**$3,057**	**1.38**	**-0.3%**	**7.0%**	**17.7%**

Observations

The table above groups members into 8 mutually exclusive risk groups[1].

- Healthy members represented 18% of the population and 3.5% of all medical and drug allowed charges during 2023. The number of healthy members decreased 15.4% from the prior period.
- The largest group by size and cost were members with multiple chronic conditions (i.e., Comorbidities). Chronic members w/ comorbidities represented 40.3% of the population and 63.2% of allowed charges.
- The number of catastrophic members increased by 13.0% year-over-year, the second largest increase of all the risk groups, behind only non-utilizers.
- The number of members with malignancies increased by 3.9% during 2023. This cohort has the second highest healthcare costs of all risk groups.

[1] See Appendices for more detailed definitions and examples for each of the risk groups.

Population Risk Review

Annual/Historical Membership

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

	Member Count					% Change	
Risk Group	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**	**YoY**	**Historical[1]**
Non-Utilizers	39,170	37,004	28,972	36,470	43,722	19.9%	2.8%
Healthy	124,094	141,963	131,459	115,858	98,039	-15.4%	-5.7%
Minor Acute	61,956	55,683	56,484	52,277	46,532	-11.0%	-6.9%
Major Acute	28,005	20,023	22,137	22,221	24,974	12.4%	-2.8%
Chronic	103,228	99,541	104,332	104,806	104,782	0.0%	0.4%
Comorbidities	187,382	190,714	197,639	208,456	220,062	5.6%	4.1%
Malignancies	6,021	6,164	5,738	5,798	6,026	3.9%	0.0%
Catastrophic	977	939	1,026	1,126	1,272	13.0%	6.8%
Total	**550,834**	**552,031**	**547,787**	**547,011**	**545,410**	**-0.3%**	**-0.2%**
Non-Utilizers%	7.1%	6.7%	5.3%	6.7%	8.0%	20.2%	3.0%
Healthy %	22.5%	25.7%	24.0%	21.2%	18.0%	-15.1%	-5.5%
Acute %	16.3%	13.7%	14.4%	13.6%	13.1%	-3.7%	-5.3%
Chronic %	52.8%	52.6%	55.1%	57.3%	59.6%	4.0%	3.1%
Catastrophic / Malignancy	1.3%	1.3%	1.2%	1.3%	1.3%	5.7%	1.3%

Observations

The table above summarizes trends in membership among the eight risk groups.

- Catastrophic is the fastest growing group with a historical trend rate of 6.8%.
- The second fastest growing group is members with multiple chronic conditions with a historical trend rate of 4.1%.
- The number of non-utilizers continues to grow with a YoY increase of 19.9% and a historical trend rate of 2.8%.
- As more members develop chronic conditions, both the healthy and acute risk groups continue to shrink in size.

[1] Historical % change reflects the average annual trend between CY 2019 and CY 2023.

Population Risk Review

Medical Cost PMPY by Risk Group

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

	Medical Claims PMPY					% Change	
Risk Group	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**	**YoY**	**Historical[1]**
Healthy	$609	$640	$707	$894	$1,125	25.8%	16.6%
Minor Acute	$1,852	$1,991	$2,116	$2,117	$2,068	-2.3%	2.8%
Major Acute	$6,620	$7,957	$8,227	$7,658	$6,642	-13.3%	0.1%
Chronic	$4,289	$4,441	$4,843	$4,785	$4,902	2.4%	3.4%
Comorbidities	$8,410	$8,322	$9,338	$8,791	$9,100	3.5%	2.0%
Malignancies	$48,648	$48,294	$54,717	$54,946	$55,954	1.8%	3.6%
Catastrophic	$218,708	$225,666	$240,997	$199,915	$199,863	0.0%	-2.2%
Total	**$5,266**	**$5,253**	**$6,036**	**$5,963**	**$6,381**	**7.0%**	**4.9%**

Observations

- Historical medical trend throughout the last five years is 4.9% and has been in-line with Segal's benchmark trend rate since 2020.
- The healthy cohort had the highest YoY and historical increases in medical costs. However, costs for this group are low and a small increase in utilization can lead to a large increase in costs.
- Aside from the healthy cohort, members with malignancies have the highest historical trend rate and the second highest overall cost. As cancer becomes more prevalent and more expensive treatments come to the market, this group will be especially important to manage in the coming years. See focus area on cancer for more information.

[1] Historical % change reflects the average annual trend between CY 2019 and CY 2023.

Population Risk Review

Prescription Drug Cost PMPY by Risk Group

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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	Prescription Drug Claims PMPY					% Change	
Risk Group	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**	**YoY**	**Historical[1]**
Healthy	$396	$449	$408	$549	$728	32.6%	16.5%
Minor Acute	$502	$576	$612	$673	$699	3.9%	8.7%
Major Acute	$899	$1,153	$1,180	$1,117	$1,156	3.5%	6.5%
Chronic	$1,430	$1,518	$1,510	$1,617	$1,713	5.9%	4.6%
Comorbidities	$3,788	$4,163	$4,503	$4,967	$5,683	14.4%	10.7%
Malignancies	$9,158	$9,827	$11,129	$12,888	$13,565	5.2%	10.3%
Catastrophic	$14,141	$15,886	$14,340	$15,030	$17,781	18.3%	5.9%
Total	**$1,873**	**$2,064**	**$2,265**	**$2,596**	**$3,057**	**17.7%**	**13.0%**

Observations

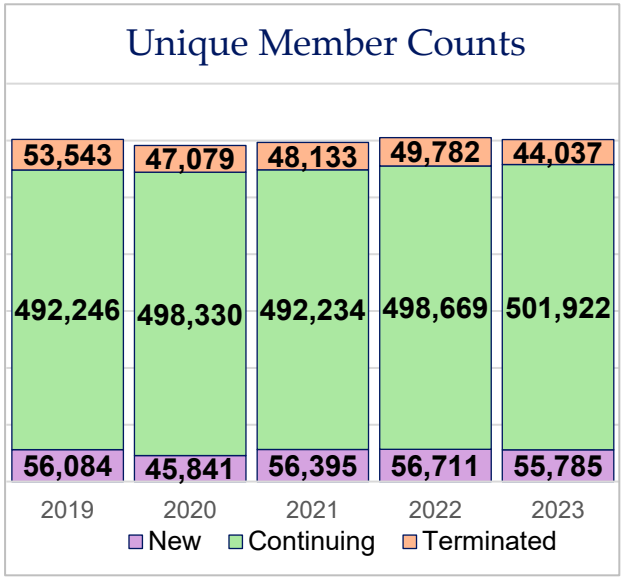
- Historical prescription drug trend throughout the last four years is 13% and has been higher than the benchmark trend rate since 2020.
- Rebates are not reflected in the gross trend shown on this page. Net trend has been historically lower than gross trend by 2-5% due to improving rebates.
- Similar to medical costs, healthy members have the highest historical drug trend rate at 16.5%, followed by members with multiple chronic conditions (10.7%).
- Members with malignancies are a main driver of both medical and prescription drug costs. Historical prescription drug trends for this cohort were 10.3%, the third highest of all groups.

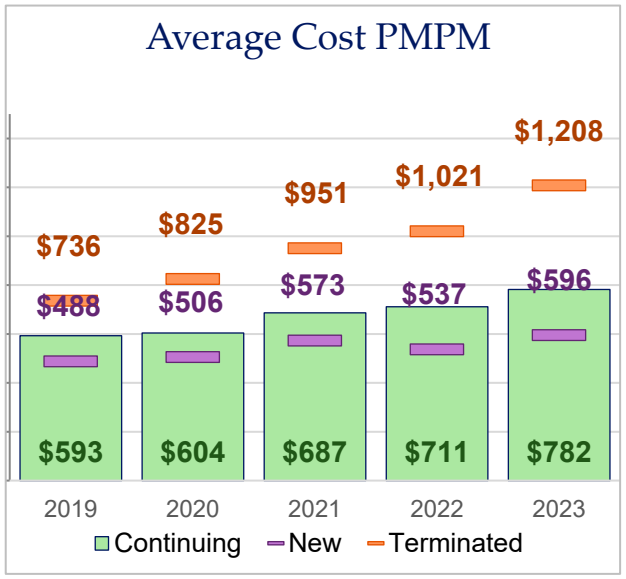
[1] Historical % change reflects the average annual trend between CY 2019 and CY 2023.

Population Risk Review

Trends in Membership and Risk (Historical)

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer





Observations

- Approximately 55k members join the Plan each year, 45k-50k leave the Plan, and 500k continue coverage.
  - Unlike other areas of this report, member counts are counts of unique individuals as opposed to average monthly member counts.
  - Definitions of each of the three transition groups (i.e., new, continuing, terminating) can be found in the Appendices.
- New members had approximately 25% lower costs than the average member in 2022 and 2023, versus about 17% lower costs in 2019 – 2021.
- Terminating members continue to get more expensive relative to the average member. In 2019, terminating members were 24% more expensive than average versus 54% more expensive than average in 2023.

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Population Risk Review

Membership Migration (YoY)

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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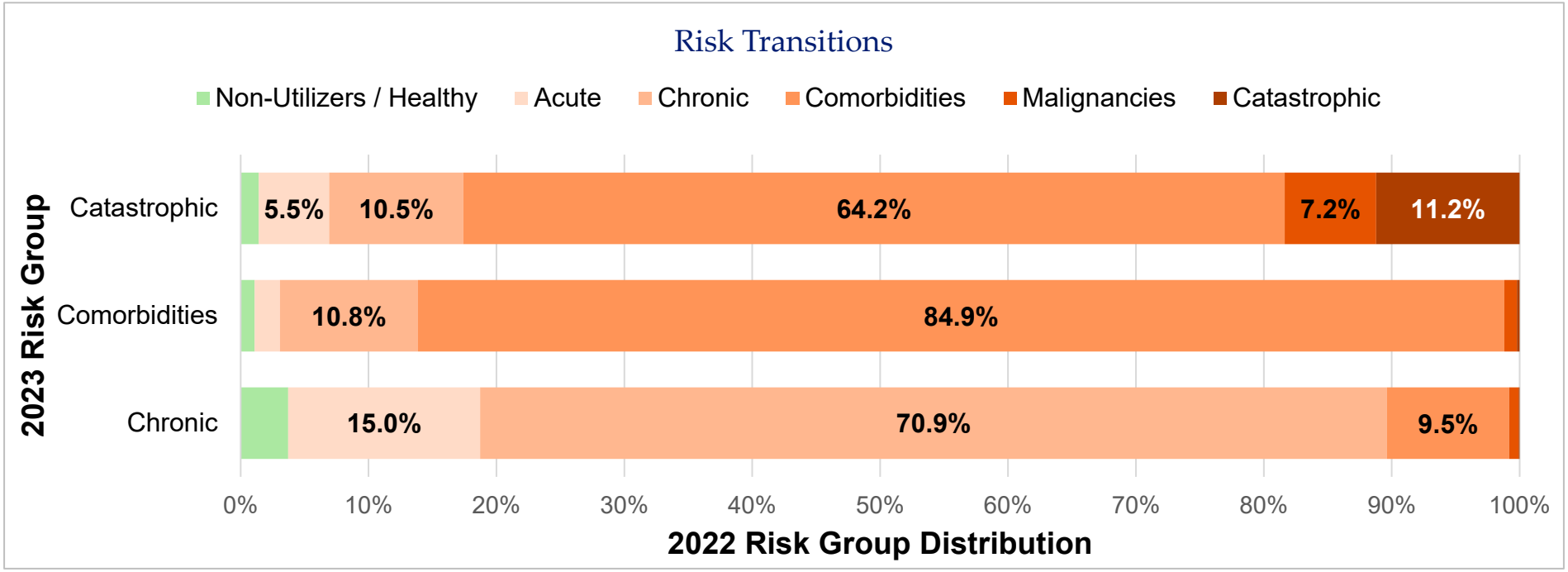

Observations

The table above shows the risk group distribution in 2022 for members who were either chronic, chronic w/ comorbidities, or catastrophic in 2023.

- For members that were catastrophic in 2023, 3.7% were healthy or did not use benefits (i.e., non-utilizers) in 2022, 5.5% had an acute encounter, 10.5% has a single chronic condition, 64.2% had multiple chronic conditions, 7.2% had malignancies, and 11.2% were also catastrophic that year.
- For members with multiple chronic conditions in 2023, 10.8% had a single chronic condition in 2022 and 1.1% were either health or did not use benefits.
- For members that developed a single chronic condition in 2023,1.4% were either health or did not use benefits in 2022.

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Population Risk Review

Risk Projection

North Carolina State Health Plan
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	CY 2023		Projected to CY 2028			Projected to CY 2033		
Risk Group	**Members**	**% of Total**	**Members**	**% of Total**	**Member Movement**	**Members**	**% of Total**	**Member Movement**
1. Healthy / Non-Utilizers	141,762	26.0%	149,209	27.4%	7,447	148,840	27.3%	7,078
2. Minor Acute	46,532	8.5%	45,121	8.3%	(1,411)	44,956	8.2%	(1,576)
3. Major Acute	24,974	4.6%	19,163	3.5%	(5,811)	19,094	3.5%	(5,880)
4. Single Chronic	104,782	19.2%	96,644	17.7%	(8,138)	96,251	17.6%	(8,531)
5. Chronic w/ Comorbidities	220,062	40.3%	227,768	41.8%	7,706	228,748	41.9%	8,686
6. Malignancies	6,026	1.1%	6,213	1.1%	187	6,224	1.1%	198
7. Catastrophic	1,272	0.2%	1,291	0.2%	19	1,296	0.2%	24
Total Members	**545,410**	**100.0%**	**545,410**	**100.0%**	**-**	**545,410**	**100.0%**	**-**
Healthy / Non-Utilizers	141,762	26.0%	149,209	27.4%	7,447	148,840	27.3%	7,078
Acute	71,506	13.1%	64,283	11.8%	(7,223)	64,051	11.7%	(7,455)
Chronic	324,844	59.6%	324,413	59.5%	(431)	324,999	59.6%	155
Catastrophic / Malignancy	7,298	1.3%	7,505	1.4%	207	7,520	1.4%	222

Observations

This page provides projections for each of the mutually exclusive risk groups through 2033.

- The chronic conditions and malignancies cohorts are expected to grow throughout the next ten years.
- The healthy / non-utilizers cohort is expected to grow the most by 2033, mostly due to a recent large increase in non-utilizers.

The projections shown here are estimates of future experience and are based on information available to Segal at the time the projections were made. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, and health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases.

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Chronic Conditions

Member Count

North Carolina State Health Plan
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	CY 2020		CY 2021		CY 2022		CY 2023			% Change	
Chronic Condition[1]	**Members**	**% of Total**	**Members**	**% of Total**	**Members**	**% of Total**	**Members**	**% of Total**	**Norm[2]**	**YoY**	**Historical[3]**
Diabetes	50,086	9.1%	51,330	9.4%	57,291	10.5%	61,997	11.4%	8.1%	8.2%	6.0%
Coronary Artery Disease	12,126	2.2%	11,947	2.2%	13,141	2.4%	14,233	2.6%	2.6%	8.3%	3.2%
Asthma	13,906	2.5%	13,312	2.4%	14,686	2.7%	15,783	2.9%	2.9%	7.5%	2.1%
Chronic Obstructive Pulmonary Disease	3,540	0.6%	3,045	0.6%	2,933	0.5%	3,230	0.6%	0.6%	10.2%	-3.7%
Hypertension	137,122	24.8%	135,194	24.7%	138,663	25.3%	140,578	25.8%	21.8%	1.4%	0.9%
Mental Health	189,286	34.3%	201,844	36.8%	215,018	39.3%	228,411	41.9%	34.4%	6.2%	6.7%
Substance Use Disorder[4]	20,686	3.7%	20,162	3.7%	19,399	3.5%	20,535	3.8%	2.5%	5.9%	1.8%
Congestive Heart Failure	2,267	0.4%	2,301	0.4%	2,491	0.5%	2,632	0.5%	0.4%	5.7%	3.5%
Total (Unique)	**282,386**	**51.2%**	**288,732**	**52.7%**	**301,439**	**55.1%**	**311,928**	**57.2%**		**3.5%**	**3.5%**
All Members (Non-Medicare)	**552,030**		**547,787**		**547,010**		**545,409**			**-0.3%**	**-0.2%**

Observations

The table above shows top chronic conditions within the population. The categories are not mutually exclusive, meaning that a member with comorbidities is shown in each line corresponding to their conditions.

- 57.2% of the population had one or more of the eight chronic conditions listed above, up from 51.2% in 2020.
- Mental health is the most prevalent condition affecting 41.9% of the population.
- Aside from mental health, diabetes prevalence has increased the most over the experience period. The Plan has been experiencing an increase in diabetes prevalence of about 6% per year.
- Chronic Obstructive Pulmonary Disease (COPD) experienced the largest YoY increase in prevalence but is the only condition to experience a decrease in prevalence over the experience period. As smoking rates come down in the general population, the State should continue to track this metric to ensure it decreases accordingly.

[1] Members with co-morbidities are shown in each applicable category.
[2] Norms are from Segal's SHAPE data warehouse for public sector non-Medicare members adjusted for age and gender.
[3] Historical % change reflects the average annual trend between CY 2019 (results not illustrated in table) and CY 2023.
[4] Substance Use Disorder (SUD) includes drug abuse and alcohol related disorders but excludes tobacco-related disorders.

Chronic Conditions

Total Allowed

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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	Medical Allowed[3]				Rx Allowed[3]				Total Allowed[3]				% Change	
Chronic Condition[1]	CY 2020	CY 2021	CY 2022	CY 2023	CY 2020	CY 2021	CY 2022	CY 2023	CY 2020	CY 2021	CY 2022	CY 2023	YoY	Historical[4]
Diabetes	$589.6	$683.2	$704.7	$799.0	$365.1	$412.0	$496.9	$608.8	$954.8	$1,095.3	$1,201.6	$1,407.8	17.2%	11.8%
CAD	$299.2	$325.9	$337.6	$391.7	$80.4	$86.0	$103.5	$125.5	$379.6	$411.9	$441.1	$517.2	17.2%	6.2%
Asthma	$196.7	$212.4	$217.8	$239.6	$69.6	$75.0	$91.1	$117.1	$266.3	$287.4	$308.9	$356.7	15.5%	6.9%
COPD	$76.3	$77.7	$71.1	$79.0	$27.3	$24.5	$28.9	$33.3	$103.6	$102.2	$100.0	$112.4	12.4%	-0.6%
Hypertension	$1,392.4	$1,552.6	$1,519.2	$1,649.2	$592.4	$650.5	$741.5	$870.7	$1,984.8	$2,203.1	$2,260.7	$2,519.8	11.5%	6.8%
Mental Health	$1,576.6	$1,861.7	$1,942.8	$2,174.0	$592.2	$673.5	$801.5	$996.9	$2,168.7	$2,535.3	$2,744.4	$3,170.9	15.5%	11.9%
SUD[2]	$289.0	$298.0	$309.2	$341.8	$85.0	$89.4	$98.7	$117.0	$374.1	$387.4	$407.9	$458.8	12.5%	5.5%
CHF	$123.2	$135.4	$126.0	$137.4	$24.2	$23.9	$27.7	$34.8	$147.4	$159.3	$153.7	$172.2	12.0%	3.4%
Total (Unique)	**$2,265.1**	**$2,595.6**	**$2,603.7**	**$2,836.4**	**$927.1**	**$1,021.6**	**$1,181.1**	**$1,413.7**	**$3,192.3**	**$3,617.2**	**$3,784.8**	**$4,250.1**	**12.3%**	**8.6%**
All Members	**$2,899.9**	**$3,306.7**	**$3,262.0**	**$3,480.1**	**$1,139.3**	**$1,240.5**	**$1,420.1**	**$1,667.2**	**$4,039.2**	**$4,547.1**	**$4,682.1**	**$5,147.3**	**9.9%**	**6.2%**

Observations

The table above shows allowed charges for members in each of the top chronic conditions within the population. The categories are not mutually exclusive, meaning that claims for members with comorbidities are shown in each line corresponding to their conditions.

- 82% of medical expenses and 85% of prescription drug expenses were due to members in one or more of the categories above in 2023.
  - The percent of expenses for the chronic conditions outlined here has increased in each of the historical years for both medical and prescription drugs.
- The increase in spend for these chronic conditions has mainly been driven by diabetes and mental health disorders. Diabetes had the highest YoY increase as well as the second highest historical increase in costs.

[1] Members with co-morbidities and their corresponding claims are combined in each applicable category.
[2] Substance Use Disorder (SUD) includes drug abuse and alcohol related disorders but excludes tobacco-related disorders.
[3] In millions
[4] Historical % change reflects the average annual trend between CY 2019 (results not illustrated in table) and CY 2023.

Chronic Conditions

Allowed PMPY

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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	Medical PMPY				Rx PMPY				Medical PMPY % Change		Rx PMPY % Change	
Chronic Condition[1]	CY 2020	CY 2021	CY 2022	CY 2023	CY 2020	CY 2021	CY 2022	CY 2023	YoY	Historical[2]	YoY	Historical[2]
Diabetes	$11,772	$13,311	$12,301	$12,888	$7,290	$8,027	$8,673	$9,819	4.8%	2.3%	13.2%	10.8%
CAD	$24,672	$27,277	$25,690	$27,518	$6,629	$7,200	$7,876	$8,816	7.1%	1.3%	11.9%	9.0%
Asthma	$14,147	$15,954	$14,831	$15,179	$5,004	$5,637	$6,201	$7,420	2.3%	1.4%	19.7%	13.7%
COPD	$21,563	$25,512	$24,247	$24,462	$7,713	$8,057	$9,852	$10,322	0.9%	0.7%	4.8%	10.7%
Hypertension	$10,155	$11,484	$10,956	$11,731	$4,320	$4,811	$5,348	$6,194	7.1%	3.3%	15.8%	11.9%
Mental/Behavioral Health	$8,329	$9,224	$9,036	$9,518	$3,128	$3,337	$3,728	$4,364	5.3%	2.8%	17.1%	10.5%
Substance Use Disorder[3]	$13,971	$14,779	$15,937	$16,645	$4,111	$4,433	$5,087	$5,699	4.4%	1.8%	12.0%	10.2%
CHF	$54,347	$58,842	$50,605	$52,191	$10,663	$10,383	$11,112	$13,221	3.1%	-1.9%	19.0%	9.1%
Total (Unique)	**$8,021**	**$8,990**	**$8,638**	**$9,093**	**$3,283**	**$3,538**	**$3,918**	**$4,532**	**5.3%**	**2.7%**	**15.7%**	**10.5%**
All Members (Non-Medicare)	**$5,253**	**$6,036**	**$5,963**	**$6,381**	**$2,064**	**$2,265**	**$2,596**	**$3,057**	**7.0%**	**4.9%**	**17.7%**	**10.2%**

Observations

The table above shows medical and prescription drug allowed PMPY expenses for the top chronic conditions within the population. The categories are not mutually exclusive, meaning that a member with comorbidities is shown in each line corresponding to their conditions.

- Congestive Heart Failure (CHF) is the costliest chronic condition with a medical allowed PMPY cost of $52,191 in 2023.
- Throughout the last five years, members with hypertension have the highest medical trend at 3.3% per year and the second highest prescription drug trend at 11.9%.
- Asthmatics had the highest YoY and historical prescription drug trend of 19.7% and 13.7%, respectively.

[1] Members with co-morbidities and their corresponding claims are combined in each applicable category.
[2] Historical % change reflects the average annual trend between CY 2019 and CY 2023.
[3] Substance Use Disorder (SUD) includes drug abuse and alcohol related disorders but excludes tobacco-related disorders.

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Cancer

Prevalence and Cost

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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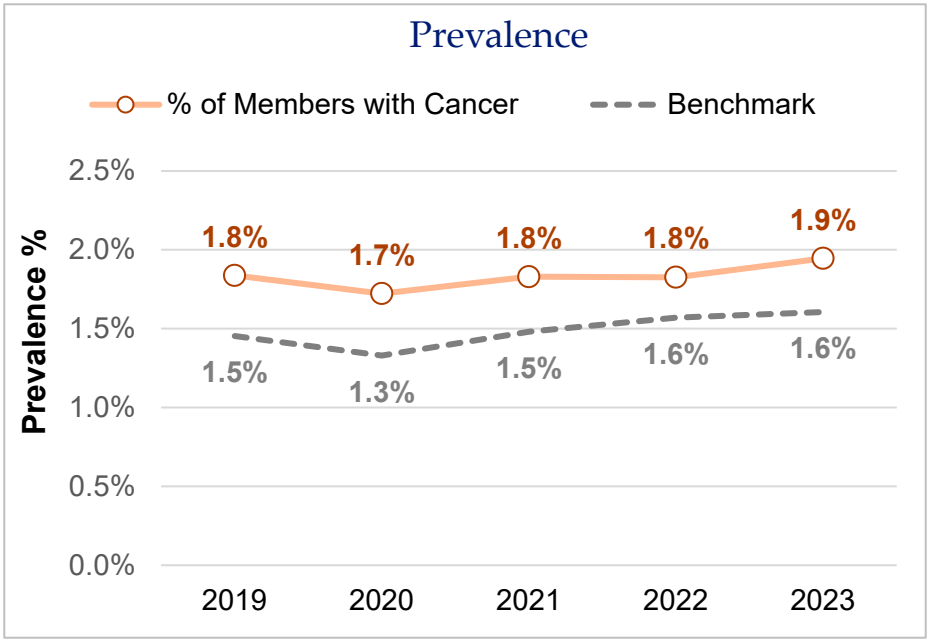
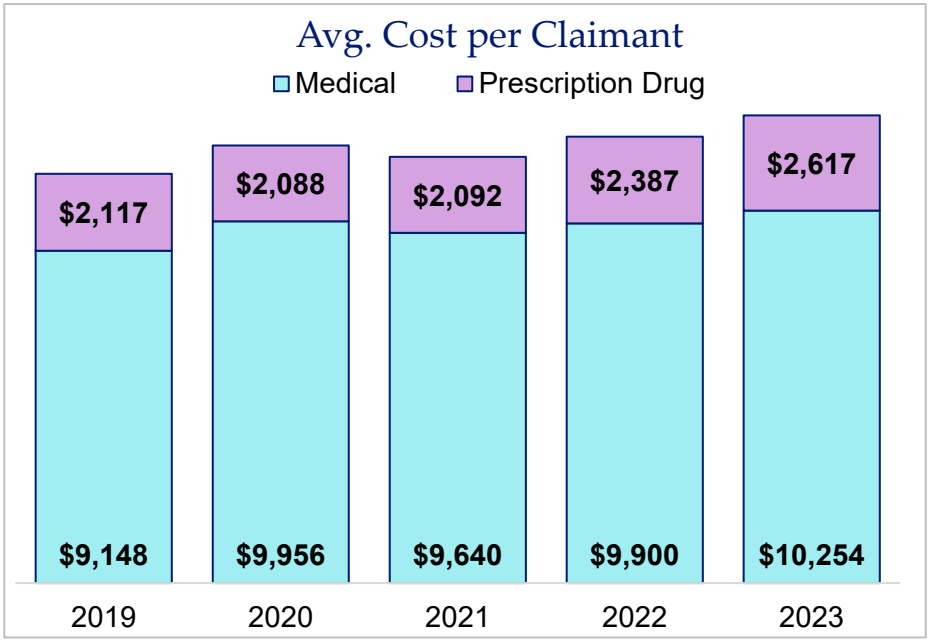




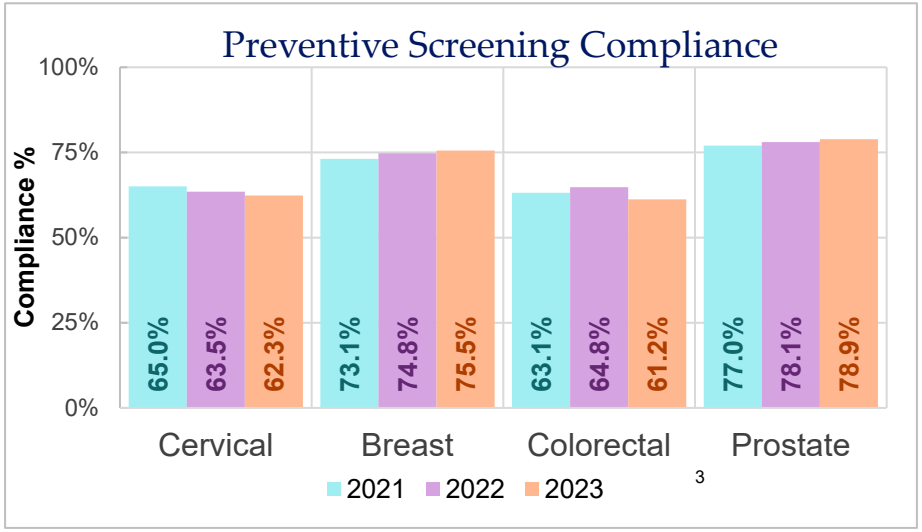
Observations

- Approximately 1.9% of the population had cancer in 2023, the highest of all years in the experience period. Cancer prevalence has increased each year since 2020.
  - The lowest prevalence was in 2020, which likely means that members delayed care which led to later diagnoses.
- 25% of the new cancers diagnoses in 2023 have recommendations for preventive screenings, including breast, cervical, colorectal, and prostate. For information on screenable cancers can be found on the following slides.
- Cancer is a major trend driver for most health plans. However, historically that has not been the case with this group. Medical costs PMPM for cancer treatment have increased 3.7% annually over the historical period and prescription drug costs have increased 6.3% annually, both below the overall trend rates for each benefit type.
  - Although historical trend rates for cancer are favorable, year-over-year medical trend for cancer treatment was 8% and was a trend driver for the Plan.

Cancer
Preventive Screenings

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Preventive Cancer Screenings					
		Compliance Rate			
Type	Target Demographic	CY 2021	CY 2022	CY 2023	Annualized Trend[1]
Cervical	Female Age 21-65	65.0%	63.5%	62.3%	-2.1pp
Breast	Female Age 40-74	73.1%	74.8%	75.5%	0.5pp
Colorectal[2]	All Age 45-75	63.1%	64.8%	61.2%	1.2pp
Prostate	Male Age 55-69	77.0%	78.1%	78.9%	0.8pp



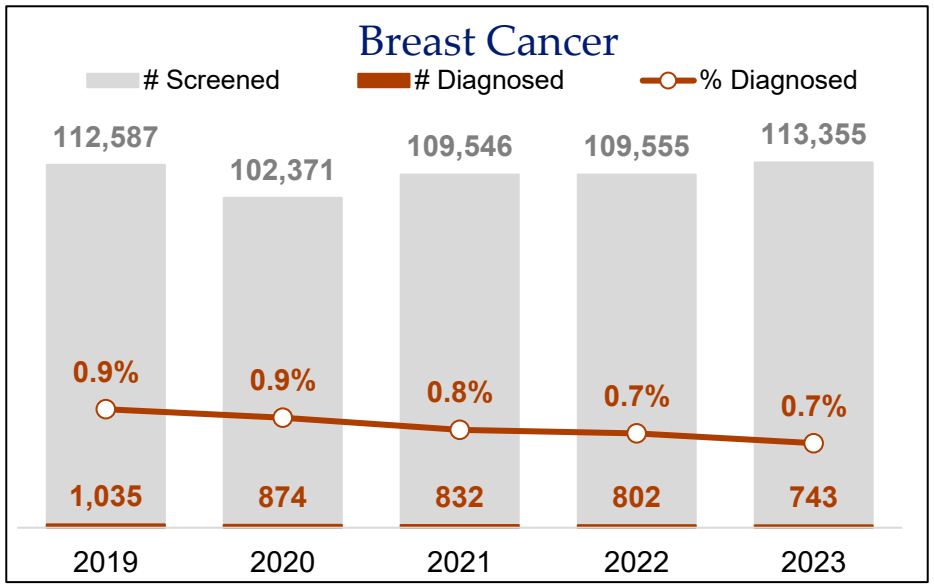
Observations

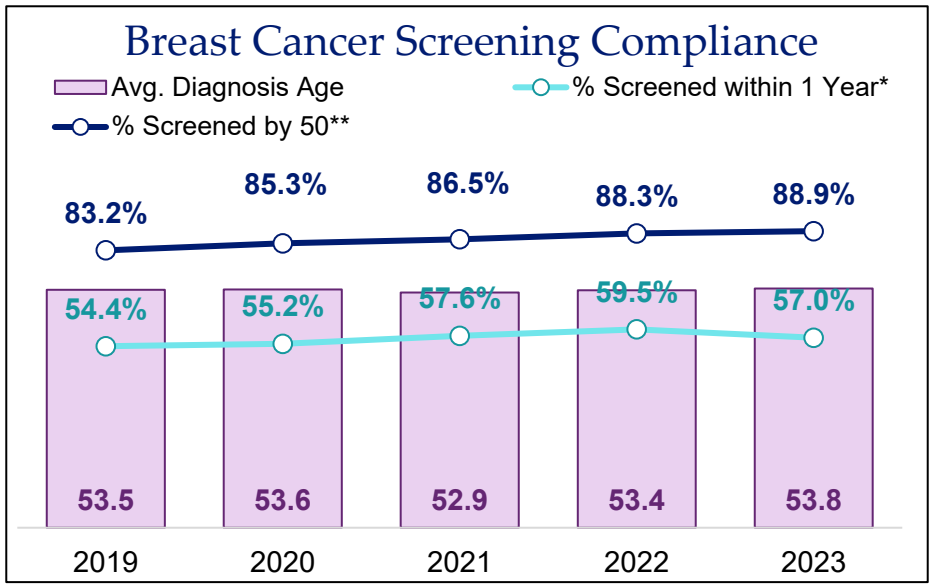
- Preventive Malignancies screenings suffered some of the largest reductions in utilization during the pandemic, particularly in April 2020. With the exception of cervical cancer, cancer screenings have mostly returned to pre-pandemic levels.
- Breast cancer and prostate cancer screening adherence is strongest at over 75%.
- We are showing low colorectal cancer screening compliance at approximately 61%. However, this metric can be difficult to measure due to the recommendations for this exam being once every ten years for some members.

[1] Annualized trend reflects the average annual trend between CY 2019 and CY 2023.
[2] Colorectal prior to 2023 reflects target demographic of age 50-75.
[3] Source: SHAPE Book of Business for public sector groups, adjusted for age and gender.

Cancer

Screenable Cancers - Breast





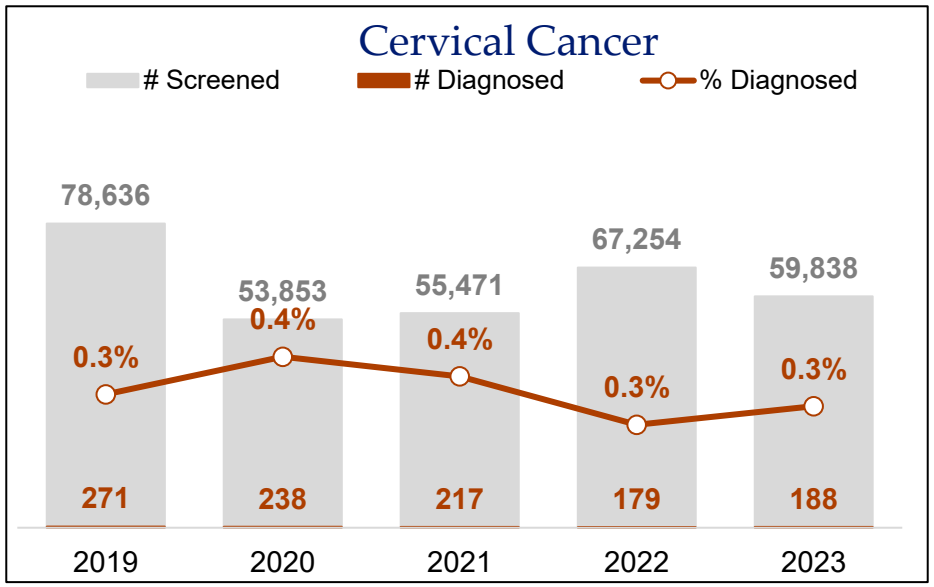
Observations

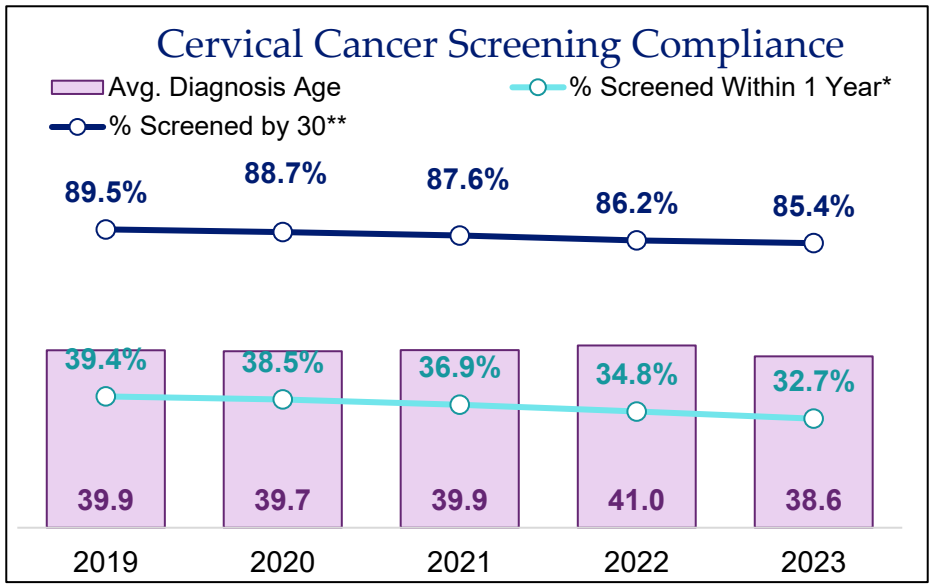
- After skin cancer, breast cancer is often the most prevalent screenable cancer and is a significant driver of both medical and pharmacy costs.
- During the pandemic in 2020 breast cancer screenings reached a low point of 102k members screened. The number of members screened has increased every year since then.
- The percent of members diagnosed (based on those screened) has decreased from 0.9% in 2019 to 0.7% in 2023. Typically, 0.5% - 1.0% of members screened will have cancer present. When over 1% of cancers screenings come back positive, it may be a sign that not enough members are getting screened.
- It is recommended that women begin breast cancer screenings at age 40. About 54% of women were getting screened within a year of turning 40 in 2019. In 2023 about 57% of women were screened within a year of turning 40.
- About 11% of females in the Plan did not have a breast cancer screening by age 50 in 2023, down from 17% in 2019.

**Screened within 1 year of turning age 40.*
***Only includes members enrolled in the Plan for at least one year prior to turning age 50.*

Cancer

Screenable Cancers - Cervical





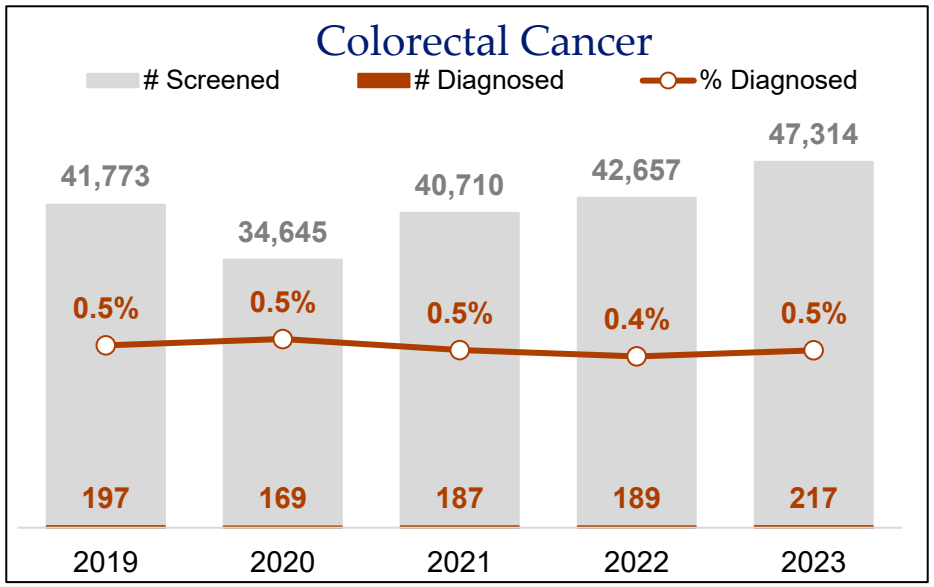
Observations

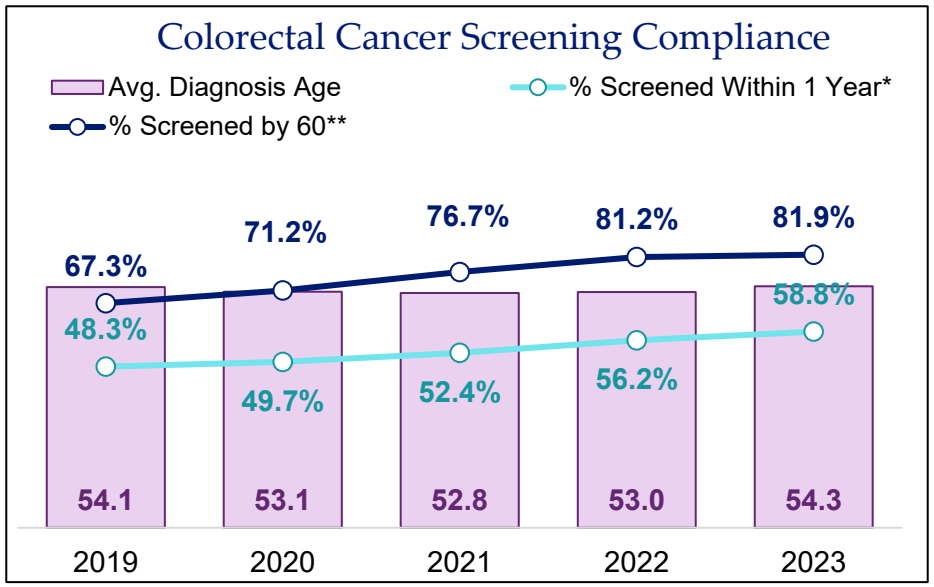
- Cervical cancer is the least prevalent screenable cancer but can be the most expensive to treat.
- Females are recommended to receive a cervical cancer screening beginning at age 21. 78,636 females in the Plan received a cervical cancer screening in 2019, the highest of any year during the experience period.
- 39.4% of females who turned age 21 in 2019 had a cervical cancer screening within 1 year, which is the highest rate during the experience period. In 2023, only 32.7% of females had a cervical cancer screening within a year of turning 21, the lowest rate during the last five years.
- Almost 90% of females in the Plan had a cervical cancer screening by age 30 in 2019 versus only 85.4% in 2023.

**Screened within 1 year of turning age 21.*
***Only includes members enrolled in the Plan for at three years prior to turning age 30.*

Cancer

Screenable Cancers - Colorectal





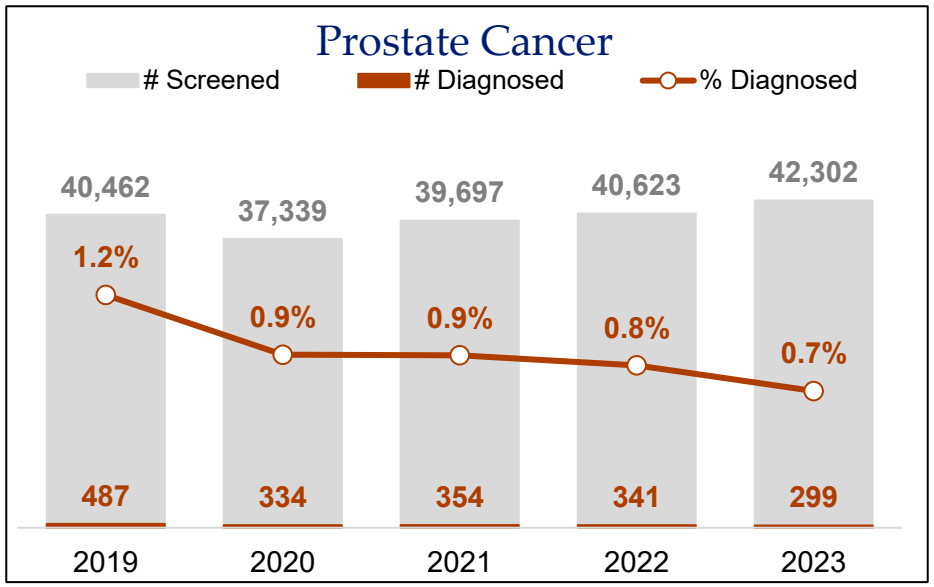
Observations

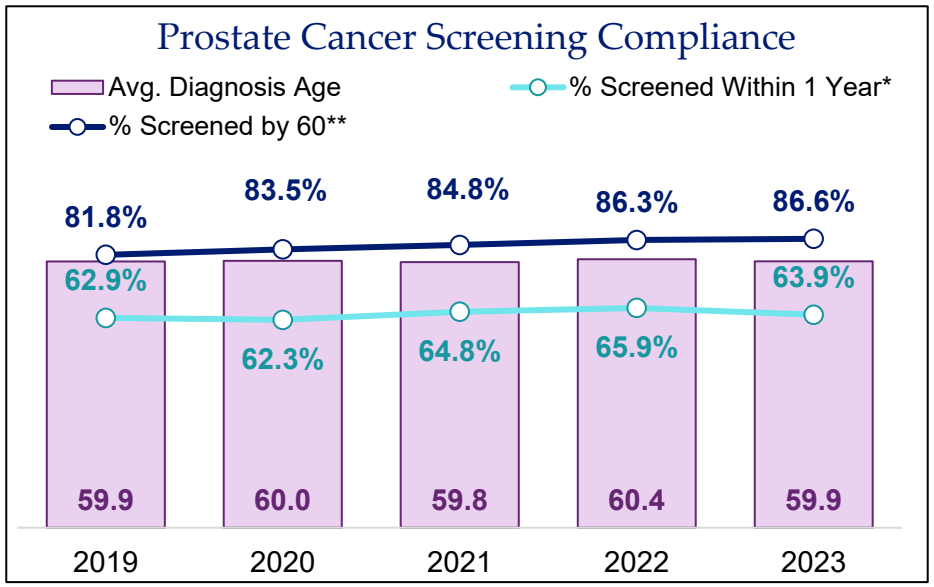
- The recommended age to begin colorectal cancer screenings recently decreased from 50 to 45. However, we are using 50 in the above exhibit due to this being a recent change.
- Colorectal cancer screenings are particularly valuable to get as soon as recommended. Although cancer is typically only detected in 0.5% - 1.0% of screenings, As much as 40% of colorectal cancer screenings find pre-cancerous polyps and typically 5-10% of pre-cancerous polyps turn into cancer. Thus, getting a colorectal cancer screening as early as recommended can help reduce cancer prevalence and/or improve outcomes.
- The percent of members turning age 50 who receive a colorectal cancer screening within one year continues to improve. Only about 48% had the recommended screening within a year of turning age 50 in 2019, but that has improved to 59% in 2023.
- Approximately 19% of members still did not receive a colorectal cancer screening by age 60 in 2023, down from 33% in 2019.

**Screened within 1 year of turning age 50.*
***Only includes members enrolled in the Plan for at least five years prior to turning age 60.*

Cancer

Screenable Cancers - Prostate





Observations

- Prostate cancer screenings, which are recommended for males beginning at age 50 who are at average risk, have the highest compliance rates in the Plan of all screenable cancers.
- Although prostate cancer screenings slipped in 2020 during the pandemic, screening rates are now higher than pre-pandemic rates.
- Almost 64% of male members received a prostate cancer screening within 1 year of turning 50 in 2023, up slightly from 2019 but down from 2022.
- Although compliance is high, there are still over 13% of members who turned age 60 in 2023 that have never had a prostate exam.

**Screened within 1 year of turning age 50.*
***Only includes members enrolled in the Plan for at least two years prior to turning age 60.*

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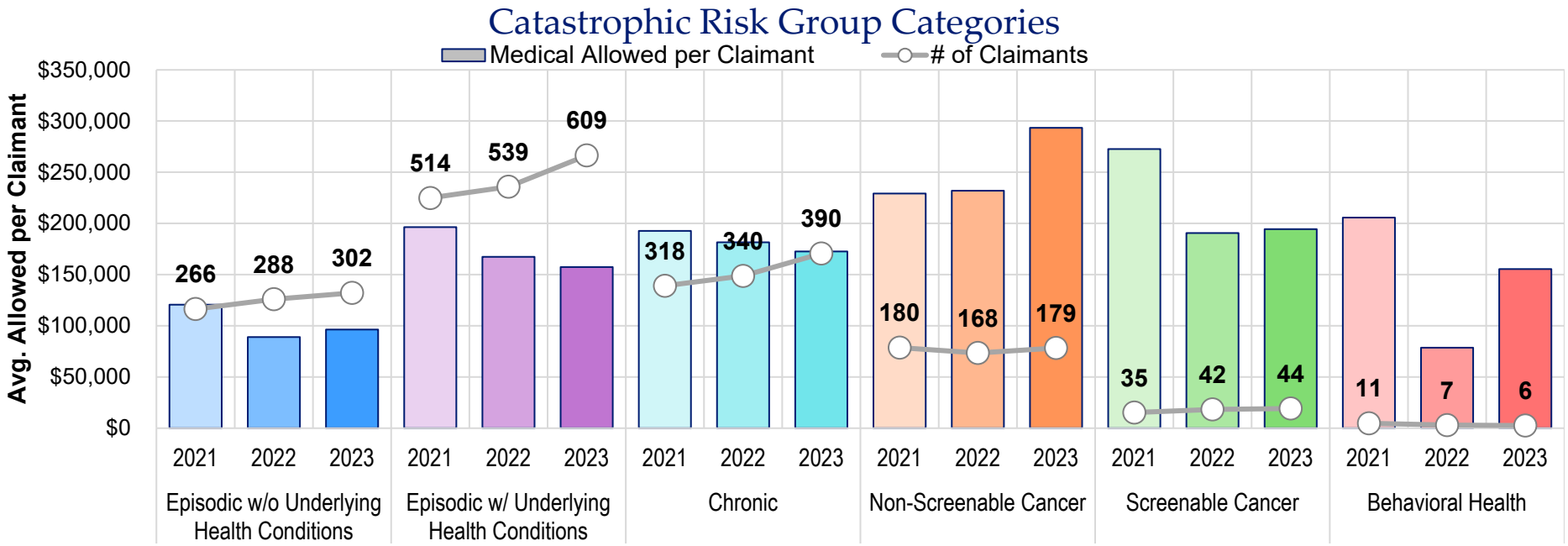
Catastrophic Risk Group

Summary by Category

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer



Observations

- The chart above shows members in the catastrophic risk group by year grouped into six different categories.
  - Episodic w/ underlying health conditions includes any member with at least one major chronic condition[1], but the high-cost claim was for an acute event.
  - Behavioral health includes both mental health and substance use disorder related claims.
  - Screenable cancer includes breast, cervical, colorectal, lung, prostate, and skin cancers.
- Typically, the episodic w/ underlying health conditions, chronic, behavioral health, and screenable cancer categories represent the greatest opportunity for intervention and prevention. These cohorts represented 69% of all high-risk members in 2023.

[1] Chronic conditions include: asthma, coronary artery disease (CAD), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, and hypertension.

Catastrophic Risk Group

Top Conditions

North Carolina State Health Plan
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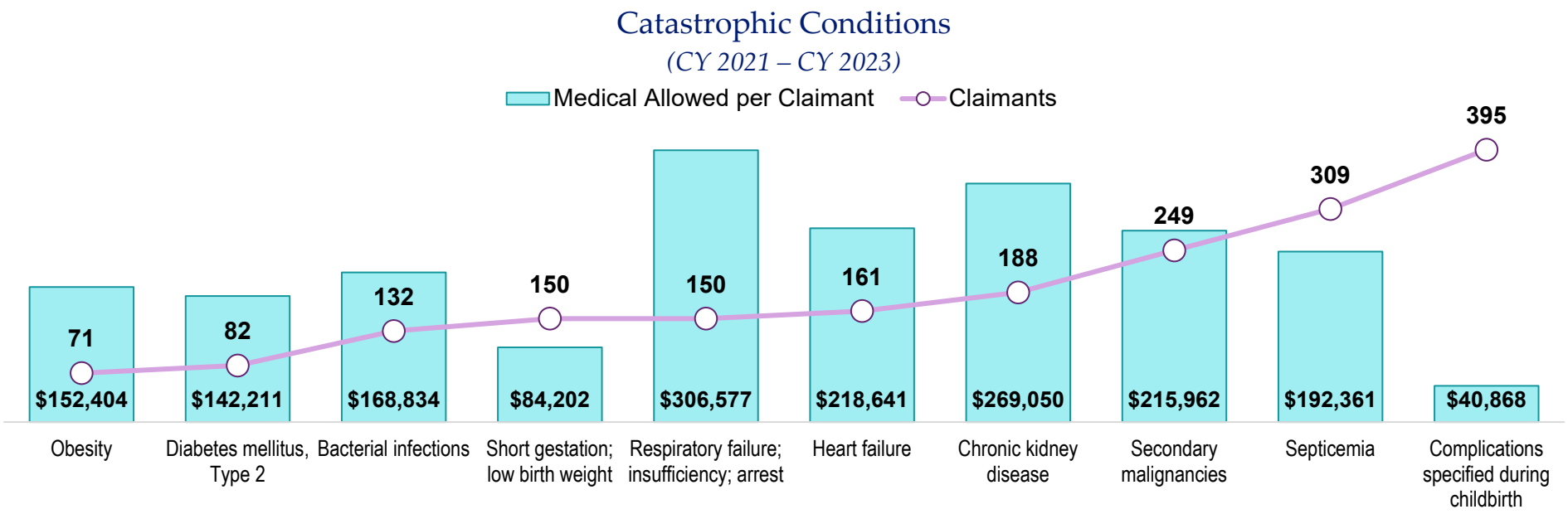

Observations

- The chart above shows the top-10 most prevalent conditions for members in the catastrophic risk group during the 3-year period of 2021 – 2023.
- Diabetes is the 9th most prevalent condition for members in the catastrophic risk group. However, several other conditions are common complications from unmanaged diabetes, including chronic kidney disease, heart failure, respiratory failure, and obesity.
- Septicemia, which is a serious condition in which bacteria infects the bloodstream, is the second most prevalent condition for members in the catastrophic risk group and can be indicative of low quality of care and insufficient post-discharge care. It was also a common condition following hospitalizations for COVID-19.

Catastrophic Risk Group

Chronic Conditions

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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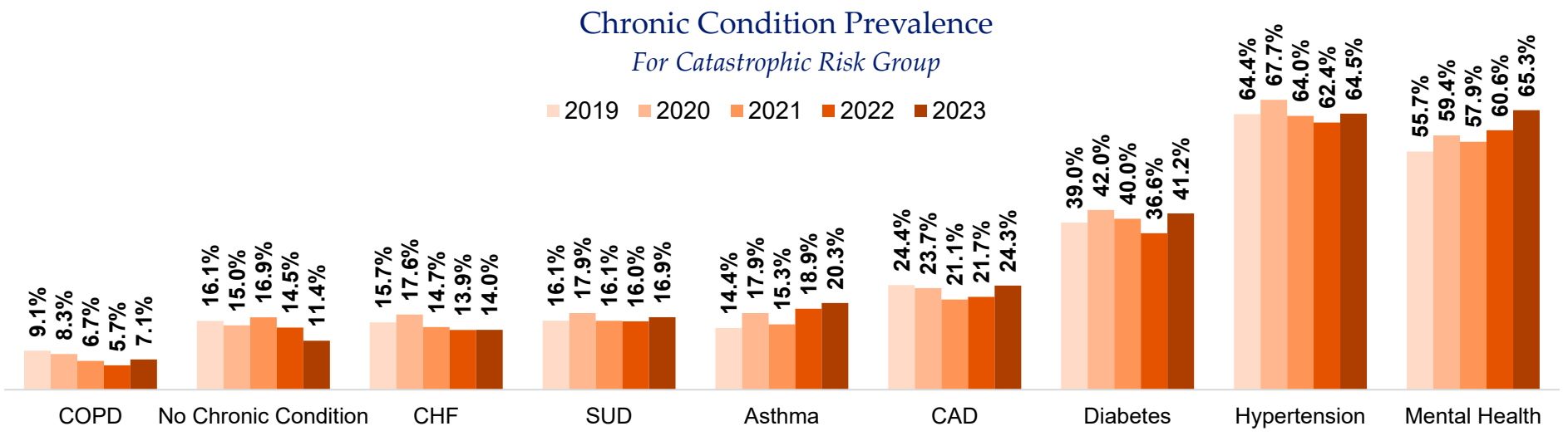

Observations

- Although many members in the catastrophic risk group have what appear to be episodic-type events, the event is often triggered by underlying chronic conditions and can be avoided through lifestyle changes, medication adherence, and other modifiable factors.
  - 89% of members in the catastrophic risk group had one or more of the eight chronic conditions listed above in 2023, up from 84% in 2019.
- 41% of members in the catastrophic risk group in 2023 had diabetes and 66% had hypertension.
  - In 2019, 39% of members in the catastrophic risk group had diabetes.
- Approximately 2/3 of members in the catastrophic risk group had a mental health condition present in 2023, up from 56% in 2019.

Catastrophic Risk Group

Chronic Conditions

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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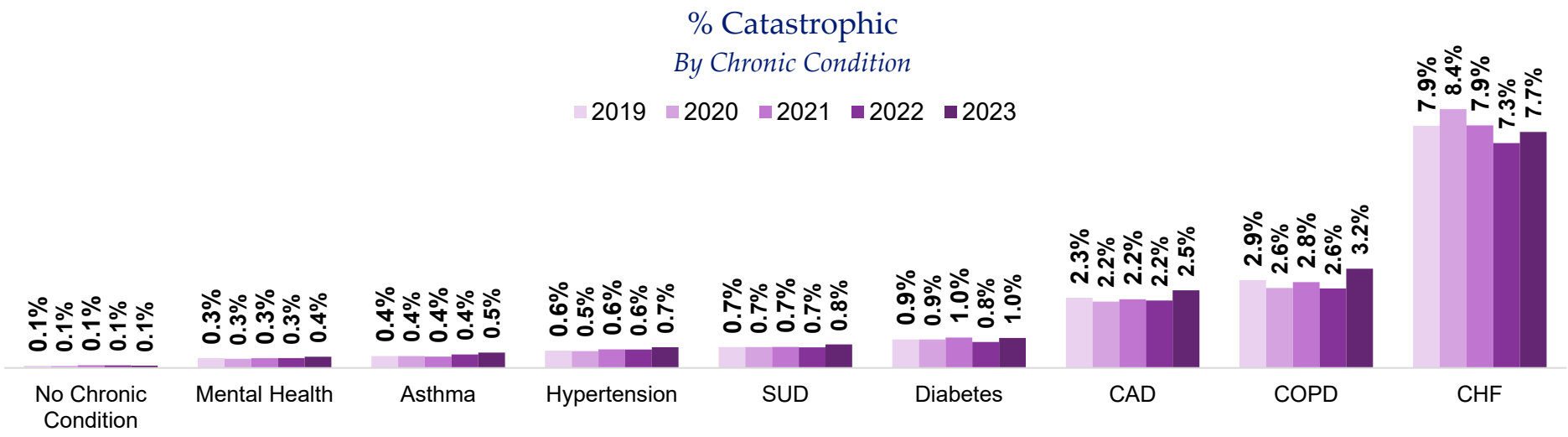

Observations

- Approximately 0.7% of members with hypertension and 1.0% of members with diabetes are in the catastrophic risk group. Although these conditions don't result in much risk on their own, if left unmanaged more serious comorbidities can develop. Coronary artery disease (CAD) and congestive heart failure (CHF) are often the result of unmanaged high blood pressure (hypertension), high cholesterol (hyperlipidemia), and/or diabetes but can also be triggered by alcohol abuse.
  - CHF presents the most risk of all chronic conditions here, with almost 8% of members with this condition in the catastrophic risk group. CAD is third with about 2.5% of members with the condition in the catastrophic risk group.
- Mental health is not a significant risk factor on its own with less then 0.5% of members with a mental health condition in the catastrophic risk group. However, mental health disorders can increase risk substantially when present alongside physical chronic conditions, partially due to lower adherence rates to recommended care. When evaluating chronic condition management, it is important to consider the mental health component as well.

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Diabetes, Cardiovascular Disease, and Obesity

Glucagon-Like Peptide-1 Agonists (GLP-1s)

North Carolina State Health Plan
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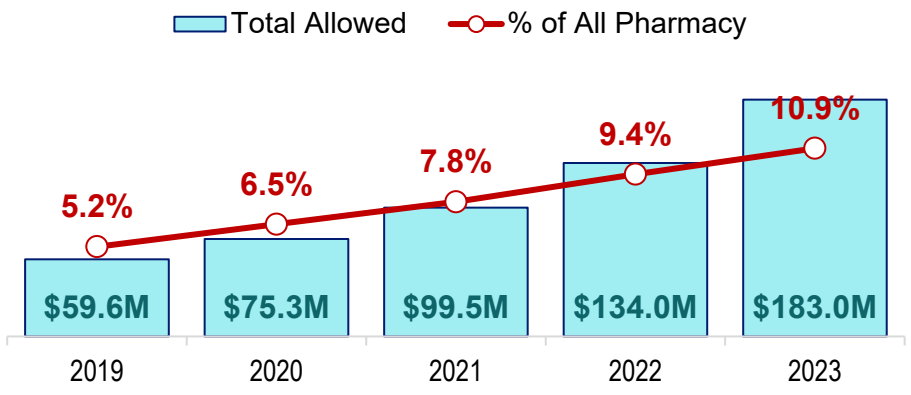
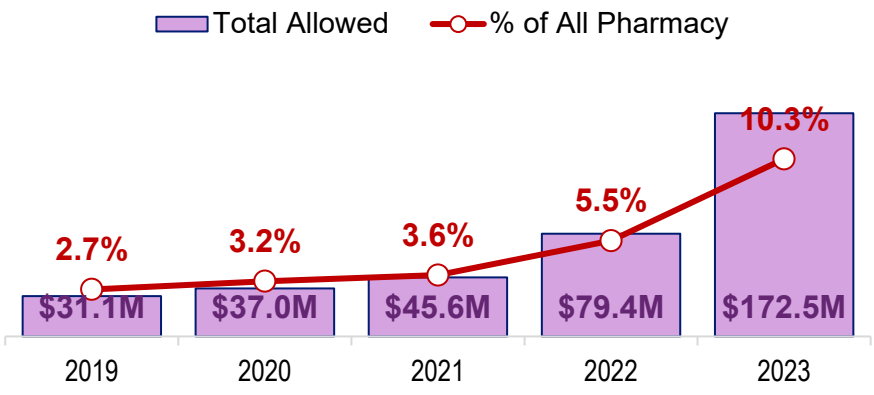
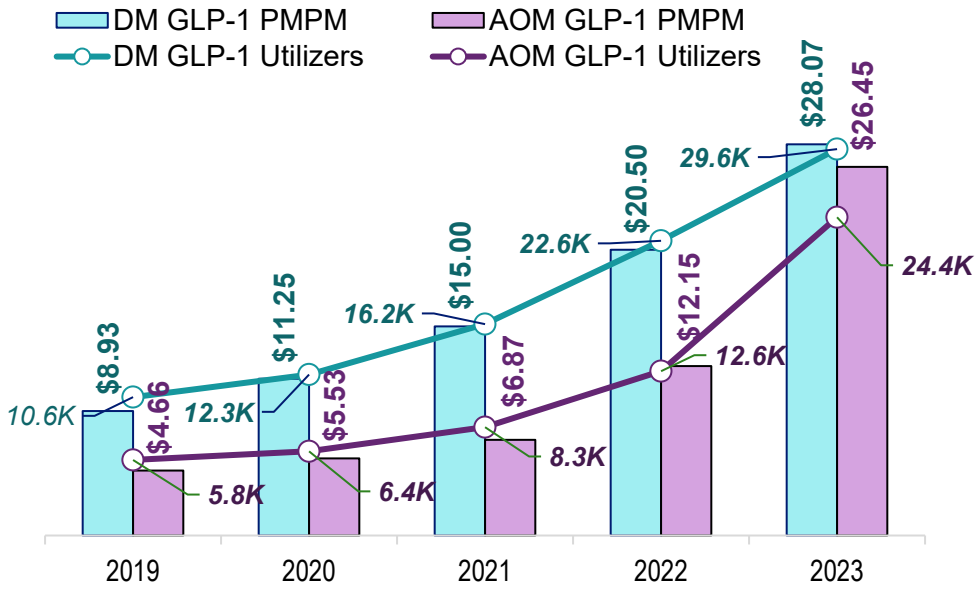
Anti-Diabetic GLP-1 Summary



Anti-Obesity GLP-1 Summary



GLP-1 Utilizers and PMPM



Observations

- GLP-1 medications have been a large part of the Plan's spend.
- Despite the small utilizer base, anti-obesity GLP-1s (AOMs) have nearly equaled the cost of anti-diabetic GLP-1s (DM) in 2023 due to their higher cost.
- While these medications can be highly effective for both diabetes and weight loss, often individuals are not aware of the potential side effects associated with them nor how to properly initiate therapy and adjust one's diet, which can lead to early discontinuation and medication waste.

Diabetes, Cardiovascular Disease, and Obesity

GLP-1s: Persistence

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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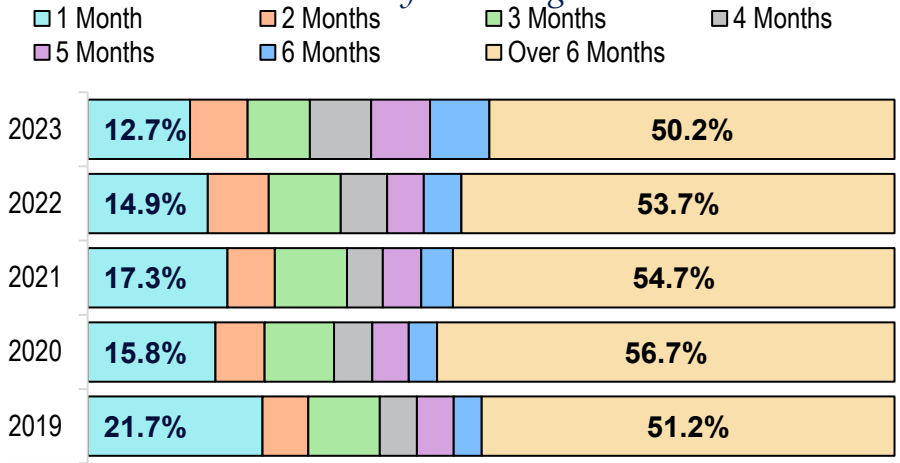
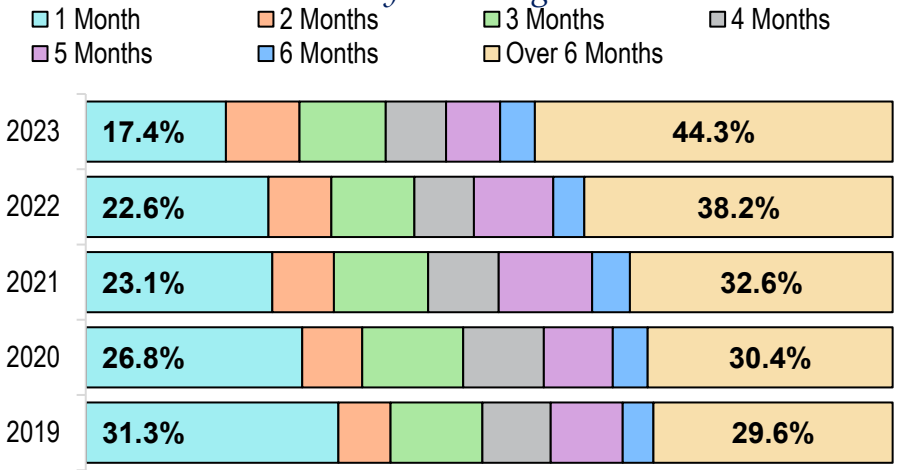
Anti-Diabetic GLP-1 Persistence

Members Only Utilizing DM GLP-1s



Anti-Obesity GLP-1 Persistence

Members Only Utilizing AOM GLP-1s

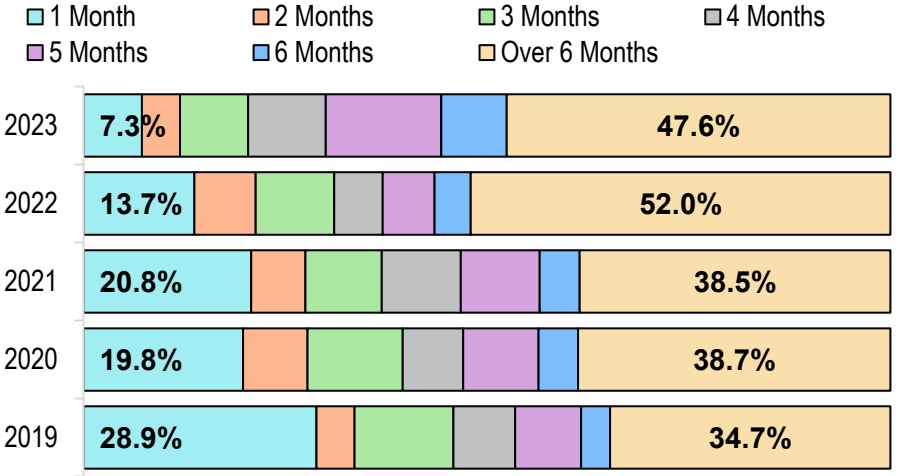


Observations

- Medication persistence is considered the duration of time an individual continues a medication after initiation until discontinuation (considered to occur if no medication refill occurs within 2x the expected duration of a prescription).
- For anti-diabetic GLP-1s, longer-term, over 6-month persistence has historically been above 50%.
- Conversely, persistence for anti-obesity GLP-1s was as low as 30% prior to 2021 but has increased to 44.3% in 2023. For weight loss treatment, 6 months is considered the minimum time until assessment of weight loss benefit but less than half of new utilizers reach this standard.
- The bottom right highlights persistence trends for members who used both an anti-diabetic and anti-obesity GLP-1 at various times, persistence for this group has also increased.

Combined GLP-1 Persistence

Members Utilizing Both Types of GLP-1s



Segal

Diabetes, Cardiovascular Disease, and Obesity

GLP1s: Target Doses

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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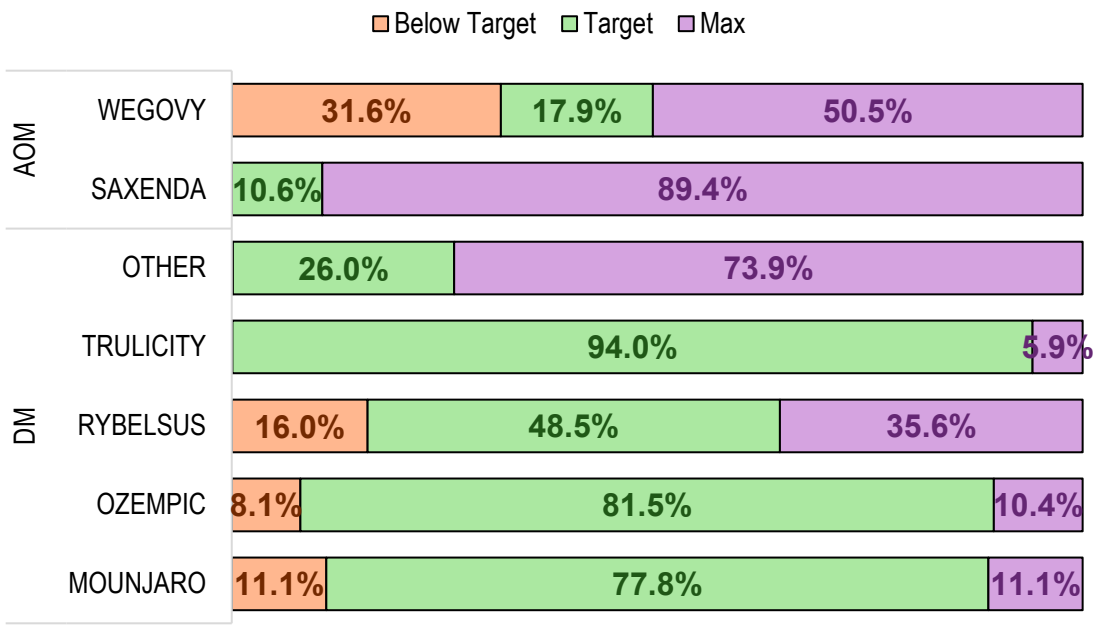
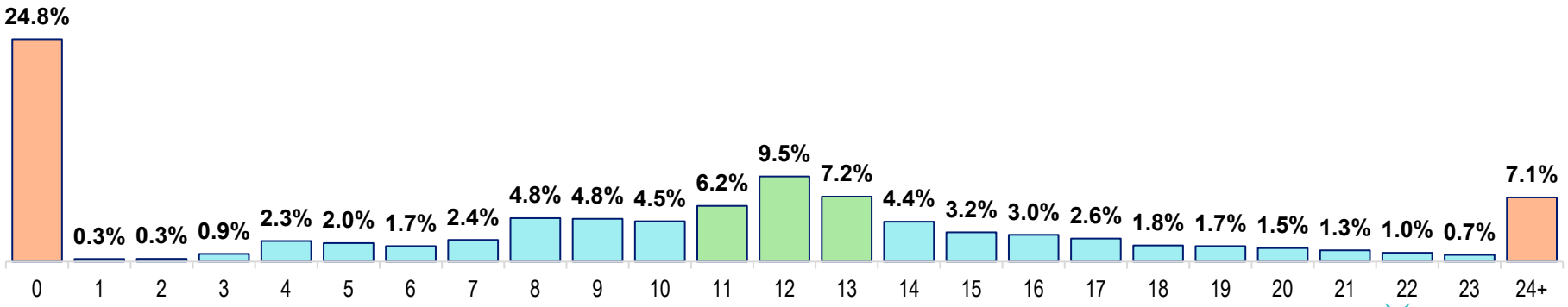
GLP-1 % Days Prescribed at Target Dosing



Observations

- Certain GLP-1 medications have target dosage ranges, which are the approved doses for clinical effectiveness. For anti-diabetic GLP-1s, Mounjaro, Ozempic, and Rybelsus all have starting doses used to reduce gastrointestinal side effects, but members should be initiated on a target dose between 4 and 6 weeks. For weight loss, Wegovy has a target dose typically reached 12 weeks after initiation, with the maximum dose the preferred. Overall, nearly one-third of prescribed doses for Wegovy are not within the target range although half of days supply are prescribed at the maximum dosage.
- Often, providers prescribed patients the full range of prescriptions from initiation to target dose, which can lead to waste if members do not tolerate therapy. For Wegovy, particularly, nearly 25% of new utilizers received a prescription for a target dosage at the start of treatment (either alone or in addition to other Wegovy prescriptions).

Wegovy – Weeks to Target Dose



Segal

Diabetes, Cardiovascular Disease, and Obesity

Anti-Diabetic GLP1s: Accrued Doses

North Carolina State Health Plan
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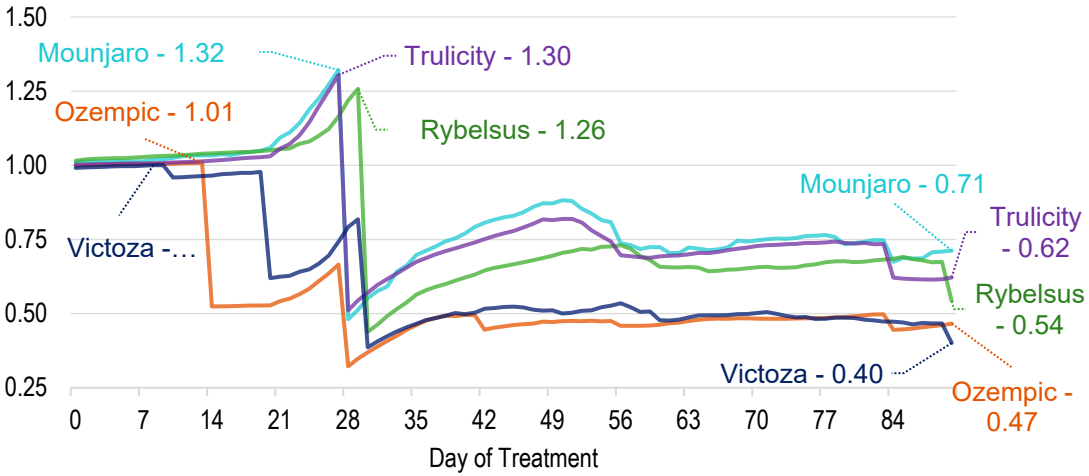
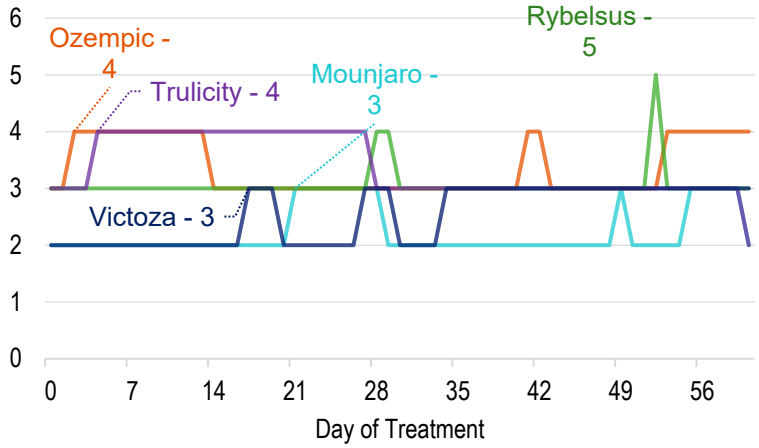
Average Doses Available - DM

Accrued Daily Doses – First 90 Days



Maximum Doses Available - DM

Accrued Daily Doses – First 60 Days



Observations

- GLP-1 medication shortages have been on ongoing concern, which can lead to over-dispensing up front, potentially resulting in stockpiling and or waste. Full assessment of stockpiling can be difficult as GLP-1 medications may be prescribed at a dose less than the maximum able to be administered. For example, Victoza may be prescribed at a dose between 0.6 mg and 1.8 mg per day, A standard Victoza pen may provide up to 18 mg, or 10 daily doses at the maximum of 1.8 mg or 30 daily doses at 0.6 mg per day.
- The above provides the average total daily doses members had available based on the actual quantity filled and the **maximum** dosage a product may provide each day after first starting treatment. Accrued daily doses above 1 indicate overlap in prescriptions due to either refiling prior to the end date of the previous prescription or filling multiple prescriptions at once.
- Mounjaro, Trulicity, and Rybelsus were the most prone to frequent, initial dispensing with averages has high as 1.32, 1.30, and 1.26, respectively. After 90 days, fill rates for all medications decreased, but members on Mounjaro were most consistently filling, with an average of 0.71 daily doses available per day. Conversely, Victoza and Ozempic had averages below 0.5, which could point to low adherence, use of lower dosages, or difficulty in obtaining medication, any of which could reduce effectiveness of treatment.
- In terms of individual utilizers, Ozempic and Trulicity saw members having medication supplies on-hand of up to 4 times more than potentially needed within the first 2 – 4 weeks of therapy.

Diabetes, Cardiovascular Disease, and Obesity

Anti-Obesity GLP1s: Accrued Doses

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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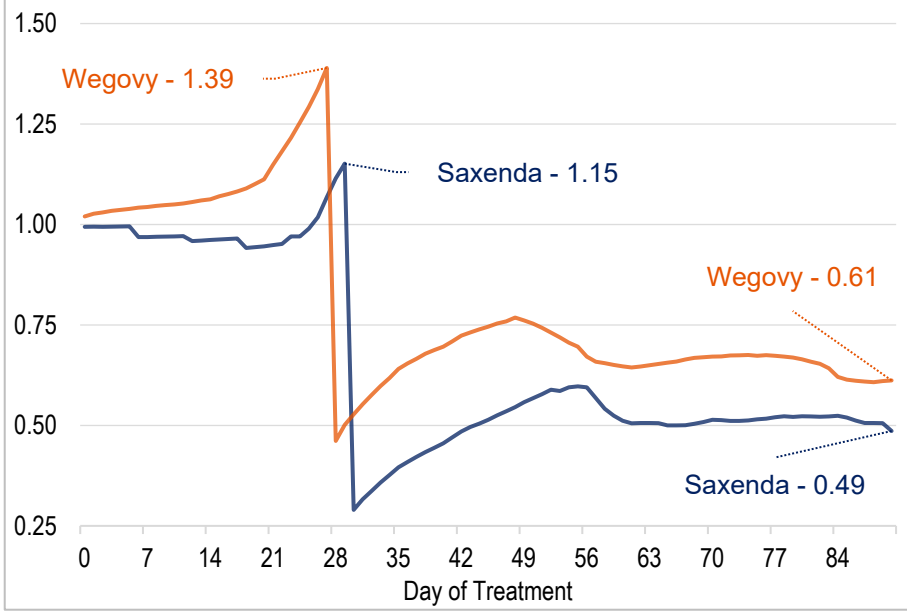
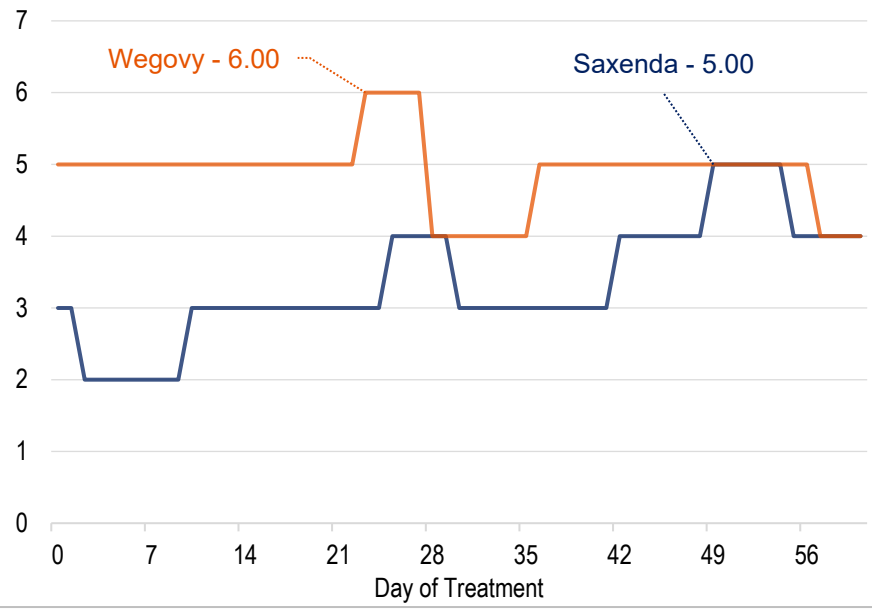
Average Doses Available – AOM

Accrued Daily Doses – First 90 Days



Maximum Doses Available – AOM

Accrued Daily Doses – First 60 Days



Observations

- For anti-obesity GLP-1s, Wegovy was most notable for frequent, initial filling, with members averaging 1.39 doses available by the end of week 4 of starting therapy compared to 1.15 for Saxenda.
- After 90 days, like with DM GLP-1s, fill rates decreased, however, Wegovy utilizers had an average of 0.61 daily doses on hand compared to 0.49 for Saxenda. As with Victoza, Saxenda may be used at a dosage between 0.6 mg per day or has high as 3 mg per day, which could indicate utilizers on lower dosages. However, Wegovy is a fixed dose per pen and despite persistence improving, low average doses on hand could point to poor medication adherence or shortages, which reduces effectiveness.
- As with DM GLP-1s, and as noted earlier, individual members may fill multiple prescriptions up front. This trend is more pronounced with weight loss-specific GLP-1s where members had 5 or even 6 doses available on hand at a time within the first 60 days.

Diabetes, Cardiovascular Disease, and Obesity

Anti-Obesity GLP-1s Utilizers with Diabetes

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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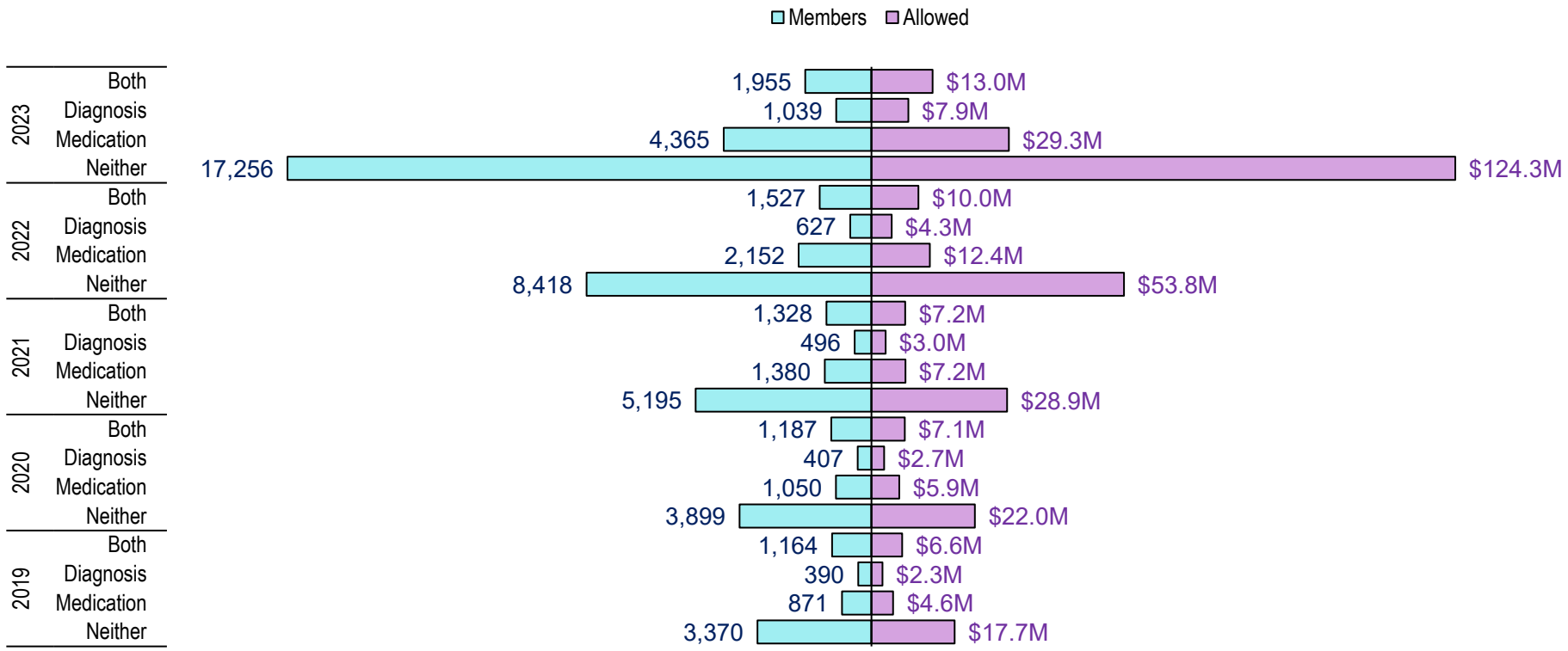
Total Members and Pharmacy Allowed

Anti-Obesity GLP-1 Users by Prior Diabetes Diagnosis or Medication Use



Observations

- The Plan excluded anti-obesity GLP-1 medications effective April 1, 2024; however, a number of members have a diagnosis of diabetes or prior anti-diabetic medication usage (GLP-1 or other) as noted above.
- In 2023, 7,359 of 24,615 members had a diagnosis of diabetes or received an anti-diabetic medication with a total of $50.1M (28.7% of total AOM GLP-1 spend). The Plan may see these members converted to anti-diabetic GLP-1s in the future.

Diabetes, Cardiovascular Disease, and Obesity

Glucagon-Like Peptide-1 Agonists (GLP-1s) Monitoring

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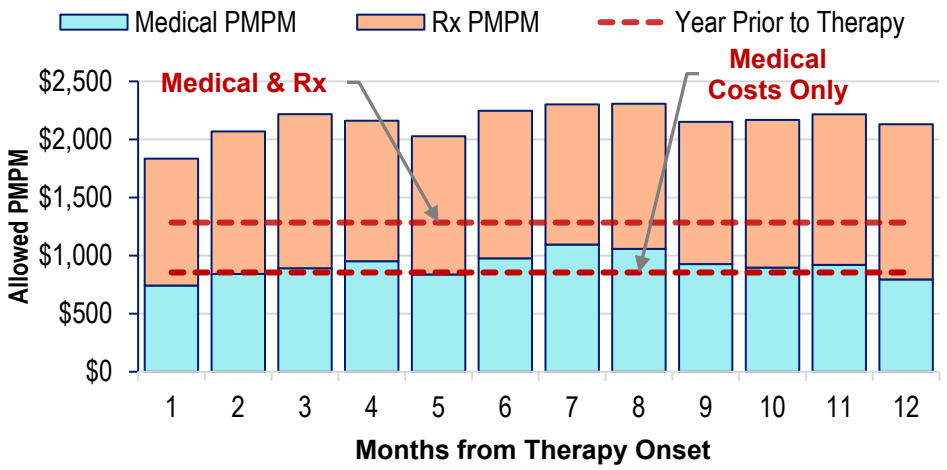
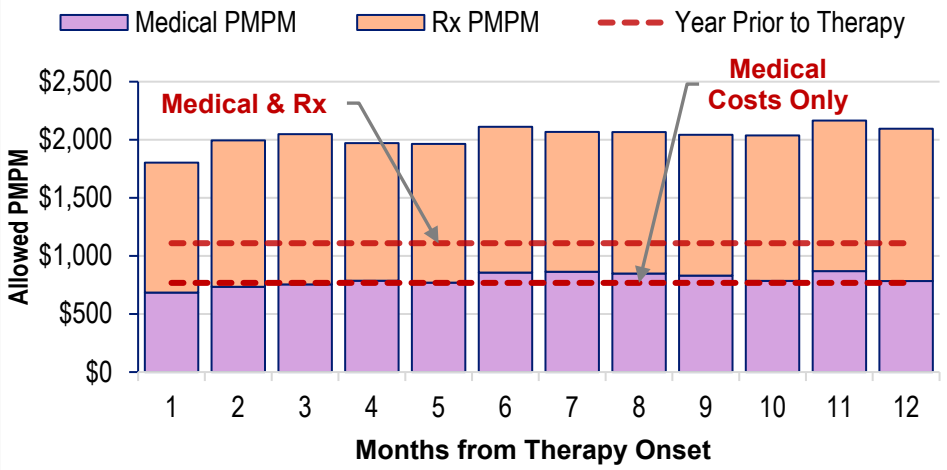
Anti-Diabetic GLP-1 Summary[1]



Anti-Obesity GLP-1 Summary[2]



Observations

- In order to review the effectiveness of GLP-1 medications, we have identified a cohort of individuals who started therapy in 2022 and had at least four scripts filled. Experience was reviewed for the 12 months following therapy onset and compared to the 12 months prior to therapy use.
- For members with at least four prescriptions of anti-diabetic GLP-1s, prescription drug costs were $430 PMPM in the year prior to therapy onset and medical costs were $855 PMPM ($1,285 total PMPM). For the year after therapy onset, prescription drug costs were $1,239 PMPM and medical costs were $910 PMPM ($2,149 total PMPM).
- For members with at least four prescriptions of anti-obesity GLP-1s, prescription drug costs were $341 PMPM in the year prior to therapy onset and medical costs were $768 PMPM ($1,109 total PMPM). For the year after therapy onset, prescription drug costs were $1,230 PMPM and medical costs were $794 PMPM ($2,024 total PMPM).
- Although there is limited evidence that use of GLP-1 medications results in material improvements on the medical side, it may take several years for benefits to manifest and should be monitored periodically.

[1] *Includes 5,655 members who started therapy in 2022 and had at least four fills.*
[2] *Includes 9,609 members who started therapy in 2022 and had at least four fills.*
Note: Rebates are not included as an offset to prescription drug costs.

Diabetes, Cardiovascular Disease, and Obesity

Atherosclerotic Cardiovascular Disease (ASCVD) Comorbidity

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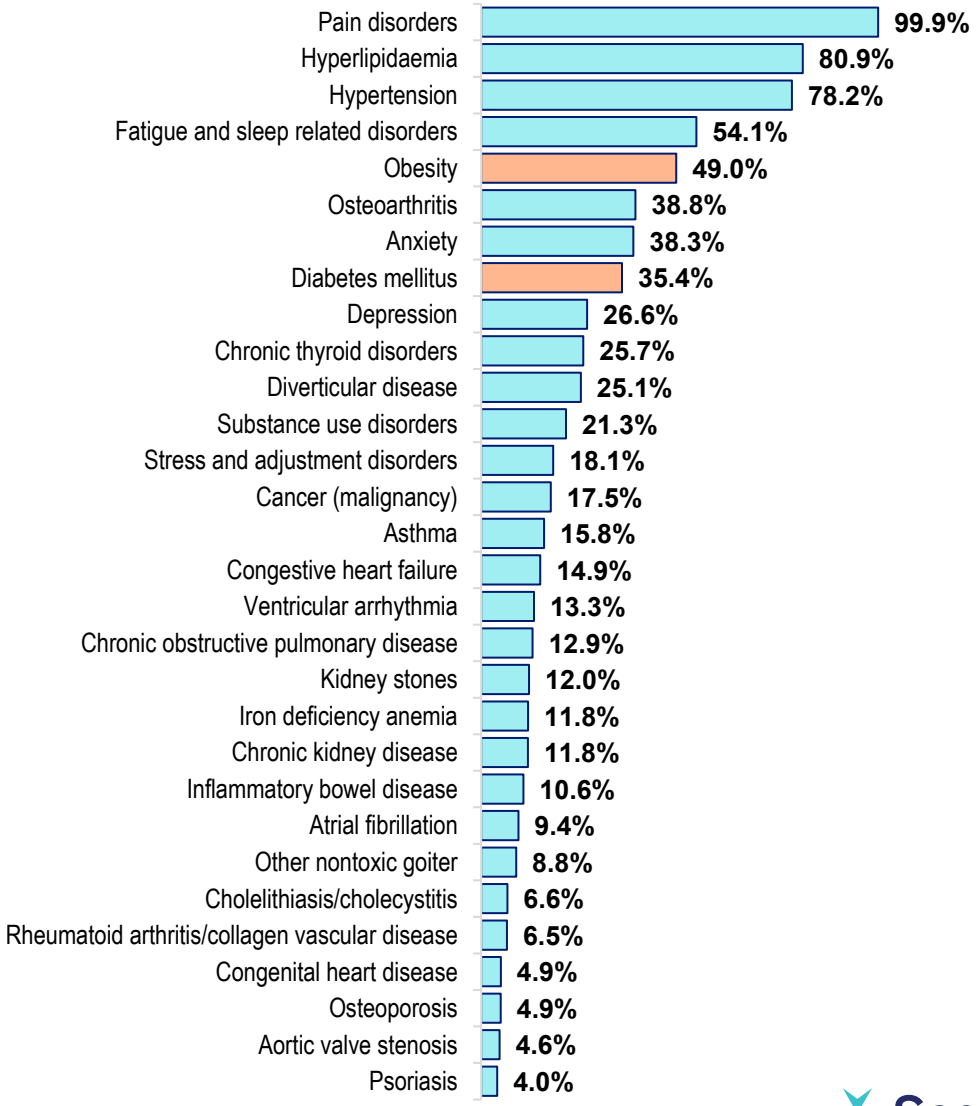
Observations

- GLP-1s medications are currently recommended or approved for both type 2 diabetics with atherosclerotic cardiovascular disease (ASCVD) and in individuals with obesity or overweight with comorbidities and a history of CVD to reduce the risk of severe CV events. Studies are underway to expand these CV risk reduction indications to non-weight loss versions of GLP-1 medications, which could increase utilization further.
- ASCVD is often accompanied by multiple comorbidities. The prevalence of comorbidities for a subset of members (24,265) with an ASCVD[1] diagnosis are shown to the right.
- Obesity and diabetes prevalence is 49.0% and 35.4%, respectively, across these members, who would be candidates for cardiovascular or renal risk reduction with GLP-1 therapy.

Comorbidity Prevalence



1. Members with an ASCVD diagnosis since 2019 and 4-years continuous enrollment after initial diagnosis

Diabetes, Cardiovascular Disease, and Obesity

Atherosclerotic Cardiovascular Disease (ASCVD) Comorbidity

North Carolina State Health Plan
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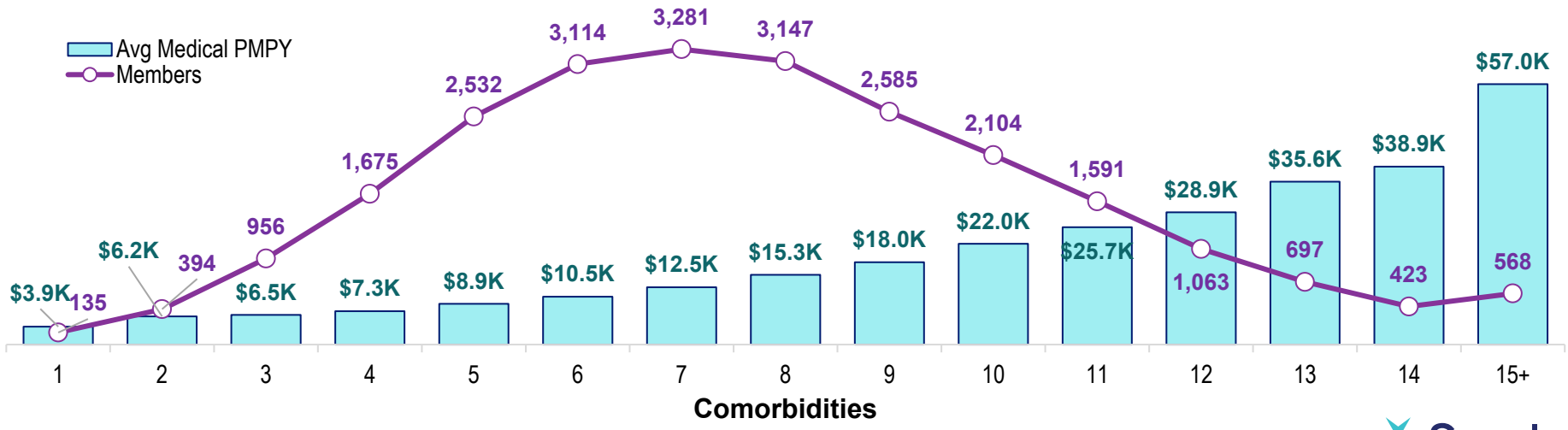
ASCVD Demographics[1]

	Female	Male	All
Average Age	53.5	54.7	54.0
Members	13,357 [55.0%]	10,908 [45.0%]	24,265 [100.0%]
Under 40	992 [4.1%]	620 [2.6%]	1,612 [6.6%]
40-49	2,207 [9.1%]	1,489 [6.1%]	3,696 [15.2%]
50-59	6,058 [25.0%]	4,979 [20.5%]	11,037 [45.5%]
60+	4,100 [16.9%]	3,820 [15.7%]	7,920 [32.6%]
Average Comorbidities	8.2	7.3	7.8
Under 40	6.4	5.5	6.0
40-49	8.0	7.0	7.6
50-59	8.3	7.4	7.9
60+	8.5	7.6	8.1

Observations

- The general demographic breakdown of these ASCVD members is shown to the right, with 55.0% female and an average age of 54.0 years. The average comorbidities is 7.8 per member.
- As comorbidities increase, the average medical PMPY rises as well. For a member with a single condition, the average medical PMPY is under $4K compared to $57.0K for members with 15 or more comorbidities.

Members with ASCVD and Average Medical PMPY[1]



1. Members with an ASCVD diagnosis since 2019 and 4-years continuous enrollment after initial diagnosis

Segal

Diabetes, Cardiovascular Disease, and Obesity

Atherosclerotic Cardiovascular Disease (ASCVD) Comorbidity

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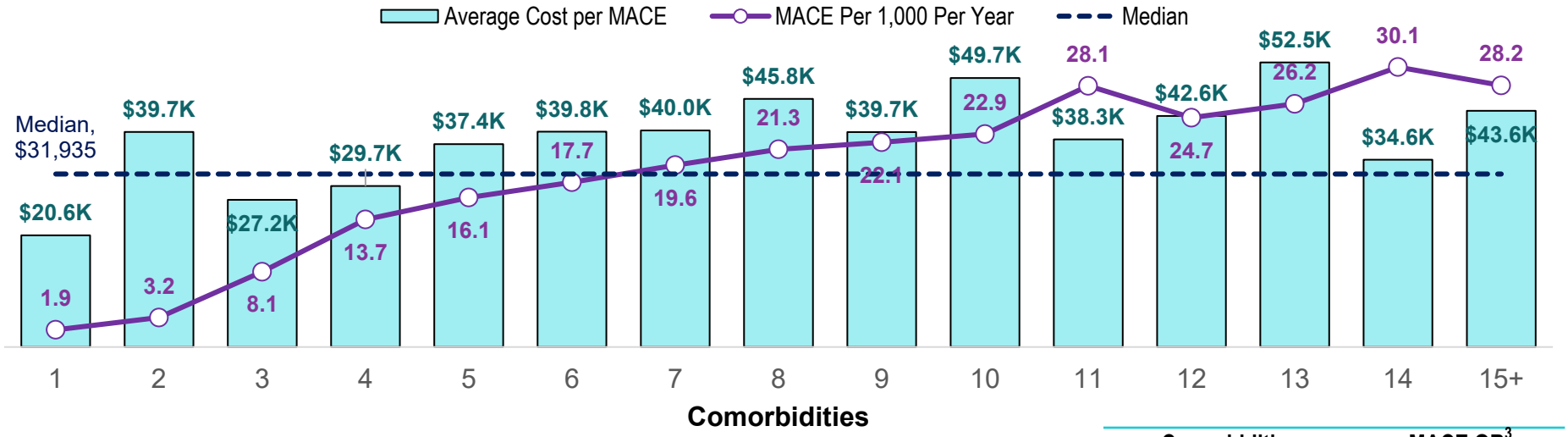
Major Adverse Cardiovascular Events (MACE)[1]



Observations

- Among SHPNC members, the rate of major adverse cardiovascular events (MACE)[2] per 1,000 ASCVD members per year is substantially higher as comorbidities increase. MACE rates for members with 11+ comorbidities is 15x higher than members with only a single condition.
- The median cost for a MACE episode was $31.9K (excluding long-term costs impacts of the event) but increases with comorbidities.
- Wegovy, originally approved as an anti-obesity treatment, obtained FDA-approval for cardiovascular risk reduction as well and now is covered under Medicare due approval of this new indication. Manufacturers are performing studies for similar risk reduction in unrelated to obesity, which could further increase the number of eligible utilizers

Comorbidities	MACE OR[3]
2	1.7
3	4.4
4	7.4
5	8.7
6	9.6
7	10.6
8	11.5
9	11.9
10	12.4
11	15.2
12	13.3
13	14.1
14	16.3
15+	15.2

1. Members with an ASCVD diagnosis since 2019 and 4-years continuous enrollment after initial diagnosis
2. Major adverse cardiovascular events include heart attack or stroke
3. OR – Odds ratio compared to MACE rate for members with 1 comorbidity

Diabetes, Cardiovascular Disease, and Obesity

Obesity Treatment

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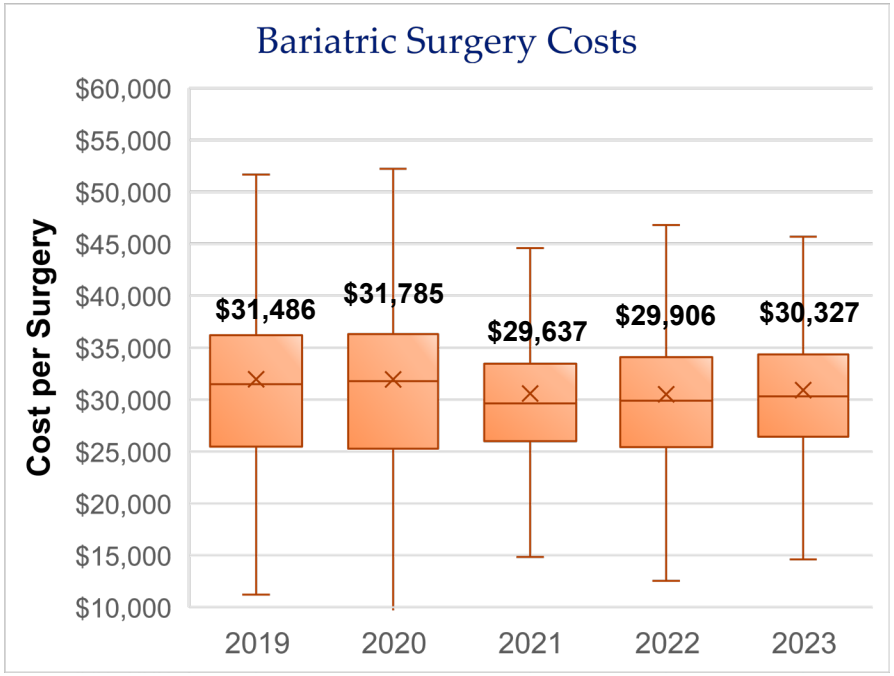

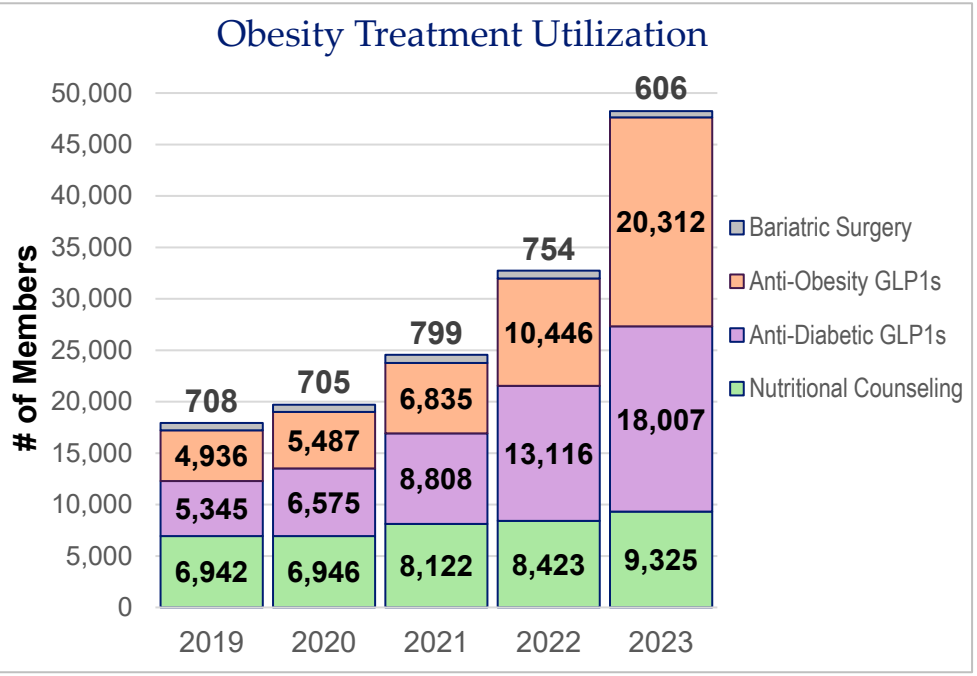

Observations

- As obesity becomes a major cost driver for the Plan it is important to review available treatment options for members.
  - Nutritional counseling was the most popular treatment type in 2019 with 6,942 members utilizing this option. However, GLP-1s are now the most popular obesity treatment option by far. In order for GLP-1s to be most effective, it is important to complement the drugs with lifestyle modifications, including diet and exercise.
- Bariatric surgery is the most effective method of weight loss but is generally only accessible for members considered morbidly obese. The popularity of the surgeries has decreased with the rise of GLP-1s. The cost for these surgeries has been relatively stable over the experience period but can fluctuate depending on the quality of the provider and presence of complications. In 2023, the average cost of surgery was $30,327 but the 25th to 75th percentile of costs ranged from about $25,000 to $35,000. For comparison purposes, the cost for a monthly supply of GLP-1s averages approximately $900 for the anti-diabetic versions and $1,350 for the anti-obesity versions, prior to rebates.

Diabetes, Cardiovascular Disease, and Obesity

Mental Health Comorbidities

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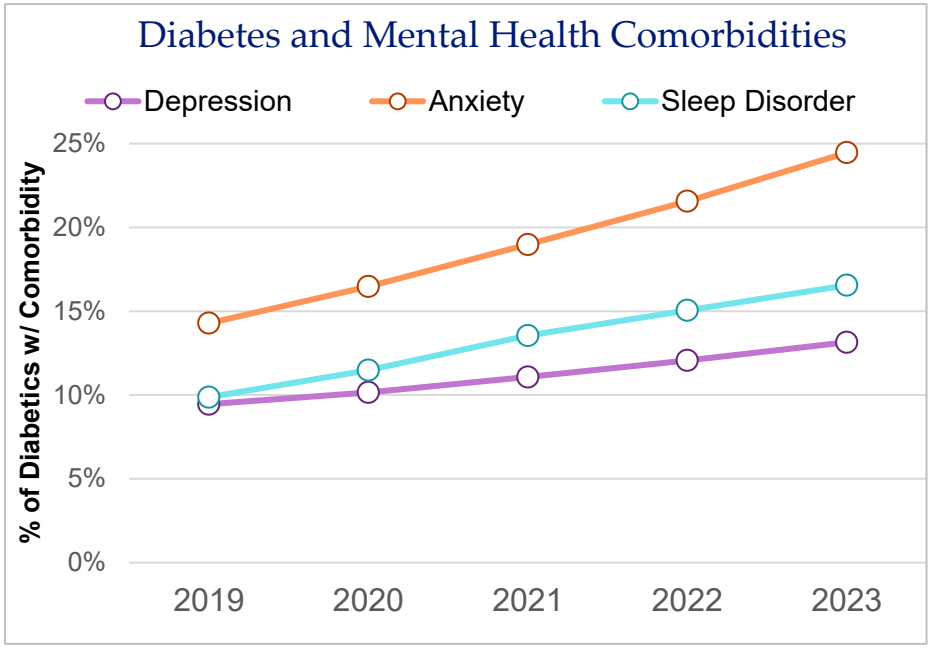

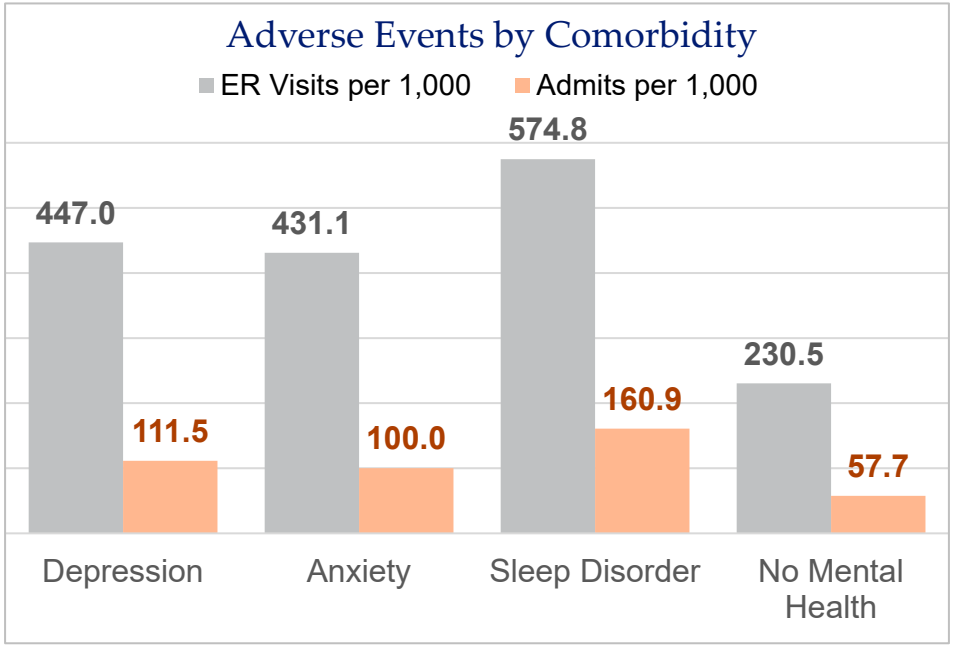

Observations

- When considering improvements in diabetes management, it is important to also factor in common mental health comorbidities that should be managed alongside diabetes.
  - The most common mental health conditions among the Plan's diabetics are anxiety, sleep disorders, and depression, in that order.
  - The prevalence of mental health comorbidities continues to increase significantly. In 2019, 52% of the Plan's diabetics did not have a mental health comorbidity versus only 39% in 2023.
- Sleep disorders have been a trend driver across Segal's book-of-business and can result in worse outcomes if not managed effectively. Diabetics with sleep disorders had significantly more ER visits per 1,000 and admissions per 1,000 than diabetics without this condition present.

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Mental Health

Cost and Prevalence

North Carolina State Health Plan
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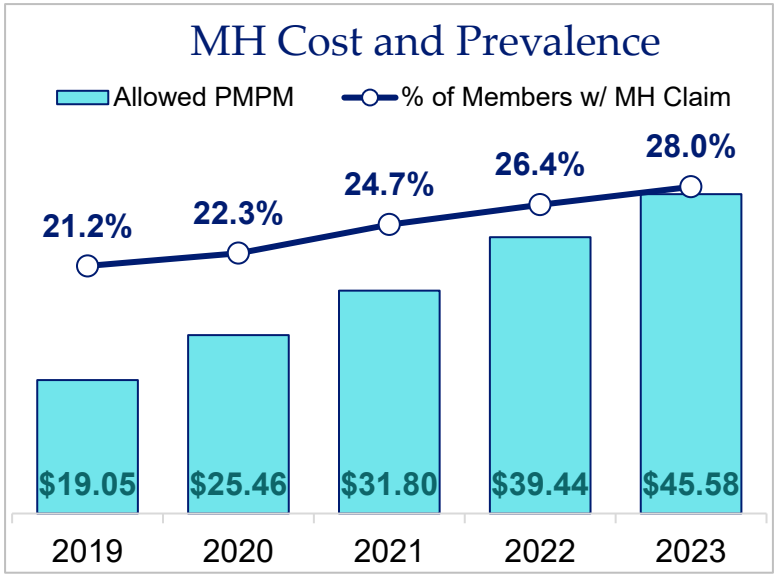

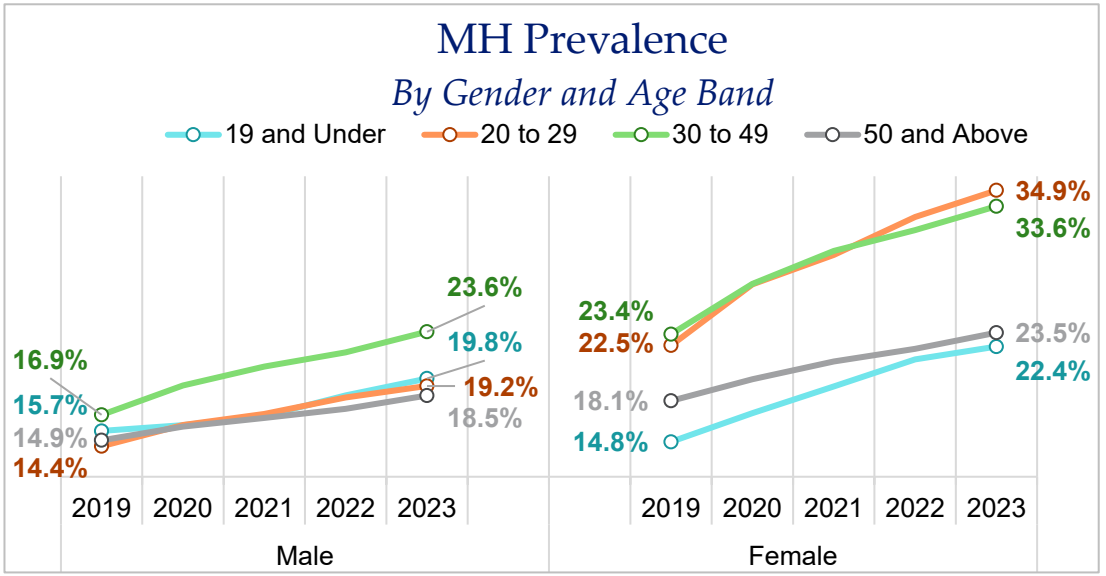

Observations

- Mental health treatment has been a major trend driver for the Plan during the last several years, partly due to increased access to treatment as a result of the pandemic.
  - Prior to the pandemic in 2019, 21.2% of members had a mental health-related encounter versus 28% of members in 2023, representing a 32% increase.
  - During that time, mental health claims increased from $19.05 PMPM to $45.58 PMPM, an increase of 139% (24% annualized).
  - Not included here are the secondary costs of untreated mental health disorders, which often cause other conditions to be more difficult and more expensive to treat.
- Female members aged 20-29 now have the highest prevalence of mental health disorders at 34.9%. Prior to the pandemic, this cohort had the second highest prevalence, behind females aged 30-49, at 22.5%.

Mental Health

Cost and Prevalence by Place of Service

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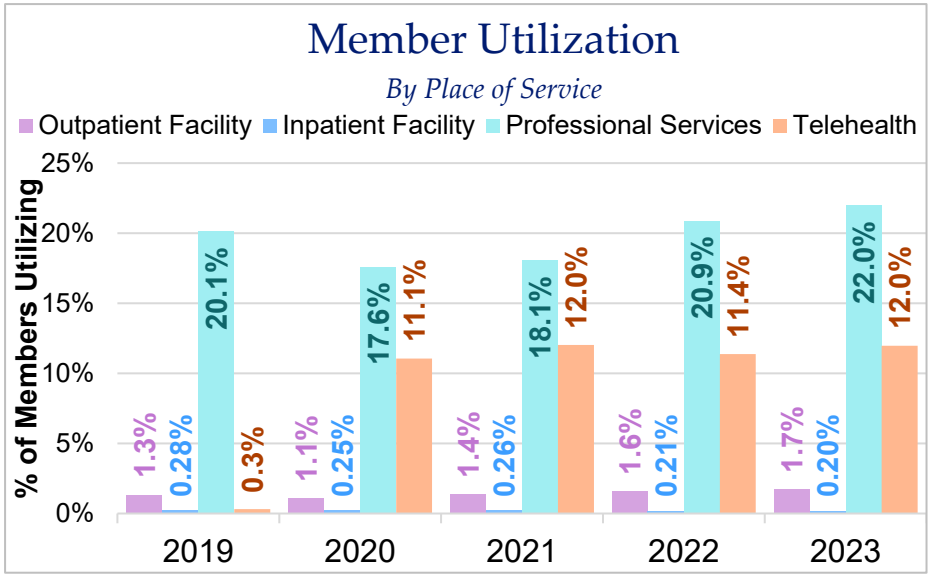

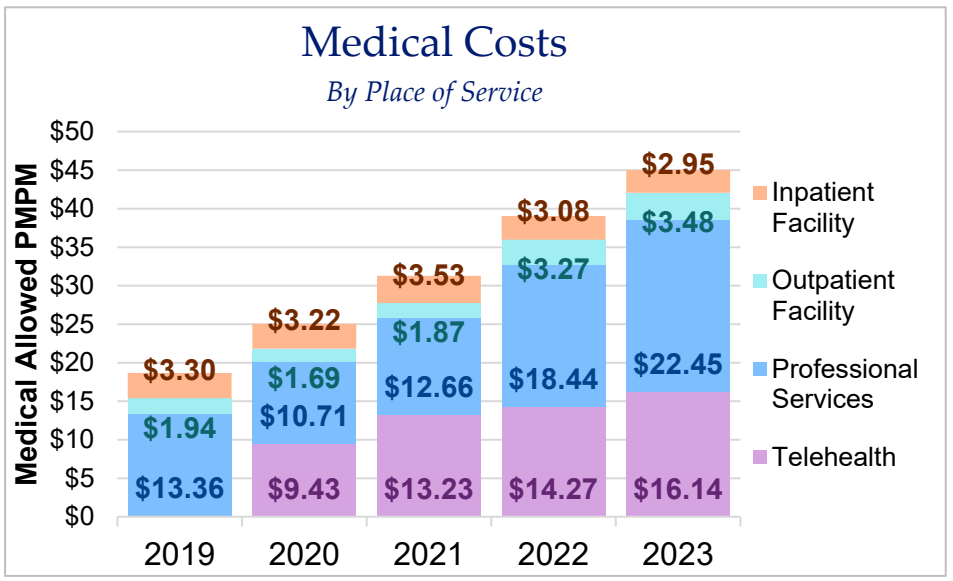

Observations

- Utilization of professional services has increased 9.4% since 2019. However, there has been a significant shift to telehealth. When combining both in-person professional services and telehealth, utilization has increased 33%, the highest of all places of service.
- To better manage costs associated with telehealth and professional services, investigate how provider quality and outcomes are tracked within the network. Higher-quality therapists greatly reduce the number of counseling sessions required for resolution of symptoms, which can reduce costs.
- Inpatient hospital utilization for mental health services has decreased the most during the experience period at -28% (from 0.28% in 2019 to 0.20% in 2023). However, outpatient utilization has increased 30% since 2019, which is similar to the increase experienced in professional services (traditional and telehealth).
- The change in spend in each place of service is more pronounced. Medical allowed PMPM in the professional setting (in-person and traditional) has increased 191% since 2019, outpatient has increased 56%, and inpatient has increased 3%. The high trend in the professional setting is encouraging as more lower-acuity / preventive care is taking place, which should result in more favorable long-term outcomes.

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Tobacco, Asthma, COPD, and Respiratory Cancer

Cost and Prevalence

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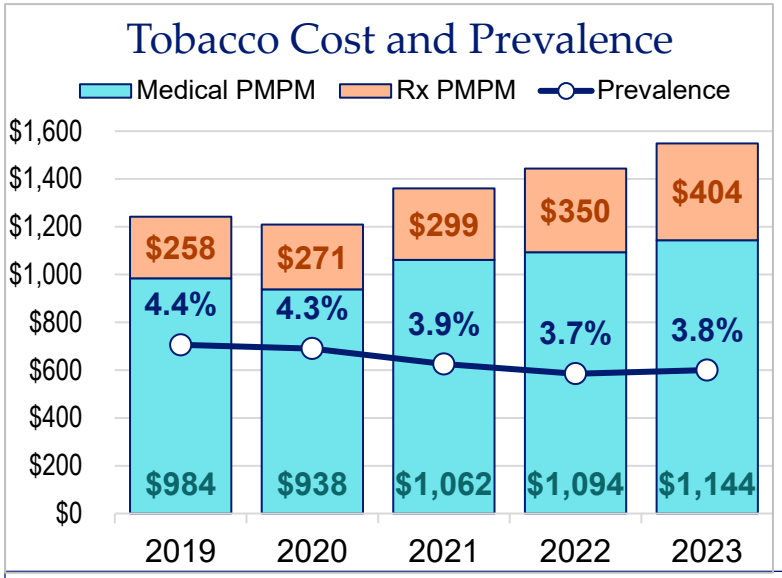

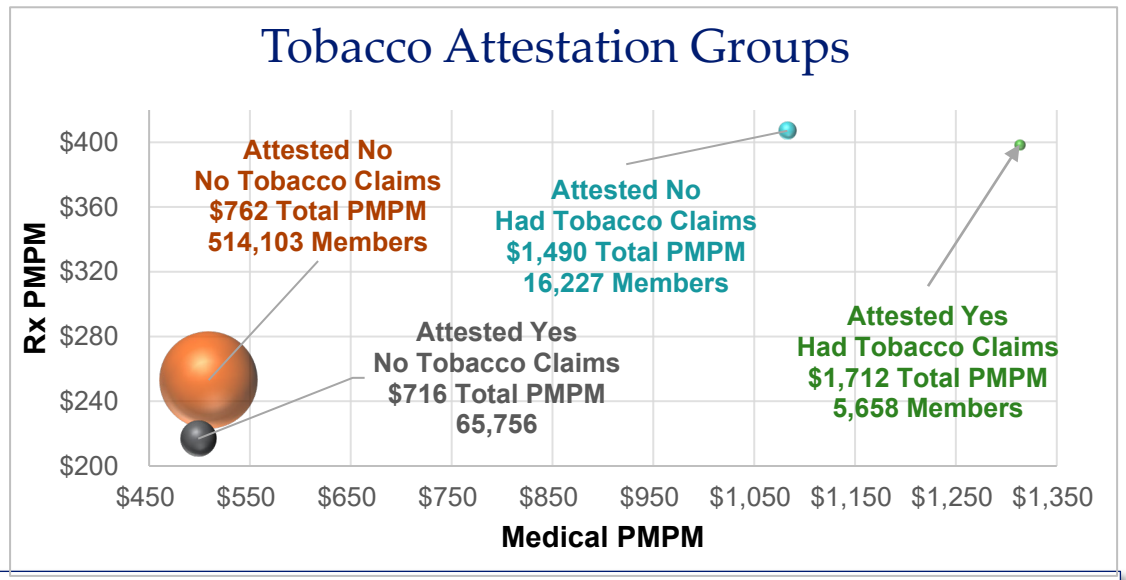

Observations

- The Plan rewards members for abstaining from tobacco use by reducing monthly premiums by $60 for completing a tobacco attestation. However, if a member attests to being a user, they may still be eligible for the credit if they undergo at least one tobacco cessation counseling session within 90 days of enrollment. The results of the 2023 attestation are as follows:
  - 5,658 members attested to being tobacco users and also had recent tobacco-related medical claims. These members cost $1,712 PMPM.
  - 16,227 members attested to not being a tobacco user but had recent tobacco-related medical claims. These members cost $1,490 PMPM, which is much closer to identified tobacco users, suggesting that they did not fill out the attestation correctly.
  - 65,756 members attested to being a tobacco user but did not have recent tobacco-related medical claims. These members cost $716 PMPM, which is much closer to non-users than identified tobacco users, suggesting that they may not be tobacco users and did not fill out the attestation correctly.
  - 514,103 members attested to not being a tobacco user and did not have any recent tobacco-related medical claims. These members cost $762 PMPM.

Tobacco, Asthma, COPD, and Respiratory Cancer

Asthma & COPD

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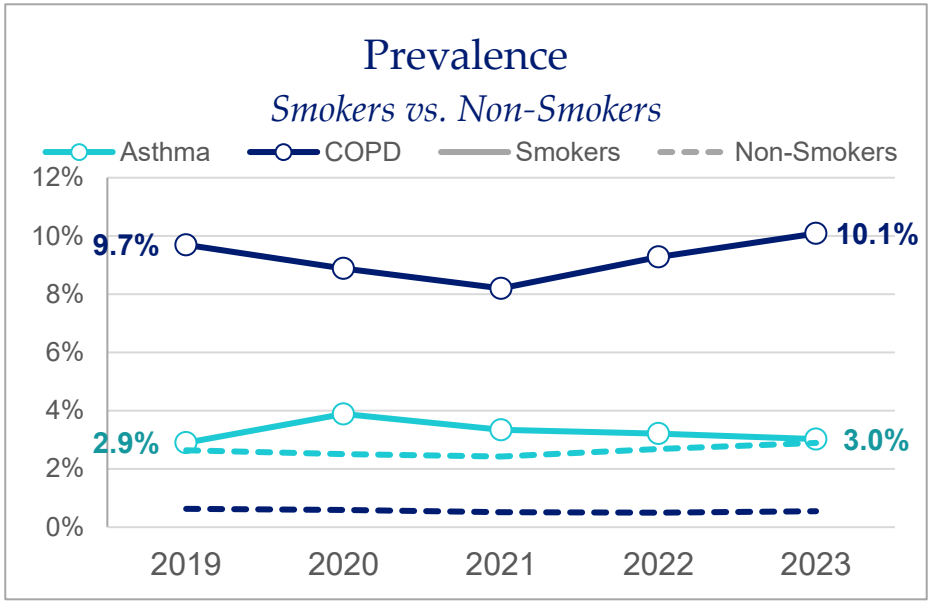
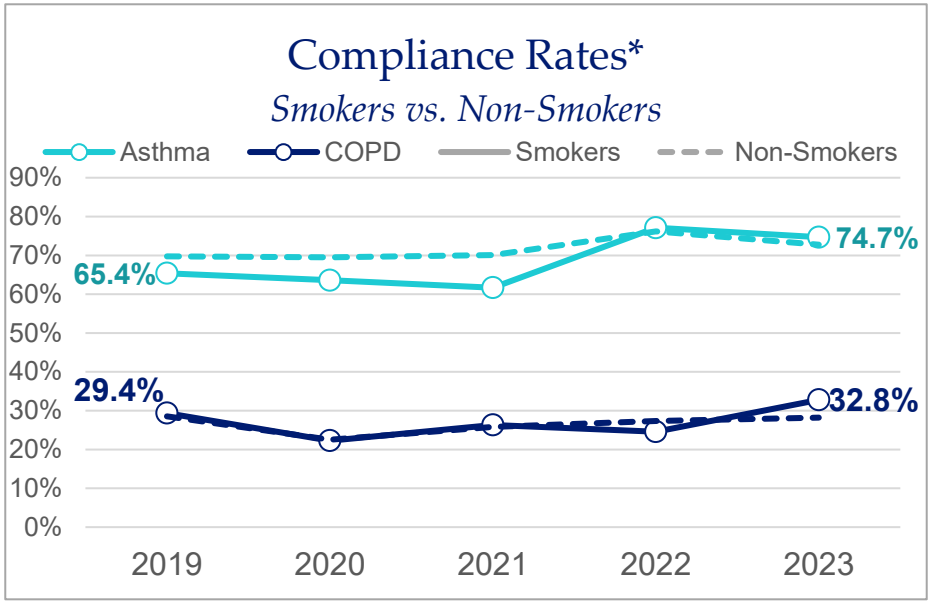




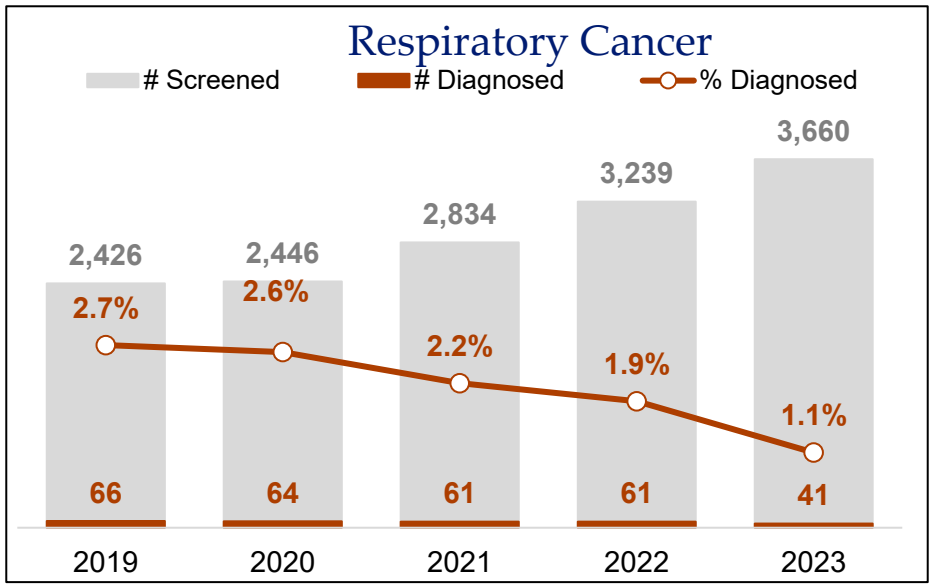
Observations

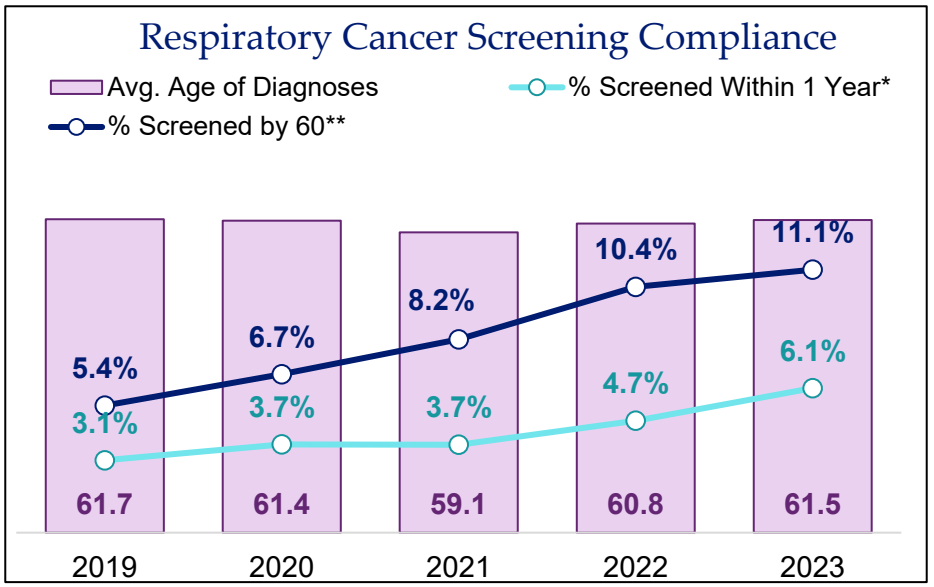
- Smoking is a significant risk factor in developing chronic obstructive pulmonary disorder (COPD). Approximately 10.1% of known tobacco users in the Plan had COPD in 2023, up from 9.7% in 2019.
  - About 0.5% of the population have been diagnosed with COPD and do not have a claims history suggesting tobacco use.
- Prevalence for both asthma and COPD have increased since 2019. As tobacco rates decrease, it's expected that prevalence for these conditions will decrease correspondingly but may take several years to manifest.
- Members with COPD are recommended to get a spirometry test every year. However, compliance is low in the Plan. Less then 1/3 of COPD members got this recommended test in 2023, which is an improvement from 29% in 2019.
- Asthmatics are recommended to get inhaled corticosteroids and/or leukotriene inhibitors each year to manage their condition and overall compliance is high at 75%. Compliance has also improved significantly from 65% in 2019.

**Compliance rates for asthmatics include getting inhaled corticosteroids and/or leukotriene inhibitors each year. Compliance rates for members with COPD include annual spirometry testing.*

Tobacco, Asthma, COPD, and Respiratory Cancer

Respiratory Cancer





Observations

- Smoking is also a significant risk factor in developing respiratory cancers. It is recommended that members aged 50 – 80 who have a 20 pack-year smoking history who currently smoke or who have quit in the last 15 years receive an annual low-dose CT scan.
- Compliance with this screening have increased significantly during the experience period. 2,426 members had this screening in 2019 and that increased to 3,660 members in 2023.
  - The percent of tobacco users receiving the screening within one year of turning 50 increased from 3.1% in 2019 to 6.1% in 2023.
  - The percent of tobacco users who have yet to be screened by age 60 has decreased from 95% to 89%.

**Screened within one year of turning 50.*

***Only includes members enrolled in the Plan for at least one year prior to turning age 60.*

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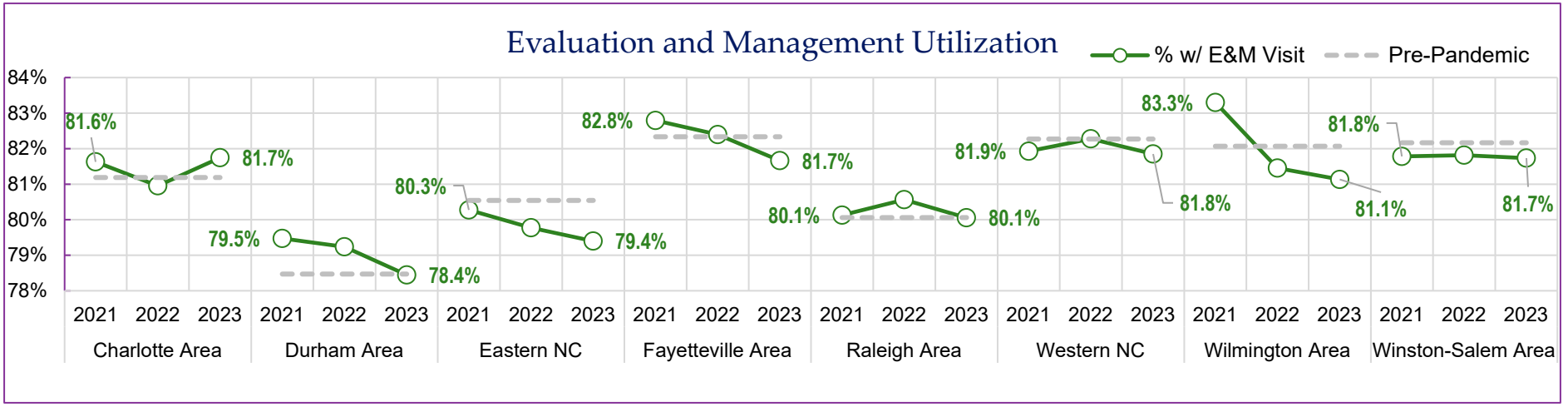
Wilmington Health Pilot

Evaluation and Management Utilization by Region



Observations

- Utilization of evaluation and management (E&M) visits in the professional setting is high at over 80% for most regions but is below pre-pandemic levels for all regions except Charlotte.
  - The pre-pandemic line (grey dotted line) represents E&M utilization rates in 2019.
- Western NC had the highest E&M utilization rate in 2023 of 82% whereas Durham had the lowest E&M utilization rate of 78.4%.
- The Wilmington Area has a pilot program in place to increase PCP engagement and the quality-of-care members receive through their PCP. The program does not appear to have increased engagement in this region as overall engagement has fallen from 83% in 2021 to 81% in 2023. However, 2021 was an exceptionally high year of engagement for this region, likely due to pent-up demand from delayed care during 2020.

Wilmington Health Pilot

Cost and Risk by Region (CY 2023)

North Carolina State Health Plan
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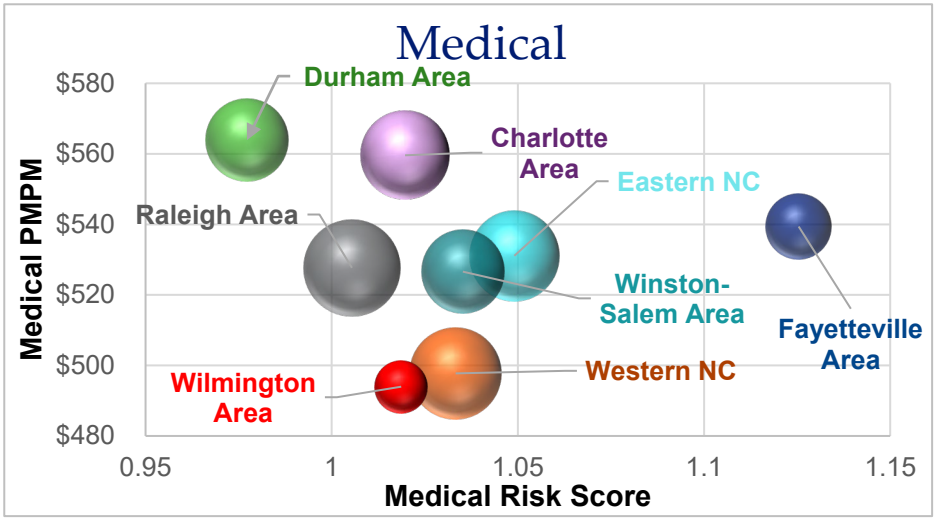

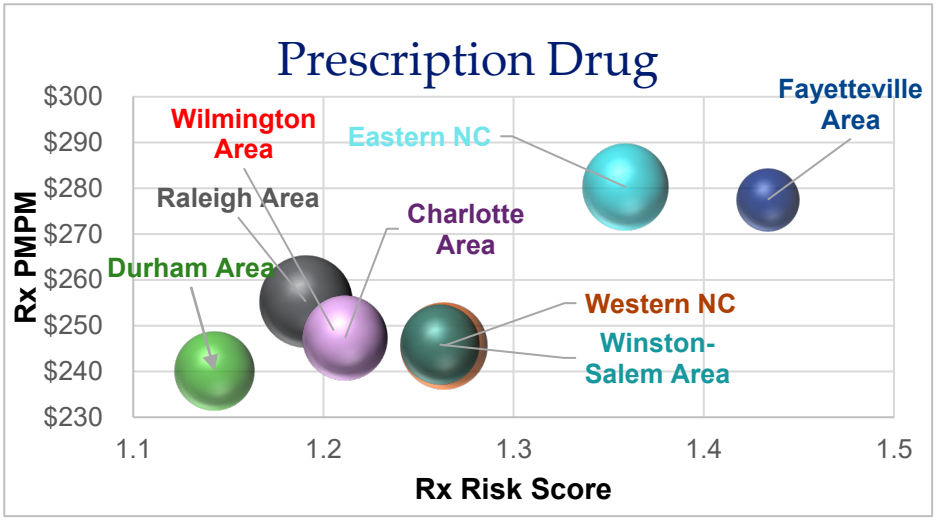

Observations

- In order to review which regions are running more efficiently, it is important to monitor cost and risk in each region. Regions that are being managed well will have lower costs than their risk scores indicate.
  - On the medical side, Fayetteville, Western NC, and Wilmington have the highest efficiency scores (i.e., costs below what their risk scores indicate).
  - On the prescription drug side, Fayetteville, Western NC, and Winston-Salem have the highest efficiency scores.
  - Durham and Raleigh have the lowest efficiency scores, which may be due to higher costs of healthcare in those regions.

Wilmington Health Pilot

Cost and Risk Trends: Wilmington vs. All Others

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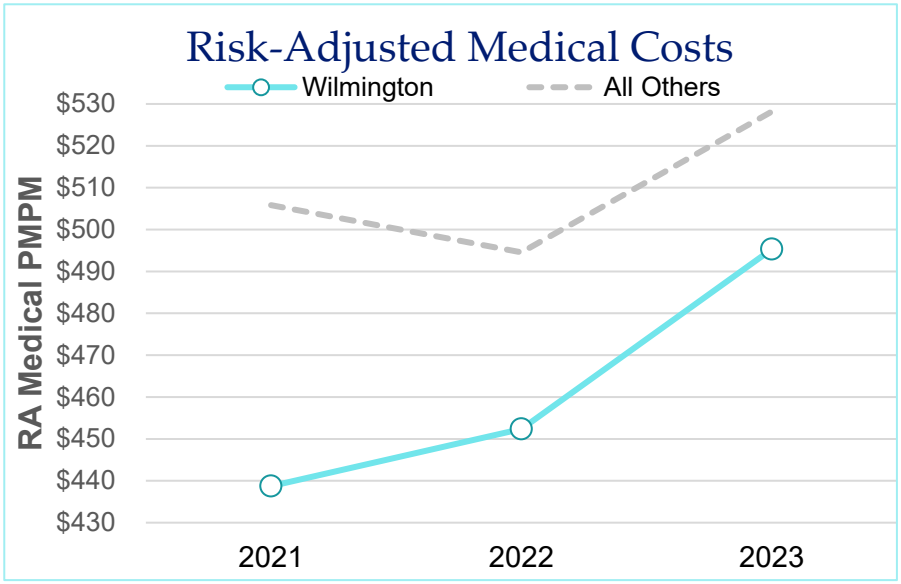
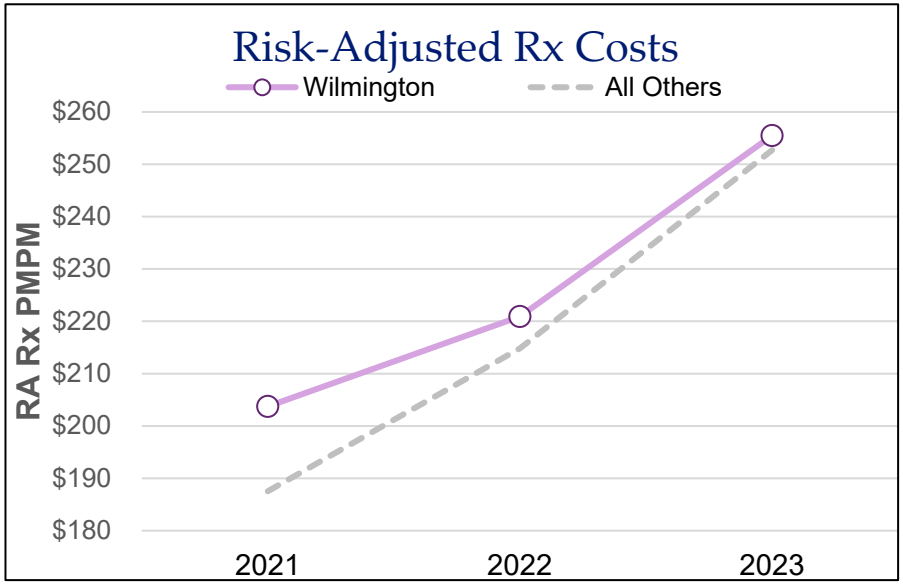


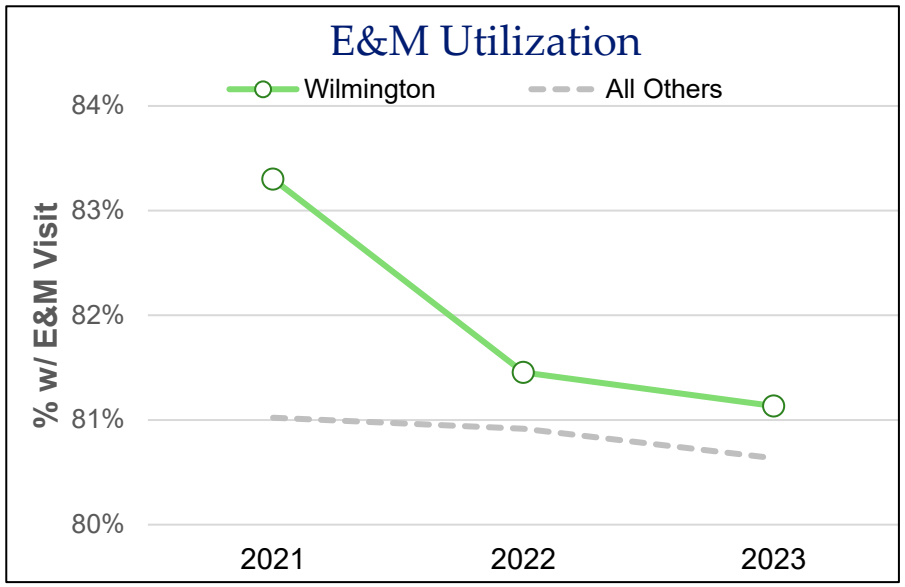


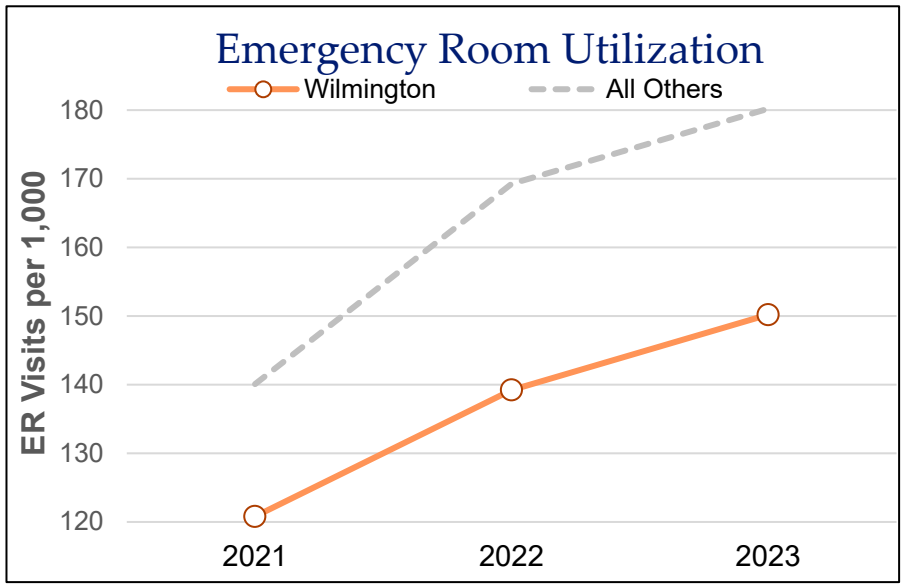
Observations

- To gauge whether the pilot program in Wilmington is having a positive effect on member costs, we have compared risk-adjusted medical and prescription drug costs for the region compared to the rest of the population.
- Risk-adjusted medical costs are lower in Wilmington, suggesting that the region is running more efficiently. However, the difference was greater prior to program implementation. Wilmington was $67 PMPM less expensive on a risk-adjusted basis in 2021 versus $33 PMPM in 2023.
- Risk-adjusted prescription drug costs are slightly higher in Wilmington. However, Wilmington was $16 PMPM more expensive on a risk-adjusted basis in 2021 versus only $2 PMPM in 2023.

Wilmington Health Pilot

E&M and ER Utilization Trends: Wilmington vs. All Others



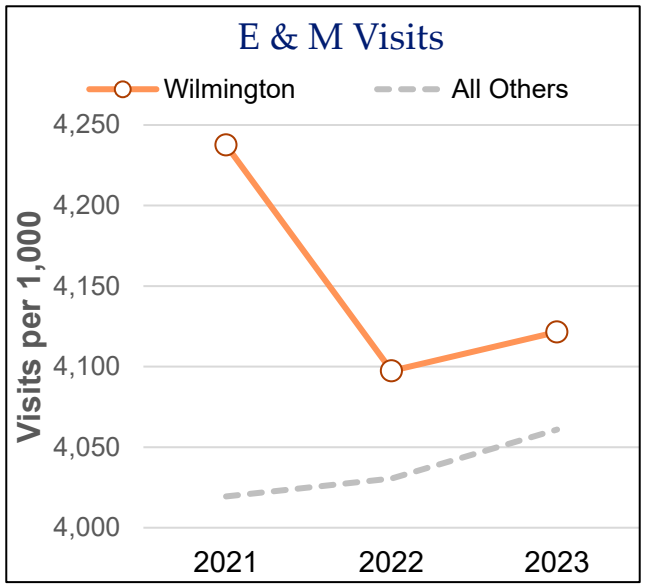


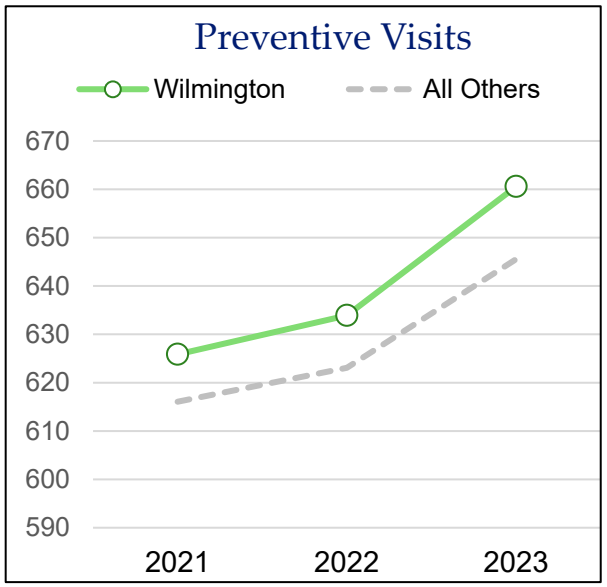
Observations

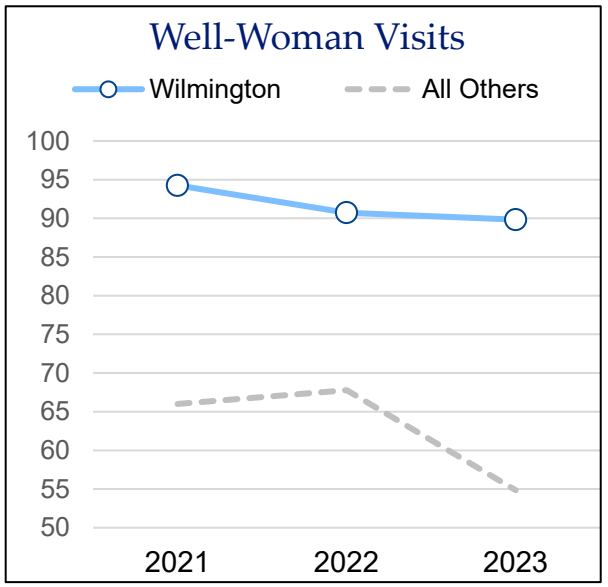
- Two other metrics used to gauge whether the pilot program in Wilmington is having a positive effect on members is evaluation and management (E&M) utilization and ER utilization. Lower E&M utilization often results in higher ER utilization where care is significantly more expensive for the Plan and members.
- Wilmington has higher utilization of E&M services than the rest of the regions. However, the difference was greater prior to program implementation.
- Wilmington has lower emergency room utilization than the rest of the group and experience for Wilmington has improved relative to the rest of the group since program implementation.

Wilmington Health Pilot

Preventive Care Trends: Wilmington vs. All Others







Observations

- Evaluation and management (E & M) visits, preventive visits, and well-woman visits, are additional quality of care metrics that should be improved through the pilot program and should be monitored.
- For E & M visits, utilization was higher for Wilmington by 61 visits per 1,000 in 2023. However, the difference was greater in 2021 by 218 visits per 1,000.
- Members in Wilmington are also utilizing preventive visits at greater rates than the other regions. Wilmington had 10 more preventive visits per 1,000 than the other regions in 2021. The difference increased to 15 more by 2023.
- Female members in Wilmington are utilizing well-woman visits at greater rates than other regions. Wilmington had 28 more well-woman visits per 1,000 than the other regions in 2021, which increased to 35 more visits per 1,000 by 2023.

Wilmington Health Pilot

Preventive Care Trends: Wilmington vs. All Others

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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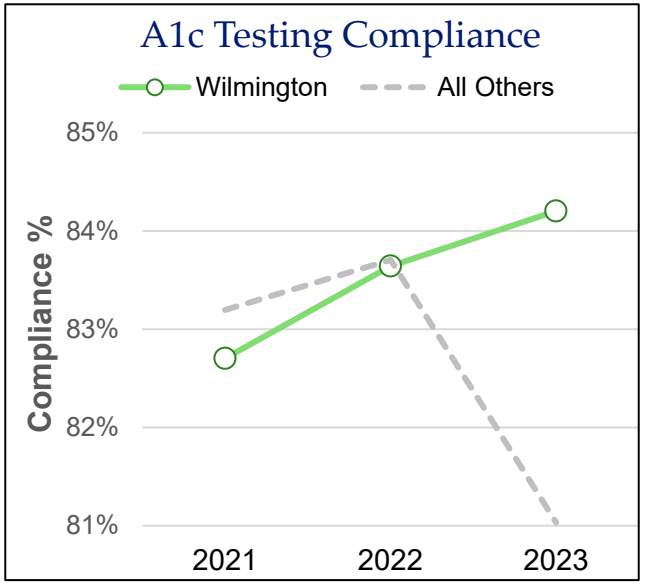

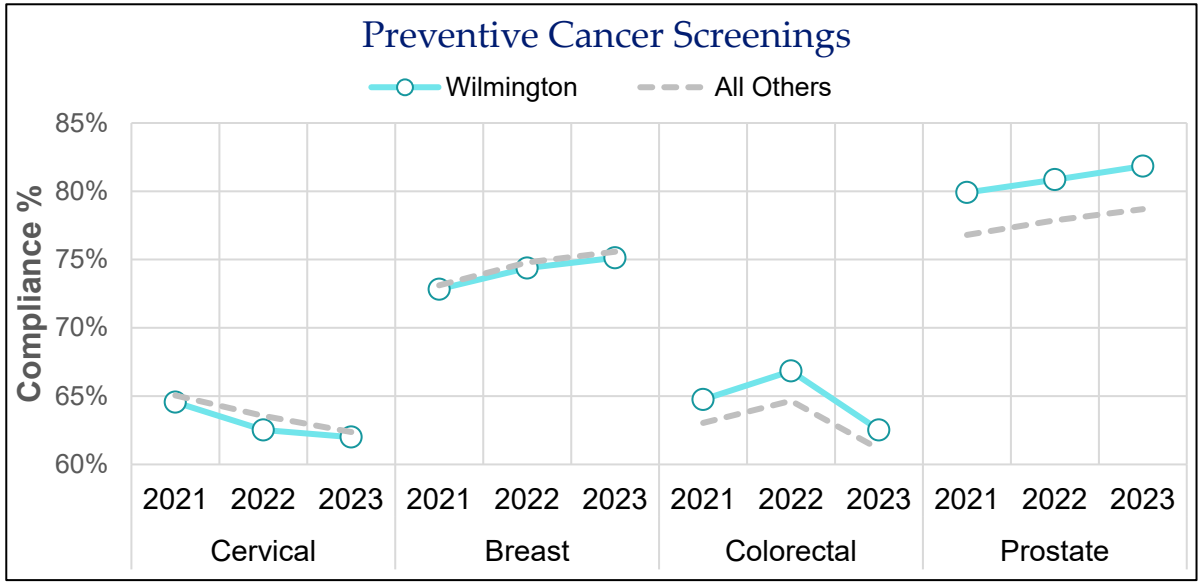

Observations

- The last metrics used to gauge whether the pilot program in Wilmington is having a positive effect on members A1c testing compliance for diabetics and preventive cancer screenings.
- The pilot program appears to be having a positive effect on A1c testing compliance. Diabetics in Wilmington continue to improve compliance rates, whereas compliance rates for the other regions decreased in 2023. The other regions had high compliance than Wilmington in 2021. However, in 2023, Wilmington had a compliance rate of 84.1% versus 80.9% for the other regions.
- The benefits from the pilot program on adherence to preventive cancer screenings is less clear. Wilmington has higher compliance rates for colorectal and prostate cancers. However, the difference was similar prior to program implementation. Screening rates for cervical and breast cancer are slightly lower for Wilmington, but the difference is consistent with pre-program experience. Note that most individuals do not need to get screened every year and it may take several years for improvements in screening compliance to manifest.

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Biosimilar Drugs

Pharmacy Benefit

North Carolina State Health Plan
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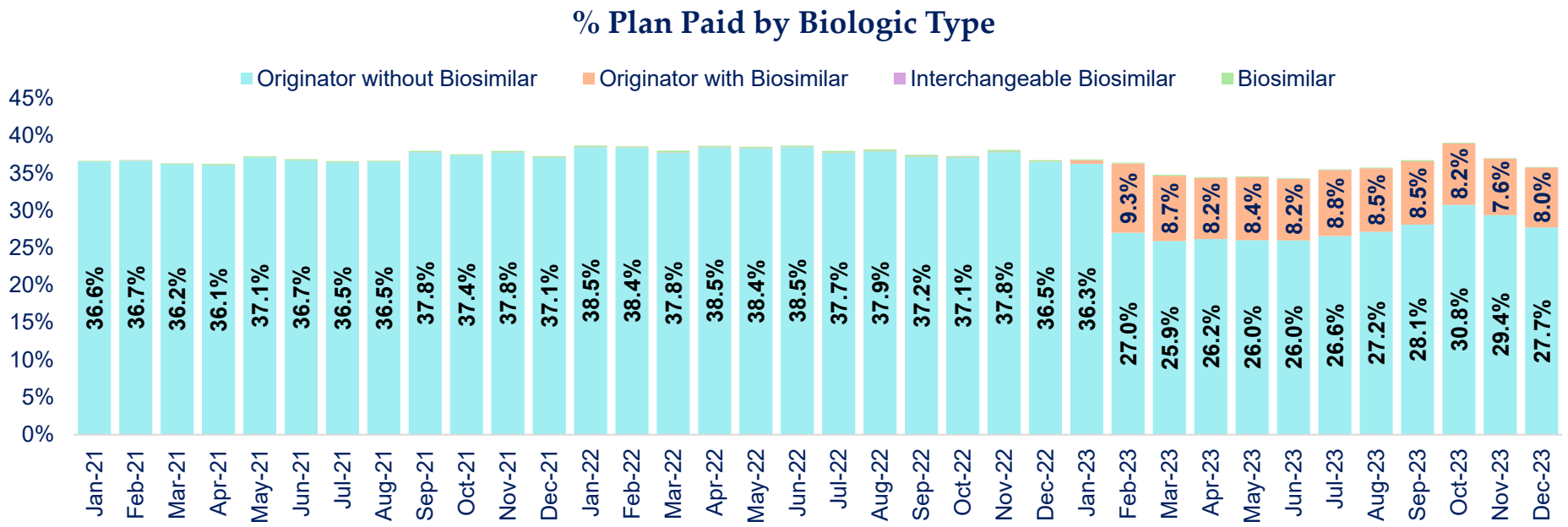

Observations

- Biologic medications account for a significant percentage of pharmacy costs paid for by the Plan, ranging from 37% in 2021 to 35.9% in 2023
- Biosimilar availability has been relatively limited under the pharmacy benefit. In 2021 and 2022, between 99.6% and 99.4% of all biologic spend was associated with a biologic agent without biosimilar availability
  - While usage has increased, biosimilars only accounted for 0.3% of all Plan spend on biologics in 2023
- However, the % of Plan spend associated with biologics with a biosimilar significantly increased in 2023 with the availability of multiple Humira biosimilars

Biosimilar Drugs

Pharmacy Benefit

North Carolina State Health Plan
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Biologic Group	Medication	Category	2021	2022	2023
Rituxan	Ruxience	Biosimilar	$7,311	$35,757	$104,466
	Rituxan (Biosimilar released)	Originator	$0	$12,951	$16,387
Remicade	Inflectra	Originator	$69,434	$0	$7,884
	Remicade (Biosimilar released)	Originator	$179,246	$562,340	$744,334
Neupogen	Zarxio	Originator	$15,996	$2,504	$2,430
	Nivestym	Originator	$256,407	$329,763	$184,005
	Neupogen (Biosimilar released)	Originator with Biosimilar	$18,188	$21,922	$12,589
Neulasta	Ziextenzo	Originator	$1,108,196	$1,887,926	$905,014
	Udenyca	Originator	$71,144	$0	$41,333
	Neulasta (Biosimilar released)	Originator with Biosimilar	$12,899	$0	$0
	Nyvepria	Originator	$0	$0	$50,515
	Fylnetra	Originator	$0	$0	$68,598
Lucentis	Lucentis (Biosimilar released)	Originator with Biosimilar	$0	$9,943	$6,511
	Lucentis (Prior to biosimilar release)	Originator without Biosimilar	$0	$1,657	$0
Lantus	Lantus (Biosimilar released)	Originator with Biosimilar	$32,924	$91,937	$76,497
	Lantus (Prior to biosimilar release)	Originator without Biosimilar	$117,382	$0	$0
	Semglee	Interchangeable Biosimilar	$0	$535	$4,985
Humira	Humira (Biosimilar released)	Originator with Biosimilar	$0	$0	$120,608,951
	Humira (Prior to biosimilar release)	Originator without Biosimilar	$123,303,448	$130,713,938	$10,542,270
	Amjevita	Biosimilar	$0	$0	$61,254
Epogen/Procrit	Epogen/Procrit (Biosimilar released)	Originator with Biosimilar	$0	$0	$0
	Retacrit	Biosimilar	$13,768	$20,566	$39,586
Total			**$125,206,342**	**$133,691,740**	**$133,477,608**

Observations

- 8 medication groups with member utilization currently have approved biosimilar products available
- A few medication groups have had more significant biosimilar utilization, such as Ruxience within the Rituxan group, Retacrit in the Epogen/Procrit group, and Amjevita in the Humira group.
- Switching to biosimilars under same settings can result in significant potential savings.
  - While too soon to know the typical average cost of therapy, the cost of Amjevita was just $6,452 for a two-pen, 4-week supply (2 doses) compared to the average 28-day cost of Humira - $7,589
  - The average 28-day cost of Semglee, a biosimilar of Lantus was $173 in 2023 – nearly 51% lower than its originator.

Biosimilar Drugs

Medical Benefit

North Carolina State Health Plan
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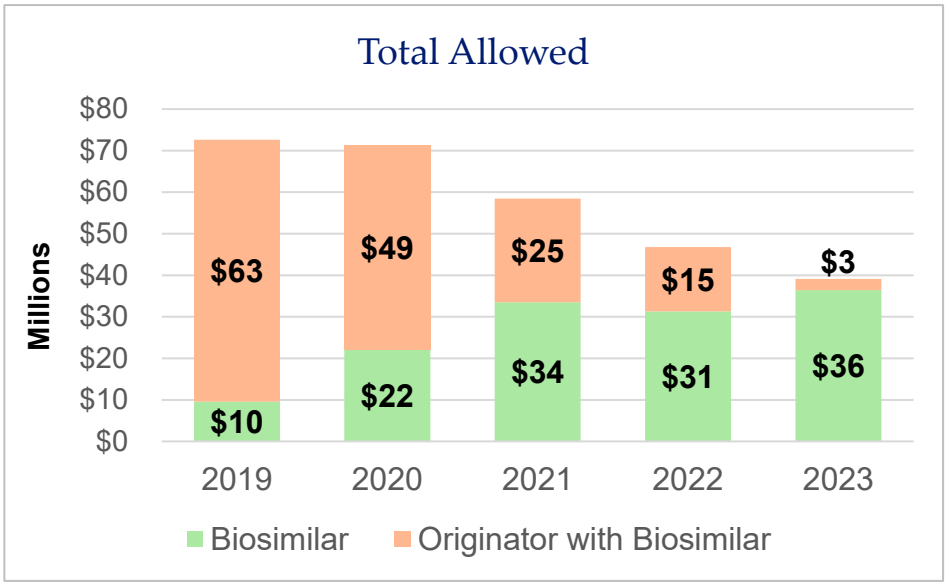
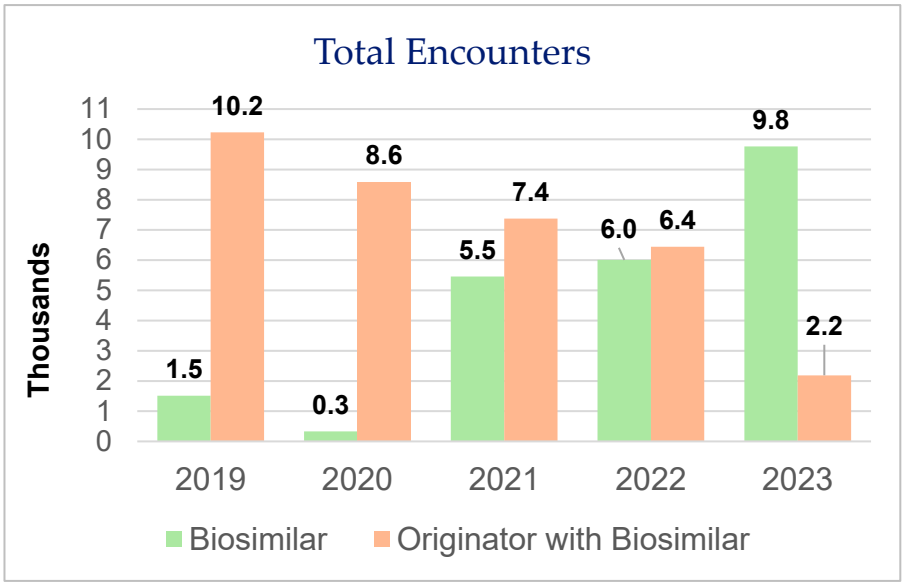
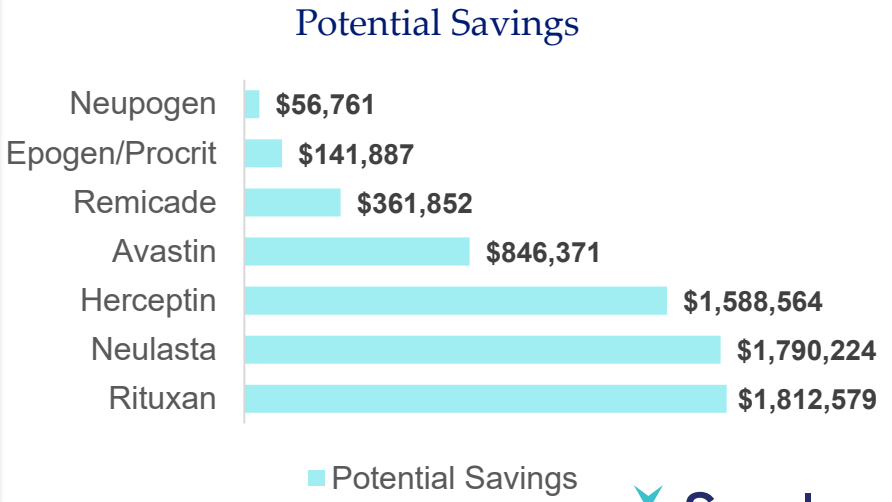




Observations

- For biologics with biosimilars now available, plan spend has shifted away from originators, decreasing from 86.8% to 6.9%. Over this time, total spend on these drug groups has decreased from $72,607,935 to $39,135,714 (a change of 46.1%). $63,028,901 was spent on originators in 2019 compared to $2,710,745 in 2023
- Biosimilar utilization has improved since 2019 growing to 93.1% from 13.2%.
- Even with usage of biosimilars, there can be price variation among the biosimilar products available within a biologic category. Based on 2023 costs, if the lowest cost biosimilar was used in all cases within the same setting (office vs outpatient hospital), the potential savings could be $6,598,238.



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Population Risk Summary: By Status

North Carolina State Health Plan
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Actives

	CY 2023											
		% of Total		Medical			Prescription Drug			% Change from Prior		
Risk Group	Members	Members	Allowed	Allowed (millions)	PMPY	Risk Score	Allowed (millions)	PMPY	Risk Score	Members	Medical PMPY	Rx PMPY
Non-Utilizers	40,145	9.0%	0.0%	$0.0	$0	0.12	$0.0	$0	0.14	20.4%	0%	0%
Healthy	90,617	20.4%	3.9%	$102.4	$1,130	0.26	$64.4	$711	0.41	-15.4%	27.6%	33.4%
Minor Acute	44,233	10.0%	2.8%	$91.5	$2,068	0.66	$29.8	$674	0.46	-11.0%	-2.4%	1.7%
Major Acute	23,847	5.4%	4.3%	$158.0	$6,624	1.62	$26.8	$1,123	0.69	13.1%	-14.0%	4.5%
Single Chronic	96,805	21.8%	14.9%	$478.1	$4,938	1.09	$164.1	$1,695	0.95	0.2%	2.7%	5.8%
Chronic w/ Comorbidities	182,596	41.2%	61.8%	$1,638.6	$8,974	1.67	$1,029.8	$5,640	2.37	6.0%	3.2%	14.8%
Malignancies	4,515	1.0%	7.4%	$260.0	$57,582	2.47	$59.3	$13,124	3.04	3.0%	1.8%	6.5%
Catastrophic	1,037	0.2%	5.0%	$196.5	$189,453	9.78	$17.4	$16,731	5.19	14.5%	-3.3%	21.0%
Total	**483,794**	**100.0%**	**100.0%**	**$2,925.0**	**$6,046**	**1.09**	**$1,391.6**	**$2,876**	**1.29**	**-0.3%**	**6.7%**	**18.3%**

Non-Medicare Retirees

	CY 2023											
		% of Total		Medical			Prescription Drug			% Change from Prior		
Risk Group	Members	Members	Allowed	Allowed (millions)	PMPY	Risk Score	Allowed (millions)	PMPY	Risk Score	Members	Medical PMPY	Rx PMPY
Non-Utilizers	3,577	6.2%	0.0%	$0.0	$0	0.16	$0.0	$0	0.23	14.3%	0%	0%
Healthy	7,423	12.8%	1.8%	$7.9	$1,064	0.29	$7.0	$940	0.73	-15.2%	5.6%	25.2%
Minor Acute	2,300	4.0%	0.9%	$4.8	$2,073	0.71	$2.7	$1,180	0.71	-11.0%	-0.8%	36.1%
Major Acute	1,128	1.9%	1.2%	$7.9	$7,033	1.49	$2.1	$1,850	1.17	-0.1%	3.2%	-2.5%
Chronic	7,977	13.7%	6.1%	$35.5	$4,455	1.13	$15.4	$1,928	1.23	-2.4%	-1.3%	7.8%
Comorbidities	37,466	64.6%	70.4%	$364.0	$9,715	1.83	$220.7	$5,890	2.78	3.3%	5.2%	12.7%
Malignancies	1,511	2.6%	12.0%	$77.2	$51,092	2.46	$22.5	$14,881	3.34	6.9%	2.5%	1.6%
Catastrophic	235	0.4%	7.6%	$57.8	$245,749	10.24	$5.3	$22,409	7.33	7.0%	13.7%	12.2%
Total	**61,616**	**100.0%**	**100.0%**	**$555.1**	**$9,010**	**1.46**	**$275.6**	**$4,472**	**2.11**	**-0.1%**	**8.6%**	**14.8%**

Appendices

Population Risk Summary: Cost and Risk by Subgroups (CY 2023)

North Carolina State Health Plan
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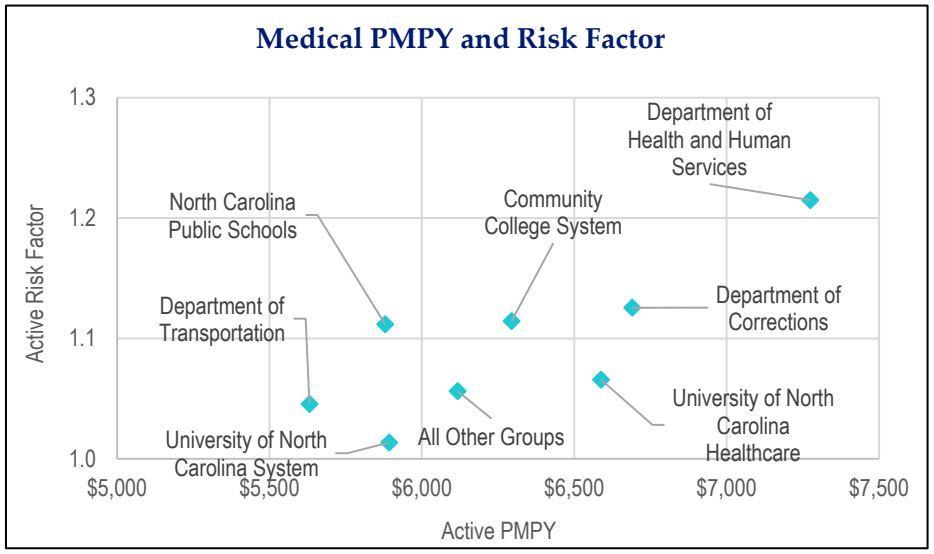
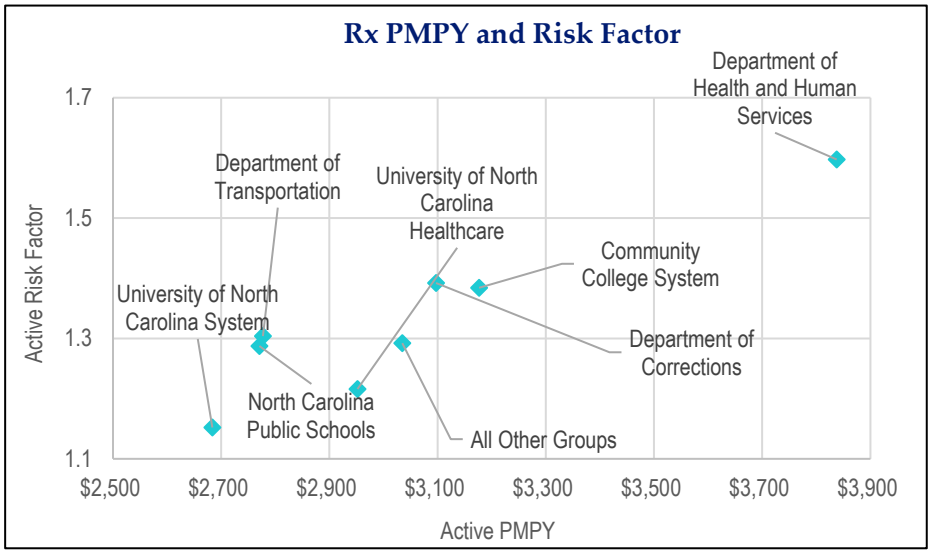
Subgroups	Members	Medical PMPY	Medical Risk Factor	Rx PMPY	Rx Risk Factor	Key Utilization (per 1,000)						
						Inpatient Admissions	ER Visits	% ER Avoidable	Urgent Care Vistis	Physicals	Telehealth Visits	Rx Scripts
1. North Carolina Public Schools	249,063	$5,879	1.112	$2,771	1.287	39.4	193	37%	215	666	1,212	11,988
2. University of North Carolina System	74,226	$5,893	1.013	$2,684	1.152	31.9	124	35%	174	693	2,142	10,255
3. Department of Corrections	25,423	$6,690	1.126	$3,097	1.392	44.0	327	40%	201	530	767	12,731
4. Community College System	24,150	$6,294	1.114	$3,177	1.384	35.6	166	35%	163	642	1,346	12,735
5. Department of Health and Human Services	18,548	$7,274	1.215	$3,838	1.597	42.6	231	38%	167	621	1,436	15,160
6. University of North Carolina Healthcare	15,836	$6,588	1.066	$2,952	1.216	41.8	183	37%	310	686	2,072	10,804
7. Department of Transportation	13,125	$5,631	1.046	$2,777	1.304	32.5	189	38%	151	547	722	12,224
8. All Other Groups	63,423	$6,117	1.056	$3,035	1.292	38.8	179	38%	186	605	1,281	12,427
9. Active Total	***483,794***	***$6,046***	***1.091***	***$2,876***	***1.288***	***38.2***	***188***	***37%***	***201***	***650***	***1,371***	***11,945***
10. Retirees (Non-Medicare)	***61,616***	***$9,010***	***1.458***	***$4,472***	***2.110***	***43.5***	***173***	***33%***	***149***	***585***	***767***	***19,116***
Total	**545,410**	**$6,381**	**1.132**	**$3,057**	**1.380**	**38.8**	**186**	**37%**	**195**	**642**	**1,302**	**12,755**





[1] Reflects the ratio of PMPY costs of members within the subgroup to the total enrolled population.

Appendices
Membership Migration (YoY)

North Carolina State Health Plan
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		CY 2023 - Member Count (% of Total within Risk Group)								CY 2022	
	Risk Group	Healthy	Minor Acute	Major Acute	Single Chronic	Chronic w/ Comorbidities	Malignant	Catastrophic	Terminated	Total Count	% of Total
CY 2022	New Members	14,244 (42%)	3,934 (12%)	3,045 (9%)	4,826 (14%)	5,082 (15%)	502 (1%)	94 (0%)	2,153 (6%)	**33,880**	**6.3%**
	Healthy	75,546 (52%)	17,547 (12%)	5,411 (4%)	21,513 (15%)	15,556 (11%)	2,958 (2%)	56 (0%)	6,747 (5%)	**145,333**	**27.0%**
	Minor Acute	14,110 (29%)	14,752 (30%)	7,241 (15%)	7,045 (15%)	2,384 (5%)	1,208 (2%)	17 (0%)	1,823 (4%)	**48,579**	**9.0%**
	Major Acute	2,921 (14%)	5,170 (25%)	6,305 (30%)	3,799 (18%)	1,243 (6%)	502 (2%)	34 (0%)	868 (4%)	**20,843**	**3.9%**
	Single Chronic	14,097 (15%)	1,164 (1%)	864 (1%)	51,278 (55%)	19,548 (21%)	2,966 (3%)	95 (0%)	3,399 (4%)	**93,410**	**17.3%**
	Chronic w/ Comorbidities	8,606 (5%)	115 (0%)	105 (0%)	6,744 (4%)	151,288(84%)	7,980 (4%)	580 (0%)	4,929 (3%)	**180,346**	**33.5%**
	Malignant	1,512 (10%)	649 (4%)	432 (3%)	2,276 (15%)	7,302 (47%)	3,065 (20%)	70 (0%)	340 (2%)	**15,647**	**2.9%**
	Catastrophic	29 (4%)	24 (3%)	45 (6%)	58 (7%)	386 (50%)	55 (7%)	101 (13%)	74 (10%)	**772**	**0.1%**
CY 2023	**Total Count**	**131,066**	**43,355**	**23,447**	**97,539**	**202,788**	**19,236**	**1,046**	**20,332**	**538,809**	
	% of Total	**24.3%**	**8.0%**	**4.4%**	**18.1%**	**37.6%**	**3.6%**	**0.2%**	**3.8%**	**100.0%**	

Observations

The table above shows how members in each of the mutually exclusive risk categories that were in the Plan in 2023 transitioned from 2022 to 2023.

- The percentages shown in each cell are additive across rows. Each percent represents the percent of members in the risk group row in 2022 that transitioned to the risk group column in 2023.
- Of the 33,880 new members in 2023, 42% were healthy versus 14% that had a single chronic condition and 15% that had multiple chronic conditions.
- 10% of catastrophic members in 2022 terminated from the Plan in 2023 and 50% had more than one chronic conditions.
- Of the 1,046 catastrophic members in 2023, 580 (55%) had more than one chronic condition.

Appendices
Top-20 CCSR Categories

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
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CCSR Category	CY2021			CY2022			CY2023			Annualized Trend[1]		
	Members	Medical Cost[2]	Cost PMPY	Members	Medical Cost[2]	Cost PMPY	Members	Medical Cost[2]	Cost PMPY	Members	Medical Cost[2]	Cost PMPY
Spondylopathies/spondyloarthropathy	40,960	$100.6	$2,455	41,085	$97.7	$2,378	41,949	$98.2	$2,341	2.0%	0.8%	-1.2%
Breast cancer	4,572	$93.5	$20,453	4,519	$96.0	$21,252	4,600	$96.3	$20,944	0.5%	2.1%	1.5%
Osteoarthritis	22,781	$86.2	$3,785	23,899	$87.4	$3,656	24,563	$94.3	$3,840	2.7%	2.2%	-0.6%
Benign neoplasms	51,159	$74.8	$1,461	53,012	$77.2	$1,455	56,587	$84.9	$1,501	3.1%	4.8%	1.7%
Musculoskeletal pain, not low back pain	93,008	$63.3	$680	93,529	$63.2	$676	96,650	$68.7	$711	0.9%	7.3%	6.3%
Trauma- and stressor-related disorders	31,021	$46.0	$1,482	33,370	$58.5	$1,753	35,945	$66.3	$1,844	8.9%	32.6%	21.7%
Anxiety and fear-related disorders	51,445	$43.6	$847	55,288	$55.7	$1,008	61,097	$66.2	$1,084	10.7%	33.4%	20.5%
Abdominal pain and other digestive/abdomen symptoms	52,938	$55.8	$1,053	52,149	$56.3	$1,080	53,802	$62.5	$1,161	-1.0%	2.4%	3.5%
Depressive disorders	31,054	$42.1	$1,356	32,821	$49.5	$1,508	36,723	$51.7	$1,409	7.5%	18.5%	10.2%
Neurodevelopmental disorders	23,618	$21.7	$919	26,176	$30.4	$1,161	29,701	$44.2	$1,489	8.8%	36.8%	25.7%
Cardiac dysrhythmias	9,099	$38.6	$4,243	9,291	$41.1	$4,420	9,184	$40.5	$4,412	2.6%	1.5%	-1.0%
Abnormal findings without diagnosis	82,020	$35.1	$428	85,712	$37.0	$431	90,506	$40.4	$446	2.6%	5.3%	2.6%
Biliary tract disease	4,171	$35.6	$8,542	4,188	$36.9	$8,813	4,488	$40.3	$8,977	2.1%	2.4%	0.3%
Chronic kidney disease	4,075	$46.5	$11,406	4,314	$37.6	$8,705	4,745	$39.7	$8,362	6.6%	-2.9%	-8.9%
Septicemia	1,312	$43.5	$33,134	1,185	$32.2	$27,184	1,430	$39.5	$27,630	3.3%	6.8%	3.4%
Nonspecific chest pain	24,160	$38.2	$1,583	23,424	$35.8	$1,528	24,263	$39.1	$1,612	-1.3%	-3.5%	-2.2%
Diabetes mellitus with complication	24,668	$38.6	$1,567	25,905	$35.8	$1,382	27,932	$37.8	$1,353	5.5%	3.7%	-1.7%
Calculus of urinary tract	7,042	$31.8	$4,520	7,248	$34.3	$4,736	7,673	$34.6	$4,505	1.3%	1.8%	0.5%
Obesity	40,652	$38.0	$935	41,703	$38.7	$928	56,477	$34.5	$610	10.7%	-0.2%	-9.8%
Liveborn	7,593	$34.2	$4,503	6,489	$34.3	$5,283	6,321	$33.5	$5,297	-4.8%	-1.5%	3.5%

Observations

The above table summarizes the top-20 CCSR categories by total allowed charges in 2023. Members can be in more than one CCSR category.

- The top-4 conditions with the highest trend are all mental health-related.

[1] Annualized trend reflects the average annual trend between CY 2019 and CY 2023.
[2] In millions

Appendices

Top-20 SegalRx Categories

North Carolina State Health Plan
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SegalRx Category	CY2021				CY2022				CY2023				Annualized Trend[1]			
	Members	Total Cost[2]	Cost PMPY	Cost per Script	Members	Total Cost[2]	Cost PMPY	Cost per Script	Members	Total Cost[2]	Cost PMPY	Cost per Script	Members	Total Cost[2]	Cost PMPY	Cost per Script
Antidiabetic Agents	28,472	$170.9	$6,001	$804	33,871	$206.7	$6,104	$874	39,959	$263.1	$6,584	$924	10.7%	21.1%	9.4%	11.5%
Disease-Modifying Antirheumatic Drugs	3,425	$183.5	$53,581	$8,011	3,507	$195.3	$55,690	$8,243	3,714	$203.7	$54,835	$8,475	2.4%	8.4%	5.9%	5.0%
Antiobesity Agents	10,427	$45.9	$4,401	$1,193	14,723	$80.0	$5,433	$1,244	26,576	$174.0	$6,547	$1,296	30.1%	51.4%	16.4%	7.5%
Antipsoriatics	2,474	$90.5	$36,568	$9,153	3,476	$117.9	$33,913	$9,551	5,299	$139.6	$26,344	$8,736	21.2%	32.0%	8.9%	11.6%
Oncology	144,283	$89.5	$620	$329	85,227	$95.3	$1,119	$728	21,844	$104.4	$4,779	$1,928	-2.6%	5.4%	8.2%	10.6%
Asthma/COPD	64,023	$44.9	$702	$178	72,556	$48.6	$670	$186	73,240	$55.8	$763	$216	-0.5%	6.0%	6.6%	7.9%
Insulin	10,908	$60.6	$5,556	$839	10,636	$57.3	$5,385	$847	10,164	$52.1	$5,125	$861	-4.7%	-4.6%	0.1%	2.7%
Skin Disorders	93,680	$36.4	$388	$166	91,199	$42.6	$467	$202	94,117	$51.6	$548	$239	-1.8%	18.8%	20.9%	19.3%
HIV/AIDS	2,006	$46.0	$22,930	$3,319	2,217	$48.7	$21,987	$3,379	2,316	$47.9	$20,703	$3,422	4.7%	3.5%	-1.1%	4.1%
Multiple Sclerosis/Paralysis	671	$48.5	$72,245	$11,369	642	$49.3	$76,786	$11,237	646	$46.0	$71,197	$10,624	-4.8%	-2.0%	3.0%	0.5%
Headaches	17,538	$25.2	$1,436	$303	18,169	$34.8	$1,916	$403	19,075	$45.5	$2,386	$487	3.8%	49.5%	44.1%	35.9%
ADHD	30,806	$28.7	$931	$129	33,993	$32.1	$943	$133	36,937	$41.0	$1,110	$163	6.8%	11.7%	4.6%	6.5%
Antidepressants	125,378	$33.6	$268	$50	128,302	$33.8	$263	$50	130,331	$38.0	$292	$57	1.7%	4.6%	2.8%	5.3%
Inflammatory/Autoimmune	85,712	$25.4	$296	$175	101,359	$27.2	$268	$160	105,353	$29.4	$279	$169	0.2%	6.5%	6.3%	6.6%
Anticoagulants	9,996	$20.8	$2,083	$460	9,676	$21.1	$2,178	$506	9,839	$23.2	$2,355	$549	-5.7%	3.8%	10.1%	13.7%
Blood Disorders	22,047	$13.2	$598	$223	21,204	$16.2	$764	$298	22,028	$21.0	$953	$383	-0.8%	12.4%	13.3%	15.7%
Antihypertensive	143,526	$25.5	$177	$28	144,212	$21.2	$147	$25	145,569	$20.8	$143	$25	-2.0%	-8.0%	-6.2%	-1.7%
Antipsychotics	10,284	$17.5	$1,703	$317	10,765	$20.0	$1,857	$353	11,450	$19.5	$1,703	$333	3.1%	7.9%	4.7%	6.0%
Lipid/Cholesterol Disorders	79,974	$14.9	$187	$45	81,798	$15.5	$189	$48	83,949	$19.3	$230	$60	-1.2%	1.8%	3.0%	6.2%
Diabetic Supplies/Monitoring	8,028	$3.4	$423	$190	9,338	$9.3	$995	$273	10,693	$16.2	$1,511	$336	6.1%	75.0%	64.9%	28.5%

Observations

The above table shows the top-20 SegalRx categories by total allowed charges in 2023. Members can be in more than one SegalRx category.

- Aside from diabetic supplies, headaches had the largest increase in cost per script from 2019. This is mainly driven by Nurtec and a few other newer drugs to market.

[1] Annualized trend reflects the average annual trend between CY 2019 and CY 2023.
[2] In Millions. Rebates are not included

Appendices
Musculoskeletal

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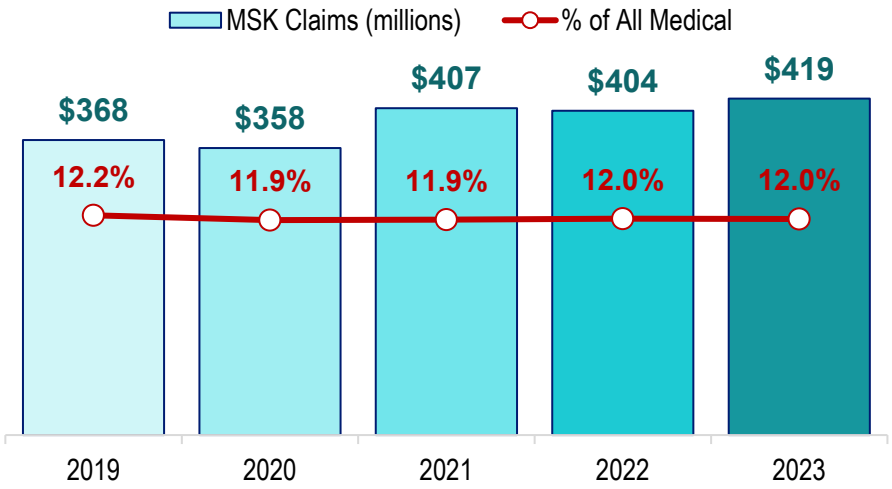
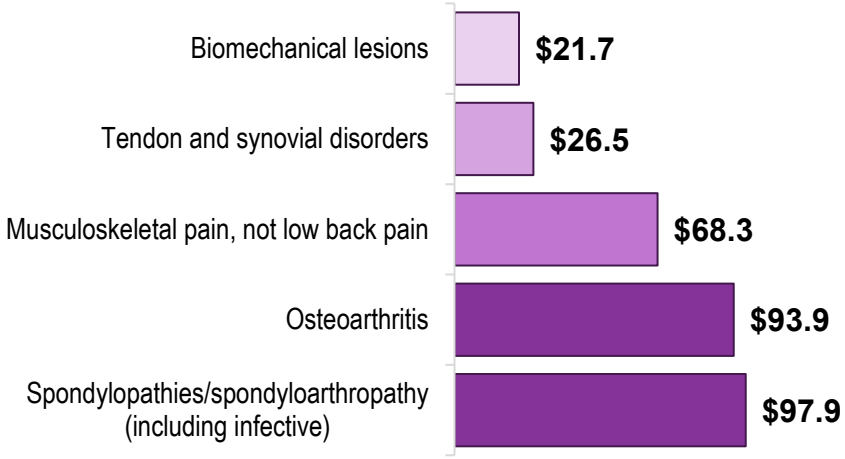
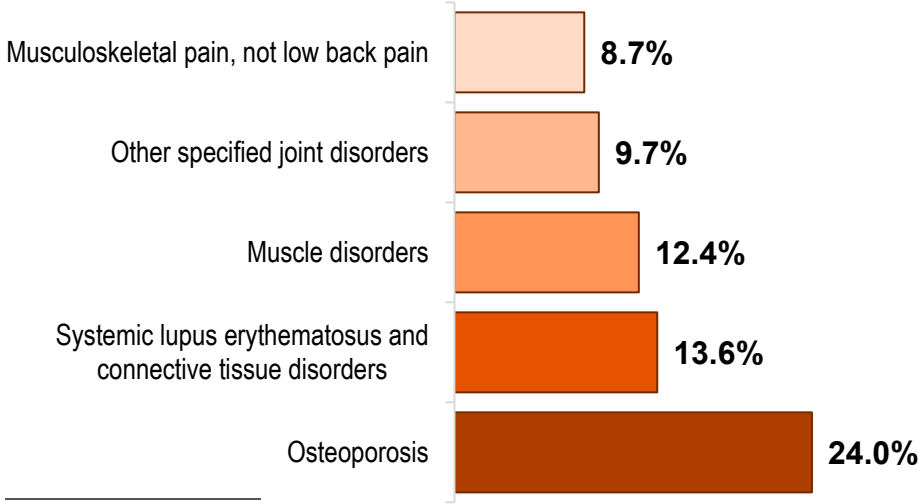
MSK Summary



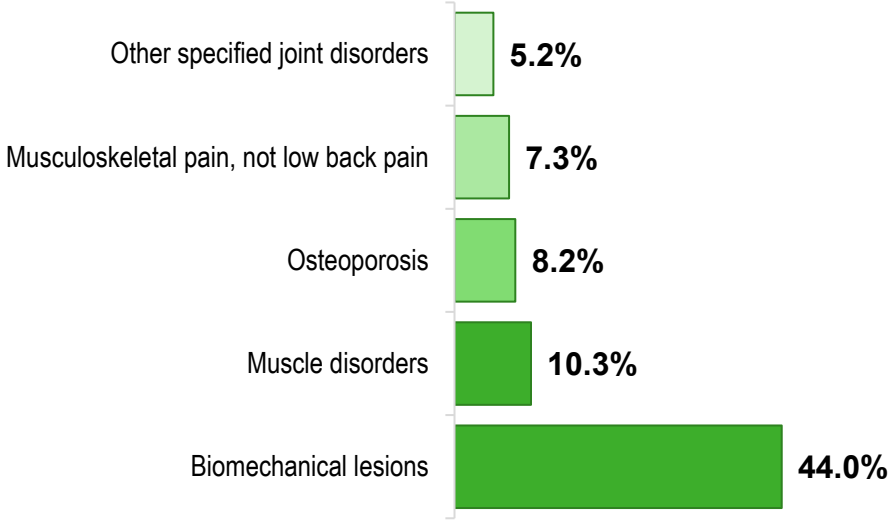
Top Conditions by Cost
CY 2023 (millions)



Emerging Trend Drivers



Historical Trend Drivers



Note: Emerging trend drivers represent the conditions with the greatest year-over-year increase in costs whereas historical trend drivers represent conditions with the greatest increase in costs from 2019 to 2023.

Appendices
Malignancies

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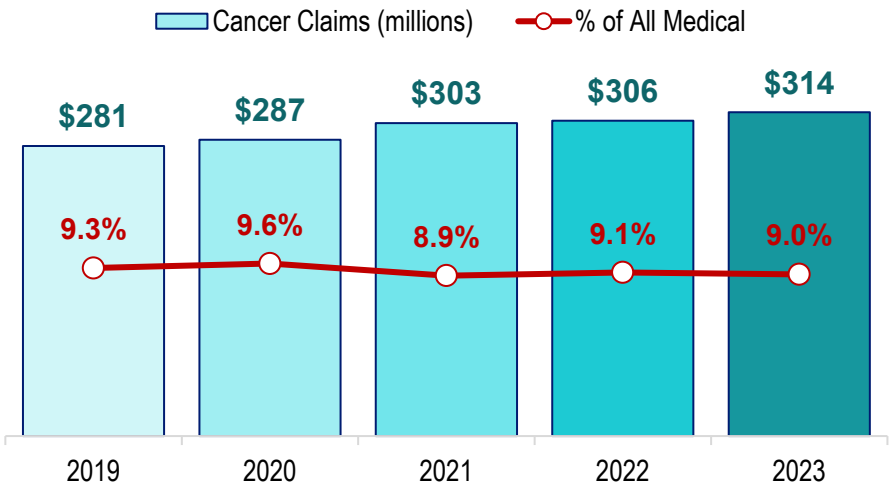
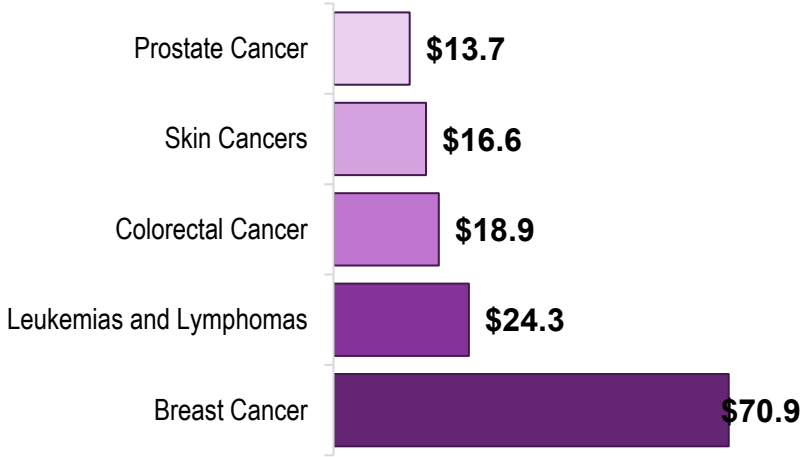
Cancer Summary

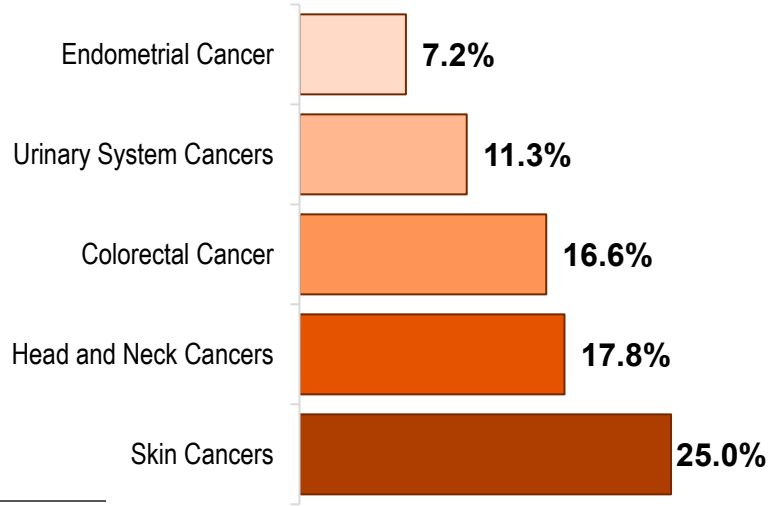


Top Conditions by Cost

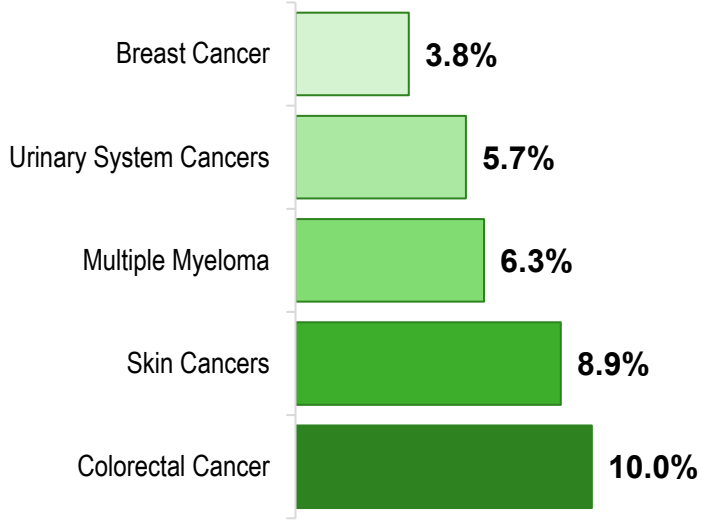
CY 2023 (millions)



Emerging Trend Drivers



Historical Trend Drivers



Note: Emerging trend drivers represent the conditions with the greatest year-over-year increase in costs whereas historical trend drivers represent conditions with the greatest increase in costs from 2019 to 2023.

Appendices
Mental Health

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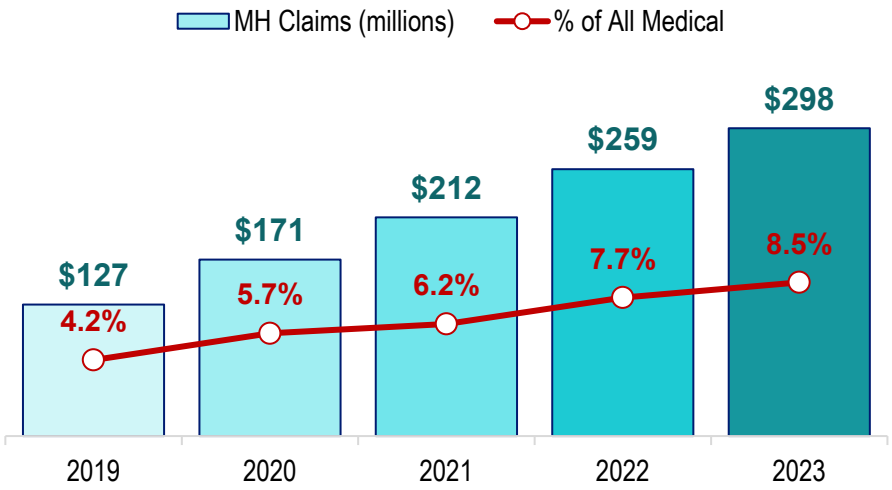
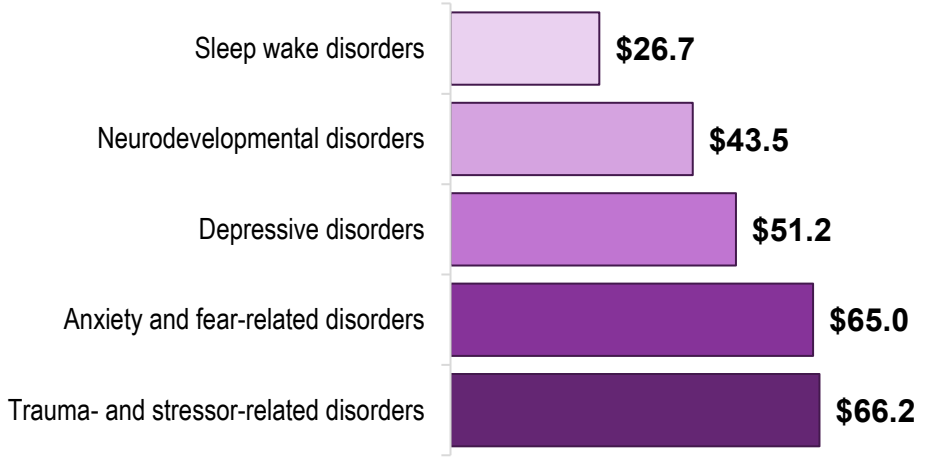
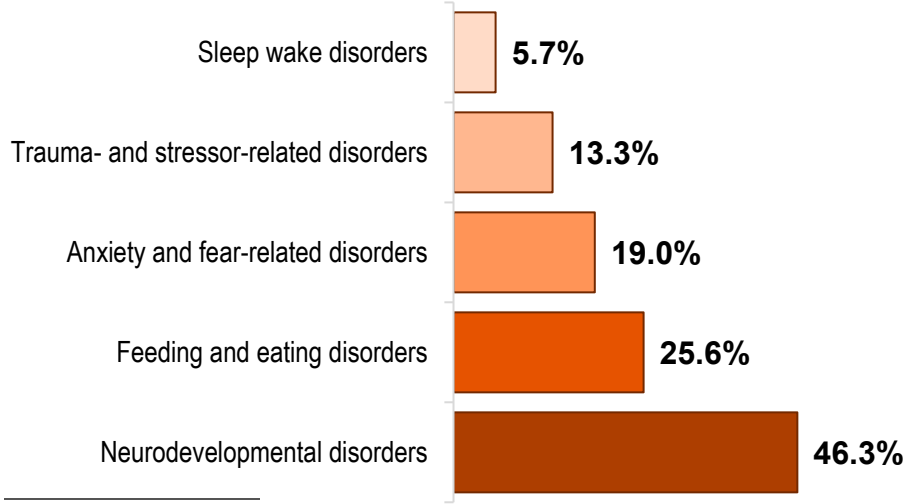
MH Summary



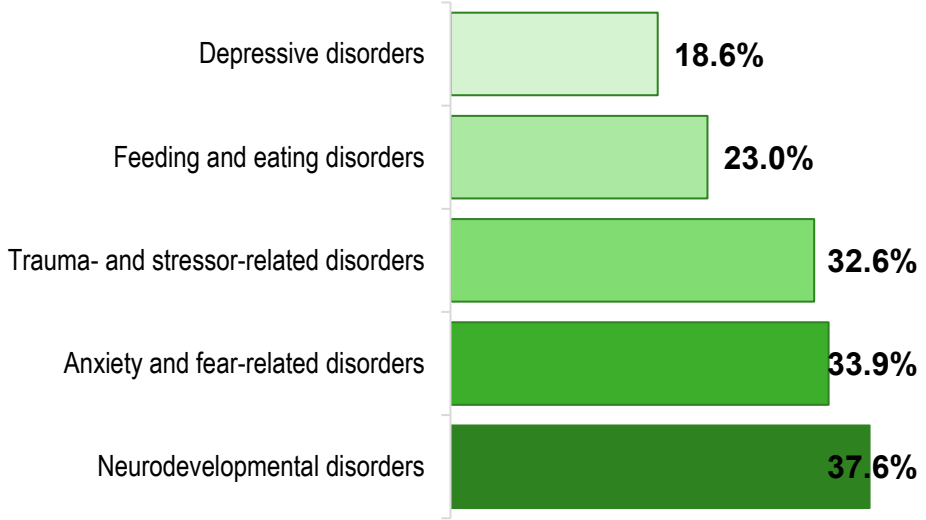
Top Conditions by Cost
CY 2023 (millions)



Emerging Trend Drivers



Historical Trend Drivers



Note: Emerging trend drivers represent the conditions with the greatest year-over-year increase in costs whereas historical trend drivers represent conditions with the greatest increase in costs from 2019 to 2023.

Appendices
Substance Use Disorder

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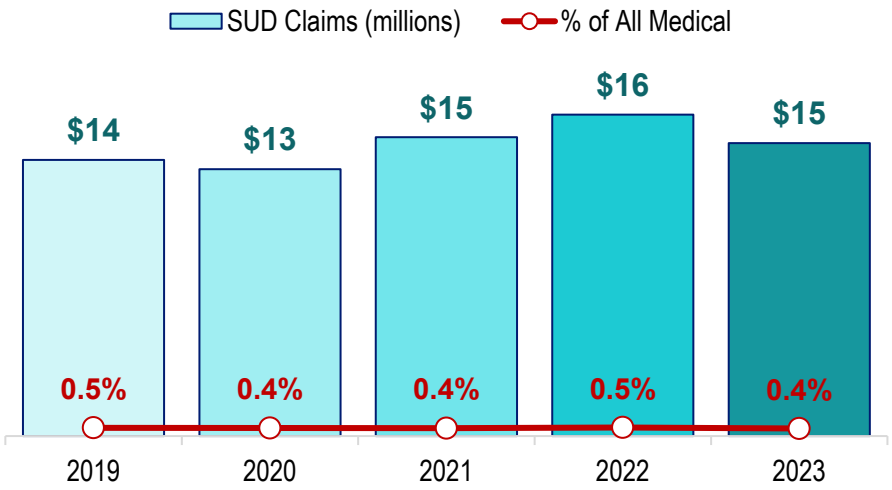
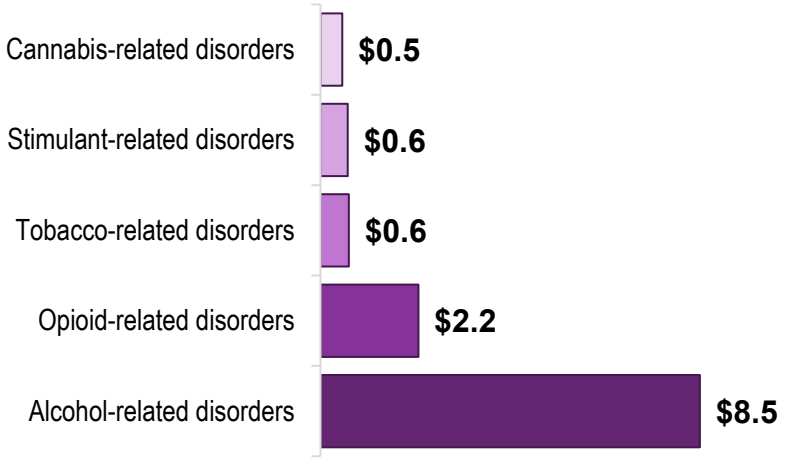
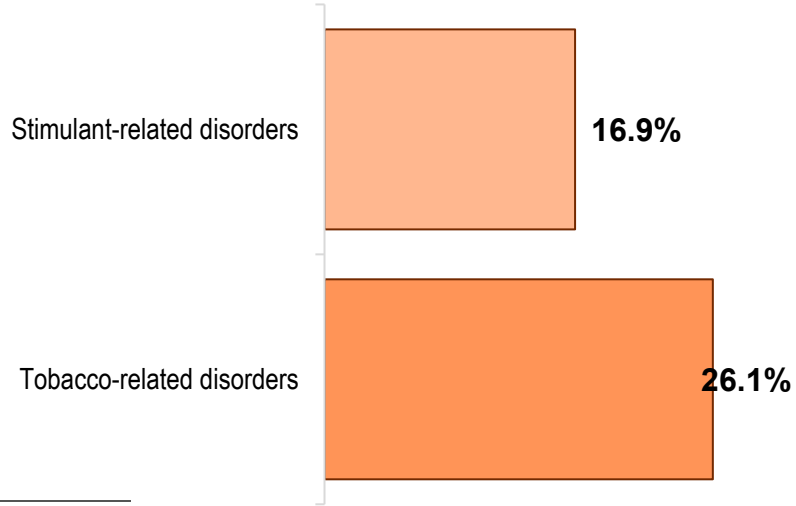
SUD Summary



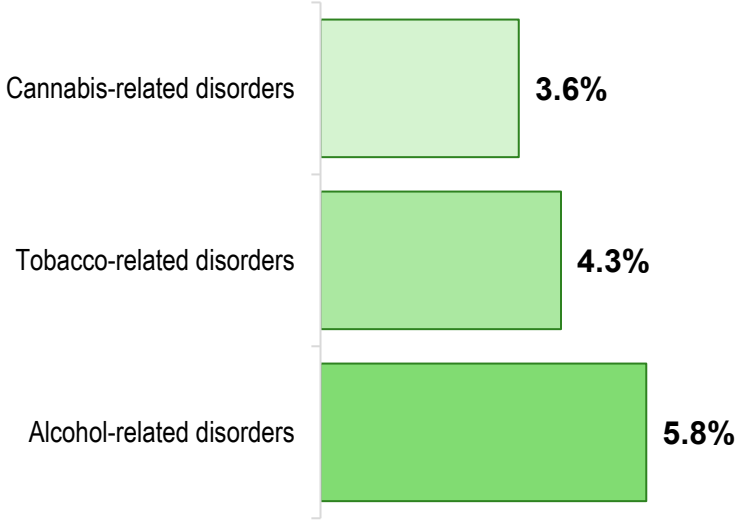
Top Conditions by Cost
CY 2023 (millions)



Emerging Trend Drivers



Historical Trend Drivers



Note: Emerging trend drivers represent the conditions with the greatest year-over-year increase in costs whereas historical trend drivers represent conditions with the greatest increase in costs from 2019 to 2023.

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Data Included

- This detailed risk study includes the following members of the SHP:
  - Actives: Any individual that is actively working, including Medicare-eligible members, and their eligible dependents
  - COBRA: Any individual receiving coverage through the Consolidated Omnibus Budget Reconciliation Act and their eligible dependents
  - Non-Medicare Retiree: Any individual enrolled in retiree coverage through the SHP and not yet eligible for Medicare and their non-Medicare-eligible dependents
- Note that individuals with any record of Medicare enrollment during a given year are excluded from this study.
- Medical and prescription drug claims incurred through 2023 and paid through April 2024.

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Member Profiles: Risk Group Definitions

- **Healthy:** Any member with a CCSR condition score below 2.4
- **Minor acute:** Members without a chronic condition identified who had a CCSR condition score between 2.4 and 6.8
- **Major acute:** Members without a chronic condition identified who had a CCSR condition score between 6.8 and 58.2
- **Single Chronic:** Members with exactly one identified chronic condition[1]
- **Chronic w/ Comorbidities:** Members with more than one identified chronic condition[1]
- **Malignancies:** Any member having the highest spend in a CCSR category related to malignancies
- **Catastrophic:** Any member with a CCSR condition score greater than 58.2

Member Profiles: Risk Group Examples

Risk Group	Description/Example of CCSR Category
1. Healthy	Contraceptive and procreative management
2. Minor Acute	Urinary tract infections
3. Major Acute	Newborn affected by maternal conditions or complications of labor/delivery
4. Single Chronic	Diabetes mellitus, Type 2
5. Chronic w/ Comorbidities	Coronary atherosclerosis and other heart disease with heart failure and depressive disorders
6. Malignancies	Nervous system Malignancies - brain
7. Catastrophic	Septicemia

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Member Profiles: Member Group Definitions

- **New:** Members who were not in the Plan in the prior period.
- **Continuing:** Members who were in the Plan in the prior period and the succeeding period.
- **Terminated:** Members who were not in the Plan in the succeeding period.
  - Includes members who were both new and terminated in the same year.
  - Does not include members who transition to a Medicare plan.

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Projection Methodology

- Segal based the projections on the Risk Group (i.e., healthy, minor acute, etc.) and Status (active vs. non-Medicare retiree) profile migration for the five-year period, CY 2019 through CY 2023.
- The migration patterns for new entrants, terminations/deaths, and remaining members were accumulated separately.
- Projections assume membership remains level at CY 2023 of 545,410.
- Each year, members are terminated/deceased based on their profile. New entrants replace the terminations/deaths.
- Members who became Medicare-eligible were considered to be terminated for purposes of this study.
- Terminations/deaths are based on historical experience while new entrants are assumed to join the plan with similar risk and migration patterns as prior new entrants.

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Why Risk Adjust?

- While allowed PMPM reflects impact of utilization and unit costs, it also reflects underlying conditions of members.
- Utilization and cost can vary significantly by health condition beyond age and gender.
- To create fair comparisons among different population sets (e.g., group, plan, carrier), risk adjustment methods can be used to normalize for differences in health conditions.
- Risk scoring, or adjusting for the health status or case mix of a population, is a way to provide a meaningful, on-level measure of a population's utilization or expenditures, whether at the patient level, provider level, hospital level, or for particular diseases.
- Population-based risk grouper models can be used for a number of business applications, including:
  - Determine the escalation of health status over time
  - Identify and stratify (prioritize) members for outreach strategies
  - Enable member outreach to improve care compliance
  - Evaluate the saving of case management and wellness program that are "true savings" and not simply a regression to the mean
  - Accurately profile providers for utilization review and quality of care
  - Support risk-based contracts and gain sharing

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What is CCSR?

- Clinical Classifications Software Refined (CCSR) is a database developed as part of the Healthcare Cost and Utilization Project (HCUP), a Federal –State-Industry partnership sponsored by the Agency of Healthcare Research and Quality (AHRQ).
- The CCSR grouper uses medical diagnosis codes to identify one of 544 clinical categories to which members can be grouped and risk adjusted.
  - All valid ICD-10 codes are mapped to a clinical category.
- The CCS software is open-source, allowing greater flexibility in using its grouping methodology.
- Separate demographic and condition scores are provided:
  - Demographic score based on age, sex, and enrollment duration
  - Condition score based on ICD-10 diagnoses and procedure codes
- Starting data set used was the IBM Watson Marketscan Commercial data (26 million members nationwide).
  - Random forest modeling was used to develop demographic and condition-specific values by eligibility band (e.g., 1-3 months, 4-6 month, 7-9 months, 10-11 months, 12 months).
- Members can fall into multiple different condition categories. Below are some examples of CCSR diagnosis categories:
  - CIR007 Essential hypertension
  - CIR008 Hypertension with complications and secondary hypertension
  - CIR009 Acute myocardial infarction
  - CIR011 Coronary atherosclerosis and other heart disease

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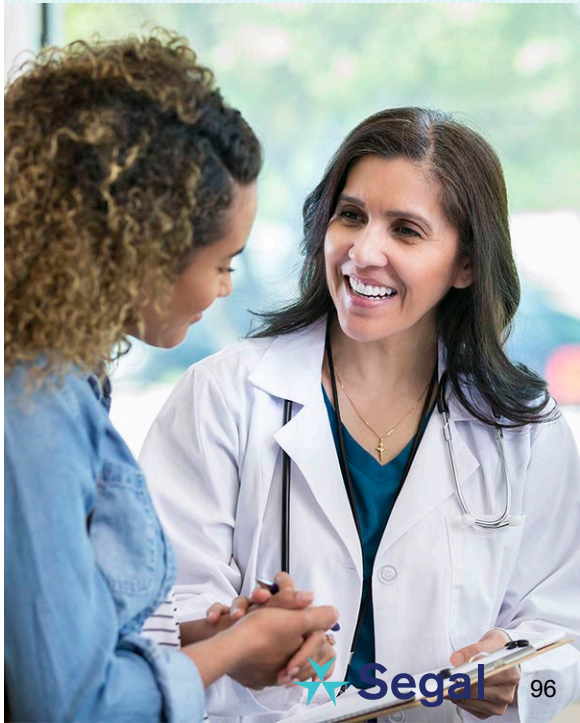
What is SegalRx?

- SegalRx was developed by health actuaries at Segal and utilizes the Medi-Span Generic Product Identifier grouper to allocate 56,167 different prescription drugs to one of 69 different conditions, based on National Drug Codes (NDCs).
- Up to four severity levels are established within each condition. Each condition category is hierarchical, meaning if a member utilizes drugs within multiple severity levels of the same condition, only the highest severity will be used for risk adjustment.
- In total, there are 135 different condition and severity levels in which prescription drugs are grouped.
- Risk scores were developed utilizing multiple regression modeling from 2023 pharmacy data in Segal's Data Warehouse (2.0 million members in the calibration sample).
  - Members with less than 12 months of enrollment or with any record of Medicare enrollment were excluded from the calibration sample.
- Risk scores were developed for both demographic and condition-specific values.
  - Risk scores are adjusted depending on how many months of enrollment an individual has during the experience period.
  - The total risk score for an individual is a sum of the demographic and condition values.
- Members can fall into multiple different condition categories. Below are some examples of SegalRx condition categories:
  - Disease modifying anti-rheumatic agents
  - Anti-hepatitis C (HCV) agents
  - Immunosuppressive agents
  - Anti-arrhythmic agents

Appendices
A Word About Privacy

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



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Disclaimer

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Healthcare Dashboard

ABC Client

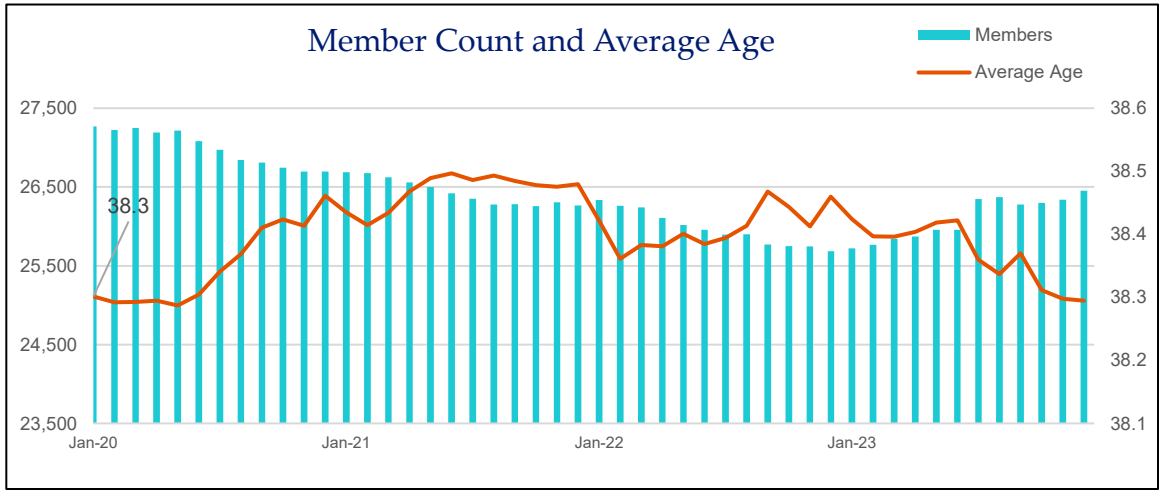
Reporting Periods

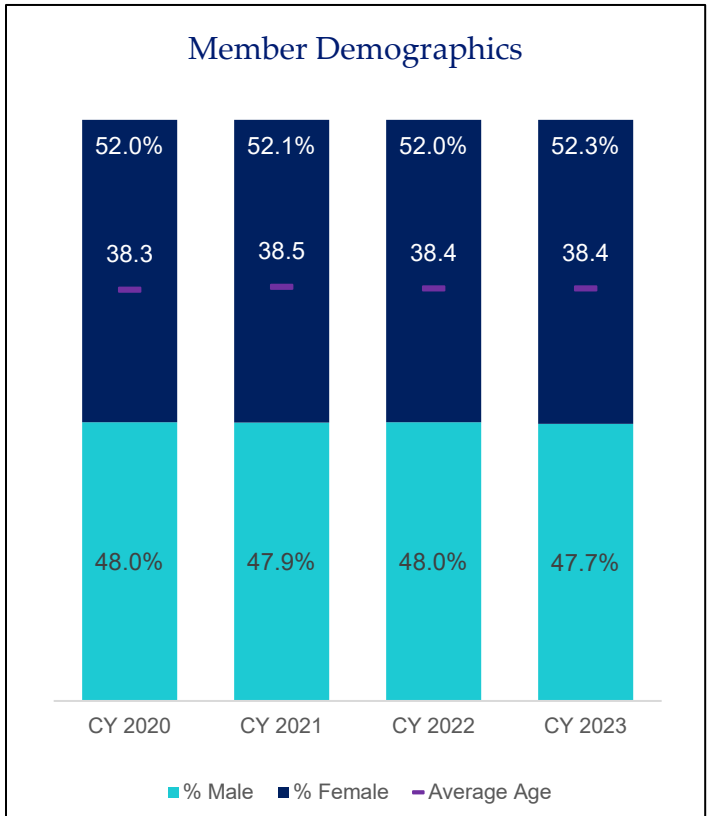
Current Period: January 2023 – December 2023
Prior Period: January 2022 – December 2022

Segal

Demographics
Actives and Non-Medicare Retirees

Data Period	Average Members	Average Member Age	Average Employees	Average Employee Age	Average Contract Size	Employee Turnover Rate[1]
CY 2020	27,000	38.3	11,684	49.5	2.31	6.6%
CY 2021	26,435	38.5	11,501	49.6	2.30	8.3%
CY 2022	25,973	38.4	11,313	49.5	2.30	10.0%
CY 2023	26,101	38.4	11,459	49.3	2.28	7.4%





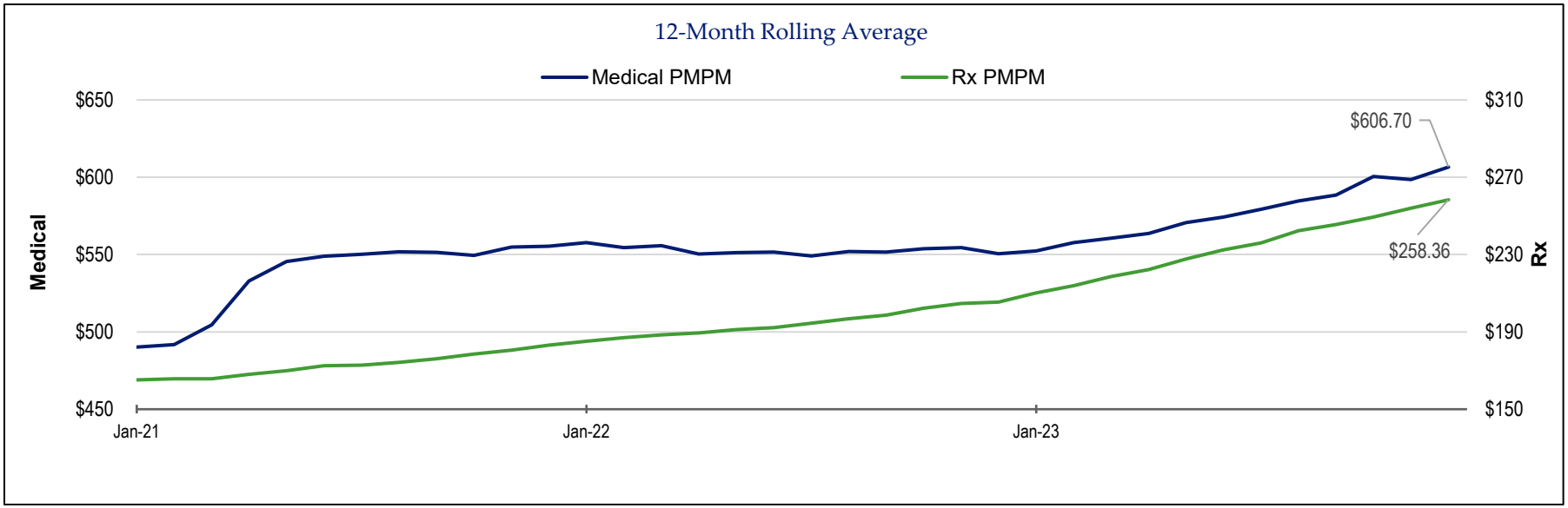
Observations

- Average member age and employee age have been steady over the past 4 years.
- The chart on the right shows that percentage of male members decreased slightly over the same 4-year period.
- The employee turnover was at its highest in CY 2022.
- Overall membership saw a 1.1% average annual decrease when compared to CY 2020, while employees saw a 0.6% average annual decrease compared to CY 2020.

[1] Reflect actives only (excludes non-Medicare retirees); turn over rate $= \frac{\#\ of\ Disenrolled\ Employees\ during\ Period}{\#\ of\ Employees\ at\ beginning\ of\ period}$

Financial and Utilization
Actives and Non-Medicare Retirees

5-Year Financial Experience – Plan Paid



Annualized Trends over Time

Period	Medical	Rx[1]	Total
Latest 12 months	10.2%	25.7%	14.4%
2-Year Average	4.5%	18.8%	8.2%
3-Year Average	6.9%	16.4%	9.4%

Observations

- Medical trends over the last three years have been volatile due to disruption introduced by COVID-19.
- Rx trends have been steadily increasing during the same 3-year period with little to no disruption caused by COVID-19.

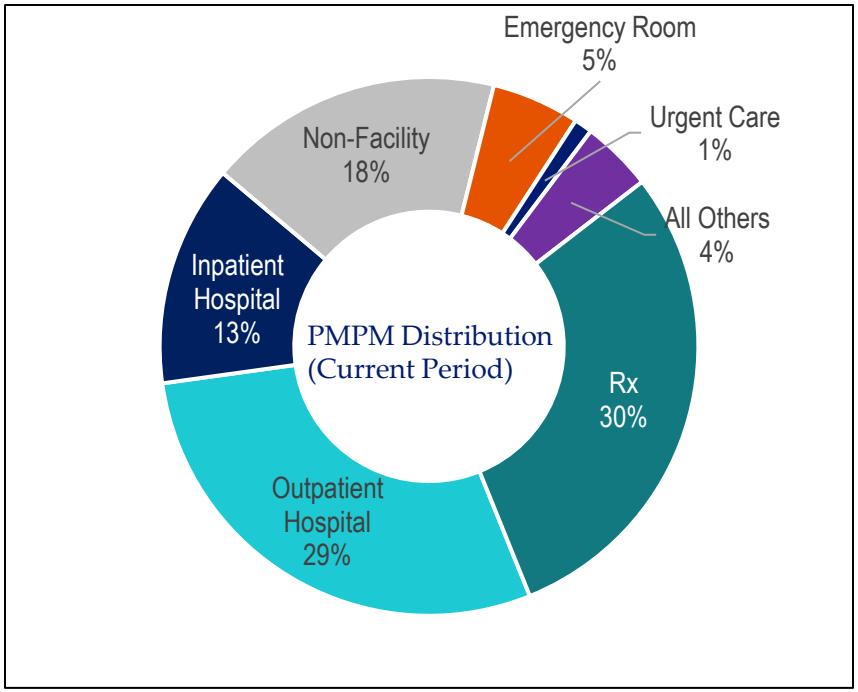
[1] Rx spend reflects gross cost and does not account for pharmacy rebates.

Financial and Utilization
Actives and Non-Medicare Retirees

Healthcare Dashboard
Current Period: Jan 2023 – Dec 2023
Prior Period: Jan 2022 – Dec 2022

Plan Financial Summary

	Current Period			Prior Period			% Change
Place of Service	Total Paid Amount	Total Paid PMPM	% of Total	Total Paid Amount	Total Paid PMPM	% of Total	Total Paid PMPM
Outpatient Hospital	$82,163,198	$262	28.9%	$75,398,418	$242	30.8%	8.4%
Inpatient Hospital	$37,858,876	$121	13.3%	$28,182,365	$90	11.5%	33.7%
Professional	$50,434,740	$161	17.8%	$45,747,638	$147	18.7%	9.7%
Emergency Room	$15,025,095	$48	5.3%	$12,863,939	$41	5.3%	16.2%
Urgent Care	$3,095,609	$10	1.1%	$3,414,608	$11	1.4%	-9.8%
All Others[1]	$12,157,511	$39	4.3%	$12,992,956	$42	5.3%	-6.9%
Total Medical	**$200,735,029**	**$641**	**70.6%**	**$178,599,924**	**$573**	**72.9%**	**11.8%**
Total Rx[2]	**$83,395,308**	**$266**	**29.4%**	**$66,310,116**	**$213**	**27.1%**	**25.1%**
Total Paid	**$284,130,337**	**$907**	**100.0%**	**$244,910,040**	**$786**	**100.0%**	**15.4%**
Member Paid	**$11,478,236**	**$37**	**4.0%**	**$10,638,319**	**$34**	**4.3%**	**7.4%**
Other Paid[3]	**$1,701,434**	**$5**	**0.6%**	**$1,358,423**	**$4**	**0.6%**	**24.6%**
Plan Paid	**$270,950,668**	**$865**	**95.4%**	**$232,913,297**	**$747**	**95.1%**	**15.8%**



Observations

- The Plan's Medical PMPM cost increased 11.8% over the prior period. Inpatient hospital saw the highest year-over-year ("YoY") trend in PMPM costs, followed by emergency room.
- The Plan's Rx PMPM cost pre-rebate increased 25.1% driven by a 23.5% increase in cost per drug (as reflected on page 10).
- The Plan paid PMPM increased 15.8% while the member cost share increased 7.4%.

[1] "All Others" includes ancillary type services such as Home Health, Ambulance, and DME.
[2] Rx amounts reflect costs prior to rebates being applied.
[3] "Other Paid" reflects coordination of benefits (or COB).

Financial and Utilization
Actives and Non-Medicare Retirees

Key Plan Utilization Metrics

Category	Current Period	Prior Period	Change[3]	SHAPE BoB[1]	Comparison to SHAPE BoB[1,3]
Average Membership	26,101	25,973	0.5%	N/A	N/A
Inpatient Admissions per 1,000	49	42	16.1%	45	10.1%
Average Length of Stay (ALOS)	5.7	5.3	8.2%	5.1	10.9%
Average Cost per Admission	$29,216	$25,238	15.8%	$34,876	-16.2%
Hospital Readmission Rate (30 Days)[2]	8.1%	6.7%	1.5pp	15.2%	-7.1pp
ER Visits per 1,000	226	212	6.8%	188	20.5%
ER Cost per Visit	$2,544	$2,339	8.8%	$2,215	14.9%
Percent of ER Visits resulting in a Hospital Admission	5.4%	4.7%	0.7pp	5.3%	0.1pp
Urgent Care Visits per 1,000	327	367	-10.8%	357	-8.6%
Urgent Care Cost per Visit	$363	$359	1.2%	$180	101.1%
Office Visits per 1,000 (non-Telehealth/Preventive)	4,778	4,400	8.6%	4,015	19.0%
Office Visit Cost per Visit	$160	$151	6.2%	$116	37.7%
Preventive Visits per 1,000	538	511	5.4%	770	-30.1%
Telehealth Visits per 1,000	1,260	1,322	-4.7%	1,889	-33.3%

Observations

- Inpatient admissions increased 16.1% when compared to last year and were 10.1% higher than the SHAPE BoB. The ALOS also increased 8.2% and average cost per admission increased 15.8%.
- ER visits and average cost per visit increased 6.8% and 8.8%, respectively. ER visits and the ER cost per visit were high when compared to the SHAPE BoB.
- Urgent care visits decreased 10.8% and were 8.6% lower than then SHAPE BoB.
- Office visits and preventive visits increased 8.6% and 5.4%, respectively.

[1] SHAPE BoB reflects public sector trends for calendar year 2022. Utilization statistics have not been adjusted for risk, severity or COVID.
[2] BoB figure is based on the national rate of readmission after discharge from hospital (hospital-wide) provided by CMS as of July 2022 instead of the SHAPE BoB.
[3] "pp" represents the percentage point difference between two percentages.

Financial and Utilization
Actives and Non-Medicare Retirees

Major Disease Conditions - Prevalence and Cost (Sorted by Prevalence)

Disease Condition[1]	Current Period							% Change	
	Members[2]	% of Total (Prevalence)	SHAPE BoB[3]	Medical & Rx Claims	% of Total	PMPY	Relative Cost[4]	Members	PMPY
Mental Health	11,250	42.5%	33.0%	$158,883,247	59.7%	$14,123	1.4x	10.4%	12.0%
Musculoskeletal	8,896	33.6%	25.5%	$152,546,618	57.3%	$17,148	1.7x	4.4%	17.2%
Hypertension	5,655	21.4%	21.6%	$117,194,435	44.0%	$20,724	2.1x	3.4%	16.6%
Asthma	2,150	8.1%	7.9%	$56,713,574	21.3%	$26,378	2.6x	4.8%	8.3%
Diabetes	2,146	8.1%	7.1%	$41,399,005	15.6%	$19,291	1.9x	12.8%	13.5%
Substance Use[5]	935	3.5%	2.6%	$21,280,402	8.0%	$22,760	2.3x	14.2%	13.4%
CAD	756	2.9%	2.8%	$34,920,018	13.1%	$46,191	4.6x	5.9%	7.6%
COPD	222	0.8%	0.6%	$10,900,221	4.1%	$49,100	4.9x	-9.4%	8.2%
CHF	98	0.4%	0.5%	$9,762,252	3.7%	$99,615	9.9x	-5.8%	9.6%
Total (unique)	**17,850**	**67.5%**	**56.5%**	**$240,728,933**	**90.5%**	**$13,486**	**1.3x**	**5.8%**	**13.1%**
All Members	**26,453**			**$266,077,871**		**$10,059**			

Observations

- Mental health remained the Plan's most prevalent condition. At 42.5% of all members, the Plan's mental health prevalence was higher than SHAPE's BoB (33.0%).
- Musculoskeletal ranked second with 33.6% prevalence. This was also higher than the SHAPE BoB prevalence of 25.5%.
- Substance use, which ranked sixth highest by prevalence, saw the highest increase in members, up 14.2%, when compared to last year.
- The number of members with diabetes increased 12.8% from the prior year while the diabetes PMPY cost increased 13.5% from the prior year.
- 67.5% of the population was identified with at least one condition listed above. This was higher than SHAPE's BoB of 56.5%.

[1] Sorted by prevalence. Members with co-morbidities and their corresponding claims are combined in each applicable category.
[2] Reflects enrollment count and total medical and Rx spend of members with active coverage as of December 2023.
[3] SHAPE BoB reflects public sector trends for calendar year 2022. See the appendix at the end of this report for more details.
[4] Reflects the ratio of PMPY costs of members with the chronic condition to the PMPY cost of the total enrolled population.
[5] Substance use disorder includes opioid and alcohol disorders; excludes members with tobacco use disorders.

Financial and Utilization
Actives and Non-Medicare Retirees

Claim Distribution Summary (Medical & Rx)

	Current Period					Prior Period					% Change		SHAPE BoB[2]	
Cost Range	Claimants[1]	% Claimants	Total Cost	% Total Cost	Cost per Claimant	Claimants[1]	% Claimants	Total Cost	% Total Cost	Cost per Claimant	Claimants[1]	Total Cost	% Claimants	% Total Cost
No Claims	2,254	7.8%	$0	0.0%	$0	1,998	6.9%	$0	0.0%	$0	12.8%	NA	5.6%	0.0%
Less than $50,000	25,692	88.5%	$151,067,212	53.2%	$5,880	26,026	89.9%	$136,216,899	55.6%	$5,234	-1.3%	12.3%	91.7%	56.3%
$50,000 - $100,000	666	2.3%	$46,435,100	16.3%	$69,722	576	2.0%	$40,504,437	16.5%	$70,320	15.6%	-0.9%	1.6%	15.0%
$100,000 - $250,000	319	1.1%	$46,510,849	16.4%	$145,802	269	0.9%	$39,895,405	16.3%	$148,310	18.6%	-1.7%	0.8%	15.8%
$250,000 - $500,000	83	0.3%	$27,686,467	9.7%	$333,572	58	0.2%	$19,569,950	8.0%	$337,413	43.1%	-1.1%	0.2%	7.6%
$500,000 - $1,000,000	17	0.1%	$11,161,019	3.9%	$656,531	14	0.0%	$8,723,349	3.6%	$623,096	21.4%	5.4%	0.0%	3.5%
$1,000,000 - $2,000,000	1	0.0%	$1,269,690	0.4%	$1,269,690	0	0.0%	$0	0.0%	$0	NA	NA	0.0%	1.3%
$2,000,000 +	0	0.0%	$0	0.0%	$0	0	0.0%	$0	0.0%	$0	NA	NA	0.0%	0.5%
Total Claimants[1]	**26,778**		**$284,130,337**		**$10,611**	**26,943**		**$244,910,040**		**$9,090**	**-0.6%**	**16.7%**		

Observations

- 7.8% of members had no medical or Rx claims in the current period; compared to 5.6% according to SHAPE's BoB.
- The number of total unique claimants decreased 0.6% when compared to the prior period, while the average cost per claimant increased 16.7%.
- Claimants with total cost between $250k and $500k increased 43.1%, 83 in the current period vs 58 in the prior period.
- 1 claimants had total cost between $1M and $2M in the current period.
- No claimants had total cost exceeding $2M in the current or prior periods.

[1] Total claimants count does not include members with no claims.
[2] SHAPE BoB reflects public sector trends for calendar year 2022. See the appendix at the end of this report for more details.

High-Cost Claimants Analysis ($50k+)

Category (Sorted by Members)	Current Period			Prior Period			% Change	
	Claimants (% Disenrolled)	% of Total[1]	Cost per Claimant	Claimants (% Disenrolled)	% of Total[1]	Cost per Claimant	Claimants	Cost per Claimant
Rx Dominant	362 (4%)	33.3%	$110,350	291 (2%)	31.7%	$107,835	24.4%	2.3%
Episodic w/ Underlying Health Conditions[2]	281 (8%)	25.9%	$118,990	249 (14%)	27.2%	$104,255	12.9%	14.1%
Chronic	246 (5%)	22.7%	$116,366	207 (6%)	22.6%	$115,908	18.8%	0.4%
Screenable Cancer	69 (4%)	6.4%	$159,444	69 (12%)	7.5%	$171,875	0.0%	-7.2%
Non-Screenable Cancer	59 (15%)	5.4%	$228,417	52 (17%)	5.7%	$210,832	13.5%	8.3%
Episodic w/o Underlying Health Conditions[2]	33 (0%)	3.0%	$81,540	24 (8%)	2.6%	$81,111	37.5%	0.5%
Mental Health	24 (4%)	2.2%	$118,940	18 (6%)	2.0%	$112,373	33.3%	5.8%
Substance Use	12 (8%)	1.1%	$85,894	7 (14%)	0.8%	$81,245	71.4%	5.7%
Total High-Cost Members	**1,086 (6%)**	**3.7%**	**$122,526**	**917 (8%)**	**3.2%**	**$118,531**	**18.4%**	**3.4%**

Observations

- 1,086 claimants, or 3.7% of all members, exceeded the $50k threshold of combined medical and Rx spend. This reflects a 18.4% increase in high-cost claimants when compared to last year.
- The top category of high-cost claimants was for Rx dominant members, which means pharmacy spend, rather than medical, was the key cost driver of those members.
- Combined episodic conditions, with and without underlying conditions, accounted for about 29% of high-cost claimants. About 23% of high-cost claimants were for Chronic conditions.
- Substance use saw the highest increase of 71.4% in the number of high-cost claimants when compared to last year.

[1] % of Total reflects the ratio of members in each category to the total high-cost members, except for the total row, which reflects the ratio of total high-cost claimants to the total population.
[2] Underlying health conditions are those conditions listed on page 6, except for musculoskeletal.

Clinical Compliance Rates

Disease Condition	Clinical Quality Metrics[1]	All Members				Employees			Dependents		
		Population[2]	Current Period	Change (in pp)	SHAPE BoB[3]	Population[2]	Current Period	Change (in pp)	Population[2]	Current Period	Change (in pp)
Diabetes	At least 1 hemoglobin A1C test	2,037	85.0%	▼ 2.1	82.5%	1,284	85.3%	▼ 3.6	753	84.6%	▲ 0.6
	Screening for diabetic nephropathy	2,037	61.8%	▲ 1.8	63.9%	1,284	61.7%	▲ 0.8	753	61.9%	▲ 3.5
	Screening for diabetic retinopathy	2,037	44.1%	▼ 2.1	34.6%	1,284	44.3%	▼ 2.0	753	43.7%	▼ 2.4
CAD	Patients currently taking an ACE-Inhibitor or ARB Drug	716	45.5%	▼ 3.7	22.2%	387	47.3%	▼ 4.0	329	43.5%	▼ 3.1
	Patients currently taking a statin	716	80.6%	▲ 0.8	71.7%	387	80.1%	▲ 3.6	329	81.2%	▼ 2.7
Hypertension	On anti-hypertensives and serum potassium	3,569	72.6%	▲ 2.0	61.9%	2,165	73.8%	▲ 1.9	1,404	70.9%	▲ 2.4
Hyperlipidemia	Total cholesterol testing	5,913	73.3%	▲ 0.2	73.2%	3,711	73.8%	▼ 0.3	2,202	72.4%	▲ 1.0
COPD	Spirometry testing	214	28.0%	▲ 3.8	27.9%	132	25.0%	▲ 2.8	82	32.9%	▲ 5.8
Asthma	Patients with inhaled corticosteroids or leukotriene inhibitors	2,017	85.4%	▼ 4.2	81.5%	975	87.4%	▼ 3.5	1,042	83.5%	▼ 4.8
Preventive Screening	Cervical cancer	9,537	27.9%	▼ 1.4	53.9%	5,310	28.9%	▼ 1.3	4,227	26.6%	▼ 1.5
	Breast cancer	6,302	60.9%	▲ 0.9	65.8%	4,153	62.0%	▲ 0.2	2,149	58.6%	▲ 2.2
	Colorectal cancer	8,934	42.1%	▲ 2.3	47.4%	5,728	43.1%	▲ 2.9	3,206	40.4%	▲ 1.4
	Prostate cancer	4,281	52.3%	▲ 1.8	44.6%	2,587	54.0%	▲ 1.5	1,694	49.8%	▲ 2.5

Observations

- Preventive screening compliance rates are critically important. Early detection of chronic conditions gives the patient a higher probability of a positive outcome, and the Plan could avoid expensive treatments in the future if these conditions are caught/managed early. The Plan should frequently communicate the value and importance of preventive screenings.
- While the comparison to SHAPE BoB is strictly informational as the ideal goal for each metric is to reach 100% compliance, most compliance metrics looked favorable when compared to SHAPE BoB.

[1] Performed in the last 12 months of the reporting period.
[2] Limited to members with continuous coverage in the reporting period. See the appendix, Clinical Quality Metrics, for further population restrictions (if any).
[3] SHAPE BoB reflects public sector compliance rates for calendar year 2022. Utilization statistics have not been adjusted for risk, severity or COVID.

Financial and Utilization
Actives and Non-Medicare Retirees

Prescription Drug Utilization and Cost

	Total			Non-Specialty		Specialty	
Category	Current Period	Prior Period	Change	Current Period	Change	Current Period	Change
Total Cost[1]	$83,395,308	$66,310,116	25.8%	$41,219,428	26.8%	$42,175,880	24.7%
% of Total Cost				49.4%	0.4pp	50.6%	-0.4pp
Total Scripts[2]	354,454	348,054	1.8%	347,782	1.7%	6,672	9.4%
% of Total Scripts				98.1%	-0.1pp	1.9%	0.1pp
Scripts per 1,000	13,580	13,400	1.3%	13,324	1.2%	256	8.9%
Days Supply per Script	43	43	1.8%	44	1.8%	38	2.9%
Drug Cost PMPM	$266	$213	25.1%	$132	26.2%	$135	24.1%
Drug Cost per Script	$235	$191	23.5%	$119	24.7%	$6,321	14.0%
Generic Dispensing Rate (GDR)	85.7%	84.0%	1.7pp	86.3%	1.8pp	52.0%	-2.0pp
Retail Dispensing Rate (RDR)[3]	64.4%	64.8%	-0.4pp	64.9%	-0.3pp	37.9%	-4.0pp
Member Cost %	3.0%	3.5%	-0.5pp	5.7%	-1.0pp	0.3%	0.0pp

Observations

- Drug cost, on a PMPM basis, increased 25.1%. The increase of 23.5% in the average cost per script was the main trend driver in Rx spend.
- On a PMPM basis, the average cost per specialty drug was up 24.1%, while the average cost of non-specialty drugs was up 26.2%
- At 85.7%, the generic dispensing rate (“GDR”) was slightly higher than SHAPE’s CY 2022 BoB GDR of 83%.
- The retail dispensing rate (“RDR”) of 64.8% was lower than the SHAPE’s BoB RDR of 96%, which reflects the Plan’s mandatory mail provision.
- Specialty prescriptions accounted for 1.9% of the total scripts, in-line with SHAPE’s BoB of 2%, and 50.6% of the total script cost, higher than the SHAPE BoB 46%.

[1] Total costs shown above are total Plan and member costs and have not been adjusted to reflect pharmacy rebates.
[2] Both 30-day and 90-day dispensed drugs are counted as one (1) script.
[3] Retail dispensing rate reflects the percentage of scripts dispensed at retail pharmacies.

Financial and Utilization
Actives and Non-Medicare Retirees

Major Drug Indicator - Utilization and Cost (Sorted by PMPM)

Rank				Current Period					% Change			SHAPE BoB[1]			
Plan	SHAPE BoB[1]	Top 10 Indications	Rank Movement	Scripts[2] per 1,000	Cost[3] per Script	Generic Fill Rate	Retail Fill Rate[4]	PMPM	Scripts[2] per 1,000	Cost[3] per Script	PMPM	Scripts[2] per 1,000	Cost[3] per Script	Generic Fill Rate	Retail Fill Rate[4]
1	1	Diabetes	– 0	805	$801	40.1%	48.8%	**$53.71**	25.1%	21.8%	52.3%	577	$513	51.5%	93.6%
2	2	Autoimmune Disease	– 0	59	$8,595	34.1%	23.9%	**$42.09**	12.3%	20.2%	35.0%	56	$4,531	27.5%	87.6%
3	4	Psoriasis	– 0	26	$16,357	13.9%	17.8%	**$36.09**	28.8%	9.4%	40.9%	14	$10,391	10.8%	89.0%
4	3	Oncology	– 0	63	$2,713	85.6%	50.3%	**$14.24**	3.6%	5.9%	9.7%	62	$2,356	84.5%	94.0%
5	6	Asthma/COPD	– 0	531	$272	70.1%	55.2%	**$12.01**	-1.8%	5.4%	3.5%	428	$161	78.4%	95.4%
6	7	Multiple Sclerosis/Neuromuscular	– 0	10	$11,605	41.4%	14.3%	**$10.12**	2.5%	-8.8%	-6.5%	8	$8,139	31.1%	85.2%
7	9	Skin Disorders	– 0	285	$420	91.7%	71.8%	**$9.95**	10.1%	22.4%	34.8%	228	$273	87.4%	97.7%
8	8	ADHD/Narcolepsy	– 0	554	$183	79.5%	91.5%	**$8.44**	7.3%	11.3%	19.4%	281	$227	57.9%	98.6%
9	21	Rare Disorders	– 0	18	$5,372	77.1%	57.9%	**$8.03**	-4.4%	41.7%	35.5%	11	$1,798	82.9%	93.7%
10	5	Cardiovascular	– 0	2,719	$27	99.1%	50.4%	**$6.07**	2.3%	6.5%	8.9%	2,125	$39	98.4%	92.3%
Total Top 10:				**5,070**	**$475**	**82.6%**	**55.8%**	**$200.75**	**6.6%**	**23.4%**	**30.9%**				
Total Rx				**13,580**	**$235**	**85.7%**	**64.4%**	**$266.25**	**1.3%**	**23.5%**	**25.1%**				

Observations

- The top 10 drug indicators remained unchanged, although slightly different ranking when compared to SHAPE's BoB.
- Diabetes was the top Rx spend indicator, in-line with SHAPE's BoB, and saw the highest PMPM increase of 52.3%. The high trend was driven by changes in standard of care for treatment – primarily in the GLP-1 category.
- The autoimmune landscape is changing rapidly with the introduction of biosimilars for highly utilized Humira. While market share has not yet shifted significantly, 2023 and 2024 are expected to be transition years which will result in cost-savings as biosimilar competition increases.
- Rare disorders, which typically ranks outside the top 10 according to the SHAPE BoB, ranked ninth. This is mainly due to a significant differential in cost per scripts when compared to the SHAPE BoB ($5,372 vs $1,798).
- Cardiovascular ranked lower than expected due to the average cost per drug costing 31% lower than the SHAPE BoB.

[1] SHAPE BoB reflects public sector trends for calendar year 2022. See appendix for more details. Utilization statistics have not been adjusted for risk, severity or COVID.
[2] Both 30-day and 90-day dispensed drugs are counted as one (1) script.
[3] Drug costs reflected on this slide are pre-rebates.
[4] Retail fill rate reflects the percentage of scripts dispensed at retail pharmacies.

Spotlight on: Hospital Admissions

Active and Non-Medicare Members

Admission Condition	Current Period							%Change	
	Admissions	% of Admission	Patients	Total Cost	% of Total	Cost per Admission	Relative Cost[1]	Admissions	Cost per Admission
Prenatal, Pregnancy, and Birth	314	24.5%	312	$3,897,222	10.4%	$12,412	0.4x	5.4%	0.7%
Gastrointestinal	111	8.7%	93	$2,211,575	5.9%	$19,924	0.7x	56.3%	14.3%
Obesity	59	4.6%	59	$2,153,293	5.8%	$36,496	1.2x	15.7%	12.2%
Injuries	53	4.1%	52	$2,727,237	7.3%	$51,457	1.8x	8.2%	10.2%
Blood Disorders	51	4.0%	44	$1,686,364	4.5%	$33,066	1.1x	8.5%	-28.7%
Hypertension	46	3.6%	44	$924,526	2.5%	$20,098	0.7x	-2.1%	-9.1%
Respiratory	41	3.2%	39	$927,531	2.5%	$22,623	0.8x	57.7%	26.2%
Depressive disorders	39	3.0%	30	$698,252	1.9%	$17,904	0.6x	30.0%	5.0%
Cardiovascular	38	3.0%	35	$1,863,819	5.0%	$49,048	1.7x	5.6%	38.6%
Joint and Musculoskeletal	37	2.9%	35	$1,927,632	5.2%	$52,098	1.8x	105.6%	-22.9%
Total Top 10	**789**	**61.6%**	**721**	**$19,017,452**	**50.9%**	**$24,103**	**0.8x**	**15.5%**	**7.9%**
Total Admissions	**1,280**			**$37,395,993**		**$29,216**		**16.7%**	**15.8%**

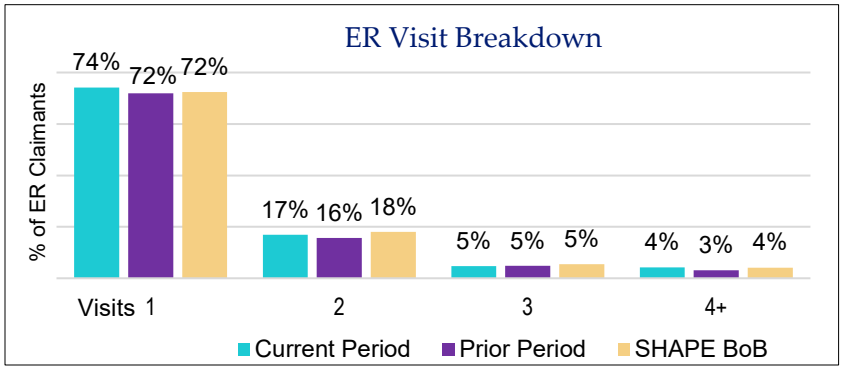
- The above chart illustrates the top 10 hospital admission conditions sorted by the number of admissions. The top 10 conditions reflects about 62% of all inpatient hospital admissions.
- As indicated on page 5, inpatient admission – on a per 1,000 basis - increased 16.1% when compared to the prior year. The above chart shows that more than one condition played a role in the increase.
- Joint and musculoskeletal had the highest YoY change of 105.6%, followed by respiratory with a 57.7% increase in admissions.
- While not illustrated above, 99% of inpatient admissions, in both periods, were in-network.

[1] Reflects the ratio of average admission cost of the specific condition to the overall cost of inpatient admission.

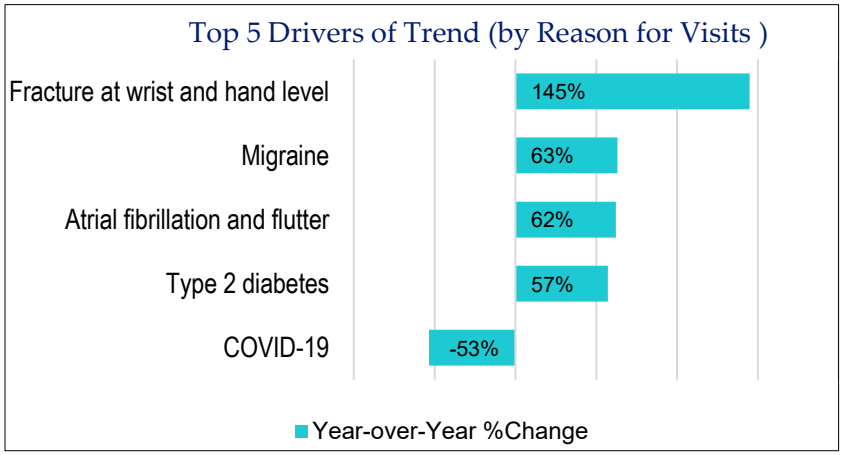
Spotlight on: Emergency Room
Actives and Non-Medicare Retirees

Healthcare Dashboard
Current Period: Jan 2023 – Dec 2023
Prior Period: Jan 2022 – Dec 2022

	Current Period			% Change		SHAPE BoB[1]	
Severity Level	Visits per 1,000	% of Visits	Cost per Visit	Visits per 1,000	Cost per Visit	% of Visits	Cost per Visit
Low	15	7%	$560	-23.7%	-5.0%	5%	$742
Moderate	123	54%	$1,901	9.3%	9.3%	57%	$1,748
High	88	39%	$3,774	10.8%	4.4%	38%	$3,360
Total	**226**		**$2,544**	**6.8%**	**8.8%**		



Rank (by Visits)			Current Period (Cost per Visit)	
Plan	SHAPE BoB[1]	Major Diagnosis Conditions	Plan	SHAPE BoB[1]
1	1	Abdominal and pelvic pain	$3,222	$2,734
2	2	Pain in chest	$3,019	$2,850
3	4	Dorsalgia (back pain)	$2,236	$2,008
4	6	Nausea and vomiting	$2,373	$2,350
5	17	Syncope and collapse	$3,492	$3,194
6	3	COVID-19	$2,651	$2,148
7	25	Abnormalities of heartbeat	$2,528	$2,596
8	7	Acute upper respiratory infections	$1,354	$1,682
9	11	Headache	$3,050	$2,516
10	9	Open wound of wrist, hand and fingers	$1,249	$1,580

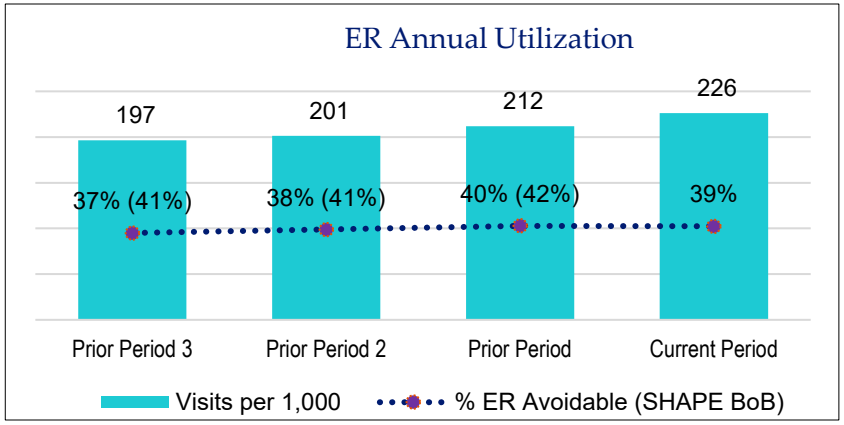


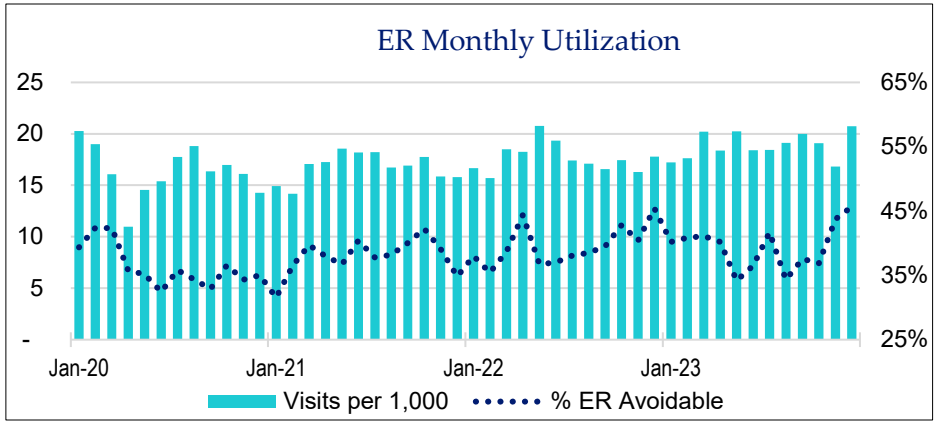
- The top left chart reflects the breakdown of ER visits by severity levels. Low severity was about 2pp higher than the SHAPE BoB, while moderate was 3pp lower.
- 74% of claimants had 1 ER visits during the current period. 4% of claimants had 4 or more ER visits.
- Hand and wrist fractures was the highest trending condition when compared to last year, it was up 145%. COVID-19 ER visit related conditions was down 53% .

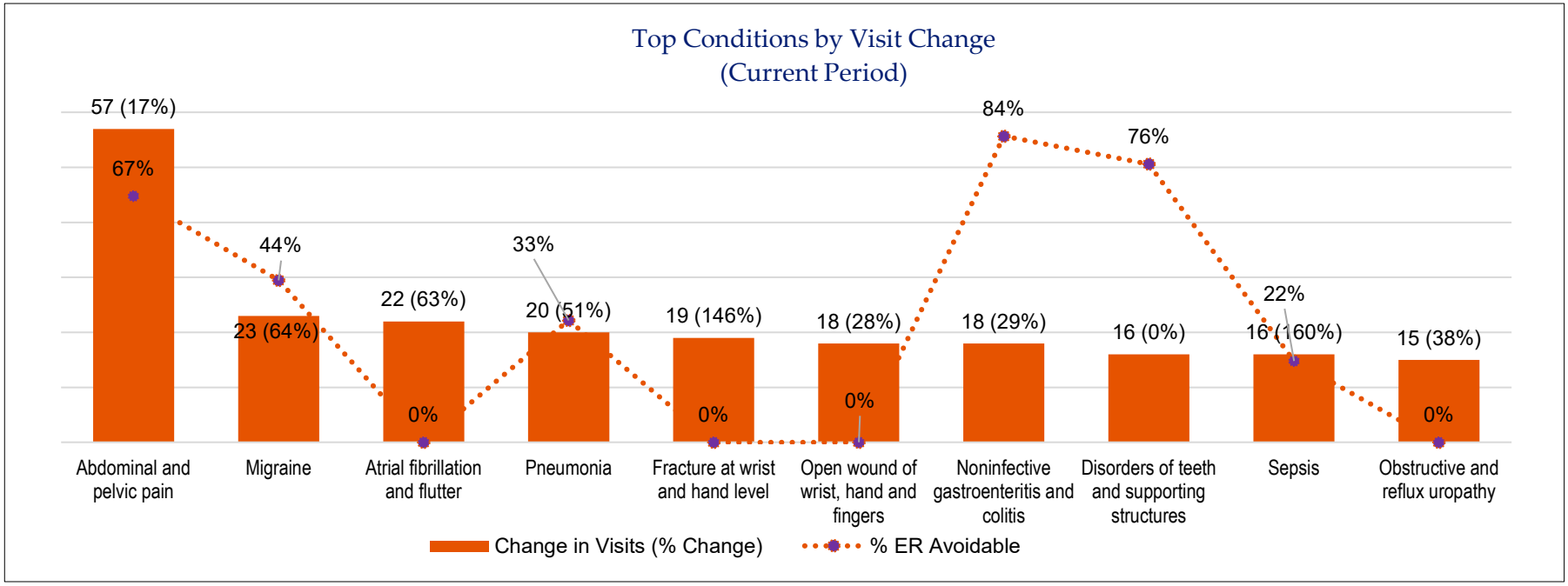
[1] SHAPE BoB reflects public sector trends for calendar year 2022. Utilization statistics have not been adjusted for risk, severity or COVID.

Spotlight on: Emergency Room
Actives and Non-Medicare Retirees

Healthcare Dashboard
Current Period: Jan 2023 – Dec 2023
Prior Period: Jan 2022 – Dec 2022







[1] SHAPE BoB reflects multiemployer trends for specific calendar year. Utilization statistics have not been adjusted for risk, severity or COVID.

Spotlight on: Musculoskeletal
Adult Non-Medicare Members (18+)

Healthcare Dashboard
Current Period: Jan 2023 – Dec 2023
Prior Period: Jan 2022 – Dec 2022

MSK Condition	Patients	Prevalance[1]	SHAPE BoB[2]	% of Patients with Surgery	% of Patients with PT	Total MSK Spend	MSK PMPY	% Change Patients	% Change MSK PMPY
Low Back	1,308	6.2%	5.2%	1%	33%	$5,147,982	$3,936	17%	30%
Knee	935	4.5%	3.4%	9%	36%	$6,653,031	$7,116	14%	25%
Neck	981	4.7%	3.1%	1%	27%	$4,895,520	$4,990	0%	49%
Shoulder	759	3.6%	2.6%	1%	42%	$3,854,175	$5,078	5%	8%
Hip	511	2.4%	1.3%	9%	40%	$3,785,636	$7,408	15%	-10%
Wrist/Hand	331	1.6%	0.9%	42%	11%	$2,629,761	$7,945	-3%	46%
Ankle	371	1.8%	1.2%	13%	29%	$2,352,711	$6,342	19%	2%
Elbow	153	0.7%	0.5%	18%	26%	$1,181,103	$7,720	38%	92%
Total Unique	**4,358**	**20.8%**	**14.7%**			**$20,860,788**	**$4,787**	**8%**	**15%**
All Other Conditions	*3,729*	*17.8%*	*15.1%*			*$5,026,038*	*$1,348*	*-2%*	*18%*
Total MSK	**8,087**	**38.6%**	**29.8%**			**$25,886,825**	**$3,201**	**3%**	**19%**

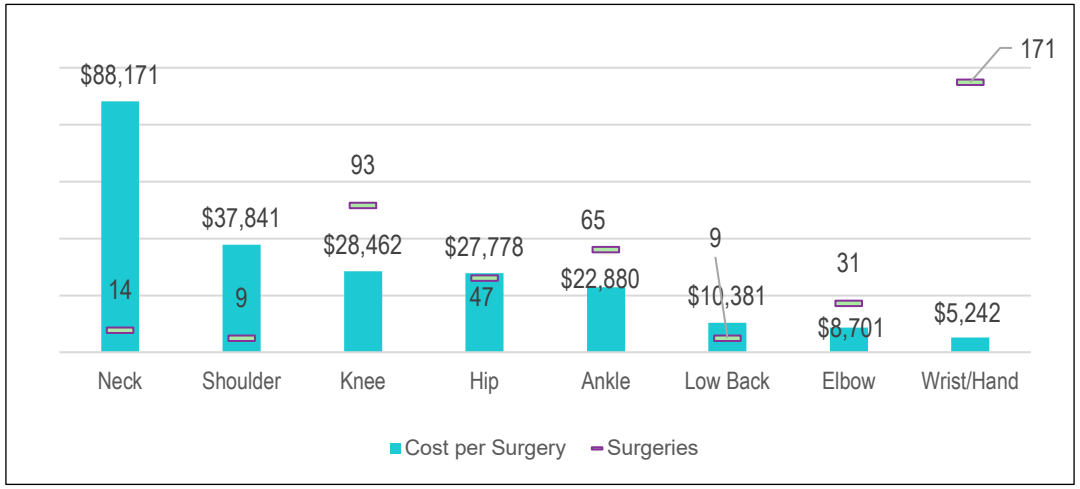
Condition Profile	Definition	Patients	% of Patients	Total MSK Spend	% of Total MSK Spend	MSK PMPY	Relative[3] PMPY	% Change Patients	% Change MSK PMPY
Very High	MSK Surgery / Invasive procedure	367	5%	$10,813,295	42%	$29,464	9.2x	1%	26%
High	1 adv img or 1 ortho visit + 1 standard img	2,275	28%	$10,599,595	41%	$4,659	1.5x	7%	15%
Medium	2+ office visits or 1 ortho visit or 1 standard img	2,311	29%	$2,794,717	11%	$1,209	0.4x	2%	10%
Low	MSK Primary Dx	3,134	39%	$1,679,218	6%	$536	0.2x	2%	7%
Total		**8,087**		**$25,886,825**		**$3,201**		**3%**	**19%**

- As of December 2023, the Plan's musculoskeletal (MSK) prevalence, for adult members, was 38.6%, which is higher than the SHAPE's BoB of 29.8%
- 33% of MSK patients were classified as high to very high severity and accounted for 83% (about $21M) of the total annual MSK spend. A suitable program may help reduce avoidable surgeries impacting the Plan's highest MSK cost drivers.

[1] Reflects the ratio of patients with the specific condition to the overall adult population.
[2] SHAPE BoB reflects public sector trends for calendar year 2022. Utilization statistics have not been adjusted for risk, severity or COVID.
[3] Reflects the ratio of PMPY costs of members with the specific condition profile to the total.

Spotlight on: Musculoskeletal
Adult Non-Medicare Members (18+)

						% Change	
Type of Surgery	**Patients**	**Surgeries**	**% of All Surgeries**	**Total Cost**	**Cost per Surgery**	**Surgeries**	**Cost per Surgery**
Neck	10	14	3%	$1,234,397	$88,171	-26%	239%
Shoulder	9	9	2%	$340,564	$37,841	80%	44%
Knee	86	93	21%	$2,646,984	$28,462	39%	-5%
Hip	45	47	11%	$1,305,576	$27,778	9%	-11%
Ankle	50	65	15%	$1,487,180	$22,880	-22%	99%
Low Back	9	9	2%	$93,432	$10,381	29%	173%
Elbow	28	31	7%	$269,731	$8,701	41%	-1%
Wrist/Hand	138	171	39%	$896,451	$5,242	-16%	20%
Total (Unique)	**367**	**439**		**$8,274,315**	**$18,848**	**-2%**	**40%**



- The above charts reflect the breakdown of surgeries by the major MSK conditions.
- Wrist/hand surgeries were the most prevalent by volume (39% of all MSK surgeries), while neck related surgeries had the highest cost per surgery.

Appendix

Dashboard Overview

The purpose of this annual dashboard is to:

- Highlight key metrics to monitor progress against strategic opportunities.
- Provide a mechanism to track:
  - **Claims and trends:** determine cost trend drivers plus analyze data on effective alternatives to manage those trends
  - **Utilization metrics vs. benchmark:** compare the Plan's utilization to benchmarks and desired targets.
  - **Population health status:** assess disease burden and recommend solutions to lessen future trend increases; Uncover opportunities for the Plan to better control Plan cost and improve the health of the covered population.

Methodology/Definitions

- Generally, financial metrics are reported on a total cost/allowed basis (i.e., total cost includes Plan paid and member cost sharing). This allows for tracking of population health status for improvement over time.
- Claims are reported on an incurred basis for the periods January 1, 2023 – December 31, 2023 (current period) and January 1, 2022 – December 31, 2022 (prior period). Both periods include three months of run-out.

Norms/Benchmarks

- Where benchmarks are shown, we are using Segal's internal data warehouse, SHAPE, public sector trends representing about 1.1 million lives for calendar year 2022 claims experience.
- Benchmark data was not adjusted based on an age, gender, geographic basis, severity, and COVID-19.

Appendix

Clinical Quality Metrics

- The table below illustrates additional restrictions applied when defining population count for each disease condition.

Disease Condition	Age/Gender Restrictions
Diabetes	None
CAD (Coronary Artery Disease)	None
Hypertension	None
Hyperlipidemia	None
COPD (Chronic Obstructive Pulmonary Disease)	None
Asthma	None
Cervical cancer	Female, age 18-69
Breast cancer	Female, age 40-69
Colorectal cancer	All genders, age 50-75
Prostate cancer	Male, age 50-75

High-Cost Claimants Categories

- Categories are developed using Clinical Classifications Software Refined (CCSR), which is a database developed as part of the Healthcare Cost and Utilization Project (HCUP), a Federal –State-Industry partnership sponsored by the Agency of Healthcare Research and Quality (AHRQ). The CCSR grouper uses medical diagnosis codes to identify one of 539 clinical categories to which members can be grouped and risk adjusted. Members can fall into multiple different condition categories. Below are some examples of CCSR diagnosis categories:
  - CIR007 Essential hypertension
  - CIR008 Hypertension with complications and secondary hypertension
  - CIR009 Acute myocardial infraction
- The above CCSR diagnosis categories are further rolled up into 8 categories. Below are examples of some of these roll-ups.

Category	CCSR Diagnosis Categories (Examples)
Episodic (with or without underlying condition)	Abdominal pain and other digestive symptoms, Respiratory signs and symptoms
Chronic	Cardiac dysrhythmias, Heart failure, Hypertension
Non-Screenable Cancer	Secondary malignancies, Non-Hodgkin lymphoma
Screenable Cancer	Breast cancer, Prostate cancer
Mental Health	Depressive disorders, Anxiety and fear-related disorders
Substance Use Disorder	Opioid-related disorders, Alcohol-related disorders

Appendix

A Word About Privacy

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

Form B, Cost Proposal

Request for Proposal Number 120005 O5

Bidder: The Segal Company (Southeast), Inc. d/b/a Segal

The term of the contract will be two (2) years commencing upon execution of the contract by the State and the Vendor (Parties). The Contract includes the option to renew for three (3) additional one (1) year periods upon mutual agreement of the Parties.

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the Solicitation. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

Prices submitted on the cost sheet, once accepted by the State, shall remain fixed for the first two (2) years of the contract. Any request for a price increase subsequent to the initial two (2) years of the contract shall not exceed four percent (4 %) of the price proposed for the period. Increases shall not be cumulative and will only apply to that period of the contract. The request for a price increase must be submitted in writing to the State Purchasing Bureau a minimum of 120 days prior to the end of the current contract period. Documentation may be required by the State to support the price increase.

The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

The State will be given full proportionate benefit of any decreases for the term of the contract.

Pricing to include all expenses including all travel expenses to Lincoln, NE.
The Annual rate will be paid by the State in 12 equal installments to the contractor.

CONSULTING and ACTUARY SERVICES					
	Initial Period Year One	**Initial Period Year Two**	**Optional Renewal One**	**Optional Renewal Two**	**Optional Renewal Three**
Annual Rate	$250,000	$250,000	$260,000	$270,000	$280,000

HEALTH PLAN RFP CONSULTING FEES

When the State issues the RFP for the health insurance plan, additional resources and time will be expected from the vendor. To compensate for this additional time and resources, provide a lump sum cost per milestone.

Implementation Claims Audit will be conducted 30 – 60 days prior to implementation and payment will be made upon completion and approval of the audit by the State.

Milestone	**Posting of the RFP**	**Posting of the Intent to Award**	**Vendor Start Date**	**Implementation Claims Audit**
Lump sum	$90,000	$70,000	$40,000	$30,000

Optional Costs:

There may arise from time to time a need for work not originally specifically delineated in this RFP but considered within the scope of work. This additional work may stem from legislative mandates, emerging trends, and regulatory changes unknown at the time of the RFP.

The State may request the vendor, subject to mutual agreement by both parties, to engage in short onetime special consulting projects, related to State benefit plans.

The bidder should provide the hourly rate for each Staff position used to complete onetime special consulting projects in the following table. Please identify any additional Staff titles and their appropriate rates, which bidder believes may be used to complete said projects.

All special consulting project costs must be based upon the hourly rates provided below.

	Fixed Hourly Rate
Account Executive Manager (AEM)	$350
Actuary	$350
Underwriter	$350
Subject Matter Expert – Executive/Manager	$350
Subject Matter Expert – Staff Consultant	$350
Office Staff	$0