Segal

Nevada Public Employees' Benefits Program

# Strategic Planning Session

July 23, 2026

# Agenda

- Overview
- Discussion Topics
- General plan design
- Composition of risk pools
- Contracting procedures
- Pharmacy benefits
- Disease management/care coordination

# Overview

- Purpose
  - Facilitated discussion providing a forum for the Board to examine priorities, goals, and strategies for PEBP to consider pursuing
  - Five topics identified for possible Board action
    1. General plan design
    2. Composition of risk pools
    3. Contracting procedures
    4. Pharmacy benefits
    5. Disease management/care coordination
  - No more than one hour discussion allocated per topic
  - Ask that Board members to indicate preferences before and after discussions

# PEPB Board Guiding Principles of Health Care Benefits Administration

- Service to the participants of the Program is the primary function of the Board and the Agency. Board members are fiduciaries who are to act for the exclusive benefit of the participants. Board members will act with integrity, objectivity, independence, prudence, and due care.[1]

[1]PEBP Duties, Policies and Procedures December 2025, Page 3

# Suggestions on Guidelines for Today's Strategy Session

- All voices matter – set times for Board Members to share opinions
- Expectation that not everyone will be excited about every idea
- Objective today is to "list reduce" from a large number of possibilities to a manageable number for focus, more detailed study, and decision making
- Using dots/stickers should enable a way to achieve this
  - **Initial** thoughts
  - Thoughts **after** presentations and Board member opinion sharing
- How would the Board like "time-keeping" to take place?
- Other suggested guidelines for today??

# Discussion Topics

# Discussion Topics & Sub-Topics

| Plan Design |
| --- |
| Full replacement with single or multiple plan options |
| Consolidation of existing plan options |
| Return deductibles to historical levels prior to buy-down |
| Expand HMO access |
| Other |

| Risk Pool |
| --- |
| Separate Actives and Retirees from the risk pool and rate separately<br>• Provide supplement funding amount to mitigate rate increase for Non-Medicare retirees |
| Non-Medicare retirees to exchange |
| Dependent subsidies |
| Other |

| Disease Management / Care Coordination |
| --- |
| Explore care navigation |
| Update condition-specific care management programs |
| Require participation to cover GLP-1s or other benefits |
| Additional Point Solutions vendors |
| Improve contract terms for utilization, care, and disease management through procurement |
| Other |

# Discussion Topics & Sub-Topics (cont.)

| Contracting Procedure |
| --- |
| Procurement for medical claims administrator |
| Direct contract with specific hospitals / providers |
| Direct contract for specific services (e.g. ambulance) |
| Reference-based pricing |
| Expand Centers of Excellence |
| Direct primary care |
| Near-site clinics |
| Coordination with Nevada Health Authority / Medicaid |
| Explore available programs through CMS (e.g. AHEAD model or waivers) |
| Additional Point Solution vendors |
| Audits |
| Other |

| Pharmacy |
| --- |
| GLP-1 management solutions |
| Specialty drug management solutions |
| Direct rebate contracting |
| Narrow formulary |
| Narrow retail network |
| Point Solution utilization management |
| Copay plan design changes |
| Other |

# General plan design

# Plan Design Topics

| Sub-topic | Potential Savings | Time Horizon |
|---|---|---|
| Full replacement with single or multiple plan options | $ to $$$ | 1 - 2 years |
| Consolidation of existing plan options | $ to $$ | 1 year |
| Return deductibles to historical levels prior to buy-down | $ | 1 year |
| Expand HMO access | $ | 1 - 2 years |
| Other | | |

- Potential savings shown as estimates and actual savings will be determined based on final decisions
- Time horizons based on time to implement and assumes no delays in Board decisions

# PY 2027 Medical Plan Design Summary

| Plan Year 2027 Medical Plan Design Features | Consumer Driven Health Plan (PPO) | Low Deductible Plan (PPO) | Exclusive Provider Organization Plan (EPO) | Health Plan of Nevada (HMO) |
|---|---|---|---|---|
| | In-Network | | | |
| Service Area | Global | | Northern Nevada | Southern Nevada |
| Annual Deductible (Medical and prescription* combined) | $1,700 Individual<br>$3,400 Family | $300 Individual<br>$600 Family | $100 Individual<br>$200 Family | Tier 4 prescription drug coverage (see Prescription Overview) |
| Medical Coinsurance | You pay 20% after Deductible | You pay 20% after Deductible | You pay 20% after Deductible | N/A |
| Out-of-Pocket Maximum (OOPM) | $5,000 Individual<br>$10,000 Family<br>$5,000 Individual Family Member OOPM | $5,000 Individual<br>$10,000 Family<br>$5,000 Individual Family Member OOPM | $4,000 Individual<br>$8,000 Family<br>$4,000 Individual Family Member OOPM | $5,000 Individual<br>$10,000 Family<br>$5,000 Individual Family Member OOPM |
| Primary Care Office Visit | You pay 20% after Deductible | $30 Copay per visit | $20 Copay per visit | $25 Copay per visit |
| Specialist Care Office Visit | You pay 20% after Deductible | $50 Copay per visit | $40 Copay per visit | $25 copay per visit with a referral<br><br>$40 copay per visit without a referral |
| Urgent Care Visit | You pay 20% after Deductible | $80 copay per visit | $50 copay per visit | $50 copay per visit |
| Telemedicine** | $59 medical visit Doctor on Demand | $10 Copay medical visit Doctor on Demand | $10 Copay medical visit Doctor on Demand | $0 Copay 24/7 Advice Nurse NowClinic |
| Emergency Room Visit | You pay 20% after Deductible | $750 Copay per visit | $600 Copay per visit | $600 Copay per visit |
| In-Patient Hospital | You pay 20% after Deductible | You pay 20% after Deductible | $600 Copay per admit | $600 Copay per admit |
| Outpatient Surgery | You pay 20% after Deductible | $500 Copay per visit | $350 Copay per visit | $350 Copay per visit Ambulatory Surgical Facility<br>$50 Copay |
| Affordable Care Act Preventive Services | $0 Copay | $0 Copay | $0 Copay | $0 Copay |

*Copayment assistance for specialty drugs will not apply toward your Deductible and Out-of-Pocket Maximum.
** Doctor on Demand for the CDHP is subject to the deductible. Copays apply after the deductible is met.

Source: PY 2027 PEBP Plan Compare

# PY2027 Plan Designs

In-network benefits

## In December, Board approved plan changes expected to result in $5M (~1%) in annual savings

| | CDHP | LDPPO | EPO | HMO |
|---|---|---|---|---|
| Actuarial Value | 77.8% | 83.1% | 89.1% | 91.4% |
| Service Area | Global | Global | Northern Nevada | Southern Nevada |
| HSA/HRA Contribution | $700 PEPY<br>+$200 per dep (max 3) | N/A | N/A | N/A |
| Annual Deductible | $1,700 Individual<br>$3,400 Family<br>$3,400 Individual Family Member Deductible | $300 Individual<br>$600 Family | $100 Individual<br>$200 Family<br>$100 Individual Family Member Deductible | N/A With exception of Tier 4 prescription drug coverage |
| Medical Coinsurance | 20% after deductible | 20% after deductible | 20% after deductible | N/A |
| Out-of-Pocket Maximum | $5,000 Individual<br>$10,000 Family | $5,000 Individual<br>$10,000 Family | $4,000 Individual<br>$8,000 Family | $5,000 Individual<br>$10,000 Family |
| Primary Care/<br>Specialist Office Visit | 20% after deductible | $30/ $50<br>copay per visit | $20/ $40<br>copay per visit | $25/ $40<br>($25 with referral)<br>copay per visit |
| Urgent Care Visit | 20% after deductible | $80 copay per visit | $50 copay per visit | $50 copay per visit |
| Emergency Room Visit | 20% after deductible | $750 copay per visit | $600 copay per visit | $600 copay per visit |
| In-Patient Hospital | 20% after deductible | 20% after deductible | $600 copay per visit | $600 copay per visit |
| Outpatient Surgery | 20% after deductible | $500 copay per visit | $350 copay per visit | Ambulatory Facility<br>$50 copay<br>Hospital<br>$350 copay |
| PY2026 Employee Only Premium | $55.26 | $91.79 | $219.91 | $219.91 |

Source: January 2026 PEBP Board Meeting

# PY 2022 Medical Plan Design Summary

## Plan Year 2022 Medical Plan Comparison

## In-Network Benefits

**The information in the tables below contain general plan benefits and may not include additional provisions or exclusions**

***To review more in-depth plan benefits, please refer to the applicable Plan Documents.***

| MEDICAL PLAN DESIGN FEATURES | CONSUMER DRIVEN HEALTH PLAN (CDHP – PPO) | LOW DEDUCTIBLE (LD-PPO) | HEALTH PLAN OF NEVADA (HPN-SOUTHERN HMO) | PREMIER PLAN (NORTHERN EPO) |
|---|---|---|---|---|
| | In-Network | In-Network | In-Network | In-Network |
| **Service Area** | Global | Global | Southern Nevada | Northern Nevada |
| **Annual Deductible** *(medical and prescription* combined)* | $1,750 Individual<br>$3,500 Family<br>• $2,800 Individual Family Member Deductible | $500 Individual<br>$1,000 Family<br>• $500 Individual Family Member Deductible | N/A With exception of Tier 4 prescription drug coverage, see prescription overview | $150 Individual<br>$300 Family<br>• $150 Individual Family Member Deductible |
| **Medical Coinsurance** | You pay 20% after deductible | You pay 20% after deductible | N/A | You pay 20% after deductible |
| **Out-of-Pocket Maximum** | $5,000 Individual<br>$10,000 Family<br>• $6,850 Individual Family Member Max Out-of-Pocket | $5,000 Individual<br>$10,000 Family<br>• $5,000 Individual Family Member Max Out-of-Pocket | $5,000 Individual<br>$10,000 Family<br>• $5,000 Individual Family Member Max Out-of-Pocket | $5,000 Individual<br>$10,000 Family<br>• $5,000 Individual Family Member Max Out-of-Pocket |

Source: PY 2022 PEBP Plan Compare

# Fixed Cost Plan Elements

Trended from PY2022 Compared to Approved for PY2027

| | PY2027 | | | Illustrative: PY2022 if Trended to PY2027 | | |
|---|---|---|---|---|---|---|
| | **CDHP** | **LDPPO** | **EPO** | **CDHP** | **LDPPO** | **EPO** |
| HSA/HRA Contributions | $700 PEPY<br>+$200 per dependent (max 3) | -- | -- | $722 PEPY | -- | -- |
| Annual Deductible | $1,700 Individual<br>$3,400 Family | $300 Individual<br>$600 Family | $100 Individual<br>$200 Family | $2,100 Individual<br>$4,200 Family | $600 Individual<br>$1,200 Family | $180 Individual<br>$360 Family |
| Out-of-Pocket Maximum | $5,000 Individual<br>$10,000 Family | $5,000 Individual<br>$10,000 Family | $4,000 Individual<br>$8,000 Family | $6,000 Individual<br>$12,000 Family | $6,000 Individual<br>$12,000 Family | $6,000 Individual<br>$12,000 Family |
| Primary Care/<br>Specialist Office Visit | 20% coinsurance | $30/ $50<br>copay per visit | $25/ $40<br>copay per visit | 20% coinsurance | $36/ $60<br>copay per visit | $30/ $48<br>copay per visit |
| Urgent Care Visit | 20% coinsurance | $80 copay per visit | $50 copay per visit | 20% coinsurance | $96 copay per visit | $60 copay per visit |
| Emergency Room Visit | 20% coinsurance | $750 copay per visit | $750 copay per visit | 20% coinsurance | $900 copay per visit | $900 copay per visit |
| In-Patient Hospital | 20% coinsurance | 20% coinsurance | $750 copay per visit | 20% coinsurance | 20% coinsurance | $900 copay per visit |
| Outpatient Surgery | 20% coinsurance | $500 copay per visit | $350 copay per visit | 20% coinsurance | $600 copay per visit | $420 copay per visit |
| **Prescription Drug** | | | | | | |
| Retail30 | 20% coinsurance | $10 / $40 / $75 | $10 / $40 / $75 | 20% coinsurance | $15 / $62 / $116 | $15 / $62 / $116 |
| Retai90/Mail | 20% coinsurance | $20 / $80 / $150 | $20 / $80 / $150 | 20% coinsurance | $30 / $124 / $232 | $30 / $124 / $232 |
| Specialty | 30% coinsurance<br>($100 min/$250 max)[1] | 30% coinsurance<br>($100 min/$250 max)[1] | 30% coinsurance<br>($100 min/$250 max)[1] | 20% coinsurance | 30% coinsurance | 30% coinsurance |

[1] Min/Max applies for specialty drugs not included in the SaveOnSP program with ESI.

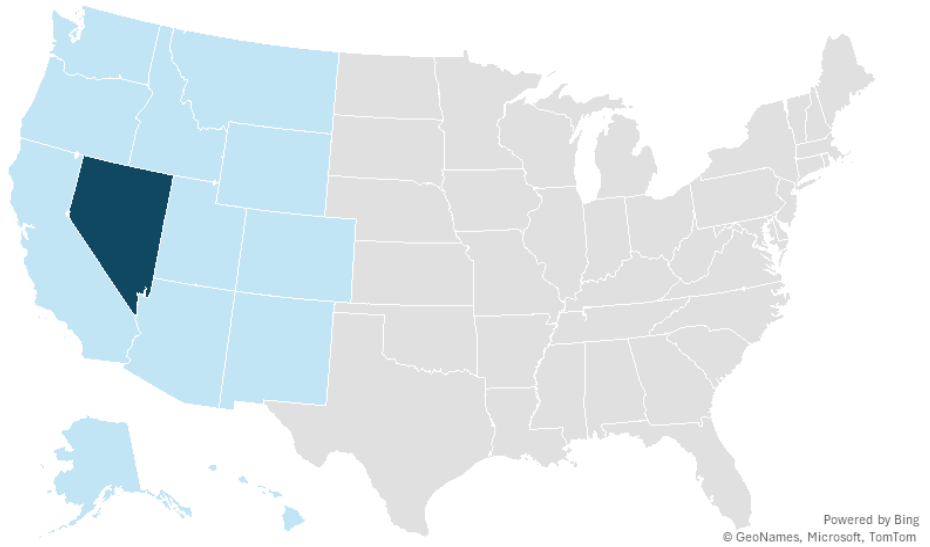
**Many fixed dollar provisions have not been updated over the last several years to keep pace with trend, resulting in higher trend increases for PEBP.**

Source: January 2026 PEBP Board Meeting

# Benchmarking Overview

- Segal conducted a benchmarking review of the current medical and pharmacy benefits provided by plans of comparable size to Nevada PEBP.

- Segal analyzed the statewide plans offered for the following states:
  - Alaska
  - Arizona
  - California
  - Colorado
  - Hawaii
  - Idaho
  - Montana
  - New Mexico
  - Oregon
  - Utah
  - Washington
  - Wyoming




- Peer data from 2026
- Compared PPO and CDHP options

Source: January 2026 PEBP Board Meeting

# Summary of Network Plan Designs and Premiums

## PPO Comparison

| | LDPPO | Benchmarking Data Richest | Benchmarking Data Leanest | Benchmarking Data Average |
|---|---|---|---|---|
| Actuarial Value | 83.1% | 92.6% | 73.5% | 81.3% |
| Annual Deductible (Med) | $300 / $600 | $0 / $0 | $4,000 / $8,000 | $733 / $1,612 |
| Annual Deductible (Rx) | N/A | $0 / $0 | $250 / $750 | $20 / $60 |
| Coinsurance | 20% | 0% | 30% | 18% |
| Out-of-Pocket Maximum (Med) | $5,000 / $10,000 | $1,750 / $3,500 | $7,350 / $14,700 | $3,431 / $7,240 |
| Out-of-Pocket Maximum (Rx) | N/A | $0 / $0 | $4,350 / $8,700 | $1,745 / $3,252 |
| PCP / Specialist | $30 / $50 | $10 / $35 | $50 / $75 | $29 / $48 |
| Urgent Care Visit | $80 | $20 | $80 | $62 |
| Emergency Room Visit | $750 | $250 | $1,000 | $525 |
| Prescription Drug | $10 / $40 / $75 / 30% | $5 / $20 / $50 / $60 | $25 / $75 / $60 / $200 | $10 / $31 / $54 / $105 |
| 2026 Employee Only Premium | $92 | $535 | $0 | $120 |
| 2026 Family Premium | $498 | $1,658 | $0 | $399 |

Coinsurances and mixed copay/coinsurances were excluded from minimum, maximum, and average calculations.
Each plan element in the comparison data is shown independently. Multiple plans may be represented across the riches and leanest comparison columns.
Benchmark plan designs and contributions effective on January 1, 2026.

Source: January 2026 PEBP Board Meeting

# Summary of Current Plan Designs and Premiums

## CDHP Comparison

| | CDHP | Benchmarking Data Richest | Benchmarking Data Leanest | Benchmarking Data Average |
|---|---|---|---|---|
| Actuarial Value | 77.8% | 84.4% | 64.0% | 75.3% |
| Annual Deductible | $1,700 / $3,400 | $1,650 / $3,300 | $3,000 / $6,000 | $1,988 / $4,175 |
| Base HSA/HRA | $700 / $1,300 | $0 / $0 | $1,935 / $3,987 | $795 / $1,496 |
| Coinsurance | 20% | 10% | 30% | 21% |
| Out-of-Pocket Maximum | $5,000 / $10,000 | $3,000 / $7,000 | $7,400 / $14,800 | $4,731 / $9,588 |
| PCP / Specialist | 20% / 20% | 10% / 10% | 30% / 30% | 21% / 21% |
| Urgent Care Visit | 20% | 10% | 30% | 21% |
| Emergency Room Visit | 20% | 10% | 30% | 21% |
| Prescription Drug* | 20% / 20% / 100% / 30% | $10 / $35 / $60 | $15 / $40 / $60 | $12 / $38 / $60 |
| 2026 Employee Only Premium | $55 | $80 | $0 | $31 |
| 2026 Family Premium | $410 | $289 | $52 | $127 |

*Only generic / preferred brand / non-preferred brand are shown due to lack of specialty copay only tiers in benchmark data.
Coinsurances and mixed copay/coinsurances were excluded from minimum, maximum, and average calculations.
Each plan element in the comparison data is shown independently. Multiple plans may be represented across the riches and leanest comparison columns.
Benchmark plan designs and contributions effective on January 1, 2026.

Source: January 2026 PEBP Board Meeting

# Local Comparator Benchmarking

Key observations comparing PEBP to local municipalities

**Local comparators include:**

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

## PEBP vs. Local Benchmarks

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

## PEBP vs. Comparator Premium Contributions

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

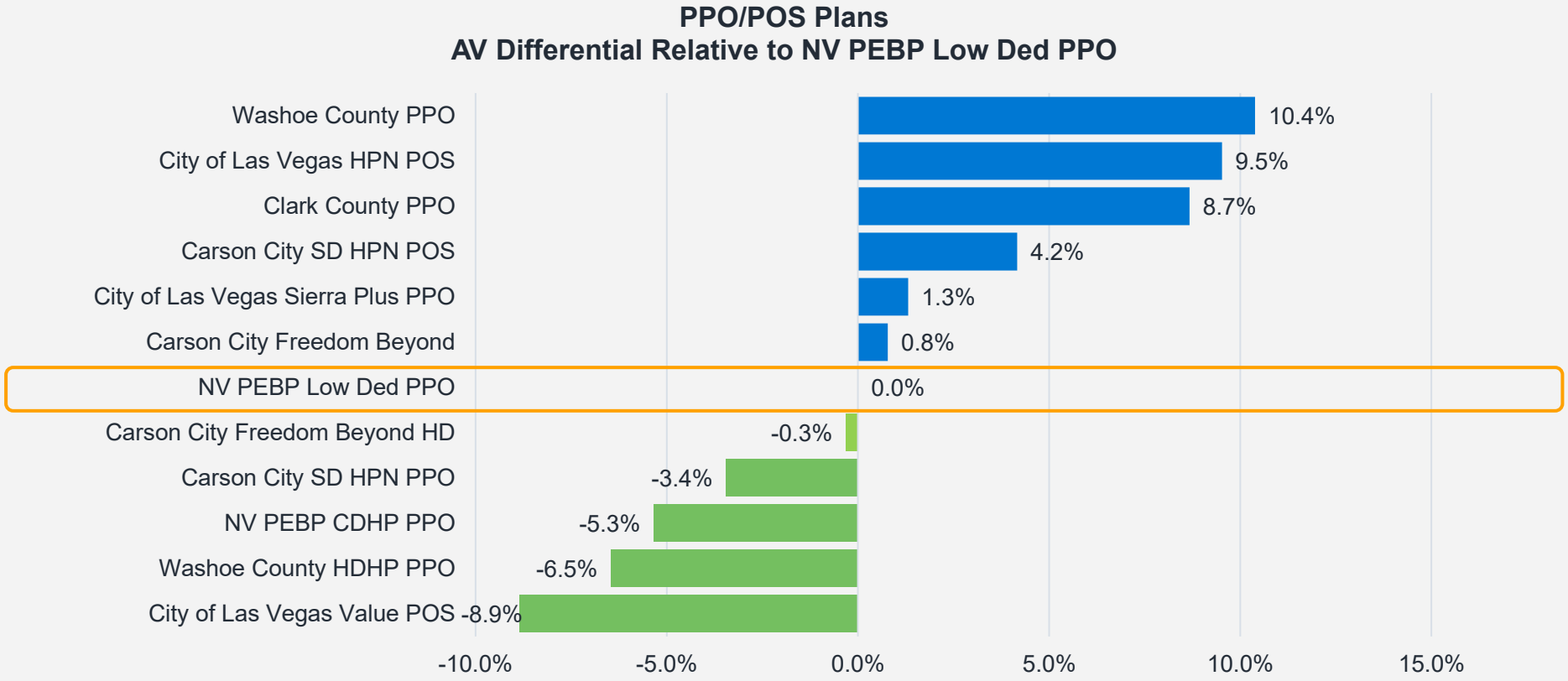
- Three have 100% subsidized employee only coverage
  - City of Las Vegas, Carson City, and Washoe County
  - CCSD Teachers Trust employee contribution < 5% of premium
- Dependent subsidies range from 25% to 60% of premium
  - Carson City, Washoe County do not exceed 50% dependent subsidies
  - CCSD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

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

Source: Information provided by Milliman July 2026

# PEBP vs. Local Comparators PPO/POS plans

Actuarial value differentials – PPO/POS plans



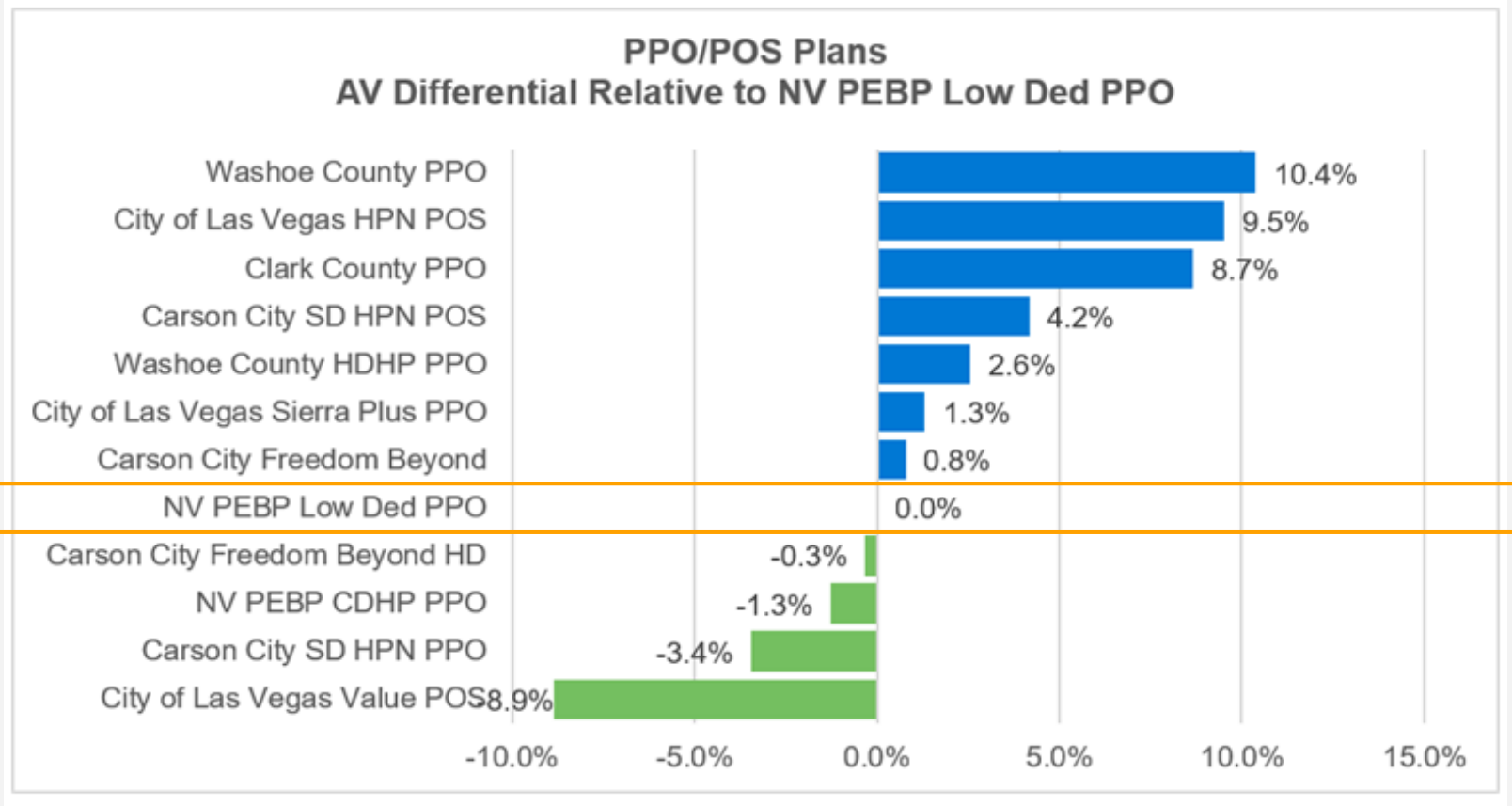

**Plans with a <u>negative differential</u> compared to the PEBP LDPPO are leaner (i.e., benefits are less generous / member cost sharing is generally higher); plans with a <u>positive differential</u> are richer (i.e., benefits are more generous / member cost sharing is generally lower).**

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

*Note: plans with tiered networks assume 75% Tier 1 utilization*
*Plans with no explicit specialty Rx cost sharing information assume 30% coinsurance*
Source: Information provided by Milliman July 2026

# PEBP vs. Local Comparators PPO/POS plans

Actuarial value differentials – PPO/POS plans




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

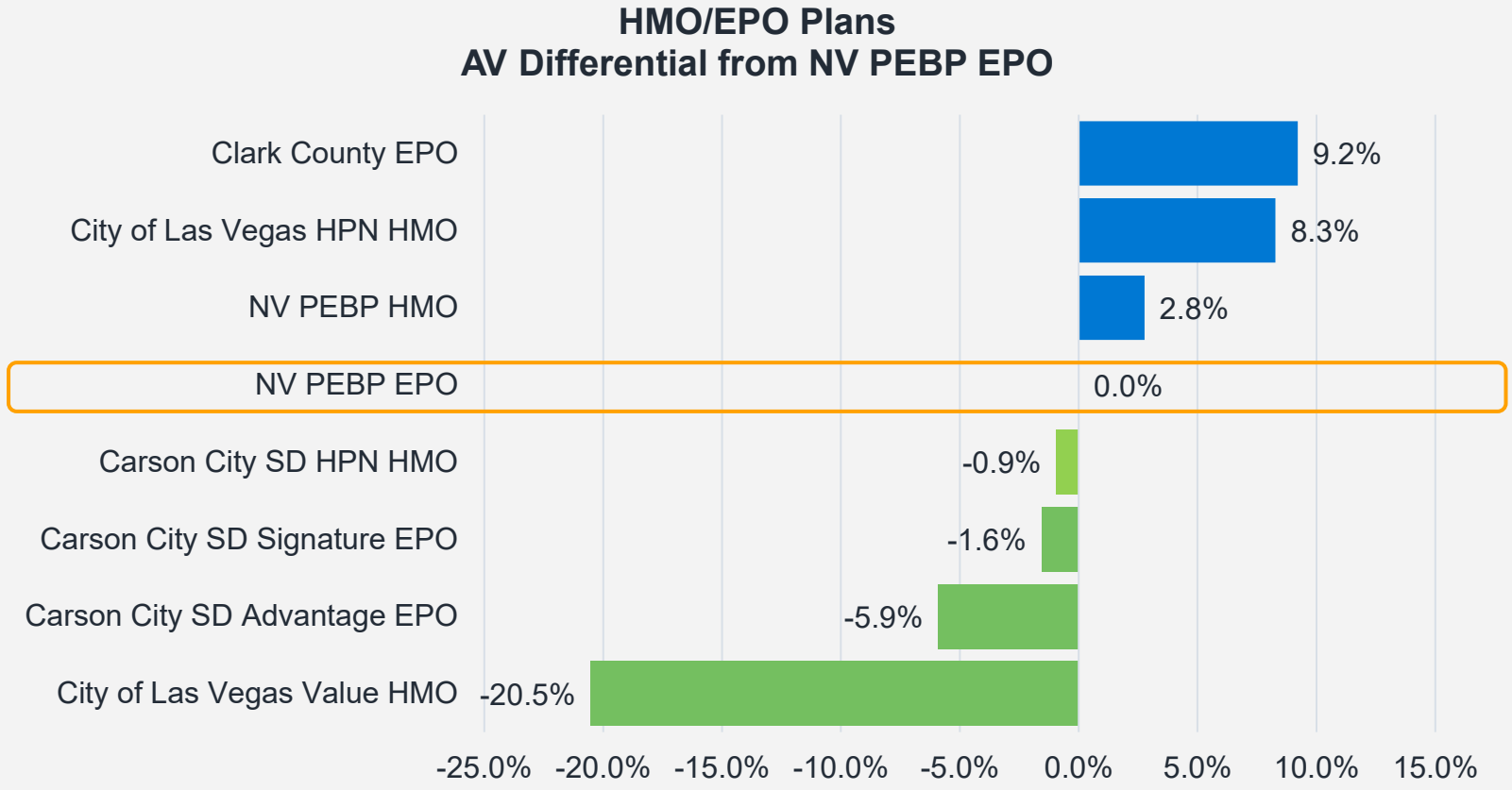
**Differentials are calculated as the actuarial value for each respective plan minus the actuarial value for the PEBP LDPPO.**

*Note: plans with tiered networks assume 75% Tier 1 utilization*
*Plans with no explicit specialty Rx cost sharing information assume 30% coinsurance*
*Includes HSA seed for NV PEBP CDHP PPO and Washoe County HDHP PPO*

Source: Information provided by Milliman July 2026

# PEBP vs. Local Comparators HMO/EPO plans

Actuarial value differentials – HMO/EPO plans

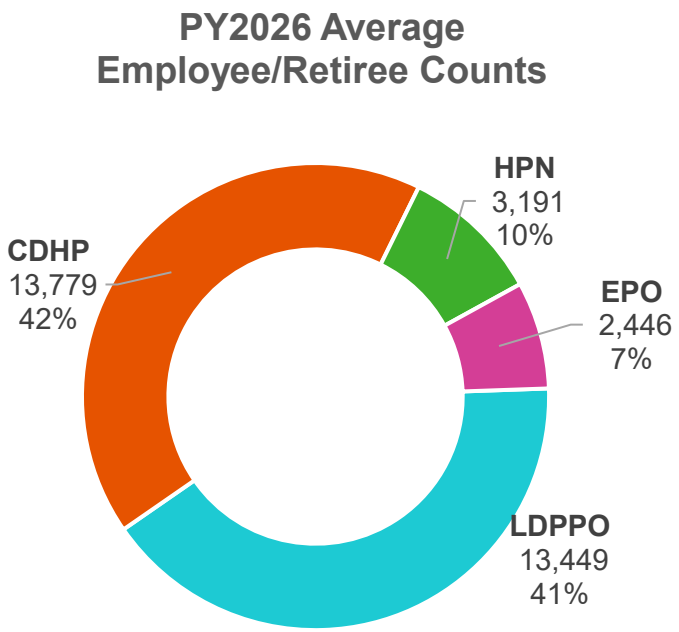


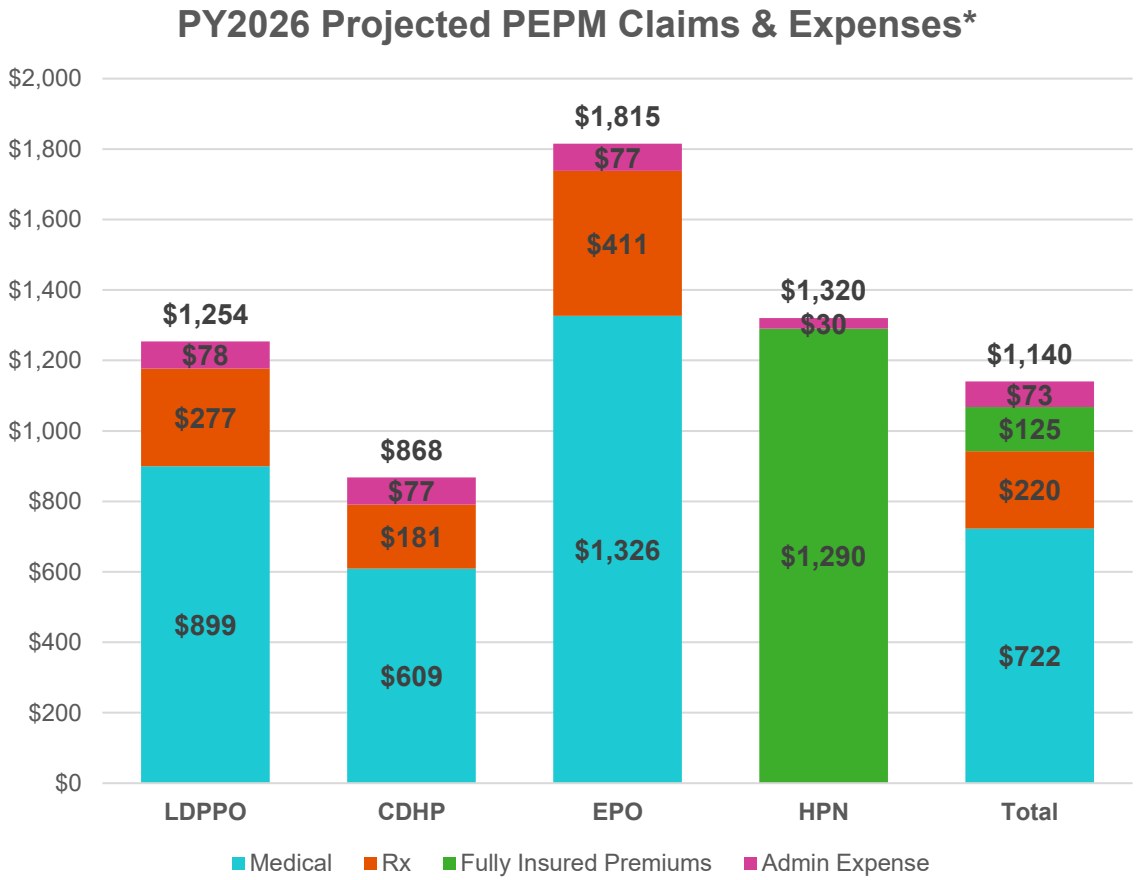

**Plans with a <u>negative differential</u> compared to the PEBP EPO are leaner (i.e., benefits are less generous / member cost sharing is generally higher); plans with a <u>positive differential</u> are richer (i.e., benefits are more generous / member cost sharing is generally lower).**

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

*Note: plans with tiered networks assume 75% Tier 1 utilization*
*Plans with no explicit specialty Rx cost sharing information assume 30% coinsurance*
Source: Information provided by Milliman July 2026

# Experience Dashboard




*Rx cost is net of rebates and includes fees for specialty copay assistance program
Admin expense does not include HSA contributions or HRA claims

Source: PEBP Experience Monitoring Report as of May 31, 2026

# PY 2027 Rates & Contributions – State Active

| Active State Employee Rates | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Monthly Rates Effective July 1, 2026 - June 30, 2027 | Nationwide PPO Consumer Driven Health Plan (CDHP) | | | Nationwide PPO Low Deductible (LD) | | | Statewide EPO/HMO Exclusive Provider Organization Plan (EPO) and Health Plan of Nevada (HPN) | | |
| | Unsubsidized Rate | *Base Subsidy | **Participant Premium** | Unsubsidized Rate | *Base Subsidy | **Participant Premium** | Unsubsidized Rate | *Base Subsidy | **Participant Premium** |
| **Employee Only** | $819.54 | $766.84 | **$55.26** | $1,063.80 | $766.84 | **$160.18** | $1,309.40 | $766.84 | **$381.24** |
| **Employee + Spouse/DP** | $1,624.28 | $1,322.80 | **$313.94** | $2,112.78 | $1,322.80 | **$521.32** | $2,603.98 | $1,322.80 | **$962.20** |
| **Employee + Child(ren)** | $1,121.32 | $975.32 | **$152.28** | $1,457.16 | $975.32 | **$295.60** | $1,794.86 | $975.32 | **$599.10** |
| **Employee + Family** | $1,926.06 | $1,531.28 | **$410.94** | $2,506.16 | $1,531.28 | **$656.74** | $3,089.44 | $1,531.28 | **$1,180.08** |

-- State employees on Leave Without Pay (LWOP), active Legislators and employees on Military leave do not receive a subsidy and therefore will need to refer to the unsubsidized rate column.

* Does not include rate adjustments paid/credited with PEBP reserves.

Source: PEBP Plan Year 2027 Premium Rates

# PY 2027 Rates & Contributions – State Retiree

| State Retiree and Survivor Rates (Non-Medicare) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Monthly Rates Effective July 1, 2026 - June 30, 2027 | Nationwide PPO | | | Nationwide PPO | | | Statewide EPO/HMO | | |
| | Consumer Driven Health Plan (CDHP) | | | Low Deductible (LD) | | | Exclusive Provider Organization Plan (EPO) and Health Plan of Nevada (HPN) | | |
| | Unsubsidized Rate | *Base Subsidy | **Participant Premium** | Unsubsidized Rate | *Base Subsidy | **Participant Premium** | Unsubsidized Rate | *Base Subsidy | **Participant Premium** |
| **Retiree only** | $813.26 | $568.70 | **$278.06** | $1,057.50 | $568.70 | **$372.66** | $1,303.10 | $568.70 | **$588.56** |
| **Retiree + Spouse** | $1,617.98 | $981.02 | **$702.82** | $2,106.50 | $981.02 | **$892.40** | $2,597.70 | $981.02 | **$1,324.38** |
| **Retiree + Child(ren)** | $1,115.02 | $723.32 | **$437.34** | $1,450.88 | $723.32 | **$567.56** | $1,788.58 | $723.32 | **$864.50** |
| **Retiree + Family** | $1,919.76 | $1,135.62 | **$862.10** | $2,499.86 | $1,135.62 | **$1,087.30** | $3,083.16 | $1,135.62 | **$1,600.34** |
| **Surviving/Unsubsidized Dependent** | $813.26 | - | **$813.26** | $1,057.50 | - | **$1,057.50** | $1,303.10 | - | **$1,303.10** |
| **Surviving/Unsubsidized Spouse + Child(ren)** | $1115.02 | - | **$1,115.02** | $1,450.87 | - | **$1,450.88** | $1,788.58 | - | **$1,788.58** |

-- For participants who retired before January 1, 1994, the participants subsidized premium for the selected plan and tier is shown above.

-- For those who retired on or after January 1, 1994, refer to the Plan Year 2027 State and Non-State Retiree Years of Service Subsidy table on page 17. Locate your years of service and add or subtract the corresponding subsidy to or from the participant premium.

-- Those retirees with less than 15 Years of Service, who were hired by their last employer between January 1, 2010, and December 31, 2011, do not receive a Years of Service Subsidy or Base Subsidy and do not qualify for a Medicare Exchange HRA unless they retire under a disability.

-- Those retirees who were initially hired on or after January 1, 2012, do not receive a Years of Service Subsidy or Base Subsidy.

-- Retirees on the PEBP CDHP, LD, EPO or HMO plan who are enrolled in Medicare Part B, subtract *up to* an additional $145.30 from the participant premium.

* Does not include rate adjustments paid/credited with PEBP reserves.

Source: PEBP Plan Year 2027 Premium Rates

# PY 2027 Rates & Contributions – Non-State Active

| Active Non-State Employee Rates | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Monthly Rates Effective July 1, 2026 - June 30, 2027 | Nationwide PPO | | | Nationwide PPO | | | Statewide EPO/HMO | | |
| | Consumer Driven Health Plan (CDHP) | | | Low Deductible (LD) | | | Exclusive Provider Organization Plan (EPO) and Health Plan of Nevada (HPN) | | |
| | Unsubsidized Rate | Base Subsidy | **Participant Premium** | Unsubsidized Rate | Base Subsidy | **Participant Premium** | Unsubsidized Rate | Base Subsidy | **Participant Premium** |
| **Employee Only** | $912.35 | - | **$912.35** | $1,386.45 | - | **$1,386.45** | $1,325.22 | - | **$1,325.22** |
| **Employee + Spouse/DP** | $1,809.90 | - | **$1,809.90** | $2,758.09 | - | **$2,758.09** | $2,635.63 | - | **$2,635.63** |
| **Employee + Child(ren)** | $1,248.93 | - | **$1,248.93** | $1,900.82 | - | **$1,900.82** | $1,816.62 | - | **$1,816.62** |
| **Employee + Family** | $2,146.48 | - | **$2,146.48** | $3,272.46 | - | **$3,272.46** | $3,127.04 | - | **$3,127.04** |

--Subsidies for non-state active employees are determined by the employer and are not published here.

Source: PEBP Plan Year 2027 Premium Rates

# PY 2027 Rates & Contributions – Non-State Retiree

## Non-State Retiree and Survivor Rates (Non-Medicare)

| Monthly Rates Effective July 1, 2026 - June 30, 2027 | Nationwide PPO Consumer Driven Health Plan (CDHP) | | | Nationwide PPO Low Deductible (LD) | | | Statewide EPO/HMO Exclusive Provider Organization Plan (EPO) and Health Plan of Nevada (HPN) | | |
|---|---|---|---|---|---|---|---|---|---|
| | Unsubsidized Rate | *Base Subsidy | **Participant Premium** | Unsubsidized Rate | *Base Subsidy | **Participant Premium** | Unsubsidized Rate | *Base Subsidy | **Participant Premium** |
| Retiree only | $906.06 | $661.50 | **$278.06** | $1,380.16 | $891.36 | **$372.66** | $1,318.94 | $584.54 | **$588.56** |
| Retiree + Spouse | $1,803.62 | $1,166.66 | **$702.82** | $2,751.80 | $1,626.32 | **$892.40** | $2,629.34 | $1,012.66 | **$1,324.38** |
| Retiree + Child(ren) | $1,242.64 | $850.94 | **$437.34** | $1,894.54 | $1,166.98 | **$567.56** | $1,810.34 | $745.08 | **$864.50** |
| Retiree + Family | $2,140.20 | $1,356.06 | **$862.10** | $3,266.18 | $1,901.94 | **$1,087.30** | $3,120.76 | $1,173.22 | **$1,600.34** |
| Surviving/Unsubsidized Dependent | $906.06 | - | **$906.06** | $1,380.16 | - | **$1,380.16** | $1,318.94 | - | **$1,318.94** |
| Surviving/Unsubsidized Spouse + Child(ren) | $1,242.64 | - | **$1,242.64** | $1,894.54 | - | **$1,894.54** | $1,810.34 | - | **$1,810.34** |

-- For participants who retired before January 1, 1994, the participants subsidized premium for the selected plan and tier is shown above.

-- For those who retired on or after January 1, 1994, refer to the Plan Year 2027 State and Non-State Retiree Years of Service Subsidy table on page 17. Locate your years of service and add or subtract the corresponding subsidy to or from the participant premium.

-- Those retirees with less than 15 Years of Service, who were hired by their last employer between January 1, 2010, and December 31, 2011, do not receive a Years of Service Subsidy or Base Subsidy and do not qualify for a Medicare Exchange HRA unless they retire under a disability.

-- Those retirees who were initially hired on or after January 1, 2012, do not receive a Years of Service Subsidy or Base Subsidy.

-- Retirees on the PEBP CDHP, LD, EPO or HMO plan who are enrolled in Medicare Part B, subtract *up to* an additional $145.30 from the participant premium.

* Does not include rate adjustments paid/credited with PEBP reserves.

Source: PEBP Plan Year 2027 Premium Rates

# Composition of risk pools

# Risk Pool Topics

| Sub-topic | Potential Savings | Time Horizon |
|---|---|---|
| Separate Actives and Retirees from the risk pool and rate separately<br>• Provide supplement funding amount to mitigate rate increase for Non-Medicare retirees | $ to $$ | 1 year |
| Non-Medicare retirees to exchange | $ to $$ | 2 years |
| Dependent subsidies | $ | 1 year |
| Other | | |

- Potential savings shown as estimates and actual savings will be determined based on final decisions
- Time horizons based on time to implement and assumes no delays in Board decisions

# CDHP Actives/COBRA



## Total Allowed PMPM

Current period

**$513.12**

2.4% Trend

$11.86 Change


## PMPM Cost Share

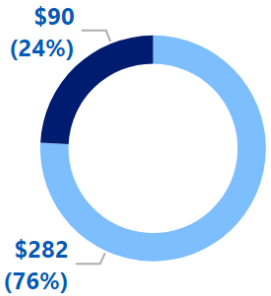
**Medical**

5.1%

Member trend

-1.4%

Plan trend



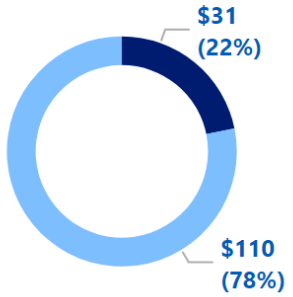

**Pharmacy**

7.6%

Member Trend

9.2%

Plan Trend




## Medical Allowed PMPM

Current period

**$372.33**

0.1% Trend

$0.46 Change


## Pharmacy

Current period PMPM

**$140.79**

8.8% Trend

$11.40 Change

30-DS Scripts per 1,000

**10,293**

4.4%

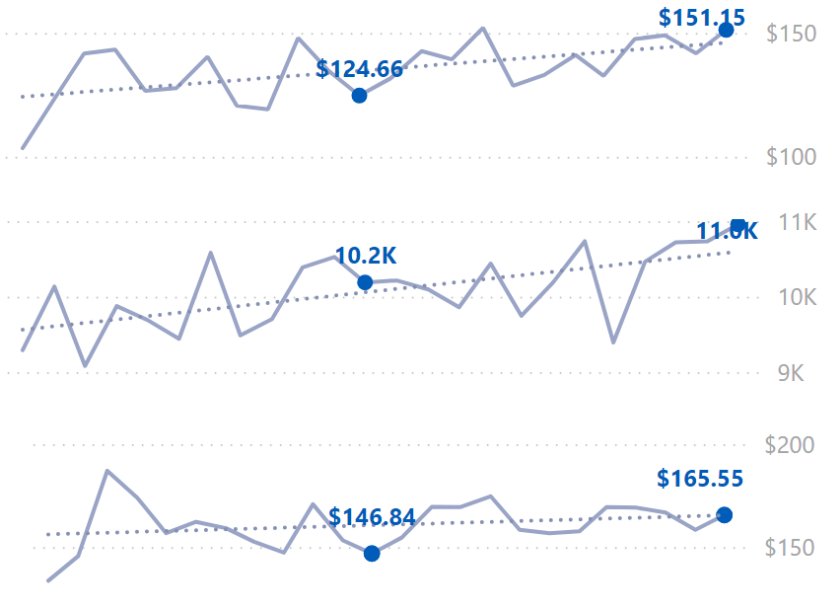
429.8

Cost per 30-DS

**$164.14**

4.3%

$6.72



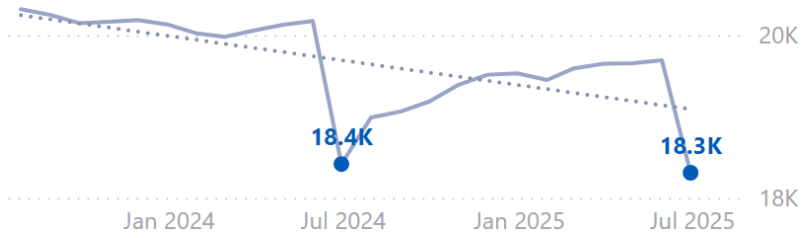

## Average Membership

Current Period

**19,334**

-3.3% Trend

-663 Change




Current Period : Incurred 7/1/2024 - 6/30/2025 : All Active Members

Source: Segal SHAPE Dashboard PY 2025

# CDHP Non-Medicare Retirees



## Total Allowed PMPM

Current period

**$953.49**

13.1% Trend | $110.41 Change


## PMPM Cost Share

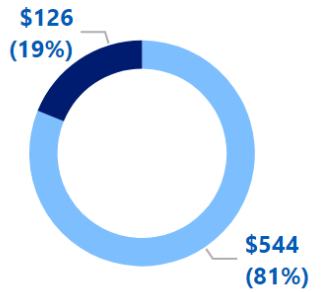
**Medical**

7.6%

Member trend

16.2%

Plan trend



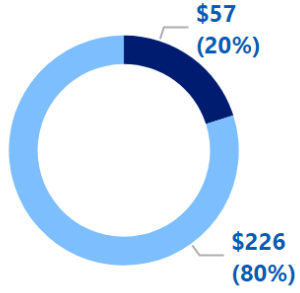

**Pharmacy**

13.1%

Member Trend

9.2%

Plan Trend




## Medical Allowed PMPM

Current period

**$670.81**

14.5% Trend | $84.79 Change


## Average Membership

Current Period

**2,445**

-12.9% Trend | -361 Change


## Pharmacy

Current period PMPM

**$282.68**

10.0% Trend | $25.62 Change

30-DS Scripts per 1,000

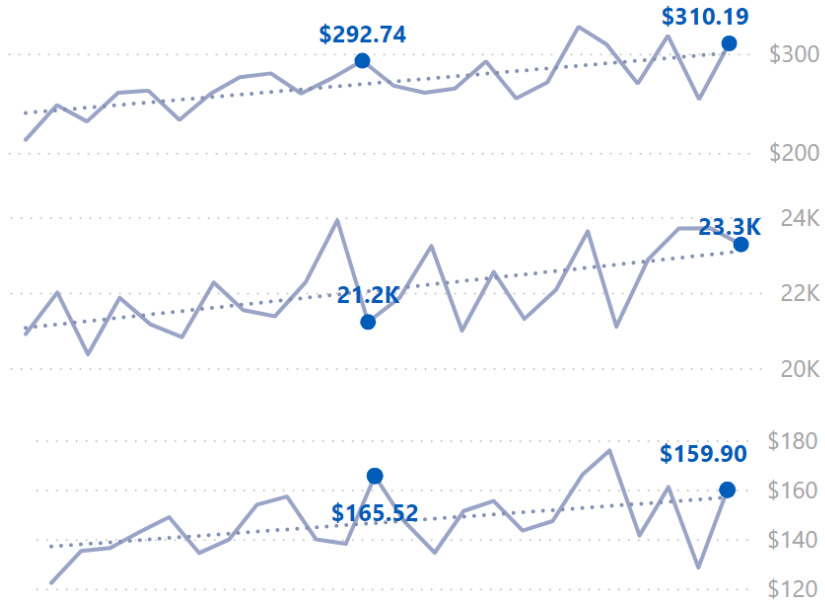
**22,508**

4.0% | 875.7

Cost per 30-DS

**$150.71**

5.7% | $8.11




- Note: Member and plan PMPM amounts may not sum to total PMPM figures due to rounding.

# LDPPO Actives/COBRA



## Total Allowed PMPM

Current period

**$674.47**

14.4% Trend

$84.90 Change


## PMPM Cost Share

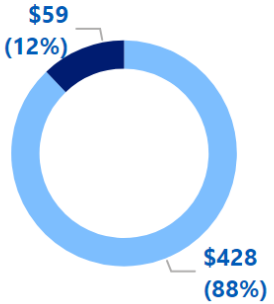
**Medical**

5.1%

Member trend

19.0%

Plan trend



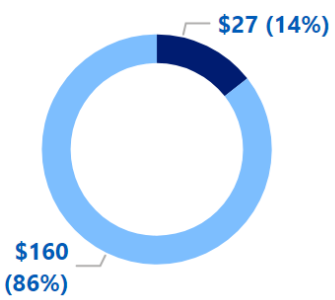

**Pharmacy**

4.6%

Member Trend

8.5%

Plan Trend




## Medical Allowed PMPM

Current period

**$487.09**

17.1% Trend

$71.21 Change


## Average Membership

Current Period

**21,687**

22.9% Trend

4,036 Change


## Pharmacy

Current period PMPM

**$187.38**

7.9% Trend

$13.69 Change

30-DS Scripts per 1,000

**12,318**

5.3%

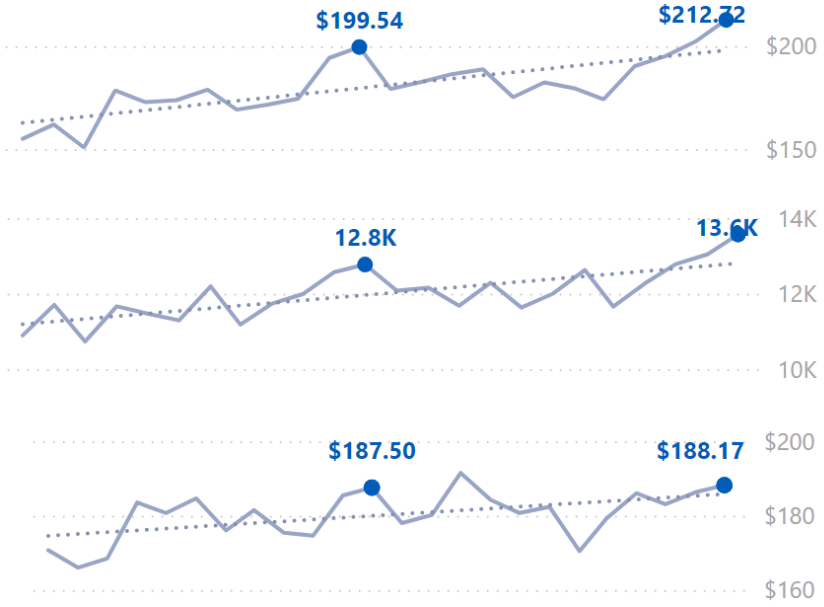
619.9

Cost per 30-DS

**$182.54**

2.5%

$4.37




Current Period : Incurred 7/1/2024 - 6/30/2025 : All Active Members

Source: Segal SHAPE Dashboard PY 2025

# LDPPO Non-Medicare Retirees



## Total Allowed PMPM

Current period

**$1,093.54**

2.7% Trend

$28.49 Change


## PMPM Cost Share

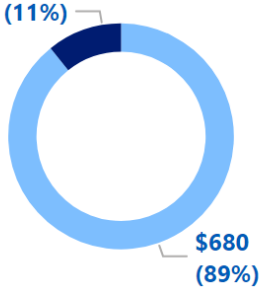
**Medical**

7.1%

Member trend

-4.8%

Plan trend



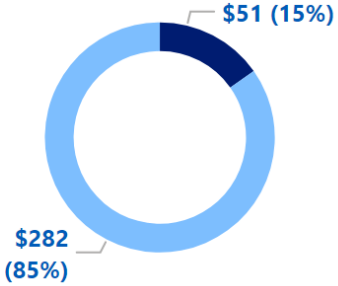

**Pharmacy**

9.2%

Member Trend

23.1%

Plan Trend



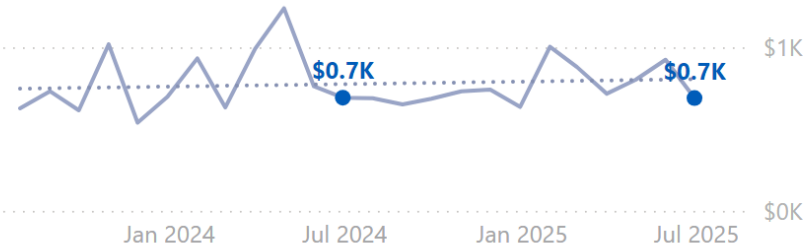

## Medical Allowed PMPM

Current period

**$761.46**

-3.6% Trend

($28.52) Change




## Average Membership

Current Period

**1,398**

9.8% Trend

124 Change


## Pharmacy

Current period PMPM

**$332.08**

20.7% Trend

$57.01 Change

30-DS Scripts per 1,000

**26,937**

5.6%

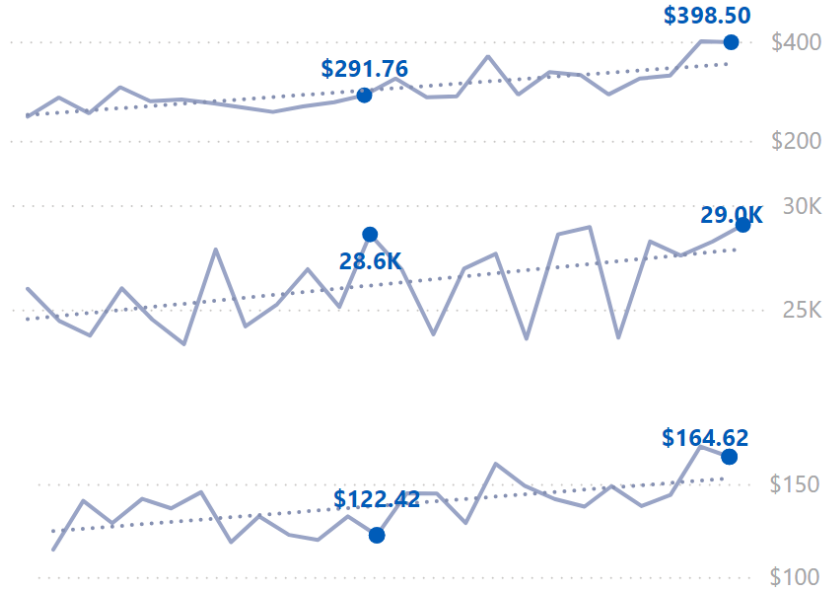
1.4K

Cost per 30-DS

**$147.93**

14.3%

$18.47




- Note: Member and plan PMPM amounts may not sum to total PMPM figures due to rounding.

Current Period : Incurred 7/1/2024 - 6/30/2025 : Non-Medicare Retirees

Source: Segal SHAPE Dashboard PY 2025

# EPO Actives/COBRA



## Total Allowed PMPM

Current period

**$989.83**

5.9% Trend

$55.35 Change


## PMPM Cost Share

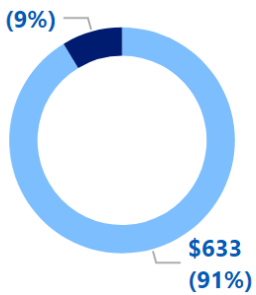
**Medical**

5.3%

Member trend

4.8%

Plan trend



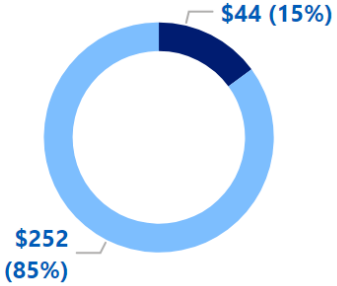

**Pharmacy**

13.4%

Member Trend

7.7%

Plan Trend




## Medical Allowed PMPM

Current period

**$693.34**

4.8% Trend

$32.03 Change


## Average Membership

Current Period

**4,378**

-10.7% Trend

-522 Change


## Pharmacy

Current period PMPM

**$296.49**

8.5% Trend

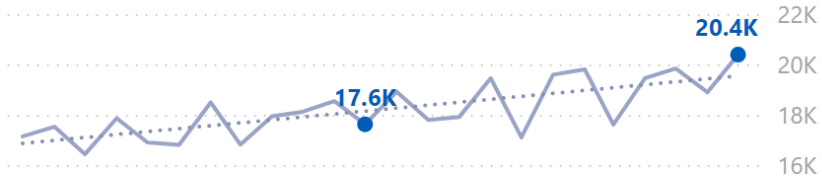
$23.32 Change


30-DS Scripts per 1,000

**18,878**

7.8%

1.4K




Cost per 30-DS

**$188.47**

0.7%

$1.30


Current Period : Incurred 7/1/2024 - 6/30/2025 : All Active Members

Source: Segal SHAPE Dashboard PY 2025

# EPO Non-Medicare Retirees



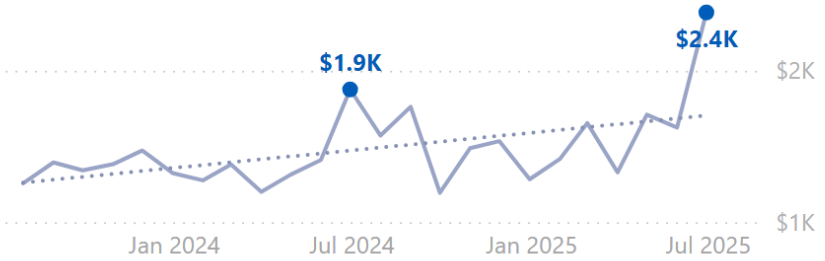
**Total Allowed PMPM**

Current period

**$1,575.16**

13.8% Trend

$191.53 Change




**PMPM Cost Share**

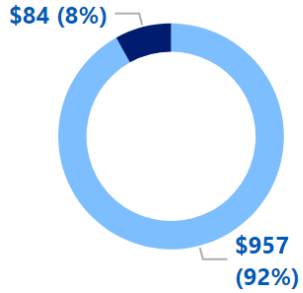
**Medical**

**12.4%**

Member trend

**28.1%**

Plan trend



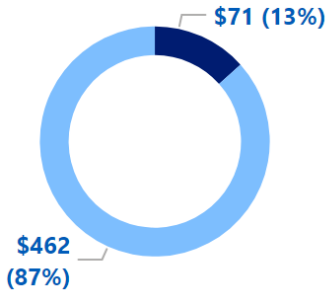

**Pharmacy**

**-28.1%**

Member Trend

**-0.0%**

Plan Trend




**Medical Allowed PMPM**

Current period

**$1,041.25**

26.7% Trend

$219.42 Change


**Pharmacy**

**Current period PMPM**

**$533.91**

-5.0% Trend

($27.89) Change

**30-DS Scripts per 1,000**

**33,737**

-1.6%

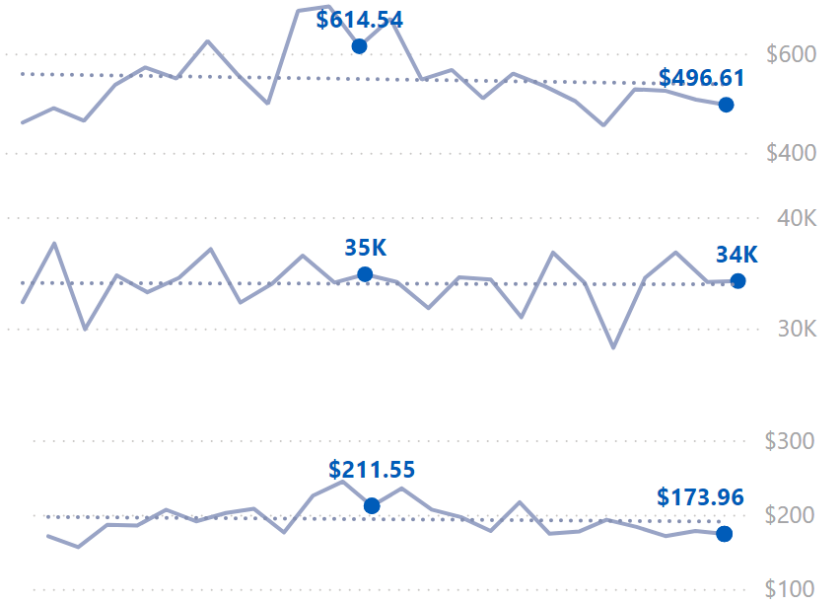
-537.7

**Cost per 30-DS**

**$189.91**

-3.5%

($6.79)



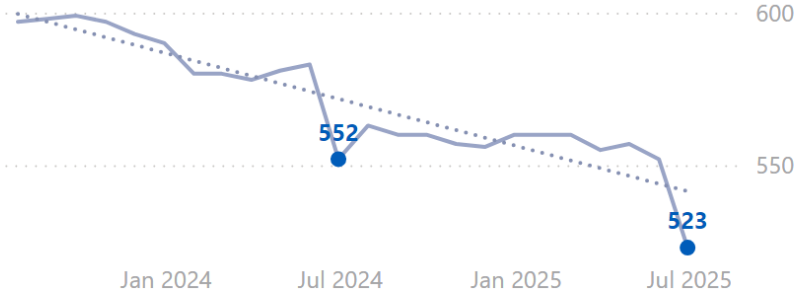

**Average Membership**

Current Period

**555**

-5.2% Trend

-30 Change




- Note: Member and plan PMPM amounts may not sum to total PMPM figures due to rounding.

Current Period : Incurred 7/1/2024 - 6/30/2025 : Non-Medicare Retirees

Source: Segal SHAPE Dashboard PY 2025

# Impact analysis of separating risk pools

- Based on pricing for PY 2027, if actives and retirees were rated separately based on their own experience we would anticipate the following budget rate impacts:

| Population | Approximate Budget Rate Impact | Approximate Impact on PY 2027 Budget |
|---|---|---|
| Actives | 5% reduction | - $15M |
| Retirees | 32% increase | + $17M |

- This analysis was based on data through December 2025, prior to plan migration, and if adopted, recommend updating projections to align with budget projections which will be finalized in August 2026

# Contracting procedures

# Contracting Procedure Topics (Non-Rx)

| Sub-topic | Potential Savings | Time Horizon |
|---|---|---|
| Procurement for medical claims administrator | $ | 2 years |
| Direct contract with specific hospitals / providers | $ to $$ | > 2 years |
| Direct contract for specific services (e.g. ambulance) | $ | 2 years |
| Reference-based pricing | $ to $$ | > 2 years |
| Expand Centers of Excellence | $ | 2 years |
| Direct primary care | $ | 2 years |
| Near-site clinics | $ | 2 years |
| Coordination with Nevada Health Authority / Medicaid | $ to $$$ | Various |
| Explore available programs through CMS (e.g. AHEAD model or waivers) | $ to $$ | > 2 years |
| Additional Point Solution vendors | $ | 2 years |
| Audits | $ | 1 year |
| Other | | |

- Potential savings shown as estimates and actual savings will be determined based on final decisions
- Time horizons based on time to implement and assumes no delays in Board decisions

# Traditional Network Discount / Disruption Analysis

Comparing United to other major national payers

**Background**

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

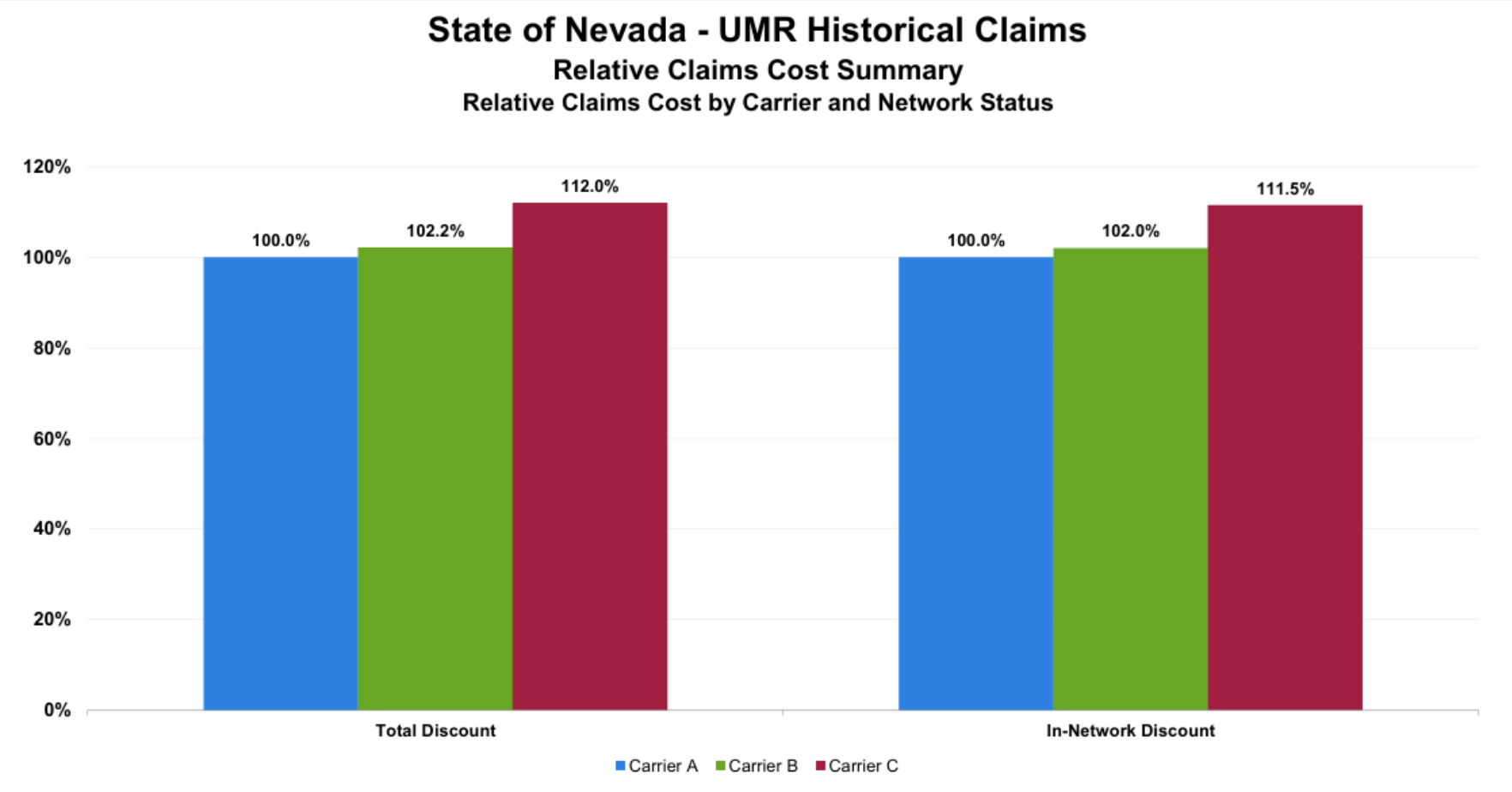
**Important Notes**

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

Source: Information provided by Milliman July 2026

# Traditional Network Discount / Disruption Analysis – Discount Relativity

Results – discount relativity by carrier

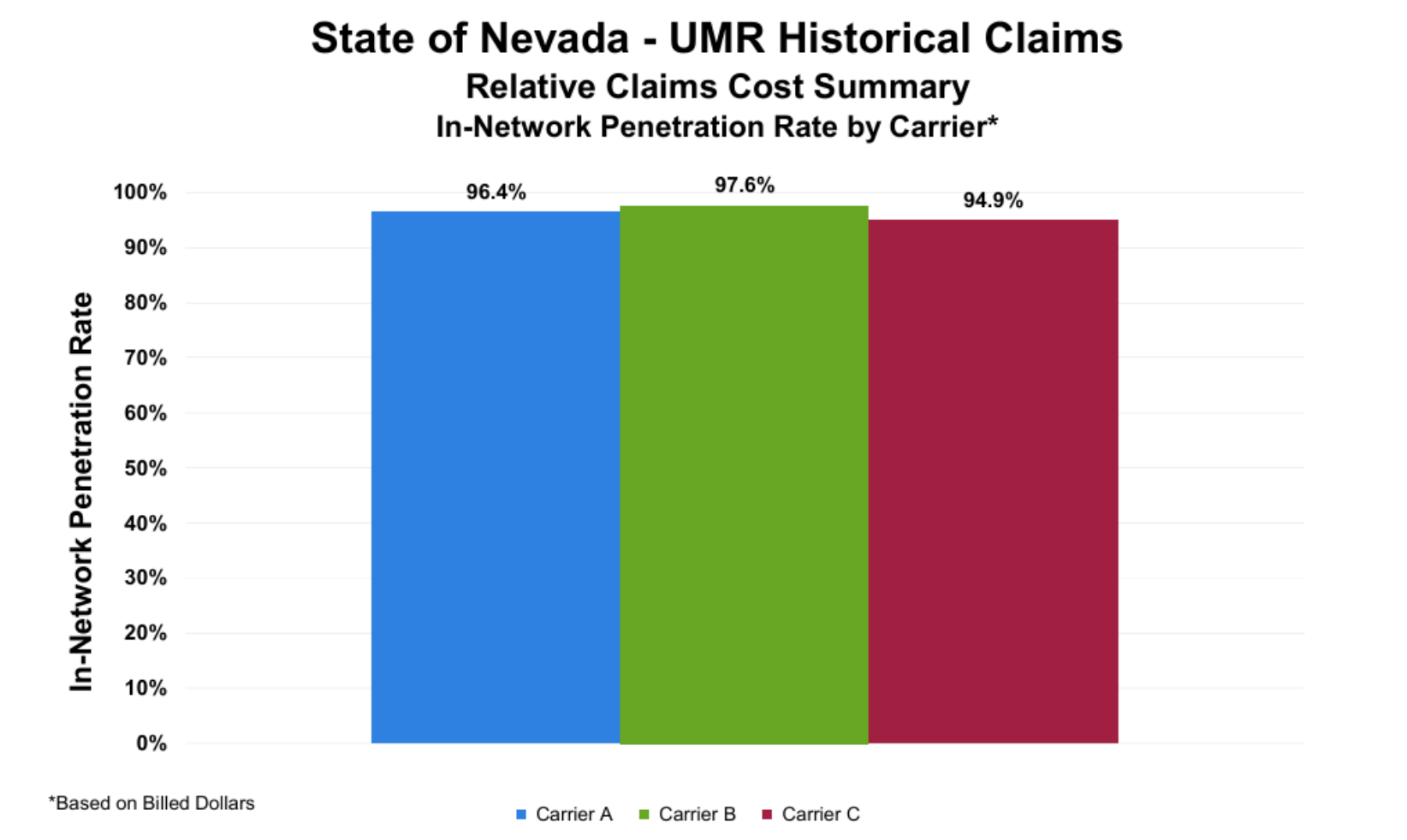



- **Carriers A and B have relatively close discounts overall**
- **Carrier C's discounts are less competitive relative to Carriers A and B**

Source: Information provided by Milliman July 2026

# Traditional Network Discount / Disruption Analysis – In-Network Penetration

Results – in-network penetration by carrier




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

Source: Information provided by Milliman July 2026

# Results Summary

## Across all service types, reimbursements are 176% of Medicare

Reimbursement by Service Category

| Service Category | % of Total Allowed Costs | % of Medicare |
|---|---|---|
| Inpatient Facility | 16% | 164% |
| Outpatient Facility | 40% | 262% |
| Professional Services | 41% | 136% |
| Ancillary | 3% | 173% |
| **Total** | | **176%** |

- Inpatient and outpatient facility combined represent 223% of Medicare
  - Outpatient facility reimbursements as a percentage of Medicare are on average 98 percentage points (pps) higher than inpatient hospital reimbursements
- Results combined for in- and out-of-network
  - Differences in reimbursement percentages for in- vs. out-of-network in total and on average were not meaningfully different

Source: Segal Medicare Repricing Analysis July 2026

# Results Summary – Geographic Region*

## Facility (Inpatient and Outpatient) experience by member area

### Facility Results by Member Area

| Member Area | % of Total Allowed Costs | % of Medicare | # of claims |
|---|---|---|---|
| Northern Nevada | 66% | 230% | 63,743 |
| Southern Nevada | 29% | 203% | 20,215 |
| Out of State | 6% | 275% | 3,750 |
| **Total** | | **223%** | |

### Dollar Distribution

| Inpatient Facility | Outpatient Facility |
|---|---|
| 29% | 71% |
| 29% | 71% |
| 30% | 70% |

### % of Medicare

| Inpatient Facility | Outpatient Facility |
|---|---|
| 177% | 262% |
| 136% | 253% |
| 198% | 331% |

* Results were provided based on where member resides given provider locations were not always reliable

Source: Segal Medicare Repricing Analysis July 2026

# Results Summary – Geographic Region* (cont.)

## Facility (Inpatient and Outpatient) experience by member area

- The Southern NV area has the lowest reimbursements on percentage of Medicare basis
- More rural settings and areas with less competition amongst hospitals tend to have higher reimbursements
- There were three hospitals whose combined facility reimbursements exceeded 400% of Medicare and they were all based in Northern Nevada
- Outpatient drives the reimbursements and represents the larger share of dollar distribution (71% compared to 29% for inpatient representing 40% of total allowed costs)
- Highest hospital reimbursement for inpatient is in Northern Nevada at 356% of Medicare and the same facility had the highest outpatient reimbursement at 566%
- The second highest outpatient reimbursement was also in the Northern Nevada at 556% of Medicare

* Results were provided based on where member resides given provider locations were not always reliable
Source: Segal Medicare Repricing Analysis July 2026

# Results – Inpatient and Outpatient Detail

## Inpatient Service Category Detail

| Service Category | % of Total Allowed | % of Medicare |
|---|---|---|
| Medical | 41% | 180% |
| Surgery | 31% | 137% |
| Maternity | 14% | 184% |
| Neonate | 8% | 153% |
| Mental Health | 5% | 184% |
| SNF/Rehab | 2% | 315% |
| **Total** | | **164%** |

- Surgery represents 31% of inpatient spend with the lowest reimbursement
- SNF/Rehab has the highest reimbursement for inpatient and represents only 2% of spend
- Dialysis, PT/OT/ST, and ER have the highest reimbursements in the outpatient service category

## Outpatient Service Category Detail

| Service Category | % of Total Allowed | % of Medicare |
|---|---|---|
| Surgery | 33% | 172% |
| ER | 32% | 497% |
| Observation/Treatment Room | 1% | 346% |
| Urgent Care Visits | 3% | 132% |
| Cardiovascular | 2% | 315% |
| Dialysis | 1% | 772% |
| GI Services | 1% | 153% |
| Pharmacy | 4% | 478% |
| Preventive | 3% | 164% |
| Lab/Pathology | 2% | 246% |
| Radiology | 10% | 421% |
| Mental Health | 1% | 200% |
| PT/OT/ST | 2% | 516% |
| Other Services | 5% | 292% |
| **Total** | | **262%** |

Source: Segal Medicare Repricing Analysis July 2026

# Results – Professional and Ancillary Detail

## Professional Services Category Detail

| Service Category | % of Total Allowed | % of Medicare |
|---|---|---|
| Evaluation and Management | 21% | 115% |
| Preventive | 9% | 148% |
| Mental Health | 8% | 92% |
| Surgery | 12% | 160% |
| Maternity | 1% | 139% |
| Anesthesia | 4% | 625% |
| Inpatient Visits | 3% | 200% |
| ER and OBS Visits | 5% | 339% |
| Lab/Pathology | 7% | 119% |
| Radiology | 7% | 151% |
| Therapies | 3% | 75% |
| Allergy Services | 1% | 128% |
| Exams | 1% | 132% |
| Office Administered Drugs | 13% | 142% |
| Medical Services | 4% | 138% |
| **Total** | | **136%** |

## Ancillary Service Category Detail

| Service Category | % of Total Allowed | % of Medicare |
|---|---|---|
| Ambulance | 58% | 420% |
| DME/Prosthetics | 35% | 91% |
| Other Services | 6% | 127% |
| **Total** | | **173%** |

- Anesthesia reimbursements are close to 625% but only represent 4% of professional allowed spend 2% of total allowed spend
- Ambulance reimbursements are over 400% but represent only 2% of total allowed spend

Source: Segal Medicare Repricing Analysis July 2026

# Conclusion

- In total, reimbursements are higher in Northern versus Southern Nevada
- Reimbursements are 223% of Medicare on average for outpatient and inpatient combined
- Outpatient reimbursements in total are higher than inpatient by 98% points and represent approximately 40% of total allowed spend
- From a total allowed spend perspective, inpatient represents 16% of total allowed spend
- Professional services represent 41% of allowed total spend with reimbursements on average around 136% of Medicare
- Medicare rates can vary by hospital

Source: Segal Medicare Repricing Analysis July 2026

# Coordination with NVHA

- Higher volume and negotiating leverage
- RFP coordination
- Potential additional considerations:
  - Capitating professional services, particularly PCP across Medicaid and PEBP
  - Standardizing inpatient facility charges across the state
  - High-volume drug purchasing
  - Others?

# Long-Term Coordination with NVHA & CMS

- **Achieving Healthcare Efficiency through Accountable Design (AHEAD)**
  - Voluntary total cost of care model for states
  - Curb health care cost growth across all payers while maintaining or improving quality
  - Strengthen primary care through increased, predictable investment and care management supports
  - Improve population health by enhancing preventive care statewide and addressing whole person needs
  - Align Medicaid and commercial payers with Medicare to reduce fragmentation and administrative burden
  - Negotiate/establish global budgets for both markets for interested hospitals

Source: https://www.cms.gov/priorities/innovation/innovation-models/ahead

- **Federal Waivers (Section 1115)**
  - Allows HHS Secretary to approve experimental, pilot or demonstration projects that assist in promoting the objectives of Medicaid program
- ***State Innovation Waiver (Section 1332)***
  - Permit states to apply for federal approval to waive certain requirements of ACA to develop innovative health insurance programs
  - Approved for Nevada for 5 years beginning 1/1/2026
    - Market Stabilization Program, including state-based reinsurance program, premium relief for some Exchange enrollees, quality incentive payment program, and provider retention program

Source:
- https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list
- https://www.cms.gov/files/document/nevada-section-1332-waiver-fact-sheet-1.pdf

# Pharmacy benefits

# Pharmacy Benefits Topics

| Sub-topic | Potential Savings | Time Horizon |
|---|---|---|
| GLP-1 management solutions | $ to $$ | 1 year |
| Specialty drug management solutions | $ to $$ | 1 - 2 years |
| Direct rebate contracting | $ to $$ | 2 years |
| Narrow formulary | $ | 1 year |
| Narrow retail network | $ | 1 year |
| Point Solution utilization management | $ to $$ | 2 years |
| Copay plan design changes | $ | 1 year |
| Other | | |

- Potential savings shown as estimates and actual savings will be determined based on final decisions
- Time horizons based on time to implement and assumes no delays in Board decisions

# PY 2027 Rx Plan Design Summary

| Plan Year 2027 Prescription Plan Design Features | Consumer Driven Health Plan (PPO) | Low Deductible Plan (PPO) | Exclusive Provider Organization Plan (EPO) | Health Plan of Nevada (HMO) |
|---|---|---|---|---|
| | **In-Network**<br>Pharmacy Benefits are not covered Out-of-Network | | | |
| Preferred Generic | You pay 20% after Deductible | $10 Copay<br>30-day supply | $10 Copay<br>30-day supply | $10 Copay<br>30-day retail supply |
| | | $20 Copay<br>90-day retail and mail | $20 Copay<br>90-day retail and mail | $25 Copay<br>90-day mail |
| Preferred Brand | You pay 20% after Deductible | $40 Copay<br>30-day supply | $40 Copay<br>30-day supply | $40 Copay<br>30-day retail supply |
| | | $80 Copay<br>90-day retail and mail | $80 Copay<br>90-day retail and mail | $100 Copay<br>90-day mail |
| Non-Formulary | You pay 100% of the cost of medication | $75 Copay<br>30-day supply | $75 Copay<br>30-day supply | $75 Copay<br>30-day retail supply |
| | | $150 Copay<br>90-day retail and mail | $150 Copay<br>90-day retail and mail | $187.50 Copay<br>90-day mail |
| Specialty (30-day supply) | You pay 30% after Deductible; for drugs not on the SaveOnSP program, there is $100 min/$250 max | You pay 30% after Deductible; for drugs not on the SaveOnSP program, there is $100 min/$250 max | You pay 30% after Deductible; for drugs not on the SaveOnSP program, there is $100 min/$250 max | You pay 20% Coinsurance |
| ACA Preventive Medications | $0 | $0 | $0 | $0 |
| CDHP Preventive Medications | You pay 20%, not subject to Deductible | N/A | N/A | N/A |

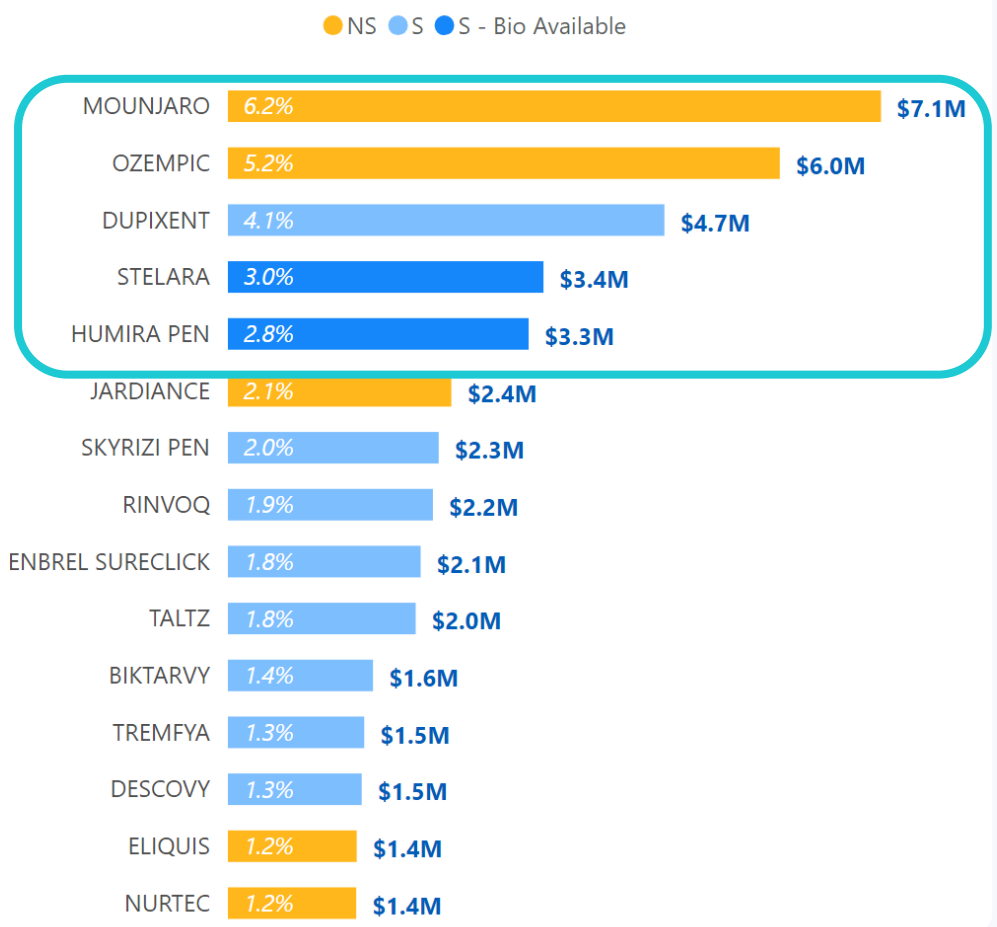
Source: PY 2027 PEBP Plan Compare

# All Enrollees



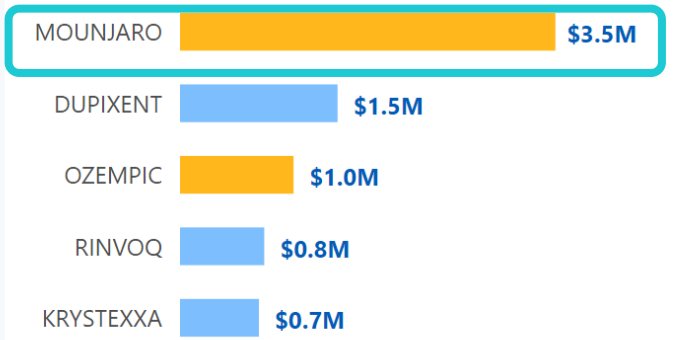
| Total Allowed | 30-DS Rx per 1,000 | Allowed PMPM | Cost per 30-DS | Generic Fill Rate | Utilizers | % Utilizing Rx |
|---|---|---|---|---|---|---|
| $114.7M | 13,299 | $192.00 | $173.25 | 87.0% | 38,193 | 67.6% |
| 13.8% | 4.0% | 7.9% | 3.8% | 0.5% pp | 1,775 | 0.7% pp |

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

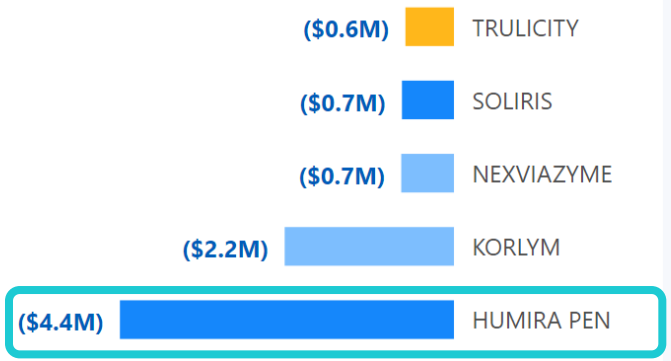



**Top 5 spend changes by drug** - Allowed change

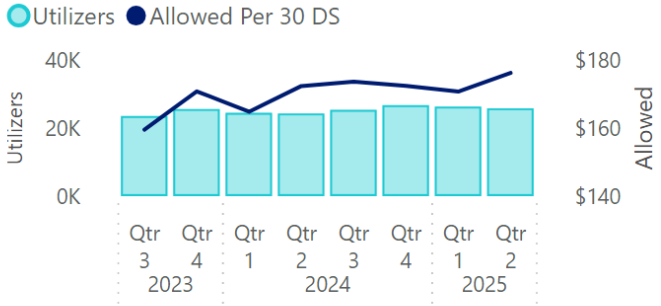
**Increases**




**Decreases**




**Cost vs. Utilization**




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

Current Period : Incurred 7/1/2024 - 6/30/2025 : Active + Non-Medicare Retirees

* S = Specialty, NS = Non-Specialty

Source: May 2026 PEBP Board Meeting

# Top 15 Pharmacy Disease Indications

## All Enrollees



| Total Allowed | 30-DS RX per 1,000 | Allowed PMPM | Cost per 30-DS | Generic Fill Rate | Utilizers | % Total Rx Cost |
|---|---|---|---|---|---|---|
| $93.8M | 3,029 | $156.90 | $621.62 | 55.7% | 22,734 | 81.7% |
| 11.7% | 7.0% | 5.9% | -1.0% | -0.7% pp | 1K | -1.5% |

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

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

Current Period : Incurred 7/1/2024 - 6/30/2025 : Active + Non-Medicare Retirees



Source: May 2026 PEBP Board Meeting

# Clinical Utilization Management

Clinical programs are designed to improve appropriateness of care, reduce avoidable trend, and support better outcomes for high-cost / highly utilized therapies.

## GLP-1 Management Solutions

**Why it matters:** GLP-1s make up a material portion of PEBP's total pharmacy spend, and current utilization and adherence patterns suggest avoidable cost and outcome variation. Tailored solutions can help align use with evidence and reduce avoidable spend

**What it means:** Holistic GLP-1 strategy; can include eligibility criteria, prior authorization, reauthorization, lifestyle and nutrition education, adherence support, side-effect monitoring, and outcomes tracking. Can be managed by the PBM, an external clinical point-solution vendor, or a coordinated hybrid model.

**Trade-offs:** Program fees, potential operational complexity, and possible member/provider friction if criteria and support pathways are not clearly designed.

## Specialty Drug Management Solutions

**Why it matters:** Specialty remains the primary cost concentration area, with a small share of scripts driving a disproportionate share of spend. Tailored specialty solutions can help control specialty spend and improve care coordination for specialty utilizers

**What it means:** A structured program for specialty therapies that may include site-of-care optimization, channel management, biosimilar conversion strategies, case management, and adherence/outcomes support. Can be administered through PBM specialty programs, external specialty management vendors, or combined solutions.

**Trade-Offs:** Added program costs and implementation effort; requires strong continuity-of-care safeguards for complex and vulnerable members.

## Point Solution Management

**Why it matters:** Standard PBM controls do not always address every high-cost condition equally well, and more targeted programs can offer a closer fit for selected problem areas.

**What it means:** Targeted utilization management programs focused on specific high-impact conditions or drug classes (for example inflammatory, oncology, rare disease, or high-cost injectables). Frequently delivered by external vendors, sometimes in conjunction with core PBM programs and plan clinical teams.

**Trade-offs:** Additional vendor/program fees, integration burden, and risk of member abrasion if workflows are not aligned across vendors and PBM operations.

Source: Information provided by Milliman July 2026

# Formulary and Network Strategy

These are access-architecture levers that can improve contracting leverage and net cost when paired with transition safeguards.

## Narrow Formulary

**Why it matters:** Multiple clinically similar products can have very different net costs, and broad formularies can dilute contracting leverage.

**What it means:** A more selective preferred drug list that limits in-class options to clinically appropriate products with stronger net-cost terms. This can help to increase negotiating leverage and improve predictability of net pharmacy cost.

**Trade-offs:** Members may need to switch medications, which requires clear transition rules and communication. May also result in increased volume of formulary exception requests.

## Narrow Retail Network Strategy

**Why it matters:** Unit costs and dispensing economics can vary significantly across pharmacies, so broad networks may limit pricing leverage and consistency. Concentrating volume at fewer pharmacies can improve terms and accountability.

**What it means:** Smaller set of preferred pharmacy partners chosen for performance, access, and economics. In a closed narrow network, coverage is restricted to smaller set of pharmacies → more savings potential, higher disruption risk

**Trade-offs:** Potential convenience/access concerns in some geographies or member segments. Some members may lose their current pharmacy option, so access standards and transition support are important.

Source: Information provided by Milliman July 2026

# Financial and Benefit Design Levers

These levers focus on economic transparency and member incentive design to support affordability goals.

## Direct Rebate Contracting

**Why it matters:** Even with pass-through language, PBM-controlled rebate structures can limit transparency and reduce flexibility in coverage decisions.

**What it means:** Greater direct plan control over rebate terms, pass-through mechanics, and reporting visibility. This can help to improve transparency and alignment between rebate economics and plan priorities.

**Trade-offs:** Can increase administrative complexity and data governance requirements.

## Copay Plan Design Changes

**Why it matters:** Current cost-sharing may not consistently steer to highest-value therapies, while premium pressure and affordability constraints increase the need for better incentive alignment.

**What it means:** Adjusting member cost-sharing structure to steer utilization toward clinically appropriate, high-value therapies.

**Trade-offs:** f not carefully designed, higher out-of-pocket costs can create affordability pressure and employee retention concerns.

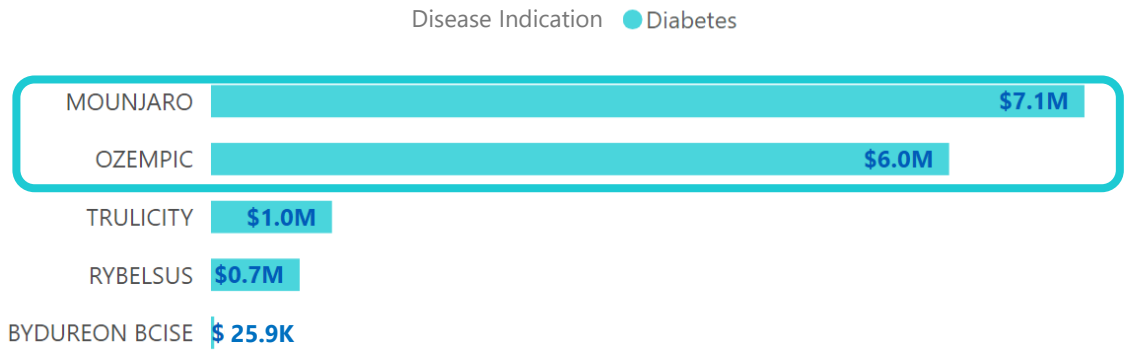
Source: Information provided by Milliman July 2026

# All Enrollees

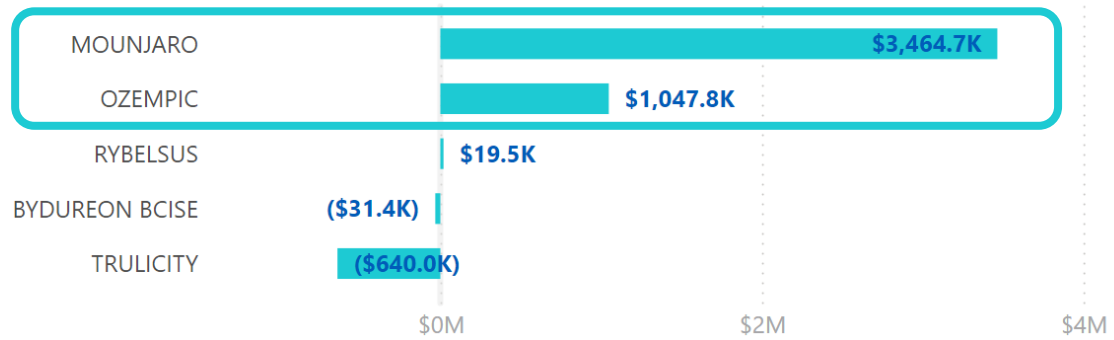


| Total Allowed | 30-DS RX per 1,000 | Allowed PMPM | Cost per 30-DS | Generic Fill Rate | Utilizers |
|---|---|---|---|---|---|
| $14.8M | 303 | $24.83 | $982.64 | 0.1% | 1,798 |
| 34.8% | 21.6% | 27.8% | 5.2% | 0.1% pp | 273 |

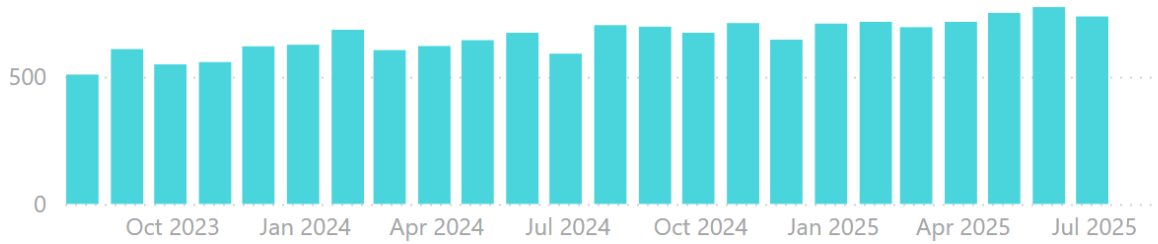
**Current pharmacy allowed - Top 5 drugs**




**Spending changes by drug** - Top 5 Allowed change period over period




**Prescriptions**




**Current cost per 30 day supply**


- Though GLP-1s continue to exert significant cost pressure, the rate of cost increases may be moderating. Between fiscal years 2023 and 2024, utilization rose 26.1%, compared to 21.6% between fiscal years 2024 and 2025.
- About 40% of diabetics currently enrolled use GLP-1s, with similar rates across plans. Potential off-label use by non-diabetics is well controlled at under 4% of all users.

Current Period : Incurred 7/1/2024 - 6/30/2025 : Active + Non-Medicare Retirees

Source: May 2026 PEBP Board Meeting

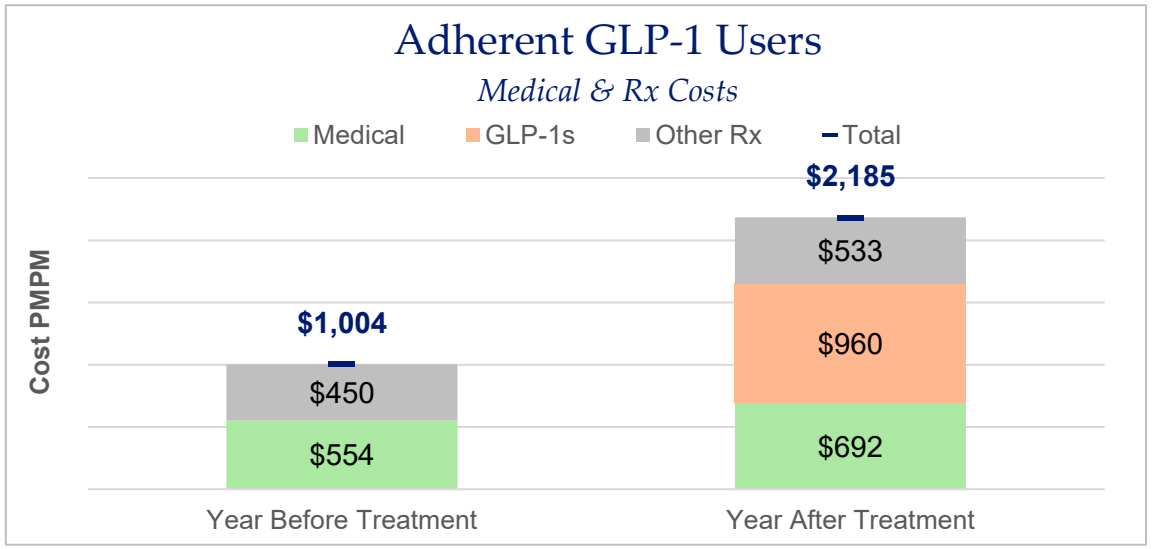
# GLP-1 Adherence Results*

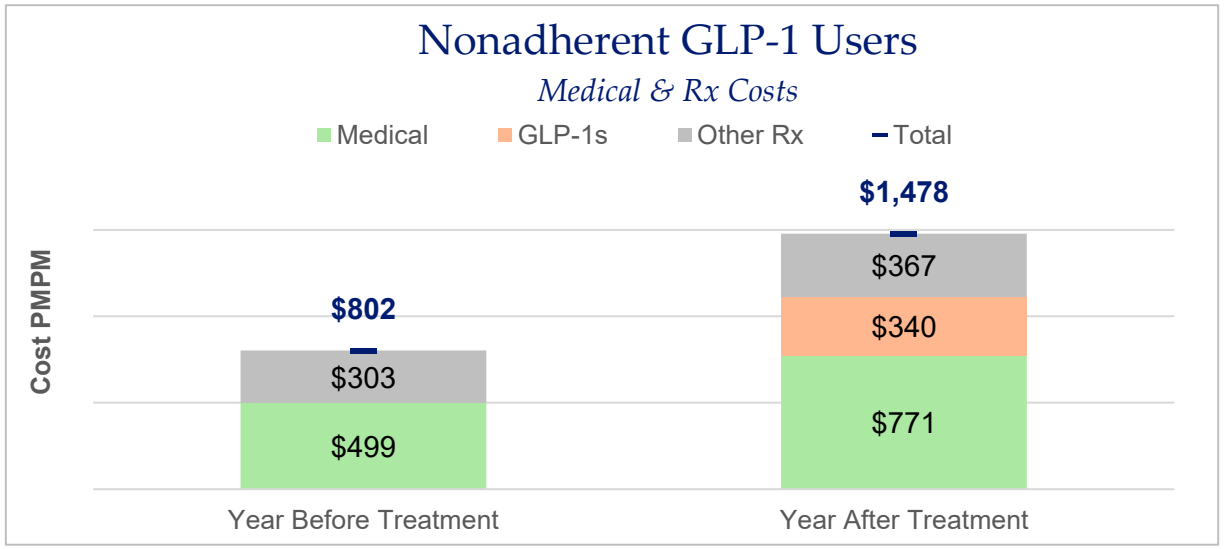
- Adherence* for GLP-1 medications is approximately 50-60% over all plans
  - Members who were not adherent in the first year of therapy exhibited nearly a 30-percentage point increase in medical costs*
  - Adherent GLP-1 users exhibited reduction in emergency room and urgent care spend
  - It is typical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

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

Source: May 2026 PEBP Board Meeting

# Cost Impact – Adherent vs. Non-Adherent




## Adherent Observations

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

## Non-Adherent Observations

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

Source: May 2026 PEBP Board Meeting

# Enhanced GLP-1 Management

| Approach | Medicaid | Commercial PBM | Kaiser |
|---|---|---|---|
| **Prior Authorization** | Very common | Very common. Screen out logic used ("smart PA" automated approvals) may be used. | Very common |
| **Metformin-first step therapy** | Common | Common. Smart logic may be used to automate approvals. | Often embedded in formulary management. KP NW requires trial/failure of metformin, SGLT2i, and liraglutide. |
| **Preferred GLP-1 strategy** | Very Common (i.e., Ozempic over Mounjaro) | Somewhat common (typically both Ozempic and Mounjaro preferred) | Very Common (generic liraglutide preferred for Kaiser NW; for Nevada members, Ozempic is preferred). |
| **Diagnosis verification** | Common | Common. Smart logic may be used to automate approvals. | Strong clinical integration |
| **Off-label weight-loss controls** | Strong | Strong | Very strong |
| **Closed formulary** | Moderate | Varies by employer | Generally tighter |
| **PA renewal criteria and duration of approval** | 12 months | Up to 36 months | If meeting initial approval, no renewal needed. |

Formulary and Utilization Management approaches utilizing a more restrictive and/or custom formulary may impact PBM rebate guarantees.

# Pharmacy (Increase Non-Preferred Brand Copay)

## Three options considered

- Only 0.4% of scripts are for Non-Preferred Brands
- Limited savings opportunity for Options 1 and 2
- Removing coverage for Non-Preferred Brands from the LDPPO and EPO (to align with CDHP) has $600,000 savings opportunity, but affects approximately 825 patients (with 2,700 scripts)

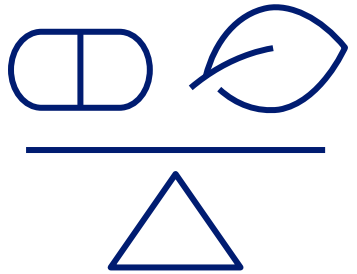
| | Retail 30 | Retail90/MO | Plan Impact |
|---|---|---|---|
| **Current** | $75 copay | $150 copay | |
| **Option 1** | 30% coinsurance<br>Min $75; Max $150 | 30% coinsurance<br>Min $150; Max $300 | ($100,000) |
| **Option 2** | 30% coinsurance<br>Min $100; Max $250 | 30% coinsurance<br>Min $200; Max $500 | ($200,000) |
| **Option 3** | Not covered<br>(member pays 100%) | Not covered<br>(member pays 100%) | ($600,000) |

Source: December 2025 PEBP Board Meeting

# Pharmacy (Three Tier Specialty Copay Structure)

- Current 30% coinsurance provides incentive to utilize lower cost options
- Current strategy has included excluding high-cost brand specialty drugs when there are viable alternatives.
  - Humira is a recent example: 1,000 scripts in PY24, 400 in PY25 and currently a single user
- Biosimilars and generic specialty medications are in the early stages.
- Three-tier cost structure may make sense long-term, but for PY2027, this is expected to be an investment

| | Specialty | Plan Cost |
|---|---|---|
| **Current (all tiers)** | 30% coinsurance<br>Min $100; Max $250 | |
| **Alternative Tier 1** | 30% coinsurance<br>No Min; Max $50 | **$25,000** |
| **Alternative Tier 2** | 30% coinsurance<br>Min $150; Max $250 | |
| **Alternative Tier 3** | 30% coinsurance<br>Min $250; Max $350 | |



Source: December 2025 PEBP Board Meeting

# Specialty Drug Spend Management: Third Party Vendors

- Some third-party vendors are targeting areas of high-cost Rx spend, such as Skin Conditions
- Claims data is used to identify members who may benefit from first-line treatments such as UVB phototherapy that can be administered by the patient at home
- Telehealth and virtual care / app can be used for real-time tracking and interventions
- Goal is to reduce spend for biologics, prevent the need to start injectables such as Dupixent, and improved outcomes

# Disease management / care coordination

# Disease Management / Care Coordination Topics

| Sub-topic | Potential Savings | Time Horizon |
|---|---|---|
| Explore care navigation | $ | 2 years |
| Update condition-specific care management programs | $ to $$ | 1 - 2 years |
| Require participation to cover GLP-1s or other benefits | $ to $$ | 1 year |
| Additional Point Solutions vendors | $ to $$ | 2 years |
| Improve contract terms for utilization, care, and disease management through procurement | $ | 2 years |
| Other | | |

- Potential savings shown as estimates and actual savings will be determined based on final decisions
- Time horizons based on time to implement and assumes no delays in Board decisions

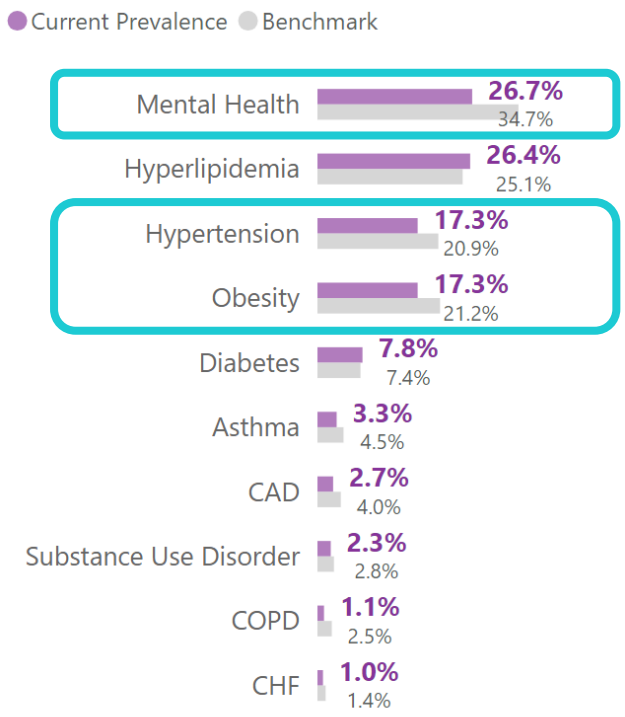
## Major Chronic Conditions

Benchmark Type: Public Sector

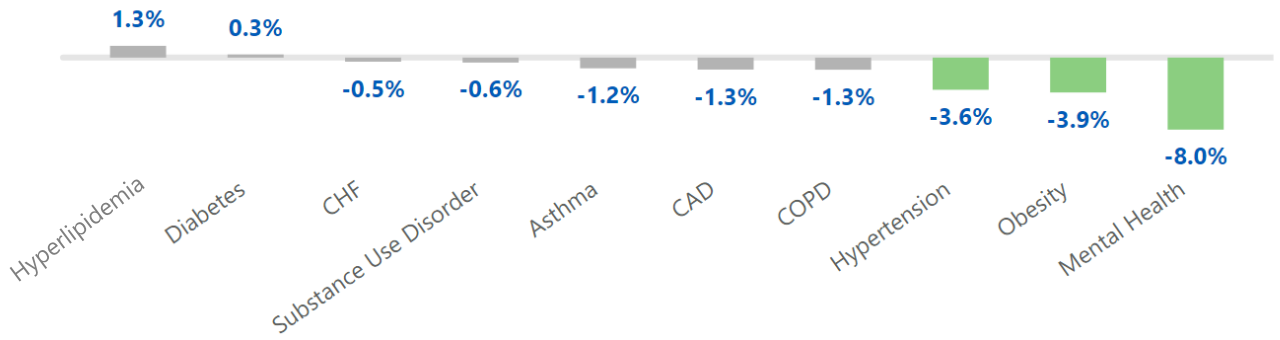
**Members**
25,131
2K

**Prevalence**
52.7%
1.9% pp

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




### Prevalence Variation from Benchmark




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

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

Current Period : Incurred 7/1/2024 - 6/30/2025 : Active + Non-Medicare Retirees

Source: May 2026 PEBP Board Meeting

# All Enrollees

## Care Gap Compliance

Benchmark Type: Public Sector

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

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

Current Period : Incurred 7/1/2024 - 6/30/2025 : Active + Non-Medicare Retirees

Source: May 2026 PEBP Board Meeting

# Overview of Programs

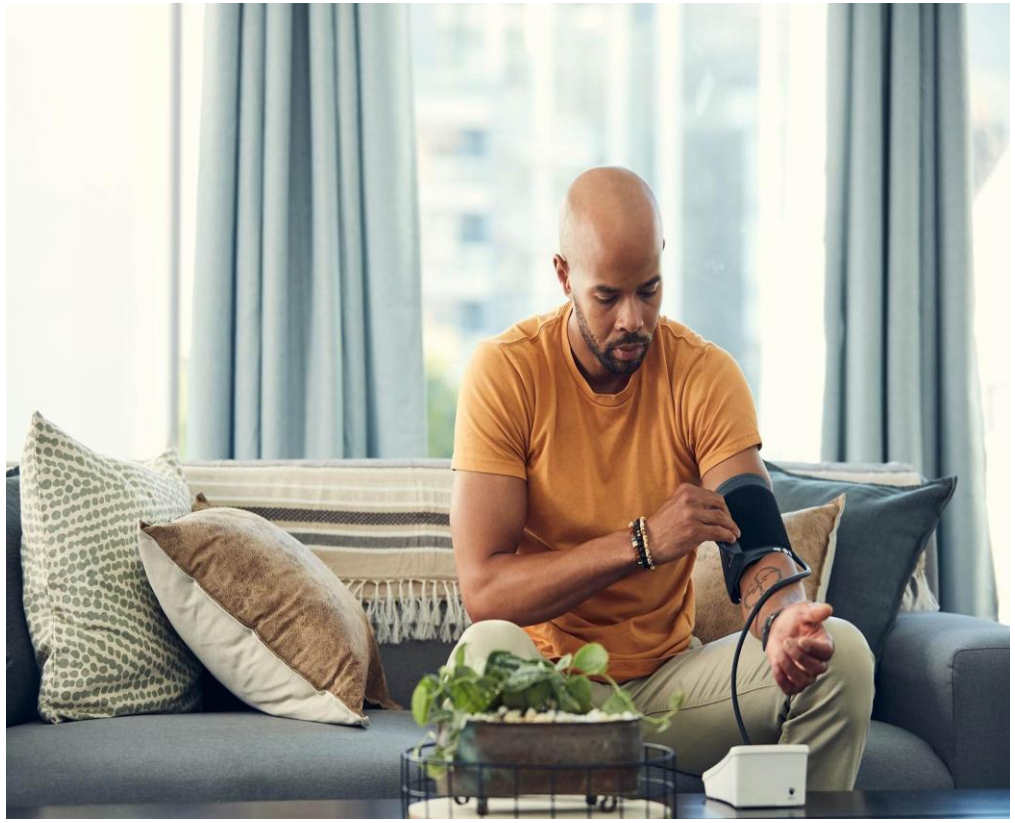
- **Diabetes Care Management (DCM)**
  - Eligible: CDHP participants and covered dependents; must meet BMI eligibility requirement
  - Description: Voluntary “opt-in” program that provides, but it not limited to, the ability to purchase diabetes related medications, such as insulin, at a copay and not be subject to deductible or coinsurance
- **Obesity Care Management (OCM)**
  - Eligible: CDHP, LDPPO, and EPO participants and covered dependents
  - Description: Voluntary “opt-in” program that provides, but is not limited to, medically supervised weight loss program, nutritional counseling, weight-loss medications
- **Real Appeal**
  - Eligible: CDHP, LDPPO, EPO and HMO participants and covered dependents; must meet BMI eligibility requirement
  - Description: Online weight management program focused on building healthier habits; offers virtual group sessions, fitness, food and weight trackers and food and weight scales
- **Nevada Business Group on Health Pilot Program (NVBGH)**
  - Eligible: PEBP participants identified as Type 2 diabetic or Pre-Diabetic
  - Description: Lifestyle change pilot program focused offered to Type 2 diabetics and Pre-Diabetic; in person and virtual options

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

Source: May 2026 PEBP Board Meeting

# Summary of Programs

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



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

Source: May 2026 PEBP Board Meeting

# Thank You

# Appendix

# All Enrollees



**Total Allowed PMPM**

Current period

**$676.07**

7.9% Trend

$49.44 Change


**PMPM Cost Share**

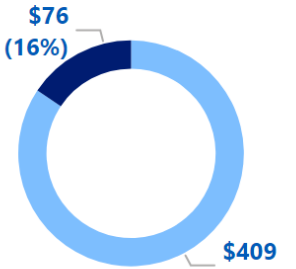
**Medical**

**3.0%**

Member trend

**8.8%**

Plan trend



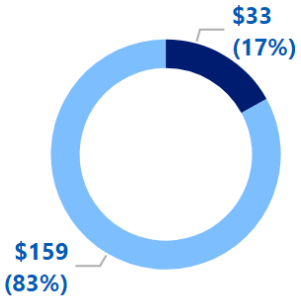

**Pharmacy**

**4.3%**

Member Trend

**8.6%**

Plan Trend




**Medical Allowed PMPM**

Current period

**$484.07**

7.9% Trend

$35.41 Change


**Pharmacy**

Current period PMPM

**$192.00**

7.9% Trend

$14.03 Change

30-DS Scripts per 1,000

**13,299**

4.0%

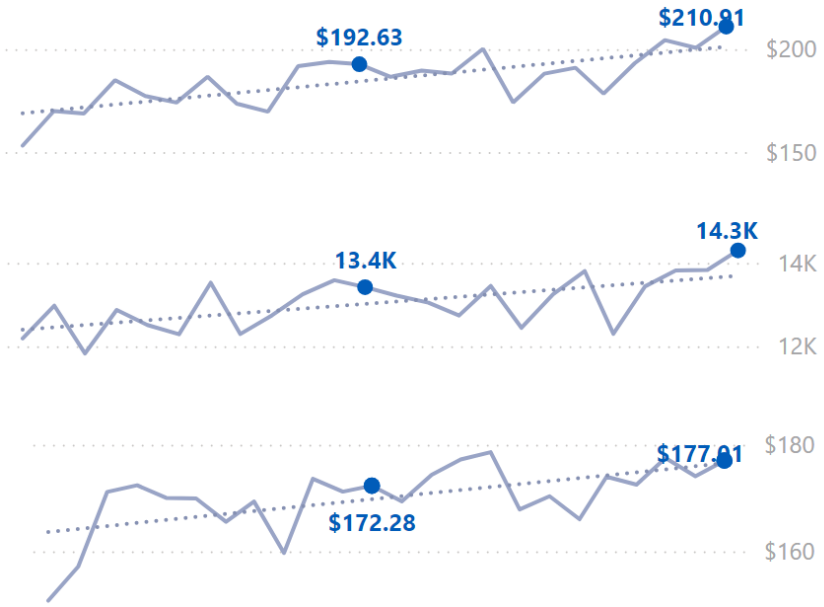
509.2

Cost per 30-DS

**$173.25**

3.8%

$6.26




**Average Membership**

Current Period

**49,796**

5.5% Trend

2,583 Change


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

Current Period : Incurred 7/1/2024 - 6/30/2025 : Active + Non-Medicare Retirees

Source: May 2026 PEBP Board Meeting

# LDPPO

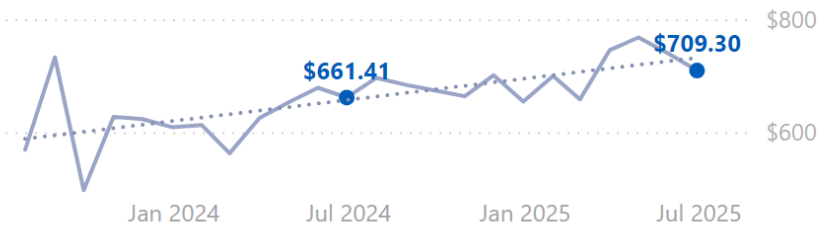


## Total Allowed PMPM

**Current period**

**$699.84**

12.6% Trend | $78.28 Change




## PMPM Cost Share

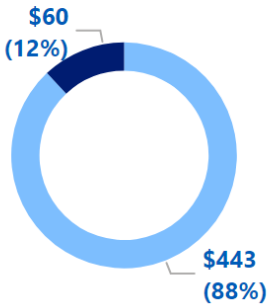
**Medical**

**5.0%**

Member trend

**15.6%**

Plan trend



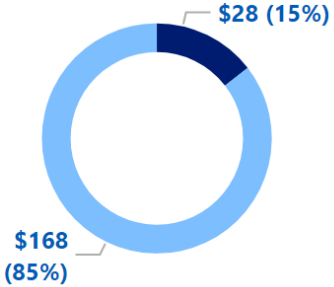

**Pharmacy**

**4.6%**

Member Trend

**9.4%**

Plan Trend




## Medical Allowed PMPM

**Current period**

**$503.70**

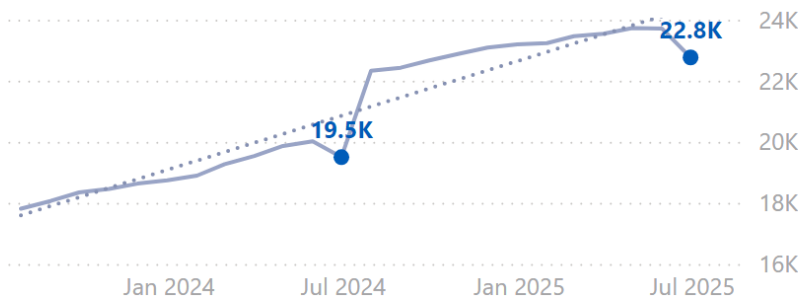
14.2% Trend | $62.65 Change


## Average Membership

**Current Period**

**23,084**

22.0% Trend | 4,160 Change

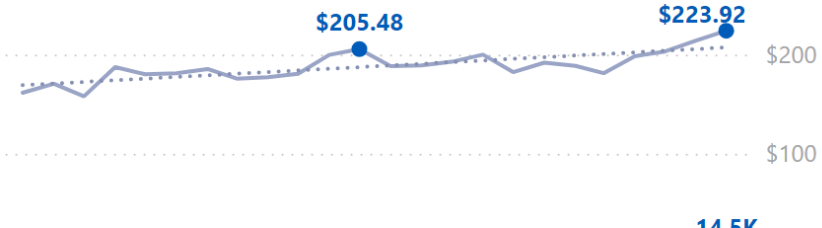



## Pharmacy

**Current period PMPM**

**$196.14**

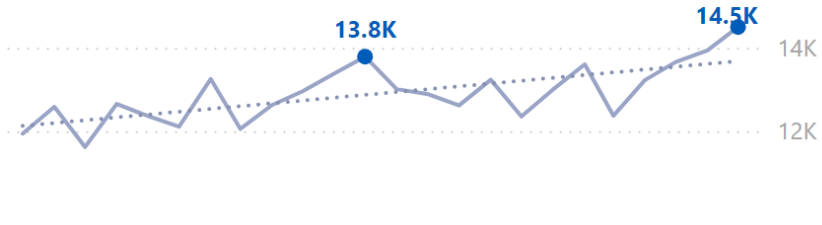
8.7% Trend | $15.63 Change




**30-DS Scripts per 1,000**

**13,203**

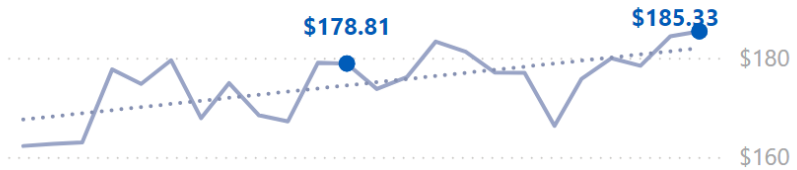
4.6% | 576.5




**Cost per 30-DS**

**$178.26**

3.9% | $6.72




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

Current Period : Incurred 7/1/2024 - 6/30/2025 : Active + Non-Medicare Retirees

Source: May 2026 PEBP Board Meeting

# CDHP



## Total Allowed PMPM

Current period

**$562.55**

3.5% Trend | $19.23 Change


## PMPM Cost Share

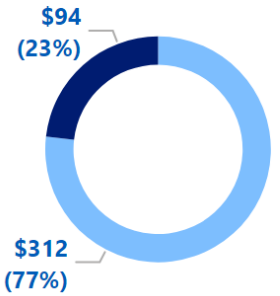
**Medical**

5.1%

Member trend

1.0%

Plan trend



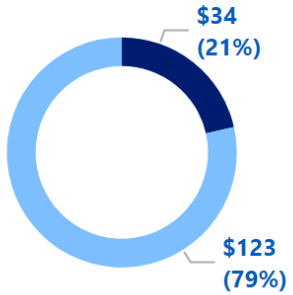

**Pharmacy**

7.8%

Member Trend

8.1%

Plan Trend




## Medical Allowed PMPM

Current period

**$405.83**

1.9% Trend | $7.61 Change


## Average Membership

Current Period

**21,779**

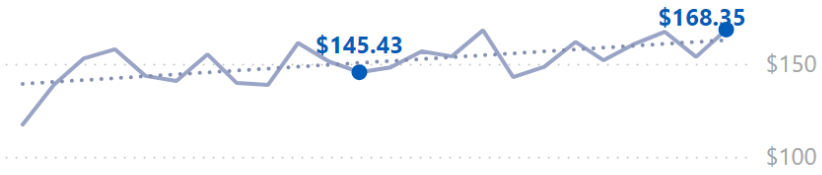
-4.5% Trend | -1,024 Change


## Pharmacy

Current period PMPM

**$156.72**

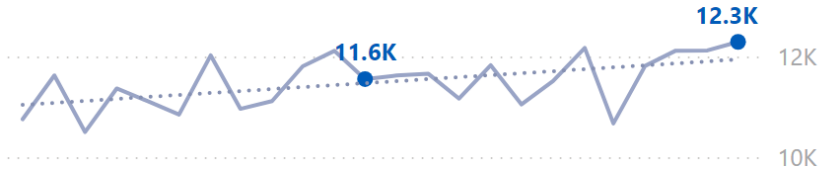
8.0% Trend | $11.62 Change




30-DS Scripts per 1,000

**11,664**

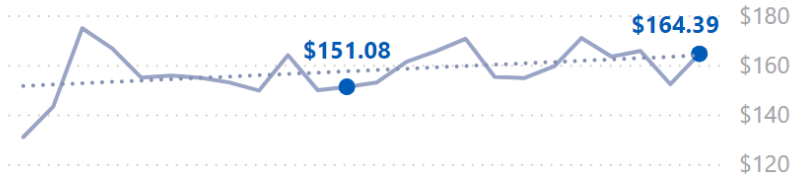
3.1% | 352.7




Cost per 30-DS

**$161.23**

4.7% | $7.30




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

Current Period : Incurred 7/1/2024 - 6/30/2025 : Active + Non-Medicare Retirees

Source: May 2026 PEBP Board Meeting

# EPO



## Total Allowed PMPM

Current period

**$1,055.71**

7.5% Trend | $73.28 Change


## PMPM Cost Share

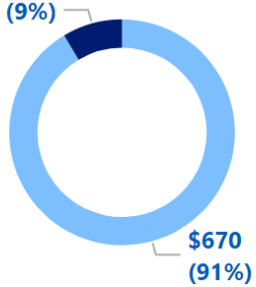
**Medical**

6.5%

Member trend

8.1%

Plan trend



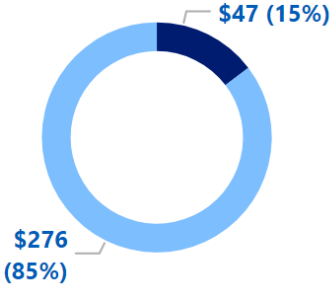

**Pharmacy**

4.1%

Member Trend

6.7%

Plan Trend




## Medical Allowed PMPM

Current period

**$732.50**

8.0% Trend | $54.05 Change


## Average Membership

Current Period

**4,933**

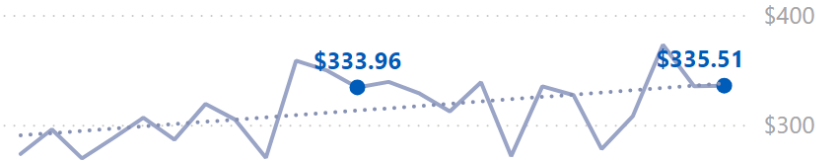
-10.1% Trend | -553 Change


## Pharmacy

Current period PMPM

**$323.21**

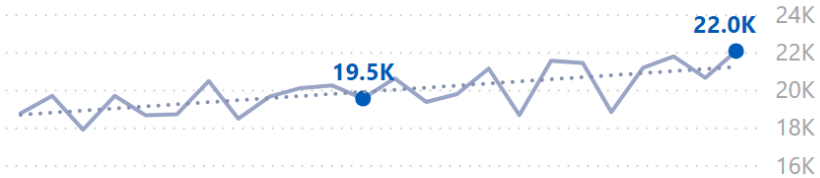
6.3% Trend | $19.23 Change




30-DS Scripts per 1,000

**20,550**

6.5% | 1.25K




Cost per 30-DS

**$188.73**

-0.1% | ($0.24)


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

Current Period : Incurred 7/1/2024 - 6/30/2025 : Active + Non-Medicare Retirees

Source: May 2026 PEBP Board Meeting

# Benchmarking

## Local Comparators

Source: Information provided by Milliman July 2026

# PPO Plan Design: Local Comparators

PEBP vs. Washoe County, Clark County, Carson City, Clark County School District, and City of Las Vegas

| In-Network | PEBP | | Local Public Employers (PPO, In-Network) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | LD PPO PY2027 | | Washoe County (PPO) | | Clark County | | | | Carson City (Freedom 9 PPO) | | CCSD – Support Professionals | | City of Las Vegas (Sierra PPO Plus) | |
| | Single | Family | Single | Family | Single | Family | Single | Family | Single | Family | Single | Family | Single | Family |
| Network | UHC Choice Plus / Sierra Care Options | | UHC Choice Plus | | Tier 1: University Medical Center | | Tier 2: UHC Choice Plus / Sierra Care Options | | Prominence / Cigna | | HPN | | Sierra Care | |
| Deductible | $300 | $600 | $375 | $750 | $0 | $0 | $500 | $1,000 | $2,500 | $4,500 | $2,000 | $4,000 | $500 | $1,000 |
| OOP Maximum | $5,000 | $10,000 | $3,450 | $6,900 | $6,000 | $12,000 | $6,000 | $12,000 | $6,500 | $12,000 | $6,000 | $12,000 | $3,000 | $6,000 |
| Coinsurance | 20% | | 20% | | 10% | | 20% | | 0% | | 20% | | 20% | |
| **Office Visits** | | | | | | | | | | | | | | |
| PCP Office | $30 | | $25 | | $10 | | $25 | | $40 | | $25 | | $35 | |
| Specialist | $50 | | 20% after ded. | | N/A | | 20% | | $60 | | $40 | | $55 | |
| Emergency Room | $750 | | $75 + 20% | | $100+20% | | $350+20% | | $150 | | $250 + 20% | | $150 | |
| Urgent Care | $80 | | 20% after ded. | | $20 | | 20% | | $50 | | $25 | | $50 | |
| **Retail Rx** | | | | | | | | | | | | | | |
| Preferred Generic | $10 | | $7 | | $12 | | | | $15 | | $10 | | $15 | |
| Preferred Brand | $40 | | $30 | | 20%/$40 min/$80 max | | | | $40 | | $50 | | $40 | |
| Non-Preferred Brand | $75 | | $50 | | 30%/$80 min/$160 max | | | | $60 | | $80 | | $60 | |
| Specialty | 30% after ded.; $100 min/$250 max | | ShaRx | | 20%/$150 max; 30%/$350 max (preferred/non-preferred) | | | | 20%; $500 max | | N/A* | | N/A* | |

Source: Information provided by Milliman July 2026

# High-Deductible Plans: Local Comparators

PEBP vs. Washoe County and Carson City

| In-Network | PEBP | | Local Public Employers (High-Deductible, In-Network) | | | |
|---|---|---|---|---|---|---|
| | CDHP (PPO) PY2027 | | Washoe County (HDHP + HSA) | | Carson City (HD 10 + HSA) | |
| | Single | Family | Single | Family | Single | Family |
| Network | UHC Choice Plus / Sierra Care Options | | UHC Choice Plus | | Prominence / Cigna | |
| Deductible | $1,700 | $3,400 | $2,600 | $3,400 | $3,400 | $6,800 |
| OOP Maximum | $5,000 | $10,000 | $5,250 | $6,350 | $4,000 | $8,000 |
| Employer HSA Contribution | $700 + $200/dep (max 3) | | $2,250 | $2,500 | Unknown | |
| Coinsurance | 20% | | 20% | | 0% after ded. | |
| **Office Visits** | | | | | | |
| PCP Office | 20% after ded. | | $0 after ded. | | 0% after ded. | |
| Specialist | 20% after ded. | | $0 after ded. | | 0% after ded. | |
| Emergency Room | 20% after ded. | | 20% after ded. | | 0% after ded. | |
| Urgent Care | 20% after ded. | | 20% after ded. | | 0% after ded. | |
| **Retail Rx** | | | | | | |
| Preferred Generic | 20% after ded. | | $7 after ded. | | $15 after ded. | |
| Preferred Brand | 20% after ded. | | $30 after ded. | | $45 after ded. | |
| Non-Preferred Brand | 100% | | $50 after ded. | | $75 after ded. | |
| Specialty | 30% after ded. | | ShaRx after ded. | | 30% after ded.; $500 max | |

Source: Information provided by Milliman July 2026

# EPO Plan Design: Local Comparators

PEBP vs. Washoe County (Surest), Clark County (EPO), and CCSD (THT Signature/Advantage)

| In-Network | PEBP | | Local Public Employers (EPO, In-Network) | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | EPO PY2027 | | Washoe County (Surest) | | Clark County | | | | CCSD – Teachers Trust Signature | | | | CCSD – Teachers Trust Advantage (Tier 1) | | | |
| | Single | Family | Single | Family | Single | Family | Single | Family | Single | Family | Single | Family | Single | Family | Single | Family |
| Network | UHC EPO | | Optum Surest Network | | Tier 1: University Medical Center / Sierra Care Options | | Tier 2: UHC Choice Plus / Sierra Care Options | | Tier 1: Health Investment Plan | | Tier 2: Sierra Care Options | | Tier 1: Health Investment Plan | | Tier 2: Sierra Care Options | |
| Deductible | $100 | $200 | N/A | | $0 | $0 | $0 | $0 | $500 | $1,500 | $500 | $1,500 | $1,650 | $3,300 | $1,650 | $3,300 |
| OOP Maximum | $4,000 | $8,000 | $5,000 | $10,000 | $6,000 | $12,000 | $6,000 | $12,000 | $7,500 | $15,000 | $7,500 | $15,000 | $10,600 | $21,200 | $10,600 | $21,200 |
| Coinsurance | 20% | | N/A – fixed costs vary by service | | 0% | | 0% | | 20% | | 20% | | 20% | | 20% | |
| **Office Visits** | | | | | | | | | | | | | | | | |
| PCP Office | $20 | | $20-$105 | | $10 | | $30 | | $0 | | $15 | | $0 | | 20% | |
| Specialist | $40 | | $20-$105 | | N/A | | $60 | | $30 | | $30 | | $30 | | 20% | |
| Emergency Room | $600 | | $600 | | $500 | | $500 | | Not Covered | | $300/$750 (1st/subsequent visits) + 20% | | Not Covered | | $300/$750 (1st/subsequent visits) + 20% | |
| Urgent Care | $50 | | $60 | | $20 | | $20 | | $0 | | $30 | | $0 | | $30 | |
| **Retail Rx** | | | | | | | | | | | | | | | | |
| Preferred Generic | $10 | | $10 | | $25 | | | | $15 | | | | $15 | | | |
| Preferred Brand | $40 | | $60 | | $75 | | | | 25%; $100 max | | | | 25%; $100 max | | | |
| Non-Preferred Brand | $75 | | $90 | | $150 | | | | 40% | | | | 40% | | | |
| Specialty | 20% after ded.; $100-$250 | | $150-$3,000 | | 20%/$150 max; 30%/$350 max (preferred/non-preferred) | | | | 25%/$500 max; 40% (preferred/non-preferred) | | | | 25%/$500 max; 40% (preferred/non-preferred) | | | |

Source: Information provided by Milliman July 2026

# HMO Plan Design: Local Comparators

PEBP vs. CCSD and the City of Las Vegas (HPN and Value HMOs)

| In-Network | PEBP | | Local Public Employers (HMO, In-Network) | | | | | |
|---|---|---|---|---|---|---|---|---|
| | HMO PY2027 | | CCSD (HPN HMO) | | City of Las Vegas (HPN HMO) | | City of Las Vegas (Value HMO) | |
| | Single | Family | Single | Family | Single | Family | Single | Family |
| Network | Health Plan Nevada | | Health Plan Nevada | | Health Plan Nevada | | Health Plan Nevada | |
| Deductible | $0 | $0 | $1,000 | $2,000 | $0 | $0 | $5,000 | $10,000 |
| OOP Maximum | $5,000 | $10,000 | $6,850 | $13,700 | $6,000 | $12,000 | $6,850 | $13,700 |
| Coinsurance | N/A | | N/A | | N/A | | N/A | |
| **Office Visits** | | | | | | | | |
| PCP Office | $25 | | $20 | | $10 | | $10 | |
| Specialist | $25 w/ referral; $40 w/o | | $40 | | $10 | | $20 | |
| Emergency Room | $600 | | $750 after ded. | | $150 | | $1,000 after ded. | |
| Urgent Care | $50 | | $35 | | $15 | | $35 | |
| **Retail Rx** | | | | | | | | |
| Preferred Generic | $10 | | $20 | | $10 | | $25 | |
| Preferred Brand | $40 | | $50 | | $35 | | $50 | |
| Non-Preferred Brand | $75 | | $75 | | $55 | | $75 | |
| Specialty | 20% | | N/A* | | N/A* | | N/A* | |

Source: Information provided by Milliman July 2026

# POS Plan Design: Local Comparators

PEBP does not offer a POS plan; local options combine HMO and PPO network tiers

| In-Network | Local Public Employers (POS, In-Network) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | CCSD (HPN POS) | | | | City of Las Vegas (HPN POS) | | | | City of Las Vegas (Value POS) | | | |
| | Single | Family | Single | Family | Single | Family | Single | Family | Single | Family | Single | Family |
| Network | Tier 1 | | Tier 2 | | Tier 1 – HPN HMO | | Tier 2 – Sierra Care | | Tier 1 – HPN HMO | | Tier 2 – Sierra Care | |
| Deductible | $2,000 | $4,000 | $2,000 | $4,000 | $0 | $0 | $250 | $750 | $2,000 | $4,000 | $2,000 | $4,000 |
| OOP Maximum | $6,850 | $13,700 | $6,850 | $13,700 | $2,000 | $6,000 | $2,000 | $6,000 | $6,250 | $12,500 | $6,250 | $12,500 |
| Coinsurance | Copay-based | | 30% | | Copay-based | | 20% | | 30% | | 30% | |
| **Office Visits** | | | | | | | | | | | | |
| PCP Office | $15 | | 30% after ded. | | $10 | | $25 | | $25 | | $40 | |
| Specialist | $30 | | 30% after ded. | | $20 | | $45 | | $45 | | $60 | |
| Emergency Room | $500 after ded. | | $500 after ded. | | $150 | | $150 | | $350 + 30% after ded. | | $350 + 30% after ded. | |
| Urgent Care | $40 | | $40 | | $20 | | N/A | | $45 | | N/A | |
| **Retail Rx** | | | | | | | | | | | | |
| Preferred Generic | $10 | | | | $15 | | | | $25 | | | |
| Preferred Brand | $35 | | | | $40 | | | | $50 | | | |
| Non-Preferred Brand | $60 | | | | $60 | | | | $75 | | | |
| Specialty | N/A | | | | N/A | | | | N/A | | | |

Source: Information provided by Milliman July 2026

# Benchmarking

## State & National Comparators

Source: Information provided by Milliman July 2026

= *Richer than government benchmark*

= *Leaner than government benchmark*

# In-Network Plan Design Benchmarking – State / National

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

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

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

| In-Network | State of Nevada | | | | Benchmark - EPO/HMO Plans | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | EPO | | HPN (HMO) | | National - All | | Nevada | | Government Organization | | Large Employers (5,000+) | |
| | Single | Family | Single | Family | Single | Family | Single | Family | Single | Family | Single | Family |
| Deductible | $100 | $200 | N/A | N/A | $1,000 | $2,000 | $0 | $0 | $1,000 | $2,000 | $1,000 | $2,000 |
| OOP Maximum | $4,000 | $8,000 | $5,000 | $10,000 | $5,500 | $11,000 | $4,000 | $8,000 | $5,000 | $10,000 | $4,000 | $8,000 |
| **ER** | | | | | | | | | | | | |
| Emergency Room | $600 | | $600 | | $350 | | $200 | | $150 | | $150 | |

- **Deductible** is significantly richer than benchmarks for each plan type
- **Coinsurance, Office Visits, and Pharmacy Copays** are all in-line with benchmarks
- **Emergency Room** copay is much leaner than benchmarks (2 to 3 times other comparator groups) – we assume this is intentional to drive more efficient plan utilization

**Other benefits generally in line with benchmarks**

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



Source: Information provided by Milliman July 2026

# Plan Structure Benchmarking

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

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

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

} Northern / Southern

## PEBP vs. Milliman State & National Benchmarks

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

## PEBP vs. State Employee Plan Benchmarks

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

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



Source: Information provided by Milliman July 2026

# Price Transparency Analysis

Source: Information provided by Milliman July 2026

# Payer (TiC) Transparency Data

## Inpatient / Outpatient Overview

**Percent of Expected Color Coding**

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

**GVRU Medicare**

**Market Data Summary**

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

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

*Please refer to the following pages for additional information, caveats, and limitations about price transparency data summaries*

Source: Information provided by Milliman July 2026

# Hospital (HPT) Transparency Data

## Inpatient / Outpatient Overview

**Percent of Expected Color Coding**

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

**GVRU Medicare**

**Market Data Summary**

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

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

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

Source: Information provided by Milliman July 2026

# Provider Contracting Opportunities

Potential use cases for Price Transparency data

## What can PEBP do with this information?

- Explore reimbursement rates by service category in more detail for select providers – specifically outpatient where United may be less competitive than Anthem and others (e.g., Hometown)
- Understand opportunities to secure the best United rates (e.g., Sierra rates at Carson Tahoe)
- Consider direct contracts with certain providers (e.g., Dignity St. Rose Dominican, where inpatient reimbursement rates appear less competitive for United than other payers)
- Leverage this information as part of reference-based pricing discussions
- Push UMR and HPN to submit more complete data and/or provide additional rate information
  - Payer data with low completeness metrics may potentially indicate vendors are not fulfilling requirements to submit complete data as PEBP's plan administrators, ultimately limiting PEBP's ability to assess contract competitiveness and creating compliance risk for PEBP

Source: Information provided by Milliman July 2026

# Price Transparency Analysis – Background

Background and key information regarding how to interpret results

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

Source: Information provided by Milliman July 2026

# Price Transparency Analysis – Results Reliability and Credibility

Interpreting results – assessing reliability and credibility of comparisons

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

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

Source: Information provided by Milliman July 2026

# Price Transparency Analysis – Interpreting Results Data

Interpreting results – Transparency data vs. claims data

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

Source: Information provided by Milliman July 2026

# Price Transparency Analysis – Interpreting Results Guidelines

Interpreting results – guidelines to consider

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

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

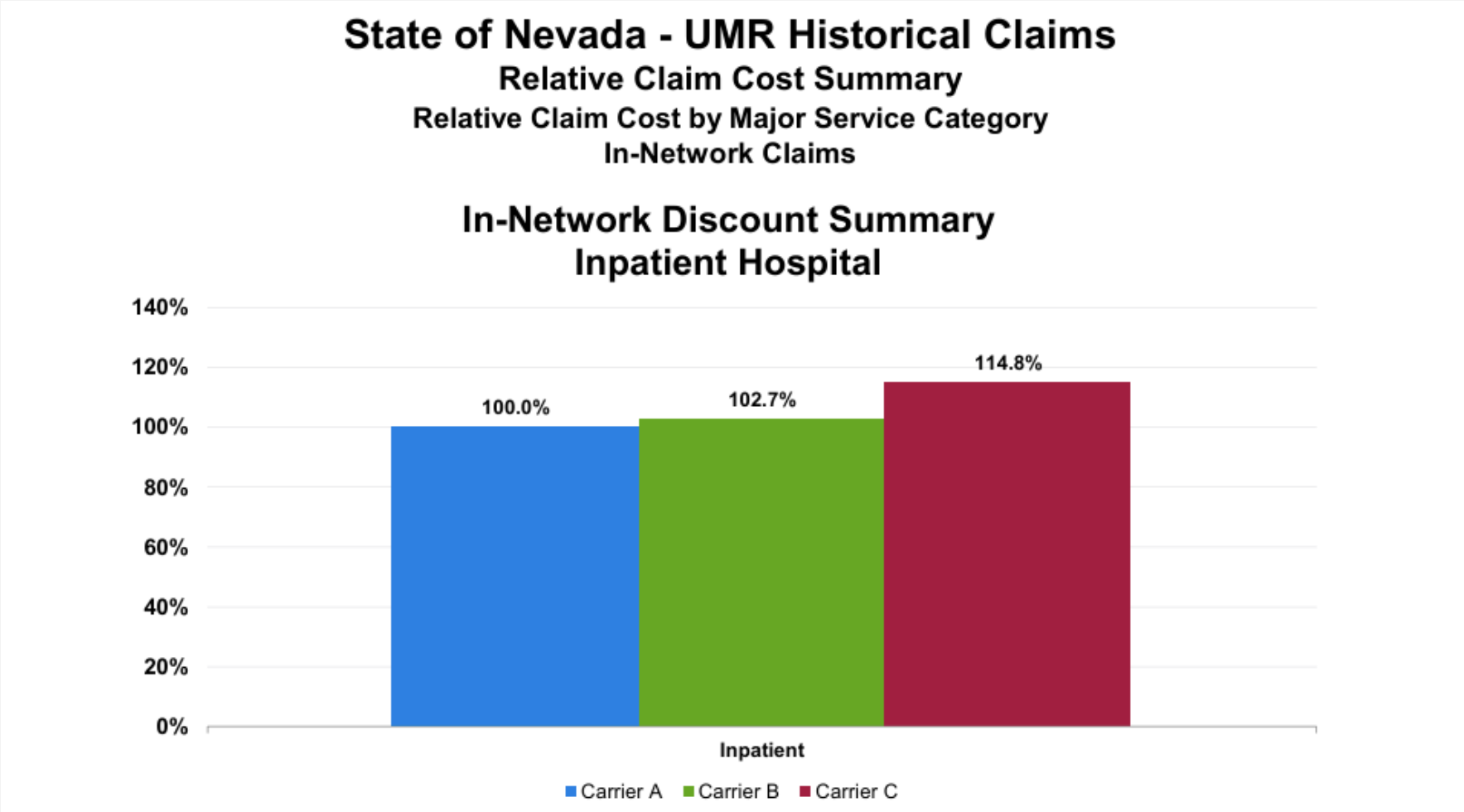
Source: Information provided by Milliman July 2026

# Network Discount / Disruption Analysis

Source: Information provided by Milliman July 2026

# Traditional Network Discount / Disruption Analysis – Inpatient Hospital

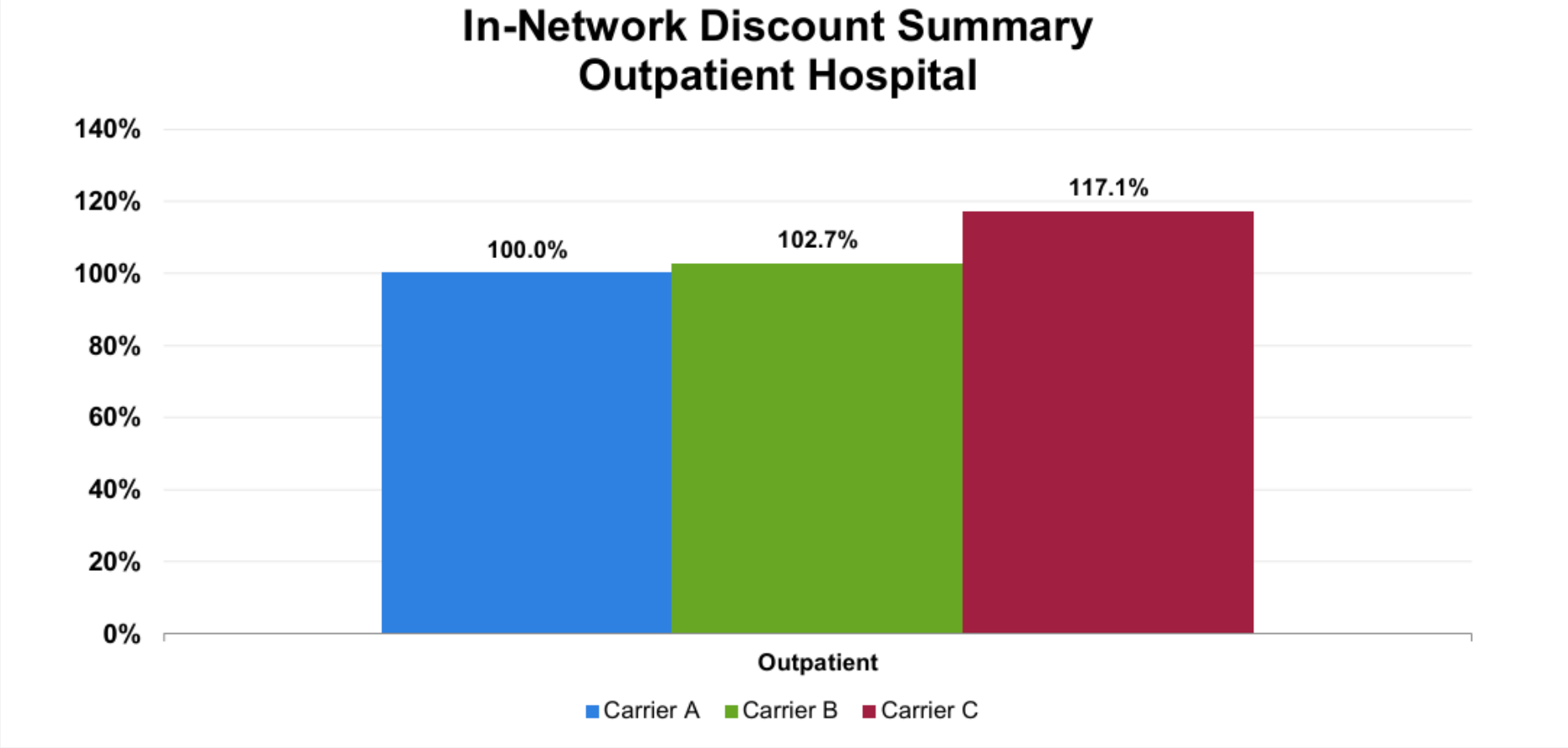
Results – discount relativity by service category / carrier – inpatient hospital




Source: Information provided by Milliman July 2026

# Traditional Network Discount / Disruption Analysis – Outpatient Hospital

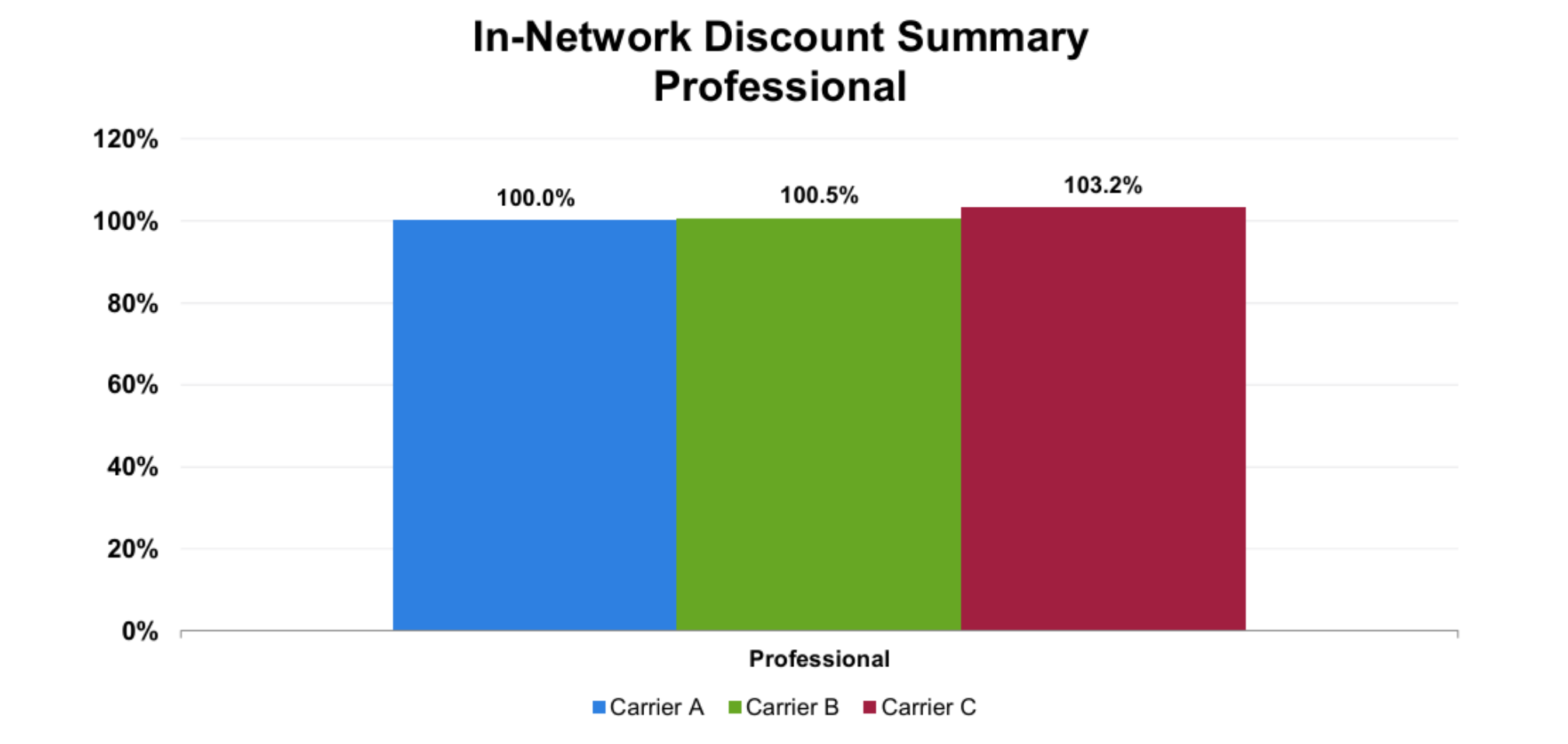
Results – discount relativity by service category / carrier – outpatient hospital




Source: Information provided by Milliman July 2026

# Traditional Network Discount / Disruption Analysis - Professional

Results – discount relativity by service category / carrier – professional




Source: Information provided by Milliman July 2026

# Network Discount / Disruption Analysis – Caveats and Limitations

Caveats and Limitations

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

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

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

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

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

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

Source: Information provided by Milliman July 2026

# Medicare Repricing Background

- PEBP approved a project for Segal to re-price claims on a percentage of Medicare equivalency
  - Medicare is a common reference price which seeks to normalize costs based on differences in mix of service acuity and other factors
- Segal analyzed results by:
  - Geographic location
  - Service category: inpatient facility, outpatient facility and professional services
  - Facility/provider
- Incorporated self-funded plans incurred claims from January 2025 - December 2025, paid through April 2026
- Eligible claims were re-priced as a percentage of Medicare according to Medicare logic and fee schedules published by Centers for Medicare and Medicaid Services (CMS)

Source: Segal Medicare Repricing Analysis July 2026

# Medicare Repricing Background (cont.)

- Re-pricing based on the Medicare Fee Schedules in effect at time services rendered to the patient
- Medicare re-pricing may not be available for:
  - Non-Medicare participating providers, provider type or healthcare services not covered by Medicare
- Excluded claims below 30% or above 2000% of Medicare and/or claims with billed amounts over $750,000 or allowed amounts over $250,000
  - 95% of claims were re-priced, which accounted for 85% of allowed claims
- In general, Medicare pricing is based on the estimated cost of inputs to deliver care, considering things like service acuity and geographic cost variances

Source: Segal Medicare Repricing Analysis July 2026

# Medicare Repricing Background (addtl.)

- Medicare rates can vary by hospital
  - E.g. teaching hospitals and critical access hospitals can receive additional reimbursements
  - There can also be varying cost-to-charge ratios
- A higher prevalence of claims paid below Medicare for outpatient hospital surgeries/procedures was noted and is not typical
  - Segal has questions out to UMR

Source: Segal Medicare Repricing Analysis July 2026

# Service Category Summary

*Excluding High Dollar Claimants*

| | In Network | Original Allowed | % of Medicare | Share |
|---|---|---|---|---|
| Inpatient Facility | Y | $41,671,021 | 163.6% | *100%* |
| Inpatient Facility | N | $37,531 | 210.9% | *0%* |
| Outpatient Facility | Y | $103,087,866 | 262.1% | *100%* |
| Outpatient Facility | N | $98,852 | 186.9% | *0%* |
| Professional Services | Y | $103,421,188 | 135.8% | *100%* |
| Professional Services | N | $593,289 | 210.3% | *0%* |
| Ancillary | Y | $7,222,099 | 174.2% | *97%* |
| Ancillary | N | $197,234 | 146.9% | *3%* |
| **Total** | | **$256,329,081** | **176.1%** | |
| | | | | |
| Inpatient Facility | All IN | $41,671,021 | 163.6% | |
| Outpatient Facility | All IN | $103,087,866 | 262.1% | |
| Professional Services | All IN | $103,421,188 | 135.8% | |
| Ancillary | All IN | $7,222,099 | 174.2% | |
| **Total** | | **$255,402,174** | **176.0%** | |

Source: Segal Medicare Repricing Analysis July 2026

# Facility Experience by Member Area

*Excluding High Dollar Claimants and Out-of-Network*

| | Member Region | Original Allowed | Medicare Allowed | % of Medicare |
|---|---|---|---|---|
| Inpatient Facility | Northern | $27,339,769 | $15,490,006 | 176.5% |
| Inpatient Facility | Southern | $11,826,316 | $8,713,898 | 135.7% |
| Inpatient Facility | Out of State | $2,504,935 | $1,264,379 | 198.1% |
| Outpatient Facility | Northern | $67,904,380 | $25,967,999 | 261.5% |
| Outpatient Facility | Southern | $29,473,471 | $11,645,441 | 253.1% |
| Outpatient Facility | Out of State | $5,710,016 | $1,725,524 | 330.9% |
| Professional Services | Northern | $60,943,235 | $41,384,174 | 147.3% |
| Professional Services | Southern | $38,315,025 | $32,009,806 | 119.7% |
| Professional Services | Out of State | $4,162,928 | $2,760,238 | 150.8% |
| Ancillary | Northern | $4,905,305 | $2,575,578 | 190.5% |
| Ancillary | Southern | $1,916,242 | $1,365,260 | 140.4% |
| Ancillary | Out of State | $400,552 | $206,194 | 194.3% |
| **Total** | | **$255,402,174** | **$145,108,497** | **176.0%** |
| Northern | All IN | $161,092,689 | $85,417,757 | 188.6% |
| Southern | All IN | $81,531,054 | $53,734,405 | 151.7% |
| Out of State | All IN | $12,778,431 | $5,956,335 | 214.5% |
| **Total** | | **$255,402,174** | **$145,108,497** | **176.0%** |

Source: Segal Medicare Repricing Analysis July 2026

# Service Detail

*Inpatient Facility*

| | Total | | Northern | | Southern | | Out of State | |
|---|---|---|---|---|---|---|---|---|
| | Original Allowed | % of Medicare | Original Allowed | % of Medicare | Original Allowed | % of Medicare | Original Allowed | % of Medicare |
| Medical | $17,293,444 | 179.7% | $10,747,683 | 195.6% | $5,345,933 | 150.7% | $1,199,828 | 206.6% |
| Surgery | $12,796,897 | 137.3% | $8,788,439 | 143.3% | $3,323,259 | 119.0% | $685,200 | 172.3% |
| Maternity | $5,761,168 | 184.1% | $3,900,976 | 216.9% | $1,626,904 | 135.1% | $233,288 | 184.0% |
| Neonate | $3,311,642 | 152.7% | $2,456,821 | 185.0% | $750,792 | 96.8% | $104,029 | 158.1% |
| Mental Health | $1,904,794 | 183.7% | $1,087,063 | 177.0% | $790,107 | 199.8% | $27,623 | 100.9% |
| SNF/Rehab | $640,607 | 314.9% | $385,640 | 280.6% | $0 | | $254,967 | 386.4% |
| **Total** | **$41,708,552** | **163.7%** | **$27,366,622** | **176.5%** | **$11,836,994** | **135.8%** | **$2,504,935** | **198.1%** |

Source: Segal Medicare Repricing Analysis July 2026

# Service Detail

*Outpatient Facility*

| | Total | | Northern | | Southern | | Out of State | |
|---|---|---|---|---|---|---|---|---|
| | Original Allowed | % of Medicare | Original Allowed | % of Medicare | Original Allowed | % of Medicare | Original Allowed | % of Medicare |
| Surgery | $34,328,655 | 171.3% | $24,077,535 | 185.9% | $7,952,549 | 129.4% | $2,298,570 | 244.8% |
| ER | $33,491,508 | 496.9% | $16,953,330 | 469.2% | $15,490,082 | 530.1% | $1,048,097 | 512.4% |
| Observation/Treatment Room | $1,189,241 | 346.4% | $1,040,940 | 355.0% | $129,792 | 306.7% | $18,508 | 237.7% |
| Urgent Care Visits | $3,377,556 | 132.2% | $1,982,588 | 130.2% | $1,311,977 | 134.9% | $82,991 | 137.4% |
| Cardiovascular | $2,138,952 | 315.4% | $1,625,757 | 306.0% | $301,554 | 316.2% | $211,641 | 411.1% |
| Dialysis | $690,906 | 771.6% | $308,691 | 778.0% | $298,069 | 795.4% | $84,145 | 679.5% |
| GI Services | $710,955 | 152.9% | $448,844 | 156.4% | $203,660 | 138.1% | $58,451 | 192.0% |
| Pharmacy | $4,046,300 | 477.9% | $3,651,460 | 447.7% | $228,634 | 1260.5% | $166,206 | 1278.8% |
| Preventive | $2,694,764 | 163.6% | $1,881,239 | 158.0% | $614,454 | 167.1% | $199,071 | 223.6% |
| Lab/Pathology | $2,541,580 | 245.5% | $1,761,001 | 199.8% | $565,913 | 571.7% | $214,665 | 390.4% |
| Radiology | $10,484,804 | 420.8% | $8,532,379 | 409.0% | $1,211,798 | 474.3% | $740,627 | 492.6% |
| Mental Health | $839,139 | 199.8% | $639,785 | 222.1% | $171,567 | 134.4% | $27,787 | 653.6% |
| PT/OT/ST | $1,616,226 | 516.2% | $1,248,963 | 527.6% | $201,679 | 415.3% | $165,584 | 595.5% |
| Other Services | $5,036,134 | 291.6% | $3,821,585 | 303.5% | $814,712 | 212.1% | $399,837 | 475.2% |
| **Total** | **$103,186,719** | **261.9%** | **$67,974,099** | **261.5%** | **$29,496,440** | **252.9%** | **$5,716,180** | **330.5%** |

Source: Segal Medicare Repricing Analysis July 2026

# Service Detail

*Professional Services*

| | Total | | Northern | | Southern | | Out of State | |
|---|---|---|---|---|---|---|---|---|
| | Original Allowed | % of Medicare | Original Allowed | % of Medicare | Original Allowed | % of Medicare | Original Allowed | % of Medicare |
| Evaluation and Management | $22,226,478 | 114.6% | $13,934,301 | 132.1% | $7,305,564 | 90.3% | $986,614 | 131.4% |
| Preventive | $9,481,530 | 147.6% | $5,963,035 | 168.5% | $3,128,338 | 117.8% | $390,158 | 172.1% |
| Mental Health | $8,278,256 | 92.2% | $5,770,973 | 93.3% | $2,204,997 | 88.3% | $302,286 | 101.7% |
| Surgery | $12,632,932 | 160.3% | $8,380,980 | 179.7% | $3,649,970 | 127.0% | $601,983 | 176.8% |
| Maternity | $1,312,727 | 138.7% | $863,796 | 154.5% | $399,453 | 113.0% | $49,478 | 147.5% |
| Anesthesia | $4,326,648 | 624.6% | $2,544,201 | 638.5% | $1,568,771 | 598.3% | $213,676 | 667.4% |
| Inpatient Visits | $3,612,768 | 200.0% | $2,287,326 | 256.5% | $1,123,842 | 135.5% | $201,600 | 237.2% |
| ER and OBS Visits | $5,365,948 | 338.5% | $3,100,042 | 360.2% | $2,099,336 | 311.4% | $166,570 | 330.8% |
| Lab/Pathology | $7,552,210 | 118.7% | $2,537,783 | 92.9% | $4,761,518 | 139.7% | $252,909 | 114.3% |
| Radiology | $6,997,108 | 151.3% | $3,298,875 | 161.6% | $3,335,274 | 138.3% | $362,958 | 210.9% |
| Therapies | $3,049,899 | 74.7% | $1,804,402 | 80.0% | $1,074,561 | 65.9% | $170,935 | 87.1% |
| Allergy Services | $605,489 | 128.2% | $421,198 | 140.1% | $165,618 | 103.4% | $18,673 | 158.1% |
| Exams | $945,758 | 132.3% | $565,879 | 153.4% | $309,930 | 105.0% | $69,949 | 137.4% |
| Office Administered Drugs | $13,064,720 | 142.4% | $7,404,279 | 163.1% | $5,431,262 | 122.4% | $229,178 | 118.6% |
| Medical Services | $4,562,006 | 138.1% | $2,533,594 | 148.0% | $1,849,942 | 125.8% | $178,470 | 146.8% |
| **Total** | **$104,014,477** | **136.1%** | **$61,410,665** | **147.6%** | **$38,408,376** | **119.8%** | **$4,195,437** | **150.7%** |

Source: Segal Medicare Repricing Analysis July 2026

# Service Detail

*Ancillary*

| | Total | | Northern | | Southern | | Out of State | |
|---|---|---|---|---|---|---|---|---|
| | Original Allowed | % of Medicare | Original Allowed | % of Medicare | Original Allowed | % of Medicare | Original Allowed | % of Medicare |
| Ambulance | $4,333,179 | 420.3% | $3,178,042 | 514.7% | $942,234 | 261.6% | $212,904 | 399.7% |
| DME/Prosthetics | $2,624,307 | 90.9% | $1,653,189 | 89.6% | $804,745 | 87.5% | $166,373 | 135.5% |
| Other Services | $461,847 | 126.9% | $238,656 | 105.7% | $200,224 | 187.8% | $22,967 | 73.0% |
| **Total** | **$7,419,334** | **173.3%** | **$5,069,887** | **188.6%** | **$1,947,202** | **140.5%** | **$402,244** | **193.8%** |

Source: Segal Medicare Repricing Analysis July 2026

# Pharmacy Benefit Considerations

Source: Information provided by Milliman July 2026

# PEBP Pharmacy Benefit Current State

**Key Takeaways**

- **Pharmacy cost pressure is elevated:** PY2025 allowed PMPM is $192 with 7.9% trend, despite no broad GLP-1 weight-loss coverage.
- **Spend is highly concentrated:** Specialty represents 53.8% of allowed on a small share of utilization, making it the biggest structural cost driver.
- **GLP-1s are now a material driver:** GLP-1s account for 12.9% of allowed; among members with diabetes, utilization is high while adherence (50-60%) suggests avoidable waste and variable outcomes.
- **Implication:** The largest opportunities are in contracting discipline, GLP-1 management, specialty controls, and rebate strategy.

| Top Drug Classes by Allowed | PY2025 Allowed PMPM | % of Total Rx |
|---|---|---|
| Diabetes | $36.53 | 19.0% |
| Autoimmune Disease* | $22.82 | 11.9% |
| Psoriasis* | $18.84 | 9.8% |
| Oncology* | $13.53 | 7.0% |
| Skin Disorders* | $10.43 | 5.4% |
| Viral Infections/HIV AIDS | $7.84 | 4.1% |
| Asthma/COPD | $7.60 | 4.0% |
| Vaccines/Immunizing Agents | $6.50 | 3.4% |
| Migraine | $5.91 | 3.1% |
| Multiple Sclerosis/Neuromuscular Disorders* | $5.90 | 3.1% |

*Specialty drug class

| | | |
|---|---|---|
| **$114.7M**<br>PY2025 Total Allowed | **$192.00**<br>PY2025 Total Allowed PMPM | **7.9%**<br>PY24 to PY25 Allowed PMPM Trend |
| **53.8%**<br>Specialty as % of Allowed | **87%**<br>Generic Dispensing Rate | **12.9%**<br>GLP-1 as % of Allowed |

Source: https://www.pebp.nv.gov/siteassets/content/meetings/2026/may/8.-segal-presentation.pdf



Source: Information provided by Milliman July 2026

# GLP-1 Overview

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

**40% (1,798 members)**

of enrolled PEBP diabetic members utilize GLP-1's

**$14.8M**

GLP-1 spend in PY2025

Source: May 2026 PEBP Board Meeting

# GLP-1 Experience Monitoring

*Methodology and Limitations*

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

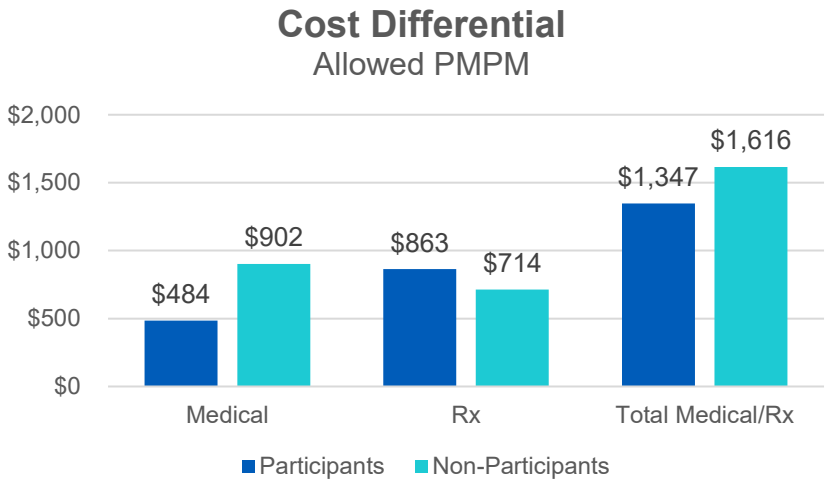
Source: May 2026 PEBP Board Meeting

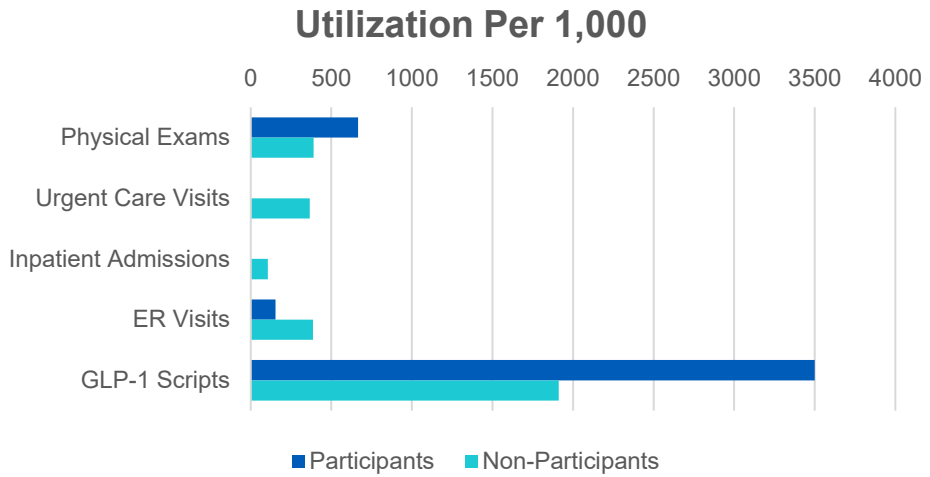
# GLP-1 Analysis – Methodology & Limitations

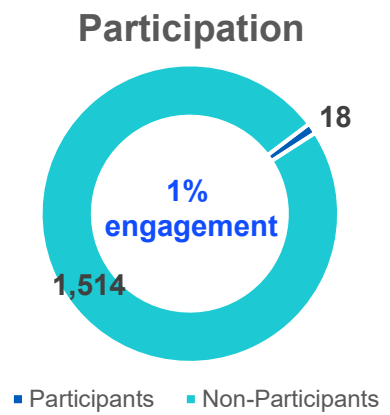
- Medication adherence is measured based on the proportion of days covered (PDC) methodology, which is the standard used by the Pharmacy Quality Alliance and Medicare. PDC accounts for the total days of therapy available to an individual (days covered) within a standardized window. For members receiving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

Source: May 2026 PEBP Board Meeting

# Diabetes Care Management Program*



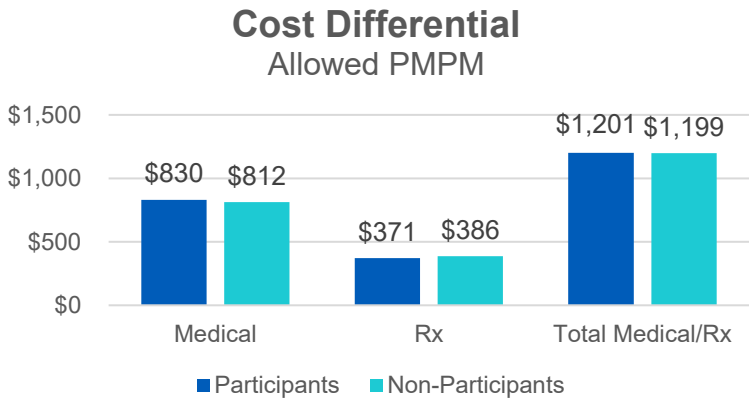

| Metric* | Participants | Non-Participants |
|---|---|---|
| Avg. Total Risk Score | 11.0 | 13.9 |
| Avg, # Conditions | 2.9 | 3.5 |
| A1 Screening | 100% | 85% |
| Retinopathy Screening | 72% | 64% |
| Nephropathy Screening | 28% | 24% |
| LDL Cholesterol Screening | 100% | 79% |

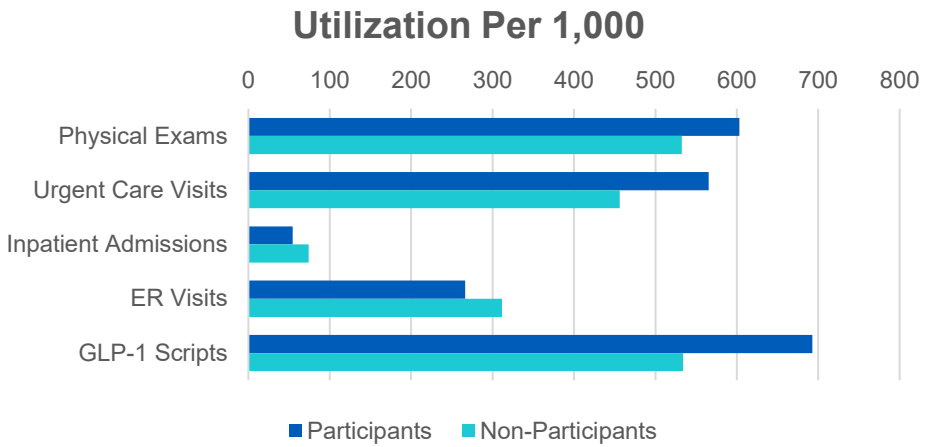
*Based on medical and Rx claims incurred in CY2025 and paid through February 2026. Given small participation size, results are not credible and could vary significantly year to year.

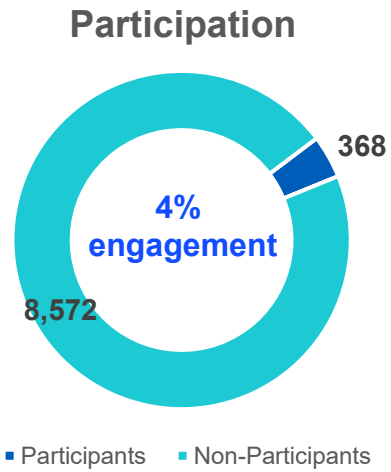
- Program developed by PEBP and offered only to CDHP participants
  - Included as a part of the base administrative fee
  - Low engagement
  - Those who participate are doing so largely to access medications prior to meeting CDHP deductible
- For the small sample of participants:
  - Medical costs for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

Source: May 2026 PEBP Board Meeting

# Obesity Care Management Program*



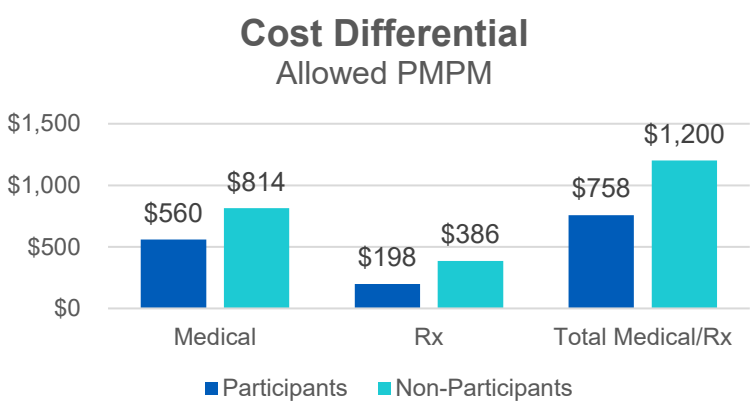

| Metric* | Participants | Non-Participants |
|---|---|---|
| Avg. Total Risk Score | 13.2 | 12.0 |
| Avg, # Conditions | 2.0 | 1.8 |
| Diabetics | | |
| A1c Screening | 85% | 87% |
| Retinopathy Screening | 38% | 65% |
| Nephropathy Screening | 23% | 30% |
| LDL Cholesterol Screening | 85% | 81% |
| Hyperlipidemia | | |
| Total Cholesterol | 87% | 80% |
| Hypertension | | |
| Annual Physical | 100% | 97% |

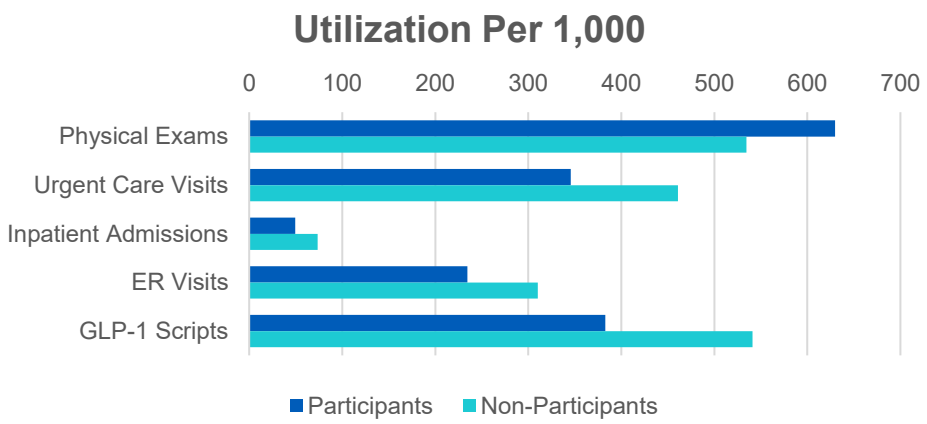
- Program was developed by PEBP and included in base administrative fee
- Higher participation than the other programs evaluated, but still low engagement (4%)
- Engaged members have higher risk scores and average more conditions, but overall costs are similar between participants and non-participants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

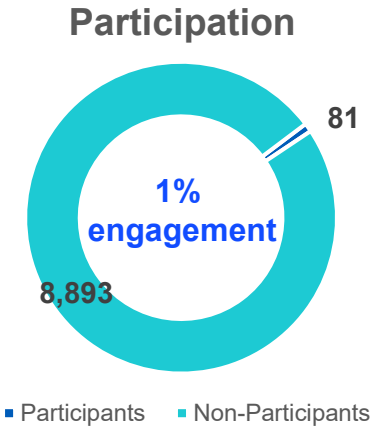
*Based on medical and Rx claims incurred in CY2025 and paid through February 2026. Given small participation size, results are not credible and could vary significantly year to year.

Source: May 2026 PEBP Board Meeting

# Real Appeal




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

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

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

Source: May 2026 PEBP Board Meeting

# Nevada Business Group on Health

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

Source: May 2026 PEBP Board Meeting

# Condition-Specific Program Analysis

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

Source: May 2026 PEBP Board Meeting

# Caveats and Limitations on Use

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

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

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

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

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

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

Source: Information provided by Milliman July 2026

# Thank You

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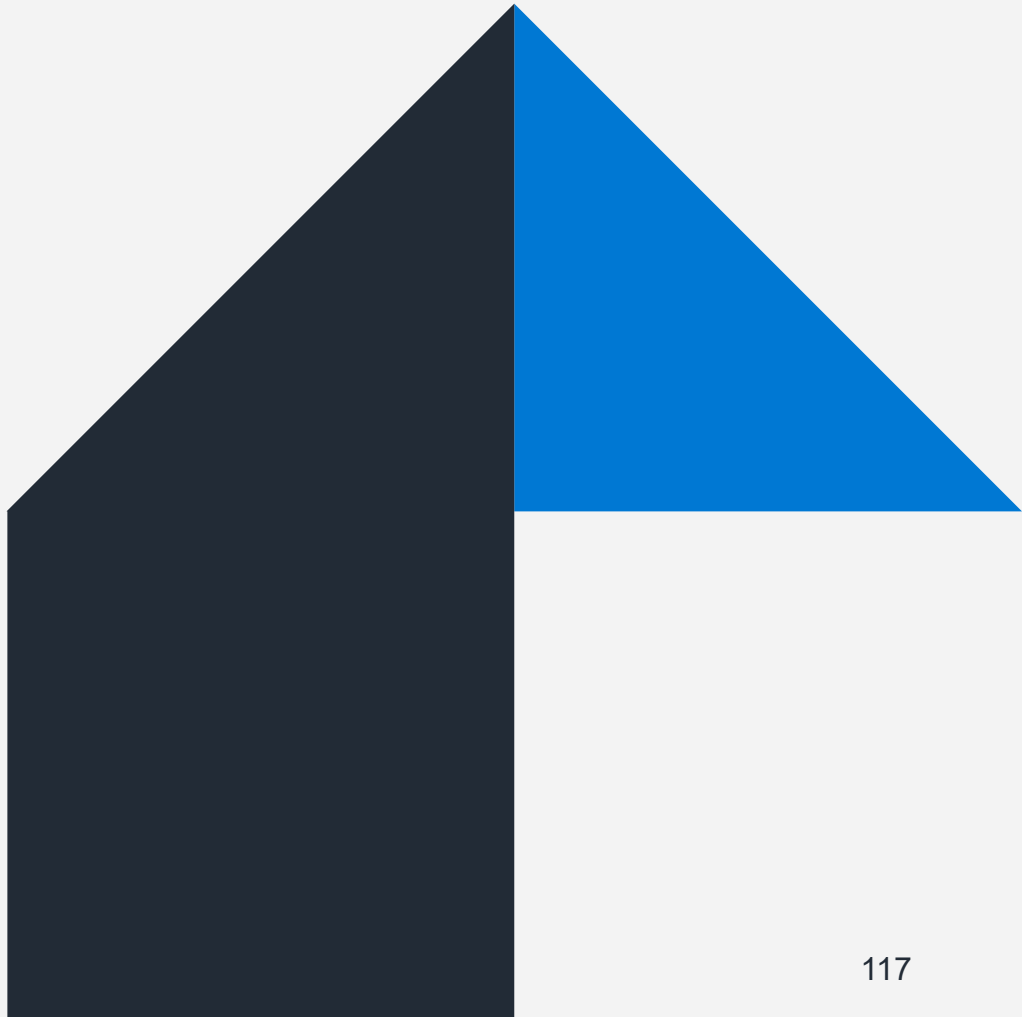

Source: Information provided by Milliman July 2026

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