



Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY

PUBLIC EMPLOYEES' BENEFITS PROGRAM

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Stacie Weeks
Director



Theresa Carsten
Executive Officer

NOTICE AND AGENDA OF STRATEGIC PLANNING RETREAT

Name of Organization: Public Employees' Benefits Program

Date and Time of Meeting: July 23, 2026 9:00 a.m.

Physical Meeting Location: 9850 Double R Boulevard, Suite 200 Reno, NV 89521

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

AGENDA

1. Open Meeting; Roll Call.

2. Public Comment.

Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda as an item on which action may be taken. Public comments to the Board will be taken under advisement but will not be answered during the meeting. At the discretion of the chair, the time for each individual to make comment, as well as the aggregate time for public comment, may be reasonably limited. Any such limitations will be announced at the beginning of the comment period. Additional comment periods, subject to similar limitations as announced by the chair, may be allowed on individual agenda items at the discretion of the chair. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the Board. Persons who wish to make comments not subject to a potential time limit may submit their public comment in writing by uploading a document to the [Public Comment Upload Form](#) located under [Contact Us](#) on the PEBP website, <https://www.pebp.nv.gov/>, no later than two business days prior to the meeting. **If you need ADA accommodation, please let us know by 4:00 pm two days before the board meeting so that we may make appropriate arrangements.** Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Jose Rivera, Deputy Attorney General) (Information/Discussion)
4. Approval of Action Minutes from the May 21, 2026 PEBP Board Meeting. (Jim Wells, Board Chair) **(For Possible Action)**
5. Strategic Planning Session. (Andrew Sherman, Segal) **(For Possible Action)**
Facilitated discussion providing a forum for the Board to examine priorities, goals, and strategies for PEBP to consider pursuing, including no more than one hour of discussion each regarding the following topics:
- (a) General plan design;
 - (b) Composition of risk pools used to determine rates;
 - (c) Contracting procedures, including current and potential future contracts;
 - (d) Pharmacy benefits offered by PEBP, including potential coordination with the Nevada Health Authority; and
 - (e) Disease management/care coordination;
- as well as additional discussion topics that arise from the Board's conversation. It is contemplated that this session will result in direction to relevant vendors/staff to prepare presentations for Board consideration and possible action at future meeting(s).

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

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at <https://www.pebp.nv.gov/meetings-events/current-board-meetings/> (under the Board Meeting date referenced above). For additional information contact Jessica Crane at PEBP, 3427 Goni Rd, Suite 109, Carson City, NV 89706, (775) 684-7020 or (800) 326-5496.

An item raised during a report or public comment may be discussed but may not be deliberated or acted upon unless it is on the agenda as an action item.

All times are approximate. The Board reserves the right to take items in a different order or to combine two or more agenda items for consideration to accomplish business in the most efficient manner. The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time.

We are pleased to make reasonable efforts to assist and accommodate persons with physical disabilities who wish to participate in the meeting. If special arrangements for the meeting are necessary, please notify the PEBP in writing, at 3427 Goni Rd, Suite 109, Carson City, NV 89706, or call Jessica Crane at (775) 684-7020 or (800) 326-5496, as soon as possible so that reasonable efforts can be made to accommodate the request.

Copies of both the PEBP Meeting Action Minutes and Meeting Transcripts, if such transcripts are prepared, are available for inspection, at no charge, at the PEBP Office, 3427 Goni Rd, Suite 109, Carson City, NV 89706 or on the PEBP website at <https://www.pebp.nv.gov/>. For additional information, contact Jessica Crane at (775) 684-7020 or (800) 326-5496.

Notice of this meeting was posted on or before 9:00 a.m. on the third working day before the meeting on the PEBP website at <https://www.pebp.nv.gov/>, at the office of the public body and to the public notice website for meetings at <https://notice.nv.gov>. In addition, the agenda was e-mailed to groups and individuals as requested.

1.

1. Open Meeting; Roll Call.

2.

2. Public Comment.

3.

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

4.

4. Approval of Action Minutes from the May 21, 2026 PEBP Board Meeting. (Jim Wells, Board Chair) **(For Possible Action)**

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

Video/Telephonic Open Meeting
Carson City

ACTION MINUTES (Subject to Board Approval)

May 21, 2026

**MEMBERS PRESENT
IN PERSON:**

Mr. Jim Wells, Board Chair
Ms. Blaine Harper, Member
Mr. Jim Barnes, Member
Ms. Keiko Duncan, Member
Ms. Laura Rich, Member
Dr. Jennifer McClendon, Member

**MEMBERS PRESENT VIA
TELECONFERENCE:**

Ms. Joy Grimmer, Vice Chair
Mr. Tom Zumtobel, Member
Mr. Paul Davis, Member

MEMBERS EXCUSED:

Mr. Christopher Viton, Member

FOR THE BOARD:

Mr. Gabriel Lither, Deputy Attorney General

FOR STAFF:

Ms. Theresa Carsten, Executive Officer
Mr. Nik Proper, Operations Officer
Ms. Brandee Mooneyhan, Lead Insurance Counsel
Ms. Monica McJoy, Chief Financial Officer
Ms. Jessica Crane, Executive Assistant

OTHER PRESENTERS:

Kurt Schlicker, Eide Bailly
Ross Armstrong, Ethics Commission
Debbie Donaldson, Segal
Amy McClendon, Segal
Amy Donohue, Express Scripts
Amy Daily, Express Scripts
Stacy McHugh, Express Scripts
Rhonda Huckaby, UMR
Neil Boyce, UHC
Jesse Stockwell, UMR
Alex Brochu, Carrum Health

1. Open Meeting; Roll Call.
 - Board Chair Wells opened the meeting at 9:02 a.m.
2. Public Comment.
 - Kent Ervin, NV Faculty Alliance
 - Noah Lowdermilk, Member
 - Doug Unger, UNLV Advisory Committee
3. PEBP Board disclosures for applicable Board meeting agenda items. (Gabriel Lithier, Deputy Attorney General) (Information/Discussion)
4. Approval of Action Minutes from the March 19, 2026 PEBP Board Meeting. (Jim Wells, Board Chair) **(For Possible Action)**

BOARD ACTION ON ITEM 4

MOTION: Motion to approve action minutes.

BY: Member, Jim Barnes

SECOND: Member, Keiko Duncan

VOTE: Unanimous, the motion carried

5. Discussion and acceptance of Eide Bailly's audited financial statement: Self Insurance Internal Service Fund. (Kurt Schlicker, Eide Bailly) **(For Possible Action)**

BOARD ACTION ON ITEM 5

MOTION: Motion to accept the audited financial statements.

BY: Member, Jennifer McClendon

SECOND: Member, Laura Rich

VOTE: Unanimous, the motion carried

6. Presentation on HIPAA. (Brandee Mooneyhan, Lead Insurance Counsel) (Information/Discussion)
7. Presentation on Ethics in Government. (Ross Armstrong, Nevada Commission on Ethics) (Information/Discussion)
8. Presentation on Program Overview. (Debbie Donaldson, Segal) **(For Possible Action)**
 - 8.1 GLP-1 Utilization
 - 8.2 Obesity and Weight Management

BOARD ACTION ON ITEM 8

MOTION: No action taken.

9. Review and discussion of Express Scripts, Inc. programs. (Amy Donohue, ESI) **(For Possible Action)**
 - 9.1 Pharmacy Benefit Manager Programs
 - 9.2 Hinge Health

BOARD ACTION ON ITEM 9

MOTION: No action taken.

10. Review and discussion of UMR programs. (UMR) (**For Possible Action**)

10.1 Obesity Care and Diabetes Care Management

10.2 2ndMD

10.3 Real Appeal

10.4 Doctor on Demand

BOARD ACTION ON ITEM 10

MOTION: No action taken.

11. Review and discussion of Carrum Health programs. (Alex Brochu, Carrum Health)
(**For Possible Action**)

11.1 Knee, Hip, Shoulder, Spine, Heart

11.2 Weight Loss Surgeries

11.3 Cancer Care

BOARD ACTION ON ITEM 11

MOTION: No action taken.

12. Executive Officer Report. (Nik Proper, Operations Officer on behalf of Theresa Carsten, Executive Officer) (Information/Discussion)

13. Contract Status Report. (Brandee Mooneyhan, Lead Insurance Counsel) (**For Possible Action**)

13.1 Contract Overview

13.2 New Contracts

13.3 Contract Amendments

13.4 Status of Current Solicitations

BOARD ACTION ON ITEM 13

MOTION: Motion to approve the contract amendment with Express Scripts through June 30th, 2028.

BY: Member, Jim Barnes

SECOND: Member, Jennifer McClendon

VOTE: Ayes: 5

Nays: 2

Motion passed

14. SFY26 Q3 Budget Report (Monica McJoy, Chief Financial Officer) (Information/Discussion)

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

16. Adjournment.

BOARD ACTION ON ITEM 14

MOTION: Motion to adjourn at 2:50 p.m.

BY: Member, Jim Barnes

SECOND: Member, Keiko Duncan

VOTE: Unanimous, the motion carried

5.

5. Strategic Planning Session. (Andrew Sherman, Segal) **(For Possible Action)**

Facilitated discussion providing a forum for the Board to examine priorities, goals, and strategies for PEBP to consider pursuing, including no more than one hour of discussion each regarding the following topics:

- (a) General plan design;
- (b) Composition of risk pools used to determine rates;
- (c) Contracting procedures, including current and potential future contracts;
- (d) Pharmacy benefits offered by PEBP, including potential coordination with the Nevada Health Authority; and
- (e) Disease management/care coordination; as well as additional discussion topics that arise from the Board's conversation. It is contemplated that this session will result in direction to relevant vendors/staff to prepare presentations for Board consideration and possible action at future meeting(s).



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

¹PEBP 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 • 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 \$3,400 Family	\$300 Individual \$600 Family	\$100 Individual \$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 \$10,000 Family \$5,000 Individual Family Member OOPM	\$5,000 Individual \$10,000 Family \$5,000 Individual Family Member OOPM	\$4,000 Individual \$8,000 Family \$4,000 Individual Family Member OOPM	\$5,000 Individual \$10,000 Family \$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 \$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 \$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.				

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 +\$200 per dep (max 3)	N/A	N/A	N/A
Annual Deductible	\$1,700 Individual \$3,400 Family \$3,400 Individual Family Member Deductible	\$300 Individual \$600 Family	\$100 Individual \$200 Family \$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 \$10,000 Family	\$5,000 Individual \$10,000 Family	\$4,000 Individual \$8,000 Family	\$5,000 Individual \$10,000 Family
Primary Care/ Specialist Office Visit	20% after deductible	\$30/ \$50 copay per visit	\$20/ \$40 copay per visit	\$25/ \$40 (\$25 with referral) 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 \$50 copay Hospital \$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 <i>(medical and prescription* combined)</i>	\$1,750 Individual \$3,500 Family • \$2,800 Individual Family Member Deductible	\$500 Individual \$1,000 Family • \$500 Individual Family Member Deductible	N/A With exception of Tier 4 prescription drug coverage, see prescription overview	\$150 Individual \$300 Family • \$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 \$10,000 Family • \$6,850 Individual Family Member Max Out-of-Pocket	\$5,000 Individual \$10,000 Family • \$5,000 Individual Family Member Max Out-of-Pocket	\$5,000 Individual \$10,000 Family • \$5,000 Individual Family Member Max Out-of-Pocket	\$5,000 Individual \$10,000 Family • \$5,000 Individual Family Member Max Out-of-Pocket

Fixed Cost Plan Elements

Trended from PY2022 Compared to Approved for PY2027

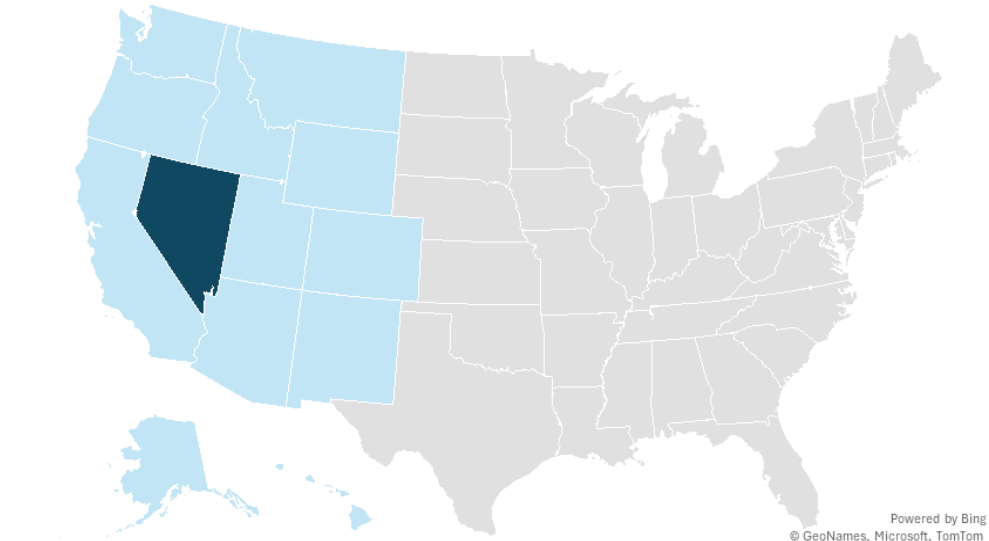
	PY2027			Illustrative: PY2022 if Trended to PY2027		
	CDHP	LDPPPO	EPO	CDHP	LDPPPO	EPO
HSA/HRA Contributions	\$700 PEPY +\$200 per dependent (max 3)	--	--	\$722 PEPY	--	--
Annual Deductible	\$1,700 Individual \$3,400 Family	\$300 Individual \$600 Family	\$100 Individual \$200 Family	\$2,100 Individual \$4,200 Family	\$600 Individual \$1,200 Family	\$180 Individual \$360 Family
Out-of-Pocket Maximum	\$5,000 Individual \$10,000 Family	\$5,000 Individual \$10,000 Family	\$4,000 Individual \$8,000 Family	\$6,000 Individual \$12,000 Family	\$6,000 Individual \$12,000 Family	\$6,000 Individual \$12,000 Family
Primary Care/ Specialist Office Visit	20% coinsurance	\$30/ \$50 copay per visit	\$25/ \$40 copay per visit	20% coinsurance	\$36/ \$60 copay per visit	\$30/ \$48 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
Retail90/Mail	20% coinsurance	\$20 / \$80 / \$150	\$20 / \$80 / \$150	20% coinsurance	\$30 / \$124 / \$232	\$30 / \$124 / \$232
Specialty	30% coinsurance (\$100 min/\$250 max) ¹	30% coinsurance (\$100 min/\$250 max) ¹	30% coinsurance (\$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.

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



Summary of Network Plan Designs and Premiums

PPO Comparison

	LDPPO	Benchmarking Data	Benchmarking Data	Benchmarking Data
		Richest	Leanest	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 richest 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	Benchmarking Data	Benchmarking Data
		Richest	Leanest	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. Source: January 2026 PEBP Board Meeting
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 richest and leanest comparison columns.
Benchmark plan designs and contributions effective on January 1, 2026.

Local Comparator Benchmarking

Key observations comparing PEBP to local municipalities

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

Local comparators include:

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

PEBP vs. Comparator Premium Contributions

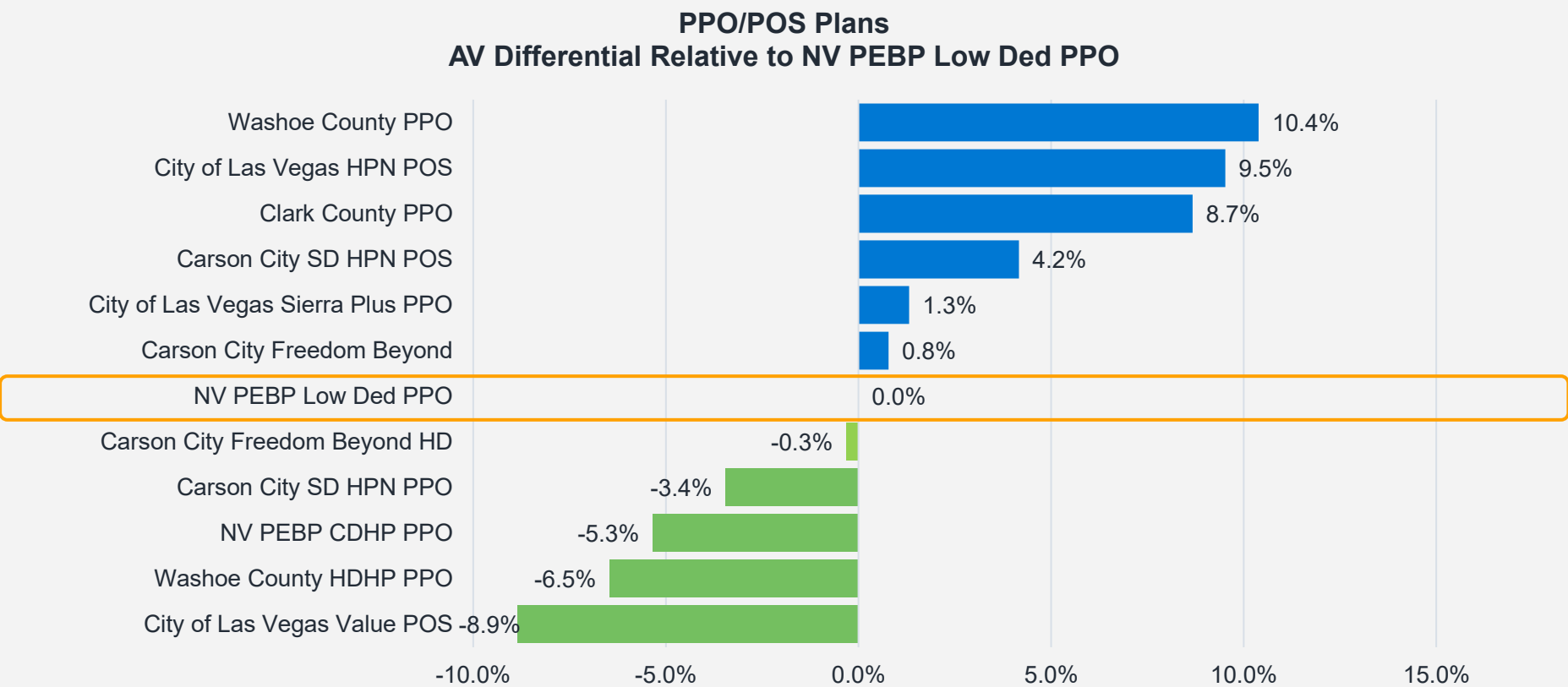
Premium contribution information was available for four of the five* comparators

- 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*

PEBP vs. Local Comparators PPO/POS plans

Actuarial value differentials – PPO/POS plans



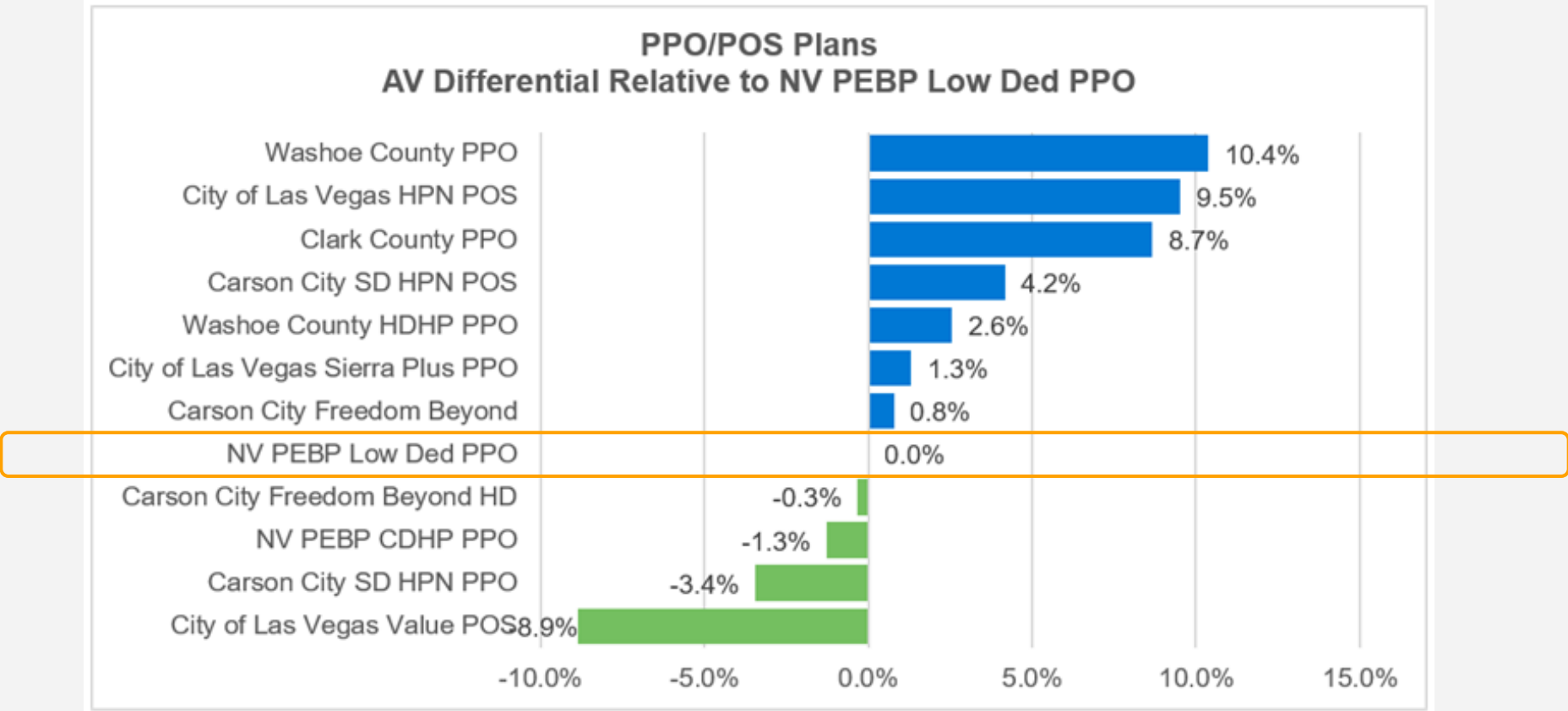
Plans with a negative differential compared to the PEBP LDPPO are leaner (i.e., benefits are less generous / member cost sharing is generally higher); plans with a positive differential are richer (i.e., benefits are more generous / member cost sharing is generally lower).

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

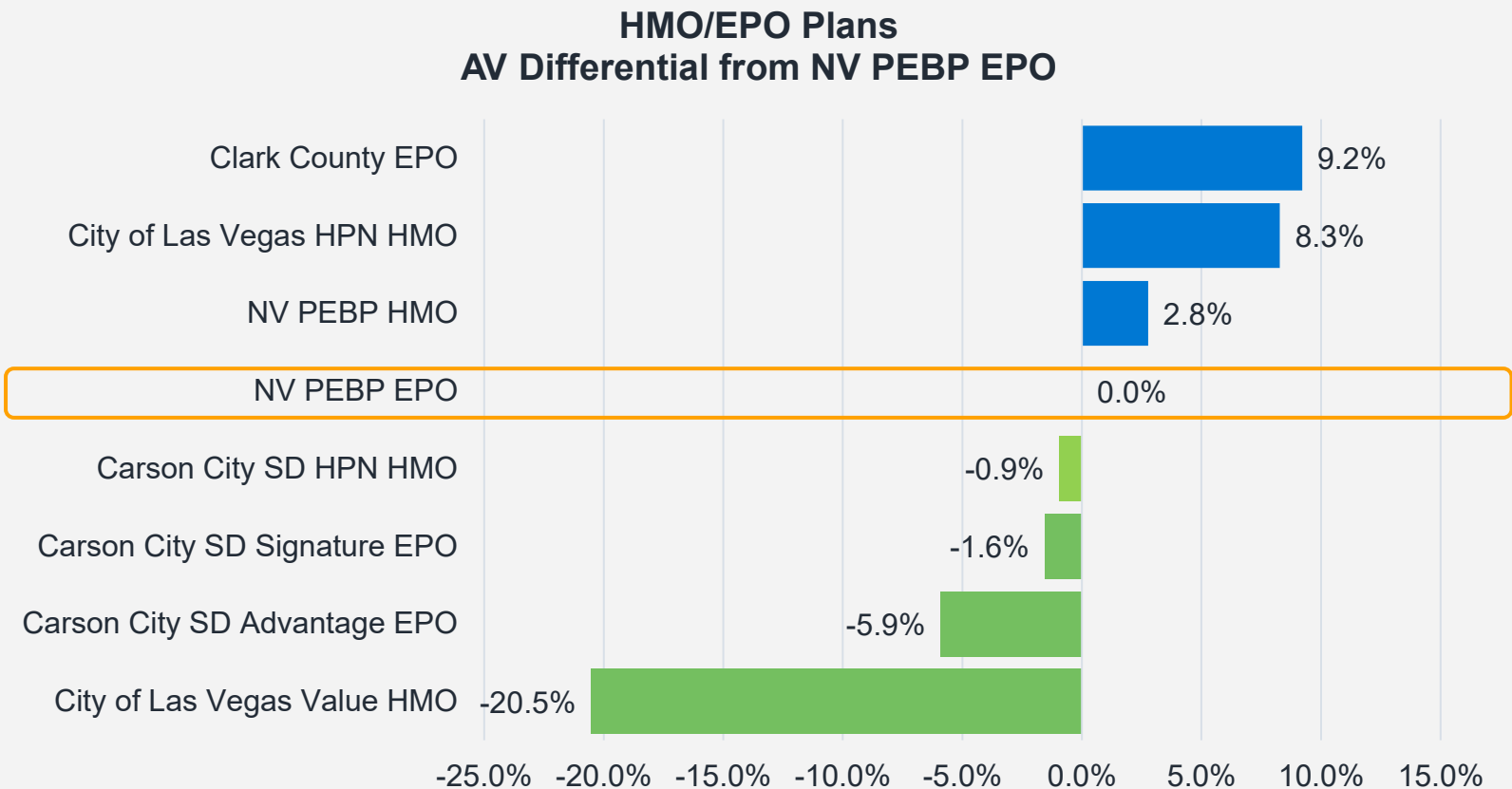
Differentials are calculated as the actuarial value for each respective plan minus the actuarial value for the PEBP LDPPO.

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



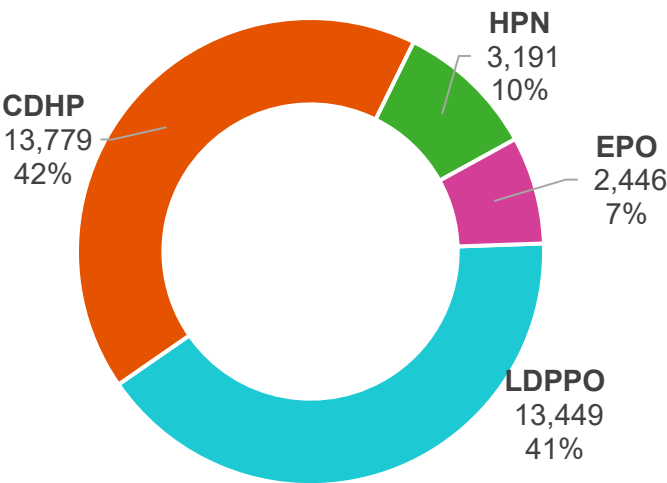
Plans with a negative differential compared to the PEBP EPO are leaner (i.e., benefits are less generous / member cost sharing is generally higher); plans with a positive differential are richer (i.e., benefits are more generous / member cost sharing is generally lower).

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

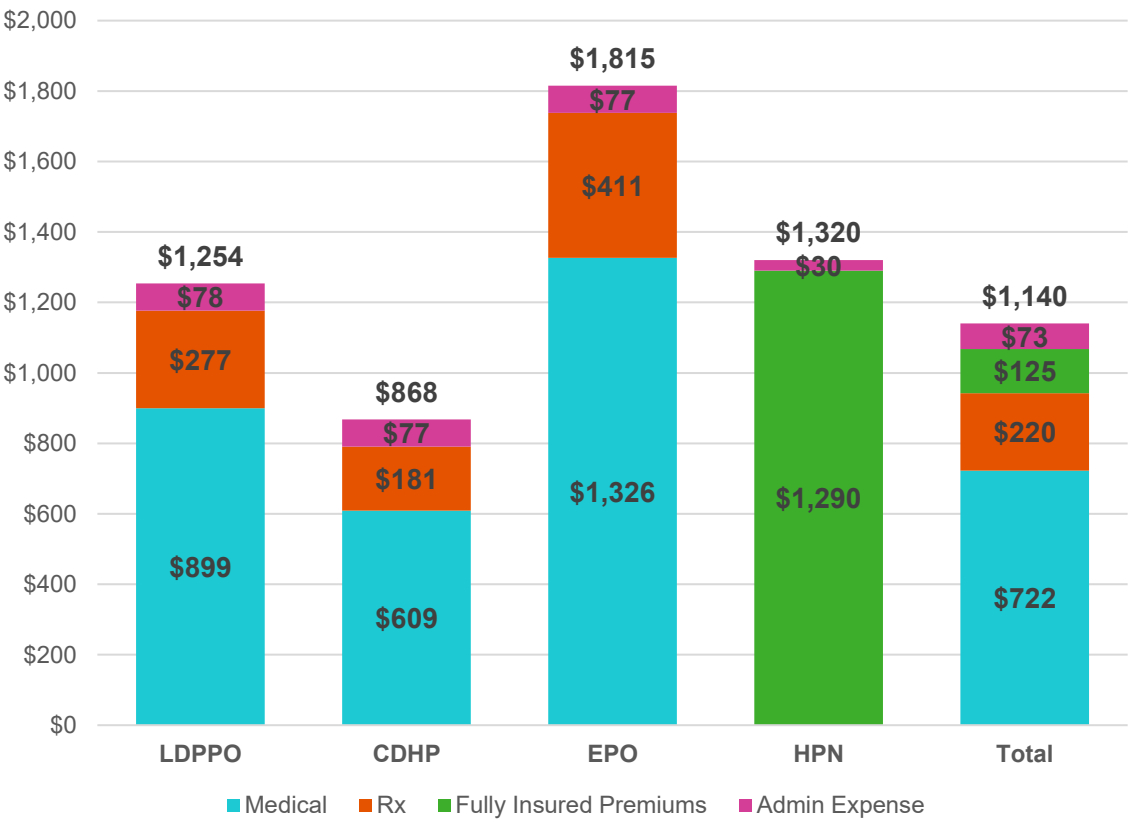
Note: plans with tiered networks assume 75% Tier 1 utilization
Plans with no explicit specialty Rx cost sharing information assume 30% coinsurance
Source: Information provided by Milliman July 2026

Experience Dashboard

PY2026 Average Employee/Retiree Counts



PY2026 Projected PEPM Claims & Expenses*



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

PY 2027 Rates & Contributions – State Active

Active 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	\$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.

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)	\$1,115.02	-	\$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.

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			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	\$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.

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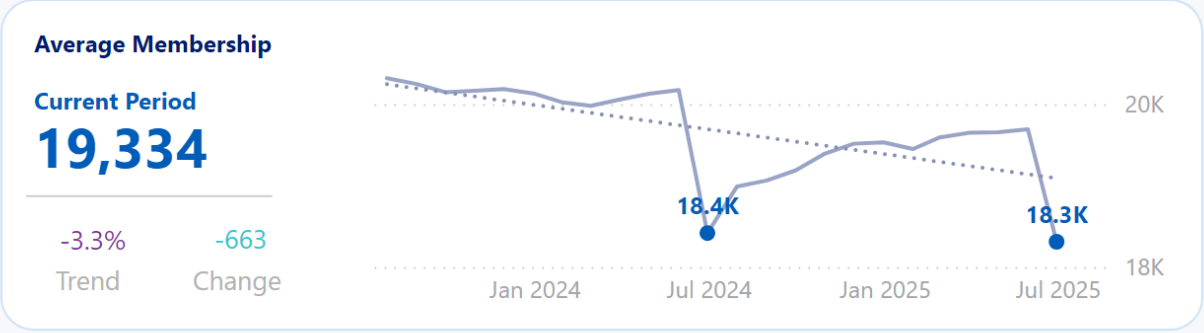
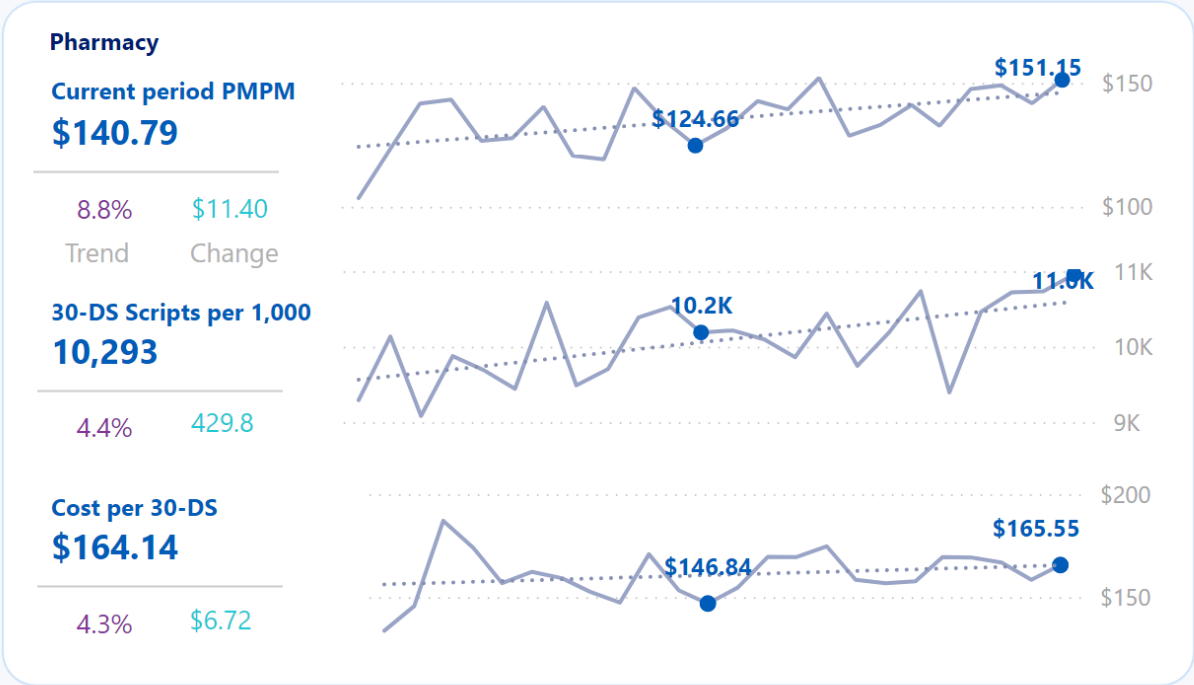
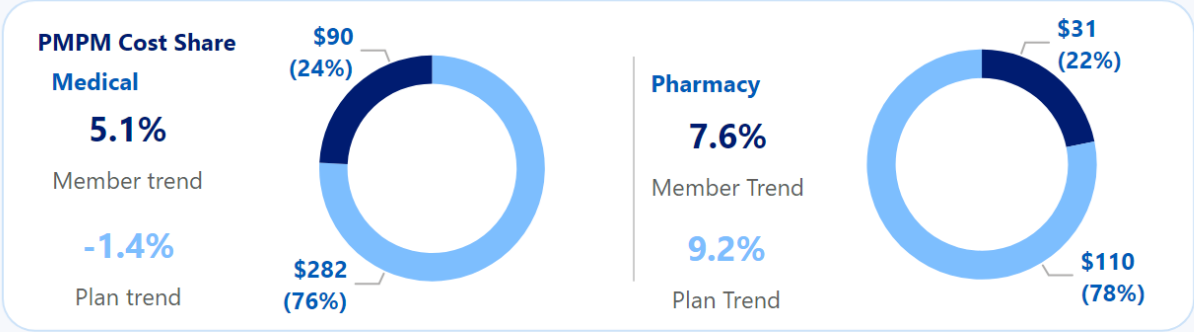
* Does not include rate adjustments paid/credited with PEBP reserves.

| Composition of risk pools

Risk Pool Topics

Sub-topic	Potential Savings	Time Horizon
Separate Actives and Retirees from the risk pool and rate separately • 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



Total Allowed PMPM

Current period

\$953.49

13.1%
Trend

\$110.41
Change



PMPM Cost Share

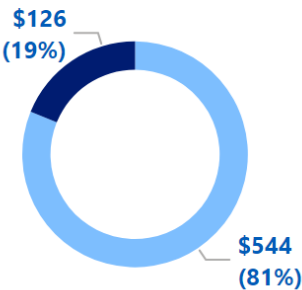
Medical

7.6%

Member trend

16.2%

Plan trend



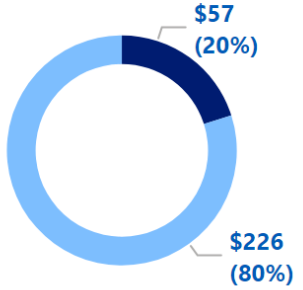
Pharmacy

13.1%

Member Trend

9.2%

Plan Trend



Medical Allowed PMPM

Current period

\$670.81

14.5%
Trend

\$84.79
Change



Pharmacy

Current period PMPM

\$282.68

10.0%
Trend

\$25.62
Change

30-DS Scripts per 1,000

22,508

4.0%
Trend

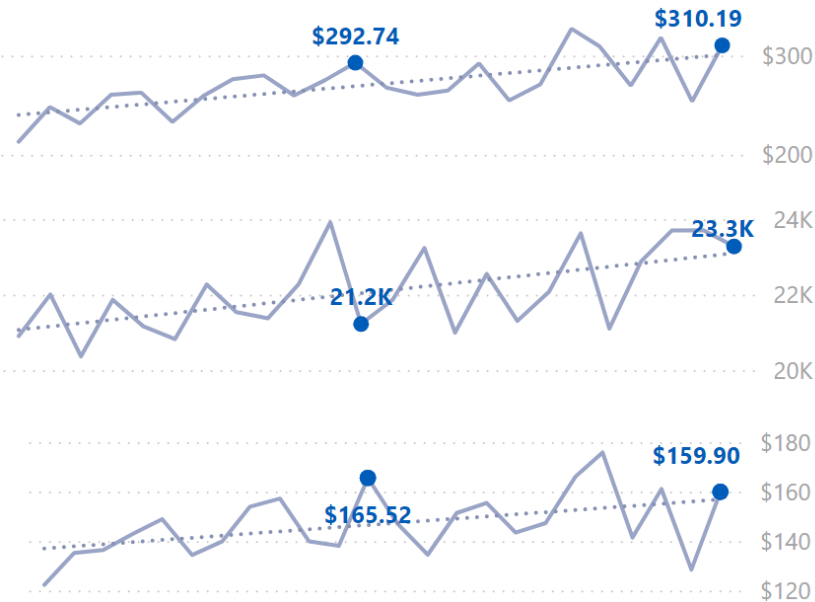
875.7
Change

Cost per 30-DS

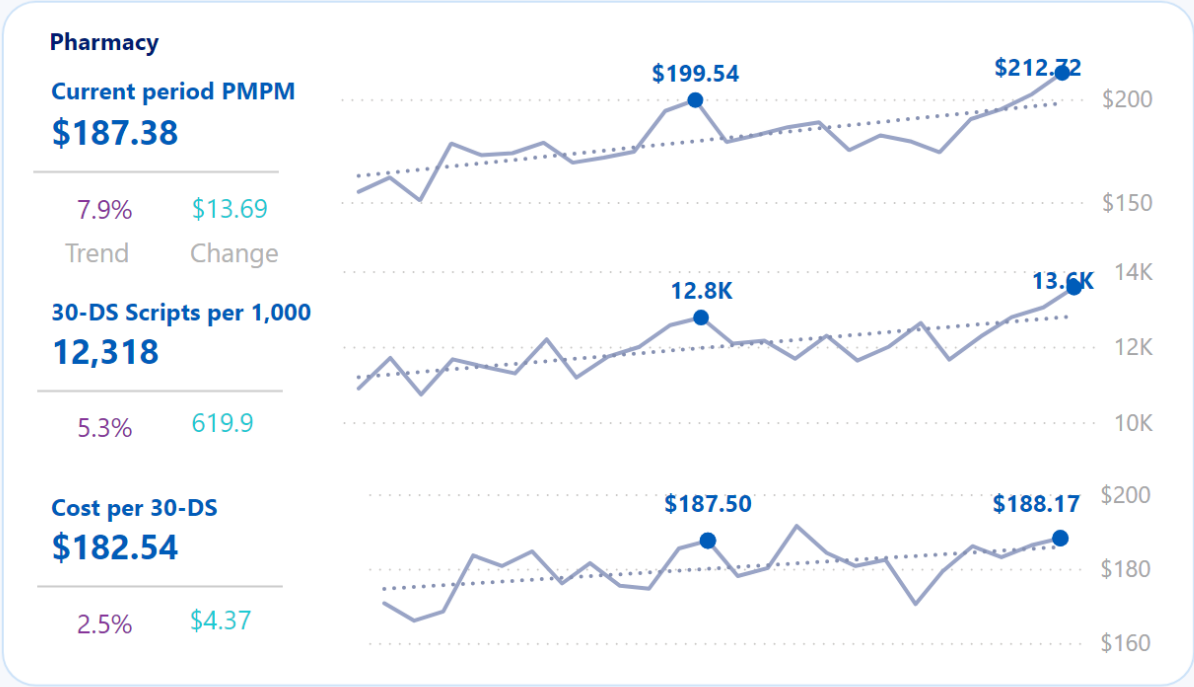
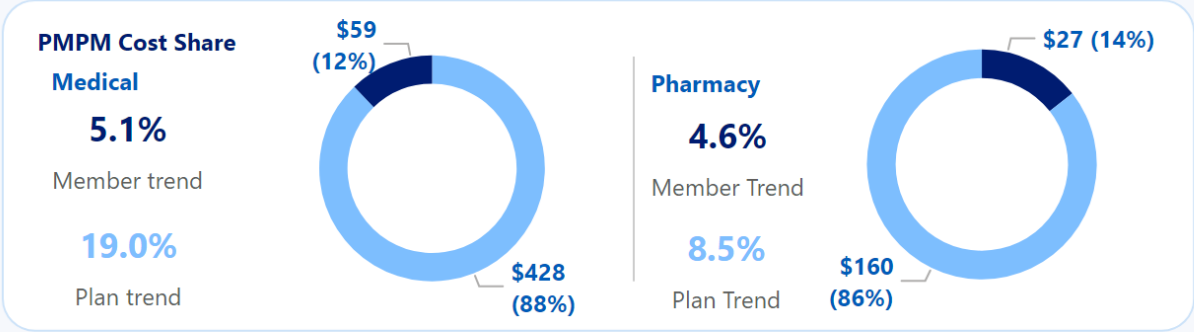
\$150.71

5.7%
Trend

\$8.11
Change



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



Total Allowed PMPM

Current period

\$1,093.54

2.7%

Trend

\$28.49

Change



PMPM Cost Share

Medical

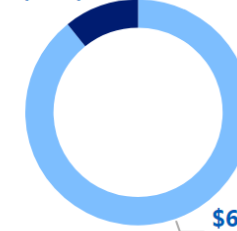
7.1%

Member trend

-4.8%

Plan trend

\$82 (11%)



Pharmacy

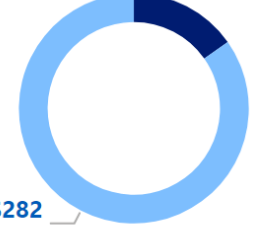
9.2%

Member Trend

23.1%

Plan Trend

\$51 (15%)



Medical Allowed PMPM

Current period

\$761.46

-3.6%

Trend

(\$28.52)

Change



Pharmacy

Current period PMPM

\$332.08

20.7%

Trend

\$57.01

Change

30-DS Scripts per 1,000

26,937

5.6%

Trend

1.4K

Change

Cost per 30-DS

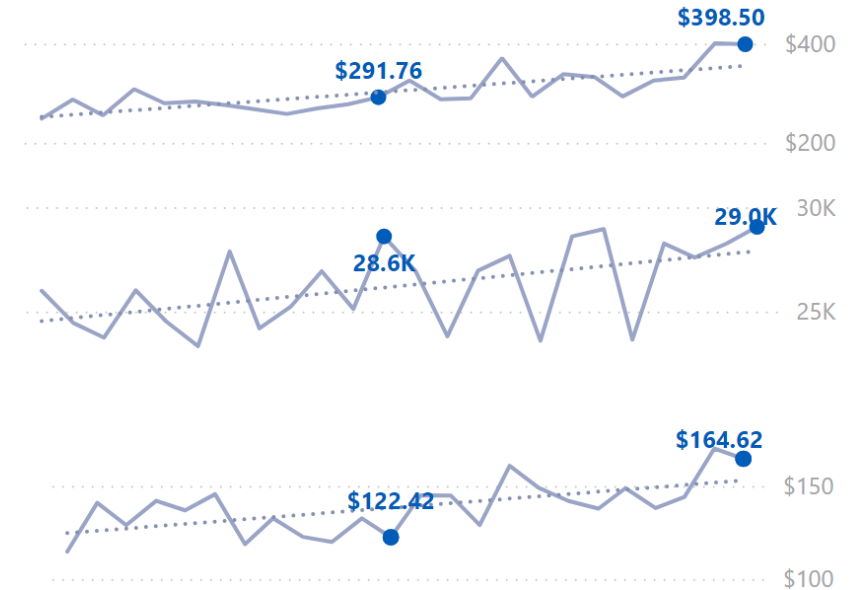
\$147.93

14.3%

Trend

\$18.47

Change



Average Membership

Current Period

1,398

9.8%

Trend

124

Change



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

Total Allowed PMPM

Current period

\$989.83

5.9%

Trend

\$55.35

Change



PMPM Cost Share

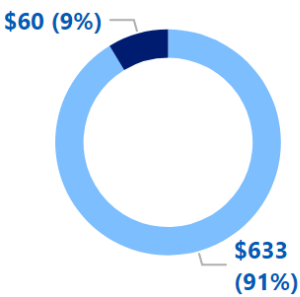
Medical

5.3%

Member trend

4.8%

Plan trend



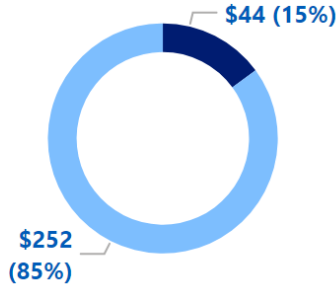
Pharmacy

13.4%

Member Trend

7.7%

Plan Trend



Medical Allowed PMPM

Current period

\$693.34

4.8%

Trend

\$32.03

Change



Pharmacy

Current period PMPM

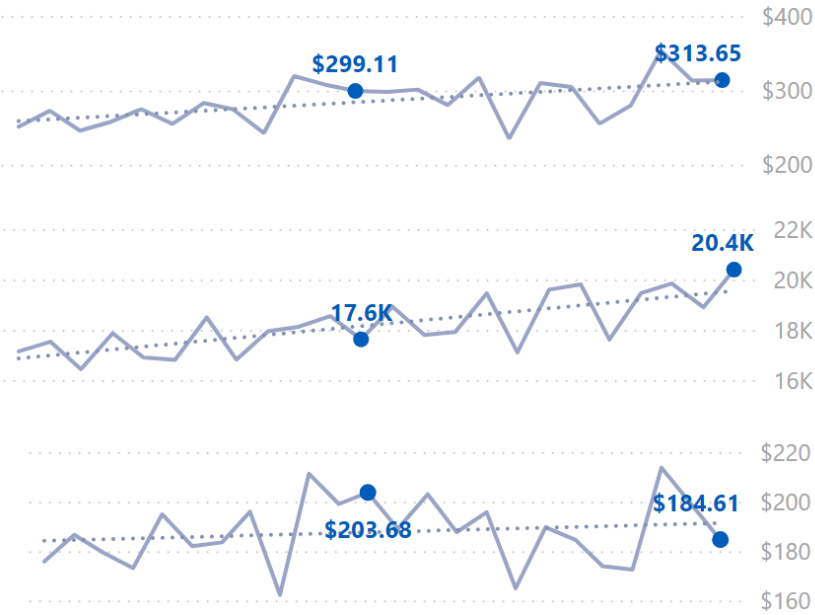
\$296.49

8.5%

Trend

\$23.32

Change



Average Membership

Current Period

4,378

-10.7%

Trend

-522

Change



Cost per 30-DS

\$188.47

0.7%

Trend

\$1.30

Change



Total Allowed PMPM

Current period

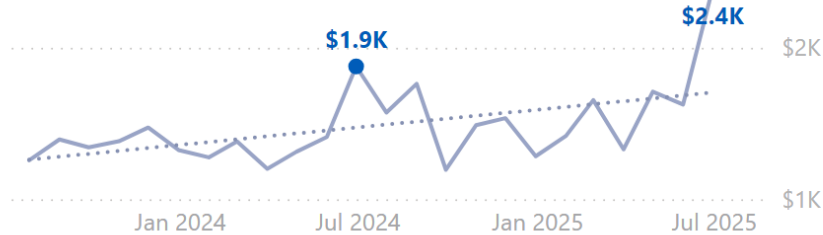
\$1,575.16

13.8%

Trend

\$191.53

Change



PMPM Cost Share

Medical

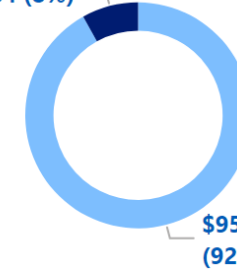
12.4%

Member trend

28.1%

Plan trend

\$84 (8%)



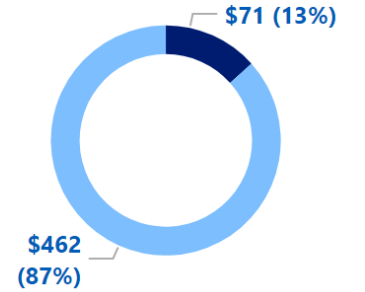
Pharmacy

-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%

Trend

-537.7

Change

Cost per 30-DS

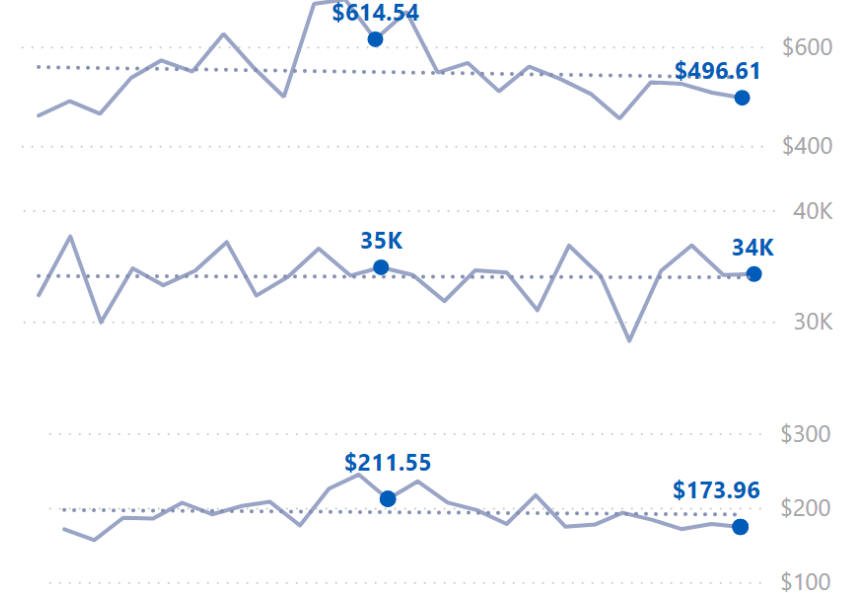
\$189.91

-3.5%

Trend

(\$6.79)

Change



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.

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

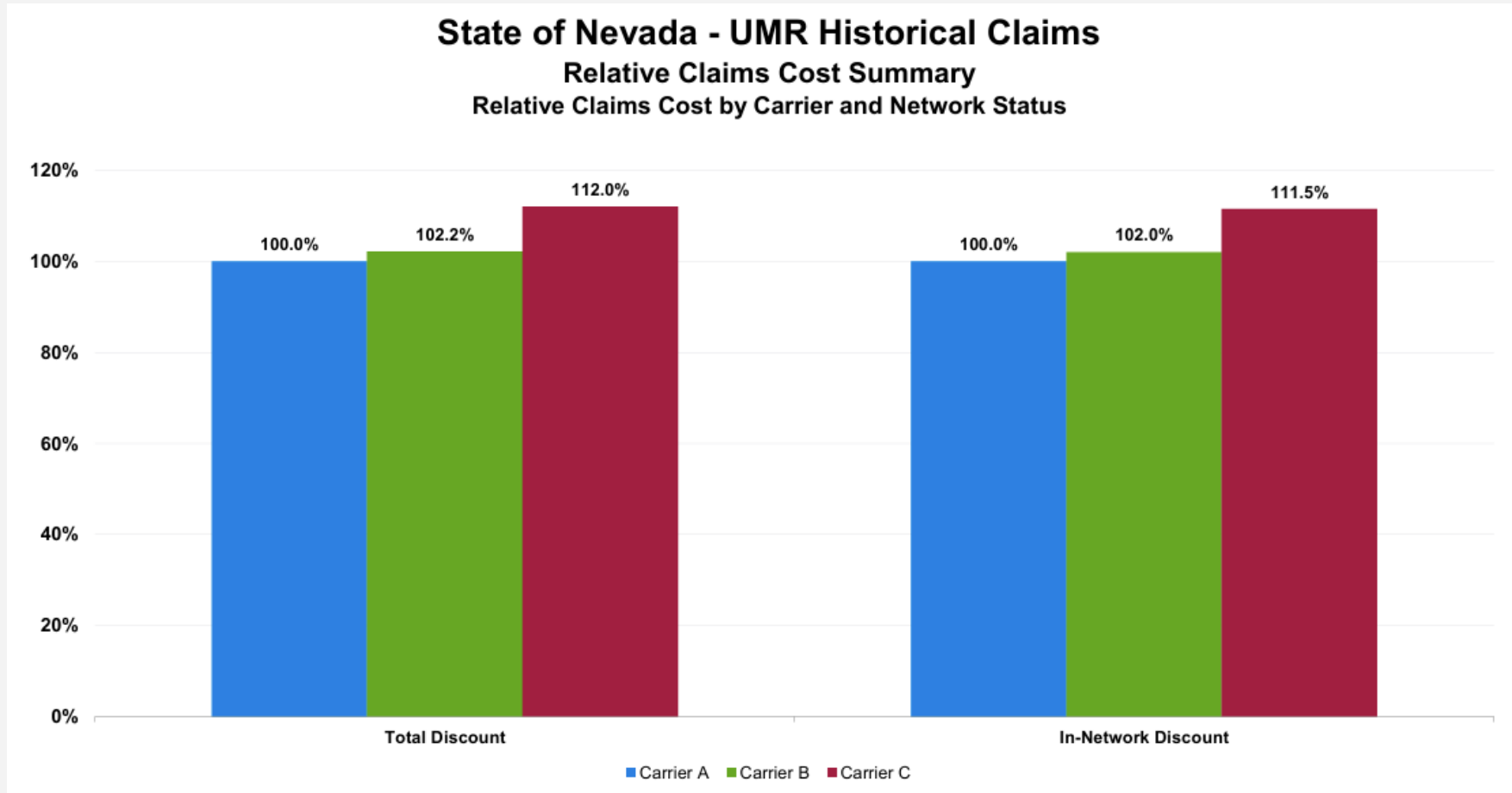
Milliman completed a medical network analysis and disruption comparison for PEBP to determine the expected relative claims cost based on providers / services utilized by PEBP members for medical claims paid between January 1, 2025 and December 31 2025. We repriced PEBP claims based on each carrier's 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

Traditional Network Discount / Disruption Analysis – Discount Relativity

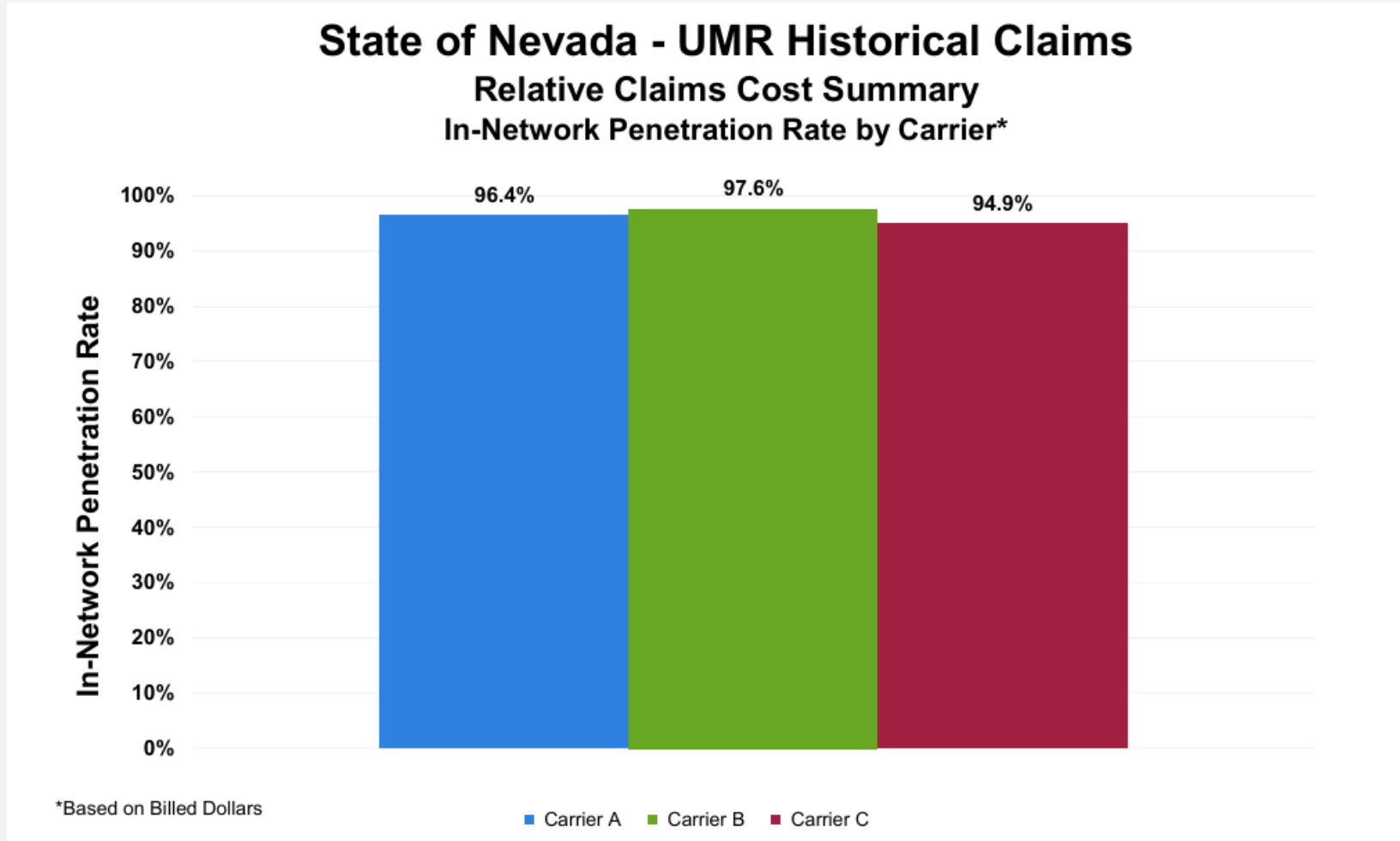
Results – discount relativity by carrier



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

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**

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

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

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

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%

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

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

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

- **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	Consumer Driven Health Plan (PPO)	Low Deductible Plan (PPO)	Exclusive Provider Organization Plan (EPO)	Health Plan of Nevada (HMO)
Prescription Plan Design Features	In-Network Pharmacy Benefits are not covered Out-of-Network			
Preferred Generic	You pay 20% after Deductible	\$10 Copay 30-day supply	\$10 Copay 30-day supply	\$10 Copay 30-day retail supply
		\$20 Copay 90-day retail and mail	\$20 Copay 90-day retail and mail	\$25 Copay 90-day mail
Preferred Brand	You pay 20% after Deductible	\$40 Copay 30-day supply	\$40 Copay 30-day supply	\$40 Copay 30-day retail supply
		\$80 Copay 90-day retail and mail	\$80 Copay 90-day retail and mail	\$100 Copay 90-day mail
Non-Formulary	You pay 100% of the cost of medication	\$75 Copay 30-day supply	\$75 Copay 30-day supply	\$75 Copay 30-day retail supply
		\$150 Copay 90-day retail and mail	\$150 Copay 90-day retail and mail	\$187.50 Copay 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

Total Allowed

\$114.7M

13.8%

30-DS Rx per 1,000

13,299

4.0%

Allowed PMPM

\$192.00

7.9%

Cost per 30-DS

\$173.25

3.8%

Generic Fill Rate

87.0%

0.5% pp

Utilizers

38,193

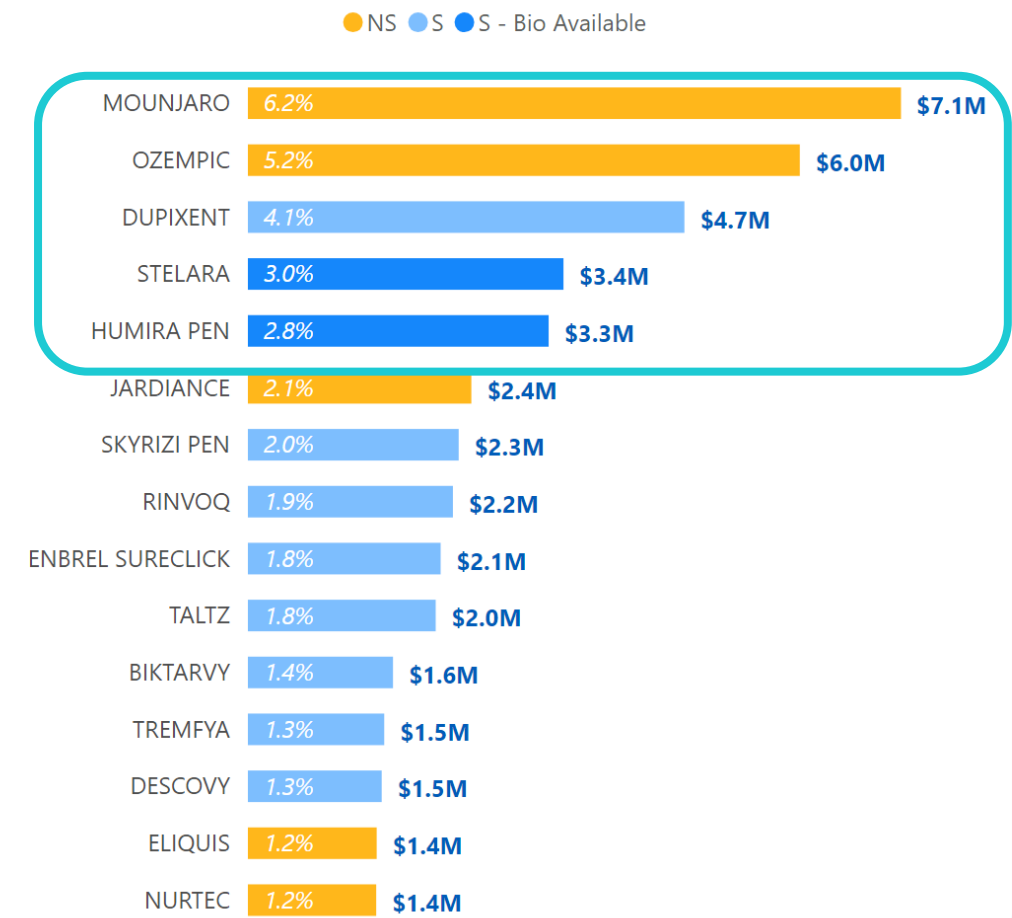
1,775

% Utilizing Rx

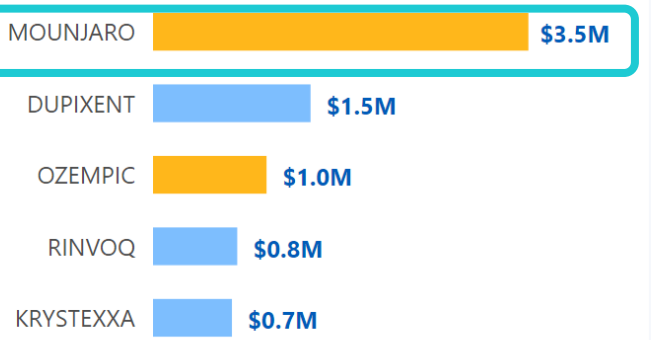
67.6%

0.7% pp

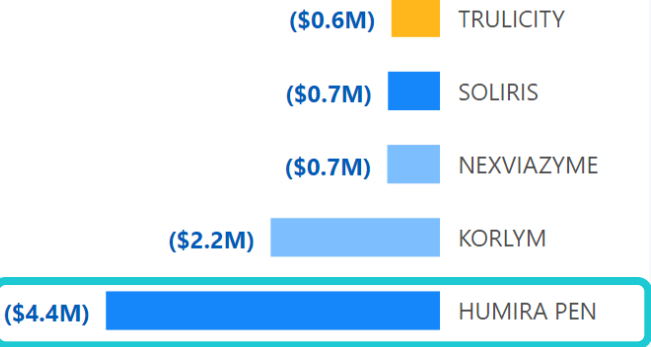
Top 15 Drugs - Pharmacy Allowed (% of Total Pharmacy Allowed) *



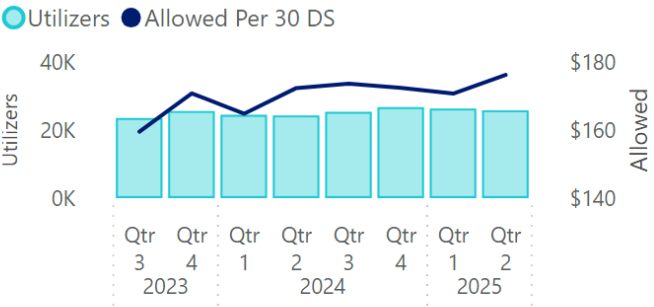
Top 5 spend changes by drug - Allowed change Increases



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.

Total Allowed 
\$93.8M
 11.7%

30-DS RX per 1,000 
3,029
 7.0%

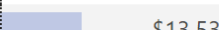
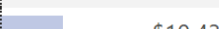
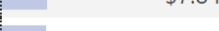
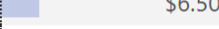
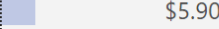
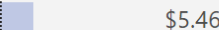
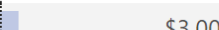
Allowed PMPM 
\$156.90
 5.9%

Cost per 30-DS 
\$621.62
 -1.0%

Generic Fill Rate 
55.7%
 -0.7% pp

Utilizers 
22,734
 1K

% Total Rx Cost 
81.7%
 -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.

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.

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.

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

Total Allowed

\$14.8M

34.8%

30-DS RX per 1,000

303

21.6%

Allowed PMPM

\$24.83

27.8%

Cost per 30-DS

\$982.64

5.2%

Generic Fill Rate

0.1%

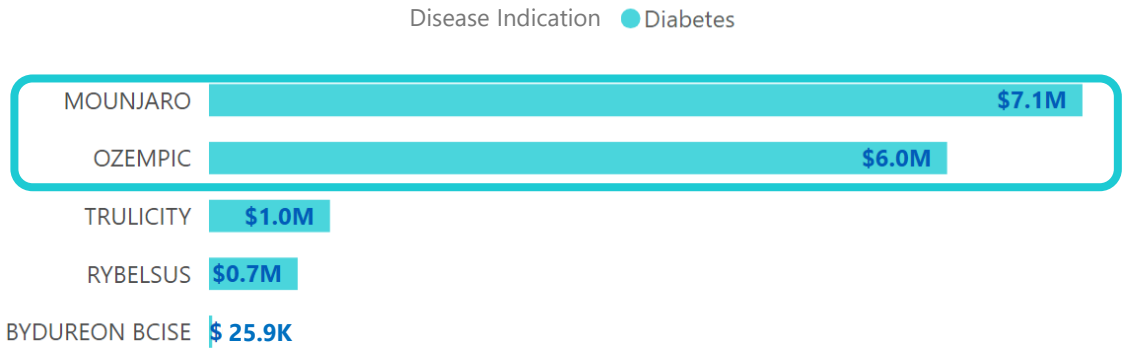
0.1% pp

Utilizers

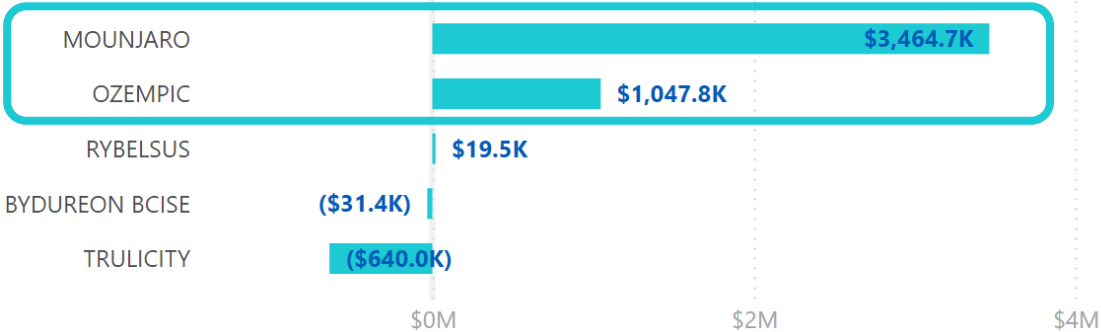
1,798

273

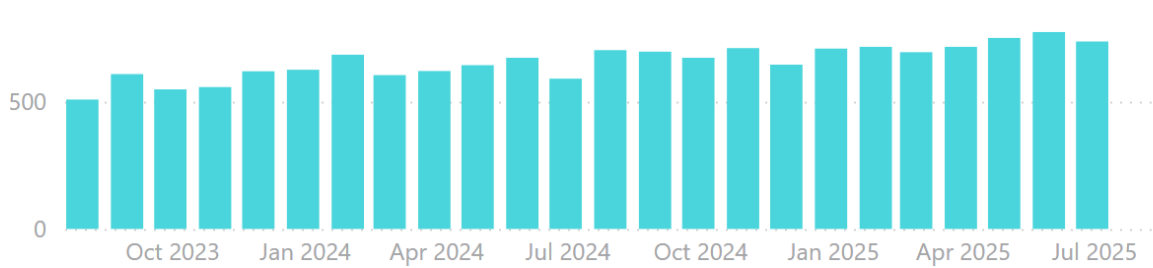
Current pharmacy allowed - Top 5 drugs



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.

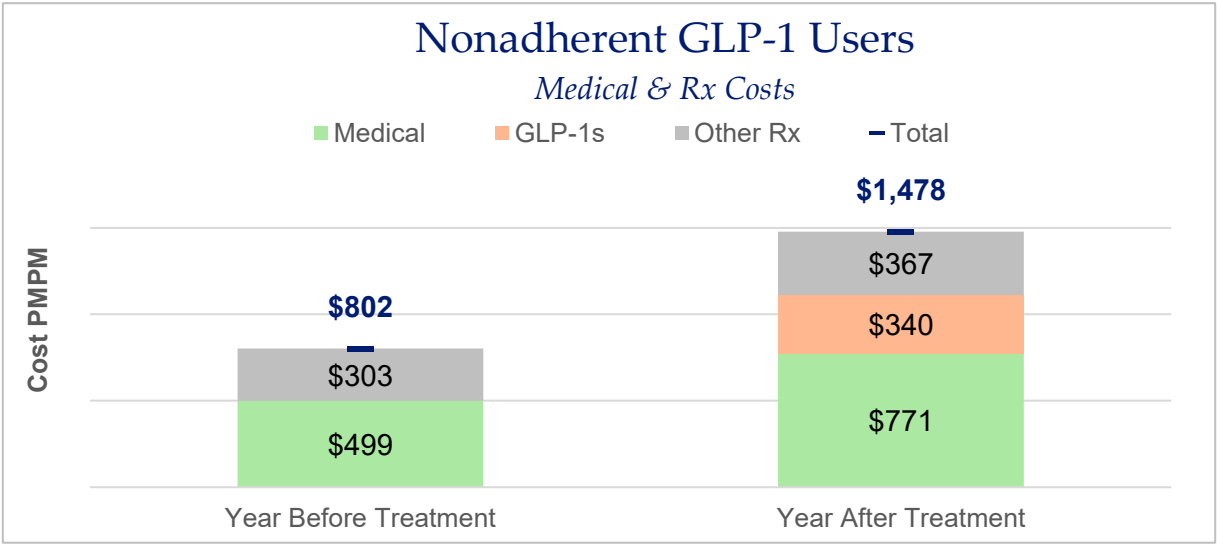
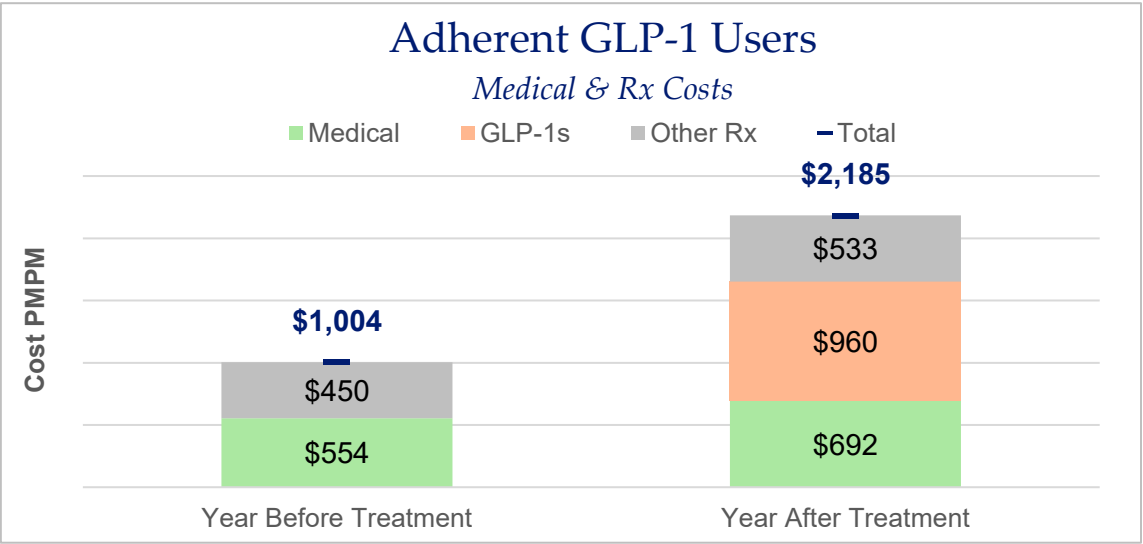
GLP-1 Adherence Results*

- 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.



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**.

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

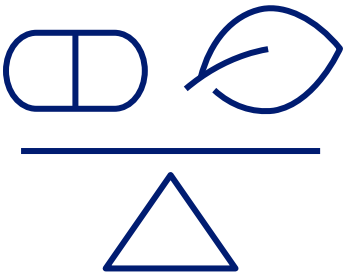
- Only 0.4% of scripts are for Non-Preferred Brands
- Limited savings opportunity for Options 1 and 2
- Removing coverage for Non-Preferred Brands from the LDPPO and EPO (to align with CDHP) has \$600,000 savings opportunity, but affects approximately 825 patients (with 2,700 scripts)

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

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 <u>Cost</u>
Current (all tiers)	30% coinsurance Min \$100; Max \$250	
Alternative Tier 1	30% coinsurance No Min; Max \$50	\$25,000
Alternative Tier 2	30% coinsurance Min \$150; Max \$250	
Alternative Tier 3	30% coinsurance Min \$250; Max \$350	



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.

Current Prevalence Benchmark

Mental Health 26.7% 34.7%

Hyperlipidemia 26.4% 25.1%

Hypertension 17.3% 20.9%

Obesity 17.3% 21.2%

Diabetes 7.8% 7.4%

Asthma 3.3% 4.5%

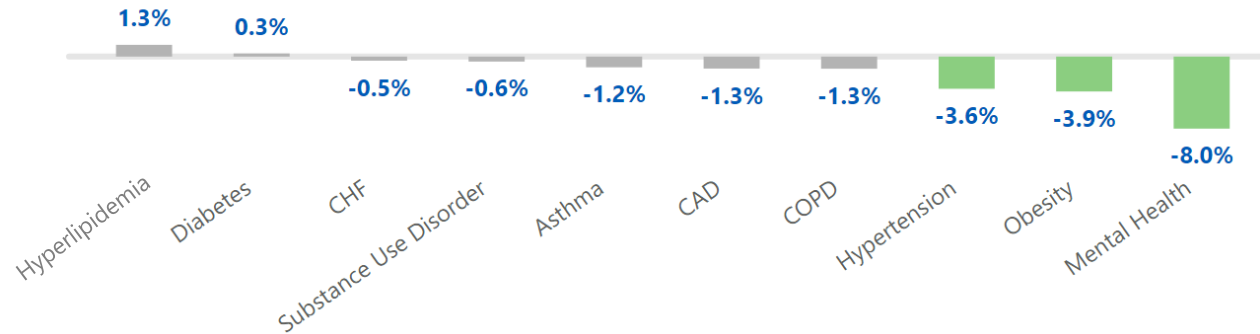
CAD 2.7% 4.0%

Substance Use Disorder 2.3% 2.8%

COPD 1.1% 2.5%

CHF 1.0% 1.4%

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..

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.

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)**

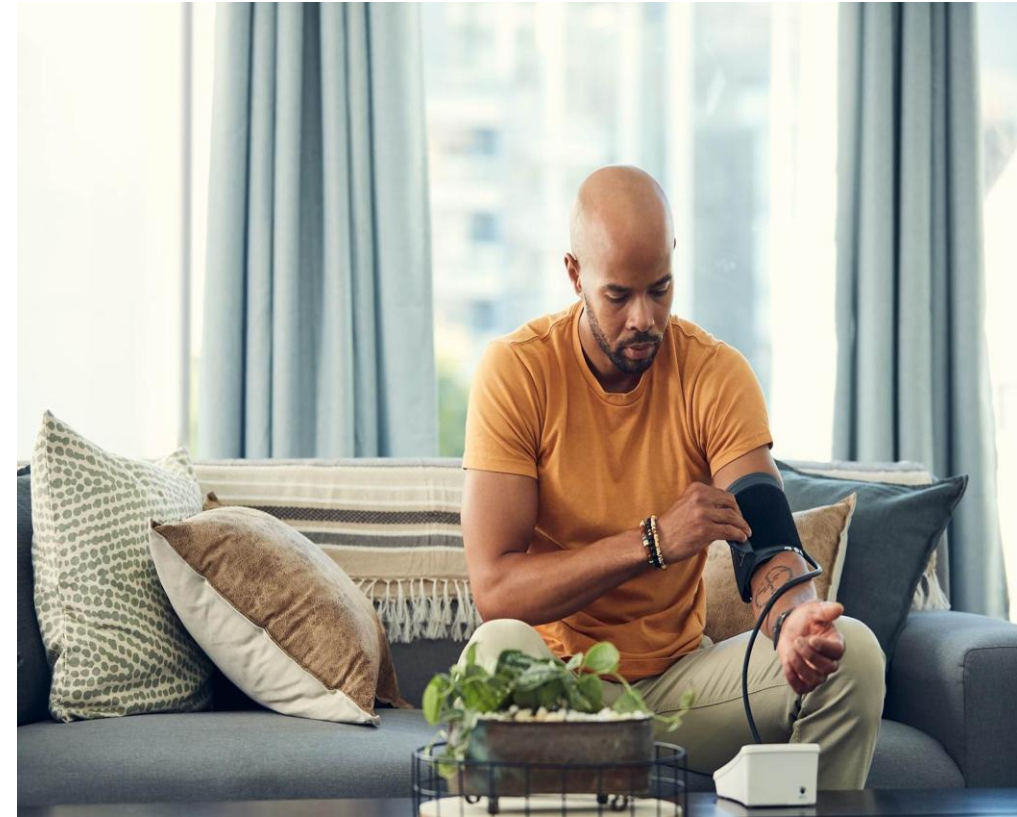
- Eligible: PEBP participants identified as Type 2 diabetic or Pre-Diabetic
- Description: Lifestyle change pilot program focused offered to Type 2 diabetics and Pre-Diabetic; in person and virtual options

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

Source: May 2026 PEBP Board Meeting

Summary of Programs

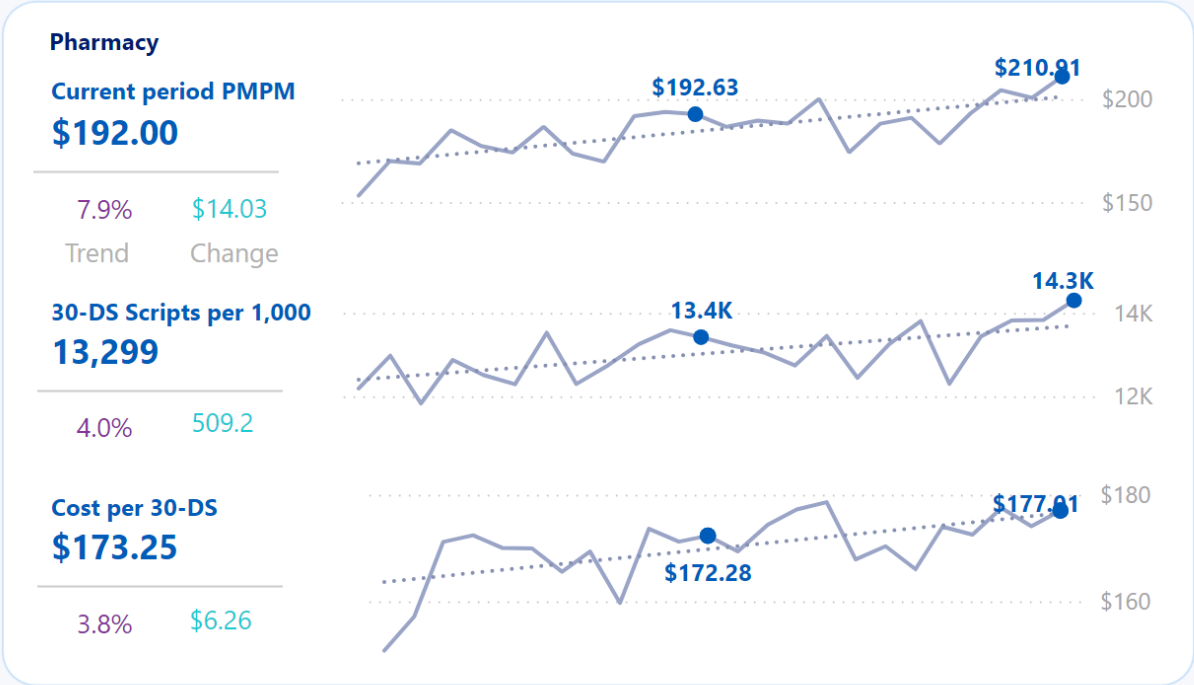
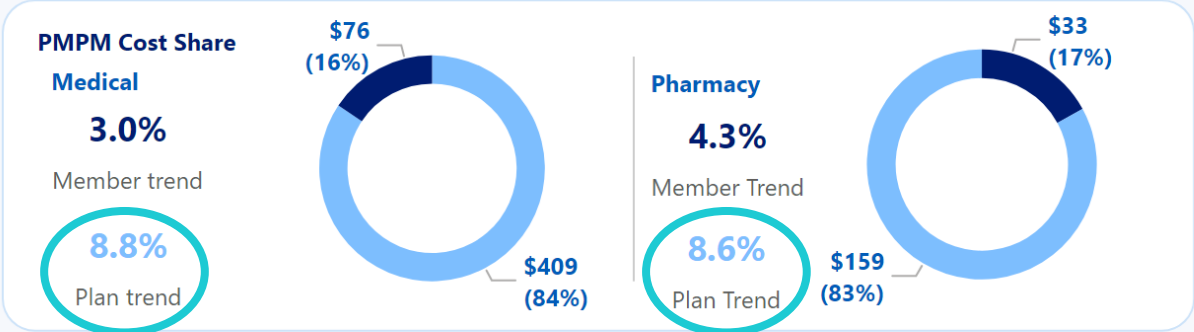
- Low engagement across all programs evaluated
- Of those participating:
 - Average of 2-3 chronic conditions
 - Lower inpatient admissions & emergency room utilization
 - Increased utilization on lower-level care settings such as physical exams and urgent care



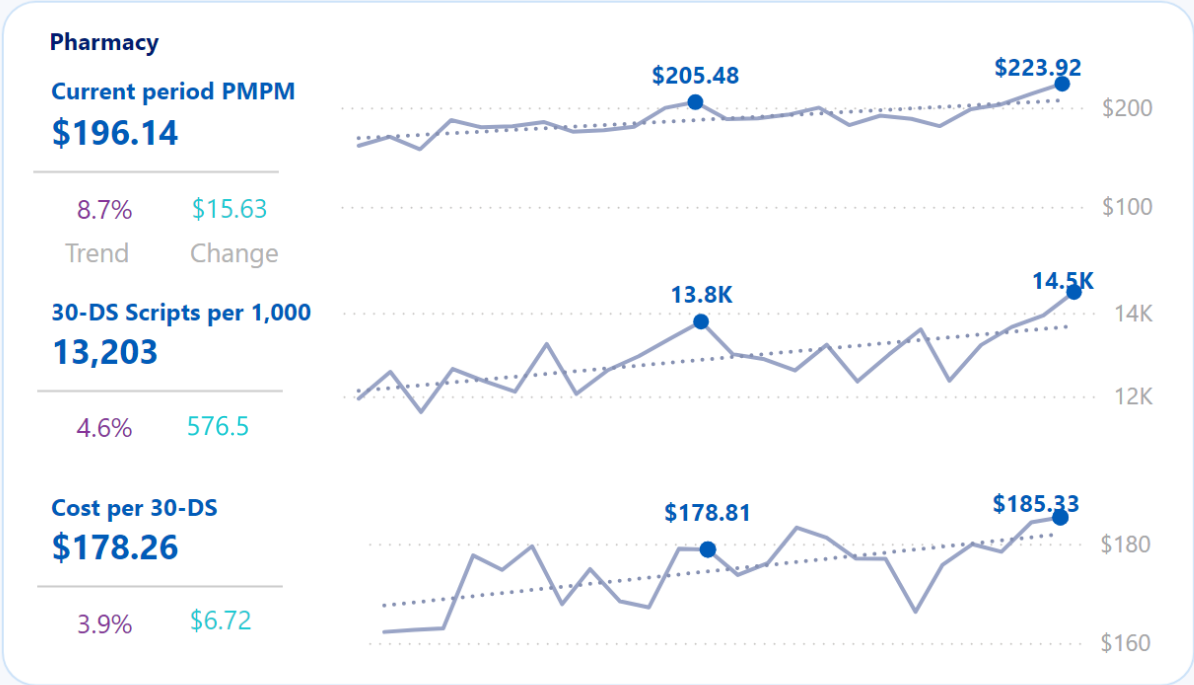
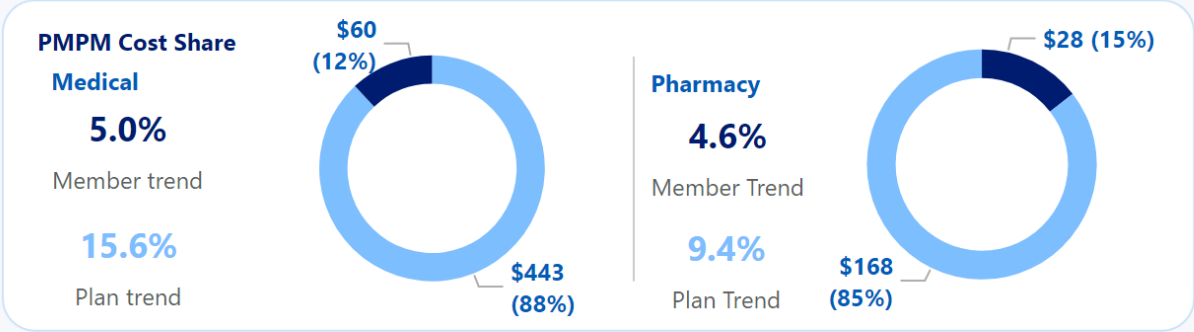
Overall, the industry is moving towards whole-person health versus programs specific to certain conditions

Thank You

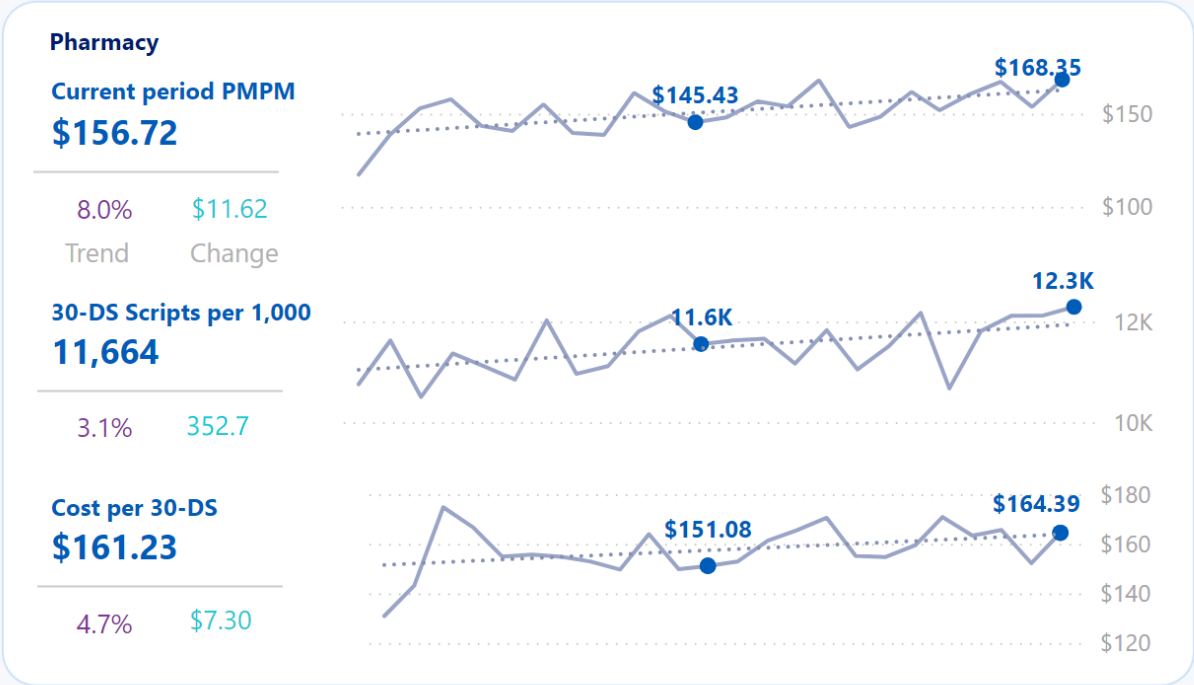
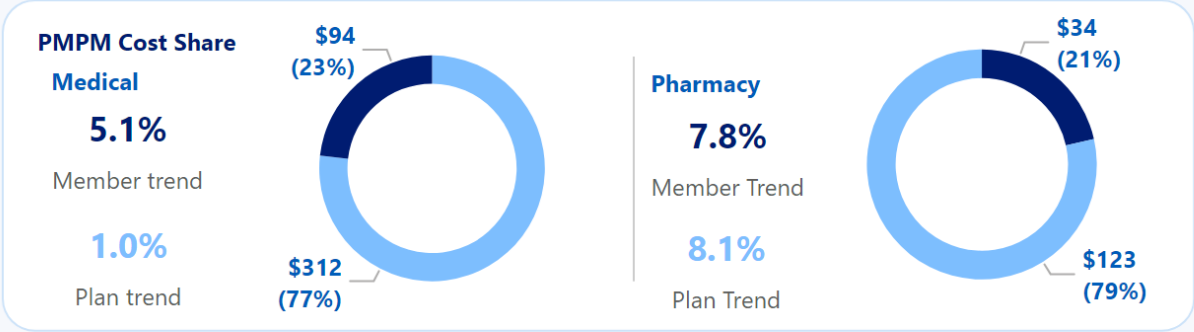
| Appendix



- 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.



- 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.



- 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.

Total Allowed PMPM

Current period

\$1,055.71

7.5%
Trend

\$73.28
Change



PMPM Cost Share

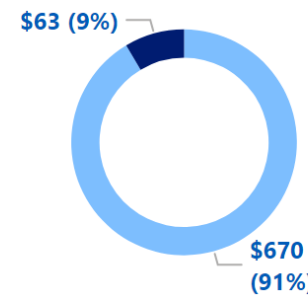
Medical

6.5%

Member trend

8.1%

Plan trend



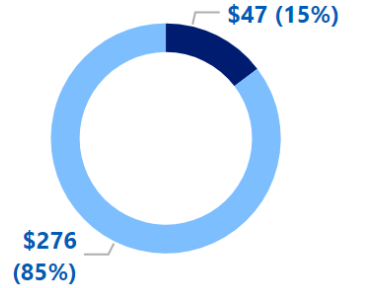
Pharmacy

4.1%

Member Trend

6.7%

Plan Trend



Medical Allowed PMPM

Current period

\$732.50

8.0%
Trend

\$54.05
Change



Pharmacy

Current period PMPM

\$323.21

6.3%
Trend

\$19.23
Change

30-DS Scripts per 1,000

20,550

6.5%
Trend

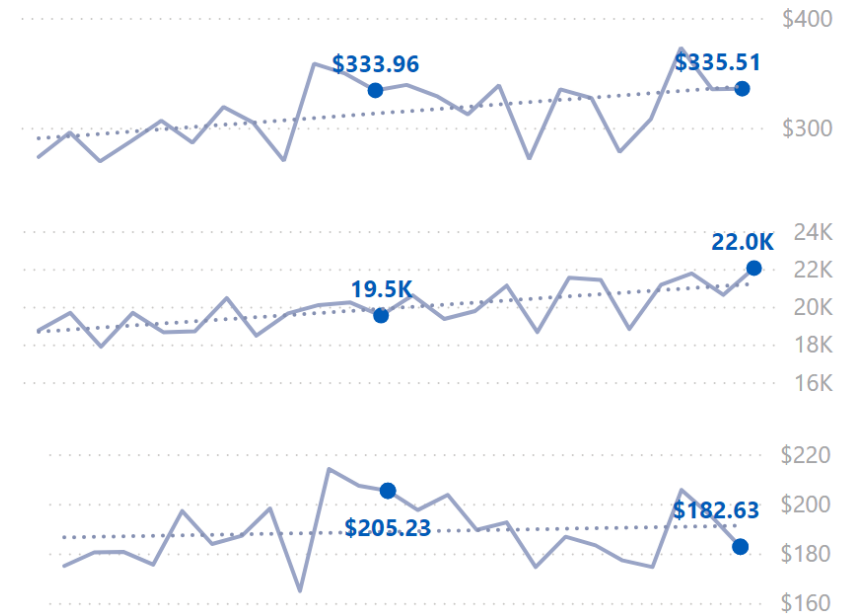
1.25K
Change

Cost per 30-DS

\$188.73

-0.1%
Trend

(\$0.24)
Change



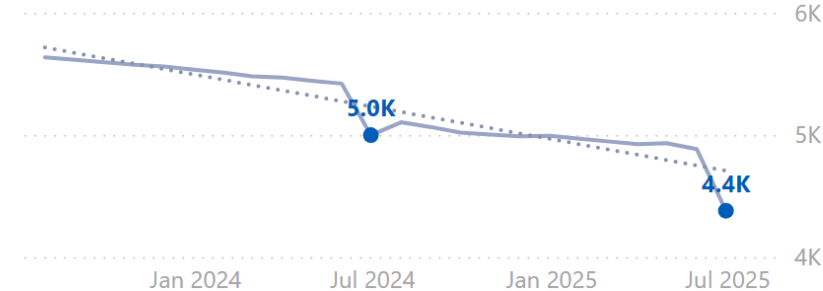
Average Membership

Current Period

4,933

-10.1%
Trend

-553
Change



- 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

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*	

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	

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 (1 st /subsequent visits) + 20%		Not Covered		\$300/\$750 (1 st /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)			

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*	

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			

Benchmarking

State & National Comparators

 = 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	

- **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

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	

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

Plan Structure Benchmarking

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

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

1. LD PPO

2. CDHP

3. EPO

4. HMO

}

Northern / Southern

PEBP vs. Milliman State & National Benchmarks

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

PEBP vs. State Employee Plan Benchmarks

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

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

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%

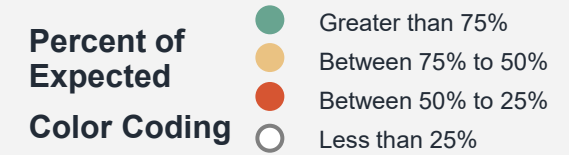
GVRU Medicare												
Market Data Summary												
Provider Name	Beds	Anthem		United				United				
		FIP	FOP	UHC Choice Plus		FIP	FOP	UHC Options		FIP	FOP	
Renown Regional Medical Center	509	354%	291%	319%	254%	319%	254%	319%	254%	319%	254%	
Carson Tahoe Regional Medical Center	211	248%	343%	n/a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

Hospital (HPT) Transparency Data

Inpatient / Outpatient Overview



GVRU Medicare

Market Data Summary

Provider Name	Beds	Anthem		United		Hometown	
		FIP	FOP	FIP	FOP	FIP	FOP
Renown Regional Medical Center	509	354%	216%	n/a	n/a	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

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

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.

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.

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.

Price Transparency Analysis – Interpreting Results Guidelines

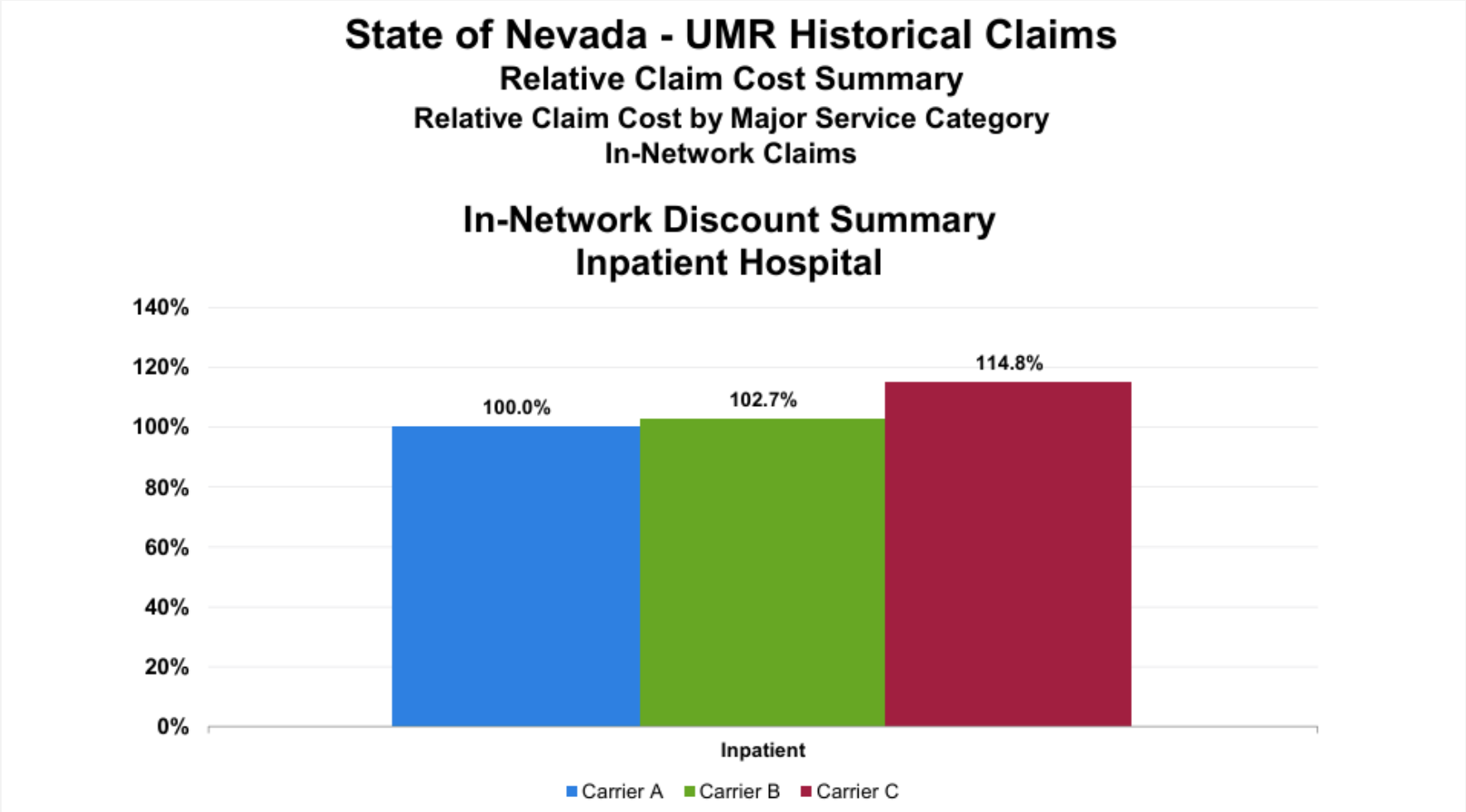
Interpreting results – guidelines to consider

- 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

Network Discount / Disruption Analysis

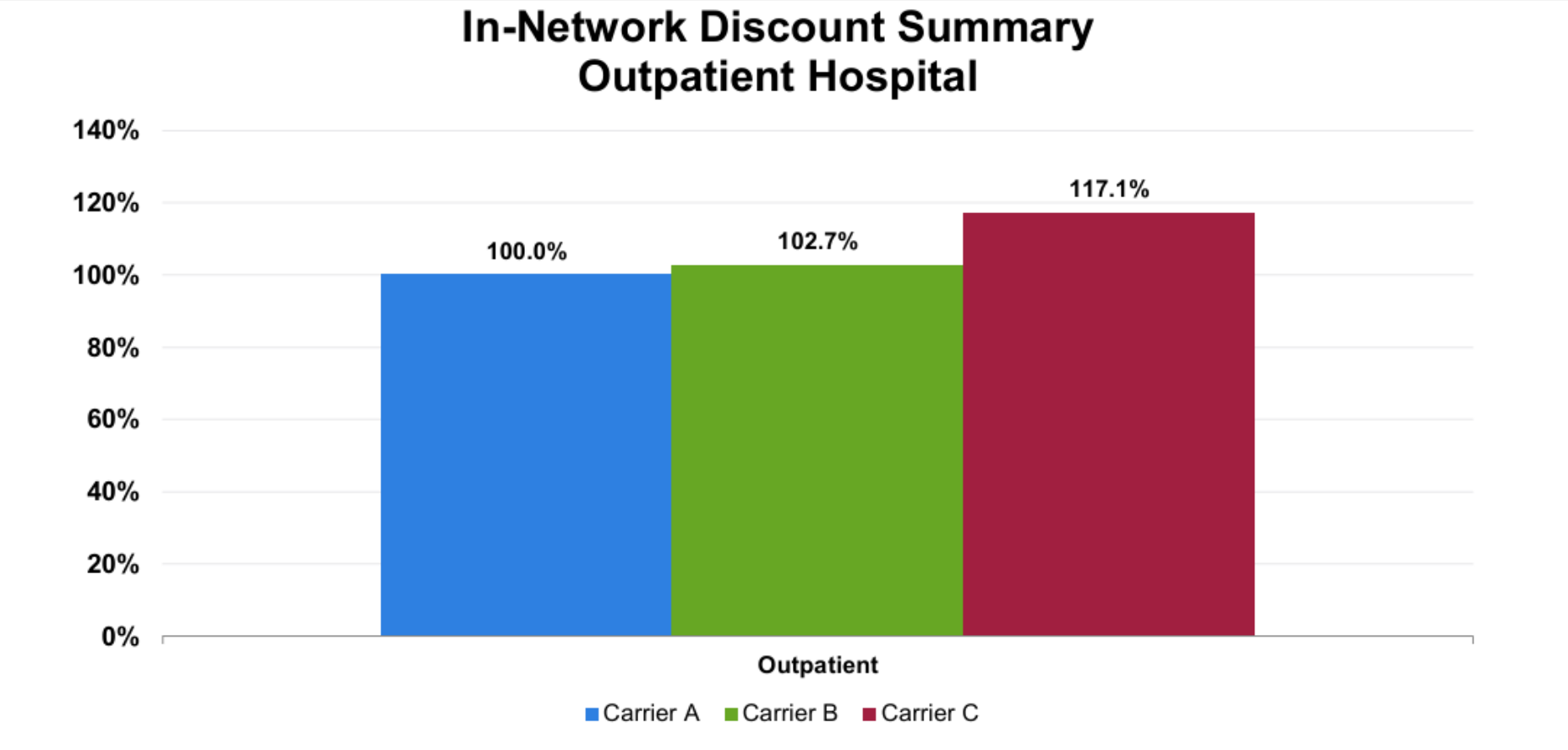
Traditional Network Discount / Disruption Analysis – Inpatient Hospital

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



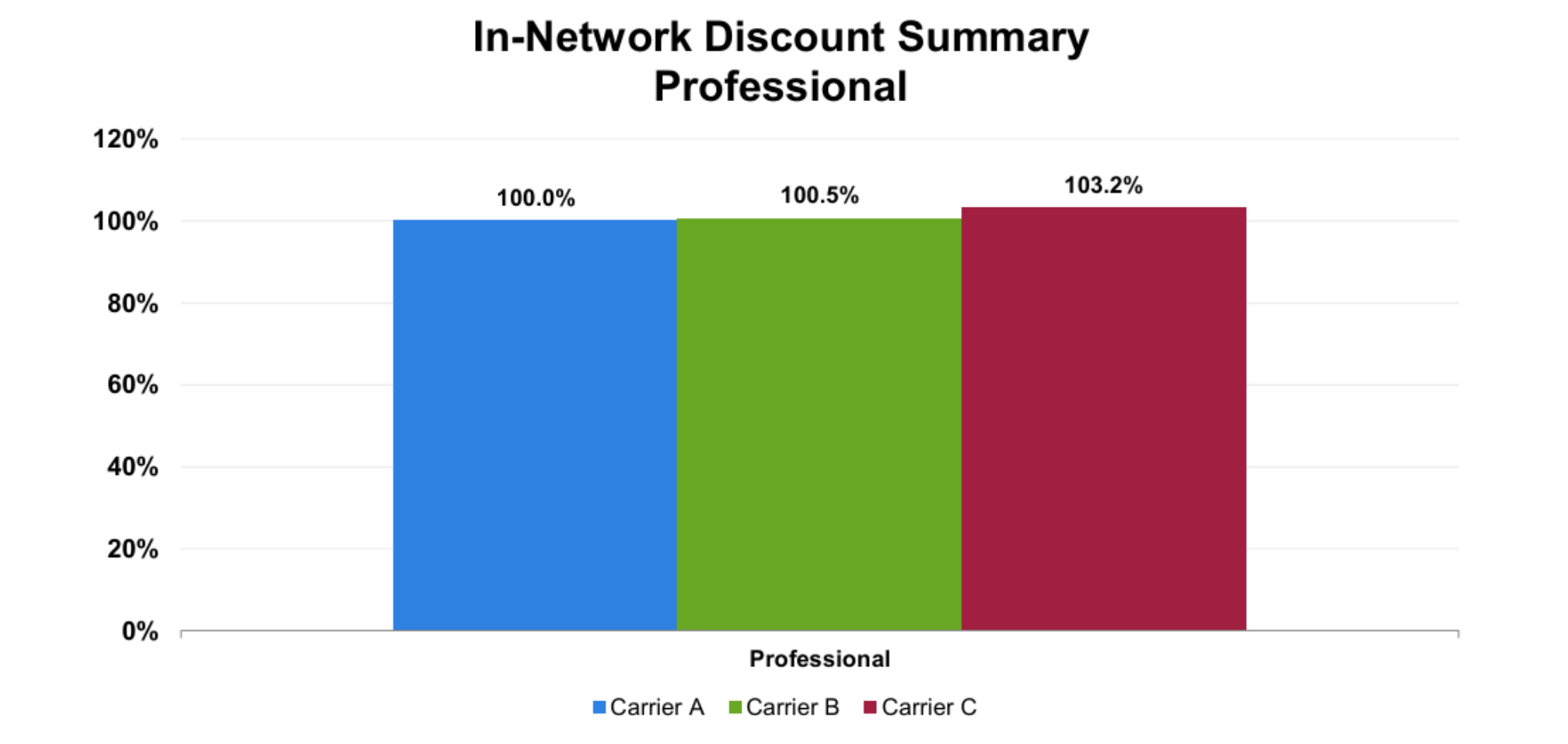
Traditional Network Discount / Disruption Analysis – Outpatient Hospital

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



Traditional Network Discount / Disruption Analysis - Professional

Results – discount relativity by service category / carrier – professional



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.

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)

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

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

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%	

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%

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%

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%

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%

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%

Pharmacy Benefit Considerations

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

PY2025 Total
Allowed

\$192.00

PY2025 Total
Allowed PMPM

7.9%

PY24 to PY25
Allowed PMPM Trend

53.8%

Specialty as % of
Allowed

87%

Generic Dispensing
Rate

12.9%

GLP-1 as % of
Allowed

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

GLP-1 Experience Monitoring

Methodology and Limitations

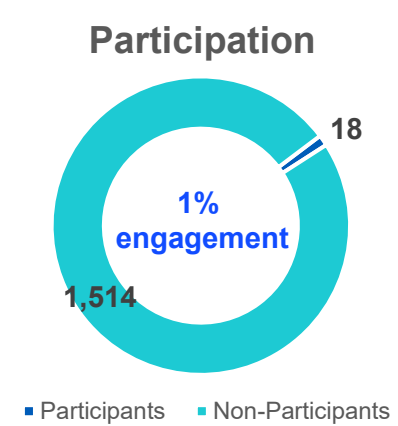
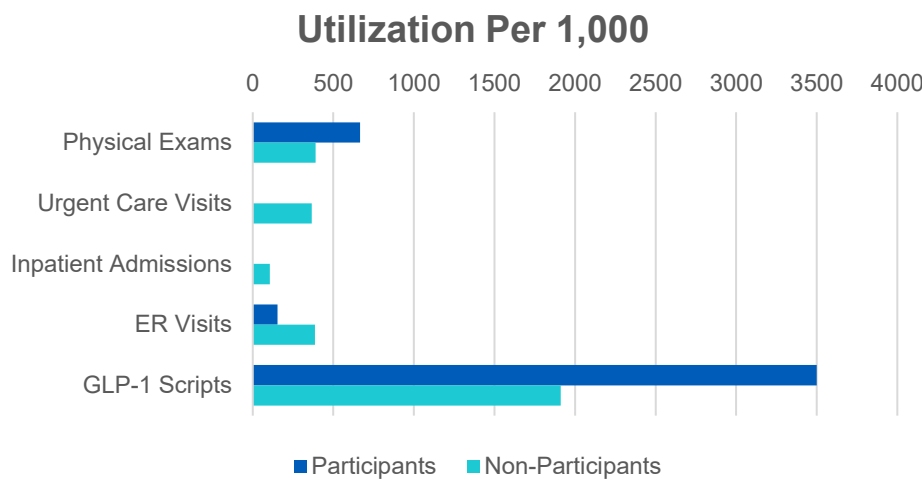
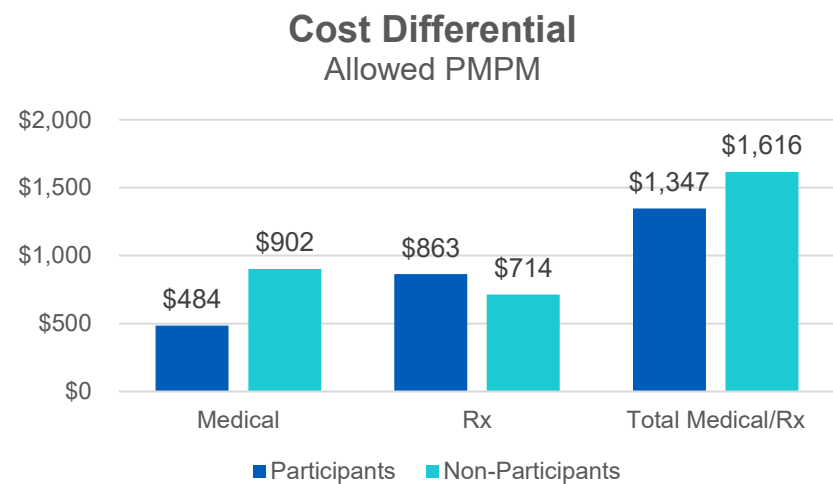
- A review of experience for members utilizing Glucagon-like-peptide-1 (GLP-1) prescription drugs was performed to monitor user adherence and drug efficacy.
 - Members enrolled in Medicare are excluded from the analysis
- The cost impact analysis includes members who initiated GLP-1 therapy between January 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.



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.

Diabetes Care Management Program*



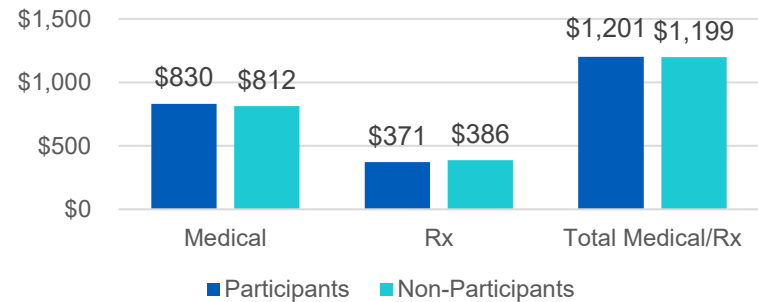
Metric*	Participants	Non-Participants
Avg. Total Risk Score	11.0	13.9
Avg, # Conditions	2.9	3.5
A1 Screening	100%	85%
Retinopathy Screening	72%	64%
Nephropathy Screening	28%	24%
LDL Cholesterol Screening	100%	79%

*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.

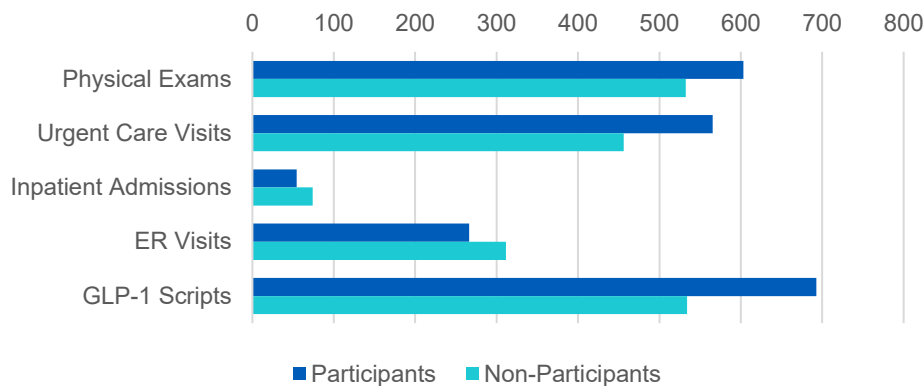
- Program developed by PEBP and offered only to CDHP participants
 - Included as a part of the base administrative fee
 - Low engagement
 - Those who participate are doing so largely to access medications prior to meeting CDHP deductible
- For the small sample of participants:
 - Medical costs for Program 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

Obesity Care Management Program*

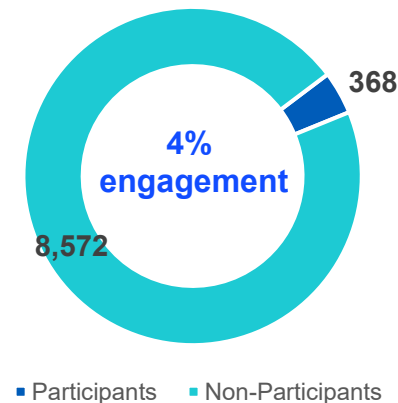
Cost Differential
Allowed PMPM



Utilization Per 1,000



Participation

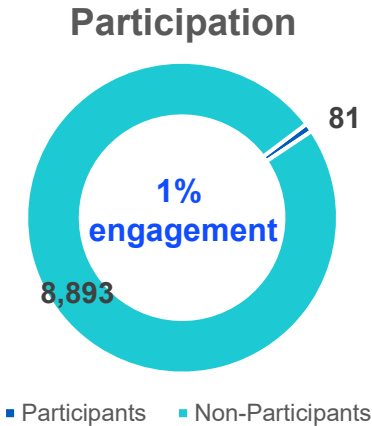
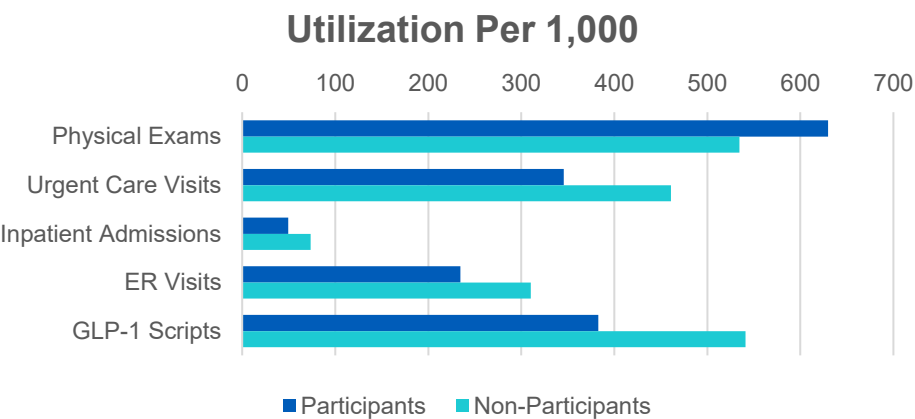
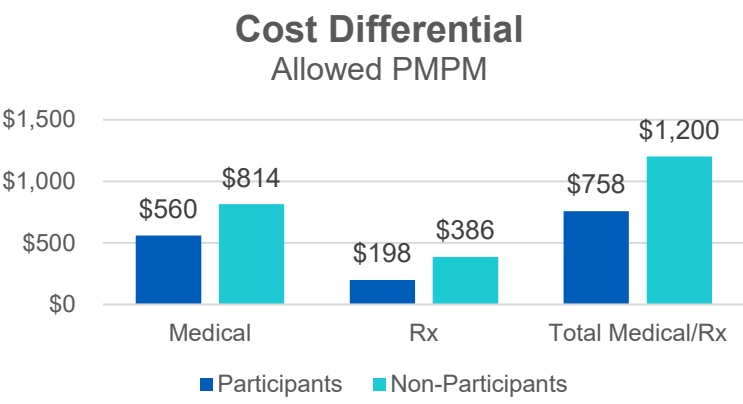


Metric*	Participants	Non-Participants
Avg. Total Risk Score	13.2	12.0
Avg, # Conditions	2.0	1.8
Diabetics		
A1c Screening	85%	87%
Retinopathy Screening	38%	65%
Nephropathy Screening	23%	30%
LDL Cholesterol Screening	85%	81%
Hyperlipidemia		
Total Cholesterol	87%	80%
Hypertension		
Annual Physical	100%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

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

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 (Multi-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

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.

Thank You

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6.

6. Public Comment.

7.

7. Adjournment.