State of Nevada Public Employees' Benefits Program (PEBP)

Program Assessment – Key Findings and Opportunities

October 2, 2026

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Executive Summary

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Executive Summary

Strengths

PEBP is generally competitive in access and benefit richness

Pressure Points

Cost and utilization is uneven across plans and member cohorts

Near-Term Opportunities

Provider reimbursement represents the clearest opportunity for true plan savings

Tradeoffs

Opportunities to better align with benchmarks exist that generate savings, but primarily through cost shifting to members

Potential Action Items

Considerations based on key findings to promote long-term PEBP sustainability

INITIATIVE	PRIORITY LEVEL	POTENTIAL SAVINGS	TRADEOFFS	EFFECTIVE DATE
TPA / Carrier Procurement	High	**$$ to $$$** If more favorable network discounts, utilization management, and / or HMO options proposed compared to current vendors	Administrative effort (procurement and implementation); some member disruption if new vendors implemented	PY 2029
Direct Contracts	High	**$ to $$**	No direct member impact; additional administrative effort	PY 2028 / 2029
Replace or Eliminate EPO / HMO	High	**$ to $$** Depending on replacement options and / or migration from elimination	Potential member disruption, but plans represent small portion of overall population	PY 2029 (aligned with TPA procurement)
PEBP / Market-Wide Reimbursement Caps	Medium	**$$$**	Provider pushback and potential legislative hurdles	PY 2030+
Split Risk Pools (Active / Retiree) ▪ Separate rating while maintaining retiree PEBP access	Medium	Minimal for State overall Potentially meaningful for active staff depending on subsidy reallocations	Potential reduced cost for actives, increased cost for retirees (depends on premium contribution strategy)	PY 2028
Plan Design Adjustments	Low	**$ to $$** Based on historical claims, results will depend on selected options	Cost shift from plan to members; potential enrollment attrition	PY 2028
Dependent Subsidy Reallocations	Low	**$ to $$** Depending on selected subsidies and enrollment shifts	Cost shift from employees without dependents to employees with dependents; potential enrollment attrition	PY 2028

Background and Assessment Process

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Background

- The Nevada Health Authority (NVHA) engaged Milliman to provide strategic and actuarial support to improve the Public Employees' Benefits Program's (PEBP's) performance with respect to access to care and cost containment
- This includes a broad assessment of the current state of the program, evaluating PEBP's strengths and weaknesses with respect to financial sustainability and accessibility, as well as a summary of options to improve these elements and recommended paths forward
- This presentation summarizes key findings and potential near-term action items, focused on the following areas of PEBP's medical and prescription drug benefits
  - Program structure and benchmarking
  - Financial performance and utilization analysis
  - Network adequacy and efficiency

Assessment Process

What we reviewed to arrive at key findings and identify opportunities

PEBP at a Glance

Program structure and enrollment breakdown

Northern Nevada

UMR
Self-funded medical administration

UHC Choice Plus network
CDHP | LDPPO | EPO

Southern Nevada

UMR
Self-funded medical administration

HPN
Fully insured HMO (medical + Rx)

Sierra Care Options network
CDHP | LDPPO

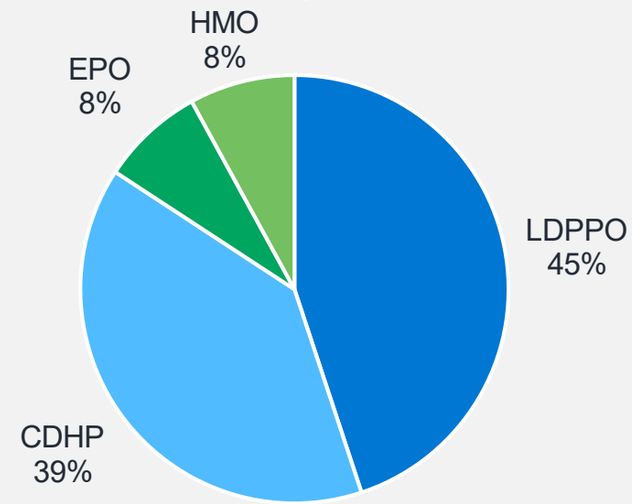
PHARMACY ADMINISTRATION

Express Scripts (ESI)
PBM for CDHP, LDPPO, and EPO

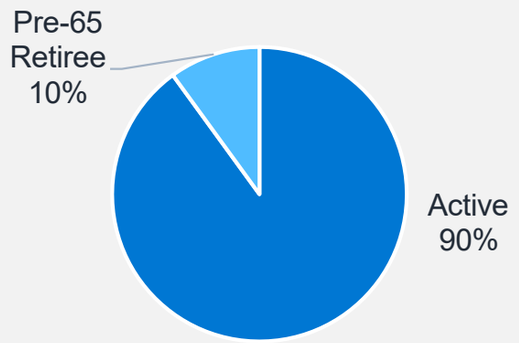
GEOGRAPHIC FOOTPRINT*

North ~50% | South ~50%

Membership by Plan*



Membership by Status*



*PY 2026 average enrollment through April 2026; cohort figures are for UMR plans where noted.

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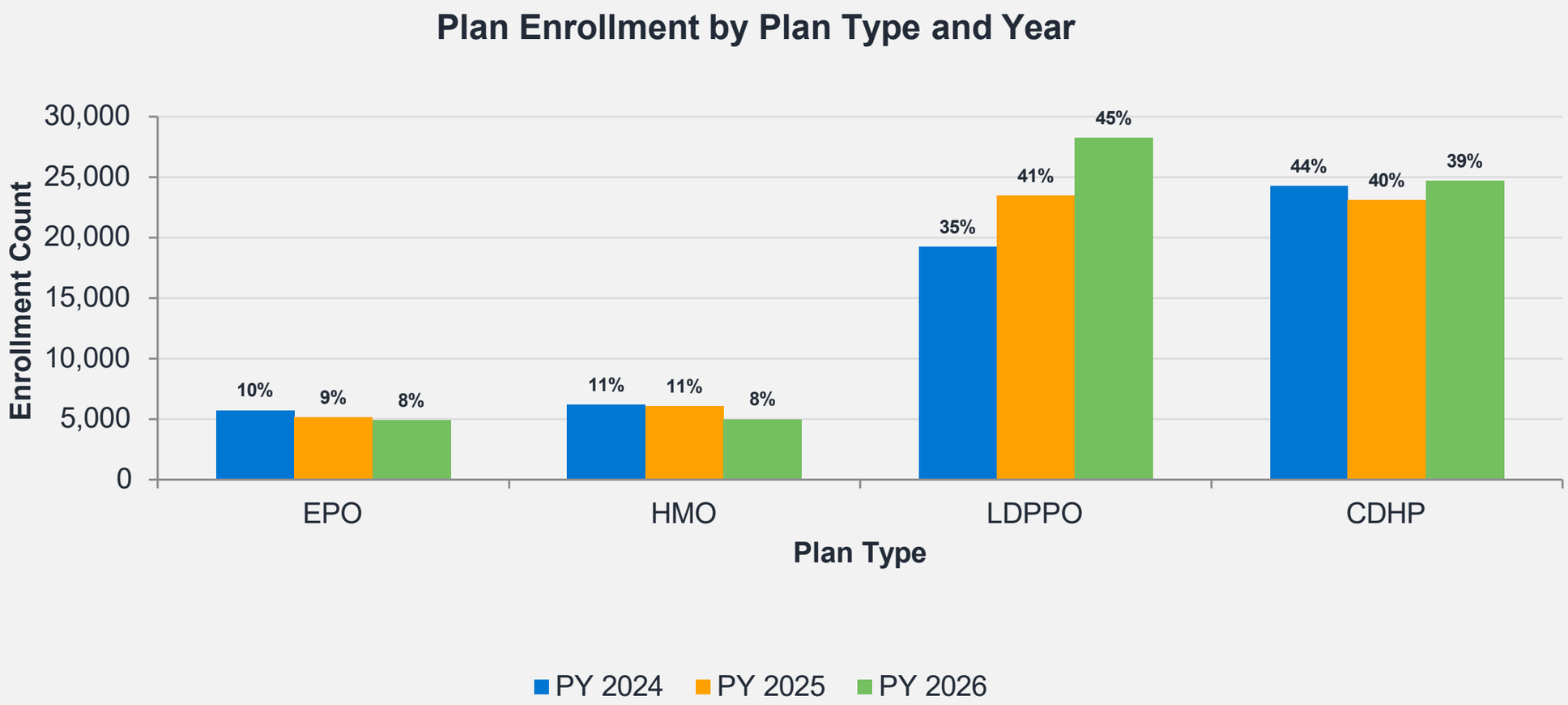
PEBP at a Glance

Year-over-year enrollment by plan, PY 2024 through PY 2026



PEBP at a Glance

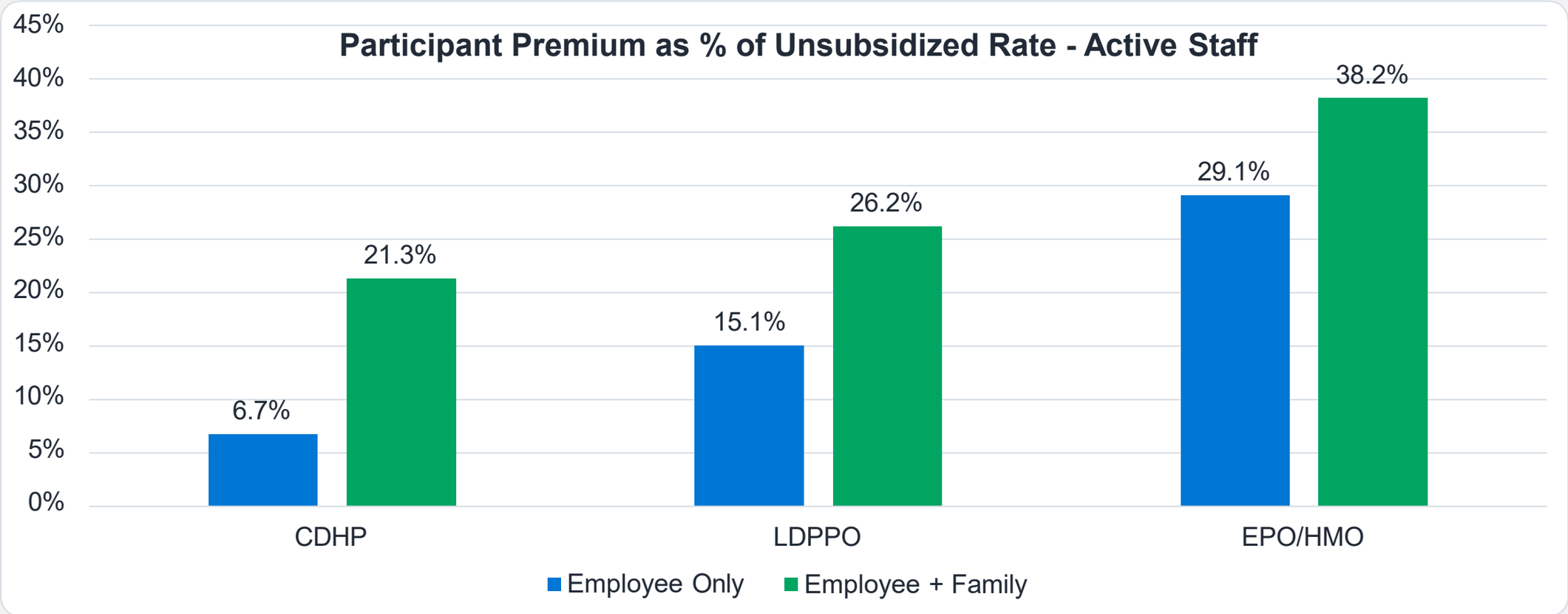
PY 2027 Plan Options

MEDICAL EXPENSE OVERVIEW (IN-NETWORK)

MEDICAL PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (PPO)	LOW DEDUCTIBLE PLAN (PPO)	EXCLUSIVE PROVIDER ORGANIZATION PLAN (EPO)	HEALTH PLAN OF NEVADA (HMO)
Service Areas In-Network	Global	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	N/A with exception of Tier 4 prescription drug coverage (see prescription overview)
Out-of-Pocket Maximum	$5,000 Individual $10,000 Family / $5,000 Individual Family Member	$5,000 Individual $10,000 Family / $5,000 Individual Family Member	$4,000 Individual $8,000 Family / $4,000 Individual Family Member OOPM	$5,000 Individual $10,000 Family / 5,000 Individual Family Member
HSA/HRA PEBP Contribution (Prorated after 7/1)	Base $700 + $200 each for dependent (up to three)	N/A	N/A	N/A
Medical Coinsurance	20% after Deductible	20% after Deductible	20% after Deductible	N/A
Primary Care Office Visit	20% after Deductible	$30 Copay	$20 Copay	$25 Copay
Specialist Visit (No Referral Required)	20% after Deductible	$50 Copay	$40 Copay	$25 Copay *with* a referral $40 Copay *without* a referral
Urgent Care Visit	20% after Deductible	$80 Copay	$50 Copay	$50 Copay
ER Visit	20% after Deductible	$750 Copay	$600 Copay	$600 Copay

Participant Premium Contributions

Active staff contributions as a percentage of unsubsidized premium rates – PY 2027



Key Findings

Program Structure and Benchmarking

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= Richer (i.e., more generous) than government benchmark

= Leaner (i.e., less generous) 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
Emergency Room	$750		$300		$350		$250		$225	
Urgent Care	$80		$75		$75		$50		$40	

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
Emergency Room	Ded; 20%		Ded; 20%		Ded; 20%		Ded; 0%		Ded; 20%	
HSA Funding (single)	$700		$780		$1,560		$800		$1,600	

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
Coinsurance	20%		N/A		0%		0%		0%		20%	
Emergency Room	$600		$600		$350		$200		$150		$150	
Retail Rx												
Non-Preferred Brand	$75		$75		$70		$60		$50		$50	

- **Deductible** is significantly richer than benchmarks for each plan type
- **Coinsurance, Office Visits, and Pharmacy Copays** are generally in line with benchmarks, except:
  - EPO coinsurance is leaner than benchmarks
  - HMO/EPO non-preferred brand Rx copays are leaner than 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
- **Urgent Care Copays** are also leaner than benchmarks for the LDPPO

Other benefits generally in line with benchmarks

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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

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

Local Comparator Benchmarking

Key observations comparing PEBP to local municipalities

Local comparators include:

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

PEBP vs. Local Benchmarks

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

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.

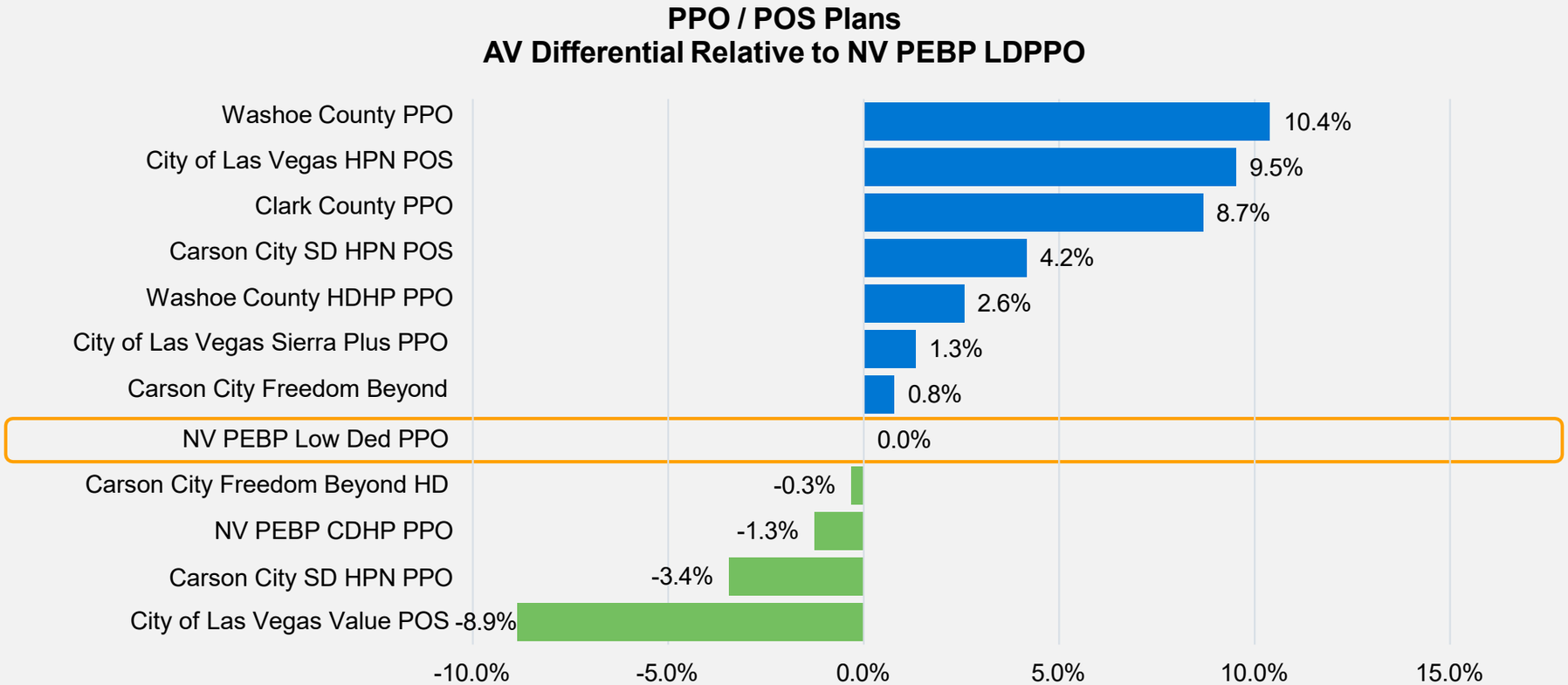
Retiree Coverage

- Information was available for Washoe County, Clark County, and Clark County School District
- Non-Medicare retirees generally eligible for the same plan options as actives, but with higher premium rates / contributions (rates appear to be set distinctly from actives, i.e., separate risk pools)

PEBP vs. Local Comparators

Actuarial value differentials – PPO/POS plans

Actuarial values include impact of employer HSA funding, where applicable / where information was available (including PEBP CDHP)



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

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

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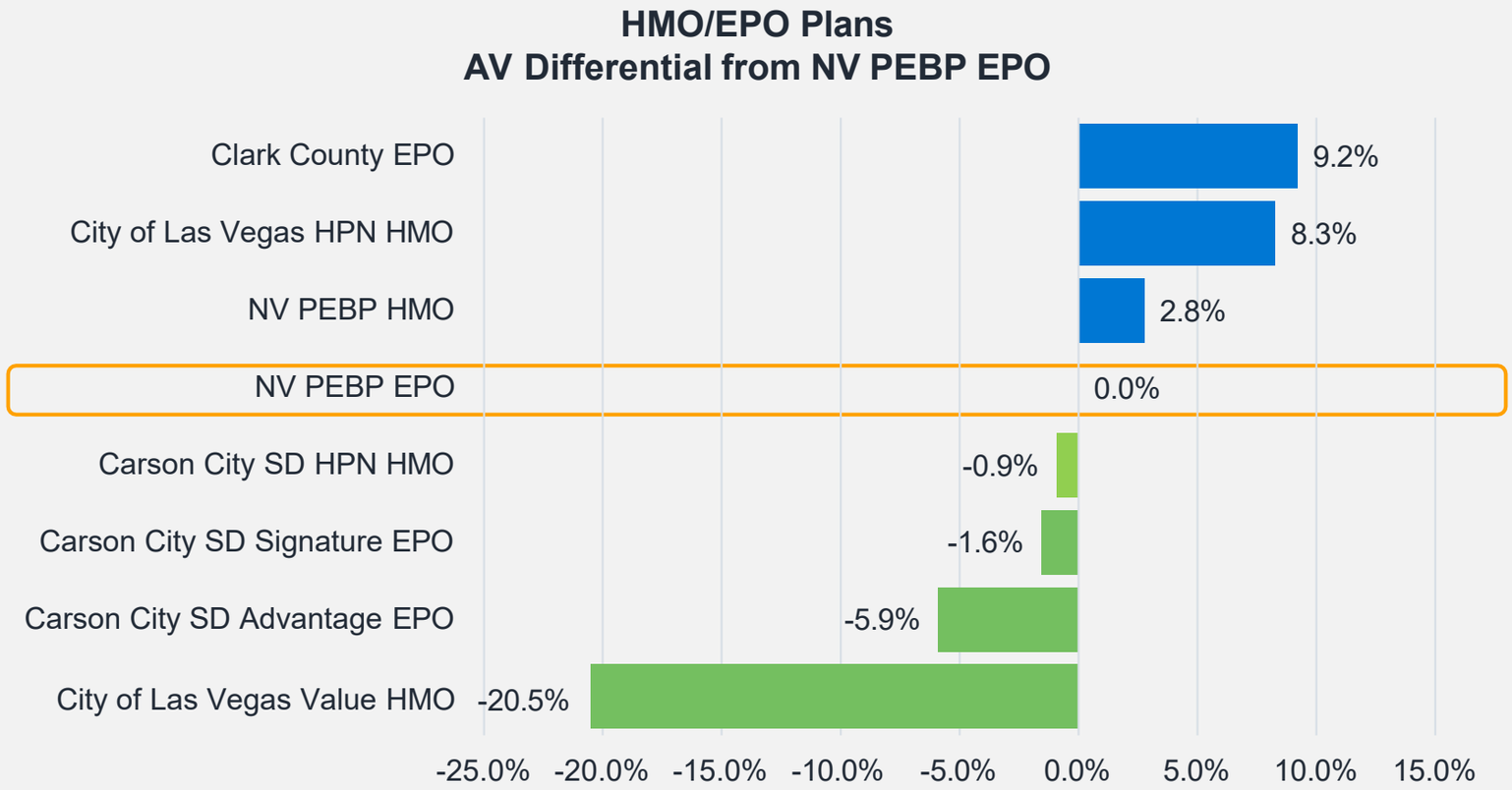
Note: plans with tiered networks assume 75% Tier 1 utilization.
Plans with no explicit specialty Rx cost sharing information assume 30% coinsurance.

PEBP vs. Local Comparators

Actuarial value differentials – HMO/EPO plans



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

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

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Note: plans with tiered networks assume 75% Tier 1 utilization.
Plans with no explicit specialty Rx cost sharing information assume 30% coinsurance.

Benchmarking – Key Takeaways and Opportunities Identified

Key Takeaways

- PEBP plans are competitive compared to national benchmarks across industries / employer sizes
- Some PEBP design components are more generous (and a few are slightly less generous)
- PEBP offers more choice than other state employee health plans on average and have higher actuarial values (i.e., plans are more generous)
- PEBP plans are generally in line with local comparators, with some components slightly less generous
  - Many local comparator plans include tiered networks to steer utilization towards narrow / more efficient provider networks
- PEBP premium subsidies deviate from local comparators
  - Several local comparators have little to no premium requirement for employees covering only themselves and much higher requirements for employees covering dependents

Opportunities Identified

- PEBP could consider:
  - Reducing the number of plans offered
  - Introducing tiered networks with differentiated cost sharing
  - Splitting active and retiree risk pools to be rated separately
  - Reallocating premium subsidies to reduce cost sharing for employees / increase for dependents
  - Increase deductibles across plan types
- These changes could potentially drive overall plan savings and promote more efficient plan utilization

Key Findings

Financial Performance and Utilization Analysis

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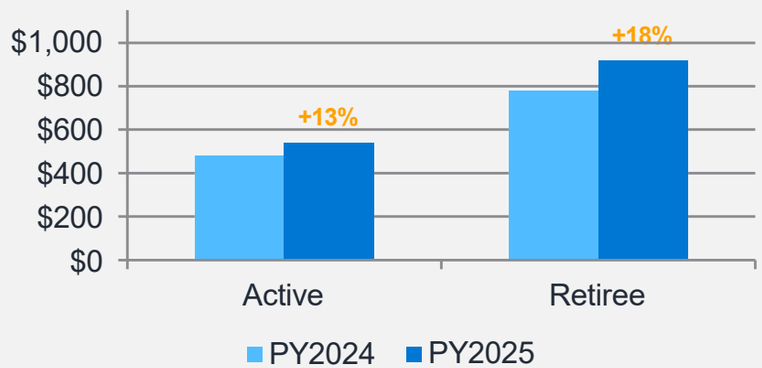
Financial Performance by Plan and Status

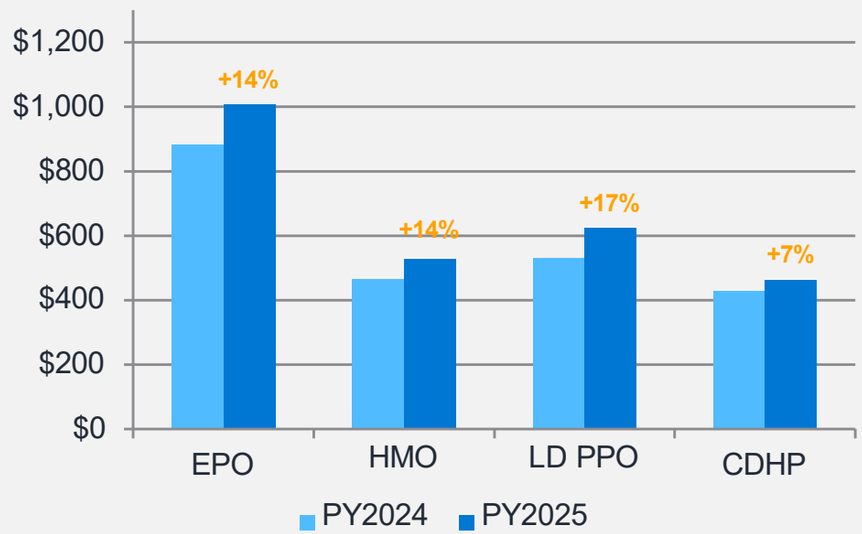
PY 2024 and PY 2025 costs PMPM by plan option and active / retiree status

PMPM by Status



- Non-Medicare retiree costs PMPM increased at a higher rate compared to actives from PY 2024 to PY 2025
- Retiree claims PMPM were ~62% higher than actives in PY 2024 and ~70% higher than actives in PY 2025

PMPM by Plan



- PMPM costs are lowest on the CDHP and highest on the EPO
  - EPO costs are higher than all other plans by a significant margin
- The CDHP also experienced the lowest actual year-over-year trend rate from PY 2024 to PY 2025

Utilization Benchmarks by Plan – LDPPO

PEBP plan costs PMPM compared to Milliman benchmarks based on utilization rates and average cost per service

	NORTHERN NEVADA			SOUTHERN NEVADA		
	BENCHMARK	PEBP	% DIFFERENCE	BENCHMARK	PEBP	% DIFFERENCE
Inpatient Facility	$64.45	$103.97	61.3%	$31.30	$77.19	146.6%
Outpatient Facility	$164.46	$204.24	24.2%	$88.09	$104.88	19.0%
Professional	$127.38	$182.85	43.6%	$104.96	$150.68	43.6%
Other	$14.74	$11.45	-22.3%	$14.17	$7.03	-50.4%
Pharmacy	$128.27	$182.91	42.6%	$120.84	$164.24	35.9%
Total	**$499.29**	**$685.42**	**37.3%**	**$359.36**	**$504.02**	**40.3%**

- High inpatient costs PMPM in both Northern and Southern Nevada appear to be driven by high unit costs (i.e., cost per service).
- High outpatient costs PMPM in Northern Nevada appear to be driven by high utilization rates. Unit costs are largely below benchmarks.
- Professional costs PMPM may be above benchmarks due to the mix of services obtained by PEBP members compared to benchmarks. There is wide variation in unit cost and utilization rates compared to benchmarks across specific service types.

Based on PEBP PY 2025 experience. Milliman benchmarks calibrated to PEBP demographics, plan design, geography, and average provider discounts.

Utilization Benchmarks by Plan – CDHP

PEBP plan costs PMPM compared to Milliman benchmarks based on utilization rates and average cost per service

	NORTHERN NEVADA			SOUTHERN NEVADA		
	BENCHMARK	PEBP	% DIFFERENCE	BENCHMARK	PEBP	% DIFFERENCE
Inpatient Facility	$59.89	$82.30	37.4%	$28.33	$76.04	168.4%
Outpatient Facility	$161.03	$147.42	-8.5%	$84.85	$91.15	7.4%
Professional	$120.33	$93.19	-22.6%	$96.98	$105.39	8.7%
Other	$11.60	$11.25	-3.0%	$10.93	$5.97	-45.4%
Pharmacy	$133.61	$134.69	0.8%	$121.95	$134.91	10.6%
Total	$486.46	$468.85	-3.6%	$343.04	$413.47	20.5%

Northern Nevada

- PMPM costs in the North were slightly better than benchmarks.
- High inpatient costs PMPM appear to be driven by high unit costs.
- Outpatient costs PMPM are below benchmarks, which appear to be driven by below benchmark utilization rates.
- Professional costs PMPM are also below benchmarks, driven by low unit cost and utilization rates.

Southern Nevada

- Costs PMPM are above benchmarks for most service categories.
- Professional costs PMPM exceed benchmarks, despite unit costs and utilization for most services generally falling below benchmark levels. This difference may reflect a service mix that differs from the mix represented in the benchmark data.

Based on PEBP PY 2025 experience. Milliman benchmarks calibrated to PEBP demographics, plan design, geography, and average provider discounts.

Utilization Benchmarks by Plan – EPO/HMO

PEBP plan costs PMPM compared to Milliman benchmarks based on utilization rates and average cost per service

	NORTHERN NEVADA – EPO			SOUTHERN NEVADA – HMO		
	BENCHMARK	PEBP	% DIFFERENCE	BENCHMARK	PEBP	% DIFFERENCE
Inpatient Facility	$66.47	$223.59	236.3%	$33.47	$118.46	254.0%
Outpatient Facility	$172.06	$240.36	39.7%	$96.77	$79.38	-18.0%
Professional	$132.10	$222.68	68.6%	$114.27	$97.22	-14.9%
Other	$15.20	$20.23	33.1%	$12.91	$16.84	30.5%
Pharmacy	$147.02	$301.57	105.1%	$138.19	$215.39	55.9%
Total	$532.85	$1,008.42	89.3%	$395.61	$527.30	33.3%

EPO

- Costs PMPM are well above benchmarks across all service categories, which appears to be driven by:
  - High inpatient unit costs
  - High outpatient utilization rates
  - Overall difference in service category mix vs. benchmarks
- High inpatient costs PMPM appear to be driven by high unit costs (i.e., cost per service).

HMO

- PEBP costs for the HMO may not be as directly comparable to benchmarks given the capitated structure for certain services on the HMO.
- In general, costs PMPM are above benchmarks for most service categories.

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Based on PEBP PY 2025 experience. Milliman benchmarks calibrated to PEBP demographics, plan design, geography, and average provider discounts.

Financial Performance and Utilization Review – Key Takeaways and Opportunities Identified

Key Takeaways

- PEBP costs PMPM are higher than benchmarks for all plans in both Northern and Southern Nevada, except the CDHP in Northern Nevada.
- Inpatient costs PMPM are significantly higher than benchmarks across all plans / geographies.
  - This appears to be driven by high unit costs (i.e., cost per inpatient day) rather than high utilization rates (i.e., number of inpatient days).
  - This could imply provider reimbursement rates are less competitive than the market, or that members are utilizing providers with higher average costs per service compared to market norms.

Opportunities Identified

- PEBP could consider:
  - Increasing member cost sharing via plan design to drive more efficient utilization.
  - Pursuing more competitive provider reimbursement rates.
  - Adjusting / eliminating underperforming plan options.
  - Implementing tiered provider networks with benefit differentials to drive utilization at more efficient providers.

Key Findings

Network Adequacy and Efficiency

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Network Discount / Disruption Analysis

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Traditional Network Discount / Disruption Analysis

Comparing UMR to other major national carriers and third-party administrators

Background

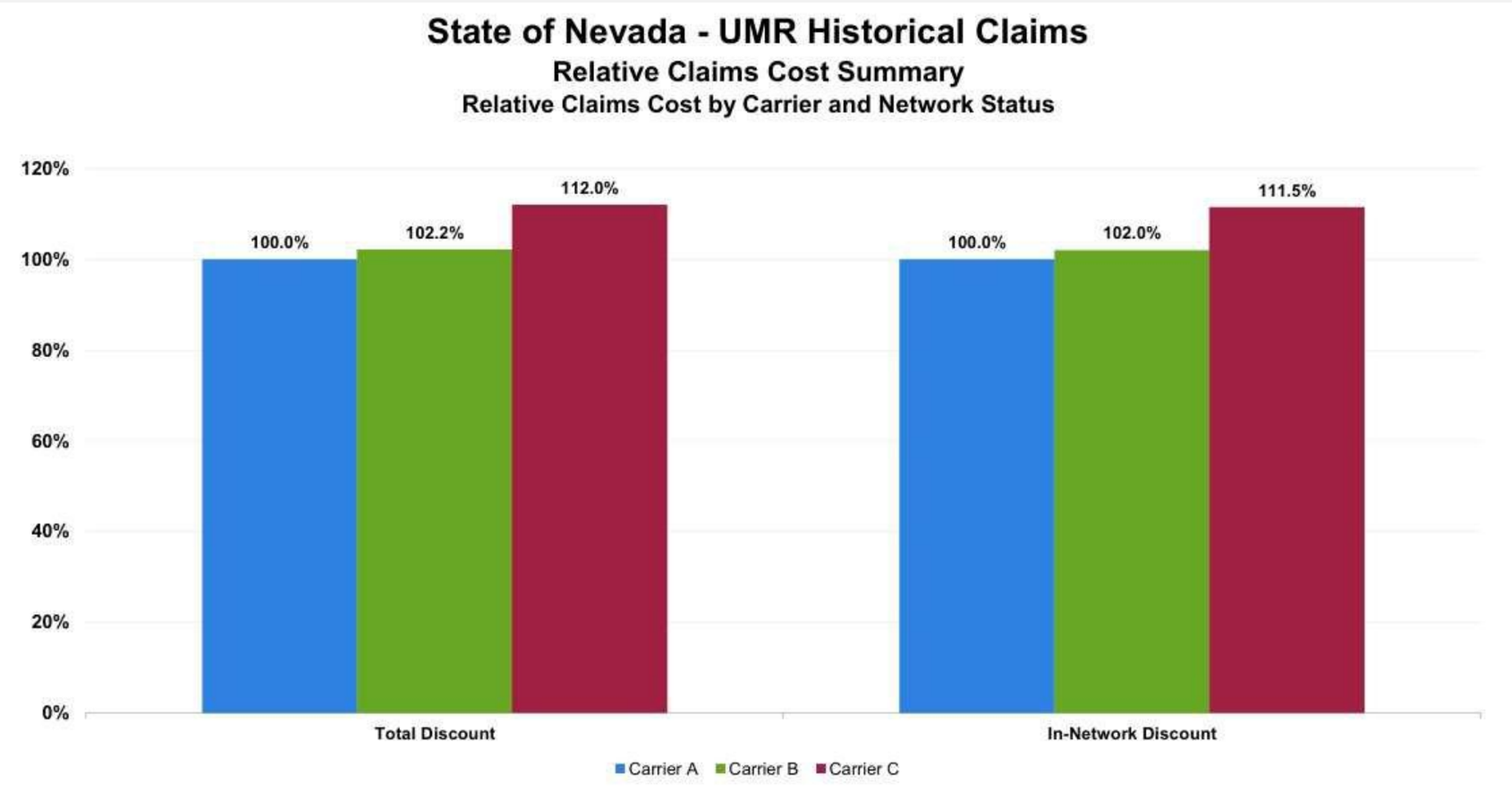
Milliman completed a medical network analysis and disruption comparison for PEBP to determine the expected relative claims cost based on providers / services utilized by PEBP members for medical claims paid between January 1, 2025 and December 31, 2025. We repriced PEBP claims based on each carrier's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

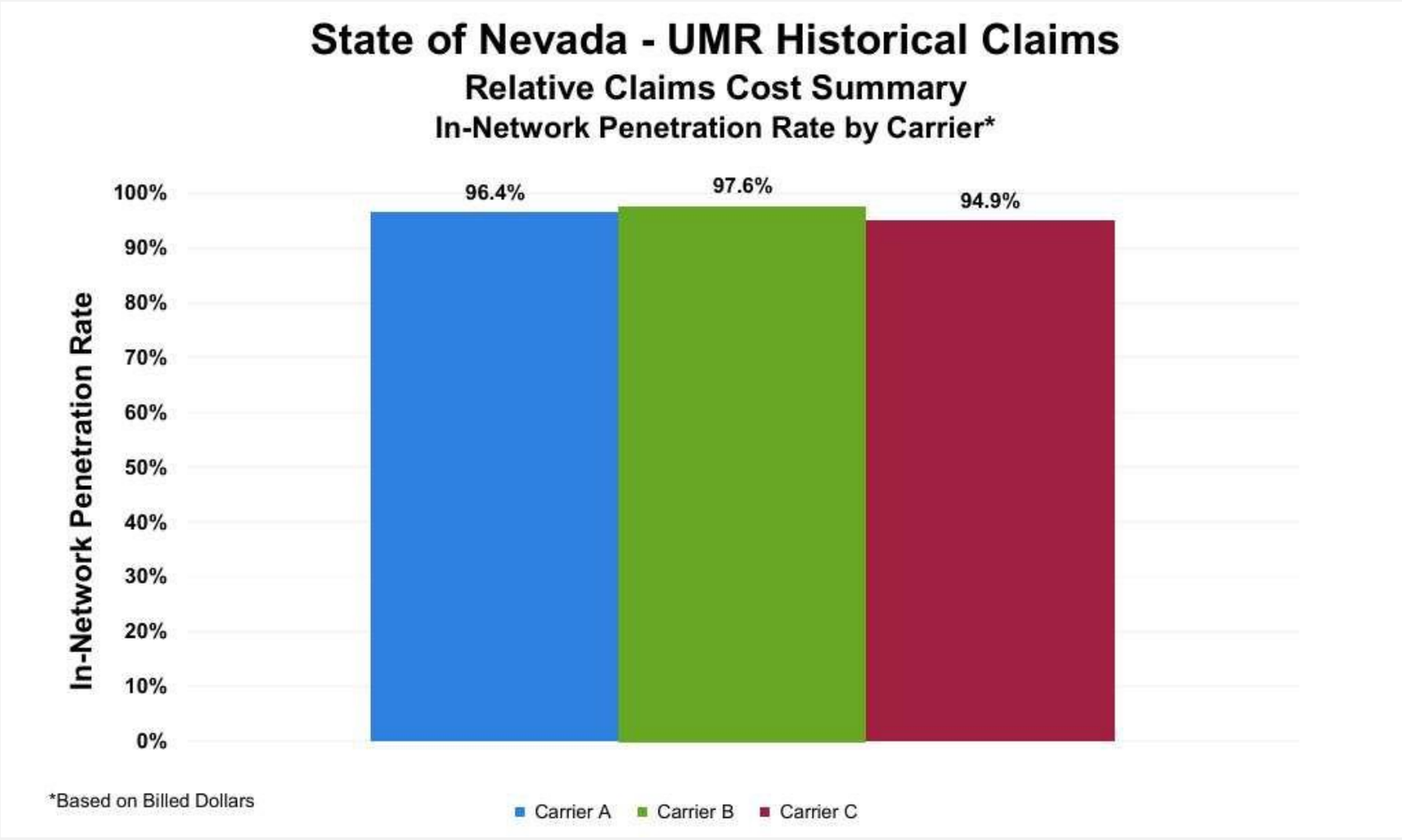
Results – discount relativity by carrier



- **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

Results – in-network penetration by carrier



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

Price Transparency Analysis

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Price Transparency Analysis – Background

- The Hospital Price Transparency (HPT) and Transparency in Coverage (TiC) federal requirements enacted in the last few years have made a vast amount of proprietary data publicly available for the first time.
- The Centers for Medicare and Medicaid Services (CMS) published a Final Rule in 2019 requiring hospitals to publish machine-readable files (MRF) of their negotiated payment rates starting January 1, 2021.
- Additionally, in 2020, the U.S. Department of Health and Human Services, Department of the Treasury, and Department of Labor collectively released the Transparency in Coverage Final Rules, requiring group health plans and health insurance issuers to publish certain information about the prices of healthcare services.
- Milliman Transparent leverages foundational data from Turquoise Health, which aggregates the publicly available data resulting from the regulations outlined above and enriches the data using Milliman's vast claims and contracting experience to improve data quality and usability. Milliman Transparent incorporates proprietary utilization profiles and standardized pricing to create case-mix-weighted percent of Medicare relativities that enable fair contract comparisons.

Price Transparency Analysis – PEBP Analysis

- In order to assess the strength of PEBP's existing TPA and health plan provider contracts, we reviewed several different cuts of data from Milliman Transparent. Broadly, we evaluated statewide data for Nevada. We then narrowed our focus to specific hospitals and health plans / TPAs that PEBP already uses and / or that may be relevant for benchmarking purposes. We grouped PY 2025 incurred claims by National Provider Identifier (NPI) to determine the top hospitals / hospital systems utilized by PEBP members based on total paid claims (combined across service categories – inpatient, outpatient, and professional). This yielded the following list of top providers:
  - Renown Regional Medical Center
  - Carson Tahoe Regional Medical Center
  - Renown South Meadows Medical Center
  - Dignity Health – St. Rose Dominican Hospitals – Siena Campus
  - Sunrise Hospital and Medical Center
  - Summerlin Hospital Medical Center
  - Carson Valley Health Hospital
  - Mountainview Hospital
  - University Medical Center
  - Centennial Hills Hospital Medical Center
- Outpatient spend generally represents a larger proportion of spend at these hospital systems compared to inpatient spend, but inpatient spend is still significant. Notably, outpatient spend is particularly high as a percentage of total spend at Renown and Carson Tahoe.

When evaluating the market at large, we focused on comparing provider reimbursement rates at PEBP's top hospitals for the following health plans / networks:

- Anthem PPO
- United Healthcare Choice Plus
- United Healthcare Options (includes Sierra Care Options)
- Hometown HMO

Health Plan Nevada data was not well populated in the HPT or TiC datasets. Information for many providers was available for Aetna and Cigna, but we did not focus on these given their overall presence in the Nevada commercial market.

Payer (TiC) Transparency Data

Inpatient / Outpatient Overview

Percent of Expected Color Coding

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

GVRU Medicare

Market Data Summary

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

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

Please refer to pages 44-47 for additional information, caveats, and limitations about price transparency data summaries

Hospital (HPT) Transparency Data

Inpatient / Outpatient Overview

Percent of Expected Color Coding
- Greater than 75%
- Between 75% to 50%
- Between 50% to 25%
- Less than 25%

GVRU Medicare

Market Data Summary

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

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

Please refer to pages 44-47 for additional information, caveats, and limitations about price transparency data summaries

Network Adequacy and Efficiency – Key Takeaways and Opportunities Identified

Key Takeaways

- The traditional network discount analysis shows two national carriers that have average discounts within a few percentage points of each other. One additional carrier did not respond to our RFI. There could be competitive network discounts available with limited disruption with other TPAs / carriers.
- Transparency data indicates UHC Choice Plus network may not reflect best-in-market rates at all hospitals, particularly for outpatient services. We performed a deeper review of transparency data at Carson Tahoe and Renown, where PEBP has significant claim spend:
  - Carson Tahoe
    - UHC Choice Plus generally appears competitive on inpatient
    - Anthem's rates appear more competitive for select outpatient service categories
    - UHC Options network (which we understand includes Sierra Care Options) appears more competitive than UHC Choice Plus for outpatient reimbursements overall
  - Renown
    - UHC Choice Plus may not be optimal for outpatient services
    - Anthem PPO and Hometown HMO networks appear more favorable compared to UHC Choice Plus

Opportunities Identified

- PEBP could consider:
  - Conduct TPA / carrier procurement, including tiered network options, alternative HMO options, and performance guarantees on network discounts / provider reimbursement rates
  - Pursuing more competitive provider reimbursement rates via direct contracts with select providers
  - Evaluate market-wide reimbursement caps / reference-based pricing strategy for select services or on a broad basis
    - Could be done as a second phase after direct contract pursuit, or if direct contracts are not viable
    - To be explored as part of broader NVHA cross-program initiatives
    - Leverage Transparency data for this evaluation

Next Steps

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Next Steps

NVHA / PEBP Decisions

Select initiatives to advance / evaluate further

Start legal / actuarial review of active / retiree risk pool separation

Develop TPA / carrier RFP

Evaluate plan design / dependent subsidy adjustments

Start direct contracting discussions with select providers

Q&A

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Caveats, Limitations on Use, and Additional Information

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Caveats and Limitations on Use

We are consulting actuaries and pharmacy benefit consultants with Milliman. Andrew Timcheck 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.

Cost and Utilization Benchmarking – Additional Information

- 2025 Milliman *Health Cost Guidelines™ (HCGs)* for average managed care as benchmark basis
  - Nationwide detailed claims and enrollment data represent over 100 million commercially insured lives

- Further, the *HCGs* were calibrated to Northern Nevada or Southern Nevada for:
  - Region and plan combination
  - Demographics
  - 2025 plan year PEBP approximated service discounts (medical and pharmacy)

- Plans by region were then compared to these calibrated benchmarks

Network Discount / Disruption Analysis

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.

Price Transparency Analysis

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

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:
    - Percent of Expected greater than 75%: Highly reliable
    - Percent of Expected between 50% and 75%: Generally reliable; consider additional investigation
    - Percent of Expected between 25% and 50%: Moderately reliable; recommend additional investigation
    - Percent of Expected less than 25%: Generally unreliable; recommend code-level investigation

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 – 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 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