# Nevada
# Public Employees' Benefits Program

October 24, 2025



Segal

# Agenda

- **Review Current Plans**
  - **Benefits**
  - **Premiums**
  - **Enrollment**
- **Reserves**
- **Trends and Cost Drivers**
- **Retiree Health (OPEB)**
- **Plan Year 2027 Plan Changes**

# Current Plan Designs and Premiums

## In-network benefits

| | CDHP | LDPPO | EPO | HMO |
|---|---|---|---|---|
| Actuarial Value | 76.0% | 85.1% | 88.7% | 91.4% |
| Service Area | Global | Global | Northern Nevada | Southern Nevada |
| Annual Deductible | $1,600 Individual<br>$3,200 Family<br>$3,200 Individual Family Member Deductible | $0 | $100 Individual<br>$200 Family<br>$100 Individual Family Member Deductible | N/A With exception of Tier 4 prescription drug coverage |
| Medical Coinsurance | 20% after deductible | 20% after deductible | 20% after deductible | N/A |
| Out-of-Pocket Maximum | $4,000 Individual<br>$8,000 Family | $4,000 Individual<br>$8,000 Family | $5,000 Individual<br>$10,000 Family | $5,000 Individual<br>$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<br>$50 copay<br>Hospital<br>$350 copay |
| PY2026 Employee Only Premium | $55.26 | $91.79 | $219.91 | $219.91 |

* Actuarial Value based on FY22 and FY23 data.
** 30-day supply Tier 1 / Tier 2 / Tier 3 / Tier 4
***Deductible: $100 Individual, $200 Family

# PY2025 Medical/Rx Plan Performance

- Total medical/Rx expenses exceeded revenue by $25.6M for active and retired employees, including State and non-State
- CDHP subsidizes the other two plans

| | CDHP | LDPPO | EPO/HMO | Total |
|---|---|---|---|---|
| Total Revenue* | $148,788,900 | $135,852,600 | $83,293,500 | $367,935,000 |
| Total Expenses** | $126,905,700 | $162,008,800 | $104,638,600 | $393,553,100 |
| Net | $21,883,200 | ($26,156,200) | ($21,345,100) | ($25,618,100) |
| Avg Enrollment | 14,176 | 12,188 | 6,279 | 32,643 |
| Revenue PEPM*** | $875 | $929 | $1,106 | $939 |
| Expenses PEPM | $746 | $1,108 | $1,389 | $1,005 |
| **Net PEPM Difference** | **$129** | **($179)** | **($283)** | **($65)** |

* State funding, employee and retiree premium contributions (excludes contributions to dental, life and general PEBP administration costs and revenue received in PY2025 attributable to prior plan years).
** Incurred claim costs, fully insured HMO premiums, HSA contributions, HRA claims (excluding supplemental) and administrative costs, net of prescription drug rebates
*** Per Employee Per Month

# PY2025 Medical/Rx Active State Employees

Participant Only Tier

- The CDHP rates subsidize the LDPPO and EPO/HMO rates
- For the CDHP, the subsidies exceed the total projected cost

| | CDHP | LDPPO | EPO/HMO |
|---|---|---|---|
| Subsidized Rate | $714.88 | $753.70 | $852.80 |
| Base Subsidy | $651.32 | $651.32 | $651.32 |
| Planned Spend-down | $8.30 | $17.12 | $20.24 |
| Employee Premium | $55.26 | $85.26 | $181.24 |
| **If No Cross-Subsidies Between Plans** (if we just let the math flow – and no migration considered) | | | |
| Unsubsidized Rate | $615.68 | $801.11 | $1,112.66 |
| Base Subsidy | $651.32 | $651.32 | $651.32 |
| Planned Spend-down | $8.30 | $17.12 | $20.24 |
| Employee Premium | ($43.94) | $132.67 | $441.10 |

**Does not consider migration, which would be significant and result in higher costs for each plan.**

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| **If No Cross-Subsidies Between Plans** (CDHP has $0 premium – and no migration considered) | | | |
| Unsubsidized Rate | $615.68 | $801.11 | $1,112.66 |
| Base Subsidy | $607.38 | $651.32 | $651.32 |
| Planned Spend-down | $8.30 | $17.12 | $20.24 |
| Employee Premium | $0 | $132.67 | $441.10 |

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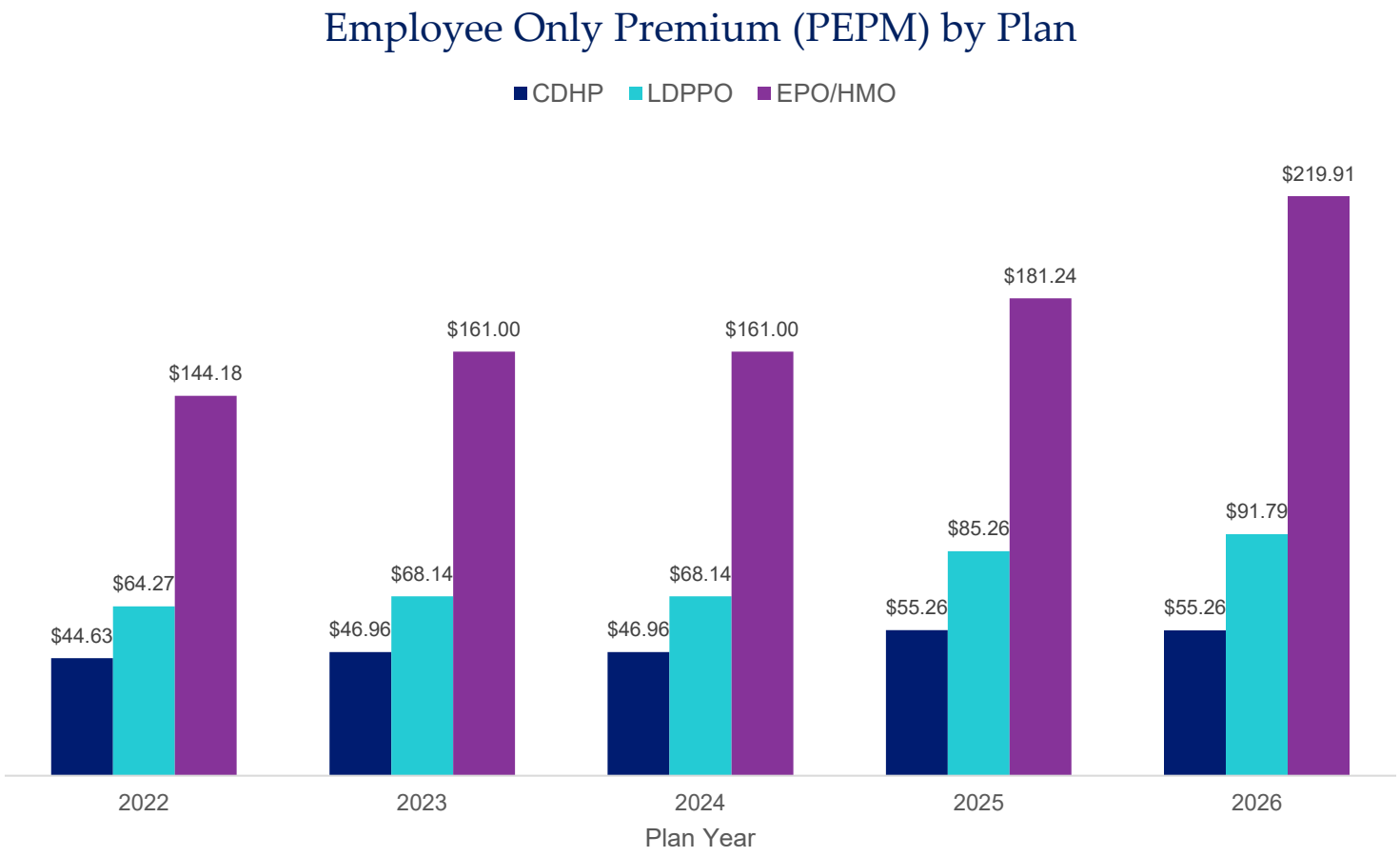
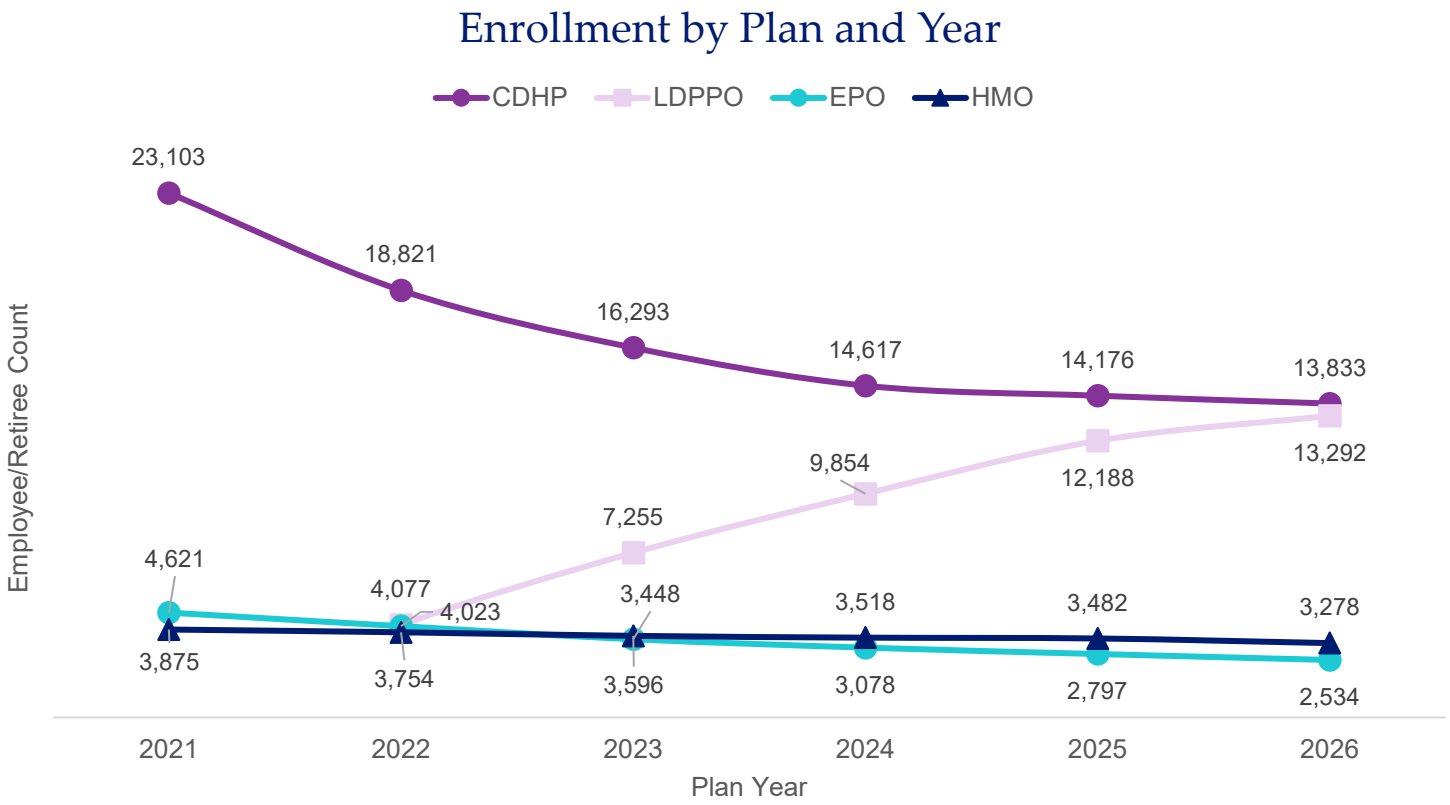
# Historical Employee Only Premiums




**EPO/HMO premiums are ~2.5x the LDPPO premiums and ~4x the CDHP premiums.**

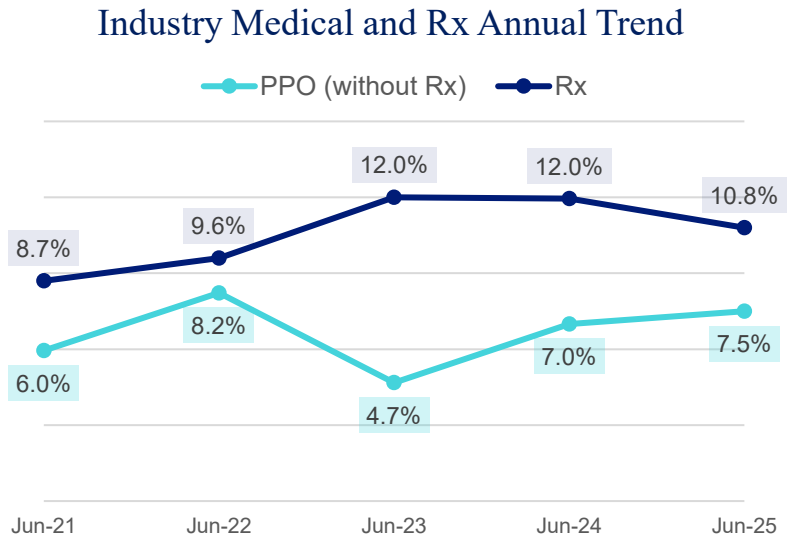
# Migration to the LDPPO

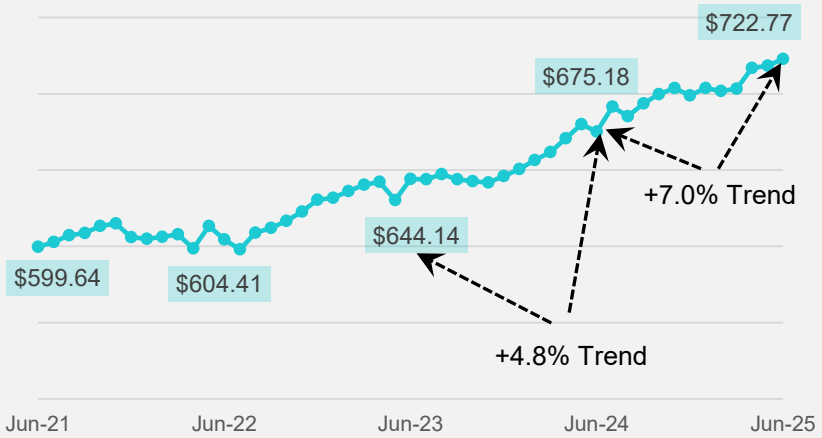


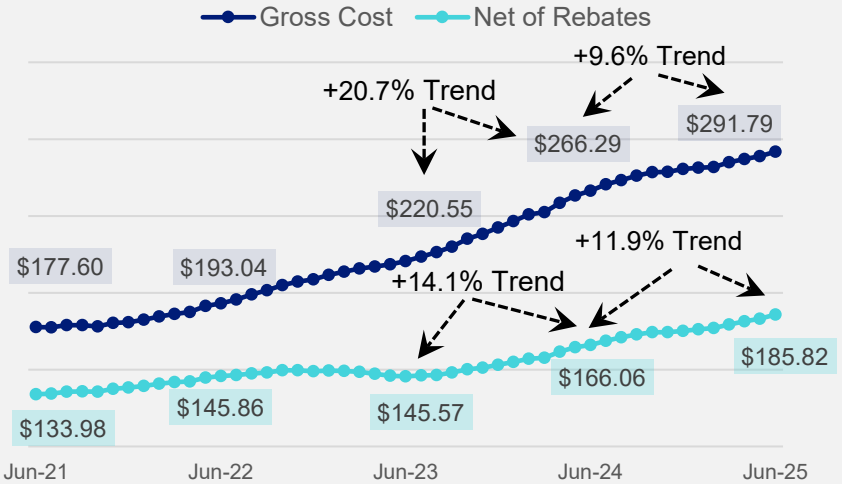

**Members are migrating to the LDPPO from both the EPO/HMO and the CDHP**

# Medical/Rx Cost Trends

- Rx trend drivers[1]
  - The number of patients utilizing Mounjaro and Ozempic continues to rise (2-3x that of prior period)
  - Specialty patients increasing by 15-20% in FY25
- Medical trend drivers[2]
  - HCCs account for $2M increase between FY24/FY25
  - Cancer prevalence is 7.9% of members
  - Diabetes prevalence is 6.4% of members
  - MSK prevalence is 18.9% of members



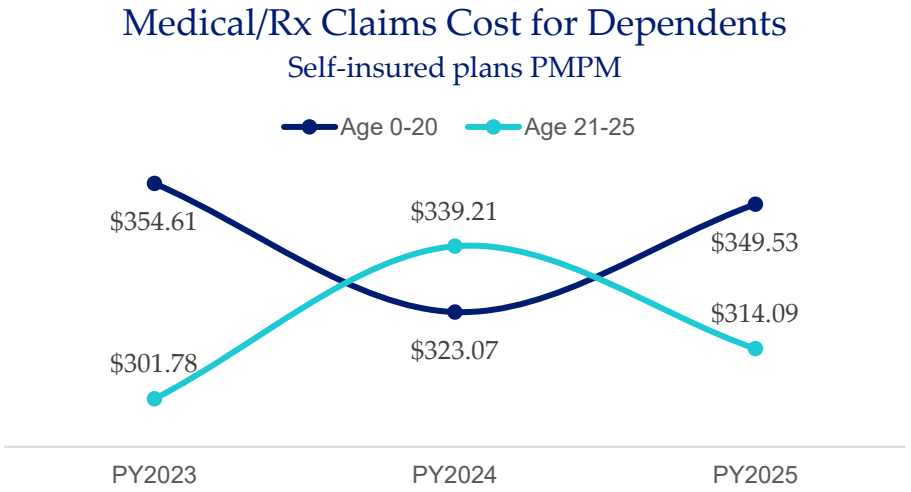



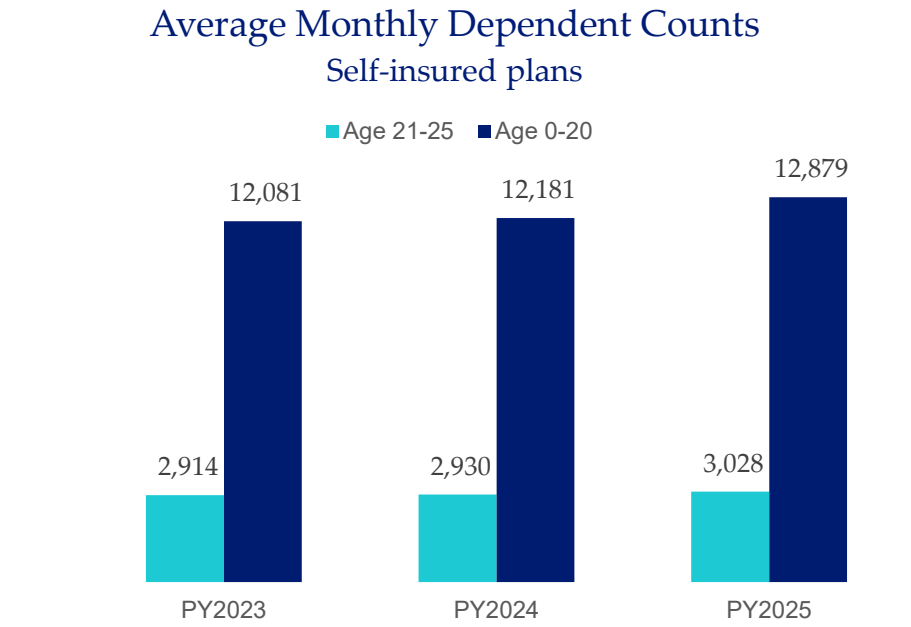

[1] Based on ESI reporting through December 31, 2025
[2] Based on UMR reporting through December 31, 2025

# Dependent Costs PMPM

## Self-insured plans

- The Affordable Care Act requires PEBP to cover all dependent children to age 26
  - Previous coverage was to age 21
- Over the last three years, dependent child enrollment has increased by 25% with the Age 21-25 dependent population.
- In PY2025
  - Total dependent costs = $65.4M
  - Age 21-25 dependent costs = $11.4M, or 17.5%
  - Age 21-25 dependents have lower pmpm costs than for those < age 21



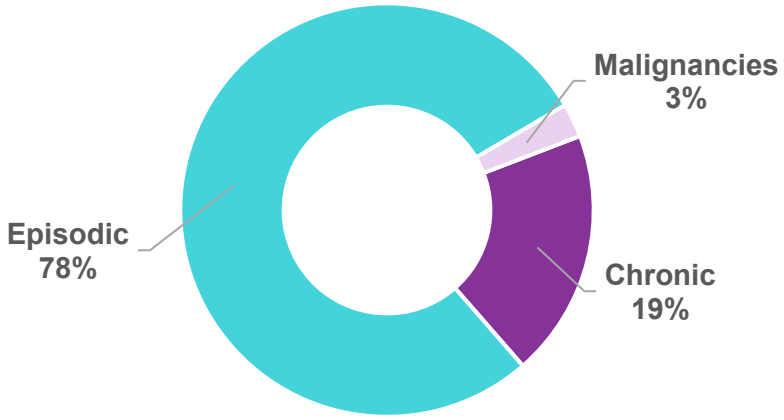

[1]PMPM costs are shown for medical and prescription drug benefits before application of Rx rebate on an incurred basis.

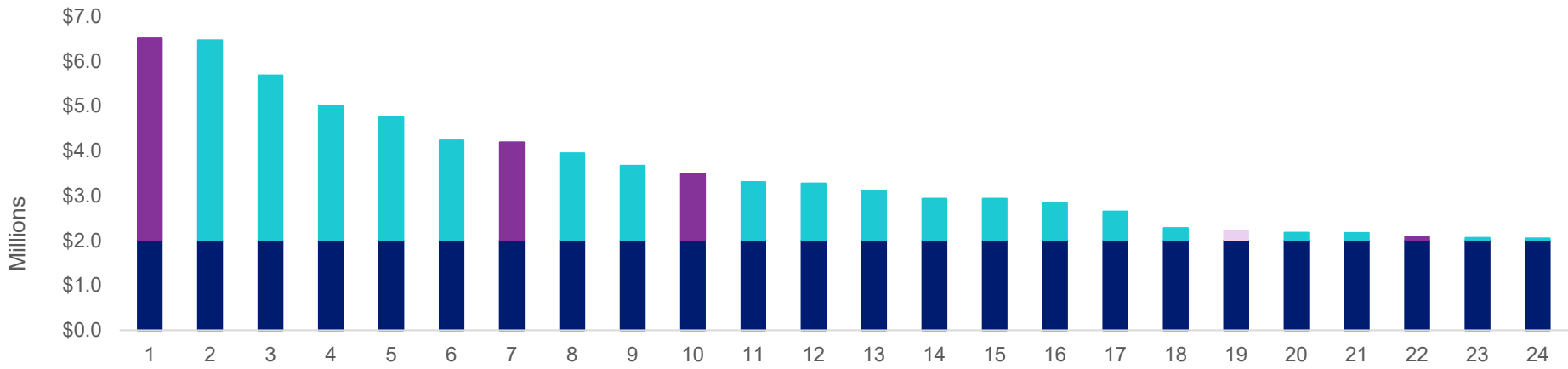
# Lifetime Maximum Benefit

July 1, 2018 through June 30, 2025

## Self-insured plans

- The self-insured plans once included a lifetime maximum benefit of $2.0M per patient.
- Lifetime maximums were eliminated from the plan design because of the Affordable Care Act.
- Over the last seven (7) years, 24 members have incurred plan costs exceeding $2.0M, totaling $84.1M. ($36.1M in excess of $2.0M.)
  - Most are episodic
- 15 of these patients are currently covered by PEBP
- 15 additional current PEBP members have at least $1.5M in claims in the last 7 years.



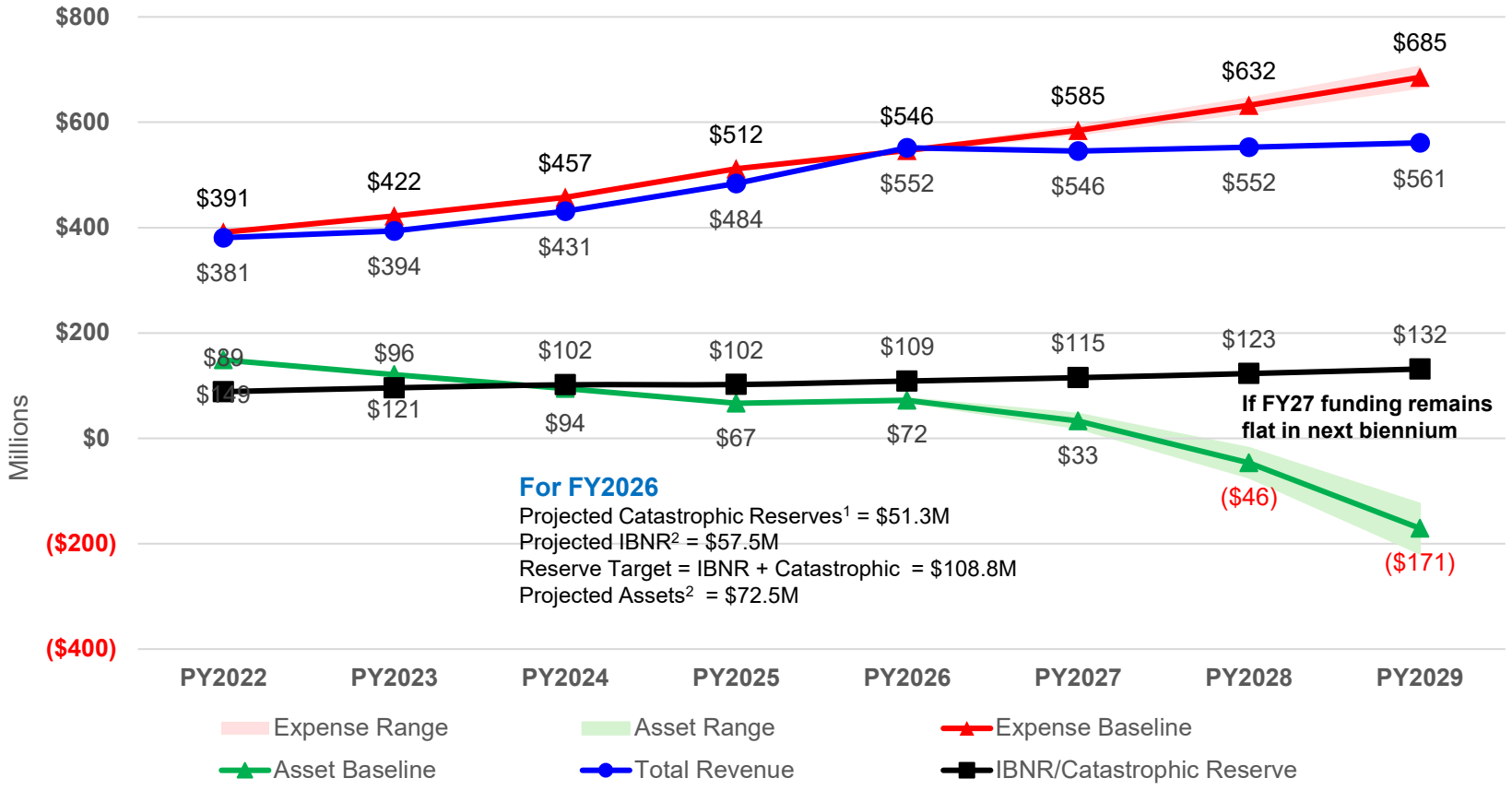




[1].Lifetime costs are based on claims incurred beginning July 1, 2018 and ending June 30, 2025 for medical and prescription drug benefits. Claims cost shown are before pharmacy rebates are applied.

# Reserves

- Leading up to FY2024, reserves were actively spent down
  - Plan changes, premium subsidies and supplemental HRAs
- Trend increase accelerated at the same time
- Recent large increase in AEGIS and REGI for FY2026 was sufficient to close the funding gap
- Decrease in AEGIS for FY2027 will resume spend-down, which will accelerate without additional increases, or cost reduction measures

| | FY24 | FY25 | FY26 | FY27 |
|---|---|---|---|---|
| AEGIS | $730 | $759 | $1,022 | $982 |
| REGI | $515 | $545 | $1,007 | $1,023 |




[1]Catastrophic Reserve set at 50 days of claims for PY2024 and earlier; 45 days of claims for PY2025 and later.
[2] Assets and IBNR estimated for FY2026.

# OPEB Valuation for GASB 74/75 Accounting

**Governmental Accounting Standards Board (GASB) Statements No. 74 and 75 - accounting requirements focusing on other long-term retiree benefit costs**

**O ther** (i.e., other than pensions)
**P ost**
**E mployment**
**B enefits** (considered part of the benefit package)

**Accounting treatment is like pension benefits**

**At PEBP, OPEB includes retiree healthcare and life insurance benefits**

- Non-Medicare retirees can enroll in PEBP plans
- Medicare Exchange for Medicare retirees
- Retiree subsidies vary based on service
- Only employees hired before January 1, 2012, receive explicit subsidies
- All non-Medicare retirees benefit from the implicit subsidy (blended premiums)

# GASB 74/75 Valuation
# How is the "liability" calculated?

Main liability measure is the Total OPEB Liability (TOL), which is the portion of the **present value** of **future benefits** attributed to **past service**

- **Present value**
  - Future benefit costs are discounted to one-point in time
  - Because PEBP benefits are not prefunded (pay-as-you-go), discount rate is based on market municipal bond yields
- **Future benefits**
  - Retiree benefits modeled using the substantive plan provisions and estimated retiree claims costs.
  - **This includes direct/explicit subsidies, as well as indirect/implicit subsidies.**
  - PERS assumptions used to model rates of termination, retirement, disability and death
  - Additional healthcare assumptions regarding trend, participation and plan elections. For example, 85% of pre-2012 employees and 35% of post-2012 employees are assumed to participate
- **Attributed to past service**
  - For current active employees, more of their present value of benefits will accrue as they continue to work
  - For current retirees, accrued liability equals present value of future benefits (liability is fully accrued)

# GASB 74/75 Valuation ($ in millions)

| Valuation Date | June 30, 2024 | June 30, 2023 |
|---|---|---|
| Net benefit payments | $68.5 | $69.4 |
| | | |
| Total OPEB Liability (accrued liability) | $1,344 | $1,427 |
| Plan Fiduciary Net Position (assets) | -14 | -31 |
| Net OPEB Liability (unfunded liability) | $1,358 | $1,458 |
| | | |
| Covered Payroll | $2,587 | $2,372 |
| Ratio of NOL to covered payroll | 52.5% | 61.5% |
| Discount Rate | 3.93% | 3.65% |

- **TOL is roughly 20 times the size of current annual benefit payments**
- **TOL decreased mainly due to:**
  - Lower than expected claims costs
  - Decrease to participation assumptions for future retirees
  - Increase to discount rate from 3.65% to 3.93%
- **Ratio of NOL to covered payroll is used to compare plans**
  - PEBP's accrued long-term liability is roughly 53% of one year's payroll
  - Employees hired on or after January 1, 2012, receive zero explicit premium support
    - 71% of active employees (21,741 of 30,699) hired after January 1, 2012

# Approved Plan Changes

## Approved at the July Board meeting

- Wigs/alopecia
  - Expand coverage to include alopecia (in addition to those undergoing cancer treatment)
- Speech therapy (statutory requirement)
  - Increase eligibility age from 19 to 26
  - Expand coverage to include stuttering and stammering
- Increase deducible in CDHP in line with federally mandated increase in minimum deducible levels for HSA-qualified plans
  - $1,650/$3,300 (single/family) to $1,700/$3,400
- Mental Health Therapy
  - More than one mental health therapy session/ therapy type may be scheduled in a single day; treated as separate sessions/ therapy types for copay and billing even if same provider.
- Autism – coverage to clarify the following are included
  - Ongoing assessment
  - Medication
  - Behavioral therapy (social skills training, applied behavioral analysis, etc)
  - Physical, as well as speech and language therapy

# Medical Pharmacy Coupon Program

**Implement coupon program for specialty drugs administered through the medical benefit**

**Why?**

- UMR program that could reduce costs for both PEBP and patients
- Leverages manufacturer coupons like ESI's SaveOnSP, but for drugs administered in an inpatient setting
- SaveOnSP applies only to outpatient medications

**Next steps**

- Review program details with UMR (is the CDHP eligible?)
- Evaluate member impact versus plan savings (shared savings terms)

# Care Access

## Streamline Access to Care

### *Why?*

- Current plan structure may add to provider burden without managing care or costs
- Current plan provisions may limit access to early intervention care

### *What?*

- Remove Prior Authorization requirement for biopsy coverage
  - Nearly 100% approval rate
  - Removes administrative step that slows access to care
  - Net cost to PEBP
- Cover diagnostic breast imaging and colonoscopies at 100%
  - Would need to be subject to deductible in CDHP
  - Removes barrier to early detection
  - May be net cost to PEBP in short-term, but provide long-term benefits to PEBP and patients

### *Next Steps*

- Determine cost and member impact

**PY2024**

| | |
|---|---|
| # PAs | 1,194 |
| Cost | $50 |
| Total Fees | $59,700 |

**PY2025**

| | |
|---|---|
| # PAs | 807 |
| Cost | $50 |
| Total Fees | $40,350 |

# Network Lab Access and Education

## Steerage and Member Education

***Why?***

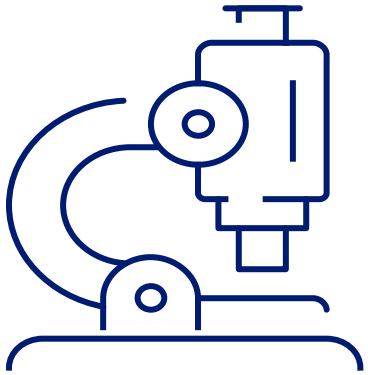
- Patients often utilize labs as directed by physician without considering network status
- Result can be higher costs for PEBP and for member

***What?***

- Cover first non-network lab at network cost share
  - Can be first every year or first ever
- Provide educational materials about network lab access and cost impact

***Next Steps***

- Determine cost and member impact



# Vision

## Modernize and Update Vision Benefit

***Why?***

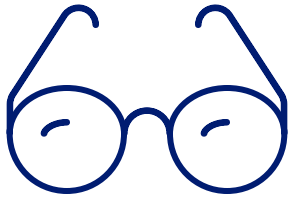
- $100 Annual Benefit Maximum may be out-of-step with current market
- Covered services/materials varies by plan
- Provider network would reduce costs – for both PEBP and members

***What?***

- Add hardware coverage to CDHP to align with LDPPO and EPO coverage
- Increase current $100 annual benefit limit to align with market
- Implement a vision provider network

***Next Steps***

- Develop specific options
- Benchmark benefits
- Determine cost impact
- Review contracting options to access provider network



# Pharmacy

## Copay Incentives to Steer Towards Lower Net Cost Options

***Why?***

- Costs for Specialty and Non-Preferred Brands continue to drive trend
- Increasing availability of biosimilars provides steerage option for specialty

***What?***

- Increase Non-Preferred Brand cost share from $75 to 30% coinsurance with a min/max
  - Incentivize more generic and Preferred Brand utilization
- Implement three-tier specialty copay structure
  - Increasing availability of biosimilars
  - Cost structure will incentivize biosimilars when available
  - Structure analogous to Generic, Preferred Brand and non-preferred Brand approach

**3-Tier Specialty Drug**

| | |
|---|---|
| Tier 1 | Biosimilars |
| Tier 2 | Biosimilar alternatives not available |
| Tier 3 | Biosimilar alternatives available |

***Next Steps***

- Develop specific options
- Determine member impact
- Determine Rebate impact

# Income Based Premiums

## Review Means-Based Premium Structures

### *Why?*

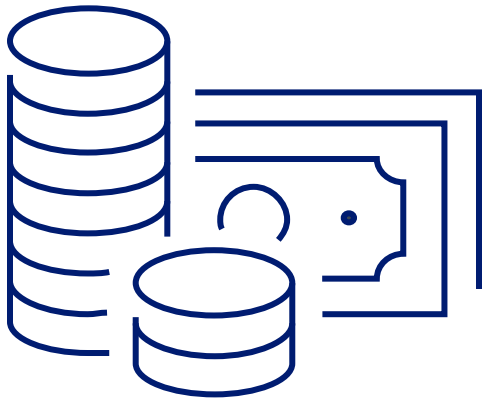
- Distribute employee premium costs according to income level
- Larger portion of premium increase is borne by higher earners

### *Considerations*

- Generally, more applicable for active employees, but Medicare uses means-based premiums
- For public sector employers, sometimes there is not sufficient spread in income levels to result in meaningful variation

### *Next Steps*

- Develop specific options



# EPO/HMO

## Review Viability of EPO/HMO and Consider Alternatives

### *Why?*

- While there is a 9% rate cap guarantee for FY2027 HMO premiums, there is no guarantee for FY2028 or FY2029
- EPO and HMO blended for rating purposes and EPO has benefited from lower HMO premiums
- HMO network and EPO network have significant provider overlap
  - Both include Southwest Medical
- EPO and LDPPO networks are the same and the difference in actuarial value is ~3%
- EPO is in-network only and many employees enroll in EPO without adequate network access
- Ongoing migration from EPO/HMO in recent years

### *Next Steps*

- Develop specific options
  - Could include changes to CDHP and/or LDPPO
- Review cost impact and risk distribution
- Consider provider disruption and access to care

# Questions