



PEBASM
SC Retirement Systems
and State Health Plan

South Carolina Public Employee Benefit Authority
Serving those who serve South Carolina

Meeting Agenda

Health Care Policy Committee | Finance, Administration, Audit and Compliance Committee

Retirement Policy Committee | Board of Directors

Wednesday, October 21, 2026 | Virtual Meeting via Zoom

Board of Directors | 3 p.m.

- I. Call to order
- II. Approval of meeting minutes – August 5, 2026
- III. State Health Plan budget requirements for 2028
- IV. Adjournment

Notice of public meeting

This notice is given to meet the requirements of the S.C. Freedom of Information Act and the Americans with Disabilities Act. Furthermore, this facility is accessible to individuals with disabilities, and special accommodations will be provided if requested in advance.

**PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
BOARD MEETING**

Meeting Date: October 21, 2026

1. Subject: State Health Plan Budget Requirements Approval for 2028

2. Summary: Laura Smoak will present and discuss the State Health Plan's budget requirements for 2028 in anticipation of the upcoming legislative appropriation cycle.

3. What is the Board asked to do? Approve the 2028 State Health Plan budget requirements.

4. Supporting Documents:

Attached:

- (a) 2028 State Health Plan Budget Requirements
- (b) 2028 Budget Requirement Factors

State Health Plan budget information and continuation requirements for plan year 2028



Annual base | Calendar year 2027

Employer funds	\$3,123.7 M
Enrollee funds	\$574.3 M
Total	\$3,698.0 M
State-appropriated portion of employer funds	\$1,584.1 M

Funds are spread throughout the annual budget on Employer Contributions lines for state agencies and State Aid to Classrooms lines for the Department of Education.

Current composite monthly contribution rate effective January 2027

Employer rate	\$831.14	72% of regional state employee plan average
Enrollee rate	\$159.47	63.6% of regional average
Total	\$990.61	70.5% of regional average

FY 2028 budget requirements for ongoing Plan operations in calendar year 2028

- **Annualization:** Because there is no contribution rate increase for 2027, there is no required annualization for July-December 2027.
- **Retiree enrollment growth:** Net retiree enrollment continues to grow at a low level—continued recent experience of 0.6% net growth in retirees, compared to 0.3% last year. It's estimated that \$3.458 M is required for the estimated net number of new retirees with state-funded insurance.
- **2028 Contribution rate increase, effective January 1, 2028:**
 - 9.7% increase in total contribution rate, which equates to \$95.26 per subscriber per month.
 - If the increase is distributed proportionately to employers and enrollees, state-appropriated funding for the increase is \$76.827 M for January-June 2028 with an average enrollee increase of \$14.80 per month.
 - If the increase is provided entirely through the employer, state-appropriated funding for the increase is \$91.034 M for January-June 2028.
 - State-appropriated funding for the increase will require annualization in the FY 2029 budget.
 - Options exist to offset continuation expenses while remaining within an ACA-grandfathered structure.

Summary of state funds for fiscal year 2028	With EE increase	Without EE increase
Required annualization	\$0	\$0
FY 2028 base retiree enrollment growth	\$3.458 M	\$3.458 M
2028 Employer increase	\$76.827 M	N/A
9.7% total increase with proportional enrollee increase		
2028 Employer increase	N/A	\$91.034 M
11.5% employer only increase with no enrollee increase		
Total continuation of current Plan	\$80.285 M	\$94.492 M
Total continuation with Plan design savings permitted under ACA-grandfathered framework	\$66.821 M	\$78.538 M
8% total increase, \$78.56/subscriber/month or 9.5% employer only increase		
Total continuation with Plan design savings and discontinuation of RDS	\$64.445 M	\$75.722 M
7.7% total increase, \$75.62/subscriber/month or 9.1% employer only increase		



Options to mitigate State Health Plan budget requirements for plan year 2028

A 9.7% increase in total contributions (employer and enrollee) is necessary to maintain the 2027 State Health Plan benefit levels through 2028. Below are options to mitigate the budget requirement.

Member benefit design adjustments

Member cost-sharing—including deductibles, coinsurance maximums, per occurrence copayments and prescription drug copayments—was last adjusted for plan year 2023 and plan year 2019. The table below includes proposed benefit design changes for plan year 2028, based on the maximum adjustments allowed under the ACA's rules for grandfathered plans. These changes would yield an estimated 1.7 percentage points in Plan savings. Note the medical items listed apply to non-Medicare members only, and the prescription copayments apply to all members.

	Standard Plan		Savings Plan	
	2027	2028	2027	2028
Annual deductible (individual)	\$515	\$585	\$4,000	\$4,700
Annual deductible (family)	\$1,030	\$1,170	\$8,000	\$9,400
Annual coinsurance (individual)	\$3,000	\$3,360	\$3,000	\$3,200
Annual coinsurance (family)	\$6,000	\$6,720	\$6,000	\$6,400
Physician office copayment	\$15	\$16	N/A	N/A
Outpatient hospital copayment	\$115	\$126	N/A	N/A
Emergency room copayment	\$193	\$210	N/A	N/A
Generic copayment (30-day fill)	\$13	\$15	N/A	N/A
Preferred brand copayment (30-day fill)	\$46	\$50	N/A	N/A
Non-preferred brand copayment (30-day fill)	\$77	\$84	N/A	N/A
Prescription drug coinsurance maximum	\$3,000	\$4,200	N/A	N/A

Note: PEBA will adjust the member benefit design for the MUSC Health Plan proportionately based on proposed changes for the Standard Plan.

Take full advantage of federal prescription drug subsidy monies for Medicare primary members

In plan year 2014, PEBA implemented a Group Medicare Part D drug plan as its standard State Health Plan pharmacy benefit for Medicare retirees. The main purpose was to gain access to generous federal subsidies available in the Group Medicare Part D space to help fund the Plan. Part D subsidies are a major source of Plan income, providing approximately 7% of total revenue in 2025.

This action was taken in the very early days of PEBA before the tenure of current agency and insurance policy leadership. At that time, the move to Group Medicare Part D was modified by permitting Medicare retirees to choose to remain in the Commercial Plan (non-Medicare) for pharmacy benefits. This was a very unusual proposition, one that is not available on the Plan's medical side and, to our knowledge, one that is not available anywhere else in the nation for pharmacy benefits. About 3% of Medicare retirees, or 3,100 members, opted out of Group Medicare Part D in favor of Commercial Plan pharmacy benefits; however, even this relatively small number has a material effect on the Plan's financials.

Effective January 2028, we propose to close the opt-out of Group Medicare Part D for the Commercial Plan. The subsidy program, known as RDS, in place for these 3,100 opt-outs pales in comparison to the Group Medicare Part D amounts. Medicare Part D subsidies per person are roughly six times higher than those in RDS. Closing the opt-out option and moving these retirees to Group Medicare Part D would generate an estimated additional \$9.6 million per year in funding for the Plan and mitigate budget requirements for plan year 2028 by 0.3 percentage points.

The Group Medicare Part D benefit design has favorable features for retirees that are not available in the Commercial Plan, and the Medicare formularies are specifically designed for an older population. We are confident this proposed change will be positive, not just for Plan finances, but for the overall Medicare membership.

Conclusion

The proposed member cost-sharing adjustments combined with the closure of the Group Medicare Part D opt-out are estimated to bring savings that would reduce Plan budget requirements by 2 percentage points. With approval of these items, the required 2028 rate increase would reduce to 7.7% to maintain the current benefit levels.



Factors that influence State Health Plan trend for plan year 2028

There are both contributing and mitigating factors that influence the State Health Plan trend, making it important to assess its long-term sustainability.

Contributing factors

Key trend drivers

Medical incurred and paid through September 2026; pharmacy incurred through June 2026

Overall trend for medical and pharmacy combined for this period increased \$14.65 per member per month, up 3.0% from 2025. Medical trend (claims processed by BlueCross BlueShield of South Carolina, the Plan's medical claims administrator) in 2026 through September equals a 4.7% increase in payments per member over the same period in 2025, which is well above the effective pricing update for 2026. Overall pharmacy claims, less rebates, per member per month are up 0.6% in 2026 through June compared to the same period in 2025. Key drivers include:

	PMPM expense+	Growth rate
Overall plan PMPM+	\$14.65	3.0%
Total medical	\$13.43	4.7%
Inpatient hospital	\$4.23	5.7%
Outpatient hospital	\$3.91	3.4%
Professional office	\$2.49	4.6%
Physician administered specialty	\$1.65	4.8%
Independent lab	\$0.54	15.3%
Telehealth	\$0.51	33.1%
Population health programs	\$0.33	11.0%
Ambulance	-\$0.23	(12.2%)
Total pharmacy	\$1.22	0.6%
GLP-1s	\$1.18	7.0%
Non-Medicare	(\$1.23)	(9.2%)
Medicare	\$12.84	37.8%
Non-GLP-1s	\$0.04	0.02%
Non-Medicare	(\$3.78)	(2.8%)
Medicare	\$20.90	5.3%

True Out of Pocket (TrOOP) threshold

The federal Inflation Reduction Act (IRA), enacted in 2022, introduced significant changes to the Medicare Part D prescription drug program. PEBA currently has nearly 96,000 Medicare-primary members enrolled in its Part D plan. One major change affecting the Plan is the reduction of the Part D True Out-of-Pocket (TrOOP) threshold—from \$8,000 in 2024 to \$2,000 in 2025 to \$2,100 in 2026. The Plan now pays the full cost of medications for approximately 30% of Medicare-primary members, up from about 8.7% in 2024, because members reach this lower threshold much earlier.

Mitigating factors

Pharmacy trend

When explaining the mitigating factors for the plan year 2027 budget requirements, PEBA described the new financial approach to the pharmacy benefits manager contract requirements, comparing the 2021-2025 contract and the current contract. This change in PBMs resulted in a decrease in unit cost, which shows positive financial results. Overall, projected net expenditure (less rebates and Medicare Part D subsidies) for 2026 is down 6.2% over the same period last year. Contributing to this trend is a decrease in unit cost of 1.9% (a one-time effect from the new contract), accompanied by a 2% increase in days of therapy. Although we had anticipated achieving 5% cash savings over the first year of the new contract, current cash savings are at 1%, which is still a strong outcome. PEBA continues to collaborate with Caremark on cost containment strategies to mitigate trend.

- Specialty medications continue to account for just over 50% of total pharmacy spending, even though only 2.4% of Plan members use a specialty drug. Similar to the Humira biosimilar strategy put in place in 2025, Caremark implemented a biosimilar strategy for Stelara in July 2026. Stelara is a specialty medication with an average Plan cost of \$14,019 per fill. Caremark successfully transitioned 65% of Stelara users to an interchangeable biosimilar with an average Plan cost of \$3,472 per fill. As a result, the Plan's monthly net cost for Stelara dropped from \$2.55 million to \$0.39 million—an 84.7% reduction in spending. PEBA will continue to collaborate with Caremark as more biosimilars become available and will monitor the resulting impact on overall cost trends.
- Although the reduction of the Part D TrOOP threshold increased the Plan's liability, the additional federal subsidies provided under the IRA have largely offset these increased costs. The federal subsidies reduce what would have been a 0.6% increase in expenditures (after rebates) by 6.8 percentage points, resulting in a net 6.2% decrease in expenditures (after rebates and subsidies).

Continued management of unit cost in direct-contracted networks

The State Health Plan has operated direct-contracted hospital and physician networks for more than 30 years (hospital network established in 1992 and physician network established in 1993). This is atypical among state employee health plans, as most rely on their third-party administrator's networks. Operating our own networks has given the Plan a critical tool in managing its expenditure over the years. Near universal provider participation in the networks is an essential component of the Plan's value; all general hospitals and more than 99% of the physicians represented by claim dollars are in network. It's important PEBA maintain these networks in a manner that promotes participation while also aligning with the Plan and state's fiscal realities.

While PEBA implemented unit cost neutrality for the Plan's hospital pricing update in 2026, hospital trend for non-Medicare members this year to date is 6%. The increase in medical trend is largely attributed to an increase in utilization and, in some part, to increased case intensity in the inpatient setting.

For 2027, PEBA implemented an overall 1.5% increase in the Plan's hospital pricing update. In inpatient settings, PEBA provided increased pay for non-complicated case rates, while offsetting that increase by amending the formula that moves a case into a high outlier status, reducing excess pay for those outlier admissions, and adjusting case rates proportionally to case intensity. In outpatient settings, PEBA provided for another general case rate increase, but offset it with various methods: continuation of the CMS policy for non-reimbursement of ancillary services (removing incentive for the hospital to bill such services); continued movement toward site-neutral pricing; and maintenance of last year's percentage discount off charges for extremely low volume case types (also made for inpatient cases).

Managing provider reimbursement such that the Plan's financial and value objectives are achieved and maintaining near universal participation will continue to be a challenge. The measured approach to hospital pricing for 2027 continues to be a mitigating factor in our budget requirements for 2028.

Pushing back on GLP-1 growth

The GLP-1 (Glucagon-like Peptide 1 agonists) class of medication continues to be a cost driver for the State Health Plan and specifically with the Medicare-primary membership. The Plan covers these products for Type 2 diabetes only; weight loss is a general Plan exclusion.

PEBA collaborated with its former pharmacy benefits manager and, with PEBA Board approval, fully implemented measures in early 2025 to address rapidly increasing GLP-1 spend. For Commercial Plan (non-Medicare) members, the Plan limited GLP-1 fills to a 30-day supply to reduce waste and introduced a phased prior authorization process to require documentation a member's condition meets Plan eligibility criteria. As a result, the Commercial Plan per member per month spend decreased 21.6% from 2024 to 2025, while Medicare-primary spend increased 30.8% over the same period. As part of the transition to a new PBM in 2026, PEBA worked with Caremark to continue this hardline approach to GLP-1 management for non-Medicare members.

Reviewing GLP-1 claims incurred and paid in 2026 through June 2026 compared to the same period in 2025, Medicare-primary per member per month net spend increased by 37.8% while Commercial Plan spend continued to decrease.

Working with our current PBM, PEBA will implement a 30-day supply per fill limit for GLP-1s for Medicare-primary members effective January 1, 2027. Although the PEBA Board also approved this initiative in 2024, implementation required additional time because of the Plan's PBM transition in 2025 and CMS approval requirements for EGWP plans.

GLP-1 management is not a solved problem, given our partial success in stemming growth on the Commercial Plan. However, implementation of fill limits for EGWP is projected to be a mitigating factor in 2028 budget requirements.