



Joe Lombardo  
Governor

## NEVADA HEALTH AUTHORITY

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Stacie Weeks  
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## August 20, 2026 Unofficial Board Meeting Transcript

Tyler Hopkins: Chair Wells, we are now live on YouTube.

Board Chair Jim Wells: Good morning. We'll call to order the meeting of the Public Employees' Benefits Program Board for today, August 20th, 2026 at 9:00 a.m. Can I get a roll call, please?

Jessica Crane: Yes. Good morning, everyone. Starting roll. Chair Jim Wells?

Chair Wells: Here.

Ms. Crane: Dr. Keiko Duncan?

Keiko Duncan: Here.

Ms. Crane: Laura Rich?

Laura Rich: Here.

Ms. Crane: Jim Barnes?

Jim Barnes: Here.

Ms. Crane: Chris Viton?

Chris Viton: Here.

Ms. Crane: Tom Zumtobel?

Tom Zumtobel: Here.

Ms. Crane: Dr. Paul Davis?

Paul Davis: Here.

Ms. Crane: Thank you. Dr. Jennifer McClendon, Dr. Blaine Harper, and Joy Grimmer are absent. We do have a quorum. Please remember to state and spell your name for the record. Thank you.

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Chair Wells: Thank you. We'll move on to agenda item number two, public comment. Public comment will be taken under this agenda item. No action may be taken on any matter raised under this item unless the matter is included on the 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 chair. Time for each individual to make public comment as well as the aggregate time for public comment may be limited. I don't believe that we need to do any limitations this morning. Additional comment period subject to similar limitations may be announced for individual items. We will not have any additional or public comment periods this morning. Members of the public may make public comment using the call-in number 669 900 6833. The meeting ID is 891 4115 0499 pound. Persons making public comment, please state and spell your name for the record. We'll start here in Carson City.

Mr. Ervin: Good morning. Kent Ervin, K E N T E R V I N. I submitted written comment on behalf of the Retired Public Employees of Nevada RPEN regarding Senior Care Plus and the cancellation of its contracts with primary care providers in Northern Nevada since it was taken over by Kaiser. While PEBP and Via Benefits do not have control over network contracts for the Medicare Advantage plans offered on the PEBP Medicare exchange, it is disappointing that PEBP and Via Benefits have not taken a proactive role in assisting our over 400 Medicare retirees and Senior Care Plus who may have lost their longtime primary care physicians, many of them elderly. They need help navigating how to either get a new provider or else change plans to keep their current provider without jeopardizing their HRA benefit by enrolling outside of the new benefits.

In comments for myself, I've submitted two additional public comments after the Tuesday morning deadline regarding board materials posted since Tuesday afternoon. First, in the draft, changes to the duties, policies, and procedures, the formulas for setting rates by dependent tier and plan options are good to have there but need to be further clarified. I have suggested some technical amendments that I hope you will consider. More importantly, the proposed policies on employer contribution percentages are really a reflection of how PEBP values active employees versus dependents and retirees. The percentages have drifted over the years with little board input other than approving final rate tables. There needs to be a robust policy discussion. The employee only CDHP plan should be subsidized by the employer at 100% rather than 93.5% because A, the health of employees is most important for their productivity in the state service. So, it's an employer interest. And B, most cities and counties that compete with the state for hiring and retention provide 100% of the health insurance premiums for their employees, at least for a basic plan. It is shocking that the state of Nevada has the fifth largest number of full-time employees on Medicaid. Those are employees who can't afford PEBP insurance for themselves or dependents or are better off on Medicaid. Helping generously with dependents is also important because employees need to take care of their families to be productive on the job and for recruitment and retention given lower salaries from the state

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compared with cities and counties. The contributions for retirees represent a long-term commitment at least for those hired by the state prior to 2012.

Second, I submitted a history of the excess and deficient actuarial reserves. As of June 30th, there was a modest improvement compared with the earlier projections, but the reserves are still seriously deficient. The two to three year phase in of premium increases that was implemented starting this fiscal year should start to correct that and add to reserves. Regarding the item on the fourth quarter budget report, it shows revenue at 74 million below the budget and expenses at 5.2 million below budget. But we know from the Millman and internal review report published in April that the legislative budget was based on erroneous information provided by PEBP during the 2025 session. So why hasn't the budget for FY2026 been corrected through the Interim Finance Committee? Will the FY2027 budget and future budget reports also be meaningless based on erroneous budgets from 2025? It seems like those ought to be corrected if you're going to use those budget reports for anything.

Now, I would like to address the budget build enhancements in the elected officers report which is the budget request for the next biennium. Bringing PEBP into the Nevada Health Authority was supposed to provide efficiency gains, but now it appears that additional positions are needed. Whether those are feasible will be up to the Governor and Legislature. What is completely missing in the budget discussion are requests for the state to fund its share of the projected rate increases for the next two years. Board members, please approve the enhancements request only with additional funding requests for AEGIS and REGI to cover the shortfalls from PEBP's fiscal crisis which was not the fault of participants. Thank you.

Chair Wells: Thank you, Dr. Evin. Seeing no more public comment here in Carson City, we'll move to online.

Mr. Hopkins: Looks like we have a couple online, Chair Wells. One moment, please. For those who have joined for public comment, your name or the last four digits of your phone number will be announced and you have been advised you've been unmuted. Please slowly state and spell your name for the record and then proceed with your comments. As a reminder, for those on the phone, please press star six to unmute. Douglas Unger, you have permission to speak. Please slowly state and spell your name for the record.

Mr. Unger: Doug Unger, D O U G U N G E R, past president, UNLV chapter Nevada Faculty Alliance and member of the UNLV Employee Benefits Advisory Committee. I'd like to point out that we didn't get budget numbers or policy paper proposals in time to be able to make coherent public comment. And I'd like to request of the Executive Officer and PEBP staff that in the future, for members, that you post these numbers in a timely manner so that we can submit appropriate public comment. Speaking to agenda item number seven, this year's increases in plan premiums paired with the cuts in benefits are really causing unacceptable financial stress for state employees. Now, further phased in three-year and two-year increases will be even more

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unaffordable. Last spring, the board agreed to discuss these plans again, and I hope that you'll do so. Board members should push back against any suggestion by the chair or others that PEBP cannot ask for increases in employer and state contributions to AEGIS and REGI in the next biennial budget. If PEBP's numbers last spring can be trusted, a one-year increase of \$90 per month for all PEBP members would have stabilized plan costs without increases and cuts. For this first year of the new biennium at least consider asking the Governor's budget to meet state employees halfway with a one-year contribution of half of this hold harmless amount or \$45 per month per member to reduce the stress and harm already being done to state workers.

Speaking to matters discussed at the July 23rd strategic planning meeting, we're very concerned that PEBP might actually consider separating active employee and retired employee risk pools so as to raise premiums for non-Medicare retirees disproportionately by possibly more than 30%. And even worse effects would result if non-Medicare retirees would be separated from PEBP and dumped onto the ever eroding and increasingly expensive Silver State Exchange. To inflict on non-Medicare retirees radical increases in healthcare premiums or for PEBP to dump them would be both punitive and wrong. Especially this would single out state employees covered under the Police Fire statutes for PERS. Our Nevada Department of Corrections, Highway Patrol, State Police, and Fire Marshall officers whose jobs are physically and psychologically demanding and for whom PERS rules suggest our state should accommodate early retirements. The NDOC has a staffing crisis. Many of you may have read about the millions in overtime charges for the state budget needed to keep our correctional institutions staffed. This staffing crisis will get worse if officers are punished by cuts in anticipated retirement benefits. The approximately 3,900 non-Medicare retirees across our state have earned and deserve comfortable retirements. PEBP should not break this promise to state retirees and in effect disparage and devalue their decades of service. Thank you.

Chair Wells: Thank you, Dr. Unger.

Mr. Hopkins: Caller with the last four digits 9199, please press star six to unmute and please slowly state and spell your name for the record if you wish to make public comment.

Ms. Opferman: Perfect. Sorry, it took me a second to unmute. Good morning, chair and members of the committee. For the record, my name is Tess Opferman. That's spelled O P F E R M A N and I am speaking on behalf of the AFSCME retirees. I apologize for not being there in person today. So, I appreciate being able to call in. First, I want to express concern for our retirees who are in Senior Care Plus and have recently lost their primary care provider due to the Kaiser changes. While I know PEBP and Via Benefits do not have control over this coverage, you do have the ability to proactively support retirees through this change. As you are aware, if retirees change their health care outside of Via Benefits, they risk losing their healthcare altogether. They are allowed a one-time mistake. We are concerned some Medicare retirees may change their plan outside of Via without realizing these potential consequences. We ask that you proactively reach

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out to retirees who are in Senior Care Plus and guide them through their healthcare options. Additionally, though again, this is being done outside of your control, this change is deeply problematic for retirees. Many received a letter giving them less than 30 days to find a new primary care provider. They would no longer be covered for their primary care at the end of August. Whatever pressure this board can apply to extend this timeline past the August deadline would be appreciated.

Additionally, in the packet you have provided a report looking at benefits for Medicare retirees versus pre-Medicare and non-Medicare retirees. I want to thank PEBP for working on this report. I've not had the opportunity to fully review and digest this information. However, I'm hoping to get a better understanding of how Medicare Part B premiums were handled. The report says we have not incorporated part B premiums in any of the analyses. Does this mean the report is short by a minimum of \$205 per month that retirees have to pay? For context, the minimum of 205 and part B plus 53 for PEBP dental totaling \$258 takes up all of the \$260 HRA subsidy for those who receive the maximum HRA subsidy. Medicare Part B premiums are an important part of this comparison. So, I hope to get more clarity with this presentation of the report. Thank you so much for your time this morning.

Chair Wells: Thank you, Ms. Opferman.

Mr. Hopkins: That is all Chair Wells. That concludes public comment.

Chair Wells: All right. Seeing no additional public comment, we'll close agenda item number two. Public comment. We will open agenda item number three PEBP Board Disclosures for applicable board meeting agenda items. Ms. Mooneyhan.

Ms. Mooneyhan: Thank you, Chair Wells. Brandee Mooneyhan Lead Insurance Counsel for the record. This item allows me to make a disclosure on behalf of board members who are eligible for benefits under the program regarding conflicts of interest. Consistent with NRS 281A.420, those members who are eligible or whose family members are eligible. On their behalf, I disclose that these members will be voting on items that may affect the benefits available to them or their family members or dependents. The law does not require abstention from voting merely because the board member or family member is eligible for PEBP benefits as long as it affects everybody equally. At this time, I invite any member of the board who has additional disclosures to make that now.

Chair Wells: Any additional disclosures for any board members? Hearing none, we'll close agenda item number three. Move to agenda item number four. Approval of the action minutes for the July 23rd, 2026 Strategic Planning Meeting. Comments, questions, changes. Motion for approval.

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Member Barnes: Jim Barnes, move approval.

Chair Wells: I have a motion for approval. Can I get a second?

Member Rich: Laura Rich, I'll second.

Chair Wells: I have a motion, a second to approve the action minutes from the July 23rd, 2026 Strategic Planning Meeting. All in favor say I.

All Board Members: I.

Chair Wells: Any opposed, nay. Motion carries. Close agenda item number four, move to agenda item number five, the Executive Officer report. Ms. Carsten.

Executive Officer Carsten: Good morning, Theresa Carsten for the record. Today we're just going to go over a couple of items related to how we closed last year and are starting this year. A brief touch point on look back analysis that Segal was asked to report on. Some budget build enhancements for the biennium 27 through 29 and then some RFP timeline information for upcoming contracts. Today I'd like to provide an update on PEBP's fiscal year 27 starting financial position and the concerns that this creates for our reserve stability. PEBP should have entered fiscal year 27 with a balance forward of approximately \$149 million. That level of funding would have fully supported our first quarter operational needs and allowed us to maintain reserves near the \$121 million level projected for fiscal year 26 for the IBNR catastrophic and HRA reserve accounts. Attached to the slide deck, you will find a version of the EMR report for program year 26. As you can see in this document, it shows by plan how revenue is received versus expended month over month. It also shows how PEBP has historically relied on the balance forward amounts received at the beginning of every program year to utilize for operational expenditures until revenues are collected and amounts that can pay for the plan services.

However, budget account 1338 began in fiscal year 27 with only \$52 million. This is a substantially lower amount than anticipated and creates immediate pressure on our financial position. It might be interesting to note that two days ago, this slide said we would have a balance forward of \$54 million and our available cash looked like a balance of 1.1 rather than the negative \$900,000 you see in this slide. However, additional expenditures cleared as part of final closeout this week. And this is what PEBP's current snapshot looks like. Also, for clarity, because we don't need to realize the \$30 million shortfall all at once, which you've seen noted in this slide, we're not, as of today negative \$900,000. Therefore, today's cash on hand is approximately \$29 million. I think we have some cash flow issues related to employer contribution groups that staff continue to reach out that maybe pay a little bit later than are

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expected. And so, PEBP staff knows that we need to track revenues and expenditures very closely, especially this year due to our stress on our budget.

Reserve requirements at a glance. Segal's actuarial determination of PEBP solvency status is for the IBNR reserve to be \$62.9 million. This amount is about 15.3% higher than the previous year. Currently, PEBP does not have enough cash on hand to meet that reserve requirement. So as of today, PEBP is not considered solvent at this time. Additionally, the catastrophic reserve level needed by policy is \$53 million in order to pay the 45 days of claims outlined in the duties, policies, and procedures manual and the 80% required for the HRA reserve is set at \$5.5 million. It's important to note the discrepancy for the large reduction in the HRA reserve from last year to this year. Last year when I started my employment with PEBP, there was not a CFO on staff and the staff at the time did not have the experience pulling reports from HSA bank. I asked HSA bank at the time for a report to help calculate the HRA reserve balance and that report I was provided included both HSA and HRA balances. Thereby the calculation was inflated. Monica received this year's report which was specific to HRA balances only and is calculated at the correct amount that you see here.

As many of you know, PEBP typically does not generate enough revenue to produce a surplus until November each year. This recurring timing gap means PEBP begins every fiscal year in a constrained cash position, but this year's shortfall is significantly more pronounced. Furthermore, it is unknown at this time how the \$30 million reduction in member revenue will impact the overall budget for program year 27. If member utilization increases seen during the last quarter of program year 26 remain, then expenditures could certainly be more than the current cash on hand, which would further reduce the available cash for reserve balances. I'm not certain solutions exist for this current program year, but as the board continues to look towards program changes for program year 28, I look forward to discussions and potential solutions. I'm happy to answer any questions about these slides at this time or we can wait till the end.

Member Zumtobel: Chairman Wells, I continue to not understand that revenue. Is it counting on a cash basis? Do we account for revenue on a cash basis?

Chair Wells: Yes.

Member Zumtobel: You reference employers haven't paid yet, I think you said. That's departments within the government or that's groups that participate, right?

Executive Officer Carsten: Theresa Carsten for the record. I was going to say we get specific transfers from our state government, from central payroll but we get other transfers from NSHE and the other board various boards and commissions and they don't always pay timely or in full.

Member Zumtobel: They don't always pay in full. Do they pay what they owe or they pay less than what they owe? What's pay in full mean in this context?

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Executive Officer Carsten: They do not always pay. In some cases they pay. I think you can speak to this better than I can Monica, but I think as we tracked in 26 in some cases they overpay and in other months they underpay. There is a reconciliation of trying to make sure throughout the year that they end up paying the entire amount for their employees.

Member Zumtobel: I assume they owe a certain amount for the employees that they cover or that the plan covers.

Ms. McJoy: Yes, Monica McJoy for the record. When we say pay in full, I bill you \$10, you pay me \$10, you're paid, right? If I bill you \$10, you pay me \$8, you're not completely paid. What we have noticed a lot is sometimes they do have turnover in certain positions and some of them don't know how to pay the amount. They don't understand the formula. A lot of times with the reconciliation process we true up every month. So by the 25th of the month if we're not paid we do apply a penalty fee on that amount. But before the penalty fee is applied, we do reach out and let them know by the 20th your payments need to be done. This is what needs to happen. And a lot of times we do understand that they don't understand the formula and sometimes the way their funds work, they don't have them and they'll send them at a later time.

Member Zumtobel: I appreciate that response. I don't want to open that can of worms because that seems like a whole other conversation. But the \$30 million, it's because we're a cash basis. It's represented as a deficit, but it's an accounts receivable also. It's money that's owed to us.

Chair Wells: The \$30 million is the cost of the transition of the premiums where we didn't charge the full amount of the premiums to the employees because of the increase. That's the \$30 million, correct?

Executive Officer Carsten: Yes, that's correct.

Chair Wells: To give you an example on the employer pay. The university system pays their employees on the first of the month for the prior month. In general, you're supposed to pay your insurance ahead. They were for years paying in arrears. I believe that's been fixed. That's an example of some of the things that we run into as far as employers not paying on a timely basis.

Member Viton: Theresa, would you mind going back to the slide that shows the cash back? Just to help me understand, the revenue and balance forward is the July revenue and the cash carry forward from the prior year. The medical claims is just the month of July. The rate revenue shortfall is the full year rate revenue shortfall.

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Executive Officer Carsten: Yes, that's what I was trying to explain. So, we're not currently \$900,000 short as of today. But we know that we will realize that \$30 million shortfall over time. So, our cash on hand right now is approximately \$29 million.

Member Viton: Does the medical claim figure also include the annual funding of the HSA balances? Does that have the annual HSA transfer? The funding, is that an expense in that line?

Ms. McJoy: No, that's not. So anything that's from the HRA, what we take is the incurred but not reported that a pending amount that we get from our HSA account at that time they say hey you have this many pending claims that's sitting out there. We include that amount in any of our expenses but the transfer is something separate.

Chair Wells: Let me clarify the question I think he's trying to ask. Is the \$61.5 million or whatever it is in HSA contributions that are sent to HSA bank on July 1.

Ms. McJoy: Yes. Sorry, I didn't understand your question, but that's true.

Member Viton: That is also an annual expense as opposed to a monthly expense.

Ms. McJoy: Annual. Yes.

Member Rich: Laura Rich, for the record. My question is for Monica. How closely are you working with state payroll right now? I'm looking at my email and I have about 25 emails between my fiscal staff and state payroll specifically about this issue. I think that it's a lot of people that are not involved in the insurance premiums and in trying to figure out what the rules are. And I think that PEBP being involved in these conversations or managing some of these conversations might be helpful. I don't know if state payroll is, I don't know how involved they are in this. I'm just seeing this from my department, which is I believe the biggest department in the state. If you know we're having this issue, I'm sure you know it's probably problematic across the state.

Ms. McJoy: I try to be involved with central payroll as much as I can when it comes to premiums, any payments that we can possibly help them with. But when we're notified of certain situations, the fire has already been burning, right? It takes time to fix an issue when someone fully doesn't understand. I always try to be available and help out as much as we possibly can. It's the constant emails back and forth that we try to be available to assist. When you're working with a lot of different groups or agencies that don't fully understand, it can be difficult on both parts. I do always assist as much as I can.

Executive Officer Carsten: Theresa Carstenn, for the record. In addition to that, there have been on more than one occasion where we've reached out with GFO to coordinate and bridge that gap

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between conversations that we've had where either monies are owed or monies were overpaid or how to process and get additional information. When we felt like we either couldn't explain it to the needs of central payroll or that we thought there was a gap in understanding. We did bring in our partners with GFO and have found solutions. They're not always quick but we have coordinated amongst agencies to try to resolve a lot of those issues.

Other questions right now? Okay, I'm going to go to slide six. In your board packet is the full detail of Segal's look back analysis for program year 25. We've discussed this a little bit in previous board meetings. The plan rates have not been set to absorb the cost of expenditures. We talked about that before, cross subsidization, etc. The report shows additional information by plan. And if you have questions pertaining to the look back analysis, Segal is available for any additional questions at this time or later during this presentation. I realize that you might not have had a lot of time to go through every page of your packet, but for any of you that have a current question, I can take those now before moving on to my next slide which is budget enhancements.

Member Zumtobel: The budget in the actual for 2025 is that 12 months?

Executive Officer Carsten: Theresa Carsten for the record. This specific slide, as I understand it, is saying when we look back at what rates were set for 2025, were they adequate for what we budgeted versus what the actual costs were? And what was the surplus or deficit? Did the rate meet the needs of the program? This slide is showing overall, over all the programs we're about \$35.9 million short for the rates that were set for plan year 25.

Member Zumtobel: Referencing back to the earlier conversation. The budget is the amount of money that we needed or required of employers. What was the requirement of each of these departments or employers to pay?

Executive Officer Carsten: It was total need. It would have included employer and member cost. It was necessary premium cost to cover total.

Member Zumtobel: If we got that, we would have gotten 100%?

Executive Officer Carsten: If we asked for what we needed and got what we needed then would we have hit our target and this shows that we were short.

Member Zumtobel: How much of that short is that people paid \$8 instead of \$10, like underpaid or how much of that? This is purely revenue, right? There's no claims expense in here or anything?

Executive Officer Carsten: Well, the expenses, the actual costs are based off the health plan claims.

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Member Zumtobel: So how much was potentially, the \$27 million that missed on the medical, we set the budget low?

Executive Officer Carsten: I think in theory look back analysis is a great idea. The last couple years have been rough, right? We've found a lot of errors in processes and systems. To your point, how much of this is somebody paid late?

Chair Wells: Sorry, let me try to help a little bit with what the look back analysis is and Segal can correct me if I'm wrong. 2025 is the last year that's closed because we have a 12-month window. You have to submit a claim for FY25 by June 30th of 2026. It is closed. No more additional claims can be processed for FY25. This is really looking at how much did we bring in in premium revenues versus how much did we spend in claims and administrative costs for a closed plan year. When it says budget and actual budget for this particular purpose is not is not budget what you think. It's how much we set premiums to collect. That budget column is kind of a little bit of a misnomer. It's not a budget. It's the actual premium revenue that we collected for FY25 versus the actual expenses in the actual column that we spent for FY25.

Member Zumtobel: I appreciate that, Chairman Wells. I'm trying to understand, whenever you run anything, you have to have the revenue right. That's what I'm trying to get comfortable that our revenue is.

Chair Wells: We knew in FY25 that FY25 was going to run at a deficit and FY26 and 27 were supposed to be set to restore the deficit that we created in FY25.

Member Viton: Just to try to make sure I'm understanding what is in our packet and what we're looking at where the slides refer to see Segal report attached for full details. Are those the pages that are later in the package that are after the presentation?

Executive Officer Carsten: Yes, I believe they got included as attachments to this pack.

Member Viton: I guess that's just my question, is that the report?

Executive Officer Carsten: That is, it's like 10 tables.

Member Viton: I think for me, it's just trying to understand the relationship between, I know that this is a different period. This is FY25 but the discussion about cash deficit, the deficit cash flow, and this slide which is reporting that for 25. Comparing that to this this page is part of the additional materials the one I'm going to ask about. It's not in the presentation but page 31 of the

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package. That is your monthly cash flow. FY26 has expenses that are less than that for the year. Unless I'm reading it wrong. Page 31.

Executive Officer Carsten: That's the EMR report. Can you ask your question again? Sorry.

Member Viton: My question is, helping me understand how the cash flow in this schedule fits into the discussion about cash deficits from claims exceeding revenue. Because this schedule appears to show claims being less than.

Chair Wells: The look back analysis is a closed period. It's only looking at, did the premiums that we collected for FY25 cover the expenses that we incurred for FY25. The EMR report is more of a cash basis that starting in July through the period of June, how much did we collect versus how much did we spend? That's EMR is cash, correct?

Member Viton: So the EMR has multiple plan years in it because we're paying out prior year expenses, but we're also collecting current year revenue, paying out current year expenses. There is a mismatch between the periods. I guess I'm just trying to help self-understand how it fits into the overall conversation about how the performance is. The budget report is that we're spending in cash deficit but the cash flow report looks like we're not spending the cash deficit unless I'm misreading it.

Chair Wells: No. FY26 should have covered and started to restore reserves. That's why you're having a surplus here in 26 and you should have in FY26 or 27 when we do the look back analysis for 26, you should see that the premiums that we set are higher than the actual expenses that we incur because that was the intent was to start rebuilding reserves in FY26. You've got a cash basis report that says here's what's going on month-to-month on a cash basis. You've got a look back analysis that just says, did the premiums that we set for a plan year cover the cost that we incurred for that same 12 month period? And that 12-month period isn't really 12 months because you can have a claim for FY25 that's not submitted until well into FY26. It's two completely separate things.

Member Zumtobel: Tom Zumtobel for the record. Are you talking about, 25 we understand, but then 27 it says we have a \$900,000 deficit and then your cash report.

Member Viton: I'm trying to understand because I feel like our conversations have fairly consistently suggested we're not building for pre-build reserves. That we've been deficit spending, the premiums were set too low, that we had to have the rate increases because we weren't restoring reserves. I don't know if I'm misreading the cash flow report or if I'm misreading the other reports because I just feel like the pieces aren't fitting together.

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Chair Wells: From a cash perspective for the 12 months that ended FY26, we had additional cash. Whether we covered all of our claims for FY26, we won't know till we do look back analysis. We could still be in a deficit for FY26 from a look back analysis even though we have positive cash at the end of FY26.

Member Rich: Laura Rich for the record. I don't know if we can get the look back analysis on the screen, but I have a question probably for Segal. We know what was in the budget. We know what was actual, right? I'm going to bring this up because it was the bane of my existence when I was in Theresa's seat. What PEBP actually asked for is based on trend and what we get from the actuaries. But what is actually approved in the budget is usually not that. It's lower. It's a much lower number and applied through GFO. My question is, if we had actually used what the actuaries had proposed, would that have been closer to the actual number rather than the budgeted number? And I think my point here is that, traditionally there's been a history of the trend that our actuaries provide does not actually get approved in the final Governor's budget. It's a different number and so maybe this is something that we need to start advocating for.

Ms. Donaldson: Debbie Donaldson for the record. D O N A L D S O N. Thank you for the question. I'd have to go back and do the analysis to see what we anticipated versus what actually happened to come up with that differential. But you are correct that historically the increases in the AEGIS and REGI had not been to the extent of what we've been utilizing for trend assumptions in the future.

Chair Wells: But they were for 26 and 27. The legislature did approve the actuaries trend rates for 26 and 27. At least they did for this biennium.

Member Rich: But this is 25.

Chair Wells: 25 wasn't included at the at the full amount but 26 and 27 were.

Ms. Donaldson: For the record, Debbie Donaldson. My comments related to the plan year 25 look back analysis and yes you are correct Chairs Wells.

Chair Wells: Any other questions?

Executive Officer Carsten: Theresa Carsten for the record. 28-29 budget build enhancements. PEBP has a minor number of enhancements we've requested to assist in running PEBP in achieving operational requirements under the Nevada Health Authority. PEBP is requesting funding to fund 50% of a contract pharmacist and two management analysts who will provide vendor oversight of the state pharmacy benefit manager. Additionally, PEBP has requested to fund one agency manager to coordinate procurement and accountability efforts with PEBP's vendors and those shared with the Nevada Health Authority. The last two changes are minor impacts to the

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budget. There are requests to reclassify three positions to a higher grade which will help with recruitment and retention of these operational positions. And lastly, if approved, our IT staff will move under the supervision of the Nevada Health Authority that has the knowledge and expertise to provide these positions in the direction of their work. This will be a cost savings as the Nevada Health Authority will pay for part of the positions, thereby shifting some of PEBP's costs. The increased costs for these items are less than \$1 per employee per month. Does anybody have any questions regarding this current side?

Chair Wells: Just to be clear, these will be discussed under agenda item number seven for action.

Executive Officer Carsten: No questions. These are some of the items that we discussed in last month's strategic planning retreat. I've outlined the priorities identified from last month's retreat. I wanted you to have these top of mind while I go over the timeline in the next slide for upcoming RFP procurements. As we will discuss later in the agenda, during the contract status report, six RFPs are due to be released for procurement in addition to the three RFPs we wish to release in coordination with the NVHA. This timeline outlines the most conservative option to procure the contracts and implement the vendors to stand up on July 1 of 2028. Staff wanted the board to have a visual as you move toward identifying which contracts you wish to revise as you discussed during the July strategic planning session. Large revisions to scope of work and unbundling some services from multi-contracts into single contracts will likely impact the budget. Contract changes that are not funded during the next biennium may have to be adjusted to be deferred until future funding is available. It may behoove PEBP to extend through amendment some of these contracts to a later start date to assist with the staggering of procurements both now and in 2032. It's difficult to lift all of these at once. The agency and the board may struggle with these procurements and this timeline that we have available to us if we want implementation of all of these by July 1, 2028. Discussion on the timeline and procurements can occur today, but any future decisions on extensions not outlined in a later section of our board agenda will be brought back in September for possible action. Questions, comments around this timeline or we can save it until we talk about it later. We can bring it back up later.

Chair Wells: Any questions?

Executive Officer Carsten: Lastly, vendors and board members are expressing interest in meeting with additional vendors to discuss possible alternative solutions to PEBP's program costs and needs. It would be helpful for staff to understand if the board is interested in meeting with these vendors and if so for how many future board meetings before scope of work revisions are determined to be finalized. I don't need answers to this right now, but I just want to bring this up as we've been tasked with meeting with a couple of vendors and if we're going to start talking about ways in which we can revise scope of works before RFPs, those considerations should probably really be seen at the board level, not the staff level. With this previous timeline we've discussed,

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that's really short for how many you may want to select to see in your future agendas. So, I just wanted to bring that to top of mind. And if there aren't any questions after that, that concludes my presentation.

Chair Wells: Any questions? That is not an action item. It's an information and report. We'll close agenda item number five. Move to agenda item number six budget report.

Ms. McJoy: Good morning. We closed our budget as far as our income. We closed at \$616 million. We projected last quarter that we were going to collect \$603 million. So we did collect \$13.2 more than expected. Any questions on any of the income? I do have it broken down and I simplified it a little more so it can be readable. If you have any questions based on the income, you can ask them. You can ask me now. I tried to be as transparent as I possibly can within this report. Do anyone have any questions on any of those breakdowns? And this also includes the \$32 million that we did find with our audit that we did when we did find out that the calculations were incorrect.

This amount does include the money that we did discover and you can see that in the state subsidies cell. So, we did close with our income \$73 less than expected in revenue, but we already mentioned that the budget was uploaded wrong. That's where you will see that deficit. Going down to our expenses, we did close at \$563 million. It's less than what we budgeted for, which is a difference of \$5.2 to less than expected. If you go down to the bottom, it has the breakdown of the total budget revenue less the total expenses with the remaining balance of \$52.5 million. Our actuary expected reserves was the \$121 million but due to issues we are going to put the \$52.4 for into reserves which leaves us under collecting the reserves at \$68.7 million.

Chair Wells: Questions?

Ms. McJoy: I just want to ask a question. Is this readable? Does everyone understand how these numbers are reported? I want to make sure that what I'm reporting to you is something that everyone can understand. When I do the next budget report that if I need to make any changes, I will take your recommendations and implement that.

Chair Wells: Questions, comments?

Member Zumtobel: Tom Zumtobel for the record. This feels more readable than what I've seen in the past.

Chair Wells: Comments, questions, any changes to future reports?

Member Viton: I'll ask a question. You mentioned the \$32 million that was found in the subsidies and just to help me see that in the reports because you mentioned I see it in the subsidy line. Do you mean that we would have been more under budget or over budget on the subsidy line?

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Ms. McJoy: If we didn't figure out the calculations was wrong in our system, that will be a lot less than where you see the actuals. It could have been \$32-\$34 less than.

Member Viton: It was recovered in the actual?

Ms. McJoy: Yes, it is. And our systems are set and everything is calculating correctly.

Chair Wells: I think that one of the things to look at as we're talking about the last one where, from a cash perspective. The funds carried forward from the prior year, that very first line of \$66.9 million, we're only carrying forward now \$52.5. From a total cash basis, we're still using money.

Member Viton: And again, I think that's really my question. Going back to the cash flow schedule because the cash flow schedule reported that for the year we had positive cash flow.

Chair Wells: That's claims. I don't believe that the EMR includes administrative or HRA.

Ms. Donaldson: I think it does.

Chair Wells: Does it include it for the Medicare retirees?

Ms. Donaldson: I'll have to go back and check. Yes, it does.

Member Viton: I'm not trying to reconcile it in the meetings, but that's my question. I'm having trouble fitting the pieces together.

Chair Wells: Yeah, that's a good question.

Ms. Donaldson: Debbie Donaldson, Segal for the record. I believe it does not include for Medicare for the Via Benefits. It does not include the HRA for that.

Chair Wells: That's why I say it does not include the costs that are associated with the HRA. That surplus gap is only for the plans that are internally HMO, EPO, PPO, CDHP. There are still expenses related to Medicare retirees that are not reflected.

Member Viton: Not knowing what that number might be I just still don't know if it makes sense. Because, between the two it's a delta of \$31 million. That's my question.

Chair Wells: It's a great question to dig into. You want to try and address it?

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Ms. Donaldson: Debbie Donaldson for the record with Segal. There's different ways to look at financial results. The bottom line that Executive Officer Carsten was trying to put forward is what our anticipation is going to look like for plan year 27. We know that plans have been, there's a phase in approach, which is an additional need of \$30 million which needs to come from reserves. The bottom line is what she's trying to show with cash with claims coming in, if they perform as projected along with how premiums were set and this additional \$30 million that need to come from the reserves plus funding your IBNR reserves, there's not enough cash on hand to be able to cover some of that. That's the issue.

Chair Wells: Let me try a different way first and then if I don't get what you're after then come back. The EMR report shows a \$17 million surplus for the 12 months that ended in June. The report that Monica just went through is also for that same 12-month period. It's showing that we went from \$68 almost \$69 million to \$52 million. We used \$14 million. We didn't gain \$17. Where is the disconnect between what the EMR report is showing as a surplus and the budget report is showing as a deficit for the 12 months that ended June 30. I think that's the question

Member Viton: Because both are cash basis and in terms of the projection, the premium increase that we implemented was because we were talking about deficits. period deficits in claims that were exceeding premiums.

Chair Wells: Theoretically, we still would have had to increase premiums because even with \$17 million, we would not have covered it.

Member Viton: I do appreciate that. We're getting a lot of numbers and we get them in different ways and as I'm trying to piece them together I'm just having trouble with that and I do definitely appreciate we can't do it in the meeting, we can't do it now on the spot.

Chair Wells: I think that it's a great question and it's something that we need to address and have brought back to the board at the next meeting.

Ms. Donaldson: Chair Wells, Debbie Donaldson for the record. Agreed and we need to coordinate and work together on how you're building the budget report compared to what we're reporting on the EMR report. And I take that as a takeaway that I'll work with the CFO, Monica to help resolve.

Chair Wells: Thank you. Any other questions? Hearing none. Again, this was also an information item. We'll close agenda item number six and move to agenda item number seven. Discussion and possible action regarding the framework for submission of the agency request budget for the 2028-2029 biennium. Ms. McJoy and Ms. Carsten are going to address this.

Executive Officer Carsten: As we discussed earlier in the executive officer report, these are the enhancements that were listed. I know during public comment, it was talked about AEGIS and

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REGI. AEGIS and REGI increases have been built into the workbook. The final amounts have not been determined. Our goal as we've worked with the Nevada Health Authority Department fiscal leadership to build our budget is to present a budget that asks for 100% of our needs. The reserves that haven't been funded. All of the things plus these enhancements that we've listed here. When you put all of that into our workbook, plus our administrative load, it backs into new AEGIS and REGI amounts at higher levels. So again, those will be presented as an ask of what PEBP needs at 100%. But we realize that is it's going to be a very significant ask. We've been advised that there's not a lot of state revenue that will exist possibly in the amount that we need. So, what we're doing is also building decision units that would allow the Governor's office and later state lawmakers to decide whether to reduce that request to fund our IBNR at 50%.

I just want to be very clear, our ask is for what we need. That's how we're submitting the budget, not for what got voted on or what we think the reserves should be at, but what we've been notified through Segal's report that we need to be solvent plus a request to state employer contributions. Premiums will still arise due to the phase in. We're still working through the finality of those workbooks and those numbers. They're not presented here today because they're not final. They're kind of ever changing and fluctuating. But if you have questions in addition to what we've already gone over, we're happy to have that discussion at this time.

Member Zumtobel: Tom Zumtobel for the record. Can you help me to understand? I think you just said it, but we're requesting what we need and that's based on the next biennium for 24 months, right?

Executive Officer Carsten: Yes.

Member Zumtobel: And is that premeditating what the premium increases are going to be to the members or is it a 100%? What we need, how does that relate to what the employees would be paying? How do you think about that?

Executive Officer Carsten: Yeah. Segal can speak to everything that's included in our underwriting tab, but it's similar to how we set rates. So historical claims cost, trend, etc. that go into the rate build, right? I see Debbie getting up, so she's going to explain it better than me. I'll wait.

Ms. Donaldson: No, keep going.

Member Zumtobel: And I'll try to simplify my question. In essence, I'm new to the board. But a few months ago, we voted on what the premiums would be for the upcoming year. If they accept whatever we present, is that also setting what the premiums will be for the employees for the next two years because we're getting everything?

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Executive Officer Carsten: When Segal projected what rates needed to be and then we voted for phase in right and so the underwriting tab for the budget build workbook should include everything for what the rates should be for costs. Then in addition to that we have to ask for additional funding to make up for the \$30 million shortfall and to rebalance the reserves. Does that help?

Member Zumtobel: No, it helps. I understand. In essence, we're saying those phase in rates are the rates for the employees then for the next two years. If we ask for everything we need, it sounds like we're assuming that we're going to pass that cost on to the employees and get everything else that we need.

Executive Officer Carsten: Costs are shared between employees and state employers. So, we're going to go in requesting additional funding from the state for state employers. But based on how we get funded, will drive what the premium requirements for the members is because we only get funded two ways. If they don't give us what we need, then those go up.

Ms. Donaldson: Debbie Donaldson, for the record. The only thing to add is that we're projecting out based upon what we know today for budgeting purposes what we think is needed. And that doesn't necessarily mean those rates are going to be set in stone. Once we get more information, we'll relook and do the analysis.

Chair Wells: I'll talk a little bit about how this works. We have a biennial budget. So, you're setting rates. You're submitting budget requests for 28 and 29. We just barely finished 2026. You're almost trying to project three years out. We're doing the best we can with the information that we have today to submit a budget a week from Monday. During the next four months, we will look at this again and update the numbers. And then as we get close to setting FY 28 rates in the spring, those FY28 rates will be pretty close to final. The first year of the biennium really is approved by the legislature because they basically are approving the budget about the same time we're approving rates. But it's that second year of the biennium that gets to it that gets to be a little bit trickier. The trend is built in, assumptions for trend are built in for both years of the biennium. Additional funding to recover the reserves are being built into the budget request.

But we're going to have to be super clear about what that means because I think that when the board set rates for 2026, from what I saw and read, there wasn't really a discussion about the money that was being added by the legislature to replenish the reserves. It was just a discussion about what are the employee rates and what is the breakout between the employer and the employee. We're going to have to be cognizant that as we set rates that we are setting rates that rebuild these reserves with any additional funds that are being provided by the legislature specifically for that purpose.

Member Zumtobel: That's exactly why I was asking the question. I wonder if we could approach it that we truly ask for everything that we need which means we ask the state or whatever

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terminology you use, ask the legislature for all the money we need to fund it at 100% based on the rates that the employees are paying now, not assuming that we're passing on new costs to the employees and then at that point at least the legislature knows the whole picture and then they could decide how much they give us and then we set premiums after that. But I feel like when it's chopped up like that, it doesn't get the whole story up there. I feel like if we're asking for everything we need, we should ask for everything we need. And then just like you explained to me, whatever they don't fund, then the only other place for it to be funded is on the employee. But when it's asked in segments, and I don't know how you ask, but I feel like we should ask for everything we need from them and then they're making a decision that they're passing it on to the employee.

Chair Wells: Part of it is, we will and then the next piece, the subsidization policy is how we split that between employees, retirees, and state subsidies. Is the employee going to pick up 7% of the rebuild reserves or are they going to pick up 7% of the premium and the state's going to pick up 100% of the reserves. Those are still discussions that will have to be had between policy makers at the at the legislative level.

Member Zumtobel: No, I agree and I'm starting to understand that a little bit.

Chair Wells: But the ask is intended over the biennium to restore reserves. The additional funding that we need to restore reserves and then as we look at the plan and the subsidization policy next that still will go into how much the employee pays.

Member Zumtobel: I agree Chairman Wells. To restore reserves in essence, it's kind of terminology also because you're really asking for enough money to fund the plan. It's almost like the budget conversation we had a few minutes ago. There's a lot of moving pieces. And what I'm asking is maybe we should ask without a lot of moving pieces. We should ask for what we need and then explain later versus asking for pieces.

Chair Wells: We will, it's being built that way. Any additional questions on these one, two, three, four administrative enhancement requests? If not, I think we'll make a motion individually for the administrative enhancements. We'll take as a single item a motion to approve these four enhancements.

Member Duncan: I make a motion to approve.

Chair Wells: We have a motion to approve the four individual administrative enhancements that were laid out by the Executive Officer. Do I have a second?

Member Rich: Laura Rich, I'll second.

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Chair Wells: A motion and a second to approve those four individual enhancements. All those in favor say I.

All board members: I.

Chair Wells: Any oppose? No. Motion carries. All right, let's move on to 7B, the state subsidization policy. That is what is laid out in the appendix to the board's duties policies and procedure. All right. Ms. McJoy.

Ms. McJoy: Okay. Anything that's marked in red was updated. This does show how the plan is broken down. Also how we have entered the G which is the general overhead cost which is going to take care of all of the administrative cost for PEBP considering the personnel, the IT, and all of the expenses that comes with operating the budget. This breaks down how those costs are going to be broken down amongst all of the categories of all the tiers. That's what this shows, the breakdown of the general cost with each tier.

Chair Wells: All right, before we move on from there, let's make sure that everybody understands how this works. Are there questions? Do we need clarifications? I have one. I'm going to start with one. This is probably for Ms. Donaldson. When we set rates for the current plan year, we set rates for the CDHP, the PPO and the EPO separately. How did we do this adjustment by plan in the current? The document that's here is reflective of what was actually done for FY27. It's not necessarily what we should have done or what we should do in the future. This is what was done for FY27. Let's just be clear about that. We just need to make sure that this is how we want to do this going forward. Can you explain a little bit about how we got from the individual plan costs?

Ms. Donaldson: Debbie Donaldson for the record, Segal. The first thing we look at is the percentages is based upon the CDHP. We were using 6 and a half% and we look at the employee only.

Chair Wells: No, not that part. How we calculated the whole the entire premium?

Ms. Donaldson: Oh, the entire premium. Sorry. When we calculated the entire premium, for plan year 27, we looked at the phase in component and what was needed. What we did look at is what would the total rate look like and then how much we are getting from AEGIS.

Chair Wells: No, how did we get the total rate column? The very first column on the rate tables, it's the total rate that we pay for employees, plus spouse, plus children, plus family. How did we derive that for the CDHP and how did we differentiate it for the other two plans? How do we

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calculate those? The total rates, not the not the AEGIS, not the state's portion or the employees portion. How do we calculate the total rates for the three plans?

Ms. Donaldson: There's a factor and there are a couple components to that and again this is based upon a model that I think has changed a little bit since I had worked on it in my previous employer. What the total rate is done is it looks at the medical and pharmacy claims. The employee only and then the employee plus spouse is twice that. What ends up happening is some of the life insurance and disability gets added on then after the fact. If you're looking at the ratio, it's not exact. For example if you look at the employee spouse it's not exactly two times the active rate. It's something a little bit different because of the adjustments for life insurance and stuff that are added in after the fact. There are different factors for the employee plus spouse, the employee plus child, and then the family based upon that employee only rate. And it's the same factor that is used for each of the plans.

Chair Wells: But what was the underlying basis? Maybe I don't know how to ask this question the right way. What was the underlying basis to calculate the premiums for each of the three plans? The claims that were associated with those individual plans? Was it a factor from one plan to a different plan based on actuarial value? Was it based strictly on the cost for the individual plans? How were those three plan total premiums calculated?

Ms. Donaldson: Debbie Donaldson, for the record. We looked at the claims for each of the different plans. Correct.

Chair Wells: Okay. They are not necessarily looking at it as a single group of people and then adjusting the other two plans from a single pool. It's setting the rates individually by the costs that were incurred by the three individual plans.

Ms. Donaldson: Correct. We were adding in some assumptions associated with, again we're looking at historical rates and then projecting forward. We did add in some assumptions as far as migration and who's coming in and adding some risk adjustments to some of those plans to account for different risk pools that we're anticipating because of the change in the rates. But yes, each of the plans was looked at and the claims were separately looked at and rated with some adjustments. Correct.

Chair Wells: One second. If we looked at our total population, the claims of our total population and did adjustments based on the actuarial value of the three different plans, what would that look like?

Ms. Donaldson Debbie Donson for the record. That is a little bit of the approach we're coming out of. Because certain plans are subsidizing other plans. In aggregate, the claims are the claims. It depends upon who's paying and who is paying for the portion of those total claims. And that's why

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we're seeing the big increases because we're getting rid of those subsidizations, if you will. And that's what's generating, at least for plan year 27, one-third, which is about \$30 million of additional funding that PEBP is picking up and not the members. We're looking, the claims are the claims. It's just how we're reallocating that. You're correct. We could do it by actuarial value, but then again, the plans are going to be subsidizing each other. Getting back to the point where the consumer-driven health care most notably is subsidizing all the other plans.

Chair Wells: And then the calculation for the children tier. I believe in looking at the workbook that it is.

Ms. Donaldson: What the ratio is.

Chair Wells: Yeah, I don't remember now.

Ms. Donaldson: It's 1.375 of the active.

Chair Wells: The thought here is that the children cost 37.5% of the total cost of an adult. The aggregate cost for all children is 37.5% of the adult population. Do we have data to back that up?

Ms. Donaldson: Chair Wells, for the record, I do think it may be prudent. Yes, we do have data. These factors have been in place for a long time. The factors of employee plus spouse is two. Employee plus child is 1.375, family is 2.375. These factors have been in place for quite a while. I do recommend that we take a look at the data. It's not just a couple years. You have to look historically at like five or so years to make sure that you're looking at it appropriately for a risk pool to make sure you're just not reactive to like the last year or two. I do recommend that we take another look because it's been a long time. These are the rates that I used 10 years ago. So I do think it is prudent for us to take a look and potentially readjust those or to confirm and validate that these are appropriate for the tier ratios. Otherwise to your point, Chair Wells what ends up happening is different tiers are subsidizing each other. The total rate won't change but how you allocate it between each of the tiers could potentially change and I'm just throwing something out depending on how the factors flow the employee only may be subsidizing tiers for the family because maybe the family is higher. Just throwing out an example. It would make sense to relook at these.

Chair Wells: The last question I have is on the general overhead costs. When I talk about general overhead, I'm talking about the PEPM costs that we pay for all of our vendors. I'm talking about the salaries and rent that we pay for staff. Those costs now according to what I saw in my review of the workbook, I will be honest I've seen the workbook, are not the same for every tier they are based on the number and it's not necessarily the number of people, it is based on the same ratio of the four tiers. The administrative costs are not the same for every tier. They are different for every

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tier based on the tier ratios that are outlined. The single person two times for plus spouse, 1.375 for plus children and 2.375 for family. All those administrative costs now are being proportionately driven based on those ratios. Is that correct?

Ms. Donaldson: Chair Wells, Debbie Donaldson. Yes, that's my understanding as well and when I look at the rating and previously it had not been like that. At some point there was a change. Essentially when you're doing that you're creating some administrative fees are a small component of the overall cost but yeah there is some cross subsidization. correct

Chair Wells: It may be a little bit bigger depending on how the reserve replenishments are built into these rates. If you build them in as an administrative component, how they would be proportioned to be different. That means that when you look at that table at the bottom, it's not  $2 * x$  plus  $g$ , it's really  $2 * \text{parentheses } x + g$ . And then there are some outliers. The life insurance is not included because it's only for the primary employee and we don't have LTD anymore but LTD was separate and so was the small administrative cost related to the Medicare retirees, was separate I believe from the administrative. There's basically two times the  $X$  plus  $G$  then plus you've got the life and then the cost related to the Medicare exchange.

Ms. Donaldson: That's correct.

Chair Wells: That would need to be both defined and updated in this table.

Ms. Donaldson: Correct.

Member Zumtobel: I'd like to understand the answer to your original question. What I heard you ask is do you start with all of the claims in a pool and then you apply some factor by plan or is the pricing based on the experience by plan. I'm not sure what the answer was.

Chair Wells: The answer that I think I got and Ms. Donaldson can correct me if I'm wrong is that it is the cost by plan adjusted for what they believe to be migration in and out.

Member Zumtobel: Leaving migration aside for a moment, the basis would be by the current experience by plan.

Ms. Donaldson: Correct. Debbie Donaldson for the record. Each plan is individually rated looking at each plan individually, correct.

Chair Wells: Because that was the issue we were trying to address at one point was that the CDHP, and if you look back at the that surplus that the CDHP was driving was basically used to offset the deficits in the other two plans. The idea was, let's set those plans to reflect what the cost of the

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plans are so that one plan's not subsidizing a different plan. I mean, this is a policy issue. That's why we're having the discussion.

Member Zumtobel: It's important. I liked where you're going with the question because I think it is a policy discussion. If it's pooled then it does at least take into account the cost. The high deductible health plan very likely attracts a lower risk and if you're pricing it against itself, it's always misleading to some degree. But if you pool it all, I think you mitigate some of that. You're the expert. How would we mitigate that?

Ms. Donaldson: Debbie Donaldson for the record. Thank you for the question. There's different ways and I'll say that states choose different approaches. In the past what has happened is the CDHP plan has subsidized the other plans. But we haven't gotten enough money from those other plans to help cover their costs even with the subsidies because we're doing it just on actuarial value. What we're doing starting in plan year 27 and what we've been looking at, because the risk pools in themselves are big enough on each plan to stand alone. At least as of now to stand alone. So, we're rating those plans separately.

Member Zumtobel: It's always tricky, but the result that we're getting with the high deductible subsidizing the other plan is not a surprise because it's a lower premium and it attracts better risk.

Ms. Donaldson: For the record, Debbie Donaldson. You are correct. However, what ends up happening is behavior economics come into play. I'm a member in the consumer-driven health plan. Golly, I know I have to have my knee replaced. I'm going to go to the low deductible PPO plan because I could pay a different amount and my out of pocket's going to be the same and I may get better service because I just have co-pays versus I have to pay these upfront deductibles and stuff. It does create different financial outcomes with the plan when you do this kind of subsidization. We've seen that particularly in the EPO HMO plan where all of your higher risk is in that plan because it's a more generous plan. We presented I believe back in March when we were looking at the risk scores. The risk scores are much higher in that EPO HMO compared to the other plans to your point. It does come down to how PEBP wants to rate these plans, if they want to be separate individually stand on their own. The members in that plan are paying the cost for that plan. That's a decision to be made. But starting in plan year 27, that's the path that we're going on and looking at each plan and then making the members in that plan pay for the cost associated with those plans.

Member Zumtobel: Tom Zumtobel for record. Because it is behavioral economics also. And it's an annual enrollment, not a month-to-month enrollment. They'd have to plan, they can't just move because they're going to have a surgery, but they could plan for a pregnancy. There's a lot of opportunities for them to do it differently. I think the high deductible is an excellent plan for certain people and it also is valuable because it does attract good risk but that's potentially part of

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the policy is that it actually does subsidize others because if we moved everybody into high deductible, the high deductible would not perform as well as it's performing now. It's performing well because it has healthier people in it.

Member Rich: Laura Rich for the record. I also want to add that the high deductible plan is the default plan as well. If someone does not choose plan, they get put into the high deductible plan.

Member Zumtobel: Which are the people that are healthier. Something needs to be on the table in this discussion. We can't just assume the high deductible is running better than other plans. There's reasons that it runs better than other plans.

Chair Wells: There are. But part of it is like the co-pays related to prescription drugs. You know you're going to take prescription drugs. Well instead of paying your total out of pocket on the CDHP it's way better to pay a co-pay, a \$25 a month, or 90-day co-pay. You see a lot of it driven by that kind of mentality too. That's the kind of behavior economics is like I have to take this drug now and I take it for a long time. I can pay the whole cost over here or I can pay \$25 over here. You see that kind of shift too. We need to be careful when we set the plan designs that we're not encouraging people that take this expensive medication to go where it costs them little but to plan a lot.

Member Zumtobel: I agree, Chairman Wells. There has to be a balanced approach and it's the reason that I asked for clarification of your question because the very foundational basis of how the pricing is critically important. And it ties back to what I've heard you say in previous meetings of right sizing the funding. You got to start at an initial point of everything is to some degree the same and then you make decisions about how you affect it no longer being the same either by driving different utilization or charging premium.

Chair Wells: When we first went to this model, 16-18 years ago, a long time ago, we only had one self-funded plan. The other two plans were fully funded HMOs. Now we have three self-funded plans or two and a half, let's call it two and a half self-funded plans and a half HMO. We've got a different plan mix and I think that we have been struggling as an organization since the inception of the middle plan to come up with equitable distribution between these now three plans. I think that's where I'm really struggling with this. What is that equitable distribution between these now three plans and I think that's where the board is struggling.

Member Zumtobel: The foundational piece. I agree.

Member Duncan: Not being an actuarial expert, can I just reiterate and I want to make sure my understanding is correct. Tell me yes or no and then I have a question. What I'm understanding is the problem that we're trying to solve for here is that we have a lot of cross subsidization like one

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plan essentially subsidizing the other. Moving to this policy is essentially we're turning that cross plan subsidization to zero. Right, we're not subsidizing plans now?

Ms. Donaldson: Debbie Donaldson. It's to get to zero over I believe it was approved two and three year period depending on

Member Duncan: Essentially to remove that subsidization. What I'm seeing as A, amongst others a potential risk is that there now could be subsidization within the plan between the tiers. Is that correct? That's what I'm hearing?

Ms. Donaldson: Debbie Donaldson for the record. That's correct. These tier ratios haven't been analyzed in quite some time. I do recommend that we take a look at that to see how these tier ratios stack up given the most recent five years' worth of historical data. Yes.

Member Duncan: That was definitely my question. Have we modeled what that would look like between each of the tiers and sounds like that's something to do. Okay, got it. To the point of reducing that subsidization over a couple years and I know we were looking at decreasing, moving around the values and such. Would instituting this policy in this now, does that account for the fact that we are slowly moving essentially to this or would instituting this policy immediately drop it to zero or are we able to, this is the policy that we're moving towards?

Chair Wells: We would still have the implementation or the phase in approach that the board approved.

Member Duncan: That phase in approach would still apply despite making this change into the policy.

Chair Wells: I don't want to approve this actual piece today because I think this part still needs some work. I think having the analysis of the of the children tier that that Ms. Donaldson was talking about needs to be done. I think if you read Dr. Ervin's second public comment, we used to have tiers, the plus spouse was more expensive than the family. You had a kid, your rate went down because what happened was the people who had kids were typically younger adults. The people who were in the plus spouse were older slash retired adults. You had some really weird fluctuations between tiers that didn't really make sense. We went to this tiered ratio of adults, two times adults, adults plus children, and two times adult plus children. And then that has morphed over the last how many years. The board has not approved this policy.

My point in putting this in here is I don't know that the board knows what the policy is behind how the rates are being derived right now. How we're getting to these X's and A's, how we're multiplying the numbers, the tier ratios across plans, I don't think the board knows exactly how the rates are being set now. Once you put this in policy, setting rates really becomes a math

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problem. We don't get to pick and choose based on the outcomes. We pick and choose based on what the math says. While we still probably need to have some more discussion about this, I wanted the board to know we need to have more discussion about how we set these plan premiums and how we analyze the difference between the tiers and how we allocate administrative costs. All of that stuff is a policy decision that if you do it the old way where the administrative costs were all charged based on the primary, the primary pays a little bit more, all the other tiers pay a little bit less.

When you allocate it based on tier ratios, they pay a little less and all the other tiers pay a little bit more. There's all these fundamental questions about how you do this that drive the tiers. And then the next part that we're going to discuss is how we subsidize those. How much the employee pays versus how much the state pays. And that decision we do need to make today because that is a key component in how the budget is built because the budget basically splits it between how much the state contributes and how much the employees and retirees contribute. So that ratio for the next piece does need to be decided today. But this piece, I wanted to have this discussion so that we can figure out and bring it back and what does this table really look like and what does it really mean?

Member Duncan: I agree. I definitely think we should have smart financial modeling to be able to see that. I have one very specific question. How are the general overhead costs allocated? Is that like a flat by enrollment or like how is that defined?

Chair Wells: It's allocated by the tier ratio. The general administrative costs are divided by a multiplication of the tiers times the ratio. The number of people in the tiers times the ratio aggregated and then divided back out. It basically it says if you are a single person, you pay one amount, one general overhead cost. If you have a plus spouse, you pay two times that overhead cost.

Member Rich: It's a very complex Excel worksheet.

Member Duncan: Which is not defined in here. Otherwise, there would be some parentheses.

Chair Wells: Yes. That's why I say this is definitely not correct.

Member Duncan: I was like there's an order of operations that you would have to.

Chair Wells: It's got to be  $2 * \text{parentheses} \times \text{plus } g$ . Not  $2x \text{ plus } g$ .

Member Rich: Laura Rich for the record. I don't know if this is part of this part of the conversation or the next one, but I was thinking about and Jim, you mentioned it where the rate for employee plus children was sometimes less than employee plus spouse because the spouse is typically more expensive than the children are. But I was thinking about it this morning and we have a rule at

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PEBP that if your spouse has access to coverage elsewhere, they cannot be covered through PEBP. The problem is, how do you enforce that? There's no way to enforce that. I know plenty of people who have added their spouse even though their spouse has access to coverage elsewhere. Despite what people say the PEBP plan is probably cheaper than what is out there in the private sector. It's cheaper for them to add their spouse than it is to have their spouse covered through their own employer.

Thinking about that, is that something that we can encourage through this policy? How can we enforce our own rules that we have and potentially if people have coverage elsewhere encourage them to seek coverage through their own employers, their spouse anyway. We have limited funds. Again, we've had this discussion. We have to be able to focus our efforts on whether it's the employee, whether it is active versus retiree, all that stuff. Maybe this is a way to enforce our own policy and thinking about that. I don't know if that's part of this discussion or if it's the next part, but it's something to think about.

Chair Wells: We have talked about in the past doing a dependent audit that basically would confirm whether the dependents are eligible to be on the plan or not. And that's one way to do it. The other thing you see anecdotally, I don't know that I know this is that somebody gets divorced and instead of having to pay for the divorcees or the ex-spouse's insurance they just keep them on. We don't necessarily catch that because they have to tell us that they're divorced and that they want to remove their spouse and they may or may not do that. Doing a dependent audit to catch some of those people that shouldn't be on our plan anymore, too. Okay. We're going to bring that part back.

The second component starts at the bottom of page 21, subsidy percentage which is the percentage of the premium that is paid by the employee and or the retiree and the amount that is paid for dependents. At the bottom, the active employees and this is the percentage of the CDHP, 6.5% of the CDHP plus 31.5% of the dependents. This is another formula that is pretty complex. It used to be a little bit more simple of a formula, comes out roughly the same. And then on the retiree side, it's 30% and then 25% differential. It's 55%. They pay 55% of the dependents. And that is for a base retiree. So that is for a pre-1994 retiree or retiree with 15 years of service and then it's adjusted up or down based on the years of service. To be clear, the 30% and 55% are adjusted up and down based on tier. These are different than what I remember. We had a public comment about do we have a base plan with a zero dollar premium for the employee which means that we would cover 100% of the CDHP. I will say those local governments that do that typically don't cover their dependents at the same percentage that we do. Do you offset that with a bigger differential between the dependents and the active person if you do that? The other thing, and it wasn't really supposed to be put in here, but it got put in here anyway, if we're setting these subsidies based on the CDHP, and the CDHP's trend is lower than the other two plans, the PPO and the EPO, that subsidy is not going to go as far if you keep the same subsidy for all three plans.

Those other plans are going to continue to get more expensive as long as those trends on those other two plans outpace the trend on the CDHP. That's just another consideration when we talk about this. If that differential and trend continues to widen, the subsidy is not going to go as far

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and those other plans are going to continue to get more expensive for the employees than the CDHP is. That would need to be part of this policy if we wanted to change that for the other two plans as well. This is set as it is. We subsidized 93.5% for the employee only and we subsidized 79-78.5% for dependents and then for a retiree subsidized 70% and 45%. Are those the right percentages and then should they be the same across all three plans? Open it for discussion.

Member Duncan: Keiko Duncan for the record. Say we set the rate by member type essentially, and it's a flat rate no matter what plan they're in. What happens if that subsidy doesn't keep pace with plan costs? Is there something that we have to analyze on an annual basis to ensure that it is proportionate or appropriate to plan costs.

Ms. Donaldson: Debbie Donaldson, for the record. We're seeing that now with your phase in. You're trying to phase in the approach from where you are today to get to the true costs. Yes, it would have to be reviewed annually if you decide to go with a different methodology than you do today. Just to reiterate, everything's set based upon the subsidy, the state subsidy, if you will, is based upon the consumer-driven health care plan. And it's the same for each. It's set starting with the biennium and what we're projecting of the money that we're going to give and then it depends on how that gets allocated.

Member Duncan: Have we modeled this yet, these numbers? Have we done a financial model of what that would look like on the premiums and such?

Chair Wells: This is what we used for 27. That's why we put it in here. This is what was used for 27. Right, wrong, or indifferent. It's what was used to calculate the employee employer split.

Executive Officer Carsten: Theresa Carsten for the record. It's also what was programmed in our workbook biennium budget.

Member Rich: Laura Rich for the record. I do have to say that we got this report late yesterday. I have not had a chance to read it, absorb it. It's a little bit of a challenge in itself. I have lived and breathed this stuff so this comes a little bit easier to me than maybe some of the other board members. In the future, we really need to be able to get these reports well in advance to be able to have these kinds of conversations. My other question comes back to, can we separate the dependent and maybe subsidize employee plus children at a different level than employee plus spouse etc. Take a look at that or is it just dependents at dependents or dependents?

Chair Wells: To me, that's a board policy. If the board's policy is to subsidize children at a higher percentage than adults, you can build that into the formula. This is all just formula driven. That's why I say at the end of the day, this narrative that's in these two or three pages equates to additions and multiplications on a table.

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Member Rich: Again, it comes back to, we have a policy that we can't enforce and I understand we have a dependent audit, but we have to pay for a dependent audit. It's very disruptive to people, which is why it hasn't been done in the past. But if we encourage it through our pricing, potentially we can enforce the policy that we have.

Chair Wells: Questions from other board members. Any question from board members online?

Member Duncan: Keiko Duncan for the record. Are we saying that this is what we've done today so we're just building it into policy for transparency sake and we are using it as a starting point to build the premiums and the rates next biennium?

Chair Wells: I thought it was important that the board sees what it is that we're actually doing because this policy, when we created this a long time ago, that was the idea. The board said this is the policy for setting rates and subsidizing them and the rates were brought back in a manner that did that. Now you see that the rates are brought back. We're not really sure what these numbers equate to. We don't see that. The idea behind this was this needs to be approved soon because we need to finalize the governor's recommended budget. The agency request is being submitted with these percentages in them because it's way too late to change the workbook and change the budget at this point. We can change them during the gov rec process to reflect different policies. But that policy still needs to be approved soon. You can approve it in September but probably not really much beyond September.

Member Duncan: It sounds like that if we need to evaluate it annually like Debbie was saying that our policy needs to reflect that this is only a starting point that would then potentially change annually or by annually whichever.

Ms. Donaldson: Debbie Donaldson for clarification. It depends on how it's set. I think the question was if you were going to change the allocations by different plans and it's based upon a percentage, you would have to look at it to see how it's trending year to year to maintain that same kind of thing. So, differential. It depends on what you as the board set as a policy if it needs to get reviewed every year or not.

Member Rich: Laura Rich for the record, Chair Wells, would you say that this is a conversation about the board prioritizing where we think the subsidy should go. Actives versus family versus spouse versus retirees. I think that's the conversation.

Chair Wells: That's the policy that according to this document needs to be recommended. Now, the legislature can still change it if they wanted to, but that's what this says. At the bottom of page 21, the employer subsidy percentages will be recommended by the board to the governor during the

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agency request phase of the biennial budget. That's where we are for the next week and a half. If we don't do anything, I'm showing you that this is what is in the agencies budget request. If we want to make adjustments to that, we can. We just need to make that soon.

Member Rich: Laura Rich for the record. I think where I'm struggling is, I see the numbers and I know where my personal opinion is about this. I would like to know, what are other states doing? What are other plans doing? How's the county doing? Because that drives what is the standard? Is the standard to subsidize retirees at 55%. I don't know. That's where I'm struggling. I know my personal opinions about some of this stuff but I would rather not make my decisions based on my personal opinions.

Chair Wells: A lot of the local governments prioritize the employee. Their employee subsidization percentages are higher. Their dependent subsidizations are lower and their retiree subsidizations if they have them, are lower. If you talk about other states have done different things. This is almost employer specific. It would be very difficult to say all the employers do it. You could do some averages maybe, but I think that in general what you see is the prioritization is employee first dependents and then retirees.

Member Rich: I do think that from a recruitment perspective, we have to think about that because that's who the state is essentially recruiting against. We already have significant salary differences between the local governments and the state government. We've got to look at this piece of it as well.

Chair Wells: You could set this for active employees at zero for the CDHP. That doesn't mean it's going to be zero for the PPO or EPO. It means they're still going to have a premium that they're going to have to pay out of pocket for the employee share. It would only be that the CDHP would have a zero premium. You could do that. We haven't for 20 plus years. We did at one point. At one point employees were free, but at the end of the day, when you try to subsidize everybody, there's only so much money. It's really about how you move that what's the policy on how you move that money around. And that is one of the things that this board has control over. So, we can do this. We can take no action on this today. The budget would be submitted based on this because this policy is what's basically in effect for 2027 plan rates. This is what would be submitted with the budget. If we want to change that, we need to change it soon. September is the deadline or it's actually October. October second. We just moved that. At the next meeting, this needs to be approved. This policy needs to be updated and approved to be reflective of what the board's position is relating to establishing rates and subsidies.

Member Rich: I feel like I've been fairly vocal about where I stand on some of these issues, but I would like to hear where the other board members feel and if they have any thoughts on this.

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Member Zumtobel: Tom Zumtobel for the record. I first agree with board member Rich about just seeing it last night and trying to digest it. With that being said, I don't know if I would feel any different with time because I don't have too much of a basis of comparison. As you're talking, which I really appreciate this conversation about having to make a decision next month, which seems very fair. I'm not sure what to ask for to make me have more information now than I would have more information next month than I have now. I don't know if you might have ideas on what we might have. I heard what you said roughly thinking about our competitors but I do think there's a significant recruitment and retention conversation. I don't work in your environment so I don't know, but it seems like that has to be part of the conversation.

Member Rich: Unfortunately, Board Member Grimmer who oversees the department of administration, she's not here today, but that would be good insight to have. I don't know if Debbie, you have an answer. Are we able to separate it by the dependents, children versus spouses and have those different subsidies? I think we are, right?

Ms. Donaldson: Debbie Donaldson for the record. I believe our data warehouse will give us that information that we need so we can see specifically looking at average cost for the employee compared to average cost from spouses versus children. And then it's to what Chair Wells said, it's a policy decision of where you want to allocate the total dollars and how you want to allocate the subsidies within each of the different tiers. We can definitely give you the information that's needed to help make decisions. If it's suitable to PEBP, we can provide some different scenarios to give you different ideas as well.

Member Zumtobel: Tom Zumtobel. What might a scenario look like when you say that? What are you envisioning that it might look like?

Ms. Donaldson: I would envision that potentially you give more subsidies to the employees and less to the dependents and what would that potentially look like? We would need to work with PEBP as far as right now to Chair Wells's point, the total state subsidy is the same across each plan. If you want to change how those are bucketed potentially, that's a bigger task for sure. We could definitely take a look at that and see how that would change things. I'll just share that if that's allocated different, it's going to change member behavior as well.

Member Zumtobel: No, that's right. Tom Zumtobel for the record. If you gave us that scenario you described, the cost impact would you also be able to tell us how you believe that would influence the migration between plans?

Ms. Donaldson: Debbie Donaldson. Yes, we could share that information.

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Member Rich: Laura Rich for the record. I think the other part of this conversation is actives versus retirees. There's that part of it too.

Ms. Donaldson: Debbie Donaldson for the record. That is correct. Looking at it from a total enrollment perspective, the enrollment for retirees is more weighted towards the retiree only and retiree spouse. There needs to probably be conversations of, do you want different tier ratios for actives versus retirees or do you want it co-mingled at that time? That could impact the employee plus spouse tier ratio for sure. Lots of decisions. Debbie Donaldson again. We want to make sure that we're not overwhelming you with lots of different choices because there's lots of different choices that you can make.

Chair Wells: It could get overwhelming.

Member Rich: That's why I don't even know where to start with this.

Member Duncan: Keiko Duncan for the record. I know we did something similar when we were looking at all the different rate settings months ago, but is there a standard or a general comparison to other employee plan models for other states? Recognizing that Nevada is special. All states are special in their own right.

Chair Wells: All employers are special.

Member Duncan: All employers are special. Would some visibility into that, of what other state plans are doing? Is that a place to start or is that just too different by state?

Chair Wells: We've seen that a little bit in some of those comparison slides that they presented.

Member Duncan: I'm not remembering, we didn't do percentages.

Chair Wells: It basically showed this is what the state pays versus what the other employer pays. It was averages, it wasn't based on percentages. It was based on employee share of the premium versus counterpart's employee share. What we could do, here's one way to model this. This is probably the best way to model it. We already have 27 rates. We could take that table for active employees and model, I don't want to do more than three scenarios. I think once you go beyond three scenarios, it's just too much. You could do the existing or, to me it's historical seven and thirty two. 7% for the employee 25% for all dependents and subsidize that the same across all three plans. You can do a second one that has a \$0 employee share on the CDHP. A slightly higher dependent share for the employee. The actuaries need to work this out so it's relatively cost neutral so that the increase in the subsidy for the states component will be offset by a decrease for the those with dependents. Same subsidy across all three plans. And then the third one, because those other plans are getting to be

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more expensive. You could do a state share for all three. You said it, whether that's 7% for the active employee 32% for dependents as the employee share but it's 7% of the three distinct plans. It's a different subsidy for all three plans. We could do four. The fourth one would be the one where we have a different subsidy for spouse versus children.

Member Duncan: Keiko Duncan for the record. So would the purpose of having a different subsidy for each plan be essentially countering those potential behavior economics?

Chair Wells: It's going to create more. It'll create a lot more movement into the middle plan, the LD PPO plan.

Member Duncan: Generally outside of this, what would the purpose be of having them subsidized differently by plan if it's just going to compound that problem.

Chair Wells: So right now, when you're creating the subsidy, the problem is that the trend is much higher for the PPO and the EPO. As those plans get more expensive and you're creating a subsidy based on the CDHP, which is not growing at the same rate, the employee shares of those other plans are continuing to grow differently than the CDHP premiums are.

Member Rich: Laura Rich, for the record. There's some other areas too that I'm looking at. For example, retiree dependents.

Chair Wells: We haven't got to retirees yet. We're trying to figure out a reasonable number of employee scenarios to pick from and what we don't really want to get into is trying to pick the scenario based on what the outcome is. This needs to be fairly objective. This becomes a math exercise. We don't want to subsidize it at such a rate that everybody moves into a plan that costs the state a lot more money. At the end of the day then what that's going to generate is the premiums going up and then the subsidy won't cover as much and the state employee share will go up anyway. At some point you've got to be cognizant of that. But I think that if we did those four scenarios, we don't have to pick one of those four, but I think those are the four to bring back and then you pick one from those four or you pick one that is maybe slightly different than those four. And then on the on the retiree side, the 70% to me was incredibly high and explains why I have much cheaper insurance than my active employee counterpart. I don't think it's been the 70% in the in the past and looking at Dr. Ervin's table which I appreciate very much by the way because I knew we had set lower retiree only shares in the past. I didn't remember the exact percentages but I think that we need to set them more aligned with historical averages. I believe when we first did this there was a differential between employee and retiree but the same differential between retiree and dependent. The employee share versus the retiree share was spread out but the differential between primary and dependent was this same 25%. We could do that with historical numbers, 64 I think is what it said on there and whatever that ends up being 64 - 25 equals 49. We could do it with primary only. We only

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subsidize their primary retiree. We don't subsidize any spouse or dependent. And we could do a third one that subsidizes scenario. Maybe the third scenario is cutting the dependent subsidy, reducing the dependent subsidies for the retiree side. A bigger share being the burden of the retiree. maybe those are the three. It's hard to think of anything else. Any other ones that people can think of on either side active or retirees. Are there other scenarios that we can start at as a baseline?

Member Zumtobel: Chairman Wells, I think what you suggest is it gives us something to look at. You can't conquer them all but at least if we have those scenarios and we could figure out a way to think through because I need something like that to understand. They sound good.

Chair Wells: Does that sound like a reasonable step to bring back to September? I don't think that's super difficult because we already have the rates. It's really just percentages of premiums. I don't think it takes too long to create those tables. Any others? Going once.

Ms. Donaldson: Point of clarification Chair Wells. Would you like us to look at the ratios, the one 2.0 and those subsidies to look to make sure? Okay, we'll bring that back and have that prepared for September as well.

Chair Wells: I'd like to update the balance of that first table which means we need to do the analysis of children. When we did this before, spouses were more expensive than primaries. I don't know, an adult's an adult. I don't know. But it would be nice to know. It' be nice to know what spouses are versus primaries and dependent children as a bucket.

Ms. Donaldson: Anecdotally, theoretically back then if it was being enforced about dependents taking the health plan of the employer, theoretically there was probably a little bit adverse selection which made the spouses be at a higher rate than employees. So yeah.

Chair Wells: All right. You're clear with seven scenarios. Four for active employees, three for retirees? Okay. Then we won't take any action on it today. Agency requests will be submitted as outlined in this document. And then if we want to update these for the Governor's recommended budget to the Legislature, we'll need to do this no later than the October 2<sup>nd</sup> meeting. All right, let's take a short break, come back at 11:25.

Chair Wells: All right, we'll call the meeting of the Public Employee Benefits Program Board back to order. Move on to agenda item number eight, the reporting costs for retired state employees to obtain coverage through PEBP under Medicare and not under Medicare for transmittable to the Interim Finance Committee pursuant to NRS 297.04347. Ms. Mooneyhan and Ms Donaldson.

Ms. Mooneyhan: Thank you, Chair Wells. Brandee Mooneyan, Lead Insurance Counsel for the record. Some background on what this report is. In Senate Bill 494 from 2025 legislative session that

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created the Nevada Health Authority. One of the provisions that the legislature included was this new provision which is now codified at NRS 287.04347. And what it asked for was that every even numbered year by August 31<sup>st</sup> that the PEBP board compile a report concerning the cost “for a retired employee to obtain coverage through the program under Medicare that is actuarially comparable to the coverage provided through the program but not under Medicare.” So in other words, compare the cost for Medicare retirees and non-Medicare retirees and then submit it to the Interim Finance Committee through the Director of the Legislative Counsel Bureau. Segal and Via worked closely together and they worked very hard on compiling all the relevant information. They created the report for your consideration to be transmitted and Ms. Donaldson can answer questions about the details of the report since she is the one that compiled it. If you have any questions for me about transmitting it, I'm happy to answer this as well.

Chair Wells: Ms. Donaldson, you're up.

Ms. Donaldson: Hello again, Chair Wells, members of the PEBP board. I wanted a special shout out and thank you to Via Benefits for their great collaboration on doing this analysis. Within your board packet, you'll see the outcomes in the report we provided based upon the analysis. And in high level terms, the conclusion of our analysis indicates that the benefits that are provided to Medicare retirees via Via Benefits does provide financially and looking at actuarial values, taking in consideration subsidies, financially better benefits that can be offered to retirees within PEBP offerings. That's the three plans, the consumer-driven health care plan, the LD PPO, and the EPO HMO. Again, considering subsidies available to the various different groups of retirees based upon the different buckets that are outlined in the plan documents. That's the high level conclusion. I'm happy to entertain any questions.

Chair Wells: Any questions for Ms. Donaldson? I have one. Can you address the rationale behind the exclusion of part B?

Ms. Donaldson: Debbie Donaldson. If you're talking about the part B premiums that the retirees pay. We did include the subsidy on the Nevada PEBP side if they're eligible for the part B premium. We assumed it. We needed a comparison of apples to apples on both sides. So, we excluded part B premiums on both the comparison of looking at the benefits and premiums paid to members who are participating in the PEBP plan as well as Via Benefits. So, we could have included both, but we had to be similar and treat both plans similarly. We decided to exclude them and really focus on the HRA contributions for Via Benefits compared to the other subsidies offered by PEBP. Either way, it wouldn't have mattered because it would be on both sides for the comparison.

Chair Wells: Any other questions? Seeing none, this is an action item to submit this to the Interim Finance Committee through the Director of the Legislative Counsel Bureau. Do I have a motion to approve it? Send the first report to Legislative Counsel Bureau staff for transition to Finance Committee.

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Member Rich: Laura Rich, so moved.

Member Viton: Second.

Chair Wells: I have a motion and a second. All those in favor say I.

All Board Members: I.

Chair Wells: Any oppose? Nay. Motion carries. Close agenda item number eight. Move to agenda item number nine. Pharmacy Benefit Manager Rebate Changes. I have Ms. Donaldson. Oh, sorry. Ms. Donahue and Ms. Daily.

Ms. Daily: Just Daily. Amy Daily with Express Scripts for the record. Today, Theresa tasked me with providing some background information on rebates. How we're seeing rebates change in the industry. We are seeing some of the rebate figures for PEBP go down and I'm going to explain why that is occurring, and then the future of rebates and pricing options as you guys look to RFP pharmacy benefits in 2028. A lot to cover. I tried to keep it fairly high level because of the audience. Certainly, if you have questions let me know. I would consider this like a 101 and then if we need a 2011 or 301, I'm happy to do that as well. Rebates traditionally have been in place. PBMs have what's called a formulary and we always do clinical first on formularies and then there are financial considerations. For example we have a PNT committee of physicians, nurses, pharmacists that decide if we have to add drugs to our formulary. There's nothing clinically equivalent on the formulary or may add medication. There's already other options on the formulary or do not add it's not safe and efficacious clinically and we do not want our members to be taking that. When the financial comes into play is when we have those may ads. When there's competition, there's other clinical drugs that are available. That is when our job as your PBM is to reach out to manufacturers and negotiate better pricing on your behalf. To be on our formulary, you have to offer better financial position than other manufacturers do. You're giving rebates behind the scenes, it's not adjudicated on the claim, that are negotiated with pharmaceutical companies that are then paid to our clients. That's basically why rebates exist.

Some background on PEBP's rebate arrangement with Express Scripts. The way we negotiate on the commercial side rebates with our clients, there's two types of rebates that we talk about. There's the manufacturer share rebates or manufacturer payments that we get directly from the manufacturers based on your claims and the drugs that your members are taking. 100% of those payments are passed back to PEBP. The way that the commercial industry has allowed clients and contracts to be built is that as the PBM when we're doing RFPs and things like that, we guarantee a rebate by claim. There's a second bucket of rebates called guaranteed rebates. Those are how states budget because we've said for every brand claim that's dispensed, we guarantee \$500, that's just an example. We guarantee \$500 for every brand claim that's dispensed for PEBP. Meanwhile, we're

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getting lots of different manufacturer payments behind the scenes. The second bucket, some of them may be higher than the guarantee, some of them may be lower. But what we're hoping is that when we guarantee that amount, it's going to basically come out somewhat equal. The guarantees are going to equal the manufacturer's share. If they do not, we have to pay you more money.

The way PEBP works is that you get paid based on the guarantees quarterly and then at the close of the year we reconcile to 100% of the manufacturer's payments. If 100% of the manufacturer payments were less than the guarantees, you already got paid what you were guaranteed. If the manufacturer payments were more than the guarantee you get that additional money. You get 100% of the manufacturer payments. Those are important terms and things as we continue to have this conversation. Just want to make sure everyone kind of understands how that all works. Rebates have existed for a very long time and they've been relatively stable. In the last three years, we've seen some significant changes in in the rebate pharmaceutical industry. It was all driven by government action. If we go to the next slide, slide two, this is a timeline from 2024 to current of what happened across the industry. This isn't just Nevada. This isn't just ESI. This is every PBM commercial rebates. This is happening across the board.

In 2024, the American Rescue Plan Act went into place. And what this resulted in is there were some really old drugs like insulin and some inhalers where through this act if manufacturers continued to offer the price that was in the marketplace on the commercial side they were going to get dinged and penalized on the Medicaid side. They were going to have to pay more on the Medicaid side. They changed the structure of how they were pricing these medications on commercial. Manufacturers control the price. They control what's called an average wholesale price, which is AWP, which is your sticker price for drugs. And then all the discounts happen after the AWP. But the manufacturer controls that AWP. As a result of the American Rescue Plan Act, these old NDC's, they reduced the AWP of their medication or the WAC. Those are somewhat interchangeable and made that lower. They effectively absorbed the rebate into the actual price on the claim of the prescription and took the rebate away or reduced the rebate. So that was our first government action that resulted in manufacturers reducing rebates. The net result to PEBP was neutral. The manufacturers reduced the AWP by an amount that the rebate change was either less or neutral. Then in 2025 biosimilars became available. Again, this was another instance. Humira and Stelara were very highly rebated drugs. Those two drugs were two of the drugs that would have been a lot higher than your guarantees and your contract, the rebates we were getting from manufacturers.

When the biosimilars came to market, they decided that they had some high WAC options and some low WAC options. On those low WAC options, they did the same thing. They reduced the amount of rebates available for the biosimilars and dropped the price of the drugs. Now in the biosimilar space it was a significant drop in price because there was a lot more competition. Before it was just Humira which is an AbbVie drug. Now we have six or seven biosimilars in the marketplace. When you have that kind of competition, they have to compete in the marketplace. We only have three biosimilars on our formulary. Those biosimilars had to show up with the best pricing to get on our formulary. There was a lot more competition and there were significant savings for PEBP on those two medications which we'll talk about. In 2026, the inflation reduction act went into place.

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This is the law where CMS is now negotiating drug prices for Medicare. They took 10 drugs and they negotiated with pharma just like we do and said this is the most we're going to put pay on the Medicare side. This has to be the price for these 10 drugs. That leaked over to the commercial side. These manufacturers, a lot of these drugs, there were 10 on the Medicare side. There's probably 7 where they also changed their pricing on the commercial side. And what that means is again, they did the same thing. They dropped their AWP or WAC and then they reduced the rebate behind the scenes. All of these changes I would say are good for PEBP because you're getting the rebate or the discount on the drug on the claim. You're not having to wait for these rebate payments that come months after. However, it does mean that your rebate payments are going to decrease over time. This is not going to stop here. Every year now, CMS is going to negotiate 10 more drugs for the inflation reduction act. We have four big biosimilars Enbrel, Ibrance, Cozentyx. Those are going to be coming out in the next two to three years. This is going to keep happening. Every year now we're going to see NDC's on one one where this pricing dynamic changes. Any questions on that piece?

We wanted to specifically address what we're seeing in PEBP rebates which is slide three. These are your payment figures. If we look at the brand claims, you can see that you're relatively steady in terms of the number of brands that are being dispensed. That means, your guarantee payments, we're not seeing a large fluctuation in the number of claims. That's one thing you can take out. The next column's minimum guarantees. Those, we talked about those. Those are the guaranteed amounts times the brand claims. When these manufacturers started to, mid-contract for PEBP, and a lot of our clients were in mid-contract. When they started changing inherently how they priced these medications, we came out with methodology, which we vetted with consultants and clients and had signed off on to ensure that these were all rebates we were capturing for these drugs. They're no longer available. They've moved into the price of the claim. Now we need to make sure we're not being held responsible for the same level of guarantee because the bucket of rebates is much less. We came up with rebate credit methodology and those credits amounts which are increasing as you can see in the adjustment column. Those are steadily changing over time based on that timeline I showed you. More NDC's are coming in, some NDC's are leaving. The total payment column is what PEBP is getting paid quarterly for rebates. That's the guarantees minus the rebate credits. Those are the actual payments. We saw a reduction of about 6.5% in those four when we're comparing fiscal year 25 to fiscal year 26.

Wanted to explain more about that 7% drop because its getting a lot of questions from PEBP and we wanted to dig into it further. I said that Stelara was highly rated and these are just directional numbers. Again, I'm trying to simplify for the audience. In 2025 for example, Stelara 90 milligrams, the AWP was about \$34,000 and the rebate was \$15,000. Big rebate. When the biosimilars came in, they dropped the AWP to \$5,000, but the rebate dropped to \$0 to \$1,500. You can see your rebates are going to go down, but on something like Stelara, PEBP is saving money overall. You don't want to chase the \$15,000 rebate. You want to get the lowest net cost, which is after the AWP minus the discount minus the rebate. You want the lowest cost. \$15,000 big rebate would have made your rebate numbers look better. But we don't want to chase a big rebate number. We want to chase the lowest cost for PEBP. When we look at all your rebate payments in that total payment column, all

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the quarterly guarantee column. If we total that up for fiscal year 25 and fiscal year 26, you see you have about a \$2.4 million difference between those two rebate numbers. That's got those AMPCAP dollars, that's got IRA dollars, that's got biosimilars. But if we just isolate biosimilars, which is the biggest difference, the biggest reason your rebates payments are going down. And if you think about it, when that rebate goes from \$15,000 to \$1,500, your guarantees are going to go down because we're taking the credits, but your manufacturer payments are going to go down too. They're not paying you in the rebate. Remember, it's in the price. When we look at that net change for biosimilars though, when we take the Humira claim compared to the biosimilar claim which we can show claim by claim, I don't have that here but we can go through that. The total savings for the biosimilars was \$2.7 million. You can already see you're better than neutral. Your rebates, yes, we can say they're all they're going down. But if you look at the ingredient cost reduction tied to the biosimilars, it outweighs the rebate loss. So that's the important thing you have to focus on. And that's just biosimilars. There's AMPCAP and the IRA drugs in there, too. PEBP came out ahead, but if we only look at rebates they are going to go down. That's the overall message.

The next slide. One of the things ESI's been working towards and you guys have been working with us on this is moving to more transparent but also simplified pricing options for clients. We don't have to continue to haggle about rebates and make sure we're protected and you're protected. Nevada, in the last RFP, you asked us to do acquisition costs, which is what we pay to buy drugs for a mail order and specialty. That is in place for PEBP today. You have 100% pass through at retail, which is what we pay the pharmacies is what we charge PEBP. You get 100% of manufacturer payments that you get all the rebates that we get on your claims. You have already taken steps to move to a more transparent non-rebate driven model. However, there is still more we can do. We are building and this is an option, not something that's required of our clients, a rebate free model that will be available in 2028. What does that mean? As I've shown you, the rebate landscape is changing and rebates are going down. That doesn't mean costs are going up. What we need to do is shift from a rebate guarantee focused pricing model to let's just guarantee the lowest net cost. If we guarantee a per member per month dollar amount for PEBP, we are motivated to get that as low as possible. If we meet that we'll have penalties if we allow your costs to go above that.

The conversation's less about how much rebates are we getting you, it's about did we save you money across the board through everything, every financial component. It's a lot more simplistic. We won't have to continue to talk about these new NDCs that draw price because as long as the price is low, it doesn't matter where you get it. From the rebate in the price of the drug, on the claim retroactively. The other thing that PBMs have been getting a lot of pressure for in the marketplace is you have all these rebates, but members aren't benefiting. One of the things we're going to do with this new model is pass, if clients want this, pass rebates back at the point of sale to members. When you have high deductible plans, those rebates can go directly to the members to reduce their deductible, out of pocket, etc. That is an option. You can also continue to receive rebate payments. We're building acquisition costs into the retail pharmacy setting. That's really new and innovative. That hasn't been done in the past. That's really to help retail pharmacies who are saying they're not getting paid enough. They're getting some negative margin drugs and some positive margin drugs. If

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we pay them based on what they're buying at plus an admin fee, that's going to help resolve that situation. The only way through this model that the PBM would make money and this is similar to your deal today is through an admin fee. It's taking out the worry of margin in different places. I can spend a lot more time on this. I think this is a good model for PEBP to consider for 2028. You'd have to structure RFP like this. I will say it is happening in the marketplace. Someone like CalPERS has a PMPM. That's what their whole contract's based on. It is relatively new and we're not seeing a lot of RFPs that allow us to bid with this type of a model today and that's because people are worried about budgeting and it's a switch in underwriting and there's a lot of different levers. This has not, while it will be available, it's innovative so it's relatively new, we have one client that's going to do it in 2027 that we already know of. It hasn't reached a tipping point. I think this is absolutely where the entire industry is heading because of all the regulation, all the focus. We're all going to have to move to this type of a model eventually.

Member Duncan: Keiko Duncan for the record. What about formulary changes because I know one of the other pieces in Express Scripts FTC had to do with low WAC drugs. Is that a part of some of the new models that ESI is suggesting? Making some formulary changes to that effect or no.

Ms. Daily: I'm going to restate the question, making sure we're using low WAC when available? At one point we were building a formulary that was going to be our standard formulary but with low WAC. Now it is a part of our formulary. There's a low WAC option. Those are typically in the biosimilar space. Those are preferred pricing options so that you can get the rebate on the claim versus, a payment that's better for you.

Ms. McJoy: I've got a question. I know you stated that retail pharmacies were complaining about the cost and things like that and you guys were going to give them an admin fee. Does that admin fee fall back on PEBP or is that coming out of ESI?

Ms. Daily: If we're going to pull through the acquisition cost of what they buy the drug at, and that's going to be a big recon process. I can definitely go into that more. I will say again today, pharmacies are making money on some drugs and losing money on some drugs. We're pulling that into the middle where they won't make money. We're saying you buy it, we'll pay you for that. Then they do need to make up cost of dispensing and things like that. They get a dispensing fee today. The way that would be structured is to guarantee a PMPM. So, you'd have to be comfortable that that cost we're guaranteeing is going to save you money. Say you have, I'm making this up, but you have a PMPM of \$90 today. We bid that business, we're going to say, we're going to guarantee \$85. Your PMPM is going to be \$85. You're going to save five bucks over that contract year and it's going to have to be more annually refreshed, right? Every year we're going to have to refresh the PMPM. You're going to save \$5 on every single one of those members. That's what you know for your books. Meanwhile, we do our business behind the scenes and we have to find a way to save \$5 or we're going to pay you penalties. It becomes less important, what's on the claim. What we're guaranteeing is that PMPM

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cost. Hopefully, that makes sense. We're trying to take out your concern about all those types of levers while making our supply chain comfortable that they're going to make some money, make a margin.

Chair Wells: Any other questions? Ms. Donaldson.

Ms. Donaldson: Thank you, Chair Wells. I want to make a couple comments on what's happening from a macro level, what we're seeing across the industry nationwide. Maybe a couple cocktail comment points for y'all. But also talk about things to take into consideration when we built your biennium budget. Also, things to potentially consider for a 2028 RFP. A couple of things that we're seeing. The industry is changing and it's changing quickly across the country on how PBMs function today. Traditionally, like your plan is set up, it was a discount. It was discount off AWP or WAC with minimum rebate guarantees. Industry is moving away from that and it's progressing away from that. I would say that the new thing is PMPM guarantees that folks are moving away to say we're guaranteeing we don't care what the discount is, what the minimum guarantees are with rebates. We want a PMPM, per member per month is what I mean by PMPM, guarantees. I would also say there's been a lot of things happening on the federal level that you may have seen in the news as well. Just so you guys know the implications. There's the Consolidated Appropriations Act that came into effect that affect how PBMs function. There's what Amy noted which was the FTC, the Federal Trade Commissions. There have been rulings and then you guys have done settlements. The big three pharmacies are in the, if they haven't already, two of the three at least I am aware of have made settlements including ESI and CVS Caremark and CVS Caremark made their settlement about a month ago.

How they're approaching that is slightly different. How PBMs are applying some of these changes that are coming up in 27 but most notably in 28 is different by PBM that we're seeing across the country. These changes on the federal level are required for plans that are subject to ERISA. A lot of the things that Amy noted that they're going to, the low WAC and the more transparency and rebates, those are requirements for ERISA plans. PEBP is not an subject to ERISA. The question is, and it's varied, we think at this point it's still rolling out, but it seems to be is it going to not be a choice of PEBP? Is this happening across the book of business to say this is where we're going? Or is it a choice? It varies by PBM. That's important for you guys to know as you write the RFP for a PBM. The other thing that I'll share is that what we've looked at and when she talked about was everything that's happening with the biosimilars because your current contracts in place that has a minimum guarantee and when you pull out the rebates there's what's called rebate credits. We want to make sure that yes there's savings going to a low WAC but we want to make sure that there's a differential the one to one you're net neutral. The savings you're getting from the discount and ingredient cost is net neutral from what we're getting in rebate credit. Before the low WAC drug was implemented compared to afterwards. We want to make sure that you're at least net neutral on that with the rebate change. More to come on that. We've been working with PEBP. We've been working with ESI to get more detailed reporting so that we can get comfortable and we're getting close I think, but that we're

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getting comfortable with that differential. That's something in the commercial plans that on the Medicaid side is more prescriptive. And so that is a difference that we're working out and trying to get comfortable with.

As we thought about doing the biennium budget, Segal aired slightly on the conservative side to say that they're telling us it's one to one, but we're not sure it's going to be one to one. We built in a little bit conservatism when we projected those rates just to be careful until we get comfortable with how things are flowing through the plan. I will say and I'll just end on a good positive note that we just got a report this week from ESI related to minimum guarantees and based upon new contract terms that is showing positive indications that was a good negotiated plan. We set the rebate guarantees. PEBP's getting about \$2 million back in addition to meet the minimum guarantees. That's a good thing. More to come as the industry starts to morph and change. Quite honestly, the PBMs are still trying to figure out what they're going to offer in 2028. A lot of change happening within the industry within the next two years.

Chair Wells: Questions?

Member Zumtobel: Tom Zumtobel. I'm not sure which one of you would respond but I was thinking about the settlement and we just extended our agreement. The settlement actually forces the transparency for ERISA plans, right? We had access to that agreement. I think it's a standard offering now, isn't it? Don't you have an obligation offered as a standard?

Ms. Daily: The last slide I showed you, the rebate free piece and some of the things we're building into that new pricing model. Those were the agreements associated with the FTC. I can give you a rundown of exactly what we agreed to and how we're incorporating that. But Debbie's right in that some of those achievable milestones aren't effective today. It's part of this new option which will be an option for clients. We will not be forcing clients to take it.

Member Zumtobel: What's the timeline on the settlement that you're obligated to start offering now?

Ms. Daily: There were different pieces for different timing and I can definitely resend that to you. The rebate free piece isn't available in 2028. And that's really what I think the federal government was excited about is making sure that if you want them to that members can get access to rebates as well. Primarily, clients have been keeping those and then using them to reduce premiums. The federal government really wanted to make sure that those rebates end up reducing co-pays.

Member Zumtobel: There was several transparency provisions though beyond rebates.

Ms. Daily: The Consolidated Appropriations Act is where a lot of the transparency reporting was required. We did agree as part of the settlement on a few additional transparencies in terms of what we're going to share with members in terms of rebates and things like that as well. It's hard to use the

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word transparency because it means so many different things. We throw it around in lots of different ways, but we are going to be required to provide more communication to members as well.

Ms. Donaldson: Debbie Donaldson, for the record. I'll just add the Department of Labor has also issued proposed rules about transparency as well and reporting, but to Amy's point, the Consolidation Appropriations Act has some transparency rules that I think would go effective. I think it's August 3rd, 2028 where those have to be effective. But again, those are for ERISA plans to your point.

Ms. Daily: And a lot of that is just submitting data to the government. It's not necessarily transparent for you guys. We're giving more information to the federal government. Is that transparent?

Ms. Donaldson: Debbie Donaldson again. The FTC, I think, is it 2029 your requirement for more transparent reporting in general? I think it's 2029 with the FTC portion of it.

Ms. Daily: I need to send the slides and I will send a breakout of exactly all the timing associated with everything we agreed to in the FTC settlement.

Chair Wells: Any other questions? Seeing none, this is information and discussion only. Close agenda item 9, move to agenda item number 10, Nevada Health Authority statewide purchasing delegation.

Ms. Carsten.

Executive Officer Carsten: Theresa Carsten for the record. This item is to recommend to the board to take action to delegate the purchasing strategies for the pharmacy benefit manager contract, our dental benefits network administration contract and our actuarial services contract to the Nevada Health Authority. Those are the three contracts that we're currently working with to coordinate procurement with them currently. We need to make that official with board approval. The intention of the Nevada Health Authority was to align a lot of our contracts under the Health Authority to help with a sustainable purchasing strategy. These likely won't be the only contracts that I bring to you asking for such delegation but these are the ones that we have current working groups with the Health Authority on currently. Questions?

Member Zumtobel: Tom Zumtobel for the record. I'm just curious, it's a Nevada Health Authority statewide purchasing delegation. Is that just a label for this item or is that a thing?

Executive Officer Carsten: It's the intention I believe for these three contracts to. Intention is important. It is the intention to release contracts with multiple scope of works for different lines of business under the Health Authority. For instance, with the pharmacy benefit manager would have a scope of work for Medicaid, a scope of work for PEBP, etc. Now, as we're building that and meeting with vendors, it's entirely possible that any one of these, I'll use example the benefit dental benefits network. The services that the Health Authority is trying to procure for Medicaid would be different

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services than what we are trying to procure with PEBP. That doesn't mean that they can't be aligned or outlined separately under a different scope of work under one RFP. So, does that clarify?

Member Zumtobel: No. But that's good. I was just mostly curious because it's statewide. It's all state. I didn't know if there was other indications of this, but really, you're just delegating our services to get their purchasing power.

Executive Officer Carsten: Correct.

Chair Wells: As part of the creation of the Health Authority, that was the idea. We're going to try to leverage our purchasing power. This is going to require a rewrite of a section of our duties, policies, and procedures under the contracts and the bill outlines some provisions about the Health Authority can do certain things that currently can only be done by state purchasing. There's part of this law that delegates contractual authority from the state purchasing to the Health Authority for these contracts. But right now, our duties, policies and procedures say the board still has that responsibility. With this we are delegating the board's responsibility for these three to the Health Authority as part of the this bigger recruitment or bigger arm.

Member Zumtobel: Potentially gaining some efficiency.

Chair Wells: Yes, there will be more and there will be a rewrite of the contract section of the duties, policies, procedures that need to go along with this. Any other questions?

Member Zumtobel: To clarify why I was acting the way I was. We're really delegating to the Nevada Health Authority. I read it as it was creating a delegation and I apologize for that, but that was the clarification that I was looking for.

Chair Wells: This is delegating the board's authority for these three procurements to the Health Authority. So, we won't be responsible for setting the review panels, hearing the presentations. That'll all be done. This is an action item. Need a motion to approve the delegation of those three RFPs to the Health Authority.

Member Zumtobel: I'll move to approve.

Chair Wells: Motion. Do I have a second.

Member Viton: Second.

Chair Wells: Second by Member Viton. All those in favor say I.

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All Board Members: I.

Chair Wells: Any oppose? Nay. Motion carries. Close agenda item number 10. Move to agenda item number 11. Contract status report.

Ms. Mooneyhan: Thank you, Chair Wells. Brandy Mooneyham, Lead Insurance Counsel for the record. This report follows on the item that you just considered. Normally this item has the chart of the current status of contracts. Once report takes into account those delegations that you just approved some extensions that we're seeking was approval of one of those is with the dental PPO. That will give the Health Authority time to figure out what they're going to do with that. I mean how they're going to go out for that plan to procure those services for PEBP and other state entities. Same with also seeking an extension for the health plan auditor and the HSA HRA account manager for the same reason, to give them close ability to pursue those strategies that they have to try to leverage their members with our members. This chart also reflects unbundling services which was discussed at the strategy session. In other words, right now UMR provides medical and dental claims administration, PPO network services and case management services to PEBP. This chart reflects perhaps those may be broken out into different contracts going forward. This is to reflect the way things may be headed. There's the current expiration date and perhaps anticipated expiration date assuming that you approve all of those extensions.

In addition, one of the contracts that's expiring at the end of this year is with Eide Bailey who does financial audits of PEBP. PEBP has negotiated with Eide Bailey a four-year extension. Currently, Eide Bailey does high quality work for PEBP. It also works on this statewide audit. They have a lot of experience working with state procedures and understand state procedures. They're working with our accounting team, our CFO to modernize and improve PEBP's fiscal processes so that those audits can get better and better. And the cost is less than 3% increase per year. In addition, the one other contract that's expiring at the end of the year, PEBP and NVHA staff are meeting with the vendor weekly and getting closer all the time to finalizing that contract. Just so you know, the other one that's set to expire really soon should be, you should be seeing a new contract on that, we hope in the next few months before the end of the year. With that, I'll take any questions and also we're asking that you approve the extensions and the amendment of the Eide Bailey contract.

Chair Wells: Any questions? Hearing none, we need a motion to approve the extension for PEBP's diversified dental contract with Diversified Dental until June 30th, 2028. The contract with Brown and Brown/Claim technologies until June the 30th, 2028 and the contract with HSA Bank our HSA HRA account management services until June 30th, 2032, and approve the amendment to the existing contract with Eide Bailey until December 31<sup>st</sup>, 2030.

Member Duncan: Motion so moved.

Chair Wells: Got a motion from member Duncan. Second from member Viton. A motion and a second on those four items. All those in favor say I.

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All Board Members: I.

Chair Wells: Any oppose? Nay. Motion carries. Close agenda item number 11. Move to agenda item number 12. The Q2 and Q3 Claims Technology Incorporated audit findings for State of Nevada Public Employees' Benefits Program administered UMR.

Ms. Amato: For the record, I'm Joni J O N I Amato A M A T O. Today I'll be discussing both quarter 2 and quarter 3 2026 UMR audit results. For quarter 2 that included medical and dental claims processed during the period of October 1, 2025 through December 31, 2025. For quarter 3 that included all claims processed during January 1, 2026 through March 31, 2026. The audit components for both of these quarterly audits included quarterly performance guarantee validations, a 100% electronic screening with 50 targeted samples and a statistically valid stratified random sample of 200 claims. I'm going to walk through the second quarter results and then I'll move on to the third quarter results.

The medical and dental claims paid during the second quarter totaled approximately \$71.5 million and included approximately 270,000 claims. UMRs performance in the financial accuracy and overall accuracy decreased in the second quarter when compared to the prior quarter's results. Claim turnaround time improved for claims processed within 14 and 30 days. The performance guarantee for claim turnaround time of 92% within 14 days was met. However, the performance guarantees were not met for financial accuracy, overall accuracy, and claim turnaround time of 99% within 30 days. This results in a penalty of 3.5% of the administrative fees for the quarter or \$50,569.38. CTI also reviewed UMR's quarterly self-reported performance guarantee results and noted that all 27 of those were met. The random sample of audit identified five errors, three of which were overpayments and two underpayments. The errors were cited in the categories of provider discount calculation, deductible, co-insurance and co-payment application and a denial of an eligible expense. Through CTI's targeted testing, we identified improvement opportunities in the areas of duplicate payments, plan limitations, payment in excess of billed charges, co-payment application, and preventive services paid with patient cost share applied. Those are the second quarter.

I'll move on to the third quarter. For the third quarter, claims paid totaled approximately \$77.6 million and included approximately 250,000 claims. Performance and financial accuracy and overall accuracy decreased in the third quarter when compared to the second quarter. Claim turnaround time improved again for claims processed within 14 days and 30 days. The performance guarantees for claim turnaround time of 92% within 14 days and 99% within 30 days were both met. However, performance guarantees were not met for financial accuracy and overall accuracy. This results in a 2.5% of the administrative fee penalty or \$36,988.57. Again, UMR met all of the 27 self-reported performance guarantees for quarter three. The random sample audit identified six errors, four of which were overpayments, one underpayment and then one under application of the deductible. Errors were cited in the categories of provider discount application and incorrect co-insurance application. And for quarter three, CTI's targeted testing we identified improvement opportunities in

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the areas of again duplicate payments, plan limitations, incorrect provider discount, payments in excess of build charges, the co-payment application, non-compliance with pre-certification requirements and unbundling. CTI recommends reviewing the errors that were identified in both the random and targeted samples to ensure that root causes are being identified and any claim processing training or system corrections that need to take place are happening where they're appropriate. Thank you and I'm happy to take any questions.

Chair Wells: Thank you, Ms. Amato. Any questions?

Member Duncan: Keiko Duncan for the record. I've got the same question and comment that I've had for the last I don't know how many. This in front of us has reflected two consecutive quarters where the financial accuracy and overall accuracy were not met. What's been done about that? Has a cap been completed by UMR? How are we preventing a third quarter consecutive of this?

Ms. Spencer: This is Jennifer Spencer from UMR. I did want to mention that we do take all of the information from CTI. We have implemented additional reporting and just looking at anywhere possible we're looking at our analysts making sure all the training is there. If we have issues, of course, identifying those, we have as I said, additional reporting that we've put in place to monitor specifically any of these types of errors that are coming back on top of everything else that we're monitoring and looking at. It is a continuous process to make sure that we are reviewing all of these claims and making sure that the goal is to meet this. Absolutely.

Member Duncan: Thank you. Keiko Duncan for the record. I appreciate that, but I'm remembering you saying the same thing at the last two meetings that I asked that. What has been done or what will be done differently because obviously those efforts have not worked.

Ms. Spencer: We have put in additional reporting processes and we have additional staff that we have implemented to monitor and audit on top of what our internal quality audits are. We have implemented additional auditing processes.

Member Duncan: Have those additional reports been reviewed by the PEBP staff or what are those reports that are now different?

Ms. Spencer: I can get those to find out for you and send those over. I know that we continually work with the PEBP staff and I believe we have UMR staff there as well. We can identify all those additional reports and provide that to the board.

Member Duncan: I'm a little bit less concerned about myself and my fellow board members reviewing said reports and more concerned about, do we have a specific action in place and a recorded result at the end of the quarter as to whether or not said action has led to improvements and/

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or if additional pivots need to be made. I mean, that's pretty standard corrective action plan work. And I think the corrective action plan should be submitted at least for the board to review and see what was completed so we can make actionable decisions that should be hopefully affecting future quarters to meet this. Not to speak for Monica, but I think for financial accuracy, if we're just continuously not meeting that accuracy, doesn't matter that it's 1.5% off. We've only done an audit on 200 random claims of the many thousands and thousands of claims that we have. I'm concerned that this is going to affect our budget planning if we are not going to be accurate in our financial reviews.

Ms. Spencer: Yes, understood. And we can provide that action plan for the board.

Member Duncan: I would like to see that at least. I don't know about you all.

Ms. Spencer: Yes, understood.

Chair Wells: Any other questions? I'll say, a lot of these appear to be manual overrides of problems. Corrective action plan on what's being done to address these manual override issues. I will tell you there's some concerning ones on here for me this time that are systemic driven. Including ones where the amount that was paid was greater than the amount that was charged. I mean that's a pretty easy system edit that seems to have colossally failed. How did that fail and what's being done to make sure that something like that is corrected because to me that's a basic one.

Member Duncan: Which is a good point. Keiko Duncan for the record. For some of those systemic ones, the resolution from UMR's perspective should not be just to resolve that particular claim that was called out in the audit but you guys need to be auditing then that entire system edit for all claims that might have hit that because my concern is yes, we found it one time, but do we have a thousand of them that all hit the same system edit and caused a problem? So, how do we make sure that's occurring. I don't know UMR, maybe a yes or no question. Have you guys then audited the full system and found additional claims that were affected in the same manner?

Mr. Braun: This is Helmut Braun from UMR. Can I jump in here and just ask a question of CTI because we do have some situations where a DRG is paid and the billed amount can be less than DRG and it's still paid correctly. Have we made sure that we've excluded all those situations?

Ms. Spencer: Helmut, this is Jennifer Spencer. Yes, when we review this information and we provide it back to CTI, we do identify if it's a DRG case rate or a contract rate.

Mr. Braun: I guess the question is to CTI though. Are they looking at those exclusions or are those ones that just because the billed amount is less than the paid amount, they're automatically throwing it on their report?

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Chair Wells: The UMR responses on this is that they agreed with the finding. Apparently the finding was a legitimate one. UMR had an opportunity to say they disagreed with it for that reason and they did not.

Mr. Braun: I just wanted clarification from CTI that that was the case then. That's fine. Thank you. We'll go back and talk to CTI about it tomorrow.

Ms. Spencer: This is Jennifer Spencer again from UMR. I wanted to answer the board's question regarding impact reports. Yes, we do run impact reports frequently. It's not just specific to this one claim or this maybe one provider or one code. We are running impact reports across the board to monitor to make sure do we have a larger issue or not. Is it again an analyst? Was it a manual error? Is it a system error? We are taking all of that into account and we are doing impact reports consistently.

Member Duncan: Keiko Duncan for the record. If that impact report was then run for say this inherent system error, can you tell us what the fiscal effect was for all claims that hit that system error?

Ms. Spencer: For this particular one, I can get back to you on that. I'm sorry I don't have that available right this minute, but I will get that for you.

Chair Wells: I think going forward, what the board is really looking for is what was the corrective action plan to fix that problem? Does that problem affect other claims? And if so, have those other claims been identified and corrected? And we're just getting agree or disagree on the claim that was identified by CTI, not what is being done to fix systemic issues. That's really what we're looking for. What caused the issue, what's been done to correct it, and does it affect other claims that were not identified as part of the 200 random samples out of 250,000 claims. I think that's what we're looking for.

Executive Officer Carsten: Theresa Carsten for the record. I will say in some of the meetings that UMR and CTI have held with PEBP, there has been requested follow up of that nature, for specific findings, not maybe all of them where we have asked for that detail on movement on that. I'm looking at Rhonda. I feel like we just had this conversation about some payments over at UMC. Maybe that's part of the piece that's missing on the report out to the board is the required follow through and action on UMRs side to rectify some of those issues.

Ms. Spencer: Jennifer Spencer from UMR. Yes, Theresa, you're correct. I know that we again continue to work with PEBP and provide this information, but as I'm understanding it, we want this documentation in the CTI report as well.

Executive Officer Carsten: Theresa Carsten for the record. I think that the board needs to see the whole picture. The report shows the findings and then UMR's response to the findings. It does not

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show the after conversation that's held with PEBP that requires further action. I'll call it close out. I made you guys work that UMC issue to death. I think that part, the final outcome, needs to be included in the total of the report. Maybe Joni, we need to follow up on that piece as well and just submit one final report. The board is identifying that this is a missing piece.

Ms. Amato: I'm happy to have that conversation.

Ms. Spencer: This is Jennifer Spencer at UMR. We will work with PEBP and CTI as well for the best way to identify that on the reporting and provide that back to CTI for the quarterly reports back to the board and PEBP.

Chair Wells: Thank you very much. Any additional questions? Okay, this is an action item to accept quarter 2 and quarter 3 Claims Technology Incorporated audit findings and assess the calculated penalties of \$51,569.38 for Q2 and \$36,988.57 for Q3. Do I have a motion?

Member Barnes: Jim Barnes, I move approval.

Chair Wells: Motion. Do I have a second?

Member Rich: Laura Rich, I'll second.

Chair Wells: Motion and a second. All those in favor say I.

Members Duncan, Rich, Zumtobel, Barnes, and Viton: I

Chair Wells: Any opposed? Nay.

Member Davis: Nay.

Chair Wells: Did you say nay, Mr. Davis?

Member Davis: Yeah, I said nay.

Chair Wells: We have one nay. Motion carries. Close agenda item number 12. Move to agenda item number 13. Willis Towers Watson's individual marketplace enrollment and performance report. Mr. Garcia.

Mr. Garcia: Yes. Hello. Can you hear me?

Chair Wells: We can.

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Mr. Garcia: Great. Thank you. This is Chris Garcia with Willis Towers Watson. I'm happy to share with the board today our Q3 quarterly report. I'm going to try to share my screen. I just want to make sure you guys can see it.

Chair Wells: We can see it, Chris.

Mr. Garcia: And do you see just the presentation? No notes or anything additional?

Chair Wells: We see it now.

Mr. Garcia: And you see the executive summary page I just changed to. I just want to make sure there's no problems.

Chair Wells: Yep.

Mr. Garcia: Okay, great. Thank you. I do want to take a moment to first walk through the executive summary of the report. We do provide this every quarter. Then I can focus on certain areas if there are questions from the board. I would also like to go towards the end of the report. There's a couple of slides that we have that are related to different projects and different communications and things that we have going on during the quarter or upcoming items. Looking at the executive summary for Q3, when we look at plan enrollment information we had over 19,000 applications that have been processed for PEBP retirees through VIA Benefits. To give you an idea of the breadth of and the scope of how many different applications we're processing over the plan as well as how many different plans are being selected and how many different carriers we have. There are 978 plans that were selected between those different applications between 105 different carriers that we have on our platform. Medicare supplement plans, they made up 82% of our enrollments. They're led by AARP at over 5,500 plan enrollments. Anthem Blue Cross Blue Shield was over 1,400 enrollments and the average Medicare supplement plan premium is \$149 per month. Conversely, the Medicare Advantage plans, those enrollments are about 18% of the overall enrollments. When we look at PEBP participants enrolling in a Medicare medical plan through Via Benefits those top providers, Humana is number one with 444 different enrollments. Hometown Health is number two with 426 different enrollments. The average premium for the Medicare Advantage plan is \$6 per month. Certainly, there is a difference between the average premiums for supplement plans versus those Medicare Advantage plans.

We do a customer satisfaction survey that's available to participants when they have interaction with our customer service team. We really try to do that almost on every interaction outside of say somebody calling us multiple times in the same day. They're likely going to get one survey versus somebody who calls us in in week one and then two weeks later they call us again, they'll get multiple surveys. We do capture if they respond to those surveys, we do capture their satisfaction scores. We break that down into two different categories. One is enrollment calls and the other is our overall customer service calls and then we kind of combine those scores to get an overall

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customer satisfaction result for that quarter. For the enrollment calls we had 28 surveys that were responded to with our interactions with enrollment calls during that quarter with a score of a 4.8 out of a 5. A 5 would be the top score that you can get. A 1 would be that the person was dissatisfied. Getting a score of a 4.8 out of 5 out of those enrollment calls is very high and something that we really take pride in when it comes to providing that service for those people that are transitioning to Medicare and looking to enroll in a new plan. What we consider a service call, which would be anything other than an enrollment call, we had 330 surveys responded to. Those customer satisfaction scores averaged a 4.2 out of 5. Think of these as somebody who maybe is having an issue with an HRA claim. Maybe there's a denied claim and they don't know why it was denied and they call in and get assistance on why that claim was denied. Then they would receive that survey and they would be able to respond accordingly. When we look at the combined satisfaction scores, it's a 4.2 out of 5 between those two different categories.

The other item that we like to include in the executive summary is the information about the HRA or the health reimbursement arrangement account. At the end of Q3 we had 12,306 HRA accounts that were active. During Q3 we processed over 118,000 claims. It gives you an idea just for one quarter of the year, the first quarter of our calendar year, we processed over 118,000 claims. The good news is that we automate a lot of those claims as much as we can. That eases burden on the participant from having to submit manual claims. It allows our claim processing team to really focus on claims that require manual review versus automation. 88.6% of those claims are auto reimbursed. They're reviewed. A common thing that we will see is we'll get a claim that comes through our different carriers that we work with. We get files from them where we receive the claim information for what the premium that the person has paid for their coverage and we load that premium as a claim against their HRA and we reimburse them accordingly. We really try to automate that as much as possible again for ease of use for the participants as well as for allowing our claims processors to focus on those manual claim submissions that we do receive through a mailed in claim form or an online submission for a claim. Something that might be out of pocket. When it comes to the total number of reimbursements, we paid out \$8.5 million worth of claims in Q3. That ended up being at 43,650 actual payments that were issued. The averaging of \$195.66 per payment. You can see we have a lot of volume coming in, a lot of claims being processed, and a lot of payments being released to participants to receive reimbursement for their eligible HTA expenses.

As I mentioned, I was going to skip to the bottom section of the presentation to highlight a couple of different pieces of information related to some different operational aspects of what Via Benefits does for PEBP and your retirees. One thing that we're doing in May, this was reported in Q3, so this would have occurred in May, at the end of May. We do an HRA cap. The purpose of this was to advise the board that we were planning on doing the HRA cap of \$8,000 at the end of May of 2026. The \$8,000 cap was an amount that was previously determined by the PEBP board as the maximum that someone can have at the end of each May in their HRA. On May 29th, we ran reporting on our system, identified people that had more than \$8,000 balance in their HRA account and we process adjustments to decrease their HRA balance to that \$8,000 cap. And then starting in June, if they received a new allocation for their monthly amount, they could go back over that \$8,000

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amount, but we did do adjustments to decrease anybody that had more than \$8,000 at the time to the \$8,000 cap. Leading up to that project, we were working with PEBP providing preliminary reporting. PEBP used to send out communications to 696 participants with available balances of \$7,000 or more. That was done, I think it was around March that those communications were sent. That allowed those participants hopefully to take action, submit claims and utilize their balance. It reduced their available balance to be below the \$8,000 amount so that they would not be impacted by the cap. In our next quarter's report, when we do the Q4 report, we'll have some more information about the finalization of that project and how many adjustments were made. I believe it was over \$700,000 of allocation adjustments that were loaded to decrease people's balances below the \$8,000 cap.

The next slide that I wanted to show you talks about some spring retiree meetings that we held. There were four virtual retiree meetings that were hosted on April 15th and April 16th. There was a live attendance option at the PEBP office in Carson City. These meetings are designed to educate pre 65 retirees who are aging into Medicare as well as educate active employees who are 65 or older who are still working but they're maybe considering retiring and transitioning now to Medicare. As well as educating Medicare eligible retirees who are already enrolled through Via Benefits. We can give them information about say open enrollment season as well as information about overall Medicare and in particular about HEA. It's a really HRA focused presentation for those participants who are already enrolled through us who are looking to get more information. We do make recordings of those trainings and the webinars and we post them out to our website. That's specific to Nevada PEBP so participants can view those presentations. We work really well with PEBP to host those meetings and answer questions during those webinars for participants. We have a Q&A session at the end for people to chat in and online and ask questions that we respond to. Overall, those presentations go really well. Those are the two additional slides that I wanted to mention in this report and I'll go ahead and pause and see if there's any questions.

Chair Wells: Any questions?

Member Davis: I have a question. I'm just curious. What are some of the reasons that participants are not utilizing their HRA accounts?

Mr. Garcia: Thank you, Mr. Davis, for the question. Again, Chris Garcia with Willis Towers Watson. What we found is one of the main things is education. When somebody first qualifies for their HRA, we do send them out a what's called a reimbursement guide or basically it's an HRA guide and it will advise them and give them information on how they can submit claims, and how they can utilize their HRA. As I mentioned earlier, we do have a lot of automation built into claim submission. Even if somebody sends in a premium claim manually, we set that up as a recurring claim for the rest of the calendar year so that that person only has to submit one claim for that calendar year. We really try to make it useful. What we've seen is a lot of people that aren't submitting claims right now. They're not familiar with how to submit claims or use the HRA. Education is a key thing.

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Another factor that we've seen is for participants that are enrolled in a Medicare advantage plan. Many Medicare advantage plans are very low cost premiums. Many of them are zero cost premiums in fact. A participant who enrolls in a Medicare advantage plan that includes a prescription drug plan, if they're generally healthy, they don't have a lot of out-of-pocket expenses that they would need to submit for reimbursement. Maybe you have a retiree, they don't need glasses or they don't do a lot of dental work. A lot of their expenses are already covered through their Medicare Advantage plan and they're not really paying a large premium for that. As they get their monthly allocation that PEBP provides, if they're not submitting claims, then that balance continues to grow. That's where we ended up, I want to say it was in 2020, the board decided to do the \$8,000 cap. We had a lot of accounts at that time who had well more than \$8,000 and we had to reduce their balances to that cap. What we've seen now is more people are utilizing their funding as education has been made more prevalent. As PEBP sends out those letters about the HRA cap coming up at the end of May, we see a lot more activity and as far as people submitting claims that could potentially be impacted by the cap. You're still going to have people who just don't have those out-of-pocket expenses. However, we do also get a file from PEBP for the PEBP dental premium. There's the PEBP dental plan and we receive that file regarding the PEBP dental plan and we load that automatically. If somebody is enrolled in a PEBP dental plan, we get that we load that automatically as a premium against their HRA and we reimburse them as a claim for that premium.

Earlier in the meeting there was a question I believe during public comment about the Medicare Part B premiums. Right now, it's \$202.90 for 2026. PEBP participants can get reimbursed for that Medicare Part B premium as well. And we can help automate that for them if they are enrolled in a Medicare medical plan through us. Again, that's education. A lot of participants don't realize that we can automate that. Even if they don't have an expensive Medicare Advantage plan or a lot of out-of-pocket expenses, they can still get reimbursed for their Medicare Part B premiums so long as they're enrolled in a Medicare medical plan through us, we can automate that. There are some participants that receive an exception from PEBP. It's called a Tricare exception for having Tricare coverage for serving in the military. If they have that Tricare exception, they don't have to enroll in a Medicare medical plan through us. They can still get reimbursed for their Medicare Part B premiums, but they would have to submit a manual form so that we could then set up as a recurring claim for the rest of the calendar year. But again, it comes down to, in a lot of cases, it's education. It's getting information in front of these retirees. And we try to do that, Mr. Davis, with these retiree meetings that we do twice a year. We do them in the spring and we actually have them coming up again in the fall. We'll be doing them in October. We also put those videos out on our website. There's a lot of education material on our website. In a roundabout way to answer your question, a lot of it comes down to education. People are leaving money on the table because they don't know how to utilize the HRA for their benefit.

Member Davis: Thank you.

Mr. Garcia: You're welcome.

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Chair Wells: Any additional questions?

Member Rich: Laura Rich for the record. I don't have an additional question, but I just wanted to bring up, especially given some of the public comment that we got. I would like to know if this board has any appetite to revisit our policy around requiring that retirees utilize the exchange in order to receive their HRA. I feel like it's my opinion that we offer an HRA to retirees. They should be able to go use that wherever they want. Administratively, I know that it's a lot of work for PEBP staff and additionally it's very cumbersome for our retirees who, come open enrollment season they're approached by every plan on the planet and they are lured into other plans that are potentially off the exchange and then it becomes the whole effort of, oh no, now I'm not getting my HRA and now you have to educate them and you have to say hey, you've got your onetime chance to come back and by the way, you lost your life insurance. That's on NRS. We can't do anything about that. And now we have to administer it in house and track all this. Obviously, Willows Towers Watson offers a benefit. It's good for retirees to use Willis Towers Watson, but I don't think that the board or that PEBP should make it a requirement to utilize Willis Towers Watson. It's a retiree's HRA. They should be able to take it wherever they want. So that's my opinion and I would like to know if there's any appetite to look at that policy and revisit that policy and maybe hear from PEBP staff on what that would look like and also from retirees in public option. I would love to hear that as well. I know that this has been hard on retirees and PEBP does everything they can to remind retirees before every open enrollment, hey, don't sign up for a Medicare plan off the exchange because you're going to lose your HRA and you're going to lose your life insurance. We do that, but of course it's really difficult when these are retirees. A lot of these are probably elderly retirees who have their family taking care of all of their issues. It's just something that I think that we should revisit.

Member Zumtobel: Tom Zumtobel. Are there benefits with this plan that they don't get otherwise or what's the tradeoff?

Member Rich: There are definitely perks to using Willis Towers Watson. They've got the customer service. They can automatically get reimbursements through their HRA. That's all set up automatically. There's definitely some benefits. There's also plans that Willis Towers Watson doesn't have. Some people may feel that going a different route is better for them as well.

Member Zumtobel: You're not suggesting we think about eliminating it, but just opening it up.

Member Rich: Yes.

Member Zumtobel: Interesting.

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Chair Wells: Additional comments? That's not an action item. I have a couple of questions, Mr. Garcia. There was a public comment earlier and we've actually seen several public comments regarding the Hometown Health Plans network contraction. What is the availability of a special open enrollment for people who are having their primary care physicians or their regular providers eliminated in the middle of a contract period?

Mr. Garcia: That's a great question. Again, Chris Garcia with Willis Towers Watson. That's part of a challenge. Those retirees, I think senior care plus retirees in Northern Nevada that are facing right now. CMS is very regulatory on when changes can be made to plans, in particular for Medicare Advantage plans. Medigap plans or Medicare supplement plans have more flexibility. They are not tied to what we would consider the Medicare open enrollment period. Medicare open enrollment period is right around the corner. It starts October 15th and goes through to December 7th. Changes made during that time are made for January 1 of the new year. It would be 1/1/2027. And Medicare Advantage plans and prescription drug plans are tied to that Medicare open enrollment period. If a person who is in a Medicare Advantage plan is looking to change plans midyear, they need what's called a special enrollment period. Loss of a provider does not allow them to make that change. From my understanding and the research that I've done, is that with the senior care plus announcing that providers are going to be eliminated and I believe it's effective at the end of this month for September 1, the participants that are in that plan or those impacted plans would have to wait until the Medicare open enrollment period to make changes for the 1/1 plan year. That unfortunately is what would occur. It sounds like for many of those participants who have a provider that is no longer going to be available to them through senior care plus, they would have to wait until that open enrollment period to make changes for next year. That's my understanding. I know that PEBP has worked on some communications related to this and I believe there's a memo on the PEBP website. We are working with PEBP to potentially send out a communication to potential impacted participants. That's something that we are currently discussing. Other than that, it sounds like the only change that they would make, unless they have some sort of other qualifying events, maybe if they move within the next month or two, then they can change. If you change zip codes, that would be considered a qualifying event and you could potentially look at another plan in your new zip code that you would want to change to. If you have some other type of life event, there could be potential changes. The participant would want to speak to a benefit advisor by calling our service center to get that additional information to see what types of changes they can make based off of the life event that they're experiencing.

Chair Wells: Disappointing. Disappointing at Hometown Health.

Mr. Garcia: To be honest sir, it's unusual for me to see a carrier make a provider change midyear like that for such a large group. Usually, you'll definitely see provider changes happen during open enrollment. We get information about the new plan year in early October in preparation for open enrollment starting October 15th. We get that new provider's information at that time as well. That's

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when you'll see provider changes for the new year. It's very rare in my opinion to see those types of changes midyear is what we're seeing right now.

Chair Wells: These are Medicare Advantage plans. If they want to change to and I don't know if their providers are on another Medicare Advantage plan in the north but if they're not then they need to be able to transition to a Medicare supplement plan. How difficult is that?

Mr. Garcia: They can enroll in a Medicare supplement plan depending on their specific situation. There could be underwriting involved. The state of Nevada has a birthday rule that does allow people to change Medigap plans if they're already enrolled in one. The people that are enrolled in a Medicare Advantage plan, they may have to go through underwriting if they are now first choosing to elect a Medicare supplement plan, a Medigap plan. Not everybody will pass underwriting or they could face larger premiums because of certain medical conditions. Unfortunately that is an aspect of changing from a Medicare advantage plan to a Medigap plan, to a Medicare supplement plan.

Chair Wells: What's the average number of people who are pass versus don't, the underwriting process? I don't have specific information on that. That's something I can reach out to our carrier team on and follow up accordingly.

Chair Wells: We need to make sure that these individuals that are affected by this change have as many options as they can come open enrollment and that they know what the process is going to have to be to deal with the next, not just three months, but January going forward.

Mr. Garcia: Absolutely.

Chair Wells: I'd appreciate a follow up on that. Any other questions? Hearing none, also an information item. We'll close agenda item number 13. Move to agenda item number 14. The quarterly vendor reports for the period ending March 31st, 2026. Any questions on any of the individual reports? Seeing none, also an information item, we'll close agenda item number 14. Move to agenda item number 15. Second public comment period. Again, public comment will be made during this item, but no action will be taken on any matter raised under this item unless the matter is included on the 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 at the meeting. Again, I don't think we need to have any limitations on time. So, please state and spell your name for the record. Start with you Dr. Ervin.

Mr. Ervin: Thank you, Kent Irvin. K E N T E R V I N. I do appreciate the discussions today and especially the effort to put practice into written policy which makes things more transparent and preserves institutional memory. Regarding Senior Care Plus, according to the Medicare website, a special enrollment period to change into a five-star rated advantage plan is allowed outside of open enrollment and there is at least one of those available in Washoe that covers some of the providers

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according to one of my retiree contacts. So could PEBP and Via Benefits verify that and include it in communications if that is really an option? On the UMR audit. Extrapolating the net overpayments from the 200 rounded samples for each of the first three quarterly audits to all claims gives \$25 million per year in potential overpayments. \$25 million. 200 samples out of 250 claims seems insufficient and it's clear that UMR is not fixing the problem on its own and CTI is catching a minuscule fraction of the errors. So what savings are possible if PEBP retained an independent payment integrity vendor to review every claim? My understanding, that's the way the industry is going. On the budget. My understanding was that the \$30 million cost of the premium phase in is relative to covering costs and completely replenishing reserves in one year.

Also, the total actuarial reserves for FY2027 went down by \$5 million mainly because of the \$20 million low value for HRA reserves. So, if the actuarial projections are correct, the reserves will rise and be just \$25 million short by the end of fiscal year 2027 versus \$74 million at the end of June. That's a big if, projections being accurate. Or maybe if UMR stopped overpaying claims, it would go down, we would completely replenish reserves this year. Short-term cash flow issues could be a separate problem, but that's not the overall budget. On the discussion for setting dependent tier rates, those formulas from 2012 fixed a problem when they were separately related with the nonsensical outcome of a negative premium to add a child. The value for children of 37.5% of the adult rate may be different than actual costs. So that means children may already be effectively subsidized differently than spouses. So that's something to look at. There is value in keeping this formula simple and as uniform across plans as possible.

Then regarding the rate settings for the three plan options, I've learned today that the FY2027 rates for each plan that each plan was rated independently based on actual experience and participation. That's compared with past board policy pooling experience across all three plans and then presumably adjusting rates by the actuarial values although that policy is not actually followed resulting in severe cross subsidization. I think it would be useful to see modeling of these two alternatives separate rating versus pooling with adjustments for actuarial rates. It's a policy decision. I don't know how it works out what's fair for participants but the question is and something that actuarial should be able to model is how those alternatives affect expected migration by different risk groups and future trends for the plan options. Regarding Segal study on Medicare retiree costs, I didn't have time to review that report that was posted yesterday, but I suggest a deeper dive for the board to understand pre-Medicare retirees, Medicare exchange retirees, and those elderly retirees who will never be eligible for Medicare in the program. I don't know how many are left. What I do know is that the HRA subsidy for Medicare retirees has not been increased since 2019 and has not kept pace with increases in Medicare B premiums and medigap plan premiums. Thank you for your work and your consideration.

Chair Wells: Thank you. Nobody else here in Carson City. Anybody online?

Mr. Hopkins: One Chair Wells. I'll get that slide up, one moment. Caller with the last four digits 8 8 5 3, you have permission to speak. Please state and spell your name for the record.

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Mr. Unger: Doug Unger, D O U G U N G E R, immediate past president of the UNLV chapter of the Nevada Faculty Alliance and member of the UNLV Employee Benefits Advisory Committee. I'd also like to thank the board for the in-depth discussion today on almost all points and I would like to also support my colleague, Kent Ervin's suggestions for several different modeling's of what might be possible to do with rates also based on past PEBP practice. I would like to speak directly to agenda item number eight which I did have a chance to review. Looking over the figures, I understood that these are perhaps silver age figures given that they do not reflect the recent plan D cuts by presidential executive order for the stabilization subsidies for plan D which are going to increase premiums in a range of \$10 to \$30. The best figure I found is an average of \$16 a month. Nor are they taking into account the \$536 billion over 10 years that will be cut by the so-called big beautiful bill that was passed. \$45 billion of which are going to hit this year. In looking over the possibilities for what this is going to do to the payments, I would guess that this is going to lower the actuarial values of all the Medicare plans under consideration there. But it brings up a larger issue which is how stable really is Medicare and putting all our state employees unsubsidized onto Medicare. I have faculty colleagues who are looking at the California system, New Mexico, New Hampshire, Massachusetts, and wondering if they should actually move. Or international professors who are wondering if they should return to their home countries because Medicare is not a stable system and is clearly under siege. The HRA subsidy for retirees is a huge help and a huge compensation for the instability of the future of Medicare. I do think it should be increased at least \$1 a month for existing retirees hired before 2011. And please know that we are going to work very hard to try to restore the Medicare HRA subsidy for retirees for post 2011 hires. Thank you very much for all your service to the board and thank you.

Chair Wells: Thank you, Dr. Unger.

Mr. Hopkins: Chair Wells, that concludes public comment.

Chair Wells: We'll close agenda item number 15. Move to agenda item number 16 adjournment. Motion for adjournment.

Member Rich: Motion to adjourn.

Chair Wells: Second?

Member Duncan: Second.

Chair Wells: All those in favor say I.

All Board Members: I.

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Chair Wells: Thank you all very much.

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