Date: 07/01/2026

Public Comment: Lori Taylor

Concern: PEBP FSA Flex Accounts

This is the first day of the State Fiscal Year (SFY27), and UMR is currently unable to provide clear online access and transparency regarding flex accounts. I need to ensure funds availability this Friday. I spent one hour from 12 PM to 1 PM communicating with the UMR Flex account, who subsequently transferred me to IT to address an issue where Flex Accounts were not visible online. IT indicated that their assistance is limited to hosting and login issues, and that UMR must add profiles to the account. When I called UMR again, I was redirected to IT at 1-866-868-0145 once more. Stephanie from UMR acknowledged they have experienced an ongoing issue today and agreed to investigate, noting that it has also affected other members. When a survey was initiated at the end of the call the phone system hung up on me.

In addition to this issue, I activated my card by calling the activation number on the card. However, it did not show as activated while I was on the phone with UMR, necessitating a manual push for activation by their team. I previously ceased using FSA accounts with the state due to numerous issues stemming from poor account management. I decided to reengage for SFY27 out of medical necessity.

It is frustrating that on Day one of SFY27, I spent an hour being transferred back and forth on the phone with individuals who seemed unaware of the situation or unable to help. I strongly encourage the board to initiate actions aimed at identifying a robust long-term solution for medical coverage in Nevada, particularly one that is reliable for state employees. The phase in system with UMR is a commitment that likely will lead to more issues.

It is essential to establish a state unit dedicated to conducting financial audits and enhancing accountability, which will facilitate improved coverage versus members chasing UMR for coverage. If this is not feasible, then it may be prudent to transition towards a system of private coverage for hospitals that bypasses insurance, utilizing membership plans to manage expenses and only resort to insurance for out-of-state coverage on a competitive bid when necessary. It is time to adopt innovative thinking and reform the process rather than merely applying temporary fixes and relying on insurances like UMR.

Thank you for your time in hearing my concerns.

Copy of Oral Public Comment for the PEBP Board, 5/21/2026, by Kent Ervin

[Submitted in writing because of technical difficulties on the phone-in line.]

Good morning. This is Kent Ervin, K-E-N-T E-R-V-I-N.

On May 7th, Director Weeks reported on the state of PEBP to the Interim Committee on Government Affairs. She gave multiple reasons for the fiscal crisis at PEBP, which resulted in reduced benefits and increased premiums for employees. The state needs to step up with its share in the next budget.

Director Weeks blamed PEBP Board decisions as partly responsible. But the Board can only make good fiduciary decisions if it has all of the information needed in time to take action. To point:

- First, the FY2024 audited financial statement for the self-insurance fund is only being released now, twenty-three months after the end of the fiscal year. Serious material weaknesses were identified by the auditors, but not fully explained and long past when corrective measures should have been taken.
- Second, today's third-quarter budget report is in a new less detailed format, with less information for the board. The report is either bad news or good news. There is an $18.5 million cash flow deficit year-to-date through March 31, but that's projected to turn into a $18.2 million cash flow surplus by the end of the fiscal year. How is **that** expected to happen?
- Third, Director Weeks reported that Milliman conducted a budget and fiscal review and audit of PEBP, and that the report was sent to the PEBP Board chair as well as the GFO and LCB. Why is the report not being shared with the PEBP Board and the public? Accountability is not just talking about transparency, it's opening up the books to scrutiny.
- In another example, the contract status reports at each meeting used include the dollar amounts for each contract, allowing the board to gauge fiscal impacts. The dollar amounts have been omitted since last summer.
- Finally, at previous May board meetings a mid-stream update on open enrollment was provided. That is missing today. With the major premium increases, it is important to monitor how enrollment is going compared with previous years.

PEBP staff and the board chair can do better to keep the PEBP Board fully informed, allowing the Board to make fiscally responsible decisions while ensuring that our participants have the best possible plan. They need to be more transparent and the Board needs to hold them accountable. You need assurances that both the actuary and PEBP staff provide all the necessary information to make your decisions.

Thank you.

TO: Jim Wells, Chair; and Public Employee Benefits Program Board

FROM: Douglas Unger, Past President, UNLV Chapter, Nevada Faculty Alliance; & Member, UNLV Employee Benefits Advisory Committee

PEBP BOARD MEETING – 7-23-26 – PUBLIC COMMENT

Doug Unger, Immediate Past President, UNLV Chapter, Nevada Faculty Alliance; and Member, UNLV Employee Benefits Advisory Committee.

As the Board engages in important strategic planning, and, presumably, preparation for the Governor's budget discussions and the 84th Legislative Session, so far left unanswered is any explanation for unacceptable accounting irregularities over the past two years. We calculate more than $100 Million in PEBP budget discrepancies between what was presented in 2025 to the Legislature and PEBP members and the budget and projections reported now. At the least PEBP members deserve an accurate accounting and explanation for this hangover budget mess.

Looking ahead, please know that the three-year planned premium increases and benefit cuts to be implemented for the PPO and the CDHP plans, and the two-year increases and cuts for the HMO and EPO plans, now imposed for the first year, are already proving stressful for many state employees. To repeat an example used before, consider that Administrative Assistant salaries, also entry level State Corrections Officer pay, fall into a general range from $45,000 to $62,000 per year (or even less). After mandatory PERS contributions, Medicare fees, and withholding, net take home pay can be at most $3,000 per month or less. The first-year planned increases in family premiums and higher Out-of-Pocket Maximums for the PPO, HMO/EPO and CDHP plans are taxing already, while further planned increases will be unaffordable. We ask that Executive Officer Carsten and the PEBP Board petition the Governor to raise AEGIS and REGI contributions from the state and its employers to alleviate this unsustainable financial stress on state employees. Not raising employer contributions will result in additional state worker shortages in the very near future.

Also please plan for a much more detailed and intensive scrutiny of contracts, especially for the administration of our plans. We hear reports from multiple PEBP members that customer service by UMR is falling off. Call centers numbers are routing members to insensitive A.I. loops that trap them into listening to maddening marketing pitches by robot voices instead of helpful, knowledgeable people. It can take hours of persistent dialing around to track down a coding error in a provider bill that results in a denial of coverage, for example, or to find out the status of an appeal. The digital appeals system does not permit a PEBP member to add any crucial, newly discovered information or documents once the initial appeal is filed. UMR must do better than this to serve PEBP members. The PEBP Board, Executive Officer and Staff should use your oversight to ensure that the level of service guaranteed in future contracts lives up to the high quality and humane courtesy state employees have earned and deserve. Thank you.

Kent Ervin

Public comment for the PEBP strategic planning session on July 23, 2026.

I appreciate that PEBP is holding its strategic planning session as a public open meeting. Closing these sessions in the past was a probable violation of the Open Meeting Law, or at best only technically in compliance. An open and transparent discussion of strategy is important for the Board to carry out its fiduciary duties. I am looking forward to a productive discussion.

The Milliman review of PEBP's budgeting, as described in the April 16, 2026, memo from Stacie Weeks, Theresa Carsten, and Monica Joy, identified serious findings that "threatened the stability for PEBP plans". These findings deserve a substantive review by the PEBP Board. Beyond the specific findings and corrective actions, how did PEBP's financial crisis arise without the PEBP Board knowing about it sooner? What structural changes are needed for PEBP governance? Part of the problem has been that policies set by the Board have not been followed by staff, and past administrations took actions without fully informing the Board. A partial solution would be an overhaul of the PEBP Duties, Policies, & Procedures to ensure that Board policies regarding plan design and rate-setting are fully defined and transparent. A PEBP CFO reporting directly to the Board and the director of the Nevada Health Authority, rather than through the Executive Officer, could provide safeguards.

As of Monday's close of business prior to Tuesday morning's deadline for submitting written public comment, the board packet has not been posted for the public. Commenting on the broad agendized topics:

a) General plan design.
    - The three plan options need to be maintained but better differentiated to serve the needs of various participant groups. Is there a cost-effective statewide HMO-like option?
    - Setting formulas in policy for regular inflationary adjustments of co-pays, deductibles, and out-of-pocket maximums would avoid the need for sudden ad hoc changes in the future. For example for the high-deductible health plan (HDHP), the deductibles could be set at the IRS minimums and the HSA contribution fixed to a percentage (say 50%) of the deductibles for single employees and families. Then they would stay in alignment from year to year.

b) Composition of risk pools used to determine rates.
    - According to Board policies, until recently at least, the three self-funded plans (HDHP, LDHP, EPO) were supposed to be underwritten as a single risk pool. PEBP transitioned to a "flat-dollar" employer contribution model where employees receive the same employer contribution as for the HDHP regardless of the plan option they choose, with the employee paying the higher cost for richer

plans. The subsidies used different percentages for "employees/retirees" and "dependents", but the same percentage for dependent spouses and dependent children. Each of these policies has been violated in recent years by ad hoc rate-setting decisions, either through explicit board action or by staff or the actuary. That contributed to significant adverse selection and excessive cross-subsidization. The PEBP Duties, Policies, & Procedures need to be revised to prevent that from happening again.

c) Contracting procedures, including current and potential future contracts.
    - Using a single vendor as both the third-party administrator to pay claims and as the medical network provider has not worked out well, at least with UMR as the vendor. Separating those functions again should be considered.
    - PEBP should hire an independent, third-party contractor to conduct payment integrity reviews of every claim. That's the only sure way we will know that payments are appropriate and reasonable, and be able to identify areas of concern and possible savings.
d) Pharmacy benefits offered by PEBP, including potential coordination with the Nevada Health Authority.
    - The idea of leveraging a larger pharmacy benefit group through the NvHA has been promised since the 2025 legislative session. When will details be available for the PEBP Board to make decisions? In the meantime, pharmacy costs continue to explode.
e) Disease management/care coordination.
    - There has to be a balance between using disease management and care coordination to help members navigate their treatments and creating hurdles that impede care just to control costs. When a vendor promises a Return on Investment, those claims should be independently audited and reviewed.

Missing from the agenda is a discussion of how to make employees and retirees whole following the benefit reductions and premium increases for FY2027 in response to financial shortfalls. First, PEBP needs to request state funding for the second and third years of projected premium increases, to restore the balance between employer and employee funding. Second, the HRA contributions for PEBP Medicare Exchange retirees have not increased for over 10 years. PEBP should request an increase and tie future contributions to inflation for Medicare and supplemental insurance premiums.

Thank you for your service and consideration.

7/22/26

From: David Smith

To: PEBP Board 7/23/2026 public comment

RE: Express Scripts Dropping the Ball

I wanted to make you aware that express scripts **has not** updated the new deductible and out of pocket maximum for plan year 2026-2027 to the 1700/5000 limits.

The prior year's limit of 1600/4000 are still listed in the member portal on their website, and when I contacted their member services by email on 7/14 and again this morning (7/22) by telephone, they confirmed that the deductible for this plan year is 1600 and the OOP max is 4000.

I'm letting you know about this not to complain that I want the higher limits, but to let you know of their management's failure to implement the changes that the Board made earlier this year.