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July 23, 2026 Unofficial Board Meeting Transcript – Part 1

Board Chair Jim Wells: All right, good morning, everybody. We'll call to order the meeting of the Public Employee Benefits Program for today, July 23rd, 2026 at 9 A.M. Can I get a roll call, please?

Jessica Crane: 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: Blaine Harper?
Blaine Harper: Here.

Ms. Crane: Christopher Viton?
Christopher Viton: Here.

Ms. Crane: Joy Grimmer?
Joy Grimmer: Here.

Ms. Crane: And Dr. Paul Davis.
Paul Davis: Yes.

Ms. Crane: That concludes the roll call. We do have a quorum. Please remember to state and spell your name for the record. Thank you.

Chair Wells: Thank you. We'll move to public comment, Agenda item #2. Public comment will be taken during this agenda item. An action may be taken on any item raised under this, under any matter raised under this item unless the matter is included on a future agenda as an item on which action may be taken. Public comments to the board would take another advisement but will not be answered during the meeting. Is there any public comment?

Mr. Ervin: Hi, good morning. Kent Ervin, K E N T E R V I N. My words for the record. Good morning. I'm looking forward to a productive discussion today. In addition to today's

agenda, the PEBP Board needs to have strategic discussions on the underlying issues raised by fiscal crisis and the April 16th memo from the Nevada Health Authority. Beyond the specific findings and correction actions, how did PEBP's financial crisis arise without the PEBP board knowing about it sooner? What structural changes are needed from PEBP board cover? I have not been able to review all 118 pages of the presentations in detail since it was only posted 16 hours ago. However, one area of concern is the discussion of risk pools beginning on page 27 and purple over there. Regarding separately rating active and retirees, NRS 287 mandates that active and retirees become legal and single risk pool, so separate risk pools are not an option. There are good policy reasons for the statute. Foremost, it prohibits direct or indirect age discrimination in employee and retirement groups.

Also, #2, the idea of moving non-Medicare retirees to the exchange is questionable. Medicare eligible retirees are already required to be on the exchange. There are two main groups of non-Medicare retirees, those who are younger than 65, not yet eligible, and those who were hired before public employees participated in Medicare, which I believe was the 1980s. These retirees are mostly in their 80s or older and will never be eligible for Medicare. I don't know how many are left, but there is both a legal and a moral obligation to continue them on the PEBP health plan. Both of these things being in the packet suggests that institutional knowledge about the plan either has been lost or not been transmitted to the consultants. A comprehensive review of the PEBP duties, policies and procedures manual is needed to ensure that board policies regarding plan design and rate setting are fully defined and transparent, as well as very defined by the board delegates to staff or consultants, and what actions must be reported to the board. Rate setting policy is defined in writing, and then any exceptions explicitly approved by the board. For example, the formula for rating the four dependent tiers within a plan option is not included in the policies and procedure manual and also has not been presumed to the board at rate setting time for the past few cycles. As I recall, the formula was established when Chair Wells was Executive Officer. The formula appears to still be operational but has not always been adhered to exactly. A written submission includes other suggestions of each of the five. Thank you for your service and consideration.

Chair Wells: Thank you, Dr. Ervin. Any other public comment here? Seeing none, we'll close agenda item #2, Public Comment. Move to agenda item number three, PEBP Board Disclosures. Deputy Attorney General Rivera.

Mr. Rivera: Thank you, Chair Wells. Hello, everyone. My name is Jose Rivera, Deputy Attorney General for the record. This agenda item is to allow me to make a disclosure regarding conflicts of interest on behalf.

Member Davis: Louder? It's really hard to hear you. Maybe we can hike up the volume?

Mr. Hopkins: Can you say that again, Mr. Rivera?

Mr. Rivera: Yes, are you able to hear me?

Mr. Hopkins: I'm adjusting a bit higher, but it doesn't seem to be going up that much more.

Mr. Rivera: Can you hear me now?
Mr. Hopkins: There we go.

Member Davis: That’s better.

Mr. Rivera: Okay. Thank you, Chair Wells. Hello, everyone. My name is Jose Rivera, Deputy Attorney General, for the record. This agenda item is to allow me to make a disclosure regarding conflicts of interest on behalf of the board members who are eligible for Public Employee Benefits Program, PEBP benefits, pursuant to NRS 281A.420 on behalf of the board members who are eligible for PEBP benefits or whose families are eligible for PEBP benefits. I offer this disclosure that will be voting on those items that may affect the benefits available to them or their family members. The law does not require absentation from voting merely because the board member or the family member is eligible for PEBP benefits. At this time, I invite any board member who has any additional disclosure to make it now. Thank you.

Chair Wells: Thank you, Mr. Rivera. Any additional board disclosures for members of the board? Seeing none, we will close agenda item number three. Move to agenda item number four, Approval of the Action Minutes for the May 21st, 2026 Board Meeting. Any comments, questions, concerns? If not, can I get a motion for approval?

Member Barnes: Jim Barnes, move approval.

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

Member Davis: Second.

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

All Board Members: Aye.

Chair Wells: Any opposed nay? Motion carries. We’ll close agenda item number four. Move to the meat of today's agenda item. I am now going to turn over the floor for Mr. Andrew Sherman. He is going to be our moderator for today's session, and so I will let him take it away.

Mr. Sherman: Mr. Chairman. Thank you. Hey everybody, I'm Andrew Sherman. I'm with Segal. My colleagues are here as well, Debbie Donaldson and Amy McClendon. Debbie and Amy and a lot of other people are part of the regular team that works for PEBP and really are responsible for delivering services to you on behalf of the participants. My role at Segal, my job at Segal is I direct and have authority over our public sector business from across the country. And it's really very special. I get invited to do things like this from time to time. And it's actually the part of my job I enjoy the most to get actually involved with issues of the day and making sure that we can bring our best consulting to you. We also have colleagues at Milliman who have prepared part of today's presentation and are going to be part of what's going on. So, I have an agenda, but just because you don't know me, I'll give you the two-minute version. In May, I celebrated my 40th anniversary with Segal, I'm one of those lucky people who found an employer that would have me for that long. I hope that I've added some value. I did have a job before Segal. I was an intern at an HMO when I was in graduate school, and I did get a master’s degree in healthcare policy at the Kennedy School at Harvard. So, somehow that got me into employee benefits consulting, and I had a really wonderful career, both delivering consulting advice, being part of Segal's management. I'm on Segal's Board of Directors as well. And now I usually

go to meetings where there's concerns. Today I'm in a meeting where we actually are going to do some problem solving, and I thank you for the opportunity.

So, here's what we're proposing, we have some discussion topics, and you'll see these as we go through. We have a proposed structure for how to spend your day. You all are the board, so the meeting should really be as you want it, and I'll do my best to facilitate in a way that I hope will be helpful to you. But if it's not, let me know. On this next slide, Just want to make sure that I think it was board member Joy, who's making sure she can hear me.

Member Grimmer: Yes, I can hear you.

Mr. Sherman: Perfect. Okay, what we'd like to do today with you is a facilitated discussion, providing a forum for board members to examine priorities, goals, and strategies for PE**B**P to consider. And we've divided this in a way that we hope makes sense in five big categories, plan design, risk pools, contracting, pharmacy, and disease management care coordination. We suggest that there not be more than an hour for each topic. And we're going to ask you to express some preferences, even before we get started. On the next slide, we have a guiding principle from your materials. So, I'm hoping you've all seen this before. And I want to pause here because this is where I give it to you, Theresa.

Executive Officer Carsten: So, as we have heard from public comment, there was a reference to a memo that Director Weeks sent out on April 16th that's located on our website. I think it might have been shared with you all beforehand, but we just kind of wanted to level set and remind people there were five findings as part of that memo. And the first finding was that PEBP's revenue tracking methodologies lacked safeguards to ensure that the state collections were accurately reflecting the employee and retiree collections. The second finding was that the PEBP internal accounting procedures for reconciling those owed payments to state employers, that those were found to be inaccurate procedures.

The third finding was a surplus of funds used to buy down member contributions after COVID to mitigate premium increases were not accurately tracked in our benefit delivery system, referred to as Ariel, and nor were they discontinued after that funding was depleted. So that continued to be offset to the premiums. Finding 4 was that the budget workbook that was submitted to GFO, the Governor's Finance Office and the Legislative Council Bureau teams during the budget build for that last biennium was outdated and incorrect. And the amount of money that was budgeted for was the total amount more than could be collected based on the budget. PEBP enrollment, expected enrollment, and then actualized enrollment. So, you hear a lot in public comment, people talking about the budget missing money. It's not missing, it's money that was given an authority, right? But we could not collect it because we did not have the number of members paying premium that was expected.

And then the 5th and final finding were that the rates and coverage decisions by previous boards over the last four years drove migration to plans that did not cover the cost of their members and increased benefit coverage with no increase to premium revenue to cover that increase in benefit coverage. So those were the findings. I think over the last several board meetings, we've talked about the different things that were put into place to correct those findings. If you guys want to take time to go over that letter or ask additional questions, we're happy to do that. But I know you guys also have a lot of work to do on your discussions of other topics. So happy to move toward whichever item you're willing to discuss right now. Anybody have questions about the memo? Has everybody seen the memo?

Member Davis: Paul Davis. How can we sure, be confident that these issues have been corrected?

Executive Officer Carsten: I think the Health Authority hired a contract position to come in and do an audit, and that's how we found all of these and implemented systems and practices to correct them. We've met with members from the Governor's Finance Office and the Legislative Council Bureau, and they seem happy with the improvements that have been put in place, and we're working with them more closely this year per budget item in build 28-29. And so far, those entities seem secure with the changes that were put in place. Do you have suggestions or ideas?

Member Davis: Well, my part 2 of my question was what were the consequences of this? What happened to the people who created these errors?

Executive Officer Carsten: So, the errors that were found were from previous administrations as well as board members, and so they're no longer here. I don't know if there's a way to hold them accountable when they're no longer here.

Member Viton: Just wanting to understand how the error, I think I understand what the memo is saying in terms of the error and how it affected the budget and the difference between legislative authority and the budget and the ability to draw the funds. The question I have is, is there not any way through, I assume we can't through IFC, but is there a way in a supplemental request at the start of the session to request a change in the authority to allow us to draw the funds that were budgeted? Because it seems like the intent was to provide the assessment, the support to restore the reserves. That was the intent of the budget. That's what the numbers were based on, but the error is leading to us not actually being able to draw it, and that's part of the reason.

Executive Officer Carsten: So, part of it was an error in drawing and the other part of it was the error in the previous board and how it was expended, right? So, what was drawn down was not expended and saved the way that it was initially given. So, at the start of this next biennium, the ask for the budget will be to cover the costs of the current budget. But I think that I'll have to go to the table and answer some serious questions about why that money under a different administration was expended differently when it was given to reestablish the reserve program. And the reason that didn't happen is because the money that was collected was used to offset the premium process. So again, those were board decisions. When you when you guys vote on rates, that impacts that. Not saying that it was anybody on this board, but those decisions resulted in those revenue streams not being used the way that they were budgeted.

Member Davis: Paul Davis, one last question. Are you prepared in case legislature does not? Do we have an emergency fallback?

Executive Officer Carsten: So, we have three reserve accounts, and those reserve accounts are what has been underfunded. That's what Board Member Viton was talking about, right? So, a portion of the money that we're supposed to receive was supposed to balance those reserve buckets and build them back up and restore them. That didn't happen because of the cost of the pharmaceutical and the medical claims, they ate that up, right? So. Can you rephrase your question?

Member Davis: Do we have a Plan B if the legislature is not positive towards us?

Executive Officer Carsten: Well, one of the things that we discussed with Segal is what the definition of solvency is, because I think we're going to be asked that. I think historically by PEBP policy, that shows that there has to be certain funding in each of those three reserve accounts. And in speaking with Segal from an actuarial perspective, they said that as long as we have the funding to maintain the IBNR account, that they would, from an actuarial perspective, sign off that the program is still solvent. So, the question will become is, as we start this year and as we move through this year, do we have enough to cover the amount that is required for program year 27. And that amount will come in a letter from Segal in the middle of August, I believe. So, I don't have that number yet. But just based off of last year's, we can assume that it'll be similar to last year's with an increase in strength and adjustment. We are balancing forward in 27, about $56 million, so it's entirely possible that that amount would cover what the letter shows, but our balance score is also the cash on hand that we use to pay bills. So, you have to understand that while we're collecting revenue, we're expending our medical and our pharmaceutical claims. So, as we're doing that out of a $56 million bucket, it's not entirely possible all that money is going to be there.

Member Davis: Thank you.

Member Rich: Laura Rich, for the record. I think to answer your question, if the legislature doesn't come in and save the day with maybe some small little exceptions, the bulk of it is either you raise premiums or you lower benefits. You reduce benefits.

Executive Officer Carsten: And I think today's discussion is to like, What can be done, possibly short-term or long-term? I think a lot of these options are more longer-term options and aren't going to hit this year. But yes, I agree, because our revenue comes from state employer contributions and member revenue, that puts us in the same pickle we were in last year, right, where we had to raise the premiums.

Member Harper: I get the sense that people are still thinking in terms of bends down, but the Q3 budget report from 2026, and I don't know, I guess, like last July there was a Q4 at the July meeting, hopefully next meeting.

Executive Officer Carsten: Yes, this is just strategic planning.

Member Harper: But I took away from the Q3 report at the last meeting that actually some recovery, things are moving in the right direction. If there's sort of a deadline for budget prep, that there's some declaration of solvency, I think that what just happened with the premiums is going to potentiate that movement in the right direction for the reserves. The impact to participants can't be ignored. I just want to make sure that that's still fresh in people's minds so that the decision making today does not continue to impact participants in the way that just happened for 2027.

Executive Officer Carsten: I agree with you, Member Harper. I would add, even though rates were increased, they are all difficult for everybody, and I think nobody here would argue that point at all. They are not reflective of the costs that we are expecting to see this year. So, they were implemented with a $30 million decrease in our revenue. So even though we see

movement forward, we're trying to figure out where to come up with $30 million. So, as we move through the year, that will show, especially where the migration occurred through the enrollment changes, how hard we are impacted by those rates and the incomplete ability to collect the entirety of the revenue.

Member Harper: Absolutely. How soon will the board be able to get a look at the changes that we're seeing from open enrollment?

Executive Officer Carsten: I believe we can present those at the August board meeting.

Member Davis: Do we have effective lobbyists representing this board?

Executive Officer Carsten: I think Chair Wells, you can clarify. I think that I am the one that's the Executive Officer position has been delegated to act on behalf of the board. The chair of the board can also speak to lawmakers. I think historically that's not happened. I know that the director, Director Weeks, and I are trying to get meetings with lawmakers to talk about the impacts to PEBP. But as far as having a hired lobbyist, I'm not aware that you guys have one of those or do that one of them.

Member Davis: Who will be presenting to the legislature?

Executive Officer Carsten: Myself and Director Weeks.

Member Davis: Okay. Well, I guess if it is effective then, Thank you.

Chair Wells: So, before we go on, to kind of follow up on what member Viton was asking, the only way for us to increase our authority is for a bill in the legislature to increase the state share. If they do that, that will impact every single budget that is in the state. So, they would have to come up with the resources and make other cuts to increase the 990 or 943, I guess it is this year. So, there's no real way for us to just get one.

Member Davis: Looks rather dire.

Chair Wells: That's the way the system is built so that everybody pays in their share, be it the employer or the employees or the retirees. So, to get a supplemental appropriation, we're not eligible to go to the IFC contingency funds, but to get a supplemental appropriation, basically means that the general fund only is participating as opposed to the way it currently is structured where all state sources of revenue participate. So, you do that in that general fund. That additional general fund then comes out of other general fund priorities. So, the program has done it twice in the early 2000s. I prefer not to do it again. That's why the catastrophic reserve was added, to prohibit that from having to be going to do it again. If we were to do that again, there would probably be, the legislature would probably require fundamental changes in the way the plan is operated.

Member Davis: Thank you, Chair.

Executive Officer Carsten: Any other questions for me? Thank you.

Mr. Sherman: Okay. So, on the next slide, this is what I'm proposing to all of you as a way to construct a strategy session today. And again, your meeting, of course, but that we would spend time today. If you will, in the weeds with some ideas. Here are these suggestions that we offer. That all voices matter, the voice of each and every board member is going to matter today and we want to have an opportunity for each of you as members to share thoughts and ideas based on this long list of suggestions that you see around the room and that we will go through. And to start with a very clear expectation that not everyone will be excited about every idea. You may be very unexcited about certain of these ideas, but there are a lot of ideas and limited time. So, the real objective of today is to list reduce, if you will, from a large number of possibilities to a manageable number, and these are my words, for focus, detailed study, and then decision making. So again, today is to talk about ideas, to come up with ones that you want to focus on or we want to help you focus on and lead to more study and then to decision making. And here's how we propose to do this. Making sure everybody's speaking. So, does everyone have their yellow dots? And you'll have other dots in the afternoon.

So, I'll get roles. And now I'm with Segal. My role is going to be to make sure we're having as good and robust discussion and as much participation as possible. My colleagues and our colleagues from Millman are going to present information in five headings, and we've talked about not more than 60 minutes on each one. In fact, what we're going to aim for is no more than 30 minutes of detailed presentation, and then at least 15 minutes, I'll say, or probably no more than another 30 for you all to be able to express opinions. If you have questions as we go, we're going to ask if it's a clarifying question or something you don't understand, please interrupt so we can explain it, but that we kind of make sure we give enough time to hear the presentations and then have discussion. All that makes sense? Seems like a way you want to go. And just because having some guidelines on time is helpful, we've put that up. I think we're already a little bit ahead. So, we didn't want to cut anything short to begin with. We're going to aim for, like I said, 30 and 15 for each. The breaks are certainly fungible. We can move them around. We have these five topics. And with that, I'm going to actually sit down and turn it over to start the presentations, if that's okay. Way to proceed makes sense? Thanks for listening.

Ms. Donladson: Thanks, Andy. Again, Debbie Donaldson. I'm A Senior Vice President and Actuary with Segal. So, what we're going to do and start off now, is talk about the main topics, and then I think we're going to have you get up and move and put your dots where they need to be. So, let's go over on a high level, and after you put your dots up, we're going to dive into each of these topics in much more detail.

Mr. Sherman: Am I supposed to talk about the dots, or are you going to talk about the dots?

Ms. Donaldson: We're going to talk about the dots afterwards. I'm going to hit the subject.

Mr. Sherman: We want to tell you what the idea of the dots is.

Ms. Donaldson: So again, we have major topics, and then under these major topics are subtopics that we want to talk about. So, plan design, on this page is plan design, risk pool, disease management, care coordination. Under plan design, some of the subtopics we want you to consider, we'd like you to consider is full replacement, with maybe single or multiple plan design options. So, we'll talk a little bit about that. Maybe consolidating some of the existing plan options. Back in the day when Jim and I worked a long time ago, there was one consumer-driven health plan when Jim was the director. Talk about deductibles. What that looks like,

maybe return the deductibles to maybe some of the levels prior to when those deductibles were bought down. That's particularly in the low deductible PPO plan, show you some of that information. Expand HMO access. Some of you guys don't know Kaiser's kind of in town here now. So, we want to talk about that. Does that make sense? What does that look like? Happy to give perspectives. I'm from Colorado. Kaisers in Colorado. I also have clients in California. Obviously, Kaiser's in California. So, I'm happy to provide perspective if you would like. And then anything else you'd like to talk about with regards to plan design.

On risk pool, we'll talk about does it make sense to separate the actors and the retirees and maybe underwrite them separately and what that looks like and then maybe provide, we'll give you some costs, some estimated cost of, is there supplemental funding needed to mitigate the rate increase from non-Medicare retirees. Again, we're talking about budget concerns as well and funding. So, we'll talk a little bit about that. Moving non Medicare retirees to the exchange and dependent subsidies. We're going to give you some information. We've done some benchmarking of what other public entities are doing within the state. Melinda's going to be presenting some of that information about what the subsidization looks like from employees versus the dependent. Again, anything else you'd like to discuss.

Disease management. As we presented in the May board meeting, we talked about kind of, there's been a change in the industry looking at the whole health of a person. We're going to explore some care navigation. Again, kind of refresh your mind about some information about some of the condition management programs you have today and the effectiveness. Talk about GLP-1 coverage. As we know, these are really expensive benefits. Is there a different path to get to those GLP-1s because they're very expensive. Talk about any other kind of point solutions. For those who don't know, point solutions are additional kind of benefit offerings. They're kind of the hot thing in the healthcare industry, if you will. There's some good and bad associated point solutions, but some point solutions are very effective that we have found. So, we'll talk about some of that. And then contract terms for utilization, care and disease management. And then through procurement, right? On this may have to go through procurement process. So, those are the subtopics under disease management care coordination. Let's go to the next slide.

We've got two other topics we're going to talk about today. Contracting procedures. Lots of items here, right? We're going to talk about direct contracting, procurement of the medical claims administrator, reference-based pricing. If you guys don't know what that is, we're going to talk a little bit more about that. Really in a high level, tying cost 2% of Medicare. Is there direct contracting we should look at with some of the providers. Near site clinics, does providing clinics provide benefit? Some additional programs. How are we going to coordinate with the Nevada Health Authority and Medicaid? So, these are some of the things we'll talk about, audits and other things. And then on the pharmacy side, again, that GLP-1 management solution. There's some new things that have been coming out in the industry to help with specialty drug management solutions. So, we'll talk about some of those and direct rebate contracting and narrow network formulary, narrow retail networks, some point solution management again in the pharmacy space, which is kind of the newer things that are happening within our healthcare industry. And then maybe looking at the pharmacy benefit offering, are there plan design changes we need to make to the pharmacy benefit offering? So, I think with that, let's talk about how we're going to do this because we're going to have you get up and use your dots, right?

Mr. Sherman: So, you each have 8 dots and those are for you to be able to express an initial preference. We'll have another opportunity in the afternoon following the presentation of the material and the board conversations for you to put up other dots. So, there's a column that says

morning dots and a column that says afternoon dots. Have any of you done the dots before? So, what ends up happening is we have an instant picture of preferences by you each can place 8 dots. You probably don't want to put two dots on the same one unless you think it's like super-duper important. And you can place the dots on any of these topics. You could place a dot on other if you wanted to do that, but we've got way more than eight. We want to see what you're thinking. So, we went through that really quickly.

Member Davis: So, you want us to utilize all the dots?

Mr. Sherman: Yes. You can express 8 preferences wherever you like. And we know it's a lot of material at once. We've set aside time to do this. You can get up and walk around and read what's on there, and then that'll kick off the conversation. Remember is it Grimmer?

Member Grimmer: Yes.

Executive Officer Carsten: I will place your dots. Yes, I can place your dots, Joy.

Member Grimmer: Okay, I'll put them in the chat.

Member Harper: So, on the agenda, it looks like plan design and composition of risk pools are the A.M. slot, but do these A.M. like, or I don't know, how do they?

Executive Officer Carsten: I have P.M. dots.

Mr. Sherman: We have A.M. and P.M., but maybe the columns should be before and after the conversation. So based on just what we said very quickly, what's your gut feel for where we should go, and then you're going to get a chance in the afternoon to put up other dots, because we think it's going to be interesting to see how your initial thoughts may have pivoted or changed in the afternoon.

Ms. Donaldson: We're going to go through all five topics. Some of them are bleeding into the afternoon, but after we go through all five topics, then we're going to ask you to score again, not score. We're going to ask you to put your dots.

Mr. Sherman: How else did I say this is what you wanted?

Chair Wells: The idea is that you put your dots on any one of the five now on where you think you would want the board to look for the various items and how they will impact the plans going forward. So, what is your preference? I mean, knowing we've got to do something. What is your preference? You know, we've talked about, this is the cost containment discussion, really. What cost containment ideas do you think are most appropriate? And this is just your gut, like you said, gut feeling for the morning. And then after the presentation, you have an opportunity to change your mind or not change your mind. You can keep them where you have them. You can move them. If you have others and have specific ideas on others, you can write them down. You can write them down if you have specific other things that you didn't think about with putting these sheets up. Just write them down and then put your dot on the other.

Ms. Donaldson: There's 5 sheets. There's 3 here and one on each side of the room.

[Various conversations as board members place their dots around the room]

Mr. Sherman: So far this is going well because we're ahead of schedule. I don't know. I'll take that as a good. So, we had pre-designed a break at this point to kind of go along, but that seems to go well. I'm going to propose that we keep going. And it's 10 to 10 that we're going to give ourselves a guideline of 10:20 for the presentations and then see where we go in the discussion.

Ms. Donaldson: Great. Wonderful. So, thank you. So, it looks like a lot of folks are interested in consolidating of the existing plans. expanding HMO access, and we had a vote on full replacement. So, what we're going to do in this first slide is kind of give a little bit more guidance from our perspective on kind of potential savings and horizons. And we're going to do that like time horizon that it would take to implement. So, we're going to do that as an introduction when we get into each of the topics. And then we'll give you some background information to help guide discussions with the board. So full replacement, depending on how you design plans, can be little to meaningful savings. And again, depending on how fast we want to go, it's probably a one to two year horizon. The consolidation is probably minimal to kind of could be middle of the road kind of savings. And that is something we could do within a year. Deductibles, which no one I think had interest in returning to historic levels prior to buy down, is probably providing minimal savings, but it does give directionally, it can change some of the member behaviors as well. And then we'll talk about expanding HMO access. Okay, so I'm sure you all are familiar with this. This is your current plan designs, a high level plan design option. Your Consumer Driven health plan has a $1,700 individual and $3,400 family deductible with 20% current co-insurance, the max out of pocket is $5,000 for individual and $10,000 for family. There is what's called seed money here of $700. And then looking at, and this is just the in-network side, your Low Deductible PPO is at $300. That's effective 7/1, $600 for family, 20% co-insurance as well. The out-of-pocket is similar to the Consumer Driven health plan. The EPO is a $100 deductible, $200 family with a $4,000 and $8,000 out-of-pocket maximum. It’s mostly co-pay driven, as you can see as you scroll down the page. And then the Health Plan of Nevada goes in line more of the HMO kind of style where there's no deductible. There is some deductible on prescription drugs. There is out of pocket, but it's really co-pay driven on this plan as well.

Member Davis: Paul Davis here. What's the percentage of enrollees for each group?

Ms. Donaldson: We'll get into that, sir. If we can skip, we can go to that. It is on slide 22. Let's move to slide 22. So, on this side is the members who participate. So, it's very close, 50-50. It's 42-41. So, 42% are in the Consumer Driven health care plan. 41% are in that Low Deductible PPO plan, followed by the HPN plan at close to 3,200 and the EPO at 2,500. So, in total, about 5,500 in that EPO, HMO option, and then split. What we have found and we have talked about in prior board meetings, if you recall, is the Low Deductible PPO plan has not been set to the actuarial rates that it should have in that other and that particularly the Consumer Driven health plan has subsidized that health plan. And so, we're seeing members with more utilization, higher costs going into that plan. And that's what partially has gotten us to where we are today from a financial perspective. That to build up those subsidies, as Ms. Carsten said, were used to help subsidize premiums versus building up the reserves. This is showing why we're here is kind of the costs that we're seeing. And this is on a per employee per month basis. And this is for plan

year 26. So, we're showing it separately for medical and pharmacy and then the admin associated with it. But you can see the EPO plan, the high dollar cost there, number of retirees in that plan, and also just in general, older members with more chronic conditions are also in that plan. The Consumer Driven Health plan was also subsidizing the premiums on that plan as well, as we've talked about. And that's where that 30 million additional monies for fiscal year 27 is needed to help kind of phase in those premiums. And then you can see the cost, this Consumer Driven health plan's cost is much lower and we've seen a rise in the Low Deductible PPO premium of $1,200.

Okay, so on to slide 13. This is giving at the top and this is important. This is the actuarial value. What do those numbers mean? The way I look at it is if you have a dollar of healthcare, dollars to spend on services, how much of the plan is going to pick up the cost of that dollar? So, you have a dollar of services, you're going to utilize services. The Consumer Driven health care plan is going to pick up 78 cents of that dollar for spending of when you utilize services. Conversely, the EPO and HMO is about 10 percentage points higher. They're going to pick up close to 89 and 91% of a dollar of the cost of the plan. And then kind of in the middle is the Low Deductible plan. which is at 83 cents of the dollar. So that's kind of a way to look at it. These and highlights are the changes that you made effective plan year 27, which was about $5 million or about one percentage point in savings. We go on to the next slide.

Member Viton: Are those actuarial percentages adjusted to reflect the changes that were made in December?

Ms. Donaldson: Yes.

Member Viton: And the premiums don't factor into that, or do they do?

Ms. Donaldson: The premiums do not factor in that. This is kind of based upon the plan design. And if you utilize services, how much would the plan pick up when you utilize the service? It doesn't reflect it.

Member Viton: So, I was curious because it's the 26 premiums with the 27 plan design. I wasn't sure why.

Ms. Donaldson: That's correct. We did this slide in the January PEBP presentation. So that's why we hadn't set finalized things yet. So, you'll see, and that's a great call out. A lot of our slides have been presented in prior board presentations. To be summed up a lot of things for prior board presentations. But you're right, it's not the 27. Okay, so these were the premiums back in plan year 22, or I'm sorry, this was the plan design back in plan year 2022, I want to point you to the Low Deductible plan. The annual deductible was $500, right? And then there was excess funds within the plan as a result of COVID. And that money was used to reduce the deductible as well as some other things, but primarily that deductible. And so we did increase that for plan year 27 to $300. So, if you go on to the next slide, we did an analysis, this is from the January head board meeting, and so this is included in the packet. We did an analysis to say, okay, here's the plan designs for plan year 27. If we took plan year 22 plan designs and trended them forward to plan year 27, What would the plan design look like? Well, the $300 would be at $600. And so, and you can see further down that like the $1,700 would be $2,100 and the deductible for the EPO would be close to $200 versus the $100 that it is today.

Executive Officer Carsten: Just for clarification purposes, if the $500 and the LDPO had been restored like it probably should have been, then that trend would have been higher for 27, correct? It wouldn't have gone from $300 to $600, it would have gone from like $500 to...

Ms. Donaldson: That's correct. I think no one really voted on this, but we wanted to have this slide available to say if just from a perspective, the benefit has become more generous than it was originally implemented.

Member Viton: Does that mean, and this may have been in an earlier presentation also, but the actuarial value of the plans under the 22 design, were they similar to where we are today or were they lower than where we are today?

Ms. Donaldson: For the LDPP, it's lower.

Member Viton: January or 22?

Ms. Donaldson: The 22 actuarial value would have been lower because it was at $500. Versus today, it's only at $300, so the actuarial value would be lower. Yeah, good question. So, the bottom line is that, you know, your plans have trend, I think the outcome of this, your plans have trended up, has picked up the cost of the trends, right? Like, and again, some of that cost has been shifted over to the employees as premiums, but there's been subsidization as we're coming out of that. As you know, that's part of the $30 million. That some of the plan designs have not kept up with trends by making changes. And so, as a result, the plan picks up more. And then theoretically, more dollars are going through to increase the premium and cover the cost of those plans. I hope that makes sense.

Okay, let's go on to the next slide. So, we're going to go into some benchmarking. I'm going to do about one or two minutes and then I'm going to turn it over to Mary Ellen. So, Mary Ellen, get ready. Okay, so we did just high level benchmarking. Again, this was in the January PEB board meeting. We did high level benchmarking of kind of Western states. What do other states provide in benefits. Let's go to the next slide. So, we're comparing the Low Deductible PPO at the actuarial value of 83%. And we looked at the leanest plans and then the more generous plans around 93%. So, your Low Deductible plan is a little bit more generous than the average benchmark of Western states. Go on to the next slide. The Consumer Driven health plan is more generous. Similarly, did the richest and the, I like to say, more generous and less generous here, anyway. But the Consumer Driven plan around 78% actuarial value is providing more generous benefits than we're seeing in other states on average, based upon the average benchmark data of the Western states. And Segal, we are the consultants to a number of these states in the West. I'm going to turn it over to Mary Ellen. And so, there was a question by a board member. What does Segal do versus what does Mary Ellen at Milliman do? So, Segal's the actuarial consultant for Nevada PEBP. Milliman was hired by the Health Care Authority to do some strategy work. And so, we've been collaborating together on this project for you today. So, I'm going to turn it over to Mary Ellen, who's representing Milliman, to go through some slides. They've done some benchmarking on a local basis within public entities within Nevada. So, take it away, Mary Ellen.

Ms. Vargas: Thank you. Can everyone hear me okay? All right. Quick introduction. My name is Mary Ellen Vargas. I'm a senior consulting actuary with Milliman. Debbie did a nice job, I think, teeing up the kind of partnership that we have here, but my team has been engaged by the

Health Authority to provide a strategic assessment across programs that the Health Authority oversees. So, Medicaid, the Nevada Exchange and Public Option, as well as PEBP. So, my background is working with employer groups on all things strategy, pricing, actuarial. So, we've been working closely with Segal in preparation for this meeting. And I've also been working in conjunction, obviously, with my team on some of those cross-program initiatives. And we'll talk a little bit more about those shortly here as well. So, in terms of this benchmarking here, we have similar detail to what Debbie just walked through. For the state comparator plans, we have similar kind of plan design detailed level tables in the appendix. So happy to flip to those if that's helpful. But just taking kind of a 10,000 foot view here of what's happening in the local market. A few highlights that we wanted to point out. So, we gathered information from 5 local comparators, being Washoe County, Carson City, Clark County, the Clark County School District, and then the city of Las Vegas. So those were identified as kind of key local comparators. Maybe these are entities that, you know, if PEBP is potentially losing employees or competing for talent, these are some of the target entities that a lot of the same talent pool is, you know, maybe floating between or considering positions between. Of those competitors, all offer between 2 and 5 plan options within their employee benefit programs. So PEBP falls right in the middle of that benchmark, right? Technically, there are four plans, but really, depending on where people live, they have the choice between three different options. And then we list out there in the sub bullets, which of the benchmark entities have two options versus three options. City of Las Vegas is a little bit of an outlier with five options. So, I would say, you know, PEBP really does fall right in line with the benchmarks, but we heard from your initial flagging of opportunities or ideas that, you know, you think might be viable, consolidating the options down to two would still keep you in line with those local benchmarks. In terms of networks and administrator partners, four of these five local comparators are partnering with UMR, Health Plan of Nevada, United Healthcare, really all falling under the same umbrella that PEBP is under today. The one exception is Carson City, who partners with Prominence at the local level and then Prominence's national partner is Cigna for those not familiar. And then we did note that for the four entities that partner with United, UMR, HPN, all of them do leverage the Sierra Care Options Network for at least one of their plan options in the southern part of the state. So again, aligned with PEBP's approach there.

Types of plans offered, each of the five entities has at least one broad PPO option. Two of them offer high deductible health plans. Four have at least one option that's either an EPO, exclusive provider organization, an HMO, or a point of service POS plan. Three of the entities have at least one option that has a tiered network, so steering, utilization via more competitive plan design and cost sharing to certain providers. In terms of premium contributions, we weren't able to gather information from every entity, but of those that had information available, we want to note that three of these five have employee only premiums that are 100% subsidized. And that's City of Las Vegas, Carson City, and Washoe County. And then for members of the Teachers Trust under the Clark County School District, those employee contributions are not zero, but they're very low, less than 5% of the premium. On the dependent side, there's a bit of a wider range. So, where information was available, those dependent subsidies ranged from 25% to 60% of premium. And we break down, you know, which entities fall kind of on either end of the range there. In terms of key takeaways, you know, our observation, I alluded to this already with kind of the number of plan options, the types of plans that PEBP offers, the vendors that you're currently partnering with, those do all seem to align pretty closely with what these other entities in your areas are doing. We think there could potentially be some opportunities under three kinds of subtopics. So premium subsidies, there's a bit of a distinction there with three of the five local comparators subsidizing employee only coverage at 100% but offering a much

less significant subsidy for dependents than what we're seeing on the PEBP plans today. So, something to consider there. Tiered networks may be worth exploring further. We'll talk in a lot more detail about contracting, as Debbie mentioned, and provider network partnerships, but potentially implementing plan designs that have different tiers and steer utilization towards more efficient, cost-effective providers could be something that we explore further. And then we've touched upon this already, but the number of plans, right? So, it does sound like there might be an appetite to explore some plan consolidation. And if PEBP did move from three options to two, again, depending on where folks reside that would still align with these local benchmarks.

And then we just put some summaries together in these next two slides. Again, I'm happy to flip to the appendix and show any of the detail for plan designs if that's helpful. But kind of going off of the theme that Debbie just walked through on actuarial value, this table compares just as a baseline using the PEBP LDPPO and shows what the difference is in actuarial value between that and all of the other plans that we benchmarked. So, you can see, you know, pretty squarely falling in the middle there in terms of PPO, but I will mention, you know, we count in this mix of PPO plans, the point of service POS plans, as well as high deductible plans. So, kind of unsurprisingly, a number of the high deductible plans are leaner or offer less generous benefits than the PEBP LDPPO. And just to orient you here, the negative numbers, the bars in green kind of below the circled plan. Those are plans that are less generous than the PEBP LDPPO. And then plans with a positive percentage that have a blue bar, those plans are richer or more generous than the PEBP LDPPO based on actuarial value. I'll pause and see if there are any questions or comments on this.

Mr. Sherman: So, during the pause, we have 10 minutes left in this segment. If that works.

Ms. Donaldson: Let's go quickly through the next slide, Mary Ellen.

Ms. Vargas: Yep. So similar story here. I don't think we need to spend much time. This slide just compares the HMO and EPO plan options, PEBP versus those local comparators. Interpretation of this slide would be the same. Green negative numbers implies a less generous benefit. We chose the PEBP EPO as the base plan here. And then those blue bars would be more generous or richer benefits.

Ms. Donaldson: Great. Thank you, Mary Ellen. All right; we've already gone on this slide. The rest of the slides in this section just provide what the plan year 27 to your point and remember, Chris, kind of what the premiums are for plan year 27 for your reference. I'm not going to go through those right now because I think let's open it up. If you're good, yes, question.

Member Davis: I'm sorry, I just had a quick question for Mary Ellen. Why is Washoe County, why do you feel Washoe County is such an outlier?

Ms. Donaldson: Go back to the other slide, please. There we go. Are you talking about Washoe County PPO being 10% higher? The question, Mary Ellen, is why do you think it's such an outlier? What's driving that 10 percentage points more?

Ms. Vargas: Yes, so I'm just flipping ahead in my deck to the appendix slide. I think it's primarily driven by a lower out of pocket maximum. So, their out of pocket maximum looks to be close to half what the, so I'm on, I think it might be slide 77. But so, the PEBP LDPPO out-

of-pocket maximum for a single is $5,000, $10,000 for a family. Most of the local competitors are around $6,000, some are at $6,500 for a single. But the Washoe County PPO has a just under a $3,500 single out-of-pocket maximum, which is significantly lower.

Ms. Donaldson: Pharmacy is more generous. The copays are lower as well. Look at the difference in ER. Again, with the 20% coinsurance, but you're at $750 copay. Yep. Yeah, so this one. The big ones the out of pocket max, for sure. And family $6,900 versus $10,000.

Member Harper: Blaine Harper for the record, does the actuarial value include any cash that is available on the high deductible plans? So, you know, for us at PEBP, it's the $700 at the individual level. I think that there are some of these plans that offer a larger amount.

Ms. Vargas: Yes, the actuarial values do reflect any seed money that the employer gives. And actually, if we flip to the next slide, that's outlined for the two entities. We weren't able to confirm for Carson City, but Washoe County does give a very, very generous amount of funding for the HSA contribution. Admittedly, that's much higher than I would say we typically see in the employer.

Ms. Donaldson: Yeah, agreed. Very generous. So basically, their deductible is essentially covered and half of the out-of-pocket maximum. That makes it incredibly generous plan.

Member Rich: Laura Rich for the record. Do we have premiums to compare here too? So, I mean, I know they're offering richer benefits, but are they, what are they charging for them? Are they subsidizing them or are they, you know, what is that? Because I think that makes a difference. You can offer whatever it is you want to offer, but someone has to pay for it. So, are the employees paying for it or is the employer paying for it?

Ms. Vargas: So, for a few of the plans, we had exact premium information. More often than not, it was kind of higher level premiums are subsidized at X level. I will say Washoe County is one of the three that does fully subsidize employee only coverage. So, employees, when not covering dependents, don't pay anything for premium for these plans. On the dependent side, though, the subsidies seem to be significantly less generous for these local comparators than PEBP. So, on average, you know, we saw about a 50% dependent subsidy from the employer for most of these plans. And PEBPs seem to range from, you know, about 60 to 80% subsidy.

Ms. Donaldson: So, something to think about here, right, and board members, is that how you're subsidizing the plans, right? Employee versus dependents, and that's probably a good discussion as well. Any other questions before we go into discussions?

Member Viton: So, can I ask just to make sure I'm understanding the actuarial value again from my prior question? The actuarial value is not; it doesn't differentiate between the employee contribution and the employer subsidy. And so, a portion of that 80% actuarial value is being funded by the employee contribution.

Ms. Donaldson: Yes, that's correct.

Member Viton: So, when comparing to benchmark averages with different employee contributions, the employee value of the plan may be different even if the actuarial values are the same if their contribution is higher or lower.

Ms. Donaldson: Yes, the actuarial value plan is solely looking at if they're utilizing services based upon the plan design, what percentage is going to be covered by the plan. It doesn't take into consideration any contribution, subsidization on the premiums. That is true. Yes. That is correct. OK, where do we go from here?

Mr. Sherman: Andrew Sherman standing back up, so, we're 2 minutes ahead of the advanced schedule, so we're doing great, meaning lots of time for you all to comment or share ideas if you'd like. Here's where we are and the way we've set up the structure. Plan design. These were the four ideas. We didn't have any other ideas, but there is still time for other ideas if you want from what you've heard. Initially, we heard, we see from your dots, most interest in the consolidation of the existing plan options, and you've seen a lot of benchmarking data. There's a lot more on what others are doing and what that might look like. Some interest in expanding HMO access, looking at other HMOs. One dot on the full replacement to a single plan, and again to differentiate full replacement is kind of very dramatic. Consolidation is more flexible. Return deductibles to historic levels. So, you saw some trending forward of information, meaning that the plan that you have today, if it just trended forward for inflation, the plan is paying more than the participants, so the participants have gained a little bit. They're paying a little bit less than they would have paid if inflation was applied. Now no one thinks about it that way because they think about the actual dollars they're spending on a deduction. Okay, the floor is yours. Observations, comments. Things to share.

Member Rich: Laura Rich, for the record, so I think one of the things we were just talking about is we've seen the benchmark of the plans and where we stand in terms of what we're offering our employees. But I think what would be helpful to see is benchmarking of what board member Chris was talking about. What do states and probably more importantly, the counties, all of our competitors really for a workforce, how much of the employee benefit are they paying, right? How much are they subsidizing? Because that's really what it comes down to is where we stand with our local competitors because we lose employees every day to the counties, and I know there's more to it than just the benefits, but they can pay them a lot more as well. But understanding, where our benefit structure stands in terms of how much we're subsidizing employees.

Mr. Sherman: So, what I'm hearing you say is the actual value is a way to look at what the design is. That is important. But from the perspective of competing for employees, which you're doing, and all your contributing employers are competing for employees every day, the potential employee or the current employee looking at maybe other opportunities, the same premium. We haven't really captured here what that premium looks like and understanding that major adjustments to the premium might have a more immediate impact because people aren't thinking about what the actual design is and so they're utilizing services.

Member Duncan: Keiko Duncan for the record. I'm also considering the concept of value, right? So, the connection between the premium and the service offered, have we done? Is that in one of these 118 slides that I just haven't placed. Because, we can say that they want to go to this other county plan because of whatever reason, and are their premiums lower? Is their premium

lower and they're offering better medical value, or is there some balance or comparison that has been done there as well?

Mr. Sherman: So, Member Duncan, I hear you saying... Is there a way to look at value of coverage and cost to the member. Now, there's also cost to the system, so PEBP is paying the cost and you can actually go up or down based on what you all decide, but you'd like to kind of see that more side by side with the value of the actual plan. Am I repeating what you're saying.

Member Duncan: Yes, you're repeating what I'm saying. Go for it, Debbie.

Ms. Donaldson: Point of clarification. I want to make sure I understand your definition of value. That's different than actuarial. I want to make sure I understand what you mean by value.

Member Duncan: Keiko Duncan for the record. We have a fiscal issue, right? And I think that's what we're trying to solve for. But in solving for that, I don't want to lose sight of the actual value that the plan provides recipients as well. And just considering if there is a comparison.

Ms. Donaldson: Other than actuarial value,

Mr. Sherman: Other than some kind of net number would be interesting.

Member Viton: Would service quality be a way of describing that, like the quality of service or the quality of the plan, not just the dollars.

Member Rich: Laura Rich, for the record, I'm actually on a board of one of these plans, and we actually have another board member who runs that plan, and they offer a lot of really unique perks for their members, right? They have, if you want to enroll in a certain kind of value-based care plan where you can enroll through a provider who that provider provides you the care through their network and you get certain things free that way, right? Certain things that you would normally pay for. If you didn't use that provider, you'd have to pay for your out of pocket co-pays. But if you're using this kind of system that they've got, then you're getting free benefits for X, Y, and Z, right? And so, they have like different things like that that are kind of neat and unique, and I think that brings a lot of value to their members that actually participate in all of those, depending on what it is.

Member Harper: Blaine Harper for the record. I think finding a way to provide offerable benefit, taking into account premiums on the participant side would be a helpful direction. To the extent that there's an issue with losing people to city and county versus state employment. I don't think that there's anything in the scope of just the PEBP board being able to change that dynamic because the PERS contribution rate does not affect these comparison cities and counties for employment. Whereas right now, the sticker price of all our salaries in-state service would be 10 percentage points higher if we weren't paying PERS out of our paychecks. So, we can become comparable in terms of healthcare coverage, but in terms of comparable as competing for state employees, there's a bigger picture.

Mr. Sherman: I'm going to pause just for a moment to try to make a couple of connections, if I can. Because I think that what some of you all are referring to, we're going to cover under what we call composition of the risk pool. But here we also really kind of get into the premium part

as well. So, I was trying to come up with, is there something that we should add here as an other, which I hope someone wants to add something now. But also, maybe we just put a pin in that until we cover the next topic.

Ms. Donaldson: And I would add for the record, Debbie Donaldson Segal. Board Member Rich, I'm wondering if you're talking more about three-tiered networks, right? If you go to tier 1 doctor, you get additional perks because they're better contracted, they have better contracted rates, and there's an incentive for the members to use those because they tend to be higher quality, they're contracted at better rates. That is certainly something we would want to consider. I think to your point in contracting procedures as well. I still want to address Dr. Duncan's, is that what you mean by value? I want to make sure as we think through things that we're addressing that appropriately.

Member Duncan: Keiko Duncan for the record, I think that's really what it is. It's value that like the nuance to it that may not necessarily be reflected in an actuarial.

Ms. Donaldson: Okay. Thank you. Very helpful. Thank you.

Member Davis: I think it's important to distinguish the type of employees between these comparisons. For example, I represent higher education. People move quickly if they don't like the medical plans. That's a key point. I would think, I could be wrong, that state and county employees probably don't have that option, or generally don't have that option, that higher education individuals do. So, I think that's important to establish.

Mr. Sherman: That's a very good point. Trying to repeat back; you are clarifying member Rich's comments about competition, that competition is actually more multidimensional for employees because of the boost. Member Barnes, member Viton. Comments?

Member Barnes: Not at this time.

Member Viton: In terms of the topics that we have under plan design, the way I'm thinking about them. Fully replacing with singular multiple is talking about changing what options are available to the participants to select on. It could be the same number; it could be fewer or more. Consolidating is definitely introducing options. Returning deductibles is reducing benefits. Expanding HMO access would just be providing a new option. In the north, that's what that item represents?

Ms. Donaldson: Potentially, but there's there's other options.

Chair Wells: For another HMO, another HMX.

Member Viton: I'm just trying to understand, some are very clearly many, we're talking about cost containment. So, most of the things we're talking about are reducing benefits.

Mr. Sherman: Can you go back to the slide with the dollars and the?

Ms. Donaldson: To kind of set the stage. To save money somethings got to change. Yeah, yeah.

Member Viton: Some of the reducing benefits, some of the things in the contracting are more aimed at cost containment without necessarily reducing benefits. Healthcare cost and healthcare benefit are in some ways the same thing, right? We pay for what? We pay for a benefit, so it costs. Reducing costs somewhat necessarily translates to reducing benefits unless it's reducing the margin on the providers, suppliers.

Ms. Donaldson: That's correct. Or narrowing the network and only going to high performing, but you get noise sometimes too.

Mr. Sherman: So, I want to really just underline what you're saying those are some very valid points. But I want to turn back to your actuaries, my direct colleagues and our other colleague, Mary Ellen, if they want to react to what you're saying in any way having to do with consolidation of risk pools and how that overlaps with the number of plan design options.

Ms. Donaldson: Depending on how you consolidate, there could be savings, right? To the point where depending on how those get consolidated and what the value of the plan is, there is savings, right? I think what I'd like to hear a little bit more is some folks' thoughts about what does that consolidation look like? A lot of you guys put your stickies at consolidation of existing plan designs and would love to hear the perspective of you all, of what your initial thoughts are around that. What does that look like from your perspective?

Member Davis: Paul Davis here. I put dots down, not necessarily saying I'm advocating that. I wanted to see what the consequences, what the cost would be to the members, and the value that we received.

Mr. Sherman: Member Davis, good job at following instructions.

Member Davis: I just didn't want you to perceive that, because we have the dots there, that means that we are advocates of that. Does that make sense?

Chair Wells: For me, looking at Washoe County on slide 19, you've got them the richest plan at 10.4% over our base, and you've got their high deductible at 10.5% below our base. Pure differentiation between plans. We don't have that. We've got a couple of percentage points between plans. Not that big difference that you see in Washoe County. Washoe County also requires you to be on the CDHP for the first two years of employment before you can pick any of the other plans. And then they pay the employee share only, and then their family and dependent costs are significantly higher than what ours are. For similar form. And so, for me, that's kind of what this whole consolidation plan is really about, is making differentiation between the plan designs that we offer to our employees and then the respective premiums that they pay to get those benefits. Because you pay one way or another. You pay when you use services or you pay in a premium upfront. That's kind of the gist of how health insurance really should work. You're not supposed to be able to pick the plans that minimizes all of your out-of-pocket costs. Because you get the enrollment, you get the adverse selection. People look at something and say, "Well, I'm going to have, you know, maybe I know I have to have a knee replacement or hip replacement." you know, next year, or I'm going to have this major event, you know, accidents and some of that stuff, much harder, but there's a lot of things that can be planned. Or I know I'm going to have to start taking this medication. I'm going to switch to a plan that has a co-pay for my medication, because I don't want to pay 20% of it anymore. I want

to pay 10 bucks when I go to the whatever it is. And so, I think that we need to look at, for me, when I think of the consolidation of existing plan options, is a wider differentiation between the plan options and then a wider difference between the premiums that you pay.

Member Davis: Just a real quick comment. A two-year waiting period would be absolutely devastating to higher education. We'd never be able to employ anybody full-time on a tenure track. They just wouldn't put up with it. Not a two-year waiting period.

Chair Wells: No, not a waiting. They have to be in the high deductible health plan for the first two years. They can't pick one of the richer plan options. They can't pick the richer plan options until they've been employed there for a minimum of two years.

Member Davis: Oh, thank you. I misunderstood.

Mr. Sherman: So, we are at that sort of time that we wanted to allocate for the first topic. I did want to make sure that MaryEllen, if you wanted to react to anything, I'm giving you this chance now.

Ms. Vargas: No, I think this has been a great dialogue and I was going to chime in with the point that Chair Wells already made. So, thank you for raising that. We did find in our research about the requirement for Washoe County to be on the high deductible plan first. So, definitely something to consider and not something that appears to be the norm for any of the other comparators that we benchmarked against, but just a consideration.

Ms. Donaldson: And just to add, I think one of the things we're looking for is direction from the board. Are there considerations that you would like us to take back and price out and present for future board meetings? Like, are there, is there interest when you say consolidation to President Wells's comment. Should we be looking at some plan designs and what that would look like from a premium perspective, from an actuarial value perspective in the consolidation? So, looking for a little bit direction of where to go next.

Member Harper: Blaine Harbor for the record. As the loan full replacement thought, I just want to clarify that it's consolidation related, that if there was a wholesale different HMO option, it's not split north south or it's a different, whatever is different about it, but it's kind of a consolidation idea. But the HMO option has been one of the trickiest things I've had. And a full replacement of the HMO option is what I'm thinking in terms for that.

Ms. Donaldson: Thank you. Thank you for that comment.

Mr. Sherman: So, from a facilitation standpoint, I want to remind you that we've done one of five. We're ahead of schedule. I want to also recognize that this is not a typical board meeting structure. It takes a different kind of energy to do this. So, I wanted to at least, through Chair Wells, ask if people feel like they want to stretch their legs before we go into the next section. Because it's like I said, you're using your brain differently than the normal course of business. So, I want to make sure.

Ms. Donaldson: One second real quick. Andy real quick before.

Chair Wells: I think the idea behind this is to kind of get the thoughts. By the end of the day, we have to kind of give the actuaries some actionable stuff for them to bring back in future board meetings for us to take action on. So, while you don't have to say anything right now. I think where you put your dots for the afternoon are going to be telling as to what kind of things that we bring back to future board meetings for real decision making.

Mr. Sherman: It's 22 of.

Chair Wells: I don't know how hard it is to get to the restroom and stuff here, so let's be back 5 of.

Chair Wells: We'll call the meeting back to order.

Mr. Sherman: I'll give it back to Debbie.

Ms. Donaldson: Great. Thank you, Chair Wells. We're going to move into the next topic, the risk pools, consolidation of risk pools. We got a lot of dots everywhere. So. we'll kind of go over these. We already talked about dependent subsidies a little bit when we were comparing plans. We'll talk a little bit about that. And this again gives you a high level of potential savings and time horizon. So, separating the actives and retirees from the risk pool and rating them separately, depending on the direction and how you go about it, can create some savings. And that's a one-year horizon. That's something you can do fairly quickly. Moving the non-Medicare retirees to the exchange can also save you money. We can talk more about that. That also helps reduce the OPEB obligation, which is the liability that they have to put in financial statements associated with the total value of the retiree health offering to retirees. That's probably a longer horizon, three to five years. Dependent subsidies can give you some savings and depending on how you reallocate those subsidies. And that's something that you could do fairly quickly within the next year.

So, let's go on to the next slide to kind of dive in. This is just giving us a high level perspective. What we've done here, and I've got some numbers for you as well, is look at the plans, look at the membership, and I'm going to go through some of these quickly. But looking up here is that these are the actives in the Consumer Driven health plan. We have about 19,300 members in that plan. And the per member per month cost associated with those members is about $513. And this number, which may be hard to read, is that trend from last year. Claims only increased about 2.4% for this group. Let's flip to the next slide in comparison and look at this slide where we're looking at retirees in the Consumer Driven health care plan. And again, the rate that we're showing is now, that $500 is now $953. And in addition, we're looking at the number of members is about 2,400. So, less retirees per se, but the costs are meaningfully more, not double, but probably 75, 80% more than the cost of actives. Going on to the next slide, we're looking at the Low Deductible plan. The per member per cost for this group is around $675. The trend for this went up 14.4% from last year. And as Chair Wells noted, we have seen in the plan, to Chair Wells' points, when members want to utilize care, we've seen migrations away from the Consumer Driven health plan into the Low Deductible health care plan to utilize services. We showed in the May board meeting materials There's higher utilization of services in this plan, but your out-of-pocket maximums are the same. So, if you're going to be a utilizer of services, you're going to go into this plan, right? And the premiums were not set such that it's fully reflective of the underlying risk profile, going to go into this plan because it was subsidized and utilize it. And then when you're done utilizing care, jump back into the

Consumer Driven plan. We've seen that happen in your membership. You have about 21,700 members in this plan. Let's flip to the next slide. Look at the actives. Cost for the for the retirees, excuse me, cost for the retirees are over $1000, almost $1100 for this group. You do have smaller number of memberships, which is around 1400.

Onto the next slide. Last but not least, the EPO. Actives, the cost for this group is just under $1,000. The trend for this was about 6%. We've got just shy of 4,400 members in this group. So more expensive than the other two plans. But look at the retirees. We're close to $1,600 per member per month. And that cost went up for the retirees by almost 14%. We have about 550, 560 members in this plan. So, when we looked at, I think it's on the next slide. When we looked at and we separately underwrote each of the populations, we looked at actives and retirees. Right now, again, they're blended into one. So, if we break them apart, the active rates would go down approximately 5%. That's about a savings of $15 million because it's a bigger membership, even though the percentage is going down smaller, bigger membership. The retirees are going up 32% to reflect the true cost. That's saying in general that the actives are subsidizing the retirees by about 32% in general or about 37%, really, that's the true differential. And the cost for that is an additional $17 million. That increases the cost by $17 million. Now, we did this based upon 2025. We're working on some budget protections for the biennium. So, These could change slightly once we get the migration and all the movement patterns that we've seen as of July 1. But we were using the data since December 25. So, this potentially may tweak a little bit once we get the updated migration. Yes.

Member Davis: Wouldn't that make sense? Because they're the average age of the actives compared to the average age of the retirees, of course it's going to be more expensive. But they spent that many years working in the system you should expect to be.

Ms. Donaldson: Yes, we expect it. Yeah, absolutely.

Member Davis: I don't want it to be perceived as an automatic negative.

Ms. Donaldson: It's not a negative for sure. It is expected. And what we're trying to show here is the true cost of the retiree rates if we were going to separately underwrite this group. You are correct. Any other questions before I move on?

Member Rich: Not a question. Laura Rich, for the record. But just for the board to understand that the retirees are non-Medicare retirees. So, we're not, for the most part, we're not talking about the 85 year olds, right, with very limited income, right? We're talking about those people who have retired at 55 and probably have other sources of income and other employers, a second employer. There's a small group of people that will never have Medicare and there will always be those. And I don't know, Debbie, if you have that number. It used to be something like 1000. It's probably way less now. But there's a group of retirees who will always be on our retiree plan regardless, because they're never going to be eligible for Medicare. But that's a small, small group. Most of these people are under 65, have retired early, at 50, 55, 60, whatever, and are likely working a second job, working another job with access to healthcare elsewhere.

Member Harper: Blaine Harper for the record. I'd like to add, I'm aware of retirees who are not retiring earlier than 65 but have dependents. They enroll or plan to enroll in PEBP. Two people are married and there's an over under age 65 situation, odds are, that that situation comes up

fairly often. So, I guess my question about people who are retiring and younger potentially taking a different job or retirees who have employer based health insurance available, eligible for PEBP? In the eligibility of enrolling in PEBP as a retiree, if you have your own employer-based health insurance, are you still eligible to choose PEBP as a state retiree?

Chair Wells: Yeah, once you retire, you can take retiree coverage and you can just stay on it, even if you have access to employer-based coverage from a second job. But the law also says that you can take that other employer-based coverage while you're working, and for one time you can cancel your retiree health care coverage and then reinstate it when you leave that job. But that's a one time. You can only do that once. I think that's the way the law used to read. I don't know if it's changed. But the law says you can reinstate one time. So, you could leave, and if your employer-based coverage was great and you wanted to use that while you were working, you could cancel your PEBP coverage as a retiree, have that second employer's coverage while you're working for them. Then when you stop working for them, you just basically re-enroll in PEBP coverage for whatever you're eligible for, whether it's the pre-Medicare or post-Medicare.

Member Davis: So, a person, when they do retire, they keep telling us higher education that you have to go to Medicare.

Chair Wells: When you're 65 you have to go to the Medicare exchange unless you have an under 65 dependent. That's what Member Harper was saying.

Member Davis: So, at sixty-five, everybody goes to Medicare?

Chair Wells: As long as you're dependents not over 65. Correct structure. And I think one of the big things for me, I don't know if you've got more that you want to talk about, but one of the big things for me is that, remember, if you were hired after January 1st of 2012, you can participate in a plan, but you pay 100%. And so, this subsidy of retirees, in many cases, because we've got a lot of people now who were hired after 2012, are paying higher premiums for a benefit they're never going to see. And that's one of the things that bothers me a little bit is that you are having these current active employees pay higher premiums. They're not going to see anything at the other end.

Mr. Sherman: So, discussion. And can we go back to the other slide? So, a fair amount of initial interest before we started on this separation of the risk pool and having the actives pay a rate where the risk pool is just actives and retirees pay a rate. And here we are talking about the non-Medicare eligible retirees who are eligible for the coverage and having them pay a rate based on that group's separate experience. And #2 up here was to take this group of Non-Medicare eligible retirees and direct them to the state exchange. And 3 was to look at the dependent subsidies. This goes right into rate. When you set the rates in the various tiers? How much are the employees asked to pay for their dependents versus what is paid for by PEBP. There's only three choices, but these are big topics for discussion, and at this point in our strategy session today, we're inviting your comments.

Member Rich: Laura Rich, for the record, just on the exchange piece, we did some analysis back in 2020 when we had to, because of COVID, potentially have drastic cuts. And so, we did that analysis and I don't know what that would look like today, but back in the day, there were winners and losers in that. People that lived in Clark County won. People that lived in the rurals

lost and people that lived in the Reno area kind of broke even for the most part. But with HRA subsidies and things like that, I think that it could actually be a potential good move for retirees in general. If we did it right, it's something that we have to obviously do the analysis and see what that looks like, but in general a good part of our population in Clark County would win.

Mr. Sherman: So remember. Because this is a strategy session, I'm going to ask you to define win and loss, winners and losers as you're putting us forward, making sure everyone's kind of on the same understanding.

Member Rich: In general, the cost of care, their premiums versus the plans that they're enrolled in, their options. Just in general, again, people value things differently. Some people just look at premiums, obviously, it's kind of a whole thing, access, right? If you go on the exchange, you've got eighty plans to choose from. I don't know what it is now, but it's a lot of plans, and so you have a lot of plans to choose from. On PEBP, you have three. But some of the deductibles are higher, you may not have HSA options and things like that

Mr. Sherman: Maybe narrower networks. I want to pause. I wanted to ask Debbie to talk about how the exchanges are rated.

Ms. Donaldson: Yes, that's what I was going to add. Great. Thank you, Andy. So, for retirees, and I've done this analysis for other states, when they've kind of considered and looked at this, All of those points need to be considered for sure and what is defined in value. And from a pure premium perspective, the exchanges have what's called a three to one ratio, but the highest tier, and premiums are age banded on the exchanges. The highest age band cannot be more than three times more expensive than the lowest age band. That tends to benefit, at least in the analysis I've done for other states, has benefited early retirees. All things being equal, because of the three to one ratio on exchanges, the lower age groups tend to subsidize the older ages on the exchanges and the premiums tend to be, again, I'm generalizing, better for the early retirees. Actives definitely have seen winners, losers for sure. Early retirees, and then you have to consider narrower networks, multiple options, all of those things are very important to consider. And from a premium perspective, many times early retirees win on exchanges because of that three to one ratio.

Mr. Sherman: To make this conversation a little more dramatic.

Member Duncan: Keiko Duncan for the record. So just in summary, what I was hearing from Debbie was basically the problem that you see existing in exchanges in which the lower age groups are essentially subsidizing the early retirees is basically the same problem, not a problem per se, but it's what's happening here as well. Is that my understanding?

Ms. Donaldson: Yes, your actives are subsidizing retirees.

Member Duncan: What I'm curious about then is what is that extent now? I think there is, to Laura's point, if we did this analysis in 2020, a lot of change in healthcare since 2020 because of 2020, right? And so, I would be very curious to see that analysis now and try to understand like the difference in those extents because if we find one that's more very affordable to the budget. And to the people, at the same time, we think maybe that that would help inform the decision.

Mr. Sherman: So, I'm hearing you say, and again, dots are not a preference for action. Dots are a preference for further study. You're guessing we might see a few more dots on the exchange for study, but we put dots up again later today. I don't mean to be putting words in your mouth. That was kind of what you were saying?

Member Rich: Well, and just to add to that, we have retirees across the country, right? People don't just retire in Nevada. And so, these are, potentially, they can be winning or losing in other states as well. You know, but again, we in Nevada or at PEBP, we are focused on Nevada. We have plans that are Nevada plans, we look at our coverage for people that live in Nevada, our residents, and our employees. So, our retirees do not necessarily get that benefit, right? Because we're not looking at plans in Connecticut for them. And so, the exchange may be actually beneficial for retirees because they're in a network that benefits them and they can choose a network that benefits them. I just wanted to put that out there as well.

Member Harper: Blaine Harper for the record. two of our plans are nationwide, right? Not just statewide. I guess I don't know as much about the plans that are on the exchange, whether those are state founded or, you know, have many more nationwide options. Is that what we have?

Member Rich: Laura Rich, for the record. If you live in Texas or if you live in Connecticut or if you live in Minnesota, they all have their own exchanges. We have Nevada Health Link in Nevada, and so those are Nevada specific plans and networks and things like that. Obviously, you have national coverage as well. But if you live in Minnesota, then you're getting plans that are Minnesota-based with national coverage, right? And so, again, our plans also have national coverage, right? But it's broad, right? If we have a retiree that lives in another state, you may or may not have the coverage that they're looking for, that they need, right? Their provider may not be in that network because that's not who we choose. And so, in this situation, it would be a benefit for retirees because they would be participating in their own state's exchange. With their own state plans.

Member Duncan: So, a question from that then, Keiko Duncan, for the record. I'm curious because they're out of network, I wonder how many in the retirement population are using out-of-network coverage and are therefore, that is a higher cost to care. because it's out of network or is it similar or comparable to in network? I don't know what the other cost is.

Ms. Donaldson: Point of clarification, Board Member, are you speaking out of network or out of state?

Member Duncan: I don't know. Well, both I guess.

Member Rich: I think she's saying, Laura Rich for the record. We prioritize in-state coverage for the most part, right? I mean, we do have national networks, right? But we don't know where these people are living. And so potentially, they want to use a provider that is not in our network, and so they go out of network.

Ms. Donaldson: Out of network are definitely more expensive and we haven't looked to see how many retirees are using out of network. We can certainly take that back and look at it. The other thing I'll add is out of state in network is really dependent on UHC's network and how strong they are in that given state and given geographical area. It could be better; it could be worse. So,

I'll just add that component as well to that. It's really dependent on how strong that United Healthcare Network is in other areas.

Member Duncan: Keiko Duncan for the record. And this might be a path we don't need to go down, but just my brain is asking questions of me. Well, I guess my next question is how strong is the network then? So just how much is that maybe contributing to some of our budgetary concerns, because they are truly out of network, it's driving up the cost of care, et cetera.

Mr. Sherman: I wanted to underline, draw out a little bit of comment that was made a few minutes ago and just to be challenged to make sure it wasn't lost. And that's as board members, you are responsible for actives and you're responsible for this group of retirees. You're responsible for, I don't want to say promises made, but I'll say expectations of actives and retirees with limited resources. So, this is really bringing to you this set of challenges of using limited resources for the employees, for the employees' dependents, and for your former employees that would be eligible for this coverage. And those are some of the decision points. So, I throw that out there if anybody wants to react to that way of expressing this.

Member Davis: So, you want us to simply prioritize which group is more important than that?

Mr. Sherman: I'm challenging you with what you want to look at. In the most general terms with resources that have limits and populations that you're addressing, how do you want to divide the pie. And what is your sense of, and this goes to observation that was made earlier, that we're competing for employees, or an observation that was made earlier about people in state versus out of state, and we didn't even get to it if you leave the country in retirement. And these are the challenges. And what these are offering you are just some specifics. There could be others. But when you think about risk pools, that's just the actuarial term for how you divide up the money. I thought of an extreme example to just hopefully add a little context for this. This is even before my time, but it used to be the plant were rated by the employee, and if you didn't have dependents, you paid the same or shared the same as someone that had 17 children, we used to say, right? And now at least we have a rate structure, and this is decades old, of employees that have coverage just for themselves don't pay the same as employees that have families, and then in your board chair combinations. So, I share that not as a history lesson, but more of a perspective. This is not a new conversation for boards of health plans to think about who pays what. Any reactions to that? Just again, I'm trying to give you some framework if that's helpful.

Member Duncan: Keiko Duncan for the record, I appreciate that. I think we need to sort of reframe how we think about that though. Like most of the people mentioned when we first started this meeting, there's give and take, right? We start with our intent, which is we have a fiscal issue that must be solved. How do we solve that? And I think it's not a consideration of who pays and who doesn't pay, and where do we put the money? I think it's a consideration of Debbie, can you go look at our network? Let's see if this is strong. What's the difference between that same concern and the exchange versus that concern here, will that close the gap a little bit further while still maintaining a high value of service for all of our recipients across the board, retirees or not, right? I would really challenge that way of thinking because I don't want us at all to think like that.

Mr. Sherman: It was intended.

Member Duncan: I get where you're going. I kind of start with this, what is the problem we're actually trying to solve? And that is, we have a bucket of money that needs to be closed. And how are we going to do that? We're going to look through all of these different methods and say, hey, which one of these closes the gaps the best while still maintaining a high value of service. And I think that's really the crux of what we're trying to solve here. So, I would challenge us to maybe think that way, but that's my opinion.

Member Davis: No, I understand what you're saying, and I don't disagree. But I can see the blowback coming from groups saying, well, they said we weren't important enough. We're the ones that are bearing the cost. I see a lot of blowbacks. So, I'm a little bit confused about how I feel about this, but I understand we have to make these decisions. Someone's going to be on the top end and the bottom end. But I think we really have to justify this here.

Member Duncan: Absolutely, I agree. I think there's, Keiko again. I think ultimately, I hate the term winners and losers, but when we talk about subsidization, there are going to be groups that may or may not more or less subsidize the other. And the one that subsidizes them more, I completely understand that feeling. And I think no matter what we pick, our Deputy Attorney General mentioned, we're all on these plans. And so, I think all these decisions we make also affect us. And so having that strong data and that assumption and having the correct information to be able to make the most informed decision, understanding that it is truly going to affect the people's lives around us, including our own. When we're talking about the ways of thinking about this, it's just a valid thing to consider.

Member Davis: No, I'd just like to say something. It seems to me I may be way off base here. In fact, you said that many of us here are on these plans. Does that not provide a conflict of interest? It would seem to me I could be wrong, but I think many members would be looking to see how does this affect me? I'd rather have an independent commission that are not under any of these plans look at this. But that's my opinion. I just think it's how do you not look at your own plan when you're making these decisions? I guess that's what I'm saying.

Member Rich: Laura, for the record, I think this is why the DAG has that disclosure at the beginning. And the DAG may be able to weigh in on this a little bit.

Ms. Crane: The DAG just stepped out for a few minutes.

Mr. Sherman: Oh, maybe we can come back.

Executive Officer Carsten: I would say based off of the NRS statute, you guys are designed to look at that plan with and do in the best, fiscal interest of the state and the employees, which is why you've been appointed. I think if there was to be a change, that has to be effectuated in state law. So, I think to the disclosure, to the point of the disclosure that the DAG made at the beginning, that's why we meet every board meeting with that is to say, yes, we know that you are all participating in one plan or another as a PEBP member, and that you will likely be voting on matters that impact you or your family members. And that's why it's disclosed at the top, right? But I think the board was designed with the specialty positions that you guys are filling. In each of those rules within state law, and so I think that's all been accounted for, and if that needs to change, that's going to have to be something that's outside of this meeting.

Mr. Sherman: I'm going to pivot us back, because I just want to offer the opportunity if there were other board members' reactions or thoughts on Member Duncan's very well-placed comments.

Ms. Donaldson: I add maybe any other items to consider or have any thoughts around changing how the plan subsidizes the employee versus the dependent. I don't know if there's any thoughts or items to discuss here. Yes.

Member Harper: Blaine Harper for the record. I know that that's been a topic in the past. Not necessarily on the agenda of board meetings, but I've been aware of it in the PEBP board context before. And I very much agree with Member Duncan's comments that tug of war type dynamics are not what. But not trying to think in those terms. And that kind of language comes up. I like to think outside of that.

Mr. Sherman: Other board members? I realize we have one board member online. I'm not seeing a hand go up or her come on the screen, but making sure she also gets the opportunity.

Member Grimmer: No, I appreciate that.

Ms. Donaldson: Any other discussion point or any other comments the board wants to make regarding the risk pool topics and any other discussion points?

Chair Wells: I want to make a couple of comments. One addresses the public comment at the beginning. The separation of the retirees at the risk pool would require a statutory change. That is not something the board could do on its own. It would have to propose legislation to actually divide the risk pools in place. Not impossible, but an additional step that would have to be taken. The legislature's role historically has been to provide the funding on the employer side for the plans. The board has chosen the benefits to provide with the money that's been allocated by the legislature. We continually have to think about, will we get more money in this upcoming legislative session, given the other priorities that are going to be out there looking for additional funding? I wouldn't expect a lot of new money or additional money, given some of the things that we know are coming down the pike. So given that, that's kind of where we are. The legislature ruled last time, last session, really, for the first time, they funded inflation at what was asked by the plan. So, they gave the additional money for the inflation that we expected for the current biennium. I think we've been above what was initially projected in the session, but the funding that was approved by the legislature included all of that additional trend. That's going to be hard to do if it keeps in the double digits. It will be hard for the state to continue to fund inflation in this plan without sacrificing somewhere else. And a lot of times those sacrifices aren't necessarily programmatic.

There are other employee-based sacrifices, cost of living adjustments, and the like. We're constantly, whether we like it or not, we're constantly in this competing for dollars with every other program that's out there. K-12, higher ed, other big generator or big users of the state resources. I think at some point, we, the board, is kind of expected to make some of these harder decisions about where do we allocate the limited resources that we get? And how do we provide the best benefits for our members at the lowest cost? I don't know if this is the right answer or not. But I think that at some point we're going to have to do something to vent the

cost curve because I don't think that the state can continue the double-digit inflation every year, year after year. That's a concern.

Member Davis: So, Jim, Paul Davis here. Would you suggest that when you come to these conclusions that we have various options based on what the legislature may or may not do?

Chair Wells: So, I think we need to look at providing the best, putting our best foot forward to the legislature that we've done our due diligence to try and vent some of the cost curves and maybe some of these other creative, we'll talk about in the afternoon and provide some of the context for doing some of that. And the legislature always tries to fund to the extent that they can. But we just have to be cognitive of it.

Member Davis: I just always like to have fallback positions in case something goes awry.

Mr. Sherman: Andrew Sherman in my facilitator role. We had planned to do two of the five before lunch. We had also planned on lunch at 12:15, which is nearly 45 minutes from now. So, we are at a point where we can dive in and do the next one. Probably be at the same time for lunch or have lunch early. Our preference will probably be to dive in. Does that work for the board?

Board members: Yep. Sounds good.

Mr. Sherman: And this is, I think, us and Millman. Check in on Mary Ellen. She's here. Okay, great. There she is.

Ms. Donaldson: Okay. So, there's a longer list, here. Lots of topics, my contracting is over here. Again, a lot of votes with coordination with Nevada Health Authority and Medicaid. I keep saying votes. Sorry. Well, dots, interesting. A lot of interest, audits are of interest. We can talk about that and what that looks like. We also have dots on direct contracting, reference-based pricing, expanding DOEs or Centers of Excellence, direct primary care as well, and point solutions. So, we're going to start off, and Dr. Duncan, the first part is to talk about is your network competitive within the state. So, I think we're going to start off with that, Mary Ellen. If you're ready to go, we'll turn it to the next slide and have you walk through this.

Ms. Vargas: Great. Mary Ellen Vargas, when we look at evaluating the strength of a provider network, there are a few different ways to do that. The first thing that we'll talk through briefly here is what we call a traditional network discount and disruption analysis. What this is trying to assess is the relative strength of the provider reimbursement rates, the network discounts available through different network partners, different carriers, different third party administrators, as well as disruption. So, if you're not familiar with that term, disruption implies, effectively the breadth of the provider network, right? So how many providers are in the network? And of the providers that PEBP members utilize today or have utilized historically, how many of those are in different networks available through different carrier TPA partners?

So that was the focus of this first analysis. A few important notes here, some caveats and some limitations to this analysis. So first being that we did not conduct a full procurement initiative, obviously, right? That's a significant undertaking. There needs to be approval in place to do that. So, this was positioned as more of a request for information. And we use a standardized database, it's called UDS, of discount data that national carriers submit to be used

for these analyses. One of the stipulations of being able to use that data and present it in a public forum like this one is that the results need to be on a blinded basis. So, we know behind the scenes, and obviously if PEBP elected in the future to go through a full procurement initiative, you would have visibility into which carriers, which networks are, you know, offering different levels of discounts and disruption. For this exercise, we're really just comparing relativities. So, you'll notice that we label each carrier, you know, A, B, C, D, and we can see where there are differences or maybe alignment. And what that tells us directionally is whether there are multiple potential viable partners or if the scope of viable partners is maybe more limited.

The other thing that I'll point out that I think is important to note here to kind of set the stage, there is one national carrier that declined to participate in this RFI request for information process that we conducted. They cited concerns over, despite our reassurances that these results would be blinded, they were hesitant to disclose what they consider proprietary network pricing information. I'll talk more a little bit about that when we talk about the second perspective from which we view network competitiveness. But I think we can jump to the next slide unless there are any questions on sort of the process here.

High level results from a discount perspective. And again, these don't show us the actual discounts, but they show us the relativity in average discounts between carriers. So, we approached 4 national carriers that have a presence in the vast majority of states, but all have a presence in Nevada. And like I mentioned, three of the four agreed to be included in this analysis. We set the carrier with the lowest average discount gets a 100% relativity, and then the other carriers we compare from there. So, you can see carriers A&B are pretty similar in terms of their network pricing and their discount strength. So, the lowest, like I said, we set it 100% and then the next closest, which is carrier B, is at about 102%. Carrier C on an overall basis is at about 112%. What does that tell us? That if PEBP were to decide to conduct a procurement exercise, not to say you would necessarily exclude any of these carriers, but this would give you a preview, that of these three, likely only A&B would be able to propose a competitive offer from a network discount perspective. A 12% differential is pretty meaningful. And for context, anyone who is not familiar, when we talk about discounts, that's really the difference between a billed charge, the list price for a medical service, and what we call the allowed charge which is what the plan is responsible for after the claim has been adjudicated and adjusted for any discounts with your TPA or your carrier. Because claims are the biggest component of your program cost, right? That's what we focus on when we are evaluating these networks rather than something like administrative fees. So again, a 10 to 12% difference in discounts translates to a really meaningful dollar amount when we look at total claims. So again, wouldn't necessarily say carrier C would be excluded from a procurement process, but this is indicative that of these three, two are more competitive.

And then on the next slide, this looks at what I referred to earlier, the disruption. So here we looked at historical actual PEBP utilization, and I should clarify as well that we focused here on the non-HMO plans. We have an analysis and we could share as a follow up if there's interest in that information on the Health Plan Nevada utilization run through these broad national networks. But to be on more of an apples to apples comparison basis, we focused on the plans that are administered by UMR today when comparing to these broad national PPO networks. So, of the providers that PEBP members are already utilizing, about 96% of them are in network with carrier A, and, just under 98% of them in network with carrier B. A slightly lower percentage at around 95%. in network with carrier C. So, the network penetration is strong for all three of these carriers. This indicates, when we think about this in conjunction with the discount information, carriers A&B, when you combine their network penetration with their average discounts, collectively, potentially could offer a competitive proposal if PEBP

went to procurement for plan administration. So, this doesn't necessarily say a procurement should be conducted. It doesn't necessarily say what the outcome would be. Again, there are vendors that didn't participate in this analysis. But at a high level, this just tells us it may be something to consider going forward and exploring if this hasn't been assessed in several years. It's also important to note that provider networks are kind of living, breathing things. They're always changing, evolving. Renegotiated contracts are a regular occurrence, especially every few years. So, these things can change, even if, you know, very similar analyses have been done. Historically, we do sometimes see things shift over, three to five plus year time horizons.

Ms. Donaldson Okay. These topics are a little bit heavy and so I'm going to continue on unless somebody stops me. So, one of the things that we've done is we looked at repricing claims, taking all the claims of PEBP during a 12 month period, historical 12 month period, and we reprice them to say, what are those claims as representative as a percentage of Medicare? There are a number of state entities that either has had legislation recently or has looked into, and this a lot of times is called reference-based pricing. So, this is what we're calling reference-based pricing. A number of states have had legislation. My own state, Colorado, had legislation last year and they tried to pass reference-based pricing. One of my other clients had it and they did get it. It is implemented in their plan in their state. And so, the question is, there is meaningful savings that we have found in incorporating reference-based pricing. There's pros and cons to that. The hospitals don't like it, obviously, because you're cutting the reimbursement rates. And so, what we're showing here and what I've typically seen in a number of states is really focusing on inpatient and outpatient.

So, one of the things that is shifted dynamics in healthcare, if you think about, gosh, you're going to the hospital, that's the expenses. And it is because maybe the intensity of care. But when we look at the cost as a percentage of Medicare, they're lower on average than what we're seeing on the outpatient side. Particularly the shift of services like surgeries, from inpatient to outpatient, that used to be a savings to the plan. It's no longer the case these days. And so, we're seeing costs similar to what they used to be on inpatient, now on the outpatient side for surgeries. And percentage of Medicare, you're seeing it. So, for your membership, we're seeing, inpatient represents 16% of allowed costs. The percentage of Medicare is 164%. Outpatient is about 40%. This includes ER, other outpatient services. This includes medications provided more intravenously on the medical side, a number of other services. That's 40% of your allowed cost. The percentage of Medicare is 262. If you combine inpatient and outpatient, it's 223% of Medicare. Now, there is potential savings limiting the amount of reimbursement provided from hospitals, but it comes with a battle. I'll just share. It's never an easy thing to do. I haven't seen, and I don't know if you guys have seen, and Mary Ellen, please step in. I yet have seen professional services incorporated into reference based pricing. Have you seen that, Mary Ellen, in your experience with other states?

Ms. Vargas: Not broadly. I would agree.

Ms. Donaldson: So typically, I've seen the focus again on inpatient and outpatient. This is looking a little bit more. We've broken out the cost from Northern versus Southern Nevada and then out of state. The story here is that this is the combined inpatient, outpatient facility. Northern Nevada is more expensive than Southern Nevada. So, depending on where you set potentially, if you're going to set the threshold at 200%, let's just say for giggles, Southern Nevada is pretty close right now, probably not much savings. In Southern Nevada, your savings are going to be coming from Northern Nevada hospitals. Just sharing that. Again, we're showing

the dollar distributions. Again, outpatient from a distribution has the higher dollars associated than inpatient. And then we're showing the differential in outpatient facility. Dr. Duncan, here's your outpatient facility out of state 331% of Medicare, 2.6% of members are out of state. The question is how many retirees are out of state? And probably most of them, right? That 6% is probably mostly retirees.

Member Harper: Blaine Harper, for the record. Clarifying question. Number of claims, there are triple the claims in Northern Nevada compared to Southern Nevada, is that accurate?

Ms. Donldson: Yes.

Member Duncan: Keiko Duncan, Is that because of population spread though, or is that really like the same population spread?

Ms. Donaldson: The members who are utilizing services in Northern Nevada. So, this is just the number of claims.

Member Viton: Does the percentage column match the number of claims column?

Ms. Donaldson: Oh, this? No, this is dollars. Oh, oh, no allowed cost. This is a percentage allowed cost.

Member Viton: That's what I wanted to say. Sorry.

Member Rich: Laura Rich for the record, I think what Keiko was asking is, do we have a larger population in the North versus the South? And I don't think that's the case.

Ms. Donaldson: That's not the case. They're just generating more claims. Which is a really interesting point, right? There's other potential things to explore there.

Member Duncan: Okay. That's what I was trying to get at. I think, to have that big of a spread, that tells me, network care, care management, utilization. I think there's a lot of other things here.

Ms. Donaldson: Yeah, there's a lot more to unpack for sure.

Member Davis: So, if you don't mind. Paul Davis. What's your analysis for this huge differential on the amount of claims between the North and the South?

Ms. Donaldson: I haven't looked at, we did look at risk scores at one point, and I don't remember offhand, but depends on the risk scores of the members, like do they have more conditions in the north versus south? And I don't remember that off hand, but we can get to that information. There's probably a number of influences which is generating this, not just one isolated influence. It could be risk score, could be how care is being offered and quality of care. Could be procedures that the doctors are ordering, there could be a number of circumstances.

Member Duncan: And just to clarify that, Keiko Duncan the record. So, this is a member area, So if the if the member is lives in Northern Nevada and say they received care in Southern

Nevada because there was specialists that they needed to go to, is that reflecting here as a Northern Nevada percentage because that member area is Northern Nevada?

Ms. Donaldson: It's by member area. So, if they went to see service, they're going to be considered North. That's correct. Their issue for that is because, based upon how claims are coming in, we get codes of providers. But sometimes the tax IDs or the provider codes aren't specific to that given northern versus southern region, if that makes sense. And so we went by member versus by the provider tax ID because of how the information is given to us can be misleading. Yes.

Executive Officer Carsten: Talking about member area, are you splitting the state in half? Like, how did the rurals get counted in that? Because I think to Dr. Duncan's point, that'll probably help. That's probably part of that.

Ms. Donaldson: We've done some analysis for you before; we've split up north and south.

Executive Officer Carsten: Is it fair to say, because a lot of rural members are going to be directed south or all over the state, really. And so, if they're rural area was considered in that Northern Nevada hemisphere, then that might be part of the 66%.

Ms. Donaldson: It could be, yes, because again, it's based upon where the member lives, but if they're using services in the South, this number of claims is going to be considered North because that's where the member lives. If they're using services in the South, the member resides in the North. The claims and all the data we're showing is based upon north versus south.

Member Duncan: Keiko Duncan for the record. I wonder where that table is relevant then. Because that that told me, not really even a network problem, I guess. I think there's a lot of other things there that could possibly be the barrier to affecting that. I think the cost differences and the percent of Medicare and the way the dollars are distributed. I think that maybe that tells a little bit more of the story specifically. As a complete aside from this specific conversation, I think that's maybe a little bit out of what this this conversation is. I think that it poses some questions about service adequacy. So not even like network. Where is the care happening and how is that management being coordinated and things like that? Maybe it might be of concern for this conversation over here.

Ms. Donaldson: I think the big takeaway too is just looking at the percentages of Medicare and the reimbursement there. We did see in the north. that there were three hospitals with combined facility reimbursements of 400% and over. Obviously Southern, this is nothing new, Southern Nevada had the lowest reimbursements as a percentage. And we've seen in general in doing this analysis, in the more rural settings, the percentage of Medicare is much higher. In comparing urban versus rural, I've seen in a number of states, including yours, much higher percentages in reimbursements, facility, hospital reimbursements in the rural areas compared to the urban. We did see the impact of Carrum Health, which is a point solution, which is something we're going to talk about later. We did see some positive effects from a pricing standpoint for those facilities which were engaged with Carrum Health. We saw some meaningful reductions in percentage of Medicare compared to similar facilities that were not engaged with Carrum.

This is breaking things out in more detail, inpatient by services and then outpatient and what's generating that 262%. So, as you can see, ER, no surprise to everybody, that's one of the more expensive sites of service to get care. Percentage of Medicare is just shy of 500%. Helping members, and we can talk about this direct, making sure they're going to the ER for the right reasons. We did some analysis on that. It looked overall that there are members that are going to the ER from one of those higher level conditions. There's potentially some noise of avoidable ER utilization. But we're also seeing those, I'll just remind everybody, there are freestanding ERs in Southern Nevada, and they're typically backed by private equity. And we have seen it systemically in a number of states where they tend to push to the higher coding of condition, the level fours and fives, and they tend to have higher costs than other ER facilities. Another thing that's breaking out, but again, we have to look at the percentages as well. And dialysis, it's only 1% of total allowed, but the percentage of Medicare is really high. So, something to think about is, do you direct contract? You know, if you're going on to dialysis, are there certain facilities that you could direct contract with to make a deal to drive your members to certain facilities?

The other area is again, PT, OT, that's physical therapy, occupational therapy. Hopefully I got that. 516% of Medicare, there's a lot of point solutions out there where you can do some of those things from the comfort of your home with direction of a provider and a therapist online that can really help save money. And that's going to get in our conversation this afternoon about point solutions, but we've seen some good savings and other plans when we've looked at and done an analysis and they've had high outcomes. That's something to think about. I should say high member satisfaction outcomes. I'll say we've seen positive outcomes from members who utilize those services. You already have Carrum right now, so we'll talk about that later, about potentially expanding that. This again is professional and ancillary. I think we can move on to The next slide. I think I covered most of this. Again, outpatient is higher than inpatient. Yes.

Member Rich: Can you go back one slide? Something interesting to me. The 92% for mental health. I've heard it over and over, we've got a shortage, we have a shortage of professionals in that mental health category, and access to care is so hard, yet we're paying them less than what Medicare is paying. So, can you speak a little bit about that?

Ms. Donaldson: Yeah, it's 8% of allowed and I don't know if you have contracts specifically, or if there's some kind of contracting that UMR has. It's definitely something to investigate, but I hear you and I don't know as well. That we could look into, I think. There's online services as well. And I don't know if that flows through UMR claims. I think we need to look into that because those tend to get reimbursed at a lower or sometimes. And so, but you're right, that is lower.

Member Rich: We're not advocating to pay more for services, but mental health is obviously such a problem and we have such a demand for mental health services. So that just is surprising to me.

Ms. Donaldson: PEBP do you have any comments or anything you want to add?

Executive Officer Carsten: We were asking if the Doctor on Demand claims were part of that. Because that goes to your online.

Ms. Donaldson: I know, I don't know. I need to look into that, please.

Executive Officer Carsten: Because right now, PEBP doesn't have access to pricing information for contracts that UMR holds. We could definitely ask about that, but we're not currently aware of the status of those.

Ms. Donaldson: Worth a little bit of investigation and exploration. Thank you. OK, how are we doing?

Mr. Sherman: You're at about twenty-six minutes of an intended 30 on presentation 3. I think we're pretty good. So certainly 5 minutes fits the schedule.

Ms. Donaldson: Did you want to address this slide or do you want me to talk about this is coordination with the Health Authority?

Executive Officer Carsten: Oh yeah. We, in the last year, talked a little bit about this. So, the Health Authority was established and PEBP was placed under the Health Authority to take some of that leverage in coordinating care and contracts to increase the number of lives and spread the cost and hopefully get better deals for certain contracting. So, I think in the next year or so, we'll be coming to the board and asking for either delegation in authority to have and NVHA and PEBP related combined RFPs, similar to our pharmacy benefit manager possibility solutions. And then again, I think the director has shared with the board that she's having Milliman do some analysis stuff. And once she has those results, she will bring that information back to the board and talk to you about any future RFP coordination that might cross over. And so, some of the things that we've talked about are standardizing, you know, networks, possibly combining key pharmacy benefit manager scope of works, and then various things that are listed here related to the possibility of direct contracting. So, when we talk about direct contracting later, that's not something that our PEBP office is set up to run, but it might be something that the Nevada Health Authority can expand into because they already have some of those infrastructures built up through Medicaid. And so that's always a possibility of piggybacking off that as well. Did I capture all that?

Ms. Donaldson: I think you did. And on the next slide, just gives them things of consideration with the coordination that they're going to be looking at some of these things over time, but more to come. These are a couple of areas just to think about as the Health Authority is thinking about ways to save money. But those are probably a couple of years out, I would think. So, there's a bunch of other things on this program on this list that we can definitely talk about. We talked about point solution vendors. I mentioned a couple, Carrum. There's a lot of other point solutions that we can think about, maybe helping some PT, OT kind of support, and then audit. Not to put you on the spot again, but we had a lot of discussion yesterday about audit, so PEBP does audits, but do you want to talk about maybe some other kind of audits that you guys have been talking about internally and thinking of exploring?

Executive Officer Carsten: Yeah, so I think currently PEBP has a contract with Claims Technology Solutions, CTI, to perform audits on our PBM, ESI, and UMR services for claims reviews. Now, when you guys read those reports, you'll see that there's a small subset of claims that are being audited on a quarterly basis. So, it's by no means going to capture fraud, waste, abuse of every claim. There are some other states that have audit entities in place that look at that from every claim level kind of a solution. And I think Member Rich could speak to at the Teachers Health Trust; they have a product called Smart Light and that's using an AI engine to

review claims as they come into the system and then trying to go back and recapture money that they think was inappropriately paid to providers. So similar to that product, PEBP and the Health Authority are looking to work with a vendor that we already have under contract doing similar work with Medicaid to see what it might cost. There's always a cost, right? But right now, they're willing to do it on a contingency basis, which basically means that for a percentage of funding that they can recapture through claims assessment, then they would do the work for a percentage of whatever they recover. So, it wouldn't be exactly us trying to find money to generate that audit vendor, right? And so, we have to be really careful, right?

I heard Debbie say to me yesterday, are you interested in getting another vendor? They can get another vendor or increase vendor services. It's always going to cost more money, so we have to be careful about that. So, this solution that we're going to try to implement in the next year will be helpful because they've agreed to do that on a contingency basis where other vendors needed to be paid up front. So, we just don't have the authority to go contract that. But I think Member Wells was speaking to me yesterday about some auditing services that have had, back under his era, where they were more intense, I believe, and more coordinated and ran through. So, I think as you guys talk about contracting, if we need to strengthen the services that we already have. Then we just need to identify in what ways we want those strengthened so that that PEBP staff can get a cost proposal to see what that change might increase in our costs. And what savings might offset there, so we'll have to do some sort of analysis if you guys come back needing additional audit services.

Ms. Donaldson: Mary Ellen, any additional comments that you would like to make on these topics?

Ms. Vargas: I would just quickly add on the topic of direct contracting with specific hospitals and providers. I kind of alluded to this when I talked about our traditional network analysis that there's another lens from which we look at network strength. I won't get into all the details. But if you're familiar with some legislation that passed at the federal level within the last five or so years, plan administrators, so carriers, TPAs, health plans, payers, we group them in as payers, as well as hospitals are now required by federal law to submit what's collectively known as price transparency data. That data is publicly available. There are many challenges that come with interpreting that data, but that's one of the analyses that we're conducting on behalf of the Health Authority. So just thought it might be useful to share. We have only really preliminary, higher level findings at this stage. We're still exploring further. But there is indication. So again, this is distinct from the traditional network analysis that we did where results are blinded. With the price transparency data, it's all publicly available information. So, we can see who each of the carriers, networks, payers are. We can see all the hospitals and all of their published rates. We have a process for normalizing all of that to get it on a standardized percent of Medicare basis, similar to the analysis that Segal presented. And we find that broadly, the United Health Group, as I'm sure will come as no surprise, does have strong provider contracts in Nevada. However, there are select hospitals, providers, health systems, where other carriers, other networks might be more competitive. For example, on the inpatient side compared to UMR. Or there might be more competitive outpatient rates available. There are certain hospitals where we find even outside of the southern part of the state that the Sierra Care Options Network is more competitive than the broad Choice Plus UMR PPO network. So, some nuances that we're exploring further, but we do think there could potentially be a case for evaluating some of these direct contracts. I just wanted to quickly provide that context that it is something that we're evaluating in more detail.

Mr. Sherman: So, I think we're right on track to have 15 minutes now for board member comment and discussion. So, let's aim for 12.30 to take a break. Okay, so coming over here in Mary Ellen, stay close by. This is your initial dot placement. And I think a lot of that has been reflected in the discussion. So, a lot around audits, a lot around health authority and coordination. And I want to come back over here. That's where we were the least specific in our savings and time horizon analysis, because it's, I think, a lot of unknowns but we think that has the potential to be significant. You all on the first pass kind of did too. Interestingly, on your first pass, and then I'll be quiet and let you all talk, There weren't a lot of dots around Direct contracting or seeking a new claims administrator. OK. Board members.

Member Rich: I'll start Laura Rich, for the record. I'm looking at the potential savings and so the things that catch my eye obviously are the ones with the more dollar signs. Can you guys maybe provide some more information about the CMS piece. That's something that I don't think I've ever considered or been aware of and maybe the board would benefit from hearing what that looks like.

Ms. Donaldson: Are you talking about the Ahead model?

Member Rich: It's the coordination with CMS programs or something like that, something along those lines.

Ms. Donaldson: I think there's some things that we, again, have mentioned to PEBP and to Health Authority, but some of this stuff is being looked at today already with the combination of Milliman and Health Authority. But the Ahead program, it's looking at aligning and we've talked about this, right, aligning the Medicaid and commercial payers with Medicare to help reduce that fragmentation, but also being able to negotiate more globally on that, and I think that's something that they're considering, and it's really using the strength of both programs in order to provide contracting broadly with both. I think there's some waivers and I believe Nevada applied for this waiver, Section 132. It's really approval to waive some certain ACA requirements. And so, I think that was implemented in January of 2026, and that's already being implemented. And so, that piece has already been done. And then there's the Section 115 that the HSA Secretary can approve pilot programs that assist in promoting objectives of the Medicaid program that could potentially help the overall program as well.

Member Rich: Do you know of any other states that have a health authority type set up, like Washington or New Mexico that have leveraged any of these? I know the New Mexico Health Authority is fairly new too, but Washington has been in place for a while.

Ms. Donaldson: And Mary Ellen, I don't know if you can speak to Washington. I'm the actuary for a number of the New Mexico plans. I'm not aware of them doing this, not to say they're not doing that on the Medicaid side. Kind of a different situation.

Member Rich: They're not leveraging Medicaid on their public employment plan?

Ms. Donaldson: They're not doing that today, no. No, they have not done that. They've kept it separate, very separate. And to this point, they procure separately. For their contracts, everything is separate up to this point, but Mary Ellen, anything to add?

Ms. Vargas: Just that for Washington my understanding is that relatively new, within the last year or two, they are starting to leverage some of this cross program efficiencies that we've thrown around for Nevada. Specifically, I'm aware of some between Medicaid and the commercial market, which the state employee plan also leverages. I'm not sure explicitly if it's through a 1332 waiver, but they did implement and are assessing the impact of some pilot programs that try to get at some of this coordination across programs.

Ms. Donaldson: Maryland has been in place for a while and we're the actuary as well.

Mr. Sherman: I was just watching the clock.

Ms. Donaldson: Okay. So just real quick for Maryland, they do some things, but they set things differently. Their reimbursement rates are higher, but they leverage similar contracting, but their reimbursement rates are different and set differently.

Mr. Sherman: I think we want to come back to this, but I'm going to come back to the chart and observe something else, unless other board members want to comment on this at this point. So, in these couple of minutes here, I wanted to draw out that there aren't any dots for near site clinics.

Member Rich: I can speak to that and why my dot wasn't there.

Mr. Sherman: I realized that we didn't even touch on it. I didn't want to miss it at this point in the conversation.

Member Rich: Laura Rich for the record. PEBP actually went down this road. I can't remember the 18, 19, something like that. It's difficult because we have state employees everywhere. And so, you put a near site clinic, you got to figure out where is that near site clinic going to go and who do you serve? And in Las Vegas, you probably have to have 20 near site clinics because nothing's going to be convenient. So that was one of the problems. The other problem was that the primary care was not necessarily our problem. It was more specialty. And so, what were we trying to solve for?

Mr. Sherman: Okay. Wanted to bring that out. Any other comments? Okay. Centers of Excellence got a dot, direct primary care got a couple of dots, reference-based pricing got a couple of dots. All things, but again, here most of these aren't big dollars and little more time to implement. Just to give it a little more grounding. The ones that have more dollars are the ones that were talked about in coordination with the health authority or around direct reference-based pricing or contracting with specific providers. Again, that's just things as we go forward.

Member Harper: What sets the timeline regarding reference-based pricing at greater than two years?

Ms. Donaldson: Thank you, Debbie Donaldson. From my perspective, and it depends on each state, so I'll lean on maybe Jim for insights, but many times this needs to be legislatively approved and going through legislative session in order to get it passed. I don't know the rules specifically. New Mexico, they were able to get it passed without legislation. It came from the

governor's office. And so, it just depends. I'm not sure what the protocol here is. So we said two years because sometimes it does take a couple of years once it goes through legislation and then negotiation, making sure the hospitals, updating systems and all that good stuff just takes a little bit more time. So, it could be shorter.

Mr. Sherman: Trustee Grimmer, I wanted to give you the floor if you wanted it.

Member Grimmer: I'm good, thank you.

Mr. Sherman: Other board members? This is some good initial direction. I think when we come back and do the second round of dots, we can get your sense a little more. And I think there's going to be plenty more time for discussion. But we're even a little ahead of where we thought for 12:30. Thank you, Chair Wells.

Chair Wells: With that we'll take a break. Let's restart at 1 o'clock.

Member Davis: Restart at what?

Mr. Sherman: 1 o'clock.

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Chair Wells: We'll get the meeting back to order. And turn it over to Andrew and Company for pharmacy.

Mr. Sherman: Thank you, Chair Wells.

Ms. Donaldson: And checking is Mary Ellen back.

Ms. Vargas: Yes, I'm here and my colleague Kali is with me as well. She's our pharmacist that will touch on some of these topics too.

Ms. Donaldson: Oh, wonderful. Great. Okay, super. Okay, so I know we have GLP-1 in a couple of spots. We presented and we'll refresh you on some slides we presented in the May board meeting. But there's potential considerations for helping manage the cost. And just to remind everybody and set the stage that GLP-1s are offered to members with a diagnosis of diabetes. GLP-1s are not offered in the plan today with members with anti-obesity, so the Zepbound and Wegovy associated with weight loss is not offered on the plan to members. So, we'll talk about some GLP-1 management solutions, some specialty drug management solutions, and GLP-1s are brand drugs. Just to clarify, they're not specialty drugs, they're brand drugs. So, we will talk about specialty drug management solutions. We'll talk about direct rebate contracting, narrow network formulary, narrow retail, point solution utilization management, then some plan design options. And you can see, depending on how far you want to go in some of these areas, particularly as far as managing, right? How tight of a management you want to be and some of the PA, prior authorizations around getting some of these medications. You could get minimal to somehow meaningful savings. And again, the time frame on these are one to two years. We put two years here for point solution utilization management because many of those would potentially require having to go out to an RFP. And so that just takes some time to make sure you're finding the best partner and carrier to help with that point solution. And so that time frame is a little bit longer. Direct rebate contracting is two years because it's just the time it takes to contract. Yes, sir.

Member Davis: Obviously, the bringing out Medicare supposedly reduced the cost to $100.

Ms. Donaldson: Sorry, say that again.

Member Davis: For the GLP drugs, that Medicare has dropped it to about $100 supposedly.

Ms. Donaldson: I've not heard that, but Medicare has issued for the Medicare participants, which is called is the Bridge Program, which was effective July 1, 2026. That's for anti-obesity medication solutions. But there's criteria you have to meet in order to get those drugs. And that's happening effective July 1. It goes through December 31st, 2027. There is some potential, and feel free to step in, the pharmacist in the room too, to help supplement. But there is also potential with that. It's the MFP list, which is the manufacturer. So, Medicare negotiates drugs. So, 2026 was the first year they negotiated like 10 drugs. 2027, there's 15 drugs and some of the GLP-1s are on that list. So, the Novo Nordisk products, which are Ozempic, for example, is included in that list for negotiation. And you are right. I don't think it's down to $100, but the cost of the drug is being significantly reduced.

The question is, how is that going to translate into commercial plans today, right? So, on average, the cost of these GLP-1s, depending on the dosage, could be anywhere from $1,100 to $1,400 prior to rebates. Now, the rebates on these drugs have been, and I'll air quote, meaningful. So maybe there's a $500 rebate on these drugs, for example, that net cost is still much higher than potentially what the negotiated price is on these MFP lists for Medicare, so that those drug lists as well. So, more to come and I think things are happening right now. And Lilly, who has competing drugs with Novo Nordisk. We haven't heard, there's talk, but nothing's come out definitively. We're anticipating, again, would like your input, but we've heard that potentially things are going to be more clarified in the fall. And hopefully, we're hoping by 1-1-27, but unclear right now. Lots of conversations between those drug manufacturers right now.

Member Davis: They've already come out with a pill form

Ms. Donaldson: They have a pill, but it's not a savings in cost. Because they can. Anything you'd like to add, Milliman, from the pharmacy perspective?

Ms. Schweitzer: No, I think you covered it all really well. That's exactly what we've been hearing. I think there's probably more to come. A lot of the lower price quotes that you hear advertised in press releases in the market tend to be for direct to consumer pricing options versus going through the plan, those prices are different. So, while they're offering these lower prices through things like TrumpRx and other direct to consumer options through the manufacturers, those same lower costs aren't directly available through, the pharmacy benefit managers.

Ms. Donaldson: Right. Thank you for that, Kali. Is that how you pronounce it, Kali?

Ms. Schweitzer: Yes, yep.

Ms. Donaldson: Okay, good. So, we have seen a number of entities looking at, do we just pull these drugs out and have them go direct to consumer because the cost right now, direct to consumer, as Kali said, is at a much lower price point. And then do we give, if they do the certain things, maybe we'll give them some HRA dollars to help ward off the cost. And that's where the point solutions comes into play. But those could be savings alternatives to the plans for sure. But we're going to talk about some of the other point solutions and other options. So, let's go on to the next slide. This is just highlighting what your plan designs are. So again, for generics, the co-pays are fairly minimal, $10 for a 30-day supply. The brand drugs are

$40 for a 30 day supply. I should say preferred brand formulary, your specialty drugs. There's coinsurance for a 30 day supply. It's 30% after deductible. There's a min and max of $100 to $50 max. So, I think your plans in general, from my perspective, they're generous plans. They're good plans. They're good pharmacy plans. I've seen other state plans with co-pays much higher than that. I'll just add. So go on to the next slide.

This maybe looks like it's hard to read. So, this is the spend. So, your pharmacy spends about $115 million. There's about a 14% increase year over year. Your top drugs are your GLP-1s, your Mounjaro and Ozempic, followed by Dupixent, Stelara, and Humira. These last two have had what's called biosimilars come into play. So, these drugs, these biosimilar drugs that are coming in are at much lower cost. And I know Dr. Duncan and the newly, we have an extended contract for two years with ESI. We had lots of conversations about the biosimilars and making sure we're getting the right discounts and the right adjustments to rebates associated with these medications and continue to have conversations with ESI. Again, on the next slide, Mounjaro, I just want to say is one of the top spend, but when we look at disease indications, diabetes is your top disease indicator. And what's driving that? That's your GLP-1 drugs driving that. Followed by autoimmune psoriasis, oncology, and skin disorders. I'm going to talk about the psoriasis and skin disorders a little bit later as we talk about point solutions. But just know that those are top disease states. Even though there's a lot of conversations today, and it's in the news so much and across the country about these GLP-1s, we don't want to lose sight of some of these other specialty drugs that are also driving spend for your plan and things to consider. Okay, moving on. So, I'll turn it over to Milliman to walk us through these slides.

Ms. Schweitzer: Great, thank you. This is Kali Schweitzer for the record. So, building on that background, I think that sets the stage really well for these next few slides and what we're going to be talking through. I think for these next few, we really wanted to focus on providing a detailed breakdown of all of these different actions and solutions under consideration. Touching on why they matter, what they are exactly, and potentially some of the trade-offs that can come with each of them. So, I split these into 3 broader categories. So, this slide will be focused more on the clinical and utilization management side of things. Then we'll get into narrow formulary, narrow network, and then we'll talk through direct rebate contracting, and co-pays.

So, starting here, I think as mentioned, those GLP-1s obviously are a top spend driver right now for PEBP. And they're a hot topic across the market. Definitely one of the top spend drivers across all clients that I work with. So, because of that, that makes them a major focal point and opportunity for potential solutions that can help to make sure that their use is aligned with the evidence, aligned with the label, and also help to reduce potential avoidable spend that can occur in this space. So, for GLP-1 management solutions, there are a lot of different flavors of this out there. This can range from solutions offered by the PBM, whether that be just limited to enhanced utilization management, so more stringent prior authorization criteria. A lot of the PBMs out there also will offer their own GLP-1 solutions. So that's like a point solution, but the PBM offers it themselves. So that'll include things like education, tracking, talking about lifestyle modifications. And outside of the PBMs, there also are a lot of vendors out there, independent vendors that offer similar programs where they're really honing in on this population and providing them all the support that they need to be adherent to these medications, take them as intended and make sure that they're receiving the intended outcomes that come with these medications. So, for the diabetes GLP-1, that would be

tracking their diabetes or their blood sugar, is their blood sugar under control? Is their A1C looking good? And are they taking the medication as prescribed and as intended. So, lots of different options for what different GLP-1 management solutions can look like. And really, these are just intended to better manage this population that right now is really driving costs and having adherence problems. I think we're seeing that across the market. There are a lot of adherence concerns with these medications due to some of the side effects that are associated with them. So, these solutions are really twofold intended to help control costs but also make sure that those members are getting the maximum benefit that they can out of these drugs.

Of course, there are trade-offs that come with some of these solutions. The most simple option, which is your enhanced utilization management, more strict prior authorization criteria. The trade-off there tends to be reduced rebates on these drugs. So, the manufacturers tend to be a little bit more restrictive and take away some of the rebates depending on if you're significantly more restrictive than the label. So that is a consideration. And then with both the PBM offered solutions and these external vendors that are out in the market, these generally come with your program fees. These are typically on a per engaged member per month type of basis. And that is charged for all those services that they are providing. Of course, they do generally quote savings that come along with that. So, it is weighing your option. The main thing with these programs, especially those that are external to the PBM, that again, are similar to some of the other things that have been discussed today, would require a procurement process to evaluate those different vendors in the market. Before I move on to specialty or point solution, any questions so far?

Mr. Sherman: Andrew Sherman here with the time checks that we've got. We're halfway through this segment and a whole bunch of slides left. So, I'm going to say maybe 5 to 6 minutes more for the Milliman piece. If that works, we can certainly come back if there are more questions or extend the time but just try to keep us on.

Ms. Schweitzer: Yep, thank you. So, these next two, I think specialty and point solution cover similar themes. So, I don't think we need to go through each of these specifically. As we saw in prior slides, specialty drugs outside of GLP-1s remain a major, major spend driver. So, there are a lot of vendors and different solutions out there that can help manage these conditions, whether they be broad across all specialty or limited to specific disease states like skin conditions or oncology. And these also come with similar trade-offs as the GLP-1 programs we just mentioned.

So going to the next slide, these next two are more of your narrow formulary, narrow retail network strategies. I think these are pretty self-explanatory in terms of what exactly they are. The narrow formulary really helps to limit that preferred drug list, limit that formulary to fewer options in order to ideally drive better rebates on those drugs while also improving predictability of that pharmacy net cost. The main trade-off here is that members, of course, may need to switch medications. So, a lot of transparency is required there on transition rules and communication. There also is potential here for increased volume of formulary exception requests for those drugs that are no longer covered on a more narrow formulary. And then from a narrow retail network perspective, this essentially limits the network to a smaller set of preferred pharmacy partners. So essentially, coverage is restricted to those pharmacies, which does have potential to drive up savings, but there's, of course, disruption risk associated with that. Members who utilize a pharmacy that is no longer included in that narrow network may,

of course, experience some disruption, have to make that change if they want to avoid high member out-of-pocket costs.

And then moving to the next slide here, we've got our last two topics. The first one is direct rebate contracting. So, with this one, the main goal that comes with direct rebate contracting is really to increase transparency from what's in place today. So even with your current contract which has pass through language stating that the PBM has to pass through their rebate revenue. There's still relatively limited transparency, and that structure can also at times reduce flexibility and coverage decisions. Like if you're trying to cover certain biosimilars, for example, or other drugs, there may be some limitations going through the PBM's controlled rebates. So, through direct contracting, the goal here is to work basically directly with the manufacturers to negotiate those rebate terms, have more oversight into what exactly those rebate terms look like and how the financials look, which really can help to improve transparency and alignment. The main tradeoff with this is primarily the increased administrative complexity. As you can imagine, going direct to manufacturers, especially a number of different manufacturers, requires a lot of infrastructure and effort internally to do those negotiations, maintain the records, maintain governance over the data. So definitely a tradeoff there.

There are also hybrid options out there that some do. They may do direct rebate contracting just for certain drug classes, like going out and contracting for just a certain drug class is definitely an option. And I think, of course, an alternative option to direct rebate contracting to help improve transparency is just improving contract language around rebates. So, making sure you're getting full reporting of all of the rebates that the PBM is getting from manufacturers on behalf, making sure they're passing through all of that. So of course, something like that, again, would require more of a procurement process to assess and pursue stronger language in the contract around rebates, but a few different options in that space. And then lastly, co-pay plan design changes. So, as mentioned, I think your co-pay design definitely looks good compared to the market. I think the main goal here with making any changes in this space is really to help steer utilization toward those preferred products. Potentially, avoiding some of those higher cost therapies and targeting those high value therapies with a goal of driving lower costs ultimately. Of course, there are trade-offs here as well. It certainly can be disruptive to members. Those higher out-of-pocket costs may at times create affordability pressure. So that is always something to keep in mind when making changes like that.

Ms. Donaldson: Thank you, Kali.

Ms. Schweitzer: Of course.

Ms. Donaldson: Okay, let's go on to the next slide. We're going to dive in quickly here. And I may fly through some of these slides, but just a reminder, we presented this in May. GLP-1 users, $15 million of spend. You have just shy of 1,800 members who are utilizing GLP-1s in the membership. That's an increase of 273 from the prior years. Mounjaro and Ozempic are the big ones. Those are the two big GLP-1s that you're hearing about these days. Let's go on to the next slide. We looked at to see, are we seeing savings from members who are taking these GLP-1s, right? And so, we're looking at members the year before treatment, year after treatment, comparing members who are adherent to their GLP-1s versus those that are not. And the bottom line is this, because today the cost of these GLP-1s, we're not seeing savings.

And in fact, those members who are adhering to their GLP-1 medications, we're seeing higher spend in total than actually those who are not adherent. So, pretty big cost differential here. And so, we're not seeing that. I think a little bit we're seeing lower cost on the medical side, but not enough to overcome the cost of these GLP-1s today. So going on to the next slide. There's other drugs that you can use that are out there that we want to talk about. So, having a PA associated GLP-1s, just want to share, there are other drugs that are affected that members could use potentially that are much lower in cost and have been affective for years for members with diabetes. The GLP-1 are just the new sexy drug. But they do great things. Don't get me wrong. They're doing great things. But they right now are coming at a cost.

These are plan designs that we presented in the December board meeting that were not approved. I'm not going to go through these, but we did look at various alternatives of changing co-pays, changing for the different options, changing how your plan designs direct members to making sure they're using formulary drugs. And so, you can see the cost here, not much of a savings there. And again, the second page is just some additional plan designs to be priced out for that December board meeting that the board did not approve. So, in this, I was talking about third-party vendors. So, this is a new thing that's being generated in the industry. Similar to third-party vendors on the medical side, we're now seeing third-party vendors within the pharmacy space. And so, what they're helping to do is help it target some of that high pharmacy spends, like skin conditions, as an example. And so, they're helping them go through more of the PA process. The PBMs today, there's not really that management per se in some of these medications. And there's a lot of medications that you can see all the commercials, right? All the ads for the new skin conditions, and they're really pricey and they're really expensive. Do they have to jump to those expensive medications today? Maybe not. There's other lower cost effective things. Providers if they can, they're going to potentially script out those newer more expensive sexy drugs. And so, there is potential and we have seen some good indications from clients who are going to these specialty drug management third-party vendors and seeing good outcomes, good savings. But to Kali's point, this is something you'll probably have to go through an RFP in order to capture. And there's also options there. There's apps and telehealth that can help support the member through this as well. So on to the next slide. Is that it? That's it.

Mr. Sherman: How's everyone doing? We're still ahead of schedule. I'm going to try to keep us on our 30/15 to leave time for the end. We are over here at pharmacy benefits. And before I open to questions, I just want to know, plan design didn't have any votes initially. Narrowing the formulary looks like, well, there's one that's on the line, but I think it's both. Narrow retail networks is on the list because it is something that was talked about. I know very few plans are using narrow retail networks. Savings don't seem to be there. So, to start the conversation, any comments on the ones that didn't have dots before we move to the ones with dots?

Ms. Donaldson: I just want to add something. On the GLP-1 management solution, just an idea to consider. I'll get the Kaiser example, right? So, Kaiser today, their utilization on GLP-1s is very low. They have a PA process in order to get to the GLP-1s. You have to try additional other therapeutic drugs that are like SLG-2s and other drugs that potentially the member could find effective outcomes at a much lower cost. And so, the big surge that we've seen across the country on the cost of GLP-1s was, interesting enough, we're not seeing that

in Kaiser and in our Kaiser plans. And that's because of the PA process they put in in managing GLP-1s. Amy and I work on a state where Kaiser is one of the players and in their commercial plan, GLP-1s are a huge cost driver. We just haven't seen it in the Kaiser plan and it's because of their PA management process. That's just something to consider or think about. Like, maybe members may need to use the GLP one, but they maybe have to jump through some steps. So, I just wanted to put that out there for maybe conversation.

Member Duncan: So, a few things. Keiko Duncan, the record. Well, first off, I don't disagree. I think we do this in Medicaid as well, they require prior authorization to ensure appropriate use of GLPs. I don't disagree with that at all. The consideration for Kaiser, you just have to remember, right, as they control the entire process. So, if they have an initiative to reduce that, they are uniquely positioned to make that happen. And that could, maybe or maybe not be contributed to a prior authorization in place, so I just want to say that. Not to say that we can't indeed meet that. I think Kaiser having a little bit more flexibility in that is helpful. But maybe that goes hand in hand with some of our other conversations about the disease management, right? So, if we also have a little bit more control over disease management and how that care coordination is happening and we pair that with a GLP solution for PEBP, that's how we get to that sort of Kaiser model. And so, I think that goes hand in hand, so I just want to say that.

The other thing, I also just want to set the stage, so the direct rebate contracting, which is an idea I love. But it does take a lot of administrative upkeep for it. The direct rebate contracting goes hand in hand with the formulary changes. So those really aren't two separate things. In order to directly rebate contracts, we must have oversight over how those drugs are being placed on the formulary. That's just how rebate contracting works. So, I would just call that out. So that's why I didn't bother putting a sticker over there because of the same thing.

Mr. Sherman: So, you're saying that the direct rebate contracting directly goes along with formulary. Does it directly go along with narrow formulary?

Member Duncan: Well, the other comment I wanted to make is that, so when we say narrow, I just don't, this is semantics. I don't like that word narrow because it's not necessary. The word implies that it is more restrictive than what's currently being covered today. And I will say, I'm sure you all have your own stories, probably have heard as well. I've gotten a lot of feedback from our recipients that they haven't been able to get drugs that they should be able to get. And so, to me, that's the way the formulary is being managed by a national entity not being Nevada specific. That may cause issues and trends. And so, I wouldn't necessarily say it's a narrow formulary, but having more formulary oversight, I think, is important so that we can adapt a little bit better to our population here. We had that conversation about in-network and designing our plans for our people, right? So, I think that's just something to consider and I would love to cross out the word narrow because I just didn't like that.

Mr. Sherman: It is so fun to facilitate when you ask the question, you get exactly the answer that you were hoping for. Because I wanted to check in that that's what you were saying. So, and I think that it'll be interesting to see your next round of votes. I just want to point out that as the board put down dots, you talked about potential statements to direct rebate contracting, and you didn't necessarily mean restricting or limiting, which is what the word narrow implies so I think you're really happy about that. Thank you.

Member Duncan: And the only other thing I want to say. I want to hear what you guys think. When we talk about the time horizons and the time it takes to implement some of this stuff, you have to take into consideration, so direct rebate contracting and the formulary isn't working. I wouldn't have two years for one, one year for the other. It's relative. It depends on having that administrative support. Do we need to go to session in order to build out a team to do this? I would say yes. Do we need a data aggregator on board? You've got to go out to purchasing for that. That is itself a two-year process about right now, right? And so, you have to take some things into consideration. Now, I want us to move towards some of these ideas because I think they could be very helpful. But, if we tackle some stuff that we can do now, like these conversations about GLPs or, potentially copays. I know we didn't really talk about that as much. Or especially drug management and how we affect some of that change. I think that can happen a little bit sooner because there's not a lot of infrastructure that needs to be built. There might be some contracting, some amendments, maybe some additional costs like we've talked about in previous board meetings, but just to say those are faster implementation pieces.

Mr. Sherman: Thank you, other board members. To pose maybe another, maybe I'm taking a little risk. As I understand it, some of this is underway. There's an RFP in the works.

Member Duncan: Well, I think we talked about last time the Express Scripts contract got extended, Segal participated in helping us negotiate some of price negotiation changes, so that we can gain a little bit more understanding and transparency and move towards this direction. So, yes, I would say it's in the works. Again, it's a contracting type of thing.

Mr. Sherman: As you're thinking about giving direction to all the actuaries for what to do next. Is this something already underway and the board should maybe look at other things or is it important to still have the dots placed there to show Board members' interest.

Member Duncan: I would love to understand everybody's interest. I want you guys to, I recognize that I'm the expert in this, but if you guys have any questions, I would love to illuminate.

Mr. Sherman: And maybe Milliman has some more comments on it as well, but other board members. Anyone on the board object to looking at these issues. May I should ask the negative. Of course we should do this. That's why they rob banks because that's where the money is, right?

Member Duncan: I just wanted to remember, because I know we talked about that copay plan design before. We talked about a bunch of different options. Were we bringing anything back with that? I know we didn't vote any of that through, but were we bringing any data back with that?

Mr. Sherman: Well, I thought Milliman made some really good points about driving behaviors with copay design. Another view of copay design is it's just a cost shift. Maybe it's an appropriate cost shift like a deductible or just keeping up with regular inflation. But there's a lot that that can be talked about with copay plan design changes. I mean, I didn't get any dots yet. That's actually probably one of the easier things to implement to just change copays.

And the amount of savings is how much you should that's part of it. But the bigger part that Milliman pointed out, and maybe they want to say some more is, does it influence behavior?

Member Rich: Well, and I have a question about that too. So, for example, the high cost spend in pharmacy is usually not like, you're not getting a high cost drug once, right? For the most part, you're on it. And so, it's a long term spend. And so, my question is, if we increase the copays, but don't do anything with the out-of-pocket max, then really, you're not making a difference, right? Because they get there anyway. So, you're just getting there faster, but you still get there.

Mr. Sherman: Which is one of the very, this is not for this table, but for those of you that also were looking at Medicare plans, now that Medicare has that relatively low out-of-pocket max for everyone in part D. I think it's $2,100 this year. For those of us that help their parents with prescriptions and are watching it get there. But that's exactly the conversation that takes place around these tables with looking at Part D plans. Right on, and it's even more compressed because it's just drugs.

Ms. Donaldson: So again, to Kali's thought, these were design options that we had for non-preferred drugs, right? Driving members to preferred drugs. And we gave three different options. All the way from just not covering non-preferred drugs, right? So, making them use the drugs that are on the formulary. Or having just more out of pocket. Driving them to the drugs that are formulary. Not a lot of savings here unless you just don't cover non-formulary drugs.

Executive Officer Carsten: Do we know how many people that is?

Ms. Donaldson: Yeah, we said about 825 patients, about 2,700 scripts. Kali, I don't know if you have any additional thoughts about this.

Ms. Schweitzer: Yeah, I think this table represents it well. I think the hard part with changing co-pays, especially for non-preferred brands, is a lot of times those people are, we use the term sticky, they're already on a non-preferred drug, so what's the likelihood of them moving to something else if that copay changes or is no longer covered. So that is a consideration. I think the main impact there that we see is like with people who are newly looking to start a medication that influences their decision. But for these 0.4% of scripts that are already on non-preferred brands, tends to be a little bit harder to get those individuals to move to something else.

Ms. Donaldson: But as far as additional data, no. We don't have, I think we provided some information in our Shape Report data on pharmacy, but happy to take back any additional thoughts with regards to, I'm sure to consider.

Mr. Sherman: Okay, let me suggest we move to topic 5. It's close to a quarter to 2:00. Maybe we target being through presentation and initial comments on the 5th list by 2:30, and then we go to the green dots. And then I think that'll leave us some time for a little more conversation afterward and still stay on or ahead of your schedule. I know it's been a super long day. Sound okay?

Ms. McClendon: Amy McClendon for the record. And most of this is a refresher from the information we presented in May. But going through the topics and subtopics we have on our list here, first was explore care navigation. I don't see any dots over there quite yet. But then updating the conditions, specific care management programs, and we talked about requiring participation to cover GLP-1s, so potential savings a little bit higher, one to two dollar signs there. And then we've talked about point solution vendors. Those can also be used for disease management, and then just contracting, which might take a little bit longer, might be a little more administrative.

So next slide. And this may be a little bit hard to read, so I'll get a little closer. So, this first slide just says in your population, what are the major chronic conditions? And you can see here at the top is mental health, but then it's also followed by hyperlipidemia, hypertension, obesity, diabetes. And so, we'll talk more about these third party solutions, but a lot of the disease management programs are going into more of the whole person, just understanding that these conditions are going to impact, it could be the same person that's impacted by all of those conditions. So, you want to really take into account not just, oh, you're a diabetic, but you might be a diabetic struggling with any number of other conditions and looking at that whole person and trying to best figure out how to help them. And so, 52.7% of your population had these major chronic conditions that we listed here.

Ms. Donaldson: That's over half of your population has one of these chronic conditions. So that's where Amy's getting to that the new move is to like, let's do the whole health of the person. Let's look at the whole health first, just isolating a certain condition because they may have multiple.

Ms. McClendon: Certainly, and especially you see mental health is towards the top. Now that can drive some of these conditions like obesity and some of those other items. And so, they are very connected. And so that's where the industry is moving toward taking care of the whole person. Next slide.

Member Davis: Amy, I have a really quick question. I've had members ask that they try to see some of these benefits. The physicians are always asking for sleep studies saying that that seems to have an effect. It's like a precursor before you can even get these things. And I was wondering why, where did this come about?

Member Duncan: So, I mean, it just depends on what specifically you're talking about. But for some certain drugs, for some certain types of disease states, especially for example, obstructive sleep apnea, that's the big conversation right now because that is a GLP that treats it. They require a sleep study to ensure that that is the appropriate diagnostic pathway for obstructive sleep apnea. And so, that's why the doctors are requesting that, because that is how they diagnose certain diseases. I don't know of any.

Member Davis: I've had someone tell me that they wanted to get on GLPs. I know that's just for diabetes. But they said that the physician told them sleep study first, maybe the insurance will pay for it.

Member Duncan: So, the assumption would be that would be for Zepbound, that's a GLP. It's the one for obstructive sleep apnea and in order to get that diagnosis, you required to do a sleep study. But there are other GLPs, so that's not the only pathway. There's cardiovascular risk. There's a lot of them.

Ms. McClendon: Okay, so then we've also looked at your data and identified any care gaps. And so, this is looking at are patients getting their annual screening test for diabetic eyes and those exams. Looking at those that are taking a statin and if they're taking an ACE inhibitor, if they have CAD. And then preventive screening is also important as well. So, this was just to see, where in your population are there certain gaps? And so, these orange items are the ones where we see a declining prevalence of getting these screenings and then also not meeting the benchmark. So just something to keep an eye on. And then this can be used to monitor if things are put into place to try to incentivize some of these screenings and see if there's movement, improvement over time.

Ms. Donaldson: When I see this and only see two greens, there's room for improvement to helping your members manage their care and condition. While we're seeing increases in preventative screenings, these are breast cancer, cervical cancer, colorectal, you're not meeting the benchmark of other states and meeting, how are they doing comparatively. So, there's definitely opportunities here for sure.

Ms. McClendon: Okay, next slide. So just a refresher again, we did present this back in May. There are a number of programs that PEBP offers. The first is the Diabetes Care Management Program. And this is really for those that are in the CDHP plan. And it really gives them the opportunity to access their medications at a lower copay or not subject to deductible/co-insurance. And so, folks that are in this program, there's very low engagement. We had about 18, I think. Again, it's a smaller population, the CDHP plan. There's less folks in that plan. But that's a high level, that's the reason why you would be in this program. The obesity care management program, that's open to a wider range of folks. So, anybody on a self-funded plan, it's more of a clinically managed program. That one, we also saw lower engagement at about 4%, and that was less than 400 participants. So again, and then the themes we've seen, we've reviewed your programs, it's not a lot of engagement. We did notice the screenings were a little bit better.

So, as you're thinking about what to replace, if you're considering that, you want to make sure that these screenings and one thing I'll note on this third program, the real appeal, we actually did see the shift away from GLP-1s. So, if you compare those who aren't in the program to those who are, they're managing more through like a nutritional approach. And so you do see the shift away from GLP-1s. Again, there was lower engagements, about 1%. Yeah, I think it was 80 members. But those are the main programs. There is a program that's offered through the state of Nevada. It's more of a pilot program. This is not something that PEBP controls. It's just something that you all have access to. So again, sometimes having multiple programs can be hard for folks to understand where to go and how to seek management of their disease. But this is just an overview of your programs that are offered. Any questions on this one? And this is just a summary.

Again, low engagement was a theme. Those who were participating had between two and three chronic conditions. So that just goes to the whole, if you want to manage, just thinking about this, the whole person, because they are dealing with multiple things. We did

see some better outcomes around lower inpatient admissions and ER. That's something you want to look for in a disease management program, something that's going to shift care to the appropriate site. And so, you're having more PCP visits or specialists and less of those emergency type situations. And that's what's noted there. And then I mentioned about the whole person. So, there are third party solutions and most of those are targeted to the whole person. So, I think that's all the slides we had and then we're happy to walk through others.

Member Davis: I'm just curious, how often do people utilize virtual options. Virtual option is that I don't think we have like telehealth, I guess.

Executive Officer Carsten: Oh, we do have telehealth utilization, but it's not for disease management or care coordination efforts.

Ms. Donaldson: One of the things to think about is additional point solution vendors. Right now, I think the programs that Amy just went over, they're through UMR. We have found more effectiveness with a third party point solution, but that's what they're just focused on, right? Is managing the care of the members through a third party versus through your administrator. Something to think about. Unfortunately, it's an additional potential vendor you have to deal with. Yes.

Executive Officer Carsten: I'll also say, if you guys decide to replace what we have with that third-party type of solution that is actually dealing in whole health, there is a potential for greater health outcomes. And so greater health outcomes up front don't necessarily turn into a dollar amount ROI immediately, but longer term can save thousands and millions depending on how many people you have utilizing them. And so, I've just heard of other states who have had really good successes with whole health models. And so, I just wanted to leave that there for you guys to talk about.

Ms. Donaldson: Thank you.

Mr. Sherman: So, looking way over here. Care navigation didn't get any dots this morning. Condition specific. Care Management. About 4. Require participation to cover GLP-1 a couple. Additional point solution vendors so far, not here. Group contract terms through procurement. That’s where we are. Other thoughts on disease management and care coordination?

Member Davis: Is this what Carrum's all about?

Ms. Donaldson: Carrum, yes. Well, Carrum is considered a Center of Excellence for certain services. I believe, and please add on, Theresa. We've seen effectiveness for the services currently utilized by PEBP, but there's opportunity to potentially expand Carrum to additional services.

Executive Officer Carsten: Yeah, so Carrum is contracted for a certain select number of services. Their health outcomes appear to be better than those similar services that are exercised through UMR. Currently, usage on Carrum is voluntary benefit. One of the things you guys could consider talking about is potentially making it a mandatory benefit and driving

participation through that program. There have been savings with that program. And like I said, their health outcomes seem to be better. But if you change that to mandatory, that is for whatever services you select, whether you expand them or keep the ones that are correct, which are newer replacements.

Mr. Proper: Yeah, musculoskeletal, spinal, bariatric.

Executive Officer Carsten: And so, if you make it mandatory then thereby limit the network available to the members, right? You're driving care for cost savings and better health outcomes to happen through Carrum contractor centers of excellence.

Member Davis: Carrum is specifically dealing with cancer.

Mr. Proper: We have two contracts with Carrum. We have an oncology contract and then a surgery centers of excellence contract.

Mr. Sherman: Any other comments, observations? I think, maybe it makes sense at this point, through the chair to go board member by board member, and you can pass. But giving each member a chance to comment on anything before we go to the other dots.

Chair Wells: I have one clarification question, Amy. When you talk about the additional point solution vendors here, you're talking about the whole person?

Ms. McClendon: Well, multiple, right?

Chair Wells: But that's what that would fall under. We were interested in that. So, explain the difference between that and the first one, the care navigation. So, what was the intent behind the care navigation?

Ms. Donaldson: I think the care navigation is helping direct care to certain Centers of Excellences. So, to the Carrum's per se. So that's helping with that.

Mr. Sherman: I have X diagnosis. I don't know what to do.

Executive Officer Carsten: And you tell them what you have and then they do a process with you and then you guys both determine whether you're qualified for that program to go to their Center of Excellence and then complete that step. So that's a navigation of like trying to figure out what your needs are and then navigating you to the best Center of Excellence in your area. And then I think, the point solution thing would be more towards potentially replacing your disease management or obesity care management through UMR to a third party vendor.

Ms. Donaldson: And can I just add on to that? Potentially, that's why the GLP-1 is separate, because while you may want to do whole health, you may want to have a sub specific towards GLP-1 management.

Ms. Sherman: So let me try to capture that. So, explore care management navigation is you have the diagnosis, so it helps you through like your rapid placement care with oncology and

musculoskeletal. Update condition specific care management programs is looking at what you have now and maybe going to another provider rather than the current provider that also does claims management. And then specifically for GLP-1 is its own line here.

Executive Officer Carsten: Well, I think that means to get your GLP-1, you must participate in in some sort of management or care coordination program as part of that GLP-1 issuance.

Mr. Sherman: So, for discussion purposes, maybe we say this, this is a mandatory one. These would not yet be mandatory or could or could not be, may or may not have to be mandatory for purchase. Is that capturing?

Chair Wells: Yeah, I'm just trying to make sure that people know, like you say, update the condition specific care management programs. Now we're talking about whether we replace them with this whole person, is that the same as an additional point solution? I think that's where I want to make sure.

Mr. Sherman: We can add that as another.

Chair Wells: Yeah, put in their dots they're interested in the right place.

Mr. Sherman: Do we want to make whole persons its own?

Ms. Donaldson: I think so. I think that may make sense. There's markers up here.

Mr. Sherman: I was going to defer to the good handwriting. That's a really good clarification.

Chair Wells: Because I like the idea and I'm just afraid that people aren't necessarily differentiating between this new program related to the whole person that we're talking about, something similar to it. And then what do we do with the programs we have versus the other solutions that might be out there for different types of care management.

Member Duncan: Keiko. I feel the update conditions specific, find GLP and improving contract terms to be one and the same. The goal and intent of all that could be to target the whole health of a patient, right? Like, so we know that we're going to be, our condition specific care management programs are, we recognize that is run by UMR and that they either need to go away or make new ones or have updates to them or we need to add things to it in order to assume this will help, right? And as a part of that, one thing that we could therefore target as a first step could be GLPs, right? I see the point solution vendors being, do we take all of that and go elsewhere? That's how I'm interpreting this.

Because for the UMR programs, we can't make updates to those without changing the contract terms, I would assume. And especially from the comments that Express Scripts has brought to us at previous board meetings, right? I can't put more specific prior authorizations on GLPs without updating our contract terms, and then probably paying for some additional things. So, I think we can accomplish this whole person, and I would love for all of us to put a sticker around whole person and be like, "Great, let's do that, right?" But how we do it, I think the two methods, at least that I've been envisioning here, is do we do it with our current

contractors or do we go out to procurement and find somebody else that can specialize in it? At least that's what I'm seeing is the actionable steps. Correct me if I'm wrong.

Mr. Sherman: I see. So, number 5 sounds like it's a little confusing and maybe needs to take what I'd like to improve, contract terms through procurement. So, through procurement might mean this vendor or another vendor, rather than it means a procurement versus a negotiation. Is that also?

Member Duncan: We can line out through procurement. That's what I was talking about. It's like we improve our contract terms because we can make amendments to our current contracts. It's where we need an entirely different service to go out to RFP in which there are multi-source vendors. So, there's no sole source. We have to go to a competitive bid. That's what makes the procurement different. And the difference between those two options, like I mentioned before, is time, right? So, you have to remember, like, the procurement process takes a significant period of time, and then we implement something, and then we're a couple quarters out to actually see improvements in data, right? Versus what can we affect now with our current contracts? Can we maybe improve the obesity program or can we supplement a GLP program on top of that? Can we mandate that obesity program and then link it to something we add, or prior authorization to GLP? So that's what I'm seeing is the pathways, if you will.

Mr. Sherman: So, this would be a procurement. As you don't have one now.

Member Duncan: Yeah, it's like whole person vendor versus whole person contractor.

Mr. Sherman: I'm sorry, I don't want to let you do that. I was thinking we have four additional point solution vendors. Sounds like it's almost duplicative, did it? So, we could maybe cross out number 4. Does that make sense?

Ms. Donaldson: Yes. So, I want to make sure we have on there, this to say whole person.

Member Duncan: Well, I think we all are generally in agreement to attend to the whole person?

Mr. Sherman: I mean, so updating conditions specifically, that would be not a whole person, that'd be a specific condition.

Member Duncan: Well, you can tackle a specific condition addressed within the whole health.

Member Harper: Blaine Harper for the record. So, my only question is, if we move to the whole person framework, then what would it mean for the requiring mandatory participation to cover GLP-1s? Because whole person doesn't necessarily fulfill the function of an interstitial prior operating process or that could be addressed through the amendments that you're talking about.

Member Duncan: Yeah, it would probably be 2 simultaneous things. When we're talking about condition specific programs that we still want to address the whole person. So, for example with obesity and I think this is what's currently happened today. Please correct me if I'm wrong, but ou want to see the provider, you want to get your labs done. They're going to maybe prescription medications. They're going to ensure you're also maintaining your lifestyle. We

have these lifestyle modifications going on. And also, then let's connect you to a cardiologist, are you having some heart conditions or can we put you on preventative medicine to ensure that you don't reach that right? then you target diabetes and then there's this whole web of things that you can target to ensure that they're preventing X, Y, and Z disease because they have diabetes, right? So, it's different from just saying we have a prevention, a health prevention program in place, right? Ensuring that they're getting their physical and going to see their doctors, right? We're targeting a specific thing but treating it as all interconnected. So, that was a very complex answer to that, but in my opinion, it's all the above. We're not just saying, okay, Here's your GLP. Thank you. Goodbye. That's what I'm trying to demonstrate is a difference. Yeah, like you must be over here and then thank you goodbye.

Member Harper: But also, that wouldn't just be, did you get your retinopathy exam within the past 12 months, but rather are you participating in the whole person program fulfilling the physical.

Member Duncan: Yeah, I think there's a lot of points that we can maybe connect it to a program.

Member Davis: I just thought about participation. You went through a whole program like that, you're asking members to really engage the whole person, the whole body. I think you have a real issue on participation. Most have a tendency, hey, this is hurting, fix it. That's all we want.

Member Duncan: It's a very valid point. What our conversation is, do we want to change that mindset? Can we affect the health of our population by helping them out as a whole? And can we still make that.

Executive Officer Carsten: and you 53% of your population has one condition, one of those three.

Ms. Donaldson: I want to make sure that, I want to get the board's perspective that we don't lose. Where, where in your mind, Theresa, do you see expanding Carrum's program? Is that under care navigation? I want to make sure we're all understanding that. Do we say dash Carrum or go ahead?

Chair Wells: that's what I thought. You see over here, the expanding the centers of excellence under contracting. And over here, you've got care navigation, which is using Carrum. I consider those to be the same.

Ms. Donaldson: You want to take this one off?

Mr. Sherman: Or do you take care of navigation off?

Chair Wells: Because I think at the end, you're using a single contractor that we currently have to expand services and try to get better health outcomes. And at the same time, they seem to have better contracts, lower cost with the vendors that are doing the service. So not only are we trying to get the people to go to these places that are better for them, better for everyone, lower cost, better outcomes. Why wouldn't we want people to do something that in the long term is better for both them and for the plan as a whole. That part, to me, that part of the expanding

centers of excellence is to make it mandatory. But to me, that we need to have the conversation about what to do with Carrum, the centers of excellence and making sure that people know that's an outlet for navigating difficult times, difficult conditions. And so, for me, it's all one and the same, it's really using that vendor that we currently have to drive people to get assistance if they need it.

Mr. Sherman: So, to play that back to you, what I'm hearing is, oh, this is really interesting because the same vendor helps participants navigate and negotiates with the providers.

Ms. Donaldson: Yeah, they're in both. I want to make sure we're all clear on point solutions, right? So. You have sword today, right? Do you have Sword or hinge? You don't have Sword You have Hinge. I get so confused.

Executive Officer Carsten: Yes, we have Hinge through ESI. Yeah, just through ESI.

Ms. Donaldson: And we've seen good outcomes on that. And when I go to your percentage of Medicare, when I see your PT and OT, really high as a percentage of Medicare.

Executive Officer Carsten: And I've heard from members that Hinge is phenomenal, like that they love it, and that it's really easy, if they need to change their treatment plan, just to call in and say, I tried this exercise, and I couldn't walk for a week, I don't want to do that one anymore. And so, I've heard really good things about it, but I think to your point, I don't know, that one, people know that it's available or how helpful it can be right before they go to the PT part of the speech.

Ms. Donaldson: And do we somehow, something to consider. There is a piece, like you have to go to Hinge before you have, or we won't pay for, I don't know, just something because we have heard and we've seen good financial outcomes from these plans.

Member Davis: I've been on Hinge for about 8 months, so I think the outcomes are excellent.

Ms. Sherman: So, are we set with this as drafted or do we want to eliminate something on this one or that one? As you're about to put your dots up again.

Chair Wells: I think it's okay like it is. But then I have a similar question on pharmacy with the GLP management, the specialty drug solutions, and then the point solutions for utilization. So, if we're doing specialty and GLP-1s, what other point solutions are really out there?

Ms. Donaldson: I think we can find this, unless I don't know if Milliman's still on, if you had differentiations between specialty drug management and point solution utilization management on pharmacy.

Ms. Schweitzer: I do think that there is a, this is Kali Schweitzer for the record. There is a lot of overlap, I think, between those two. A lot of the point solution vendors out there really just tend to cover a more specific class within the overall specialty space, like atopic dermatitis, for example, or other autoimmune conditions. So, there is definitely quite a bit of overlap there in that space as well.

Ms. Donaldson: So, what would you recommend taking off the specialty drug management solution or the point solution utilization? Point solution utilization management.

Mr. Sherman: So, just to test where we are here because there was some conversation as the data presented about dermatological treatments

Ms. Donaldson and Chair Wells: That would be specialty.

Executive Officer Carsten: I think you could identify the different classes.

Mr. Sherman: Okay. I think so too. I just wanted to make sure I didn't miss anybody's thoughts. We didn't miss anybody's thoughts. Okay, any other board member observations? And again, if you want, there will be more, there certainly will be more time to talk once the work is done. Again, a reminder, you're not expressing a preference for a direction, you're expressing a preference for further study and to bring it back. And a thank you from me. We've been at this for five hours plus, and I really appreciate everyone's attention. So, I think where we go now is green dots, and maybe we combine it with a stretch break and some candy or soda. And through the through the chair, what time does it make sense to reconvene?

Chair Wells: Let's do 2:30, you have a pretty few minutes to think.

Mr. Sherman: I didn't want anyone to feel rushed. Trustee Grammer, should I call on you again? I want to make sure we didn't raise your hand if you wanted to say something. Great, Thank you so much.

Member Harper: Oh, I just thought of something. Blaine Harper for the record. So, the coordination with the Health Authority and the Explorer available programs through CMS, I see those as related because the Health Authority is talking to CMS, so something is a little bit great for that one.

Chair Wells: Especially the 1332 labor that there's been talk of using the 1332 labor. We can do some of the things we talked about, so that's right.

Mr. Sherman: Board member Harper is suggesting we combine seven and eight here.

Member Harper: 8 and 9.

Mr. Sherman: I'm sorry, if I could redo it would be helpful. 8 and 9, we're going to combine these, yes. Wait, I don't trust myself to draw on your chart.

[Various conversations as board members place their dots around the room]

Ms. Donaldson: I think the first thing we want to do is a clarification point. Is Mary Ellen, yes. So, we have the slide, Mary Ellen, we're going to pull it up, what you sent over. But there was a slide that showed the relative values of the Low Deductible plan and Nevada's

plan, what's in your deck does not include the seed money. And the key thing, and Milliman just reran this because the key thing is that, especially for Washoe County. Oh, this is the original one. So, Washoe County is showing here negative 6.5 without the seed money. Mary Ellen, do you want to walk through, I think you've updated this slide to include seed money, both PEBPS and the other CDHP plans, correct?

Ms. Vargas: Yes, so appreciate the opportunity to clarify here. For comparison, I think we've got, yeah, we have the prior slide up previously. We can leave it on this updated version. But the changes here were this PEBP CDHP was previously at about a negative 5.3% relative to the LDPPO. And now, as you can see, that's a negative 1.3%. And then the Washoe County HSA was previously at a negative 6.5%. When we factor in that HSA funding, if you remember, it was extremely generous for Washoe County. That actually moves that plan up to a positive 2.6% differential from the LDPPO.

Ms. Donaldson: So, the differential from Washoe Plan is now 3% compared to 10, so, seven point difference, but that's a much smaller difference. So, I think that's important as you guys think through things and compare the PEBP plans to these other entities.

Chair Wells: But I think one of the things is watching the PPO at 10.4 versus the high deductible health plan at 2.6, so there's still meaningful difference. There's still almost a 7% difference. But then you look at our PPO versus our CDHP, only 1%. So, there's no meaningful difference. That's what I tried to take away from this before. We don't have real meaningful difference between our plans still.

Ms. Donaldson: Yeah, we're showing a little bit. We're showing from like 78 to 83, so we're actually showing 5% differential.

Member Viton: Is that also without the seed money or something?

Ms. Donaldson: That includes the seed money. A little bit different actuaries doing different AVs, clearly. I consider things within 3 percentage points close. But again, to Chair Wells' point. Thought around potentially having bigger differentials, maybe something to think about. Thank you, MaryEllen.

Mr. Sherman: Members of the board. Eyeballing it, looks to me like there's been some consolidation of areas of interest for further exploration, review, and then your neck up decision making. So, starting at the at the beginning. Seems like expanding HMOs is something that's now, not within the top eight of anybody. Similar amount of interest in consolidating plan options, and interest, but of different board members in in the full replacement. Comments.? Certainly, interested in looking at risk pools and rating. Separating actives from retirees, again, with the recognition that this is.

Member Davis: Joy just wrote that she didn't see any of the slides.

Chair Wells: We're not looking at slides.

Mr. Sherman: She can't see them. We don't have a camera.

Member Grimmer: No, and that's okay. I just didn't know if you had something up that I was supposed to be able to see.

Chair Wells: No, we're doing the ones on the wall.

Member Grimmer: Okay, perfect.

Mr. Sherman: Thanks, thanks for checking in. You can even see me. Oh, there I am. A little increase in interests in looking at moving Non-Medicare retirees to the exchange. The same level of interest in risk pooling and dependent subsidies. Comments? Similar, but a little bit of consolidation here? Audits, still a good idea, but a couple people didn't put it in their top eight. Coordination with the Health Authority and exploring possible programs through CMS and otherwise, real concentration of interest there. Direct primary care contracting seemed to have fallen off of anyone's top eight and interest in reference-based pricing and expanded centers of excellence, still some interest. Direct contracting for specific services, for example, ambulance, no one's top eight at this point. Again, if we're going to see the consolidation, we're also going to see other things drop off just from the arithmetic. Pharmacy benefits, continued interest in specialty drug management solutions and direct rebate contracting. Very consistent with the conversation that took place. The new winner is the whole person. Your conversation circle is there, led to then make sense. Some now new interests thinking about Carrum and being mandatory possible expansion of some services. My appreciation. About 5 1/2 hours together. And thank you for lunch. I think that we have some direction.

Ms. Donaldson: We do, but I'd like some clarification, if you will. With regards to consolidation of plan signs. Can we maybe chunk it down to another level because I want to make sure that we have good direction of what that looks like for you guys. Is there general consensus that the consumer-driven health plan should continue? With a raise of hands, everyone thinks consumer driven should stay. So, when we say consolidation, then we're between the LDPPO and the HMO/EPO. Can anyone help give me direction of where consolidation is going to be? What are your thoughts on those plans?

Member Davis: My thought is just taking the ones that are enrolled, the very lowest one based on participation, combining possible sort of consolidation.

Ms. Donaldson: That would be your EPO HMO. And I don't know if there's more consolidation that we can do on those plans. One's an HMO and the other's an EPO one's in the north and one's in the south.

Member Viton: I guess, can that include combining into an HMO, doing Kaiser or not.

Executive Officer Carsten: Theresa Carsten for the record. So that would require a new RFP for services.

Ms. Donaldson: Kaiser has pros and cons. I'll just share. Kaiser's just different. From my perspective and our experience. There's good and bad things with Kaiser. I'll share that Kaiser's community rated. There's little to no negotiation. They don't care because they know

they're like, we're Kaiser. And we have seen in many large entities, I've got major, like a meaningful number of memberships of members in Kaiser. And they pass on an increase and they're like, sorry, this is what the rate is. There's little to no negotiation. It is fully insured. Do we see sometimes savings and how they're really strictly managing that network. Yes, but there's pros and cons we need to consider with Kaiser. I think we have to do some more research. That maybe a longer term play of how they're going to play in Nevada. Yes.

Executive Officer Carsten: Well, if you're talking about fully insured product, right? So, if they are really limited with their utilization management, that's their bank account, right? So, what they charge us and what they don't negotiate with us is our bank account. And that's different than what we operate with our other plans as self-insured, right? When UMR goes and gets a bunch of network contracts and pays, to board member Rich's mental health, lower, that's our bank account, right? Like they're negotiating rates on behalf of us. But when you go to fully insured, we pay a premium price for that, and then they do whatever they want within their plan to manage the health care, the pharmaceuticals, et cetera, of the people in that plan.

Ms. Donaldson: Can I throw out a wild idea just to consider and you guys can push back? Is there potentially one thought you want us to come back and price eliminating the EPO HMO and taking the Low Deductible health plan and maybe making it a larger differential? So, you would have two self-insured plans that have a bigger disparity of out-of-pocket deductible, and there's more of an actuarial value difference. Yes.

Executive Officer Carsten: Yes. So, that was what I was going to say. So, when you say that, move it more to standard deductible PPO, right, which would increase the actuarial value.

Ms. Donaldson: It would lower the actuarial value.

Executive Office Carsten: It would be in the middle between the LDPPO and HMO.

Ms. Donaldson: Yes. Thoughts on that? So right now, let's go to the actual value.

Executive Officer Carsten: So, a previous board had this presented to them by previous administration, right? Moving from the LDPPO and the HMO EPO and merging them together. Then having your CDHP at like a 78% actuarial value and then averaging those and strengthening the LDPPO or the PPO, I think they were calling it a standard PPO in that meeting, so that that actuarial value ranges between that 83% and that 92%. And then only having two plans.

Ms. Donaldson: Maybe we go to 85 percent, but the premiums would be set to recognize the risk and the actual value of 85% as a standalone plan. Yes.

Member Rich: Laura Rich for the record. So, my question is, the reason we have the EPO and the HMO. The EPO is self-funded, the HMO is fully insured. The reason we have the EPO versus a fully insured plan in the north is because being self-insured, it was financially advantageous to be self-insured in the north. The analysis at the time was, we can't beat the HMO in the South. It is the HMO ran just more efficiently based on what the HMO plan could do and the setup in that HPN had in the South. Is that different today? So, if we eliminated that

and did a self-insured option, because again, we're blending the rates, we have to blend the North and the South. We know the South is less expensive than the North. And so really the South subsidizes the North in terms of the rates. Can we beat that?

Ms. Donaldson: We need to look at the analysis and do the analysis. I'll just share in general that's fully insured. There's profit on top of that in that plan. So, my initial guide is self-insured and it's the network with UMR. So theoretically, we should be utilizing the same networks that they're using for that health plan. And there's profit with that. So, I think they're doing well. I'm not sure they're doing utilization management or anything. I don't know if it's much better to say that HMO plan is better than what could be happening in self-funded. That's my perspective. But we'll need to run the numbers and look at them for sure.

Chair Wells: Yeah, or like what you were talking about with Kaiser, that's a lot more restricted. That's what HPN used to be. To me, that's what HPN was for the longest time. They managed care well. I don't see them doing that.

Ms. Donaldson: So, is that an option you would like us to look at and maybe bring back to the board for consideration?

Member Davis: I would.

Chair Wells: So, before you do that, one of the things. Kaiser is supposedly here, but we don't know to what extent. And I think it behooves us to find out to what extent they're here. Are they going to offer an HMO plan here? I don't even know if we know the answer to that question yet.

Ms. Donaldson: We don't. We need to do some research.

Chair Wells: And so, if they're going to and there's a desire to stay with the HMO in the north, is there a desire to go to something like the Kaiser as opposed to the EPO? And keep a three plan differential. We still have to make differential between the plans, but keep it on the table. I don't know if they're offering or plan to offer or what their time frames or timelines are. I'd like to know. Because I think people want to be in a managed care plan that's actually going to manage care appropriately, then I'm okay with that. And I'm okay with having the rich benefits if people really want to pay for them. But I still think there needs to be a little bit more separation between the plans and the premiums.

Ms. Donaldson: By separation, are you looking to adjust the LDPPO or the Consumer Driven plan or both?

Chair Wells: Possibly both.

Member Rich: Laura Rich for the record. I don't disagree with Jim, but at the same time the whole reason that the Low Deductible was put in is because we did have two plans and there was a desire for members to have something in the middle. And so now we're going backwards, right? Personally, I like the idea of just having two plans because healthcare is very difficult to navigate to begin with. The more options you give people, the more confusing it gets. But also, if you've got two very different plans, there's that desire, well, this one's not great, and I don't

want this, but I don't want that. Why don't we have something in the middle? I'm just putting that out there because that was the intent. That's why the LD PPO is there today.

Executive Officer Carsten: From an executive officer's perspective want to bring this back to choice is great. Member Rich, like you said, I think when we're funded and we have all the pennies in the world, we would love to have a perfect set of plans that are not a lot of money. But I think right now the goal is to figure out in this unprecedented time where we don't have a lot of good decisions to make. What are the most impactful for the least amount of pain, right? We have to come back to, are we going to stay solvent or are we going to give choices that might lead to insolvency?

Member Viton: From my perspective, the solvency and choices are not connected.

Executive Officer Carsten: Well, that goes to your rates, right? This board is different than previous boards, right? So, if you vote for rates that cover the cost of the plans, but just remember, you guys voted for rates that deferred $30 million this year and next year, so we're already behind.

Member Rich: Laura Rich, for the record. I just have a question. Regardless of if we have 10 plans or one plan, the cost is the cost, right?

Ms. Donaldson: You're picking up 91% of the cost. Granted, there's employee cost share, but your actuarial value is more generous here under these plans, which means the plan's picking up.

Member Viton: Self-insured versus fully insured and how we're subsidizing the plans is factored into whether you're covering our cost. And so, I don't disagree. We made the choice to defer some of that, but that's because the alternative was putting all that on the back of the employees in one year, but it wasn't a one year issue.

Executive Officer Carsten: No, I fully understand why the decision was made.

Member Viton: For me, choices don't equate to accepting there'll be deficits. I don't accept that. I think the choice is what makes sense to offer to the employees in terms of the benefit design. And I don't think having three choices versus 2 choices should be suggesting that we would end up necessarily accepting deficits.

Executive Officer Carsten: I'm just saying that whatever choices you make, as long as we remain solvent, if we don't remain solvent, then nobody gets a choice because we're not going to have a plan, right? That's the most severe case, right? If we lose solvency and we don't have funding, then nobody has coverage, and that's the worst.

Chair Wells: So for me, I ultimately would rather have two. I wasn't thrilled when we went back to three because I don't think there's enough difference between the between the plans. I get that there's some people that like the HMO planned down south. And we don't have that managed care structure in the north with the EPO - it's just not there. And so, if we want to keep a like plan, then I think we need to see what's out there in the north for some kind of a managed care

plan. It's a little bit different now than it was when the EPO was created because you've got some of the managed care vendors that do Medicaid and the public options now have to have statewide plans. So, I think there's some other options that we could look at. Recognizing that the richer the plan, the more your premium is going to be. And I think that we do need to go back and figure out how we want to subsidize plans for the dependents because that is going to what these plans cost to the people who want to enroll in that. But ultimately, the plans need to cover the costs through a combination of what the state provides and what we charge the participants.

Ms. Donaldson: And I was going to make the next suggestion. Do you want us to come back with different alternatives of allocations of employee cost share versus dependent cost share.

Member Davis: Yes, I agree.

Chair Wells: I think we should.

Ms. Donaldson: Some could be cost neutral, but some could be savings. I'm thinking the ultimate is savings, right?

Chair Wells: I don't know if I see it as a zero-sum game. Maybe, maybe not. It depends. I think we could look at it in a couple of different ways and see. Some of it might ultimately resolve cost savings. But I think we did at one point have in the duties, policies and procedures how we were going to subsidize plans. It made it so that the board didn't have as much discretion about it's not the right word, one-off thing, how much we subsidize plans. And part of that is what's gotten us where we are. And so, I think having a set subsidization policy and the state providing what the state provides, to balance the responsibility of the participant. They want the richer plan, it's going to cost more money. But I think having it where it's a policy, as opposed to just board decision, because a board decision can change, your policy can too. But it's less likely to get changed if you have a policy.

Member Harper: Blaine Harper for the record, what's on my mind in that context is, if we are facing a solvency issue, how is all of this not a problem at the city and county comparison level? Because their price differentials between plans with very different actuarial values are not as significant as what we are now between our plans. I think we need a closer look at the premiums next time. They need to dig into that a little more. We are depending right now on planned migration to manage some of these costs and premiums are the signal for that. But there are lower premiums overall, regardless of actuarial value at these other plans at the city and county level. And I just don't know how they're not seeing the same issues. Or are they seeing the same issues?

Chair Wells: Do you want to know?

Member Harper: Yes, please.

Chair Wells: The answer is that most of them don't cover retirees. That's the answer. The few retirees that do participate pay the full rate. A couple of them, there are a couple left, I think, that have some grandfather subsidies, but most do not. Most cities and counties and school

districts no longer subsidize retirees. They forfeited them for raises in the late 70s and early 80s. That's why they have lower rates, because they're not paying for the 55 to 65 year old retiree population or 55 to whatever. That's why they can have lower rates. And some in the south have the benefit of southern cost. The cost structure itself is lower. So, the some of the southern ones have the benefit of that as well.

Ms. Donaldson: So we can come back with different subsidy scenarios. We'll come back with some plan design alternatives. Thank you, that helps give us clarification. I think we can coordinate action plans with Director Carsten because there's action, there's things that need to happen not legislatively, but maybe legislatively to make this happen. We talked about the pending subsidies. And then we'll work and coordinate stuff about, because some of this stuff is going to potentially require RFPs so more to come. Thank you very much for that direction. Appreciate it.

Chair Wells: I thought it was we would bring back more discussion. We'll have to look at, August is a pretty quick turnaround, so probably won't be August, but September. September meeting will have the first look at some of this stuff and then narrow it. We have to decide how fast we want to implement whatever it is, but we'll have to set rates in March, so we have to know between September and end of the year, the direction. Anything else? Any other comments, questions?

Ms. Donaldson: I do have a question about how this all affects the budget?

Chair Wells: We'll do it the same way we've always done it. That budget has been submitted. We get better information in December, if we update it.

Ms. Donaldson: Okay, great.

Chair Wells: Any other questions, comments?

Member Davis: One thing. I'd like to especially thank the two presenters, the moderator, all this good job. Seriously, it’s hard to do what they do.

Ms. Donaldson and Mr. Sherman: Thank you. Thank you. Thank you very much.

Chair Wells: Yeah, I'd like to thank both the people at Milliman and the people at Segal, Andrew for moderating today. It was much better than I could have done. It’s nice to have somebody come in from the outside and moderate. But I do appreciate all the work that went into this, both from the Segal staff and those from Milliman.

Mr. Sherman: We have some challenges, but we were able to get to help, and we're going to help more.

Chair Wells: All right, if there are no further questions, comments, we'll close agenda item number 5. Move to agenda item number 6, public comment. Any public comment.

Mr. Ervin: Hi, thank you, Kent Ervin K E N T E R V I N. Thank you for all the discussion. I'm just going to concentrate a little bit on risk pools. Number one, separating risk pools, that's a legislative issue. The board can't do that on its own. Number 2, moving Non-Medicare retirees to the exchange. I totally misunderstood what that meant. So, in my initial public comment, I was thinking the Medicare pay would be a benefit if you can't do that. This will get a lot of push back unless you can show that's a better deal to the wide majority of retirees. And a lot of that goes to, well, what employer subsidy will they continue to get. And the experience with the VIA benefits Medicare exchange folks is their state subsidy hasn't changed for 10 years. And their cost of Medicare have gone up. Same thing is going to happen in the future with moving people off the PEBP into the exchange. That's a big problem. But what the PEBP board does have full discretion over is in #3 here but expanding that to not be just the dependent or contributions, but retirees versus activities, you get to set those percentages. And I don't know why, but the retiree percentage for single retirees has gone up from 64% to almost 70%. No more discussion of that, so I don't know why that happened. But, when you have the discussion of relative cost of retirees versus actives, it's an age thing on average. But correlation is not causation. If it's really about ages, should the rate be different for a 55 year old retiree typically versus a 55 year old active employee? But where you have discretion really distinguish between an active retiree is then what subsidy again? And you get to set that. Retirees pay more of their benefits, not 100%, as it could be for some local governments. Washoe County still pays 100%, and they recently added some retiree health benefits back, like the state remained after the Great Recession. So maybe moving in the other direction. Again, I think the state ought to move in the other direction too. For now, to fix some of these issues, a complete review of those subsidies for actives. If I … here, actives versus retirees, you can make adjustments, just don't do it too quickly, so that single groups feel like they're singled out.

Chair Wells: Thank you, Dr. Ervin. I don't see any other public comment? Close agenda item number six, public comment. Motion to adjourn.

Member Viton: Motion.

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

Member Rich: I'll second.

Chair Wells: All those in favor say aye.

All board members: Aye

Chair Wells: Thank you all very much. We'll see you on August 20th back in Carson City.