March 19, 2026 Unofficial Board Meeting Transcript

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

Chair Jim Wells: Great. Thank you. Good morning, everyone. We'll call to order the meeting of the public employee benefits program scheduled for today, March 19th, 2026 at 9:00 a.m. Can I get roll call, please?

Jessica Crane: Good morning. Starting roll. Jim Wells?

Chair Wells: Here.

Jessica Crane: Joy Grimmer is absent today.

Ms. Crane: Jennifer McClendon?

Member Jennifer McClendon: Here.

Ms. Crane: Laura Rich?

Member Laura Rich: Here.

Ms. Crane: Jim Barnes?

Member Jim Barnes: Here.

Ms. Crane: Blaine Harper?

Member Blaine Harper: Here.

Ms. Crane: Chris Viton?

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Member Chris Viton: Here.

Ms. Crane: Keiko Duncan?

Member Keiko Duncan: Here.

Ms. Crane: And Tom Zumtobel?

Member Tom Zumtobel: Here.

Ms. Crane: Thank you. We do have a quorum.

Chair Wells: Great. Thank you very much. Move to agenda item number two, public comment. No action may be taken on 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 will be taken under advisement but will not be answered during the meeting at the discretion of the chair. Time for each individual to make comment as well as aggregate time for public comment may be reasonably limited. We will keep the three minute per person limitation. You'll see I don't think we need to limit the total amount of time. Additional comment periods may be allowed on individual agenda items at the discretion of chair.

Today we will have one after agenda item number five and we are going to take agenda item number nine before item five. So, we'll do the budget report and then the information from the actuaries. Again, those comments will be limited to the relevant agenda item under consideration and it will also be limited to three minutes per person. Members of the public may make public comment using the call-in number provided. That number is 669-9006833. Today's meeting ID is 84530496510#. Persons unable to attend the meeting in person or by telephone or who wish to make public comment not subject to the time limit may submit that public comment in writing. At the beginning of your public comment please state and spell your name for the record before beginning your testimony. With that we'll open public comment here in Carson City. Anyone going to come to the table for public comment?

Mr. Salls: Morning members of the board. For the record, my name is Kevin Salls. That's K E V I N S A L L S. Here to provide comment on the proposed changes to the employee health insurance rates. I've worked with the state for about nine years now. My particular role has involved remediating hazardous chemicals. My wife works for the state as well. I love the work I do for the state. I care about it deeply and I believe that it's valuable. I work to protect the health of everyday Nevadans and this decision threatens my health and the health of my family.
My wife and I are expecting our third child this year. In order to prepare for that, we selected the EPO plan as the best balance of cost and benefits for our situation.

The proposed changes would raise what we pay for that plan from approximately $800 a month, sorry, $700 a month to $1,800 a month per the document provided by Segal at the last meeting, the PowerPoint from February. That's pretty cumbersome. I don't know many people that have $1,100 of extra disposable income handy to pay for health insurance every month. If

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you do, board members, then I envy you. But what you're proposing is essentially a $13,000 pay cut for anyone on that plan. The changes to the other plans are better, but not by much. If these changes proceed, my family and I will have to make some hard choices. Do we just eat the cost and I go get a second job and sacrifice valuable time with my family? Do we switch to a lower health to a different healthcare plan and compromise on the care that we provide for our children? Or do we leave state service entirely, a job that we love and that we consider valuable? It's not just us that's going to have to make this decision.

Many of my co-workers have voiced similar concerns. I know more than a few are already looking for the door in a time when we're already struggling to fill our vacancies. In a time when our turnover is pretty severe and we're already being squeezed by inflation. This is a change that we cannot afford to make. It is going to hurt the state. It is going to hurt state employment. It's going to hurt our ability to fulfill our basic mission. I understand the need to make the budget balance. I'm as horrified by the shortfall as I'm sure you guys are. But to balance that shortfall on the backs of state employees is the height of treachery. It is absolutely unfair and I cannot believe that you would countenance it. I urge the board to look elsewhere for funds to make up these shortcomings. Thank you.

Chair Wells: Thank you, Mr. Salls.

Ms. Corino: My turn. I don't, I get very nervous speaking in front of a bunch of people but this impacted my issue impacted me. I'm not quite as organized. My name is April Corino. A P R I L C A R I N O a loyal state employee of approximately 30 years going through many agencies throughout the state. Consider myself loyal. My issue is my healthcare. I transferred out of using Via Benefits with my benefits transferred out from a supplemental to an advantage plan not knowing, unbeknownst to me which ignorance of law or whatever it's not an excuse, but I lost my life insurance. I knew I lost my funding and my dental. That was fine. I was fine with that. I had no idea, never heard of losing my life insurance policy if I went outside of using Via Benefits. And to me, I don't recall that in any of the meetings, any of my discussions, talks with Via Benefits, which by the way are hard to get a hold of. Never, never heard that I would lose my life insurance. I can reinstate myself. Well and good. I received my $260 towards health insurance. That's great. I can get back on my dental, but I cannot get my life insurance back. Why is that? And I understand United Healthcare runs that. I imagine it's a financial decision as everything in this world is now financial. I'm wondering how much the state can save by cancelling our life insurance. That's outrageous.

Unbeknownst, I would never have switched. It's not a great deal of money, but it's enough to make a difference in my life that I cannot get that back. I think it's outrageous. And not having heard of this, I don't recall this and I guess I have to look at my pamphlet to find out in fact that yes, if you go outside of using Via Benefit services, you will lose your life insurance. Never heard that. I understand you can't make a comment from reading this about my issue. I see there's budgetary during this meeting, vendor reports from United Healthcare who runs United, runs our life insurance and they're saving money granted, but at what cost and I don't know I guess I need some help and I'd like to be able to be put on the record regarding the life insurance. Do I need to

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come to a meeting when you're talking about Via Benefits or benefits? Do I need to come to a specific meeting to address this horrific situation?

I don't know if I need to do that. So that's really why I'm here. Yeah, it seems. And I got a letter telling me after the after that you no longer have life insurance. You can get back your $260 a month. You can go back to dental, but you cannot get your life insurance. One of the major parts of that tree, that three prong I can't get it back. Horrible. So that's my main issue. Actually, the only issue and I know it's financial at what cost? United. Boy, no wonder they got a bad rap. And I understand finance. Everything in this world is about money. But I've worked 30 years, you know. I can't believe that the state would agree to that, to cancel our life insurance. $10,000. Excuse me. And it keeps going down every year, which is fine. $12,000. Is it worth that to the state? 30 years I have worked for the state.

Oh, by the way, it's kind of tucked away in their large packet of information Via Benefits. Tucked away. Don't go away. Don't go outside of Via Benefits or you're not going to get your life insurance back. And I guess that's it. I can't think of anything. I think that's it. And I am getting reinstated. I am going back to the supplemental because supplemental is the best. Advantage plans are no good. But, one month I made the mistake and within one month after digging and talking to Via, finally getting Via and the outside agent, independent, who of course knows nothing about our plans. I find out within one month I've lost a huge amount of why I work for the state of Nevada. I raised my kids by myself through the state and I enjoyed working for the state. But to me, this is beyond treasury. So that's it.

And hopefully I'll call somebody to find out if I can come and put this on record if you're having meetings about this. I understand being cancelled, that's fine, but not life insurance. That should not be a part of the health insurance. Would I be able to make any kind of a comment during your item number 12?

Chair Wells: Uh, no, we're not making public comment during that item.

Ms. Carino You don't? Okay. So, I guess that's it. And I don't know the procedure, but it's horrible. And I bet I'm not the only one that this has happened to. Got to do something about it. I could write letters to the insurance commissioner who has nothing apparently to do with this, but I'm going to write to him anyway and the AG and hopefully something could be done if I'm not the only one. It's just terrible travesty. It really is. I can go outside and try to get out their life insurance, but I don't have a lot of money. I have; in fact I don't have a savings. So, I worked hard and my $12,000 for my final expenses is now gone. Of course, I can buy it now. I guess that's it. Thank you for your patience. I appreciate it. Not happy with United. Not happy. Thank you.

Chair Wells: Thank you, Ms. Carino.

Mr. Ervin: Kent Ervin K E N T E R V I N Nevada Faculty Alliance. I request that my comments be entered into the official record for the open meeting law. Where to start? In December, we were told that the budget would restore mandatory reserves this year. In January, there's a fiscal crisis and PEBP will not have funds to pay all claims within a few years. In February, that was

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worse by 56 million because the actuary had been using wrong numbers since last spring. Today's budget report shows revenues are meeting expenses so far this year, which is good news. Board members have been told the legislative budget is wrong. How and why? Before making any rate decisions, the board must receive credible explanations. How can rates be set with everchanging numbers? Today's rates proposals were not posted in time for written comments. We've been struggling to analyze the report issued Tuesday morning. Board members are likely struggling to understand also. That alone is a reason to defer any action on rates.

If you do move ahead, there are nine scenarios in the brand new packet. The board chair has verbally committed to a three-year phase in option C. In round numbers, Option C will increase PEBP's cash reserves from 60 million currently to 80 million in FY 2027 toward the 120 million actuarial target. Given the 1/3 2/3 split in employee versus state revenue overall, that's really the entire employee share in one year. Questions. What is the breakdown of the total rates between the ongoing health care expenses versus replenishing reserves? The new actuary should be able to answer. Option D should be to keep the reserve deficit from getting worse and fixing the problem in the 2027 session. That's worth consideration at a special meeting. The other choice is whether to maintain the increases and out-of-pocket maximums that were approved by you in December with bad information. The $1,000 to $2,000 increases for the out-of-pocket maximums for the high deductible and low deductible plans will hurt most the low income employees who need significant health care to remain productive in their jobs. Option 3 C is the least bad of the nine scenarios. Option 1 C does not change premiums much versus 1A and versus those letters and numbers keep confusing me. I think that one's wrong. So, option 1 C versus 3C does not really affect premiums much and it's just not worth it when employees are being asked to come up with tens of millions of dollars to fix a deficit that's not of their making. The juice is not worth the squeeze. It's insult on top of injury. Please defer action to receive better information and better options. Thank you.

Ms. Opferman: Good morning, chair and members of the PEBP board. For the record, Tess Opferman, that is O P F E R M A N, here on behalf of the AFSCME retirees. We echo the grave concerns expressed here today by both actives and retirees. Our state employees and retirees simply cannot afford a significant increase to their premiums like some of those proposed. The past three months have revealed a failure of our public employee benefits program that has existed for years and is now coming to light in a big way. Kent has done an excellent job of explaining these failures and inconsistencies. I've frequently spoken to this board and to the legislature about the lack of increase to the health reimbursement arrangement, the HRA, that Medicare retirees receive. They get at most $260 a month and this has not increased for nearly 10 years despite the fact that the cost of healthcare has gone up considerably.

Another point of contention is the cost of dental care for our retirees, which is consistently 35 to 45% higher than the state PMPM rates. We also heard from a retiree just a few minutes ago uh that expressed complaints about the Via Benefit system which has also been very problematic for our retirees and I hear about that frequently from our AFSCME retirees. All of these issues will not be fixed at today's meeting but I sincerely hope this board takes these failures and inconsistencies seriously. Dedicated state workers and retirees are not being treated fairly for their years of dedication to the state. With regards to this decision you'll make today,

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we second Kent's advice and recommend postponing any decisions until we have a better idea of the numbers that PEBP faces. We thank you for taking all of these concerns seriously and working with our actives and retirees to make sure this is a system that is affordable and also provides quality health care for all of our actives and retirees. Thank you.

Chair Wells: Thank you. Anybody else here in Carson City? Seeing none, we'll move to the phone.

Mr. Hopkins: Chair Wells, we actually have 32 people in the lobby. One moment. I'll get the slide up. I'll make another announcement shortly. Joining this Zoom meeting as an attendee is for making public comment only. If you do not wish to make a public comment, please leave the Zoom meeting now so that you're not accidentally called upon. Please feel free to watch it via the YouTube live stream on the PEBP YouTube channel. The link to the live stream is located on the agenda. For those who have joined for public comment, your name or the last four digits of your phone number will be announced and you'll be advised you have been unmuted.

Please state and spell your name for the record and then proceed with your comments. Since we have so many people in the lobby right now, I'm going to call on those who have their hands raised, I will call upon them first. Then I will call upon those joined via their phones and then so on and so forth. Please also make sure that your username in the Zoom lobby is an actual name, not just a random username or something similar. Thank you. Susan Mowers, you have permission to speak. Please slowly state and spell your name for the record.

Ms. Mowers: Thank you. Hello. My name is Susan Mowers. That is S U S A N M O W E R S. And I have served as the creative director for the Nevada division of tourism now for the state for nine years. You know, I'm here because I love being a public servant. I'm an activist at heart and I choose to serve my state even though I know I could earn significantly more in the private sector. But today it really feels like I'm being punished for that choice. You know, being told that our PEBP premiums must go up with some projections showing staggering increases, you know, even for 2026. At the same time, our raises have been cut or frozen, and the promised initiative to reassess and fix our lagging compensation was quietly halted. My question to the board is simple. Why was this decision made? And why must the dedicated employees of the state bear full accountability for the budget shortfalls we did not create?

Governor Lombardo has stated that he wants to retain state employees and keep our compensation competitive. This proposal contradicts that goal entirely. You cannot claim to value retention while simultaneously giving your workforce a functional take-home pay cut, the state continues to ignore the compensation crisis while raising our health care costs. It will face a mass exodus of the talent that Nevada needs to function. I urge this board to table this item. Do not rush into a plan that shifts this entire burden onto the workers. I encourage you to be more diligent in searching for a better plan or even a different insurance carrier that doesn't force your employees to choose between their health care and their rent or their mortgage. It is better to take the time needed to find options that protect the people who keep this state running. Thank you very much.

Chair Wells: Thank you, Ms. Mowers.

Mr. Hopkins: Paul Lunkwitz. You have permission to speak. Please state and spell your name for the record.

Mr. Lunkwitz: Good morning. My name is Paul Lunkwitz. Excuse me. P A U L L U N K W I T Z. I am the president of FOP Nevada CO Lodge 21. I also served as a correctional officer for 21 years and then retired successfully in 2021 and I'm currently a retiree from the state of Nevada. These increases will cripple the state's ability to recruit and retain employees. Employees are already seeking other insurance options to opt out of the current plan. FOP has already started discussions with providers who have indicated they currently provide more benefits at a lower premium with a smaller employee base and paying a lower subsidy. If FOP is doing this, I guarantee you other organizations are as well. The current provider does not appear to be competitive and I question why there are no efforts made by PEBP to seek a provider that will salivate over the idea of a 17,000 employee participant base with better rates. If I can get preliminary numbers with a group of 10% the size of all state employees, I guarantee you there are providers that will save employees and the state of Nevada money.

However, you bow at the whims of the current provider to allow these ridiculous increases to occur. Local government agencies have similar insurance with better benefits at a lower cost. There are better options and the sheer complacency being exhibited by PEBP is absolutely unacceptable. You have a duty to serve the interests of the state of Nevada, but more importantly, the employees who participate in this program. Your failure to fulfill this duty will be compounded when employees begin opting out of these plans. The shortfalls are going to grow significantly larger when you lose thousands of group participants who are seeking alternative options for health insurance. FOP urges you to take drastic action to avoid these increases to premiums and decreases to benefits. There are better options available and we are absolutely willing to work with you to find them. Thank you for your time.

Chair Wells: Thank you, Mr. Lunkwitz.

Mr. Hopkins: Douglas Unger, you have permission to speak. Please state and spell your name for the record.

Mr. Unger: Doug Unger D O U G U N G E R immediate past president UNLV chapter Nevada Faculty Alliance and member UNLV employee benefits advisory committee. For the record, the preparation and notifications by PEBP and its administration for this much anticipated meeting to discuss and vote on plan designs and rates for the 27th fiscal year and perhaps beyond are extremely disappointing. I believe it is unprecedented that such important proposals are not posted within a reasonable time in advance for state employees and the public to be sufficiently informed and afforded a fair and reasonable opportunity to make public comments to the PEBP board as to the real life effects of board decisions. This lack of public notice and standard process transparency is not acceptable. Regarding agenda item number five, now that it has been posted, the only affordable option for the majority of state employees is 3C. To phase in premium

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increases over 3 years and keep out-of-pocket maximums to the 2026 levels so as not to extract a minimal increase in revenue from those who suffer acute medical issues or chronic illnesses so can least afford the costs.

As example of why the other options are not affordable, consider that administrative assistant salaries fall into a general range from 42,000 to 62,000 per year. After mandatory PERS contributions, Medicare fees, withholding, net take-home pay can be 3,000 per month or less. Even the approximately $164 increase in family premiums on the PPO or $251 for the HMO EPO and option 3C will be stressful. While the proposed cost increases in the other options will be grotesquely unaffordable. Please keep in mind that many lower income tier state employees already rely on food banks and other community support systems and second jobs to make ends meet. I know several in these hard pressed circumstances.

Regarding agenda item number nine, just last night I passed news that the more than 200 million in discrepancies that state employee advocates uncovered between projected revenues and the PEBP budget closing before the 83rd legislature last April 2025. and PEBP's current numbers are at least in part due to erroneously inflated figures somewhere in the budgeting process that may have miscalculated enrollment, state contributions, and premiums. These discrepancies remain to be explained. On the other hand, Segal's figures reported today, though showing some increases in overall numbers over past reports, don't seem quite right. For the sake of restoring trust in PEBP's numbers, it would be beneficial to report in much more detail the why and how PEBP is looking at shortfalls in AEGIS and REGI and projected shortfalls in employee premiums for this fiscal year. These seem like very large deviances from previous projections. I hope that PEBP and its actuary will make it a top priority to provide much more reliability and clarity in its accounting in the future for the many thousands of state employees PEBP serves. Thank you.

Chair Wells: Thank you, Dr. Unger.

Mr. Hopkins: Janell Woodward. You have permission to speak. Please state and spell your name for the record if you wish to make public comment. Janell, you have your hand up. Please unmute your mic if you wish to make public comment. Gabriel Mortensen, you have permission to speak. Please state and spell your name for the record.

Mr. Mortensen: Hello. Um, thank you. Yes. Good morning. My name is Gabriel Mortensen. That is G A B R I E L M O R T E N S E N. I work for the state of Nevada as a computer programmer and research analyst. I want to start off by saying that I truly value the work we do. I choose public service not because it pays the most, but because I care deeply about Nevada and contributing to something meaningful for our communities, especially our rural communities. I'm also here today as a father. Uh my wife is a stay-at-home mom and we have two children under the age of two. Like many families, we rely heavily on the stability of our benefits to make ends meet and plan for the future paycheck to paycheck. The proposed changes to health insurance premiums are deeply concerning for my family and for many of my colleagues.

While I understand the need to balance budgets, the impact of these changes is not abstract. It directly affects whether families like mine can afford to remain in public service. In

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my role as a programmer, I am aware of the opportunities that exist in the private sector financially. Quite frankly, the state already does not provide um private industry compensation. Many of us accept that trade-off because we believe in the mission. However, when rising health care costs are added on top of that gap, for example, my healthcare would go from 800 a month to 1,500 a month, it becomes increasingly difficult to justify staying.

We are already seeing the effects um here at my department. One member of our group has left due to financial instability after having her baby and that was before these proposed healthcare changes. Since this information has been released, I've had multiple conversations with co-workers, many of whom are in this group queue and many of whom have families and who are considering leaving the state. I want to be transparent as well. I'm now considering that decision myself, not because I want to leave at all. I really love my job, but because I may not have a choice and I need to be there for my family. This proposal risk is creating a situation where the state loses experience, skill employees in an effort to address short-term budget concerns.

Over time, the loss of institutional knowledge and technical expertise will carry its own costs both financially and operationally. I respectfully ask the board to consider deferring action on this proposal. Taking additional time to explore alternatives could help prevent unintended consequences that impact not only state employees, but the effectiveness of the services we provide to the people of Nevada and Nevada families that work for the state. Thank you for your time and for considering the real impact these decisions have on families like mine.

Chair Wells: Thank you, Mr. Mortensen.

Mr. Hopkins: Stinehour, you have permission to speak. Please slowly state and spell your name for the record if you wish to make public comment.

Mr. Stinehour: I'm Officer Jason Stinehour. J A S O N S T I N E H O U R. I've been with the Nevada Department of Corrections for uh 10 over a little over 10 years and I'm Sergeant at Arms with FOP Nevada CO Lodge 21. I've been with the department through the COVID mandates, the exits of officers leaving due to the mandate of the COVID shot, making us get the shot or lose our jobs, been through furloughs. If you think the COVID exit of employees was bad, this is going to be worse. Since I've had this job, my wife didn't have to work and it was great because we didn't have to pay for child health care. But now either she's going to have to get a job or I'm going to have to get a second job and not have time for my family. We have the HMO coverage which is about $800 a month and that's going to go up to $1,500 a month which is, I can't even explain. It's just crap. And I'll have to get a second job and I won't be able to spend time with my family. And that is not right.

The whole point of saving the state saving money is to retain your uh employees. If you don't retain your employees, you're going to be spending more money elsewhere to train, hire, whatever the cost is. It's just I don't know. This is just everything's going up and I you guys really need to rethink about going with another uh insurance company. Also, in the last legislative session, FOP did put a bill together to have competition so companies would come in and bid for our health insurance and it was turned down. Please reconsider such a huge increase. Everybody

is going to end up quitting or getting a second job or searching for insurance on the outside. Thank you.

Chair Wells: Thank you, Mr. Stinehour.

Mr. Hopkins: Caller with the last four digits 3876. Please press star six to unmute and please slowly state and spell your name for the record.

Ms. Bledsoe: Good morning. For the record, my name is Marie Bledsoe and I am a state of Nevada employee. I need to express my deep concern regarding the future of our employee health benefits. Recent reporting on the mismanagement of this employee benefit has been alarming. The fact that the program is $16.5 million underwater and budget discrepancies are projected to put the program at 56 million deficit by the end of this fiscal year is untenable. Reporting has gone on to say that the only way to fix this problem is to increase what employees pay by 84%.

I want to express two concerns. First, the raises state employees received after the 2023 legislative cycle could only be described as a celebration. It felt like the state finally appreciated its employees. Today, that feeling has disappeared. It now feels that raise is being taken away. Second, I have concerns over a mass exodus from the state by its employees. I agree that this may be an issue, but let's look at what is currently happening right now. As of this morning, there are 273 open positions listed on the state of Nevada's careers page. Of those open positions, 212 or 78% of the currently open positions do not have a closing date. State employees know this means these positions are not going to be filled anytime soon. So, current positions are not being filled. If this body agrees to raise health benefits by 84% then more positions will be added and the rate at which these positions are going to be filled will go higher than 78% unfilled.
The remaining employees must continue doing the work of two or three people to get the job done. Please consider very carefully the impact this decision is going to have. Thank you.

Chair Wells: Thank you, Ms. Bledsoe.

Mr. Hopkins: Janell Woodward, you have permission to speak. Please unmute your mic if you wish to make public comment.

Ms. Woodward: Good morning. Janell Woodward, J A N E L L W O O D W A R D. The process of determining costs for our insurance benefits is complex and challenging. We understand that health care costs continue to rise each year and that some level of increase is likely unavoidable. However, the 2027 plan year is of particular concern to employees and retirees due to the missteps that have occurred along the way. At a time when employees are not receiving pay raises both this year and the next, the affordability of health care has become an urgent issue.

Many employees are placed in the difficult position of having insurance coverage but lacking the financial ability to utilize it. Those with health conditions often feel stigmatized for incurring costs even as a growing share of those costs is shifted on to the employees. Once again, it appears that budget challenges are being addressed at the expense of state employees. When

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Governor Lombardo introduced the creation of the Nevada Health Authority in his state of the state address, he emphasized the potential benefits of combining Medicaid participants with state employees and retirees to increase purchasing power. However, to date, there has been little communication regarding any measurable benefits or outcomes from this initiative. We recognize that insurance costs will continue to increase. However, I respectfully urge the board to keep in mind the real and significant impact these decisions will have on the lives of employees and retirees. I asked the Public Employee Benefit Program board to adopt option 3C as the most balanced and equitable choice for the majority of state employees and retirees if not to delay decision until accurate and consistent information is obtained. Thank you.

Chair Wells: Thank you, Ms. Woodward.

Mr. Hopkins: Caller with the last four digits 0891, you have permission to speak. Please press star six to unmute and please slowly state and spell your name for the record.

Ms. Laird: Good morning, board chair Wells, fellow board members, executive officer Carsten, and fellow remaining PEBP staff. My name for the record is Terri Laird T E R R I L A I R D. I'm the Executive Director at RPEN, the Retired Public Employees of Nevada. We represent nearly 7,000 due spaying members, mostly retirees, but honestly, we represent all public employees, retirees and actives, because RPEN is among a public employee coalition who lobby together for protection of the pension and health care benefits they all earn while working and then once they've retired. It is sad to see what is happening with PEBP now. Once again, there are many concerns expressed in written and oral public comment before you this morning. We won't go into depth, but RPEN concerns reflect all of the concerns you will hear or read today. We too encourage this board to seriously consider all of these comments and take additional time if necessary to further vet the recommendations before you today.

Health care just keeps going up faster than ever. And yet, you're asking your hard-working state employees to somehow find the money to cover huge increases in their premiums without a full explanation of how it happened. PEBP has had financial difficulties before, but this appears to be something that should have been avoided. And yet, we don't know who dropped the ball to let this happen. Like others mentioned in their public comment, we urge you to consider delaying the start of open enrollment if this issue cannot be resolved in a more timely and fair manner. Your hardworking state employees deserve better than this. Finally, I'll once again note the fact that PEBP retirees moved to a Medicare exchange years ago have gone without a raise in their health reimbursement arrangement for about 10 years in spite of the public employee coalition's efforts to seek minimal raises of one or two dollars at the last legislative session only to have the request denied. Retirees are out of the workforce living on fixed incomes. and how long must they wait for the HRA to be raised to keep up with the ever escalating cost of health care at a time when they need it most as they grow older. Thank you.

Chair Wells: Thank you, Miss Laird.

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Mr. Hopkins: Caller with the last four digits 1026. Please press star six to unmute and please slowly state and spell your name for the record.

Ms. Charles: Good morning chair and members of the committee, members of the board. My name is Cassie Charles rep with AFSCME representing our hard work working state workers. You have heard from state workers who are struggling to pay bills. State workers who have to make the hard choice not to seek care when they are sick and state workers who have had to make the choice between paying for their basic needs or going to the doctor. Our public employees simply cannot afford to take the brunt of PEBP's economic crisis. It is becoming too expensive to be a state employee and the state workers have made their voices heard regarding the impact of rising costs. Thank you.

Chair Wells: Can you state and spell your name again, please?

Ms. Charles: This is Cassie Charles. C A S S I E C H A R L E S.

Chair Wells: Thank you, Miss Charles.

Mr. Hopkins: Caller with the last four digits 1240. Please press star six to unmute and please slowly state and spell your name for the record. We have an odd one. So, I actually have two people with the same last four digits of the phone number. I unmuted one 2830. Please press star six to unmute. Remove you and I'll try the other one really quick. Please press star six to unmute other caller with 2830. If you wish to make public comment, please slowly state and spell your name for the record. Apologies, it has this never happened before. So. Looks like they are both not available or not working. Go to the next one. Caller with the last four digits 1240. Please press star six to unmute and please state and spell your name for the record.

Ms. Barnthouse: Hi for the record. My name is Tracy Barnthouse. T R A C I E B A R N T H O U S E. I am a state employee and I deeply love and have a passion for my job and the work that my department does. I truly work with the best people. I am making a public comment to express my concerns over the proposed insurance rate increases for state employees. As the proposal stands, I would go from paying $800 per month to nearly $1,600 per month for insurance for my family to be covered medically each month. That is not an action I support at all being made in one fell swoop. I understand that shifts in the economy require a look at insurance premiums and the cost of the state, but to double the amount being paid each month is irresponsible and certainly does not put employees first. I highly encourage the board to look elsewhere for cuts to balance the budget. If that cannot happen and shifts must be made to health insurance for employees, I highly encourage it being made over the three years to allow families to adjust their spending to account for this larger deduction. Thank you.

Chair Wells: Thank you, Miss Barnthouse.

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Mr. Hopkins: Caller with the last four digits 3416. Please press star six to unmute and please slowly state and spell your name for the record. Caller with the last four digits 6150. Please press star six to unmute and please slowly state and spell your name for the record. Caller with the last five digits 66150. Please press star six to unmute and please slowly state and spell your name for the record. Ashley Hogan, you have permission to speak. Please uh state and spell your name for the record.

Ms. Hogan: Hello, my name is Ashley Hogan. A S H L E Y H O G A N. I'm a psychiatric case worker. I originally started at Denny Townsen. Shortly afterwards COVID started, I've stuck it out with the state going on 7 years now. And this would be detrimental to my livelihood. I would no longer be able to live in the state of Nevada. Nevada already has an issue where mental health care workers are fleeing to other states because it's not sustainable and I would have to move. There's no, it would be foolish of me to try and stay in a place where my work is not respected, where I'm expected to take on the shortcomings of this board and to cover budget cuts.

I think this decision needs to be deferred to the 2027 legislative session. I don't think this board understands the true impact this is going to have on employees, but I think the people that have spoken today have made it clear that you will cause a mass exodus of employees from the state of Nevada. You will personally impact the community that is already struggling. Every single day in my work, I am fighting the housing crisis. I am fighting the mental health crisis that we have in the state of Nevada. Our administrator just put out an article about the increase in suicides in Carson City and the impact that's having to our first responders. Our work is only getting harder and I don't understand why you're expecting us to take the brunt of these cuts. It's not sustainable and you will harm not only public employees but the citizens who rely on our services. I urge you to reconsider this decision and defer it to the 2027 legislative session. Thank you.

Chair Wells: Thank you, Ms. Hogan.

Mr. Hopkins: Caller with the last four digits 6789. Please press star six to unmute and please slowly state and spell your name for the record. Caller with the last four digits 4893. Please press star six to unmute and please slowly state and spell your name for the record. Caller with the last four digits 6970. Please press star six to unmute and please state and spell your name for the record.

Ms. Caldwell: Hi, my name is Brittnie Caldwell. B R I T T N I E C A L D WE L L I'm here to express my strong opposition to the proposed 160 133% increase in health insurance premiums and the shortening of open enrollment period for the state of Nevada employees and retirees. This proposal is not just unreasonable, it's dangerous. For many of the most public facing employees in our state, this increase would push insurance premiums to more than half of their monthly income. That level of financial strain would put employees at real risk and make it impossible for many of us to maintain basic necessary health care coverage. State employees already have taken multiple financial hits through increased PERS deductions and prior premium

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hikes. Adding to an increase of this magnitude places an unacceptable burden on Nevada's workforce.

And I have to ask, if these premiums become unaffordable, do you expect us to rely on welfare programs to make up the difference? Because those systems will also be impacted by this decision, creating a ripple effect of financial instability across the board. Without a major increase in wages, even a gradual version of this proposal would still cause severe hardship for employees and retirees who have devoted years of service to the state. I strongly urge the board to reject this proposal and protect affordable, accessible health care for the very people who keep Nevada running. Thank you.

Chair Wells: Thank you, Miss Caldwell.

Mr. Hopkins: A Angiano, you have permission to speak. Please state and spell your name for the record if we should make public comment. As a reminder, if you do not wish to make public comment or you're unavailable to make public comment, please drop from the meeting lobby now and watch the meeting on the YouTube live stream. Brittney Caldwell, you have permission to speak. Please slowly state and spell your name for the record. Oh, I'm sorry. Always bounce back and forth. CA Smith, you have permission to speak. Please slowly state and spell your name for the record. Follow with the last four digits. 5692. Please press star six to unmute and please state and spell your name for the record.

Ms. Barker: Hi, this is Velisity Barker. V E L I S I T Y B A R K E R. This increase is absurd. I don't understand how we ended up in this situation realistically because you guys refused to tell us and the governor as much as he has stated that he would like you know to keep retention and have worthwhile state employees hasn't said anything either. I would also like to point out I think it's interesting that you guys have your YouTube comments shut off. So, the only way to comment on this is to know where to go or go to your website. So, I just recommend that you guys hold off on this decision and see if there's anything else that you can do because asking for state employees to brunt your mistakes is wildly inappropriate at this point, especially with the price of everything else and our PERS. Thank you.

Chair Wells: Thank you, Miss Parker.

Mr. Hopkins: Chelsey Coggin, you have permission to speak. Please slowly state and spell your name for the record.

Ms. Coggin: Yes, this is Chelsey Coggin. Can you hear me?

Mr. Hopkins: Yes, we can. Thank you.

Ms. Coggin: Thank you. I just wanted to make a comment. I'm a fairly newer, state employee., I've been, here almost five years and I've been both classified and professional. And in that time, I have seen the increase in PERS. I have seen the that has been a couple times in an increase in

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the health insurance and with this huge of an increase it is definitely scary without any help. I mean everything has gone so far up and then there's talks of course of PERS increasing again within the next year or two. So with this and that I mean we can barely make it as it is and you're just asking us to try to make it with that big of an increase. I don't think you are going to see a huge amount of people leaving from this day and I don't want to. I love my job. I work for a community college and I definitely love what I do and love what we support. But that big of an increase I think is going to hurt many many people across the board, not just the lower people but even the administrators. So we're just asking that either something where this could be spread out over three years um like you said and I think there's an option on that and see I think I believe or just wait until the legislative session and see if the state can help you make up these differences. Just please consider something else and think about us when you're considering this. Thank you.

Chair Wells: Ma'am, can you please state and spell your name?

Ms. Coggin: Oh, I'm sorry. Yes. Uh Chelsey Coggin. C H E L S E Y C O G G I N.

Chair Wells: Thank you, Miss Coggins.

Mr. Hopkins: Caller with the last four digits, 8472. Please press star six to unmute and please slowly state and spell your name for the record. Corey, you have permission to speak.
Please slowly state and spell your name for the record. Will FMWCC Solis You have permission to speak. Please slowly state and spell your name for the record if wish to make public comment. G Binercolly apologies. You have permission to speak. Please slowly state and spell your name for the record. K. Quinn, you have permission to speak. Please state and spell your name for the record. I'm going to go back into a couple people that tried earlier. And those of you if you do not if you're not here for public comment, please drop from this meeting. With the last four digits, 2830, please press star six to unmute. Do the other 2830. Please press star six to unmute. Caller with last four 3416. 4893. Last five digits 66150 please press star six to unmute. 6789. 6970. Beth Jacobsen. Please slowly stat and spell your name for the record.

Ms. Jacobsen: Good morning everyone. My name is Beth Jacobson. B E T H J A C O B S E N. Just ensuring you can hear me.

Chair Wells: Yes, we can hear you.

Ms. Jacobsen: The details of this plan increase for 2027 have come to me through co-workers. I don't know if it's been easily available, but the numbers are beyond concerning. Even for an individual like myself, it is incredibly difficult to remain a state employee. I do not know how I can continue to remain employed. A few of my co-workers have made the same comments.
Us as workers paying for issues at the higher level continues to be a pattern we see in day-to-day life. It's becoming untenable. I just don't know how we can continue to remain employed at a place where we can be state servants and we feel that we make a difference. This is important

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work and it's just incredibly depressing. I hope the board really takes into consideration how this will affect everyone, including retirees, people that gave their life to service. That's really all I have to say. I just I really hope that empathy can be found. I really appreciate you listening to my comments today. Thank you.

Chair Wells: Thank you, Miss Jacobsen.

Mr. Hopkins: Apologies if I butcher this. Design Nekron. Negron, please press. You have permission to speak. Please slowly stay and spell your name for the record. Caller with the last four 8120. Please press star six to unmute. Chair Wells, we have about 14 people still in the lobby, but I believe I've gone through all of them. Would you like me to conclude public comment?

Chair Wells: Yeah, they haven't responded and we're going to close public comment.
Mr. Hopkins: That concludes public comment. Chair Wells. Thank you.

Chair Wells: We'll close agenda item number two, public comment. We'll move to agenda item number three, PEBP board disclosures. Mr. 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 of the board members who are eligible for Public Employee Benefits Program, PEBP benefits. Uh, pursuant to NRS281A.420, 420. On behalf of the board members who are eligible for PEBP benefits or whose families are eligible for PEP benefits, I offer this disclosure uh that they will be voting on those items that may affect the benefits available to them or their family members. The law does not require abstention from voting merely because the board member or their family member is eligible for PEBP benefits. At this time, I invite any member of the board who has any additional disclosure to make it known. Thank you.

Chair Wells: Any additional disclosures from board members? Seeing none, we'll close item three. Move to agenda item number four, approval of the active minutes from the January 20th, 2026 and February 24th, 2026 PEBP board.

Mr. Barnes: Jim Barnes move approval.

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

Mr. Zumtobel: Tom Zumtobel, Second.

Chair Wells: We have a motion, a second. Any further discussion? All those in favor say I.

All Board Members: I.

Chair Wells: Any oppose? Nay. Motion carries. Close agenda item number four. We're going to take agenda item nine out of order.

Ms. McJoy: Good morning. For the record, my name is Monica. Last name McJoy. M C J O Y. And today I'll be going over the quarter 2 operational budget. The date is for December 31, 2025. In your attachment, you will see the operational budget shown below in the summary. It accounts for status as of December 31st, 2025 with a comparison to the same period in fiscal year 2025. The budget status is reported on a cash basis and does not include any incurred expenses and income owed to the fund. The budget status reflects actual income of 258.4 million as of December 31st 2025 compared to the 205.4 million as budget December 31st 2024 or you consider it as an increase of 25.9%. Total expenses for the period has increased by 31.2 million for the same period. The budget status report shows realized funding as 58.3 million. This compares to 63.8 million for the same period of last year.

If you go to the next table, the table below finds out of order. We're going to be talking about the current budget projections. The following represents projections for fiscal year 2026. The projection reflects total income by less than budget by 14.1%. which is comparison of 690.1 million versus the 593.1 million. Total expenditures are projected to be less than budget by 6.1% which is 568.8 million versus the 533.9 million. And the total reserves are projected to be less than budget by 51.2%. The state subsidies are projected to be less in the budget amount by 61.4 million which 14% or non-state subsidies are projected to be less than budgeted by 3.2 million is 14.4% and premium income is projected to be less than budgeted by 27.6 million. If you look at your operational budget, there was a typo for the premium income and the other income. If you just switch those, those was a typo. So, the premium income that was collected should be 45.957 million and all other income should be 577 million 316. Expenses for the fiscal year 2026 are projected to be 34.9 million which is six 6.1% less than budgeted when changes to the when changes to reserves are excluded. Operational expenses are projected to be less than budgeted by 1.3 million. Employees and retiree insurance costs are projected to be less than budget by 33.7 million when taken total. If you want the specifics, you can look through the budget for that information.

And I want to also take this time to discuss my findings with the fiscal year 26 budget. I took a deeper dive into the fiscal year 2026 budget and discovered several errors were identified such as the AEGIS and REGI. The rates for AEGIS and REGI were not tested by the previous administration and were loaded incorrectly into the financial database which resulted in lower revenue being collected. After completing my audit on the unreported revenue, I discovered that the subsidies created in 2023 to offset participant premiums were not turned off in 2024 and revenue continued to be generated in those subsidy accounts. After extensive research I identified a total of $18.4 million that was that weren't allocated. That was 14 million in REGI and 4.4 million in AEGIS. These funds have been moved to the operational budget and will reappear in the quarter 3 CFO report because turning off these subsidies require significant system testing. It is not a quick fix. So, I will continue to run reports on these subsidies monthly and manually move those amounts to resolve the issue. So, monthly I'm going to manually move the revenue to report in the operational budget because they're not reporting right now and we're looking to fix this during the open enrollment. So, this will be fixed for by 7-1-26.

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Another error I found was the budget bill. Although I don't have enough information to fully understand what data was used to create the budget, I do know that the budget was inaccurate and the wrong workbook was submitted to the legislature for approval. My findings indicate that the revenue assumption were based on a lower employee vacancy rate and inflated number of projected enrollees. Due to these errors, the budget amounts will never align with our projections. Another one I've read in the public comments that there is interest in having an audit completed on PEBP's operational budgets. auditors have completed the FY24 audit of the bed's budget and summer 2026 is when they will audit the fiscal year 25 budget. I want everyone to keep in mind when looking at the operational budget, budgeted and projections are totally different. Budgeted is the amount that legislator approved at the beginning of the fiscal year. It reflects what the leadership expected in revenue and expenses to be when the budget was created and the budget the projection is the updated estimate of what revenue or expenses are at that time expected to be based on the current trend and the actual activity. As a CFO of PEBP, I'm working closely with our partners to clear up any past mistakes and straighten out any miscommunication or misinformation. Thank you. Wait, is there questions?

Chair Wells: Any questions for Miss McJoy?

Member Zumtobel: Miss McJoy, I have several questions. I really new to this format. So I'm trying to get my head around it. But first, so I hear what you were saying at the end, the budget versus the projection. Where's reality in that? Right. So, there's the budgeted number and then there's a projected number, but where does the actual amount of money that was received as revenue is that called budgeted?

Ms. McJoy: No, that's in their projections. So, budgeted is what they submitted to legislator and said this is what we're going to collect based on the data they use to create the budget.

Member Zumtobel: So, you use that like a typical budget to create but it's legislatively established. So, it should be the number that's received, right? I mean, if the legislature said we're going to fund you at that level, isn't that the level it should be funded at?

Chair Wells: No. Budgets are budgets. Budgets are estimates that are made by the legislature as to what's going to happen in the next two years for everything. And PEBP is no different. It's predicated on the enrollment. It's predicated on the plan selection. It's predicated on a bunch of things, that may or may not come true just like every other agency's budget may or may not come to fruition as they go through the budget.

Member Zumtobel: But fair, right, that so like any other budget then it's an estimate. But you base it off of the rate that is established and then a projection of the headcounts, right?

Chair Wells: So yes. Part of this and Ms. McJoy attempted to explain it as the legislature was moving through and making some changes to our budget. They were approving enhancements requests that were submitted on behalf of the agency. They asked to get a new workbook

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reflecting the changes that the legislature had approved. From what we can tell, that workbook was never created and never submitted. So, what was put into the budget was not necessarily exactly reflective because it wasn't updated information from here from previous staff and so they just made a few assumptions to close the budget and so had PEBP revised their workbook at the time and submitted it, the numbers likely would have been different.

Member Zumtobel: So, if we actively tracked against our budget, we should you would know on a on more of a real time basis that that's occurring. Is that not clear?

Chair Wells: Again, there’s a budget process and then there's actuals once you get into the year. That's the budget process. The budget process is done during the legislative session. I just said that file was not resubmitted by former PEBP staff resulting in the legislature approving a budget that was not based on exact details from this agency. The projection numbers that we are using are now what will likely be based on the latest information come to fruition.

Member Zumtobel: So, I feel like I'm not asking my question correctly, but with the projected then do we have something in place that on a monthly basis we'll know if we're tracking close to the projected?

Chair Wells: Yes. So, every month they get information on how much they can bring in from the

Member Zumtobel: but we didn't have that before?

Chair Wells: We have it but part of the problem was that when they set rates last March, they input the rates into a system. The system then bills either the employer or the employee to deduct it from their paycheck. The rates for the employee share were tested. he rates for the employer share were not and they were under collecting on the employer side and for the entire year and no one caught it until we were doing the reviewing it a couple of months ago.

Member Zumtobel: Yeah. I'm not trying to make anybody relive it. I'm just trying to understand it because to me the way I hear that so I know I must not be hearing it correctly. If they were under collecting on the employer side and the employer is the state of Nevada and the employer had a budgeted number that's a cash problem.

Chair Wells: Again. T budget is based on a variety of projections that may or may not come true. If they say we're going to get 400 million, we may get 450 million. We may get 350 million. It's a projected number and it's based on a variety of conditions. The projected number now reflects more in line with what we intend to collect for the for the fiscal year ending in June.

Member Zumtobel: And I'm not too stuck on that, but I guess I don't understand the under collecting then. What does that mean if they were under collecting?

Chair Wells: So the under collecting is being corrected and if it has been corrected through

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February that's the 14 million plus the 4 million that Ms. McJoy referenced. Now they have to do that every month for the balance of a fiscal year. They have to adjust the amount that's coming in from the employer share because changing the system midyear is from what we're told more difficult than us doing the reconciliation and bringing in the additional money.

Member Zumtobel: Yeah. Yeah. I'm just trying to catch up. But if and I know we've talked about this and sometimes I think I get it, but then I obviously don't get it. If the if the rate increases are being based on revenue and there was under collected

Chair Wells: the actuaries have been provided with the updated revenue projections that are reflected in the item number five.

Member Zumtobel: So the revenue is correct when the actuarial projections they're based on

Chair Wells: the projected revenue that the actuaries used to go through 26 and set to 27 rates is reflective of the additional money that should have come in from the employer in the first place

Member Zumtobel: And the 14 plus 4 the 18 million is included in the projections also?

Chair Wells: Correct

Ms. McJoy: But they're not than this one because this is quarter 2 ended December 31. So the funds were done last month. So it'll you'll show you'll see it in quarter three.

Chair Wells: And there and there was another problem with payroll did not deduct from employee paychecks the first quarter or the first payment in in December. That wasn't received until the first quarter of the calendar year, the third quarter of the fiscal year. So there's some revenue that's coming in the first quarter of third quarter, the January to March quarter that is not showing on these two because this is as of December 31st. It'll show up in in March. But that but we did give the information to the actuary so that they could use that to project the revenue for 26 and use that for 27.

Member Zumtobel: Yeah. I hate that I still don't quite get it. I just don't quite get it, you know, and it's hard to make decisions when you are or to be part of a decision- making when you when when I don't feel comfortable and I'm just trying to get comfortable with the revenue.

Chair Wells: So, when we build a budget, we think there's going to be so many people and they're going to pick such and such a plan.

Member Zumtobel: Absolutely.

Chair Wells: That may or may not be the case during open enrollment. They may add dependents. They may remove dependents. They may change which plan that they're on. The

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dollar amounts that come into the budget to the plan differ based on that selection. And so it's always an estimate when we close and create a budget.

Member Zumtobel: And the part that I'm missing with that is you have revenue per unit and a number of units, right? I'm not seeing anything except you and I did talk about that there were vacancies that weren't filled.

Chair Wells: Yep.

Member Zumtobel: But but if the vacancies weren't filled, the budget was based on the on the on every position getting filled.

Chair Wells: Not every position. We always use a vacancy factor. We used a much lower vacancy factor than is reality. So we used a mid double digit vacancy factor. The state's still sitting in 13ish%.

Member Zumtobel: Yeah. Yeah. But because that's the way you would build a budget with what you describe, but you would also I guess know right after open enrollment what the counts are.

Chair Wells: Not necessarily. We have people who are joined every day. We have new employees who are hired every day.

Member Zumtobel: Yeah.But not not big swings.

Chair Wells: You can. The legislature approves new positions effective October. So you usually see between October and December a fairly significant number of of new hires and then you've got retirements or separations. So it's a it's a moving target.

Member Zumtobel: The number just the 100 million or whatever feels bigger than that explanation I guess is my challenge.

Chair Wells: And that is that is a direct reflection of the workbook not being updated by prior staff because the numbers that are in the workbook that were provided were significantly less.

Member Zumtobel: Yeah. And I apologize for dragging it through. I just trying to get a baseline understanding and I keep trying. Okay. Thank you,

Chair Wells: Mr. Viton.
Member Viton: Sure. Chris Viton, sorry. Just to make sure I'm understanding what is in the report and what's not in the report. the $18 million that's gonna be reflected in the next report. It's not reflected in the projection either though. I understand 63 million in bottom line deficit as of December 31st does not reflect $18 million of revenue in this quarterly report, but would in the next report.

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Ms. McJoy: Yes.

Chair Wells: If you look at the box on the on the bottom of this second page, you'll see the REGI coming in. You don't see the AEGIS coming in. It was done. It was finished later. So, it drops the 6o to 46 and then you'll drop another four.

Member Viton: And I don't know if I'm looking at the same page on the operating budget page.

Chair Wells: The next page, budget projected, there's a box under the budget projection.

Member Viton: So, the 46.8 million at the bottom of that page does reflect the 18 or does not?

Chair Wells: It reflects 15. There's another fourish coming in.

Member Viton: And is that the same? So, okay. So, that's on the projection. And the employee contribution that is hidden in the third quarter fiscal year

Chair Wells: That I do not believe is included in either one because there was some problems with how it. So, when they collected it and so I don't know that that number is completely reflected in the projections.

Member Viton: Thanks.

Chair Wells: Any additional questions? Hearing none, we'll close agenda item number nine and move to agenda item number five. We'll have you introduce yourself.

Ms. Donaldson: Morning, Mr. Chair, members of the PEBP board and PEBP staff. My name is Deborah Donaldson, last name D O N A L D S O N. I'm with Segal. I'm a fellow in the Society of Actuaries and a member of the American Academy of Actuaries. And joining me today at the table is Amy McClendon.

Ms. McClendon: Hi, I'm Amy McClendon. I'm also a fellow of the Society of Actuaries and a member of the American Academy of Actuaries.

Ms. Donaldson: And we're here today to present two presentations. Bear with us one moment as we get this up and running. It's there.

Chair Wells: Go ahead, Amy. Present.

Mr. Hopkins: Let me get a sec. I'll share it.

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Ms. Donaldson: Wonderful. So this is the first of two presentations. The first presentation we're going to do today is our trend presentation. It's going to show the Segal trend survey results. This is on a national basis. So you'll get a sense of the trends that we're seeing historically and projected on a national basis. Then we'll go into specific PEBP trends and talk a little bit about our fiscal or plan year 27 pricing methodology and assumptions. So let's dive in into it. So a little bit of background about the trend survey. We are using the 2026 health plan cost trend survey. It's our 29th annual survey and this survey is actually well recognized throughout the industry. We gather survey information from over 70 national and regional insurance carriers. So that includes HMOs, EPOs, high deductible health care plans and PPOs. We also gather information from TPAs or administrators like what you have and then pharmacy benefit managers or PBMs such as ESI. It represents more than 80% of the commercially insured and self-insured market. And so we're going to go into some of the details, but I first want to take a step back as to what's behind the numbers and what makes up trends.

So in general, price inflation is usually a primary component of overall health care trend. And you've seen this in the news recently. Well, where health care trends are increasing more than general inflation. And what drives that? Well, historically in the most recent, it's been due to labor costs rising because of demand and limited supply. We've seen some regulatory changes that help contribute to that price inflation and ongoing workforce shortages. That can impact both the medical and the pharmacy. But on the pharmacy side, we've been seeing lots of higher trends and we'll go into those details in a minute. Really on the specialty drug side of things, we've seen higher trends. These are usually drugs utilized by a small proportion of members, but they tend to be very expensive and that's why they're called typically they hit a category called specialty drugs. They're usually drugs that can treat cancer or other really good things, but they are very expensive and they trend up at higher trends. So, just taking in another detailed level, what drives trends? And so, I've mentioned some of those. But just to kind of look at kind of the list, there's a lot of things that can potentially drive trends and they can have different impacts on a given year. And some things I just kind of want to talk about is, you know, the increased burden due to the aging population. It is known that as members age they utilize health care more frequently and so as memberships overall risk pools the age increases kind of the cost and the inflationary cost kind of increase along with that and then we're going to go into a little bit more detail when I talk about the rate setting but also driving trend is an erosion of deductibles and co-payments. So when you keep plan design stagnant i.e. you know deductible amounts and co-pays amounts trend is going up but those amounts stay flat and so there's almost a wear away or a leveraging impact because those dollar amounts are staying the same while inflation continues to increase.

All right so let's get into some of the details. This is again our results from our national survey. And so, there's a lot of colors and squiggly lines, but I'll point you to a couple of key areas. In the middle, you'll see the blue colored lines. There's a dark blue colored line and then a teal line. And this is really showing historical trends on a plan year basis. It is showing the high deductible health care plan as well as PPO. So, the high deductible health care plan in the Segal trend survey is very similar to PPO and we'll talk about that um for your plan. We're using the same assumption for the high deductible plan and the PPO plan. You can see in that plan and actually in most of these lines there is an upward you know if you were going to draw the trend line it would be an upward sloping or a positive sloping trend line. The national survey has noted

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that for plan year 25 the average trend is 7 and a half% for the PPO a little bit higher for the high deductible plan and then in plan year 26 it's projected to be 8.6 and then 8.7 for the high deductible plan. And again, these are projected numbers because you the plan year isn't over yet. And so we will be updating our trend survey next year to update some of these results. But I really want to point you also as I just mentioned previously to the pharmacy, which is that green line. And we have continued to see very high trends and now we're in the double digits, right? Double digit trends for pharmacy. And this has been driven, you know, as I mentioned, by specialty drugs, but it's also been driven by, and I'm sure you're hearing about it because it's the sexy drug today is the GLP1s. GLP1s are great drugs but they're expensive and they come at a cost. This trend line that we're showing is a combination of entities that are covering GLP1s for both diabetes and weight loss and for those who are just maybe covering them for diabetes such as PEBP. So, I'll just share that for those for those entities that are covering both GLP1s for diabetes and weight loss, their trends tend to be two to four percentage points higher in general. And I've seen plans actually reach in the 20% trends because of the impact of these GLP1s on weight loss drugs. And sometimes they're referred to as AOM or anti-obesity medications. So that's our national survey.

Now we're going to get into a little bit um refinement and looking at PEBP's results. So the first one is looking at the medical trends and there's a lot of curvy lines here. So we are mapping out the Segal survey results for your reference. But I'll point you now to the Nevada PEBP line. And you can see there's some ebbs and flows here. And that's great. That's kind of what we traditionally see in large risk pools such as yourself. Ebbs and flows every year on trends. For plan year 25, we're anticipating you're going to end up of around or at plan year 25 you were at 9.2 5% 9.3%. We're projecting for plan year 26 that it's going to be around 6%. So another way on the next slide we're again we're looking at it. We're just showing you kind of PEBP's trend a little bit different and we're really tracking kind of year-over-year trends. Really looking at starting in plan year 23 and showing in that bottom chart what was legislatively approved, what the pricing trend was and what actually occurred. And then that top chart is actually showing you kind of actual trends. And so you'll see that when the legislative approved trends are less than the actual PEBP and PEBP meaning the plan or the members have to pick up the difference and we're going to talk about what drives some of that trend as well and we're going to go into that in a little bit detail in the rate setting process. Looking at the pharmacy trends similar to what we did for the medical trends. Oh, actually I want to take you back to the prior slide. My apologies. Over in the words there above the teal box, we're really highlighting some of the medical trend drivers that we have seen through December 2025. High-cost claimants, and I'm going to go into a little bit more detail in a little bit, but high-cost claimants are driving some of your trends. And when we get into rate setting, I'll have some more details to share with you. We are seeing cancer prevalence, diabetes prevalence, and MSK prevalence kind of driving the cost of your plans as well. So those are the top conditions kind of driving um medical costs for your plans.

So now we can go to the next slide and we'll look at the pharmacy trends. So similar to medical. We are actually showing a couple of lines on the pharmacy. The teal line is the gross trends and then the purple line is the net trend. So gross trend is kind of what Amy and I look at when we're projecting numbers. We'll project out what we anticipate to be the gross trend is and

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then we net out rebates. So the net trend that you're showing is the ultimate result after rebates have been adjusted from the claims. And if we look at plan year 24, you'll see that the PEBP gross trends were high, right? They're in that 20% range, but the net was only about 14%. And then we had next year the lower trends, right? We see that downward sloping curve. But I want to point you to what we're seeing in plan year 26. So plan year 26 we're projecting the gross trend to be less than the net trend. And so why is that happening? There's been a wear away kind of in the contract of some of your rebates which we are working with PEBP right now to discuss. They're in the midst of renegotiating that contract. But you know that is a difference there that we're looking at to help try to solve because you typically want your net trends to be lower than your gross trends.

All right. And then similarly to the medical we are mapping on the top kind of again the gross trends and the net trends are there in the yellow which is about a 40% reduction and then the then the year-over-year trends. And similarly the legislative approved over to the left. So, you know, for example, for plan year 26 and 27, the legislative approved trend was 15%. The actual for 26 came in a little bit lower and still to be determined. At least the gross trend, but the net trend was higher. And then 27 is still to be I'm sorry, 27 is still to be determined. Obviously, we'll talk about that in the rate setting process. Some of your drivers of trend is again some of the GLP ones for diabetics. They're great drugs, but they come at more additional cost than the alternatives previously. And so really starting in kind of 23, we saw that ramp up of spend and cost and trends associated with these drugs. Even though they've been around for a while, there was really a ramp up. As you can see, there's TV commercials, song and dances about these. So there's been just a lot of hype in around the country with these drugs. So, Mounjaro is one of those diabetic drugs as well as Ozempic. Then we're also seeing your specialty spend increase as well. And then last but not least is our dental trends. And this gave me a little bit of surprise I think when we were looking at it. You know, we need to kind of put this in perspective and it'll show the trends in dental have been. I've seen greater variability than I typically see in a large risk pool like yourself. I mean dental trends tend to be kind of more predictable and we tend to not see these large swings year to year. I want to tamper that because the spend on the next slide, you know, we're talking about going from $57 from $51. So, it's a six bucks change, which is a lot when you look at the small dollar amount. You know, that's very different when you look at medical and pharmacy where we're in the hundreds, right? So, the $6 would be a blip on the medical side, but it is showing larger trends. So again, the legislative approved has been 3% and for plan year 26, we're projecting it to be around 73. And we're using a pricing trend for 27 of 3 and a half%.

So on this next slide, we looked at, we kind of summed it up. So, we're looking on that first right top box kind of what the average trends were in 23 to 25 and we're comparing PEBP to the industry. So, when you look at PEBP medical self-insured, you've been trending from plan years 23 to 25 at 6.8% which is about a half a percentage point above industry. I would say that's fairly close to industry. Your pharmacy has been around 14.8 a little bit higher than industry and your dental on conversely has been a little bit lower. When we look at plan year 26 however your medical is projected to be for 26 is projected to be a little bit lower than what we're seeing nationally and across the country which is about two and a half percentage points. So, good thing, right? You're trending lower than we're seeing on a national industry basis. Your pharmacy

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trend again is still trending a little bit higher than we're seeing in the industry. And then there's that high trend rate for dental that again not too concerned about. And then on the bottom, we're really showing what we're projecting and using in our projections to project um forward for plan year 27. We're going to be using a 6% medical, 11% pharmacy, and 3 and a half% dental. And so we're aligned with what we're seeing on the industry for pharmacy. I'll just share that your last six months of pharmacy spend, we've seen the downward slope. So, we've seen it kind of level off. And if you think about underwriting cycles that Amy and I think about, you know, there are ebbs and flows. So, if you're coming off high years, you would expect potentially a low year. And again, your medical is continuing to trend lower than we're seeing in national trends. And I work with a number of large other state entities, and I will share with you, they would love to be having a 6% trend right now. They're trending more to the national industry level.

So, just quickly to give you a brief overview of kind of the work Amy and I are doing when we're projecting pricing. We look at historical claims and enrollment. We take into consideration what's happening in your plan actually. We look at any kind of change like we look at shared savings fees, we look at capitation fees, we look at your rebates and we've discussed that. We are projecting on to the experience period and then we take any kind of other things we need to take into consideration demographic changes, seasonality adjustments because there are different claims come in there's seasonality to claims on a month-to-month basis. And then we also look at plan design, incorporate plan design changes. Then we add in administrative fees which are more of a hard dollar cost, right, based upon your contracts. You know, just to share with everybody in general, you know, admin fees are the lowest percentage overall. So, typically they're 10% and lower. PEBP fees are like 5% of your total cost, right? So, really your cost are your claims. Then we determine the budget and the rate and contributions. So to take that down another level, we'll go into the next page. Again, we look at claims and enrollment and then we project it out using those projections. We do look at your last 24 months of experience and we weight it. So we weight it to 60% of the most recent 12 period is 60% weighted and then the second 12 is 40% weighted and then we do a bunch of adjustments. That migration comment. We're going to talk about that in detail when we go into rate setting because that's going to play into big into that and I'll just share I'm always wrong like but I don't want to be wrong by a lot but as actuaries, we're we try to hit the 50 percentile but we're going to be wrong. We want to be wrong by just a little bit. Then we also take into consideration minimum guarantees on your ESI contract for pharmacy.

The one thing I want to point on the next slide that we've been looking at is we're doing all of this on your self-insured plans. Then we look at your HMO premiums and we incorporate that as well. When we look at your overall budgets for your plan. I'll just note that you'll see here that your HMO premiums are going up 9% year-over-year. And I'll just a shout out to the PEBP team. You know, you're trending much lower than the 9%. So, you're self-administering, self-insuring your plan and you're trending at a much lower rate. So, when I combine the medical at six and the pharmacy at 11, that combined rate ends up being about 7 and a half% compared to the 9%. So, from a self-funded perspective, you're actually trending lower. And again, you're trending lower than national on the medical side, which from a percentage point is the larger portion of the overall claims compared to pharmacy. And with that, Mr. Chair, that concludes the first of the two presentations.

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Chair Wells: Thank you, Miss Donaldson. Are there any questions from the board members regarding the trend presentation?

Member Rich: I don't have any Laura Rich for the record. I don't have a question per se,
But, I do want to just give some context to trend as well just because I was looking at you know specifically for the dental trend I believe in the year that we had that 11.5% trend the maximum benefit was raised from 1500 to 2000 right and so that contributes to trend. You know similarly, when you look at the graph for medical, if you change benefits it also contributes to the trend. So I just wanted to you know say that for context that it's not just your experience but it's also the decisions that the board makes as we you know if you look at that historical context.

Ms. Donaldson: Thank you for that comment and that's a good segue as well into the setting.

Member Zumtobel: Is the pharmacy trend on page 12. So we're currently trending at, oh 213 PEPM. That's at first I looked at I read it as PMPM, but it's actually per employee. So $213 per employee per month.

Ms. Donaldson: Yes.

Member Zumtobel: Thank you.

Chair Wells: No other questions. We'll move on to the second presentation.

Ms. Donaldson Thank you, Mr. Chair. All right. The second presentation is our rate setting presentation. The way we're going to start this conversation is we're going to kind of talk about the current state. We're going to review some of the kind of assumptions that have gone into the rates and then we're going to get into the different rate scenarios. The nine different scenarios. So, just as a background to refresh everybody, the board did approve in December, deductibles and out-of- pocket maximum changes for all of the plans for plan year 27. That was projected to be an annual savings of around $5 million. We're going to go over how enrollment has changed over time from migrating towards the low deductible PO plan and away from the Consumer Driven Health Care plan and to some extent, but a little less extent also being driven away from the EPO HMO plans. We'll go into more detail, but just a reminder that the premium increase for plan year 26 was 13% in aggregate while the state funding increased 30%. At the same time, the Consumer Driven Health Care plan premiums remain stable or the same as plan year 25 levels. The trend increases that we've been talking about have largely been absorbed by the plan by PEBP and we're going to go into more detail and show you that visually and talk about the dollar impact associated with that. Then we're going to talk about kind of what I call the purpose of insurance, right? That there's a small portion of members that generates a lot of the costs that get shared by all of the members. And so for PEBP, it's 1% of the members generates the responsibility. They represent 31% of the total plan costs. We're going to go into that in more detail and it does vary by plan. And then we're also going to talk about details about you know

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we've looked at members reaching and the percentage of members reading reaching out of pocket maximums and plan year 25.

So let's go on to the next slide. This is should be a familiar slide. It's been in a number of previous board member meetings. The red items are the items that was approved by the board in December of 2025, i.e. the deductible changed for the consumer-driven health care plan as well as the Low Deductible PPO and then the out-of-pocket maximum. I just kind of want to point you to the out-of-pocket maximum line and then I want to point you down to the bottom line which shows the employee only premiums. You can see that the out-of-pocket maximum for the Consumer Driven and the Low Deductible plan in the December board meeting packet was approved to go from 4,000 to 5,000. So, previously that deductible was one of the lower deductibles in all your plan offerings. And conversely, the EPO plan had a $5,000 out-of-pocket maximum, which the board approved in December to go down to 4,000. Typically, when you have a plan and you look at the premiums, the plans with the lowest premium should have the highest out-of- pocket maximum. And when I think through this, if I'm a member and I know I'm going to have an expensive surgery, maybe I've been putting off having a knee surgery because I like to ski and I hurt my knee, but I you know, I'm going to wait till the next year. I know I'm going to have an expensive surgery. I'm going to know I'm going to hit the out-of- pocket maximum. I'm going to choose the lowest premium plan. Right? If the out-of- pockets are the same, I'm going to choose the lowest out-of- pocket maximum. What does that do? That causes losses to the PEBP that PEBP has been picking up because those members, you're losing the premiums and maybe a higher premium plan that they're in. They're going to choose the plan that has the lowest premium and PEBP is losing picking up that premium. So, we're going to go into more details of that, of behavior economics and kind of the thoughts when we go into all these different scenarios. As an actuary I would not recommend going back to the previous out-of-pocket maximums. I would um recommend staying at the December board approved premiums.

Member Zumtobel: Debbie, Tom, for the record. So the actuarial value are in, they're in red and that all changed because of some of the benefit changes. Can you tell us, do you know about how much each of those shifted? Like the High Deductible health plan is 77.9. Was it a percent better?

Ms. Donaldson: So, it was previously with the 1,600 4,000 the AV was 76.7.

Member Zumtobel: So it got a point and a half richer. Okay. And then how about the the Low Deductible?

Ms. Donaldson: The low deductible was at 85.2.

Member Zumtobel: So it went down a little. Okay. And EPO

Ms. Donaldson: EPO was 88.3%. Oh, I'm sorry. EPO was 88.3%. Sir,

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Member Zumtobel: thanks for having those details ready. So the High Deductible got just a little bit. Sorry, you said and I already forgot the first one.

Ms. Donaldson 76.7.

Member Zumtobel: Yeah. Okay. Okay. All right. Thank you.

Ms. Donaldson: We need to check that 76.7 includes theHRA dollars. Okay. This page really highlights there were other board approved plan design changes made in December. This is showing the impact. So, the UMR pharmacy coupon program generated savings. The prior out-of-pocket labs and diagnostic colonoscopies generated small additional costs. So, the deductibles and out of pockets generated about a $4.5 million savings. And that total impact was $5 million. So let's go on to this slide. And this is really showing the migration that we're seeing. We're seeing that downward sloping enrollment by plan year in the um and I was just confirmed sir that yes it does include the HR in my previous the actual values. So, the Consumer Driven Healthcare plan, you can see we've had migration out of that plan and that kind of pink line there is the um Low Deductible PPO plan and you're really seeing that ramp up since plan year 22. Then in the EPO and HMOs it looks flat just because the enrollment is small in comparison to the other two plans. But you are seeing some migration out of those two plans as well. And then on slide seven we're showing just a comparison of plan year 25 and plan year 26 premiums. And if I point you down to the bottom of that. Overall as I mentioned, that premiums were going up 13%. But if you look at premiums to premiums it was a 10% increase and 3% is associated with migration. So migration of members shifting tiers members leaving the plan and going into the retiree tiers. We're also seeing kind of the migration of going to different plan designs as well. So, all of that comes into the migration which accounted for 3%. So, overall when we compare premiums to premiums overall it's a 13% increase.

Member Zumtobel: I got lost again. So, it's a 13% premium increase 25 to 26. But the trend is pretty good at 7.5. Isn't that correct?

Ms. Donaldson: The overall combined assumed projected plan year 27 trend is seven and a half. Yes.

Member Zumtobel: And the 27 is being used to set 26 premiums. I'm just trying to track with you. How does the 13% relate to the this the 7.5%.

Ms. Donaldson, So the the 13% shows the premium changes for plan year 25 to 26. We don't know what the final trend is yet for plan year 26.

Member Zumtobel: What was the 7.5 then?

Ms. Donaldson: It's the blended projected 6% that we're using for trends. So 6% medical, 11% pharmacy, 7 and a half. It's like 7.3

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Member Zumtobel: And that's 7.3 higher than for next year.

Ms. Donaldson: That's going from 26. That's the projection trend we're using for plan your year 27. 27. Yeah.

Member Zumtobel: But we don't know 26 yet.

Ms. Donaldson: That's correct. Because the plan year won't end until June 30th. This is premiums versus claims. The trend that we're looking at is looking at claims.

Member Zumtobel: Yeah. If you're setting premium off of 27 claims and the trend is 7.3, it seems like then the premium would somehow be taking that into account. I don't understand.

Ms. Donaldson: Well, we're going to talk about 27 premiums that will take account that trend. Yes. You can ask me questions when we get to the rate settings.

Member Zumtobel: No, I just want to track so when I get there I'm not that far off but that's fine.

Ms. Donaldson: This is historical. This is looking at kind of year-to- date and historical. Okay. So, let's move on to slide eight. And this is really looking at the distribution of revenue sources. When we look at plan year 22 which is on the left hand side and these bars are all different colors. So the rebates are shown in the pink. The AEGIS and REGI as a percentage of revenue is shown in the purple. The members out-of-pocket claims are shown in the teal and the member premium are shown in that dark blue. So if you look at the portion that the members are paid, excuse me, in plan year 22 it's about a third of the total revenue, right? Members are paying about a third's picking up that other 2/3. I'm going to shift you to the far right hand side again this is year to date plan year 26 it's through December so we still have six months to. But I'll point you to the difference and the shifting that we've seen and now the members are paying 28%. So back in plan year 22 their proportion was one third and now we're down to 28%. Meaning that the PEBP plan has picked up a larger share of the total contributions. And so, that's why I talked about inflation and trend. For the most part, PEBP has been picking up all of those trends, because you know, member cost share, and we'll get into the member premium in a minute, but the out of pockets, because of those flat dollar amounts and they're not keeping up with inflation, that has shifted more money that PEBP has picked up. And in fact, when you look at that difference of about five um percentage points, 5.3, it ends up being that's about a $30 million shift that PEBP has picked up that the members were picking up, but now PEBP is picking up.

Member Harper: Blaine Harper for the record. I'm wondering can you comment further on what we see from plan year 2022 to plan year 2026 comparison where it looks like the bulk of that shift is coming from a change in employee out-of-pocket claims. Would that potentially be more explained by plan migration over that time period?

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Ms. Donaldson: the out-of-pocket maximums. Oh, I'm sorry. Mr. Chair, board member, Donaldson, Deborah, for the record, the out-of-pocket maximums have stayed the same. And so, claims have gone up with medical trend, but the amount that the members are paying out of pocket has stayed stagnant. That's why that percentage of the overall cost has reduced because the members are still paying the same, claims are still going up but the members are still paying the same. That's why I'm saying PEBP is picking up a larger portion and a larger share. So there could be but the way that the plan was set up I mean that's like a thousand bucks a difference. There was kind of it that could be a little bit but that's not the reason why we're seeing the dramatic reduction in the member out of pockets. It's mostly due to inflation. Yes.

Okay. We're gonna look at it in a slightly different way. Kind of similar things in a slightly different way. This is on a per employee per month basis. And what we're tracking here is the annual premiums and the average annual member out-of-pocket cost for each of the plans. And if we look at the CDHP, you can see on that top line, the premiums are smaller proportion, right? Compared to the member out-of-pocket costs, the total amount that is circled in red is very comparable to the Low Deductible Healthcare plan. When you look at the shift there, you'll see that the members in the Low Deductible PPO plan are paying more premium, but their out-of- pocket costs are lower. And then when you look at the EPO plan, the premiums are higher and the member out-of-pocket costs are lower. That, you want to see again in plans that have higher premiums, you want to have lower out-of-pocket costs. I like to see more disparity. It's interesting that the way it's been set up is that you know net, the Consumer-Driven Health Care plan and the Low Deductible PPO plan net, year to date in total has been about the same. There's some subsidy there that we're going to be talking about and that we want to kind of do some unraveling on. And we'll go through that in a minute. In the next slide, we're showing just the dollar amounts. And this is really weighted because there's more members in the Consumer Driven and the Low Deductible PPO plan. When you look at a dollar perspective.

Okay. So, this is the next the triangle chart and we try to break it up into two slides. This is looking at all plans combined. And again, this is really kind of showing the law of insurance where there's a small portion of members who drive a large proportion of the costs. And in fact, that 1% of your members, which represents about, let me look at my notes real quick. 400, it's about 480 members. So, that 1% is about 480 members, drives 31% of all plan cost. That's $103 million that that 1% is driving. That ends up being about $270 per employee per month that that 1% is driving in cost. It is on a per member per year basis about $217,000. So, on average, these members are generating over $200,000 worth of claims in a given year. Conversely, the bottom 85% of your membership account for only about 19% of total cost with the average spend of around $3,400 per member per year. It does vary by plan. And so, on this page, which is a little bit busy, albeit on the bottom we're doing that same triangle broken out by each of your plans. And so, you can see in the Consumer-Driven Health Care plan that 1% is close to 34% of the members, but the average spend is much lower. And then when you look at the bottom you know the bottom tier, the average cost is much lower compared over to the very right hand side, the EPO plan where that 1% is driving higher cost. So, there's more higher cost claimants with average higher cost in that plan. There's more compression in that plan because look at your low bar. The average spend of your bottom percentage members is 1,600. And that's about, the 1% on

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your EPO is about 26% of members. So proportionately it's lower but there's more compression in that plan because there's just higher spend in general for members in that plan.

Member Zumtobel: That's so interesting. Tom Zumtobel for the record. So, then the High Deductible, we have more, 33% are actually a high risk not high risk, high cost. But their PMPM is the amount of the overall PMPM that they utilize is less. Is it more members that might make that PMPM? Is there other reasons because they wouldn't be necessarily high cost and necessarily less sick, right? What are the math reasons that PMPM might be different?

Ms. Donaldson: Board Chair Wells and board members. This is a great question. So, to your first question, yes, there's more there's it's a larger risk pool, right? Your Consumer Driven Healthcare plan has more people in it to spread the risk across more members. That's a really important point. You also have to remember that that deductible in that plan is much higher. So, members are taking on a good part of that first dollar coverage themselves as well. And yes, there's compression. There's a lower portion of members to spread over the risk, but they're higher consumers and there's just higher risk. Yeah. In in that population as well compared to the Low Deductible and CDHP. And that is like something that when we get into the rate setting, I'll talk about migration and what that looks like in that plan.

Member Zumtobel: It's such an interesting slide. Consumer driven health plans aren't necessarily proven that they give the consumers tools to make better choices, right? And so, you could also worry that because of the high deductible, they're putting off care and they're actually having more utilization on the top end because they're not doing the wellness, not partaking in the wellness benefits that they are with the EPO and the other plans, right?

Ms. Donaldson: Board chair and board member, I've heard that being raised in a number of various different situations. That they're potentially putting off care. I have never seen it actuarily prove that that is the case. In general, Consumer Driven Health Care plans tend to attract people that are more healthy and doing good behaviors, they're utilizing healthcare spend less. So there is that component that we have seen. I have heard that before. I think plans, you know, and I think we've talked about it. Plans do try to make sure that there's good tools available to the members with wellness programs and everything like PEBP has to make sure that folks do have those tools available to help them in their healthcare journeys. And if they should have a unfortunate condition or event, there's a lot of care management and other programs there to support the member if they choose to utilize it.

Member Viton: Just a question, Chris Viton just while we're on this slide. In the last presentation when you talked about our trend being generally favorable compared to national norms. Here are pyramids pretty standard as far as the as far as the market. Are you able to comment on how our costs per member on this slide compared to national?

Ms. Donaldson: I'm not prepared to make that comment. That's certainly something we can take back and bring forth to another board meeting. But it it really varies on different plan designs

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that are being offered by the plans and then we would have to adjust by the plans.So it's kind of shard to comment because plan designs vary by different state entities and that actuarial value comes into play. Yeah. But we can do some benchmarking. I think we have done some benchmarking and we can kind of look at that if that's helpful information.

Member Viton: Thank you.

Ms. Donaldson: Okay, so this slide is looking at historical performance, looking at revenue over expenses. This slide has been updated to incorporate the 18.4 million that Miss McJoy had presented previously and earlier. Of that 18.4, four, it's about 9.3 went to fiscal year 26 and the remaining went to fiscal year 25. So this has been updated. When you look at the bottom in totality um plan year 23 24 25 you're showing negative amounts and you know as we think back. you know there had been some specific measures made by the board and staff as it related to excess funds associated with COVID and there was intention to spend down some of the excess reserves that had been built up as it related to COVID and that's reflected. I think what has been interesting and an addition particularly in 25 but most notably in 26 if you all remember that the 26 REGI and AEGIS and we'll get into that in next slide increased 30% and so while we are projecting a relatively flat um revenue over projections for 26 we should be having more revenue because of that 30% increase. And what has happened is that increase that was supposed to go to build back some of the reserves for 26 was used to supplement employee premiums. And so essentially like buy down rates and reduce the member premiums. And so, I just wanted to make note of that as we go into looking into fiscal year 27 as well.

And that leads me to the next slide which really shows that. And so the 30 and the negative -4 are in combination. So that's the combination of increase of it's the weighted average composite of the AEGIS and REGI by enrollment. So, you can see that 30% in plan year 26. Yes, REGI's going up um in plan year 27. It has less overall it has less than a 1% impact. The 991 is going down about 5% to 943. Net it's a negative four. And so, we are seeing a reduction in plan year 27 you know revenues coming in. So there is additional pressure there. Okay. So now we're going to get into kind of rate setting. Hope you all with me still. So okay. So I'll point you to the bottom there and this is based upon last month. The first column is the plan year 26 published PEPMs for each of the plans. If we took out the subsidization between each of the plans, these are what the rates would look like in plan year 27. The Consumer-Driven Health Care plan would go down just shy of about 2%. But conversely, the Low Deductible PPO plan is going up 19.3% and the EPO HMO is going up almost over 29%. This is looking at these plans in isolation. We took a look, Segal took a look to say, okay, how long has these subsidies been going on between plans? And I'll just share there are other state entities that will underwrite as a risk pool and then there is cross subsidy. So I'll just share with that there are other state entities that do that. There are specifics within PEBP that that we need to remove these cross subsidies and they need to be separate. These plans need to stand on their own. But we looked back and we could see subsidies being taken place all the way back from 22, plan year 22. So the subsidization is not something new that's happened. It's been kind of clumping along for quite some time. These are what the true rates would look like if we underwrote them on their own merits. So as we look to do that as actuaries, we have to say, okay, these rates are potentially

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going up by significant amounts and that's going to create member behavior. The thing that always gives us actuaries as pause is trying to predict what members will actually do. And there's behavior economics that says even though from a financial perspective members may need to choose option A there are other factors that members may not choose option A and choose another option because of other factors they could be more or less risk averse they don't you know they're in health condition they don't want to make a change in plan there's a lot of other various things so we are making assumptions about migration based upon right sizing these rates. So as we just talked about in the prior slide, the EPO is going up about 29%.
We do believe that that is going to cause migration and we are assuming that about 30% of the members that are currently in the EPO HMO are going to migrate to the Low Deductible Health Care plan. In addition, we think an additional 10% of members are going to go from that plan to the Consumer Driven Health Care plan. Now, it makes a difference on who are these members. So, we've got we're assuming that 60% of the membership is going to be left. And who are those 60%. They're not the average. We assume that the people that are going to stay in that plan are high consumers of health care and they're your higher spend members. We're assuming that the members that are moving from the EPO HMO are your lower consumer members and they're going into the CDHP plan. They're lower consumers on the EPO, but they're higher consumers compared to the average on the CDHP plan today, if that makes sense. And similarly on the Low Deductible plan, we're assuming kind of a middle of the road, if you will, of consumers out of the EPO will go into the Low Deductible PPO plan, but they're still going to be higher than the low deductible healthcare plan is today. So, they're going to drive the cost for these overall plans up, if that makes sense. And then just to add, we are assuming that with the change to the Low Deductible PO plan that some of those members are going to move into the CDHP plan. And again, it's the members that are typically lower consumers are going to go into the CDHP plan. And when I say lower consumers, they're utilizing health care spend um not to the extent as as other as other members.

Member Zumtobel: Excuse me.

Ms. Donaldson: Yes.

Member Zumtobel: Are there any assumptions? I heard all your clinical assumptions and they felt thoughtful. Are there any social economic assumptions? Like assuming people are going to go in because they just can't afford anything else but the lowest premium and then they go into the high deductible and they don't have enough money to even see the doctor, right? I mean, how many of those people shift over or how do you think about that?

Ms. Donaldson: Yeah. Board Chair Wells and board member we don't have payroll information so we you know that's a hard assumption so I would say it's incorporated into our combined total migration assumption so we do think about that for sure, but we don't get granular on it given the limited information we have.

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Member Zumtobel: I liked your example when you were talking through how if you really do, all the people who sit down and do all the math you know, but that's kind of actuary. That's what you would do, right? You would understand. A lot of people, you know, if you have kids and you're a single mom and you just have to take the lowest premium price, it's hard to afford to get your kids to the doctor if you have to hit a deductible. I just worry about that increasing utilization and increasing cost.

Ms. Donaldson: There could be some of that for sure. That's really hard to predict. That would go into the overall gain loss. So this is an area that we may be wrong on, right? Like it's hard to predict migration and there's we tried, we were thorough, we thought through this but we could be off and I'll just share that we did this for plan year 27 and based upon what actually happens in 27 we may need to reset the migration assumptions for 28.

Member Harper: Blaine Harper for the record. I apologize for kind of integrating some information from earlier on slide nine of this presentation where it shows the PEPM. Since we're in the frame of addressing behavioral economics, what are the behavioral economics of the EPO HMO as it stands where it looks like people are paying about $600 a year extra in total spend, participant side. What is it the participants are buying by spending that additional 600 relative to the LD PPO, or what do people think they're buying?

Ms. Donaldson: Board Chair Wells, board member Harper, can you point me to the 600? I'm sorry, I'm not tracking.

Member Harper: Sorry, I'm talking about slide nine, the PEPM data. We had data highlighted from the CDHP and the LD PPO. I'm just comparing here what that total spend looks like across the EPO HMO versus the LD PPO. Blaine Harper for the record.

Ms. Donaldson: I'm sorry. I'm not seeing this.

Member Harper: So, the 423 in plan year 25 versus 369.81 in plan year 25 for the LDPO. And then the 470.59 versus 368.96 comparing EPO, HMO, and LD PPO in plan year 26. So what I'm seeing in that is that people think that that additional spend is worth something in the EPO HMO, but it's not saving on total spend. Correct?

Ms. Donaldson: Board President Chair, Board Member Harper. So what you're saying is that members in the EPO HMO plan are still paying more than in the the PPO and the Consumer Driven Healthcare plan out of pocket spend. And and yes, you are correct. This is on average and to the point there are there are more expensive people consuming health care in the HMO EPO plans. That's what's driving up some of that cost. That's why you're seeing a higher premium, but you're seeing that kind of it's really in the premium and what the cost is. And so that's that is driving up the cost. This is just the out-of- pocket cost. And so when they consume care, they may be going to the doctor and paying a co-pay, but the members plan is picking up a larger portion of the overall total cost, which then gets reflected in higher premiums. And so, this is an

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example where, you know, there are just more utilizers in the plan, more utilizers of care, and they're more expensive in this plan compared to the other plans.

Member Harper: Thank you.

Chair Wells: Did that answer your question?

Member Harper: I think there's still something that's you know, the dust is settling.
Chair Wells: Are you trying to ask by paying that higher premium and lower out of pocket? What is the plan paying on their behalf versus what it's the plan is paying on their behalf for the other plans?

Member Harper: Yes.

Chair Wells: I think if you look at the the slide the slide 13 where we're running deficits for the those two plans you're seeing the plan is picking up money or picking up costs that are not reflective in in the total premium that's why those plans are running those deficits and so yes by picking a $400 or $300 a month premium and the co-pay structure that that's reflective in the HMO EPO plan. PEBP, the plan is paying a higher percentage of the out-of-pocket costs when they use services. That's what they're buying.

Member Harper: Okay.

Ms. Donaldson And I'll just add to that when we look at slide 15, they're not picking up enough cost because they're being subsidized by the other plans. And so we're trying to right size that because we're saying that they should be paying more than they're actually paying at premiums.

Ms. Donaldson: So we're going to get into the scenarios now. So on the left hand side, we did three different plan designs. The changes approved in December. Resetting the Consumer Driven Health Care plan to the plan year 26 out-of- pocket maximum deductible would still apply per board approved in December. And then in three is reset all of the out-of- pocket maximums to plan year 26 maintaining the out the deductible board approved. Within each of those we're saying immediate application of the premiums to right size them. That's option, it says one here, but it's A. B is a two-year FA phase in and C is a three-year phase in of these rates. I will share that a two-year and a three-year phase in requires additional funding from somewhere. It's additional cost to the plan because the members are not picking up their full share yet. And so, we're phasing it in and that costs money. And so, we'll talk about each of those different scenarios. So, there's nine scenarios each. We've broken out and we had on the prior slide just so you know of that kind of four and a half million of plan design changes the deductible and out of pocket the Consumer Driven out-of-pock max reset was 2.2 2 million and the total of all plans was 3.2 million. So that gives you the numbers to work from. And on this slide, as I mentioned, the 2-year phase in depending on alternatives, is going to cost 26.4 million to 28.6 million in just 27. The three-year phase in is going to cost 35.1. And again these are projections 35.1 million to

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37.7 million in 27. Again we have included you know our migration assumptions readjustments to what we think the impact's going to be to the risk pool associated with the migrations, but as I mentioned this is one year based upon what actually happens we would need to re-evaluate 28 as a reset and figure out what additional migration would happen based upon what we actually saw.

So visually this is just another way to see it. This is all of the different scenarios. You'll see that no phase in is creating a small surplus. That's because when we reset the rates, remember it was like 1.8% below. We're recommending that you don't drop the Consumer Driven Health Care plan rates. It just doesn't look, to drop the rates and then increase it back up. So, we're recommending that the rates stay flat for the Consumer Driven Health Care plan. And that's generating a small amount of savings, basically a wash. It's not a lot over all of your members. And again, I want to remind you guys like your budget. We're talking about $465-$470,000 million, $2 million. It's a lot of money to me, but it's not when you look at it in proportion percentage of the plan. Okay. So, here is the state. So, the way we've broken up in the rest of these slides is we look at state actives and then we look at state retirees. Let me go to the next slide. And then on the far right hand side we're comparing what the change would be from plan year 27 into plan year 26. 1A which we're showing here. Again, this is a full you would move in plan year 27 full movement to the standalone rates, right? Rates stand on their own. Again, Consumer D riven Health Care plan would have no impact. Then the Low Deductible PPO plan the rates would go up between $205 per month for the participant only up to 477.20 for the participant and family and then similarly for the EPO HMO it would be an increase of $322.65 for the participant and for the family would be $756.19. Similarly we have done the same exhibit for the retirees and we're showing those rate differences there for the retirees. I think for a sake of time, Board Chair Wells I was just going to go over the active rates and then just show the retiree rates. So, 1B is the two-year phase in. And so, you'll see that the rates on the far right hand side, again, Consumer Driven Health Care plans, not changing, but the rates are lower for the EPO, HMO, and the Low Deductible Health Care plan. Again, 102.59 for the participant only in the Low Deductible co-pay plan to $238.60 for the family in the low deductible. and then $161.33 increase for the EPO HMO for the participant and then $378.11 per month for the EPO HMO. Similarly, 1B for the retirees as shown here. Then 1C is showing the rates assuming a three-year phase. In the three-year phase in again no change to the Consumer Driven Health Care plan. The Low Deductible PPO is going up you know smaller increase than the two-year phase in for the Low Deductible PPO and the co-pay plan and the HMO plan. And in the bottom for both 2B and 2C, we're seeing the additional funds needed for each of these scenarios that we've highlighted earlier. And then the same for the retirees. 1C is generating about $35 million of additional funding needed.

2A is again the change is reverting the Consumer Driven Health Care plan back to plan year 26 out-of- pocket maximums which I would not recommend. You are seeing the costs go up for the Consumer Driven Health Care plan in 1A go up slightly, $5.30 for the participant and family $2.52. And then the PPO and EPO are similar to the 1A because they didn't have changes. And then 1B is a two-year phase in. Again the rates for the Consumer Driven Health Care plan are a little bit lower than full phase in. Again, we're talking you know, less than $5 per member per employee per month. 2B would require a $28.1 million additional funding to support this scenario. And then we're showing the retiree rates. And then 2C. 2C is a three-year phase in from

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a $1.78 for the participant in the Consumer Driven plan to 84 cent increase for the participant family and the Consumer Driven Health Care plan. Again, similar increases on the Low Deductible and EPO. This would require $37 million phase in. And then last but not least, and again we have the retirees as well.

Last but not least is scenario three. That means all of the out-of- pocket maximums would revert back to plan year 26 levels. This does come at again changes. So the Consumer Driven Health Care plan changes are similar to what we discussed in scenario two. And the Low Deductible Health Care plan and co-pay plan is at 211 and the family goes up to 492.14 for full phase in and then 320.33 for the EPO HMO and 757.71 for the family and the EPO HMO and then similar for retirees. And then phasing in over two years. Again, a little bit more mitigated because we're assuming you know we need additional funding and that would be 28.6 million to cover the member cost sharing and spend associated with that. And that would result in the rate shown on this slide and then the retirees in the next slide. And then 3C is all of the plans revert back to plan year 26 out of pocket maximums and again similar rates. The EPO HMO is at 106.79 for the participant and 250.25 with a three-year phase in for the participant and family. So, that was a lot. And, I think at this point I'd like to turn it back to Chair Wells. And happy to take any questions.

Chair Wells: Questions from board members?

Member Rich: I have a question, Laura Rich, for the record. So the multi-year phase in is going to obviously come with a cost. Is PEBP building its budget to ask the legislature for funding to cover this? Are we maybe keeping catastrophic reserve levels lower for the time being? Like What is the approach?

Chair Wells: I don't know how far along they are in building the budget yet. I think part of it part of this discussion that we need to have if we pick a three-year phase and model is cost containment initiatives to try to forego those year two and three increases. Kind of containment measures that prevent the year two and three increases from going into effect. So that basically this is a one-year kind of uplift. But those cost containment measures themselves will have to be discussed at future meetings. And frankly, I think we need to start them at the next meeting. I think my plan is just to start that discussion at the meeting with an overview of the Obesity and Diabetes Care Management programs and what return we're getting for them and whether or not we should continue them, change them, whatever. You know, that kind of a discussion. And that that's the first thing I think there needs to be more discussion.

I think it's ongoing on the pharmacy benefit side as we renegotiate the extension from ESI, that we need to get some give or take from ESI that's showing in the last slide that she had. I think there's some things that we can do in the interim to try and mitigate that ask for next biennium. The second thing that I think we can do as part of this, there is or there's projected to be additional money sitting in the AEGIS and REGI accounts. So, the AEGIS and REGI accounts were intended to rebuild reserves in 2026. That's why they're higher in 26 and lower in 27. So that money that is being generated is not necessarily all being transferred as part of the rates. So I would look to take some of the money that is being carried forward from this current

year to next year, bringing that in to offset some of the dollar amount that we select. So that you're basically going back and doing what the legislature approved, taking the money from AEGIS and REGI to help rebuild reserves. It won't cover 35 million. I think we can probably get close to 10, somewhere between 9 and 10 from doing that. And then as we build the 28 and 29 workbook and budget that the rates become reflective of what we need to rebalance the entirety of the three reserves with the traditional kind of 2/3-1/3rd split. But I think the best thing that we're going to be able to do is talk about cost containment measures to keep this from continuing to explode. Yeah. So that's kind of what my thoughts are as a as a plan for building the budget.
Member Duncan: Keiko Duncan for the record. First off I would definitely agree that I think cost containment and your idea about the AEGIS REGI and carry forward I definitely like that. So the way I see the decision that we're making today is kind of a balance between finding an actuarial sound sort of middle ground of what can we do to get us a little bit closer to that so that the cost containment strategies that you know we will hopefully develop can kind of carry us a little bit further along that way. So, I like that. I think that's probably the best way to tackle this at this point. So, a couple questions. On slide 16, when we are considering the migration, give me a second. Okay, so this split of the 3030 10 general migration level, is this kind of the overall underlying assumption through all of these different strategies or is this specific to one?

Ms. Donaldson: It's underlying all the specific strategies, you know, and there's that secondary assumption of who's going to migrate into what plans and then the impact of that is going to play on to overall premiums. That is incorporated and yes, and we thought a lot, we've been talking a lot about that. I mean, could there be different migration assuming on which choice yes. We felt that we tried to find more of a middle of the road kind of assumption knowing we could be a little bit off on each side but changing those assumptions given all the other underlying ones we had. We felt like we were trying to get too refined on something that we're still, we just don't know, We're trying to guess on members behavior and if they're going to respond financially versus more risk averse if that makes sense.

Member Duncan: No, I agree and I know some of my fellow members have brought up some additional points to how migration could potentially change, but I agree that that's rather variable and you know severely assumption based. What I'm understanding from the information that you've laid out which thank you, because I feel like the way you've laid it out was very clear and helped me understand it so I just kind of want to reiterate some of it. So, what I'm understanding is like these assumptions and this was my understanding before as well, the general assumption that in a world in which we have normal plans and normal like actuarial rates for each of these things, those that migrate are those that tend to have lower health risk. So those that stay are essentially the higher cost. Those that want to stay on you know essentially a richer plan which in this case would be our EPO HMO. That's correct. My understanding. Okay. My understanding is that that base migration assumption which is probably the least assumption based assumption if you will is based on a very normal consideration in which a lower cost premium plan should and or typically has a higher out-of-pocket max. Okay. So my understanding is those kind of two things combined is a more actuarial sound base assumption for how we go about in the plan setting. Is that correct?

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Ms. Donaldson: Board Chair Wells, and yes member thank you for that question. Yes, you are correct. And I will add, I'm working on another state where they had out-of- pocket maximums similar to PEBP where the out-of- pocket maximums were really similar, but the premiums were different, kind of like what you have today. And we have been seeing consistent losses in the plan because people have figured out, oh, I'm going to have this. I'm gonna go in for my knee surgery and I know I'm going to hit the out-of-pocket max, but I can pay this lower premium and it's over time has whittled and created loss over time.
We fixed it and that change was made prior to us, but like they've fixed it. And so that's my concern with going back to the plan year 26 rates is we're going to have to address that situation at some point. We've been talking, at some point I'd like to see the Consumer Driven Health Care plan have a higher out-of- pocket max than the Low Deductible plan. That's something for future that we'll talk about. But for now, I would that's why I'm recommending the board approved changes as of December to continue on with those board approved changes for out of pocket max. Yes.

Member Duncan: Okay. Yes, that definitely makes sense. Understanding that you mentioned some of the socioeconomic or other changes in migration as you indicated here would be things that we would maybe want to, once we make this change move a little bit closer to that soundness we can then address that potential migration that would occur and theoretically if maybe that cost containment the work that we do there can also help solve some of that problem. Okay, I like that. That sounds a little bit more stepwise. The other thing that I just wanted to clarify is to make sure I'm understanding. So in terms of plans that are subsidizing others um even with you know kind of a projected migration getting back to that sort of sound as we just talked about my understanding is that there is still that the EPO plans still essentially have the highest or I guess I should say are being subsidized the most like proportionately higher than any other potential subsidization that's occurring between CD and LD.

Ms. Donaldson: Chair Wells, board member. Yes. So, you can see that the EPO, we would have to increase the rates 29%. So, they are being more subsidized. And when we went into the when we looked at this from our migration assumption, just to remember, we're assuming that 40% of the members are going to leave the plan. Those are the lower consumer members. And so, you know, that rate in plan year 28 could be even that much. You know, we're making an adjustment to those rates for plan year 27, assuming that the 60% there are the higher consumer and higher spend, but it could be more than what we're assuming. So, there may need to be additional adjustments in 28.

Okay. So, with a higher amount than EPO though, I guess I'm curious then and I know in these different scenarios that we've created, it's kind of across the board similar rate of adjustment between all of these three different plans. So what I'm understanding from that it being such a significant difference and higher amount of subsidization occurring for EPO. Would it make sense essentially for us to increase the EPO at a slightly higher rate the premium being than we would the CD and LD. Meaning that we would essentially do like the three-year 1C plans for the

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CDs and LD's, but maybe we do the two-year type of plan for what is that 1B for the EPO. To sort of level that out?

Ms. Donaldson: Board Chair Wells, board member, yes, that is an option we could consider.

Chair Wells: Questions? Member Harper.

Member Harper: Blaine Harper for the record. I understand the actuarial soundness and recommendation of ultimately setting the CDHP out of pocket max higher than the LD PPO. None of these scenarios present that. That's, you know, not what the board asked for. From the participant perspective and the people who will actually be making decisions to change plans using this premium information, the less than $3 million difference between scenario 3C versus 1C doesn't seem to justify making the out-of-pocket maxes max changes that were adopted in December. We just found $18 million doing due diligence on our budget at PEBP and I think that participants are going to really feel stuck if the rates are changing by this much and so is the information about the coverage they have to decide between. They have to re-evaluate all of that right now. I just want to raise that point. Thank you

Chair Wells: Any other questions?

Member Viton: Chris Viton. Just so I'm understanding in the phase in proposals when we're referring to the cost that has to be covered. Can I just make sure I'm understanding if that's a out-of-pocket cost or if it's a delay in replenishing the reserves or building back the reserves? It's not because the plans in the current year projection it's covering its expenses. We're just not replenishing the reserves the way we expected to. Right? The delay phase in approaches would provide an opportunity to determine if a request could be made with legislature supported to help offset this as opposed to going through the full three-year needing to fund through only the employee premium changes.

Chair Wells: Yes. So, you're basically pushing the rebuilding of reserves to the second and third or fourth and fifth year, whenever that occurs. I don't know that you're going to, you know, everybody's being told to build flat budgets. It's going to be very difficult to see another significant increase in state contributions like we got from last biennium to this one.

Member Harper: Blaine Harper for the record. I just want to clarify whether the net cost of two-year phase in or three year phase in, is that spend down of reserves or is it just relative to the full one-year version?

Chair Wells: So, the way I understand it, and Ms. Donaldson, correct me if I'm wrong, is that if you picked 1C, which I think is $35 million, we will bring in $35 million less than we are projected to spend in claims costs for the year, for one year, not the three years, for one year. So it's $35 million next year, $35 million for 27 or 28, and $35 million more 29. And so at some point that premium differential is going to have to be picked up somewhere.

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Member Harper: Okay.

Ms. Donaldson: I would just add, Board Chair Wells, that it's 35 million plus trend in each of those years two and three. So that 35 million would go up with trend, the 7 and a half % trend projected.

Member Harper: Blaine Harper for the record: Thank you. And I'll observe that when we sit down to set rates next year, we will not have new complete information from the legislative session. Is that correct?

Chair Wells: Usually by the time we're that far along, the legislature will give what we have asked for the first year. They won't change it after being set. Traditionally they have not changed it after. They could but they traditionally have not so what we build into our budget for the first year which changes over time so we have to submit a budget by September 1st. The governor has submitted the budget by January 18th-ish. We have the opportunity between September and December to make some adjustments based on assumptions for inflation and trend, the enrollment counts and so forth before the governor's budget was submitted. So, it's not perfect information, but it's a lot closer than what we have in August.

Member Harper: Thank you.

Chair Wells: Any additional questions from board members? All right. So, I said I would take additional public comment before we take any kind of action on this agenda item. So, we will open the floor for public comment for agenda item number five. We'll start here in Carson City.

Mr. Ervin: Kent Ervin E R V I N for the record. So, mistakes were made in collecting revenue starting in 2024. Mistakes are being corrected. Not clear if that's retroactively to 2024. Employers, especially the state as the major employer, should be on the hook for those past errors and deficiencies, not employees. We are now told that the rates for the three plans have been mispriced for years. Resulting in cross subsidization since 2022. We also should not try to fix that all in one year. And now is the wrong time to increase out-of-pocket maximums all at once 5% or $1,000 or $2,000 when you're also making employees pay to replenish the reserves due to past mistakes. Page eight of the Segal presentation says there has been a $30 million shift in cost from employees to the plan, but the data in the chart simply don't show that. The ratio of employee and employer revenue has remained about constant except for the first half of FY 2026 when you aren't collecting revenue and don't have a full year. The shift from FY2022 to FY25 according to the chart is actually due to a more than doubling of pharmacy rebates on a percentage basis which has benefited the plan overall. It's false to attribute that to employees paying less.

Page 16 of the report. Migration apparently has not been modeled for each of the nine scenarios separately. Migration should be much less for the three-year phase in than for no phase in. The actuaries should be asked to come back with refined assumptions. When Segal presents

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facing in as a cost of PEBP, what is really happening is that the cash reserves are not being increased towards the actuarial target as rapidly. Replenishing reserves is mostly a one-time cost whether in one year or three years. After that the rate should in principle go down or at least help cover trend. And we have not been told what is the breakdown in the proposed rates between ongoing expenses for healthcare and replenishing reserves. That's an important piece of information to get from the actuaries. If the actual cash balance is 18 million higher than reflected in the second quarter budget report after under collections are corrected and as Chair Wells an additional $10 million can come from AEGIS and REGI surpluses then the reserves are deficient by only about 30 million not 60 million if I followed all that correctly. That suggests and that's compared to the you know so they'll come up to 90 million of the $120 million actuarial target. That suggests PEBP could get through this year and the next without burdening employees with huge premium increases for reserves. You should defer a decision today and ask for another option that just prevents the problem from getting worse in FY2027, perhaps with an additional $5 million to $10 million buffer to be fiscally responsible. So, defer decision, get all the information, or at least take option 3C. Thank you.

Chair Wells: Thank you, Dr. Ervin

Ms. Charles: Good afternoon. My name is Cassie Charles here on behalf of AFSCME. The state's largest state employee union. The public Employee Benefits Board is tasked with managing state employee health plans. Essentially, this board is tasked with protecting workers and giving them the tools to stay healthy. It has been made clear throughout today's discussion that the need to raise rates is not due to socioeconomic trends or the ever rising cost of healthcare in this country, but instead this board is considering raising premiums for state workers because of previous staff errors. This is unjust. State workers should not have to pay more to stay healthy and keep their families healthy because of staff errors. State workers should not be held responsible for making up the deficits caused by lack of proper budgeting from prior staff. If rates need to be voted on today, we are inclined to support option 3C along with our Nevada Faculty Alliance colleagues, which does the least amount of harm to current workers. Thank you.

Chair Wells: Thank you, Ms. Charles.

Mr. Hopkins: Chair Wells, we have seven in the lobby, though I I'm not sure if they want to make one. I'll call them out, but I'll make an announcement by slide out. One moment please. For those who are in the lobby right now, if you do not wish to make public comment, please leave the lobby now so you're not accidentally called upon. If you have called in via your phone number, I will identify you shortly with the last four digits of your phone number. All with the last four digits 3190. Please press star six to unmute and please slowly state and spell your name for the record.

Ms. Mowers: Thank you. My name is Susan Mowers. S U S A N M O W E R S. I commented earlier, so thank you for another chance to offer public comment. I've listened carefully to the technical and detailed information presented today and I understand in my job I also have to

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work with the problems of projections versus actual collected funds and how to make the numbers work especially when there are shortfalls. I appreciate the work that went into these presentations and can see you know why these increases are being considered, despite who at fault. However, we've reached a point where traditional solutions are no longer sustainable for the people who keep this state running. While PEBP has absorbed past rate increases, forcing employees to catch up now is not a viable solution. It is far too easy to talk about spreadsheets and forget that there are real people behind those numbers. You've heard those real stories today earlier and how these hikes will affect employees who are already financially strapped.

You know, in regards to the various health programs have offers to help members stay healthy, these programs look good on paper, but they really are not viable solutions to the larger financial issue. These programs are often like putting a ping pong table in a break room that employees can never use because they have too much work to do. These programs sound nice, but they don't add a ton of benefit and more especially don't solve the underlying crisis of affordability. In my professional role as creative director in the Department of Tourism, my job is to look beyond the obvious. I ask, "What else haven't we considered? Does the state even need to work within a traditional insurance company model? Can the state negotiate directly with health providers on our own?" Now is the time really to challenge legacy thinking. The justification that this is how it's always been done just really doesn't work anymore, especially in today's economy. Our health care and health insurance system. You know, those are conversations for a larger, venue and not what we need to discuss for today's um needs. But I encourage the board to challenge their own thinking. f PEBP continues to have shortfall if they refuse to raise rates for employees, the word so what that may send up your spine, but I challenge you to think of that in a different perspective. Isn't the goal of health insurance truly about providing quality health care to the state employees? Not if the state takes a loss due to rising medical trends that should be accounted for as a necessary investment in employee compensation, not a debt to the employees to repay. You know, what if the state accounted for that loss in another way perhaps in a different department?

There are radical solutions that may seem impossible, but you know, as Nevadans, we're mavericks. We didn't settle this state by playing it safe and accepting the status quo. Even in a world of actuarial science, there's always room for creative thinking. I urge the board to pause and look deeper. Think about the long-term benefit of your decisions, not just for the state employees, but you know, via the state employees to the citizens of the state as a whole. I'm going to end by just asking you to reject increases that function as a direct pay cut. Explore, you know, more outside the box funding and provider structures. I'm also going to say I know this seems like this process is very deep already into it to where seems like decisions are needing to be made, but I'm going to advise to and encourage you guys to not fall into the funk cost fallacy. You know, to think that you're locked into this course. You know, government's run by the people and for the people, right? We are the people. We can pivot .If we need to really just start from scratch or start from a, you know, back it up, these are nothing but good things for us in the long run. You know, I believe in our state. I believe in the board and your desire to do your jobs well and without malice. Don't think that you're on your own. You know, hold other hearings or brainstorming sessions. Tap into the resources. You know, there we're all in this together. And I

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think I don't want it to seem like it's a us versus them, a you versus us, you know. We are Nevadans and I think we can find the solution. So, thank you.

Chair Wells: Thank you, Ms. Mowers.

Mr. Hopkins: With the last four digits, 1261, please press star six to unmute and please state and spell your name for the record. Caller with the last four digits 6789. Please press star six to unmute and please slowly state and spell your name for the record. Caller with the last four digits 8008. Please press star six to unmute. Please slowly state and spell your name for the record.

Mr. Mosley: Hello. Can you hear me?

Mr. Hopkins: Yes, we can. Thank you.

Mr. Mosley: Thank you. Name is Jesse Mosley. J E S S E M O S L E Y. My public comment is I've spent nearly two decades working for the citizens of Nevada. The decision to move forward I believe is going to cripple employees, retirees and the citizens. Based on the last two meetings that PEBP has held, it appears that the accurate figure the figures aren't accurate regarding this under collection, these shortfalls or the overall budget. There's so many unknown factors. I urge everybody to vote no at this time. It was mentioned an audit is going to happen in the summer of this year. Without all the data, how can anybody make an intelligent, educated decision? So, I just urge you to vote no at that time. I concur with the other people that mentioned it as well. Maybe a more competitive rate needs to be sought after instead of all these increases. The only other thing is after all this is said and done, is the state or PEBP going to seek a different contractor to get figures again so these mistakes won't be happen in the future? And the last thing I'm going to point out before I close is last year it was reported I think during the last board meeting as well there's a rainy day fund as we call it that hit a high of about $1.24 billion. Is that a consideration in this factor? Again please vote no on this increase. Thank you for your time.

Chair Wells: Thank you, Mr. Mosley.

Mr. Hopkins: Caller with the last four digits 1261. Please press star six to unmute and please slowly state and spell your name for the record. Follow with the last four digits 5779. Please press star six to unmute and please state by your name. caller with the last four digits 8853. Please press star six to unmute and slowly state and spell your name for the record.

Mr. Unger: Hello. Doug Unger, D O U G U N G E R, immediate past president of the UNLV chapter of the Nevada Faculty Alliance and member of the UNLV Employee Benefits Advisory Committee. In listening to the budget reports and to the various numbered possibilities for plans and rates, I can only say that, most state employees are going to leave a bit confused over the shifting numbers. The lack of accountability still for numbers that haven't been reported for state agencies that perhaps haven't made their employee contributions etc. So, it all reminds me of that old saying by a farmer who is looking at the weather and saying gosh I hope it stops hailing

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pretty soon. So I don't think the board has enough information to be able to make a decision. If it does make a decision, I will say again that only option 3C is viable and will be acceptable to state employees. This will give us a chance to appeal to the Governor and to our state agencies and to the legislature to increase employer contributions to the PEBP plan rather than penalize state employees for past accounting errors and a lack of fiscal responsibility in managing PEBP and rising health care costs. So I would recommend that especially the out-of-pocket maximums not be increased. That will put a real life burden on people with acute medical issues and serious chronic condition. Thank you for your consideration and I hope you all make the right decision.

Chair Wells: Thank you Dr. Unger.

Mr. Hopkins: Caller with the last question. is 5779. I see you joined back in. Please press star six to unmute and please slowly state and spell your name for the record if you wish to make public comment. Katrina Albridge you have permission to speak. Please state and spell your name for the record if you wish to make comment.

Ms. Aldridge: Hello. Can you hear me?

Yes, we can.

Ms. Aldridge: Hello, my name is Katrina Aldridge. K A T R I N A L D R I D G E. I'm an employee with NSHE. I'm a young professional. I've been in the business world for about seven years now. I'm a single person. I do not have a spouse or children. I can only imagine what it would be like to have a spouse or children in this economy, but it has been incredibly difficult to keep up with the economy as a single person. My position here is ineligible for union representation because my position type is in the personnel series. Despite the position type at my organization not having the ability or reach to anybody with the ability to influence union representation or contracts. It's difficult to reclassify employees for promotion to give people raises to help people make more money. I am somebody that helps in trying to get people reclassified for the work that they're doing here. At every step of my employment, it feels like there's a block or something else from preventing us from making more money to keep up with these costs that are being imposed on us. I'm being told that PERS is slated to increase in 2027. 20% of my paycheck is already gone before taxes or other deductions. And what I'm being told now is that my insurance rates are going to benefit me. You know, we say PERS is amazing, but that's 26 years away for me. What am I supposed to do to feed myself and house myself today and for those next 20 years?

Earlier this year, I was notified that PEBP was dropping my dental provider. It's been incredibly difficult in my area to find a dental provider that I trust. I've had many different and terrible experiences that have resulted in additional dental problems. I have continued to pay out-of-pocket costs despite them now being out of network, and I've paid hundreds and will pay thousands of dollars to continue to see them over the years. I understand incremental and thoughtful increases to provide better care options, but rates are increasing and our options are reducing. This is unacceptable and unsustainable. We cannot continue to pay more if our benefits

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are going to get worse. Especially if the current deficit was not an error in part of the members and there's no additional benefit being provided to the employees by increasing the premiums. If you're going to increase the premiums, I really encourage those to be thoughtful and to provide additional benefit to members. We've already seen that it's just increasing and there's been no benefit and it's not going to do anything but create more of a hardship for people that are already living paycheck to paycheck and trying to survive and support the state and the organizations that we have devoted so much time to. Thank you.

Chair Wells: Thank you, Ms. Alridge.

Mr. Hopkins: Negron, you have permission to speak. Please state and spell your name for the record if you wish to make public comment. G Ben Halari, you have permission to speak. Please slowly state and spell your name for the record if you wish to make public comment. Tay Quinn, you have permission to speak. Please slowly state and spell your name for the record if you wish to make public comment. I'm going to try caller last four digits 5779 one more time. They joined in another time.

Ms. Rosenberg: Hi, this is Rachel Rosenberg. R A C H E L R O S E N B E R G. I am an employee of ndot and I have to say that I think that the estimates of migration are fairly low. If you increase the Low Deductible plan by over $100 per month, I can guarantee you that significant amount of people are going to go to the High Deductible plan where they can then have an HSA where they can then take money out of their own paychecks, put it into an account that they can gain interest on that they can then use to pay for their deductibles and their co-insurance that's going to be higher because they're on a high deductable plan. There is absolutely no point in staying on a low deductible plan when I can't even take any money post or pre-tax out of my account into a health savings account because that deductible is too low to even qualify for those plans. I think you guys really need to seriously, I agree with everybody else in this comment that you should delay this this adjustment until you get proper budgeting from the state because I guarantee you if you talk to legislators, they will try to fund our employees significantly better than this. So that's my comment. I really highly suggest, I hope that you table this and hold it off until you guys get some better budget numbers from the money that you found. Please don't put the burden of migration all the way down to the Low Deductible plan on us as employees. I've talked to multiple people. Like I said, that the previous person, I am single, so I only have to pay for myself. But the people with families, if you're talking about a $1,500 per month deduction when you only make about 3,000, that's ridiculous. That's your car payments. That's your house payments. So, I hear what you guys are saying, and I appreciate what you're trying to fund, but please, please I implore you to find other ways to deal with what the actuaries have been telling you. Thank you.

Chair Wells: Thank you, Ms. Rosenberg.

Mr. Hopkins: I have two more, Chair Wells. I’m on it. Call with the last four digits 9211. Please press star six to unmute. Please slowly state and spell your name for the record. Caller with the

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last four digits 3896. Please press star six to unmute. And I saw that you rejoined caller 1261. Please press star six to unmute if you wish to make a public comment.

Mr. Doe: Good morning. Understanding the close relationship that this chair has with the Lombardo administration, I do not feel safe providing my name. So, for the purposes of public record, please record it as John Doe. This board has heard a number of public comments so far this morning, and I echo the sentiment of all of them. However, I think they have taken an inappropriately respectful tone to the actions of this board. Even under the three-year phase and approach, the increase in premiums for some plans is similar to the cost of a car payment and will not only harm existing employees in their pocketbooks, it will cause some to default on mortgages, some to issue health insurance altogether, and through that will likely lead to avoidable poor health outcomes and even death. The figures for the immediate approach with no phase in cannot be described as anything other than apocalyptic. How this kind of catastrophe can be pushed onto public employees without the resignation of the chair of this board is a prime example of how there is no remaining integrity in the upper echelons of public leadership. If these premiums are mathematically necessary to maintain solvency, that's one thing. It does not, however, excuse the efforts of this board to comply with only the bare minimum public noticing requirements and go through zero effort to communicate these potentially catastrophic changes to public employees with sufficient time to review their insurance options and identify how to spare their family from this absolute evisceration of household budgets.

The chair of this board is widely known to hold nothing but malice and contempt for public servants. And that is a then this is a continuation of a pattern of everything Chair Wells touches turning to absolute shambles and being balanced on the back of hardworking public servants. Not only has the board failed to provide anything remotely resembling reasonable communication to affected employees, but the board is now considering shortening the open enrollment period, effectively attempting to prevent plan migration and trap public employees in these immensely higher cost insurance plans. I strongly recommend that the chair of this board tender his resignation immediately and that the board offer an apology for how this has been handled to date. If there is to be a change in the open enrollment period at this time, then that should be an increase in the amount of time available for people to review and change their plans, not a decrease. Every detail of how this has been handled has been a blatant attack on public servants and through them an attack on the citizens of Nevada who will be harmed by the reduced ability of public agencies to serve constituents. Thank you.

Mr. Hopkins: Ali Anderson. You have permission to speak. Please slowly state and spell your name for the record.

Ms. Anderson: Hello. My name is Ali Anderson. A L I A N D E R S O N. Thank you so much for taking my comment. I'm a little nervous right now. My palms are sweaty and my voice is going to shake. I just wanted to speak on this. I am a single income household. I have to know where every single dollar that I have for my paycheck goes to. It's a little disappointing to hear that that was not the case with PEBP. When it comes to my insurance, it's already frustrating having to call providers offices and then also have to fight with my insurance to ensure that when I do get a

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procedure done, I'm not going to be financially burdened by this. So now to hear additionally with my plan, now I'm going to have to pay for me. This is a this is a tough one. Additional $100. That's rough. Especially when you're in a single income household. So, I really urge you guys to please reconsider this increase. If I have to be creative when it's my budget each and every month, I encourage you guys to be creative. That's your job. Thank you.

Chair Wells: Thank you, Miss Anderson.

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

Chair Wells: All right, we'll close public comment on agenda item number five. Anything else you want to add Ms. Donaldson ? Any other questions for Ms. Donaldson?

Member Zumtobel: I have a question. What are the implications of delaying the decision?

Chair Wells: First of all, we have to shorten open enrollment right? And we still have to make a decision within a couple weeks. We're running out of time. And I think we have enough information. I'm not inclined to delay a decision today.

Member Zumtobel: Yeah. So we'd have to we'd have to shorten. So, backing in from I guess July 1st is that when the plan has

Chair Wells: You have every open enrollment, I don't know exactly what the law says, there's a there's a legal requirement for us to notify in advance

Member Zumtobel: okay and, yeah I just think that you know it's been raised and we should at least express what the what the barriers. If we did that and we still had to meet our obligations to communicate open enrollment and to do a timely enrollment then best case it gains us a couple weeks. Is that a fair interpretation of what you said?

Chair Wells: At absolute best at best and the information is not really going to change from what you're seeing here today.

Member Zumtobel: That's what I'm trying to understand. If we had a couple weeks is it going to look that different? The collection of the, it's not gonna…

Member Duncan: Excuse me. Keiko Duncan for the record and just reiterating slash confirming what I've heard Ms. Donaldson say is that the corrections to AEGIS and REGI and all of those various projections have been included in these numbers that we have seen today for these rates. Can I just get a yay or a nay.

Ms. Donaldson: Yay.

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Member Duncan: All right. So, what we are looking at is the corrected information?

Executive Officer Carsten: Theresa Carston, for the record. We're not finding more money like that. That was the audit. It's complete. That is the amount of money and it's been incorporated in these documents.

Member Duncan: I appreciate that. Thank you,

Chair Wells: Member Harper.

Member Harper: Blaine Harper for the record. I don't know if the actuaries had time for a look back on whether spend down was higher in plan year 25 and or 26 than previously reported. I'm wondering whether the expected spend down in these scenarios presented to the board might be on the high end of what is to be expected.

Ms Donaldson: Board Chair Wells, for the record, Deborah Donaldson, board member, you know, I'll point you to the slide that had all of our financials in it that had revenue and expenses, and those reflect actual amounts. So through December of 2025 that does reflect all the actual amounts.

Member Harper: Blaine Harper for the record. Can you identify which slide?

Ms. Donaldson: Yes. So slide 13 which shows revenue and expenses. Total revenue and expenses. So for plan year 25 it shows in total you know $33 million short. We are projecting basically break even plan year 26 actual with projected for the rest of the six months years and slide 13.

Member Haper: Blaine Harper for the record I just find it shocking that in these scenarios, premiums could change on the participant side by such a high dollar amount and we would still be looking at spenddown comparable to previous years where there was planned spend down on those expensive plans, the LD PPO and the EPO, HMO. So even though we’re taking out that expectation, we still have essentially the same dollar figure of spenddown happening. Like I don't know if I'm missing something.

Ms. Donaldson: Board member, Chair. I'll point you to slide 15 which shows the cross subsidies and the overall increases that each of the plans need to have and that represents the additional dollars that we had in each scenario. That the members have to pick up. And so, depending on, if the members pick it up in plan year 27, that has a different financial implication to needing additional funds than it does over a two-year period versus a three-year period. Where you know slightly somebody has to pick up those additional costs because the rates are still the rates unsubsidized and so yes.

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Member Viton: Just in that regard on that slide 15 those percentage increases seem much lower than the percentage increases in the scenario A's that are that are representative of the correction so I think that's part of what's confusing for me also in terms of understanding what's increased related to changing reserves versus what's increased related to ongoing costs and the actual experience in the plans today in the projected spec.

Ms. Donaldson: Yeah. Board Chair and board member if you go let's look at 1A. So again there's additional standalone rates but then we also incorporate the migration of the plans that are remaining, the members remaining in the plans. There's that adjustment because we think that those plans are going to be even higher if that makes sense. So, the migration has some perspective of it. But if you look at some portion of that, there is some leveraging because the base subsidy is the same right? So, the rates are going up, the base subsidy is staying the same and so there is a little bit of leverage associated with the net member cost share.

Member Harper: Blaine Harper for the record. I agree with the observations of member Viton and I think the percentages I mean across scenarios are quite remarkable. So if the plan migration is pushing the percent increase higher and that's some of the data we know the least about. What PEBP has clear data on is movement in the opposite direction of what we're looking for this year. Is it your recommendation that the board should include the full assumption of plan migration? Or is there potentially some room for discretion on that?

Ms. Donaldson: Board Chair and board member. The actuaries have been directed to remove any of the cross subsidizations in the plan for plan year 27 per direction of the last month's board meeting. I want to make sure that we're looking at the same things too because when you say increases you are correct if you look at participant premiums in 26 from a percentage standpoint to participant premiums in plan year 27 that's not going to translate to the 30% that we're seeing the uplift. If you look at the budget rates compared to the published rates you're seeing that happen. Now it's not perfect but there's some nuances. Again, the base rates are the same for each of those plans and so there is a little bit of leveraging impacting to those plans. I hope that helps clarify.

Member Harper: I accept for the record.

Member Duncan: Keiko Duncan for the record. So, to the previous point of migration. So sorry, I'm just trying to make sure I make this question make sense. So, in looking across these three scenarios, one being we keep everything as we've already voted, two being the CDHP max resets, three being all the max resets. What I'm understanding from this conversation is that the migration risk increases in either scenario two or scenario three. So the migration risk would probably increase greater than our base what we've already talked about in terms of that 30 10. Meaning that those numbers you have projected in scenario two and three could theoretically be more volatile than scenario one because of the greater risk, potential of risk.

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Ms. Donaldson: Board Chair Wells. Yes, board member. So, part of my concern is that member behavior and the unintended consequences with not having appropriate out-of-pocket maximums that align with premiums and we have seen that happen in other plans where as much as you try to project member behavior is different. So, yes, I am concerned that there could be folks going into the Consumer Driven Health Care plan because the premiums low. They know they're going to hit the out-of-pocket maximum, but they're going to pay a lower out-of-pocket cost share because the out-of-pocket maximums are not set to kind of a you know what I mean with the premiums and so they're going to choose a lower premium plan and that is a concern of mine that I'm going to be off more than what I expect in the migration yes that that is a concern of mine. And again, I have to reiterate, you want the lowest premium to have the highest out-of-pocket maximum. And that's my concern, if the board makes a decision to not do that. I am concerned that there's going to be unintended losses that we couldn't have potentially captured. Again, it's member behavior. Are they doing the math? They could. Some could be doing the math. Maybe some aren't.

Member Duncan: So just to restate to make sure I'm understanding correctly. So, in scenarios two and three, there are essentially more variables that could potentially be unaccounted for in this current data that would essentially lead to potentially greater variances of the negative sort for our reserves.

Ms. Donaldson: Board Chair Wells, board member. Yes, there is potential for that. And then if that ends up happening to fruition in year 28, we could have even higher premiums than we're showing here for plan year 27. Unless, if the out of pockets kept the same.

Member Harper: Blaine Harper for the record. What I'm understanding from that is that it may not have the impact upfront. I personally would like to collect that year of data to know what migration we're actually seeing and I understand it could have that impact to the finances. I guess impact that we could anticipate being most likely on the front end of that it. I kind of don't see it being the reserve specifically since this number, you know in the scenarios would already kind of account for it I imagine. But it's that the CDHP would be more likely to face a rate increase as a result of you know some of that migration risk. Is that accurate? And that would be for plan year 28 that I'm asking about.

Ms. Donaldson: Boar Chair Wells, member. That could be but it could be if they go into the Low Deductible Health Care plan it could impact the Low Deductible Health Care plan as well.

Member Harper: Thank you.

Ms. Donaldson: I'd like to add a comment to that as well. We may not see it as much in year one once folks start figuring it out. That's my concern and I've seen it in other plans. I'll just share it's happened in other plans and that's my concern.

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Member Rich: I didn't have a question. Laura Rich, for the record, I didn't have a question, but I just wanted to make some comments just to kind of address some of the public comment that came up. And part of it is, I think that there was some concern over, you know, obviously making a decision today. Chair Wells, as you stated, I think it's very important to make a decision today. We're up against a timeline and we don't have the ability or the luxury to not make a decision. But I think the other piece of it too is that it's an unfortunate situation that we're in. We as PEBP, it sounds like we should have been incrementally raising rates throughout the last few years and that has not happened and so we are forced in a situation today where you know instead of the incremental now it's kind of a slap in the face, you know to put it bluntly and it's not fair. Unfortunately, we're also in a situation to where we can't not do it because the alternative is to wait and to ask the legislature for that money and that's a year from now. There's no guarantee that the legislature is going to come and save the day. I don't know if they can come, you know, we don't know what the economic situation is going to look like. And so if we did something like that, it would be in my opinion fiscally irresponsible because if we put it off, ask the legislature for additional funding and then they say no, we're in a worse position than we are today. And so I just wanted to put that on the record. It's unfortunate, we're between a rock and a hard place, honestly. And it's just an unfortunate situation we're in.

Member Duncan: Keiko Duncan for the record. I just wanted to clarify based on that comment because that was very illuminating. Thank you. So kind of what I'm hearing from all of the above is that these quote unquote, mistakes that have may have been made in terms of the overall budget that was entered originally and in past is not actually the entire source of why we are needing to increase premiums. Rather, it is a combination of potentially yes, an error in the original budget and the fact that no prior decisions have been made to increase premiums at a rate consistent with health care costs rising in the United States. Is that generally correct?

Executive Officer Carsten: Theresa Carston, for the record, based off of today's presentation and our revenue audit, I would agree with that. You said that very eloquently.

Member Duncan: Okay. Just so I make sure I'm understanding well. Thank you.

Chair Wells: Any other questions, comments? Anybody want to take a shot at a motion?

Member Barnes: Jim Barnes, I'd like to move that we adopt scenario 3C.

Member Harper: Blaine Harper. Second.

Chair Wells: Second. Is there a second to adopt recommendation 3C. Right?

Member Barnes: Correct.

Chair Wells: Any further discussion?

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Member Duncan: Can I make a comment on that difference? Not necessarily for discussion but just for the record. 3C. The change in premium rate for 3C. While not significant is greater than the change in premium under for example 1C. And while that changes of the dollars. There's also consideration the difference in strategy being also a change of out-of-pocket max, just would like to note that the premium change is actually higher than in another scenario.

Member Zumtobel: And I'd like to make a comment that we've been advised that it would not be in our best interest to have that plan with the lower out of pocket max and it might feel like the right thing to do but it feels like it's also going down the wrong direction as far as managing long term. We have to look more long term, right?

Member Harper: Blaine Harper for the record. The way that I see scenario 3C in relation to scenario one is deferring that out-of-pocket max change because three would keep it the same as plan your 26 and we have a lot more information now than we had in December and I think it will help to see the plant migration data in combination. You know, how our cost containment measures that we'll be discussing during strategic planning this summer. We'll be able to see some of these changes start, you know, producing some kind of results and make observations and then make a much more informed decision than the one that we made in December that. So I I do see us as coming back to that consideration. Um but I think to the extent that any decision can be deferred today that is what we can defer. Thank you.

Member Rich: Laura Rich for the record. I think that as we heard from the actuaries today, scenario 3C would be essentially kicking the can down the road and introducing a level of volatility. I don't know if we need any more volatility in this plan than we're already facing and so I would not be supportive of that because of that. And yes, while we would have the ability to, you know, as member Harper mentioned, we would be able to have that experience, but remember, we're always looking into the future. So, even six months from now, we're going to be looking, two years into the future. And so, you're learning from your experience, but you're still having to look to the future. I don't know if that would be extremely helpful in that sense.

Member Duncan: Keiko Duncan for the record. I just want to make sure I was looking at the right number here from the presentation. Scenario three would be a $3.2 million cost increase to premiums. Again, just stating the fact.

Chair Wells: Any additional comment? We have a motion and a second. All those in favor say I.

Member Harper and Member Barnes: I.

Chair Wells: All those oppose, nay.

Member Duncan, Member Rich, Member Zumtobel: Nay.

Chair Wells: A miscount. I don't think I have enough to pass.

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Ms. Mooneyhan: Do you want to do a roll call? A yes or no?

Member McClendon: I was a yes.

Chair Wells: So, we have three yes's and four no's. You were a no, Chris? So, we have three yes's and four no's. Motion fails. Anybody want to try again?

Member Duncan: Keiko Duncan for the record, I would like to make a motion to essentially adopt scenario 1C which is plan year the 27 benefits approved from the December board meeting with the rates specific to a three-year phase in.

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

Member Rich: I'll second.

Chair Wells: Motion and a second. Any further discussion?

Member Rich: Actually, I have one. Keiko, I liked your idea of using a scenario for one plan and a different scenario for another plan. And given the volatility and just kind of the spiraling of the HMO and EPO, can I amend that?

Chair Wells: You would have to accept that.

Member Rich: Okay. Yes, that's I forgot about that.

Member Duncan: Okay. I amend my motion then. Just going to say it all again to make sure we got it straight. So that would be scenario one. Again, keeping the benefits from December board meeting option 1C for the plan specific rates with the three-year phase in specific to the CDHP and LD PPO. For the EPO then would be scenario 1B as in boy for EPO the specific rate for the 2-year phase just for that plan.

Chair Wells: You accept that amendment?

Member Rich: I do accept that amendment.

Chair Wells: Okay. So, we have a motion and a second to adopt 1C for the CDHP and the PPO and 1B for the EPO HMO plan. Further discussion?

Member Zumtobel: I would like some consideration if we take that route that we do get the numbers even if it takes a month or whatever that we get clarifications on the revenue numbers even if it's just me understanding, right?

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Chair Wells: We will continue to refine the revenue numbers and the budget projections.

Member Zumtobel: I would think monthly accountability, right, on those numbers that they would be reported to the board and we would not fall behind again. Right. And then I also would like to, and you stated it earlier that the objective is that for plan year two and three is to accommodate that through cost containment and other areas. I don't really like approving a three-year premium. I think maybe we look at it this might be the first year and then we agree to look at it each year or are we approving these premium increases for the next that's not the intent.
Chair Wells: We are only approving the premium for plan year 27 with an intent to revisit the cost containment options to prevent subsequent increases to 28 and 29. Any additional comments from board members? Seeing none, all those in favor of adopting 1C for the PPO and CDHP and 1B for the EPO HMO plan say I.

Member McClendon, Member Rich, Member Zumtobel, Member Duncan: I

Chair Wells: All those opposed, nay.

Member Barnes, Member Harper, Member Viton: Nay.

Chair Wells: So we have a four to three. It passes. Okay. So we have an adoption of rates. I'd like to have the board consider a couple of other issues. I think we should probably take a vote to use the funding from the REGI and AEGIS counts and accept the dollar amount. Today. Did I tell you it’s 20 and 50?

Executive Officer Carsten: Yeah, that’s what you told me.

Chair Wells: So, it'll be $20 per month per active employee from the AEGIS account, $50 per month per retiree from the REGI account. That'll reduce the projected shortfall by about 9.4 million. Can I get a motion to do that?

Member Rich: Laura Rich for the record, I move accordingly.

Chair Wells: Can I get a second?

Member Duncan: Keiko Duncan, second.

Chair Wells: So, I have a motion and a second to take additional funding from AEGIS with no impact to employee or retiree rates, but to take $20 per month from the AEGIS account per employee, $50 a month per retiree from the REGI account to offset the shortfalls to rebuild reserves for 2027. All those in favor say I.

All board members: I.

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Chair Wells: Any oppose? No. And then the last thing, and this is kind of a little bit personal to me, is based on the years of service adjustments we have certain retirees who get the benefit of a lower premium than active employees. And I think that fundamentally that is wrong. We should not have a retiree that has 20 years of service paying less than an employee who's still working with 20 years of service. So, I'm interested in a motion that would cap the deductions for retirees at the amount that the employee pays for like coverage.

Member Rich: Laura Rich for the record. So moved.
Chair Wells: I have a motion. Do I have a second?

Member Duncan: Can I ask question?

Chair Wells: You can second it then we can have a discussion. You don't have to vote for it.

Member Duncan: Keiko Duncan. Seconded

Chair Wells: The motion is second. Any further discussion?

Member Duncan: Keiko Duncan for the record. So when you say cap, I just want to make sure I heard it correctly. So we're capping it to what exactly?

Chair Wells: So we would cap the reduction. So the years of service, so retirees get years of service adjustments up or down based on the number of years of service that they have, right? In the current plan year, an active employee with 20 years of service on the CDHP single person only pays 55.26. A retiree with 20 years pays 17.91. They're already being subsidized because they're retirees and they're usually in the more expensive age group. We're further subsidizing them by having a premium that is actually less than the than a like employee pays. So what it would do is cap the reduction at the amount that an active employee contributes for the same plan.

Member Duncan: Okay. So the theoretical narration of that is essentially saying that a retiree can get no more reduced than a state employee that is currently serving today.

Chair Wells: If the premium for a single person on the CDHP is 55.26, a retiree single person can never pay less than 55.26.

Member Duncan: Correct. Okay. All right. Okay. I'm understanding that correctly. Yes.

Member Rich: Laura Rich for the record, do we have data on how many people fall into that category?

Chair Wells: No. Do you know how many people? I know the average years of service used to be about 18. So, I doubt that's changed much.

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Executive Officer Carsten: The enrollment file, does it show years of service though?

Ms. McJoy: No.

Mr. Proper: It’s about that.

Chair Wells: So we don't have that. Member Harper.
Member Harper: Blaine Harper for the record. Similar question, what’s the dollar amount of difference would be to PEBP if that were implemented?

Chair Wells: It's not significant. I mean, under the current structure that the retiree pays 17.91 they would go to 55.26. So what? $28 time 12 times a couple thousand maybe. It's not going to save the day. I just think that fundamentally it's inappropriate for a retiree to pay less than that active. Any additional comments?

Member Rich: I have one additional question actually for staff. How difficult would this be to implement operationally because I know that's a math problem. So I just have a question for staff as to how difficult it would be to implement.

Mr. Proper: Nik Proper for the record. I don't want to, you know, speak for Monica, but I think this will be a heavy lift for open enrollment and for members because they're going to be looking at all of our rate sheets, looking at the years of service and calculating it and we're going to have to adjust all of our years of service. This is really changing the years of service policy.

Chair Wells: Theoretically it only affects single, it doesn't affect all the other ones. The deduction is not enough to make it so that it goes below what a significant employee pays. It's only for single and it's only for those with 20 years of service. Those with 19 years of service still pay more than an active pay. So, you have to have 20 years of service and be single for this to have any impact.

Member Rich: So, I think our vendor would have to be able to make that change in the system to be able to adjust for those scenarios where it never goes under that cap. So, I think that would be the operational difference, right?

Chair Wells: Which I think they do for total premiums. They have a cap for total premium. That's why there were certain payroll deductions that didn't work because they have a cap on the deductions. So, they have something similar in place already.

Member McClendon: This is Jennifer McClendon for the record. I just have a thought on this listening to the conversation. I think what you're saying Chair Wells makes a lot of sense but on the flip side it just feels like the cost to PEBP as an organization to figure this out in terms of policy and implementation and then the cost to potentially retirees who put in 20 years of service

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at relatively low paying jobs who are now going to be confronted with something that is confusing and difficult and maybe a hardship on their fixed income and we won't know that and then there's relatively little benefit to us as an organization. I'm just I'm just not sure if it makes sense to do the heavy lift for very little benefit on a matter of principle and the principle only applies to maybe half the people who are in this situation which is already a small number. I'm getting probably lost in the weeds on this but it's hard to see a way forward that makes sense in my mind.

Chair Wells: Any additional comment?

Member Rich: Is there any way to delay it for the year and just make the decision? I think we can make the decision today and then delay the implementation until plan year 28?

Chair Wells: Or we can make or we can just delay it until 2028. I think it's a change that needs to happen. I think you made comments at previous meetings about you know, the focus really should be member or active employee based. I think this is just one area where I feel the plan is not accurate.

Member Rich: I 100% agree. I mean it seems unfair to me that a retiree would be getting a greater benefit than someone who is an active employee. I support it. I'm happy to amend it to implement in plan year 2028 if that would that give staff some time to operationalize it and plan for it and it gives vendors time to make the system changes without having to rush to make those changes.

Chair Wells: Right. So, you amend it to implement for plan year 2028. You accept the amendment?

Member Duncan: Yes.

Chair Wells: Okay. We have a motion and a second for modification to the years of service subsidy starting in July 1, 2027 for plan year 28 so that retirees do not pay a lesser premium out of their pocket than an active employee. Any additional discussion? All those in favor say I.

Member Rich and Member Duncan: I

Chair Wells: any opposed, nay.

Member McClendon, Member Viton, Member Harper, Member Barnes, Member Zumtobel: Nay

Chair Wells: Motion fails. All right, with that we'll close agenda item number five and we will take a short break.

Break.

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Chair Wells: Okay, we're going to call the meeting of the Public Employee Benefits Program board back to order. We have completed agenda item number five. I believe that because we adopted rates today, we do not need to take any action on agenda item number six, which would have shortened the open enrollment period. So, we will move to agenda item number seven, Executive Officer Report. Ms. Carsten.

Executive Officer Carsten: Theresa Carsten, for the record, An update on the HPN premium reduction due to the medical loss ratio. There have been some errors in the premium reduction efforts that were supposed to roll out in December and January. So PEBP decided to delay the interest owed due to the members. There was a small percentage of interest that needed to go out in a second deduction or reduction to deductions. So now all of the file layout issues between PEBP and central payroll have been caught up and the additional $3 per member should go out to those 3,213 members in the second pay period of April.

After the last meeting, PEBP received a complaint identifying that there was a concern about us following open meeting law. Previously, PEBP had a contractor with court reporters for transcription services. Open meeting law requires meetings to either be recorded or transcribed. As PEBP's meetings are are recorded, we allowed our transcription services contract to expire. There was some requests for transcription services. So in lieu of that we've decided to take the YouTube transcription and have our staff clean it up. You'll see that in months as we go forward. It'll be posted with meeting minutes just or ease of use for people that were interested in that.

And then my last update is PEBP's received about 28 applications for the Quality Control Officer position. And so we will be working to reach out and schedule those interviews in the coming weeks. Any questions on those items or any other items?

Chair Wells: Questions for Ms. Carsten?

Member Harper: Blaine Harper for the record. Just a question about what the previous cost of the transcription services was in terms of what savings PEBP has from the end of that contract.

Executive Officer Carsten: I don't have that off the top of my head but we can look it up and provide it. Yeah, we'll follow up.

Member Duncan: Keiko Duncan for the record. So just confirming, you said that despite not currently having a transcription we are currently in compliance with open meeting law?

Executive Officer Carsten: We are in compliance with open meeting law. Back to the transcription contract. It ironically expired unknowingly. We did work with purchasing to obtain three bids. We actually tried to contact quite a few people because Purchasing wasn't happy with the three people that didn't contact us back. So our staff contacted multiple people. The issue really was that not a lot of court reporters wanted to provide a cost proposal or a bid to PEBP. Since it was not required as we record the meetings, we kind of moved on into other areas. I can tell you what the cost of that contract is. I'll follow up on that piece.

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Member Duncan: So, I'm curious. So, I'm just not familiar with the YouTube transcription or anything, but my understanding would be that that transcription would be taken in-house and quote unquote cleaned up. And so I'm just curious how much work that would be for our staff given that it's not an actual paid transcription service. So making it fully accurate knowing the experience that I've had with like offhand transcriptions being wildly different. I'm curious how significant of an impact that's going to be. Would our costs kind of offset essentially, would we need additional staffing to be able to do that? Would it take additional time?

Executive Officer Carsten: You know last month's meeting was pretty lengthy with public comment as compared to other meetings that we've had and I think she told me it took her like two to three hours so I mean not totally off

Member Duncan: It wasn't totally off. Yeah okay I appreciate that being an option.

Chair Wells: Any additional comments, questions? We will close agenda item number seven move to agenda item number eight, contract status report. Ms. Mooneyhan.

Ms. Mooneyhan: Thank you, Chair Wells. Brandee Mooneyhan, Lead Insurance Council for the record. Just an update on PEBP's contracts. The overview, all those expiration dates are accurate. Footnote one, noted that we were waiting for approval by the Board of Examiners yesterday and it was approved. So, those dates are accurate. Footnote two. We kind of wanted a place to keep the board apprised of the CTH issue. Of course, PEBP doesn't have a direct contract with CTH, but we do want to keep the board apprised of the status of that. So, this will continue to stay in this report just so the board can keep track of what's going on with CTH.

Some of the other contracts that are expiring relatively soon. The financial auditor, that contract expires at the end of the year. The contract does provide for potential extension of the contract with Eide Bailey and we are working with them to get a quote, what it would cost to do a couple more years worth of audits of PEBP and we hope to be able to report back at the next board meeting or the meeting after that. Discussion of an extension with ESI is ongoing with the help of our colleagues at Nevada Health Authority. Again, we hope to be able to report back to the board on a potential amendment including an extension at the May board meeting. And then we also continue to work with the vendor chosen for the RFP for the benefits management system and that continues and we hope to be able to also get that done before it expires at the end of the year. But there are no contracts or amendments or RFPs for the board to approve at this time. So no action is necessary. With that, I am able to answer any questions.

Chair Wells: Any questions for Ms. Mooneyhan?

Member Zumtobel: I have a question. Would the ESI agreement, is it extended for months or years or what kind of extension is being negotiated?

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Ms. Mooneyhan: That's actually a subject of negotiation. So I'll have more information for you next month. So, it's contemplated to be more than a few months.

Member Zumtobel: Yeah. But not a three-year extension or something like, you wouldn't extend them three years without coming to the board and us talking about that or how does that work?

Ms. Mooneyhan: Yes, no extension will be entered. If the discussions are continuing and any approval of the of those negotiations come to will be presented to the board.

Chair Wells: Any additional questions

Member Harper: Blaine Harper for the record. General question of the timeline. When contracts are brought before the board for decision, is it generally that the decision cannot be deferred or is there room in the timeline?

Ms. Mooneyhan: Brandee Mooneyhan for the record. I hate to sound like a lawyer, but it depends. It depends on the individual contract of course and efforts are made to get them in front of the board as soon as possible to give the board more time. Sometimes that can't always be accomplished and it may be brought to the board kind of made a more urgent decision.

Member Harper: Thank you.

Chair Wells: Any additional questions? Okay, this does not require action. We'll close agenda item number eight. Already done, agenda item number nine. Agenda item 10. The Q2 Sierra Healthcare Options for Utilization and Large Case Management.

Ms. Operario: Hi, good afternoon. For the record my name is Joan Operario, J O A N O P E R A R I O with Sierra Healthcare Options Utilizations Management, specifically prior authorizations team. Good afternoon, PEBP Board Chairman, members of the board, and PEBP staff. I will be presenting the executive summary for the medical utilization management for Q2 2026. This encompasses October to December 2025. Together, I will be presenting this with my colleague Sabrina Semaan for the behavioral health executive summary part. For ease of reference, I will refer to the pages on the executive summary located at the bottom right corner of the file as I go along. So for the page one, this is a summary of all inpatient cases. It encompasses along-term acute care hospital, acute inpatient rehabilitation, skilled nursing facility, and out of area lengths of stay or LOS. Just a little bit of background as point of reference for you. Generally, the national length of stay average is 7.1 days. Despite a decrease in discharge volume in November, the average length of stay improved compared to October. Overall, the LOS remained relatively stable across the quarter, averaging 5.0 days with no significant outliers. So, for the bed days per K, this is a utilization metric representing the total number of inpatient hospital days calculated for every 1,000 members. November was an atypically low utilization month. December rebounded to October levels with a rebound attributed to acuity respiratory seasonality. The data reflects stable inpatient acute care utilization with effective LOS management length of stay

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management while December experienced higher volume and slightly higher average length of stay. The change is incremental and does not indicate adverse throughput or utilization issues.

Now for the page two of the report, this shows a breakdown of average length of stay by facility. And then for page three, this shows a breakdown of bed days by facility. On the end of page three, you will see a breakdown of admissions by facility. And then right next would be on page four. This would show a breakdown of admissions by facility. Moving on to page five and six. The readmits shows that the national 30-day all cost hospital admission rate in the US is approximately 13.3% to 14.67%. So, the readmission rates were 6% in both southern and northern Nevada and 6.8% for out of area facilities. Overall, these rates are below the national average reflecting high quality care delivery across settings. The results suggest effective discharge planning, strong care transition processes and appropriate post discharge follow up. All of which contribute to improved patient outcomes and reduced avoidable readmissions. On page seven, you will see the outpatient case management report. So, throughout quarter 2 of 2026, the outpatient case management team opened a total of 740 cases. Of those members, 427 successfully engaged with the case manager, resulting in an engagement acceptance rate of 57.7%. The primary barrier to engagement during the quarter continued to be inability to contact members, which remains the most significant factor impacting the overall engagement rates. Also on page seven you will see inpatient case management. So there are 473 cases open for Q2. There are there are 20 denied days and there are various reasons. For example, facility delay denials. Our explanation for that is facilities are not able to provide the care at a reasonable time frame thus extending the admission days. For example, a member while admitted needs a cat scan and the cat scan was not scheduled right away while the patient is admitted and so they have to schedule it at another time and so that extends the admission days. Another reason is benefits exhausted etc.

Now, for the prior authorizations on the same page on page seven. During Q2 from October to December 2025 we have reviewed an approximate total of 11,800 service requests. Of those requests, we have approved 11,400, bringing our approval rate to nearly 97%. This demonstrates our strong commitment to accuracy in reviewing requested medical services or prior authorizations. We apply nationally recognized criteria and evidence-based policies to ensure medical necessity while comprehensively considering the plan's benefits and limitations. Of the 11,800 cases, 367 services were denied either due to not meeting medical criteria or plan stipulations. And because of this, SHO PA or SHO prior authorizations, has saved an approximate has saved approximately $365,000 for the plan. The denial rate is at 3% which is at par with our other books of business. On page seven, you will see the breakdown of denial reasons which are as follows. A total of 350 cases were not medically necessary and 17 cases lack clinical information after clinical review. On the next page, which is page eight, you will see the turnaround time for the prior authorizations. I want to highlight that 98% of the cases we have received were completed within the compliance time frames. You will also see there stat or urgent cases on the same page. Um these are received also for Q2. The total we have received is two 2,985 averaging 995 cases per month. Please note that the stat cases or urgent cases are reviewed within 24 to 72 hours upon receipt.

For page eight also um we have the records of the app appeals. For first level appeals we have received total of seven cases. This is an indicator of process efficiency. Of these, one was

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overturned and eight were upheld, reflecting our rigorous quality controls and adherence to medical necessity standards. This also demonstrates our commitment to clinical accuracy and streamlined review process practices. On the next page is page nine. It has the retro reviews or the retrospective reviews. These are cases wherein the services were already rendered. So for the quarter two, a total of 11 cases were received and reviewed averaging to four per month. For the telephone advice nurse. It's still the same page. I'm sorry. It's the telephone advice nurse or as we call it TAN T A N. So, during the quarter two the telephone advice nurse line received a total of 114 calls. The call dispositions were as follows. Five callers were directed to call 911. 16 callers were directed to the emergency room. 24 callers were directed to urgent care. 21 callers were advised to follow up with their primary care provider. Eight callers received self-care or home care advice. One caller was directed to the poison control center. Four callers contacted the line for information or advice only. The 35 callers, as you see there, had a disposition of other. This primarily consisted of benefits related questions or inquiries not associated with an immediate clinical need. The next page you will see the bed day summary that's on page 10. So this is a report which is a comparison of acute inpatient bed days across our commercial lines of business. you will see their SHLPPO that is our Sierra Health and Life PPO line of business and also you see their SHO those are other SHO self-funded groups, so with the comparison shows strong performance for PEBP. The admissions perk are lower for PEBP at 34.4 four compared to Sierra Health and Life and other self-funded groups that we handle. Admission rates per K for PEBP is 2.2. These are lower than those in our other commercial lines of business and other ASO self-funded groups we support. Moreover, PEBP has readmission rates of 6.4% while the others are at 6.5 to 6.8%. So in summary, these results are reflective of effective comprehensive inpatient care management. Overall as reflected in the metrics above we have consistently met our performance guarantees with respect to utilization management case management and prior authorization maintaining results on target year after year. That concludes the medical executive summary. Are there any questions before I turn it over to my colleague Sabrina Semaan, director of the behavioral health team?

Chair Wells: Any questions?

Member Duncan: Keiko Duncan for the record. One just basic question. Based on just adding up these numbers, the column that you have reflected as a year to date is actually just a quarter to date or is that supposed to be reflective of a full year?

Ms. Operario: Yes, ma'am. It's just for the quarter. I'm sorry, we have put there year to date but that's the accumulation of October to December. So, three months.

Member Duncan: Okay. All right. Then on page eight of the summary specific to the turnaround time, I was just curious what the target turnaround time is. Is there a general performance guarantee that we are looking at?

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Ms. Operario: In our contract it stated there per NCQA guidelines. So the NCQA guidelines for commercial, it's 15 days upon receipt. So, we need to have a completion of the of the request within 15 days.

Member Duncan: Okay. And I thought as much but there are ones that were over 15 days actually, a good amount in December. Was there a reason for why those exceeded the performance guarantee and was there a corrective action plan issued for how that was going to be prevented?

Ms. Operario: That is a good observation. I will look at it, at the data to pinpoint what are the issues that were indicated for having over 15 days. I will take that back and present the findings at the next board meeting. Okay.

Member Duncan: I mean just in general, right? Like what serves the board here and ensuring that our members have an appropriate benefit, right? I would be curious ongoing not just for this one but anytime that we are outside of the appropriate quality measure or the performance guarantee in the contract we need to understand why that occurred and what corrective actions are being taken specifically not just a generic yes we're improving training. I need to understand what happened and what we are going to do to prevent that going forward. While you know, numbers like eight or four or three are you know seem to be rather low 75 is of a concern and I know that's maybe at the end of the year and that's very typical for most people going to you know gain more care but those are all things that I think should be presented to the board so we can understand if there's something that we need to vote upon to improve.

Ms. Operario: Understood. That's very reasonable ma'am.

Member Duncan: And then on the page prior to that in page seven, I had a couple questions. You made a comment that I think was you know, very very accurate when it comes to admission days for inpatient case management in which you know, the admission days would extend or be longer should there maybe be a scan or something that needs to occur that they're not able to schedule right away and it would therefore expand the admission days. So, what I'm curious about for that again as it relates to how our benefits are being you know, seen by our patients, is you know, is that truly happening on a rather regular basis? Is that the main reason, the main barrier for why these admission days are expanding? And if so, you know, how many days of a wait is that that's causing them to be admitted for longer? So, you know, kind of a breakdown in that would probably be appreciated if you don't currently have that information.

Ms. Operario: Yes, I will take that back to our inpatient case management team so that they could look into it, so that they could provide the more specific reasons and also how many days are extended because of the delays.

Member Duncan: Okay. That's great. And then just below that in terms of authorizations, you made a comment which you know is very typical for plans that denials might occur. You stated

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based on medical criteria or plan stipulations and that we're at 3% which appears to be the average of your national average. And then following that in the denial reason breakdown, we only have two reasons, not medically necessary and lack of information. Which doesn't necessarily tell me what plan stipulations you know, may or may not have been met. You know, just from my experience I know administrative denials are very common and that's not necessarily has anything to do with medical necessity of a drug that or a service or a lab right? That might have something to do with how they did it, who they got it from. There's a lot of other reasons there. So just simply saying that it's not medically necessary or lack of information and that's all we're categorizing our denials in does not provide me with information as to how we can improve our benefit or ensure that our providers have appropriate information to administer it properly. So, I would love to see a breakdown of you know, if all of those plan stipulations like you mentioned are in this 350 of the last quarter of not medically necessary. I'd like to understand what was involved in some of those not medically necessary and where did some of those admin denials live. Was it truly that a service itself was genuinely not needed for that appropriate diagnosis for that patient or was it simply a matter of administering the benefit? There was an issue. I imagine you don't have that information right now.

Ms. Operario: Yeah, I could explain it because I work with prior authorizations for the not medically necessary. We do review it against a national guideline. We use Interqual. We also have the UnitedHealthcare medical policy which is also available to the public. It's on a website. So, we use that as well. We also use medical directors to review it. So, if the member does not meet the criteria that is stipulated in the medical policy criteria, that is considered not medically necessary. I have seen some members that the doctor's office has submitted to us a prior authorization but there's no attachment. It's zero clinicals and so we do not have anything to base the medical review on. And so, we give chance to the provider's office to send us the additional clinical information and we also specify what we need. Do we need health and progress notes any diagnostic tests that were done? So, and at the end of the time frame that we give them, which is actually a totality of 45 days from the date we have sub we have received the request, some doctor's offices did not submit anything to us. And in the MPD it says there has to be a medical reason why this particular service is requested. Therefore, there should be an attachment to support the requested service. So, those are the reasons why there are denials.

Member Duncan: Yeah. And I appreciate that.

Ms. Operario: Also, if they're not going to the correct provider, especially for the EPO, we also have to deny that based on the benefit plan the MPD.

Member Duncan: Right, but it's that last scenario that I'm getting at, right? So, this data that's presented to me suggests that there are only two reasons why an authorization would be denied. It is truly not medically necessary or it lacks some information for like that scenario you said, you get 45 days later they never got you that information. That makes sense, right? That makes sense to, you know, be comparing it against guidelines and data. That's fine. But that last scenario, right, like administrative types of denials, that does not appear to be reflected in this. So

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it's those scenarios, just in my experience two reasons for denials is not the extent of what a plan denies. There is not only two buckets for denial reasons. So that's what I'm saying is I'd like to see it, you know, broken out. Because again, I imagine that that's not the only two buckets that exist for why we are denying services.

Ms. Operario: Okay. I could bring that to our IT the health informatics team who can probably or potentially include that. So, I will consult them with that suggestion ma'am.

Member Duncan: Okay that's wonderful. Then my last note is on page nine of your utilization summary about the telephone advice nurse. I appreciate that you mentioned that the 35 quarter to date other is essentially, you know, most often a benefit questions. That's not necessarily of clinical need. So, I imagine an advice nurse would not need to address that. So, I'm curious just what that procedure is. Are they getting transferred to an appropriate PEBP staff line to be able to answer their PEBP questions or to United Healthcare's member line to be able to answer their questions? I just want to ensure that the questions are indeed being answered because it would make sense that such an advice nurse that needs to be prioritizing whether or not somebody needs to call 911 or go to the ER may not be spending a significant amount of time to ensure that those questions are answered. So, I just want to make sure I'm understanding how that process occurs and that those members are still taken care of maybe in a different metric.

Ms. Operario: I will take that back and I will ask our team about the calls that pertains to other and then I will report my findings on the next board meeting. That's a great question.

Chair Wells: Any other questions?

Member Zumtobel: How often does staff meet with UMR? Is this the only report we get or do you guys have weekly meetings or regular meetings with UMR to get this type of information?

Executive Officer Carsten: Quality control staff meet with UMR once a month. Thank you, Rhonda. I was like I'm pretty sure it's on my calendar once a month. Yeah, once a month. They're going over cases and other outstanding issues that have been reported to PEBP.

Member Zumtobel: So going over large case management cases and once a month. In this type of data do you go over, is this the only time this data is reported to PEBP then?

Executive Officer Carsten: Yeah we get this I believe quarterly for the for the board meeting.

Oh this is a quarterly report not even a monthly report. Okay. For the board for the board. But the staff doesn't get it besides the fact that we get it once a quarter. You don't get it monthly or on a regular basis?

Executive Officer Carsten: I don't believe the staff are receiving it monthly.

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Member Zumtobel: We have a great quarterly report that we get from UMR. They call it the PPAR. Do you guys get a PPAR with them?

Executive Officer Carsten: Yes, we get a PPAR I think annually.

Ms. Huckaby: Yeah, we do annual PPAR. Sorry, Ronda Huckaby with UMR. We do an annual PPAR with them, but PEBP has a very custom quarterly utilization report that we do.

Member Zumtobel: Different than this?
Ms. Huckaby: Different than the PPAR. So, it's very customized.

Chair Wells: Any additional questions? All right, let's move on to the behavioral health executive summary.

Ms. Semaan: Yes. Good afternoon, Sabrina Semaan. S E M A A M for the record. I'm the Director of Behavioral Health, Care Advocacy Team. I will be going over the 2025 performance review dates October through December with you this afternoon. I will continue where Joan left off on either page 106 of your packet or 11 of 18 in the bottom right hand corner. The behavioral health executive summary is what we are starting with first. And so, the discharges for a total of 64 discharges this quarter then we have an average length of stay of 8.1. Overall this is suggesting that utilization is stable. But you will see in further reports that that average length of stay is going to be driven primarily by out of area key drivers. Bed days represent the total number of days a member occupies a bed over a given period. So, we will look at bed days per K next and you will see that our total average for this quarter for hospital is 12.5, RTC is 1.7, and then we see that out of area is substantially higher at 25.7. We are then going to see the metric for admits by facility. 13 for hospital which would be an acute facility, RTC 1, and out of area is 8 admits per K. Average is three for hospital 0.2 for RTC and out of area is 1.8 eight. And then at the very bottom of that page, we are going to see those readmits which is one for hospital and one for out of area. On the next page, we are looking at average length of stay by facilities. for this first box, page 107 or 12 of 18 you will see that Carson Tahoe Regional Medical Center is 4.1, Desert Hope is six, and Virtue Recovery is 8.0 as an average length of stay. There's nothing surprising to us here. Virtue Recovery and Desert Hope hospital stays would account for inpatient detox which is in line with a behavioral health length of stay. At the bottom you have your out of area average at 13.6 and then for bed days by facility we have Carson Tahoe average 15 and then Reno 23. We also have out of area average is 113.

We're going to scroll down to admits by facility for BHO for hospital and this next box 108 of your packet, 13 of 18. We have Reno again with an average of six. And then an out of area average of eight. Readmits as we look at the bottom of this page by facility for both boxes remain pretty low. There's a total of two, and two out of area. So, we are going to scroll down to page 110 of your packet 15 of 18 to go over the BH utilization review summary. And so, this will show you all of the opened cases. Average of four and then average length of stay again as we've discussed earlier was 8.1. Total services reviewed for this quarter were 274 with an increase in December as you can see a substantial increase which we do contribute to seasonal behavioral

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health operations. Then you will see the denied charges. 73,486, 15% denial rate. Approval rate was 85%. Then if you look over at the quarters, you can see that the approval rate for November was substantially higher with primary those inpatient or total services being reviewed in December. Really as the outlier of data of this set. Denial reason at the bottom. 31 not medically necessary and then one for going out of network. So, this was the question earlier about administrative denial. This is stating that we had one for going out of network. The rest were denied for medical necessity. On the next page, 16 of 18 or 111 in your packet. We had zero stat requests. And then when you look at appeals, there was a total of four. Three were upheld and one was overturned, which is indicating successful UM practices. On the next page, our retrospective reviews, we had zero. On the following page 113 of your packet, or 18 of 18, we have the bed day summary for behavioral health. So, when we look at our bed days per thousand, we had an average of 15.8 with that slight increase really being contributed to December as we previously mentioned. Admissions dipped in November but increased in December. Length of stay increase. We do see a month to month which we contribute behavioral health to seasonal factors. We see a lot of inpatient and RTC admissions at the end of the year. The readmission rate is 7.2 year to date for SHO. And if you see on the top, that's all of our SHO plans. And then the average, not ex not including RTC was 7.8. Um, and then overall utilization decreased each month. So that is our behavioral health data for this quarter. I will like to open it up for questions.

Chair Wells: Any questions?

Member Duncan: Keiko Duncan for the record. So specific to authorizations, I don't see there's a turnaround time broken down in here. Are these authorizations included in the previous medical turnaround time that Joan provided or is there a separate turnaround time specific to behavioral health?

Ms. Semaan: That is a good question. I can go back to our team who comprised the data and see if they added us to the turnaround time data or if it's separate. I would imagine that it's separate. But I will follow up with you at the next meeting and break it out if not.

Member Duncan: And if it is separated, I mean, I imagine the performance guarantee is probably still the same, 15 days, but if not, I'd like to verify that bottom line.

Ms. Semaan: Yes, it is. We follow the same guidelines.

Member Duncan: I imagine so. Okay, great. This question I realize is probably the same question for medical that I did not ask before, but what is the readmit percent target?

Ms. Semaan: I could find a national for you, what the national average is. You can see that

Member Duncan: Not the average. Is there a target that we have? I know 0% is beneficial but is there a target that we are trying to meet?

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Ms. Semaan: I will look that up for you and see. I know with this data set it was a little skewed because it's showing 9% but we only had three which I know is very low and below the average of three readmits I believe it was. But I will look it up and see. We don't have a set target in behavioral health that we look for when we see a low readmit rate like this. It's telling us we are doing appropriate discharge planning and we are following with those members and transitioning to the appropriate levels of care. I don't have an exact number for you.

Member Duncan: Yeah. Okay. I guess the same, I'm just looking to see if maybe this didn't occur to me before or maybe this wasn't data presented in the medical. So same question for the medical one. We do have readmit rates by hospital, some of which are extremely high. Which is interesting. So same deal for medical. I would like to understand if there is a general target. I'd also like to understand if the plan is doing anything in terms of care coordination or quality based metrics or value metrics to ensure that those numbers decrease. Because like you mentioned, yes absolutely having a lower readmit rate says that the discharge planning and or the care received during the actual admission was at an appropriate level. So those are some things that I would like to understand better.

Ms. Semaan: Yeah, and I can answer those questions. So, we actively work on our readmission rate. We have embedded care coordinators in our acute inpatient facilities. Both teams have case management teams that outreach from admission to begin discharge planning and to coordinate alternate levels of care. So, anytime we see a readmission rate or anytime we see a member readmitting, we are working closely on the UM and CM team to figure out what the barriers are to keeping that member out of treatment. Specifically for behavioral health. A lot of the readmissions that you see are for hospital admissions because we have a high acuity of inpatient hospital admissions. And so that is what majority of our readmission rate for BH is.

Member Duncan: Okay. Interesting. Yeah, I would love that that kind of commentary on the medical side as well as what's leading to that readmission.

Ms. Operario: I will take that back also ma'am to our inpatient case management team.

Member Duncan: Wonderful

Ms. Operario: Yeah, thank you for that comment and observation. Pretty astute.

Chair Wells: Any other questions? Seeing none, this is information only. We'll close agenda item number 10. Move to agenda item number 11. The Q2 Express Scripts Utilization Summary Report.

Ms. Daily: Good afternoon. Amy Daily for the record. D A I L Y from Express Scripts. I am going to go quickly through these reports and save time for questions. I know there will be some. I am looking at hopefully the same time period you guys are. Last time I was here we had different slides. But second quarter the school year 26. I'm on slide two. The first thing we look

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at in these reports is the total plan. It includes all three plans underneath it. So, this is a summary and then we break down each plan after these initial slides. I'm going to focus on what I think are the important numbers and then certainly if I go too fast or you want more detail I will happily answer questions. First and foremost you'll see that overall, the plan has a consistent percentage so percent of utilizing members, third line from the top. It has remained relatively flat over the time period. As you heard earlier from Segal you are seeing increasing cost. So what that means is that some of these patients are taking more. So we're not seeing a lot of new utilization come in with like comparatively but the people who are utilizing the plan are using it more. You'll see that when you go a little further down total claims non-specialty and specialty. You'll see that a majority of the claims increase is specialty which again Segal highlighted earlier. Generic fill rate which is the dark bolded figure in the middle of the slide 86%. This is something I think we should and yes I will dig in deeper before the strategy session because I think that can be improved. We want people to take generics when they're available. So, we really want to dig into that. I've seen it as high as 90 these days. So that's something we'll want to look at. If you have high specialty utilization, which you do, there's less opportunity for generics. But I think we could improve that and that would save members money and the plant money. So, that's something to dive into moving forward.

If we go to the next slide, I think this is where page three, this is where the important financials are. If you look at the bottom of the slide, you start with plan cost per member per month. This tells you that your trends year-over-year. You'll see here and really you want to look at the bottom figure because that incorporates rebates. For specialty, you're looking at about a 30% trend and then non-specialty is a 3.6% trend. Over all of your plans, each one's a little different in terms of utilization, but your main cost drivers are inflammatory conditions. That tends to be the number one cost driver for most of our clients. That includes things like rheumatoid arthritis, psoriasis, things like that. And that is an area where there's a lot of drugs available, some new expensive drugs available. They're doing a lot of direct to consumer advertising. A lot of the commercials you see on the TV are surrounded these conditions underneath the inflammatory conditions. The other thing is that people can need to you know go from like a Humira to a Skyrizi or Rinvoq. So we're seeing some of those costs escalate in the in the plan as well. The other category that's really driving the utilization for specialty is cancer and this is where the pipeline is. All of pharma is really focused on bringing new and innovative products to market in the cancer space, saving lives but they do come at a cost. So that's the second category really driving that specialty plan cost up. The category of driving the non-specialty is your Mounjaro’s and Ozempic’s which Segal touched on earlier. That is another area we can look at during the strategy session. I think we have some recommendations that could help. When plans don't cover weight loss. I know you cover some weight loss, but when you're not covering these products as weight loss, some physicians are working around that and getting people approved on the diabetes side even though these people don't have diabetes. So, we've seen them say they do have diabetes when they don't. And then we have to ask for documentation from the physician. So, that's something we'll want to talk to this more about.

Okay, digging into the individual plans. Starting off with a Consumer Driven Health plan. Again, this plan has a slightly higher generic fill rate. You'll see that the EPO and PPO are dragging down the generic fill rate a little bit, and that's just based on the plan design associated

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with the plans. If we go to slide two and look at the PMPM costs again, you'll see that specialty makes up even more of the increase under the Consumer Driven Health plan. I think you are getting some people here who know that they're going to exceed the out of pocket. And so that's why you're seeing those types of increases on this plan. Specifically for Consumer Driven, inflammatory is the big driver. You've got some new utilization for atopic dermatitis, some new inflame drugs. So really, all the plans see are seeing increases with inflammatory conditions but some of them have other specialty conditions contributing as well. On the EPO plan, if you go to the slide seven again the bottom net plan cost per member per month, you'll see that the increases are smaller here in terms of single digit trend increases. This plan is small enough that you get one cancer patient though and that could really change the picture. We are seeing some more growth in MS category multiple sclerosis for this plan as well as inflam and then Mounjaro is also causing that 6% increase there for the non-specialty. On the PPO, slide eight you're going to see that the generic fill rate is the lowest on the PPO plan. So again, something we'll dive into and want to see what we can do to help improve that. If you go to slide nine, here you'll see a negative trend for the non-specialty and a 22% increase on the specialty for the PPO plan. It's Skyrizi and Rinvoq that are really driving the costs up here. You also have some new cancer patients and then some expensive members who are taking enzyme deficiency specialty medications. I think that is most of the comments I want to make. The other slides do break down the plans further and show you a breakout of state active, state retirees. I think the general theme there is the retirees are taking more medications and therefore are a lot more expensive than the actives. But other than that, I think I covered most of the high level information.

Chair Wells: Great. Thank you. Any questions?

Member Duncan: All right. Keiko Duncan for the record. I won't ask most of my questions because I think there's definitely a lot to be done. Looking through cost and payment and such. So, I think I'm interested to see what Express Scripts goes after in terms of that analysis. I was going to make a comment about the generic fill rates and so I definitely would want to kind of break that down especially by plan. You know, to kind of mirror some of the conversations that we have had about rates in terms of the general usage of each plan and what is happening in each one. I think to some extent looking at them individually might be helpful instead of just looking at it as a whole. So, I definitely would appreciate that view. Also, just to ask a question to verify a comment from Segal when we are rate setting, when Express Scripts is going after all of our rebates, are those rebates coming back to us at 100% or is Express Scripts taking an administrative fee off of that?

Ms. Daily: No, Nevada gets 100% of all rebates.

Member Duncan: Okay, great. Just wanted to confirm. And then also just to confirm my understanding. Is PEBP in Express Scripts are we utilizing essentially the Express Scripts National Formulary minus the things that we've said that we certainly do not cover?

Ms. Daily: That is correct. Yes.

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Member Duncan: Okay. So, at any point in time has Express Scripts evaluated Nevada specific and PEBP specific utilization against that formulary to see where that national average may not apply or be optimal for Nevada?

Ms. Daily: Yeah. So, in preparing and given some of the rate increases, we have other formularies available that we were interested in. Generic based formularies that we were interested in modeling. For this particular time frame it wasn't going to be done in time but that's something we would take a look at is moving to our more generic based closed formulary for PEBP and seeing if given the member disruption because there will be some member disruption if that's something you would want to move forward with.

Member Duncan: Okay. Yeah. I mean I think that would definitely be interesting but very specific to the application of Nevada PEBP utilization on this, right? Because when we look at a national formulary and we're talking Express Scripts is massive in you know just about every state I presume right? You know things that happen in other states may not be applicable to us because we are so unique. So I just want to make sure that we're evaluating that based on our current utilization and then they're going from there and identifying what problems you know?

Ms. Daily: We always evaluate everything based on your utilization. I think where the larger formulary comes in is we're able to negotiate better rebates because of the number of lives on that formulary. When you start, you know, moving away and going towards a low lower net cost option with generic base and stuff that makes rebates less important. And so that's one of the considerations

Member Duncan: And that may be true across the board, but I'm picturing in my mind right now Segal's presentation of their national survey as compared to where our pharmacy trends are going and it essentially reflected and you have mentioned too in past conversations here, that our rebates are essentially not keeping up with the total cost. So that tells me that for the Nevada specific utilization there may be a circumstance in which yes not participating in that national negotiation may be of benefit specific to our population and is that a part of the reason of why we have flipped into the opposite direction which we theoretically should not be. So that's where I would be curious. To that extent you made a comment and I just wanted to follow up, so not specific any of our rate conversations. We had talked previously about biosimilar usage and my understanding was that in our current formulary, there is a preference especially now for example biosimilars to Humira. Is that correct? We are preferring?

Ms. Daily: Humira is excluded.

Member Duncan: Right and so the biosimilar should be preferred? Okay, and I know that was a very recent change for many clients across the board not just us. So I'm just curious because of the very significant cost difference between those and we talked about that before. Is there

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anything being done to actively switch patients or are prior authorizations being honored for a full plan year so therefore we would actually not see cost savings?

Ms. Daily: Yeah. So for the people who were on Humira, they were directly transitioned to the biosimilar. I think what we're seeing is it’s interchangeable. So, at the point of sale any pharmacist can swap in the biosimilar for Humira. I think unfortunately what we're seeing is a lot of the physicians, they're being profiled by pharma are now new patients are going on more expensive therapies like Skyrizi and Rinvoq. They're heavily out there doing commercials and consumer advertising on those products. So, it's not a question of you know, when we get a new script, we're seeing a lot of those more expensive drugs, but when we can interchange, we do. And the pharmacist should be forced to do that at the point of sale.

Member Duncan: Right. So that's the question. Regardless of whether or not a pharmacy will or will not because yes, there’s NRS that says that they may and it is entertainable. Is there something that Express Scripts is doing at the point of sale in terms of the coding to force that switch?

Ms. Daily: Yes. If they're trying to prescribe Humira we cannot say hey you're on Skyrizi we're going to force a switch to the biosimilar for Humira.

Member Duncan: Right. But within the actual drug like if they're prescribing Humira at the point of sale, there should be a code that says to switch to the biosimilar of Humira. Yeah. Never between drugs. Absolutely not. Yes. Okay.

Ms. Daily: And Humira is actually excluded now.

Member Duncan: Okay. Great. Great. Yeah, that's all.

Chair Wells: Any additional questions? Seeing none, we'll close agenda item number 11 to agenda item number 12, which is the vendor report for the period ending December 31st, 2025. Are there any of these reports that members want to pull out and ask a question about? Member Duncan?

Member Duncan: It it's a simple question, but for 12.8. HPN's performance review. Is there somebody that can speak to that? I have a very simple question. Okay. All right. Let me pull up my question. And this is just Q2 data that we're looking at?

Ms. Walker: Correct. Michelle Walker with HPN for the record.

Member Duncan: Thank you. Keiko Duncan for the record. So, I was looking at, this might have been something that happened in previous quarters and I'm just not remembering. But I thought it was rather significant that the emergency room and urgent care visits have decreased rather by a lot. But the average paid amount per either an ER visit or an urgent care visit increased even

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more. And I'm curious, because I was looking through and I know in some of the summaries there was, a breakdown of infections and other things. But I'm curious, specifically what has contributed to that. Is that something, again I might not be remembering from a past quarter, is that something that we are seeing consistently going up in terms of cost even though utilization is going down?

Ms. Walker: Yeah. So, it's actually a little bit surprising to me that our visits per 10,000 are increasing, right? Because we've seen, so our utilization is in southern Nevada. So, we have a lot of freestanding ERs. I don't know if you're familiar with those down in the south. There's, you know, 20 or 30 of them. So, what we're seeing is an uptick in ER utilization where members are going to those facilities and then this spend is increasing. So, I would want to dig into it a little bit to see if it's decreasing, but that paid is contributing because some of them are higher. So, I can look at that. And then the decrease in urgent care, it's not something that we typically see. So, because it's a quarter data, I'm always hesitant to like kind of dive in. But I can definitely look at that because urgent care visits are capitated for us. But, can I dig into that a little bit more just to look at that?

Member Duncan: I think that would be interesting information especially because this quarter is around RC and flu season.

Ms. Walker: No, it is. October, November, December. That's what I was thinking. I was thinking of, yep.

Member Duncan: If anything, I would definitely imagine the number of visits to go up to go up. But the fact that they've gone down and the paid amount has gone up. I find, what I find most curious about it is like what type of service do we find that they are billing for higher more expensive services? Is this something that we need to look at in terms of care management or you, know utilization management? Or is it just one random outlier?

Ms. Walker: Right. Over on the diagnosis. Could it have been one longer like that?

Member Duncan: Yeah. Right. To understand if there's something that we can actually affect in the benefit because I think we've talked about this before, right? ER and urgent care but probably more so ER, is far more expensive and we would want to reduce the visits, reduce the total cost amount, and hopefully you know move that to wellness visits and primary care and to ensure that people are using the maximum amount of the benefit. So, that's why I'm curious about that.

Yeah. No. Yeah, absolutely. When I was looking at the ER page on slide eight on the utilization summary, right? Yeah. I see where the cost is up. Urgent care visits still pretty low rate. So, yeah, I will dive in to see if anything contributed to the emergency room on maybe we had a couple high diagnoses that were built that could have contributed to that in this population. Yeah, absolutely.

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Member Duncan: And I'm curious, Chair if, I know very often we bring these vendor reports and it's a lot of information all at once and I know we all do our best to read through it and find things. But I'm really curious if there are some things that might be slipping simply because, there's just a lot of information or, you know, one member over the other may not have the experience in that area to understand what we're looking at. So, I wonder if we can limit the time, but even just a five minute presentation from these vendors to say, hey, you know, just like Express Scripts brought, which I love how she did that. Hey, these are some of the things that I would call out. These are some of the things that I would look into a little bit further. I think that might be helpful so that we can actually make effective decisions.

Chair Wells: Absolutely, and I think that was kind of the intent. We started with the Utilization and ESI but the intent was to kind of go more to those at least for board education and then at some point back.

Member Duncan: Yeah. I mean, even if we put a little egg timer out and that's all we did. I think that would be very helpful.

Chair Wells: Any additional questions on the member reports and item 12? Seeing none, we'll close agenda item number 12. Move to agenda item number 13, public comment. No action may be taken on any matter raised under this item unless it was included on a future agenda item as an item on which action may be taken. Following comments to the board will be taken under advisement but will not be answered at the meeting. Let's go ahead and go at Carson City first.

Mr. Ervin: K E N T E R V I N my words for the record. Thank you for the discussions today. It is good that the high premium increases are being phased in over three years. Although other options should have been considered given the new budget information. Past mistakes should not be a pretext to cut benefits in the future. We still do not know how much of the new rates go toward replenishing reserves versus ongoing healthcare expenses. I'm baffled as to why EPO HMO members should be expected to pay more toward replenishing reserve than other members. Perhaps the real goal is to kill off the EPO HMO plan. And although we now know more about the budget situation and past mistakes, the details remain murky. An external investigative review beyond the financial statement audit is still needed to learn lessons and avoid recurrences. The ambush on long-standing retiree benefits was outrageous but fortunately was voted down. The legislative mandate for a combined single risk pool for all state actives and retirees. So, comments about age related healthcare utilization are misplaced. Younger employees are future older employees and retirees earn their benefits.

On another topic, I was very surprised that Janell Woodward spoke in public comment and is not here as a board member. I see she has been removed from the PEBP website. Her initial term has expired, but the PEBP statute says board members continue to serve until a successor is appointed. Quoting NRS 241 section 41 subsection 4. The term of an appointed member of the board is four years and until the member successor is appointed and takes office unless the member no longer possesses the qualifications for appointments or is removed by the

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governor. End quote. That's an important and to my knowledge a member to replace Miss Woodward's position on the board has not been appointed. She still possesses the qualifications for appointment as a classified state employee and she has not been removed by the governor and she did not resign. Why wasn't she here to vote? She is obviously available. Miss Woodward's vote today could have changed an outcome that calls into question the validity of the actions. Thank you.

Mr. Hopkins: One moment, Chair Wells. I'll get the slide up. As a reminder, attending this Zoom meeting in this lobby is for making public comment only. If you do not wish to make a public comment, you may drop so now so you're not accidentally called upon. Caller with the last four digits of 0891. Please press star six to unmute. And please slowly state and spell your name for the record.

Ms. Laird: Thank you. Good afternoon. My name for the record again is Terri Laird. T E R R I L A I R D. I serve as the Executive Director at the Retired Public Employees of Nevada. I feel the need to comment on an effort led by Chair Jim Wells, who for those that don't know is also a former Executive Officer of PEBP, to make a change in the plan for state retirees going forward that they do not pay less than an active employee. A motion wholeheartedly accepted by board member Laura Rich who is also a former Executive Officer at PEBP. Both supported this measure. That is unacceptable to RPEN, an organization with over 6,000 members statewide, thousands of them who are retirees who paid their dues with lower salaries as was mentioned earlier by a board member while they worked and many who are no longer working. Therefore, we believe they earn the health care benefits they deserve today. We also believe this board should want to fairly represent all participants in PEBP, the hard-working state actives you heard from today and the well-deserving retirees who also earned the benefits that they received. For that reason, it just seemed unsavory for a couple of board members, including the chair, to make the statements made during this board meeting. Thankfully, they were outvoted and the motion failed. Remember, the working today are the retirees of tomorrow. Thank you.

Mr. Hopkins: Thank you. And then username with K. Quinn, you have permission to speak. Please state and spell your name for the record if you wish to make public comment. Chair Wells, that is everyone online.

Chair Wells: Great. Thank you. With that, we'll close agenda item number 13, public comment. Move to agenda item number 14, adjournment. Motion for adjournment.

Member Barnes: This is Jim Barnes. I move adjournment.

Chair Wells: Can I get a second?

Member Rich: I'll second.

Chair Wells: motion and a second for adjournment. All those in favor?

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All board members: I

Chair Wells: Thank you all very much.

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