In The Matter Of:

PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD ZOOM/TELEPHONIC MEETING NOTICE AND AGENDA

March 28, 2024

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

ZOOM/TELEPHONIC MEETING NOTICE AND AGENDA

THURSDAY, MARCH 28, 2024

CARSON CITY AND LAS VEGAS, NEVADA

The Board:	JACK ROBB - Chair MICHELLE KELLEY - Vice Chair LESLIE BITTLESTON - Member APRIL CAUGHRON - Member BEPSY STRASBURG - Member JIM BARNES - Member JANELL WOODWARD - Member JENNIFER MCCLENDON - Member BETSY AIELLO - Member
For the Board:	RADHIKA KUNNEL Deputy Attorney General
For Staff:	CELESTENA GLOVER Executive Officer JESSICA CRANE Executive Assistant MICHELLE WEYLAND Chief Financial Officer NIK PROPER Operations Officer
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THURSDAY, MARCH 28, 2024, CARSON CITY, NEVADA

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CHAIRMAN ROBB: Okay. It is 9:00 o'clock, March 28th. It is the Public Employees Benefit Program meeting. I will open the meeting, and can we have roll call, please.

MS. CRANE: Good morning, everyone. To start roll call, Chair Robb?

CHAIRMAN ROBB: Here.

MS. CRANE: Michelle Kelley?

MEMBER KELLEY: Present.

MS. CRANE: Betsy Aiello?

MEMBER AIELLO: Present.

MS. CRANE: Jim Barnes?

MEMBER BARNES: Here.

MS. CRANE: April Caughron?

MEMBER CAUGHRON: Here.

MS. CRANE: Leslie Bittleston?

MEMBER BITTLESTON: Here.

MS. CRANE: Jennifer McClendon?

MEMBER MCCLENDON: Here.

MS. CRANE: Bepsy Strasburg?

MEMBER STRASBURG: Here.

MS. CRANE: Janell Woodward?

MEMBER WOODWARD: Here.

MS. CRANE: And Stacie Weeks is absent for this Board meeting. We do have a quorum.

Please, remember to state your name and speak loudly and clearly for our transcriber. Thank you.

CHAIRMAN ROBB: Okay, thank you.

We will move on to public comment. Public comment will be taken during this agenda item. No action may be taken on any matter raised on this item unless matters include future agenda items. Do you want -- do we have anybody on line?

MR. HOPKINS: We do have a few on line. Chair Robb, do you want me to do that slide first or go to Carson first?

CHAIRMAN ROBB: Let's go to the ones on line first, and then we'll get to the ones in Carson.

MR. HOPKINS: Hold on one second. I need to get the slide up. In Carson City, let's start with Carson City. Public comment in Carson City?

MS. OSBORN: Good morning, Mr. Chairman, Board members, staff. My name is Margaret Kelly Osborne, and I'm here to thank the Board and staff for reinstating the reimbursement rates for out-of-state travel, reimbursement for medically induced -- medically required travel. I just

wanted to thank the Board and everyone for your help.

CHAIRMAN ROBB: Thank you for participating in these meetings.

MS. BONER-WELCH: My name is Leanne Boner-Welch L-e-a-n-n-e. Last name B, as in boy, o-n-e-r dash W-e-l-c-h. I'm a member. This is my husband, Bill, who will spell that on his testimony. Today I'm here in follow-up to my presentation or my testimony in January regarding your appeals process.

Our appeal involved a non-assigned claim for a medical device covered for those suffering baldness, secondary to cancer from chemotherapy. I'm seeking an exception to the plan for the actual diagnosis of alopecia totalis, which is a permanent hair loss, an autoimmune condition.

So let's think about this. You'll cover it for someone who is suffering cancer, and I would assume that's because society looks at them and treats them a certain way, and they have a lot of emotional things to go through. And baldness is something that we can help them with because they also lose their eyebrows and their eyelashes and sometimes all the hair on their body. That's called alopecia totalis. You won't cover it for that permanent condition. I just find that unbelievable.

I have tried for a year and a half for this process of submitting the non-assigned claim and the appeal. UMR and PEPB have mismanaged the claim, and I'm now convinced that's purposeful. UMR originally adjudicated the claim at 50 percent, thus acknowledging the medical necessity. I challenged the 50 percent coverage by phone with UMR because there's no preferred provider for this medical device in your organizations.

Your policy says when you don't have a preferred provider, you'll cover it at 80 percent. Within hours, I was called by UMR. The claim had been reversed. The check was in the check run, and I was told to return it or they would seek action against me.

I had provided all of the elements you wanted for a non-assigned claim, medical necessity, the bill, the tax I.D. number, everything. I thank you for looking into it last January's meeting, but I'm not surprised that yet another excuse was found.

I have appealed on the basis of exception to the plan document. UMR and PEPB have had nothing but excuses or ignoring the reason for the appeal. I heard it's not our job from UMR. And then I heard from PEBP that it's not our responsibility. And then I even had one where it regurgitated all my information for six pages and then said

it's not covered by the plan document. I know. I was seeking an exception.

I now find that the latest excuses after attending this meeting was no one covers it so we won't either. I should have known this process would be a farce. I was not going to come to this meeting because I've spent so much emotional energy on this. And, really, shouldn't the focus be on the wellness of our daughter and the appropriate -- I should be able to consider this organization helping me. That has not been the case.

You use the same form letter for all your denials. So I'm kind of convinced the template must say insert new excuse here. I do not believe you have an effective process for appeals based on plan document exception based on medical necessity and equity. Thank you.

CHAIRMAN ROBB: Thank you.

MR. WELCH: Good morning. For the record, my name is Bill Welch, and I'm here to follow-up on my public comments presented at the January 26th, '24 PEBP Board meeting. At that time, I requested this Board formally consider a plan benefit exception to the coverage, which would provide the same coverage of medical device for patients suffering from alopecia totalis as is provided to patients who suffer loss of hair from current cancer

treatment.

As I stated in my public comments on January 26th, 2024, it is appropriate that cancer patients are provided this coverage and believe patients who suffer from alopecia totalis should receive same benefits to receive equitable coverage for all PEBP enrollees. I'm going to leave a copy of that testimony because I did formally request this Board, not staff, to consider that.

Instead of the matter being brought to the PEBP Board, as requested, after having been ignored for over a year, we did finally receive a letter from your executive officer, denying our specific request for a plan exception to coverage. And I emphasize that, as I pointed out last time, because they went around non-cover, all the different excuses, but never spoke to the specific request of a plan exception to coverage, but we did receive that letter.

And I guess I'm happy -- we should be happy that we finally got acknowledged the specific request that we had submitted. The letter from the PEBP Executive Officer to my wife, denying our request for plan benefit exception, a coverage date of February 9, '24, referenced a review performed, analyzing plan documents and clinical policies of various health insurance providers, both government and private sectors. And based on this review, our request for

plan exception to coverage was denied. This communication of February 9th, 2024, also acknowledged not all plans deny coverage.

And with that in mind, at this time, I'm formally requesting a written copy of that review, dated on what percent of all plans in Nevada were reviewed, both private and government, to determine denial of our request, a report on all plan benefit exceptions to coverage, PEBP has proved and what the rationale for those exceptions were. How many times has the PEBP benefit plan been modified to ensure equitable benefits coverages for its members and what the rationale for those plan modifications were.

And, again, we just heard testimony, and I was going to reference that, but not the specific case. At the January 26th meeting, you made such a plan modification. Your staff has our contact information and address. We look forward to receiving this information in a timely manner. If it is not going to be provided, I request written acknowledgment and the legal rationale for denial.

Finally, I have to say, how this matter has been handled by PEBP has and continues to be very disappointing. I hope none of you ever have to go through this kind of experience that our family has had to go through in the last year and a half. Thank you.

I will leave a copy of the letter from your staff, my testimony of 26, where I formally requested this Board, not staff, instead of this matter, and the testimony of today so that you have a written list of the information that I'm requesting in writing.

CHAIRMAN ROBB: Okay. That sounds like a public records request that will be handled in a separate matter.

MR. WELCH: Well, if they would provide me the process for doing that, I will do that, sir.

CHAIRMAN ROBB: I think we have everything we need to start that process at this point. If you'll leave everything.

MR. WELCH: And who would be your secretary that I would leave this with?

CHAIRMAN ROBB: We will consider that a public records request.

MR. WELCH: Do I leave it here? Thank you.

CHAIRMAN ROBB: Thank you.

Next in Carson City?

MS. ANTONUCCI: Good morning, Chairman Robb. I'm Patty Antonucci, and I'm a 12-year state employee. The reason I'm here is I'm deeply concerned by the agendum -- Agenda Item 6. Agendum -- sorry, agendum -- why can't I say agenda today? Okay. Item 6 informs the Board that Carson

Tahoe Hospital has the intent to terminate the contract with UMR. Carson Tahoe Hospital recently sent a letter to the PEBP's members, informing the members that they intend to terminate the contract with UMR.

Carson Tahoe Hospital is our local hospital. You have residents in Carson City, Gardnerville, Dayton, Minden and the surrounding areas that are not going to be able to go to Carson Tahoe Hospital as in-network provider if they cannot negotiate their contract.

If Carson Tahoe Hospital terminates the contract with UMR, you can force us to choose between lifesaving measures and our wallet. If I suddenly am going to have a heart attack, I have to think about an out-of-network charge from my local hospital or driving into Reno to get healthcare. That's ridiculous. This Board needs to work with UMR and find out why Carson Tahoe Hospital wants to terminate our contract with our local hospital.

While the letter did not specify a contract termination date, I am here today to voice my concern and bring forth this issue to the Board. I hope that this Board will actively work with Carson Tahoe Hospital and UMR to ensure that the contract concerns will be negotiated and an in-network continuation of care is provided. Do not leave your PEBP members and retirees in this area without a local

hospital to go to. Thank you.

CHAIRMAN ROBB: Thank you.

Next in Carson City?

MR. HALLMEIER: Good morning. My name is Michael Hallmeier. I'm a TMCC employee, also an AFSCME member. I'm here to try and make sure our insurance doesn't go up any more than it has. I am thankful for the insurance. That's one of the reasons why I am working for the State of Nevada. And it's -- so on a personal note, I'm a kidney pancreas transplant so, therefore, again, back in 2007, thankful for that. But with the price potentially that's proposing going up, it's gonna weigh a lot on the employees that don't make as much.

So with that, I would -- I wouldn't say highly suggest, but make sure there's some other way you guys can come up with not putting it on the state employees' backs as far as putting for the insurance, for medical -- for medical and that so it's all I got.

CHAIRMAN ROBB: Okay. Thank you very much.

MR. HALLEMEIER: Thank you.

MR. ERVIN: Good morning, Chair Robb, Vice Chair Kelley, members, Officer Glover, Kent Ervin, E-r-v-i-n, Nevada Faculty Alliance, for the record. We are very concerned about the impact of employee premium increases on

our members and our classified employee colleagues. The increases subtract from hard one, cost of living adjustments and are especially hard for lower paid state employees who already struggle.

The 2023, '25 biennial budgets for PEBP were approved with insufficient funds to cover the cost trans projected by PEBP's actuaries. With no recourse for new funding in the second year of the biennium, PEBP is now in the position of having to fund increases either through employee premium increases or by using reserves.

When the state deliberately underfunds the second year of the biennium, it should be the policy to use PEBP's ample reserves to cover claims than true-up the reserves in the next budget cycle. PEBP's reserves as of December 31st, 2023, in the budget report today were 121,000,000. 5,000,000 of that is excess reserves. 42,000,000 is in catastrophic reserves, formerly known as rate stabilization reserves and 53,000,000 is in the incurred but not reported reserve, which will never be needed unless the state suddenly eliminates employee healthcare benefits entirely.

Using up to 15,000,000 of reserves to cover the entire increases to employee premiums would be reasonable. However, we recognize that PEBP has a fiscal goal to keep the so-called mandatory reserves intact. Therefore, NFA does

support the 50 percent mitigation plan on the fifth page of Executive Officer Glover's report for Agenda Item 7, which only uses the excess reserves as reported as of December 31st. That plan at least lessens the impacts for employees. The 50 percent mitigation plan appears distribute the available funds more fairly among the three plans and four tiers than using the ad hoc premium adjustments from fiscal year 2024.

For the future, if PEBP faces the same situation, which it is likely, policy should be put in place to use reserves to increase the employer contributions, also known as base subsidies across all three plans and the four tiers to maintain employee premiums. That preserves the Board's policy of equal employer contributions regardless of the employee's choice of plan.

Then the next budget cycle could adjust the State appropriation per employee to set the reserves at a level that anticipates potential needs. We should not be in a position where benefits have to be cut or employee premiums have to be increased in the middle of a biennium. That's just poor fiscal planning and poor business practice. Thank you.

MS. OPSERMAN: Good morning, Board. Thank you for the opportunity to speak today. Tess Opserman here on

behalf of the AFSCME retirees. We echo much of what was just said by Kent, our previous speaker. We're deeply concerned in the increases in the rate. We do understand that the excess reserves went to zero and the need to make accommodations for that, but we are concerned about these increases. Our retirees and active employees are living on fixed incomes and simply cannot afford the additional cost, so we're concerned about that, and we do ask the Board to do whatever you can possible to try to limit those increases to their rates.

I also do -- as you continue to consider the budget, I will reiterate that the AFSCME retirees feel strongly that their HRA benefits need to be increased. Currently, they still get the calculation of $13 per year or excuse me, $13 per month per year worked. That rate has remained the same since 2013 and we ask that be increased to at least $15 per year -- per month per year. We've asked that at the legislative body. But as you continue to think about the budget, we want that to be top priority, so thank you very much for your time, and we look forward to your conversation.

CHAIRMAN ROBB: Next public comment in Carson City.

MS. LAIRD: Thank you. Good morning, Chair Robb,

and fellow community members. My name for the record is Terri Laird. I'm the executive director of the Retired Public Employees of Nevada, RPEN, here in Carson City. We've been around since 1977, and we have close to 7,000 dues paying members. I echo all the remarks made by Kent and Tess as well.

It's alarming to hear that Carson Tahoe Hospital was going to not renew the contract. I am a recent Medicare participant of two years now. And I can tell you, cost keeps going up for all of us, especially retirees on a fixed income, but I can tell you that services are not competing with the cost.

I have knee problems that I have to have corrected, and five weeks ago I was told it would take two to three weeks to get Medicare to approve what I need to have done, and I'm still waiting. Two to three weeks is five weeks tomorrow since I've heard on this, and my knees aren't getting any better. So I just sympathize with our folks who are on a fixed income. I'm still working. I'm not retired yet.

But it's sad to see what's happening to healthcare, and hopefully you folks can do something to alleviate all of the issues that you heard from today. Thank you.

CHAIRMAN ROBB: Any further public comment in Carson City? Seeing none --

MR. HOPKINS: Chair Robb, we have about five on line right now. Hold on. I've got to get the slide back up.

As a reminder, the Zoom is used for public comment only. This meeting is streaming live on the PEBP YouTube channel, if you want to watch the meeting there. The YouTube link is located on the agenda. For those who have joined for public comment, your name or last four digits of your phone number will be announced. You will be advised you have been unmuted. Please slowly state and spell your name for the record and then proceed with your comments. As a reminder for those on the phone, please press star six to unmute.

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

MR. UNGER: Doug Unger, D-o-u-g U-n-g-e-r, president UNLV Chapter Nevada Faculty Alliance and Chair of the Government Affairs Committee. Thank you, Director Robb, and, the PEBP Board, for your service and consideration.

Regarding Agenda Item Number 7, we wish to express most strongly that we would be disappointed if rates for 2025 would increase 35 percent or more for premiums across the PEBP plans, which would hurt most state workers

with dependents and families.

Please note that PEBP maintains something in the neighborhood of 120,000,000 or more in other reserves, including catastrophic reserves. In the past considered, quote, rate stabilization reserves. State employees believe that we were assured by executive leaders that there would be a rate stabilization action next fiscal year should a shortfall materialize. After all, it's the Governor and his staff who underestimated medical and prescription drug inflation by amounts which looked to us a lot like the Medicare inflation underestimates in the Three Card Monty game of the federal budgeting process.

We strongly recommend action that draws from the catastrophic or rate stabilization or other reserves to mitigate premiums by 50 percent in accordance with the graph presented in the comparison tables in section seven, page 53 of the Board packet. We recommend PEBP do this, with the understanding that it will request of the next biennium budget the restoration of the approximately 7.4 million dollars to those same reserves.

Another approach would be to address state contributions for PEBP, which dropped from approximately 93 percent to 91 percent of the cost per employee. This budget cut percentage is a cause of reason why state workers

will pay more in premiums next fiscal year.

In a job market in which it's still difficult to hire and to retain all state agencies, including at our colleges and universities, for the PEBP Board not to approve drawing from reserves to mitigate rate increases would contribute to extending the understaffing crisis and worker shortages that still plague our state agencies.

We ask the PEBP Board to look to approve the 50 percent mitigation option that we understand will be one of the public -- possible actions presented by the executive officer. Thank you.

CHAIRMAN ROBB: Thank you.

Next public comment online, please.

MR. HOPKINS: Person with the first name Chip, please slowly state, and spell your name for the record, if you wish to make public comment.

Fernando J., please slowly state and spell your name for the record, if you wish to make public comment.

Jen C, you have permission to speak. Please, slowly state and spell your name, if you wish to give public comment.

And, Rasheda, you have permission to speak. Please, slowly state and spell your name for the record, if you wish to make public comment.

Chair Robb, that looks like they might just be in the lobby so I don't think they're trying to give public comment. We will have another public comment section at the end of the Board meeting and the last agenda item or second to last agenda item.

CHAIRMAN ROBB: Okay, thank you.

We will close Agenda Item Number 2 and go on to Agenda Item Number 3, PEBP Board disclosures for applicable Board meetings and agenda items from the Attorney General's office.

MS. KUNNEL: Thank you, Chair Robb. This is Radhika Kunnel, 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 PEBP benefits.

Pursuant to NRS 281A.420 on behalf of the Board members who are eligible for PEBP benefits or whose families are eligible for PEBP benefits, I offer this disclosure that 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 now. Thank you.

CHAIRMAN ROBB: Okay. Any further disclosures by any Board members today? Seeing none, we will close Agenda Item Number 3 and move on to Agenda Item Number 4, consent agenda. Consent items will be considered together and acted on in one motion unless items are removed to be considered separately by the Board. 4.1, approval of action items or action minutes from the January 26th, 2024, PEBP Board Meeting. 4.2, receipt of quarterly staff reports for the period ending December 31, 2023. 4.2.1, Q2 budget report. 4.3, receipts of quarterly vendor reports for the period ending December 31, 2023. 4.3.1, Q2, Sierra Healthcare Options and UnitedHealthcare Plus Network, PPO Network. 4.3.2, Q2 UnitedHealthcare Basic Life. 4.3.3, Q2, Express Scripts, summary report.

Any items that any Board member wants pulled to be considered separately? Seeing none, I will entertain a motion for all of these items to be considered together.

MEMBER STRASBURG: Motion to approve agenda items.

CHAIRMAN ROBB: Okay. Do we have a second?

MEMBER MCCLENDON: Jennifer McClendon. I'll second.

CHAIRMAN ROBB: Okay. We have a motion and a

second. Any further discussion? Seeing none, I'll call for the vote. All in favor signify by saying aye.

(The vote was unanimously in favor of the motion.)

CHAIRMAN ROBB: All those opposed? Motion passes.

Move on to Agenda Item Number 5, discussion and possible action regarding a proposed contract with Carrum Health - Oncology Concierge to maintain a network of National Center of Excellence. A portion of this item may be conducted in closed session of allow review and results of evaluation of proposals for the contract in accordance with NRS 287.04345 subsection (4). Any action on this contract will occur in open session in accordance with NRS 287.04345 section (5).

We will close the public meeting at this point, go to closed session. Just in case any Board members have questions, we can review. So we will have the public to please step out at this point, and we will go to closed session before any action will be taken. We will bring the public back for the final vote. So let's close the session. Thank you.

(After a closed session, the following proceedings were had:)

CHAIRMAN ROBB: Call the meeting back to order. We are back on Agenda Number 5. I want the record to note that during the time we were going to be in closed session, we had quite a few of the public participating before we went into closed session. We came back from closed session and staff did everything they could to find the individuals that were participating in the meeting before we came back into open session. They checked the lobby. They went in the parking lot and checked cars. We've done everything we can to ensure that we're not leaving the public out at this point.

So we're going to continue with Agenda Item Number 5, and it is for possible action. We did have short discussion. Is there any other discussion before we entertain a motion? Hearing none, we'll entertain a motion for Agenda Item Number 5.

MEMBER KELLEY: It's Michelle Kelley here. I'll make a motion that the Board approve the proposed contract with Carrum Health as presented. Yeah.

CHAIRMAN ROBB: Okay. We have a motion.

MEMBER BITTLESTON: I'll second.

CHAIRMAN ROBB: We have a second. Any further discussion by the Board? Seeing none, I'll call for the vote. All those in favor, signify by saying aye.

(The vote was unanimously in favor of the motion.)

CHAIRMAN ROBB: Any opposed? Motion passes, unanimous.

We will move on to Agenda Item Number 6, to Executive Officer Report, Celestena Glover, information and discussion. 6.1 Wrap document, Centers of Excellence.

MS. GLOVER: This is Celestena Glover for the record. What you have before you is my Executive Officer Report. Starting off, we recently had the budget kickoff meeting. In that meeting, we discussed timelines, what our requirements are going to be, deadlines for certain requests, such as our BDR's or bill wrap requests, any technology requests we may have.

I put some timelines in the report that are probably most significant to PEBP at this point. This is not all of the deadlines and timelines that the budget office gave us, but I just wanted to give you an idea of what we're looking at. Some individuals maybe are involved with budget and seen this and so they're aware of it.

This year they did separate the meetings. They put the directors in one meeting. So directors and deputy directors, so we got a higher level overview for what is expected for this upcoming budget billing cycle.

The fiscal staff, so your ASO 4s, your chief financial officers and some of those folks have a separate, more in-depth technical meeting where they were essentially given their marching orders as to what will be expected of them.

During the May meeting, we will come back with some ideas of what we would like to include in our budget, the same as we did last go around, last session. We will schedule meetings when we go into session to talk about bill draft request or bills that are pending that may affect PEBP, even though it's not necessarily something that PEBP is bringing up. We'll ask for direction as far as how you would like us to respond to any bills, and that can be fiscal notes. That can be testimony, whether it's in neutral or against. Typically PEBP will stay neutral unless we know that the impact of that bill is really significant to the program in general, whether it's for or against. So we will schedule those meetings as needed.

A lot of those meetings will probably be virtual because they may be short notice meetings but we will make sure that we have enough time to get the agendas posted and we meet our open meeting law. So I just wanted to give you an idea of what was coming up, so that's that portion.

We have the Carson Tahoe issue. There is a lot

of public comment about that. You've heard public comment here. I've had some discussions with one individual from Carson Tahoe. I've talked to UMR. The network agreement is between UMR and the hospital. We're not privy to those contracts. They are confidential, so we don't know what's in them.

Carson Tahoe came to us, hoping that we would do something, but we know what they said their issues are, but their issues are across the book of business. They're not just PEBP specific. Obviously, we can't get involved with some other employer's plan. But all we can really do is, you know, listen to what they had to say and simply address the issues and ask them to continue to work with UMR. I know UMR has been having weekly meetings to review those claims and to determine what the problems are, what can be done, what is owed, every aspect of that.

Carson Tahoe decided to go ahead and send out the letter to all of their patients that come under UMR, so it's not just PEBP members. As I said, it's any of their book of business that says they intend to terminate the contract. They didn't give a date. We're hoping the issues will be resolved and that won't happen. We are looking to have a meeting with Leadership at Carson Tahoe, and that meeting will include myself, our Board Chair, Jack Robb and the UMR

staff, along with, as I said, Carson Tahoe Leadership. That meeting has been all over the board as to what dates, so it keeps moving. But as soon as I have a set meeting and I have something to bring back, I will bring that to the Board hopefully next Board meeting so that I can give you an update as to the results of that meeting, if the issues aren't resolved prior to then.

Carrum Health Benefits Wrap Document, so I attached the wrap document, as I said, in the previous agenda item. Depending on the approval of contract, we would add the oncology services to the wrap document and it was in here originally. They gave us a draft of what they like to see, edited and rewrote it essentially to be more in line with PEBP's other wrap documents. So we will add the oncology services. It will go in as a general oncology. We won't list probably every single service. It's just something to say, okay, here's the various services you can -- you can get by going through this.

It is a voluntary option for members. They do not have to go to Carrum if they want to stay with their regular providers for whatever service they're having and go with whatever other providers their provider will refer them to, but this gives them another option in the event that they want to seek Centers of Excellence, oncology through the

concierge services, so that's -- that's where that document is.

I didn't put it as an action item. It's information so that you can see what that document looks like because all of the services are rolled into our master plan documents anyway. We cover all of these benefits through a regular plan. This just gives them an option to go to a different provider. So with that, I will take any questions.

CHAIRMAN ROBB: Yes.

MEMBER BITTLESTON: Leslie Bittleston for the record. You mentioned BDR's, you know, those of us that are state employees are very familiar with BDR's. Is PEBP planning on bringing up or doing any of their own BDR's. And if yes, can you give us kind of an outline or what those are.

MS. GLOVER: This is Celestena Glover for the record. We are reviewing our own statute, so we have 287, to see if there are any changes there that we need to make. I'm working with my staff and I'm trying to determine what the -- what the changes are that we should submit. I have a meeting scheduled with the Governor's Office on, I believe, it's the 12th of April. They are doing a review with each of their agencies to look at any BDR request we may have.

Primarily what we're looking at is streamlining 287 to make our processes a little easier. Part of that is

around a closed meeting for RFP's that the contractor try to streamline that, so we can get through that process quicker. That is our main focus, and then just any language in there that we think needs cleaning up more than anything else.

MS. BITTLESTON: Thank you.

CHAIRMAN ROBB: Okay. We'll go to Ms. Aiello and then Ms. Kelley.

MEMBER AIELLO: Betsy Aiello for the record. Most of our public comment that was written did come in regarding the Carson Tahoe issue. As we all know, the State of Nevada and Carson City, the surrounding areas, a lot of state employees, and so it's extremely concerning. I know you said it's just one of the UMR lines of business that feeds into Carson Tahoe. But my guess would be, it's a very big line of business, and I'm not -- and I'm happy to hear that you and Chair Robb are going to meet with Carson Tahoe. I'm not sure what the meetings are going on with UMR. I'm guessing as our vendor, there will be meetings going on with that.

And I'm not sure if there's any entity getting together because someone is having a heart attack, they live in this area, they call an ambulance. They will get brought to Carson Tahoe very likely. The ambulances aren't going to say, oh, you're out of network. We're going to drive you all

the way to another area.

I mean, I don't know, I'm wondering, based on the percentage of state employees in PEBP that what leverage we have both with Carson Tahoe or UMR or I'm guessing there are things that we aren't as privy to that are being done. But I just wanted to go on the record that it's a very concerning issue because I think it could happen. If they cut the contract, disastrous outcomes, and I don't even know how that would impact our relationship with UMR and their ability to provide services for our employees. Because I think there's a relationship that they have to have a network that's sufficient to provide for, and I guess it's not my employees, the state's employees.

CHAIRMAN ROBB: Okay. Thank you for your comment. Jack Robb for the record. Listening to this conversation, listening to Ms. Glover's update and public comment, I can assure that I've reached out to multiple members of Carson Tahoe's Leadership, and we have a common goal and that's serving the people of Carson City and state employees. So we have a common goal. We're working towards a resolution. We're going to continue working towards that resolution, everything we can do within our power. Some of it is not within our power. There's third party providers and there's a hospital. We're one of three legs. So we're

going to do everything we can in our power to make sure we continue to serve the state employees and the people in the Carson Tahoe.

MEMBER AIELLO: I'm guessing we're doing a similar thing with UMR because they're our contractor, right?

CHAIRMAN ROBB: There is -- we all have the same common goal. So we're working towards a resolution to make sure that they can meet all their goals and all their financial obligations but serve the people we need to serve to, so I can assure you we're working towards that.

Ms. Kelley.

MEMBER KELLEY: Thank you, Chair Robb. Michelle Kelley for the record. Thank you for that update on the Carson Tahoe because, you know, it feels like this comes up often with Carson Tahoe, every three to five years, where we're back talking about them, sending letters to our employees. And, you know, obviously contracting is always difficult, and I think it seems to be getting more difficult. But I appreciate everyone's attention to it and, you know, as you say, everyone is working toward a common goal, which is to make sure our state employees in Carson City are served appropriately by the plan.

On that note, and I thought it was in your report, Executive Officer Glover, but I wanted to ask about

the REMSA ambulance service in Northern Nevada. We've had a fair amount of public comment on that as well, and I've had participant comments about the lack of ambulance service in the north. And I wonder if that's something that also can be elevated and the fact that we don't have a contract with the only ambulance provider in the north. And I understand that it's covered for participants but, of course, their costs aren't capped except for the out-of-network maximum out-of-pocket which is huge.

So I'm wondering, is there anything that can be done about the REMSA situation in the north?

MS. GLOVER: This is Celestena Glover for the record. I did not include the REMSA issue in my report, and we are aware of the public comment. REMSA is not the only ambulance, ground ambulance for most of the north in the -- everything outside of Washoe County. Typically the ambulance services are through the fire departments. So those entities, you know, those are the ones that are serving our members say in Carson City or Yerington, Gardnerville, wherever.

REMSA has an agreement with Washoe County. It's a longstanding agreement. So Washoe County covers primarily Reno and Sparks and the surrounding area. Their pricing has been approved by Washoe County. We don't necessarily know

exactly what that pricing is. We've had kind of a difficult time trying to figure out what pricing is.

We've asked with UMR, if we can potentially get them into the network and agree to some sort of cap on payment. That has not come to fruition. We pay 140 percent of Medicare. And then, of course, the members, depending on the plan they're on, may have an 80/20 split of that 140 percent.

It's -- that is where the issue comes in is then they balance bill our members. They'll take what we pay them, but then they'll balance bill the members, and we haven't been able to come to an agreement. All we can do is keep trying to get them to work with us and make them an in-network provider. But it's -- it's really in their ball court to go along with us.

What they do when they balance bill a member is they will tell that member to go ask us to make an exception to the plan rules. And, you know, we can't administer the plan by exception, and so we're hoping we can come up with some sort of an agreement that will work for both parties, but we need that to be a reasonable cost.

MEMBER KELLEY: Thank you for that explanation, and I totally understand the cost issues.

I'm just wondering, the fire department, can --

can you explain to me -- so can participants in Reno and Sparks use -- also get ambulance services through the fire department? Do they have options and if so, I think one of the examples in public comment was a lady who went to urgent care. And they said, no, you need to go to the emergency room and they put her in a REMSA ambulance. So are there options and how would someone exercise the option in that situation?

MS. GLOVER: This is Celestena Glover for the record. I don't know if there's an option in Washoe County. I'm seeing some people shake their heads no. I understand REMSA is the contractor there, but I do understand that there are ambulance services with some of the fire departments, and sometimes those ambulances get to the patient first. So it's kind of whoever gets there first is the one that's going to transport. But I don't know that there's a mechanism where somebody can say, oh, I want REMSA. I want X, Y, Z fire department in Sparks. And this is anecdotal. I don't have that information in writing, so.

CHAIRMAN ROBB: Jack Robb for the record. Being a long-time Washoe County resident and know multiple members of City of Reno Fire Department, they do not have ambulance service. They dispatch to the same medical emergency but they'll dispatch a truck. They do not dispatch any

transport. So you get an ambulance and fire truck at any medical but their transport option is one.

MEMBER KELLEY: Okay, thank you. I feel like since I got the mic, one of the comments kind of talked about how REMSA is not for profit. And, you know, that doesn't mean that they don't have high expenses. You know, I mean, not for profit just means there's no shareholders to pay. It still means they have to pay their employees and their executives of their salary or a salary. So, you know, I'm not sure that not for profit means that the rates that maybe, you know, Washoe has agreed to are low. So I just wanted to put that out there.

But I also, I have a follow-up. If we're done with kind of REMSA about the wrap document and the oncology services, but I'll wait to see if that's appropriate right now.

CHAIRMAN ROBB: I'm fine. Go ahead.

MEMBER KELLEY: Okay, thank you.

Executive Officer Glover, I just was wondering if you could share what services are -- like not the level of detail that's in the wrap document, but the wrap document itself kind of breaks out the conditions that we're covering under the regular Center of Excellence. So can you talk about what specific, maybe cancer, like, is it by diagnosis

or is it by service. And if it's -- is it simple for you to just kind of outline some of the major diagnoses or services covered under the oncology concierge.

MS. GLOVER: This is Celestena Glover for the record. I can go through the contract and the response to see what, maybe from a higher level what specific services or diagnosis, at least to get some idea of what's in there. It may not be all encompassing but, yes, I can get that information into the wrap document under the oncology services.

MEMBER KELLEY: That would be fabulous. And then just as an aside, since staff had done all the work on the wrap document and then, you know, obviously, you just agreed to do some work on the oncology concierge, is there a way we can put together or will the concierge services provide a nice glossy brochure that catches our participants' eyes to kind of promote this program since we've gone to so much trouble to put it in place.

What kind of -- obviously, open enrollment is one thing. But open enrollment, there's so much talked about that people don't take most of it. But if we can promote these services, I think that would be outstanding. And I just want to also, while I'm talking about promotions, give kudos to the staff to the Hinge Health promotional materials

because I've been inundated. I definitely know Hinge Health is in place, and I appreciate that knowledge, so thank you.

MS. GLOVER: This is Celestena Glover for the record. We are in the process of going through the implementation with Carrum for the Centers of Excellence, and then we'll wrap oncology into those discussion. Part of that is a campaign of getting the information out to our members, similar to what Hinge Health has done so that they are aware that that service is available to them. So it will go in our newsletter. It will go on our website. We'll do e-mail blast. I believe Carrum will use some mailers. So there is an effort or there will be an effort to get that information out to our members so that they know that that's available to them.

CHAIRMAN ROBB: Okay. Any further questions?

Seeing none, we will close Agenda Item Number 6 and move on to Agenda Item Number 7, discussion and possible action, including improving plan year 2025 plan rates for State of Nevada and non-state employees, retirees and their dependents for the Consumer Driven Healthcare Plan, CDHP, low deductible plan, LD, Exclusive Provider Organization plan, EPO and Health Maintenance Organization plan, HMO.

Ms. Glover, for possible action.

MS. GLOVER: This is Celestena Glover for the

record. So as you see, Agenda Item 7 is to discuss the plan year rates and what our options are. This agenda item is essentially in three parts. My report gives you an overview of how the rates are set in the first place. That's probably the same information for those that have been around for while. Because in every report, it's pretty much a copy/paste because the process is the same.

So when you look at the underwriting, the enrollment, the admin loads, so the admin load is essentially our cost to do business and salaries. It's operating. It's the admin services fee we pay to our vendors, the tiering, so single participant, a participant plus a spouse, plus children or plus a family and then adding life insurance to that mix.

One of the things that does go into our admin load that I don't know that everybody is aware of, but our Medicare Exchange folks, they go to the Exchange and they get their plans through there. So they're not part of this rate except for any of the admin load for the cost for those individuals, as well as their life insurance premium. That -- that dollar amount is spread amongst all of our retirees and employees that are on the self-funded and HMO plan, so that all makes up that admin load.

I looked at what occurred last year and the year

before to get some more recent history. I know what I was involved years ago. But to get some more recent history, and back in I believe it was December of 2022, the Board at that time had approved utilizing projected reserves to mitigate rate increases over a three-year time frame and that was covered plan year '23, '24 and '25. We exhausted all of the excess reserves at the end of plan year '23. So for plan year '24, although those amounts were already approved, I couldn't hold them out obviously. It was already set in stone. We didn't actually have the reserves to cover that.

We are doing okay in the budget. We are projecting a shortfall in some of our claims areas. And so if that materializes when we're probably in about another month or so, then we will have to tap in catastrophic reserves to make that category whole again so that we can pay claims and admin fees per our contract. So right now we're kind of watching it and trying to get a better idea of what that number looks like.

In plan year '23, we actually had close to a 9,000,000 dollar shortfall in claims for the state employees and retirees. They're grouped together for payment purposes. The shortfall this year is for the non-state employees and retirees. Again, they're grouped together for payment purposes. So that projection is, they're a smaller amount.

But it's still something if we can absorb it from within our budget, we will. Otherwise we have to tap into catastrophic, and that is part of the reason we have those reserves is to cover shortfalls and claims and for any high dollar claims that we may have.

We get regular reports to give us an idea of what our high dollar claims look like, and we've had several this year that we use $100,000, but these are $1,000,000, $3,000,000, $2,000,000. So we've got some significant claims and that's the amount we're paying toward those claims. It's not the bill charges. I just recently received two reports in the last week, a two and a half million dollar claim that we're paying a million and a half for, two and a half million claim that we're paying about 700,000 for. So those are the things that we have to be concerned about and that is part of what is driving our trend and our rate increases is those types of claims. So I just want to set kind of a stage as to what we're looking at.

Segal, our team here, Richard Ward and Amy Cohen, they're going to talk about trend and what they're projecting for trend, where we're at now, where they think we're going to be to help us get to where we are. So with that I'll take any questions. If no questions, I'll hand it over to Segal.

CHAIRMAN ROBB: All right. Please proceed with

7.1 all right, on the agenda.

MR. WARD: So that is page 59 of the Board packet, I believe. Thank you, Executive Officer Glover. For the record, I am Richard Ward with Segal.

MS. COHEN: And I'm Amy Cohen with Segal.

MR. WARD: And we're pleased to have an audience with you to talk about trends and the self-insured portion of the PEBP program.

On page two, which is page 61 of the Board packet, the summary -- summary version of -- of the trends that we've experienced, that we've witnessed and that we're projecting. The recent experience in the top table on the right is at and near industry trends. So we have a comparison of PEBP trends and what is happening out in the industry.

And so for -- for recent experience, the last couple of years, medical, pharmacy and dental has tracked fairly close to national trends. And just for reference here, out of about a 270,000,000 dollar claim spend, the majority of it is for medical. That's about 190,000,000. And about 60,000,000 is for pharmacy, and then about 20,000,000 for dental. So just to keep in mind, that mentally put more weight to what is happening with the medical than with the other two trends. In particular,

dental is a relatively small portion of the overall spent. Although, the trends for pharmacy are significant and that does have an impact on what we're expecting to see.

For the current plan year '24, medical continues to -- medical looks to be fairly flat and run -- we expect it to continue to run below industry trends, four percent versus seven percent.

Pharmacy though is, as we say, is running hot. It's running really hot. This is just claims trends before it's offset by rebates and it's close to 20 percent, at 19 percent is what we're expecting for this current plan year, which is about twice what we see in the industry.

And then dental is also running at a high rate, but several points of that is due to the change in the annual benefit limit that went into effect for this year. So benefits were enhanced and that's worth about four percent of the nine points. So it's still running above what we see in the industry, but a good portion of that is due to the recent benefit change.

And then our projections for plan year '25 incorporate what we've seen, what we are seeing, what we expect to see which includes what we're gathering from industry expectations. So we perform an annual trend survey where we get input from about 70 carrier -- insurance

carriers, administrators, PBM's and all the Blue Crosses, all the Kaisers, UnitedHealthcare, UMR, Express Scripts, and they tell us what as an organization they are expecting for trend and we amalgamate that into what we're representing here for the industry.

So it's not Segal's expectations necessarily what's going to happen in the industry. We're synthesizing the industry's expectations into our report and that also helps. One, it provides a benchmark for discussions like this. But it also provides us that broader perspective of what the industry and the market is anticipating, and so we incorporate that into our assumptions for plan year '25, which has a slightly lower medical trend of three percent, a higher pharmacy trend of ten, and then we expect dental to come back down to a more -- to be more in line with prior experience at two percent.

I'll move on to the next couple of slides where we have a little bit of detail for medical, pharmacy and dental respectively. In this graph to the left, so this shows the per capita costs on a rolling 12-month incurred basis and it's -- it's I think a good graphic way to see how costs have evolved over the last several years. And you may note that in the far left here for 2020, costs were substantially lower than what we see in the most recent two

or three-year period, but that was when PEBP and the -- and the industry in general was experiencing a -- the COVID effect where people were not accessing care in the way that they had prior and they have subsequently.

So trends for 2021, in particular, you can see for PEBP, the table at the bottom, was about 15 percent and that's due to a bounce-back relative to the suppressed costs that we saw in 2020 during -- during when COVID was new.

And then since then, PEBP's trends and the table in the far right are fairly -- are in low single digits, and this is a comparison of the Governor's budget trend. And then pricing trend is what we assumed or the actuary at the time prior to our working with PEBP assumed for rating purposes and budget projection purposes. And you can see that generally speaking, the budget trend is lower than what was assumed for projections. And then generally speaking, it's lower than what actually happened.

And then for pharmacy is the same format of the -- of the graph where we're showing a rolling average for per capita cost per member cost. You can see it's increased fairly steadily from the top line there, claims cost. $164 in the far left in June of 2020, growing steadily to 263 or 240 currently through December, and then the dotted lines for the next six months indicates what we're projecting for the

second half of the current plan year.

And drug utilization and drug claims were relatively unaffected by COVID because people could still get their meds, have mail order delivery, and so it wasn't the same effect on accessing care and utilization and costs. So there wasn't really a dip for pharmacy for COVID, like we see with medical and dental. And those trends are continued to run at a high level.

And in PEBP -- in the PEBP plan, three primary drivers for the pharmacy trend, although not the entire story but three -- three important factors are GLP-1's which are weight loss medications that there's been industry-wide, market-wide phenomenon where costs have come from -- from very low point, below utilization to fairly high costs, a couple of million dollars in the plan just in the last year or two, and this is not a PEBP specific phenomenon. We see this in really all of our clients.

And then also anti-inflammatories and diabetic supplies and insulin continue to be drivers of trend. The lower line, the orange-ish line is net of rebates. So true pharmacy costs are the claims costs and then -- and then once we consider the rebates that Express Scripts collects and passes back to PEBP, that's how we get to the true pharmacy costs or the net pharmacy costs, and that is tracking at a

lower level and at a lower trend rate.

So for 2024, while we're expecting claims costs to increase 19 percent for the plan year, that's offset by enhanced rebates, which lowers the trend to 10.8 percent by our projections, so still a high rate of increase, but not as high as the 19 percent. So you can see in past years, similar effect, especially for 2023, which reduce the gross costs by about the same amount, by about nine points from 14 percent to about five percent.

And then for dental, consistent with what we saw elsewhere in the market in the industry, dental costs during the COVID period, again, far left of the graph in 2020 were, we saw the most effect for dental. People deferred care, didn't have their annual check-up early in 2020 and -- and then once we get into 2021, especially later in the year, calendar year of 2021, you can see a return to care.

And then in PEBP, relatively level costs over the next two-year period or so and then now we're seeing in '24, plan year 2024, an increase in cost and while the trend increase is close to ten percent, it's an increase from 51 to $55 is what we're expecting, so it's a relative per capita cost. So it's -- while it's a large percentage from a dollar basis, it's still -- it's still low single figures. And, again, about half of that is due to the change in the annual

benefit that was -- that went into effect for this year.

Now, just a few words, a few more words about our trend survey. So, again, I'm on page 65 of the Board packet and page six of our materials. So every year, we survey the industry, carriers, administrators, PBM's and to get their -- their expectations for trends. And then also, excuse me, also what their actual trends were, and we've done this for over 20 years. So we have a -- we have a good history of tracking what expectations were relative to what actually happened.

And, generally speaking, the industry is conservative with their trends, and I think that's -- that's not surprising. When we look at actual trends, with the benefit of hindsight, compared against what had been projected, we generally see that the actual is a little bit lower than -- than the projected, with some exceptions, and that was -- there was a period where pharmacy costs went up at a higher rate than what the industry expected but generally -- generally the industry is conservative by a little -- by a little bit.

So the next couple of slides compare industry expectations, the actual that the industry reports that they expected, that they experienced and then PEBP trend, and we'll do this -- go through this by medical, drug and dental.

The first slide of these graphs on page seven of our materials of page 66, the Board packet shows medical in the dark blue, purplish graph line. Pharmacy is in green. And -- and dental is in orange, just to see how trends have fluctuated over the last -- over the last decade or so, not quite decade.

You can see pharmacy costs -- pharmacy costs were higher about eight years ago, 9.6 percent, dropped down to a lower level, about five percent and then in recent times have come back up to ten. Again, this is industrywide, and this is actual experience.

And then the last -- the last figures here are projected or what the industry is reporting as expectations.

And then medical has also -- has also moved around a little bit, especially beginning in 2020.

And dental has been fairly consistent, except for the COVID era in '21 and immediately after that.

So now let's -- let's move to the next one, which is page eight of our materials. And the -- the teal line that moves around more and looks like a sign graph is PEBP -- is PEBP trend. So PEBP trend in plan year 2020 was negative and that was when there was -- when -- that was during COVID when people were not seeking care, especially routine care, like they had in previous years, and jumped up to 14.9, like

we saw, like we reported a couple of slides ago for the bounce-back and then dropped back down to lower levels.

The solid line is actual industry experience. And then the dotted line is what the industry projected. And so I was saying in 2020 and 2021, expectations were higher than actual by a little bit. And then now we're -- we're seeing that the industry is continuing with a fairly consistent projection of about seven, seven and a half percent for the next couple of years. And we expect PEBP's trends to continue at a few points lower than that.

Pharmacy is a different story, same colors and same -- PEBP is the -- is the teal line for claims costs and you can see we're projecting that claims costs will continue to increase at a high rate. 14.3 was the actual trend in plan year '23. And then we're expecting that to be almost 20 percent in '24 but reduced by rebates and that's the -- that's the lower -- lower purple. Thank you. Thank you. I am slightly colorblind when it comes to shades. So don't ask me about different shades of green or purple. I'm a little handicap there.

So the 5.1 is the -- just to orient us here is the net of rebates, and we're expecting that to be 10.8 percent. And then you can see that the industry has been for 2021 and 2022 pretty good at projecting what costs

would be. That's why those lines are so close together.

And then dental, you can see PEBP trend oscillating quite a bit above and below industry expectations, which continue to be the two to three percent range.

Okay. Just a quick word on what the main components of trend are, that you have -- you have unit cost trends. So just the -- just the cost of prescriptions, the same pill, the same medication or the same treatments. So an office visit may increase from say $100 to $110, and that would result in a ten percent trend for office visits if utilization remains consistent. Utilization also changes from year to year. So the two together can work to offset one another or they can -- they can compound in one direction upward or downward, depending on how they're moving from year to year.

And then another component is just what we call utilization or case mix. So you may have an example of that is generic and brand medication. So someone may be on the same -- same therapy, the same medication regimen for a condition. But if they switch from a brand medication to a generic medication, the utilization is the same but they've -- that switched to a different cost of therapy and so that change in mix can also affect trend, in either

direction.

Some of the challenges that we're seeing, we continue to see challenges with medical providers in the cost of labor and just the cost of supply. So with -- we're seeing with a number of industries, the cost of doing business continues to increase. And so we're -- we're seeing provider groups across the country, wanting to negotiate different terms than they've agreed to historically in some instances.

And then I'll just move to, Executive Officer Glover talked about the methodology a little bit, so I won't belabor that hopefully not too much. But on page 13, page 72 of the Board materials, the main components of our analysis that we take claims and enrollment, we project them forward by these trends. We make adjustments for changes and benefits or maybe there's new programs that are being implemented.

So for example, the Center of Excellence network as that's -- as that goes into effect for the next plan year, we're making an adjustment for the anticipated impact of that coming online, same for the oncology concierge program and -- and then we add administrative fees so that the medical, pharmacy, dental fees, any other applicable fees that Ms. Glover mentioned. And then we develop those rates by

coverage tier and by plan rate, using the established methodology that the Board has approved and directed to be utilized.

And the next couple of pages have some more detail on that. The next one, summary of our trend assumptions and then a summary of the changes that were being -- that we're accounting for, such as the increase in the deductible for the high deductible health plan and the co-pay changes for EPO and co-pay plan and the other programs that -- that I just referenced.

And I think that will conclude the prepared comments. So I'll take questions, if there are any.

CHAIRMAN ROBB: I don't know if it's a question or some statements because I'm listening to what you have stated. And just for everybody to know, I did have occasion to meet with the Segal Group and Executive Officer Glover in-between meetings to go over some of this, and I've read all of the public comment and looked at where we're at.

And some of the things I want to put on the table today is there's some assumptions in some of the public comment, that we have a bigger reserve than we have, listening to Ms. Glover's comments about some of our major claims that we are recognizing at this point.

So what we show on paper as a reserve, we really

don't have because these major claims have taken a bigger hit than anticipated. The cost for everybody continues to go up. The weight loss drugs, nobody could have forecasted that. It's stuff that's happening nationwide. Where we miss, industry misses, everybody misses. We're all on the same page, like I said, on other items. We're to provide quality care at the most affordable price to our plan participants. That's staff's goal. That's this Board's goal. That's all of our contracted goals to do that. It's trends. That's all we can say.

You forecast, and I always say hope is not a strategy, but that's what we rely on is hope and that's really not a strategy but we do our best. We do the best as a Board. I know staff does their best because they're subject to the cost increase as we are. Nobody is immune to this.

But I think there's some compounding issues. Having three plans and the plan confusion and the plan migration between plans because of the confusion, I think that can be a confounding issue. I think we need to look at the possibility of going back to two plans to keep some of this swing out to plan migration.

Because what I understand is somebody thinks something is better, so you get a migration here, but then it

affects those costs and that forecasting going forward and so it becomes even more difficult when you put three plans in the mix. It compounds the issue, so our forecasting ability is limited with the three plans. It could be much more streamlining to -- I'm summarizing. I'm going to look at the Segal Group and Ms. Glover to help me through some of this, but I just want to put this on the table before we start discussion, so the possibility of going from three back to two.

And then another thing I want to talk about is we're doing our best to recruit employees for the State of Nevada. And when you recruit employees, a lot of time they're in entry level positions. With these cost increases, it is hitting our entry level employees much harder than it is our more senior staff. And I want to put on the table, maybe we look at going forward some type of plan design that if you're under 30, it's X percentage. Instead of a flat dollar amount for everyone, if we can come up with a flat percentage of gross pay, we can equalize some of this stuff out.

One of my concerns is in our lower salary grade individuals, we fought all sides, everybody, to get state workers more money. But on our lower salary people, pretty much 100 percent of their pay raise that we have afforded

them is eaten up by these increases. They're not seeing any appreciable income adjustment. So somebody in a lot of our position that sit at this table, we're going to obtain your employees and we have higher salary, we still recognize the pay raise, even though we have an increase in premium, but it's not 100 percent eaten up.

So I'm looking to maybe explore different options going forward as to how we can equitably right size this so everybody feels the same percentage of pain. My tax premium, my -- everything, if you look down below on your paycheck stub, everything is on percentage, but healthcare is a flat rate, and maybe it's time for the Board to ask staff and Segal and the others to explore different options on how we don't hit those lower tier employees as hard as everybody else.

So those are just my thoughts. I would ask Ms. Glover to correct my thoughts if I missed anything throughout my time. And I would ask the same of the Segal Group to maybe clarify some of the things I might not have stated exactly correct, and then we will start some further discussion around the table, and then we'll come out with a plan to go forward.

MS. GLOVER: This is Celestena Glover for the record. Going off with what Chair Robb has just said,

internally, we've already started some discussions, very preliminary. I talked a little bit to Richard in a meeting. What are our options? What can we do? And this was predicated on the comments that were made regarding how we apply the employer contributions, what is the best way to do that? Is it a percent so that the lower paid employees are not as affected by rate increases while still making sure that, you know, we are funded the way we need to be in order to make this plan work.

So those are things we will be bringing back to the Board when we have some more concrete ideas of what that might look like, what that -- how that might affect how we rate the plan in the future, what changes are we going to have to bring potentially during the budget building cycle. Will it require us to make any regulation changes, statute changes, any of those things. So we are looking at that because we do understand that rate increases are not something that everybody can absorb without any problems.

For some people, maybe, you know, a 20 dollar increase may not seem like much, and for others it's a lot. So we are aware of that. We try to do everything we can to mitigate those increases, but at the same time we have to deal with reality and part of my review in doing this report this time is I went back in history to see where our rates

have been and what have we done over time. We've done a combination of things.

Sometimes -- you know, a lot of times when it's an economic downturn budget cuts, flat budget, whatever we're directed to do, it's resulted in benefit reductions. We've reduced life insurance. We've reduced out-of-pocket costs. We have reduced benefits within the plan. Like, we've done everything within that realm, not ideal because nobody ever seems to know what their -- what's covered and what's not covered and to what degree is it covered.

So I would like to try to get away from that habit and determine what our plan design needs to look like and leave that alone, other than technical adjustments. Because, you know, there's been some federal law that's changed, some state law that's changed that requires us to do something different in the plan. But what does that plan design look like? Are we there right now? Probably not. Can we get there? I think we can. I think it's just going to take some analysis and some work, and we'll work with our partners to determine what that looks like.

Then it's the cost of the plan. So we have the plans rated according to trend, experience. Everything that Mr. Ward has explained in his report, that has been considered in every year that we've done any type of rating

to set our premium and our employer cost.

When I look back, I look back at 2013, and our plan rates premiums to the employee have been relatively flat since 2013. So we've been in that 30, 35 dollar range to 45, 46 dollar range for a single person on the CDHP for quite a long time, and part of that is because we did use excess reserves when we needed to to keep rates flat.

As I said earlier, the reserves have been exhausted. It was mentioned here that we had $7,000,000 in reserves, in excess reserves right now. That is -- as of December 31st, that is our cash on hand. It is not reserves as of yet. It is captured in the reserve area, but our projection is a negative $17,000,000 for the end of the year. We're gonna run those projections again next week to see what the third quarter looks like. But that means moving forward, we have a hole in the budget in excess reserves, which is going to affect our available cash going forward, and that's a lot of technical stuff that I'm not going to try to explain at this point in time. I just want you to understand that excess reserves right now, based on our budget projections, do not exist. 7,000,000, negative 17, that's a negative ten. So, you know, keep that in mind.

There is proposal for mitigating the increase, so there would still be rate increases but not to the degree

that we're seeing in the rate tables. That is going to go against catastrophic reserves, which we can use for rate stabilization. A part of the purpose of catastrophic is to offset the cost of those high dollar claims, whether it's in medical, pharmacy, wherever it might be that as was stated earlier is not anticipated, that we can't really project.

So we -- that is kind of our -- that's kind of our safety net, for lack of a better term. It's our -- it's our pot of money that we can go to if for some reason what we have in the budget is insufficient to cover those type claims and any other cost that might come up.

So I just want people to fully understand that the excess reserves as of today do not exist in our plan. It is going to come out of catastrophic reserves. If we should have a good idea year and we don't see that we're going to exceed our budget allowance, then -- then we'll leave the catastrophic alone, and we'll live within our means. But if we should need it for whatever reason, then that will be our avenue.

And so with that, before we get into the tables, and I see people wanted to ask questions, probably to Richard, so I'll stop here.

CHAIRMAN ROBB: Richard, do you have anything further then from what I said and what Ms. Glover stated, is

there anything I missed upon that needs to be clarified? Did I miss anything during my statement?

MR. WARD: Richard Ward for the record. No, nothing -- nothing was overlooked. One additional comment is that regarding the plan options, I think somebody mentioned that -- you may have mentioned that there's migration between plan options. And when there's movement between plans that -- that creates usually pressure on plan costs. So it results in increases and plan costs as people are migrating from -- between plans. And having two plans relative to three can generally lead to more stable overall risk pool.

So the risk, if membership and enrollment remains constant within the plan options and there's not movement between on an annual basis, then things are more stable and a little more predictable.

CHAIRMAN ROBB: Thank you for talking about the migration between plans. I know even sitting in the position I sit in currently, I have confusion with the three plans. I'm not gonna say I don't, and I think 99 percent of our participants have confusion between plans and that causes some of that migration because we have the three options. And two of the options sometimes causes more confusion, and I want to have options, but I do believe that the three options confuses me even more than if there was just two. And so I

just want to state that. And we will start with Vice Chair Kelley and questions or comments.

MEMBER KELLEY: I have so many of both, so excuse me. Firstly, Chair Robb, you know, I welcome your wanting to explore premium options or employee premium options and plan design options. I think -- I think it's time. I would say though that our membership petitioned very hard to get the second PPO or a PPO that actually covered medical, you know, in the same way that the HMO covered medical. We had the high deductible in an HMO. So, you know, our membership worked really hard to get that mid tier PPO.

I'm not saying that I'm closed minded to two plans, but I do think that we need to give these structural changes to the way benefits are offered to the state employees, the time and discussion that is necessary for making big changes that will happen every ten years or so. So I welcome the opportunity. I hope we would do it in a strategic planning session where we can kind of look at both items individually and get constituent feedback and really take a considered deep dive into how things are currently working. That's my comment on that. I think it's a great idea. So thank you for your willingness to explore those items.

I have a lot of questions about trend. So before

I go on, if anybody else wanted to respond to -- I don't know if we want to structure this in some way or just a free for all. So I'm looking to you, Chair Robb, how you would like to handle this.

CHAIRMAN ROBB: Let's -- go ahead, Ms. Aiello.

MEMBER AIELLO: This is Betsy Aiello for the record. Just a quick question to what you said, Ms. Glover, is that there have been a few kind of unexpected high cost claims. Is that because of an unexpected medical condition or there something new in medical care that is occurring that we might expect that to increase more? I mean, maybe that would have come in the trend. But I could see that as there's new medical processes and procedures, they may be expensive.

So I think my question is, okay, we've had this and we had some reserve, excess reserve. Now it's gone down and we're going to -- is that something we would expect could continue to happen because of something that's happening in healthcare or would that have shown up in your trends?

MS. GLOVER: So this is Celestena Glover for the record. So the high dollar claim, the two examples I provided, they were result, those specific claims were a result of some medical conditions that --

MEMBER AIELLO: Okay. Not changes in medical

science?

MS. GLOVER: Not necessarily treatment.

MEMBER AIELLO: Okay. So it's not really expected that that would continue to happen -- I mean, you're not against it in the future.

MS. GLOVER: Right. Right. This is Celestena Glover. I mean, if somebody comes, who's new on the plan, comes onto the plan and they have a genetic condition that results in expensive treatment, expensive medications, you know, obviously, that's unexpected. It can happen. It does. We've had that happen or it could be something as simple as an accident or something of that nature that results in a long-term in-facility care. You know, there's a lot of things that can happen.

That's not to say that there isn't the possibility of a change in treatment methods. New medications come out all the time and when they come out, they're typically much higher price until, you know, a bunch of years from now when they finally become a generic, if they ever do. So I think it's probably a combination because the samples I provided were as a result of medical conditions.

MR. WARD: May I comment?

CHAIRMAN ROBB: Yes, please.

MR. WARD: Richard Ward for the record. In

reviewing the top 20 high cost claimants for each of the last two years, more than half of those 20 are what we would consider episodic.

MEMBER AIELLO: Okay.

MR. WARD: So it's due to a specific instance or circumstances and once that is addressed, then we wouldn't expect that particular individual to continue to be at that level or likely it will be someone else so that will cycle through. So it's due primarily just to normal fluctuations for episodic high cost claims.

MEMBER AIELLO: Thank you.

CHAIRMAN ROBB: Any other comments, questions that's in the room, before we go back to Board Member Kelley?

MS. BITTLESTON: I have a question. Leslie Bittleston for the record. A couple of -- I guess I have two questions. The pharmacy trend seems to be extremely high, and I'm not sure if this is an Express Scripts question or a Segal question. But, you know, it doesn't seem like $2,000,000 in diet medication would account for all of that. I guess that's one question.

I guess another comment, you know, the diabetic drugs and supplies are astronomical. You know, you've got insulin needless, pumps, all kinds of things that are just extremely expensive.

Anyway, my second question is about the Governor's Finance Office. You know, they seem to have been estimating trends a lot lower than our actuaries over the last couple of years or few years. And so my question is what -- is there anything the Governor's Finance Office can do to increase the subsidy the state is paying for -- for medical for those?

MS. GLOVER: So this is Celestena Glover for the record. Historically that has been the case. We've come in with the trend of whatever, five, six percent, and the budget office has reduced that. Part of the reason for that reduction too was because even though we were projecting say a six percent trend in medical, we kept experiencing positive, which is a good thing, we were experiencing positive years. So the claims we thought would come in didn't occur.

We took as many steps as we could internally to introduce programs that would help save the program money, as well as the members. So I think that combination is how we ended up in that area. So we're saying we need, you know, $100 and they're saying no, we think you really only need 90, and it's because they're looking at what historically has happened, and we're trying to project forward. We're saying this item is going to cost $10 and based on the information

we have and what we expect. And they're saying, no, we think it's $9. And so they're likely to do that in the future if they feel like what we're bringing to them is not reasonable.

But we will work with them to give them an idea of what our histories look like and, you know, where we think we're going to be, so hopefully we can come to a more level agreement, if we're saying six percent, that they're somewhere in that ballpark as well.

I think we were relatively close. Pharmacy was probably the outlier, but I think we were probably close on a budgeted side versus what has actually happened but, again, some of that is going by some of these high dollar claims that we couldn't project, so.

MEMBER BITTLESTON: And the higher cost of supplies, like Mr. Segal just said --

MS. GLOVER: Exactly.

MEMBER BITTLESTON: -- just a few minutes ago about just the cost to do business, and it seems like we're missing the mark on our projections on the cost of doing business, so.

MS. GLOVER: That's correct.

MS. STRASBURG: This is Betsy Strasburg. I also noticed that the budget office has the same percentage for year one and year two. Is that something that can be

addressed during the budget process given that fluctuations are happening more often than before?

MS. GLOVER: This is Celestena Glover for the record. We can address all those issues and we will. We will present to them, with the help of Segal, what we believe our budget should look like, and that will include projected trend going forward, and that's gonna be based on what we're seeing over the last few years, what has happened even past that and try to sit down and have some discussions. I've already asked the director of GFO and we can have a sit down, just her and I, to discuss, you know, what she thinks they may do and what I think we probably are likely to do as far as our request.

CHAIRMAN ROBB: Go ahead.

MEMBER CAUGHRON: April Caughron for the record. Just a quick thank you to you, Chair Robb, and, Director Glover, for kind of walking us through some of the options that you're already exploring. I am interested to see where maybe we can head with regards to looking at the current plans that we have and options there. Also, the use of catastrophic funds and then how we might be able to incorporate some of that.

I think we are hearing from the public that our services are not competing with the costs, and that is very

concerning to me because we continue to raise prices and they're not getting the services that they need.

Also, I'm interested to hear, have you explored what other states are doing from a public perspective? What do their plans look like? And how does Nevada kind of fit into that? Maybe there might be some other plan options that we're not aware of that could be already in existence where other states have run into these issues, and I'm just wondering if we've considered that or looked at that?

CHAIRMAN ROBB: I think that's where the Segal Group comes in and that's what they're contracted to do.

MR. WARD: Richard Ward for the record. Segal works with about 25 state health plans nationally and ten here on the West and within the Mountain West, the premiums for the -- for the PEBP plans are within, I would say are comparable. There's one state that is an outlier. If we look at Idaho and Montana and Colorado and Utah and Arizona and Wyoming, the premium levels are comparable.

From a plan design perspective, I would say -- I would say there are some other options to look at, but primarily PPO's and where the market supports it, HMO's are the primary design structures that are used, and there's a mix of use for CDH plans. Most states do have a CDH option. PEBP is unusual in the level of enrollment in year CDH plan.

In a lot of states it's offered as -- it's offered as an option, but they generally don't have the same enrollment that the PEBP CDHP plan has. Usually it's below ten percent.

MEMBER CAUGHRON: April Caughron for the record. Just one more real quick question. In those other states, are they looking at the economic situation for like entry level positions, do they take that into consideration when creating their plans? Have we seen that?

MR. WARD: Yeah. You -- sorry.

MEMBER CAUGHRON: Go ahead.

MR. WARD: Richard Ward for the record. Yes. And one of the things that we often do is work with -- is work with our clients to consider the -- sometimes we call it the mission statement, but what's the reason for a particular plan option being offered? What need is it looking to fill? And that way, as Chair Robb was mentioning, you can address different -- you can have different options to serve a specific purpose.

And so you can have a plan option that might appeal but -- that might appeal to one segment of the membership that might want to -- that might value a lower cost option and that might come with a leaner benefit design, and you might have another plan option that is -- that has better benefits but might be more expensive and would appeal

to that segment of the membership and so on. So that's -- that's something from -- we're thinking about it from a strategic review perspective. We found that to be helpful to serve as -- as -- provide some guidance and thinking about how to construct different plan options.

MEMBER CAUGHRON: Thank you. April Caughron for the record. Just one more thing.

CHAIRMAN ROBB: Yeah.

MEMBER CAUGHRON: I don't recall the last time we actually did a survey out to our community, out to our members, but I think that it might be something to consider that we throw out some of the options that we're exploring or we reach out to hear and gather a little bit more information about what it is that they're wanting.

I'm honestly a little more surprised that we didn't have more public comment around this issue. And I don't know if it's people just aren't comfortable or what, but I think it would be really a good idea to consider, just really giving our members another opportunity to weigh in and share. Thank you.

CHAIRMAN ROBB: Any other comments before we go back to Ms. Kelley? Please go ahead, Vice Chair Kelley.

MEMBER KELLEY: Thanks, Chair Robb. So I have some specific questions around the trend that I'm hoping

Mr. Ward might be able to help with. Firstly, and maybe I'll just give you my questions so that we don't have to go back and forth on the video because I know that can be kind of distracting, and I apologize for being on video today.

Okay. So the first question I've asked before and I think, you know, when I'm looking at the -- you know, the breakdown of medical, pharmacy and dental, 6.1, you know, 4.0, 19.2, 9.4, I would like to know of 100 percent of those three trends, how much money we're talking about. And then for PEBP, and I'm talking specifically for PEBP, so of medical, dental, pharmacy, how much is our spend say annually? And then what portion of, if you think of that spend as a pie, what portion is medical? What portion is pharmacy? And what portion is dental?

Because, obviously, you know, I know from Executive Officer Glover that dental is a tiny, tiny portion of the big pie, but I'm just curious about the split, especially the split between pharmacy and medical these days. So that's my first question.

And then my next question is, you know, obviously the focus is here is RX, right. I mean, I think medical we can all understand, but I'm still trying to get my head around how pharmacy works because, you know, obviously none of us are experts.

So when we're thinking of pharmacy, Mr. Ward, you said that the top three trend drivers with pharmacy were the GLP-1 weight loss, diabetes, weight loss medicines, the inflammatories and three, I thought you just said diabetic supplies as opposed to diabetic medicine, but can you correct that if I'm wrong.

I wanted to inquire about the weight loss GLP-1, which is number one on your list of drivers. I assume these are in order. So this weight loss medicine is driving the trend the most. But what I'm confused about is that PEBP really doesn't cover weight loss medicine, unless you're on the specific PEBP program and then they only cover -- and then we only cover generic drugs. So we're not covering the stuff that's getting a lot of media attention at the moment, like the Wegovys, and I don't even know all of the names. You know, I know there's quite a few of them.

MR. WARD: Uh-huh.

MEMBER KELLEY: So how is that driving -- like, how is that driving our costs if we don't even cover them? That's my -- that's the question.

And then, let's see, special -- actually, I have a question about the rebates because, obviously, our costs are 19 -- our trend is 19 percent before rebates but comes down significantly after rebates are applied, and I'm gonna

show my ignorance here and ask you to do a Dummy's 101 on what exactly the rebates are and how they work for the plan.

So I understand rebates when I go to, you know, the Safeway or whatever the stores are called these days, and I hand over a coupon, I get a little prize, but I'm not really sure how they relate to health insurance. So if you could help me there by answering that question, so I can understand why they are so prevalent and they bring the cost down so much, which I'm grateful for. Don't get me wrong, so that's that question.

And then -- and then talking about specialty meds, I always thought kind of specialty meds were the compound stuff, you know. And, obviously, the use is exploding, and I see that they're still kind of unique kind of drug. So we're not talking about brand name drugs, and I'm phrasing this -- this is more phrased, but please correct me when I'm wrong because I probably am. So these specialty meds are kind of compounded or they're very unique infusion kind of drugs.

So I'm just wondering, and there's more and more of them being introduced, so for our participants, I guess I'm wondering for the plan, I'm wondering a few things about the specialty things. Firstly, what are -- like is there an other, a top five or ten conditions that specialty meds are

being developed for and rolled out for? You know, where's our top spend for those medical conditions or what are the medical conditions that we're spending specialty on?

When people get specialty meds, is there like the step therapy, like there is for other regular medicines or if -- if they need the specialty med, they just get it? That's my second question around specialty.

And then my third question is and this is, I'm -- I apologize even as I say this. Are other plans limiting the specialty meds? If they're really driving costs to such an extreme, you know, is our plans doing unique things in this area to kind of try and cap costs?

And that seems like a lot of questions, but I appreciate your patience and everyone -- everyone's patience, and hopefully you can answer those. Thank you.

MR. WARD: All right. This is Richard Ward for the record. I may need a reminder here or there on a particular aspect of one of questions. I took some notes, and I'll endeavor to respond here completely. But if I overlook something, just remind me, please.

Going to the first question, which is the split of costs by medical, pharmacy and dental, I'm going to use round figures here of a 270,000,000 dollar annual spend. About 190,000,000 is for medical. About 60,000,000 is for

pharmacy, and about 20,000,000 for dental. So with a four percent trend on 190,000,000, I'm going to make the math easy here, at least for myself. It's just shy of an 8,000,000 dollar increase.

For pharmacy, about a 20 percent trend on 60,000,000 is about 12,000,000. And then on dental, it's 9.4, let's say that's ten, so 20,000,000 translates to about a 2,000,000 dollar increase.

For the trend drivers, the pharmacy trend drivers, you are correct, the plan only covers generic for GLP-1's and weight loss medications. PEBP is -- is -- only covers generics, which is most plans cover -- provide broader coverage. And so covering generics does reduce the exposure to PEBP for these medications but the increase in those medications that are -- that are covered has been significant over the last couple of years. And even though they're generics, they're still higher cost medications than most generics. They're not in the three, four, five dollar range like you might think a lot of generics are.

Then for rebates, there are, for brand name drugs and for specialty drugs, the drug manufacturers will provide a rebate for specific medications to offset the costs. So you can think about it along these lines, if there is -- if a drug costs -- let's say a month's supply costs $2,000, there

might be a 500 dollar rebate that is paid, that is provided by the manufacturer to offset the cost of that drug, and Express Scripts and every other PBM in the industry negotiates those terms with each of the manufacturers, and that is incorporated into the development of their formularies and -- and how those are instructed.

PEBP has an agreement in the contract with Express Scripts, which we renegotiate every year to ensure that it remains competitive, has a minimum rebate guarantee per brand drug. And the current -- for the current contract for -- for the current contract, those guarantees are for a -- for specialty medications, they are about $2,600 per script. So for every specialty medication that's filled, Express Scripts is guaranteeing that PEBP is going to receive $2,600 in a rebate to offset the cost.

Express Scripts is passing back 100 percent of every rebate that's collected. So that will vary from medication to medication. And ideally, the actual amount in aggregate on average will be more than that $2,600, but that's what is guaranteed to the plan.

For nonspecialty, they're at lower levels for a 30-day prescription at retail, it's about $300, and then it's about $900 for 90-day, either 90-day at retail or mail order, and that's for nonspecialty.

Specialty medications in this context are not -- are not compounded medications. They're more biological in nature, and you think of an example is Humira, which is often the most heavily -- which is often the most utilized drug in plans experience when we look at the top X drugs, and that is a high cost medication so that falls under specialty.

And until recently, there haven't been alternatives for the specialty medications. So there are things now that are emerging, biologic equivalence. You can think of it like a generic -- it's parallel to being a generic alternative to a brand medication. Until recently, for these specialty medications, there hasn't been a clinically equivalently effective alternative.

So when someone needs a specialty medication, whether it's Humira or maybe it's an oncology medication, they need -- they need that particular drug for their particular case, and they don't have another option. So there's not a steerage opportunity, like there might be between brand -- many brands and generics.

And we don't see our clients limit coverage for these higher cost medications. It's generally, especially with public plans and employers public sector plans and employers, they have a focus on access to care and providing quality care, and they try to do so as affordably as

possible.

And so not covering a particular medication that someone may need for -- for a rare condition or a complicated condition or a condition that requires a complicated treatment is not something that our clients generally do.

And then I think the -- hopefully I'm working through these. The last is about the higher cost conditions or the top conditions that constitute -- that drive pharmacy expense, so you would see for specialty. So you would see things like anti-inflammatories which would be Humira, oncology medication and what other?

MS. COHEN: Utilization patients.

MR. WARD: Is this in the Board packet?

MS. COHEN: Yes, page 32.

MR. WARD: Okay. On page 32 of the Board packet, I think it's in consent agenda, there's some utilization reports that show the top medications and the top -- the top classifications or drug classes or condition classes.

And so you see a lot of oncology medications in the top ten or 20, specialty, in the list of specialty medications or classes that are used and then inflammatories. And then you'll also see things if in rare instances, if someone, for example, is -- is -- if someone has, what's the, hemophiliac, thank you. If someone is a hemophiliac and has

-- the treatment for hemophilia is very expensive, and so you may or may not have any or more than one or two members that need that treatment. But when you do, you'll often see just that one or two prescription rise into the top 20 from a cost perspective because it's such a high cost treatment.

I'm not sure if I answered everything there. But at the risk of continuing to belabor the point, I'll pause.

CHAIRMAN ROBB: Is there any follow-up questions in the room before we go back to Vice Chair Kelley? Any follow-up questions?

MEMBER BITTLESTON: I guess just one more question. This is Leslie Bittleston for the record. Do we need to make a decision today on or do we need to vote today on what is being presented or is this where we're gonna send some more stuff back to Segal to --

CHAIRMAN ROBB: Jack Robb for the record. My understanding is we have to make decisions today, but we need to look at other options, look at keeping three options going back to different rates for different salaried brands. All the things that I threw on the table are not today decisions. The decision on where we need to go is today decision, decision on some of the stuff that I suggested we are looking at as a Board.

MEMBER BITTLESTON: Okay.

CHAIRMAN ROBB: Are future decisions to be made after Executive Officer Glover and Segal will give more information and more information to help with that decision making. Yes.

MEMBER AIELLO: Betsy Aiello for the record. Just based on what you finished saying, Mr. Ward, is medical is the high, high cost of the items. And looking at your -- your PEBP and industry every -- all of the years, PEBP has actually come below or is projected to be below the industry, which then would either indicate we're managing somewhat well or lack of access or whatever it is. But for the rate costs and the projections, since the majority of it rides on medical, that's fairly good, I guess, at least, even though we're ending up with a huge rate increase because of prior ways we've been spending money or lack of the Governor's budget or whatever it's been, correct? Is that?

MR. WARD: Richard Ward for the record.

MEMBER AIELLO: You don't want to comment.

MR. WARD: Well, I would agree that the recent trends on medical is an indication of a combination of effective managements. You've been looking to implement and introduce measures to make the plan more efficient. So I would say that the Center of Excellence network is one example of that.

MEMBER AIELLO: Yeah.

MR. WARD: There's also -- there's also just -- there's also some chance and luck involved in that too because claims costs will vary on their own. And so you -- you've had a couple of year period of good experience. That happens.

Overall, even though medical is the -- is the majority of the cost, the high increase on pharmacy is having an impact on the overall trend, and so we have 420 at nine percent trends, that averages out among the three to the six or seven percent range because the pharmacy is so high. Even though it's not the majority of the cost, it does bring that average up. And so the trends from last year to next year are higher than the increase in the AGIS and the REGI.

MEMBER AIELLO: Which is a follow-up question. It doesn't make as much sense because you would think, well, we have a healthy group if our medical is down, but all of those changes in meds and things are happening throughout the country, not just in Nevada.

MR. WARD: Right.

MEMBER AIELLO: So it kind of is a disconnect if our medical is so high when -- I mean, the medical has been maintained, but the pharmacy is going really high for some reason.

MR. WARD: Richard Ward for the record. There is at times an inverse correlation. So people with chronic conditions.

MEMBER AIELLO: If they're more compliant.

MR. WARD: Correct.

MEMBER AIELLO: Yeah.

MR. WARD: So that will increase pharmacy costs.

MEMBER AIELLO: That makes sense.

MR. WARD: But level out medical costs as --

MEMBER AIELLO: That's a good --

MR. WARD: -- you're managing the complications that may come with chronic conditions.

CHAIRMAN ROBB: Okay. Go ahead.

MEMBER WOODWARD: Janell Woodward for the record. I think to your point, sometimes we don't know why the medical was a little lower. What I hear a lot from our lower -- lower level staff is that they can't afford to go. They can't afford the co-pay to go and get your MRI done or your whatever test that has a high co-pay. You know, taking that, you can't afford the more expensive drug because Express Scripts doesn't necessarily pass that onto the -- the employee because you're required to get it from them. But if you go to the local pharmacy, they're going to pass that onto you. So I think that those things all play into that where

our -- where our fellow employees just can't afford that, and it's unfortunate, but it's a reality.

And I think that's just something to keep in mind when we're looking at developing what can we do going forward? Can we make better plans by just going to fix the cost by, you know, making it based on your income, you know, just different ideas that you flush out and see.

But -- but while we're trying to be fiscally responsible with everything, we also have to keep in mind the people that this program is for. And if you can't afford it, it's like why pay for insurance that you can't afford to use at all. And that's -- that is a lot of what I hear. I -- I have that situation sometimes as a cancer survivor that you can't really afford. You know, can I afford to go get the MRI done or can I or should I do this instead? Can I afford that medication or not or can you even get it because everybody in the world is on it, and there's a shortage. And so I think that, again, it's just important to keep in mind who -- what -- who this program is for.

CHAIRMAN ROBB: Before we have any further discussion, I'm going to ask Executive Officer Glover. There's multiple options on the table and then we can have further discussion, and none of the options are going to be good. They're not going to feel good. It's going to be

difficult. But we sit on the Board to make difficult decisions. That's our job. But there's probably a good decision, a semi-good decision or poor decision to be made right now. And I want your input as to the best path forward out of all of the options what -- knowing what our reserves are, knowing what our catastrophic claims are, knowing -- you have more information than anybody. So I would like some guidance, and then we can have further discussion upon what your guidance is.

MS. GLOVER: Celestena Glover for the record. So included in my report were several tables. One was the rate table. This is a preliminary table. It's not the final. So you'll see the employees portion may be a little bit off from what the other tables show, but I just wanted you to be aware of that.

So that is the table that just says plan year rates. It looks like this, for those of you in the room. It doesn't have a page number on it, and that's just an overall rate. So it's gonna show you the rate, the subsidy and then the participant premium for the different plan and tiers.

Then I put together a premium comparison table, and so this is the employees portion of the premium comparing 2024 to what we're looking at in plan year 2025 and then what the difference is. So if you look at the CDHP for

participant only, it was 46.96, their portion. We're looking at 63.56. The difference is $16.60, and then it compares all the plans and tiers accordingly. So that is just more of the picture of what those premiums look like. If we just take the rates as they are calculated currently without making any adjustments, that's what it would look like.

Then I did a table. It's two sided. On the one side, it will -- what I did is I took the premium so the employees' portion, that table shows 2024 premium, 2025s premium, the difference between the two, so you can see what that increase was. And then I took the dollar amount that was applied in plan year '24, utilizing excess reserves to bring those rates -- to keep the rates flat.

So the $7.22, that was applied to the CDHP single participant. That's what all of these amounts reflect. I took that dollar amount that was applied to the employees only and then applied it to the retirees groups of the state and non-state groups so we're using the same dollar amount across the board.

The other table which is what I would probably recommend is the 50 percent table so what that does is take the difference between 2024 and 2025 and says, okay, the increase is X, take 50 percent of that and pay for and utilizing catastrophic reserves.

The other 50 percent, the employees are going to see that price increase. So instead of the $16.60 increase for the CDHP member, it will be $8.30. Take those dollar amounts and, again, apply them to the retiree group because on a percent basis, I believe the employees were seeing a little bit higher percentage increase than the retirees were.

That table also is probably easier to explain and to implement because you're just taking that 50 percent. So when we do our technical adjustments to make sure that we have right down to the penny the correct rate tables, then we'll apply 50 percent, and then that's going forward. So regardless of what you're due, you're looking at an increase in premiums to the members.

But this ideally helps soften that blow. It's not ideal. I get it. I know from discussion, we talk about our lower paid employees and how it affects them, but it affects everybody to some degree. And, you know, the cost of medical treatment, drugs, dental, whatever it is that an individual may need to access, those costs have gone up, and we're doing what we can to try and keep what has come out of the employee's pocket to the -- to the minimum that we need to do, and we keep ourselves fiscally sound. And, like I said, we will tap into catastrophic reserve if that's the direction the Board would like to take.

Going forward, with all of the ideas that came up in the discussions, those are ideas that we will come back when we've had a chance to further analysis and come back with some ideas on what that looks like.

From the rates themselves, that has to be approved today because we've got to get them loaded and tested, and open enrollment is the first of May. That's only a month away, so we need to have this out there for everyone.

MEMBER AIELLO: This is Betsy Aiello. But, so the 50/50, it is coming from catastrophic reserves?

MS. GLOVER: Yes.

MEMBER AIELLO: Yeah, okay. You're just talking about if more came, but your recommendation is that there's enough in catastrophic reserves to hopefully be able to handle that, and then I guess in the budget bill to ask for back bill for next year.

MS. GLOVER: So this is Celestena Glover. So in the catastrophic reserve we have, this year it's 42,000,000. I believe it goes up to 48,000,000 in the future plan year. This cost is going to be about seven and a half million based on projected enrollment in the plans and tiers. You know, that projection is fluid because we don't know if people are going to change plans or bring dependents onto the plan or things like that, new hires, people moving into retirement,

whatever it is. So this is based on projected enrollment, so this is a moving number. This is our best -- the best we can come up with the information that we have today to say this is where we think we are. It is going to come from catastrophic reserve.

And when we build a budget, we will get an updated memo. Segal looks at our data and gives us a memo each year and tells us where our IBNR and catastrophic reserves need to be, and then we will build that into our budget moving forward.

CHAIRMAN ROBB: Any other questions? What I'm hearing is we're trying to -- Jack Robb for the record. I apologize. We're trying to soften the blow to the employee and keep the plan healthy and not dip into our reserves that we would be in financial jeopardy if something were to occur is what I've heard.

MS. GLOVER: This is Celestena Glover for the record. That is correct.

CHAIRMAN ROBB: Okay. Vice Chair Kelley.

MEMBER KELLEY: Michelle Kelley for the record. I just want to put on record, thank you, Executive Officer Glover, and, staff, for exploring these kind of -- you know, the way we -- the Board can choose to subsidize our employees. I think I am supportive of your recommended rate

mitigation measure which was the 50 percent. And I agree with you, that, you know, whenever I look at these things, I'm looking at how to explain to employees what we're doing. But then for future Board members, when we look back, how do we explain or how do they see and understand what we did.

And I think that the 2025 solution, which is the 50 percent mitigation of the state premium does that. It's easy to explain. I appreciate you saying it's also easier to implement because obviously we -- you know, where if possible, we want to make this easy to audit and to, you know, for the technical adjustments you talked about. So I'm supportive of the 50 percent premium, and I appreciate all of the work you guys did on this.

Before I give up my mic though, I did have a request that once we're finished voting on this item, I keep hearing that employees are having a hard time covering their out of costs expenses. And this year the state legislature gave all employees HRA money. So, and I believe that is happening for the next plan year as well. And so can someone remind us how much those dollars are at today's meeting and if -- if possible, can you tell us have employees used that money from their HRA's for the plan through today or can we get that information at a future meeting. Thank you.

MS. GLOVER: This is Celestena Glover for the

record. I did not bring that information with me for this Board meeting, but I can bring it to a future one. We do know that some individuals are using their HRA's. And you are correct, we are funded by the legislature for plan year 2025. I can't, off the top of my head, remember what those dollar amounts are. But, yes, we put in our newsletters and e-mails and such to let the people know the monies are out there. But for those plans that typically don't receive HRA money, that's probably a foreign language to a lot of them. So we keep trying to put the information out for members to access those funds as they become available. So we'll continue to do that, and we can bring you something back at the next Board meeting.

CHAIRMAN ROBB: Okay. Thanks, everyone. I'm gonna ask one more question. Timing of known pay raises coming up and timing of our premium shift, they coincide.

MS. GLOVER: Celestena Glover for the record. You're correct.

CHAIRMAN ROBB: Yeah. I knew that. I just wanted it on the record because it would be catastrophic if it didn't line up. If you gave somebody a raise and a month later you took part of that raise away or if this went into effect right before the raise went into effect, it would have a financial impact to those individuals. I just wanted to

share that and have that on the record, so, all right.

MEMBER KELLEY: Michelle Kelley for the record. Chair Robb, I just want to put some NSHE specific information out there because NSHE professional employees which include our, you know, both our faculty and our professionals, they do not get the pay raise until October 1st. So I don't -- you know, I don't think it can change any of our conversations here. But because the legislature didn't fund NSHE salaries, NSHE had to push that pay raise for professionals and for faculty, some of whom, you know, earn less than classified employees. And just -- I just wanted to correct that. So there is a large portion of employees out there who this would not line up for.

CHAIRMAN ROBB: And thank you for clarifying that. That's why I wanted to put it on the record to make sure I wasn't off base, and it sounds like I was including one portion of the people that are covered by this plan.

Any other discussion before I call for a vote? Seeing none, does anybody have a motion?

MEMBER BITTLESTON: Leslie Bittleston for the record. I move that we accept option number three, as presented by staff, which is the 50 percent option. What's it's called?

MEMBER STRASBURG: Premium mitigation.

MEMBER BITTLESTON: Oh, 50 percent premium mitigation option.

MEMBER KELLEY: Michelle Kelley for the record. Second.

CHAIRMAN ROBB: Okay. We have a motion and a second. Any further discussion? Seeing none, I'll call for the vote. All those in favor, signify by saying aye.

(The vote was unanimously in favor of the motion.)

CHAIRMAN ROBB: All those opposed? Motion passes unanimous. I do appreciate the whole discussion. I do think we have some avenues going forward. I do think they're important discussions and topics that we need to explore on how we set rates for all employees, to give some parity and to not impact the lower employees or lower paid employees. And I do really want to explore, even though I know some individuals, push to get that third option in there, I think the confusion and migration between plans, it makes it extremely difficult and that's where we find ourselves in these situations, making tough decisions, like we just did.

So I appreciate everybody's time on the agenda item. We're going to move on to Agenda Item Number 8, Discussion and possible action of UMR's Medical RX Coupon Program. Celestena Glover, Executive Officer for possible

action.

MS. GLOVER: This is Celestena Glover. The report before you is a recommendation to not move forward with the medical or RX Coupon Program. In discussions after the January Board meeting, at which time this was approved, it was brought to our attention that there was some potential issues with this being a program we could utilize on all three plans. So the EPO and the PPO plans, we could apply this coupon program. However, the high deductible plan, those members would likely still be subject to meeting deductibles before they would be able to take advantage of this coupon program. I think that is probably still something that is being reviewed and considered on whether that is actually the case.

It was also brought to our attention that this was a pilot program for some of UMR's clients and that they had come across some operational challenges. From my standpoint and my recommendation, we require our members already to jump through a lot of hoops to access the various things, prior authorizations, you know, co-pays, co-insurance, whatever it might be. There's a lot of discussion about what the cost of the plan is to members in bringing in a program that potentially still has some bugs in it that need to be worked out. I just as soon not put that

on the plan or our members.

That's not to say once the kinks are worked out of this that we might not bring it back at a future date or a future plan year, but right now the timing is ideal for this program that PEBP is offering.

With that, I'll take any questions.

CHAIRMAN ROBB: Any questions? Seeing none, this does require action today. So do I have a motion?

MEMBER WOODWARD: Janell Woodward for the record. I make a motion that we accept Director Glover's recommendation to not go with that program of the, what do we call that, the Medical RX Coupon Program and relook at it maybe down the road.

CHAIRMAN ROBB: And we have a motion?

MEMBER STRASBURG: Second. Bepsy Strasburg.

CHAIRMAN ROBB: I have a motion and second. Any further discussion? Seeing none, I'll call for the vote. All those in favor, signify by saying aye.

(The vote was unanimously in favor of the motion.)

CHAIRMAN ROBB: All those opposed? The motion passes unanimous.

We'll move on to Agenda Number 9, appeal process. Celestena Glover, executive officer. Informational for

discussion.

MS. GLOVER: So this is Celestena Glover for the record. There was a request at the last Board meeting that we bring to the Board a report that outlines the claims appeals process, and so this document gives you the information that was requested.

So if the appeals process is broken down in different areas, so a claim could be adjudicated and paid or not paid in a certain manner, the employee could then go back to UMR and say, hey, what's going on with this claim? I thought this benefit is covered. And sometimes it's just an error, and they will go back and look at that, say, yep, you're right and they'll re-adjudicate and they'll go ahead and pay the claim. That is not an appeal. That is just a customer service type inquiry, and those things can be internal as well.

If we say something, you know, someone is not eligible for a plan and they come back and ask us additional questions and we respond to those questions, that does not rise to the level of a complaint or an appeal. It is really an inquiry, and we try to handle as many things as possible at that level to keep them from becoming appeals.

Once the person decides that they want to file an appeal, there is guidance and timeline. So level one claims

appeals, that goes to, in this case, UMR, they're our TPA, they will go back and gather the data, do the research, make the determination on whether their process was correct or the member's process was correct or maybe some combination and then take action accordingly.

If the decision at that point is still negative to the member, then they have the ability to file to appeal. That comes to PEBP. So PEBP will go back and look at it. They'll work with UMR and they'll do the research to try to determine where the breakdown is. Is this something that we should have paid? Is our documentation accurate and easy to understand or as clear as we can make it possible because nothing in medical seems to be easy to understand. But in our documentation is clear that we put in those documents what our intent is as far as approving certain benefits and what we will or won't cover based on the plan that the individual is enrolled in, and then we respond to that level of appeal.

And then in some cases, if they still don't like that decision, they can go to an external review. So that review is done outside of our agency and outside of UMR, and we have a third party look and it's at PEBP's cost. The member pays nothing for those external reviews. So they can go outside and say, okay, they'll gather all the records,

look at medical records, whatever it is -- whatever information they need, and they will make a determination on whether or not we should have covered it or not.

We don't have a lot of external reviews and of those that we have had, probably about 30 percent or so have been our level two has been overturned by the external review, and then we go back and provide that information to UMR so that those claims can be paid at that time.

The other piece of the whole process is the exceptions. When an exception is requested, there are some places where we cannot grant an exception in any way, shape or form. If it is by law, something has to be done, I can't reverse that and say, yeah, well, the law says X, but I'll give you Y. So if the law says you have to do something a certain way, we cannot grant an exception in that case.

In other areas, what we look at is what is the intent of the plan? What do the documents say? What are our requirements legally and otherwise? And we try to determine where our documents are clear enough or did the circumstances in that particular situation warrant an exception be granted? We do not grant a lot of exceptions. We do grant them in very specific cases. When we look at everything, the research is done, I go back and look at all the research that has been done, typically by our QC team and make a

determination at that point that, yes, the situation warrants an exception, and then I will do so.

If our documentation is clear, the plan benefits are outlined well, in those cases, no, I won't make that exception because if you -- I can't say, well, Mary's exception is more important than Billy's, and they both have similar situations. So in those cases when there isn't a valid reason to grant that exception, then we don't.

We cannot administer the plan by exception, so we try to make our plan documents as clear as possible. Staff are trained to the best of our ability so that if a question comes into our member services unit, they're giving out good information. If they want to take that up to the quality control team, they're giving out good information. And if we need to get somebody else involved because we're not certain, we now know have our in-house legal counsel, and we'll take things there to make sure we are on good ground, whether we're going to grant the exception or not grant the exception. So that's the process in a nutshell. There is a lot of detail and their statute dictates what we can and can't do, what our requirements are, and we follow those guidelines.

With that, I'll take any questions.

CHAIRMAN ROBB: Any questions? Go ahead.

MEMBER AIELLO: This is Betsy Aiello for the record. So we had a public at the beginning, public comment regarding a request for exception. It's my understanding that someone probably would have explained to us what was just explained to us as a Board to the public that was requesting the exception so they understood some of those limitations or do you not because sometimes that might help the outcome.

MS. GLOVER: So this is Celestena Glover for the record. I went back and looked at how some of the memos were written back to the members, and there was a lot of information attached that maybe wasn't real helpful. And so we are in the process of revising those memos and letters to better explain to the member why the decision was made. That right now, that is an ongoing process.

Our QC officer position recently became vacant, so I'm helping in that arena. I'm having Brandee Mooneyhan to actually assist with that, to make sure that what we're doing makes the most sense, and we're providing the information back to those individuals.

MEMBER AIELLO: It sounded like it could have been a communication issue as much as for understanding.

MS. GLOVER: Yes, and it likely was. One of the things we are doing, especially in a more difficult situation

or when trying to explain it in a letter isn't ideal or isn't clear is to make a phone call to that individual and let them know the letter is coming and the outcome of that request so that they maybe can ask more questions, and hopefully staff can clarify the reasons behind the decision.

CHAIRMAN ROBB: Thank you.

MEMBER STRASBURG: Bepsy Strasburg. Just some clarification for myself, do people who go through the exception process, do they -- can they or do they decide to go to the claims process afterwards if they're not getting anywhere? That's question number one.

MS. GLOVER: This is Celestena Glover for the record. I think it depends on what the situation is. If it's actually a claims payment process, typically we refer them to UMR so they can talk to the right people because, obviously, we adjudicate the claims in-house.

If it's something else, like we've had people request exceptions for being allowed to bring a spouse on the plan when they missed their deadlines for getting the documentation or even letting us know they got married in the first place, we have a 60-day window for that. So sometimes, you know, it's pretty clear, we set a time frame and documentation required. And then somebody said, well, I got married six months ago. Can my spouse get on the plan? And

without some qualifying life event that would qualify that to happen outside of that 60-day window, in those cases, those kind of exceptions typically aren't granted. There has to be something real specific for us to go there.

MEMBER STRASBURG: And then the second question was on the 163 level claims, and it went through all of the levels in 2023. So by my calculation that was about 58 claims through one, two and three level, that was overturned, that's about 36 percent. Is that kind of normal or is that high or low?

MS. GLOVER: This is Celestena Glover for the record. I think that's pretty normal. That's what I've seen over the years. Obviously, it would be, probably a lot less if we just granted exceptions for everything, then nobody would file any kind of appeal. But, yeah, that's -- that is pretty much what we've seen over the years.

CHAIRMAN ROBB: Vice Chair Kelley.

MEMBER KELLEY: Thank you, Chair Robb. I just have a question, I guess, around the exceptions to the -- you've got it listed as exceptions to plan rules. I seem to recall that at some point during a Board meeting and, you know what, I've watched these for too long. I've only been part of the Board for two years. I think there's a specific Attorney General's opinion that says the exception process

can't be used to overturn plan rules made by the Board. Is that -- maybe I'm paraphrasing wrong, but I thought there was an A.G.'s opinion out there.

And the only reason I raised this is you kind of got -- you listed it as exception to plan rules, but really it's not exception to plan rules because the plan rules are black and white. And, you know, you can't really make exceptions to those. What you're looking for is what exceptions -- I'm trying to understand when exceptions can be made because it's more in the gray areas where there isn't a plan rule that supports or doesn't support a request, right? That where you can then look at supporting document to make an alternative decision. Is that -- can you explain that a bit better maybe?

MS. GLOVER: This is Celestena Glover for the record. You're correct. If the plan rules are very clear, such as the 60 days to bring a new spouse onto the plan, then, no, I can't write that exception. It's where the plan rules maybe are a little murky. And it's not that the plan rule is murky. It's how it's explained in our documents. If it's not clear in there that something can or cannot be done, then we have to look at those and go, okay, our intent was this, but it's not clear in the documentation. And in this case, yes, we may need to approve that exception. That does

not happen very often.

And if -- if the plan rules say, you know, you have to do step one, two and three, I'm not going to grant an exception to step two because somebody asked for it because they don't want to do with that step or they don't agree. That has been approved in our plan design and our plan documents and it's clear. But if we somehow missed putting that information in the documents, so it's not clear, then that's when we have to look at does the situation warrant an exception. And in that case, that's when I will have to make that decision.

MEMBER KELLEY: All right, thank you. And then I just have a follow-up regarding so I guess all of the levels of appeal. I did the statistics as well, and I see level one claims, basically, 28 percent were overturned. When it comes to staff, you're only overturning 19 percent of those submitted. And then when it's going to the outside, the external review, they're approved 30 percent of the request.

So I'm kind of interested in, you know, the essence of continual unproven. When do you -- does PEBP staff kind of review these appeals in aggregate, kind of a few times a year to see if there's any learnings on improve the plan document or change the procedure to cut down on a particular issue. Like if there's trends coming out through

these appeals, that's for stage one and two. And then specifically for stage three, I'm surprised that 30 percent overturn rate. And so I'm wondering what kind of supporting documentation or explanation, I guess, does the external review body give to PEBP to kind of justify that 30 percent review. And then once again for continual improvement, what do you do with that information?

MS. GLOVER: So this is Celestena Glover for the record. We do review internally what those appeals are and what they're doing. So for us, it's typically going to be level two and external reviews, but we work with our vendors. So in this case, UMR, if it's a claim issue, to determine, you know, why are we getting the number of claims we're getting, and are they all in a specific arena. So, yes, that's looked at. If it's related to how are documents worded or is it difficult to find the information in the documents?

Recently myself and our legal counsel have been looking at our master plan documents to determine, can they be formatted in a different manner? And where can we make the language more clear so it's easier for people to navigate through the documents and understand what is allowed and what isn't? And that is driven by when we get -- when we hear public comment, when we get level one and two appeals,

external reviews, all of the different processes, including request for an exception to a plan rule, do we need to change the plan rules? Is that something we bring back to the Board for future plan year. So, yes, we do look at all of that to make a determination.

As far as external reviews, those reviews a lot of times, some recent requests for reviews that I have seen, it's because the plan doesn't cover a certain medical procedure for one reason or another could be considered experimental or not proven. But the medical provider and the member still believes that that treatment should be done, and so they have the right to make an appeal to an external review and then the organization that does that review will gather all of the medical records. They will look at what is considered experimental, not experimental, where they think we should go, and they'll make the decision to uphold our initial decision or to overturn it, and that's obviously case by case.

CHAIRMAN ROBB: Okay. Any further discussion? Seeing none, we will close Agenda Item Number 9 and move on to Agenda Item Number 10, public comment. That's three minutes each person.

In Carson City?

MR. ERVIN: Kent Ervin, Nevada faculty Alliance.

So thank you for mitigating employee premium increases. No increase for employees is ideal, but we appreciate that you soften the blow today. We will continue to advocate with the legislature for stable benefits and stable employee premiums.

Today's discussion went well beyond next year's rates. We would welcome a strategic discussion about the premium structure. A first way to address entry level employees is to go to 100 percent coverage of the premium for the employee only tier of a base plan, as most of our local governments do for their employees. NFA has suggested income adjusted premiums in the past and been rebuffed, that idea, so we do welcome that discussion.

Regarding migration among the three plans, we did advocate for having this middle option. It has only been in existence for several years. So migration is likely to stabilize over a few years over time. A problem leading to confusion is that a deductible was added to the HMO/EPO plan. And the middle low deductible plan was converted to zero deductible plan and those issues of the differentiation of the three plans need to be addressed.

Another topic, REMSA and Carson Tahoe are monopoly and dominant providers in their localities, and they really must be in-network or state employees, however that gets accomplished.

Next, the Executive Officer Report indicated that the quality control officer position is vacant. That's a very important position for PEBP. It's specified in statute 287.026. Director of the department of administration, Chair Robb, appoints the QCO, and he finds their duties with the concurrence of the Board, so that's different than the other executive staff at PEBP.

The reporting the line is special because the QCO should be able to report fiscal issues directly to the Chair and Board without interference by the executive administrator. There was -- it's not a problem now, but there was a notorious case in the 1990s where the Board or committee wasn't being informed of serious deficits, and that's really where that position and it being in statute came from.

In the past, the QCO served as the contracts and procurements officer. They also played a participant service role, basically as an omnibus person. Recently, it seemed that it shifted to strictly a compliance role. So now with the vacancy would be a really good time to look at the job description and figure out what's best for the plan and the Board and the participants.

Finally, please excuse my skepticism about midyear projections of reserves. We have a dozen year

history of projections being way off, mostly leading to excess reserves or this could be the year when that reverses, but we won't know until the close of the fiscal year. So thank you for the opportunity to comment.

CHAIRMAN ROBB: Okay, thank you.

Any other public comment in Carson City? Seeing none, any other public comment on line?

MR. HOPKINS: We have one on line right now. One moment, please.

Douglas Unger, please slowly state and spell your name for the record.

MR. UNGER: Doug Unger, D-o-u-g U-n-g-e-r, Nevada Faculty Alliance. I also would like to thank the Board for approving the 50 percent mitigation for employee premiums. And I understand that it is not the most desirable outcome, but it's the best possible outcome for this coming plan year.

I would like to speak up for the PPO plan, which is so new that employees are just getting adjusted to it. And I think the movement back and forth between plans is as state employees are trying it out, we really needed, as do most other states and I could say all other university systems in the region, we needed that third plan as a co-pay option to balance out the CDHP and the HMO plans that were available.

The actuaries reported that Nevada is unusual in that it has a high CDHP enrollment. The reason it's high is because of the dire physician and provider shortage in the state and the fact that the CDHP offers opportunities, ample opportunities to travel out-of-state to seek necessary medical care.

Please note that there's an article in the current Nevada Current about the Nevada Board of Medical Examiners being one of the impediments to physician and provider access in our state because of its draconian practice in overregulating physicians in order to basically defend physician turf and income.

It seems to me that this would be a good opportunity for Director Robb and the Board to recommend to Governor Lombardo that he should look into reforming the practices of the Nevada Board of Medical Examiners in order to mitigate the physician shortage in the state. We are 45th of all the states in our access and quality of medical care.

In conclusion, I would like to welcome Director Robb's suggestion that it might be possible to look to an income percentage tiered premium scale. The Nevada Faculty Alliance has looked into this. I would refer the Board to a report that I made to the Nevada Board of Regents in January of 2019, which examined higher education plans. And I

pointed out the University of New Mexico plan has a tiered premium scale, which is different than the university systems of other states. It's fairly high cost for the high income employees, but it's very low cost for the low income employees.

But the difference is that the University of New Mexico has a medical school clinic based HMO option that's very low cost and provides a kind of relief valve for high premiums for those who perhaps in the upper income tiers who really also can't afford it. So we're way behind other states in our provider base. I've hoped that our UNLV and UNR medical schools can grow their clinical practices to be able to offer a state based clinical practice HMO. Until that happens, I think the tiered income proposal, at least for higher education employees, is going to be an issue.

In conclusion, I think the overall position we should take is that the state should raise its contributions per employee back to the 93 percent level. There really is only a difference of the price of a fast food hamburger between what the state paid in 2013 per employee and what it's contributing per employee this year, and there's been lots of inflation over the past 11 years.

If we could get the 93 percent contribution, that would provide -- that would more than take care of the rate

increases that you voted on today, plus supply about four to $5,000,000 extra into PEBP's budget to take care of medical inflation over the next biennium.

Thank you very much for everything you do. I appreciate and we appreciate everyone on this Board and thank you very much. And thank you to Executive Officer Glover for maintaining the healthcare advocates meetings, which are so extremely helpful for us to be able to explain to our members and to employees what's going on with the PEBP plan. Thank you so much.

CHAIRMAN ROBB: Okay, thank you.

MR. HOPKINS: Chair Robb, that is all the public comment.

CHAIRMAN ROBB: Seeing no more public comment in Carson or on line, we will close public comment and go on to Agenda Item Number 11 and stand in adjournment. Thank you.

STATE OF NEVADA,)
) ss.
CARSON CITY.)

I, KATHY JACKSON, Official Court Reporter for the State of Nevada, Public Employees' Benefits Program Board, do hereby certify:

That on Thursday, the 28th day of March, 2024, I was present on Zoom for the Public Employees' Benefits Program, Carson City, Nevada, for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 113, is a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Carson City, Nevada, this 14th day of April, 2024.

KATHY JACKSON, CCR
Nevada CCR #402

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