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In The Matter Of:

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

March 28, 2024

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1 PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

2 TRANSCRIPT OF PROCEEDINGS

3 ZOOM/TELEPHONIC MEETING NOTICE AND AGENDA

4 THURSDAY, MARCH 28, 2024

5 CARSON CITY AND LAS VEGAS, NEVADA

8 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

13 For the Board:

RADHIKA KUNNEL
Deputy Attorney General

14 For Staff:

CELESTENA GLOVER
Executive Officer
JESSICA CRANE
Executive Assistant
MICHELLE WEYLAND
Chief Financial Officer
NIK PROPER
Operations Officer

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1 THURSDAY, MARCH 28, 2024, CARSON CITY, NEVADA

2 -000-

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

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

9 CHAIRMAN ROBB: Here.

10 MS. CRANE: Michelle Kelley?

11 MEMBER KELLEY: Present.

12 MS. CRANE: Betsy Aiello?

13 MEMBER AIELLO: Present.

14 MS. CRANE: Jim Barnes?

15 MEMBER BARNES: Here.

16 MS. CRANE: April Caughron?

17 MEMBER CAUGHRON: Here.

18 MS. CRANE: Leslie Bittleston?

19 MEMBER BITTLESTON: Here.

20 MS. CRANE: Jennifer McClendon?

21 MEMBER MCCLENDON: Here.

22 MS. CRANE: Bepsy Strasburg?

23 MEMBER STRASBURG: Here.

24 MS. CRANE: Janell Woodward?

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1 MEMBER WOODWARD: Here.

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

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

6 CHAIRMAN ROBB: Okay, thank you.

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

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

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

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

20 MS. OSBORN: Good morning, Mr. Chairman, Board
21 members, staff. My name is Margaret Kelly Osborne, and I'm
22 here to thank the Board and staff for reinstating the
23 reimbursement rates for out-of-state travel, reimbursement
24 for medically induced -- medically required travel. I just
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1 wanted to thank the Board and everyone for your help.

2 CHAIRMAN ROBB: Thank you for participating in
3 these meetings.

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

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

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

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1 I have tried for a year and a half for this
2 process of submitting the non-assigned claim and the appeal.
3 UMR and PEPB have mismanaged the claim, and I'm now convinced
4 that's purposeful. UMR originally adjudicated the claim at
5 50 percent, thus acknowledging the medical necessity. I
6 challenged the 50 percent coverage by phone with UMR because
7 there's no preferred provider for this medical device in your
8 organizations.

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

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

19 I have appealed on the basis of exception to the
20 plan document. UMR and PEPB have had nothing but excuses or
21 ignoring the reason for the appeal. I heard it's not our job
22 from UMR. And then I heard from PEPB that it's not our
23 responsibility. And then I even had one where it
24 regurgitated all my information for six pages and then said
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1 it's not covered by the plan document. I know. I was
2 seeking an exception.

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

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

16 CHAIRMAN ROBB: Thank you.

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

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1 treatment.

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

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

17 And I guess I'm happy -- we should be happy that
18 we finally got acknowledged the specific request that we had
19 submitted. The letter from the PEBP Executive Officer to my
20 wife, denying our request for plan benefit exception, a
21 coverage date of February 9, '24, referenced a review
22 performed, analyzing plan documents and clinical policies of
23 various health insurance providers, both government and
24 private sectors. And based on this review, our request for
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1 plan exception to coverage was denied. This communication of
2 February 9th, 2024, also acknowledged not all plans deny
3 coverage.

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

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

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

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

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

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

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

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

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

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

18 CHAIRMAN ROBB: Thank you.

19 Next in Carson City?

20 MS. ANTONUCCI: Good morning, Chairman Robb. I'm
21 Patty Antonucci, and I'm a 12-year state employee. The
22 reason I'm here is I'm deeply concerned by the agendum --
23 Agenda Item 6. Agendum -- sorry, agendum -- why can't I say
24 agenda today? Okay. Item 6 informs the Board that Carson
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1 Tahoe Hospital has the intent to terminate the contract with
2 UMR. Carson Tahoe Hospital recently sent a letter to the
3 PEBP's members, informing the members that they intend to
4 terminate the contract with UMR.

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

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

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

2 CHAIRMAN ROBB: Thank you.

3 Next in Carson City?

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

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

19 CHAIRMAN ROBB: Okay. Thank you very much.

20 MR. HALLEMEIER: Thank you.

21 MR. ERVIN: Good morning, Chair Robb, Vice Chair
22 Kelley, members, Officer Glover, Kent Ervin, E-r-v-i-n,
23 Nevada Faculty Alliance, for the record. We are very
24 concerned about the impact of employee premium increases on
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1 our members and our classified employee colleagues. The
2 increases subtract from hard one, cost of living adjustments
3 and are especially hard for lower paid state employees who
4 already struggle.

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

11 When the state deliberately underfunds the second
12 year of the biennium, it should be the policy to use PEBP's
13 ample reserves to cover claims than true-up the reserves in
14 the next budget cycle. PEBP's reserves as of December 31st,
15 2023, in the budget report today were 121,000,000. 5,000,000
16 of that is excess reserves. 42,000,000 is in catastrophic
17 reserves, formerly known as rate stabilization reserves and
18 53,000,000 is in the incurred but not reported reserve, which
19 will never be needed unless the state suddenly eliminates
20 employee healthcare benefits entirely.

21 Using up to 15,000,000 of reserves to cover the
22 entire increases to employee premiums would be reasonable.
23 However, we recognize that PEBP has a fiscal goal to keep the
24 so-called mandatory reserves intact. Therefore, NFA does
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1 support the 50 percent mitigation plan on the fifth page of
2 Executive Officer Glover's report for Agenda Item 7, which
3 only uses the excess reserves as reported as of
4 December 31st. That plan at least lessens the impacts for
5 employees. The 50 percent mitigation plan appears distribute
6 the available funds more fairly among the three plans and
7 four tiers than using the ad hoc premium adjustments from
8 fiscal year 2024.

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

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

23 MS. OPSERMAN: Good morning, Board. Thank you
24 for the opportunity to speak today. Tess Opserman here on
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1 behalf of the AFSCME retirees. We echo much of what was just
2 said by Kent, our previous speaker. We're deeply concerned
3 in the increases in the rate. We do understand that the
4 excess reserves went to zero and the need to make
5 accommodations for that, but we are concerned about these
6 increases. Our retirees and active employees are living on
7 fixed incomes and simply cannot afford the additional cost,
8 so we're concerned about that, and we do ask the Board to do
9 whatever you can possible to try to limit those increases to
10 their rates.

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

22 CHAIRMAN ROBB: Next public comment in Carson
23 City.

24 MS. LAIRD: Thank you. Good morning, Chair Robb,
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1 and fellow community members. My name for the record is
2 Terri Laird. I'm the executive director of the Retired
3 Public Employees of Nevada, RPEN, here in Carson City. We've
4 been around since 1977, and we have close to 7,000 dues
5 paying members. I echo all the remarks made by Kent and Tess
6 as well.

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

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

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

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

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

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

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

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

21 Regarding Agenda Item Number 7, we wish to
22 express most strongly that we would be disappointed if rates
23 for 2025 would increase 35 percent or more for premiums
24 across the PEBP plans, which would hurt most state workers
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1 with dependents and families.

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

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

21 Another approach would be to address state
22 contributions for PEBP, which dropped from approximately
23 93 percent to 91 percent of the cost per employee. This
24 budget cut percentage is a cause of reason why state workers
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1 will pay more in premiums next fiscal year.

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

8 We ask the PEBP Board to look to approve the
9 50 percent mitigation option that we understand will be one
10 of the public -- possible actions presented by the executive
11 officer. Thank you.

12 CHAIRMAN ROBB: Thank you.

13 Next public comment online, please.

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

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

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

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

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

6 CHAIRMAN ROBB: Okay, thank you.

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

11 MS. KUNNEL: Thank you, Chair Robb. This is
12 Radhika Kunnel, deputy attorney general for the record. This
13 agenda item is to allow me to make a disclosure regarding
14 conflicts of interest on behalf of the Board members who are
15 eligible for PEBP benefits.

16 Pursuant to NRS 281A.420 on behalf of the Board
17 members who are eligible for PEBP benefits or whose families
18 are eligible for PEBP benefits, I offer this disclosure that
19 they will be voting on those items that may affect the
20 benefits available to them or their family members. The law
21 does not require abstention from voting merely because the
22 Board member or their family member is eligible for PEBP
23 benefits

24 At this time, I invite any member of the Board
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1 who has any additional disclosure to make it now. Thank you.

2 CHAIRMAN ROBB: Okay. Any further disclosures by
3 any Board members today? Seeing none, we will close Agenda
4 Item Number 3 and move on to Agenda Item Number 4, consent
5 agenda. Consent items will be considered together and acted
6 on in one motion unless items are removed to be considered
7 separately by the Board. 4.1, approval of action items or
8 action minutes from the January 26th, 2024, PEBP Board
9 Meeting. 4.2, receipt of quarterly staff reports for the
10 period ending December 31, 2023. 4.2.1, Q2 budget report.
11 4.3, receipts of quarterly vendor reports for the period
12 ending December 31, 2023. 4.3.1, Q2, Sierra Healthcare
13 Options and UnitedHealthcare Plus Network, PPO Network.
14 4.3.2, Q2 UnitedHealthcare Basic Life. 4.3.3, Q2, Express
15 Scripts, summary report.

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

19 MEMBER STRASBURG: Motion to approve agenda
20 items.

21 CHAIRMAN ROBB: Okay. Do we have a second?

22 MEMBER MCCLENDON: Jennifer McClendon. I'll
23 second.

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

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

5 CHAIRMAN ROBB: All those opposed? Motion
6 passes.

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

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

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

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

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

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

20 CHAIRMAN ROBB: Okay. We have a motion.

21 MEMBER BITTLESTON: I'll second.

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

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

3 CHAIRMAN ROBB: Any opposed? Motion passes,
4 unanimous.

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

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

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

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

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

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

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

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

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

17 Carson Tahoe decided to go ahead and send out the
18 letter to all of their patients that come under UMR, so it's
19 not just PEBP members. As I said, it's any of their book of
20 business that says they intend to terminate the contract.
21 They didn't give a date. We're hoping the issues will be
22 resolved and that won't happen. We are looking to have a
23 meeting with Leadership at Carson Tahoe, and that meeting
24 will include myself, our Board Chair, Jack Robb and the UMR
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1 staff, along with, as I said, Carson Tahoe Leadership. That
2 meeting has been all over the board as to what dates, so it
3 keeps moving. But as soon as I have a set meeting and I have
4 something to bring back, I will bring that to the Board
5 hopefully next Board meeting so that I can give you an update
6 as to the results of that meeting, if the issues aren't
7 resolved prior to then.

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

19 It is a voluntary option for members. They do
20 not have to go to Carrum if they want to stay with their
21 regular providers for whatever service they're having and go
22 with whatever other providers their provider will refer them
23 to, but this gives them another option in the event that they
24 want to seek Centers of Excellence, oncology through the
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1 concierge services, so that's -- that's where that document
2 is.

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

9 CHAIRMAN ROBB: Yes.

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

15 MS. GLOVER: This is Celestena Glover for the
16 record. We are reviewing our own statute, so we have 287, to
17 see if there are any changes there that we need to make. I'm
18 working with my staff and I'm trying to determine what the --
19 what the changes are that we should submit. I have a meeting
20 scheduled with the Governor's Office on, I believe, it's the
21 12th of April. They are doing a review with each of their
22 agencies to look at any BDR request we may have.

23 Primarily what we're looking at is streamlining
24 287 to make our processes a little easier. Part of that is
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1 around a closed meeting for RFP's that the contractor try to
2 streamline that, so we can get through that process quicker.
3 That is our main focus, and then just any language in there
4 that we think needs cleaning up more than anything else.

5 MS. BITTLESTON: Thank you.

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

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

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

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

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

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

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

11 Ms. Kelley.

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

23 On that note, and I thought it was in your
24 report, Executive Officer Glover, but I wanted to ask about
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1 the REMSA ambulance service in Northern Nevada. We've had a
2 fair amount of public comment on that as well, and I've had
3 participant comments about the lack of ambulance service in
4 the north. And I wonder if that's something that also can be
5 elevated and the fact that we don't have a contract with the
6 only ambulance provider in the north. And I understand that
7 it's covered for participants but, of course, their costs
8 aren't capped except for the out-of-network maximum
9 out-of-pocket which is huge.

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

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

21 REMSA has an agreement with Washoe County. It's
22 a longstanding agreement. So Washoe County covers primarily
23 Reno and Sparks and the surrounding area. Their pricing has
24 been approved by Washoe County. We don't necessarily know
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1 exactly what that pricing is. We've had kind of a difficult
2 time trying to figure out what pricing is.

3 We've asked with UMR, if we can potentially get
4 them into the network and agree to some sort of cap on
5 payment. That has not come to fruition. We pay 140 percent
6 of Medicare. And then, of course, the members, depending on
7 the plan they're on, may have an 80/20 split of that
8 140 percent.

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

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

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

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

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

20 CHAIRMAN ROBB: Jack Robb for the record. Being
21 a long-time Washoe County resident and know multiple members
22 of City of Reno Fire Department, they do not have ambulance
23 service. They dispatch to the same medical emergency but
24 they'll dispatch a truck. They do not dispatch any
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1 transport. So you get an ambulance and fire truck at any
2 medical but their transport option is one.

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

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

17 CHAIRMAN ROBB: I'm fine. Go ahead.

18 MEMBER KELLEY: Okay, thank you.

19 Executive Officer Glover, I just was wondering if
20 you could share what services are -- like not the level of
21 detail that's in the wrap document, but the wrap document
22 itself kind of breaks out the conditions that we're covering
23 under the regular Center of Excellence. So can you talk
24 about what specific, maybe cancer, like, is it by diagnosis
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1 or is it by service. And if it's -- is it simple for you to
2 just kind of outline some of the major diagnoses or services
3 covered under the oncology concierge.

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

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

19 What kind of -- obviously, open enrollment is one
20 thing. But open enrollment, there's so much talked about
21 that people don't take most of it. But if we can promote
22 these services, I think that would be outstanding. And I
23 just want to also, while I'm talking about promotions, give
24 kudos to the staff to the Hinge Health promotional materials
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1 because I've been inundated. I definitely know Hinge Health
2 is in place, and I appreciate that knowledge, so thank you.

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

15 CHAIRMAN ROBB: Okay. Any further questions?

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

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

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

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

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

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

19 In plan year '23, we actually had close to a
20 9,000,000 dollar shortfall in claims for the state employees
21 and retirees. They're grouped together for payment purposes.
22 The shortfall this year is for the non-state employees and
23 retirees. Again, they're grouped together for payment
24 purposes. So that projection is, they're a smaller amount.

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

6 We get regular reports to give us an idea of what
7 our high dollar claims look like, and we've had several this
8 year that we use \$100,000, but these are \$1,000,000,
9 \$3,000,000, \$2,000,000. So we've got some significant claims
10 and that's the amount we're paying toward those claims. It's
11 not the bill charges. I just recently received two reports
12 in the last week, a two and a half million dollar claim that
13 we're paying a million and a half for, two and a half million
14 claim that we're paying about 700,000 for. So those are the
15 things that we have to be concerned about and that is part of
16 what is driving our trend and our rate increases is those
17 types of claims. So I just want to set kind of a stage as to
18 what we're looking at.

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

24 CHAIRMAN ROBB: All right. Please proceed with
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1 7.1 all right, on the agenda.

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

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

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

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

16 And so for -- for recent experience, the last
17 couple of years, medical, pharmacy and dental has tracked
18 fairly close to national trends. And just for reference
19 here, out of about a 270,000,000 dollar claim spend, the
20 majority of it is for medical. That's about 190,000,000.
21 And about 60,000,000 is for pharmacy, and then about
22 20,000,000 for dental. So just to keep in mind, that
23 mentally put more weight to what is happening with the
24 medical than with the other two trends. In particular,
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1 dental is a relatively small portion of the overall spent.
2 Although, the trends for pharmacy are significant and that
3 does have an impact on what we're expecting to see.

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

8 Pharmacy though is, as we say, is running hot.
9 It's running really hot. This is just claims trends before
10 it's offset by rebates and it's close to 20 percent, at
11 19 percent is what we're expecting for this current plan
12 year, which is about twice what we see in the industry.

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

20 And then our projections for plan year '25
21 incorporate what we've seen, what we are seeing, what we
22 expect to see which includes what we're gathering from
23 industry expectations. So we perform an annual trend survey
24 where we get input from about 70 carrier -- insurance
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1 carriers, administrators, PBM's and all the Blue Crosses, all
2 the Kaisers, UnitedHealthcare, UMR, Express Scripts, and they
3 tell us what as an organization they are expecting for trend
4 and we amalgamate that into what we're representing here for
5 the industry.

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

17 I'll move on to the next couple of slides where
18 we have a little bit of detail for medical, pharmacy and
19 dental respectively. In this graph to the left, so this
20 shows the per capita costs on a rolling 12-month incurred
21 basis and it's -- it's I think a good graphic way to see how
22 costs have evolved over the last several years. And you may
23 note that in the far left here for 2020, costs were
24 substantially lower than what we see in the most recent two
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1 or three-year period, but that was when PEBP and the -- and
2 the industry in general was experiencing a -- the COVID
3 effect where people were not accessing care in the way that
4 they had prior and they have subsequently.

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

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

18 And then for pharmacy is the same format of
19 the -- of the graph where we're showing a rolling average for
20 per capita cost per member cost. You can see it's increased
21 fairly steadily from the top line there, claims cost. \$164
22 in the far left in June of 2020, growing steadily to 263 or
23 240 currently through December, and then the dotted lines for
24 the next six months indicates what we're projecting for the
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1 second half of the current plan year.

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

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

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

2 So for 2024, while we're expecting claims costs
3 to increase 19 percent for the plan year, that's offset by
4 enhanced rebates, which lowers the trend to 10.8 percent by
5 our projections, so still a high rate of increase, but not as
6 high as the 19 percent. So you can see in past years,
7 similar effect, especially for 2023, which reduce the gross
8 costs by about the same amount, by about nine points from
9 14 percent to about five percent.

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

17 And then in PEBP, relatively level costs over the
18 next two-year period or so and then now we're seeing in '24,
19 plan year 2024, an increase in cost and while the trend
20 increase is close to ten percent, it's an increase from 51 to
21 \$55 is what we're expecting, so it's a relative per capita
22 cost. So it's -- while it's a large percentage from a dollar
23 basis, it's still -- it's still low single figures. And,
24 again, about half of that is due to the change in the annual
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1 benefit that was -- that went into effect for this year.

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

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

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

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

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

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

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

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

18 So now let's -- let's move to the next one, which
19 is page eight of our materials. And the -- the teal line
20 that moves around more and looks like a sign graph is PEBP --
21 is PEBP trend. So PEBP trend in plan year 2020 was negative
22 and that was when there was -- when -- that was during COVID
23 when people were not seeking care, especially routine care,
24 like they had in previous years, and jumped up to 14.9, like
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1 we saw, like we reported a couple of slides ago for the
2 bounce-back and then dropped back down to lower levels.

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

11 Pharmacy is a different story, same colors and
12 same -- PEBP is the -- is the teal line for claims costs and
13 you can see we're projecting that claims costs will continue
14 to increase at a high rate. 14.3 was the actual trend in
15 plan year '23. And then we're expecting that to be almost
16 20 percent in '24 but reduced by rebates and that's the --
17 that's the lower -- lower purple. Thank you. Thank you. I
18 am slightly colorblind when it comes to shades. So don't ask
19 me about different shades of green or purple. I'm a little
20 handicap there.

21 So the 5.1 is the -- just to orient us here is
22 the net of rebates, and we're expecting that to be
23 10.8 percent. And then you can see that the industry has
24 been for 2021 and 2022 pretty good at projecting what costs
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1 would be. That's why those lines are so close together.

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

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

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

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1 direction.

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

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

18 So for example, the Center of Excellence network
19 as that's -- as that goes into effect for the next plan year,
20 we're making an adjustment for the anticipated impact of that
21 coming online, same for the oncology concierge program and --
22 and then we add administrative fees so that the medical,
23 pharmacy, dental fees, any other applicable fees that
24 Ms. Glover mentioned. And then we develop those rates by
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1 coverage tier and by plan rate, using the established
2 methodology that the Board has approved and directed to be
3 utilized.

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

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

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

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

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

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

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

23 Because what I understand is somebody thinks
24 something is better, so you get a migration here, but then it
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1 affects those costs and that forecasting going forward and so
2 it becomes even more difficult when you put three plans in
3 the mix. It compounds the issue, so our forecasting ability
4 is limited with the three plans. It could be much more
5 streamlining to -- I'm summarizing. I'm going to look at the
6 Segal Group and Ms. Glover to help me through some of this,
7 but I just want to put this on the table before we start
8 discussion, so the possibility of going from three back to
9 two.

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

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

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

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

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

23 MS. GLOVER: This is Celestena Glover for the
24 record. Going off with what Chair Robb has just said,
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1 internally, we've already started some discussions, very
2 preliminary. I talked a little bit to Richard in a meeting.
3 What are our options? What can we do? And this was
4 predicated on the comments that were made regarding how we
5 apply the employer contributions, what is the best way to do
6 that? Is it a percent so that the lower paid employees are
7 not as affected by rate increases while still making sure
8 that, you know, we are funded the way we need to be in order
9 to make this plan work.

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

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

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

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

21 Then it's the cost of the plan. So we have the
22 plans rated according to trend, experience. Everything that
23 Mr. Ward has explained in his report, that has been
24 considered in every year that we've done any type of rating
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1 to set our premium and our employer cost.

2 When I look back, I look back at 2013, and our
3 plan rates premiums to the employee have been relatively flat
4 since 2013. So we've been in that 30, 35 dollar range to 45,
5 46 dollar range for a single person on the CDHP for quite a
6 long time, and part of that is because we did use excess
7 reserves when we needed to to keep rates flat.

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

23 There is proposal for mitigating the increase, so
24 there would still be rate increases but not to the degree
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1 that we're seeing in the rate tables. That is going to go
2 against catastrophic reserves, which we can use for rate
3 stabilization. A part of the purpose of catastrophic is to
4 offset the cost of those high dollar claims, whether it's in
5 medical, pharmacy, wherever it might be that as was stated
6 earlier is not anticipated, that we can't really project.

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

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

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

23 CHAIRMAN ROBB: Richard, do you have anything
24 further then from what I said and what Ms. Glover stated, is
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1 there anything I missed upon that needs to be clarified? Did
2 I miss anything during my statement?

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

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

16 CHAIRMAN ROBB: Thank you for talking about the
17 migration between plans. I know even sitting in the position
18 I sit in currently, I have confusion with the three plans.
19 I'm not gonna say I don't, and I think 99 percent of our
20 participants have confusion between plans and that causes
21 some of that migration because we have the three options.
22 And two of the options sometimes causes more confusion, and I
23 want to have options, but I do believe that the three options
24 confuses me even more than if there was just two. And so I
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1 just want to state that. And we will start with Vice Chair
2 Kelley and questions or comments.

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

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

24 I have a lot of questions about trend. So before
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1 I go on, if anybody else wanted to respond to -- I don't know
2 if we want to structure this in some way or just a free for
3 all. So I'm looking to you, Chair Robb, how you would like
4 to handle this.

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

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

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

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

24 MEMBER AIELLO: Okay. Not changes in medical
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1 science?

2 MS. GLOVER: Not necessarily treatment.

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

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

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

22 MR. WARD: May I comment?

23 CHAIRMAN ROBB: Yes, please.

24 MR. WARD: Richard Ward for the record. In
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1 reviewing the top 20 high cost claimants for each of the last
2 two years, more than half of those 20 are what we would
3 consider episodic.

4 MEMBER AIELLO: Okay.

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

11 MEMBER AIELLO: Thank you.

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

14 MS. BITTLESTON: I have a question. Leslie
15 Bittleston for the record. A couple of -- I guess I have two
16 questions. The pharmacy trend seems to be extremely high,
17 and I'm not sure if this is an Express Scripts question or a
18 Segal question. But, you know, it doesn't seem like
19 \$2,000,000 in diet medication would account for all of that.
20 I guess that's one question.

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

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

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

17 We took as many steps as we could internally to
18 introduce programs that would help save the program money, as
19 well as the members. So I think that combination is how we
20 ended up in that area. So we're saying we need, you know,
21 \$100 and they're saying no, we think you really only need 90,
22 and it's because they're looking at what historically has
23 happened, and we're trying to project forward. We're saying
24 this item is going to cost \$10 and based on the information
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1 we have and what we expect. And they're saying, no, we think
2 it's \$9. And so they're likely to do that in the future if
3 they feel like what we're bringing to them is not reasonable.

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

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

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

16 MS. GLOVER: Exactly.

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

21 MS. GLOVER: That's correct.

22 MS. STRASBURG: This is Betsy Strasburg. I also
23 noticed that the budget office has the same percentage for
24 year one and year two. Is that something that can be
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1 addressed during the budget process given that fluctuations
2 are happening more often than before?

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

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14 | CHAIRMAN ROBB: Go ahead.

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

23 I think we are hearing from the public that our
24 services are not competing with the costs, and that is very
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1 concerning to me because we continue to raise prices and
2 they're not getting the services that they need.

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

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

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

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

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

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

9 MR. WARD: Yeah. You -- sorry.

10 MEMBER CAUGHRON: Go ahead.

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

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

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

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

8 CHAIRMAN ROBB: Yeah.

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

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

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

23 MEMBER KELLEY: Thanks, Chair Robb. So I have
24 some specific questions around the trend that I'm hoping
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1 Mr. Ward might be able to help with. Firstly, and maybe I'll
2 just give you my questions so that we don't have to go back
3 and forth on the video because I know that can be kind of
4 distracting, and I apologize for being on video today.

5 Okay. So the first question I've asked before
6 and I think, you know, when I'm looking at the -- you know,
7 the breakdown of medical, pharmacy and dental, 6.1, you know,
8 4.0, 19.2, 9.4, I would like to know of 100 percent of those
9 three trends, how much money we're talking about. And then
10 for PEBP, and I'm talking specifically for PEBP, so of
11 medical, dental, pharmacy, how much is our spend say
12 annually? And then what portion of, if you think of that
13 spend as a pie, what portion is medical? What portion is
14 pharmacy? And what portion is dental?

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

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

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

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

17 MR. WARD: Uh-huh.

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

21 And then, let's see, special -- actually, I have
22 a question about the rebates because, obviously, our costs
23 are 19 -- our trend is 19 percent before rebates but comes
24 down significantly after rebates are applied, and I'm gonna
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1 show my ignorance here and ask you to do a Dummy's 101 on
2 what exactly the rebates are and how they work for the plan.

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

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

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

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

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

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

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

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

21 Going to the first question, which is the split
22 of costs by medical, pharmacy and dental, I'm going to use
23 round figures here of a 270,000,000 dollar annual spend.
24 About 190,000,000 is for medical. About 60,000,000 is for
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1 pharmacy, and about 20,000,000 for dental. So with a four
2 percent trend on 190,000,000, I'm going to make the math easy
3 here, at least for myself. It's just shy of an 8,000,000
4 dollar increase.

5 For pharmacy, about a 20 percent trend on
6 60,000,000 is about 12,000,000. And then on dental, it's
7 9.4, let's say that's ten, so 20,000,000 translates to about
8 a 2,000,000 dollar increase.

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

20 Then for rebates, there are, for brand name drugs
21 and for specialty drugs, the drug manufacturers will provide
22 a rebate for specific medications to offset the costs. So
23 you can think about it along these lines, if there is -- if a
24 drug costs -- let's say a month's supply costs \$2,000, there
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1 might be a 500 dollar rebate that is paid, that is provided
2 by the manufacturer to offset the cost of that drug, and
3 Express Scripts and every other PBM in the industry
4 negotiates those terms with each of the manufacturers, and
5 that is incorporated into the development of their
6 formularies and -- and how those are instructed.

7 PEBP has an agreement in the contract with
8 Express Scripts, which we renegotiate every year to ensure
9 that it remains competitive, has a minimum rebate guarantee
10 per brand drug. And the current -- for the current contract
11 for -- for the current contract, those guarantees are for
12 a -- for specialty medications, they are about \$2,600 per
13 script. So for every specialty medication that's filled,
14 Express Scripts is guaranteeing that PEBP is going to receive
15 \$2,600 in a rebate to offset the cost.

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

21 For nonspecialty, they're at lower levels for a
22 30-day prescription at retail, it's about \$300, and then it's
23 about \$900 for 90-day, either 90-day at retail or mail order,
24 and that's for nonspecialty.

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

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

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

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

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

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

12 MS. COHEN: Utilization patients.

13 MR. WARD: Is this in the Board packet?

14 MS. COHEN: Yes, page 32.

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

19 And so you see a lot of oncology medications in
20 the top ten or 20, specialty, in the list of specialty
21 medications or classes that are used and then inflammatories.
22 And then you'll also see things if in rare instances, if
23 someone, for example, is -- is -- if someone has, what's the,
24 hemophiliac, thank you. If someone is a hemophiliac and has
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1 -- the treatment for hemophilia is very expensive, and so you
2 may or may not have any or more than one or two members that
3 need that treatment. But when you do, you'll often see just
4 that one or two prescription rise into the top 20 from a cost
5 perspective because it's such a high cost treatment.

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

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

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

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

24 MEMBER BITTLESTON: Okay.
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1 CHAIRMAN ROBB: Are future decisions to be made
2 after Executive Officer Glover and Segal will give more
3 information and more information to help with that decision
4 making. Yes.

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

17 MR. WARD: Richard Ward for the record.

18 MEMBER AIELLO: You don't want to comment.

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

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1 MEMBER AIELLO: Yeah.

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

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

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

20 MR. WARD: Right.

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

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

4 MEMBER AIELLO: If they're more compliant.

5 MR. WARD: Correct.

6 MEMBER AIELLO: Yeah.

7 MR. WARD: So that will increase pharmacy costs.

8 MEMBER AIELLO: That makes sense.

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

10 MEMBER AIELLO: That's a good --

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

13 CHAIRMAN ROBB: Okay. Go ahead.

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

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

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

20 CHAIRMAN ROBB: Before we have any further
21 discussion, I'm going to ask Executive Officer Glover.
22 There's multiple options on the table and then we can have
23 further discussion, and none of the options are going to be
24 good. They're not going to feel good. It's going to be
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1 difficult. But we sit on the Board to make difficult
2 decisions. That's our job. But there's probably a good
3 decision, a semi-good decision or poor decision to be made
4 right now. And I want your input as to the best path forward
5 out of all of the options what -- knowing what our reserves
6 are, knowing what our catastrophic claims are, knowing -- you
7 have more information than anybody. So I would like some
8 guidance, and then we can have further discussion upon what
9 your guidance is.

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

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

21 Then I put together a premium comparison table,
22 and so this is the employees portion of the premium comparing
23 2024 to what we're looking at in plan year 2025 and then what
24 the difference is. So if you look at the CDHP for
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1 participant only, it was 46.96, their portion. We're looking
2 at 63.56. The difference is \$16.60, and then it compares all
3 the plans and tiers accordingly. So that is just more of the
4 picture of what those premiums look like. If we just take
5 the rates as they are calculated currently without making any
6 adjustments, that's what it would look like.

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

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

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

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

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

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

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

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

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

11 MS. GLOVER: Yes.

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

17 MS. GLOVER: So this is Celestena Glover. So in
18 the catastrophic reserve we have, this year it's 42,000,000.
19 I believe it goes up to 48,000,000 in the future plan year.
20 This cost is going to be about seven and a half million based
21 on projected enrollment in the plans and tiers. You know,
22 that projection is fluid because we don't know if people are
23 going to change plans or bring dependents onto the plan or
24 things like that, new hires, people moving into retirement,
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1 whatever it is. So this is based on projected enrollment, so
2 this is a moving number. This is our best -- the best we can
3 come up with the information that we have today to say this
4 is where we think we are. It is going to come from
5 catastrophic reserve.

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

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

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

19 CHAIRMAN ROBB: Okay. Vice Chair Kelley.

20 MEMBER KELLEY: Michelle Kelley for the record.
21 I just want to put on record, thank you, Executive Officer
22 Glover, and, staff, for exploring these kind of -- you know,
23 the way we -- the Board can choose to subsidize our
24 employees. I think I am supportive of your recommended rate
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1 mitigation measure which was the 50 percent. And I agree
2 with you, that, you know, whenever I look at these things,
3 I'm looking at how to explain to employees what we're doing.
4 But then for future Board members, when we look back, how do
5 we explain or how do they see and understand what we did.

6 And I think that the 2025 solution, which is the
7 50 percent mitigation of the state premium does that. It's
8 easy to explain. I appreciate you saying it's also easier to
9 implement because obviously we -- you know, where if
10 possible, we want to make this easy to audit and to, you
11 know, for the technical adjustments you talked about. So I'm
12 supportive of the 50 percent premium, and I appreciate all of
13 the work you guys did on this.

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

24 MS. GLOVER: This is Celestena Glover for the
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1 record. I did not bring that information with me for this
2 Board meeting, but I can bring it to a future one. We do
3 know that some individuals are using their HRA's. And you
4 are correct, we are funded by the legislature for plan year
5 2025. I can't, off the top of my head, remember what those
6 dollar amounts are. But, yes, we put in our newsletters and
7 e-mails and such to let the people know the monies are out
8 there. But for those plans that typically don't receive HRA
9 money, that's probably a foreign language to a lot of them.
10 So we keep trying to put the information out for members to
11 access those funds as they become available. So we'll
12 continue to do that, and we can bring you something back at
13 the next Board meeting.

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

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

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

2 MEMBER KELLEY: Michelle Kelley for the record.

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

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

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

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

24 MEMBER STRASBURG: Premium mitigation.
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1 MEMBER BITTLESTON: Oh, 50 percent premium
2 mitigation option.

3 MEMBER KELLEY: Michelle Kelley for the record.
4 Second.

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

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

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

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

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

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

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

6 With that, I'll take any questions.

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

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

14 CHAIRMAN ROBB: And we have a motion?

15 MEMBER STRASBURG: Second. Bepsy Strasburg.

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

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

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

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

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

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

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

23 Once the person decides that they want to file an
24 appeal, there is guidance and timeline. So level one claims
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1 appeals, that goes to, in this case, UMR, they're our TPA,
2 they will go back and gather the data, do the research, make
3 the determination on whether their process was correct or the
4 member's process was correct or maybe some combination and
5 then take action accordingly.

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

19 And then in some cases, if they still don't like
20 that decision, they can go to an external review. So that
21 review is done outside of our agency and outside of UMR, and
22 we have a third party look and it's at PEBP's cost. The
23 member pays nothing for those external reviews. So they can
24 go outside and say, okay, they'll gather all the records,
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1 look at medical records, whatever it is -- whatever
2 information they need, and they will make a determination on
3 whether or not we should have covered it or not.

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

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

16 In other areas, what we look at is what is the
17 intent of the plan? What do the documents say? What are our
18 requirements legally and otherwise? And we try to determine
19 where our documents are clear enough or did the circumstances
20 in that particular situation warrant an exception be granted?
21 We do not grant a lot of exceptions. We do grant them in
22 very specific cases. When we look at everything, the
23 research is done, I go back and look at all the research that
24 has been done, typically by our QC team and make a
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1 determination at that point that, yes, the situation warrants
2 an exception, and then I will do so.

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

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

23 With that, I'll take any questions.

24 CHAIRMAN ROBB: Any questions? Go ahead.
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1 MEMBER AIELLO: This is Betsy Aiello for the
2 record. So we had a public at the beginning, public comment
3 regarding a request for exception. It's my understanding
4 that someone probably would have explained to us what was
5 just explained to us as a Board to the public that was
6 requesting the exception so they understood some of those
7 limitations or do you not because sometimes that might help
8 the outcome.

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

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

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

23 MS. GLOVER: Yes, and it likely was. One of the
24 things we are doing, especially in a more difficult situation
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1 or when trying to explain it in a letter isn't ideal or isn't
2 clear is to make a phone call to that individual and let them
3 know the letter is coming and the outcome of that request so
4 that they maybe can ask more questions, and hopefully staff
5 can clarify the reasons behind the decision.

6 CHAIRMAN ROBB: Thank you.

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

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

17 If it's something else, like we've had people
18 request exceptions for being allowed to bring a spouse on the
19 plan when they missed their deadlines for getting the
20 documentation or even letting us know they got married in the
21 first place, we have a 60-day window for that. So sometimes,
22 you know, it's pretty clear, we set a time frame and
23 documentation required. And then somebody said, well, I got
24 married six months ago. Can my spouse get on the plan? And
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1 without some qualifying life event that would qualify that to
2 happen outside of that 60-day window, in those cases, those
3 kind of exceptions typically aren't granted. There has to be
4 something real specific for us to go there.

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

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

17 CHAIRMAN ROBB: Vice Chair Kelley.

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

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

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

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

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

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

19 So I'm kind of interested in, you know, the
20 essence of continual unproven. When do you -- does PEBP
21 staff kind of review these appeals in aggregate, kind of a
22 few times a year to see if there's any learnings on improve
23 the plan document or change the procedure to cut down on a
24 particular issue. Like if there's trends coming out through
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1 these appeals, that's for stage one and two. And then
2 specifically for stage three, I'm surprised that 30 percent
3 overturn rate. And so I'm wondering what kind of supporting
4 documentation or explanation, I guess, does the external
5 review body give to PEBP to kind of justify that 30 percent
6 review. And then once again for continual improvement, what
7 do you do with that information?

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

18 Recently myself and our legal counsel have been
19 looking at our master plan documents to determine, can they
20 be formatted in a different manner? And where can we make
21 the language more clear so it's easier for people to navigate
22 through the documents and understand what is allowed and what
23 isn't? And that is driven by when we get -- when we hear
24 public comment, when we get level one and two appeals,
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1 external reviews, all of the different processes, including
2 request for an exception to a plan rule, do we need to change
3 the plan rules? Is that something we bring back to the Board
4 for future plan year. So, yes, we do look at all of that to
5 make a determination.

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

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

23 In Carson City?

24 MR. ERVIN: Kent Ervin, Nevada faculty Alliance.
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1 So thank you for mitigating employee premium increases. No
2 increase for employees is ideal, but we appreciate that you
3 soften the blow today. We will continue to advocate with the
4 legislature for stable benefits and stable employee premiums.

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

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

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

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1 Next, the Executive Officer Report indicated that
2 the quality control officer position is vacant. That's a
3 very important position for PEBP. It's specified in statute
4 287.026. Director of the department of administration, Chair
5 Robb, appoints the QCO, and he finds their duties with the
6 concurrence of the Board, so that's different than the other
7 executive staff at PEBP.

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

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

23 Finally, please excuse my skepticism about
24 midyear projections of reserves. We have a dozen year
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1 history of projections being way off, mostly leading to
2 excess reserves or this could be the year when that reverses,
3 but we won't know until the close of the fiscal year. So
4 thank you for the opportunity to comment.

5 CHAIRMAN ROBB: Okay, thank you.

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

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

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

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

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

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

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

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

19 In conclusion, I would like to welcome Director
20 Robb's suggestion that it might be possible to look to an
21 income percentage tiered premium scale. The Nevada Faculty
22 Alliance has looked into this. I would refer the Board to a
23 report that I made to the Nevada Board of Regents in January
24 of 2019, which examined higher education plans. And I
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1 pointed out the University of New Mexico plan has a tiered
2 premium scale, which is different than the university systems
3 of other states. It's fairly high cost for the high income
4 employees, but it's very low cost for the low income
5 employees.

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

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

23 If we could get the 93 percent contribution, that
24 would provide -- that would more than take care of the rate
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1 increases that you voted on today, plus supply about four to
2 \$5,000,000 extra into PEBP's budget to take care of medical
3 inflation over the next biennium.

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

11 CHAIRMAN ROBB: Okay, thank you.

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

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

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

3
4 I, KATHY JACKSON, Official Court Reporter for the
5 State of Nevada, Public Employees' Benefits Program Board, do
6 hereby certify:

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

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

14

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

17

18

19

20 KATHY JACKSON, CCR
Nevada CCR #402

21

22

23

24

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ZOOM/TELEPHONIC MEETING NOTICE AND AGENDA**

March 28, 2024

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