In The Matter Of:

PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

December 5, 2022

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

ZOOM/TELEPHONIC MEETING NOTICE AND AGENDA

MONDAY, DECEMBER 5, 2022

CARSON CITY AND LAS VEGAS, NEVADA

The Board:	LAURA FREED - Chair JIM BARNES - Vice Chair LINDA FOX - Member LESLIE BITTLESTON - Member APRIL CAUGHRON - Member TOM VERDUCCI - Member MICHELLE KELLEY - Member BETSY AIELLO - Member JANELLE WOODWARD - Member JENNIFER MCCLENDON - Member
For the Board:	RADHIKA KUNNEL Deputy Attorney General
For Staff:	LAURA RICH Executive Officer WENDI LUNZ Executive Assistant CARI EATON Chief Financial Officer TIM LINDLEY Quality Control Officer NIK PROPER Operations Officer
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MONDAY, DECEMBER 5, 2022, CARSON CITY, NEVADA

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CHAIRWOMAN FREED: Staff, would you please call the role.

MS. LUNZ: Laura Freed.

CHAIRWOMAN FREED: Oh, wow. So we're like a ten second lag on YouTube.

MR. HOPKINS: We're live on YouTube now.

CHAIRWOMAN FREED: Do you want me to start over?

MR. HOPKINS: Yes, Madam Chair, we're live on YouTube now.

CHAIRWOMAN FREED: All right, great. It's 9:00 o'clock, 9:01. I'll call the PEBP Board meeting for December 5th, 2022 to order.

Wendy, once again would you like to take the roll.

MS. LUNZ: Laura Freed?

CHAIRWOMAN FREED: Present.

MS. LUNZ: Linda Fox?

MEMBER FOX: Fox here.

MS. LUNZ: Betsy Aiello?

MEMBER AIELLO: Present.

MS. LUNZ: Jim Barnes?

VICE CHAIR BARNES: Here.

MS. LUNZ: April Caughron?

MEMBER CAUGHRON: Present.

MS. LUNZ: Leslie Bittleston?

MEMBER BITTLESTON: Present.

MS. LUNZ: Jennifer McClendon?

MEMBER MCCLENDON: Present.

CHAIRWOMAN FREED: Tom Verducci?

MEMBER VERDUCCI: Here.

CHAIRWOMAN FREED: Janelle Woodward?

MEMBER WOODWARD: Here.

CHAIRWOMAN FREED: Michelle Kelley?

MEMBER KELLEY: Here.

MS. LUNZ: We have a quorum.

CHAIRWOMAN FREED: Okay, thank you.

Okay. Agenda Item 2 is public comment. I -- if there is any public comment in the room, I will take that first. Okay. Seeing none, I think I'll hand it off to Tyler for on-line public comment. Thank you.

MR. HOPKINS: As a reminder, Zoom is used for public comment only. This meeting is streaming live on YouTube. If you wish to just listen to the Board meeting agenda or if you want to listen just to the Board meeting, the YouTube link is located on the agenda.

For those who have joined for public comment,

your name or last four digits of the phone number will be announced. You'll be advised you have been unmuted. As a remainder for those on the phone, please press star six to unmute. Please slowly state and spell your name for the record and proceed with your comments. Due to time considerations, each caller will be limited to three minutes.

Will Brooke Maylath, you have permission to speak if you wish to make public comment.

MS. MAYLATH: Good morning. For both the PEBP Board and the members of the, in the audience, you probably are aware that, I, Brooke Maylath, have been cautioning the PEBP Board to drop any sort of exclusionary language about servicing medically necessary, you know, procedures and treatments for transgender people over many many years. I mean, this goes back almost ten years that I've been cautioning.

Most recently the issues have been about coverage of medically necessary gender affirming procedures in coverage. The lack of which did result in a legal complaint through the Nevada Equal Rights Commission and the EEOC, and the PEBP Board having to end up covering facial feminization surgery and paying settlement costs, legal expenses out-of-pocket for $45,000, $45,000 of public money going to legal expenses that are, external legal expenses I should say

for the plaintiff that did not go for any sort of true medical coverage.

You know, this is equal parts of sadness and infuriation. Still before us is the fact that there is a gatekeeping mechanism on the simple access for gender affirming medication, primarily hormone therapy. It is discriminatory, at its very basis to have a behavioral health component to be able to access hormone therapy for transgender people than it is for SIS general people.

As long as this is there in writing and in practice, this is a discriminatory action and can and will lead to legal actions that you'll end up on the losing side again. Please make this change. Remove that gatekeeping mental health diagnostic requirement. You know, it is against the law, both Nevada statute and federal statute. Save the money. Make the changes. It's -- it's no harm off of you. Please stop the discrimination. With that, I'll close my comments. Thank you.

CHAIRWOMAN FREED: Thank you.

MR. HOPKINS: Thank you.

Kent Ervin, you have been unmuted. Please unmute your mic if you wish to give public comment. And please slowly state and spell your name for the record.

MR. ERVIN: This is Kent Ervin, K-e-n-t

E-r-v-i-n. I'm the State president of the Nevada Faculty Alliance, the Independent Association of Factually at NC colleges and universities. We work to empower our faculty members to be fully engaged in our mission to help students succeed.

I have a couple of comments today, mainly first on the plan design discussion. The first six items in the plan design discussion indicate a savings of between 3.3 million and 5.1 million. That's a net savings to PEBP and participants. And so all of those, you know, the Board finds those, at least the base services to be valuable should be covered and that provides extra funds to cover other things.

The next item is raising the dental maximum. This is long overdue. The dental maximum has been stuck at one value for years while, actually decades, while the cost of dental services have gone up by a factor of three or more.

And so the modest step of increasing the dental maximum to $2,000 for just $750,000 or so ought to be covered and is well within the savings that are projected for items one through six, even if those are inflated savings estimates.

The next priorities of those savings should be to keep the premiums stable, at least at current levels but preferably bring the premiums, the employee premiums back

down to pre-pandemic levels.

And then of the options presented by staff to give out, to return excess reserves to the participants who earn them by way of higher premiums and lower benefits and higher out-of-pocket costs that were instituted during the pandemic, as well as possibly pandemic suppression of claims. It seems to offset the most fair way to do that is through the health reimbursement arrangement mechanism because it is available to all of the participants in the self-funded plans which created these excess reserves, and we're taking about the nine point some million in excess reserves that were generated as of last year, the end of the fiscal year, not the continuing one that are being used over several years.

But the HRA mechanism of giving this back is the -- a way to give it back as soon as possible to the people who actually suffered. It's available to everyone in the self-funded plans that would include active employees except for the HMO and retirees on the self-funded plans.

And secondarily, the HRA, because it follows IRS rules would, the funds would go to legitimate health care expenses of the needs of participants, not on what could be considered luxury items which are included in the list of the other option which is the lifestyle savings account. Also, the lifestyle saving account has extra administrative costs

that you wouldn't have with the HRA.

So I believe the preferred method of returning excess reserves, meaning excess charges to participants is the HRA mechanism.

Then finally I want to comment on the employees' survey. It's not a surprise that when you ask employees what features of the plan are most important personally to them which was the question that they list premiums and they list deductibles and out-of-pocket costs because those are the things that the great majority of participants see. But PEBP is an insurance program. The whole point is to pool assets.

CHAIRWOMAN FREED: Mr. Ervin, I'm going to ask you to wrap your comments up, please.

MR. ERVIN: Okay. So it's not a surprise that things that affect small numbers of people, like long-term disability insurance and chronic conditions naturally get lower ratings when you ask the question that way. Thank you very much.

CHAIRWOMAN FREED: Thank you.

MR. HOPKINS: Thank you. Will Diane Emm please unmute your microphone if you wish to make public comment. We'll come back to you afterwards.

Will the caller John SF46 please unmute your mic if you wish to make public comment.

Julie K., please unmute your mic if you wish to make public comment. You have permission to speak.

Steven H., please unmute your mic. You have permission to speak if you wish to make public comment.

Brenda Peters, please unmute your mic. You have permission to speak if you wish to make public comment.

This is a reminder, there will be a second public comment at the end of the Board meeting for those who have technical issues and still wish to make public comment.

Madam Chair, that concludes public comment.

CHAIRWOMAN FREED: Okay, thank you. You took the words right out of my mouth. There will be a second public comment at the end of the business agenda.

Okay. Agenda Item 3, PEBP Board disclosures for any applicable Board meeting agenda items. I'll throw it to the deputy attorney general.

MS. KUNNEL: Thank you, Madam Chair. Good morning. This agenda is to allow me to make a disclosure regarding conflicts of interests on behalf of the Board Members who are eligible for PEBP benefits. First NRS 281A.420, on behalf of the Board Members who are eligible for PEBP benefits or whose families are eligible for PEBP benefits, I offer this disclosure, that they will be voting on those items that may affect the benefits available to them

or their family members.

The law does not require abstention from voting merely because the Board Member or their family member is eligible for PEBP benefits. At this time, I invite any Member of the Board who has any additional disclosure to make it now.

CHAIRWOMAN FREED: Okay, thank you. Hearing none, I will move on for Agenda Item 4, consent agenda. It's smaller than our usual consent actually.

Board Members, does anybody want to pull the action minutes from September 29th or in the Claim Technologies' audit for HealthSCOPE from July 21st through June 30th, '22.

MEMBER VERDUCCI: Tom Verducci for the record.

CHAIRWOMAN FREED: Uh-huh.

MEMBER VERDUCCI: Is the section 4.2 going to be covered in the separate agenda item, Item Number 6?

CHAIRWOMAN FREED: So Agenda Item 6 is CTI's audit of HealthSCOPE for April 1st of '22 to June 30th of '22, so there's a little bit of overlap but not a lot of overlap there.

MEMBER VERDUCCI: So --

CHAIRWOMAN FREED: And this is the health -- 4.2 is HRA so I'm assuming they are, in fact, different audits.

MEMBER VERDUCCI: Okay, thank you. I'm not going to pull either one of those items.

CHAIRWOMAN FREED: So since nobody wants to pull 4.1 or 4.2, I will accept a motion to approve the consent agenda items.

MEMBER BITTLESTON: This is Leslie Bittleston, so moved.

CHAIRWOMAN FREED: Okay. Thank you.

So we have a motion from Member Bittleston. Second from Member Kelley. All in favor say aye.

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

CHAIRWOMAN FREED: Any opposed? Motion carries. Thanks.

Okay. Moving on to the Executive Officer Report, which is an informational item.

MS. RICH: Good morning. Laura Rich for the record. The Executive Officer Report, there's just a few staffing updates and things about just operational updates here.

First of all, staffing update, our levels continue to fluctuate, MSU member services unit where, that's where turn over is the most frequent. It is also the most impactful to members because you've got that -- that group of

people who are answering the phones and answering questions when members do call in, inquiries relating to eligibility and things like that. They are also directing them to the right vendors for any kind of claims informations.

So the staffing shortages really do affect the -- our ability to provide accurate and throw customer service to members. Right now our vacancy rate is about 27 percent. That's pretty much in line with I think the rest of the state right now. You know, it's up and down, depending on the day, but it is -- it's very challenging.

I know that I've had, you know, some of the advocacy groups reach out to me and typically we have done a lot of, you know, we address their questions. We address their -- their issues that they bring to us on a case by case basis, and so we do provide that concierge level services of those advocacy groups. I had to cut that off. Unfortunately we just can't keep up. Everybody has to go through the same channel unfortunately.

We just don't have the manpower. We've got a lot going on with not a lot of manpower. And so I apologize for that. I know that those that, you know, I have had those conversations with and understand but it's -- it's what we're dealing with right now. And until -- until these staffing challenges can be addressed on a State level, you know, I

don't see this changing much.

But I know internally staff is working really really hard and doing their best to keep up with -- with the workload and, you know, doing their best to train new staff and bring on as many new people as we can. But it is definitely impacting not just at PEBP but at every level of State government our ability to meet our mission.

Office move update, so we are continuing to make progress towards a -- I do have an update on this one, not so much February 1st. I know that was pretty optimistic. February 1st potential move date. That's now at the earliest, some time in the middle of February.

CHAIRWOMAN FREED: Okay.

MS. RICH: You know, there's some supply chain issue, labor shortages, things like that. We need to, you know, get a lot of things in place before we can actually move in. IT is the main one. And without having the ability to have internet connections, we cannot get into that building. So there's a lot of things going on there.

But we do anticipate that the lease agreement is going to be considered at the board of examiner's meeting in January, crossing my fingers. That's still not 100 percent but we're moving towards that.

Once we get BOE approval then that actual move

date will be very dependent on that IT equipment installation and vendor availability and things like that. So we are optimistic we will be moving some time soon and that it won't be very disruptive in terms of, you know, legislative session and things like that starting. I have said that if this does not happen by March, it won't happen. By the month of March it won't happen because not until after the summer because of open enrollment and things like that.

Budget updates, so the -- the impact of the November election on the budget is yet to be determined. We don't know much of anything yet. There's still -- there's a transition team that has been put in place. But as far as the details around that, we don't know but really nothing changes. The timeline to deliver the Governor's recommended budget doesn't change and agency budgets will likely be the first thing on the priorities of the new administration, so we will continue to advocate on behalf of its members as we -- of our members as we, you know, work with this new administration and the transition team.

Just a quick update on the interim retirement and benefits committee, that's IRBC. It has been scheduled for December 14th at 10:00 a.m. with PEBP presenting first on the agenda, so.

CHAIRWOMAN FREED: Yay.

MS. RICH: We will be down in Vegas presenting at that committee meeting. It is NRS 287.0425 is basically the series of reports that are required statutorily for PEBP to present. Really, it's -- it's nothing new to this group of folks. It's all plan year '22 related things that we're presenting. Although, the last couple of years what I've done and I think has been very helpful is after, which is usually the November Board meeting, but it's a December 5th Board meeting today, I will put together a quick report and provide it as an addendum to the IRBC, just so that that committee is aware of what is going on and has the ability to weigh in on -- on matters on PEBP matters, you know, in a proactive way rather than a reactive way.

Again, legislative reminder, I just wanted to remind the group that we are going to be scheduling more interim meetings in addition to our normal Board meetings during legislative session. This is really when we're going to bring up legislation that affects PEBP. And it gives the PEBP Board the ability to weigh in on this legislation.

We still don't have a lot of -- there's no language out there but we are -- I can't remember what the number is now, but we are well over 100 in BDR's that we bill draft requests that we are tracking as of right now. So I'm hoping that dwindles once the language comes out. But I have

a feeling that this legislative session is going to be very very busy for anybody in the health care arena.

So we will begin scheduling those meetings shortly, probably, you know, in the month of January and just getting something on the calendar. Hopefully those meetings are short and sweet. But depending on how much legislation is out there, we may be meeting a lot more in the next six months.

So I will stop there for any questions.

MEMBER VERDUCCI: Tom Verducci for the record. You know, I want to thank the PEBP staff for all of the work you're doing and participants for being patient. I know that whenever I've been behind in what I'm doing, it's a very difficult task and certainly goes appreciated.

I did have a question. I notice that the budget was not in this report. It's usually in the utilization report, and I'm just wondering how we're going with the cash differential and why perhaps that report didn't show in utilization.

MS. RICH: Laura Rich for the record. So that report is generally in the quarterly reports and so you'll see that report in January. I will warn that any of the budget related items, especially early on in the year is -- it's premature, right. So right now, you know, we're --

well, we're getting into now, you know, we're almost into six months of the plan year.

You're not going to see six months of reporting. You're only going to see probably three or four. So that is -- members are still paying, picking up most of the portion, right, because they are still picking up the deductibles and the out-of-pocket expenses those first few months, and so you don't see a lot of that, the impact the first few months of the plan. You're seeing it later on.

And that's actually, Tom, why we discussed that differential cash in September because it allows the plan to run out claims and we'll have that, the ability to get a better grasp of where things are.

MEMBER VERDUCCI: Thank you very much.

CHAIRWOMAN FREED: Member Kelley, did you have a question on -- oh, okay. If nobody has any questions about the Executive Officer Report, we will move on to Agenda Item 6, Claim Technologies' audit for HealthSCOPE for April '22, through June '22, the last quarter of this last fiscal year.

MS. RICH: CTI is on Zoom.

CHAIRWOMAN FREED: Okay. So CTI is on Zoom?

MS. RICH: Yes.

CHAIRWOMAN FREED: Okay.

MS. AMATO: Can you hear me?

CHAIRWOMAN FREED: Very faintly.

MS. AMATO: Okay. Let me try and turn that up. Is that better?

CHAIRWOMAN FREED: A little bit, yeah.

MS. AMATO: Okay, sorry.

CHAIRWOMAN: You're actually very quiet.

MS. AMATO: Thank you, Madam Chair. Good morning. For the record my name is Joni, J-o-n-i- Amato, A-m-a-t-o. I would like to direct you to page three of the report, the executive summary section that's in your packet. The scope of the audit of HealthSCOPE Benefits included claims processed during the period of April 1, 2022 through June 30th of 2022.

The audit included medical, dental and health reimbursement arrangement claim processed by HealthSCOPE. The medical and dental paid claims totaled approximately $53,000,000 and 189,000 claims. And for the HRA segment, there were 8,500 claims with a total paid amount of approximately $835,000.

The audit included the following four components, an operational review and performance guarantee, validation. I should note the operation review encompassed the entire 2022 fiscal year. And electronic or 100 percent electronic screening of targeted samples which also included eligibility

screening for the entire 2022 fiscal year, a statistically balanced stratified random sample audit and finally data analytics.

In our auditor's opinion, HealthSCOPE's financial accuracy and payment accuracy decreased in the fourth quarter audit from prior audit periods. While the payment accuracy performance guarantee was met, the financial accuracy performance guarantee of 99 percent was not met. This results in a penalty of 2.5 percent of the administrative fees or $28,267.93.

While we understand the administration is now moved over to UMR, we still recommend reviewing the financial errors identified and the random sample audit to ensure that the root causes have been identified and those issues don't carryover into UMR's claim administration. In a similar fashion, we recommend review of the electronic screening and targeted sample results to focus on the most material categories identified and this includes the eligibility screening results as well.

Thank you. If you have any questions.

CHAIRWOMAN FREED: Board Members, do you have questions for Ms. Amato? Okay. Seeing none, HealthSCOPE folks, would you like to testify in response to the audit finance?

MS. HUCKABY: Good morning. This is Rhonda Huckaby with UMR formerly HealthSCOPE Benefits. And in our response to the Claims Technologies' audit for the quarter plan year 2022, I identity three -- three errors which were manual errors made by analysts.

As with each audit, we have education, continuing education. We go over the claim systems to look to see if there's any coding that we need to redo or any edits that need to be modified.

But yes, we do agree with the three errors that CTI did identify in this part.

CHAIRWOMAN FREED: I'm having trouble with my mic.

Mr. Verducci, comment or question?

MEMBER VERDUCCI: Yes. Tom Verducci for the record. So it looks like there's a penalty of $28,267. And I'm looking at the not met 98.92 percent. It almost appears it was just a nanosecond. It seems like a stiff penalty for the guarantee being so close. And it's almost like they made it and, I don't know, I just have a little bit of a hard time with that because it's so darn close and that's just my comment there.

CHAIRWOMAN FREED: Thank you.

Member Kelley.

MEMBER KELLEY: Thank you, Madam Chair. Michelle Kelley for the record. I'm just wondering, so HealthSCOPE disagrees. I guess how does your disagreement impact that accuracy percentage? Has anyone kind of re-looked at that? Did CTI look at that? Did HealthSCOPE recalculate it?

MS. HUCKABY: Sorry, this is Rhonda Huckaby with UMR again. So the original findings, we did disagree and we met with CTI and PEBP and went back through the things that they identified and they recalculated that percentage. So we agree to the three items addressed on page 14.

MEMBER KELLEY: Okay. Okay. So you do agree?

MS. HUCKABY: Yes.

MEMBER KELLEY: That you failed, kind of that particular metric.

MS. HUCKABY: Right.

MEMBER KELLEY: Okay, thank you.

CHAIRWOMAN FREED: You guys are quiet this morning. What's going on? All right then. So the action before us is to accept this audit, including the penalties. And I would accept a motion to accept the findings of the audit and HealthSCOPE's response and penalties assessed.

MEMBER KELLEY: Michelle Kelley for the record. I so move.

CHAIRWOMAN FREED: Thank you. Do I have a

second?

MEMBER CAUGHRON: April Caughron for the record. I'll second.

CHAIRWOMAN FREED: Thank you. All in favor say aye.

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

CHAIRWOMAN FREED: Any opposed? All right. Motion carries. Thank you.

Moving on to Agenda Item 7, it's the biennial compliance report.

MS. RICH: So Laura Rich for the record. NRS 287.0425 requires PEBP to conduct a biennial review of the program to determine whether our program is in compliance with federal and State laws relating to taxes and employee benefits.

The review must be conducted by an attorney who specializes in employee benefits. So PEBP enlisted the, our consulting services of Segal and their legal counsel to perform a very thorough review and assessment of the PEBP program.

So today with us we have the two representatives from Segal, Richard Ward and Amy Dunn, who I believe Amy will be presenting the -- the findings and after she is done

presenting the findings, then I'll kind of go through and talk about the PEBP response to each one. So, Amy, go for it.

MS. DUNN: Good morning. Good morning. My name is Amy Dunn with Segal and it was a pleasure to really review the documents and to interview the staff as well for PEBP to look through a variety of federal and state statutes. And in your documentation we have provided our compliance report, but I want to go ahead and give you a high level of our findings today.

Generally speaking I would say that they are in area of five different components of areas of what we've seen. First we have seen some opportunities for the PEBP staff to update the master plan documents with appropriate language and that could be anywhere from for example tweaking certain things, we're finding certain levels of language. Just to clarify, certain things again throughout the entire documentation as we see.

The second area of what we see too is the ongoing and upcoming requirements under the federal No Surprises Act and transparency laws and these are things that as we notice that we're learning throughout the law, things that are coming up into the next plan year, into the plan year 2024 with items for example of notifying individuals, giving

individuals the opportunities to access tools, to understand what prices throughout their costs of health care, that is also coming up as well.

We also find there is an area of opportunity for nondiscrimination of testing of the welfare plans. And generally under the internal revenue code and the regulation, it requires certain welfare benefits to be provided on a nondiscriminatory basis and provide tests to assure that the plans do not discriminate in favor of highly compensated or certain key employees. In certain plans that must be tested for example include section 125 plans, your flexible spending accounts, including your spending care spending account.

And there are certain things that are required with those tests. They look at for example some of the tests look at your eligibility. Some of the tests look at your benefits and contributions. For example, what is to be considered when benefits are, as well as utilization and contemplates just looking at who's actually using these benefits. And so that I think is an area of which PEBP too is more nondiscrimination testing of those plans.

The fourth area which I would say is really an area that has evolved more recently and that is in the mental health parity, an Addiction Equity Act of 2008. And generally this law requires parity between medical and

surgical benefits as well as mental health and substance use disorder benefits.

And under this law, plans are required to comply with parity with respect to both financial and quantitative treatment limitations that are notice QTL's. For example, your co-payments, co-insurance, day or visit limits, as well as non-quantitative treatment limitations or NQTL's. That ranges for example things like medical management, techniques such as prior authorization, network admission standards and failed first policies. Well, this is back again in 2008.

Fast forward to the commerce actually amended this law through the Consolidation Appropriations Act and that was signed in law in December of 2020 and the strengthening parity and mental health and substance use disorder benefits provisions, it amended this law. It requires group health plans to perform and document comparative analysis and the design and application of the non-quantitative treatment limitations, and this was actually required. It went into effect in February of 2021. So that would be our first finding is to perform these analysis.

Part two of this actually too to bring your attention, self-funded non-governmental plans are permitted to elect an exemption or an opt out from certain provisions of federal law, including the mental health parity

provisions. So PEBP should determine if it will elect to follow the federal opt out and determine its plan for performing the QTL and NQTL analysis.

And the fifth area which we would say is called excepted benefits. It's specifically under your dental program. It is our understanding that the self-funded PPO dental plan is integrated really with the medical plan. And part of that is really considered, your dental plan is part of the medical plan so much that excepted benefits are exempt from certain provisions of the Affordable Care Act, including certain marker performance specifically restrictions on annual dollar limits.

And to give you a discussion of this, for self-funded benefits, limited scope dental benefits qualify as excepted benefits and they are not an integral part of the group health plan. And part of that means that for example, participants can decline coverage that your claims for benefits are administered under a contract separate from the claims administrator.

Here, participants are not charged a separate contribution for the coverage. Participants cannot opt out of dental coverage after electing medical coverage. And that their both medical and dental benefits are both administered by the same administrator, UMR. So we believe that the

dental PPO benefit is not considered an excepted benefit.

With that said, essential health benefits under the Affordable Care Act, there is a set of ten categories of services for health insurance that must be covered under the Affordable Care Act. And one of those is actually the Federal Pediatric Dental Services. Well, under the Affordable Care Act, plans cannot have annual or lifetime maximum on essential health benefits.

And so for your dental program there is pediatric dental across the board. That there is a lifetime max or excuse me, annual maximum of $1,500. And so we wanted to bring that to your attention because then there are some options how to comply with the Affordable Care Act either to for example give individuals the opportunity to opt out of the dental program, looking at the contract with your administrator or in turn, removing the annual limit for pediatric dental services, that annual $1,500 maximum for -- for that benefit level.

So I wanted to then turn that back over -- those are the key level of findings for it. I'll turn it back over to you. Thank you.

MS. RICH: Perfect. So first of all, I would like to thank Amy and her team. This was a really good education experience for all of us I think, and it allowed

Segal to better understand our plan and what we -- what we do as our new consultants, but it also was an education piece for -- for staff as well, so very thankful for that.

This is also the first piece -- just to remind the Board, this is the first piece of the compliance review. This is where we're looking at the, specifically the federal and state laws but we are in January expecting to bring back more of the clinical side of things as well. So we are -- we're in the middle of that.

So our response to a few of these. There's two big ones here I think that Amy touched on which is the mental health piece and the excepted benefits piece. So the first one I would like to just touch on is the mental health parity and Addiction Equity Act. We did accept this finding and we do need to make some decisions as to how -- what path we want to take moving forward in order to be -- to get into compliance and be in compliance with this -- with this act.

As Amy mentioned, there are some -- there are some requirements that were added in 2021 that PEBP has not taken the steps to, you know, federal requirements, the reporting and the analysis and those pieces.

Now we do have some considerations moving forward so we can as a self-funded program, we have the ability to opt out and this allows the program to, we can still continue

following the spirit of the law, right. So we can still -- we can still offer what this is intended to offer and that's the parity.

But by opting out, we then reduce that our risk to federal audits and everything that comes with that piece, right, so we can continue to follow the spirit of the law. And we can even do all of the analysis and testing and things like that that is required to meet the -- the requirements. But by opting out we would then eliminate that risk.

The other piece, or the other option that we have is to continue by default. If you don't opt out, you opt in. So PEBP will have to complete and you can see on page two there, you can see the four -- the four requirements to -- to get back into compliance, right. So there's going to be some work that's associated with that. We'll definitely need to look at our contracts to a see if there are -- if we need some amendments to the contract so we have vendors that can perform a lot of this analysis. But that is -- so I want to stop there because I think that this is a piece that we probably need to discuss as a Board.

CHAIRWOMAN FREED: Betsy, please go ahead.

MEMBER AIELLO: Hi. This is Betsy Aiello, and I have a question. So what I think I'm hearing is that we are pretty much in compliance with that Parity Act that came in

2008. But the part that we aren't in compliance with is the 2000 -- the 2021 analysis and reporting or is it because we haven't done the analysis, we're not sure where we are with the 2008?

MS. DUNN: I'll take that. Yes, I would agree with the latter part more of what you said. I believe the testing would need to be done in order to make that evaluation.

CHAIRWOMAN FREED: This is Laura Freed. I just have a question for my own understanding. What does it look like to report to the feds on quantitative treatment limitations as opposed to non-quantitative treatment limitations?

MS. DUNN: And I'm also going to ask if on the phone is Elaina Lynette from Segal on the phone as well. She is also part of my team. She has called in I believe and I also believe may be able to answer that question as well or share some information as well.

MR. HOPKINS: Amy, what is her name again?

MS. DUNN: Elaina Lynette. Do you see her on the phone?

MR. HOPKINS: I do not.

CHAIRWOMAN FREED: I'm not seeing her on the Zoom.

MS. DUNN: It's okay. I can --

CHAIRWOMAN FREED: Okay.

MS. DUNN: -- shoot from the hip.

CHAIRWOMAN FREED: Okay. Go ahead.

MS. DUNN: The quantitative limitations is looking more along the lines for things that are actually, if you will, numbers driven, co-payments, you know the actual dollar type limits.

The other pieces of this are the non-quantitatives are more, if you will, in the design, in the language of it with medical management in looking at things that might be considered actually more written in nature versus the actual numbers in nature, if that makes sense.

MR. WARD: Richard Ward. With seeing that example for non-quantitative would be for example, prior auds or --

CHAIRWOMAN FREED: Okay.

MR. WARD: -- requirements just necessary to access as opposed to the harder dollar co-pays kind of components.

CHAIRWOMAN FREED: Okay, thank you.

Member Kelley, please.

MEMBER KELLEY: So what does an audit look like

and how often are the IRS, DOL conducting these audits? Have they started? Is there a whole team, like?

MS. DUNN: Yes, they are in fact. They -- you know, I wish Elaina were on. She could actually share with you some more information about that. But, yes, they are underway for looking at that information specifically too for in looking at that focus of the non-quantitative treatment limitations. There are, you know, certain things that they are looking for.

There is more information too that are -- there are tools that are self -- that are available on the government website, self-compliance type of tools and different type of things that they are looking for as well but, yes, they are underway.

MR. WARD: And to supplement. This is Richard Ward with Segal. They can be very extensive and invasive and take up a substantial amount of staff time and over a prolonged period of time. We have a handful of clients that have been audited or in the midst of an audit and it's the -- sometimes the experiences. The audit team will make a request. The plan staff will respond to that request, but that's not the only request.

There's -- and there's not a clear path to conclusion with some of these audits, and they can stretch

out over months and require a substantial amount of staff time to satisfy the auditors.

CHAIRWOMAN FREED: Member Aiello.

MEMBER AIELLO: So this is Betsy again. And so my understanding is any entity can comply with it. However, you know, without having to submit to the audit, a self-funded plan. You can opt out of the audit portion if you're self-funded and determine philosophically you want to comply with it.

Do you know why, and maybe not without reading the congressional background or what, why self-funded plans have the ability to opt out versus other plans, what the philosophy behind that. The self-funded wouldn't need to have these audits.

MS. DUNN: This is Amy Dunn. To be clear, its sponsors of self-funded non-federal governmental plans to be clear. So it's not all self-funded plans, just to make that clarification, okay. That's the only one. So self-funded plans in general do not have this ability. It is just for the non-federal governmental plans that have that -- have that option.

Why -- why that is for that history, we would have to see to look into that. I'm not aware what that is.

MR. WARD: This is Richard Ward with Segal. I

can comment that this law has, its predecessors has a history of providing exceptions for compliance. The original mental health parity law in the '90s had a provision that if compliance, increased cost for a plan by more than one percent of total costs then you could opt out. So that's no longer the case here with this -- with this current law. But there's been a -- commenting, there's been a precedence or history of there being opportunities for under special cases for compliant sponsors to opt out.

MEMBER AIELLO: And this is Betsy again, just responding back and forth, and I'm just thinking out loud as I'm hearing these things which maybe could be dangerous, who knows.

But my -- my thought might be just based on the size of plans, maybe that's where they're coming from because it sounds like you say this audit process could be quite extensive and take a lot of staff time just during an audit, not actually the money that it would cost to do staff time to complete this audit with entities versus the use of funds for actual care.

CHAIRWOMAN FREED: Member Bittleston, you have a question.

MEMBER BITTLESTON: Leslie Bittleston. I want to thank both of you from Segal for that high level overview. I

think I learned something today as well so thank you very much.

My question is more specific about dental. What would it look like to opt out of dental? And I guess I'm just trying to piece it together. Would it -- you know, could somebody opt out of medical and opt in with dental? Is it just going to be a separate plan or service that has its own premium? I guess I'm just trying to figure out what that looks like. If you can opt out, can you opt out of medical? What really does that look like? Dang it. Disregard until later.

MR. WARD: It's good practice.

MS. RICH: Laura Rich for the record. I actually do have one question that maybe would help and maybe you don't have this information. But are there any -- can you give us an idea of penalties or -- or, you know, anything that comes out of this audit if we were to continue to opt in, what kind of penalties do we look at as a group plan or what kind of risks are we at risk for?

MS. DUNN: And some of the information is also in section three of this -- of the report. You know, in general we can ultimately get you some further information about that as well.

CHAIRWOMAN FREED: Member Kelley.

MEMBER KELLEY: Member Kelley for the record. I'm just wondering what's involved in opting out for the mental health parity piece?

MS. DUNN: Hi. This is Amy Dunn with Segal. That's also located in section three. There is a process, a prospective process to file. There's also a notice requirement to participants as well.

MR. WARD: This is Richard Ward. May I supplement that? When you then, plan sponsors opt out, it becomes part of -- it's publicly available information.

MS. DUNN: Uh-huh.

MR. WARD: So there's a list that the federal government maintains for the public on-line plan sponsors that opt out.

MEMBER KELLEY: A follow-up question I guess for staff. So I feel like -- I feel like this is really helpful but because there's been no testing done of the Mental Parity Act, we don't really know where we sit. And I guess I'm kind of, I feel like we need more information before making a decision before to opt in or out to understand how the plan is functioning right now, right, as opposed to making a decision without that information. But I don't know how other people feel.

MS. RICH: So Laura Rich for the record. We can

still do that analysis. We can opt out and do the analysis and if it turns out that we are, you know, not, that there's areas that need improvement, we can make those improvements. We're just not subject to the federal audits and things like that. And so we can still comply with the law without having to opt into it. We can -- we can opt out. So we can still be in compliance and do all of the testing that needs to happen to ensure and to prove that the plan is in compliance but we just eliminate the federal piece of it.

MEMBER KELLEY: Just a follow-up then, Executive Officer Rich. So I guess my concern with that strategy, firstly, is have you taken a look at the requirements to opt out. And I wonder, my first part of the question is how long will that take?

My second question is really just to verbalize a fear, that is that we opt out and then all urgency goes and because it costs money and time, we don't actually do any of the testing, even though potentially the committee would like to see it. And so I kind of as a side, I'm wondering if you investigated that, but then how do you respond to kind of that fear there's always -- there's always things that come up, right. There's never time. So how will we guarantee that we actually get the testing done.

MS. RICH: And that's a good point. Laura Rich

for the record. And that's why this is agendized the way it is. It gives the Board an opportunity to spell out we want to opt out but at the same time we want staff to do X, Y, Z to ensure we come back at a later time, to come back with this information and analysis to ensure that we are in compliance, even though we're opting out. So it gives the Board that ability to, you know, to do that moving forward, so.

CHAIRWOMAN FREED: This is Laura Freed. I have a follow-up on the process. So sort of a follow-up to Member Kelley's. So we have to file with CMS before the first day of the plan year, okay. And it looks like we have to re-up every year with the feds, okay, great.

Okay. But I do not -- to your question, Member Kelley, I do not see many estimate of how long it might take CMS to opine on such an opt out request.

Okay. So it feels like everybody on the Board has exhausted their questions. Am I right about that? Oh, no, Member Aiello.

MEMBER AIELLO: Sorry. I was wondering and maybe this is not for Segal or maybe. If we follow-up and say we want to do the testing, which you should do either way, whether you opt in or opt out, you need to test because you're either going to get audited to see people comply or

you aren't going to get audited. But if you have the spirit you want to comply, you have to do the testing. Do we know actually what that testing takes? Is it something staff can do? Does it require an outside audit? Do we know the amount of costs? Have we got any idea because in my mind the testing has to be done either way. But do -- are we prepared to, sort of a follow-up to yours.

MS. RICH: Laura Rich for the record. I'm going to be honest. Staff -- with the staffing challenges that we have. We have a lot going on to begin with. So, you know, I'm just going to be honest. At adding this layer of work is not ideal. It does not mean that it is -- it's still something -- I think mental health is going to be and will continue to be a subject of focus.

I think it's in our best interest to go down this path anyway. So it's crossing my fingers that the staffing challenges will eventually improve. But, yes, it's something -- I mean, it's definitely going to take not just on staff but on our vendors, like I said, we'll have to go through. And we actually just got this finalized report not very long ago so we haven't had the opportunity to dive into what exactly all of the details are as to, you know, meeting those requirements.

But we will definitely have to enlist the help of

vendors, which may or may not require, depending on the degree of -- of analysis that needs to be done. We may have to amend a contract and add authority to that contract, et cetera, et cetera. So it's something that we do have to spend some time on figuring out what exactly this entails. But, you know, in my opinion, I think it's something we need to do regardless.

MEMBER KELLEY: Member Kelley here. Just one additional question for Segal, the audits. Can they be retroactive. So if we opted out for the next plan year, can they still come in and look at all of the years we didn't opt out and can we opt out for all of those previous years?

MS. DUNN: My understanding -- this is Amy Dunn. My understanding is the opt out is prospective but the going backward to do previous years to try to opt out is my understanding no, you cannot do that. And can they look at previous years, my understanding is yes.

MEMBER KELLEY: Thank you.

CHAIRWOMAN FREED: A bit of nervousness, that's fine. Okay, friends, I think I'll do the easy one first. Nobody seemed to have any heartburn with eliminating the annual maximum for pediatric dental. I'm sorry, this is where I guess I turn it over to Member Bittleston who wanted to talk about pediatric dental. You're assuming we haven't

read our books. Man, okay, I'll stop now.

MS. RICH: Okay. So on the -- Laura Rich for the record. On the excepted benefit for dental, so again we do accept this finding. I am going to put it on the record that this was actually a finding back in -- in earlier compliance audited in like 2015 or maybe 2017. I went back and did some research myself on this to see why -- why PEBP never took any action. I actually did some e-mail searches and I don't know. I don't have any answers as to why this was not no action was taken, but it looks like we need to take action moving forward.

As the Segal representatives said, we are in a position to where our -- because our dental is bundled into our medical program in our medical benefit. It doesn't qualify as an excepted benefit. And when I say excepted benefit, it's an exception to those ACA essential health benefits.

And so we've got -- we've got a few choices here. We can unbundle the dental by allowing members to opt out of the dental coverage and so this makes it, we're unbundling it. We are now making it an excepted benefit. It's an exception to those ACA requirements.

To do this, there's going to be a heavy lift. We have to do this by the beginning of the plan year. This

means that we've got some -- our own enrollment eligibility system would have to be updated to ensure that there's -- that members have the ability to opt in our out. We would have to make decisions. Is it a default opt in. Is it a default opt out. We've had -- we would have to communicate that to members. Premiums would be -- have to be, right. You would have to split those premiums out.

Long story short, this is not the ideal plan of action not right now. It's a lot of work with not a lot of time and it creates a lot of confusion.

The next one is to also create an excepted benefit by administratively unbundling the dental through, on a contractual basis. So this is by -- right now we've got UMR who is processing the dental and medical claims. So what we do here is we would split them out and we have a different TPA process, the dental claims. And this creates, again, the excepted benefit which provides us the ability to, you know, to not have those, the ten essential health benefits and that dental, the pediatric dental being a piece of that.

Again, we have to go out to RFP. We would -- no one can say that louder than a lot of people in this room here. We would have -- we would have to go out to RFP. We would then have to communicate this change to members as well. We would have a new claims administrator. Again, it

creates confusion for members' disruption, not ideal.

The third one is basically to comply by these ACA required -- pediatric dental essential health benefit. And the way we do that is to eliminate the dental annual maximum for children under the age of 19. This is not very expensive. It's about a 40,000 dollar a year cost. The projection is about a 40,000 dollar a year cost. And then it's -- it's really, it's an enhancement of benefits for children under 19. And then we will be in compliance with the ACA, and we don't have to create that disruption of, any kind of member disruption. So that's -- that's the PEBP recommendation. So I'll stop there.

MEMBER KELLEY: Michelle Kelley for the record. So, Executive Officer Rich, I just wanted to just clarify those. So we can remove the maximum for children under the age of 19. But the covered services are okay. And so we -- the plan already excludes orthodontia. So it's really just more of the regular dental that they are already getting, is that?

MS. RICH: That is correct.

MEMBER BITTLESTON: Leslie Bittleston for the record. My apologies for skipping ahead. That answered a lot of my questions.

Just kind of to wrap my head around this, I agree

that we do need to eliminate the maximum for pediatric dental to be in compliance. But looking at dental in the long-term, is that something that PEBP or the PEBP staff recommends, not maybe for this plan year since, but is that something more on a long-term basis that we think we need to look at?

MS. RICH: Laura Rich for the record. I'm assuming you mean unbundling the dental.

MEMBER BITTLESTON: Yes.

MS. RICH: We actually did consider that, what was that a couple of years ago, right, during the -- when we were looking at cost savings, at cost savings. We did look at that. It's something that we can consider moving forward. I think that if we do consider that, we probably need to have a longer runway.

Right now we would be rushing things and -- and so and then also we need to have justification as to why it doesn't make sense. Is it something that members would want because does it create more confusion or does it create more choice? You know, maybe a little bit of both.

We already have situations now where we've got the default rule. If a new employee is -- is hired and takes no action, they are automatically defaulted into the plan, into the high deductible plan, and we have a lot of problems with that already where people don't understand that they

have to take action. And once they are in the plan, they are stuck in the plan for the year.

And so now if we're also doing this with -- with dental and you're unbundling it and now there's another, you know, default where, you know, do you default into dental or out of dental. And it just -- it's a lot of confusion. And right now PEBP has gone through a lot of change. And you'll hear me talk about it a little bit in the survey report but there's been a lot of change.

Members and employees really just want consistency right now. And I think that it's probably something we need to table at least for the time being.

MEMBER AIELLO: This is Betsy. And I just have a little bit of a question. As a Medicare PEBP enrollee, I have an option to take dental alone. So dental in some sense or some process within PEBP is an unbundled service somehow, right? It may run through the medical process engine. I don't know, but I'm not sure how that plays together because that is just you can or you can't put dental alone.

MS. RICH: That is correct. Medicare -- Medicare retirees do the have ability to purchase dental, but I would argue that children under 19 are going to fall under the Medicare retiree category.

MEMBER AIELLO: No. This is -- I just mean

there's a process somewhere within PEBP where dental was separated. I wasn't thinking that but just there's some process built into our program already.

CHAIRWOMAN FREED: Member Kelley.

MEMBER KELLEY: Thanks. For the record Michelle Kelley. So I just wanted to put on record, I'm supportive of removing the pediatric maximum. And I just wanted to make a comment that I do think that we really need to have a detailed conversation about the unbundling because what I think we do know through research is that dental really does impact medical down the line, and I think that's historically why PEBP has always bundled it because there's so many positive medical outcomes that are connected with good dental health. So I want to really have a good conversation about that. Thank you.

CHAIRWOMAN FREED: Okay. With that, I'll go back.

MS. RICH: Okay. So we went through the two big ones. I just wanted to touch on some of the other findings before we get to the -- to the actual recommendation and vote. You heard about non-discrimination testing. PEBP does accept this finding. We will be taking the appropriate action to ensure this is completed.

There's a lot of suggestions here on MPD's. Like

I said before, language in the MPD's and things that are coverage specific to clinical, we're going through that and that should be presented in January. So a lot of these findings are actually in the works already.

The summary benefits and coverage language, we've incorporated that language. Preventative care, same thing, we are going to be bringing those changes in January. Provider non-discrimination, this is something that PEBP will need to work with our vendor partners to incorporate those, also the suggested changes.

The notice of right to continue care, this is something that we will have to work very closely with UMR on because while there's already a process in place, there is an NRS today that addresses this. The requirement is a little bit different because today that request relies on the member triggering that. Whereas, this new requirement is really PEBP proactively identifying members that meet that criteria. So we will be working with UMR on that.

No Surprises Act, we're actively working again with our partners to make those suggested changes in the MPD. There's a group health plan transparency rule which I'm sure that's gotten a lot of attention in the industry. Again, we'll work with UMR to ensure those self-work service tools offered through the member portal meet those requirements.

Qualified medical child support order, same thing, we're incorporating those changes. There's dependent care FSA and coordination with Health FSA as well and the sickle cell anemia. Again, all of those things, you'll see those things in the -- at the January Board meeting. So with that, those were -- those were the findings.

I will have to say with the craziness of the last three years and all of the new laws and rules and requirements that, especially the feds have put out recently, the No Surprises Act in trying to keep up with all of that, I'm -- I'm pretty pleased with the results of this compliance review. I -- I would have expected maybe even more things to fall through the cracks based on, you know, the craziness of the last three years. So I'm pretty proud that we've kept up with a lot of the requirements and a lot of the changes despite the challenges.

So with that then the recommendation you've heard, the two that we need to discuss and decide are on the mental health parity and the excepted benefit for dental.

CHAIRWOMAN FREED: All right. This is Laura Freed. I'll do them into pieces so that we can have a little bit of discussion about the Mental Health Parity Act. So I will accept a motion to eliminate the annual maximum for pediatric dental for children under 19.

MEMBER AIELLO: This is Betsy. I'll make that motion.

CHAIRWOMAN FREED: Thank you. Do I have a second?

MEMBER BITTLESTON: This is Leslie. I'll second.

CHAIRWOMAN FREED: Thank you.

All in favor say aye.

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

CHAIRWOMAN FREED: Any opposed? For the low low price of 40,000 per plan year.

All right. Now the MHPAEA, what is the sense of the Board? I mean, I've heard don't opt out. I've heard opt out but continue doing the analysis. How are you all feeling?

MEMBER FOX: This is Linda Fox for the record.

CHAIRWOMAN FREED: Sorry. Laura, go ahead.

MEMBER FOX: Who's going first? Linda Fox.

CHAIRWOMAN FREED: Linda Fox, please go ahead. I'm sorry.

MEMBER FOX: I think we should opt out simply because I'm afraid of committing to something we can't keep up with. We know we're short staffed. And we know we can at least attempt to do the same work without the commitment to

the federal audits. So that's my -- my first choice.

MEMBER MCCLENDON: This is Jennifer McClendon for the record. I agree with Linda but I also think it would be helpful for me to understand if you have any fears about the optics of this. I guess we're in a state that has most significant challenges, some of the most significant challenges of substance abuse and mental health. And it looks potentially like we're saying State employees, well, we're not totally committed to parity in this area. And I just, I don't know. While I understand in this room I think we all understand how and why we would make that decision. Do we have concerns about moving forward? Is there anything the Board can help support you and the team?

MS. RICH: Laura Rich for the record. Yes, there's obviously the optics of opting out, which we've discussed early on in these conversations. There is -- there could be an optics problem and that's why I think that we need to take those proper steps to at least do everything that we would normally be doing it order to opt in.

We just -- I mean, it's just removing that layer of federal oversight that, you know, we don't want to avoid if we can. But I do believe that we need to -- we need to focus on maintaining compliance regardless.

MEMBER KELLEY: Michelle Kelley for the record.

Executive Officer Rich, if we were going to make a motion and include the requirement that we still go ahead and do this testing, how long do you expect the timeline for these testing, both qualitative and quantitative would actually take before you could bring it back to the Board?

MS. RICH: Laura Rich for the record. I'm going to defer that maybe to Amy Dunn to see if maybe she has got an idea of how long this type of analysis and research takes.

MS. DUNN: I can defer this to Richard Ward if you would like.

MR. WARD: Richard Ward with Segal. Generally it takes six months and it can vary depending on the complexity of the plan. You have an HSA qualified plan in addition to more conventional plans and then turn into, and so there's a number of plans.

MEMBER KELLEY: Thank you for that. So just a follow-up I guess. Do we have to actually do that testing for the fully insured products or are they doing their own testing on their fully insured products even though it's our plan design?

MS. RICH: I don't want to speak on behalf -- Laura Rich for the record. I don't want to speak on behalf of the fully insured plans, but I would assume they are doing their own testing, and but I will verify that. And I'm

getting a nod out there so it looks like yes.

MEMBER KELLEY: Okay. So thank you. Just to clarify, we only need to do the PPO plans of both high and low, okay. Thank you.

MS. RICH: And the EPO as well.

CHAIRWOMAN FREED: Member Kelley, I feel like you're on the verge of making a motion.

MEMBER KELLEY: Yeah, I think I'm comfortable making a motion that directing staff to move forward with the opt out process.

CHAIRWOMAN FREED: Okay.

MEMBER KELLEY: And then but also directing that we would like to have the both qualitative and quantitative testing done on the self-insured plans.

CHAIRWOMAN FREED: Right.

MEMBER KELLEY: With results brought back to the Board, you know, within nine months.

CHAIRWOMAN FREED: Okay, thank you. Do I have a second for that motion?

MEMBER BITTLESTON: This is Leslie. I'll second.

CHAIRWOMAN FREED: Okay, great. You heard the motion. Any discussion, okay. All in favor say aye.

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

CHAIRWOMAN FREED: Any opposed? The motion carries.

All right. So I think we'll take about a ten-minute break before we go to Agenda Item 8 so everybody can get up and stretch.

(Whereupon, a brief recess was taken.)

CHAIRWOMAN FREED: Okay. I will call the meeting back to order again. And it's 10:32. And with that, we'll go to Agenda Item 8, which is dental master plan changes.

MS. RICH: All right. Laura Rich for the record. So this is the first of many different master plan document changes that we plan on bringing to the Board. There will potentially be more but these are recommendations that we can make in the middle of the plan year and that we are -- we are able to bring to the Board for basically their -- their processing and operational type changes, not benefit coverage changes.

So when PEBP on-boarded to UMR, the new third-party administrator, PEBP plan rules were applied as written in the MPD, but we had HealthSCOPE for many, many, many years. And so, you know, in practice things change. When there's discrepancies, when there's vague language, you -- we would have HealthSCOPE call and say, you know, what is the intent here, PEBP? What -- how do you want to cover

this? But when we moved to a new plan or a new third-party administrator, they applied the plan rules as they should as they were written.

So some of the plan rules that we have in here were -- were vague. The interpretations between what HealthSCOPE Benefits had and what UMR had interpreted as were different. And additionally, CTI being a new auditor as well, this has been the subject of many, you know, many questions and clarification, you know, during those audits.

This has also been the subject of the provider complaints because when we switched over from HealthSCOPE Benefits, UMR changed, and providers started asking, well, why are you doing this versus what you were doing before.

So as a result, PEBP, CTI and UMR staff, all reviewed the MPD in-depth to identify areas that could be improved immediately without any impact to coverage or benefits and also avoiding a special open enrollment period. So the report proposes plan language to the dental master plan document really for clarity in the current plan year and then moving forward.

So I'm going to go through just some of the -- some of the changes here. You can look at, we've attached attachment B. There's the actual language and in the sections where this is affecting. On page 13, the basic

services explanation and limitation section, really the language of, in the plan document needed to be clarified for oral surgery. Due to that there was a language conflict again between dental and medical, so we made some changes.

We removed some -- some language regarding oral surgery and addressing bruxism and the nightguards or the occlusal, and I'm not a dental expert here but the -- really, there was the teeth grinding, the nightguard for bruxism.

And then we added a lot of language around the emergency pallet of treatment for pain and really just provided that clarification for those, the nightguards and bruxism, the requirements, et cetera, et cetera. Again, just clarification.

On page 21, we removed the requirement for invoices to pay claims. We do this in the medical -- on the medical side because on the medical side you've got medical devices where they are very high cost. And you have providers who are marking those -- those devices up considerably. And so what the plan does is we say we want the invoice. We want to see what we're paying for and we'll only pay for what you paid for that device.

We also have this in the dental plan or the dental MPD. And so while this makes sense on the medical side, it doesn't really make sense on the dental side. It

creates just a lot of manual work. And the return on investment for this is just, you don't -- you don't see it so we did remove that.

Pages 37 to 38, we just added some clarifying United Health Care for basic life insurance, we just had to change that and diversify dental services and also added principal dental network for services outside of Nevada. Just some clarity for members there.

Pages 40 to 44, we updated some key terms and definitions and then updated the medically necessary which, gosh, if someone has a black and white term for medically necessary, I would love that. We are going through that quite a bit in many areas of the master plan document.

And the big one I think here is that we excluded references to cost efficient and appropriate. So what was happening is that claims were being -- they were coming in and they were being repriced due to a more cost efficient benefit.

Specifically, what we're looking at here is fillings, right, on the dental side. Claims were coming in for composite. Those were those white fillings and the plan was replacing them and paying them at silver levels, the cost of a silver level. That's -- that's antiquated. There's a lot of dentists who are not even using silver fillings

anymore, right. So it just made sense to these at why are we paying the dentist for a silver filling when what they really did is provide a composite filling. And so that's really what that was meant to address is that area. It's just antiquated. You're not getting a lot of those silver fillings anymore. Why are we paying them, you know, at a silver level.

So, again, this is, a lot of it is clarification. A lot of it is just updating for antiquated certain services and processes and just providing clarification for Board Members. The staff recommendation here is to approve the proposed changes for dental and life master plan document for plan year '23 and moving forward.

MEMBER AIELLO: Just a quick question. Since this is a dental master plan, the medical necessity definition is only being changed regarding dental and not medical, correct?

MS. RICH: Correct. This is Laura Rich for the record. Correct. We are addressing only the master plan document here. We will be bringing back other master plan documents for other plans in January. And I am almost positive that things in that area will be addressed as well.

MEMBER AIELLO: Okay. But this one here currently --

MS. RICH: Correct.

MEMBER AIELLO: -- is just the dental one. Thank you.

MEMBER KELLEY: Just a clarification as well. So you said this earlier but I just wanted to make sure that what I heard was correct. So these changes are actually ensuring that the plan continues to operate the way it was operating in 2020, 2019, 2018. There will be no -- these changes won't impact our participants' services at all really.

MS. RICH: Laura Rich for the record. Not in a negative way. For example, the white versus the composite versus the silver filling, that's going to be a positive impact for members, right. So there's -- yeah. But for the most part, yeah, this is just behind the scenes claims processing changes.

MEMBER KELLEY: Thank you.

CHAIRWOMAN FREED: Well, this is Laura Freed. I'm not seeing a whole lot of discussion, questions. And this would -- my question is this, so it just goes into effect July 1st of 2023, okay. Yep, I've got it in my head. Send it to the Board.

MS. RICH: Just to clarify, this goes into effect immediately. It can -- because it's no -- there are no

changes to coverage.

CHAIRWOMAN FREED: Oh, okay.

MS. RICH: It can go into effect immediately.

CHAIRWOMAN FREED: Oh, I'm sorry. You said plan year '23. We're in plan year '23. Jeez, I'm really out of it today. Okay, cool. Yep. Thank you. Sorry.

Any other thoughts? Motion to approve?

MEMBER AIELLO: This is Betsy. I motion to approve the proposed changes as presented and recommended by PEBP staff.

CHAIRWOMAN FREED: Okay. Do we have a second? Thank you. All in favor.

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

CHAIRWOMAN FREED: Any opposed? Okay. Motion carries.

Agenda Item 9, wage and benefit survey results.

MS. RICH: Laura Rich for the record. The results of the 2022 employee wage and benefit survey. Just to give a little bit of background, earlier this year, I think I mentioned it at a prior Board meeting, the Governor's Office established a working group that was tasked with developing suggestions and opportunities to create a more robust wage and benefit package for State employees.

The working group included leadership from the Governor's finance office, the division of human resource management, PERS, PEBP and the Governor's Office.

As part of this process, the group composed and released a short survey to all student or students, sorry, to all employees, including NSHE, which included questions regarding employees really desires relating to wages and benefits. Well, what is it that they found important to them?

So PEBP was given permission to share the results with the PEBP Board just in anticipation of that -- of the plan year '24 benefit design considerations. But, again, this is -- this is an attempt to figure out what it is that the -- that the State can do for employees and what is it that they -- the intent was to figure out what is it that they find most important in employee benefits in their packages.

So the survey was released on October 25th and it remained active through November 1st. We had a really really high response rate, 7,400, a little over 7,400 responses. That is higher than anything PEBP has ever put out in the past and this isn't even including retirees. It only went to actives. And so we were, you know, pretty -- pretty impressed with that response rate.

If you go on to page two, we'll kind of go over the questions that were asked in this -- in the survey. It was very short, just five questions. The first two are really to see who is responding to these questions. And the first one asked, what best describes your role in State government? Again, we had a pretty good mix of people that responded to this. As you see, State employee, the front line employees, that was -- that was the highest amount, almost with 50 percent of the -- of State employees describing themselves or identifying themselves as front line employees.

We had State employees, supervisors, upper management, sworn police and fire. We did break it out NSHE classified staff and NSHE faculty. We thought that was important to identify the two differences here. We had a pretty good turn out with NSHE faculty. A lot of faculty responded to the survey. And then legislative staff and boards and commission, a very tiny portion but that's a fairly small group to begin with.

The next question was how many years of service do you have as a State employee. And, again, we had a pretty good mix here. It was, you know, what are we looking at? Who is -- who is answering these questions? Is it the newbies? Is it the lifelong State employees? You know,

who -- who is responding to these surveys? And we had a good mix of -- of the four different levels there.

CHAIRWOMAN FREED: Do you have actual numbers for the, this is Laura Freed, for some of these bars because they seem, for instance six to ten years in service and 15 plus years of service seem pretty close and I'm -- do you know?

MS. RICH: I do -- Laura Rich. I do have them.

CHAIRWOMAN FREED: Okay.

MS. RICH: I don't have them --

CHAIRWOMAN FREED: Okay.

MS. RICH: -- right now.

CHAIRWOMAN FREED: Okay.

MS. RICH: But I could definitely share them with the group.

CHAIRWOMAN FREED: Okay.

MS. RICH: If that's the request.

CHAIRWOMAN FREED: I think for me it's really number three because there are a couple of -- when you get to that, there are a couple that seem almost tied.

MS. RICH: Yeah.

CHAIRWOMAN FREED: Yeah.

MS. RICH: So the third question was rating employee benefits. Those -- what people found the most important. And there was -- there was a lot of options here.

Higher wages, employer match, and you can't see on the chart there, but it's employer matched 457 or 401K, work from home capabilities, flexible working hours, tuition assistance, lower health insurance premiums, more robust health benefits, child care assistance or professional development. Higher wages obviously number one by far. It was. And I'll get to the last question but higher wages was the focus of attention by far.

The -- in second place was lower health insurance premiums. That was surprising to me because our health insurance premiums, I think as I showed in the last, in the September Board meeting I think, they are not -- they are relatively comparable to what other public sector entities are offering in Nevada.

What I think is important here is that those public sector entities that we are comparing them to offer much higher wages, right. And so the difference between the wages and the premiums, while our premiums may be in line with the industry, the wages are not and so that, they are just not comparable. That's my opinion as to, you know, why this ranks so high.

Employer match 457 or 401K, that ranked very very high as well and more robust health benefits. Those were -- you know, those were the top followed very closely by the

work from home capabilities and flexible working hours.

Question number four was specifically around PEBP. We wanted to include a PEBP specific question there. Again, health insurance premiums, number one, lower deductibles, lower out-of-pocket costs. So people are looking at their, you know, the first dollar spent to accessing health care. That's very -- you know, that's very clear there.

Something that caught my eye is that, you know, mental health, I thought it would be higher, and it was not as high as I thought. Improved dental coverage is up there, as well followed by vision. The last one, I think that surprised me as well. In last place was more chronic disease coverage and programs. And long-term disability coverage was second to last.

Question number five, no one liked this question. It was originally the intent of this was to capture what is it that the State offers already that people are happy with? And we wanted to capture the top three. When the survey was released, it was a requirement to -- and it was an oversight. It was a requirement to pick three. Otherwise you couldn't move on. People did not like that they had to pick three. There were a lot of comments about how they wouldn't have picked any but they had to pick something.

But you see here it did at least get to -- you know, it gave us the information we were looking for which was the intent of what is it that we're doing. What is it that people are happy with already. And that was paid time off. Obviously, people are happy with the paid time off. That is the one benefit that -- that received the most feedback on that one.

Then we had a free form text field where people could provide comments regarding employee benefits. I actually did take the time to read through. I mean, there were a lot of them. I can't remember, I think it shows on here, you know, 3,700. So 3,700 out of the 7,400 provided additional comments.

I browsed through. I think I read almost all of them, if not all of them. The overwhelming majority of comments were really to wages, either the disparity between the State and private sector or any other public sector, PERS matching, you know, COLA increases, things like that. They were -- they were overwhelming majority were really surrounding wages. That was the subject of focus.

Another area that received a lot of attention was regarding tele-communicating and flexibility. People seem to really appreciate that benefit. They like it has created a work life balance and that this benefit is something that

people want to have moving forward.

There were many comments regarding the high cost of health care, whether that's premiums or deductibles. There were some around the high cost of urgent care in emergency room visits. And I will argue that that's by design because you don't want people using the emergency room as their primary care provider. And unfortunately in a state where we have no access to -- to doctors because we have such a low -- low percentage or per capita, providers per capita that there's a good chance that people are using the emergency room to access care. And so we all know that the emergency room is very expensive and you don't want to incentivize members to access care through emergency room services.

There were also some comments regarding the need for HR on-boarding and off-boarding and then some advocacy or assistance just to navigate the complex health care landscape. We do have this -- you know, Director Freed and myself have talked about this and also the administrator of DHRM, as well employees have a difficult time navigating employee benefits. That's just -- you know, that's the reality. Everyone works it in silos. PEBP is different than PERS. Although, we have an effect on each other.

And then you've got, you know, ERP benefits that

are offered through DOA and they are also offered through PEBP. We're all very siloed and employees don't appreciate that there's not one central place to go to.

There was definitely a desire for longevity pay to be reinstated. There were also some comments regarding the aid for consistency in PEBP. There were comments around, you know, constantly changing networks and providers and things like that. The benefits are up, down. We talked about this as a Board as well and it's very important. I know we've had some changes in the last couple of years to just kind of level it out and not continue the road of change year over year, so hopefully that consistency will remain for a while.

And then as I said, a lot of comments, a lot of them were about there were angry people, they were not very happy that they had to pick three on question five. So a lot of them said that paid time off was the only one they would choose if they had to pick any. Many of them said they wouldn't have chosen anything.

So I thought it was informational. I don't know if it was -- it wasn't super surprising. There were some things in here that did surprise me. We all know that wages are number one. This is a subject that we've all talked about, not just at PEBP but across the state, that something

needs to happen. And so now the Governor's Office has some data to work with, so I was happy about that. I'll stop there.

MEMBER KELLEY: So I just wanted to go back to the response rate. So it looks like around 7,400 participants. But what percentage of that is -- what is that a percentage of all of the people asked? So I don't know how many there are State employees and I'm sure it was to all employees, part-time as well. So do we know two percent, one percent?

CHAIRWOMAN FREED: It's a little bit over ten percent.

MEMBER KELLEY: Ten percent.

CHAIRWOMAN FREED: Yeah, that means roughly 17,000 filled positions across the bureaucracy out of about 23,000 authorized.

MEMBER KELLEY: Okay.

MEMBER VERDUCCI: Chair Freed, I had a comment. You know, I wanted to point out, Social Security Administration came out this weekend with 8.7 percent increase in their social security benefits. And reading through this survey, my observation is that, you know, we're really seeing the impacts of inflation. I think the State workers, even before we went through this inflationary time

were really complaining about the wages not keeping up with comparable employers.

What really jumps out here is wages, lower deductibles and lower out-of-pocket costs. So my observation is that employees are really looking forward to more money in their paychecks from what I'm reading here.

MEMBER BITTLESTON: This is Leslie Bittleston. I also have a comment. In looking at wages, I think it's a lot more complex than just the paid disparity. I recently lost a staff member who told me the job was too hard with the amount of money that they get.

So I think that there's -- the way that the State classifies positions and what we expect of our employees and the wages, I think is a big -- a big piece. You know, I know when I interview staff and tell them the job, they're like and that's as high as it is. So I think -- you know, and I took the survey as well.

But I think that the wages and the way that we classify our positions is really paramount to what we're seeing and why Executive Officer Rich has a 27 percent vacancy rate and why the rest of us has vacancy rates as well, but I just think there's more to it than wages.

CHAIRWOMAN FREED: This is Laura Freed. I have to actually get out my calculator before I mouth off. Member

Kelley asked what's the response rate. Just looking at my calculator, 7,413 out of 17 odd thousand people is about a 40 percent response rate, so sorry.

THE MCCLENDON: Does that also include NSHE?

CHAIRWOMAN FREED: No, it does not. So, okay, so it's less. And I don't know the universe of NSHE classified plus faculty because we don't have that in our HR system when I can't see work done. It does include boards and commissions, no. I can't see that those folks are in the HR system either, but there's only -- of the -- there's only a few dozen I think of those occupational boards and commissions that opt into PEBP. Yeah, it's -- it is actually a pretty good response rate, and I think that's because the Governor's Office really tried to push it out multiple times to people to get them to respond.

MEMBER KELLEY: So Michelle Kelley here. I guess I just have a comment. You know, I think Executive Officer Rich indicated a couple of times she was surprised by the response. I guess, you know, when I look at question four which deals specifically with the PEBP benefits, I guess I would say I'm not surprised, right. What's floating to the top are things that we all feel. And what's floating to the bottom, more specifically you don't know you need them until you need them, right. So, I mean, we're talking about the

chronic disease stuff, even the LTD. You know, I mean, life insurance is right down at the bottom as well and you don't need them until your spouse needs it, right.

So I think that, yeah, it is clear that people are just feeling -- feeling the pinch in the PERS at the moment. And anything they can do to increase that is going to serve the purpose. And I would also I guess would just like to say that Member Verducci brought up the eight percent social security raise this year. Last year there was a five percent social security raise. So in that time, State employees have been given a one percent COLA. And countrywide, retirees have been given 13 percent. So like, I mean, I think -- yeah, you know, I think it's pretty dire for many of our employees unfortunately.

And I see on the agenda today, just to bring it back, sorry, I know I go on, but we're talking about chronic diseases which are all -- you know, of the plan enhancements that we're talking about today are really the less one to buy the majority, so.

CHAIRWOMAN FREED: Well, this is an informational item. So there's no action required. So in the absence of more questions and comments, we can move on, okay.

Agenda Item 10, plan year 2024, possible program design changes.

MS. RICH: All right. Laura Rich for the record. So just to provide a little bit of background, at the September 29th Board meeting, staff reported that PEBP is left with a projected balance of approximately nine and a half million dollars in excess cash. It can be allocated towards new benefits incentives or other enhancement. So PEBP presented a list of potential programs and plan design options to, so that staff could go back and perform additional research and analysis and bring it back to this Board meeting for final consideration. So that is what we did with the assistance of some vendor partners.

PEBP has completed the analysis on the Board requested items, in addition to a few other things that we kind of stumbled upon while we were doing our analysis. So I'm going to pass this off. We're going to tag team this a bit. We've got a lot of our partners in the room, Segal spearheaded a lot of the analysis. So I'm going to pass this off to Richard Ward, who is going to go through part of the presentation.

We also have some subject matter experts attending virtually. So if there are any subject matter experts that want to weigh in or have any input, please just raise your hand. We are happy to or even or raise your hand or if we don't see you, chime in. Because if there's

anything additional that we don't -- that would be helpful, please feel free to chime in.

So, Richard, with that, I'll let you start.

MR. WARD: All right, thank you. And as Laura mentioned, this was a collaborative team effort. I want to thank PEBP staff, other PEBP vendors for the team approach to developing materials here to discuss. I also have from Segal our medical director, Dr. Sadhna Paralkar and our director of clinical consulting Joanna Balogh-Reynolds, you know, as we cover some of these different topics and options.

Just from a logistics perspective, does everybody have materials in front of them? Okay. So it is -- then let's go to, I guess it's page three, took -- well, sorry. The agenda here on page one of the slide deck, I have a list of the ten items that we're going -- that we're going to discuss and review.

So let's flip to page three for Real Appeal, which is a digital weight loss program that -- that has an on-line application process that involves coaching sessions. It provides tools, equipment and support, as well as a means to track weight loss. It would be available to all PEBP members, age 18 and above regardless of current weight or BMI. It's -- I'm flipping to the next page.

It's a program that is currently available in the

HMO program in Southern Nevada so it's already part of the PEBP program. And members in the HMO, there's good engagement, there's and participation for those and satisfaction for those that are utilizing the program. There are about 250 members enrolled. The graph at the bottom of page four shows pretty good utilization for the percentage of numbers that in the last plan year have engaged in multiple coaching sessions. I think there is several that have had nine or ten plus coaching sessions during -- during the plan year.

Moving on to the next page, the proposal here, the consideration is to extend this program to the three self-insured programs, to the high deductible, low deductible and the EPO, and that would put all members, all members would have access to this program as opposed to it being available just to those in the HMO.

It's easy to implement, accessed via the existing TPA contract. It's relatively low cost. It's about $50 per coaching session. And administratively, it would be billed as preventative care so there would be no cost share members. So it's -- it's a really very limited barriers, if you will, to members accessing this.

UMR has indicated the ability and willingness to provide support for communication outreach so via open

enrollment or additional materials on website or while or in existing resources, and it supplements a current program that's already in place.

Flipping to page six here, so right now there's an obesity management program that is in place and UMR has identified about 2,100 known members with the BMI 40 and above that would benefit from this particular program. Right now only about half of the 2,100 are engaged in the program. So there's, you know, let's say roughly 1,000 have members that have a BMI of 40 and above.

There are also several thousand that have that are just below that have BMI of 30 and above. And it's -- it's been documented that with -- with weight reduction, the health risk improves and also health costs are reduced. So this is an opportunity to provide another -- another program for members to utilize and -- and manage their way in their own way so it's another -- it's another option.

And so there would be savings for not just the members that opt in and participate that lose weight that are BMI of 40 and above, but there's also a benefit of current members that are -- that very possibly would gain weight over the next ten or 20 years, not gaining as much weight. And so there's something just from a plan savings perspective and health risk improvement assessment, there's the prospect of

current members with high BMI, with high BMI's reducing -- having weight reduction and those that would avoid future weight reduction, so essentially making healthier 50 year olds in the future.

And the table at the bottom of the page shows some industry data regarding, there's a five percent weight reduction or reduction in BMI, difference elevated BMI's that there's some pretty significant savings. So for people who have a BMI of 40 and above, just a five percent reduction in weight would reduce -- would result on average an annual savings about $2,000 in PEBP.

So moving on to the last page there, the savings here may be somewhat modest relative to current total plan spent of $170,000 but that's first year savings, and I would expect that this program would gain momentum as more people are able to engage in it and experience the benefits of the program over time. I don't know if we're going to discuss these as we go along.

MS. RICH: Yeah, I think we'll just take one by one.

MEMBER KELLEY: I'm sorry, I'm always the first to go. Sorry about that, everybody. So I guess I just -- so it's a savings to the plan. So is the only cost associated with this, the coaching sessions.

MR. WARD: Yes.

MEMBER KELLEY: So there's no administrative cost. There's no PEPM to join the program?

MR. WARD: Correct.

MEMBER KELLEY: Can I ask a couple of follow-up?

MR. WARD: So nobody opts in.

MEMBER KELLEY: Yeah.

MR. WARD: There's no cost.

MEMBER KELLEY: No cost, okay. And then I'm just curious about so the sessions are what cost? So who are -- how are the people accessing the coaching or the counseling and then what's the expertise of these people?

MR. WARD: I will defer to those that want to speak on behalf of the programs since we have people here.

DR. PARALKAR: So the people who are expert coaches are trained --

MR. WARD: This is Dr. Paralkar.

DR. PARALKAR: Yes, sorry, I forgot to introduce myself. I'm Dr. Sadhna Paralkar with Segal. And this is a United program, which I'm very familiar with. That's my former employer. These expert coaches or head coaches are trained behavioral health coaches in weight management. Also they could have a training in nutrition, in physical education or a combination of both, and they do have to go

through a certification program of coaching of California -- we call them California health coaching on this case management if they have that background as well.

So they do have an expertise in getting the people engaged, interested and then tweak the innovations based on people's readiness to change, as well as some of the background and their culture and other social that will allow them to follow a sort of level of diet, physical education, as well as other means.

MEMBER KELLEY: Thank you.

CHAIRWOMAN FREED: Board Members, do you have any other questions, thoughts on Real Appeal?

Okay. I guess we'll move on to the next one.

MR. WARD: Hinge Health on page nine of the slide deck is another virtual program that provides virtual physical therapy, both rehabilitative, as well habilitative. So for particular instance if there's an injury, there's rehabilitative capabilities and components. And then if you have say chronic back pain or just a chronic ongoing issue, there's a habilitative element to it, and it's supplemented with expert medical opinion consultation and health education. So it's a virtual platform, virtual care that enables the patient or member to have visual access to physical therapy expertise and to do so when, on their own

time. Essentially there's an on your own time element to it. So this digital platform is supplemented with clinical consultations and other education.

Moving on to page ten, musculoskeletal services, care is the sixth most prevalent. It rates six on plan spent for the most recent plan year and it's about six percent total spent. So it's pretty significance -- it's pretty significant cost, and it's one just industry wide that we see that continues to grow as people have more ongoing chronic pain and chronic conditions.

This one, Hinge Health is also from contractual perspective easy to implement. It's available, accessible through the ESI contract. There will be PMPMD so the contract would need to be amended. The cost rather than being on a per session basis for this so on a -- on a bundle basis, so it's about $1,000, $995 per engaged participant per year and then that provides as much access as is necessary.

This digital program, the digital therapies provides additional access point for members, particularly those in rural areas where it can be a real challenge accessing in person, traditional in-person physical therapy.

As I mentioned before, there's also the ability to access care on your own time as opposed to needing to make an appointment for a physical session with a physical

therapist or in-person session.

This provides ongoing coaching, guidance and progress without the need to see a physical therapist every time so you can do a lot of your physical therapy benefits from members and patients working on their own and that can be a real challenge where people very often only engage in their treatment regimen when they have a session scheduled. And so having this digital supplement or this digital option will make a -- will facilitate their being able to feel more comfortable with their at-home work, if you will.

We have a number of clients that have implemented Hinge Health. There's been a lot of positive feedback, both from the plans and the members. So there's a very positive engagement. It's had a positive. I keep using the word positive. It's had good impact and there's savings and satisfaction with the members and we have some information in a couple of spots on that.

On page 11, Simon, do you mind just giving an overview of the member experiences and a little bit on the operation components of the program.

DR. PARALKAR: I'm going to have Joanna to speak because she has kind of, I don't want to disclose too much, but she actually has used this as a virtual physical therapy as well so she can speak a lot more with that.

But this is basically you are putting on sensors on your body and the physical therapist is on the screen who can actually see your movement just like a physical therapist in person can. So it's really a virtual physical therapy. They have a device called Enso which is a pain management device that uses TENS which is a transcutaneous electrical nerve stimulation which works really wonders in back pain, and any kind of a muscle pain. Instead of taking a pain killer, you actually use that device and they have managed to bring that to a home setting. Previously this kind of technology was available only in our patient settings. So we really find that very beneficial cost and value proposition.

And then just like the pervious program, the cost is only for a part engaged for engaged participant per year. So there is no PEPM or PMPM. So that's another one that you only pay if somebody enrolls.

Joanna, do you want to add more to this?

MS. BALOGH-REYNOLDS: Yeah. This is Joanna Baloh-Reynolds. From a member user experience perspective, you know, I have something that is either an acute injury. So I was, you know, playing catch with my son in the backyard and hurt my shoulder or you have a chronic pain issue or you're going for a surgical procedure or knee replacement or shoulder or something. So that's a point of entry into the

system.

You fill out sort of a clinical questionnaire that evaluates, you know, what's the right therapist for you. What's the right kit for you. You'll do a video visit like this with a therapist, walk you through all that clinical stuff. They also have coaches and different behavioral specialists. So they will evaluate, are you having mental issues related to your pain. Are you having issues with activities of daily living? Are you sleeping at night or not? So based on your responses, then they prescribe that program.

And to Dr. Paralkar's point, the wearable sensors are for your big joints. And they do have motion technology for things like wrist and hand that can't do a joint. And it interacts like this with a prescribed treatment plan.

To Richard's point, there's no out-of-pocket to the members. You don't have the barriers of co-pays adding up and then people abandoning therapy early because they can't afford it. Also, they sometimes can't go to PT and be compliant because they can't take off of work, and so we're checking about using PTO now and that kind of adds up. And then you don't hit cap limit. So that 995 is unlimited. Now as a member, I can do PT every day on my lunch for 15 minutes or in the evening while I'm watching the news after dinner.

And so you get a higher compliance rate and more engagement in therapy.

Then as you use the system, the therapist can see are you doing well? Are you doing too good? And then they need to up your therapy. Are you not doing it correctly or are you having pain and issues and they can real time modify your prescription and treatment.

So from a member experience, we had some really good feedback. We have other public sector clients with it. You know, a good example is we have a city that has police officers. And you think are these men going to use these systems while they're carrying heavy flack jackets, getting in and out of car. A lot of lower back pain in police and fire. And we actually saw people, one Dr. Paralkar mentioned, the Enso device, wearing it at work and dulling some of that pain so then they can function better. And then just by doing some therapy they were actually more functional at work. So we got a lot of good feedback from other clients as well.

CHAIRWOMAN FREED: This is Laura Freed. I have a question about how a participant would move into Hinge Health from looking at page 11. So if one's orthopedist or PCP prescribes Hinge Health, almost like another medicine, BSI bills PEBP for the 995. Then they enter the system, if you

will, that way or can somebody self-refer who's just got chronic low back pain?

MS. BALOGH-REYNOLDS: Any point of entry, so there's a preventative platform that is free for your membership that has exercises. So people can just download it and read it and use that. You can self-refer.

You can self-refer. You can, if you go for surgery and they recommend PT, this could be an option versus in-person or if you're prescribing providers, say knees, you go to physical therapy. Let's say you had X-rays or something like that and they can kind of see what the problem is. So you can enter in either way, that's why there's that clinical intake form. So if you self-refer and maybe it's not appropriate, they can direct you to the more appropriate level of care.

MS. RICH: And this is Laura Rich. I just want to add too that as it is a per member per month fee to PEBP, this would be free to an employee or a member of PEBP would go and seek the service. So if you go to a physical therapist, you're actually paying your out-of-pocket cost. You're paying a co-pay in this situation because it's a PMPM and it's not a claim, we are -- the member would get this free. So it is a -- it's an incentivized benefit.

MEMBER AIELLO: This is Betsy and I just have a

couple of questions because I heard a couple of different things. That there's a 995 fee but there's also a PMPM where it says. So I'm a little confused about those two things on page ten under easy and low cost.

And then I just want to throw out another question because we all know as we've been hearing earlier today that people don't understand their health plan anyway, the dental is embedded. It's not embedded. What are we going to do. Do referrals come to this, sort of like claims processing and generate like I know some of the case management products from insurance companies, they notice the bills coming in.

A person gets tripped to their case management entity that then calls the person and says, hey, this might be an option for you because it's hard for me to understand unless we really educate providers that a recipient would say, hey, let me or a member or whatever, hey, let me do this. Anyway, those are my comments in the PMPM and the cost.

MS. RICH: Laura Rich for the record. Betsy, I apologize. It's per member per year and so that is that 95 -- $995. I misspoke. I'm so used to saying per member per month on everything but it is per member per year and that is the cost of 995.

MEMBER AIELLO: Okay. On page ten, it does say PMPM, and that is usually applied over every member versus engaged.

MS. RICH: Correct, per engaged, yes. It's per member per year. I think we're just so used to saying per member per month.

The other piece is we do have the ability to working with our TPA. We do have the ability to target members who have physical therapy claims and potentially target them with collateral or, you know, mailings and things like that to provide them that option of, you know, hey, you could be using this, so we do have that ability.

MEMBER KELLEY: Michelle Kelley for the record. I'm just wondering, so if we have members who -- who want to use in-person physical therapy, this would not hinder that ability. The plan would still allow them to go off and see the physical therapist they need.

MS. RICH: Correct.

MEMBER KELLEY: So thank you for that clarification.

Have you run into issues or do you have a process in place whereby people are using an in-person physical therapy and they decide to supplement? I mean, we have overachievers that decide to supplement through the program.

Is that accommodated? Is that a no go? How is that handled generally?

DR. PARALKAR: Joanna, do you have any?

MS. BALOGH-REYNOLDS: Yeah. So as part of the intake process, that's where you would fill out and then you -- like I said, before you mail a kit, you're required to have a video visit with a doctor of physical therapy. That's where they would flush all of that out. And then they would make the recommendation, do you continue with in-person PT or is this more appropriate and they would provide that kind of clinical guidance. So we as the plan or you as the plan wouldn't want to get in-between that. You let the doctor, physical therapy flush that out and then guide them. There will be clinical situations where supplemental might be needed for a couple of visits. Let's put it that way, like if somebody needs to manually manipulate your body.

MEMBER KELLEY: And then so just one more question I guess. I haven't spent a lot of time at physical therapy, but I think they use a lot of stretch ropes and all kinds of different things. So does this program provide that kind of, the tools or would members have to go out and self -- self seek the tools to help their physical therapy?

MS. BALOGH-REYNOLDS: They do provide the weighted bands that have the three different, it's light,

medium, heavy, the bands that you use in PT usually is what you're kind of talking about. And then they would, you know, as they are prescribing, they would tell you how to use those. So having used some of this myself, they may tell you instead of, you know, being at a face to face PT, you might use a chair or your kitchen table and they would explain those modifications on, you know, what things you might need to hold onto or if you need to tie a band. A lot of times they will show you how to do it on a doorknob or a railing and then that's how you would use the actual physical bands. So they do have that that they send to you. Outside of those bands, there's not other equipment that they would send you.

MEMBER KELLEY: Thank you.

MEMBER WOODWARD: Janelle Woodward for the record. I wanted to mention to Betsy that as far as outreach from PEBP, I've seen not necessarily in this program but in some other ones where e-mails come through saying your, this is through your insurance and no cost to you. Sometimes it takes a couple of those for you to notice when you're getting a lot of e-mails that, you know, they're sending it to your personal e-mail. So if employees or members are looking at their e-mail, they can find those types of things.

Like I said, if you're getting tons of e-mails, you don't always notice some right away. So I don't know if

there's other ways, you know, to reach out. But -- but it is -- you know, I've seen PEBP do it and I've seen some other companies do that as well.

CHAIRWOMAN FREED: Okay. I'm not seeing anymore discussion on Hinge Health. I guess we can move on.

MR. WARD: On page 12 there's a detailed for projected savings for the first year and the second year. So we would estimate about 2,000 participants would engage an impact on health care savings of about 3.4 million offset by about 2,000,000 fees. That's the $995 for net savings of about 1.4 million in first year ROI. That would grow in year two.

Page 13, there's a couple of case studies that say with these three states and this large city, there's been significant pain reduction that's been reported by the participants. I'm on the fourth row. Generally reporting about a 50 percent pain reduction. It's a similar savings and higher ROI that these are reported after the first year or two of the program having been implemented.

And so I think the initial savings projections for PEBP are somewhat on the conservative side. And I recall at the September meeting, there were questions and discussions about member satisfaction, what has been stated, how do they like the program from the member's view. And so

on a scale of ten here, satisfaction scores, eight and a half to nine. So pain reduction, savings, positive ROI and satisfaction grown.

MEMBER KELLEY: Okay. I'm sorry, I've got to ask. Michelle Kelley for the record. Does Kentucky make everyone participate? Like, why are their numbers so high? It's not that big of a state, and I'm like 200,000 people.

MR. WARD: The State health, the Common Wealth includes local governments and school boards.

MEMBER KELLEY: Oh.

MR. WARD: So there's some state plans in the southeast that is like bigger than you think. North Carolina has 700,000 members.

MEMBER KELLEY: Wow.

MR. WARD: It's all of the school boards are impacted.

So Doctors on Demand, another virtual program here across PEBP. The graph on page 15 shows virtual utilization for both behavioral health and for -- it's for behavioral health, excuse me, for mental health encounters shows virtual visits in the more purply color. And then in the turquoise color is in-office visits.

And prior to 2020 it's almost all in office. And then as the -- as the pandemic started and then into 2021

there was general -- there's more virtual utilization for plan year '21. Some of that displaced in-person care as the turquoise. It's a lower number for plan year '21. It looked like the number got better.

And -- and then we've seen in plan year '22 that virtual utilization has waned a bit, and so we're considering here providing some incentives through plan design to bring some more visibility and reduce barriers to accessing that care.

Access to in-person care is not -- is not consistent across the entire membership as with a lot of providers care. It's much more limited in the rural areas. So this provides -- it provides more access, more uniform access to members regardless of where they live.

And on page 16, so one of the options here is to reduce member cost share to $5 a visit for behavioral health. That would have to be after the deductible for high deductible health plan.

And the anticipated impact is that we would see an increase in engagement for virtual visits. There would be some in-person care replaced by virtual. We are expecting that this would generate and result in an overall increase in utilization and access to care. So there's a cost increase associated, but I think that's a result of members accessing

care.

CHAIRWOMAN FREED: This is Laura Freed. What is the cost for a behavioral health visit now?

MS. RICH: I have that right in the front of me. I was going to add that for context. Laura Rich. So on the CDHP, a 50-minute visit, so there's different -- there's categories. You can do, you know, a 15-minute follow-up, things like that. But for a -- a 50-minute psychology visit, it's $129. So that's on the CDHP.

On the low deductible plan it is a 30 dollar co-pay visit per visit. And then on the EPO it is a 20 dollar per visit co-pay.

MEMBER WOODWARD: Janelle Woodward for the record. Just for clarification at the risk of sounding uninformed, do we currently have Doctors on Demand? Because there's been a lot of talk about in the workplace that that went away. So maybe that's a little bit of why the use has gone down so it is still current?

MS. RICH: Laura Rich for the record. Yes, it is currently. We do currently have this benefit. What we are providing here today is incentivizing this to, so that members will use it over a physical provider. That being said, behavioral health and mental health providers are nationally very very hard to come by. But in Nevada there's

a drastic shortage and depending on where in Nevada it's even worse. So this just provides an additional layer of access that anyone can access at any time and where you don't have to find a provider, go to a provider. It's a virtual visit.

MEMBER KELLEY: Michelle Kelley for the record. I guess I -- I'm not 100 percent comfortable with incentivizing this so that we end up with people who have an established mental health provider that they see in-person, they actually have to pay more for the privilege. That -- I'm concerned about that because it feels like, you know, we get into a situation where mental health providers, it's such a personal thing.

And I know people can look for mental health providers for a very long time before they find one that they can do what they need them to do. So then -- so then are we providing a discount service on-line because maybe there's not the flexibility to pick and choose your provider or is that -- is that available.

But more to the point, I just -- I feel if I was a member using mental health and I was paying $30, I think rather than being incentivized to go on-line, I would be a little angry that somebody else is getting it for $35 less than me. When my mental health issues are just as important to me than that person.

So I'm sorry, I just want to follow-up. The question is real. So when you're using Doctors on Demand for mental health or behavioral health, how much flexibility is there when you're meeting with a therapist maybe that you don't like? I don't know -- I don't know any other way to put it but doesn't meet your needs for whatever reason, how do -- how does that participant go? I don't -- I don't want to use that provider. I want to try a different one. And how often can they do that and who helps them do that? Because in-person you just don't go back again.

MS. RICH: Is this something UMR can address. Do you guys have that?

MR. WARD: Just to clarify here. You're asking about if you're connected with provider X, you don't care for provider X.

MEMBER KELLEY: Yes, that's correct.

MR. WARD: How are you able to explore other providers?

MEMBER KELLEY: Yeah, that's exactly right. Thank you.

MS. HUCKABY: Sorry, this is Rhonda with UMR. Once again, UMR works mostly with several of our preferred tele-medicine vendors, and Doctors on Demand is one of them. For your question, Ms. Kelley, that is something we would

have to have confirmation from Doctor on Demand on how they handle those things to satisfy the member on that question.

MR. WARD: I'll ask on-line if they have anything to add.

DR. PARALKAR: One thing I can comment on is it's becoming more and more common for behavioral health, physical therapy, sorry, mental health counseling for more on-line. It's becoming a preference of choice for physicians as well as patients. So it could be a personal preference if somebody who sees the therapist in-person now. But we see a gradual shift and not just because of COVID. COVID may have accelerated it. But even before COVID, we have seen a gradual shift to seeing therapists more and more on-line.

The providers like it for two reasons. One is they can accommodate more patients than they could. But what I've been told they also like to see the surroundings of the patient. The patient is seeking therapy a lot of times from their home, and they like to see what kind of environment the person is housed in and are there any changes to be made that way, like if you're in a dark room versus a light room, so on and so forth, if you have enough noise in the background. So they can perceive some of those intrinsic needs or other hidden needs that a patient may have.

And patients like it for a few other reasons too.

One is they can get these counseling sessions privately instead of being seen to be not going to visit a provider for behavioral health therapy. And two, it's convenient, there's no doubt about it. It's easier to get an appointment. You can actually get an appointment from a physician across the state who is licensed to practice in your state. So you have more choices as well. So we have seen this shift happening and it's for a lot of beneficial reasons.

MEMBER AIELLO: So I have a couple of little questions because I hear what Michelle is saying. I also wonder about reverse parity and quantitative. If we're offering mental health visits for 5 dollar co-pays but we aren't offering medical visits for 5 dollar co-pays, in a way that might be a reverse parity issue. So I just thought I would throw that out.

The issue is the service is there. And in Nevada we don't have many mental health providers. Is it, again, a reach out to members to say, hey, if you're having trouble finding an in-person mental health provider, remember we have Doctors on Demand and you can get it because of that reverse parity question and then also it -- because to me it does make sense that behavioral health might be one of the easier ones to do over telehealth, so those are a couple of things I want to throw out also.

MR. WARD: This is Richard Ward. I can, in response to the parity question. There are no compliance concerns so it would be a strategy or a policy issue. So you can provide mental -- you can provide access to mental health benefits with a richer benefit than nonmental health of the compliance requirements.

MEMBER KELLEY: So, Executive Officer Rich, Michelle Kelley for the record. Just a question for you. So you gave us the current cost of behavioral health care cost visits now. Is that utilizing the Doctors on Demand, so that the 129 30 and 20?

MS. RICH: Correct, yes.

MEMBER KELLEY: Okay. So today we're discussing Doctors on Demand with and or a 5 dollar co-pay. Could we also discuss if people like the 5 dollar co-pay for mental health making that part of the core plans as well.

MS. RICH: Laura Rich for the record. That's not in the analysis that we did but it's not something that we can't do and bring back to the January Board meeting, bringing down that mental health co-pay just in general.

MEMBER KELLEY: Thank you.

MEMBER VERDUCCI: Tom Verducci for the record. I see a lot of advantages to this in terms of cost. There was a trend towards virtual meetings that we saw earlier in this

presentation. And I do think we have a lot of employees in the rural areas and this will give them, you know, choice and ease, as well as the doctor was mentioning, their own privacy. So I do see a lot of benefits, and it looks like it also falls in line with the current trend in terms of virtual meetings.

MR. WARD: Okay. Moving on to item number four, which the content begins on page 18, which is providing an additional travel benefit or medically necessary abortions. There are some PEBP members that reside in states that do not have access to medically necessary abortions which is the current PEBP's coverage for abortions as when it's medically necessary.

There are about 50 to 60 medically necessary abortions covered in PEBP. Reviewing recent experience data for the past three years and we estimate that there are between five to 700 females between ages 18 and 50, and I'm saying estimated because there are a number of college students that in the consensus file and zip codes and addresses that are associated with the parents and we're not sure exactly where they live. So this is a bit of an extraction of zip codes outside of Nevada that -- that we see.

So this proposal would extend travel benefits to

members who are required, who need a medically necessary abortion but are unable to receive care where they are, whether they are traveling or where they reside. And this is something that can be implemented immediately. So this would cover -- this would cover the travel benefits.

The care, there would be no impact on the cost of care because the care is covered currently and it will -- we're estimating five to ten instances annually with most of these being able to it be accommodated with regular commercial travel but there may be a couple of instances that are more acute where there's emergency medical transport, either air or ground necessary to transport the patients to a state where she can receive the necessary care.

So estimated costs would be, like I said, just for the travel component because the cost of care is already covered and that would be about 25 to 50,000 annually with that expanded travel coverage.

CHAIRWOMAN FREED: Question. Laura Freed for the record. The footnote says while the IRS has determined that abortions are medical care, per IRS pub 502, the conditions surrounding employers paying for travel to have an abortion are yet to be determined given existing and changes to state law. Is the IRS in the rule making process on this point or no?

MR. WARD: The IRS determines -- hold on. I have my friend back here.

CHAIRWOMAN FREED: That's fine. You guys can get back to me just on that. I was just --

MR. WARD: So we can get back. Is she coming? Thank you.

MS. DUNN: Amy Dunn. On the -- the current is really about not looking at again because I think everything is trying to be looked at globally in this. I'm not seeing they are in the rule making officially in this point, but it's a very open question going on right now.

MS. RICH: Laura Rich for the record. I just want to add that there's a lot of health plans nationally that have taken the step and have, you know, this step and even much more broader, more extensive actions in response to the Supreme Court decision over the summer, and so there's a still a lot of gray areas out there and have yet to be determined by the feds.

MEMBER BITTLESTON: This is Leslie Bittleston. So I guess I have a comment. So we have, you know, members maybe living in Georgia going to college. And I guess I'm concerned about the term medically necessary because by the time the person is medically necessary, they are probably real acute by that time. And we're relying on other states

that to determine this medically necessary. Before we fly them back to Nevada for the, I guess I'm just trying to wrap my head around what this looks like. I mean, I support the benefit. I'm just trying to understand how it would work if we've got a kid, a young female in another state who's pregnant and now needs a medically necessary abortion but she's already acute and we're going to send her back?

MS. RICH: Laura Rich for the record. We're not necessarily sending people back to Nevada for care. It is they -- the closest geographic location that they can access care. So for example, in Utah, for example, where there's obviously some limitations there, they would probably go to, you know, to Nevada, you know, depending on the region where they live in or Washington or so there's options. So it's not just bringing them back to Nevada, it's wherever that closest area of care is that they can access care.

A lot of these situations are also where because of the laws that have been implemented in those states, you have provider access issues where there are providers that don't offer that service so they have to travel out of state to access that benefit.

MEMBER KELLEY: So, Executive Officer Rich, Michelle Kelley for the record. So can you just clarify then, what does that look like for a participant because

you've kind of I think just thrown in a few more things that have to be done for someone who is in this situation.

So right now if a person is in one of these states, are we not paying for travel? Are we prevented from paying for travel?

MS. RICH: In our master plan document there are a few services that qualify for that travel benefit. So for example, transplants, right, or when you have to travel to a Center of Excellence. If you're receiving bariatric surgery and need to travel to a Center of Excellence because that is required by the plan, we do offer that travel benefit where the person can get reimbursed for the travel expenses. What we're proposing here today is adding medically necessary abortion to that list of services.

MEMBER KELLEY: Thank you, so that's hopeful. Let's use Georgia for example. Someone is pregnant in Georgia, somehow they find out obviously the baby's life is at risk or there's a problem. They need medically necessary. So at that point what happens if and when we pass this?

MS. RICH: So at that point it would be similar to what the process that's in place today. So any person who is receiving a benefit or a procedure is going to receive a procedure that is, covers -- it's covered under the travel benefit, they would provide the, there's a form that they

fill out and they receive those.

The expenses or the approval for those expenses, moving forward, sometimes there are people it's a retroactive request. And so, you know, in cases where disease or something like that, we would process that as a retroactive request, but there's a process in place to get that travel benefit today.

MEMBER KELLEY: I guess I'm -- I'm sorry, I guess I'm still not clear on how it works because if there's all these barriers within the state, so like how would -- how would a participant even identify a provider? Like, is there a way that these people are actually given more support than just reading the master plan document or calling and sitting on hold for the long wait times. How would they find out how to do this? I don't know how better to put it, sorry.

MS. RICH: Laura Rich for the record. So I might have to put UMR on the spot here. Is this something that case management would provide assistance for if this was a -- if a member called and said I'm in this situation and I need -- I need some hand holding.

MR. STOCKWELL: Jesse Stockwell for the record. Yes, you should be able to manage that.

MEMBER KELLEY: Thank you.

CHAIRWOMAN FREED: This is Laura Freed. The box,

third box says can be implemented immediately or at the start of the plan year. If it were implemented immediately, wouldn't that trigger the 30-day notice change in coverage part of the statute?

MS. RICH: Laura Rich for the record. I would argue no because it's equally being applied to all of the plans so it doesn't -- it does not trigger an open enrollment program or a special open enrollment period.

MR. WARD: Moving on, staying with travel with item number five, on page 21 of the terms. The more broadly, there are medical travel programs that provide access to Centers of Excellence or quality care, high quality care nationally. So Executive Officer Rich was mentioning that there's provisions right now and the plan document, that's the plan document for transplants and other specific services. So this -- think of this as an expansion of that provision where with more of a concierge component to it.

So there are a number of high costs and scheduled surgical procedures. There's a list here on page 21, knee and hip replacements, think of bariatric surgery for example colonoscopies in some instances. And so these programs provide access with a number of these considerations here. This provides a broader access to quality and often times lower cost care.

There are Center of Excellence networks that are, utilize value based contracting. A lot of ways to pay is with on go payments with the provider. So rather than being a separate bill for anesthesiologist, the facility and for the surgeon, it's all rolled into one cost. It's been negotiated between the member and the providers. And this approach generally -- generally results in lower costs and improved outcomes since your providers are, they are specialists in this. So rather than someone seeking care locally for a joint replacement and utilizing a surgeon that does a couple of dozen of these knee replacements a year, this provides access to a surgeon that maybe does hundreds of knee replacements a year and has -- has the procedure, is an expert in this particular procedure.

We just a few minutes ago we were talking about how do people access this care and findings for that. So the member experience, we'll stick with the knee replacement. So you've been determined that you would benefit from a knee replacement and you have this access to this program so you contact this vendor and there's an intake process where they evaluate the opportunity. Does it make sense for you to seek care locally? Maybe that makes more sense, maybe in Las Vegas affordable, quality care there. You live somewhere else.

There's other options. There are with these provider networks, these COE networks, a number of networks have providers in Nevada so it's not exclusively. They are out of state, not necessarily. And the -- during the -- during the counseling session or the intake of initial portion of the process, if it is determined that there's an opportunity here then generally speaking they are provided three or four options of providers in different cities to choose from.

And then once they make a selection then all of the travel arrangements and the costs are covered without their meet pay out-of-pocket. So generally there is books. They often can come with a travel companion. Hotel is covered and they may even be provided a debit card preloaded for instance. It really smooths out the member experience. And, like I said, offer options for not necessarily the closest city. Maybe you have family in Boston. That's not the closest city. There's closer care in Seattle or San Francisco or Minneapolis but because you have family in Boston that would help with your recovery so as a member you the option -- you have the option to choose.

Since this provides access to lower cost, higher quality care, often times these are implemented with incentives to -- to make the option more attractive. So

often the reduction or elimination of member cost share that would not be the case with the high deductible health plan that need to be after the deductible but you could eliminate all after deductible cost sharing and then for the other two plans. It could be without -- without cost share.

Implemented at any time, we have a number of clients that implemented in the plan year, not necessarily the beginning of the plan year. And it's likely that an RFP would be necessary to align this better. And the annual savings, we estimate the year that savings between one and one and a half.

Moving on to page 24, again, reviewing the data, just two examples, joint replacements, knee replacements. We see variations. In cost 2020 it's 60,000 roughly. And for hip replacements, between 15 and 40,000. So there's a wide variation in cost currently that providers are overcharged. Generally speaking there are higher cost in more rural areas than urban where there's more competition of choice for members.

One of our state clients, the State of Alaska recently implemented one of these programs in 2019. They have about 14,000 total numbers in the state plan. And the most recent year in 100 -- about 120 potential cases and it was determined the member followed through and traveled for

care for 35 procedures out of those 120 potential cases. And in total there's about a million dollars in savings for those 35 procedures. 90 is direct savings just for the actual cost and care of the procedure. And then there's roughly another 100,000 for a few instances where it led to a reevaluation of the initial diagnosis and ultimate care was utilized.

And just some select procedures from -- from the most recent year in Alaska. Just looking at bariatric surgery, there are eight procedures and the current TPA network, the provider costs were just under 60,000 per procedure. And through the travel vendors COE network, there were less than that. Well, a little under 30,000 for procedure and then for orthopedic which is generally the joint replacements. Six procedures at 40,000 per on average were reduced to 50,000 for procedure.

So it -- it not only accesses the lower cost of care but it addresses the variation that all plans have right now and that is really dependent upon where the member is accessing the care.

So I'll pause here.

MEMBER BITTLESTON: Leslie Bittleston for the record. That was a lot to process. So the vendor that you're talking about is somebody we don't have yet. Is that what you're saying or is it UMR?

MS. DUNN: We would have to RFP for this.

MEMBER BITTLESTON: Okay. Once we have a vendor and is it the physician that is recommending the knee replacement to let the client know they need to contact the vendor? I guess I'm just trying to piece that together how the individual who needs this service gets in contact with the vendor.

DR. PARALKAR: Yeah, this is Dr. Paralkar. So there is extensive communication that will happen from the vendor as well as from you guys through your communication with the members. And then there is the communication stays and they kind of do it pretty regularly about if these are the procedures that your doctor says you need, call this number. I mean, you can collectively call for certain symptoms if they are appearing.

And then the number, usually these vendors have a case manager service that kind of walks you through your symptoms. It also has a second opinion service if needed. I think they send your case to a second opinion. And partly if the surgery needs to be done then they advise you where to go. So the vendor does allow communication but they also need your help enhancing that communication so that you make sure that it goes in places where members actually access the information.

MEMBER KELLEY: Michelle Kelley for the record. And I just, once again clarifying, so this is a medical travel program for travel within the United States, Center of Excellence always within the United States?

DR. PARALKAR: Yes. Yes, this one specifically is only in the United States. They will not be sending you outside the U.S.

MEMBER KELLEY: Okay, thank you.

MEMBER WOODWARD: Janelle for the record. So apparently the EPO does not allow you to go outside of the area, the north with this constituted then to that plan?

MS. RICH: Laura Rich for the record. The EPO doesn't allow for out-of-network services and it's -- usually it's regional with exceptions. If there's lack of providers in the area, you know, things like that. So there's gap exceptions, yes, this would be part of that network. It will be utilized for that as well.

MEMBER AIELLO: And this is Betsy for the record. It's my understanding it would always be a choice. Someone can go the traditional method, but if they wanted to go to the Center of Excellence that's hence the incentive.

MEMBER KELLEY: I'm sorry. One last question I thought of. Michelle Kelley for the record. So you talked about a member would get, you know, multiple quotes, if you

will, they have options. Do those options includes qualitative metrics so that they can see, oh, maybe this person does it best but they're all the way over here or is it purely price driven what a member is given?

MR. WARD: Not price driven. What the members are provided varies.

MEMBER KELLEY: Okay.

MR. WARD: That's something how that communication interaction occurs is something to explore.

MEMBER KELLEY: Okay, thank you.

MR. WARD: Okay. Item six, Oncology Concierge. I'm going to ask Joanna to provide or Dr. Paralkar to provide an overview of how these programs work.

MS. BALOGH-REYNOLDS: So this is Joanna Balogh-Reynolds with Segal. In the slide packet on slide 26, we have a grid breakdown. So with oncology and especially whenever you're managing catastrophic claimants, usually the population is very broad. And so intensive case management through your carriers, their focus on the most catastrophic individuals with high stage malignancies. And they're requiring things like inpatient surgical care, very intensive chemotherapy, radiation that you actually have reactions to or you have metastatic cancer and then hospice.

So there is a subset of cancers that are not

generally qualified or oncology case management. So currently with UMR, you know, the goal of the case management is care coordination focusing on those acute catastrophic type of cases. They can help you with navigations to center of excellences. If you're an individual and you're not sure where you want to go for treatment and then they assist you with personal care needs.

So part of what they do, it's a registered nurse. You know, they usually have a background in oncology. They're managing you through symptom management as well. So they might talk with you about are you nauseated? Are you having any infections? What is your sort of sick day plan if you have reactions to chemotherapy and you're at home on the weekend. So they guide you through that catastrophic need.

But then there's that whole other subset of individuals with cancer needs that maybe are not getting those access to case management because they are physically okay but they are not getting guidance or steerage to second opinions.

One of the biggest things we see in oncology care, there's about a 20 percent misdiagnosis and/or mistreatment rate, and that usually comes down to looking at, one, the pathology. So having a pathology read directly so you get the right diagnosis is key.

But then secondly, in the regional space, it's very difficult because oncology treatment is rapidly evolving and nutrient protocols come out all the time. And so it really does become difficult if you're an independent practitioner or in a more rural setting but you don't have access to the tumor boards and research entities to be able to keep up with the treatment plan.

So in this grid over on the right, what we're showing is the opportunity for enhanced and/or concierge type of oncology care. So we would take that sort of care management with oncology, flip it. Put it kind of on steroids, so to speak, and add in more services like dietary counseling, pharmacy and channel management with your medications, second opinions that you are getting access to, you know, the latest clinical trials, the most appropriate treatment for your care and then enhancing any other services across a broader population.

If we go to slide 27, this is what we're kind of over-viewing. So this can be implemented midyear, off cycle and we would review, you know, anything with UMR for a possible RFP. So talk to UMR about enhanced options that might be available and then potentially RFP the market to find a partner that can bring that sort of second opinion concierge type of program to your employees or your members.

And then below we have savings projected. So cancer is the second highest cost in your high deductible, number four in the EPO. For most clients, it's either number one or number two. There's been some recent research articles that's predicting this will be the highest cost driver over the next five years. So you spend 20,000,000 in annual claims cost, that's about 1,500 people. Your PMPM is anticipated to be about two to $5. And the concierge can really reduce cancer cost by five to ten percent. And so that comes from the annual savings of one to 2,000,000. And, like I said, that comes from the diagnosis and treatment being optimized. And then on the flip side, so that will enhance programming around nutrition, social determines of health and decreased mortality. So that's really where we would derive these kind of savings from.

And, Dr. Paralkar, is there anything I missed or you want to add?

DR. PARALKAR: No. I think you covered everything that is in the program.

MEMBER KELLEY: I've actually got a question. Michelle Kelley for the record for Executive Officer Rich. This one doesn't say it needs board of examiner's approval but there is a cost associated with it. So does it need board of examiner's approval?

MS. RICH: So Laura Rich for the record. It's actually IFC. So there is a cost associated with it. We may actually, because it's a total cost savings or projected cost savings or it's not a total cost. We wouldn't have to -- we would be able to justify that. But we may have to go out to bid. UMR does offer options and we would be able to leverage that through our existing contract if that's what we wanted to do or we would also have the ability to go out to RFP and see what's out there and consider against what UMR has to offer.

So we potentially would have to bring this back as a contract and a new contract in which case, yes, that goes through -- that goes through the, as a, you know, that goes through the Governor's finance office and has to be approved that way.

CHAIRWOMAN FREED: This is Laura Freed. I got lost here. Okay. So obviously, yes, if we did an RFP to see what was out there, might cause an IFC, well, a workaround. But if you're paying a couple of hundred thousand dollars in PMPM's and you're using the current -- you're just adjusting the current UMR contract, I do think that would be a board of examiner's visit. Correct, yes. Right, right.

MS. RICH: Yeah.

CHAIRWOMAN FREED: So yes to your question, would

go to the board of examiner's because it's a contract amendment, yes. If they went with the current -- if they use this service provided by the current vendor, so.

MEMBER KELLEY: I guess just as a follow-up. Two to $5 is a really broad range.

CHAIRWOMAN FREED: Yeah.

MEMBER KELLEY: You know what I mean. It's kind of as big as a whole dart board. So do we have an idea of really like what drives the per employee per month cost? Is it just sheer numbers, demographics?

MR. WARD: This is the administrative cost associated with an external concierge program. So it's going to vary -- excuse me, it's going to vary by the range and level of concierge services. So from a more basic perspective where it's, the program is focused on care management to those that provide access to a network of COE's, Center of Excellence, to those that provide an enhanced level of care and personal assistance. There are programs that -- that will make your daily life easier, for want of a better term, when you have cancer and you're undergoing care, so taking care of your house.

MEMBER KELLEY: Thank you. You know, we've heard a number of times from people, from our participants that this kind of a program would be very helpful. I guess I'm

just trying to understand. You know, $2 is one thing. $5 is a whole nother ball park. So but what I'm hearing you say is it would probably -- we would be best served by going to RFP so we can compare products.

MR. WARD: You would compare what you're getting with what you're putting in.

MEMBER KELLEY: Thank you.

DR. PARALKAR: So I -- this is Sadhna for the record. I finally learned what you say. It -- it varies and that's why we have the range to two to $5. And some of the programs that we saw recently that are models of these programs, one can be something called an expert case review that's triggered directly through your claims data and they can completely do it case rate way, meaning you will be charged only if your case is reviewed, so there will be no PM.

But there are some certain things with this enhanced cancer support team that Joanna explained about, you know, hand holding of the patient and the member's family and allow, you know, kind of just arranging some more staff at home, that will need a PEPM. Expert advisory review will also need a PEPM. And then there's another way where they can also do just a case rate, where you send the patient for expert consultation in a physical facility. That's a case

rate way too. So there are variations of these programs and definitely it will reveal a lot more if we do a comparison through an RFP.

MEMBER BITTLESTON: This is Leslie Bittleston for the record. I guess this may be a dumb question. But it says the highest stage malignancies and acute, so we're talking stage four and higher I assume. And it seems to me that our stage two's and three's may be falling through the cracks a little bit. They may not need enhanced concierge services but the basic care coordination -- I guess I'm trying to wrap my head around what we currently offer is only to the highest stage folks and we're just enhancing that so we don't offer anything to oncology patients or cancer patients that are lower stages; is that right?

MS. RICH: Laura Rich for the record. Yes and no. I mean, anyone can utilize our current case plan management but they're not -- they're not identified, right. So for example, there's -- I heard a story the other day from someone who has a son-in-law who is 30ish years old and just got diagnosed with cancer. He got the runaround and he's covered under our plan. He got the runaround.

And it went from being perfectly healthy to is now hospitalized. He went to go see a lot of different, a lot of different providers. They didn't give him the right

information. They didn't coordinate with each other. They didn't -- and this person is a 32-year-old man. He's probably never had to go through any of this. He doesn't know what to do. And so this is a situation where this kind of service would have helped, you know, to -- to coordinate that care and to make sure that, you know, Dr. A is talking to Dr. B and that things are happening between providers.

Another situation, and I brought this up before about a previous Board Member who passed away from cancer. Her concern was handling her -- she was on the high deductible plan and handling her bills. She couldn't keep up with the bills that she was getting from all of the providers. And what had hit her out-of-pocket when, just following up on that, and when she entered hospice care, she specifically asked PEBP to help her long-term partner to -- to help him navigate through that financial mess.

And so there's different areas of this to where we don't currently do today that we just have that extra level of attention.

MEMBER BITTLESTON: And this is Leslie for a follow-up. I just would like to see, you know, if you're an oncology patient to be able to access, you know, care coordination services.

I did lose my father to cancer and he was -- he

was a state employee. So -- so I guess what I'm saying is, you know, they start out at level one, level two and they can progress very quickly. So, you know, I think this is a great benefit, but I would just hate to see if focused on those highest folks and not the rest of the folks that may need this like -- like Executive Officer Rich's comment of the 32-year old man. So that's it. Thank you.

MR. WARD: If I may comment. This is Richard Ward from Segal. On slide 26, that language is referencing what is in place today currently. So it is -- the current program is as focused as you're -- as you're stating but we're suggesting considering expanding it. I think -- I think, and I don't want to put words in your mouth, but in the way that you're -- you're -- yes.

MEMBER WOODWARD: Janelle Woodward for the record. Just from a personal standpoint, I was one of those people who went into my cancer diagnosis as a -- all your imaging shows this is early cancer. And when I went into surgery, which I would have chosen very differently had I known what was really there, it was advanced, and stage 3C is advance. It's right before metastatic cancer.

I felt they were correct because my doctors didn't communicate with each other. And I had -- there's one oncology group in Reno, one, and they all worked together.

So my oncologist said, well, you're past that, you know, what the studies show for -- for chemo so we'll just hope for the best. No, I don't want to do nothing and hope for the best. I wanted somebody -- so I contacted my personal physician, livid over that experience and was referred to a different person who at the time was with Renown so I was confused. I didn't realize there was only one group and he was loaned to Renown so now we're back in that original group because he's no longer there but that would have helped having somebody.

And at that point somebody did come in and try to coordinate and coordinate that second opinion with a different doctor. And then going over to California just to make sure that they agreed that we were doing the right thing. But when your life is involved, you want -- you want somebody to help you through that process, and I have a medical background and it still happened to me following through.

But I don't want a doctor saying, well, we'll just hope for the best. Tap you on the shoulder. This type of thing is very important and I'm thankful that you pointed out that this is the current thing because I didn't notice that either. And I was thinking that if it's only for, you know, the highest malignant rate, that would be disappointing. And -- and even, you know what, you know this

too, all of us know this because of cancer experience of people that we know. It doesn't stop once you're done with your surgery and your chemotherapy and your radiation. It keeps on going.

And even today sometimes there are times that I don't do the follow-up tests because I can't afford that co-pay or co-insurance cost of it. So things like this can be so helpful at any point in your treatment for any of our members who are going through that. And you don't know just because they said oh, we think it's like this big, you know. And then they go into surgery and find out, well, it wasn't just this big. It was this big and makes a big difference, so that's just from a personal standpoint.

MEMBER KELLEY: Michelle Kelley. We still have got other programs to talk about. But I'm just wondering so potentially two RFP's, how is staff situated to actually action RFP's and then when, we probably would be talking about potentially not next plan year, right, but the one after, so.

MS. RICH: Laura Rich for the record. So this can actually be implemented at any time during the year and so regardless of when the solicitation was completed, we could put it into place.

As far as staffing, no one wants to go through

RFP's. I think we went through a lot of RFP's in the last two years. However, the next agenda topic is the contract status report where I'm actually suggesting proposing bringing back a former employee on contract and so that should help out this process as well, not to minimize, yes, we are very busy and we have a lot on our plate. But I think these are important and they are definitely -- they are services I think we can -- we can have our consultants help us with as well so it should be doable.

MEMBER KELLEY: Yeah, Michelle Kelley for the record. I guess what I'm hearing when I listened to everyone's comments about the Oncology Concierge program especially, it seems like we need some expert in the room to evaluate the apples and the oranges and the pears, right, because the devil is going to be in the detail of what you're paying for. So thank you.

CHAIRWOMAN FREED: So if we are finished with Oncology Concierge thoughts and questions, what I think I'm going to do is have Ms. Ward and Ms. Rich go through seven through ten, discuss them, then take a break and come back and deliberate as a Board just so you guys get the lay of the land. I'm not going to let you just sit here forever.

MR. WARD: Okay. Dental plan maximum, I take that it's my key, right. Okay. Number seven, on page 29,

the current annual benefit limits the ADL, $1,500 has been in place for over ten years. As far as we can tell it was implemented in 2011. In comparing against some benchmarking data, we'll thank UMR for providing us a perspective on their book of business. That is the most prevalent ABL, but there are a number whose movements in their book of business and then also in industry data towards higher ABL's due to rising costs.

Looking at other industry data for public sector and large employers, 1,500 to 2,000 is a typical range. But there's roughly 40 percent reports, I mean benefit limit of $2,000 or greater and there's five percent that have no limit at all.

And then for those that have limits and that report, there's one study that reported geographically. I found this interesting is that western employers and plans tend to have higher limits than those from the midwest and east so that bottom bullet, about $500 higher.

There are a number of procedures such as implants, crowns and some specific surgeries that with a single claim, members hit their annual medical. So -- so the limit is really having an affect on numbers. When you have a year where you have a high cost, you're having to pay quite a bit out-of-pocket once you hit the limit.

On page 30, according to the most recent plan year data, it's about eight percent of members that hit the benefit limit and that's fairly typical. We see seven to ten percent, depending on the benefit level and the year, just looking at our other clients. And it's usually not the same members every year. Usually somebody has a particular need. They hit the benefit limit and then for the next couple of years they're back to receiving regular care or more routine care.

Increasing the benefit limit would increase dental costs and have an impact on the rates and we modeled two specific changes, one to 1,750 and another to 2,000. You can see the cost increases are -- annual cost increases are 600 to 750,000, two and a half to roughly three percent. Increase on dental costs, once it's combined with the medical. For single premiums, that's about a dollar or two what's there.

MEMBER KELLEY: I guess I just have one question. So -- so we've been talking about the earlier benefits that we were talking about them impacting the self-insured products. But dental actually benefits all employees, including self. So did the dental plan generate some of the savings we're talking about spending?

MS. RICH: I'll have Richard confirm. But the

dental plan is very minimal spend over the plan itself. So it's likely it did not generate the savings.

MEMBER KELLEY: Okay, thank you.

MR. WARD: I'll concur. So moving on to item 8, I'll pass it back to Executive Officer Rich.

MS. RICH: So item eight is premium credits. I want to start off these next few sections with just talking about how PEBP has the ability to direct the -- any money that is applied towards or that is the spend-down of the nine and a half million dollars. And Michelle Kelley actually set it off, you know, in her last question where it's -- where was -- where is the savings, this nine and a half million dollars, where is it coming from?

It is likely most of it is coming from active participants on the self-funded plan. And the reason it's coming from active participants is because actives tend to subsidize the retirees. Retirees are generally more expensive. And so more of -- more of the plan spend is going towards that versus how much we're bringing in, right. So but we have to keep in mind how do we want to give back those nine and a half million dollars, however we choose.

So these next three items are -- I know we talked about a few items that are the due cost the plan or, you know, would reduce that nine and a half million dollars.

They are fairly low dollar amounts. So this is really these next three items are ways to reduce and take that nine and a half million dollars and spend it specifically back to the plan or back to the members.

The first one is premium credits. We can apply excess cash towards premium credits. The advantage to that is that it's immediate reduction to those premiums. So people are -- people who are paying premiums are getting that back.

Now if you take a look at the chart here, really that premium credit per month, at the most we can provide, it's about $25 a month per person per employee so per primary member.

There's a major disadvantage here in my opinion, and that disadvantage is that there is no guarantee that this credit can be continued beyond this year. So this is one year. We have nine and a half million dollars of excess. We don't know if we're going to have that next year. So this is one year.

So what happens is people get used to that credit and they forget that it's a credit, and so they get used to the price of that premium per month and they just assume that's the price of the premium per month.

When that money runs out and when we don't have

that money, then those premiums have to then go back to normal levels, right. They return to normal levels and not just that, but there's likely going to be increases because the cost of health care increases year over year.

And so that second year, if we don't have the funding available to bring down those premiums, it's just going to anger participants. People are going to -- to not appreciate. They are going to forget that it was a credit versus, you know, they are going to think that this is just the cost of health care. And so there's a risk of angering participants because they are going to think that PEBP just raised rates instead of we just ran out of that excess money. So that is definitely a disadvantage there.

The other thing is would we want to apply that just to active members? Do we want to apply it to the non-Medicare retirees, right? So these are all things we have to think about as to, you know, if we do choose this, where does that premium credit go to?

We're also highlighting just on this chart here State. There's also non-State as well. So there's a lot of options here as to, and we do have Cari, who's ready with her calculator to -- there's a lot of different -- there's a lot of different ways to do the math and how to spend down that nine and a half million dollars. We couldn't put charts for

every single one of these scenarios so Cari has come prepared with a few different scenarios, but we do have the ability to kind of quickly calculate that cost based on that enrollment and what -- what path we want to take.

The next one is HRA credits. We do have the ability to offer a one-time HRA credit to members that are enrolled in PEBP. This does not impact HSA contribution requirements, so we -- we cannot provide an HSA because an HSA is only available to members on the high deductible plan. You cannot have an HSA per IRS requirements if you're not enrolled in a high deductible plan, but we can provide an HRA.

By providing an HRA, we also don't make -- we don't impact those people who have an HSA who are contributing to their -- their annual contribution limits, right. So if we were to contribute and add money to someone's HSA, it could potentially put them over the IRS limit, so we don't want to do that either. So by offering an HRA credit, it avoids that.

And we also can limit a time frame. So we can say you have a year to spend this HRA money, whatever that is, if it's 300, 200, 100 or 400, whatever it is, and you're able to, then anything that's spent over that year goes back to PEBP.

Again, we have to think about is this something we want to do for actives for non-State, for State, for retirees. You know, we have to figure out what kind of credit we would be giving and to who. An HRA is, just to back up, it's very similar to an HSA. It's just you're reimbursed. It's a health reimbursement arrangement. You are reimbursed for IRS eligible expenses, medical expenses. So there's a list of IRS medical expenses that are eligible for reimbursement through an HRA. So those members who had that HRA, let's say you have a 300 dollar HRA credit and you need glasses, you can go out and buy glasses and use that 300 dollar credit.

The next one is actually something we stumbled upon and not necessarily a specific to health care but more of an option to I think PEBP play a role in the overall staffing, state staffing challenges. Although, it is not our -- our obligation or our duty, our responsibility to fix this staffing problem in the state. I mean, we are part of the benefits part of the overall compensation package.

And so the lifestyle spending account is something that was brought to our attention in just some of these other conversations that we had with our vendor partners. And what this is, it allows an employer to fund an account that supports everyday needs that are not typically

covered by like an HRA for example, that's a specifically medical expense identified by the IRS as eligible.

It's -- it's very similar to an HRA or FSA where eligible expenses can be reimbursed. It's just these eligible expenses are things that in this case PEBP can't identify what is an eligible expense.

With an HRA, the eligible expense, the $300 would be or I'm just saying $300 as an example, it would be pre tax. In this situation it is post tax with the LSA. It is post tax and only taxable when that money is spent. So just like on your W-2, PEBP provides reporting for HSA and HRA and things like that. On your W-2, we would do the same thing for the lifestyle benefit as well.

So as I said, the employer can establish eligible expenses. And in this case, if we did go down this route, PEBP's recommendation would be to focus on health and wellness expenses that are not necessarily something that would be in -- you know, identified as a -- as a medical expense but still a health and wellness expense.

Again, it's funded on an annual basis. So anything not used after that year would be reverted back to PEBP. And the reason that we're doing this is because it would be a -- it has a fee associated with it so you don't want to continue paying that forever.

It could help towards recruitment and retention challenges. It's kind of a unique benefit that hasn't been discussed and analyzed in the past. We do have both UMR and HSA Bank offer this. HSA Bank provided a 75 cent per member per month quote. This is not formal but just in -- in last minute conversations about what that cost would be.

UMR did come in as well and it was pending at the time. It's a bit higher on the per member per month fee on UMR. It would require a contract amendment, but it is still something that is, we checked with purchasing. It is within scope of both of our contracts and so it could be we wouldn't have to go out to RFP. It would be something we could do as early even as March 1st if we wanted to do this right away.

Again, how do you want to -- how do you want to use those funds? Is it only going to State actives? Is it also going to the retirees? You know, this is something that -- that the Board has to consider.

So if you look at page 38, there's some sample eligible expenses. And when I say health and wellness focused, it's things like gym memberships, dance classes, athletic gear, massages, child care, elder care, things like that, LTD premiums, identity theft, things we offer through reimbursing the premiums that we offer through our voluntary benefits, legal expenses, counseling, cooking classes, even

state and national park passes. Things that would -- you know, we have a broad ability to identify what kinds of categories would be reimbursable. But I think that these are, you know, a good sample of eligible expenses that if we were to go down this road, you know, they really tie into health and wellness versus just medical.

So there are three things right there that -- where we spend the whole nine and a half million dollars. I will -- I will stop there.

MEMBER AIELLO: This is Betsy. With the lifestyle spending account, can you reimburse medical expenses if you want or only with the HRA?

MS. RICH: So Laura Rich for the record. You probably -- because it's post tax, you would want to stay away from those medical expenses because you want those to be pre tax. So you want people to be using their HSA or their existing HSA or HRA funds for that.

The other thing that I would say too is that these categories are, for example, with an HRA, a, you know, young 25-year-old on our plan may not have any reason to -- may not have any eligible expenses. And so that 300 dollar credit for an HRA would, they wouldn't use it because they wouldn't have any eligible expenses. Whereas, the lifestyle spending account, you look at the list. I can't think of one

person who wouldn't qualify for something on that list. So it does open the doors to a broader -- it's a perceived better benefit because it's not just focused on medical expenses.

MEMBER KELLEY: Michelle Kelley for the record. So I guess I want to go back to the tax reporting. You know, where on the -- where on the W-2 is this reported? Is it gross income? Is it an actual box? I actually do have a lot of concerns. I think at the moment you report into boxes and it's kind of separate from our gross income.

I think that if we try to start, if we put in place a program that requires our payrolls then as due to add money into gross income, we kind of run into a lot of issues potentially, you know, that worry me.

MS. RICH: Laura Rich for the record. I think we have someone from HSA Bank that can speak to this. I think maybe Ruth. Is she on?

MR. WARD: For the record, it's actually Luis. Ruth is on but Louise will jump in. It doesn't have to be added to gross income. It's actually additional benefit. So it -- it can be utilized as its own separate box.

MEMBER KELLEY: Does it add to the gross income? If it's a taxable benefit, then it will increase people's gross earnings, right?

MR. WARD: It will increase but it increases it as an additional health care benefit but I will -- I will triple confirm with our legal partners, and I will provide that detail to Laura as well.

MEMBER KELLEY: Okay, thank you.

MR. WARD: So I can give you very specifics which is what I think you're looking for.

MEMBER KELLEY: I guess I have some other questions, just on the last three items that you priced out for us. You have written in the pricing all State employees, all active State employees. So is that so not just the self-funded plans. But into the pricing at the moment is all actives. So people who haven't contributed to the savings. I'm sorry, I'm going to keep saying that because it's meaningful to me.

MS. RICH: Correct. And that's something that, again, we have to consider because you can, you know, make the argument that retirees have not contributed to those savings. So do we exclude those -- you know, do we exclude the retirees as well? Do we want to look it as a benefit where -- do we want to make an impact in the workforce situation that we are -- that we are faced with. If that's the case, then actives, it would make sense to direct this towards the actives. And this is a -- whatever benefit we

choose would be a perk, perceived perk for actives.

But, again, we're a health plan and we have different categories of different people. You know, is this something that we want to equally distribute to members, right. So it's something that we have to think about as a Board.

MEMBER KELLEY: So I guess my response to that as a follow-up, Michelle Kelley, is that when we price these plans in March is when we price them, there was already money, differential money left over, but we still priced really conservatively, and it's the pricing that's driving this excess revenue as well as the people not seeking the level of services we're expecting.

So the $50 a month or $250 a month that the people in the self-funded plans are paid have literally generated the X's. So my attitude is that because we price the plans specifically for their use that any savings, it's my opinion, should go back to the people who generate them because otherwise the pricing exercise at the front end is kind of what are we doing? Why are we bothering, you know.

CHAIRWOMAN FREED: This is Laura Freed. This is very valuable discussion. But I think it's -- I think I want to ask for questions and comments -- questions of the Executive Officer and Mr. Ward and then have a break, and

then we'll come in and tackle these kinds of policy issues I think. So if you have informational fact questions, please pose them. But if you want to dive into the merits of the policy, let's do that after our break.

MEMBER KELLEY: I have one other question.

CHAIRWOMAN FREED: Okay.

MEMBER KELLEY: I'm sorry. So Michelle Kelley. Regarding the lifestyle benefit, just knowing some of our history with kind of the legislators and what they haven't liked, are we likely to run into issues with them thinking this is kind of -- that they don't agree that this is necessary expenditure. So are we kind of -- if we put forward a lifestyle account that participants can spend on anything, whoever it is, are we -- are they likely to think that we're not managing the plan very well. I mean, they cut out wellness benefits, right, because they got participant complaints and they didn't see the value in this. Will they see the value in this?

MS. RICH: So Laura Rich for the record. This is one of the -- so since we would be spending down the excess reserves and it would be on a benefit, this would have to get approval through the interim finance committee, and so this would have to be approved essentially by the legislature, and this is where they would have the opportunity to say no, we

don't agree with this benefit, and it wouldn't pursue beyond that.

MEMBER WOODWARD: Janelle Woodward for the record. Do any of these affect or leave out any of the claims, meaning -- I guess I'm referring to the State so, you know, deductible plans, the EPA or I mean EPO, I got to work on that, and the HMO, is anybody neglected as State employees from any of these suggestions?

MS. RICH: Those, the last three options can be applied to any employee on any plan regardless if you're active, retiree, State, non-State. So it can be applied across the board to every PEBP participant. It's just a matter of who -- you know, who -- there's limited amount of funding and so where does this go?

CHAIRWOMAN FREED: Okay. It's 12:56. Let's take a break until 1:10.

(Whereupon, a brief recess was taken.)

CHAIRWOMAN FREED: Everybody, welcome back. It's 1:10. So we're on Agenda Item 10. And Board Members, if you would look at page 39 of this Segal report. It's got a summary of everything we've been hearing about over this agenda item. And what I would like to have PEBP staff do, as we go down this item, remind the Board whether this can be implemented in plan year '24 basically just on approval of

the Board without any other sorts of administrative processes, like board of examiners or the interim finance committee or anything like that and which of these items we were advised could go out to RFP or they might even recommend an RFP for them.

So with that, we'll start with Real Appeal, the weight loss program.

MS. RICH: Okay. So for Real Appeal, that's very simple. That's already something we can do in our existing contract and it's -- it's through a claim so that is a very simple fix and something we can implement without, you know, relatively any lift whatsoever.

On the -- sorry, I'm going through these.

CHAIRWOMAN FREED: Hinge Health.

MS. RICH: Hinge Health.

CHAIRWOMAN FREED: The virtual physical therapy.

MS. RICH: Hinge Health, again, relatively easy to implement. We would definitely need a contract amendment to cover the PMPM phase, but it's something that we can do relatively easily and because it's through an existing ESI contract, again, it's not -- not too difficult to implement.

I think the implementation would be the communication and just outreach to members that may potentially benefit from this. I think it would just be

that -- that outreach that would be a little bit of work.

CHAIRWOMAN FREED: Okay. Doctor on Demand, virtual behavioral health visits at $5.

MS. RICH: That one is very easy to implement. All we have to do is change plan design and -- and, again, adjust that through the TPA and how they pay those claims but that's very easy to implement. It would require IFC approval.

CHAIRWOMAN FREED: Okay. Because there is a cost.

MS. RICH: There is a cost associated with it.

CHAIRWOMAN FREED: Okay.

MS. RICH: So it would require IFC approval to ensure that, you know, we get approval. To spend-down, it's a benefit --

CHAIRWOMAN FREED: Uh-huh.

MS. RICH: -- that we are spending excess reserves on.

CHAIRWOMAN FREED: Okay.

MS. RICH: And so that would require that.

CHAIRWOMAN FREED: Okay.

MS. RICH: The expanded travel benefit, this is just adding that to the, adding travel for medically necessary abortions onto our list of items that are covered

under that travel benefit. Again, very easy to implement. That's just something internally that we would have to, you know, update the master plan documents and that's about it.

CHAIRWOMAN FREED: That we would not have to visit IFC for the 25 to 50,000 dollar anticipated cost.

MS. RICH: That would also require IFC approval because it is a cost. So it would definitely be on the list of things that would go to IFC.

CHAIRWOMAN FREED: Okay.

MS. RICH: Likely in, it depends on which --

CHAIRWOMAN FREED: Yeah.

MS. RICH: -- meeting.

CHAIRWOMAN FREED: January, March? March would be late.

MS. RICH: I would say February I was thinking.

CHAIRWOMAN FREED: Okay. Okay. Medical travel for generally Centers of Excellence procedures.

MS. RICH: So medical travel, this is likely -- we have two options. We have the ability to leverage what UMR already offers through their program. This would eliminate us having to go out to RFP. However, this, it may actually be a benefit or advantageous for PEBP to go out to RFP just to see what's out there and consider the options.

And so the -- an RFP would be a solicitation that

was noticed. And but once that is done, it would be -- it does not come at a cost. It's at a savings. And so this would need BOE approval because it would be a contract but would not need IFC approval.

CHAIRWOMAN FREED: Okay. Oncology Concierge.

MS. RICH: Same with this as well. We would have to, likely it would be in our best benefit to go out to RFP on this. We can definitely see what UMR offers through that contract. We're able to do that, but it is advantageous for us to go out to RFP and what path we want to choose. Again, it's at a cost savings so this would be -- it would go to BOE but not to IFC.

CHAIRWOMAN FREED: Okay. Dental, improve the plan maximum.

MS. RICH: This is also relatively easy. It's just a matter of updating our master plan documents and having the -- having UMR process these appropriately. But it does come at a cost and so it will require IFC approval.

CHAIRWOMAN FREED: And then the last three I think we know would require interim finance approval.

MS. RICH: Right.

CHAIRWOMAN FREED: Okay. But a lifestyle spending account is an RFP possible. Am I right?

MS. RICH: I would not recommend an RFP.

CHAIRWOMAN FREED: You would not recommend that, okay.

MS. RICH: Because we have two vendors that offer that.

CHAIRWOMAN FREED: Okay. So with that, thank you for that. And then going back to the original staff report, the staff's recommendation is to approve Real Appeal, the first one, Hinge Health, expanded travel benefit. Does that mean, okay, abortion travel and Cancer Concierge to begin on the first day of the plan year of '24, okay. And then -- and those are all -- oh, there's a nominal cost for the one but those are all savings, okay.

And then Board Members approve implementation of one or more plan design options to spend-down 9.5 million in differential cash.

So with that, I think I want to, if I see Cari is ready to do all kinds of scenarios about premium credits, that's great. I think I want to open it up. I feel like Michelle Kelley is dying to talk.

MEMBER KELLEY: You know, I guess taking the staff's recommendation, I have -- I don't have any concerns with real -- approving Real Appeal, Hinge Health, the expanded travel for medically necessary abortions and the Oncology Concierge. I have no problems with any of those,

and I don't have any additional questions on them.

CHAIRWOMAN FREED: Okay.

MEMBER BITTLESTON: This is Leslie Bittleston. Can we do a motion for those separately, just to get those off the table?

CHAIRWOMAN FREED: I would appreciate that.

MEMBER BITTLESTON: This is Leslie Bittleston. I move to accept staff's recommendation to adopt Real Appeal, extended abortion travel, Hinge Health and the oncology program. Did I get them all?

CHAIRWOMAN FREED: Yeah.

MS. RICH: Would you mind adding to your motion a solicitation for those two that will require an RFP for.

MEMBER BITTLESTON: And -- and for staff to solicit or conduct an RFP as needed.

CHAIRWOMAN FREED: Let me see if I got this, okay. So the motion is to approve Real Appeal, Hinge Health, enhanced travel for medically necessary abortions and the Concierge Oncology with an RFP for any of those or all of those or cancer --

MS. RICH: I think you missed the medical travel, so medical travel.

CHAIRWOMAN FREED: I'm sorry, did you include medical travel as well as abortion travel in your motion?

MEMBER BITTLESTON: I don't think so. Let me redo this.

CHAIRWOMAN FREED: All right, starting over.

MEMBER BITTLESTON: Leslie Bittleston. I move to accept staff's recommendation.

CHAIRWOMAN FREED: Okay.

MEMBER BITTLESTON: AND adopt Real Appeal.

CHAIRWOMAN FREED: Okay.

MEMBER BITTLESTON: Hinge Health, abortion travel, medical travel and the Oncology Concierge program and for PEBP staff to conduct RFP's on any or all of those as needed.

CHAIRWOMAN FREED: Okay, great. Do I have a second?

MEMBER KELLEY: Second.

CHAIRWOMAN FREED: All right. Okay. So you heard the motion. Is everybody clear on the motion? Okay, cool. Any discussion on the motion? Okay. Hearing none, all in favor say aye.

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

CHAIRWOMAN FREED: Any opposed? Okay. Motion carries.

All right. Now the harder bit. Well, folks, how

do you feel about premium credits? How do you feel about one-time HRA increases? And how do you feel about lifestyle spending accounts as a way to do something for participants that is, again, we have to rely on this being one time in nature.

Yeah, Mr. Verducci.

MEMBER VERDUCCI: Yes, Tom Verducci for the record. I could see a problem with the premium credits because of the $25 that will eventually have to go away and it's ongoing. One-time HR -- HRA is really good. We have the discretionary -- the discretionary power of maybe one-time contribution. It's not an ongoing situation. The lifestyle spending account, I like the idea you give expenditures for dance classes, gym, pets and so forth. But I just don't think that would really go through the legislature.

I do remember a few years ago having wellness programs, the Blue Book and all of that, work really hard and it just went away. The legislators didn't like it from input they were getting. So I just don't think a lifestyle spending account would just really make it through.

MEMBER KELLEY: Michelle Kelley for the record. I tend to agree with Member Verducci. I would be supportive of the HRA contribution. I think our mission is health care.

And while I understand kind of the lifestyle impacts health care, I do think we should focus on our mission first. And if our mission was perfect and we completed it and everyone was very happy, leave it at that. But what we know is, you know, that's not true at the moment.

So I think I'm supportive of the HRA over all of the other options. I like premium credits too but everybody has talked about the issues we have when they go away, so less -- less inclined to do that. But I do -- the one thing I feel strongly about is the population served, so when we get to that section.

CHAIRWOMAN FREED: Yeah, well, that was going to be my next question to both of you. So if there is emerging support for an HRA credit, for whom is the credit? The reason I ask specifically is because if you're a State active and you don't have other health insurance, you have an HSA.

Now being as I am a rational economic actor, I'm not going to use my HSA if I can use my HRA first. So my question to PEBP staff is if you give me a credit in an HRA that I have to ask you to reimburse, do I get to use that first and then save my HSA?

MS. RICH: Laura Rich for the record. Yes, you can, and we can actually operationalize so that the, when HSA Bank applies that, they apply the HRA first before the HSA.

CHAIRWOMAN FREED: All right.

MEMBER CAUGHRON: So April Caughron for the record. I just have a quick clarification around the eligible expenses for -- that are the IRS on the list for the HRA. Do we have any idea what some of those expenses would be or what we could use that on?

MEMBER KELLEY: I think off the top of my head, I think it's things like the HRA is your, you know, co-pays, deductibles, over-the-counter medicines, prescription, you know, any prescription drug coverage.

MEMBER CAUGHRON: Okay.

MEMBER KELLEY: So any out-of-pocket for clearly medical, I think it's simple under HRA. I think there's a more technical side of it too.

MS. RICH: Yeah, and that's what I was looking up is like, you know, can you get into I think like glasses and contacts and things like that as well. So, you know, it's medical -- generally any kind of medical expense.

MEMBER CAUGHRON: Okay. So it's not specific to the point when we wouldn't be able to use the 300 dollar credit because it's so specific that it doesn't --

MS. RICH: Correct.

MEMBER CAUGHRON: Just making sure.

MS. RICH: Now if you're, you know, a healthy

25-year-old, there's a good chance that, you know, you don't have any co-pays. That you're not going to the doctor. You're not getting -- you know, you don't have prescription medications. So there's -- you know, there's certain people that may not have eligible expenses, but generally yes.

MEMBER CAUGHRON: Thank you.

CHAIRWOMAN FREED: This is Laura Freed. That leads to a great question about the younger employees, and I think I know the answer, but I'll ask Laura and Mr. Ward to confirm it. Medicare retirees can use their HRA to pay their premiums, but I don't believe the actives with HRA's are eligible. Darn it, okay, so I didn't think so.

MR. WARD: If I may. Richard Ward. It's, the eligible expenses are not limited to the covered expenses of the plan. So I'm trying to read something into your question but like for example, for my personal HRA, I don't have vision coverage, but I can still get reimbursed for contacts, glasses.

MEMBER CAUGHRON: Okay.

MR. WARD: And somebody mentioned over-the-counter medications. So there's a broader definition of what's reimbursable from an HRA. And so maybe some of those 25 year olds that don't currently have a claim may have other need for OTC meds or other things that they

would find beneficial.

MEMBER CAUGHRON: Okay, thank you.

CHAIRWOMAN FREED: So, Board Members, what is the thought in terms of actives and early retirees or just actives? How much -- as far as the demographics go, so the self-funded plans that generated the credit, the high deductible PPO, the low deductible PPO and EPO, is that right, so EPO included. So how many people are then in the Southern Nevada fully insured product?

MS. RICH: Off the top of my head, Cari has it. Do you have the exact number? Go ahead.

MS. EATON: Cari Eaton. There's about 3,000, 3,100 I believe on the HMO.

MS. RICH: So that's not total lives. That's, just to clarify, for the primaries.

MEMBER KELLEY: And how many primary participants in the other three plans combined or separately, whatever?

MS. EATON: Approximately, almost 24 -- no, I'm sorry.

CHAIRWOMAN FREED: This is Laura Freed. Cari, I have a question about the numbers on page 34. Are these assuming only primary insured or is this dependents also?

MS. EATON: Only primary.

CHAIRWOMAN FREED: Only primary, okay. And this

is all coverage tiers?

MS. EATON: Yes.

CHAIRWOMAN FREED: Okay, thank you.

MS. RICH: So, Ms. Kelley, I just want to -- you know, when you were talking about where that excess is coming from, I do want to say that the EPO generally runs, so and I'm looking at our latest EMR report here. Our CDHP typically has it, we're projected at a loss ratio of deficit of point three million whereas so we're coming out even, and this is very early on in the plan year, right, but this is generally how it goes.

The CDHP is break even. The co-pay plan is actually as of today, you know, we're generating a surplus, but the EPO and this is historically the case, we're definitely -- we have the most deficit from people on the EPO plan. But that's really the way it's -- that's why they are paying the higher premiums. You know, it's generally the people that are on that, the EPO plan, on the EPO plan because they have ongoing medical expenses and would prefer to pay those higher premiums and just stick to those co-pays.

MEMBER KELLEY: So after all that, where is the savings generated from? It the CDHP.

MS. RICH: CDHP and low deductible for the most part.

MEMBER KELLEY: Is the EPO record kept separately? So are the finances separate to the other -- the PPO plans?

MEMBER VERDUCCI: Laura Rich for the record. All three of our self-funded plans are together.

MEMBER KELLEY: Commingled.

MS. RICH: Right, it's the HMO that is separate because that is fully insured and we pay PMPM for the HMO.

MEMBER KELLEY: Are the retirees, the early retirees, such as it is, are they commingled in that group as well?

MS. RICH: No. So yes and no. So they are rated. Statutorily they are rated together, right. We are not rating them separately. But when we do reporting and we can see through the reporting, who's -- what group of individuals are costing the plan more, and that's just -- that's out of reporting but they are commingled in terms of how they are rated.

MEMBER KELLEY: So just would we run into issues if we tried to exclude them from a benefit here because of that, the fact we have to rate them as a whole. So that tells me we're not allowed to penalize them, right?

MS. RICH: So statutorily we are required to rate them, meaning the premiums have to, the experience and

premiums all have to be looked at together. Now in terms of a benefit, we often times applied a benefit to one group of people versus another group of people.

So for example, you know, the -- the premium buy-down, we didn't apply to non-State retirees, right. And so we didn't -- we applied it only to the State, so we've done that before. We can do that. It's just a matter of do we want to.

MEMBER BITTLESTON: This is Leslie Bittleston. I have a question. Would the HRA credit increase for active employees if we eliminated retirees?

MS. RICH: It would and I think -- Laura Rich for the record. I think Cari can tell you what that number is. I don't know if you have it off the top of your head or if you just have to do the math really quick.

MS. EATON: This is Cari Eaton for the record. So if we increase the benefit say from 300 to 325, then we would be spending 8.8 million just for State employees so we can go up from there.

CHAIRWOMAN FREED: So that would be State actives. At 325, it would cost 8.8?

MS. EATON: Yes. So $350 would get us right to it.

MS. RICH: And I'm sorry, I just want to

interrupt. I think Luis from HSA Bank had his hand up and we haven't noticed it, sorry.

MR. DOFFO: No, that's okay. Luis Doffo for the record. I just, I wanted to make sure that there was a question earlier from -- from a Board Member that if they had -- if they were given this HRA money and they had an HSA, could they use the HRA before touching the HSA, and I just want to make sure everybody understands that.

If you are actively participating and contributing into an HSA, you cannot also have traditional HRA. They can't both be active --

CHAIRWOMAN FREED: Okay.

MR. DOFFO: -- for an employee.

CHAIRWOMAN FREED: So we now -- okay. That turns the whole discussion on its head.

MR. DOFFO: I apologize.

CHAIRWOMAN FREED: No, thank you for weighing in. I'm glad you did. So I feel like that turns this into an HSA contribution discussion as we've done in past plan years.

MS. RICH: Okay. So that actually conflicts to earlier to information that we got earlier which is -- but if that is the case, I'm hearing this from HSA Bank, it would be an HSA and HRA. So those members who have an HSA would then get an HSA versus those who have an HR -- or --

CHAIRWOMAN FREED: You already get.

MS. RICH: Right. Now the only problematic issue with that is we have to make sure to -- make sure to communicate this because those people who are contributing to an HSA, it can put them over. Lucky enough, we are at the beginning of the calendar year and so they have -- this is by calendar year, not by plan year.

And so -- so it's -- we are early. You know, we're at month one of the calendar year so we do have the time to be able to do that. So it doesn't really change anything. Just, we would just have to contribute to the HSA or HRA.

MR. DOFFO: And that's why there was the recommendation -- I apologize. Luis Doffo again for the record. And that's why there was the recommendation of considering the lifestyle spending account because it wouldn't impede on the contribution maximums of the HSA or -- you know, or those that are participating in only the HRA against maximum flexibility and overall plan design. There is no testing that's required for it. PEBP can control not only who was eligible but as mentioned what items are eligible to be reimbursed as well and it can be -- it can be terminated at -- at any time.

I also want to add one additional piece that I

promised. It does go towards gross income. It's not a separate box. I wanted to make sure I provided the Board with all of the information that it's basking to date.

CHAIRWOMAN FREED: Mr. Verducci.

MEMBER VERDUCCI: Tom Verducci for the record. I just wanted to point out that two years ago when we had to make these mandated cuts, I think we tried as hard as we could to keep the cuts evenly for all of the membership of who, you know, they were bearing the burden of our mandates that we had to do.

So as we're restoring some of the benefits coming back here to the best of our ability, it seems to me that we should cover the broadest group that we can, actives and retirees. I just don't -- I feel like I'm sort of discriminating against the group on giving the money back when everyone had to pay the same price on terms of reductions. So that's just my suggestion. A personal thought, I should go back to the same group that we had to take from.

MS. RICH: Laura Rich for the record. I think that the Board attempted to equally make cuts to all areas, but in the end actives actually ended up taking the deepest cuts because the HRA was reimbursed at the higher. The Board cut it to that $11 and then it was later reinstated by the

legislature at a later date. So while the Board -- while the Board took that step, ultimately the actives were hit with the, hardest.

MEMBER VERDUCCI: So in terms of the percentage participation in the whole program, what percentage is retirees as far as -- you know, my question is pertaining to if we made an across the board, you know, restoration, is the retirees a smaller group?

MS. RICH: So we're talking about non-Medicare retirees. So there's retirees. There's Medicare retirees and non-Medicare retirees. So the non-Medicare retirees are the ones that we're specifically talking about because this is on the self-funded. So those non-Medicare retirees, I think, Cari, can you provide the exact number? I know what the number is but not the exact number.

MS. EATON: The non-Medicare State retirees is 4,175 that I have in my projections and that does include CDHP low deductible, EPO/HMO.

MS. RICH: And what is the State actives?

MS. EATON: State actives is 27,038.

MEMBER VERDUCCI: So with the -- Tom Verducci. So for the smaller representation of the retirees, it doesn't seem like in terms of a dollar amount that that much more is actually going back to the actives. So if we make an HSA

across the board contribution, I just would feel better if it went back proportionately to the whole group. It's my personal thoughts. There's ten of us here so I'm one of ten.

MEMBER KELLEY: So Michelle Kelley here. I guess, you know, essentially, you know, I feel like we're knit-picking. But I guess we come back to when we price the plan, we price it for participation in certain -- you know, people sign up for certain conditions of courage, if you will. And -- and right now what we're talking about is money that basically wasn't spent by people in three programs, so the self-funded programs right.

And further, Executive Officer Rich is saying that those savings weren't generated by retirees. They were generated by active employees in the self-funded plans. And, you know, I think Cari said that there's 3,100 people enrolled in the HMO in the south that didn't contribute toward the 9,000,000 of savings. And, you know, yeah, it's 3,100 people. So whatever the Board decides is going to be the right decision.

But I guess it just comes back to when we're pricing these plans, if we're consistently not pricing them correctly and then we're giving the excess back to all employees, there's one group that loses every time and it seems to be the consumer driven health plan, high deductible

plan because they are the ones that are not using the plan and eventually they will need to use the plan. So contributions to the HSA or the HRA for those folk hugely beneficial because they need to satisfy the deductible before any benefit is paid once it becomes due.

So, you know, as I said, I don't think there's a wrong answer here. We're talking about giving back, so that's a nice conversation to have. So for me it's -- there's fairness involved in it, right. And I link it back to the discussions we're going to have again in March, but we had last March about how we're pricing the plan, so.

MS. RICH: So Laura Rich for the record. This may be somewhat off topic but I think it's important for the Board to understand when we talk about pricing the plans correctly. One of the -- one of the components to pricing the plan is we use the Segal team to every biennium as part of our budget building, we look at many, many different variables and components, but one of the most important is trend. So that is, trend and experience, that's how -- that's the cost of health care. It is how often people are utilizing that health care. So those two things are very very important when we price the plan.

And that is every two years when we're budget building, we use the actuaries to price the plan using those

actuarial numbers for the next two years. What has happened in the past is that historically when PEBP submits that budget, we used, in this case for example, we used trend of five percent for medical, eight percent for RX. And then I can't remember what the dental, three? Okay. Three percent for dental. That is what we're thinking is going to be the trend over the next -- over the next year. And so when we submit our budget, the subsidy is based on that.

When the budget is then reviewed through the Governor's recommended budget process, historically, and this has not just been the case in the last biennium but every biennium that I can remember, what has happened is that those actuarially provided trends, recommended trends have been adjusted. When our budget makes it into the Governor's recommended budget, that's adjusted. So that five eight three percent might go to three six two percent or something like that.

So right there the pricing of our plan is, right, we don't have control over that. That's what the State has done. In the past has applied the same to PEBP to corrections to Medicaid. I have made -- tried to make the argument that PEBP is not the same as Medicaid. Medicaid has fixed reimbursement rates. We're subject to market conditions. And so whether that argument is going to stand

up this time around, I don't know. Remember, we have a new administration coming in with a new budget and so there's -- those conversations still need to happen. But when we price the plan that that's a major component to why, you know, it is not priced correctly.

Another piece is most of that price overall, right, is being paid for not by employees but by State agencies. And so the State agencies are picking up a major portion of that cost. And so really State agencies are driving most of the, if you want to make that argument, State agencies are driving most of the savings because they're the ones that are paying into -- into that overall rate. So it gets very complicated is really what it, you know, what it comes down to.

CHAIRWOMAN FREED: This is Laura Freed. I'm glad you brought up inflation because, yeah, I'm -- so we have nine and a half million dollars to spend, if you will. I'm a little worried about spending all nine and a half million. If we end up with some scenario that the Governor's recommended budget instead of five, eight and three ends up three, three and three. And then some time around mid 2024, when people, you know, hit their deductibles and hit their out-of-pocket maximums, then the cost of claims shifts to the plan, we may or may not have money to cover that in terms of

excess cash generated. I mean, maybe we will now that we're in the second half of '23 generate a few more million dollars in excess cash that could be put toward offsetting claims costs.

But that is -- I was -- I was like -- personally I just want to say this. I can spend, you know, 8.1, 8.2 million dollars but I don't feel great about spending all nine and a half because that doesn't give us any cushion and from the pure mechanic standpoint, it doesn't give Cari Eaton anything to balance the budget at the end of the session and hasn't done it before. I know what a bear it is when you can't watch everything through reserve. So that's -- that's my pitch on that.

But, you know, I agree with you, Member Kelley. I mean, we're giving money back to participants. My -- also my inclination is to give most of it back to the State actives, both as a Band-Aid that PEBP can offer to State employees who are in a pretty bad place right now. They are in bad head space and because, you know, fiscally degenerated most of it.

MEMBER WOODWARD: Janelle Woodward for the record. And I agree with what you're saying, but I'm going to give you the other side of that because people who are on the EPO are -- you know, so maybe that's -- you know, they're

going to be at a deficit. But we're lumping a whole group of people together, same with the other. So you're not -- I mean, everybody who had an EPO didn't spend a whole bunch of money on it. There's a whole lot of people of the HMO or EPO who haven't had things done because they can't afford the co-pays or, you know, I hear that constantly. I know that for myself.

So it really is anybody who didn't spend a lot in their health care cost generate that -- that money that's available. So I -- I think it's not -- even though you're clearly going to have more people spend more and some spend way less in any given group, you know, there's going to be everybody who's getting into that excess I think. Just a thought.

MEMBER VERDUCCI: Tom Verducci for the record. So do we know what percentage of the HSA money that's given to participants is actually spent? I mean, some of it does come back to the program or the HRA money.

CHAIRWOMAN FREED: HRA, I think you mean HRA.

MEMBER VERDUCCI: Yes.

CHAIRWOMAN FREED: Yeah, that comes back. HSA just goes to the participant.

MEMBER VERDUCCI: Correct. HRA is what I was intending to say.

MS. RICH: So HRA for Medicare retirees does -- we do cap it. And so anything above that cap every year comes back to plan. But for HRA -- HRA for actives, that remains with -- with them until they terminate. So once they terminate that that does come back to the plan, but an HSA is yours forever. And so whether you leave State employment and leave PEBP, that HSA remains with you. And so there's people that contribute to that HSA. It is -- there's tax advantages and so on and so forth. There are people who contribute to the HSA and leave State service with thousands of dollars in their HSA funds. So but generally, you know, the HRA, you cannot contribute to it and it does come back to the plan once you terminate.

MEMBER VERDUCCI: So if we were to make, you know, 10.9, say we're making HRA contribution and we spend X dollar amount, not necessarily X dollar amount is going to be spent because there's going to be some of those funds that actually end up not being used and they get forfeited and they come back to the state; is that correct?

MS. RICH: That is true. However, that would be we would want to budget for 100 percent unless and, Richard, feel free to chime in here. But we would want to budget for 100 percent unless we would put a time limit.

So for example, you have one year to use this.

The problem is with an HSA, I don't think you can do that, and so that HSA money is theirs too keep. So you would likely want to budget for if not 100 percent, pretty close to 100 percent because you're going to have to assume that people that receive that HRA are terminating. And so it's -- it's probably safer to budget for closer to the 100 percent or maybe even 90 or, you know, something along those lines rather than, you know, 50 percent or lower.

MR. WARD: And this is Richard Ward. So, yes, usually with HRA's where there's not a limit to the accrual, it only reverts back at termination, we usually say 80 to 90 percent utilized. Especially if the terminations are voluntary, they are going to -- employees will utilize it before they -- before they leave service or leave employment.

And with lower allocations, we see a higher percentage of utilization. It's just easier to use $200 than it is $1,000. And Executive Officer Rich is correct about the HSA, it's cash. So there's no control over what, how it is used after it's been provided.

MEMBER VERDUCCI: So a spend-down of say $9,000,000 might not necessarily mean spending the full 9,000,000 because some money will be reverting back into the plan.

MR. WARD: That is correct. I'm not disputing

that.

MEMBER VERDUCCI: Okay.

MR. WARD: But it would be a small margin.

MEMBER VERDUCCI: Got it.

CHAIRWOMAN FREED: Especially -- this is Laura Freed. Especially if most of the participants are on HSA's, that money is just gone to a good place.

Okay. Well, gosh, I don't -- I know. Well, guys, I don't know what to do here, so let me ask a question. Maybe I've already asked it, but this is -- this is actually for Cari Eaton.

So if having had the new information from HSA Bank, if we did HSA's and four people with HSA's and HRA's for people with HRA's, does that change the estimates on page 34 very much? No, okay.

MEMBER KELLEY: It will still be the same amount.

CHAIRWOMAN FREED: Okay.

MEMBER KELLEY: I just have a follow-up then based on the pricing on page 39. It looks like for these, you've actually built in administrative costs. But if we're using people preexisting HSA, there wouldn't be an additional cost, right? That would already be -- because I'm seeing premium credits, there was 3,700 to 9,300. One time HRA was 31 -- - 3.1 million versus 9.3. So I'm just wondering, is

that different of 600,000 administrative costs or what was that?

MS. EATON: The only -- the only one with the administrative costs was the lifestyle spending account which had a 75 cent PMPM. The HSA does not have an additional administrative fee at all. It's just the one time credit to the participant.

MEMBER KELLEY: I guess I'm just wondering why premium credits, there was a plan cost that started at 3.7 million versus a one-time HRA started at 3.1 million. Do you see what I'm saying?

MR. WARD: This is Richard Ward. That's because the two benefit amounts are different at the lower end.

MEMBER KELLEY: Oh, okay.

MR. WARD: So for the premium credits, you're modeling 10, 15 to $25 so $10 a month is $120, and that's different than the $100 for the HRA.

MEMBER KELLEY: Okay, thank you. Thank you.

CHAIRWOMAN FREED: So, Board Members, I'm getting the sense that people are fairly comfortable with sort of refunds to HSA and HRA's. What I don't quite know is everybody comfortable with actives and non-Medicare retirees, just actives and how does that affect the dollar level for plan year '24?

MEMBER BITTLESTON: This is Leslie Bittleston. I really support just the actives, only because I agree that it's a Band-Aid. And I also agree that they were the ones that contributed mostly to it. I don't know if that affects the dollar amount. I would really like to support retirees. But where we are today, I think we need to focus on actives.

MEMBER VERDUCCI: Tom Verducci for the record. You know, I remember driving around this beautiful State of Nevada, signing up employees in their deferred comp plan in 1987. And I look at some of these retirees that retired in the '90s and what their salary base was. And a lot of them retired with 30 years service making $24,000.

And the reason I'm pushing for that group is I know that's the struggling group right now. You know, an extra $50 a month might mean them traveling to see their family, but they retire on a really low salary level years and years back. I just have some empathy for that group. And as I mentioned, I'm one of ten, I'm going to, you know, go along with what gets voted for, but I am going to fight the group so that's my two cents there.

MS. RICH: So Laura Rich for the record. I don't have any data to support this, but I would assume that the non-Medicare retirees are those who like Ms. Eaton who will retire well before she's 50. And -- and so they are retiring

because they can, not because they have to. Otherwise, they would be working until 65 and would likely, you know, wait until that Medicare coverage takes place.

So a lot of these non-Medicare retirees are those people who, you know, started with the State early and are retiring early, and they are retiring, you know, at an early age because they can afford to retire.

CHAIRWOMAN FREED: I think the other thing I would say about retirees is PERS guarantees a COLA and the State doesn't guarantee that for actives and hasn't. We've all recently been through as actives no COLA, one percent COLA. Whereas, retirees get them on schedule every three years and it's at least three percent.

MEMBER VERDUCCI: Yes. And if you look at the social security increase in wages and 27 percent of vacancy rates, employees are very much due for a raise and we have a booming economy in terms of tourism. I think I heard that on the radio driving to this meeting, a booming economy with tourism. So let's make working for the State a booming job again, and they need a raise, and we're doing what we can to restore benefits. But that's my voice, just rambling on here so I'll discontinue.

CHAIRWOMAN FREED: No, I appreciate that, Mr. Verducci. That's all salient stuff.

MEMBER BITTLESTON: This is Leslie Bittleston. I agree with you. But I will make a motion.

CHAIRWOMAN FREED: Okay.

MEMBER BITTLESTON: I move that we select the HSA/HRA option for active employees. It is currently at $300 at the maximum. But I allow staff to look at that as well, up to 325 or 350, somewhere between 350 and 300 for active employees.

CHAIRWOMAN FREED: All right. That's doable for PEBP fiscal? All right, okay, do I have a second for the motion?

MEMBER CAUGHRON: This is April Caughron. I second that motion.

CHAIRWOMAN FREED: All right. It's been moved and seconded for plan year 2024 to provide an HSA slash HRA credit of somewhere between 300 and $350, depending on excess cash and PEBP fiscal staff's magic to active employees.

The question from PEBP staff is when. And I would assume July 1st, but.

MS. RICH: The HSA component somewhat muddies that a little bit. I would say -- I would recommend July 1st.

CHAIRWOMAN FREED: July 1st?

MS. RICH: Yeah.

CHAIRWOMAN FREED: Okay. Not just first pay cycle of plan year 2024? I like to make things complicated. Let's go over there.

MEMBER BITTLESTON: This is Leslie Bittleston. I add to my motion July 1st.

CHAIRWOMAN FREED: Okay, all right. Does everyone understand the motion? All right. Discussion? All right. All those in favor signify by saying aye.

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

CHAIRWOMAN FREED: Any opposed? Motion carries.

All right. With that, we will move on to contracts, our standing contracts, Agenda Item 11. And I will turn it over to Ms. Eaton.

MS. EATON: Thank you. Cari Eaton for the record. I will just move on to 11.2.1. PEBP is requesting a contract with a former employee, Nancy Spinelli, through the use of Manpower Temporary Services. The request is made in accordance with the State Administrative Manual because Ms. Spinelli was employed by the State of Nevada within the past two years. Ms. Spinelli was previously the quality control officer for PEBP and worked at PEBP for nearly 20 years.

Through this contract, Ms. Spinelli would work

out -- work with our current quality control officer to assist with various compliance related projects that will be required as part of the compliance audit that you all just heard today. She will also assist PEBP staff with legislative analysis and assessments throughout the upcoming legislative session.

PEBP is recommending that the Board authorize staff to request to contract with Ms. Spinelli. If authorized, the contract will be scheduled for approval at the December 13th board of examiner's board meeting for a January 1st start date.

CHAIRWOMAN FREED: Okay. Questions?

MEMBER VERDUCCI: Is there a dollar -- Tom Verducci for the record. Is there a dollar amount associated with this contract?

MS. RICH: Laura Rich for the record. So when this request, this request will be at BOE next week I believe. And when we submitted this request, there was an estimate as to how many hours versus and the wage, there was a dollar amount. There was just an approximation of hours that was requested to the board of examiners in that contract.

But I would expect -- I would expect that the hours to be about 25 on average, 25 a week on average. As

you can see, there's a lot that needs to happen in the next year, and this contract is actually through the calendar year of 2023.

MEMBER VERDUCCI: Does this have to go through the board of examiners as well? It would be my opinion to have some dollar amount associated with this in terms of a cap or, you know, something to consider. Usually when we've seen these types of items come through, they usually have some kind of contracted dollar amount or cap just so we don't overspend if we ended up running into more RFP's than anticipated.

MS. EATON: This is Cari Eaton for the record again. The documentation that was put together and it looks like the Manpower hourly rate for her would be $52 an hour with an average of 25 hours per week. So I don't think they like to limit the hours but that is our approximate what we expect.

MEMBER KELLEY: Michelle Kelley here. Why is she coming through Manpower? Why are we paying such huge markup when you could have contracted directly with her as a temporary employee, right?

MS. RICH: So Laura Rich for the record. It affects PERS.

MEMBER KELLEY: Oh, so this way she's not subject

to --

MS. RICH: Right.

MEMBER KELLEY: -- the PERS maximum earnings? Oh, wow. So we're actually facilitating PERS avoidance?

CHAIRWOMAN FREED: This is Laura Freed. If she went directly back to work as Nancy Spinelli for PEBP, she would then cease drawing PERS contributions. Correct me if I'm wrong, she's drawing PERS right now. So she would go back into active status, contribute to PERS and not draw it. But since she's only making about $1,300 a week extra over and above her pension, this is a way to ensure that the agency -- this is the way the board of examiner's ensures that the agency needs the help of a subject matter expert, if you're going to continue to draw PERS and the State will pay yet the Manpower fee on top of your page.

MEMBER KELLEY: Wow, okay. Thank you.

MS. RICH: Just to add to that. This is -- sorry. Just to add to that, this is not unique. The State does this across the board. I know just in the Governor's finance office and the legislature right now, there's been a lot of retirements. And so retaining that subject matter expertise, especially during budget building and during legislative session is very important. And so this is something that is done to bring back those retired employees

in order to, you know, retain that subject matter expert and to have the help that they may not have.

CHAIRWOMAN FREED: Other questions?

MEMBER WOODWARD: Janelle Woodward for the record.

CHAIRWOMAN FREED: Okay.

MEMBER WOODWARD: We were just discussing -- did we skip -- this goes back to the previous number ten, but did we skip dental or did we decide that dental was not going to be included or because I marked all that was included in the motion of the recommendation. So I just wanted to -- I'm just increase, sorry.

MS. RICH: Cari, do we have additional funding for that one though? If we spend the 350, how much do we have left?

CHAIRWOMAN FREED: This is Laura Freed. Well, first I want to ask the D.A.G, can we reopen Agenda Item 10 to deal with it? If not, we'll have to bring it back in next month fortunately.

MS. KUNNEL: Was that a question for me?

CHAIRWOMAN FREED: It is a question for you, Ms. Kunnel.

MS. KUNNEL: Can you repeat that, please.

CHAIRWOMAN FREED: I'm sorry, we can't hear you

very well.

MS. KUNNEL: Can you repeat that, please.

CHAIRWOMAN FREED: Yes. The question is, Member Woodward is absolutely right, in motion number one, we approved Real Appeal, Hinge Health, enhance travel benefits and Oncology Concierge. In motion number two, we approved a one-time refund of HSA and HRA monies and we totally skipped the dental plan maximum, and that's on me. Okay. I thought we decided Doctor on Demand was a no, but, okay.

Anyway, the question for the Attorney General's Office is this, can we reopen Agenda Item 10 or does it have to be brought back to next month's meeting?

MS. KUNNEL: You should be able to reopen it by a motion.

CHAIRWOMAN FREED: Okay. Board Members, would you like to discuss --

MS. KUNNEL: Yes.

CHAIRWOMAN FREED: -- dental.

MS. KUNNEL: A Board Member can put in a motion to reopen it.

CHAIRWOMAN FREED: Okay.

MEMBER BITTLESTON: This is Leslie Bittleston. Can we deal with 11 first. I can move to approve the contract as submitted by PEBP Board. And once that is done,

we can go back to Item Number 10.

CHAIRWOMAN FREED: Sounds great. Do I have a second for that motion? Okay. All in favor.

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

CHAIRWOMAN FREED: Any opposed?

Okay. So with that, the one contract under consideration under Agenda Item 11 is approved and we will reopen Number 10 to deal with the --

MS. RICH: Chair Freed, can I just interrupt?

CHAIRWOMAN FREED: Yeah, sure. I give up.

MS. RICH: I do -- I do want to add just some context on to 11.5 before we close this agenda item.

CHAIRWOMAN FREED: I thought that was -- okay.

MS. RICH: There's nothing on here but I do want to just verbally provide some input on, you know, the enrollment and eligibility system. We have had our consultants come in and deep dive in and provide some requirements gathering so we should be receiving that shortly.

I anticipate bringing this back to the January Board meeting as we have further conversations with the office of project management and how our paths are going to intertwine and what kind of options we have moving forward

after we have this requirements gathering, you know, really we have an understanding. And so I just wanted to provide that to the Board that there may be some extra considerations on this RFP moving forward but a lot of -- a lot of the different movements of State government are, you know, taking place and may intertwine with PEBP. So I just wanted to put that on the record.

CHAIRWOMAN FREED: Okay. With that, I think we're back on Item 10, just to talk about dental plan maximums.

Member Woodward, since you brought it up, since you cleverly caught it, what are your thoughts?

MEMBER WOODWARD: Janelle Woodward for the record. I would like to make a motion.

CHAIRWOMAN FREED: Okay.

MEMBER WOODWARD: That we add the dental increased ABL. What else do I need to add to that?

CHAIRWOMAN FREED: Okay, dollar amount.

MEMBER WOODWARD: Between 600,000 and 750,000.

CHAIRWOMAN FREED: No. I mean moving it from 1,500 to.

MEMBER WOODWARD: I'm sorry, should I say that again? Janelle Woodward. I make a motion to increase the ABL on the dental from 1,500 to 2,000.

CHAIRWOMAN FREED: Okay. And there is a fiscal impact on that. PEBP staff, correct me if I'm wrong, the plan year '24 cost is somewhere between 600 and $750,000. Is that assuming the 2,000 dollar level?

MS. RICH: The 2,000 dollar level, let me pull up the report, is 750, yeah, 750. And then the 1,750 is 600,000, yeah.

CHAIRWOMAN FREED: It was on the next page.

MS. RICH: Yeah.

MEMBER BITTLESTON: This is Leslie. I will second the motion.

CHAIRWOMAN FREED: Okay. So if we have flexibility on the previous motion about HSA and HRA, between 300 and 350 and we're spending 750 for a 2,000 dollar dental max, that is workable, okay. PEBP fiscal is nodding at me so that's a yes, okay, great.

Any discussion on the motion?

MEMBER KELLEY: I guess Michelle Kelley for the record.

CHAIRWOMAN FREED: Yeah.

MEMBER KELLEY: This is one item that we're actually putting back into the core benefits program and so -- so I just want to make sure everyone is comfortable with maintaining that $2,000 dental maximum. We kind of

introduce it one year and then take it the next year and so that will be -- I mean, that's a plan design decision we're making today that really probably should be done in March when we know what the next year looks like, right? I'm sorry, I'm looking at Executive Officer Rich.

MS. RICH: Laura Rich for the record. We priced the plan in March based on the -- that's why we're discussing it today is because we have to understand what we are pricing in March. And so the plan design, we need to have an understanding of what that plan design is so that we're able to price it in March.

Now, we note Segal has done the analysis. We're looking at about $750,000 is the projection to raise that to $2,000. To maintain that, I would say we're relatively safe. It's a relatively low dollar amount in the grand scheme of things to say that we can continue it. But obviously there's, you know, our -- our budget, our economic situation of the State. Everything is, you know, next time that there's a recession, you know, two years from now we can be in this situation where we're being asked to figure out ways to cut costs and that may be one of the ways to cut costs, so it's hard to say.

But I think knowing that consistency has been reported and that's something good that came out of the

survey. You know, people want consistency. They are tired of the up and down, and it's difficult to follow, well, what does PEBP cover this year versus what does it cover next year. So I think it's a relatively small dollar amount that we can prioritize to keep -- you know, to keep consistent.

CHAIRWOMAN FREED: Okay. We have to vote on the motion on the table, on the floor. So all those in favor of increasing the dental maximum to $1,500 say aye.

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

CHAIRWOMAN FREED: Any opposed? Okay, motion carries.

Okay. Hopefully we're on an agenda item I can't screw up too bad, public comment. I will turn it over to PEBP staff.

MR. HOPKINS: One moment, Madam Chair.

As a reminder, Zoom is used for public comment only. This meeting is streaming live on YouTube. If you just wish to listen to the PEBP meeting, the YouTube link is located on the agenda.

With those who have joined in for public comment, your name or last four digits of the phone number will be announced and you will be advised you've been unmuted. As a reminder for those on the phone, please press star six to

unmute. Please slowly state and spell your name for the record and proceed with your comments. Due to time considerations, each caller will be limited to three minutes.

Kent Ervin, you have permission to speak. Please unmute your mic if you wish to make public comment and please slowly spell and state your name. Kent Ervin, do you wish to make public comment?

Bowie Hogg, you have permission to speak. Please unmute your mic if you wish to make public comment. And spell and state your name for the record.

Madam Chair, we only have a couple public comment in the lobby but do you want me to wait around for another minute or so?

CHAIRWOMAN FREED: Yeah, why don't we hold for a few seconds here.

MR. HOPKINS: Sounds good. Thank you.

CHAIRWOMAN FREED: PEBP staff, have our public commenters been able to reach us?

MR. HOPKINS: Yes, they have, Madam Chair.

CHAIRWOMAN FREED: Okay. Let's see if we can.

MR. HOPKINS: Madam Chair, that concludes public comment.

CHAIRWOMAN FREED: Okay. With that, public comment has ended. We are at the end of our business. Thank

you everyone for your work today, for your indulgence of me. We are adjourned. It is 2:22. Thank you.

(End of meeting.)

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

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

That on Monday, the 5th day of December, 2022, I was present on a teleconference for the Public Employees' Benefits Program, Carson City, Nevada, for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 187, is a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Carson City, Nevada, this 14th day of December, 2022.

KATHY JACKSON, CCR
Nevada CCR #402

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