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**In The Matter Of:**

*PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD  
VIDEOCONFERENCED OPEN MEETING*

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*March 3, 2023*

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*Capitol Reporters  
628 E. John St # 3  
Carson City, Nevada 89706  
775 882-5322*

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD  
TRANSCRIPT OF PROCEEDINGS  
VIDEOCONFERENCED OPEN MEETING  
FRIDAY, MARCH 3, 2023  
CARSON CITY AND LAS VEGAS, NEVADA

The Board: JACK ROBB, Chairperson  
JIM BARNES, Vice Chair  
LINDA FOX, Member  
LESLIE BITTLESTON, Member  
MICHELLE KELLEY, Member  
TOM VERDUCCI, Member  
BETSY AIELLO, Member  
JENNIFER MCCLENDON, Member  
JANELLE WOODWARD, Member  
APRIL CAUGHRON, Member

For the Board: RADHIKA KUNNEL, Deputy  
Attorney General

For Staff: LAURA RICH  
Executive Officer  
NIK PROPER  
Operations Officer  
CARI EATON  
Chief Financial Officer  
TIM LINDLEY  
Quality Control Officer  
WENDI LUNZ  
Executive Assistant

Reported by: CAPITOL REPORTERS  
Certified Shorthand Reporters  
BY: CHRISTY Y. JOYCE  
Nevada CCR #625  
628 E. John Street #3  
Carson City, Nevada 89706

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FRIDAY, MARCH 3, 2023, 9:00 A.M.

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CHAIRMAN ROBB: Good morning, everyone. It's March 3rd, 2023. This is the Public Employees Benefits Program meeting. Will you please call the roll? Will staff please call the roll?

MS. LUNZ: Chair Robb.

CHAIRMAN ROBB: Here.

MS. LUNZ: Linda Fox.

MEMBER FOX: Here.

MS. LUNZ: Betsy Aiello.

MEMBER AIELLO: Here.

MS. LUNZ: Jim Barnes. And I do not see Jim yet. April Caughron.

MEMBER CAUGHRON: Here.

MS. LUNZ: Leslie Bittleston.

MR. HOPKINS: Wendy, Leslie is in. She just messaged everyone saying she can't hear us.

MS. LUNZ: Okay. Jennifer McClendon.

MEMBER MCCLENDON: Here.

MS. LUNZ: Tom Verducci.

MEMBER VERDUCCI: Here.

MS. LUNZ: Janelle Woodward.

MEMBER WOODWARD: Here.

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1 MS. LUNZ: Michelle Kelley. I see you, Michelle.  
2 You're on mute.

3 MEMBER KELLEY: Sorry.

4 MS. LUNZ: And I do see Jim Barnes joined.

5 Thank you. We have a quorum.

6 CHAIRMAN ROBB: Thank you very much.

7 We'll move on to item Number 2, public comment.  
8 Any individuals prepared to make public comment, please limit  
9 those comments to three minutes. Please state and spell your  
10 name for the record. Do we have any public comment to start  
11 this morning's meeting?

12 MR. HOPKINS: Yes, we do, Chair Robb. I have a  
13 couple in the lobby, so I'll go ahead and get the slide ready  
14 for you.

15 CHAIRMAN ROBB: Okay. Thank you.

16 MR. HOPKINS: As a reminder, Zoom is used for  
17 public comment only. This meeting is streaming live on  
18 YouTube if you wish to watch the PEBP board meeting there.  
19 The YouTube link is located on the agenda.

20 For those who have called for public comment,  
21 your name or last four digits of the phone will be announced,  
22 and you will be advised that you have been unmuted. As a  
23 reminder for those on the phone, please press star six to  
24 unmute. Please slowly spell and state your name for the  
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1 record and proceed with your comments.

2 Kent Ervin, you have permission to speak. Please  
3 slowly spell and state your name for the record.

4 MR. ERVIN: Hello. This is Kent Ervin, K-e-n-t  
5 E-r-v-i-n, State President of the Nevada Faculty Alliance.  
6 Thank you.

7 You will be looking at many bills today and there  
8 are more bills being introduced to address health care  
9 issues, and, therefore, it may affect PEBP.

10 But I want to talk today about the overall  
11 benefits and the sentiments that we see in the legislature  
12 for restoring some of PEBP's benefits to pre-pandemic levels.

13 In our recent survey of faculty, while we found  
14 that faculty -- And this was for academic and administrative  
15 faculty at NSHE at all seven educational institutions. We  
16 found that although the top priority was -- and concern was  
17 around low salaries, benefits are close behind, including  
18 restoration of benefits, such as long-term disability  
19 insurance.

20 As I said, we see sentiment at the legislature  
21 for restoration of those benefits, but, frankly, it's just  
22 not helpful if PEBP indicates that there's no flexibility in  
23 the plan design or in restoring any of those PEBP benefits  
24 for the next fiscal year, given the legislative -- the known  
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1 legislative processes for approving budgets and going through  
2 the budget process.

3 So we would ask the board and PEBP to be as  
4 flexible as possibly can be in helping the legislature to  
5 restore benefits, as the PEBP board has asked the legislature  
6 and staff to advocate for. Thank you.

7 CHAIRMAN ROBB: Thank you.

8 Next public comment, please.

9 MR. HOPKINS: Douglas Unger, you have been  
10 unmuted. Please slowly spell and state your name for the  
11 record.

12 MR. UNGER: Doug Unger, D-o-u-g U-n-g-e-r. I'm a  
13 member of the UNLV Employee Benefits Advisory Committee and  
14 I'm also Southern Nevada Representative for Nevada Faculty  
15 Alliance.

16 I reiterate President Ervin's concerns about the  
17 PEBP timeline and long-term disability, the insurance and its  
18 restoration, which I believe the legislature will probably  
19 recommend. So thank you for flexibility at least with this  
20 part of the PEBP budget and plan going forward.

21 I would like to refer you to the written public  
22 comment in support of AB 37, which is not on your list, to  
23 establish the Nevada Rural Behavioral Health Policy Board,  
24 and also SB 146.

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1 I want to point out that one of the long-term  
2 goals the faculty and university employees has been -- that  
3 we've been pursuing is to see a functioning clinical practice  
4 plan and provider system to establish at our medical schools.  
5 The timeline for this is clearly way ahead, eight years,  
6 maybe ten years. But, imagine what PEBP could do if we had a  
7 fourth and fifth choice among our plan options offered  
8 through UNR and UNLV medical school.

9 Please consider supporting SB 146, which is going  
10 to remove a road block that the provider networks are  
11 currently putting in the way of achieving that long-term goal  
12 by prohibiting their practicing physicians from also  
13 practicing at the UNLV medical school in particular.  
14 Removing that stumbling block is one major step toward  
15 eventually establishing these clinical practices and vastly  
16 expanding provider access and health care in our state.

17 Thanks very much for listening and thanks so much  
18 for your service. Thank you.

19 CHAIRMAN ROBB: Thank you. Next public comment,  
20 please.

21 MR. HOPKINS: VV, please slowly spell and state  
22 your name for the record if you wish to make public comment.  
23 You have permission to speak. VV, if you wish to make public  
24 comment, please unmute your mic.

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1 Chair Robb, that is all for public comment.

2 CHAIRMAN ROBB: Okay. Thank you very much.

3 We will close public comment and move on to  
4 Agenda Item Number 3, discussion of possible action regarding  
5 the 2023 legislative bills that may impact Public Employee  
6 Benefits Program, including the following, assembly bills,  
7 senate bills, bill draft requests.

8 Before I turn this over to Laura Rich, I'm going  
9 to remind people we are early in the process. We haven't  
10 seen everything yet. And there is a few of us on this call  
11 today that do have an 11:00 o'clock meeting. Just know that  
12 we do have another meeting coming up in March and we can  
13 discuss a lot of these issues further if we need to at that  
14 point.

15 So, Ms. Rich.

16 MS. RICH: Good morning, everybody. Laura Rich,  
17 Executive Officer, for the Public Employees Benefits Program.  
18 As Chair Robb mentioned, the bills out there right now, these  
19 are the bills that either affect PEBP or potentially codify  
20 something that typically have in policy today that's not  
21 necessarily in law.

22 There is a lot of bills out there that still  
23 don't have any language, and so we're waiting on those.  
24 Every night we get them, some more trickle in. And so that  
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1 list is very long that we are tracking. So far we haven't  
2 seen a whole lot of bills that are super impactful to PEBP.  
3 But this is a -- It's still early on and I expect there to be  
4 many more bills that we bring to the PEBP board.

5 So let's start with the first one, which is  
6 you'll find on page three of 19 of your board packet. Or I'm  
7 sorry. Of the board report itself. So this is -- It's still  
8 in BDR status. It is BDR 57-161. This is one that we put a  
9 fiscal note on. It removes cost sharing for diagnostic  
10 mammograms, ultrasounds, and MRI's and extends coverage to  
11 all members regardless of age or gender.

12 Currently, the plan covers the first 2D or 3D  
13 mammogram at a hundred percent for women ages 40 and over  
14 regardless of diagnosis and then at 35 and older for high  
15 risk members. So this would just be extending that coverage  
16 basically and removing all cost sharing for that.

17 There is one caveat to that. We would not be  
18 able to remove cost sharing for those members on the high  
19 deductible plan because that is an IRS regulation and  
20 something that all high deductible plans must adhere to.

21 The fiscal note we've placed on that is 150,000  
22 in fiscal year '24 and 300,000 in fiscal year '25. The  
23 reason it's half of that in '24 because the bill doesn't take  
24 effect until January and so it's only half that year.

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1           So I think I'm going to stop at each one of these  
2 so that we can discuss each one of them if there are any  
3 questions or any comments. That way I'm not going through  
4 all of them and going back to the bill. So I'll just stop  
5 there and see if there's any questions, comments, discussion  
6 on this one. It looks like Ms. Kelley has a question.

7           CHAIRMAN ROBB: Yes. Michelle Kelley, do you  
8 have a question?

9           MEMBER KELLEY: Yeah. Thank you, Chair Robb.  
10 And I think my question is going to cover anything with a  
11 fiscal note. Laura, can you just talk about how for this  
12 particular one you came up with the costs? Did you use  
13 real -- Did you go back and look at the last couple of years  
14 of all the mammograms? I would appreciate it. Thank you.

15           MS. RICH: Laura Rich for the record. So, first  
16 of all, PEBP doesn't do this on its own. We will use our  
17 actuaries, our consultants, and they do a lot of analysis.  
18 Not only do we use -- Sometimes I actually will use -- I'll  
19 get the numbers from our CPA and then separately get it from  
20 our, like, PBM, and just to make sure that they're aligning  
21 and we have two different data sources.

22           So, on this one, Segal did do the analysis.  
23 Richard, would you like to just kind of go in to how that  
24 analysis was done and, you know, what data Segal used to get

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1 to that.

2 MS. WARD: Sure. Good morning, everyone.  
3 Richard Ward with Segal for the record. We did review PEBP  
4 experience for the prior three years, the most recent three  
5 years that we have in our data warehouse, actual PEBP claims.  
6 And, based off of the service codes, we're able to determine  
7 which mammograms were preventive and which were for  
8 diagnostic purposes. And we focused our analysis on the  
9 diagnostic instances.

10 And, as Executive Officer Rich noted, for the  
11 CDHP, there would be no impact because diagnostic mammograms  
12 would still need to be covered with some cost share, so they  
13 would need to be subject to the deductible. So we removed,  
14 essentially, or modeled the effective removing co-insurance  
15 that would be associated with those -- with that particular  
16 service. And, then, for the other two plans, we removed all  
17 cost sharing of the 150,000 and 300,000 that's listed in this  
18 table as a result of that analysis.

19 MEMBER KELLEY: Just a follow-up question,  
20 Richard. How did you work in the removal of gender  
21 specific -- the gender? Since it's going to require all  
22 genders be covered, how does that work?

23 MR. WARD: There were already claims for both  
24 gender -- for all genders in data.

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1 MEMBER KELLEY: Okay. Thank you.

2 CHAIRMAN ROBB: Thank you. Any further  
3 questions?

4 Seeing none, Executive Officer Rich. You're on  
5 mute.

6 MS. RICH: Sorry about that. Okay. So moving on  
7 to the next one, BDR 40-330. This is also still in BDR  
8 status. This was a very lengthy bill, about 99 pages to be  
9 exact, so there's a whole lot of information in here. We put  
10 an unable to determine fiscal note on this because it  
11 really -- it has a lot of potential changes that we're really  
12 unable to attach a dollar figure to. For example, in section  
13 19 and 27, it adds some, you know, licensing and indefinitely  
14 some more requirements to pharmacy benefit managers that --  
15 who might result in PBMs choosing to not do business in  
16 Nevada. And so it could lead to less competition and  
17 therefore higher drug costs for PEBP.

18 So, if it's not -- if it becomes too much of a  
19 hassle for PBMs to deal with a proposal when we go out to  
20 bid, it potentially would make it instead of, you know,  
21 getting five or six proposals from PBMs, we might get one or  
22 two, you know, depending on what those requirements are.

23 Additionally, in Section 31, it places  
24 restrictions on what kind of revenue and income can be  
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1 received by the PBMs. So, currently, PBMs do receive, you  
2 know, they have different revenue streams from drug  
3 manufacturers and things like that on a national level. And,  
4 so, if those fees cannot be applied to Nevada-specific  
5 contracts, then the PBMs are going to get their money one way  
6 or the other. And so, you know, PEBP may end up paying more  
7 to offset this.

8 Also -- And this is a pretty significant one --  
9 it requires that rebates be applied at the point of sale.  
10 So, currently right now, PEBP receives rebates and it's a  
11 pretty hefty number. I think the last time -- Cari, can you  
12 tell me what we got last year? Something around 15, 17  
13 million dollars in rebates. Do you know off the top of your  
14 head?

15 MS. EATON: Yes. This is Cari Eaton. Last year  
16 it was about almost 15 million dollars and this year we're  
17 expected to have over 20, 25 million.

18 MS. RICH: So you can see that rebates are fairly  
19 substantial. So what we do today is those rebates come back  
20 to the plan and then they offset cost in general, right, so  
21 they kind of get spread across the entire membership versus  
22 just going back to the member. And so this changes things.  
23 This makes it so that those rebates don't go back to the  
24 plan. They are applied at the point of sale. So, if a

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1 person is receiving, you know, drug X and that drug X has a  
2 \$500 or a thousand dollar rebate associated with it, it's  
3 going to be applied at that point of sale.

4           Operationally, I don't know if we're even  
5 equipped to be able to do that. I know I've had some  
6 conversations with, you know, pharmacies, are they able to be  
7 equipped to do that.

8           But, it would definitely have a positive  
9 short-term impact on members, because they're going to get  
10 that -- the person who is getting that high cost drug is  
11 going to see an immediate reduction in that. However,  
12 because the plan is likely going to lose out on, you know,  
13 some of the co-insurance and zero dollar claims that are out  
14 there, we're ultimately going to see higher costs. And so  
15 those premiums or those costs will be spread out among all  
16 members. And, so, I think the long-term impact may not be --  
17 may not be positive for most people.

18           And then the last one is that Section 12 provides  
19 the Department of Health and Human Services the ability over  
20 PEBP for PBM contracting. So, in that section, it really --  
21 it authorizes before any PBM contract can be approved, DHHS  
22 must first authorize if it is appropriately licensed. And  
23 then, second, if it is reasonably priced. So, if we're  
24 receiving -- if our cost proposal is reasonable.

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1           The problem with that is who determines what is  
2 reasonable? What is that -- What's the definition of  
3 reasonable? And is DHHS equipped to do that? What's  
4 reasonable for the DHHS population, Medicaid population, may  
5 be different than what is considered reasonable for a PEBP  
6 population.

7           On top of that, you know, we've had some  
8 conversations with the DAG about whether it, you know, the  
9 board has statutory authority over the ultimate approval of  
10 contracts, right. So where does that start and end? At what  
11 point? Who gets to determine? Is it DHHS who has the final  
12 authority? Is it the board? We now start to muddy those  
13 waters. So there's some concerns there in that bill.

14           I do know that DHHS will be submitting their  
15 concerns if they haven't already as well. I haven't seen  
16 them yet. But I expect a pretty significant fiscal note  
17 coming from DHHS on this one.

18           So I'll stop there for questions. And it looks  
19 like we've got a couple.

20           CHAIRMAN ROBB: Board Member Kelley.

21           Board Member Aiello.

22           MEMBER AIELLO: Hi. Good morning. This is Betsy  
23 Aiello. I just have a question. Usually bills come from  
24 somewhere. There's some problem or something that has

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1 sparked a bill to start. When bills get so long and so  
2 complicated, sometimes they're almost impossible to  
3 implement. It's like building the mansion before you have  
4 your first house to get it correctly.

5 But I just wondered what need is this trying to  
6 fulfill? Because I don't know that PEBP has seen any because  
7 we haven't discussed this before. But do you know where it's  
8 coming from?

9 MS. RICH: Yeah. So it's coming from the Joint  
10 Interim Standing Committee on Health and Human Services. I  
11 have not been a part of these conversations. PEBP has not  
12 been asked to provide any information and/or data. So this  
13 was the first that I had heard of it. Just from some  
14 conversations from some folks at DHHS, it didn't sound like  
15 they were a part of those conversations either. So it's a  
16 good question as to, you know, what is the intent. And I  
17 think that's part of what we're going to be looking at once  
18 this, you know, does get a bill number and we'll start, you  
19 know, discussing with, you know, with those that -- having  
20 conversations with those people that we need to have  
21 conversations with.

22 Because I think that there -- You know, it's --  
23 there's going to be a lot of PBM bills nationwide. I mean,  
24 they're just nationally PBMs are coming under scrutiny

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1 because of the lack of transparency and just drug prices in  
2 general, right. So there's some question as to what they're  
3 trying to achieve here. And so those are conversations that  
4 we're going to have to have. But this will definitely have  
5 an impact on PEBP. It's just very difficult to put a dollar  
6 amount on to that.

7 MEMBER AIELLO: And it's been a while since I've  
8 been involved in this process. And, thankfully, you do start  
9 to forget it, which is nice to know some day after you  
10 retire. But my suggestion would be definitely we should know  
11 the intent and if it could come back to our next board  
12 meeting. But there may be some sections that were somewhat  
13 supportive. But, again, as I said, when you build something  
14 too big, sometimes it's almost impossible to have a  
15 successful implementation. But to know what specifics that  
16 they're trying to solve with all of these things would be  
17 very helpful. So maybe it can come back next time if we know  
18 more by then. Thank you.

19 MS. RICH: Agreed.

20 Any other questions on this one?

21 CHAIRMAN ROBB: Board Member Verducci.

22 MEMBER VERDUCCI: Yes. Tom Verducci for the  
23 record. In reviewing this bill, there's lots of unknowns.

24 And my biggest concern here would be what the financial  
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1 impact would be to PEBP. And I'm hearing here that we're  
2 going to have less competition, perhaps giving up some  
3 rebates, conflicts of authority. But would it be possible to  
4 find out if this is going to be a significant financial  
5 impact or something that might not be too big to PEBP? It  
6 looks like it does have some significant bearings on us. And  
7 perhaps maybe at the next meeting coming up, I'm wondering if  
8 we could find out the actual significance of the financial  
9 impact to PEBP.

10 MS. RICH: Laura Rich for the record. I think  
11 I'm going to put Mr. Ward on the spot here. But I would  
12 agree that the rebates themselves are going to be pretty  
13 significant and then the, like I said, the inclusion of DHHS  
14 over PEBP contracts just kind of muddies the water quite a  
15 bit. So those are the two I think that are big on this one.

16 Richard, do you have anything else that you would  
17 want to add to that?

18 MS. WARD: Richard Ward with Segal for the  
19 record. I think also the -- you noted, Ms. Rich, the  
20 national -- the fees and income that the PBMs receive  
21 nationally or with drug manufacturers and other parties in  
22 the industry. This bill would prohibit those fees, that  
23 income being applied to Nevada contracts. And to what extent  
24 the PBMs are going to leverage that in to higher admin fees

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1 or less competitive pricing guarantees in Nevada contracts is  
2 unknown. But it would -- it would be cost neutral at best.  
3 And, if there's any movement, it would increase -- increase  
4 cost for Nevada plan sponsors, PEBP and others. That and the  
5 rebates, I think, are the two -- the rebate impact are the  
6 two main financial impacts here.

7 MEMBER VERDUCCI: This is a follow-up. Tom  
8 Verducci for the record. I don't see any compelling reasons  
9 really to support this bill. And perhaps this might be one  
10 that at this stage we don't support until we find out the  
11 compelling reasons behind this. And I can see a lot of  
12 negative aspects that could come from this and lots of  
13 unknowns.

14 CHAIRMAN ROBB: Thank you.

15 Board Member Caughron.

16 MEMBER CAUGHRON: Yes. April Caughron for the  
17 record. I would be very interested to see if this is  
18 happening in other states. And, if so, what is the outcome?  
19 Where do they stand? What issues have they found because of  
20 this or what benefits have shown? But it would be very  
21 interesting to see what they look like before we make --  
22 before we get too involved in this.

23 CHAIRMAN ROBB: Thank you.

24 Any other questions?

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1           Okay. We'll move on.

2           MS. RICH: Laura Rich for the record. Do we want  
3 to vote on a board position as we go through these? I should  
4 have asked that at the beginning.

5           CHAIRMAN ROBB: I think we're early in the  
6 process. We can vote if the board thinks we need to vote on  
7 them. But, we're early enough in the process, all I've heard  
8 is comments at this point, really no position being taken,  
9 just follow-up questions and asking for more information at  
10 the next board meeting. If we come across one that does  
11 require action of the board, if somebody notes that they want  
12 to have action taken, we can at that point call for an action  
13 from the board, if that works for everybody.

14          MS. RICH: So, I think, like, for example, on the  
15 first one it is still a BDR. But, if it does get a hearing  
16 scheduled, I need to be able to testify -- to provide  
17 testimony at the direction of the board. And so I would  
18 rather have a board position. And it can be no position.  
19 That's fine as well. For example, the PBM one that we just  
20 went over, I think that's probably a no position.

21          But, if, for example this mammogram one, we did  
22 put a fiscal note on it, is it something that we support, is  
23 it something that we do not support? I do have to provide  
24 testimony in the neutral position. All executive branch

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1 testimony must be provided in the neutral position. But I  
2 can relay the intent or the desires of the board during that  
3 testimony. So I think -- I think we should at least on some  
4 of these either choose to take a, you know, take a position  
5 one way or the other or even neutral position, so that way  
6 it's -- I know when I provide testimony how to -- in what  
7 direction the board would like me to provide that testimony.

8 CHAIRMAN ROBB: Okay. So we can go back to BDR  
9 40-330. And do we have a motion from any of the board  
10 members to provide direction that Executive Officer Rich  
11 could bring the board's thoughts at a hearing? Ms. Woodward.

12 MEMBER WOODWARD: I would make a motion to  
13 support BDR 40-330.

14 MEMBER KELLEY: Second. Michelle seconds.

15 CHAIRMAN ROBB: Okay. Ms. Woodward was the  
16 first. Michelle Kelley was the second. Do we have any  
17 further comments?

18 MEMBER AIELLO: This is Betsy. I think that the  
19 mammogram bill is BDR 57-161. So the -- I think the motion  
20 is going towards that big PBM bill that we --

21 MEMBER WOODWARD: You're correct. I said the  
22 wrong thing.

23 CHAIRMAN ROBB: You're correct.

24 MEMBER WOODWARD: Can I amend that?  
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1 CHAIRMAN ROBB: Yes.

2 MEMBER WOODWARD: So Janelle Woodward for the  
3 record. I make a motion to support -- that the board  
4 supports BDR 57-161, which relates to the mammograms.

5 CHAIRMAN ROBB: Is the second still good with  
6 that?

7 MEMBER KELLEY: Yes. Accepted.

8 CHAIRMAN ROBB: Okay. Any further discussion?  
9 Seeing none, I'll call for the vote. All of those in favor  
10 signify by saying aye.

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

12 CHAIRMAN ROBB: Any opposed? The motion passes  
13 unanimous.

14 Now we'll move on to BDR 40-330. Do we have any  
15 further discussion or direction to offer Ms. Rich when she  
16 testifies?

17 MEMBER AIELLO: This is Betsy Aiello. And I  
18 think we need to stay at least neutral until we learn more  
19 about this. I don't think we can be supportive at least.

20 CHAIRMAN ROBB: If I don't see anything other  
21 than neutral, we won't call for the vote. Because that's  
22 what we always sign in as neutral. So, if it's something  
23 other than neutral, we'll just skip past it.

24 MEMBER VERDUCCI: Chair Robb, Tom Verducci.  
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1                   CHAIRMAN ROBB: Yes.

2                   MEMBER VERDUCCI: I would like to make a motion  
3 to not support BDR 40-330.

4                   CHAIRMAN ROBB: All right. We have a motion. Do  
5 we have a second? Not seeing a second, it will die for lack  
6 of a second. So we will remain in a neutral.

7                   Okay. Now are we ready to move on to the next  
8 one?

9                   MS. RICH: So the next one is Senate Bill 119.  
10 Really what this does is it continues the telehealth benefits  
11 that were enacted during COVID-19 indefinitely. We do not  
12 expect that -- We did not put a fiscal note on that because  
13 we do not expect any kind of fiscal impact. I think that  
14 telemedicine is becoming much more common than it used to be  
15 and I think this just codifies the ability to offer those  
16 telehealth services and in parody. So I think this one -- we  
17 already do this at PEBP and this just codifies it. So  
18 there's not much of an impact. But I think that we would  
19 need a board position on this one way or the other.

20                  CHAIRMAN ROBB: Okay. Ms. Aiello, do you have  
21 any comments?

22                  MEMBER AIELLO: Well, Chair Robb, if it's okay  
23 with you for me to make a motion, I would make a motion for  
24 the board to support this one.

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1 CHAIRMAN ROBB: I'm good with the motion.

2 MEMBER BITTLESTON: This is Leslie. I second.

3 CHAIRMAN ROBB: We have a motion and a second.

4 Any further discussion? Seeing none, I'll call for the vote.

5 All of those in favor signify by saying aye.

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

7 CHAIRMAN ROBB: All of those opposed? Motion  
8 passes unanimous. We can move on.

9 MS. RICH: All right. The next one -- Laura Rich  
10 for the record -- is SB 134. This bill prohibits an insurer  
11 from setting limits on the amount a vision provider can  
12 charge, as well as requiring a vision provider to use  
13 specific labs. This does not impact PEBP because we  
14 currently do not have a vision network and we also don't  
15 require that members use certain labs to purchase their  
16 vision, you know, their glasses, their contacts, or any kind  
17 of vision equipment like that. So this legislation would not  
18 affect the program as it stands today.

19 However, if PEBP wanted to require members to use  
20 certain labs as a cost-saving measure, obviously this bill  
21 would restrict that ability to do so. We did not add a  
22 fiscal note to it, because, obviously, there is no fiscal  
23 impact to that one. So I'll stop there for questions and  
24 board position.

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1           CHAIRMAN ROBB: Any questions? Seeing none, we  
2 can move on.

3           MS. RICH: Is there board position on this one?

4           CHAIRMAN ROBB: Do we have a board position? It  
5 doesn't really affect us.

6           MEMBER BITTLESTON: This is Leslie for the  
7 record. I was just going to recommend that it be a neutral.

8           CHAIRMAN ROBB: Okay. Thank you. We can move  
9 on.

10           MS. RICH: All right. Senate Bill 146, this is a  
11 version of an any willing provider bill. But it only applies  
12 to university faculty and, therefore, would not really impact  
13 PEBP. The bill, as you heard through public comment, is  
14 intended to remove barriers for UNR and UNLV medical schools  
15 so that they can hire medical school physicians and in turn  
16 hopefully increase the number of medical school graduates,  
17 which would be helpful, I think, not just to PEBP but to  
18 Nevada because of our critical shortage of providers.

19           There is no fiscal note expected here. And I  
20 will just say that I do agree with public comment that I  
21 think that this is a position that we should be in support of  
22 this because of the ultimate outcome of positive impact on  
23 our access eventually.

24           CHAIRMAN ROBB: Okay. Board Member Aiello.  
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1                   MEMBER AIELLO: I just want to reiterate that  
2 even though it doesn't directly affect PEBP, I think having  
3 providers and the development of providers within Nevada  
4 through the medical schools is highly important for the State  
5 of Nevada. And so I would also be supportive of this.

6                   CHAIRMAN ROBB: Board Member Verducci.

7                   MEMBER VERDUCCI: Thank you, Chair Robb. Without  
8 any impact on PEBP and this helping out UNR and UNLV, I would  
9 like to make a motion to support SB 146.

10                  CHAIRMAN ROBB: We have a motion by Board Member  
11 Verducci. Do we have a second?

12                  MEMBER WOODWARD: Janelle Woodward. I'll second.

13                  CHAIRMAN ROBB: We have a motion and a second.  
14 Any further discussion? Seeing none, I'll call for the  
15 motion. All of those in favor, please signify by saying aye  
16 and raising your hand.

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

18                  CHAIRMAN ROBB: Any opposed? Seeing none, the  
19 motion passes. We'll move on.

20                  MS. RICH: Laura Rich for the record. The next  
21 one is SB 156. There is various open meeting law bills out  
22 there right now and this is one of them. Obviously we have a  
23 board and so any open meeting law does affect -- does affect  
24 PEBP.

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1                    Luckily, none of them have major impactful  
2 language to them. It's, you know, a lot of housekeeping, it  
3 seems like. So this one here just codifies a lot of the  
4 nuances related to virtual meetings. COVID, the pandemic,  
5 changed a lot of how we hold meetings. We used to hold them  
6 in person. And now a lot more public bodies are holding them  
7 virtually as we are today. And so this just kind of codifies  
8 some of those, you know, things like remote meetings must  
9 have ADA assistance technology. We use Zoom. Zoom does.  
10 The Zoom applications, they are compliant with ADA policies.  
11 So really there's no impact here. You know, there's just  
12 some kind of housekeeping things that apply in -- that we're  
13 already really doing for the most part anyway. So there's  
14 really no fiscal note attached to it or really any impact of  
15 significance on this bill.

16                    CHAIRMAN ROBB: Okay. Any discussion? Any  
17 questions? If no discussion or questions, we will remain in  
18 the neutral. We can move on, Ms. Rich.

19                    MS. RICH: Okay. The next one -- Laura Rich for  
20 the record -- is SB 163. This requires certain health  
21 insurance to cover treatment of certain conditions related to  
22 gender dysphoria. PEBP, as we already know, we provide  
23 coverage and affordance to the provisions of this bill. So  
24 there's not really any fiscal impact there.

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1           It does, however, expand coverage to children  
2 under 17, which PEBP doesn't currently have today. That  
3 expanded benefit, we've talked to our actuaries about this,  
4 and that expanded benefit isn't really projected to impact  
5 the plan significantly enough to warrant a fiscal note, so we  
6 did not put a fiscal note on this one.

7           With that, I'll take any questions, discussion,  
8 board position.

9           CHAIRMAN ROBB: Any questions or comments? With  
10 no questions or comments, I think we can move on, Ms. Rich.  
11 Unless you want a position on it.

12           MS. RICH: I will assume if there's no motion to  
13 be in support, I will assume it's neutral.

14           CHAIRMAN ROBB: Yep. Okay. Thank you.

15           MS. RICH: The next one is SB 167. So this plan  
16 requires -- this bill, sorry, requires the plan to allow  
17 members that are prescribed certain psychiatric drugs to  
18 bypass step therapy. And there's a few step therapy bills  
19 out there right now.

20           So, right now, we have -- we did an analysis and  
21 we have about 6800 members that are taking at least one of  
22 the 29 impacted drugs, at least one. Some of them are taking  
23 more than one.

24           So the reason that step therapy exists is to keep  
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1 drug costs down by having patients try less expensive  
2 alternatives prior to moving to the more expensive drug.

3 And in 37 percent of cases, patients do find that  
4 the less expensive drug or the less expensive alternative was  
5 just as effective or effective for them.

6 So, in this situation we did have to place a  
7 fiscal note, because it does bypass step therapy and,  
8 therefore, those patients that would have taken potentially  
9 the less expensive, equally as effective, drug, would not --  
10 they would be -- they would not be trying the less expensive  
11 drug and going straight to the more expensive drug.

12 And so the fiscal note on this one is \$20,000 a  
13 year or \$40,000 in the biennium moving forward.

14 So I'll stop there.

15 CHAIRMAN ROBB: Any questions? Board Member  
16 Verducci.

17 MEMBER VERDUCCI: Yes. Tom Verducci for the  
18 record. I would ask is 37 percent, is that actually an  
19 effective figure there? It seems like having somebody use a  
20 less expensive drug and it's only successful 37 percent of  
21 the time would equate to 63 percent of the time being  
22 ineffective. So I just want to see if there's any comments  
23 on -- Is that 37 percent a good figure or not?

24 MS. RICH: Laura Rich for the record. So it's  
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1 not -- So the way step therapy works is a patient is  
2 prescribed a drug that perhaps is non-formulary or is a brand  
3 name version of something that, you know, that's available in  
4 another drug form. And, so, what step therapy does is it --  
5 if a patient is prescribed that drug then the patient is  
6 asked to try out for a certain period of time the less  
7 expensive drug that is supposed to be just as effective.

8 In 37 percent of the cases, members or patients  
9 are -- they find that that drug is effective. If it is not  
10 effective, then, yes, they do move on to the other drug that  
11 is originally prescribed.

12 And so it's not that they're stuck with that  
13 drug. It's that they just have this trial period of try this  
14 to see if it works. If it doesn't, we'll move you to the  
15 more expensive, you know, alternative.

16 So it's a cost-saving measure. And, granted, it  
17 can be perceived as a barrier as well. I don't -- Hopefully,  
18 Ms. Fox, you're the pharmacist on the board, I don't want to  
19 put you on the spot. But do you have anything to add to that  
20 in your subject matter expertise?

21 MEMBER FOX: Linda Fox for the record. I'm  
22 having internet problems today, so I feel like this is going  
23 to be broken up. But I don't think we should support it.  
24 Because I think step therapy is -- it's how health care is  
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1 managed these days. That's how it's done.

2 And, so, step therapy, if I can just make one  
3 little correction so yes, you tried the drug that's  
4 recommended rather than what's prescribed. But then you  
5 don't necessarily go to that expensive drug, but you go to  
6 the next step. So, in some cases, there are some steps that  
7 you have to go through. But that's -- I think that that's  
8 here to stay and I think that's how it has to be or we aren't  
9 going to be able to manage our costs.

10 CHAIRMAN ROBB: Board Member Kelley, do you have  
11 a question?

12 MEMBER FOX: So I think don't think we should.

13 MEMBER KELLEY: Thank you, Chair Robb. Michelle  
14 Kelley for the record. I guess, Board Member Verducci, I  
15 appreciate your math. So, using your math, you know, like,  
16 at the moment in 63 percent of cases where people are seeking  
17 treatment for their mental health, the step therapy is  
18 causing a delay in their treatment. Because, what I'm  
19 hearing is if the drug doesn't work, to me if a drug doesn't  
20 work, then the symptoms are continuing, they're not becoming  
21 stable.

22 So I think for me, as we think about mental  
23 health and kind of the scrutiny that we're all paying to  
24 people's mental health, it seems that if we were going to

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1 make an exception to step therapy, mental health is the place  
2 to do it. And so I guess I would say that I'm supportive of  
3 this bill.

4 Because, while I absolutely understand Board  
5 Member Fox's position that step therapy is an important  
6 protocol for keeping our costs constraining and managing our  
7 plan, I think mental health is different and that, you know,  
8 there are a lot of side effects to all of these medicines.  
9 And I think that we should be helping our members get  
10 treatment as soon as possible, effective treatment as soon as  
11 possible.

12 And, if in 63 percent of cases step therapy  
13 doesn't work for mental health, then maybe it's not the right  
14 place to use step therapy. Thank you.

15 CHAIRMAN ROBB: And I have a comment. And I  
16 haven't had many comments since I've been on the board. But  
17 the 63 percent that aren't helped in a first round are 100  
18 percent helped with a more expensive drug. That's what I  
19 don't know. Is it still step after that? Just because it's  
20 only effective in 37 percent, does the drug, the next step  
21 solve a hundred percent? I don't think it does. I think  
22 there's other things associated. So I think that number can  
23 be played multiple ways.

24 But I also look at this bill and it's got some  
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1 very strong bipartisan support. So, if we have a position  
2 one way or another, this is going to be hard to overcome  
3 because it has a lot of support.

4 MS. RICH: Laura Rich for the record. I will say  
5 that the fiscal note on this is pretty minor. And so the  
6 impact -- the fiscal impact versus maybe the member impact,  
7 you have to weigh that. There is another one here where the  
8 fiscal impact is a lot more.

9 CHAIRMAN ROBB: Board Member Aiello.

10 MEMBER AIELLO: Yes. Just a quick comment. I  
11 was thinking the same thing that Chair Robb was. Having  
12 practiced in the medical field my whole life, there isn't a  
13 hundred percent fix for anything or we would be in a lot  
14 better shape than we are. So it just doesn't mean that 63  
15 percent of folks will get better or, as Board Member Fox  
16 mentioned, there is in-between steps.

17 And I thought the same thing. The fiscal impact  
18 isn't very much. But, if you do something for one condition,  
19 who's to say you shouldn't do it for another and another and  
20 another? And then are you treating people with different  
21 conditions? So I think there could be long-term impacts.  
22 But I also would have great grief that some people might not  
23 get what they need right away. So I'm really torn on this.  
24 But I can see both sides. Medicine is never as black and  
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1 white as people want to try to make it. So I've said a lot  
2 meaning nothing, but...

3 CHAIRMAN ROBB: Do we have a motion on a position  
4 one way or another? Board Member McClendon.

5 MEMBER MCCLENDON: Thank you. This is Jennifer  
6 McClendon for the record. And I just want to note that  
7 psychiatric medication generally takes four to six weeks to  
8 determine whether there's an impact, sometimes three to six  
9 months, and that's a really long time to be on a medication  
10 that's not working. And, as a health insurance company, we  
11 want to get people back to work and we want to get them  
12 functional as quickly as possible.

13 And so my bias is that we trust the patient and  
14 the doctor to make a good decision about medicine. I know  
15 there's reasons why that might not be the case. But I just  
16 wanted to make that comment. Thank you, Chair.

17 CHAIRMAN ROBB: Okay. Thank you.

18 Board Member Verducci.

19 MEMBER VERDUCCI: Tom Verducci for the record. I  
20 think we take a neutral position on this, Board, hearing both  
21 sides of the argument within the board. It would appear the  
22 direct course of action, the correct course should be a  
23 neutral position. I don't think that requires a motion.

24 CHAIRMAN ROBB: No. At this point it does not.  
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1 Unless somebody disagrees, we can move on to the next one, or  
2 if there's any further comment.

3 Okay. Thank you. We'll move on to the next one.

4 MEMBER FOX: Sorry. Linda Fox for the record. I  
5 would actually like to make a motion that we not support this  
6 bill rather than be a neutral.

7 CHAIRMAN ROBB: Okay. There is a motion on the  
8 floor before we moved on. So do we have a second to that  
9 motion? Not seeing a second, the motion dies for lack of a  
10 second.

11 Okay. We can move on.

12 MS. RICH: It sounds like Ms. Fox wants to make a  
13 motion to not support.

14 CHAIRMAN ROBB: Was I muted? I'm sorry if I was  
15 muted. I heard the motion. I called for a second. I didn't  
16 hear a second, so I let it die for lack of a motion. But do  
17 we have a second on Board Member Fox's motion to not support  
18 this bill? I do not see a second. So, without a second,  
19 that motion dies for lack of a second.

20 MS. RICH: Laura Rich for the record. I think  
21 that leaves in support. Because neutral and not supporting  
22 are off the table. So it sounds like maybe we need to -- If  
23 someone is in support, there needs to be a motion on that  
24 one.

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1 CHAIRMAN ROBB: Do we have a motion to support?

2 MEMBER AIELLO: This is Betsy. So I'm a little  
3 confused. Can I make a motion that we are neutral on this  
4 bill?

5 CHAIRMAN ROBB: Yes.

6 MEMBER AIELLO: That's what I'd like to do is  
7 make a motion.

8 CHAIRMAN ROBB: Okay. We'll make a motion that  
9 we stay in the neutral. Do we have a second?

10 MEMBER CAUGHRON: April Caughron. I'll second.

11 CHAIRMAN ROBB: Okay. Thank you. We have a  
12 motion and a second. All of those in favor of staying in the  
13 neutral signify by raising your hand and saying aye.

14 (Nine members voted in favor of the motion)

15 CHAIRMAN ROBB: Okay. All of those opposed to  
16 that motion?

17 MEMBER FOX: Nay.

18 CHAIRMAN ROBB: Okay. We will note that Board  
19 Member Fox is opposed to the motion. So motion passes. Now  
20 we can move on.

21 MS. RICH: All right. Laura Rich for the record.  
22 Another step therapy bill. This is Senate Bill 194. This  
23 bill requires a plan to establish an appeal and exemption  
24 process for step therapy. There's already one of those in  
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1 place. ESI already has a process in place. So just adhering  
2 to, you know, the specifics of those requirements in this  
3 legislation would require only minor changes. So we're not  
4 concerned about that.

5 The bill does require the insured to grant an  
6 exemption to step therapy if the provider submits  
7 justification and documentation to support that argument.

8 Again, step therapy exists as a cost-saving  
9 measure. This is not just applying to psychiatric medication  
10 but all drugs in general. And this allows the provider to  
11 bypass step therapy if they feel that the patient should not  
12 be required to or an exemption to be granted to that patient.

13 Again, you know, this is a cost-saving measure.  
14 It's something that, you know, does keep the cost of drugs  
15 down. And, so, in almost 40 percent of cases, patients do  
16 find the less expensive alternative is an effective option  
17 and so it's reasonable to assume that if step therapy can be  
18 bypassed it would probably be bypassed somewhere in the  
19 approximately 40 to 50 percent of the time.

20 So this is going to increase the cost to the plan  
21 of about one and a half million dollars annually. After  
22 speaking to Express Scripts, we see anywhere from about three  
23 and a half million dollars in savings as a result of step  
24 therapy. So, assuming that 40 to 50 percent of those times  
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1 step therapy is bypassed, we're probably going to be looking  
2 at one and a half million dollars annually in increased  
3 costs. So that is the fiscal note that we have attached to  
4 this.

5 And, so, with that, I'll take any questions or  
6 discussion and board position as well.

7 CHAIRMAN ROBB: Board Member Kelley.

8 MEMBER KELLEY: Thank you. Michelle Kelley for  
9 the record. I'm just -- I'm actually confused on your  
10 write-up on this and your description of it. So, in the  
11 first paragraph where it says impact to PEBP, you say we  
12 already have this appeals process in place. But then you  
13 say, additionally, it requires an insurer to grant an  
14 exception. I'm confused. If we already have that appeals  
15 process in place, doesn't that imply that if the provider can  
16 submit and can justify that jumping at step therapy, the  
17 waiving of step therapy I guess is a better description, that  
18 that already happens? Otherwise why do you have the appeal?  
19 So, if those two statements are true, then why such a big  
20 step, fiscal note, 3.4 million if it's just minor tweaks?  
21 I'm totally confused. Sorry. Thank you.

22 MS. RICH: Laura Rich for the record. And,  
23 unfortunately, we don't have anybody from Express Scripts.  
24 They may be able to join at ten. But I would love if they

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1 were able to more in depth describe the process.

2 But, yes, there is already an appeal process in  
3 place. This appeal process that's in the bill, essentially,  
4 it loosens it up. It loosens up the requirements quite a  
5 bit. And, really, what it is, it's not even really an appeal  
6 process. What it is is if you submit enough documentation --  
7 And, again, it's kind of vague because, you know, the  
8 provider can submit what they feel is justification and  
9 documentation to support that. But maybe perhaps the PBM  
10 does not.

11 But, in this case, it really gives the last final  
12 say to the provider and it does provide an exemption on or it  
13 gives the authority of that exemption ultimately on the  
14 provider, whereas now it's not necessarily the case.

15 The process, it really -- there's some language  
16 in there that basically says, you know, there's a time limit.  
17 If you don't respond in a certain time limit, then  
18 automatically step therapy is bypassed and things like that.

19 So, the process that's in place, it's really  
20 adding some time requirements and things like that around it.  
21 But the --

22 Mr. Barnes, you're not on mute.

23 MEMBER BARNES: Oh, sorry. I'm having problems  
24 here. I'm sorry. I'm trying to get on mute.

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1 MS. RICH: So, ultimately, what this does is it  
2 loosens up the requirements quite a bit and places the  
3 ultimate authority to bypass this on the provider and not on  
4 the, not on the PBM or not on the plan.

5 CHAIRMAN ROBB: Okay. Board Member Aiello. I'm  
6 sorry. I always butcher your name.

7 MEMBER AIELLO: It's okay. It's the three  
8 letters, I-L-O. I wouldn't know how to say it if it wasn't  
9 mine, so don't worry.

10 I just keep going back. And I think part of the  
11 reason I said neutral last time is I believe there's -- this  
12 is such a big issue. Step therapy relates a bit to medicine.  
13 But, in my mind, some of these changes can roll over to all  
14 kinds of care like do you need to go to physical therapy  
15 before you have back surgery. Do you need -- There's just so  
16 many things in medicine that have step processes, whether  
17 they have the exact name.

18 And, I have a little grief. Maybe I'm skirting  
19 some duties. But, me as a board member on PEBP, although we  
20 aren't passing it, it's the legislature and there's lot of  
21 politics in this. But these are huge, huge issues, believing  
22 that you may say it says 20,000 or 1.5 million. But, I just  
23 wonder where the overall trend will go? We want people to  
24 get what they need. But sometimes the outcomes aren't a

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1 hundred percent anyway.

2 So, for me, it's hard to go either way, because  
3 these are huge, huge issues that can have big impact long  
4 term. So I thought I would just state a little. Thank you.

5 MS. RICH: Laura Rich for the record. It looks  
6 like we just had someone from ESI join.

7 Nancy, I appreciate you joining. We're actually  
8 talking about Senate Bill 194, which is the bypassing of step  
9 therapy, the one where we had placed a one and a half million  
10 dollar fiscal note on it. Can you kind of provide a little  
11 bit of background as to the process today that ESI uses to  
12 allow a provider to justify an exemption to step therapy and  
13 how that works.

14 MS. LANGE LAND: Yeah. So the process today is  
15 that if there is step therapy in place for a particular  
16 medication, they would need to work with our coverage review  
17 department to submit the criteria request. There's a series  
18 of questions that are typically asked, like have they tried  
19 other drugs in the past and what their condition is.

20 And, based on the medical criteria that's  
21 submitted by the physician, at that point, the coverage  
22 review department at Express Scripts would make a  
23 determination. Typically that's done within three to five  
24 days. And then it would either be approved or declined.

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1           And, if it were declined, then, of course,  
2 included in the declination would be the right to appeal for  
3 the patient. But that's the high level overview of how the  
4 process works.

5           CHAIRMAN ROBB: Any further questions?

6           MEMBER KELLEY: Chair Robb, I have another, a  
7 follow-up question, if you don't mind. Michelle Kelley for  
8 the record. So, just following up from that explanation, who  
9 makes up the coverage review board? How many people review  
10 these things and what are the qualifications?

11          MS. LANGELAND: Well, I mean, that's a good  
12 question. I don't know exactly how many people. I can  
13 definitely get those details for you if that's needed. But I  
14 can tell you it's a series of pharmacists and pharmacy  
15 technicians and other administrative support that make up the  
16 team.

17          MEMBER KELLEY: And do you guys -- I'm sorry.  
18 Michelle Kelley for the record. Do you guys also do the  
19 non-pharmacy? Because we're talking I think this is more  
20 general than just pharmacy. So who does the core medical  
21 step therapy?

22          MS. RICH: Laura Rich for the record. This is  
23 actual pharmacy specific.

24          MEMBER KELLEY: Thank you.

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1                   CHAIRMAN ROBB: Any other questions, comments, or  
2 a position on this, SB 194?

3                   MEMBER KELLEY: Michelle Kelley for the record.  
4 You know, I think with some of these, given that we're still  
5 awaiting a lot of information that the best position is  
6 neutral position until, kind of, some of this stuff is  
7 flushed out and we see the intent of the bill, I guess.  
8 Because I understand the fiscal note. And it's certainly our  
9 responsible to the plan is to keep it financially healthy.  
10 We also have a responsibility to our members though. You  
11 know, it is a shared equal responsibility between members and  
12 fiscal responsibility.

13                   And so, you know, I think that what we hear from  
14 our participants often is that the step therapy is where all  
15 the angst comes from, right. It delays coverage. They don't  
16 understand it, necessarily. So there's always a lot of noise  
17 around step therapy. So, in my opinion, we should stay  
18 neutral and see what comes of it.

19                   CHAIRMAN ROBB: Okay. Do we have a position  
20 other than neutral? I don't see one. We'll move on to the  
21 next one. Okay.

22                   MEMBER FOX: Sorry. Again, Linda Fox for the  
23 record. I think we should oppose this as well. I make a  
24 motion that we oppose.

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1           CHAIRMAN ROBB: We have a motion to oppose. Do  
2 we have a second? Not seeing a second to the motion, the  
3 motion dies for lack of a second.

4           Do we have a motion to support? Not seeing one  
5 of those, we will stay in the neutral.

6           MS. RICH: All right. Laura Rich for the record.  
7 Our next bill is AB 6. This is a -- Basically what this is,  
8 is an implementation of a cap on health care costs. And it's  
9 a PPC bill, patient protection commission bill. And, as the  
10 executive director at PEBP, my position sits as an -- Sorry.  
11 I can't talk today -- ex officio member on that commission.

12           The new administration has issued a memo just  
13 recently to the PPC stating that they do not support this  
14 bill and has asked the PPC to not move forward on this. So,  
15 at this point, I do not think it will move forward in its  
16 current status.

17           That said, there's really two schools of thought  
18 on this one. I think that everyone wants to cut the cost of  
19 health care. That's a no-brainer. But Nevada is also 49th  
20 in the nation on physicians per capita. And we're also  
21 around 49th in the nation on health care spending per capita.  
22 So there is a concern here that further compressing the  
23 health care market will have a negative impact on the already  
24 critical access issues. Cutting the cost of health care

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1 potentially may worsen the already critical provider shortage  
2 if you're placing caps on, you know, what they can make.

3 So, with that, I will take any questions.

4 CHAIRMAN ROBB: I'm not seeing any questions. Do  
5 we have a motion one way or the other? Not seeing any  
6 questions or motion, we will stay in the neutral on this and  
7 we can move on.

8 MS. RICH: All right. Laura Rich for the record.  
9 Assembly Bill 52 is another open meeting law bill. And this  
10 really has no major changes here, some housekeeping. The  
11 only thing to note is that a quorum is now -- The definition  
12 of a quorum is being modified to exclude any vacant position.  
13 So let's say that we had on the PEBP board two or three  
14 vacant positions, those wouldn't be counted when determining  
15 if we have a quorum. So it kind of makes it easier if you  
16 are unable to fill the position on whether or not you have a  
17 quorum. So that one is pretty easy. No fiscal impact  
18 expected on that one.

19 CHAIRMAN ROBB: Any questions or comments?

20 Any motions in support or against? Seeing none,  
21 we can move on.

22 MS. RICH: The next one is Assembly Bill 85.  
23 Laura Rich for the record. This bill establishes fixed rates  
24 on facility charges, so not professional charges, just  
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1 facility charges, and establishes an independent commission  
2 to oversee rates.

3 That condition would approve rates to allow those  
4 facilities to earn fair and reasonable profit and provide  
5 fair and adequate compensation to employees. It does  
6 eliminate, by design, balanced billing, because, really, all  
7 of the facilities would really be in network and will likely  
8 reduce cost to PEBP.

9 However, again, in a state where we have very  
10 limited access and we have a provider shortage, this could  
11 also be perceived as an unfavorable market condition in the  
12 provider industry and further strain the provider shortage in  
13 Nevada.

14 I'll stop there. There is no fiscal impact,  
15 obviously, to this bill. There may be an access impact.  
16 But, again, there's arguments on either side of that one.

17 CHAIRMAN ROBB: Board Member Bittleston.

18 MEMBER BITTLESTON: Thank you, Chair. My  
19 question is related to Medicaid reimbursement rates. So,  
20 Nevada is one of the last, maybe is last in Medicaid  
21 reimbursement rates for places and facilities such as these.  
22 So, would this affect Medicaid reimbursement rates or not, I  
23 guess, is my question.

24 MS. RICH: Laura Rich for the record. I would  
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1 assume that it would. Because if you are in -- I'm pretty  
2 sure that -- Actually I am positive that there is a fiscal  
3 note attached to this from Medicaid.

4 And so the commercial market -- And PEBP is part  
5 of the commercial market -- really subsidizes the Medicaid  
6 market the Medicare market. Anything that provides --  
7 Providers are losing on Medicaid. They're also losing on  
8 Medicare. And so where do they make that money up? They  
9 make it up in the commercial market. So, if you are now  
10 fixing rates, capping them in the commercial market, you  
11 would assume that Medicaid rates would have to increase in  
12 order to make up those costs.

13 So that's -- You know, there's a lot of -- I,  
14 obviously, cannot represent Medicaid. Ms. Caughron probably  
15 has some comments here. But there's a lot of complexities in  
16 this bill as to what the overall effect would be.

17 CHAIRMAN ROB: Okay. Board Member Caughron.

18 MEMBER CAUGHRON: April Caughron for the record.  
19 Just, I would be interested to know how the independent  
20 commission would be created, who is involved in the  
21 commission, and what is considered when establishing the  
22 procedure for fixing the rates, what are they looking at? Is  
23 it industry standard across the board? What goes in to those  
24 decisions being made? I think it would be good to get a

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1 little bit more information on this.

2 MS. RICH: Laura Rich for the record. The bill  
3 does -- And I don't have the bill right in front of me. But  
4 the bill does go in to who sits on that board and so the  
5 governor-appointed positions. And, if I remember correctly,  
6 there's certain requirements, just like on the PEBP board  
7 there's requirements, there's requirements for those  
8 positions as well.

9 And the onus here really does fall on Medicaid.  
10 Because it is -- it eventually requires Medicaid to do the  
11 analysis on what these fair and reasonable rates would be.  
12 There is an argument as to is that the right place for it to  
13 live, right, because Medicaid isn't focused on the -- You  
14 know, they're focused on the Medicaid population, not on the  
15 commercial population. And this is really more of a, you  
16 know, commercial rate.

17 So I expect -- And this will get a hearing. I  
18 think there's a hearing this afternoon. And so I will be  
19 watching this to get more information. I think that there's  
20 going to be a lot of questions about this bill.

21 MEMBER CAUGHRON: Thank you.

22 CHAIRMAN ROBB: Okay. Board Member Aiello.

23 MEMBER AIELLO: My question was very much along  
24 these same lines except from the commercial market end of it.

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1 When we reviewed our request for proposals for our  
2 intermediaries and our medical management and that, a big  
3 portion of that review was the cost too. I mean, we had a  
4 lot of services. But, if there is a fixed rate at the  
5 facility level, which is the level that drives most of the  
6 costs, the commercial plan rates will probably all come in.  
7 Because I know that if you're a plan that has a hundred  
8 thousand members or a plan that has a million members or two  
9 million members, the insurer is able to negotiate different  
10 rates because of the amount they carry. But if there's a  
11 set, already-set, rate, it's really going to change a lot of  
12 how things are managed and even how bids are reviewed for  
13 amenities such as PEBP.

14 CHAIRMAN ROBB: Okay. Thank you. Do we have a  
15 position or any further comments on AB 85?

16 Seeing none, we can move on to AB 147.

17 MS. RICH: Laura Rich for the record. AB 147  
18 really just amends NRS 287.04335 to remove the end date for  
19 tele-dentistry under the declaration of emergency as a result  
20 of the pandemic.

21 Prior to the pandemic, PEBP did not cover  
22 tele-dentistry, unlike normal telemedicine. So this just  
23 adds tele-dentistry to the whole telemedicine, you know,  
24 parody, payment parody. So we don't have any fiscal note

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1 attached to this really. This is just allowing dentists to  
2 perform certain services over, you know, virtual environment  
3 or, you know, to bill for certain types of, you know, patient  
4 services over that telehealth-type scenario.

5 There is no fiscal note because it's -- that  
6 service would have been done in person regardless. It's just  
7 a different venue to perform that in.

8 There is another bill that does address what is  
9 tele-dentistry and who can perform it and things like that.  
10 It's more licensing related, which is why it's not on here.  
11 And so it kind of, you know, it does indirectly affect this  
12 bill. But we don't have any concerns as far as impacts to  
13 the program.

14 CHAIRMAN ROBB: Okay. Any questions, comments,  
15 or a position on this bill?

16 Seeing none, we can move on to AB 155.

17 MS. RICH: All right. Laura Rich for the record.  
18 AB 155 adds biomarker testing to insurance coverage. We  
19 already do it. PEBP already covers that -- provides that  
20 kind of coverage. We have currently about \$700,000 in annual  
21 plan spend associated with it. So, really, this is a policy  
22 that we have in place that is now being codified in to law.  
23 There is no fiscal note because we're already covering it as  
24 it is.

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1           CHAIRMAN ROBB: Any questions, comments, concerns  
2 or a position?

3           Seeing none, we can move on to AB 219.

4           MS. RICH: All right. Last one. Assembly Bill  
5 219, another open meeting law bill. This is -- It talks a  
6 little bit about, you know, open public comment and virtual  
7 meetings and how you have to provide instructions to the  
8 public. You know, it really, again, lines out how you are to  
9 perform and allow for those virtual meetings.

10           The biggest piece of this here that I think would  
11 impact PEBP is that in this bill it does require that each  
12 member of a board must attend at least 25 percent of all  
13 meetings in person. So, for PEBP, this would be two  
14 meetings.

15           We did not add a fiscal note to it because it was  
16 such a small fiscal note. We already budget for travel. And  
17 so this was somewhere along the lines of, like, a thousand  
18 dollars or something like that. And so we did not -- It was  
19 not worth our time to add a fiscal note on to this one.

20           But there will be that requirement of 25 percent  
21 of all in-person meetings. Now, we have made the decision to  
22 begin in-person meetings. We have our March meeting in  
23 person. And so I don't see this as being significantly  
24 impacting. But it now does make that a requirement moving

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1 forward if this passes. Any questions on that one?

2 CHAIRMAN ROBB: Any questions, comments,  
3 concerns, position? Seeing none, that's all the bills that  
4 we have to review.

5 Does anybody want to review anything before we  
6 move away from this agenda item?

7 Okay. Seeing none, we can move on to Agenda Item  
8 Number 4, public comment. Do we have any public comment?

9 MR. HOPKINS: Chair Robb, we have no one in the  
10 lobby right now. But I can put up a slide and leave it on  
11 for a minute so they can potentially join.

12 CHAIRMAN ROBB: Yeah, let's put up the slide,  
13 just in case people watching on YouTube, they can link back  
14 in. We'll wait a minute and move on.

15 MR. HOPKINS: Sounds good. I'm popping it up  
16 right now.

17 CHAIRMAN ROBB: Thank you.  
18 Have we had anybody join?

19 MR. HOPKINS: Not at the moment, Chair Robb.

20 CHAIRMAN ROBB: And I understand there's a delay  
21 between YouTube and Zoom. Sometimes it's one minute.  
22 Sometimes it's three minutes. I'm going to give every  
23 opportunity for public participation. That's part of having  
24 a board meeting and having open meeting laws. So I know it's  
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1 going to take a minute. I appreciate everybody's patience.  
2 But we want to make sure that we provide all avenues for  
3 public participation in these meetings.

4 MR. HOPKINS: Chair Robb, I don't know the exact  
5 delay. I know it's less than ten seconds, because I am  
6 listening to the recording on another device.

7 CHAIRMAN ROBB: All right. Well, knowing that  
8 it's a very short delay, we have no public comment. So we  
9 will adjourn. Thank you, everyone, for your time and  
10 participation.

11 (Hearing concluded at 10:23 a.m.)

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1 STATE OF NEVADA )  
2 CARSON CITY )ss.  
3 )

4 I, CHRISTY Y. JOYCE, Official Court Reporter for  
5 the State of Nevada, Public Employees' Benefits Program  
6 Board, do hereby certify:

7 That on Friday, the 3rd day of March, 2023, I was  
8 present, via Zoom, for the purpose of reporting in verbatim  
9 stenotype notes the within-entitled public meeting;

10 That the foregoing transcript, consisting of pages  
11 1 through 53, inclusive, includes a full, true and correct  
12 transcription of my stenotype notes of said public meeting.

13  
14 Dated at Reno, Nevada, this 16th day of March,  
15 2023.

16  
17  
18 \_\_\_\_\_  
19 CHRISTY Y. JOYCE, CCR  
20 Nevada CCR #625

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**PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD  
VIDEOCONFERENCED OPEN MEETING**

March 3, 2023

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VIDEOCONFERENCED OPEN MEETING**

**March 3, 2023**

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**PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD  
VIDEOCONFERENCED OPEN MEETING**

**March 3, 2023**

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