In The Matter Of:

PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD VIDEOCONFERENCED OPEN MEETING

March 3, 2023

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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
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A G E N D A

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.

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

MEMBER KELLEY: Sorry.

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

Thank you. We have a quorum.

CHAIRMAN ROBB: Thank you very much.

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

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

CHAIRMAN ROBB: Okay. 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 watch the PEBP board meeting there. The YouTube link is located on the agenda.

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

record and proceed with your comments.

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

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

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

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

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

As I said, we see sentiment at the legislature for restoration of those benefits, but, frankly, it's just not helpful if PEBP indicates that there's no flexibility in the plan design or in restoring any of those PEBP benefits for the next fiscal year, given the legislative -- the known

legislative processes for approving budgets and going through the budget process.

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

CHAIRMAN ROBB: Thank you.

Next public comment, please.

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

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

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

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

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

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

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

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

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

Chair Robb, that is all for public comment.

CHAIRMAN ROBB: Okay. Thank you very much.

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

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

So, Ms. Rich.

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

There is a lot of bills out there that still don't have any language, and so we're waiting on those. Every night we get them, some more trickle in. And so that

list is very long that we are tracking. So far we haven't seen a whole lot of bills that are super impactful to PEBP. But this is a -- It's still early on and I expect there to be many more bills that we bring to the PEBP board.

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

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

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

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

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

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

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

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

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

to that.

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

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

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

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

MEMBER KELLEY: Okay. Thank you.

CHAIRMAN ROBB: Thank you. Any further questions?

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

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

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

Additionally, in Section 31, it places restrictions on what kind of revenue and income can be

received by the PBMs. So, currently, PBMs do receive, you know, they have different revenue streams from drug manufacturers and things like that on a national level. And, so, if those fees cannot be applied to Nevada-specific contracts, then the PBMs are going to get their money one way or the other. And so, you know, PEBP may end up paying more to offset this.

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

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

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

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

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

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

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

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

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

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

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

CHAIRMAN ROBB: Board Member Kelley.

Board Member Aiello.

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

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

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

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

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

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

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

MS. RICH: Agreed.

Any other questions on this one?

CHAIRMAN ROBB: Board Member Verducci.

MEMBER VERDUCCI: Yes. Tom Verducci for the record. In reviewing this bill, there's lots of unknowns. And my biggest concern here would be what the financial

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

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

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

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

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

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

CHAIRMAN ROBB: Thank you.

Board Member Caughron.

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

CHAIRMAN ROBB: Thank you.

Any other questions?

Okay. We'll move on.

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

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

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

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

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

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

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

MEMBER KELLEY: Second. Michelle seconds.

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

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

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

CHAIRMAN ROBB: You're correct.

MEMBER WOODWARD: Can I amend that?

CHAIRMAN ROBB: Yes.

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

CHAIRMAN ROBB: Is the second still good with that?

MEMBER KELLEY: Yes. Accepted.

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

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: Any opposed? The motion passes unanimous.

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

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

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

MEMBER VERDUCCI: Chair Robb, Tom Verducci.

CHAIRMAN ROBB: Yes.

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

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

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

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

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

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

CHAIRMAN ROBB: I'm good with the motion.

MEMBER BITTLESTON: This is Leslie. I second.

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

(The vote was unanimously in favor of the motion)

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

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

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

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

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

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

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

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

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

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

CHAIRMAN ROBB: Okay. Board Member Aiello.

MEMBER AIELLO: I just want to reiterate that even though it doesn't directly affect PEBP, I think having providers and the development of providers within Nevada through the medical schools is highly important for the State of Nevada. And so I would also be supportive of this.

CHAIRMAN ROBB: Board Member Verducci.

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

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

MEMBER WOODWARD: Janelle Woodward. I'll second.

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

(The vote was unanimously in favor of the motion)

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

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

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

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

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

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

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

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

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

CHAIRMAN ROBB: Yep. Okay. Thank you.

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

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

So the reason that step therapy exists is to keep

drug costs down by having patients try less expensive alternatives prior to moving to the more expensive drug.

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

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

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

So I'll stop there.

CHAIRMAN ROBB: Any questions? Board Member Verducci.

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

MS. RICH: Laura Rich for the record. So it's

not -- So the way step therapy works is a patient is prescribed a drug that perhaps is non-formulary or is a brand name version of something that, you know, that's available in another drug form. And, so, what step therapy does is it -- if a patient is prescribed that drug then the patient is asked to try out for a certain period of time the less expensive drug that is supposed to be just as effective.

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

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

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

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

managed these days. That's how it's done.

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

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

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

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

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

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

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

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

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

But I also look at this bill and it's got some

very strong bipartisan support. So, if we have a position one way or another, this is going to be hard to overcome because it has a lot of support.

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

CHAIRMAN ROBB: Board Member Aiello.

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

And I thought the same thing. The fiscal impact isn't very much. But, if you do something for one condition, who's to say you shouldn't do it for another and another and another? And then are you treating people with different conditions? So I think there could be long-term impacts. But I also would have great grief that some people might not get what they need right away. So I'm really torn on this. But I can see both sides. Medicine is never as black and

white as people want to try to make it. So I've said a lot meaning nothing, but...

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

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

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

CHAIRMAN ROBB: Okay. Thank you.

Board Member Verducci.

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

CHAIRMAN ROBB: No. At this point it does not.

Unless somebody disagrees, we can move on to the next one, or if there's any further comment.

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

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

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

Okay. We can move on.

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

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

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

CHAIRMAN ROBB: Do we have a motion to support?

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

CHAIRMAN ROBB: Yes.

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

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

MEMBER CAUGHRON: April Caughron. I'll second.

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

(Nine members voted in favor of the motion)

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

MEMBER FOX: Nay.

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

MS. RICH: All right. Laura Rich for the record. Another step therapy bill. This is Senate Bill 194. This bill requires a plan to establish an appeal and exemption process for step therapy. There's already one of those in

place. ESI already has a process in place. So just adhering to, you know, the specifics of those requirements in this legislation would require only minor changes. So we're not concerned about that.

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

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

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

So this is going to increase the cost to the plan of about one and a half million dollars annually. After speaking to Express Scripts, we see anywhere from about three and a half million dollars in savings as a result of step therapy. So, assuming that 40 to 50 percent of those times

step therapy is bypassed, we're probably going to be looking at one and a half million dollars annually in increased costs. So that is the fiscal note that we have attached to this.

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

CHAIRMAN ROBB: Board Member Kelley.

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

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

were able to more in depth describe the process.

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

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

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

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

Mr. Barnes, you're not on mute.

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

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

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

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

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

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

hundred percent anyway.

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

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

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

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

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

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

CHAIRMAN ROBB: Any further questions?

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

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

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

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

MEMBER KELLEY: Thank you.

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

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

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

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

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

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

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

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

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

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

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

So, with that, I will take any questions.

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

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

CHAIRMAN ROBB: Any questions or comments?

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

MS. RICH: The next one is Assembly Bill 85. Laura Rich for the record. This bill establishes fixed rates on facility charges, so not professional charges, just

facility charges, and establishes an independent commission to oversee rates.

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

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

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

CHAIRMAN ROBB: Board Member Bittleston.

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

MS. RICH: Laura Rich for the record. I would

assume that it would. Because if you are in -- I'm pretty sure that -- Actually I am positive that there is a fiscal note attached to this from Medicaid.

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

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

CHAIRMAN ROB: Okay. Board Member Caughron.

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

little bit more information on this.

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

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

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

MEMBER CAUGHRON: Thank you.

CHAIRMAN ROBB: Okay. Board Member Aiello.

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

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

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

Seeing none, we can move on to AB 147.

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

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

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

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

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

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

Seeing none, we can move on to AB 155.

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

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

Seeing none, we can move on to AB 219.

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

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

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

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

forward if this passes. Any questions on that one?

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

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

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

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

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

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

CHAIRMAN ROBB: Thank you.

Have we had anybody join?

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

CHAIRMAN ROBB: And I understand there's a delay between YouTube and Zoom. Sometimes it's one minute. Sometimes it's three minutes. I'm going to give every opportunity for public participation. That's part of having a board meeting and having open meeting laws. So I know it's

going to take a minute. I appreciate everybody's patience. But we want to make sure that we provide all avenues for public participation in these meetings.

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

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

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

STATE OF NEVADA)
)ss.
CARSON CITY)

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

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

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

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

_____
CHRISTY Y. JOYCE, CCR
Nevada CCR #625

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