In The Matter Of:

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

March 23, 2023

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

ZOOM/TELEPHONIC MEETING NOTICE AND AGENDA

THURSDAY, MARCH 23, 2023

CARSON CITY AND LAS VEGAS, NEVADA

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

AGENDA ITEM		PAGE
1.	Open Meeting; Roll Call	5
2.	Public Comment	
	Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda as an item on which action may be taken. Persons making public comments to the Board will be taken under advisement but will not be answered during the meeting. Comments may be limited to three minutes per person at the discretion of the chairperson. Additional three minute comment periods may be allowed on individual agenda items at the discretion of the chairperson. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the Board. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.	6
3.	PEBP Board disclosures for applicable Board meeting agenda items. (Radhika Kunnel, Deputy Attorney General)	13
4.	Consent Agenda (Jack Robb, Board Chair)	
	Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.	14
	4.1 Approval of Action Minutes from the January 26, 2023 PEBP Board meeting.	14
	4.2 Clifton Larson Allen Audited Financial Statements of Public Employees' Benefits Program Self-Insurance Trust Fund and Retirees' Health & Welfare Benefits Fund for FY22	14
5.	Executive Officer Report (Laura Rich, Executive Officer)	15
6.	Discussion and possible action on Diabetes	

INDEX

AGENDA ITEM		PAGE
	Prevention/Diabetes Self-Management Education and Support pilot program (Laura Rich)	47
7.	Discussion and possible action on recommended changes to Master Plan Documents for Plan Year '24 (July 1, 2023 - June 30, 2024)(Laura Rich)	63
8.	Discussion and possible action on Executive Order 2023-003 (Laura Rich, Executive Officer)	72
9.	Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR Benefits for the period July 1, 2022-September 30, 2022. (Laura Rich)	77
10.	Presentation on PEBP claims experience and trend (Richard Ward, Segal.)	115
11.	Discussion and possible action to include approving Plan Year '24 (July 1, 2023 - June 30, 2024) rates for State and Non-State employees, retirees and their dependents for the Consumer Driven Health Plan (CDHP), Low Deductible (LD) Plan, Exclusive Provider Organization (EPO) Plan, and Health Maintenance Organization (HMO) Plan (Laura Rich)	132
12.	Information and discussion regarding the Office of Projection Management statewide ERP implementation and the integration of PEBP's enrollment and eligibility functionality (Laura Rich, Executive Officer)	36
13.	Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitations (Cari Eaton, Chief Financial Office)	149
	13.1 Contract Overview	149
	13.2 New Contracts	149
	13.3 Contract Amendments	149
	13.3.1 Segal	149
	13.4 Contraction Solicitations	
	13.5 Status of Current Solicitations	152
	13.5.1 Enrollment and Eligibility System RFP	151

INDEX

AGENDA ITEM		PAGE
14.	Public Comment Public Comment will be taken during this agenda item. Comments may be limited to three minutes per person at the discretion of the chairperson. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.	152
15.	Adjournment	154

THURSDAY, MARCH 23, 2023, CARSON CITY, NEVADA

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CHAIRMAN ROBB: Thank you. It is 8:30. I would like to call the meeting to order. This is the Public Employees' Benefit Program Board Meeting, March 23rd, 2023.

Can I please have staff take 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?

MEMBER BARNES: Here.

MS. LUNZ: April Coughron?

MEMBER CAUGHRON: Here.

MS. LUNZ: Leslie Bittleston?

MEMBER BITTLESTON: Here.

MS. LUNZ: Jennifer McClendon?

MEMBER MCCLENDON: Here.

MS. LUNZ: Tom Verducci?

MEMBER VERDUCCI: Here.

MS. LUNZ: Janelle Woodward?

MEMBER WOODWARD: Here.

MS. LUNZ: Michelle Kelley?

MEMBER KELLEY: Here.

MS. LUNZ: We have a quorum.

CHAIRMAN ROBB: Thank you. I appreciate it. And I want to start by thanking staff. I know it's been a long time since we've had an in-person Board meeting. Everybody has become accustomed to doing it on Zoom. It took extra effort to be able to have this meeting in person, but I truly do believe in having meetings in person, and I do thank staff for that.

We're going to start with public comment. Public comment will be limited to three minutes. Please state and spell your name when you make public comment. And we will start in Carson City. Do we have any public comment first in Carson City?

MS. LAIRD: Thank you. Good morning, Chair Robb, and Board members. My name for the record is Terri Laird. I'm the executive director for RPEN, Retired Public Employees Of Nevada. We represent actives and retirees. We were created in 1976. RPEN currently represents nearly 8,000 dues paying members and we are a nonprofit, non-partisan federally tax exempt organization with 17 chapters statewide.

We appreciate the work this Board and PEBP staff face and how much more difficult it is with the staffing

shortage, which the agency has experienced since COVID. We've learned and heard a lot about the State struggles with staffing shortages at nearly every State agency, including the Legislative Counsel Bureau, who requested the extension -- extended the bills submission deadline this week by seven more days on Monday, March 20th.

We've testified many times about the problem at the legislative session currently going on, and we hope a solution will come via retention bonuses and salary adjustments, especially for entry level workers.

We're also in favor of the PEBP budget process returning to pre-COVID levels of funding, including restoration of long-term disability and the stabilization of life insurance for actives, as well as retirees who have been subjective to a yo-yo effect over the years.

We're also concerned about issues with our members who have had recently experienced Via Benefits and United Healthcare after they received notices from Via Benefits because they lost their healthcare reimbursement arrangement citing something that they did, which they did not do, something that Ms. Rich will explain in our next member newsletter.

We thank you for your time and thank you.

CHAIRMAN ROBB: Thank you very much.

Any additional public comment?

MR. ALLEN: Good morning. My name is Ken Allen, A-l-l-e-n. I'm here representing AFSCME Local 4041 and AFSCME International Union. Previously I was the director of board in AFSCME for 22 years and negotiated state employee contracts covering healthcare costs. We also worked in Oregon with a very similar board, the Public Employees' Benefits Board or PEBP, and they provided all of the state employee benefits, much like you do and a very, very successful program. They had great benefits at reduced cost, and that PEBP Board has been around for over 40 years. It's great work that they do. They provide great benefits for the state employees for many years.

I know you're going to consider the plan design of the health insurance plans offered to our members and future costs of those plans. For our members and all State workers, these decisions are very important. Health insurance issues, both plan design and cost to the employees is one of the single most important factors in acting prudent and intention.

The comparison of local governments and other State governments, Nevada State insurance costs are high. Reviewing the cost to State employees in Arizona, Utah, Idaho, California and Oregon, premium co-pays in Nevada are

up high.

The time of high vacancies, the State needs to try to minimize the cost of impacts on employees in two areas, a premium co-pay and a co-pay at providers offices. We need to pay particular attention to how these impact the lowest State workers and entry level employees.

Just this week, I've had three different members tell me that the high co-pays and the providers have prevented them from getting needed medical care. They actually had to make a decision not to go forward with the care they needed.

I had to review the single presentation that you have reviewed today. We're encouraged that the recommendations not increase premium co-pays. However, we would encourage the PEBP Board seek additional legislative funding to approve the plan design, the plans and reduce the premium co-pay cost to State employees. It's too late this year to make cost reductions. They should be considered for the next plan year.

I want to thank you for allowing our union to present testimony. And if you have any questions, I would be happy to answer.

CHAIRMAN ROBB: Okay, thank you.

MR. ALLEN: Thank you.

CHAIRMAN ROBB: Further public comment in Carson City? Seeing none, is there any public comment on-line?

MR. HOPKINS: Yes, there are, Chair Robb. I'll get the slide ready in a moment.

CHAIRMAN ROBB: Okay, thank you.

MR. HOPKINS: As a reminder, Zoom is used for public comment only. This meeting is streamed live on the PEBP YouTube channel if you wish to watch the Board meeting there. The YouTube link is located on the agenda.

For those who have joined for public comment, your name or last four digits of the phone number will be announced. You will be advised 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.

The caller with the last four digits of 3247, please press star six to unmute if you wish to give public comment. Caller with the last four 3247.

The caller with the last four 6358, please press star six to unmute if you wish to make public comment.

MR. COFFEY: Yes, may name is Larry Coffey. Last name spelled C-o-f-f-e-y. I am -- I work for DETR under voc rehab in the bureau services for the blind and visually impaired. I'm an orientation and mobility instructor

teaching our clients how to use the cane and get around independently, increasing their independence and improving the quality of their lives. I am an AFSCME member of Local 4041.

I request that PEBP's focus should be on improving our benefits at a lower cost to us employees. PEBP staff should request legislature to provide additional funding to PEBP for changes as well as the second year premium so that employees do not have to bear the burden of the increased premiums on year two.

Also PEBP should focus on keeping co-pays low as well. We're being priced out of using our health benefits because of rising co-pays. I've been having dental problems and I've had two surgeries. I try to do my procedures at the end of the insurance year and the beginning and ended up having to have multiple surgeries.

I just got a bill for $700 for part of the surgery that the insurance did not cover. Currently I have six teeth in my mouth since June and I need dentures and I can't afford it. We need to be taking care of us employees. We should not have benefits that we can't even access or utilize. It's embarrassing for me to be in front of our clients and the public when I present with having no teeth in my mouth. And so I really encourage PEBP to really look at

this and try to do what's right for us employees. Thank you. I appreciate your time.

CHAIRMAN ROBB: Thank you.

Do we have any further public comment?

MR. HOPKINS: Yes, we do, Chair Robb.

CHAIRMAN ROBB: Okay, thank you.

MR. HOPKINS: Rosa Moreno, you have permission to speak. Please unmute your mic if you wish to make public comment.

MS. MORENO: No, I didn't have anything to say.

MR. HOPKINS: Thank you.

Margaret Lewis, you have permission to speak. Please unmute your mic if you wish to make public comment.

Vanessa Delgado-Acosta, you have permission to speak. Please unmute your mic if you wish to make public comment and slowly spell your name for the record.

MS. DELGADO-ACOSTA: My name is Vanessa Delgado-Acosta. Last name D-e-l-g-a-d-o hyphen A-c-o-s-t-a. All I would really like to say, yes, this should definitely be a focus of our benefits. Our payments keep going up. Even though we may be getting some bonuses in the near future or possible raises, that is always offset by higher premiums.

My husband recently had to cover some insurance. He also works for the State, and he had to get some

medications filled but his medication was overly priced even with insurance. So, yeah, it's kind of hard to get appointments scheduled when you're kind of scared to go to the doctor because you never know how much you're going to have to pay out-of-pocket. So, yes, I'm glad that this is being discussed and I hope it is a focus moving forward. Thank you.

CHAIRMAN ROBB: Thank you.

MR. HOPKINS: Thank you.

Will t-a-y-l 45349, please slowly state and spell your name for the record and unmute your mic if you wish to make public comment.

Chair Robb, that is all for public comment.

CHAIRMAN ROBB: Okay, thank you. I'm going to call public comment one more time, just in case somebody, okay. Thank you.

We're going to move on to Agenda Item Number 3, PEBP Board disclosure for applicable Board meeting agenda items. Deputy Attorney General.

MS. KUNNEL: I'm sorry, I didn't realize I was on mute. Good morning, everybody. I apologize for that. I guess by this time I should be used to un-muting ourselves. But this item -- thank you, Madam -- thank you, Chair.

This agenda item is to allow me to make a

disclosure regarding conflicts of interest on behalf of the Board members who are eligible for PEBP benefits. Pursuant to NRS 281A.420, on behalf of the Board members who are eligible for PEBP benefits or whose families are eligible for PEBP benefits, I offer this disclosure. That they will be voting on those items that may affect the benefits available to them or their family members.

The law does not require abstention from voting merely because the Board member or the family member is eligible for PEBP benefits.

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

CHAIRMAN ROBB: Thank you very much.

We'll move on to Agenda Item Number 4, consent agenda, for possible action. Consent agenda items will be considered together and acted on in one motion unless items are removed to be considered separately by the Board.

Consent Agenda item 4.1, approval action minutes from the January 26th meeting, 2023 of the PEBP Board and Item 4.2, Clifton Larson Allen Audited Financial Statements of Public Employees' Benefits Program Self-Insured Trust Fund and Retirees' Health and Welfare Benefits Fund for FY22.

Those are the two items on the consent agenda. Is there any discussion or any of those need to be pulled?

Seeing none, do we have a motion to pass the consent agenda?

MEMBER FOX: Linda Fox for the record. I'll make that motion.

CHAIRMAN ROBB: We have a motion to approve. Do we have a second?

MEMBER BITTLESTON: Leslie Bittleston. I'll second.

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

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

CHAIRMAN ROBB: All opposed by saying no. The motion passes unanimous.

We are going to take things a little out of ordered today. We're going to take Agenda Item Number 12 before Agenda Item Number 5. So we'll go to 5, and then we will go to 12 and then 6.

So Executive Officer Report. Laura Rich, Executive Officer, informational, on for discussion.

MS. RICH: Good morning, everybody. Laura Rich for the record. The Executive Officer Report goes over, we're going over a lot of the same things that we've done. We've gone over in the past staffing. Unfortunately, the

situation hasn't changed. I think that's no surprise. We're at about a 30 percent vacancy rate right now.

Our recruitment efforts have been challenging, challenging to say the least. We've had a few recruitments for our call center staff and they have not been successful. We've made -- we've made some offers, and the only offer that was accepted was a promotional opportunity within our -- within our agency. We promoted our front desk receptionist to the call center staff. So it doesn't change the numbers obviously at PEBP.

It does help during open enrollment to have more folks on the phones and in staffing, you know, at MSU, member services unit. But, you know, I'm not going to sugar coat it. Open enrollment is going to be rough. It was rough last year. It will continue to be rough this year. You know, when you don't have very many staff and you've got 70,000 people that you're servicing that are calling in, that are e-mailing, we don't have the ability to keep up. So, you know, it is -- we are doing everything in our power internally to -- to staff.

All staff the month of May have been cut off from annual leave, including executive staff. We are all in the office being 100 percent present trying to support open enrollment efforts.

So we've also put more people than just member services on the phones. You know, we've got our accounting staff answering accounting phone calls. Usually we've got member services that will assist us with that.

So we are doing everything in our power to make open enrollment go as smoothly as possible. I think the one thing that we have going in our favor is that there are not a lot of plan changes this year. So everything is fairly status quo. So you don't have a lot of members that are calling in and asking questions about new benefits other than, you know, we will have some new benefits but they're not, you know, things that can help that are specific to physical therapy and things like that where you're -- it's not new deductibles. It's not new out-of-pocket maximums, things like that.

We don't have a new TPA like we did last year so open enrollment should go a little bit more smoothly. That is assuming that the legislature doesn't do anything crazy. So, and I'll talk about that in a minute.

Additionally, we do have an office move coming up. This is why we have kind of band-aided the situation today. You see that our room is not how it used to look. We are going to be moving to our new office space in the next couple of weeks, and so we've got staff who are packing up

and we were -- we're trying to get all the logistics in place so that we can start moving over in waves.

There will be a little bit of downtime for PEBP just because you've got to switch off IT stuff here in this building and then move it over to the other building, but we think it's just going to be a matter of hours so it shouldn't be too much downtime, but that is adding to the challenges of, you know, just staffing in general.

Legislative matters, we provided a budget presentation to the joint senate finance and assembly ways and means committee on February 17th. There was definitely a lot of focus on -- on benefits for sure and finding ways to, I think the legislature is really interested in finding ways to help employees both through wages and in the form of benefits.

During the committee meeting, PEBP did testify to the committee. We made it very clear that this is -- during a legislative session, you're doing a lot of work that leads up to open enrollment. Open enrollment is May 1st. Our budget typically closes some time in April. They make changes to the budget. Everything, you know, during open enrollment changes, right.

And so I tried to make it very clear that on a normal year, this is very difficult for staff to accommodate

but specifically in this year, it's even more challenging. And so I think that resonated with the committee members and we've been having some conversations behind the scenes as to, you know, what kind of options the legislature has to -- to increase benefits or even, you know, increase funding to PEBP in ways that don't affect that last minute budget at least for this year.

So in the second year of the biennium, they can do whatever they need to do. But in that first year of the biennium, we're already set to go and, you know, open enrollment meetings have been scheduled. We have documents that have been updated. We have -- in fact, I know in my note box I have something from PEBP right now and so we've already -- we've already done all the work that leads up to open enrollment. So when things change at the last minute, it really is difficult to go back and undo it and then it creates member confusion and all sorts of things.

And so I think that's really resonated working with the legislators to figure out ways and there are many options of, you know, getting around that and figuring out ways to really improve benefits throughout that immediate disruption.

There is a committee meeting scheduled for March 30th that is focused on employee compensation and

benefits. That's about it that I know. We've been asked to attend but we will not be presenting. It's just PEBP has been asked to be there for questions, and so we'll be there on March 30th. And I believe it is a work session so we'll see what they have in mind. So with that, I'm happy to take any questions.

CHAIRMAN ROBB: Mr. Verducci.

MEMBER VERDUCCI: Yes, thank you. Tom Verducci for the record. Officer Rich, what would you say is leading to the vacancy rates at this level and what do you think as a Board and what do you think the State could do to actually help out? It's a pretty severe, almost crisis situation. What do you think is leading to the level where we're at today?

MS. RICH: Laura Rich for the record. My personal opinion, just based on the interviews that we've done internally at PEBP, it comes down to pay. It is 100 percent down to pay. Yes, there's obviously benefits do take into account into the bigger picture, but we're just not competitive in pay.

So I do want to add and thank you, Chair Robb, because I know he spearheaded this effort. We do have the ability now to hire incoming new candidates. We used to have to hire them at a step one. That's the lowest for those, I

know you're not a State employee. So that's the first step and in the entry level step to come in. And so as you progress, you can go from step one all the way to step ten and you usually progress every year up until you get to step ten and then you're topped out.

We have been given the flexibility as agencies to hire at higher levels than the step ten and so that may help some recruitment efforts as well, but it's -- it's still challenging.

What can we do as a Board? You know, I think that having these types of conversations where, you know, we're -- we only have the ability to affect benefits today, premiums, right. And I plan on talking about it when we get to premium, to the plan year '24 premium agenda item. But, you know, if we look at that as -- there was some discussion about employees where our premiums are potentially, you know, they are higher than other local governments. We talked about it before, yes, they are, but the State has taken a different methodology.

We tend to subsidize the whole family versus just the employee, right. Whereas, local governments, they give out -- you know, their premiums usually for an employee is free. Adding your family is a lot more costly. If you look it up, other local governments, and we've had the comparison,

right. Adding your family is typically more costly at those local governments.

Whereas, we don't provide free premiums to employees, but we also make it less costly to add the family members and so we take on kind of a different methodology. Is that the right one? Maybe that's something we need to look at moving forward because, you know, where is our focus. Is our focus if we want to recruit and -- and I don't know if that's the right answer because maybe people are looking for those lower premiums for families and not just the zero dollar premiums for employees.

So, I mean, there's things like that that we can consider, but I do believe the legislature is really doing what they can to, you know, to put out options out there, and I know I'm working with them pretty closely on, you know, what kind of options. We provided a lot of different options to them.

MEMBER VERDUCCI: Thank you.

MEMBER BITTLESTON: Thank you, Mr. Chair. Leslie Bittleston for the record. I'm a 24-year State employee myself and a hiring manager with 50 percent vacancy rate in my own unit right now so I've been doing a lot of interviews. So I kind of wanted to add to what Ms. Rich said regarding I think there's a couple of problems, at least that I'm seeing.

Candidate quality is one. I don't know how some candidates get through the vetting process. That's been interesting.

And then secondly another thing that we're seeing is we'll schedule interviews with employee or with individuals. Either they don't show up or they've gotten another job before our interview or we have interviewed them and possibly offered the job and they say nope, that job's too hard for the amount of money that we're getting. So I think that there's a lot of factors at play, and I just kind of wanted to add to what Ms. Rich said to that.

The other thing if I could about legislature, the one thing I have presented my own programs in front of the legislature over the years, and this year seems to be a lot of new legislators so we find that we're spending a lot of time educating our new legislators rather than, you know, getting into some of the meat and the heart of the issues.

So no question, just comments. Thank you.

CHAIRMAN ROBB: Thank you.

Ms. Kelley.

MEMBER KELLEY: Thank you, Chair Robb. Michelle Kelley for the record. Executive Officer Rich, you know, I appreciate all the work you do, and I'm glad we've had this discussion around staffing because I've heard from the HR departments that I work with that everyone is feeling extreme

trepidation about this enrollment period.

I think that, you know, people are already having issues getting -- getting in contact with PEBP sometimes and so we're not even, I hate to put it that way, and we're not even in open enrollment period. So I guess I have a question about that and then I have another comment.

So I just wonder, we have a month of open enrollment. It's the only time our employees can pick and choose and make important choices for the year. And I keep hearing both in public comment and just generally about how employees can't afford the co-pays and, you know, the co -- the premiums. I think there's some confusion about what a co-pay is and what a premium. But I keep hearing that, you know, the people can't afford to get the services they need or can't afford the plans and I think there has to be a happy medium.

And I'm just -- when I see in the numbers that we still have most of our members are in the high deductible plan which, of course, doesn't provide co-pays and does make accessing those services more difficult but we have introduced the middle tier I think for the low deductible plan. And, you know, we're in a -- open enrollment will be the third year of the low deductible, maybe the fourth.

Anyway, we have this low deductible plan that's

only slightly more expensive from an employee's perspective. I think it's $20 which, you know, what you get from that $20 there's affordable co-pay so I'm doing a bit of editorializing in case there's people on the plan.

But I wonder, my concern is open enrollment is the opportunity for these people to have to switch and they're also turned off at the moment. How are they going to be educated about these plans. If they can't get onto -- get onto PEBP to kind of talk to somebody about this is my situation. How do I pick? And I know none of us can give advice. But we can guide, right. We can point out important aspects.

So my concern is we get to May 15th and we have all of these people that suddenly go, oh, I need help selecting a plan. This is my one opportunity and nobody gets back to them. So I guess, you know, how do we -- what do you say to that? Like, what do we say to employees who say, you know, I've made this call and I've not heard back? How do we provide guidance to them? How are you going to ensure that I guess that these people are given the answers they all, an answer, maybe not the answer they're looking for but an answer.

MS. RICH: Laura Rich for the record. I appreciate that. And last year we definitely, we had a lot

of changes, right. We changed TPA's. We changed -- there was a lot of vendor changes, and so there were a lot of people that were confused. And I would say we were fairly flexible if there was any -- if we could show that the person made an effort and that there was, you know, there was an e-mail, there was a phone call, there was, you know, something to show that they've tried, they have attempted it and, you know, so we did make a lot of exceptions in that situation.

Now, if someone came in August and said, you know, hey, now I want to change, that's a little bit -- we're too far along, right. But, you know, first week of June, we had a lot of exceptions. It continued just because of the situation that we were in. I anticipate that happening again this time around.

MEMBER KELLEY: Okay. I appreciate that response. And so you're saying if we get our employees, just make sure that they're reaching out to PEBP. That they can provide that triangle. And then if whatever answer they get changes their opinion, close to after open enrollment, they could give some leeway. Thank you very much. That's a great answer.

And then my next question is just, I guess maybe it's more of a discussion later, but I wanted to put it on

the table. Sorry, Chairman Robb. I know we're getting out of here at 2:30.

So, You know, every -- every employee and we end up in the situation where we're disappointed at the, you know, the initial budget we've been given and the legislators are talking about maybe doing something for us, but open enrollment always happens at the same time. It's always May. And so it's always -- you know, I'm sure the message is always the same. You know, it's really difficult for us to make changes.

But since I've been in PEBP and since I've, all the years I've watched PEBP, we've never actually made substantive changes in the off years because we never had the money. So I'm just wondering, what is the nexus of we can't improve benefits this year because it's too close to open enrollment versus improving the benefits for our employees.

You know, we have, all year we talk about what we're taking away from employees. And we just never had a time to talk about thoughtfully what we're going to give employees. And so in a legislative session where there maybe is an opportunity to improve, I guess I'm wondering, other than HSA's and HRA's which, you know, which really don't impact our employees that much. They don't seem to value them the same way they value a lot of co-pay. How do we

actually make structural changes and start giving things back to employees in a meaningful way that they actually recognize the benefits they are getting?

MS. RICH: Laura Rich for the record. It's -- that's a very good question and it's a very, I think very complicated political answer because there's so many steps along the way in a budget process, right. First, I think, you know, PEBP, we -- we try to have strategic sessions at least every other year to where we have these discussions and we try to bring things to the table and we bring -- so that we can include it in our budget request.

When the executive branch is -- typically the process for the executive branch is you get -- agencies get a set of instructions to build the budget. And this year, really it was last year, the set of instructions were make do with what you have with the flat budget, right. And so knowing the situation PEBP was in where a flat budget for us is really a reduction in benefits, right, because you have to keep up with the cost of healthcare.

And so the first thing I did was, you know, make the frantic phone call to the Governor's finance office and say, is there any way, you know, that we can get an exception to this. There's -- you know, this is going to result in a reduction to benefits and they were very amenable to that.

There's a few other agencies who have that as well, and so we got that exception to the rule. But, again, you have criteria that you have to meet.

And so that's -- that is, you've got the Board that has a bit of control. Then you've got, you know, the executive branch who then builds a budget and that is -- that becomes the Governor's recommended budget and that's something that's really out of our control. And then you get to the legislature and that is now in, you know, the hands of the legislature. And so you have the ability to influence but, you know, we really -- a lot of that is out of our control because it's -- you know, there's steps along the way.

Something that I've thought of that potentially we could do is in the off year leading up to our budget-building session, we can have a strategic planning session and we can potentially come up with, you know, option enhancements, you know, not just cost saving programs but potentially enhancements as well and we can build them into the budget and we can provide similar to what we did this time where it was this is the PEBP budget adhering to the, you know, GFO guidelines and this is the PEBP budget, what we really want.

And so that -- the second PEBP budget may not go

anywhere. You know, we don't have any control over that but at least we do have this is what we're recommending. And then at least it provides a guideline not just for the Governor's recommended budget, but it also provides a guideline for potentially if it does make its way to the legislature, that as well. And so but we would have to do that in the off year so that we can -- in our budget, it's all about timing in this two-year legislative process, so.

MEMBER KELLEY: Okay, thank you. You know, and I appreciate you outlining the challenges that, you know, we currently operate under.

You know, in thinking about this, and I understand that the State works on a fiscal year, but why can't the plan year be changed? Why can't we change the plan year to October 1 or September 30?

MS. RICH: That is something that could potentially -- Laura Rich for the record. That could potentially happen. I'm going to look over at Cari because she's giving me the stink eye right now.

MEMBER KELLEY: She's smiling.

MS. RICH: For fiscal accounting, State accounting purposes, that's also a nightmare. So it's not something that is impossible. That is something I've actually thought about. It's just very difficult.

MEMBER KELLEY: Michelle Kelley for the record. This is the second legislative session that I've been on the Board. The first one I was brand new, but it is also the second legislative session that I've heard that the legislators show some willingness, but it's just so problematic. That then the last time, they just moved away from it, right. They just went, ah, too far.

And so if we are -- if because of -- you know, and I don't want to minimize the accounting because I know just the normal accounting is terrible. But if moving the plan year ends up having a bit of product for all employees, including PEBP staff who are doing the accounting, then, you know, I would just propose that it's something that we should, maybe should be discussing.

Because I just, I feel like when we make it so hard for the -- I've watched a few legislative workshops this time. And when it gets too hard, like they have so many other hard things, it's kind of a potato. They just kind of drop and go, all right, well, next time, you know. So thank you for the opportunity. That's the end of my comments.

CHAIRMAN ROBB: Ms. Woodward.

MEMBER WOODWARD: Janelle Woodward for the record. A quick question. We did do two budgets, correct, or you guys did? Is that a case where that second budget

just didn't go anywhere? Is that something we could put forward to them for the second year?

MS. RICH: Laura Rich for the record. So the budget process is part of the executive branch. So we don't recommend to the legislature. This is the Governor's budget. And so the -- it's up to the Governor to present a budget. So as a Board, we present it. We presented two options for our budget.

And so the option number, the first option is what made it into the Governor's recommended budget. So as part of the executive branch, I don't have the ability to overstep the Governor and say, hey, legislature, you know, that would probably be inappropriate and I might not have a job.

So I -- but then you do have conversations with legislators. So for example, that second budget had enhanced -- you know, the life insurance was restored. Long-term disability was restored. And so some of the questions were how much is it going to cost to restore long-term disability? I've provided the legislators with that cost. I provided the legislators with not just the cost but, you know, what it's going to take to do that kind of thing. So, no, we didn't hand them over a budget. But they asked the questions and we provided the answers that

basically encompass what was in that budget.

MEMBER WOODWARD: So does it make a difference for employees to speak up on their own behalf to the legislature for the future? You know, if we can't do something right now, maybe they can influence a, we're going to give some extra for that second year. Because I know in conversations that I've had with the legislators, they had no idea that costs go up the second year because they're not thinking that way at all.

MS. RICH: So Laura Rich for the record. The cost, typically they would go up just because the cost of healthcare usually goes up every year, right. And so it's -- but we budget so that that subsidy is typically more that second year to cover that cost. And so the problem is when it goes up more than what we projected, there's no way to increase that subsidy, and so that's when we have to increase premiums that second year.

So we try to do things to mitigate that. It's just -- it's a, you know, planning two years in the future for healthcare is somewhat difficult. So, you know, you try to hit it, but it is -- you're not always right on the mark. But, yes, I would say power in numbers, right. The more -- the more voices the more noise. Usually just, you know, the squeaky wheel gets the grease.

MEMBER AIELLO: Just real quick. Kind of question, comment but you don't really have to answer. In thinking for next time or next year, I know like we did two budgets, but I wonder if there's an ability to do a module. So that if the legislature says it looks like we're going to have more money, we could shop for this thing or this thing. And then in our prep for open enrollment, we could say this is what we have now, but we think they may approve one of these modules and we have a slight iteration of stuff ready so that then if they approve one of those modules, the stuff is ready to roll so everyone is not scrambling May 1.

Maybe there's two modules so we have three iterations that are not that and we pull the correct open enrollment, I'm just trying to think of so we don't have this same problem for eternity, which is what I think Michelle was trying to get at, is maybe there could be something like that. Just throwing ideas out.

MS. RICH: Laura Rich for the record. So that sort of works. But because everything is built into the rate, it changes everything.

MEMBER AIELLO: Uh-huh.

MS. RICH: It changes the premiums, you know. And so if you pull this lever, say some other ones do this, right, you know, and so it does become pretty complex, and so

there are things that can be done that are outside of rates and they can fund things outside.

Like, increasing an HSA or HRA, especially if you're going to do it for all plans, that's easy because all we're doing is really just changing the number. And so yes, you have to change it in the system. You have to change it in -- you know, you're changing a three to a six or whatever in the plan documents and so those -- that's semi-easy.

But when everything is worked into a very, very complex math equation with -- you know, if anyone has seen our budget workbooks, it's like, you know, 15 tabs of Excel, you know, sheets and they all tie. It is a very, very complex situation. And so the math behind it is -- it's not -- it changes everything. And so that's where because everything is built into that budget and into the cost of plan, it becomes very complex.

So there are certain things that if they -- if done the right way, it's very easy. There's other things that if they do them the normal way, how things should be done at the last minute, it becomes just overly complex and changes -- changes the rates. And, I mean, the rate tables themselves are -- you know, it's a lot of work that goes into it, so that's the problem.

CHAIRMAN ROBB: Any other questions?

MEMBER KELLEY: I'm sorry, just one last question, more a practical question. You did indicate PEBP was going to have some downtime but probably only hours. How are you going to communicate that to all of the agencies to let them know that everyone is going to be offline?

MS. RICH: So Laura Rich. The agency reps will get updated. They will receive a memo on this. The system will also have, you know, a banner saying PEBP is down. And, you know, then the phones will also say, you know, from 3:00 to 5:00 p.m. on this day, you know, we are shut down because of an office move, and so we're doing everything we can to communicate that. It's only going to be a matter of hours so it shouldn't be terrible, but that's assuming everything goes smoothly. And we all know, you know, IT, sometimes when you turn something off here and turn something on here, it can be problematic, but our IT staff is, they have done a great job and they have assured me that everything is planned to work fine.

We also have EIT supporting us, you know, the State IT department, and so that should help as well.

MEMBER KELLEY: Thank you.

CHAIRMAN ROBB: Okay. Any further discussion? Seeing none, we'll move on to Agenda Item Number 12, information and discussion regarding the Office of Project

Management statewide ERP implementation and the integration of PEBP enrollment and eligibility functionality. Laura Rich, Executive Officer, informational/discussion. I would also like to bring Bryan Bowles to the table, just in case there's question.

MS. RICH: So Laura Rich for the record. Just a little bit of background on this. In -- on March 24th of 2022, the PEBP Board did approve the recommendation to terminate PEBP's contract with LSI and that was -- I know a lot of us are trying to forget about it in their memories but it was just a result of an unsuccessful implementation and go live.

So we went back to our previous lender, who is LifeWorks, who we are using today for our enrollment and eligibility system. The PEBP Board at the time approved that staff move forward with an RFP request for proposal for a new eligibility and enrollment system with a proposed go live date of January of 2025.

So in 2019, LSI was also chosen as the contracted vendor to integrate the Smart 21 ERP. So that is the statewide, you know, financial and HR basically overhaul of all of our antiquated systems.

Shortly after PEBP decided to terminate our contractual arrangement with LSI, the State also issued its

own termination to LSI for its role as an integrator in the Smart 21 project.

So since then, PEBP with the assistance of Segal IT Consultants has developed some, a comprehensive list of requirements, and we have been working on rolling out, developing and rolling out an RFP or an enrollment eligibility system.

The office project management has also been working on contracting with a new integrator for what was previously known as Smart 21. I think there's some re-branding happening. But OPM is currently engaged in that process today, and there should be a decision made here shortly on who that integrator is going to be.

So although PEBP and Smart 21, we experienced our own setbacks with, you know, our respective implementation, we did learn a lot of lessons throughout that process. We did -- I think one of the most important lessons is PEBP touches everything in the State. We touch HR. We touch payroll. We have just a lot of overlap in the entire ERP system that the State is going to be putting in, and so it's really imperative that we work really closely with that ERP implementation.

And so as a result, I have reached out to the folks that are working on that project and said, look, we're

both at square one. Let's work very closely together because if PEBP is doing this and smart -- and OPM is doing this and then at some point we come together, that may not work. We need to be completely, go on very similar paths. We can't -- we cannot contract with different vendors and then tell those vendors to work with each other and expect everything to go smoothly.

So I began working with OPM and their partner, SAP Software at the time to capture specific requirements to, so that we can include all of what was necessary in that partnership and that project.

And as a result of these conversations, we decided, okay, it's -- it's in our best interest to work collaboratively and figure out how we can move forward together versus, you know, in separate directions.

So OPM currently has a service agreement that's authorized by the board of examiners under a statewide contract for Cloud Solutions with Carahsoft. And so as a result of some of these conversations, it, with purchasing, the division purchasing made us aware that PEBP doesn't have to RFP. In fact, you know, there's already an RFP out there that captures exactly what we need, the HR and financial systems. And so we could leverage that RFP through current statutes and not have to release our own RFP.

So that -- we're using that contract vehicle. It's under NRS 333.475 to not just join that contract. It's actually negotiating our own contract. So we do not have to RFP. We would negotiate a contract with the OPM vendor, and that OPM vendor, whoever that is awarded to, we would -- PEBP would negotiate our own contract with that OPM vendor and we would then utilize their, either their subcontractors or potentially, you know, some of their partnerships to then move forward with an enrollment eligibility system.

We think that this process by doing this, not only does it, instead all of the time we would be spending releasing an RFP, we're able to actually do the work and implement it and put something, you know, together and work with the project management to ensure because the State is really, it's the bulk of our membership, right. NSHE is the remainder or, you know, then we've got some boards and commissions and things like that, but the State is really the bulk of membership.

By going down this route, utilizing that RFP, we are able to then negotiate our own contract and so it wouldn't be an OPM contract. And we would then use that integrator to vet other industry solutions and additionally using our consultants, our IT consultants to ensure that the solution we have, one, they're able to meet all of the

requirements, the scope of work.

And two, that the -- the cost that we're getting is, you know, is a -- an appropriate cost and, you know, competitive cost. So we would have a little bit more flexibility. And on top of that, I think just working with the office project management, we would be using the same vendor, the same -- we're both starting at square one. We are able to work together versus taking two different paths and coming together at the end and saying, okay, you know, two vendors work together. And I know that this vendor has done this and this vendor has done that but now you've got to merge two IT solutions. It never works out that way. It doesn't work out well that way.

And that's really what happened with the LSI situation, you know, PEBP started much later in the process than Smart 21. And so by the time that we came onboard and said, okay, now we're going to be integrating with the Smart 21 project, it was -- there were already things that were identified. They hadn't even taken into account PEBP's specific situations.

So given that this is an HR and financial systems overhaul and PEBP touches every single point of that, it just makes sense to coordinate and work closely with office project management on that. And so then we do have Mr. Boles

here who is the administrator now, right, administrator of the office project management in case there's any questions as well.

CHAIRMAN ROBB: Mr. Verducci.

MEMBER VERDUCCI: Yes, Tom Verducci for the record. I noticed this is an action item here. And would this come back to the Board in order to make a decision or is it somewhere else on today's agenda?

MS. RICH: So Laura Rich for the record. This is actually an information item. The action is later on in the contract report. So in the contract report is where we have all of the, you know, contracts and procurements that are in progress. And so during that agenda item, we're going to be recommending the cancellation of a -- of that RFP because of this agenda item.

MEMBER VERDUCCI: Fantastic. Thank you.

CHAIRMAN ROBB: Ms. Kelley.

MEMBER KELLEY: Thank you. Michelle Kelley for the record. I just have more of a comment slash request. I think this is a great idea. Thank you for exploring this. I know PEBP isn't the biggest in state but PEBP is big. We have a lot of eligibility issues with PEBP.

So my request would be that through this project NSHE actually be included as someone that the contractors

work with to integrate some of our eligibility systems. I don't know if that's already planned but certainly, you know, I think it would behoove all of us to get ahead of this and included in the initial contract so that NSHE -- so that it's easier for all of us. That would be great.

MS. RICH: Laura Rich for the record. Yes, so while this is the ERP implementation is really just for the State, we've made it very clear that we service those that are outside of the state, such as NSHE, such as the Legislative Counsel Bureau, such as the boards and commissions, right. So we do have to make those accommodations to all of those other, you know, entities that we service because it's not just the State and but the State and NSHE are the two biggest ones and so that is really where, you know, a lot of the folks in attending goes to in order to facilitate and make that those processes more efficient.

The good thing is that NSHE uses Workday and so that is something that, you know, is fairly well known in the marketplace and something that, you know, we can probably work with. While we work with the vendor to make sure they can accommodate and use that Workday solution to the best of our ability and to make things more efficient because right now they're just, they're not.

MEMBER KELLEY: Thanks. Michelle Kelley for the record. Just a follow-up. I think that -- I think that if NSHE and the Workday, because just to be clear, the NSHE Workday solution is not the Workday solution where you just pick it up and drop it in. It is customized, which is how Workday, you know, works. You know, in colleges they just pick it up and drop it.

But we do have a robust IT staff and I think that they would be appreciative of being included, especially for the integration files. You know, I think if we can integrate some of this automatic stuff as if we are also HR, right, because I'm sure that's your goal as well. But I think if it's really put in the contract that this is essential and then NSHE IT people are included from the get-go, I think it would be really good use of everybody's time.

And then I'm sorry, I have to say this, testing, testing, testing, please. You know, I mean, I think like some of the integrations this year that we've all gone through, you know, I continue to hear just about how there was just a lack of testing, especially with NSHE. I don't know if it was across the board but we did not get the opportunity to test things the way we should have and as a result I think clean up is still happening. So testing, test, testing, testing, testing and then please test again.

I would appreciate it. Thank you.

MS. RICH: Laura Rich for the record. I think part of the reason for the lack of testing was a lack of time and so this extends the runway that we have, and I think that's going to actually increase our ability to test thoroughly and work out all the kinks, right. And so I really do think that this is a good path for that because we're using the time to do that kind of stuff versus RFP, so.

MR. BOWLES: Brian Bowles for the record. If I could comment since this is the first time that I'm speaking. Thank you to the Board and the Chair for your flexibility and moving this agenda item up. I do really appreciate that.

To your point, I think not only will we be reaching out, what I heard and I thought was a very robust offer of help to my office from NSHE, and so we will absolutely be reaching out when the time is right to bring your IT folks and your subject matter experts into the room when we're discussing design and discussing integration and development because it's critical to do so.

In my conversations with Executive Officer Rich, when we talked about the plan that she laid out for you today, we immediately asked for help from her staff to work on the integration and the design of the ERP that we're doing now. And so Ms. Eaton and Mr. Proper are going to be coming

into our building and we're going to be pulling all of the contents of their reigns out so that we can build the ERP and build the necessary hooks within the software. So when the time comes for the enrollment and eligibility piece to begin work, they already exist within the system that we're building so that we can have that seamless integration, which is really what the State and PEBP needs to get a robust system and it works.

And so in the same manner that we would be pulling in early and often from our subject matter experts and our resources that we would be doing the same with NSHE when the time comes to do the enrollment eligibility piece.

MEMBER KELLEY: Thank you very much. We appreciate it. And I nominated them. I haven't told them, but I know they'll be -- I know they'll be energized by the thought.

MR. BOWLES: Volunteer, voluntold.

MEMBER KELLEY: Exactly. Thank you.

CHAIRMAN ROBB: I'm going to add to what Mr. Bowles brought and follow-up on your testing. I am one of the three members of the executive committee. I know Laura is going to be working with us at the executive committee level. We are championed by Jim Wells out of the Governor's Office and there's going to be a high ask of all

agencies to ensure that we have only subject matter experts in the room to make sure we get it built right but the super users of the system to make sure it gets tested right.

I have in my prior roles worked on a lot of billing systems and customer interface systems, and we tested the heck out of it, but there's a difference between under people testing something robustly and 20,000 people using a system. There is a big difference. I came from wildlife. We rolled out a new system. We tested the heck out of it. You roll it out to 85,000 people, they are going to find things you never thought of. So it will be robustly tested but we're going to remain nimble.

So when those folks are discovered through rollout that we can act on those and get them taken care of before they become huge issues.

MEMBER KELLEY: Thanks, Chair Robb. It sounds great. Thank you very much.

CHAIRMAN ROBB: Any other questions? Seeing none, we'll close Agenda Item 12. Thank you, Mr. Bowles, for your time this morning.

And we will move on to Agenda Item 6, discussion and possible action on Diabetes Prevention, Diabetes Self-Management Education and Support pilot program. Laura Rich, Executive Officer.

MS. RICH: Laura Rich for the record. We do have I believe Chris Syverson virtually. It looks like she's available.

MS. SYVERSON: I am here.

MS. RICH: Okay, perfect. So I'm just introducing Ms. Chris Syverson with the Nevada Business Group on Health. I want to give props to Ms. Fox here, who actually brought this idea to my attention and got both myself and Ms. Syverson together to have these discussions. And I'm really going to just hand it off to Chris and she can kind of go over our idea for a pilot program related to diabetes, so.

MS. SYVERSON: Thank you, Agency Director Rich, and the PEBP Board. I appreciate the opportunity to speak with you today. I do have one logistic question. Do you have my presentation and can you see me or my presentation?

MS. RICH: We can see you and we have your presentation available, yes.

MS. SYVERSON: Okay. May I share my screen then?

MS. RICH: I think you can. If IT, yeah.

MR. HOPKINS: Yes, you should be able to. Give it a try.

MS. SYVERSON: Okay. Can you see it?

MEMBER KELLEY: We can see you.

MS. SYVERSON: You can see me, so.

MR. HOPKINS: It doesn't show that you're sharing yet.

MS. SYVERSON: Okay. Just one moment, sorry. Okay. Can you see it now?

MS. RICH: Yes.

MS. SYVERSON: Great. First of all, I would like to take the opportunity to introduce myself and my organization and give you a little heads up on what we're going to talk about today. So I am the CEO for Nevada Business Group on Health and Nevada Health Partners. We're two organizations. We have been around for, going on 30 years, and we are a public private partnership that works with employers, all different kinds of employers, self-insured primarily, but we do work with some fully insured programs.

Some of the names of the companies that we work with would be Washoe County, Washoe County School District, City of Sparks, as well as Click Bond, Carson Nugget and other organizations.

Today, we're also going to talk about the CDC programs for diabetes prevention and diabetes self-management. We're going to talk about an association that we have with the State of Nevada and the CDC to provide

these programs and offer the opportunity to pilot some of these programs for State of Nevada PEBP members.

Our ultimate goal in this is to increase awareness of type 2 diabetes and pre-diabetes and eventually to hopefully provide coverage within benefit plans for these benefits.

As I mentioned, we are a Nevada Business Group on Health and Nevada Health Partners. NVBGH is really both our nonprofit. And the first really is for NVBGH to work on clinical programming, cost effective healthcare and community health.

We also have just recently signed a robust data platform. I know you all are talking about data platforms. Ours is much similar to do data aggregation, where we can take all the claims from all our employers and look at where they're spending their money and look at disease states and try to help them target some of those -- those areas. That's actually how this diabetes program came about.

What we found was that diabetes was maybe not a primary diagnosis in a lot of situations but diabetes was a comorbidity in a lot of situation and certainly aggravates and compounds the care when you're facing another chronic disease or any disease, as COVID taught us with diabetes being a complicator.

We do have a secondary organization that we're not going to talk about today, that is Nevada Health Partners. We have direct contracting whenever our pharmacy program and other -- other areas that we work with our employers.

We are also a part of the National Alliance of Healthcare Purchasing Coalitions, which is a really big mouthful, but it's approximately 50 healthcare coalitions and clinical coalitions like ours across the United States. We support about 12,000 healthcare purchasers providing healthcare coverage to over 45,000,000 Americans. We represent a huge cross section.

I also have the distinct pleasure of chairing the board for this organization nationally. So it's been a very exciting time. I'm also chairing a national committee on high cost claims. What we found was small to medium, even large employers are really struggling with the cost of high cost claims. And, again, diabetes is one of those things that can really drive the cost of health claim up.

Today I want to talk about the DPP or Diabetes Prevention Program. This program was developed by the CDC. It is a public private partnership of community organizations, employers, a lot of different groups to really work to establish evidence based programming to help reduce

type 2 diabetes. It is a year long program. So this is not for the faint of heart, but it's an evidence based program. Sections are weekly for six months and then monthly for six months. That's kind of hard to say.

It's to train employees to make real lifestyle changes. They meet with a coach. We have several different organizations that we are working with to provide this training. We actually don't provide the training, but we've been able to partner with a couple of other organizations to do it at no cost.

Participants meet with a coach and work on lifestyle training. And it's been proven to cut a person's risk of developing type 2 diabetes by 50 percent. So the DPP program is for those employees or members who may have been diagnosed with pre-diabetes, okay. Things such as healthy eating, exercising, stress, you can see all of the things here. That is part of the program.

We can do several different delivery methods. They could be in-person. During COVID, we certainly did virtual. We did two virtual classes, distance learning or any combination thereof. Sometimes what happens is they start meeting in person to get founded and then get the relationship founded and then move to a virtual situation.

Results of the CDC's DPP program is weight loss

of five to seven percent of body weight is achieved by reducing calories and increasing activity resulted in 58 percent lower incidents of type 2 diabetes. For people 60 and older, the program reduced the incident of type 2 diabetes by 71 percent. And after ten years, 34 percent had a lower incident of type 2 diabetes.

So here's the simple math, the type 2 diabetics costs a plan, like PEBP, $10,000 more a year than a non-diabetic. So depending on the number of pre-diabetics or diabetics that you have in your plan, this can be a big cost strain. The cost, the normal cost of the DPP program is anywhere from $150 to $600 in total. I would probably go more towards that higher $600 cost for a program. But a one-time cost of the program and saving $10,000 a year for member or employee could be significant.

The second part of this program is what's called DSMES, Diabetes Self-Management Education and Support. This is for people who have already been diagnosed as a type 2 diabetic. It is, again, evidence based foundation to provide people with tips and tricks and lessons on how to eat healthier and how to identify triggers for yourself.

I actually had the opportunity to go through a DSMES class as an observer to find out how the program worked because we were offering it. We wanted to -- I wanted to

know how it worked and it's very, very good and a lot of simple things.

It's a six-week program offered for people who have type 2 diabetes. Sessions are two and a half hours a week for six weeks, and we have trained leaders. People who have provided training for us in the past is Access to Healthcare and Sanford Center for Aging.

If we were to rollout the PEBP program, we've also identified trainers who can work throughout the state and in the south as well.

Why is this important to PEBP? Laura, and Agency Director Rich and I worked on, with the PEBP third-party administrator and found that the State of Nevada had approximately 3,700 diabetics on their plans and 2,400 pre-diabetics.

In addition, the CDC statistics show that eight out of ten adults have pre-diabetes and don't know it. So of those 2,400 with pre-diabetes, those are ones that we've already identified, and we know that that number could be much, much greater.

Our program, we received a grant through the State of Nevada. It's actually a sub-grant of the CDC to bring employees and employers to the table to talk about the coverage of DPP and DSMES in their benefit program.

We have partnered with our employee groups. Seven of our employer groups have taken advantage of these programs. And we also were able to find groups that could provide the training at no cost. So what we were able to do is bring the employees and the numbers and bring the people to provide the training together. And what we did is we called it a pilot program.

I've worked with public agencies in the past, having retired from the City of Sparks and know that sometimes making plan changes is very, very difficult. And so we what we wanted to do is to offer this on a pilot basis to see how it works and see how the State or our employers that have been utilizing this program like it, and then we would have the evidence base to perhaps look at offering it as a covered benefit.

We have no stake in this program. We get nothing by offering this as a benefit or not. Our goal is just community and population help.

There's very little workload for the agency. The other important thing is to confidentiality at a member level is preserved. So many of you probably feel like a lot of people in the world, which is I don't really want my employer to know what is going on with my health, right. That's private to me. So what we do is we work with the people that

provide the training and identify those people through the third-party administrator and reach out to them, either directly or passively, meaning we can do a communication to all State employees generically or we can reach out specifically on and around the state and let them know that this program is available.

What are we asking? We're asking permission to move ahead to identify potential pilot group, communicate the program, certainly in conjunction with the State, identification of potential eligible members, reviewing and giving you all results of the program. And then some time down the road, depending on the results, consideration of PEBP to cover the DPP and DSMES in their self-funded benefit plan moving forward.

So I have given you just a lot of information in a very short time period. So I would be happy to answer any questions that you may have.

CHAIRMAN ROBB: Thank you very much for an informative presentation.

Do we have any questions from the Board? Ms. Aiello.

MEMBER AIELLO: This is Betsy Aiello for the record. And it's not really about this program itself. But I know that we've seen it in our meetings and in our agendas,

presentations on obesity management and diabetes management already within our program. And I'm not sure if this, because it sounds like a very good program, but I don't know if this is duplicative to what we already have or how that plays.

MS. SYVERSON: Very good question. One of things that we have found is there are so many different -- different situations that come into play here. There's weight management. There's, you know, certainly hypertension. There's all different things.

And a lot of times what we see are different disease states are targeted. We have, Agency Director Rich and I talked about this, and what we feel is that this would be a complimentary program and give a different alternative to just weight management but actually focus on lifestyle.

MS. RICH: And Laura Rich for the record. Just to add to that, we do have a diabetes management program but it really is just, you know, a value based program where we're providing those types of benefits at lower costs, you know, the insulin at a lower cost and stuff like that. We're not providing -- we don't really have anything in place today that provides the counseling type services and things like that specifically for diabetics.

Now we will be implementing on July 1st the Real

Appeal program which is specifically more for weight loss, and we all know that weight loss and diabetes go hand-in-hand. But, you know, as Ms. Syverson said, there's a complimentary aspect to it versus a duplicative aspect.

So, and the important thing is it doesn't -- it comes at no cost and so it doesn't hurt to, you know, really to offer this in as many different ways as possible so that people can take advantage of these types of programs whether it's, you know, through the Real Appeal weight loss or if it's specifically and in this situation, we would be specifically reaching out to those who have been identified as type 2 diabetics.

MEMBER AIELLO: This is Betsy again. And it comes at no cost because of the grant that you mentioned?

MS. SYVERSON: That's correct.

CHAIRMAN ROBB: Ms. Bittleston.

MEMBER BITTLESTON: Thank you, Mr. Chair. Two questions. What is included in that 10,000 dollar average for folks that are pre-diabetic or type 2 diabetic because they are not insulin dependent at that point?

And my second question is you've identified 3,700 diabetics and 2,400 pre-diabetics. What percentage of those folks will be the pilots or what -- how -- what percentage would be the pilot program I guess?

MS. SYVERSON: Very good question. Chris Syverson again for the record. In regards to, let me see, your first question was --

MS. BITTLESTON: What goes into the 10,000 dollar average.

MS. SYVERSON: The $10,000, right. First of all, people with type 2 diabetes often are on insulin. I know for instance my husband is. So there's definitely increased cost of medications. Most people are either type 2 diabetes or pre-diabetes, many times are on medication so part of that is medication class. It's increased in visits to the physician and definitely complications of diabetes.

There are, you know, vision, neuropathy. There are conditions that are caused by diabetes that would cause these increased health claims.

And secondly was, who would be identified in the pilot. We would be working with the State to find out what they wanted to do in regards to identifying the specific populations. In my other employers, what we did is we were able to go out and identify specifically those people. We opened it up to employees, as well as retirees and dependents because we feel it's a problem that is affecting all of them.

What we'll do is we'll work with the State. We'll look at our capacity to offer the programming and we'll

stage it. So we may do it -- I don't know if we'll do it by location or we'll do it by group or area, but we'll work with the State to see what works best for them or what they would recommend.

MEMBER BITTLESTON: Thank you.

CHAIRMAN ROBB: Ms. Kelley.

MEMBER KELLEY: Michelle Kelley for the record. So, I'm sorry, just help me understand. Are you looking for one group of PEBP participants or is this a pilot program, actually a 12-month period with multiple groups?

MS. SYVERSON: We can do either. We will probably start with one, one, at least one DSMES class and one DPP class. Depending on the response that we get back or those identified groups that we have worked with with the State, we'll identify how many and roll them out as we go.

MEMBER KELLEY: Okay, thank you. And just a follow-up there. Oh, what -- what -- I'm not sure who to address this question to. But what metrics, how do you measure success or otherwise? Like, what are the metrics there?

MS. SYVERSON: Sure. If we have it, one metric we would measure is your A1C level, which is typically how diabetics are measured as far as how they are doing in managing their diabetes. Weight loss is another one.

Adherence to coming to the class and attendance is certainly another. And then they also look at increase in physical activity percentage as well.

MEMBER KELLEY: Michelle Kelley for the record. And is that just over the six weeks? Is there a follow-up period or --

MS. SYVERSON: Yes, for the year, it's for the year period. They measure I believe monthly with the statistics we were getting earlier. For the DSME class, it's a little bit harder because it's really hard to measure within a six-week period. You know, we can target, you know, weight loss and exercise but that's a little bit harder. And then, yes, there's follow-up as they go.

MEMBER KELLEY: Thank you.

CHAIRMAN ROBB: Mr. Verducci.

MEMBER VERDUCCI: Yes, Tom Verducci for the record. Hi, Chris. How are you?

MS. SYVERSON: Hi, Tom. Good.

MEMBER VERDUCCI: You know, I'm happy to see this Board bringing up financial or health wellness incentives. And I do remember a number of years ago, it was probably six or seven years ago, we had rolled out incentives, Blue Book and a lot of incentives for employees to take better care of themselves, and it did get overwritten I believe by the

legislators. It was actually done away with. It did require employees to go out and have to, you know, take an exam and it was an incentive for them, and I'm glad to see us bringing this discussion back up. I think it's something we don't really spend enough time on.

You know, it's going to protect the plan in the future, less cost, healthier work staff. And I'm happy to see it getting implemented again. I wasn't happy to see it go away in the first place.

CHAIRMAN ROBB: Okay. Any further comments?

Thank you for your presentation today. It will be neglectful of myself if I did not represent the logo on your background and tell you how much I appreciate that.

MS. SYVERSON: Well, for those in the north, we are Wolf Pack families.

MS. RICH: It would be an action item to approve.

CHAIRMAN ROBB: Okay. So do we have any further discussion or do you have a motion?

MEMBER FOX: I have a comment. Linda Fox for the record. So I think it's a great idea. It's a free sample basically for us to see how it works. I think it would be interesting to see what participation looks like, not only who wants to enroll but who just over the course of the year, but all we can do is try and see how it works, but I'm really

happy to make a motion as well to do this.

MEMBER KELLEY: Second.

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

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

CHAIRMAN ROBB: All those opposed signify by saying nay. The motion passes unanimous. Thank you.

MS. SYVERSON: Thank you very much. I look forward to working with you.

CHAIRMAN ROBB: Before we move on to the next agenda item, it is straight up 10:00 o'clock, why don't we take a 15-minute break and allow us to walk around and use the restrooms and go outside and get some fresh air.

(Whereupon, a brief recess was taken.)

CHAIRMAN ROBB: Let's call the meeting back to order. Okay, it's 10:15. All Board members are present. We're going to move on to Agenda Item Number 7, discussion and possible action on recommended changes to the Master Plan Documents for Plan Year '24, the removal IUI benefit and low deductible and EPA plans July 21, 2023 through June 30, 2024. Laura Rich, and this is an action item.

MS. RICH: Laura Rich for the record. We had

previously brought this to the past Board meeting and it was the request of the Board to bring some additional items back, including the IUI to a few agenda item, so this is why we're bringing this back. In the meantime there were a few other things that we captured, mostly clean up, housekeeping items that are also included in this report.

But I think that the two major items here, I'm not going to go over every single one of them because it's just clarification and some updates and things like that. The two major items in this report, you can see on page three, the first one is item number six, which is the update to the COVID-19 benefit. So the federal government has confirmed that the federal or the emergency will be ending on May 1, 2023. So we had updated all of our master plan documents to show that as well and to basically we are reverting back to the pre-COVID benefit. So everything that was triggered during COVID is now normal rate.

Then additionally, we added a section for the smoking and tobacco cessation. It was accidentally, we had overlooked that it was not in the low deductible and EPO plans and did not -- it didn't explicitly state this benefit so we wanted to make sure that was in there.

Additionally, the IUI benefit has been, it was something that the Board discussed previously. You can see

this on page five. We did some additional analysis. As you can see, it's a very -- there's very low utilization for this benefit.

Just to give a little bit of context as to why this was brought up as well as other items that the Board approved during the last Board meeting. PEBP had, it had been a while, if ever really we had gone through and nearly did a deep dive into the clinical coverages that, you know, that the other plans provided.

And so the goal of that activity was really to ensure that PEBP coverage benefits and coverage levels were fairly industry standard. And when I say industry standard, it's, you know, medicine changes and insurance also changes along with it. And so we had had things in place since 2011 when, you know, the high deductible plan was put in place. That hadn't really, you know, been really looked at, and so we didn't -- we had not really taken the time to do that deep dive.

And so there were a few things that were uncovered that were antiquated or that needed some updates. The IUI benefit was one of those things that was identified as potentially the recommendation for the updates. The plan currently that the Board asked for utilization and as you can see on page five, you don't have a whole lot of utilization

of this benefit. It's not the industry standard, if that's, you know, what we want to call it. It's not really -- it's more of an antiquated type procedure. People that are looking for fertility services are using IVF and things like that. And so this kind of just, it remained in the plan and it was identified as potential for removal just because of the low success rate and low utilization of this type of benefit. It's not industry standard to cover it in most insurance plans.

The utilization as you can see in the last few years, it's been pretty low. Less than 20,000 people have used it. Out of that, the success levels are, you know, they're not -- they're not really high. They are -- it's a low success rate. If you Google this type of benefit, you'll see that it's typically, this is in line with the success rate nationally.

The reason why this was -- why this was called out, you know, for the removal is because of the potential for unsuccessful pregnancies out of this type of -- this type of procedure and not just one successful but high risk high cost pregnancies. It's just not something that is considered the industry standard today.

And -- and it, although our plan has not experienced the high cost pregnancies out of the utilization

that has taken place, we've just been lucky, it, typically these new results in multiple births or births that are high risk or complicated situations, and so it's not a benefit that's utilized as commonly anymore.

So the recommendation is still to remove this benefit. It was never on, available on the CDHP so this is just removing it from the low deductible and EPO plans.

And that is it -- that is it. The rest of the document is really just housekeeping type items that we've identified as things that just needed to take place before the beginning of the following plan year.

CHAIRMAN ROBB: Any discussion?

MEMBER KELLEY: So Michelle Kelley for the record. You know, I think the clean up items, you know, make a lot of sense. I'm not in support of IUI being removed from the plan at this time. I think that -- I think that I don't really understand because I'm hearing from Executive Officer Rich, and I think the consultants last meeting that this isn't standardly used anymore as best practice, and yet we did get public comment both from a fertility specialist and another doctor in the north saying that IUI is actually still used by them as part of a treatment plan.

Also I think at last meeting, the consultants indicated that people could go anywhere and get these shots.

But what I read from, in the public comment, what I read was that, in fact, most fertility specialists will refer to an endocrinologist before kind of putting those treatments together and that they do do thorough testing before people are prescribed IUI.

So I think -- so I am concerned about that. I think that I want to better understand and perhaps hear from an endocrinologist where this IUI sits in this whole fertility spectrum.

Secondly, I think that, you know, I keep hearing that it's not that much and I don't have my language right. I keep hearing that it's not -- the pregnancies aren't successful. But what I'm seeing here on these charts for 2022, there were 18 women who could not get pregnant through natural means, and there was three babies out of their treatment. And so, you know, yes, that's small, but these were women who previously had been unable to get pregnant, so that's a good outcome and that's the smallest outcome of them all. Because in 2020, out of 17 people getting this treatment, there were six pregnancies.

Third, and then I will let people have a go. My third concern is that I've heard a lot about these expensive pregnancies. If -- if we don't cover this, people will probably -- it's 300 bucks a pop, so people will probably

still have it. Does that mean that if we don't cover the treatment, PEBP won't cover the babies when they're born? Okay. So the high cost babies are still going to exist and they do currently exist.

And so -- and then my last point is just that I am very uncomfortable with this coming -- this removal of an entire benefit coming outside the normal timeline because generally we're talking about plan design in October and we do get lots of members of the public paying attention at that time. And so this is kind of, even though it now does state on the agenda what it actually is, I think that our members are kind of used to our timeline of we review plan design in October and they can come and talk to us about what's important then.

And with that, I appreciate everyone's patience.

CHAIRMAN ROBB: Okay. Any other comment?

Mr. Verducci.

MEMBER VERDUCCI: Thank you, Chair Robb. You know, I wanted to make a comment here on item number six as far as COVID restrictions going away. We had to drop $72,000,000 out of our budget, and now we've put back two items or two budgets and we don't even know if the second budget is being approved or not. So we're mandated to reduce benefits and here we're doing away with the COVID

requirements, but we're not getting back to where we were before. And now we're going into a discussion, item 12 with reducing or eliminating a benefit. And I feel sorry for the Nevada family who did that because, you know, they're trying to get pregnant. And, you know, this would take away some of the hope that they have, and I don't see it's a big cost for the plan.

But the secondary cost is something that we don't know what they are. But I think, you know, with the focus on families, adoption, what we can -- I just don't want to be part of a decision that could take away a human life and I think we're okay on one through 11 but not too crazy about number 12.

MEMBER AIELLO: This is Betsy. And I just want to say the same thing, especially with the point that Michelle made that the babies that might be high cost would be covered anyway, the actual procedures in that higher cost. And I was surprised, based on our hearing, that it wasn't standard of care and that there were medical risks. But then we got two or three, at least two, I think there were three public comments from physicians themselves, as well as meaning people, this drew a large level of public comment even outside the cycle.

And so based on these costs, I would be the same,

I'm not -- and the fact that it's so hard to add something back. We're seeing it's, once it's gone, it's really hard to add something, and this might not be the thing to add back, something more modern might be, but it's hard to add, so.

CHAIRMAN ROBB: Any other comments?

MEMBER WOODWARD: Just a quick question.

CHAIRMAN ROBB: Ms. Woodward.

MEMBER WOODWARD: Janelle Woodward for the record. We've covered other types of fertility treatment. This was it. Thank you.

MS. RICH: I think, do we have -- is Joanna able to join.

UNIDENTIFIED SPEAKER: In about three minutes.

MS. RICH: We do have a physician, right? She is a physician?

UNIDENTIFIED SPEAKER: She has a doctorate in nursing.

MS. RICH: Okay, a clinical expert. We do have a clinical expert in, available if there's any questions that would -- if the Board would like her to join.

MEMBER KELLEY: I'll make a motion.

CHAIRMAN ROBB: Any further discussion? This is an action item.

MEMBER KELLEY: So Michelle Kelley for the

record. I will make a motion that we, let me get my number right, that we approve the recommendations one through 11 and but not 12 but keep IUI in the plan at this time.

MEMBER WOODWARD: I'll second.

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

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

CHAIRMAN ROBB: All those opposed? Motion passes.

We'll move on to 7.2, HRA summary plan description.

MS. RICH: That was part -- that was --

CHAIRMAN ROBB: Okay.

MS. RICH: -- part of number eight.

CHAIRMAN ROBB: I'm sorry.

MS. RICH: Yeah.

CHAIRMAN ROBB: We'll move on to discussion or to Number 8, discussion and possible action for Executive Order 2023-003. (Laura Rich Executive Officer.)

MS. RICH: Laura Rich for the record. So some background, one of the first things that the Governor, Governor Lombardo did on January 12th was issue a second

order of 2023-003, and this requires every executive branch, department, agency, board and commission to provide a list of at least ten regulations that are recommended for removal and ranking them in descending order of priority. So staff went through NAC 287, which is the applicable regulations to PEBP and identified ten, and I feel like I'm just gonna say, you know, these are a bit easy, low hanging fruit that I think will meet the requirements of the executive order that I feel are or staff feels are things in regulation that really don't need to be in regulation.

So I'll just cover -- cover them. I'll go one by one. NAC 287.318, that is -- again, this is just talking about enrollment forms and how those forms need to be filled out and submitted. This is not something that needs to be in regulation. It can be something that is in master plan documents. It's really just part of the process, you know, not something that needs to be part of regulation.

287.319, notification or change of address by participant to program. Again, this is not something that needs to be in regulation. We can put it in our master plan document. It's really just asking people to change their address. You know, it's -- everyone knows anyway. So it really doesn't need to be in regulation.

287.510, this is coverage of persons referring to

work with a previous employer. Again, it's all about the process of how we do our eligibility. It's not something that needs to be in regulation if we have a master plan document or specifically for eligibility. It can just be in there as an eligibility requirement, something that the Board can change if necessary by adding it into -- by adding it in statute or in, sorry in regulation. It does limit the Board in terms of being able to change it as well because we would have to do workshops. There's a process to change regulation. And so by removing some of these process type items, it just makes it easier to change the process if necessary.

Again, same thing with 287.515, it's an eligibility type situation where we can change that. It doesn't need to be in NAC. And same thing with number five, 287.3125.

Item six through ten really are just regulations that are addressing our Board meetings and there's plenty of open meeting law. NRS 241 I think is open meeting law. I don't know if we need duplicative. NAC is to talk about open meeting law and how we're going to hold our meetings. I think one NAC that just kind of condenses everything into one, you know, should be sufficient.

We can point to Robert's Rules of Order so I

think these are just some low hanging fruit that we can submit. And if the Board is onboard with this list, then this is -- this is what we'll be submitting to the Governor and I think the deadline is May.

CHAIRMAN ROBB: Any discussion?

MEMBER KELLEY: I actually have a question. I don't have a problem with any of these. But 287.510 and for that matter, 515, is this all of the language? So this isn't even a question of definition because it appears to me as I read it that these rules are the same as for a new hire anyway.

MS. RICH: Right. So Laura Rich for the record. There's -- it would be pages long if I would have copied it and put in there. It gets the bulk of it, but there's more to that NAC. I think there's some additional items under that as well, but that just captures the gist of it. It's, really it's eligibility rules and it doesn't make any sense to capture them in NAC. I see what was done at one point, but it makes it difficult to change them if we ever want to.

MEMBER KELLEY: We're not removing definitions of what are original employees or what an active employee is. That stays in NAC. Thank you.

CHAIRMAN ROBB: Okay. Mr. Verducci.

MEMBER VERDUCCI: Thank you, Chair Robb. Tom

Verducci for the record. I was just wondering how we ended up with five items total under item number six. I was counting the ten items that were required and we hit number six and it reads, six through -- through ten and the last item covers five items, so I'm only counting six items total in here. I was wondering how that breaks down to five additional items.

MS. RICH: So Laura Rich for the record. It is NAC 287.170 through 287.178. So it's several different NAC's and they're all addressing -- it's addressing how you choose a -- how you choose a vice chair. How you -- how you take action items, you know, things like that. And so all of these are -- you know, this is not specific to the PEBP Board. It's really -- it's not unique to PEBP. It is overall either covered in open meeting law or it is something that we can just point to Robert's Rules of Order and it really, it applies across the board.

MEMBER VERDUCCI: Thank you for the clarification. I was just having trouble adding the five and I just wanted to register it in my mind so thank you.

CHAIRMAN ROBB: Any further discussion? May I add that this process is going to frustrate the Board because this is step one on a multi, multi step process. We submit this to the Governor and then they tell us, yes, we want

to -- we concur with what you selected. Then we have to go through the rule-making process and you have multiple steps through that. So just because we said and decided on something today doesn't mean that we're done with this. It's going to keep coming back.

MEMBER KELLEY: You said that with a smile, Chair Robb.

CHAIRMAN ROBB: I've been on boards and been staffed for boards for years and for people that aren't familiar with the process, they get really frustrated. It's like we've already talked about this. Yeah, we're going to talk about it three more times.

MEMBER KELLEY: I'll make a motion.

MEMBER WOODWARD: I'll second the motion.

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

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

CHAIRMAN ROBB: All those opposed? Motion passes unanimous.

We will move to Number 9, discussion and acceptance of Claim Technologies Incorporated audit findings

for State of Nevada Public Employees' Benefit Program Plans administered by UMR Benefits for the period July 1, 2022 through September 30, 2022. For possible action.

MS. RICH: Laura Rich for the record. I think we have our auditors attending virtually I believe.

MS. SUCKOW: Here we are.

MS. RICH: Oh, sorry, I didn't even see you. If you want to go ahead and take the table. I think we'll start with the auditors and they are going to present their findings. We also have UMR in the room as well, and we'll bring them up as we get to that part. Thank you.

MS. SUCKOW: Michelle Suckow for the record, M-i-c-h-e-l-l-e S, as in Sam, u-c-k-o-w. Also on virtually is Joan Operario. I will be presenting the executive summary from our most recent audit. We have been auditing on behalf of PEBP prior to this time HealthSCOPE. This is the first quarter that we actually audited UMR.

So in your packet you have a quarterly findings report that isn't in draft status. It will remain in draft status until we receive formal approval.

If you would like to follow along with me on page three of the executive summary. The scope for this audit was exactly the same as what we have been using for HealthSCOPE. Nothing has changed. The quarter one for fiscal year 2023,

the audit population as you can see for medical and dental was $19,802,190 paid and a total of 121,231 claims. Now that is significantly lower than what we have seen on a quarterly basis from HealthSCOPE, and a lot of that is attributed to the backlog situation and the claim turnaround time that UMR has experienced.

We validated quarterly performance guarantees as part of our audit scope. We ran all of our algorithms and your plan design, electronic screenings and 100 percent of the claims data was run through our screening. We performed a statistically valid random sample, and then we ran some data analytics.

In our opinion, UMR's financial accuracy, overall accuracy and claim turnaround time did not meet the surface objective and penalty is owed. There's a chart at the bottom of this page that I will go over in further detail.

UMR should review the financial errors identified in our random sample to determine if changes or claim processor training could occur to help reduce or eliminate similar errors going forward. Specific focus should result around duplicate claim payments.

Second recommendation is we do 100 percent electronic screening with sample results and focus on the most material findings. The most material findings are in

the categories of duplicate claims, marriage counseling and specialty medications.

And then finally where appropriate, verify claim processor coaching feedback and retraining has occurred. As most of the errors identified through the audit were attributed to manual processing errors.

On the bottom of page three, you will see a summary of UMR's performance guarantees. In three performance guarantees that were not met were subject to a total of 4.5 percent penalty, with the highest 1.5 percent attributed to financial accuracy, resulting in $19,553.48.

I want to call to the Board's attention there is an error in this total penalty. It should be 58,660.44. We will make that correction upon issuance of the final report.

The other pages in this report you have are the detail behind this executive summary. And at the end of the report is UMR's formal response. UMR has seen this report. We have worked with Tim and team to agree upon these errors, these calculations and agree upon next steps in terms of remediation.

Any questions regarding the high level executive summary of our findings for Q1?

CHAIRMAN ROBB: Any questions? Mr. Verducci.

MEMBER VERDUCCI: Tom Verducci for the record.

Am I reading this correctly that total penalties is in the neighborhood of $162,000. I don't think in the last six, seven years, as long as I've been here I've seen any penalty close to that. So are we seeing a suggested recommended suggested penalty in the amount of $162,000 thereabouts?

MS. RICH: So Laura Rich for the record. So that's actually in addendum supplement that Zach put together. The auditor's -- the auditor's findings was, and I don't remember what -- do you remember the number, the corrected number?

MS. SUCKOW: 58,066.

MS. RICH: Okay. Additionally there's other performance guarantees that are not captured in this audit that are either self-reported or, you know, those types, and so that is in that supplemental and that does add up to $162,000.

MEMBER VERDUCCI: Okay. Thank you very much. So we'll also have the opportunity to speak with UMR and ask a few questions as well.

CHAIRMAN ROBB: Ms. Kelley.

MEMBER KELLEY: I just have a -- thank you, Chair Robb. Michelle Kelley for the record. So I wanted to ask you, it's a question for UMR as well, but I want to -- when I was reviewing the duplicative claims and I reviewed kind of

what the issue was and then UMR's response. And in many times they're quoting that they have this proprietary policy and process and they didn't agree with you. And so I'm just wondering if have you seen this proprietary process with other vendors you have audited, and were you able to glean anything about this secret process that UMR claims to have that doesn't appear to five dupe claims?

MS. SUCKOW: So it's not uncommon for every administrator to have two sets of duplicate procedures, one for its auto-adjudicated claims. These are the system rules that are in place. These four or five criteria have to be exactly the same and then the system will auto deny.

Any time that isn't met, if maybe four out of the five criteria are met but it's not a hard dupe, not five out of five, that will fall to a Q for an examiner to process and manually review. Any time you have processes and procedures that are subject to manual review, it's open for interpretation.

We are pretty strict, if it's the same person getting the same procedure on the same day from the same provider, there better be a modifier or office note justifying why a second repeat procedure was performed. And if the provider fails to provide that documentation the justification to support a second billing, we do consider a

duplicate.

And so anything -- there are a number of duplicate claims that UMR did agree to. But for the few that they did not agree to, we are pretty hard and fast on our rules. Prove to us that it's not a duplicate and when that proof was not provided, we held on that.

MEMBER KELLEY: Michelle Kelley for the record. Just a follow-up then, so this proprietary information, have you seen that before in this particular identification of duplicates and their process and policy?

MS. SUCKOW: It's not uncommon for administrators to say their procedures are proprietary. That is not uncommon. We still have not seen evidence that their proprietary procedures result in this not being a duplicate in cases where we helped on those few disagrees.

MEMBER KELLEY: Thank you.

CHAIRMAN ROBB: Any questions? Ms. Aiello.

MEMBER AIELLO: Is there within a system any reason proprietor, vendor would want to pay duplicate claims? I mean, it seems like someone wouldn't want to and they want to fix this unless it's a claim line so you get money. I don't know. So is there an incentive for paying duplicates?

MS. SUCKOW: Michelle Suckow again for the record. No, there is no valid reason why a provider should

be paid for a duplicate claim. However, the identification and the determination is whether or not that claim is or is not a duplicate can sometimes be gray. It may not always be black and white.

And so we take a hardline stance that it is up to the provider. There are repeat modifier procedure. There are office notes that can be appended to claims. We take the hard stance that if a provider is performing services on the same day twice, it is up to them to justify and rationalize that second. And when administrators don't ask for that proof, we cite that as an error.

MEMBER AIELLO: This is Betsy again, just to follow-up. I thought I saw a lot of duplicates that were related to labs and lab draw. And I -- maybe it's hard for me, but I would think that you, unless maybe you ate food and they said wait another eight hours. Do you know of reasons labs would pay in this or maybe I should -- you're not the person I should be asking.

MS. SUCKOW: Michelle Suckow again for the record. I think UMR is probably the better group to ask. But I will tell you, we saw a duplicate PSA test and it is highly medically unlikely that any male would have two PSA tests performed on the same day.

And, again, we as the auditor would ask for

medical justification or medical necessity to support having that second test not only performed but then obviously paid in this case.

CHAIRMAN ROBB: Any further questions? Yeah, UMR. UMR, I'm so used to saying UNR.

MS. HUCKABY: Good morning.

CHAIRMAN ROBB: Do you have any statements before we open it up for questions? Do you have anything you want to present?

MR. BRAUN: You know, maybe I would start with the fact that obviously, you know, we made a transition from one claim platform to another and that was one of the challenges that we sort of encountered, okay. So making sure that that all happened appropriately is always a challenge, okay. And we did find some things that remained at transition. It slowed things down because we were fixing some of the things that we discovered weren't paying correctly, okay.

What happened, we discovered some of those things in August. We slowed down some of the claim payment to make sure that we weren't making any more claim errors. It took until, well into September to get those things all corrected and that was some of the slow payments that occurred, and that's part of the reason for the timeliness issues that we

encountered, okay.

You know, I would say that the audit was fairly done. You know, I understand how the sampling process works. I think the audit team did a good job. I'm certainly happy to answer some questions. I have some people on the phone with me. So I'm actually Helmut Braun, the chief operating officer for UMR, for those of you who don't know. Definitely I think they have been here many times before so you're probably familiar with them.

And then we have Darren Ashby on the phone, who is our director of claims for this particular audit, and I know I have -- I'm not sure who else might be on the phone but those two are on the phone for sure to help me with the technical questions.

CHAIRMAN ROBB: Board questions? Ms. Aiello.

MEMBER AIELLO: Hi. This is Betsy Aiello for the record. And I do have a few, about three questions specifically. And one of them is more the outcome of inaccurate or delayed claims that I have not experienced through this contract. I'm on the Board but I'm under Medicare now.

MR. BRAUN: Sure.

MEMBER AIELLO: But I have experienced in my history when claims have paid way delayed or inaccurate --

MR. BRAUN: Yeah.

MEMBER AIELLO: -- both in-network and out-of-network providers sometimes result in fail the patient, fail the client, fail the enrollee and go to the extent of threaten people to go to claims collection. And, of course, because it's not under the insurance product, insurance may pay 200 for, they're threatening the person has to pay 1,500 or 1,800 and based on some of my past experience working with other people, helping with these things too. I don't know if there's been any way or anything that your entity does to help or to notify people if they are getting inaccurate billings or billings they don't believe are right that you can reach out and help them solve the problem.

Having worked within some of the insurance industry for many, many years, I'm savvy enough to call the insurance company and then they usually call and talk with the provider and talk about balance billing, but that doesn't always work out. So one is just a concern of this sounds bad and there's a fee being paid, but it could be really bad to people who get these bills who then are scared and things are going to bill collectors and credit and just further outcome down the line that some of these things can occur. So I wanted to say that since this has happened in the past.

And then that would lead into the -- where like

your telephone service, it talked about the report that your response was from March 9th, but I read that it is expected that based on having added stuff, this would be resolved in January and with call abandonment rate, with, let me see some of the others because there was three or four that you added with callback guarantee. A lot of them said with this, it should be resolved in January. Well, now we're in March.

So the question would be are these things in your eyes resolved because I would think the report could have said this was resolved, not expected to be resolved.

MR. BRAUN: So I actually have Darren on the phone with me, and he probably has more up-to-date statistics. But in general, our average speed to answer phone calls dropped dramatically after the first of January. We had -- first of January, obviously that first day is always a challenging date for us, okay. You know, there's been the holiday and new people have enrolled, so the first week or ten days in January are a little bit tough. But after that I think our metrics have improved dramatically.

And, Darren, I don't know if you have specific numbers for the State that you could give us for January and February to give them some assurance that obviously those numbers have gone down from where they were back in last year.

MR. ASHBY: I do. So for the month of January -- sorry, this is Darren Ashby, A-s-h-b-y for the record. For the month of January, we did show a 34 second average speed to answer, which was a marked improvement over previous months. And then for the month of February, we came in at 25 seconds average speed to answer. So for those two months combined, the overall speed to answer came in at 29 seconds average speed to answer. So we did make a marked improvement over pervious months as it relates to the calls.

MEMBER AIELLO: So improvement. And I'm sorry, I shouldn't have asked so many in a row. Back to the one about is there a process to help our, you know, members if they are at collections or something for a claim that should have processed?

MR. BRAUN: Absolutely, yeah. I mean, if they call us and let us know that they're being asked from the provider to balance -- on a balance bill situation that is inappropriate, okay, I mean certainly sometimes there are balance bills that are due by the members based on a situation.

MEMBER AIELLO: Oh, yeah, co-pays, yeah.

MR. BRAUN: But if there's some other error that occurred or some balance bill amount that's inappropriate, then our team will absolutely help reach out, talk to the

provider, figure out what the situation, correct the bill if there was a mistake on the bill, if they helped them with credit issues, if they end up, you know, with some sort of credit, attachment or something like that, yeah, we absolutely will help the team members with that.

MEMBER AIELLO: So then it might be our own as a Board that we let members know that because there might be some rough times, if you found yourself in certain situations, this is who you should call for help possibly because that's -- that's one of the concerns was the ultimate outcome, as well as providers being angry, and --

MR. BRAUN: I understand.

MEMBER AIELLO: -- and not wanting to, yeah.

MR. BRAUN: And I would say too that, you know, we had some inventory issues. You know, our inventory got up into the mid 20,000 range, okay. Today it was down to 14,000, okay. So we've dropped that inventory pretty dramatically. I would say by the end of the month, we expect that total inventory to be down in that ten to 12,000 range and the over 30 day to be in that 2,000 to 2,500 range. So, you know, we've made some dramatic improvement in that over the last 30 to 60 days and have no reason to expect we're not going to stay at that level.

I mean, to some degree we were operating, you

know, both claims systems because there were claims coming in on the old system, and so we still had to keep some people working on that old claim system. That has now pretty much subsided. I mean, it's down to a trickle where we've got, you know, a handful of claims or maybe a few dozen claims every week. Those people have all been retrained, put on the new system so we have more capacity on there. So the ability to keep up at this point should be rather strong. I don't expect any reason that we're not going to be able to keep up with the incoming volume to keep those inventory levels at the level which you expect or that we promised to keep them at.

MS. RICH: And then just a final one, and I'll give everyone else, was when I mentioned earlier about what I could tell. I saw a lot of duplicate matter claims that seemed to jump out at me. Like I said, that doesn't seem to make sense to me, same thing.

MR. BRAUN: Yeah, I would say that we -- you know, we don't expect that a lot either. There are a few situations where duplicate lab claims could occur. And I think I've got Hollie Moon on the phone or, Hollie, I don't know if you want to maybe address that because I know you specifically looked at some of those situations.

I would say, you know, in total, remember, we do

process 120,000 claims here. And what the auditors have described is exactly what happens on our system, okay, so we do have a number of things that we look for in match. And if we get an exact match on, you know, six or seven items, then we'll automatically deny that claim because it looks highly likely, you know, 99 percent plus that that's a duplicate, so it makes sense.

If we get three or four item match, then that gets an edit on there. It says check for duplicate and it pans out to one of our processes and they look at it and they have to make an interpretation as whether it's a duplicate or not.

All right. So if for some reason in some of these situations, they obviously probably decided it was not a duplicate. I can't tell you exactly what it was. And I'm assuming they found something. Maybe they called. The provider talked to them. Maybe there wasn't enough documentation to satisfy the auditors. But, again, you know, those are the things we do look into.

But, Hollie, if you want to talk about a few situations where maybe it is appropriate to have two lab claims in the same day, if you found any or if it wasn't and tell us that as well. Is Hollie on?

Darren, do you know if Hollie is on?

MR. ASHBY: Hollie was on earlier. Yeah, Hollie is on and it looks like she's on mute right now.

MR. BRAUN: Okay.

MR. ASHBY: Okay. It looks like she's off mute.

MR. BRAUN: All right. We still can't hear her though.

MEMBER AIELLO: It's okay.

MR. BRAUN: We'll give her a minute and try again.

I do know there's one situation that they did brief me on. And in one of the situations, sometimes what happens is somebody goes to a primary care doctor over the lab work and then they may end seeing a specialist the same day and the specialist may order the lab work again. So we get lab work from two different doctors. Now, if we have a different referring physician for that lab work, we will accept those two claims as two different claims and pay both, okay.

CHAIRMAN ROBB: Ms. Bittleston.

MEMBER BITTLESTON: Thank you, Mr. Chair. I want to zoom out a little bit and kind of look at this whole report at a much higher level. So as I read this report, I really identified two major issues, one is claims processing and the other is customer service.

So looking at those two things from a much higher level, have you been able to identify the root cause? What caused these problems because there was a lot of areas not met, and so you mentioned the claim processing change. So I'm just kind of asking why we're seeing a report like this.

MR. BRAUN: Yeah, I mean, I would tell you that the biggest reason was that we did change claim systems, okay. And in that claim system change there were some benefits that weren't coded correctly. We did some testing of that. We found that those claims weren't coded correctly so we stopped processing those types of claims for a period of time until we could get it corrected and then had to go back in and fix those claims. So all that took time and effort, et cetera. That caused a lot of the turnaround issues. So obviously if you have that stoppage or that delay when you're fixing benefits, that caused us to not get claims paid timely. So we missed a number of things with that.

And we also missed some inaccuracy. If we paid something incorrectly and then had to go back and fix them. So, you know, those are the two issues that probably created, not all, but a large majority of the misses that we had.

We also had a new set of parameters that we had to meet because this was not in-contract, and so there are now more requirements from a performance guarantee

perspective than we've ever seen before, okay. In the old contract we might have had six to ten and now we have like 30 plus, okay. So there's more opportunity for us not to meet. And if we don't meet, obviously penalties are incurred. Trust me, we do not want to pay $162,000 in penalties every quarter, okay. That doesn't work for us either, okay.

It's been a challenging transition. We understand we made the mistakes, okay. We're going to end up paying the penalties, all right, but we're working very hard to get those things corrected. We made significant effort here over the last, you know, six months to straighten this out. And hopefully, you know, it seems significant improvement. It's taken us a little while. I don't know that the second quarter is going to be much better than the first, okay, because we were well into that second quarter before we saw their audit report for the first quarter so we started to make all the changes, not that we weren't working on things already.

But the same team that was working on these claims before is working on this -- this group now. So it's not like we have new people. So they do know and understand the group, okay, and they have helped us sort of work through the issues that we had, and I think we've made some good progress.

And, like I said, you know, we do have our claim inventory in control now. So obviously that's going to help us with turnaround time. Also it should also help us with accuracy. We've added some additional edits. We've looked at that due process to see if there's anything we can do to enhance that.

You know, I think for the most part, sure, there were some dupes here. But when you look at the magnitude, the total number of claims that they looked at and the number of dupes that we actually had, it's not like it's one percent or two percent. It's like a tenth of one percent or something like that. You can most certainly go back and request that money back in the plan made whole again.

MEMBER BITTLESTON: Just to follow-up. So that addressed the claims issue. What about the customer service issue? So what was causing those problems?

CHAIRMAN ROBB: Well, I mean, obviously if we had issues with the way the claims were being paid that caused more phone calls, and so more phone calls made it more difficult for us to keep up with the number of calls that were coming in. So they all kind of, you know, compounded.

MEMBER BITTLESTON: So you're saying it's just a cause and effect?

MR. BRAUN: Yeah. Well, and obviously we've

added more people onto the plan as well, to help service the plan. I mean, you can see the numbers in January and February improved. We haven't had the same challenge.

Now, I will tell you, overall, we've had a staffing challenge over the course of the last, you know, 12 to 18 months, okay. It's been very hard to find people to come in and do this job. It's not an easy job. I mean, I think it's one of the most difficult customer service jobs that are out there. You have to know a lot about benefit plans, the idiosyncrasies of those plans, and you're dealing with people who are often times in challenging situations because they're undergoing some medical issues, okay.

So, you know, we really do look for top notch customer service people and have fairly high intelligence and are able to know and understand and interpret those plans and figure out how benefits should be paid and advise people the best way to sort of understand their benefits and utilize their benefits, okay.

Those people also in the course of the first couple years that they work for us, they learn a lot, okay. So it's not like we use up people and move them somewhere else. A lot of them get promoted within the company. But what that does, it creates, you know, probably 35 to 50 percent of those people sort of turn over every two to

three years and we gotta keep bringing new people in. It's part of our process. It's something we do.

But this was all sort of exaggerated during the COVID period where, you know, there was just a little shortage of workers and so it was challenging for us to keep up from that perspective as well. We've done everything we could. We've increased our salaries. We've increased our benefits. We've given them more flexibility, okay. So all of those things took place.

And I think we're in a better position now in that I think the workforce has stabilized a little bit. I don't anticipate that we're going to have those issues going forward.

MEMBER CAUGHRON: April Coughron for the record. You know, it's concerning to hear that we have providers reaching out to PEBP, complaining that they have a backlog of claims. They're not being paid appropriately when we have access to care issues already in the State of Nevada. We don't have enough providers.

I would like to hear what you're doing proactively to get ahead of that. I work very closely with the claims payment system. Now that I know any time we implement enhancement changes, we are proactively running reports to identify red flags. Are we seeing a peak in edits

or audits tied to denials? Why, right. What's going on? So we can kind of follow the trends and know what's happening.

So what -- what are you doing to get ahead of this so that we can make sure that it doesn't end up in audit findings, right? I mean, can you identify it and make the fixes before you report it, before the audit is done or when the audit report comes back, can you help those audit findings?

You know, you have -- you're able to say, yes, we had this finding but this is what we did already to get ahead of it to fix it. What kind of trending is being done?

MR. BRAUN: Yeah, so, I mean, I think those things did happen. Obviously, in third and fourth quarter of last year, you know, I said we found some things in the benefit plan that we didn't code correctly. We stopped that payment for a period of time to get those corrections made. We've seen the audit report from first quarter. We've taken that into consideration as we've made some additional changes in second quarter. And now we've obviously addressed that with adding more staff to it too.

Inventory climbed up to, you know, in that mid 25,000 range, over in that 25,000 claim range. We worked hard over the last 30 to 60 days to get that back down to 14,000 so that's a significant drop in the inventory that's

out there, and we're committed to keeping it at that level or below as we go forward.

MEMBER CAUGHRON: So just one more question. Is there like a formal corrective action plan then that's been drafted where you're regularly reporting to PEBP, all of these steps that you're taking and what's coming out of it?

MR. BRAUN: There is a corrective action plan that I believe is included, is it not?

MS. RICH: It should be.

MR. BRAUN: Yeah.

MEMBER CAUGHRON: So is it something that's reported regularly, like every 30 days you're hearing about it? This is maybe for Director Rich or how do we keep on track of this, right to make sure.

MS. RICH: Laura Rich for the record. So our TPA has historically always gotten audited quarterly. And we are constantly in communication. Rhonda hears from me at least everyday and if not, it's someone else on staff. We're constantly in communication.

Any time anything comes up, it is -- I will have to say they are very good about, you know, the second it gets escalated from anyone at PEBP, they are very good about resolving the issue. And I think our concern has been more about, well, what's causing the issue because it's always

resolved.

Once -- you know, once it's come to their attention, within a day it's resolved usually. It's more about why it's an issues versus, you know, having it be resolved. They do get audited quarterly. We don't have access into their claim system. You know, we're not trained to, you know, audit that type of -- you know, that's not something we would even know or to begin. That's why we have auditors.

But what we do know, we hear from members. We hear from providers. You know, and while that's anecdotal, it gives us an idea, you know, of what's really happening in the plan and so those are things that we follow-up on in-between that time, but I think that that quarterly audit is there for a reason and it's because we don't have that ability to -- you know, I'm sure that you guys on your end are looking at it everyday.

We do get things like aging reports and inventory reports, things like that. We also have consultants. Segal is also aware of this situation and because this also has an impact on own projections and our own plan as far as for example IBNR incurred but not realized. Its claims aren't being paid and there's -- you know, they're taking a significant amount of time to get paid. Then that affects

IBNR, and so the actuaries are also looking at this too. So there's a lot of eyes on this in different ways.

MEMBER CAUGHRON: Okay. I think I was just mainly concerned that I don't want to -- you know, none of us really want to wait the full quarter then to find out that we have issues, right, when we've had our customers, when the customers have been having issues, the providers have been having issues all along and then all of that is brought to light every quarter. That's three months, right, where we've had people struggling, so.

MR. BRAUN: Well, we actually do. I mean, I think you get weekly inventory reports.

MS. RICH: We do.

MR. BRAUN: Right, so we do share what our weekly inventory reports are. And if you want to enhance reporting as far as phone metrics or anything like that, I mean, I think you're getting some. But we can look at if there's something else you want to see on a more regular basis. We're more than happy to share that.

MS. HUCKABY: April, this is Rhonda Huckaby for the record, and I've been the account executive with PEBP since 2001. And as you know, we require UMR. That's what we were talking about the new claim system. I just wanted to reassure you that, you know, we have staff, our claims

manager. And then we also have from a network perspective where we have monthly calls with some of the large utilizers, for now Carson Tahoe, to discuss if it's an issue from a contracting network perspective or if it's a claim processing issue.

MEMBER CAUGHRON: Okay.

MS. HUCKABY: So behind the scenes we do have calls with the top providers. And then we're constantly running impact reports. If Laura gets, you know, a call or Tim, and we identify those certain providers, we run an impact report on that provider's tax ID number, and then we have people internally to audit the claims. And then if we discover an issue, then we begin the process.

MR. BRAUN: And we do have an internal audit team and we do audit between two and three percent of the claims every month.

MS. HUCKABY: Yes.

MR. BRAUN: Okay. So for each processor, for each type of claim we do that focused audit to make sure that, you know, that we are working as best we can from our perspective. So and managers look at those reports and check those. So there is additional things besides what you're bringing in from an external perspective.

MS. RICH: And Laura Rich for the record. I just

want to add too that one of the conversations I had with the UMR team is that PEBP is -- I mean, I assume it's a somewhat unique situation where, especially in Carson City where we have the condensed population of State employees who are covered under PEBP.

And so any provider in Carson City that, you know, were delayed payments, they're feeling it. They're feeling it because, you know, maybe 50 percent of the patients are -- are PEBP, you know, PEBP -- under PEBP. And so I've had the conversation of we really do have to really pay special attention to the geography because it doesn't happen as much in Las Vegas because there's a lot of providers in Las Vegas. People are spread out. In Carson City they're not. In Reno not as much either. You do, maybe not as significant or, you know, you don't see the impact like you do in Carson City but you see it somewhat in Reno.

Providers feel the pain. When we mess up, providers are feeling the pain. And so you -- I get to hear about it because they call me and -- and so this is a conversation I've also had with the UMR team. It's like, look, we have to look at the geography and realize that, you know, these people in Carson are severely affected and not only are they affected but they -- you know, they escalate to myself, to legislators to -- you know, there's a lot of

noise, and so we need to make sure that, you know, we are, like I said, providers, there's not a lot of them and so we need to keep them happy.

CHAIRMAN ROBB: Ms. Kelley.

MEMBER KELLEY: Thank you, Chair Robb. Michelle Kelley for the record. So I just, I kind of want to set the stage, right, because I think for me, customer service is, it's my job. I'm 100 percent focused on my customers, and I believe it should be your job.

And it's -- for me it's complicated with you guys because our members think you are PEBP. So when they reach out to you and they get bad service, what they say is, you know, our premiums are too high. Our monthly costs are too high and you provide awful service. So they put us all together, as they should, because you're one of our closest partners, right, and it should be a very close partnership. It needs to be.

I had -- I got an e-mail from one of our employees and she was talking to me about the customer service. She was incredibly frustrated about a claim she had. It was a wellness claim or she thought it was a wellness claim. It wasn't billed as a wellness claim. I thought before we transitioned to UMR and with HealthSCOPE, a lot of the noise around that, is it wellness? Is it -- is it

a procedure or code had kind of died down. But I gather with this change in relationship, that noise, and I call it noise because it's -- it's very hard to solve, right, because we providers not using the right codes or employees are conflating their appointments when they're visiting.

But, anyway, I had an employee reach out to me because she had a claim that was denied by UMR because it was a procedural code, and I think that the billing here was incorrect. So I'm not gonna -- it's not about your billing. But what happened afterwards is your problem and became our problem because I got a very irate e-mail from a senior member about organization, who couldn't find anyone to talk to.

When she finally got through to someone at UMR and she wanted to have the claim reprocessed essentially, they told her in order for that to happen, it was an appeal, and she had to go to the post office, get a postage stamp and mail in an appeal. Is that -- is that your standard process for taking first level appeals because PEBP will take a second level appeal on-line, and I made that comment to Executive Officer Rich.

So I guess that brings me to my question. Can you talk to us about what are you able to provide answers to for employees via phone. So what kind of information can you

help with via phone? What kind of information can people get through the secured portal when they e-mail you? Where's the differentiator? And then if you can talk specifically about the appeal process, that would be helpful. Thank you.

MR. BRAUN: Well, I mean, they should be able to get a lot of information on the portal, okay. So if you just want to see your claim and see whether it's been paid or not or see your benefits and what's covered and what's not covered, all of that should be on the portal, right.

Eligibility information is on the portal for each of your members, et cetera. You know, if they call up, they should be able to get all that same information from by talking to somebody. If they don't want to figure out how to use the portal or how to use an app, they should just be able to call up and talk to her and get that information as well.

Specifically, on appeal information, we do have a tool where you can actually file an appeal on-line, okay. So here, I mean, I'm assuming that's turned on for State of Nevada, right?

MR. ASHBY: Yes, it is on.

MR. BRAUN: Yeah, so you don't have to go. And maybe one of our representatives wasn't familiar with that and, Darren, I guess I'm going to go back to you and make sure everybody gets trained on that, end of conversation.

It's pretty simple because the tool actually brings up the claim. You click on the claim that you want to appeal and it fills in all the boxes for you and you just have to kind of sign it at the end and send it in and that starts your appeal process, okay.

MEMBER KELLEY: Okay. That sounds -- I mean, that sounds really good. So I'm just, I'm confused that this employee got kind of -- by the time she got to me, she spoke to UMR several times and not being able to get a straight answer. And I think that I did escalate it to Executive Officer Rich because I didn't know what to do.

But, you know, I think that as I say, like the relationship is so important and to see this audit report. And I hear you saying that things that we're measuring is much broader now. But, of course, you did agree with those and you potentially even put them forward, so.

MR. BRAUN: I understand. I mean, you know, obviously your consultant did a good job in putting a lot of performance guarantees in and that's going to hold us to a higher standard, okay. Now, unfortunately it's taken us a little bit longer to get to that standard that I would have liked. I mean, I addressed we're not happy that we have what was reported and all these situations that we didn't meet the performance guarantees, okay, but we're working hard to try

to improve those.

And, you know, I know we're making progress. I'm telling you, second quarter is probably not a lot better. But I think by third quarter and fourth quarter we should be, you know, trying to meet hopefully the majority of these.

MEMBER KELLEY: Okay. And so Michelle Kelley for the record. Just a follow-up. And so, of course, you were here when we talked about open enrollment and how concerned I think we are internally just about meeting employee needs.

MR. BRAUN: Yes.

MEMBER KELLEY: So can you tell me are you gearing up for our open enrollment to help our members kind of what is your role in that process?

MR. BRAUN: I'm going to turn that over because she works with that.

MS. HUCKABY: So Rhonda Huckaby for the record. So we work closely with PEBP staff. You know, we know that open enrollment, you know, they start sending out the open enrollment materials in April and then it officially starts May 1st to May 31st. So, yes, every year -- you know, this year we don't have a lot of plan changes but we work with our staff and, you know, we have to submit work orders for the benefit coverage to change any type of, you know, design plan. And then we work closely with customer care to let

them know about the upcoming changes.

So when members do call in, because sometimes members call us, thinking they're calling PEBP and then vice versa, as you said, same thing happens with they think we're Express Scripts. But, yes, we prepare for that every year.

And then as was said, we added like seven additional staff to customer care to kind of help with that volume of -- you know, we always see an increased volume of calls in April and May. And then, you know, June is when we're sending out their ID cards and then the benefits start July 1st.

MEMBER KELLEY: Okay. Michelle Kelley for the record. Just to follow-up, is the PEBP self-funded plans, are they quite unique compared to the other plans you manage or is every plan unique?

MR. BRAUN: I would tell you that every plan is unique, okay. And so the fact that you have some different benefits isn't something we can't understand or accommodate. We can, all right. It's just, it's been a little bit of a challenge for us, you know, coming from one system to another and retraining people on the system, and unfortunately we didn't do as good a job as we should have. That's what I'll tell you.

MEMBER KELLEY: And I think my understanding was

that it was going to be pretty seamless because HealthSCOPE was already our provider and, you know, the same team was providing services and so then to experience the issues that have been experienced has been very frustrating I would say.

Just as a follow-up and for my own understanding, so it used to be that at HealthSCOPE, when you had wellness and it was coded incorrectly, I could call and say, hey, can you take another look at this and resubmit and it was as simple as that. You know, the customer service rep would go oh, yeah, that is kind of odd. Maybe it wasn't about wellness but it had been denied for some reason. I just called and they would resubmit. Does that still happen or is that more routinized where you have to go into the portal and you have to appeal it or can our members get things that they think have been processed incorrectly repriced themselves.

MR. ASHBY: This -- oh, sorry.

MS. HUCKABY: Go ahead, Darren.

MR. ASHBY: This is Darren Ashby for the record. I would like to first off ask if, Ms. Kelley, you could provide to Rhonda the name of that particular member because I would like to look further into that situation.

A member when calling in, if they outline for us that they believe a claim paid incorrectly, we should be able to take that information and create what we call a call track

and send that to the claims area for further review and determination as to whether or not the claim was just paid incorrectly and can be reprocessed or if we deem that it was paid correctly, it's at that point in time that we would communicate to the member that they would then need to appeal because based on the plan of benefits or what have you, the claim paid correctly.

But if we review that and determine that it was paid incorrectly, we should be able to make those adjustments and correct the claim accordingly. So I would like to look into that particular instance a little further.

MEMBER KELLEY: Okay, thank you. And just a follow-up since I've got the audio. What happens, when an employee calls, and I know they do it because they do it to all of us but, you know, something they felt was a wellness and the doctor codes it incorrectly, what advice is UMR giving to people to resolve that issue?

MR. BRAUN: So, I mean, if the claim was truly a wellness visit and the doctor didn't code it correctly, okay, Darren, I think we would be willing to reach out to that physician's office and say, hey, we have a member who says they were in for a wellness visit. You guys coded this as a diagnostic visit, can you change your coding? Can you go back and look at your medical records, verify that this was a

wellness visit and resubmit that claim with the wellness coding?

MR. ASHBY: That is correctly -- that is correct.

MEMBER KELLEY: Okay.

MR. ASHBY: We would reach out to the provider on behalf of the member and ask that they submit a corrected claim if, in fact, it was submitted incorrectly.

MEMBER KELLEY: And is the outreach electronic or is it human?

MR. BRAUN: Human.

MR. ASHBY: It's human, yep.

MEMBER KELLEY: Okay, thank you.

MR. JEFFERSON: I want to touch base. Jacy Jefferson for the record. As far as the appeals, I saw you were taking notes down, Board Member Kelley. When you submit that appeal through the portal, they can, they also have the ability to have attachments with it. So they will -- there's an appeal form that they fill out and then they submit that, but it has the ability to actually submit attachments, so any supporting documentation they have.

I don't know the actual amount that can be submitted on there, like how much or how many medical records can be submitted but they have the ability to do that.

MEMBER KELLEY: Okay, thank you.

CHAIRMAN ROBB: Okay. Any further questions?

MEMBER BARNES: Yeah, thank you. For the record, Jim Barnes. One of the problems we've seen as providers don't get their claims paid sometimes within 90 days or more and then when they're escalated to PEBP then they seem to get paid immediately. Is there some reason that the providers have to bring the claims to PEBP first and you can't get them paid in a timely fashion without them, when they just go directly to you?

MR. BRAUN: Like I said, we've had some challenges over the first six months and we had some inventory that grew and so we fully expected that inventory to get down in normal levels. We should have, you know, somewhere between six and ten days worth of inventory on hand. There's going to be some that get extended because we ask for records and so those could take longer, okay. But in general I think that issue hopefully should subside here in the next one to two months.

MEMBER BARNES: Okay.

CHAIRMAN ROBB: Any more questions? No more questions. Thank you for your time today and being here. This is listed as an action item.

MEMBER BITTLESTON: Is the action to accept the report?

MS. RICH: Accept the report and the penalties.

MEMBER BITTLESTON: Leslie Bittleston for the record. I move that the Board support the report and the assessed penalties.

MEMBER FOX: I'll second. Linda Fox.

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

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

CHAIRMAN ROBB: The motion passes unanimously.

We'll move to Agenda Item Number 10, presentation on PEBP claims experience and trend. Richard Ward from Segal.

MR. WARD: Good morning. For the record I'm Richard Ward with Segal.

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

MR. WARD: I have Agenda Item 10, here which is the presentation on PEBP trends and I'm gonna hit the highlights and as we work through the 20 something pages that we have here.

It's the summary of the agenda, the main cost and the main points. We're going to review recent PEBP costs that are specific to the plan for medical, drugs and dental.

We'll compare those trends and costs against market and industry trends which are summarized as annual survey with Segal.

And then we'll have the opportunity to talk a little bit about how we use that information in our pricing methodology and, of course, questions either at the end or along the way.

I'm on page two now of the executive summary. So medical trend is running favorably in the last couple of years. We're projecting for the current plan year, it would be about 3.3 percent.

And pharmacy claims are running higher than in the past, excuse me, are running higher than medical but that's an industry-wide dynamic. Pharmacy claims are, trends are running higher, and so the PEBP trends for pharmacy are not unusual. We would like to see them lower, of course.

And dental, particularly post COVID is running low, well below market trends, and we'll get into some specific comparison here in the slides.

Page three, this is a little bit, a little comment on different types of trends. The trends that we're primarily discussing here especially are assumed trends going forward are what we sometimes refer to as market trends. So it's not that I'm going to draw a distinction between that

and a budget trend.

A market trend reflects the cost without making program changes. So just continue forward on a baseline manner and that reflects changes in utilization, changes in per service or per drug costs and does not account for any action that PEBP or the Board might take. So it's before implementing new contracts or new programs or new initiatives or making plan changes, and this is an important initial step to understand just how costs are expected to change in the program before considering those specific items.

And on page three here, we have two tables on the right side. One is comparison of projected plan year '23 and '24 trend. So medical, we're assuming -- we're doing rate developments and budget projections. Four percent for medical, eight percent for pharmacy and that is on claims. I'll talk a little bit about claims, pharmacy claims trends and then also factor into the effective rebates. And then dental, we're seeing one percent and compared to higher rates that are largely in the industry or expected in the industry.

And then the table in the lower right, looking back a couple of years, the last three years or so, average trends for PEBP, for medical and pharmacy have run lower than industry trends and then dental is about the same, 1.7 versus .5 in the industry.

Okay. Moving on to page four, this graph shows per capita cost, so PEPM cost, per employee per month and that's all costs for dependents and employees and then -- and then allocated to each covered subscriber, so we use for retirees, for a family unit. And the way to read this, there's a couple of other graphs that are similarly constructed. At the beginning of the time period that we're reviewing here, which is midyear of 2019 per PEPM, it's $566. And the most recent data that we have at the end of '22 is $598 and that's -- that translates to, excuse me, to an annual trend of about 1.6 percent.

But trend is not level every year. There's some volatility too. I'll direct you to the table down below and on the right column there's actual -- actual historic trend for 2021 in the second row, coming out of COVID or coming out of the initial effect of COVID where there was utilization suppression in 2020. Claims trends was 15 percent on a per capita basis but that's bracketed by two much lower years. So on average that's how we get the one to two percent or perhaps three percent average.

And then the other two columns compare the trend that's used in the government's budgets and the pricing trend that was assumed. The later, the lower two, the last two row is five, Segal and predecessors prior to that. And the

distinction between the pricing trend and the budget trend accounts for or recognizes that there might be initiatives implemented, plan design changes or just new contracts.

Moving on, pharmacy, we have two lines here in this slide. The blue line at the top is claims and this is outpatient pharmacy. And, again, on a per capita basis, PEPM, $158 at the beginning of the period and 208 dollar per employee per month rate at the end of the period. That's about a 90 percent annual trend and that increases in pharmacy and less volatile than you see in the medical for claims cost.

At the -- in the table below that, the trend rates have been steadily increasing over the last couple of years and we're expecting ten and a half percent or 20. That is mitigated by the new contract that began this plan year with Express Scripts. It has a much more favorable rebate guarantees. So these are payments from the drug manufacturer's that ESI collects on behalf of PEBP when specific medications are prescribed and utilized by PEBP members.

And the, as the claims are increasing for this year, the increase in rebates was substantial enough that we're anticipating a negative net trend for those two but that's because of this one topic, mostly one time reset of

the rebate guarantees. I wouldn't expect that same dynamic in future years.

What's happened is the new contract as recent to a higher level and then that higher level is going to gradually increase and we would over time rather than another giant step. So I would expect on a net basis a similar claims trend going forward.

Move to dental, you can see in the graph in the middle there, there's, again for the effective COVID and claims trend on a per capita basis flat. It started out at $51 to PEPM, far left, and then right behind at the end it's $50. And similar to the medical, the actual -- directing you to the table at the bottom, the actual trend in the far right, 2021 has 13.1 percent trend and that's also bracketed by much lower trends in the year before and the years after. And that compares between the pricing trends and the budget trend and generally speaking dental trends at the lowest rate of the -- of these three service categories.

Now, moving on to compare against what's happening in the industry, every year Segal conducts a health cost trend survey. So the result, what we do is we solicit expectations and results for prior years from carriers, administrators, PBM's, insurers in the industry. So we get information from Express Scripts, from UMR, from UHC and

dental and other like entities in the industry. And they tell us, they indicate what they expect trend to be for the next year.

And then they also tell us what they experienced in their books of business the prior year. So the Segal trend survey is really an amalgamation that's representative of what is happening in the industry. It's not our assumptions. It's -- it's a compilation of industry expectation, so it's a good comparison to use when reviewing a particular plan as a benchmark against the industry.

And this -- this most recent year, and I think our -- our reach into the or the input that we receive from the industry, it's fairly comprehensive. We receive input from 323 insurers, administrators, carriers and PBM's, so pretty broad representations.

Page eight, this shows the actual trends in the industry for medical, drug and dental. The green line is pharmacy. The blue line, it starts off in the middle is medical and then the orangish line is dental. And across the industry we saw similar -- similar activity or similar retail to PEBP where there was a client in 2020 and then a strong bounce back and then maybe a return to what you might consider more normal trends.

And for 2023, the industry is indicating on

average 9.8 percent trends for pharmacy and that compares to eight percent trend we're assuming for PEBP. 7.4 percent for medical compared to four percent that we're assuming for PEBP. And then for dental, four percent if you have expectation in the industry and our projections 3.1 percent.

We have a couple of slides that compare PEBP with actual to expected in the industry. And on page nine, so the dotted line is the expected trend or the projected trend in the survey. So in calendar year 2019 the market, the industry expected a trend of 7.1 and next year 6.8.

And what actually happens was 6.8, pretty close to the 7.1 but then a minus 2.1 percent trend in 2020, well below the 6.8, and you can see the lighter blue line is PEBP that mirrors that for those two years. And then we're expecting to level off here or get closer to industry, and that's similar for performance.

I want to say a few words here about how we use these and there's trips of, oh, maybe, some of this for pleasure. On page 14, so high level overview of the basic steps for our pricing and rating methodology, we take historic claims. We generally take 24 months of experience so that helps provide stability that you're seeing in some of these prior years. There could be some volatility from year to year. So we want to use a reasonably credible set of data

that provides stability to the degree possible in our projections.

So we take the historic data and enrollments and we trend it forward on a per capita basis using these market trends, project that forward to the experience period and then we account for changes that we know or that are anticipated between the experienced period and the projection period and that could be changes to demographics, enrollment, migrating from one plan to the other.

Some of the programs that approved would be implemented for the next year through contracts, things that, better contracts, things that we anticipate to happen with provider cost, to all of those things get accounted for and projected, claims per capita cost and then we add admin fees. Sometimes we call them fixed costs, for PEBP admin, for your vendor contracts, just other operational administrative cost that get included into the full rates. And then we develop those rates specific to by plan and by year and by member category. And by that I mean State versus non-State, active employees versus retirees and the different coverage tiers, single family and so on and the three plans.

The next couple of pages, this had had some detail provided, pretty much more detail.

I'll stop there and see if there's any questions.

MEMBER BITTLESTON: Leslie Bittleston for the record. This is a question about the pharmacy, since you said it was a big up. Is that due to cost or more folks taking medications or more folks taking multiple medications? What was really the driver?

MR. WARD: It is due to utilization and the continued introduction and development of high cost medications, so the new drugs that come to market that have come to market and are expected to continue to come to market are higher cost medication. So there's some -- there's some categories, there's some specific drugs where it only takes a handful of people to -- for that medication or that category to appear for the first time in your top 20 from cost or top -- your 20 most expensive drugs.

MEMBER BITTLESTON: And we see doctors prescribing these newer medications.

MR. WARD: Okay.

MEMBER BITTLESTON: Okay.

CHAIRMAN ROBB: Ms. Aiello.

MEMBER AIELLO: This is Betsy Aiello for the record. Do you -- you have PEBP projected consistently lower than the industry and I'm just curious. Is -- do you think its access to medical providers or from what you gleaned, are you able to see why you are projecting as slower?

MR. WARD: That could be some of it. We see State health plans in general being more stable than other plans or other employers in the industry. So the industry data here is market-wide for the entire commercial markets. So you get from, like I said, UMR, UHC, Cigna, Aetna and Kaiser even and those -- the groups and the employers represented in that industry data are very diverse, private employers large and small, State health plans.

But generally State health plans run more stable. They may have higher cost or lower cost but the annual changes are generally less volatile than we see in trend.

MEMBER AIELLO: Some of these scraps look good.

MR. WARD: Setting the last couple of years aside.

MEMBER AIELLO: Okay, yes.

CHAIRMAN ROBB: Thank you. Ms. Kelley.

MEMBER KELLEY: So I'm looking at page 12 of your presentation and item number two, and I wonder what is the real risk to PEBP, because we do have a lot of new contracts in place, which is a good thing, but what is risk of inflation driven by providers to ask when does it become a bigger risk? If we have -- like how long do our contracts go because, you know, I think all of us can say that it took us a little while. But even I'm feeling price increases at the

grocery store now. So if medical starts to follow, we could be in for a really rude shock. So I'm just wondering how our contract is going to protect us and when the risk becomes real for the plan.

MR. WARD: Excellent question. The -- because this is a relatively recent -- the highlights --

MEMBER KELLEY: Right.

MR. WARD: In the discussion, it's always been there, but we talked about with the staffing shortages and vacancy rates, providers are feeling the same thing. It's becoming more challenging for them to recruit not just clinicians but administrative staff, billing staff and to recruit and retain the talent that they need. They are in many cases needing to pay more or they need to pay more and that's going to create some upward pressure on their cost.

And when UMR or other network -- other networks are negotiating with their -- with their contracted providers, those providers may not be able to agree to the same level of discounts they have historically because they have these cost of business pressures.

MEMBER KELLEY: Right.

MR. WARD: And I think we're going to see that as these contracts come up for negotiation and renewal. And that the terms of these contracts vary. Sometimes they're

handled renewal. Sometimes they're for two or three-year guarantee periods, periods of guarantee so some provider contracts might not change for another year or two.

MEMBER KELLEY: Right.

MR. WARD: We're still not sure what that's going to look like. One of the things that we had been concerned about six months ago, maybe a year ago more so now, supply chain pressures, which is creating price pressures for the material stuff that providers need to provide care. That's maybe less of an issue now.

So I think we've -- we've identified it as something to be mindful of, monitor, but we still don't really know what that pressure is going to -- the effects of that upward pressure.

MEMBER KELLEY: Okay. Just a follow-up. You know, I would be remiss if I as a pro-employee person, if I could point out that a lot of inflation is actually being driven by the fact that companies haven't been able to increase their profits for a long time and they are now doing that. And I'm sure the medical field is the same because they are -- you know, they're constrained so much to these contracts. So I'm sure that there's -- I'm sure the providers are all seeing the potential for an opportunity to raise their profits.

So saying that, how much transparency do we have into kind of our contract with whoever is providing our network? How much transparency do we have into their contracts about when they are going to renew? You know, how long they're for? I don't know. Does anybody know?

MR. BRAUN: Yeah, I was just going to say, we might want to jump in here. I think typically our contracts are three-year contracts, okay. They don't all come together. They kind of space out, okay. So some renew it this year, some next year, some the year after, okay. But I think and I'm going to let my compatriot here answer too, but we've seen across the country a lot of pressure on our pricing, okay.

On top of that, we've also just seen recently the Medicare made some changes in reimbursements, okay. So when government reimbursements go down, there's also more pressure on the facilities and the physicians to raise commercial rates because they have got to still sort of balance the books, right. So all of those things are having an impact. So everything that he told you is absolutely true. There is considerable pricing pressure, but I'm going to see if he wants to add anything to what I just said.

MR. JEFFERSON: I'm sorry, Jacy Jefferson for the record. Yes, so I manage the contract negotiations per

healthcare planning and in the Nevada market. As Helmut said, yes, our agreements are normally three to five years. We try to do five years but most of them are around three years.

And over the last couple years since COVID, I've been hearing that from hospitals, providers, like I said, they're seeing inflation and costs go up so they're asking for higher, high increases and some of them are raising their bill charges.

The other reason that Helmut mentioned too is Medicare, I'm hearing that as well, where Medicare is decreasing rates so contracts will be, pay up to a percent of Medicare. They're looking for us not harm them to where, you know, especially for the commercial members to pay a commercial rate. And Medicaid and Medicare owe, they don't want to get hit with the Medicare increases for their commercial payments because they're going to get hit on Medicare. So they're looking for commercial plans to subsidize some of those increases from the government too.

MEMBER KELLEY: Okay, thank you.

MS. RICH: Laura Rich for the record. I actually, I just want to add to that. I believe it was the Nevada Hospital Association, I watched them testify at the legislature, and they had a pretty good presentation. You

know, as they are saying, the commercial market has to subsidize Medicaid and Medicare and because providers are, they are not recouping their cost through any Medicare or Medicaid patients.

Medicaid, I think it's between 25 and 33 percent of the population in Nevada and so, is that right, April? Okay. So we've got a lot of Medicaid recipients in the commercial market, which is PEBP, PEBP and every other, you know, private and public insurer is picking up the cost. And we're, you know, subsidizing for the Medicaid population and Medicare population.

And so, yeah, that pressure, if Medicaid rates don't go up, if those reimbursement rates don't go up, if Medicare reimbursement rates are dropping or also not increasing, it puts additional pressure on the commercial market, and so we are subject to that, and I think that's very important to recognize that we're the -- we subsidize.

MEMBER KELLEY: Can I ask a follow-up?

CHAIRMAN ROBB: Yes.

MEMBER KELLEY: Michelle Kelley for the record. A follow-up for UMR actually. So we have -- you have contracts for three to five years. Do providers have an out as in if they came to you and they said, you know, our costs have gone up so much, we need to renegotiate. We need to do

it now and you said no, do they -- do they have like a 30-day termination?

MR. JEFFERSON: Oh, yes. Most of our contracts allow both of us to get out any time. In most we try to put a time frame on it and say, okay, after this date, you have 90 to 180 days to terminate the contract on agreed terms.

MEMBER KELLEY: So that's a risk as well that we don't pay and then we lose small providers from the plan I guess.

MR. JEFFERSON: Yes.

MEMBER KELLEY: Thank you.

MR. BRAUN: It's not 30 days. It's at least 90 or 180.

MR. JEFFERSON: Yeah, at least 90 to 180.

MEMBER KELLEY: Okay.

MR. BRAUN: You have notice. Sometimes they typically use that as a negotiating strategy too. Say we're going to drop out of the network unless you give us more rates and so then that puts pressure on us to negotiate with them. Obviously, in some those situations we'll notify you a provider might be dropping out so that you're aware of that as members.

And we have -- at a certain point in time we have an obligation to notify members within 30 days, 30 days

before providers can drop. We do have to notify members that this provider's contract is going to terminate so we use member notification, if we get to that 30 day mark.

MEMBER KELLEY: Okay, thank you.

CHAIRMAN ROBB: Any further questions? All right, thank you.

MS. RICH: Richard, you may as well stay. Oh, unless are we going to take a break?

MEMBER KELLEY: He's a task master over there.

CHAIRMAN ROBB: That's where I was going. It's right at noon. Do we want to tack a 15-minute break and get through the rest of the day or do we want to take a longer day and get lunch?

MS. RICH: Short break.

CHAIRMAN ROBB: Short break. We'll come back at 12:15.

(Whereupon, a brief recess was taken.)

CHAIRMAN ROBB: We'll move on to Agenda Item Number 11. We'll call the meeting back to order and move on to Agenda Item 11. Before we go on, everything is good on the YouTube and Zoom? Everything is still connected? Everybody is good?

MR. HOPKINS: Yes, Chair Robb, everything is good to go.

CHAIRMAN ROBB: All right. Thank you very much. Number 11, discussion and possible action to include approving Plan Year '24, July 1, 2023 through June 30, 2024, rates for State and Non-State employees, retirees and their dependents for the Consumer Driven Health Plan, Low Deductible Plan, Exclusive Provider Organization Plan and Health Maintenance Organization Plan. For possible action.

MS. RICH: So Laura Rich for the record. This is, I'm not going to go into the background portion of this report because I think the Segal team did a good job of explaining how rate development, what goes into the rate development process and how that -- how that typically goes.

But just for newer Board members who haven't been around, typically we at least provide a little bit of that background as we get into the rate setting process, but there obviously is some underwriting. We look at enrollment. Again, we apply the admin lows, admin of our contractual type, you know, the operational expenses, things like that and then we look at the tiering, and so the tiering is a Board approved methodology to identify the rates for each of the different tiers. And then the last step is the additional employment of that life insurance.

So as you heard from the Segal team, fortunately PEBP has had favorable claims experience this year overall.

And on top of that, we've had several programs that we have approved with projected savings as well, and so all of this is going to have a very positive impact on -- on overall rates. And when I say the overall rate, it's the cost of the plan.

Although, the EPO and HMO have independently experienced a high medical loss ratio, which means that you're -- for those plans, we're actually bringing in less revenue than we are paying out in claims. The CDHP annual deductible plan have more than offset that and so those deficiencies have been offset, offset with the lower utilization costs of those plans.

Additionally, we had a PBM market check that is going to be brought to the Board at the May Board meeting. That has not been taken into account into these rates. So that's going to be almost like an additional cushion because it came, the rate setting was already done by the time that we finalized the PBM rate check. So that should help future costs as well.

So when we did the -- when Segal did the rate setting and looked at the rates, if we would have just supplied the standard methodology, it would have resulted in a reduction of rates for this year. We're not proposing a reduction. We are proposing to maintain everything flat.

And the reason for that, first of all, as you've seen, it's not reasonable to expect that healthcare costs are going to go down. They are going to increase.

And so by keeping those rates flat, it lessens the pain when they -- when we have to increase them in the future. And so by declining -- by decreasing the rates, even if it's just minor, next year, you know, we're yo-yoing again, right. And so the whole point is to kind of keep things stable.

And so what we're recommending is that these rates basically stay as is. There's a couple of anomalies there. I think there's, remind me, is it the surviving spouse? You know, there's a few different tiers specific that have to either increase or decrease.

But for actives and retirees, State actives, State retirees, they are -- we are maintaining the status quo. The rates, the premiums that are in place today are being proposed to stay in place for the next plan year. By doing this, we are generating a plan surplus is what we're going to call it is because we know we're bringing in more revenue than we need.

So what we're going to do with this or what the proposed plan to do with this is that next year we do know that there is a potential because in our budget we've got

lower budgeted trend than what the Segal team has projected.

Now that's, we've seen that things change and that there's, you know, projected versus actual, but we have to be somewhat realistic. We have to be realistic and we have to understand that in that pharmacy trend specifically we have -- we're expecting much higher pharmacy trend than we have budgeted for in our budget. So there's things like the PBM market check that will help offset that.

This, by keeping rates flat, we are basically creating a two and a half, almost two and a half million dollar, almost 2.4 million dollar nest egg, projected nest egg so that next year when there's a potential to have to increase rates, we have that little chunk of money to mitigate that, to mitigate the impact on members.

If it turns out that things are amazing and great and healthcare cost didn't go up and we don't have to increase rates, well, then that's great. Then we'll take that two and a half million dollars and we distribute it in other ways. For example, HRA and HSA funding, that's an easy way to distribute that money back to members. But in that bogged year when we don't have a safety net, it's good to be able to create our own safety net.

And so the proposal here is really just to keep rates flat. There is no changes to majority of the rates,

and I think this is going to -- the purpose of this is to really create some stability in, you know, member premiums and just in general in our plan so that we're not continuing to yo-yo up and down for members and that disruption is mitigated as much as possible.

So with that, I'll stop. I don't know if Segal wants to add anything to that.

CHAIRMAN ROBB: Mr. Verducci.

MEMBER VERDUCCI: Yes, Tom Verducci for the record. What is the State policy on the or the Board policy on the State subsidy contributions? It says even all three groups.

MS. RICH: Correct. So the subsidy is applied evenly to all three groups, correct.

MEMBER VERDUCCI: So in the pricing model, is the subsidy middle even all three or are there, you know, one or two groups that are receiving more or maybe one or two receiving less?

MS. RICH: So that methodology was applied, but I'm going to pass it to the Segal team because I know there's adjustments as well for other things where it changes it a little bit.

MEMBER VERDUCCI: Okay, thank you.

MR. WARD: So the base -- Richard Ward for the

record. So the base subsidy, the AEGIS or the REGI is applied uniformly. It varies by coverage year. And when a family appear as a high dollar allocation, single for example, from the high deductible to the low deductible to the EPO within one coverage year. Where there are some variations is to account for the plan design buy-down that was adopted a year ago or two years ago. I'm sorry, it was before my time.

MS. RICH: A few years ago, yeah.

MR. WARD: And those plan design changes are not uniform from one plan to another. So the -- that has resulted in the second adjustment being specific to each plan to align with benefit changes that were implemented for each of those plans.

So just to summarize, the base subsidy that comes from the budget, AEGIS, REGI, that is uniformly applied to each plan and then adjustments because of some changes in plan benefits and how that's being tracked and allocated and funded. There's some additional small amount that is a little bit different from one plan to another because those changes are specific to each of the three plans.

MEMBER VERDUCCI: Very good. Thank you.

MEMBER AIELLO: This is Betsy Aiello. So I would like even a little bit more clarification. I know things are

so complex, it's hard to simplify them. So I'm just going to say, let's start with employee only. The rate for CDHP is 650 to base subsidy, 620. Then that adjustment is a negative adjustment and so that means that that plan got some benefits that made it richer so that the subsidy has, the other way, has less? What is that? I know you tried to make it simple but it's hard.

MR. WARD: That's a combination of the method buy-down plus the amounts needed so that the number on the right, the participant premium is exactly the same as what it is this year.

MEMBER AIELLO: So that's -- that's -- that -- to keep the premium the same, the rate itself that you've worked out, that would be the cost for this year?

MR. WARD: The 4696.

MEMBER AIELLO: The 652.46.

MR. WARD: The 652.46 is the projected full cost.

MEMBER AIELLO: For this year?

MR. WARD: Correct.

MEMBER AIELLO: And so then there's the subsidy.

MR. WARD: Right, that's the AEGIS allocation.

MEMBER AIELLO: And then so the participant's premium to keep it the same for this year, that's where the other number came from.

MR. WARD: Right.

MEMBER AIELLO: It's not for added benefits or decreased benefits. It's an in-between number.

MR. WARD: It is. It accounts for both actually. So with the added benefits, there's -- there's a -- there's a cost to that. But then to get the -- so the participant premium matches this year because as Officer Rich was saying, it would otherwise go down, and the proposal is to keep them level, the balance of the two results in a projected surplus of $14.59 for that particular.

MS. AIELLO: Which then helps pay for the EPO and HMO that has a positive 9.59, would you say that then, or would that have to go up, 9.59, if this one didn't have the 14?

MR. WARD: No. The -- the adjustments are two components. There's the benefit buy-down and any other adjustment that might be needed so that the employee, the participant premiums are exactly the same as this year.

MS. RICH: And I just want to clarify. So the benefit buy-down, because we live this, they don't, so I just want to clarify. So the benefit buy-down is, if you recall a couple of years ago when we had an excess, we had $26,000,000 and the Board chose to plan -- to steer step the benefits to reinstate the benefits and pay for them over three years.

And so in our budget, what happened and the way that this occurred is that that excess was just worked into our budget and so that's really, that's when we talk about the benefit buy-down, it's spending that excess that is kind of absorbed into our budget to pay for those reinstated benefits, so it's two components. It's that and it's also the -- the keeping premiums the same so there's two price tags associated to that.

MEMBER KELLEY: And Michelle Kelley for the record, a follow-up. But just to be really clear, whatever the reason, this chart, in order to keep rates flat, high deductible PPO participants, so participants who choose to pay the least every month but pay 100 percent of the cost when they need services, they are, we're saying to them, hey, we're going to keep your $14.59, instead of reducing your premium in case rates go up next year.

But then if we go over to the EPO, that plan for this year already costs $10 more than we're charging and so we're applying credit. So we're moving away from the $620.09 subsidy, employer subsidy because we're giving them an extra $9.59 to keep them even so that we can keep that flat and that's across all of the tiers on both the high deductible and the EPO.

And while I'm actually, I'm very much in favor of

this. I think you've done a great job, Laura, so please. I know I tend to be the critical one, but I really just want the best plan and I think these discussions sometimes are really helpful.

But however you phrase it, right now one employee is not getting the same subsidy because if I'm in the high deductible PPO, I'm actually getting $606.41 subsidy, okay, because that adjustment is not coming back to me. And it might not come back to me, right, because we don't know what the trend is going to be.

And whereas someone who's in the EPO/HMO, where they have agreed to pay more every month because they do have more coverage, although it's still not ideal, so. I'm going to get all those e-mails saying the EPO isn't really very good but that's the reality, right. So they are actually getting $630 in subsidy.

At some point I think when we come back to the formula, they are going to have premium shock because if the EPO continues to cost more than we're charging, that's a problem, right.

MS. RICH: Do you want to address that, Richard? I think you might do a better job.

MR. WARD: Well, let's find out. Currently -- currently employees in different plans do receive different

subsidies once you combine everything together because the value of the benefit buy-down, I keep using that term, is not exactly the same from plan to plan. So already employees in the EPO versus the CDHP are, there are different total subsidies based in the rates for plan year 2023.

And as I was saying earlier, that's due to the benefit enhancements being different from one claim to the next. So there's a different dollar allocation associated with those different benefit enhancements.

MEMBER KELLEY: Can I just interrupt. I was on the Board when we did that. And a big part of deciding how to do it was the actuarial -- ensuring the actuarial value of each of the things added back in was the same to maintain the integrity of the rates I thought.

MR. WARD: Uh-huh.

MS. RICH: There were some changes because of the low deductible plan. So the low deductible plan did not exist when we -- we tried to bring things back to pre-pandemic levels, right. But the low deductible plan did not exist during that pre-pandemic, right. It was brought in in '20 to '21 I think. So there had to be adjustments to both plans in order to kind of squeeze in the low deductible in the middle rate so the EPO and the CDHP, otherwise you have three of the same plans. You know, so we had to make

different adjustments to that, that middle plan or actually to the other two plans so that the middle plan fit in. So there were some changes.

And, yes, the EPO, just because it is a richer plan when you reinstate benefits, you know, you're giving really a higher, yeah, it's costing more, it is, and with the CDHP it's costing less.

CHAIRMAN ROBB: Any further discussion or questions?

MEMBER KELLEY: Just a follow-up, I'm sorry. Michelle Kelly for the record. So how do we get back to the formula without it hurting? You know, I mean, we keep hearing we've got this X plus X. You know, X is an adult. Y is a child and that we apply the employer subsidy kind of equally, we try to be agnostic about what plan people select. So then how do we get back to the formula without someone having to feel some pain and when do we do that?

MR. WARD: I think with this -- Richard Ward for the record. I think with this proposed approach there's -- there's going to be, as Officer Rich was noting, there's an anticipated surplus to be filtered, a nest egg, that is available for plan year '25, provide the Board with flexibility and considering different method combinations and different premiums, participant premiums. And I think you

end up, conversely you're more likely to have a situation when you don't have that flexibility where you're forced to make everything balance out with the budgeted, with the AEGIS and the REGI. So you have an additional amount that you can use to attribute to your discretion to smooth out changes from year to year or keep them the flat for another year if things work out favorably.

Then going into the second year of the biennium, without that, then you may be in a situation a year from now where we have the projected costs, the full costs and then we have whatever comes from the AEGIS and the REGI and then participants have to pay for everything else. And so this gives you some flexibility in that regard, like what we're discussing right now or you're discussing right now.

MEMBER KELLEY: Thank you for that. Michelle Kelley for the record. You know, I'm in favor of the approach presented today. I think my concern is and I want our members to understand that this approach is subsidizing one plan a little more, a tiny bit more over the others. And at some point, if we apply Board policy and Board decisions before, those people who are currently getting subsidization because I think the EPO has been running high --

MR. WARD: Yes.

MEMBER KELLEY: -- for this long. You know, so

if it continues to run high, at some point there's going to be a real sticker shock there. I mean, the rates are already going not low because they do get these, you know, fixed affordable co-pays when they seek services.

So I just -- you know, for me it's really about warning participants, yeah, the rates are staying flat but that's not really the story, you know. And then it would be remiss of me not to mention that many people are in the -- our most population is in the high deductible plan. And we keep hearing from participants, they are paying too much every month and then they're not getting any coverage.

And while this is only 2.5 million, so it makes sense to keep it in the kitty, like that $15 is significant on a plan that doesn't provide any coverage for the first, I'm going to get it wrong, the first $2,000. I'm not sure what the deductible is, $1,500. So you get no coverage for $1,500. So, you know, people paying $46 for that a month, so they're really just ensuring the risk of a catastrophic incident, right.

But as I say, I'm in favor of this approach. I just think that every time we do something like this, I think that getting back to applying the formula gets a little further out of our reach I feel like. How do we get back to balancing the plan so that we are subsidizing each equally?

MEMBER WOODWARD: This is Janelle Woodward for the record. So a thought on that, people take the EPO or HMO because it's easier for them to pay that higher rate and pay as you go because they have used typically more things that they have to go the doctor for or whatever. They don't have $1,500 in their pocket to start out the year with.

So and then people who are gonna be in that high deductible are going to be ones that are, go less to the doctor and have less to cover. So, yeah, they get -- they get less rate at the first, but they are also paying $46 versus 160 something every time. So it kind of works out.

When I was working with insurance, it was, we would explain it, you're either paying it up front or you're paying it later. So you make your choice on what plan you pick, but the coverage is essentially the same. It's just when you're paying that cost up front or because the EPO now has a deductible. It has the co-pay. It has all the same things.

MEMBER KELLEY: Right. So Michelle Kelley for the record. Absolutely, I understand that. The only thing I would maybe disagree with you on is that only, the only people in the high deductible PPO are people who have $1,500 available to spend on their medical because I actually think for many of our low paid employees, they stay on that plan

because --

MEMBER WOODWARD: It costs less.

MEMBER KELLEY: -- it costs less, and they just hope or they deny themselves coverage or whatever. But I guess, you know, my point is still that when this measure goes through the EPO people are, we're subsidizing their benefit, all employees are subsidizing those members benefits just a tiny bit. And at some point all the members aren't going to do that anymore.

MS. COHEN: For the record, this is Amy Cohen. I just wanted to also remind everyone that the high deductible health plan isn't HSA qualified plan, meaning that's a minimum deductible prescribed by the IRS. And the -- and they do have a 1,500 dollar deductible but they're also getting that HSA and HRA contribution. So they don't have to have the full 1,500. They're going to get funded that $600 right at the beginning of the plan year so they have that, plus anything that accumulated in prior years.

MEMBER KELLEY: Thank you.

CHAIRMAN ROBB: Any other discussion? Seeing none, do we have a motion?

MEMBER KELLEY: I'll make the motion to approve the rates as outlined and recommended by staff.

MS. RICH: With technical adjustments.

MEMBER KELLEY: With the approval for technical adjustments as we go through the process.

CHAIRMAN ROBB: Okay.

MEMBER FOX: I will second. Linda Fox.

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

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

CHAIRMAN ROBB: All those opposed? It passes unanimously.

Thank you for your presentation and time today.

We already did Agenda Item 12. We'll move on to Agenda Item 13, presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitations. Cari Eaton.

MS. EATON: Thank you. For the record Cari Eaton. Item Number 13.1 is just a review of the current active PEBP contracts and no action is necessary.

13.2, we don't have any new contracts for approval.

13.3.1 is requesting the PEBP Board approve a contract amendment to the Segal contract. PEBP contracted with Segal for actuarial consultant services April 12th, 2022

for the termination date of June 30th, 2027. This contract amendment increases the maximum contract authority for the duration of the contract by $295,410. This increase is mostly due to several unplanned projects this year and updated in the schedule of future RFP's.

PEBP recommends the authorized staff to amend the contract between PEBP and Segal to update the fee schedule and increase the contract maximum.

I'll stop there for questions.

CHAIRMAN ROBB: Any questions, okay.

MEMBER BITTLESTON: Leslie Bittleston for the record. Is this already budgeted, this additional funds?

MS. EATON: Carry Eaton for the record. Yes, we have a work program moving funds around and we did include this in our program for next month's IFC.

CHAIRMAN ROBB: I made you count on IFC.

MS. EATON: Yes, and surprisingly we were told we were off and now we're back on.

Did you want to approve this one now and then move on or just everything at once?

MEMBER BITTLESTON: Leslie Bittleston. Move to approve as recommended by PEBP.

MEMBER KELLEY: Second.

CHAIRMAN ROBB: We have a motion and a second.

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

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

CHAIRMAN ROBB: All those opposed? Motion passes unanimous.

MS. EATON: Thank you. Cari Eaton for the record. Item 13.5.1 is due to the item number 12 report. It's requesting the PEBP Board cancel the solicitation, ratification for the eligibility enrollment RFP that was approved on March 24th, 2022. PEBP staff will collaborate with the State Office Project Management to identify a vendor for the new PEBP eligibility and enrollment solution and the State's ERP project. Due to this path, the RFP is no longer necessary. PEBP recommends the Board cancel the previously approved solicitation and ratification.

I'll take any questions.

CHAIRMAN ROBB: Any further discussion?

MEMBER FOX: Linda Fox for the record. This is what we discussed earlier, correct?

MS. EATON: Yes.

MEMBER FOX: Okay. So I'll make a motion to cancel.

MEMBER BITTLESTON: Second.

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

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

CHAIRMAN ROBB: Any opposed? The motion passes unanimous.

MS. EATON: Cari Eaton for the record again. Item Number 13.5 is an overview of the current in progress solicitations. We are continuing to work on the Cancer Concierge and medical management RFP with Segal and should have a better grasp of the timeline of these procurements soon and no action is necessary on this item.

CHAIRMAN ROBB: Okay. Any questions or discussion? Hearing none, what's that? Okay. I just wanted to make sure.

All right. We'll move on to Agenda Item 14, public comment. Any public comment in Carson? None. Any public comment on Zoom?

MR. HOPKINS: Chair Robb, we don't have anyone currently in the attendees lobby. Do you want me to put up the slide and give them a moment?

CHAIRMAN ROBB: Please do, just in case somebody is on YouTube.

MR. HOPKINS: Will do. One moment, please.

CHAIRMAN ROBB: Nobody switched over. We will adjourn. Thank you everyone for your time.

MR. HOPKINS: Chair Robb, I'm just putting up the slide right now. Sorry.

CHAIRMAN ROBB: Oh, okay. I'm just trying to get out of here.

MR. HOPKINS: I know.

CHAIRMAN ROBB: I'm trying to help everyone else get out of here too. Nobody?

MR. HOPKINS: No one has joined, Chair Robb. I can end it right now if you would like.

CHAIRMAN ROBB: Yes, that's fine.

I would like to thank staff. This is a well put together meeting. I know it took work to have it in-person, but I truly do appreciate it.

With that, we will adjourn.

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

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

That on Thursday, the 23rd day of March, 2023, I was present via Zoom for the Public Employees' Benefits Program, Carson City, Nevada, for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 154, is a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Carson City, Nevada, this 27th day of March, 2023.

KATHY JACKSON, CCR
Nevada CCR #402

$

$1,500 (4)
146:16,17;147:6,22
$10 (1)
141:18
$10,000 (3)
53:8,14;59:6
$14.59 (2)
140:10;141:15
$15 (1)
146:13
$150 (1)
53:12
$158 (1)
119:7
$162,000 (4)
81:2,5,16;95:5
$19,553.48 (1)
80:11
$19,802,190 (1)
79:2
$2,000 (1)
146:15
$20 (2)
25:2,2
$26,000,000 (1)
140:22
$295,410 (1)
150:3
$46 (2)
146:17;147:10
$50 (1)
120:12
$51 (1)
120:11
$566 (1)
118:8
$598 (1)
118:10
$600 (3)
53:12,13;148:16
$606.41 (1)
142:7
$620.09 (1)
141:19
$630 (1)
142:16
$700 (1)
11:17
$72,000,000 (1)
69:21
$9.59 (1)
141:21

A

A1C (1)
60:22
abandonment (1)
88:4
ability (13)
16:18;20:23;21:12;29:10;32:11;34:4;43:23;45:5;91:7;101:16;113:17,19,23
able (28)
6:8;40:12,20,24;41:8;48:21;52:9;55:3,4;59:20;71:11;74:8;82:5;91:9;94:2;97:15;99:9;106:23;107:5,12,14;108:9;111:23;112:9;124:24;126:18;127:18;136:22
absolutely (6)
45:16;89:15,24;90:5;128:20;147:20
absorbed (1)
141:4
abstention (1)
14:8
accept (3)
93:17;114:23;115:1
acceptance (1)
77:24
accepted (1)
16:7
access (5)
11:21;54:6;98:18;101:6;124:23
accessing (1)
24:20
accidentally (1)
64:19
accommodate (3)
18:24;43:22;110:18
accommodations (1)
43:12
accordingly (1)
112:10
account (7)
20:19;41:19;102:21;117:5;123:6;134:15;138:6
accounted (1)
123:13
accounting (7)
17:2,3;30:21,22;31:9,10,12
accounts (2)
119:2;140:4
accumulated (1)
148:18
accuracy (4)
79:13,14;80:11;96:4
accustomed (1)
6:7
achieved (1)
53:1
A-c-o-s-t-a (1)
12:18
across (6)
44:21;51:9;76:17;121:19;128:12;141:22
act (1)
47:14
acted (1)
14:16
acting (1)
8:19
action (22)
14:15,18;42:6,10;47:22;62:16;63:20,23;71:23;72:20;76:12;78:3;100:4,7;114:22,23;117:6;133:2,7;149:14,19;152:13
active (3)
75:21;123:19;149:19
actives (4)
6:19;7:14;135:15,15
activity (4)
53:2;61:3;65:10;121:20
actual (9)
70:17;113:21;118:14,14;120:12,13;121:16;122:7;136:3
actually (42)
9:10;20:11;27:12;28:1,2;30:24;40:3,12;42:10,24;45:5;48:8;50:18;52:8;53:22;54:22;57:15;60:10;62:1;67:21;69:11;75:6;78:17;81:7;86:6;88:11;96:10;102:11;107:17;108:1;113:19;122:11;127:17;129:22;130:21;134:8;140:4;141:24;142:7,15;144:1;147:23
actuarial (3)
143:12,12;149:24
actuaries (1)
102:1
add (17)
20:21;22:4,23;23:10;46:19;57:17;71:1,3,3,4;76:22;81:15;104:1;123:14;128:22;129:22;137:7
added (9)
64:18;88:3,5;96:4;97:1;110:6;140:2,5;143:13
addendum (1)
81:7
adding (7)
18:7;21:23;22:1;74:6,6;76:19;99:20
addition (1)
54:16
additional (18)
8:1;9:15;11:7;14:12;64:2;65:1;75:15;76:7;96:4;99:18;103:22;110:7;130:15;133:22;134:16;138:19;145:4;150:12
Additionally (6)
17:20;40:22;64:18,23;81:12;134:13
address (5)
60:18;73:18,22;91:22;142:21
addressed (3)
96:15;99:19;108:22
addressing (3)
74:18;76:10,10
Adherence (1)
61:1
adhering (1)
29:21
adjourn (2)
153:3,17
adjustment (5)
138:12;139:3,4;140:17;142:8
adjustments (9)
7:10;112:9;137:21;138:17;140:15;143:21;144:1;148:24;149:2
admin (4)
123:14,15;133:17,17
administered (1)
78:2
administrative (2)
123:16;126:12
administrator (5)
42:1,1;54:13;56:2;82:9
administrators (4)
83:11;84:10;120:23;121:14
adopted (1)
138:7
adoption (1)
70:10
adult (1)
144:13
adults (1)
54:17
advantage (2)
55:2;58:8
advice (2)
25:11;112:16
advise (1)
97:16
advised (1)
10:12
AEGIS (5)
138:1,16;139:21;145:3,11
Aetna (1)
125:5
affect (3)
14:6;19:6;21:12
affected (2)
104:22,23
affecting (1)
59:22
affects (1)
101:24
afford (4)
11:20;24:11,14,15
affordable (2)
25:3;146:4
AFSCME (4)
8:3,4,5;11:3
afterwards (1)
106:10
again (25)
26:14;29:2;44:24;51:18;53:19;58:13;59:2;62:8;73:12,19;74:1,13;83:23;84:12,19,24;92:18;93:9,14;96:13;119:6;120:9;133:17;135:8;152:8
against (3)
116:1;120:19;121:10
agencies (6)
21:6;28:13;29:1;36:4;47:1;55:8
agency (9)
7:1,3;16:8;36:6;48:13;54:11;55:19;57:12;73:2
agenda (32)
10:9;13:17,18,24;14:14,15,15,18,23;15:1,16,17;21:14;36:23;42:8,13,15;45:12;47:19,21;63:13,19;64:3;69:11;115:12,18,22;132:18,20;149:13,14;152:17
agendas (1)
56:24
aggravates (1)
50:21
aggregation (1)
50:14
Aging (2)
54:7;101:18
agnostic (1)

144:15
ago (8)
61:21,22;127:7,7;
138:7,7,9;140:22
agree (7)
80:18,19;82:3;
83:3,4;108:15;
126:18
agreed (2)
131:6;142:12
agreement (1)
39:16
agreements (1)
129:2
ah (1)
31:7
ahead (7)
43:3;56:8;78:8;
98:21;99:3,10;
111:17
Aiello (36)
5:11,12;34:1,21;
56:21,22,22;58:13;
70:14;83:17,18;
84:12;86:15,16,16,
23;87:2;89:10,21;
90:6,13;93:7;124:19,
20,20;125:12,15;
138:23,23;139:12,16,
18,20,22;140:2,11
air (1)
63:15
algorithms (1)
79:8
align (1)
138:13
ALLEN (4)
8:2,2;9:24;14:20
A-l-l-e-n (1)
8:3
Alliance (1)
51:6
allocated (2)
118:4;138:18
allocation (3)
138:3;139:21;
143:8
allow (3)
13:24;63:14;131:4
allowing (1)
9:20
almost (4)
20:12;134:16;
136:10,11
along (7)
26:12;28:7;29:12;
65:14;78:21;102:8;
116:7
alternative (1)
57:14
although (4)
38:14;66:23;134:6;
142:13
always (14)
12:22;27:7,7,8,9;
33:21;84:3;85:14;
87:18;88:16;100:16,
24;110:8;126:8
amalgamation (1)
121:6
amazing (1)
136:15
amenable (1)
28:24
amend (1)
150:6
amendment (2)
149:23;150:2
amendments (1)
149:16
Americans (1)
51:11
amount (7)
23:8;81:5;89:23;
101:24;113:21;
138:19;145:4
amounts (1)
139:9
Amy (2)
115:17;148:10
analysis (1)
65:1
analytics (1)
79:12
anecdotal (1)
101:11
angry (1)
90:11
announced (1)
10:12
annual (6)
16:22;116:2;
118:11;119:9;
125:10;134:9
anomalies (1)
135:11
anticipate (3)
26:14;98:12;
123:12
anticipated (2)
123:7;144:21
anticipating (1)
119:23
antiquated (3)
37:22;65:20;66:3
anymore (3)
67:4,19;148:9
apologize (1)
13:21
app (1)
107:14
Appeal (14)
58:1,9;106:16,18,
20;107:4,16,17;
108:2,4;111:14;
112:5;113:16,18
appeals (2)
106:19;113:14
appear (3)
82:7;124:13;138:3
appears (1)
75:9
appended (1)
84:7
applicable (2)
13:18;73:5
applied (4)
137:13,19;138:2,
16
applies (1)
76:17
apply (3)
133:17;144:14;
145:20
applying (2)
141:19;146:22
appointments (2)
13:3;106:5
appreciate (14)
6:4,23;12:2;23:22;
25:24;26:16;30:10;
45:1,12;46:14;48:14;
62:13;69:15;153:16
appreciative (1)
44:9
approach (4)
144:19;145:17,18;
146:20
appropriate (3)
41:3;80:3;92:21
appropriately (2)
85:14;98:17
approval (5)
14:18;78:20;149:1,
15,21
approve (11)
9:16;15:4;34:8,10;
37:8;62:16;72:2;
148:22;149:22;
150:19,22
approved (8)
37:15;65:6;69:23;
123:10;133:20;
134:2;151:11,16
approving (1)
133:3
approximately (2)
51:8;54:14
April (8)
5:15;18:20;98:14;
102:20;109:19;
110:9;130:6;149:24
area (2)
60:2;112:1
areas (4)
9:4;50:17;51:4;
94:3
Arizona (1)
8:23
around (13)
8:11;11:1;19:20;
23:23;26:15;49:12;
56:5;63:14;79:21;
105:24;129:3;
133:14;150:14
arrangement (2)
7:20;37:24
Ashby (12)
86:10;89:1,2;93:1,
4;107:20;111:16,18,
18;113:3,5,11
A-s-h-b-y (1)
89:2
aside (1)
125:14
aspect (2)
58:4,4
aspects (1)
25:12
assembly (1)
18:10
assessed (1)
115:4
assist (1)
17:4
assistance (1)
38:3
associated (2)
141:7;143:8
association (2)
49:23;129:23
assume (1)
104:2
assumed (2)
116:22;118:23
assuming (7)
17:18;36:13;92:16;
107:18;117:13;
122:2,3
assumptions (1)
121:8
assurance (1)
88:22
assured (1)
36:17
ate (1)
84:15
attachment (1)
90:4
attachments (2)
113:17,19
attempted (1)
26:7
attend (1)
20:2
attendance (1)
61:1
attendees (1)
152:21
attending (2)
43:15;78:5
attention (6)
9:5;48:8;69:9;
80:12;101:3;104:11
Attorney (1)
13:19
attribute (1)
145:5
attributed (3)
79:4;80:6,11
audio (1)
112:13
audit (23)
77:24;78:15,22;
79:1,8;80:5;81:13;
86:2,4,11;95:16;99:4,
6,7,7,17;101:7,14;
103:12,14,15,19;
108:13
Audited (5)
14:20;78:17;82:5;
100:16;101:5
auditing (1)
78:15
auditor (1)
84:24
auditors (5)
78:5,9;92:1,18;
101:9
auditor's (2)
81:8,8
audits (1)
99:1
August (2)
26:10;85:20
authority (1)
150:2
authorized (2)
39:17;150:6
auto (1)
82:12
auto-adjudicated (1)
82:10
automatic (1)
44:11
automatically (1)
92:5
available (8)
14:6;48:3,18;56:6;
67:6;71:19;144:22;
147:23
average (10)
58:18;59:5;88:13;
89:3,6,8;117:21;
118:19,20;122:1
awarded (1)
40:5
aware (3)
39:20;101:20;
131:21
awareness (1)
50:4
away (9)
27:18;31:6;62:1,9;
69:20,24;70:5,11;

141:19
awful (1)
105:14
aye (8)
15:10;63:5;72:7;
77:18;115:8;149:7;
151:2;152:3

B

babies (4)
68:15;69:2,3;70:16
back (42)
19:16;25:16,18;
28:1;37:13;42:7;
60:13;62:4;63:17;
64:2,4,16;69:21;
70:1;71:2,3;77:5;
88:23;89:11;94:13,
19;96:12,13;99:7,23;
107:23;112:24;
117:21;121:22;
132:15,19;136:20;
142:8,9,17;143:13,
18;144:11,16;146:22,
23;150:18
background (5)
37:7;62:13;72:23;
133:9,15
backlog (2)
79:5;98:16
bad (3)
87:18,19;105:12
balance (8)
87:17;89:17,17,19,
23;128:18;140:9;
145:3
balancing (1)
146:24
band-aided (1)
17:21
banner (1)
36:8
Barnes (5)
5:13,14;114:2,3,19
base (6)
55:14;113:13;
137:24;138:1,15;
139:3
based (12)
20:16;51:24;52:2;
53:19;57:18;70:18,
24;87:8;88:3;89:19;
112:6;143:5
baseline (1)
117:3
basic (1)
122:19
basically (6)
33:1;37:21;62:21;
64:15;135:11;136:9
basis (8)
55:11;79:4;102:18;
118:18;119:6;120:6,
10;123:4
bear (1)
11:9
became (1)
106:10
become (4)
6:7;34:24;47:15;
125:21
becomes (4)
29:7;35:16,20;
126:3
becoming (1)
126:11
began (2)
39:8;119:15
begin (3)
46:4;101:8;103:13
beginning (5)
11:15;67:11;118:7;
119:7;148:17
behalf (6)
14:1,3;33:3;78:15;
113:6;119:18
behind (5)
19:3;35:13;80:16;
103:7;120:11
behoove (1)
43:3
below (5)
100:2;116:18;
118:13;119:12;
122:13
benchmark (1)
121:10
Benefit (33)
5:5;50:5;54:24;
55:15,17;56:13;
63:21;64:12,16,21,
23;65:3,21;66:1,8,14;
67:3,6;69:7;70:3;
78:1;97:9;99:15;
109:23;138:13;
140:16,20,21;141:3;
143:2,7,9;148:7
Benefits (56)
7:17,19;8:8,9,10,
12;11:6,12,21;12:20;
14:2,4,5,6,10,21,22;
17:10,11;18:12,15;
19:5,21;20:1,18;
21:12;27:15,16;28:3,
18,24;50:6;57:19;
65:11;69:24;78:2;
94:9,16;97:16,17,18;
98:8;107:8;110:10,
18;112:6;138:18;
139:4;140:2,3,5,23,
24;141:5;144:5;
148:7
besides (1)
103:22
best (7)
39:13;43:22;60:3;
67:19;97:17;103:20;
142:3
Betsy (8)
5:11;56:22;58:13;
70:14;84:12;86:16;
124:20;138:23
better (10)
61:23;68:7;82:21;
84:20;95:14;98:10;
109:3;123:12;
142:22;152:12
biennium (3)
19:8,10;145:8
big (7)
42:21;47:8;51:7;
53:10;70:6;124:3;
143:11
bigger (2)
20:19;125:22
biggest (3)
42:21;43:14;94:7
bill (7)
11:17;87:21;89:17,
23;90:1,2;129:9
billed (1)
105:22
billing (6)
47:5;82:24;87:17;
106:8,9;126:12
billings (2)
87:12,12
bills (3)
7:5;87:20;89:19
births (2)
67:2,2
bit (26)
17:17;18:3;25:3;
26:11;29:5;31:11;
37:7;41:4;61:10,12;
65:4;73:7;88:18;
93:21;98:11;108:21;
110:19;116:5,20;
117:16;133:14;
137:22;138:20,24;
145:19;148:8
Bittleston (26)
5:17,18;15:6,6;
22:19,20;58:16,17;
59:4;60:5;93:19,20;
96:14,22;114:23;
115:2,2;124:1,1,15,
18;150:11,11,21,21;
151:24
black (1)
84:4
blind (1)
10:23
Blue (4)
61:22;119:5;
121:18;122:13
Board (68)
5:5;6:6,17,23;8:5,
7,8,11;9:15;10:8;
13:18,18;14:2,3,9,11,
17,19;20:11;21:10;
29:4;31:3;32:7;37:8,
15;39:17;42:7;44:21;
45:11;48:14;51:14;
56:20;61:20;63:18;
64:1,2,24;65:5,6,23;
71:20;73:2;74:5,7,
18;75:2;76:14,17,22;
86:15,20;90:7;
113:15;115:3;117:6;
133:13,20;134:14,14;
137:10;140:23;
143:11;144:22;
145:20,20;149:22;
151:9,15
boards (4)
40:16;43:10;77:8,9
Board's (1)
80:12
body (1)
53:1
bogged (1)
136:21
Boles (1)
41:24
Bond (1)
49:19
bonuses (2)
7:9;12:21
Book (1)
61:22
books (2)
121:5;128:19
born (1)
69:2
both (15)
8:18;18:14;24:10;
39:1;41:7;48:8;50:8;
67:20;87:2;91:1;
93:17;131:4;140:4;
141:22;143:22
bottom (3)
79:15;80:7;120:13
bounce (1)
121:22
Bowles (6)
37:4;45:9,9;46:17,
20;47:19
box (1)
19:13
boxes (1)
108:3
bracketed (2)
118:18;120:14
branch (6)
28:12,13;29:6;
32:4,11;73:1
brand (1)
31:3
BRAUN (34)
85:10;86:6,22;
87:1;88:11;89:15,22;
90:12,14;91:18;93:3,
5,8;94:6;96:24;
99:12;100:7,10;
102:11,14;103:14,18;
107:5,21;108:17;
109:10,14;110:16;
112:18;113:10;
114:10;128:6;
131:12,16
break (5)
63:14;132:8,11,14,
15
breaks (1)
76:6
Brian (1)
45:9
brief (3)
63:16;93:11;
132:17
bring (11)
28:10,10;37:4;
45:16;54:23;55:5,5;
64:2;78:11;114:7;
143:18
bringing (7)
61:20;62:3;64:4;
98:1;103:23;134:8;
135:20
brings (2)
106:22;108:1
broad (1)
121:15
broader (1)
108:15
brought (7)
46:20;48:8;64:1;
65:5;102:8;134:14;
143:20
Bryan (1)
37:4
bucks (1)
68:24
budget (43)
7:11;18:9,20,21;
19:6;27:5;28:7,11,14,
16,17;29:6,7,20,21,
22,24;30:4,7;31:24;
32:4,5,6,8,10,16,23;
33:1,13;35:11,15;
69:21,23;117:1,14;
119:1;120:16;
135:24;136:7;
138:16;141:1,2,5
budget-building (1)
29:16
budgeted (4)
136:1,7;145:3;
150:12
budgets (4)
31:23;34:4;69:22;
118:22
build (4)

28:14;29:19;46:2,3
building (4)
18:5,5;46:1,6
builds (1)
29:6
built (3)
34:19;35:15;47:2
bulk (3)
40:15,18;75:14
burden (1)
11:9
Bureau (3)
7:4;10:23;43:10
Business (5)
48:6;49:11;50:7;
121:5;126:20
buy-down (7)
138:6;139:9;
140:16,20,21;141:4;
143:2

C

calculations (1)
80:19
calendar (1)
122:9
California (1)
8:24
call (35)
5:4;13:15;15:9;
16:5,9;25:18;26:6;
28:21;63:4,17;66:2;
72:6;77:17;80:12;
87:15,16;88:4;89:16;
90:9;103:9;104:19;
106:2;107:11,15;
110:2,3;111:7,24,24;
123:15;132:19;
135:20;149:6;151:1;
152:2
callback (1)
88:6
called (5)
53:16;55:7;66:17;
92:16;111:12
caller (3)
10:16,18,19
calling (4)
16:17;17:10;110:3;
111:22
calls (10)
17:3;88:14;89:9;
96:19,19,20;103:2,8;
110:9;112:14
calories (1)
53:2
came (9)
26:10;41:16;47:8;
50:18;89:5,7;130:23;
134:17;139:24
Can (106)
5:6;17:12;18:2;
19:8;21:3,10;22:12,
14;24:8;25:10,11,11;
26:18;28:11,22;
29:16,17,19,20;30:7;
33:5;35:1,2;36:11,
15;39:10,14;43:20,
22;44:10;46:2,6;
47:14;48:10,16,17,
20,23,24;49:1,5;
50:14;51:19;52:16,
18;53:10;54:9;56:3,
4;58:8;60:11;61:11;
62:24;64:10,24;65:2,
23;66:10;69:13;
70:10;73:15,20;74:4,
6,14,24;75:1;76:16;
79:1;84:3,7;87:13,
22;96:5,12;97:2;
99:2,4,5,7;102:17;
103:20;106:22,24;
107:1,3,17;109:11;
110:19;111:7,14;
112:3,23,23;113:16,
21,23;120:8;122:13;
125:23;130:18;
132:1;141:21;
143:10;145:4;153:12
cancel (3)
151:9,15,23
cancellation (1)
42:14
Cancer (1)
152:10
Candidate (1)
23:1
candidates (2)
20:23;23:1
cane (1)
11:1
capacity (2)
59:24;91:7
capita (6)
118:2,18;119:6;
120:10;123:4,14
capture (2)
39:9;75:18
captured (2)
64:5;81:13
captures (2)
39:22;75:16
Carahsoft (1)
39:18
cards (1)
110:10
care (12)
9:9,11;11:20;
47:14;50:22;61:23;
70:19;93:12;98:18;
109:24;110:7;127:9
Cari (5)
30:18;149:16,17;
151:7;152:8
carriers (2)
120:22;121:14
Carry (1)
150:13
CARSON (12)
5:1;6:14,15;10:1;
49:19;103:3;104:3,6,
13,16,22;152:18
case (8)
13:15;25:4;31:24;
37:4;42:2;85:3;
141:16;152:23
cases (2)
83:15;126:14
catastrophic (1)
146:18
categories (3)
80:1;120:18;
124:11
category (2)
123:19;124:12
CAUGHRON (6)
5:16;98:14;100:3,
11;102:3;103:6
cause (3)
59:14;94:2;96:23
caused (5)
59:14;94:3,14,16;
96:18
causing (2)
96:16;100:24
CDC (5)
49:21,24;51:21;
54:16,22
CDC's (1)
52:24
CDHP (6)
67:6;134:9;139:2;
143:4,23;144:7
center (3)
16:5,9;54:7
CEO (1)
49:10
certain (4)
35:17;90:8;103:10;
131:23
certainly (9)
43:2;50:21;52:19;
56:9;57:9;61:1;86:4;
89:18;96:12
cessation (1)
64:19
cetera (2)
94:14;107:11
chain (1)
127:8
Chair (23)
5:7;6:16;10:3;
12:5;13:13,23;20:21;
22:19;23:20;45:11;
47:16;58:17;69:18;
75:24;76:11;77:6;
81:21;93:20;105:5;
132:23;152:20;
153:4,11
chairing (2)
51:13,15
CHAIRMAN (91)
5:3,8;6:4;7:24;
9:23;10:1,5;12:3,6;
13:8,14;14:13;15:4,8,
13;20:7;23:18;27:1;
31:21;35:24;36:22;
42:4,17;46:19;47:18;
56:18;58:16;60:6;
61:15;62:10,17;63:3,
8,12,17;67:12;69:16;
71:5,7,22;72:5,10,15,
17,19;75:5,23;76:21;
77:8,15,21;80:23;
81:20;83:17;85:4,7;
86:15;93:19;96:17;
105:4;114:1,20;
115:6,11;124:19;
125:16;130:19;
132:5,10,15,18;
133:1;137:8;144:8;
148:20;149:3,5,10;
150:10,16,24;151:5,
18;152:1,6,14,23;
153:2,6,9,13
challenge (4)
85:14;97:3,5;
110:20
challenges (4)
18:7;30:10;85:13;
114:11
challenging (9)
16:3,4;19:1;21:9;
88:16;95:7;97:11;
98:5;126:11
championed (1)
46:23
change (23)
16:9;19:15;26:11;
30:14;35:6,6;73:18,
21;74:6,8,9,11,14;
75:19;94:4,7,8;
106:2;109:23;
112:23;117:9;127:3;
136:2
changed (5)
16:1;26:1,1;30:14;
78:24
changes (44)
11:8;17:8;18:21,
22;26:1,2,20;27:10,
13;28:1;34:20,22;
35:14,21,21;52:6;
55:10;63:20;65:13,
13;79:18;95:17;
98:23;99:18;109:21;
110:1;117:3,4,4,8;
119:3;123:6,8;
125:11;128:15;
136:24;137:21;
138:10,13,17,21;
143:16;144:3;145:5
changing (2)
35:5,7
channel (1)
10:8
chapters (1)
6:22
charges (1)
129:9
charging (2)
141:18;142:19
chart (2)
79:15;141:11
charts (1)
68:13
check (5)
92:9;103:21;
134:13,18;136:8
chief (1)
86:6
child (1)
144:14
choice (1)
147:14
choices (1)
24:9
choose (4)
24:9;76:11,11;
141:12
chose (1)
140:23
chosen (1)
37:19
Chris (5)
48:2,6,10;59:1;
61:17
chronic (1)
50:22
chunk (1)
136:13
Cigna (1)
125:5
cite (1)
84:11
citing (1)
7:20
CITY (10)
5:1;6:14,15;10:2;
49:19;55:9;104:3,6,
14,16
claim (42)
51:19;77:24;79:5,
14,18,21;80:3;83:21;
84:1,2;85:12,20,21;
89:13;91:3;92:5;
94:4,7,8;96:1;99:22;
101:6;102:23;103:4,
19;105:20,21,22,22;
106:7,15;107:7;
108:2,2;111:23;
112:2,7,10,18;113:1,
7;143:7
claims (62)

50:15;51:16,18;
59:15;79:2,10;80:1;
81:24;82:6,7,10;83:3,
19;84:7;86:11,19,24;
87:5;91:1,1,5,5,15,
20;92:1,22;93:17,17,
23;94:10,11,13,16;
95:20;96:9,15,18;
98:17,22;101:22;
102:24;103:12,15;
112:1;114:4,7;
115:13;116:12,14;
117:15,16,16;118:17;
119:5,11,21;120:7,
10;122:21;123:14;
133:24;134:9
clarification (3)
64:9;76:19;138:24
clarify (2)
140:19,21
class (6)
53:23;59:11;60:12,
13;61:1,9
classes (1)
52:20
clean (3)
44:23;64:5;67:14
clear (5)
18:17,23;43:8;
44:3;141:10
Click (2)
49:19;108:2
client (2)
87:4;121:21
clients (2)
11:1,23
Clifton (1)
14:20
climbed (1)
99:21
clinical (5)
50:10;51:9;65:8;
71:18,19
clinicians (1)
126:12
close (6)
26:20;27:15;47:19;
81:4;105:16;122:11
closely (7)
22:15;38:21;39:1;
41:23;98:21;109:17,
24
closer (1)
122:15
closes (1)
18:20
closest (1)
105:15
Cloud (1)
39:18
co (1)
24:11
coach (2)
52:6,11
coaching (1)
80:4
Coalitions (3)
51:7,8,9
coat (1)
16:13
code (4)
99:15;106:1,8;
112:19
coded (4)
94:9,10;111:7;
112:22
codes (2)
106:4;112:16
coding (2)
112:23;113:2
COFFEY (2)
10:21,21
C-o-f-f-e-y (1)
10:22
COHEN (4)
115:17,17;148:10,
10
collaborate (1)
151:11
collaboratively (1)
39:14
collection (1)
87:5
collections (1)
89:13
collectors (1)
87:21
collects (1)
119:18
colleges (1)
44:6
column (1)
118:14
columns (1)
118:21
combination (2)
52:21;139:8
combinations (1)
144:23
combine (1)
143:1
combined (1)
89:7
coming (14)
17:20;41:9;45:24;
61:1;69:6,7;77:5;
91:1;96:21;100:6;
110:20;118:15,15;
142:8
comment (34)
6:11,12,13,14;8:1;
10:1,2,7,10,18,20;
12:4,9,13,16;13:12,
13,15;24:6,10;34:2;
42:19;45:10;62:19;
67:20;68:1;69:16,19;
70:22;106:20;
116:21;152:18,18,19
comments (6)
10:15;23:17;31:20;
62:10;70:21;71:5
commercial (9)
125:4;128:17;
129:14,15,17,18;
130:1,8,15
commission (1)
73:2
commissions (2)
40:17;43:11
committed (1)
100:1
committee (8)
18:11,16,17;19:2,
23;46:21,23;51:15
commonly (1)
67:4
communicate (4)
36:4,12;56:8;112:5
communication (3)
56:3;100:17,19
community (3)
50:10;51:22;55:18
comorbidity (1)
50:21
companies (2)
49:17;127:18
company (2)
87:16;97:22
compare (4)
116:1;118:21;
120:19;122:6
compared (3)
110:14;117:18;
122:3
compares (2)
120:16;122:1
comparison (5)
8:21;21:24;116:19;
117:12;121:9
compatriot (1)
128:11
compensation (1)
19:24
competitive (2)
20:20;41:4
compilation (1)
121:8
complaining (1)
98:16
completely (1)
39:4
complex (6)
34:24;35:10,13,16,
20;139:1
complicated (3)
28:6;67:3;105:10
complications (1)
59:12
complicator (1)
50:24
complimentary (2)
57:14;58:4
components (2)
140:16;141:6
compounded (1)
96:21
compounds (1)
50:22
comprehensive (2)
38:4;121:13
concern (6)
25:5,13;68:22;
87:18;100:23;145:17
concerned (5)
7:16;68:6;102:4;
109:8;127:6
concerning (1)
98:15
concerns (1)
90:10
Concierge (1)
152:11
concur (1)
77:1
condensed (1)
104:4
condenses (1)
74:22
conditions (1)
59:14
conducts (1)
120:20
confidentiality (1)
55:20
confirmed (1)
64:13
conflating (1)
106:5
conflicts (1)
14:1
confused (2)
26:3;108:7
confusion (2)
19:17;24:12
conjunction (1)
56:9
connected (1)
132:21
consent (5)
14:14,15,18,23;
15:1
consider (4)
8:14;22:13;82:24;
121:23
considerable (1)
128:21
consideration (2)
56:12;99:18
considered (4)
9:18;14:16,17;
66:21
considering (2)
117:10;144:23
consistently (1)
124:21
constantly (3)
100:17,19;103:8
constrained (1)
127:21
constructed (1)
118:7
consultant (2)
108:18;149:24
Consultants (6)
38:4;40:23,23;
67:18,23;101:19
Consumer (1)
133:5
contact (1)
24:3
contents (1)
46:2
context (1)
65:4
continue (4)
16:15;44:19;117:3;
124:9
continued (2)
26:13;124:7
continues (2)
142:19;146:1
continuing (2)
137:3;152:10
contract (31)
37:9;39:5,18;40:1,
2,3,4,6,20,21;42:11,
11;43:4;44:13;86:20;
95:2;119:15;120:3;
126:3;128:2,24;
131:6;132:2;149:15,
23,23;150:1,2,3,7,8
contracted (3)
37:19;126:17;
149:23
contracting (3)
38:9;51:3;103:4
contractors (1)
42:24
contracts (22)
8:6;42:12;117:7;
119:3;123:11,12,16;
125:19,22;126:23,24;
127:3,22;128:4,7,8;
129:12;130:22;
131:3;149:15,19,20
contractual (2)
37:24;133:17
contribution (1)
148:15
contributions (1)
137:11
control (5)
29:5,8,12;30:1;
96:2
conversation (3)

104:10,20;107:24
conversations (8)
19:3;21:11;32:15;
33:7;39:12,19;45:20;
104:1
conversely (1)
145:1
coordinate (1)
41:23
co-pay (7)
9:4,4,17;24:13;
25:3;27:24;147:17
co-pays (9)
8:24;9:8,14;11:11,
13;24:11,19;89:21;
146:4
copied (1)
75:13
corrected (5)
81:10;85:22;94:12;
95:10;113:6
correction (1)
80:14
corrections (1)
99:16
corrective (2)
100:4,7
correctly (9)
81:1;85:18;94:9,
10;99:15;112:4,7,19;
113:3
cost (70)
8:10,18,23;9:3,17,
18;11:6;28:19;29:18;
32:19,21,21;33:11,
11,14;35:15;41:2,3,4;
50:10;51:16,17,18,
19;52:10;53:10,11,
11,13,14;55:4;57:20;
58:6,14;59:8;62:7;
66:21,24;69:3;70:6,8,
16,17;115:22;117:2;
118:2,2;119:11;
120:21;123:13,14,16;
124:3,7,10,13;
125:10,10;126:15,20;
130:3,9;134:4;
136:16;139:14,17;
140:6;141:13;
142:19;147:16
costing (2)
144:6,7
costly (3)
21:23;22:1,4
costs (24)
8:6,16,22;33:8;
53:8;57:19;70:24;
105:13;115:23;
116:1;117:5,9;118:3;
123:15;129:7;
130:23;134:12,19;
135:2;141:18;
145:10,10;148:2,3
Coughron (2)
5:15;98:14
Counsel (2)
7:4;43:10
counseling (2)
57:22;80:1
count (1)
150:16
counting (2)
76:3,5
country (1)
128:12
County (2)
49:18,18
couple (14)
17:24;22:24;52:9;
97:20;116:9;117:21;
118:6;119:13;122:6;
123:22;125:13;
129:5;135:11;140:22
course (9)
24:19;62:23;87:6;
97:5,19;108:15;
109:7;116:6,16
cover (11)
11:18;12:23;33:14;
56:13;66:8;68:23;
69:1,2;73:11,11;
147:9
coverage (16)
50:5;51:11;54:24;
65:11,11;73:24;
109:23;123:20;
138:2,5;142:13;
146:11,14,16;147:15;
148:4
coverages (1)
65:8
covered (8)
55:15;70:17;71:9;
76:15;104:5;107:8,9;
118:4
covering (1)
8:6
covers (1)
76:5
COVID (12)
7:1;50:23;52:19;
64:17;69:20,24;98:4;
116:17;118:15,16;
120:9;129:5
COVID-19 (1)
64:12
crazy (2)
17:18;70:12
create (4)
111:24;126:15;
136:22;137:2
created (2)
6:20;94:20
creates (2)
19:17;97:23
creating (2)
127:8;136:10
credible (1)
122:24
credit (4)
87:21;90:3,4;
141:19
crisis (1)
20:12
criteria (3)
29:3;82:11,14
critical (2)
45:19;142:2
cross (1)
51:12
curious (1)
124:22
current (4)
39:23;116:10;
149:18;152:9
currently (12)
6:20;7:8;11:18;
30:11;38:11;39:16;
65:23;69:4;142:23,
24;145:21;152:21
cushion (1)
134:16
customer (10)
47:5;93:24;96:15;
97:8,14;105:7,19;
109:24;110:7;111:9
customers (3)
102:6,7;105:8
customized (1)
44:5
cut (2)
16:21;52:12
cycle (1)
70:23

D

Darren (9)
86:10;88:11,20;
89:2;92:24;107:23;
111:17,18;112:20
data (10)
50:12,13,14;79:10,
12;118:9;122:24;
123:3;125:4,7
date (4)
37:18;88:16;131:5;
150:1
day (12)
36:10;82:20;84:9,
23;88:15;90:20;
92:22;93:14;101:3;
132:3,12,13
days (11)
7:6;88:18;90:22;
99:23;100:12;114:4,
14;131:6,12,24,24
deadline (2)
7:5;75:4
dealing (1)
97:10
decided (4)
37:23;39:13;77:3;
92:14
deciding (1)
143:11
decision (4)
9:10;38:12;42:7;
70:11
decisions (2)
8:17;145:20
declining (1)
135:6
decrease (1)
135:14
decreased (1)
140:3
decreasing (2)
129:12;135:6
deductible (27)
24:18,21,23,24;
63:22;64:20;65:15;
67:7;133:6;134:10;
138:4,4;141:12,22;
142:7;143:17,17,19,
22;146:9,16;147:8,
17,22;148:11,13,14
deductibles (1)
17:14
deem (1)
112:3
deep (2)
65:8,17
deficiencies (1)
134:11
definitely (6)
12:19;18:11;25:24;
59:8,12;86:7
definition (1)
75:9
definitions (1)
75:20
degree (2)
90:24;123:1
delay (1)
94:15
delayed (3)
86:19,24;104:7
D-e-l-g-a-d-o (1)
12:18
Delgado-Acosta (3)
12:14,17,18
delivery (1)
52:18
demographics (1)
123:8
denials (1)
99:1
denied (2)
106:7;111:11
dental (12)
11:13;79:1;115:24;
116:17;117:18,23;
120:8,17;121:1,17,
19;122:4
dentures (1)
11:19
deny (3)
82:12;92:5;148:4
department (2)
36:20;73:2
departments (1)
23:24
dependent (1)
58:20
dependents (3)
59:21;118:3;133:5
depending (3)
53:9;56:12;60:13
Deputy (1)
13:19
descending (1)
73:4
described (1)
92:2
description (1)
72:13
design (12)
8:14,18;9:16;
45:18,23;69:8,12;
79:9;109:23;119:3;
138:6,10
desk (1)
16:8
detail (4)
79:16;80:16;
123:23,23
determination (2)
84:2;112:2
determine (2)
79:18;112:8
DETR (1)
10:22
develop (1)
123:17
developed (2)
38:4;51:21
developing (2)
38:6;52:13
development (4)
45:19;124:7;
133:11,12
developments (1)
117:14
Diabetes (27)
47:22,22;48:12;
49:22,22;50:4,18,19,
20,23;51:18,20;52:1,
13;53:3,5,6,17;54:4;
57:1,17;58:2;59:7,9,
12,14;60:24
diabetic (2)
53:19;58:19
diabetics (7)
53:7,10;54:14;

57:23;58:12,22;
60:23
diagnosed (2)
52:15;53:18
diagnosis (1)
50:20
diagnostic (1)
112:23
died (1)
106:1
difference (3)
33:2;47:6,8
different (36)
9:7;21:19;22:5,16;
39:5;41:8;49:14;
51:23;52:6,18;57:7,8,
10,11,14;58:7;76:9;
93:15,16,17;102:2;
110:17;116:21;
123:20;133:21;
135:13;138:20;
142:24,24;143:4,7,8,
9;144:1,23,24
differentiator (1)
107:3
difficult (11)
6:24;18:24;19:16;
24:20;27:9;30:24;
33:20;55:10;75:19;
96:20;97:8
digits (2)
10:11,16
direct (2)
51:3;118:13
directing (1)
120:12
directions (1)
39:15
directly (2)
56:3;114:9
director (7)
6:18;8:4;48:13;
54:12;57:12;86:11;
100:13
disability (3)
7:13;32:18,20
disagree (1)
147:21
disagrees (1)
83:15
disappointed (1)
27:4
disclosure (4)
13:18;14:1,5,12
discounts (1)
126:19
discover (1)
103:13
discovered (3)
47:13;85:17,19
discretion (1)
145:5
discuss (1)
103:3
discussed (3)
13:6;64:24;151:20
discussing (6)
31:14;45:18,18;
116:22;145:14,14
discussion (33)
14:24;15:9,20;
21:15;23:23;26:24;
36:22,24;47:21;62:4,
18;63:4,19;67:12;
70:2;71:22;72:6,19,
20;75:5;76:21;77:16,
23;115:7;126:8;
133:2;144:8;148:20;
149:6;151:1,18;
152:2,15
discussions (3)
28:9;48:9;142:3
disease (4)
50:16,23,23;57:12
disruption (2)
19:22;137:4
distance (1)
52:20
distinct (1)
51:13
distinction (2)
116:24;119:1
distribute (2)
136:18,20
District (1)
49:18
dive (2)
65:8,18
diverse (1)
125:7
division (1)
39:20
doctor (7)
13:4;67:21;93:12;
112:16,19;147:5,9
doctorate (1)
71:16
doctors (2)
93:15;124:15
document (3)
67:9;73:21;74:4
documentation (3)
82:23;92:18;
113:20
documents (5)
19:11;35:8;63:21;
64:15;73:16
dollar (9)
22:11;58:18;59:4;
119:7;136:11,11;
138:3;143:8;148:14
dollars (1)
136:18
done (18)
15:23;19:14;20:17;
35:1,18,20;36:16;
41:11,11;62:1;75:18;
77:4;86:3;98:6;99:6,
11;134:17;142:1
dotted (1)
122:8
down (23)
20:17,18;36:8,10;
40:19;56:12;76:6;
85:16,20;87:22;
88:23;90:16,19;91:4;
99:23;106:1;113:15;
114:13;118:13;
128:16;135:3;137:4;
140:8
downtime (3)
18:3,7;36:3
dozen (1)
91:5
DPP (7)
51:20;52:13,24;
53:11;54:24;56:13;
60:13
draft (2)
78:19,19
drafted (1)
100:5
dramatic (1)
90:21
dramatically (3)
88:14,19;90:18
draw (2)
84:14;116:24
drew (1)
70:22
drive (1)
51:19
driven (3)
125:21;127:18;
133:5
driver (1)
124:5
drop (7)
31:19;44:5,7;
69:20;99:24;131:18;
132:1
dropped (2)
88:14;90:17
dropping (2)
130:14;131:21
drug (3)
117:5;119:17;
121:17
drugs (4)
115:24;124:8,11,
14
DSME (1)
61:9
DSMES (5)
53:17,23;54:24;
56:13;60:12
due (8)
89:19;96:5;124:3,
6;143:6;150:4;151:8,
14
dues (1)
6:20
dupe (2)
82:7,14
dupes (2)
96:8,10
duplicate (17)
79:21;80:1;82:9;
83:1,3,5,14,19;84:1,
3,21;91:15,20;92:6,9,
11,15
duplicates (3)
83:10,22;84:13
duplicative (4)
57:4;58:4;74:20;
81:24
duration (1)
150:3
during (10)
16:11;18:16,17,21;
42:13;52:19;64:17;
65:6;98:3;143:20
dynamic (2)
116:14;120:1

E

earlier (5)
61:9;91:14;93:1;
143:6;151:20
early (1)
46:10
easier (3)
43:5;74:11;147:3
easy (5)
35:4,18;73:7;97:7;
136:19
eat (1)
53:20
eating (1)
52:16
Eaton (12)
45:24;149:16,17,
18;150:13,13,17;
151:7,7,21;152:8,8
edit (1)
92:9
editorializing (1)
25:4
edits (2)
96:4;98:24
educated (1)
25:8
educating (1)
23:15
Education (2)
47:23;53:17
effect (3)
7:15;96:23;118:16
effective (3)
50:10;117:17;
120:9
effects (1)
127:13
efficient (2)
43:17,23
effort (5)
6:8;20:22;26:5;
94:14;95:10
efforts (3)
16:3,24;21:8
egg (3)
136:11,12;144:21
eight (6)
54:16;72:16;84:16;
117:15;121:16;122:2
EIT (1)
36:19
Either (13)
23:5;40:7;56:2;
59:9;60:11;76:15;
81:14;91:19;95:6;
104:14;116:6;
135:14;147:13
electronic (3)
79:9,23;113:8
eligibility (17)
37:2,15,17;38:7;
40:9;42:22;43:1;
46:4,12;74:2,4,5,14;
75:17;107:10;
151:10,13
eligible (5)
14:2,4,4,10;56:10
eliminate (1)
79:19
eliminating (1)
70:3
else (8)
42:8;86:12;91:14;
97:22;100:18;
102:18;145:12;153:9
e-mail (4)
26:6;105:18;
106:11;107:2
e-mailing (1)
16:18
e-mails (1)
142:14
embarrassing (1)
11:22
emergency (1)
64:13
employee (21)
8:5,9;19:24;21:1,
21,22;22:20;23:4;
27:3;53:15;55:1;
75:21;106:6;108:8;
109:9;112:14;118:2;
119:8;139:2;140:17;
142:5
Employees (46)
6:18;8:13,18,23;
9:3,6,17;11:6,9,20;
12:1;18:14;21:16;

22:4,11;24:8,11; 25:17;26:17;27:16, 18,20,23;28:2;31:11; 33:3;52:5,14;54:23; 55:5;56:4;59:21; 61:23;62:2;75:21; 104:4;105:19;106:4, 24;118:3;123:20; 133:4;142:24;143:3; 147:24;148:7
Employees' (4) 5:5;8:7;14:21;78:1
employee's (1) 25:1
employer (5) 55:2,22;74:1; 141:20;144:14
employers (12) 49:14,14;50:15; 51:5,17,23;54:23; 55:12;59:19;125:3,6, 8
employment (1) 133:22
encompass (1) 33:1
encountered (2) 85:13;86:1
encourage (2) 9:15;11:24
encouraged (1) 9:13
end (19) 11:15;27:3;31:20; 41:9;80:16;90:3,18; 93:13;95:8;99:4; 101:16;107:24; 108:4;116:6;118:9; 119:8;120:11;145:1; 153:12
ended (2) 11:15;76:1
ending (1) 64:13
endocrinologist (2) 68:3,8
ends (1) 31:11
energized (1) 46:15
engaged (1) 38:11
enhance (2) 96:6;102:15
enhanced (1) 32:17
enhancement (1) 98:23
enhancements (4) 29:18,19;143:7,9
enough (5) 62:5;87:15;92:17; 98:19;119:22
enroll (1) 62:23
enrolled (1) 88:17
enrollee (1) 87:4
enrollment (36) 16:11,14,24;17:6, 17;18:19,19,22; 19:11,15;24:1,5,8,22; 25:5;26:20;27:7,16; 34:7,14;37:2,14,17; 38:6;40:9;46:4,12; 73:13;109:8,12,18, 19;123:8;133:16; 151:10,13
enrollments (1) 123:3
ensure (5) 25:19;40:14,23; 47:1;65:11
ensuring (2) 143:12;146:18
entire (3) 38:19;69:7;125:4
entities (2) 43:12;121:1
entity (1) 87:11
entry (3) 7:10;9:6;21:2
EPA (1) 63:22
EPO (16) 64:20;67:7;134:6; 138:5;140:11; 141:17,23;142:14,19; 143:4,23;144:4; 145:22;147:2,16; 148:6
EPO/HMO (1) 142:11
equally (2) 144:15;146:24
equation (1) 35:10
ERP (8) 37:1,20;38:19,21; 43:7;45:23;46:2; 151:14
error (3) 80:13;84:11;89:22
errors (6) 79:17,20;80:5,6, 18;85:21
escalate (2) 104:23;108:10
escalated (2) 100:22;114:5
ESI (1) 119:18
especially (8) 7:10;35:3;44:9,20; 70:15;104:3;116:22; 129:14
essential (1) 44:13
essentially (2) 106:15;147:15
establish (1) 51:24
et (2) 94:14;107:11
eternity (1) 34:15
even (23) 11:21;12:21;13:1; 19:1,5;24:4,5;41:19; 51:16;69:10,22; 70:23;75:9;78:7; 101:8;108:16;125:6, 24;135:6;137:11,16; 138:24;141:21
evenly (1) 137:14
eventually (1) 50:4
Everybody (5) 6:6;13:21;15:21; 107:24;132:22
everybody's (1) 44:15
everyday (2) 100:18;101:17
everyone (8) 23:24;34:11;36:5; 73:22;91:14;148:11; 153:3,9
everyone's (1) 69:15
evidence (5) 51:24;52:2;53:19; 55:14;83:13
exact (1) 92:4
exactly (9) 39:22;46:18;78:23; 82:12;92:2,15; 139:10;140:18;143:3
exaggerated (1) 98:3
exam (1) 62:2
examiner (1) 82:15
examiners (1) 39:17
example (4) 32:16;101:22; 136:19;138:4
Excel (1) 35:11
Excellent (1) 126:5
exception (2) 28:22;29:2
exceptions (2) 26:8,13
excess (3) 140:22;141:2,4
exciting (1) 51:15
Exclusive (1) 133:6
excuse (2) 116:13;118:10
executive (29) 6:18;15:19,20,22; 16:22;23:21;28:12, 13;29:6;32:4,11; 37:3;45:20;46:21,22; 47:24;67:17;72:20, 21;73:1,8;78:14,22; 80:16,21;102:21; 106:21;108:10;116:8
exempt (1) 6:22
exercise (1) 61:12
exercising (1) 52:16
exist (5) 46:5;69:3,4; 143:18,20
expect (10) 39:6;90:18,22; 91:9,11,19;120:1,6; 121:2;135:2
expectation (2) 121:9;122:5
expectations (1) 120:22
expected (9) 88:2,10;114:12; 117:9,19;122:7,8,10; 124:9
expecting (3) 119:14;122:15; 136:6
expenses (1) 133:18
expensive (3) 25:1;68:22;124:14
experience (6) 87:8;111:3;115:13; 122:21;123:5;133:24
experienced (11) 7:1,17;38:14; 66:24;79:6;86:19,23; 111:4;121:4;123:7; 134:7
expert (2) 71:18,19
experts (3) 45:17;46:10;47:1
explain (2) 7:21;147:13
explaining (1) 133:11
explicitly (1) 64:21
exploring (1) 42:20
Express (3) 110:5;119:16; 120:24
extended (2) 7:5;114:15
extends (1) 45:4
extension (1) 7:4
extent (1) 87:5
external (1) 103:23
extra (3) 6:7;33:6;141:20
extreme (1) 23:24
eye (1) 30:19
eyes (2) 88:9;102:2

F

face (1) 6:24
facilitate (1) 43:16
facilities (1) 128:17
facing (1) 50:22
fact (8) 19:12;39:21;68:2; 71:1;85:11;110:17; 113:7;127:18
factor (1) 117:17
factors (2) 8:19;23:9
fail (3) 87:3,4,4
fails (1) 82:23
faint (1) 52:2
fairly (7) 17:8;26:3;43:19; 65:12;86:2;97:14; 121:13
fall (1) 82:15
familiar (3) 77:10;86:9;107:22
families (4) 14:4;22:10;62:15; 70:10
family (10) 14:7,9;21:20,23;

22:1,4;70:4;118:5;
123:21;138:3
Fantastic (1)
42:16
far (9)
26:12;31:7;60:23;
69:20;101:21;
102:16;113:14;
120:11,13
fashion (1)
114:8
fast (1)
83:4
favor (21)
7:11;15:10,11;
17:7;63:5,6;72:7,8;
77:17,19;115:8,9;
141:24;145:16;
146:20;149:7,8;
151:2,3;152:3,4
favorable (2)
119:16;133:24
favorably (2)
116:9;145:7
February (4)
18:11;88:22;89:5;
97:3
federal (2)
64:12,13
federally (1)
6:21
fee (2)
87:19;150:7
feedback (1)
80:4
feel (10)
31:15;55:21;57:13;
59:22;70:3;73:6,8;
104:17;144:17;
146:23
feeling (6)
23:24;104:7,8,18;
125:24;126:10
feels (1)
73:9
fees (1)
123:14
felt (1)
112:15
fertility (5)
66:4;67:20;68:2,9;
71:9
few (17)
16:4;29:1;31:16;
64:3,4;65:19;66:10;
81:19;83:3,15;86:17;
91:5,19;92:20;
122:17;135:13;138:9
field (1)
127:20
figure (5)
19:19;39:14;90:1;
97:16;107:13
figuring (1)
19:20
file (1)
107:17
files (1)
44:10
fill (1)
113:18
filled (2)
13:1;73:13
fills (1)
108:3
filtered (1)
144:21
final (2)
80:14;91:13
finalized (1)
134:18
finally (2)
80:3;106:14
finance (2)
18:10;28:21
Financial (8)
14:20;37:21;39:22;
41:21;61:20;79:13,
17;80:11
find (10)
23:14;47:10;53:23;
55:3;59:17;85:15;
97:6;102:5;106:12;
142:23
finding (3)
18:12,13;99:10
findings (9)
77:24;78:10,18;
79:24,24;80:22;81:8;
99:5,8
fine (2)
36:18;153:13
first (34)
6:14;19:9;21:1;
26:12;28:7,20;31:3;
32:9;45:10;49:7;
50:9;59:3,6;62:9;
64:11;72:23;78:16;
88:14,15,15,17;
95:15,16;97:19;
99:17;106:19;
111:19;114:7,11;
124:13;135:1;
146:14,15;147:10
fiscal (3)
30:13,21;78:24
fit (1)
144:2
five (17)
53:1;65:1,24;
74:15;76:2,5,6,19;
82:7,11,14,14,15;
118:24;129:2,3;
130:22
fix (4)
83:21;94:13,19;
99:11
fixed (2)
123:15;146:3
fixes (1)
99:6
fixing (2)
85:16;94:16
flags (1)
98:24
flat (11)
28:16,17;120:10;
134:24;135:4;136:9,
24;141:11,21;145:6;
146:6
flexibility (7)
21:6;41:5;45:11;
98:8;144:23;145:2,
13
flexible (1)
26:4
focus (11)
11:5,11;12:20;
13:6;18:12;22:7,8;
57:15;70:9;79:20,23
focused (3)
19:24;103:19;
105:8
folks (9)
16:12;38:24;43:15;
45:17;47:13;58:19,
23;124:3,4
follow (3)
78:21;99:2;126:1
following (1)
67:11
follow-up (18)
44:2;46:20;60:17;
61:5,13;83:8;84:13;
96:14;101:13;109:7;
110:13;111:5;
112:13;127:15;
130:18,21;141:10;
144:10
food (1)
84:15
forced (1)
145:2
forget (1)
37:10
form (2)
18:14;113:18
formal (3)
78:20;80:17;100:4
forms (2)
73:13,13
formula (4)
142:18;144:12,16;
146:22
fortunately (1)
133:23
forward (18)
9:10;13:6;22:7;
32:2;37:16;39:14;
40:9;56:14;63:11;
79:20;98:13;100:2;
108:16;116:23;
117:3;120:7;123:4,5
found (9)
50:19;51:16;54:13;
57:7;90:8;92:16,22;
94:10;99:14
foundation (1)
53:19
founded (2)
52:22,23
four (12)
10:11,16,18,19;
82:11,13;88:5;92:8;
117:14;118:1;122:3,
4
fourth (3)
24:23;99:13;109:4
Fox (14)
5:9,10;15:2,2;48:7;
62:19,19;115:5,5;
149:4,4;151:19,19,22
frame (1)
131:5
frantic (1)
28:21
free (3)
21:23;22:3;62:20
fresh (1)
63:15
front (5)
11:22;16:8;23:12;
147:13,16
fruit (2)
73:7;75:1
frustrate (1)
76:22
frustrated (2)
77:10;105:20
frustrating (1)
111:4
full (5)
102:5;123:17;
139:17;145:10;
148:16
fully (2)
49:15;114:12
functionality (1)
37:2
Fund (3)
14:21,22;35:2
funded (2)
138:19;148:16
funding (5)
7:12;9:16;11:8;
19:5;136:19
funds (2)
150:12,14
Further (26)
10:1;12:4;15:9;
36:22;62:10,17;63:4;
71:22;72:6;76:21;
77:16;79:16;85:4;
87:21;111:21;112:1,
11;114:1;115:7;
132:5;144:8;146:23;
149:6;151:1,18;
152:2
future (9)
8:16;12:21;33:4,
19;62:7;120:2;
134:18;135:6;150:5
FY22 (1)
14:22

G

gather (1)
106:1
gearing (1)
109:12
General (6)
13:19;18:8;88:13;
114:17;125:2;137:3
generally (6)
24:10;69:8;120:17;
122:21;125:9,11
generating (1)
135:19
generically (1)
56:4
geography (2)
104:11,21
get-go (1)
44:14
gets (10)
25:15;31:17;33:24;
47:3;75:14;92:9;
100:21;103:9;
107:24;146:22
GFO (1)
29:22
giant (1)
120:6
gist (1)
75:16
given (6)
21:6;25:20;27:5;
41:21;56:15;98:8
gives (2)
101:12;145:13
giving (6)
28:1;30:19;56:11;
112:17;141:20;144:5
glad (3)
13:5;23:22;62:3
glean (1)
82:5
gleaned (1)
124:23
goal (4)
44:12;50:3;55:17;
65:10
goes (11)
15:22;33:12,15;

35:22;36:13;43:15;
59:4;93:12;133:11,
12;148:6
gonna (4)
73:6;106:9;115:19;
147:7
Good (34)
6:16;8:2;13:21;
15:21;28:5;43:18;
44:15;45:7;54:1;
57:3,6;59:1;61:18;
68:18;85:6;86:4;
95:23;100:21,22;
108:7,18;110:22;
115:15;121:9;
125:12,20;129:24;
132:20,22,23;133:10;
136:21;138:22;
142:15
Google (1)
66:14
gotta (1)
98:1
government (3)
64:12;128:16;
129:19
governments (6)
8:21,22;21:17,21,
24;22:2
government's (1)
118:22
Governor (6)
32:6,12;72:23,24;
75:3;76:24
Governor's (6)
28:21;29:7;30:4;
32:5,10;46:24
gradually (1)
120:5
grant (2)
54:21;58:14
graph (2)
118:1;120:8
graphs (1)
118:6
grasp (1)
152:12
gray (1)
84:3
grease (1)
33:24
great (13)
8:10,12,12;26:21;
36:16;42:20;43:5;
47:17;49:7;62:20;
136:15,17;142:1
greater (1)
54:20
green (1)
121:17
grew (1)
114:12
grocery (1)
126:1
Group (9)
48:6;49:11;50:7;
56:8;60:2,9;84:20;
95:20,22
groups (10)
51:23;55:1,2,3;
60:10,14;125:6;
137:12,14,17
guarantee (4)
88:6;94:24;127:2,2
guarantees (8)
79:7;80:8,9;81:13;
108:19,24;119:17;
120:1
guess (11)
13:22;24:5;25:16,
20;26:23;27:21;
58:24;106:22;
107:23;131:9;148:5
guidance (1)
25:19
guide (1)
25:11
guideline (2)
30:3,5
guidelines (1)
29:22
guys (4)
31:24;101:16;
105:10;112:22

H

half (5)
54:4;119:14;
136:10,10,18
hand (3)
32:23;48:10;
114:15
handful (2)
91:5;124:12
hand-in-hand (1)
58:3
handled (1)
127:1
hands (1)
29:9
hanging (2)
73:7;75:1
happen (6)
30:18;99:13;
104:12;106:16;
111:12;123:12
happened (7)
41:14;85:14,19;
87:23;106:10;120:3;
141:1
happening (7)
26:14;38:11;44:23;
99:2;101:12;120:20;
121:7
happens (7)
27:7;52:21;92:2;
93:12;110:4;112:13;
122:11
happy (12)
9:22;20:5;24:15;
56:16;61:19;62:7,8;
63:1;86:4;102:19;
105:3;108:22
hard (21)
13:2;23:8;31:16,
17,18;52:4;61:10;
71:1,2,4;82:14;83:4;
84:8,14;95:9;97:6;
99:23;106:3;108:24;
139:1,7
harder (2)
61:10,12
hardline (1)
84:5
harm (1)
129:13
hate (1)
24:4
heads (1)
49:9
health (22)
8:15,17;11:12;
14:22;48:7;49:11,11;
50:8,8,11;51:2,19;
55:23;59:15;61:20;
120:20;125:2,8,9;
133:5,7;148:12
Healthcare (15)
7:18,19;8:6;28:19;
33:12,20;50:10;51:7,
8,10,11;54:7;129:1;
135:2;136:16
healthier (2)
53:21;62:7
HealthSCOPE (6)
78:16,23;79:4;
105:23;111:1,6
healthy (1)
52:15
hear (9)
44:19;68:7;93:5;
98:15,20;101:10,11;
104:18;108:14
heard (7)
7:2;23:23;25:18;
31:4;45:14;68:22;
133:23
hearing (13)
24:10,13;67:17;
68:10,12;70:18;
77:16;100:12;129:6,
11;144:13;146:10;
152:15
hears (1)
100:17
heart (2)
23:16;52:2
heck (2)
47:6,9
held (1)
83:6
Helmut (3)
86:6;129:1,10
help (31)
16:11;17:12;18:14;
20:12;21:7;25:14;
36:20;45:15,22;
50:17;51:24;55:18;
60:8;79:19;86:13;
87:11,13;89:12,24;
90:5,9;96:2,3;97:1;
99:7;107:1;109:12;
110:7;134:18;136:8;
153:9
helped (3)
83:15;90:2;95:22
helpful (2)
107:4;142:4
helping (1)
87:9
helps (2)
122:22;140:11
here's (1)
53:7
hey (5)
26:11;32:12;111:7;
112:21;141:14
Hi (3)
61:17,18;86:16
high (35)
8:22;9:1,2,8;24:18;
46:24;51:16,17;
65:15;66:13,20,20,
24;67:2;69:3;70:16;
80:21;97:14;105:13,
14;122:19;124:7;
129:8;134:7;138:3,4;
141:11,22;142:6;
145:22;146:1,9;
147:7,22;148:11
higher (20)
12:22;21:7,17;
53:13;70:17;93:22;
94:1;108:20;116:12,
13,15;117:18;120:4,
4;124:10;125:10;
129:8;136:6;144:6;
147:3
highest (1)
80:10
highlights (2)
115:20;126:6
highly (2)
84:22;92:5
hire (4)
20:23,24;21:7;
75:10
hiring (1)
22:21
historic (3)
118:14;122:21;
123:3
historically (2)
100:16;126:19
history (1)
86:24
hit (5)
33:21;76:3;115:19;
129:16,17
HMO (3)
134:6;140:12;
147:2
hold (2)
74:21;108:19
holiday (1)
88:17
Hollie (7)
91:21,21;92:20,23,
24;93:1,1
hooks (1)
46:3
hope (4)
7:8;13:6;70:6;
148:4
hopefully (4)
50:5;95:12;109:5;
114:17
HOPKINS (14)
10:3,6;12:5,7,11;
13:9;48:21;49:2;
132:23;152:20;
153:1,4,8,11
Hospital (1)
129:23
hospitals (1)
129:6
hours (5)
18:6;36:3,12;54:4;
84:16
housekeeping (2)
64:5;67:9
HR (6)
23:23;37:21;38:18;
39:22;41:21;44:11
HRA (4)
35:3;72:12;136:19;
148:15
HRA's (1)
27:22
HSA (4)
35:3;136:19;
148:12,15
HSA's (1)
27:22
HUCKABY (8)
85:6;102:20,20;
103:7,17;109:16,16;
111:17
huge (2)
47:15;51:12
human (4)
70:11;113:9,10,11
hurt (1)
58:6

hurting (1)
144:12
husband (2)
12:23;59:8
hypertension (1)
57:10
hyphen (1)
12:18

I

IBNR (2)
101:22;102:1
ID (2)
103:11;110:10
Idaho (1)
8:24
idea (6)
33:8;42:20;48:8,11;62:20;101:12
ideal (1)
142:13
ideas (1)
34:17
identification (3)
56:10;83:9;84:1
identified (15)
41:19;54:9,19;58:11,21;59:16;60:14;65:21;66:6;67:10;73:6;79:17;80:5;93:23;127:11
identify (11)
53:21;56:1,8;59:20;60:15;94:2;98:24;99:5;103:10;133:20;151:12
identifying (1)
59:18
idiosyncrasies (1)
97:10
IFC (2)
150:15,16
immediate (1)
19:21
immediately (2)
45:22;114:6
impact (9)
9:5;27:23;101:21;103:9,11;104:15;128:19;134:3;136:14
impacts (1)
9:3
impaired (1)
10:24
imperative (1)
38:21
implement (2)
40:13;98:23
implementation (5)
37:1,11;38:15,22;43:7
implemented (4)
62:8;119:3;123:11;138:13
implementing (2)
57:24;117:7
important (12)
8:17,19;24:9;25:11;38:17;54:11;55:20;58:5;69:14;108:13;117:8;130:17
impossible (1)
30:23
improve (4)
19:21;27:15,21;109:1
improved (2)
88:19;97:3
improvement (5)
89:4,8,10;90:21;95:13
improving (3)
11:2,6;27:16
inaccuracy (1)
94:18
inaccurate (3)
86:19,24;87:12
inappropriate (3)
32:13;89:18,23
in-between (2)
101:14;140:3
incentive (2)
62:3;83:22
incentives (3)
61:20,22,23
incident (3)
53:4,6;146:19
incidents (1)
53:3
include (4)
28:11;39:10;133:2;150:14
included (8)
42:24;43:4;44:9,14;58:18;64:6;100:8;123:17
including (5)
7:3,12;16:22;31:12;64:3
incoming (2)
20:23;91:10
in-contract (1)
94:23
Incorporated (1)
77:24
incorrect (1)
106:9
incorrectly (8)
94:19;111:7,15,23;112:3,9,16;113:7
increase (18)
9:14;19:5,5;33:16,16;45:5;50:3;61:2;119:22;120:5;127:19;135:3,5,14;136:13,17;150:3,8
increased (7)
11:10;59:8,11,15;98:7,7;110:8
increases (6)
119:9;125:24;129:8,16,19;150:2
increasing (6)
11:2;35:3;53:2;119:13,21;130:15
incredibly (1)
105:20
incurred (2)
95:4;101:22
independence (1)
11:2
independently (2)
11:2;134:6
indicate (2)
36:2;121:2
indicated (1)
67:24
indicating (1)
121:24
individuals (1)
23:5
industry (30)
40:22;65:12,12;66:1,8,22;87:15;116:2;117:19,19,23,24;120:20,23;121:1,7,8,10,13,17,20,24;122:5,7,10,15;124:22;125:3,3,7
industry-wide (1)
116:14
inflation (3)
125:21;127:17;129:7
influence (2)
29:10;33:5
information (14)
36:24;42:10;56:15;83:8;106:24;107:1,6,10,12,15,16;111:24;116:5;120:24
informational (1)
15:20
informational/discussion (1)
37:3
informative (1)
56:19
initial (4)
27:5;43:4;117:8;118:16
initiatives (2)
117:7;119:2
in-network (1)
87:2
in-person (3)
6:6;52:19;153:15
input (2)
121:12,13
instance (2)
59:8;112:11
instead (2)
40:11;141:15
instructions (2)
28:14,15
instructor (1)
10:24
insulin (3)
57:20;58:20;59:7
insurance (17)
7:14;8:15,18,22;11:15,18;12:23;13:2;32:17;65:13;66:9;87:6,7,14,16;133:22;147:12
insured (1)
49:16
insurer (1)
130:9
insurers (2)
120:23;121:14
integrate (3)
37:20;43:1;44:10
integrating (1)
41:17
integration (5)
37:1;44:10;45:18,23;46:6
integrations (1)
44:18
integrator (4)
38:1,9,13;40:22
integrity (1)
143:14
intelligence (1)
97:14
intention (1)
8:20
interest (2)
14:1;39:13
interested (1)
18:13
interesting (2)
23:2;62:22
interface (1)
47:5
internal (1)
103:14
internally (4)
16:20;20:17;103:12;109:9
International (1)
8:4
interpret (1)
97:15
interpretation (2)
82:18;92:11
interrupt (1)
143:10
interview (1)
23:6
interviewed (1)
23:6
interviews (3)
20:16;22:22;23:4
into (43)
20:19,19;23:16;29:19;32:10;34:19;35:9,15,15,22;41:19;45:17;46:1;57:8;59:4;65:8;70:2;74:6,22;85:22;87:24;90:16;92:19;95:15;99:18;101:6;111:13,21;112:11;116:18;117:17;121:12;123:17;128:2,3;133:9,11,15;134:15,15;141:2,5;145:8
introduce (1)
49:8
introduced (1)
24:21
introducing (1)
48:6
introduction (1)
124:7
inventory (14)
90:15,15,17,19;91:10;96:2;99:21,24;101:18;102:12,15;114:12,12,14
invite (1)
14:11
irate (1)
106:11
IRS (1)
148:13
issuance (1)
80:14
issue (12)
72:24;82:1;96:15,16;100:23,24;103:3,5,13;112:17;114:17;127:10
issued (1)
37:24
issues (22)
7:16;8:18;23:16;24:3;42:22;47:15;85:24;90:3,15;93:23;94:15,20;95:23;96:18;97:12;98:12,18;101:4;102:6,7,8;111:3
Item (44)
13:17,23,24;14:14,18,20;15:16,17;21:14;36:23;42:6,10,13,15;45:12;47:19,21;62:16;63:13,19,23;64:3,11;69:19;70:2;71:23;74:17;76:2,5;92:8;114:22;115:12,18;125:18;

132:18,20;149:13,14,18;151:8,8;152:9,13,17
items (23) 13:19;14:6,15,16,23;64:2,5,7,10;65:5;67:9,14;69:22;74:11;75:15;76:2,3,5,5,7,12;92:4;117:10
iteration (1) 34:9
iterations (1) 34:13
IUI (9) 63:21;64:3,23;65:21;67:15,21;68:5,8;72:3
IVF (1) 66:4

J

Jacy (2) 113:13;128:23
Janelle (4) 5:23;31:22;71:8;147:1
January (12) 14:19;37:18;72:24;88:4,7,14,15,18,21;89:1,3;97:2
JEFFERSON (7) 113:13,14;128:23,23;131:3,10,14
Jennifer (1) 5:19
Jim (3) 5:13;46:23;114:3
Joan (1) 78:14
Joanna (1) 71:11
job (14) 23:6,7;32:14;36:16;86:4;97:7,7;105:8,9;108:18;110:22;133:10;142:1,22
jobs (1) 97:8
job's (1) 23:7
join (3) 40:2;71:12,20
joined (2) 10:10;153:11
joint (1) 18:10
July (5) 57:24;63:22;78:2;110:11;133:3
jump (2) 91:16;128:7
June (6) 11:19;26:12;63:22;110:9;133:3;150:1
justification (2) 82:24;85:1
justify (1) 84:9
justifying (1) 82:22

K

Kaiser (1) 125:6
keep (33) 12:20;16:18;24:9,13;28:19;68:10,12;72:3;77:5;91:2,8,9,10,11;96:20;98:1,5;100:13;105:3;135:8;136:23;139:13,23;140:8;141:11,15,21,21;143:2;144:12;145:6;146:10,13
keeping (5) 11:11;100:1;135:4;136:9;141:6
Kelley (90) 6:1,2;23:19,20,21;26:16;30:9,20;31:1,1;36:1,21;42:17,18,18;44:1,1;46:13,18;47:16;48:24;60:6,7,7,16;61:4,4,14;63:2;67:13,13;71:21,24,24;75:6,20;77:6,13;81:20,21,22;83:7,7,16;105:4,5,6;108:6;109:6,6,11;110:12,12,24;111:19;112:12;113:4,8,12,15,24;125:16,17;126:7,21;127:4,15;129:20;130:18,20,20;131:7,11,15;132:4,9;141:9,9;143:10;144:10;145:15,16,24;147:19,19;148:3,19,22;149:1;150:23
Kelly (1) 144:11
Ken (1) 8:2
kind (43) 13:2,3;17:21;19:4;22:5,16,23;23:9;25:9;31:18,18;32:22;34:1;45:8;48:11;52:4;66:5;68:3;69:10,12;74:22;81:24;93:21;94:5;96:21;99:2,11;105:6;106:1,24;107:1;108:3,8;109:12;110:7;111:10;128:2,9;135:8;141:4;143:22;144:14;147:11
kinds (1) 49:14
kinks (1) 45:6
kitty (1) 146:13
knowing (1) 28:17
known (2) 38:10;43:19
knows (1) 73:22
KUNNEL (1) 13:20

L

lab (7) 84:14;91:20;92:21;93:13,14,15,16
labs (2) 84:14,17
lack (3) 44:20;45:3,3
laid (1) 45:21
LAIRD (2) 6:16,17
language (2) 68:11;75:8
large (5) 51:17;70:22;94:21;103:2;125:8
largely (1) 117:19
Larry (1) 10:21
Larson (1) 14:20
Las (2) 104:12,13
last (35) 10:11,16,18,19,21;12:18;16:14;17:16;19:6,15;25:24;28:15;31:6;35:20;36:1;65:6;66:10;67:18,23;69:5;76:4;81:2;88:23;90:22;95:11;97:5;99:14,23;116:9;117:21;118:23;119:13;125:13;129:5;133:21
late (1) 9:17
later (5) 26:24;41:15;42:10;118:23;147:14
Laura (34) 15:19,21;20:15;25:23;28:4;30:17;32:3;33:10;34:18;36:6;37:2,6;42:9;43:6;45:2;46:22;47:23;48:1;54:11;57:16;63:23,24;72:21,22;75:12;76:8;78:4;81:6;100:15;103:9,24;129:21;133:8;142:1
law (5) 14:8;74:19,19,21;76:15
lead (1) 87:24
leaders (1) 54:5
leading (3) 20:9,13;29:15
leads (2) 18:18;19:14
learn (2) 38:16;97:20
learned (1) 7:2
learning (1) 52:20
least (14) 16:4;19:6;22:24;28:9;30:2,3;60:12;70:20;73:3;100:17;131:12,14;133:14;141:13
leave (1) 16:22
leeway (1) 26:21
left (1) 120:11
Legislative (11) 7:4,8;9:15;18:9,18;27:20;30:8;31:2,4,16;43:10
legislators (11) 19:19;23:14,15;27:5;31:5;32:16,20,21;33:7;62:1;104:24
legislature (15) 11:7;17:18;18:13;19:4;22:13;23:11,13;29:9,10;30:6;32:5,12;33:4;34:5;129:24
lender (1) 37:13
Leslie (7) 5:17;15:6;22:19;115:2;124:1;150:11,21
less (15) 22:4;62:7;66:11;119:10;125:11;127:10;134:8;137:18;139:6;144:7;147:8,9,10;148:2,3
lessens (1) 135:4
lessons (3) 38:16,17;53:20
level (24) 7:10;9:6;20:10,13;21:2;46:23;55:20;60:22;70:22;80:21;90:23;91:11;93:22;94:2;100:1;106:19,20;118:12;120:4,4;122:15,19;126:19;140:9
levels (7) 7:12;21:7;65:11;66:12;91:10;114:13;143:19
lever (1) 34:23
leverage (1) 39:23
Lewis (1) 12:12
life (4) 7:14;32:17;70:11;133:22
lifestyle (3) 52:5,12;57:15
LifeWorks (1) 37:14
light (1) 102:9
lighter (1) 122:13
liked (1) 108:22
likely (2) 92:6;145:1
limit (1) 74:7
limited (1) 6:12
Linda (6) 5:9;15:2;62:19;115:5;149:4;151:19
line (9) 66:15;83:21;87:22;119:5;121:17,18,19;122:8,13
lines (1) 119:4
link (1) 10:9
list (3) 38:4;73:2;75:2
listed (1) 114:22
little (31) 15:15;17:17;18:3;26:11;37:7;41:4;

49:9;55:19;61:10,12;
65:4;88:18;93:21;
95:13;98:4,11;
108:21;110:19;
112:11;116:5,20,20;
117:16;125:24;
133:14;136:13;
137:22;138:20,24;
145:19;146:22
live (4)
10:7;37:12,17;
140:20
lives (1)
11:3
lobby (1)
152:21
Local (7)
8:3,21;11:3;21:17,
21,24;22:2
located (1)
10:9
location (1)
60:2
logistic (1)
48:15
logistics (1)
18:1
logo (1)
62:12
Lombardo (1)
72:24
long (8)
6:5;52:1;75:13;
81:3;125:22;127:19;
128:5;145:24
longer (4)
108:21;114:16;
132:12;151:14
long-term (3)
7:13;32:18,20
look (31)
11:24;17:22;21:15,
23;22:7;30:18;38:24;
50:15,16;55:14;
59:24;61:2;63:10;
92:3,10,19;93:21;
96:8;97:13;102:17;
103:21;104:21,21;
111:8,21;112:10,24;
125:12;127:6;
133:16,19
looked (5)
65:16;91:23;96:4,
9;134:21
looking (11)
22:9;25:21;60:8;
66:4;94:1;101:17;
102:1;117:20;
125:17;129:13,18
looks (6)
34:5;48:2;62:22;
92:5;93:2,4
lose (1)
131:8
loss (7)
52:24;58:1,2,9;
60:24;61:12;134:7
lost (1)
7:19
lot (60)
7:2;15:23;17:8,9;
18:12,18;21:23;
22:16,22;23:9,13,14;
25:24;26:2,2,8,13;
27:24;29:11;35:22;
37:10;38:16,19;
42:22;43:15;47:4;
50:20,21;51:23;54:1;
55:21;56:15;57:11;
61:23;65:24;67:15;
68:22;79:4;84:13;
88:6;91:15,19;94:3,
14;97:9,20,22;102:2;
104:12,24;105:2,24;
107:6;108:18;109:3,
21;125:19;127:17;
128:12;130:7
lots (1)
69:9
low (23)
11:11;24:21,23,24;
63:21;64:20;65:2;
66:7,7,11,14;67:7;
73:7;75:1;116:18;
133:5;138:4;143:17,
17,19,22;146:3;
147:24
lower (17)
11:6;22:10;53:3,6;
57:19,20;79:3;
116:16;117:20,22;
118:18,23;120:15;
124:21;125:10;
134:11;136:1
lowest (3)
9:6;20:24;120:17
lows (1)
133:17
LSI (5)
37:9,19,24;38:1;
41:14
lucky (1)
67:1
lunch (1)
132:13
LUNZ (11)
5:7,9,11,13,15,17,
19,21,23;6:1,3

M

Madam (1)
13:23
magnitude (1)
96:8
mail (1)
106:18
main (2)
115:22,23
mainly (1)
102:4
maintain (2)
134:24;143:13
maintaining (1)
135:16
Maintenance (1)
133:7
major (3)
64:7,10;93:23
majority (3)
94:21;109:5;
136:24
makes (5)
41:23;74:11;75:19;
92:7;146:12
making (6)
55:10;85:13,21;
109:2;117:2,8
male (1)
84:22
manage (2)
110:14;128:24
Management (13)
37:1;38:8;40:14;
41:6,24;42:2;57:1,1,
9,15,17;151:12;
152:11
manager (2)
22:21;103:1
managers (1)
103:21
managing (1)
60:24
mandated (1)
69:23
manner (2)
46:9;117:4
manual (2)
80:6;82:17
manually (1)
82:16
manufacturer's (1)
119:18
many (20)
7:7;8:13;16:16;
19:19;28:6;31:17;
55:21;57:7;58:7;
59:10;60:15;82:1;
86:8;87:15,15;89:11;
113:22;126:14;
146:8;147:24
MARCH (9)
5:1,5;7:6;19:24;
20:4;37:7;88:2,7;
151:11
Margaret (1)
12:12
mark (2)
33:21;132:3
marked (2)
89:4,8
market (15)
116:1,18,23;117:2;
122:9;123:4;124:8,9,
9;129:1;130:1,8,16;
134:13;136:8
marketplace (1)
43:20
markets (1)
125:4
market-wide (1)
125:4
marriage (1)
80:1
Master (6)
63:20;64:14;73:15,
20;74:3;132:9
match (3)
92:3,4,8
matches (1)
140:7
material (3)
79:24,24;127:9
materials (1)
109:19
math (3)
35:10,13;53:7
matter (7)
18:6;36:12;45:17;
46:10;47:1;75:8;
91:15
matters (1)
18:9
maximum (2)
150:2,8
maximums (1)
17:14
may (31)
10:21;12:21;14:6;
16:21;18:19;21:7;
25:13;27:7;29:24;
34:8,11;39:3;48:19;
52:14;56:17;60:1;
64:14;75:4;76:21;
84:3;87:7;93:13,14;
109:20,20;110:9;
125:10;126:18;
132:7;134:14;145:9
Maybe (33)
22:6,9;24:23;
25:21;26:23;27:6,20;
31:14;33:5;34:12,16;
50:19;82:13;84:14,
15,17;85:10;91:5,22;
92:16,17,21;100:13;
104:8,14;107:22;
111:10;121:22;
122:18;127:7,10;
137:17;147:21
McClendon (2)
5:19,20
mean (28)
22:12;35:21;44:17;
69:1;77:4;83:20;
89:15,18;90:24;91:4;
94:6;96:17;97:2,7;
99:5,12;102:11,16;
104:2;107:5,18;
108:6,17,22;112:18;
123:19;144:12;146:2
meaning (3)
56:3;70:22;148:12
meaningful (1)
28:2
means (4)
18:11;68:15;134:7;
139:4
meantime (1)
64:4
measure (5)
60:19,22;61:8,10;
148:5
measured (1)
60:23
measuring (1)
108:14
meat (1)
23:16
Medicaid (7)
129:15;130:2,4,5,7,
10,12
medical (25)
9:9;70:19;79:1;
85:1,1;97:12;112:24;
113:22;115:24;
116:9,13;117:13,15,
22;119:10;120:12;
121:17,19;122:3;
124:23;126:1;
127:20;134:7;
147:23;152:11
medically (1)
84:22
Medicare (12)
86:21;128:15;
129:11,11,13,15,16,
18;130:2,3,11,14
medication (5)
13:1;59:10,11;
124:10,12
medications (8)
13:1;59:9;80:2;
119:19;124:4,4,8,16
medicine (1)
65:13
medium (2)
24:16;51:16
meet (11)
29:3;40:24;52:6,
11;73:8;79:14;94:23;
95:3,4;108:23;109:5
meeting (24)
5:4,5;6:6,8;10:7,8;
13:18;14:19;18:16;
19:23;52:22;63:17;

64:1;65:6;67:18,23;
74:19,19,21;76:15;
109:9;132:19;
134:14;153:15
meetings (5)
6:9;19:11;56:24;
74:18,21
MEMBER (169)
5:10,12,14,16,18,
20,22,24;6:2;7:22;
11:3;14:9,9,11;15:2,
6;16:12;17:1,4;
19:17;20:8;22:18,19;
23:20;26:16;30:9,20;
31:1,22;33:2;34:1,
21;36:1,21;42:5,16,
18;44:1;46:13,18;
47:16;48:24;53:15;
55:20;56:22;58:13,
17;60:5,7,16;61:4,14,
16,19;62:19;63:2;
67:13;69:18;70:14;
71:6,8,21,24;72:4;
75:6,20,24;76:18;
77:6,13,14;80:24;
81:17,21;83:7,16,18;
84:12;86:16,23;87:2;
89:10,21;90:6,13;
93:7,20;96:14,22;
98:14;100:3,11;
102:3;103:6;105:5;
106:12;108:6;109:6,
11;110:12,24;111:20,
22;112:5,12,21;
113:4,6,8,12,15,24;
114:2,19,23;115:2,5;
123:18;124:1,15,18,
20;125:12,15,17;
126:7,21;127:4,15;
129:20;130:18,20;
131:7,11,15;132:3,4,
9;137:2,9,15,23;
138:22,23;139:12,16,
18,20,22;140:2;
141:9;143:10;
144:10;145:15,24;
147:1,19;148:2,3,19,
22;149:1,4;150:11,
21,23;151:19,22,24
members (43)
6:17,21;7:17;8:15,
16;9:7;14:2,3,7;17:9;
19:2;22:5;24:18;
46:21;50:2;52:14;
56:10;63:18;69:9,11;
89:12,19;90:5,7;
101:10;105:11;
107:11;109:12;
110:2,3;111:14;
119:20;129:14;
131:22,24;132:1;
133:13;136:14,20;
137:4;145:18;148:7,
8
membership (2)
40:15,18
memo (1)
36:7
memories (1)
37:10
mention (1)
146:8
mentioned (5)
50:7;58:14;91:14;
94:4;129:10
merely (1)
14:9
merge (1)
41:12
mess (1)
104:17
message (1)
27:8
met (4)
80:9;82:13,14;94:4
method (2)
139:8;144:23
methodology (7)
21:19;22:5;116:6;
122:20;133:20;
134:22;137:19
methods (1)
52:18
metric (1)
60:21
metrics (4)
60:18,19;88:19;
102:16
mic (4)
12:8,13,15;13:11
Michelle (24)
6:1;23:20;31:1;
34:15;42:18;44:1;
60:7;61:4;67:13;
70:16;71:24;78:12;
81:22;83:7,23;84:19;
105:5;109:6;110:12;
130:20;141:9;
144:11;145:15;
147:19
M-i-c-h-e-l-l-e (1)
78:13
mid (2)
90:16;99:21
middle (7)
24:21;120:9;
121:18;137:16;
143:23;144:1,2
midyear (1)
118:8
might (17)
32:13;70:16;71:3,
4;86:12;90:6,7;95:2;
117:6;119:2;121:22;
127:3;128:7;131:21;
140:17;142:9,22
migrating (1)
123:9
million (4)
136:10,11,18;
146:12
mind (2)
20:5;76:20
mindful (1)
127:12
minimize (2)
9:3;31:9
minimum (1)
148:13
minor (1)
135:7
minus (1)
122:12
minute (5)
17:19;19:6,15;
35:20;93:8
minutes (3)
6:12;14:18;71:13
mirrors (1)
122:14
missed (2)
94:17,18
misses (1)
94:21
mistake (1)
90:2
mistakes (1)
95:8
mitigate (3)
33:18;136:14,14
mitigated (2)
119:15;137:5
mobility (1)
10:24
model (1)
137:15
modern (1)
71:4
modifier (2)
82:21;84:6
module (1)
34:4
modules (3)
34:9,10,12
moment (5)
10:4;25:7;49:4;
152:22;153:1
Monday (1)
7:6
money (8)
23:8;27:14;34:6;
50:16;83:21;96:13;
136:13,20
monitor (1)
127:12
month (13)
16:21;24:7;89:1,3,
5;90:18;103:16;
118:2;119:8;141:13;
142:12;146:11,17
monthly (4)
52:3;61:8;103:2;
105:13
months (12)
52:3,4;89:5,6,9;
95:11;97:6;102:9;
114:11,18;122:21;
127:7
month's (1)
150:15
Moon (1)
91:21
more (77)
6:24;7:6;13:15;
16:11;17:1,17;19:1;
21:23;22:1;24:20;
25:1;26:24;33:13,15,
22,23,23;34:6;36:2;
41:4;42:19;43:16,23;
53:8,13;58:1;66:3;
71:4;75:14;77:12;
85:21;86:18;88:12;
91:7;94:24;95:3;
96:19,19,19;97:1;
98:8;99:20;100:3,23;
101:3;102:18,19;
111:13;114:4,20,20;
119:16;121:23;
123:23;124:3,4;
125:2,9;126:11,14,
14;127:7;128:16;
131:18;134:10;
135:20;137:17;
138:24;141:18;
142:12,13,19;144:6;
145:1,19,19;147:4
Moreno (2)
12:7,10
morning (7)
6:16;8:2;13:21;
15:21;47:20;85:6;
115:15
most (20)
8:19;24:18;38:17;
59:9;66:8;68:2;
78:15;79:24,24;80:5;
96:7,12;97:8;118:9;
121:11;124:14;
129:3;131:3,4;146:9
mostly (3)
64:5;119:24;150:4
motion (36)
14:16;15:1,3,4,8,
12,14;62:18;63:1,3,7,
9;71:21;72:1,5,9,10;
77:13,14,15,20,21;
115:6,10,11;148:21,
22;149:5,9;150:24;
151:4,5,22;152:1,5,6
mouth (2)
11:19,24
mouthful (1)
51:8
move (27)
13:17;14:14;17:20;
18:5;36:11,23;37:16;
39:14;40:9;47:21;
52:23;56:8;63:12,19;
72:12,19;77:23;
97:21;115:3,12;
120:8;132:18,19;
149:13;150:20,21;
152:17
moved (1)
31:6
moving (12)
13:6;17:23;18:2;
22:7;31:10;45:12;
56:14;118:1;119:4;
120:19;141:19;
150:14
MSU (1)
16:12
much (41)
6:24;7:24;8:9;
13:4;14:13;18:7;
26:21;27:23;32:19;
41:15;46:13;47:17;
50:14;54:20,20;
56:18;62:13;63:10;
68:11;81:17;91:3;
93:22;94:1;95:14;
104:12,14;108:15;
113:22;118:18;
119:16;120:15;
123:23;127:21;
128:1,3;130:24;
133:1;136:6;137:5;
141:24;146:10
multi (2)
76:23,23
multiple (5)
11:16;60:10;67:2;
77:2;124:4
mute (3)
13:21;93:2,4
myself (5)
22:21;48:9;49:8;
62:12;104:24

N

NAC (9)
73:5,12;74:15,20,
22;75:15,18,22;76:9
NAC's (1)
76:9
name (12)
6:13,17;8:2;10:11,
14,21,22;12:16,17,
18;13:11;111:20
names (1)
49:17
National (2)
51:6,15

nationally (2)
51:14;66:16
natural (1)
68:15
nay (1)
63:9
near (1)
12:21
nearly (3)
6:20;7:3;65:7
necessary (7)
39:10;46:3;74:6,12;149:19;151:15;152:13
necessity (1)
85:1
need (25)
9:5;11:19,20;14:24;19:9;22:6;24:14;25:14;39:4,22;73:10,13,23;74:15,20;105:1,3;112:5;126:13,14;127:9;130:24,24;135:21;141:14
needed (6)
9:9,11;65:20;67:10;139:9;140:17
needing (1)
126:14
needs (8)
9:2;46:7;73:14,17,20;74:3;105:17;109:9
negative (2)
119:23;139:3
neglectful (1)
62:12
negotiate (4)
40:4,6,20;131:19
negotiated (1)
8:5
negotiating (3)
40:3;126:17;131:17
negotiation (1)
126:23
negotiations (1)
128:24
neighborhood (1)
81:2
nest (3)
136:11,11;144:21
net (4)
119:23;120:6;136:21,22
network (5)
103:1,4;126:16;128:3;131:18
networks (1)
126:16
neuropathy (1)
59:13
NEVADA (21)
5:1;6:19;8:22,24;48:6;49:10,11,24;50:2,7,8;51:2;54:13,22;70:4;78:1;98:18;107:19;129:1,23;130:6
new (32)
17:10,11,14,14,16,23;20:23;23:14,15;31:3;37:16;38:9;47:9;67:2;75:10;88:17;91:7;94:22;95:21;98:1;102:23;117:7,7,7;119:3,15;120:3;124:8;125:19;149:15,20;151:13
newer (2)
124:16;133:13
newsletter (1)
7:22
next (22)
7:21;9:19;17:23;26:23;31:19;34:3,3;63:12;80:19;114:18;121:3;122:10;123:11,22;128:10;135:7,18,23;136:12;141:16;143:8;150:15
nexus (1)
27:14
nightmare (1)
30:22
nimble (1)
47:12
nine (1)
122:7
nobody (3)
25:15;153:2,10
noise (5)
33:23;105:1,24;106:2,2
nominated (1)
46:14
non-diabetic (1)
53:9
none (17)
10:2;15:1,9;25:10;36:23;47:19;63:4;72:6;77:16;102:4;115:7;148:21;149:6;151:1;152:2,15,18
non-partisan (1)
6:21
nonprofit (2)
6:21;50:9
non-State (2)
123:19;133:4
noon (1)
132:11
nope (1)
23:7
normal (8)
18:24;31:10;35:19;53:11;64:17;69:7;114:13;121:23
normally (1)
129:2
north (2)
62:14;67:21
notch (1)
97:13
note (2)
19:13;82:21
notes (2)
84:7;113:15
notice (1)
131:16
noticed (1)
42:6
notices (1)
7:18
notification (2)
73:18;132:3
notify (4)
87:11;131:20,24;132:1
noting (1)
144:20
NRS (3)
14:3;40:2;74:19
NSHE (12)
40:15;42:24;43:4,9,14,18;44:3,3,14,20;45:15;46:11
Nugget (1)
49:19
number (41)
10:11;13:17;14:14;15:16,17;32:9;35:5;36:23;53:9;54:19;61:21;63:19;64:11;69:19;70:13;72:1,16,20;74:15;76:2,3;77:23;81:9,10;83:2;92:3;94:17;96:9,9,20;103:11;115:12;125:18;132:19;133:2;139:9,24;140:3;149:18;151:8;152:9
numbers (7)
16:9;24:17;33:22;55:5;88:21,23;97:2
nursing (1)
71:17
NVBGH (2)
50:8,9

O

obesity (1)
57:1
objective (1)
79:15
obligation (1)
131:24
observer (1)
53:23
obviously (17)
16:10;20:18;85:2,11;88:15,22;92:14;94:15;95:4;96:2,17,24;99:13,19;108:18;131:20;133:16
occur (3)
79:19;87:22;91:20
occurred (4)
80:4;85:23;89:23;141:2
o'clock (1)
63:13
October (3)
30:15;69:8,13
odd (1)
111:10
off (13)
16:21;18:4;25:7;27:13;29:15;30:7;36:15;48:10;93:4;111:19;121:18;122:15;150:18
offer (7)
14:5;16:6;45:15;50:1;55:11;58:7;59:24
offered (3)
8:15;23:7;54:3
offering (3)
53:24;55:14,17
offers (1)
16:6
office (17)
16:23;17:20,23;28:21;36:11,24;38:8;41:6,23;42:2;45:15;46:24;82:21;84:7;106:17;112:21;151:12
Officer (15)
15:19,20,22;20:9;23:21;37:3;45:20;47:24;67:17;72:21;86:7;106:21;108:11;140:7;144:20
offices (1)
9:4
officially (1)
109:19
offline (1)
36:5
offset (5)
12:22;134:10,11,11;136:8
often (3)
46:10;59:7;97:11
old (3)
91:2,3;95:1
older (1)
53:4
onboard (2)
41:16;75:2
once (5)
71:2;101:2,2;143:1;150:20
one (87)
8:19;13:15;14:16;17:6;20:24;21:3;22:6;23:1,12;25:15;31:3;34:8,10;36:1;38:17;39:1;40:24;41:7;46:20;48:15;49:4;51:18;57:6;60:9,12,12,12,13,21,24;64:8,11;65:21;66:20;70:12;72:2,23;73:11,12;74:22,23;75:18;76:23;78:24;82:9;85:12,12;86:18;87:18;89:11;90:10;91:13;92:10;93:10,11,23;96:10,11;97:8;100:3;104:1;105:15,18;107:22;110:20;114:3,18;117:12,18;118:19;119:24,24;123:9;127:6;137:16,17;138:5,11,20;140:13;142:2,5;143:7;145:19;150:19;153:1,11
ones (4)
34:23;43:14;54:18;147:8
one-time (1)
53:14
on-line (3)
10:2;106:20;107:17
only (20)
10:7;16:6;21:12;24:8;25:1;36:3,12;40:11;45:13;47:1;62:22;76:5;85:2;104:23;124:11;139:2;146:12;147:20,21,21
onto (3)
25:8,9;97:1
oOo- (1)
5:2
open (29)
16:11,14,23;17:6,17;18:19,19,21;19:10,15;24:5,7,22;25:5;26:20;27:6,15;34:7,13;74:19,19,20;76:15;82:17;85:8;109:8,12,18,18
opened (1)
59:21
Operario (1)

78:14
operate (1)
30:11
operating (2)
86:6;90:24
operational (2)
123:16;133:18
opinion (3)
20:16;26:20;79:13
OPM (8)
38:11;39:2,8,16;
40:4,5,6,21
opportunity (14)
16:7;25:6,15;
27:21;31:20;44:22;
48:14;49:8;50:1;
53:22;81:18;95:3;
116:4;127:23
opposed (7)
15:13;63:8;72:10;
77:21;149:10;151:5;
152:6
option (3)
29:17;32:9,9
options (6)
19:4,20;22:14,16,
16;32:7
orangish (1)
121:19
order (15)
5:4;42:7;43:16;
63:18;72:20;73:1,4,
8;74:24;76:16;93:14;
106:16;132:19;
141:11;143:22
ordered (1)
15:16
orders (1)
109:22
Oregon (2)
8:7,24
organization (7)
6:22;49:9;51:1,14;
106:12;133:6,7
organizations (5)
49:12,20;51:23;
52:7,9
orientation (1)
10:24
original (1)
75:21
others (2)
88:5;145:19
otherwise (3)
60:19;140:8;
143:23
Ours (2)
50:14;51:9
ourselves (1)
13:22
out (96)
11:12;15:15;19:19,
20;20:12;21:5,22;
22:14,14;25:11;
26:18;27:1;29:8,11;
34:17;38:5,6,23;
39:14,21;41:12,13;
45:6,14,16,21;46:2,
23;47:6,9,9,10;53:23;
54:17;56:2,4;58:11;
59:17,20;60:15;
61:22;62:2;66:12,18,
19,24;68:15,19;
69:21;73:14;82:13,
14;87:13,18;89:24;
90:1;91:16;92:10;
93:21;95:12;97:9,16;
98:16;100:1,6;102:5;
104:13;105:12;
106:6;107:13;
109:18;110:10;
112:20;113:5,18;
118:15,15;120:10;
127:17;128:9;
130:22;131:4,18,21;
134:9;136:15;
139:14;142:23;
145:3,5,7;146:23;
147:6,11;153:7,10
outcome (5)
68:18,18;86:18;
87:21;90:11
outline (1)
111:22
outlined (1)
148:23
outlining (1)
30:10
out-of-network (1)
87:3
out-of-pocket (2)
13:5;17:14
outpatient (1)
119:6
outreach (1)
113:8
outside (6)
35:1,2;43:9;63:15;
69:7;70:23
over (37)
7:15;8:11;15:22,
23,24;18:2,5;23:13;
30:1,18;32:23;48:11;
51:11;61:5;62:23;
64:8;79:16;89:4,9;
90:20,21;93:12;
95:11;97:5,24;99:22,
23;109:14;114:11;
119:13;120:5;129:5;
132:9;140:24;
141:17;145:19;153:2
overall (7)
76:15;79:13;89:7;
97:4;133:24;134:3,4
overhaul (2)
37:21;41:22
overlap (1)
38:19
overlooked (1)
64:20
overly (2)
13:1;35:20
overstep (1)
32:12
overview (2)
122:19;152:9
overwritten (1)
61:24
owe (1)
129:15
owed (1)
79:15
own (14)
22:22;23:12;33:3;
38:1,15;39:24;40:3,6,
20;90:6;101:21,21;
111:5;136:22

P

Pack (1)
62:15
packet (1)
78:18
packing (1)
17:24
page (14)
64:10;65:1,24;
78:21;79:16;80:7;
116:8,20;117:11;
118:1;121:16;122:7,
19;125:17
pages (4)
75:13;80:15;
115:20;123:22
paid (22)
79:2;84:1;85:2;
86:24;87:19;94:17,
18;96:18;97:16;
98:17;101:23,24;
107:7;111:23;112:2,
4,7,9;114:4,6,8;
147:24
pain (4)
104:17,18;135:5;
144:17
pans (1)
92:10
parameters (1)
94:22
part (20)
11:17;32:4,11;
45:3;51:6;52:17;
53:16;59:10;67:22;
70:11;72:14,16;
73:16,17;78:11;79:8;
85:24;96:7;98:2;
143:11
participant (5)
73:19;139:10;
140:6,18;144:24
Participants (7)
52:11;60:9;141:12,
12;145:12;146:6,10
participant's (1)
139:22
participation (1)
62:22
particular (7)
9:5;83:9;86:11;
111:20;112:11;
121:10;140:10
particularly (1)
116:17
partner (2)
39:8;52:9
partnered (1)
55:1
Partners (4)
49:11;50:8;51:3;
105:16
partnership (4)
39:11;49:13;51:22;
105:16
partnerships (1)
40:8
pass (2)
15:1;137:20
passes (8)
15:14;63:9;72:11;
77:21;115:11;
149:10;151:5;152:6
passively (1)
56:3
past (7)
15:24;54:6;55:8;
64:1;87:8,23;116:13
path (2)
45:7;151:14
paths (2)
39:4;41:8
patience (1)
69:15
patient (1)
87:4
patients (2)
104:9;130:4
pay (26)
9:5;13:5;20:17,18,
20;83:19;84:17;87:7,
8;93:17;95:5;104:11;
126:14,14;129:12,14;
131:8;140:11,24;
141:5,13,13;142:12;
145:12;147:3,3
paying (12)
6:21;69:9;83:22;
85:17;95:9;134:9;
146:10,17;147:10,13,
14,16
payment (3)
85:20;98:22;99:16
payments (6)
12:20;79:21;85:23;
104:7;119:17;129:17
payroll (1)
38:19
PBM (3)
134:13,18;136:8
PBM's (2)
120:23;121:14
peak (1)
98:24
PEBP (113)
6:23;7:11;8:8,11;
9:15;10:8;11:6,8,11,
24;13:18;14:2,4,5,10,
19;16:10;18:3,16;
19:5,13;20:2,17;
24:3;25:9;26:18;
27:11,12;28:8,17;
29:21,22,24;31:12;
36:2,8;37:2,8,15,23;
38:3,14,17;39:2,20;
40:5;41:15,22;42:21,
21,22;46:7;48:14;
50:2;53:8;54:8,11,
12;56:13;60:9;65:6,
11;69:2;73:5;76:13,
14;78:16;98:16;
100:5,22;102:21;
104:2,5,9,9,9;105:11;
106:19;109:17;
110:3,13;114:5,7;
115:13,19,23;116:15;
117:6,22;119:18,19;
121:21;122:2,4,6,13;
123:15;124:21;
125:19;130:8,8;
133:24;149:15,19,22,
23;150:6,7,22;151:9,
11,13,15
PEBP's (3)
11:5;37:9;41:19
penalties (6)
81:1;95:4,5,9;
115:1,4
penalty (5)
79:15;80:10,13;
81:3,5
people (73)
16:17;17:1;22:9;
24:2,14;25:4,6,14,20;
26:3;44:14;47:7,7,
10;53:3,18,20;54:3,5;
55:5,22,24;56:1;
58:8;59:7,9,20;66:3,
11;67:24;68:4,19,21,
23,24;70:22;73:21;
77:9;86:5;87:5,9,11,
20;88:17;91:2,6;
95:21;97:1,6,11,14,
16,19,21,24;98:1;
102:10;103:12;
104:13,22;107:1;

110:21;112:17; 124:12;144:15; 145:21;146:8,17; 147:2,7,22,22;148:6
PEPM (4) 118:2,8;119:7; 120:11
per (14) 117:5,5;118:2,2,2, 8,17;119:6,7,8; 120:10;123:4,14; 128:24
percent (42) 16:2,23;20:18; 22:21;52:13;53:1,3,5, 5;79:9,22;80:10,10; 92:6;96:10,11,11; 97:24;103:15;104:8; 105:8;116:11; 117:14,15,18;118:11, 17,19,20;119:9,14; 120:14;122:1,2,2,3,4, 5,12;129:12;130:5; 141:13
percentage (3) 58:22,23;61:3
perfect (1) 48:5
performance (8) 79:7;80:8,9;81:13; 94:24;108:19,24; 122:16
performed (4) 79:10;82:22;84:23; 85:2
performing (1) 84:8
perhaps (3) 55:14;68:7;118:20
period (17) 24:1,5;56:16; 60:10;61:6,8,11; 78:2;94:11;98:4; 99:16;118:7;119:7,8; 123:5,7,8
periods (2) 127:2,2
permission (4) 12:7,12,14;56:7
person (8) 6:8,9;26:4;52:22; 82:19;84:18;87:7; 127:16
personal (1) 20:16
persons (1) 73:24
person's (1) 52:12
perspective (7) 25:1;95:1;98:6; 103:1,4,21,23
pervious (1) 89:9
pharmacy (15) 51:3;116:12,14,15; 117:15,16,22;119:4, 6,10;121:18;122:1; 124:2;136:5,6
phone (17) 10:11,13;17:3; 26:6;28:21;86:5,10, 12,13;88:12,14; 91:21;96:19,19; 102:16;106:24;107:1
phones (3) 16:12;17:2;36:9
phrase (1) 142:5
physical (2) 17:13;61:2
physician (4) 59:11;71:14,15; 93:16
physicians (2) 70:21;128:17
physician's (1) 112:21
pick (5) 24:8;25:10;44:5,7; 147:15
picking (1) 130:9
picture (1) 20:19
piece (2) 46:4,12
pilot (9) 47:23;48:11;50:1; 55:7,11;56:8;58:24; 59:17;60:9
pilots (1) 58:23
place (12) 18:1;57:21;62:9; 65:14,15;67:1,10; 82:11;98:9;125:20; 135:17,18
plan (108) 8:14,18;9:16,19; 17:8;21:13,14;24:19, 22,24;25:4,15;30:14, 14;31:11;35:8,16; 45:21;53:8,10;55:10; 56:14;62:6;63:20,21; 64:14;65:15,22;66:5, 23;67:11,16,22;69:8, 12;70:7;72:3,12; 73:15,20;74:3;79:9; 96:13;97:1,2;99:15; 100:4,7;101:13,21; 109:21,24;110:15,16; 112:6;115:24; 116:10;117:8,12; 119:3,15;121:10; 123:9,18;126:4; 131:8;133:3,5,6,6,7; 134:5,10;135:18,19, 23;137:3;138:6,10, 11,12,17,18,20; 139:4;140:23; 141:17;142:3;143:3, 3,5,17,17,19;144:1,2, 5,15,22;145:19; 146:9,14,24;147:14, 24;148:12,12,17
planned (2) 36:17;43:2
planning (3) 29:16;33:19;129:1
plans (33) 8:15,16;9:16; 24:15;25:8;35:4; 50:5;54:14;63:22; 64:21;65:9;66:9; 67:7;78:1;97:10,10, 15;110:13,14; 123:21;125:2,3,8,9; 129:18;134:8,12; 138:14,21;142:24; 143:22,24;144:2
platform (2) 50:13;85:12
platforms (1) 50:13
play (2) 23:9;57:8
plays (1) 57:5
please (15) 5:6;6:12;10:13,14, 17,19;12:8,13,15; 13:10;44:17,24; 142:1;152:23;153:1
pleasure (2) 51:13;122:19
plenty (1) 74:18
plus (5) 92:6;95:3;139:9; 144:13;148:18
pm (1) 36:10
pocket (1) 147:6
point (20) 25:11;39:3;41:22; 45:13;58:20;69:5; 70:15;74:24;75:18; 76:16;91:8;112:4; 127:17;131:23; 135:8;142:17; 145:20;146:1;148:5, 8
points (1) 115:23
policy (5) 82:2;83:10;137:10, 10;145:20
political (1) 28:6
pop (1) 68:24
population (7) 55:18;79:1;104:4; 130:6,10,11;146:9
populations (1) 59:19
portal (7) 107:2,6,9,10,14; 111:13;113:16
portion (1) 133:9
position (1) 98:10
positive (2) 134:3;140:12
possible (13) 12:22;14:15;17:6; 47:22;58:7;63:20; 72:20;78:3;123:1; 133:2,7;137:5; 149:14
possibly (2) 23:7;90:9
post (2) 106:17;116:17
postage (1) 106:17
potato (1) 31:18
potential (7) 56:8,10;66:6,18; 127:23;135:24; 136:12
potentially (10) 21:16;29:14,17,19; 30:5,17,18;40:8; 65:22;108:16
power (3) 16:19;17:5;33:22
PPO (3) 141:12;142:7; 147:22
practical (1) 36:2
practice (1) 67:19
pre-COVID (2) 7:12;64:16
predecessors (1) 118:24
pre-diabetes (5) 50:4;52:15;54:17, 18;59:10
pre-diabetic (1) 58:19
pre-diabetics (3) 53:9;54:15;58:22
pregnancies (6) 66:19,21,24;68:12, 20,23
pregnant (3) 68:14,17;70:5
premium (14) 8:24;9:4,14,17; 11:9;21:14,14;24:13; 139:10,13,23;140:7; 141:16;142:18
premiums (18) 11:10;12:22;21:13, 16,22;22:3,10,11; 24:12;33:17;34:22; 105:13;135:17; 137:2;140:18;141:7; 144:24,24
prep (1) 34:7
pre-pandemic (2) 143:19,20
prepare (1) 110:5
prescribed (3) 68:5;119:19; 148:13
prescribing (1) 124:16
present (8) 9:21;11:23;16:23; 32:6,7;63:18;78:9; 85:9
presentation (13) 9:12;18:10;48:16, 16,18;56:19;62:11; 115:12,19;125:18; 129:24;149:12,14
presentations (1) 57:1
presented (3) 23:12;32:7;145:17
presenting (2) 20:2;78:14
preserved (1) 55:21
press (3) 10:13,17,19
pressure (9) 126:15;127:13,14; 128:12,16,21;130:12, 15;131:19
pressures (3) 126:20;127:8,8
pretty (14) 20:12;22:15;34:24; 66:11;82:19;83:4; 90:17;91:3;108:1; 111:1;121:15; 122:11;123:23; 129:24
prevented (1) 9:9
Prevention (3) 47:22;49:22;51:21
previous (3) 37:13;74:1;89:4

Previously (6)
8:4;38:10;64:1,24;
68:17;151:15
price (3)
125:24;127:8;
141:7
priced (2)
11:12;13:1
pricing (8)
116:5;118:22;
119:1;120:16;
122:20;128:13,21;
137:15
primarily (2)
49:15;116:22
primary (2)
50:20;93:12
prior (7)
47:4;78:16;118:24;
120:22;121:5;
122:23;148:18
priority (1)
73:4
private (5)
49:13;51:22;55:24;
125:7;130:9
proactively (2)
98:21,23
probably (16)
32:13;36:3;43:20;
53:12;55:21;60:12;
61:21;68:24,24;
84:20;86:9;88:12;
92:14;94:20;97:23;
109:3
problem (10)
7:7;33:14;34:15;
35:23;59:22;75:7;
87:13;106:10,11;
142:20
problematic (2)
31:6;36:16
problems (5)
11:13;22:24;94:3;
96:16;114:3
procedural (1)
106:8
procedure (6)
66:3,20;82:20,22;
84:6;106:1
procedures (6)
11:14;70:17;82:9,
16;83:12,14
proceed (1)
10:15
process (37)
7:11;23:2;28:7,13;
30:8;32:4;38:12,16;
40:10;41:15;73:16;
74:2,9,10,11;76:22,
23;77:2,10;82:3,4,6,
15;83:10;86:3;89:12;
92:1;96:5;98:2;
103:13;106:18;
107:4;108:5;109:13;
133:12,15;149:2
processed (2)
89:14;111:15
processes (3)
43:16;82:16;92:10
processing (5)
80:6;93:23;94:4,
11;103:4
processor (3)
79:19;80:4;103:18
procurements (2)
42:12;152:12
product (2)
31:11;87:6
pro-employee (1)
127:16
profits (2)
127:19,24
Program (45)
5:5;8:10;14:21;
47:23;48:11;50:18;
51:4,21,21;52:1,2,14,
17,24;53:4,11,13,14,
16,23;54:3,8,21,24;
55:7,13,16;56:6,9,11,
23;57:2,3,14,17,18;
58:1,24;60:9;73:19;
78:1;117:3,10;
150:14,15
programming (3)
50:10;51:24;59:24
programs (11)
23:12;29:18;49:16,
22;50:1,2;55:3;58:8;
117:7;123:10;134:1
progress (6)
21:3,4;42:13;
95:24;109:2;152:9
Project (14)
36:24;38:2,8,24;
39:11;40:14;41:6,18,
24;42:2,23;123:5;
151:12,14
projected (12)
33:15;117:12;
122:8;123:14;
124:21;134:2;136:1,
3,11;139:17;140:9;
145:10
projecting (2)
116:10;124:24
projection (1)
123:7
projections (4)
101:21;117:14;
122:5;123:2
projects (1)
150:4
promised (1)
91:11
promoted (2)
16:8;97:22
promotional (1)
16:7
proof (2)
83:6;84:11
Proper (1)
45:24
proposal (3)
37:16;136:23;
140:8
propose (1)
31:13
proposed (4)
37:17;135:18,23;
144:19
proposing (2)
134:23,24
proprietary (5)
82:2,4;83:8,12,14
proprietor (1)
83:19
props (1)
48:7
protect (2)
62:6;126:3
Prove (1)
83:5
proven (1)
52:12
provide (25)
8:12;11:7;22:3;
24:19;25:19;26:19;
29:20;49:24;50:5;
52:7,8;53:19;55:4,6;
56:1;73:2;82:23;
105:14;106:23;
111:20;122:22;
127:9;133:14;
144:22;146:14
provided (10)
8:8;18:9;22:16;
32:20,21,24;54:6;
65:9;83:6;123:23
provider (16)
82:21,23;83:24;
84:6,8;87:17;89:17;
90:1;92:17;104:6;
111:2;113:5;123:13;
127:2;131:21;133:6
providers (29)
9:4,8;87:3;90:11;
98:15,19;101:11;
102:7;103:8,10;
104:13,17,18;105:2;
106:4;114:3,6;
124:23;125:21;
126:10,18,18;127:9,
23;129:6;130:2,22;
131:8;132:1
provider's (2)
103:11;132:2
provides (4)
30:3,4;57:22;123:1
providing (5)
51:10;57:19,21;
111:3;128:2
prudent (1)
8:19
PSA (2)
84:21,22
Public (37)
5:4;6:11,11,13,14,
18;8:1,7;10:1,2,7,10,
17,20;11:23;12:4,8,
13,15;13:12,13,15;
14:21;24:10;49:13;
51:22;55:8;67:20;
68:1;69:9;70:21,22;
78:1;130:9;152:18,
18,19
pull (2)
34:13,23
pulled (1)
14:24
pulling (2)
46:1,10
purchasers (1)
51:10
purchasing (3)
39:19,20;51:7
purpose (1)
137:1
purposes (1)
30:22
Pursuant (1)
14:2
put (18)
17:1;22:14;24:4;
26:24;32:1;40:13;
44:13;65:15;69:21;
73:20;75:14;81:7;
91:6;105:14;108:16;
131:4;152:21;153:14
puts (2)
130:15;131:19
putting (4)
38:20;68:3;108:18;
153:4

Q

Q1 (1)
80:22
qualified (1)
148:12
quality (2)
11:3;23:1
quarter (14)
78:17,24;95:6,14,
15,16;99:13,17,19;
102:5,9;109:3,4,4
quarterly (6)
78:18;79:3,7;
100:16;101:5,14
quick (3)
31:23;34:1;71:6
quite (1)
110:14
quo (2)
17:9;135:17
quorum (1)
6:3
quoting (1)
82:2

R

raise (2)
127:24;128:17
raises (1)
12:22
raising (1)
129:8
ran (2)
79:8,11
random (2)
79:11,18
range (5)
90:16,19,20;99:22,
22
ranking (1)
73:4
rate (25)
16:2;22:21;34:20;
35:21;64:17;66:7,14,
16;88:4;117:13;
119:8;120:17;
129:15;133:11,11,15;
134:4,17,18,20;
139:2,13;143:23;
147:3,10
rates (36)
20:10;35:1,21;
117:18;119:13;
123:17,18;126:10;
128:18;129:12;
130:12,13,14;131:19;
133:4,20;134:4,15,
21,23;135:4,6,11,17;
136:9,13,17,24,24;
141:11,16;143:5,14;
146:2,6;148:23
rather (3)
23:15;91:8;120:5
ratification (2)
151:10,16
rating (1)
122:20
ratio (1)
134:7
rationalize (1)
84:9
reach (10)
56:2,4;87:13;
89:24;105:11;106:6;
112:20;113:5;
121:12;146:23
reached (1)
38:23

reaching (5)
26:18;45:14,16;
58:11;98:16
read (6)
68:1,1;75:10;88:2;
93:22;118:5
reading (1)
81:1
reads (1)
76:4
ready (3)
10:4;34:9,11
real (7)
34:1;52:5;57:24;
58:9;125:19;126:4;
146:2
realistic (2)
136:4,4
reality (1)
142:15
realize (2)
13:20;104:21
realized (1)
101:22
really (86)
11:24,24;12:19;
18:13;19:16,18,21;
22:13;27:9,22;28:15,
18;29:8,11,23;34:2;
35:5;38:21,21;40:15,
17;41:14;43:7,14;
44:13,15;45:7,12;
46:7;48:10;50:8,9;
51:7,17,19,23;55:22;
56:23;57:18,21;58:6;
61:10;62:5,24;65:7,
10,16,16,17;66:2,13;
67:9,17;71:2;73:9,16,
21,23;74:17;75:17;
76:14,17;77:10;
87:19;93:23;97:13;
101:12;102:5;
104:10,10;108:7;
121:6;124:5;126:2;
127:13;136:23;
137:2;141:3,10;
142:2,4,14;144:6;
146:5,7,18
reason (15)
45:3;66:17;83:19,
24;85:24;90:22;91:9;
92:13;94:7;101:15;
111:11;114:6;
129:10;135:1;141:11
reasonable (1)
135:2
reasonably (1)
122:24
reasons (1)
84:16
reassure (1)
102:24
rebate (2)
119:16;120:1
rebates (2)
117:17;119:22
re-branding (1)
38:11
recall (1)
140:21
receive (5)
36:7;78:20;121:12,
13;142:24
received (2)
7:18;54:21
receiving (2)
137:17,18
recent (6)
78:15;115:23;
118:9;120:3;121:11;
126:6
recently (4)
7:17;12:23;50:12;
128:14
receptionist (1)
16:8
recess (2)
63:16;132:17
recipients (1)
130:7
recognize (2)
28:2;130:17
recognizes (1)
119:2
recommend (2)
32:5;60:4
recommendation (4)
37:8;65:22;67:5;
79:22
recommendations (2)
9:14;72:2
recommended (8)
29:7;30:4;32:10;
63:20;73:3;81:4;
148:23;150:22
recommending (3)
30:2;42:14;135:10
recommends (2)
150:6;151:15
record (86)
6:17;10:15;12:16;
13:11;15:2,22;20:9,
15;22:20;23:21;
25:23;28:4;30:17;
31:1,23;32:3;33:10;
34:18;37:6;42:6,9,
19;43:6;44:2;45:2,9;
48:1;56:23;57:16;
59:2;60:7;61:4,17;
62:20;63:24;67:14;
71:9;72:1,22;75:12;
76:1,8;78:4,12;
80:24;81:6,22;83:7,
24;84:20;86:17;89:2;
98:14;100:15;
102:21;103:24;
105:6;109:7,16;
110:13;111:18;
113:14;114:2;115:3,
15;124:2,21;128:24;
129:21;130:20;
133:8;137:10;138:1;
141:10;144:11,19;
145:16;147:2,20;
148:10;149:17;
150:12,13;151:8,19;
152:8
records (3)
112:24;113:22;
114:16
recouping (1)
130:3
recruit (3)
22:8;126:11,13
recruitment (2)
16:3;21:8
recruitments (1)
16:4
red (1)
98:24
reduce (4)
9:16;51:24;69:23;
79:19
reduced (2)
8:10;53:4
reducing (3)
53:2;70:3;141:15
reduction (4)
28:18,24;134:23,
24
reductions (1)
9:18
refer (2)
68:2;116:23
referring (2)
73:24;93:16
reflects (2)
117:2,4
regard (1)
145:13
regarding (4)
14:1;22:23;36:24;
80:21
regards (2)
59:2,18
REGI (4)
138:1,16;145:4,11
register (1)
76:20
regular (1)
102:18
regularly (2)
100:5,12
regulation (9)
73:9,10,15,17,20,
23;74:3,7,10
regulations (3)
73:3,5;74:17
rehab (1)
10:23
reigns (1)
46:2
reimbursement (3)
7:19;130:13,14
reimbursements (2)
128:15,16
reinstate (2)
140:24;144:5
reinstated (1)
141:5
related (2)
48:11;84:14
relates (1)
89:9
relationship (3)
52:23;106:2;
108:13
relatively (1)
126:6
release (1)
39:24
releasing (1)
40:12
remain (2)
47:12;78:19
remainder (1)
40:16
remained (2)
66:5;85:15
remediation (1)
80:20
remember (4)
61:21;81:9,9;91:24
remind (2)
135:12;148:11
reminder (2)
10:6,13
remiss (2)
127:16;146:8
removal (5)
63:21;66:6,18;
69:6;73:3
remove (1)
67:5
removed (2)
14:17;67:15
removing (3)
67:7;74:10;75:20
renegotiate (1)
130:24
renew (2)
128:4,9
renewal (2)
126:23;127:1
Reno (2)
104:14,16
rep (1)
111:9
repeat (2)
82:22;84:6
Report (27)
15:19,22;42:11,11;
64:6,10;78:19;80:14,
15,17,17;88:1,9;
93:22,22;94:5;95:16;
99:6,7,17;103:11;
108:13;114:24;
115:1,3;133:10;
151:8
reported (2)
100:12;108:23
reporting (2)
100:5;102:15
reports (7)
98:24;101:18,19;
102:12,15;103:9,21
represent (3)
6:19;51:12;62:12
representations (1)
121:15
representative (1)
121:6
representatives (1)
107:22
represented (1)
125:7
representing (1)
8:3
represents (1)
6:20
repriced (1)
111:15
reprocessed (2)
106:15;112:3
reps (1)
36:6
request (8)
11:5,7;28:11;
37:16;42:19,23;64:2;
96:13
requested (1)
7:4
requesting (2)
149:22;151:9
require (3)
14:8;62:1;102:22
required (1)
76:3
requirement (1)
74:5
requirements (6)
38:5;39:9;41:1;
70:1;73:8;94:24
requires (1)
73:1
reset (1)
119:24
resolve (1)
112:17
resolved (8)
88:3,7,9,10,10;
101:1,3,5
resolving (1)
100:23
resonated (2)

19:2,18
resources (1)
46:11
respective (1)
38:15
response (5)
26:17;60:13;80:17;
82:1;88:2
rest (2)
67:8;132:12
restoration (1)
7:13
restore (1)
32:19
restored (2)
32:17,18
restrictions (1)
69:20
restrooms (1)
63:15
resubmit (3)
111:8,12;113:1
result (10)
28:23;37:11;38:23;
39:12,19;44:23;
79:20;83:14;87:3;
120:21
resulted (3)
53:2;134:22;
138:12
resulting (1)
80:11
Results (7)
52:24;56:11,12;
67:2;79:23;120:22;
140:9
retail (1)
121:20
retain (1)
126:13
retention (1)
7:9
Retired (2)
6:18;55:9
retirees (8)
6:19;7:14;59:21;
118:5;123:20;133:4;
135:15,16
Retirees' (1)
14:22
retrained (1)
91:6
retraining (2)
80:4;110:21
return (1)
121:22
returning (1)
7:12
revenue (2)
134:9;135:21
reverting (1)
64:16
review (9)
9:12;69:12;79:17;
82:16,17;112:1,8;
115:23;149:18
reviewed (2)
9:13;81:24
Reviewing (5)
8:23;56:10;81:24;
118:8;121:9
RFP (14)
37:16;38:6;39:21,
21,23,24;40:4,12,19;
42:14;45:8;151:10,
14;152:11
RFP's (1)
150:5
Rhonda (4)
100:17;102:20;
109:16;111:20
Rich (98)
7:21;15:19,21,21;
20:9,15,15;22:23;
23:10,21;25:23,23;
28:4,4;30:16,17,21;
32:3,3;33:10,10;
34:18,18,22;36:6,6;
37:3,6,6;42:9,9;43:6,
6;45:2,2,20;47:24;
48:1,1,5,13,17,20;
49:6;54:12;57:12,16,
16;62:16;63:23,24,
24;67:18;71:11,14,
18;72:14,16,18,21,
22,22;75:12,12;76:8,
8;78:4,4,7;81:6,6,12;
91:13;100:9,13,15,
15;102:13;103:24,
24;106:21;108:11;
115:1;129:21,21;
132:7,14;133:8,8;
137:13,19;138:9;
140:7,19;142:21;
143:16;144:20;
148:24
Richard (6)
115:13,16;132:7;
137:24;142:21;
144:18
richer (2)
139:5;144:4
right (89)
12:1;16:2;18:22;
19:13;21:13,21;22:1,
6,9,22;25:11;26:1,12;
28:7,16,18;30:19;
31:7,19;33:5,12,21,
22;34:24;35:18;
40:15;42:1;43:11,23;
44:11;45:6,16;47:2,
3;55:23;59:6;68:11;
71:14;72:2;75:12;
87:12;92:13;93:2,5;
95:9;99:1,5;100:14;
102:6,9,14;105:7,16;
106:3,4;107:9,19;
110:19;117:12,20;
118:14;120:11,14;
126:7,21;127:4;
128:19;130:6;132:6,
11;133:1;135:8;
139:10,21;140:1;
142:5,9,15,20;
143:19,20;145:14,14;
146:19;147:19;
148:17;152:17;
153:5,12
rising (1)
11:13
risk (9)
52:13;66:20;67:3;
125:19,20,22;126:3;
131:7;146:18
risks (1)
70:19
road (1)
56:12
ROBB (108)
5:3,7,8;6:4,16;
7:24;9:23;10:1,3,5;
12:3,5,6;13:8,13,14;
14:13;15:4,8,13;20:7,
21;23:18,20;27:1;
31:21;35:24;36:22;
42:4,17;46:19;47:16,
18;56:18;58:16;60:6;
61:15;62:10,17;63:3,
8,12,17;67:12;69:16,
18;71:5,7,22;72:5,10,
15,17,19;75:5,23,24;
76:21;77:7,8,15,21;
80:23;81:20,22;
83:17;85:4,7;86:15;
93:19;96:17;105:4,5;
114:1,20;115:6,11;
124:19;125:16;
130:19;132:5,10,15,
18,23;133:1;137:8;
144:8;148:20;149:3,
5,10;150:10,16,24;
151:5,18;152:1,6,14,
20,23;153:2,4,6,9,11,
13
Robert's (2)
74:24;76:16
robust (4)
44:8;45:14;46:7;
50:12
robustly (2)
47:7,11
role (2)
38:1;109:13
roles (1)
47:4
roll (4)
5:6;34:11;47:10;
60:15
rolled (2)
47:9;61:22
rolling (2)
38:5,6
rollout (2)
47:14;54:8
room (4)
17:22;45:17;47:2;
78:10
root (1)
94:2
Rosa (1)
12:7
rough (4)
16:14,14,15;90:8
route (1)
40:19
routinized (1)
111:13
row (3)
89:11;118:15,23
RPEN (2)
6:18,20
rude (1)
126:2
rule (1)
29:2
rule-making (1)
77:2
Rules (6)
74:24;75:10,17;
76:16;82:10;83:5
run (5)
79:10;103:10;
117:22;125:9;146:1
running (8)
98:23;103:9;116:9,
12,13,15,17;145:22
runway (1)
45:4

S

safety (2)
136:21,22
salaries (1)
98:7
salary (1)
7:9
Sam (1)
78:13
same (46)
15:23;27:7,9,24;
34:15;41:6,7;46:9,
11;70:15,24;74:13,
15;75:10;78:23;
82:12,19,20,20,20;
84:9,23;91:17;92:22;
93:13;95:19;97:3;
107:12;110:4;111:2;
117:23;120:1;
126:10,19;127:20;
139:10,13,23;140:18;
141:7;142:6;143:3,
13,24;147:15,17
sample (4)
62:20;79:11,18,23
sampling (1)
86:3
Sanford (1)
54:7
SAP (1)
39:9
satisfy (1)
92:18
saving (2)
29:18;53:14
savings (1)
134:2
savvy (1)
87:15
saw (6)
84:13,21;91:15;
95:16;113:14;121:20
saying (23)
15:10,13;26:17;
36:8;41:9;63:5,9;
67:21;72:7;77:18;
85:5;96:22;108:14;
115:8;128:1;130:1;
140:7;141:14;
142:14;143:6;149:7;
151:2;152:3
scared (2)
13:3;87:20
scenes (2)
19:3;103:7
schedule (3)
23:4;150:5,7
scheduled (3)
13:3;19:11,23
School (1)
49:18
scope (3)
41:1;78:22;79:8
scrambling (1)
34:11
scraps (1)
125:12
screen (1)
48:19
screening (2)
79:10,23
screenings (1)
79:9
Scripts (3)
110:5;119:16;
120:24
seamless (2)
46:6;111:1
second (48)
11:8;15:5,7,8;19:8;
29:24;31:2,4,24;32:2,
16;33:6,8,14,17;
53:16;58:21;63:2,3;
69:22;72:4,6,24;
77:14,16;79:22;

82:22,24;84:10;85:2;
89:3;95:14,15;99:19;
100:21;106:20;
109:3;115:5,6;
118:15;138:12;
145:8;149:4,5;
150:23,24;151:24;
152:1
secondary (2)
51:1;70:8
secondly (3)
23:3;59:16;68:10
seconds (2)
89:6,7
secret (1)
82:6
section (2)
51:12;64:18
Sections (1)
52:3
secured (1)
107:2
Seeing (24)
10:2;15:1,9;22:24;
23:3;36:23;47:18;
63:4;68:13;71:2;
72:6;81:4;93:13;
94:5;98:24;115:7;
117:18;122:22;
127:23;129:7;
148:20;149:6;151:1;
152:2
seek (2)
9:15;146:4
seem (3)
27:23;91:16;114:5
seemed (1)
91:16
seems (3)
23:13;83:20;95:12
Segal (19)
38:3;101:19;
115:14,16,17;116:3;
118:24;120:20;
121:5;133:10,23;
134:20;136:1;137:6,
20;149:23,24;150:7;
152:11
select (1)
144:15
selected (1)
77:1
selecting (1)
25:15
self-funded (2)
56:13;110:13
Self-Insured (2)
14:21;49:15
Self-Management (3)
47:23;49:23;53:17
self-reported (1)
81:14
semi-easy (1)
35:8
senate (1)
18:10
send (2)
108:4;112:1
sending (2)
109:18;110:10
senior (1)
106:11
sense (6)
41:23;67:15;75:17;
91:17;92:7;146:13
separate (1)
39:15
separately (1)
14:17
September (3)
30:15;78:3;85:22
service (16)
39:16;43:8,13;
88:1;93:24;96:15;
97:1,8,14;105:7,12,
14,20;111:9;117:5;
120:18
services (13)
10:23;16:13;17:2,
4;24:14,20;57:22;
66:4;84:8;111:3;
141:14;146:4;149:24
servicing (1)
16:17
session (8)
7:8;18:18;20:4;
27:20;29:16,17;31:2,
4
sessions (2)
28:8;54:4
set (6)
19:10;28:14,15;
94:22;105:6;122:24
setbacks (1)
38:15
sets (1)
82:9
Setting (4)
125:13;133:15;
134:17,21
seven (7)
7:5;53:1;55:2;
61:22;81:3;92:4;
110:6
several (6)
52:6,18;76:9;
108:9;134:1;150:4
severe (1)
20:12
severely (1)
104:22
share (3)
48:19;102:14,19
sharing (1)
49:2
sheets (1)
35:12
shock (3)
126:2;142:18;
146:2
shop (1)
34:6
short (3)
56:16;132:14,15
shortage (2)
7:1;98:5
shortages (2)
7:3;126:9
Shortly (2)
37:23;38:13
shots (1)
67:24
show (8)
23:5;26:4,7;31:5;
49:2;54:16;64:15;
89:3
shows (2)
118:1;121:16
shut (1)
36:10
side (1)
117:12
sign (1)
108:4
signed (1)
50:12
significant (7)
53:15;95:10,12;
99:24;101:24;
104:15;146:13
significantly (1)
79:3
signify (9)
15:10;63:5,8;72:7;
77:17;115:8;149:7;
151:2;152:3
similar (11)
8:7;29:20;39:4;
50:14;79:20;120:6,
12;121:20,20,20;
122:16
similarly (1)
118:6
simple (5)
53:7;54:2;108:1;
111:9;139:6
simplify (1)
139:1
single (6)
8:19;9:12;41:22;
64:8;123:21;138:3
sits (1)
68:8
situation (24)
16:1;17:21;20:12;
25:10;26:9,14;27:4;
28:17;35:13;41:15;
50:21;52:23;58:10;
74:14;79:5;89:17,20;
90:1;93:10;101:20;
104:3;111:21;145:1,
9
situations (13)
41:20;50:20;57:8;
67:3;90:9;91:20,23;
92:14,21;93:11;
97:11;108:23;131:20
six (25)
10:13,17,20;11:19;
35:7;52:3,3;54:5;
61:5,21;64:11;68:20;
69:19;74:17;76:2,4,4,
5;81:2;92:4;95:2,11;
114:11,14;127:7
six-week (2)
54:3;61:11
slash (1)
42:19
slide (4)
10:4;119:5;152:22;
153:5
slides (2)
116:19;122:6
slight (1)
34:9
slightly (1)
25:1
slow (1)
85:23
slowed (2)
85:16,20
slower (1)
124:24
slowly (3)
10:14;12:16;13:10
small (5)
51:16;68:16;125:8;
131:8;138:19
smallest (1)
68:18
Smart (7)
37:20;38:2,10,14;
39:2;41:16,17
smile (1)
77:6
smiling (1)
30:20
smoking (1)
64:19
smooth (1)
145:5
smoothly (4)
17:6,17;36:14;39:7
Software (2)
39:9;46:3
solicit (1)
120:21
solicitation (2)
151:9,16
solicitations (2)
149:16;152:10
solution (6)
7:9;40:24;43:22;
44:4,4;151:13
Solutions (3)
39:18;40:22;41:12
solve (2)
87:13;106:3
somebody (5)
13:15;25:9;93:12;
107:13;152:23
someone (7)
26:10;42:24;83:20;
100:18;106:14;
142:11;144:16
sometimes (16)
24:3;36:14;52:21;
55:10;84:3;87:3;
89:18;93:11;110:2;
114:4;116:23;
123:15;126:24;
127:1;131:16;142:3
somewhat (4)
33:20;104:2,16;
136:4
somewhere (3)
42:8;97:21;114:14
soon (1)
152:13
sorry (17)
13:20;27:1;36:1;
44:16;49:4;60:8;
70:3;72:17;74:7;
78:7;89:2,10;111:16;
128:23;138:7;
144:10;153:5
sort (8)
34:19;85:13;90:3;
95:22;97:17,24;98:3;
128:18
sorts (1)
19:17
sounds (5)
47:16;57:3;87:18;
108:6,7
south (1)
54:10
space (2)
17:23;128:9
Sparks (2)
49:19;55:9
speak (6)
12:8,12,15;33:3;
48:14;81:18
SPEAKER (2)
71:13,16
speaking (2)
45:10;120:17
spearheaded (1)
20:22
special (1)
104:11
specialist (3)
67:20;93:13,14
specialists (1)

68:2
specialty (1)
80:2
specific (16)
17:12;39:9;41:20;
59:18;76:13;79:20;
88:20;115:24;
116:19;117:10;
119:19;123:18;
124:11;135:13;
138:12,21
specifically (13)
19:1;56:5;57:23;
58:1,10,11;59:20;
74:4;86:18;91:23;
107:3,16;136:5
spectrum (1)
68:9
speed (5)
88:13;89:3,6,7,8
spell (4)
6:13;10:14;12:16;
13:10
spelled (1)
10:22
spend (2)
62:5;147:23
spending (4)
23:14;40:11;50:16;
141:4
spoke (1)
108:8
spouse (1)
135:13
spread (1)
104:13
square (2)
39:1;41:7
squeaky (1)
33:24
squeeze (1)
143:22
stability (3)
122:22;123:1;
137:2
stabilization (1)
7:13
stabilized (1)
98:11
stable (3)
125:2,9;135:9
staff (34)
5:6;6:5,9,23;11:7;
16:5,9,16,20,21,22;
17:3,24;18:24;31:12;
36:16;37:16;44:8;
45:22;62:7;73:4,9;
99:20;100:18;
102:24;109:17,22;
110:7;126:12,12;
148:23;150:6;
151:11;153:14
staffed (1)
77:9
staffing (8)
6:24;7:3;15:24;
16:12;18:8;23:23;
97:5;126:9
stage (2)
60:1;105:7
stake (1)
55:16
stamp (1)
106:17
stance (2)
84:5,8
standard (10)
65:12,12;66:1,8,
22;70:19;106:18;
108:20,21;134:22
standardly (1)
67:19
star (3)
10:13,17,20
start (13)
6:5,11,14;18:2;
28:1;52:22;60:12;
78:8;85:10;109:18;
110:10;139:2;147:6
started (3)
41:15;95:17;
120:10
starting (1)
41:7
starts (4)
108:4;109:19;
121:18;126:1
state (64)
6:12;7:2,3;8:5,8,
13,16,22,22,23;9:2,6,
17;10:14;12:24;
13:10;20:11;21:1,18;
22:20;30:13,21;
36:20;37:24;38:18,
20;40:14,17;42:21;
43:8,9,13,13;46:7;
49:24;50:2;54:9,13,
22;55:12;56:4,5,9;
59:17,23;60:3,15;
64:21;69:10;78:1;
88:21;98:18;104:4;
107:18;123:19;
125:2,8,9;133:4;
135:15,16;137:10,11;
151:12
Statements (2)
14:20;85:7
states (3)
50:16;51:9;57:12
State's (1)
151:14
statewide (4)
6:22;37:1,21;39:17
statistically (1)
79:11
statistics (3)
54:16;61:9;88:13
status (5)
17:9;78:19,20;
135:16;149:15
statute (1)
74:7
statutes (1)
39:24
stay (5)
90:23;132:7;
135:11,18;147:24
staying (1)
146:6
stays (1)
75:22
steadily (1)
119:13
steer (1)
140:23
step (13)
20:24;21:1,2,3,3,4,
7;76:23,23;117:8;
120:6;133:21;140:23
steps (6)
28:6;29:12;77:2;
80:19;100:6;122:20
sticker (1)
146:2
still (17)
21:8;24:18;44:23;
67:5,21;69:1,3;
83:13;91:2;93:5;
111:12;127:5,12;
128:18;132:21;
142:13;148:5
stink (1)
30:19
stop (3)
123:24;137:6;
150:9
stoppage (1)
94:15
stopped (2)
94:11;99:15
store (1)
126:1
story (1)
146:7
straight (2)
63:13;108:9
straighten (1)
95:11
strain (1)
53:11
strategic (2)
28:8;29:16
strategy (1)
131:17
streamed (1)
10:7
stress (1)
52:16
strict (1)
82:19
strong (2)
91:8;121:21
structural (1)
28:1
struggles (1)
7:2
struggling (2)
51:17;102:10
stuff (8)
18:4;34:9,10;
44:11;45:8;57:20;
88:3;127:9
subcontractors (1)
40:7
sub-grant (1)
54:22
subject (6)
45:17;46:10;47:1;
80:9;82:17;130:16
subjective (1)
7:15
submission (1)
7:5
submit (7)
75:2;76:23;109:22;
113:6,15,18,19
submitted (4)
73:14;113:7,22,23
submitting (1)
75:3
subscriber (1)
118:4
subside (1)
114:17
subsided (1)
91:4
subsidies (2)
143:1,5
subsidization (1)
145:21
subsidize (4)
21:20;129:19;
130:2,17
subsidizing (5)
130:10;145:18;
146:24;148:6,7
subsidy (16)
33:13,16;137:11,
13,16;138:1,15;
139:3,5,20;141:20,
20;142:6,7,16;144:14
substantial (1)
119:22
substantive (1)
27:13
success (5)
60:19;66:7,12,14,
15
successful (4)
8:10;16:5;66:20;
68:13
SUCKOW (10)
78:6,12,12;81:11;
82:8;83:11,23,23;
84:19,19
suddenly (1)
25:14
sufficient (1)
74:23
sugar (1)
16:13
suggested (2)
81:4,5
summarize (1)
138:15
summarized (1)
116:2
summary (8)
72:12;78:14,22;
80:8,16,22;115:22;
116:8
super (1)
47:2
supplement (1)
81:7
supplemental (1)
81:15
supplied (1)
134:22
supply (1)
127:7
support (8)
16:23;47:23;51:10;
53:17;67:15;82:24;
85:1;115:3
supporting (2)
36:19;113:20
suppression (1)
118:17
sure (29)
18:12;26:18;27:8;
43:21;44:12;47:2,3;
57:2;60:17,21;64:22;
85:13,21;86:12,13,
22;96:7;99:4;100:14;
101:16;103:19;
105:1;107:24;127:5,
20,22,22;146:15;
152:16
surface (1)
79:14
surgeries (2)
11:14,16
surgery (1)
11:18
surplus (3)
135:19;140:9;
144:21
surprise (1)
16:1
surprised (1)
70:18
surprisingly (1)
150:17
survey (4)

116:2;120:21;
121:6;122:9
surviving (1)
135:12
switch (2)
18:4;25:6
switched (1)
153:2
system (25)
35:6;36:7;37:15,
17;38:7,20;40:9;
46:5,8;47:3,8,9;
82:10,12;83:18;91:2,
3,7;92:2;94:8;98:22;
101:6;102:23;
110:20,21
systems (8)
37:22;39:23;41:21;
43:1;47:5,5;91:1;
94:7
Syverson (22)
48:2,4,6,9,13,19,
23;49:1,4,7;57:6;
58:3,15;59:1,2,6;
60:11,21;61:7,18;
62:14;63:10

T

table (9)
27:1;28:10;37:4;
54:23;78:8;117:20;
118:13;119:12;
120:13
tables (2)
35:21;117:11
tabs (1)
35:11
tack (1)
132:11
tags (1)
141:7
Tahoe (1)
103:3
talent (1)
126:13
talk (24)
17:19;25:9;27:17,
19;49:10,21,23;51:2,
20;54:23;69:13;
74:20;77:12;87:16,
17;89:24;92:20;
106:12,23;107:3,15;
116:4;117:16;141:3
talked (8)
21:17;45:21;57:13;
77:11;88:1;92:17;
109:8;126:9
talking (8)
21:13;27:6;50:13;
69:8;73:12;102:23;
105:19;107:13
target (2)
50:17;61:11
targeted (1)
57:12
task (1)
132:9
taught (1)
50:23
tax (2)
6:22;103:11
t-a-y-l (1)
13:10
teaching (1)
11:1
team (13)
80:18;86:4;89:24;
90:5;95:19;103:14;
104:2,20;111:2;
133:10,23;136:1;
137:20
technical (3)
86:14;148:24;
149:1
Technologies (1)
77:24
teeth (2)
11:19,23
telephone (1)
88:1
telling (1)
109:3
ten (15)
21:3,5,7;53:5;
54:17;73:3,6;74:17;
76:3,4;88:18;90:19;
95:2;114:14;119:14
tend (2)
21:20;142:2
tenth (1)
96:11
term (1)
143:2
terminate (4)
37:9,23;131:6;
132:2
termination (3)
38:1;131:2;150:1
terms (4)
74:8;80:19;126:24;
131:6
Terri (1)
6:17
terrible (2)
31:10;36:13
test (6)
44:22,24,24;45:5;
84:21;85:2
tested (4)
47:3,5,9,11
testified (1)
7:7
testify (2)
18:16;129:23
testimony (1)
9:21
testing (13)
44:16,17,17,20,23,
24,24,24;45:3;46:20;
47:7;68:4;94:9
tests (1)
84:23
thanking (1)
6:5
Thanks (2)
44:1;47:16
therapy (1)
17:13
thereabouts (1)
81:5
thereof (1)
52:21
thinking (4)
30:12;33:9;34:3;
110:3
third (5)
24:23;68:21,22;
99:13;109:4
third-party (2)
54:12;56:2
thorough (1)
68:4
thoroughly (1)
45:6
though (3)
12:21;69:10;93:6
thought (10)
29:14;30:24;45:14;
46:16;47:11;84:13;
105:21,23;143:14;
147:2
thoughtfully (1)
27:19
threaten (1)
87:5
threatening (1)
87:7
three (35)
6:12;9:7;34:12;
35:7;46:21;64:11;
68:15;70:20,20;
71:13;77:12;78:22;
80:7,8;86:17;88:5;
92:8;98:1;102:9;
103:15;116:20;
117:11,21;118:20;
120:18;123:21;
129:2,3;130:22;
137:11,14,16;138:21;
140:24;143:24
three-year (2)
127:1;128:8
throughout (3)
19:21;38:16;54:9
throwing (1)
34:17
THURSDAY (1)
5:1
tie (1)
35:12
tied (1)
99:1
tier (1)
24:21
tiering (2)
133:19,19
tiers (4)
123:20;133:21;
135:13;141:22
Tim (2)
80:18;103:10
timeline (3)
69:7,12;152:12
timeliness (1)
85:24
timely (2)
94:17;114:8
times (9)
7:7;57:11;59:10;
77:12;82:2;86:8;
90:8;97:11;108:9
timing (1)
30:8
tiny (2)
145:19;148:8
tips (1)
53:20
tobacco (1)
64:19
today (22)
9:13;15:16;17:22;
20:14;21:12;37:14;
38:12;45:22;48:15;
49:10,21;51:2,20;
57:21;62:11;66:22;
77:4;90:16;114:21;
135:17;145:17;
149:12
today's (1)
42:8
together (16)
14:16;39:1,3,15;
40:13;41:8,9,10;
48:9;55:6;68:4;81:8;
105:15;128:9;143:1;
153:15
told (4)
46:14;106:16;
128:20;150:17
Tom (8)
5:21;20:8;42:5;
61:16,18;75:24;
80:24;137:9
took (6)
6:7;85:21;94:13;
98:9;125:23;153:15
tool (2)
107:17;108:1
top (8)
41:5;97:13;103:8;
119:5;124:13,14;
128:14;134:1
topic (1)
119:24
topped (1)
21:5
total (11)
53:12;76:2,5;79:2;
80:10,13;81:1;90:19;
91:24;96:9;143:4
touch (3)
38:18,18;113:13
touches (2)
38:18;41:22
tough (1)
88:18
towards (1)
53:13
TPA (2)
17:16;100:15
TPA's (1)
26:1
track (2)
100:14;111:24
tracked (1)
138:18
train (1)
52:5
trained (3)
54:5;101:6;107:24
trainers (1)
54:9
training (8)
52:8,8,12;54:6;
55:4,6;56:1;79:19
transition (3)
85:11,16;95:7
transitioned (1)
105:23
translates (1)
118:10
transparency (2)
128:1,3
treatment (5)
67:22;68:16,20;
69:2;71:9
treatments (1)
68:3
trend (34)
115:13;116:9;
117:1,2,13;118:11,
12,14,21,22;119:1,1,
9,12,23;120:7,10,13,
14,17,21;121:2,6;
122:2,8,8,10,12;
123:4;125:11;136:1,
5,6;142:10
trending (1)
99:11
trends (22)
99:2;115:19;116:1,
2,14,15,18,21,21,22,
23;117:16,22,23;
118:17;120:15,16,17;

121:16,23;122:1;
123:5
trepidation (1)
24:1
triangle (1)
26:19
trickle (1)
91:4
tricks (1)
53:20
tried (4)
18:23;26:7;139:6;
143:18
triggered (1)
64:17
triggers (1)
53:21
trips (1)
122:18
trouble (1)
76:19
true (1)
128:20
truly (3)
6:8;112:18;153:16
Trust (2)
14:21;95:5
try (15)
9:3;11:14;12:1;
28:8,10;33:18,20;
48:22;50:17;62:24;
93:8;108:24;129:3;
131:4;144:15
trying (9)
16:23;18:1;34:14,
16;37:10;70:4;109:5;
153:6,9
turn (4)
36:15,15;97:24;
109:14
turnaround (4)
79:5,14;94:14;96:3
turned (2)
25:7;107:18
turns (1)
136:15
twice (1)
84:9
two (63)
9:3;11:10,14;
14:23;31:23;32:7;
33:19;34:3,12;41:2,8,
10,12;43:14;49:12;
52:20;54:4;58:17;
64:7,10;69:21,22;
70:20,20;82:9;84:22;
86:13;89:6;92:21;
93:15,17,17,23;94:1,
20;96:11;97:24;
103:15;114:18;
116:8;117:11;
118:18,19,21,23,23;
119:4,23;122:14;
125:18;127:1,3;
136:10,10,18;137:17,
17;138:7;140:9,15;
141:6,7;144:2
two-year (1)
30:8
type (26)
50:4;52:1,13;53:3,
4,6,7,18;54:4;57:22;
58:12,19;59:7,9;66:3,
7,14,19,19;67:9;
74:10,14;101:7;
103:19;109:23;
133:18
types (7)
21:11;57:19;58:8;
71:9;81:14;94:11;
116:21
typically (13)
18:20;22:1;28:12;
33:11,13;60:22;
66:15;67:1;128:7;
131:17;133:12,14;
147:4

U

u-c-k-o-w (1)
78:13
UHC (2)
120:24;125:5
ultimate (2)
50:3;90:10
UMR (26)
78:2,10,17;79:5,
17;80:17;81:18,23;
82:6;83:3;84:20;
85:5,5;86:7;102:22;
104:2,20;105:23;
106:7,14;108:9;
112:16;120:24;
125:5;126:16;130:21
UMR's (4)
79:13;80:8,17;82:1
unable (1)
68:17
unanimous (5)
15:14;63:9;77:22;
151:6;152:7
unanimously (10)
15:11;63:6;72:8;
77:19;115:9,11;
149:8,11;151:3;
152:4
uncomfortable (1)
69:6
uncommon (3)
82:8;83:11,13
uncovered (1)
65:20
under (11)
10:22;30:11;39:17;
40:2;47:6;75:15;
76:2;86:20;87:6;
104:5,9
undergoing (1)
97:12
underwriting (1)
133:16
undo (1)
19:16
Unfortunately (3)
15:24;108:20;
110:21
UNIDENTIFIED (2)
71:13,16
uniform (1)
138:11
uniformly (2)
138:2,16
Union (2)
8:4;9:20
unique (5)
76:14;104:3;
110:14,15,17
unit (3)
16:13;22:22;118:5
United (2)
7:18;51:9
unless (5)
14:16;83:21;84:15;
131:18;132:8
unlikely (1)
84:22
unmute (7)
10:14,17,20;12:8,
13,15;13:11
unmuted (1)
10:12
un-muting (1)
13:22
unplanned (1)
150:4
UNR (1)
85:5
unsuccessful (2)
37:11;66:19
unusual (1)
116:16
up (74)
9:1;11:15;12:20;
16:18;17:21,24;
18:19;19:14;21:4,24;
23:5;27:4;28:19;
29:15,17;31:11;32:6;
33:3,8,11,12,15;44:5,
7,23;45:12;49:9;
51:19;59:21;61:20;
62:4;63:13;64:5;
65:5;67:14;76:2;
78:11;81:15;84:5,9;
85:8;90:3,15;91:8,9;
95:8;96:20;97:21;
98:6;99:4,21;100:20;
104:17;107:11,15;
108:1;109:12;124:3;
126:23;129:7,12;
130:9,13,13,24;
136:16;137:4;
140:13;141:16;
145:1;147:13,16;
152:21;153:4
upcoming (1)
110:1
update (2)
64:11;150:7
updated (4)
19:12;36:7;64:14;
150:5
updates (3)
64:9;65:20,22
upon (3)
80:14,18,19
up-to-date (1)
88:12
upward (2)
126:15;127:14
use (16)
11:1;40:21;43:22;
44:15;63:14;97:21;
107:14,14;116:5;
118:4;121:9;122:17,
24;131:17;132:2;
145:5
used (12)
10:6;13:22;17:22;
20:23;66:12;67:19,
22;69:12;85:5;111:6;
118:22;147:4
users (1)
47:3
uses (1)
43:18
using (12)
11:12;37:14;40:1,
23;41:6;45:8;47:7;
66:4;78:23;106:4;
123:4;143:2
Usually (7)
17:3;21:4,22;
33:12,23;87:16;
101:3
Utah (1)
8:23
utilization (10)
65:2,23,24;66:7,10,
24;117:4;118:16;
124:6;134:12
utilize (3)
11:22;40:7;97:17
utilized (2)
67:4;119:19
utilizers (1)
103:2
utilizing (2)
40:19;55:13

V

vacancies (1)
9:2
vacancy (4)
16:2;20:10;22:21;
126:10
valid (2)
79:11;83:24
validated (1)
79:7
value (5)
27:23,24;57:18;
143:2,12
Vanessa (2)
12:14,17
variations (1)
138:6
varies (1)
138:2
vary (1)
126:24
Vegas (2)
104:12,13
vehicle (1)
40:1
vendor (12)
26:2;37:20;40:4,5,
6;41:7,10,11;43:21;
83:19;123:16;151:12
vendors (4)
39:5,6;41:10;82:5
Verducci (30)
5:21,22;20:7,8,8;
22:18;42:4,5,5,16;
61:15,16,16,19;
69:17,18;75:23,24;
76:1,18;80:23,24,24;
81:17;137:8,9,9,15,
23;138:22
verify (2)
80:3;112:24
versa (1)
110:4
versus (13)
21:20;27:16;39:15;
41:8;45:8;58:4;
101:4;117:23;
123:19,20;136:3;
143:4;147:11
vet (1)
40:22
vetting (1)
23:2
via (5)
7:9,17,18;106:24;
107:1
vice (2)
76:11;110:3
virtual (3)
52:20,20,23
virtually (3)
48:2;78:5,13
vision (1)
59:13

visit (4)
112:19,22,23; 113:1
visiting (1)
106:5
visits (1)
59:11
visually (1)
10:23
voc (1)
10:22
voices (1)
33:23
volatile (2)
119:10;125:11
volatility (2)
118:13;122:23
volume (3)
91:10;110:8,8
Volunteer (1)
46:17
voluntold (1)
46:17
vote (16)
15:9,11;63:4,6; 72:7,8;77:17,19; 115:7,9;149:6,8; 151:1,3;152:2,4
voting (2)
14:6,8

W

wages (1)
18:14
wait (2)
84:16;102:5
walk (1)
63:14
wants (3)
62:23;128:22; 137:7
Ward (28)
115:13,15,16,18; 124:6,17;125:1,13; 126:5,8,22;127:5; 137:24,24;138:10; 139:8,15,17,19,21; 140:1,4,15;142:23; 143:15;144:18,18; 145:23
warning (1)
146:6
Washoe (2)
49:18,18
watch (1)
10:8
watched (3)
27:12;31:16; 129:23
waves (1)
18:2
way (24)
21:3;24:4;27:24; 28:2,7,22;29:13; 30:5;33:9,15;35:18, 19;41:12,13;44:22; 86:24;87:10;96:18; 97:17;116:7;118:5; 136:20;139:5;141:1
ways (9)
18:10,12,13;19:6, 19,21;58:7;102:2; 136:19
week (6)
7:5;9:7;26:12; 54:5;88:18;91:6
weekly (3)
52:3;102:12,14
weeks (3)
17:24;54:5;61:5
weight (9)
52:24;53:1;57:9, 15;58:1,2,9;60:24; 61:12
Welfare (1)
14:22
wellness (12)
61:20;105:21,22, 22,24;111:6,11; 112:15,19,22;113:1,1
Wells (1)
46:23
weren't (5)
85:17,21;94:9,10; 95:17
what's (13)
12:1;53:16;69:13; 99:1,2;100:6,24; 101:12;107:8,8; 120:3,19;152:15
wheel (1)
33:24
whenever (1)
51:3
Whereas (3)
21:21;22:3;142:11
Where's (1)
107:2
Whereupon (2)
63:16;132:17
white (1)
84:4
whole (6)
21:20;65:24;68:8; 93:21;96:13;135:8
who's (1)
142:11
whose (1)
14:4
wildlife (1)
47:8
willing (1)
112:20
willingness (1)
31:5
wish (7)
10:8,17,20;12:8,13, 15;13:11
within (14)
16:7,8;46:3,5;50:5; 57:2;61:11;83:18; 87:14;97:22;101:3; 114:4;131:24;138:5
without (5)
114:8;117:2; 144:12,16;145:9
Wolf (1)
62:15
women (2)
68:14,17
wonder (4)
24:7;25:5;34:4; 125:18
wondering (6)
27:14,21;76:1,6; 82:4;126:2
Woodward (15)
5:23,24;31:21,22, 22;33:2;71:6,7,8,8; 72:4;77:14;147:1,1; 148:2
words (1)
122:17
work (58)
6:23;8:12;10:22; 18:18;19:14;20:4; 23:22,24;35:22; 36:17;38:21;39:1,3,6, 13;40:12,13;41:1,8, 10,13,23;43:1,21,21; 45:6,22;46:5;49:15, 17;50:9;51:4,24; 52:11;54:9;55:24; 59:23;60:2;62:7; 74:1;87:18;93:13,14, 15,16;95:6,22;97:20; 98:21;109:17,21,22, 24;115:20;145:7; 150:14;152:10; 153:15
workbooks (1)
35:11
Workday (6)
43:18,22;44:3,4,4,6
worked (13)
8:6;35:9;47:4; 53:23;54:1,12;55:8; 60:14;80:18;87:14; 99:22;139:13;141:2
workers (4)
7:10;8:17;9:6;98:5
workforce (1)
98:11
working (20)
19:18;22:15;38:5, 9,24;39:8;41:5; 46:22;52:7;59:17; 63:11;87:9;91:3; 95:9,17,19,20; 103:20;108:24; 147:12
workload (1)
55:19
works (14)
12:24;30:13;34:19; 41:12;44:6;46:8; 49:13;55:12;60:3; 62:21,24;86:3; 109:15;147:11
workshops (2)
31:16;74:9
world (1)
55:22
worth (1)
114:14
wrong (1)
146:15

Y

year (103)
9:18,19;11:8,10, 15;16:15,15;17:8,16; 18:24;19:1,7,8,9; 21:4,14;23:13;24:9, 23;25:24;27:15,17; 28:9,14,15;29:15; 30:7,13,14,15;31:11; 32:2;33:6,8,12,14,17; 34:3;44:18;52:1; 53:8,14;61:7,8; 62:23;63:21;67:11; 78:24;88:24;99:14; 109:20,21;110:5; 116:10;117:12; 118:12;119:15,22; 120:15,20;121:3,5, 11;122:9,10,23,24; 123:11,18;127:3,7; 128:10,10,10;133:3, 24;134:23;135:7,18, 23;136:12,21;138:2, 5,7;139:11,14,18,23; 140:7,18;141:16,18; 143:5;144:22;145:6, 6,6,8,9;147:6;148:17; 150:4
years (39)
7:15;8:5,11,13; 23:13;27:12,13; 33:19;49:13;53:5; 61:21,22;66:11;77:9; 81:3;87:15;97:20; 98:1;116:10;117:21, 21;118:18;119:14; 120:2,15,22;122:14, 23;125:13;129:2,3,4, 5;130:22;138:7,9; 140:22,24;148:18
yep (1)
113:11
YouTube (4)
10:8,9;132:21; 152:24
yo-yo (2)
7:15;137:4
yo-yoing (1)
135:7

Z

Zach (1)
81:7
zero (1)
22:10
Zoom (5)
6:7;10:6;93:21; 132:21;152:19

1

1 (5)
30:15;34:11;64:14; 78:2;133:3
1,500 (3)
87:8;148:14,16
1,800 (1)
87:8
1.5 (1)
80:10
1.6 (1)
118:11
1.7 (1)
117:23
10 (2)
115:12,18
10,000 (2)
58:18;59:4
10:00 (1)
63:13
10:15 (1)
63:18
100 (6)
16:23;20:18;79:9, 22;105:8;141:13
11 (5)
70:12;72:2;132:19, 20;133:2
12 (11)
15:16,18;36:23; 47:19;70:2,13;72:3; 97:5;125:17;149:13; 151:8
12,000 (2)
51:10;90:19
12:15 (1)
132:16
120,000 (1)
92:1
121,231 (1)
79:2
12-month (1)
60:10
12th (2)

72:24;149:24
13 (1)
149:14
13.1 (2)
120:14;149:18
13.2 (1)
149:20
13.3.1 (1)
149:22
13.5 (1)
152:9
13.5.1 (1)
151:8
14 (3)
122:19;140:14;
152:17
14,000 (2)
90:17;99:24
15 (2)
35:11;118:17
15-minute (2)
63:14;132:11
15th (1)
25:13
160 (1)
147:11
17 (2)
6:22;68:19
17th (1)
18:11
18 (2)
68:14;97:6
180 (3)
131:6,13,14
1976 (1)
6:20
1st (4)
18:19;57:24;
109:20;110:11

2

2 (13)
50:4;52:1,13;53:3,
4,6,7,18;54:4;58:12,
19;59:7,9
2,000 (1)
90:20
2,400 (3)
54:14,18;58:22
2,500 (1)
90:20
2.1 (1)
122:12
2.4 (1)
136:11
2.5 (1)
146:12
2:30 (1)
27:2
20 (5)
115:20;119:14;
124:13,14;143:21
20,000 (3)
47:7;66:11;90:16
200 (1)
87:7
2001 (1)
102:22
2011 (1)
65:14
2019 (3)
37:19;118:8;122:9
2020 (4)
68:19;118:17;
121:21;122:12
2021 (2)
118:15;120:14
2022 (6)
37:8;68:14;78:2,3;
149:24;151:11
2023 (9)
5:1,5;14:19;63:22;
64:14;78:24;121:24;
133:3;143:5
2023-003 (2)
72:21;73:1
2024 (2)
63:22;133:3
2025 (1)
37:18
2027 (1)
150:1
208 (1)
119:7
20th (1)
7:6
21 (8)
37:20;38:2,10,14;
41:16,18;63:22;
143:21
22 (2)
8:5;118:9
23 (2)
5:1;117:12
23rd (1)
5:5
24 (5)
21:14;63:21;
117:13;122:21;133:3
241 (1)
74:19
24th (2)
37:7;151:11
24-year (1)
22:20
25 (3)
89:6;130:5;144:22
25,000 (2)
99:22,22
26th (1)
14:19
281A420 (1)
14:3
287 (1)
73:5
287.170 (1)
76:9
287.178 (1)
76:9
287.3125 (1)
74:16
287.318 (1)
73:12
287.319 (1)
73:18
287.510 (2)
73:24;75:7
287.515 (1)
74:13
29 (1)
89:7

3

3 (1)
13:17
3,700 (2)
54:14;58:21
3.1 (1)
122:5
3.3 (1)
116:11
3:00 (1)
36:9
30 (15)
16:2;30:15;49:13;
63:22;78:3;90:20,22;
95:2;99:23;100:12;
131:12,24,24;132:3;
133:3
300 (1)
68:24
30-day (1)
131:2
30th (3)
19:24;20:4;150:1
31st (1)
109:20
323 (1)
121:14
3247 (2)
10:16,18
33 (1)
130:5
333.475 (1)
40:2
34 (2)
53:5;89:3
35 (1)
97:23

4

4 (1)
14:14
4.1 (1)
14:18
4.2 (1)
14:20
4.5 (1)
80:10
40 (1)
8:11
4041 (2)
8:3;11:4
45,000,000 (1)
51:11
45349 (1)
13:10
4696 (1)
139:15

5

5 (3)
15:17,17;117:24
5:00 (1)
36:10
50 (5)
22:21;51:8;52:13;
97:24;104:8
515 (1)
75:8
58 (1)
53:3
58,066 (1)
81:11
58,660.44 (1)
80:13

6

6 (2)
15:18;47:21
6.8 (3)
122:10,11,13
60 (3)
53:3;90:22;99:23
620 (1)
139:3
6358 (1)
10:19
650 (1)
139:3
652.46 (2)
139:16,17

7

7 (1)
63:19
7.1 (2)
122:10,12
7.2 (1)
72:12
7.4 (1)
122:2
70,000 (1)
16:16
71 (1)
53:5

8

8 (1)
72:20
8,000 (1)
6:20
8:30 (1)
5:3
85,000 (1)
47:10

9

9 (1)
77:23
9.59 (2)
140:12,13
9.8 (1)
122:1
90 (5)
114:4;119:9;131:6,
12,14
99 (1)
92:6
9th (1)
88:2