In The Matter Of:

PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD
VIDEOCONFERENCED OPEN MEETING

December 7, 2023

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

VIDEOCONFERENCED OPEN MEETING

THURSDAY, DECEMBER 7, 2023

CARSON CITY AND LAS VEGAS, NEVADA

The Board:	JACK ROBB, Chairperson MICHELLE KELLEY, Vice Chair JIM BARNES, Member BETSY AIELLO, Member LESLIE BITTLESTON, Member JENNIFER MCCLENDON, Member JANELL WOODWARD, Member STACIE WEEKS, Member BEPSY STRASBURG, Member
For the Board:	RADHIKA KUNNEL, Deputy Attorney General
For Staff:	CELESTENA GLOVER Executive Officer NIK PROPER Operations Officer CARI EATON Chief Financial Officer TIM LINDLEY Quality Control Officer JESSICA CRANE Executive Assistant
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A G E N D A

THURSDAY, DECEMBER 7, 2023, 9:00 A.M.

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CHAIRMAN ROBB: We'll call the meeting to order of the Public Employees Benefits Program. It is December 7th. The meeting is occurring in Carson City, Nevada, at PEBP's headquarters. I am attending from Las Vegas, Nevada. And I do believe that Michelle Kelley is also attending from Las Vegas, Nevada this morning. So we will open the meeting. Please call roll.

MS. CRANE: Chair Robb.

CHAIRMAN ROBB: Here.

MS. CRANE: Michelle Kelley.

MEMBER KELLEY: Here.

MS. CRANE: Betsy Aiello.

MEMBER AIELLO: Here.

MS. CRANE: Jim Barnes.

MEMBER BARNES: Here.

MS. CRANE: April Caughron. Oh, she's absent. Sorry.

Leslie Bittleston.

MEMBER BITTLESTON: Here.

MS. CRANE: Jennifer McClendon.

MEMBER MCCLENDON: Here.

MS. CRANE: Bepsy Strasburg.

MEMBER STRASBURG: Here.

MS. CRANE: Janell Woodward.

MEMBER WOODWARD: Here.

MS. CRANE: And Stacie Weeks.

MEMBER WEEKS: Here.

MS. CRANE: Thank you. We have a quorum. And just a friendly reminder to state your name and speak loudly and clearly for our transcriber.

PEBP STAFF: Michelle, I think Chair Robb --

(The court reporter interrupts)

PEBP STAFF: This is PEBP staff. Michelle Kelley, can you please run the meeting since Chair Robb is unavailable right now? He's having technical issues.

MEMBER KELLEY: Yes, I can. Michelle Kelley for the record. We've just completed roll call.

So, moving on to Agenda Item Number 2. This is the opportunity for public comment. Is there any public comment?

UNIDENTIFIED SPEAKER: We don't have any virtual at the moment, so I will get public comment ready for in person in Carson City. One moment.

MEMBER KELLEY: Okay. If there are folks in Carson City who would like to give public comment, if you could get prepared now and move up to the podium as it

becomes available, we would appreciate it. We are limited to three minutes per person. So if you could keep your comments to the point. Thank you very much.

And, Mr. Ervin, I think you're at the podium. So please go ahead when you're ready.

MR. ERVIN: Kent Ervin, E-r-v-i-n, Nevada Faculty Alliance. I usually have a thing or two to say about the agenda, but today I just want to talk about what's on my mind. Not a good morning. Yesterday we had a tragic shooting at the UNLV campus. Three dead, not identified yet, but probably faculty and staff PEBP members. This hits home.

Just another mass shooting. It won't even last 24 hours on the news cycle. But we must not become desensitized.

The entire UNLV campus was on lockdown for hours and buildings were reportedly impressively and forcibly evacuated. Our colleague, Doug Unger, is dealing with that aftermath now. There's a lot of trauma around students and staff. Counseling services will be available for students. But sometimes faculty and other employees are just expected to stay strong, Vegas Strong. At least we can reach out to colleagues with support.

What can PEBP do? Acknowledge that members are in pain and communicate about the mental health support

services that are available through the program through Doctors on Demand or otherwise.

Back to the agenda, it was, frankly, hard to decipher the plan design options based on the power point slides and the board packet. In the past, PEBP board shares have opened up public comment on similar agenda items after the presentation and discussion and before board action. That would be appreciated. Thank you.

MEMBER KELLEY: Thank you.

MS. OSBORNE: My name is Margaret Kelly Osborne. I am a retired state employee, 30 years of service. In 2019, I contracted COVID. As such, I have stage four irreversible lung damage. I'm looking at needing a lung transplant within the next two to three years. And I'm here to ask the board to please agendize travel appeals -- appeals for adverse travel, travel decisions.

Presently you have an appeals process under NAC 287 for adverse -- adverse determinations for medical issues but not for travel. The PEBP board met with the -- Our master plan for PEBP does not allow for appeals for travel decisions now. But you allow appeals for other adverse decisions.

So I'm asking that the board agendize and look in to these determinations so I could spend more than three

minutes discussing the issue that will potentially put my family in to financial bankruptcy while trying to save my life.

Right now you are -- present before you, you used to allow for reimbursement of travel of lodging at GSA rates. So, for San Francisco, where the closest Center of Excellence is, would be $285 a night. Right now you are allowing $50 a night per person.

I had to go to San Francisco two weeks ago for my pre-transplant consultation. The cheapest hotel I could stay at was $180 a night. Next door to that, to my hotel, was a tent. Next door to that tent was a gentleman with a bucket, and we will leave it at that.

When I do have my transplant, one of the major conditions of survival is to stay away from bacteria, to stay away from infections. Putting me in a hotel next to a bucket, that probably could cause problems.

What I'm asking is that you put up an appeals process so I can go over. The reason why I feel that your new determination is flawed based on an audit finding that you guys had in September of 2022 that was one audit finding of over 500 audit findings you had.

So I feel that this is a knee jerk reaction to an issue that you guys literally gave 30 seconds attention to in

your board meeting in January by looking at the minutes and reviewing the board meeting. I would appreciate if I could have more time to address this life-altering situation if you do put it on your agenda. I thank you for your time. I'm also asking if I could address the board later this afternoon when you discuss transplant Centers of Excellence. Thank you for your time.

MEMBER KELLEY: Thank you for your comment. I will talk to the executive officer about the issues you've raised. Thank you.

Is there any other public comment in Carson City?

UNIDENTIFIED SPEAKER: No.

MEMBER KELLEY: Okay. Thank you. I'm not sure if it's appropriate, but I did just want to take this opportunity regarding the horrendous situation at the UNLV campus and surrounding areas yesterday. Mr. Ervin raised the issue of support for employees and students, of course. But, on the employees' side, I just wanted to let everybody know that NSHE does have an EAP. We have circulated that information yesterday to employees. So, if anyone is watching, please utilize the services that are available. And that includes the EAP through NSHE through Comp Sky and then, of course, please, if necessary, your health insurance. So please make sure that you prioritize your mental health

and get taken care of. Thank you.

Okay. I see Chair Robb is still not connected. So, with that, I guess we will move on to Agenda Item Number 3, which are the board disclosures.

MS. KUNNEL: Thank you, Vice Chair Kelley. For the record, this is Radhika Kunnel, Deputy Attorney General.

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 their family member is eligible for PEBP benefits.

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

MEMBER KELLEY: Okay. I'm not seeing any board members who have any disclosures to add. Thank you for that.

We will move on to the consent agenda, which is Agenda Item Number 4. Are there any board members that

wanted to pull any of the issues on the consent agenda for conversation?

MEMBER AIELLO: I do. This is Betsy Aiello. And I would like to pull just a little item, 4.1 and then 4.2.2.

MEMBER KELLEY: All right. Thank you. Anyone else? Okay. So if we can pull Agenda Items 4.1 and 4.2.2 from the consent agenda. Is there anyone willing to make a motion to approve the consent agenda with 4.1 and 4.2.2 removed?

MEMBER BITTLESTON: This is Leslie Bittleston for the record. I move to approve the consent agenda with the exception of 4.1 and 4.2.2.

MEMBER MCCLENDON: Jennifer McClendon. I'll second that.

MEMBER KELLEY: Wonderful. We have a motion and a second. Is there any discussion? Not seeing any discussion, all of those in favor, please say -- raise your hand or say aye.

(The vote was unanimously in favor of the motion)

MEMBER KELLEY: Motion passes unanimously. Thank you very much.

Okay. So Agenda Item 4.1. Ms. Aiello, did you want to take the lead on that conversation?

MEMBER AIELLO: Sure. And this is just a little

technical item and it's probably been there since we were on Zoom and I never noticed it before. But in the section where it says members present, it says via teleconference, but we're meeting in person now. And so it's just a small little technical thing.

And, with that correction, I would be willing to say I would like to move to approve the action minutes, unless anyone else has anything.

MEMBER KELLEY: Great. Not seeing any disagreement with that. Is there a second for that motion?

MEMBER BITTLESTON: Leslie Bittleston. I'll second.

MEMBER KELLEY: Great. Thank you. All of those in favor of passing Agenda Item 4.1 with the technical correction of changing from video conference to in person, all of those in favor.

(The vote was unanimously in favor of the motion)

MEMBER KELLEY: Anyone against? Great. Thank you. Motion passes.

And Agenda Item 4.2.2.

MEMBER AIELLO: And this is Betsy Aiello for the record again. And I would just like to ask if we could have someone with a budget report. Most of the things we'll be dealing with in this meeting are either spending more or

saving more money and to have a fuller understanding of the budget report. And, especially, because the way it's laid out, it's sometimes hard to understand where we are with excess reserves and along that line also. So, if someone could just review it first, that's all I would request. Thank you.

MEMBER KELLEY: Great. Thank you.

Executive Officer Glover, is someone in Carson City available to review that report?

MS. GLOVER: Yes. I will take that report. And did you have a specific -- This is Celestena Glover for the record -- Sorry -- executive officer for the Public Employees' Benefits Program.

Did you have a specific area you wanted to --

MEMBER AIELLO: This is Betsy Aiello for the record. When I look at things like realized available funding, it says that the actual as of September this year was 82 million and the year before was 125 million. And I do know we approved a lot of things to spend down some of the excess reserves.

But, for me to understand, is 82 million good? Is it bad? Is it right on the edge? I can see that there's been a big change in cash. And I know that when you look we've got catastrophic reserve and HRA, which is things that

have to stay. But, just to get an understanding of where we are, if we decide to approve more spending later or that kind of thing. How did we do in spending down our excess reserves? What do we have left? A little bit more understanding with that.

MS. GLOVER: So this is Celestena Glover for the record. So, the realized funding, that tells us what our actual cash on hand is at that point. As long as we're bringing in the cash we need to cover expenditures, then that's essentially what we're looking for. So it's a combination of both what's going out and what's coming in.

The reserves, which I know have been a question, so what occurred -- the report you're looking at is ending year for the budget and then we're going with that first quarter. When we closed fiscal year '23, there's a reserve amount of nine million dollars, just over -- just shy of ten million dollars. When we balance forward, we're due for a certain amount in starting cash. In the case of our particular budget, we were approved a little over 144 million dollars to balance forward. We only had 120. So we had a 24 million dollar shortfall.

To adjust that, what we had to do is first we look at our reserve categories. We had already received our annual memo from Segal letting us know what our IBNR and our

catastrophic reserves needed to be set at, so we adjusted those first and they were a little bit lower than they have been in the past. The next thing I looked at is excess reserves. I adjusted that. Well, that took us to zero. So we no longer have those additional funds to apply to any extra benefits or enhancements to benefits like we have in past years.

And, then, once we were done with that, we were still at a point where we were shy by 1.3 million dollars to make that balance forward to be able to open our new year. That adjustment came out of our HRA reserve. That's the next place to go, short of reducing expenditure authority. So that's where we went next. And we still maintain between 65 and 70 percent of what we see in the HRA balances. That's what that reserve does. It covers us in the event that suddenly everybody decided to spend down whatever was in the balances.

So our starting cash is 120 million versus 140. And then any other revenue we bring in which comes through employer contributions, employees contributions are rebates from medical or from -- excuse me -- pharmacy and treasures and trust. That makes up the rest of our revenue for the year. And then we monitor that through the year to make sure that anything that we need to spend, so our primary focus is

going to be claims, make sure that we have the cash that we can cover those claims.

If for some reason we have a shortfall, then we will go to our reserves, either catastrophic or the incurred but not realized reserves to address those shortfalls, because that's what those --

MEMBER AIELLO: So this is Betsy Aiello. In a follow-up then, what I think I heard was that we came in with a shortfall but we were able to make it up with some reserves. So, when we're looking at new spending or savings, we did come in with a shortfall. But, this may sound crazy, but I think a little bit with PEBP and my background with Medicaid, one million is not very much. So, it may sound strange, but it really isn't much. And so we're pretty much even right now, not a lot of extra money to spend, but not having to try to generate a lot of extra money would be my assessment from what I heard, maybe.

MS. GLOVER: This is Celestena Glover for the record. You're correct. The million dollars is nowhere near. That doesn't -- I mean, that's obviously not going to help us a lot. Right now we have what we need to cover current expenditures and will continue to monitor that as we always do through the quarterly projections.

MEMBER AIELLO: And then one more follow-up

question. Sorry. This is Betsy Aiello again. So let's say something really strange happens and we get a little bit, partway through the year, because I know we set contribution levels, we set rates, everything. The reserves are the only way. And that's part of the reason why there is a catastrophic reserve would be my guess to make up any shortfalls that may occur in the next quarter or next quarter.

MS. GLOVER: Correct. This is Celestena Glover for the record. That's correct. We will go to catastrophic reserves first if we should have a shortfall. Typically, we would go to the excess or the differential cash. We would go there first. We don't have that. So our next place would be to go to catastrophic reserves if we had a shortfall. And, if for some reason we expended that entire reserve, then we would go to our IBNR and HRA. It would depend on what's generating the shortfall.

MEMBER AIELLO: Thank you. I don't know if anyone else has any other questions.

MEMBER WEEKS: Stacie Weeks for the record. So it sounds like -- I just want to make sure I'm following. There's projected spending. And so I think going off of that we're making decisions today for add-ons. How much do you feel -- Like, do we only add one or two? Like, what is your

recommendation around that in terms of how much we have to spend? Or is that a question for later?

MS. GLOVER: This is Celestena Glover for the record. Kind of a combination. It depends on what you approve. Obviously, what we are showing in our plan design recommendation is a combination of savings and expenditures and it really depends on how high. And then once we start the rate-setting process, we'll bring rates back in March, that's going to determine really, you know, what the plan is going to cost. So they'll start analyzing that Segal is our consultant. They'll start analyzing that as soon as they're aware of what's been approved and what has not. And then we will look at what our experience is looking like for the last year and current year and then rates will be set for that. If it looks like rates are going to, you know, blow up and we can't do these things, then we'll bring it back.

MEMBER KELLEY: Great. With Chair Robb's permission, I'll finish out this item and hand back the gavel to him.

So, with that, is there any other board members comments or questions on the budget report, Agenda Item 4.2.2?

Not seeing that, I'll accept a motion, if someone would like to make it.

MEMBER AIELLO: This is Betsy Aiello. I'll move that we approve the budget report.

MEMBER KELLEY: Thanks, Betsy. Second.

MEMBER STRASBURG: Second. Bepsy Strasburg.

MEMBER KELLEY: Thank you, Bepsy. All right. Any discussion on that item? Nope. All those in favor of approving budget report 4.2.2, please raise your hand or say aye.

(The vote was unanimously in favor of the motion)

MEMBER KELLEY: Is there anyone in dissent? Nope. Motion passes unanimously. Thank you very much.

And, back to you, Chair Robb. We're up to Agenda Item 5.

CHAIRMAN ROBB: Okay. Thank you very much. I appreciate that. I apologize for the technical difficulties down here in southern Nevada. We should be good now. Discussion and possible action, Number 5, discussion and possible action regarding a proposed contract with Carrum Health to maintain a network of National Centers of Excellence. A portion of this item may be conducted in closed session to allow review of results of evaluation of proposals for contract, in accordance with NRS 287.04345(4). Any action on the contract will occur in open session in accordance with NRS 287.04345(5).

Michelle Weyland, Chief Financial Officer, how do you want to proceed from here and going in to closed session? Do we need to do in public before we go to closed session?

MS. WEYLAND: Michelle Weyland for the record. We would like to go in to closed session and allow purchasing to do their presentation.

CHAIRMAN ROBB: Okay. We will go in to closed session. Closed session will be done for those participating electronically on the Teams channel that was sent. So we will close out this agenda item and we will keep this live. I will mute and turn off my camera. Please, if you're participating remotely, do the same, and we will switch over to the Teams channel is what I understand, okay. Thank you very much.

MS. KUNNEL: You need somebody from the board make a motion, if I may jump in. This is Radhika Kunnel, Deputy Attorney General.

MEMBER KELLEY: It's Michelle Kelley for the record. I make a motion that we close the public meeting and go to Teams for a closed-room discussion on the contracts.

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

MEMBER KELLEY: This is Betsy Aiello. I'll second.

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

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: All of those opposed? Okay. We will go to closed session. Thank you very much.

MS. OSBORNE: Excuse me, if I may? When -- May I ask when I can give public comment about this agenda item?

MS. GLOVER: This is Celestena Glover. There is not a specific public comment to this agenda item. We will have another public comment at the end.

MS. OSBORNE: Could I ask to be -- I understood that I could ask to make a public comment on an agenda item.

MS. GLOVER: At the end of the meeting.

UNIDENTIFIED SPEAKER: It's in the Chair's discretion. He can allow public comment on individual items.

CHAIRMAN ROBB: This is Jack Robb. Public comment was agendized in Item Number 2. But, to be open and transparent, I believe it's at the discretion of the chair if we allow some public comment. I would rather air on the side of caution. And, if somebody does want to make public comment on this item, I will allow public comment on this item prior to a vote occurring. But, at this point, we do

have a motion and a second and the motion is passed. We are going to go to closed session. So we will ask all of those participating in closed session to exit the room and then we will come back in to an open session. And, prior to any vote being cast, I will allow a member of the public to voice their concerns or have any public comment on this item prior to an action being taken.

(Recess was taken to move to a closed session)

(Closed session was reported and put into a separate transcript)

CHAIRMAN ROBB: I'd like to call the PEBP board meeting back to order. We are still on Agenda Item Number 5. And I think everybody that participated -- Okay. We're on Agenda Item 5. I would like to call the meeting back to order. I believe everybody that participated in the closed session does understand what motions need to be taken one way or the other, so I will call for the motion.

UNIDENTIFIED SPEAKER: Public comment.

MS. GLOVER: This is Tena. Jack, did you want to do public comment before that or after that?

CHAIRMAN ROBB: I apologize. I did say we would take public comment, so thank you for reminding me. I forgot about that. I noted it and didn't look at my own notes. So let's go to public comment.

MS. OSBORNE: Thank you for hearing me out again. My name is Kelly Osborne, K-e-l-l-y, Osborne, O-s-b-o-r-n-e. I just wanted to address the board again if I may about transplant issues and Centers of Excellence. I don't know what you guys discussed in this contract negotiation. But I am currently under consideration for a transplant at UCSF in San Francisco, which is a Center of Excellence. It's the closest transplant center to our location. It's 220 miles away.

A six-month process to be considered for transplant, to be trusted for transplant, to receive the transplant, and then follow-up care. So I just ask that you all take that in to consideration when making this decision. To see a face, to see a person when you're making these decisions. I felt that during this process in dealing with staff members with PEBP that I found my concerns that I have been put on the back burner, that it's blase. When the board made the official -- the initial decision about sending -- about this Center of Excellence and travel decisions, they liked it with bariatric surgeries and with a three-second mention to transplants and things like that. That's how you guys were addressed when it came to transplants, life-altering decisions.

I would just like you to know that I'm a person.

My life depends on this. I have education for you all about what's required of a lung transplant of me and of my family and my duty to my donor. I appreciate your time. I'll leave these here for you all. I don't know if I'm allowed to pass them out, but I'll leave them here for you all to see and take. Thank you for your time.

CHAIRMAN ROBB: Thank you very much. I appreciate that comment.

And do we have any other public comment either on line or in person in Carson City?

UNIDENTIFIED SPEAKER: No public comment, Chair Robb.

CHAIRMAN ROBB: Okay. Thank you very much.

I will bring it back to the board for a motion.

MEMBER WEEKS: Stacie Weeks. I move -- make a motion to continue.

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

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

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: All of those opposed? Motion passes. Thank you very much.

We'll move on to Agenda Item Number 6, Executive Officer's report, Celestena Glover, Executive Officer, for information and discussion. Thank you.

MS. GLOVER: Thank you. This is Celestena Glover, Executive Officer for PEBP. The report for this meeting is fairly short. I just wanted to let the board know that we are finally starting to fill some of our vacant positions, so our vacancy rate is down to 21 percent. We still -- We have seven positions vacant. We just interviewed for one in the accounting unit. The person has accepted, but they haven't come on board yet. They have a week to two weeks. So that will give us six vacancies. The majority of them are operations side of the house in our member services unit and they are working on recruitment there to attempt to get those positions filled.

The other item is the interim retirement and benefits committee. Right now that meeting is scheduled for the 16th of January in Las Vegas. Right now we have submitted our report. It's been posted. LCB posts those reports. We will follow up with whatever approvals the board does for plan design after this meeting and anything else that LCB might need us to add for the committee meeting. There's nothing that I am seeing right now that's cause for concern. This meeting happens routinely. And both PEBP and

PERS present. The plan is for Michelle Weyland and I to travel to Las Vegas to attend the meeting in person versus going virtual.

And, with that, any questions?

CHAIRMAN ROBB: Seeing no questions, move on to Agenda Item 7, discussion and possible action for plan design changes for plan year 2025, July 1st, 2024, through June 30, 2025. Celestena Glover, Executive Officer. For possible action.

I do believe we need to move on to 7.1 first to discuss those potential plan changes and then we'll go back to Agenda Item 7 for a vote. So, 7.1, potential plan changes. Please proceed.

MS. GLOVER: So this is Celestena Glover. So just to tee it up. This is a follow-up on the last board meeting where we presented some ideas for analysis and consideration. And we had that done. We're bringing those ideas back. Segal, Richard Ward, will walk us through the analysis and the results. And then when we come back to this agenda item, we will discuss the solutions and the vote.

And, with that, I'll hand it over to Mr. Ward.

MR. WARD: All right. Thank you. Richard Ward for the record. Our materials start on page 196 of the PDF, just to ground everybody.

And what we have is a review of the items that the board approved at the prior meeting for further investigation and consideration and analysis.

The first one is open access pharmacies is how we're characterizing it. So that would be to provide access to additional pharmacies than is currently available in the express advantage of Tier 90 networks that were implemented in plan year 22.

On page 197 of the PDF, this is a bit of a reset slide. This is identical to materials from the prior board meeting. Why is this worth considering and what are some of the next steps?

So, currently, members utilize -- utilize a narrow pharmacy network or narrow networks for retail prescriptions, for retail pharmacies.

There is an option to provide broader access. And the next steps were to review the additional access and any cost or savings for the plan and for members that might result from that change. So we're back to -- we're back here to review that.

Results of the analysis is that there be a minimal change in access either by broadening the network. I would add either CVS or Walgreen's, which are available in more populated areas where there are already other

pharmacies. So members have, in those areas, already have access generally. About 99 percent plus members have access to network pharmacies.

And, broadening -- And broadening that access would erode the discounts available and would lead to higher cost for both the plan and for the member. And, in conjunction with Express Scripts, we developed some estimates that that would be for the plan 625,000 to 900,000 annually for expanding both the Retail-30 networks. And then because there's a member cost sharing component to the total cost of the medications that that would lead to higher member cost also, primarily in the CDHP. We're owed about 330 to 440,000.

So, to summarize, access would be largely unaffected. It's very broad now. And it would lead to higher cost for both the plan and the members.

Moving on to the specialty drug cost share, specialty co-pay, on page 199 of the PDF and the board packet. Right now for members that are on specialty medications, the plan has a 20 percent after deductible cost share in the CDH plan and in the EPO and the HMO and 30 percent after deductible in the low deductible health plan. So the consideration here is to reduce the cost share exposure for members that are on these medications.

And, for members that are on these medications, some of them -- some of these drugs are on the SaveOnSP drug list, which means that they're eligible for manufacturer coupons, are on a drug that's eligible for manufacturer coupons and they enroll in the SaveOnSP program and then they're cost shared if it's, let's just use the low deductible health plan to illustrate this, would go from 30 percent to zero.

If they don't have -- If they're on a medication that is not eligible for manufacturer coupon or is not eligible for participation in the SaveOnSP program, then they -- then they have that 30 percent cost share. And, as we know, a number of these drugs are high cost. There's an example on the -- There's an example at the bottom that if a member has a $10,000 medication then their exposure is $3,000. And so the consideration is, is there a way to manage or minimize that exposure to the members and what is the cost to the plan for doing so. Plan options are developed.

One -- So, first of all, if both options -- And I'm on page 200 of the PDF. If a member has a medication that is on that SaveOnSP drug list, then the co-insurance as it stands is currently constructed still applies. And that's important because it provides the member an incentive to

enroll in the program they get -- the member has no cost share as a result and then the plan gets savings from the coupon. So it is a win-win situation. And, having the current cost share in place provides an incentive for members to participate.

The two options are for members that are on medications that are not on the SaveOnSP drug list. Option one is to apply the -- apply the benefits for tier one, tier two, and tier three medication, so for non-specialty medications to specialty. And that's shown in the table at the bottom of page 200.

In the EPO, the low deductible health plan, ten dollar co-pay, $40 co-pay, $70 co-pay, depending on what tier that specialty medication would fall in to. Primarily it would be tier three I would expect. But there's a -- It would be a $70 co-pay, which is lower exposure than a lot of members have currently. And if they're in the high deductible health plan, then it's the percent after the annual deductible.

Option two is to continue to apply the 30 percent co-insurance but with a minimum and a maximum. So it would still be the 30 percent co-insurance but it would, in the example on the prior page, instead of it being $3,000, the number would be capped at $250.

And, in conjunction with Express Scripts, we have analyzed the cost impact of those two options. They are both cost increases. I want to be clear there. But there are -- There is a cost shift from the member to the plan. And that's $50,000 on an annual basis for option one and $20,000 for option two. And one of the reasons that it's more moderate than you might think because there are a number of people on these medications and they are high cost medications is that the current cost share leads to the vast majority of these members hitting the annual maximum out of pocket and they -- their situation -- their overall medical situation and their care needs would still result when they're hitting the annual maximum out of pocket even with this change.

So, it provides, I think -- While it may not affect the overall out of pocket for the members or the plan, it does result in members not needing to pay that full $3,000 in that prior example earlier in the year and it spreads out their cost during the year. I think that's a non-financial consideration here.

Okay. Moving on. Another consideration is medical pharmacy coupon program. So this is a new program that UMR has available beginning January of 2024. It will be implemented here in PEBP July of 2024. And it's a program

that is very similar to the SaveonSP program in nature except that in that drug manufacturer coupons that are already available except that it applies to a different set of medication. The SaveOnSP program that Express Scripts has is for patient medications. The UMR program is available for inpatient. So there's drugs that run through the medical claims component of the program. And, currently if there are drug manufacturer coupons available, there's no mechanism to access the value of those programs the benefit plan for the number. This program does that. So, mechanically, it works in a similar manner in that a list of medications where there are -- where there are coupons available, UMR maintains that list, when a member, when a member is prescribed one of those medications, then there's outreach to the member to enroll them in to the program and then the value of the coupon is used to the benefit of the plan and the member.

So when we reviewed this slide here on page 206 -- I'm getting ahead of myself. The next steps were to review the program ETLs with UMR and then to review the member impact plan savings that may be available.

Moving on to page 202, there's a review of the program. So the name of the program is the co-pay maximizer program. Patient advocate will handle the member outreach and provide support to enroll in the program. And

participation is voluntary and it can be added or removed, a member can opt out if there is a comment of the program that they don't care for. The member receives the medications with in most cases zero cost share and in a case where there may be lower cost share than there is now. And the amount similar to -- similar to the outpatient programs, the co-pay assistant amounts or the coupon values are excluded from the jackpot accumulators, so that maximizes the benefit to the plan.

UMR does retain 30 percent of the savings. That savings, it's estimated the plan would save about 700,000 a year. So there's about a million gross savings and then net of that 30 percent.

The detail here, the questions, UMR's analysis indicates that it's about 150 members that are on medications that would be eligible for the program. And so these are also very high cost situations or medications. And so it's relatively small number of people that enrolling in this program and then accessing the value of these coupons can benefit both the members and the plans in a fairly material manner.

Page two of three -- Sorry. I'm using page and slide interchangeably. Page two of three has an illustrative example of how this works. And on the bottom right corner

this is -- these are materials provided by UMR as an example. So without co-pay assistance currently with this example with a $4,000 medication and a $2500 per claim -- Also using coupon and co-pay assistance interchangeably. I apologize for that. Co-insurance would be $800 and that's what the member would pay. The member would pay $800 or it would be applied to deductibles and depending on where they are with their max out of pocket. That's a member share and the plan is $3200.

With the program, start out with calculating co-insurance, $800. The co-pay card would -- or the coupon would absorb that, reducing the member cost share to $25 and the employer cost -- Excuse me. Then this is without the program. So the member would receive $775 in cost share relief of the 800, down to $25. And then there's no benefit to the plan. The plan still pays $3200. With the program in the far right, the total value of the card or the coupon is applied to cost and reduces the plan cost down to about $1500.

So, in this instance, there's a reduction of about $1700 in this particular instance, just looking down at the bottom and following the line across. I know it says employer, but it's really PEBP as a plan. So it's a plan.

And the member costs are reduced by $775. So the

member is paying $25 instead of $800. Savings to both parties. And this is comparable to how the SaveOnSP program works. The math isn't exactly the same, but the concept is the same.

Okay. Moving on. Page 204. At the prior meeting there was discussion being the EPO and the HMO and exploring some alternative options and ongoing viability of the HMO and the EPO and HMO as a combined plan offering or a consolidated blended. This was in anticipation of a 20 percent increase with the HMO renewal. Experience had been leading -- had been indicating that the renewal would be capped at the 20 percent cap. Prior years had been capped at nine and a half percent. But, for the plan year 25, that cap was increasing from nine and a half percent to 20 percent and the loss ratio and claims experience was indicating that that's what the renewal -- that's where the renewal would come in.

So we talked about exploring some -- beginning to evaluate some potential alternative scenarios and wanting to be post impact, benefit value, risk distribution between whatever plans were in place in future years. So, since then, we have a review -- This is I think at this point mostly -- At the prior meeting there was some discussion about current plan benefits as well as the actuarial value

for the plans. So on page 205 we have a summary here of the deductibles and out-of-pocket maximums, co-insurance, and offset of the cost share or co-pays or co-insurance, depending, for the different plans and for all four plans and then the actuarial value in the up row.

I think more germane for right now is the review, all of it were anticipating a 20 percent renewal, which would be a sizeable increase in the HMO and then therefore becomes the HMO and the EPO are blended together would be a sizeable impact on the rates of those blended rates.

Well, I have good news. The renewal came in at 12 percent rather than 20. And, on page 206, we have a comparison of what was expected. So the first row is the calculated renewal action. So about 29 percent is what the claims were supporting, would support. And, if that had been the case, then the HMO premium blended would have been 1355. It is currently 1220. So sizeable increase. With the renewal cap -- Sorry. Yeah. For the -- With the cap increase, it would be 1263. However, with the 12 percent increase, it's 1180. And I misspoke. It is not 1220. The blended is 1085 currently.

So that's a net difference. I hesitate to use the word savings. But it's a net difference from what was expected of $83, which translates to about three and a half

million annually.

So that is the -- Tena, do you want to talk to that or can I -- I can.

So the option on the table for plan year 24, plan year 25, excuse me, is to accept the renewal and then explore more -- continue to explore potential alternatives for future years so that -- so that the experience continues to -- on an elevated path that there is thought and consideration put in to alternative approaches over a time period.

Okay. And then the last thing here that we're going to talk about is the Mental Health Parity and Addiction Equality Act. In this meeting a year ago, the board directed PEBP to opt out of compliance with mental health parity. And that was an option that at the time was available to non-federal governmental plans employers. And the intent was not to be out of compliance. But the intent was to provide benefits that are on parity between medical, surgical, and mental health, substance use disorder benefits. But the benefit of opting out was to avoid the possibility of a federal audit, which we've had some clients that have been audited by the feds, and it is an extensive, time-intensive, intrusive process.

Part of the decision and the direction from the board at that meeting was for Segal to perform a parity

compliance review and to come back a year later and with the results of that. So we're here.

Something that has happened that was unanticipated at the prior board meeting is that about two weeks after that board meeting the federal omnibus bill eliminated the opportunity for public plans to opt out of compliance. So you no longer had the opportunity or the option to opt out. So it really became more necessary for us to -- for a compliance review. So we've done that.

And I'm just going to -- We're going to I think speak in more detail and more specifics at the January board meeting. But there is one item that is up for consideration today. But let me talk a little bit just about the review process.

And the review process is not something that Segal has determined. Really we're following the guidelines, the statutory guidelines, and the regulations on how this review needs to be performed.

There are two main components to this review. There's quantitative treatment limits. QTL is probably the term I'll use. And non-quantitative treatment limits, NQTL. The quantitative are the -- essentially the cost-sharing measures, the deductibles or the co-pays or the maximum out of pockets, co-insurance, are those provided parity between

medical, surgical, and mental health and substance use disorder benefits.

And then you have NQTL, which are, say, more softer components of the benefits. So those could be prior loss or some benefit exclusions or coverage exclusions that maybe don't show up in the open enrollment guide.

And so we've reviewed from both aspects. And, within the QTL, we look at -- we're required to look at specific coverage categories. You have inpatient, outpatient office visits, and then you have outpatient other services, so that would be diagnostic. And maybe if there's an outpatient facility. And then you look at those three for in network and out of network. And, for each of those categories, you look at the benefits that are provided for medical surgical and there's very specific parameters on how you determine what is called the predominant financial requirement. So, what, is it primarily deductible co-insurance, is it co-pay, do you review the medical and surgical benefits and reach that conclusion and then you have what is provided for mental health and substance use disorder.

The CDHP plan, primarily because it's deductible and co-insurance, put that aside. There are no issues there.

For the low deductible health plan and the EPO,

everything is fine for QTL except for outpatient -- other outpatient services for network benefits. Out of network is fine because that's also a deductible or co-insurance provision across the board and it's the same.

For the -- For the low deductible health plan and the EPO, there's a mix of deductibles, co-pays, and co-insurances that apply for medical surgical, for outpatient surgery facility, for diagnostic tests, diagnostic imaging. And, because there's this mix of cost structure, there is no predominant financial requirement.

And so our recommendation to ensure compliance is to change -- is to update the benefit provision for either or both medical surgical and substance medical use -- not medical use -- mental health substance use disorder benefits.

And there's a couple of options that we developed that are on page 207. And option one is to add co-pays to the medical surgical benefit so that there are co-pays on -- for both types of benefits across the board.

And, since that would add co-pays that aren't there currently, there's some savings involved and that is really a cost shift from the plan to the member, if that's the option.

Option two is to add co-pays and change some of the co-insurances from a hundred percent to 80 percent. So

the co-insurances are 80 percent of the medical surgical because that increases the co-insurance. There is -- There is less of a savings there.

For item three is maybe the most complicated. You're making changes on both. As it turns out, it's about comparable from a cost-savings perspective for option three.

And, option four, which is maybe the most straightforward, is to remove a co-pay from mental health substance use disorder that doesn't exist, that isn't present for medical surgical benefits. So the issue is there is a co-pay on mental health substance use disorder that is not in the benefit, that is not present for medical surgical, and that creates an imbalance. So if you remove that co-pay then you have alignment and you have parity. And that comes with a bit of an increase in cost. Three to 400,000 is our estimate. Within the context of about 360 million dollar increase.

And, moving on to page 208. For the NQTL, again, the non-quantitative treatment, this is a review of exclusions, prior ops, just some language clarifications in the plan documents, updating some key terms and definitions. Generally things that we've identified that could be characterized as clean-up that should not have a financial impact, should not affect member out-of-pocket cost. We're

still working through that detail with PEBP. And, similar to the compliance review report from last year, the anticipation is we'll be here in January for a more detailed discussion and review of that part of the analysis.

And then the last slide here, page 209, has a summary of each of those -- each of these options for the open access pharmacy, specialty co-pay change, the UMR RX coupon program, the HMO renewal for plan year 25, and the mental health parity compliance options. Discussion or questions?

MEMBER WEEKS: This is Stacie Weeks. On that last slide, on the third one there, the coupon program, I know it says a million, but we're really only able to keep, what, 700,000 of that. Don't we have to give 30 percent?

MR. WARD: That's 700,000.

MEMBER WEEKS: That's really 700,000, okay.

MR. WARD: I'm sorry. That was a -- After the ink was -- That was a last-minute clarification on the value of that, to net out the added. I apologize for that. Thank you for noting that.

CHAIRMAN ROBB: Okay. Any further discussion or questions?

MEMBER MCCLENDON: Jennifer McClendon for the record. I have a question about open access pharmacy. I

think this is a question for PEBP. I just remember hearing a lot of grumbling when we switched to the plan that didn't allow CVS and Walgreen's. I'm imagining that people who are on, like, long-term medications have made the switch at this point. But do you get a lot of claims that you don't pay? Or, like, is that still an issue? Because let's say I take my child to the pediatrician, my child needs an antibiotic. I don't know that the change has happened, because no one in my family is on a long-term, are we getting a lot of feedback from people that that is still very frustrating for them? Do you sense there would be a value of going back? I just don't know what the user experience is.

MS. GLOVER: So this is Celestena Glover for the record.

I'll let Tim answer about appeals regarding claim denials. But, I would say based on the analysis and my discussion with Segal, that if we went to this more open network at this higher cost to both the members and the plan, it really doesn't provide as much of a benefit as we were hoping, because exactly what you said. People have already made that change, so the likelihood is that they're not going to change again. I personally haven't heard a lot of comments. I know from personal experience I've had to have an antibiotic myself and I just go to Walmart and get the

thing and move on. I don't even really think about it because, you know, I know that is one of the places that I can go. But I haven't seen a lot. I don't know if Tim has received a lot of appeals in the last year since we've changed this.

MR. LINDLEY: Tim Lindley for the record. We do get some member questions. And I think it ties down to education because of the narrow network. And what typically happens is a member will get a reoccurring medication, go to CVS or Walgreen's, and the price jumps after the first two bills, where there's penalty involved or paying the actual cost of the medication or the lower of the two. And then it's steerage to the SaveOn pharmacies and that's the most common thing that we see. And, once that steerage happens, it tends to resolve itself at that point. But we don't see it very -- I don't see very high complaints or appeals for that.

CHAIRMAN ROBB: Any further questions?

MEMBER AIELLO: This is Betsy Aiello for the record. And I have a question regarding the medical pharmacy coupon program and how it actually works. Because it says co-pay assistance without the maximizer the co-insurance is 800 and with the program the co-insurance is 2,525. And I understand that if the card only requires you to pay 25 if

you raise the co-insurance, then the card is going to pay more, so we don't have to pay more. But does that mean we make a plan to change where co-insurance and inpatient is higher?

MR. WARD: Yes.

MEMBER AIELLO: And would every one of the drugs then or will someone get stuck with a higher -- if there isn't a card, a higher co-insurance amount than they would?

MR. WARD: So very important distinction. And I'm glad you're asking that. And I apologize I wasn't clear on that. So it should work -- it would work in a way that the elevated co-insurance only applies if they're on a medication that is eligible for the program.

MEMBER AIELLO: So that's how the plan document would be?

MR. WARD: Right. You're speaking on behalf of their program. So I want to make sure that it's -- that the answer is accurate.

MEMBER AIELLO: That's a big jump.

MR. WARD: It is, yes. So it would operate similarly to how the proposed change would work for the Express Scripts program.

MEMBER AIELLO: And, currently, without the program, the employer cost is higher, but the member pays 25

if the co-insurance -- it says without the program co-insurance 800, co-pay with card 775. So that says with today. So that must happen today.

MR. WARD: And that's if a member goes and -- That's if a member on their own goes and gets it.

MEMBER AIELLO: Oh, on their own does it. It doesn't do that just automatically.

MR. WARD: Correct. So, it would happen on a limited basis, I would expect.

MEMBER AIELLO: And, with the program, UMR is doing it?

MR. WARD: That's correct.

MEMBER AIELLO: Okay. That makes a difference. Because I was going to say the cost accumulated goes down a lot. But there's probably very few members that know to get this coupon themselves, unless -- I don't know who would be telling them, the pharmacist or the inpatient.

MR. WARD: They may find out from a provider. They might.

MEMBER AIELLO: Is that that GoodRX that sits at every provider?

MR. WARD: No.

MEMBER AIELLO: That's outpatient.

MR. WARD: That is outpatient and that is to

evaluate cost differences that are available between different pharmacies essentially.

MEMBER AIELLO: Oh, okay.

MR. WARD: So this is a coupon available from the drug manufacturer.

MEMBER AIELLO: That someone would have to figure out --

MR. WARD: And they would have to enroll in the manufacturer's --

(The court reporter interrupts)

MS. AIELLO: Okay. Sorry. I'm good at that.

MR. WARD: Me too. So we're a good team. That is Richard Ward for the record.

CHAIRMAN ROBB: Okay. Board Member Weeks.

MEMBER WEEKS: Thank you, Chair Robb. I still have a couple of questions. So the first one, I just want to say, really nice job on getting the savings of 3.5 million. I'm guessing that was some good negotiations. So thank you. That's nice to see. I think that would have been a bigger ticket item and I think it gets us there.

So, when I look at the coupon program, the 30 percent admin spend in my world is super high. Is there any room to go down there so we get more money back? Even 25 percent or even 15 or 20. I mean, 30 percent admin cost for

the coupon program feels a little high in my mind. So that's my first question.

My second question is compliance parity. But I'm looking at -- So I'm looking at option three. Is that essentially saying we would really say for our medical spent and co-pays we're keeping people holding them harmless and we're bringing mental health up to be kind of equal with that. We're not slashing on the medical side to make it equal for behavioral health. We're sort of equalizing on option three. Is that -- Am I reading that correctly? And that's all I have. Thank you.

MR. WARD: I would have to, regarding negotiating the 30 percent, that's -- I would have to defer to UMR to comment on that. I do know that this is a program that they now have through an acquisition. So the program is already in operation with another TPA that they purchased. And perhaps there's more flexibility in the cost structure going forward after it's been -- I mean it hasn't even gone live yet with any of their customers.

MEMBER WEEKS: Stacie Weeks for the record. Well, what I've learned if you don't ask and you don't push, you're never going to get a good deal for the state. So I think we should push if we can.

UNIDENTIFIED SPEAKER: It would have to be a

senior leadership decision.

MEMBER WEEKS: Okay. Stacie Weeks for the record. Yeah, that would be good to know. And if you could ask. Thank you.

And then, again, on the mental health on the option three, is that correct to say that we would really be just bringing mental health up to where medical is and co-insurance and kind of equalizing?

MR. WARD: No. Actually there would be, there are some co-insurance -- some outpatient surgery facility where medical surgical is a hundred percent after a $500 co-pay and so that would be reduced to 80 percent. Other outpatient services for mental health and substance use disorder is at a hundred percent after a co-pay. But that would be at 80 percent. Diagnostic tests are at 80 percent. That would be unchanged. Diagnostic imaging. Also medical surgical, it's currently 80 percent, so that would be unchanged.

Back to mental health and substance use disorder, partial hospitalization is at 80 percent, so that would be unchanged.

And then intensive outpatient treatment is hundred percent after a co-pay. That would be reduced to 80 percent. So there would be -- there would be increased cost

share on both.

MEMBER WEEKS: Stacie Weeks for the record. Is there any way -- And I'm sure you've done all of the back and forth. Is there any way though to -- Because I think about IOP. Like, that's an important one, and I would hate to see us lose -- Behavioral health is a huge challenge across our state. And I would hate to see mental health lose on this at the same time. But I know you've tried to find a sweet spot. But, I don't know, is there a sweet spot here or is this just really reality, we're just going to do 80 percent across the board and be like, okay, well, this is, like, the safest way to do this and be in compliance and know that we may see some losses for people in terms of cost?

MR. WARD: Are you asking what our suggestion is?

MEMBER WEEKS: Yes, I am.

MR. WARD: Option four is our suggestion, which removes -- So right now on outpatient, so for the mental health substance use disorder, there is a $30 co-pay for other outpatient services. Again, this is not office visits. And, for intensive outpatient treatment, there's a $30 co-pay. Option four removes those co-pays and care is available at a hundred percent as a result. And so there's a cost increase associated with that -- Let me go back to my screen here -- of three to $400,000 annually, which is about

.1 percent.

It pains me to say this, but our trained assumption is going to be wrong by more than that. So, it's a relatively minor cost impact, in my opinion. That's open to -- open to other consideration, I suppose.

And that's I think a clean change. It's relatively easy to communicate. It's a change to the mental health substance use disorder benefits to become compliant with mental health parity, so I think there's an alignment there as well. But that's our opinion.

MEMBER WEEKS: Stacie Weeks for the record. Thank you for that. Yes. It seems -- That helps me understand. Because, I was reading option three wrong, apparently. And what I hear you saying is we pay a little bit to do no harm and maybe even improve access.

MR. WARD: Yes.

MEMBER WEEKS: Okay. Thank you.

MR. WARD: And, if I may, just additional clarification. I don't know if it's necessary or not. But the office visit co-pays would be unchanged. This is for other outpatient. So the overall utilization and volume is relatively low compared to even other mental health and substance use disorder care.

CHAIRMAN ROBB: Okay. Board Member Kelley, do

you have a question?

MEMBER KELLEY: Yes. Thank you, Chair Robb. Michelle Kelley for the record, K-e-l-l-e-y. I actually have maybe four questions. Some of them are just clarifications, so I promise to be quick.

Firstly, I wanted to start out at the specialty drug program as outlined on this. And I think it is just the clarification question. Is there -- Between the SaveOn program -- I know I'm getting -- The SaveOnSP drugs program and the non-SaveOnSP drugs program, if we implemented, say, option one or option two that are outlined here, could there ever be a case where the SaveOnSP drugs, someone who is using that program has a co-insurance payment greater than zero? Because I think I did hear you say that if they're on that program there's zero co-pay. But I just want clarification that that is true. So, if you are participating on the SaveOnSP drugs program that's currently in place, you would have a zero co-payment?

MR. WARD: That is correct.

MEMBER KELLEY: Great. Thank you.

And then what percentage of drugs are available on the SaveOnSP drugs program that currently exist? Do we know that?

MR. WARD: You mean -- Richard Ward here. You

mean as a percentage of specialty medications?

MEMBER KELLEY: Yes.

MR. WARD: There are -- Currently there are about 600 members that are enrolled in a program that's here.

MEMBER KELLEY: Okay. But we don't know what percentage of drugs, specialty drugs, are available on that program.

MR. WARD: Yeah. The list -- The list changes from time to time. I'm going to phone a friend here and ask Express Scripts to comment on the -- how broadly applicable or available the -- what percentage of specialty medications are on the SaveOnSP drug list.

MS. LANGLAND: So, hi. I'm Nancy Langland for the record. Thank you. So I would like to confirm what percentage is off line and circle back with you. What I can tell you is that the drug list does change two times a year, typically in January and July, and potentially see changes. It's not a guarantee that would go with the changes. But we can have changes up to two times a year.

MEMBER KELLEY: Okay. And so no one has a rough percentage of what -- You know, is it 40 percent? Is it 20 percent? 60 percent? No one can provide kind of a ballpark?

MR. WARD: If we're allowed to speak more broadly, I would say it would be somewhere between 25 and 50

percent.

MEMBER KELLEY: Okay.

MR. WARD: And it depends that -- The impact numbers and number of prescriptions, of course, is dependant somewhat on the utilization and how that utilization aligns with that drug list.

MEMBER KELLEY: Okay. Thank you.

MR. WARD: You may have drugs on that list that nobody is taking and vice versa.

MEMBER KELLEY: Okay. I getcha.

So my next thing, scrolling just down your presentation, my next question about the medical pharmacy coupon program is I just really wanted to support Member Weeks. I do think that 30 percent seems high. And, when I look at specifically slide nine of your presentation on the enhancements, when I look at with the program, I'm assuming -- Maybe I'm wrong. Let me ask that as a question. Is the savings going to be the difference between the 2525 and the 1475? So, when I'm thinking about UMR earning 30 percent on savings that this program makes, would that be basically the thousand dollar difference between what's listed here and with program co-insurance and the employer cost?

MR. WARD: I will -- I believe it would be the

difference between the 3200, because that's today, and the 1475. So that's the 1725. So it would be 30 percent of that in this illustration.

MEMBER KELLEY: Okay. Okay. So that -- You know, I mean, I think that, yeah, that seems very high, especially if it's just -- they're just identifying a coupon program. This is technology doing most of this.

MR. WARD: Well, they are -- I'm sorry I interrupted. Thank you. I apologize.

MEMBER KELLEY: I was just going to say I support, you know, trying to negotiate perhaps a lower share of the savings until we do actually see what's been realized and what's been paid through this I think maybe as a stop gap measure. So just in support of that.

(The court reporter interrupts)

MEMBER KELLEY: No. I'm sorry. I was satisfied with that answer. Thank you.

And that was all the questions I had. So, thank you, Chair Robb.

CHAIRMAN ROBB: Okay. Thank you.

Any further member questions? I can't see the room. There we go. Any further member questions? Seeing none, we're going to close Agenda Item 7.1 and move back to Agenda Item 7. And Agenda Item 7 is for possible action of

plan changes.

MS. GLOVER: This is Celestena Glover for the record. So the first change that we're required to make is to the CDHP program plan. The IRS is raising the deductible minimum to allow us to continue to offer health savings accounts. That is $1600 for the single tier and 3200 for the family tier. If we want to continue providing health savings account, that is something that really, although the board needs to vote on it, there's not really an option there other than to cancel the HSA.

We are not proposing any change to the out-of-pocket maximums. They have a maximum allowed for out of pocket, not a minimum, and we're well within that requirement. So that is one of the things we do need to do.

And the other thing that is a must do, but you do have four options, and that is to align a low deductible in the EPO plan so that we are meeting the Mental Health Parity Act requirement. So, those two things, things you can choose or not choose.

The recommendation from staff and from our consultants is to accept the renewal from Health Plan of Nevada to continue our HMO. And we know that's going to affect our bottom line. It's going to affect rates. It's going to affect our members. But we're not at a place now

where we're considering terminating that contract or terminating that plan.

We're also recommending the minimum co-insurance portion of the drugs that are not covered on the SaveOnSP program, consider the UMR RX program. And then our recommendation is to not expand the pharmacy.

With the other things that are going to increase the cost of the plan, this is the one thing where we believe that this is not a good time to do that. So, with that, I can answer any questions the board may have.

MEMBER WEEKS: Stacie Weeks for the record. So when you said -- So I just want to make sure I'm understanding. So no open access pharmacy for now. Specialty co-pay, are you saying option one or two, do you have a preference?

MS. GLOVER: This is Celestena Glover for the record. My preference would be option two. I think that keeps the cost down for the member of compared to where we're at right now and also helps the plan. So we're trying to help and that's the option I believe works for us the best.

CHAIRMAN ROBB: Okay. Any further discussion? Seeing no further --

MEMBER WEEKS: I'm sorry. Stacie Weeks for the record. I'm sorry. Thank you, Chair Robb. Can we maybe

take these one at a time or are we doing them all at once?

CHAIRMAN ROBB: I think taking them one at a time we will take the motion as you feel comfortable presenting the motion. Sounds like you're ready to make a motion. So I'm standing by.

MEMBER WEEKS: Stacie Weeks for the record. I move to not accept the open access pharmacy network at this time.

MEMBER BITTLESTON: Leslie Bittleston. Second.

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

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: Okay. That motion passes. Do we have another motion?

MEMBER STRASBURG: Bepsy Strasburg. I would like to make a motion to accept option two, which is the recommended option with a specialty co-pay.

MEMBER AIELLO: Betsy Aiello. I'll second it.

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

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: All of those opposed? Motion

passes.

Do we have another motion?

MEMBER BITTLESTON: This is Leslie Bittleston. I move to accept the renewal of the HMO as recommended.

CHAIRMAN ROBB: Do we have a second? Okay. We have a motion and a second. Any further discussion? Seeing none, I'll call for the vote.

THE COURT REPORTER: I'm sorry. I didn't hear who seconded.

MEMBER MCCLENDON: Jennifer McClendon.

CHAIRMAN ROBB: Okay. I'll call for the vote. All of those in favor signify by saying aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: All of those opposed? Motion passes.

MEMBER AIELLO: This is Betsy Aiello. And I move to select option four for the MHPAEA compliance process.

MEMBER STRASBURG: Second. Bepsy Strasburg.

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

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: All of those opposed? Motion passes.

MEMBER AIELLO: This is Betsy Aiello. Do we need to make a motion on rates and IRS requirements for the CDHP?

MS. GLOVER: This is Celestena Glover. It's best to just go ahead and do it.

MEMBER AIELLO: This is Betsy Aiello. And I move that we increase the deductible as required by the IRS for the CDHP plan.

MEMBER BITTLESTON: Leslie Bittleston. Second.

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

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: All of those opposed? Motion passes.

MEMBER AIELLO: This is Betsy Aiello. I guess this is a question which we've gone past. But can we make a motion that would suggest that we do the UMR RX coupon program but to direct PEBP staff to negotiate a more favorable administrative fee, if possible? Can that be made that way or -- I don't know. It's a negotiation, so I don't know. That's why I think everyone jumped over that one.

MS. MOONEYHAN: This is Brandee Mooneyhan, Lead Insurance Counsel. I welcome input from the attorney general as well. But I believe you can make any motion that you want

that's within reason. But, if you make a motion for PEBP to negotiate and then it doesn't have the result that you like, you may want to structure your motion in a way that perhaps brings it back for the board's consideration.

MEMBER AIELLO: That makes it much -- This is Betsy Aiello for the record. That makes it much harder. So I guess I can't have that. But I appreciate what you're saying.

CHAIRMAN ROBB: Okay. Do we have a motion?

MS. GLOVER: This is Celestena Glover. Obviously the board can decide to go with the program the way it sits right now. That would be the motion. If you are uncomfortable with it, you could make the motion to not approve the program.

MEMBER AIELLO: This is Betsy Aiello. Or we could make a motion to ask you to do a further negotiation and bring it back in the January meeting? This is Betsy Aiello. And I move that we will request PEBP staff to do further discussion on the UMR RX coupon or further negotiations on the UMR RX coupon program and bring that back to the January meeting, any outcome from that.

MEMBER WEEKS: This is Stacie Weeks. I second that motion.

CHAIRMAN ROBB: Okay. We have a motion and a

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

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: All of those opposed? Motion passes.

MEMBER KELLEY: Thank you, Chair Robb. Michelle Kelley for the record. I wondered whether the AG's office had a question about Agenda Item Number 5 and I just wasn't sure if you had seen that and if we needed to circle back.

CHAIRMAN ROBB: I have seen that. As soon as we close Agenda Item 7 -- Are we done with everything that we need to do on Agenda Item 7?

MS. GLOVER: Yes.

CHAIRMAN ROBB: Okay. Now we will close Agenda Item Number 7.

At the request of the attorney general's office we are going to go back to Agenda Item Number 5. And there's a request to clarify the motion. So I'm going to ask -- We opened Agenda Item 5. I'm going to ask for a clarified motion on Agenda Item Number 5 as to what we are directing staff to do in regards to Agenda Item Number 5 and then we'll revote on that.

MEMBER BITTLESTON: This is Leslie Bittleston.

Can we have the court reporter read back the motion to refresh our memory?

THE COURT REPORTER: I can do that, but it's going to take me a while to go back and try to find it, so --

MEMBER WEEKS: This is Stacie Weeks. I think I messed up on that one. I kind of went blank on what we were doing too. So I made a motion and I didn't clarify. The motion is to continue the negotiations and bring back to the group the contract proposal for approval, you know, for decision.

MEMBER BITTLESTON: In January?

MEMBER WEEKS: Uh-huh.

MEMBER KELLEY: Can I make a friendly amendment to that?

CHAIRMAN ROBB: Yes.

MEMBER KELLEY: I think we need to make it clear to bring back -- to continue contract discussions for the proposal for the Center of Excellence travel concierge program and bring it back to the committee.

CHAIRMAN ROBB: Does the original motion maker accept the friendly amendment?

MEMBER WEEKS: Yes. This is Stacie Weeks.

CHAIRMAN ROBB: Okay. With that understanding can I get a second on that?

MEMBER BITTLESTON: Leslie Bittleston. Second.

CHAIRMAN ROBB: Okay. So we have a motion. We have a friendly amendment. We have a second. Any clarification or discussion on the motion on the table? Seeing none, I'll call for the vote. All of those in favor signify by saying aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: All of those opposed? Motion passes.

We will close Agenda Item Number 5 and we are going to move on to -- The agenda is going to get a little screwed up here for a minute. I'm going to move on to Agenda Number 9 and then we will do 8 and 10 together because they both work with UMR.

So let's go to Agenda Item Number 9 at this point. Acceptance of Claim Technologies Incorporated audit findings for the State of Nevada Public Employees Benefits Program third-party administrator, Via Benefits, WTW, for period July 1st, 2022, through June 30th, 2023, Claim Technologies Incorporated. For possible action.

MS. AMATO: Good morning. For the record, my name is Joni, J-o-n-i, Amato, A-m-a-t-o.

The scope of the Via Benefits audit included all HRA claims processed during the period of July 1, 2022,

through June 30th, 2023. The HRA claims made during the audit period total approximately 18 million dollars and included approximately 218,000 transactions.

The Via Benefits HRA audited included the following components: The annual operational review and performance guarantee validation, a random sample audit of 200 HRA claims, eligibility verification, which included obtaining data from LifeWorks, which is now known as TELUS Health.

In our auditor's opinion, Via Benefits showed improved service from the prior audit period and exceeded all but one of its 2023 performance guarantees. While only one financial error was cited in the random sample audit, the error was large enough to drive the financial accuracy performance below the guaranteed metric of 98 percent. And a $10,000 penalty is owed PEBP.

CTI noted a substantial improvement in Via Benefits customer service speed to answer performance from prior audit periods.

We recommend reviewing the financial error identified in the random sample audit to ensure the root cause has been identified and claim processor training or coaching has taken place.

So does anyone have any questions about the Via

Benefits report?

CHAIRMAN ROBB: I can't see any questions. Thank you for your presentation. I'll bring it back to the board. Agenda Item Number 9.

MEMBER BITTLESTON: This is Leslie Bittleston. I move to accept the audit findings as presented.

MEMBER STRASBURG: Second. Bepsy Strasburg.

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

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: Opposed? Motion passes.

We will move back to Agenda Item Number 8, acceptance of Claim Technologies Incorporated audit findings for the State of Nevada Public Employees' Benefits Program third-party administrator, UMR, for the period April 1st, 2023, to June 30th, 2023, for possible action. Claim Technologies Incorporated.

MS. AMATO: For the record, this is Joni Amato. So the scope of the audit included all claims processed during the period of April 1, 2023, through June 30th, 2023, and included both medical and dental claims. The medical and dental claims paid during the quarter four totalled approximately 57 million dollars and included approximately

188,000 claims.

The audit included the following components: Quarterly performance guarantee validation, 100 percent electronic screening with 50 targeted samples, a statistically valid and stratified random sample of 200 claims, data analytics. The audit also included an annual operation and review and eligibility verification incorporating eligibility data obtained from TELUS Health.

In our auditor's opinion, the financial accuracy and overall accuracy improved this quarter, but we did not see an improvement in claim turnaround time. Performance guarantees for both financial accuracy and overall accuracy were met, but the two performance guarantees for claim turnaround time were not met. This results in a penalty of two percent of the administrative fees for the quarter or $25,887.16.

We recommend that the financial errors identified in the random sample audit are reviewed to ensure that root causes have been identified, and in claim processor training, there are system fractions that need to take place have been made. Similarly, we recommend reviewing the electronic screening and targeted samples. Results to focus in on, potential opportunity for recovery and just improvement in the systems itself.

We also recommend that PEBP review the eligibility verification results to determine if the improvements -- if their improvements could be made in the work flow in honor of reducing any payments for ineligible members.

Any questions regarding the UMR report?

CHAIRMAN ROBB: Any questions from the committee? Board Member Kelley.

MEMBER KELLEY: Thank you, Chair Robb. Thank you for the order. I guess I just heard you say one of the improvements that could occur is PEBP could review the work flow to look for inefficiencies. You know, I think that, obviously, we have been working with UMR now for almost two years because they came on for implementation purposes I think in January of 2022. So we are kind of two years in to this relationship, even though they've only been paying claims for, you know, 18 months.

So I just wonder -- Oh, I'm sorry about that nasty echo. I think someone has got their mic open.

I wonder if there's other recommendations that you have -- that you could make that would help us help UMR get this right. You know, I mean, I think ultimately we all, UMR, PEBP, the board, we want, you know, obviously we need these metrics to be met because it's providing service to our

employees. And, when they're not met, the services to our employees get impacted. And, definitely, I think the metrics around especially our providers getting paid in a timely manner and in a correct manner is really important because we do have some very small work centers where if a provider says, you know what, I'm not taking new patients until you resolve this issue, it really has a significant impact on our population. And when our population are impacted, you know, they use sick days, they can't work. You know, ultimately we want everyone to be healthy and at work, I guess, unless they're on annual leave.

So, you know, pointing back at you, are there other recommendations that you have that could help, you know, us manage and assist UMR in getting these things right?

MS. AMATO: Sure, sure. This is Joni Amato. I look back at the year in total, because even though this was fourth quarter, I looked at the errors throughout the year to see if there's something that's repeated. And I think maybe taking some of those issues that we see repeatedly, we see some provider discounts not being applied appropriately and maybe look at remediation plan. How do we fix these? Ask UMR to look at these and provide feedback on how do these errors occur and how were they remediating that to stop that from happening in the future.

Earlier in the year, we met with UMR to talk about duplicate claims, because we had seen a lot in the electronic screening and they have been implementing some system changes to help remediate that problem. So I think some of that type of activity and some of the other categories would be beneficial.

CHAIRMAN ROBB: Okay. Thank you.

Any further -- Board Member Weeks.

MEMBER WEEKS: Thank you, Chair Robb. The only question I have is this at risk and I see it's one percent. Is that one percent of their total contract year payment? Like, what is that one percent exactly? I'm sorry. I'm kind of new to the contract.

MS. AMATO: So this is Joni Amato. I'm sorry. Like, the one percent penalty fee?

MEMBER WEEKS: Yes.

MS. AMATO: It's one percent of your administrative fees that you're paying UMR.

MEMBER WEEKS: Okay. Thank you.

MS. AMATO: Sure.

CHAIRMAN ROBB: Any further questions or discussion? Seeing none, this is an action item.

MEMBER BITTLESTON: This is Leslie Bittleston. I move to approve the audit findings for UMR as presented.

MEMBER KELLEY: Michelle Kelley. I'll second that motion.

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

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: All of those opposed? Motion passes.

We will move on to Agenda Item Number 10, discussion and possible action regarding UMR performance under a contracted third-party administrator services. Celestena Glover, Executive Director. For possible action.

MS. GLOVER: This is Celestena Glover for the record. This agenda item was essentially to provide the board the opportunity to discuss the concerns they may have with how things are going with UMR. They've had four quarterly audits. They've had some penalty imposed each quarter. And, so, typically, we keep our discussions tied to the audit itself. But I know there's been some concerns expressed to me either by members or board members or providers in regards to the services that UMR provides.

So this is just an opportunity for the board to have a more open discussion about any concerns they have and any direction they want to provide staff or our vendors in

relation to going back to taking some additional action outside of what the audit has recommended.

CHAIRMAN ROBB: Before I go on to Board Member Kelley, I do appreciate this agenda item being on here. And I have a question. There has been audit findings in all four quarters. But you, as staff, are you comfortable in seeing progress -- Even though there are findings, do you see progress becoming more comfortable with the process?

MS. GLOVER: This is Celestena Glover. We are seeing that the audits are improving, the results. We are seeing movement in a positive direction. I think from my point of view I'm a little bit frustrated because I want to see it better faster.

You know, we've had previous relationships with other TPAs and this is not the experience we historically have had. And I do know that we get calls or letters from providers. We get calls and letters from members that are frustrated because they go to their doctor, and their doctor or their dentist, who ever, is coming back and saying, I haven't even been paid for your last visit. And then we get called. Why isn't this paid. Is my benefit not covered? And then we need to direct them back to UMR.

I know UMR has a process they go through. We've discussed some of those and I think some of the things in

place are necessary, like reviewing prior to adjudication for payment. But, at the same time, the longer it takes for turnaround times, the more we get calls. It's frustrating for the member or the provider, but there's also more work on staff because you see us doing more appeals, you know, we're trying to respond in a positive manner to address the concerns of everybody. And, you know, I've been asked how do we make it better and, you know, I'm trying to come up with some ideas, but I really need some feedback from the board on what they're hearing from the members that they represent. And is there anything specific that you want staff to look at to work with UMR directly?

CHAIRMAN ROBB: This is Chair Robb again. I'm going to follow up. I appreciate that. What do you need out of the board? Before we get in to too much board discussion, how can the board help staff rectify the issues that you see? How can I help you? How can the board help you get to a better spot? That's -- I want to help you. It's just I don't know how at this point.

MS. GLOVER: Celestena Glover for the record. I think it's understanding specifics that you may be hearing versus -- We get information, but I know that members talk to each other, providers talk to each other. Members and providers may be talking to you. So is there something

specific that you've heard that you would like us to look in to? Is there some thing that you think maybe we can do differently? We're reviewing it and we're looking at the audit specifically. And then if we get a call or a complaint or even if we get positive feedback, typically we don't hear from the people that are happy. We're going to hear from the people that are not happy because something has gone wrong.

So I'm really looking for the board's experience, the board's concerns if any of your members, co-workers, other advocacy groups -- I cannot talk -- that you may have heard from that have had specific issues or concerns that may or may not have come to PEBP directly. So it's more of a is there something specific that you're hearing that you can provide to us that we can take that along with what we're hearing to get back with our vendor and say, okay, here's all the issues. You've given time to the board to express their concerns and here's the plan, let's develop a plan that we can hopefully resolve the issues that we're seeing. I hope that helps.

CHAIRMAN ROBB: And I understand what Ms. Glover is asking and I hope that all of the board members understand being a board member, we don't have to wait for these meetings to reach out to Ms. Glover and staff to ensure that we are continuing to communicate what we are hearing and

continuous drive to make things better for our members.

So, with that, I will go on to Board Member Kelley.

MEMBER KELLEY: Thank you, Chair Robb. Michelle Kelley for the record. And I appreciate the thoughtful approach to this agenda item. I guess I feel -- I guess I would like to request that perhaps this agenda item be pushed to a future meeting. We, you know, there was significant -- there were a number of issues in the south with UMR paying claims. Unfortunately, due to the events yesterday, many -- well, none of the advocacy groups were able to attend today. And I think that, you know, that started rather early yesterday and so we didn't even really get public comment from those groups and also the individuals in the south from NSHE, because I know they have been the squeaky wheels. So I would like to give those individuals and those groups an opportunity. And, obviously we have audits every quarter. You know, I know that UMR have spent time trying to address the participant issues in the south and I do believe that they have put in place some processes that are helping our participants.

So I think that, you know, I really -- I do want to commend them for taking the time out to meet with UNLV faculty and staff and really looking and listening to the

concerns of those groups. As I say, so saying that, the groups were unable to be here today.

And, just a last comment is that I think -- I think that we're probably at the place where we need a remediation plan of some description. I think that UMR have, you know, have been making strides to improve, so I am, you know, a year in, Q-4 of the last plan year, you know, we're still -- they're still identifying issues.

So I think that this -- I definitely have questions for UMR. I'm not sure why it is taking so long to fix these issues, especially since we had a contract with HealthSCOPE who they absorbed. So we're not even -- I know that we're a new client because they changed platforms for us. But, you know, our plan is not new to the group as a whole. And so I would like to personally hear from UMR to hear their response, maybe an aggregate to kind of the four audits. But I also think that staff should perhaps start thinking about a remediation plan. And thank you for the time.

CHAIRMAN ROBB: Okay. Thank you. This is Chair Robb again. I understand what Board Member Kelley has expressed. And I think it's the duty of this board to work to make things better for our members. So I will work with Ms. Glover to come up with an agenda item for a future

meeting very similar to this one but to also ask UMR to be present so we can ask them questions. It's not agendized for us to ask UMR questions today. But maybe on a -- Not maybe. But on a future board agenda we will have something very similar and make it open to ask UMR questions to ensure we are getting better and going forward.

Any other board member comments or questions? Board Member Weeks.

MEMBER WEEKS: Thank you, Chair. I just want to say thank you for the candor. I think it's hard -- I mean, I work at the state as well, and I just want to say that I think that these benefits obviously are one of the few things that we have to offer our staff and it's super important. And the money we're spending it's their contributions, our state taxpayer dollars, they're limited. And so I do support holding our vendors accountable. And I just want to be clear on my stance. And I also feel to make some of those decisions, if it's available next time we meet, to have more information about some specific concerns about generally maybe some three dockets that you're hearing staff know that providers are complaining about, members are complaining about, just to help us be better informed. I mean, I can ask my staff. But I would rather know, like, what you're hearing as well. And then also thinking about, like, provider

surveys and other things that we've done, if we can see should of that information. That will help, I think, the conversation. That's my only request.

CHAIRMAN ROBB: Any further board member comments? Yes. I can't see. You're kind of out of the screen there. So go ahead.

MEMBER MCCLENDON: This is Jennifer McClendon for the record. I would just like to follow up on Board Member Weeks' comment and say from my perspective most of what I hear is that people's providers are leaving the plan. And, in northern Nevada where we have limited providers, that's a significant concern. But it's hard for me to understand what is anecdotal, like, what is someone crying because they have lost their one provider that they love and what is, like, a broader issue. So I'm wondering if we can get some sort of report of how many providers have been lost in the last two years, maybe broken apart by region. Because just from my own experience hearing members' complaints from experiences when they come to me, that seems to be a bigger issue. I hear about, you know, appeals processes and things like that as well. But mostly people are distressed when they can't use the providers they've been using.

CHAIRMAN ROBB: Okay. Any further comments?

This is an action item. And I think the

discussion has given staff quite a bit of direction. Do we need to have a motion or are you good with -- is staff good with where we're at with the discussion or do you want a motion to wrap up the discussion?

MS. GLOVER: This is Celestena Glover. I'm good with it as long as we're not breaking any rules.

MS. MOONEYHAN: This is Brandee Mooneyhan, Lead Insurance Counsel. If the board does not want to take any specific action today, it does not violate the open meeting law.

CHAIRMAN ROBB: I couldn't hear all of that. I apologize. But what I know of it says for possible action. It doesn't mean we need to take action.

MS. MOONEYHAN: Correct.

CHAIRMAN ROBB: And I think the discussion has led us to an outcome that we know where we're going to go.

So, with that, any further discussion on Agenda Item Number 10 before we close?

UNIDENTIFIED SPEAKER: Chairman Robb, is there any chance I can comment here?

CHAIRMAN ROBB: No. It's not agendized for UMR comment and I wouldn't want to go out of turn at this point.

UNIDENTIFIED SPEAKER: Fair enough. I understand. I appreciate all the comments that have been

made today and we'll take those in to consideration when we respond next time. Thank you.

CHAIRMAN ROBB: Yeah. We'll make sure it's agendized so we can get a full interaction with you and your group to figure out how we move forward.

UNIDENTIFIED SPEAKER: Sounds good. Thank you.

CHAIRMAN ROBB: Okay. Thank you.

MS. KUNNEL: Chair Robb, this is Radhika Kunnel, Deputy Attorney General. If the board wishes to put this matter back on the agenda on a future date, that maybe could be a motion. Like, I agree with Brandee, that because it's a possible action, if the board does not wish to take possible action on it, it doesn't violate the open meeting law. However, if you wish to bring this back at a future date, maybe a motion is warranted.

CHAIRMAN ROBB: Okay. I would entertain a motion to bring this agenda item back with the additional information discussed during this meeting.

MEMBER KELLEY: Michelle Kelley. So moved. Sorry.

MEMBER BITTLESTON: We'll all make a motion. So second.

CHAIRMAN ROBB: So we have a motion and a second to bring this agenda item back with the additional

information to discuss during this agenda item. All of those in favor of the motion signify by saying aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN ROBB: All of those opposed? Motion passes.

We will close Agenda Item Number 10 and move on to Agenda Item Number 11, public comment. Public comment will be taken during this agenda item. Comments are 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.

Do we have any public comment in Carson City?

MR. ERVIN: Good afternoon. Kent Ervin, E-r-v-i-n, Nevada Faculty Alliance. I have several items I want to address related to today's meeting.

First, the contract report was in the board packet under Agenda Item 5, the usual discussion was not agendized. I had a question about the Via Benefits contract, which the question was raised last time why Via Benefits was not listed as a contract, and we were told it was a no cost contract. But when it does show up on the list, it's a 1.5 million dollar contract over time. So, certainly, I would have hoped the board would have asked about that, but it

wasn't agendized, so maybe we can get the contract report at another time.

Regarding the increase in the deductibles for the high deductible health plan per IRS minimums, of course, that's something we have to do. But that's a higher cost for participants. And, to keep the plan value and benefits the same, there ought to be an offsetting benefit change, either an increase to the HSA contribution or some other change now. You know, the hundred dollar difference, maybe a hundred to $200 difference isn't huge at this point, but overtime that will move the benefit design of the program. And so that's something that really ought to be discussed in terms of policy. Since it's the minimum, probably the policy should be that it's at the minimum, and you wouldn't have to have a board motion just to raise it to what you have to do. But, anyway, also to have a formula for what else happens with the program.

We moved forward to the rate setting in I presume March. In the policies and procedures document for PEBP, it states that the employer contributions, the state subsidy, are identical across all three plans in each tier. But, in fact, in last year's -- in FY 23 and 24 rates, that's not quite true anymore. The employer contributions were adjusted in a different way to make the premiums not vary at all.

So that's going against your own policy. And I see no reason not to keep that policy because it was put in for a reason and that was to be fair to all participants across all plans by providing the same employer contribution. And then if participants choose to pay differential cost for different various plans. The differentials are not huge now, but particularly with the HMO increases, they could get larger and so that needs to be addressed.

Finally, and this is related to the conversation about UMR, and I appreciate you bringing that back and allowing our UNLV colleagues, southern Nevada colleagues to chime in on those issues which have been raised more down there than in the north, although there are also issues in the north. I would say that it's also PEBP's responsibility to respond to issues and complaints. And what we've seen and I've heard from constituents over the last period of time is we don't feel like we have anyone we can go to at PEBP anymore. It used to be if you needed to escalate an issue, the quality control officer was the person who had your back, who you could talk to, who worked with the various entities and deal with the problem and help get problems resolved for your members.

Now that's become a very kind of impersonal process. You get an e-mail back that's not even signed by a

person. It just says from quality control. The member we heard from today has had similar experiences. And so my question is, well, who are we supposed to go to for help when there is a situation that a member needs help to go between UMR, the provider, and PEBP and fingers being pointed in various directions and they're just at wit's end. And then there needs to be somebody to go to at PEBP who would really care and help that member. Thank you.

MS. OSBORNE: Thank you for allowing me again. Kelly Osborne, K-e-l-l-y O-s-b-o-r-n-e. Just to follow up with what Kent was just saying. I'll give you a for instance what happened to me in October when I came in to this -- came in to PEBP to talk to somebody about the transplant procedure, I asked the quality control officer if I could meet with him in an office. I was told, no, I had to meet with him in a open room where there were members of the public available, sandwich vendors, people meeting with their other staff. I wasn't even given an opportunity for a private conversation. I just feel like I've been dismissed.

You guys are better than this. You guys want better for your members. I trust that you guys will keep our interest at heart. Thank you.

MS. OPFERMAN: Hello. Tess Opferman here on behalf of the AFSCME retirees. I will keep this brief. But

I just want to echo some of the concerns that we've heard from the last two public comments. I know that the retirees have similar concerns and often times asked for kind of a point person that they can go to with questions, concerns. Especially when we're dealing with retiree population, they don't necessarily know how to navigate on line systems or navigate communication bases that way. And so I just want to echo that because I think it is important. And I know they specifically have asked for some sort of point person within PEBP that can help them. Like I said, an ombudsman of sorts that can help them navigate complaints and be a person, an actual number they can call, an e-mail they can e-mail that's not just a complaint system on line. So thank you for that.

UNIDENTIFIED SPEAKER: Chair Robb, that is all the public comment we have in Carson City. And we do not have any virtually. Jack, we can't hear you right now. Chair Robb, we can't hear you right now. You're on mute.

CHAIRMAN ROBB: So sorry. We'll close Agenda Item Number 11.

We're on to Agenda Item Number 12, which is adjournment. And we will stand adjourned until the next meeting. Thank you very much.

(Hearing concluded at 12:12 p.m.)

STATE OF NEVADA)
)ss.
CARSON CITY)

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

That on Thursday, the 7th day of December, 2023, I was present, via Zoom, for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 84, inclusive, includes a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Reno, Nevada, this 30th day of December, 2023.

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CHRISTY Y. JOYCE, CCR
Nevada CCR #625

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