In The Matter Of:

PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD
VIDEO-CONFERENCED OPEN MEETING

September 26, 2024

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

Original File 9-26-24 PEBPFinal.txt
Min-U-Script® with Word Index

STATE OF NEVADA

PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

VIDEO-CONFERENCED OPEN MEETING

CARSON CITY/LAS VEGAS, NEVADA

THURSDAY, SEPTEMBER 26, 2024

The Board:	**Joy Grimmer, Chairperson** **Janell Woodward, Member** **Michelle Kelley, Member** **Jennifer McClendon, Member** **Bepsy Strasburg, Member**
For the Board:	**Radhika Kunnel,** **Deputy Attorney General**
For Staff:	**Celestena Glover** **Executive Officer** **Jessica Crane** **Executive Assistant** **Michelle Weyland** **Chief Financial Officer** **Nik Proper** **Operations Officer** **Leslie Bittleston** **Quality Control Officer**

Reported by: **Shellie Loomis, RPR**

NV CCR #228

CAPITOL REPORTERS (775) 882-5322

MEETING NOTICE AND Agenda

Agenda

Public comment will be taken during this Agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future Agenda as an item on which action may be taken. Persons making public comments to the Board will be taken under advisement but will not be answered during the meeting.

Comments may be limited to three minutes per person at the discretion of the chairperson. Additional three minute comment periods may be allowed on individual Agenda items at the discretion of the chairperson.

These additional comment periods shall be limited to comments relevant to the Agenda item under consideration by the Board. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

5. Executive Officer Report. (Celestena Glover, Executive Officer) (Information/Discussion) 8-81

6. Plan Design Report (Celestena Glover, Executive Officer and Segal) 81

7. Public Comment 81-97

Public comment will be taken during this Agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future Agenda as an item on which action may be taken.

Persons making public comments to the Board will be taken under advisement but will not be answered during the meeting. Comments may be limited to three minutes per person at the discretion of the chairperson. Additional three minute comment periods may be allowed on individual Agenda items at the discretion of the chairperson. These additional comment periods shall be limited to comments relevant to the Agenda item under consideration by the Board.

Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

8. Adjournment. 97

CARSON CITY, NEVADA, THURSDAY, SEPTEMBER 26, 2024

-o0o-

(Meeting in progress.)

(Whereupon public comment was held.)

CHAIRPERSON GRIMMER: Okay. Thank you. Okay. Any further public comment here? Seeing none, we'll close Agenda Item Number 2 and go to Agenda Item Number 3, PEBP board disclosures for applicable board meeting Agenda items.

Deputy Attorney General Radhika Kunnel.

MS. KUNNEL: Good morning. Radhika Kunnel, Deputy Attorney General for the record. 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 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 legible for benefits.

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

Thank you.

CHAIRPERSON GRIMMER: Okay. Seeing no additional disclosures being brought forward, I will close Agenda Item Number 3 and move on to Agenda Item Number 4.

MS. KUNNEL: Madam Chair, if I may make a comment?

CHAIRPERSON GRIMMER: Yes.

MS. KUNNEL: Before moving on to the next Agenda item. Having heard a number of comments during the public comments session that they had received some sort of notice and within the last two day or two, I would like for somebody from the PEBP administration to comment on the notice just to ensure that the notice requirement meets the Nevada open meeting law requirements.

EXECUTIVE OFFICER GLOVER: This is Celestena Glover for the record, Executive Officer of PEBP. The Agenda was posted on Friday. Once it's out of our hands and into the system to get properly posted, we don't have a lot of control over that. But it could get posted as late as, what, 12 o'clock that night so the Agenda did go out.

We have routine meetings on the -- right around the 22nd to the 25th of the month every other month. So we do have a standing schedule for our board meetings and the agendas typically are posted a week before that board meeting

is held.

So if you have a question about whether a meeting is coming up you can always contact PEBP and we will let you know when the next one is scheduled so if there is something on the Agenda that you want to participate in, make a public comment on or submit a written public comment, you can get that in a timely manner.

CHAIRPERSON GRIMMER: Okay, thank you.

MS. KUNNEL: Thank you, Madam Chair. Thank you, Celestena.

CHAIRPERSON GRIMMER: Okay. So we'll now close Agenda Item Number 3 and move on to Agenda Item Number 4, consent Agenda.

All items for possible action consent will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

Is there any item the Board members wish to have pulled?

MEMBER KELLEY: Michelle Kelley for the record. Can we pull 4.1? I wasn't present at that meeting so I can't vote.

CHAIRPERSON GRIMMER: Okay.

Okay. Any others?

Okay, seeing no other items, do I have a motion

to approve all of the items except for 4.1?

MEMBER KELLEY: So moved.

MEMBER STRASBURG: Second.

MEMBER KELLEY: Michelle Kelley for the record. I made the motion to accept 4.2 -- all items in the consent except 4.1.

MEMBER STRASBURG: Bepsy Strasburg. Second the motion.

CHAIRPERSON GRIMMER: Okay. Any further discussion? All those in favor signify by saying aye.

Any opposed?

Okay. Motion passes.

(Motion carries.)

CHAIRPERSON GRIMMER: And now we vote on this other one separately. Okay. Do I have a motion to approve 4.1, approval of action minutes from the July 25th, 2024, PEBP board meeting.

MEMBER WOODWARD: Janell Woodward. I'll make the motion to accept the minutes as written.

MEMBER STRASBURG: Second, Bepsy Strasburg.

CHAIRPERSON GRIMMER: Okay. Any further discussion? Okay.

All those in favor signify by saying aye.

Any opposed?

Okay. Motion passes.

(Motion carries.)

CHAIRPERSON GRIMMER: We will close Agenda Item Number 4 and move on to Agenda Item Number 5, Executive Officer report, Celestena Glover for information and discussion.

EXECUTIVE OFFICER GLOVER: Good morning again, this is Celestena Glover, Executive Officer with the employee benefits program. Before you is the Executive Officer report. It provides general information to the PEBP members, Board Members and stakeholders.

There is only a few things that I've included this time, the first one being the budget update. For those who may have reviewed the budget report, you see where we ended the year. We have had some significant expenses. We were eating into a catastrophic reserves to make sure that we can meet our obligations for the year. That is affecting our availability of cash because whatever we have left in one year we forward to the next.

We saw a $43 million shortfall to balance board cash from 2024 into 2025. So some of what we are discussing today is predicated on what available funding we have and what we believe we may receive during the upcoming legislative session.

So I just wanted to make sure that the Board was aware that, you know, we are in some pretty restricted positions with funding at this point in time, and we don't know where we're going to land with 2025 and obviously I can't predict what the legislature will do in the upcoming session.

Speaking of which, the upcoming session starts in February. We have committed our budget report per the Governor's finance office direction, which was due on August 30th. We did start tracking some of the BDRs that we're seeing out there. The last time I looked was about a week and a half ago. There was 520 BDRs posted at that time. I know personally I have like 120 on my list because we're tracking anything that says related to health care, related to mental health care, related to insurance. Because there's no language yet for us to look at, anything that might affect PEBP and the program and its members we're trying to keep track of.

Once we've seen language we'll fine tune our list of BDRs that we're tracking. We know some will become bills; some bills will die in committee before they even get heard.

So as we get the information, we start identifying bills that will affect us, we will be having meetings as we have done in the past to discuss potential bills with the board for direction on what action they would

like us to take.

We have the strategic planning meeting coming up; that is the 1st and 2nd, which is next week. We have an Agenda of items we are going to be speaking about, and essentially what we're looking at is where we are today and where we believe we should be taking the plan.

We'll be discussing potential options for benefit offerings in the future, plan design changes that might come out of this board meeting, and a whole host of other ideas that our vendors will participate in helping us kind of flesh out.

Any brand new ideas that are not just simply plan design adjustments but new programs, we are looking at plan year '27 to ensure we have sufficient time to analyze those options, bring them back to the Board for discussion, and really look at is that something that we can support, can we afford it, is there an interest in utilizing those benefits.

So all of that will come out of this strategic planning meeting and we will be bringing back information from that meeting at the November board meeting and board meetings thereafter for further discussion.

And then finally, we have the Medicare open enrollment. This is just a reminder to our Medicare retirees. Open enrollment starts October. It begins the 15th through

December 7th. Please ensure that if you are on Medicare and you're enrolled through VIA, if you wish to make any plan changes that you can continue to enroll through VIA. If you enroll in a plan outside of VIA you run the risk of losing your basic life insurance and your HRA funding.

So it is critical that if there's a plan option you're looking at, you've seen a commercial, you've read an ad, your next door neighbor told you, whatever it is, make sure you contact VIA to ensure, one, that that option is available on their platform, and two, that if it is, you're enrolling through them.

We are going to have some HRA specialists in the office for the Medicare exchange on November 6th and November 7th. They're going to be here to assist members with either transitioning into VIA or assisting them with any current issues they maybe having.

And there's also a phone number. It's listed in my report. It's also on the website. It's 1-844-266-1395, and you can schedule an appointment with the specialist at that time.

For more information, keep track of it on our website. And also you can call VIA directly. You can also call PEBP and we will provide you whatever information is asked for if it's within our power to do so.

And with that, I'll take any questions.

MEMBER WOODWARD: Chair, for the record, Janell Woodward for the record. Just a question. I've had a number of sticklers or participants reach out regarding this meeting and wondering if you can explain the reason for not having that as an open meeting that people can participate in, either some discussion of what are they trying to hide, you know, the typical type things that come up. But if you could just address that, that would be great.

EXECUTIVE OFFICER GLOVER: So this is Celestena Glover for the record. The strategic planning meeting is an internal meeting between staff and vendors to flesh out ideas to bring to the Board. It's like any staff meeting I would have with my staff or one of the meetings I may have with vendors; they're not public meetings.

We don't invite members to come sit in my office at all the meetings I attend. It's just not -- it's not always appropriate, and there are times where we need to talk about information that isn't appropriate to say in a public meeting because we're talking about any particular situation. If I'm addressing your situation you don't want the rest of the world to know about it.

So it's -- sometimes sensitive meeting we're talking about. So it's just away of figuring out where PEBP

is now and where we think we need to take it, and all that information, once we decide which things we're going to be looking at, we'll always come back to the Board.

MEMBER WOODWARD: Thank you.

MEMBER STRASBURG: Bepsy Strasburg. Director, can you please help me for my clarification, the open enrollment will not have the changes that was the subject of all the public comments earlier; correct?

EXECUTIVE OFFICER GLOVER: This is Celestena Glover for the record. So open enrollment, that's a forum for members wishing to change their existing plans. If we make a plan change, all that information will be discussed and voted on by the Board and then documents will be updated and that information will get out on our website.

So there will be some things that we'll be looking at, so this meeting and the next meeting, those will be things we'll be looking at for the upcoming open enrollment, if there's any plan changes, things that are coming out of strategic planning will probably be for the following year depending on what that is.

MEMBER KELLEY: Michelle Kelley. I just got a couple questions. The first one, Executive Officer, I was interested in the budget update. I thought I would wait for you to talk about it. I guess I'm a little concerned and

confused. You know, I understand that anything you submit to the GFO is confidential, but I wonder -- honestly I wonder how the Board is meant to do its job if we're talking about plan design, we're talking -- you know, you are telling us we're basically in the red, which I have a question about, but how are we meant to design a plan for our participants when really we don't know the finances.

And kind of that leads me to, you know, I've suggested it before to the horror of staff, but, you know, our plan year is not designed for the fiscal year because it -- you know, I mean, we can't -- we don't have any certainty on having a finalized plan design. So stop for there now.

EXECUTIVE OFFICER GLOVER: So this is Celestena Glover for the record. As far as the budget submittal, when we submit the budget we use existing plans designed the way they sit, we make no changes unless something has come up like we know that the deductible is going up to maintain the CDHP. So things like that are considered.

But typically what we do is we assume no changes, and then we look at where we are today with the budget, and do we have a shortfall, do we have an excess, and we adjust our budget request to account for that.

We're not in the red; we're just very restricted with the funding that we currently have. A lot of it is

because over the last three years I've seen significant increase in claims costs. Even the HMO renewal this last go around is double digit renewal. So all of that plays a part in our overall financial health.

And then anything that we approve that enhances benefits. So a lot of decisions were made in prior years to use excess reserves to either decrease premium, increase HSA or HRA contributions, and those excess reserves weren't there, they weren't available, so that came out of the regular funding which then tightened us even more as to the cash that we had on hand to pay bills.

So we're not in the red. I'm just very cautious with where we are now because I've seen that shortfall compared to what we budgeted for.

MEMBER KELLEY: Okay. Thank you for that explanation.

So then I just -- actually Medicare open enrollment was a really simple question. I just wanted to confirm, this information you provided here is not different from past years, you're just reminding people how it has to work.

EXECUTIVE OFFICER GLOVER: This is Celestena Glover for the record. Correct.

MEMBER KELLEY: Thank you. I was reading and I'm

like I've never not sure I've ever seen it spelled out in this detail so I want to confirm it's nothing new.

EXECUTIVE OFFICER GLOVER: Celestena Glover for the record. I just want to say on the Medicare, the reason I put the reminder in there because we do have a number of people every single year that even though they've been in the exchange for a long time, we still get some that somehow get mixed up and end up in enrolling in XYZ plan over the year with a broker, not realizing or not thinking about the fact that they needed to go through VIA. It happens. We don't know why it happens.

You know, it sounds like a good deal, and so they go down the good deal path and then they get sideways. So we always try to help them, but sometimes we're not even made aware of it until a couple months after the start of their plan year, which is January 1st.

MEMBER KELLEY: Great. You know, I really appreciate the reminder for everybody. And I think it's good for us to know as well because we do -- I know in the south people fall into that trap because so many people are selling really -- I guess it's quite lucrative, right, to sell all these Medicare exchange programs. And so if your neighbors that you know really well and you trust it's easy to fall into that trap. So thank you for that reminder.

And then the last question I've got is actually about something not on your report, but I've had a number of employees contact me about that HSA Bank investment cultural switch for there -- so I think sometime this year we switched from one company to Schwab, and now I think it's just past, but on September 24th they've now introduced their own version of investments that cost changes.

I'm wondering has staff had a lot of feedback about that because I've had a few, but I'm just wondering what kind of due diligence did HSA Bank allow us on that contract switch again. And, you know, and then there's been a change of the costs of investing with them. They've introduced some new fees that they themselves are charging. So I'm just wondering about all of that switch.

EXECUTIVE OFFICER GLOVER: So this is Celestena Glover for the record. I've heard a little bit of feedback, but not a lot, from members on the HSA Bank. You know, typically whenever they're getting ready to do something, we ask them if there's going to be a campaign or something that they let us know in advance and we look at the documentation that's going out, but their business decisions we really don't have a lot of say in.

So the only thing I can really do is I can attempt to get an HSA rep -- I can get an HSA rep here for a

future coordinating and have them speak to that directly so they can answer your questions accurately.

MEMBER KELLEY: I think that would be helpful, because I'll be honest with you, that I do reach out to PEBP with a list of questions, and Jessica, thank you, Jessica, worked really hard to get the responses for me, but then I've got to tell you that every time you call HSA Bank their customer service agents actually tell you something different.

And so the -- some of the answers Jessica gave me, which I probably trust more than the customer service, but they're giving different answers. And I can certainly give more specifics on that, but it's just a concern when it's -- you know, when -- when you ask a question you want someone to give you, you know, a specific and correct answer and that does not seem to be the case with this transition. And it's finance stuff so it's all regulated. They can't just -- they shouldn't just be making it up as they go.

But I feel like I'm getting a lot of contrary answers. I'll leave it at that. But I appreciate that. So I think it would be helpful to hear from them about that switch.

And maybe also the migration, because they were mapping people, which is the automatic movement of monies, and then they were also allowing people to stay invested in one option and not in another. There's lots of moving parts to it

I think is what I think concerns me the most.

Thank you.

CHAIRPERSON GRIMMER: Any further questions? Okay. We will go ahead and close Agenda Item Number 5 and move on to Agenda Item Number 6, plan design report, Celestena Glover, Executive Officer and Segal for possible action.

EXECUTIVE OFFICER GLOVER: This is Celestena Glover for the record. As I mentioned in the previous report, the first item on the plan design discussion is the budget status. As I've said, we have the $24 million shortfall going into plan year '24 and that worked out to a $43 million shortfall going into plan year '25.

So those are things we need to consider moving forward is what monies do we have on hand and what do we foresee being provided during the legislative session.

So I wanted to tee it up with where we're sitting right now and provide some level of understanding as to why some of the recommendations are being made in the plan design considerations.

So one of the things that we did take into account with our benefits are to get our life insurance back to 25,000 for active employees and 12,500 for retirees. Those amounts were reduced due to budget constraints, which is typical of what happens. I wish it wasn't the case but it is.

The legislature, however, did provide some general funds that funded the portion that we reduced. So we have been offering the 25 and 12.5, for these last two years but I want to make sure it is part of our budget and not asking them for general funds.

Because we typically don't receive general funds, at the end of the year those general funds are reverted so it can cause a bit of a nightmare to try and figure out how much of that money did we really use in our life insurance payments.

So having it -- I would like to see our benefits stabilize and not hit every time we have a budget issue. It's just a matter of who pays for the benefits, because it's a combination of the employer and the employee and if the employer isn't willing to provide the contributions we need, then that is on the backs of the employees and the retirees.

So that is something that is always in the back of our mind when we make any recommendations or suggestions or we start looking at what our options are. So that's just one of the things that we are looking at when we do this.

The consumer-driven health plan has been our primary plan since I think 2012 I want to say; I'm not even for sure. And that is the plan that was introduced to allow us to offer health savings accounts and health reimbursement

arrangements for our members.

The ability to provide the HSA funds, health savings account funds, is to ensure that we are at the minimum level required by IRS for the deductibles for a single person and a family. Those deductibles are going up to 1,650 for self only coverage and 3,300 for family coverage, which is a $50 increase for the single person and $100 increase for the family.

We have no control over that. As long as the Board wishes to offer an HSA we have to meet that requirement. So we have always historically stayed at the lower end of the deductible to ensure that our plan is in compliance. We have made no changes to the out of pocket max. We've kept that at a fairly low level compared to what the IRS allows us to do. So we continue to try to maintain that.

Once we get to a point where our out of pocket starts to fall below what they're -- what they say we can do, they have a max versus a minimum, then we'll look at adjusting those but right now we're still in safe territory.

As people have said, you know, we are able to raise the contributions members can make toward their HSA accounts, but it's kind of offset with the cost of the deductible. But it doesn't make sense to leave the deductible at 1,600 and the contribution where it's been, or raise it and

raise the other to go with it. So you have to ask the IRS why they make the decisions they make, but we are going to keep our plans in compliance until such time as the Board decides that they no longer want to offer an HSA option.

We have -- the HSA was another one of those things where the primary, their contribution was reduced to $600 and we eliminated contributions to family members. We did receive additional funding from the legislature to supplement some of that funding.

Again the drawback with the general fund, having to revert it, we revert those funds, we keep whatever was technically put into the HRA accounts, but that's not -- the HRA accounts aren't real money until the individual actually files a claim on those monies.

Well, they have a year to file their initial claim and then any balances they have carry forward. Well, the general fund doesn't carry forward with it. So we're in this position that if they use their entire balance in the year they were given it, we're fine, but most people don't. They carry over some amount; whether it's $50 or $600, they carry over something.

We have a lot of people that we term savers. They're saving that dollar amount for a bigger ticket health care item, versus the smaller co-pays and deductibles or

whatever that they may incur during their -- during the year.

So we have a mix of people. We have some people that they choose not to use their HRA funds because there's a requirement to submit receipts to prove that you went to the dentist or you went to the doctor or whatever, and that again is an IRS requirement.

And some don't want to go through that. They feel that that's a hassle so they don't use their funds in any way, shape, or form so those balances sit there. But we have to treat it as if at some point, until that person leaves the plan altogether, that they may access those funds.

So my proposal in the budget took everything back to the $700 for the primary and back to the $200 for dependents up to three dependents.

Whether or not that will get through GMO and the legislature, I don't know that at this point. So it is built into the budget to kind of restore some of our benefits to some of the levels prior to COVID.

The new plan, which we've had for a couple years now, the low deductible preferred provider option, that one did have a deductible at one time. My understanding, and this occurred before I came back to PEBP, is that the legislature decided to remove the deductible. It wasn't a PEBP decision or PEBP board decision.

So there is language in there of coinsurance. So 80/20 is typically is what we set our coinsurance at. There's also co-pay language in there. So some visits have a co-pay, $50 or whatever it might be, some are the member pays 20 percent, the plan pays 80 percent. And I understand that to be confusing, but depending on the decisions the Board makes today, we will look at the payment structure in the low deductible.

As you've heard, a lot of discussion about keeping the HMO, not keeping the HMO and the EPO and the cost of around it and the certainty of knowing what that payment is going to look like when you do go for your provider care visit.

My proposal would be that we structure the payments in the low deductible to be a co-pay structure, not a coinsurance, so you always will know what that dollar amount is, whether it's a $30 doctor's visit or a $50 specialist or whatever is the appropriate amount. So it will look similar to what an HMO co-pay structure looks like although it maybe a different dollar amount than what we're seeing right now.

And I propose that it becomes a traditional PPO without the deductible. So that would mean renaming it because low deductible doesn't make sense if there is no deductible, but that is something for the Board to decide.

That takes me into the HMO EPO plan viability. So we have several issues there outside of just the cost of those plans. So we hear individuals saying that, you know, they're certain of their costs and there's been some discussion of one plan costing more than the other as far as what they pay out of pocket, but keep in mind the out of pocket is also your premium and the premium payment on the HMO EPO combination plan is $100 more a month for a single person on the plan.

So you got to take into account that $1,200 a year that you're paying out in addition to your co-pays. So when you say I go to the doctor three times and I had to pay $30, you paid $90 for doctors visits; you may or may not have medications as a result of those visits, but you also had $100 a month on top of that so you're $1,290 more.

If the co-pay is very similar in the low deductible plan but your premium is less, you're actually out of pocket for less. Also out of pocket max is less than the low deductible than it is in the EPO and the HMO plans.

So those are considerations that we looked at when these recommendations were made. We do have an RFP out right now. We have not received the responses yet. There is the possibility that we get several people or several companies submitting proposals.

Historically that's not the case. We gently get two, maybe three from providers in the area. HPM, our current vendor, is usually one of our responders. But we don't know what that renewal is going to look like, so for budget purposes we built the budget assuming that it's going to come in at the highest rate of the current contract. That contract expires on June 30th of 2025, so at the end of this current plan year.

The timing for considering coming down to the two plans, the CDHP and the low deductible, if you're going to do it you're not in the middle of a contract. So that is another consideration.

The EPO is a self-funded plan so that is a consideration the Board can make at any point because the contracts that we have would be TPA network and things like that that we have from the other plans anyway so it's working with the vendors for what those payment structures are going to look like for the existing plans.

We did have double digit increases for plan year '25 on the HMO that came in at 12 percent, which was lower than we expected but higher than we were hoping for, and again it is related what claims costs are.

So we're looking at trying new experiments and what does that look like. We're seeing costs go up across the

board on all the plans. So it's not unique to the HMO and the EPO, but the other two plans right now are costing significantly less from a base plan structure for both the employer and the employee, so again another consideration in our discussions on whether this makes sense to keep these plans.

And then we are also seeing the migration from those plans into the low deductible. We're seeing a lot of migration from the HMO and the EPO to the low deductible plan. We are also seeing migration from the high deductible, but right now the high deductible plan still has our highest number of members.

We're at about 11,900, maybe 12,000 employees and retirees in that plan. We're just over 11,000 in the low deductible. The HMO has about 3,400 participants and the EPO has about 2,600 participants current enrolled; that's employees and retirees both.

So between the two plans we have about 10 percent of our total population not including the exchange, 10 percent of our population enrolled in the HMO and 9 percent enrolled in the EPO.

Those plans are going to be -- they're essentially going to sunset themselves if we keep seeing the type of migration that we have seen over that last few years

because people are leaving those plans because although they may like the payment structure, a lot of people are going to opt for the other plan because the premium is lower. And that is out of pocket every month regardless of whether you go see a provider or not. So another consideration when we looked at this.

We are not looking at it strictly on an employer cost. We know we've set the structure for the contribution from the employer at a flat rate, but can we adjust that to make that -- bring in the same dollar amount from the employer but apply it to just the two plans versus the three plans to maybe to soften the premium, I don't know yet. That's an analysis we have to do and it will be dependent on what is approved during the legislature.

So those are all considerations we discussed. I have Segal here who have put together a presentation to talk about the comparison of the EPO and HMO and to help answer questions. Keeping in mind that we have been talking about this, Laura Rich, who was the Executive Officer previously, had discussed the potential that at some point these plans would not be viable.

I have continued that discussion and we are now at a point that I think it's time for the Board to look at it and to really consider whether this is the right time to make

that decision also.

With that I turn it over to Segal.

CHAIRPERSON GRIMMER: Okay, thank you.

MR. WARD: All right. Good morning.

CHAIRPERSON GRIMMER: Good morning.

MR. WARD: For the record, I'm Richard Ward with Segal Consulting. We're the consultants and actuaries to PEBP. And we have a couple -- we have some materials here to review to continue the discussion that Executive Officer Glover just initiated. Our materials are -- begin on page 67 of the board packet -- excuse me -- 65 of 77 pages in the PDF, if that's a helpful reference point.

And while we recognize there are a number of considerations, some objective, some subjective, some tangible, some intangible, and there's a range of perspectives for consideration like this, and we acknowledge that those are important considerations in a decision such as this.

The materials that we've provided for this discussion are more technical and financial in nature but not intending to diminish the other considerations that are very important. It's just our contribution to this discussion so that the Board can have this perspective when considering this decision.

So on a little bit of background here, we're on

page 66 of the board packet which is page 2 of our materials. It's just a review of some of the metrics for the different plans.

So we've got here across in the first -- in the first row for the four plans the actuarial value. Just as a refresher, the actuarial value is a reflection of the total costs that are paid on average by the plan with the balance being paid by the member.

So let's -- so looking at the CDHP plan, that has an actuarial value of 76.7, and what that indicates is that the plan pays let's just call it 77 percent -- 77 percent of total costs of care with the members paying the balance, 23 percent in deductibles, co-pays and coinsurance. And that's on average.

Members, depending on their utilization and needs, will have different -- will experience different levels of costs sharing, some more, some less, but that's a measure of the overall value that the plan provides on average.

And the CDHP plan, having the lowest premium, the premiums for the employee-only coverage only are shown in the bottom row and then some highlights of some of the main plan provisions are shown in between deductibles, maximum out of pocket, some coinsurance, some key co-pay levels, and pharmacy costs -- costs share.

The low deductible health plan has a richer benefit design and also the next highest premium. So there's about a $30 difference in the monthly premium for single coverage, and the actuarial value is about 8 points different. So what that means is for every thousand dollars of health care costs the members are paying $80 less -- their share is $80 less and the plan is paying an additional $80.

And then we have the EPO and the HMO. And the EPO, the actuarial value is really not that different. The plan value is about 3 points -- 3 percentage points different from the PPO. So it is a richer plan, and the costs and the premiums are -- for the employees are higher.

As Executive Officer Glover was mentioning, the difference in the premiums is greater than the difference in the maximum exposure or the maximum out of pocket for member for the year.

So in particular, in the middle there's a row for the out of pocket maximum, and just looking at the low deductible and the EPO, on the individual basis there's a $1,000 difference, and then Executive Officer Glover noted that the difference in the premiums is almost $100 a month, so almost $1,200 for the year.

So members that are choosing the EPO and the HMO -- or choosing the EPO, let's just stick with that, are

paying $1,200 roughly more a year for $1,000 less in maximum exposure. So you're actually paying more than you're getting in return.

And I think that's an important consideration here, just the -- how the balance or the comparison in the value to what members pay to get into these plans.

And then you have a similar differential for the HMO as well. There is a $1,000 difference in the maximum out of pocket, and because the two plans are blended together, the premium is the same from the employees' perspective or from the members' perspective, and so you have that same differential of about $1,200 versus $1,000.

Moving on to the next slide. At the last meeting we reviewed a concept that we referred to as plan efficiency, and I thought it would be helpful just to review that again in the context of this discussion. And I won't revisit all of the detail that goes into determining plan efficiency, but what -- plan efficiency is a measurement of how well a plan manages the cost and health risk for the membership covered in that plan.

So as we're looking at the EPO, which has higher cost share, has higher premiums, has, well, higher costs and we saw that it has higher health risk, how does that really compare against the CDHP. So is the CDHP lower cost just

because all the healthy people are in it, or is one of these plans managing health risk better than the others. And that's just a combination of plan design, incentives, steerage, health management programs and -- and so the calculation for this metric is to take the PMPM costs, the per member per month dollar amounts, and normalize for plan design.

So the CDHP has lower plan costs partly because it has leaner plan design, so let's level the playing field for plan design differences, and then let's also compare -- let's incorporate the overall health risk for the members and normalize for that as well.

So it's costs divided by plan design, value, actuarial value and divided by risk score. And the risk score is something that we determined using a set of risk factors that are -- they're commonly used in the industry.

And we reviewed the claims for every single member and then assigned -- determined a risk factor based off of the claims activity and the care needs that they've had, the medications that they're on, the diagnoses codes that are indicated in their claim. So people that are diabetic have a higher health risk than those that aren't. So the more chronic conditions that we can see in the claims data, the higher the risk score. So with a higher risk score comes higher expected costs.

So just looking at what the net measurement here of all of this is we think a helpful way to look at which plan is performing better, for want of a better characterization, and the lower the efficiency score the more efficient it is.

So what we see with this is that the low deductible plan, the low deductible PPO, has the lowest value for this measure, and I don't think -- I think that's to be expected, and the membership is recognizing that as well with the migration from the other two plans into the low deductible health plan; so it's providing the best value to PEBP, and by PEBP I mean the plan as well as the members.

And here's a couple of slides we reviewed at the last meeting. So moving on to page 4 of our materials. Just looking at the historical costs, this is on a per member basis, PMPM, per member per month. And the green is the EPO.

So it's been the highest cost plan over the last couple of years. And then the three lines at the bottom you have -- in order from top to bottom, you have the HMO which is based off of premiums, you have the low deductible health plan in orange, for those of you with color printouts and slides, and then CDHP is the bottom one in that lighter blue.

And then the second one from the top in kind of the darker purple or blue, that's the blend between the EPO and the HMO. So the HMO has been historically lower cost than

the EPO, and then when we blend them together we still get the highest cost plan out of the three plan options.

Moving on to the next slide on page 5, a little more historical perspective here. Executive Officer Glover talked about the HMO and the recent renewals. So in the current contract there were premium increases for plan year '23 and '24 that were capped at 9 percent.

At each of those two years, the renewal came in at 9 percent and the costs that were being reported that we were seeing that were being experienced by Health Plan of Nevada were substantially higher than that 9 percent.

So it's an unusual situation from -- from our perspective as -- in our role with our clients usually we're able to negotiate with our clients' insurers when they have insured plans, but there really was nothing to negotiate because the costs were substantially higher than the cap.

And so for plan year '25 I recall about a year ago being here and having a discussion about the cap for the last year of the contract being 20 percent, not 9 as it was for the prior two years, and costs were expected to be above that 20 percent and we'd have a similar situation, just -- just that the cap was substantially higher.

So we're all prepared and braced for a 20 percent increase. And the costs in the renewal supported that --

would have supported that from our perspective. Costs were 29 percent above the current -- then current premium, and Health Plan of Nevada's renewal proposal was -- as Executive Office Glover noted, was about 12 percent, which, when you're prepared for 20 percent is good news, but 12 percent in other situations is very challenging.

We were -- we're typically working towards mid single digit proposal -- mid to -- mid single digit renewals, 5, 6, 7 percent. Once you start to get near 10, then that is very concerning.

So just some perspective. We were expecting 20; we felt good about 12, but really, as Executive Officer Glover noted, 12 percent is pretty high.

And so premiums are lagging expenses by 17 percent. So from our perspective, the 17 percent pent-up increase that is not -- that is not reflected in the current premiums.

And over the -- over the longer term, we would expect that -- I'm moving on to the next slide here -- we would expect that to be reflected in the premiums. Maybe not next year, maybe gradually over the next couple of years, but no insurance carrier or combination of carriers is going to subsidize the costs for a plan over the long haul. They just financially can't do it.

And so we expect that the HMO is going to increase at a fairly high trend rate. This is smoothed out. It may happen all in one year with the RFP. It may happen gradually. But it will be above trend, and we expect that for plan year '23, we'll no longer be in a position where the -- with the current three plans, the three current options, that the HMO is going to be subsidizing the EPO; those costs will catch up to the EPO.

And you can see those lines converge at the top, the top point there. And again this is on a per member basis, but the costs will -- for the combined plan will go from about 690 to about 1,403. $1,400 is we're expecting. So about a $600 difference between that and the CDHP.

And if you think about it from an employee premium perspective, the CDHP, the single premium is a little bit less than 10 percent of the total cost. And so if the CDHP is at about -- let's say it's in the 80 to $100 range, just some rough figures -- again we're forecasting several years into the future here. We don't know what the AEGIS and the REGI and the state funding is going to be. We don't know a number of things that will be determined over this six-year period.

But with the current approach where the same funding is applied to all plans, that means the premium for

the EPO HMO will be about $600 higher than it is for the CDHP. So whether it's $600 or maybe something a little bit less or a little bit more, it will be substantially greater than it is now.

Now, a little more historic perspective, just a review of the premiums for the plans. These are the same slides that were in the July board meeting packet. It's just really for reference and context and perspective here in a moment.

EPO has been the highest premium plan and it's about two times the premiums for the low deductible health plan and about three times the CDHP premiums. So these are just the single employee premiums.

We've reviewed migration. I think we're all familiar with migration from the CDHP and the EPO to the low deductible health plan. And the HMO as well. We're seeing the HMO enrollment decline maybe a little bit more gradually than any of the other plans, but that's contributing to the increased membership in the low deductible health plan. I'm trying to get my own slides to advance here.

So now I'm on page 9 of our materials which is page 73 of the board packet. And what we have here in the top right is a projection of total plan costs for state employees. We just simplified the analysis here. But the implications

and the general concept is applicable to PEBP from the broader perspective.

So over this six-year period we're projecting plan costs to increase from about 460 million to about 625 million for the current program and without the EPO and the HMO that those costs would be lower. The initial reduction would be about 5 million and then that gap, that differential, will grow over the six-year period to a difference of about 30 million for plan year '30.

And then so eliminating the EPO and the HMO will reduce overall plan costs and that's for both PEBP and the member. And that results in savings of about let's just say 40 to 50 bucks EPM for plan year '30 and that is for every member in the plan, not just those -- not just for the EPO. That is spread over the entire membership. So reduces the costs for everyone.

The savings come from -- well, there's going to be a difference in plan design. These are the two richest plans so there is a plan design savings component to this. There's also retention and administration costs. So the HMO right now has retention of about 17 percent. So if the -- for every -- if the premium -- it's not $100, but if the premium is $100, $87 is going to claims costs -- $83, excuse me, is going to claims costs and 17 percent is going to everything

else. That's -- that's risk margin, that's profit margin, that's admin. And the prospective relative -- the margin for the self-insured plans is more in the 3 to 4 percent range. So there's savings there.

Right now it's unclear to what extent pharmacy rebates are incorporated into the premium for the HMO. They're fully recognized and passed through and received by PEBP for the self-insured plans so we expect there to be some savings there. There's reduced trend for the HMO; we're expecting -- there's that 17 percent pent up -- excuse me -- 19 percent pent up demand for the HMO.

And there are some cost increases. So the HMO does have a more let's call it hands-on style and health and care management. There's less of that in the self-insured plan. So there might be a little bit of an increase in costs due to that less aggressive managed -- approach to managed care.

And from discussions with UMR, we understand that there is -- maybe there's a slight difference in provider costs. So the provider contracts pay a little bit more in the self-insured plans than they do in the HMO. So there's less capitation, maybe less bundled payment agreements in those contracts and so the costs are a little bit higher.

But when you bundle all that -- let me use a

different term -- when you put all that together there is an expected net savings to PEBP, and again that's the plan and the members.

I think one last slide here. It's challenging to estimate the employee premium impact. There's a number of factors that are yet to be determined, one of which is what funding is going to be provided to PEBP. What is the AEGIS and the REGI, or what are the AEGIS and REGI going to be for the next biennium. We don't know that yet.

There's some other final plan design considerations to be discussed, and then once we see what the funding is and final plan design, what do we think the migration and the risk selection might be if the two -- the low deductible health plan and to the CDH.

But we did some rough estimates here and we have to acknowledge that the costs of the EPO and the HMO membership are higher for those members than for people in the -- currently in the other two plans and that's reflected in the premium differential. So those members going to those two plans will raise the costs for those two plans and we expect that may be reflected in the premium.

And so there be will be higher premiums for the CDHP we think and the low deductible health plan, but that's subject to funding and the AEGIS and the REGI and the

decisions that you all make about what those premiums are going to be.

And so for just next steps, we have a couple of things here. We talked -- Executive Officer Glover talked about reviewing the plan design and the low deductible health plan; that's something to undertake.

And then also this would result in several thousand members being added to the self-insured plans so we would expect there's an opportunity to negotiate the pricing guarantees in the pharmacy contracts due to the increased membership. So that's something that could be accounted for in the next cycle with the next market check.

And I think that's our last slide. And slide -- at our own peril, I should post slide 11, invites questions.

CHAIRPERSON GRIMMER: Okay. Any questions?

MEMBER KELLEY: I have a bunch of questions. I also don't want to monopolize and so I'm happy for everyone else to go first. I do -- bit one specific question I have that I've been curious about for a long time around the actuarial analysis. So going all the way back to slide 1 which is the current plan design and premiums.

MR. WARD: Um-hum.

MEMBER KELLEY: You know, you've given an actuarial value of each of the plans. Does this actuarial

value include all of the cash give backs from the last legislative session and previously? So there was HRA, HSA, deductible --

MR. WARD: Um-hum.

MEMBER KELLEY: -- minimization, so this is a true reflection of all of the money that's gone into the plan, not just the PEBP revenue; it also includes the general revenue.

MR. WARD: Is it's a reflection of the benefit design.

MEMBER KELLEY: Okay.

MR. WARD: So it's not the revenue or the funding. So if --

MEMBER KELLEY: But the plan design changed when we got more HSA and HRA --

MR. WARD: That is reflected in here.

MEMBER KELLEY: Because I asked this question -- so -- Okay.

MR. WARD: This is not a complete summary and I suppose maybe for space we did not include HRA, HSA allocations, but all of that is accounted for in this determination. And it is a bit of a moving target because when you're -- when you're determining actuarial value you can use a model that estimates what the average costs share would

be, but then you could also look at claims data.

And when you have claims data you can really look at -- you can just total up what did the members pay, what did the plan pay, and that's the number. But that's going to change a little bit from year to year just because utilization and costs will vary a bit from year to year. It's not a -- it's not quite as precise as maybe we're indicating here with a decimal point.

So I would say review these with a grain of salt and that we're really interested in the relativities between them rather than the precise numbers.

MEMBER KELLEY: Yes.

MR. WARD: But in the HCA parlance, three of these plans are platinum plans -- or the three on the right, and the CDHP plan is a gold plan.

MEMBER KELLEY: If no one else is going to go I'll keep going.

MR. WARD: You want to come sit down here.

MEMBER MCCLENDON: Do you want me to jump in?

MEMBER KELLEY: Yes.

MEMBER MCCLENDON: Jennifer McClendon for the record. These are questions that I have that I don't think can be answered today, but one of the issues I've been thinking about is less about the impact of this -- clearly

this change would have a good financial impact on PEBP over the long run and then that in turn helps the members who are paying to fund PEBP.

However, I'm just wondering if there's a way that we can visualize the impact of losing the HMO or the EPO for like an exemplar family that is on the plan, right.

So if we could look at a family that's on this plan that has very high health costs, moderate health costs, and low health costs, so that we can see this family, you know, families with high health costs are paying on average $2,500 out of pocket, not including their premiums, right, because then we can do that math later, but per year to pay for their child's cancer treatments or to pay for a substance abuse issue, whatever that might be, and then if they were changed over to what we now call the low deductible plan, what would their out of expenses be. I just think it would be helpful to see what the difference would be for like a --

MR. WARD: Um-hum.

MEMBER MCCLENDON: -- an example family.

Does that make sense? Is that possible? Is that something that we can get or --

MR. WARD: I can respond to that verbally right now actually.

MEMBER MCCLENDON: Please do. That would be

helpful. Thank you.

MR. WARD: So Richard Ward from Segal from the record. On page 2, this will be maybe more simplistically than you're envisioning because I'm doing it verbally.

The difference in the family maximum out of pocket, so the high costs, so the family that has higher needs. So let's just assume that that family hits their maximum out of pocket. So in the HMO, they have $10,000 a year that they are paying out of pocket.

MEMBER MCCLENDON: Yes.

MR. WARD: To -- in addition to that they're paying a difference in the premium; they're paying $651 a month in premium. If they go to the low deductible health plan that 10,000 becomes 8. Let's just say they continue to max out, that 651 becomes 423. And so their out of pocket costs -- their out of pocket costs go down by $2,000 and their premiums also go down.

MEMBER MCCLENDON: Right. So if I could ask a followup question. Again this Jennifer McClendon for the record. Do we know how many folks max out on each of these plans every year? Do we have away of getting that data? Or how close people are to maxing out on these plans? Are 80 percent of the people who have HMO or EPO coverage, are 80 percent of them within, you know, within $500 of maxing

out. Like I'm just trying to get a sense of where people are at in these.

MR. WARD: We can certainly get that. The next example that I had was anybody that has more moderate needs. So they're not maxing out but they're -- they're lower -- they're having lower out of pocket costs, their costs generally go down as well and they're paying a substantially lower premium.

MEMBER MCCLENDON: If I could follow up with just one last quick comment. I think it would be very helpful to have a visual for that.

MR. WARD: Sure.

MEMBER MCCLENDON: Because I understand the panic for someone who's a member thinking I know what to expect. I can see from this math that it probably is going to be a win for most people, but I'd also like to know maybe who it wouldn't be a win for so that we can make this decision with some compassion for families that might be in very specific health situations that would struggle in ways that we can't see just from looking at --

MR. WARD: Sure.

MEMBER MCCLENDON: -- averages. That's my 2 cents.

MEMBER STRASBURG: Yes. This is Bepsy Strasburg.

I think -- you know, I have a finance background and this is very, very convincing to me, but I think it's more important to satisfy the concerns of the many people who came here to do their public comment, and some visual of taking some scenarios and having that communication with them would be very, very helpful because irrespective of the math, it's the emotional impact of a change from three options to two options and I think we need to be cognizant of that.

MEMBER WOODWARD: Might I just add on to that. Janell Woodward for the record. So one thing, and correct me if I'm wrong on this, but I made that change from the EPO to the low deductible and one thing that I've noticed is that your medication costs go towards your out of pocket with low deductible but they don't do that for the EPO.

So even with high costs for myself, I didn't meet the out of pocket for the EPO and I kind of feel like I might on the other one. And I've had to make that change in the past from previous jobs where they made the choice to take away that.

I am not saying it's easy or not scary or whatever, but I think that your idea of the visual is so important because that does show somebody who is in that situation where they're an HMO and that's what they're used to what would be the -- you know, the result of making that

change and then maybe they are more comfortable if that is the choice that is made. Thanks.

MEMBER KELLEY: Michelle Kelley for the record. So starting at the global position, you know, as we heard during public comment, I think some of the -- so I represent NSHE south, and some of the institutions in the south sent around -- I think actually one institution in the south sent around an email on Tuesday, which is -- in the morning, just saying hey, heads up, there's this Agenda item. And I think that there was another communication go to a limited number of people at all of the other institutions.

And just some -- so personally, beginning on Tuesday I received around 43 emails that were directed specifically to me and mostly from people in the south. And I would tell you that that's an unprecedented number of emails from a very limited group of people, because obviously the state has many more employees in the south that maybe don't go out and check the PEBP board materials on a bimonthly basis. I wish they would because I think getting that specific feedback from participants is so helpful, you know, when we're talking about things like this.

And so as I said, 43, I've never had that many emails. I actually felt like it was more because then I was thinking how do I respond to all -- sorry, people, if I

haven't got back to you yet I will. But -- and so the concern kind of fell into two categories. I think, you know, overwhelmingly what I was hearing from people was that they like the predictability of the costs in the HMO.

We heard verbally that people don't mind paying more per month because it's their -- it's their risk mitigation strategy is to pay for it monthly so they know what it would cost if they had to take their child to the emergency room; it's going to cost them $600.

And I understand that. The way the PPOs bill, you just need to be in a PPO once and if you're a very conservative person you run screaming, right. The billing is just off the charts. The way the hospital tells you what it's going to cost and they go we don't care about the contracts, you're on the hook for a hundred thousand dollars, they may -- at Renown they make you sign for that amount before they even apply any of the contracted -- so using a PPO is very confronting for people. So there's that aspect of the HMO and the EPO.

I think the other aspect is just that disruption, right. From participants, we've heard people have had years of relationships with their doctors, their therapists, and they don't want to lose that. Obviously we can never guarantee that anyway because we've heard about the

Carson-Tahoe, but there's that issue as well.

And so on a very global level I think -- I think that this actuarial analysis, I appreciate all the work that goes into it and I understand I guess the theoretical nature of this, but health insurance is more than theoretical though. So much of health insurance is emotional, about how you want to pay for things. It's kind of understanding your own personal risk, what you can tolerate.

And so for many of the people I got public comments from, they talked about how as a sole parent responsible for multiple children there was no way they would be able to do the PPO. You know, there was, you know, there was other people with their own chronic illnesses who just didn't think that they could work with the PPO.

And so that's what I heard from participants, and I think -- I think structurally for me, I've been at NSHE way too long, but I was at NSHE when PEBP reduced the plans from three to two, you know, and state employees and NSHE employees worked so hard to get the choices back to three.

And so just a few years later we're now talking about taking it back to two. And I see the very long term there's a huge amount of money we're talking about. In the short term, honestly, it doesn't really seem like a lot of money.

And then if we -- when I start to try and identify the costs between EPO and HMO it becomes even more murky, right. Obviously everyone I heard from is in the south. So I don't want to minimize the impact that the EPO has on people in the north, but certainly in the south -- in the south people have been paying for an HMO and they've been paying a lot for the HMO compared to its costs.

Now we're talking about the HMO maybe having to kind of catch up a little bit and we're talking about removing that benefit from them, and I think like from just a structural, just a human perspective, I think that as a board member I am very challenged by that thought.

And now I'm going to get to my questions I promise. So I was kind of interested here. So some of these slides, I'm going -- and I'm sorry, your slide numbers aren't actually -- they don't have a number on them, but I want to go --

MR. WARD: Nor do mine. I'm sorry.

MEMBER WOODWARD: They do on mine.

MR. WARD: I'm in the Board packet.

MEMBER KELLEY: I'm in the Board packet but mine doesn't have page numbers.

So "HMO increases have been capped" is the title of the slide.

MR. WARD: Okay.

MEMBER KELLEY: I'm really challenged by some of the data on this and so I want to understand how Segal is saying that, you know, that there was a 29 percent increase in costs. You know, the contract calls -- I understand the contract called for a maximum of 20 percent cost increase for fiscal year 2025, but then HPN came in with a 12 percent increase.

MR. WARD: Um-hum.

MEMBER KELLEY: Isn't the fact that the necessary premium renewal should have been 29 percent -- firstly, isn't that theoretical and irrelevant because it wasn't?

MR. WARD: I'm trying to think of the best point of entry to respond to that. The 29 percent, first of all, is -- this is Richard Ward for the record. That it's not a 29 percent increase, it's that the expected cost levels are 29 percent higher than the current premium.

So that's a -- you say it a different way. Costs were already above the premiums. The 9 percent caps -- the cap on the premium increase of 9 percent was already -- was resulting in the premiums lagging expenses by a considerable amount.

So costs didn't go from parity with the premiums to 29 percent higher all in one year; they were already up

there. So when we -- when we're approaching plan year '25, the renewal, the projection for claims costs was 29 percent higher than the current plan year '24 premium.

So for that -- so there's 29 percent to catch up, if you will. But there was a 20 percent cap. So we expected a 20 percent increase which would still leave a 9 percent gap to be dealt with at some point.

Instead the Health Plan of Nevada proposed a roughly 12 percent increase which was surprising.

MEMBER KELLEY: And so how did they -- Michelle Kelley for the record. I guess that was a very long way of saying to me it's still kind of irrelevant, right, because HPN came in at 12 percent increase so how do you reconcile that?

MR. WARD: Well, we don't have line of sight into their inner workings as a business, but I will speculate that the pharmacy rebates among maybe some other revenue streams that have been profit for them were used to offset that increase.

MEMBER KELLEY: Okay. So --

MR. WARD: They made a business decision.

MEMBER KELLEY: They made a business decision.

MR. WARD: All I can do is speculate. I'm sitting here with somebody from -- you know, that could perhaps comment more directly than I can.

MEMBER KELLEY: Right. But so I guess what I'm hearing is that maybe there's money out there that they're receiving that they used to -- that is part of the plan design that you didn't account for but that brought the costs down.

MR. WARD: Historically they haven't shared it so --

MEMBER KELLEY: So we're missing data potentially.

MR. WARD: That we would commonly not get.

MEMBER KELLEY: Okay.

MR. WARD: We're just not going to get it.

MEMBER KELLEY: That's okay. But we're missing it so we're not looking at a full picture here.

MR. WARD: Right. In a self-insured environment we would know all the revenue streams, we would know what the pharmacy rebates are. We would know what the admin costs are. But in an insured -- in an insured arrangement you're only going to know so much.

MEMBER KELLEY: And, you know what, I'm asking hard questions but it's not directed at you.

MR. WARD: I understand.

MEMBER KELLEY: You know --

MR. WARD: I'm giving you the best answer that I can --

MEMBER KELLEY: From the data you've got.

MR. WARD: -- from our perspective and acknowledge that we're -- even though I'm sitting across the table from you we're actually on your side of the table --

MEMBER KELLEY: I get it.

MR. WARD: -- in this whole consideration.

MEMBER KELLEY: But so right now we have a RFP out in the market and so we also -- so that's also another data point that we don't know what -- because we don't even know all the income sources they have, and one would have to assume that, just like our self-plans get rebates, that hopefully the HMOs do because otherwise they're missing out apparently.

But we to have a RFP out there that could illuminate this issue more for us about what the actual costs are going to be, because I guess I keep coming back to, you know, you know, obviously I was not born and raised in Nevada and I was lucky enough to come from a country where I didn't have to know about health insurance.

That's the reality of living in a county that has universal health care is that it's not that it's cheaper, better, different, it's just you don't have to know and I got to tell you there's a beauty to that.

MR. WARD: Part of my family is Canadian and so I

am told on a regular basis how much better and how superior that is.

MEMBER KELLEY: And it's because you don't have to know, right. We all have to know. And so but --

MR. WARD: You can share the weather though. I live in San Diego so I usually share the weather with them when we have these discussions.

MEMBER KELLEY: Yeah. When I moved to this country I was on obviously a really steep learning curve. That's kind of where I was going with this. And so -- and my very first job was in health insurance so go figure, right.

But so I always come back to the foundations of for me the difference between the plans, right. Some of it -- and that now I work in retirement so understanding your own risk profile is such an important aspect of living in the United States, you know, for retirement, for health insurance.

MR. WARD: Yeah.

MEMBER KELLEY: And many people choose the HMO specifically for that risk minimization. And I hear -- Executive Officer Glover, I appreciate that you want to look at the PPO -- whatever we're going to call it -- the PPO plan down the line, but I think that for me -- for me I think for transparency purposes we should be looking at both issues together.

I don't personally want to make a decision on the HMO, you know, and incorporating into my decision process the thought that down the line we can turn the PPO into more of a HMO but then that never eventuates, and so then we just have two options that are PPO and people have coinsurance that -- and the max out of pockets are fantastic on the PPOs. They really are great max out of pockets. People are protected.

The problem is is that many people can't walk into an emergency room and flip out a credit card and pay the first $10,000 of treatment for their child. And that's an issue for all of our employees, and I think -- and I think I've taken the mic enough.

I think for me that's where I end up. I think we need more data. I'm not -- I can't in good conscience vote to remove the HMO at this point after hearing from all of our participants and truly not understanding what the RPF might show -- we could get a state-wide network -- and not exploring other options like separating the EPO and the HMO out.

And so I think for me it's a limitation because I kind of need to see the whole picture so that I can understand both from an emotional perspective but also from that risk minimization or the risk profile to make sure our employees get what they need from health insurance, because every time we take away a plan we're taking away morale and we're losing

some employees. Employees are actively saying they can't stay and that's a problem for me so...

EXECUTIVE OFFICER GLOVER: So this is Celestena Glover for the record. So a couple of points of clarification and some history. I'm not proposing we make the LD PPO act like an HMO. I'm simply suggesting that we consider permanently eliminating the deductible portion if we eliminate these other two plans. I'm also suggesting that we consider taking the language for coinsurance out and making it all a co-pay structure, whatever those dollar amounts look like.

So that would give our members a level of confidence of knowing if they're going to the emergency room it's $600, or it's $50 to see a specialist or whatever those dollar amounts should look like. So I'm not saying it's going to look like a HMO because it's not.

The other thing as far as the PPO and the HMO with the blended rates, the reason that was done years ago, we had two HMO plans, one of which acted more like a PPO than it did an HMO, a traditional HMO. There was a certain level of concern that if those rates weren't blended the HMO in the north was significantly more expensive than the HMO in the south, and so to keep all the employees that were at the same level of pay, if they were a single person on the plan they all paid whatever the dollar amount was. If it was $100 a

month they all paid 100.

We didn't have the group in the north paying 120 and the group in the south paying $80 for essentially a similar plan. So there was some level of equity considered, so that is how we got to the blending and that decision was made before my time.

So just -- I just want the Board members to understand that. And also what I said earlier, we are getting to a point -- critical point in enrollment where the enrollment numbers themselves will not sustain those plans.

I look at enrollment that we're projecting for plan year '26 in the retiree group, I'm looking at a hundred retirees on the non-state -- in the non-state group in the HMO plan and a similar number -- actually less than that in the EPO, and about 260 in the -- or in the HMO for the state retirees and less than that in the EPO.

So just the retiree group we're talking about roughly 300, 350 retirees in those plans. With those numbers, they're already making moves, so they're already moving into the other plans. It's the employees.

As I said, we have roughly 2,500 right now. We're looking at that number going down to about 2,200 in EPO. I got about 34, 3,500 in the HMO. I'm looking at that number potentially going down to 3,200. There's been a lot of talk

about how many people are losing those plans.

I know we've had a lot of comments from UNLV and some of the other education systems down south and they really only make up about 12 to 15 percent of the total HMO enrollment. So it's really the other members, the state members.

And based on the information that Segal has provided for us in the information, I have tried to put together the one example of the out of pocket. So somebody who maxes out if they're paying $8,000 as their family out of pocket, that's a $2,000 savings. Their premium savings right now in the current plan here is a little over $2,700. So they're saving $4,700 over the course of a year because once they hit their max out of pocket of course the plan picks up a 100 percent.

So there is a safety net regardless of the plan; each of them have a max out of pocket for a single person and a family where the plan will pick up.

And the comment about the cost of your medications going towards your out of pocket, that is true on the low deductible and the high deductible plans. That's part of the accumulator. It goes toward the deductible in the high deductible plan. So all those things are considered.

So another place where you may be -- if you have

a lot of high cost medications, you may be hitting those out of pocket maxes quicker than you expect simply because you have high cost drugs to go along with your medical.

And the one question that we were asked was how many people hit their out of pocket and how many people don't. I would say that I don't have exact data and that is something we can look to see how many people actually hit those numbers, but the higher users of the plan probably don't hit their max out of pocket; they're probably somewhere in the middle.

They're not the, you know, I go in once a year to see my doctor person; they're the I go in a couple of times a year and I have some of medication I have to take. Those are probably what we see more consistently. And then it's episodic care. Something comes up that drives them to the hospital, drives them to a specialist, whatever that case is, but ideally, you know, that's taken care of and they don't do it year after year; it's not a chronic condition that may cause them to reach their max out of pocket.

So we can look at those numbers to see what percentage of our population actually stays somewhere in the middle, which percentage actually hits their out of pocket max.

MEMBER STRASBURG: Bepsy Strasburg. Director Glover, can you share us whether this decision of reducing the

number of plans, whether we have some options of making that decision today versus the November meeting when we may have that communication done with the members as well as the RPF information coming in.

And maybe you can't share with us, but maybe with your discussions with the State you may have a better idea of what the budget might look like and what the State can assist in this manner.

Can you share your understanding.

EXECUTIVE OFFICER GLOVER: Yes. This is Celestena Glover for the record. So the Board can choose to delay the decisions. I would say probably the only one that you could make now with no concern would be the life insurance, the health savings accounts, and then table the low deductible EPO HMO discussions for November. But at the November meeting we have to have final decisions.

We can't delay beyond that because we're running up against time to set rates for whatever those plans look like. We won't know what GovRec looks like until probably the end of December, maybe early January so I won't know where we are with the AEGIS and REGI request. I know what I've asked for; whether I get it or not, that's always a different ball game. And then as far as the RFP goes, you'll have the results of the RFP.

The evaluation committee will pick a vendor prior to the November board meeting. That meeting when we talk about whoever wins that bid will be a closed meeting, so the public will not be part of that discussion until such time as the Board makes a decision to approve or not approve the contract itself.

I won't see what the responses are. I will only see what the negotiation points are because that's the only place I'm allowed to be involved in.

I know that typically we have one or two Board Members on the evaluation committee, so those Board Members will know what the renewal rates are coming in at and who has responded, but they aren't at liberty to share that information. So those are things to consider.

We're still going to be somewhat in a silo or in a, you know, in a cloud of not knowing what all the information is.

And the thing I want everybody to keep in mind too with the HMO yields, whether we -- HPN wins maybe get to the south, we find one for the north, we get two regions, whatever that might look like. If we got one that was state-wide that would replace the EPO and the HMO in the way it sits now because we wouldn't have the EPO on top of two HMOs. That would be a nightmare for enrollment.

So keep that in mind. The renewals may come in really good for the first year. The second year they may blow up and we won't know that until we get close to the second year when we start asking for renewal costs.

So you run the risk of having to terminate a contract mid-term, because we typically go out for a four-year contract, sometimes five. So, you know, keep that in mind too, that you may have to make that decision to terminate an existing contract where this one is actually expiring; it's coming to an end through its natural course.

So all of those are things to consider in addition to everything else that goes with this. And like I said during my presentation at my report, we didn't go into this thinking oh, PEBP's going to save a lot of money. It really was looking at what is going on in these various plans, what do we believe is the best place that we can stage ourselves and our members to give them the best benefit package possible.

And we can't grow benefits in the other plans when we're having to spread them out the way we are right now. Some don't make a difference; life insurance, life insurance goes to everybody. But in other cases if we want to lower co-pays or increase HSA and HRA money, if we don't get that funding from the employer side of the house that means the

members have to pay, so that stifles our ability to really look at benefits to make them stronger.

And we get a lot of discussion about employees leaving state employment because they don't like the benefit structure, but our hands are tied when we have to spread ourselves that thin. So that's another consideration. We are looking at retention and everything else that goes with it so...

MEMBER KELLEY: Can I ask a couple of followup questions?

CHAIRPERSON GRIMMER: Um-hum.

MEMBER KELLEY: Michelle Kelley for the record.

One of the questions I did have earlier in the session is so the increase to life insurance because, of course, the Board made the difficult decision a couple of years ago to reduce that to 12, 5. I think the legislature increased it again. Now you're going to build it into the base budget.

What's the cost of that for biennium of putting that back into the plan?

EXECUTIVE OFFICER GLOVER: This is Celestena Glover for the record. I don't remember off the top of my head, but I want to say 2 and a half, 3 million a year. Somewhere in the $3 million a year range to get us back to

those levels.

MEMBER KELLEY: And I think I'm right in my recollection of how you stated this, but when you submitted to GovRec you did that as part of the budget but an enhancement. So it wasn't kind of we're going -- it was an add-on to -- if it was $300 last year, it's 300 plus X this year for the life insurance.

EXECUTIVE OFFICER GLOVER: This is Celestena Glover for the record. That's correct. We build the budget with the assumptions that things were going to reset. Part of my thought process was if the legislature was concerned about us making those cuts and part of it was budget-driven because we're given certain direction that we have to follow, it -- from a truly are funding and administration -- financial administration standpoint it's much easier on my staff if we fund it from our own sources than having different funding sources, because if this different funding source doesn't continue we then drop the insurance again.

And I would like to somehow -- I don't know if I'll be successful, but get us to a point where the benefit structure is set at a certain amount, whatever the Board thinks it should be, we will bring our recommendations obviously for the Board's consideration, but we quit -- this year it's 25,000, so somebody, sad to say, passes away, car

accident, their family gets 25; the next person next year their family gets 12,500.

I would like us to hopefully get to a place where we can quit doing that. I can't guarantee because some of that is beyond our control, but I would like to see our benefits stabilized to the point where we aren't constantly messing with those numbers. I was going to say something else.

But we're not constantly adjusting those numbers, and our members don't know what their coverage is from year to year because we keep changing it. So I would like us to get somewhat stable within the resources we have, and my plan is to make that argument to the GFO and to the money committees when I can sit in front of them and make those arguments.

So that's -- that's the hope and that is my plan. Whether I'm successful or not, we shall see.

MEMBER KELLEY: Well, personally I appreciate your strategy because I think that's the best starting point. You can only do what you can do, but certainly I think for all of our participants we do hear that stability is so important.

One last question and maybe a request. So talking about your idea of kind of changing the structure of the PPO, can you -- and I apologize because I said kind of turning it into a HMO -- can you talk to me about what

maybe -- and to the public about what -- how you see that working. So how is it still a PPO if we get rid of coinsurance; it's all co-pay based I guess is where I'm challenged.

And then my request, so I don't have to interrupt again, would be how early -- so if the Board chose to table the HMO/EPO decision until November because we'd like to see kind of a chart of what it would all look like together, how early -- or would we be able to get the documents for the plan design discussion earlier than a week before the meeting so that our constituents could actually take a look at it and have time to consider it and think about it and ask questions and not just react?

EXECUTIVE OFFICER GLOVER: Checking with my -- make sure I don't say something that is not accurate. What we can do -- and Segal, I'm about to give you a lot of work and us too -- what we can do is we can -- with the information we have available as far as the HMO, it's not going to be specific to whoever the bidders are. So keep that in mind.

Even if we're able to present you with those documents early, there's still going to be some gray area where the HMO is concerned.

But we can look at what we have today, what the structure looks like, and do an analysis and present a report

that says if nothing changes, the HMO and the EPO are going to look like this, the low deductible will have some small deductible and the payment structure will look similar to what it looks like now, but if we eliminate the HMO and the EPO, this is what the low deductible will look like. So you'll have the two.

I'm not sure how early we can get that to you but we will try and get that to you with enough time so that you have time to review those documents and maybe talk with your stakeholders in that case.

So I don't want to put words in other people's mouths, but maybe two weeks out before the Board meeting. That doesn't give us a lot of time. That's about six weeks from now before the next board meeting. We're scheduled for the 21st or 22nd, whatever that Thursday in November is, that is the time our next board meeting is scheduled, so it would be about two weeks before that would be the earliest I would think.

Can you do that?

MR. WARD: We can do that. This is Richard Ward with Segal.

May I make another comment just regarding the terminology of PPO and EPO and HMO. PPO, preferred provider organization, I think primarily refers to the network

structure, so you have preferred network providers and you have out of network providers. While they may commonly be associated with coinsurance, that's not necessarily a strict correlation. So you can have a PPO with co-pays. So it's more of a reference to the network structure rather than the benefit design.

And then EPO, being exclusive provider organization, means no out of network. And again, while that may often come with more of a co-pay driven design, that's not necessarily -- yeah, that's not a requirement or doesn't necessarily need to happen.

MEMBER KELLEY: And so just a follow up then. So when we're talking about getting rid of -- I'm putting words in your mouth -- but when we're talking about PPO and a little built of a redesign of the structure, we would be looking at co-pays in the PPO portion, so the preferred providers you'd have co-pays.

MR. WARD: Yes.

MEMBER KELLEY: And if you want to go out of network you would have that ability it would be coinsurance and deductible?

MR. WARD: It could.

MEMBER KELLEY: Yeah.

MR. WARD: Right.

EXECUTIVE OFFICER GLOVER: So this is Celestena Glover for the record. So my proposal and recommendation would be if we didn't have an HMO and the EPO, that we make the PPO in or out of network a co-pay structure. The coinsurance really comes in -- because if you'll see the documents say 20 percent after deductible, but we have no deductible and so it's 20 percent after you pay nothing.

MEMBER KELLEY: It's still 20 percent.

EXECUTIVE OFFICER GLOVER: It's still 20 percent. So if we -- whatever that thing is, if we say medical coinsurance 20 percent after deductible, well, if we call primary care specialist office visit 30 and 50, then we would look at that in the same way that we wouldn't have a coinsurance at all. There would be no 80/20, it would be it's $100, it's $50, it's $30 or whatever the --

MEMBER KELLEY: So you would be just monetorizing the percentages --

EXECUTIVE OFFICER GLOVER: -- yes --

MEMBER KELLEY: -- yes.

MR. WARD: I would recommend that there be a coinsurance provision for the -- because I don't know that you can anticipate every single scenario and assign a co-pay in the plan document to it. So you may need an "and for everything else" which you may expect to be de minimis, but

just from a plan design perspective -- right, and the attorney is just nodding -- you want to add that just so you can cover the waterfront more completely for every possible scenario for whatever care someone might need.

EXECUTIVE OFFICER GLOVER: Celestena Glover for the record again. But things like, you know, the emergency room visits, your standard doctors visits, your specialist visits, those things can be co-pay.

The things we know are pretty consistent can just be in a co-pay structure. And then like Richard said, the other items that are kind of outside what you typically expect to see we can leave that 80/20. And that's going to be probably for situations that don't occur real often. It's not your regular -- those midlevel people who use these plans a lot but they don't reach their out of pocket max.

MEMBER KELLEY: And so just to delve into that, I'm sorry, Janell, and so you're talking about hospital admission we would also have a co-pay though, right?

MR. WARD: Yeah.

MEMBER WOODWARD: You always ask great questions. Janell Woodward for the record. I just wanted to reiterate, I think with a HMO or that type of plan it's as a pay as you go, and then you have your PPO where you're paid up front. And so people are -- they choose that, and I've been there, you

choose that HMO because you know you're paying as you go because a lot of people don't have that money up front to pay like you would in the CDHP plan.

So I think it would be important to educate along the way on how if the choice were to be made to sunset those programs, we're doing our best to make this as easy as possible because you still are going to have people who just don't have that money up front to pay 20 percent before they can have something done, and you don't have that situation with a HMO so...

EXECUTIVE OFFICER GLOVER: So this is Celestena Glover for the record. So I'm going to reiterate this. If we don't have the HMO and the EPO for as many of the services that make sense, we are proposing we go to a co-pay. So it is a pay as you go structure.

And right now, based on the current options of what we know about the current HMO, that is what we'll use as our model for the reports that we come up with for the November meeting.

So the low deductible, if it's already costing you less monthly, if the out of pocket max is a lower amount so they're going to get a 100 percent coverage sooner, those are considerations.

And yes, it's education to our members to

understand those plans, but we can provide the information, but our hands are also tied that we are not licensed benefits specialists so we can't be telling members which plans they should choose.

So I can't tell you to enroll in this plan or that plan. I can tell my kid that but I probably can't tell anybody else that. But having a payment structure reboot, so to speak, so that members will know I'm going to see my doctor, it's X dollars, I'm going to the emergency room, it's X dollars, versus it's 20 percent of whatever that emergency room wants to charge.

That is what we're trying to address in the restructuring of payments in the low deductible plan, which at that point if we go that route I would propose we call it the PPO plan, not the low deductible plan. And as Richard had brought up with the exclusive provider option, there is no out of network coverage in any way, shape or form for the members on that plan.

So in the other two plans, the low deductible and the high deductible, if you go to an out of network provider the plan still covers a portion of that. You will pay a higher amount out of pocket but the plan will pay a portion of that. Same thing with medications.

On the EPO, if a person goes out of network

they're on the hook 100 percent; there is no coverage. Same things with drugs that are not in the formulary, they could potentially be on the hook for 100 percent of those meds.

So those are other considerations. And we've seen that happen where somebody went out of network not understanding that their network is pretty restricted, and went out of state for care or without getting prior authorization and then they got billed for it.

And then they were coming back to us asking us to fix it, but it's very clear in the documents and we don't want people to get into that situation.

And as much as we try to share the information and provide the documents, some people read it, some people don't, some understand it, some don't. We do the best we can to try to help them. And our partners with Neymar and Segal and HMOs, HPN, whoever they were talking with, they try to help as well.

But if the member doesn't call or doesn't read it or doesn't let us know they're having an issue we can't help so...

MEMBER STRASBURG: Bepsy Strasburg. One last thought. I mean, we are already seeing migrations. What I'm hoping the ideal result will be with the information that you're going provide before the next meeting that people will

take the trouble of looking at it, and that might accelerate the migration and that's the best thing we can help for to make our decision process more effective.

MEMBER MCCLENDON: Jennifer McClendon for the record. There is one other piece of information that would be helpful for me and that's just listening to public comment about people who are worried about losing their providers, particularly in the south with the HMO.

If we could just get -- I've seen these before, but the network percentage coverage map thing that would be great.

EXECUTIVE OFFICER GLOVER: This is Celestena Glover. One of the things -- and this was a discussion I had with some stakeholders a couple of days ago, one of the things that we typically do anyway is a disruption analysis to see how changes affect.

Even if we were going out to bid for a new network or GPA, we look at disruption analysis and as part of that we'll look at can we get it more narrowed down.

I think we'd look at it maybe holistically from a state-wide perspective. But my comment to the group at the time was I'm not sure that we necessarily asked the right questions when we saw that. We said oh, yeah, we have 99 percent coverage, but we didn't necessarily say but not in

Tonopah or not in, you know, Pahrump or wherever we may have --

MEMBER MCCLENDON: The entire 1 percent was every specialist in the state gov --

EXECUTIVE OFFICER GLOVER: -- yes --

MEMBER MCCLENDON: -- and that is one of the things we've heard from public comment and that I've gotten emails about is that there are specialty providers who are covered under the HMO who are not covered under the other plans and it sounds like we might have some flexibility to work on that --

EXECUTIVE OFFICER GLOVER: This is Celestena Glover. We'll bring all that information back or as much of it as we can get together in this time frame because it does take a little bit of time to do a good analysis, keeping in mind that we're still going to have somewhat of a coordinator for a different HMO because we don't know what those renewals are going to look like for anybody who has submitted it. So we'll bring back whatever information we have available.

But I will say this: regardless of what the board wants to do, the things I do need a vote on today is the health savings account and the life insurance which if I know where the board is going and then we can take them together, items and if there's anything else, anything else we need to

vote on, from our discussions.

MR. WARD: And may I comment. They may not be needed to vote on today, but what the deductible change for the CDHP, is that something you would like consider today?

EXECUTIVE OFFICER GLOVER: This is Celestena Glover for the record. If you want to maintain the HSA you don't have a choice, right. There's no voting and that was informational because to maintain our eligibility to provide that, unless the Board wants to decide with an HSA and then it really will blow up. There's way more people getting HSA money than there are people on the HMO --

MR. WARD: -- I request we break for lunch if we're going to add that.

MEMBER KELLEY: Michelle Kelley for the record. Just a comment. Firstly, I think that -- honestly I think that being able to show employees what the PPO structure will look like, especially since the proposal is to go to majority of co-pays which would probably be 90 percent of common items, I think that that will go a long way to assuaging a lot of the concern we have heard.

Obviously the network is a different piece, but I think that co-pay -- seeing that laid out is why I would like the extra time so our participants can actually see it and gauge that it looks, you know, it looks like they can afford

to seek services from an agent.

So saying that, I will make a motion per the -- per the Agenda item to -- a motion to approve the proposed increase to the HSA and HRA to $700 for the primary participant and 200 for each dependent up to a maximum of 600 for those enrolled in the CDHP, and I also make a motion to maintain the new life insurance benefits at $25,000 for employees and 12,500 for retirees for all primary plan members.

MEMBER STRASBURG: Bepsy Strasburg. So second.

CHAIRPERSON GRIMMER: We have the motion and the second.

Is there any further discussion? Okay.

I'll call -- I'll call for the vote. All those in favor signify by saying aye.

Any opposed?

Okay. Motion passes.

(Motion carries.)

CHAIRPERSON GRIMMER: We'll move on to Agenda Item Number 7, public comment.

MEMBER STRASBURG: We don't need to make a motion on the transition of the HMO and other things? To table it?

CHAIRPERSON GRIMMER: Okay.

MEMBER STRASBURG: Bepsy Strasburg. I make a

motion to table the transition to the LD PPO to a standard PPO plan and also the elimination of the EPO and the HMO plan for the November meeting.

CHAIRPERSON GRIMMER: Do we have a second?

MEMBER KELLEY: Michelle Kelley for the record. I second.

CHAIRPERSON GRIMMER: All those in favor?

Anyone opposed? Okay.

(Motion carries.)

CHAIRPERSON GRIMMER: Now we'll move on to Agenda Item Number 7, public comment period. Public comment will be taken during this Agenda item. Comments are limited to three minutes per person.

MS. PARTEE: Hi again. I'm sorry, the first time I spoke I didn't spell my name. First name is Lisa, L-I-S-A. Last name Partee, P-A-R-T-E-E. Kelley brought up the Carson-Tahoe issue and it's -- I hope that it can come to a good conclusion and I hope -- because Carson-Tahoe basically is a monopoly. That's where the majority of our doctors and specialists are.

So I hope that with this UMR -- my bills are getting paid, so I'm not sure what Carson Tahoe is talking about because my bills are being paid very efficiently. I get my explanation of benefits and I'm not seeing any problems

with UMR paying for my insurance, for my bill.

So I hope that maybe you guys could get this worked out with Carson Tahoe and try not to let them drop us because otherwise it's going to put us in a big bind, especially people that have significant issues.

Thank you then for today. Appreciate it.

CHAIRPERSON GRIMMER: Thank you.

MR. GRIMMER: Chuck Grimmer. I have received comments from two participants who were unable to get through on the phone lines so with your permission, if they can't get through now, I would read their comments into the record later.

CHAIRPERSON GRIMMER: Okay.

MR. ERVIN: Kent Ervin, E-R-V-I-N, Nevada PEP Alliance. First of all, please trust our members to know their needs. While there maybe some misunderstandings out there about the maximums and so forth for various plans, they do know what they're paying now and how they're being billed and what their risk tolerance is, so please listen to our members.

And then I have a -- just a few reactions to things that have been said today. We talked about wanting to stabilize the benefits, for example, for the life insurance. I totally agree with that. That applies even more to

maintaining the three plan structure. That's part of our benefits; we want to keep that stable.

It was mentioned that dividing the same state funding between two plans versus three plans would be advantageous. I don't understand that, because the state subsidy is on a per employee basis, so it doesn't matter how many different plan choices there are, it's the same funding per employee. So I just don't understand that comment.

As far as the cost of the EPO in the north versus the HMO in the costs. We know care costs are different geographically in the state regardless of the plan. It's just that for those two plans because they're separated geographically you see the numbers.

For the other two plans, those cost differentials are there, they're just in the totals. So our position has always been that employees -- state employees should be treated the same regardless of where they live or work as far as their benefits costs and so forth.

If conditions are so different in the north and south that that needs to be changed that's a major discussion to have, but it's not the EPO versus HMO, it's the cost of health care in the state and how different it is in different areas.

It was -- the low non-state retiree numbers was

mentioned. That's a separate problem that applies to all three plans. At some point those non-state retirees will have -- as their numbers decline because we aren't getting new active employees into those plans, they'll need to be merged into the state member group for rate setting purposes, but that's a legislative issue.

That may be something you want to bring to the legislature next time if the numbers are now so low that it doesn't make sense to rate them separately.

It was mentioned that the low numbers on the EPO will make it unsustainable at some point. I kind of understand that, but my understanding was that all of the self-funded plans were being underwritten together as far as the claims costs, and so I don't understand why low numbers in one of the three makes that much difference if we are now, as I understood it, doing the underwriting all together anyway.

Finally, please just don't make major structural changes at least until FY 2027, that is, to start July 2026. Doing this again when you're under time pressure and you don't know what the legislature is going to fund means that we're just doing things in the dark and we're changing benefits to meet some goal that we don't really know is there or not until the legislature meet.

So if you want to develop a plan through

strategic planning and put it forward for the second year of the biennium, then that can be presented to the legislature and get buy in and maybe funding for it, but doing it when the Board doesn't have all the information is problematic.

And finally, you got this RFP evaluation committee. The statute allows any number of Board Members to be on that evaluation committee, so all of you could be on it and get that information confidentially. I know it's a lot of work and time.

But if more Board Members are on that evaluation committee, keeping the bids confidential, that's the point, but at least you would have input on the future of the HMO plan by knowing what the -- by rating those bids according to how they come in. So that's my suggestion for that. Put as many Board Members as possible that you can do on the evaluation committee.

So thank you, and at the end of phone public comment I'll come back with those other statements.

CHAIRPERSON GRIMMER: Okay. Any other public comment?

MS. OSBORNE: Hello. I do. My name is Kelley Osborne. K-E-L-L-Y O-S-B-O-R-N-E. If I may make a comment about these plan structures. Prior to me getting sick I was on the EPO plan and I was on it because I -- because of an

aversion to risks. And I was not aware of the 20 percent coinsurance until I got sick, until three weeks in a hospital landed me with over a million dollars worth of hospital bills.

So that had changed over during COVID to the 20 percent coinsurance, and when they had the open enrollment and that was discussed, it was just glossed over.

So if -- when you have open enrollment and you make these decisions and you are informing your members, if you could please make sure they know of the specific plan changes, because that was -- I almost went bankrupt over this.

So because I thought I was in a low risk program, I thought I was just going to have to pay $350 out of pocket, and then I was -- it was crazy. So if you guys could be very mindful when you're informing your members of these significant plan changes I would greatly appreciate it.

Thank you so much.

CHAIRPERSON GRIMMER: Thank you. Any further public comment in Carson? We will go to the phones.

MR. HOPKINS: One moment, Madam Chair. As a reminder, joining this Zoom meeting as an attendee is for public comment only. If you do not wish to make a public comment please leave the meeting so you're not accidentally called upon. Please watch it via the live stream on the PEBP YouTube channel. The link to the live stream is also located

on the Agenda of the PEBP website.

For those who have joined public comment, your name or the last four digits of your phone number will be announced. You will be advised you have been unmuted. Please slowly state and spell your name for the record and then proceed with your comments.

Debbie Arteaga.

MS. ARTEAGA: Yes. D-E-B-B-I-E A-R-T-E-A-G-A. I would want to point out that in terms of our faculty, we do not make astronomical salaries, especially those who are new or administrative faculty who at include -- they include advisors. So any increase in premiums.

I would also like to state that the purpose of health insurance is to protect us all, and if you only need to go to the doctor once a year then you're subsidizing those members who really need health care.

I would also like to say to Board Member Kelley. I know you received 43 emails. I lost count. So this is a matter of great seriousness.

And I do want to make a statement of the low deductible PPO, the $500 maximum for outpatient surgeries and the 750 for the ER. I understand from the plan structure that they want us to go to urgent care and I appreciate that. However, if you have an asthma attack at 2 o'clock in the

morning like I did, you don't have any choice; you have to go to an ER because there's no urgent care open.

So the expense for me I could shoulder. For a lot of our employees, they cannot. So they have to make a decision, does my child really need to go to the ER or can I wait for the next day, and I do think that that is of great concern to a lot of our employees.

Thank you.

MR. HOPKINS: Thank you. Amelia Davis. Please slowly state and spell your name if you wish to make public comment.

MS. DAVIS: Hi. My name is Amelia Davis. First name is spelled A-M-E-L-I-A. Last name is spelled D-A-V-I-S. I have a prepared statement but I would like to thank the Board members really quickly who championed the HMO. You understand this is more of an emotional toll on us rather than purely financial.

I have been the graphic designer and creative coordinator for UNLV for about two years now. I'd like to make my comment against the cancellation against the cancellation of the HPMO plan.

As a chronically ill individual myself who relies on this coverage, this plan best supports my frequent doctors visits and monthly medication expenses. Without this plan and

its predictable exact co-pays I understand that I would not be able to afford much of my health care needs.

Additionally, as the health care in Nevada has consistently been ranked one of the lowest in the nation, I know that I am personally incredibly lucky to have the doctors that I do that fight for my care and take me seriously as a single female patient. I am understandably afraid to lose some of my amazing health care providers should the HMO plan be terminated. The legwork that is also required to find new doctors, especially ones take my health personally, is incredibly daunting.

Lastly, I implore you all to remember well that many of us state workers feel that the benefits provided to us are a very important part of feeling valued and appreciated for the work that we do and that the state takes care of us in turn.

Thank you.

MR. HOPKINS: David Kelsey, you have permission to speak. Please state and spell your name slowly for the record. I've been communicating with Kent Ervin and he's going to make David Kelsey's statement for him. Sorry, apologies for the technical issues, David.

MR. ERVIN: I'm speaking on behalf of David Kelsey, D-A-V-I-D K-E-L-S-E-Y. My name David Kelsey. I am

deaf. I am here to express my concerns regarding potentially eliminating HMOs. My husband suffers from a chronic illness so I strongly advise against discontinuing HMOs. We would face difficulties in the absence of HMOs.

Thank you for your time. David Kelsey.

MR. HOPKINS: Thank you, Mr. Ervin. Will the caller with the last four digits 0891 please press star 6 to unmute and please state your name and spell your name for the record if you wish to make public comment.

Caller with the last digits 0891.

MS. LAIRD: Can you hear me okay now?

MR. HOPKINS: Yes, we can, thank you.

MS. LAIRD: Thank you. Good morning Chair Grimmer, Executive Officer Celestena Glover, Board Members, staff and guests. My name for the record is Terry Laird. I'm the executive director at RPEN, Retired Public Employees of Nevada, a non-profit nonpartisan organization where we represent nearly 7,000 dues paying members statewide.

I'd like to continue my request that I mention nearly every board meeting regarding retirees and the Medicare exchange. PEBP in recently abandoned mailing newsletters and important information, favoring instead to place all of this information online. I can tell you many of our members still do not use the internet, preferring instead to talk with

someone or someone on the phone or in person.

The upcoming open enrollment is a perfect example of the important information that PEBP and VIA benefits have for retirees and the Medicare exchange. They have been told many times they must stay within VIA benefits if they want to keep their benefits, as Ms. Glover mentioned during the meeting today, but confusion arrives when the all too good offers began to arriving in the mail and on TV.

I received such an offer this week, weeks before October 15th. We wish some of this valuable information about the risks during open enrollment could be disseminated more than just online.

Moving on, RPEN is happy to see life insurance amounts which will raise at the 2023 legislative session remain the same in this new budget. I too am interested in seeing additional legislative discussion at the next session about raising the HRA health reimbursement arrangements for Medicare retirees.

One last concern I have is with the fourth quarter update from VIA benefits about their HRA available balance cap of $8,000. This report states that effective May 31st of this year, they processed the annual $8,000 HRA available balance cap reduction impacting 605 accounts with over $1 million of adjustments being made to the available

balances.

Now that these funds have been removed because they're over the $8,000 cap, they can't be added back. This is another one of those issues that many retirees still are not aware is happening. They need more education and/or assistance to know of the many uses this money can be used for so they don't lose it.

Thank you. And we appreciate PEBP and their staff for assisting our members with issues because they contact us when they can't get help any other way.

Thank you again.

MR. HOPKINS: Thank you. David Cooper, you have permission to speak. Please slowly state and spell your name for the record if you wish make public comment.

MR. COOPER: Hello. My name is David Cooper, D-A-V-I-D C-O-O-P-E-R, and I'm an assistant professor at Nevada State University and I'm also the serving chair of the faculty senate at NSU.

I thank you for tabling the change in plans but there was ample time to review the proposed changes. The conversation -- sorry, the conversation of the HMO has largely been based around only the total yearly cost comparison between the different options and I am going to emphasize two points, the first being that unexpected costs can occur at

inopportune times and cause an imbalance in pay for medical emergencies on the LD PPO plan and CDHP plan that is mitigated by the steady costs found in the HMO plan, especially if these costs occur at the beginning of the year when out of pocket costs have just been reset.

The steady payment plan provides state of mind to know well ahead of time what medical cost will be and be able to be budgeted accordingly.

The other is the availability of providers is not the same for the different plans, that a forced switch to a new plan will cause stress and instability for participants of the HMO plan.

While it is impossible to predict whether providers will still be supported on plans in the future, it is almost guaranteed that there will be a disruption for those members who are forced on to other plans. I therefore urge caution and thorough examination of these issues on considering change in plan options.

Thank you.

MR. HOPKINS: Thank you, Mr. Cooper. Mary M, you have permission to speak. Please slowly state and spell your name for the record if you wish to make public comment.

MS. MKRTCHYN: Hello. My name is Mary Mkrtchyn. For public record M-A-R-Y, last name M-K-R-T-C-H-Y-N. And I

would like to greatly appreciate the Board members today and for their time and dedication to helping state employers.

My concern is that I've been continuously going to doctors offices and specialties to address my medical concerns, and so having that predicability and also knowing how much I have to pay out of pocket up front is a huge importance because then I don't have to worry about that extra stress or if I have stay with my budget or anything along those lines.

And my position here at UNLV does not require me to travel, so most of my visits are within the in network providers. And I know there might be other out of network within the same state but I typically stay within that region.

It's just my concern is knowing how much I have to pay, making sure I have coverage, and being informed if I have to reinstate to a different plan or would I be automatically placed into a different plan. And I apologize, this is my first time making a public comment so if it's not making any sense, I greatly apologize for that. And I am at administrative faculty here at UNLV and I'm the site coordinator.

Thank you so much for your time.

MR. HOPKINS: Thank you. Ozioh (phonetic) you have permission to speak. Please slowly state and spell your

name if you wish to make public comment.

Stacy Wallace, you have permission to speak. Please slowly state and spell your name for the record if you wish to make public comments.

Vie McFadden, you have permission to speak. Please slow state and spell your name for the record if you wish to make public comment.

Madam Chair, Mr. Ervin, has one more comment.

CHAIRPERSON GRIMMER: Go ahead.

MR. ERVIN: Thank you very much. I have a comment from Laura Naumann who was I unable to get through on the phone line. Laura Naumann, L-A-U-R-A N-A-U-M-A-N-N.

Executive Officer Glover and the consultant continue to oversimplify the out of pocket expenses that the HMO participants are incurring via monthly premiums compared to PPO participants to fit their narrative.

I am fully aware that I pay a higher per month premium totalling approximately $1,200 over the year than those on the PPO. I do so because I value predictable pricing and never second guess whether to go to the doctor because I'm worried about unexpected costs or procedures that may not be fully covered.

Every year I use all of my preventative screenings, for example, annual pap, annual checks ups, labs,

mammogram, and I don't receive any bills for these. What EO Glover and the consultant are failing to discuss is the unpredictable costs incurred at any given health visit or emergency event to PPO participants.

Some visits could have low costs but others could require a lump sum payment of greater than $1,200 in one fell swoop that many Americans have not budgeted for or could not afford.

EO Glover discussed the possibility of moving to a co-pay only option for the new PPO that wouldn't have coinsurance and I think that would be an important consideration if we are eliminating the HMO. I just have no idea what my visits, preventative care and lab testing prices would look like if I were on the PPO and it would be a rude awakening to start receiving those bills.

There will definitely need to be lots of messaging to HMO EPO participants on what is changing and what kind of pricing we should expect.

Finally, no one has addressed the availability of providers for the influx of HMO members and ensuring that there's adequate quality coverage for all forms of health care including mental and behavioral health.

That's the end of the comment. Thank you for your indulgement, and thank you, all Board members, for your

discussion today.

CHAIRPERSON GRIMMER: Thank you.

MR. HOPKINS: Madam Chair, looks like Debbie wants to raise her hand again. Debbie, you have permission to speak. Please slowly state and spell your name again.

CHAIRPERSON GRIMMER: Okay.

DEBBIE: Thank you. I don't think I hit my three minutes so I'm just going to say a couple of things. Thank you, Board Members, for agreeing to table this critical decision. I know that I speak on behalf of all the faculty and administrative and academic at UNLV in giving you my thanks.

I do -- I understand that the -- because you posted the Agenda it does not -- only sending the email to all of us on Tuesday at 10:01 a.m., does not violate Nevada public meeting law, but what I would like to respectfully request is that when this is posted on, on your website, if you could send out the kind of email that you sent out on Tuesday. Thank you so much.

MR. HOPKINS: Thank you. Madam Chair, that concludes public comment.

CHAIRPERSON GRIMMER: Okay. Seeing no further public comment here in Carson or online, we'll close Agenda Item Number 7 and we will adjourn. Thank you.

(Proceedings concluded at 12 o'clock.)

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

I, Shellie Loomis, Court Reporter for the State of Nevada, Public Employees' Benefits Program Board, do hereby certify:

That on Thursday, September 26, 2024, I was present via Zoom for the purpose of reporting in verbatim stenotype notes the within-entitled meeting to the best of my ability;

That the foregoing transcript, consisting of pages 1 through 97, inclusive, includes a full, true and correct transcription of my stenotype notes of said meeting to the best of my ability.

Dated at Carson City, Nevada, this 28th day of October, 2024.

//Shellie Loomis//
Shellie Loomis, RPR
Nevada CCR #228

B

D

E

F

G

H

I

M

N

Q

R

S

T

U