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**In The Matter Of:**

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

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*January 23, 2025*

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

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD  
TRANSCRIPT OF PROCEEDINGS  
ZOOM/TELEPHONIC MEETING NOTICE AND AGENDA  
THURSDAY, JANUARY 23, 2025  
CARSON CITY AND LAS VEGAS, NEVADA

The Board: JOY GRIMMER - Chair  
MICHELLE KELLEY - Member  
STACIE WEEKS - Member  
JIM BARNES - Member  
JENNIFER MCCLENDON - Member  
BESY 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

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1 THURSDAY, JANUARY 23, 2025, CARSON CITY, NEVADA

2 -oOo-

3 CHAIRWOMAN GRIMMER: Thank you, everyone. This  
4 is the Public Employee Benefit Program Meeting on  
5 January 23rd, 2025, at 9:04 a.m. We're conducting this  
6 meeting virtually.

7 I would like to call the meeting to order. Would  
8 staff please call the roll.

9 MS. CRANE: Good morning, everyone. Starting  
10 roll call, Joy Grimmer?

11 CHAIRWOMAN GRIMMER: Present.

12 MS. CRANE: Michelle Kelley?

13 MEMBER KELLEY: Present.

14 MS. CRANE: Jim Barnes?

15 MEMBER BARNES: Here.

16 MS. CRANE: Jennifer McClendon?

17 MEMBER MCCLENDON: Present.

18 MS. CRANE: Betsy Strasburg?

19 MEMBER STRASBURG: Present.

20 MS. CRANE: Stacie Weeks? Okay. It appears  
21 Stacie is absent, but we do have a quorum.

22 Please, remember to state and spell your name for  
23 our transcriber before speaking. Thank you.

24 CHAIRWOMAN GRIMMER: Okay. We will move on to  
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1 Agenda Item Number 2, public comment. Public comment will be  
2 taken during this agenda item. No action may be taken on any  
3 matter raised under this item unless the matter is included  
4 on a future agenda item as an item on which action may be  
5 taken. Public comments to the Board will be taken under  
6 advisement, but will not be answered during the meeting.

7 I'll turn it over to IT to conduct public comment  
8 online.

9 MR. HOPKINS: One moment, Madam Chair. I've  
10 gotta get the slide up and do a couple configurations real  
11 quickly.

12 Let's see, if you would like to call in to  
13 provide public comment, please dial 669-900-6833. When  
14 prompted to provide your meeting ID, please enter  
15 870927380987, then press pound. When prompted for  
16 participant ID, please press pound. Joining the Zoom meeting  
17 as an attendee is permitted for making public comment only.  
18 If you do not wish to make a public comment, please leave the  
19 meeting, so that you're not accidentally called upon.

20 Please feel free to watch it via the YouTube  
21 livestream on the PEBP YouTube channel. The link for the  
22 livestream is also located on the agenda, on the PEBP  
23 website.

24 In addition to the first -- I'm sorry. For those  
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1 to join public comment, the name, with the last four digits  
2 of your phone number will be announced, and you'll be advised  
3 you've been unmuted. Please slowly state and spell your name  
4 for the record, and then proceed with your comments. For  
5 those who are on the phone, please press star -- star six to  
6 unmute.

7 Timothy, Timothy Hoft, please slowly state and  
8 spell your name for the record, if you wish to make public  
9 comment.

10 MR. HOFT: Timothy Hoft, T-i-m-o-t-h-y H-o-f-t.  
11 Can you hear me?

12 MR. HOPKINS: Yes, we can. Thank you.

13 MR. HOFT: Okay. Thanks. Forgive me, I'm quite  
14 tired this morning. The reason why I'm tired is because  
15 yesterday, I had to have an infusion of REMICADE for my  
16 chronic illness of Crohn's disease, which I've had for  
17 23 years.

18 I'm 43 years old right now. I've been working at  
19 UNLV for 13 years, and I'm a tenure professor. This medicine  
20 that I had to take yesterday, it's a lifesaving drug, but it  
21 does kind of make me very, very tired for the first 24 hours.

22 In a couple of weeks, I'm gonna get a bill for  
23 this drug, and it will say that the drug will cost \$12,000.

24 Of the \$12,000, I only have a 25 dollar co-pay because I'm on  
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1 an HMO. I have to take this drug once every eight weeks.  
2 So, every eight weeks, I get a bill for \$12,000, in which I  
3 only pay \$25.

4 This disease will progress as I grow older, which  
5 means I'll have to take the drug every six weeks, instead of  
6 every eight weeks and then eventually every four weeks  
7 instead of every eight weeks, and it is a drug that my doctor  
8 has told me that I'll have to take for the rest of my life.

9 This news that I might be thrown off of my HMO  
10 and replaced with a PPO is the worst news I have received  
11 since becoming an employee at UNLV. I'm absolutely terrified  
12 what will happen. I looked at all of the numbers. 80  
13 percent -- 80 percent coverage of this drug is not going to  
14 cut it. I'm going to go bankrupt if that happens. I'm gonna  
15 have to start a GoFundMe page. I'll have to work a second  
16 job. Although, I don't have the energy to work a second job.

17 There has to be a better solution than this. I  
18 don't appreciate the Board treating me like I'm just a  
19 number, and that you're just looking at how much money you  
20 can possibly save because my life is at risk, and you need to  
21 figure out a better solution than removing the HMO. Thank  
22 you.

23 MR. HOPKINS: Thank you.

24 Stephanie Goodman, please slowly state and spell  
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1 your name for the record if you wish to make public comment.

2 MS. GOODMAN: Hi. My name is Stephanie Goodman,  
3 S-t-e-p-h-a-n-i-e Goodman, G-o-o-d-m-a-n. I am a university  
4 regent with the Nevada System of Higher Education, and we've  
5 had several, actually multiple complaints regarding the fact  
6 that this Board is contemplating eliminating the HMO and also  
7 changing the low deductible PPO to a standard PPO.

8 You are leaving so many people in our community  
9 in dire straights if this happens. And I would just ask you  
10 to really consider the ramifications of doing something so  
11 dire. I guess, you know, it gets old hearing about how we  
12 all, you know, as people who represent our state, how we say  
13 that education is a priority. Not only did the State at the  
14 last session only fund our COLAS for our professors and all  
15 of our individuals that are working with NSHE at a 64 percent  
16 rate rather than 80 percent because of a clerical error, and  
17 it was an unprecedented raise. It was a 23 percent raise  
18 that we finally were able to give our individuals that are  
19 working at NSHE. And the problem is, is that they hadn't had  
20 a raise since 2008.

21 So, I just, I don't understand how you could now  
22 be wanting to effect, you know, the thing that is of dire  
23 importance to them, which is their health insurance. You are  
24 putting so many people in a space where they are worried.

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1 They have been worried for months ever since this news came  
2 out that you were considering eliminating the HMO. The  
3 gentleman that just spoke before me, there are so many cases  
4 like, and we really just need to say how do we take care of  
5 the people in our state, and this is a way that we can  
6 continue to take care of the people in our state.

7 And I would just really ask for you to consider  
8 the ramifications of this are dire. We are putting people's  
9 lives at risk. And I think it's very important for you to,  
10 please, if you would, find another way to make this work so  
11 that individuals can keep their HMO's. Thank you very much.

12 MR. HOPKINS: Minnie Wood, please slowly state  
13 and spell your name for the record if you wish to make public  
14 comment.

15 MS. WOOD: My name is Minnie Wood, M-i-n-n-i-e  
16 W-o-o-d, And I'm speaking on Agenda Item 7.1 today. I'm a  
17 faculty member at the University of Nevada of Las Vegas in  
18 the School of Nursing, and I'm also a nurse practitioner in  
19 our local community.

20 So the past nine years, both myself and my two  
21 teenage children have been covered by the PEBP HMO insurance  
22 plan. It's hard to imagine the last two years without the  
23 coverage that an HMO plan provides as I battled breast cancer  
24 and will remain in treatment to prevent recurrence for the  
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1 next five to ten years. During this time, one of my children  
2 also had surgery, and another had an urgent medical  
3 situation. With our HMO plan, our costs were both  
4 predictable and manageable.

5 I'm commenting today to ask the Court to not  
6 proceed with elimination of the HMO insurance plan, leaving  
7 people like me and my children with only a PPO option. With  
8 a PPO plan, my medical costs will be difficult to forecast  
9 but will likely reach the out-of-pocket maximum each and  
10 every year.

11 Having a stable HMO plan with clear and  
12 reasonable out-of-pocket cost is one of my most valued  
13 benefits as a faculty member. I fear losing it and the  
14 impact it will have on both my finances and the quality of  
15 care I receive in our community based on insurance  
16 interruption and what I can afford.

17 I urge you to do everything in your power to keep  
18 an HMO among the health insurance options that public  
19 employees in the State of Nevada can choose from. Thank you.

20 MR. HOPKINS: Thank you.

21 Debbie, you have permission to speak. Please  
22 slowly state and spell your name for the record if you wish  
23 to make public comment.

24 MS. ARTEAGA: Yes. It is Deborah, D-e-b-o-r-a-h  
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1 Arteaga. It's A-r-t as in Tom e-a-g, as in girl, a. Good  
2 morning, Board members. I am faculty senate chair of UNLV,  
3 and I'm speaking on behalf of our employees. I have received  
4 dozens of calls and e-mails, and I have been CC'd on the  
5 written comments.

6 I wish to speak against eliminating the HMO, PPO  
7 in the north and converting the low deductible PPO to which  
8 Segal named PPO Option 2. I have carefully studied the  
9 report from Segal, and today I have questions and comments.

10 The presentation suggests that keeping the HMO,  
11 PPO is not fiscally viable. At what price point does it  
12 become viable? In other words, how much would employees have  
13 to raise the premium? My colleagues have told me that an  
14 increase in premium is preferable to losing their HMO  
15 coverage.

16 Moreover, health insurance premiums are  
17 deductible on a pre-tax basis. Several pages present a  
18 comparison of insurance coverage. The following states are  
19 used for comparison. Alaska, Arizona, Colorado, Idaho,  
20 Montana, New Mexico, Utah and Wyoming. It is unclear whether  
21 those states in particular were chosen.

22 For example, colleagues who have previously  
23 worked in California have told me that the health insurance  
24 there is much better. In this data there is no HMO. In the  
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1 appendix, a graph is given that shows migration of employees  
2 from one healthcare plan to another.

3 The trend is for employees with the Consumer  
4 Driven Healthcare Plan to the low deductible PPO. The  
5 enrollment of those in the HMO isn't steady. Has anyone  
6 reached out to those employees to find out why they stay in  
7 the HMO?

8 Based on my communication with UNLV employees, my  
9 perspective as faculty senate chair is that the HMO, EPO  
10 should continue to be an option. The low deductible PPO  
11 should either be converted to PPO Option 1 or left as is.  
12 Under no circumstances should PPO Option 2 be approved.

13 You have received dozens of written statements  
14 and public comments. Our employees are terrified about the  
15 repercussions of losing their current healthcare plans. Do  
16 the right thing, keep the HMO, EPO, and do not convert the  
17 low deductible PPO to Option 2.

18 In the words of an UNLV employee who has  
19 contacted me, we are all more than just dollars saved. Thank  
20 you.

21 MR. HOPKINS: Thank you.

22 Kelly, you have permission to speak. Please  
23 slowly spell or state and spell your name for the record if  
24 you wish to make public comment.

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1 MS. SCHERADO: Hi. My name is Kelly Scherado,  
2 K-e-l-l-y S-c-h-e-r-a-d-o. I'm interim chief human resources  
3 officer for the Nevada System of Higher Education, and I'm  
4 speaking on behalf of Chancellor Patty Charlton for the  
5 Nevada System of Higher Education, as well as the Chair and  
6 Vice Chair of Nevada System of Higher Education Board of  
7 Regents.

8 The Nevada System of Higher Education stands in  
9 support of our employees, who have expressed significant  
10 concerns about the proposed changes to the PPO, HMO and EPO  
11 plans have announced in late 2024. As one of Nevada's  
12 largest employers, we believe it's our duty to advocate for  
13 the well-being of our employees and their families.

14 The changes under consideration would prevent the  
15 effect of over 6,000 NSHE employees and by extension,  
16 thousands of their family members.

17 As of December 2024, NSHE has over 600 employees  
18 enrolled in the EPO plan. Approximately 4,200 employees  
19 enrolled in the low deductible PPO plan and around 1,000  
20 employees in the HMO plan. The proposed changes would  
21 disrupt coverage for these individuals, leaving many with  
22 uncertainty about the cost and accessibility of the now PPO.

23 We understand that PEBP's goal is to reduce cost  
24 and administering these programs. The lack of clarity and  
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1 preparation for these changes has raised significant concerns  
2 of the non-employees.

3 At the PEBP Board Meeting on November 21st, 2024,  
4 20 NSHE employees called in, and another 50 submitted written  
5 comments in opposition to the recommendation changes. During  
6 this time, and since then, NSHE has received communications  
7 from countless employees, voicing their distress if these  
8 recommendations were approved.

9 The concern NSHE has -- the concerns NSHE has  
10 heard from employees across our institutions can be  
11 summarized in briefings, continuity of care, financial and  
12 overall plan clarity.

13 Under continuity of care, NSHE shared their  
14 concern about the destruction to the ongoing medical care,  
15 including having to change providers, resulting in delays and  
16 treatments or the need to re-establish relationships with new  
17 providers, and scheduling delays due to waiting for insurance  
18 cards or adjustments to coverage and disruptions to ongoing  
19 treatment for serious medical issues causing potential  
20 setbacks to help outcomes.

21 Under financial impact, employees currently  
22 enrolled in the HMO plan rely on its predictability. They  
23 know how much they pay for their doctor visits and treatment,  
24 allowing them to budget accordingly.

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1           The proposed elimination of the HMO plan raises  
2 the following concerns, increased out-of-pocket costs for  
3 employees, potentially leaving to delayed or avoided care due  
4 to financial uncertainty, and a loss of the co-pay structure,  
5 which many employees prefer, over plans requiring deductibles  
6 that can result in unexpected medical expenses.

7           Under overall plan clarity, in addition to  
8 employee concerns surrounding the elimination of healthcare  
9 plans, we also received current feedback surrounding what  
10 many say is a lack of detail information regarding the  
11 proposed changes. Specifically, employees expressed  
12 frustration, with the lack of comparisons between existing  
13 plans and proposed alternatives and a desire for clear  
14 explanations of how coverage, cost and provider networks  
15 could change.

16           There is insufficient information about the  
17 projected cost of retaining current plans versus  
18 transitioning to new plans, and employees are requesting  
19 additional educational training sessions for PEBP to help  
20 them navigate changes and making informed decisions.

21           In conclusion, NSHE opposes the proposed changes  
22 to the PPO, HMO and EPO plans because of the significant  
23 concerns raised by our employees. These changes as outlined  
24 will cause disruptions to healthcare access, create financial  
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1 uncertainty and potentially erode the trust employees placed  
2 in their benefits.

3 We urge PEBP to reconsider these changes and  
4 prioritize the needs of employees and their families by  
5 maintaining the current plans. However, if PEBP determines  
6 that some changes must proceed, we encourage a thoughtful  
7 approach to minimize disruption. This could include  
8 providing detailed comparisons of the current and proposed  
9 change, offering comprehensive education and outreach to help  
10 employees understand their options and adopting the phase of  
11 implementation timeline to allow employees adequate time to  
12 prepare for and adjust to the changes.

13 NSHE remains committed to advocating for the  
14 health and well-being of our employees and their families.  
15 We appreciate PEBP's efforts to balance program costs, the  
16 quality benefits, but don't feel the proposed changes are the  
17 right course of action at this time. Thank you.

18 MR. HOPKINS: Thank you.

19 Kent Ervin, please slowly state and spell your  
20 name for the record if you wish to make public comment.

21 MR. ERVIN: Good morning, Chair Grimmer,  
22 Executive Officer Glover, and members. Kent Ervin,  
23 E-r-v-i-n, for the Nevada Faculty Alliance, the Independent  
24 Association of Professional Employees at Nevada's Public  
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1 Colleges and Universities. We work to empower our members to  
2 be fully engaged in our mission to help students succeed. I  
3 have submitted detailed written comments on behalf of the  
4 Nevada Faculty alliance, so I will be brief here.

5 We oppose the elimination of the HMO, EPO option  
6 and the proposed modifications to the low deductible plan do  
7 not fulfill the same purpose. We ask the Board to keep the  
8 plan design as it is with three options, at least for Plan  
9 Year 2026. Making a major change during a legislative  
10 session and when there are many unanswered questions and much  
11 opposition from members would be a mistake. It might well  
12 backfire at the legislature.

13 So, please retain the HMO, EPO option and  
14 postpone changes to the low deductible plan until plan year  
15 2027 and after better engagement with and education of our  
16 members. Thank you for your consideration.

17 MR. HOPKINS: Thank you, Mr. Ervin.

18 Jennifer Carr, please slowly state and spell your  
19 name for the record if you wish to make public comment.

20 MS. CARR: Good morning. This is Jennifer Carr,  
21 J-e-n-n-i-f-e-r C-a-r-r. I am an employee of the State of  
22 Nevada, I have been for 28 and a half years. I am the  
23 insurer for our family, and we're on the low deductible PPO,  
24 which I have been appreciating for the last couple of years  
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1 that it's been available.

2 I have permission from my daughter, Lindsay Carr,  
3 to speak on our UMR ordeal. She's also on the line today and  
4 may provide additional perspective. But I wanted to make  
5 sure that we provided the perspective that you might not be  
6 getting by simply reading reports from your vendors.

7 Our particular case, and many of the things that  
8 I struggle with UMR, don't ever get to an appeal stage, so  
9 you may not -- you may not receive information on them.

10 For Lindsay, in 2023, or 2024, excuse me, she is  
11 23. She's in grad school at UNR. And during 2024, she's  
12 been battling cancer. She's had two surgeries and two cancer  
13 treatment procedures. One, to plan her treatment in July and  
14 one to execute that treatment in September.

15 For the surgeries, I've had to spend time  
16 addressing surprise billing issues, which has been worth  
17 hundreds of dollars. And the last one, that I'm still  
18 working on, has been a struggle for over six months from her  
19 last surgery back in June. But very much worse, however, is  
20 our denials and struggles with the two cancer procedures  
21 leaving us with a denial total of over \$52,000.

22 The most egregious part is that UMR is playing  
23 games. The procedures were coded into the system by Carson  
24 Tahoe Hospital's preauthorization department and rejected out  
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1 with documentation that no preauthorization was required.  
2 Then, when UMR processes the billings, they're denied for no  
3 preauthorization received. Each time I've spent hours, many  
4 hours on the phone with Carson Tahoe Hospital's pre op  
5 department, who has been fabulous, and UMR.

6 And with the most recent round of my struggles  
7 with Sierra Healthcare Options, the preauthorization entity.  
8 We have done retroactive preauthorization which, was also  
9 kicked back initially to Carson-Tahoe Hospital with no  
10 pro-authorization required again. But, somehow, it did  
11 eventually get to Sierra Healthcare Options, and we're  
12 working through the September billing at this point in time.

13 I even have letters from Sierra Healthcare  
14 Options granting retroactive preauthorization, and they are  
15 still being denied by UMR's claims department.

16 In early October, when the first billing was  
17 denied for no preauthorization, Carson Tahoe Hospital's  
18 reaction was, this is really a poster child for the struggle  
19 that Carson Tahoe Hospital has been having with UMR, and it  
20 was immediately elevated to additional levels of supervision  
21 and management at Carson Tahoe to advocate and assist on our  
22 issue and to continue to try to work between Carson Tahoe and  
23 UMR to address these issues and not, you know, end up in the  
24 position that we're in with Carson Tahoe right now in

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1 Northern Nevada.

2 Most recently, in my discussion with the Carson  
3 Tahoe Hospital pre op rep, she shared with me that she has  
4 had 11 of these major issues just in the last two weeks, and  
5 I spoke with her last Monday. And there are 26 people on her  
6 team that are having similar cases. She further shared that  
7 Prominence Health Plan and Aetna do better. And UMR is just  
8 clearly, you know, engaging in these shenanigans that are  
9 completely unacceptable.

10 As administrator for the Division of  
11 Environmental Protection, I also want to advocate for all of  
12 my employees. I have 280 of them. And the mental health  
13 toll on patients is also unacceptable. You know, Lindsay has  
14 had me to take these reigns while she has dealt with her  
15 health issue and go to grad school at the same time, but not  
16 everyone has such an advocate to fight for their issues while  
17 they themselves are going through major or even just routine  
18 health issues. I want to stick up for them now as much as  
19 anything.

20 The loss of Carson Tahoe Hospital as a result of  
21 UMR's shenanigans is, again, unacceptable. Carson Tahoe  
22 Hospital providers have literally saved my daughter's life.  
23 The type of cancer she had could metastasize to lung cancer  
24 and the physicians and surgeons and endocrinologist and  
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1 everyone she has been working with have gone just to great  
2 lengths to treat her well and treat her condition well. And  
3 we need to make sure that Carson Tahoe remains a provider for  
4 Northern Nevada and we need a better third party  
5 administrator that is not UMR. Thank you.

6 MR. HOPKINS: Thank you.

7 Just a reminder, those who have made your public  
8 comment already, we're kind of asking because we have over 63  
9 attendees in our lobby currently. If you've already made  
10 your public comments, I'm, please, asking to watch the  
11 YouTube link livestream instead of being in the lobby, so I  
12 don't answer the call.

13 Caller with the last four digits 0891, please  
14 voice, state and spell your name for the record if you wish  
15 to make public comment.

16 MS. LAIRD: Yes. Thank you. Good morning. My  
17 name is Terri Laird, T-e-r-r-i L-a-i-r-d. Good morning,  
18 Executive Officer Glover, Board Chair Grimmer, and, fellow  
19 Board members and staff. I'm the executive director for  
20 RPEN, the Retired Public Employees of Nevada. We're a  
21 nonprofit, non-partisan organization with chapters throughout  
22 the state, and we were created in 1976, nearly 50 years ago  
23 to protect the pensions and benefits earned by all public  
24 employees.

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1 the Via Benefits contract. The original Extend Health, when  
2 it started, had some issues, but we believe now that many are  
3 accustomed to us, and we were hesitant to see a new vendor come  
4 in. So, we hope that will be approved today.

5 Because there's another legislative session  
6 around the corner and RPEN and our public employee coalition  
7 will be lobbying for an increase in the health reimbursement  
8 arrangement, HRA, currently \$13 per month. For years of  
9 service, we asked for a 2 dollar increase at the last  
10 session, and we will be back to get that hopefully this  
11 session since it wasn't approved the last time.

12 Also, I would like to go on record in support of  
13 the issues that folks are having with the HMO. It sounds  
14 dire, and we're hoping that you can answer their concerns  
15 today. We thank the PEBP staff and the Board for the hard  
16 work you do for your participants, many of whom are also  
17 members of RPEN. Thank you.

18 MR. HOPKINS: Thank you.

19 Lindsay Carr, you have permission to speak.  
20 Please slowly state and spell your name for the record if you  
21 wish to make public.

22 MS. CARR: Yes, Lindsay Carr, L-i-n-d-s-a-y  
23 C-a-r-r. Thank you to the Board for giving us the  
24 opportunity for public comment today. As my mom, Jennifer  
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1 Carr, who was just previously on, mentioned, I'm a  
2 23-year-old graduate student that's halfway through the  
3 counseling master's program at UNR. I am also a young adult  
4 cancer survivor, recently told that I was in remission.

5 She was also here for public comment today, and  
6 you heard from her the story of my cancer treatment nearly  
7 being denied of coverage. My plea for this Board is to  
8 consider looking into other options than UMR for our state  
9 insurance plan that is a possibility.

10 As a young adult cancer survivor, I can tell you  
11 firsthand that working with UMR has been a nightmare in the  
12 most difficult period of my life. I walked through hell  
13 going through this cancer treatment, and UMR did not make it  
14 any easier. I was diagnosed with stage one of an aggressive  
15 type of thyroid cancer in April 2024, meaning that my doctors  
16 wanted to treat it as aggressively as possible to give me the  
17 best prognosis.

18 And my treatment was a whirlwind of multiple  
19 surgeries, some fun stuff called radioactive iodine. It  
20 makes you very sick and had to isolate from people for days  
21 at a time, in addition to other things.

22 On top of this, UMR tried to deny coverage for my  
23 radioactive iodine treatments, in addition to Carson Tahoe  
24 denying me simple procedures at the hospital, like getting

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1 required blood work for my treatments. Since UMR evidently  
2 had not paid them for months and they started refusing to  
3 work with UMR and me moving forward.

4 In the future, if we continue to have UMR as our  
5 insurance plan, I will lose access to my cancer care doctor.  
6 If you have anyone in your life that has had cancer and has  
7 gone into remission, you know that cancer care continues  
8 years into remission. I would hopefully be able to go back  
9 to my endocrinologist, who is also my cancer care doctor, and  
10 retain access to my ear, nose and throat surgeon who would do  
11 further surgeries if I were to have a further occurrence.

12 But if we were to continue with UMR, since they  
13 are having -- since Carson Tahoe Health is having so many  
14 issues with UMR as an insurance company, I would lose access  
15 to all of those doctors in my care network. I urge you to  
16 try to find another option than UMR for our insurance plan.  
17 Nevadans like me and an employee of UNR and a future  
18 therapist that will work providing low cost therapy to your  
19 colleagues, like my mother, an employee of NDEP, like all of  
20 us who work for our home state, we deserve better than this.  
21 Thank you.

22 MR. HOPKINS: Thank you.

23 Caller with the last four digits 2157, please  
24 press star six to unmute and please slowly state and spell  
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1 your name for the record.

2 We'll go to someone else. Caller with the last  
3 four digits 8853, please press star six to unmute and please  
4 slowly state and spell your name for the record.

5 MR. UNGER: Doug Unger, D-o-u-g U-n-g-e-r, acting  
6 President UNLV Chapter, Nevada Faculty Alliance and Chair for  
7 Government Affairs Committee, also a member of the UNLV  
8 Employee Benefits Advisory Committee. Thank you, Chair  
9 Grimmer, and, the PEBP Board, for your service and  
10 consideration.

11 Faculty and staff at UNLV strongly oppose the  
12 elimination of the HMO plan in the south still under  
13 consideration. Furthermore, we find the Segal document, HMO,  
14 EPO viability to be flawed in its representation, when it  
15 obviously blends both HMO and EPO costs versus benefits into  
16 a case for elimination when the actual cost to the plans are  
17 so different.

18 Dare we state this feels wrong to do, perhaps  
19 even unethical to do when so much is at stake for the future  
20 of the third choice for state employee healthcare. The EPO  
21 in the north has a troubled cost versus benefit history.  
22 Indeed, that has always functioned as a plan closer in spirit  
23 to PPO than a true HMO. This is not the case with the HMO in  
24 the south, demonstrated by its stable enrollment numbers

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1 compared to the Northern Nevada EPO, which indicates some  
2 degree of member satisfaction.

3 This brings up an off debated question. Why must  
4 PEBP offer similar health plan choices in the north and the  
5 south when the cost in provider networks are so different?  
6 Other states separate out employee healthcare plans  
7 geographically. Look at Oregon as a comparable example.  
8 Oregon offers differing menus of healthcare plans regionally,  
9 reflecting service area and provider network differences.  
10 Why can't Nevada do the same?

11 Furthermore, not enough feedback has been  
12 gathered by PEBP fully to comprehend real life patient impact  
13 of eliminating the HMO and EPO. We recommend PEBP keep both  
14 the HMO and EPO plans at least through next enrollment year  
15 while actively soliciting employee feedback by detailed  
16 surveys and hosting Town Halls. At least PEBP members would  
17 be more prepared and might better understand such a drastic  
18 change in health plan choices.

19 In conclusion, based on the Segal document, it  
20 appears that PEBP is considering changes to the PPO by either  
21 a PPO 1 Option or PPO 2 Option. We judge the PPO 1 Option  
22 provides improved benefits versus costs than the PPO 2  
23 Option, and it does not levy burdensome deductibles. Its  
24 changes in the PPO plan must be made for next year's

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1 enrollment. We strongly request that the PPO One plan to be  
2 offered as an optimal choice to show Nevada cares for and  
3 values its employees. Thank you.

4 MR. HOPKINS: Thank you.

5 Sorry if I butcher this, Arbreall Tou (phonetic),  
6 please slowly state and spell your name for the record if you  
7 wish to make public comment.

8 Angela, please slowly state and spell your name  
9 for the record if you wish to make public comment. Angela  
10 P., please slowly state and spell your name for the record if  
11 you wish to make public comment.

12 Let's see. Austin Connell, you have permission  
13 to speak. Please slowly state and spell your name for the  
14 record if you wish to make public comment.

15 Bridgette, Bridgette P., please slowly state and  
16 spell your name for the record if you wish to make public  
17 comment.

18 Claudia, you have permission to speak. Please  
19 slowly state and spell your name for the record if you wish  
20 to make public comment. Claudia, I see that you're unmuted.  
21 Can you hear me? Okay. I might try to come back to you.  
22 Thank you. One moment.

23 Dan, you have permission to speak. Please slowly  
24 state and spell your name for the record if you wish to make  
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1 public comment.

2 David Cooper, you have permission to speak.  
3 Please slowly state and spell your name for the record if you  
4 wish to make public comment.

5 MR. COOPER: Good morning. My name is David  
6 Cooper, D-a-v-i-d C-o-o-p-e-r, and I'm here today as the  
7 Chair of the Nevada State University Faculty Senate to speak  
8 on Agenda Item 7 with regards to the proposed elimination of  
9 the HMO, EPO options for healthcare coverage. Like many of  
10 my colleagues, I'm here to ask the Board to vote against this  
11 elimination.

12 These plans offer valuable choice in how to  
13 receive healthcare in Nevada. Many of the people on these  
14 options rely on predictability of pricing and comfort of  
15 knowledge that no single health crisis will financially ruin  
16 them. Even if the annual cost of other programs are lower  
17 than that of the HMO, EPO plans, that does not mitigate the  
18 spacing out of those costs, as it does not help if all of  
19 those costs are consolidated to a single large payment.

20 My fellow faculty who are on the HMO currently  
21 have also talked to me about the worry they are being forced  
22 to switch health plans. They have told how they are  
23 concerned that they will need to find new providers and  
24 rebuild relationship with doctors that have been years in the  
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1 making. They have stated that they are aware of the  
2 differences between the standard PPO and HMO plans and chosen  
3 the HMO plan because that offers them the best path for their  
4 healthcare needs. Please do not eliminate this option for  
5 them. Thank you for your time.

6 MR. HOPKINS: Thank you.

7 Brian Cordova, you have permission to speak.  
8 Please slowly state and spell your name for the record if you  
9 wish to make public comment.

10 MR. CORDOVA: I'm just listening.

11 MR. HOPKINS: Okay. Thank you.

12 Delayna, Delayna T., you have permission to  
13 speak. Please slowly state and spell your name for the  
14 record if you wish to make public comment.

15 MS. TONOGAA: Hi. My name is Delayna Tonogaa,  
16 D-e-l-a-y-n-a T-o-n-o-g-a-a, and I'm a faculty member with  
17 UNLV. I would just like to ask to not have the HMO be  
18 eliminated from our plan. Like many of the other colleagues  
19 that have spoken before me, many of us are experiencing a lot  
20 of healthcare needs. They're on a consistent basis because  
21 we have chronic needs.

22 And to have the HMO plan is comforting, knowing  
23 that we are able to have our predictable co-pays. We know  
24 when we are going to be able to see our providers. We have  
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1 an established set of relationship with them, and that really  
2 leads to our overall care. Not only are we talking about our  
3 physical health but in conjunction with that, having that  
4 rapport with your providers also leads to a good mental  
5 health, and those are very important to work together when we  
6 are trying to heal ourselves.

7 For my situation, I have a husband who is on the  
8 post of getting a liver transplant, so we've been working for  
9 that process since July. So, it's very disheartening to hear  
10 this might not be an option for us that is reasonable as far  
11 as the coverage of our financial situation if an HMO plan is  
12 eliminated.

13 So, I know I'm one of many people who are on here  
14 today speaking to you all, but I really hope you do take that  
15 into consideration as far as our future and just really look  
16 out for the employees that you have. Thank you.

17 MR. HOPKINS: Thank you.

18 Claudia, you have permission to speak. Please  
19 slowly state and spell your name for the record to give  
20 public comment. Claudia, I see your hand is up, but I cannot  
21 -- we cannot hear you. Sorry, Claudia. We'll come back to  
22 you.

23 Diana, you have permission to speak. Please  
24 slowly state and spell your name for the record if you wish  
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1 to make public comment.

2 Gabe Rodriguez, you have permission to speak.  
3 Please slowly state and spell your name for the record if you  
4 wish to make public comment.

5 Jesum Seelin (phonetic), you have permission to  
6 speak. Please slowly state and spell your name for the  
7 record if you wish to make public comment.

8 As a reminder, if you do not wish to make public  
9 comment, please leave the Zoom attendee lobby and watch the  
10 YouTube livestream on the -- located -- the link is located  
11 on the agenda for this meeting.

12 Hugh Wang, please slowly -- you have permission  
13 to speak. Please slowly state and spell your name for the  
14 record if you wish to make public comment.

15 Mark V., please slowly state and spell your name  
16 for the record if you wish to make public comment. Mark, are  
17 you there? I heard something.

18 MR. VALENTIN: Do you hear me now?

19 MR. HOPKINS: Yes, I do.

20 MR. VALENTIN: Okay, perfect. It's Mark  
21 Valentin, M-a-r-k V-a-l-e-n-t-i-n, and I am speaking on  
22 keeping the HMO. I -- currently I am on the PPO myself, but  
23 I was on the HMO, and I do have a lot of co-workers, very  
24 close co-workers that are on the HMO plan that do have  
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1 chronic conditions, and I worry for them. If they have to  
2 have a disruption of their service, I know how hard it is to  
3 go through when you have an insurance change. I've done it a  
4 few times, and you have to kind of go back to square one.  
5 And I know a lot of the people at the university who don't --  
6 I'm, frankly, really concerned if they have to go back to  
7 square one and how their health might be affected if they  
8 have to change insurance if they're getting denied on things  
9 they were previously approved for.

10 And so one of the great things about working at  
11 UNLV was having a consistent health insurance in the HMO plan  
12 and not having to worry about out-of-pocket costs. And it's  
13 disheartening to hear that they are trying to get rid of one  
14 of the few plans that we have. So, I really would implore  
15 that it's -- that we keep the HMO. We have so many workers  
16 here that it is crucial for their mental and physical health  
17 well-being that they have that plan. So, let's hope we keep  
18 that.

19 MR. HOPKINS: Awesome. Thank you, Mark.

20 Caller with the last four digits 2157, you have  
21 permission to speak. Please slowly state and spell your name  
22 for the record if you wish to make public comment. He  
23 dropped off.

24 Kimberly Dawes, you have permission to speak.  
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1 Please slowly state and spell your name for the record if you  
2 wish to make public comment.

3 MS. DAWES: My apologies. I'm in there  
4 incorrectly. Please remove me. I'm sorry.

5 MR. HOPKINS: No problem. Thank you.

6 Marcy, you have permission to speak. Please  
7 slowly state and spell your name for the record if you wish  
8 to make public comment.

9 McNulty 6, you have permission to speak. Please  
10 slowly state and spell your name for the record if you wish  
11 to make public comment.

12 Michael A., you have permission to speak. Please  
13 slowly state and spell your name for the record if you wish  
14 to make public comment.

15 Caller with the last four digits 7132, please  
16 press star six to unmute and please slowly state and spell  
17 your name for the record if you wish to make public comment.

18 MS. LOPEZ: Hello. Can you hear me?

19 MR. HOPKINS: Yes, we can.

20 MS. LOPEZ: Hello. My name is Josie Lopez. I am  
21 an admin assistant two with the State of Nevada, and I wanted  
22 to have a public comment that I did submit to the Board, but  
23 I did also want to let it be heard. So, you, Board members,  
24 I hope this year is going well for you, first and foremost.

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1 I wanted to comment regarding the Obesity Care  
2 Management Program. On May 23rd, 2024, Board Member Michelle  
3 Kelley stated, people weren't accessed to these medications  
4 with the weight loss medications. And, obviously, I would  
5 hope they make people healthier. But, you know, PEBP  
6 certainly as it's currently funded, we just couldn't afford  
7 to cover these. Also, just a comment more for public, that  
8 there also the line of diabetes drugs, and we do cover those  
9 for people who have type two diabetes. Those necessary  
10 medications are actually covered, end quote.

11 I'm writing this to express my concern regarding  
12 the current limitations of the Obesity Care Management  
13 Program. While I appreciate the program's intention to  
14 promote healthier lifestyles, I believe it falls short in  
15 several key areas.

16 Firstly, the program appears to have limited  
17 medication coverage currently restricted for certain type  
18 medication. This information was not readily accessible to  
19 members requiring direct inquiry with PEBP support. I did  
20 try to call UMR, as well as Express Scripts.

21 Secondly, the current program structure seems to  
22 prioritize addressing health issues after they arrive,  
23 exemplifying the type two diabetes that she quoted. Rather than  
24 proactively preventing, this approach appears to prioritize

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1 cost containment over member well-being, as members are  
2 burdened with co-pays and deductibles for conditions that  
3 could have potentially been mitigated through more  
4 comprehensive preventative care.

5 Thirdly, while PEBP offers resources like Health  
6 App, as well as Real Appeal and the Obesity Care Management  
7 Program lacks the necessary tools for members to fully  
8 optimize its use. This includes limited medication options  
9 hindering the ability for many members to achieve their  
10 health goals.

11 I propose that the Obesity Care Management  
12 Program be expanded to include a wider range of medications  
13 such as the GLP1's for those who require them to address  
14 potential care of potential cost concerns and optimal premium  
15 could be introduced for those expended coverage similar to  
16 the optimal programs like life insurance or vision.

17 This would allow members to choose a level of  
18 coverage for their individual needs and budgets. I believe  
19 that a revised approach would better serve the needs of our  
20 members and provide them with tools and resources necessary  
21 to achieve and maintain optimal health. Thank you for your  
22 time.

23 MR. HOPKINS: Thank you.

24 Scott, you have permission to speak. Please  
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1 slowly state and spell your name for the record if you wish  
2 to make public comment.

3 Shana Rivers or Shana Rivers, please slowly state  
4 and spell your name for the record if you wish to make public  
5 comment.

6 Susan, you have permission to speak. Please  
7 slowly state and spell your name for the record if you wish  
8 to make public comment.

9 Tony Terell, you have permission to speak.  
10 Please slowly state and spell your name for the record if you  
11 wish to make public comment.

12 Claudia, let's try you again. Please slowly  
13 state and spell your name for the record.

14 MS. CEDILLO: Hello. Can you hear me?

15 MR. HOPKINS: Yes, we can. Thank you.

16 CHAIRWOMAN GRIMMER: Claudia Cedillo,  
17 C-l-a-u-d-i-a C-e-d-i-l-l-o. I'm an administrative assistant  
18 at UNLV, and my comments, thank you so much for taking them,  
19 are on two things. One is, I know someone very close to me  
20 here that is on the HMO and highly depends on their  
21 treatment. They have had cancer more than once. It's been a  
22 devastating ride, and they have had to struggle and fight to  
23 get coverage, to get appropriate healthcare, and it's  
24 somebody that is a colleague that I care about very much.

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1                   Now, regarding my personal experience with UMR,  
2 when I first started here a few years ago, the PPO, I had the  
3 regular PPO, and I had excellent doctors. I really started  
4 to get healthier with some conditions that I have, and then  
5 slowly I started seeing the providers leave to where I would  
6 go, and I would search for providers that had good ratings.  
7 All of the ratings were low. It's like I'm searching from  
8 the bottom of the barrel to see who's on top of that. I just  
9 feel like the quality of the care that I've gotten, which I'm  
10 now on the low deductible PPO, has gone down as well.

11                   My latest provider that I just found about a year  
12 ago, I finally found someone that had good ratings and seemed  
13 to care about my health, she's no longer contracted as well.  
14 It seems like UMR is just somehow weeding out the good people  
15 that treat us, and they're leaving for some reason.

16                   At the same time, I have to continuously talk to  
17 the doctor's office and to anywhere I might have testing. I  
18 have to have regular testing. And if the coding is incorrect  
19 or the wording is incorrect, I'll get hit with a 500 dollar  
20 deductible, which should be covered.

21                   If I didn't learn about this, if I didn't call  
22 constantly and try to figure things out on my own, I would be  
23 left paying \$500 every time I go to the doctors for certain  
24 testing that I need done.

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1 I come from a different state where an HMO is \$30  
2 a month. A PPO is about maybe 150. But the care that I've  
3 gotten is completely different. We have places like Kaiser,  
4 where you go in with an HMO. You know what you're paying  
5 when you go to see a doctor. Your healthcare is easy. It's  
6 covered. But just basic things with women's healthcare are  
7 easy to navigate.

8 Whereas, UMR has been extremely difficult and,  
9 like I said, for some reason, all of the providers that have  
10 been good and that I've dealt with that I felt comfortable  
11 with, they're not contracted anymore. So, now I'm left again  
12 having to start over and look for a new provider and try to  
13 get my healthcare established and go through the routine of  
14 are you sending my lab work requests correctly.

15 And I've had to call the place where I'm going to  
16 four or five times until they finally have the order correct,  
17 and I'll delay in my own healthcare and in my own testing  
18 because I know if I go and I don't have that code correct, I  
19 have to pay \$500, and it's -- it just happened several times,  
20 and it doesn't matter what doctor. It's just a constant  
21 fight to try to get appropriate healthcare and covered the  
22 way it should be.

23 I just wanted to let you know that. It's -- it's  
24 been difficult with the system that's there now. But taking  
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1 away something like the HMO for those who use it and really  
2 depend on it, is really devastating. So, as the other young  
3 lady, I forgot her name, who was going through the cancer  
4 treatment, as she said, maybe consider something aside from  
5 UMR. I don't know if we can get other kind of healthcare up  
6 here, but it would really help retain employees, and it would  
7 help take care of the people who work for the government.  
8 Thank you so much for your time.

9 MR. HOPKINS: Thank you.

10 Tiffany or Tiffany Howard, you have permission to  
11 speak. Please slowly state and spell your name for the  
12 record if you wish to make public comment.

13 John, John M., you have permission to speak.  
14 Please slowly state and spell your name for the record if you  
15 wish to make public comment.

16 Andrew P., you have permission to speak. Please  
17 slowly state and spell your name for the record if you wish  
18 to make public comment.

19 John Jacobs, you have permission to speak.  
20 Please slowly state and spell your name for the record if you  
21 wish to make public comment. John, I see you're unmuted.

22 MR. JACOBS: Oh, sorry. My name is John Jacobs,  
23 J-o-h-n. Last name J-a-c-o-b-s. I've worked at UNLV for  
24 27 years now. And when I started, I started out with the HMO  
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1 plan. I am a diabetic. You know, as a diabetic type one, I  
2 didn't choose to be a diabetic. So, coming into the  
3 university, you know, I was somewhat limited as to what  
4 options I had that would allow me to receive care with the  
5 preexisting condition.

6 HMO has been a blessing for me for the past  
7 27 years. My wife is under the HMO plan as well too  
8 through -- through my -- through my employment, and this  
9 benefits our family tremendously. I just can't imagine  
10 living without having that HMO or a health insurance that  
11 doesn't provide as much quality care that I currently get  
12 through the HMO.

13 I spent half my life with the university. I will  
14 end up retiring here. And I just hope that, you know, the  
15 value that I put into the university, into our community and  
16 into our state is appreciated, and I hope that you  
17 reconsider, you know, getting rid of the HMO policy. Thank  
18 you.

19 MR. HOPKINS: Thank you.

20 Will the caller with the last four digits 2560,  
21 please press star six to unmute. You have permission to  
22 speak. Please slowly state and spell your name for the  
23 record.

24 MR. WAGNER: Hi. My name is Michael Wagner,  
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1 M-i-c-h-a-e-l W-a-g-n-e-r. I would just like to make a  
2 comment on Carson Tahoe Health and on the Aetna Medical  
3 Advantage plan and Humana's Advantage Plan. Carson Tahoe  
4 just sent a letter out that they are going to get rid of  
5 coverage by Aetna and Humana, and they are pushing us to go  
6 to a coverage by either the local HMO's or I should say the  
7 local Medicare Advantage Plans, which are not covered by PEBP  
8 or by Via Benefits, and I would like to have that rest aside.  
9 Thanks. Bye.

10 MR. HOPKINS: Thank you. Carolyn Arrita, you  
11 have permission to speak. Please slowly state and spell your  
12 name for the record if you wish to make public comment.

13 Okay. We still have about 19 people in our  
14 attendee lobby. Those who want to make public comment,  
15 please raise your hand on the Zoom app, and I will call upon  
16 you. If not, I may ask for you to hang out in the lobby, and  
17 then I will call back on you during the second public comment  
18 agenda item towards the end of the meeting.

19 Michael A., you have, you permission to speak.  
20 Please slowly state and spell your name for the record.

21 MR. AMESQUITA: Michael Amesquita, M-i-c-h-a-e-l  
22 A-m-e-s-q-u-i-t-a. I did public comment last time. Between  
23 now and then, I now have to have shoulder surgery, which I  
24 would not be able to afford, period, if you took away the  
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1 HMO. I think something else has been brought up a lot this  
2 time around, is the un-Godful level of low healthcare in  
3 Nevada, in Southern Nevada.

4 I have had Kaiser in California. I have had  
5 University of Utah Healthcare System, and I've had George  
6 Washington Medical Faculty Association. And here, in Nevada,  
7 it is so hard to find good healthcare that is not a redone,  
8 remade business office into a medical office, and it's  
9 scattered, and it's horrible. I've never seen anything like  
10 it, and I am 50, and I've worked at three or four  
11 universities.

12 If you all remove the HMO, it will  
13 disproportionately affect people with marginalized background  
14 and color. I don't know if you've figured that out yet. So,  
15 please don't do this now because we now have a President who  
16 may lift tariffs, and that's going to make everything more  
17 expensive. Please don't make healthcare more expensive for  
18 us. Thank you.

19 MR. HOPKINS: Thank you.

20 Since I called upon the majority of the people  
21 that are still in the lobby, I'll give you all one more  
22 opportunity to raise your hand if you wish to make public  
23 comments in case you are still just listening in.

24 Okay. So, what I'm gonna do, Madam Chair, we do  
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1 have one other public comment with a member. I'm gonna  
2 change my configuration out slightly, so just one moment,  
3 okay?

4 CHAIRWOMAN GRIMMER: Thank you.

5 MR. HOPKINS: Thank you. One moment. May I ask  
6 that everyone besides David Kelsey and Michelle, please turn  
7 off your video camera at this time.

8 David Kelsey, you're good to go or, Michelle, you  
9 can start whenever he's ready.

10 MS. MONTELONGU: Okay. Thank you.

11 MR. HOPKINS: Thank you. Sorry about that.

12 MS. MONTELONGU: Good morning. I very much  
13 appreciate you listening to my comments. My name is David  
14 Kelsey, D-a-v-i-d. My last name is K-e-l-s-e-y. And I  
15 have -- I have concerns regarding the elimination of the HMO  
16 because my husband and I, specifically my husband, we utilize  
17 it. Now, understand, my husband has type two diabetes, and  
18 so this affects him having various chronic conditions  
19 relating to it.

20 With the elimination of the HMO, that would  
21 increase our cost that we would have to pay out, and so thank  
22 you so much. I appreciate your time for hearing my concerns.

23 MR. HOPKINS: Thank you. Can you tell David  
24 thank you as well.

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1 MS. MONTELONGU: Thank you.

2 MR. HOPKINS: Perfect.

3 Okay. Madam Chair, that concludes public comment  
4 for this agenda item. And as a reminder for those who were  
5 not able to give public comment due to a technical issue or  
6 they weren't available when I called upon you due to the  
7 volume of public comment, you will be able to present your  
8 public comment again towards the end of the meeting.

9 CHAIRWOMAN GRIMMER: Okay. Thank you very much.  
10 We will now close Agenda Item Number 2 and go on to Agenda  
11 Item Number 3. PEBP Board disclosures for applicable Board  
12 meeting agenda items. Deputy Attorney General Radhika  
13 Kunnel.

14 MS. KUNNEL: Thank you, Chair Grimmer.

15 Good morning, everyone. This agenda item is to  
16 allow me to make a disclosure regarding conflicts of interest  
17 on behalf of the Board members who are eligible for Public  
18 Employees' Benefits Program, PEBP benefits.

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

24 The law does not require abstention from voting  
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1 merely because the Board member or their family member is  
2 eligible for PEBP benefits. At this time, I invite any  
3 member of the Board who has any additional disclosure to make  
4 to make it now. Thank you.

5 MR. HOPKINS: All right. Madam Chair, Jessica  
6 Crane has something to say really quick. We're trying to get  
7 Stacie, Stacie Weeks in the lobby, but I'll have her take  
8 over.

9 MS. CRANE: Hi. This is Jess Crane. And I just  
10 wanted to put on record that Stacie is in attendance. She is  
11 not absent for today's meeting.

12 MR. HOPKINS: Yeah, she's in the attendee log.  
13 We're trying to move her over as a panelist right now. So,  
14 she has to accept it. There she is.

15 Good ahead, Madam Chair.

16 CHAIRWOMAN GRIMMER: Thank you. Okay. Seeing no  
17 additional disclosures being brought forward, I'll close  
18 Agenda Item Number 3 and move on to Agenda Item Number 4,  
19 consent agenda. Consent agenda, all items for possible  
20 action, consent items will be considered together and acted  
21 on in one motion unless an item is removed to be considered  
22 separately by the Board.

23 Are there any items the Board wishes to pull?

24 Yes, Jessica?

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1 MS. CRANE: Sorry. I didn't realize my hand was  
2 still up. I'll take it down.

3 CHAIRWOMAN GRIMMER: Is there any discussion by  
4 the Board? Okay. Seeing none, I will -- do I have a motion  
5 to approve this item?

6 MEMBER KELLEY: Michelle Kelley for the record.  
7 I make a motion to accept the consent agenda as presented in  
8 the meeting packet.

9 CHAIRWOMAN GRIMMER: Thank you. Do we have a  
10 second?

11 MEMBER STRASBURG: Betsy Strasburg. Second.

12 CHAIRWOMAN GRIMMER: Perfect. We have a motion  
13 and a second. Is there any further discussion? Okay.  
14 Seeing none, I'll call for the vote. All those in favor  
15 signify by saying aye.

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

18 CHAIRWOMAN GRIMMER: All those opposed? Okay.  
19 Motion passes.

20 We'll close Agenda Item Number 4 and move on to  
21 Agenda Item Number 5. Discussion and possible action  
22 regarding enhancements to current supplemental health  
23 voluntary benefit offerings. Nik Proper and Neale Hegarty,  
24 and this is for possible action. Please go ahead.

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1 MR. PROPER: Thank you, Chair Grimmer. Nik  
2 Proper for the record. I'm providing the report on  
3 supplemental health voluntary benefits. With Corestream, we  
4 offer six supplemental health benefits, and these are  
5 accident, critical illness, hospital indemnity, additional  
6 life insurance, short-term disability, and long-term  
7 disability plans, and they're all bundled with a standard.

8 Well, Corestream released an RFP for these same  
9 supplemental health products. And based on the results, we  
10 recommend moving the bundled offerings to MetLife beginning  
11 Plan Year '26, including this upcoming open enrollment. And  
12 with that recommendation, if approved, we'll create a  
13 communication plan. And since MetLife is currently  
14 integrated with Corestream, there's actually no -- sorry.  
15 There's no action required of members, as all of the policies  
16 will be transferred over, so it will be seamless. Members  
17 can continue the same policy or they can, you know, forward  
18 it to an individual policy with a standard, but our  
19 recommendation is to move these bundled offerings to MetLife.

20 With that, we can pause for questions or move to  
21 Neale with Corestream to provide, you know, a brief overview,  
22 answer additional questions if needed.

23 CHAIRWOMAN GRIMMER: Okay. Thank you for that.

24 Are there any questions or discussions?  
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1           MEMBER KELLEY: Michelle Kelley for the record.  
2 I have a question or two. I think they're easy ones. Thank  
3 you for the agenda item. And I'm Michelle Kelley for the  
4 record, M-i-c-h-e-l-l-e K-e-l-l-e-y.

5           I just have a couple of questions. Firstly, I  
6 notice the life insurance that MetLife has agreed to do a  
7 guaranteed issue for the next open enrollment for all  
8 employees. And I'm just wondering, it doesn't say how much.  
9 So, what would be the limit on the guaranteed issue that  
10 MetLife is offering?

11           MR. PROPER: Nik Proper for the record. Neale,  
12 can you answer that?

13           MR. HEGARTY: Yeah. Neale Hegarty for the  
14 record, N-e-a-l-e H-e-g-a-r-t-y. I can go ahead and look  
15 that up right now. That will take me about one minute, but I  
16 can answer that question shortly.

17           MEMBER KELLEY: I think I have a second question,  
18 as well, on that line. So, for the rest of those products,  
19 so the accident and critical care hospital indemnity, are  
20 they -- do they have waiting periods when people sign up or  
21 are they automatically guaranteed issue, whether you're a new  
22 hire or sign up during open enrollment?

23           MR. HEGARTY: This is Neale Hegarty. There is no  
24 waiting period, and they are guaranteed if you sign up during  
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1 open enrollment.

2 MEMBER KELLEY: Thank you.

3 CHAIRWOMAN GRIMMER: Okay. Any other questions?  
4 Okay. Seeing none, do I have a motion on this item?

5 MR. HEGARTY: Neale Hegarty. Just to answer your  
6 question, the guaranteed issuance level for employees is  
7 \$100,000 and for spouse is \$25,000.

8 MEMBER KELLEY: Thank you.

9 With that, I make a motion to agenda item as  
10 presented and to switch our voluntary product offerings as  
11 listed to MetLife from the standard.

12 CHAIRWOMAN GRIMMER: Okay. Thank you. Do we  
13 have a second?

14 MEMBER MCCLENDON: Jennifer McClendon. I'll  
15 second it.

16 CHAIRWOMAN GRIMMER: Thank you. Is there any  
17 further discussion? Seeing none, all those in favor signify  
18 by saying aye.

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

21 CHAIRWOMAN GRIMMER: All those opposed? Okay.  
22 Motion passes.

23 We will close Agenda Item Number 5 and move on to  
24 Agenda Item Number 6, Executive Officer Report. Celestena  
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1 Glover, information and discussion. Please go ahead.

2 MS. GLOVER: Thank you. Good morning. This is  
3 Celestena Glover, C-e-l-e-s-t-e-n-a. Last name Glover,  
4 G-l-o-v, as in Victor e-r.

5 Before you is the Executive Officer Report, which  
6 gives the Board and members of the public updates on agency  
7 operations.

8 The first thing in the report is recently we had  
9 a presentation before the interim Retirement and Benefits  
10 Committee. Per NRS 287.0425, PEBP is required to present  
11 certain reports whenever this committee meets. They met on  
12 December 17th, and we did come with our presentation as  
13 required.

14 The primary questions that came out of that  
15 meeting were related to the percentage increase when  
16 comparing the HMO to the self-funded plans. The percent was  
17 lower with the HMO, but the dollar amount that the HMO  
18 started at was a higher amount. So, when comparing the  
19 self-funded plans to the HMO, in 2024, the PMPM, per member  
20 per month cost was \$186 versus the self-funded plans where  
21 the PMPM was approximately \$150. So, although, we saw a  
22 greater percent increase, the per member cost is still lower  
23 than the HMO for 2024.

24 In addition, the committee observed cancer  
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1 treatment being a top diagnosis for PEBP members, and they  
2 were questioning whether or not care was being received  
3 outside of the state, and in many cases that is the  
4 situation. They wanted to know what percent of individuals  
5 went out of state, primarily the reason why. We did present  
6 a report to them, which showed that 10.6 percent of members  
7 in 2024 did seek care outside of Nevada. Some of the reasons  
8 for that was provider referrals, member preference, and we  
9 also use a lot of Centers of Excellence outside of Nevada  
10 that may provide some specialty care that's not available in  
11 the state. So, this report was provided to the -- to the  
12 committee as requested.

13 The next item on the report is the Governor's  
14 recommended budget. I know many people watched the State of  
15 the State and may have questions. We submitted our budget  
16 per our request back in August, as it was due on August 30th,  
17 by close of business that day. Everything that PEBP  
18 requested was included in the budget. We essentially kept  
19 our budget the same as we have. We made adjustments to  
20 account for the shortage in our reserve categories. We also  
21 asked to increase the subsidy for the Part B premium that  
22 members are required to purchase if they are Medicare age and  
23 are retired.

24 The only thing that was done a little bit  
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1 differently from what we typically do, PEBP will put in the  
2 experience and trend for our plans based on analysis that  
3 Segal provides and our observation in our utilization  
4 reports. Typically what happens, is we may put in that we  
5 believe the increase of six percent. The Governor's finance  
6 office generally will reduce that to match what Medicaid and  
7 corrections utilizes. That doesn't always work for PEBP.  
8 So, this year, what they've done is they reduced what we put  
9 in the budget. But what they did do is give us enhancement  
10 unit to make up the difference.

11 So assuming that the legislature agrees with our  
12 increase that we believe is going to happen because that's  
13 what's been going on for the last three years, rather than  
14 being cut to three percent, we should see the increases  
15 towards subsidies in our overall budget cost so that we can  
16 continue to fund our plans.

17 And then finally the Carson Tahoe issue, at the  
18 last Board meeting, the PEBP Board directed staff to release  
19 an RFP to get a secondary network that would include the  
20 Carson Tahoe Hospital and providers under their umbrella.  
21 That RFP is being worked on. We're hoping to release it in  
22 the early part of February of 2025. During that time, I've  
23 also had contact with Carson Tahoe.

24 Specifically Melissa Williams has called me or  
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1 has e-mailed me, and they have agreed to extend their  
2 existing contract to the end of the calendar year, so  
3 December 31st, 2025, to allow sufficient time to get the RFP  
4 released and then to complete their implementation process  
5 once a new vendor is selected. So, there will be some  
6 outreach probably from Michelle Weyland, our CFO, to request  
7 members to sit on the evaluation committee.

8 And, finally, for the moment, the Board meetings  
9 will be held virtually until the end of the session. Right  
10 now, session, of course, ends in the beginning of June. We  
11 may have the May 2025 meeting in person if we are close to  
12 being done with PEBP business, but we will let the Board and  
13 the public know if there's any changes there, but currently  
14 we are looking at March and May also being virtual. And with  
15 that, I'll take any questions.

16 CHAIRWOMAN GRIMMER: Is there any discussion?  
17 Okay. Seeing none, I'll close Agenda Item Number 6 and move  
18 on to Agenda Item Number 7, discussion and possible action to  
19 continuing to offer HMO and EPO options. Celestena Glover  
20 for possible action.

21 MS. GLOVER: Thank you. This is Celestena  
22 Glover. Before you is the summary of the EPO and HMO plan  
23 sunset. We presented this originally in September. The  
24 Board asked that we come back with additional information,  
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1 which Segal has put together a presentation to -- to provide  
2 that additional information.

3 That report was sent to the Board members in  
4 December so that they would have time to actually review it  
5 before this meeting. There's a lot of discussion about  
6 whether or not this should happen or shouldn't happen. I  
7 understand that there's concerns. But if you will look at  
8 the report that Segal put together, it does show that the  
9 majority of those providers are in our network anyway.

10 In addition to that, with the RFP for Carson  
11 Tahoe, we don't know if we'll pick up additional providers  
12 through that process. So, we are looking at trying to make  
13 the transition should the Board approve it as smooth as  
14 possible, and we are taking into consideration the concerns  
15 that our members have.

16 We have released an RFP for the HMO because the  
17 one that we currently have is expiring at the end of this  
18 plan year, which is June 30th, 2025. We have results of that  
19 RFP. They will be discussed in a closed session if the Board  
20 has questions. None of that can be discussed in this open  
21 meeting at this point. So, if there are questions, we will  
22 need to close the meeting to the public and only have the  
23 Board and the appropriate vendors in that meeting, and that  
24 will be Segal, as they do our analysis of the results, so.

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1                   With that, I can turn it over to Segal to talk  
2 about their presentation.

3                   CHAIRWOMAN GRIMMER: Thank you.

4                   MR. WARD: Good morning. This is Richard Ward.  
5 Sound check, am I coming through okay?

6                   MR. HOPKINS: Yes, you are, Richard.

7                   MR. WARD: Can I share the slide deck? If  
8 everybody has their own copy would be preferable.

9                   MR. HOPKINS: Actually, I think it would be  
10 better if you shared it so I pin the ASL interpreter on the  
11 top corner of it.

12                   MR. WARD: Let's see if I can do that.

13                   MR. HOPKINS: No problem. Thank you, Richard.

14                   MR. WARD: Okay. Is that showing for everybody  
15 okay?

16                   MR. HOPKINS: Looks good on our end, Richard.  
17 Thank you.

18                   MR. WARD: All right. Thank you. Good morning  
19 to Board members and staff and anybody in the public that is  
20 attending the meeting.

21                   I'm gonna start off here with a review of some of  
22 the materials that we have discussed in prior meetings. The  
23 first slide here is review of the current plan designs for  
24 the four plan options with the understanding that the EPO and  
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1 the HMO are offered on or priced on a blended basis when --  
2 when employees are -- when members are making plan  
3 selections.

4 The EPO and the PPO, I want to point out, are  
5 primarily co-pay driven. They're not -- there are -- there  
6 are some elements that have co-insurance, in particular  
7 inpatient hospitalization. And then when there's lab  
8 screenings for other diagnostic services that are tied to --  
9 to a surgery or an office visit, those are subject to the  
10 deductible, if there is one, and co-insurance. Whereas, the  
11 HMO, almost everything is co-pay driven.

12 The actuarial value in the first line shows that  
13 the low deductible PPO and the EPO have very similar overall  
14 plan values. And just as a reminder, the actuarial value is  
15 a measure of the total, the portion of total costs paid by  
16 the plan.

17 So, just as an example here, the low deductible  
18 PPO has about an 85 percent actuarial value. What that means  
19 is that for every thousand dollars of total costs, the plan  
20 pays \$852, and the member pays the remaining \$148 in -- well,  
21 there's not a deductible but in co-pays, co-insurance and  
22 that's on average across the whole plan. Of course,  
23 out-of-pocket amounts and levels will vary based off of  
24 utilization and circumstances.

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1           And at the bottom, we -- we show the employee  
2 only premium with the CDHP plan having the lowest premium at  
3 about \$55, the PPO at \$85 and then the EPO and HMO blended to  
4 be about \$100 higher, at about 181 bucks.

5           The recap of summaries, also material that we've  
6 reviewed in prior meetings. The EPO and HMO is the highest  
7 cost option. I don't think that's news to anybody. This is  
8 primarily driven by the EPO currently. The cost in the EPO  
9 are higher than in the HMO. The HMO premiums have been  
10 contractually suppressed. The claims costs that we see  
11 reported by Health Plan of Nevada are higher than the  
12 premiums, and we expect that over time that's not  
13 sustainable. That will -- the premiums will catch up, that  
14 no insurance company is going to subsidize any groups costs  
15 over a prolonged period of time.

16           And reviewing the premiums, we just reviewed  
17 that. The EPO and HMO premiums are roughly two times the  
18 premiums of the PPO and about three times the premiums in the  
19 CDHP, and those are the employee premiums.

20           And we do have ongoing migration over the last  
21 couple of years from both the EPO and the HMO from the low  
22 deductible health plan. There has been more migration from  
23 the EPO, but the HMO enrollment is also declining year over  
24 year.

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1           And as we reviewed, the low deductible PPO is the  
2 most efficient plan. So, just as a reminder, that's when we  
3 consider costs, plan design, value and then the health risk  
4 in the -- in the group in each of the plans. And the low  
5 deductible PPO shows to be in aggregate, the plan that  
6 provides care in the most efficient manner. And the EPO is  
7 the least sufficient plan of the -- of the three self-insured  
8 plans.

9           This is a review of cost over the last several  
10 years for the EPO, at the top, on a PMPM basis. For the  
11 self-insured plans, we have it netted out pharmacy rebates,  
12 so these are net claims cost. For the HMO, we are using the  
13 premium because that's the cost to PEBP is the premium.

14           And the top line, the light green is the EPO.  
15 The darker blue navy line, just below that is blended between  
16 the HMO and the EPO. And then the bottom three lines grouped  
17 together, that's the CDHP, the low deductible health plan and  
18 the HMO.

19           Over the next several years, we expect the low  
20 deductible health plan and the CDHP to trend forward at  
21 market trends and have a flatter trend line than the EPO and  
22 the HMO if those continue to be blended, and this is because  
23 we expect the suppressed premiums of the HMO to increase at a  
24 higher rate than the other plans to catch up to the cost of

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1 the HMO. And then after a few years, we expect the EPO and  
2 the HMO to be comparable in cost. And so that's the gray  
3 line there in the middle is the HMO increasing at a more  
4 rapid rate than the other plans.

5 And the dark blue or navy line there in the  
6 middle between -- between the green and the gray line, that's  
7 the blended rate, so that's also going to increase at a  
8 higher trend than the other -- than the other two plans.

9 At the September Board meeting, there was  
10 discussion and questions from the Board about provider access  
11 and disruption, and so we worked with UMR and with Health  
12 Plan of Nevada to review HMO experience and if the HMO or the  
13 EPO are sunsetted, what would be the disruption, and then  
14 what would be the access or the numbers that were in those  
15 plans.

16 So, the first comment is that the CDHP, the low  
17 deductible PPO and the EPO all use the same network, so  
18 there's no disruption for the EPO sunsetted, to have access  
19 to the same providers that people in the EPO have today, with  
20 the addition of access in non-network providers that the EPO  
21 doesn't -- doesn't currently cover.

22 For the HMO, we reviewed current members,  
23 current and current utilization and the providers that were  
24 being -- that were utilized by people in the HMO, and those  
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1 were compared against the providers in the UHC network, and  
2 we see that there's significant overlap. That's the table in  
3 the middle. So, we see that the vast majority, while all  
4 hospitals are in both networks, almost all PCP's and then  
5 almost all specialists.

6 There are actually a few providers that aren't in  
7 that HMO network that are in the UHC network, so there would  
8 be a net enhancement of access, just looking at the raw  
9 numbers here. We would lose three PCP's from the HMO network  
10 but gain an additional 15 PCP's.

11 And then -- and then looking at the bottom here,  
12 just a measure of access, which is we may use the term geo  
13 access. This is looking at where each member lives and do  
14 they have access, does that particular member have access to  
15 a hospital within 15 miles of where they live? Do they have  
16 access to two primary care physicians within ten miles of  
17 where they live and then two specialists, specialty  
18 physicians within 50 miles of where they live. And between  
19 the HMO network and the UHC network, the access is virtually  
20 the same. In all cases is over 99 percent, which is a very  
21 good -- a very good result when looking at this sort of  
22 access measurement.

23 So, next we look at the particular patients that  
24 were using the -- that would be disrupted or are using HMO  
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1 network providers that would no longer be in network. And  
2 we -- we see that there are ten patients that utilize the  
3 PCP's that would not be in network in the UHC network, but  
4 only five of those patients are still enrolled in the HMO.

5 We have five individuals that are utilizing or  
6 have utilized providers that we expect would become out of  
7 network if the HMO is sunsetted. And so we can see the  
8 number of claims associated with that and -- and this is  
9 measured as of November 1st, so a few months have passed  
10 since then. And, but we see there would be five, five  
11 members that would be -- that would be potentially affected  
12 by this change.

13 And in situations like this, I don't want to  
14 speak for Health Plan of Nevada or UMR or UHC, but often  
15 times when there's a move or transition like this, the --  
16 there will be an outreach to the providers that are currently  
17 not participating in the UHC network to see if they want to  
18 contract with UHC.

19 And then we can see below, there's -- the table  
20 below is for specialty providers, specialty physicians and  
21 there's -- there's most of the -- 30 percent of the claims,  
22 not most, but a good number of the claims are for sleep  
23 studies. And we have, you can see the other specialists that  
24 are utilized that are not in the UHC network, and this --

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1 this represents the number of patients is -- there -- there  
2 are -- I believe, there are 49 patients and 94 claims  
3 associated with this utilization.

4 So, again, I would expect, not to speak on their  
5 behalf, but I would expect UHC may reach out to these  
6 specialists to attempt to get them to contract with the UHC  
7 network if the HMO is sunsetted.

8 At the September Board meeting, there was also  
9 question about what do the out-of-pocket costs look like or  
10 what would they be between the different plans? So, we  
11 developed a couple of straw person scenarios here of  
12 particular instances.

13 We looked at claims data in the detailed claims  
14 data that we have, and we used some specific real life  
15 examples here to review what the members' out-of-pocket would  
16 be for a given year or for a given year, accounting for both  
17 the premium and the member cost share associated with  
18 coverage, which would be deductibles, co-pays, co-insurance.

19 And we developed four distinct scenarios and then  
20 looked at them for employee and family coverage at different  
21 levels of cost. And we -- we did not include the HMO here  
22 for a couple of reasons. One, we don't have the detailed  
23 claims data for the HMO that we have for the other plans.

24 So, we wouldn't be able to in the same way extract an actual  
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1 case study or an exact -- or an actual example that occurred.

2 And we -- we also in our opinion that the benefit  
3 levels are comparable and with both, between the EPO and the  
4 HMO, and with both plans being co-pay driven, the results we  
5 think would be very comparable. And, actually, the HMO would  
6 have slightly lower out-of-pocket than the EPO.

7 So, the first one that we have here is someone  
8 who only had routine care, so they have routine preventative  
9 care. They have an annual physical, the recommended  
10 preventative screenings, and so they really have no  
11 out-of-pocket because those sort of services are covered at  
12 100 percent, so they only have the annual premium. And so  
13 this first example here for employee only coverage is really  
14 just comparison of the monthly premiums annualized.

15 For family, same thing, annual physical, two  
16 annual physicals, we assumed a family of two parents and  
17 multiple children, so two annual physicals, two well child  
18 visits and then the relevant preventative screenings for  
19 their age and overall and health risk and demographic. So,  
20 again, no member cost share, no out-of-pocket associated with  
21 those services.

22 Next, we reviewed examples of what we would  
23 consider to be low to moderate care. So, the next step up is  
24 where there is some member cost share. And so for the

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1 employee, not only did they -- did the employee have an  
2 annual physical and the applicable preventative screenings,  
3 but they're also on two maintenance medications, one brand,  
4 one generic, and they had one emergency room visit, and so we  
5 ran that through the cost share and reviewed the  
6 out-of-pocket and the claims data. And -- and due to the  
7 deductible and co-insurance nature of the CDHP, they would  
8 hit the maximum out-of-pocket for the year and then add that  
9 to the -- to the premium.

10 And at this level, with this example, the CDHP  
11 would have the highest out-of-pocket once you combine the  
12 premium and the out-of-pocket associated with care, and then  
13 much lower out-of-pockets for the low deductible PPO and the  
14 EPO. And once -- once combined with the premium, the low  
15 deductible PPO has the lowest total spend for the year.

16 And then for family coverage, where the layering  
17 on from the prior example, some additional care and service  
18 needs, so annual physicals, annual well child visits,  
19 preventative screenings, a couple of ER visits, urgent care  
20 visit, one outpatient surgery and then multiple medications  
21 for this -- for this family. And, again, the CDHP has the  
22 highest at total spend. The low deductible PPO has the  
23 lowest. And the EPO is right in the middle, with the EPO  
24 having the lowest member cost share, not considering premium,

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1 so the lowest cost of care in deductibles, co-pays and so on.

2 Okay. So, now moving up one, maybe one more  
3 layer, where there's an inpatient stay for the -- that's  
4 added to the care needs for single employee. And, again, the  
5 CDHP is the highest total spend, has the highest total spend.  
6 The low deductible PPO has the lowest. And the EPO,  
7 consistent with the other examples, has the lowest member  
8 cost share but the highest overall total spend. And at  
9 this -- at this level of care and cost, the total cost for  
10 the three plans, there's less separation between them from  
11 low to high.

12 And for family coverage, there, added a normal  
13 maternity and newborn delivery to the care needs. And in  
14 this instance, the family hits the out-of-pocket for the  
15 CDHP, and the out-of-pocket is not met for the low deductible  
16 PPO or the EPO and similar results for the low deductible PPO  
17 has the lowest total costs once you consider the premium.  
18 The CDHP has highest total cost. And the EPO has the lowest  
19 cost associated with care, the out-of-pocket associated with  
20 care needs with deductibles, co-pays and other cost share  
21 mechanisms.

22 And then we look at high utilization where the  
23 care needs in all plans result in the member out-of-pocket  
24 being reached. And so when the member out-of-pocket is maxed

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1 out in all plans, the CDHP is actually the lowest cost plan  
2 because the maximum out-of-pockets for the three plans are  
3 very comparable, and the CDHP has the lowest premium. So  
4 members that expect to reach their max out-of-pocket in a  
5 given year would be better off overall by choosing the CDHP  
6 plan.

7 And I do want to mention, we have it in a  
8 footnote here, but this doesn't consider that some of the  
9 member cost share of the CDH plan would be offset by an HSA  
10 balance if the member has one. So, this is just strictly  
11 their exposure. So, in the same old coverage, if they got  
12 600 dollar HSA allocation for the year, that 4,000 actually  
13 would be 4,400.

14 At the September Board meeting, there were  
15 questions about the number of members that reached the  
16 out-of-pocket. And so we coordinated with -- with UMR for  
17 the three self-insured plans, and we see that in the CDHP  
18 because of -- largely because of the co-insurance we have.  
19 And the higher cost share, about 36 percent reached the  
20 out-of-pocket. The blue here, the 15 percent is single  
21 coverage. And 21 percent is from the other three tiers for  
22 employees that cover family members, whether it's family or  
23 plus one or plus spouse, plus child, plus spouse.

24 And the low deductible health plan, the EPO, the  
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1 portion that is hitting the max out-of-pocket is lower, and  
2 that's largely due to that coverage being more co-pay driven.  
3 So, members, just for the same level of care have less  
4 out-of-pocket for the same -- for the same services, and so  
5 their out-of-pocket cost will accrue at a slower rate towards  
6 a max out-of-pocket, so fewer, a lower portion of the people  
7 in those plans hit their max out-of-pocket.

8           If the EPO and HMO are sunsetted, we have had  
9 some discussions about revising the low deductible PPO as the  
10 -- as the other plan, along with the CDHP. And so for some  
11 perspective, we reviewed plan designs and premiums for PPO's  
12 and high deductible health plans for other comparable states  
13 in the west. And the reason that these states were selected  
14 is that in the west, they are the -- they are the most  
15 similar to Nevada.

16           And by that, I mean California, Oregon,  
17 Washington and Hawaii have Kaiser, and Kaiser has a --  
18 because of Kaiser, the healthcare markets in those states are  
19 very different, and there's a lot of insured plans. For  
20 example, in California, you have very large entities that are  
21 100 percent insured. The City of Los Angeles is 100 percent  
22 insured for zero and for the other carriers if they have, so  
23 it's a different healthcare market than in Nevada.

24           And also the state health plans in California,  
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1 Oregon and Washington and Hawaii are significantly larger  
2 than in Nevada. PEBP is comparable in size to the other  
3 state health plans in Alaska, Arizona, Colorado, Idaho,  
4 Montana, New Mexico, Utah and Wyoming, and those states are  
5 largely also self-insured. So, you have comparable size.  
6 You don't have the same HMO and particular Kaiser influence  
7 in the markets. So, in comparing the plan designs and the  
8 employee premiums with Nevada and with PEBP, we think is --  
9 was -- is a good same fruit sort of comparison.

10 And since we're using this as perspective to  
11 consider what a re-imagined or redesigned PP would look like,  
12 we didn't include HMO's in this benchmark here.

13 I also want to mention that when reviewing --  
14 when reviewing market data or benchmark data, it's done as a  
15 snapshot in time. And, so we're having a discussion about  
16 what the Board and what PEBP might do for Plan Year '26, and  
17 you're thinking about what those benefit design features can  
18 look like and what the premiums can look like next year.

19 What we're looking at here are the benefits of  
20 the cost that were in place in calendar year '24. So, those  
21 other states are also thinking about what they're going to do  
22 in 2026, and so it's a bit of a moving target. So, I think  
23 that's helpful -- that's helpful context here when reviewing  
24 healthcare compares with -- with your other peers, your other

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1 peer states.

2 And so we looked at, there's some highlights,  
3 some monthly premiums. The premiums for the -- for employee  
4 coverage for PEBP are, let me just provide some bragging here  
5 on what this graph and the table shows. So, we're showing  
6 the minimum, the maximum and the average for -- for all four  
7 tiers. And single coverage for the low deductible PPO is a  
8 little bit below the average. The average is in the far  
9 right column, so \$84 versus \$94. So, it sits in the middle  
10 between the minimum and maximum when you're the average.

11 And for the other tiers, the employee plus spouse  
12 is higher than the average. And employee plus children is  
13 about on average. And employee plus family is higher than on  
14 average, just have these, showing these as actual dollar  
15 amounts and then a graphical representation.

16 We also looked at deductibles, and there's only  
17 one state that has a separate pharmacy deductible. So, we  
18 looked at overall deductibles on a combined basis. And on a  
19 combined basis, the deductible on average is \$550. It's gone  
20 down about two-thirds of the way in that table on the far  
21 right. And the low deductible health plan has a zero dollar  
22 deductible, so it's lower than even the minimum for the  
23 states that we reviewed.

24 The maximum out-of-pocket, there are some states  
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1 that have a separate maximum out-of-pocket, but we -- so we  
2 reviewed on a combined basis so that we're looking at the  
3 total annual exposure that a member might have. And going  
4 down to the bottom there, we have individual family  
5 out-of-pocket max comparisons. And for the low deductible  
6 PPO is \$4,000. That's a little bit below the average, which  
7 is about 4,500. You can see the range there is 2,750 to  
8 7,350. And then for family, at 8,000 for PEBP, that's a  
9 little bit lower than the average, which is about 9,800. You  
10 can see the range is 5,500 to 14,700.

11 We also looked at office visit. We looked at  
12 co-pays for office visits, urgent care and emergency care.  
13 And overall the -- for physicians, the co-pays are in line  
14 with the average for the market. So, the table on the left,  
15 \$30 for PCP's compared to a 26 average, specialist 50 versus  
16 an average of 44 and urgent care and ER visits are quite a  
17 bit higher than what we see in the market, in the peer group,  
18 and urgent care is actually higher than the maximum for peer  
19 states.

20 Next, we looked at pharmacy, and, generally,  
21 other states also utilize co-pays. So, all of the PEBP plans  
22 or all of the PPO plans, the non CDH plans use a primarily  
23 co-pay based design per cost share for outpatient pharmacy.  
24 And so for generic medications, you see right in line, ten --  
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1 \$10 currently compared to an average of 11, and there's not  
2 much variation in the market, ten versus 15, a minimum of  
3 ten, so a maximum of 15, with the average being 11. Most of  
4 these states are at the 10 dollar level.

5 We started to see some more variation for brand  
6 medications. So, PEBP is at \$40 for formulary, for preferred  
7 brand compared to an average of 34 and then 75 for  
8 non-preferred or non-formulary compared to about 60 bucks in  
9 the market. And then in specialty, PEBP is a little more  
10 favorable than the average.

11 Next line just pulls all of that together into a  
12 line by line comparison and then adds the, including the  
13 premium, including the premium at the bottom, so just a  
14 review for deductible, for the low deductible PPO compares  
15 favorably since there isn't one.

16 The out-of-pocket maximum in general, it slots in  
17 near the mid point, near the averages for the -- compared to  
18 those other states. The office visit, co-pays for PCP and  
19 specialist are also fairly in line with the averages. Urgent  
20 care and ER visits are higher, including drug co-pays compare  
21 pretty well with what we see on average from the other  
22 states.

23 And then for the premium, you're showing a single  
24 premium here, that's pretty comparable to the average, and  
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1 there's quite a bit of variation in the market among those  
2 plans from 30 to about 150 dollar for their highest value  
3 EPO.

4 We also looked at CDHP plans and the deductible.  
5 We just have one slide here to share the line items here.  
6 The annual deductible at \$1,600 currently for PEBP is just  
7 below the average of about \$1,800 for the peer group. And  
8 not all states, all of the other states have high deductible  
9 health plans. I'll comment there.

10 The HSA, the account balance, the account  
11 allocation per year at \$600 for PEBP is right in line with  
12 the average for other states. Co-insurance is, compares  
13 favorably well. The out-of-pocket maximum is a little bit  
14 below the average. The office visit is co-insurance driven,  
15 like the others are, that's right in line with the average,  
16 same with urgent care and emergency room visits.

17 Interestingly, though, PEBP is a bit of an  
18 outlier with drug coverage in the CDHP plan, being  
19 co-insurance driven. So, PEBP, the plan design in PEBP is  
20 co-insurance up and down the line, which is very straight  
21 forward and consistent with a lot of other CDHP plans in the  
22 market in general. But the states in the west that have high  
23 deductible health plans utilizes a co-pay driven benefit.  
24 So, if it's -- but that's after meeting the deductible. So,  
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1 they just have co-pays after meeting the deductible instead  
2 of co-insurance. And then the -- then the premiums range  
3 from zero to \$80 with an average of 30 for single coverage  
4 and PEBP's premium is \$55 currently.

5 The next slide, so with that context of PEBP's,  
6 the current PPO and the CDHP compare with other states, we  
7 reviewed the current plan designs for the PPO and considered  
8 how those could be updated to consider a number of -- a  
9 number of factors.

10 So, one factor is that if the EPO and the HMO are  
11 sunsetted, then those, with those plans being largely co-pay  
12 driven, the Board has expressed concern about having plans --  
13 having plans that or not having a plan option, excuse me.  
14 Not having a plan option that is co-pay driven or heavily  
15 co-pay driven or almost exclusively co-pay driven.

16 So, the PPO plan designs, one of them, the EPO  
17 Option 1 has a larger co-pay. It is more co-pay driven. So,  
18 in particular for primary care and specialist office visits,  
19 about halfway down, the 30 and 60 dollar co-pays that are in  
20 this proposed plan design would also cover any associated  
21 testing, labs, scans, et cetera.

22 So, if you go for an office visit and the  
23 physician orders a diagnostic test or the physician orders a  
24 diagnostic test to further investigate what conditions he

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1 might or symptoms he might be presenting or trying to  
2 determine what the course of treatment would be in PPO Option  
3 1, those would not incur additional cost. So, there wouldn't  
4 be a co-insurance component associated with those additional  
5 tests and screenings with this benefit design.

6 Also compared to the current low deductible  
7 health plan, inpatient hospital would be, rather than  
8 20 percent co-insurance, would be a 750 dollar co-pay. So,  
9 this mirrors the HMO design and the EPO design that for  
10 inpatient has a fixed dollar benefit.

11 In outpatient surgery, currently the PPO has a  
12 500 dollar co-pay and this PP -- the PPO Option 1 and PPO  
13 Option 2 also have a co-pay, but there's a difference in the  
14 benefit between the HMO and the EPO. The HMO incentivizes  
15 utilization at ambulatory facilities, so non-hospital  
16 surgical centers, which are considered to be more efficient  
17 sites of care. So, there's a co-pay difference that aligns,  
18 mirror -- that mirrors the differential and the current HMO  
19 that does not exist in the PPO currently.

20 So, if you're having a joint replacement, as an  
21 example, and you can do so on an outpatient basis, then the  
22 -- and you can do so not in a hospital setting then the  
23 co-pay will be lower if you choose to go to a surgical  
24 center.

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1           Now, this, I'll also highlight the top here, the  
2 deductible PPO Option 1 maintains a zero dollar deductible  
3 that the current low deductible health PPO plan has. PPO  
4 Option 2 introduces a 500 dollar deductible, and that's  
5 offered for consideration for a few reasons. One, we see in  
6 the peer group data that the other PPO's have a deductible,  
7 so want to develop an option here that includes, that  
8 introduces a deductible.

9           Also, differential here is the out-of-pocket  
10 maximum for these plans. Currently, the EPO and the HMO have  
11 5,000 dollar maximum out-of-pocket, so we're maintaining  
12 that. So, that would be an increase compared to the low  
13 deductible PPO.

14           In PPO Option 2, the 30 and 60 dollar co-pays  
15 does not cover any additional associated testing, labs, live  
16 scans, et cetera. That would be covered by the deductible  
17 and the co-insurance. So, there is that, that is I think a  
18 material difference here that has been a topic of discussion  
19 over the last several Board meetings. And then the rest of  
20 the coverage items are identical between the plans.

21           Now, the difference in the deductible, there  
22 being a deductible and how additional testing, labs, scans,  
23 et cetera, how that's covered between the two plans. One  
24 being covered by deductible and co-insure or subject to

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1 deductible and co-insurance and the other being covered by  
2 the co-pay. Those differentials are -- I mean, there's a  
3 cost associated with that. The -- and that difference, going  
4 to the top line there, that difference is about four percent,  
5 so 87.1 compared to 82.8 actuarial value or plan value. So,  
6 the plan would pick up about four percent more in total costs  
7 between these two PPO options.

8           And PPO Option 1 is a richer plan design than the  
9 current low deductible health plan. And PPO Option 2 is a --  
10 is a lower only plan design.

11           I skipped over to CDHP to focus on the PPO, but  
12 there are -- there will be -- there should be some changes to  
13 the CDHP in the deductible -- well, in the deductible to  
14 align with IRS requirements for the plan to continue to be  
15 qualified for health savings accounts to be an HSA qualified  
16 plan. That's an annual exercise here for PEBP as the  
17 required deductibles by the feds are indexed and make change  
18 from year to year, PEBP's deductibles mirror those changes,  
19 and that's just a regulatory driven change from year to the  
20 next.

21           We also looked at the multi-year projection for  
22 introducing or transitioning, sunseting the EPO and the HMO  
23 and then replacing the low deductible PPO with either one of  
24 these two options. Looking at PPO Option 1, would happen

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1 with PPO Option 1, there's a small amount of savings year  
2 over year. So, for Plan Year '26, there would be about half  
3 a million dollars in savings, and that would grow to about  
4 2,000,000 compared to a baseline projection. So, that's --  
5 that's largely due to the enhanced benefit design in the PPO  
6 Option 1 compared to the current low deductible PPO.

7 There would be some savings largely from  
8 sunseting the HMO. The premiums include a fair amount of  
9 retention, higher admin level, so margin for -- for profit  
10 and for risk. That's common. That's -- that is always the  
11 case with insured premiums.

12 PEBP would also get access to pharmacy rebates or  
13 enhanced pharmacy rebates, and so there's some savings that  
14 come with sunseting the HMO and then there would also be  
15 reduced trend for the HMO because, remember, we expect that  
16 to catch up over time.

17 And then for PPO Option 2, we would see more  
18 savings largely due to, so there's still the same savings for  
19 sunseting the HMO. And then the PPO Option 1 has a leaner  
20 plan design, and so there's savings associated with that plan  
21 design differential.

22 We also expect there to be savings as people  
23 migrate to the -- to the PPO, which has shown to be the more  
24 efficient plan of the three self-insured plan options. So,  
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1 the PPO Option 1, we would see about 15,000,000 in expected  
2 savings in Plan Year '26 and then that growing to about  
3 22,000,000 over -- over the five-year period here through  
4 Plan Year '30, excuse me.

5 This assumes that employee premiums would be set  
6 in a manner comparable to historic practices. So, where the  
7 prior slides, these figures are net and cost, which are net  
8 of the employee premiums, and the employee premiums are  
9 driven by plan design, as well as funding from the state, so  
10 the AGIS and REGI, which are the funding mechanisms for  
11 retirees, and active employees are being considered right now  
12 for the next biennium and have not been finalized yet.

13 So, that -- that is a key driver of what the  
14 employee premiums will be, and then also the plan design  
15 that's decided by the Board of PEBP. The impact, we expect  
16 that the -- if the EPO and HMO are eliminated, the CDHP  
17 premiums will be comparable to what they are now and what  
18 they would be without sunseting the EPO and the HMO, which  
19 would still be within the range of the peer group.

20 And for low deductible health plan, we do think  
21 the premiums would increase because the higher -- there's  
22 higher cost members in the EPO and the HMO, would largely  
23 migrate to the low deductible health plan which would  
24 increase the cost for that plan, but we think that that may

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1 be a moderate -- may be a moderate increase and would still  
2 compare well against a peer group.

3 And I'm mentioning often how PEBP compares with  
4 the peer group, how I want to acknowledge and comment that  
5 really, PEBP's situation is PEBP's situation. We're just  
6 providing -- shouldn't necessarily make decisions based off  
7 of what your peers are doing, but we do think it's helpful  
8 context for, to see what's going on and what other states are  
9 doing, how they price their plans and how they design them.

10 So now back to out-of-pocket considerations here.  
11 We have PPO Option 1 and PPO Option 2 compared to the CDHP,  
12 the low deductible PPO and the EPO. And for single and  
13 family, we just looked at case three here, the high moderate  
14 utilization, which is the, excuse me, the next to high, not  
15 the highest one, but the one just below that.

16 And for PPO Option 1, the number of cost share is  
17 lower than for the low deductible, but it is a little bit  
18 higher than the EPO. And then since PPO Option 2 has a  
19 leaner plan design, the out-of-pocket is higher than PPO  
20 Option 1. And, but both of them have a lower total spends  
21 based off of these estimated premiums. We don't really know  
22 yet what the premiums are going to be until we know what the  
23 funding is from State.

24 And, then based off our current estimates, those  
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1 two plans would have -- either of those two plans would have  
2 the lowest total out-of-pocket. And then for family  
3 coverage, we see much the same. PPO Option 1 is lower, in  
4 fact, both PPO's are lower than the current low deductible  
5 PPO but higher than the EPO from a number cost share  
6 perspective and then from a total spend perspective, both of  
7 them would be lower than any of the current two plans once  
8 you consider premiums and number out-of-pocket.

9 And that's the -- that concludes the prepared  
10 materials. I'll pause for questions and discussion. And let  
11 me know if I should take down the slide.

12 CHAIRWOMAN GRIMMER: Board members, are there any  
13 questions?

14 MR. HOPKINS: Richard, you can bring down the  
15 slide, if you would like.

16 CHAIRWOMAN GRIMMER: Yes, Michelle. You're on  
17 mute, Michelle.

18 MEMBER KELLEY: Sorry. Thank you. I do have a  
19 lot of -- I would like to see the results of the RFP before I  
20 -- I have a lot of questions, but many of them are predicated  
21 on understanding what the RFP looks like. But I'm also  
22 conscious that Executive Officer Glover had her hand before  
23 me, and I wonder if she had something to add to the  
24 conversation before that.

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1 CHAIRWOMAN GRIMMER: Go ahead.

2 MS. GLOVER: Thank you. This is Celestena  
3 Glover. So, I just wanted to include additional comments to  
4 the presentation that Mr. Ward gave. What we are proposing,  
5 depending on obviously what the Board decides, if we sunset  
6 the EPO and the HMO, our recommendation is to consider Option  
7 1, so there is no deductible in the new low deductible PPO  
8 plan.

9 Low deductible is a misnomer because there is no  
10 deductible in that plan, so we're proposing that we just  
11 refer to it as the PPO. In addition, if the Board opts not  
12 to sunset either plan outside of the required change to the  
13 deductible in the CDHP, which the Board did approve in  
14 September in order to maintain the HSA qualification, that we  
15 make no changes to plan design for the low deductible, the  
16 EPO or the HMO outside of benefit changes that might have to  
17 have happen should the funding not come through from the  
18 State. Because we don't receive the funding necessary to  
19 support the plans. Obviously, Premium will go up. So, we  
20 just have to make sure that we keep that in mind.

21 Also, decisions cannot be deferred because we  
22 need to set the rate-setting process. So, regardless of the  
23 decision, whether it's sunsetting the plans or not, we need  
24 to make that decision today so we can get the rates set

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1 because we need to bring those back to the March meeting.  
2 So, those are just some considerations.

3 To get the questions answered on the results of  
4 the RFP for the HMO, that will need to be done in the closed  
5 session. And at the same time, we'll review the Medicare  
6 Exchange RFP results, as well, and that's Agenda Item 8.  
7 We'll do that all in one closed session, so we don't have to  
8 close, open and close.

9 So, with that, I will get off of here.

10 CHAIRWOMAN GRIMMER: Okay. So, for Agenda Item  
11 Number 7, do we have a motion to approve? Yes, Board Member  
12 Kelley.

13 MEMBER KELLEY: Thank you. Michelle Kelley for  
14 the record. So, firstly, I have a comment. You know, I do  
15 want it on record, you know, I want to thank Executive  
16 Officer Glover, the PEBP staff and Segal for bringing forth  
17 this item. We have to -- as a Board, we have to explore all  
18 options to keep the PEBP program healthy and viable for our  
19 participants. But I also want to thank all of our  
20 participants.

21 For the last three months, including Christmas  
22 Day, I have received public -- public comment directly from  
23 participants, explaining, you know, just their concern about  
24 the potential loss of the HMO. I am the NSHE south  
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1 representative, and that's where most of my -- you know, the  
2 participants that have outreached me have come from. And  
3 it's really, honestly, it's been quite overwhelming the  
4 number of public comments I've received. And I want to thank  
5 our participants for that because I do think it's important  
6 that they are engaged in these decisions because everything  
7 we do impacts them. So, I do appreciate everyone taking  
8 their time and sharing their stories.

9           You know, and, obviously, I've spent a lot of  
10 time because every time I've had these public comment, I've  
11 re-engaged the issue and, you know, understanding both  
12 staff's point of view and participants needs. But I do think  
13 this is a major shift in direction for PEBP. So, I have a  
14 lot of concerns. I have questions about the presentation,  
15 but I do think my concerns are really not in the detail of  
16 the presentation.

17           But, you know, I mean, one of the big gaps for me  
18 in the presentation is we actually compete for employees,  
19 both the State of Nevada and NSHE, with city and local county  
20 government and so we don't -- I don't really know what they  
21 offer their participants. But certainly in the last few  
22 years, I think, that's where many of our skilled, highly  
23 trained employees have gone to, you know, not just because of  
24 health insurance but for many reasons, but health insurance

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1 is one of their many considerations.

2 So, I would say, you know, for a number of  
3 reasons, I think I've got five, actually I've got seven  
4 reasons after listening to the presentation and public  
5 comment, I am not in favor of sunseting the EPO, HMO this  
6 year.

7 I think, you know, employee morale and employee  
8 needs this year, really important. And I think we've  
9 already -- we're probably going to have a retirement  
10 contribution this year. You know, we've heard from employees  
11 about the continuity of care, just the way they like to pay  
12 for their health insurance, they like to front load through  
13 their premium so that they don't have to deal with billing or  
14 anything like that when they seek services.

15 So, I think that, you know, I think employee  
16 morale and just the cost of living stuff at the moment is  
17 very loud for everybody. And so for that reason, I think  
18 it's a bad time to sunset the HMO and PPO.

19 You know, the other thing that came to light, I  
20 think that really clarified for me during public comment  
21 today is that, you know, we continue to have issues with UMR  
22 and their billing practices and the network access. And, you  
23 know, I saw -- obviously, we saw the disruption. But, you  
24 know, it seems like UMR is not coping with the volume of

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1 business we have right now. So what will adding, you know, 4  
2 or 5,000 participants and all of their payments do to that?

3 You know, we also don't know -- so, there's also  
4 some unknowns now. So, we don't know what the second, what  
5 the out of pay for the second network might show, and that  
6 might actually enhance this conversation and make it a lot  
7 easier.

8 You know, let's see, the legislative session, in  
9 the last two sessions, the legislators have actually  
10 overwritten some of the decisions the Board made due to  
11 public outrage or participant outrage. I don't know what the  
12 right word is but certainly the activism has undercut some of  
13 the decisions we made. And I think just from the volume of  
14 public comment around this issue, I think that the  
15 legislators could override us anyway, and so I think we  
16 should let them know what we're planning for 2027 and see  
17 what they have to say.

18 The next unknown is just something brand new and  
19 that is, I see Stacie in the meeting, but what is the Nevada  
20 Health Authority? How is that going to change the dynamics  
21 here? You know, I have no idea. I don't know if even Stacie  
22 knows that right now but certainly, you know, it's another  
23 aspect of unknown.

24 And then just my last, this is very  
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1 argumentative, so I want to apologize, and then I'm going to  
2 be quiet and let someone else have some air. It is the EPO  
3 that's pushing this conversation. It's the EPO that is, you  
4 know, a very expensive plan that works like a PPO. And, so,  
5 honestly, if we actually have to take the step, then I think  
6 we need to separate. The HMO in the south is viable. Well,  
7 I haven't seen the RFP results. But assuming we have got a  
8 bid and it's acceptable, the HMO is viable, and we could  
9 separate that out.

10 Yes, you know, I'm sorry for northern  
11 participants that there's not potentially a viable HMO there,  
12 but I don't really see why a large geographic center in  
13 Nevada has to be punished because there's not a viable option  
14 in Reno. Thank you very much for your time.

15 CHAIRWOMAN GRIMMER: Thank you.

16 Are there any other comments from the Board  
17 members?

18 MEMBER WEEKS: I have my hand up, Joy. Stacie  
19 Weeks for the record.

20 CHAIRWOMAN GRIMMER: Go ahead.

21 MEMBER WEEKS: I agree with Michelle Kelley. I  
22 think we need to wait. I think there's enough going on  
23 during session. I think something does need to change in how  
24 we purchase healthcare with large carriers across all of our  
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1 markets. I think the opportunities are different now, and  
2 they can be in the next year for state employees, and so I  
3 would support what Michelle said and wait.

4 And I also really appreciated the feedback from  
5 the recipients. I think going forward, we really do need to  
6 think about the needs of our state employees, and I know we  
7 all care about them at this table or we wouldn't be here and  
8 our retirees. But, you know, we have very little to offer in  
9 Nevada, sometimes in salary. And the one thing that we  
10 should be offering is really good benefits. So, I think it  
11 behooves us to wait, get through session, see what happens  
12 with this new authority and purchasing strategy that we can  
13 achieve, maybe a better deal, and I think the Board deserves  
14 a better chance to look at those opportunities.

15 So, I'm gonna stop there, Joy, but that's where  
16 I'm at right now. Thank you.

17 CHAIRWOMAN GRIMMER: Thank you.

18 Any further comments?

19 MEMBER BARNES: Yes. This is Jim Barnes. I'm in  
20 agreement with Stacie and Michelle. I think we should wait.

21 CHAIRWOMAN GRIMMER: Okay. Thank you for the  
22 comment.

23 Bepsy?

24 MEMBER STRASBURG: Hi. This is Bepsy Strasburg.  
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1 I -- I mean, this is the probably the first time I'm going  
2 through the presentation, and I think it's important to let  
3 the participants also be informed in the same way as we are  
4 if there needs to make a change, and I don't think we have  
5 given then the opportunity to understand the ramifications of  
6 their healthcare by any potential change. So, I do not  
7 support making changes at this time.

8 I think that as the other speaker said, we should  
9 wait until the session is over, find out what we are allowed  
10 to do and also give them a heads up of what might be  
11 happening when PEBP goes to present their budget to the  
12 legislature. Thank you.

13 CHAIRWOMAN GRIMMER: Thank you.

14 Okay. So, this item is for possible action.  
15 Counsel, do I need to take a vote on tabling the item?

16 MS. GLOVER: Can I make a comment?

17 CHAIRWOMAN GRIMMER: Yes. Go ahead, Executive  
18 Director.

19 MS. GLOVER: So, this is Celestena Glover. We  
20 would need to actually vote to not sunset the plans versus  
21 tabling it because tabling it makes it sounds like we're  
22 gonna bring it back before the plan year even starts, which  
23 we can't do. There's no time for that.

24 I also, depending on whether or not we close the  
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1 session to talk about the RFP results, one of the things I  
2 will need to move forward, is that the Board would need to  
3 approve moving forward with an award of a contract, which  
4 would be done in the public, in the open meeting, and also  
5 allow me, as the Executive Officer, to finalize any  
6 negotiations and to sign the contract so we can get it to BOE  
7 by the next deadline. So, there's a couple of things that  
8 need to happen in there. It's similar to what is needed in  
9 the Agenda Item 8. So, whatever the motion is, needs to  
10 include those things. Thank you.

11 CHAIRWOMAN GRIMMER: Thank you. Do I have a  
12 motion?

13 MEMBER KELLEY: It's Michelle Kelley here. I  
14 will make an attempt to start a motion and if everyone --  
15 anyone wants to make a friendly amendment, please feel free  
16 to do so so that I capture everything that Executive Officer  
17 Glover requested.

18 Okay. So, my motion -- I make a motion that  
19 we -- we continue to offer the HMO, EPO plan through Plan  
20 Year 2026, right, 2026, on the condition that we have a  
21 viable -- that we can enter into a viable contract with the  
22 highest, with the selected bidder for the RFP for the HMO  
23 product in the south. And as part of that, that the  
24 Executive Officer Glover have the authority to negotiate with  
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1 the HMO provider to enter into a satisfactory contract.

2 CHAIRWOMAN GRIMMER: Thank you.

3 MS. GLOVER: And to sign the contract. Sorry.

4 MEMBER KELLEY: I accept that friendly amendment  
5 and to sign a contract with the HMO provider.

6 CHAIRWOMAN GRIMMER: Okay. Thank you.

7 Do I have a second?

8 MEMBER BARNES: This is Jim Barnes. I'll second  
9 that motion.

10 CHAIRWOMAN GRIMMER: Okay. Any further  
11 discussion?

12 MEMBER STRASBURG: This is Betsy Strasburg. So,  
13 my question is, is the, and maybe I didn't catch it. Is the  
14 proposal to separate the EPO and the HMO when Director Glover  
15 goes to negotiate and sign the contract?

16 MEMBER KELLEY: No. My motion was that we  
17 continue to offer the HMO, EPO product. The EPO though is  
18 self-funded, so there's no contract with that. Whereas, our  
19 contract with the HMO expires on June 30th. So, we would  
20 need a new contract.

21 MEMBER STRASBURG: Okay.

22 CHAIRWOMAN GRIMMER: Okay. Any further  
23 discussion? Seeing none, all those in favor signify by  
24 saying aye.

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

3 CHAIRWOMAN GRIMMER: All opposed? Okay. Motion  
4 passes.

5 We will move on to Agenda Item 7.1, discussion of  
6 possible action regarding a potential contract with Health  
7 Plan of Nevada Inc. to provide a fully insured regional  
8 health maintenance organization, HMO, medical and pharmacy  
9 group plan for PEBP's active employees and non-Medicare  
10 eligible retiree populations.

11 A portion of this item may be conducted in closed  
12 session to allow review of the results of the evaluation of  
13 proposals for the contract. In accordance with NRS 287.04345  
14 section four. Any action on the contract, including  
15 potentially awarding the contract pursuant to NRS 333.335,  
16 cancelling the request for proposals or modifying and  
17 re-issuing the request for proposals will occur in open  
18 session in accordance with NRS 287.04345 section five.  
19 Celestena Glover for possible action.

20 MS. GLOVER: This is Celestena Glover. So,  
21 essentially the motion from Agenda Item 7 covered most of  
22 these requirements, so, the contract, me signing the  
23 contract, finishing the negotiations and so fourth. What we  
24 need to do now is if the Board does have specific questions  
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1 as to the result of the RFP, we do need to close the session  
2 to allow those questions to be asked. So, that's the first  
3 thing.

4 Are there going to be questions on either the RFP  
5 HMO or the Medicare Exchange HMO or Medicare Exchange RFP,  
6 sorry. And if there are, then we need to go ahead and close  
7 the session and only have the Board members, staff and Segal  
8 be a part of that closed meeting.

9 MS. KUNNEL: This is Radhika Kunnel for the  
10 record. If I may say, kind of jump in here and then provide  
11 advice that we should probably go into the closed session  
12 pursuant to Chapter 287. I believe we should go into the  
13 closed session, and Executive Officer can provide an update  
14 on the process and give an opportunity to the Board members  
15 to discuss and ask any questions you may have.

16 CHAIRWOMAN GRIMMER: Okay. With that, do I have  
17 a motion to move into closed session?

18 MS. GLOVER: This is Celestena Glover. I don't  
19 think we need a motion to move into the closed session. I  
20 think we can just have staff put the slide up for this one,  
21 and then I believe the closed session is in Teams.

22 MR. HOPKINS: Yes. Yes, Officer Glover. Yeah, I  
23 can put up the slide if you want for this agenda item. And  
24 then are we also going to do that for Agenda Item 8, not to  
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1 go too far ahead.

2 MS. GLOVER: Yes. For the closed session, we'll  
3 take both 7.1 and 8 together, rather than closing, opening  
4 and closing again, and we can discuss both RFP's. We'll take  
5 all the actions when we come back to the open meeting, if  
6 that makes sense to everybody.

7 CHAIRWOMAN GRIMMER: That works. Thank you.

8 MS. GLOVER: Thank you.

9 MR. HOPKINS: Madam Chair, I'll get the slide  
10 going. I'll let everyone know that the Zoom meeting slash  
11 YouTube livestream is still going to be continued onward.  
12 Those who have invites to the closed meeting, please drop  
13 from the Zoom meeting. Join the separate Teams meeting. And  
14 when we have concluded with the Teams meeting, jump back over  
15 to Zoom via the e-mail you received with your panelist invite  
16 or you can always click on the Zoom link when we move back  
17 over. One moment, I'll remove the slide.

18 (After a closed session, the following  
19 proceedings were had:)

20 MR. HOPKINS: All right. Madam Char, we are  
21 back. It's 12:15.

22 CHAIRWOMAN GRIMMER: Okay. Good afternoon.  
23 Welcome back to the PEBP Board Meeting on January 23, 2025.  
24 We are coming back from the closed session, and we have up  
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1 for discussion a possible action item number -- Agenda Item  
2 Number 7.1. Is there any discussion by the Board? Okay. Do  
3 I have a motion to -- do I have a motion on this item?

4 MEMBER KELLEY: Michelle Kelley for the record.  
5 I make a motion that we accept the RFP committee's  
6 recommendation to -- for Executive Officer Glover to begin  
7 negotiations with the company with the winning, with the  
8 successful bidder to enter into a contract for HMO services  
9 in the south and to enter into that contract assuming  
10 negotiations are successful.

11 CHAIRWOMAN GRIMMER: Okay. Thank you.

12 Do I have a second?

13 MEMBER BARNES: This is Jim Barnes. I second the  
14 motion.

15 CHAIRWOMAN GRIMMER: Okay. Thank you.

16 Is there any further discussion?

17 Okay. Seeing none, I'll call for the vote. All  
18 those in favor signify by saying aye.

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

21 CHAIRWOMAN GRIMMER: All those opposed? Okay.  
22 Motion passes. We will close Agenda Item 7.1 and move on to  
23 Agenda Item Number 8.

24 Are there any questions on Agenda Item Number 8?  
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1 MS. GLOVER: So, this is Celestena Glover. Just  
2 for clarification, as I said, I would repeat the requirement.  
3 This agenda item does provide the Board the option to take  
4 one of three actions. They can cancel the request for  
5 proposal. They can modify and re-issue the request for  
6 proposal or essentially move forward with an award of the  
7 contract to a -- to the winning vendor.

8 And with this recommendation, I put two separate  
9 requests, and that is to approve the contract for the  
10 Medicare Exchange and to allow the Executive Officer the  
11 authority to finalize negotiations and to sign the final  
12 contract for submittal to Board of Examiners. Sorry. My  
13 words are getting a little twisted. Thank you.

14 CHAIRWOMAN GRIMMER: Thank you.

15 Do we have a motion on Agenda Item Number 8?

16 MEMBER MCCLENDON: This is Jennifer McClendon. I  
17 move to award the contract to the winning vendor and give  
18 Executive Officer Glover the authority to negotiate and sign  
19 any contracts related to that action.

20 CHAIRWOMAN GRIMMER: Thank you.

21 Do I have a second?

22 MEMBER BARNES: This is Jim Barnes. I second  
23 that motion.

24 CHAIRWOMAN GRIMMER: Thank you.  
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1           Okay. I have a motion and second. Is there any  
2 further discussion? Seeing none, I'll take a vote. All  
3 those in favor signify by saying aye.

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

6           CHAIRWOMAN GRIMMER: All those opposed? Okay.  
7 Motion carries. We will close Agenda Item Number 8 and move  
8 on to Agenda Item Number 9, discussion and acceptance of  
9 Claim Technologies Incorporated, audit findings for State of  
10 Nevada Public Employees' Benefit Program plans administered  
11 by UMR for the period of July 1st, 2024 through  
12 September 30th, 2024. Joni Amato, Claim Technologies  
13 Incorporated for possible action.

14           Please go ahead.

15           MS. AMATO: For the record, I'm Joni, J-o-n-i,  
16 Amato, A-m-a-t-o. The scope of the first quarter audit for  
17 2025 for UMR included claims processed during the period of  
18 July 1, 2024 through September 30, 2024, and it included both  
19 medical and dental claims. The medical and dental claims  
20 paid during the quarter one totaled approximately  
21 \$66,000,000, and it included approximately 236,000 claims.

22           That audit included a quarterly performance  
23 guarantee validation, 100 percent electronic screening, with  
24 50 targeted samples, the statistically valid stratified  
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1 random sample audit of 200 claims and a focused random sample  
2 audit of 100 claims from Carson Tahoe Hospital.

3 In our auditor's opinion, UMR's performance and  
4 financial accuracy, overall accuracy, claim turnaround time  
5 within 14 days all improved this quarter when compared to the  
6 prior quarter results.

7 Claim turnaround time within 30 days decreased a  
8 bit from the prior quarter. The performance guarantees for  
9 overall accuracy, claim turnaround time of 92 percent  
10 processed within 14 days and 99 percent processed within  
11 30 days were all met. And all of the financial accuracy  
12 performance did improve in this quarter. It still did not  
13 meet the performance guarantee in the contract, and this  
14 results in a penalty of 1.5 percent of the administrative  
15 fees for the quarter or \$20,902.26.

16 And in response to a request last year, we added  
17 a new table in the report that you'll find page four in the  
18 end of the executive summary section, and it provides a quick  
19 snapshot of UMR's performance for these measures for the most  
20 recent four quarters or will update this table with the most  
21 recent four quarter results. I hope you all find that  
22 helpful.

23 CTI also reviewed the quarterly UMR self-reported  
24 performance guarantee results and noted that 26 out of the  
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1 27 quarter -- quarterly results were met.

2 We recommend reviewing the financial accuracy  
3 errors identified in the random sample audits to ensure the  
4 root causes have been identified and claim process training  
5 and system corrections have been made where appropriate.

6 And we also recommend reviewing the electronic  
7 screening and targeted sample testing results to focus on  
8 potential recovery and process improvements in the categories  
9 where we did find errors.

10 And, finally, as mentioned before, the quarterly  
11 -- this quarter's audit random sample of 100 claims from  
12 Carson Tahoe Hospital for the period included an extra  
13 quarter, so this included the April 1, 2024 through  
14 September 30th, 2024. The audit identified only one error  
15 for an incorrect provider discount applied.

16 CTI did identify 11 claims in that 100-claim  
17 sample where Carson Tahoe billed using the incorrect form,  
18 and this resulted in the incorrect amount being paid on those  
19 11 claims. These errors were not the result of anything on  
20 UMR's part. It was Carson Tahoe identified their error.  
21 They re-billed on the correct claim form that they needed to  
22 bill on so the claims could be correctly reimbursed, and that  
23 has taken place.

24 So, if you have any questions, I'm happy to  
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1 answer any.

2 CHAIRWOMAN GRIMMER: Okay. Thank you for that.

3 Board members, are there any questions?

4 Okay. Seeing none, do I have a motion to approve  
5 this agenda item?

6 MEMBER MCCLENDON: Jennifer McClendon. I move to  
7 approve.

8 CHAIRWOMAN GRIMMER: Thank you.

9 Do I have a second?

10 MEMBER KELLY: Michelle Kelley. I'll second.

11 CHAIRWOMAN GRIMMER: Thank you. Any further  
12 discussion? Okay. Seeing none, I'll call for the vote. All  
13 those in favor signify by saying aye.

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

16 CHAIRWOMAN GRIMMER: All opposed? Okay. Motion  
17 carries. We'll close Agenda Item Number 9 and move on to  
18 Agenda Item Number 9.1, response to audit findings overview  
19 of performance guarantees for the period of July 1, 2024  
20 through September 30th, 2024. Rhonda Huckaby, UMR. And this  
21 is information and for discussion. Please go ahead.

22 MS. HUCKABY: Hi. For the record, this is Rhonda  
23 Huckaby with UMR. We would like to thank you for the  
24 opportunity to respond to the audit performed by Claims  
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1 Technologies for quarter one Plan Year 2025. We are  
2 dedicated to improving the overall experience and our  
3 commitment to meet all performance guarantees.

4 Per request from the last Board meeting, as Joni  
5 previously stated, that we are doing a quarter back quarter  
6 comparison. So, UMR has 39 performance guarantees for  
7 claims, network and UMC administration. In the Board packet,  
8 under agenda Item 9.1, page 312, we have included a quarterly  
9 breakdown on the self-reported performance guarantee for last  
10 plan year and the quarter one 2025 audit, which reflects an  
11 overall improvement in our remediation progress.

12 We send a monthly performance guarantee to PEBP  
13 executive staff, and the goal is to document our efforts and  
14 meet the standards established in the remediation plan. We  
15 strive to have the highest possible quality and work  
16 diligently to address all issues identified in the CTI  
17 quarterly audits.

18 We continue to review process improvement  
19 opportunity within the organization. We value our  
20 partnership with the State of Nevada, and we will continue to  
21 work with PEBP and their vendor partners to perform high  
22 level service to the participants and the provider community.  
23 And we have leadership on the call from operations to address  
24 specific questions from PEBP Board members related to our  
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1 enforcement guarantee or are those CTI audit results.

2 CHAIRWOMAN GRIMMER: Okay. Are there any  
3 questions, Board members?

4 Okay. Thank you for your reports. Seeing no  
5 questions, I will close Agenda Item Number 9.1 and move on to  
6 Agenda Item Number 10, Via Benefits presentation. Chris  
7 Garcia, Willis Towers Watson for information and discussion.  
8 Please go ahead. You're on mute.

9 MR. GARCIA: Thank you. Sorry about that. Hi.  
10 This is Chris Garcia with Willis Towers Watson. Today I  
11 would like to present some information about the services we  
12 provide to PEBP, retirees and spouses of those retirees.  
13 We're going to go over some general information, but I'm  
14 gonna share my screen first. So, bear with me for one  
15 moment. And can you see my screen? Can someone confirm  
16 that, please.

17 MS. BITTLESTON: Yes, we can.

18 MR. GARCIA: Thank you.

19 So, I have a -- several different items I would  
20 like to discuss with Nevada PEBP today. The first item we'll  
21 go over will be just kind of an overall summary of the  
22 individual marketplace and what Via Benefits is, who we are,  
23 what kind of services that we can provide to your retiree  
24 population, your Medicare eligible retiree population.

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1           We'll talk about the retiree experience, how they  
2 enroll through us, how they can utilize our services, some of  
3 the different communications and different meetings that we  
4 have, and then we'll also talk about a big component of what  
5 we do, which is the HRA administration and some of the  
6 advocacy for your retiree population as well.

7           So, first, kind of an overview of who Via  
8 Benefits is. We are the oldest and largest Medicare  
9 marketplace in the United States. We have over 18 years of  
10 service working with different retiree populations. We have  
11 over 2.3 million retirees that we've serviced over 800  
12 clients right now, and we have processed 5,000,000  
13 applications last year, in 2024, across our entire population  
14 and with hundreds of carriers, so over 100 different carriers  
15 that are on our platform.

16           We've had 3.2 million retiree conversations in  
17 2024. That's how many interactions we've had with different  
18 inbound calls that we've received across our entire book of  
19 business and then, you know, several different Fortune 500  
20 clients that we work with, and we do customer satisfaction  
21 surveys. We've actually shared some of that information with  
22 PEBP in our quarterly reporting.

23           And one of our survey questions is if the  
24 participant feels like they've enrolled in the best plan that  
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1 meets their need, then we typically get responses of around  
2 98 percent of those retirees are finding that are enrolling  
3 in the best plan that meets their need that's available on  
4 our platform.

5           So, what is an individual marketplace? So, an  
6 individual marketplace is an area -- it's a marketplace that  
7 individuals can compare and enroll in individual healthcare  
8 plans, and we offer that personalized help. You know, a  
9 marketplace gives expanded choice to, you know, help plans  
10 that fit all needs.

11           We have typically greater affordability with the  
12 largest risk pools, right. So, there's 42,000,000 Medicare  
13 eligible participants. You know, we also do -- we're pre-65  
14 retiree enrollments as well. We don't currently do that for  
15 Nevada PEBP. But if there's a marketplace of over  
16 12,000,000, 365 retirees out there, and so we certainly help  
17 participants who are interested in utilizing our services and  
18 choosing enrolling in and using their different plans that we  
19 have available to them, and I'll talk about those different  
20 plans in just a little bit.

21           And then how the marketplace helps Nevada PEBP.  
22 We, you know, hopefully, significantly just decrease the  
23 administrative burden that would come with managing a retiree  
24 population on your own. Typically we have greater

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1 affordability, as well as reduce the liability, and then we  
2 continue to bring value to retired employees and their  
3 families.

4 So, how we work, so we've actually been a partner  
5 with Nevada PEBP since July of 2011, so even longer than I've  
6 been with Via Benefits here, which is great to have you all  
7 as a partner since that period of time. We do not charge  
8 Nevada PEBP for any of the services that Via Benefits  
9 provides to your retirees. So there's no, you know, account  
10 cost. We don't charge any HRA administration fees, anything  
11 like that.

12 Participants can shop and enroll in different  
13 medical plans that meet their needs. We give them education  
14 either through printed materials or available on our website.  
15 We also have retiree meetings that we schedule throughout the  
16 year. And, again, I share a lot of that information in the  
17 quarterly Board meetings information, the quarterly reporting  
18 that we share with the Board.

19 We provide lifetime advocacy for enrollees, in  
20 which we are the agent of record, for their plans, that they  
21 have enrolled through. And then we also administer the HRA,  
22 which is a big component for Nevada PEBP based off of the  
23 number of people that you have that are eligible for the HRA  
24 that submit claims on a regular basis through our services.

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1           For the retiree experience, what kind of plans  
2 are available on our platform, right. So, that's the first  
3 thing is the different plans that we have, we have Medicare  
4 Advantage plans, which we typically have a prescription drug  
5 plan included, which would be considered a Part C plan,  
6 Medicare supplement plans which are also referred to as  
7 Medigap plans.

8           Prescription drug plans, so if you were to choose  
9 a Medicare supplement plan as a retiree to enroll in, that  
10 does not typically include a prescription drug plan. You  
11 would have to choose a separate prescription drug plan, so we  
12 have those available to retirees to enroll in, and then we  
13 also offer dental and vision plans as well.

14           We work with several different carriers. I'm  
15 gonna flow through this relatively quickly. ARP, Aetna,  
16 Anthem, Blue Cross, Blue Shield, Cigna, Hometown Health,  
17 Humana, United Healthcare, as well as numerous other ones,  
18 maybe some that are more regional plans.

19           And the good news is that our plans are not just  
20 focused in Nevada, right. So, you have retirees that live in  
21 all 50 states, across the country, and we have plans  
22 available in every state through, with different carriers,  
23 whether they're regional carriers or not, these are just some  
24 of the top, you know, carriers that we have available on our  
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1 platform. It gives you a good idea of the types of different  
2 insurance carriers that we are working with on a regular  
3 basis.

4 How do participants enroll through us, right?  
5 So, what are the channels that they can contact us to enroll?  
6 So, we really have two channels in which people can enroll  
7 through us, the first being, they can enroll through our  
8 website. They can enroll through my Via Benefits dot com  
9 slash PEBP.

10 And on the website, they can compare different  
11 plans by doing a side to side comparison. They can select  
12 their plan. They can enroll directly on the website. They  
13 don't even need to speak to a Benefit advisor. If they find  
14 a plan that they want and they are happy with that plan, they  
15 can go ahead and enroll directly on the website.

16 We do a verification through identity, so it is a  
17 secured site. The participants will review their disclaimers  
18 and confirm information on the site. So, there's -- when  
19 you're filling out an application for coverage, there are a  
20 lot of different application disclaimers that have to be  
21 processed and read, and the participants take care of all of  
22 that right through the website at their own convenience.

23 And then what's good about the website is a lot  
24 of older retirees might need assistance, and they can get  
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1 that assistance through a friend, and that friend can help  
2 them review or even a family member can, of course, help them  
3 review that information right on the website.

4           Once they've selected their plan, it takes  
5 usually about 15 minutes to complete the process to actually  
6 do the enrollment, and that's a lot different than what we'll  
7 talk about for the second option, which people can enroll  
8 through us which is enrolling through the phone. So, they  
9 would call our Via Benefits service phone number that's set  
10 up specifically for Nevada PEBP. That number will help them  
11 review or even a family member can, of course, help them  
12 review that information right on the website.

13           Once they have selected their plan, it takes  
14 usually about 15 minutes to complete the process to actually  
15 do the enrollment, and that's a lot different than what we'll  
16 talk about for the second option, which people can enroll  
17 through us which was enrolling through the phone. So they  
18 would call our Via Benefits Service Center phone number  
19 that's set up specifically for Nevada PEBP. The number is  
20 888-598-7545. It's a toll free number. And they can call  
21 that number, and they can set up an appointment to speak with  
22 a Benefit advisor or they can call that number without an  
23 appointment and speak to a Benefit advisor.

24           Typically the appointments are recommended to  
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1 ensure that the participant has enough time to do a complete  
2 review of the different plans that we have available based  
3 off their zip code, and, you know, share information in  
4 regards to the physicians that they see, the types of  
5 prescriptions that they utilize. An enrollment plan  
6 typically takes at least 50 minutes. If you're doing --  
7 excuse me. Enrollment through the phone takes at least  
8 50 minutes, if not longer. So, we want to make sure the  
9 person has enough time allowed for that call.

10           So if they call in and they only have 30 minutes,  
11 they may not be able to complete the full enrollment call.  
12 So, an appointment allows them enough time to plan and ensure  
13 that they have all the information that they need, but an  
14 appointment is not necessary. They can enroll without an  
15 appointment. They just want to make sure they call in with  
16 enough time to do so.

17           The Benefit advisor will help the participant  
18 review the different plans, as I mentioned, and choose a  
19 plan. Again, there is a verification that is done of who the  
20 participant is over the phone. And then if the participant  
21 doesn't want to provide permission over the phone, they can  
22 have a family member or friend speak to a Benefit advisor to  
23 help them walk them through any assistance that they might  
24 need in regards to reviewing plan information and talking  
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1 about what plan or plans might best meet the participant's  
2 need.

3 But, I think the big thing is both channels are  
4 great channels. It really depends on the participant  
5 preference. We even have some retirees that will go online.  
6 They'll review their plans and shop and compare. I'll talk  
7 about the shop and compare availability in just a moment, but  
8 they can shop and compare their plans, and they'll be able to  
9 see that they want to call in and speak to a Benefit advisor  
10 just to make sure that they made the best decision, and that  
11 saves them quite a bit of time over phone if they shop and  
12 compare online first and then call in.

13 So, as I mentioned, the shop and compare  
14 functionality is available. You can see that it has an  
15 estimated annual cost function there. They can shop up to  
16 three different plans side by side. So, you'll see, as I  
17 move through this slide, we'll highlight different sections  
18 of what's available on the website. So, they'll see the  
19 estimated annual cost there for the plan. You'll see if what  
20 drug coverage is available, so formulary covered drugs, if  
21 they're in-network doctors.

22 If we have that information from the participant,  
23 if they enter in their prescription information, if they  
24 enter in the physicians that they see, the tool will utilize  
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1 all that information and do the shop and compare so they can  
2 see what prescriptions are covered and what physicians might  
3 be available in that plan or through that network.

4 And then they will also be able to choose  
5 additional plan details and they can see an expanded list of  
6 additional plan information online, so probably very similar  
7 to what an active employee would see when shopping and  
8 looking at plan information. We carry that type of display  
9 and ability to shop and compare plans for the retiree  
10 population as well on our site.

11 One important thing to note is that the shop and  
12 compare feature on the site can be utilized without an online  
13 account. So, if somebody is considering retiring and they  
14 haven't really officially notified PEBP that they're going to  
15 be retiring, they can still go out to our website and shop  
16 and compare plans and just look and see what's available in  
17 their zip code and what those, you know, different prices are  
18 now.

19 Now, of course, premiums increase, you know,  
20 typically each year. We'll see some premium increases. So,  
21 if somebody shops and compares now, but they don't retire  
22 until next year, the pricing might be different, but it gives  
23 them an idea of what is available for them to choose from.

24 We have support for your retiree population.  
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1 Every step of the way for their initial enrollment is  
2 transitioning say from a group plan as an active employee to  
3 being a Medicare eligible retiree and even beyond that,  
4 right? So, as they age into Medicare and they enroll through  
5 us and what that future support look like.

6 So, on a year-round basis, we typically have over  
7 400 licensed agents, as well as 250 plus customer support  
8 staff from a -- you know, we bring on seasonal staffing  
9 typically during the Medicare open enrollment season.  
10 Medicare open enrollment is from October 15th through  
11 December 7th, and we typically will bring on staffing  
12 starting in the summer to anticipate that additional call  
13 volume that we know we're going to receive during the open  
14 enrollment season.

15 So, we bring on that additional staff and we  
16 maintain a lot of that seasonal staff even after the open  
17 enrollment season ends so that we can anticipate additional  
18 call volume that we typically see say in January and  
19 February. Just based off of a historical call volume, if  
20 people are calling in, checking on the status of whether it's  
21 a claim for the new year or whether it's checking on their  
22 plan information for the new year, we want to keep that  
23 additional seasonal staffing in place for an extended period  
24 time when applicable, okay.

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1                   One thing to know that's about our licensed  
2 Benefit advisors, I know that this has probably come up in  
3 the past from some retirees who have had some concerns. But  
4 our licensed Benefit advisors are not commissioned. They are  
5 salaried, and they make unbiased decisions. They are looking  
6 for the best plan for the participant based off the  
7 information that the participant provides to them during the  
8 conversation that they have.

9                   The licensed Benefit advisors, they make -- they  
10 can make extra additional money, such as bonus, based off of  
11 Customer satisfaction scores. It's not based off of  
12 enrollment information. So, again, it's important to note  
13 they are not commissioned. They receive no commissions at  
14 all.

15                   They are state licensed across the U.S., and they  
16 have to be carrier certified within all regional and national  
17 carriers, and so there's a lot of training that they have to  
18 go through, a lot of licensing that they have to go through  
19 to be able to sell plans in different states throughout the  
20 country.

21                   So, for example, a new Benefit advisor who comes  
22 on may be only licensed in four or five different states.  
23 But somebody who has a longer tenure with us could be  
24 licensed in all 50 states, not just depending on their  
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1 experience and their knowledge and the process that they have  
2 gone through to become licensed.

3 The average Benefit advisor is 52 years old, with  
4 over ten years experiences. But, of course, we do have some  
5 new Benefit advisors who are learning the process and getting  
6 licensed and getting the different licensures across  
7 different states, but they must be licensed, appointed and  
8 certified to speak to retirees, independents, you know, based  
9 off the different states they are licensed in.

10 We do have a workforce management team that  
11 manages all of our Benefit advisors, our application  
12 processors, our regular customer service team members who  
13 might answer a more focused call about the HRA, so the  
14 Benefit advisors do not answer those HRA calls. We have  
15 other representatives that do that. But that workforce  
16 management team does all the forecasting and scheduling and  
17 gets everything in place. So, we have a great support staff  
18 in place to assist retirees. It's a managed call volume that  
19 we do receive on a regular basis.

20 Okay. Again, Benefit advisors, they do provide  
21 that concierge service, unbiased. They do senior sensitivity  
22 training, which I've had the opportunity to attend in the  
23 past where it's interesting. They'll have, you know, the  
24 representatives wear specific glasses that are designed to  
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1 make, you know, a, be more like somebody who is an older  
2 person who might have vision problems. So, it gives them a  
3 better understanding of what that experience might be for a  
4 retiree who receives information in the mail, but it's hard  
5 for them to read and to try to help, you know, have that  
6 sensitivity around some of the challenges that an older  
7 retiree might be experiencing, whether it's based off of, you  
8 know, vision or hearing or something along those lines.

9           They are 100 percent focused on the retirees.  
10 Again, they have to be state licensed and certified. They  
11 have to do over 40 plus certification tests, and that all  
12 happens, again, typically during the summer when they're  
13 gearing up for the open enrollment season.

14           And then another thing is that all of our  
15 licensed Benefit advisors are 100 percent in the United  
16 States. So, we have different service centers within the  
17 United States, as well as some virtual, you know, Benefit  
18 advisors who service our population. We have three different  
19 locations. We are in, right outside of -- right outside of  
20 Salt Lake City and right outside of Phoenix, Arizona and then  
21 in Richardson, Texas, which is right outside Dallas.

22           Once somebody does enroll through us, they're  
23 going to get different communications. So, they do get a  
24 selection confirmation letter. They're gonna get, that's

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1 going to confirm the different plans that they've chosen.  
2 They're going to receive information in a packet with their  
3 new insurance cards and information about their new plan  
4 benefits. That's going to come directly from the insurance  
5 carrier and Via Benefits. So, our services will send them a  
6 welcome letter as well.

7           And then if somebody does qualify for their HRA,  
8 I'll talk about it a little bit later on, but they'll get  
9 some information from us after they enroll when they qualify  
10 for their HRA.

11           One thing to note is we do have educational  
12 videos out on our website to help really educate participants  
13 on Medicare, Medicare Part B, the HRA, how to utilize the  
14 HRA. You know, I would highly suggest as members of the  
15 Board, if you get a chance to go out to our website, the my  
16 dot Via Benefits dot com slash PEBP and maybe view those  
17 educational materials and those videos, it doesn't take too  
18 long, but it kind of gives you an idea of what information we  
19 have available to participants when they're looking to get  
20 information about the different services that we have  
21 available and how to utilize our services, in particular how  
22 to utilize the HRA.

23           I mentioned Medicare open enrollment earlier.  
24 So, this slide really just reiterates the periods of time.

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1 This is our busiest time of the year is October 15th through  
2 December 7th, as you can imagine. In particular, that last  
3 week of the season, usually the week following Thanksgiving  
4 through December 7th is extremely busy. The -- but the key  
5 thing that's to note if you're a retiree is that it is a  
6 passive enrollment.

7 So, if the same plan or plans that you are  
8 currently enrolled in are available in the new year, you  
9 don't need to take any action if you want to keep those  
10 plans. But if you are somebody who is considering changing  
11 plans or moving to a different plan, you can certainly  
12 contact us, and you can shop and compare on the website and  
13 see what new plans might be available that you might want to  
14 choose or you can shop and compare through a Benefit advisor  
15 through a phone call.

16 I would recommend doing it online first, just  
17 because of how busy we are. The phone calls can have longer  
18 wait times during the open enrollment season. So, shopping  
19 and comparing plans online first and even enrolling in a new  
20 plan online would be preferred, but, you know, certainly  
21 calling us is an option as well.

22 Moving on to the different communications that we  
23 and the meetings that we do. So, we have multi-faceted  
24 communications. We do print communication, which include  
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1 educational guides and reminders throughout the course of the  
2 year. I've shared some of those communication materials with  
3 the Board during our quarterly reporting that we provide.

4 We do virtual retiree meetings in which gives  
5 participants an opportunity to ask questions. We do meetings  
6 twice a year, once in the spring and then once again in the  
7 fall. I shared information with the Board on that when we  
8 have those meetings, and that information is in that  
9 quarterly reporting as well.

10 We, obviously, have our website available. It's  
11 co-branded with PEBP information, and we have the enrollment,  
12 as well as HRA tools are available. It is a personal account  
13 where participants will access. They'll set up a user ID and  
14 password to access the account to secure it that you would  
15 typically suspect with like a bank type of situation.

16 And then, of course, we have our phone support  
17 with that one on one personalized support, whether if it's  
18 through a regular customer service representative or a  
19 Benefit advisor.

20 Okay. So, I mentioned the virtual retiree  
21 meetings. We do those two days or two meetings per day, and  
22 we do a total of four virtual meetings right now, two in the  
23 spring and two in the fall. The first meeting is typically  
24 going to be focused on people that are aging into Medicare.

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1 So, new potential retirees who are maybe already retired as  
2 pre-65, another aging in and becoming Medicare eligible or  
3 somebody who might be a retiree or active employee, excuse  
4 me, who is over 65 who is considering retiring.

5 And so that meeting is typically focused on  
6 Medicare basics. You know, they'll go through Medicare  
7 Advantage plans, Medicare supplement plans, prescription drug  
8 plan, dental, vision, how they can enroll through us, how  
9 they can contact us, how they can set up an appointment. A  
10 lot of the information that somebody would need to really get  
11 engaged and start considering that transition from either  
12 being, from going from a group plan and retiring or being a  
13 pre-65 retiree moving into a Medicare eligible retiree  
14 status.

15 The second meeting that we typically have will be  
16 one that's focused on participants that already enrolled  
17 through Via Benefits, okay. So, that will be focused more on  
18 the Medicare open enrollment season. When we do the meeting  
19 that we do typically in the fall, which is in September,  
20 maybe September-October time period, and then it will also  
21 focus more on the HRA and how to utilize the HRA. So  
22 that's -- that's a meeting that's really designed for people  
23 that are already enrolled through us.

24 We don't go too much through the enrollment  
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1 process, except for maybe if somebody wants to consider  
2 making a change or they have some sort of special enrollment  
3 period that they might want to consider making a change to  
4 the different plans that they enrolled through with us.

5 Okay. One of the great things is that we do  
6 record a couple of those different meetings, one of each  
7 type, and we put them out in the website. So, currently, we  
8 have the fall version of those meetings available for  
9 participants to view. And, you know, if the Board -- anybody  
10 can go on the website at any time and take a look at those  
11 meetings and listen in and kind of see the information that  
12 we currently share and make available to participants who  
13 would like to review those recordings.

14 I did want to provide some call stats to give you  
15 an idea of the volume of calls that we do receive. So, this  
16 slide shows metrics from 2023, as well as 2024. So, you can  
17 see the total inbound calls that we have for Nevada PEBP.  
18 This is specific to PEBP. We had over 20,000 calls in 2023  
19 and over 21,000 calls in 2024.

20 The average in inbound handle time, so I  
21 mentioned like the, the enrollment calls are typically about  
22 an hour. But, of course, HRA type call would typically be  
23 less, maybe ten minutes, 15 minutes or so. So, on average,  
24 the handle time, so how long we're on the phone with the  
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1 participant is usually about 18 minutes and change. So, you  
2 can see for 2024, it was 18 minutes and 56 second. In 2023,  
3 it was 18 minutes and 10 seconds, but it kind of gives you an  
4 idea of the volume of calls we're receiving specific to PEBP  
5 and then how long those calls on average last.

6 Of course, each experience is a little bit  
7 different, depending on why somebody is calling in. So,  
8 somebody could certainly call in about an issue that could  
9 take longer to review than somebody just calling in and  
10 checking on the status of a payment. But it's -- you know,  
11 we're here to help them, and our Benefit advisors and  
12 customer service representatives will engage with the caller  
13 as much as they need to and address their situation. They're  
14 not pushed to drop the calls or end calls early. They want  
15 to help resolve the situation for the participant as much as  
16 possible.

17 Some enrollment statistics, just to give you an  
18 idea of how many people for Nevada PEBP are enrolled through  
19 our platform. Again, some of this information this year in  
20 the quarterly presentations that we do provide to the Board,  
21 but I wanted to summarize, this is the data through the end  
22 of 2024 that we have.

23 So, for PEBP, the total eligible population is  
24 around 18,800 people. Of those, we have 13,483 participants  
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1 that are enrolled through us. And the plan is at the end of  
2 the 2024. So, that's 71 percent of the population has  
3 enrolled through us. And then below that, you'll see a chart  
4 showing you the different types of plans that participants  
5 have enrolled through us, whether it's a Medicare Advantage  
6 plan, a Medicare supplement plan, a Part D plan, which is  
7 prescription, drug, dental or vision.

8 So, we have a good breath of people that are  
9 enrolling in those dental and vision plans, as well as, you  
10 know, the Medicare supplement plans or Medigap plans, as well  
11 as the Advantage and Part D plans. This is pretty consistent  
12 with what we've seen historically for Nevada PEBP on a  
13 regular basis. But it gives you an idea, again, of the  
14 volume of calls that we're getting, as well as the number of  
15 participants that we're helping with being their exchange and  
16 helping them enroll.

17 This slide here shows information that is related  
18 to people that made plan changes, as well as what we would  
19 consider an agent participant. So, an agent participant,  
20 again, is somebody who is becoming newly eligible through the  
21 Exchange. And so we have -- we receive a data point called  
22 an eligibility -- program eligibility start date, and that  
23 program eligibility start date would be, if it was in 2024,  
24 they're on this report, in this bottom section. So, for

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1 that, I'll focus on that first.

2 We had 668 people that came across with a program  
3 eligibility start date in 2024. Of those people, we were  
4 able to help convert 621 of them to enroll in some sort of  
5 plan through us. Of those, so that's 93 percent enrollment,  
6 which is really high, and that's really great. That means  
7 we're reaching a lot of your retirees that are becoming  
8 eligible each year and getting enrolled through us.

9 So, 93 percent is a really strong score.  
10 Obviously, we would like to help everybody. But some of  
11 those people who did not enroll through us, maybe they had a  
12 plan available through a spouse who or maybe they decided to  
13 retire from PEBP and is a PEBP retiree and they go to work  
14 somewhere else, and they have coverage through that new  
15 employer. So, to see 93 percent is a really good score.

16 The top chart shows, again, the people that made  
17 changes for the new year, and we have some historical data  
18 here, just to give you an idea of the ebb and flow of what we  
19 see from which types of plan changes people are making. Some  
20 of it is driven off of industry wide changes, such as if a --  
21 you know, we're seeing an increase in prescription drug  
22 premiums, that might draw more people to change prescription  
23 drug plans. If we're seeing some changes in Medicare  
24 Advantage plan offerings, we might see some more changes

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1 there.

2 So for the most recent plan year, so enrolling  
3 into 2025, you can see the most changes that we saw were for  
4 prescription drug plans. We had over 1,000 people make  
5 changes from one prescription drug plan to a new prescription  
6 drug plan.

7 For Medicare Advantage plan, we had 474 people  
8 change from one Medicare Advantage plan to another Medicare  
9 Advantage plan.

10 The other changes are less common. As you can  
11 see historically, that's the case. Typically, you have  
12 prescription drug plan to another prescription drug plan  
13 being the most common change or from Medicare Advantage plan  
14 to another Medicare Advantage plan. But it gives you, again,  
15 an idea of volume that we see during open enrollment and who  
16 is making a change for the new year.

17 The next section, we'll talk about HRA  
18 administration and advocacy. So, one thing about the HRA  
19 administration, I'm gonna talk a little bit about what it is  
20 and how PEBP has it set up, and how we help administer the  
21 services for your retiree population and then also how  
22 participants can submit claims.

23 So, you know, we have a fully integrated  
24 experience. We try to do one call resolution, as well as we  
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1 have an integrated website. Obviously, not every situation  
2 can be resolved in one call. Something might recall --  
3 require additional research or it could be something that is  
4 just needed to, you know, have some data on an account, and  
5 we have to get that data requested and then sent over to us.  
6 So, certainly, because we try to resolve everything in one  
7 call, there could be a situation where that doesn't occur.

8           Typically, we'll see for the HRA, where the  
9 client will be allocating the dollars for each retirees' HRA  
10 account. We'll set up that HRA account once the person  
11 qualifies for it, and then the retirees are going to be  
12 reimbursed through the eligible, you know, for their claims  
13 if they're an eligible expense and they're approved. They  
14 have different ways, again, that they can reach us. They can  
15 do it through the phone. They can do it online. And online  
16 is a great tool, and I'll talk about that a little bit more.

17           And then more recently, we have rolled out a  
18 mobile app that participants can download to their smart  
19 devices, and I'll have a slide later on that talks a little  
20 bit more about that. But they can actually view balances and  
21 they can submit claims right directly on the mobile app.

22           Okay. There is a requirement for the HRA  
23 participants for Nevada PEBP. Participants must enroll in a  
24 Medicare medical plan through Via before their enrollment  
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1 period ends to qualify for the HRA. And then to continue to  
2 qualify for the plan, they must remain enrolled in a  
3 qualifying plan through Via Benefits. So, they can change  
4 plans from one Medicare medical plan to another Medicare  
5 medical plan. But if they have a gap and they drop coverage  
6 by mistake, then they become dis-enrolled and disqualified  
7 for their HRA.

8           The one exception that PEBP has is for people  
9 that are on Tricare. They do receive an exception, and they  
10 do not need to enroll through Via Benefits in a Medicare  
11 medical plan to qualify for the HRA. They would qualify  
12 automatically, but they do need to contact PEBP directly to  
13 set up that Tricare exception.

14           I mentioned earlier, when we were talking about  
15 communication, that there is an additional communication that  
16 we do send out after somebody qualifies. That is the  
17 reimbursement guide. So, the reimbursement guide will go out  
18 to a participant after their account is set up through the  
19 HRA, and that reimbursement guide includes information on how  
20 they can submit claims, eligible expense list information,  
21 how they can set up direct deposit for their accounts. So, a  
22 lot of that great information that a participant typically  
23 needs to -- to really be successful in utilizing their HRA  
24 account.

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1                   Sorry. Let me go back one slide. I was doing  
2 that too quickly. The tax account for the -- excuse me. The  
3 HRA is a tax-free account, right. So, it is used to  
4 reimburse participants who are eligible in healthcare  
5 expenses. But the key is that the participant will need to  
6 pay first and then they will need to submit a claim and be  
7 reimbursed for their HRA.

8                   If the participant is eligible and they qualify,  
9 again, the key is they have to qualify for the HRA, PEBP will  
10 make a monthly contribution or you might refer to it as an  
11 allocation to the HRA, and that is the money that the  
12 participant can use to get reimbursed for eligible expenses.

13                   The participant can use it for their spouse or  
14 for themselves for any eligible medical prescription, drug,  
15 dental, vision, Medicare Part B premiums, as well as  
16 out-of-pocket health care expenses, and I have an eligible  
17 expense list coming up in just a moment. But the key to note  
18 is PEBP does have a running 365-day claims submission  
19 deadline, deadline for participants to submit claims, and  
20 that's from the date that the claim was incurred.

21                   So, for example, if a person incurred an expense  
22 on January 5th of 2024, and they tried to submit that expense  
23 today, even if they have all the right documentation to  
24 substantiate that claim, it would be denied because they

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1 missed that rolling ten-month deadline, okay. So, that has  
2 come up in the past, and that's just something important to  
3 note. That is a requirement that PEBP has in place for the  
4 HRA.

5           What's great is that any unused balances are  
6 available in future years. However, as you may know, the  
7 Board did elect back in May of -- back in 2021 that we were  
8 going to start an 8,000 dollar HRA cap on the available  
9 balance. So, anybody can accrue more than an 8,000 dollar  
10 balance through the year. However, any balances over \$8,000  
11 will be reduced to the 8,000 dollar cap on or around May 31st  
12 of each year. It takes a little bit of time to get  
13 administratively done, so typically it's in the first week of  
14 June that we have the balances updated. But we're reviewing  
15 and looking at balances at the end of May to determine who  
16 has money over \$8,000 that needs to be adjusted and reduced.  
17 So, certainly something that retirees want to be aware of.

18           The HRA is designed to reimburse it for eligible  
19 expenses. It is not a savings account. There is no  
20 beneficiary that is awarded the money if somebody were to  
21 pass away. So, it's important for retirees to utilize and be  
22 reimbursed for eligible expenses as soon as possible, not  
23 only because of the cap but also because of that 12-month  
24 rolling deadline.

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1           This is a list of some of the eligible expenses,  
2 so some of the most common items. This is not an all  
3 inclusive list. The participants can refer to IRS section  
4 213D for a complete list of eligible expenses. So,  
5 obviously, premiums is probably the majority of the types of  
6 expenses that we see. So, you have Medicare medical  
7 premiums, prescription, drug, dental, vision, Medicare Part B  
8 is big. We encourage people to turn on Medicare Part B.  
9 Premiums is an eligible reimbursement and get those submitted  
10 to us. They can do office co-pay, eye exams, dental  
11 treatments, deductibles, co-insurance.

12           Other types of expenses would be contact lenses,  
13 hearing aids, lab fees, oral surgery, wheelchairs, X-rays.  
14 The list is pretty large. But this just gives you an idea of  
15 the types of expenses that people can submit for  
16 reimbursement with the appropriate supporting documentation.

17           MS. BITTLESTON: It looks like Chris froze.

18           MR. HOPKINS: It looks like his slide is still  
19 up.

20           Madam Chair, you can hear me okay, right?

21           CHAIRWOMAN GRIMMER: Yes, I can hear you.

22           MR. HOPKINS: Just making sure we still have  
23 connection.

24           CHAIRWOMAN GRIMMER: Okay. We'll give him time  
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1 to rejoin. And if not, then -- there we go.

2 MS. BITTLESTON: Here he comes.

3 Chris, are you there? You're on mute.

4 MR. GARCIA: I am. I don't know what happened.

5 I don't know when I lost you all. I'm so sorry.

6 MS. BITTLESTON: You were just -- you were on  
7 slide 24.

8 MR. GARCIA: Okay. So it just happened, okay.  
9 My apologies.

10 CHAIRWOMAN GRIMMER: Thank you.

11 MR. GARCIA: I don't know what happened. Let me  
12 share my screen again. I apologize. Okay. Can you see my  
13 screen again?

14 MR. HOPKINS: Yes, we can.

15 CHAIRWOMAN GRIMMER: Yeah.

16 MR. GARCIA: Okay. Thank you, again. Let me  
17 scroll back one more page, okay.

18 So, did you hear me go through the expenses,  
19 through the whole -- did I move on to the other slide yet?

20 MS. BITTLESTON: You were just finishing up the  
21 expenses, moving onto the next slide.

22 MR. GARCIA: Okay. Thank you, Leslie.

23 MS. BITTLESTON: Sure.

24 MR. GARCIA: Again, Chris Garcia for the record.  
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1 So, I believe that I was mentioning that there's just a large  
2 number of different types of eligible expenses. You can see,  
3 again, just some of the common ones here. So, I'm gonna move  
4 on to the next slide. But if there are any other questions  
5 about eligible expenses, I'll take some questions at the end,  
6 of course.

7 How the HRA works. So, again, participants will  
8 pay for the eligible expense for an incurred eligible  
9 expense, they'll pay out-of-pocket for, whether it's, you  
10 know, premium or some sort of out-of-pocket expense, like a  
11 prescription drug. They're gonna submit that reimbursement  
12 request either through the mobile app, through the website or  
13 through the mail. And then we're going to review that claim  
14 and that reimbursement request and the supporting  
15 documentation that's provided with it, and we'll make a  
16 determination.

17 If the claim is approved, we will reimburse the  
18 participant up to their available balance in their account,  
19 depending on how much the claim is for. And then if the  
20 claim is denied, we will send out what's called an  
21 explanation of unpaid expense to the participant, advising  
22 them the claim has been denied and why it's been denied, and  
23 typically it has to do with the supporting documentation or  
24 perhaps the expenses determined to be an ineligible expense,  
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1 such as maybe cosmetic surgery, those would not typically be  
2 considered an eligible expense. But once a determination is  
3 made on the claim, the participant is either notified by  
4 receiving a reimbursement or if there was a portion of the  
5 claim that was denied or a full denial, there will be a  
6 notification as to why.

7 We have different ways to help retirees automate  
8 their HRA as much as possible. One way that we do that is  
9 through what's called an automatic premium reimbursement, and  
10 this is where we work with the different carriers that we  
11 have to receive files from them for the different premiums  
12 that participants are paying for their coverage. And then we  
13 can take those files and the data through those files, and we  
14 can load those premiums as claims against the HRA. And the  
15 vast majority of claims that we receive are going to be  
16 premium claims.

17 And so if a participant is paying out-of-pocket  
18 say for a Medigap plan, and they turn on the automatic  
19 premium reimbursement functionality, if we have it available  
20 on that plan, we have it available on about 93 percent of all  
21 of the plans that we have on our platform. If they turn that  
22 functionality on, instead of the participant having to submit  
23 claims on their own, we just wait for that file to come in  
24 from the different carrier, and we load that premium

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1 information that we receive from the file that gets the HRA  
2 and we will reimburse the participant accordingly.

3 So, the participant just needs to turn on the  
4 functionality when they have a plan, and then they would only  
5 need to make a change if they choose a new plan at a later  
6 time. They would want to turn that -- see if that  
7 functionality is available in that new plan and turn it on.

8 Ideally, we would want the person to have direct  
9 deposit set up so we can automate as much as we can. So,  
10 they turn on the automatic reimbursement with the plan they  
11 have enrolled in. The participant does that the only one  
12 time. They get the file over on a regular basis each month.  
13 We load that premium as a claim, and then we send a  
14 participant direct deposit for their claim reimbursement, and  
15 that would be the ideal situation. That's the best way to  
16 automate their reimbursements for their plans as much as  
17 possible.

18 If they don't set up direct deposit, they would  
19 just get a check. It just adds a little bit more time for  
20 them to receive the reimbursement. So, direct deposit  
21 usually takes two to three days. Whereas, a check might take  
22 seven to ten days to receive in the mail.

23 We do have HRA assistance available for your  
24 Nevada PEBP retirees. Obviously, we have our regular toll  
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1 free number that participants can call to get assistance.  
2 That's available Monday through Friday from 5:00 a.m. to  
3 4:00 p.m. Pacific Time. And if they call, they can get help,  
4 you know, that number, their available balance and eligible  
5 expenses and check on the status of a claim. They can turn  
6 on automatic reimbursement, et cetera through speaking  
7 through a regular customer service representative.

8           However, if a participant does have an escalation  
9 and that has not been able to be resolved, after they call  
10 our regular customer service center, they can seek additional  
11 assistance and they can set up an appointment with an HRA  
12 specialist by calling the 844-266-1395 number. That number  
13 is manned by two of our specialists from our HRA team, Sandra  
14 Rose and Michael Rosenberg, and they will assist participants  
15 and try to help engage with them as much as possible to help  
16 resolve their issue, especially if it is something that has  
17 been escalated.

18           And you'll notice that, I'll talk a little bit  
19 more when we talk about, well, let me take a step back. We  
20 -- I mentioned previously that we do the retiree meetings.  
21 We also have the specialists come to PEBP in Carson City, and  
22 they'll be available to help retirees if they have questions  
23 related to their HRA. And Sandra Rose and Michael Rosenberg  
24 are two of the different folks who might travel to PEBP to be  
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1 there in person.

2 Another person that, from our service center who  
3 might attend is Stacie Nelson. She used to be the primary  
4 HRA specialist for PEBP. So, she will also come in person to  
5 assist retirees if they need assistance with their HRA, and  
6 they have some sort of challenges, whether it's submitting  
7 claims or, you know, something with a denied claim, anything  
8 like that, those specialists are great resources and experts  
9 to help resolve.

10 We have, our website is available, so  
11 participants can sign in and set up and automate as much as  
12 they can online. They can set up direct deposits. They can  
13 go paperless. If they want to be eco-friendly, they can do  
14 that where they don't receive anything through the mail.  
15 It's done online through e-mail and, obviously, submit  
16 reimbursement requests. So, once they get online, this slide  
17 gives you an idea of what's available, what shows up on their  
18 account. It will show like the available balance information  
19 and historical balances that they might have from prior years  
20 that they can still utilize with new claims.

21 As I mentioned earlier, the mobile app is the  
22 newest tool that we have available to retirees to utilize the  
23 mobile app. It is something that's available through IOS, so  
24 that's through Apple store or through the Google Place Surfer  
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1 on Android. It is a way they can check their reimbursement  
2 status, check their available balances. They can submit  
3 their new reimbursement request directly through the phone.  
4 They can just take a picture of their supporting  
5 documentation. They'll enter in the claim information and  
6 they upload it right to their account online.

7 It's a great tool to utilize. Obviously, we  
8 encourage new utilization. It's currently the lowest number  
9 of claims are coming through the mobile app, but we are  
10 seeing some small growth there over time as more and more  
11 people become aware that the app is available.

12 When we look at the HRA, just to kind of give you  
13 an idea of volume of the HRA accounts that we're managing and  
14 how much we're paying out through the HRA administration  
15 platform. In 2024, we paid out \$33,364,000 worth of claims.  
16 In 2023, it was around the same number, 33,124,000 in claims,  
17 so a lot of activity going on when it comes to claims being  
18 reimbursed to participants for the PEBP HRA.

19 At the end of the 2024, we had over -- we had  
20 13,733 accounts. Of those, 1,187 of them had no  
21 reimbursements at the end of the year. So, there are some  
22 people who are not utilizing their HRA or have not utilized  
23 their HRA. I'm not sure why. We do try to educate them as  
24 much as possible. So, we have talked to PEBP in the past

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1 about maybe doing some additional outreach to those  
2 individuals, but we do send out balance reminders to  
3 participants twice a year, once in the spring, once in the  
4 fall to help remind them of their balances if they haven't  
5 had any payments in the last 90 days.

6 So, hopefully those individuals who are not  
7 taking any action will ultimately decide to go ahead and  
8 submit claims so that they can utilize their account. And  
9 then we do see at the end of the year a large number of  
10 retirees reduce their account to zero. So, they're using up  
11 all their funding every month. So, we had over 8,000 people  
12 do that at the end of 2024, which is great, but they do get  
13 new money each month, right, as long as they stay qualified  
14 in that plan.

15 Direct deposit, I can't stress this enough. I  
16 encourage as many people to sign up for direct deposit as  
17 possible. It's so much easier to receive that direct deposit  
18 reimbursement than waiting for a check. Waiting for a check  
19 can lead to a check getting lost or stolen or you can be a  
20 retiree who puts a check away, planning to cash it and it  
21 sits in a drawer for two years. And when you find it, the  
22 check is no longer good, and then you have to request a new  
23 check. We don't want that to happen. So, we do encourage  
24 people to set up direct deposit.

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1           And the great news is, is that PEBP already has  
2 good utilization for direct deposit for your retiree  
3 population. You have got about 76 percent of the total  
4 number of accounts have set up direct deposit at the end of  
5 2024, which is great. You know, some other clients of ours  
6 have like 40 percent or 30 percent. So, with the length of  
7 time that PEBP has been with us, I think we've done a great  
8 job of trying to get as many people as possible to turn on  
9 direct deposit.

10           And then we look at the funding activity itself.  
11 So, this gives you an idea of the claims by source and how  
12 people or what types of claims people are submitting what the  
13 channel is. So, I mentioned auto reimbursement before, so  
14 that's the premium claims, and that's where we automate the  
15 process with those different carriers.

16           Last year, we had over 4,000 claims come through  
17 auto reimbursement. Then we had what's called paper claims,  
18 which would be somebody mailing in a claim or fax. And I  
19 will mention that fax is no longer an option as of 2025, but  
20 it was available last year. So, somebody sending in a,  
21 quote, unquote, paper claim, could be doing it through the  
22 mail or through fax, so that was about 26,000 claims.

23           We're doing it online. There's 27,000 online  
24 claims. And that mobile app, again, mobile app is the  
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1 smallest percentage, just over 12,000 claims coming in  
2 through the mobile app. So last year, you know, for 2024, we  
3 had 475,000 total claims that we received and processed. So,  
4 even if the claim was denied, we had to -- someone had to  
5 take time to review it and process it.

6 Obviously, the automated claims, there's nothing  
7 that needs to be done there. We encourage automation. It  
8 helps our processors decrease the volume of claims that they  
9 have to review. But, certainly, people are going to send in  
10 manual claims, whether it's for out-of-pocket expenses or a  
11 premium that isn't able to be set up on automatic  
12 reimbursement if we have those other channels available for  
13 those claims.

14 And that's the end of the information that I  
15 have. Whoops. Sorry, guys. So, I'll go ahead and take  
16 questions if anybody has any questions.

17 CHAIRWOMAN GRIMMER: Go ahead, Ms. Kelley.

18 MEMBER KELLEY: I'm sorry. I'm the only one.

19 CHAIRWOMAN GRIMMER: You're good.

20 MEMBER KELLEY: Michelle Kelley for the record.  
21 Thank you for this presentation. It has been -- it's long,  
22 but I found all of the information very valuable, so thank  
23 you.

24 I have -- so, I really like that automatic  
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1 premium reimbursement that you talked about. Do you do that  
2 for Medicare Part B?

3 MR. GARCIA: So, we do. It is available for  
4 Medicare Part B in certain situations. So, the person has to  
5 be enrolled through us in a Medicare medical plan. So, if  
6 somebody has that Tricare exception, that I mentioned  
7 earlier, they're not going to be enrolled through us in a  
8 Medicare medical plan, so they would not be able to turn on  
9 the auto reimbursement for Medical Part B.

10 But, if they are enrolled through us in a  
11 Medicare medical plan, they can turn on auto reimbursement  
12 for Medicare Part B because we know that they're -- if  
13 they're going on a Medicare medical plan, that means they  
14 have Medicare Part A and Part B. That means they're paying  
15 Part B premiums, and so we can reimburse them up to the  
16 standard Medicare Part B premium for the year.

17 If somebody is getting charged more than the  
18 standard, then they do have to submit documentation, but we  
19 can still help automate that and set that up as a recurring  
20 claim.

21 MEMBER KELLEY: And, sorry, just a follow-up. I  
22 guess that would be the same for if they're charged extra for  
23 Part D?

24 MR. GARCIA: Correct.  
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1                   MEMBER KELLEY: Okay. Thank you. And then just  
2 a question based off of, we heard during public comment from  
3 a retiree who lives in Carson City who uses the Carson-Tahoe  
4 Hospital, who I guess had sent out a letter to some of our  
5 retirees, saying that they're cancelling their participation  
6 with some of the advantage plans. And I wonder if you  
7 could -- if you know about that, do they inform aggregators  
8 such as yourself and/or what PEBP could do about it to better  
9 support of our employees. Because I think Carson Tahoe seems  
10 to be playing hard ball with -- I'm sorry. Carson Tahoe, the  
11 participants said, is recommending some advantage plan that  
12 don't appear to be on your network.

13                   MR. GARCIA: Chris Garcia, again, for the record.  
14 That is a great question. So, we have heard from retirees,  
15 as well as from PEBP regarding the situation in the Carson  
16 Tahoe area. There has been a request that has been submitted  
17 to our internal carrier relations team to look at adding a  
18 carrier called Prominence Health to our network. So, that  
19 has to go through some vetting, of course, and there's a  
20 process to add a carrier to our new platform. So, that is  
21 something that we are exploring.

22                   But we have had a member of our customer service  
23 team who works specifically with PEBP who's received numerous  
24 calls and had several conversations with PEBP retirees in  
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1 regards to adding and looking at the opportunity to add some  
2 additional carriers to our platform in that area. So, I  
3 can't commit to anything right now, but it is something we  
4 are certainly exploring based off of the information we  
5 received.

6 MEMBER KELLEY: Wonderful. Thank you. And thank  
7 you, PEBP staff.

8 CHAIRWOMAN GRIMMER: Okay. Any further  
9 questions?

10 Okay. Thank you, Mr. Garcia.

11 I will close Agenda Item Number 10 and move on to  
12 Agenda Item Number 11, Diabetes Pilot Program Presentation by  
13 Chris Syverson, Nevada Health Partners. For information and  
14 discussion. Please go ahead.

15 MS. SYVERSON: Hi. Thank you, Joy. Thank you.  
16 My name is Chris Syverson. I'm the CEO of Nevada Business  
17 Group on Health and Nevada Health Partners. I want to thank  
18 you for the opportunity to present today and, Madam Chair,  
19 the PEBP Board, and, staff, for your patience. I will try to  
20 make our presentation brief, but give you the information  
21 that you need and allow you to ask questions at the end.

22 First, I'm going to share my screen. Okay. Can  
23 everyone see that?

24 MR. HOPKINS: Yes, we can. Thank you.  
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1 MS. SYVERSON: Perfect. Thank you.

2 About a year and a half ago, Nevada Business  
3 Group on Health came to PEBP and talked about a pilot program  
4 that we wanted to present for PEBP members and their  
5 families, and we were granted -- oops, sorry. I'm changing  
6 my slide. I wanted to just give you a brief update of where  
7 we are to date and the results we've been seeing.

8 Just a reminder, Nevada Business Group on Health  
9 is actually two organizations, and we work with employers  
10 mostly in the north, but we are branching out and working  
11 with employers statewide on clinical issues, data management  
12 and on direct contracting.

13 As far as the diabetes goes, there are two  
14 programs. There's the National Diabetes Program, which is a  
15 year long program for people who have been diagnosed with  
16 type two -- been diagnosed with prediabetes, type two  
17 prediabetes, a year is a long commitment. And so one of the  
18 things we have looked at is, are people staying with a  
19 program? I'm happy to say we've had really good results, and  
20 we'll get to those in just a little bit.

21 The national DPP is an evidence based lifestyle  
22 program. It's a year long. Sessions are weekly for six  
23 months, and then monthly for six months. That's a mouthful.  
24 And we're geared towards having employees and participants  
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1 make real lifestyle changes. They meet with a trained  
2 lifestyle coach and a small group of people who are also  
3 making lifestyle changes, and it's proven to cut  
4 participants' risk in developing type two diabetes by  
5 50 percent. So, if you can stick with it, it's a great  
6 program.

7 I've invited several of our partners onto the  
8 call today, and I'll have them introduce themselves as well.  
9 One of the things that we've been so excited about has been  
10 the response that we've received from PEBP employees. It's  
11 been really overwhelming.

12 Again, the national DPP is about eating healthy,  
13 exercising, managing stress, navigating challenges, setting  
14 goals, diet and exercise and staying motivated. Again, a  
15 year long is a long time. But if they can make it through,  
16 the results are really great.

17 There are different delivery methods, and we've  
18 been fortunate to work with our partners. We do a lot of  
19 them as virtual sessions, and it's been especially helpful  
20 when we're working with people from rural areas or people who  
21 can't make it to a specific site.

22 There are other groups, however, that want to  
23 meet every Saturday or they have a different cohort group  
24 that just want to meet in person. And our partners have been  
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1 very good at designing those programs and developing around  
2 participants' needs.

3           What happens is we have sent mailers, direct  
4 mailers to potential participants, and they then meet with  
5 our providers. And they'll say, well, these are the days  
6 that are good for me or I prefer virtual, and then our  
7 partners develop a program around what the participant needs  
8 are. I do believe we have one Spanish class, Spanish  
9 speaking class also that's going to be offered as well.

10           The second part of the program is what we call  
11 DSMES, which is Diabetes Self Management and Educational and  
12 Support Programs. The DSMES is for those people who have  
13 already been diagnosed as a type two diabetic, and so it's to  
14 help those people to learn how to manage that condition.

15           Now, this program is a six-week program. So, as  
16 you can imagine, we have much better followthrough with the  
17 DSMES program. I actually had the opportunity to attend one  
18 of these with my husband. I wanted to see, one, what was the  
19 program about. But, secondly, as a person who cooks for  
20 someone who has type two diabetes or prediabetes, I could  
21 also understand and hear what they're hearing because often  
22 times it's the family that needs the support. That's also  
23 one of the reasons why we send our mailers to the  
24 participant's home.

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1           Why is this program important? When I first came  
2 to PEBP, we had about 3,500 people that have been diagnosed  
3 with type two diabetes or prediabetes. And in addition, the  
4 CDC statistics show that eight out of ten adults have  
5 prediabetes and don't even know it. So, this is a big, big  
6 problem out there.

7           We received a grant from the State of Nevada,  
8 which is a sub-grant from the CDC, and we are able to bring  
9 this program to employers at no cost. The grant has been  
10 able to pay for the training and the education materials and  
11 the fliers and all that out of our grant budget.

12           So, the ultimate goal is to have benefit -- have  
13 programs like PEBP possibly cover this as a paid benefit down  
14 the road. Meaning that an -- consider in your benefit plan.  
15 We target self-insured employers because they, honestly, have  
16 the most flexibility in plan design.

17           But through this program, we preserve the  
18 confidentiality. We protect all HIPAA data, and the  
19 reporting is only at group level, which you'll see. And I  
20 think PEBP would agree there's been very little additional  
21 workload on the agency to have this program.

22           I would like to first introduce one of our  
23 partners, Sanford Center for Aging, which is part of the UNR  
24 School of Medicine. Hannah, are you?

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1 MS. LINDEN: Yes, I'm here.

2 MS. SYVERSON: Hannah, if you would introduce  
3 yourself and your program.

4 MS. LINDEN: All right, yes. My name is Hannah  
5 Linden. I'm the director of the Health and Wellness programs  
6 at the Sanford Center. As Chris said, we're part of the  
7 School of Medicine. We're an aging services organization  
8 within the School of Medicine. And our mission is to enhance  
9 the quality of life and well-being among elders through  
10 education, translational research and community outreach. As  
11 evidenced by working with everyone here and employees, we  
12 don't only work with older adults, but we do a lot of work  
13 with chronic disease, self-management and prevention for  
14 different age groups as well.

15 So, we offer diabetes self-management program and  
16 the diabetes prevention program, along with a number of other  
17 programs. We're fully grant funded. So, we've been offering  
18 diabetes self-management for over ten years. We do that  
19 virtually, and we do it in person, as well, in the  
20 Reno/Sparks area. And I think this is still all right. We  
21 have about ten active facilitators. We have some peer  
22 leaders, some staff trained. We offer that program in  
23 English and Spanish, and we've been offering diabetes  
24 prevention program for about five years, and we are a  
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1 recognized site, so we've been successful and having good  
2 outcomes in that program.

3 We offer most of our diabetes prevention program  
4 sessions online and especially with this partnership, we get  
5 a lot of people who are working during the day, but they're  
6 able to take their hour lunch break to join the diabetes  
7 prevention program from work or they go to their car or  
8 something like that, so that's been really successful.

9 And we have five lifestyle coaches. And, again,  
10 we offer them in English and in Spanish. Yeah, I think  
11 that's everything I was planning on saying. So, thank you  
12 for having that slide for me, Chris.

13 MS. SYVERSON: Thank you.

14 Jemaima, are you on?

15 MS. TAGAYUA: Hi, Chris. I'm on.

16 MS. SYVERSON: Thank you.

17 MS. TAGAYUA: All right. Good afternoon,  
18 everyone. Thank you, Chris, for inviting me on this call.  
19 We are Nevada Health Partners, partner down here in the south  
20 in Las Vegas, Nevada. I am a health educator and program  
21 coordinator for the Dignity Health St. Rose Dominican  
22 Community Health Department. Our vision is a healthier  
23 future for all inspired by faith, driven by innovation and  
24 powered by our humanity. Although, we are a faith based  
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1 hospital system, we do serve all folks, all walks of life,  
2 and we don't turn anyone away.

3 We have seven locations throughout our valley in  
4 the Las Vegas and Henderson areas, and we have three main  
5 hospital campuses and seven neighborhood hospitals.

6 Next slide, please, Chris. Thank you. And like  
7 Hannah mentioned, whenever they have to offer up in UNR, we  
8 are offering similar services down here in the south as well.  
9 We also provide diabetes health management programs. We have  
10 local in-person classes within the Las Vegas and Henderson  
11 Valley. Through this grant and partnership with Chris, most  
12 of our classes have been online and are operated in person  
13 when needed, depending on the participants that are reaching  
14 out to our programs.

15 We offer virtual classes that will open to  
16 anybody statewide. So, let's say participants aren't able to  
17 join any of Hannah's class offerings, they are free to join  
18 ours as well. Currently, within Dignity Health St. Rose, we  
19 have nine active facilitators for diabetes self-management  
20 programs. And although most of our classes have been offered  
21 in English, we can offer them in Spanish as well if needed.

22 And our organization down here in the south  
23 offers two master trainers who then train other facilitators  
24 of the program. When it comes to diabetes prevention, we

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1 offer in-person classes, and we can offer them online if  
2 needed. Much like Hannah, we are also a fully recognized  
3 site for in person and distance learning with the CDC. We  
4 are fully accredited. We have six active lifestyle coaches  
5 down here in the south.

6 All of our classes have been in English, but we  
7 can offer them in Spanish as needed. And our organization  
8 houses the only master trainer in the State of Nevada to  
9 train other lifestyle coaches that would be interested in  
10 facilitating the diabetes prevention program as well.

11 I think that's all I have to say, Chris. Thank  
12 you.

13 MS. SYVERSON: Thank you, Jemaima. I also have  
14 to say, since we've had this presentation, we have also added  
15 a third training opportunity and that is through Carson Tahoe  
16 Health in Carson City. We found that we have a number of  
17 employers and potential participants in the south,  
18 southern -- southern north, if that make sense, in the Carson  
19 City, Gardnerville area. And so Carson Tahoe Health also  
20 will be providing programs for us in the future.

21 I won't go over the scope of work. This was our  
22 scope of work for your number one, and I'm happy to say we've  
23 completed all of our objectives. We had 70 PP and nine DSMP  
24 programs held. So, we had identified 3,478 as type two

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1 diabetic or prediabetic.

2           The number of individuals expressing an interest  
3 in the class was about 198 from PEBP, which doesn't sound  
4 like a lot but 198 is actually really good. We had the  
5 number enrolled, we estimate PEBP to be about 42 members, and  
6 DSMP maybe nine members. And then the member completed, at  
7 the time we did this slide originally, we had 42 in process  
8 and 66 from PEBP in the DSMP program.

9           We actually have updated the numbers since we did  
10 this program for staff. The dollars spent by the employer  
11 program is zero. The potential savings to the plan, it's  
12 been highly documented, and I actually think these numbers  
13 are a little aged, but \$10,000 is about what an employer can  
14 save if they prevent someone from having type two diabetes or  
15 they can control it, right?

16           So, if we anticipated that 26 percent -- 26  
17 participants from the State of Nevada completed, then that  
18 would be about \$260,000 in savings in claims avoided. Again,  
19 I think that that's a pretty conservative approach on that.  
20 We currently have 73 more registered. If we only manage to  
21 keep 25 percent of those, that would be an additional  
22 \$180,500 savings.

23           For the DSMP or DSMES, it's estimated that about  
24 800 to \$1,700 a year could be saved in claims. Again, being  
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1 very conservative, that would be about another \$82,500 in  
2 year on savings to the PEBP plan.

3 That is really all of the information that we had  
4 for you today. I did want to give one shout out to Kara, and  
5 I'm not going to say her last name, with PEBP. But she  
6 actually contacted us and wrote an article for the PEBP  
7 Newspaper or PEBP Newsletter, I'm not sure which one, but we  
8 saw a huge uptick in people that called and wanted to  
9 register for the programs after that article appeared. We  
10 were adding programs.

11 I know Hannah was calling me, saying, how many  
12 programs can we add because we had such a good interest in  
13 the programs. So, thank you for allowing us. We are now in  
14 year two of our grant year and still going gangbusters. So,  
15 that concludes my presentation, and I'm available for any  
16 questions that you might have.

17 MEMBER KELLEY: This is Michelle Kelley for the  
18 record. What does -- what does the end of the program, the  
19 pilot program look like to you? So, how does it end and what  
20 numbers or what data are you going to be able to provide to  
21 the PEBP Board and PEBP staff?

22 MS. SYVERSON: A lot of them will be similar to  
23 what we have. What we're doing is every year that we've been  
24 in this grant, we've been better at tracking our statistics.

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1 And one of the things that we're doing this year is really  
2 capturing the specific employer that a participant is  
3 identified with.

4 So, we will be able to give you the exact numbers  
5 of how many PEBP people have gone through the program. The  
6 ultimate at the end of the program, it's a five-year grant,  
7 would be that PEBP would decide to cover DPP and DSMES as a  
8 covered benefit within their plan, that they would see it as  
9 a program that has provided benefits to the employees.

10 And, you know, we talk about savings and claims.  
11 That's kind of my wheelhouse is dollars and cents. But the  
12 simple fact is these people are much healthier. They're  
13 eating. They're leading healthier lives. We are tracking  
14 the exercise that they're getting before and after their  
15 program completion. So, I don't have an end as far as the  
16 number of people, but I take everyone as a win.

17 MEMBER KELLEY: Absolutely. And, I'm sorry, I  
18 should have thanked you for offering the program to us and  
19 implementing it.

20 As far as the data goes, is there a way that you  
21 can -- that you can share real data for PEBP participants?  
22 Are you already pulling real data as opposed to the  
23 estimates? So, for example, if someone completes the disease  
24 management program, is it possible to feed those participants

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1 to PEBP so that they can pull real data to see from the  
2 baseline if there has been changes. You know, what -- what  
3 are we seeing from, as you say, a fiscal perspective in  
4 realtime?

5 MS. SYVERSON: That's a great question, Michelle.  
6 What we have found is many of our employers participate in  
7 our employer database, meaning that all of their claims go  
8 into a data warehouse, if you will. And we've been talking  
9 to our employers about, we, as the coalition, we refer to as  
10 the coalition, I have access to all of their data as well.  
11 And I could go in and I could see what participants  
12 registered for the program and what their claims were prior  
13 to entering the program, how they progressed through the  
14 program, and what their claims are through the end of the  
15 program, so it is possible.

16 I have not talked to the data and claims  
17 providers for PEBP to see if they can do that. It's very  
18 important that we shield the actual participants from the  
19 employer, if that makes sense. You know, you'll only get  
20 aggregate data, but you could possibly get the identified  
21 data by participant. So, that's something we could pursue  
22 with maybe Segal. I'll have to look at that and talk to PEBP  
23 staff, but I think it's possible, yes.

24 MEMBER KELLEY: All right. Thank you.  
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1 CHAIRWOMAN GRIMMER: Okay. Any further  
2 questions? Okay. Thank you for your presentations. With  
3 that, we will close Agenda Item Number 11 and move on to  
4 Agenda Item Number 12, public comment.

5 MR. HOPKINS: One moment, Madam Chair. I'll go  
6 ahead and get this slide up. We have about five attendees in  
7 the lobby.

8 CHAIRWOMAN GRIMMER: Perfect. Thank you.

9 MR. HOPKINS: You're welcome.

10 During this Zoom meeting as an attendee is for  
11 making public comment only. If you do not wish to make  
12 public comment, please leave the meeting, so you're not  
13 accidentally called upon. Please feel free to watch it via  
14 the YouTube livestream on the PEBP YouTube channel. The  
15 length of the livestream is also located on the agenda on the  
16 PEBP website.

17 For those who have joined for public comment,  
18 your name or the last four digits of your phone number will  
19 be announced, and you'll be advised you've been unmuted.  
20 Please slowly stand and spell your name for the record, and  
21 then proceed with your comments.

22 Debbie, please slowly state and spell your name  
23 for the record if you wish to make public comment.

24 Dyer, you have permission to speak. Please  
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1 slowly state and spell your name for the record if you wish  
2 to make public comment.

3 Hugh Wang, you have permission to speak. Please  
4 slowly state and spell your name for the record if you wish  
5 to make public comment.

6 Christine -- oh, sorry. Susan, Susan, you have  
7 permission to speak. Please slowly state and spell your name  
8 for the record if you wish to make public comment.

9 Last call, if you do wish to make public comment  
10 raise your right hand right now. I've called upon you, but  
11 you have not responded.

12 Madam Chair, that concludes public comment.

13 CHAIRWOMAN GRIMMER: Okay. Thank you for that.

14 Seeing no further public comment, we will close  
15 Agenda Item Number 12, and we will adjourn.

16 MS. GLOVER: Thank you.

17 CHAIRWOMAN GRIMMER: Thank you, everyone.

18 MR. HOPKINS: Thank you, everyone.

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

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

That on Thursday, the 23rd day of January, 2025, I was present on Zoom for the Public Employees' Benefits Program, Carson City, Nevada, for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 158, is a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Carson City, Nevada, this 28th day of January, 2025.

KATHY JACKSON, CCR  
Nevada CCR #402

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