In The Matter Of:

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

January 23, 2025

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

Original File 1-23-25 PEBP.txt
Min-U-Script® with Word Index

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 BEPSY STRASBURG - Member
For the Board:	RADHIKA KUNNEL Deputy Attorney General
For Staff:	CELESTENA GLOVER Executive Officer JESSICA CRANE Executive Assistant MICHELLE WEYLAND Chief Financial Officer NIK PROPER Operations Officer LESLIE BITTLESTON Quality Control Officer
Reported by:	CAPITOL REPORTERS Certified Shorthand Reporters BY: KATHY JACKSON Nevada CCR #402 628 E. John Street, Suite 3 Carson City, Nevada 89703 (775) 882-5322

INDEX

INDEX

INDEX

THURSDAY, JANUARY 23, 2025, CARSON CITY, NEVADA

-oOo-

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

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

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

CHAIRWOMAN GRIMMER: Present.

MS. CRANE: Michelle Kelley?

MEMBER KELLEY: Present.

MS. CRANE: Jim Barnes?

MEMBER BARNES: Here.

MS. CRANE: Jennifer McClendon?

MEMBER MCCLENDON: Present.

MS. CRANE: Bepsy Strasburg?

MEMBER STRASBURG: Present.

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

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

CHAIRWOMAN GRIMMER: Okay. We will move on to

Agenda Item Number 2, public comment. Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda item as an item on which action may be taken. Public comments to the Board will be taken under advisement, but will not be answered during the meeting.

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

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

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

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

In addition to the first -- I'm sorry. For those

to join public comment, the name, with the last four digits of your phone number will be announced, and you'll be advised you've been unmuted. Please slowly state and spell your name for the record, and then proceed with your comments. For those who are on the phone, please press star -- star six to unmute.

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

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

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

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

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

In a couple of weeks, I'm gonna get a bill for this drug, and it will say that the drug will cost $12,000. Of the $12,000, I only have a 25 dollar co-pay because I'm on

an HMO. I have to take this drug once every eight weeks. So, every eight weeks, I get a bill for $12,000, in which I only pay $25.

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

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

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

MR. HOPKINS: Thank you.

Stephanie Goodman, please slowly state and spell

your name for the record if you wish to make public comment.

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

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

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

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

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

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

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

So the past nine years, both myself and my two teenage children have been covered by the PEBP HMO insurance plan. It's hard to imagine the last two years without the coverage that an HMO plan provides as I battled breast cancer and will remain in treatment to prevent recurrence for the

next five to ten years. During this time, one of my children also had surgery, and another had an urgent medical situation. With our HMO plan, our costs were both predictable and manageable.

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

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

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

MR. HOPKINS: Thank you.

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

MS. ARTEAGA: Yes. It is Deborah, D-e-b-o-r-a-h

Arteaga. It's A-r-t as in Tom e-a-g, as in girl, a. Good morning, Board members. I am faculty senate chair of UNLV, and I'm speaking on behalf of our employees. I have received dozens of calls and e-mails, and I have been CC'd on the written comments.

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

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

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

For example, colleagues who have previously worked in California have told me that the health insurance there is much better. In this data there is no HMO. In the

appendix, a graph is given that shows migration of employees from one healthcare plan to another.

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

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

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

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

MR. HOPKINS: Thank you.

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

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

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

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

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

We understand that PEBP's goal is to reduce cost and administering these programs. The lack of clarity and

preparation for these changes has raised significant concerns of the non-employees.

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

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

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

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

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

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

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

In conclusion, NSHE opposes the proposed changes to the PPO, HMO and EPO plans because of the significant concerns raised by our employees. These changes as outlined will cause disruptions to healthcare access, create financial

uncertainty and potentially erode the trust employees placed in their benefits.

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

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

MR. HOPKINS: Thank you.

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

MR. ERVIN: Good morning, Chair Grimmer, Executive Officer Glover, and members. Kent Ervin, E-r-v-i-n, for the Nevada Faculty Alliance, the Independent Association of Professional Employees at Nevada's Public

Colleges and Universities. We work to empower our members to be fully engaged in our mission to help students succeed. I have submitted detailed written comments on behalf of the Nevada Faculty alliance, so I will be brief here.

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

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

MR. HOPKINS: Thank you, Mr. Ervin.

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

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

that it's been available.

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

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

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

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

The most egregious part is that UMR is playing games. The procedures were coded into the system by Carson Tahoe Hospital's preauthorization department and rejected out

with documentation that no preauthorization was required. Then, when UMR processes the billings, they're denied for no preauthorization received. Each time I've spent hours, many hours on the phone with Carson Tahoe Hospital's pre op department, who has been fabulous, and UMR.

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

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

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

Northern Nevada.

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

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

The loss of Carson Tahoe Hospital as a result of UMR's shenanigans is, again, unacceptable. Carson Tahoe Hospital providers have literally saved my daughter's life. The type of cancer she had could metastasize to lung cancer and the physicians and surgeons and endocrinologist and

everyone she has been working with have gone just to great lengths to treat her well and treat her condition well. And we need to make sure that Carson Tahoe remains a provider for Northern Nevada and we need a better third party administrator that is not UMR. Thank you.

MR. HOPKINS: Thank you.

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

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

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

In the first couple of years in our new year, we've received several phone calls from members who had a lot of struggles with the Medicare Exchange, as well as the Carson Tahoe Hospital effect that you just heard about. And others who made the mistake of leaving the Medicare Exchange for something less expensive during open enrollment and only after they switched, realized that the mistake, how much it cost them.

For the benefits of membership in RPEN is our good working relationship with PEBP and also with PERS and our ability to reach out to Ms. Glover and know she will do her best to help our members. The same holds true with Chris Garcia at Via Benefits.

I know Ms. Glover has been too busy to write our health manage column in our member newsletter that we mail to nearly 7,000 RPEN members statewide, many who are in PEBP. However, I asked Mr. Garcia if he would be willing to step up and provide the column for us, and he happily agreed. So, we're very happy that the experts will be speaking to all our members about what happens when you look for something outside of the Medicare Exchange since PEBP only now puts information online only.

Speaking of Via Benefits, we are happy to see that PEBP has an item before you today to consider renewing

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

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

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

MR. HOPKINS: Thank you.

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

MS. CARR: Yes, Lindsay Carr, L-i-n-d-s-a-y C-a-r-r. Thank you to the Board for giving us the opportunity for public comment today. As my mom, Jennifer

Carr, who was just previously on, mentioned, I'm a 23-year-old graduate study that's halfway through the counseling master's program at UNR. I am also a young adult cancer survivor, recently told that I was in remission.

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

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

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

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

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

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

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

MR. HOPKINS: Thank you.

Caller with the last four digits 2157, please press star six to unmute and please slowly state and spell

your name for the record.

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

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

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

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

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

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

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

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

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

MR. HOPKINS: Thank you.

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

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

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

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

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

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

public comment.

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

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

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

My fellow faculty who are on the HMO currently have also talked to me about the worry they are being forced to switch health plans. They have told how they are concerned that they will need to find new providers and rebuild relationship with doctors that have been years in the

making. They have stated that they are aware of the differences between the standard PPO and HMO plans and chosen the HMO plan because that offers them the best path for their healthcare needs. Please do not eliminate this option for them. Thank you for your time.

MR. HOPKINS: Thank you.

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

MR. CORDOVA: I'm just listening.

MR. HOPKINS: Okay. Thank you.

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

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

And to have the HMO plan is comforting, knowing that we are able to have our predictable co-pays. We know when we are going to be able to see our providers. We have

an established set of relationship with them, and that really leads to our overall care. Not only are we talking about our physical health but in conjunction with that, having that rapport with your providers also leads to a good mental health, and those are very important to work together when we are trying to heal ourselves.

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

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

MR. HOPKINS: Thank you.

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

Diana, you have permission to speak. Please slowly state and spell your name for the record if you wish

to make public comment.

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

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

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

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

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

MR. VALENTIN: Do you hear me now?

MR. HOPKINS: Yes, I do.

MR. VALENTIN: Okay, perfect. It's Mark Valentin, M-a-r-k V-a-l-e-n-t-i-n, and I am speaking on keeping the HMO. I -- currently I am on the PPO myself, but I was on the HMO, and I do have a lot of co-workers, very close co-workers that are on the HMO plan that do have

chronic conditions, and I worry for them. If they have to have a disruption of their service, I know how hard it is to go through when you have an insurance change. I've done it a few times, and you have to kind of go back to square one. And I know a lot of the people at the university who don't -- I'm, frankly, really concerned if they have to go back to square one and how their health might be affected if they have to change insurance if they're getting denied on things they were previously approved for.

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

MR. HOPKINS: Awesome. Thank you, Mark.

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

Kimberly Dawes, you have permission to speak.

Please slowly state and spell your name for the record if you wish to make public comment.

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

MR. HOPKINS: No problem. Thank you.

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

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

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

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

MS. LOPEZ: Hello. Can you hear me?

MR. HOPKINS: Yes, we can.

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

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

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

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

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

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

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

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

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

MR. HOPKINS: Thank you.

Scott, you have permission to speak. Please

slowly state and spell your name for the record if you wish to make public comment.

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

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

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

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

MS. CEDILLO: Hello. Can you hear me?

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

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

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

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

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

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

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

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

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

I just wanted to let you know that. It's -- it's been difficult with the system that's there now. But taking

away something like the HMO for those who use it and really depend on it, is really devastating. So, as the other young lady, I forgot her name, who was going through the cancer treatment, as she said, maybe consider something aside from UMR. I don't know if we can get other kind of healthcare up here, but it would really help retain employees, and it would help take care of the people who work for the government. Thank you so much for your time.

MR. HOPKINS: Thank you.

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

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

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

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

MR. JACOBS: Oh, sorry. My name is John Jacobs, J-o-h-n. Last name J-a-c-o-b-s. I've worked at UNLV for 27 years now. And when I started, I started out with the HMO

plan. I am a diabetic. You know, as a diabetic type one, I didn't choose to be a diabetic. So, coming into the university, you know, I was somewhat limited as to what options I had that would allow me to receive care with the preexisting condition.

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

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

MR. HOPKINS: Thank you.

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

MR. WAGNER: Hi. My name is Michael Wagner,

M-i-c-h-a-e-l W-a-g-n-e-r. I would just like to make a comment on Carson Tahoe Health and on the Aetna Medical Advantage plan and Humana's Advantage Plan. Carson Tahoe just sent a letter out that they are going to get rid of coverage by Aetna and Humana, and they are pushing us to go to a coverage by either the local HMO's or I should say the local Medicare Advantage Plans, which are not covered by PEBP or by Via Benefits, and I would like to have that rest aside. Thanks. Bye.

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

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

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

MR. AMESQUITA: Michael Amesquita, M-i-c-h-a-e-l A-m-e-s-q-u-i-t-a. I did public comment last time. Between now and then, I now have to have shoulder surgery, which I would not be able to afford, period, if you took away the

HMO. I think something else has been brought up a lot this time around, is the un-Godful level of low healthcare in Nevada, in Southern Nevada.

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

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

MR. HOPKINS: Thank you.

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

Okay. So, what I'm gonna do, Madam Chair, we do

have one other public comment with a member. I'm gonna change my configuration out slightly, so just one moment, okay?

CHAIRWOMAN GRIMMER: Thank you.

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

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

MS. MONTELONGU: Okay. Thank you.

MR. HOPKINS: Thank you. Sorry about that.

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

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

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

MS. MONTELONGU: Thank you.

MR. HOPKINS: Perfect.

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

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

MS. KUNNEL: Thank you, Chair Grimmer.

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

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

The law does not require abstention from voting

merely because the Board member or their family member is eligible for PEBP benefits. At this time, I invite any member of the Board who has any additional disclosure to make to make it now. Thank you.

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

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

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

Good ahead, Madam Chair.

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

Are there any items the Board wishes to pull? Yes, Jessica?

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

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

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

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

MEMBER STRASBURG: Bepsy Strasburg. Second.

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

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

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

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

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

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

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

CHAIRWOMAN GRIMMER: Okay. Thank you for that.

Are there any questions or discussions?

MEMBER KELLEY: Michelle Kelley for the record. I have a question or two. I think they're easy ones. Thank you for the agenda item. And I'm Michelle Kelley for the record, M-i-c-h-e-l-l-e K-e-l-l-e-y.

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

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

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

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

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

open enrollment.

MEMBER KELLEY: Thank you.

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

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

MEMBER KELLEY: Thank you.

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

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

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

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

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

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

We will close Agenda Item Number 5 and move on to Agenda Item Number 6, Executive Officer Report. Celestena

Glover, information and discussion. Please go ahead.

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

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

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

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

In addition, the committee observed cancer

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

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

The only thing that was done a little bit

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

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

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

Specifically Melissa Williams has called me or

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

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

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

MS. GLOVER: Thank you. This is Celestena Glover. Before you is the summary of the EPO and HMO plan sunset. We presented this originally in September. The Board asked that we come back with additional information,

which Segal has put together a presentation to -- to provide that additional information.

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

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

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

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

CHAIRWOMAN GRIMMER: Thank you.

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

MR. HOPKINS: Yes, you are, Richard.

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

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

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

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

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

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

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

I'm gonna start off here with a review of some of the materials that we have discussed in prior meetings. The first slide here is review of the current plan designs for the four plan options with the understanding that the EPO and

the HMO are offered on or priced on a blended basis when -- when employees are -- when members are making plan selections.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For the HMO, we reviewed current members, current and current utilization and the providers that were being -- that were utilized by people in the HMO, and those

were compared against the providers in the UHC network, and we see that there's significant overlap. That's the table in the middle. So, we see that the vast majority, while all hospitals are in both networks, almost all PCP's and then almost all specialists.

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

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

So, next we look at the particular patients that were using the -- that would be disrupted or are using HMO

network providers that would no longer be in network. And we -- we see that there are ten patients that utilize the PCP's that would not be in network in the UHC network, but only five of those patients are still enrolled in the HMO.

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

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

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

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

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

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

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

And we developed four distinct scenarios and then looked at them for employee and family coverage at different levels of cost. And we -- we did not include the HMO here for a couple of reasons. One, we don't have the detailed claims data for the HMO that we have for the other plans. So, we wouldn't be able to in the same way extract an actual

case study or an exact -- or an actual example that occurred.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And the low deductible health plan, the EPO, the

portion that is hitting the max out-of-pocket is lower, and that's largely due to that coverage being more co-pay driven. So, members, just for the same level of care have less out-of-pocket for the same -- for the same services, and so their out-of-pocket cost will accrue at a slower rate towards a max out-of-pocket, so fewer, a lower portion of the people in those plans hit their max out-of-pocket.

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

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

And also the state health plans in California,

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

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

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

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

peer states.

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

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

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

The maximum out-of-pocket, there are some states

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

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

Next, we looked at pharmacy, and, generally, other states also utilize co-pays. So, all of the PEBP plans or all of the PPO plans, the non CDH plans use a primarily co-pay based design per cost share for outpatient pharmacy. And so for generic medications, you see right in line, ten --

$10 currently compared to an average of 11, and there's not much variation in the market, ten versus 15, a minimum of ten, so a maximum of 15, with the average being 11. Most of these states are at the 10 dollar level.

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

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

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

And then for the premium, you're showing a single premium here, that's pretty comparable to the average, and

there's quite a bit of variation in the market among those plans from 30 to about 150 dollar for their highest value EPO.

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

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

Interestingly, though, PEBP is a bit of an outlier with drug coverage in the CDHP plan, being co-insurance driven. So, PEBP, the plan design in PEBP is co-insurance up and down the line, which is very straight forward and consistent with a lot of other CDHP plans in the market in general. But the states in the west that have high deductible health plans utilizes a co-pay driven benefit. So, if it's -- but that's after meeting the deductible. So,

they just have co-pays after meeting the deductible instead of co-insurance. And then the -- then the premiums range from zero to $80 with an average of 30 for single coverage and PEBP's premium is $55 currently.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We also expect there to be savings as people migrate to the -- to the PPO, which has shown to be the more efficient plan of the three self-insured plan options. So,

the PPO Option 1, we would see about 15,000,000 in expected savings in Plan Year '26 and then that growing to about 22,000,000 over -- over the five-year period here through Plan Year '30, excuse me.

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

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

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

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

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

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

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

And, then based off our current estimates, those

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

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

CHAIRWOMAN GRIMMER: Board members, are there any questions?

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

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

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

CHAIRWOMAN GRIMMER: Go ahead.

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

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

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

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

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

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

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

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

For the last three months, including Christmas Day, I have received public -- public comment directly from participants, explaining, you know, just their concern about the potential loss of the HMO. I am the NSHE south

representative, and that's where most of my -- you know, the participants that have outreached me have come from. And it's really, honestly, it's been quite overwhelming the number of public comments I've received. And I want to thank our participants for that because I do think it's important that they are engaged in these decisions because everything we do impacts them. So, I do appreciate everyone taking their time and sharing their stories.

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

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

is one of their many considerations.

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

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

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

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

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

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

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

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

And then just my last, this is very

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

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

CHAIRWOMAN GRIMMER: Thank you.

Are there any other comments from the Board members?

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

CHAIRWOMAN GRIMMER: Go ahead.

MEMBER WEEKS: I agree with Michelle Kelley. I think we need to wait. I think there's enough going on during session. I think something does need to change in how we purchase healthcare with large carriers across all of our

markets. I think the opportunities are different now, and they can be in the next year for state employees, and so I would support what Michelle said and wait.

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

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

CHAIRWOMAN GRIMMER: Thank you.

Any further comments?

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

CHAIRWOMAN GRIMMER: Okay. Thank you for the comment.

Bepsy?

MEMBER STRASBURG: Hi. This is Bepsy Strasburg.

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

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

CHAIRWOMAN GRIMMER: Thank you.

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

MS. GLOVER: Can I make a comment?

CHAIRWOMAN GRIMMER: Yes. Go ahead, Executive Director.

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

I also, depending on whether or not we close the

session to talk about the RFP results, one of the things I will need to move forward, is that the Board would need to approve moving forward with an award of a contract, which would be done in the public, in the open meeting, and also allow me, as the Executive Officer, to finalize any negotiations and to sign the contract so we can get it to BOE by the next deadline. So, there's a couple of things that need to happen in there. It's similar to what is needed in the Agenda Item 8. So, whatever the motion is, needs to include those things. Thank you.

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

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

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

the HMO provider to enter into a satisfactory contract.

CHAIRWOMAN GRIMMER: Thank you.

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

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

CHAIRWOMAN GRIMMER: Okay. Thank you.

Do I have a second?

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

CHAIRWOMAN GRIMMER: Okay. Any further discussion?

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

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

MEMBER STRASBURG: Okay.

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

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

CHAIRWOMAN GRIMMER: All opposed? Okay. Motion passes.

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

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

MS. GLOVER: This is Celestena Glover. So, essentially the motion from Agenda Item 7 covered most of these requirements, so, the contract, me signing the contract, finishing the negotiations and so fourth. What we need to do now is if the Board does have specific questions

as to the result of the RFP, we do need to close the session to allow those questions to be asked. So, that's the first thing.

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

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

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

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

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

go too far ahead.

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

CHAIRWOMAN GRIMMER: That works. Thank you.

MS. GLOVER: Thank you.

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

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

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

CHAIRWOMAN GRIMMER: Okay. Good afternoon. Welcome back to the PEBP Board Meeting on January 23, 2025. We are coming back from the closed session, and we have up

for discussion a possible action item number -- Agenda Item Number 7.1. Is there any discussion by the Board? Okay. Do I have a motion to -- do I have a motion on this item?

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

CHAIRWOMAN GRIMMER: Okay. Thank you.

Do I have a second?

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

CHAIRWOMAN GRIMMER: Okay. Thank you.

Is there any further discussion?

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

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

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

Are there any questions on Agenda Item Number 8?

MS. GLOVER: So, this is Celestena Glover. Just for clarification, as I said, I would repeat the requirement. This agenda item does provide the Board the option to take one of three actions. They can cancel the request for proposal. They can modify and re-issue the request for proposal or essentially move forward with an award of the contract to a -- to the winning vendor.

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

CHAIRWOMAN GRIMMER: Thank you.

Do we have a motion on Agenda Item Number 8?

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

CHAIRWOMAN GRIMMER: Thank you.

Do I have a second?

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

CHAIRWOMAN GRIMMER: Thank you.

Okay. I have a motion and second. Is there any further discussion? Seeing none, I'll take a vote. All those in favor signify by saying aye.

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

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

Please go ahead.

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

That audit included a quarterly performance guarantee validation, 100 percent electronic screening, with 50 targeted samples, the statistically valid stratified

random sample audit of 200 claims and a focused random sample audit of 100 claims from Carson Tahoe Hospital.

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

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

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

CTI also reviewed the quarterly UMR self-reported performance guarantee results and noted that 26 out of the

27 quarter -- quarterly results were met.

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

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

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

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

So, if you have any questions, I'm happy to

answer any.

CHAIRWOMAN GRIMMER: Okay. Thank you for that.

Board members, are there any questions?

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

MEMBER MCCLENDON: Jennifer McClendon. I move to approve.

CHAIRWOMAN GRIMMER: Thank you.

Do I have a second?

MEMBER KELLY: Michelle Kelley. I'll second.

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

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

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

MS. HUCKABY: Hi. For the record, this is Rhonda Huckaby with UMR. We would like to thank you for the opportunity to respond to the audit performed by Claims

Technologies for quarter one Plan Year 2025. We are dedicated to improving the overall experience and our commitment to meet all performance guarantees.

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

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

We continue to review process improvement opportunity within the organization. We value our partnership with the State of Nevada, and we will continue to work with PEBP and their vendor partners to perform high level service to the participants and the provider community. And we have leadership on the call from operations to address specific questions from PEBP Board members related to our

enforcement guarantee or are those CTI audit results.

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

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

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

MS. BITTLESTON: Yes, we can.

MR. GARCIA: Thank you.

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

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

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

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

And one of our survey questions is if the participant feels like they've enrolled in the best plan that

meets their need, then we typically get responses of around 98 percent of those retirees are finding that are enrolling in the best plan that meets their need that's available on our platform.

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

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

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

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

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

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

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

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

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

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

And the good news is that our plans are not just focused in Nevada, right. So, you have retirees that live in all 50 states, across the country, and we have plans available in every state through, with different carriers, whether they're regional carriers or not, these are just some of the top, you know, carriers that we have available on our

platform. It gives you a good idea of the types of different insurance carriers that we are working with on a regular basis.

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

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

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

And then what's good about the website is a lot of older retirees might need assistance, and they can get

that assistance through a friend, and that friend can help them review or even a family member can, of course, help them review that information right on the website.

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

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

Typically the appointments are recommended to

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

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

The Benefit advisor will help the participant review the different plans, as I mentioned, and choose a plan. Again, there is a verification that is done of who the participant is over the phone. And then if the participant doesn't want to provide permission over the phone, they can have a family member or friend speak to a Benefit advisor to help them walk them through any assistance that they might need in regards to reviewing plan information and talking

about what plan or plans might best meet the participant's need.

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

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

If we have that information from the participant, if they enter in their prescription information, if they enter in the physicians that they see, the tool will utilize

all that information and do the shop and compare so they can see what prescriptions are covered and what physicians might be available in that plan or through that network.

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

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

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

We have support for your retiree population.

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

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

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

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

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

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

So, for example, a new Benefit advisor who comes on may be only licensed in four or five different states. But somebody who has a longer tenure with us could be licensed in all 50 states, not just depending on their

experience and their knowledge and the process that they have gone through to become licensed.

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

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

Okay. Again, Benefit advisors, they do provide that concierge service, unbiased. They do senior sensitivity training, which I've had the opportunity to attend in the past where it's interesting. They'll have, you know, the representatives wear specific glasses that are designed to

make, you know, a, be more like somebody who is an older person who might have vision problems. So, it gives them a better understanding of what that experience might be for a retiree who receives information in the mail, but it's hard for them to read and to try to help, you know, have that sensitivity around some of the challenges that an older retiree might be experiencing, whether it's based off of, you know, vision or hearing or something along those lines.

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

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

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

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

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

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

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

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

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

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

Moving on to the different communications that we and the meetings that we do. So, we have multi-faceted communications. We do print communication, which include

educational guides and reminders throughout the course of the year. I've shared some of those communication materials with the Board during our quarterly reporting that we provide.

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

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

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

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

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

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

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

We don't go too much through the enrollment

process, except for maybe if somebody wants to consider making a change or they have some sort of special enrollment period that they might want to consider making a change to the different plans that they enrolled through with us.

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

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

The average in inbound handle time, so I mentioned like the, the enrollment calls are typically about an hour. But, of course, HRA type call would typically be less, maybe ten minutes, 15 minutes or so. So, on average, the handle time, so how long we're on the phone with the

participant is usually about 18 minutes and change. So, you can see for 2024, it was 18 minutes and 56 second. In 2023, it was 18 minutes and 10 seconds, but it kind of gives you an idea of the volume of calls we're receiving specific to PEBP and then how long those calls on average last.

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

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

So, for PEBP, the total eligible population is around 18,800 people. Of those, we have 13,483 participants

that are enrolled through us. And the plan is at the end of the 2024. So, that's 71 percent of the population has enrolled through us. And then below that, you'll see a chart showing you the different types of plans that participants have enrolled through us, whether it's a Medicare Advantage plan, a Medicare supplement plan, a Part D plan, which is prescription, drug, dental or vision.

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

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

that, I'll focus on that first.

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

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

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

there.

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

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

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

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

So, you know, we have a fully integrated experience. We try to do one call resolution, as well as we

have an integrated website. Obviously, not every situation can be resolved in one call. Something might recall -- require additional research or it could be something that is just needed to, you know, have some data on an account, and we have to get that data requested and then sent over to us. So, certainly, because we try to resolve everything in one call, there could be a situation where that doesn't occur.

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

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

Okay. There is a requirement for the HRA participants for Nevada PEBP. Participants must enroll in a Medicare medical plan through Via before their enrollment

period ends to qualify for the HRA. And then to continue to qualify for the plan, they must remain enrolled in a qualifying plan through Via Benefits. So, they can change plans from one Medicare medical plan to another Medicare medical plan. But if they have a gap and they drop coverage by mistake, then they become dis-enrolled and disqualified for their HRA.

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

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

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

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

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

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

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

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

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

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

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

MS. BITTLESTON: It looks like Chris froze.

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

Madam Chair, you can hear me okay, right?

CHAIRWOMAN GRIMMER: Yes, I can hear you.

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

CHAIRWOMAN GRIMMER: Okay. We'll give him time

to rejoin. And if not, then -- there we go.

MS. BITTLESTON: Here he comes.

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

MR. GARCIA: I am. I don't know what happened. I don't know when I lost you all. I'm so sorry.

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

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

CHAIRWOMAN GRIMMER: Thank you.

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

MR. HOPKINS: Yes, we can.

CHAIRWOMAN GRIMMER: Yeah.

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

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

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

MR. GARCIA: Okay. Thank you, Leslie.

MS. BITTLESTON: Sure.

MR. GARCIA: Again, Chris Garcia for the record.

So, I believe that I was mentioning that there's just a large number of different types of eligible expenses. You can see, again, just some of the common ones here. So, I'm gonna move on to the next slide. But if there are any other questions about eligible expenses, I'll take some questions at the end, of course.

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

If the claim is approved, we will reimburse the participant up to their available balance in their account, depending on how much the claim is for. And then if the claim is denied, we will send out what's called an explanation of unpaid expense to the participant, advising them the claim has been denied and why it's been denied, and typically it has to do with the supporting documentation or perhaps the expenses determined to be an ineligible expense,

such as maybe cosmetic surgery, those would not typically be considered an eligible expense. But once a determination is made on the claim, the participant is either notified by receiving a reimbursement or if there was a portion of the claim that was denied or a full denial, there will be a notification as to why.

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

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

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

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

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

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

We do have HRA assistance available for your Nevada PEBP retirees. Obviously, we have our regular toll

free number that participants can call to get assistance. That's available Monday through Friday from 5:00 a.m. to 4:00 p.m. Pacific Time. And if they call, they can get help, you know, that number, their available balance and eligible expenses and check on the status of a claim. They can turn on automatic reimbursement, et cetera through speaking through a regular customer service representative.

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

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

there in person.

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

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

As I mentioned earlier, the mobile app is the newest tool that we have available to retirees to utilize the mobile app. It is something that's available through IOS, so that's through Apple store or through the Google Place Surfer

on Android. It is a way they can check their reimbursement status, check their available balances. They can submit their new reimbursement request directly through the phone. They can just take a picture of their supporting documentation. They'll enter in the claim information and they upload it right to their account online.

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

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

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

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

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

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

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

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

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

We're doing it online. There's 27,000 online claims. And that mobile app, again, mobile app is the

smallest percentage, just over 12,000 claims coming in through the mobile app. So last year, you know, for 2024, we had 475,000 total claims that we received and processed. So, even if the claim was denied, we had to -- someone had to take time to review it and process it.

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

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

CHAIRWOMAN GRIMMER: Go ahead, Ms. Kelley.

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

CHAIRWOMAN GRIMMER: You're good.

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

I have -- so, I really like that automatic

premium reimbursement that you talked about. Do you do that for Medicare Part B?

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

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

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

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

MR. GARCIA: Correct.

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

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

But we have had a member of our customer service team who works specifically with PEBP who's received numerous calls and had several conversations with PEBP retirees in

regards to adding and looking at the opportunity to add some additional carriers to our platform in that area. So, I can't commit to anything right now, but it is something we are certainly exploring based off of the information we received.

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

CHAIRWOMAN GRIMMER: Okay. Any further questions?

Okay. Thank you, Mr. Garcia.

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

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

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

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

MS. SYVERSON: Perfect. Thank you.

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

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

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

The national DPP is an evidence based lifestyle program. It's a year long. Sessions are weekly for six months, and then monthly for six months. That's a mouthful. And we're geared towards having employees and participants

make real lifestyle changes. They meet with a trained lifestyle coach and a small group of people who are also making lifestyle changes, and it's proven to cut participants' risk in developing type two diabetes by 50 percent. So, if you can stick with it, it's a great program.

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

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

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

There are other groups, however, that want to meet every Saturday or they have a different cohort group that just want to meet in person. And our partners have been

very good at designing those programs and developing around participants' needs.

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

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

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

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

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

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

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

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

MS. LINDEN: Yes, I'm here.

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

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

So, we offer diabetes self-management program and the diabetes prevention program, along with a number of other programs. We're fully grant funded. So, we've been offering diabetes self-management for over ten years. We do that virtually, and we do it in person, as well, in the Reno/Sparks area. And I think this is still all right. We have about ten active facilitators. We have some peer leaders, some staff trained. We offer that program in English and Spanish, and we've been offering diabetes prevention program for about five years, and we are a

recognized site, so we've been successful and having good outcomes in that program.

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

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

MS. SYVERSON: Thank you.

Jemaima, are you on?

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

MS. SYVERSON: Thank you.

MS. TAGAYUA: All right. Good afternoon, everyone. Thank you, Chris, for inviting me on this call. We are Nevada Health Partners, partner down here in the south in Las Vegas, Nevada. I am a health educator and program coordinator for the Dignity Health St. Rose Dominican Community Health Department. Our vision is a healthier future for all inspired by faith, driven by innovation and powered by our humanity. Although, we are a faith based

hospital system, we do serve all folks, all walks of life, and we don't turn anyone away.

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

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

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

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

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

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

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

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

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

diabetic or prediabetic.

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

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

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

For the DSMP or DSMES, it's estimated that about 800 to $1,700 a year could be saved in claims. Again, being

very conservative, that would be about another $82,500 in year on savings to the PEBP plan.

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER KELLEY: All right. Thank you.

CHAIRWOMAN GRIMMER: Okay. Any further questions? Okay. Thank you for your presentations. With that, we will close Agenda Item Number 11 and move on to Agenda Item Number 12, public comment.

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

CHAIRWOMAN GRIMMER: Perfect. Thank you.

MR. HOPKINS: You're welcome.

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

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

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

Dyer, you have permission to speak. Please

slowly state and spell your name for the record if you wish to make public comment.

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

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

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

Madam Chair, that concludes public comment.

CHAIRWOMAN GRIMMER: Okay. Thank you for that.

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

MS. GLOVER: Thank you.

CHAIRWOMAN GRIMMER: Thank you, everyone.

MR. HOPKINS: Thank you, everyone.

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

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

That on Thursday, the 23rd day of 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

D

E

F

G

N

O

Q

R

T

U

V

W