In The Matter Of:

PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD
VIDEOCONFERENCED OPEN MEETING

March 20, 2025

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

VIDEOCONFERENCED OPEN MEETING

THURSDAY, MARCH 20, 2025

CARSON CITY, NEVADA

The Board:	JOY GRIMMER, Chairperson MICHELLE KELLEY, Vice Chair JIM BARNES, Member JENNIFER MCCLENDON, Member JANELL WOODWARD, Member THERESA CARSTEN, Member LAURA RICH, Member
For the Board:	RADHIKA KUNNEL, Deputy Attorney General BRANDEE MOONEYHAN, Lead Insurance Counsel
For Staff:	CELESTENA GLOVER Executive Officer NIK PROPER Operations Officer MICHELLE WEYLAND Chief Financial Officer LESLIE BITTLESTON Quality Control Officer JESSICA CRANE Executive Assistant
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A G E N D A

THURSDAY, MARCH 20, 2025, 9:07 A.M.

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CHAIRPERSON GRIMMER: Good morning, everyone. This is the Public Employees Benefits Program meeting on March 20th, 2025, at 9:00 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. Thank you. Board Chair Grimmer.

CHAIRPERSON GRIMMER: Here.

MS. CRANE: Michelle Kelley.

MEMBER KELLEY: Present.

MS. CRANE: Jim Barnes.

MEMBER BARNES: Here.

MS. CRANE: Jennifer McClendon.

MEMBER MCCLENDON: Here.

MS. CRANE: Janell Woodward.

MEMBER WOODWARD: Here.

MS. CRANE: Theresa Carsten.

MEMBER CARSTEN: Present.

MS. CRANE: Laura Rich.

MEMBER RICH: Here.

MS. CRANE: Bepsy Strasburg. Okay. It appears Bepsy is absent. But we do have a quorum. Please remember

to state and spell your name before speaking for our transcriber.

CHAIRPERSON GRIMMER: Okay. Thank you. 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 as an item on which action may be taken. Comments may be limited to three minutes per person at the discretion of the chairperson. Can you please put up the slide. Thank you.

MR. HOPKINS: Yes, Madam Chair. I have the slide up and I'll make my announcement real quick. It looks like we have four people in the lobby at the moment.

CHAIRPERSON GRIMMER: Okay. Perfect. Go ahead.

MR. HOPKINS: If you would like to call in to provide public comment, please dial area code (669)900-6833, and then when prompted to provide your meeting ID, please enter 867 2016 1489 and then press pound. When prompted for the participant ID, please enter pound. During the Zoom meeting -- Joining the Zoom meeting as an attendee is for making public comment only. If you do not wish to make public comment, please leave the Zoom meeting now, so you're not accidentally called upon. Please feel free to watch it via the YouTube live stream on the PEBP YouTube channel. The

link for the live stream is located on the agenda.

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

Caller with the last four digits 6837, please press star six to unmute and please fully state and spell your name for the record.

MR. ERVIN: This is Kent Ervin, E-r-v-i-n, with the Nevada Faculty Alliance, the statewide association of professional employees at our public colleges and universities.

Good morning, Chair Grimmer and Members. The rate setting meeting at PEBP is one of the most important of the year. Board members have a fiduciary duty to balance the benefits and costs of the plan design in setting rates. This year for the first time since the pandemic, the meeting is not being held in person.

The board packet includes just two rate options for the board to consider and no analysis whatsoever on the two scenarios.

However, we support scenario one, which appears to follow existing board policy on rate setting methodology.

Scenario two arbitrarily raises employee premiums above the actuarial requirements. With no reasons presented to do so, that is simply punitive to our state employees participants.

On the legislative bill review NFA opposes AB 22 and SB 52 as introduced which would alter the governance of PEBP and reduce the authority of the board.

The Nevada Faculty Alliance supports AB 188, restoration of retiree health benefits for post-2011 hires, AB 169 to expand speech therapy treatments for minors and AB 349, which would cap PEBP claim statements, potentially saving PEBP up to 36 million per year. A full analysis of AB 349 by PEBP is needed today determine the actual savings that could be realized.

For AB 188 and AB 169, PEBP's fiscal notes are highly exaggerated and should be reduced or withdrawn. Thank you.

MR. HOPKINS: Thank you.

Doug Unger, you have permission to speak. 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 member of the UNLV Employee Benefits Advisory Committee. Thank you, Chair Grimmer, Executive Officer Glover, and the PEBP board

for your service and consideration.

March is rate-setting month. And this year, which feels ever more economically challenging everywhere, Agenda Item Number 6 feels more important for how best to keep premiums low as possible for faculty and state employees.

Reason: We'll all have a mandated 1.75 percent increase in PERS and defined contribution retirement deductions which will reduce take-home pay. Looking at the possible scenario one versus scenario two of proposed rates for possible action next year, no rationale is provided by PEBP for the executive officer and the PEBP team to recommend the higher premiums in scenario number two.

Both scenario one and two promise significant monthly increases for state employees with families, though individuals will see premiums either reduced a little or left more or less flat. The difference between one and two means a premium increase of 588 per year versus 888 per year for the PPO, to look at just one plan, which is more than a small sting when an increase of, say, $1225 per year is also deducted for retirement. That would mean $176 per month take-home pay reduction for an assistant professor or state employee making $70,000 per year with a family on the low deductible PPO as an example. And this in a year when, due

to draconian federal funding cuts to budgets that will affect almost every conceivable work life occupation for state employees, plus the anticipated higher inflation rate due to federal tariff tax increases on imports that, by the way, I can't find one single economist of sound mind recommending. All of this is bound to cause additional collateral economic distress for state employees and their families.

At least PEBP has the power to offer some relief by choosing scenario number one for the lowest rates and reducing the sting. Thank you for being mindful of this when making the important rate setting decision.

Regarding Agenda Item Number 9, legislative bills, I wish to point out that AB 188, which will restore health benefit contributions for state employee retirees hired after 2011, we believe will have a very minimal fiscal impact, less than the 2.5 million guesstimate cited, and no immediate fiscal impact whatsoever. The fiscal note is really a hazarded guess added to a speculation about additional staff.

AB 188 is the right thing to do, especially in these uncertain times. Thank you.

MR. HOPKINS: Thank you, Mr. Unger.

Caller with the last four digits 0891, please press star six to unmute and please slowly state and spell

your name for the record.

MS. LAIRD: Thank you. Good morning, Chair Grimmer and board members and staff. My name for the record is Terri Laird, T-e-r-r-i L-a-i-r-d. I'm the executive director of RPEN, a non-profit, non-partisan organization founded nearly 50 years ago to protect the pension and health care benefits they earned while promised at the start of their careers.

RPEN has nearly 7,000 members, and the majority are retired and in PEBP's Medicare exchange. And so it was with great concern when we heard PEBP's former executive officer and now new board member, Laura Rich, who markets your recent legislative board meetings that PEBP would have more money to increase benefits for active participants in PEBP if they can do health care benefits for retirees. This is quite a surprise and very alarming and something RPEN is very much opposed to for obvious reasons.

Ms. Rich has said Nevada is one of the few states offering retiree benefits. Is there proof of this statement? And how cruel would that be to take away these benefits when they need it the most.

In addition, RPEN is on the record of being opposed to those PEBP presented recently to the Nevada legislature, AB 22 and SB 32, for reasons already shared

about the proposed Nevada Health Authority and await more information about the impact on active and retired public employees. We do support AB 188 as mentioned also by previous callers. And I thank you for your time and statements.

MR. HOPKINS: Thank you.

Madam Chair, that concludes the public comment. We have no one else in the lobby.

CHAIRPERSON GRIMMER: Okay. Thank you very much.

We will close Agenda Item Number 2 and go on to Agenda Item Number 3, PEBP board disclosures for applicable board meeting items. Deputy Attorney General Radhika Kunnel.

MS. KUNNEL: Thank you, Chair Grimmer. Good morning, everyone. My name is Radhika Kunnel for the record.

This agenda item is to allow me to make a disclosure regarding conflicts of interest on behalf of the board members who are eligible for Public Employee Benefits Program.

Pursuant to NRS 281A.420 on behalf of the board members who are eligible for the 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 disclosures to make to make it now. Thank you.

CHAIRPERSON GRIMMER: Okay. Seeing no other disclosures, I will close Agenda Item Number 3 and move on to Agenda Item Number 4, consent agenda. Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the board.

Does anyone have any items to be pulled? Yes, Ms. Kelley.

MEMBER KELLEY: Michelle Kelley for the record. Could we pull 4.3.8? I just have a quick question regarding that agenda item.

CHAIRPERSON GRIMMER: Okay. Okay. Are there any others? Okay. Seeing none, do I have a motion to approve everything but 1.3.8?

MS. GLOVER: It's 4.3.8.

CHAIRPERSON GRIMMER: Four? I'm sorry. Okay. Sorry. I couldn't hear you. Okay. 4.3.8. Do I have a motion to approve everything but 4.3.8?

MEMBER KELLEY: Michelle Kelley. I make a motion

to approve the consent agenda item except for Item 4.3.8.

CHAIRPERSON GRIMMER: Okay. Do I have a second?

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

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

(The vote was unanimously in favor of the motion)

CHAIRPERSON GRIMMER: All of those opposed? Okay. Motion carries.

Can we please have someone present on 4.3.8 please.

MEMBER KELLEY: Chair Grimmer, I just actually have a quick question.

CHAIRPERSON GRIMMER: Okay. Go ahead.

MEMBER KELLEY: Thank you. So I noticed that there was a public comment about, once again, Carson-Tahoe, the stepchild in Carson City. And I just wonder if Ms. Bittleston perhaps -- I think this was her agenda item -- can talk about if there's been any analysis done on our retirees in Medicare Advantage access to Carson-Tahoe in Carson City and/or through the Medicare Advantage program and/or if we can get such an analysis done to see which health insurance programs are still -- still offer

Carson-Tahoe as in network.

MS. BITTLESTON: Leslie Bittleston for the record. No, we have not conducted such an analysis at this point, but more than willing to do so. One thing that was conducted and presented at the last board meeting was a audit of a small percentage of claims that was presented by CTI at the last board meeting. And, I can't remember, my apologies, off the top of my head, the results of that audit from the last board meeting. But we can do an analysis of who was -- who Carson-Tahoe is accepting and have that ready for the next board meeting.

CHAIRPERSON GRIMMER: Thank you.

Ms. Rich.

MEMBER RICH: Thank you, Chair. I just wanted to point out that while I think that PEBP has a -- there's a great offer with the Medicare Exchange platform in terms of, you know, the customer service that is provided to our retirees, but, you know, just to reenforce what's been said on public comment, by forcing them to use that platform and tying them to the Medicare Exchange rather than allowing them to get their health care coverage through any plan they wish, you know, that we do have these problems, right.

And so there might be something that, you know, PEBP might want to look in to opening it up. I know in the

past it has been discussed and I know, you know, the benefits are that there's things that through the Medicare Exchange we have things like the automatic reimbursements and things like that. And then you can also handle and oversee the customer service and things of that sort.

But, on the flip side, you are completely, you know, forcing the retirees to use that platform and not looking at other options. So, it's just something that, you know, maybe that's another analysis that needs to be done.

CHAIRPERSON GRIMMER: Thank you.

Nik, please go ahead.

MR. PROPER: Nik Proper, Operations Officer, for the record. Vice Chair Kelley, excuse me, we were confirmed that Prominence and Senior Care Plus will remain in network for Carson-Tahoe.

CHAIRPERSON GRIMMER: Okay. Thank you for that.

Michelle, did you have a -- Go ahead.

MEMBER KELLEY: Yes. Thanks so much, Mr. Proper. I just wonder is someone going to follow up with Mr. Wagner who made public comments saying he couldn't find any Advantage plans that were accepting Carson-Tahoe anymore. If there are insurances that he could select, if that facility is important to him, I think it would be great to let him know if we can. Thank you.

MR. PROPER: Nik Proper, Operations Officer for the record. Yes, absolutely, we can do that and just confirm that yes there are some Medicare Advantage plans that will remain in network.

MEMBER KELLEY: I appreciate that.

CHAIRPERSON GRIMMER: Thank you for that.

Okay. Anything else? Okay. Seeing nothing, we will close this item and move on to -- or I'm sorry. Can we take a vote on Agenda Item 4.3.8? Do I have a motion?

MEMBER KELLEY: Michelle Kelley here. I'll make a motion to accept Agenda 4.3.8 as presented.

CHAIRPERSON GRIMMER: Thank you. Do I have a second?

MEMBER RICH: Laura Rich. Second.

CHAIRPERSON GRIMMER: Thank you. Okay. Any further discussion? Okay. Seeing none, all of those in favor signify by saying aye.

(The vote was unanimously in favor of the motion)

CHAIRPERSON GRIMMER: All of those opposed? Okay. Motion passes.

We will close Agenda Item Number 4 and go on to Agenda Item Number 5, executive officer report. Celestena Glover, Executive Officer. Information and discussion only. Thank you.

MS. GLOVER: Good morning. This is Celestena Glover, Executive Officer for PEBP. The executive officer report just gives you a basic overview of what has been happening. Obviously the staff and our vendor partners have been extremely busy with responding to fiscal notes for the many bills that are coming out. It seems like every 30 seconds we get another request.

So far during this legislative session, PEBP has presented their budget. That was done on February 14th. We presented to the full Joint Committee, Senate Finance and Assembly Ways and Means. There were a lot of questions on the presentation. Many of them were around the cost of the plan, what our plan design and the timing. I made sure that was included. What our steps are as far as the timing of when various decisions are made and when we have to, you know, make our final decisions.

They also had questions about Carson-Tahoe leaving the network. I tried to explain the processes we're going through. We did have -- One of the committee members had definite concerns about whether providers were being paid sufficiently through the network and what we were doing to address it.

We are releasing the RFP for the secondary network. We've had it ready to go. It's been in

Purchasing's hand. I'm not sure at this point. They have some additional questions that we're trying to get answered. So hopefully that can get resolved and that can get posted soon because we're really running out of time to implement a secondary vendor and there's a lot of moving parts when we bring in a second network to coordinate between the TPA and the vendors.

So I tried to answer those questions the best way I could. And I also let them know that as soon as that RFP was available I would provide copies to their staff so that they could see what was going on.

We also presented on Senate Bill 32 on February 19th and Assembly Bill 22 on February 21st. Those were just presentations for introduction of the bill. There's been no work sessions. And so far we have not seen any follow-up meetings for those bills.

And then future board meetings we're looking at starting up in-person meetings again in May. Obviously if we have board members that need to attend virtually, we will accommodate their requirements based on their own schedules. The May meeting is scheduled for May 22nd, 2025. That will be here at the PEBP office. And we are planning on update meetings for the legislative action in April and May. Right now we have one scheduled for April 7, I believe. And May

will be determined on everybody's availability and the need for that meeting. If something comes up and changes the need for the April 7th meeting, then we'll reschedule it to another date if we have no further updates to provide the board.

And, with that, I'll take any questions.

CHAIRPERSON GRIMMER: Are there any questions? Okay.

Seeing none, we will close this item and move on to Agenda Item Number 6, discussion and possible action to include approving Plan Year 2026 rates for state and non-state employees, retirees, and their dependants for the consumer driven health plan, low deductible plan, exclusive provider organization plan, and health maintenance organization plan. Celestena Glover, Executive Officer. For possible action. Please go ahead.

MS. GLOVER: Yes. Again, this is Celestena Glover for the record. So we're going to take 6 and 6.1 together. I'm going to have Segal do the trend presentation first and then we'll go through the tables that were provided for potential rates and then answer any questions the board has as we go along.

And, with that, I will turn it over to Richard Ward from Segal. Thank you.

MR. WARD: Good morning. Richard Ward for the record. Sound check. Am I coming through okay? All right. Is it alright if I share the slide for that report?

MR. HOPKINS: Yes. Go ahead, Richard. Thank you.

MR. WARD: All right. For those of you that may be following without visuals that have the full board packet, there's about a 214-page differential between the pagination in our report and the full board packet. So I believe I'm on page 215 right now of the full board packet.

So, just to set the table here for what we're going to review, we're going to review historic plan costs and trends for PEBP versus the industry, actual versus projected. We're also going to review the Segal health plan cost trend survey for 2025 to get a broader market perspective, and then a review of the methodology that's used when we're developing market rates, developing the employee premiums, both the methodology and the assumptions.

For summary here, this reviews medical, pharmacy, and dental and we have here on the tables to the right PEBP compared to the industry. The top right table is the last three years of actual trends. Then we have the current plan year projected. And then we have projected for Plan Year 26. And, generally, the trends are in the industry and then in

particular pharmacy trend has been above industry. And I want to note here that this pharmacy trend is just for claims. It doesn't consider the effective rebates, which we'll show the effective rebates on cost and trend here in a few slides. But, generally, we're showing this comparison without considering rebates because that's how trends are reported in the industry. And so it's easier to find that industry benchmark with that comparison.

I will say that even though pharmacy trends have been very high the last couple of years, they are cooling off a little bit, which is I think very -- which is favorable and a good thing for PEBP, for the state, for PEBP, and the members.

For medical trend, we see -- we've seen a fairly steady climb over the last couple of years. This shows from June 2021 through June 2025, the last couple of months projected. And that's the dotted part of the line out to the right. So the way to read this, so it's on a per employee per month basis, and average costs having risen from $600 on the far left up to $726 per employee per month. And this is just medical. And with the trend being generally between five and a half and six and a half percent annually.

And then at the table on the bottom we have comparison between the pricing trend that is used in the

budget projections, the set rates, which is correlated to the governor's budget trend and then a comparison with actual. And, generally, the governor's budget trend has been significantly lower than the actual trend, which has created some pressure on the asset level and the reserves of PEBP.

I would note that in 2026, at least the preliminary budget for the state has a higher than, in my opinion, more realistic trend assumption for medical at five percent, which is more in line with what we would expect and what we're assuming for the next plan year.

Trends have been pretty persistent for a variety of reasons. You have upward pressure on provider costs due to an ongoing labor shortage. They're having difficulty in the last couple of years in recruiting staff, retaining staff, cost of supplies, access to supplies has been -- have been a challenge. And then also in Nevada there's one of the lowest provider per capita ratios in the country. So, with fewer providers, that generally results in more difficulty in negotiating with those providers. Again, in a commercial setting. Not considering Medicaid or Medicare where there's a fee schedule that the providers accept or don't accept. Again, there's negotiation between the provider and the network manager in the commercial market. So it takes both parties to agree to the terms.

And, as these provider contracts, network contracts that generally have a two or three-year term, as they've been coming up for renewal the last couple of years, there's been upward pressure from the providers, making it more challenging to manage those increases.

And then also within PEBP we're seeing an increase in virtually all condition and disease categories, where in the consent agenda there is a wealth of material showing disease prevalence, cost, but some of the main drivers are increases. And I'm going to say MSK because I have a hard time saying musculoskeletal. And then also diabetes, cancer are some of the leading drivers in cost increases. But then also recently behavioral health has become a more highly accessed, highly utilized, highly in demand need in the membership. And then there's significant increases in people that have high blood pressure and high cholesterol. And that's maybe not driving cost now. But, for a lot of people, it's an indicator of their increasing health risk.

So, pharmacy, and it is eye-popping to see a 20.8 percent trend there in the middle. We don't often see that. Although we are seeing several plans, several state plans, with strong double digit, in the teens, annual trend for claims. We have two lines on this particular exhibit. One,

the blue line at the top, is for claims. And then the orange line below that is once rebates have been netted out. So, in the far right, on a per employee per month basis, we have claims, plan paid claims of $308, and once rebates are netted out, it's $198. So that's a significant difference, 36 percent, and about $110, I believe, is the difference. So it's a significant portion of the claims that are offset by pharmacy rebates.

And in the table down below, we add a column to show the effect on trend. So, in 2023, I'm going to call that out, there's a pretty significant difference between the claims cost trend of 14.3 percent and the net trend of .5 percent. And that's due to having significantly renegotiated the rebate terms for the 2023 plan year. And, so, as the rebates increase significantly, that offsets almost all of the trend increase for that year. But then since then we've had essentially trend increases in the rebate guarantees. So, a little bit stronger than trends, probably about two percent. You see about a two percent difference here of 20.8 versus 18.8 and 15.5 versus about 14. So one and a half to two percent.

Another highlight here, another callout, is the governor's budget trend compared to the pricing trend that's been assumed to set rates. Historically, it's been very low,

3.67, four percent, excuse me. And that has been significantly lower than the actual trend. And so for 2026, the preliminary governor's budget uses I would say a more realistic trend assumption of 15 percent, which is more in line with the experience that we're seeing with the plan and what we're seeing when it comes to setting budget rates.

Dental. You see there's significant increase from 23 to 24, but that is due to the where there is a change in the annual benefit limit and so that has not been normalized or netted out here. This is just strictly the plan paid cost of that increase led to -- that increase in benefit or that benefit enhancement led to about a 12 percent increase in cost. I will note though that the dollar amounts here are pretty small, so that 12 percent increase is six dollars on a per employee per month basis. And, once you blend dental in with medical and drug, you're looking at dental being about five percent of the total cost.

And, trends generally for dental benefits are more modest, more in the two to three percent range, which except for that one year is generally what we've been seeing with PEBP and what we expect to see going forward.

Okay. Now, the -- Every year Segal conducts a health plan cost trend survey and it's a survey -- I think this is an important thing to note here is we survey

carriers, administrators, PBM's, HMO's in the industry and they respond with their trend assumptions or expectations for the next two years. And then they also report on what their actual costs were. So every year we compare the actual with what they had told us the prior year they were projecting. And then we have an actual to expect the comparison that we have going forward every year. And then we also have their expectations going forward.

And so what the report provides is the industry's expectation. It's a synthesis of all of those organizations' trend assumptions. It's not Segal's trend assumption. Although it does provide guidance for recommendations that we provide clients or what we think is going to happen in the industry. That's maybe a fine point but an important one.

And we get responses from pretty much everybody, over 70 national and regional insurance carriers, administrators, and PBM's. And, historically, we might have reported that as 200 entities. But that was when we considered all the Blue Crosses to be separate, all the Delta Dentals are separate by state also. And now it's just we consider Blue Cross as one and Delta Dental as one.

So the network is about 80 percent of the market. And we look at medical PPO and POS plans, HMO and EPO plans, HSA-qualified, high deductible health plans, we get it

separately for medical, dental, drug, vision, and so on.

This shows the actual trends in the industry for medical, drug, and dental. The green line at the top that generally has the highest trends is for pharmacy. And the bluish-purple line in the middle, or that's generally in the middle, that's medical. And then the orange at bottom is dental. And we don't know yet from the industry what their -- And this is shown on a fiscal year or a plan year basis. The survey actually works on a calendar year basis, but we converted that calendar year basis to match PEBP's timing. So, for Plan Year 24 and 25, we're actually showing what the industry is projecting here rather than the actuals, because that's not known yet.

And I also want to note that these are the increases. So when you see a line go down, like in the middle here for the purple, the 6.6 percent for the medical going down to 2.4 percent, that just means that cost increased at a lower rate. It's not an actual decline in cost. The only point here that's an actual reduction in cost is in Plan Year 2020 for dental that where cost reduced by half a percentage. All of these others are increases.

But I think this is an illustration of, one, the effect of the pandemic in 2020, that hit dental and medical trends pretty significantly. There is a significant

reduction. And then there was a rebound after the fact. And then since then we're seeing pharmacy costs just continue to increase in the industry, even though about six or seven years ago they were about five percent. They were significantly lower. Now we're seeing them six, seven points higher in trend every year.

This graph shows the dotted line that's pretty flat across the middle for medical -- this is for medical is the industry expectations. And then the solid blue dark blue line is the actual. So, for Plan Year 21, the industry expected a 7.3 percent trend for medical and 2.3 percent is what actually happened. And, then, the next year, 7.5 is what was expected, is what they were assuming. And then the actual was six percent. And then the light blue line is PEBP. And you can see for a couple of years the PEBP trend was fairly volatile. Now, Plan Year 21 is coming out -- I don't know if it's coming out of the pandemic, but it's the years immediately after the very first year of the pandemic. And, so, there's some volatility here, I think. 21 with a 14.9 percent is a bounceback. And then because you have a very high year as the baseline for the following year, things are fairly flat. And then you have trend becoming more normal over the last couple of years; 6.5, 5.5, and now we're projecting 6.8 for the current plan year, 25.

So, generally, at least for right now, we're seeing -- we're expecting trends to be a little bit low than what the industry is expecting.

And, for pharmacy, we have -- we have the dotted line is the expected, the dark line is the actual. And the industry assumptions have been lagging what's actually been happening. So the industry has been a little more optimistic than what has actually been happening. So, like, right now for Plan Year 23, the most recent year that we have experience, the industry was expecting 9.1 percent. And the actual industry increases in pharmacy claims cost was 12 percent. And that light blue line is PEBP. And, for the most recent couple of years, PEBP is exceeding industry trends on a claims basis. But then the purple line that's just below that, that's what we're expecting or what has happened and what we're expecting once rebates are considered. So you can see the beneficial impact of rebates on not just cost but also on trends. Trends are a little bit lower once we consider rebates.

And, for dental, PEBP's trend has been pretty volatile mostly because of that benefit change and also coming out of the pandemic. And then also for dental, the industry's assumptions have been lagging actual trend increases over the last couple of years.

Also, imagine some of the reasons for increases. Just to revisit a few of those. I think nationally we have new treatments, therapies, and technologies that are generally high cost that are treating -- that enable us to treat conditions that were previously untreatable. And, so, while that is a great thing on a personal level and for the patients and for us as a society, it does come with cost.

We have another state client that recently had a 13 million dollar claimant. And so we're starting to see more of these high cost claimants that are in -- they're infrequent, but they're occurring more often. But they're challenging the budget. You're not going to predict a 13-million-dollar claim. That's just not something that we're expecting at this point.

Also, provider price increases. I mentioned that providers have financial challenges that are -- that are affecting how they're approaching negotiations with commercial payers in a way that's different than it was five, six years ago.

And then also I mentioned earlier Medicare and Medicaid. Medicare and Medicaid have a fixed fee schedule that providers either accept it or they don't. And, those fee schedules, the increases in those fee schedules, have been lower than in the commercial market. And also there's

an increasing Medicare and Medicaid population. So, think about it from a provider's standpoint. That provider may be seeing Medicaid patients, may be seeing Medicare patients, and also seeing commercial patients or patients that are covered through commercial insurance.

And, as the Medicare and Medicaid, their income associated with providing care for Medicare and Medicaid is not increasing at the rate that their costs are increasing and also maybe they're seeing more patients on that fixed fee schedule, it's creating more pressure on the commercial -- on the commercial component of their business as a provider. And, so, we're feeling that with really all commercial plans, including PEBP.

Just an overview here of the pricing methodology and how we go about it. So we look at historic claims and enrollments. We take 24 months of PEBP claims and enrollment. We develop per capita cost for medical, pharmacy, and dental. And then we make -- We also look at the effect of programs, so the effective rebates, for example. Also, if there's any capitation fees that are included with the claims and the effect of any savings programs, so the SaveOnSP pharmacy coupon management program, that comes with a benefit and a savings. So we consider all of that. And then we trend it forward to, in this case, Plan

Year 26, using the assumptions mentioned earlier, five percent for medical and so on. If there are any plan changes, we consider those and make an adjustment for those and really make an adjustment for everything that would be different from the experience period to the projection period. It might be differences in demographics. We might look at if we have an ongoing migration from the CDH plan and the EPO and the HMO to the low deductible PPO, so we're accounting for all of that stuff.

And then we add on administrative fees. There's ASO fees for PEBP's vendors. There's internal operation and administrative costs. And we consider all of that stuff in developing the total budgets rates.

And then we look at -- And then we allocate those costs across all plans, all the coverage tiers. And then when it comes time to determine the employee and retiree contributions, we consider funding, so the AGIS and the REGI, the funding for -- that comes from the state for PEBP. And we're seeing, and we've just reviewed here for the last little while, significant and ongoing increases in claims costs. And the last couple of years, that has contributed to PEBP reserves being spent down. And so the funding and the revenue that's going to come in from the state is important in determining what the net differential is for the employees

and the retirees today. So, currently, for Plan Year 25, the AGIS, which is the active employee funding rate from the state, is $780 per employee. And, in the preliminary initial, not final, governor's budget, that is increasing to 10.2. So we're seeing significant increases in expenses, but then for this year we're seeing, at least initially, a significant increase in the AGIS for the first year of the biennium. However, for the second year of the biennium, that may go down to 982, and the effect that that reduction would have on employee premiums could be significant.

So that's a $40 difference and with the -- and there's essentially a dollar for dollar effect on employee premiums and the -- Think about it as a percentage. There's significant leveraging. So the CDHP single premium is about $55. So, a $40, dollar for dollar, impact on that rate on that premium while costs continue to increase would be significant.

And so there's some -- I'm about to hand it over here to Tina. Hopefully I'm transitioning okay here. So there's a premium consideration to hold some of that back for the second biennium so that the increase in the second year is more manageable. And so that's the thinking behind the different rate scenarios that are included in the board packet.

The next couple of slides just have details on how we do it. I'm not going to read through that. If you have questions on it. But I think that's for reference and additional information.

And, with that, I'm done, pending any questions.

CHAIRPERSON GRIMMER: Yes, Ms. Kelley.

MEMBER KELLEY: Thank you, Chair Grimmer.

Thank you for that presentation, Mr. Ward. Very thorough. I just have a couple of questions. You know, I know RX, obviously, isn't the largest part of our coverage plan, if you will. But, given the trend, it's going to get there eventually, right. It feels like that.

And I'm doing some reading. Yay for Michelle. And I was reading that, like, especially in this specialty job area, which is, of course, what's driving our trend that one of the big changes from -- that's driving the trend is how pharmaceutical companies are pricing these drugs, where they used to kind of work out how much it cost them to make per their research and their product development and end up building a profit margin and then set a price. It's my understanding that now they are setting the price based on lifetime therapeutic value, which many of these drugs are one and done, you know. And, so, instead of just pricing them at five million dollars, they're kind of doing this

pseudo-calculation of, well, if you had to take a drug every month for your entire life, it would cost you this much. And so that's where we're going to price this drug.

And what I was reading said that they really -- no one had successfully pushed back on that model of pricing, except for perhaps Medicaid, but they won't release the data because it's kind of confidential. Can you talk a little bit about that and Segal's experience in kind of that specialty area and the pricing?

MR. WARD: It's a very frustrating situation. So the increases in drug cost primarily with specialty but also with non-specialty, there's some very high cost non-specialty medications as well. But specialty is generally half of the pharmacy cost, trending up towards 60 percent or more. And it's a very small portion of the actual scripts. So these are very high dollar medications and the drug manufacturers are setting prices, in my opinion, at what they can get away with. If you have a -- If they make a drug -- If there's a drug that exists, it's the only drug that exists to treat a specific condition and it has a significant effect on quality of life or is perhaps even life-saving, then they have correctly read or assumed that they have the leverage and they are pushing that leverage. And it has resulted in new very high cost medications and recurrent medications to have

significantly high trends.

And you mention that it becoming a significant portion of the cost. Generally right now we're seeing pharmacy costs between 20 and 30 percent of the total medical and pharmacy spent. I remember not that long ago -- Maybe I'm aging myself here -- it was between five and ten percent. And so that's just the force of significantly higher trends over a ten, 15-year period.

And one other comment that I have is that there's a lot of medical drugs spent that is included in the medical numbers. So, the inpatient infusion, cancer treatment that -- So treatments and medications that are provided in a medical setting or in a provider's office setting. When you take that -- those costs with pharmacy costs, which I might just further refine as being outpatient pharmacies. If you take the inpatient pharmacy, the medical pharmacy, and the outpatient pharmacy and put it together, for a lot of our clients, that is the largest main category of spent. It's larger than inpatient facility. It's larger than outpatient facility. It's larger than professional. And it used to be -- And, that is hidden a little bit, because it's split between the two categories. And so it's very concerning. I'm not sure if I'm answering your question or just agreeing with you, but it is very concerning.

MEMBER KELLEY: Just a quick follow-up because I know Ms. Rich has got her hand up. I just -- Since we did strategic planning, I just can't get my head around the pharmacy. And I just, you know, you wonder about these pharmaceutical companies. They're single-handedly going to destroy the health insurance industry. Because, at some point, even as a group, we just aren't going to be able to afford to offset the pricing -- the prices that they're charging. I mean, t feels like we're already getting close to it. Our employees are -- The majority of employees who don't actually use very much pharmacy are drowning under the cost of, as you said, kind of these infrequent but super expensive drugs. But, as a whole, we're covering them.

So I appreciate your response. But I just wonder as an industry how can employers in health insurance and consultants, what can we do to start -- I don't know. What can we do? Because it feels like, as you said, they're charging whatever they feel like because -- And then if an insurance policy doesn't cover it, what happens? Because that's how it's made, you know. It's the insurer and the employer who is failing as opposed to passing a drug at 15 million dollars for one shot. Anyway, thank you.

CHAIRPERSON GRIMMER: Thank you.

Ms. Rich.

MEMBER RICH: Thank you. Laura Rich for the record.

Yeah, Ms. Kelley, you asked the bazillion dollar question, so I appreciate that.

My question, Richard, is specifically on the pharmacy trend, your presentation points out that PEBP is well above industry standard. Can you explain what -- why that is? Do we just have -- Is utilization up quite a bit? Is it that, you know, PEBP has some, you know, handful of high cost claimants that are, you know, those anomalies, you know, that they have a diagnosis that requires really, really expensive drugs, whether it's a one-shot drug or a lifetime therapeutic drug? Can you explain why -- what is putting us above the industry standard?

MR. WARD: It's primarily due to the overall increase in -- I guess increase in health risk. So I mention this mostly primarily in conjunction with the medical. But the increase in people with diabetes, the increase in cancer incidents, as well as the cost associated with those treatments. The -- Also, the increase in MSK that comes with -- that comes with or results in people having more medications for anti-inflammatories, so for Humira and such. It's really just across the board. It's not like every year -- So hemoglobins -- or hemophiliacs, excuse me --

Hemophiliacs, care for those patients are extremely high. They're extremely expensive. It's not like each year there's a new instance of a hemophiliac that is being a high cost claimant that on its own is driving cost. It's really kind of across the board.

And so I think the PEBP memberships' overall health risk is I think is a primary driver. We can certainly look, as we review utilization and specifics, we can point to a couple of -- a couple of indicators, specifics, but overall it's due to the ongoing increase in health risk.

MEMBER RICH: Thank you. Just one quick follow-up. I don't know if we're at this point or not. Laura Rich for the record. I don't know if we're at this point or not where we're talking about rates. But I appreciated your explanation on the AGIS and how you are adjusting those, in that scenario you're adjusting for the lower -- the lower AGIS in year two. I think that's important because in year two there's no way for PEBP to get additional money from the legislature and so you potentially put employees at risk in that second year by having to raise premiums very significantly. So I think that it's, you know, it's important to adjust for that as you explained. So I just wanted to put that on the record.

CHAIRPERSON GRIMMER: Thank you for that.

Ms. Kelley.

MS. BITTLESTON: You're on mute.

MEMBER KELLEY: I've got a bit of a -- So, firstly, I wonder -- I'm not sure who this question is for. But, you know, when -- decades ago when I worked in private practice, we had stop-loss insurance and, you know, it was more to protect us from -- At that time the cost drivers, of course, were preemie twins who ended up having to stay in a hospital for months. It seem like now we're on the hook for a pharmacy.

So I wonder if stop-loss is something that PEBP needs to consider and even if stop-loss would help mitigate some of those expensive pharmacy costs. So that's my first question, if you will.

And then my second question is very controversial and it really is a question. I just want to put it out there, it is a question. At what point -- You know, is it worth doing an analysis on separating pharmacy from medical? I know it doesn't -- You know, anyway, I'm just going to leave it there. At what point do we have to actually consider that pharmacy is such a big bucket item and people have so many different needs when it comes to that pharmacy that we actually do have to price it and people select the pharmacy program they need. As I said, controversial, but I

just wanted to put it out there.

MR. WARD: I can comment on both of those if that's okay. Richard Ward for the record. For stop-loss, generally speaking, over the long term for a plan like PEBP, it is far better to self-insure that risk. And the reason for that is that the best time to have stop-loss is in the one year that you have a spike in claims and you get a reimbursement via coverage for that unexpected incidents and then you terminate the policy. Because, if you don't do that, then it's not whether it's your current carrier or another carrier, you're going to pay that back with successfully -- successively higher premiums. And loss ratios for stop-loss policies are 50, 60, 70 percent. So, because the experience is very volatile, you're just looking at the catastrophic tail end of the experience. So it could be really volatile if you're looking at an individual deductible at a million dollars. The number of million dollar claimants that you're going to have in a given year, it could be two one year, it could be five the next year. And that variation from two to five in isolation is really significant.

So stop-loss policies are developed with a very fat margin and retention for that purpose. And there is -- And so it's just better over time to reserve appropriately.

And PEBP generally has reserved appropriately to absorb those occasional spikes. But, with an ongoing steady increase, that's more of a funding perspective -- more of a funding consideration, in my opinion.

And, then, for separating medical and drug, we do have a couple of clients that have considered that and that do it, but it results in a little more exposure to selection from the membership or anti-selection, depending on what perspective you're viewing this.

So, members generally choose the plan that suits them the best, which is often, being so it's in their best interest and then that is generally not in the best interest of the plan. And so when you -- if we add that kind of choice, someone that has high drug costs may choose a lower benefit medical plan with a richer pharmacy plan, which is great for them, but it might create financial challenges for PEBP as the plan.

But that's a policy consideration for PEBP to consider. There's certainly pros and cons to that approach.

CHAIRPERSON GRIMMER: Okay. Thank you for that.

Are there any other questions?

Okay. Go ahead.

MS. GLOVER: I'll go ahead with the rate tables. So Richard explained why we had the two scenarios. So,

scenario one may work if we know we can get additional funding in the second year, which, you know, Member Rich and Mr. Ward explained isn't an option for PEBP typically. Right now the budget is set where the second year is at a lower AGIS rate. And that could cause some major spikes if we see increases in our plans like we have over the last couple of years.

So, for myself, I did some back-of-the-napkin math. What -- The way we funded the plan for 2025, we use 91 percent for a single person on the CDHP. That's where we got the $651.32 for the employer contribution portion and then carried that to the other plans. If we use that same percentage and just continued the way we have been, we would have a employer contribution of $773.72. That means based on the increase base rate, the member on the CDHP that's a single on a plan would pay $75.50 versus the $55.26 we're recommending. So that is significantly higher. You're talking a $20 a month bump, essentially.

If you look at your board packet on the last page of the rate tables, it shows you what the rates should have been for 2026. So -- or for 2025. A single person on the CDHP would have paid $63.56, but we opted to mitigate that increase using catastrophic reserves. So, we artificially lowered the rate, when our experience shows we needed that

rate to be 63. Now, we brought in additional funding through RX rebates and additional employer contribution, which did help us.

But, right now, we will be going to IFC on April 3rd, asking for 33 million dollars to bump up our claims category, because that is the shortfall we're projecting for now to the end of the year.

Last year, so for Plan Year 2024, that was ten million. And, in Plan Year 2023, that was also ten million. We are not going down. We are going up. It's costing us more to run this plan.

The other thing we have to take in to consideration is not just the employer contribution that is going to be lower in the second year. We have a lot of bills out there that could require PEBP to cover more benefits, reduce prior authorization, include benefits we don't currently include, change how we apply RX rebates to the plan.

If those happen, they will all happen in Plan Year 2027. So, not only will we have a lower AGIS rate, we will also have potentially an increase to our base rate, which means sticker shock for year two will be significant. Unless there's some, I don't know, miracle, for lack of better word that is going to cause our rates to go down, I

don't see how we're going to survive that.

In addition, we've been tapping in to IBNR and catastrophic reserves to keep the plan afloat. That is our stop-loss insurance. And we are having to build that back up. So the amount we actually need is higher than we're asking for.

So, with the discussion of fiduciary responsibilities in making sure the plan stays afloat, my recommendation is that we go with scenario two, which would reduce the amount of AGIS transferred from the 806. It will reduce it down by the $12.28 that it shows in that table, so that subsidy would be somewhere in the neighborhood of 700 and -- I think it's 775 or something.

So, to try to hopefully offset, if we get -- if we have a good experience year, that's great. But the cost is already high. So, I am just trying to be conservative in my thought process, and that is why we've gone to scenario two.

And, with that, I'll take any additional questions.

CHAIRPERSON GRIMMER: Are there any questions? Okay. Seeing none, this is for possible action. Do we have a motion to approve? Oh, go ahead, Michelle.

MEMBER KELLEY: Oh, no. I was just going to make

a motion to approve the rates as laid out in scenario two, which reserves money for -- to support the rate structure in fiscal year 2027. I just want that to be clear to anyone watching. So, yes, my motion is to approve staff's recommendation, scenario number two.

CHAIRPERSON GRIMMER: Thank you.

Do we have a second?

MEMBER RICH: Laura Rich. I'll second.

CHAIRPERSON GRIMMER: Thank you. Any further discussion? Okay. Seeing none, all of those favor signify by saying aye.

(All members voted in favor of the motion, except for Member Barnes)

CHAIRPERSON GRIMMER: All of those opposed? Okay. Motion passes.

Oh, sorry. Jim, did you vote opposed?

MEMBER BARNES: Yes, I'm voting against that.

CHAIRPERSON GRIMMER: Okay. Okay. Did the court reporter get that?

THE COURT REPORTER: Yes, I did. Thank you.

CHAIRPERSON GRIMMER: Okay. Motion still passes.

We will close Agenda Item Number 6 and go on to Agenda Item Number 7, discussion and possible action on recommended changes and updates to the master plan documents

for Plan Year 2026. Leslie Bittleston. For possible action.

MS. BITTLESTON: Thank you, Madam Chair. Leslie Bittleston, Quality Control Officer, for the record.

In your packet of materials, I believe it is page 271, there is a report, item number seven, that I will go over in just a minute. I do want to premise this agenda item with talking about the major challenge of MPD's, and that is keeping the MPD's up to date. There are a lot of changes that happen that affect MPD's such as federal guidance, industry standards, FDA approvals, and legislation within our own state.

So all of those things affect MPD's. And we find that we play catch up a lot. So, I mean, our goal is to be as proactive as we can and have MPD's that are as up to date as possible.

One of the things that we will be updating after this meeting, of course, is the rates that go along with the services, because we just approved the rates just a minute ago. So keep that in mind as I move through the report provided.

And I am going to share my screen maybe, somehow. There we go. Perfect.

Okay. So MPD changes. Can everybody see the screen? Perfect. Okay. This report will go over benefit

changes and updates for the master plan documents and summary of benefits coverage for Plan Year 26 for the three PEBP plans, the consumer driven health plan, the low deductible plan, and the exclusive provider organization or the EPO plan.

I just started this position in July of last year, so I got a late start on these. So a lot of documents have not yet been reviewed and touched and those -- there's a list of those, the dental plan, the health reimbursement arrangement. So all of those documents have not yet been touched. And I will address that in a few more minutes later in the report.

For those of you who were or are interested in looking at the three documents that have been changed, the redline versions are available at the following link at the bottom of page one. It is kind of a mess. So just please know that these are working documents.

So, throughout the plan year, plan document verbiage and various changes occur. And, to prepare for the changes that are presented today, PEBP staff and vendors reviewed master plan documents and discussed some proposed changes. I would like to thank, personally thank, ESI staff for their assistance in going through the pharmacy portion of the master plan document.

So, moving on to the proposed changes, on page three, we have three enhancements. Enhancement number one is an addition, a prescription drug addition of Lofexidine, which is an additional FDA-approved drug to treat substance use disorder. So that is an enhancement. Another enhancement added coverage of FDA-approved drugs used for the prevention of HIV. And enhancement number three is around mammograms.

There's been some industry standard changes around mammograms recently, so this change kind of brings that more in to line with industry standards. So mammograms for women begin at age 40. However, there is recommendation that women at high risk, and the industry standard states 20 percent chance or greater risk of developing breast cancer can get mammograms or other screenings at age 30 and women who have identified genetic mutations may start cancer screenings at age 20. Industry standard also recommends that men at high risk or with genetic mutations present may receive breast cancer screenings, including mammograms or other diagnostic testing. So that is an enhancement which lowers the age and also outlines the fact that women at high risk can receive mammograms much younger and men are -- can receive mammograms as well or other screenings.

Going on to the next section, this is where

there's the premise of what I talked about, the challenge of keeping MPD's up to date.

The next section is clarification. These are things that the plan has already been covering, but the master plan documents didn't keep up with the fact that the plan was covering these things. And most of these were identified at the biennial compliance review that was conducted by CTI and presented at a previous board meeting.

So, clarification, we removed the age limit for vision services. There is no limit for children under the age of 19.

Under the prescription drug benefits, we clarified routine vaccinations, so there is a list of routine vaccinations that are covered at a hundred percent.

Added a co-pay structure for telehealth and removed co-insurance requirement. Clarified that telehealth is not provided out of network. It is only provided in network.

Added number five. This clarification is around the individuals that are required to cover children as a part of a child support agreement. So this language was added per recommendation in the compliance report.

Let's see. Clarified that the plan does cover testing for HIV and Hep C.

Clarified that abortion services are covered pursuant to 422.250. Our master plan documents were kind of in conflict. In one stage we would say we don't cover abortion services and then in another area we said we do cover it. So it's really trying to make sure we are clarifying and saying the same thing throughout the document.

Number eight, gestational carriers are covered for maternity services. That is clarification.

Clarified payment procedures for mental health and substance use providers clarify that vendors must use overpayment standards pursuant to the NRS listed there.

Clarified that members may obtain three emergency prescriptions, prescription refills per plan year, and may also receive an emergency refill if in a designated disaster area.

Talk about additional services and testing around maternity, women that are pregnant. There is a whole list of testing requirements for pregnant women that include STD's, syphilis, gonorrhea, HIV, Hep C, a lot of those things. So, as I stated, the plan was covering that, we just wanted to outline that in the MPD.

Clarified that hormone replacement therapy is covered.

Verified that coverage for condoms for

individuals, that's both males and females, age 13 and older, is covered. And, for clarification, condoms can be covered either on the pharmacy or the medical side, can be covered by the pharmacy with a prescription or the medical side with a proof of receipt submitted to UMR for reimbursement.

And then the FDA-approved drugs for HIV.

Now, the next section is clerical. This is -- encompasses a lot of the MPD's. So what happened is in looking at the MPD's and the fact that we try to be proactive in keeping up with the changes, the MPD's, unfortunately, became kind of convoluted over time with sentences that weren't completed, information that was out of order, outdated definitions, and just a lot of cleanup, so to speak. So there were seven major clerical areas that were addressed within the MPD's.

We updated the travel requirements. We made formatting changes throughout. We removed the PEBP one-time funding for the HRA and HSA that was approved in past board meetings. We moved paragraphs to flow better within sections. We updated the plan year from 7-1 2025 through 6-30 2026. We updated definitions with more newer language. We also removed the definition sections and sections within each MPD and included the definitions within the areas that it applies. So, if somebody, you know, doesn't know what

something is, it's now right there in the area, rather than having to go to the definition section to look up something that somebody may not know what it means.

Lastly, we also looked at and updated and revised all references to NRS and NAC. So those are all of the changes made.

With those changes, there is still a lot of work to be done with the MPD's. So, internally, PEBP QC has a plan to update all of the MPD's over the next two years. And this next section talks about that plan and what our plan is going forward.

So, to go over this, the plan is to have one master plan document that includes the CDHP, the LD PPO, and the EPO. Those are all the medical plans. This is how things were several years ago and then somehow plans got split up into individual MPD's and that caused problems in itself, as MPD's, you know, got convoluted and sometimes didn't say the same thing. So we are proposing going back to one large document, like I said, down the road in two years having this done.

The second area is there is currently an eligibility and enrollment master plan document. This document is more internal and more has processes for internal staff, so the proposal is to remove the enrollment and

eligibility master plan document and have an eligibility and enrollment policy. There will no longer be a public-facing document for enrollment and eligibility. However, there will still be information that the public needs to know in other documents, the qualifying life events guide and the benefit guide. Both of those provide all the information that the public needs to know about their eligibility for PEBP plans.

The policy -- The document as it stands today is more for eligibility staff internally, which is why we are moving to a policy.

The next one is there are two wrap documents, one for actives and one for retirees. We are going to consolidate and have one wrap document.

The next proposal is to put the HRA, the health reimbursement arrangement, flexible spending, and the Medicare health reimbursement or arrangement all in to one large master plan document for that specific -- those specific areas.

Lastly, the Section 125 master plan document, which is a requirement, that unfortunately didn't really fit in any other documents, so that will remain its own document.

Additional changes for this year which will be made prior to open enrollment, we will have the 2025 benefit guide updated to the 2026 benefit guide. It will also

include the general plans option details one-page documents, so that will be included in the 2026 benefit guide.

The 2025 plan comparison will be the 2026 plan comparison. The qualifying life events document will be reviewed and ensure that it is still accurate. And then the commonly used medical terms will remain.

This was a large report. Sorry about that. But, we do have some recommendations, as this is an action item. Staff recommendations to the board is to approve PEBP staff proposed changes as presented to allow staff to continue formatting documents, the document to allow staff to update the table of contents prior to publication because that has not yet been touched, allow PEBP staff final review prior to publication, allow vendors, which would be UMR and ESI final review prior to publication, and allow for technical adjustments as necessary.

The technical adjustments includes the fact that we do have to update the rates now that -- Now that we have the rates, we can update those. So that is my report and I can take any questions.

CHAIRPERSON GRIMMER: Okay. Thank you for that.

Are there any questions? Okay. Go ahead, Ms. Kelley.

MEMBER KELLEY: Quick question. Leslie, thank

you for all the work you've done, Ms. Bittleston. It looks like it's been a lot of work and time well spent. And your report is very thorough and I appreciate that as well.

I just had one question. You know, I know at NSHE we have obviously eight institutions and all of the institutions do open enrollment and assist employees with understanding their benefits enrollment eligibility, all of that kind of stuff. So that enrollment and eligibility guide that you said is internal has most likely been very helpful to those people. And I'm just wondering if you plan to send that out to, you know, all agency reps who support PEBP. Because I do think that, you know, if you utilize those people they're incredibly helpful and getting information right the first time is always helpful as well. So that would be my question.

MS. BITTLESTON: Leslie Bittleston for the record. That is an excellent idea that I had not thought about sending that out to agency representatives because they do -- they do play a big role in educating staff and, you know, they're the ones that report all new hires to PEBP so PEBP can get them enrolled and all of that.

Another thing I do want to say is even though something may be an internal policy does not mean that it is a secret document. We, you know, are willing to share any

document upon request if it is something that is not publically-facing. So, if a member or somebody wants the eligibility and enrollment policy, we will be more than happy to send them a copy.

But I agree that it would be a really great idea to send that out to agency representatives when it is completed.

CHAIRPERSON GRIMMER: Thank you for that.

Go ahead, Ms. Rich.

MEMBER RICH: Laura Rich for the record. I just wanted to commend Leslie on the work that she's doing. I think that everything that was proposed, great ideas, especially bringing those MPD's all in to one document. I think that's going to be super helpful for members as well as staff. Every single year that is a lot of work for staff to do and go through and there's, you know, there's so many documents and not enough hands and eyes to go through all of those and time. So consolidating that is a great idea. So I just wanted to commend her on that.

CHAIRPERSON GRIMMER: Thank you for that. Are there any other questions or discussion? Okay.

Seeing none -- Laura, did you have another item? I'm sorry. Okay. Just making sure. Seeing no others, do we have a motion to approve this item?

MEMBER RICH: I'll move to approve the item. Laura Rich for the record.

CHAIRPERSON GRIMMER: Thank you.

Do we have a second?

MEMBER KELLEY: I'll second it.

CHAIRPERSON GRIMMER: Thank you. Any further discussion? Seeing none, all of those in favor, signify by saying aye.

(The vote was unanimously in favor of the motion)

CHAIRPERSON GRIMMER: Any opposed? Okay. Seeing none, motion passes.

We will close Agenda Item Number 7 and move on to Agenda Item Number 8, discussion and possible action regarding the permanent appointment or recruitment of the PEBP executive officer. Is there any discussion on this?

Go ahead, Celestena.

MS. GLOVER: Okay. So this is Celestena Glover for the record. So we put this out there so the board can be -- begin discussing how they want to approach recruitment and appointment of my replacement. I have not given notice yet. I have not met with PERS. I have not set a final date. So those -- that information is still coming. We also need to consider that we're still waiting to hear whether the Nevada Health Authority is going to actually be approved by

the legislature and how that will affect PEBP. Will PEBP be included? Will they not?

If that happens and PEBP is included, then you're likely recruiting for an administrator level position versus a director level position. And that may change who you get applying for the position. So something to keep in mind. Also may affect how you word the recruitment. And we don't know what that's going to look like until probably May.

Part of this process, the board does have the ability to appoint an interim, if that makes more sense, since we do have some moving parts until we get a definite answer one way or the other about the health authority. And, obviously, you can delay making a final decision on that. We can add it as an agenda item on one of our legislative update meetings or we can include it at May. I know there's probably some concern waiting that long since right now my plan is to retire somewhere around mid-summer, but it will be between 15th of July and 15th of August. Like I said, I haven't set a final date. I haven't met with PERS yet. So I just wanted to get that on the record so that the board has a full picture before they start deliberating and to be able to answer whatever questions you may have.

CHAIRPERSON GRIMMER: Okay. Are there any questions or discussion?

Go ahead, Ms. Kelley.

MEMBER KELLEY: Thank you. Michelle Kelley for the record. Firstly, I just want to thank Executive Officer Glover, even though it's a bit premature. I want to thank her for her service and coming back to support PEBP over the last couple of years. I think, you know, health insurance is challenging at the best of times and I think it's certainly been a challenging period. And I really appreciate her service and, you know, respect her knowledge and everything she's done for PEBP immensely.

So, saying that, I do think it's my personal belief that we should wait on recruiting for the position on a continuing basis for all of the reasons Executive Officer Glover outlined, specifically kind of the unknowns around where PEBP will end up and what the job might look like.

I do think that if PEBP ends up sitting under the Nevada Health Authority then that executive officer or director -- I'm not sure what the position is going to be called. Sorry -- that the leader of that organization probably should be able to hire their own -- their people. And I think that the way the bill is currently laid out that would be the case.

So, saying that, I do wonder if we couldn't look internally to see if there is any interest from PEBP senior

staff on acting on an interim basis, assuming that interim -- an interim person would be allowed to apply for the continuing position when it is recruited for. That -- For me that would perhaps provide some continuity for PEBP staff and also allow some knowledge transfer prior to Executive Officer Glover retiring. Thank you.

CHAIRPERSON GRIMMER: Thank you.

Go ahead, Ms. Carsten.

MEMBER CARSTEN: Thank you. Theresa Carsten for the record. I agree with Michelle and with Celestena. I would prefer to wait. I think Michelle has an interesting idea to make sure that staff feels supported. I think as we get closer to May, Celestena, if you start making your appointments and find that we're moving at a faster pace, then we definitely would probably be interested in an interim person so that everybody is covered.

CHAIRPERSON GRIMMER: Thank you for that.

Any other discussion?

Go ahead, Celestena.

MS. GLOVER: So I just wanted to -- This is Celestena Glover. I just wanted to say that as soon as I have an actual date picked out, I will send an e-mail out to the board to let them know what that date is. I'll also be notifying the governor's office of the final date so that all

the folks that need to know will know. I am planning on trying to get over to PERS some time in the next couple of weeks to set that date. So, barring no changes, the time frame is going to be mid-summer.

CHAIRPERSON GRIMMER: Okay. All right. Thank you for that.

Do we have -- Does anyone want to make a motion on this item?

MEMBER KELLEY: Michelle Kelley for the record. I don't even know if it's a motion. But I think -- I wonder if we -- if the motion -- Let me formate this. Sorry. My mouth has got to catch up with my brain. My motion would be that we put together a request for interest from qualified PEBP staff to explore any interest in an interim, you know, in holding an interim position, you know, but perhaps it's a recruitment for the interim position, and have that brought back to the next meeting so that we can review it and potentially send it out to staff to see the level of interest in someone internal. That was really choppy. I don't know.

CHAIRPERSON GRIMMER: Go ahead, Legal Counsel.

MS. KUNNEL: Hi. This is Radhika Kunnel for the record. That motion, one, is very -- sounds complicated. But also, more importantly, I am concerned that it may be deviating from the noticed agenda item. And I'm also

concerned that there are other complications with the issues and may be something that we have to first reach out to the employment personnel division. I am not sure if that would comport with the noticed agenda item.

CHAIRPERSON GRIMMER: Okay.

MEMBER KELLEY: Michelle Kelley for the record. I'll withdraw my motion and perhaps ask that the chair reach out to HRM, I guess, and find out kind of what we can do, the parameters of what we can do or what -- because I think -- Yeah, that would be perhaps my request. I don't even know. Just a request that we get more information on how to fill an interim position or a continuing position.

CHAIRPERSON GRIMMER: Okay. Celestena.

MS. GLOVER: So this is Celestena Glover for the record. So, based on the, just this recent back and forth, then maybe my suggestion would be that pending further information that you table this discussion and that we include it on a future board agenda. That might be the way to go. And that should meet the requirements of what the agenda item says. And then you can make a more definite decision and we can clarify that on that future agenda item so that we're doing things appropriately.

CHAIRPERSON GRIMMER: Okay. Thank you for that. Do we have a motion on this item, a different motion?

MEMBER KELLEY: So moved.

CHAIRPERSON GRIMMER: Okay. Do we have a second to table this item? Let me clarify.

MEMBER CARSTEN: For the record Theresa Carsten. I'll second.

CHAIRPERSON GRIMMER: Thank you.

Okay. Is anyone opposed? Okay. Seeing none, all of those in favor, signify by saying aye.

(The vote was unanimously in favor of the motion)

CHAIRPERSON GRIMMER: Any opposed? Okay. Seeing none, the motion passes.

We will close Agenda Item Number 8 and go to Agenda Item Number 9, discussion and possible action regarding 2025 legislative bills that may impact the Public Employees' Benefits Program, including the following: Assembly bills, senate bills, bill draft requests.

Ms. Glover.

MS. GLOVER: Thank you. This is Celestena Glover for the record. So the table that was included in the board packet includes the same bills that we had on there at our last legislative update and it includes some additional bills.

The ones I probably would like to bring your attention to would be AB 349. That is on, I believe, page

four of the document. I don't know what page of the board packet. AB 349 revises some requirements around hospital and ambulatory surgical facility payments. The way the bill is written right now it infers that PEBP direct contracts, which we do not. We use a network vendor. So this is something we would get -- we would need our network vendor to assist with and to comply with. That is why our fiscal note says cannot be determined. We didn't have the information and we typically don't. We don't know what the various provider contracts say as far as their level of payments.

The bill says the lesser of the billed amounts, the 2024 rates, which we're in 2025, so I don't know that, you know, facilities would be willing to go back to 2024 rates or 175 percent of Medicare.

At this stage, I don't know which hospitals may be getting 175 percent, 200 percent, 250 percent. I don't know who those are. So there was no way for us to calculate whether or not we would actually see a savings. My guess is we likely would. But, what that savings would be, we don't know. Obviously, if it can lower rates for the program, we're all in, because our plan, you know, is, as we've seen during the rate setting agenda item, our plan is increasing in cost over the years.

So I had a brief discussion with the plan

sponsor, but he had worked with Dr. Murray out of Oregon. And neither of those individuals had talked to PEBP ahead of this. So we weren't exactly sure what they were trying to do and I don't think they a hundred percent understood how we typically contract with our providers.

So, that one, we have asked Segal to continue to work on what that might look like, give us an analysis so we can determine is it really a savings to PEBP, and, if it is, how much that savings is. So that is one of the items we are watching to see if it goes anywhere.

I did attend the hearing. I did answer some questions, which I don't think helped the bill sponsor in any way, shape, or form. But it essentially was I couldn't tell them if the 36 million he had presented in his bill really was going to materialize through this. So, it's not that I wanted to, you know, oppose his bill, because that was not the case. It was simply a presentation and me answering the question.

I will say from my take he didn't have anyone supporting the bill when it came to that. I think we're going to see opposition. Because, if that will lower the rates the hospitals are going to get paid, I can't imagine they're going to support this and, you know, how will it affect their bottom line. So, it is a wait and see, but it

is something we're monitoring.

The next one that I'm keeping track of -- There's actually two that are very similar, and that's going to be SB 209 and SB 316. Both of those bills are related to how we apply the RX rebates to our plan. Right now, the rebates that we get in, we apply it to the plan as a whole and reduce the funding we need from employer and employee contributions. If either one of these bills are passed, that would require a supply to the individual who actually has the prescription, which may benefit the individual from a plan perspective as far as paying for their drug. However, what will happen is because we're losing those revenue streams, that will go in to the expenditure side which then would increase the rates across the board, and that increase will be affected by employer premium -- or employer contribution as well as employee premium.

So, ultimately, it could still end up costing those individuals that are trying to help just as much money as they pay now. It's just they're going to pay it through premium versus paying it through their co-pays or co-insurance.

So we're not sure where that is going to end up going at this point, but those are two that we're mostly concerned about. If you look at the fiscal note, you'll see

we're talking about 21 to 23 million dollars, because the two bills have a couple of different provisions in them. And then that doubles to about 46 million dollars in future biennia, depending on, you know, the drugs that are purchased, how the rebates come in and those kinds of things.

So, we'll keep monitoring them, we'll see where it goes, and we will bring updates back to the board as they become available.

And, with that, I'll take any questions.

CHAIRPERSON GRIMMER: Go ahead, Ms. Rich.

MEMBER RICH: Laura Rich for the record. I just have a question on AB 349. So, Tena, you said that we don't know what we pay in that analysis. I'm thinking back, I think it was, like, 2015 or 2016 when I remember PEBP did do an analysis, because Montana did something like this where they did their statewide employee plan basically capped rates. And so PEBP was doing an analysis to see if that would be beneficial. And, it was determined that it was in some areas, it wasn't in other areas, and overall it would not be beneficial to the plan. And so I don't think that that ever really got any traction.

But I believe, you know, while PEBP doesn't have access to those claims, Segal and UMR do. And so they would be able to pull claims data and bump it against that 175

percent. I can't remember what the Medicare number was in that bill. But they would be able to bump it up against that and do the analysis and figure out what exactly, you know, if there would be a savings or if there would not be a savings. Is that something that's being done or can that not be done because of the information that's available in the bill? I'm just kind of confused on that one.

MS. GLOVER: So this is Celestena Glover for the record. That is something that we've asked Segal to work on at the time that we needed to submit the fiscal note. Because, you know, the turnaround time is pretty short. We couldn't get the analysis done in time.

I am aware that Montana bill from back then and the analysis. We can see if we still have that data on file. We may not at this point in time. And I know other states have done various things to kind of combat that cost. You know, I believe Oklahoma has their own network, but they have the staffing to monitor that, too. So we'll pull whatever data we have and we'll continue to work with Segal and UMR to get that information. We'll be able to provide it in aggregate to the board.

Obviously we're not going to talk about what hospital gets what amount, but we'll bring back whatever data we have available at that time.

MEMBER RICH: And, just one follow-up, Chair, if I could. Laura Rich for the record.

CHAIRPERSON GRIMMER: Yes.

MEMBER RICH: On the RX bill, I just want to say, I appreciate your explanation and I do agree with it. I mean, I think that the way that rebates are handled today, it's more fair, right. The cost gets spread out between everybody, but the rebates also do as well. It's not -- It's, you know, not fair if costs are spread out evenly within, you know, the entire population but then the rebates are specifically directed towards one individual. So one individual gets to benefit from that versus everybody. And I think that the way that we do it today is just more fair to all members versus, you know, directing it to benefit one member in particular.

MS. GLOVER: Thank you for that. This is Celestena Glover. I agree. I think, you know, trying to make this plan from a cost structure be as, you know, get the funding in that we need so that we can cover the cost of those benefits, but trying to mitigate the increases to our members to the best of our ability is the way we need to do this and that is what we're trying to do.

I have not talked to the bill sponsors on either one of these bills. So that is something that we can

potentially bring to them to try to figure out what it is they're trying to do.

During my budget presentation, I did explain how PEBP utilizes their rebates, so I'm not sure that that was considered at the time.

CHAIRPERSON GRIMMER: Thank you for that.

Any further questions or discussion? Okay. Seeing none, we do have this listed as for possible action, but I don't know if there as a motion on it or not.

MS. GLOVER: So this is Celestena Glover for the record. I think the motion, if one is needed, is if the board would like me to take any particular action on any of these bills.

CHAIRPERSON GRIMMER: Okay.

MS. GLOVER: Like I said in a previous update meeting, you know, typically we will testify in the neutral stance, regardless if you want me to go to those hearings when they come up, if they come up, then I can do that. Otherwise, I can sit back quietly and just wait and see what happens. At the board's pleasure.

CHAIRPERSON GRIMMER: Okay. Thank you.

Okay. Any direction for Ms. Glover or we will close the item?

Okay. Seeing none, we will close Agenda Item

Number 9 and move on to Agenda Item Number 10, public comment. Public comment will be taken during this agenda item. Comments are limited to three minutes per person.

Staff, can you please put the slide up.

MR. HOPKINS: Yes, Madam Chair. We have no one in the lobby, but I will go ahead and make my announcement.

CHAIRPERSON GRIMMER: Okay. Thank you.

MR. HOPKINS: Thank you. Joining the Zoom meeting as an attendee is for making public comment only. If you do not wish to make a public comment, please leave the Zoom meeting now, so you're not accidentally called upon. Please feel free to watch it via the YouTube live stream on the PEBP YouTube channel. The link for the live stream is located on the agenda. For those who have joined for public comment, your name or the last four digits of your phone number will be announced and you will be advised you have been unmuted. Please fully state and spell your name for the record and then proceed with your comments.

I'll give another 30 seconds to a minute, Madam Chair. There's still no one in the lobby.

Madam Chair, we have no one in the lobby, so that concludes public comment.

CHAIRPERSON GRIMMER: Thank you. So thank you.

Okay. Thank you. We will close Agenda Item

Number 10 and we will adjourn. Thank you for everyone's time today.

(Hearing concluded at 10:58 a.m.)

STATE OF NEVADA)
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CARSON CITY)

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

That on Thursday, the 20th day of March, 2025, I was present, via Zoom, for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 72, inclusive, includes a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Reno, Nevada, this 29th day of March, 2025.

_____
CHRISTY Y. JOYCE, CCR
Nevada CCR #625

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