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May 21, 2026 Unofficial Board Meeting Transcript

Tyler Hopkins: Chair Wells, we are now live on YouTube.

Board Chair Jim Wells: Thank you. Good morning. We'll call to order the meeting of the Public Employees' Benefits Program Board scheduled for today, May 21st, 2026 at 9:00 a.m. Can I get roll call, please?

Jessica Crane: Good morning. Starting roll. Chair Jim Wells?
Chair Wells: Here.

Ms. Crane: Joy Grimmer?
Joy Grimmer: Here.

Ms. Crane: Jennifer McClendon?
Jennifer McClendon: Here.

Ms. Crane: Laura Rich?
Laura Rich: Here.

Ms. Crane: Jim Barnes?
Jim Barnes: Here.

Ms. Crane: Blaine Harper?
Blaine Harper: Here.

Ms. Crane: Keiko Duncan?
Keiko Duncan: Here.

Ms. Crane: Tom Zumtobel?
Tom Zumtobel: Here.

Ms. Crane: Paul Davis?
Paul Davis: Here.

Ms. Crane: Chris Viton is absent today. We do have a quorum. Thank you.

Chair Wells: Great. Thank you. We'll move to agenda item number two, public comment. No action may be taken under any matter raised under this item unless the matter is included on a future agenda 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. At the discretion of the chair, the time for each individual to make comment as well as the aggregate time for public comment may be reasonably limited. We will have an individual limit of three minutes but not since we need an aggregate limit today. Additional public comment periods subject to similar limitations may be allowed on individual agenda items at the discretion of the chair. We will not have any additional public comment periods other than the closing public comment period. Members of the public may make public comment using the call-in number 6699006833. The meeting ID is 893 4262 3148 and the pound key. When you hear the participant ID, press the pound. Persons unable to attend the meeting in person or by telephone or who wish to make public comments not subject to potential time limits may subject their public comments in writing. We ask members making public comment to please state and spell your name for the record. Any public comment here in Carson City? Seeing none, online?

Mr. Hopkins: Chair Wells we have three online. I'll get the slide up, one moment. 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 will be announced and you have been advised you've been unmuted. Please slowly state and spell your name for the record, then proceed with the comments. As a reminder, for those on the phone, please press star six to unmute. Caller with the last four digits 6837, please state and spell your name for the record.

Mr. Ervin: Good morning. This is Kent Ervin. K E N T E R V I N. On May 7th, [Unclear speaking]

Chair Wells: Dr. Irvin, you're breaking up. We can't we can hear, only garble testimony. Is there something you can do to try and fix it?

Mr. Ervin: I have all the bars. I'm in an airport.

Chair Wells: That's much better.

Mr. Ervin: Okay. The state needs to step up with its share of PEBPs budget. [unclear speaking] decisions if it has all the information needed in time to take action. Point. First, the FY2024 audited financial statement for the self-insurance fund is only being released now 23 months after the end of the fiscal year. Errors identified by the auditors, but not fully explained and long past when corrective measures should have been taken. Today's third quarter budget report is in a new musty format with information for the report is either bad news or good news. There's an 18.5 million cash flow deficit year to date through 31st, but that's projected to turn into an 18.2 million cash flow surplus by the end of the fiscal year. How is that expected to happen? Third Director Weeks reported that Milliman conducted a budget and fiscal review and audit of PEBP and that the report was sent to the PEBP Board Chair as well as GFO and LCB. Why is the report not being

shared with the PEBP board and the public? Ability is not just talking about transparency, it is opening up the books to scrutiny. In another example, the PEBP access reports at each meeting used to include contract. [unclear speaking]. The dollar amounts have been omitted since last summer. Finally, at May board meetings, an update on open enrollment was provided, that is missing today. The major premium increases is important to longer is going to previous staff and the board chair better to keep the PEBP board fully informed allowing the board to make responsible decisions while ensuring that our participants have the best possible plan. They need to be more transparent and the board needs to hold accountable. You need assurances that both the actuary and staff provide all the necessary information to make your decisions. Thank you.

Chair Wells: Thank you, Dr. Ervin. We did post the letter that you're referring to that was sent to the board chair and to LCB and GFO that was posted on the website yesterday and provided to the board as well. I did not realize that that had not been done yet.

Mr. Hopkins: Looks like caller or they just have the username iPhone. You have permission to speak. Please slowly state and spell your name for the record if you wish to make public comment.

Mr. Lowdermilk: Hi, can you hear me?

Mr. Hopkins: Yes, we can. Thank you.

Mr. Lowdermilk: Sure. My name is Noah Lowdermilk. I'm a classified staff member at the University of Nevada Reno. I just called the general helpline for PEBP with some complaints about the health insurance situation. I spoke with Sarah. She took my call there and she suggested I join this meeting and share my experience with you all. When I took the job with the state, I was really looking forward to good state benefits, and I've been consistently disappointed with the coverage. I've been diagnosed with ulcerative colitis, which is an autoimmune disease that involves severe inflammation of my colon, bloody stools, pain. I've suffered a great deal with that disease. Recently I got a notice from Express Scripts, the specialty pharmacy that's attached to the health coverage provided through my job. They let me know that the immunosuppressant drugs Stelara that I take every eight weeks that has helped me a great deal as I'm currently in remission will no longer be covered. I'm aware that there's an appeal process etc. that I can go through. This is this is one of multiple experiences that I've had where I am just yeah disappointed, bewildered. Worth noting is the way that my stress levels directly impact my health in regard to this condition. Another example of a disappointment is me seeing a fantastic doctor who wanted to do a colonoscopy, which is a very normal thing for people with ulcerative colitis. It suggested that you get scoped once a year. The insurance company said no, that's not covered. But because you've been diagnosed with this disease, it isn't covered. And I just think that's unacceptable. And I don't understand why I pay every month for quote unquote coverage when the reality is that I'm met with more denials than I am the coverage that they're supposed to provide. Those experiences on top of it coming down the pipe that their rates are increasing substantially over the next few years really has me wondering why I engage with this system at all. Has me wondering why I stay at this job if I'm not being taken care of by my employer in the state. The bottom line is, I think it's unacceptable and I think you all could do much better and choosing health care that gets people coverage. Before working here, I worked at the hospital in Truckey Tahoe Forest and the coverage was excellent and based

on my experiences just trying to get normal health care, I've had my regrets about changing jobs and I just wanted to voice those concerns and ask that you all could consider people like me when you're making decisions about coverage and prioritizing the bottom line over the experiences of the people that you're on this board to serve.

Chair Wells: Thank you, Mr. Lowdermilk.

Mr. Hopkins: Douglas, 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, immediate past president, the UNLV chapter, Nevada Faculty Alliance and member of the UNLV employee benefits advisory committee. First of all, I would like to thank Chair Wells and Executive Officer Carsten and PEBP leadership for posting the accounting on agenda item number five and also the third quarter accounting on agenda item 14. Even though there are some concerning amounts and numbers in those reports, they're a step in the right direction for finally getting PEBP accounting straight. And I hope these efforts, certainly the Milliman audit and further auditing of fiscal year 25 in addition to 23 and 24 will help to produce accurate numbers that we can use for the 84th legislative session in order to avoid the discrepancies that appeared between the April 25 session and what's being reported to PEBP now. We need accurate numbers. I think that should be the top priority. I want to say that I observed the May 7th testimony of Nevada Health Authority, Director Weeks to the Joint Interim Committee on Government Affairs. I was concerned by a tone in Director Weeks's testimony that she kept pushing all PEBP problems on the PEBP board. I want to state for the record that I do not believe that PEBP's accounting problems and the decisions that were made are really the fault of the PEBP board when the PEBP board was not functioning with accurate numbers. Having observed the discussions and the thoughtful consideration of issues before the board, I believe the PEBP board has acted in a very exceptionally beneficial way for Nevada state employees with the numbers that they were given. It's an accounting issue and an audit issue that needs to be resolved before the 84th session. I would also like to alert the PEBP board that Director Weeks, Chair Flores of the Committee and Assembly Aember Nguyen and others seem very open to an appeal to the 84th legislature to increase employer contributions in order to avoid the additional shock of the three-year phase in of premium and of out-of-pocket maxim increases for the CDHP in PPO and the 2-year phase in for the HMO. I think this legislature will be very focused on first of all raising employer contributions to PEBP and also doing all the cost cutting that Director Weekes outlined might be possible with further examination of UMR, provider Express Scripts and other contracts in order to produce a situation that lowers our costs. I'd like to add a comment to our member, Louderdermilk. Having heard similar complaints and issues from the UNLV campus, from NFA members, just keep appealing to UMR, keep appealing to UMR, keep appealing to UMR. Eventually, some relief is usually received if you keep appealing. Also on the specialty medications, I've helped guide NFA members to appealing to the pharmacy
companies, which often have coupon programs and other programs that hold harmless the 30% specialty medication co-pay. Thank you very much for your consideration and thanks to all members of the board.

Chair Wells: Thank you, Dr. Unger.

Mr. Hopkins: Vivian D Borba, you have permission to speak. Please state and spell your name for the record. Chair Wells, the former public comment is also raising his hand again. Would you like me to? Apologies? I forgot your name. Can you please state and spell your name for the record?

Mr. Lowdermilk: Absolutely. Sorry I didn't spell it last time. It's Noah Lowdermilk. It's spelled N O A H. My last name is spelled L O W D E R M I L K. I missed the title of the person who spoke before me. I appreciate the response, but if I could respond to what you're saying, you said the word appeal three or four times, and I'd like to point out how my maybe I said this, maybe I didn't, but my stress levels directly impact my wellbeing. And when poor coverage is provided to me, the burden of taking care of those things and the way that you say appeal, appeal, appeal is put onto me and I think it's unacceptable because ultimately it results in my health failing and my quality of life suffering. So I don't I reject that and I don't think it should be on me to appeal, appeal, appeal. I think it's you all's job to buy coverage that takes care of me that doesn't require four appeals or coupon programs that I have to navigate. I've navigated those programs before and it's a huge pain in the butt and I really appreciate the thoughtful response, but I reject that and I really think it could be better and it should be better. I can't take the burden of navigating those appeals while working a full-time job at the university. If you want me to be able to serve the university well, I'd appreciate it if we could have better health coverage.

Chair Wells: Thank you, Mr. Lowdermilk.

Mr. Hopkins: Call back on Vivian. You have permission to speak. Please state and spell your name for the record if you wish to make public comment. If not, I'll drop you and we'll move on. Chair Wells, that concludes public comment.

Chair Wells: Thank you. Close agenda item number two. Public comment. Move to agenda item number three. PEBP Board Disclosures for the applicable board meeting. Agenda items. Deputy Attorney General Lither.

Mr. Lither: Hi, this is Gabriel Lither. Can you guys hear me?

Chair Wells: We can

Mr. Lither: Fantastic. I had just a bit of a problem this morning figuring out Zoom. Much more familiar with Teams. Just want to say my name is Gabriel Lither, Senior Deputy Attorney General. For the record, this agenda item is to allow me to make a disclosure regarding conflicts of interest on behalf of the board members who are eligible for Public Employees' Benefits Program, PEBP. 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 it. Thank you.

Chair Wells: Thank you, Mr. Lither. Is there any additional disclosures from board members? Hearing none, we'll close agenda item number three. Move to agenda item number four, approval of the action minutes from the March 19th, 2026 PEBP board meeting.

Member Barnes: Jim Barnes, move approval.

Chair Wells: Motion. Do I get a second?

Member Duncan: Keiko Duncan, seconded.

Chair Wells: A motion and a second. Any further discussion on the approval of the action minutes? Hearing none. All those in favor say I.

All board members: I.

Chair Wells: Any oppose? Nay. Motion carries. Close agenda item number four. Move to agenda item number five. Discussion and acceptance of Eide Bailly's audited financial statements for the self- insurance internal service fund for fiscal year 2024.

Mr. Schlicker: Hi, thank you. Kurt Schlicker, partner with Eide Bailly for the record. I'm here today to present the year-ended June 30, 2024 self-insurance financial statements. I'll certainly go through a couple of key items. I'll keep it at a high level, but more than happy to answer any questions that anybody may have. First and foremost, starting on page one, we did issue an unmodified opinion. Now to clarify what an unmodified opinion is, that means that the financial statements, the figures, the numbers represented in them, there's reasonable assurance that they can be relied upon to a material level. It's not absolute assurance. It doesn't mean we audited every single transaction but we audited to such a level to have reasonable assurance that they're materially accurate. So that's the best result that we give in an audit as far as the accuracy of the financial statements presented.

The statement of net position or more commonly known as a balance sheet starts on page four. I'm not going to go through ratios and stuff. I'm happy to answer some if anybody has anything alarming or questions. The balance sheet starts on page four and five. You'll see that the net position of the self-insurance fund changed from 72 million down to 28 million. That's pretty much directly related to increased costs, claims expense. The revenues for the fund were relatively flat. During the year, you had increased healthcare costs, claims costs, and that drove the net position of the self- insurance fund down. That's a little bit better illustrated on page six where you can see the increase in the operating expenses of a little over four $40 million. So that's really the big driver of the decrease in net position for the self-insurance fund. And again, even more so reflected on page seven and cash flows where you see a negative $40 million cash used operating activities.

Moving past cash flows and again I promise I'm not going to go through the footnotes in any detail. I just want to highlight that if you have any questions on significant accounting policies, how PEBP accounts for certain balances in the financial statements, the notes are a really good resource for that activity. Happy to dive into any of them. That being said, they're pretty standard for the self-insurance fund. Nothing that you know gives me super alarm or to highlight to the

board other than the disclosures on the OPEBP liability and PERS but those again are continuing from previous years. I'm going to skip to the back and then I'll talk about timing a little bit as well. Page 37 is our report on internal controls with respect to financial reporting. So as part of an audit under government auditing standards, we're required to report on internal control matters. So, we do the audit, we have adjusting journal entries or we see other gaps in internal controls, we report those to the board.

This year we did find a matter that was necessary to report to the board and we labeled that 2024-001. The details of that begin on page 39. The big picture maybe simplified nature is that hires Eide Bailly to prepare the financial statements and that's an inherent weakness in internal control because the auditors are supposed to audit the financial statements that management prepares. Now, it's not unusual for management to hire the auditor to prepare the financial statements, but that's kind of an inherent internal control matter that we report to the board. It's very common, so it's not alarming, but it is an internal control matter that we report. In addition to that, our audit procedures noted that revenues and expenses were overstated by 2.5 million and 2.3 million in a couple of different journal entries that happened from transactions that were recorded in the improper Period and or duplicated couple of different factors playing in there. So, as part of our audit, we saw that they reported incorrectly, corrected them, which is why it's an unmodified opinion in the financial statements, but then reported the matter in the finding as required under government auditing standards.

Real quickly, I know there's a lot of concerns on timing. We issued our report, I think, on April 29th, which is significantly after June 30 of 2024. We've had multiple discussions with PEBP management and with the Controller's Office just to highlight a little bit of this process. There's some accounting dependency on both the Controller's office and PEBP where they're sharing duties and sharing journal entries and financial reporting. If the Controller's office is responsible for some accounting in PEBP's financial statements, we have to wait on that until that accounting is performed or done. We can't audit an incomplete trial balance. And so currently, for the most part, the Controller's office handles a lot of the accrual accounting for PEBP. PEBP management handles a lot of the cash basis accounting for PEBP. This, what I'll call codependency, due to delays in the Controller's office that are well documented with their financial reporting has filtered to PEBP and has caused PEBP to also be delayed in the financial reporting because the numbers, the journal entries, the trial balance are just not complete. We've talked at length about this. We've talked at length with PEBP, again the Controller's office. We're committed to trying and getting the audit done as quickly as possible. We certainly don't want it to drag. That's never our intention, but there's a significant amount of time pressure placed on the audit currently because of how delayed a complete trial balance is receded. And I see that continuing into the 25 audits because, you know, this is the 24 audit. 25 audit is coming up at almost a year past. We don't anticipate having a trial balance until the summer with kind of a loose estimated time. So again, this timing issue is not exactly going to be corrected in the next month or two. There needs to be a very concerted effort to address it. I completely agree with that. I just wanted to say that we are committed to working with PEBP to address those timing issues, but it's going to take a team effort with the Controller's office as well. I'd be more than happy to answer any questions that anybody has.

Chair Wells: Thank you, Mr. Schlicker.

Member Davis: Yeah, I have a question.

Chair Wells: Mr. Davis.

Member Davis: Okay. So you're saying, if I understand this correctly, the bottom line is that the fault is the Controller's office, not your office. Is that correct?

Mr. Schlicker: Well, Kurt Schlicker, partner with Eide Bailly for the record. We can only audit a complete trial balance. If balances are not ready to be audited, we can't audit an unknown. So, we have to wait on that timing. There is codependence between the Controller's office and PEBP to produce a complete trial balance. The primary cause of the delays here were delays in receiving a complete trial balance. I don't necessarily want to point fingers, I'll say on the record that delays in the Controller's office did impact that.

Member Davis: Thank you.

Chair Wells: Any other questions from board members?

Member Zumtobel: This is Tom. I have a question. If nobody else there's local. So, it seems like nobody takes accountability, it's always somebody else's fault. And so, at the audit level I understand you're saying that you're going to work and it takes accountability. It takes relying on PEBP to push the Controller to make this happen at more timely and I appreciate that. Is there a specific action plan or a corrective action plan?

Mr. Schlicker: Kurt Schlicker partner with Eide Bailly. I can't write your corrective action plan. I'm the auditor. That being said, I would recommend that a corrective action plan be, PEBP work with the Controllers to bring as much of the accounting in-house to PEBP as possible to reduce the reliance on the Controller's office assisting with PEBP's financial statements. Yes, that will require some training and some education there and additional time and effort placed on PEBP management, but ideally PEBP can prepare and produce its own financial statements and results with as little reliance on the Controller's office as possible. That way, PEBP can take accountability and drive the process rather than being dependent on somebody else to drive their own financial statements. That would be my recommendation. I can't control that. I'm the auditor, but that would be my recommendation.

Member Zumtobel: I think part of an audit is to influence change, to help us to influence change. Though maybe you don't want to take accountability, and help us to get there. But isn't that part of the role of an auditor?

Mr. Schlicker: Well, right. What I'm saying is, I fully encourage PEBP to bring the accounting in house and drive the process and take the necessary steps. We'll certainly assist and train and go back and forth with what information we receive from the Controller's office and how to do that. I can't take on the role of management. I have to be independent.

Member Zumtobel: I'm not asking you to do that. But in most cases, also with an audit, there's a letter from management that actually acknowledges what's been pointed out and they address how they're going to correct what has occurred. I didn't see that in this audit. Is that not part of this process?

Mr. Schlicker: Yes. Thank you. Kurt Schlicker, partner with Eide Bailly. The corrective action plan is only required in what's called a single audit. So, it's optional for an audit such as this to prepare a corrective action plan. That being said, fully support PEBP management preparing a corrective action plan and I'd even work with them on that to see what was feasible and work together on that. That doesn't bother me at all. It's just not reported in this report. It's not required.
Member Zumtobel: Okay. The copy of the audit that I got was really hard to follow. It didn't line up. The columns didn't line up. The rows didn't line up. Is that what your copy looks like also or was it just what was submitted to us?

Chair Wells: Mine's aligned, but I had it printed.

Mr. Schlicker: Mine is aligned as well.

Chair Wells: All right. So maybe it may be just how it was. It looks like it was online as well, lined up. I will say that I've talked to Ms. McJoy and I've talked to Mr. Schlicker this morning. We are going to try and take some of this stuff in house. 25 is still going to be delayed. There are still issues with 2025, getting data for 2025. So, 2025 is still going to be probably significantly late. The hope is that shortly after we finish 25, we can also finish 26 for the PEBP only plan and divorce ourselves from the problems that are being noted in the state Controller's Office. So, we are going to try to take this inhouse.

Member Zumtobel: No, I appreciate that because I was trying to understand too, that if Bailly prepared the financial statements because we contracted with you to prepare the financial statements but then did you also find errors in the financial statements that you prepared? Correct?

Mr. Schlicker: So, let me clarify that process. Kurt Slicker Eide Bailly for the record. We received what's called a trial balance. It's essentially the chart of accounts with the financial statements represented in them. We take that chart of accounts and we translate it from an Excel docent into the financial statements with the formatting and the column and the grouping and all of that. Then we audit those balances. So, we prepared the financial statements, meaning we translated the trial balance into a financial statement format. Then we audit those numbers which we found errors in those numbers, corrected those and then reflected the corrections in the financial statements.

Member Zumtobel: Okay. Chairman Wells, I'm just trying to figure out our role, because ultimately the board, I believe, is accountable and I'm trying to figure out how we get the tools to hold others accountable. I'm very uncomfortable, and I know there's not much that can be done about it, but we're sitting here having a conversation about this audit today and almost putting a stake in the ground that the next one's going to be late also and we're not doing anything about it. And maybe there's not much we could do about, but it should be documented what our efforts are. As a board member, we need to have tools to start to hold some of our vendors accountable.

Chair Wells: We are taking actions to fix it. The problems are, as Mr. Schlicker said, the problems are well documented. The Controller's office has been significantly behind for years now in producing financial statements. And the problem is, part of the documentation for this audit has to come from the Controller's office. We cannot complete our financial statements independently. There is data that comes from the Controller's office. What we're going to try to do is isolate that data and get that done first. And as soon as we can get that done, we can do the rest of it in house.

Member Zumtobel: Yeah. Okay.

Mr. Schlicker: If I may just highlight one item for some clarity as an example because I think that might help provide some context. The Controller's office provides your cash and investment balances. Those cash and investment balances might not be prepared or provided to us under audit until more than a year after year end. So, we can't complete the audit of PEBP until we know what your reported cash and investments are. Cash and investments is a very material dollar item for the PEBP financial statements and we're reliant on the Controller's office to provide us PEBP's cash and investment balances. And if those are significantly delayed, our hands are tied. We can't issue a report on PEBP without having the support for your cash investments. It's too material.

Member Zumtobel: No. I'm sorry. I'm sorry. Go ahead, Paul. Go ahead, Paul.

Member Davis: Just real quick question. You mentioned that the Controller's office has been doing this for years. Can you give me a ballpark figure of how many years? When you say years, what does that actually indicate? Has it been 5 years, 10 years? What does this mean? Years? How many years?

Mr. Schlicker: Kurt Schlicker, partner with Eide Bailly for the record. I can't speak to the exact date, but I want to say it was in late, 2018, 2019ish time frame is my understanding.

Member Davis: Thank you.

Chair Wells: I actually have a couple questions. The RSI, the management discussion and analysis, has that traditionally been done for this fund? Has that been excluded?

Mr. Schlicker: Kurt Schlicker, partner Eide Bailly. It's traditionally been excluded at the direction of management. It does not result in a qualified opinion. It's just an item that's not included in the financial statements and we call it out.

Chair Wells: As long as it hasn't been done traditionally. That's fine. The only other question that I had is, there was one of the footnotes that talked about, footnote 12, contingencies, talks about transferring claims to unrecorded payment over as unclaimed property. I thought state agencies were exempt from unclaimed property by law. I thought there was a statute that said after the six years it goes back to the fund from which it came.

Mr. Schlicker: I would have to look at that in more detail. We do have the NRS 353.140 there. So, I'd have to read that in detail to be able to give you a direct answer.

Chair Wells: It's somewhere, but I don't know if it's 353.140, and I didn't go and look it up. I do believe that there was. I will tell you, I know that there was. Whether it's been repealed or revised.

Mr. Schlicker: Okay. I'd have to look in detail at the statute.

Chair Wells: I don't believe that there were subject. Any other questions?

Member Zumtobel: Yeah, Chairman Wells, I have one more. I know this is probably not the right place, but we get so little information. I just need to understand in the audit, it talked about there was a 27% assumption for the part B Medicare, a 27% rate increase assumption. I don't know where those assumptions come from and is it actuary or whatever, but that sets the new basis for our retiree plan that's going to go on well into the future. Was that validated by Segal or by the board or now it's set in stone moving forward? It just seems like such a significant number to increase the baseline for, it's concerning.

Chair Wells: Where did you see that number?

Mr. Schlicker: It's on page 28, I believe. If I may, Chair Wells, I'll just address that from the audit perspective. As far as the OPEBP liability, the assumptions, PEBP management works with Segal to develop the actuarial assumptions and the actuary report and the liability part of the audit. We review the qualifications of the actuary to make sure they're a licensed and appropriate actuary. We don't overrule an actuary's judgment. That's their job. They're an actuary. We report on what the assumptions are unless they're just grossly inaccurate, but we had no basis for that. Segal has been noted to be a well-qualified actuary firm. So, we take that from the report, make sure it's recorded correctly, but we're reporting the assumptions that are developed between Segal and PEBP management.

Member Zumtobel: No, I greatly appreciate that answer. I mean, that's the point of an audit is to kind of identify things that are a little bit outlier, right? I just don't know, Chairman Wells, maybe Segal did present that at some board meeting previously and we approved it. I don't know that process but that number is concerning, to increase the retiree baseline by 27%. If it's appropriate it's appropriate but we should understand it.

Chair Wells: Yeah. We do talk about the OPEBP audit. We had that in December I think. So, the OPEBP audit was presented to us in December. That's where you see all these assumptions laid out. There'll be another one in a few months.

Member Zumtobel: I hate being difficult but that's the challenge that I'm facing there. There's such volumes of information that's presented when it's presented. Just to try to weed through it to figure out where you make sure we understand the ramifications of some of these things that we approve right? It is as a new board member a little bit drinking out of a fire hose but I appreciate that that'll come back again. I don't know for sure the way that it was represented in the audit is it's in the

baseline. Now going forward our retiree audit, our retiree valuation, we do adjust it back down again. I'm not clear when it's appropriate when we impacted the claims volume and the claims expense then that number went down and I assume that same thing would happen here but it's a concerning baseline number for me.

Mr. Schlicker: Just for a point of clarity please if you will, Kurt Schlicker, Eide Bailly for the record. The 27% reference, and maybe it's not written clearly, that's for part B reimbursement.
Member Zumtobel: Oh, thank you.

Mr. Schlicker: It's for that in initial year effective July 2024 and then thereafter it smooths to 4.5%. so it's not 27% per year indefinitely. It was a 27% initial increase in the part B reimbursement valuation and then it's moved to 4.5% over the long term just for clarity for that trend rate.

Member Zumtobel: But it does in that case increase the base by 27%?

Mr. Schlicker: Yeah in the initial year.

Member Zumtobel: Yeah. Thank you.

Chair Wells: All right. Any other questions? Hearing none. This is a this is an action item to accept the audited financial statements. Can I get a motion to accept the audited financial statements for fiscal year 2024 for the self-insurance internal service fund.

Member McClendon: Jennifer McClendon. I move to accept the audit statements.

Chair Wells: Second?

Member Rich: Laura Rich. I'll second.

Chair Wells: Motion and a second. Any further discussion? Hearing none. All those in favor say I.

All Board Members: I.

Chair Wells: Any opposed? Motion carries. Thank you, Mr. Schlicker. Close agenda item number five. We're going to take agenda item number seven out of order. So, we will skip to agenda number seven. Presentation on Ethics in Government.

Mr. Ross: Thank you for having me today. I'm Ross Armstrong. I'm the Executive Director for the Nevada Commission on Ethics. And so, we're doing ethics training , for your board today. So because it's a board training and not an agency training, we'll focus a little bit more on disclosure and abstention since as board members that's probably the ethics issue. You are going to be facing the most. A little road map, we're going to talk about why ethics matters, what some barriers to compliance are. We'll talk about what the ethics commission does so you're a little bit familiar with us, who's covered. We'll talk about the key areas of the law. And then we want to make sure to

provide you resources and contacts. So if you have ethics questions pop up as you're doing your work, you know how to reach out and find some resources.

We have ethics law in Nevada because of Richard Nixon. Actually the vast majority of ethics laws around the country occurred after the Watergate scandal and Nevada was no different. So we established our first ethics law in 1975. We just turned 50. There's been changes over time. At some point there was a separate legislative and executive branch ethics commission and neither of them did much. So then they combine them into what we are today in 1985. And there have been adjustments to the ethics commission over time. Common theme of that adjustment is with an arc towards greater enforcement. So when the ethics commission first started, it's basically just an advisory group that could say, "Yeah, that's unethical. Nope." Or, “that's unethical or you're good to go.” Now there's actually enforcement mechanisms where individuals can get fined and other things for violating the law. We'll go over lots of technical rules, but in the legislative declaration that establishes the ethics commission, there's a statement of public office as a public trust and shall be held for the sole benefit of the people. For the sole benefit of the people, not for the sole benefit of the people in government, not for the sole benefit of friends of People in government, but for the sole benefit of the People. And so, if you keep that in mind as we go through, that'll help you stay on the good ethical path.

Why do we care about ethics? One, we have unethical government actors. It dissolves trust in government. It also undermines all the great work that you as public servants do every day. You work hard for the People of the state of Nevada. If you get bogged down in ethics issues, it overshadows all the great work that you do. What are some barriers? Why do we find that People violate the ethics law? We kind of see two different types of folks who come before the ethics commission in trouble. One is People who really think they should just be able to use government to enrich themselves and the other are folks who just stumbled into ethics trouble either because they weren't thinking about it, they weren't thinking about relationships that they have or they just didn't have awareness. In addition, we see some issues when people maybe transfer or have lots of experience in the private sector where there aren't all these government rules and they come into the government and there's all these new rules that you know the way of working is a little bit different when we're in government entities. What does the ethics commission do? We have three major functions and they're all along the specter from prevention to enforcement. So, we do education and outreach. I'd much rather be here today providing training than here interrogating a bunch of your staff about something that happened. So, we do lots of education and outreach. The legislature has made investments for staff and other resources. So, we've really expanded that in the last five years. We also provide advisory
opinions. So as public officers and employees, you are all able to request an advisory opinion from the commission confidentially and say, "Hey, I have this potential ethics issue. I need to know what to do to comply with the law." We provide that advice. And then also we receive and process ethics complaints. So, if somebody sees a public officer or employee they think is maybe violating the law, they file a complaint with us and we do a review and in some cases, take up a case, do an investigation and go all the way through. Who is the ethics commission? We have eight members of our commission. Half are appointed by the governor. Half are appointed by the legislative commission. We have rules that no more than four at any given point can be from the same political party or from the same county. We also have certain requirements that a certain number be licensed attorneys or former public officers and employees because we're looking at the actions of government.

We want people with experience in government taking a look at those. So, what falls under the jurisdiction of the ethics commission? Because I think if I say the word ethics, what other kind of words pop into mind? Morals. Anything else? I was somewhere and someone yelled from the back “bribes” and I was like “oh, that's definitely one of the attorneys” because they're like worst case scenario bribes right so there's stuff that just seems icky it can kind of be easier to define something that's like unethical than it can be to say this is the rules for ethics. We just enforce the ethics law so if it's not a rule in our ethics law like just bad government is not under our jurisdiction right there has to be actual statutory authority for us to take a look. We have this little infographic. Everything in the river are things that we have jurisdiction over and can take a look at. The stuff up above are things we can't. So we get lots of people who complain or call our office about, harassment or employee grievances, open meeting law, public records. None of that is in our jurisdiction. We have three main topics. Improper benefits, cooling off, and disclosure and abstention. The big thing to remember today is that we only have jurisdiction over public officers and employees. I'm going to say that term a lot. A public officer is just someone who has the authority to exercise governmental functions and their position is established in law. So, your board is established in law as members of the board. Therefore, you're public officers because you do more than just advise. You actually perform a government function. Public employees just anybody who's getting compensation and working for a public officer. So the staff, the great team at PEBP, they're public employees. As members of the board you are public officers and we have a two-year statute of limitations. So, if there's something really terrible happened five years ago, we can't really do anything about it. Any questions about who falls under the jurisdiction of the commission?

Another term that's important before we launch into the rules is commitment in a private capacity. I talked about individuals who stumble into ethics issues and it's typically because they're not thinking about this. This is what I like to call your magical list of relationships. This by law establishes conflicts of interest. It's not bad to have a conflict of interest, right? Or to have these relationships. It's bad when you're using your government position to benefit somebody on this list. Most people get like, "Oh, I can't use my government position to benefit myself." But the ethics law includes these relationships. So, we'll go over them real quick. Your spouse or your domestic partner, a member of your household, and then a bad flashback one for any attorneys in the room is the third degree of consanguinity or affinity, which is just a fancy legal term for how closely you are related to someone. So, this is a consanguinity chart. You're basically at the zero degree. Your parent and your children are at your first degree, and it fans out from there. Everyone to the left of the dotted line is within the third degree of consanguinity. So nieces, nephews, aunts, uncles, brothers, sisters, those types of folks are within that third degree of consanguinity. The ethics law doesn't care if you like your family. If your if the person we're talking about is on the left hand side of that dotted line, then there's going to be an ethics issue. The other relationships, your employer, and when we're training at agencies, it's like, well, my employer is the state, so why would there ever be a conflict? But if especially for those of you on the board, if you have a private employer, if we have a city council person and that city council person works for a coffee shop, they have a commitment and private capacity to that coffee shop. Let's say that city council person owns a coffee shop, then they have substantial and continuing business relationships with all the vendors of that coffee shop, right? The supplier, the beans, and the cups and those types of things, the person they're renting from. So, they need to keep those individuals in mind. And just for fun, we have a category called substantially similar, which says if it's substantially similar to

those other ones, then it also counts, which can be very hard when you're trying to follow the rules because it's kind of a mushy rule. So, I'll give you some examples of what the commission has found to be substantially similar. Service on a nonprofit board, you have a substantially similar relationship as a substantial and continuing business relationship. Right? It's not quite the same, but you have a fiduciary duty to that board. And so you have a substantially similar relationship. We have found in certain circumstances you may have a substantially similar relationship to your ex-spouse that you would if they were still your spouse. For example, if there's still financial entanglements and investments or you're still living together or you have child support, those types of things. Clearly some exes are definitely not substantially similar to spouses, but others may be closer and that becomes challenging. And then really close and long-standing friendships can fall into that substantially similar bucket as well. So again, these are the six relationships. There's like 15 different rules in the ethics law that talk about this particular thing. But just remember if your public work comes into collision with anybody who's on your magical list of relationships, you want to take a moment and really look at the ethics law and make sure you're not running a foul of the law.

Member Davis: Quick question. Does this prohibit me from discussing the various issues on the on the board that is shown in the agenda with my president of my college?

Mr. Ross: Not likely. There's one rule that could if it it's confidential information that's not public.

Member Davis: It's not. I would never discuss confidential information but non-confidential information.

Mr. Ross: Yeah. If it's if it's public information there's no ethics rule about discussing that.

Member Davis: Okay. Thank you.

Mr. Ross: There are three main parts of the ethics law like the buckets improper benefits disclosure and abstention and cooling off. We're going to talk about each one of those particular buckets today. Again, for the board members, the disclosure abstention one is the one you're probably going to run into the most. However, as leaders of your agency, you also want to be thinking about some of the policies because you'll see in some of the improper benefits bucket, some of the policies you have can sort of shape what may happen in an ethics case. Lots of different rules in the improper benefits bucket, but there's this basic formula. You cannot use your government position to create a benefit or gift or a loan for yourself or someone on your magical list of relationships. Right? That's the basic formula. We'll talk about some of the more specific rules. We'll start with gifts. It's popular. It's fun. We're still a ways away from Christmas, but around the holidays when we do training, everyone gets a little bit wild about gifts because we've probably all received a gift, right, in the last year, birthday, anniversary, Christmas, whatever. Obviously not all gifts are ethical issue. Under the ethics law as public officers and employees. You cannot receive a gift, service, favor, or engagement that would tend to improperly influence a reasonable person to depart from the impartial discharge of their duties. Super clear, right? Like that's a crazy definition. Some other states have like clear guidelines like no gifts over $50. local agencies. You could certainly for here adopt some sort of policy that says no gifts over a certain amount, but under the ethics law, this is

our standard. So, what does the commission look at when we get a question about gifts? Either an advisory or a complaint question. We say, "Okay, how did this gift come about?" Right? Was it like, "Hey, I'm about to vote on something. I'd really like this new car." Or, was it like, "Hey, we, you know, we provide, you know, those fruit baskets around the holidays to thank everyone we work with," type of thing. The value of the gift, right? Is this gift a nominal gift? Like if you go to a conference and you get one of those stress balls that probably cost 50 cents for them to get, that's going to be different than like a full-blown, you know, fancy dinner or private flight, those types of things. And then is there some sort of nexus between the gift giver and the giftee? I'll give you some examples because I think case examples can be the most helpful. The city of Reno, that's a Century Theatre's case. So, Century Theater said, "We want to honor the members of the Reno City Council for their public service and give them annual passes to the theater." And the city of Reno said, "Well, before we accept these gifts, let's go ask the commission for one of those advisory opinions." The commission took a look at it. They did the values and said, "Hey, like this is actually worth a couple thousand dollars for each of these city council members." Oh, and Century Theaters is trying to get approval to build a theater on the river, right? The one that just closed. And so the ethics commission said do not take this because a reasonable, even if you're the most ethical public, you would never be swayed by any gift you got no matter how fancy it was, the question isn't whether you were influenced it's would a reasonable person be influenced and the commission said that would violate 401. Some improper complaint cases, a recent one was in McClinton's the director of the Governor's Office of Energy, he received Golden Knights tickets and tickets to an exclusive party, Golden Knights party, while the Golden Knights were trying to get a like multi hundred thousand sponsorship from the Department of Energy, right? So, it was like, "Hey, come watch a game and we'll treat you and like try to give us a couple hundred thousand dollars of taxpayer money." That was a violation, accepting the tickets, right? The money never went to the Knights, but the gift itself was the violation. And then re Lopez was an agency director who received a coach purse and some luggage and lunches from a vendor, right? A vendor. So, there was that nexus between the gift receiver and the person providing the gift. So that was a violation of the ethics law. Questions about gifts?

Member Rich: I just have a question because this comes up quite often in state government. You have vendors that you do work with and they come and visit let's say you know monthly or you know bi-monthly and they bring the office lunch is that inappropriate? What does that look like as long as there's no RFP open and you have a working relationship with them? How is that viewed?

Mr. Ross: All my answers are mostly going to be like, it depends on all the facts in part because I work for an 8 member commission and sometimes they surprise me where they go on cases. I think I know where they're going to go. But that Lopez case, I mean that was lunches that was specifically to her. I don't know that there was an open RFP at the time, but it was still an ongoing vendor.

Member Rich: I'm actually very familiar with the Lopez part of it.

Mr. Ross: I would just be cautious about those free lunches and stuff. As far as like people, a lot of people ask about like the Christmas gift basket things and I'm kind of like, is that going to make an independent person? Like if they have the piece of cantaloupe, you put it in the break room and

you get one piece of cantaloupe. Unless there's like a $100 bill tied to the bottom of the cantaloupe, you're probably going to be okay. You can use me as the bad guy and say, "Oh, we can't do that because the guy at ethics said I get in trouble." For some folks, especially agency directors you have to file a financial disclosure with the secretary of state every year there is a specific threshold for that so even though I say “oh there's no threshold for gifts” it's this other standard for the secretary of state. Just know it's a totally different standard.

Some of the other some of the other rules under improper benefits so one we see a lot in terms of complaints and where people sometimes get in trouble the most is this one called you cannot receive an unwarranted privilege, preference, exemption or advantage using your position. so that is a little bit tricky. The statute defines unwarranted as without merit. Thank you legislature for clarity. But the way the commission approaches those cases is we take a look at you know is there a legitimate government purpose for that benefit. So, for example, when I go train, like if I go train in Ely, I am getting a state funded car and hotel and I'll get per diem for food. Sure, everybody would like the state to pay for a travel, so I get a privilege preference. I'm getting state funded travel, but it's not unwarranted because I'm out doing state business. Give you an example from another state. In Oregon, liquor is pretty highly regulated. Which is always interesting because I think of Oregon as like, you know, hippies and free love and all that stuff. So, they have a very strict liquor control board where like all the liquor flows through the state. They have state-run liquor stores. And so, members of the Oregon Liquor Commission were setting aside rare whiskies for themselves, right? They're saying, "Oh, they weren't stealing the whiskey, right? There was no financial gain, but they were like, oh, like that bottle of like Papy Van Winkle or whatever, that's not going to go to the public. I'm going to go buy and purchase that for myself. Right? That would be an example of a warranted privilege or preference.

Contracts are becoming a hotter topic. So, you cannot negotiate a contract with yourself or others with your current agency. Why would we not want somebody negotiating a contract with themselves? Any thoughts?

Member Davis: I would think they would want to increase their benefits and salary.

Mr. Ross: Yeah. If you have a contract, let's say you own a painting company, and you're going to paint the state offices and you go to that contract negotiation, you're supposed to duke it out for the best most competitive rate to save the taxpayers money. If you're making money on the other end, you're probably not going to negotiate too hard for the people. So, can't negotiate with yourself. There's also a 410 that's around the same one. We've had a couple issues recently where public officials are preparing to depart public service and they negotiate a contract with themselves with their agency prior to departure and that has been found to be a violation of those contracting rules. If you are a public officer employee, can't yourself be in contracting with any other government agency. So, not just your agency, but any other government agency. That one is tricky. There's a lot of loopholes, but there's a lot of exemptions under that one. And then there's a provision where you can ask us for permission to do it if for some reason it's in the best interest of the public for you to be that person. But people kind of get the sense they shouldn't contract with their own agency. Just know that it prohibits you from contracting with other government agencies as well. You cannot receive salary or compensation from a private source. That's our version of a bribe. So don't take a bribe. You can also not use subordinates to benefit yourself or others. So, you can't be using your staff to do things to benefit your own private or pecuniary gain. So, you

have the city council person who owned the coffee shop. You can't be like okay city maintenance guy go work at my coffee shop for a while, right? Like that's not going to work. There's one that's honorarium for speaking and I bring this up mostly to say like be cautious. You can't get paid just to show up and like speak somewhere. But let's say that there was a Public Employees' Benefits conference and Nevada is honored as the agency of the year and there's going to be an award ceremony and they want you to give a keynote. They can pay the reasonable expenses to get you to the conference and that type of thing. That's not considered the honorarium. It's really like the Kim Kardashian showing up at the club and getting paid to be there type of thing. You can't do that as a public officer or employee.

This one's very interesting, especially if you think about the policies of your agency. You cannot use government time, property, equipment or other facilities to benefit your significant personal or pecuniary interest. This is one where we're not just talking about money. It can be just a personal interest. An example I like to give is let's say it's shortly after the first of the month you get a ping from your landlord. Hey, you forgot to pay rent. You hop on your state computer and you pay rent. Ethics violation or not? I'll take head nods and shakes too. You don't have be bold. And I see some no's. The question is, it depends actually, right? Because I think you have a significant personal interest in maintaining housing. Some people go it can't be because you're losing money. You're paying rent. It's like no, you have a personal interest, right, in maintaining housing. Another example might be let's say you're at your job and you have to assume that all your leave is taken up. You've taken all your breaks for the day. You get a call, your daughter broke her leg playing football at recess. You spend time coordinating medical care, right? You're using government time. You have a personal interest in daughter's medical care. Could it be a violation? It could be, but we'll check in a second to see what that is like. Some recent examples. In re Pimentan, the Chief of Staff for Lieutenant Governor's Office, was using state email to try to figure out his car registration with the DMV and get his son some interviews with ROTC and so using the state email to do personal business and time working on a nonprofit. And then Henry Hall was a kind of a wild one. She was a rural county commissioner and she used the county credit cards and she bought a bunch of booze and food at Costco for her restaurant. She paid it back eventually finally when it got figured out but that was use of that government equipment in terms of the credit card.

So, you don't lose your humanity just because you're in public service, right? Life happens. Your kid breaks their leg or whatever. And so, the ethics law says we need to have something in place where people can't get in trouble just for being people. Under 407 there's this limited use exception and you have to hit all four of these in order for the exceptions to apply. The first one is it has to be properly authorized by policy that allows the use or the result of an emergency. So the leg break, right? That's an emergency. The policy, we all have kind of that state agreement when you use the computer. I think there's some language in there about like nominal non-commercial use. So you want to be thinking about that. What is your agency's policy with respect to use? Would you would you ding the person who's paying rent, hops on for five minutes and pays their rent or is that going to be an allowable use under your agency policy? When I was in law school, I worked at the Morgan lottery and it was very clear you could not do anything personal on the computers because they didn't want anything getting in and messing with like the random number generators or anything. So they had a lot they had a room like in the break room there were terminals where it was like you need to do banking or check your personal email this is where you do it. So you think about how that works for your agency. Another example, I don't know if you have your own

fleet or you go through fleet services but agencies that have lots of cars, like law enforcement those types of folks who might have trucks and stuff. What are the limits of the use of that? Can you swing by and get a slurpee when it's hot in the summer in your state car? That's probably allowed, right? You want to make sure you got some wiggle room in the policy for that. Can't take your family to Disneyland in the state car type of thing. So, be thinking about that if you've got policies on use of equipment, computers, vehicles, facilities, you know, like this room. Can the public rent this room? If not, then can you like use it for your own personal like if you volunteer with a nonprofit? You want to be thinking about those types of things.

Member Davis: I have a question. On the first one we're saying if it's exempted if use is the result of an emergency. Is the definition of the emergency based on the eye of the beholder? Who determines what an emergency is?

Mr. Ross: I do not believe it's defined in our statute. So that would be like a statutory interpretation for our commission to decide if it was an emergency or not.

Member Davis: Okay. So, the individual doesn't decide him or herself if that's

Mr. Ross: No, it would be it would be defined by the commission when they got a case because how it would work as a commission even if it was an advisory opinion, it'd be hard to do advisory opinion in emergency because they take like 60 days. If they got a complaint case and the defense was saying "oh, this was the result of an emergency" then we would take a look and say does that meet the actual, we look to other legal cases that define what an emergency is.

Member Davis: Okay, thank you.

Mr. Ross: So, the second one is it can't interfere with the performance of your public duties. The example sometimes I like to give is, let's say you have an accounting tech and she's running an Etsy shop out of her state cubicle, right? She's got the glue gun plugged in. She's got invoices up on the state computer. She's got the mail room shipping off custom doilies or whatever she's doing. You probably got problems before you get to this one. But if she's not doing the accounting job, even if there was a policy that said go ahead and run the Etsy shop out of your cubicle, she'd violate because on this one she's not doing her particular job. We had a rural county treasurer, I think, who had issues with this where he was not doing his treasurer's job, was like taking online college courses or something. The cost has to be nominal. So think about your typical state office supply closet, right? Like if you take your paperclip home, that's got nominal costs, right? There's another jurisdiction that had like lots of ink cartridges they were sending to all their family members and stuff, that would not be a nominal cost because it adds up.

And then the last one is sort of the trickiest one. It does not create the appearance of impropriety. And where people get stuck on this one is when they're using their uniforms or police cars or equipment to campaign. The commission has said you can't use your items of government to make it look like government is endorsing your campaign. That's antithetical to how we do actual campaigns and elections in this country. So we had one rural sheriff. We the commission is pursuing him on the 407 and he had uniform in his campaign ads and stuff. And he said, "Well, I'm the sheriff. Whatever's in my head is the policy. There's no requirement on the law that it be

written," which is kind of true and wild, so he said, "Okay, that's fine." He said, "It doesn't interfere. Like, I'm still out there fighting crime. Just having my picture on the campaign site doesn't stop me from fighting crime." True. The cost is nominal. I had to have a uniform because I'm the sheriff. I didn't go buy a new uniform just for the campaign pictures, but where he ran into trouble was the appearance of impropriety. So, think about that during campaign season. Remember, all four of the conditions have to be met. And as agency leaders, you just want to be thinking about what policies do you have in place to help protect your employees if there's nominal use of equipment that you do not think is going to be an issue.

Then the last one, and this was the one Mr. Davis sort of asked about in terms of talking about information, and I asked if it was confidential or not. A government resource that we have that you have access to as a government official that is not as intuitive as like a state car is information. And there's basically two rules that are represent both sides of the same coin. You cannot use non-public information to benefit yourself or others. At the same time, you cannot suppress a government report to try to benefit yourself or others. So, think about like, you know, a county commissioner who happens to know that there's going to be a new road that's going to go somewhere and buys land along the way because she finds out early through non-public information that that's where they're going to vote to put the road. That might be an example. Or has anyone found the Kalshi poly market like betting on what color tie the president is going to wear on Wednesday, like if you have that insider information. Or there was the one guy who's now being prosecuted for betting on an invasion of Venezuela because he knew a day before so he put the bet on it. That would be an example of using non-public information to benefit yourself or others. Okay, any questions about that improper benefits bucket?

All right, now we're going to get to the good stuff for boards. Take a minute to read this quote from Woodrow Wilson. The disclosure abstention part of the ethics law, if you think about improper benefits, you're actually getting something that is inappropriate. Disclosure abstention is about transparency and helping to build faith in the public and our government servants because if they come into collision with their own personal interests or someone on their list of magical relationships, they're shining a light on that particular conflict. Disclosure and abstention we put in the same bucket, but there's different analysis for each one. Sometimes we see people who don't want to disclose because they think that means they can't vote. Not true at all. Right? We'll walk through that. Disclosure says that before approving, voting, or acting on a matter, if you've received a gift or a loan, or if you have a significant pecuniary interest, that's our fancy word for money, money interest, or you might be reasonably affected by somebody on your magic list of relationships, you need to disclose that conflict of interest, right? You need to put on the record that you have this interest. They're going to have an interest in the decision you're about to make. So, you're letting the public know that. In order for it to be a good lawful disclosure, it has to be sufficient in detail for the public to understand what's going on. If you look at the left, there's a very insufficient peanut butter and jelly sandwich, right? There's just the bread. It's missing some stuff. The same thing can happen in disclosure. If you have a matter and you look at the agenda, you go, "Oh, I have a conflict of interest." In the board meeting, you can't just say, "I have a conflict of interest on item five, just so you know, like I do." No, you need to provide the details about exactly what that conflict of interest is. We'll do some examples later, but let's say that, we'll go back to the painting one, right? Let's say you guys are approving a contract for painting of all the PEBP offices. Your uncle is one of the vendors. You're going to disclose that you have uncle who has been on this contract and he has a pecuniary interest in the outcome of the vote. That would

be sufficient for the disclosure. And a recent example, in re Gibson in all, it was about five Clark County commissioners who took tickets to go see F1 when it first came in. The tickets were valued at $10,000 each and at a subsequent meeting, they voted on a financial agreement between Clark County and F1, and none of them disclosed that they had received the gift of the ticket. So that was a violation of the disclosure requirement.

Abstention on the other hand is completely sitting out the vote. In cases where you're going to abstain, you'll always disclose before but not every time that you disclose do you need to abstain. So, the abstention rule says a public officer shall not vote or even advocate. So, you can't even argue one way or the other on a matter if it's that same list. You have your own pecuniary interest. You have a commitment in a private capacity or you've received some sort of gift or loan related to the matter. Now, the reason why I say sometimes you can disclose and still vote is that there's a presumption in the law. You've been selected to do an important government job and we can't have an abstention rule that basically knocks out people all the time because you've been selected to do your particular job. There is a presumption, what I call the presumption of participation under the law where as long as you made the disclosure, right? The law is always going to lean in on if you're being transparent about your conflicts, then the standard for when you have to abstain goes up and it is only required in clear cases where the public officer situation is materially affected. We'll talk about that. But sometimes we get complaints where somebody's like, "Well, this person voted on this thing and in 10 years", let's say it's this group, right? "Well, in 10 years their cousin might retire and get benefits like in 10 years they might" "in 10 years their cousin might get a job at the state and then might retire." Like no, that's not a clear case. Like this is not going to require abstention. The other one is it's presumed permissible if the action you're taking even if you have impact if it has no greater or lesser impact. We'll get into some items. For example, with the uncle and the paint right. you're not creating a regulation for all painters. If that was the case you would disclose that you have an uncle who's bound by that regulation but it applies to all painters and so you can still vote. A contract award is going to affect someone very specifically. So, you would be required to abstain. It's a case-by case basis, item by item. So just because you have a relationship that requires you to disclose on one item doesn't mean that on another item you might have to. So, this is a good one to check with your board council, your agency council before and we'll give you some compliance tips at the end of the training. I put in there an example of in re Ancho. This was a great one especially for this audience. So, Ancho was a county commissioner in rural county and they were as a county commission considering some benefits for their retired employees. She was not only a county commissioner but she was a retired county employee who if they made the specific decisions would have benefited from I think it was like being able to buy into the current employee insurance or some fact pattern like that. And we told her like here's the situation. If you need to disclose every single time, but if you're making decisions that's going to affect all retired employees the same, you can still participate as long as you make that disclosure and are transparent. It's not like I'm just getting this benefit for myself. Everybody's getting it so I can still vote. You can just explain that on the record.

Member Davis: Quick question. In my situation, I have an ex-spouse that is a Nevada State legislative lobbyist. How does that come into play?

Mr. Ross: So, they're a lobbyist. So, ex-spouse. The first question is do you have a commitment in a private capacity to that ex-spouse? And ex-spouses are not automatically on the list of

relationships. So the only way that you could have a commitment in a private capacity is if you had a substantially similar relationship to that ex-spouse as you did when you were married. The commission 10 years ago looked at a case where they lived in different states. There was no child support. I got a sense from making the opinion they didn't like each other, right? There was clearly not a substantially similar relationship. We just had a case that we did the final order on yesterday at our meeting where there were two ex-spouses who still lived in the same home, share finances, see each other every day, go to lunch. We said that is substantially similar to an actual spouse. It doesn't matter if you're legally divorced, you have a commitment in private capacity. So, we'll do some test cases. Let's say there's the medical benefits. The board is considering increasing costs that her nephew as a public employee will have to pay for benefits. Does she have to disclose and abstain? Thoughts?

Chair Wells and Member Zumtobel: Disclose.

Mr. Ross: Yeah. So, Mr. Wells said disclose and vote. So, you disclose, right? Nephew is within the third degree of consanguinity. He's going to be impacted by the vote. But everybody's having the same increase, right? It's everybody's being treated the same. They're not taking a vote specifically to the nephew. So, you can still vote, right? But you've got to remember what we see is people get nervous, they want to vote, so they don't disclose and then they don't get that presumption of participation and it gets bad news for them. So, just be aware of that. And again work with your agency attorney. There's another state board and they brought me in to do training because everybody was disclosing on everything like "oh, I had lunch with that person in high school 25 years ago" No that's not enough. Get the work done they need to get done. We'll do another example. Vendor selection. You're picking a vendor and your friend from high school works for the vendor. Thoughts?
Chair Wells: Depends.

Mr. Ross: Depends. Yeah, the answer's going to be probably not. If it's your friend from high school and maybe you have lunch six, seven times a year, that's not going to be a commitment in a private capacity. If it's your friend from high school that you have like a 30,000 day snap chat streak with and you're in a book club together and you go on vacation. These are questions when we get complaints, we'll ask do you go on vacations together? Do you spend holidays together? Do you know how often do you talk? Those are the types of things we ask to determine if it's substantially similar to a relative. So, probably not, right? If it's your spouse who works for the vendor, right? Clearly, you're going to need to disclose and abstain because they're being directly impacted, not like everyone else. Questions about disclosure and abstention?

Okay. Cooling off, which is our last bucket, our smallest bucket. It's a one slide bucket. You got to love the ones slide buckets. You guys are probably aware that sometimes people leave public service. There's certain things that, there's certain people you can't work for for a year, and there are certain things you can't do, no matter who you work for, for a year. So, let's talk about those. So, one year after somebody leaves public service, they cannot go work for a vendor of the agency they worked for. They cannot if they were a regulated industry cannot go work for that regulated industry. That applies only to state folks which is us. Right? So those are people you cannot go work for. Now there's some interesting exceptions in here. Right? For the contract the contract has to be above $25,000. It has to have been awarded 12 months before the person left

and you have to have been in a position to have potentially influenced the contract, right? And that one's sort of interesting because you don't have to have evidence that you actually affected the contract, but if you're in a role that could have had any influence on that, you cannot go work for that particular vendor. Under that first one, you can also say, I know that's the rule, but it's really important and good for the state for me to go work for this person. And sometimes the commission will say, yeah, that makes sense. So, I think we had one during the pandemic, right, where the government was doing a bunch of testing or vaccination and they finally figured out how to offload that to a third party through a grant and the person said like, I was hired just to do testing and I just want to keep doing testing and it's going to this thing that's technically a vendor because they got a grant and they said, yeah, it's in the best interest of the public to let you keep doing your job. The second one is no matter who you go work for, you cannot get paid to counsel or lobby them on issues before the agency while you were there, or to go lobby your old agency. So, let's say you had the vendor RFP going, you depart, you cannot go get paid by one of the people who's going to go apply for that to help them with their RFP application. And I told you, that's the one slide bucket questions about cooling off? I talked about our advisory opinion process. We see a lot. Our top two questions we get through the advisory opinion process are cooling off and the disclosure and abstention because people want to not screw up and usually, they have it planned when they're going to go, right. I'll tell you though, because we've had somewhere it's like it doesn't matter if you're fired, the one year clock still goes. We don't care how you left public service. All that matters is that you left public service.

Member Rich: What is the consequence if you do that?

Mr. Ross: Oh, it's such a great question because there's been lots of debate. So, we can fine somebody for up to two times the amount of financial benefit they received. In my position as Executive Director being aggressive in the enforcement of the law, I would say we could take one year salary and times it by two. We've never done that. Mostly because a lot of people ask for advisory opinions and we say don't go work there and people follow that advice. We're about to see one where they didn't. So that'll be kind of interesting. We had one where it was a Reno city council woman who went and worked for a vendor and we came up with some fine that was the percentage of the budget that was increased while she was there and it was a $3,500 fine or so based on that. We see it sometimes on the disclosure abstention. “The city council is going to meet next week and they're going to vote on this thing and you’ve got to stop this person because they're cousin blah blah blah”. We don't have any power to do injunctive stuff or tell you, we can only react after it happens. So, we can't force them to resign. I think our biggest stick with the cooling off is the finite “well we're just going to take your salary and times it by two”.

Oh that's a perfect lead into what can happen if you get in trouble. So I come in and tell you all these rules and then I'm going to scare you with all these things that we do and then I'll tell you how to stay out of trouble. So, when we get complaints of the lowest level, we can just dismiss case. We dismiss a lot of cases that we get. We say this isn't an ethics issue where we investigate and we go “oh no, these facts were not correct”. We just dismiss. The commission can also issue confidential letters of caution or instruction. And the way I explain it is a confidential letter of instruction is “hey, somebody complained about you. We kind of took a look what was there and we said you didn't cross the line but you could probably use some education. Just know that these are the rules”. A letter of caution is like you definitely kind of cross the line there. It's not worth

our time to do a full-blown investigation and case. Know that these are the rules and then those kind of go into your file, ethics file. It goes into your history. So, if somebody has that issue again, then it's go time, you know. So, we try to do lots of education up front. So that's kind of the lowest level. You didn't violate the law. Then if it goes forward and there's a determination of willful willfulness or non-willful, two types of violations, it's a terrible word because it's really about severity, not like I meant to violate the law. So, if there's non-will violations, we can do the financial payback of stuff that you got. we can issue an admonishment which is formal governmental finger wagging. What's more typical is, we'll mandate ethics training and we had one, he was the head of the Clark County Library. He took tickets to the Super Bowl. One of the requirements in his case was that he get all 800 people in the library trained on ethics, right? So, he spent a couple weeks training all their folks. Then if it's willful, we can do the flat fines and penalties. So, it was a cooling off case and we could do the salary piece if it's non-willful or willful, but if we find it's willful, we can do the flat 5, 10, and $25,000 for first, second, third offense. And then for public officials who are not constitutional officers, if they get three willful violations, so any members of the board, if you were to get three willful violations, we're required as the commission to file an action in district court to have you removed from office. So, the only one I'm aware of is the Kathy Augustine case. People remember that she was impeached and they remember she was murdered. What they don't tend to remember is that that case all started as an ethics case. So, it was an ethics case about using her office for campaigning and the negotiated agreement included fines and willful violations. And because there were willful violations, the commission was required to refer her to the legislature for the impeachment proceedings.

Okay, so that scary stuff out of the way. What can you do to avoid ethics issues? The first one I say is know your magical list of relationships, right? Relationships change. But when I talked about people stumbling into an ethics issue, it was because they weren't thinking about some business partner that was interested in an item they were on. So, be thinking about that. You know, maybe when you change your batteries in your smoke detectors, you look at your list of relationships and because it just triggers you to go, "Oh, I should actually ask my attorney or I should go look at the ethics manual and figure out what I need to do in this situation." Understand your local agency policies. Again, you're the leaders of this agency. And so, you want to be thinking about, do we have good policies in place to protect our folks from goofy ethics issues. You want to be proactive to identify potential conflicts of interest. So, you're in a board meeting, you get your agenda packet. Most people review the agenda packet primarily to figure out what they need to do, read, how they're going to vote, what questions they might ask. You want to also, maybe take a second look at that agenda and go, do I have anybody on my magical list of relationships that is involved in this agenda? We had one county commissioner, she got halfway through advocating and talking about an issue before she realized that the person in front of her was her realtor client, right? Oh, and she did a good job. She stopped and so she just got a letter. We didn't send her off to ethics jail or anything. But, she was just totally unaware and wasn't thinking and was just trying to do her job. When it comes to disclosure, if you're unsure, I say it's always best to disclose rather than not disclose because you at least then get the presumption of participation on the vote. Again, consult with your legal counsel. I said the advisory opinion process is great but it does take some time because we have to do research then we have to get it to our eight commissioners. Our eight commissioners have to vote and come back and do all that. If it's like “hey, it's Tuesday and I have a board meeting Wednesday” that's when you contact your agency council. When we go help train agency councils of course they're like “well yeah, my client asked

me two minutes before and I couldn't ask him any questions". You know as soon as you identify an issue, maybe ping your agency counsel. Because one of the things we talked about willful and non-willful. If you get legal advice from there, it has to be your agency attorney. You can't just find a regular random attorney on the street. But if it's your agency attorney and they give you advice on the ethics law and you follow that advice and it turns out they were wrong, which happened to the library guy, then you cannot be found to have willfully violated the ethics law. The highest the commission can find is a non-willful. And then of course you can always request an advisory opinion. And those are confidential. We won't disclose to anybody that it happened. People sometimes wave those and make them public, but it's a confidential process for you.

Some reasons why people sometimes struggle for help is they fear asking or I don't want to disclose because people think I have a, it's okay to have a conflict of interest. It's not okay to take government action when you have a conflict of interest. So, also know if you have something unethical going on in your agency, if you file a complaint and the complaint is against somebody at your agency, you can request confidentiality protections and the law requires that the commission does not reveal the identity of the person who works at the same agency. And then some ethics resources. So ethics.nv.gov, that's a great site to bookmark. You can also look at us on LinkedIn. We have lots of great public employees on LinkedIn who find our posts. We have ours posting educational resources. But we really did just in the last year or two revise our ethics manual. We got rid of the 1997 word art graphics and stuff and we put it by chapter. So, if you go to our website now and you click on the manual, you don't have to read this 90 page document. You can go "I have a question about gifts" and click on the gifts thing and then you get two pages on gifts and links to opinions. You can search all of our prior opinions on our website. So, if you go to our website, you click on the opinions tab, you can then go into the database and if you've got a question about cousin or travel or something like that, you can type in some words and see. It's not the greatest search function. We're trying to get that improved, but you can look at prior opinions. We have online self-paced ethics training. There's actually a training going on right now in Carson, just for anybody. We also have a newsletter which most state folks are now subscribed to our newsletter. We put that out quarterly and it kind of talks about the latest cases which can always be interesting to see what some of your colleagues are up to. But it has the latest cases and trends and always some educational information. So, that concludes my part. I'm happy to answer any questions that you may have. Confessions. Always a little harder to get confessions during a public meeting that's being broadcast. Any questions, I'm happy to answer that you may have any questions. Hey, thank you. It's always weird to come in here and be like, "I'm going scare you with a bunch of ethics stuff. I do truly appreciate all the work you do. My entire career has been with the state and in public service and I understand especially now, is all the pressures we face and the hard work and so we know that too. We're not like out to hunt down people and find the bad stuff. We mostly want to handle bad actors but also support people and in maintaining compliance and doing whatever. Because again if you can avoid ethics issues then the good work you're doing everyday shines through and that gets to be your story, not the ethical issues. Thank you for having me and have a good rest of your meeting.

Chair Wells: Thank you, Mr. Ross. That was an information discussion only. We'll close agenda item number seven. We'll move to agenda item number six, presentation on HIPAA.

Ms. Mooneyhan: Thank you. For the record, Brandee Mooneyan, Lead Insurance Counsel for PEBP. Chair Wells has asked me to do a brief overview of the HIPPA law and how it applies to the PEBP board. All of you, when you first came on to the board, probably got a huge packet of information. Included in there was about 60 pages of HIPPA information. This is a refresher just to remind you of its existence and if you come into contact with protected health information. HIPPA stands for the Health Insurance Portability and Accountability Act. It was adopted in 1996 by Congress and signed into law by President Clinton. So, it's been around for a while. Most people are kind of generally aware that it covers people's protected health information and identifying information as it is connected to your health information. PEBP of course is one of the entities that is covered by HIPPA. HIPPA covers a variety of entities but including your doctor, your dentist providers, but also the health plan including your government agencies of course are subject to that. As a board member you may learn to protect health information in carrying out your board duties. Probably very rarely, obviously we don't discuss it at board meetings. Any particular person, any information the board discusses is usually de-identified and presented in aggregate. If you were at the PEBP offices and happened to overhear a member services employee speaking on the phone, somebody that you knew, over something like that. So maybe in passing you might become aware of protected health information. Also, as the board, your duty is to ensure that PEBP of course is compliant with HIPPA. So, we just wanted to acquaint you with some of the policies that PEBP has adopted to make sure that we are compliant with the HIPPA. The focus of course. I think in general and in this presentation is the privacy rule. HIPPA is a very long statute because it's been around for 30 years. You can get volumes and volumes of information about it, lots of cases about it and people that specialize in this area. In general for purposes the high level information that the board needs to know this covers protected health information. So those are things that conditions people might have, the doctors they've gone to or not gone to.

Sometimes people choose not to get treatment for a condition and that's also protected health information. Name, address, social security number. All those things that you tell your doctor and your health insurance agency of course; they cannot generally be shared except for purposes of carrying into effect healthcare operations. So, of course when PEBP speaks with the vendors, there is an exchange of protected health information but that is carrying out the healthcare operations to make sure that healthcare is paid for. If there was an investigation by a federal or state agency that information may be used, for example, when PEBP has been audited by the legislature if they want to look at information to make sure that PEBP is complying with law then that would be a time when that information may be disclosed. And in carrying out any activities that the legislature may require to basically help health in in general. The main thing is that in all of those cases, it's still the minimum necessary. If the person that is paying the bill doesn't need to know specific information, that is not included in what is shared. So, the agencies that are covered entities like PEBP are very careful to make sure that the minimum amount of information necessary to carry that into effect is what is shared.

HIPPA also has, in addition to the privacy rule, they're very fond of different sub rules. There's a security rule that's part of HIPPA and that protects electronic PHI which of course has become more prevalent since HIPPA was originally adopted 30 years ago. That requires agencies like PEBP to adopt administrative, physical, and technical policies and controls to make sure that members electronic PHI is protected. For example, a lot of information that PEBP has is behind locked doors. You have to have a specific key to get in. Not anyone can walk through where information is kept even among co-workers. Things are locked and protected by passwords and

encryption when we do share with vendors and when they share it with us. Listed in the presentation are a few examples of that. You know, PEBP hardly anything's thrown in the garbage. It's mostly shredded. Our IT professionals take great care to make sure that all of our information is encrypted and make sure that it's not attacked and that it's very secure from sharing. Of course, I'm sure you've all received letters from maybe perhaps providers over the years that there have been attacks on different agencies that have let out personal information, identifying information that you'd rather not be out there. Part of HIPPA also requires that there's a designated privacy officer. There is a person that makes sure that PEBP is complying with HIPPA all the time. There's usually our Quality Control Officer. Right now, that position is vacant, and in that vacancy, Ms. Carsten is the privacy officer for now. There is a complaint procedure. PEBP's website that's also required by HIPPA. If a member believes their personal health information has been breached or improperly shared, there is a procedure to follow on PEBP's website to complain and it will be addressed by the privacy officer and disclosed to the proper authorities.

The Nevada Revised Statutes in chapter 287 requires a biannual compliance review. So, we had one in 2024, we'll have one this year. Part of that compliance review to make sure that PEBP is compliant with all applicable federal and state laws including HIPPA. So, the vendor that that completes that assessment does an in-depth review, reviews all of PEBP's procedures, documents to make sure and if there are any findings, PEBP will address those. PEBP staff also upon when they are hired kind of like you when you became a board member, they get an initial training in HIPPA and then they were annually reminded of the requirements and responsibilities and PEBP does maintain those records so that in the case of an audit of that or inquiry about our compliance, we do have records that that training is done regularly. The law also requires that PEBP provide a notice of privacy practices to all participants which it does annually and it's also on the PEBP website. There were some recent updates to the federal law about what can be shared under what circumstances and PEBP did make those appropriate changes and we did consult with our actuary on that to make sure that we were in full compliance with that and that is on the website. If PEBP realizes that it has breached somebody's personal protected health information, another rule requires that we tell the person. So, we're very aware of that and if we become aware of any potential breaches or breaches, part of the way we address that is letting the person whose information was breached know about that.

In 2009, about 13 years after HIPPA was adopted, Congress adopted the high-tech act. It's a really long name. Kind of unwieldy. I think they did it because high-tech sounds cool. So, it's the Health Information Technology for Economic and Clinical Health Act. Basically, it was because times had changed a little bit. It promoted the adoption of electronic health records and made the compliance requirements stricter. That includes making sure that any associates that PEBP works with also complies with HIPPA. So, all of our vendors are usually subject to HIPPA in their own right. But even if they're not, part of every PEBP agreement is to make sure that they are aware of that. And we have a business associate agreement which is part of each contract. If we do share information with a vendor they are aware of those procedures and what they need to do if there is a breach. Kind of similar to the ethics presentation, there are penalties that PEBP may face and/or specific persons may face for not complying with HIPPA. In general, the federal government will impose monetary penalties, set forth an action plan, training, that sort of thing. For criminal penalties to attach, it would have to be intentional and again kind of similar to the ethics training. So that would be if somebody on purpose tried to violate somebody and disclose somebody's protected health information. Those are very rare.

When I looked at the database on the US Department of Health and Human Services, they hadn't put out any press releases on any criminal prosecution. So I think purposely doing that is thankfully rare, but there are times when it's done by accident. So there are a few examples in the presentation materials, but also if you are interested in more, there are a lot of them on the Department of Health and Human Services website. They have kind of a database. Two of the ones that I thought were most interesting just to kind of drive home why we go to the lengths we go to to protect health information, there was a case involving Anthem. This is the largest settlement to date under HIPPA. In that case, cyber attackers were able to gain access to the system through fishing emails. The way the opinion is written is it was at least one employee responded to a malicious email and that opened the door. So it may have been as simple as one Person clicking on the wrong email. Over the course of two months they were able to steal a lot of electronic health information. It said 79 million persons and I double checked that because it seems so large but it really was 79 million persons. They were able to get names, social security numbers, information about where they worked, lived, dates of birth and that sort of thing. Anthem did what they were supposed to do under HIPPA and self-reported the breach to the Office of Civil Rights. But even with that they, in addition to most of the state Attorneys General in the country, did investigations. I believe it was 43 state Attorneys General. They faced a class action lawsuit by folks whose information had been violated. And then in addition to that, they've paid a $16 million fine to the Office of Civil Rights and had to undertake a lot of corrective action in order to settle that. Then in a more recent case that was several years ago, seven, eight, nine years ago was the Anthem case. Again, that was the biggest one to date. Another interesting case was the Cadia Healthcare Facilities. Again, this was the OCR. They settled a case just last year. This one, this agency had disclosed a patient's name, photo, and information. On their website they were showing off how they had helped this Person as a success story. One person was upset about that, didn't realize that was going to happen. Made a complaint. When the OCR investigated, they found out that that had happened 149 other times. Nobody else had complained, but because of the large number of violations, they'd never gotten the proper waiver to do that. So, they ended up paying $182,000 penalty. Based on that, because of the large penalties, because the OCR has made a point of trying to get stronger and enforcing HIPPA, that is why PEBP is so careful about sharing information, making people sign in when they visit. that sort of thing. I want you to be aware that PEBP is aware of that and tries to make sure that we are in full compliance. That is it, unless anybody has any questions.

Chair Wells: Any questions?

Member Zumtobel: I have one question. It's interesting with the public comment. The member actually disclosed some of their clinical situation. If we engaged in a conversation specific to that member and we're trying to solve his problems, what kind of parameters around the discussion would you suggest?

Ms. Mooneyhan: Well, Brandee Mooney for the record, it's funny that you brought that up. I thought about that when he made his comment. Obviously, a person can wave that and give their own information. If you were as a board member following up and wanted to find out what happened, of course you would be able to have that discussion, it would fall under one of those

uses that was allowed under it if you were speaking to a member, maybe Ms. Carsten, or Quality Control Officer if we were trying to figure that out. But I would not come back to the next board meeting and talk about it in detail unless the member himself said it was okay and we he we had had it in writing that he approved of that discussion.

Member Zumtobel: No, it's really interesting. I appreciate it because even if today we talked about it, it's not like we're talking about it amongst ourselves. We're talking about it with anybody who might be listening, right? So, it is fairly tricky. I had never thought about it before.

Chair Wells: Any other questions? Hearing none. This was information and discussion only. We'll go again to item number six. Does anybody want a 5 to 10 minute break? We'll take a 10-minute break.

Chair Wells: All right, welcome back. We'll call the meeting back to order. Move to agenda item number eight, presentation on program overview from Segal on GLP1 utilization and obesity and weight management.

Ms. Donaldson: Thank you, Chair Wells. For the record, Debbie Donaldson, actuary with Segal and Senior Vice President. And sitting next to me is Amy McClendon, also actuary and Vice President, Segal. Today we're going to go over some data, some results of PEBP's data. We're going to go over all kind of what we call the shape results kind of overview. We're going to talk about some GLP1 utilization and things that we have seen in members who are taking these medications. Amy's going to go then into some condition specific programs to look at those who are participating versus not participating in some metrics around that. Really trying to tee up to some of the other presentations that are going to be after ours on your various different programs. The first thing we're going to do is go to the population overview and just highlight real quick. So, we're setting the stage. We are going to be talking about the results of PEBP's overall self-funded membership. We're looking at all the plans, both actives and retirees who participate in the PEBP program. Those are your three different plan designs. The appendix is quite extensive. We are showing the results by plan. So, each of the plans metrics are presented specifically for those given plans and members who participate in those plans. But you're going to hear me talk about our shape warehouse or a shape data warehouse. Shape stands for Segal Health and Analysis of Plan Experience. We're going to be looking at your plan year 25 results. So incurred results and comparing it to 24. We're also comparing it to what we call our book of business. Our book of business is state and other public sector plans. Just to highlight, Segal works with over half of the states in the US. So, this shape warehouse of the public sector is quite extensive. Not everyone participates in the shape of our clients, but it is quite extensive. Then again, we have some breakouts between actives and the non-Medicare retirees, but we're just going to go over totals.

So, we're going to dive into it right now. We're going to skip on to slide six of our presentation really quick. I'm going to go over some of those details of the executive summary information as we talk through the slides. So, on this slide is just kind of setting the stage. Some of this may be hard to read, but I'll go down the left hand side. We're looking at what the allowed per member per month cost is and the annual trend. So, when I talk about allowed per member per month, that's the total cost. Again, we're not talking about premiums. We're looking at the claims cost and what is generating the cost that's actually used to set your premiums, but we're looking at

the claims cost. An allowed incurs all the amounts that the member's paying, right? So any kind of deductible, co-pay, cost sharing, that's included in the allowed amounts. You can see that there was just shy of an 8% trend. That allowed per member per month cost is about $676. Right now, not every member is spending that. It's the law of insurance where some members are spending more and others are spending less. And on an average basis, it comes out to about $676. That's total medical and pharmacy. When we look at medical of that $676, it's $484. And it trended around the same as overall. The other thing that I'll point you to on this slide is if you go over to the right, there's two circles and we're showing kind of what the per member per month cost share is between the plan and between the members and we had circled there because of the 79, PEBP is actually trend is higher because you can see that the member spend is not as high. So members costs are only going up 3%. Right? A lot of that has to do with there's co-pays and deductibles that haven't, we have recently increased those, but they haven't kept up with medical trends. PEBP is picking up the lion share of plan costs. This is really a depiction to really highlight and show that.

Over to the right of that was medical but similarly to pharmacy, PEBP is picking up close to over 8 and a half %, 8.6% that was the trend to PEBP's plan cost versus members were only picking up 4.3%. Now I just wanted to note a couple of things additional on this slide that this is a total across all your membership. You'll see in the appendix that the low deductible PPO plan, that plan is really where we're seeing more significant trends, right? Their trends instead of the 79 is more like 12.6 and it is attributable to higher utilization. So, members are utilizing benefits more but it's also been an increase in membership. We have seen the highest cost and the highest chronic conditions in the EPO plan. That is an aging population. It's a declining membership and those that are in there have the highest cost and the highest chronic conditions out of all the PEBP membership. Then conversely on a good note, the Consumer Driven Health Care plan has had very good trends which is bringing down that overall net because their allowed trend is only about 3.5%. I'm going to go a little bit more into the differences a little bit later, but let's go to the next slide.

We're going to dive into medical. So, what's driving your medical trends? On this slide, we've broken it up by how services are being utilized. For the most part, we're seeing year-over-year cost increases or the trends being generated by outpatient and professional spend. You can see that the inpatient in that bottom kind of teal chart is pretty negligible, right? That's a year-over-year increase because we're seeing a change of services move away from inpatient into outpatient. I'd say a couple years ago that was a really good thing, right? Because we were seeing savings because it was a lower level of care and a lower cost versus having a surgery or something done in the inpatient setting. That's changed, right? So, now we're seeing really the outpatient cost, the surgical cost really kind of dramatically increase and we're actually seeing that in your plan as well. It's really just the cost of those surgeries. In the middle I want to highlight, what are the some of the major drivers of the changes of cost year-over-year. We've highlighted kind of the top two. One is ER, we're going to go into that next on the next slide. And then the other driver is outpatient surgery. As I just noted, you've had some good things. Again, on the bottom, as I noted, your surgeries have gone down on the inpatient setting. So, that's a good thing, but unfortunately, it's being offset by the outpatient surgeries. One of the things I'll just say is that we have seen kind of a shift when members want to utilize services. They're tending to move away from the Consumer Driven plan into the Low Deductible plan. And we're seeing a lot more inpatient cost go into the members utilizing inpatient cost in the Low Deductible plan especially for neonatal some muscular surgeries and other services.

Let's do a deep dive on ER. I'll just share, with accessibility there was a little oomph there as we changed it to accessibility. So sorry about that. I'll read that number, but the total allowed for ER was close to $32 million. It was $31.9 million and the allowed per member per month cost for ER was $53.37. So, when we look at ER, there's different levels of services and we've outlined them here on the left hand side and we've really boxed in level fours and fives because we really want to make sure that folks are going to the ER that should be going to the ER. Right? So if we see a lot of level ones and level twos, that's telling us that there may be other appropriate site of services that they could utilize such as the urgent care, calling their PCP, using virtual visits. But the fact that most of the prevalence is in level four and five to me is an indication of a good thing. However, there has been some freestanding ERs bubble up into southern Nevada. We tend to see higher level acuity cares sometimes go through that based upon my experience in other states. So, there's something that we should watch. Why are they going to the ER? This is one thing to maybe talk about and we talked about with PEBP staff is we're seeing the highest spend has been complications and pregnancies. So that's an area to potentially look at of helping support members making sure that they're getting the proper neonatal care and they're getting kind of the pre-pregnancy cares. That is a main reason and cost driver for ER visits. We are seeing kind of more of the cost in ER being driven by utilization compared to unit costs.

All right. So, let's go on to the next slide which is looking at the major chronic conditions within the PEBP self-funded membership.When we're looking at this slide, we're seeing that about 53% of your members have one or more chronic conditions. 7% of members have four or more chronic conditions. Again, compared, when we look at the EPO plan, 65% of that membership has one or more chronic condition. On the left hand side when we look at your top chronic conditions, mental health is at the top. It's also that top of our book of business. So PEBP's number is kind of that dark purple and then underneath it kind of the shadow color is looking at the benchmark or the book of business. So, it is your top condition. It is in the top condition in our book of business, but PEBPs prevalence is lower than what we see in
our book of business at around 35% via PEBP is around just shy of 27%. So other kind of conditions that we're seeing are hypolipidemia, PEBP's a little bit higher. Conversely on
hypertension and obesity, the PEBP membership is lower than what we see in our book of business. Over into the kind of middle and the bottom we look at the chronic conditions. We look at the number of members who have these conditions. We look at the year-over-year change. We also show of this population what is the average number of conditions that other conditions that they have. Right? So, they may have mental health but they may have a couple of other conditions that they're dealing with as well. Then we look at the total cost. So, I'm going to point you down to the diabetes. We're going to go into diabetes a little bit more, but when we look on total, looking at medical and pharmacy spending in total, it's about $1,800 of total spending.
We're going to go into some of the programs that members can participate in if they have diabetes and kind of look at some details in some future slides.

The other thing I'll just point you to is the conditions of COPD which is coronary artery retinal disease. Do I have that right Dr. Duncan? And CHF which is congestive heart failure. These two conditions, they have low prevalence as you can see on the left hand side but if you look over to the right hand side, the average cost and spend for these members are fairly high. If we go on to the next slide, when we're looking at care gap compliance, these are the members who are complying like they are going to their doctors and they're getting the basic care that they need associated with their conditions. Coronary artery disease, we've highlighted, there's opportunity in

the PEBP programs. We're seeing less prevalence of them, going and taking a statin, less prevalence of members having an ACE inhibitor, taking an ACE inhibitor compared to our book of business. But we're also seeing decreases in that condition of members
utilizing these two medications. Conversely, we're seeing some good adherence with members who have COPD. And then in diabetes, we're seeing members, they're getting their A1C tests done at least once within 12 months, which is good. And there's opportunity for screening tests for nephropathy and retinopathy. And nephropathy is looking at damage caused to some of the nerves. So getting their foot tested, getting foot exams and making sure there's no nerve damage. And then retinopathy is getting eye exams to make sure that there's no damage to the blood vessels within the retina. There's opportunity there. While we're seeing some good things, there's still opportunity there. I'll just point you lastly to preventive screenings. This is for cancer screenings for breast cancer, cervical, colorectal, and prostate. There's still some opportunities. We are seeing improving numbers as you can see by the green arrows going up, which is wonderful. But there's also some opportunities maybe to help your members in making sure they're getting the annual exam and care.

So, moving quickly to look at some pharmacy spend and not a surprise, we're seeing GLP1s at the top spend. Looking at Mounjaro and Ozempic as the top spend, these are GLP1s. Dupixent and Stelara are used for skin and psoriasis. We're seeing big costs. There's a lot of commercials on TV around these. So, if you see commercials, what I'm seeing is then it bubbles up and this is a common theme that I'm seeing on a lot of public sector plans of these higher spend and cost of these medications. This is again fiscal year 25. So, we were still seeing some spend in HRA. With the biosimilar coming out, we have really seen dramatic increases since fiscal year 25 in the use of Humira with the biosimilar. So that's been a good improvement. One of the things that we have seen as well is that when we look at utilization versus the cost but we are seeing increases in utilization on the number of scripts particularly in the Low Deductible plan and the Consumer Driven Health plan. We're going to go into that a little bit more. A lot of that's GLP1 driven. When we look at top 15 pharmacy diseases, obviously diabetes and the spend around that, that's being driven by your GLP1s, autoimmune disease is what we talked about. It's some of those drugs that also used for psoriasis and other skin disorders. Psoriasis is actually next, followed by oncology. Notable in many plans, I tend to see oncology bubble up and higher and it's number four for you. You can see that the ranking changes of these top five have not changed year-over-year.

So I'm going to skip quickly over to GLP1 utilization. I covered a lot of the highlights differences by plan, but what we did is, we looked at members who are taking GLP1s. We found out that about 40% of members identified with a diabetes condition are taking these GLP1s. That's just shy of about 1,800 members. These GLP1s have been on the market for quite some time, just FYI. We saw a huge wave of these medications particularly with the popularity of Ozempic and as you can see, I'm sure you're aware of the pipeline for these GLP1s are incredibly strong in the next two or three years. There's additional manufacturers who are going to be coming out with these medications. There's pill forms that are now coming up and I tend to call them budget busters within public sector plans because they're always in the top drug spend. Just to note that GLP1s for anti-obesity is not a condition on the formulary for your plan. So, we're just talking about members using these drugs for diabetes. Although if you look at the bottom point, we did look at your data and there's, what we call leakage or off label, there was about 4% of users that we could not find any kind of indication that they had diabetes that were using some of these GLP1s. So,

something that we want to think about. I actually was thinking it was going to be more. So, even though 4% is a high number of members, I was pleasantly surprised with that result.

But one of the things that we looked at is year-over-year the spend has really increased. So close to $4 million was the increase to your plan looking at 25 over 24. When we look at, I think on this slide, it's really looking at the two drugs that are really driving it. It's Mounjaro and Ozempic and they represent close to $15 million of plan spend in your pharmacy spend. This represents about $25 per member per month. So, the law of insurance, right? So, it gets spread out across all your memberships, which results in an additional spend of about $25. And just the average cost of these drugs for a 30-day, this is on average, it depends on the level and dosage, but it's just shy of about $1,000. That's allowed prior to rebates, but it's about $1,000 for a 30-day supply on average. So, one of the things we looked at in the next slide is okay is this helping our members, right? Because we have heard anecdotally, is it helping the members and for the most part we are seeing it. I'll talk about that in a minute. First I want to just highlight we looked at members who were adherent and our definition of adherent was members who were taking these medications for at least 80% of the time over the year that they had the prescription. So if they were filling their scripts every 30 days, great, but they had to fill it for 80% of the entire year. So, we compared those who were adherent versus they were not adherent. Well, unfortunately overall though, we found that those who were adherent did have over higher overall costs. It's really being driven by the cost of these drugs. We saw that overall those adhered members did have reductions in emergency room and urgent care spend which is a good thing. We also saw members were going to their doctors, they were checking in with their doctors, going to see their PCP, that's a great thing and we want to promote that. It was really the cost of these drugs are still at a price point that it's any kind of benefit we're seeing on the medical side is being offset by the cost of these medications. On the next slide, we dove into this a little bit looking at adherent versus non-adherent. So, we looked at what the spend was prior to treatment and then what the spend was after treatment. And you can see here on the left hand side in that orange box, that's the cost of the GLP1s. So comparing that to the box over to the left, that's one of the main drivers why the overall cost for GLP1 users is really high. You can see that for the medical spend, we are seeing lower medical spend. That's a good thing. That's what we want to see. So the average cost is just shy of $700 versus non-inherent we're seeing it close to $770. So, we are seeing savings on the medical side but those cost of the medications are just overwriting that. The overall spend for those GLP1 members still, is showing to be on average, close to $600 to $700 more than we're seeing for members who are not taking these GLP1s on a regular basis. I'm going to turn it.

Member Zumtobel: I'm sorry, Deborah. This Tom, can I ask a question? Great presentation. So it's $770. It's $692 for People who are actually adherent and $771 for those that are not. Does that include the cost you referenced earlier on that the people that quit after 30 days their cost goes up by 30% or so. You said they account for 30% of the cost? Is that in that number?

Ms. Donaldson: I'm not sure I'm tracking your 30%.

Member Zumtobel: I think it's two slides before slide 17. You said 30 percentage point increase in medical cost for people who were non-adherent.

Ms. Donaldson: Oh, sorry. Okay. Sorry, got it. Members who were not adherent. 30% point increase in medical cost. If you look on the next slide, we're looking at before treatment versus after treatment, right? Those non-adherent, we're seeing increases in the cost before they treated versus after the GLP1. So it could be that maybe they had an adverse reaction to this medication, that they had a side effect with this medication. That there is gastro

Member Zumtobel: No, I understand better now. I misunderstood this. This is almost just exactly that population, right? The non-adherent is the 30% more. I was thinking it was the people that might have had diabetes and never did a GLP1 and that was their cost of care, but that's not necessarily what this is showing, correct?

Ms. Donaldson: No, but we're going to go into some of that and Amy's going to go into that, Tom in just a little minute in our next slide. Feel free to ask questions after that. Thank you for the question. All right. Chair Wells, should we stop at this point to gather additional questions? You want us to continue?

Chair Wells: Yeah, we can ask we can stop here for any other questions regarding what we heard so far.
Member Duncan: Keiko Duncan for the record. I just had some questions and I lost the slide that I had put the note on, but a couple things. One just to correct the record. Diabetic nephropathy is kidney disease, not neuropathy disease. You mentioned that, again, I don't know what slide it was, but about 4% had no indication of diabetes, right? I just wanted to clarify. What indication, what things were you guys looking for as markers for that? Were we looking at encounter data diagnoses submitted on claims?

Ms. Donaldson: We're looking at claims data. We do get some lab data as well into our shape database. We didn't see any indications that A1C would have indicated that they were diabetic. We're not seeing any kind of visits from in claims indications that based upon the claims that we're seeing coming into the database that there was any indications indicating that this member had diabetes. They could have been pre-diabetic. They're not meeting the definition of diabetes to get to get these medications.

Member Duncan: Okay. Then I just wanted to clarify on the slide I did tag was slide 12. This particular pharmacy disease indications where we say diabetes is the number one disease indication, is this just a correlation of the FDA indications being that Ozempic was the highest utilizer. This is not reflective of actually looking at ICDS or anything.?

Ms. Donaldson: This is looking at indicators on our database to say this member has diabetes. We're looking at claims cost.

Member Duncan: This is not a correlation between we have Ozempic as the highest and Ozempic is used for diabetes. Therefore, diabetes is the highest?

Ms. Donaldson: No, we're looking at their claims data to say, okay, based upon the criteria that we utilize, what kind of members just have claims cost of diabetes versus oncology, right? We can tell

based upon claims, CPT codes, all that kind of stuff, the conditions. That's how we're gathering it. We're combining medical and pharmacy data and then coming up with the conditions and then looking at the drugs associated with those numbers.

Member Duncan: For the non-adherence for the GLP users, how did you define non-adherence?

Ms. Donaldson: So non-inherence, if you go to slide 17 and the little, tiny writing at the bottom it says we're defining adherence as members who filled scripts for at least 80% of the days in a year. If they didn't fill their GLP1 scripts that met that criteria of 80%, they're considered non-adherent. They may have been on the GLP1s for three or four months. They would be considered non-adherent but still have that diabetes condition.

Member Duncan: When we say a year, are we talking about a rolling 12 months from the day that they had their first fill?

Ms. Donaldson: It's a good question. We'd have to get back to specifics on how they pulled that, but I know they pulled it on, this is on a plan year basis. I think you're getting to what if a member was diagnosed in March, right? Would they be considered non-adherent? And that I need to look into on how they hold that criteria.

Member Duncan: Yeah. Or the difference between if you're looking at a plan year and somebody starts Ozempic in month 11, right? Or if they are diagnosed and we see claims data that shows that they were diagnosed and they did not receive appropriate treatment until month 11, right? I think there's different versions of non-adherence here to look at.

Ms. Donaldson: Okay. Board member Duncan and Chair Wells, I'd like to follow up on that if we can give a follow up.

Member Duncan: That'd be perfect.

Member Zumtobel: Thank you. I have a few questions. On the PMPM where you were showing the diabetes it would be interesting in the future, because you would assume even though that cost is up, I think year-over-year, you would assume it's shifting into pharmacy, right and it would be interesting to see how much it's going down on the medical side but that's just more interesting. One of the concerns I have is in the early presentation you talked about the trend for the high deductible plan is down or lower and the others, especially the EPO is higher, and I don't think that's purely driven by plan design. I believe there's adverse selection that occurs and I think that your healthy people tend to pick the higher deductible plan and that trend should be down. I would love your opinion on that, frankly.

Ms. Donaldson: I do think you're right. The EPO plan has an older membership than the rest of the plans. We are seeing some evidence that members are moving from the Consumer Driven Health plan into the Low Deductible PPO plan when they need to utilize services such as going to the hospital and getting a procedure or for pregnancies. We are seeing that happen which then creates the positive trends we're seeing in the Consumer Driven Health plan. We're seeing the rising trends

and the higher trends and the Low Deductible Health care plan. And then the EPO plan, we're seeing just high overall membership with more conditions that's driving costs.

Member Zumtobel: Yeah. Yeah. And your statement's not unique to us. That's kind of reality, correct? As far as any plan selection anywhere that you see that consistently people, if they have an option and they know they have a medical condition coming up or they're sicker, they tend to move over to the plan that is quote unquote richer.

Ms. Donaldson: Yes. Board member, Chair Wells that tends to happen. I think sometimes there are some plan design features that you can put in to help mitigate that to the extent possible. I know that maybe something we'll be looking at in future board meetings. But yes, if someone is looking at plans from a purely financial perspective, that may happen. Although you have to put behavior economics sometimes into play as well. Sometimes people don't make the best financial choices for themselves because they may be change agnostic. So, it really depends. But yes, if they're financially driven, they could potentially be looking at what plan is financially the best for them given the services that they need to have in a given year, their plan services.

Member Zumtobel: I just wanted to get on the table because it's a great conversation for us to eventually have and not to just assume the high deductible plan's running better, but it truly does attract better risk and that's fine. That's great for the people that are healthier and they have that option and they get to save money. That's wonderful. But we have to think about the people who, young moms who have children who can't afford that high deductible and what kind of options. I don't want us to keep deteriorating the option for those people. We have to think of the whole picture, is what I'd like us to do. So, on the pharmacy it said that the PMP was $156 PMPM. I assume that must be before rebates, right?

Ms. Donaldson: That's correct. And point of clarification, Chair Wells and board member. This is the PMPM associated with the top 15. The $156 PMPM is associated with these top 15 disease indications. It's not the total pharmacy spend. Yes, it is prior to rebates.

Member Zumtobel: Okay. I was trying to interpret that slide and I couldn't tell that. That makes a little more sense. On the GLP1s, it sounded like in the presentation because there's 4% of the people that are accessing it that might not meet the criteria. So, our GLP1 medical policy is you must have a diabetes diagnosis to qualify?

Ms. Donaldson: Chair Wells and board member, I believe, and happy to turn this over to Executive Officer Carsten, but I believe you have to have a diabetes indication in order to get one of these GLP1s.

Member Zumtobel: Okay. So, it's not offered only for weight loss?

Ms. Daily: This is Amy Daily with Express Scripts. Mounjaro and Ozempic are only approved for diabetes, not pre-diabetes, just diabetes. Then they re-went through approvals through the FDA for weight loss and those products are called Zepbound and Wegovy. Same drugs, different names, different indications. For these drugs currently today, there's a prior authorization where the doctor

has to attest that the member has diabetes. They just have to say yes. And then we're going to talk about additional steps that you can take to require documentation that that is the case during our presentation. But today they say for the member to get the drug they say they have diabetes but they're not proving it basically.

Member Zumtobel: Okay. They don't have to show their A1C or anything. Okay.

Member Rich: Laura Rich for the record. Can I just ask on that, the 4% would that be the people in that 4% category that would get weeded out?

Ms. Daily: With additional documentation requirements? Yes. But we think it could be bigger than that because they're using diagnosis codes in the medical data and those can change over time. But a lot of those can be old and dated. We would recommend you know everyone going through the prior authorization to provide documentation and that would ensure that even if it goes beyond the 4% that you're catching everyone.

Chair Wells: Anything else? Any other questions before we move on?

Member Rich: I just have one quick question, Laura Rich, for the record. It's way back in the beginning. It just caught my attention. On slide nine on the mental health, it shows that our prevalence and in the plan is much lower than the benchmark. Nevada has a severe shortage of mental health providers. Could it just be that we just don't have the providers and people are not seeking services and that we're just not paying for it because there's no providers?

Ms. Donaldson: Chair Wells and board member Rich that that could possibly be a portion of it. The folks that we've identified with mental health, it's come in on a claims data, but there certainly could be folks that may have a mental health condition that have not been treated. It has not been diagnosed by anybody in professional services that have put that on a claim as an indicator. Certainly, that could be a portion of the case.

Chair Wells: Any other questions? All right, let's move on.

Ms. Donaldson: A quick point of clarification with regards to board member Duncan about our methodology on GP1s, Amy.

Ms. McClendon: We looked at those that initiated GLP1 therapy between January 2023 and December 2024. So, that 2-year period. And then we looked for folks, they had to be on for at least six months. We looked at claims data all the way through March, but we wanted to ensure that they had at least 12 months of experience with GLP1s, including the runout. So, that was the analysis that we did. So, we looked at before treatment, after treatment, but those time periods could vary depending on when they started and what that 12-month period looked like.

Ms. Donaldson: All right. So, let's move on to look at some specific programs.

Ms. McClendon: Next we did an analysis of the programs offered to PEBP participants with regards to diabetes and obesity or weight management. The first program we looked at was diabetes care management. This program is only available to those who are enrolled in the CDHP plan. It's an opt-in program that they have to voluntarily participate in, but they do have to meet some BMI eligibility requirements. It covers some office visits and labs. But I think the main motivation for enrolling in this program is that diabetes related medication is covered first dollar instead of being subject to deductible. So those high deductible folks are able to get the medications first dollar and sooner, the plan picks up the cost sooner. Next, the obesity care management program. This is open to a wider audience. So, the CDHP, LDPPO, and EPO participants. Again, it's voluntary. There are some BMI requirements, and it's more of a medically supervised weight loss program with nutritional counseling is kind of the key there. Real appeal is a third-party program that you all access through UMR's arrangement and it's open to even the HMO participants. You again have to meet some BMI requirements but that's more of an online virtual focus compared to some of the others. There's some scales that are provided as well for tracking food and weight. And then last we looked at the Nevada Business Group on health pilot program. So, these are for folks who are type two diabetic or pre-diabetic and it offers both a virtual component and an in-Person component. We also wanted to mention a disease management program available to HMO participants, but we don't have claims data that runs through our claims data warehouse to be able to analyze that.

So what we did was we took lists of participants of your PEBP folks who are participating in these programs and compared it to the claims data that we have in our data warehouse. And overall, some of the sample sizes are a little smaller. So just keep that in mind. Overall we saw some themes that we thought we'd point out. First is just in general we saw lower engagement in these programs. So this may be an opportunity to potentially communicate the programs more, get the word out there, but in general, we saw some lower engagement. Keep that in mind as we're reviewing some of the analysis. But in general, the folks who are participating have between two or three chronic conditions. They did have lower impatient admissions in emergency room. That means that we can we can asse that they're managing their condition a little bit better, they're not having those higher cost treatment settings by being admitted into a hospital or in the emergency room. We did see a higher prevalence of just going to the PCP and even urgent care but having that more maintenance type care that you want to see as to control condition. And then lastly, we've got the call out box here. Just in general, the industry is moving more towards a whole person or holistic well-being. So instead of looking at specific conditions, I think we said 53% had chronic conditions and 7% had more than four. So just being able to manage all of that is a lot. Looking at more than just the physical, but the emotional and the behavioral health side of things and even social. So that's kind of looking at the whole person to manage what that person is going through and trying to manage.

Next we have the diabetes care management program. We're going to dive into these. I'll start on the right. The participation we mentioned it was lower. In this program, we have 18 participating which is about 1% engagement. When we look at those who are, what we would identify as diabetic, there were 1500 that are not participating that we would have identified. Then I'll point you to the top left graph around the allowed cost. We see with the folks who are participating, they have lower medical costs but higher RX. And in total, the non-participants have higher total spend and the participants are actually lower. What we're seeing is that folks are using

this in order to get the prescriptions first dollar compared to having to pay the full cost before they meet their deductible. We're also seeing some benefits on the medical side. If you look at the utilization per thousand, we see that there's a higher prevalence of those physical exams. We actually had no impatient admissions with those who were participating, which is good. And smaller ER visits, but you see the GLP-1 scripts is much higher. And so folks are just utilizing the program as intended to get their medications first dollar. Regarding the cost of the program. This is included as a part of the base administration fee. There's no additional cost for administering this program. UMR administers the program. It is a smaller sample size but there is a potential opportunity to communicate. We do see better screening. You see on the left side, the A1C screening and cholesterol screening those are all at 100%. There is some benefits, some monitoring. We just don't have a lot of activity or engagement with that program.

Next, we looked at the obesity care management program. This had a little more engagement. If we look at the total population for those who we would identify based on their claims as being obese. We have 4% engagement which is about 368 participants compared to about 8,600 who are not participating. When we look at the cost on the top left you can see the medical RX cost is pretty much very similar between the participants and non-participants. But then when we look at the utilization per thousand, again same kind of themes where we see more physical exams more urgent care at that lower care setting versus inpatient admissions and ER. Again we do have the GLP1 scripts being used with this program. It's same thing with the admin fee. There's no additional cost. It does have a little higher participation than some of the other programs we looked at. In general, if you look to the left, folks who are participating have a higher risk score and a little bit higher number of conditions. The folks that are participating, it's helpful for them to participate because they have higher risk. There is an opportunity potentially, the A1C screening is just a little bit smaller on the participant versus non-participant side. Potentially some of those kidney and retina screenings, there's potential opportunity there. But we do have 100% getting their annual physical and that's because that's how the program's designed that it's encouraging that activity.

All right, next program real appeal. This one we had 81 participants in the list we were provided that's about 1% engagement. When we look at their costs the medical RX in total for those who are participating is lower than those who are not. In general the population is a little bit lower cost for those who are participating. We see some similar themes, but I'll just note the call out here on this program is that there are a lot less participants using GLP-1 scripts than non-participants. So rather than controlling the weight using medication, they're looking for alternative methods or using nutrition. We do see that coming through in the data. There's an additional charge for this program about $799 over 52 weeks. There is an additional charge. We only have 81 participating which is a smaller amount. We do see those lower cost settings. We don't have the as many admissions or ER visits. And we do see the compliance is a lot better. If you look at that bottom left chart, 94% for both A1C and LDL is very good. They're seeing their physicians.

Last, we just have a note, on the Nevada Business Group on health, this is a pilot program. There's two components. There's a national diabetes prevention program, which is a year-long. It's weekly for six months and then it shifts to monthly. There's also a diabetes self-management education program which is a six-week group program. I would say we were able to get some information on one of the two locations, the Sanford Center for Aging. We see that there were 44 participants. However, when we wanted to match it up to the claims data, we didn't have enough credibility to be able to present. We did have 44 participants participating in that program and then

the other wasn't tracked. We just aren't aware of how many that are participating in the program. But it's no cost. It's a pilot program offered through the state the business group on health.

Ms. Donaldson: Chair Wells, that's the end of our formal presentation.

Chair Wells: Thank you. Any questions?

Member Duncan: Okay. Keiko Duncan for the record. For the CDHP, they have to be in the diabetes care management program in order to access the medications for just a co-pay is my understanding. Do they have to stay in the program to then get each subsequent fill or is it just a one time in that year on the DCM program?

Ms. Huckaby: This is Rhonda Huckaby with UMR. Yes, they have to re-enroll every year on the DCM program.
Member Duncan; So, they must be in the program for the full time to continue to get refills throughout the year?

Ms. Huckaby: Right.

Member Duncan: Have we tracked anybody who doesn't enroll in the next year? Say they enroll for year one, they don't enroll in year two, and they continue on GLPs. Has that A, ever happened or B, have we tracked anybody that has their costs then gone up to this non-participant level or are they able to maintain their decrease in spend?

Ms. Huckaby: yeah I don't know if we've actually tracked that. Segal have you guys done the year for year?

Ms. Donaldson: Chair Wells, Dr. Duncan, we have not yet based upon the data we received. I don't know if we have a lot of that historical anecdotal data.

Member Duncan: I'm curious in terms of, especially when we talk about non-adherence and especially with this particular drug class of our GLPs, there's a lot of weight rebound if you stop the medication. But I'm curious because my understanding is as part of the program, maybe there's some lifestyle modifications and stuff. So, I'm wondering if we have some data as to if they've in the program, they are no longer in the program, they pay their deductible or what have you, do they continue to have the benefits long term? Then I was curious for the obesity care management program, I know we saw some diabetic screening percentages in here as well, but how many do we have? How many people that are in the obesity care management program are also in the diabetic care management program and that is why they are getting the GLP1 scripts?

Ms. McClendon: That's a good question. We only had 18 participating in the diabetes. At most it would be18 but we can take a look.

Ms. Daily: This is Amy too with Express Scripts for the record. You don't cover the brand obesity drugs today. So, what would likely be happening is they're either taking the generics if they're in the program or they're trying to get GLP1s through the diabetic group.

Member Duncan: And that's what my question is. So, those that are in the obesity care program that are also in the diabetes care management program, right? So, just as a as a potential source. For the obesity care management program understanding that there are only 18 people in it. Looking at the screening metrics and the participation levels for all of these things, I see overall across the board it's all very low. The screenings that these people should be doing they're not doing. Is that not a part of the program to get them to their providers to do the screenings or how do we help that number go up? Question for anybody in the room.

Ms. Donaldson: I can speak. Chair Wells, Dr. Duncan, I can speak in general. It's proactive reaching out to that member. When we see that the indications are not happening, it's coordination with the providers to say, "Hey, this member has not gotten their annual." So, the those are things that we've seen in programs that really help actively engage that member to get better adherence results.

Member Duncan: Yeah, absolutely. So is that what is what is happening in the program?

Ms. Huckaby: We'll go through in the UMR presentation because on the, sorry this is Rhonda with UMR. In the obesity care program it is a medically supervised weight loss program. There are specific providers within the state that the PEBP participants see and they do the initial enrollment form and they tell us if they're going to enroll them in the program and then they have to submit monthly engagement forms. So, it's like I said, totally supervised by those OCM providers that we have in the state. If they do not submit their monthly engagement forms, they do not get the enhanced benefits tied to the program. And that's on the medical and the pharmacy side.

Member Duncan: Okay. I'll wait to hear more about the program. Thank you.

Chair Wells: Any other questions?

Member Harper: Blaine Harper for the record: I wonder if the really low enrollment in the diabetes care management program is related to, I've heard outside of public comment, that program, it's jumping through hoops. It's pretty low touch in terms of actual interactions. I wonder if a large proportion of our participants who would benefit from it choose different plans since this is only offered under the CDHP. Only having 18 people enrolled for a condition as common as diabetes, it could be just a low engagement effect. It could also be a plan selection effect. That could be something to keep in mind. It could be that people are dropped from this program if they miss a monthly form? Could that negative experience be driving people entirely off of CDHP because they don't want to deal with this program? Just some factors that I'm thinking of given the really low enrollment that we're seeing there.

Member Zumtobel: I would like to go back to that GLP1 analysis methodology and limitations.

I think it's such important work and I'm not quite sure that we understand it. I'm not sure if somebody's in the program for three months continuously if they're considered non-adherent and then that goes into, and I don't need to understand it right now. I just think it's worth understanding. If you could you bring back exactly that methodology so we can make sure that we understand it because I think it'd be extremely valuable to track.

Ms. Donaldson: Chair Wells, board member happy to follow up with that.

Member Zumtobel: The other question I had is that in the beginning when I asked about the pharmacy data, you said that's only based on the high diagnostic categories or chronic care is. All of the PMPM that you showed, that total PMPM spend, it was a carveout?

Ms. Donaldson: I want to make sure I'm understanding your question board member chair and board member. If you look on slide 11 of our presentation, I want to make sure we're all on the same page, is the total pharmacy spend. The allowed spend for pharmacy is $192 per member per month. It's allowed total dollars of about $115 million.

Member Zumtobel: I thought when I heard the answer before, but I was talking about the $150. I interpret your response to say that was for a carve out of the most expensive categories. Is the $192 our PMPM for the whole population?

Ms. Donaldson: That's correct. So, of the $192, $156.90 is the spend for these top disease indications, which means the majority of the spend is associated with these top 15 disease conditions. But yes, there's other costs that make up the difference between the $157 up to the $192, but the $192 is the total pharmacy allowed spend per member per month prior to rebates.

Member Zumtobel: What I hear is the $192 and then you would minus the $156, so all of the rest of the population is $40ish dollars PMPM?

Ms. Donaldson: Board member, chair. Yes, if you're trying to find the net of the remaining folks that are not in the top 15 conditions. Yes, that is the correct math.

Member Zumtobel: I was trying to find something else. It's hard to compute that. Then our total PMPM is $192 before rebates?

Ms. Donaldson: Chair Wells, board member. Yes, that is correct.

Member Zumtobel: And like our plan here, we're $112 before rebates and coverage is probably very similar. It'd be interesting if we could somehow compare the two and see where some of the difference lies. That's what we've done here. That's part of how we've kept the premium down was every year we find $10 or $20 million in pharmacy spend consistently. But that number is just is wild, right? Is that out of line with your block of business?

Ms. Donaldson: Chair Wells and board member. It depends on many factors. It depends on the formulary. I'm not sure what formulary and drugs you're allowing on the plan versus not allowing

on the plan. There's a lot of factors of that. It's the risk conditions of the members within that population and the drugs they're utilizing. For example, oncology which was number four of condition but those drugs and medications can be very expensive and really add to the overall pharmacy spend but we're also seeing, I'm not sure how your GLP1 spend which is one of the top drugs used in your population. I'm not sure. So, there's a lot of factors in order to be able to compare one risk pool to the next because formularies and there's a lot of other things that come into play.

Member Zumtobel: Yeah. I mean it's everything and that's the challenge. There's so many moving pieces that we could kind of always bounce around and always have some kind of answer that that doesn't help us to get to action, right? That's a big number frankly. Chairman Wells, do we ever get a presentation of side by side on the experience by plan? So the High Deductible plan, I've never seen claims cost, what is our total medical claims cost on a PMPM basis and then break down by plan and then potentially revenue in just kind of those simple slices so we can kind of see at a snapshot how plans are Performing. We always get such a volume of data you always it's so hard to kind of figure out how to step through it.

Chair Wells: We get the UMR reports every quarter that have the medical in it and ESI's reports every quarter have the pharmaceutical broken down by plan by per member per month costs. So, we do get that, but we do not tie it back to the premium revenues.

Member Zumtobel: Yeah. I'm just saying as a board member, we have a responsibility to try to act accountably. I feel like we need some tools that give us a snapshot. Now, as a board member, are you saying we need to go back and piece that together or is there a way for staff to give us a useful tool at the meeting that we can kick off the meeting and understand where we stand?

Chair Wells: We can look at different different methodologies for presenting data. It's a lot of data. I mean, that's the problem. It's a lot of data. 45,000 members that have different utilization and different conditions.

Member Zumtobel: No, that's exactly right. And then as a board member for us to get this amount of data and then have to sort it through I would think that's what we have staff for versus us having to try to push this together and figure it out, you know? I mean, these are all hard questions to ask unless you have a really extensive background to dig through and we have to
hold our vendors accountable. I think somehow staff needs to give us some tools so we could start to hold People accountable.

Chair Wells: Yeah, we can look at a couple options.

Member Zumtobel: Thank you.

Chair Wells: Any questions from other board members? Seeing none, I don't think we need any action on this particular agenda. We'll close agenda item number eight. Move to agenda item number nine, Review and Discussion of the Express Scripts Programs.

Ms. Donohue: Thank you for letting us take a few minutes today to talk about recommendations and savings for the current programs that you have in place today. One of the recommendations that we have for you is to have the Encircle RX program. We talked about a little bit, with the GLPs. Your number one medication is Mounjaro. $3.4 million for that drug. That's your number one drug. And then you have Ozempic which is over a million dollars and that's your number four drug. We see this across our book of business. With all of our clients seeing the same increases with GLPS. What we are recommending is additional clinical criteria for your GLPS. Right now you do have a prior authorization in place where the doctor as, Amy Daily, mentioned the doctor attests that the patient has diabetes. With the Encircle RX program, we're going to take in information based on A1C and ICD numbers to make sure that it's medically appropriate for the member.

Ms. Daily: And it's through documentation. So basically, we require rather than just a check mark, this member has diabetes, we require that the physician submit charts, chart notes that we review to ensure that we're actually seeing a diabetes diagnosis through the testing and those pieces and the regular visits with the physician to prevent people from, the doctor. And we've seen this in the past. This is a trend where doctors are just checking a box saying that the member has diabetes when they do not. As I mentioned earlier, Mounjaro and Wegovy are only approved for type 2 diabetes, not pre-diabetes, not type one, not weight loss. So that's really what this program is enforcing.

Member Davis: I have a quick question. What do you project the reduction will be by implementing these requirements? The reduction in the amount of usage in the program?

Ms. Daily: So, the estimate today, we're estimating your annual spend would be $8.85 per member per month for these medications. And with the program, we would be reducing it to $8.39 per member. And we hadn't gone over that piece yet. So that's a good question. The way this program really saves you money as you see claims drop out of the system. So just people who previously had access to these drugs being taken off, no longer can get access to the GLP ones because they do not have diabetes.

Member Davis: Have other companies utilized these requirements?

Ms. Donohue; Yes. I have another state and again we talked about there's variables. I have another state that added it January 1st 2026. After a quarter, we've seen a 28% reduction in their GLP spend.

Ms. Daily: I think over our book of business, almost everybody's put this in at this point, especially if you do not cover the brand weight loss. There's a lot of people trying to get through the diabetes diagnosis.

Member Harper: Blaine Harper for the record. How does the estimate for diabetes diagnosis with medical data with this approach compared to Segal's approach which estimated that it's about maybe 4% that we're currently seeing that may not be meeting criteria. I think that's where I spoke to earlier. We can put this program in using medical data for diagnosis. We've seen a step approach where some of our clients have started there and then they've moved to taking out the medical data

because I think sometimes diagnosis and UMR can speak to this too. They're old their old diagnosis codes that are on these members and with diabetes you can become diabetic then pre-diabetic then diabetic. So, we would recommend not using the diagnosis code. I think that's the best way that Segal had to get to the number and they're using all the information they have available to them. But by requiring that doctors always submit the chart notes, that's the best way. So, I think you probably do have a good population. There's not a ton of leak through, but I would guess and I it's probably more than Segal's estimating through their analysis just based on using diagnosis code in a lot of cases. The real test is the A1C. If they're using that, I think when they're getting it, but they're not getting it in every case. Hopefully that helps.

Member Duncan: Keiko Duncan for the record. A couple things. First off, I just want to level set that the cost of this program is 25 cents PMPM. And it says the levers for this are increased GLP monitoring and fraud detection. So, what have we done today for normal fraud auditing?
Ms. Daily: There is fraud already included as part of the base for PEBP. Alot of times I think when we're seeing a lot of the weight loss clinics and things doing a lot of prescribing, we're addressing those types of pieces, especially when you don't cover weight loss, right? If we see claims come in from those types of organizations. Also when there's referrals from other folks where “hey, you need to investigate these pharmacies” we also have a very rigorous retail pharmacy program and things like that. There's a good base of fraud, waste, and abuse, but I think this is where we're really digging deeper and making sure that for example, the chart notes, we're really going through the chart notes with clinical eyes to make sure that the patient is diabetic.

Member Duncan: If this is currently happening today and has happened, what has been our cost avoidance or cost savings for fraud auditing of GLPS?

Ms. Donohue: We’ll take that back.

Member Duncan: Next question. Why does it cost money to have a sufficient prior authorization?

Ms. Daily: I think on the Medicaid side, having documentation requirements is fairly common but on the commercial side, this is the first instance where we've really required chart notes. We've been relying on physician attestation and with that there's a big input of data that comes in that needs to be reviewed by clinicians. That's where the cost comes in, the additional workload to review the chart notes and things that did not exist previously.

Member Duncan: So you're saying today we have no clinical criteria, prior authorizations on any.

Ms. Daily: You have prior authorizations. They require attestation. The doctor says this patient, they check a box that says yes, they're diabetic. This is adding getting chart notes and review. That really did not exist until GLP1's on the commercial side. That’s where the additional pieces and staffing's required.

Member Duncan: To clarify, this checkbox and attestation, is this in the form of an auto-PA?

Ms. Daily: It's not necessarily. I mean it's e-prescribing sometimes that they fill out the criteria. But we send them criteria, either fax it if they're not on e-prescribing or they complete it electronically but it's a check, like yes.

Member Duncan: Right so is it automatically approved if they've checked yes or is there somebody manually reviewing the attestation before approval.

Ms. Daily: Yes. We get the criteria, we go through the criteria and that's not the only question. I can share the criteria as it exists today. There is a pharmacist who reviews the PA before it's approved.

Member Duncan: Okay. So, it's not an automatic approval. So, it's not an auto-PA. They check a box. A pharmacist manually approves that all of the things are aligned and then an approval or denial is then issued.

Ms. Daily: Correct.

Member Duncan: You're saying that in order for that pharmacist to review chart notes instead of verifying the attestation on the rest point that is what is costing the money.

Ms. Daily: Exactly. Taking in the chart notes the review of the chart notes.

Member Duncan: Is there any data about how much time spent those pharmacists are currently doing to manually review each of these and how much time spent that pharmacist will then spend on reviewing chart notes?

Ms. Daily: I do not have that data, but I can ask for it.

Member Duncan: Yeah, I'd like to understand what time we're paying for that.

Ms. Daily: Well, I will say there's this 25 cent fee, which I would recommend. We have, for 15 cents, we can use the medical data. But again, I think that would not result in actually weeding out who you want to weed out. Ther are some efficiencies we can create by using the medical data, but I think that lends itself to more people getting through than you want.

Member Duncan: I just want to clarify then going back to my original question for the fraud auditing to audit a claim for fraud. Are we not taking a random sampling of claims and then requesting chart notes to validate that claim from the prescriber? what is actually occurring during that audit?

Ms. Daily: If someone's identified to research for fraud, if we get someone on the tip line or something like that, we will reach out to the pharmacy to get copies of the prescriptions. We will reach out to the physicians as well. That's all done through our fraud waste and abuse team.

Member Duncan: I'm wondering if, we've already identified that while it seems to be a low number about 4% don't have any indications for diabetes. What has Express Scripts done to audit those?

Ms. Daily: We would have gotten attestation from the physician that they have diabetes.

Member Duncan: But again, we're saying it was brought to us that we're suspecting fraud because there are no indications despite some maybe checking a box. That would tell me that we should initiate a more complex fraud audit, no.?

Ms. Donohue: Physician now to test that the patient has diabetes.

Ms. Daily: We can look at those new people if you want offline to see what's going on.

Member Duncan: Okay.

Ms. Daily: If it doesn't catch new people coming in. That's really the value of the program is trying to put a system in place so we're not doing retroactivity.

Member Duncan: I understand that. But I'm trying to figure out what we've done so far to cover this cost. Right. You're saying something was flagged as fraud and then you go in and you ask for the prescriptions and the physician notes and all of that. So, what causes a claim to be flagged as fraud?

Ms. Donohue: Going to multiple providers and going to multiple different prescription pharmacies.

Ms. Daily: That's one of the things, but we also have tip lines. We have investigations from other clients that parlay and do, book a business investigations. There's a lot of different ways that things could be identified. Problematic physicians.

Member Duncan: So, but up to this point, Express Script has not done a comprehensive audit on the prescription claims for GLPs for PEBP?

Ms. Daily: I think we're watching GLP1s in general,

Member Duncan: But we have not done a comprehensive audit on GLPs for prescription drugs and PEBP?

Ms. Daily: Not for PEBP, no.

Member Duncan: Okay. Can we do that?

Ms. Daily: Well, I think we'd start with these 70 people and we could take a look at them for you. And if you wanted to stop their utilization. That's what we do with fraud, waste, and abuse. We'd come and say to you, do you want to stop claims? Do you want to exclude the physician? Do you want to exclude, take out the pharmacy?

Member Duncan: Right. Before we move forward with accepting a cost for any new prescriptions that come on board, I think it would be prudent that we evaluate the prescriptions that we've already had. Not to necessarily stop, unless there was blatant fraud that you obviously find, not necessarily to stop previous claims but to inform this decision because if we do that review and we see that everybody actually does have an entirely valid and proven reason to be on that then I would question whether or not we're actually going to realize some of the savings that that is in this presentation, right?

Ms. Daily: Yeah, I think 70 people, let us take this back and see what plan we can put together for 70 people because the investigation we would do is basically what I think Segal's already done, which is, hey, there's no medical claims to justify this. I don't know, what action do you want us to take after that? Go to the physician and say, "Did you lie? Prove you didn't lie."

Member Duncan: Well, that's what you're saying with like a fraud audit, right? You're asking them to prove that they didn't lie by asking

Ms. Daily: Well, we asked for scripts and things like that.

Member Duncan: You said you go to the physician and you ask them for their chart notes. So, does that not happen?

Ms. Daily: I think that for 70 people, if there was a trend for a certain physician that's when we would be able to say you're being fraudulent, right? Like you've attested to 70 people and we know they don't have diabetes. But if it's 70 different physicians with 70 different patients and there's no trend, it would be challenging to go to that physician and say like you're doing something wrong, which is what fraud, waste, and abuse programs trying to do, right? Find trends and activities to address, right?

Member Duncan: But what I'm hearing in the course of all these presentations is that there is a potential for fraud, waste, and abuse given this GLP utilization trend. I'm trying to understand how that is being investigated when we're being told that there is obviously a potential problem.

Ms. Daily: If if we look at these 70 claims and it's all the same physician, I agree with you. But if it's 70 different physicians and there's no trends, then it would be hard for me to draw a conclusion that there's something fraudulent happening. But we will take a look. I think we're happy to take action on those 70 people and tell you, you know, we'll engage you and figure out what you would like to do.

Member Duncan: Okay. I think that evaluating our own trends first before we pay more money for something, I think is important.

Ms. Daily: I think that's fair. We're happy to do that.

Chair Wells: Any other questions?

Ms. Donohue: Next recommendation is our unlimited AUM. Right now we have four different levels of advanced utilization management and you're at the third level. We're recommending that you move up a level to our unlimited, which includes all of our prior authorization, step therapy, and drug quantity management. The list that we're recommending is over there on the right which includes very high cost medications and medications that have waste. A couple examples of those, it would include the PCSK9s which are $14,000 a year medications to make sure that they're medically appropriate for the member, that they're using the first agent like a statin to begin with before moving to an injectable PCSK9 for their cholesterol for their
LDL. Then also includes medications like injectable testosterone to make sure that it's being used medically appropriately and not used for cosmetic purposes. There's also another example with an inhaler. There's an inhaler that includes the rescue and the daily inhaler that costs like $500 each where you could get two different inhalers for $100. Those are some of the additional prior authorizations we would be putting in place. I can give you the full list by medication. It would impact approximately 1,200 - 1,300 people and that estimated cost savings is about a million dollars.

Member Duncan: Keiko Duncan for the record. I need so much more data.

Ms. Donohue: I know. I only had, I was told about 10 minutes. I knew you would want more and I could share more.

Member Duncan: I just want to be clear, these are not decisions that I think we can make today until we have more data broken down. I would also love to see, especially when we talk about putting prior authorizations on. Express Scripts is a massive company, could you even share aggregate average PA approval rates for these drugs that we're putting Pas? Because I think one thing that well is dealt with everywhere in the United States right now is I don't want to just put prior authorizations on stuff willy-nilly. I need to make sure that it's actually accomplishing something and that we've done our due diligence before we put a prior authorization on. And then once we put a prior authorization on it that is maybe more extensive than a doctor attestation, are we evaluating that regularly and are we trying to figure out what is our approval rates? What are people saying? Is it affecting what we want to affect? Are they getting the appropriate medications first? Are they on it for a significant period of time or are they just trial and failing stuff just so they can get to the thing that they want? Just a commentary. I appreciate that you know that I want more data.

Ms. Donohue: Yeah, I just wanted to give you a few examples. But definitely we can dig into the to the data to get you what you need.

Member Zumtobel: Tom Zumtobel, I have a question. Along those lines, if we dig into the data, is there an opportunity to grandfather existing and then start to require prior auth for some of these drugs moving forward instead of making people move off their drugs or is that something you're not able to do?

Ms. Donohue: Yes, we can definitely grandfather. I'm trying to give you opportunities to also save money, right? But definitely, you can grandfather and start with the new users.

Member Zumtobel: I don't think we would, across the board grandfather, but I just wanted to know if there was that opportunity. Were you present for the public testimony when, I think his name was Lowdermilk.

Ms. Donohue: Yes, I have the information to be able to provide you later today. Unless you want me to speak to it now. All right. I did include savings for the current programs that you have in place today. I know you wanted us to take a few minutes to talk about Hinge Health and I know Stacy's on the line and I can share that presentation. Do you want me to share the whole presentation for that Stacy? Or just the high level executive summary?
Ms. McHugh: Let's just do high level. Yeah, I'll keep it very high level. Thank you everyone for letting me join here today. I just wanted to quickly walk through a claim study that we recently completed for PEBP. I'll quickly walk you through the methodology in a moment. The bottom line is, Hinge Health participants saved $1,318 per member on average on chronic MSK services versus a matched control group. So, we saw a 2.33x return on investment totaling about $1.2 million in savings for PEBP for the analysis period. Most of your savings are coming from two main areas. Avoided spend for invasive procedures accounted for approximately 65% of your total savings. That's $861 less per member in surgeries, injections, and ER visits. We also saw avoided spend for conservative care that made up about 6% of your total savings. It's very common for invasive spend to make up the majority of your savings with these analyses as these events tend to happen much less frequently, but are very expensive when they do occur.

We know that about 6% of your population typically drives about 85% of your MSK cost with those invasive procedures. I'll also call out that the remaining 29% of savings from the study were attributed to other categories outside of invasive or conservative care. Those include DME, imaging, and other services. When we looked at prior MSK claimants have saved $1,280 per Hinge Health member on chronic MSK services from the baseline period to that post period. These folks are the ones who we know are already in the care pipeline and tend to cost the most. To give you a quick highlighted overview of the methodology we used to conduct this study, we looked at again a matched cohort of Hinge Health members versus non-hinge health PEBP members who had access to the program but weren't using it. We required a minim of six months health plan enrollment during the pre and post period to be included in the analysis. We designed our matched cohort groups in this manner so that we captured as much medical spend within the analysis period as possible. For example, if a Hinge Health member included in the study was not on the medical plan during the pre- or post-period, we'd miss their MSK spend in that time, making our results less representative. We did exclude members who were pregnant or had cancer during the analysis period because those higher profiles would skew the results. We excluded RX claims as well. The reason being that pharmacy claims don't usually include diagnosis codes. We're not always 100% clear that a medication prescribed is for MSK pain and not something else.

This study looked at Hinge Health participants who started in one of our chronic programs between July 1st, 2023 and June 30th, 2024. And we also looked at a comparison group of PEBP employees and/or dependents who did not use Hinge Health but had one or more MSK related office or therapy visits during that same period of time. That comparison group again, did not take part in our program but they did have at least one or more MSK related office or therapy visits in

the time period. We looked at a sample size of 855 Hinge Health members compared to 855 matched non-Hinge Health members, all 18 plus. Using propensity score matching, we made sure the two groups were as similar as possible because we wanted to ensure that we were comparing them accurately in our analysis. The bottom line is we saw very strong ROI higher than our book of business. Our book of business is about 1.5x. We saw 2.33x for PEBP with that average savings of $1,318 saved per Hinge Health member for our analysis Period. I'll stop there.

Chair Wells: Thank you. Any questions?

Member Zumtobel: I was curious does Segal or the PEBP staff validate your data you submit to us? Is there any validation process?

Ms. McHugh: We do use a validated approach. We walked through it with the PEBP team last week but also happy to share the results with Segal as well if that would be helpful.

Member Zumtobel: I don't need to drag Segal in. You reviewed the methodology in some detail with PEBP staff?

Ms. McHugh: Yes, absolutely.

Ms. Donaldson: Point of clarification, Debbie Donaldson with Segal. We have done this analysis for other state entities. I'll just talk in general. We tend to come in with lower ROIs than what is presented in general, but we're happy to do that analysis.

Chair Wells: Any other questions? This is the potential for action. Is there anything, any actions that we want to take on this particular item with the two different proposed or is there additional information that we want to request be brought back?

Member Davis: Actually, I have a question. It just occurred to me. I'd like to ask, what was the percentage of people that started in the Hinge program and then dropped out?

Ms. McHugh: For the study period?

Member Davis: well the study period and the overall. The reason I'm asking is that actually I'm in the program for knees and I found it incredibly effective. I was very impressed with it. You just use these videos, you do it every day, you get positive feedback and it's been very effective for me. I haven't had any problems since I started that program.

Ms. McHugh: That's great to hear that, Paul. We don't really look at dropout. We look at engagement. When a member joins the program, they have access to a 365 day subscription with us. They can engage as much or as little as they please. As you likely know, Paul, everybody's journey is a little bit different. If you have an acute injury, that typically has a quicker onset and a quicker resolution, whereas chronic pain tends to require a little bit more time. We're available for people to come and go, right? We know that pain is a journey. It ebbs and flows. It comes and goes. What we often see is that someone may join the program, work on a specific body part or area of

pain. They may drop off for a while, but if they have a flare up or a new episode of pain, they'll come back. That that's how it works. Does that help answer your question?

Member Davis: Yes, it does. Thank you.

Chair Wells: I don't know that we make necessarily a motion, but I also don't want to come back and have them present data and ask them to come back. So I'd like to be clear because I do want to do something.

Member Duncan: Anybody remember all the things I said? Help me out here. We want to do some level of fraud, waste and abuse analysis on GLP1 usage and we would like that to be robust. I mentioned for these other ones, we need to know exactly what drugs we're looking at to put prior authorizations on. I would love to understand ESI's global perspective on average PA approval rates and general cost avoidance and cost savings. Time management. To support this PMPM cost for any of these programs, I'd like to understand since it was stated that a pharmacist will manually review an attestation. What is the additional time spent for a pharmacist to be manually reviewing a chart note? I was also thinking about, what is it exactly that the pharmacist is reviewing? When I think about this stepwise, we're essentially going to be looking at the things that we would look at that the physician would be attesting to. So, do they have an A1C? Do we have a lab? Is that necessarily a significant cost of additional time? I also had a question and concern about all of the PMPM costs for all of these prior authorization programs. I'm assuming that this is a PMP across the board. So, we're paying for patients that are not taking these medications.

Ms. Donohue: That's the way our clinical programs are charged out.

Member Duncan: In that case, I'd like to understand percent of populations for all of these drugs that we're proposing to put PAS on. Especially given that if we're going to put a PA on something and we're going to pay a 27 cent PMPM across the board for these other ones and I only have 12 patients out of 70,000 in PEBP on this that's not worth the ROI on that.

Chair Wells: Do you want to have them present on the results of the advanced utilization management that's already in place?

Member Duncan: That’s already in place? I thought we were talking about the ones that are additional.

Chair Wells: We're already at step three of four of the additional one. If I understand correctly, the next tier of utilization management.

Member Duncan: I thought this package was the recommended option of additional things.

Chair Wells: Going from step three to four is the recommendation. We already do advanced utilization management that they say saved us $17.5 million, therapy prior authorization.

Member Duncan: A lot of these numbers might be of the current population, right? But I'm trying to understand where we're at. What additional are we necessarily going to be bringing in with these patients or we can look at our current approval rates, I could do that too, right? Do those approval rates go up or down if we add this step forward to it based on global averages? What additional improvements are we going to see in this particular population? I think that I found that's visible, right?

Chair Wells: Prepare that and bring it back to us. I think with that we do not need any additional actions. Any further discussion? We have further questions? Hearing none, we'll close agenda item number 9. Move to agenda item number 10. Review and discussion of UMR programs for Obesity Care, Diabetes Care, 2ndMD, Real Appeal and Doctor on Demand.

Ms. Huckaby: Good afternoon, PEBP board. This is Rhonda Huckab, account executive with UMR, and with me is Jesse Stockwell, who is our account manager for the State of Nevada. Thank you for the opportunity to present today. The presentation we will review provide an overview of PEBP's clinical programs, member engagement, financial and utilization performance through March 31st. We'll highlight key outcomes, notable trends, and the value delivered through existing programs. We'll touch on opportunities to further support cost management, access to care, and member experience. We'll begin with an overview of the clinical engagement and care management followed by program specific performance results.

On page two of our presentation we wanted to give an overview of all the current programs that are available to participants. As you can see we have two different types of weight management programs. We have the Obesity Care program as well as the Real Appeal program and both of those are administered by UMR. For diabetes, we have the Diabetes Care management program. You have the diabetes program through Nevada Health Partners business group and then you also have the diabetic value care program through ESI. We also have Doctor on Demand, 2ndMD which is your second opinion services. We have the integrated case management which includes our prior authorization, inpatient case management, outpatient case management, transplant case management and then the total population health. We also have payment integrity in place and that is where we look at fraud, waste and abuse with edits and various types of medical audit reviews that we do on facility and physician claims. And then for effective July 1st, PEBP is putting in the medical RX advisor program. And that's where we look at the specialty drugs that are paid through the medical plan. You also have Hinge Health which they presented which is the program to treat and prevent MSK which is through the ESI agreement. And then you also have the Carrum health program which is the cancer concierge and the COEs for orthopedic bariatric surgery and cardiac surgery and Carrum health will be presenting. On the line we have Neil Boyce. He's with our SHO clinical team and he will go over our integrated clinical solutions and that will be on page three, four and five of the presentation.

Mr. Boyce: Excellent. Hello my name is Neil Boyce and I serve as the RN director of case management for the health plan. It's a pleasure to be with you today. I appreciate the opportunity to spend some time walking through our approach to care management, specifically how we're evolving and strengthening our integrated clinical model. Over the next few minutes, I'll provide a high level overview of how we bring together clinical services, case management and interdisciplinary coordination to improve patient outcomes with the goal of enhancing care

transitions and ensuring that care is being delivered at the right time and in the right setting. Our focus is on creating a more seamless experience both for patients and care teams by aligning processes, improving communication and leveraging data to drive decision-making. I'll also highlight some of the key components of this model, what it looks like in practice and the impact we're seeing across quality, efficiency, and patient satisfaction.

Our engagement strategy is driven by an integrated clinical model. It's designed to support members across the full continuum of care. It aligns specialized teams and real time clinical support where we ensure that again members receive the right care at the right time in the right setting. On the front end and you can see in the puzzle pieces there our prior authorization team plays a critical role in early engagement. We apply evidence-based guidelines and collaborate closely with providers and help ensure that services are both medically appropriate and minimize delays and avoid unnecessary care. Then our inpatient case management team engages members during acute episodes or hospitalizations. They coordinate care through hospitalization. They focus on clinical advocacy, discharge planning and transitions that can help decrease length of stay, prevent avoidable complications, and support safe timely discharges. Our outpatient case management team, and I'll go into further detail on the next slide on all these programs. Our outpatient case management team provides ongoing support for members with chronic complex conditions. They care, coordinate, educate and connect to community and provider resources and they drive adherence, close gaps and help prevent avoidable impatient utilization. Supporting our members at any hour, our access center
is a 24/7 access center and it's a critical engagement touch point. It's around the clock, providing clinical guidance like telephone triage. Members that they can receive immediate support, symptom assessment and direct to the appropriate level of care and this this often prevents unnecessary emergency department visits and utilization.

For our highly specialized needs, our transplant team provides dedicated longitudinal engagement right from evaluation through post-transplant. This team coordinates complex services, supports adherence, and helps optimize outcomes for some of our most high-risk members. And then finally, our total population team brings these efforts together by addressing preventative care, risk stratification, the whole person approach and proactively engages members across risk levels. They help improve outcomes and enhance experiences and drive sustainable cost management. Together, these integrated clinical solutions create an engagement model that's proactive, coordinated, and centered on delivering high quality, efficient care for every member. We can advance the slide.

So just building on that foundation, I want to focus on some of the most critical components of our integrated clinical model. Beginning with inpatient case management. At the core of our approach is what we describe as a boots on the ground model. Our case managers are not operating remotely. They're physically present in the hospitals in both southern Nevada and northern Nevada. This in-person presence allows us to build stronger relationships, identify needs in real time and collaborate effectively with hospital teams and influence outcomes while the care is being delivered. The inpatient case management is centered on three key pillars discharge planning, care transitions, and utilization management for our hospitalized members. Our goal is to ensure that every patient receives high quality care in the most appropriate setting while also establishing strong connections to the outpatient services and community-based support once they're hospitalized or once they leave the hospital rather.

To support that work, we provide case management covered seven days a week. Our case managers conduct comprehensive evidence-based assessments on every member. Not that they go beyond their clinical status. It's physical assessment, functional, financial and psychosocial needs to fully understand the member's care better. We develop individualized discharge plans in close collaboration with the patient, the caregiver and the inter disciplinary team. That ensures alignment and their readiness to transition to the next level of care. We implement those discharge plans by coordinating resources across the continuum. We ensure that the health plan benefits are adhered to. Finally, we maintain this strong focus on monitoring variances that could impact timely high quality outcomes. Meaning we're performing daily rounds on each hospitalized member to make sure that they're receiving the care that they should be receiving based on the guidelines each day. Overall this model helps us stay closely connected to members during some of the most vulnerable moments of their life. It drives better coordination, efficiency and drives better health outcomes.

Next we'll move into outpatient case management. This is where the outpatient complex care management once a person's discharged from the hospital plays a vital role in reinforcing what we're doing while the member is in-patient. We have a dedicated local outpatient case management team as well. It's embedded here in Nevada and we work closely with our members, providers, and community partners. This team serves as a bridge, they ensure continuity of care once the member leaves the hospital and to help them navigate the sometimes complex healthcare system. Referrals to the outpatient case management team can be direct handoffs from our inpatient case management team. They can be referrals from providers and specialists through risk stratification based on utilization and also member self-referral. That empowers the member or the individual to engage when they feel they need extra assistance. And one of the reasons why we refer to it as complex case management because it focuses on members who may be experiencing critical events or new diagnoses that require like a higher level of coordination and support. They sometimes may have to navigate multiple conditions, complex treatment plans, significant social determinance and we identify that that impacts their ability to manage their care independently. The focus here is that there's a central point of contact for coordination of care once an individual's discharge from the hospital as well. They can reach directly to an outpatient case manager there. It's not a generalized 800 number. They get a direct telephone number to an outpatient case manager that'll work together with them to ensure that gaps are closed and addressed.

Just beyond the coordination of care again we're helping navigate the system once they're discharged from the hospital with the overarching goal of self-management. We want to improve their experience, reduce any avoidable admissions once they're outpatient and again provide that single point of contact once they're discharged from the hospital. As we continue to build on this fully integrated model, two additional components are essential in ensuring we're addressing both specialized clinical needs and the broader social factors that impact health outcomes. Our NICU case management and social work teams I'll discuss next. Starting with our NICU program. This is another area where our commitment to is shown through a local hands-on approach. Our NICU case management team is fully managed locally. There's no delegation and that allows us to maintain close oversight and alignment with our providers and families.

Our team is made up of specialized NICU trained medical directors and registered nurses who bring a deep clinical expertise to some of the most vulnerable members, such as newborns and their families. Then the nurses and medical director perform level of care and bed day review. We have that on-site hospital engagement with routine visits to facilities so that we can collaborate directly with the NICU teams and then of course education and care coordination for the parents,

helping them understand their baby's needs and prepare them for the transition home. The major focus again is on discharge planning which begins early in the NICU hospitalization and it ensures that the family is fully supported post discharge by arranging clinical services like private duty nursing, home health visits and necessary durable medical equipment, billy blankets, ventilator supplies etc. Equally important in the NICU is the engagement with the parents. We help them feel confident, informed and support them during what we consider a very stressful and emotional experience.

Then we'll move to our social work. Complementing this clinical work is the social work team and this plays a critical role in addressing the non-medical drivers of health. We realize that that can sign significantly impact outcomes. Our social work team addresses such things as financial needs, housing stability, food security, community based resources for issues such as domestic violence, clothing assistance, legal and veteran services. Together, these teams ensure that we're not only addressing the clinical needs of our members, but the social and environmental factors that we realize directly influence the ability to heal and thrive. When we step back and look at our model from inpatient case management to outpatient complex case management to NICU specialty care and social work support what emerges as a comprehensive clinical model from end to end. It's locally driven again. It's highly coordinated and deeply patient centered and ultimately designed to meet our members where they are right clinically, emotionally, socially and overall to ensure better outcomes at every stage of the healthcare journey. We can advance the slide. As we bring this all together, I'll close by grounding our model in the measurable impact we're seeing across our programs. When we look at utilization management efforts, our team reviewed and that's on my screen on the left hand corner where it says utilization management. Our team reviewed over 37,000 services, completing 66% within 5 days while maintaining a low denial rate of just 2.6%. Most importantly, this work directly contributed to over $902,000 in savings through avoidable services and optimizing sight of care decisions. On the case management side, if you look at the second box down, our region engagement continued to expand. Our outpatient case management team supported over 2,000 members actively managing 1,373 of those members with a 60% acceptance rate and that reflects strong member engagement. Meanwhile, if we look at our inpatient case management, we opened nearly 1,500 cases and helped avoid over 506 inpatient bed days. And that translates to approximately $2 million in savings. Then looking at the next box down, our telephone advice nurse line, that further enhances access to real-time guidance and we handled nearly 400 calls with a significant number of cases successfully redirected to more appropriate levels of care including emergency room diversions. That generated over $590,000 in savings. When we combine those efforts across the programs, the results were over $4.43 million in total savings strong performance in both per employee and per member per month value and some meaningful reductions in unnecessary utilization.

So those results of course are not driven by a single program. They're really the outcome of this fully integrated locally embedded clinical model that that we pride ourselves in. Our teams again are on the ground in hospitals, supporting members through complex transitions, engaging with families in the NICU, and addressing the social determinance of health that impact the long-term success and lead to positive outcomes. So ultimately there's more to it than just the numbers but this is about delivering coordinated high quality compassionate care and meets the members where they are and helps guide them to better outcomes. That concludes my overview of our clinical model and our care management model. Any questions?

Member Duncan: Keiko Duncan for the record. Super quick. When we talk about ER diversion after the care management, what period of time do we measure that diversion in? What I'm trying to get at is, have we tracked that member through time who after maybe three months of doing this case management, they then go into the ER. So, we're just considering that first three months to be diversion savings, but not actually.

Mr. Boyce: We have what we call a predisposition. So anytime a member reaches out, and I can talk about some of the proactive steps we take. But in this particular case, let's say an individual reaches out to our telephone advice nurse team. We have a predisposition and we ask the question, what would you do if you didn't call us today? And from that we can determine when they say I would have gone to the emergency room we understand that we have diverted them from the emergency room to a more appropriate level urgent care.

Member Duncan: So you're calculating ER diversion based on a comment from the patient once they've completed that call.

Mr. Boyce: Well, at the onset of the call, we'll ask if we weren't here today, what services would you have sought? And sometimes it'll be urgent care, sometimes it'll be PCP, sometimes it'll be they were treated at home. But that is one of the calculations. From that encounter with a telephone advice nurse, again we talked about the outpatient case management and referring that triggers a referral to our outpatient case management team that will reach out to the member within 72 hours of that telephone advice nurse call to further engage and help them coordinate so that they don't return to the acute setting unnecessarily.

Member Duncan: What I'm trying to get at is for any of these people that at the start of the call they've said I would have gone to the ER if I had not called you, which is awesome. That's great. Have we tracked that patient through time to see if they then went to the ER within the next week or two weeks or month?

Mr. Boyce: Yes. Yes, absolutely. That's where the outpatient outreach would take place. All of our systems are integrated. Our telephone advice nurse team sees what our outpatient case management team sees. Also sees what our behavioral health team sees. It's one centralized documentation system. And then we receive reporting that.

Member Duncan: Sorry I don't know if maybe I'm not asking the question well. You presented an ER diversion rate and then you told me that the ER diversion rate is based on a survey question when the patient is helped. Would you have gone to the ER? They said no. You then qualify that ER diversion rate as great we've diverted an ER case. Have we evaluated whether or not that patient then indeed has gone to the ER in the next week or two? Because you're telling me that true ER diversion, not based on a survey question. Are we seeing that this patient really has not had an ER visit validation of the self-reported survey? Have we validated that the self-reported survey?

Mr. Boyce: I'll have to check with our health team to see. My presumption would be yes, that there are several reports that indicate when individuals are ER utilizers and that triggers a referral to our outpatient case management team as well. My presumption would be yes that we are tracking ER

utilization and seeing if that's a true ER diversion. But those numbers that we're seeing here are only for those diversions that take place when we're diverting from a higher level of care to a lower.

Member Duncan: I would want to see, because we're attaching monetary value to an ER diversion, at least when we think just generally, something I think we we've had a conversation about in other meetings too. If we're attaching a monetary value to ER diversion I would want to attach a monetary value to a validated diversion rate, not something that's just from a survey. I would like to understand the actual claims and behavior.

Mr. Boyce: That's all that sounds fair.

Member Duncan: Thank you.

Mr. Boyce: My pleasure.

Chair Wells: Any other questions? All right, just continue.

Ms. Huckaby: Thank you, Neil.

Mr. Boyce: Oh, my pleasure. Thank you.

Ms. Huckaby: On the next slide, we're going to rediscuss the Diabetes Care Management program. This was a program that we took over from PEBP's previous medical management vendor in 2017. As we stated, this is a voluntary opt-in disease management program that provides enhanced benefits to participants diagnosed with diabetes. The enhanced medical benefit is administered as part of your base admin fee and then ESI administers the enhanced RX benefits associated with this program. There is a specific form that is located on the PEBP website and the Diabetes Care Management program is outlined in the master plan docents. The members take this form and it outlines the name and then they take it to their physician and they complete the biometric assessment which includes cholesterol, A1C, glucose, blood pressure, their height, their weight, their BMI, last eye exam and last dental exam. This is where we collect the information to provide the quarterly utilization report that we send to the PEBP staff. As stated, the participant completes this form once a year and the form is sent to UMR. We have indicators built into the system. We enroll them into the program and then this is how we monitor the enhanced benefits. We then send eligibility to ESI so they can monitor the enhanced RX benefits associated with this program.

Once the member enrolls in the program, they have to comply with the requirements outlined in the master plan document. They have to complete two office visits per year. They have to comply with the diabetes medications prescribed by their physician. They've got to complete the necessary lab testing and then they must remain compliant with the physician's prescribed treatment plan. Within the enhanced benefits they get two office visits per plan year. They get two A1C blood tests paid at 100%. And then on the pharmacy side, they see their diabetes medications, the glucose monitor, the diabetic supplies. Most of the people, as Segal presented earlier today, most of the people enrolled into this program from the to benefit from the pharmacy benefits, not necessarily the two office visits and the lab test. On the next slide, as we've discussed, the participation in this program is low. Go back one slide, Jesse. This program is only offered to the

CDHP participants. One of the things that we have presented to PEBP in the past is expanding this coverage to the other two medical plans. I know there was some discussion and I would have to refer to PEBP staff but I think the reason they didn't offer it to the other two plans was due to the co-pay structure on the ESI side of it. This is one of the things that we have talked about. Do we want to keep this program, it has been in place since 2017, or do we want to look at enhancing it through what we call our total population health offering? We have presented this to PEBP in the past they did not elect to opt into that program. Also we have some integrated solutions with some other third-party diabetes programs that also include some obesity and weight management. So, we can certainly bring this back to the strategic planning meeting. We can have some of these vendors present at the board member whatever PEBP or the board would like us to do. Any questions on the diabetes care program?

Member Harper: The non-participants summarized on this slide is that across plan options that PEBP offers or is that specifically the CDHP?

Ms. Huckaby: No, that's for all plant. We're reporting on as at the bottom we report on anyone who's had a diagnosis of diabetes and that nonparticipant is across all three plans.

Member Harper: Would it be possible to bring back the figure for if that number is restricted to the CDHP?

Ms. Huckaby: Yes, we can certainly do that. So, you just want to see CDHP People? We can certainly do that.

Chair Wells: Any other questions?

Member Rich: Laura Rich, for the record. Rhonda, is there proactive outreach to members to get them on? Their team just is so low.

Ms. Huckaby: When they call in to customer service, we have a lot of people calling in, but then most of the people that call in are on the EPO or the Low Deductible, so they're not eligible for the program. And then also our case management team. We do education through that. I know PEBP does it through their newsletters. We've done some targeted outreach over the years. We just never saw a huge increase in the program.

Member Rich: The targeted outreach was that you know they had they had a diagnosis of diabetes, you sent something out via mail or something like that, right?

Ms. Huckaby: We've done targeted outreach through mail. We've done email campaigns. I know PEBP has helped us over the year do some targeted outreach.

Chair Wells: Any other questions?

Ms. Huckaby: The obesity care program. So, this is a program we helped PEBP develop back in 2012. We worked with PEBP's QC Officer, their medical management vendor at the time, their

network management, and then we had a local provider who had a program called Innerthin. We worked with her to create and develop the program that's custom to PEBP. This is not a UMR offering that we do for any other client. Like I said, it was custom developed strictly for the PEBP account. The medical director for the medical management company developed the criteria for the program and then we worked with network management to do outreach to providers to determine who would be willing to participate in the program. One of our challenges is during this program, the provider, it is a medically supervised weight loss program. So, there are like three providers in the south and two in the north who agreed to do this. PEBP reached out to us last year and we added a new provider, a local provider here. One of the challenges with the providers is from the administrative perspective. They have to complete the obesity care initial evaluation form. They make their appointment with the doctor. The doctor reviews them. They determine if they think that they should join the program. They determine if prescription medicine will be needed for the program and then they also determine if they would like meal replacement with this program. Once they're enrolled in the program, the doctors submit their initial evaluation form to UMR and then every month that we have a monthly engagement form that the physicians have to complete and that just keeps, that they're actively engaged. We have parameters set and programming in place that if they don't submit a form and we receive a claim, if we do not have a form to associate that with the claim they do not qualify for the enhanced benefits. We pay the claim at standard benefits. We have something in place if they're not compliant, if we don't receive a form within three months, we terminate them from the program. It could be various reasons. 90 days was determined by PEBP staff. They can, anytime go back and re-enroll into the program. They just have to make another appointment with the doctor and go through the monthly evaluation and determine if they should be re-enrolled into the program. Once again there are enhanced benefits tied to this program on the medical and the pharmacy side. On the weight loss medications, there is a very small short-term generic medication list that was approved by PEBP staff. As Amy from ESI said, there's no GLPS tied to this program. We could see, I believe one of the board members asked, you could see some people that are in the program that also have diabetes. So, they could be getting the GLP1s through their diabetes diagnosis. Within the program, we pay the office visits, of course, the lab, they can get nutritional counseling and then the small list of weight loss medications that are associated with the program. Any questions?

Chair Wells: Any questions?

Ms. Huckaby: Real Appeal is a different program that PEBP had asked us to look at some different solutions that we could do that did not include medications. I'm going to let Jesse present on the Real Appeal program.

Mr. Stockwell: Jesse Stockwell for the record. I'm just going to do a high level overview of the Real Appeal program and the metrics related with PEBP's population. This program was put in place 7/1/23 or plan year 24. Real Appeal is a virtual lifestyle program that focuses on the weight loss through proper nutrition and exercise. The program is available for anyone enrolled with PEBP under a medical plan that is 18 and older and with the body mass or BMI of 23 or higher. There are no admin fees or PMPM costs for this program for PEBP. The Real Appeal is a pay for Performance program. It's 100% paid through medical claims. Real Appeal uses interactive virtual

coaching to drive small behavioral changes. The program is designed to support participants who are looking for a healthier lifestyle or just simply wanting to lose weight.

Here's our dashboard. This is provided to PEBP on a quarterly basis. Some of the metrics here since enrollment, which I stated before, since 7/1/23, there's been 1,900 members that have been enrolled and there's been 85% of enrollees that would fall under what was at risk which are members with a BMI that are greater than 30 or a BMI between 25 and 29.99 and a qualifying co-mobility which would be a member with diabetes, pre-diabetes, hypertension or tobacco user. There's also been members at the third metric there which is 1,038 engagement members attending one or more coaching sessions. With the program, there's it's a 52- week program. There's 12 sessions that are mandatory to be done. Members can participate in multiple sessions, however many sessions they want to partake in, they can. They can do more than just one or they could do as many as they want. There's multiple sessions per week with multiple different types of coaches. Currently we're showing that there's 83 members that are actively engaged right now. We're showing on the bottom left within that 80 at risk attendance there was 67% of the membership had four or more sessions. Also of that 85%, 40% or almost 50% of the membership had nine or more sessions and attendance. And then also at that same 85% at risk population there was this on the far right there of 745 members reporting weight loss with a total amount of almost 7,000 total pounds lost. And as far as those metrics, with those people that engaged, I think it just shows that there's a positive outlook as far as the participation goes and the weight loss that they were partaking in.

Ms. Huckaby: Questions.

Chair Wells: Any questions?

Ms. Huckaby: We'll move on. 2ndMD. 2ndMD is PEBP's second opinion vendor. You've had this in place for about five years now. As they stated on their slide, this is offering members virtual consult, excuse me, consultations with the national network of specialists. They have independent expert advice. They specialize in personalized member support. They have comprehensive digital tools across all their medical and behavioral conditions. Can you advance to the next slide? 2ndMD, they prepare a packet that we send to PEBP on a quarterly basis. We just pulled the executive summary slide from their packet. This shows the total cost savings there on the right and the average savings per member and then the average savings per consult. This is a per case fee to the PEBP account. 2ndMD sends a quarterly packet that we forward on to PEBP. They work directly with PEBP's Education Officer on communication campaigns. All of this information is available on the PEBP website. Any questions on this?

Member Rich: Laura Rich for the record. Rhonda, can you remind me is this free? I think it is free to the participant.

Ms. Huckaby: There's no cost to the member. It's just a per case cost to PEBP.

Chair Wells: No further questions.

Ms. Huckaby: The next slide is for Doctor on Demand. I do not recall what year PEBP put it into place. I think it was around 2015.This is the telemedicine or telehealth vendor. As you can see, we asked them to send a report up through March of 2026. On their slide, at the bottom, they have lifetime visits. They have the unique people who have visited the website. They have the registration numbers. How many people have done it in the last 12 months, the new registration guides, they also send a complete reporting that we send to PEBP on a quarterly basis. They have a monthly engagement report that we send to the PEBP staff.

Chair Wells: Any questions?

Ms. Huckaby: On this last slide, we have custom utilization reports that we provide to PEBP on a quarterly basis broken out by plan dental. We also provide the OCM and DCM quarterly reports. But in addition to the custom reports that we have in place for PEBP, we also do an annual what we call the PAPR review, which is the Plan Performance Analysis. We just recently presented this to PEBP staff. On this slide, we pulled out some of our observations and proposed solutions that we have. On the left hand side, based on the utilization, PEBP's medical trend continues to track below benchmark, 98% of your members. The medical spend dollars were to in-network providers. We also have $13 million in savings from 2025 from the payment integrity program, which is the program that I mentioned earlier that we have in place that's looking at prospective fraud, waste, and abuse. We're looking at what the auditors call up coding or unbundling on physician and facility claims. We also do prepaid reviews and we do post-paid reviews. There is a report that we provide to PEBP on a quarterly basis on this also. And then as we looked at the annual plan performance as Segal had presented earlier, your emergency room utilization has increased across all three medical plans. We are partnering with Doctor on Demand to develop an ER avoidance flyer that they will be distributing and that we will be posting to the PEBP website. We're looking at some different types of things that we can put into place for ER utilization. I know over the years PEBP has increased the ER co-pay. We've tried to avoid some of these things and that is why we offer like Neil said earlier, we have the nurse line, we have Doctor on Demand. We encourage people to use other avenues rather than going to the ER.

On the right hand side, we have recently put into place a new enhanced ABA program. , and we have one of the nurses on the line if there's questions. We are seeing across our book of business an increase in applied behavioral analysis utilization. For the PEBP account, they currently have a prior authorization requirement in place for that. A lot of it is just rising ABA diagnosis, expanded coverage. Some of the cost containment strategies that we've put into place with this new program; to increase medical necessity and prior authorization controls, working with the providers to promote and encourage gradual step down goals and transition planning. And overall just monitoring the volume of claims that we are seeing across our book of business for ABA therapy. On the PEBP account, we ran some reports. In 2024, PEBP paid $1.7 million in ABA and in 2025 it increased to $1.9 million. It looks like there's 35 unique members that they've identified through ABA therapy. If there's any additional questions, we have a nurse on the line for that.

Going back to this slide on the right hand side, medical RX advisor is a program that we're putting into place 7/1/26. This is where we monitor the specialty drugs that are paid through the medical plan. We already have the program in place with ESI for what they refer to as the MCM program where we carve out a lot of drugs that are on their list and we don't pay those under the

medical plan. We steer those people to ESI, but there are some drugs that are paid under the medical plan and that's what this program will do. And that was for outpatient only. Then on the right side we have the health activation index. This is our HAI where it measures decision making across metrics including various services like preventive, ER, imaging. We presented this to PEBP during the PPAR evaluation and we did some preliminary analysis on looking at health activation by region. We looked at it by pay centers and then we worked
with PEBP staff to even try to get down to the agency level so we can see where some of these areas of concern are. We can do more with that. If we want to present it to the PEBP board, we can present it at the PEBP strategic planning meeting if you would like some more information on that. We look at it from a national average and then drill it down to Nevada average. The last thing on the right hand side is we have access to Medicine on the Move. And this is a mobile clinic initiative created to improve access to preventive care for employees. This van travels throughout Nevada focusing on communities with limited transportation access. We're already in the works with PEBP staff at looking at trying to get something in place for August in the Gardnerville area. We wanted to start out with one location, look at what the outcome was, what the partition participation would be, but this is something that we can certainly do for PEBP. there'll be no cost to the PEBP plan for that. If the members participate in the Medicine on the Move van, they will just build a claim through the medical account.

Mr. Stockwell: They primarily focus on preventative services. But if any members are going in for anything that's associated with the them being sick, they will see them for that as well. But they mainly are looking to do preventative wellness visits, which obviously would be covered at
100% and then if they're seen there for something that's related to a sickness, then just normal benefits would apply.

Ms. Huckaby: They do a lot with mammograms, too. I know board member Tom, and I can never pronounce his last name. I think he's done this on one of his accounts. So, he could elaborate more on that. As well as the Haya data that we've used to look at all of our clients in the Nevada market.

Member Davis: I have a question. When this Medicine on the Move goes through rural areas, I'd like to know, how long do they stay in each area and generally ballpark figure how many people access it and what are the hours for people being able to access it?

Mr. Stockwell: So it's going to be relatively from an 8am to 4pm time frame scenario. As far as utilization, this is going to be the first time we're doing that with PEBP. We're trying to get this first event set up to gauge what that utilization is going to be. We can take a look at that as seeing how frequently we can utilize them going forward. One of the other things we should probably mention too is there's certain restrictions as far as utilizing them. During the winter, coming
up north. We call it a van but it's more like a bus. There are certain restrictions to get into certain areas, based off of weather conditions.

Member Davis: Generally, do you spend a week in one area or do you spend two days in one area?

Mr. Stockwell: Yeah, they can spend up to a couple days. The team would stay for a couple days in a certain area and at a certain location.

Member Davis: Okay. Thank you.

Ms. Huckaby: And they have vans in the south and vans in the north.

Member Zumtobel: Rhonda, this is Tom Zumtobel. You're always welcome just to call me Tom. We have had good success with medicine, gradual success with Medicine on the Move. The important thing that I think we learned was it's so hard because you market and you tell people and the van shows up and sometimes you think it's a free service and you think it'd be great and they don't get out there sometimes. It's really important if you could get a champion at the site, especially if it's a leader at the site that encourage. I think people, a lot of times are afraid to leave their job, they don't know if it's okay, that if they leave their desk for an hour or whatever it is, but if you can get the leaders at the site to be a champion, it makes a big difference as far as participation for sure. That's kind of lessons learned for us. Then on the HAI, the health activation, it's fantastic work that you guys have done and I would love to figure out how to be helpful to introduce it to PEBP because we've had great success identifying people who are actively engaged in their healthcare, not only primary care but with endocrinology. And then we started to shift the benefits based on how do we help people to get to health and then we have a different mentality when it comes to health care. Healthcare might be co-insurance and deductible and other things but if we're getting people to health we really have figured out
through this health investment, health activation index, a lot of things that that we were doing it gave us a chance to measure them. It's really a fantastic tool.

Chair Wells: Any other questions?

Ms. Huckaby: I believe we have Nevada leadership on the phone if they want to make any comments. Nathan, are you on?

Chair Wells: I don't know if we needed any actions from this one for this for today. Obviously a couple things to think about especially as they relate to the obesity and diabetes care management. We have big planning decisions to come for that. Thank you both.

Mr. Stockwell: Thank you.

Ms. Huckaby: Thank you for your time.

Chair Wells: We'll close agenda item number 10. Move to agenda item number 11. The review of professional health programs for knee, hip, shoulder, spine, heart, weight loss, surgeries, and cancer care.

Mr. Brochu: Morning everyone, board members, Chair Wells, thank you for the opportunity. My name is Alex Brochu. I am a client success manager at Carrum Health. Today we're going to provide you with a quick Carrum overview. Take a look at an executive summary, then look at engagement results both from a communication standpoint as well as a performance standpoint. Look at some opportunities for expansion in both service lines. Then finally finish out with some

plan design changes as well. For the overview, Carrum Health, we are a specialty surgery, cancer treatment and substance use treatment benefit that is sponsored by PEBP. Really the goal is for us to provide world-class care and make it easier and less expensive for your members to access this coverage. We are able to negotiate pre-negotiated rates with our Centers of Excellence. These are top tier providers and facilities across the country. With that we are able to save upwards of 45% per unit cost for surgeries and cancer treatment. Also here, comparing our Center of Excellence network providers to the national average were able to reduce readmissions by 80%. On average, we are currently supporting 6.7 million lives on our platform and to date the average distance from a member on our platform to one of our Carrum COE's across the country is 29 miles. We are continuing to add to that network month over month to make sure as we expand and support the number of lives on our platform that we continue to have local access of high quality care for them. Finally our net promoter score, our book of business is a 92 right now. That is the member's willingness to promote or recommend Carrum to others based on their experience with our program. Something that we are proud of today. For reference net promoter score anything above 70 is considered excellent. We like to stand by that, making sure that patients are satisfied with our care.

Secondly, what separates Carrum Health from others is that we have a true value based care model which is as I mentioned earlier pre-negotiated rates with our Centers of Excellence and our providers which includes primarily the anything from admission to discharge for a surgical episode. That can include preparation procedures and the recovery. But what really sets us apart are the two bookends here. The assessment meaning that every patient in order to have a procedure through care must go through a consultation with that provider. That just makes sure that the provider is putting the patient at the best path forward only recommending surgery when it is medically necessary which oftentimes lead to avoidable unnecessary surgeries to begin with. Finally our providers back their performance by 30-day guaranteed warranties. If there are any complications within 30 days of a surgical episode, the provider is on the financial is taking financial responsibility for any complications or services required. PEBP is not responsible, Carrum is not responsible. It's really the provider putting their performance behind their that warranty.

Taking a look at the executive summary and how it relates to PEBP. These are rolling numbers from our initial partnership starting on 7/1/2024 until last Friday. What we have so far to date, we have over 2200 registrations. We have completed 109 either consults or surgeries. The PEBP member specific MPS score that I talked about the book of business for Carrum was 92. PEBP members have a reported 87 MPS score. Our conversion rate today that is a member creating an episode of care which either leads to at least a consultation or a surgery is at 12.1%. Our overall utilization rate. The number of eligible procedures that are able to come through Carrum either going through the carrier UMR or through Carrum is currently at 8.4%. So 8.4% of all surgical procedures that are available are coming through Carrum Health. Lastly a 1.4% complication rate. On the right hand side here is just a quote from one of your PEBP members and their experience with our Centers of Excellence and our care team for their cancer journey that they were being seen for treatment at City of Hope in Forte, California.

Taking a look at a precursor of areas of opportunity here. This is all the available surgical lines or procedure lines that are available through Carrum Health today. The green obviously highlighting what is active for PEBP members and have access to, call out that far one on the right hand side is newly implemented as of February. You all had agreed to an amendment to add these

additionalsurgical lines. That is active as of February 13th. What I want to call attention to is the two categories that are highlighted in blue listed as inactive but available. The first one is our cancer treatment program. That is an expansion of what is currently in place today. Currently what is in place for PEBP members is what we called our bundled treatment plan which is specific to breast cancer and thyroid cancer has since expanded to prostate and colon. There are some restrictions in order to be available for those bundled treatments. First-time diagnosis, non-metastatic, cannot have started any type of treatment or surgery prior to coming to Carum Health really allows our providers to be able to control the treatment plan without having to see what's already been administered as far as treatment for that bundled approach. Our P4P, which is now an expansion of our cancer offering, is able to provide chemotherapy, radiation, and even potentially surgery for almost all cancer types at this point. So, we've really expanded from that niche box of that first-time diagnosis, breast, thyroid cancer to almost all cancer types that we're able to service today. Doesn't matter if you've already started treatment, if you've gone under readmission and it's reoccurring cancer, it doesn't matter if you're currently undergoing treatment at another facility. You can come over to one of our Centers of Excellence and receive the necessary treatment for your specific cancer type.

Secondly, substance use disorder. This is a program that's available. We are the only kind of value based care Center of Excellence company that offers this type of this program today. Substance use focusing primarily on alcohol, opioids, stimulants, sedatives, cannabis. Really taking that surgical approach that we built out of value based care, high quality providers, predictable bundled pricing, and we've adapted that to our substance use program. We can treat every level of care from detox to intensive inpatient rehab all the way down to outpatient rehab to virtual coaching. I'll talk a little bit more about both of those here in a couple slides, but just giving you an idea of what's available today and where there are a couple areas of opportunity.

Taking a little bit of a closer look here at engagements results. This is specific to communications. PEBP has been great partners in adopting a lot of our recommended communication approaches specifically out to their members. The box there with the chart is just highlighting the number of communications that we've done since inception of this partnership. We typically send out quarterly email communications. This year we're also sending out quarterly broad home mailers. Different targeted campaigns, one to the household, one to members email addresses. We are getting very good engagement results out of that. As you can see on the right hand side, 29.6% is the open rate. Whenever a member does receive an email, 29.6% are opening the email. We then have a 15.2% of a click-through rate, which is about four to six times higher than our average book of business. So, what we're showing here is that members are receiving our emails and they're being receptive to the call to action and they're clicking to not only either just register with Carrum Health or even going on to create an episode of care. And then finally, that 41.4% is the average registration to episode conversion. So that's somebody again looking at the email, receiving an email, not only going on to register through Carrum Health, but also creating an episode of care about a particular procedure that they're interested in pursuing. Finally here on the bottom, just a couple highlights. One thing I do think is very notable, worth calling out, campaign performance. Around 60% of PEBP members that receive a broad email are registering within 24 hours of receiving that email. It's about 2,200 people have registered thus far we can directly correlate 1,500 of those registrations or about 69% from broad communications. To give you an idea of some of the areas of interest or the categories of interest bariatric surgeries, MSK which is primarily total joint replacements knees and hips, oncology, gynecology and cardiac as

well. Touching on one more thing as far as communication goes. This is two of our targeted marketing approaches. Geo targeting is where we take the PEBP population. It can be in the State of Nevada or it can be dependent outside of the State of Nevada based on their geographical region. We send them out an email communication highlighting Centers of Excellence within their area. Bringing this program closer to home to say that not only do you have this benefit through PEBP but also here are some Centers of Excellence that within close proximity to where you live. Out of that geo access, 9 in10 recipients go on to register with Carrum. Reinforcing that there is local available high quality access for them. Same thing from the previous broad communications, bariatric, total joint replacements, which is knees and hips. Also, spine is included in that category. And then oncology, those are all the top drivers of interest. Finally, another targeted marketing approach is our new member awareness campaign. Based off of the eligibility file that we receive from UMR, if there is somebody that was not present on the previous eligibility file, we consider them a new hire or a new member to the program. With that, we go ahead and send out a communication just notifying them about this benefit that they now have available to them through PEBP. One person shy of 100% completion rate. We had 409 members out of 410 that we sent these emails out to that went on to register with Carrum. Effectiveness of our consistent communication broad awareness education about this benefit. We do realize that this is a specialty surgery plan. This is a oncology treatment plan doesn't always fit the box for everybody, all employees. As long as you can at least just register to verify that you are eligible, there may not be a need for it right now, but there might be a time and place in a 6 months to a year where you could use our services. So, what we really want is just members to engage with us, register, and then come to us when they need it.

Okay, so this is looking at member engagement. Date range 7/1/2024 through 5/15. showing you the number of registrations. Cascading down to cases created. That is a member who has elected a specific bundle or a procedure of interest to want to find out more information on consultations. As we talked about, this is a requirement in our surgical category for every member to have a consultation with our provider so that provider can give their clinical expertise on yes, we think you're a good candidate for this surgery or we actually prefer that you try more conservative treatment. Go over to Hinge Health for some physical therapy, try some knee injections, try to work on some modifiable risk factors. Our providers in our network, they're really great in only offering surgery when it is absolutely necessary and they understand that their commitment to our program is not just operating for the financial gain, it is making sure that we're doing the best for their member. A lot of times we are just avoiding unnecessary surgery altogether through these consultations. Lastly, we've had surgery 70 surgeries completed to date. That number has grown since I last pulled this information last Friday. Giving you an idea on the right hand side breakout of what type of surgeries have been completed in our program to date.

Here is just comparing some averages. This is again providing high quality care for PEBP members. If we look at the complication rate on a national level, average is 6.5%. Looking at it Nevada State specifically, 7.6% and through Carrum Health we've had a 1.4% essentially that was one complication in those 70 surgeries and because it happened within that 30 days it was covered underneath the warranty and the provider took care of it at no cost to PEBP, the member, or Carrum Health. These averages cover all service lines that are available today. The cardiac, the MSK outpatient, which is your sports medicine procedures, total joint, spine, bariatric, it encompasses all of those. Here, I'm not going to read all these but just putting up here for a second, but one of the things that we really pride ourselves on is not only just the high quality care but it's that the

patient satisfactions at the Centers of Excellence making sure that they're feeling well taken care of, they have their best interest in mind, making sure that these patients understand the level of care that they're going to receive not only before but after the surgery as well. These are all PEBP members that have provided their feedback via survey after completion of their surgery and had very positive things to say. This is specifically about our Carrum Centers of Excellence.

Double clicking on those expansion opportunities. Starting with the cancer. Similar to our surgical providers, our cancer providers as well for adding them to our network, we look at over 50 qualitative metrics that they're evaluated on. The providers in our network include both NCI designated centers as well as some community oncology centers. We've talked a little bit about the bundled treatments. That's that all-in rate for a treatment episode includes the cost of the therapeutics. Any related complications if surgeries involved, it's really that bundled approach that everything that's required for that treatment plan is in one line item if you will on an invoice, one cost. The expansion model to be able to offer cancer treatment, primarily chemo or radiation to other cancer types is what you see at the bottom here, the pay for performance. That is where the oncologist is able to treat the patient based off of the most appropriate treatment plan that the provider recommends and then from there is a 10% penalty if they do not meet quality or patient satisfaction. Essentially, we would be invoicing PEBP for 90% of the total charges accumulated and we reserve 10% until we do an evaluation on the patient's outcome, the performance of the provider where they've adhered to timeliness of care as well as up-to-date treatment plans. A lot of different factors go into that to make sure that we are providing the most appropriate care for each patient.

Understanding that our bundled approach is where we want to go over time. Like I said, we started with breast and thyroid cancer, expanded to prostate and colon. Once we have more experiences in the ability to treat other cancer types, we'll be able to predict a little bit better what treatment is involved in each of those and hopefully, over time, put those into a bundled pricing as well. We understand oncology diagnosis, cancer diagnosis can change over time become metastatic one treatment can be effective and then not again later on. So that is why we leave it up to these providers to make sure that they are providing the best appropriate care as they see fit to these patients and then we evaluate thereafter. Giving you a quick idea of what is entailed in that expanded cancer offering. Expert advisory review, which could include an in-person assessment, review of medical records and pathology. If there's any additional testing that's required, that's included as well. And then evidence-based treatment planning. Making sure that the most up-to-date treatment is adhered to. If there's any advancements in technology that we are looking into those as well. As far as treatment is concerned. Everything from excision surgery, chemotherapy, radiation, related labs and imaging, symptom management, and then palliative care. That's specific to treatment, but what's even better is the wraparound services outside of the treatment plan. Members with our cancer or oncology services have up to two years of support. So even if their treatment ends and they're in remission or they no longer are going through chemotherapy or radiation, they still have access to this cancer service
team that is able to provide additional care and coverage. If they need questions answered about nutrition, behavioral health, if they're looking for some type of counseling for themselves or a caregiver, if they're looking for a beautician for a new wig, all this stuff is included in that wraparound services to help them continue on with their recovery outside of the treatment itself. So that was cancer.

This is substance use here. Stats say over 30 million US employees currently struggle with substance use today. Nearly one in six of US working adults suffer with some form of substance use addiction. Nearly 40% of those have a severe or moderate need to enter some type of comprehensive treatment plan. We know that substance use and programs like that have been very hard to come by. Access is really hard to get into. Sometimes coverage only lasts for 14 to 21 days which is not enough. A lot of times facilities utilize the revolving door to make sure that they have patients coming back in. One thing that we are trying to do is really address that using our surgical approach partnering with some of the best high quality facilities in the country to make sure that we're providing patients with the best treatment options. These Centers of Excellence are committed to not having a revolving door. Often times, these members are staying in treatment a little bit longer. So not your typical 90-day program, more like 180 days. We want to make sure that we are trying to get it right the first time, lowering the possibility for readmission. In the event that there is potential readmission, same warranties apply in our substance use category as in our surgical category. There are different breakdowns, but let's say for instance within 60 days if somebody does relapse and they reenter treatment, that patient could go into treatment free of charge under the warranty. It would be covered by this this Center of Excellence. We really want to focus on rapid access to a nationwide network. We have put a lot of focus this year in expanding our substance use specifically in the West Coast. I know that we have two more facilities coming on board in Reno in a couple months. We have two more in Las Vegas and we are building out our network extensively in California. To touch on the predictable pricing here. Our value based care model extends into substance use as it does in surgical bundle pricing. Every step of treatment there is a negotiated price. Once the member step downs into a lower level of care there is another price associated with that. So all predictable pricing available to you with the intent of making sure that again we provide adequate care as long as that patient needs until the Center of Excellence feels comfortable in stepping them down giving them the best shot at not relapsing over time.

Last thing here is dedicated clinical navigators. You'll see a trend in our surgical offering. We have a patient care team that operates and works one-to-one with all of our members, pretty much taking on that administrative burden. Anything the patient needs from the time they create an episode of care all the way through surgery and even 30 days after surgery, that person is there for them. An oncology service line, we have the same approach. Our care navigators, they're there to help the patient going through cancer treatment every step of the way. We've replicated that here in our substance use program as well. We have clinical navigators that are constantly staying in touch with the patient and as Centers of Excellence on a weekly basis getting updates on their performance.

Last section here. Looking at plan design changes. Currently to date PEBP is on a voluntary model meaning that all the services that we offer today patient has freedom of choice. They can either come through Carrum for these services or they can go through UMR where normal rules apply, out of pocket, co-pay deductible etc. Members coming through Carrum if you're on the EPO or PPO plan, there is zero cost share to utilize our program. All surgery or cancer related costs are covered by the PEBP plan. If you're on the CDHP plan first you have to meet the IRS federal minim deductible before that cost share kick in. The emphasis here on the program is opportunity for member savings should they come through our program. This is a slide I like to present here. This is the building blocks on how to get the maxim utilization and potential for maxim savings to the plan. The first four here is something that's already in place today by PEBP. You have great access which means you not only just opened up COE access to the western United States or

Nevada but you have access to the entire country. Zero patient cost share something I just talked about. Ecosystem referrals, working with the likes of Hinge and UMR to make sure that we are referring the member to the most appropriate care. Somebody might come through to Carrum, they may not be a good fit or conservative treatment might be an option. We can then refer them over to Hinge to get the necessary treatment that they need. Broad and precision marketing, we touched on that. That's all available today. And again, PEBP has been great partners in being able to allow us to communicate their population.

Now, the last Lego block here is plan design change. As I mentioned, PEBP is currently on a voluntary model operating with freedom of choice. We do have what's called a voluntary flex model. That is utilizing Carrum as the preferred provider for select procedures. Those categories that we do offer this for is in three areas. Bariatrics, total joint replacement, knees and hip replacements as well as spine surgeries, spinal fusions and decompressions. These are the three service line categories where we offer this voluntary flex or we would recommend being the preferred provider. In that, you can see 91% of PEBP members today live within 50 miles of a Carrum COE. We use 50 miles as that gauge. Understand that 50 miles in Los Angeles is a little bit different than 50 miles in Nebraska, but that is our barometer of seeing closest in proximity. Great coverage across these Centers of Excellence for PEBP members today. When we're talking about becoming a preferred partner or provider for these select procedures, we really are on average talking about 6 out of every 1,000 members. Not a huge disruption to the others in the population.

When it comes to potential savings, implementing this model from a voluntary to more of a preferred partner, you can save upwards of four times, per cost for each member's usage. Quickly here, this is to show you the effects of going from a voluntary to a voluntary flex model. This is a case study that was done with one of our current clients, which is a major US airline. Showing you what some of the year one outcomes versus the year two outcomes look like. They did just mandate, if you would want to use that term, bariatrics as the only service line. To give you an idea, 45% of our book of business today has at least one of those three service lines activated as a mandate. Over 55% of our total population that we support today is in one of these mandatory models, if you will. It has become very popular in a way to drive engagement and drive utilization ultimately producing in savings. Essentially what this case study here is showing you is in year 1 the 9% utilization that they received from their population which constituted only three bariatric surgeries. Primarily their savings of $382k came from avoided surgeries. This is where our Centers of Excellence were saying let's work on modifiable risk factors. Let's work on some other things before just going through with the surgery. Look over at year two. That utilization went up to 93% from three surgeries in year one up to 31 surgeries and as you can see with that increase in utilization also that increase in total savings. Giving you an idea of what that can look like from a progression standpoint from switching from that voluntary model to the voluntary flex.

Okay, couple more slides here. Bringing this closer to home. The left hand side is based off of claims data. The red is highlighting surgeries that were applicable in these voluntary models that went through the carrier. The ones highlighted in black are what have gone through Carrum. If we take those surgeries on the left hand side and look at them in distance to a Carrum facility, we have an exponential amount of surgeries that happened within 25 miles of a Carrum Center of Excellence. About 76% of those in total were within 50 miles. There is a lot of area of opportunity to capitalize on members either do they not know about Carrum Health, are they unaware are they seeing a provider at this facility that's not in the network and understanding what that means and

how we can capture some of this additional utilization which leads to ultimate savings to the plan. Lastly down here on the right bottom section, this is just a couple of the Centers of Excellence in the state that we have agreements with today that are in our network. To close out here, reasons for utilizing Carrum as that preferred provider. It's really positioned as an approach to contain premium increases. An opportunity to increase plan savings. My understanding is that there is some level of steerage already in place today for joint and spine procedures through UMR, which means that there would be very minimal member disruption if members are already through the utilization management getting steered to specific facilities. There is a high likelihood that those facilities are Carrum Centers of Excellence. Instead of going through the plan, member cost share, member copay, out-of- pocket deductible, it can go through the Carrum Health program. Member disruption, minimal if that is what is in place today. Lastly, there's an empathetic exception process that Carrum offers. While we do have a let's say a requirement for these select procedures to come through Carrum there are reasons that we would work with PEBP on defining for what reasons can they get out of it. If they're medically unsafe to travel, we allow them to continue locally. If they are experiencing financial hardship, we'd allow them to pursue that locally. There's a number of categories where we can provide them an exception approval where they can continue to have the surgery through UMR. This is my last slide. Some additional quotes. This is again PEBP members experience not about the COE's but this is about their patient experience with the care and patient care team. I'll just leave this here but open it up if there are any questions.

Chair Wells: Any questions? Member Duncan.

Member Duncan: Keiko Duncan for the record. Who certifies these COE's. Who certifies them as what Carrum Health is defining as a Center of Excellence?

Mr. Brochu: For the record, Alex Brochu, Carrum Health. We have a provider land team that does a review of all these providers before adding them to our network. Again, it's based off of at minimym 50 different metrics from number of surgeries performed, patient satisfaction, readmission rate, complication rate, certification. There's a whole list of things that we look at to make sure that they are qualified and meet our criteria that we set to add to our network.

Member Duncan: Who determines the patient satisfaction? Is this survey that the provider does and they provide it to Carrum? Is this something Carrum does?

Mr. Brochu: This is all stuff that we have gathered from their documentation and history. If they have patient satisfaction records, we collect that as well. You're talking about just the provider specifically, right?

Member Duncan: The providers you certify as a Center of Excellence or the locations you certify as a Center of Excellence. Am I to understand that Carrum Health only has what Carrum Health has certified as COE's under their network?

Mr. Brochu: Correct. Yeah.

Member Davis: I have a question. You showed on the list here Northern Nevada Medical Center as one of your key hospitals, but I thought under PEBP we were mandated to use Renown. So, I don't understand how does that work?

Mr. Brochu: That is a good question. For the record, Alex Brochu Carrum Health. They are in our network as a Carrum Center of Excellence. I'm not familiar with the requirement to use Renown through PEBP.

Dr. Davis: That's my understanding. Here in in Northern Nevada, we have to use Renown.

Mr. Brochu: I will also touch on this. While I figure out the answer to that question, but I will call out that we do have Centers of Excellence. These are the facility names, but our Center of Excellence actually goes down to the provider level. You can have a hospital or facility that has five surgeons that all do total joint replacements, but we only actually have one in our network because they're the ones that passed our review process. Just because we can say, let's use Renown for example. Just because we have Renown, does not mean every provider within that that facility is part of our network. Our network goes down the provider level.

Member Duncan: Keiko Duncan for the record. Understanding that Nevada has a healthcare workforce issue, if you guys are only certifying a particular provider amongst the five or so in that example, that can do the particular service, are we noticing a backup and a queueing of patients that aren't able to be seen? What's the time to service?

Mr. Brochu: Good question. Alex Brochu for the record, Carrum Health. Time to service, it varies to give you a non-answer depending on the surgical requirement. If it's a total joint maybe a little bit more straightforward. Typically, about two to four weeks before we get them into a consultation. Keep in mind that because these providers are in the Carrum Center of Excellence network does not mean they're exclusive to us. They are obviously seeing other patients and they have other practices. We have to fit within their schedule. So that can vary. If a patient is unresponsive to our communications to collect the necessary medical records that could extend the time as well. It's really a mutual partnership here. If the patient wants to move forward, we need them to fill out the necessary forms, help us collect medical records and then at that point it's really on the provider to do their clinical review and then schedule that consultation. It can vary depending on the type of procedure.

Member Duncan: I understand from especially a lot of specialists, there's periods of times in which they're not even accepting new patients. I would be curious of how many of these run into that. Specifically, for our PEBP members. I would love to know how long on average our PEBP members are waiting and are there outliers in which a particular type of specialist, we've got an 18 month wait or something. Are they being seen within their plan year or are there delays that are happening? Are they truly getting the care in a prompt manner or are they not getting the care for an extended period of time? Because again, our workforce shortage and therefore maybe their disease state is worsening during that time and now we have higher cost care?

Mr. Brochu: Understandable. Alex Brochu for the record, Carrum Health. Part of the program that we offer today as well, travel is associated. If there is not a Center of Excellence that, to your

example, maybe has a backlog, the member can go on to our website and look at potential availability in California. They can go to San Francisco; they can go to Southern California at other facilities that provide the same type of procedure and that cost is covered upfront for the for the member because what we feel is traveling to get to high quality care is still going to help with the cost savings overall based on our negotiated pricing. They do have the opportunity if there is nothing available within close proximity or there's a backlog, they have the opportunity to research other Centers of Excellence across the country, to fly to in order to receive that care.

Member Duncan: That's super cool that you cover travel. I know that's quite expensive, especially to get patients over there. If all of our patients are having to leave Nevada again because of workforce shortage, it's not necessarily a Carrum Health problem, right? Don't they have a higher co-pay for out-of-network or out of state? Is that absorbed?

Mr. Brochu: Alex Brochu, Carrum Health for the record. Everything through the Carrum Health program, again if they're on the PPO, EPO plan, zero cost share for any surgery related costs. Anything kind of 3 days before surgeries, 3 days after surgery, all of that is covered by the plan. Nothing out of the member's pocket. If they're on the CDHP plan before surgery, if they have a scheduled surgery before the actual surgery, they have to meet the IRS federal minimum. So, for an individual, $1,700 is the IRS federal minim. If you're a family, it's $3,400. That's what they have to pitch in before that cost share kicked in. Travel if they needed to fly to San Francisco because there's not availability in Reno, they can fly to San Francisco. We provide them with a stipend upfront to cover all their travel related costs, airfare, hotel, daily meals stipend. Once the surgery is completed, we get the invoice from the Center of Excellence. Travel is added to that invoice for PEBP to cover the cost but nothing out of the member's pocket.

Member Duncan: What about follow-up care then? Say there was a complication of surgery, how does that work in the model?

Mr. Brochu: Good question. Alex Brochu for the record. If they are local, they can go be seen at that Center of Excellence, that provider if it's outside of 30 days. If they traveled for it and there was a complication, we would recommend that they go to their local care through their UMR insurance and then we would obviously work with the provider on reducing the overall charge for that because they could not treat that complication. We would reduce the fee.

Member Duncan: Travel is not necessarily paid for the second time around. If they have to go out of state again because there was complication of surgery, they got to get opened up again, that's not paid for?

Mr. Brochu: If they're willing to go back to that Center of Excellence, yes, it would be covered. But if it’s urgent and they need to go to the emergency room, they can't put them on a plane. If they're willing to go back within those 30 days, yes, we would cover that. A lot of times for those patients that are traveling, especially for spine procedures or knee replacements, something like that, we would keep them there for a couple days before they have a follow-up; 3 days after to get that medical clearance to travel so they're not having spine surgery and then two days later they're

jumping back on a plane. We're going to probably keep them there for a week or two to make sure that they are of good health and on a process to recovery before they fly back home.

Member Duncan: If they've been discharged from a hospital, Carrum would cover a hotel stay or something in that time?

Mr. Brochu: Yep. If they needed to extend that that hotel stay, we would extend it for them.

Chair Wells: Any other questions? Okay. A couple things to consider for the next meeting regarding the extension of the cancer and the substance use programs. So take that up as part of our review of all of the other programs. Thank you. Close agenda item number 11. Move to agenda item number 12, the Executive Officer Report.

Ms. Carsten: Theresa Carsten, for the record. In May, I traveled to Rhode Island and attended the SALGBA Conference. I attended some presentations related to diabetes, cancer, and HER health programs to address cost drivers in the states. We're having Segal work with us on a couple of questions related to our data. If any of these solutions are viable or interesting related to the data that we get back, I will present them at our strategic plan meeting. The same week that I was in Rhode Island, Chief Financial Officer Monica Joy and Operations Officer Nik Proper attended the Joint Interim Standing Committee on Government Affairs and provided
presentation and answers to questions that those committee members had related to the status of PEBP's budget and the reasons for our rate adjustments and program year 2027. The last little bit is, I'm off here shortly to go to the Joint Interim Committee on Commerce and Labor to do a similar presentation with Director Weeks. At that last meeting on May 7th with government affairs, Director Weekes talked about a report on fiscal findings and the Chair addressed this at the top of the call but I just want to reference for everybody, that can be found on our fiscal reports web page and it's titled Fiscal Evaluation and Review of PEBP Budget for anybody that wants to review the findings from that evaluation from our consultants. That is my report.

Chair Wells: Thank you. Any questions? Hearing none, we'll close agenda item number 12. Move to agenda number item number 13, Contract Status Report.

Ms. Mooneyhan. Thank you, Chair Wells. Brandee Mooneyan, Lead Insurance Counsel for the record. I want to start out by saying I didn't hear the complete public comment at the beginning, but I think it referenced the contract status report and I just wanted to point out to the board if there's anything that you think is missing from the report that you'd like to be included in the report going forward. Please don't hesitate. You can tell me now. You can a week from now if you think of it before the next meeting you think of it, let me know. This is meant to keep the board updated on the contract. Please if this is not helpful or something else would be more helpful, please let me know. I'll go into the report now.

You'll see there a list of PEBP's current contracts. We did give an update on the ones, of course are focused by necessity, are the ones that are expiring soon. Our financial auditor who presented earlier today, Eide Bailly. We have an auditor of course that does an audits of our vendors and then we have our auditor that helps us keep our books straight. Eide Bailly's contract is set to expire on December 31st of this year. We have discussed with them potentially extending it, what

that would cost, what that would look like. We're currently seeking State Purchasing's approval to pursue an extension, which is necessary if we wanted to do that. We hope that we can present more information on that time and cost and all that for consideration by the board at its next general meeting in July or August. I'm not sure when that will be. The pharmacy benefit manager, our contract with ESI is also set to expire June 30th of this year. In a moment, I'll address the amendment to that contract for an extension for two years until June 2028. Our benefits management system, that is also set to expire December 31st, 2026. Currently PEBP and staff from NVHA are meeting weekly with the vendor that was chosen during the RFP process. It's being managed through a project management process. It's getting there and we do anticipate being able to present that also to the board at next normal meeting.

There are no new contracts for the board's consideration and the solicitations. I'm going to skip the amendments. I'll do that one last because that one I'm going to ask for action by the board. We're still working on completing the RFP for the benefit management system which we hope will be done soon. Looking to the future and expiring contracts, we are working with NVHA to develop RFPs for contracts set to expire in 2027. That includes health plan auditing services, the dental network and consulting services. We hope to be able to update you on that at future meetings as well. Going back to the contract amendments. PEBP did work with subject matter experts at NVHA and just in the interest of full disclosure, on behalf of member Duncan, I wanted to let you know that she did assist us in negotiating that contract. Consistent with our training earlier today. Of course, she got no personal gain. Her personal situation was not materially affected by those negotiations and she's not receiving any greater benefit or lesser benefit than any other person under the contract. I don't think there's a reason for her to not participate in the vote, but I just wanted to disclose that for the record. With Dr. Duncan's help and our consultant, we were able to negotiate the terms of an amendment that would extend our contract, PEBP's contract with ESI for two more years. We do recommend to the board that they approve that amendment. If you have any questions, happy to answer.

Member Zumtobel: I have a question. Tom Zumtobel. How come it's extended to two years. not one year? What requires it to be for two years?

Ms. Mooneyhan: There's no requirement either way. Part of the calculation was that it's difficult to get a pharmacy benefit management contract up and running that two years is a minimum. If we wanted to start one, for example next year, we would probably have needed to already do the RFP. We did consider different lengths of time and with our partners at NVHA, the vendor, and purchasing.

Ms. Carsten: I'm just going to interrupt you, Brandee. Theresa Carsten for the record. As part of our initiative at the Nevada Health Authority, one of the things we're doing is looking at if we might combine purchasing power with other divisions that are under the umbrella of the Health Authority. Although we probably cannot secure one single statewide PBM, I think the goal at the Nevada Health Authority is to work towards releasing RFPs for Medicaid and PEBP at a similar time and effectuate scoring based off of good faith bids possibly. In alignment with the Health Authoritie's goal for their contract execution, these dates align with that for this extension.

Member Zumtobel: I support that logic. It doesn't feel like this is a high performing agreement by any stretch and then that's two years that we're stuck with this type of result. I know they're big and they have a big name, but those pharmacy costs are not well managed. Through the two years then we're just doing the same thing with them?

Ms. Carsten: Theresa Carsten for the record, I think initially when we sat down with the Health Authority, we did discuss the possibility of further extending this contract to 2031 because that was an original target of the Health Authority. We sat down with Segal and Chair Wells and we determined it would not be in the best interest of the state to extend the contract that period of time because we could probably get some better pricing if we went out to bid earlier. With that, we are earlier than the 2031 original deadline. To align with the Health Authority, which is one of the reasons why PEBP was placed under the Authority, we need to align with that timeline and bridge that and that's going to be right around that 2028 time frame. Otherwise, we would possibly execute a contract for a year and then cancel it to do another one if that makes sense.

Member Zumtobel: Okay. I have some sense of the situation and I know it's difficult and things have to sometimes move slowly. I do see the value in in dovetailing it with the Nevada Health Authority for sure. Two years is a long time with these types of results, frankly.

Chair Wells: Any other questions? Are the financial terms of this relatively the same far as our PMPM administrative costs, rebates.?

Ms. Mooneyhan: Yes, they're very similar. The attachment that contains that is confidential, but it was included in the board's packet. You can look at it. Per member per month costs were the same. All of those costs came through and a lot of the changes have to do with more information about rebates and that sort of thing. So we hope to be getting more.

Chair Wells: All right. Motion for approval of the contract amendment with Express Scripts through June 30th, 2028. Can I get a motion?

Member Barnes: Jim Barnes. So moved.

Chair Wells: Motion. Can I get a second?

Member McClendon: Jennifer McClendon. Second.

Chair Wells: I have a motion and a second to amend the Express Scripts contract through June 30th, 2028. Any further discussion? Hearing none. All those in favor say I.

Board Members Grimmer, McClendon, Barnes, Harper, Duncan: I.

Chair Wells: Any oppose? Nay.

Member Zumtobel and Member Davis: Nay.

Chair Wells: Motion passes. Close agenda item number 13. Move to agenda item number 14. Q3 FY 26 Budget Report.

Ms. McJoy: Monica McJoy for the record, good afternoon. I'm going to go over the budget as of 3/31/26. The numbers that you see in the actual columns is what we collected. That includes the amount of the AEGIS and the REGI that we collected when we did the audit. It shows that we are at $277 million. Keep in mind as stated in the last budget meeting that the numbers were inflated. The budget numbers will never align with the numbers that were sent through the budget workbook. Looking at our actuals, we're projecting that we're going to close at $603 million. In the difference columns, you can look at the budget numbers and compare them to the projected collected and you can see the difference based off the inflated numbers that were introduced at the beginning of the budget. Going down to our expenses, those numbers were inflated as well. We're going to be closing less in our operating expenses and our total insurance cost. Looking at the close of the budget, looking at the bottom columns, looking at the total budget revenue, we're going to come in at $603 million less the projected expenses of $517 million, which will give us a balance remaining of $85 million less the actuary estimate reserves. We're going to be expected to project under at $36 million. If you have any questions, I'm ready for them.

Chair Wells: Any questions?

Member Davis: I have a quick question. I'm just not sure about this. On these projections, I know things change, so I understand that. Do you have a margin of error? Can we assume that it comes within 4% either way? What is it?

Ms. McJoy: We only do our projections based on the actual. The percentages, we're not going to look at that. We're only doing it based on the actual cash, the income received, and also the expenses because the numbers were inflated in the beginning. They're never going to align with the budget. So, if you would just look at the actuals and compare that to the budget, that's where you'll have answers to some of your questions that you may have.

Member Davis: You're confident with this projection?

Ms. McJoy: Yes, I am.

Member Zumtobel: The actuals then, it's a projected actual, is that what it is? If it's a budget.

Ms. McJoy. The actuals and the projections are two different columns. Actuals is what we collected as of 3/31. Projections is based on the average that we're getting based on each quarter.

Member Zumtobel: I was trying to understand the actuals on the expenses. There's not actuals on expenses. You have actuals but that hasn't occurred yet, right?

Ms. McJoy: No that is actuals as of 3/31.

Member Zumtobel: The projected then is based off?

Ms. McJoy: Based off of the quarters that we have. Everyone is based off the quarter. If you're looking at the expenses, we broke those down into the amount that's collected what the expected. The expenses are based off of what we collected divided by our quarters. We're expecting the difference. That's where you see the projection at. You add those together, but it was an average of what we collected each quarter.

Member Zumtobel: But the expenses aren't collected. That's what's been paid in each quarter?

Ms. McJoy: Yes. In total. Yes. As of 3/31, that's what we paid.

Member Zumtobel: Okay. So what I'm trying to understand is it's just the first two quarters and then you just doubled it and then came up with an annual projection or is it an actuarial projection?

Chair Wells: The second column that says actual as of 3/31 $404,850,096 was paid out in the various categories as of March 31st. The next column, the projected is how much they expect to increase from $404 million through June 30th.

Member Zumtobel: Then that is projected. I understand that, but projected, is it just doubled or how's it projected, right? What's the is it an actuarial number or is it just?

Ms. Carsten: No, it's based off of expenses. Each month you have a plus b, right. Then those are averaged to get to the best guess for the remainder of the months. Those can be adjusted throughout the year. There's also specific invoices that we know what they're going to be, right? And they don't have to be projected. It's a known that they're not going to inflate or decrease, so those are all taken into account. We have two months remaining essentially. Well, three months based off of the of this report. That's the difference of what's expected to be expended at the end versus what's been expended through quarter 3. The actuary doesn't project or make our projections in our budget.

Member Zumtobel: Okay. The budget is really just the current budget for the rest of the year. That's all this is?

Chair Wells: The budget column. The first column. It's the legislatively approved budget for the program.

Ms. Carsten: Based off of an incomplete workbook. It was built with more enrollment saying that we would collect more revenue. When Monica said earlier, we were not expected to receive that or collect that, that's a true statement. That's what we've been saying over and over since we've had the findings in our evaluation.
Member Zumtobel: That's what I thought was on the revenue side. That the legislature deemed the revenue. I thought we talked about that last time, but we're talking about expenses now. The legislature doesn't deem our expenses, do they?

Ms. Carsten: The legislature approves the amount of money we can expend in each operations category. We have general ledger items and they approve them.

Member Zumtobel: Well, they can't, they could approve. They could do whatever they want. How would they know what amount to approve for health care expenses? They don't know that in advance. Unless they use an actuarial projection.

Ms. Carsten: Well, we built it into the workbook and the workbook.

Member Zumtobel: That's where my question was. That's what I asked you guys. you guys are so tight to share information. I feel like you never want anybody to know what's going on. You make every question hard and you make everything hard.

Ms. Carsten: I think we're not understanding where your question comes from because when you asked how it's projected, you never said medical expenses.

Member Zumtobel: I did say expenses in the beginning because she was talking and I specifically said expenses.

Ms. Carsten: No, expenses. You said expenses. I thought you just said medical expenses, right? So that's different than our overall operating expenditures.

Member Zumtobel: But it's part of them. Correct. It's different. But if we have to split hairs on every question and every word that I have to figure out how to ask every word in the language you guys want me to ask, I don't know how I could be accountable in this role if it's so hard to get correct information or even have a conversation about information. It's fairly straightforward on the question.

Chait Wells: The answer to your question is the legislatively approved budget. The column in yellow was based on actuarial projections and projected enrollments. The actual column is the actual payments made through March 31st. The projected column is the amount of additional expenses that are expected in the last quarter of the year. The difference column is the actual to the legislatively approved budget.

Member Zumtobel: Okay.

Chair Wells: Your question is, in the projected column for expenses, how is that projected from March 31st to June 30th? Is that your question?

Member Zumtobel: Yes.

Chair Wells: Do you know?

Ms. McJoy: Yes. What we do is take the amount of what we have for each quarter and we average that out and we divide it by how many quarters we have and that's how we come up with the projected amount.

Member Zumtobel: Okay. And that's exactly what I thought. What I did is, I used the wrong terminology to ask the question and then I got a bunch of information. I mistakenly thought this was two quarters worth of expenses and I asked if you just doubled it. But then this was three quarters and so you just add the other quarter. It really was just exactly the question that I asked. Shame on me for asking it incorrectly.

Chair Wells: Yeah. The actual is three quarters. The third quarter. We have one quarter a month left. The question as to whether or not there's a variance. I mean these are projections. This is not going to be the amount that's going to come in on June 30th. Guaranteed. It will be different. How different will depend a little bit on the utilization that we see in the fourth quarter. Again, something that we don't really have control over, but based on historical amounts for the current year, this is where we think we're going to end up. Any other questions?

Member Harper: Blaine Harper for the record. I'm trying to synthesize some information with this question or sanity check on whether this is a way to synthesize it. When we look at the budget for funds carried forward from prior year. If we compare the projected balance remaining of $85 million to that $66-$67 million does that suggest a projection that some of the reserve deficit we've talked about in recent meetings is being addressed within plan year 26.

Ms. McJoy: Yes.

Member Harper: Okay. Thank you.

Chair Wells: Any other questions? Hearing none. This is an information item only. We'll close agenda item number 14. Move to agenda item number 15. The second public comment period. No action may be taken on any matter raised under this item unless the matter is included on a future agenda item or future agenda 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.

Mr. Hopkins: I'll put up the slide right now. We don't have anyone in the lobby. You want me to just leave it up for about a minute to be safe?

Chair Wells: Yeah, just put it up. I don't see anybody in Carson City. We will move online. Say that nobody will be online either. Hearing no additional public comment. We will move to item number 16, Adjournment.

Member Barnes: Jim Barnes, move adjournment.

Chair Wells: Second?

Member Duncan: Keiko Duncan. Second.

Chair Wells: All those in favor say I.

All board members: I.

Chair Wells: Our meeting is adjourned. Thank you very much.