Joe Lombardo
Governor

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October 2, 2026 Unofficial Meeting Transcript

Rick Nguyen: Chair Wells, we're live on YouTube.

Board Chair Jim Wells: Thank you. Good morning. We'll call to order the meeting of the Public Employees' Benefits Program for today, October 2nd, 2026 at 9:00 a.m. Can I get roll call?

Jessica Crane: Good morning, everyone. Starting roll. Chair Jim Wells.

Chair Wells: Here.

Ms. Crane: Dr. Keiko Duncan.

Keiko Duncan: Here.

Ms. Crane: Laura Rich.

Laura Rich: Here.

Ms. Crane: Jim Barnes.

Jim Barnes: Here.

Ms. Crane: Dr. Blaine Harper.

Blaine Harper: Here.

Ms. Crane: Chris Viton.

Chris Viton: Here.

Ms. Crane: Joy Grimmer

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Joy Grimmer: Here.

Ms. Crane: Dr. Paul Davis

Paul Davis: Present.

Ms. Crane: And Tom Zumtobel. Okay, it appears Tom is absent. We do have a quorum. Please remember to state and spell your name for the record.

Chair Wells: Thank you. We'll move on to agenda item number two, public comment. Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda as an item on which action may be taken. 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. I don't think we're going to have to do that today. Any such limitations will be announced at the beginning of the public comment period. Additional comment periods subject to similar limitations as announced by the chair may be allowed on individual agenda items. I don't think we're going to have any additional public comment periods today. Members of the public may make public comment by using the call-in number 669 900 6833. Meeting ID is 85830573823 pound. Persons unable to attend the meeting in person or by telephone or who wish to make comments not subject to potential time limit may submit their public comments in writing. Please state and spell your name for the record at the beginning of your testimony. Any public comment here in Carson City?

Mr. Ervin: Good morning. Kent Ervin, K E N T E R V I N. I'm a Medicare retiree and I am the chair of the Legislative Committee for RPEN, the Retired Public Employees of Nevada. RPEN will be keeping a close eye on PEBP through the legislative session. Most of the options on the table today would save the plan money simply by shifting cost to employees, retirees and dependents. That is the wrong direction and approach. PEBP needs to proactively advocate with the state for full funding of current plan design and restoration of the mandatory reserves. Cuts to benefits or increases of employee premiums should be the very last resort after the Governor's executive budget is known next January even if some contingency planning is required. However, there are good ways PEBP can reduce costs without reducing benefits or increasing premiums.

First of all, the reasons need to be found for revenue failing to come in as expected from the very generous funding approved by the 2025 legislature. There has still been no full quantitative explanation of the tens of millions of dollars of revenue shortfalls for FY2026. The Executive Officer's fiscal report today shows revenue for the first 72 days of the fiscal year coming in far below expectations and expenses far above budget. What's going on? Second, the

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Milliman report indicates the best opportunities for savings are improving provider reimbursements and contracting. That work should be expedited. The CTI audits of UMR in Q1 through Q3 of FY2026 showed large over payments from small random samples of claims. Extrapolating to all claims gives savings of $25 million for a year which should be recovered. Today's Express Scripts delayed audit from 2023/24 also showed overpayments. PEBP should concentrate on optimizing provider payments and getting better contracts without reducing benefits. It is especially unfair to raise premiums for the elderly non-Medicare retirees who are not eligible for Medicare A because they were hired before the state started paying into Medicare in 1986. They have no good alternatives and were promised retiree health benefits.

Option C, separating the risk pools of actives and retirees is a terrible idea besides being prohibited by NRS 287.0432A. It would greatly increase the rates for non-Medicare retirees by 27% while only saving 4% for actives, which is less than one year's trend. It is inequitable for a 60-year-old retiree to have a different overall rate more than 30% higher than a 60-year-old active employee, for example. Their insurance risks are similar. The retiree already gets a different subsidy, but that's a separate policy decision. Also, the small retiree group would have higher rate volatility giving year-to-year fluctuations. The point of insurance is to spread out risks over as broad a group as possible. Board members, please reject options that just shift cost to participants or subgroups of participants and concentrate on reducing claims costs for everyone through better contracting and cost controls and on actually collecting employer contributions. Thank you.

Chair Wells: Thank you, Mr. Ervin.

Ms. Crane: Sorry to interrupt. I just wanted to let everyone know that Tom Zumtobel is now in attendance.

Chair Wells: Great. Thank you. Any additional public comment here in Carson City? Seeing none, we'll go to the phones.

Mr. Nguyen: One moment Chair Wells. We have about 14 in the lobby. Let me get that side 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 live 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 of your phone number will be announced and you'll be advised that you have been unmuted. Please slowly state and spell your name for the record and then proceed with your comments. As a reminder for those on the phone, please press star six to unmute. Martha Hildreth iPad, you have permission to speak. Please slowly state and spell your name for the record. Bruce B, you have permission to speak. Please slowly state your name.

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Mr. Blackadar: I'm here. Good morning. My name is Bruce Blackadar. I'm a retired UNR professor. I'm concerned about the proposed reduction in subsidies for health care for retired employees. I was a UNR professor of mathematics for 46 years from 1975 until my retirement in 2021. I was a UNR outstanding researcher of the year in 1986 and a foundation professor. I'm among a relatively small number of retired UNR faculty and probably other state employees hired during the 1970s and 1980s who are ineligible for Medicare because the state did not pay in at the time. We were promised that the state would take care of our medical instead. We would be disproportionately impacted by further reductions in health care subsidies. The state started paying into Medicare for later hires but not for us and employees hired after this period have access to benefits we do not. I and many other retired employees live on a fixed and limited set of resources. Current state employees maybe including yourselves will someday be in the same situation. The state has a moral obligation and a social contract to support former employees who retired after decades of service to the state, especially with regard to health care, which is even more critical for older retirees. Reducing benefits for retired employees may be expedient but is just not morally justifiable. Thank you.

Chair Wells: Thank you, Mr. Blackadar.

Mr. Nguyen: Caller with the last four digits 1571. You have permission to speak. Please slowly state and spell your name for the record and press star six to be unmuted.

Mr. Bubb: Yes. Good morning, Chairman Wells. My name is Daniel Bubb. D A N I E L B U B B. I'm a professor in the Honors College at UNLV and I serve on the UNLV School of Medicine's interview board. I would like to offer an alternate solution for the board to consider because as you're hearing, nobody really supports these proposals that are being offered. I was wondering if you and the board might consider an alternate solution. What if we took two people from every organization whom PEBP serves and we work with PEBP to collaborate on a health plan that works for everybody. We go through multiple iterations of it and then it goes to the board for a vote and ultimate approval. Is that something that the board would consider? Thank you.

Chair Wells: Thank you, Mr. Bubb.

Mr. Nguyen: Caller with the last four digits 1892. You have permission to speak. Please slowly state and spell your name for the record and press star six to be unmute.

Mr. Murillo: Chairman Wells, members of the board, my name is Ruben Murillo. R U B E N M U R I L L O. I am the president of the Retired Public Employees of Nevada, representing 7,000 active and retired members across the state from Las Vegas to Reno to Elko to Ely and all areas in between. As mentioned by my colleague Kent Ervin, we strongly urge you to find solutions to the

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PEBP funding challenges by finding ways to balance potential increases without doing so on the backs of PEBP participants. We look forward in engaging our members and those who are PEBP participants and having a voice and changes this board considers. We also look forward to working with this board and throughout the legislative session with other public employee groups to ensure that PEBP is fully funded and participants are spared unnecessary financial burdens. We do have a new Executive Director who is beginning on Monday and that will be Cabrina Feeser who has retired from PERS and now will be joining us to help guide us through the next legislative session. We look forward to working with you to find common sense solutions that will not overly burden our PEBP participants. Thank you.

Chair Wells: Thank you, Mr. Murillo.

Mr. Nguyen: Caller with the last four digits 6795, you have permission to speak. Please slowly state your name, spell your name, and press star six to mute.

Ms. Renwick: Good morning, Chair and members of the board. My name is Adrienne Renwick. A D R I E N N E R E N W I C K. I'm a teaching associate professor at the University of Nevada Reno in the School of Public Health and CASAT and I'm the new Secretary of the Nevada Faculty Alliance UNR chapter and I'll be our chapter's representative at these meetings going forward. I look forward to working with you. Speaking now as an individual, I'm asking the board to support a full independent audit of PEBP's finances, reserves, and rate setting procedures. I'm a licensed Clinical Professional Counselor and a licensed Clinical Alcohol and Drug Counselor. In my profession, both state law and our codes of ethics require full transparency about fees and billing. Clients must understand what they're being charged and why before they agree to it. Public employees and retirees deserve the same standard from their health plan. The 2025 legislative budget assumed about 6.3% enrollment growth. Actual growth was under 1%. Even after adjusting for that, an analysis of PEBP's own public quarterly reports shows budgeted revenue far above what actually reached the operating account. The gap may be as large as $50 million. Participants deserve to know where that money went and how this crisis developed in specific numbers. Before PEBP shifts more costs onto employees, retirees, and families, we need a clear and independent accounting of how we got there. Thank you for your time.

Chair Wells: Thank you, Ms. Renwick.

Mr. Nguyen: Caller with the last four digits 2675. You have permission to speak. Please slowly state your name for the record and click star six to mute.

Mr. Kagan: Hello, my name is Michael Kagan. I am a faculty member at the University of Nevada Las Vegas and speaking to you today as chair of the UNLV Faculty Senate. We represent all faculty, including administrative faculty at UNLV. We have grave concerns once

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again about the proposals that are on the table, specifically agenda items 6 and 8 for this board for the effect that it would have on the health insurance that is already quite poor for our employees. Once again, we have significant concerns about the recurring proposals to eliminate the HMO which many of our faculty find to be the best option for them and that they depend on and once again that seems to be in the crosshairs.

We have also serious concerns about not just one specific proposal that is in the two different consultant reports but some general themes which is to try to balance the spreadsheets by dividing different members of the insurance pool against each other. Dividing different members of our community against each other. Some proposals divide current employees against retirees. We do not want to keep current employees' premiums down on the backs of retirees who have already served the state. That is especially alarming. We are also alarmed that some of the proposals to appear to favor single employees again at the expense of employees who have families, spouses and dependents. That is also not the way to go. These are jobs from which people should be able to support a family. We do not want to divide people with and without spouses and children against each other. Overall, the declining quality of the health insurance policies and their increasing expenses amount to pay cuts for employees who have had at best a feast and famine experience with the availability of COLAs with far more years of famine than feast. This is not sustainable and it degrades the mission of our institutions. It will make it harder to retain staff. It will make it harder to recruit staff and it makes us a much more harsh place to work. Rather than these divide and conquer approaches that we see in many of these proposals, I join with others who have asked for much more clarity and transparency about exactly where the money is in these accounts and far more attention to the need to keep subsidy levels high and to ask for more state support to prevent betraying retirees and current employees of key state institutions. I hope that these approaches are reconsidered by the board and thank you very much for listening to us today.

Chair Wells: Thank you, Mr. Kagan.

Mr. Nguyen: Caller with the last four digits 3896. You have permission to speak. Please slowly state your name for the record and press star six to unmute.

Ms. Lindauer: Hello, my name is Trisha Lindauer. L I N D A U E R. I apologize my voice isn't there much today. I'm calling for important issue with a different transparency.
I suddenly found out in July that five of my key medications, which I was paying $80 every 3 months to get my 90-day supply of long-term maintenance medications, were suddenly without warning, no longer available to me. They all increased between $800 to $1,800 a month. Now, these are five medications. The cost of which now to maintain those medications that I have been on for a long time as maintenance medications is now higher than my monthly income with the state. When trying to find alternatives, I have found it is impossible to actually view the formulary to find what medications my doctor might be able to approve as an alternative

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because for one indication which is my thyroid medication, it only recommends meds that are in pill form and I can't take pills because of other medical issues. There's no way to find something that my doctor can give me that I can then take to my doctor at my doctor's appointment, which I have to pay for to say, "Hey, how about this one?"

Now, all of these medications had active prior authorizations that were under three months old. And then I suddenly just found out, no, we aren't covering them anymore. Some of the suggested alternatives are impossible to get because Express Scripts just won't stock them. Like too bad, we don't have them. They will cancel the order and then not tell you about it or tell you why. Then I have to again have another appointment with my doctor to find another different medication and pray that it's going to be on the formulary because there's no way to check that in advance. One of the medications we found said it looked like it would be on the formulary, but then the dosage that my doctor needed to prescribe me, he was told he wasn't allowed to prescribe me that dosage even though the name of the medication was on file. So now I'm having to take my thyroid medication at a lower dose than what I need, which is going to cause additional health issues for me. It's not tenable. Other medications that got changed, my asthma medication, my inhaler is no longer formulary. Some of my diabetes medications are no longer formulary. Those are three things that are very critical for people that need them. I've been on thyroid meds for over 30 years. I've been with the state for 17. I should not have had any medication that I am told is no longer $80 every three months and is now in excess of $1,000 a month or I just can't have it.

So, that's a different transparency because there's no way for a person to research alternatives to take to their doctors and the doctor just has to guess. And then we found out, nope, you can't have that one either because this one looks like it's there and then it's not and it's not covered either and it's still going to be $300 a month, but half the dose that I need and they won't allow him to fill a full dose. So, I'm going to have other problems. Well, this is a problem. You guys need to fix it because you didn't give anybody any warning. There was no way to look any of this stuff up. I called Express Scripts and they're like, "Yeah, no, you have to be able to give us the exact name and the exact dosage and then we'll tell you if it's approved." How do you find an alternative if you don't know where you're looking? I'm not a medical professional. I don't know the names of every possible drug that could be an equivalent. That's something I should be able to get if I have to find one that's going to get covered. So, this is what I have to say, and you guys need to fix it because that is unacceptable. Nobody should have the cost of their medications that they need to survive be more than their monthly income. And I am not a low-income employee. My pay grade is in the 32s and I am stepped out. I am not a low income employee. There are people that make a lot less than I do. And what are they doing if they have any of these medications? Because as I said, it's now one and a half times my monthly income if I were to try to stay on the medications I was on. That's not reasonable. Not at all. So, that's what I have to say. Thank you very much.

Chair Wells: Can I get your last name again, please?

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Ms. Lindauer. L I N like November. D like delta. A U E R.

Chair Wells: Great. Thank you. We'll have someone follow up with you.

Mr. Nguyen: Caller with the last four digits 7056. You have permission to speak. Please slowly state and spell your name for the record. Press star six to unmute.

Mr. Kohl: Good morning. I'm Steven Kohl. It's S T E V E N K O H L. I'm the Faculty Senate Chair for the Desert Research Institute. I appreciate this opportunity to address the Board. Over the past few years, medical costs along with the costs of most of life essentials have increased dramatically due to inflation and other factors. Particularly hard hit by these increases are employees with families to support and retirees. The plan adjustments proposed here ship most of the burden onto these two groups, those who can least afford an increase in their premium rates. Affordable quality medical benefits are an important tool used to retain and recruit top talent. The proposal to eliminate the HMO option decreases choice and for many paying a higher HMO premium for more predictable health care expense planning is desirable option. Plan choices are important and increase the value of the overall employee benefits package. I therefore, respectfully request that this Board advocate for more state funding for employee medical benefits during the upcoming legislative session. And now while negotiations are underway to establish the budget for the next biennium. A legislative remedy without burdening employees with higher premium rates or less choice would be the ideal outcome here. Thank you for your attention.

Chair Wells: Thank you, Mr. Cole.

Mr. Nguyen: Caller with the last four digits 0070, you have permission to speak. Please slowly state and spell your name for the record. Press star six to unmute.

Mr. Fonseca: Hi, my name is Jorge Fonseca and I'm calling to oppose these premium increases. Plan year 2027 rates are already in effect and the employer only is $55 for the CDHP and the scenarios given are either increasing $5 to $17 a month. But they're pitting different groups against each other whether it's retirees or families or individual employees. And I think that’s the wrong way to look at it because we're all in this together and we're discouraging families and people who are retiring early which are people who may be more vulnerable to these things and the packet itself says that these are illustrative and not adopted. I ask that you please do not adopt these and that you hold participant premiums where they are. Do not cut the spouse or retiree subsidies to close the funding gap that the state created. State workers and retirees should not be the backflow for shortfalls in the in the budget. Thank you and have a good day.

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Chair Wells: Thank you, Mr. Fonseca.

Mr. Nguyen: Adrienne Renwick, you have permission to speak. Please slowly state and spell your name for the record.

Ms. Renwick: My apologies Board. I've already submitted my comment.

Chair Wells: Thank you.

Mr. Nguyen: Daniel Bubb, you have permission to speak. Please slowly state and spell your name for the record. Doug Unger, you have permission to speak. Please slowly state and spell your name for the record.

Mr. Unger: Doug D O U G U N G E R, past president, UNLV chapter, Nevada Faculty Alliance, and a member of the UNLV Employee Benefits Advisory Committee. It's with no little dismay that I and other state employee advocates have reviewed the PEBP Board agenda for this week. Serious accounting discrepancies amounting to tens of millions of dollars carry over from last spring and these remain unexplained. The Executive Officer's one page of numbers in item number five hardly seems trustworthy. The Milliman program assessments in item number six read like a litany of suggestions to shave provider payments, eliminate the HMO EPO choices, and dump rising health care costs onto the spouses and children of our state workforce and retirees. Then we get the Segal plan design and state subsidization report in item number eight for possible action that suggests A and B options to eliminate our HMO and EPO or junk the HMO in the south for an EPO like the one in the north which is baffling since the EPO plan has historically suffered high costs requiring cross plan subsidies. In 2024 when the HMO and EPO were last considered for elimination, hundreds of PEBP members wrote or voiced strong opposition. A significant percentage of state workers rely on the HMO for its cost predictability and stability.

Segal’s option C then proposes to quote decouple unquote actives and retirees so as to shift high costs to retirees and their families. NRS287.043 subsection 2A mandates PEBP to quote co-mingle the claims experience of each active and retired officers and employees and their dependents. I'm not an attorney but as an English professor I can assure the PEBP Board that to quote decouple is pretty close to a direct antonym to quote comingle. This suggestion if implemented would violate the statute. Segal's proposal C plus stabilization scenarios four and five similarly suggest breaking Nevada law. The least bad proposal by Segal is number one that lowers subsidies to so-called historical levels, which means further cuts to benefits and/or new cost burdens for state workers already struggling to carry the premium increases and benefit cuts for this year. In sum, none of these proposals is acceptable. Table them all, please. I recall vividly Governor Lombardo's address to the 82nd legislature when he promised to remedy the short staffing crisis at state agencies by increasing wages and benefits. I hope the Governor and PEBP leadership will continue to keep that promise. I hope this Board will convene again

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with proposals to increase support for state employee healthcare based on the Governor's next biennial budget. Thank you.

Chair Wells: Thank you, Dr. Unger.

Mr. Nguyen: Martha Hildreth, you have permission to speak. Please slowly state and spell your name for the record.

Ms. Hildreth: This is Martha Hildreth. M A R T H A H I L D R E T H. On Tuesday, I submitted a rather long letter and I hope that you all had a chance to read my letter. I raised several of the points that's been made already by other speakers in my letter. I would just like to add one more thing that I think I didn't put in my letter, which is I don't think there really has been sufficient communication between the Board and the retirees that are in my special and unique group. I was hired in 1982 and I retired early in 2018. I might say parenthetically that I was in the group that no longer had access to PERS. That means my retirement felt extremely insecure to me. I particularly worried that I wouldn't have Medicare, but I was assured time and time again when I talked to HR at UNR where I was employed not to worry, that the state would take care of me. It has done so far although with considerable cost to me as well. If those costs go up, this is more of a burden to someone like me who is on a fixed income.

I would also like to address the point of communication, which is that I think there really needed to be a lot more publicity of what you guys were thinking specifically to my particular group of employees since you're considering to, as other speakers have said, to make cost savings that discriminate really against us and probably violate state statutes. I noticed that PEBP is good about communicating certain things. I got a lot of information about Carrum for example, emails, several emails and a letter, at least one letter. PEBP is capable of communicating and I think you should let us know when something is going to happen that's going to specifically impact our group. I only found out about this through just happen stance of entering into a conversation with somebody at a social event otherwise I wouldn't have any idea that this was going on. Anyway, thank you for your time and I hope you did all have a chance to read my letter where I raised a number of points. Thank you.

Chair Wells: Thank you, Ms. Hildreth.

Mr. Nguyen: Dustin Club, you have permission to speak. Please slowly state and spell your name for the record. Ruben Murillo Jr., you have permission to speak. Please slowly state and spell your name for the record. Dmitri K, you have permission to speak. Please slowly state and spell your name for the record. Moving on. Sue Wainscott, you have permission to speak. Please slowly state and spell your name for the record. Moving on. Tracy D, you have permission to speak. Please slowly state and spell your name for the record. Caller with the last four digits

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8853. You have permission to speak. Please slowly state and spell your name and press star six to unmute. Chair Wells. That concludes public comment.

Chair Wells: All right. There are no additional public comment. We'll close agenda item number two and move on to agenda item number three.

Ms. Paige: May I speak? I'm sorry. My name is Christine Paige. Last name is P A I G E and I'm a member of Retired Public Employees of Nevada. I just want to say that many many of our retirees are affected by this and are very concerned about increase in prices and so on. And I just want to mention as a couple of people mentioned on the speaker phone that am a member of that group that was hired in the late 1970s early 1980s when my agency didn't participate with social security. It's important for me to be able to continue to have affordable access with that.

Chair Wells: Thank you, Ms. Paige. Seeing no additional.

Mr. Nguyen: Chair Wells, we may actually have one. She just raised her hand. Sue Wainscott, you have permission to speak. Please slowly state and spell your name for the record.

Ms. Wainscott Hi. My name is Sue Wainscott. S U E W A I N S C O T T and I'm the UNLV Nevada Faculty Alliance Chapter President. Good morning, Chair and members of the board and everyone online. Thank you so much for the opportunity to comment. I've reviewed the posted public comments and I've been listening this morning. I urge everyone to share their comments from this meeting with their state legislators and candidates for those offices and vote. Most members of this board are appointed by elected officials. We need our employer, the state of Nevada, to chip in more of the cost of providing basic benefits to state employees and retirees. Elected officials need to hear directly from plan members. For this board meeting today, I have three questions and I'll be reviewing your recording to see if you manage to answer them during your scheduled discussions. How will pursuing provider reimbursements be used to reduce these proposed increases of plan member costs? How will penalties for contracted companies be made stronger when services fall far below the standards set in those contracts? And finally, will there be a full audit to address the concerns repeatedly raised about discrepancies between actual and budgeted revenues? In other words, where is the money? Thank you very much.

Chair Wells: Thank you, Ms. Wainscott.

Mr. Nguyen: Chair Wells, that concludes public comments.

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Chair Wells: All right, we will close agenda item number two, public comment. Move to agenda item number three, PEBP Board disclosures for applicable board meeting agenda items. Mr. Rivera.

Mr. Rivera: Thank you, Chair Wells. Hello everyone. My name is Jose Rivera, 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 Benefits. Pursuant to NRS281A.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 we'll be voting on those items that may affect the benefits available to them or their family members. The law does not require absentation 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 now. Thank you.

Chair Wells: Thank you, Mr. Rivera. Are there any additional board disclosures? Seeing and hearing none, we'll close agenda item number three, move to agenda item number four, approval of the action minutes from the August 20th, 2026 board meeting.

Member Barnes: Jim Barnes, move approval.

Chair Wells: I have one change or one addition on page four on the board action item number 12. The second was by member Rich just has a blank after the member. Can you make your motion to include that change?

Member Barnes: Yes. Including the proposed change. Jim Barnes, move approval of the minutes.

Chair Wells: Motion. Can I get a second?

Member Duncan: Keiko Duncan. Seconded.

Chair Wells: I have a motion and a second. 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, the Executive Officer report. Ms. Carsten.

Executive Officer Carsten: Good morning Board. Theresa Carsten for the record. Just want to get into the meat of this short Executive Officer report. Want to note that the budget status report is not on this month's agenda. I included this snapshot as an update and courtesy to the board as the last snapshot I provided at the last meeting did not account for the AEGIS and REGI transfers

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that were voted on in the month of March by the Board. As of September 10th, this is where our cash stood. With the $52.5 million carry forward, the revenue at $65.3 million dollar expenditures at $129.9 million and then the amounts transferred for July and August for those AEGIS and REGI transfers. We expect that if enrollment remains flat through the remainder of the year that there will be approximately $12.6 million total transferred from those accounts into our operating account. That leaves us with about $1.6 million in cash as of 9/10.

Updates on staff reorganization. The Nevada Health Authority has moved fiscal and IT components over to the Director's Office. The staff will remain in our budget account operating and doing PEBP work. But this allows more support from a management side for operational decisions at fiscal. With our CFO coming in, she has great knowledge of fiscal work but not so much of state systems and this will allow support of understanding those state systems and processes. In addition to that, our IT folks will have greater direct support and broader experiences made available to them which will allow them to continue to grow in their careers. This is what our current organizational structure will look like. Our PEBP recruitments currently are for Operations Officer, Legal Counsel, Management Analyst position and Administrative Assistant position. Those last two positions are in our Accounting team. That is my update if there's any questions.

Member Davis: Yeah, I have a question, Theresa. Now, I'm a recent member on the board, as . I'd like to see what was sent to the state that we're going to be requesting. I know Jim Wells has seen the full report that was sent. I'm wondering if other members have seen it because according to the handbook, my understanding is that each board member are to see it before it's sent off to the state for our request. That's my that's my question and if not, I'd like to get access to the full report.

Executive Officer Carsten: I believe the agency recommended budgets will not be publicly available until October 15th.

Member Davis: Okay. And then all the board members will have access to it?

Executive Officer Carsten: I believe the entire public will have access to it.

Member Davis: Excellent. All right. Thank you very much.

Executive Officer Carsten: I will say that at the last meeting I did go over with the board the differences, the exceptions that we asked for within the budget. So those are on the slides from last month but the detail of everything will be released October 15th.

Member Davis: Thank you.

Member Zumtobel: I have a question Chair Wells. Can we go back to the financial snapshot slide?

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I appreciate your efforts to include this information and to try to keep us informed. The starting cash $52.5M that was the start of the previous month or start of the fiscal year? Starting as of when?

Executive Officer Carsten: Starting the fiscal year. Every July we transfer forward an expected amount of funds and that was our starting cash as of July one.

Member Zumtobel: Okay. Okay. And then the revenue of $65M then is what's been actually collected this year or received or whatever the right terminology is? It's cash in hand from other departments interdepartmental transfers or whatever?

Executive Officer Carsten: Correct.

Member Zumtobel: Okay. Do we track what is short, what was expected to be collected at this point?

Executive Officer Carsten: You're asking to see the reconciliation logs. Or a shorthand version of what we have in the reconciliation logs I would imagine, correct?

Member Zumtobel: Yeah, I don't know that terminology necessarily. It makes sense because it would be some form of reconciliation, but each department that has a member or an employee that participates in PEBP owes us a certain amount of money for their headcount every month and $65 million worth has been paid. There's some amount that is owed to us that we're aware of, but that has not been paid.

Executive Officer Carsten: Yes, there are some outstanding individuals that are on independent bills that we don't receive direct payroll information from. You are correct. There's a percentage. So that's what you're looking for. I think the thing that Monica and I are struggling with is that we want to make sure we're providing the Board what you want to see and what you need to see and then we hear feedback from the community when we change things that we're trying to hide things and we're not. We just need to know what you want to see. We can come back with that during the budget status report. I have Monica making a note right now to make sure that when we're doing that revenue, we're also showing the outstanding cash balance.

Member Zumtobel: I think you're doing a good job trying to figure out how to meet everybody's needs and I appreciate that.

Executive Officer Carsten: And this report, this slide is different. At the last meeting I told you guys we were going to have a $30 million shortfall. This slide was really to tell you I had not incorporated the AEGIS and REGI transfers into that previous presentation and I wanted to account for that because that is going to reduce that $30 million shortfall that's expected from the

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from the phase in by that $12.6 million if our enrollment remains flat. I thought that was important to note, but this was in no means meant to be the full budget status report because that usually doesn't end up on October's agenda.

Member Zumtobel: Yeah. Okay. I appreciate that. What you provide, again, I hear your intentions when you provide it and I respect those intentions. I think you're just trying to provide helpful information as best you can. The challenge is, we continue to get snapshots and so we don't know where we stand. As a board member, I have a fiduciary responsibility and we all have a fiduciary responsibility. Mine is actually a little bit different when I think about it.

A board member is supposed to act within the realm of their capabilities and I understand how to manage a health plan and that's why I get a little bit more aggressive trying to get the right numbers because I feel like I'm not meeting my fiduciary obligation if I allow us to continue to have snapshots instead of getting the whole picture. It's starting to make me continually more nervous because if you look at this snapshot and I know your intention I hear your intention and I believe that intention is right-minded for sure. But if you go to D available cash, that snapshot, my health plan, if I did that I would be telling my board that I'm insolvent. You don't have a health plan of this size and have $1.6 million in available cash.

Executive Officer Carsten: But sir, I told you guys at the last presentation we were insolvent and so did our actuary. I understand that frustration and I think this is a moving target as you're aware of as you run a plan. The week after that, we had a lot of invoices come in and we were negative cash for a hot minute. I can bring back a report, but no matter what report I bring back to you, it's always going to be a snapshot of a date that has to be prior to this board meeting's posting required by public open meeting law. I'm never going to be able to give you the details of everything as it's rolling in and rolling out, but I understand the frustration and I think that's why I keep saying it's important to try to keep you guys apprised of where we are and I truly am doing my best.

I will say that as of last week when our fiscal team went under the Director's Office at the Health Authority, they have much better experience with presenting fiscal presentations to you and I think with that help and oversight there can hopefully, if the Board decides what changes you want made for the next budget status report, we can definitely come back with the support of the fiscal administration through Monica to provide you a more solid report, but this is what I had available to me and I just wanted to update and capture those transfers because I think that they had not been included in my last presentation.

Member Zumtobel: Again, I appreciate that and I appreciate the comment about the insolvency and the reason that I go there is I don't believe that we are insolvent and I don't believe that. It's an accounting function that we need to get to the bottom of because if you look at the claims, your next line of $129 million in claims and our revenue is $65 million. There's no way this health plan is running at 150% medical loss ratio. Every piece of information, go ahead.

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Executive Officer Carsten: Sorry. No, I think at least in the first month of every new fiscal year, we see an increase of expenditures then we expect to see through the remaining months of the year. And that's because all of the dates of service from the prior fiscal year hit like that July, August, those months. Those are routinely higher medical claim months than the remainder of the year. This is the first year where we've had rates set where they were supposed to cover the cost of the program. But in previous years historically, our revenue doesn't catch up to our expenditures until typically the month of November. I hear what you're saying and I don't necessarily disagree with that. I would just say that's not been our experience since I've been here.

Member Zumtobel: No, I'm not trying to make it a point for you to agree or disagree with. If the claims expense and I understand because we don't know the details. Maybe you had to do the HSA funding in the first month, too. I mean, there's lots of times timing issues, but at the bottom line, when you run a health plan, you look at the claims and the revenue for the entire year. We don't look at it month to month. And the reason that I think it's extremely important is now we're getting ready to potentially have discussions about making changes based on a fact that we're seeing information that leads us to believe that we're insolvent and I truly don't believe that is correct.

If we got a 30% increase for the employees last year from the legislature and we got a 19% increase or 18% increase for the retirees. I know we had to catch up on IBNR and there were catch-up reasons. I've seen nothing in any of our reports that our medical trend is running out of norm with most of the market. We're high single digit and so there's no reason with those rate increases that we would be running at this much of a deficit and we're not. We just aren't capturing the cash, we're not capturing the revenue and I'm afraid what's going to happen is we're going to be forced to make decisions based on the fact that we think we're in a deficit, that's not true, not correct. I know that there's cash accounting, it's on a cash basis, but we have to have some accrual view of it so we really understand what we're looking at.

Member Rich: Laura Rich for the record. Can I ask for, I think there's confusion here around our revenue and the shortfalls and things like that. I think Tom makes a good point, but I also think that being on the other side of this, I also know that state budgeting complicates things a lot. There are so many other layers and components and timing factors and things like that. Sometimes what you see in these reports is really difficult to navigate and understand for the outside person who's not living and breathing this. My request is, Theresa, on the next board meeting agenda, if we could get an explanation, discussion, or a better understanding of some of these. What you guys have found out through your process of investigating some of the revenue issues and things like that. If we could get a basic presentation of what the issues are, what you guys found and potentially some of the layers that we're talking about. I think that would help a lot of the board members that haven't lived and breathed state budgeting understand those pieces as well. I think that would be helpful.

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Executive Officer Carsten: Absolutely.

Chair Wells: Member Harper.

Member Harper: Blaine Harper for the record. I think one of the potential mismatches in expectations and the information that we're able to get is it sounds like there are lots of questions that would rely on accrual accounting when there's statute that we operate on a cash basis. It would be great for some of that follow-up explanation to lay out the difference there because we aren't working with a dollar amount of revenue that hasn't been collected yet. At the same time, I think it would be helpful to know what proportion of payments from agencies are made within 30 days of when they would be timely. Is there a large proportion of payments that are the wild card for when they will be paid or is it a relatively small proportion? What's the latest? Are those things that can be tracked under the accounting principles that the agency is operating under?

Chair Wells: Member Davis. Member Davis. Go ahead.

Member Davis: Hi Paul Davis. Dr. Davis, board member. Just a point of information I think the Board may find interesting since we're on this topic. Even though the legislature and current governor or the legislature okays it, whatever the final budget is. Our present governor had broke the precedent when he got elected of being able to make changes. That's never happened before. So, I'm just throwing this out here. If and I'm saying it's a big if we have a new governor, they can also make changes. Even when we think that this is the final numbers or the final results, doesn't necessarily mean that's how it's actually going to come out. So, I just thought that would be a point of information that I thought maybe the board members would find interesting and the public. That's it.

Chair Wells: Thank you. Member Viton.

Member Viton: Chris Viton for the record. I may be suggesting some of the same suggestions member Rich made. I think you've heard a lot of concerns in the public comment around the question of where is the money? And what I think we're asking is a better understanding of why we're not seeing the 30% increase in the assessment translating into revenue in PEBP's accounts. Unless I'm missing it, I think that's the question why revenue appears so much lower than budget. Revenue is lower than budget and cash basis or not, the budget's cash basis and the revenue in the budget is cash basis. For there to be a mismatch, it appears there's something missing or we're missing something. I don't know. I'm assuming that that's something you've been looking into and getting to member Rich's question of what is the status of that research? How comfortable are you with whether or not we've collected all the revenue we should collect?

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I think the question there for me also is, when we've talked about the rate errors in the past and the issue of what rates were submitted to the legislature versus what rates were implemented and then in my own mind a question of whether those rates were ever adjusted to be able to bring the revenue in that that increase in the assessment represented. I don't feel like that's ever been made fully clear. The comparison of expectations to actual budget to actual prior year to actual incorporated enrollment, some level of analysis that would provide a clearer picture of, are we getting the revenue we should expect or not? There's also been comments about the timing of the payroll contributions and whether those are received. But I think while I agree that things are complicated, there's also basic simplicity to it. The legislature provided a higher assessment that was budgeted to go to our account, but we're not seeing that in the account. And so somewhere I think we're still concerned about whether that's there and making decisions on employees' premiums without that information is very difficult as a board member.

Executive Officer Carsten: Theresa Carsten for the record. I appreciate that board member. I think that we have had various discussions over the last several months about those key pieces. I think what we can do for the next board meeting is perhaps put it all down in a timeline on paper with some supporting information. I think there has been answers related to that. There was additional funding, but the way that it was expended was more to meet the increased costs rather than to feed the reserves. But I think there is still some money in our other accounts that needs to be verified. There's still some accounting that's being done that hasn't been finalized and so hopefully that can be brought back as well at the next board meeting.

Member Viton: Chris Viton, thank you. A couple other comments. I may be missing it and that's why I'm asking or saying it's not clear to me. I'm not sure if it's clear to others, but the legislature's approval of the increased assessment comes after the board approved rates for the year that that increased assessment would apply to. If we did not adjust rates after that assessment was approved, I don't know how the funds would be brought into our budget. I think a fairly basic question would be, what is the balance in the AEGIS and REGI accounts and do those correspond to what we were expecting that increase to assessment to generate? The other concern is about our role in approving the agency request for the budget. To Member Davis's point, I may misunderstand what our policy and procedure book says our role is compared to what it seems our role is because I think what we approved last meeting was really just the administrative cost, the office expense for the PEBP budget, not the PEBP budget. Hearing we'll see the agency request when it's made public doesn't feel consistent with what the policy manual says. And that just may be my misunderstanding of what our actual role is in submitting that request.

Chair Wells: All right, I'm going to I'm going to chime in. We're going to ask for a few things at the next meeting. I've already asked for a couple of them. The first one is, I've asked the actuaries who if you look at one of the slides in Segal's presentation, gave you the revenue and expenses and surplus and deficits by plan. That was tied to the cash change for FY26. I've asked them to

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go back three more years, 25 24 23, tie that to the cash in the expenses by plan surplus and deficit by plan tie that to cash. We'll start with cash coming into FY23. Go through those four years that we have. We'll go through 23 24 25 26. That will tell you whether the plans were bringing in sufficient revenue based on the premiums that were set.

Second thing that we'll do, there will be a new fiscal report that's going to come at the next meeting that will basically take enrollment and premiums and multiply them, the counts, by month times the premium that is assigned to each of those tiers to show how much revenue we're bringing in by plan, by tier, by group, state and non-state actives and retirees and then it will show the expenses that are related to those groups and plans. Basically, it's going to show by month or by period how those plans are performing and we'll put that on every agenda starting with the next meeting.

The third thing that I'll have Ms. Carsten work on is a flowchart of how the budget process works. Because the board doesn't approve the spreadsheets that create the budget. There's a process that creates the budget that the board approves and then that flows into what is submitted to the agency request. And I don't think there's ever been a good a good flowchart of how that works. Basically it starts with the plan design inflation, any programmatic changes or plan design changes and then the subsidization rates that the board has not put into a policy yet. That is on one of the additional agenda items further down. Those three things I think should explain a lot of what we've had the discussion here today.

Member Zumtobel: Chairman Wells, Tom Zumtobel. That sounds fantastic. I'd like to make a motion that we receive what you have just described as far as it's going to start next month and start to receive it on a regular basis. The revenue and the expense by plan will be provided to the board each month.

Chair Wells: By plan and by group.

Member Zumtobel: By plan, by group. I think that's ideal. It'd be also ideal if we had a top number, we'd have the total revenue and expense and then a breakdown. But I'd like to make a motion that we actually either begin to receive that or if for some reason we don't, we get an explanation each meeting until we do start to receive it.

Chair Wells: This is not an action item. We can't take a motion. But I have committed to putting that on the December agenda. It's done. The report is done. It just needs to be populated.

Member Zumtobel: Okay. I think once we start to see that, then we could start to make some decisions. But I feel like the picture is not clear enough that if the revenue is short, it's not right to make some other plan decisions based on not knowing where the revenue is.

Chair Wells: Any further questions? Hearing none, we'll close agenda item number five. Move to agenda item number six, the PEBP options report from Milliman. Ms. Weeks, Director Weeks.

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Mr. Timcheck: All right. Thank you, chairman. Can everyone hear me?

Chair Wells: We can.

Mr. Timcheck: All right. Very good. And then uh for the slides, uh it will I be sharing them?

Executive Officer Carsten: Yes, Andrew. I think you should be able to share them from your office.

Mr. Timcheck: Okay, perfect. All right, very good. Can everyone see my screen?

Executive Officer Carsten: Yes.

Mr. Timcheck All right. Wonderful. All right. Well, first off, just want to say thank you for giving us the time to present our report today to the board. Today, we'll be presenting our program assessment of the PEBP program with the key findings and opportunities. To start off, since I see a number of new faces here, my name is Andrew Timcheck and I'm a principal consulting actuary at Milliman based out of Chicago. Been working with health and welfare plans for the last 15 plus years related to anything medical and pharmacy plan related. Before I dive into the results of our analysis, I did just want to spend a couple of minutes going over the background like every report. Within our report, the NVHA, they engaged us to provide strategic actuarial support to improve PEBP's performance with respect to access, to care and cost containment. And for our assessment, this included a broad assessment of the current state of the program, evaluating PEBP's strengths and weaknesses with respect to financial sustainability and accessibility. As well as developing a summary of options to improve these elements and recommend potential path forwards.

For the presentation I'll be covering today, I'll be going over the key findings and potential near-term action items for the board's consideration with a focus on a few different areas as it relates to medical and prescription drug benefits. Particularly around program structure and benchmarking, financial performance and utilization analysis, and then finally going over network adequacy and efficiency.

All right. Starting off with an overall executive summary as we reviewed the PEBP program, I want to highlight some of the strengths as well as some of the additional pressure that the program may be feeling, as well as near-term opportunities and trade-offs for the board's considerations. Starting off with the strengths is that following our review, it is worth noting that PEBP is generally competitive both in terms of the benefits from an access and also the benefit richness standpoint. And where we're seeing typical pressure that's being placed on the program is related to cost and utilization which may be uneven across the various plans and member cohorts that are enrolled in the plan. For near-term opportunities. Near-term opportunities exist in the realm of provider reimbursement that represents the clearest opportunity for true plan cost

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savings. And we'll talk about some of these various types of near-term potential opportunities for consideration in more detail as we go through the presentation today. And then the other opportunity to also potentially reduce cost for the plan would be via trade-offs. And there's various opportunities to better align with benchmarks that exist to generate savings, but these would primarily be through shifting costs to members.

Looking forward to the potential action items for consideration. What I want to start out with is just a really high level overview of the various types of potential action items that we developed as part of our analysis. We'll go through each of these at a high level to start out with and then we'll dive into each of them in more detail as I continue to go through the prepared materials for today. Starting off with the first initiative, this is the medical TPA or third party administrator or carrier procurement. This is one potential action item that we listed with high priority. And if I'm moving off to the right, you'll notice that we have a list of potential savings, trade-offs, and an effective date. For the potential savings portion of it, the information I'll be going through today is high level directional potential savings. Oftent times with these different types of initiatives that would be brought before the board's consideration, the actual dollar savings associated with them would require additional analysis and also be dependent on the types of changes that were made.

Just generally speaking starting off with the first one for the TPA and care procurement the potential savings, that is towards the higher end of the spectrum of the potential initiatives that we evaluated and this would be something if the board wanted to consider it, would be going out and conducting a competitive carrier procurement for a medical TPA and as part of that would be negotiating more favorable network discounts, utilization management programs, as well as potentially evaluating various types of HMO options compared to the current vendors that are in place today. Some of the considerations or trade-offs around this would be additional administrative effort that would be associated with that procurement and implementation. And there also would be the potential of member disruption if new members are implemented. That's something that would need to be evaluated as part of the process.

Member Zumtobel: Chairman Wells, it's Tom Zumtobel again. I’m sorry. I don't want to interrupt and so I'll wait. I don't know the best time, Andrew, to ask questions. I just want to have one clarifying thing before you go much further. The TPA is the third party administrator and the HMOs or whatever. Are you talking about them as the same thing or are they separate opportunities?

Mr. Timcheck: It would be a consideration as far as the opportunities. It could be viewed either separately or combined. It could be taking a look at it from the standpoint of taking a look and evaluating other medical TPAs. Currently, the plan is with UMR today. So be evaluating other types of medical TPAs on a self-insured basis. As part of that analysis could also incorporate some additional analysis for also evaluating fully insured HMOs as part of that overall carrier procurement process.

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Member Zumtobel: They're the same, but they're also apples and oranges. It's hard to throw them in the same bucket to some degree. I just want to make sure that's what you were saying. I needed to understand it. Thank you.

Member Davis: Paul Davis here, board member. On your tradeoffs, some member disruption if new vendors are implemented. To me, that's nebulous on the grounds of what are we talking about if there is a disruption? Are you perceiving it as something that would be one month, two months, a year, two years? It's just a general term. Any feedback from you would be appreciated, thank you.

Mr. Timcheck: I can clarify that. When it comes to member disruption within this context, when it comes to a medical TPA, it would be disruption in terms of the providers that would be considered in network. For example, if there was a change to be made effective plan year 2029, changing carriers for instance, there's going to be some differences as it relates to which providers fall in network or out of network and that could be for various professional services, certain doctor offices, could also be differences in the facilities that are in network. The disruption here is referring to that one-time member disruption for when the change in a medical TPA or a change in plan occurs. That is what that's referring to. Paul, does that help answer your question?

Member Davis: Yeah. Yeah. Somewhat. I know members will say how long is this going to take before it's really effective to implement these if we had new carriers? So, I'm confused and I don't know if this is probably a good idea, a good time to bring this up, but my question is for example, one of our carriers or one of our provider hospitals is Renown and that was purchased by Kaiser. So my question is is Kaiser going to be called Kaiser? And more importantly

Chair Wells: Member Davis. Let's hold that question. That's not really related.

Director Weeks: Renown did not get bought out by Kaiser. We can move on that one.

Member Davis: My point was, does this open us up now that we could have other provided hospitals?

Director Weeks: Yeah, it helps us get better contracts for the state. It's called a purchasing strategy in healthcare and it helps us get a better rate with providers that we're not getting today. It's an option that has been discussed many times and that we do in other programs. So, it's a way for us to get a better deal. Kaiser, yes, is coming in. It is a bigger issue into conversation, but what we're talking about here has nothing to do with Renown. It's more the Carson Tahoe side where we struggle to keep a contract for our Carson City members, for people who live in

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Carson City. We have a hard time keeping a network. It's really important that we value those employees.

Member Davis: Oh, of course. All right. Well I'll bring it up later. Thank you.

Chair Wells: All right, Mr. Timcheck, let's move on.

Mr. Timcheck: All right. Very good. All right. Next item on here is direct contracts. This is another potential opportunity. This would be direct contracting with the provider and typically this would be done outside of the medical TPA arrangement. Instead of going through a medical TPA in order to have access to a provider and relying on the medical TPA's contract, this would instead, be evaluating potential opportunities for direct contracting to where utilizing the PEBP's overall size and leverage in order to negotiate a more effective reimbursement rate on behalf of the plan. And with this one, there'd be no direct member impact associated with this, but there would be the additional administrative effort potentially as it relates to setting up this type of arrangement with providers.

Next item on here is to replace or eliminate the EPO or HMO. And this is another one listed with high priority. Potential savings are going to be dependent on the replacement options as well as any type of migration from that elimination. And the trade-offs there as I think was brought up even earlier in discussion today and also during the public comment piece is the potential member disruption associated with any type of change associated with that. Next item on here is the PEBP market wide reimbursement caps. This would be instituting something similar to a reference based pricing like on providers for certain types of services. With this one, there is the potential for additional savings there. But the potential considerations is that there would be likely potential provider push back and then also potential legislative hurdles in order to put that in place.

Next item on here is to split risk pools. That's splitting up the risk pools between the actives and the retirees. This would be a separate rating while maintaining a retiree PEBP access. With this one, we have this listed as a medium priority. The savings associated that would potentially be minimal for the state overall. There could be a potential difference for the active staff depending on how the subsidies are reallocated. As far as the trade-offs, there's a potential reduced cost for actives, but an increased cost for retirees to the extent that those risk pools are separated, but that does depend on the overall premium contribution strategy.

Next item on here is the plan design adjustments. This is lower priority listed on here. The potential savings of this is going to vary. It's ultimately going to be based off of the plan design adjustments that are being considered and to the extent of those plan design adjustments. And the considerations there is that there would be a cost shift from plan to members. Also a potential enrollment attrition to the extent that there are differences being made to the overall plan designs.

And then finally the dependent subsidy reallocations. Once again, when it comes to the overall financial impact associated with this, it's ultimately going to depend on the selected

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subsidies that are provided at the employee and employee plus dependent levels. This would take the form of some level of cost shifting from employees without dependents to employees with dependents. And then there also would be potential changes in enrollment associated with these dependent subsidy changes.

As we continue to go through these various types of initiatives that are presented on here, they fall primarily into two buckets. The first bucket is the sense where it's more efficient purchasing. The more efficiency purchasing that would fall under the TPA carrier procurement, the direct contracts and then the PEBP and market wide reimbursement caps. Then there are other options that are more so focused on general cost shifting which is going to be replace or eliminating the EPO and HMO. Also, the split risk pools between the active and retirees plan design adjustments and dependent subsidy reallocations. As we go through our additional conversation today, I know Segal's going to be commenting on some of these items as we continue our discussion today. That's something that we can continue to discuss as the meeting continues here.

All right. Now I want to dive in a little bit into more detail regarding our assessment process and this is what we did to review and arrive at our findings and opportunities. We started off by first taking a look at a plan design and enrollment analysis and then we did some extensive benchmarking at the local, state and national level and we'll dive into some more details as it relates to that benchmarking later on in my prepared remarks today. We also took a look at historical claims and utilization analysis to identify opportunities. Then for number four, we actually also took a look at provider network and price transparency data in order to identify potential opportunities that the plan could consider in order to potentially realize more efficient purchasing. Finally, we did modeling around the strategic options that are available. Going on to the PEBP programs at a glance. This is something that I'm sure the group is very familiar with. Want to highlight on here is that we did take a look at the plans that are currently being offered today. Have the majority of folks within the UMR a self-funded medical administration option but there's also various EPO designs that are available or there is an EPO design available in Northern Nevada. There's also an HPN, the fully insured high performance network in southern Nevada and these were all taken into account for the purpose of our analysis.

Taking a look at the PEBP at a glance, just to set a baseline here. We did also take a look at the year-over-year enrollment by plan taking a look at plan year 2024 through plan year 2026 with this, highlight to call out on here is that we've seen a steady decline in the EPO, steady decline in the HMO from 24 to 26 and we've really seen the sharpest increase in the Low Deductible PPO option while also the CDHP has also remained similar in terms of overall enrollment. One of the things that we did take into account as we go through some of our benchmarking information here is that we did review the plan designs and how they stack up by comparison to local, state, and national benchmarks as we previously talked about. And this is just on here as a summary and a reference point around the overall medical plans that are being offered today.

Taking a look at the baseline that we contemplated as part of our analysis is that we did take a look at participant premium contributions. As you can see here is that the way that the

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premiums are set up today is that we have this graph where we're showing participant premium as a percentage of the unsubsidized rate. As you can see here for the CDHP, is that the participant premium or the employee contributions are roughly 6.7% of the total unsubsidized premium rate. For the CDHP, if you're looking at the employee plus family tier, it's around 21.3%. Similar story with the Low Deductible PPO as well as the EPO and HMO to where the employee plus family tier has higher contributions as a percentage of the unsubsidized rate versus the employee only tier. And we'll dive into this more as we continue on with our discussion today, how that compares to some of the benchmarks that we took a look at as it relates to the subsidization percentages that we're currently seeing in the PEBP plan today versus what we're seeing based off those local, state, and national competitors.

All right, so now we're going to dive into some of the key findings. And the first segment of these key findings is going to be the program structure and benchmarking. With this one, we took a look at the in network plan design benchmarking and we first took a look at it at the state and national level and the bottom line here is that several components are richer than benchmark, but there are some deviations on the emergency room copay. The way to read this chart is that if we're comparing the state of Nevada to PPO plans at the National Nevada Government Organization large employer level, that is the first chart that is up here. The items I'd like to call out on here is that the deductible is actually significantly lower on the Low Deductible PPO plan by comparison to benchmark and that is why that is highlighted in green. You'll notice here that the amount that it is lowered is quite significant to where we're seeing $300 for single coverage, $600 for family coverage, whereas the national benchmarks are all significantly higher.

Where we're seeing the opposite here is specifically related to the emergency room copay. The emergency room copay is $750 versus what we would typically see at a benchmark level be something closer to that $200 to $350 range.

Member Zumtobel: Tom Zumtobel. The deductibles you say it's benchmark. Is that just an average?

Mr. Timcheck: What's that?

Member Zumtobel: The benchmarks on deductibles. because $1,000 a single deductible for government organizations. You probably see them all over the place. Do they average out to a thousand or what is the mean or what is that number?

Mr. Timcheck: That's the median 50th percentile. To your point there's going to be a range as far as what we see and I know we don't have the numbers explicitly on this slide but if we were to take a look at that range and take a look at the various percentiles within our benchmarking tool that $300 is going to be significantly better than, even above our 75th percentile benchmark. Where we're showing the 50th on here at $1,000 but $300 is going to be significantly more favorable. I talked about the emergency room. Urgent care is also worth noting that it is slightly higher than what we typically see from a benchmarking perspective. If we're moving down to the

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CDHP, with that one, very similar story there where we see the deductible being more favorable than what we see from other high deductible health plans that are offered within the comparator group. And then it's also worth noting for the HSA funding and we took a look at this from a single basis, it is slightly below from what we're seeing at a benchmark level. Finally for the EPO and HMO plans, this is one certainly Tom, I guess to your point, you do see a very fairly wide dispersion as far as the types of plan designs that are being offered on both EPO and then also on a fully insured HMO basis. Generally speaking, here with the overall deductible levels significantly lower than what we typically see. We do see some variations around some of the co-pays associated specifically with the emergency room is the call out here to where the emergency room co-pays are higher for the EPO and then the high performance network HMO than what we see from a benchmarking perspective.

All right. Moving on to the overall plan structure benchmarking. This is where we dive into the level of choice that's being offered by PEBP sponsored plans. And with this one to draw your attention to the bottom right hand corner is that when we're taking a look at PEBP versus what we see in our state and national benchmarks is that the number of plan options being offered at PEBP is higher than what we typically see for most plans that are either with the state and national benchmarks that we took a look at. Specifically, as it relates to the state employee plan benchmark that we took a look at is that we typically see on average one to two plans being offered and with PEBP we currently have 3 plan designs being offered within each separate northern and southern region and then the other item worth noting too is that when it comes to the overall actuarial value, and actuarial value that's the AV on here, that is a proxy of the overall generosity of the plan. The easiest example that I have is for 87, if a plan is an actual value of 87%. It takes a look at the total charge of a service basically 13% of it's going to be picked up by the member and then 87% of it is going to be picked up by the actual plan. What we see there from a plan AV range standpoint is that for PEBP it's actually higher or more generous than what we typically see. We typically see AVs in the 80% to 90% range but with PEBP among the various types of programs that are being offered see that in the 87% to 92% actuarial value range.

Member Zumtobel: Tom Zumtobel again. Is the right way to interpret that then our lowest value plan is 87% and our highest value plan is 92%?

Mr. Timcheck: Correct.

Member Zumtobel: The high deductible plan, after deductible and everything has a 87% actuarial value?

Mr. Timcheck: Yeah. And that also feeds into the overall HSA funding is also taken into consideration as well. A lot of the time that narrows the gap between the overall deductible level since you're adding the $700 of the HSA funding on top of that.

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Member Zumtobel: Is that inclusive of pharmacy?

Mr. Timcheck: Yes.

Member Zumtobel: Okay. Thank you.

Mr. Timcheck: Sure. All right. Moving on here, I'm going to talk a little bit about the local comparator benchmarking. And for this purpose, these are our observations when comparing to other local municipalities. And then our local comparators for the sake of this comparison are the five that I've listed in the upper right hand corner on the slide here. A couple things to point out here from a local comparator standpoint is that they typically offer between two and five plans. Somewhat higher than what we'd see based off our national benchmarks that we take a look at, for state employees, state employers, I should say. When we're taking a look at the local benchmarks, offering three plan designs is consistent with those local benchmarks. The other item worth noting here too when it comes to premium contributions and this is something that we'll continue to talk a little bit more about is that when it comes to the premium contributions three actually provide 100% subsidized employee only coverage meaning that they do not have any contributions for the employees. That is something that we wanted to point out. It's also worth noting too that dependent subsidies those range from 25% to 60% of premium. The way to interpret this is that if we're comparing PEBP versus the local comparators, the local comparators are providing a greater subsidy for employee only coverage by comparison to PEBP. But for the dependent, PEBP is actually providing a greater subsidy for those with employee plus dependent coverage versus what we see at the local comparators.

All right. Then we'll dive in a little bit to more about the overall actuarial value differentials. This is another one to where we're seeing some differences to what we talked about as it relates to some of the national and state employer benchmarks that we took a look at versus what we're seeing at a local level. The way that we took a look at this is that we actually compared the plan design that is offered through the Low Deductible PPO option for PEBP by comparison to other plan designs that are offered by local comparators. Main takeaway here is that for the Low Deductible PPO option it's actually somewhat in the middle by comparison to the various Low Deductible PPO options that are offered by local competitors which is a little bit different than what I talked about before as it relates if we're taking a look at things at a state or national level to where we're seeing the Low Deductible PPO option with PEBP being towards the higher end of benefit richness being offered. If we do take a look at local comparators, it's more within the middle.

And then we're seeing also something very similar for the HMO and EPO options as well. Specifically taking a look at the HMO and EPO options those are also towards the middle slash higher end of the actuarial values as far as what is offered via EPO and HMO plans by local comparators. Tying this all up when it comes some of the key takeaways. For the key takeaways on the left hand side of the slide already talked about these as I was going over the materials today. I do want to talk about some of the opportunities that have been identified. As far as opportunities

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that PEBP could consider. One is going to be reducing the number of plans offered in order to align more closely to benchmarks. Another one would be introducing tiered networks with differentiated cost sharing. This could be a situation to where there may be a tier network as it relates to various types of high performing networks that could be offered via a self-funded medical TPA. Another option that we talked about for opportunities to be splitting that active or retiree risk pool that could be rated separately. Another item is reallocating those premium subsidies to reduce cost sharing for employees and increasing it for the employee plus family tiers. Finally, also increasing deductibles across plan types. The final note on here is that these changes could potentially drive overall plan savings and also potentially promote more efficient plan utilization depending on how they're designed.

All right. We went over some of the benchmarking results. Now we want to dive into some of the key findings related to the financial performance and utilization analysis. To start off on this, one of the things that we took a look at when it came to financial performance by plan and status would be taking a look at the differences in cost both for plan year 24 and 25 as it relates to the various statuses between active retiree and then also between the various plans. For this one, I think what I want to highlight on here is that we do want to mention that non-Medicare retiree cost PMPM. These have actually increased at a higher rate than actives from 24 to 25. Also, that retiree claims PMPM, these are around 62% higher than actives in plan year 2024 and about 70% higher than actives in plan year 25. For the PMPMs by plan, we also took a look at the claims amongst the various plans. Taking a look at the claims between 24 and 25, main takeaways here is that we're seeing the highest claim cost within the EPO plan design and as we continue to take a look at the other ones as it relates to the HMO, the Low Deductible PPO and the CDHP is that for the claims associated with those plans significantly lower than the EPO design and then the lowest amount of claims and as well as the lowest increase is related to the CDHP.

Next, taking a look at the utilization benchmarks by plan. With these ones, what we took a look at was we take did take a look at PEBP's plan cost PMPM compared to Milliman benchmarks based on utilization rates and average cost of service. The couple of items that we'd like to point out on here, and I'll go through these slides fairly quickly, but I'll hit some of the key takeaways in a few slides here, is that when we took a look at the Low Deductible PPO option, generally speaking, when we're taking a look at utilization cost benchmarks and split them up via inpatient facility, outpatient facility, professional, other services, which may typically include like DME, which is durable medical equipment and other types of services, and then also pharmacy. Generally speaking what we're seeing from utilization perspective is that in northern Nevada we are seeing higher overall costs by comparison to benchmarks and we're also seeing something similar in southern Nevada as well where we're seeing higher costs for the PEBP plan by comparison to benchmark specifically for that Low Deductible PPO plan. For the CDHP, well we have seen more favorable experience by comparison to benchmark. With the CDHP when we take a look at that in northern Nevada overall we're seeing PEBP costs roughly align with benchmark. And then in southern Nevada we are still seeing some differences in terms of total overall spend for the PEBP by comparison to benchmark seeing around a 20% difference. Finally, for the EPO and HMO options, for the EPO, we're seeing significantly higher costs associated with the EPO by

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comparison to other benchmark EPO plans. A lot of that's being driven by high inpatient unit costs, high outpatient utilization rates and just an overall difference in the service category mix by comparison to benchmark and that high inpatient PMPM cost that we are seeing for the EPO does appear to be driven by high unit costs. It's looking at it more from an overall cost perspective as opposed to the number of services that are being utilized. For southern Nevada, like with the HMO, we're also seeing costs come in higher for inpatient facility. Other in pharmacy we're seeing it less for outpatient facility and professional but still overall seeing costs that are higher than benchmark for the Southern Nevada HMO for the PEBP by comparison to those benchmarks.

Key takeaways here from this information is that PEBP cost PMPM are higher than benchmarks for all plans in both southern and northern Nevada with the exception of the CDHP in northern Nevada. And those inpatient costs like PMPM are significantly higher than benchmarks across all plans and geographies. It's worth noting with this one that does appear to be driven by high unit costs as opposed to higher utilization rates as I mentioned before. What this could potentially imply that may require some additional analysis is that this could imply potential provider reimbursement rates that are less competitive than market and that members are utilizing providers with higher average costs per service compared to market norms. Then what that leads to based off of what we've seen in the utilization data versus the benchmarks would be related to some of the potential opportunities that the board could consider.

One of those could be potentially increasing member share member cost sharing via plan design to drive that more efficient utilization towards plans that may have greater negotiated discounts. Another one is going to be pursuing those more competitive provider reimbursement rates. The way that that can be done is via the medical TPA RFP or procurement process I talked about earlier. Another one related to direct contracting as well as putting in place those potential market wide reimbursement caps. Another option would also be adjusting or eliminating those under underperforming plan options. And then finally also implementing a tiered provider network with benefit differentials in order to drive more utilization towards those that are identified as more cost efficient providers.

The final key area that I want to talk through is the key findings associated network adequacy and efficiency. Starting off with the network discount and disruption analysis. The way that we took a look at our network adequacy and efficiency analysis is that we took a look at it two ways. One was via a traditional discount analysis model which is done via the uniform data specification and the other way that we took a look at it is by utilizing price transparency data and I can talk about some of the differences between those two types of analyses. For the first type of analysis that we used it was via the uniform data specification and what this does this is a compilation of rates that are submitted by carriers in which the carrier basically signs a sworn affidavit that they followed the data standards that are associated with the uniform data specification that basically compiles network discounts across various types of services. We'll take a look at it from both an inpatient perspective, an outpatient perspective and also professional services. One of the things that we did take a look at as an initial step within our analysis was comparing the overall discounts that are currently provided under UMR to other types of medical TPAs that could potentially be available for PEBP. Taking a look at our overall results as it relates

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to that by carrier. This is an analysis to where we took a look at UMR historical claims information and then developed relative reimbursement rates by carrier. And what this says is that taking a look at the various carrier options is that for carriers A and carrier B when we compared UMR rates to the discounts that are provided by other carriers, carriers A and B, they're pretty similar. With carrier C, those discounts are less competitive by comparison to carriers A and B for the total discount and the in network discount.

The other piece that we took a look at too is we also took a look at the overall level of disruption as it relates to the in network penetration rates for the various carriers evaluated. What this takes a look at, it takes a look at the utilization that is currently in network with UMR today and then basically says if the PEBP decided to make a change among the carriers we evaluated, how much of that would shift stay in network versus what would shift out of network. And for this one as it relates to the percentage that would stay in network, did see some fairly high percentages as well as I would say these percentages are generally aligned with what we typically see within industry. When we evaluate the various carriers between carrier A, B and C, the in network penetration rate would stay in the mid to high 90s and that is typical of what we would see. Now I would say one of the things that would be evaluated both on a discount perspective as well as an in network penetration rate perspective to the extent that the PEBP would want to potentially evaluate other carriers. This is something that we would dive into more detail in a subsequent analysis to the extent that the PEBP would want to explore something along those lines.

Moving on to some of the price transparency analysis. I talked about how we evaluated discounts from a uniform data specification perspective. The other way that we took a look at the data was by utilizing hospital price transparency and then also transparency and coverage data. What this data represents is that there were law changes going back to CMS where they published a final rule in 2019 requiring hospitals to publish machine readable files of their negotiated payment rates starting in 2021. With our tool that we utilized as part of this analysis, we basically took those reimbursement rates based off of publicly available information. And that publicly available information it's got an unbelievably large data set. As you can imagine, if you have all the hospitals that are basically publishing all these various reimbursement rates among all the various carriers that they contract with. What we did as part of our analysis is that we took a look at the facilities with the highest utilization within PEBP's claim data and basically took a look at those top 10 providers specifically we call them out on this list here.

Starting I think this camp earlier we did take a look at Renown Regional Medical Center also Carson Tahoe Regional Medical Center and we took a look at that information within the price transparency data and took a look at the reimbursement rates that are currently contracted with UMR today and basically compared them to other major carriers within the state of Nevada in order to identify potential contracting opportunities. With this one just to give you a general overview of what we took a look at as part of our analysis is that we did take a look at this as I mentioned the price transparency data across the top 10 providers based off of utilization. And the way that we did this is that we took a look at the UMR contracted rates which is the United UHC Choice Plus option and then compared it to Anthem and then United and then did a comparison as it relates to what the reimbursement rates are. Generally speaking, with the

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reimbursement rates the lower numbers on here are better. And then we did that as it relates to all the various types of providers that we include in our analysis which as I mentioned are the top 10 based off of utilization. We took a look at this for both an inpatient outpatient view. We also took a look at it two ways using the data that was submitted by payers as well as the data that was submitted by hospitals. For the purpose of our discussion here, I think we can go over some of the key takeaways as it relates to the network analysis that was performed.

Starting off on the left hand side here for key takeaways. For the traditional network discount analysis it showed that two national carriers have average discounts as I previously discussed that are a few percentage points within one another and then there could be potentially competitive network discount that's available with limited disruptions with other TPAs and carriers to the extent that the PEBP did want to consider a competitive procurement process for a medical TPA. The other piece from the transparency data is that it also indicated when we took a look at the UMR network which is the UHC choice plus network it may not reflect best in market rates for all hospitals particularly for outpatient services. And then when we performed a deeper review utilizing that transparency data specifically at the highest utilized facilities at Carson Tahoe and Renown, we did identify a few different potential areas of potential improvement and these could be utilized potentially from a direct contracting perspective. At Carson Tahoe, it's worth pointing out that the UHC Choice Plus it generally appears competitive on inpatient, but then Anthem for example would be more competitive on select outpatient service categories. For the UHC options network which we understand includes the Sierra Care options which may be more similar to a high performing more restrictive network. They do appear to be more competitive than UHC Choice Plus for various types of outpatient reimbursements. For Renown, United Choice Plus also may not be optimal for outpatient services. And that's also worth noting for the Anthem PPO and Hometown HMO networks. They do appear to be more favorable overall by comparison to that UHC Choice Plus option.

As far as opportunities, go back based off our analysis. One potential opportunity could be conduct a TPA or carrier procurement that would take a look at potentially tier network options could be taking a look at alternative HMO options. I think Tom, I think you mentioned that point earlier and then also taking a look at various types of enhancements as it relates to performance guarantees on network discounts and also setting up additional guarantees as it relates to provider reimbursement rates. Another item would be also pursuing more competitive provider reimbursement rates via direct contracts with select providers. And then finally, as we talked about as well, would also be evaluating market wide reimbursement caps or a different type or reference based pricing strategies for select services to the extent that we are seeing differences as far as how UMR is contracting for those services versus what we're seeing within the market.

Finally, I'll conclude my statements by wrapping up with next steps. At next steps, we have the NVHA and PEBP decisions. The primary next step is selecting the initiatives to potentially consider in more detail and potentially advance and evaluate further. Specifically for next steps, it's taking a look at the legal and actuarial review of the active or retiree risk pool separation which I think has already begun that Segal's going to talk a little bit more about in detail later on today. Another item is also potentially considering developing a medical TPA or carrier RFP. Next item on

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here is also to evaluate plan designs and dependent subsidy adjustments. Finally, also consider direct contracting discussions with select providers. That concludes my prepared remarks but certainly wanted to open it up for questions from the group.

Chair Wells: Questions from the board members? Member Rich.

Member Rich: Laura Rich for the record. I have a question regarding the network or I guess TPA network. On the first slide, you identify the savings as two to three dollar figures, which is significant. Then later on in the presentation when you did the network analysis, it looks like you looked at three different carriers and the reality is there aren't that many carriers. You probably chose the three national carrier options that we could probably go with. The results were that the discounts were, one was less competitive and the other two were pretty comparable. I'm just wondering where you got that, where that opportunity comes from if when you did the repricing it really came out pretty similar.

I know that some networks are stronger in some areas where they've got better pricing in some areas and other networks have better pricing in other areas. But overall, you've got to take it overall because you can't use one network or it becomes very muddy to use one network for certain things and then another network for other certain things. You end up losing in your admin costs and stuff like that. You end up losing the advantages if you have multiple networks. Can you explain that a little bit as to what that opportunity is in the network pricing that you had recommended or came up with originally?

Mr. Timcheck: I can talk about that a little bit more detail. To answer your question as far as what the potential opportunity exists. When we were doing our analysis, our initial analysis we were comparing the broad UMR network that's in place today by comparison to other broad networks where potential additional opportunity could potentially arise. We'll be developing a potential tier network to where there's a certain subset of providers that are preferred within the plan design that we may be able to negotiate deeper discount rates that these providers would be willing to give in exchange for more steerage toward said providers. So that's one component of the discount component. The other piece that is not specifically addressed via the discounts is also via competitive procurement process. We'd also negotiate for improvements in administrative fees as well. That's another area to where there could be potential improvements as it relates to the overall administrative services fees that are currently being charged today versus what would be charged after a competitive procurement process. That could come through in the form of either potential improvements with the incumbent or also improvements by comparison to other bidders. That type of analysis was outside the scope of the analysis that we performed but that's something that could be potentially explored in more detail.

Member Rich: Okay. Thank you.

Mr. Timcheck: Sure.

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Chair Wells: Other questions? Member Zumtobel.

Member Zumtobel: Thank you very much. Andrew, the benchmarking was interesting and I think I went through those three or four slides and what I thought I saw was the hospitals and the outpatient was always well above your benchmark and then the professional utilization was well below the benchmark and the professional I assume is physicians?

Mr. Timcheck: Correct?

Member Zumtobel: What always concerns me is that the access to care in Nevada is always a challenge and then as it is almost anywhere anymore. That it's becoming more and more of a challenge than access to care that it's made more complicated because expensive premiums and or expensive deductibles and co-insurances. And even when you have a deductible, but then you have a $30 co-pay on top of it, it's actually added on to the deductible. It doesn't apply to the deductible, So, it actually makes it more expensive than your spreadsheet would say.

One of the things we always have to worry about is that we actually cost shift and we don't truly direct people to value or direct people to and there's not a lot of consumer tools for them to direct to value. I'm a little bit concerned about that benchmarking that we would be so far off on the professional. We have a lot less people accessing doctors. Potentially they're not going to the doctor, they're getting sicker or the emergency room, they're going to the emergency room because they can't get access. I know that's not an easy answer for you, but how do you think about cost shifting in benefits versus benefits that really direct people to value? And how can you help us to make sure we keep that on the table?

Mr. Timcheck: That's a very good question. There's a few different ways that you can potentially increase professional utilization. I think to your point, it is beyond the scope of the analysis that we performed so far. But one of the things that the board could consider would be diving that additional level deeper to really understand what is driving some of those differences in the professional utilization and why that is low by comparison to benchmark relatively speaking. Does it become an access issue? Has it become a navigation issue? It's really diving into what those core like drivers are and then developing a combination of plan design changes in order to encourage the appropriate utilization. That could be done in a number of different ways as it relates to the plan design itself. It could be also coordinating with either the medical TPA in conjunction with even a third party solution in order to provide care navigation to the appropriate individuals incorporating telehealth solutions. There's a number of different things that can be considered and that's something that could be explored in more detail.

Member Zumtobel: To Trustee Rich's point about, not point but the discussion about the networks, we're probably with one of the stronger discount networks in Nevada but then when you get up to Carson Tahoe there's a tremendous opportunity for us to do a direct and then actually do a value based relationship and maybe actually enhance benefits and at the same time

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get a greater value out of that hospital by having a direct relationship. So, I love the opportunity you uncovered there. It actually seems pretty actionable, too, to tell you the truth.

Chair Wells: Director Weeks.

Director Weeks: Well, I want to make sure Chair Wells that there aren't any other questions. If there are, I'll wait. Let me know and I can go last. I just want to wrap up a couple things since this was a study we commissioned and have done for the board. Are there any other questions you think, Chair Wells?

Chair Wells: Any other questions from members? Not hearing any.

Director Weeks: Okay. Thank you. I just want to say, Tom that your comments are exactly what I think the story is being told here and so are the findings. One of the things in the new law that was passed by the Health Authority, our job was to go and look at these strategies and options for PEBP, recognizing that our commitment to state employees for all employees, not just one portion of employees, but all employees and all the groups that we serve and the commitment that the state's made to retirees is important. Milliman has done a great job and I really want to thank them for their professionalism throughout this and the work they've done with Segal as well. Thank Segal for their partnership. I think what you have in front of you are some options and we're asking you to take those seriously to help us make our commitment to the Legislature which is to come back with a strategy to control cost.

I know there's been a lot of conversation about solvency, but I would just note that what you will see probably in December when we come back with our Chief Financial Officer Lynette Aaron and Monica McJoy and myself, you will learn a little bit more about where we're at with these reserves. And I think it's an important conversation. This board needs to take that seriously and we want to make sure that you guys have all that information because we do have to make sure this plan is sustainable. I don't think the Legislature said go NVHA and come back and tell us how to bail it out. It's really important to us that we present options from this board if you're willing to make them to the Legislature to make this a sustainable program so we can also honor our commitment to our state employees.

I had an employee recently who left the state and said to me on her way out that the employee rate increases made her decision. While I hear everyone talking about everything, we still have to remember there are a lot of people that work for us that make less than you would make at Starbucks. That is real. We have to honor that and make sure that they're doing right by those folks, too. They show up every day and make a difference in our agency and ensure that Medicaid and other benefits are provided to people. I just really want to ask this board to take that seriously and remember not everyone makes over $200,000 a year. There are some people that make not much at all and what can we do to make sure this coverage is affordable for them and their families? So, with that, Chair Wells, I really thank you and I just want to thank

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Milliman and the Board for taking the time. I know it was a little meaty for a Friday but hope that it was helpful information for all of you in making your decisions.

Chair Wells: Thank you, Director Weeks. Member Harper.

Member Harper: Blaine Harper, for the record. Clarifying question because people are talking about a December meeting today. Is the next PEP board meeting moved from November 17th?

Chair Wells: It's actually November.

Member Haper: November. Okay. Thank you.

Chair Wells: Any other questions? Hearing seeing none this is an information discussion item only. There's no action for this particular item so we'll close agenda item number six move to agenda item number seven strategic planning decisions.

Executive Officer Carsten: Debbie did we decide part of this Segal? I think we talked about splitting seven and eight.

Ms. Donaldson: We can certainly do our presentation now.

Executive Officer Carsten: Part of their presentation is in one area and part of it hit the other. I think that didn't get caught till after the agenda posted.

Ms. Donaldson: Good morning, Chair Wells, members of the Board, and PEBP staff. Apologies ahead where you're having another actuary present to you. Hopefully I'll make it a little bit lively and we'll keep it going. For the record, Debbie Donaldson, Senior Vice President with Segal and Actuary. Joining me at the table is Amy McClendon and also fellow in the Society of Actuary and Vice President Segal. What we're going to do today and we've worked in collaboration with Milliman and PEBP on looking at various different alternatives to consider. We're going to start our presentation. Let's go to the agenda. We're going to look at a couple of different items. What we thought would make most sense is talk about, and I know we've been talking about a lot of financial numbers, but I wanted to share what we believe the current state is today. If we look at where we were at the end of fiscal year 26, we're looking at it on a cash basis. Not budget which is projected numbers but really on a cash basis.

Fiscal year or plan year 26 ended in a cash balance of $52.6 million. I have in the second line what the incurred but not reported amount is. That is the reserve that needs to be held by PEBP as a self-funded entity. That is $63 million. If you just look at the difference the IBNR the reserve that needs to be held is higher than the amount on cash. That is from an actuarial perspective when the reserve is greater than the cash that is technically meaning this plan is insolvent i.e. there's not enough cash on hand to cover the obligation or the reserve. That doesn't

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mean you don't have cash. That just means that it's not covering that reserve that needs to be required. I want to make sure we all understand the definition of insolvent. You're not negative cash, but you're not covering your reserves. A reminder for everybody of what happened, and I think we're all aware, but just a reminder for plan year 27, we're phasing in those full rates. There's an obligation that is on PEBP, not on the members, but on PEBP to come up with between $32 and $36 million. When we presented in March the board meeting, we were thinking it was $30 to $32 million. We're thinking now it's going to be $32 to $36. It depends on plan performance during the year, but that's what our projections are.

That money wasn't included in our budgets. That's going to have to come out of cash and reserves during the plan year. When we're projecting what we think the end of plan year 27 cash balances assuming claims are going to perform as we projected with all of our trend assumptions and everything. We're anticipating a cash balance at the end of plan year 27. So that'd be June 30, 2027 to be $16 million. Again, the $52.6 is being reduced to $16 million. Still not enough to cover that reserve amount. That's about a $47 million difference. We've got to figure out how to find that dollar amount to cover your obligations. I just wanted to set the stage here and I know board member Tom Zumtobel is going to maybe ask this question so I'm going to get ahead of it. We're showing here on plan year 27 the plan designs and our actual values are slightly different than what Milliman just noted. I'll work with Milliman to come up with the differences. We're feeling pretty comfortable with these AVs, actuarial values. You can see ours are a little bit lower. The Consumer Driven Healthcare plan of 78% includes the seed money or that $700 plus $200 additional for dependents. We're seeing that actuarial value is 78% and the Low Deductible PPO at 83%. And yes, the EPO and HMO are at 91%. You guys are aware of this. This is the plan year design for plan year 27. We showed the employee only premiums there at the bottom. I'm going to turn it to Amy because we're going to show you how migration changed as a result of some of the different rates and premiums from looking at May of 26 to July of 26.

Ms. McClendon: Thanks Debbie. Let me just orient you to this chart. We are showing the migration of folks. We expected a response as the rates were increased. We expected folks to make different plan elections and what this is showing is the outcome of that. We used May 2026. Sometimes we see a drop in June and in our data that we don't always see in the other vendor reporting. We use May because we think that's the best representation of before and after and then we compare it to July. Sometimes this chart can be a little tricky. We'll follow along the first line and I think that'll help orient you. The first line, the CDHP, the green box, we've got 12,027 folks there. Those are folks that previously had the CDHP plan and stayed in the CDHP plan. As we move along the row, the 357 are folks that had a CDHP and then decided to actually go to the LDPPO plan. Then we had five that had the CDHP and went to the EPO. And then we had a number of folks who dropped in total that was about 1,369 people. We also had new plan enrollees come on. This in general shows you from what plan folks had in plan year 26 and where are they headed for plan year 27.

Some of the things we'll call out, you can see on the far column the blue that represented the prior share. There was about 45% in the CDHP, 47% in the LDPPO, and 8% in the EPO.

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Based on plan elections in response to some of the changes, we now see at the bottom for July, the CDHP instead of 45% is making up about 48%. We saw a migration into that plan and we'll talk through where those folks came from. The LDPPO percentage share stayed about the same. And then the EPO, as you would expect, we had migration out of that plan. It was about an 8% of the share and now it's around 6%. So, we did have people migrating. We put some boxes around where the greatest migration came from and it was people that previously had the LDPPO and then elected the CDHP plan. We had about 9% move to the CDHP from the LDPPO. As we were setting rates, we anticipated certain levels of migration. We anticipated about 10% if you take into account the phase in. That pretty well aligned with what we were expecting. On the EPO plan we had 21% move to the LDPPO. If you look on the box that's the 474, those were people that were in EPO and went to the LDPPO 21%. We were expecting about 15% so we had more actually move there but we had less moving into the CDHP. That was about 2% we had expected around 5%. Generally, the migration occurred as we expected but in general we had less folks in the CDHP plan than we were expecting and it also is very dependent on who actually is moving and what those claims experience will look like throughout the year. We'll continue to monitor this, but this was our initial look at how people moved based on the changes that were made for 2027.

This next slide is a high level overview of plan year 2026. I believe this was the exhibit that we were referencing earlier that will be replicated going back to 2023 in the future. For 2026 overall, we saw expenses exceeded revenue by about $14.6 million and we have it listed here by plan. We've got revenue expenses and then the difference. We've also calculated on a per employee per month basis. Looking by plan you can see CDHP, the revenue that was coming in was exceeding expenses and overall per employee per month that's one about $133. The LDPPO is being subsidized. The expenses were higher by about $140. And then the EPO HMO, that's where we get to that you can see the higher costs of that plan. The revenue taken in is not covering the expenses for those plans. It's $218. Dental generally was in line and Medicare. I know one of the takeaways we had from last meeting was to better align our EMR report, our experience monitoring report that we provide monthly with reporting provided by PEBP. We worked with them and we believe now we're reflecting the Medicare HRA accurately based on the revenue that's coming in and the expense going out. Our net is $14.6 which I believe in the budget report was about $14.4. We're aligned now in in those things. In general, expenses exceeded revenue what we saw by $14.6 million.

Ms. Donaldson: Going to the next slide, we've done a visualization of historical expenses, assets, revenue, and reserves. It looks like when we did our ADA accessibility, we lost our legend. Let me refresh that for you because that'll be really helpful. The red line is the expense line. The blue line is revenue. The green line is your assets. That's your cash on hand. And then the black line is the IBNR and catastrophic reserve. Then over to the right hand side we are showing from plan year or fiscal year 24 through plan year fiscal year 27 what the AEGIS and REGI amounts are per employee per month. One of the things that does stand out is that the expenses is above the revenue in almost every year. Now, for plan year 26, we were very close, but you can see

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that difference we're projecting for plan year 27, and that's because of the phase in amounts. Our expenses are going to come in higher than we're expecting for revenue. Yes, I think a comment that was made in the public comment we did see an increase in the AEGIS and REGI amounts coming in. You can see the revenue blip up in plan year 26. However, that was used to offset premiums, to subsidize the premiums. That was actually supposed to go to help build back reserves and it was used to offset premium increases. That has really gotten us to where we are today.

As Director Carsten had mentioned, in a given month, at a snapshot point in time, she only has about couple million dollars in a given day. Now that can ebb and flow given cash coming in and expenses. That's not a lot of excess reserve to cover if you have a high cost claim or something. That is something that the board does need to consider. I know there's difficult decisions with plan designs and other kinds of things, but that is something that you need to keep in the back of the mind to keep the plan beneficial for your members. Again, we're seeing I want to show quickly that green line and you can see the degradation over time and the downward slope of your assets. You were in a good cash position in plan year 22, but it is continually decreased over time to the extent that we're close to zero now or projected close $16 million at the end of plan year 27. Chair Wells, if it's appropriate, I can continue, I know there's a lot of content in this document. I'm happy to take questions now or just continue.

Chair Wells: Any Questions?

Member Viton: Chris Viton. I have just one if you could go back on the migration slide. Are we missing the HMO migration?

Ms. Donaldson: Chair Wells and member, yes. We're just tracking the self-funded plan so yes the HMO is fully insured but from an obligation of self-funded we're just tracking the self-funded.

Member Viton: I understand that, I guess. But wouldn't there still have been movement from HMO into or out of, wouldn't there still have been migration because this seems to suggest there's no migration other than this.

Ms. Donaldson: We'll take that away to just double check to make sure that we're capturing both EPO and HMO. I believe we are, but we'll double check.

Member Viton: Similar point on the next slide, HMO is on this slide, but HMO is fully insured. The excess or deficit of expenses and revenue is really just related to self-funded. It's really just the EPO.

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Ms. McClendon: This includes the HMO as well. We bring in the fully insured. We actually get claims information from the HPN HMO as well. We're able to bring in the premium. This slide here captures the HMO and the EPO. This is the full look.

Member Viton: Which are we talking the claim expenses in this slide for HMO or what PEBP's expense was which was the premium?

Ms. McClendon: This is the fully insured HMO premium.

Member Viton: Then there would not be loss on the HMO.

Executive Officer Carsten: It should be the revenue from the premiums and the subsidy. Correct?

Ms. Donaldson: Correct.

Executive Officer Carsten: All revenue for the EPO and HMO for that plan less the expenses for the EPO plus the HMO. And together their net loss was $14.7.

Ms. Donaldson: That's correct.

Executive Officer Carsten: Are you asking to see those separated out to see how the fully insured plan is performing?

Member Viton: I guess I am curious if we're actually incurring a loss on a fully insured plan.

Member Rich: Laura Rich for the record. We blend those rates. The reality is the cost of the HMO is much lower than the cost of the EPO. And the reason why is because the cost of health care in the south is much cheaper than it is in the north. We don't do that with any other plan. We don’t do that with the way we pay employees. In order to keep it fair, you blend those rates. That's where the confusion is coming in is we combined the self-funded and the fully insured and it just becomes a little bit confusing and convoluted. But I can see why there's confusion around this and maybe Jim you can weigh in on this.

Chair Wells: When we first did this there were two HMOs, the HMO in the north we blended with the HMO in the south for the premium side. The renewal from the HMO came in so high that it was determined we could better provide that benefit under an EPO plan, a self-funded EPO plan but we kept the benefits similar and this case we continue to blend the premiums for the north and south.

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Executive Officer Carsten: Help me understand, Chris. I think your concern is the premiums might be blended, so the revenue coming in might be the same for each plan. Your concern is the expenses or the expense losses for each plan. The performance.

Member Viton: I was curious. Yes. And I understand I'm sorry to interrupt. I appreciate member Rich's explanation. I do understand now why it has to be blended on this page. I was asking because it's not lost on me whether Low Deductible, High Deductible combined. We have the issue of the migration and the challenge between not having adequate differentiation between the High Deductible Low Deductible plans in FY26. I think we made changes in 27 to try to create a greater differentiation but in in that year those two plans in the aggregate were closer to break even and it's the HMO EPO that are not and I understand why they're combined answers my question.

Chair Wells: Any other questions? All right let's continue.

Ms. Donaldson: Okay, great. We're going to then dive into talking about, and some of these have already been discussed, some plan design scenarios. Option A is eliminating the EPO and HMO and enhancing the plan design for the Low Deductible PPO plan. We'll go into that. We're projecting about $8 million of savings. Option B is changing that HMO from a fully insured to self-funded option. Not changing the plan design per se, not changing benefits, but just changing the funding structure. I want to make sure that's very clear. The funding structure from fully insured to self-funded. That is projected to have a plan year 28 savings of $7 million. And we can go into that in a little bit, but that is just getting profit out of it. Admin fees and different cost of those hard dollar costs. There's a savings there to going self-funded. Option C is the decoupling that we've talked about. Again, we're projecting yes, there's savings on the actives. It's being offset by additional costs onto the retiree rates because of the blending today in a single risk pool. Net it's about a million dollar additional impact when you look at that in total.

Let's dive into option A right now. The actuarial value again, we designed a plan to enhance the LDPPO, so that's increasing the plan by about a percentage point. In addition, we have also updated the specialty pharmacy benefit in the Consumer Driven plan as well as the LDPPO plan. We'll show those plan designs on the next page. The additional thing we have to take into consideration is for plan year 28, the Consume Driven health care plan, the deductible has to increase to comply with IRS requirements. We incorporated that. Of the savings, we're showing a savings of about $8 million. Most of it is associated with moving that HMO to a self-funded arrangement.

As we were thinking about plan design, we wanted to look at options and enhance the Low Deductible health plan with not incurring additional costs to PEBP because of the financial situation that they're on today. As you can see in the right hand side, we did increase the deductible from $300 to $500. That was basically based upon output from the benchmarking study of Milliman where that $300 was well below benchmarks and even the $500 is still well below benchmarks. We are increasing and proposing an additional deductible. If you guys

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remember, it used to be at that amount and then there were plan design changes in 22 23 that brought that down and we are suggesting that that maybe go up to where it was in historical level. On the offset, if you can see on the out-of-pocket maximum, we're proposing a reduced out-of-pocket maximum. Based upon the Milliman study on other public sector entities, I think the average was about $4,500 for the individual and we're proposing that to be even lower. The thought behind that is to really make a difference between the Consumer Driven plan and the Low Deductible health care plan. Offering a lower out-of-pocket maximum at the same time by slightly increasing that deductible by $200.

We've also proposed potentially making changes in urgent care as well as emergency room, lowering those amounts as well as lowering the co-pay per visit for outpatient surgeries. With regards to the pharmacy, you'll see that on the specialty line for both Consumer Driven and the LDPPO, we're suggesting a reduced min and max of 75 and 150. That was previously $100 min and 250 max. And really the thought behind that is these are for drugs that are not subject to SaveOn SP program where many of those specialty drugs can get dispensed at a $0 or very low cost for members and it's for those drugs that are not covered by the SaveOn SP, but really helps for members who are on these drugs potentially not by choice. Specialty drugs, cancer drugs, and other such as cancer drugs, some of those specialty medications. Trying to ease the burden a little bit for members. With the plan design option B, it is really just changing the funding structure. It's changing it from fully insured to self-funded. Option C is the decoupling on slide 14 which is showing that for actives there would be a reduction of about 4% in the rates which quantitates into about a $19 million savings and then for retirees it is about a 27% increase which represents about a $20 million savings. We'll go into tier analysis and then maybe we'll stop.

Chair Wells: Member Rich.

Member Rich: I actually have two questions specifically on changing the HMO to self-funded. Can you go into where those savings are because I know right off the bat you've got your fully insured plans. You're not paying the 3 and a half % premium tax. So that's a huge savings to begin with. The whole reason that the HMO is still around in the south and not in the north is because originally when the analysis was done it was shown that PEBP could not run the plan in the south more efficiently than HPN, how they were running it at the time. I understand that things have changed. This was a long time ago. I just want to get an understanding of where you came up with the seven million.

Ms. Donaldson: It's mostly in the hard dollar fees such as administrative profit and the tax that you were talking about. I'll just share that this plan, we have noted and I think last year it was presented to the board, fully insured plans have to meet loss ratio thresholds and plans in general have to say that they have to have at least an 85% loss ratio and if not they have to return funds back to the plan. For last plan year they did not meet that 85% threshold which means they were capturing a lot more profit. That means they were taking in premiums much higher than their costs so they had to return money back to PEBP. We're anticipating that same there is a return.

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They are not meeting the 85% loss ratio again for plan year 26 and there are funds that are going to be returned back to PEBP so that's part of it. The plan is taking in more in premiums than expenses. It's really just the hard dollar costs that we're showing here of around $7 million.

Member Rich: Okay. My second one was not really a question. It's really around the decoupling. I appreciate the information and the work that's gone into even presenting it to us. This is a legislative change. This is not something that the board can really make a decision on or take action on today. I just wanted to you put that out there that I don't know how much control we have over this. I don't know if it's even an agenda item that we can do anything about.

Chair Wells: Any additional questions? Member Zumtobel. Member Davis.

Member Zumtobel: Thank you. I'd like to follow up on Laura's question about the HMO. I think the description made a lot of sense of the hard savings. What was the amount of the refund in the last two years roughly? Do on the 85% medical loss ratio? Didn't you just reference that?

Executive Officer Carsten: Theresa Carsten, for the record. We believe the last year was around $300,000 and I think the email I saw recently is for $220,000.

Member Zumtobel: Okay. Not a big part of the 7-8 million savings, but some. They do run a tighter ship than we run on the self-funded side. I don't think we should necessarily assume that we're going to run it at the same number they ran it at. The other thing I would caution us about, and I'm all for self-funding, so I love the idea. The risk is unless we have access to Southwest Medical or Optum Medical in our PPO, and I'm not sure that we do, there's a lot of displacement that will occur with members. Their staff model group. A lot of people will lose their doctor. I think we need to understand if we have access to those providers before we would make this decision.

Executive Officer Carsten: Theresa Carsten, for the record. I think this was last year's presentation on elimination of the HMO. Segal had done a network analysis and Debbie, I don't remember if you remember the figure but it was very small, a very small number of doctors that were not in the UMR network that are in the HMO network and we can bring that information back. I know networks change quite frequently. I don't expect that they would be that different but with that being said, going out to procurement for a different network would maybe not yield the same results. I think that's definitely something to consider. I know when we talked about this last year, there was, I want to say, six doctors that weren't in the network comparatively.

Chair Wells: My understanding is that Southwest Medical is now in the network that we use for the CDHP and the PPO.

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Member Zumtobel: If we know that for sure that's helpful. Great. All the benefit changes on the Low Deductible health plan, the little bit of increase with the deductible and then some of those other changes basically net out to 1%. Is that the right way to interpret it? 1% actuarial value increase.

Ms. Donaldson: Correct. Board member. It's an increase in actuarial value of 1%. That is correct. Mostly driven by out-of-pocket maximum, but yes, we have lowered the amounts of co-pays for some of the services.

Member Zumtobel: Okay. Thank you.

Chair Wells: Member Davis. Any questions? I have one. When we talk about the HMO, they use capitated payments. When we when we move away from that capitated payment to the providers and move to a reimbursement model under a self-funded plan, did your model take that into consideration? Were you able to get enough utilization data, enough detailed information data to tell that difference?

Ms. Donaldson: Chair Wells, we did not get that information. That is definitely something we would have to dive in more. One of the thoughts is potentially and I think Milliman noted this too is potentially, if the Board was interested to pursue this a little more. One of the ideas is potentially look at a tiered network. Which is a tier one is a more cap if you will, but going to those high performing providers versus tier 2. That would be something potentially to explore with this type of change that we would have to investigate. But no, we did not look into that because of limited data and we'd have to explore that further with UMR.

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

Ms. Donaldson: Great. The next section just to set the stage from a financial perspective this is a zero sum game. What we're presenting here is to shift and change subsidies based upon the cost within each of the tiers.

Ms. McClendon: It's the approach we've taken on the medical side. Folks are paying for the plan and that they're having to pay for the richer benefits. This is assessing the people that are covered within the plan and what their risk is and how that affects the plan and charging a more appropriate rate. In total it's not going to change but then by tier we actually do see some changes to the premiums themselves that people are having deducted. We'll just start at the top box. The current tier ratios, right now it's a two factor for employee + spouse. So that's assuming an employee and a spouse are the same risk and have the same costs. When we look at the experience from the past five years, we do see that spouses do tend to cost more. Sometimes there's some anti-selection. They're picking the plan when they need it. If we were to adjust the tier ratios to be more reflective of the past experience, we would recommend increasing the 2.0

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to the 2.2. Reflecting the fact that spouses cost more. We also looked at children as well and right now the factor that's applied to calculate the rates is a 1.37 when we look at the experience of those children we actually see something more like 1.45. We would recommend increasing that slightly. Both of those changes impact the combined tier factor for the employee plus family. The 2.375 effectively goes to 2.65.

We do have an example at the bottom to show once you apply these tier factors, how would that impact rates? You can see the first section is actually CDHP. We have a typo there, apologies, but that's the CDHP current 2027 rate and what it would look like if we had applied these tier factors. You actually see a reduction to employees. And that's because we're looking at the total and there's no impact there, but the family and spouse tiers are going to pay more. The employee would actually see a reduction of about $9 on the CDHP and $21 on the LDPPO. For spouses and family, we do see increases and that's mostly driven by the spousal factor being updated. Potentially $20 and $40 for employee plus spouse tiers and then on families between $30 and $70 depending on the plan. The employee plus children, again those children, that factor is not changing by that much. So not as much of an impact.

Ms. Donaldson: Essentially what we're saying is that spouses are costing about 20% more than the active employees. What this exercise does is just reallocate and remove the employee only tier is subsidizing the dependents. This is removing that subsidization similar to what we did with rate setting with Consumer Driven plan. That is what we're proposing and showing here to true up so that members within the tiers are paying the appropriate amounts.

Chair Wells: Questions from board members on that?

Member Zumtobel: I have some questions. Tom Zumtobel. The first grid, I just don't understand how one gets to the next. I just want to make sure. I understand that you identified that spouses end up costing more and it looks like families cost a little bit more and so that projects out to the suggested tier ratios and then we have the Consumer Driven plan and the High Deductible plan. Are those exact same ratios applied to both of these equally, down below?

Ms. Donaldson: Correct. Yes. We're looking at the total PEBP membership. We're not looking at each plan and determining tier ratios by plan. The tier ratios above is looking at the total PEBP self-funded membership.

Member Zumtobel: That $55 rate currently though that you have as 2027 is what the rate would be in 2027. The $55 for an employee?

Ms. Donaldson: That is the rate today. That is the plan year 27 rate today that members are paying in the employee only tier and that should say Consumer Driven health plan in the second tier if you updated the tier ratio that $55 should really be $46.

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Member Zumtobel: But is it still 27 or is it 28?

Ms. Donaldson: We're showing illustrative rates looking at plan year 27. This is just an illustration, member Zumtobel to show how plan year 27 rates would change with updated tier ratios.

Member Zumtobel: Okay. We're not talking about 28 rates at all. You're just giving us an example currently.

Ms. Donaldson: That is correct.

Member Zumtobel: Okay. That makes sense. It would go down a little bit. On the Low Deductible plan, it also goes down, but why do those go down? Because they don't change up above. The ratio is one and then the five year it and the suggested ratio is one. Their actual experience you're doing 1% of their true experience or one times their true experience that's why it actually goes down?

Ms. Donaldson: Yeah, it's a math formula, member Zumtobel. It takes into effect all the updated tier ratios and so it reallocates what the employee pays. Even though we're using 1.0 in both scenarios. You're correct. But how it's allocated changes. Yes.

Member Zumtobel: Okay. This is not necessarily proposal or something we're going to make a decision on. This is just informational at this time?

Chair Wells: The chart for the bottom is informational. The chart at the top is part of what is in the board policies and procedures for how we set rates. This isn't going to affect 2027 rates. If you approved a change, it would affect 2028 rates going forward.

Member Zumtobel: Okay. Thanks, Chairman. I do have one. I made a mistake a couple years ago and I'm still bailing myself out of it and it's the employee plus child, employee plus children. I wish I had done five tiers at the time and now I moved to five tiers because it tends to be more expensive than for single moms or single dads with one child. I think this model is something that we need to consider. I like that it feels like a fair rate if you have multiple children, but if you're a single with one child and all of a sudden you're paying $100 more for your kid to be covered than a single employee is. What's your thought on that or what have you seen people do in that regard?

Ms. Donaldson Chair Wells, member Zumtobel. I've seen it vary across states. I've seen two tiers. Some states have two tiers. Employee only and then everybody else. It truly varies across state entities and I don't know if there's consistency from what I've seen. It truly does vary and it really is dependent upon what you think is best for your members.

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Member Zumtobel: It can get punitive for us for a single parent and with one child is the risk that we have to be aware of.

Chair Wells: Member Harper.

Member Harper: Blaine Harper for the record. I know that the illustrative rates are about what plan year 27 would have looked like. The Board adopted a phase in approach for rates over two and three years for the LDPPO and the EPO HMO plans. I just want to highlight that this change would increase what is already going to adversely impact participants. It would be useful to see those numbers for perspective for plan year 28 based on what was already discussed by the Board previously. I think that there's no benefit to this, there's no change in overall costs. There's no savings and it's playing a tug-of-war between participants and the plans.

Chair Wells: Any other questions? Okay, seeing none.

Ms. Donaldson: All right, moving on to the subsidy analysis. This is looking at the subsidy, the AEGIS and REGI base subsidy and the allocation of this across all plans. Today, the AEGIS and REGI percentage is based upon the Consumer Driven health plan rate. You can see in that first line it takes the total rate and it says okay AEGIS is going to pick up 93 and a half % of the total cost in the employee only rate i.e. members in the Consumer Driven health plan are going to pay 6 and a half %. For the dependent, it is going to pick up 68 and a half % of the dependent portion of the rate. There's the employee only portion which is at 93 and a half and then the dependent portion is at 68 and a half %. Similarly, for the REGI for the retirees, the plan is picking up 70% of the Consumer Driven health plan total retiree only rate and then for dependent it's 45% of that dependent portion of the Consumer Driven health care rate.

We have shown on the bottom how those percentages play out by tier and then by plan. You can see because the cost in the LDPPO and the EPO plan are more expensive, that AEGIS and REGI amount is going less further than the Consumer Driven health plan. Now, there's pros and cons to that because it's driving people. The good news is right now it's incentivizing people to use that Consumer Driven health plan, and there's a lot of benefits to that from a financial perspective. We're going to talk about some different kinds of proposals and there's a lot of different scenarios you could take into play for this. This is just some ideas, but if there's others, we're open for that as well.

Chair Wells: Just for clarity on that, the retiree portion that is for a 15-year retiree not adjusted for years of service.

Ms. Donaldson: Yes, that's correct. Thank you. That's a great clarification. Thank you. Let's look at the different subsidy scenarios. Scenario one, we'll go into more detail, is saying, let's return the AEGIS and REGI based subsidy to what their historical levels are. It's about a $6 million

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savings. Scenario two is saying we're going to take the Consumer Driven health plan and further incentivize. If members want a low dollar premium plan, i.e. zero dollar, let's give a zero dollar employee only Consumer Driven health care plan premium. What does that look like for the rest of the dependents reallocating it? It's zero dollar cost impact overall. No changes to the REGI. The AEGIS based subsidy in scenario three is going to look at different percentages that vary by plan. Instead of the 93 and a half, we're going to give some more to a certain extent to the LDPPO and EPO, but we're going to increase those percentages in those plans. Again, not much of a savings there. It's really more of a reallocation, if you will. Scenario four is saying, Okay, we're going to reduce the AEGIS base subsidy by 5% and we're going to also reduce the REGI base subsidy. That is about an $8 million savings. When we're thinking about, we wanted to give the board alternatives because of the financial situation and where we're at today, potential opportunities for savings while trying to maintain the employee portion of the subsidy intact. And then scenario five is changing for the REGI based subsidy and we'll go into more detail there. Changing only the REGI based subsidy keeping the AEGIS the same and that's about a $9 million savings. Let's dive into it.

Scenario one and again there was changes to increase the subsidy levels. This is in scenario one returning them to more historical levels. That historical level is 93% for employees, 68 for dependents for the actives. REGI is 64% and 39% for dependents. You can see the savings there. It's a couple million dollars for the AEGIS for the actives and it's about a $4 million savings associated with a REGI account. We have also provided, again these are illustrative based upon plan year 27 premiums, with this change how would the premiums change similar to what we did with plan design changes and with I'm sorry similar to tier ratio changes? You can see for the AEGIS there is some changes but they're fairly mitigated. We are seeing a little bit more impact on the REGI account for the retirees. Scenario two as I mentioned is returning the Consumer Driven health care plan. Not returning but moving the Consumer Driven health care plan premium to $0 and then reallocating the AEGIS amount such that it's a zero sum game.

What does that look like? That would be looking at instead of the 68 and a half it would go down to 47.4% for dependents. You can see in the illustration that $55 for Consumer Driven would go down to zero. That $55 savings is shared across all of the other plans because all the other plans are based upon that amount. We are seeing some increases on the other tiers associated with less subsidy for the dependent. This is actually being prompted when we were looking at strategy in July. When we were looking at what other plans, public sector plans in Nevada, how they do their premiums and how they subsidize. What we did see is there is more subsidy for the employee and less subsidization for the dependent. This was an alternative for you all to think about saying, okay, this is providing a zero premium plan for your employees. Zero premium in the Consumer Driven, but unfortunately, yes, dependents would have to pay more. But again, it's being in line a little bit with what we're seeing on the benchmarking for other public employers in Nevada.

Scenario three is looking at different subsidies by plan. We had a lot of internal conversations about this because we looked at a number of different scenarios and as we present different scenarios we also have to think about how this is going to impact the plan overall. If

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you change dramatically the allocation of the base subsidy for AEGIS for the LDPPO and EPO, you're going to incentivize more members into that plan and we know that that plan costs more. That's going to be cost increases to PEBP. We were thoughtful about that and we looked at various different scenarios and again we can come up with more if the board pleases, but we landed on 95% for this illustrated subsidy for the Consumer Driven plan, 75% for the Low Deductible and 65% for the EPO HMO. Again, dependents, the percentage is a little bit lower. We're trying to get to a zero-sum game. There's a million dollar savings, but essentially a zero-sum game. The dependents are at 40%. You can see that in this scenario in line where based upon what we saw from benchmarking, the employee only premiums across all plans are decreasing for the Consumer Driven and LDPPO. For all the other tiers, we are seeing increases in that purple box to the right, but the EPO plan, we're seeing some savings.

Scenario four. I know this is a lot. Scenario four is saying we're going to reduce the spousal and retiree subsidies. You can see that the spouse's subsidy is going down for the AEGIS five percentage points. From 68 1/2 to 63 1/2. The REGI is going down from 39 to 29. And that is going to generate about $3 million of savings for AEGIS and $5 million for REGI. Note for the children, we kept that subsidy at the 68.5% on AEGIS. Just reducing the subsidy for spouses. Again showing the differences. We are seeing increases in the spouse tier for AEGIS and in the family but no change in the employee only and employee plus children. We are seeing some changes for state retirees. Last, if you're still with me, scenario five is we're going to return the REGI subsidy to the historical level again from 70 to 64%, but we're not going to subsidize dependents. And so that generates about $9 million of savings. Here we're showing the difference here for retirees. It's going up $48 on a monthly basis for the retiree only, but obviously dependents are going to pay their own way and pay the full rate. Before we take questions, we wanted to show a combined scenario that incorporates multitude changes to give you guys a sense of magnitude of savings.

Ms. McClendon: This incorporates the plan design and the subsidy scenarios that we just reviewed. First, taking the plan design, this shows eliminating the EPO and HMO, some of the changes to the specialty medical and pharmacy plan designs for LDPPO and CDHP. Making those changes option one I believe it was and then applying the change in subsidy. Returning back to the historical levels. Going back to the 93 78 for AEGIS and 64 39 for REGI. Overall if PEBP retains the savings fully and then shares the subsidy would be about a $14 million savings if you add those together.

Chair Wells: Questions? Member Harper.

Member Harper: Blaine Harper for the record. What does historical levels mean? What year are we talking about? Because we only have two years available of back records on the PEBP website right now about the various board meetings.

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Ms. Donaldson. I think the 93 and a half change was made in the last biennium is my understanding. It used to be at 93%. Honestly, I'm not clear of when the retiree subsidy changed. I'll have to go back and double check the year for that.

Member Harper: I guess more of a comment. An overall observation that some of these ideas have come up before. The EPO HMO conversation happened in multiple years. Zero sum is a phrase that I used in a September 2023 public comment about something that was going on then. I think none of this requires board action today. A lot of this looks like the kinds of materials that would be presented for the November meeting.

Chair Wells: I will tell you the 93 that those historical rates when we made the significant plan changes in 2011, those were what were put in place. When they changed to the 93 and a half % and when they increased to 70% for retirees, I don't remember the discussion being around it but they were also in the board duties policies and procedures. The board duties policies and procedures are there to help the board set rates, not artificially change premiums to reflect what they want when the rates come out. There needs to be a policy for this. The board needs to adopt a policy. The board has not adopted this policy today. The Governor's Office, the GFO, and the and the Nevada Health Authority will have to do it because they've got to put together a budget and they can't wait for the board anymore. Today is it. If you want to make changes to the subsidization policy. It should have been in the policies and procedures all along. When it got taken out, I don't know. I've been trying to put it in for almost a year now. If we don't put it in today, then the Health Authority and the Governor's Office and the GFO will have to determine what that proper percentage allocation will be.

Member Harper: Blaine Harper for the record. How do these proposed subsidization structures relate to the previous board action of the planned phase in? Because some of these would overwrite those prospective decisions. If a percentage basis is applied by plan.

Chair Wells: You would still have the phase in for the HMO/EPO, next year it's fully implemented. For the LDPPO, you would still have a one-year remaining phase in that would have to be adjusted regardless of whether we change the percentages or not.

Member Harper: Blaine Harper for the record. I think that some of these reintroduce the cross plan subsidization that currently isn't part of the board's decision in the phase in discussion.

Chair Wells: Where do you think that occurs? I don't see that.

Member Harper: Blaine Harper for the record. If a fixed percentage is adopted as board policy and that is what the board follows then when costs are changing differently across plans there will be an enhanced subsidy for plans that are costing more, where the expenses are increasing the most.

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Chair Wells: We made that comment. I made that comment at the last meeting because we continue to do the subsidization percentage based on the CDHP, which if you looked at the Milliman presentation, the CDHP had a lower utilization and inflation increase. That's not going to go as far. Those other two plans with the higher inflation and utilization increases are going to continue to cost more as long as we continue to base the subsidy on the CDHP and that has been in place. You may know when that change was because we used to do different percentages for different plans and at one point it was changed to be the same subsidy across all three plans. There was, I forget which number, three I think that was how it was done originally. There was different percentages for the different plans and then at one point in the past it was changed to say we're going to do the same subsidy regardless of plan. I don't know when exactly that happened.

Member Rich: Laura Rich for the record. When the Low Deductible plan was introduced there was a discussion with the board about being plan agnostic. They're all self-funded plans. We don't care which one you choose, but that also requires that the plan gets priced appropriately as well. I think that's where there was a disconnect.

Chair Wells: Any other questions? Member Duncan.

Member Duncan: Keiko Duncan for the record. I'm trying to understand member Harper's comment as well because wouldn't creating the subsidies by plan thereby relatively eliminate the cross subsidization between employees and retirees because I understand didn't we have a conversation during a board meeting previously about how the employees were essentially subsidizing the retirees up to a certain percentage? Wouldn't doing this essentially separate that creating a subsidy specific to the plan and the tier?

Chair Wells: No. Because the subsidization between actives and retirees is built into the base premium. The base premium for both plans the same. There are slight differences in the life insurance that account for the difference in the total premium. There used to be a couple other differences, but I think now it's down to just the difference in active life insurance is a higher dollar threshold than retirees. That's the only difference in the premium. The subsidization between retirees and actives is already built into the single premium. The only way you get that is to separate the risk pools.

Member Duncan: What about between the employees and the children and the spouses? That sort of round of subsidization?

Chair Wells: The first slide, the one that had the tier ratios the one and the one so that would affect how you are allocating money between the tiers. Right now, we do it based on what's in the current column. What they're saying is based on the last five years, what's in the current

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column, what we're allocating to families to those people with dependents is really costing more than what we're allocating to them.

Member Duncan: Got it. Okay, I'm following.

Chair Wells: If we were to change and do the suggested tier ratios, yes, the box at the bottom shows that those with dependents would pay more, but the tier ratio analysis says that they're costing more. That would realign the tiers into the box or into the different tier or would realign the premiums in the different tiers to reflect the actual cost of the dependent.

Chair Wells: Member Harper, you had your hand up.

Member Harper: Oh, I think member Zumtobel.

Chair Wells: Member Zumtobel.

Member Zumtobel: I align with member Harper. I just don't quite understand. She understood it better than me, so I don't want to throw her in that boat. One thing that makes it hard for me to figure out what we're trying to accomplish and I understand there's rebalancing, but when we call it savings, it throws me off in the first place because it really is just cost shifting to the member. The plan doesn't save any money. We just shift the cost to somebody else.

Chair Wells: Under the scenarios that have savings it means that the state would contribute less, that the employees would contribute more and that the state would contribute less. I don't think that there's a recommendation that we reduce the state subsidy but in other words use that to rebuild the reserve use that difference to help rebuild reserve. We wouldn't ask the state for less money but we would use that difference to help rebuild reserve.

Member Zumtobel: The objective is to create a scenario where the state has less obligations and the employees have more obligations, but we're able to rebuild the reserves. Is that the objective of this conversation?

Chair Wells: Not necessarily. The conversation really needs to be what is the correct subsidization policy for these four groups of people? Employees and their dependents and retirees and their dependents. There's been a lot of discussion about the local government entities in Nevada offering a zero plan that we do not. If you want to do that and stay cost neutral and we subsidize dependents at a higher percentage than local governments do, that's a policy decision. Is that the policy decision that this board wants to continue to subsidize employees less and dependent more? The same thing with retirees. There are probably a handful that have any subsidization for retirees at all. I guarantee you that none of them are at 70%. It's a policy decision. You have a bucket of money. How does the board want to allocate it? If the board

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wants to leave it with employees paying a higher share and dependents paying a lower share than their local government counterparts, that's a policy decision, but it's one that the board needs to address and actually decide on.

Chair Wells: Member Rich.

Member Rich: Laura Rich, for the record. I agree. I think decisions need to be made. The board can't just keep kicking the can down the road because either we make decisions or decisions are going to be made for us. I feel like at some point if we don't make a decision then we are not going to be able to complain about what the outcome is after this because we're not going to have a say in it. I do think that a decision needs to be made. In terms of specific just to the subsidies it's been made clear that actives are essentially subsidizing retirees at a higher rate than has been historically. And I don't know when that changed or how that changed, but it has changed. We are subsidizing retirees. I'm going to go back and I'm going to use the term early retiree because I think somewhere in public comment there was something along the lines of we are affecting the grandmas and grandpas and really trying to stick it to them. That's quite honestly fear-mongering, these are not grandmas and grandpas these are early retirees. Mr. Wells is one of them who have the luxury of retiring early. They have likely other jobs. These are 50, 55 year olds that have other jobs that have retired early and they probably have access to other healthcare plans. They are remaining on the PEBP plan because it's probably very likely a much more rich plan than what is offered in their new private sector position.

I don't feel like we should be subsidizing those folks at the expense of active employees. Especially since active employees don't even get this retiree, the new active employees. If you were hired after 2012, you do not get this. You've got a large group of active employees right now who are paying into a system to subsidize retirees at a higher rate for something that they are never going to get access to. I think that's very unfair to begin with. I think member Grimmer is on but I would assume that this is probably having an impact on our ability to retain or to bring in and also retain our workforce. I think these are all things that we need to consider.

I am looking at two scenarios here and I don't know maybe if we can do a combination of both but I do like scenario four and I also like scenario five. Scenario five reduces, basically eliminates the subsidy for dependents and the argument for this is I feel like when these people signed up for state service, they signed up with the promise that they would have access to healthcare when they retired. I think you need to keep that promise, but at some point did we promise fully subsidized dependent care? This is not that they don't have access. We're just not subsidizing the dependents. You still are giving them access to the plan and access to health care. You're just not subsidizing the dependents. You're subsidizing the early retiree. I do like scenario five. I also like scenario four because where we're bringing the subsidy. I like the subsidy rates for the employees and bringing those spousal rates down and really focusing again on the actives because again we have spouses who are on the plan who likely have access to other health care through their own employer. Yet we're covering them on the PEBP plan even though it is a policy decision not to if they have access but there's really no way to enforce it. I think that this is just

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another way to really encourage those people who have access, if their spouse has access to healthcare through their own employer to leverage that. We're really again focusing our priorities on the active employees and I feel strongly about that. I think that active employees, we need to serve our active employees and that should be our focus.

Chair Well: One comment and then I'll go to member Harper who had her hand up. There is nothing that says that these five are the only five and I believe that Ms. Donaldson and Ms. McClendon are ready to adjust and give us some alternatives if we want to see what some other combinations or variations might be. Member Harper, did you have a question, a comment?

Member Harper: Blaine Harper, for the record. To point out making sure that we're keeping in mind the non-Medicare retirees. I don't know how large a proportion that is. Maybe it's a tiny sliver on the pie chart that showed 90% active, 10% pre-65 retiree. That is a population. Anything in the policy the way that it's updated given that that's the time-sensitive issue for the board today it should be clear on.

Chair Wells: You're referring to the pre-86 hires that don't have access to Medicare part A? I don't know that number. It is dwindling but I don't know what the exact number is at this point.

Executive Officer Carsten: I don't have a count on that right now we can try to find that.

Member Rich: Laura Rich and that can always be a carve out. I don't know what the number is either but that can probably be a carve out. That small group of people to ensure that the impact is mitigated for that small group of people because those are the grandmas and grandpas. I would support something like that and maybe that's something to look at.

Chair Wells: Any other questions comments. Member Duncan.

Member Duncan: I really appreciate some of the comments you made member Rich and especially hearing from some of the public comments. I really feel like I think member Zumtobel said something very similar. I really feel like we have of course a fiduciary duty to make a sound decision here and ensure that we are not insolvent, but I think we also have an intergenerational duty, if you will. I'm wondering what sort of combination of some of these subsidy scenarios would apply all of the above. At first glance, I'm seeing the subsidy varying by plan.

In scenario three, eliminating to some extent the cross subsidization by tiers in combination with a subsidy scenario of four, reducing the spousal subsidy and reducing the retiree subsidy, not necessarily completely eliminating the dependent subsidy entirely as is in scenario five. I feel like some combination of these two would span the gap a little bit better. That's just my opinion. I also am curious if, well no, I'll leave that there. I don't know if anybody has another comment on that, but I think maybe my question for Segal would be is that even possible to combine essentially those different types of tiering?

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Ms. Donaldson: Point of clarification. Can you go to scenario three? I want to make sure I understand. Scenario three we are showing it varying for employee by plan and to get to basically a net neutral or it's a million dollar savings the dependents are going down 40%. If you wanted to add, that's just for the AEGIS. If you wanted to add I think what I heard the REGI scenario four. That would be a $5 million savings. To REGI, if you did the 64 and 29, so that's a question. Right now, you're at 70 for retirees. Looking for a little bit more direction there. It's reducing the subsidy for dependents as well. Historical it's 64 39. It would be 64 29. Scenario three is reducing the subsidy for all dependents which is down to 40% because we're giving more to the employees. In the LDPPO, well, actually in all groups, from a percentage. It's going from the Consumer Driven to 93 and a half to 95. It's increasing the LDPPO and the EPO HMO subsidy percentages for the employee only. If we move the dependent any higher than 40, you're going to start generating costs unless you change the subsidies, unless you lower the percentages for the employee only.

Member Duncan: In that case, Keiko Duncan for the record. I feel like four would actually then therefore be the most balanced.

Member Rich: Laura Rich, for the record. Chair Wells, can we take these as like pieces because I think there's a lot of decisions to be made and I think this is just the subsidy scenario but then we have the HMO earlier in the deck so maybe we take them as pieces?

Chair Wells: Yeah, we're absolutely going to take them as pieces. This was a discussion of where the board was for percentages on this piece. I need to go back to agenda item number seven which includes a couple of other things that weren't really addressed in the presentation and does the board want to make any decision regarding Disease Management Care Coordination, Pharmacy Benefit Coverage and Contracting Procedures for the board to take to consideration for FY28? Do you have the slide?

This was the recap from the last meeting on things that we may or may not want to pursue as a result of the strategic planning session in July. Now it's time to give the staff some directions on where we want to go. I think on the pharmacy side, I would table the pharmacy side because we're in the in the middle of now is it's been released, correct?

Executive Officer Carsten: It's expected to be released as soon as we get feedback from CMS, the PBM RFP. Yes. We're thinking within the next week or so.

Chair Wells: It's imminent that we're going to release

Executive Officer Carsten: That's what Maria told me, end of the month. That could be 28 days.

Chair Wells: We're imminently going to release a PBM that's going to hopefully make a difference for not just PEBP, but for a variety of those that are under not just the Health

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Authority. I think it's being expanded beyond that. That leaves the disease management. There was some discussion about the whole person vendor procurement, expanding the Carrum Centers for Excellence, and improving contract terms for utilization and disease management through contract amendments. Is there any of those three bullet points that the board wants to have the staff start to enter into either RFP or negotiations to do any of those three things?

Member Rich: Laura Rich for the record. I think looking at improving the contract terms, this is why the Health Authority was put into place and so I think that for sure should be an item.

Member Duncan: Keiko Duncan for the record. I would agree. I think to that point, the Nevada Health Authority is well positioned to leverage a larger purchasing pool of lives. I think renegotiating or improving upon those contract terms is going to be really important. I'm curious though because I think some of those improvements on the contract terms might also encompass some of these changes. I think we touched on that before as well where there might be improvements in various utilization management care programs which is maybe a little bit of part of the whole person vendor procurement and my eyesight is terrible and I can't read the other one. I think that's maybe a nice overarching. I still can't read it. Don't make me say I still can't read.

Executive Officer Carsten: Which one do you want me to read to you?

Member Duncan: Well, Jiminy crickets. I really need to get my glasses.

Executive Officer Carsten: You have eye insurance.

Member Duncan: I think my point is clear though. I think anything to do with the utilization management under contracting is a branch of the improvement of contract terms is really what I'm trying to say. Thanks Theresa.

Chair Wells: What I'm hearing at this particular juncture without any additional is that for now we're not interested in doing a procurement for the whole person care coordination and management. We're not interested in expanding the mandatory selection for using Carrum for Centers of Excellence. We are interested in looking to improve contract terms and through contract amendments to deal with utilization and disease management. Is that what I heard?

Member Duncan: Generally.

Chair Wells: Any other comments or questions? Anybody want to make a motion to that effect?

Member Duncan: Keiko Duncan. I'll motion what he said. Yes, I'll motion to move forward with the improving of the current contract terms, etc.

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Member Rich: Laura Rich. I'll second.

Chair Wells: We have a motion, a second. Any further discussion? Hearing none. All those in favor say I.

All Board Members: I.

Chair Wells: Any opposed? Nay. Motion carries. This is to have staff work on contract amendments to improve contract terms for utilization and care management. We'll hold off on the pharmacy until after the PBM procurement has been completed. That leaves the contracting procedures. Get that back up.

Executive Officer Carsten: I thought you were moving on. I apologize. There you go.

Chair Wells: Under the contracting, we had the expansion of the Centers of Excellence, coordinating with NVHA and CMS and then audit contracting revisions. I think our current TPA contract runs through June 30th, 2028. And I think that's why the Milliman presentation had plan year 29 as a start for any of the TPA contract renegotiations because that does take a while, one to do the procurement and to transition if we change to a different provider. I think what I'm hearing is that we would want to coordinate with NVHA and getting out a new procurement for the TPA as opposed to trying to procure one on our own. That we would look to expand like we did for the pharmacy benefit manager that we would look to coordinate with NVHA on a procurement for the TPA and to move forward with that procurement.

Any other questions or comments? Keep in mind that when we talk about the TPA at this point, there are three, is it three contracts that are part of that? It's the TPA, the network, and the utilization and case management. It's those three components. I'm hoping that the TPA or the procurement will potentially separate them if we can get better deals separate or combine it if it's that the RFP is written in such a manner that we get the best of everything. If it's all one vendor, it's all one vendor. If it's three different vendors, it's three different vendors. Is that part of the contract report number nine? I don't know that we need to do that one at this point either. Is there anything anyone wants to do on the expansion for the Centers of Excellence services at this juncture? Our audit contract with Claims Technology?

Member Zumtobel: Chair Wells does that include the conversation we had about Carson Tahoe and possibly doing a direct, would that fall in this category or do we need a different action to move them?

Chair Wells: I think that that's going to fall under the contracts agenda item number nine. I think that's going to fall in there.

Member Zumtobel: Okay.

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Chair Wells: Claims Technology. I was trying to see when they expire. That also expires June 30th, 2028. We'll need to be going out to bid for that contract for the claims auditor, claims based auditor also within the next probably year-ish. I think we'll handle both of those through the coordinated, I don't know what NVHA is doing on claims audits, but I think that's another one where I think coordination with the Health Authority looking at that with that forward. I think with those we'll hold that off until agenda item number nine. So that will conclude the items under agenda item number seven. Then under agenda item number eight, I think we're going to go back and have Amy share and then we'll start at the at the beginning of this one.

Is there any desire from board members to have a discussion about the three plan design option considerations which were the elimination of the EPO HMO, changing the HMO to the to a self-funded EPO option, and decoupling active and retirees? I think I heard member Rich say that that C probably just needs to be left to the legislature since it would require us to submit a BDR. It's really beyond the point where we can submit a budgetary BDR to do such. I think that we will not be discussing option C leaving options A and B. I'll be honest, after the discussion today, I don't know that this is ready because I don't think we've had the discussion about the change from capitated payments to what that would look like if we were paying on a fee for service basis.

If we're really interested in converting it to an EPO option or my guess is most of the savings from option A are also tied into the elimination of the profit motive and not addressing the potential for capitation payments not being anywhere near equivalent to fee for service items. Is there an appetite at this point to either ask for additional information and I don't know what that would look like? You're going to have to help us with what does the capitated payment model look like if we eliminate it and move to fee for service. How do we even start to look at what that costs?

Ms. Donaldson: Chair Wells, Debbie Donaldson for the record. It sounds easy, but it's going to be more complicated. It's almost like we need a claims repricing and looking at what the claims would be repriced under the capitated arrangement today versus what would be offered in a self-funded similar offering within UMR and what they could provide. Hopefully they'll coordinate with us and help us with that. We're not in an RFP so hopefully they'll be good partners with us in that. It's looking at that but the question is also, is there appetite to do any tiered arrangement along that as well and would like a little bit of direction from the board for us to explore that potentially as well.

Chair Wells: It's probably important to remember. I don't know if this has been part of discussion. I believe that there are rate caps, increase caps in the HMO contract. They can only increase their premiums by a certain percentage as they move through this five-year contract, but I believe that if they fall below or if they have a migration out exceeding a certain percentage that that provision is gone. You could see as. we get to renewal time that the FY28 rates for the HMO product in the south could go up significantly more than was already allowed in contract.

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Then the question becomes, it's really too late to do this for 28. Do we want to do an RFP to see if we can find either a statewide HMO or a HMO plan both north and south to replace the EPO and for HPN contracts. I don't know if we could do that. I don't know how long that

Executive Officer Carsten: I don't think that that would be feasible for 28.

Chair Wells: I think that's important to keep in mind that the FY28 rates for HPN and EPO could go up significantly based on the provisions in their contract that allow them to opt out of that rate increase cap. It's going to be a discussion for when the rates, we'll get those in January, we should have an overview of where we're headed for rates. We should start seeing some of the trend information from the actuaries. If you do the current schedule that we use this year of January and then basically setting rates in March you're going have to have information earlier. Hopefully we can get the initial premium information from them and then some trend information from the actuaries at the January meeting. That's where I'm at. Certainly, open to other comments or questions regarding the plan design scenarios.

Member Rich: Laura Rich for the record. I think we've heard from members that there's not really a desire to get rid of the HMO in concept. We know that the HMO is essentially in a death spiral. We have to do something about it. I do like the option of going back and doing the analysis of really what that self-funded option looks like. Debbie, like you had said, doing a claims repricing and just looking at it at a more granular level just to ensure that move would be appropriate. I do like that idea and then if there are other ideas similar to the tiering that might even make it more beneficial. But then again, would that be statewide or are we only looking at the south? I think it really needs to be a statewide. We'd have to look at the EPO in the north as well. Historically, the EPO and the HMO have tried to mirror each other as most as much as they possibly can just to keep that fairness between the north and the south. I think just as much as we can continue to do that, that would be good.

Chair Wells: I have one question. Does the EPO currently have a narrow network or is it the same generic network that we use?

Ms. Donaldson: Is it a narrow or generic?

Chair Wells: Does the EPO have a narrow network or is it the same network as the CDHP?

Ms. Huckaby: It's Choice Plus.

Chair Wells: It's the same. All right. One of the things that we could do is to look at a narrow network on the EPO that would mirror what we got at the HPN which is a narrower network. Maybe we look at that plus the capitated payments.

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Member Rich: Laura Rich for the record. I just caution and maybe Rhonda, you might want to jump in. A lesson we learned is that the EPO is administratively burdensome especially in the north where access is much less than in the south. When people are enrolling in the EPO plan, they don't realize that they're enrolling in a closed network like the CDHP, the Low Deductible. When they want to go places like Sacramento to get care, it becomes very problematic and they are caught off guard that this is not an option. Narrowing the network, especially in the north may just become an administrative headache.

Chair Wells: It could but it was originally an HMO to begin with. It had a narrow network. It was an Anthem HMO network and it had a different and a narrower network than the CDHP. At that time, it was just the CDHP but it had a narrower network and I think it's something that we probably need to explore. Doesn't mean we have to adopt it. I think we just should look at it. I don't know does that need a motion? Or do we want to just have to bring that back. Member Duncan, did you have something to add?

Member Duncan: I did, but then I was going to say what member Rich just said about the narrower network. I would be curious to see what it is. I think it's fair if we could bring it back and to maybe analyze that impact. I can imagine the difference in what the volume and type of care is today versus what it was before when we had that narrow network and how potentially our members now would be impacted differently. I don't know it just throws up some concerns for me as well.

Chair Wells: Any other comments or questions regarding the scenarios A, B, and C under the plan design?

Member Duncan: Keiko Duncan for the record. I did generally want to also agree that I don't think the elimination of the EPO and HMO plans, I don't know that that's necessarily the right option as well. I do like the idea of the self-funded HMO. I agree with this spiral of an idea and I think we have significant decreasing enrollment and drastically increasing PMPMs and potentially the increase in the premiums. I am curious if moving to a self-funded model would allow at least marginally a greater semblance of control for PEBP focusing a little bit more on true cost and not necessarily like Debbie what you mentioned earlier as well the premium tax and the insurers profit margins essentially that we're paying for. I do agree that we need to potentially evaluate a repricing because I think there might be a little bit of an offset there when you start looking at true costs as well. Just a ditto, I guess.

Chair Wells: I think that's the instruction. Do we want to do this as a motion or do we want to just have them bring it back? An option for narrowing the network under the current EPO in the north, a repricing of the capitated versus defer service type payments in the south and what that would look like as far as savings, comparing that to the insurance premiums tax and the profit margin.

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Ms. Donaldson: Yes and potentially looking at other network opportunities to help.

Chair Wells: That gets us through those. The next one becomes the tier analysis. Currently, the tier analysis that's being used, what I plan to do is update whatever the decisions are from today into the appendix for the document, the policies and procedures document and bring that back so that you see what it looks like. Right now, there's two choices. It's to maintain the current tier ratios or use the suggested updated tier ratios. This one I do want a motion on what the preference of the board is as far as the tier ratios. This is a policy decision. Comments, discussion?

Member Rich: I was going to make a motion. Laura Rich. I move to adopt the suggested tier ratios.

Chair Wells: A motion. Can I get a second? Keiko Duncan, seconded.

Chair Wells: We have a motion and a second. Any further discussion? The motion is to adopt the suggested updated tier ratios that are one for an employee, 2.2 for an employee plus spouse, 1.45 for an employee plus children, and a 2.65 for employee and family

Member Zumtobel: For discussion, Tom Zumtobel. I am troubled by that child only rate with a single, but I know that's a big move to ask everybody to make and so it's on my mind. The other thing is, I feel like when we make this decision that we're making a rate decision at the same time and we don't know the implications of that rate decision. Maybe I'm wrong, but I feel with these tiers, the rates that we've already dialed in are going to be different than what we've seen. It seems like instead of just what they look like in 27, we should be looking at what they're going to look like in 28. I know it's a policy decision. I understand what you're saying, chair, but I think the vote is a rate decision, frankly.

Ms. Donaldson: Point of clarification. I just want to make sure we're all on the same page Chair Wells. The CDHP rates for plan year 27, those are the rates that that are in place today. If you go over to the dollar change, just to be clear, for the employee plus children, it's only going up $2. It's going from $152 to $154. I just wanted to make that clarification. This decision is impacting the employee plus children tier by $2 for the Consumer Driven health plan and $3 for the Low Deductible PPO plan as an illustration based upon plan year 27 rates and what members are paying today.

Chair Wells: That is part of the rate discussion. You're correct member Zumtobel. That's what the impact would be. Member Viton.

Member Viton: Along the same lines as member Zumtobel’s concern, this decision may lead to stacked impacts when we get to the next decision on the subsidy question. We're looking at them

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individually and I know you want to take action on them individually but as we walk through this each one of them can result in some stacking changes and we're not seeing what the total impact would be as we're talking about them individually.

Chair Wells: That's correct. Further discussion? Hearing none. All those in favor say I.

Four board members: I.

Chair Wells: All those opposed? Nay.

Three board members: No.

Chair Wells: Three nays and four ayes. Motion carries. The ayes were Member Duncan, member Rich, member Barnes, member Davis. The opposed were member Viton, member Harper, member Zumtobel. Did I get that right? Okay. Now, let's talk about the subsidization policy analysis and I get from the earlier discussion and given what we just did to the spouses and those with dependents changing the tier ratio slightly. Is there any appetite to make changes to the to the existing subsidization policy that's in place? That's shown on slide 18. The 93 and a half %, the 68 and a half % for dependents of actives, 70% for retirees and 45% for retiree dependents. Discussion. And again, we do not have to live within the five scenarios. We can propose a different scenario and then take a short break and come back with what that scenario looks like.

Member Rich: Laura Rich, for the record, I like the compromise scenario that member Duncan brought up earlier. I think that it really addresses some of the issues that we need to address.

Chair Wells: Did you remember what that was?

Member Rich: That was scenario four.

Chair Wells: Four would basically decrease the subsidization for spouses, which given what the tier policy was, will increase the number for the employee spouse and employee plus family and it will reduce the subsidization policy for retirees and retiree subsidies or spousal subsidies from 70 and 34 to 64 and 39. Member Duncan.

Member Duncan: Keiko Duncan for the record. I hate to do this, but I feel like we need to see those changes because I'm wondering if based on the tiering changes to create that balance. I'm wondering if we don't need as severe of a change in scenario 4. I'm wondering if there is a good way because of that compounding change that member Zumtobel brought up. I'm wondering, I had previously, I don't know if I got the numbers correct but I think we had for the retirees specifically in scenario 4 I think it's proposing a 64% and then the spousal 29% and I believe a midway would be 67 and 37 because it was 70 and 45, I don't know.

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Member Rich: I don't I don't think we need to touch, actually it's the retiree right because we didn't make any impacts to the retiree. I think just the dependents.

Member Duncan: Yep, thank you wrong one.

Chair Wells: What I'm hearing is leave the employee at the 93.5 correct?

Member Duncan: Correct. Then impact the spouse and the children.

Chair Wells: The 68.5 is the current amount for dependents. Scenario four has reducing that to 63 and a half %. You're saying increase that 63 and a half % back to reflect what we just did all the way to the 68 and a half or somewhere in the middle?

Member Duncan: No, somewhere in the middle is what I'm saying. With the changes of tiers.

Member Rich: Can I just ask a question? Are you able to provide us with, I hate to put you on the spot because I know actuaries, you like to have real data and models but do you have an idea of what scenario 4 blended with the decision we just made looks like? Even if you could just give us an idea, not holding you to exact numbers.

Ms. Donaldson: We would need a break.

Chair Wells: We can do that. Let's do that, let's take a break. It won't take long I don't think to adjust the unsubsidized rates to deal with the adding the to change. Because we have them by tier and then look at what scenario four ends up being.

Ms. Donaldson: Point of clarification Chair Wells. Right now are there other alternatives so we can prepare. For the actives, the active employee only subsidy and the child subsidy is staying the same in as currently in this scenario. The only thing we're changing in this scenario is the spouse's subsidy, we reduced it 5% from 68 to 63. Question is, is that something you want us to come back with the updated tiers?

Chair Wells: Yes. And reducing the retiree dependents to somewhere between.

Member Viton: Chris Viton. Scenario four on the actives it's reducing the spouse subsidy by 5% and on retiree the dependent by 5%.

Ms. Donaldson: By 10. As well as the point of clarification the retirees going from 70 to 64.

Member Viton: And your request was on this active just to bring the spouse midpoint.

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Chair Wells: And possibly do something on the retiree dependent. See what that looks like.

Member Duncan: See what it looks like. I think those two different scenarios.

Member Viton: But not others.

Chair Wells: Are there any other scenarios that people would like to see? Not hearing any. How long do you need?

Ms. Donaldson: 10.

Chair Wells: Let's take 15 minutes. We'll be back at 1:20 pm.

Mr. Nguyen: Chair Wells, we're back on.

Chair Wells: Thank you. We'll call the meeting of the Public Employee Benefits Program Board back to order.

Ms. Donaldson: For clarification, we want to show you what we model. We're going to show you again, this was high level. We did it very quickly. I think it's going to give you guys good direction. But it's not pretty. What we're going to show you is not pretty. Just to clarify, what we're going to be showing you is a function of scenario 4 with the updated coverage tier analysis numbers using 1.0 for employee, 2.2 for employee spouse, 1.45 for employee children, and 2.65 for employee family. Scenario four, what we priced out.

Ms. McJoy: Can you make the screen bigger?

Executive Officer Carsten: You're going to have to zoom in Amy.

Ms. Donaldson: Scenario four for AEGIS, what we're looking at is with updated tier ratios and the subsidy for employee only of 93 and a half, for children of 68 and a half, and for spouses of 65 and a half. These are the differences that we're showing in illustrative plan year 27 rates how they would change in these scenarios. You can see in all cases that the participant only is going down because of the reallocation of subsidies because of the tier ratios. The spouse and the family are going up because of that reallocation. Spouses are 20% more expensive. Children are a little bit more expensive, but you can see in the participant plus children tier, the subsidy or the net premium is going down because that participant only premiums going down. There's savings in that tier. An employee only and employee plus child or children those tiers would see a reduction in premium. The employee plus spouse and family would see increases in premium.

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Again, these are illustrative plan year 27 changes in the premiums in each of the tiers. Did you come up with those numbers, Jim? For an active person. We haven't showed retirees yet.

Mr. Ervin: This screen is not showing to people online.

Multiple speakers: I'm seeing that it's on there. Everyone sees it. I don't know what to say. I'm seeing this.

Chair Wells: Can you refresh your web page?

Mr. Ervin: Okay. Thank you.

Member Viton: Chris Viton. I guess in the presentation slide 16 where we just added the impact of the tier, the employee and children was not going down, it was going up. Even it was only at $2.

Chair Wells: This is the result of the implementation of the scenario where we subsidize children.

Member Viton: The tier change we approved, the model in the presentation didn't show a decrease for participant and children. The proposal we're talking about isn't changing the subsidy for participant or child. I'm not understanding how stacking it is resulting in a reduction for participant and children when the tier alone didn't have that impact and we're not changing the subsidy allocation to children or employee.

Ms. Donaldson: We are changing the allocation on the base subsidy as well. The tier ratio changes on the base subsidy that gets changed as well. That base subsidy that we're talking about, those tier ratios get changed as well.

Chair Wells: The savings to employees gets passed on to all tiers. The savings in the employee. What she's saying here is the savings to the employee was more than the increase. The way the subsidization policy works, everybody gets the same subsidy for the employer. The subsidization for the other tiers is the difference between that tier and the single person times the lower rate and then you add it to the same subsidy for everybody, for every individual for every single person.

Member Viton: I'm hearing you. I think not seeing it makes it hard.

Chair Wells: If you have a $1,000 premium for individual one. We subsidize $900 of it. They pay $100. A two $2,000 premium for a spouse, but we only subsidize 60% of it. We paid for $600 of that, they still get the $900 from the individual. We only take the difference at the lower

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rate. What this is saying is that the savings in the employee only tier is more than offsetting the increase in the tier percentages, tier ratios for the plus children.

Member Viton: I'm sorry. Maybe it would be more apparent to me. I guess in the slide that we were looking at when we were talking about the tiered policy and the impact that it would have. We were looking at the employee contribution to their tier, to their coverage. This is only showing us the net impact difference and so maybe it's a different base of what is changing.

Chair Wells: If you remember the tier reallocation decreased the individual but that affects everyone. It affects all four tiers because you get the same savings for the employee. It's the differential of the premium for the different tiers that's subsidized at the lower percentage. Everybody gets the advantage of the lower subsidy or the lower premium for the individual.

Member Viton: I guess I'll go back. Maybe I'm not understanding at all if because we talked in the tier as a redistribution a zero sum there was no gain and now we're saying the individual reduction is benefiting everybody all tiers.

Chair Wells: For the individuals. Member Harper.

Member Harper: Clarifying question. Blaine Harper for the record. What's going on behind the scenes? An employee is an employee at any tier? Is it also the case that a spouse is a spouse at any tier? A child is a child?

Chair Wells: Correct.

Ms. Donaldson: Point of clarification. Chair Wells, you are correct that it's affecting all tiers for the employee, but the spouse and the children, the costs are going up. What's happening here is that the reduction for the employee only is helping to offset what that increase is for that child. When we reallocate with the subsidy changes this is ending up what the results are. There's reallocation of the subsidy too.

Chair Wells: Any other questions? This is compared to the current rate.

Ms. Donaldson: Correct. Chair Wells. It's based upon plan year 27 premiums.

Chair Wells: Do you know the savings that's associated with this?

Ms. Donaldson: I think we're coming up with pretty close to zero.

Chair Wells: It's basically that there's no savings associated with this scenario.

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Ms. Donaldson: Very little. How about for the REGI? I think we need to look at the REGI. The REGI should have savings. So, if we're doing the REGI, just to clarify, we're going from 70 to 64 for the retiree. Dependents are currently at 45 and you wanted to go to 34. If you look at scenario one, there's a $4 million savings going from 64 to 39. The 64 is going to stay. The 39 is going to go up five points. Four millions probably going to get cut. It's going to increase. It's going to cut the four million probably to like two to three.

Chair Wells: No, it's going to increase it, more savings.

Ms. Donaldson: Yes. It's going to increase the savings. Should be around five six savings. We would need more time to double check our number. There's a lot of moving pieces in a very complex model that we need to make sure.

Member Viton: Scenario one, for the REGI for retirees is the same as scenario four except for the dependents which is going from 39 to 29. The difference in the estimated savings between those two before any change is a million dollars.

Ms. Donaldson: That's why I was saying it's going to be about five a million. the 455. Yeah, if that helps the board make a decision. That's correct, sir.

Member Viton: It's probably four and a half million instead of four to five.

Chair Wells: You would pick up a little more savings on the REGI side. You would lose a little savings on the AEGIS side compared to scenario one.

Ms. Donaldson: Correct.

Member Viton: Because compared to scenario one, it's less than scenario four and more than scenario one.

Ms. Donaldson: Scenario one's very little savings if any little savings.

Chair Wells: You can put that up there. I have a question. The $9 change that was in the tier analysis is only for the employee share, not for the entire premium. Is that correct? It shows the CDHP going from 55 to 46 which is a $9 change but that's only the employees share that's not the entire premium.

Ms. Donaldson: That's assuming that the savings, well it is $9 on the total.

Chair Wells: Is it $9 on the total or is it $9 on the employee only share because that's where I'm getting confused.

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Ms. Donaldson: It's $9 on the employee only share.

Chair Wells: Is the state also saving money on their subsidized share?

Ms. Donaldson: No, because it's just reallocating those.

Chair Wells: Then I'm having a problem getting from 9 to 41. Because you're saying the participant share goes down by nine from 55 to 46 but then goes down another 32 when we're not changing the subsidy allocation for the employee only.

Ms. McClendon: Part of the calculation is the average tier factor and that changes along with the tier change that we just talked about. Let me pull that. One second. The average tier factor previously was .761. If you average by enrollment and tier, maybe that's think about it backwards one over that. That moves to .727. There's a change in the average which applies to everybody across actives and retirees.

Member Zumtobel: You're calculating the new tier and then the new subsidy, is that what you're trying to do? Both of them.

Ms. McClendon: Correct.

Member Zumtobel: I wonder if it would make sense for us to only look at what I understand the tier is going to happen or whatever, but only look at the old rate and the new rate and then understand the impact and then maybe we in our minds we could figure out the ratio thing next or something because I think it would give us a clearer impact of the change. It give us a sense to track along with it. I don't know if that's complicated based on how you're doing it.

Chair Wells: You want another short break?

Ms. Donaldson: Yeah, I'm sorry.

Chair Wells: Let's take a 10-minute break and I'll figure out how to present this in a way that makes sense.

Chair Wells: All right, we'll call the meeting back to order. Just a minute to pull it up.

Ms. Donaldson: Excuse the little mess. I'll see if I can make it bigger. Our prior version, we were putting the subsidy stuff in the employee bucket versus savings. This is the difference that we're seeing now with the change in the tier as well as the base subsidy changes. The employee only is changing less than a dollar because the actual rate ended up for plan year 27 being lower than plan year 26. We made it just flush. That's really the difference from where it's coming in. That's

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why you're not seeing the full dollar amount coming in. But back to your point, the employee plus child is increasing only about three bucks, but we are seeing more of the change in the employee plus spouse and family of about 17 bucks for this Consumer Driven health plan for employee spouse and about 20 bucks for the employee plus family. Similarly, we're seeing changes in LD PPO. We're seeing about a savings of about 13 bucks to the employee only tier. Again, that flows through and all which represents about a $34 increase for the employee plus children tier and then around 40 to 57 bucks change again and illustrative plan year 27 for employees plus and family. That's the ages change. Questions before we move on to the retirees?

Member Harper: Blaine Harper for the record. What about EPO HMO?

Ms. Donaldson: For this quick analysis, this is what we have for now. So sorry, but it's similar.

Member Zumtobel: When you say it's similar, you think it'll hit all the categories the same is what you're saying?

Ms. Donaldson: Correct.

Chair Wells: You've got to remember for the EPO, it will affect it. The HMO will depend on what the premium we get from HPN is correct. We don't have any real control over that particular piece right now, but the EPO side of it would be relatively close. That's why it's hard to meld the two together because you're only doing for part of it, not for the other part of it.

Member Viton: Chris Viton. I think we're only doing this math as it pertains what it would look like on FY27's rates.

Chair Wells: You got all variables for 2028 as well.

Ms. Donaldson: That's correct. Should we move on to the retiree? For the retiree, again just to refresh, we're using 64% for the retiree and 39% for the dependent. This is a little archaic, but this is the difference right here, that we're seeing the difference in premiums. There are more changes. This is the Consumer Driven health plan. For this group again primarily focus on the employee only, employee plus spouse. That's where most of the membership resides. From about $46 to up to $111 for employees plus spouse for CDHP and then for the Low Deductible plan about a $34 increase for the employee only and $136 for the employee plus spouse. That represents, it's about a $4.5 million savings in total. Again, that will vary with plan year 28 rates but most of the savings if not almost all of it is coming from the REGI and the retirees.

Chair Wells: Keep in mind, this is a 15-year retiree. It's a base retiree so there's additional. This is the base subsidy.
Ms. Donaldson: Correct.

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Member Duncan: Keiko Duncan for the record. You said for the AEGIS, the savings is basically nil. It was it was about $5 million in savings for the REGI for the 29% for spouse the original scenario?

Ms. Donaldson: 64 29 was $5 million. The 64 39 was $4 million.

Member Duncan: I guess I'm not really seeing, there to be a significant enough impact specific to the REGI change here. I guess in my opinion, I do prefer the AEGIS changes here given that we've already made the changes to the tier. I think that would be my general opinion on that.

Member Rich: Laura Rich. I second that too. I like the AEGIS changes. I think the REGI changes are appropriate as well.

Chair Wells: Other comments, questions?

Member Zumtobel: I was wondering about Laura's earlier points she raised about some spouses have access to other coverage and I just wondered why are we going from the 70? Why are we subsidizing the spouses? Why don't we just go with the full 70 on the retiree? Operationally, how does that feel to people? I don't really have too much skin in this game, but it felt like her comments made sense that if the spouse is at work, they have an opportunity to potentially pick up coverage.

Chair Wells: I think that was more on the active side. That was more intended for the actives and technically you're not allowed to be on our plan if your spouse has other employer based coverage, you're not supposed to be able to cover them on our plan. Member Davis.

Member Davis: Yes. When she talked about that, she said that in actuality they have no idea, no way to actually know that. I think there should be some sort of procedure where they have to know that otherwise I mean it's wrong.

Chair Wells: It's really difficult without doing, a dependent audit is what is required to figure out and then you basically send out certifications to enrollees and it's hard to force that issue. It's easier not to put them on because they have to prove that they don't have coverage. But once they're on.

Member Davis: It's too bad we can't find some other way to enforce that.

Member Rich: Laura Rich for the record. I think that this approach actually helps reinforce that in other ways. If spousal coverage is more expensive, then it really does encourage those people that have access to health care through their own employer to access their own employer

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coverage versus PEBP coverage. Whereas kids are not ever going to have, potentially through another parent. That's not something that you can impose on kids, but I think for a spouse it's appropriate.

Chair Wells: Other comments, questions? Anybody want to take a shot at a motion?

Member Duncan: Keiko Duncan, for the record, I would motion and Debbie, please correct me if I wrote this down wrong, that we slightly modify subsidy scenario four for the AEGIS specifically. We keep the 93.5% for the employee, we change the spousal to 68.5%. Okay. And the children to 65.5%.

Ms. Donaldson: Nope. Other way.

Member Duncan: Sorry. Spouses to 65.5% and children to 68.5%. Keep it at 68.5%. And then for the REGI, we would keep the retirees as indicated here in this scenario from 64% and the spouse to the 29%.

Chair Wells: This actually left the spouse at 39%, the scenario that we had up there.

Member Duncan: We were saying based on if we were to just go back up, was it worth it to increase to that?

Chair Wells: If you drop it to 29, it will make the dependent higher on the retiree side which she had up there had 39%. 64 and 39, not 64 and 29. 64 and 39 is what's current or what's the historical.

Member Duncan: Oh, got it. Okay.

Ms. Donaldson: Which is about a $4 million savings going from 70 45 to 64 39.

Member Duncan: Okay. Then 64 and 39. Okay.

Chair Wells: There's the motion. I'll restate it to make sure we got this right. Retain employees at 93.5. Retain children at 68.5. And reduce spouses to 65.5 and reduce retirees base for retiree only because it's from 70 to 64 and dependents from 45 to 29 or 39. Oh, that’s not what you want. Edit.

Member Duncan: What was the spouses again?

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Chair Wells: On the active side the employee would stay at 93.5. Spouses would drop to 65.5 and then the children would remain at the 68.5 that they are today. Then on the retirees, the retiree only would be 64, dependent would be 39.

Member Duncan: But not the 29.

Member Rich: Yeah. Is there a reason why we move that to 39 instead of 29?

Chair Wells: 64 and 39 is the historical. That comes from scenario one.

Member Duncan: We were saying that the difference between the 39 and the 29 was only like half a million?

Member Viton: The difference between 39 and 29 is a million. The difference between, they modeled 34.

Member Duncan: Oh, that's okay. I didn't write it down correctly.

Member Rich: What was modeled up there was 39%?

Chair Wells: On FY27 is about a $1.2 million.

Member Viton: Was it 39 or 34?

Ms. Donaldson: We modeled 39. Scenario one is 64 39. That's a $4 million savings. Scenario 4 modeled 64 29 which I'm showing. That's about additional million dollar. If you wanted to move it halfway up to 34, it's about a half million, it's four and a half.

Chair Wells: Other questions or comment. You got your motion right. That's where we were.

Member Duncan: I guess 64 and 39 is what was thinking.

Chair Wells: So the motion is for retaining the 93 and a half percent for employees, to 68 and a half for active children, reducing spouses to 65.5% and for retirees reducing them from their current 70% to 64% and retiree dependent from 45% to 39%. That's the motion. Can I get a second?

Member Grimmer: Joy Grimmer. I'll second.

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

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Four board members: I.

Chair Wells: All those vote nay?

Four board members: Nay.

Chair Wells: All right. Roll call. Ayes. One, two, three four. Nayes. One, two, three, four. I vote yes. It'll be 5 4.

Ayes: Members Duncan, Rich, Grimmer, Zumtobel, and Jim Wells.

Nayes: Members Viton, Barnes, Harper, Davis. That concludes agenda item number eight. We'll move on to agenda item number nine Contact Status Report.

Executive Officer Carsten: I'm going to take this over. Shannon has allowed me to share with the board that she had dental surgery yesterday, so I'm going to be doing this. This first table is just a list of our contracts and their anticipated expiration dates and statuses of extensions etc. that we're currently working on. On the second page, our recommendation is that PEBP fully consolidate its procurement functions with the Nevada Health Authority. Centralizing procurement processes and decisions under NVHA will significantly reduce administrative burden, eliminate duplicative efforts across agencies, and create a more efficient and unified process for managing vendor relationships and RFP development. By aligning with NVHA's statewide procurement structure, PEBP can leverage the state's combined purchasing power to negotiate more competitive contracts, strengthen vendor oversight, and ensure the procurement decisions support long-term cost stability for both public employees and the state. This strategic alignment will enhance consistency across contracts, enable more effective monitoring of vendor performance, and support a coordinated approach to purchasing across Nevada's health programs. Overall, delegating procurement responsibilities to PEBP staff and NVHA administration is a practical and fiscally responsible strategy that will enhance PEBP's ability to secure high quality services, improve operational efficiency, and safeguard the long-term sustainability of the program.

Similar to our last meeting where the board delegated the authority for the purchasing and procurement process to the health authority for the PBM, the dental contract and the actuarial services contract. We're asking to do that with the remainder of the contracts that we have coming up. If we do that, it allows us to use the resources of the Nevada Health Authority to not only combine purchasing power for our larger projects, but to also utilize some of their vendors to assist us in the work in lifting those RFPs. Attached to this is the timeline that I gave at my last month's meeting. If we have to stand all of these up, then it's essentially right now me and Shannon in combination with all the other stuff that we've got going on to write, develop, post, and procure. That process of posting and having all of those RFPs ready would be May. That

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would be a really heavy lift on PEBP right now. Allowing us the opportunity to delegate some of these decisions and processes to the Health Authority allows us to work together on determining which of these could be extended easily, which of these would more easily go into combined RFPs with multiple scope of works that could be worked on by outside vendors with PEBP staff rather than us solely lifting them ourselves.

Chair Wells: Any questions? Hearing none. Can I get a motion? This is an action.

Member Grimmer: Motion to approve, Joy Grimmer.

Chair Wells: A motion to approve the delegation to NVHA administration.

Member Viton: Second.

Chair Wells: I have a motion and a second. Any further discussion? All those in favor say I.

All board members: I.

Chair Wells: Any oppose? Nay. Motion carries. Close agenda item number nine. Move to agenda item number 10. PY24 Claims Technology Incorporated audit findings for the State of Nevada Public Employees Benefits Program administered by Express Scripts. Ms. Amato.

Ms. Amato: Good afternoon. Joni Amato for the record. For the presentation of the 2024 plan year Express Scripts audit results, I'm going to turn it over to my CTI colleague Julie Weissmann. Julie.

Ms. Weissmann: Hi, Good afternoon. My name is Julie Weissmann. I'll be presenting the audit results for Express Scripts for fiscal year 2024. Would you like me to share the presentation or do you have it in front of you?

Chair Wells: If you could share it.

Ms. Weissmann: Absolutely. Going to grab the right screen. Make sure I'm ready pulling the right thing to share. Can you guys all see that report in front of you?

Chair Wells: We can.

Ms. Weissmann: Perfect. Thank you. This report is of the fiscal year 2024 for Express Scripts. The report actually shows both Pillar RX and Claim Technologies. Pillar RX was the auditing firm at the time. We are now merged together and Claim Technologies just so there's no confusion there. This is a full detailed executive summary and full detailed report of this audit

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that we completed for PEBP of Express Scripts. We reviewed 484,411 pharmacy claims with an overall net plan paid of $88,195,345. The audit looked at both pricing and fees which is dispensing fees and discounts within the PBM contract. We reconciled those based on those contract discounts. We looked at the benefit payment accuracy review which is the plan design. We did a full rebate review and a performance guarantee review of that period of time as well. Our overall findings for that audit period was for the pricing and reconciliation of the dispensing fees. We found that there was no additional money owed to PEBP for that particular audit period. Even though at the conclusion of the audit there were some confirmed findings and there were some variances. However, they did not result in any financial impact owed to PEBP.

We also found that there was service level performance guarantees that were missed. Of those performances, there was nine total performance guarantees with an overall calculated performance of $529,865 that would be owed to PEBP. There are some additional details on that. ESI had only calculated that penalty of $936,000. Then also the minimum rebate guarantees. We found that the rebates that were paid to PEBP were appropriate and within all the contract standards that were being met appropriately and there was no additional money needing to be paid back out for that period of time. The detail with the performance guarantees. I provided some of those missed targets here on the screen. For the ongoing service for the network access, they did not meet those penalties. The retail direct reimbursement timeliness, they did not meet that penalty. Some of which we calculated a lower penalty, some of which ESI calculated a higher penalty. I'm not quite sure what math ESI was using at that particular time, but theirs was a better number than ours was. I'm going to go ahead and use theirs. The mail order turnaround time, they did not meet that for any of the four quarters based on clean prescriptions.

Also, the same with the mail turnaround time with their protocol RXs, which means they weren't perfect prescriptions and they needed to do some additional work or review on those claims. Their phone average speed of answer, they did not meet those in three of the four quarters. The phone abandonment rate, they missed that in one of the quarters. They missed the first call resolution. I have five quarters written on here, which looks a little odd. It was a catch-up quarter dollar amount that was provided to us. So, we included that in here as well. Their prior approvals also did not meet the one quarter and their overall member satisfaction also did not meet those performance guarantees. Before I move on to any additional details, does anybody have questions or want me to go further into the details of the audit?

Chair Wells: Let's finish and then take questions at the end.

Ms. Weissmann: Absolutely. On a more detailed level of the particular audit that we looked at, again the audit scope is just a repetitive piece that we've already talked about here. The first item that I will talk about I'm going to go down here is the discount review. This is the contract discounts within your contract versus what the actual performance was versus actual claims. You can see on the very right hand column, anything in red means they did not meet those performance discounts that were listed within those contracts. Anything in black means they did meet them or overperformed their discount contract guarantee. Overall, it was an

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underperformance of $1,186,000 in an underperformance amount in the discount guarantees. The way their total meets only the underperforming components are added up as being the shortfall. Anything as an overperformance in the black is a plan benefit or plan positive back to PEBP. That means it's more money in your pocket than in Express Script's pocket. But these dollars down here, this $1.186 million means they did not meet their guarantees in the mail generic component by almost two full percentage points. The specialty brand, just shy of .3% and the specialty generic by 1.6% almost in that specialty generic component bucket.

Some of the reasons why not only did they miss their performance guarantees but there were some additional differences that they did not follow the contract methodology to roll up those performances. There was an accepted COVID antiviral product they should have been excluded from all of those pricing guarantee documentation. However, they included it in all of their components. This was a positive in your favor and a negative on ESI's favor. We accepted that moving forward. Let's see, what was the next one? There was also 60 claims that they incorrectly classified as a brand or a generic medication. You have an all-in guarantee notwithstanding based on the way your contract is written. They wanted to follow their methodology or that they appropriately reconciled those guarantees in the generic bucket based on some additional protocols. I'm going to strongly disagree with them. However, it was only 60 claims. It did not truly make a difference in the financial impact no matter which direction I put them in. I just wanted to share those couple things that we found in there.

When we move into the dispensing fees here, there were several sections in the retail side and a few on the mail where they overcharged the dispensing fee when those prescriptions were being picked up. Overall, there was about $43,000 in overcharges on those dispensing fees. What that means is those four top categories are all at retail. That means all of those retail claims that were being charged at the point of sale had a little bit extra, a few extra pennies every time those members picked up those prescriptions of a dispensing fee that was being charged on there. Now again, we are only using the red categories to roll up those underperformance dollars to determine what that underperformance or overperformance was in there. However, in summary, we had calculated an over collection of $43,000 that was overcharged. However, this was exactly in alignment the same way ESI had reported in their self-reported information. There was nothing that we saw that they did incorrectly. It's exactly how they reported it. They just didn't follow all of the right contract methodology to make sure that the right dispensing fee was being appropriately charged.

When we take all of those numbers and then we roll them up together. What we say is that reconciliation at the end of the day we take the discounts, we take the dispensing fees, both the underperforming amounts, those red amounts, and then you have a price assured savings that’s a positive offset on both of those numbers. ESI calculated an overall underperformance amount of $1,230,000 and Pillar RX, also known as CTI, calculated an underperformance of $1,159,000. While the numbers aren't exact, we are going to agree with ESI's numbers. It was a little less than $100,000 more than what we had calculated here. They had already paid that electronic transfer to you guys back in October of 2024, so there should be no additional money based on that discounted and dispensing fee guarantee being sent back to PEBP.

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Moving into the benefit payment accuracy or plan design audit portion. This is where we look at the benefits that are being administered to your members. We're looking at co-payments, co-insurance, exclusions, prior authorizations, if there's agent gender rules, day supply maximums, quantity limits, anything specific to your plan that you administer to your members. We want to make sure that that is being adjudicated appropriately from one end to the other. We take all 100% of those claims. We run them through our adjudication tool as though we look like the PBM to make sure everything is being applied appropriately. We had calculated about $18,878,000 in co-pays were collected for those claims. We took about 181 samples that originally looked like they could have been findings or things that could have been incorrect based on the plan designs that we had looked at based on five separate sample observations or unique different types of observations and based on the individual responses that we received back from ESI based on those samples and the responses that we provided to them everything actually appropriately adjudicated correctly. Their responses that they replied back to us were appropriate and we found that there were no errors made on those samples that we had provided and we agree with the way they were adjudicating all of their claims.

When we looked at the drug exclusions and prior authorizations, we found that ESI was appropriately adjudicating those prior authorization claims correctly and appropriately applying the prior authorizations where necessary and making sure anything that was supposed to be excluded was actually appropriately excluded. Same with the age and gender rules. Everything was processing as expected. Nothing fell out of the norm. When it comes to the quantity limits and day supply maximums, again everything was processing as normal. Nothing stood outside of the box that we had to question or was a problem based on those plan design documents that we had reviewed and verified. When we come to the rebate review, this is the rebate reconciliation review to verify that the minimum rebate guarantees listed within your contract are being adhered to along with the methodology in their contract. Meaning all of the appropriate eligible claims are being counted and all the ineligible claims or methodology to exclude those claims are also being calculated. Based on our calculations, we calculated a total minimum rebate due to PEBP was $30,033,453.60. ESI had already paid out a total of $31,055,486 to PEBP, which there was a difference of about a million dollars in PEBP's favor based on the differences that we had determined. Again, it was in your favor. We found nothing egregious or incorrect with the way they are processing it. They just allowed more eligible claims through than would have been anticipated based on the review that we were looking at the time. There was nothing additional that was required during the rebate review in that category. There was two incorrect classified claims based on mail order and they had corrected those. Again, there was nothing big on the financial period.

Moving into the performance guarantee review. This is where it got a little bit more detailed on here based on the penalties that were provided or reported or not reported. We've also provided some additional recommendations to PEBP whether you want to work with your account management team to help implement some of these. We can also help you work with some of these as well. I'm going to go towards the issues where there was truly findings or things that needs to be really discussed. Based on the ongoing services or network access, we found that

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in quarters one through four it was a 93% met which overall was a penalty of $46,925,000 based on the guarantees in your contract. We would just recommend that they expand that rural network along with providing that mail order service for you guys as well just to give your members a little bit more mileage for those ongoing network services. The other areas that were not met were the retail direct reimbursement timeliness. They should be fulfilling those claims in about five business days. We found that in quarter one only 97% were met and not all of them. There was a penalty of about $20,000 that is due to PEBP for those. We would recommend that they review their workflow process to make sure things are being met in a timely fashion. Maybe even set alerts to make sure things are obviously being done more appropriately.

In addition to that one, there was a mail order turnaround time for clean prescriptions in two business days that those claims be fulfilled from the time they are entered into the mail order pharmacy to the time they are shipped. We found that in all four quarters they did not meet that guarantee and the penalty for that one was about $93,850. We would just recommend that those delays are investigated with your mail order turnaround time, why they're being delayed so long. Maybe provide additional automated services. Find the root cause as to why they're taking so much time into turning those clean scripts around in the mail order service. When it comes to mail order claims where they have to have a little bit more hands-on work on those, there's a four business day turnaround on those. We found again that all four quarters were not met there as well. Meaning only between 92 and 95% of those claims going out within the right turnaround time. Again, with a penalty of about $93,850. Again, same recommendations here. Investigate why those delays are happening, maybe implement different automation processes, find out what the root cause is and why those are being delayed as much as they really are.

Moving on to the phone average answer speed of time, you have a less than 25 second minimum guarantee there. We found in both quarters three and quarter four, only 79.9 or 39.8% of those phone calls were being answered in the appropriate time period representing a $46,455 penalty. We would just recommend that they train their representatives, maybe adjust staffing for a higher turnaround time, maybe when your phone calls are coming in just to make sure they're handling your calls appropriately. The phone abandonment rate was pretty high in quarter three. They did not meet that guarantee for you guys as well. It's probably a staffing issue. Train those representatives, maybe put different people on the phones during high volume periods of time. First call resolution. There were several, all four quarters did not meet that. They were low in all four quarters, anywhere between 96 and 97% with a penalty of $93,850. Again, train the representatives, monitor those metrics so they can adjust their staffing on the fly, maybe put additional phone calls, maybe hire representatives to help answer some of those phone calls.

Along with your prior approval process, you have a two business day turnaround time on those. They were not met in that turnaround time in quarter 1, only meeting 94% actually being turned around in two business days with a $20,767 penalty. Again, review those workflows, set alerts with that team who are reviewing those prior authorizations just to make sure that they are being approved in a timely manner. Then the member satisfaction. Apparently your members were just not satisfied in any of those four quarters, showing an 87 to 93% satisfaction rate with an overall penalty of $93,850. If you haven't seen it, I would request that feedback to improve

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their service to see why those members were just unhappy with the members that they had looked at or talked to to figure out what that satisfaction was. Then the last two had met, but we calculated that overall penalty at $529,865. We agreed with the performance guarantees that missed all those things that were listed out there. That's what ESI had stated with us. Everything that was out here, we did originally calculate it based on the admin fees that we had in place. We put in some additional figures in here based on the way they calculated their dollar amounts and their penalties within this report as well on how they did everything the way they did all of their reporting. And that is the last of my reports. The ESI rep provided responses at the end of this report as well. Now I will answer any questions that you guys have.

Chair Wells: Thank you, Ms. Weissmann. Member Duncan.

Member Duncan: Keiko Duncan for the record. First question for CTI and then the rest for Express Scripts. I'm hoping somebody is online for that still. Working backwards about the SLA's and the difference in the calculation. I'm not understanding why Pillar didn't calculate this in the same manner. Did you guys identify the discrepancy? What number is correct?

Ms. Weissmann: That's it's an interesting situation. I'm not quite sure if we were off a quarter or not. I'm going to be brutally honest with you here. The auditors specifically that were working on this report at the time it was being handled are no longer with my team. This was actually taken care of and we actually put it to bed a long time ago. I'm jumping in trying to close this out for you guys now. I wasn't honestly doing all of the back and forth on all of these pieces at the time it was being handled. We had numbers based on the numbers we were provided by PEBP. I don't know if ESI was using the same numbers we were using. We did provide them with the numbers we had. That's the best I can tell you at this moment in time. Like I said, our number was less. That's the best I can tell you. Apologies on anything else I've got there for you.

Member Duncan: Okay. Obviously, this report is a few months old and so I'm sure staff will have followed up on this and calculated it but in the future for these audits, you can't just leave it at a discrepancy. It needs to be resolved. For future audits that's certainly what I think.

Ms. Weissmann: I completely agree. I will be honest, we struggled with ESI on this one on a couple of the items on this one.

Member Duncan: Okay. Still working backwards. ESI, who do we have on? Oh, people. Great! I've got a few. If you want to hang back there or you want to come up here?

Ms. Weissmann: Do you want me to continue to share this?

Member Duncan: No. I think we're good. Thank you. Still working backwards from the SLA's. I'm curious. I guess ESI obviously had this audit back in April is what I was seeing from the ESI

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responses. Has ESI, maybe just generally, has ESI done any further digging or investigation into some of these discrepancies or these SLAs specifically that were not met?

Ms. Donohue: We looked at the member satisfaction report. We looked at that one. It has been a few months, but I think we probably should look at the phone with the phone abandonment and the ASA as well. I think that's probably a takeaway from the report.

Member Duncan: Yes, totally. I appreciate that. I'm really curious about the mail order turnaround time for a clean claim. Just for level setting here, a clean claim means that it came in perfectly, it had everything it needed for it to be reviewed. For that not to have been done in the two business days. I'm just very curious why that is. I think that's certainly worth investigation. Obviously for those that are non-clean claims as well. I hear from members all the time about their prior authorizations that are either denied erroneously or taking forever or what have you. I feel like in terms of member satisfaction, I think making sure that they know what the answer is to their benefit in a timely manner is really important. I'd be very curious as to why every single quarter ESI has failed at that. I was going to work backwards, but it's just going to confuse me. Again, since this is old, ESI's response to the rebate reconciliation was that there was going to be some payments in May. Were those completed? Those were sent for sure.

Ms. Donohue: Yes.

Member Duncan: Okay, sweet. Just want to make sure. I had a question regarding the pricing guarantees and such. First and maybe not for ESI, but just for staff. I think where Pillar disagreed with 60 claims being incorrectly classified as brand or generic and ESI is claiming that was correct. Being that the contract is subject to DAW protocols and it generally describes some protocols but I would love to understand what exactly those defined protocols are from ESI's response and maybe you can confirm for me but from what ESI's response is I'm understanding that basically any of the DAW codes on a brand drug that would have otherwise allowed substitution, ESI is claiming that those are subject to the generic dispensing?

Ms. Donohue: Right.

Member Duncan: Okay. I also find it interesting that one of those is a DAW6 and I know that one's not commonly used anymore. I'm curious why that's been included. Maybe we can dive into a little bit further stuff for contracting. Also, in the performance guarantees. The COVID antiviral I'm really curious about this. Pillar is saying that the COVID antiviral products were to be excluded from the pricing guarantees even without contract documentation and ESI is stating that PEBP was enrolled in ESI's COVID antiviral program and sent an email to that effect which was then attached. Now I read this email and this email was just a notification to opt in for a $0 co-pay. That email though did not detail that opting in would thereby provide an exclusion from the pricing and rebate guarantees.

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Ms. Donohue: It was in a link that when you clicked on the link there was a terms and conditions document and it was within the terms and conditions document. I can pull that terms and conditions out.

Member Duncan: I'm assuming that link was a form that had to be completed and so ESI would, I'm assuming would have documentation of PEBP having completed that form.

Ms. Donohue This was an opt out. Everyone was opted in and then opted out.

Member Duncan: It was an opt out of providing the $0 co-pays

Ms. Donohue: Because of the federal emergency at the time. That's why our business decision was that it was an opt out because of the federal emergency at the time.

Member Duncan: If they were to click that link and then opt out of it, then they would have still maintained the pricing guarantees. Is that correct?

Ms. Donohue: They wouldn't have coverage.

Member Duncan: I'm curious about that though. I don't think we need to spend too much time about it, but logically I'm thinking that as a general response, if everybody was automatically opted in, we had $0 co-pays for patients, then there would have been no reason for staff to have clicked that link and thereby opted out and then seen the terms and conditions that would have eliminated it from the pricing guarantees. I'm unsure how that was maybe communicated to PEBP otherwise. What then worries me is maybe this is more of a comment and maybe for future process is that should anything like this come up again which would affect the pricing guarantees I think we need to think about a formal notice and does that look like a contract amendment, does that look like very detailed terms and conditions that are sent over in an attachment that we can actually review and save? I think the way that this was presented as a rebuttal is a little bit vague. It's vague enough I don't think we can verify it one way or the other, but I think it is of a concern.

Ms. Donohue: More transparency when we would do some type of adjustment in the guarantees.

Member Duncan: Yeah. Then overall, CTI obviously recommended an action plan for how we were going to follow up with all of these various discrepancies and such and so when can the board expect that to be presented?

Ms. Donohue: We can have it for the next, November 17th.

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Member Duncan: Okay. I would defer to the chair if we have time in that meeting to put it on there but I would certainly like to see it presented.

Chair Wells: Any other questions from other board members? Hearing none. This is an action item to accept the report and to allocate the penalties. Can I get a motion?

Member Rich: Laura Rich. So moved.

Chair Wells: I've got a motion. Can I get a second?

Member Duncan: Keiko Duncan. Seconded.

Chair Wells: Motion and a second to accept the audit report and assess the penalties against Express Scripts Incorporated. Any further discussion? All those in favor say I.

All Board Members: I.

Any opposed? Nay. Motion carries. Thank you. We will close agenda item number 10. Move to agenda item number 11. Public comment. Again, public comment will be taken during this agenda item, but no action may on any matter raised under this item unless a matter is included on a future agenda as an item on which action may be taken. All the comments to the board will be taken under advisement but will not be answered during the meeting. Members wishing to make public comment using the call-in number is 669 900 6833 Meeting ID is 858 3057 3823 pound. Please state and spell your name for the record at the beginning of your testimony. Any public comment here in Carson City? Seeing none, any public comment on the phone?

Mr. Nguyen: There's no one in the lobby.

Chair Wells: Okay, we'll close agenda item number 11 public comment move item number 12 adjournment. Motion for adjournment.

Mr. Nguyen: Actually there is one. Let me just get this slide. One moment. For those who have joined the public comment, your name or the last four digits of your phone numbers will be announced. You'll be advised that you have been unmuted. Please slowly state and spell your name for the record and then proceed with your comments. As a reminder for those on the phone, please press star six to unmute. Caller with the last four digits 0766. You have permission to speak. Please slowly state and spell your name for the record. Press star six to unmute.

Ms. Tyson: Good afternoon, Chair Wells and members of the board. For the record, my name is Davida Tyson, D A V I D A T Y S O N. Here on behalf of AFSCME, Local 4041, the union representing thousands of dedicated state employees. Our members work hard every day and rely

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on PEBP to provide stable, affordable, and comprehensive health care for themselves and their families. As we move into plan year 27, AFSCME urges this board to prioritize affordability and plan stability above all else. Our state workers have absorbed rising costs, shrinking networks, and increased out-of-pocket maximums. Any strategic plan design changes for the upcoming years must focus on protecting the bottom line of employees, not shifting the fiscal burden onto workers who are already feeling the inflation in the economy. As discussions continue regarding policy changes, shrinking premium protections will severely damage state agency recruitment and retention. Shifting the fiscal burden of health care onto workers is a disservice to public employees who should not have to bear the brunt of rising costs. Moving forward, we want to partner to fix this legislatively. It is our priority to secure stable long-term funding structures that protect workers and ensure they have sustainable healthcare. Thank you.

Chair Wells: Thank you, Ms. Tyson. Others?

Mr. Nguyen: Chair Wells, there's no one in the lobby.

Chair Wells: Okay. And now we'll close agenda item number 11, public comment. Motion for adjournment. Ms. Rich. Second?

Member Duncan: Second.

Chair Wells: All those in favor say I.

All Board Members: I.

Chair Wells: Thank you all. A wonderful weekend.

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