Unofficial AI Minutes

Public Employees' Benefits Program (PEBP) Board Meeting

November 17, 2026 — 9:00 a.m.

3427 Goni Road, Suite 117, Carson City, NV 89706 (with video/teleconference)

---

1. Open Meeting; Roll Call

Chair Jim Wells called the meeting to order at 9:00 a.m.

Members present (roll call):
- Jim Wells, Board Chair
- Dr. Keiko Duncan
- Laura Rich
- Jim Barnes
- Dr. Blaine (Wayne) Harper
- Joy Grimmer
- Dr. Paul Davis
- Chris Paton (noted as arriving ~9:30 a.m.)

A quorum was present. Members were reminded to state and spell their names for the record.

---

2. Public Comment (First Period)

The Chair announced no time limits would be imposed. The following public comments were received:

Kent Irvin (PEBP Medicare retiree, RPEN member, speaking for himself):
- Asserted the Board has not been fully informed of cash balances in the AEGIS

and RGGI accounts, which are necessary for informed fiduciary decisions.
- Stated that as of end of Q1, the 1338 operating account balance was ~$30 million; AEGIS and RGGI held ~$68 million, for a combined ~$98 million — below the required ~$121 million reserve for FY2027, but not supporting a claim of insolvency.
- Alleged cash-flow management issues among the three accounts that could be fixed, and questioned when reconciliation (pending since the April memo) would be finished.
- Criticized the October 15 agency request budget: premium revenue projected to more than double while state support rises only a few percent; AEGIS/RGGI balances projected to rise to $250 million by end of biennium; no requested increase to Medicare retiree HRA contributions (unchanged since 2019 while Medicare Part B premiums rose over 50%).
- Called for an independent audit and management review of accounting, budgeting, and rate setting, and urged the Board not to make further plan design or benefit-cut decisions in the meantime.

Tess Opferman (on behalf of AFSCME retirees):
- Echoed Mr. Irvin's budget concerns; noted the 2025 Legislature made a substantial investment yet benefits could not be maintained.
- Called for a comprehensive independent audit of PEBP finances.
- Raised concerns about Via Benefits: retirees struggling with enrollment, inaccurate provider/pharmacy information, and difficulty identifying Medicare plans—highlighted by recent Senior Care Plus changes.
- Requested that PEBP provide the HRA directly to retirees rather than through Via Benefits.
- Opposed balancing the budget "on the backs" of retirees and active employees.

Catherine Ann Murders (retiree):
- Reported that to keep her $260/month HRA she must enroll through Via Benefits, which does not list Prominence (which includes her doctor of 20 years).
- Noted Medicare.gov lists 18 plans from six companies while Via lists 12 plans from four companies, excluding three Prominence plans and one Champion Ally plan.
- Noted Via Benefits receives commissions from insurers and argued it is not fulfilling its HRA duty by restricting plan choice.
- Recommended that at contract renewal, any Medicare-qualified plan be eligible for HRA reimbursement and that adequate counseling staffing be provided during open enrollment.

Lars Jensen (retired mathematics professor, Truckee Meadows Community College):
- Referenced his written comment including an email chain with Via Benefits' senior escalation specialist.
- Alleged Via Benefits is violating federal Medicare law (42 U.S.C. §1395ss) by misclassifying transitioning retirees under guaranteed-issue rules, hiding over half of available Medigap plans (showing only 10–15 of 33–35).
- Stated lower-cost plans (e.g., Mutual of Omaha High Deductible Plan G) are suppressed, steering ~1,000+ retirees/year toward plans costing ~$200 more per month while generating higher commissions for Via.
- Cited a written admission (dated October 2) from "Ms. Boyce" that Via and Mutual of Omaha have a private agreement to require underwriting and hide the plan online.
- Urged staff to walk through the website intake screen, audit the portal, and require Via to display all contracted plans without underwriting filters.

Doug Unger (past president, UNLV chapter, Nevada Faculty Alliance; UNLV Faculty Senate Benefits Committee):
- Opposed Agenda Item 7's proposed elimination/cannibalizing of the HMO plan in Southern Nevada; asked the Board to vote for **Option 3, no change**.
- Raised concerns about Item 5's accounting, particularly "negative reversions," arguing these should be positive rollovers used for member benefit per NRS 287.
- Questioned why active employees and retirees should pay for past systemic administrative errors via premium increases exceeding 100%, and why the agency request is only about half of anticipated 9% healthcare cost increases.
- Argued the Board should not make plan design changes or raise premiums based on uncertain accounting.

A caller (last four digits 7248) did not respond. Public comment was closed.

---

3. PEBP Board Disclosures

- **Isaac Rowe**, Senior Deputy Attorney General (standing in for Jose Rivera), made the standard disclosure under NRS 281A.420 on behalf of Board members eligible for PEBP benefits, noting they may vote on items affecting their benefits and are not required to abstain.

- In response to a member question, Mr. Rowe confirmed current members of the state university system are eligible to vote despite benefit eligibility.
- No additional disclosures were made.

---

4. Approval of Action Minutes — October 2, 2026 Board Meeting

- **Motion:** Jim Barnes moved approval.
- **Second:** Paul Davis.
- No additional comments or revisions.

Vote: Motion carried unanimously by voice vote (ayes; no nays).

---

5. Executive Officer Report — Theresa Carsten

Key points presented:
- Available cash as of November 9, 2026 calculated at ~$52 million; revenue alone remains behind claims costs.
- Removed a previously provided reserve table after discovering the figures were drawn from the work-program column rather than initial approved budgets; table will be corrected with Deputy Director Aaron and aligned with Segal reserve letters.
- Provided a four-year history of Board decisions on use of CAFs, including: reserves voted to be spent over three years but expended in two; premium offsets not adjusted when funds ran out; benefits increased without corresponding rate adjustments. PY26's additional $37 million in state funding largely went to continued premium offset rather than rebuilding reserves. PY27 projected loss estimated at ~$36 million.
- Staffing updates: Operations Officer Janice Hadlock Burnett started November 9; Jose Rivera to join as in-house counsel December 7 (stationed in Las Vegas). NVHA continues recruiting for a CFO, management analyst, and administrative assistant.
- Reviewed the biennial budget-build timeline (March through February).
- The Interim Retirement and Benefits Committee tentatively scheduled to meet in December (no firm date); EO will present per NRS 287.0425.
- Reported CMS-authorized Special Enrollment Period (October) for Senior Care

Plus Medicare retirees following July provider-termination notices; PEBP worked with Via Benefits and RPEN on member notification.

HPN Medical Loss Ratio (MLR) Premium Reduction — For Possible Action

- Segal provided a letter regarding HPN returning funds for not meeting MLR requirements.
- Staff recommended a one-time premium reduction of **$26.64 plus any owed interest** for members currently enrolled in HPN, processed no later than January 2027; non-state employers to receive checks with instruction to return amounts to their HPN enrollees. Consistent with last year's similar MLR return.
- **Motion:** To approve the recommendation to refund $26.64 plus applicable interest to members currently enrolled in HPN by January 2027.
- **Second:** Received.

Vote: Motion carried by voice vote (ayes; no nays).

Discussion Following the Report

- **Chair Wells** clarified (responding to public comment) that "reversions" is a technical state budget term meaning a carry-forward to the next fiscal year—not a reversion to other state agencies.
- **Dr. Paul Davis** noted a Nevada Independent report that Governor-Elect Aaron Ford and lawmakers will have ~$13.4 billion for the next biennium budget (an 8% increase).
- **Tom (Zimtabel)** asked whether removed financials would become a recurring report; EO Carsten and the Chair confirmed a detailed recurring revenue/expense report is expected by December and ongoing. The Chair noted a possible short, single-item December meeting to address identified budget issues.
- **Tom** expressed discomfort regarding the Board's unclear oversight role over Via Benefits and requested a framework/briefing. The Chair directed EO Carsten to follow up offline and bring back to the floor if needed.

---

6. Mid-Quarter Fiscal Report — Director Stacie Weeks & Deputy Director Lynnette Aaron (NVHA)

Director Weeks emphasized the team takes the fiscal role seriously, that many issues require a "forensic audit," that NVHA welcomes an LCB audit, and that resources are strained by a concurrent ~$18 billion Medicaid budget build.

Part 1 — How PEBP is Financed / Solvency / Reserves

- PEBP funded by employer contributions, member premiums, pharmacy rates, and other revenue. The Legislature sets the employer contribution rate; PEBP cannot raise it or accept state contingency funds mid-interim.
- The three budget accounts (AEGIS, RGGI, Admin) hold money; spending occurs only through the Admin account.
- Solvency concerns IBNR (incurred-but-not-reported) claims, not cash. Reserves are the only backstop and are funded bottom-up: IBNR first, then HRA reserve (~80% of unused CDHP/Medicare Exchange HRA balances), then catastrophic reserve (target ≥45 days of claims). Reserve targets set by the plan actuary.

Part 2 — Five Key Findings Since PEBP Moved Under NVHA

1. **No safeguards verifying employer contribution amounts** — old method back-calculated headcount from funds received, missing shortfalls. New method multiplies enrolled employees by approved rate. RGGI had similar gaps (manual checks, missing retiree payroll data from some employer groups, no running balance). Corrected via new tracker.
2. **Lacking reconciliation process** — no procedures to follow up on short/late contributions; errors ran both ways, including possible double payments from Central Payroll. Funds cannot be recognized as revenue until reconciled per SAM manual. Staff moved under full fiscal team with added controls; some CoreNV rollout issues noted.
3. **COVID buy-down and placeholder accounts** — ~$26 million COVID surplus (2022) used to buy down member premiums and later buy back benefits; funds exhausted by end of PY2023 but system rates were not corrected, creating an ongoing hole covered by HRA and catastrophic reserves (neither replenished). Employer contributions were "parked" in placeholder accounts, likely contributing to AEGIS/RGGI balances.

- **Recovery update (Deputy Director Aaron):** ~$31 million identified carried into FY27 — ~$15 million placeholder activity (Board approved transfer to Admin in March 2026; ~$3.7 million transferred July–Sept) and ~$16 million requiring reconciliation (in coordination with GFO and Central Payroll; not yet recognized). Controls established: corrected rates, removed placeholder accounts, limited buy-downs, activity monitored through state BETS system, and AEGIS/RGGI balances to be reported regularly beginning December.

4. **Budget workbook reliance on manual projections** — workbook not updated as assumptions changed; approved revenue estimates exceeded enrollment-based projections (overstated by ~$56 million per Segal). New budget-build workbook being developed with NVHA contractor, CFO, actuary, and LCB fiscal staff.
5. **Plan losses left unaddressed / cross-subsidization** — LD PPO cross-subsidized; EPO/HMO lost ~$25 million each year and still runs a deficit; LD PPO in deficit since 2024. Benefits restored with COVID funds that ran out in PY2023 while PY2024 rates assumed the funds remained. Initial assessment suggests expected one-time PY2025 session funding may never have come over or was used for premium decreases rather than rebuilding reserves.

Part 3 — Current Standing

- Clarified the $50.1 million referenced in Dr. Irvin's letter: ~$18.7 million is an FY27 payment posted early in FY26 (a 13th payment not automatically journaled to FY27 by the new system — expected to generate another I. Bailey audit finding). Adjusted carry-forward into FY27 is ~$31.4 million, of which ~$15 million was previously Board-approved for transfer to Admin and ~$16 million remains under reconciliation.
- Reserve requirement ~$121.5 million (IBNR ~$63M, catastrophic ~$53M, HRA ~$5.5M). Available cash ~$1.6 million as of September 10; projected ~$16 million by June 2027 (best case ~$32 million if reconciled funds belong to PEBP). IBNR shortfall ~$47 million (best case ~$31 million short). Projected cash would fund only ~25% of IBNR (best case ~51%), leaving HRA and catastrophic reserves unfunded.
- **PY2026 net results by plan:** CDHP surplus ~$21.9 million; LD PPO deficit ~$22.6 million; EPO/HMO deficit ~$14.7 million; overall program deficit ~$14.6 million (covered by reserves). Segal noted a 15% rate

increase needed for LD PPO and 44% for EPO/HMO to match claims; 21% of EPO members moved to LD PPO for PY2027. PY27 medical trend 6%, pharmacy trend 11%.

- **Next steps:** finish reconciliation/forensic audit (goal end of year), monthly internal reconciliation via BETS, rebuilt budget workbook, centralized fiscal team, actuarial services going out to bid, Segal reevaluating PY2028 phase-in steps, corrections in Gov-Rec budget, a one-time ~$40 million request to rebuild reserves, support for an independent legislative audit, and alignment of the upcoming TPA procurement.

Board Discussion

- **Dr. Davis** (former EO during the relevant period) sought clarification on the $26 million, recalling it was set aside to enhance benefits and estimated by actuaries to last three years. Director Weeks said initial findings suggest the one-time money was used for both buy-downs and benefits and was exhausted within one year; former EO Celestina Glover notified the Board the money was gone, but the system side was not corrected. Dr. Davis expressed concern that a three-year estimate lasted only one year.
- **Chair Wells** and **Director Weeks** clarified the $50 million (Dr. Irvin's figure) and the separately identified ~$56–60 million are different: the latter is budget authority without revenue behind it. The 2025 Legislature approved a reserve-replenishment decision unit without cash funding; everyone (budget creators, GFO, LCB) missed it. The money is not sitting in any account. The December/January meeting will not reveal a missed opportunity but will confirm the authority/revenue gap. The 28–29 budget workbook now includes a reserve-replenishment line item.
- **Tom (Zimtabel)** asked about the effective date of the new contribution-verification process (implemented ~April this year) and raised recurring concerns that loss ratios are shown against amounts collected rather than owed. He offered NVHA assistance from the Medicaid eligibility team and reiterated concern about cost-shifting in the high-deductible plan harming sicker/younger lower-income members. Chair Wells added detail on steps provided to DHRM/Central Payroll and the State Controller, noting implementation remained unconfirmed.
- Discussion confirmed reconciliation is complete through end of FY26 (June), pending Comptroller's Office processing of journal entries.

No action taken (information/discussion).

---

7. Board & Agency Duties, Policies, and Procedures; Budget Expenditures; Plan Design Changes — For Possible Action

Updates to Duties, Policies & Procedures (EO Carsten)

- Presented language updates reflecting prior Board votes: tier factors/ math equations (p. 20) and subsidy percentages (p. 22): active employees 6.5% (of CDHP total employee rate); active employee spouse/domestic partner 28% (of spouse/DP portion); active dependent children 25% (of dependent portion); retirees 36%; retiree dependents 25% (of dependent portion).
- These reflected prior decisions; no additional motion was required.

Segal Presentation (Debbie Donaldson & Amy McClendon)

- Reviewed PY23–26 financials: expenses exceeded revenues each year, totaling ~$128.4 million drawn from reserves. Noted the LD PPO is more generous today (deductible originally $500 with $5,000 OOP; later eliminated, now $3,000 deductible / $5,000 OOP).
- Reviewed EPO/HMO plan design and costs: EPO/HMO is the highest-cost option (~25% above LD PPO; PY27 participant-only premium ~2.4× the LD PPO); driven largely by the northern (EPO) market. Older, higher-risk population; ongoing anti-selection as healthier members migrate out (membership fell from ~4,100 in PY21 to ~1,700 today, with a ~25% drop in PY27). PY27 is the first of two phase-in years to the true rate.
- The fully insured HMO produced loss ratios below 85%, generating refunds to PEBP and participants (second such year).
- HPN presented an initial PY28 fully insured renewal of 8% (conservative trends: medical 9%, pharmacy 18%; ~17% retention).

Plan Design Options Presented:
- **Option 1:** Move HMO from fully insured to self-funded EPO ("back-room" change, largely invisible to members); projected savings ~$6–9 million (mostly pharmacy rebates; Save-On SP savings not included and could add more).

- **Option 2:** Self-funded with a two-tiered in-network option (Tier 1 = preferred/value-based providers based on cost efficiency, risk adjustment, and HEDIS quality; Tier 2 = all other in-network). Total projected savings ~$7–10 million. Tier 1 co-pays lowered; Tier 2 slightly less generous (e.g., $200 vs. $100 deductible) to steer members. ~17% currently use Tier 1 providers (North 18.5%, South 16.1%).
- **Option 3:** No change (continue fully insured; negotiate the 8% down).
- **Option 4:** Previously presented EPO/HMO options.

Member Discussion:
- **Dr. Duncan** raised rural access concerns regarding tiering, asked about provider movement between tiers based on access, and frequency of tier re-evaluation (annually). She expressed interest in the value-based nature of Option 2 and stressed the importance of clear provider-tier identification on HPN's website.
- **Chair Wells** confirmed northern market costs drive higher EPO costs (also affecting CDHP and LD PPO).
- **Laura Rich** noted the HMO would need to be re-bid regardless, which could itself cause disruption; argued self-funding (Option 1 or 2) creates more long-term stability with the same network and providers; changes would be mainly on the pharmacy side.
- **Dr. Harper** asked whether grouping the entire participant pool together would be advantageous for the next TPA procurement; Segal indicated it eases administrative load.
- **Chris Paton** sought clarification on whether the HMO itself generates the deficit; Segal clarified HMO premiums more than cover HMO costs (hence refunds), but the blended EPO/HMO rate means the HMO slightly subsidizes the EPO. Discussion addressed the relationship between anti-selection and the below-85% loss ratio, and that the HPN refund reflects a broader book of business, not solely PEBP's population.
- **Tom (Zimtabel)** confirmed Options 1 and 2 open the door to value-based contracting discussed in strategy sessions.
- **EO Carsten** emphasized staff and Board are not "tone deaf" to HMO retention; self-funding could mitigate cost increases while preserving the plan design.

Motion 1 (Option 3 — No Change):
- **Motion:** Jim Barnes moved to adopt Option 3.
- **Second:** Paul Davis.

Vote: 2 in favor (Barnes, Davis); remainder opposed. **Motion FAILED.**

Motion 2 (Modified Option 2):
- **Motion:** Dr. Duncan moved to move the HMO to self-funded and to work on creating a two-tiered network option, with the tiers brought back to the Board for review prior to execution.
- **Second:** Laura Rich.
- Discussion clarified the motion executes tiering (allowing HPN negotiations to begin) with final Board review/approval of the networks; Tier 2 would remain essentially the same for members (only one provider not included).

Vote:
- **In favor:** Duncan, Rich, Paton, Harper, Grimmer
- **Opposed:** Barnes, Davis

Motion CARRIED.

---

8. Express Scripts Corrective Action Plan — Amy Donohue & Amy Daily (Information/Discussion)

- Reviewed PY25 (July 2025–June 2026) performance guarantees (PGs) met (eligibility, account management, reporting).
- **Non-protocol (clean prescription) PG:** Missed every quarter for the last three years. ESI explained the PG (100% within two business days) is "aggressive" and, as written, cannot realistically be met due to provider outreach, weather/shipping factors, and high volume; a single late prescription causes a miss. ESI argued an "average of two days" standard would be consistently met and pays PEBP when the metric is missed. Mitigation: patient notifications and a 7-day retail fill (copay typically waived, cost covered by ESI) while mail order processes.
- **Member satisfaction PG:** Missed in prior years; improved in last three quarters. Low response rate (~350 responses/year, ~20% satisfied noted in commentary). Account team added customer-service information to address Smart 90 confusion. Proposed increasing mobile app/website adoption.

Board Discussion:
- **Dr. Duncan** stated this "is not an action plan"—lacking targets, deadlines, and root-cause analysis. Noted 9% were late (more than "one prescription"), that clean prescriptions requiring no outreach were also delivered late, and that

accredited specialty pharmacies should have summer/winter shipping policies. Challenged the member-satisfaction response that promoting online tools addresses members who lack smartphones or web access and may be calling in. Requested ESI confirm what policies are in place and provide a true corrective action plan with dates and root-cause analysis.
- ESI apologized, committed to improving percentages (while stating the PG as written will never reach 100%), to continue paying penalties, and to provide a better action plan with dates. ESI also offered to share per-call satisfaction survey results.
- **Tom (Zimtabel)** emphasized the PG's importance to patients awaiting medication, not the administrative penalty, and asked about patient recourse.
- **Dr. Harper** asked whether the 7-day retail fill is proportionately priced (yes; copay typically waived; ESI absorbs cost) and observed that pharmacy prices can be appreciably lower than mail, suggesting many members use pharmacies.
- **Joy Grimmer** asked about the percentage of members using retail pharmacies vs. mail; ESI did not have the figure on hand but confirmed members may fill 90-day scripts at retail. Noted price-assure/GoodRx pricing is pulled in for Nevada PEBP members.

No action taken (information only).

---

9. PY26 Claims Technology Incorporated (CTI) Audit Findings — Willis Towers Watson / Via Benefits (Joni Amato, CTI) — For Possible Action

- HRA claims during the audit period: ~$15.7 million across ~156,000 transactions.
- Financial precision, processing precision, and turnaround time all remained high and improved; all three measures exceeded metrics—no performance penalty due for the HRA plan.
- Two errors in the random sample (one financial — denial of an eligible expense; one procedural — incorrect date of service).
- Eligibility screening identified 83 members with ~$50,000 in payments not appearing eligible; CTI recommended internal review.
- Via Benefits self-reported PGs: two Q2 metrics missed (quarterly customer service speed-to-answer and quarterly customer satisfaction), each carrying a $2,000 penalty — **total $4,000**.

Board Discussion:
- **Chair Wells** requested more information on Via Benefits' overpayment recovery process and success rates (Report p. 6 noted 2,086 transactions / ~$1 million overpayments without recovery amounts). **Chris Garcia** (WTW/Via Benefits) explained the three-attempt notice process, that many overpayments date to the first plan year (bad data) or delayed death-status notifications, that future payments are offset against overpayments when members remain eligible, and agreed to provide a breakdown by cause and aging.
- Discussion of the $50,000 eligibility findings (retroactive terminations, members not on file, payments after end dates); Via Benefits agreed to work with TELUS Health to clean up eligibility and provide overpayment information.

Motion: To approve the audit and assess $4,000 in penalties.
- **Motion:** Laura Rich (noted as moving); **Second:** Dr. Duncan (confirmed as voting second).

Vote: Motion carried by voice vote (ayes; no nays).

---

10. Q4 CTI Audit Findings — State of Nevada PEBP Plans Administered by UMR (Joni Amato, CTI) — For Possible Action

- Scope: Q4 PY2026 (April 1–June 30, 2026). Total paid medical/dental claims ~$87.7 million across ~259,000 claims.
- UMR's financial accuracy, overall accuracy, and turnaround time (14- and 30-day) all improved; PGs met, no penalty due. UMR met all 34 self-reported PY2026 metrics.
- Random sample identified three financial errors (two provider discount calculation; one incorrect coordination of benefits). Targeted testing identified improvement opportunities in provider discount calculation, duplicate payments, plan exclusions, and preventive services with cost-share applied in error.
- Post-audit remediation actions were included in the report text (as requested after Q3).
- Eligibility screening identified 178 members with ~$259,000 in payments not appearing eligible; CTI recommended PEBP review workflow.

Board Discussion:
- **Dr. Duncan** noted roughly a third of appeals were overturned and asked about root-cause analysis, criteria changes, and prior-authorization removals. **Rhonda Huckabee (UMR)** described monthly appeals reporting to PEBP, a prior-authorization review conducted two years ago, and annual UMCM review. Dr. Duncan expressed concern about denials of preventive services and requested further review. She also raised recurring manual repricing errors (SHO pricing).
- **UMR** explained SHO pricing is migrating to the Facets platform (phase one underway; PEBP move scheduled ~December pending success with other Nevada clients) so pricing is handled by staff who know the contracts.
- **Director Weeks** cautioned that system transitions require extensive data cleanup and asked about preliminary transition efforts; UMR affirmed the goal is to resolve the problems.
- **Chair Wells** requested overpayment history/aging (broken down by plan year; top causes: corrected billing, corrected pricing, other insurance) and discussion of the eligibility verification process. **PEBP/TELUS/UMR** explained retroactive terminations are the leading cause, plus newborn additions under NRS and eligibility-data discrepancies between vendors.
- **UMR** provided a two-year PG overview: 324 of 336 PGs achieved across PY25–26 (100% in Network and UMCM administration; 156 of 168 in Claims Administration, with 10 of the 12 missed by less than 1%).

Motion: To approve the Q4 CTI audit findings for UMR-administered plans (no penalties).
- **Motion:** Laura Rich.
- **Second:** Joy Grimmer.

Vote: Motion carried by voice vote (ayes; no nays).

(A ~10-minute recess was taken at the request of Dr. Harper after ~3 hours 15 minutes; the meeting resumed thereafter. Dr. Harper noted he would leave by ~1:45 p.m.)

---

11. Acceptance of Biennial Compliance Report — Amy Dunn (Segal) — For Possible Action

Ms. Dunn (with Pinar Shapiro and Debbie Donaldson of Segal) summarized the review required under NRS 287.04252(2)(b) for PY2027. Most findings relate to plan-documentation clarifications rather than operational issues. Highlights:

- **Federal notices:** Revise certain notices; continue distributing mandatory notices via new-hire packet and annual distribution; update CHIP notice to the July 2026 DOL model; verify wellness-program requirements for voluntary disease management programs.
- **Document consistency:** Resolve inconsistencies among Master Plan Documents (MPDs) and between MPDs and SBCs (vision benefits, physician references, dependent maternity benefits).
- **Mental health parity:** CDHP, LD PPO, and EPO MPDs limit autism treatment to age 22; consider removing the age limit to reduce federal parity risk and review September 2026 guidance.
- **No Surprises Act:** Clarify that prior authorization does not apply to emergency inter-facility air ambulance transfers; address continuing-care protections in the CDHP MPD.
- **Clinical trials:** Clarify coverage of routine patient costs for approved cancer/life-threatening-condition trials per the ACA.
- **Nevada findings:** Telehealth (permit audio-only for mental health/substance use disorder); HIV/hepatitis C (clarify HIV prevention/treatment drug coverage and STD testing/treatment/prevention); prescription drug provisions (MAT for opioid use disorder, step-therapy exemptions for stage 3/4 cancer, emergency prescription procedures, medication synchronization partial fills, and early refills of topical ophthalmic products).

Board Discussion:
- **Chair Wells** confirmed PEBP staff will lead document updates, targeted for the January meeting.

Motion: To approve acceptance of the biennial compliance report.
- **Motion:** Paul Davis.
- **Second:** Joy Grimmer.

Vote: Motion carried by voice vote (ayes; no nays).

12. Contract Status Report — Jennifer Gill — For Possible Action

- **Overview:** PEBP continues coordinating contract administration/ oversight with NVHA following the transition.
- **New Contract:** TELUS Health — participant enrollment, eligibility, and accounting system; term January 1, 2027–December 31, 2030; NTE ~$6,271,190 over four years; two optional one-year extensions.
- **Contract Amendment (Action):** Extension with Claims Technology Incorporated for continued independent audit/monitoring services (HRA claims, quarterly/annual UMR monitoring, pharmacy auditing); pharmacy audit estimated 5–9 months; proposed cost $179,420; extension through June 30, 2028.
- **Solicitations:** NVHA, through State Purchasing, issued a competitive RFP (October 22, 2026) for Pharmacy Benefit Manager services for Nevada Medicaid and PEBP; anticipated award June 8, 2027 (subject to Board of Examiners approval).

Board Discussion:
- **Laura Rich** raised concern about the number of PEBP contracts ending in 2028 and whether staff are prepared for the procurement timeline, particularly the large TPA procurement. **EO Carsten** noted a planning meeting scheduled that Thursday with Director Weeks's team, that postings for 2028 contracts would need to be ready by ~May, that some contracts may be amended to stagger procurements, that TPA/network is viewed as a priority, and that additional vendor support for RFP writing is being considered.

Motion: To approve extending the health plan auditor (Claims Technologies) from June 30, 2027 to June 30, 2028 at $179,420.
- **Motion:** Received; **Second:** Received.

Vote: Motion carried by voice vote (ayes; no nays).

13. CY27 Meeting Dates — Theresa Carsten — For Possible Action

- Discussion focused on January: the proposed January 21 date may conflict with pre-session budget hearings and State of the State. The Chair recommended holding the January date until those events are announced, with intent to move it up (not back), noting actuaries must price plan designs by March.
- Legislative update meetings to be added (likely starting late February), to be held virtually; action may occasionally be required.
- Remaining dates generally fall on the third Thursday of each month.
- Chair Wells noted he likely will not be present for January.

Motion: To approve the CY27 meeting dates with the exception of January 21 (to be held pending further information), and to add legislative update meetings.
- **Motion:** Paul Davis.
- **Second:** Joy Grimmer.

Vote: Motion carried by voice vote (ayes; no nays).

---

14. Receipt of Quarterly Vendor Reports (Period Ending June 30, 2026) — Information/Discussion

No reports were pulled for discussion. Reports received as presented.

---

15. Public Comment (Second Period)

No public comment was offered in Carson City or on the phone.

---

16. Adjournment

- **Motion:** To adjourn; **Second:** Received.

Vote: Carried by voice vote (ayes).

The Chair thanked attendees and wished all a happy Thanksgiving. The meeting was adjourned.

These minutes are an unofficial AI-generated summary based on the meeting transcript. Some speaker attributions and figures may be approximate due to transcription limitations. Official minutes are maintained by PEBP.