In The Matter Of:

Public Employees Benefits Program Board

Transcript Proceedings Telephonic Open Meeting

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

TELEPHONIC OPEN MEETING

THURSDAY, SEPTEMBER 26, 2019

CARSON CITY AND LAS VEGAS, NEVADA

The Board:	DEONNE CONTINE, Chair LINDA FOX - Member JOHN PACKHAM - Member TOM VERDUCCI - Member LEAH LAMBORN - Member JET MITCHELL - Member
For the Board:	BRANDEE MOONEYHAN Deputy Attorney General
For Staff:	DAMON HAYCOCK Executive Officer LAURA LANDRY Executive Assistant LAURA RICH Operations Officer CARI EATON Chief Financial Officer NANCY SPINELLI Quality Control Officer
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THURSDAY, SEPTEMBER 26, 2019, CARSON CITY, NEVADA

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CHAIRWOMAN CONTINE: It looks like it's 9:00 o'clock. So we'll go ahead and get started. This is the time and place for the meeting of the Public Employees' Benefits Program. It is September 26th, 9:00 a.m. We are at the Legislative Building at 401 South Carson Street in Room 1214 with videoconferencing to the Grant Sawyer office building at 55 East Washington, Room 4412, and we're also streaming from the PEBP website.

I'll go ahead and open the meeting with a role call.

MS. LANDRY: Deonne Contine?

CHAIRWOMAN CONTINE: Here.

MS. LANDRY: Linda Fox?

MEMBER FOX: Here.

MS. LANDRY: Leah Lamborn?

MEMBER LAMBORN: Here.

MS. LANDRY: Jet Mitchell?

MEMBER MITCHELL: Here.

MS. LANDRY: John Packham?

MEMBER PACKHAM: Here.

MS. LANDRY: Tom Verducci?

MEMBER VERDUCCI: Here.

MS. LANDRY: And members Christine Zach, Mandy Hagler and Don Bailey are excused.

CHAIRWOMAN CONTINE: Okay. It looks like we have a quorum.

Item Number Two, public comment. Is there any public comment in Southern Nevada? No.

MR. UNGER: Yes.

CHAIRWOMAN CONTINE: Oh, yes. Go ahead.

MR. UNGER: Yeah, are we on? Can we see each other?

CHAIRWOMAN CONTINE: Yes. Go ahead, Mr. Unger.

MR. UNGER: Yes, Douglas Unger, employee benefit -- U-n-g-e-r. Employee benefits representative UNLV Faculty Senate and immediate past chair.

Good morning. And as ever, thank you for all of the work you do to help sustain the quality of life of Nevada state employees. We are all in this together doing our best to provide optimum health plans within available resources, and we're grateful for your service.

Regarding Board Agenda Item Number 11, we have asked two very modest but meaningful improvements, a 300 dollar increase to our dental benefits. With that over the past eight years have lost 20 to 25 percent of coverage value for basic care such that state employees are regularly

putting off dental procedures at potential risk to their health.

We've also requested a modest lowering of out-of-pocket deductibles by $100 for single employees and $200 for families to provide at least token relief to the estimated 50 percent of PEBP members who incur the deductibles yearly in a work environment which state employees' salaries are continuing to lose purchasing power when adjusted for inflation, healthcare costs continue an increasing burden, as well as an alarming disincentive for the retention of faculty and staff.

We estimate the cost of dental plan improvement to be $757,000 and the modest lowering of the deductibles which would also bring the CDHP plan precisely in line with announced 2020 federal guidelines would cost a very roughly estimated 1.1 million dollars. We believe both are reasonable prudent requests. Still, we understand the executive director will not recommend either today based on estimates for excess reserves far lower than expected.

As a representative who has followed actuarial projections and audits of PEBP for the past seven years, I must express no little skepticism about the figures being reported today. Historically projected excess reserves have been underestimated by millions every year and for financial

year 2019 by some 16,000,000. We place no faith whatsoever in the accuracy of the estimated 3.2 million in excess reserves for financial year 2020, and we believe the increased IBNR and catastrophic reserve increases are in excess of what they need to be.

Past history is often prophecy. We believe that's the case with the current reserve projections. So even though today's Board decision may be not to approve, we ask that you leave the door open for a reconsideration of these modest improvements by tabling them for now but only for now and revisiting our requests should next quarter's figures prove like last year's and the year before when excess reserves accumulated by many millions more than estimated.

If the Board can leave open the possibility of such a reconsideration, we pledge to work together to advocate before the interim finance committee in a united strategy to avoid any negative reception of PEBP and its capable staff by our legislative leaders should excess reserves accumulate in amounts that might draw negative scrutiny.

In sum, we propose leaving these plan improvements available as backup possibilities with priority for the dental benefit and informing the IFC of this

contingency.

Regarding Agenda Number Item Five, the Unum issue, we recognize option number two rather than option number three or to extend the payroll deduction capability four more years to allow enrolled members and the company in more seamless and free transition.

We also agree with the Nevada Faculty Alliance that it might be a very good idea to retain an outside consultant to review Aon and PEBP and the way they have been estimating costs and reserves to make sure our plan is conforming the best practices.

We note last spring's disagreements of PEBP estimates with those presented by the Governor's finance office as further reason for an outside consultancy which could provide PEBP with additional authority before the legislature should any similar disagreement happen in the future. Thank you very much.

CHAIRWOMAN CONTINE: Thank you, Mr. Unger.

Is there anybody else in Las Vegas? Okay. Is there anybody in Carson City for public comment?

MR. ERVIN: Good morning. My name is Kent Ervin, E-r-v-i-n, representing the Nevada Faculty Alliance, the independent association of Faculty, all eight institutions.

Thank you for your hard work and your

consideration of what is in the best interest for the Public Employees' Benefits Program and its members. I'll have to leave to go to teach.

So we have some comment today on several of today's agenda items for your consideration. On Agenda Item Five, Unum, you know, some employees and for full disclosure, including myself, who bought into Unum long-term care insurance years ago based on good group rates at younger starting ages. I was younger then. Our -- we're hanging on despite the increases of premiums because of the long-term care policy.

Having payroll deductions makes it easy to keep up with monthly payments. We fear that pushing the policyholders to private direct payments will increase the likelihood that they will inadvertently lose coverage because of changes in bank accounts or credit cards. We know that's the situation for retirees, but working people are busy and things happen.

Since payroll deductions are already being done by the payroll centers, there's no increase in administrative burden to continue to grandfather those premium payments. So those should continue regardless of the decision on extension of the group contract for new enrollees.

On Agenda Item Number 11, plan design, we echo

everything that Unger had to say about that. We respectfully request inclusion of the proposals that I've submitted in writing for cost analyses in the November meeting. So that potential cost saving measures can be offset with more broadly applicable benefits if funds turn out to be available, and so that employee groups like NFA have the data needed to advocate with the legislature on these issues.

So those include increasing the dental maximum and decrease of the HDHP deductible as recommended by the UNLV group and faculty sense.

And also in addition of no cost preventive services from the recently expanded IRS list for chronic conditions, lowering the HDH -- oh, and a free preventive coverage for an annual benefit exam to make that a uniformed benefit across all of the PEBP plans, and finally lowering the HDHP out-of-pocket maximums as we requested previously, so especially the two that Dr. Unger talked about.

So why this whole list because that's what our members tell us they want for one thing and what we need to attract and retain the high quality faculty that help with our mission to help students succeed.

With that said, we have made the recommendations for cost analyses modest and affordable based on the continued revenue exceeding expenses according to the

financial, quarterly financial reports we've been seeing and until today's projections in Agenda Item 11 regarding changes to the mandatory report for the reserves.

Regarding the dental maximum, I retired in 1990 and this was the booklet I got. I had to move offices so I cleaned up and found this. The dental maximum at that time was $1,500 with a lifetime deductible of $100. So it's still -- it went up. Then it came back down. It's currently 1,500, the same it was almost 30 years ago. Instead of -- apparently, it wasn't my lifetime for the lifetime deductible because now it's an annual deductible.

The other deductible is also quite low here for a completely different plan design, but dental costs have gone up about a factor of three since then. Are we're still doing a 1,500 dollar deductible? Folks needing a crown to avoid needing a root canal are delaying those procedures, either not doing them or delaying them to another plan year because of the cost. They still have to pay 50 percent which was the same in 1990. But, you know, we just need to keep up with dental inflation over the last 30 years, and so the modest proposals that have been presented would just start raising the -- those maximums to help people out, and we know that dental health is critical for overall health.

Finally, also in my submitted comments, I created

a table because I was having trouble deciphering all of the data in the -- in the -- the projections versus the closing year actuals. So I've submitted that. Hopefully Board members either have or will get a copy of that.

So the attached table shows a comparison. I projected 2019 reserves from a year ago at this time. This meaning a year ago versus actual closing at the end of the fiscal year and projected reserves in Agenda Item 11. Although a 14,000,000 dollar spend down was listed a year ago with projected ending reserves of 5.5, instead of being spent down, the actual ending cash balance increased by 7,000,000 with new ending excess reserves at the close of the year of 22,000,000.

The reason these reserves go away in the projections for the current fiscal year is that the actual -- actuarial mandatory excess reserves are increasing by 9.5 million which is 7,000,000 increase for the IBNR. That's a 13.5 percent increase. It will be interesting to hear Aon why they are going up so much all in one year and 2.5 million for the catastrophic reserve. Plus the 9.6 million that's being paid out in the HSA supplemental contributions.

So that leaves a projected ending balance for this fiscal year of only 3.3 million and then the reserve goes for the next year with the projected HSA contribution

goes down to 240 or so thousand which is essentially zero.

However, the fact that these projections have been wild underestimates almost every year in the HDHP plan, a certain degree of skepticism is warranted as Dr. Unger said. It's curious how these seem to fluctuate at this time of year, low, low available funds versus at the end of every fiscal year.

So to understand this, we would like to have a breakdown of the mandatory reserves for the HDHP plan and the EPO plan since the EPO was just implemented last year. We believe it's important for you as Board members to know where the excess reserves are going to and coming from between the two plans for fairness and to avoid a cross subsidization.

Secondly, we strongly recommend that the assumptions and methods used by the PEBP Board and its actuary Aon be reviewed in comparison with best practices by an independent actuarial consultant.

The likely outcome of a review is that they will say PEBP is extraordinarily well funded as far as its annual reserve levels. So that's good news to have. Then either they will say, great. Stay the course or they might say there's a systematic underfunding or over-funding issue here, and here are the best practices in the industry of what could be done about that to avoid these fluctuations and these

continuing evolving excess reserves or generated excess reserves that are going to be a target in the next legislative session.

So I believe this is simple due diligence that the Board ought to carry out, and I don't know the cost, but I think spending a few tens of thousands of dollars on such a review is money well spent.

Thank you for this opportunity to provide input for the improvement of the program.

CHAIRWOMAN CONTINE: Thank you.

Go ahead whenever you're ready, Ms. Lockard.

MS. LOCKARD: Thank you, Madam Chair, and members of the committee. My name is Marlene Lockard, and I'm representing the Retired Public Employees Of Nevada.

I would like to associate myself with the comments made by Dr. Unger and Dr. Ervin. We too would like to add an emphasis on the actuarial review. We have now had almost nine years of the excess reserves from 2011, yeah, nine years. And the fluctuations, we've testified numerous times at numerous committee hearings, and we think there needs to be a true up of what actually is being expended in benefits versus the income from premiums. So we -- we echo that call.

The Retired Public Employees recently met in Las

Vegas last weekend. We want to thank Executive Director Damon Haycock for coming and presenting to our convention, but it was quite clear at the convention that we would really ask that this body review the life insurance coverage for our retirees, as well as the dental and the vision benefits. We do not feel that those have been restored to the pre 2011 stages and are inadequate in today's with cost of living increases over that period of time.

So with that, I thank you in allowing me to speak. Thanks. Bye-bye.

CHAIRWOMAN CONTINE: Thank you.

MS. MALONE: Good morning to the Board. Priscilla Malone with the AFSCME retiree chapter.

As usual, I'm piggy-backing on the excellent work of Dr. Ervin and Ms. Lockard. I did speak to my president of my board as in regards specifically on the item agenda in the agenda on the Unum contract. And the problem for us right now is we have no way quickly of ascertaining how much of our membership is effected by that, but as always, Dr. Ervin does an excellent job of covering all possible concerns about how that specific item on the agenda is handled, and so we would just -- I ask my board permission to just give a resounding me too to everything that's been said by both the RPEN representative and the Nevada Faculty Alliance

representative, so thank you.

CHAIRWOMAN CONTINE: Thank you.

Is there any other public comment? Go ahead ma'am.

MS. PECORINO: Good morning.

CHAIRWOMAN CONTINE: You have to push the button.

MS. PECORINO: Good morning. This is Nikki Pecorino. That's N-i-k-k-i P-e-c-o-r-i-n-o with Unum long-term care out of the Reno field office for Unum.

And I would like to address the last comment made in regards to access on how many retiree members are in the pool of around 804 for our existing policies. The migration to what we call the individual direct paid division 999 is a very hard number to extract out of the Unum system only because the national pool of direct pay includes many states and movement of addresses and so forth, but I can now with the request, thank you very much, try to exceed that.

There is a division in the billed section of the policy language called division 11 for PERS retirees. And PERS retirees may if they have a deduction move that long-term care deduction in there. We don't know the number of lives, but currently it holds about $8,500 a month in premiums. So it's an option for those retirees either to go into direct bill.

The one area that's even a little harder to qualify, and this is coming from the NSHE side is the fact that most of the NSCHE eligible are not utilizing PERS because they are not eligible for PERS. So they are probably landing mostly into direct pay. In 2013 direct pay was around 193 direct pay billed into the pool of Unum. Currently there's about 470.

So when we do see the migration into retirement that even though the policy number has remained severely static during these rate increases in the last part of this contract, we -- we do see the migration over into direct pay.

And if I may make a final comment and I wasn't sure I would be up here this morning to do so, but I really want to thank PEBP executives not only for their patience and their very educated comments and inquiries regarding the contract. It's -- when the contract was renewed six years ago it was with the benefits committee here with PEBP. It was also trying to look into that crystal ball of benefits which we all know is a very challenging area to look at. And the estimation of what was going to occur in the marketplace in the last six years has certainly been surprising, especially for Unum, one of the larger underwriters of the long-term insurance.

As the original procurement team back in 2001

seeing these generational products develop to meet consumer need, the landing into group voluntary in the public sector was a very strong icon for Unum. The ability for them to retain new enrollees, they are one of the very few companies in the nation when these closed contracts happened in 2015 and the marketplace changed to -- to retain new enrollees is very important. It sustains the contract actuarially, meets consumer access needs.

And as we see the growing need for long-term care coming, as I'm unfortunately kind of an age appropriate person to be talking long-term care, not only as a person who gives care to family members but coming into where my family is going, mom, are you going to need long-term care. This is a sustainable product through public sector, and we hope that retains not only the ability for new enrollees but also for payroll, and we will certainly adhere to whatever the Board decides in regards to this policy.

And it does have a lifetime policy for those people who are in a direct bill environment and have the opportunity to convert into that direct bill environment depending on your decision here today.

And the final comment is made and like how much coverage does this policy actually provide. It wasn't really a fact that I've been thinking about very much until the last

few days and weeks. So out of the 804 insureds, if we take the average because this is a number that we couldn't really extract out of the system either because some policies have increased inflation benefits and so forth. But if we take the average purchase of a 3,000 dollar benefit for three years, that lifetime maximum is $108,000 with private dollars for long-term care times the 804 policies. If we averaged out without any kind of inflationary protection growth is over $86,000,000 of private funded personal long-term care dollars coming into this state to meet the need of our growing seniors. So thank you very much.

CHAIRWOMAN CONTINE: Thank you. Is there any other public comment in Carson City?

Okay. Then we'll go on to Agenda Item Number Three, PEBP Board disclosure for applicable Board meeting agenda items. For PEBP is Brandee Mooneyhan from the Attorney General's office.

MS. MOONEYHAN: Thank you, Madam Chair. As counsel for the Board and pursuant to Nevada ethics law, I'm making this disclosure on behalf of the Board members who are eligible for PEBP benefits. All current Board members except Ms. Zach and Mr. Verducci are eligible for the Public Employees' Benefits Program which means that they, their spouses and/or their dependents may receive health, dental,

life insurance and other benefits through PEBP.

On today's agenda, Agenda Item Five relates directly to benefits available to PEBP members. As it concerns the status of the voluntary long-term services contract with the vendor. And, of course, several items really indirectly to benefits available to PEBP members.

When PEBP members, Board members vote on matters affecting benefits for themselves, their spouses and/or their dependents that may trigger disclosure requirements under NRS 281A.420. Pursuant to the law I'm offering this as a general disclosure on behalf of the Board members who are PEBP participants.

I would also like to note that Board members who are PEBP participants can still vote on matters directly affecting their benefits as long the benefit or detriment to them is not greater than that for similarly situated Board members.

Thank you, Madam Chair, for allowing me to make this disclosure and I invite any member who has anything to add in this regard to do so now.

CHAIRWOMAN CONTINE: Thank you.

Is there anybody that has anything to add?

Okay. We'll move onto Agenda Item Number Four, the consent agenda. The consent items will be considered

together and acted on in one motion unless an item is removed to be considered separately by the Board.

Does any Board member have a consent agenda item they would like to have considered separately? Mr. Verducci?

MEMBER VERDUCCI: Yes, Tom Verducci for the record. 4.2.1.

CHAIRWOMAN CONTINE: Okay. Is there anybody else?

Okay. Can I have a motion to approve the consent agenda except for Item 4.2.1.

MEMBER PACKHAM: So moved.

CHAIRWOMAN CONTINE: Okay. I have a motion from Mr. Packham. Is there a second?

MEMBER LAMBORN: I second the motion.

CHAIRWOMAN CONTINE: Okay. There's a motion and a second. All those in favor plea signify by saying aye. Any opposed?

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

CHAIRWOMAN CONTINE: Okay. The motion carries six to zero. And then we'll consider 4.2.1, the budget report.

Go ahead, Mr. Verducci.

MEMBER VERDUCCI: Yes, Tom Verducci.

In terms of the budget, the projected income under all other we're showing a budget of 1.8 million. We're showing the actual at 12.2 million. So that's a difference of $11,000,000 of 584 percent, and it's under a column titled other. So I think I just would like to have a little more understanding of if that's from rebates and if that's sustainable year after -- year over year.

MS. EATON: Cari Eaton for the record. Thank you, Mr. Verducci.

That all other revenue category consists of treasurer's interest which is based off of funds that are in our -- mostly in our required reserve accounts, also prescription rebates and Medicare Part D subsidies, so all of that revenue adds up to those.

And our treasurer's interest and prescription rebates were much larger than when we built the budget two years ago. So moving forward, if they remain increased then our future budgets will -- will have larger starting points. Because that's -- the 1.8 was what we budgeted two years ago. So we couldn't see that we would be -- have that increased revenue at that point.

CHAIRWOMAN CONTINE: So, Cari, when you say the reserve, you're talking about just the general reserve that all budget accounts. So we're not talking about any of our

other reserves. We're just talking about the regular budget reserve?

MS. EATON: It's actually all of the funds that are just kept in our account during the year we gain interest on, and because of our required reserves being so large at this point we are getting more interest on those.

CHAIRWOMAN CONTINE: Okay. All right. Are there any other questions?

MEMBER PACKHAM: Yeah. John Packham for the record.

So what proportion of that $11,000,000 is interest and what proportion is rebates, a ballpark. I'm just curious.

MS. EATON: Right. I believe we ended fiscal year '19 with just over $9,000,000 in prescription rebates and just over $2,000,000 in treasurer's interest.

MEMBER PACKHAM: Thank you.

CHAIRWOMAN CONTINE: Are there any other questions? Any questions in Southern Nevada?

MS. SPINELLI: None.

CHAIRWOMAN CONTINE: Okay. Are you good, Mr. Verducci?

MEMBER VERDUCCI: Yes, I sure am. Thank you.

CHAIRWOMAN CONTINE: Okay. So is there a motion

to approve the budget report Item 4.2.1?

MEMBER VERDUCCI: I will make that motion. Tom Verducci.

CHAIRWOMAN CONTINE: Okay. Is there a second?

MEMBER PACKHAM: John Packham. I'll second.

CHAIRWOMAN CONTINE: There's a motion and a second to approve Item Number 4.2.1. All those in favor please say aye. Any opposed?

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

CHAIRWOMAN CONTINE: Okay. Motion carries six to zero.

Okay. Moving onto Agenda Item Number Five, discussion and possible action to determine plan year 2021 and beyond disposition of the Unum contract for voluntary long-term care services to include either extending the current contract an additional four years, closing the policy to new enrollees and continuing payroll reduction for existing enrollees or allowing the policy to terminate June 30th, 2020, and current enrollees can elect continuation of coverage through direct billing. For PEBP is Laura Rich.

MS. RICH: Thank you. Good morning. For the record Laura Rich, operations officer.

This report is to provide information on the Unum

voluntary long-term care contract and ultimately discuss and vote on renewal options. To give a little bit of background, PEBP has been offering this voluntary product since 2001 because of some significant changes in the marketplace and long-term viability of the product in the marketplace. This contract was terminated back in 2013 and then renewed in 2014. At that time there were no other carriers that were offering this type of product to large group employers on a voluntary basis. So PEBP was able to waive the solicitation process, and a six-year contract was extended to Unum. That contract expires on June 30th of 2020.

If you recall back in September of 2018, the Board approved a two-year amendment to the Morneau Shepell contract that included a fully integrated Voluntary Benefit Platform. The intent of this platform was really to be able to offer more voluntary products without having to maintain those direct relationships with each one of the carriers, and this means that there would be a reduced administrative load on PEBP. So there would be no need to manage contracts or to go through all of the separate procurement processes for each of these products.

And although the Board has ultimately or PEBP has ultimate authority over which benefits are offered, really that administrative burden shifts away from PEBP with the

implementation of that platform.

So as a result with the exception of Unum, PEBP cancelled all contracts relating to voluntary benefits and those carriers instead established relationships directly with Corestream, who is a subcontractor for Morneau Shepell, and those existing voluntary policies transition to the new platform and are now being offered along side a lot of new products.

Today, Corestream manages everything from the enrollment files and payroll deductions, as well as a one stop shop for our members to call in, and -- and they have that ability to provide information and answer questions on all of the voluntary benefits that are offered. But due to some technical limitations and lack of approval from its broker, Unum was unable to participate in this process.

So instead, currently, today what we do is we display a link for Unum on the Voluntary Benefits Platform but members do not the have ability to enroll through the platform or really manage their elections, and they -- the various pay centers cannot leverage that single payroll deduction process that's currently managed by Corestream.

Enrollment and utilization in this product is fairly low. About 40 percent of the people who apply for this product do get declined through the medical

underwriting, and today we have about 320 active members who are enrolled. However, a lot of that, the bulk of that enrollment occurred early on because Unum is only reporting in the last two years 24 new applications and of those 24 only 18 new policies were effectuated.

Enrollment in long-term care policies across the board really has dwindled mainly due to significant rate increases in that market. In Nevada specifically, the Nevada Division of Insurance determines the acceptable and fair rates for all companies who offer LTC products. And since 2014 the DOI has approved about a ten percent plus rate increase year after year. And anyone who decides to purchase LTC products after January 1st, 2020 will see a minimum of 15 percent more expensive rates and in some cases really depending on the plan and your age, it can be up to 40 percent more expensive than the 2019 rates.

It's also important to note that since the inception of this contract members have paid 7.5 million dollars in premiums while they have only collected about 2.6 million in benefits.

So there's essentially three options that the Board can select from today. Option one extends the contract by another four years. So in this scenario there's no impacts to members but pay centers would be -- continue --

would continue to be required to manage those separate payroll deduction processes. PEBP would also continue to provide the administrative and contract oversight for a product that has really relatively low new enrollment.

And also there's an element of confusion for members. When all of our other voluntary products are displayed and they are able to be managed in our new portal and all of those payroll deductions come out in one single paycheck deduction, and then we have Unum which is sort of the outlier.

Option number two closes the policy to new enrollees but continues the payroll deductions for the -- for existing members. This option also has no impact to existing members, but this process creates a long-term burden on pay centers because there's really no end date to that, and I can give you a good example of that.

Recently I discovered that some of the pay centers are carrying out payroll deductions from a or for a product that I believe, and I say I believe because there's no documentation to support this, was offered through the committee on benefits back in the '90s. So those payroll deductions continue to occur, and there's no documentation to really support those. They will be occurring until those policies terminate or until the end of time.

I will also add that Unum has reported to PEBP that this is their least favorable option, and that they believe that the cost to Unum to sustain a closed policy without any actuarial growth is risky.

Option three is to allow the policy to terminate and the current enrollees can port their policies by electing to continue coverage through a direct billing process. There's some impact to members because they would -- they would have 60 days to choose to transition that policy, but there would be no change to their premiums or their plan benefits. So it's very similar to how members who leave state service or retire and want to keep those policies, they can continue that through the direct billing process.

This eliminates the burden of managing separate payroll deductions by the pay centers and also eliminates the administrative oversight by PEBP, but let's also not forget that it also gives Unum through the end of June to move onto that platform and make the similar transition that all of the other existing carriers made during last open enrollment. So if Unum is able to accomplish this by June 30th, it will essentially eliminate any impact to members.

PEBP recommends option three. The product experience or this product experiences significant rate increases annually and new utilization is low. Last year the

PEBP Board established the voluntary benefits policy of using a single partner on a single platform. Therefore, for consistency, PEBP also recommends allowing Unum to work with Corestream for inclusion on that platform moving forward.

With that, I'll take any questions.

CHAIRWOMAN CONTINE: Thank you.

Are there any questions in Southern Nevada?

MS. SPINELLI: No, ma'am.

CHAIRWOMAN CONTINE: Okay. Are there any questions here?

MEMBER PACKHAM: John Packham for the record.

I will be supporting option number three if at some later date we got a report or update on what that impact was or wasn't to the members, small numbers, but it would be nice to know.

MEMBER FOX: This is Linda Fox for the record.

I do have a question. So if we chose option two does that mean Unum could not move to the new platform? Could they at some point?

MS. RICH: So that would really be a Board decision. The Board has ultimate authority over what -- what product is offered on the platform. We can certainly make it happen from a PEBP staff perspective.

MR. HAYCOCK: For the record Damon Haycock.

One thing I want to add. Ms. Rich talked about it, but I want to kind of pound it home. There's a policy decision that was made by this Board last year to consolidate all voluntary benefits under one provider for all of the reasons that Ms. Rich has relayed again today, but it also positions the plan in a place where we can offer more benefits than we ever have.

And in that process there were a couple of voluntary benefit providers that provided a little bit of pushback to PEBP ultimately because they had brokers or they didn't have brokers that were collecting commissions on these products and that commission structure would shift over to the new broker which is jointly shared by Corestream and Morneau Shepell as licensed producers in this state.

And if you remember, we had a very strong willed individual come up and discuss one of our products back then and say how much worse it would be if PEBP eliminated a direct contract, and we don't have any data to show that that has occurred.

For consistency sake though, I would imagine that person would come back to the Board if we carved out Unum and gave them a pass on participating on this platform and treated them special compared to all of the voluntary benefits that we provide today because Unum and their broker

would be able to retain those commissions on these products, and none of the other entities that are on that structure that were with PEBP directly before would be able to as well.

So my concern is if we allow Unum to remain off of this platform and offer this voluntary benefit that you will see other contractors or other vendors coming up and saying we would like the same deal, and it will dismantle the ability for us to reduce our administrative burden, and it may jeopardize the long-term sustainability of providing all of those voluntary benefits as one singular package.

So what we -- why we're asking for number three isn't to take benefits away from members. In all of these exact options, nowhere does it say that members are going to lose this benefit. It's just what mechanism do they utilize to get it and how can they keep it, and will we be providing this benefit as a benefit moving forward to new members and there's a way to do that.

So in option three, if we cancel the policy and we cancel the or we allow the policy to expire and we cancel the contract, if Unum can get back onto the Voluntary Benefit Platform and decide to make that businesses decision, then we can renew that actual business policy and move forward. But if they don't, then our opinion, PEBP's opinion is that they are making a business decision to no longer offer this

benefit as a group benefit to the Public Employees' Benefits Program.

So we received comments from Ms. Pecorino on these options and even Unum has said that do not support, and please correct me if I'm wrong, Ms. Pecorino, but Unum doesn't support option two because with no new entrance the risk is higher on Unum.

MS. PECORINO: Do I need to step up?

MR. HAYCOCK: Yeah, you can come up if you want to, but my understanding from the comments is that -- I shouldn't say you wouldn't support, but you would recommend not moving forward with option two and continuing direct billing for these members because the risk is increased to Unum that there are no new entrance to offset the costs as people then start to activate this benefit as they age.

MS. PECORINO: Let me make a first comment in regards to the status of the policy. In 2015 when the marketplace exited the second generational cash reimbursement indemnity plans, Unum also closed that bank of business which set in place static policy language. So it's been very difficult for Unum to come back and say we can make amendments to the contract. We can reinstate this contract or policy and if it does expire without the full integration onto the BV platform, and I fully understand what that

entails now, then that policy does stay closed only to those individuals, and no one can enroll.

I would like to clarify and correct the statement in regards to Unum's presence on the Corestream platform. Prior to the open enrollment when we -- we entered a little late in understanding what that was meaning, and we are current on-line information partner known as AGIS, which is a Unum partner nationwide, and it's one of the largest long-term care information systems out there, allowed us to offer to Corestream a, what I'll call a workaround or a presence on the Corestream site but not fully integrated into the payroll.

Which means if you go out there and you log in as a new hire or as an existing eligible member and you see that Unum long-term care, it does go to a full website with enrolling electronic enrollment and electronic signaturing. So people can enroll there. It's a matter of perception and, again, with Morneau Shepell doing some performance changes as we speak for this next open enrollment, any granted amount of time with new enrollees is appreciated. As a newly broker, I do see a lot of move coming towards new enrollees particularly since there is this electronic enrollment process on the AGIS' site through Corestream, and that's a good thing.

The need purchase power of the enrollees coming to that site is somewhat limited because it's usually a need purchase price. It's a group product that's closed. There's just factors there that don't put them in the same place as other voluntary individually issued products such as Aflac or the standard STD. This is a group voluntary, and you do have control over that.

Ultimately, Unum had told us through the brokerage since this is a closed policy contract, there is no reinstateable event. If we -- if it expires and we weren't given another status of extension at 6-30 2020 and everybody goes to direct bill on that option, then it's not reinstateable back to a benefit offered through PEBP in an active environment. So that's a high concern there in regards to consumer access and the need for growing long-term care private dollars supporting our seniors here in the State of Nevada. So that's fairly important.

Do I think we could actually have Unum move to a more integrated site to engage payroll? That was our first hurdle with the billing system in Unum, and it appears that there is a PEBP requirement for allowing that payroll service to be integrated into Unum and that is an authorization to allow Corestream to have private access to all of the policy information including the name, date of birth, all of that

HIPAA driven information and that has yet to come forward.

If that got triggered between now and the end of the contract, then we do see that payroll system and service on that platform to function, not particularly on individual VB products like the Aflac's and the STD's because, again, this is a group bill, group applied premium against individually paid products. So there is movement there. So I would certainly appreciate option three over option two in any case.

Option one gives everybody the right to perform better as space for technology to meet one another. I think that was a large hurdle regarding a closed contract policy was that there's not a lot of movement in these closed books of business for new technology to integrate because there -- it's a closed policy. There's no new language in other words for that to occur for Unum. So we do have some just intrinsic closed policy language problems.

But anytime we get for more enrollee and for the entities because technology moves quite quickly to integrate would be appreciated. I think it's going to take more than nine months. I certainly will give you reporting on new enrollees on the new marketplace, any new movement but there is certain authorization that's required at any point in time for Corestream and their payroll services to be moved forward

into Unum, what we call eye services system.

May I answer any other questions?

CHAIRWOMAN CONTINE: This is Deonne Contine for the record.

So you say you think it will take longer than nine months and that is to basically be integrated with the Corestream and allow that single, the pay structure that we all desire?

MS. PECORINO: Right.

CHAIRWOMAN CONTINE: So how long do you think it will take if you -- I mean, you want to move forward to do that, and so what is your estimate on that?

MS. PECORINO: Again, that's like six years ago when we renewed the contract, looking into that technology crystal ball is very difficult.

I've spent quite a bit of time talking to Bruce in regards to the performance on the platforms and they are basically there. With the PEBP authorization to give Corestream eye services access, that's a huge piece. So it would be linking again the Corestream enrollment process.

One statement that was made by Unum up front back in May when this first came to light was, and this came right out of Unum contracts, and I'm just the liaison here is since they already have spent over, I can't tell you exactly how

many millions on the AGIS platform which is a fully functional electronic event to allow another system to be built. This has to do with underwriting compliance and a closed language. So there's some components there that I don't fully understand because the language coming from Unum contracts, Portland, Maine basically says since we already have one in place, we're not going to probably authorize the building of that other platform.

So I can't quite tell you since technology has come forward through the AGIS process. Again, arm length away from the Unum core LTC division of operations. That's the only component I couldn't say would take longer, but we can certainly integrate with PEBP authorization the Corestream payroll event. It looks a little bit differently than that individual billing that's currently having with STD standard, even though that platform doesn't look fully integrated out there getting behind the PEBP portal.

But even a two-year extension opposed to nine months may be a space for all parties to be able to say here's a better performance on the Corestream platform. Here is now more integrated payroll and with Unum, I can't really speak fully out of operations contract for them but gives us the brokerage a lot more time to delve into the opportunity for perhaps a, what we call a collaboration between

Corestream and the AGIS because it's already built out.

There was a comment made out of the Corestream in Morneau Shepell early on saying they didn't realize how in depth it was to even build the STD platform, how many inputs that takes. And that would be like if I could bring it down to a lay person's terms to build that particular voluntary product, not a group product, not group billing because it's age rated. It has multiple plan designs. There's thousands of inputs.

So AGIS came forward and said we built over 20 variable programs that are continually changing because there has been these rate increases. So I would say for Morneau Shepell and Corestream to embrace building that database for that electronic enrollment would be something that would have to be really looked at strongly because now we're having a a single age rate from 18 to 80, four plan designs with one to $8,000 in each choice.

So the matrix of building that particular platform into Corestream, it may not -- I don't know its capabilities. I don't know if they can do that. I don't know how deep their platform goes. So that space to find these things out, we have only had five months in open enrollment and a lot going on is certainly beyond nine months, but maybe it's a directive to the brokerage to give

you a report every time AGIS or Corestream connect or we look at that -- that unilateral building into it.

Because Unum's desire, of course, is to be able to provide this very valuable product. Because in the third generation in the marketplace today, you're just -- we're age rated events, there's just things going on. The marketplace has not come forward commercially to be able to meet the need of this product.

CHAIRWOMAN CONTINE: Okay. So from that, you think maybe a year and nine months, is that kind of what I got from that?

MS. PECORINO: Well, that might be something before you make a decision that Morneau Shepell could answer in regards to how deep their platform goes or where they are at in their performance improvements.

I know that the standard got in there and integrated, but I don't think it was a full integration in regards to the electronic enrollment. As well as AGIS hasn't really come forward. They are really kind of waiting for the decision here by the PEBP Board.

CHAIRWOMAN CONTINE: Okay. All right. Go ahead, Damon.

MR. HAYCOCK: Just a couple of quick questions. Damon Haycock for the record.

Ms. Pecorino, hopefully you give me quick answers.

MS. PECORINO: I know. I'm sorry. I give longwinded answers.

MR. HAYCOCK: The Unum product that you offer PEBP today is approved by the Division of Insurance and its total rate structure which includes commissions that are paid to brokers, correct?

MS. PECORINO: Yes.

MR. HAYCOCK: And AGIS is Unum's dedicated broker that collects those commissions?

MS. PECORINO: No. They're a servicing agent to our brokerage.

MR. HAYCOCK: Okay.

MS. PECORINO: We were the original procuring brokerage and still are. I became the lead broker in May. The other gentleman when we procured it in 2001 is what we call a semiretired open or broker.

MR. HAYCOCK: So Damon Haycock again for the record.

Sorry, and I'm not trying to cut you off.

MS. PECORINO: No. That's all right.

MR. HAYCOCK: So if Unum were to move onto the Corestream Voluntary Benefit Platform in a similar manner and

a similar setup and a similar condition structure that exists with all of our other voluntary benefits would that mean that Unum and unfortunately you would lose those commissions. They would be transferred there or would they be split or have you guys had that conversation yet?

MS. PECORINO: Great question. Thank you very much. We're currently paying Corestream for a limited integration platform. They receive commissions on a quarterly basis. It was a very large decision between AGIS, Unum and our brokerage to have a third party fiduciary listed as a broker of record with Unum, has some contractual questions that haven't been answered yet.

However, we as the broker have been paying servicing -- AGIS is a servicing agent to those commissions. We pay it. I was a servicing agent in a dual capacity and now I'm a broker and not a servicing agent. We pay another servicing agent for division one payroll because it's the largest payroll. So it would be a negotiation of what level of services are rendered by the Morneau Shepell and Corestream for how many commissions are paid to them as service agents.

So Unum has their only particular model for group voluntary benefits commissions. It's driven by compliance in departments of insurances.

MR. HAYCOCK: Sorry, I don't want to cut you off. I just want to make sure we get to the meat of the questions. Again, Damon Haycock for the record.

In your testimony you said that you believe that there's going to be, there is today and there will be a large use of the long-term care product in the State of Nevada. Out of 24 applications over two years only seven were issued.

MS. PECORINO: I think it's 17.

MR. HAYCOCK: There is a couple of million people that live here and there's an aging population, and we're talking seven new policies in two years.

MS. PECORINO: Right.

MR. HAYCOCK: Could this be considered, and I'm going to leave this a rhetorical question.

MS. PECORINO: Okay.

MR. HAYCOCK: That this could be a mountain of work for a very limited impact. So I will -- I think Ms. Rich had, if you're comfortable, Madam Chair, or let me turn it back over to the Chair, sorry.

CHAIRWOMAN CONTINE: Yeah. The point I was trying to make. I mean, I think there's only 320 people, but they are getting direct with how old, right. So is there some middle place -- I mean, if they are working towards being on this platform and being a part of that and all of

them working together, then maybe there's a way we can structure something so it wouldn't be a four-year extension or, but I kind of don't get that from the -- from the comments that they have made today, but I think Mr. Chazza (phonetic) has a question or a comment.

MS. RICH: For the record Laura Rich.

I just wanted to add that we did -- we were able to integrate a very similar product which is the voluntary life which also is age rated and so it's similarly or similar to a long-term care product, and the standard was able to integrate into the Morneau Shepell system or Corestream system in under six months. So it is possible.

MS. PECORINO: Oh, good. That's good to hear.

MS. RICH: Like you said, you -- AGIS already has a system that is built. They are utilizing that system and there's a little bit of hesitation to move onto the Corestream platform.

CHAIRWOMAN CONTINE: Okay.

MS. RICH: And transition into the --

CHAIRWOMAN CONTINE: Okay. I'm going to cut off the staff and additional conversation. I'm going to turn to the Board members.

Are there any other questions or comments? In Southern Nevada, anything? Okay. I think Ms. Lamborn has a

motion then.

MEMBER LAMBORN: So really I'm more concerned about the 40 percent denial of those that apply and the increases in the policies that far exceed the normal inflation for healthcare costs. It seems like it's being -- the client is being cherry-picked. So I'm ready to make a motion that we go with option three and terminate the contract as of June 30th, 2020.

CHAIRWOMAN CONTINE: Okay. Is there a second?

MEMBER PACKHAM: John Packham. I'll second it.

CHAIRWOMAN CONTINE: Okay. Motion and a second. Is there any discussion?

I would just like to say I'm going to vote yes on this, but I also know and I'm taking Dr. Ervin's comments earlier. There are people who are used to this. They have probably been on the program or on this for a long time. So just whatever the agency can do, whatever PEBP can do to make sure that everybody fully understands how it's going to work in the future. And, again, maybe we can have a little bit of report back on -- I mean, the impact, potential impact to the -- and maybe just talk about that at the next meeting just so that's one way people will know what's going to happen.

Okay. So with that said, there's a motion and a second on the table. All those in favor please signify by

saying aye. Any opposed?

MEMBER MITCHELL: Opposed.

CHAIRWOMAN CONTINE: Was that, I'm sorry?

MEMBER MITCHELL: Jet Mitchell for the record.

CHAIRWOMAN CONTINE: Ms. Mitchell.

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

CHAIRWOMAN CONTINE: Okay. The motion carries five to one then I believe. Okay. Thank you.

Okay. Item Number Six, discussion and possible action to approve an amendment to the Morneau Shepell eligibility and enrollment system contract to lower per employee per month fees from 1.78 to $1.50 beginning September 1st, 2019 through the remainder of the contract. And for PEBP is Cari Eaton.

MS. EATON: Thank you. Cari Eaton, chief financial officer.

On July 26th, 2018, the Board approved a contract amendment with Morneau Shepell to extend the contract two years through 2023 and for an enhanced eligibility system and Voluntary Benefit Platform.

On July 25th, 2019 an open enrollment update report was provided to the Board that stated Morneau Shepell would reduce the per participant per month fees in response

to the new enrollment tool and Voluntary Benefits Platform rollout.

Morneau Shepell has agreed to reduce the administrative fees from $1.78 per participant per month to $1.50 per participant per month beginning September 2019. This reduction to the administrative fees is projected to save PEBP approximately $670,000 through the term of the contract.

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and Morneau Shepell to reduce the administrative fees through the term of the contract.

And I'm available for any questions.

CHAIRWOMAN CONTINE: Okay. Are there any questions? Any discussion? Is there a motion? Mr. Verducci?

MEMBER VERDUCCI: Yes. Tom Verducci for the record.

I don't see any disadvantage here. We're saving $670,000, and it seems very clear cut that if we go from $1.78 to $1.50 it's going to be more money for PEBP and I'll make a motion unless there's further discussion. I don't know if you're ready for a motion.

CHAIRWOMAN CONTINE: Go ahead.

MEMBER VERDUCCI: Yeah, I would like to make a motion that PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and Morneau Shepell to provide an enrollment and eligibility system for all PEBP plan participants in Contract Number 15941 to reduce fees through the term of the contract.

CHAIRWOMAN CONTINE: Okay. Is there a second?

MEMBER PACKHAM: John Packham. I'll second.

CHAIRWOMAN CONTINE: Okay. There's a motion and a second. All those in favor please or I'm sorry, is there any other discussion? All those in favor please signify by saying aye. Any opposed?

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

CHAIRWOMAN CONTINE: All right. Motion carries, six to zero.

Item Number Seven, presentation of the State of PEBP. And Damon Haycock for PEBP.

MR. HAYCOCK: Thank you, Madam Chair. Damon Haycock for the record.

The State of PEBP report is an annual report provided after the end of the plan year that summarizes all of the actions, activities and different data points that the plan experienced. It is basically our report card, and we

provide it every year now at this Board meeting as soon as we get the close of the year's statistics and results.

On the first page of this presentation we go over our purpose, mission, vision and values. Those are those items that are approved through our strategic plan every year, and then we move into the overview. Of course, we provide, as you well know, a Consumer Driven Health Plan coupled with an HMO in the south and an exclusive provider organization or EPO plan in the north this year. That was the new thing that we rolled out.

We have on page two a table that describes all of the different program enrollment in each of the plans, as well as employees, pre Medicare retirees and their dependents. So you can see we cover just under 72,000 lives over the period of last year.

Then we break out the report into various plan sections. First is the Consumer Driven Health Plan, our primary plan. We did get a slight increase in enrollment, just under three percent. We also got a slight increase in state retirees as well. So that first number was state employees. We did get a decrease in non-state retirees which does happen as that is a closed group. And so as folks age into Medicare or no longer have our plan, they will move off or some will unfortunately pass away, and so that number will

continue to decrease over time.

As far as utilization and costs, this is my first State of PEBP where I get to say we actually had an increase in costs on the medical plan, almost five percent medical costs on a per employee or per retiree basis from plan year 2019 to 2018. We ended up having an increase in high cost claims and that's what drove that increased utilization.

We had 34 additional high cost claimants, an increase of 21 percent of the previous year. This is significant and we define high cost claimants as members with claims greater than $100,000. I believe the HMO and Nevada utilizes a 50,000 number. I think the previous HMO in Northern Nevada uses 50 but we use $100,000.

And our average costs for each of those claims is just under $220,000. So when you look at the amount of folks that were increased from year to year and the total average cost, you're looking at about seven and a half million dollars, and I'm going to pause here for a second because that number is going to help describe what happened to our excess reserves later.

So 700 and a half more million dollars went to 34 people. So without these claims, if we were to carve them out, we actually would have realized only a small increase in total overall costs, but the enrollment would have offset it

and we would have had another year of negative trend. So if you're looking for a culprit, it is the high cost claims which is why our medical trend was increased this year.

On the pharmacy side it was a nine percent increase and total cost. But when you factor in the rebates, as we do at PEBP, we are a one for one plan. Not all plans do that. It was only about a 5.1 percent. And if you remember this time last year, we were -- we were saying that it was a dramatic increase, somewhere I think around 17 percent. So we were able to through good management and decision-making by the Board implement cost saving activities that helped slow down that trend on the pharmacy side.

There were new programs and services that were provided, one Healthcare Blue Book. That's our shining star program. We had over 77,000 searches conducted by our members to try to find a low cost, high quality providers of care. We had almost 5,000 guided tours, and we provided about 26, almost $27,000 in incentive checks to provide members who chose high quality lower cost alternatives. This is a dedication to that value on the first page of transparency where folks can get on and shop and look.

And a little sneak peek here yesterday, we were told from the state and local governments benefits association, the major organization that is the national

organization where just about every state plan and local plan who tries to attend every year their annual conference, PEBP has been selected to present on this specific program. So we will be presenting in their annual conference in Louisville, Kentucky next April. So we're very excited to be honored with that.

To combat the rising pharmacy costs, right, we, as I mentioned earlier, there was an implementation of a voluntary network for 90-day drug fills. We also implemented enhanced funding for the health savings accounts and health reimbursement arrangements where we require folks to observe or to attend four different activities, preventive or wellness activities to see a doctor, to see a dentist, to get their teeth cleaned and to get their associated lab work.

We also included a requirement to at least be exposed to the two technology applications that we provide. One, Doctor on Demand which is our on-line virtual visit so folks that want to get help for certain types of acute scenarios and not wait until the next day or not wait for a doctor's appointment to get on immediately and seek services. That has been a very good program for PEBP.

And then, of course, the introduction of Healthcare Blue Book. We wanted to expose as many people. We met with them for an end of year outcomes meeting last

week or maybe, excuse me, I think it was earlier this week and we exceeded far -- far higher engagement that they ever anticipated and we credit that to that incentive program.

We also included 3-D mammography or three dimensional mammography as a preventive benefit paid 100 percent by the plan and then continued programs and services included higher level of life insurance and, again, enhanced HSA/HRA benefit of $200.

We released, this is now on page four, a self-insured exclusive provider organization or EPO plan that replaced the northern or rural Nevada HMO plan provided by Hometown Health many years to PEBP. We were, of course, faced with significant increases and rates, and this was our solution.

We were able to drop rates even though they were blended with Southern Nevada significantly from what was paid prior so eight percent. I think you've heard me say this before, that's eight percent of the year before where we were facing a 13 percent increase this last year so that's a 21 point swing. We were very lucky to be able to do that.

We did pattern our EPO plan closely to the outgoing HMO plan to minimize disruption, and we did have a pretty significant enrollment as compared to what it was before. I think it went up even higher than what was in the

previous HMO plan, but about 8,500 covered lives. Utilization and cost there -- you know, there's some numbers here that we describe with per participant per month or per employee costs were. One thing that is very important is that the high cost claims on a per capita basis were the same on the EPO plan as they were with the CDHP. So they are both experiencing the same level of high cost claims per capita. So if that trend continues that could become a problem, if those increased high cost claims continue to increase even further.

We will be able to report a year of your trend at this time next year because it being the first of the year of the plan, we don't have a previous plan trend, and it's truly unfair to match our trend against what the HMO outgoing trend was since they managed the plan a little differently.

As far as accomplishments here for the program, we completed strategic planning. The planning session was held last year in August, and in November the Board approved the revised plan. We, of course, outlined three simply and purposeful strategies, improving the access to care, improving the member experience and reducing cost to the program. Everything that PEBP presents to the Board and to our stakeholders is framed within that strategic initiative.

The -- we, again, conducted a member satisfaction

survey from October through December in 2018, and we can report very, you know, favorably that all of our results for all of the same questions that we asked have increased between four and nine percent per category. So we believe our customer service and our ability to support our membership is increasing through this survey.

We still are a little low on training and education. You'll see that number somewhere near the bottom of page. 59 percent of those reported responses were between eight and ten. Those were the highest levels. But at 59 percent we would love to see something a lot higher. Personally I would like to see 100 percents in all of these. So we will not stop striving to be better at what we do for our membership.

CHAIRWOMAN CONTINE: I have a question.

MR. HAYCOCK: Please.

CHAIRWOMAN CONTINE: This is Deonne Contine for the record.

I just had a quick question. What is the overall member participation on the surveys or what percentage or just employees not covered lives, but.

MR. HAYCOCK: Excellent question, Madam Chair. Damon Haycock for the record.

We only send these out to households, and so we

don't have folks and like their children also respond. I can't say that they don't but that's not the intent. I think we send it out to 35, 40,000 households, and we get somewhere between eight and 10,000 responses depending on the year.

And the report that was actually presented back I believe in January of this year on this satisfaction survey has those numbers. I just didn't bring it with me today so I apologize, but we're well ahead of the five to ten percent national standard of reporting to an outside survey.

We received another award last year for, actually earlier this year for the American Business Awards for Organization of the Year, a Gold Stevie. So we're very excited to be recognized nationally for our efforts.

And then as the pattern continues, PEBP can't leave contracts alone so we continue to work with all of our old contracts and then we also implemented new contracts. We brought in American Health Holdings. We signed a contract last pan year, but it didn't go into effect this plan year so we don't have any State of PEBP yet to talk about that transition for utilization management and large case management services.

We performed again a second year in a row a market check on our Pharmacy Benefits Manager which resulted in millions of dollars of savings which is about 5,000,000 as

they were compared against other PBM's and other book of business clients, and we were able to renegotiate that contract.

We were able to renegotiate the HealthSCOPE Benefits third party administrator contract and reduce fees about 55 cents, as well as some recoveries on shared savings programs. With Willis Towers Watson and the Medicare Exchange via benefits we were able to eliminate all of the administrative fees as of this July, and so there is no cost, direct cost to PEBP to access the HRA reimbursement processes through Willis Towers Watson.

We extended, as you've heard from an earlier report from Ms. Eaton, we extended the Morneau Shepell contract for the Voluntary Benefit Platform as well as an improved member facing portal, and then we cancelled the voluntary life and short-term disability contract standard because they moved onto that platform.

The bottom of page six, customer service, you've seen these numbers every quarter from PEBP, but for the year our phone calls, walk-in's and e-mails, we received about 46,000 phone calls in plan year '19, an increase of almost 5,000 over the previous year.

Our average time to answer calls increased as well as our abandoned call rate. Something that we're going

to call an outlier this year because of a couple of significant factors that effected PEBP especially during open enrollment. One being that there was a lot of concern and confusion about when rates were going to be posted, as well as the pushing of that open enrollment to adhere to the legislative decision-making process, as well as a new system with a new voluntary benefit program, of course, will cause not concern but questions as it is -- was brand new to the program with a lot of new benefits, and so that prompted a lot more interaction between PEBP and the membership which then increased our calls, e-mails and those type of things and those associated statistics like average time to answer or abandon calls or the like.

Then we don't -- we assume, I'll go out on a limb this year and say we believe that those numbers will improve next year as things settle down. And to our knowledge today, unless something significantly changes at the Board meeting the benefit package you see today will be pretty similar to the benefit package we'll see next year. If that occurs it should reduce the type of statistics where we're getting peppered with calls on new products.

We dedicate ourselves on in-person education and outreach. Not everybody likes to take phone calls or e-mails. So during the month of May we report that almost

500 employees attended a series of enrollment meetings across the state, and we also provided a webinar. Our solution, the materials were available to folks who could not attend. That's only one form of in-person education outreach in our communication plan.

And in our required statutory reports to the legislature and to you as a Board every year, we outline all of the different communication activity. So we didn't rewrite them here. But in the back of that communications report there is page after page of the opportunities that we share communication about our plan and the benefits and how to maximize those throughout the year.

We do have fiscal year performance indicators. It's something required by the budget every biennium. We try to set goals that are achievable, often we exceed them, rarely do we not. In this specific occurrence we missed it by a fraction. For most of these it was by about one percent except generic drug utilization. I think, and this is the number I provided for this report, but there are two generic drug utilization numbers. There's the generic drug utilization number as a totality of all drugs, and then there's a generic utilization number based on how many brands actually have a generic equivalent.

And I think I grabbed a number for the totality

and not the generic equivalent, and this number is supposed to be higher, and I can fix that moving forward, but we have a generic over brand policy here at the State at PEBP, and so every opportunity that there is a generic and a brand drug that we require folks to use the generic drug unless they have gone through a series of utilization management practices like step therapy or if they have a bad result utilizing the drug and it is all managed through our Pharmacy Benefits Manager to ensure that we maximize generic drug utilization.

On page eight we go into the finances. We took in just about $519,000,000 of revenues split up over our standard revenue -- our standard revenue categories from our beginning cash, all of our reserves to the state subsidy or the employer contribution that we take in, as well as the member premiums, and then we spend, of course, the same amount because at the end of the year you end up closing the year in balance of $519,000,000, and you'll see that the lion's share of what we spend on self-funded claims, as well as reserves. A very small amount was used in administrative costs and operations. And then, of course, there's a small portion that we shoot out in premiums to the fully insured products like our HMO's.

I'm not going to go necessarily over, too much

over page nine because we've already talked about them at a high level. We can go -- I can go into more detail if you would like. The reserve utilization is the same type of reserves that we've had every year here at PEBP that you've all seen. You know, we have the IBNR occurred but not reported reserve. We have the catastrophic reserve. We have the HRA reimbursement reserve that we fund at 100 percent, and then we have whatever is left over becomes excess at the end of the year.

We did use those reserves for plan year 2019 as excess reserves to increase basic group life insurance from employees and retirees. That is now part of the base plan in this biennium. So it will not need to be paid for out of excess reserves moving forward, and we did increase enhanced CDHP HSA/HRA funds, as well as continued to pay those Medicare life insurance and Medicare Exchange, HRA fees which those HRA fees will now go away as of this July.

You guys also used it again to cover 3-D mammography and a one-time supplemental to the Medicare Exchange Retirees of $2 per month per year of service. That's spent down reserves approximately 5.4 million.

So you've heard already some of the future challenges, the rise of high cost claimants. That's something that we have to watch. It would be very fortunate

if this was just one of those bad years where you just got a run on those high cost claims and that they reduce again 20 to 30 and become a little bit more expected or if this is something that is kind of a precursor as to what is to come, and we're going to watch this very carefully because if this becomes the new normal then we're going to be coming back with recommendations on how we manage this population and more importantly how we can prevent these moving forward.

And there's also, of course, the continued increases to specialty drugs. There are new drugs that come out on the market everyday. There are new drugs or old drugs that get new indicators that could be used for other -- other disease states, and so those costs are something that we work very closely with our Pharmacy Benefits Manager to try to manage through a myriad of programs and services in an effort to not reduce the benefit to our membership.

One thing I will say that every utilization report I get from my Pharmacy Benefits Manager, it just seems that PEBP seems to be absorbing more of the cost of the drugs and the membership is absorbing less on a per percentage basis even though everybody is paying more, and it's really hard to see and understand that you're actually getting more help from your plan when your prescription costs go up, but we're actually more of the lion's share of those costs.

So that's the overview of the State of PEBP. We're very proud of this program. We're very proud of our recognition. We're very proud of our national presence, and we're very proud of our ability to manage this program to value the membership, as well as the plan's solvency and ultimately the Nevada taxpayer who pays for it.

And with that, we'll take questions.

CHAIRWOMAN CONTINE: Any questions?

MEMBER PACKHAM: John Packham for the record. I have a question, a question of curiosity. 4.6 per 1,000, is that statistically remarkable that it was the same across both of the high deductible and the EPO, and I'm just curious, how does that compare nationally or maybe regionally?

MR. HAYCOCK: For the record Damon Haycock.

You stumped me, Mr. Packham. I don't have that number but I will get it back. I'll make sure that you guys have that.

MEMBER PACKHAM: Moving on.

CHAIRWOMAN CONTINE: Mr. Verducci?

MEMBER VERDUCCI: Yes, Madam Chairman. I would like to ask Damon a question here.

I'm reading here that we have 34 high cost claimants that cost us seven and a half million and earlier

in the report we saw from rebates we had an additional 11,000,000. So now our excess reserves are down, and I see additional income, but we're down with a 34 high cost claimants, and I'm also questioning the elimination of the preventative and wellness programs and how that has had an impact on our excess reserves.

MR. HAYCOCK: For the record Damon Haycock. All good questions.

A lot of these answers are in a table I think on Item Number 11, and I'll briefly talk about them here, and we can go in more detail there. The 34 high cost claimants are in addition to what we had the year before, so it's not total 34, but it's 34 additional. And what that did is it did lead to a higher medical trend than we thought.

And if we can define what an excess reserve is, we can all agree what an excess reserve is then it all kind of makes sense. We report projected excess reserves every quarter, but really at the end of the day an excess reserve is excess cash on hand once you've satisfied all of your liabilities. And part of those liabilities is the increase to our required reserves moving forward. If we don't backfill those required reserves with excess when we have it then we are actually supposed to raise rates to fill that need.

And so we have been able to not raise rates even though our required reserves have increased over time because we have had that excess reserve bucket to backfill them first.

So kind of think of it with your own checking account. By the time at the end of the month, once you've paid all your bills and you bought all your food and you've had all your fun, what's sitting there as a balance for the next month is excess, and so that's how PEBP looks at it, but we can't know our excess reserves truly until we close the fiscal year because we might have a mountain of cash in December but then we have 34 more high cost claims that burn it down, and they actually increase that medical trend and, therefore, that excess reserve isn't truly an excess reserve.

So you will hear from folks, public comment. You'll hear from us trying to describe, well, where are you on excess reserves? What do you project? What do you think? If you go back and look at every report that we provided you on projections, I don't think we have ever hit it at the end of the year, and so it is such a volatile number that we have put our name to this September report as the actual determination of excess reserves because that's how we close the fiscal year and that's the true cash on hand that we have left. Anything else is a projection and nobody that I found

has been able to project it accurately.

Now, how does the, you said the rebates and everything else, rebates are already built into the rates that we have today. We'll see if the rates that we were provided by -- by the legislature will hold true to those determinations. We won't know until we close next fiscal year. And so, remember, there's a cycle to how revenue comes in and how expenses go out when it comes to claims because we have a one-year timely filing requirement for claims.

So Damon Haycock can go to the doctor today and his doctor cannot bill PEBP for almost a year, but Damon Haycock is paying premiums today, and so we may be receiving a lot more revenue than what we're outlaying in expenses, and then it all catches up. And so I know it's kind of like an accordion, but it's something that occurs with health plans all the time.

So how does it work on our excess reserves? I'll go into the numbers on 11 if you're comfortable with me waiting because I'm just going to repeat myself then as well, but I think it will answer your questions better.

MEMBER VERDUCCI: So come November will we have a better idea in terms of knowing those exact figures and those excess reserves?

MR. HAYCOCK: For the record Damon Haycock.

You're going to see the same table in November. That is how we close the fiscal year. We can project what we will have, but it is extraordinarily premature to say we know what we're going to bank by the end of August next year. It would be unfair to the program, it would be unfair to the Board and it would be unfair to all of our stakeholders to come out and say, wow, for three months we've had X. So we think it's going to go for 12 and that just -- it would be inaccurate.

MEMBER VERDUCCI: Thank you very much.

CHAIRWOMAN CONTINE: Are there any other questions on this item? Okay. Hearing none, before we go on to the next item, why don't we take a ten-minute break. So see you back at 10:40.

(Whereupon, a brief recess was taken.)

CHAIRWOMAN CONTINE: All right. We're ready to get started again. So we're on Agenda Item Number Eight -- no, Number Nine, discussion and possible action to update PEBP's -- PEBP's Board's duties, policies -- oh, wait, sorry. Are we on eight? Yeah. Sorry, we are on eight. Discussion of possible Board direction regarding updating the PEBP strategic plan, and Damon Haycock for PEBP.

MR. HAYCOCK: Thank you, Madam Chair. Damon Haycock for the record.

What you have before you is a document. It's basically last year's strategic plan and then there's some comments put off to the side for really ease for the stakeholders to see how we reported, if we actually met some of these strategic initiatives or not. It follows the same format. We talk about our background, our mission, vision and values.

We actually met. In the back of this document is a strategic planning session overview that occurred in 2019 on August 7th and 8th up in South Lake Tahoe, and we outlined who all attended. One of the requests last time was to ensure that we brought Willis Towers Watson, which we did. Mr. Verducci, you were there for one of those days, and so we believe we had a pretty good representation. It was a large room, a lot of people, a lot of ideas moving around.

The first day we discussed are end of year statistics and success in meeting those goals and then started talking about opportunities in round Robin type of process. And then on day two we collectively prioritized what recommended strategies we would present Board members today.

And, again, we discussed some of the nuances that now effect our program. But as many of you already know, during the 80TH Legislative session the legislature approved

our budget with a couple of new requirements that they got to determine the specific employer contribution which then determined the overall rates by default, and then any use of accumulated excess reserves must be approved first by -- recommended by the Governor and then approved in the interim finance committee.

And so that created a different type of environment for us to look at how we were going to spend any potential excess reserves or recommend the spending because of that additional couple of steps that had to clear through the Governor's office and through the interim finance committee.

One of the things we looked at and strategized is taking a slower pace which had been recommended by our advocates many times in the past, and so we have not only looked at what we could do for this next plan year but what we could also do preparing up for the next budget development cycle next summer which we have yet again start this process and develop the budget and talk about what we want to do to the plan for the next session, the 81st session which is going to come up sooner than we all like in February of 2021. So that's how we framed it.

We framed those in short-term strategies, those that we thought we could implement as early as this next plan

year and those that we thought would require more dialogue with the executive branch, more dialogue with the legislature, and those would be ultimate decisions as supported in our approved budget from the next session.

So some of those strategies, and I'll get to that in a minute. But just a little more on what we did on the strategic plan, you'll of see on page three where all of the little red, if you have a color copy. If not it's in gray. That we -- we went through our goals. We felt that the goals were pretty similar. We went through our strengths, weaknesses, opportunities and threats.

And one of our weaknesses, reaching all members consistently. We believe we are reaching them consistently. It doesn't mean that we can't improve upon these. But, again, if we go back to the report that we provide to the legislature and to this Board every calendar year on our communications activities, you'll see that it's pretty massive. But, of course, we can always improve, but we replaced that one with a struggling eligibility enrollment system. You have heard Morneau Shepell already testify to that or they will actually here in a few agenda items, as well as PEBP staff have attested to that as early as the July Board meeting. We did struggle a little bit through open enrollment.

We also lost, not we, but the Board lost final approval for employer contributions, rates and excess reserve utilization so that changes the dynamic of the ability that the Board has to make decisions and then implement immediately.

As far as opportunities exist, we crossed out on-line decisions support because we're not ready to improve upon the system until we have what we feel is a well run system today. We don't want to add more to it.

Direct hospital contracting, that we ended up bargaining away with Hometown Health when we decided to incorporate the exclusive provider organization plan members onto their network and hold Renown to a year over year cost containment strategy. Although, I'm going to talk a little bit about later the potential to direct contract with Banner Churchill which has been cleared through Hometown Health and they should not be complaining or be concerned about that process.

Increasing network providers. So what I have is this comment is, we're still coordinating better with our current networks to ensure a comprehensive level of fair pricing exists, so it still is occurring.

Coordinating assets with HPN. We have worked, reached out to them. They continue to provide us better

reporting and we can see a little bit better under the utilization of the programs that they offer.

Leverage more centers of excellence. We still are in the process of working with our partners and designing or designating what those centers of excellence looks like and that will lead a little bit more into our conversation about what we could potentially do to improve upon the network providers for certain disease states that I will go into in a little bit.

But we did replace increase -- we added increase voluntary benefit offerings and revisited the PPO benefit contracting. Those are the things that we always have as an opportunity. It doesn't mean we need to move forward on those. And at this exact moment we would not recommend increasing voluntary benefits until the platform is working as it is intended, but this does mean we have an opportunity to do so, and then revisit the PPO network contracting. I know that has been -- was brought up by Mr. Verducci every Board meeting just to keep an eye on it based on the position the Board was kind of painted into last year.

We also are looking at cost containment. Last year we talked about mandatory Smart90 network. That is that network with 90-day drug fills applied to the CDHP and that there's an opportunity to potentially apply it to the PPO

plan. And we looked last year at adding more pre-authorizations that's PA's or precertification, but there is a cost and a benefit to those. And with our new partner we have realized that we may have pre-certified things that didn't add value but added cost to PEBP, and so we've reduced those and we're watching it.

And then there's an opportunity eventually to bring back wellness programs. There was a question at the last session as to what does PEBP do for wellness, and I thought wellness was a dirty word. So perhaps there's an opportunity to start looking at and exploring and then providing it back to the legislature to see if they are interested in allowing PEBP to pursue that in the future.

Threats, we had was the new administration 2019 supportive? You know, at this point in time we're working very well with the Governor's office, the Governor's finance office. So we don't believe that there's any issue there.

Policy decision-making potentially influenced by political decision-making. Again, that goes back to the final say that the legislature will have on the use of excess reserves which means they are dictating by default indirectly the benefits that are being offered to the program, and that, of course, could potentially be influenced by political decisions versus by the policy board decisions that you all

have had for the last 19 years.

The rest of those opportunities and threats in the SWOT analysis remains the same as far as we talked about at the strategy session.

A couple of things that, you know, the next session on page four is this actual specific strategies that we're looking to implement and did we do them. One of the things was approve rates with gradual changes versus a sharp impact that we've been smoothing out that process for -- for years. A good example is that if we let the experience of each of the tiers exist without any -- any smoothing, there will be an opportunity for some employees on some tiers to have a rate reduction while some employees on some tiers would have a rate increase. But when you put them altogether, there was a way to flatten it for everybody so no employee felt the actual hit. We have been doing that for the last few years and that's not something that we may be able to continue.

We also looked at if there was an ability to increase the rate by 12 cents or lower the rate by three cents, did we even bother going through the programming of pennies and we did. So that's what I mean by gradual changes.

We also were going to look at researching and

cataloging a comprehensive digital solution, we did get that from Aon. That is something that we need to get updated, but we are constantly and consistently looking at technology and applications that are low cost but high impact to help our membership.

Revamping the member dashboard, that was completed. Although, we do want it be improved, it was actually completed on -- well, it was completed according to this plan, and then to acknowledge and address the disparity between northern, southern, rural Nevada. We do that. We believe that it has become completed. We have acknowledged that.

We -- and one of the greatest examples is that there is a rate -- a rate or excuse me, an employer contribution reduction for the HMO plans, right, and now the HMO and EPO plans. And the difference between the employer contribution percentage or the employer contribution rate that the state provides on the CDHP versus what was provided to the HMO's many years ago was a 15 percent number, so it was a 15 percent spread. We are now as of this session, we have gotten that down to 12 percent. So we are bringing those contribution levels closer and closer little by little, and we have been moving that needle a point or half a point since the last -- last session.

We also recognize that there are three distinct different marketplaces, and those marketplaces have their own advantages and disadvantages. You have more competition in Southern Nevada. You have greater access in Northern Nevada compared to the population surge in Southern Nevada, even though there's many more providers in Southern Nevada, and folks in rural Nevada still have to travel for care, right. So we recognize the disparity.

As far as transparency, we wanted to improve the HMO reporting data to include more program results, and we have reported that we can do that as of the third quarter reporting that was presented last -- last Board meeting. And, again, in our consent agenda, in our utilization report you have the end of year reporting.

So what did we want to basically add to or let me back up. What are the specific strategies that we talked about? We spent a good few hours, three, four hours talking about all of the different opportunities around the table. What were the things that we thought we could move forward, and there was a lot of them, and then we dialed back and thought, well, how much of this process can we really bite off and successfully implement based on the short-term and long-term buckets.

And so for short-term, there was three things

that we thought we could do. And, again, we wanted to potentially frame these on the use of or lack of excess reserves, and how could we if had to not necessarily avoid but incorporate the lack of timing that we would now need to implement to get some of these things off the ground due to the new IFC requirement. So adding the Smart90 network from the CDHP, we would be replicating that to the EMO plan. We thought there may be some cost savings there. We think that that is a strategy worth exploring.

We're also looking at implementing second opinions for high cost high value healthcare. Example, like oncology diagnosis. There are different centers of excellence like the Mayo and Cleveland Clinics, and they report that there's miss diagnosis of cancer all the time and then there's expensive cancer treatment, as well as the pain and suffering members have to go through and that could -- could be a benefit as long as that the return on investment is appropriate, right. If we are going to spend money on a second opinion process, we would hope at the end of the day that we could track and we would track how many -- how much care has been diverted from that was unnecessary and what that cost was compared to how much we paid for that service.

One of our highest cost is disease states is chronic kidney disease, and there's an opportunity that we

can look at or strategy to look at how we better manage that population and see if there's ways to increase compliance with various regimens to ensure that they don't continue to be higher cost as they move forward or any higher cost than they already are today.

Long-term potential strategies, these are things to consider for -- for actually for the budget development for the next session. Stuff like tiered co-insurance, our PPO networks today have this available in one fashion or another, whether it be physicians or just facilities or both, and basically it's another steerage process where if you go to provider A for a service within the network PEBP will honor the AD 20 co-insurance level. That's in our plan. But if you go to provider B who is high quality, lower cost, maybe we look at 90/10, and so there's an incentive which shifts the decision-making onto the member on where they go, and PEBP will honor that -- that decision if it's -- if it saves money and it meets a minimum level of quality to -- to reduce the -- you know, if it's reducing our cost, it should also reduce the member's cost as well. So it's something we can strategize and look at both of the networks to see what that would look like moving forward.

Then there's a program called the Save On Pharmacy program. This program is something that we can

adopt on top of or in place of our co-pay accumulator program. The co-pay accumulator program, if you remember somewhat of a slightly controversial program. We implemented for this plan year was that the manufacturers' coupons that people get for high cost drugs can still be used every month without fail, but the money that is provided to them from the manufacturers does not go against their accumulator, their deductibles, co-insurance and -- and out-of-pocket maximums.

So as they don't satisfy their out-of-pocket maximum sooner in the air, we collect more of those manufacturers' coupons, but one of the drawbacks is some folks will have to continue to pay any of the differences. So this Save On Pharmacy program basically provides PEBP and we need to continue to -- to check the legality of this. I have worked with our DAG, and she knows she's been assigned to look at the legality of this to make sure it meets all of the requirements of the HSA plan like ours.

But the primary function of the Save On Pharmacy program is to designate certain high costs drugs with high levels of co-insurance -- excuse me, of coupons from the manufacturers as non essential. And if they are considered non essential, they don't apply towards the formulary which then applies towards the requirements for deductibles and those types of things, and we can actually set the co-pay for

those drugs at the manufacturer coupon level.

So if you got a coupon that you get for $500 every month off of $5,000 a month drug, we can set the co-pay at $500, and the member just hands us the available coupon and they don't pay anything else, and it doesn't go towards deductibles and it doesn't go towards out-of-pocket maximums, but the member has zero co-pay for this high cost drug for the entire year. So the member wins. We win because we are able to collect that coupon throughout the year, and it's a pretty important program. It could save us millions of dollars. As long as it's legal we'll probably be bringing this back for future discussion.

We also talked about implementing disease management programs or disease management services. We have some ideas on how to help better manage those folks with chronic disease so that way they get the best care that they can while also being the most cost effective.

There has been a request of PEBP over the years to provide an orthodontia benefit. Instead of bolting on an additional benefit with additional dollars to orthodontia, we could actually just build it within the current dental benefit as an accessible item. So you can go get root canals. You can go get, you know, cavities filled, sealed, teeth filled. You can use your annual maximum to go towards

getting orthodontia. So it's something to look at, recognizing if we do that people are going to use that benefit more, and so there will be a cost associated.

And then last but not least, we pitched an idea out there at the strategic planning session about fairness and how folks pay their premiums. You know, I as the executive officer of the Public Employees' Benefits Program can absorb a 30 dollar increase in premiums next year but can every employee or retiree across the state do the same, and we believe the answer is no.

And so with that in mind, is there an opportunity to look at tiering the amount of premiums that members pay based on their income like a sliding scale. I will tell you ahead of time that the major administrative burden is to effectuate this at the pay center level as to how they are going to be able to collect those premiums, especially as people promote from one tier to the next or from one job to the next. So it is we feel a very heavy lift, but it's something we can explore.

These -- these are not the totality of strategic options that exist. These are just what we thought we could bite off and look at for both the near term and for the long-term. And when we get into the plan design discussion, we'll push back to these again, and it's repeated there, and

we'll talk a little bit more about what these look like, but this was what the strategic plan -- planning session was, and these are the results, and I know we had a couple of Board members that are here today that attended, both the Board members down in Las Vegas. Mr. Verducci attended one day here in the north. Mr. Packham did both days and Chair Contine was there the last day.

So at this point I'm going to turn it back over to the Board if you guys have anything else you want to add, those that attended. And then what we're looking for today is basically input on this strategic plan, if you like it, if you want changes, if you want to see additional things added, if you want to see things taken out, and then at the November Board meeting we'll bring you a clean copy for approval to be effectuated at that time.

CHAIRWOMAN CONTINE: Thank you, Damon.

Are there any questions or any discussion about the strategic plan?

MEMBER PACKHAM: John Packham, minor, for the record.

Regarding the disparities between north, south and rural, I was wondering if we could just keep that in there somehow. Maybe continue to address or something to that effect because they haven't gone away.

MR. HAYCOCK: For the record Damon Haycock.

Easily we can add that back in there with a continued statement.

CHAIRWOMAN CONTINE: Mr. Verducci?

MEMBER VERDUCCI: Yes, Madam Chair. I just want to point out that it was a very productive day that I had up there. I think we had all four seasons occur in about one hour from lightning, and we had helicopters going above us, and Damon was worried that we were going to spend $65,000 on an ambulatory expense.

And but, you know, it's nice seeing the faces that show up here and actually hear them talk and their ideas that they came up -- they have come up with, you know, Spartan 90, EPO, Banner now being opened up for the folks out in Fallon where they don't have to take a two-hour drive to be seen, and I would encourage you to keep those going every year.

And I'm happy to see the financial wellness back on the table here as something we're going to be looking at going forward. I think that's important that we have a financial, you know, a healthy membership to keep our catastrophic costs down.

CHAIRWOMAN CONTINE: Thank you.

Any other comments or questions or discussion?

All right. I think that if there's no more discussion, we'll just let Damon go back and finalize the plan and bring it back to us next meeting.

Okay. So we'll move onto Agenda Item Number Nine. I'm having trouble following along with myself. Discussion and possible action to update PEBP Board's duties, policies and procedures to align with legislative action during the 80th session. And Damon Haycock again.

MR. HAYCOCK: Thank you, Madam Chair. Damon Haycock for the record.

This -- we didn't add a report. We just provided the actual red line versions of the duties, policies and procedures. There's some housekeeping things changing the dates throughout the document. There's some grammatic changes. I worked with our grammar expert and Deputy Attorney General Brandee Mooneyhan, who found these as she went through. So thank you, Brandee.

But there's really two areas where there was some significant changes, and I'm going to direct you all first to pages ten and 11 and that talks about under our premiums and contributions and how we set rates the reserve policy. Back in 2017 I presented to the Board and the Board approved that the basic uses of excess reserves and what they could be dedicated to be utilized for because prior to that time the

policy itself said you could only use it to do certain things even though the Board was making policies to improve benefits and make other investments, and so we aligned it back then to what we actually were trying to accomplish and did accomplish. And now based on what was put into the law and the Appropriations Act in the 80th Legislative Session, there's really -- the only ones who can choose what we do with excess reserves is the legislature.

And so we took out on the bottom of page ten, the top page of 11 what we were looking to use excess reserves for, and then we printed out from, and this is the middle of page 11, the exact wording from the Appropriations Act as to how excess reserves could be utilized to include the requirement that it must be approved by the interim finance committee, and everyone has talked about that to include our advocates, but don't forget the last few words, upon the recommendation of the Governor.

So if the Governor doesn't recommend it, it appears, and Ms. Mooneyhan can tell me if I'm wrong, that IFC doesn't have anything to approve, and so it's got to go through a two-step process. Then moving -- well, three-step process, thank you. There will be a recommendation -- well, four really. PEBP will recommend to the Board. The Board will recommend to the Governor. The Governor will recommend

to the legislature, and IFC will approve it.

Then the next area that we did some changes to, you'll see starting on page 16 and into 17, we added some updates. One, we added the EPO plan which we should have added that last year but didn't, and then we added now the additional voluntary benefits for transparency on the middle, top middle page of 17.

And then last but not least, back on pages 19 and 20, we adjusted some of the language there. How we -- how we used to create the employer contribution differential between the HMO plans and the Consumer Driven Health Plan, and we added the EPO plan in here now because that is married up with the HMO plan.

But we -- the purpose of that reserve adjustment, you know, there was a reserve adjustment that we don't use anymore. So we do not use excess and we haven't for years. We don't use excess reserves to buy down the HMO rate.

And that -- the actual subsidy allocation, this is further down on page 19, it's no longer determined but we changed it to recommend by the Board to the Governor during the agency request phase of the biennial budget, which is what we do anyway, and that the legislature through the various money committees will approve the final employer contribution percentage for each biennium when approving

PEBP's budget, right. That's the result of the last session.

So we ensured that the rest of the language here was changed to adhere to that, and that it's based upon their determination, and we plug it into our rate setting and as Ms. Ervin likes to say turn a knob and out comes the rate and that's what they will be for our membership.

And with that I'll take any questions.

CHAIRWOMAN CONTINE: Are there any questions?

I have a question. Do you update these every two years?

MR. HAYCOCK: For the record Damon Haycock.

That's the plan. We can update them faster or sooner based on what the Board would like or if we see something that is missing but, yes, generally every two.

CHAIRWOMAN CONTINE: I'm just asking because the -- that language changing the processes in the back, you know, it's back language. It's not in statute. So, you know, each year it would maybe be updated if it's changed, okay.

Are there any other questions? Do you just want a motion to update the -- yeah, okay.

Okay. So if there's no other discussion, is there a motion then to approve the updates to PEBP Board's duties, policies and procedure?

MEMBER VERDUCCI: Madam Chair, I would like to make that motion.

CHAIRWOMAN CONTINE: Okay. I have a motion. Is there a second?

MEMBER PACKHAM: John Packham. I'll second.

MEMBER MITCHELL: Second, Jet Mitchell.

CHAIRWOMAN CONTINE: A motion by Mr. Verducci and a second by Dr. Packham. All those in favor or is there any other discussion? All those in favor please signify by saying aye. Any opposed?

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

CHAIRWOMAN CONTINE: Okay. The motion carries six zero.

All right. Moving onto Item Number Ten, discussion and possible action to review and approve the Morneau Shepell eligibility and enrollment system performance improvement plan. And it looks like somebody from Morneau Shepell is at the table here in Carson City. Go ahead, sir.

MR. BORGES: Good morning. Bruce Borges, B-o-r-g-e-s, representing Morneau Shepell. I am the customer relationship partner assigned to PEBP and am here to present a summary of the performance improvement plan that Morneau and PEBP have agreed to in relation to our role in supporting

the enrollment eligibility and billing management solution for PEBP.

We have constructed this plan because last year we agreed to a series of enhancements. These included migrating from the existing enrollment platform to Morneau's -- Morneau's most current version, making that enrollment tool accessible and formatted to smart phones and tablets, the integration of an expanded voluntary benefits offering supported by Corestream, the automation of a number of current administrative processes moving from PEBP's current document management system to Morneau's system and putting in place an HRAS feed and employer portal for agency reps to automate data collection.

While these enhancements were meant to be fully functional and live by May 1st, some were delayed to various degrees. In the end we did not deliver all elements of the planned enhancements. We are here to commit to our partnership and have developed a performance improvement plan with resources, milestones and delivery dates that will resolve these issues.

The key elements of the plan include a number of tactical items for completing the solution such as the HRAS interface, decommissioning of the AX document management system currently in place and launching an on-line portal to

capture data changes from the agency representatives.

Additionally, these include revisiting some of the areas of the delivered solution and fine tuning them to better to deliver -- to better deliver to PEBP plan participants and PEBP staff.

There are also a number of elements at the partnership level that we will be adjusting that will help avoid recurrence of these types of issues and provide a better long-term solution for PEBP.

Our goal overall is to deliver a fully integrated member facing intuitive portal that will improve the member experience when enrolling in both standard medical offerings and Board approved voluntary benefits.

PEBP also desires an upgraded client side system where manual processes conducted by PEBP staff are placed with less risky or replaced with less risky thoroughly tested and valued automated processes for eligibility and enrollment and program services.

Morneau Shepell shall create a fully integrated benefits platform incorporating voluntary benefits where possible into an intuitive industry leading member portal and will streamline to the extent possible based on PEBP rules and procedure requirements, all in scope client side operations through collaboration with PEBP employers, and we

will ensure a strategic and robust automation of internal PEBP processes.

In November we will come back and again in January and again in March and finally in May to provide an update on our progress and demonstrate our commitment to resolve all items in the plan to PEBP's satisfaction by April 1.

And with that I will take any questions you may have.

CHAIRWOMAN CONTINE: Are there any questions at this point? Mr. Verducci?

MEMBER VERDUCCI: Thank you, Madam Chair. Tom Verducci for the record.

I first want to acknowledge the reduction in your cost from $1.78 to $1.50. That saves the plan well over 600,000. And how are we in terms of going from a paper environment to paperless? How is the technology in terms of your platform? Are we seeing any improvements or where do we stand?

MR. BORGES: Bruce Borges again for the record. So that's a very good question.

We -- first of all, to your first point, again, we are constantly looking at ways where we can partner with PEBP to make our relationship and the services we provide to

PEBP participants as valuable as possible. So we were happy to make that change on the PEPM rate.

Regarding going paperless, we have made significant strides and continue to work on and that's also part of the performance improvement plan where we're putting more automated processes in place and getting rid of the old document management system through the more automated Morneau document management system.

CHAIRWOMAN CONTINE: Are there any other questions or I don't know if PEBP staff have any comments on the plan or.

MR. HAYCOCK: For the record Damon Haycock. As Mr. Borges has stated, PEBP has worked very diligently and will continue to work diligently with Morneau Shepell on getting this system that we all know and we all deserve to have moving forward. We're dedicated partners. We've been with Morneau Shepell since I believe 2006. And as one person has told me many years ago the heartburn to replace the system has to be less than the heartburn to keep a system or it's a bad decision.

And so before we come to the table and talk about the potential changeover, we want to ensure that Morneau Shepell has every opportunity to provide a good system as they have promised. We feel confident they will, and we feel

confident that this performance improvement plan is a great accountability for that to be showcased. As Mr. Borges said, he will be attending these Board meetings every two months and will be reporting on the actual status.

The one from PEBP who's doing, you know, the lion's work is Ms. Rich. She's been in charge of this process, and so her and her team will be working with a designated technical expert that will be onsite I believe at PEBP in a couple of weeks, and they are going to manage this process moving forward.

We've already seen some great strides by Morneau Shepell from what we were handed in May 1st to today, and we believe that they are going to be able to meet those requirements by April. If not, it won't be a surprise because you'll see them coming up here in November and in January and in March, and you'll know just almost as soon as we do if they are going -- if they are going to make good on it.

But if you recall we had some concerns with another vendor many years ago where we were concerned about the client side service and the customer service, and they turned it around using the same exact process, and so it's not in PEBP's best interest to walk away from long-term partners, but it is in our best interest to hold them

accountable, and that's all I have.

Laura, do you have anything else you want to say?

MS. RICH: For the record Laura Rich.

I just wanted to address Mr. Verducci's question. We're actually starting that testing process in mid-October and we hope to go paperless, I'm crossing my fingers, by January.

MEMBER VERDUCCI: Great. It's much easier without having to fumble through paper and we're in a digital age. So good to hear.

CHAIRWOMAN CONTINE: Are there any other questions or anything else? Anybody? If not, I just wanted to note on the last -- it says a target resolution date of 1-31-19 on the very last row so I just think that should probably be '20, right, 1-3-20.

And then the other thing I would ask, you know, as we come back and look at this and when we have these target resolution dates that it's very clear that if a date hasn't been met in this that we have some indication of the original date and then an explanation or a status on why the original date wasn't met.

So for instance if we come back, you know, and this last one says 2-28-20, you know, if it's just replaced there then we would have to go back to the original

spreadsheet to know that that was changed. So if there are changes and dates and things aren't being met that it's clear in the information that we receive, so that we know -- and it's fine. I mean, sometimes target dates have to change, but we should know when they do change, a way that this could be set up so we could know that and then any explanation of why. That would be my only comment.

All right. So do you want to make a motion to approve this, okay. So is there a motion to approve the Morneau Shepell eligibility enrollment system performance improvement plan with obviously the date change, the one typo?

MEMBER PACKHAM: John Packham for the record.

I move that we approve the plan with changes noted.

CHAIRWOMAN CONTINE: Okay. Is there a second?

MEMBER MITCHELL: Second. Jet Mitchell, Las Vegas.

CHAIRWOMAN CONTINE: Thank you. So there's a motion and a second. Is there any other discussion?

MEMBER VERDUCCI: Madam Chair, Tom Verducci.

In terms of the discussion, should we have a date be brought up in April. Should there be a date that's incorporated with deliverables?

CHAIRWOMAN CONTINE: I think all of the dates -- well, is there the target resolution dates are in the -- we're going to go ahead -- we're going to get an update every or every six weeks or two months. So go ahead, Damon.

MR. HAYCOCK: For the record Damon Haycock.

That date that Mr. Borges mentioned is the do or die date for us receiving everything, but each date within these target resolution dates are for each specific area. And, no, we're not going to replace the dates with new ones. If we push those dates, it will either add another column or it will show it in the status as you see on page -- page -- the page nine that you'll see that there's this contract and they have specific dates even though they happen to match the ease of things change. I think that's where you'll see it.

CHAIRWOMAN CONTINE: The April date, Mr. Verducci, is on page eight. It's right --

MR. HAYCOCK: Yeah.

CHAIRWOMAN CONTINE: -- April 1st.

MEMBER VERDUCCI: Thank you, Madam Chair.

CHAIRWOMAN CONTINE: All right. So all those in favor, is that where we are, please signify by saying aye. Any opposed?

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

CHAIRWOMAN CONTINE: Okay. The motion carries six zero.

And we're moving to Item Number 11, discussion and possible direction from Board on potential design changes for plan years '21, '22, '23 for which the Board requested additional information and cost to be presented at the November 21st meeting. And for PEBP is Damon Haycock.

MR. HAYCOCK: Thank you, Madam Chair. Damon Haycock for the record.

Similar to the last few years and basically on Board policy, we bring to this September Board meeting ideas. Unlike what Mr. Unger had stated, we're not making recommendations today. We're just presenting ideas, and we want to know what you all think, and then we will come back in November and actually make those recommendations on any of the elements that you would like us to look into.

The beginning of this report, bottom of page one, it leads into page two is a reserve reconciliation we've been providing for the past few years. It's kind of paint by numbers approach. So you can see where all of the money has come in and where it is being earmarked. So we closed last fiscal year at 150,000,000 and change and that becomes our starting cash on hand, and of that we have to set aside our required reserves.

The first set of reserve numbers there are what is legislatively approved in our budget. So those figures have been approved by the legislature, have been approved by the Board when we initially presented them, and those are our starting figures.

Then what we do every June 30th of each year is we go in and we look at what are the actual HRA balances on all of our HRA accounts to include those on the CDHP, as well as those on the Medicare Exchange or on via benefits and so we looked at those and as of June 30th that number was about 2.4 million dollars higher than what we have in the HRA reserve budget for, and so we backfilled that HRA reserve budget with 2.4 million of that 150,000,000 cash on hand to make that at 100 percent funded.

We also receive every summer from our actuaries the -- the projections for the incurred but not reported or IBNR reserve, as well as the catastrophic reserves and from their estimation on the speed at which we pay our claims, as well as the fact that our claims costs have increased from one year to the next. Those 34 high cost claimants have something to do with this as well that the IBNR reserve needed to increases.

Mr. Ervin asked if we could have these separated out. I literally copied the old table and updated it. We

did get it separated out by our actuaries and I can provide that moving forward, but they project that we need in totality over both plans an additional 4.4 million to make that reserve at the level in which the Board sets its policies. So let's not forget that Board policy for many years is to set that reserve at a 95 percent confidence level which means 95 percent of the time we're going to have enough money to handle anything. That is an increase amount on top of what the normal projection reserve would be. So based on policy, Aon sets the reserve level.

Then moving forward onto the next page, on the top of page two, you'll see that increase to the cat reserve and there was not an increase. There was actually a decrease. And so what you'll see, there's no parenthesis around it because that money is coming back to the plan. So there isn't a 400 dollar increase to the cat reserve. It's actually a decrease cat reserve or catastrophic reserve, and that's based again on the utilization and their projections and that is across both -- both plans as well.

So what does that leave us with? If you started 150,000,000 and you took away all of the legislatively reserved figures and you added back or you took away the HRA and IBNR increases and then you gave back 400,000 from the catastrophic reserve, that leaves us 12.9 million dollars.

So that's the amount of available reserves as effective for July 1 after closing of fiscal year for this -- for the next two years. And so 12.9 million dollars is the amount of money.

And then we look at, well, what are we required to spend on that already? As we all know, the legislature approved a 400 dollar enhanced CDHP HSA/HRA funding. We had a minor amount of equipment replacement, and we reclassified one of our personal staff. It's a very small amount of funds. The most, I think about 9.5 of that 9.6 million dollars is HSA and HRA funding and it went out the door July 1. It's gone because there was no requirements attached to it. There is no earning process where that would filter in over time. So that money is gone. It's already gone. It's already deducted.

Then we also have a legislative requirement through our budget to provide $3,000,000 worth of additional HSA/HRA funding next plan year. So once you earmark that money and you earmark the money that we have already spent, that leaves us with just under $240,000. And if you recall, one high cost claim averages $220,000 on the CDHP, and I think it's closer to 270 on the EPO. So that's one claim away from being gone. It's two claims away from going negative.

And so normally I get to come here to you guys and say look at all of this money we have. Let's talk about how we're going to carve it up and spend it on benefits and different populations and see who we can take care of, but today I don't see the money there. We don't see it.

And, again, if we do the quick math, seven and a half million dollars were spent on high cost claims above and beyond what we spent last year. Another four and a half million dollars was spent in IBNR reserves. Another -- so that's -- that's 12,000,000, and then we also have given out nine and a half so that's 21 and a half there. We need to give out three next year so that's 24 and a half. We had to increase the HRA budget another 2,000,000. There's 26,000,000. There's all your excess reserves. They are already marked.

Now, does that mean this time next year that we're going to come back and say, look, we're at zero? Well, we don't know how the rates are going to react and to be completely transparent, the rates the Board approved in March are not the rates that we ended up getting in May so we don't know what it's going to look like. It could be higher. It could be lower. It could be negative. We may have to dip into catastrophic reserves or we may be flushed with four to $5,000,000 of excess. We don't know, and we're not going to

know until the end of the year because we're not going to see those claims come in for the totality of that rate collection until the end of the year.

And so although we have all of these strategies and we have talked about things and we have included what, you know, Dr. Unger had submitted in public comment, and we recognize what the Nevada Faculty Alliance is asking for, it's not that PEBP isn't in support of these ideas. It's that we can't show where the money is at. And if it does materialize, we won't know until this time next year because as of today we only show if we have to give out $3,000,000 next year in HSA or HRA funding $235,000 left.

So what does that mean for the environment of PEBP? Well, that means that anything we do on an increase and benefits has to come at a cost savings, right? We're going to have to offset and at least have a return on investment of one to one in that first year or then we're arbitrarily increasing the cost of this plan, and I'm concerned that I'll have to testify to the interim retirement benefits committee and to the IFC and again to the legislature through their full session why -- why PEBP increased their cost when they funded a specific benefit plan, a benefit plan design, and so it's just something to think about as you all direct PEBP as to what you want us to

implement.

So the short-term and long-term strategies have been repeated from the strategic planning agenda item, and you'll see there's an additional one which is the advocate request strategies, and they wanted these strategies or they wanted this plan benefit design to be implemented July 1 of next year, and we don't see that there's funding for it today. And I will tell you right now that number is not going to change by November, but it doesn't mean that some of these things aren't good things for our membership or we can't build them into a budget enhancement item moving forward.

And so there's a lot of strategies. There's a lot of opportunities. Any major benefit design PEBP recommends, and we're not recommending for a vote today, but PEBP will be recommending that any change -- any significant change to the program be built into our budget submission next August, and we're willing to work with our advocates, with RPEN, AFSCME, Nevada Faculty Alliance and have them give us what they are looking at and build that unit for your approval to go into the budget, and then the Governor's office and the legislature can make that decision. So we're not trying to cut out anybody. We're trying to empower all parties and give them an opportunity to have this go through

the Governor's office and the legislative office for final approval.

So to reiterate the short-term things that we see that can be explored for the next Board meeting is narrowing the network for that Smart90 day fill on the EPO plan, implementing second opinions for the high cost -- those high costs services and -- and trying to address chronic kidney disease.

One of the things we put down in long term which is implementing additional disease management programs, we think we may have a way to just increase the level of providers that address those diseases that may be able to provide certain services and options to our membership through -- through bringing them into the network to address that earlier. That will be offset by a cost savings and claims. So instead of claims going for one thing, it could go to these other services, and we'll bring that to you guys in November.

We also have Mr. Ervin's request and we have no problem. He asks for those every -- every year and we have no problem redoing the analysis and updating those again and bringing those back. But if -- if there's anything you don't want to see or if there's anything additional that you haven't heard today and you do want to see, that's what we

need to do, and we can go back and get our partners to price that out and show what that's going to like look for the November Board meeting.

I'll turn it back to you, Madam Chair.

CHAIRWOMAN CONTINE: Are there any questions or comments or discussion?

MEMBER PACKHAM: John Packham for the record. I just want to confirm that what Kent requested have to have cost out to be done.

MR. HAYCOCK: Uh-huh. For the record Damon Haycock.

He asked for things like deductible reductions, out-of-pocket reductions, waiving the fee for or waiving the co-pay for vision. All of those things he submitted in public comment were all submitted in the writing, and it's posted on our website. We'll take directly from there and cost those out.

MEMBER PACKHAM: Because I think it's inclusive of what Mr. Unger is requesting.

CHAIRWOMAN CONTINE: Is there any other --

MEMBER MITCHELL: Chair Contine?

CHAIRWOMAN CONTINE: Go ahead.

MEMBER MITCHELL: Jet Mitchell.

Chair Contine, I have a question for Damon

Haycock. At the beginning of your remarks you said that you were not adding additional items for deeper analysis in November. I just wanted to clarify the beginning of your comments because I wanted to add one future agenda item for consideration in November.

MR. HAYCOCK: For the record Damon Haycock.

I don't think I heard you correctly, but we are here to add whatever we need to for this. It's not that -- it's your call. This is your opportunity as Board members to give us direction, and we will add whatever it is that you deem appropriate.

MEMBER MITCHELL: Chair Contine, Jet Mitchell for the record.

I would like to propose a future item for consideration for November to add an item on the agenda in November to investigate where using Centers of Excellence would be cost effective and provide better health outcomes for PEPM -- PEBP members and all covered by PEBP.

CHAIRWOMAN CONTINE: Okay. Is there anybody -- anybody else?

So I just want to drill down a little bit on something you said earlier that 95 percent on the reserve, and can you kind of explain that a little bit more. You said it was a policy. Is that a written -- is that in the written

policies of the Board and just kind of give the history of that.

MR. HAYCOCK: Yeah, for the record Damon Haycock.

This -- this 95 percent confidence level predates me. I don't know if it -- how much it predates or if it does predate the implementation of Consumer Driven Health plan. My understanding is it was implemented at least as far back as then. We have folks from Aon here who may be able to help out, but it is a conservative policy to ensure that we never have to go back to the legislature and ask for funding.

So back in 1999 the committee on benefits was dismantled and the Public Employees' Benefits Program was created in response to some concerns over a legislative council bureau audit and health benefits of the state.

Then in the first two years, 1999, the session, in the first two years the then executive officer had to go back to the legislature and ask for 20,000,000 dollar bailouts because of the solvency of the plan. And so from that a series of policies and processes have been implemented, a couple through statute but mostly through PEBP Board policy. One is the -- through statute based on the budget award process, the implementation of a catastrophic reserve, right. And then how -- how to set those reserves, that 95 percent. I have to do some homework on to get you

the exact answer, but I know it's been here. As long as I've been here, I know it was here. It predated me. My predecessor had it. I don't know how much it predated him. So we can go back but it's a conservative process and policy that the Board sets.

Here's kind of the trick to it, the Board could potentially change that, right, but then that is changing the overall required reserve level for those two reserves that then would have to go I would assume to IFC for approval because we're changing how those buckets of money look like, and so I think the policy can be approved, but then we would have to release the funds. I have a suspicion they would release any funding back into excess reserves that they would want to have a say in on how it was spent. So just keep that in mind how that -- would you agree, Ms. Mooneyhan? I see your head nodding. That's the legality part of it.

Go ahead, Madam Chair.

CHAIRWOMAN CONTINE: So doing an analysis, doing some type of analysis of the reserve level, the percentage would require IFC approval even if we weren't spending any money?

MR. HAYCOCK: No. For the record Damon Haycock.

I apologize. I took it three steps forward. Analyzing it, we can do it easily. Changing it may require

IFC approval ultimately or legislation.

MEMBER MITCHELL: Chair Contine, Jet Mitchell.

I have a clarification question for Damon Haycock. When you talk about the analysis, would that be an independent analysis, an actuarial independent or would that be Aon analysis?

MR. HAYCOCK: For the record Damon Haycock.

It could be either. If we are going to have an independent party that we don't have on contract perform the service, we have to go through the state solicitation process, develop an RFP, evaluate bids and then put in place a contract for another entity to do this. We can try to get creative and see if there is already an entity with the state that performs these services that we can piggyback on their contract. I don't know if we can do that, but I guess it all depends on what analysis specifically.

Do you want to analyze if Aon is actually applying a 95 percent confidence level or do we want to analyze is 95 appropriate or do we want to analyze -- you know, it's really what is the question being asked will determine the process moving forward.

CHAIRWOMAN CONTINE: And why is that? Could Aon do some of it or is that -- is that why? So explain that, please.

MR. HAYCOCK: So for the record Damon Haycock.

If you want to know like the history of it, why it was put into place and what is the process that Aon does to provide a 95 percent confidence level, I can tell you today it's a 30 percent load on the reserves, right. So that's what the math is, but we can ask them to articulate exactly their process in determining what that should be and why they chose a 30 percent load which equals 95 percent, and I can have Aon do that very quickly.

If you want an analysis done that says is that an appropriate way to run a plan, that then we can also ask Aon to do, and they can go back to their book of business and see and compare us to the rest of their clients and determine yes, we have this many clients that do it or this many clients don't or you're the only outlier or we can go to an independent third party and say what do you guys think, go to another actuarial firm, like a Milligan or a Segal or a Beloit or whoever and say we want to pay you to determine if we are over conservative, right, ultra conservative, right? Are we too conservative? Do we need to release some funds or are we with best business practices.

This wasn't the question asked but I think it's important to state. As costs of care go up our claims will go up which will drive our required reserves up and every

time we give out more money in HSA and HRA funding, we add to the HRA balances of our HRA reserve and if people don't spend it that goes up.

Every time our enrollment goes up, we have to give out more HSA/HRA funding even if it's on the HRA side increases that reserve, and some of you were on the Board, I don't think many of you were at the time. It was in 2017 that PEBP came and recommended we reduce the HRA reserve from 100 percent funded to 85 percent to meet a budgetary need that we thought we had to for that 2017 session.

Actually, I think I did it in 2016 for 2017, right, and it turned out that the budget concerns that were coming out of the budget office at the time, the revenue came in from the economic reform refine, and we were able to fund it 100 percent, but we've looked at it before on that specific reserve that doesn't have a 95 percent confidence level and thought about reducing it because we are convinced that all of the members that have an HRA today cannot spend all of their HRA balances in one year.

And at the time we did the analysis it averaged somewhere around 60 to 65 percent of the funding was utilized and in the worse year it was something around 72, 75 percent and so we added a buffer of ten and said we can release about I think at the time about $5,000,000 back in to cover -- to

cover benefits.

So there's -- there's all kinds of things we can do, but I know that once you make specific changes to your budget categories, the budget office gets involved and then the IFC will want to get involved. So that's just something to think about, but we just need direction on where you want us to go with the analysis. Do you want us to pitch it to Aon or do you want us to go for an independent one that may add some time but could also be valuable.

CHAIRWOMAN CONTINE: I'm not really advocating anything at this point. I just -- I just -- I mean, it seems like we just continue to have reserves, and now there's limited ability to even, you know, consider plan needs to get some of the, you know, spent down. And so, I don't know, I'm just -- you know, and I know, I understand that if the reserve -- if the reserve percentage is less and that just goes to excess and we still have the same problem, but it just seems like we're holding a lot of money that we're not able to utilize for plan participants, and so I was just curious of maybe that looking at some of that could -- could possibly alleviate some of that. So that was -- that was the reason for my question.

MEMBER PACKHAM: This is John Packham for the record.

I do forecasting in my day job. I'm weary of critiquing people who do that, and I appreciate all of the variables that have to be considered. But I think and I hope I'm not a minority on the Board, at a minimum I would appreciate a presentation on their methodology and the assumptions built into those so I can go back and I can explain or defend, you know, my votes on this Board and what we do or think about doing with reserves.

MR. HAYCOCK: For the record Damon Haycock.

We can definitely task Aon to provide that at the November Board meeting and walk through how the IBNR and catastrophic reserves are set. PEBP can take the lead on the HRA but, again, it's just 100 percent of available funds, but we can add in some utilization numbers so you can see how much they are actually using of those funds every year, and then excess is just what is left over, right.

I think it's important and please stop me if you disagree but PEBP has had excess reserves every year since the inception of the Consumer Driven Health Plan and every year someone who is in my position will sit there and say we think it's going to go away and every year it's not, and then we close the fiscal year and we have a bunch of money and we backfill any other reserves and we still have a bunch of money. So it becomes kind of a who can -- who can come up

with the best idea on how to use them.

We all knew, I know, my predecessor knew, his predecessor knew or actually his predecessor, I don't think she created excess reserves. I could be wrong, but we knew that they were eventually going to dwindle, and we cannot develop a program that is based on utilizing excess, and so our plan benefit design that you all approve in its totality is supposed to, I thought was supposed to meet the needs of the membership that utilize it.

And if there's a need we're not meeting, we don't have to have excess reserves or create excess reserves or shift other required reserves to meet that need. We can develop an increase in benefits to provide our membership and then ask to cost share that with the State. So we have options. It's not just, well, we're going to wait for excess reserves before we start looking at additional healthcare benefits.

So before I continue, those in Vegas, can you still hear me?

MEMBER MITCHELL: Yes.

MR. HAYCOCK: Okay. Thank you. We must have had a call in number that was reserved.

So with that, there are other mechanisms that health plans use to increase or decrease benefits and

increase and decrease costs, and we don't have to rely on this excess reserve bucket every year if in doubt or if indeed, excuse me, that that money gets shifted to required reserves. There's nothing stopping us. And to be honest, we ask for more money every session, and so far we've been getting more money every session in state contributions, and rates have been flat or gone down. So I don't know if it's out of the realm of possibilities to look at some of the things that we want to do for our membership and just build them into our budget submission and see if they want to support it.

CHAIRWOMAN CONTINE: So that would essentially involve costing out then those long-term strategies as well by November?

MR. HAYCOCK: For the record Damon Haycock.

For those long-term strategies we can do some of those, but we're not asking -- I don't think it would be fair to ask the Board to make a decision on what we're going to submit August 30th or 31st of next year by November. I think we'll T up some more of those conversation in November and I'm sure between now and then there will be more conversations. I plan to get with RPEN, AFSCME, the Nevada Faculty Alliance and come up with some strategies that we can build into our next budget that we will also talk about in

November. We don't necessarily need approval on those, but then we'll bring it back in January, and then in March is probably the time we really need to talk about approving these so we can actually go forth and build the budget.

CHAIRWOMAN CONTINE: Okay. Mr. Verducci, do you have something else?

MEMBER VERDUCCI: Yes. Tom Verducci.

As part of this analysis we will be incorporating RPEN's and Nevada Faculty Alliance's suggestions in terms of this item?

MR. HAYCOCK: For the record, yes. The answer is yes. Even though I know it sounds like we don't have money and I don't believe that we do in the manner in which we've structured our required reserves, we're still going to perform the analysis by November on everything and as they have asked for.

MEMBER VERDUCCI: So this is an analysis as we as a Board no longer actually approve the expenditures of excess reserves so I think it will put us in a position to see what the cost would entail. So I think it's a good idea.

CHAIRWOMAN CONTINE: So -- okay. So for -- is there anybody else that has -- that wants discussion on this or has questions on this agenda item?

So just to see if I can kind of summarize what we

talked about. So you're asking for a recommendation that we essentially request that you cost the short-term potential strategies so one, two and three for November for discussion?

MR. HAYCOCK: For the record Damon Haycock.

That and what Ms. Mitchell has asked for for the Centers of Excellence which Dr. Packham for Aon and NFA's request.

CHAIRWOMAN CONTINE: Right. Right. So you've asked for one, two, three.

MR. HAYCOCK: Yeah.

CHAIRWOMAN CONTINE: And then Ms. Mitchell has asked for cost for Centers of Excellence, and then there has been additional discussion that's not in the request to cost for the Faculty Alliance and Mr. Unger's group. They are aligned, their requests that were submitted. So that would be essentially the motion.

And then the presentation by Aon we'll just deal with under a different agenda item or do you want to incorporate it into this in some way? Is there going to be a cost to it or?

MR. HAYCOCK: For the record Damon Haycock.

I think we'll build that into the agenda as a separate item that we can go through the process that we have today to assign that agenda number.

CHAIRWOMAN CONTINE: Okay.

MR. HAYCOCK: I don't think we can truly get into it today because it wasn't agendized.

CHAIRWOMAN CONTINE: Okay. All right. I just wanted to clarify what the -- what the motion would be. So if we're ready at this point, is there any additional discussions or questions or?

MR. HAYCOCK: Do you want to entertain public comment? It's up to you.

CHAIRWOMAN CONTINE: Okay. So the motion --

MEMBER MITCHELL: Chair Contine, I have a question.

CHAIRWOMAN CONTINE: Oh, go ahead.

MEMBER MITCHELL: Chair Contine, Jet Mitchell for the record. I have a question.

In the advocate requested strategies which is Dr. Unger's UNLV Faculty Senate Employee Benefits request, those included the dental maximum and the lowering the deductibles for the high deductible and those benefit increases were included, but then the Nevada Faculty Alliance requested proposal also included the no cost preventative services and the vision exam as well. So I just wanted to clarify that the asks were fourfold on for Dr. Kent Ervin and twofold on Dr. Unger, just for clarification purposes for

what the advocate requested strategies were.

CHAIRWOMAN CONTINE: Yes. So the motion would be that, plus the short-term options one, two and three in the report and your other request for costing the Centers for Excellence. So that would be the motion to bring back to us those things in November. If I have that right, can I get that motion?

MEMBER MITCHELL: I will make that motion, Chair Contine. Jet Mitchell for the record.

CHAIRWOMAN CONTINE: Thank you. Is there a second?

MEMBER LAMBORN: Leah Lamborn. Second the motion.

CHAIRWOMAN CONTINE: Okay. So there's a motion and a second. Is there any other discussion? Okay. All those in favor please signify by saying aye. Any opposed?

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

CHAIRWOMAN CONTINE: Okay. The motion carries six to zero.

Okay. So we're moving onto the executive officer report. This is an informational item and not for nothing, Damon, but we heard from you a lot today so, you know. No, I'm just joking.

MR. HAYCOCK: So for the record Damon Haycock.

I will be reading page by page word by word this report to you.

CHAIRWOMAN CONTINE: What?

MR. HAYCOCK: No, I'm kidding. There's only three things on this report that I wanted to share with you outside of any other agenda item. It was the only place we could put it. One, we are very proud to receive URAC accreditation for Core accreditation for a three-year period. URAC has done away with it, and there is no replacement accreditation program that we can participate in. So we were the first and only and now we are the last public sector entity to have been accredited for quality standards on a higher national standard requirement, but that thing will tail out April 1st, 2021 with nothing to replace it.

We are -- one of the reasons why we were able to write out the administrative fees for the Medicare Exchange for the HRA administration is because they were going to replace their third party administrator who we were pushing the funding to for that process to an in-house design but based on the ability to make payments to our membership for HRA reimbursements, we ran into a couple of stumbling blocks, and we need a little bit more time to move forward with that. So we're still going to utilize their third party

administrator through it looks like March, and then in March we'll have a period where we will move from their administrator to the internal Willis Towers Watson benefits management process. From a member perspective, they shouldn't see any changes so there shouldn't be a problem but we will notify them through appropriate communication channels closer to March if there's any delays in the reimbursement.

And then last but not least, we reached out to Banner Churchill Hospital to try to find a way to bring them back into the network. It's something that was affordable. We have been able to take the first steps in discussing and negotiating emergency services because those are causing balance bills for our members, and we have come to an agreement that we are putting pen to paper on so that way we can continue to have our folks go there, and that there won't be any balance bills to our membership.

They were exempt from the balance bill legislation because they are a critical access hospital. So they are the only hospital system that we do not currently have on network, and we're going to be able to have a direct relationship with them. We reached out to Hometown Health providers to see if they would have any concerns about us having that direct relationship. The conversation I had last

week is, no, they had no problem with that, and so we will be able to implement a three-year agreement with Banner Churchill to provide emergency services to our members at a -- at a certain affordable rate, and they have agreed to a cost control keeping that rate flat for those three years.

So we think it's the best deal we're going to get, and we don't like having our members get balance billed out in Fallon, Nevada. So we're going to with -- we're going to bring you back the contract. If you decide you don't want to approve it, then we won't move forward on it, but in the meantime we're going to develop that contract so you can see what it looks like and hopefully by the November Board meeting, and that's it.

CHAIRWOMAN CONTINE: Thank you, Damon. It's always nice to hear from you.

All right. Are there any questions for Damon?

All right. We'll move onto Item Number 13, public comment.

Ms. Lockard, do you want to go first?

MS. LOCKARD: Thank you very much. For the record Marlene Lockard representing Retired Public Employees of Nevada, and I'll be very brief and hopefully a little bit more coherent.

With respect to the discussion on excess

reserves, I'm concerned that this whole issue is getting overly complicated. As advocates we would like the review and study done by third party, number one. Number two, we have never advocated using excess reserves for ongoing, one-shop money, if you will, for ongoing expenses. In the past what we have demonstrated where we have had benefits that had been reduced restored for just a limited period of time. We went through enough time that we were able to persuade Damon to put those enhancements back in the base.

So when we're talking about additional benefits we are talking about adding them back into the base and are not advocating. It's a Cardinal Rule not to use one shop for ongoing expenses, but we do maintain that and especially with respect to the Medicare retirees, and I have said this before, but when the Medicare retirees exited the system, they are saving the state, and Damon and I disagree slightly on we're between 10 and $20,000,000 a year of the savings that go back to the state each year. That isn't being expended.

So our concern is that excess reserves stay within the health plan system and not eventually be swept to go into other general fund activities, and that's why we think it's important to get a final reconciliation of exactly where we are and what can be funded long term, not short

term, so.

And, you know, now increasing the requirements for the required reserves is something new being discussed so I'm a little concerned about that. We'll have conversations. Thank you.

MS. MALONE: We're almost afternoon, so good morning to the Board. Pricilla Malone with the AFSCME retirees.

And I just want to say, of course again, me too to everything Ms. Lockard said. But for historical reference points, I think this point needs to, and I brought it up before and reminded the Board, but we've got some new members, and we're now through another legislative session so and I expect Mr. Haycock will correct me if I'm wrong, but just so the Board is clear, when Mr. Haycock references his predecessors, plural, it's important to remember the context of how this issue of excess reserves came to be which was my understanding historically from listening to both legislative testimony and then testimony here within the executive branch is that prior to the legislative session of 2011 which was, in fact, as part of the overall change from a standard, for better -- for lack of a better term PPO type employer offered healthcare plan, the Medicare retirees were put on the exchange during -- as part of the legislative acts of that

session. It was not part of the appropriations. It was plan design change.

And the plan design change that was fundamentally different from that PPO type plan, and I hope the experts will correct me if I'm using that term improperly, was the bifurcation, if you will, of the offering of the plan for non-Medicare retirees. The Medicare retirees as part of that legislative session were put on the exchange. And then the non-Medicare retirees and the actives were put into a choice of a CDHP and I believe it was just HMO's at that point offered. That is my understanding historically of when these excess reserves started to be generated by that plan design, and I think that was part of the subsequent 2013 legislature's discomfiture at, my God, all of a sudden for the first time in the history of our employer State of Nevada offered healthcare plan, we've got these enormous reserves. The question is why.

So that's all I have to say, and Mr. Haycock may want to, you know, close the loop for me historically because, again, I think we have some new Board members, and that's where it gets kind of muddy is when did we start generating these excess reserves. What factors contributed to that? And so the CDHP and the HMO plan offered in 2011 was the start of that phenomena taking place was my

understanding. So thank you.

CHAIRWOMAN CONTINE: Thank you.

Is there any other public comment in Carson City? Is there any public comment in Las Vegas? Okay. Seeing none --

MEMBER MITCHELL: Yes, there is.

CHAIRWOMAN CONTINE: Oh, there is. Sorry.

MR. UNGER: I'll try to be very brief. I have to run off to an appointment.

CHAIRWOMAN CONTINE: Okay.

MR. UNGER: Doug Unger, U-n-g-e-r, representing UNLV Faculty Senate, past chair of the Senate and of the Council of Faculty Senate Chairs for NSHE.

I want to thank you all for a very good Board meeting. I also want to add to the historical context because I was there in 1999 with an unpaid bill of $9,800 from the L&H administrators mess. When we had an administrator that basically went insolvent, did not pay claims and we had many state employees with unpaid claims, my claim was presented as evidence in the legislative session that then worked and eventually established PEBP, and I think that's the reason for this -- this great conservatism in the plan that our legislators resolved that they would never see that happen again with employees who went six and eight and

even nine months with unpaid claims. So if that's helpful, as a reason for our long-term conservatism there is a good reason for it, and there may still be a good reason for it.

I just wanted to speak to Agenda Item Number Eight in a very positive way, the strategic planning. I note all of the participants in this strategic planning and note that our Board members are really designed to represent us, all of the employees in the state and you all do a very good job at it, but I would like to suggest to the executive director and the Board that maybe a couple of patient advocates be included. It might be a very good idea to ask the NSHE's counsel, Senate Chair, NFA rep, AFSCME rep and RPEN rep to participate in the strategic planning sessions if only for to cement the community participation in our health plan and really encourage our understanding of what is happening and allow us to have a voice in the long range planning of the plan.

A good example of where that might be helpful is Item Number Five in long range planning where you're thinking of a tiered income possibility. We know people in other states. We're in touch with them who are participants in such plan, and we can give very active feedback to that kind of thing. I'm just saying that we would I think be very helpful in that process and we would be more than willing to

participate in it and grateful to do so. Thank you.

CHAIRWOMAN CONTINE: Thank you.

Is that it? Anybody else?

All right. Then we'll go to Item Number 14, and we're adjourned.

Thank you everyone.

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

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

That on Thursday, the 26th day of September, 2019, I was present for the Public Employees' Benefits Program, Carson City, Nevada, for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 130, is a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Carson City, Nevada, this 6th day of October, 2019.

KATHY JACKSON, CCR
Nevada CCR #402

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STATE OF NEVADA

PUBLIC EMPLOYEES' BENEFITS PROGRAM

AFFIRMATION

Pursuant to NRS 239B.030

The undersigned does hereby affirm that the following document DOES NOT contain the social security number of any person:

1) Public Employees' Benefits Program Board
Regular Meeting, 9/26/19

KATHY JACKSON DATE

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