In The Matter Of:

Public Employee's Benefits Program Board

Telephonic Open Meeting

November 21, 2019

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

TELEPHONIC OPEN MEETING

THURSDAY, NOVEMBER 21, 2019

CARSON CITY AND LAS VEGAS, NEVADA

The Board:	LINDA FOX, Vice Chair JOHN PACKHAM - Member TOM VERDUCCI - Member LEAH LAMBORN - Member JET MITCHELL - Member CHRISTINE ZACK - Member DON BAILEY - 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, NOVEMBER 21, 2019, CARSON CITY, NEVADA

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VICE CHAIRWOMAN FOX: This is the time and place for the Public Employees' Benefits Program Board meeting. We're here at the legislative building here in Carson City, video-conferencing to the Grant Sawyer Building in Las Vegas, as well as video-streaming on the PEBP website.

I want to also introduce myself. I'm Linda Fox and I'm the vice chair for this Board. We are between chairpersons. So our chairperson was replaced. Peter Longley is our now chairperson. So he was appointed this week, but he was unavailable today. So in his absence I am going to conduct this meeting today.

With that said, I'm going to go ahead and get started with Agenda Item Number One, role call.

EXECUTIVE ASSISTANT: Linda Fox.

VICE CHAIRWOMAN FOX: Here.

EXECUTIVE ASSISTANT: Mandy Hagler is excused.

Leah Lamborn?

MEMBER LAMBORN: Here.

EXECUTIVE ASSISTANT: Jet Mitchell?

MEMBER MITCHELL: Here.

EXECUTIVE ASSISTANT: John Packham?

MEMBER PACKHAM: Here.

EXECUTIVE ASSISTANT: Tom Verducci?

MEMBER VERDUCCI: Here.

EXECUTIVE ASSISTANT: Christine Zack?

MEMBER ZACK: Here.

EXECUTIVE ASSISTANT: And Don Bailey?

VICE CHAIRWOMAN FOX: We are expecting Don Bailey but he is not here yet.

So before we go to public comment, I believe Damon had a comment he wanted to make.

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

The Board packet that was posted last week was missing a certain item that was an attachment to the plan benefit design agenda item, Item Number Seven. That was rectified early this morning. We also have printouts of that attachment here for the public and the audience if you would like to see it.

There's also printouts. Thank you, Dr. Unger, for bringing them to Las Vegas. It was in reference to the UNLV Employee Benefits Committee and Nevada Faculty co-designed, plan benefit designed recommendations and budget recommendations moving forward for the program in the next biennium. That was also sent to the Board previously. So you all have seen it. However, it is, again, up on the

website and if any Board member would like a physical copy, Wendy I'm sure can provide it to you.

That's all I have. Thank you, Madam Vice Chair.

VICE CHAIRWOMAN FOX: Thank you.

And with that, we will go to public comment and start here in Carson City. Is there any public comment here?

MS. LAIRD: Thank you and good morning. My name for the record is Terri Laird, and it's T-e-r-r-i L-a-i-r-d. I'm the executive director for RPEN, the Retired Public Employees of Nevada, and we represent all public employees retirees, as well as those still working.

First we want to express our thanks to Damon Haycock for his years of cooperation with RPEN and our colleagues that you see at this table nearly every meeting. We greatly appreciated being brought back in for pre PEBP Board meetings after his predecessor saw fit to eliminate them, and we certainly hope the next executive officer will be just as accommodating as Damon because PEBP and the Medicare Exchange is quite important for our nearly 8,000 dues paying members. We also want to wish Damon success in his future ventures.

We also again want to echo comments made during the September Board meeting by our lead lobbyist, Marlene Lockard, who is unable to be here today. We still are asking

for an independent actuarial review of findings being reported by PEBP's actuary Aon due to the fact that each year at this time reserves are reported to be much more than they actually end up being a few months later which could lead to a dangerous situation in legislative years. And as Marlene mentioned two months ago, PEBP has had nine years of excess reserves since 2011 and in light of the change in leadership ahead for PEBP, we hope this issue can be addressed with an independent review at some point in the new year.

I'm also aware of Kent Ervin's written testimony today submitted on-line, as he too is unable to be here, but he is asking for the Board to table the enhancements to PEBP's next meeting when more might be available as it relates to the reserves, and we would also encourage that as well.

Again, thank you, and I wish everyone a Happy Thanksgiving and, again, good luck to Damon. Thank you.

VICE CHAIRWOMAN FOX: Thank you.

Anymore public comment?

MR. COSTA: Good morning. My name is Mark Costa. I'm a state employee and a medical insurance plan user.

I wanted to go ahead and bring into the Board's attention about a recent and severe problem that I've experienced concerning continuing authorization for some

durable medical equipment. Previously when I had a question about a claim either for myself or for my wife, I could go ahead and call up the medical insurance provider and get a quick and easy answer and resolution. This time I was not able to do that.

We received in the mail letters that amounted to collection letters saying that we -- you know, our authorization had expired and that we were going to go ahead and have our account referred to collection, and we didn't really understand what these letters were. There were a variety of sources that were contacting us that we didn't know, Pacific Pulmonary for example, Adapt Health which I understand purchased Bennett Medical Services which is the provider for durable medical equipment.

I tried a dozen different phone calls to different people, and they were not able to help me. Sometimes I was transferred not only to a different person but to a different company. Apparently, there's a network of subcontractors and contractors for authorization for medical insurance benefits. And I understand that American Health is the main person but was not able to get information from them as to this problem.

I went to PEBP and the story has a happy ending in that after a couple of weeks, PEBP employees were able to

contact the appropriate person and found out what we needed to do, and we needed to get an extension because now a letter from a specialist is required to go ahead and continue authorization for this medical equipment, and there's a plan in place to do that. We were able to get an extension instead of being cut off earlier because as all of you probably know, it takes a couple, three months to get in to see a specialist because they are booked up so heavily. So we have a plan in place to correct this, and I'm optimistic the problem will go ahead and be resolved.

I ask the Board to go ahead and keep that in mind when we're approving medical contracts that this is explored as to what are the recourses and a protocol is set for how when clients or their spouses have issues they can go ahead and get a fast response and certain procedures are in place that are followed by the companies, whether they are contractors or subcontractors to make this process easier and to get responses quicker so action can be taken. Thank you.

VICE CHAIRWOMAN FOX: Thank you.

Is there anymore public comment in Carson?

Nancy, is there any comment in the south?

MS. SPINELLI: Yes. We do have two.

MR. UNGER: Doug Unger representing the Employee Benefits Committee of UNLV and the UNLV Faculty Senate for

the record.

I had had a different statement prepared for today regarding the letter sent by our employee benefits committee and our Faculty Senate and a prioritized list of benefits that I'm very happy has been corrected and included in your Board packets today.

I also would like to thank Damon Haycock, executive officer of PEBP, for what I consider to be excellent leadership of the Board. More than anything what Damon has done is to rebuild the culture of PEBP as a truly responsive state Board and organization to employee requests and demands and collaborations. He's done a lot behind the scenes to help us have much more confidence in PEBP, in our benefits and in the possibility that there will be improvements in the future.

Also, his efforts to keep premiums stable and even lower than when possible is greatly appreciated by Nevada state employees. We wish him well and all good fortune in whatever he chooses to do next professionally.

There is in the Board packet attached to Item Number Seven now our letter which represents not only UNLV but also it's a collaboration with all of the Nevada System of Higher Education, Faculty Senates and the Nevada Faculty Alliance. We put in priority order a list of requested

enhancements for the plan that we believe are modest enough to be reasonable to consider.

Whether or not you are able within the available resources of PEBP to make a commitment to such enhancements now is, of course, up to the prudence of the Board. We do request that if you cannot approve them today that you table them or postpone them for the January meeting to consider when we believe there will be quite possibly and quite serendipitously enough accumulative excess reserves to cover these requested enhancements.

Basically an order, it's a dental maximum improvement benefit. We have not had an improvement for 30 years, and our plan is now approximately 29 to 30 percent of what it was. That's our top priority.

Lowering the individual family out-of-pocket maximum to be more competitive with high deductible plans and surrounding states which really will help us with hiring and retention of faculty and other state employees.

An unusual request, quite possibly to look at the HSA/HRA contributions and to add more to cover families because our constituents with families report to us that they are suffering the greatest burden with the cost of healthcare.

The preventive vision exam is a very small

enhancement. It's a popular one that's requested by our constituents.

The total amount of the enhancements we request are $5,000,000. Please know that under the new organization of PEBP, with its approvals before the legislature we will be there at interim finance committee meetings and interim retirement and benefits committee meetings to advocate for these enhancements should PEBP add them to their budget request for the next plan year.

Thank you again to all of you for your public service, and thank you for including these documents in today's Board packet.

VICE CHAIRWOMAN FOX: Thank you.

Also for the record, did you know that Don Bailey is now present?

MS. MALONEY: If the Chair is ready in Carson.

VICE CHAIRWOMAN FOX: Go ahead.

MS. MALONEY: Thank you.

VICE CHAIRWOMAN FOX: Yes.

MS. MALONEY: Good morning to the Board. That's fine. Priscilla Maloney down here at Grant Sawyer representing the AFSCME Retiree Chapter of AFSCME Local 4041. We are the only union retiree chapter that represents all public employees who are also qualified to be members of

PERS. That's how our new amended bylaws and constitution designate that.

To start out with, first of all, yes, absolutely piggybacking on everything that Mr. Unger and Ms. Laird said. We so thank Damon for not just his stint but his service to Nevada for I believe it's the last 15 years. So we will miss him. He has done a tremendous amount to move the needle forward on -- on the overall health, internal health of the organization itself, the PEBP organization. Well, I shouldn't call it an organization, but I believe the Board knows what I mean, and so we thank him from the bottom of our heart. We enjoyed his outreach to us and allowing us to come and meet with him before every scheduled PEBP Board meeting and go over things on the agenda that we had concerns about.

Then moving on to the presentations already given by Ms. Laird and Mr. Unger that the AFSCME Board has not yet come to a conclusion on the efficacy of and wisdom of these proposed design enhancements. They like the sound of them very much, but they recognize that, first of all, we have a fiscal situation where, and I believe when we get to Agenda Item Number Six, we'll have a more deep dive into the different reserve accounts and how they function.

So we understand that currently the current figures from Aon are that we've got less than $300,000 right

now in the overflow reserves, and so our position right now is we don't -- we don't want to say yay or nay on these individual suggestions. We think they are great for instance the dental max because the dental max is going to capture our Medicare retirees, and so they think that they are good ideas, but we would like to get more information from our members and more feedback before we take a formal position.

But more to the point and this goes straight to the heart of what the Faculty Alliance through Dr. Ervin and Mr. Unger? Dr. Unger, I'm sorry. I am so sorry. Boy, you earned it so you should say it. But what they reference which is we still have an ongoing discussion on the table and in theory on the -- on the agenda under Item Number Six about our position in the coalition that we need a second opinion on these reserves.

And so to make a -- we would ask the Board to postpone as did Dr. Unger and Dr. Ervin postpone any action, robust discussion, sure, on Item Seven, but let's wait until we have settled the issue of whether or not this Board is going to approve and then implement a second actuarial assessment of these reserve accounts because it's my understanding under -- under the new budget agreement with the state through the last session is this body will be going to IFC to ask for permission to use what excess reserves are

available to do these things if we do them before the budget period for the next biennium in which case we really need to have accurate numbers of what we are talking about and how much is actually available to implement some of these very, you know, again, very positive suggestions. So that's our position for this morning.

And, again, thank you so much, Damon. I'm sorry I'm not there personally to say goodbye.

VICE CHAIRWOMAN FOX: Thank you.

Nancy, anymore public comment?

MS. SPINELLI: No other public comment.

VICE CHAIRWOMAN FOX: Okay. So we'll move on to Agenda Item Number Three, PEBP Board disclosures for applicable Board meeting agenda items. Brandee Mooneyhan from the deputy attorney general.

MS. MOONEYHAN: Thank you, Madam Vice Chair. Brandee Mooneyhan, Deputy Attorney General for the record.

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 Mr. Verducci are eligible for Public Employees' Benefits Program. And Ms. Zack's situation is unclear. She was adjunct faculty and may or may not be eligible for PEBP, but she is not currently accessing PEBP

benefits, but those that are eligible, they, their spouses, their dependents may receive health, dental, life insurance and other benefits through PEBP.

On today's agenda, Agenda Item Seven and Eight relate directly to benefits available to PEBP members as they concern possible plan and benefit changes. When PEBP Board members vote on items effecting benefits for themselves, their spouses and/or dependents they may trigger disclosure requirements under NRS 281A.420. Pursuant to that law, I'm offering this as a general disclosure on behalf of the Board members who are PEBP participants and that will be voting on these matters.

I want to note that they, those participants may still so vote on items directly effecting benefits as long as the benefit or detriment to them is not greater than that for other similarly situated members.

Thank you, Madam Vice Chair, for allowing me to make this disclosure, and I invite any member if they have anything to add to do so now.

VICE CHAIRWOMAN FOX: Thank you.

Do any Board members have anything to add?

Moving on to Agenda Number Four, consent agenda. Items will be considered together and acted on in one motion unless an item is removed to be considered separately by the

board. So there are four items here, and is there any that any Board member would like to have separated to consider?

MEMBER VERDUCCI: Tom Verducci for the record. I would like to pull 4.3.

VICE CHAIRWOMAN FOX: Okay. So we will consider 4.1, 4.2 and 4.4. So could I have a motion then to approve those without 4.3?

MEMBER LAMBORN: Leah Lamborn for the record. I make a motion to approve 4.1, 4.2 and 4.4 agenda items.

VICE CHAIRWOMAN FOX: Thank you.

So we have a motion. And is there a second?

MEMBER ZACK: Madam Chair, I'll second the motion. Christine Zack for the record.

VICE CHAIRWOMAN FOX: Thank you.

Is there any discussion? Okay. So we have a first and a second. All in favor say aye.

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

VICE CHAIRWOMAN FOX: Any opposed?

Okay. And, Tom, you wanted to discuss 4.3?

MEMBER VERDUCCI: Yes. Tom Verducci for the record.

By any chance do we have a representative from Casey Neilon here?

MS. OLSEN: Good morning. My name is Suzanne Olsen. That's S-u-z-a-n-n-e O-l-s-e-n, and I am a shareholder and I was the partner in charge of the Casey Neilon or the PEBP that was before Casey Neilon.

MEMBER VERDUCCI: Thank you so much for coming here today.

MS. OLSEN: You're welcome. Thank you for inviting us.

MEMBER VERDUCCI: I just had a few questions on the variances in your report.

MS. OLSEN: Which report exactly?

MEMBER VERDUCCI: Specifically this is going to be on the self-insurance trust fund.

MS. OLSEN: Okay.

MEMBER VERDUCCI: The balance sheet that was put together. I had a few questions on the variances within this report. Specifically, we show in 2019 a 3.6 million dollar unearned liabilities and in 2000 -- I'm sorry, make that 3.6 million and in 2018 was 48,000.

MS. OLSEN: Yes.

MEMBER VERDUCCI: So I think it has something to do with unearned revenue but I want to gain a better understanding because the big variance in that number.

MS. OLSEN: Right.

MEMBER PACKHAM: Can we reference a page number, Tom?

MEMBER VERDUCCI: Yes. Okay. That would be page three.

MS. OLSEN: It's on the statement of net position, page three.

MEMBER VERDUCCI: And then it will be under the column liabilities and the subcategory unearned revenue, and it's broken down into two categories, 2019 and 2018. And specifically in 2019 the unearned revenue is 3.6 -- 3,662,898. In 2018 it was $48,916. So it's a big difference in the numbers, and I just want to gain an understanding of the additional $3,000,000.

MS. OLSEN: The difference has to do with in 2018 there was a shortfall reported, a major shortfall reported, and in 2019 there was a surplus, and that is discussed in note one, page seven and it is discussed under the receivables heading even though for 2019 it was under the unearned revenue due to it being a surplus. So for comparative purposes we included it in that section.

The difference between the cash contributions and revenue recognition resulted in surplus of contributions over premiums of 3.1 million dollars and a shortage of contributions over premiums of 2.4 millions dollars for the

years ended 2019 and 2018.

The -- the short -- the shortage that we reported in 2018 was recorded as receivable, and the surplus in 2019 was recorded as a payable which is why you're seeing that difference. Normally there's a consistency between the unearned revenue from one year to the next.

MEMBER VERDUCCI: Okay. So that was based on shortfall of unrealized liability?

MS. OLSEN: That was based on a difference between contributions coming in and revenue recognized to pay the premiums.

MEMBER VERDUCCI: And then at what point would the revenue actually be recognized?

MS. OLSEN: When the premiums have been earned. When the money is needed to pay the premiums that have been -- so revenue is recognized when it's earned, and expenses are recorded when they are -- when they come due when they are used. So at the time that the monies needed to pay the premiums has warranted pulling from the surplus that's when that money would be recognized or realized that -- those contributions would be realized.

MEMBER VERDUCCI: Okay. Thank you --

MS. OLSEN: You're very welcome.

MEMBER VERDUCCI: -- for clarification. As we

continue on to page four, we do go into a column called operating expenses and under subcategory claims expense, we're showing 2019, 314,000,000. In 2018 it was 227,000,000 and is a pretty big variation. Does that have to do with the catastrophic claims? Specifically, why would there be such a big variance from 2019 at 314,000,000 and 2018 at 227,000,000?

MS. OLSEN: I think when you're looking at this, you really need to take two items into consideration. You need to look at the claims expense and the insurance premiums and contractual obligations.

And, Damon, and, Cari, if you need to step in because I'm not explaining it correctly feel free to do so, but there was a change that happened in fiscal year 2019 where PEBP implemented an exclusive provider organization plan, and that changed the dynamics and the flow of those transactions on the -- on the income statement. And so what was reported previously in 2018 under insurance premiums and contractual obligations has been, it's not the same. I don't want to make it seem like it's the same but it's been kind of reworked or rerouted and it's being reported under claims expense just due to the nature of how those policies flow.

MEMBER VERDUCCI: Okay. So with the new plan that was implemented that caused the variation there?

MS. OLSEN: Yes, sir. That is how the -- how the transactions flow through the claimed expense now versus the actual contractual payments because you no longer are making those contractual payments because they are being serviced -- they are being self -- thank you.

MR. HAYCOCK: For the record Damon Haycock.

Let me see if I can try to simplify this. I'm not an accountant so I won't speak in accountese. But basically we implemented the EPO plan last year and instead of us pitching out premiums through our contract with Hometown Health which is recorded in a different part of this -- this statement, we are actually paying those claims because we took on that self-insured risk.

So our claims increased almost $100,000,000 because we're actually paying the claims instead of paying the premiums to our fully insured provider, and that's where it's being recorded.

And just to go back on the original question on unearned revenue, the reason why we have deficits and shortfall in our main accounts that Casey Neilon will often or not often but annually audit is because when we get our budget and we get our employer contribution dollar amount that is taken out of every agencies' funding, that is predicated on an enrollment that was projected to include an

enrollment mix.

So if more people enroll on the family side or if more people enroll on the single tier then that mix changes and the total amount of subsidy needed to cover that will falter, right, will change. And so when that changes in certain years we will end up creating a shortfall, and in certain years we will creating a surplus. That surplus though will sit in that AIGS account until we need to draw money from it. And if we don't draw it over the biennium it will be used to offset the next biennium's contribution. And so that's how it was reported in the Casey Neilon audit, and really it's just a point in time shot at where our financial position was as all balance financial statements should look, and that's about as good as I can get in accounting right now.

MS. OLSEN: That was a great job. Thank you.

Do you have any --

MEMBER VERDUCCI: One additional. On page -- on page five of the reconciliation of operating income and we get down to increase or decrease in payables and accruals, we're showing for 2019 an increase of 30,760,000 versus 2018 was roughly 2.8 million. So there's a big aberration, and I just want to have a better understanding of what those numbers reflect in layman terms.

MS. OLSEN: All right. I think we should look at page -- now this report isn't going and I didn't -- I don't have the 2017 information here with me today. So, but I can compare the '18 and '19 but if we go to page --

MEMBER VERDUCCI: Page number five.

MS. OLSEN: If we go to page number 19, the unpaid claims liabilities, so it's note seven under risk management continued unpaid claims liabilities, the first section of that page, if you compare there's two components to the unpaid claims liabilities. There's the reserve component and then the actual claims reserve component, and then there's the HRA liability components. And you can see where the increase happened. The HRA liability stayed, there was about a 2,000,000 dollar, a little over a 2,000,000 dollar change there.

The reserve component increased from 37,000,000 to 58 or $59,000,000 2018 to 2019. Prior to that, from 2017 to 2018, it was fairly consistent. This in my mind is attributable to those claims, those additional claims payments based on that new self-insured risk program that was implemented. So that in my opinion is why you're seeing that increase.

MEMBER VERDUCCI: So this would be an increase in liabilities; is that correct?

MS. OLSEN: Yes. It's an increase in liabilities and increase in that reserve estimate number.

MEMBER VERDUCCI: Okay.

MS. OLSEN: Uh-huh.

MEMBER VERDUCCI: Thank you for clarification.

THE JUVENILE: For the record Damon Haycock.

So just to dovetail on that because we have additional claims, we also had to approve additional reserves, and those required reserves incurred but not reported or incurred and not paid in catastrophic, and so those are still considered future liabilities that must be shown on an accounting balance sheet.

MS. OLSEN: That is correct. That is correct.

Do you have any follow-up questions to that?

MEMBER VERDUCCI: No.

MS. OLSEN: Okay.

MEMBER VERDUCCI: I just noticed a big aberration in numbers, and I wanted to gain an understanding because they are so huge and that was very helpful.

MS. OLSEN: Good. I'm glad.

MEMBER LAMBORN: I just have one quick question. I'm not sure if it's for you or for Damon, but you made the statement, I just want to clarify. The 58,000,000 in reserve for incurred but not received claims, that's an estimate, a

projection?

MS. OLSEN: It is an estimate which is why they do hire the actuary to come in and perform those calculations. They have the expertise behind them to substantiate the rationale behind how those estimates are built.

MEMBER LAMBORN: And then, of course, at some point in time we can go back and get actuals, what it actually was and can compare it to the estimates.

MR. HAYCOCK: For the record Damon Haycock.

The actual reserve need is in the, it's showcased right now in Agenda Item Seven in that table for each of the reserve buckets. It is inclusive all of the plans. PEBP has been asked and we will move forward separate on those out into the EPO versus the CDHP plan, but those numbers aren't separated in this balance sheet per plan, and so it actually ties in kind of nicely of what you're asking here today to show what the actuals were.

VICE CHAIRWOMAN FOX: Are there any other questions or discussion?

So I think we need to separately now vote on 4.3 to approve that item. So I need a motion for 4.3.

MEMBER VERDUCCI: Tom Verducci for the record. I'll make a recommendation to approve section 4.3 and section

4 of the report.

VICE CHAIRWOMAN FOX: We have a first. Is there a second?

MEMBER MITCHELL: Jet Mitchell for the record, second.

VICE CHAIRWOMAN FOX: Okay. So we have a first and a second. Is there anymore discussion? So I'll ask for a vote. Those in favor say aye.

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

VICE CHAIRWOMAN FOX: Any opposed? Okay. The motion carries.

All right. So we'll move on to Item Five, update on the Morneau Shepell improvement plan. Morneau Shepell.

MR. BORGOS: Good morning. Bruce Borgos representing Morneau Shepell. Last name is B-o-r-g-o-s.

I'm here today to present a progress report on the performance improvement plan that I summarized for the Board in September and which addressed a number of issues. I think you have the larger report in your handouts.

Since September we begun holding regular steering committee meetings with Mr. Haycock and Ms. Rich to update them on our progress and solicit their feedback. At a high level, we have decided in consultation and agreement with

PEBP that we will move the enrollment of voluntary benefits to the Corestream Platform rather than maintaining some of those enrollments on the Morneau Platform to provide a more user friendly experience for PEBP members and increase the participation in these valuable benefits.

The only possible exception to that right now is the Standards Life product and potentially the STD product. At some point in the future we're just going through some discussions right now to see what's feasible in that regard and whether or not we can move the standard over to Corestream in time for next year's enrollment. We expect the rest of that work on voluntary benefits to be completed by April 1st, 2020.

Regarding another follow-up to the last Board meeting, Morneau Shepell, Corestream and Unum are in active discussions about integrating Unum's long term care product information, as well as a link to Unum's enrollment site through this product through Corestream. There are some technical considerations that we're reviewing currently. We have another meeting scheduled for tomorrow to discuss again the feasibility of whether or not we can adhere to some of the requirements that Unum has for this product, and I'll have another update for the Board at the next meeting in January.

Additionally, we recently completed the significant step on a major item of the improvement plan. Rolling out Morneau's more robust co facts document management system for the new benefit events requiring supporting documentation. This will simplify work that PEBP staff is doing on employee qualifying life event administration. We also continue to make progress on streamlining other work efforts of PEBP's various member employers with the creation of a central HRA system. We have completed two rounds of testing and expect a third round to be completed prior to us bringing the system on-line by March 31st of next year.

Also, a new portal agency reps will use to automate data collection it's targeted to forego live data February of 2020.

As I mentioned at the September meeting of this Board, we have also been working on fine tuning our processes to better provide service to PEBP plan participants and PEBP staff. To that end and as promised, Morneau Shepell has placed a representative on site at PEBP's office to expedite issue identification and resolution and gain a deeper understanding of the day-to-day operations of the PEBP team. This collaboration seems to be working well at this point.

I'll have a further update on our progress in

January and again in March, and I'm happy to take any questions you may have now.

VICE CHAIRWOMAN FOX: Any questions from the Board?

MEMBER VERDUCCI: Yes. Tom Verducci for the record.

Mr. Borgos, I just wanted to ask you about the one item that was listed in the report at risk in terms of catch up and management of the backlog issues. I'm wondering if you could maybe just address where you folks are in terms of the backlog issues.

MR. BORGOS: Sure. Again, Bruce Borgos for the record.

We have a ticketing system at Morneau Shepell in which issues that are identified either by the staff at PEBP or internally at Morneau Shepell get logged for purposes of tracking and reporting. And they -- that way they get escalated to the right individuals within Morneau Shepell who actually have to do work.

So there was a backlog and there still is a backlog of issues. Most of those tickets are very old tickets which are now to some degree probably no longer relative. So one of the things that we're doing right now is assigning folks to going back and reviewing each ticket to

determine which ones are still pertinent and/or which can be automatically closed. So we have kind of a refreshed look at the number of tickets that open. So there's been a little bit of a delay just going through that backlog as some of those actually go back a few years.

MEMBER VERDUCCI: So how is the progress going and clearing up the backlog issues?

MR. BORGOS: So the progress is good at this point. It's continuous. It's never as fast as we would like it to be, but we have no expectation that we won't have those cleaned up to -- that would result in any further risk to the process improvement plan.

MEMBER VERDUCCI: Thank you very much.

MR. HAYCOCK: For the record Damon Haycock.

As Mr. Borgos said, Ms. Rich and I have been meeting with Morneau Shepell. At this time we feel comfortable with the progress that they have made and that they are on track to meeting the requirements of this performance improvement plan.

We will always reserve the right to be skeptical, but they have worked diligently with us and have provided us the right resources so we can address things immediately and internally with those folks that they have sent to us in our office. So we commend Morneau Shepell for continuing to

provide us those resources.

We keep our fingers crossed. We want you to be successful because we want to be successful with you, but we will reserve the right to make final judgment later.

VICE CHAIRWOMAN FOX: Thank you.

Anymore discussion or questions from the Board? Okay. Thank you.

All right. And we will move on to Agenda Item Number Six, presentation on the development and history of PEBP's incurred but not paid catastrophic and health reimbursement arrangement reserves. Aon and Cari Eaton, our chief financial officer.

MS. MESSIER: Good morning. My name and words for the record is Stephanie Messier. Last name is M-e-s-s-i-e-r, and I'm with Aon. I've been with Aon for almost seven years now, and I've been in the actuarial industry for about 18. And with me I have Kelly Wilson.

MS. WILSON: Good morning. My name is Kelly Wilson. I'm a CPA, and I've been with Aon for about a year and a half. Prior to that I was with the State of Oklahoma as the deputy director of internal audit.

MS. MESSIER: So I've been asked to kind of move through this a little bit quickly this morning. I did want to provide you a little bit more details in terms of our

presentation. I know the Board gets the packet about a week in advance, and so that's why I gave you a little bit more details for your readthrough. Today I plan to go a little bit more high level. Certainly we are here to answer any questions that the Board may have, and we are happy to do so, but I just wanted to call that. I plan to go a little more high level through the slides, but certainly if there is a need for a deeper dive we are here and happy to do so.

I believe the impetus that we are presenting here today are some comments we've heard this morning, as well at the September Board meeting from NCHE and RPEN and others. First about the -- are best practices being followed as we're setting PEBP's reserves? Is the 95 percent competence level on both the IBNP and catastrophic reserves appropriate? And finally why do excess reserves keep being generated year after year despite spend-downs.

We are fully capable and prepared today to talk about those first two items, but I think it's important to note for the public record given the comments that were made again earlier today, AON has not been involved in the projection or the reporting of excess reserves for PEBP. That is done by PEBP staff. Aon has not been asked to report on those items. We have not been asked to project those items. We have been asked to project and work on your IBNP

and catastrophic reserves, and those are the two items that we'll be walking through today.

And we also thought it was important given our industry knowledge and our work with other clients that we talk to you about some benchmarks and industry best practices. What are we seeing other states do, as well as what are some other approaches that PEBP could adopt. So I went ahead and added that as part of our last part of the presentation, and I think that's a good spot for us to spend a little more time on today. So I'm going to again breeze through methodology portions and kind of get to the meat of the presentation and which I think again really is what folks are asking about. Is that 95 percent competence interval the right level to have for PEBP?

This slide was just really included as to why do you need to have an IBNP. And I think as Board member Tom's questions earlier today for the auditor was getting at this -- this question. Why did your IBNP reserves go up when you had the EPO plan when you first implemented the self-funded EPO plan. Really that was very light payments that first month. If you were on a fully insured plan, you would have had premiums to pay.

But when you switch to self-funded plans there's naturally a lag in payment. When you go to a provider your

provider doesn't immediately bill PEBP that day for your visit. If your at a hospital the hospital will not send a bill to PEBP that day for your visit. And if they do send it to HealthSCOPE Benefits or to PEBP usually HealthSCOPE Benefits is going to take a look. Is this everything included in that claim? Are we missing anything? Are there things that we need to negotiate? So bills don't get paid on the same day they are incurred which is why you have an incurred but not paid reserve when you do a self-funded plan.

So we also wanted to talk about the fact that as Aon, an actuarial firm, we are using actuarial standards, best practices when we're producing our IBNP estimates. In our modeling we have included emerging of the two best practice methods out there via actuarial standards. There's the development method, as well as a projection method. So the development method is going to take your historical claim, like payment patterns, we're going to adjust it for any large claims payments that may have come through that may throw off those average estimates.

We then combine it with a projection method with those more recent and immature months in order to come up with a best estimate IBNP and again that's according to actuarial standards. So it's important to note with most clients what we do is we take a look and we really do provide

our best estimate of what your incurred but not paid liabilities as of a certain date.

Then there would be other things that the plan would have to pay on that date for the runout of claims. You would still have to pay HealthSCOPE Benefits to administer any claim payments that may occur after that plan date. That is why you have an expense load on your IBNP, and for PEBP we use 1.025 factor to do a best estimate of how much fees HealthSCOPE Benefits would charge you for paying those additional runout of claims.

In addition to the expense load for your account specifically, the Board has requested that Aon add on a catastrophic reserve margin. So that PEBP can be assured in 19 out of every 20 years our estimate is enough to cover the amount of claims outstanding. That is the 95 percent confidence interval that, again, the PEBP Board has selected I believe back in 2011, 2012 for us to add on to our best estimate of IBNP. Again, that's not an industry standard. That's not an actuarial set number that we have to follow. That is something that you have directed us to load, and so we have done statistical calculations to come up with an assurance that out of 19 out of every 20 years we are confident that the number we're providing you would be sufficient to pay the amount of claims outstanding.

And here we thought it might be helpful to show a numerical example of how sometimes there's large claims that will come in after a plan would end, and so that's what we try to highlight along that yellow diagonal. Here in February of 2018 a large claim was incurred of 1.3 million dollars, but it wasn't paid until July of 2018. So that would have been on Plan Year '19 that that claim was paid, but it was incurred in Plan Year '18.

And typically as you move along the diagonal line in month five, you tend to pay out about $275,000 of claims. If our IBNP estimate for just that month was 275,000, in that particular year it would have been short by about a million dollars to pay that outstanding claim that had been incurred. So it is wise to include a margin on top of the best estimate IBNP for such instances as the one that PEBP had seen in 2018. However, again, the 95 percent is larger than we have seen with other clients.

And finally the last part of a best practice actuarial IBNP analysis is really to do a historical reserve adequacy study which is also called a lookback analysis. Every year we take a look at how well did we do last year? We estimated last June how much claims we thought were outstanding, and now that we have a 12-month period has ended we're able to see how close were we to that estimate.

So in the first column of the numbers at the bottom of this page, and I do want to spend just a little bit of time on it, is in the green is your actual claims that came in after the plan date, for anything incurred prior to that date how much in claims was paid out after that date. So you'll see in 2012 there was 28.4 million dollars in claims that was paid out. And most recently in June of 2018 and the next 12 months you saw almost $32,000,000 of claims paid out.

And, again, here it's important to note you're EPO plan started right after that date, and I don't have the full 12 months of runout from that since we just ended that first 12 months of the plan. So right now we only have three to four months of runout. So we didn't include June 30th of 2019 because I don't have the actual runout to say how well did the estimate do.

Our best estimate IBNP is in that second column of numbers and that was what we had provided before we loaded it for the administrative expense, as well as for the 95 percent competence interval. So you will see in most years, especially from 2012 up until 2016 we -- our best estimate IBNP was slightly above the actual claims IBNP. But in our most recent two plan years, if we had just provided PEBP with the best estimate IBNP, our best estimate would

have been short. There was more large claims outstanding at the end of the plan year than our models had indicated would be outstanding. So if we had just given you the best estimate IBNP, you would have been short.

However, because PEBP opted to load it at a 95 percent confidence interval, that's the first blue column of numbers. Here you will see and the comparison is, so you don't have to do the math yourself, is in that final column that is also shaded in blue. It almost looks gray from here. Gives you the difference between the claims loaded at the catastrophic margin level and the actual claims that were incurred and paid after the plan year ended.

So you will see on average PEBP is running about $5,000,000 over with that catastrophic load, and some years you actually did need it, like in the most recent 2017 and 2018. Again, our best estimate was 25.5 million in 2017, but the actual claims paid out was 27.9. So if you had only set aside the 27.5 that would have been short by 2.4 million. However, because it was loaded to the 95 percent you were actually over by 4.8 million.

And I know that's a lot of numbers, and I apologize to the court reporter.

Any questions on there? Do you want me to stop right there for questions?

MR. HAYCOCK: So for the record Damon Haycock.

First, Stephanie, thank you. That was very very helpful. And for those that don't live and eat and breathe this everyday, I think one of the most important things to recognize is really why you have an incurred but not paid or incurred but not reported reserve and a good example is today we have the exclusive provider organization plan or EPO plan in northern and rural Nevada. We self-insured it last year and stopped our fully insured Hometown Health HMO plan.

If we were to go back to them next year we would have a claims runout that we would have to pay. And those -- those bills that would have come in, really almost to the beginning of the plan year because we have a one-year timely filing requirement for provider claims. When those claims would come in, we would have to pay them even though we wouldn't be getting any premiums coming in to us because we would be farming them back to Hometown Health for their fully insured plan. Again, this is all hypothetical, but that's what that incurred but not reported or incurred but not paid reserve is for, and then we would have to pay HealthSCOPE to adjudicate those claims even though we technically don't have -- the contract would change to only payout that runout.

And so, again, all of our costs associated with paying claims and fees continue past the end of a plan year

when you shut the plan down. So that's what is really important in this -- in this part of the incurred but not reported reserve. I just wanted to add that. Thank you, Stephanie.

MS. MESSIER: Thanks, Damon.

Any other questions before we move on to the catastrophic reserve?

Okay. The second, it is fairly common with our other public sector entities, as well as other state plans to hold a set of reserves aside. Sometimes it's called the contingency reserve, and sometimes it's called a catastrophic, but basically they are trying to do the same thing. It's covering any unforeseen circumstances that may incur within that plan year.

There's -- it's possible that as we set your actual medical trend rate in a given plan year, when we do your underwriting at the March Board meeting, let's say we assume that costs are going to increase 44 percent that year, something could occur within the medical community. Other new treatments could come about or there could just be a sicker group of the population causing that trend to actually come in higher than we had projected.

There's also utilization changes that I mentioned in Medical Pharmacy Services. A good example of this is when

the Hep C drug came out a few years back, PEBP's population saw a very high utilization of that hepatitis C drug. That's not something we would potentially know about when we were setting your plan rates in the prior year. And those sort of things will cause your rates within a given plan year to come in higher than what you set your budget for at the time of underwriting.

Other things can happen that we have seen in other clients, such as demographic shifts, changes at open enrollment. There could be a lot of people coming onto the plan or if the state had again gone back to hiring which it did a few years ago after it had not been hiring for a four to five-year period because of the economic downturn. There's a large group of people coming onto the plan.

As well as in the hypothetical situation here if PEBP was to lose, let's say in the NCHE population, if they decided to go out and get their own plan design, that would cause a shift in the underlying risk that remains on the PEBP plan, and that would change the PEPM's that you would see in that given year.

You could see an unexpected rise as PEBP has seen in the last 12 months in catastrophic claimants. This would also cause our estimates of what you're going to see in that given plan year to shift.

When I was speaking with Mary Catherine yesterday from HealthSCOPE, she mentioned that there's currently about a 6,000,000 dollar claim outstanding for PEBP right now. So should something like that come through, which it will be coming, that was bill charges. So it will be coming in less, but that's the sort of thing you have a catastrophic reserve for. PEBP does not have stop loss insurance.

So and I have another colleague who's currently adjudicating another 14,000,000 dollar claim for hereditary edema. These claims are out there. So that is why it is prudent for someone such as PEBP to maintain a catastrophic reserve. So I just wanted to give a little history as to why states kind of hold catastrophic or again sometimes you'll hear it as contingency reserve.

And here we wanted to provide in the blue box what PEBP's catastrophic reserve has been from again the same time periods 2012 through 2019 and here because we're not doing a true-up, there is no true-up here because you haven't used your catastrophic reserve. So we were able to report the most recent June of 2019 because, again, we are not looking for 12 months of runout to see how good this prediction was. This is something separate.

It did increase, as you noticed in your auditor's report, because you introduced the EPO plan. So I broke out

the two figures below. The CDHP is most recently at $31,000,000, and the EPO plan added an additional 11.4 million dollars. And, again, this is to protect against unforeseen events such as the 6,000,000 dollar claim that PEBP has currently coming its way.

Okay. Any questions about the catastrophic reserve before we move on to best practices or what other states are doing?

Okay, Tom?

MEMBER VERDUCCI: Yes. Tom Verducci for the record.

In reading your report here, it seems the 95 percent catastrophic reserve was set after the financial crisis. Does it appear to you today that we're being too conservative on that number being that we've had a robust economy, lots of economic growth and that was set nearly ten years ago when we were in a complete different economic environment?

MS. MESSIER: It certainly appears that we -- I guess seeing different entities take a look at it now that the economy has recovered and they are feeling a little more optimistic of how much reserves they need to have on hand. However, I think it's prudent to caution that it really depends on how easy it is for that particular state to go

back to the legislature and find additional monies should they need it.

Because if you would have two or three of these large claimants, again, it's very hard to predict who's going to get sick and how sick they are going to get or where they are going to get care and how much that care is going to cost. Should PEBP have two or three in a particular plan year if they were to preserve, I would say a 50 percent level could maybe be confident they could go the legislature and they could ask for more money and get it in order to pay out the claims they would need to pay.

So it's very dependent each different state as to how easy it is for them to go back to the legislature and get more money in that instance, but certainly it's -- it's on a state by state basis, and we have seen a lot of them move away from that 95 percent. I do think it was pretty popular, again, coming in 2010, 2012 era when we were all coming off of the recession to have a 95 percent level, and some folks have definitely moved off of it.

What I do think that you're doing is a little bit different than the others is the 95 percent load on your IBNP. That's the one we typically don't see that high of a margin on the IBNP portion.

MEMBER VERDUCCI: Yes. We're certainly in a

different economic environment and, you know, maybe there are some ideas that could be put in place that could free up some other requests that are being made to this Board. So thank you.

MS. MESSIER: Yep. Absolutely.

So going to that part, the benchmarking data, here we are seeing, I just want to give you some other examples from states that are nearby. Arizona is holding their contingency reserve at 1.5 months which is actually 75 percent confidence level. The rate that you're holding at today is equivalent to about two full months of claims payments which is 60 days on hand for that 95 percent confident interval.

Oregon is only holding about ten percent of annual expected claims. We have three other Aon state clients who are only using an IBNP reserve. They do not have a contingency reserve. Two of our other Aon state clients does similar to what Oregon does. They are holding ten percent of your annual claims as a contingency. One of them is using 200 percent of risk based capital, and another one is similar to you and is using 60 days.

So as you can see here, PEBP is definitely on that very conservative end on what other states are doing. These are in ascending order of magnitude, and PEBP would be

again at that bottom, most conservative growth.

MEMBER MITCHELL: Jet Mitchell for the record.

Quick question about under what are other industries doing.

MS. MESSIER: Yes.

MEMBER MITCHELL: The statement they typically do not hold a separate contingency reserve, what is the rationale behind not holding -- as a general rule what is the rationale for that benchmark of not holding a separate contingency reserve?

MS. MESSIER: I think with private sector folks they have different ways. It's one of those things where you can make more widgets. With a state it's different. It's just a different organization. You have taxpayers in different ways of funding items. Whereas with a private sector entity, it's just a different organizational makeup as to where they can go to get additional funding.

MEMBER MITCHELL: Thank you.

MS. MESSIER: Yeah, good question.

I mean, here it is important to point out there usually -- it's like usually like a five, ten percent margin we see on IBNP for them. Whereas yours is closer to 25, upwards of 25 percent load on your IBNP. So your IBNP is definitely being loaded at a much higher rate than we see for

other entities.

So going to other approaches that I think PEBP could consider. You definitely could look into lowering your margin on the IBNP down to 50 or 75 percent confidence interval. As Tom mentioned, this would be able to release 6.6 million up to 11,000,000 of reserves back to the plan.

Jet, do you have another question?

MEMBER MITCHELL: Jet Michelle for the record.

If that -- if that lowering was done, just to clarify, that release of reserves would be a one time release back into the plan?

MS. MESSIER: That is correct.

MEMBER MITCHELL: Thank you.

MS. MESSIER: Yep.

Next we wanted to provide you with a couple of different options. It's important to know what the catastrophic reserve too. There is no actuarial standard for catastrophic reserves, and that's why I, again, you see private entities aren't holding it. Whereas, when it comes to an IBNP reserve it's an accounting standard that you're required to hold, and there's actuarial standards around setting the IBNP.

With catastrophic or contingency reserves, there's multiple different methods out there that are being

adopted either by states or public entities, and so some of them, again, are using a days on hand measurement. If PEBP decided to go with a 50 days on hand rather than current 60 days, you could release 8.2 million of reserves off of your catastrophic back to the plan. Again, as to Jet's question, that's a one time release.

You can also move to a risk based capital approach. Some states are holding a 200 percent authorized control level. Some states wanted to be more conservative and down to the 400 percent. If you went to 200 percent, that would release 15.5 million dollars of reserves back to the plan. Conversely, if you wanted to go to the 400 percent, that would actually increase your catastrophic reserves by 11.4 million or another option would be to just go with ten percent, as we've seen other states do, such as Oregon, as well as a couple of other of our state clients and that would release 18.4 million back to the plan.

Ultimately, again, the margin levels and methodologies are set at your discretion and based on your own risk tolerance, and that's what we see in the private sector.

And then finally in our appendix we wanted to include just more details about the reserve calculations for those of you who like the additional details. We provided

that back to the -- based on an LCB audit request in April, and we just wanted to include it here for completeness.

Any other questions?

VICE CHAIRWOMAN FOX: Anymore questions from the Board?

MR. HAYCOCK: For the record Damon Haycock. Again, thank you, Stephanie, for presenting on these two reserves.

And before we turn it over to Cari, one of things that I think is important to consider when we look at other approaches to consider all of those returning funds back to the plan, those reserves back to the plan, as Ms. Mitchell asked Stephanie, which is one of the things I wanted to make very clear is that it would be a one time money grab, and it has not been prudent in the past to provide benefit enhancements on one time funds.

And so this is only a depletion of the reserves to give back a certain amount immediately. And so, yes, there may come a point in time when the State is back in a position where it needs money, and they may look to our reserves to reduce that risk but recognize that if the state needs money maybe it's pretty risky, and maybe it's a good time to hold onto that anyway.

So there's a bunch of arguments to be made of is

there a true benefit or advantage to change the reserve levels and return funding back to the plan when as Stephanie mentioned we had a very difficult time trying to go back to the legislature in the off year to ask for additional funds, right. They don't create a supplemental funding source large enough at times for a big issue that PEBP can't solve, and there is no real mechanism outside of going there with hat in hand and saying you know what, we were wrong on our assumptions and now we need money, and that will eventually if it was funded which it would have to be because we have claims would be taking away from other programs and services already approved budgetarily for other agencies across the state.

And so, yes, it may seem like PEBP is ultraconservative to set the types of reserve levels that it does but recognize it's set that way so we don't have to go back to the legislature and ask for money. And if there was a way to reduce our reserves to have continuous benefit enhancements to return back to the employees, the retirees and the families, you would be hearing me say something different today, but one time funding is just a money grab that goes away and it becomes an additional risk moving forward.

That's all I wanted to add. Thank you, Madam

Vice Chair.

VICE CHAIRWOMAN FOX: Thank you.

Anymore discussion? Jet?

MEMBER MITCHELL: No thank you.

MS. MESSIER: Thank you.

VICE CHAIRWOMAN FOX: Thank you.

Cari?

MS. EATON: Thank you. Cari Eaton, chief financial officer for the record. I'm going to discuss the HRA reserve. PEBP currently has two types of HRA accounts available to employees and/or retires. There's the CDHP HRA and the Medicare Exchange HRA. I provided an overview of the CDHP HRA on page two of the presentation.

Employees who are on the CDHP plan who are not eligible for a health savings account or who failed to establish an HSA and retirees covered under the CDHP plan will receive a CDHP HRA account. Funds in this type of HRA account may be used tax free to pay for eligible medical expenses as defined by the IRS to include payments of deductibles, co-insurance and other out-of-pocket qualifying healthcare expenses.

Payment of premiums are not allowable on the CDHP HRA accounts. HRA contributions for employees and retirees on the CDHP plan are determined based upon the availability

of funds and Board action.

HRA contributions are available for use by a participant of a lump sum around July 1st of each year and participants and dependents who become eligible for PEBP coverage after July 1st each plan year will receive a prorated base contribution for the participant and their dependents based upon their coverage effective date and the months remaining in the plan year. Participants cannot contribute additional funding to their HRA account.

The next page is an overview of the Medicare Exchange HRA. All retirees enrolled in the Medicare Exchange who have five or more years of service will receive a Medicare Exchange HRA account. Funds in the Medicare HRA account may be used to reimburse eligible medical expenses just like the CDHP one, except they do include payment of premiums.

Retirees on the Medicare Exchange receive a monthly contribution. That is determined based upon available funds and Board action, and the approved monthly amount is calculated on a per month per year of service basis. So for example, the contribution amount for the current plan year is $13 per month per year of service. So a Medicare retiree with 15 years of service will receive $195 per month in available HRA funding.

All HRA contributions for the CDHP and the Medicare Exchange that are not utilized by the participant will roll-over for use in the next plan year. All HRA contributions that are available in an HRA account at the time that a participant terminates coverage are reverts and are no longer available for the participant's use and are no longer a liability of PEBP.

You'll see the policy that is used for the HRA reserve on page four of the presentation. The HRA reserve is a fully funded reserve based on the total balance remaining as of June 30th each year.

The Board has chosen for many years to provide supplemental contributions to spend-down excess reserves, and this does directly increase the HRA reserve balance. Page five shows the enrollment history that also has an effect on the HRA reserve balance. PEBP transitioned to the CDHP plan and the Medicare Exchange beginning in fiscal year 2012. This table outlines the enrollment as of July 1st each year for CDHP participants on the HRA plan and the Medicare Exchange retirees. With the exception of the fiscal year 2013 the total HRA has increased each year.

The next page outlines the HRA contribution decisions from 2012 through the current fiscal year. So each year the Board decides what the HRA contribution amounts will

be depending on available funds. The Board has kept the base contribution similar to years past and added a one-time supplemental contribution to utilize excess reserves. Additional contribution amounts will increase HRA reserve balance if participants do not utilize their additional available funds.

Page seven shows the HRA balance history since fiscal year 2012 as compared to our legislatively approved budget. Since 2012 the HRA reserve balances have varied from what is budgeted and balances suddenly increased most years.

PEBP utilizes the total balance as of June 30th of each even numbered fiscal year to project the amount to budget for the following two years. So for the fiscal year 2020-2021 budget we used fiscal year 2018 actual fund balances to project.

To summarize the main causes of the steady increase to the HRA reserve CDHP employees and retirees and Medicare Exchange retirees have been provided with a significant amount of funding to allow them to offset their medical expenses since 2012. HRA reserves continue to grow each year because of additional contributions, enrollment growth and participants not utilizing the funds that are available to them, and I'm available to answer any questions.

VICE CHAIRWOMAN FOX: Any questions from the

Board or discussion? I don't think so.

Thank you, Cari.

Okay. So I think we're ready for Agenda Item Number Seven, discussion of possible action regarding proposed plan design changes for the Plan Year 2021. Damon Haycock.

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

One of the things that wasn't discussed in the last agenda item but you heard some discussion about it in public comment this morning is what about excess reserves. And one of the things that I wanted to bring up that I quickly looked up while we were having this meeting today is the reporting of excess reserves throughout the year can change dramatically. And so one of the requests you heard today from public comment was to table the decisions and see what those excess reserves looked like in January.

So I'm going to give some reporting numbers that we have reported in our budget reports every quarter for the last plan year to show the dramatic variances that occur based on the timing of funds and the timing of claims because they are not all equal every month and every quarter.

So in January of this year, 2019, we reported the first quarter of Plan Year '19s budget and -- budget and

utilization report. And in that budget report we showed that we were projecting about $6,000,000 of excess reserves at the end of the year. Then in March of 2019, we reported the second quarter's excess reserve projection and that was up to 44.6 million dollars.

The third quarter report was provided in July of this year, and that dropped it back down to 23.8 million dollars. And the fourth quarter finalized it at about 22.4 million dollars which was provided at the very last Board meeting. And I know the question is why on earth did it go from six to 44 down to 23? And when we receive all of our revenue and we pay all of our expenses, there are times when we are ahead of the game in the revenue and there are times when we are behind the game in the revenue and same with the expenses. And so when we take a point in time on the last day of every fiscal quarter, we report what we see.

Now, imagine we would have made decisions last year based on -- actually, there were -- let me back up. There were decisions based on excess reserves last year for Plan Year 2020 this last, almost exactly a year ago today. And imagine if we would have tabled those and waited for January and said, oh, no, there's only $6,000,000 left. A lot of those decisions that we were contemplating would have been invalid. And so what we try to do on excess reserves is

come up with an exact point in time where we know we can defend them based on a very simple ideology.

At the end of every fiscal year we close. We close it on August 31st or some day a few days prior. And at that day we know exactly what our new requirements will be for our required reserves, our IBNP and our catastrophic and if there's any changes, we make those adjustments. We generally have to backfill them because they have been increasing.

We know what has already been earmarked either by the legislature or this Board or both for that plan year. So we reduce that number of excess again. And then we also look at what has been approved for the following plan year if there was an idea to move forward with spending excess reserves over the biennium. A good example is the legislature approved enhanced HRA/HSA funding for both years even though we look at approving benefits each year during the November time frame.

And so the excess reserve decision, if we want to table any of these conversations until January, if you used January's number, chances are you're going to be wrong. If you use March's number chances are you're going to be wrong. And so the best recommendation that PEBP has is to utilize the excess -- the true excess reserves that are reported on

-- in our accounting when we close the fiscal year, and that's a great segue into the very first page of this report where we outline exactly that process.

So this was done in September and we copied it over to the November report because the closing of the fiscal year didn't change. We have way too premature data to talk about any additional potential reserves and the fact that you heard from AON today that we have a 5,000,000 dollar, 6,000,000 dollar claim on the books coming in, that isn't taken into account into our utilization to show are we really gaining or losing excess reserves.

So the first part of the report, of course, says when you get down to it after there was a remaining available 12.9 million dollars, similarly to what we talked about in September, that a large chunk of that has already been earmarked, and we can tell you today that a lot of it has already been spent. There was an about 9.6 million dollar approval at the legislature to send out HSA/HRA funding to replace some much needed equipment at PEBP and to reclassify one of our positions. Those last two are very minor compared to about nine and a half almost that went out, nine and a half million to the HSA and HRA contributions.

So we also have a budget that is earmarked $3,000,000, again, in the second year which is the $125

enhanced HSA/HRA funding, additional, again, equipment replacement based on the state's replacement schedule and, again, we have to pay a little bit more for that personnel reclassification.

So when all is said and done, we are reporting again today about $235,000. Now, I know right now if Ms. Lockard was here she would call foul and say you report low every September. Then in November it comes in higher. We can show you today that we had no clue today that we would be at $235,000. We thought we would be somewhere in the couple of million dollar range all throughout last year even when the legislature decided to do a one -- a one-year initial significant reduction to those reserves.

So this was a little bit surprising to us, and I think we talked about it in the State of PEBP last Board meeting as to why -- where did the money go. How did it all get spent, and we can basically back into the final budget report that we gave you last -- last Board meeting on what happened to the $23,000,000 and that's why we're back down to the 235,000.

So you can table this entire discussion to another some month, but I don't think it's going to change, and I think that it would be -- I would caution the Board to contemplate based on current reporting exactly how volatile

that the -- that excess reserve number truly is because at the end of the day, it is PEBP's opinion that an excess reserve is the money that is left in our account, the cash we have on hand after we've satisfied all of our obligations for the year and we've earmarked all of our obligations for the next. And if we can accept that or if we agree to accept that then it becomes a very simple math perspective and that's what we've been doing for the last three years running.

So before I go into each one of these separately, I do want to talk about what the overall recommendation is because I think it's going to be important to start from the back and move forward with one disclaimer and this is something I think is very important that everybody keep in the back of their head as we talk about plan design changes.

During the last legislative session the legislature approved PEBP's budget by overruling some of the decisions that this Board had made back in November and again in March, decisions that were made in establishing rates, decisions that were made in setting plan design, decisions that were made in -- in the development of this program. I'm not saying that's good or bad. I'm just saying it is.

And because the decisions were changed, it appears at least to PEBP that the Nevada Legislature would

like to have a more active role in the program design moving forward, and that I have personally had to testify and defend why PEBP and our Board has changed benefits after the budget has been approved for the biennium. That has been a consistent concern that I have had to address at the legislative testimony table.

And so when we talk about what is available and or what we recommend and what this Board can approve I think it is prudent to keep that in the back of everyone's mind that it may not make sense to make any changes to the plan in the off year if we are going to have potential issues when we have to justify our budget in the next session.

So with that in mind, we have looked at the fact that we only have a couple of hundred thousand dollars of projected excess reserves. That's what we closed the fiscal year at. We don't know if that's going to change, go up or go down, but we do know that's the number at the point in time that we can honestly claim without a shadow of a doubt that is the excess reserve level June 30th or August 31st of this year.

So with that that is basically about the average cost of one high cost claim. So in PEBP's mind we -- we don't really feel we have excess reserves. So that could be wiped out very quickly with one visit to the hospital for one

of our members. And so -- so we looked at what were the types of opportunities that would pay for themselves that had an initial first year return on investments so we were not over-obligating the plan's resources.

As I was told recently by folks at the legislative counsel bureau, it is, let's see if I can say this accurately. Any executive branch state agency who knowingly increases their obligations after the legislature has appropriated funds for those obligations does so at their own risk.

So, again, with that in mind, we have a basic -- a basic recommendation today, and I'm going to read the recommendation, and then we're going to go through each of these separately because I think it's important we keep what we're looking at ultimately moving forward.

And that is there are two items here that have no or excuse me, that have an initial return on investment. There is another item here that aligns the decision-making of the Board what the legislature has already approved, and then the rest of it is basically member education and looking at pushing some of these requests from our advocates and some of the requests that we have thought internally to the budget building process that we can talk about in the next agenda item.

So the two issues or the two opportunities we have today that don't cost PEBP anymore money than what we're going to save is a piloted chronic kidney disease program or set of services, as well as a second opinion opportunity to utilize a third party to assist our members.

Again, I can be very strong in my recommendations. I'm not strongly recommending anything today. I think if we do nothing and continue with what we have in the plan that we'll continue to be solvent. We'll continue to be aligned with the Nevada Legislature, and that we won't have to get up there and defend why we had made changes to the plan in the interim.

So going back to the beginning, I'll take these one at a time and then we'll pause, Madam Vice Chair, if there's question or people want to vote or if we want to wait until the end. But the first thing we looked at was implementing the Smart 90 Network on the exclusive provider organization or EPO plan.

For reference we implemented a -- the Smart 90 Pharmacy Network. It's a narrower network for 90-day fills of maintenance medication on a voluntary basis last plan year on the CDHP, but we also made it mandatory this year as more folks had already started utilizing this network voluntarily.

We were able to save -- save money. Right now I

think we're looking at about 194,000 was saved in Plan Year 2019, so not a whole lot, but it did create a savings to the plan, and it was something that we wanted to research and analyze if we could mimic it on the EPO plan, but the EPO plan was designed differently. It's designed with co-pays for the most part on the prescription benefit and only co-insurance on the specialty drug side.

And so when we talked with our pharmacy benefits manager Express Scripts and analyzed the data, it didn't look like we could save any money at all. So why would we narrow a network on a buy-up plan to not save any money and to just add more hoops for those members who are paying more in premiums to have a richer plan design. So we are definitely not recommending today that we move forward with that. We will continue to watch that and analyze and see if there are savings.

RPM did, however, analyze the opportunity to do a mandatory mail order program. A lot of states that I have talked to have this in place to control costs. They force the members for their 90-day fills to go through mail order through their vendor. We do not have that program today. It does have the opportunity to save the plan money. However, I don't know if now is the time to -- to place a restrict -- restrictive process on our members, especially when that

restrictive process has not been evaluated by our legislature, and I don't know if we want to cause the turmoil that that would occur for folks, especially the members I've talked to in Las Vegas who don't want their medicine sitting on their front porch in the 110-degree weather, and so it is something that is available.

We're showing you this option just for transparency sake to show that we did our due diligence, but PEBP is not recommending either of those options, the Smart 90 Network on the EPO plan or a mandatory mail order option today, and we recommend potentially looking at that mandatory mail order as a budget enhancement to build into the next biennium so the folks at the Governor's Office and legislature can decide if they want to utilize that to save some money.

And I'll stop there, Madam Vice Chair, and take questions or comments.

VICE CHAIRWOMAN FOX: Is there any question or discussion?

MEMBER VERDUCCI: Yes, Tom Verducci for the record.

You know, I'm trying to understand what's different from this year than from last year, and what I'm reading here in this report is the 9.6 million dollars in the

legislative approved excess reserves spend. Is that an annual expense to the program and was that budgeted for a year ago when we did our budgets?

MR. HAYCOCK: For the record Damon Haycock.

The 9.6 million was for specifically Plan Year 2020. It was not initially built in our agency request budget but it did make it into the Governor's recommended budget announced on January 15th of this year, and it did make its way through the legislature for ultimate approval. If you recall, I think it was the January Board meeting that I brought it back to the Board for the Board approval to align the decision-making, but excess reserves spent for HSA funding has been pretty traditional here at the Public Employees' Benefits Program all the way back to like 2013.

MEMBER VERDUCCI: And also as a follow-up, I believe we had 34 catastrophic claims that totaled $7,000,000 plus and I believe that's a one-time expense and that was something that had changed the figures that we were looking at from, you know, perhaps a year ago.

MR. HAYCOCK: Yeah, for the record Damon Haycock. Thank you, Mr. Verducci.

The high cost claims had a significant increase in utilization, and the increased amount was those additional 34 folks over the year prior. Yes, if we were to take the

average high cost claim times those 34 folks it was about seven and a half million dollars. I actually think the reality, it was a little higher but because of averages it was easier to hone down into that dollar figure. That didn't reduce excess reserves. The way to look at it is excess reserves occurred after all of our obligations. So that was a standard claims payment that we would make regardless of excess reserves or not. So the excess reserves intrinsically were reduced but they really never should have existed because of that claim. They only exist after the claims are paid.

MEMBER VERDUCCI: So this was due to 34 high cost claimants. So let's say for example we had a big flu outbreak and there were now 3,000 claims, at what point does it go into the catastrophic reserves?

MR. HAYCOCK: For the record Damon Haycock. Thank you, Mr. Verducci.

We will utilize our catastrophic reserves when we do not have enough revenue to meet expenses. That's probably the easiest way to look at it. As we collect premiums, as we collect funds, as we collect employer contributions, we still have to pay our claims, and we pay them. To be truly transparent, we're probably dipping into the excess reserves and then building it back up throughout the year as the

timing of the money comes in and the timing of the money goes out.

So at the end of the year we will show -- let me back up. Probably around July and August we'll know if -- if our claims exceeded our projections and if they exceeded the amount of funding that we assign to them, and that's when we will have automatically reduced our excess -- our catastrophic reserves.

MEMBER VERDUCCI: As far as getting a true assessment of what the excess reserves are going to be, is there any additional reports or gage that we can get? It seems like every year around this time we look at the excess reserves being low, and as we get into subsequent meetings the figures look a little bit different. I'm wondering if there's any special study or reports that can be produced where we could gain an accurate assessment.

MR. HAYCOCK: For the record Damon Haycock.

As Aon mentioned today, PEBP has been the entity that has looked at our revenue and expenses and at the end of the day reported what we thought excess reserves would look like. We can utilize their expertise and reserve calculations and have them assist us in the projection of excess reserves. I would just again caution that we spend money before we have it. Even though we project that we're

going to have it because you never know when the 6,000,000 dollar claim is going to come in and I think you're going to kick yourself if you utilize that projection and the projection is wrong.

A great example was the Aon presentation where they said their best estimate of IBNP was a certain dollar amount and they are off a couple of million dollars, that's why we have some of the conservative policies at the Board. And so if you want to spend the money before you have it, it could come back and bite you.

MEMBER VERDUCCI: So to me it would make sense on the no cost items here be approved and the other items that we're not clear on, to me it makes sense they should be tabled until the January meeting.

MR. HAYCOCK: For the record Damon Haycock.

I think that's pretty close to what our recommendation is here. Although, the ones that require funding, I can't imagine whoever is going to be here is going to come back and then find excess reserves by January, but I suppose they could, but I don't see it because it doesn't appear we have it. Not only did we have those 34 high cost claimants that soaked up on average seven and a half million dollars, we also had to increase by about four and a half, $5,000,000 our required reserves because of the new exclusive

provider organization plan and the utilization and the slower payment of claims and the higher cost of those claims that increased the catastrophic reserves.

And so back to that table on page one and page two, you'll see that we had to increase our IBNR reserves by 4.4 million, and our catastrophic reserve, actually it went down, which is nice, by about 400,000, but our HRA reserve went up 2.4 million, and we gave out nine and a half million dollars of HSA/HRA funding, cash went out out for the HSA, but the liability was created on the HRA. So we have to have cash and reserve to cover it.

And so every time we give away more HRA funding people don't spend it immediate. Whereas we give away HSA funding, we consider it expenditures of PEBP. It's just gone. And so every time we give away HRA funding, those balances increase, and we have to hold the cash in case they use it. So, again, it's kind of a snowball effect. When claims go up and costs go up, catastrophic reserves go up, if we start paying a little bit slower for many good reasons why we would, claim or IBNR goes up and then we also have to, if we're giving away more money, then HRA goes up, and so all of these reserves compound when we have years like we did last year.

MEMBER VERDUCCI: Well, it makes sense what

you're saying there that you want to see the money there before it's spent.

VICE CHAIRWOMAN FOX: So are we okay with having Damon go through all of this before we vote on any of it? Yeah, okay. All right.

MR. HAYCOCK: For the record Damon Haycock. I will then continue through.

So the next one is on second opinion services. Today we have that plan offered or on our plan we offer those services. We utilize the Mayo Clinic and the Cleveland Clinic. There is a potential travel benefit for folks that would like to utilize that second opinion service. However, our partner, our third party administrator HealthSCOPE Benefits has found another provider that can potentially assist even more of our members to navigate through this process and receive second opinions on a whole slough of different types of services. I have them here on page three of the report.

They include basically like musculoskeletal, nervous system, oncology, digestive system, female reproductive system and circulatory system types of services. What this second opinion entity is willing to do is provide expert medical opinions, treatment, decisions, support, referrals to local high value providers and, of course,

ongoing support. The company is called Second MD, but they would be treated just like any other provider and bill the plan a claim for services. So it's not like there's a specific direct relationship we need to have with them, just like we don't have direct relationships with doctors today or with hospitals today, right? We have networks, and so this would be a network addition, basically operated through the HealthSCOPE contract.

They are guaranteeing a 1.25 to one based on episode of care costs, the episode of care for the expert opinion and with a member ultimately chooses. So if a member is told they need to have a certain type of treatment and a certain side of care and they get a second opinion and they don't decide to utilize that -- that service, then the difference in cost will be -- will be utilized for the savings amount, and that savings will be matched against what we pay in claims for the second opinions, and so they have agreed to do 1.25 to one.

I think it will be viewed as a member enhancement or a benefit enhancement so our members that would utilize these services will see a richer benefit, but it's not like we don't do this today in some fashion and so I'm not, you know, ready to beat down the doors and say this is something we need to do. This is the right thing to do. If this is

something we want to wait on based on my initial disclaimer at the beginning of this agenda item, I don't think we are going to harm anybody because there already are second opinions today.

Then there is a chronic kidney disease management pilot program. We currently partnered with American Health Holdings for our utilization management and large case management, and they have a series of services that they provide for chronic kidney disease for other clients throughout their book of business. It was something we didn't activate initially when we negotiated our contract. However, they can as a typical provider also bill for this service through -- through medical claims through HealthSCOPE Benefits.

We -- we do have a high cost for chronic kidney disease. About 7.4 million dollars we spent last year and there are five stages, and I'm not a doctor. I'm not going to try to pretend to be one, but my research shows there are five stages of chronic kidney disease and as you move through those stages, your health, of course, gets even worse, and by the stage five you're in total kidney failure and you're either looking at transplants, dialysis or both. So how do we get people to avoid getting dialysis and transplants and basically saving those kidneys.

And so there is an opportunity through a disease management process to try and pilot this. Though we would -- we would get a return on investment of one to one, and the way that we would look and measure that return on investment is those folks with chronic kidney disease in each of these stages that seek care through this service would be matched up against those similarly situated that didn't and the delta or the difference between their cost would be recorded as savings, and then we reduce the amount of those savings by what we paid for the services, and if we pay more than what we saved they would make us whole. That's the return on investment.

If we save more than what we paid, well, then there's a little bit of gain sharing involved there to try to motivate them to continue to do better. And so if the savings, it's that final bullet on page four, if the savings outweigh the total annual spend, we'll share 25 percent which is pretty standard of the savings up to -- up to a cap. It's up to about $100,000 of shared payment savings, and I show some math in there. But basically if they save us a billion dollars we're not going to give them a quarter of a billion dollars, right. I mean, we're not going to do that. It's not in our best interest. Do we think we're going to save us a billion dollars, of course not, but that's just an extreme

idea as to why you want to put caps on gain share so there's an amount you share back but then if you get really good savings, most of it or all of it stays with the plan.

So we can pilot it. Again, it's not something that we can't put off. It's not something that we have to put in place this next plan year. And if you followed, again, my disclaimer at the beginning of this report, it may be prudent to push this off into the next biennium and present it as a value at a benefit addition, a richer benefit design as part of our budget development through the legislature next session.

The next items is CDHP HSA and HRA funding. We basically said would you like to approve what the legislature already did which is $125 for primary participant in the next plan year. When we voted on the $400 that was approved for this plan year, we only brought that portion for your approval. So to clean it up, we're bringing it back again to align the decision-making.

Then as far as centers of excellence, this was for Ms. Mitchell. She wanted to know if there was a way to increase the utilization of them. We currently have a mandate to use them for bariatric surgeries and transplant -- transplants, and the provider recommending the service works with PEBP's case management partner and third party

administrator to ensure folks get access to those centers of excellence.

We can develop a program that either incentivizes the use of them or de-incentivizes the not use of them, right. Similar to our reference based pricing program we have for hips and knees where we pick champion locations and say that's what we're going to pay off of and if people go anywhere else they pay the difference. That can be looked at as a benefit reduction. It can be a paying point to some of our members who don't want to go to one of these locations.

Although, we think it's important to use a center of excellence, it also may be more costly so we also have to think about that as well because sometimes, not always but sometimes quality incurs a higher cost. And so what we recommend is pending the decision, of course, that you guys decide on the second opinions because part of second opinions is also steerage to centers of excellence. We think it may be in our best interest to showcase what those centers of excellence are and post them on our website, reference them in our newsletter, send them out to -- send notices out to our members so they know they have these benefits and know where these designated centers of excellence are.

Something I should have said at the beginning of this section, there is no like federal definition of a

centers of excellence or a state definition. So it's incumbent upon every health plan to kind of determine their own, and so we utilize the Etna National Network, and they have a series of centers of excellence for all types of services that -- that they have provided us and we can -- we can post them. We can educate our members on them, and that's what we think probably is the right thing to do at this stage.

Then moving onto the page six and into page seven, these are mostly the requests of the Nevada System of Higher Education, Nevada Faculty Alliance. These are talking about reducing deductibles, eliminating co-pays for vision exams, increasing the dental benefit maximums, and you'll see different layers and levels and tiers of what it could look like and what the costs would be to PEBP.

Normally we would have a deeper conversation about these when we had a significant level of excess reserves, but with $235,000 I don't think we can do anything on here. So our recommendation for these three items and the one that isn't in here that was in Dr. Unger's attachment which was increasing the HSA funding for dependents by $100, that additional cost and these costs we believe should be built if you are interested into a budget enhancement unit, and we'll talk a little bit more about that in the next

agenda item.

Then there was another request at the last meeting by Mr. Ervin from the Nevada Faculty Alliance. He's not here today. He told me he wished he could be, but I'm going to bring this up for him. That there was an announcement that came out I think from the IRS about the potential increasing to preventive benefits and if the plans wanted to utilize that, we have a preventative drug benefit today where we bypass the deductible to allow folks that need preventive medicines and maintenance medicines, first dollar coverage from the plan to help them pay for those much needed prescriptions. There were basically five things that were on that IRS issued update.

The first was the addition of selective serotonin, reuptake inhibitors or SSRI's that's for anti-depression. Then there's inhaler cortisone steroids for more of those asthma, COPD folks, peak flow meters and asthma assistant devices, diabetic medication and glucometers and blood pressure monitors. So we already covered inhaler cortisone steroids on our current list and diabetic medications and glucometers are provided through our diabetes care management program today.

The blood pressure monitors are available through the medical benefits. So the only additions would be the

anti-depressants and peak flow meters. And when we had that utilization, the current utilization of those two on our plan, our pharmacy benefits manager came back and said it would cost 216,000. However, that's for current utilizers only. So we don't know if additional utilizers would come to the table and start utilizing this more because of this preventive drug benefit.

A good example, we developed a preventive drug benefit for a bunch of different drugs when we first created that list a few years ago, and I sat in front of the Board and said we anticipate a half a million dollars of cost out of our excess reserves. It turned out to be 1.5 million because more people started utilizing it, which is a good thing, but it did drive up the cost by a factor of three with new utilizers, utilizers and stopped taking it and then started again.

So we don't feel there's enough excess reserves available to cover the potential increase in costs for this benefit, and a lot of these benefits are already covered today. But if it's something you want us to continue to analyze, we can either -- of course, you all can approve it anyway or if you decide to put in our budget, we can put it into our budget in the next budget build as a potential cost increase to be offset by other cost saving activities.

So that's really all of it in a nutshell. The recommendation stays the same. Again, I'm not coming out pretty strong on the two items. There is -- we don't feel we're going to put the plan in jeopardy if we don't do them, and it may be prudent to be patient and allow the process to be built into the budget. So, therefore, it's -- it's consistent every two years and both the Governor's Office and the legislature know how the program will be moving forward and they know what they are paying for every time they vote and approve our biennial budget.

With that, I'll turn it back over to you, Madam Vice Chair, for any questions or comments.

VICE CHAIRWOMAN FOX: So my only comment is the SSRI's, if we can break one thing out of here, I would love to see it. I mean, if we included generic SSRI's because they are so cheap, I would love to see that included at this point, but other than that I like PEBP's recommendations.

Does anybody, any other Board members have questions or comments for Damon?

MEMBER MITCHELL: Jet Mitchell for the record.

I do have a comment about the second opinion services for CDHP and EPO. So in addition to cost savings, I don't have the site here of the research studies, but research studies have shown that patients that do seek a

second opinion persist in the treatment of that second opinion more quickly and persist throughout their treatment. Additionally, patients that seek second opinions tend to be happier with their plan and with the fact that that has been offered to them as a patient.

Also, in the extensive, on patient cancer advocacy work that I've done, extensive conversation has been around access to second opinions. So I have strong, firm strong thoughts about having second opinions services available through the plan not only for that cost savings which is obviously something we should keep in mind to be prudent fiscally but also from the high satisfaction that can be gained from patients that not only have that option, even for patients that don't use that second opinion. Knowing that that is available can be very strong. And then as I mentioned earlier, knowing that patients access that second opinion then carry through with their treatment.

MEMBER LAMBORN: I wanted to go back to the kidney, the chronic kidney disease management, the case management, and I see here that it would be the company, the case management company would sign an agreement with HealthSCOPE. Where would the pay for performance and the measuring of performance fall? Would that be an agreement with PEBP directly or with HealthSCOPE?

MR. HAYCOCK: Good question, Ms. Lamborn. Damon Haycock for the record.

We have a similar arrangement with Healthcare Bluebook, Doctor On Demand. We get reports directly from those entities, and then we -- we do the -- we do the internal look at savings. We can also as part of the Health Claim Auditors, every 90-day audit to HealthSCOPE add those audits so to validate those savings every 90 days as well. So we can make sure whatever you guys agree to that no one is pulling the wool over your eyes and that it's vetted.

MEMBER LAMBORN: Along that question, again, Leah Lamborn for the record.

So that's kind of where I'm going with is whatever we agree to, I have found that these pay for performance type of arrangements, if it's not spelled out exactly how it's measured and what's going to be taken into account during that measuring of savings that it gets very gray and that the contractor generally gets to get the pay for performance.

MR. HAYCOCK: So for the record Damon Haycock.

I spend a lot of time working with American Health Holdings and try to figure out how we're going to return on investment because if there's one thing that I dislike the most is bad return on investment metrics. And we

-- anytime I come up here and present to you a potential savings, it is my name and my recommendation and my credibility on the line. So I take it very personally to ensure that whatever savings that we project that if there is a guarantee that that guarantee is upheld to the most strictest standards.

And so the initial return on investment wasn't going to be as detailed as what we wanted and we told them this is the only way we're going to do it, and it's pretty -- it's not standard in this area but it's something that PEBP already uses today. So for chronic kidney disease, the savings methodology is going to mirror the savings methodology for the obesity care management report. Again, it's similarly situated people. Those that are on the program versus those that are off the program, how much did they incur in medical costs throughout the year and how much did they incur in medical costs throughout the year and the difference we can attribute to savings.

Now, there's always outliers we can talk about. Well, this person incurred this major accident and it had nothing to do with their chronic kidney disease, and we can look at pulling those out, but on average we find that this is a pretty fair way to look at these pay for performance. And so if we do it on the negative end, if they don't meet

it, then we can also use the same metrics on the positive end if they exceed it.

MEMBER LAMBORN: Just one final follow-up on that. So those outliers and that's where it gets really gray, those are spelled out in this agreement and contract.

MR. HAYCOCK: So for the record Damon Haycock.

We anticipate HealthSCOPE Benefits doing is signing a letter of agreement with American Health Holdings for this specific process and the billing and the guarantees. We'll make sure that any agreement has that spelled out and if it doesn't we won't sign it.

MEMBER LAMBORN: Okay.

MR. HAYCOCK: Or they won't sign it. Excuse me.

MEMBER LAMBORN: Thank you.

MEMBER ZACK: Madam Chair, Christine Zack for the record.

So, Damon, with these current agreements with second opinion services, are those via telemedicine or via phone or you actually travel to the Mayo Clinic and Cleveland Clinic?

MR. HAYCOCK: For the record Damon Haycock.

My understanding, and I'll let Mary Catherine correct me, but that we actually provide a travel benefit for folks to attend, as well as the ability to do it from I think

pier to pier, doctor to doctor but if you want to come up and bail me out I appreciate it.

MS. PERSON: Mary Catherine Person for the record.

The way that it's worked, actually there's the ability to do an E-review. So if the patient wants their records to be reviewed, they contact us. We help them collect those records. We then provide them to Mayo or Cleveland Clinic. And then based on that review, then they make a travel or no travel recommendation based on the review of those records.

MEMBER ZACK: Thank you.

MS. PERSON: Uh-huh. Can I have one other point on that. The other component to the whole second opinion story is the fact that today your members do have access to the nationwide Etna Network. And so at any time we can work with your numbers around getting a second opinion from another provider. It's certainly in concert with American Health Holdings. So that is also another option available to all of your members today.

MEMBER ZACK: Thank you. My concern was more over the travel cost and the cost associated with people having to take off time from work, maybe arrange childcare and whether or not this is a benefit that we actually don't

currently have in that it could be done virtually. I still support it but just had those questions about what we're currently offering.

MS. PERSON: The -- excuse me, the additional benefit that we were talking about was a fully virtual program as well which would be really in addition to all of the other things you have.

MEMBER ZACK: Great. Thank you.

MS. PERSON: Uh-huh.

VICE CHAIRWOMAN FOX: So any other questions for Damon or discussion?

So, Mr. Verducci, you didn't actually make a motion but had a suggestion that you liked PEBP suggestions other than you wanted to revisit in January rather than at the next budget cycle.

MEMBER VERDUCCI: Tom Verducci for the record.

Madam Vice Chair, I wanted to see if I could clarify the suggestion that you were making because that could perhaps be intertwined into a motion.

VICE CHAIRWOMAN FOX: Okay. So my suggestion was simply regarding the IRS approved drug list that we actually at this point include generic SSRI's. So I know there's a list of five things here. Some have already been addressed in our plan, but I would suggest we include the SSRI's at

this point. I know this doesn't specify if they are generic or not generic. I'm going to assume they are because the cost was so low that you mentioned, but I would request if they are generic that they be included.

MEMBER VERDUCCI: Thank you. I'm willing to make a motion on this item.

VICE CHAIRWOMAN FOX: Okay. Let's hear that motion.

MEMBER VERDUCCI: For the Plan Year 2021, the motion would be that PEBP recommend implementing second opinion services with second MD from the CDHP and EPO plans to piloting chronic kidney disease services in the CDHP and EPO plans. Three, approving the 125 dollar enhanced individual HSA/HRA funding as approved by the legislature for increasing member educational benefits of utilizing the centers of excellence. And five, tabling all other analyzed enhanced benefits above for possibly inclusion in the '22-23 budget development, plus the inclusion of the generic SSRI suggestion as Vice Chair Fox has suggested.

VICE CHAIRWOMAN FOX: Thank you.

So we have a motion. Is there a second to that motion?

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

VICE CHAIRWOMAN FOX: So I have a motion and a

second. All in favor -- is there anymore discussion before we vote? Okay. All in favor say aye.

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

VICE CHAIRWOMAN FOX: Any opposed? Okay. Motion carries.

I'm going to ask that we take a short break before we move on to Number Eight. Ten minutes.

(Whereupon, a brief recess was taken.)

VICE CHAIRWOMAN FOX: Okay. I'm going to call our meeting back to order, and we're going to start with Agenda Item Number Eight, discussion and possible action and to approve benefit changes for Plan Year 2021, PEBP's master plan documents for the CDHP and premier EPO plan. Damon Haycock.

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

So there's a couple of pieces to this report that we need your approval on first, and we talked about it after the last session ended back in June or at the Board meeting in July. There was a couple of bills that passed that addressed things like sickle cell anemia or gestational carriers and things that our plan was not quite in compliance with when these benefits are to begin on January 1.

And so when a plan wants to change their master plan documents or their summary plan documents, they -- for the current plan year, they need to do it through an amendment log and post it out there for all of the memberships so they know a change has occurred.

This is the first time we made a change since I've been here at PEBP. I don't know if my predecessors have had to make changes but to -- to align our plan and our benefits with legislative approval over the last session, we need to do a couple of things.

And so the first section on page -- the first page of the report talks about what we're going to revise for this current Plan Year 2020 and for these amendment logs. First we're going to talk about the benefit limitations and exclusions. We used to just blanket exclude certain types of fertility and infertility services.

And what we've done, I should have said this earlier, we actually posted this report in the track changes mode. So you're going to see exactly what we're doing to the language in the document. The things that are crossed out are things we're taking out, and the things that are underlined red, if you don't have a color copy, they are the underlying ones under key terms and definitions on page two and page three, but those are the new language we're going to

put into these plans.

And so under benefit limitations and exclusions, you'll see starting out on page two that we're -- we're going to take out of the exclusion maternity services related to our participants serving in the capacity of a surrogate mother.

And if you recall at the last session and afterwards, we brought a report summarizing what happened. That the legislature has now requirements of health plans to cover surrogacy which we didn't before. So we need to take these exclusions out of our plans to be -- to be in line. We also want to define them in the key terms and definitions. So we define what a gestational carrier is and we also define sickle cell disease, and so that's the first part of this report.

Then, again, in exclusions on the CDHP amendment log, you'll see on page two we take out surrogate parenting from that exclusion. So the first part of page one and the top of page two is the EPO document. The bottom of page two, into page three is the CDHP document. We're aligning the benefits in accordance with law. Again, we're taking out exclusions for maternity care and delivery expenses associated with a surrogacy mother's pregnancy, and we're adding those two definitions. So for that part we recommend

that you approve and incorporate the revisions described so we can go ahead and notice and announce and post for our membership so they have an accurate document. These benefits begin lawfully on January 1st.

Then the second section describes proposed changes to the CDHP and EPO master plan documents for the next plan year. We traditionally bring these to you in March, but there was some pretty valid comments by the advocates last March that said how come you're changing benefits in your plans and you're not talking about them at the November Board meeting. So we backed it up to be more transparent and give everybody an opportunity. You can make a decision today and technically undo that decision in January or March. So there is some time so folks can digest what we're recommending.

What you don't see here today are all of the administrative housekeeping things, like we changed a date or we updated the has amount from the IRS. Those things we'll bring back to you in March, just a summary real quick of what we've done because they don't change the benefits outside of what we have to do when it comes to those contributions so they're not a decision necessarily that is made by the Board, but we do want you to continue to approve the things that need to be approved.

So the first thing that we're going to do in section two is we're going to define, and this is on page three, we're going to talk about a breast augmentation benefits for the CDHP and EPO plan. And so right now we have a blanket exclusion for breast augmentation, but there are folks that are going through gender reassignment, I don't want to say services, but gender reassignment therapy, and as part of that therapy they are issued hormones to complete that transformation. And if those hormones do not take effect then there are benefits that are provided and, you know, in other areas. Most importantly as a comparison, Medicaid covers breast augmentation if someone had 12 continuous months of hormonal therapy and failed to result in a certain level of tissue growth.

And so in order to be in compliance with the trans or excuse me, the gender reassignment and transgender laws, as long to align with Medicaid, we recommend adding this benefit just really to kind of protect the plan and to ensure that we're consistent across the state. Basically we would -- the revision will remove the exclusion for medically necessary breast augmentation related to gender reassignment surgeries.

The second part is wanted to clarify the Healthcare Bluebook incentive reward. If you recall, you

approved Healthcare Bluebook last year for this, not only for this current year but it was -- yeah, excuse me. It was introduced with incentives. There are certain high quality, low cost providers that are shown on the website that if folks do select, they get an incentive check.

But one of the problems we ran into is some folks weren't catching them, and they become a stale check and how do we deal with that and how does that money come back. And so we wanted to come up with a pretty standard accounting practice which is participants earning a monetary reward from Healthcare Bluebook will have 180 days from the date the check is issued to cash it, and those that aren't cashed will be forfeited and funds will be returned to the plan. So we just want to make sure we aren't carrying this liability for these very small checks year over year until the end of time.

Then as far as CDHP, HSA/HRA contributions, we wanted to align with what we're actually doing in policy, but it wasn't quite clear enough in our plan documents. This is for the Consumer Driven Health Plan that we wanted to add the language that under no circumstances will a participant or dependent who received contributions during the plan year be eligible for additional contributions due to reinstatement.

So if you are in our health plan on July 1 and you are an employee and you have HSA, you get an HSA amount.

If you have HRA, you get an HRA additional balance. If we do supplemental funding, it goes out on July 1. Again, this is strictly for the Consumer Driven Health Plan.

And then if it turns out that you have an HSA or an HRA and you end up terminating from state service but then you get rehired a couple of months later, we want to make sure that we're very clear that you can't double dip. You're not going to get it all back again, right. You're going to be able to carry forward the HRA funds that were on the books that were for the plan year and you're not going to get an additional HSA amount because it was already provided back in July. So this is just to clarify that part of the program. We feel it's important that we make sure that we protect ourselves by outlining it directly in our plan document.

That is also on page five, again, reinstated employees who have active employment in the same plan year and have an HRA. Traditionally we have the ability to, we don't do this, but you could have accumulated thousands of dollars of HRA funding, started the plan year with us, got another supplemental from, you know, the legislature and the Board and then you left state service. What's supposed to happen immediately when you leave state service as Cari mentioned earlier in the HRA reserve discussion, those funds are forfeited and they go back to the state and the

liabilities get reduced.

When a member gets reinstated within the same plan year as a member benefit, we allow them to keep the amount of money that they had in their HRA before. A good reason for this is if you get an HSA, you get the cash in your account. If you get an HRA you get balance. If both of these people leave and come back, that person still has the HSA money that was left there, but the person with the HRA loses all of it.

And so to try to be a little bit fairer and provide a benefit, especially for those that are retired and on fixed incomes that are on our plan, it's something that we have been doing in practice, but we have not really had it outlined in the plan. So we would like to outline it in the plan to protect the decision-making of the Board and PEBP.

Last but not least, we want to talk about the dental anesthesia. This effects really all plans. If you think about it, our dental program is offered to CDHP, EPO, HMO. They are also offered to -- to the -- for the Medicare Exchange, but this specific is for the CDHP and EPO plan because it's when dental benefits are being accessed on the medical plan.

And so we have current language, we show in the 2020 CDHP that if a patient is under the age of seven, that's

the real important part because in -- we don't have that same age aligned in the EPO, and so this benefit is provided to folks under seven. I believe on the EPO it's for folks under or it just says under 18 and has a physical, mental or medically compromising condition. So basically this benefit allows folks that have -- that need certain type of dental services through the medical plan, say they need reconstructive surgery or they were in a car accident and need to get it done through an inpatient location, this is to align the age requirements so that way we're giving both of our plans the same benefit.

So at the top there or in the middle of the page, on page five we tell you what the EPO plan language is, just three bullets and then below that with the CDHP language, it goes into more detail, and so we're recommending that we align both of the benefits to the one singular benefit today. That you are under 18, that you do have dental needs which local anesthesia isn't effective because of infections or anatomic anomalies or allergies that you documented mental or physical impairment requiring general anesthesia, is under the age of seven. So we clarify that and that no pain is extended towards the dentist or assistant dental provider under this plan. Refer to the dental benefits described in the PPO dental plan for those.

So we went over those pretty quickly. We're not really recommending new benefits. We're not saying anything that isn't already either approved by the legislature or approved in practice but not delineated as well or clarified as well in the plan documents. But for transparency we wanted to bring them to you all today because these do outline benefit changes that are different than what we have in our documents today. They don't really outline benefit changes that we're offering with the exception of the surrogacy law that is going to into effect January 1.

With that I'll take any questions.

VICE CHAIRWOMAN FOX: So I'm going to ask, this might sound like a silly question. How is eight different from seven? Is eight just different than -- it's just clarified language?

MR. HAYCOCK: For the record Damon Haycock.

So seven, it talks -- had you guys approved a whole slough of new benefits then we would need to put them into our master plan document, and so one kind of leads into the other into the other. And so seven, Item Number Seven talks about what do you want to do different in the next plan year. And the only difference that I think you guys added was the generic anti-depressants and then expanded the use of second opinions and expanded the use of assistance for our

chronic kidney disease program. Those that we can delineate in our master plan documents, we'll add that documentation as well, but think of it kind of like, I don't want to make light of it, but think of it like a check the box thing. You make a decision on a design, but then you also need to approve the documents that we post and that will keep us safe legally.

And so this is -- this is the kind of follow the bouncing ball. You start with benefits, benefits get put into document and then they get posted and sent to our membership. So I hope that answers your question.

VICE CHAIRWOMAN FOX: It does. Does anybody have any questions for Damon?

MEMBER VERDUCCI: Yes. Tom Verducci for the record.

I just want to discuss the Bluebook checks. It seems rather archaic that we are sending these small checks to people and they are going un-cashed. You know, it's costly generating a check. Is there any possibility or any past discussion of maybe getting a routing and transit number and setting up a direct deposit?

I just find in my line of work people, you know, nowadays are much more willing to give their banking information and it alleviates cost in the paper and checks

going un-cashed?

MS. RICH: For the record Laura Rich.

Yes, you are right, Mr. Verducci. It is -- it is costly to generate a check, and I personally get it. A 20 dollar check, it's not the, you know, it's not the easiest to go and cash it and deposit it. It's, you know, somewhat archaic like you say.

Unfortunately, a lot of members that receive these checks are, they are receiving them as a result of a service. So they -- they have that service that is qualifying them for a 25 dollar, 50 dollar check from Healthcare Bluebook. Healthcare Bluebook does not necessarily know that they are going to receive that service, and so we only know of them or Healthcare Bluebook only knows of them after they receive that service a check is generated.

There might be a possibility to reach out to Healthcare Bluebook and ask them if they have a process to maybe reach out to these members and say, hey, can we do an electronic deposit or how do you wish to -- to have this money deposited? Would you like a check or but for the most part these services are a result or these checks are result of a service that we didn't know was going to -- were going to occur and so they qualify for that -- for that check or for that incentive check as a result of that. So I can

certainly reach out to Healthcare Bluebook and see if they have a process for that and let you know.

MEMBER VERDUCCI: I think that would make a lot of sense. It seems like we're in a digital world nowadays, and I just know from, you know, my work experience that typically generating a check costs about $10 minimum. If it's a 25 dollar check it's a pretty big waste. I just don't know if logistically if they are set up to do a banking, but that would be a good thing to look into if they can capture the banking information.

MEMBER LAMBORN: Leah Lamborn for the record.

Just to follow-up on that. I think the ideal thing, if it's possible, is if our employees are getting direct deposit payroll can that information be shared or can Health Bluebook provide the information for our payroll department I guess to deposit into their account if they have that, if the information is available. I think that would be more ideal.

MR. HAYCOCK: So for the record Damon Haycock.

Just a couple of things I want to talk about. One, I'm going to do yours first, Ms. Lamborn. We have I think 151 pay centers. So, yes, the bulk of our folks are either in central payroll or in the Nevada System of Higher Education. We have a descent amount in PERS as well, but we

have a lot of one-person shops that have to do payroll deductions and inclusions, and I don't know how well they are set up to do that, and a lot of them are also local governments as well that support our non-state retirees that are still on our plan that have access to these services on the CDHP today.

One of the things that I was surprised, surprised me very much is when I did get a check, this was some time last year, who still uses checks, and my wife picked up her phone and took a picture of it and 30 seconds later it was in my bank account. So there are some other technological advances that people have access to today to be able to instantly cash checks or receive them.

There's also a potential concern, and I wanted to address your comment, Mr. Verducci. There are a lot of people that have no problem giving out their banking information but there are a lot of people who do, and I don't know if folks are going to be okay with a third party that works with -- a third party that works with PEBP to give them routing numbers and a direct link to their bank account for, again, a small check that they may or may not actually cash. So just thinking both sides of the fence on this one.

I would be careful about trying to collect anymore information from our members than we need to because

our role is to be the health plan, right. So, you know, as an example, I don't get to know anyone on my -- any retiree or employees health status or what they are seeking services for unless they reach directly out to me to do some investigation, and so there's a great separation there that protects their information, and so I don't know if you would get pushed back. I think we've had a lot of pushback from a few very vocal members, on, you know, Doctor On Demand and required to enroll in electronic, you know, health benefits process. Just some things to think about to weigh. There is a great benefit and a cost savings to doing this electronically, but there's kind of a personal disadvantage to some folks.

VICE CHAIRWOMAN FOX: Okay. Anymore discussion or questions for Damon?

So would anybody like to make a motion? I think we would need a motion for staff to approve staff to make required technical changes as well as approval for the staff request for Premier EPO and changes that Damon went over. So we would need a motion for both of those things when you are ready to do that.

MR. HAYCOCK: For the record Damon Haycock.

There's a number missing in the staff recommendation. So we request approval for the Premiere EPO

and CDHP Master Plan Document amendments described in sections one and two for Plan Year '20 and Plan Year '21, as well as approval to make any required technical changes. We do need to make those changes to the current plan year documents as well.

VICE CHAIRWOMAN FOX: Okay. So with that change noted would anybody like to make that motion?

MEMBER MITCHELL: Jet Mitchell for the record. Motion.

VICE CHAIRWOMAN FOX: So we have a motion. Would anybody like to make a second?

MEMBER BAILEY: For the record Don Bailey. I second that motion.

VICE CHAIRWOMAN FOX: We have a first and a second. Is there any discussion? All right. So I will ask that we now vote. All those in favor say aye.

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

VICE CHAIRWOMAN FOX: Any opposed? Okay. So that motion carries.

That brings us to Agenda Item Number Nine, discussion on PEBP's fiscal year 2022-23 budget development and direction of staff on budget enhancements for submission of PEBP's biennial budget August 2020. Damon Haycock.

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

This agenda is designed -- this agenda item is designed to be more of an open conversation, an open dialogue on potential processes moving forward. We did make it for possible action just in case you decided you wanted -- you felt very strong about something, you wanted us to do something immediately, but there is no written report because we wanted to really have a strategizing conversation and not hone in too much on one specific avenue.

So in years past, we had followed a very similar chronically or a similar set of steps that basically followed this process. September, again, we would come up to you guys and talk about potential plan design opportunities. You would tell us if you wanted to add or change any of those, and then we would go back with our partners and analyze them. At this meeting every year we would bring them back to you, what is available both in cost savings and benefit enhancements, and then we would go ahead and make recommendations. You guys would approve what you decided to approve, whether it was our recommendations or not. I think today was a great example as to how you guys differ which is excellent as part of this process, and then we would go ahead and get trend in January on how we're doing. In March we

would get rates, make any final decisions if somehow magically we felt money was -- there was more money on the table and then we would implement by July 1.

Based on the conversation or in the reporting earlier today at the meeting, I talked a little bit about how the legislature and the Governor's Office has become more involved in this process, and really this agenda item here is to highlight again what I think we may have done in the past.

In my conversations with LCB and the Governor's Finance Office recently, PEBP was reminded that in years past this Board would select benefits that they wanted to either cut or increase or change and they would do it on a cycle and it would be on a cycle through the budget, the budget development process. And since I got here, I've been a little more, I don't want to say innovative but a little less patient maybe in wanting to do things a little bit quicker for our members to restore more benefits to them faster than in the biennial process, and it has received some mixed reviews by the legislature and the Governor's Office.

And so what we're wanting to talk about today is, you know, is there a benefit and I think there is to going back to that process of introducing new benefits but also providing a more collaborative process with the Governor's Office and the legislative counsel bureau and the legislature

ultimately to decide what they want to fund as is their role.

And so before we would get a bunch of recommendations and suggestions from advocates, from our partners and then PEBP would go through and pick them apart and cherry-pick the right ones and that would be our recommendation. What we're suggesting today is we kind of open up the table up a bit and say, you know, what do folks want to do. We received a response from Dr. Doug Unger from UNLV. I received a text during the meeting from AFSCME, employee representative who said he's going to be submitting what they feel that they want on behalf of the employees.

And really in this process maybe, maybe we put it altogether, and we say here is all of the different options, think of it ala carte style and present it in our budget, all of these budget enhancements because there will be changes to what we're currently funded for today and whatever makes it in through the Governor's recommended budget process makes it to the legislature, and then PEBP will go and defend that Governor's recommended budget as we do every other year. And at the end, if the legislature changes it they change it, if they don't they don't, but it follows a pretty simple streamline path.

As Board members throughout this process, if you do it in this mechanism, utilizing this mechanism then

everything is transparent, as it has been before, but that you're not making final decisions on where the program is going. Whether that's right or wrong is for someone else to deal with later but for -- for the environment that we're in today, it allows -- it allows the opportunity for folks to have more influence on what we're building, and then the decision-makers who are in charge of deciding what our budget is and how we're funded at the legislature get to make that ultimate decision I personally feel was the message of the last legislative session. So if that's the message then should we -- should we continue to go against the grain or should we follow along as other state agencies do and present our budgets accordingly for review, and I'm very much on the latter at this point.

So my suggestion, and I've reached out to the advocates and you've seen some of their stuff come in is that we basically think of it like a jigsaw puzzle, right. We get different pieces. These are cost savings activities. These are benefit enhancements and we put it all into a multiple set of budgeting enhancement units and we present it to the Governor's Office and talk to them about it, and they kind of pick and choose. Okay, we want to save money here. We want to increase benefits there and, therefore, they kind of build it the way they want it, and we move forward with defending

it.

But if the legislature disagrees with the executive branch they will have it all in public transparency based on what the Board has built. And so to -- to take it full circle, what is PEBP suggesting is that we start talking about what we want to do with budget at the November meeting in the odd year because if there's things for this off year of the biennial cycle it may be more prudent as we have talked about today to push them into the budget building process. So one kind of leads into the other.

As an example, if we really think that it's important to lower deductibles and lower out-of-pocket maximums and decrease the dental benefit and get rid of the co-pays for vision, all of the requests that UNLV document requested, we can literally just build that unit by itself and move it forward through the budget process.

And then we have a really awesome opportunity for cost savings to address more of the manufacturer coupon issue through a program called Save On through Express Scripts that will adjust the benefit to meet the -- the coupon amount so members pay nothing and we reap all of the benefits from those coupons, and I don't have it flushed out for you today and it's a significant change to the program, and we're recommending no significant changes until it goes through the

legislative process and the budget building process, but we firmly expect to see from Express Scripts what that looks like, and it could be -- it could be two or $3,000,000 of savings through our pharmacy cost.

So what I envision personally was that you would have these cost saving activities as individual as enhancements and you would have these benefit enhancements to offset. Normally we would do that in this report today and say, look, we're going to take money here and we're going to put it here and it's all going to washout and this is what we want to do, but now we are a little more collaborative with the Governor's Finance Office and legislative counsel bureau and ultimately the legislature.

And when I pitched this idea to the Governor's Finance Office and LCB, it appeared and I don't want to speak for them, but they were amenable to it. So it kind of laid the groundwork if you're interested in this process, but all of the things that everybody has asked for, we generally have to say yes or no to, now we can kind of defer that to the folks that are ultimately going to make that decision. That's my idea that I wanted to present today and I'll turn it back to you, Madam Vice Chair, for comments and questions.

VICE CHAIRWOMAN FOX: Would your idea be that we start, like when we do the planning session in the summer, we

start there and then coordinate our ideas systematically and then some point we put our ideas together and put that forth to the legislature and I mean, is that the path that I understand?

MR. HAYCOCK: For the record Damon Haycock.

It's pretty close to what I envisioned. So in August we have our strategy session, and we talk about the things we can do next year and the things that doesn't necessarily do dramatic diagram changes to the plan, like the second opinions and the -- and the chronic kidney disease, right. And we also talk about the really nice things that we want to adjust, major design change, co-pays, whatever, and we start circling the wagons on those, right, with our partners, and we talk a little bit about them in November or we continue -- and then we bring it back to you guys in January, talk a little bit more about them, and then in March we get final approval to move forward and build the budget.

In May we can give you an update but at the July Board meeting, we'll come and say this is what we built. This is exactly what we talked about. It's completely transparent. And what that does is give multiple Board meetings for you all to noodle on some of these things, as well as ask additional questions, see if there's additional items you want included. You talk to the various

stakeholders and get their opinions, and so we're probably premature talking about it today, but I didn't want to discount all of the hard work that was done by our advocates, our partners in analyzing these costs and we kind of shelve them forever.

I wanted to talk a little bit about it today to T it up, have a conversation that -- I mean, we can wait until January. We can wait until March. It also leads into the other process of the bill draft request process that we need to talk about. Is there any BDR's that we want to bring forth because policy BDR's without a budget impact have to be approved by the Governor's Office well in advance of the budget submission. Anything with a budget impact becomes a budgeted BDR that goes with the budget in August of next year.

And so as an example, please don't go run off and say Damon wants to do this, but if you wanted to decrease or increase the size of the Board that would be a BDR, that is a policy BDR. And if there's something you wanted accomplished we probably should talk about it well before the March Board meeting. And I feel like the last couple of Marches that I came to the Board and presented budgets, budget ideas that maybe we didn't give all of the stakeholders enough time to weigh in on that, and so we wanted to try to rectify that,

and that's why we're talking about it as early as today.

MEMBER LAMBORN: I have a question. Actually, I like the idea, the change, but I would like one thing added to that, for the PEBP Board to have the ability to prioritize those budget items. At least we can -- because we're -- we're hearing from our participants, and so we hear the testimony. So we know what is more important than what is just presented in a budget item. So I think we should have the ability to prioritize the decision units enhancements.

MR. HAYCOCK: For the record Damon Haycock.

Ms. Lamborn, I think we can easily do that and make sure as we build those enhancement units that we place a statement for the Board that says this is the Board's number one priority, number 12 priority and anything in-between both for cost saving activities, as well as for benefit changes and enhancements.

VICE CHAIRWOMAN FOX: Any questions?

MEMBER PACKHAM: I have one other thought. Hopefully it's not a tangent, but I'm hoping since we can walk and chew gum at the same time that we can have kind of a parallel discussion of what I think has been presented as pretty conservative reserve requirements. I feel that we're a little boxed in when we see a reserve, excess reserve figure in six figures versus seven or eight, and so I don't

know if that's possible but maybe again have that ongoing discussion as well if that makes sense.

MR. HAYCOCK: For the record Damon Haycock. Thank you, Dr. Packham.

I think that the best mechanism to look at adjusting reserves is through the budget building process, right, is to allow those folks that are going to fund us, especially if we miss the opportunity to weigh in on that, that conversation as well because if we get too aggressive and we miss our reserves and we don't just dip into catastrophic reserves, we obliterate them, then it's PEBP that has to go back and ask for more money, and I think that conversation is probably best had at the table with the legislature that we would be receiving that supplemental request.

MEMBER VERDUCCI: Tom Verducci for the record.

So I'm going to try to analyze what I'm hearing here. So this would be to move PEBP to develop a budget to analyze the enhancements that the UNLV document, as well as AFSCME is requesting us to review is number one. Number two would be to look at the rebates through Save On and potential savings through E-Scripts, is that how I see it? And also three for the Board to prioritize what they see fit.

And I wanted to ask on number four, could that

perhaps to dovetail on what Dr. Packham was saying to develop a plan to independently review the excess reserves that the program has. See with those four items in terms of what we're discussing here.

MR. HAYCOCK: So for the record Damon Haycock. Thank you, Mr. Verducci.

I would suggest that you don't limit it to that. There are many opportunities that we haven't even really touched the surface on that can go on into budget building. Often agencies don't even start thinking about or building budgets until February. We don't even get instructions from the Governor's Finance Office until March, and so we can have all of these ideas, but at the end we kind of need to know what box we're in.

But if I could waive a magic wand, I would love to have better partnerships with DHHS to cost allocate and utilize their pharm deed that's on their staff and cost allocate and utilize their chief medical officer because we don't have clinicians at the plan level. We have to rely on outside third parties. There's, again, do we have the right staff? Do we need to look at outside counsel? No offense to Ms. Mooneyhan. Do we need to look at, you know, Las Vegas presence, you know, for staff. The sky's the limit to a point when you think about building budgets, but then you get

the instructions and then that's what you end up being able to build too.

So I would -- like I said, I know now it feels like, at least to me it's premature to start coming up with decisions and direction. We're totally willing to take it and move forward, but I would hope that we don't get so kind of boxed in where we can't go look at other things that can truly move the needle forward in our program for our membership.

MEMBER VERDUCCI: So how about including the wording other enhancements and cost savings which would be just an open ending -- open ended inclusion?

MR. HAYCOCK: So for the record Damon Haycock.

PEBP will support any motion that the Board decides. PEBP is not actually looking for one today. So we just want to, again, have a conversation. I like, you know, what Mr. Dr. Packham has said that we look at things and we can as you mentioned walk and chew gum at the same time, and we can look at these requests.

We can also if need be follow the requests that we heard from RPEN and the Nevada Faculty Alliance and UNLV to have an independent look from another set of actuaries, right. Whether that's something you want to do in the future can definitely be explored, but I'm really kicking myself for

putting it on for possible action today, but really the goal was just to -- just to kind of open eyes and say let's think about this. Who do you want to be in the next session? What do you want PEBP to be?

There's conversations about networking, and do we want to have a more open access network in our network contract, and our network contract ends June 30th, 2001. So some time during next year, probably in May you're going to get a report that says should we RFP and go out to bid and what type of solicitation do we want? Do we want to increase access too? Do we want to allow the cost savings of exclusivity, right? These are things we have to figure out who we want to be and what type of vision that you guys have, and we have a strategic plan that outlines a lot of it, but it doesn't mean you can't explore other avenues.

And so I think that there's -- this is the first part of it. Our stakeholders are going to go back and say, wow, maybe it's an open table. Let's see what we think is the most important. One of the things that I did get analyzed that I didn't put in today's meeting materials is an increase to the life insurance amount through the standard as the base amount for employees and retirees.

You heard through public comment I think last meeting in July a request from Marlene Lockard that that be

looked at. We did look at it. I actually sent it back to her, so she saw it, but it's something that really should be a budget enhancement so we can talk about that. So there's opportunity that I'm trying not just to ramble on, but I don't want -- I don't want to put too many constraints on this for -- so that you only can go in one direction when I think what's really important is a unified Board, you figure out who you want to be and how you want this program to move forward, and if it's move forward as is that's great. But if there's changes that you want to make the time to make it is next summer.

VICE CHAIRWOMAN FOX: I was also going to ask like what action you're looking for here. So maybe there just will be no action unless somebody wants to make a motion, and maybe it's just something we continue to discuss at a future meeting.

Any other comments regarding number nine?

MEMBER VERDUCCI: Tom Verducci for the record.

You know, I just want to point out there's been some excellent suggestions made from UNLV, and it looks like it's about a 5,000,000 dollar request, and this Board manages multi millions of dollars and if there's a way going forward, perhaps it's spring so at least throw those ideas out there. We're going to look at it, if we don't restrict ourselves to

this one small universal idea that we try to put forth the potential budget to make an intelligent decision to see if those funds are there, and I don't know if it's going to fit into a motion here today that the Board is going to support, but that was my thoughts.

VICE CHAIRWOMAN FOX: Thank you.

All right. So we'll move on to Agenda Item Number Ten, executive officer report. Damon Haycock.

MR. HAYCOCK: Thank you, Madam Vice Chair. For the record Damon Haycock. You're probably tired of hearing from me today already.

I traditionally since I started with PEBP have presented a written report. I almost didn't have anything that really would apply to this. So far a lot of the things that we have been talking have been covered in all of the reports, but I wanted to reserve this item for a couple of things. One, to respond to anything that was presented either in public comment or in conversation that we could provide some response or answer to and second of all, of course, to provide an announcement that the Nevada Appeal beat me to which is that I am, of course, moving on from the Public Employees Benefit Program effective January 1 of this year. It is -- it was a hard decision to make. It was -- I made it in conjunction with my family, and I think it's time

to have new leadership with new eyes and new focus.

I have not worked for a better organization or around a better group of people, and I am leaving with a heavy heart. The team that was built over the last four years, they are in my opinion second to none. I will pit them against any other agency in the state and any other entity across the nation. The things that we've been able to accomplish I never thought we could.

So to kind of recap my last four years, when I walked into PEBP, you know, I was asked to come in and work on culture, and I think you heard today from public comment that a lot of that culture has been repaired which is important to us, and it's important as we move forward collectively.

I was told when I first got here don't worry about the plan. The plan is solvent. It will work itself and then I would find out that we have benefits we're going to sunset. And I thought, wow, we do need to worry about this plan, and I'm very proud of the team and our partners and our ability to restore those benefits and move them forward without question or argument again. I think that's a testament to all of our hard work and the Board's leadership and vision and really your allowance to let me get creative and innovative to make that happen.

We also kept rates down. For most of the time we have kept them flat. Sometimes we've even lowered them. And it was interesting. I went to lunch yesterday, and I spent more on my lunch here in town than what a single employee pays their monthly premiums on the CDHP. And most people don't realize exactly how cost effective our program really is for the member, and some of the reports that we gloss over, our pharmacy benefits have been growing in cost to the plan, but they have actually been going down in cost to the member, and so we have made the member first. We've returned to a strong strategic planning process, and I felt that it has been one of the honors of my time to have served the State of Nevada and to have served all of you and to serve our membership, and I am looking forward to reading about and hearing about what you guys do next.

With that I'll turn it over to the Vice Chair.

VICE CHAIRWOMAN FOX: Thank you, Damon, and I have some comments about Damon, and I have some comments about the position. But first I'm very sorry to see you go. On a personal level I enjoyed working with you. Even before I was a Board member we ran into each other a couple of times, and I certainly understand and I'm happy for you, but I am sorry to see you go just on a personal level.

As a Board member I'm sorry to see you go because

it's really hard to replace somebody who is so motivated and dedicated to their job and so available and knowledgeable. I don't think that's going to be an easy thing to do. And even as a member, someone who partakes of these benefits, I'm sorry to lose you. It's good to know that somebody like you is looking out for myself and my family. So I'm sorry -- I'm really sorry to see you go.

I do have more comments, but I want to let the other Board members weigh in, and then I want to talk about the position itself. So does anybody else have anything else they want to add?

MEMBER BAILEY: Madam Vice Chair, for the record Don Bailey.

I -- I was on the Board that hired Damon. So I'm the oldest member on this Board right now in a way of years and the way of service. I have to comment on Damon and his excellent staff. The staff always makes the leader, but this leader has helped the staff become 100 percent efficient, and I've seen the changes over Damon's term of four years, and I've seen the changes over my eight years.

So it's an outstanding organization and I was -- I am still proud to be on this Board, always have been. I think we've done an excellent job for our membership. Sometimes we've had squabbles with our membership but that's

understandable. You cannot make everybody happy and most cases I think we have.

We have tried to take our reserves and I bring up reserves because it's something dear to my heart that we had 100 percent control on somewhat and that has changed and with that change the Board will have to change with it, but the members is where we took the benefits back to the members in a way of benefits and that's dental, that's eyes, that's the whole program. And under Damon's leadership we have become nationally recognized throughout the United States on these issues. In fact, we go to a conference and they want Damon to speak and they ask other Board members who attend ten million questions. So we should be proud of that, and I'm proud of the Board. I'm certainly proud of Damon and his staff. So I will miss you, but I have your phone number.

VICE CHAIRWOMAN FOX: Thank you.

MEMBER ZACK: Madam Vice Chair, Christine Zack for the record.

I serve on a number of boards and what I can say and putting and taking that into perspective these different boards I'm involved with is that I never ever when I come to a PEBP Board meeting need to worry about the expertise from the staff or its leader. I never have to worry about the thoroughness of the information that's being presented, and I

certainly never have to worry about the accuracy of the information, and that may be something that we just take for granted as PEBP Board members or as people that attend these meetings, but let me tell you that not every organization is that lucky. And so I think that there's going to be a huge gaping fall in PEBP with Damon gone, and I want to thank him for his leadership and for displaying all of those qualities that I just mentioned.

VICE CHAIRWOMAN FOX: Thank you.

MEMBER VERDUCCI: Yes, Tom Verducci for the record.

Damon, do you think after that testimony you'll change your mind? But, you know, I just want to thank you for your loyalty, dedication. You've been there. We worked on the weekends together. Your calls are awesome before the meetings. Whenever I have questions, you're faster than anybody, and I've met with employees, same employees in the '80s, the '90s 2000s and 2010s. They don't come nicer than Damon Haycock. It's going to be a true loss to this agency, but you've put procedures in place that will benefit state employees for years to come, and I'll truly miss you.

VICE CHAIRWOMAN FOX: Anybody else?

MEMBER BAILEY: If you don't cry.

MS. RICH: Laura Rich for the record.

I just wanted to say from staff perspective I would like to thank Damon as well. He's been a great leader, a great mentor. We have all learned a lot from him. He's been very inclusive. He -- he allows all staff to -- he has an open door policy. He allows all staff, especially the executive staff to really be involved in every step of the process and be a part of all of the -- everything going on within PEBP, and I think that's helped all of the staff at PEBP just become better overall. So I just like to add that and thank him.

VICE CHAIRWOMAN FOX: Thank you all.

So the one other thing I wanted to add is we're going to have to have a couple of more meetings this year to discuss, first of all, putting somebody in an acting position for Damon's position and also what we do about recruiting for his position or appointing for his position. So I'm not in a position where I can ask for those meetings today.

As I mentioned before, we do have a chairperson assigned to this Board. He's just not here today. So I think we'll leave that to him to let him call those meetings, but I think we can plan on having these meetings before the end of the year. And as I understand, it will be two separate meetings, one to appoint -- perhaps it can be one meeting. I'm not sure. I guess -- is it going to be two

meetings, Brandee? Okay. Probably two meetings. So one meeting to appoint an enacting person and another meeting to either appoint or recruit for a new executive director. So I don't think I have anything more to add about that because I don't know too much more about that.

Okay. So we will move on to public comment. All right. So we'll start with public comment here in Carson City.

MS. BOWEN: Well, I know we're coming close to Thanksgiving, but I wasn't expecting that turkey to fly.

Mr. Damon Haycock, you cannot imagine with what pride, maybe pride is not a good word, but with what pride I had when watching the Today Show on national TV Channel 4 NBC and hearing when other states were -- were dying with their -- with their insurance policies for their employees and they had gone bankrupt because programs had been rated by others to use the money, and you have kept this program as the model for the nation to use and -- and you with all your staff, not you as an individual, you, when I say you as an individual, you created an entity where we the consumer here felt like we could come to you and ask questions and we weren't bugging you. We were -- you were going to the extra effort. You were looking up information at the drop of a hat to help us or adding to the conversation and making sure

things were on the agenda.

You made this our program and you as our representatives, we're part of you and you're part of us. You made us one. You as an individual cleaned up and you said a few things. You cleaned up a mess, an absolute mess where we weren't functioning, and there was a case where things were going to be taken away from this Board where we have a voice. Over at the legislature you get three minutes at a podium maybe if you're lucky, and you might get a little extension if you wait until midnight to talk again in public comment, but you made it so this is -- is the panel where we can come where the voices are heard, where department heads are heard, where individual teachers are heard, whatever it is where the public is heard so it is a public employee program.

You have been an asset, and I hope you -- you go and move and the wife and kids don't like the schools and don't like the area in which they have to live and that you can come back. And so instead of saying that giving your notice January 1st, why don't you just take a little sabbatical and get yourself in order like we teachers get June, July and August and other professors get sabbaticals. Think of it as why don't we plan a vacation for Mr. Haycock. Let him take his breath. This man hasn't taken a breath

since he's been here. It's been one fire after another, one crisis after another. We ought to make him the captain of the PEBP Board Fire Department because of all of the things he's done and all of the people he brought together where he made the people feel like they counted.

At the university, one suggestion for the future for you all to consider is have -- have them hold meetings and summits of their department heads to say what is it you need for insurance in the chemistry department that you don't need in the theater department? What does your plan need to look like so they are more inclusive and more transparent. Make transparency a disease catchable by all of the stakeholders, please, please, please.

And -- and I guess I'm about my three minutes up, but from my heart and soul thank you. Would you please thank your family for sharing you with us because when you've been with us you're not with them, and would you all, all please totally, and that comment goes for all of you, would you please have the most marvelous, fabulous, tremendous Thanksgiving on the planet. Thank you. Thank you. Thank you.

VICE CHAIRWOMAN FOX: Thank you.

MS. BOWEN: And thank you for the public comment and letting me go over once in a while or like always.

VICE CHAIRWOMAN FOX: Thank you, Peggy.

Is there any other public comment in Carson?

Nancy, in Las Vegas?

MS. SPINELLI: Yes, we do have one.

MS. CAMERON: My name is Vicky Cameron. I am a PEBP participant and have been since 2006.

And I want to thank Damon for his wonderful service. Prior to your coming here we had miscommunications. We had wrong information. We had loss of benefits, and you have restored most of those, and you have restored our confidence in this system. Thank you very much, and I wish you very well in any future endeavor.

MS. SPINELLI: No further public comment.

VICE CHAIRWOMAN FOX: Okay. Thank you, Nancy.

Well, I think we are on to Number 12, and we are adjourned. Thank you everybody.

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 21st day of November, 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 131, is a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Carson City, Nevada, this 6th day of December, 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, 11/21/19

KATHY JACKSON DATE

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