In The Matter Of:

PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD
TELECONFERENCE OPEN MEETING

November 23, 2020

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

TELECONFERENCE OPEN MEETING

MONDAY, NOVEMBER 23, 2020

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The Board: LAURA FREED, Chairperson
LINDA FOX, Vice Chair
MARSHA URBAN, Member
MICHELLE KELLEY, Member
TOM VERDUCCI, Member
BETSY AIELLO, Member
JENNIFER KRUPP, Member
TIM LINDLEY, Member

For the Board: BRANDEE MOONEYHAN, Deputy Attorney General

For Staff: LAURA RICH
Executive Officer
STEVEN MARTIN
Chief Information Officer
CARI EATON
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A G E N D A

MONDAY, NOVEMBER 23, 2020, 9:14 A.M.

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CHAIRWOMAN FREED: Good morning, everybody. It is 9:14 a.m. and I'd like to call the meeting of the Public Employees' Benefits Program Board to order.

Staff, would you call the roll.

MS. PLUTA: Okay. So Laura Freed.

CHAIRWOMAN FREED: Here.

MS. PLUTA: Linda Fox.

MEMBER FOX: Here.

MS. PLUTA: Betsy Aiello.

MEMBER AIELLO: Here.

MS. PLUTA: Don Bailey is excused.

Michelle Kelley.

MEMBER KELLEY: Here.

MS. PLUTA: Jennifer Krupp.

MEMBER KRUPP: Here.

MS. PLUTA: Tim Lindley.

MEMBER LINDLEY: Here.

MS. PLUTA: David Smith is excused.

Marsha Urban.

MEMBER URBAN: Here.

MS. PLUTA: Tom Verducci.

MEMBER VERDUCCI: Here.

MS. PLUTA: Okay. We have a quorum.

CHAIRWOMAN FREED: Agenda Item 2 is public comment. And I know there are going to be a lot of people in the queue for public comment. And, Board Members, we received some written public comment in advance of the meeting. It was e-mailed to you, and it was also posted on the PEBP Board viewing material section of the website. I read all the ones that we got up through last night, last night, and I read some of them this morning. And there are some really heartfelt and thoughtful comments. So if you haven't read them, please do so on another screen while you're participating.

And, let's see. Comments, I think I'll try and limit them to about four minutes to let everybody have a chance. Because, again, I know there are a lot of people waiting. And we started this meeting late to let everybody who wants to comment get on deck to do that.

So, also, please state your name if you're making public comment. State your name for the record and spell it if it's one of those confusing names that we might get wrong for the minutes.

With that, I'll turn it over to PEBP staff to do their magic.

MS. PLUTA: Thank you, Madam Chair. Okay. So if you have public comment, as a reminder, the Zoom phone number is for public comments only. This meeting is being streamed live on YouTube. To listen to the PEBP board meeting, please access the YouTube link located on the agenda. I do notice that we have quite a few participants that are wanting to share for public comment. Just a reminder, if you logged in to the Zoom meeting, this is for public comment only. For those who have called in during the period for public comment, the last three digits of the phone number will be announced and advised that the phone line has been unmuted, at which an audible message from Zoom will say that you're unmuted. After the caller has unmuted themselves, they may proceed with their comment. Because of time considerations, each comment will be limited to three minutes. If you don't have public comment, please let us know that you don't have any public comment at this time.

We're going to go ahead and start with Jason Wasden. You are unmuted.

MR. WASDEN: My name is Jason Wasden. It's J-a-s-o-n W-a-s-d-e-n. And my public comment is coming from the UNLV administrative faculty and the classified staff counsel.

While the UNLV administrative faculty committee and the classified staff counsel at UNLV understand the desire to keep premiums stable, the proposed changes in benefit structures are draconian and cruel. We cannot express our opposition to the proposed changes and benefits more definitively.

Many of us experienced our benefits being cut during the recession of 2012, and we are painfully aware that once benefits are cut, they are never restored. We have no reason to believe this proposed cut would be any different.

We are frustrated and we are mad that you seem indifferent that these proposed cuts will destroy the health and well-being of the employees of one of the state's largest employers.

With the proposed plan design, an individual on the CDHP will pay 2,600 more for their health care until they have reached the out-of-pocket maximum. We are already facing a 4.6 percent furlough reduction in pay for January to June and we expect possible furloughs in the next biennium. The proposed cuts to our health plan in addition to the already-approved pay cut will amount to more than a 12 percent pay cut to an employee's take-home pay.

In addition to the increase and out-of-pocket cost, the reduction in the value of the plan received is also proposed to go down. The proposal that PEBP would move from having gold and platinum plans to three vastly inferior plans is disheartening and demoralizing. Reducing benefits in this way in the middle of a pandemic is abhorrent. You should be adding to our health benefits, not taking them away.

Rather than reducing plan benefits, we argue that plans should be kept whole and that a COVID-19 surcharge in the amount of necessary added premium dollars be applied with the clear understanding the surcharge resets when the economy has returned to its pre-pandemic levels.

We are asking that this board provide the governor with multiple plans to keep our benefits in place to create a stable revenue source and stop balancing the state budget on the expense of state employees.

Additionally, we request that the board delay your consideration and vote until your January meeting when budget savings amounts can be clear and after the December 3rd report of the economic forum further clarifies state revenues.

To be quite frank, we are asking the board to consider any other options that do not include reducing plan benefits and increasing out-of-pocket maximums. The administrative and classified staff at our universities cannot and should not shoulder the burden of our state's economic crisis. Our populations will not weather the storm and will not bounce back. This will cripple our population and thus continue to decimate the economy of the State of Nevada. We implore you to do the right thing. Do not put balancing the budget on the backs of the most underpaid populations at our universities. Thank you for your time and consideration.

MS. PLUTA: Thank you.

And, Kent Ervin, your line has been unmuted.

MR. ERVIN: Good morning. This is Kent Ervin, E-r-v-i-n, representing the Nevada Faculty Alliance, the Independent Statewide Association of NSHE Faculty.

First, I need to thank Executive Director Rich for discussions and for providing information about the proposed benefits cuts. As a state policy, cutting employee benefits to solve a revenue shortfall is short-sided and wrong. Benefit cuts or premium increases are the most regressive way to expect state employees to fix the budget.

Coming on top of probable furloughs, likely no COLA, and an increase in the employee retirement contributions, it is unconscionable that PEBP is being asked to make benefits cuts in the midst of the COVID-19 public health emergency when our employees need health care the most.

We join our public employee partners in opposing these cuts and hope that the governor and legislature will agree that PEBP is the wrong place to cut.

That said, we realize that PEBP has no choice in responding to the governor's request for 12 percent budget reserves. We ask that in doing so you limit the long-term damage to the PEBP program in solving a short-term budget problem.

Specifically, Agenda Item 8, the large increases in the deductibles and out-of-pocket maximums in Section 8.1 are unacceptable. Large out-of-pocket maximums turn the plan in to catastrophic only plans and hurt the members most who are supposed to held by insurance, spreading the risk pool to help those with large medical expenses.

These need to be reduced to close to the existing CDHP and HMO/EPO plans with a new low deductible plan placed in the middle. Instead of the 20 million of the 36 million savings from these plan benefit reductions, it should be limited to much less than that, ten or 12 million. At a minimum, a reasonably priced middle plan should be in the middle to high gold range in actuarial value.

Proposal 8.7 could eliminate long-term disability coverage is completely unacceptable. Without social security, state employees have become disabled, need a safety net. Nevada has chosen not to participate in social security unless it provides the long-term disability benefit.

Proposal 8.8 to eliminate -- reverse Medicare B premiums is unacceptable. PEBP saves money and claims by requiring Medicare B for eligible employees and should pay for it.

Proposal 8.9 to eliminate subsidies for dependants and retirees is unacceptable. Families of already-retired employees depend on this.

Proposal 8.12, perhaps the worst, is to push non-Medicare retirees in to the ACA and Silver State Exchange. That is unacceptable. After the legislature finally fixed the ortho problem in 2019 -- in 2017, this would create a whole now larger set of neglected children. We don't even know if ACA will serve on the Supreme Court case.

All of these proposals just mentioned really carve out a -- some of the most vulnerable populations in PEBP and leave them stranded. That leaves the other bad but less bad proposals.

We fear it will be necessary at 8.11 to impose a temporary COVID-19 emergency surcharge to premiums to cover a third or more of the mandated reductions. These premium increases should have a definite subset, be labeled as temporary, and have a trigger to be removed when the economy does come back. Hopefully that's with a vaccine soon.

Thank you for your hard work. These are difficult decisions. But we need to limit the damage -- the long-term damage to the PEBP program as we go forward. Thank you.

MS. PLUTA: Line ending in 003, your line has been unmuted.

Line ending in 048, your line has been unmuted.

Line ending in 094, your line has been unmuted.

Line ending in 101, your line has been unmuted.

Donna Healy, your line has been unmuted.

MS. HEALY: Good morning. My name is Donna Healy, H-e-a-l-y. And I'm here as a UNR classified employee and I'm also a member and representing the NSHE classified counsel executive board and the counsel.

Regarding the need for PEBP to determine how to formulate a request to 12 percent cut, I request that consideration be given to the following:

Number one, create all budget changes due to COVID-19 as an emergency temporary COVID-19 surcharge to be authorized for the first year of the biennium only. With the recent increase in health insurance premiums and the 4.6 percent furlough pay cut, it would be harmful, impossibly financially devastating to classified staff if imposed as permanent cuts to benefits and/or premium increases.

Number two, please keep in mind that any increases in premiums and decreases in coverage would be the most harmful to your lowest paid and sick classified employees with the average pay of around $40,000 per year.

Imagine, if you will, facing the challenges of managing a family's or individual's expenses at that income level, especially if having to pay medical costs related to an existing illness.

Number three, of all the benefit reductions under consideration, please do not unbundle dental coverage from health coverage. With a restricted budget, many people will not elect to keep their dental coverage. With dental health being integral to one's overall good health, not having preventive regular cleanings and exams could be detrimental to overall health and inevitably cost much more than the immediate savings provided to PEBP.

With that, I thank you for your time and your consideration.

MS. PLUTA: Line ending in 101, you have been unmuted.

Line ending in 118, you have been unmuted.

MR. GARCIA: Hello. This is Jose Garcia, G-a-r-c-i-a. And I am a 24-year state employee who has actually purchased some retirement time and I'm getting close to retirement.

First of all, thank you for hearing me today. I actually just became aware of some of these changes and just wanted to give you a few comments.

I get that we are in a tight situation that you do have to make some reductions, but I would also like you to understand and know that many of us have made life decisions based on what our benefits are currently. Those of us covering dependants when we retire, those of us younger than the Medicare age, all of those are going to be devastating to our budgets financially. Someone mentioned earlier devastating.

And I just wanted to express that as a 24-year state employee, the benefits have been chipped away at for years since I started back in 1996. And I know times have changed. Health insurance was free when I first started with the state and since then has gone up considerably. But longevity was eliminated. There's been a number of benefits eliminated. Life insurance was reduced and now there's a consideration of eliminating it. I would just like all of those things to be taken in to consideration when you make these tough decisions. Thank you.

MS. PLUTA: Just a reminder that when your line is unmuted, it's going to tell you that your line has been unmuted, and you need to hit star six in order to talk.

Line ending in 237, your line has been unmuted.

MS. LOCKARD: Good morning. My name is Marlene Lockard representing the Retired Public Employees of Nevada.

Today's agenda poses difficult questions and decisions you will have to make as a member of the PEBP board. It is, indeed, a very difficult time for our state in trying to preserve critical services, programs, and compensation and benefits for the state's workers, all of this while facing ever increasing negative economic impact as a result of COVID-19.

We know the pain that will ensue at all levels of government will be severe. We understand the directive given to all state agencies to cut their budgets by 12 percent.

We also understand and appreciate the hours of hard work that Laura Rich and her staff have expended to deliver a substantive package to you for your consideration that complies with the governor's order. We appreciate her efforts to include the advocate in preliminary discussion and to keep us apprised of each step.

We believe we have a responsibility to offer input on other ways to meet the 12 percent challenge that would perhaps offer a more successful path to recovery and restoration of benefits. The advocates work daily with their respective constituency and understand how profoundly these proposed cuts will affect vulnerable populations like our seniors with fixed incomes who rely on that one dollar per year service to their HRA account or life insurance to pay for their ever-escalating costs of burial. And the proposal to move early retirees to the state health exchange is so fraught with unintended consequences and hidden costs. It also creates yet another tier of state employees.

I personally lived through the hastily approved and incredibly poor implementation of the decision to throw Medicare retirees out of PEBP and in to an exchange in 2011.

What never gets mentioned is how much money Medicare retirees left in PEBP and the annual millions of dollars of savings that PEBP enjoys every year as a result.

I implore you to consider the alternate proposals being submitted to you today. Retirees have contributed mindedly to helping the state meet the economic challenges of the past and will continue to work with you, the governor, and the legislature to meet this crisis as well. Thank you very much.

MS. PLUTA: Line ending in 238, your line has been unmuted.

Line ending in 282, your line has been unmuted.

MR. UNGER: Hello.

MS. PLUTA: Please go ahead. Sorry.
MR. UNGER: Yes. Doug Unger, D-o-u-g U-n-g-e-r. I'm a member of the UNLV Employee Benefits Advisory Committee and the UNLV chapter president of the Nevada Faculty Alliance.
And I'm speaking only for a small group of us because really our constituency is divided between a group that is so vehemently opposed to any of these cuts and remedies that they want to kick it all back to the governor and the governor's finance office and say an emphatic no and another group of us who understand that we really must come to the table and try to assist the board in making the 12 percent budget reduction.
We wish to express our sincerest gratitude to Executive Officer Laura Rich for working with us and letting us know about these proposed cuts and to all of you for your serious consideration of possible alternatives for actions on Agenda Item 8, which taken altogether can and will radically diminish health and other benefits for state employees for years to come.
What we're basically proposing, the group of us -- And you've heard from the vice president of NFA and Kent Ervin and others -- is a three pathway solution to achieving the 12 percent.

For Agenda Item 8.1, we very strongly recommend not changing the deductibles and out-of-pocket maximums on the plans. And looking at premium surcharge that will balance out and reach that 20.1 million target that is being proposed in the new plan design. This may require postponing your vote on the new plan design until some future date, perhaps the January date, when we will also know more about the condition of the finances of the state and the State Economic Forum will have reported on December 3rd.

Mainly, for Agenda Items 8.2 and 8.12 and then a written comment about line, what we could do for the other third of that is to achieve 10.5 million dollars by hitting a little bit the minimum amounts of those proposed budget reductions. We are vehemently opposed to any cuts to 8.7, 8.8, 8.9, and 8.12, as we consider all of these to be unconscionable and unethical breaches of promises and violations of trust.

Eliminating long-term disability coverage in a state system that has opted out of social security is too cruel to contemplate.

Other provisions will upend entirely retirement plans and existing retirement, causing unanticipated financial distress. And even to consider dumping non-Medicare retirees off when insurance exchange, the very future of which numbers in doubt are shifting federal policies is draconian and the extreme. Please do not consider any passing of any of these actions.

If you do raise premiums on a different plan design and call it a COVID-19 pandemic surcharge, that will allow the state to approach the legislature and ask that this be sunsetted first for the first budget implementation to be removed, should the state budget situation improve, which we have every expectation that it will over the next two -- two or three years.

Compromise means working out differences to accommodate the desires and interests of the many for the benefit of all. We know a just compromise when we see it or hear it. And we hope that you see and hear the balance and fairness of this three halfway action plan we propose for you to meet the challenging budget demands you must act on today.

Thank you again for your consideration. Thank you to Chair Freed and all on the PEBP board and staff for your service to our state. Thank you.

MS. PLUTA: Line ending in 304, your line has been unmuted.

Line ending in 338, your line has been unmuted.

MS. MALONEY: Good morning, Chair Freed, Members of the Board. This is Priscilla Maloney with the AFSCME retirees. Can you hear me?

MS. PLUTA: Yes, we can.

MS. MALONEY: Chair Freed, I would like to read my statement in to the record. And then with permission, I know we normally would submit these ahead of the meeting, but given the crisis that we're in, I would like permission when I'm done to also then submit this to the e-mail address on the agenda as part of the record for today's meeting if that's acceptable to you.

CHAIRWOMAN FREED: That is a-okay, Ms. Maloney.

MS. MALONEY: All right. Well, thank you.

So, November 23rd, 2020, Priscilla Maloney representing the Nevada Retiree Chapter of Local 4041 AFSCME. To the PEBP Board in regards to today's meeting and Agenda Item Number 8, it was announced several years ago by our governor through his finance office, the GFO, that all state agencies, including PEBP, would be required to flash budgets in anticipation of a coming budget crisis precipitated by a deep decline in state revenue caused by the public health crisis of the localized effect of the global COVID-19 pandemic.

It is our, and this is in parens, the retiree chapter of Local 4041 AFSCME understanding that this board will be asked today to review cuts to benefits and increases in costs to the PEBP members, both active employees and retirees, that are outlined in 11 subcategories under the Agenda Item Number 8 and then prioritize them so that PEBP staff can submit a revised budget to the GFO, and this is in quotes, as soon as possible.

It isn't clear, I believe, at least to me as a member of the advocacy groups, exactly the time constraints we're under. I know we are under those.

Our objections to this process, these cuts, and the underlying basic public personnel fiscal philosophy that these proposals are built on are many. First and foremost, whenever there is a fiscal crisis in Nevada state government, the default -- And this is emphasized in bold -- is immediately to look -- to cut in benefits to both active employee and retiree state provided health care insurance, in combination with reductions in pay for active employees through furloughs, pay freezes, and the like.

As we are sure you will hear from active employees today, this is a dysfunctional way to govern while maintaining a robust work force through recruitment and retention. The state work force in general has not recovered from the cuts in benefits and pay imposed over a decade ago in the 2009 session and beyond.

With regards to specifically Agenda Item 8, it is important to note the advocacy groups have met and we thank her -- This is not in my written remarks. I should have put more adjectives in here like wonderful and hard-working and tireless -- Executive Director Ms. Rich.

And there seems to be consensus, just to make the record clear today, that the proposals in Subcategory 8.2, 8.3, and 8.4 are not an issue. The AFSCME retirees do oppose the cuts and changes as set out in 8.5, 8.6, 8.7, 8.8, 8.9, as well as 8.12. Subcategories 8.10, unbundling the dental premiums, and 8.11, the premium costs to be factored in by Aon, are still being discussed is our understanding.

Finally, the changes as explained to the basic plan designs in table 8.1 are applicable to both active and -- active employees and non-Medicare retirees. It is crucially important to note that non-Medicare retirees are grouped differently. The pre-Medicare retirees for purposes of this discussion today are those that are eligible for Medicare when they become 65. The non-Medicare retirees involve several groups as Nevada as the employer was not paying in to Medicare for several years after it was first created in 1965 globally. Those retirees have always in the past been defaulted to one of the PEBP offerings. And some will never be eligible for either Medicare Part A and B and some only eligible for Part C. And I put in parens see

Agenda Item 8.8 and 8.9.

We have asked PEBP staff for clarification on the numbers of each of these categories. I note that Ms. Rich has put down that Subcategory 8.8 will affect apparently 1100 members and 8.9 will affect 2,106 members. But, again, breaking it down by which folks are non-Medicare versus pre-Medicare retirees would be helpful for this discussion today.

So, finally, one member of my AFSCME retiree comments, I asked him permission for him, he's a little shy, to make his statement in public comment. And he preferred me read it in to the record.

He says, first, what was the point of making a career out of public service. I never expected to get rich enough to provide my own benefits during active or retirement years. I accepted the pay and my understanding of my retirement years when I chose this path back in 1972 and now it seems my former employer is asking why am I not dead yet.

Second, as benefits are taken away or reduced, how many employees and retirees simply won't seek services they may need because they can't afford it, like dental or prescription drugs. Retirees who plan -- And that's the end of his comments.

Retirees who planned their entire careers and lives in public service deserve better than these proposals. We understand the urgency. We understand the crisis. And this is the final concluding point. The proposal in 8.12 is beyond the scope of time limits for public comment. There are many aspects of this proposal that are highly uncertain. The economic forum has not met yet for the final time this year and will not until December 3rd, 2020. The future of the Affordable Care Act is unknown and the fate and thus the fate of the Silver State Exchange is unknown as well, as the federal case challenging the Affordable Care Act existence was just argued and submitted to the US Supreme Court on November 10th, 2020.

In these circumstances and climate of both a public health and fiscal crisis, haste is not the friend of sound policy. These challenges will need the full attention to detail from both Nevada's executive and legislative branch. Thank you very much.

MS. PLUTA: Line ending in 354, you have been unmuted.

Line ending in 404, you have been unmuted.

Line ending in 490, you have been unmuted.

Dustin, you have been unmuted.

Ian, your line has been unmuted.

MR. KNIGHT: Good morning. For the record, my name is Ian Knight. That's spelled I-a-n K-n-i-g-h-t. And I am an active state employee and so is my wife.

In consideration of Agenda Item 8 this morning, I want the PEBP board members to know how vital it is to have input from all state employees. So, in addition to whatever recommendations you make today, I want to see a survey go out to all state employees asking them to do the same ranking that you are doing in Agenda Item 8. And I want the results of that survey shared at the same time as your recommendations are shared during presentation to the legislature. I also want to see each board member show up to the legislature during the PEBP budget hearings and express clearly that PEBP should be exempt from the governor's recommended budget reductions because increased premiums or reduced benefits during a pandemic is just plain wrong.

I also want to know what each board member has done to stick up for us to urge congress to pass additional relief for state and local government budgets so these cuts don't have to be made. If the board members have engaged with our representatives and senators in congress, I want to know the extent of the interaction. If the board members have not reached out, I want to know why not.

That is all that I have to say. Thank you for your time.

MS. PLUTA: Line ending in 500, your line has been unmuted.

Line ending in 502, your line has been unmuted.

MR. BEAM: Good morning. Can you hear me?

MS. PLUTA: Yes, we can.

MR. BEAM: Thank you today for the opportunity to speak with you all. I appreciate the chance. My name is Jerry Beam, B-e-a-m, And I work for the state in a supervisory role for eight years. I currently work for the hospices of the military.

I strongly oppose the cuts to our health care benefits. I understand that when a crisis affects an organization that cuts must be made. I, however, don't feel that this should be in an area that can or should be cut, given the nature of a medical pandemic.

Our health insurance is one of the few good things about working for the state. As a supervisor, I already have limited applicants due to 20 to 30 percent less than market rate wages. If the state would have made serious attempts at bringing up our income to keep up with the rising costs in our society, our health insurance would be more easily acceptable to these types of cuts.

For the state to cut benefits to retirees is unconscionable. By shifting the program to a fund instead of directly being responsible is just another way to begin to care less for the employees who have earned the care that they deserve.

As the other speakers have pointed out, the state has chipped away at the employee benefits for years. And I have witnessed it in my limited employment with the state.

In summation, the health care system is the best asset the state has going for getting and keeping employees, but certainly it isn't the pay. Thank you for your time.

MS. PLUTA: Line ending in 642, your line has been unmuted.

Line ending in 643, your line has been unmuted.

Line ending in 650, your line has been unmuted.

MS. SCHELLHASE: Good morning. Can you hear me?

MS. PLUTA: Yes, we can.

MS. SCHELLHASE: Thank you. For the record, my name is Maria Schellhase. That's S-c-h-e-l-l-h-a-s-e. I'm a professor at the College of Southern Nevada.

My colleague, Dr. Jett Mitchell, was diagnosed with stage four breast cancer and lost her battle in September, despite a valiant fight. Some of you might remember Jett, as she was a community college representative on the PEBP board. Dr. Mitchell was an advocate for faculty and often spoke up about the need to improve quality health care options while reducing and maintaining the cost for faculty.

As the faculty senate share at the College of Southern Nevada, I have received many e-mails and phone calls from faculty who are extremely concerned about the proposed changes.

Please considering the following: With a 4.6 furlough in place and the possibility of more cuts in the future, is it responsible to increase rates or change plans now? Is it responsible to reduce the health care options and increase benefit cost for retirees and others like Dr. Mitchell who need it most. Cuts and benefits will negatively affect faculty retention and recruiting efforts.

I understand that we have a budget crisis on our hands. However, if we do not have our health, we have nothing. Now is not the time to approve changes or make reductions. I urge you all to maintain the cost and benefit options currently offered and to wait to make any hasty decisions. Thank you for listening.

MS. PLUTA: Amena, your line has been unmuted.

Line ending in 754, your line has been unmuted.

Line ending in 764, your line has been unmuted.

Line ending in 884, your line has been unmuted.

MS. SUMNER: Good morning. Can you hear me?

MS. PLUTA: Yes, we can.

MS. SUMNER: Great. My name is Raven Sumner, S-u-m-n-e-r, and I am providing this public comment as an active UNLV administrative faculty staff member with 16 years of service.

I understand the challenging financial and public health issues encompassing our state. We have weathered economic recession before. But this time we are faced with the impacts of a global pandemic, which has challenged us to new heights.

While state employees are facing furloughs, which may very well continue in to the next biennium, these dramatic cuts to our access to health care is dangerous and causes further harm to our physical, emotional, and mental health.

The cuts to our benefits from the last recession were never ever restored. Personally, I have outstanding loans that I had to take out for my surgery, my radiation treatments that I also had for my brain tumor and my optical nerves. Every year my high out-of-pocket expenses for my continued treatments pile up on top of my loan. There are expenses that current insurance does not include, which includes things such as the travel I have to take to UCLA Medical Center, and my vision care, which costs me out-of-pocket expenses every year of about 1500 or more.

I implore you to please rethink these cuts and the impact it will have on the hard-working and loyal employees. Thank you.

MS. PLUTA: Line ending in 909, your line has been unmuted.

Line ending in 943, your line has been unmuted.

MS. WOODWARD: Good morning. Thank you, Madam Chairwoman and Board, for the opportunity to speak. My name is Janell Woodward. That's J-a-n-e-l-l W-o-o-d-w-a-r-d. I am a state employee and member of AFSCME Local 4041 and a PEBP PERS committee member.

We have already heard many comments regarding Agenda Item Number 8. This pandemic year has truly impacted everyone from a personal level and from a state budget level. Who could have foreseen such a difficult time and the need for very difficult decisions?

From a personal standpoint, I am an advanced breast cancer survivor who was already left with large amounts to pay for my medical treatment, secondary to the cuts and changes to our health care plan two years ago. Of note, my bills are in collections.

As a former user of the state -- the Silver State Health Exchange, a move by PEBP to this exchange would be detrimental to state employees. These plans are unaffordable and non-sustainable and cover almost nothing.

These proposed changes would be devastating to me and to my fellow state employees. Many employees are already in a situation having a difficult time living paycheck to paycheck. And adding to this situation by making these cuts or trying to rebuild the reserve when we already have a difficult time making a living is unconscionable.

In this year of a major pandemic I have both continued to work my essential position and I also spent a week in the hospital, which significantly increased my debt load.

Please do not cut our very important medical benefits further than they already have been.

Having worked 28 years in health care, I understand that we need to find savings. However, at one of the largest employers in the state, we have some of the worst benefits. Look to the hospitals that have very low cost plans and good benefit coverage. They are low because they utilize their own insurance programs.

There are many options that could be considered instead of just cutting everything. Please consider further alternatives to provide the governor. And do not make employees bear the load of needed costs that we are already facing with our pay cuts. Thank you very much.

MS. PLUTA: And, just as a reminder, when I unmute your line, you will be asked to select star six to unmute your line.

Margarethe, your line has been unmuted.

MS. MILLER: Yes. This is Margarethe L. Miller, spelled M-a-r-g-a-r-e-t-h-e, middle initial L, last name Miller, M-i-l-l-e-r. Good morning. I am a retired 30-year state employee and I've already sent you an e-mail outlining my concerns with several of your agenda items today.

First and most concerning is the 8.12, my removal from having major medical coverage to having none because of my age, which is 78, and my income which is approximately 45,000, and where I live, which is Churchill County. I have looked in to my situation and have found out that due to my age of 78, my income of 45,000, that I am -- that I will not be qualified for any discounts and will have to pay over $1800 a month to get any major medical plan on any of the exchanges. And I do not qualify for Medicaid, as again, that is income-based and I make too much and also I'm kind of old.

Most retirees are not 78 years of age. Most retirees qualify for Parts A and B. I do not. I have never worked outside the State of Nevada. I consider myself a notch baby of the State of Nevada due to the fact that I started working for the state at the age of 17 and I have stayed until retirement 30 years later.

The State of Nevada did not start paying in to Medicare until December of 1989. I retired with my 30 years at November of 1989. The details are in my e-mail.

I also have concerns with the 8.8, the elimination of my Part B subsidy. This is what helps me to be able to afford to have an affordable major medical plan. If you eliminate this, I will be paying over $250 more a month. I am a 78-year-old widow and I'm already on a reduced income. And if you reduce or eliminate, my income will even be further reduced.

The third item I have concerns your 8.6, the reduction or elimination of the basic life insurance. Because I'm 78 years old, I have no possibility of getting any more life insurance or even paying for more. I would hope that you will be able to find other avenues to cut instead of gutting the majority of my 30-year retirement benefits at my age of 78.

It is the State of Nevada's fault that I and many others like me find themselves in this -- in looking at a major reduction in our benefits. I view this as age discrimination and a form of genocide, as I am unable at my age to earn more income and buy more life insurance, and my major medical coverage, which is part of my 30-year benefits, will be non-existent. The result will be taking away any quality of life for me, especially in this time of Coronavirus, the Coronavirus pandemic.

My suggestion would be that the State of Nevada would step up to the plate and work out some type of payment arrangement with the government or who ever has to be -- has control over that, that I and others who are similarly-affected have an affordable major medical plan. I really don't know what the answers to this are. As a 30-year retired state employee, I've been through many budget cuts and many budget planning and that and so I know it's pretty tough.

And so I submit that perhaps there is other possibilities that won't drastically affect me. Because at my age I really don't know what I'm going to be able to do.

Thank you for your time and I appreciate it and I know you have a hard thing to do. I appreciate your time. Thank you.

MS. PLUTA: Line ending in 960, your line has been unmuted.

UNIDENTIFIED SPEAKER: Good morning and thank you for allowing me this opportunity to speak. I too am a member of AFSCME Local 4041 and a long-time state employee. I've worked for the state for over a quarter of a century and still am working. When I started with the state, myself and my family, like many others have stated, were covered completely and yet it was affordable.

My dental deductible, for example, when I started was a hundred dollars for a lifetime. Well, my life is not over, but my deductible has changed, not surprising.

I have a friend who works for a small California county and has better health benefits than I do working for the State of Nevada. And it just amazes me and I don't understand.

One of the things that I don't understand also is every time there's a budget deficit it always falls on the backs of the state employees and we are already not working at a living wage. And our basic living expenses are not even keeping up with our salaries because our basic living expenses are increasing faster than our salaries.

It is extremely important to keep the Nevada state employees as healthy as possible, especially during this pandemic. We have to keep our state alive, and, therefore, we have to keep our state employees, as well as possible as well.

I do thank you for your time and I understand your situation because all of us are facing the same in our homes, at our work, and in our country. And I thank you for your time. And enjoy your Thanksgiving.

MS. PLUTA: Line ending in 968, your line has been unmuted.

MR. ALLEN: Good morning. My name is DT Allen. I am an employee with the Department of Health and Human Services, and I am also a member of AFSCME Local 4041.

Thank you all for listening to these comments here today from so many of us.

But with the many uncertainties of COVID as a new infectious disease and maybe as much as half of the people in disagreement as to the severity and actuality of the virus, I do see your efforts to protect you, but you must see how your proposed changes will almost certainly devastate the very work force that has been and would continue to provide essential services.

I know for me and my family there are medical needs that we cannot afford to have disrupted. And, if they are disrupted, the hardship created will certainly have a negative impact on my ability to work. I imagine you foresee the same for many families.

Please consider the viewpoint that with pay more and get less proposals that you're making, you are flirting dangerously with being more of a burden than benefit. I ask that as we provide the services we were all hired to do that you do the same. We are all being tasked with doing our best on the very tight circumstances and conditions. And I respectfully say I believe that you can do better. Thank you.

MS. PLUTA: Line ending in 987, your line has been unmuted.

MR. HOPKINS: Good morning. Can you hear me?

MS. PLUTA: Yes, we can.

MR. HOPKINS: My name is Cameron Hopkins. I am 28 years old, state employee with DHHS, and a member of AFSCME Local 4041.

I speak to you today in opposition of the proposed cuts to health care benefits and the proposed heightened premiums in the midst of a global pandemic.

While some state employees have the opportunity to work remotely, many more do not. Nevada state employees interact with the public on an almost daily basis in ways that cannot be done remotely. CPS workers still need to go in to people's homes to protect our children. Aging and disability workers need to see that our elderly are safe. And corrections need to ensure safety in close quarters environments, amongst many others. Public services see more people during times of economic upheaval when Nevadans need us more than ever. Even with the greatest precaution, state employees put themselves at risk to serve their fellow Nevadans.

We have done our job during this pandemic and we will keep doing our job while our communities need us most. This dedication should not be taken advantage of by the state. We still have medical and dental needs that for several months were unable to be addressed. During this pandemic, dental offices were closed for months, elective medical procedures were delayed, and even routine physicals were postponed.

Cutting these benefits now when these medical and dental services are so overwhelmed that some people can't get in for months, taking services away when they are most needed, public services are already stretched razor thin and our work loads continue to grow heavier.

Higher increases means we're taking on the work of those unfilled positions, we're taking on the stress of the pandemic like everybody else, and additionally taking on the stress of the public we interact with. Stress wreaks short and long-term havoc on the human body in terms of both mental and physical health. Cutting benefits will increase stress on state employees and their families even further and the increased financial burden will force employees to make impossible choices on salaries still recovering from the last recession.

Please don't make our lives harder in the midst of a pandemic. Thank you for your time.

MS. PLUTA: Kevin Ranft, your line has been unmuted.

MR. RANFT: Hello. Can you hear me?

MS. PLUTA: Yes, we can.

MR. RANFT: Good morning, Chairwoman Freed and Committee Members. My name is Kevin Ranft and I represent AFSCME Local 4041, active state employees.

I would first like to thank you and PEBP staff for all the hard work during these difficult times. I would also appreciate Laura Rich reaching out to us as an advocacy group dealing with the hardships of PEBP and the revenue issues that PEBP is facing.

With the challenges that come with surviving a pandemic, state employees still have regular medical needs that will affect -- that will clearly be affected by these cuts. The design plan by cutting just by itself 20 million dollars is really not being discussed today. This is really going to change the dynamics of how employees utilize their health benefits or should I say really no benefits without having on the back end numerous expenses that they cannot afford.

State employees have done their job during this pandemic and will continue to care for not only all of us citizens of the State of Nevada but for their co-workers and ultimately they have to go back and take care of their families. That's what these benefits are for. These benefits are to ensure that their health and their well-being of them and their families, they have that ability to do so. Without that, they cannot provide services to the State of Nevada and the communities around them.

As the governor is asking for 12 percent proposed reductions for his consideration to build his budget for gov rec, health care benefits are not the place to cut, as it dramatically harms the employees and their families.

We are strongly opposed to the benefit cuts being proposed today. Respectfully, we ask that this board reach out to the governor and tell him that you cannot make this big of a cut. Making a 12 percent cut in benefits is not realistic nor is it viable. Further, we are opposed to any increases -- increases to premiums upon the reserves. Millions of dollars was just released from the reserves and sent to the general fund. There has to be other alternatives to fund the reserves.

In a normal time it would be appropriate to build a plan design during this meeting. However, we are in a pandemic, and there are numerous unknowns. Is there going to be a federal stimulus? We don't know. We are very hopeful on the front lines. What is the projections going to be in December with the economic forum? We don't know. Again, there's a lot of unknowns.

The governor has asked you to send a proposal not to gut the benefits of the state employees but to merely present a proposal. By voting today you are edging the plan design that will seriously affect the lives of state employees. And family lives are the most -- I'm sorry. Families and state employees ultimately are the most vulnerable. Further, retirees is really going to take the brunt of this when it comes to the standalone of these cuts. We should not be addressing this at this moment. We really need to look at what the revenues are and then come back and address what's going on with our benefits, our plan design, and everything that relates to PEBP.

I implore this board to send a clear message that you cannot gut the -- I'm sorry. You cannot cut the governor's 12 percent request. These cuts should be -- should not be on the backs of state employees and not on their health care. State employees know going in to the state jobs that they are paid less than city and county employees. They took this job knowing that the benefits would be a part of their overall employment package.

Again, the governor is asking for a proposal, not implementations.

Finally, you are being asked -- you are being asked again by this governor to make this recommendation. I urge this board to really look at what the other alternative options are, asking the governor for a lower percentage. 12 percent is not viable.

Facing the employer portion on fiscal year 2022 is what you guys are really looking at as a standpoint to be similar to fiscal year 21 when it comes to the employer portion. We cannot assume that that's going to be the case. The employer portion of fiscal year 22 could be different. What happens if that takes place? That could ultimately be employer portion is going to have a dramatic impact in regards to premiums of state employees.

That leads me in to a lot of the discussion today by some of the individuals speaking earlier. That would be an immediate increase to premiums in regards to the COVID-19 surcharge. You can call it what you want, respectfully. And I respect all of the individuals who spoke about a COVID-19 surcharge. Unfortunately, this would not be a fair, across-the-board cut and again would be a direct out-of-pocket expense. This could not be applied to all PEBP participants and with the unknown impact of state revenue and unknown what the legislature is going to do, the COVID-19 surcharge as discussed would not be viable.

As state employees, we are facing furloughs, PERS contribution increases. On top of that employees will be often required to work two or three positions to fill the void of positions that are being affected by the hiring freeze during this pandemic. We ask you to suspend any vote on PEBP reductions or premium increases until January when the state will have a better idea of the incoming revenue. PEBP's budget will ultimately need a legislative review.

With that being said, we thank you for your time and consideration. Thank you.

MS. PLUTA: Tina Marie, your line has been unmuted.

Priscilla, your line has been unmuted.

Robin, your line has been unmuted.

Sarah, your line has been unmuted.

Madam Chair, the public comment has been completed.

CHAIRWOMAN FREED: Thank you. This is Laura Freed. We've been at this already for an hour plus. So what I think I'm going to do is give everyone a five-minute break to go to the bathroom, get a drink of water. And just in case anybody had trouble unmuting themselves and still wanted to make comment, let's see, it's 10:24. We'll call it 10:25. Everybody please be back on at 10:30 and I'll double-check for any more public comments. So I'll see you all in five minutes. Thanks.

MS. PLUTA: On top of that, I would like to add that if you did join the meeting for public comment, that you hang up via Zoom and you join via YouTube. That way we can see who is still in the queue that has current public comment to make.

(Recess was taken)

CHAIRWOMAN FREED: This is Laura Freed. Good morning again. It is 10:30. And I'll call the meeting back to order. I'll check once again with PEBP staff. Is there anybody who has public comment to make who logged in via the YouTube stream and wants to make public comment and had technical difficulties previous to then -- previous to now?

MS. PLUTA: It doesn't look like we have any new numbers, Madam Chair.

CHAIRWOMAN FREED: Okay. Thank you. Then with that we will move to Agenda Item 3, PEBP Board disclosures for board meeting agenda items. And I'll pass it to Deputy Attorney General Mooneyhan.

MS. MOONEYHAN: Thank you, Madam Chair. This agenda item is to allow me to make a disclosure on behalf of all of the PEBP board members who are eligible for PEBP benefits. Of course, most of the items on today's agenda will have an indirect effect on PEBP benefits.

But, in particular, Item Number 8, which deals with post-plan changes for the next year relates directly to PEBP benefits that may be available to members, including most of the board.

Pursuant to NRS 281A.420, on behalf of those board members who are eligible for PEBP benefits, I'm offering this general disclosure that they may be voting on items that affect the benefits that are available to them or their family members. I know the law does not preclude them from voting on these items. And I would invite any board member who has any additional disclosure to add to do so now. Thank you.

CHAIRWOMAN FREED: Board Members, if any of you feel that you would be affected more than anybody else by anything on the action agenda, now is the time for disclosures. If not, we will move on to Number 4.

Okay. So Agenda Item 4 is the consent agenda. And we have 4.1 through 4.5. I hope you've all reviewed those. And, as per usual, I will accept a motion to take all of these items at once in one motion, unless there's a board member who wishes to pull one of these items for discussion.

So do any of you wish to talk about anything in Item 4?

MEMBER AIELLO: This is Betsy Aiello. I just have one question on 4.5 I would like to ask.

CHAIRWOMAN FREED: Okay. Please go ahead.

MEMBER AIELLO: I just would -- I know that the report is just saying that everything looked good the way they put it together. But I had a question about the 5.6 million, trying to understand law that is on page three or in the board packet it would be page 130 of 191. And I'm just trying to -- I would like it if someone could explain to me what the 5.6 million loss at the end of the year was and how that would impact some of the things that we're talking now about.

CHAIRWOMAN FREED: Okay. So I think this is, yes, as you say, this is page three of the state retiree health and welfare benefits plan, summary of the net position for 2020. Mine says 5,651,615. Do I have that correct?

Okay. Ms. Rich, can you field that one or do you want to hand it off to Casey Neilon?

MS. RICH: Actually I think Cari Eaton is able to answer this with the support of Casey Neilon.

MS. EATON: Thank you. Cari Eaton for the record. The net position is mostly due to the liabilities of the 11.7 million dollars. And the liabilities are that high because it's just the timing of the regiments that were transferred over the years. So anything that was transferred after June 30th has to be booked as a liability. And so I think it's just mostly the timing of when those revenues came in and were transferred from the main account.

MEMBER AIELLO: Okay. So it's not really a change in how something is functioning, it's based on when the report was completed is what I'm hearing? Thank you.

MS. EATON: I believe so. But Ms. Olsen can correct me if I'm wrong.

MS. OLSEN: No, you're not wrong, Cari. These financial statements are prepared using full accrual gap standards. And, therefore, anything that was received post 6-30 was accounted for as either a receivable or a payable or a liability, sorry. And in this case that's about 11.7 million came in. So they're accounting for items that were paid that belonged to the fiscal year but were paid subsequent to June 30.

CHAIRWOMAN FREED: Okay. Board Members, any other questions on any of the reports in Item 4?

I have one question on 4.2. It seems in Health

Claim Auditors report there were a number of dental claims that had the diagnostic code D1999 for PPE. And there was clearly some dental, like, a lot of dental billings for personal protective equipment that was not covered. Has this been discussed with the dental network provider on a more global scale?

MS. RICH: For the record, Laura Rich. This has not. Mary Katherine, do you have any insight on this? I know unfortunately Bob is -- Bob Carr, the auditor, is not on today. But I'm thinking Mary Katherine might be able to provide insight.

MS. PEARSON: Yes. This is Mary Katherine Pearson with HealthSCOPE benefits for the record. This actually we were able to discuss this with the dental network. So initially this code was listed on their fee schedule as what we call by report code so that it went to a certain type of discount arrangement. They later clarified, once Nancy Spinelli and others were involved, that that code should actually not be covered. And so the decision was made to not go back and reprocess the claims for members who had already had those claims processed but -- and to leave those providers as they were.

And then, going forward, once Diversified Dental provided that clarification, then we put that clarification in place and then those are no longer covered.

They're not member responsibility. I'll make that clear. It is provider responsibility. So it does not add any cost to the individual patients.

CHAIRWOMAN FREED: Okay. Thank you for that clarification. Yeah, I noticed there were 4,000 plus claims identified per Bob Carr's notes. And I would assume that is because some of them were older than a year and the administrative burden of repricing them would be tremendous.

Okay. With that, I will accept a motion from the board to accept all of these reports.

MEMBER FOX: Linda Fox for the record. I will make that motion.

CHAIRWOMAN FREED: Thank you, Vice Chair Fox.

Do I have a second?

MEMBER KRUPP: Jennifer Krupp for the record. I will second.

CHAIRWOMAN FREED: Thank you. Any discussion on the motion?

All right. PEBP staff, are we still doing roll call votes because we're on Zoom, or because everybody is on camera do you want us to all raise our hand if we say aye and then raise our hand if we say nay? How would you like to handle this?

MS. RICH: For the record Laura Rich. I think in this situation I think we're safe to probably just -- Probably Agenda Item Number 8 is going to be a different story.

CHAIRWOMAN FREED: Okay. Well, with that, all in favor, please raise your hands so we can see you. Great.

Any opposed? Okay. The motion carries unanimously. Thank you.

Moving on to Agenda 5, discussion and possible action to approve a six-year contract beginning January 1st of 2022 with LSI for an enrollment and eligibility benefits system. Take it away, Ms. Eaton.

MS. EATON: Thank you. Cari Eaton, chief financial officer, for the record. PEBP is requesting that the board authorize staff to award a new contract to LSI Consulting to provide eligibility and enrollment benefits management system services in response to the RFP that was released on July 1st, 2020.

On August 14th, 2020, PEBP received six proposals. A six-member evaluation committee that included two PEBP board members evaluated the proposals from August 15th through September 11th. LSI Consulting received the highest score from that evaluation committee.

PEBP staff has completed negotiations with the vendor and would like to bring the contract to the December 8th board of examiners meeting to allow LSI Consulting a full year to complete the implementation and transition from our current vendor.

The effective date of the contract is anticipated to be December 8th on BOE approval through June 30th, 2027, with an option to extend to June 30th, 2029. Implementation will begin on BOE approval, while the services and associated fees are expected to begin on January 1st, 2022, after the implementation.

The maximum amount of this contract is 6.8 million dollars. And staff is recommending that the board ratify the evaluation committee's recommendation that a contract be approved with LSI Consulting to provide eligibility and enrollment benefits to management systems. And I can take any questions.

CHAIRWOMAN FREED: Board members, any questions on these contracts?

MS. RICH: This is Laura Rich for the record. I just want to make one correction here. We actually received three proposals, not six. I just want to make sure that that's corrected for the record.

MS. EATON: Sorry about that. There's too many of them. Getting them all mixed up maybe.

MS. RICH: Right.
MEMBER KELLEY: Chairperson Freed, can I just ask a quick question?
CHAIRWOMAN FREED: Sure.
MEMBER KELLEY: So, the 6.8 million dollars, is that for the six years of the contract or is that per annum?
MS. EATON: This is Cari Eaton again for the record. That is for the six years of the contract.
MEMBER KELLEY: Thank you.
CHAIRWOMAN FREED: I have a question. How does the per person per month charge for the new vendor compare to what we pay our coverage center?
MS. EATON: This is Cari Eaton for the record. This is an increase to the per person per month charge. And let me get the exact numbers for you. But we have renegotiated our current contract many times. So our per member per month fee for our current vendor is very low. But we did negotiate out implementation fees and things like that with this vendor as well.
UNIDENTIFIED SPEAKER: While Cari is looking that up, I do want to add that PEBP put out an RFI earlier this year, and we've received several responses on that RFI and were expecting industry standard is much higher than what we're currently being charged by our current vendor. So we

were expecting higher fees. And I believe that the first two years of -- And I hesitate to say this -- And maybe, Laura, you can tell me if this is appropriate, but are we -- is it appropriate to talk about the per member per month fee that was negotiated at an open meeting like this or is it too soon?

CHAIRWOMAN FREED: Well, I wish had a purchasing administrator or a team lead from the purchasing officers to tell me that. Where I wish I could answer -- And I would have to look through NRS 333 to see if there's a actual specific prohibition on discussing the fiscal details. But for me it would be thinking about, as I normally do, did we budget for a higher PPPM in our agency request budget. Because, of course, that plays in to our discussion on Item 8 and with what about 70,000 covered lives, we've got to account for the difference between what we're paying currently and what we'll start paying in the middle of FY 22 when this contract is set to begin and can we cover that with what we have now?

MS. RICH: So for the record Laura Rich. The answer to that is, yes, we anticipated this. This was the reason that we put out an RFI earlier this year is to understand what the -- what the industry standard was going to be and what the expectation would be when we -- if and when we went out for the bid on this. And when we submitted our agency request budget, we definitely took in the responses in to consideration and we did budget accordingly to those responses. So, yes, we are -- the PMPM is within the budgeted ranges.

CHAIRWOMAN FREED: Okay. That's reassuring. Board members, any more questions about the eligibility contract?

MEMBER VERDUCCI: Yes. Tom Verducci for the record. After going through the RFP process, do we experience getting cost savings as a result? It's an appropriate question.

MS. RICH: For the record Laura Rich. Yes. We were able to negotiate a lot of the proposed costs out of the contract. And so I feel pretty good about where this contract has landed and the opportunities that we have working with this vendor moving forward. So, I would say, yes, it is still coming in higher than what we are seeing for today. But, like I said, it was expected due to the responses in the RFI that we received earlier this year.

MEMBER VERDUCCI: We're looking at a December 8th board of examiner approval. And from there when will the implementation date be? Are we looking at approximately January 1 of '22?

MS. RICH: For the record Laura Rich. Yes. We will be -- The organizational company will start, LSI, with benefit focus will be starting their implementation immediately, as soon as it gets approved at the board of examiners. This is a big implementation. It's going to be a big project. And even with a years time frame we're still cutting it close. And so they're getting -- they're hitting the ground running as soon as we can get this group a BOE.

It will be -- It will go live on January 1st of 2022. And the reason for that is because we don't want anything to go live during open enrollment. So we want it to -- we want it to go live during a time where we have a few months of working out some of those little kinks that are expected in every big implementation like this. So it will go live on January 1st of 2022.

MEMBER VERDUCCI: Thank you.

MEMBER KRUPP: This is Jennifer Krupp for the record. When does the contract with the current vendor end in the middle of a transition?

MS. RICH: For the record Laura Rich. The contract ends on December 31st of 2021. And so the new contract would then start the day after that. The transition is -- So the new vendor will come in and do what they call a discovery phase. And so they're going to be working with our staff, they're going to be really getting in to our system. There's only so much that they understand through the RFP process, through the negotiations. They have to really get in to it and understand what exactly needs to be done and what our system does today and what we would like it to do tomorrow. And so that's going to be likely the first several months of that discovery phase.

And then after that we move towards that implementation. They will be working with the current vendor obviously to get the data. And I'm assuming -- I'm not an IT person, but I'm assuming that there's a lot more that goes in to it other than just transitioning that data, so they will be working very closely with staff with the current vendor, who is Morton and Chappell. And I'm assuming there's going to be a lot of -- a lot of effort that will need to be made by current staff here, PEBP staff, probably on the Smart 21 system as well and additionally with the vendor.

So, it's going to be a big, big project moving forward that is going to take -- I think you've heard me say before, this is going to take a lot of the staff's time. This is definitely going to be time-intensive for our staff because they have some -- we have to make sure that they build a system that we can use.

MEMBER KELLEY: Chairperson Freed, this is

Michelle Kelley. I wonder if I can ask a question.

Executive Officer Rich, I'm just curious if you can give us a top level summary, I guess, of any enhancements that this contract would bring to the eligibility system. I think you talked about how your, you know, PEBP as a whole has been unhappy with the current provider. So perhaps you could just kind of address a couple of points about enhancements that might be built in and/or kind of what provisions they have that were better, I guess, than what we're currently getting.

MS. RICH: So my hope -- For the record Laura Rich. My hope with this new vendor is the biggest thing for me I think is reporting. I know in the last two weeks I have struggled to, you know, get data that you need because I can't just split myself. I have to -- I rely on our vendor to pull that data. I don't have automatic insight in to can I just pull -- For example, one of the public comments was how many of this subgroup of people are the -- those that don't have Part A and Part B. There's currently no way for me to go in to the system today and be able to pull that report.

So, just things like that, just everyday things that make us, things that make our job more efficient I'm hoping will improve.

Additionally, on the PEBP side, the staff side, there's currently a lot of, you know, a lot of Band-Aids in place. And so there's a lot of workarounds in our current system that the PEBP staff are using. And in not only with PEBP staff but as well as the agency reps too. Agency representatives have had some issues with our current system as well. So the data integrity, and things like that, I'm hoping will be much improved moving forward.

There are a lot of offerings that this vendor can offer us. Unfortunately, we are in a situation where I had to turn a lot of those -- those optional products down because we do not have -- we're not in a fiscal position where those must be nice to have or would be nice to have are things that we can afford right now. And so hopefully when we do get in a situation where PEBP can afford those would-be-nice-to-have products, we can move forward and maybe trigger those in our contract as well. So do a contract and then to include those. But for right now it was a lot of those extras are having to wait for obvious reasons.

MEMBER KELLEY: Okay. Thank you.

CHAIRWOMAN FREED: And one question from me. This is Laura Freed. So the contract would begin January 1st of 2022 and go for six years, which means December 31st of 2028. But on the staff report it says through June 30th,

2027. Am I confused?
MS. EATON: Cari Eaton for the record. 2027, June 30th, 2027, would be six years of paying for the service. So even though the contract is technically going to start upon BOE approval, we're not going to start paying until that January 1st, 2022. That's actually five and a half years.
CHAIRWOMAN FREED: Right, right, right, right. That's a little bit shorter than six years. June 30th, 2027. Okay. Just confirming the term date. Okay. With a contract max of six-million-849. Okay. Got it. Okay.
So if there are no other questions from the board, I would accept a motion to -- Oh, Mr. Lindley, go ahead.
MEMBER LINDLEY: I have a quick question. I'm a new board member. And one of the things I've heard, and maybe it's just an educational thing. We submitted a budget draft and the budget draft anticipated a higher cost than the 6.8 million; is that correct?
MS. RICH: For the record Laura Rich. Yes. So we -- Every state agency in August has to submit an agency request budget. And so this is where we basically put together our budget and do our best to project cost for the next two years.

MEMBER LINDLEY: So this item was budgeted higher than what the current contract offer is?

MS. RICH: For the record Laura Rich. Yes. And the reason behind that is we did a request for information, an RFI. And the responses that we received -- Because we've had this vendor for many years. And so we did not know what to expect when the -- when we -- if we were to budget for this. At the time we did not know if this was something that we were going to go out to bid for. And so just in case, we put out an RFI to see what those costs were going to look like so that we would be able to budget accordingly. And so when we put together the budget, we took those responses and adjusted our PMPM, what we included in our PMPM for this cost, to better reflect the -- basically the industry standard of these responses that we got, the cost proposals that we received from the RFI.

MEMBER LINDLEY: So the budget on section eight, Agenda Item 8, that is cuts to the proposed budget draft?

MS. RICH: So it's separate. And this is Laura Rich for the record. It's different. So the agency request budget that we are referring to in Agenda Item 8 is really focusing on our subsidies, it's focusing on (unintelligible) and so those are the premiums, the employer premiums, that we get from the state. This is more of the operational side of the budget, if that makes sense.

MEMBER LINDLEY: Okay. Makes sense. I just was curious if the savings of the budget from this contract is factored in to the Agenda Item 8.

CHAIRWOMAN FREED: If I may. The way the PEBP budget is structured, we have a -- So what we have traditionally called administrative load and so it's all these kind of vendor contracts, whether it's the enrollment and eligibility system, the health networks in the north and south, the dental network, the actuarial services, the auditing services, all of these things that we buy that everybody in the program, regardless of coverage to your benefits from. So the per participant per month cost for each of those contracts is rolled together, to oversimplify it, in to the admin load. And so that was the genesis of my first question to the staff, did we account for this higher PPPM for enrollment and eligibility in agency request. And the answer was yes. And so we don't need to adjust the admin load as -- We need to adjust the plan design to conform to the governor's finance office mandate with a 12 percent reduction, as we're going to discuss in Item 8, but we don't need to adjust admin load. So I hope that helps.

MEMBER LINDLEY: That does. Thank you.

CHAIRWOMAN FREED: Okay. With that, if nobody has anymore questions, concerns, information, desires, I would accept a motion to authorize the PEBP staff to execute contracts for the December BOE for the enrollment and eligibility system contract with a maximum of $6,849,000 for the term of the contract.

MEMBER FOX: Linda Fox for the record. I will make that motion.

CHAIRWOMAN FREED: Thank you, Vice Chair Fox.

Do I have a second?

MEMBER KELLEY: Michelle Kelley for the record. I'll second.

CHAIRWOMAN FREED: Thank you. PEBP staff, would you like us to roll call or would you like us to raise our hands --

Oh, Mr. Verducci, question?

MEMBER VERDUCCI: No question.

CHAIRWOMAN FREED: Okay. Well, if there's no discussion on the motion, all of those in favor, signify by raising your hand so we can see you. Thank you.

All of those opposed, raise your hand.

Okay. Motion passes unanimously. Thank you very much, everybody.

Agenda Item 6, discussion and possible action to approve American Health Holding contract amendment, another contract item, addressing temporary ownership of the toll free number. Ms. Eaton.

MS. EATON: Thank you. Cari Eaton for the record. PEBP is requesting that the board authorize staff to complete a contract amendment with American Health Holding to amend the negotiation -- the negotiated items and performance guarantees allowing American Health Holdings to take ownership of the UMCM 1-800 phone number for the duration of their contract.

Upon termination of the contract, the phone number would then be released back to the State of Nevada and a performance guarantee would be added that would require American Health Holdings to pay PEBP a hundred thousand dollars if the phone number is not returned upon termination.

This amendment request was brought to the board and denied in September because of concerns this PEBP had no recourse if the vendor refused to return the phone number, which is why the performance guarantee is being added.

And to put it in more perspective and give more information, currently, the State of Nevada Enterprise IT Services Division or EITS Division owns this phone number on behalf of PEBP and bills the UMCM vendor directly for the monthly charges, whoever our UMCM vendor is. And EITS is being charged 15 cents per minute on half of those charges through to American Health Holdings. With an average of almost 22,000 minutes per month, this phone bill costs American Health Holdings on average of $3200 per month. American Health Holdings has phone rates in place of .0088 cents per minute, which would save them nearly $3,000 per month. And there is a typo in that report. Sorry about that.

So, while this amendment would not save PEBP money directly, we would like to be good partners with American Health Holdings and allow them to save money while keeping the same phone number with no member destruction. And I can take any questions.

MEMBER VERDUCCI: Tom Verducci for the record. So it appears this is going to save 3,000 a month or $36,000 a year for American Health Holding. They have put together a hundred thousand dollar guarantee. And this looks really good. Is there any disadvantage to the state if we were to take action and approve this?

MS. RICH: For the record Laura Rich. Mr. Verducci, I think you and the other board members may recall that this was brought to the board last time around and there was some concern about there being a risk to the state if the vendor did not return the phone number. And so when we went back to the vendor, they said -- that's where they came back and said, you know what, we'll even back this with a hundred thousand dollar guarantee that we will give this phone number back.

At this point I don't see -- I see that risk as being eliminated. So I don't see a problem here. I think it, you know, saves the vendor some unnecessary fees in phone costs, obviously, and they're significant. And so it's a good idea for us. They've been a good partner and this is just something that we can do to help them save some money as well.

MEMBER VERDUCCI: Well, thank you, Executive Officer Rich. I think that this does look like a very good cost saving for the vendor. They're backing with a hundred thousand dollar guarantee. And I think this looks like a very good package. And so I don't have any objection with it.

MEMBER KELLEY: Chair Freed, I have a follow-up question.

CHAIRWOMAN FREED: Please, go ahead.

MEMBER KELLEY: Michelle Kelley for the record. So I'm going to come across pretty hard-nosed here. But I just -- Why is there no consideration for what PEBP is giving to the vendor? Obviously this is a contractual matter, and we currently have a contract with the vendor, and I assume that contract includes the arrangement for the 1-800 number. So while I don't object to actually, you know, allowing them to transfer it in to their name because of the guarantee, given that Item 8 we're talking about decimating health insurance coverage for our employees, I'm just wondering why there's no consideration built in the biggest savings -- You know, and I understand it's only around $27,000 a year, so we're not going to fix the budget with the consideration. But there's no consideration. So I'm just kind of wondering.

I hear that you're saying that they're a good partner. You know, we pay them to be a good partner. But I am wondering why there is no shared savings potentially or especially since we're trying to dig ourselves out of a hole.

MS. RICH: Laura Rich. And I'm not too familiar with our EITS storm system. I don't know if maybe Chair Freed is since she oversees it.

CHAIRWOMAN FREED: I am not, except for the need to upgrade the digital phone lines to handle all of the DETR UI volume this spring. That I know that. But, sorry, guys. I can send a quick e-mail.

MS. RICH: I don't think that the vendor -- And we had this vendor for about a year. I don't think that the vendor was at all under the assumption that the phone charges through the state were going to be so much higher than what they would receive on their own, right. So they're -- Essentially, to use this phone number, they have to pay the state. And the state is charging them almost $3300 a month, whereas they could do -- get the same service for less than 200.

And so, you know, when we signed this contract, yes, it was, I think, somewhere in that contract -- I would have to pull it -- but somewhere in that contract probably says that they agree to use the phone number offered by the PEBP program. But I don't think at the time that they had any idea that it was such a difference in pricing. And this is probably something -- It's just an unnecessary cost to the vendor versus it's not really a cost -- or a cost savings, if that makes sense.

CHAIRWOMAN FREED: Well, this is Laura Freed. If it's a cost savings for them, it's not a cost savings for my deep budget because by -- Thank you, Executive Officer Rich. I have legislatively approved costs all over the EITS. And, yes, they are higher than what you might get on the street because there's overhead built in to the range. And I know that e-traits are really okay for a lot of agencies. And that's one of the things I'm trying to work on actually.

But -- So letting American Health Holdings go out, have these -- disassociate from EITS and pay for, you know, what they can get on the street at a much cheaper price actually deprives the EITS telecom budget of some money. So that's -- I'm just throwing that out there.

I'm not necessarily opposed to this amendment. This would be -- Just to clarify with PEBP staff, this would be a no-cost scope adjustment; right? Okay. I'm not necessarily opposed. But it does take away from my agency's revenue streaming.

Okay. The silence is deafening. How do we feel, Board Members?

MEMBER FOX: Linda Fox for the record. I think it makes sense. I think it's cost savings. I think it makes sense. I'm prepared to make that motion if there's nobody else that wants to discuss it.

MEMBER AIELLO: This is Betsy. I was just going to say I agree it makes sense. It doesn't look good overall if vendors think the state requires some of the state processes that drive up the overall cost of contracts when they bid. I mean, if you think more globally. I know it might hurt the EITS budget. But if it was in a bigger scope, the 800 number, like with the Medicaid agency where I came from, it could be a significant savings, which would show up in contract bids.

CHAIRWOMAN FREED: Okay. So Vice Chair Fox has

moved approval.
Member Aiello, is that --
MEMBER AIELLO: That's a second.
CHAIRWOMAN FREED: That's a second. All right. Cool. Thank you.
Any discussion? Okay. All those in favor, raise your hand so we can see you in your box. Okay. It looks like motion carries unanimously. Thanks, everybody.
All right. Now the executive officer's report, Agenda Item 7.
MS. RICH: Okay. And for the record Laura Rich. This is Agenda Item 7, the executive officer report. There's just a few things here that I wanted to report on.
First of all is the COVID-19 update. PEBP has been working with the governor's finance office, the GFO, to ensure that all of the COVID-19 related expenditures of our program are captured and hopefully reimbursed.
So from the Coronavirus relief fund allocation, as of November 12th, PEBP has incurred almost 2.5 million and I think we actually received that number last week. It was over 2.5 million in COVID-19 related cost. But we are projected to incur approximately 4.7 million by the end of December.
So, because of that, we actually submitted the

4.7 million number to GFO, and because the CRF funds will expire at the end of the year, that number is included in a work program that was -- that is going to be included as part of the December interim finance IFP meeting in December. So let's cross our fingers that we do get some of those funds back to the program.

But I do want to just emphasize that that is it. In December those run out and anything that the program incurs moving forward unless there is anything near that happens on a federal level, those are done. And so we will not be getting those reimbursed that we know of in the future at this point.

The next item here that I wanted to provide the board an update on is the feasibility study for a public health insurance option. The factor in the 2019 legislative session, FCR-10, was passed directing the legislative committee to study the feasibility, viability, and design of a public health care insurance plan offered through the Public Employees' Benefits Program to all Nevada residents.

So back in August of this year, PEBP and also the Silver State Health Insurance Exchange were approached by Manatt Health. And that's the organization that was charged with conducting the feasibility study. And since then both the director of the Silver State Health Insurance Exchange as well as the Medicaid administrator and myself have been working with Manatt to provide information, data, and feedback on possible options and solution.

So Manatt is expected to provide the draft report and I actually have it and owe them my input by the end of today, I think. And they will be providing their analysis of potential solutions by the end of this month to the legislative commission. We will continue to update the board as more information becomes available on the study moving forward.

The next one is the solicitations update. There's, as you heard Cari, there is a lot of solicitation. This has been taking up time for all PEBP staff, not just myself, but a lot of PEBP staff, and then it uses an enormous amount of time that has to be dedicated, not just by PEBP staff but also the evaluators and core purchasing division. They are inundated as well by us right now. Many of the solicitations that staff was hoping to be able to bring to the board in November is actually not going to be able to be presented until January.

So you did hear that the LSI contract, we got that one through. But there are still many of them in the works right now. We're hoping that if we bring these all to the board in January we can still meet all the necessary contractual deadlines that need to happen so that the implementations can be issued by open enrollment this year.

So, as you heard, LSI, we are pleased to announce that we have had successful negotiations with them and they have partnered with Benefit Focus to offer an integrated enrollment and eligibility system. That one will go live in 2022 for PEBP. But, through the Smart 21 system that they are also spearheading, that should go live in 2021. And so we're really excited to partner with them. And hopefully this is going to be a big improvement for PEBP moving forward.

In addition, the purchasing division has issued letters of intent for the medical network, dental network, and HMO contract. So we are in the process of negotiating each of these so that they can be presented in January and then subsequently included in the board of examiners meeting for final approval in February.

The health plan auditor RFP has been finalized and it has been submitted to purchasing and hopefully that will be released soon. I know I got an e-mail earlier today asking for the a-okay for that one to be released. So hopefully that will be released within the next week or so.

Overall, I just want to thank staff. This has been a lot of work for PEBP staff. Not just writing the

RFP's, being part of the evaluation committee, being part of the negotiations, we have had to live and breathe the solicitations. My kids actually asked me the other day what the heck an RFP is because that's all they hear me talk about when I work from home.

So this is, you know, this is obviously been something that has taken up a lot of PEBP staff's time and I just want to thank the entire staff that has been a part of this because it has been a lot of work.

For an operational update, the first thing that we want to talk about is the flu shots. So, as we have in previous years, PEBP hosted two flu shot clinics during the month of October, one in Carson City and one in Las Vegas. Governor Sisolak attended the event in the Carson City location to show his support and stress the importance of flu shots during the pandemic.

Although PEBP expected a significant decrease in participation, in fact, we weren't really going to do them because everyone is working from home. We went ahead and moved forward with them. And we actually had a very strong showing. In Carson City we had almost 300 people show up to get their flu shot, employees. And in Las Vegas we actually had more than we had last year. So 140, which is about 50 percent more than what we got in 2019. So that was big.

I want to give a shout out to Nicole Pluta, our education and information officer, who really just -- she worked really quickly to get these up and running and work with our vendor partners to make sure that we could put these all in place in, like, two weeks time. So we were really grateful for her help on this and all the efforts that she put in to this -- in to the flu shots.

Staffing. Staffing continues to be a challenge. Although PEBP received approval to staff several open positions, we had some internal promotions, which then created new vacancies. So then we had to ask for those positions to be filled. So we found it very challenging. A lot of these positions, especially these entry level positions that we have in, for example, our call center, we found it very challenging to staff the positions.

We also -- We did staff an executive level CIO position, which he should be watching here today. It's his first day. So his name is Steven, and he will be joining the PEBP staff. So I'm excited about that. We haven't had a CIO in a couple of months.

We have chosen not to submit JTS justifications to fill for some positions that we have within the agency that we have determined to not be vital at this time. For example, a front desk position. When our offices are not open, that is a position that is not necessarily necessary. So, to date, we have 30 of 34 positions filled internally here at PEBP.

Conclusion. With all of the upcoming changes to the core plan design and possible reductions to other benefits, PEBP expects a very, very busy year. And we will be depending on each and every one of our staff to ensure that PEBP's 73,000 staff members have care and attention moving in to this next plan year.

So, with that, I'll stop here and take any questions from the board.

MEMBER AIELLO: This is Betsy. I do have a question. As we heard in public comment where one of the gentleman was encouraging us to reach out to the federal level to try to get some more COVID funds. And, as you mentioned in your report, we are getting some, but there's no guarantee for anything past the end of December. If the state was to get more COVID funds, that would make a difference in the budget because that would bring in some money to help backfill that 12 percent or -- I'm not sure how much medical costs are focused in to this because the budget doesn't really start until next -- July 1. So I'm curious about that.

MS. RICH: This is Laura Rich for the record.

You know, I think this all depends. It depends on what this -- You know, if there is a stimulus bill, what -- what the requirements are of this.

So, for example, the CARES Act right now has very specific requirements. The only -- The only money that we are getting back from the CARES Act are specific to COVID-19-related funds. And so those are the testing that is the -- any kind of care that is received as a result of a COVID-19 diagnosis. So that, it's very limited.

Moving forward, I don't know. I don't know what that stimulus bill is going to look like. Are those requirements going to be specific to only COVID-19-related costs? Yes. That would help. Because I expect, as you've seen that there's a surge, there's a lot of testing, there's a lot of cost associated with COVID-19.

Does that play in to the global picture of, you know, what our fiscal landscape looks like moving forward and is that going to save the state out of this or help the state out of the financial crisis we find ourselves in? You know, I don't know. There is no stimulus bill out there right now, so we don't even know what that's going to look like.

CHAIRWOMAN FREED: This is Laura. Oh, Jennifer, please, go ahead.

MEMBER KRUPP: Regarding the CARES Act, is that going to be any claims that you're going to be seeking reimbursement for that are received with a date of service of, like, December 31st and prior? And then how long will you have -- how long for the regular claims processing times? When do you expect to have a number on the volume and the amount of those claims?

MS. RICH: For the record Laura Rich. The claims actually, by statute, providers have a year to file those claims. So, technically, if, you know, we could receive claims for a service date of, you know, December 20th, 2020, on December 20th of 2021. So, yes, that is -- And typically that's not what happens. Obviously providers want to get paid and so that's not typically the case. But, yes, there is a claims lag time. And that's when we're trying to get in as much as we can by the end of the year.

CHAIRWOMAN FREED: This is Laura Freed. Just out of curiosity, we expect to incur 4.7 million in claims cost by the end of this calendar year and then we're getting the CARES Act reimbursement for those claim costs. How does that compare with the box -- the box of four boxes that Aon presented to us in the past couple of meetings of expected claims expenses offset by claim suppression? Do you remember? This is just for my curiosity really to see how close we came.

MS. RICH: So I think we're right in line. But, Stephanie from Aon, do you want to just kind of speak on that really quickly? Because I know you mentioned you had a couple of comments on this.

MS. MESSIER: Yeah. I would say of those boxes it's kind of coming in to just really our average estimate. It's not really on the high or the low. It's kind of right in the middle. And, as you might imagine, if I re-ran it today, the 4.7 million is probably a different number, especially given we're all in the middle of a pretty big upswing.

CHAIRWOMAN FREED: Right, right. That's true. And actually keying off of Stephanie's last comment, PEBP staff, have you seen since we've been spiking in this so-called third wave, have you seen any spikes in claim cost in the last couple of weeks for COVID?

MS. MESSIER: So I get those -- I get them weekly. I get a claims -- an e-mail basically of what our claims look like weekly. At the beginning of all of this, I would see that the claims were increasing 20, 25,000 a week. That's up to now easily at a hundred thousand plus a week. And so it's -- Yes, we are definitely seeing a spike. However, remember that there's a lag in the claims, right. So what is happening today, the surge that's happening today, we probably won't see for a couple of months.

CHAIRWOMAN FREED: Again, Laura Freed. Oh, I heard somebody was --

MEMBER AIELLO: I'm sorry. This is Betsy again.

CHAIRWOMAN FREED: Sure. Go ahead.

MEMBER AIELLO: Based on what I heard Stephanie just say, are we, like, locked out or would we be able to run another projection and request more than the 4.7 million?

UNIDENTIFIED SPEAKER: So that's a good question. Probably something we would have to ask the governor's finance office. They had asked us earlier, I think it was last month, to come up with a projection, what do we think that we -- what kind of expenditures are we going to incur by the end of the year, and we had to come up with approximate. We had to run those projections. And so that is what is being submitted in a work program for the December IFC.

I don't know if we are able to go back in and make any changes to that. I think that there may be some deadlines that we would have to -- we would have to work with GFO on that. And I apologize. I have not been intimately involved in this. We have actually had one of our accounting staff have been working with the GFO on this directly.

MEMBER AIELLO: And my gut feel would be it might be worth asking the question because the governor's office is super aware that there's a surge that people were hoping or not expecting to this extent to occur but they may have already allocated all the money so they didn't leave any on the table. But they may also be willing at the last minute. I don't know. But I always think it's probably worth asking if it really will help us out some.

CHAIRWOMAN FREED: This is Laura Freed again. One more question, if I may. On the Manatt study, based on the draft report -- And if you haven't had a chance to read it, I understand. Preparing for this board meeting was a Herculean task for you all. Are they recommending commingling with non-state just members of the public with PEBP participants? Or are they -- I mean -- And, if so, I find that curious, given that that would require more subsidy dollars, and the biggest agenda item on this agenda is reducing subsidy dollars. If we struggle to provide a quality plan design to our own members, is it really the right time to recommend to the legislature that we open up PEBP in a way that would make state employees and state retirees have to subsidize people who have never worked for the state?

MS. RICH: Yes. And, for the record, Laura Rich. While I haven't had a chance to read the entire 40-page document, I have had a chance to discuss with Manatt directly. They are very aware of the cost that is -- that is associated with any of these recommendations or potential recommendations. I don't know if they're exactly making the recommendations that they're going to have to take back to the legislative commission and discuss with possibly Senator Kenfarro specifically to see if this is something that is going to really gain any traction moving forward. I think it's still too early in the process to say what it is that they plan on doing or don't plan on doing. I think we're still in that, you know, discovery phase of what, given the expense, potential expense, or costs that come with these public options, is this the time to do it or is this maybe -- is the study going to be used as a potential educational study to maybe take to a -- you know, in a different -- on a different level, on a different path moving forward and maybe another biennium when hopefully they have recovered economically. I don't know. I think it's still too early to see what they're planning on doing. I think the final recommendation when that comes out will be very interesting.

CHAIRWOMAN FREED: Okay. Thank you.

Board Members, any other questions for the executive officer? Okay.

Well, it is 11:33 and the next is a big, big agenda item. So would you all like to take a bathroom break for a couple of minutes? Okay. I'm seeing nods. All right. So let's come back at 11:40 and we'll undertake Agenda Item 8. Thank you.

(Recess was taken)

CHAIRWOMAN FREED: We will undertake Agenda Item 8. And, just for organizational purposes, because this is such a long item with so many facets and so many choices for the board, I think what I will ask is the executive officer to do is to, you know, go through background and staff report, obviously, and then go through Options 8.1 and then if you would go through Option 8.1.1 and 8.1.2 received this morning by the board. And I hope -- I haven't checked the website, but I assume they've been posted by now, so everybody at home can play along. And then go through 8.2 through 8.12 or 8.2 through the rest of them I guess I should say. Does that sound feasible?

And, if we -- Board Members, if you get lost, if you want me to slow down, if you want to go back over something, please just raise your hands. Because this is, like I said, this is a lot to endure. So, with that, I will turn it over to the executive officer.

MS. RICH: Okay. For the record Laura Rich. Deep breath. Yes, this is going to be a very long report. This is not something that any of us wish to present or wanted to present today, but we are in an unfortunate situation.

So I'll begin with a little bit of background. So, earlier this year, agencies were asked to submit budget reserves of six percent for FY 20 and 21. Originally, PEBP was exempt from FY 20, but we managed to come up with almost 25 million dollars for FY 21. We did that mostly by reducing the reserve levels.

But then agencies were also asked to submit blast budgets for the 2022 and 2023 biennium. And, because of trend, the same dollars don't go as far. So for PEBP at the last budget is actually about a five percent cut.

So, because of this, we introduced back in August or in July, sorry, the July board meeting, the concept of a new plan design and made adjustments to all of the existing plans that we had or the bulk of the existing plans that we have today. So back in August PEBP submitted a budget that used the proposed plan design and stuff with those last budget cuts.

On November 3rd, the governor's finance office released a memo to agencies telling us really what we all expected to hear, that the state was expected to experience a significant revenue loss. And, in order to prepare, agencies were being asked to submit 12 percent budget reserve proposals. For PEBP that 12 percent is about 72 million dollars for the biennium or 36 million dollars each year of the biennium.

So where does that leave us? Typically, the PEBP board meets in November to discuss an approved plan design for the upcoming year. So finalizing the plan design allows staff to prepare for that upcoming open enrollment and it also allows the actuaries to start building rates to be able to present and approve those rates in March. That is still the goal of the agenda item today. We are still going to discuss and hopefully approve Plan Year 22 plan design. But we are not here to finalize Plan Year 23 plan design. I just wanted to emphasize that, that we are only finalizing Plan Year 22 plan design.

The other piece of this, however, unlike what we've done in the past, the board must approve what is going to be submitted in the PEBP budget, sort of like what we did in July when the PEBP board authorized the PEBP staff to submit a budget with the new plan concept. This time what the board is going to have to do as part of this agenda item is approve the proposed budget reserves for fiscal year 22 and 23.

Most agencies had to submit those proposals by last Friday. But because PEBP requires board approval, we actually have until tomorrow to submit ours. So what is approved today will be submitted tomorrow to the governor's finance office.

While we are asked to submit proposals for 12 percent, that number could very well change in December when the economic forum meets and presents their forecasting. We could easily find ourselves in a situation or in a predicament where we only need ten percent hopefully or we might need 14 percent.

So the approach here is in order to have the flexibility and not have to call an emergency board meeting the week of Christmas is to rank these options that are being presented today from most palatable -- And I say that with some hesitation, because I don't know if any of these are palatable -- to the least. That gives PEBP that flexibility to work with GFO and make any last-minute budgetary changes. So that's a little bit of a background.

But what I do want to say, and I will emphasize in every report, every presentation, and every public presentation that we have moving forward, there is a disclaimer here on the second page. It is important to emphasize that although standard actuarial methodology has been used to develop Plan Year 22 budget savings options, there are so many variables in the PEBP programs and the PEBP budget right now that not even the actuaries have this crystal ball and that this is just a -- this is a very, very odd year for PEBP. Not only do we have the renewal of several major contracts, a lot of them which you guys were hearing about in January, but we also have the whole COVID-19 variable as well. We do not know how that is going to play out. We do not know what the surge is going to look like, how it will affect our plan and our program and claims cost.

That also leads in to trend, right. Trend is going to be -- It's going to be hard to predict. This is not a normal year. And so predicting trend is going to be difficult.

And then we also have the introduction of a new plan. And anytime that you introduce a new plan -- I think some of you were on the board when we introduced the EPO. Anytime that you have that new plan there's unknown utilization. So you really have to account for that as well. And then the legislative session. So we're going in to session. We do not know what that's going to look like. What kind of BDRs are going to be heard, what kind of budget decisions are going to be made. And so that is all -- those are all variables that play in to the PEBP budget. And as one of the largest budgets in the state, this is -- this is big. And so I'm going to continue to make this disclaimer over and over and over again so that everyone understands that we do not have a crystal ball and that there's so many variables out there right now that next year we may be very close or very well off to our predictions. It's hard to say.

So, with that, I will get in to the meat of the report starting at 8.1. But, first, I do want to start out with a few remarks. First of all, we all know this is a very, very unfortunate situation. No one wants to cut benefits. This is not what I -- When I was appointed, I joke with my staff that one of the concerns I had when I was weighing whether I wanted to interview for this position was that I was concerned that we were going to have to raise premium prices. And now looking back, I think, gosh, that was the least of my worries. We are in a much different situation today. And raising premiums is not the only thing we're looking at today.

The last several years we had a lot of gains in PEBP and in the program. And so this is just a very, very unfortunate situation.

But PEBP was handed a directive and we literally had less than two weeks to come up with these options. So I do want to thank all of our partners who were just immediately willing to huddle and come to the table with ideas. Mary Katherine Pearson from HealthSCOPE. Amy Daley from Express Scripts. And an absolute huge thanks to Stephanie Messier from Aon who has spent many, many sleepless nights plugging away with these numbers and responding to my many off-the-cuff, what-if scenarios that I keep sending her. I know you've dedicated countless hours, many of them at 2:30 in the morning, to helping us to come up with an actuarial process that has been necessary for these options.

So I want to make sure that, you know, that our partners are recognized in all of the work that they've put in, as well as the PEBP staff as well.

The other thing I want to emphasize is that none of these options are being presented lightly. While the expectation is that board members will and should have questions and shouldn't just rubber stamp what staff is presenting, these options are not being presented without a great deal of thought and careful analysis. I personally would have loved to have been able to send out a survey to get feedback from our members before presenting any of these options, but we didn't have the luxury of time. So, you know, we had not even two weeks. We had I think 13 days to come up with these options and do all of the analysis.

So this has been a lot of work in the making and there's been a lot of time and effort that has been put in to this by all parties.

So, as Chair Freed mentioned, the report is divided in to two sections. And the first is the plan design where we can potentially get the majority of the savings, and the second are the additional items or options using levers that are outside of those plan designs.

So the first one is the 8.1. These are the proposed plan designs. Originally there was one proposed plan design that was being presented in the report. We came back and late last night, and in my case at 4:30 this morning, put together a couple other plan designs as well along with Stephanie from Aon's help. And so we kind of scrambled at the last minute based on the public comments that we were getting that was coming in.

So, the first one -- And I'm just going to go over the one that was originally in the report first -- is what we're looking at, the plan design. This assumes a 2.5 percent reduction and head count due to hiring freezes. So that's something that I want to point out that is very important. This assumes that there's going to be varying freezes and some positional eliminations throughout the state and as a result of everyone else's 12 percent budget reserve proposals as well.

As you can see, those three plan designs here are we modify the CDHP so that it has higher deductibles. The

HSA employer contribution is obviously much lower than what it is today. You can see that the actuarial value here is a 78.4 percent actuarial value versus the 87.3 percent actuarial value that was -- that is in place today. So that plan, the new plan, is what would fall in to the middle tier of a high silver plan.

The next one is the low deductible with a co-pay, which is a low gold plan. You can see there's an 81.8 percent actuarial value. It does have some deductibles here, 1,000 and 2,000. However, really the deductible does not apply for most of these services. Most of the services are on a co-pay level. So you're only hitting the deductible if, for example, you are in an inpatient hospital service or specialty medication or some of these other services such as imaging and things like that.

And then we have our EPO and HMO, which, again, that has been modified in such a way to where now there is a small deductible as well and -- but, again, it is mostly based on co-pays versus the co-insurance. And this is a high gold level plan. You can see that the rates here at the bottom are basically the rates that are -- We tried to keep the rates flat in this scenario. So they're fairly flat with the exception of the EPO and HMO, which were lower.

And the reason why that is, is because if you remember in July, the board made the decision that -- the policy decision that all plans were going to be subsidized equally. So, before that, we had and in fact in this plan year, the CDHP is actually being subsidized at a much higher level than the EPO today. And so when you equalize those, obviously, that EPO and HMO rate drops a bit while the CDHP increases. And so that is the reason for the seemingly lower rates on that -- on that EPO and HMO scale right there.

So that is the first one. I don't know, Chair, if you want me to stop there and maybe have -- give everyone an opportunity to ask questions before I go to the other two.

CHAIRWOMAN FREED: Yes, please. Let's do that.

Okay. I'm not hearing any questions. So everybody understands that were the board to make the proposed Plan Year 2022 changes, that would get us 20.1 million of the 36 million dollars for FY 22. So 16 million to go to meet the target demanded by the GFO. All right. Okay.

All right then, why don't we move on to what you called Option B, Option C, which I responded is 8.1.1 and 8.1.2, and talk about the differences between this and those two.

MS. RICH: Okay. So the next option that was introduced this morning was -- So this option uses the initial plan design presented at the July 2020 board meeting. So this is -- that plan design is a little richer than the one that I just went over now. Those actuarial values you see are a little bit higher. And so the benefit levels are a little bit better in this scenario.

But in order to -- If you're going to increase the benefits, you've got to make it up somewhere. And so we -- you'll see that the participant premium here is much higher. So we have adjusted those levels so that you can see that -- And the grid that was included here includes the five and ten percent. So we're only looking at that five percent. And I apologize. I should have actually kept -- eliminated the ten percent. But, you know, I was doing this at 4:30 in the morning, so you'll have to excuse that.

So the -- This is assuming that those five percent level is there. So the 2,000, 4,000 on the modified CDHP. You see that those out-of-pocket maxes are a little bit lower and you see that there's a $500 HSA contribution versus the $300. So it's a little bit richer plan design on this one. Again, the low deductible with co-pays also, you know, 1,000, 2,000, deductible. And then you'll see the co-pays are slightly different. And, again, on the EPO and HMO there's -- it's slightly different as well on that too.

So you'll see that the actuarial values here are slightly richer in these plans than in the one I just presented. However, you can look again at the -- at the rates, and you'll see that those rates go up to, you know, from about $43, what it is today, what employees are paying today on the employee only, to 74.65. And those are illustrative rates. Just so everyone knows, obviously, rates will change. This is what it would look like if we were to price them today. So we do not price our plans until March until we have much more experience. So those are just as an example only and only show what it would look like if we had them today.

This plan design, again, it meets the 20 million dollars in savings. And so we would have to make up that other 16 million in the other option.

The next plan design was one that was suggested by the Nevada Faculty Alliance. So they had requested that CDHP deductibles be reduced back to 1500 and 3,000, 750 in HSA funding and reduce those out-of-pocket maxes back to today levels of 3900 and 7800. They have also asked for the co-pay plan to be reduced. There was those deductibles be reduced from 750 or reduced to 750 and 5,000 and 10,000 for their -- those out of pockets. And the EPO go back to that no deductible and reduce the out-of-pocket maxes to 5,000 and 10,000.

That -- This plan design does not evenly distribute the actuarial values. So you see in the other plan options you've got the actuarial values of the plans are kind of spread out a little bit. It gives people choices. These, in those scenarios, those actuarial values are very, very similar. They're right in that 81 percentile. And I don't have numbers right in front of me. But Stephanie can correct me. Those actuarial values are very, very similar. So you're essentially giving people the same plan design, just different ways to get there.

In these scenarios, again, adjusting the premium so that we can at least get to that 20 million dollar mark to make up for that 16 million that's left over after this, you're looking at premiums that are, you know, fairly high. $108 for the employee only premium. You're going from $43 to 108. So, you know, those rates are definitely going to increase when you -- when you make that plan design richer.

So, with that, I will stop and take questions here.

CHAIRWOMAN FREED: This is Laura Freed. So just to be clear on Option C, you basically want us to disregard the approximately ten percent column in CDHP and HMO, right? Okay. So these are -- And those are Plan Year 2022 illustrated state rates for actives. So it would go from the original staff report EE only of 44.60 to 74.65 and on the HMO 149.47 to 162. And then this appears to be kind of a mix of proposed Plan Year 22 from the original staff report. But -- And then increasing the HSA contributions for CDHP. Okay.

MS. RICH: And then I do want to point out here that I have a note to myself here. So these are Plan Year 22. The thing that we need to keep in mind is Plan Year 23 because of trend and because of the way that the subsidies work, we will likely see a 30 to $40 increase in Plan Year 23 premium. So we need to keep that in mind too that while this is for Plan Year 22, these subsidy levels do not change in the second year of the biennium. And so any trend that is -- that is experienced within the plan, those costs get shifted entirely on to the member. So we have to keep that in mind that the Plan Year 22 increases in premiums are going to be likely higher in '23.

MEMBER AIELLO: Laura, just -- Laura and Laura, I have a question. This grid, I heard you say that this was based on projections today, and the premiums could be different when run in March. And so that goes back to if the federal government gets some subsidies for COVID, the premiums might be okay or we may not be able to count on them. So in a negative frame, likely, the premiums are going to be higher than what you have here because of the surge and the expectation, even in the 2022 year.

MS. RICH: So, not necessarily. So, again, we're not going to price out the plan until March. What we do in November is we have to establish what is it that plan design looks like. Because then at that point the actuaries take in to account our plan design, policy decisions, et cetera, et cetera. And they use their actuarial methodology in March to say, okay, this is what you had in claims. And they look at claims through March. And then if they're able to say, okay, using our projections, this is what we think your plan is going to cost. And so this is what the participant premiums will be. And so that's all going to happen in March.

What we're using is claims data. And so right now it's too early in the plan year to be able to comfortably say this is what your claims experience is going to look like. We need more data. We need more time. And this is why we don't do that until March.

Yes, COVID costs will definitely play a part in this. But, yeah, we don't know what that's going to look like. And I don't know, Stephanie, if you want to add anything to that.

MS. MESSIER: You know, one other thing that I wanted to say is outside of COVID what we've seen so far in

Plan Year 21 through the first quarter is an increase in pharmacy cost just with the specialty medication that I believe about six of your members are now taking that are very, very high cost drugs to the tune of -- You know, you're seeing a trend upwards of 20 percent, let's just say, in the first quarter. If that 20 percent maintains throughout the year, we don't typically price for a 20 percent trend on pharmacy. So if we continue to see that increase in pharmacy cost through the first half of this year and in to the third quarter of Plan Year 21, that's definitely going to put additional pressure on the rates that we've calculated for you here today.

We did take a little bit of more of an aggressive stance on trend, trying to be sensitive to the fact that the last time Nevada was in a fiscal crisis, your participants definitely saw some decreased utilization of the plan, and we were tying to be mindful of that and not view an even bigger disadvantage of, you know, getting excess reserves built up because we were overly conservative in resetting. So I will say that these rates are erring on the side of being somewhat aggressive in trying to project your rates. So I just want everybody to keep that in mind as well.

MEMBER AIELLO: And I do have another question. So the actual budget cut is in the base subsidy, correct, and that's why the premiums are going up?

MS. RICH: So, for the record, Laura Rich. It is in -- Yes, it is in the state subsidy. And that is where the bulk of our revenue comes in.

MEMBER AIELLO: And so then that's where -- And I'm just listening to what some of the folks have said. And let's just take that first in number B -- or in B, the premium that says 74.65, technically we could say something like the premium is 54.65 plus a $20 COVID whatever they were asking for, co-pay or something, which would stay in place and let the legislature give us back some more money. Just throwing that out from what I'm seeing here. Maybe it's a thought.

CHAIRWOMAN FREED: So this is Laura Freed. So I'm going to ask the board a policy question. The executive officer said something very apt in her presentation. She said you can either arrange subsidy dollars, paraphrasing obviously, Laura, you can bring subsidy dollars out via the plan side or via the rates. Which does the board prefer? What do you think of -- Of the bad choice before you, which do you think is the least bad choice?

MEMBER KELLEY: Michelle Kelley here for the record. I think, obviously, none of the choices are good. But I do think that -- I think that Option 1-A disproportionately impacts the folks who need it the most. And so I would say that what I see when I look at Option A as well as some of the other cuts we're going to get in to is that we're really impacting Nevada's social safety net for our participants, right. I mean, when you increase maximum out of pocket to 6,000 for an individual or 12,000 for the family, people can't afford that.

And, yes, I, you know, I mean, I think in the report, Executive Officer Rich does comment that only a few people use the out-of-pocket max, deliberately so, right. But there are also people clearly who have extraordinary mental events going on. And so to increase it so drastically -- I think it's around 53 percent in 1-A -- is crushing for the small number of people who use it.

And for me, you know, I think that for our plan the idea here is to look after people in those catastrophe -- in those catastrophic situations as best we can.

So my preference, if we have to -- My preference, first of all, is that the board petition the governor and the legislature to either exempt us from these budget cuts or be more realistic about the budget cuts once they see the depth of the cuts that we're going to be discussing today. Personally, I think that we have to do all we can. But I do think that we have to spread the paint, if you will, across plan design, across the rates. You know, plan design for both retirees and active employees, you know. But I do think we need to maintain the safety net aspect of our plan. You know, we can't -- Because if we don't pay some of these things that people can't afford it themselves, they end up on social services one way or another, right. They end up using other saved monies to fund some of these claims if they can't afford them themselves. So, you know, I -- And, with that, I'll let someone else have a say.

MEMBER FOX: Linda Fox for the record. So, if I understood your question, your question, Chair Freed, was if we prefer -- if we had to pick one if we refer higher rates or decreased benefits; is that correct?

CHAIRWOMAN FREED: Yes, that is correct.

MEMBER FOX: Okay. So I would prefer a higher rate. And I like the proposal that was made in public comment about a COVID surcharge I think they called it, simply because it could be more simply removed if the time came to do that.

And if we discuss doing that, I wonder if we can also discuss doing that on a sliding scale based on income. And I know that's complicated because I proposed that before for insurance. But I wonder if we can just discuss that based on the pay rate, you know, maybe it's like an hour of pay per month or something like that, if we are going to discuss a surcharge. Thank you.

CHAIRWOMAN FREED: Okay. Anyone else want to weigh in on the essential question of do you find subsidy savings in the plan design or in the rates by shifting the cost of the rates more to the participant?

MEMBER AIELLO: Well, this is Betsy. And I tend to agree with what the two folks have said, that it's probably better to have the little bit higher premium, because when people are in high medical need, it's very hard for them. But I also realize I'm saying this from someone that could flow that in my income and I worry about some of the single mothers -- So I guess that's where Linda Fox is -- that are in some of the lower pay grades. But I'm not sure, again, how you could possibly do a sliding scale.

CHAIRWOMAN FREED: Yeah, that's really complicated. And, I mean, although I appreciate the thought, because I think Vice Chair Fox has hit on one of the problems with a COVID surcharge, the function of flat tax on employees and early retirees. Because right now, I mean, this 8.1 A, B, C here just deals with actives and early retirees, non-Medicare retirees. We haven't even gotten to the Medicare retirees yet.

So, you know, what -- At least the premiums you pay based on the coverage tier selected has some basis in actuarial experience of the people in that coverage tier, whereas, a flat surcharge is regressive. So that's my feeling on that.

But what I'm hearing so far is that Option B or Option C, if the objective is to bring out 20 million dollars in subsidies, Option B or Option C is more palatable.

MEMBER AIELLO: So this may be way out there too. But I just figure we should hash everything out. What if we looked at whether the person wanted to choose it, like someone would choose the CDHP that was in the original plan that has a smaller premium but it has -- So it's like adding more plan options, but they decide they don't want to have the up-front and they'll pay that less rich CDHP, or if someone says, I would rather pay the more up front, I don't know whether that would work or not either. Just throwing -- It's going from three plans now to maybe more plans than that. And it's -- We're probably getting -- I'm probably getting way too complex, because that requires computer programming and eligibility and tracking and so.

MEMBER KELLEY: So Michelle Kelley here. Sorry.

UNIDENTIFIED SPEAKER: I was just going to ask you related to Betsy's question if you would be able to measure potential savings to the budget? Have we done that?

And I guess we might -- My preference, I would certainly say, you know, again, none of these options are good. You know, the board has done the best that they can and PEBP staff has done the best that they can with a very unfortunate situation that we have to look at. But I would say that I would be in favor of slightly higher participant premiums versus a less rich benefit design or cuts to benefits, simply because I think the impact to the individual employee paycheck each month would be a little bit less. One thing to consider is that, you know, premiums are paid pre-tax. So when an employee gets their paycheck, a difference of, you know, $44 versus $74 is not going to impact them nearly as much as an additional thousand dollars in out-of-pocket deductibles that they're going to have to eat, which are also going to be, unless they have the health savings plan, it's going to be an after-tax cost for them.

MEMBER KELLEY: Michelle Kelley here. And I know, Chairperson Freed, you asked for a more general take from people. I actually have a couple of specific questions about -- not about any of the proposals but about each of the proposals. That is I wonder -- And, I'm sorry, because this is only my second meeting. But I'm interested in what Aon and PEBP staff use the actuarial value to doing a design. I understand what the actuarial value is. But I'm kind of curious about how they use that to determine design. So that's one question.

And then the second question is something that Executive Officer Rich commented on in her report. And that was back in the July meeting the board made a policy decision to change the way the subsidy for the EPO and HMO as in, I guess, that was increasing it so that each of the subsidies were equal. And what we're seeing here is that that did result in significant decreases to that EPO/HMO plan. So I'm just wondering if -- what that would like look but for that policy decision. Because where I'm going is that the actuarial value -- I know you've referred to them as silver or low silver, gold, low gold. And so I am saying just kind of line them up with the private or the health exchange.

But I just -- I guess from my perspective, if we don't have a base plan anymore, then shouldn't they all have the same actuarial value and the difference be in premium? So that's really a general question. It's not about any of the specific options. I'm just trying to educate myself, I guess.

UNIDENTIFIED SPEAKER: So I can probably explain the actuarial value piece of it, but I think the actuary might be -- might be better at explaining it. Stephanie, do you want to kind of explain actuarial value and how it works?

MS. MESSIER: Yeah. So in terms of while you would have three different plans and not have their actuarial values the same, the point of offering three different plans is to really give folks choice. If you offered three different plans with the same actuarial value, it would be very hard to do, because actuarial value is very heavily weighted to the deductible, the out-of-pocket max, and the co-insurance threshold. So, in order to offer three different plans with an actuarial value, you would have to have those values be very similar to each other.

The reason that people offer plans with different actuarial values is that it's then letting the employee decide do I want to pay more or less than my paycheck to pay conversely the opposite when I need services. So from the folks that are paying less out of their paycheck, they know that if something happens or if they need to go to the emergency room or to the inpatient hospital, they're going to be paying more than someone who is paying more at time of their paycheck. So like the folks in the HMO plan, they pay higher knowing that every time they go to the doctor it's a co-pay. I don't have to wonder is it going to be a $200 bill, is it going to be a $300 bill. I know it's going to be my co-pay, which is, you know, 25 to 30 dollars.

Similarly, on the patient hospital, it's a set amount. It's a very predictable number. So they pay more for that. They pay a premium today to get that stability.

So what we were trying to do by offering the three new plans is to offer, again, a more diverse choice. We had put the AB's at equal distance apart. So we're offering that new plan halfway between the CDHP and the EPO plus HMO today to really give people choice and say, okay, I want to pay a little bit more than I was paying on the CDHP plan, but that middle plan now gives me the ability to go to my doctor for $30. And I know when my kid gets sick I don't have to worry about my CDHP having to hit my deductible first before my insurance technically kicks in. And then I can just go get my kid to the doctor for $30. And so that was kind of the point of introducing that middle plan.

And then I hope I answered your question on the actuarial value, but let me know, and I can elaborate more.

MEMBER AIELLO: No. I think you did. So, just extrapolating on that, so if you were able to come up with a rating for the premium, what you're saying is each of these, the actuarial value is a hundred percent, it's just where you're paying, front or back?

MS. MESSIER: Yeah, exactly. So our point was with also making that change in July that over time when PEBP had originally introduced the CDHP with the HMO alongside of it, this was very clear that their intent was the difference that you're paying in your paycheck you get back over the course of a year by how much less you pay utilizing services. However, because that wasn't monitored over time and the prices of the HMO was strictly tied to the renewals that PEBP was receiving from the vendors as a fully-insured product again proved to the point where a single employee was paying about 400 percent of what they should have been paying in terms of what they were saving during the year for services. So we really wanted to correct that situation that had gotten to a very disproportionate gap over a ten-year period but kind of resetting PEBP to a more actuarial standard structure and getting in to a point where again now the differences that folks are paying is in a more equitable place to what they are conversely saving or spending during the course of the year as they seek services.

MEMBER AIELLO: Thank you.

MS. MESSIER: Uh-huh.

CHAIRWOMAN FREED: Okay.

MEMBER LINDLEY: Hello, Chair.

CHAIRWOMAN FREED: Yeah.

MEMBER LINDLEY: Yeah, I wanted to chime in on your questions. I'm an active employee, I guess, representing active employees. Well, I am representing active employees. And one thing I considered is, to answer your question, is I'm a fan of lower initial premiums because we are already expecting -- I'm expecting furloughs which will directly impact my take-home pay. And looking at the rates shown, I'm the breadwinner of the family, and my whole family is on the CDHP plan. And Option A has a projected rate of 272. Option B is 343. And Option C, I would say, for the employee plus family is a lot higher than Option A. And as far as -- The choices we make today are temporary or could be changed in a year from now.

My wife works from home. I work from home. As far as getting sick and utilizing services, I can tell you that it's gone down significantly. I do know some people in the medical field where they are seeing less patients because they're not in school. There's less sickness being spread. We are actively maintaining social distancing, wearing our masks in public, and now with the governor's new three-week pause, with more action being taken to reduce transmission, not only of Coronavirus but of sickness in general, which would reduce our participation in utilizing services from primary care providers and specialists.

The last thing I want to see is my take-home pay go down even further. And that's why I do like Option A for the CDHP. So at this point that's kind of my opinion and my position.

One question I do have is I do like -- are we able to combine aspects of Option A with aspects of Option B and potentially aspects of Option C?

MS. RICH: For the record, Laura Rich. I think you have to be more specific. Because, obviously, every -- everything is a lever here. You move this -- You move this up, this goes down, and vice versa, right. So there's levers. I guess we would need to know what specifically you're looking at.

MEMBER LINDLEY: Option A I like the CDHP proposal. Option B I like the HMO proposal.

MS. RICH: So I think it goes back to what Stephanie mentioned is you have to look at this globally, right, you've got to -- you're presenting options that need to be -- if they're too close then it's basically the same option and the actuarial value is basically the same option. So you want to give people different options.

And let me look at Option B. What exactly are you looking at in the HMO in Option B that you would prefer to see differently?

MEMBER LINDLEY: Option B the HMO actuarial value is projected to be 87.2 for the HMO. Option A the CDHP actuarial value is 78.4 projected. The deductible increased by $500 and is even split between CDHP and HMO participants. The out-of-pocket maximum favors HMO at 5,000 versus CDHP at 6,000. The co-insurance favors the HMO at 15 percent versus 20 percent. And, of course, it goes down. The biggest benefit is to both a reduction in premium for the HMO. Because currently the HMO employee is at 171 and it still goes down to 162. And the family of that 689 going down to 551. I'm rounding here, of course. But the CDHP it goes up to slightly with a family reduction from 301 to 272. But the increase between the employee only, employee spouse, and employee plus children is all within ten dollars a month, which is about $60 a year. And it impacts my paycheck less than raising rates by a sizeable factor.

MS. RICH: Stephanie, do you want to chime in here?

MS. MESSIER: Yeah. I do just want to point out that if you enrich one of the plans -- Because we also made the decision in July to co-underwrite together the EPO with the CDHP, as Laura mentioned, so the CDHP will apparently go up. So you can't pull the premium dollars from one option and one plan design and directly put it on top of another because, again, the way the pooling works together. It is going to shift things a little bit differently. It's not a one-to-one change.

The other reason we were trying to keep the out-of-pocket maximum constant among the different plans for each of the different options is because, again, we're trying to really look out for the employees, I think. We're going to offer you a minimum, regardless of which plan you pick, the same maximum coverage. At most we want you to pay either $5,000 in one of the options or $6,000 in another option. We don't want you to have inherently picking the plan and something bad happens that year.

And I believe Prior Board Member Mitchell, given her situation, had mentioned that, you know, she looks for the lowest out-of-pocket maximum because she knows that she's going to hit it, right. And so the purpose of trying to get the same out-of-pocket maximum regardless of which plan is to really to protect the employees that don't understand health care as well and is more equitable in terms of protecting employees at the same level regardless of which plan they pick. So I just wanted to mention there was some logic behind the decisions on the out-of-pocket maximums from one option to another.

MEMBER LINDLEY: Well, I just wanted to express my answer to Chairman Freed. Chairwoman. Pardon me.

CHAIRWOMAN FREED: I appreciate that. I think I hear something of a consensus. Although I want to say I understand and share your remarks, everybody, around Option B to kind of -- because it takes sort of a way of increasing premiums for '22 and bumping up the deductibles and out-of-pocket max but not in a way that is quite so drastic as Option A. Is that a fair statement to make? I'm viewing this kind of in discrete chunks because I'm trying to keep the discussion focused on one thing and one chunk of subsidy at a time. So, number one, is that a fair statement?

Number two, the other thing that I would note is that if the governor's finance office in consultation with the governor's office says, no, we don't want to do that to PEBP, I think this is the -- 8.1 is the way to give something back. And I think what they would give back there is deductibles and out-of-pocket max if they wanted to spare PEBP a subsidy cut.

MEMBER AIELLO: This is Betsy. I do have one last question. So when we're talking about the Option B, we're looking, according to Laura, at the five percent level. And is that giving us the same amount or close to the same amount off of the 36 million that the other grid is?

CHAIRWOMAN FREED: Yes. Option 8.1-A, B, and C are all designed to basically yield 20 million dollars in subsidy savings, just using different levers to do it.

MEMBER AIELLO: Okay. Thank you.

CHAIRWOMAN FREED: Okay.

MEMBER VERDUCCI: This is Tom Verducci for the record. I want to answer Chair Freed's question that I would not prefer plan design changes. I would really like to see the changes in a temporary fashion with higher rates. You know, I would like to see a sunset provision as well and see if we're in better shape to restore benefits. I don't want to see anything permanent or any elimination of benefits on a permanent basis. I think that if we could get through with a surcharge and have it sunset at some point that hopefully in the future we can get back to the exact same benefits or even better benefits than we have today.

I just really hate reducing benefits and just the impact that it has on so many people. Whatever we could do to restore them and get through this crisis on a temporary basis is what I would prefer.

CHAIRWOMAN FREED: Okay. Thank you, Mr. Verducci.

MEMBER LINDLEY: Chairman, can I add too?

CHAIRWOMAN FREED: Sure.

MEMBER LINDLEY: I do remember, I started state service in 2013, and I do remember reviewing the health benefits plan for my wife and I. And I looked through my old documents. I do know that the individual deductible back in

2013 was about $1900 with an out-of-pocket individual max of $3900. And today they're at $1500. And I do know that during the public comment section, they said, you know, benefits get reduced and they don't go back. But, just on my seven years of state service, they have gone down, although I do understand that's not pre-recession rates. But they do change in reflection of current economic status. Another example would have been co-insurance. Co-insurance was 25 percent back when I started and now it's down to 20 percent.

So, I do like the idea of a sunset. I love that idea because it doesn't hog-tie us to permanent changes. That's all.

CHAIRWOMAN FREED: Okay. Thank you. All right. So, Board Members, I think I'm going to ask you to choose one of these three to put forth and then go on to the other 16 million in subsidy reductions.

And I hear that most board members would prefer to do as little to the plan design as possible and make it up in the higher premiums and make a policy statement to the governor's finance office that we would really like to see this -- see the subsidy levels return to what they were before we entered this fiscal crisis.

And I can well sense the board's reluctance to make a motion or talk more about it. But we are, unfortunately, not in the position of deferring this decision because our next board meeting is in January and January is when the governor's recommended budget is released to the legislature. So, if the board does not decide, the governor's finance office will decide for you. And you may very well not like what you get, so.

UNIDENTIFIED SPEAKER: I just have one quick clarifying question, please. Because these are only specific to Plan Year 22, as Laura indicated when she was giving her -- Laura Rich, the executive director, had indicated when she was giving her review of these three options, that in Plan Year 23 we can still expect to see an additional 30 to $40 on each of these premiums; right?

MS. RICH: Right. So Laura Rich for the record. Yes. So the way trend works is your -- the way that the PEBP program works is the legislature approves a subsidy level in the first year of the biennium. That subsidy level then, depending on what trend is on the second year, the participants get to absorb that entire amount because there is no way to go back to agencies and essentially say, you know, we need more money. And so it gets kicked back to participants. So, expecting that there is going to be a certain amount of trend in that second year, those premiums will be expected to go up in Plan Year 23.

So if you're looking at 74.65 for an employee only, today they're paying $43. About $43 is going to go up to almost 75. And in Plan Year 23 it could go up, you know, potentially by another $30.

MEMBER AIELLO: I have a question. And, again, I'm just -- So could we take -- This is a slightly new plan design like we said in the B. So we are giving back with some of the plans in mind. But could we -- If we took that plan design, could we say the premiums are the same as this year plus excess surcharge, which would be the difference? So the one that's 74.65, if it's 43 now, that's $31. I'm just rounding it. So we would say the premium is $43 and whatever, plus a $31 COVID surcharge. So you are getting the same amount of money but it feels like it's not as much the premium raising. It would honor some of the public comment, get to the same place. Just throwing that out as an option. I don't know.

CHAIRWOMAN FREED: This is Laura Freed. I'm confused. So, the surcharge, what in that instance is the difference between a surcharge and just raising the rate?

MEMBER AIELLO: There is no difference in the final outcome. But I think what I heard from the public comment was people were more comfortable paying that added money in a surcharge because the surcharge didn't seem like it might last as long.

CHAIRWOMAN FREED: Oh, but that's a rhetorical design, is it not?

MEMBER AIELLO: It is. It is. But that's still what I thought I read in all the public comments from everyone once they felt that they knew that more money was going to have to be paid, but they were more comfortable with it being called a surcharge. Unless I missed what they --

CHAIRWOMAN FREED: Okay. I think maybe your understanding of it is different than mine. Because when I was reading the public comment was is everybody pays the same surcharge and that's where I characterize it as a flat tax as opposed to just increasing the premium based on coverage tier.

MS. RICH: This is Laura Rich. Can I just add something to the COVID surcharge that I think is important to emphasize? A year from now, crossing my fingers, COVID-19 will be hopefully a thing of the past, we'll have a vaccine, and it will be something that we -- it doesn't dominate our lives like, you know, it does today. We will be imposing the surcharge for the very long foreseeable future, potentially.

I think PEBP is going to be a hard -- is going to have a hard time spinning that and selling that in, you know, after COVID is, you know, said and done and gone. People are going to be asking why is it that PEBP is imposing a COVID surcharge. We have a vaccine. Oh, and if there is potentially a stimulus package that gets passed, they're going to ask, well, why is it just that PEBP is imposing a COVID-19 surcharge when the feds have released this, you know, stimulus package. Why are we working out the cost for this while the state is bringing in revenue from, you know, the federal government. And so these are all potential communication challenges that we're going to have by calling it a COVID-19 surcharge.

MEMBER VERDUCCI: Yes. Tom Verducci for the record. So I think if we had a sunset provision where if everything was readdressed one year later and maybe we come out of COVID and also the legislature in the next plan year could make a decision to increase subsidies and funding. And I do think if it expires, you know, we're forced to readdress it and see if we're mandated to continue to see higher premiums, or if it sunsets, it goes away a year later and we get right back to where we were.

MEMBER KELLEY: This is Michelle here. I have a question about Option B and also just a comment. So, in previous years, Executive Officer Rich, hasn't the legislature actually approved health insurance subsidy increases in the second year of the biennium to cover

inflation? And isn't that something we could request this
year even if it's just a small increase? We could take the
full 12 this year. Obviously we will be passing that on.
But if we can somehow build in that cost of living, the
increase of subsidy in the second biennium, that would be
great, right.
But, specifically, my question regarding Option
B, I'm just a little -- I'm getting in to the details, so I'm
very sorry about this. But I'm looking comparing the
modified CDHP with the low deductible PPO and just purely
using the rate for employee only, you know, I subtracted the
74.65 from the 102.92. The difference in premium per month
is $28.27. If you multiply that out by 12, the difference in
premium for the whole year for the co-pay plan is $340. And
on the high deductible plan you're giving $500 in to the HRA.
I'm having a hard time seeing how the average
employee wouldn't go to the low deductible high PPO. There
doesn't seem to be, you know, like the co-pay plan seems to
be extraordinarily cheap I guess is what I'm saying, compared
to the CDHP, which has been gutted in the proposal; right?
MS. RICH: So let me -- let me chime in on the
first part of your question. And then, Stephanie, I think
you can probably address her second question. So, yes, to
answer your question, the legislature does -- they do approve

a subsidy in year one and a subsidy in year two. However, if the trend is different in that second year, if there's circumstances that PEBP hasn't accounted for, that is 100 percent picked up by the employee, because there is no mechanism in place to go back and ask the legislature to increase that subsidy in the second plan year. I know that we have worked with GFO -- And Ms. Eaton might want to chime in as well. But we have worked with GFO to try to even out these increases a little bit and possibly apply more toward -- or less in year one and more in year two to make up for that difference. So we're trying to try to even it out as much as we can. But, again, with these significant cuts, you know, I mean, we're talking 72 million dollars, it's really difficult to not have some major impact, whether it is in premiums or benefits. You just can't get away from it one way or the other.

So, Cari, do you want to add to anything that I just said?

MS. EATON: No. You really hit it spot on. We are able to, you know, just to shift a little bit more of the subsidy to the second year just, you know, in anticipation of that increase in trend and to even out the hurt to the people paying more when trend does increase.

MS. RICH: Stephanie, do you want to maybe take that second part of that question?

MS. MESSIER: Can you repeat it? I apologize. It's been a few minutes and I want to make sure I remembered it correctly.

MEMBER KELLEY: Yeah. I just -- What I was just pointing out is that if you do the math purely on rate, the low deductible PPO is a total of $160, for employee only, the low deductible PPO on an annual basis is only $160 more expensive than the consumer driven high deductible plan.

MS. MESSIER: Under which option? I just want to make sure I'm following the right page.

MEMBER KELLEY: Oh, I'm sorry. I'm looking at Option B. And so what I've done is I just kind of took the difference in the premium, I subtracted the $500 that the HSA provides for the difference of $160 for all of those co-pays. So I'm just a little confused about, you know -- And that's spread over 12 months and you get the co-pay. So I guess I'm confused about how these are being -- And I understand that the premiums are, you know, will change, but they're accurate, I guess, up to kind of the claims that are up to date, right? So why would the actuarial values be so much -- yeah, the actuarial value, why is -- I just don't see how everyone wouldn't switch in to the high deductible PPO plan because it was only employee only that is only going to cost you $160, but you get predictability when you go to the doctor.

MS. MESSIER: Well, I think it depends. I think some folks that are in that employee plus family tier that do not pay $343 today but tomorrow if you pick Option B they do have to pay $343. They may not have that additional $70 to cure up in to the co-pay, the new co-pay plan, that's 410. So each individual family, if you're making 30 grand a year or 40 grand a year, any kind of change that's being made on that participant premium is already probably a burden to those folks, right? So I think you're going to see a lot of people sticking with the CDHP plan and not moving in to the co-pay plan.

Now, we designed the co-pay plan with the hopes that people would take a hard look at it, right? Like, we do feel like it's a good plan, and that's why we're proposing it. We want those folks to be able to have that predictability and be able to go to see the doctor, you know, on a co-pay. Same thing with getting their prescriptions filled on a co-pay. But it does come with a little bit of an increase in cost, because, again, the plan is paying the same regardless of which plan people pick. And you see that in the base subsidy amount. So then the cost that comes out on top enters the participant premium.

MEMBER KELLEY: I guess I'm just curious about shouldn't there be some risk factor built in to the CDHP?

MS. MESSIER: There is.

MEMBER KELLEY: So employees are incurring all of that risk for employee only $160 a year?

MS. MESSIER: They're actually getting a benefit. It's assuming the people that are less expensive are in that plan. So they're actually getting a benefit of being lower risk folks.

UNIDENTIFIED SPEAKER: So can I add some context to this, maybe? So, for example, let's say that there's a young couple, they're, you know, 25 years old, they are, you know, in entry level positions in the state, they're young. Most of the time when you're 25 years old, you are not necessarily -- you don't have chronic conditions. You're not incurring high cost in health care. But, at the same time, health care is really not too important to you because you don't -- really don't receive care very often. But at the same time it's your -- you're 25 and broke. You don't have the ability to pay, you know, $150 a month for something that you don't necessarily utilize.

And so a lot of these people on the CDHP are a-okay with that benefit because what they're paying out of pocket monthly is very, very low, and they are assuming that they are not going to be using health care as often as, you know, many others would.

And then you get in to the low deductible co-pay plan. That's kind of a middle option. So, let's say that there's possibly, you know, a family with children who happen to go to the doctor quite frequently. So if your family has children, any time you go to the doctor, you're paying out of pocket because chances are you have not met your deductible, you have not met your out-of-pocket max. So what that low deductible plan offers is the ability for that family to take their sick child who has an ear infection and they can do that for 30 bucks versus having to pay the entire cost of an office visit, this co-pay option does offer that choice.

And then you've got the EPO and HMO, those are people who usually have more chronic conditions. They want to rely on those co-pays, on the expected premiums, out-of-pocket premiums that they know that they're going to pay and they will be then -- You know, they know what to expect, they know what their health care is going to cost.

Now, obviously this is just an example. This only covers, you know, just these are examples that I'm using for each type of person or type of experience. There is, obviously, people with very chronic conditions who are okay with being on the CDHP. They are okay with they want to contribute to the HSA. So that just kind of puts some context in to why people would choose one over the other.

MEMBER KELLEY: I guess I'm just troubled because we're -- I think in July when the board passed their policy of subsidizing each of the plans at the same rate, I don't think anyone anticipated the plans ending up in saving such a huge amount. And so when I think what I heard from employees and when I look at kind of the design, it feels like the budget is being made whole on the back of the CDHP. And I guess so, you know, I mean, and in some ways the design as it is, I feel like it is self-fulfilling philosophy where you're kind of going to drive -- you'll either have -- you'll have modified CDHP where people are already defaulted. Or they're looking for another way.

But I do think -- But it concerns me that there's not a base plan, you know, whereby if you subsidize the base plan at a slightly higher rate obviously that impacts the premiums for employees, which comes back to some of Tim's comments.

So just, I think, the unintended consequences of a policy change in July in a vacuum and now the 12 percent that's needed to be saved are kind of (unintelligible) to me. It just feels because it's all changed, right, the actuarial values, everything has changed, to kind of fit in the 12 percent cap and then also the subsidy being the same across all three plans. So that's my concern.

MEMBER LINDLEY: Tim here. I just wanted to thank Laura for that context because, yeah, I am the CDHP plan and I may eventually go to the co-pay plan as my family grows and wind up in the HMO plan as I get even older. Or more experienced. Pardon me.

MEMBER KELLEY: The only other question I have is an easy, so it won't take long. So just the detail between calling it just your monthly premium and the COVID surcharge, could we run in to issues with the taxability or the pre-taxability of a surcharge on health insurance if we call it something like that?

MS. RICH: This is Laura Rich. That's actually a very good question. I think, I mean, it comes down to semantics. I think it's all how the plan is built. That's probably a question that we would want to run through compliance and possibly through legal as well just to make sure that that would be feasible. Because, you're right, it's got to -- it has to -- in order for it to be pre-tax, it has to be meet certain --

MEMBER AIELLO: This is Betsy. That is a great point. I was just responding to public comment. But that's a really good point.

CHAIRWOMAN FREED: So, based on Member Kelley's comments, is there any appetite to reverse our policy decision about the plan design from July and just have as we do now a CDHP and an EPO/HMO?

MEMBER LINDLEY: Thank you for that curve ball.

MEMBER KELLEY: Well, and just to reiterate, I thought one of the policy decisions Executive Officer Rich stated was to make it in July was how the subsidy was applied. The subsidy would be equal across all three plans. So I wasn't sure if that was actually wrapped up with the low deductible or the regular PPO plan or whether they are two separate letters, I guess.

MS. RICH: Chair Freed, I just need to go back. If we do -- If we're looking at really going back just to CDHP and the HMO and EPO, there's honestly no way that we can submit a budget tomorrow because we would have to go back and draw up the analysis --

CHAIRWOMAN FREED: Well, the workbook part, I get it. I was just trying to -- I think the answer to Member Kelley's question is that if that is the application of the subsidy equally rolled in to this, and I think -- I'm almost sure the answer is yes. And I was trying to address her concerns that we might be causing some -- inadvertently causing some sort of adverse selection away from the CDHP.

MEMBER AIELLO: Probably would be an open meeting law issue too because the policy change for that isn't really on the agenda item.

CHAIRWOMAN FREED: Fair point. Fair point. Okay. So that kind of brings us back to this 8.1 as the way to get most of the subsidy reductions that we are asked to submit, you know, being forced to choose the least worst option, do you like A, B, or C better. I have heard general least discomfort with B.

MEMBER LINDLEY: Tim here. I'm a fan of Option A just because it's --

CHAIRWOMAN FREED: Fan of Option A, okay.

MEMBER LINDLEY: -- a lot less.

MEMBER KELLEY: So Michelle Kelley here. So my -- So, obviously, I think that I prefer Option C. However, I am conscious that we still have to look at all of the other items that are about, you know, 12 million dollars, right, that are not the 20 million dollars and 16 million dollars. So I think that based on that -- based on whatever happens out of that, then I think Option B might be the place to start today.

MS. RICH: This is Laura Rich. I just also want to say, one of the, obviously, one of the options, Option 8.10, unbundle dental, which will add yet another premium to an already higher premium if we move to Option B. So it's definitely something that has to be taken in to account.

MEMBER FOX: Linda Fox for the record. Should we rank these to get through this, which items should be ranked A, B, and C?

CHAIRWOMAN FREED: We've done, like, choice voting in the past.

MEMBER FOX: I think that might be the simplest.

CHAIRWOMAN FREED: And so I think I have to ask staff to get their score sheets out and then I can then do a roll call as we have done in the past and then each member can state their one, two, three preference for A, B, or C, and we'll see how we arrive at your census that way.

MEMBER AIELLO: And this is Betsy. I'm just wondering -- And maybe would it behoove us to talk some of the others through ahead of time? Because one of the other options is to adjust premiums down below. And so if there's a bunch of things down below we don't want to take, then maybe we would lean more to the plan on Option A but with an adjusted premium from that? Just wondering if we need to -- Because it is levers that play.

CHAIRWOMAN FREED: Right. I'm going to throw that to the executive officer to see if -- I think it's 8.2 through, like, 8.8. It's fairly discrete savings measures.

But, you're absolutely right, that 8.10 does and then in 8.11 increases in premium saving varies. So how does that -- how does that play in to 8.1?

MS. RICH: So, yeah, I mean, I think that maybe going through a lot of these other options and discussing those first might be helpful before voting on this first part.

CHAIRWOMAN FREED: Okay. Then take it away with 8.2.

MS. RICH: Okay. So, I mean, I'll just throw it out. The first -- Go ahead.

UNIDENTIFIED SPEAKER: Before we move on, can I just request a quick, like, five-minute break?

CHAIRWOMAN FREED: Absolutely. It's 1:06. I'll see you guys at 1:10.

(Recess was taken)

CHAIRWOMAN FREED: Hello again, everyone. It's 1:12. Let's call the meeting back to order and go back to 8.2 and so forth.

MS. RICH: Okay. So, for the record, Laura Rich. I'm going to start out with saying that the first three here are fairly benign options. The rest of them not so much. But at least we do have a few here that are benign.

The first one is 8.2, which is addressing the out-of-network bill charges. What we're doing here is today on the CDHP, when we have an out-of-network part, what we do is their health is historically then considered basically be the claims payment market solution for the pricing of these non-contracted providers. They maintain a database of bill charges by service code and zip code and we pay them essentially office tax. This is referred to as their health usual and customary charge.

What we are proposing here is moving to a reference-based pricing Medicare model where we use Medicare to essentially control the pricing and establish a price point in a geographic location. And so what we're doing here is proposing that we move to basically instead of using fair health standards as the usual and customary charge is moving to 140 percent Medicare premium. What we do is we would pay for these services at 140 percent of what Medicare pays today. So it's a fairly standard method of payment as something that providers are very used to and comfortable with and understand and that this will bring in approximately almost two million dollars, 1.9 million dollars on that. So I will stop and see if there's any questions on that one.

MEMBER KRUPP: This is Jennifer Krupp. Oh, excuse me. That 1.9 million, is that claims payments that would be reduced or is it just a contract that we would be

terminating? I'm a little confused on that.
MS. RICH: So they're not contracts. So essentially for out-of-network bill charges, so when someone goes out of network, it means that there is no provider contract in place, we have no contract in place there outside of that network. There is no contract in place. So we have to pay them somehow. And so what is a fair price to pay? Right now we use that usual and customary charge instead of what we are moving to with the Medicare reference-based pricing model of that 140 percent of Medicare. So if Medicare pays X, PEBP will pay in our plan rules. Our plan rules will change, so it will be -- it will say that PEBP will pay X times 140 -- It's 140 percent of Medicare, which is a reference-based pricing model that is -- that people are moving to, that plans are moving to nationwide.
CHAIRWOMAN FREED: This is Laura Freed. One question. So this is out-of-network claims obviously for actives and non-Medicare retirees; right?
MS. RICH: Yes. Sorry. So this is anyone on the PEBP -- on any of the PEBP.
CHAIRWOMAN FREED: Thank you.
MEMBER KELLEY: So, Laura, it's Michelle Kelley for the record. Do we have employees and retirees in Nevada who live so rurally they don't have access to a network?

And, if so, do you know personally how many and how those communities are going to fare with a reduction essentially because the employee ends up having to pay that cost, right, or the provider has to eat it? So I'm just wondering, like, how it impacts our rural folks.

MS. RICH: So the rural folks, unfortunately, they're going to be impacted but not so much because of the network. It's -- So, obviously, our network is an in-state network, it's provider-based. And so that's something that is a challenge in Nevada, not just in our plan but in health care in general, right. So you get up to the rurals and there's a shortage of providers, there's a shortage of specialists and things like that. So whether they have access, yes, they have access, but maybe not within five miles, maybe not within ten miles. So that is a challenge within our health care system, not necessarily on a PEBP level. Does that make sense?

MEMBER KELLEY: Yes. Thank you.

MS. PEARSON: Laura, can I add something there? This is Mary Katherine Pearson for the record. Just to clarify, while this reasonable and customary fees will not really have any impact on the people who are in the rural areas, but the providers who are there, and there's not a lot of them, those providers typically participate in the network. This is really, you know, there's out-of-network utilization sort of spread all over. So whether it's southern Nevada, whether it's northern Nevada, whether it's folks who are out of state, it's fairly all over.

But this is also something that we're really seeing across our book of business. So it's a change that a lot of people are making. And we've also seen it in some of the choices really encourage providers to move in to a network because there's more of a reason to do so versus, you know, staying at that higher reasonable customary level that's coming through.

MEMBER KELLEY: I see. Uh-huh.

MEMBER VERDUCCI: This is Tom Verducci. I think 8.2 is a reasonable cost-cutting measure and we save 1.9 million, in that range, number one, and I do think that the out-of-network billing is very acceptable and I'm in favor of adopting that one.

MEMBER LINDLEY: I would second Tom's position as well.

UNIDENTIFIED SPEAKER: I agree with it.

MEMBER VERDUCCI: Okay. Tom Verducci. Can I turn that in to a motion?

CHAIRWOMAN FREED: Of course. So I feel like you and I had the same thought at the same time. Please go ahead.

MS. RICH: So I think what we need to do here eventually is rank them. Not so much -- Not so much a motion needed for each one of them. I think that there needs to be a ranking of what is most palatable to least palatable of these options.

MEMBER VERDUCCI: Tom Verducci. That was the number one rank on my grid sheet. So, 8.2, I rank that one number one. That is most palatable.

MEMBER LINDLEY: Do we want to raise our hands perhaps?

CHAIRWOMAN FREED: Well, I guess in going back to the discussion we were just having about rank choice voting on 8.1, I guess we can pull out the score sheet again and have everybody tell you -- tell staff their rankings on 8.1 through 8.10. But, I mean, I would prefer, honestly, from a legal standpoint that the board take action on all of them. And we can do that all at once or we can do that separately.

But, I mean, to help staff in case the governor's finance office in consultation with the governor's office wants to put some of it back, I mean, I am hearing a lot more consternation on 8.1 and the plan design premiums than we might hear on, well, at least a few of these things. Okay. So let's do that.

Let's have the executive officer and the staff go through 8.1 through 8.10 and then we can hear the rankings from everybody, and then we can vote on them. Sound good? Okay. Let's do that.

MS. RICH: So moving on to 8.3, some of you may recall that in Plan Year 19 PEBP implemented Smart 90 to the CDHP on a voluntary basis and then in Plan Year 20 it became mandatory.

For those of you who do not know what the Smart 90 program is or need a refresher, basically Smart 90 improves drug pricing on the 90-day maintenance medications through that program. And what it does is essentially it narrows the pharmacy network to only Smart 90 participating pharmacies. The two major ones that are excluded from this network are CVS and Walgreen's.

When we did this on a voluntary basis on the CDHP, you know, there were obviously complaints here and there. But, for the most part, I think that that transition was made fairly easily, especially since we did it on a voluntary basis the first year and then mandatory the second year. Essentially, what it does is it mandates that 90-day prescription be filled in through any participating pharmacy.

What we are proposing here is to add this to the EPO and low deductible plan as well, and that should bring in approximately half a million dollars in savings through this program alone. I'll stop there for questions.

Okay. So 8.4 is very similar to this, similar to Smart 90. The express advantage network will -- it moves it to the 30-day prescriptions for both members and -- I'm sorry. 30-day prescriptions, narrowing of that pharmacy to fill those 30-day prescriptions, not just the 90-day prescriptions as in the Smart 90 but also the 30-day prescriptions.

The difference here with this option versus the Smart 90 is that with Smart 90 we mandated and the program or the plan does not pick up the cost of the medication if it is filled outside of one of these pharmacies. However, in this situation, the advantage network using that express advantage network, if you use it, great. If you do not, you pay a ten dollar fee, essentially.

And this is the proposal here is to be adding it to the CDHP, EPO, and low deductible plan. So in these two options this does affect the active pre-Medicare retirees on the CDHP and EPO and low deductible plan as well. So it excludes any Medicare exchange retirees. Any questions on that one?

Okay. Next one is 8.5. This is a reduction to the Medicare health reimbursement arrangement contribution.

This affects Medicare exchange retirees. These are the only group able to receive a Medicare health reimbursement -- Medicare health reimbursement arrangement contribution. Right now that contribution is $13 per year of service up to $260. So you top out at 20 years of service. What we are doing here is proposing reducing that from -- And there's two options -- from $13 per year of service down to 12 or from $13 per year of service down to 11. The difference there is down to 12 saves the plan 1.7 million dollars. Down to 11 saves the plan 3.4 million dollars. Any questions on that one?

CHAIRWOMAN FREED: I have a question. This is Laura Freed. How many Medicare retirees spend 2,000 -- Because $13 per year of service times 12 months times 15 years comes to $2,340 a year. How many people spend that from their HRA on their Medicare premiums? And if we were to reduce it to 2160, which is $12 times 12 months times 15 years of service, how many people spend that out of their HRA, if we know?

MS. RICH: We could certainly do that analysis. I know that back in, if you remember back in April, we did -- we capped the HRA's because there were a lot of members who were not using their HRA at all. Whether it is because they did not need to use it, whether it's because they don't know it even exists, it's still a mystery to me as to why some of these retirees are not using it at all.

Now, there are retirees who use their HRA on premiums. You've got your Medicare Part B premium. You have, you know, they've enrolled in our dental plan. They can pay for that premium as well. And then there's also obviously out-of-pocket costs that they can incur on their Medicare plan.

And so there's -- while it is -- it's definitely a very beneficial contribution, there is a certain percentage of the population who, as you heard back in April, doesn't use it at all. And then there's many, many Medicare exchange retirees who are on zero premium plans as well. And so, really, they're not using it to the degree that they could be using it or that they have a better benefit than what they need.

Now, I'm sure there's, on the flip side, there's people who probably use it every single month and use it for out-of-pocket costs or any premiums that they have. So we can definitely -- We can do that analysis.

I don't know, Cari, is that something that you can do just sort on the fly while we're talking?

MS. EATON: I can try to see what I received from Towers Watson, our utilization. But I may need Towers Watson to give definitive useful information. But I will look.

CHAIRWOMAN FREED: Any other questions?

MS. RICH: Okay. So 8.6 is the reduction or elimination of the basic life insurance benefit. This affects all PEBP members. Currently we've got actives who are receiving $25,000 in basic life insurance benefits and retirees who are receiving $12,500. So the options here are to reduce it or eliminate it. Reducing it to $20,000 and $10,000 brings you down to about 1.3 million dollars in savings. Reducing it to ten and five brings about four million dollars in savings. And completely eliminating it brings about seven million dollars in savings.

I do want to state here that the average burial -- I looked that up the other day -- is about $7,000. And so this life insurance benefit is a basic life insurance benefit. We do offer voluntary life as well through our voluntary platform. There's plenty of people that have a voluntary buy-up life insurance option. But this is, here, this basic benefit is, it's not a very rich benefit.

So, that being said, covering the cost of a burial, I think, is important. It's important to be able to at least do that and to keep that benefit. So even, you know, reducing it to that option two makes sense. Eliminating it might be -- it might be one of the more extreme options. But I just wanted to put that out there that I did look that up and an average burial is about $7,000. Obviously that changes with location and, you know, other variables as well.

So the next one is the elimination of the long-term disability benefits. And I'm sorry. I should have paused there. Is there any questions on the life insurance before I move on?

MEMBER LINDLEY: Just a point of reference because I did mention I looked up the benefits back in 2013 when I started. At that time, the employee retiree benefit was 10,000, 5,000. And, knowing that it was that amount, I did go private and secure my own life insurance benefit.

MEMBER VERDUCCI: Tom Verducci for the record. I don't really like the idea of eliminating any benefits. I mean, I really don't even like the idea of reducing it. But I think elimination should really come off the table. I don't really see us being asked to eliminate benefits. We're trying to get through a catastrophe here. And, once we go in to elimination, we're looking at plan design changes. I do agree that it's barely enough for burial. One of the problems we face is we are managing a health insurance program. We have some ancillary products that are tied in to it that affects the pricing, life insurance, long-term disability. But I'm very much against creating any kind of catastrophe for anybody. In creating a catastrophe, we're going against our mission statement, which is not to create a catastrophe, especially when we're looking at the retired, elderly group that are probably getting hit the hardest in terms of their income levels. So, you know, my thought is to really avoid any kind of elimination.

MEMBER URBAN: Marsha Urban for the record. I agree. I think that at least guaranteeing someone that they can be buried for $5,000 maybe, you know, have to kick in some extra money. But I think that that's important. And eliminating it is just not something that I would like to do. I myself have no children, so I don't need life insurance. But this would guarantee that my family wouldn't have to pony up to pay my funeral.

MEMBER KELLEY: Michelle Kelly here. Just a last point in support of not eliminating. It's great that, you know, that once you finally realize that the life insurance was a lot if you elect voluntary, but a new hire is an opportunity where you get guaranteed coverage. But, if we eliminate life insurance, there is many people that would not qualify for health reasons for picking up life insurance and/or couldn't afford the premium for the insurance they could get. And so the elimination of the life insurance could create a lot of issues. One would mean that they can't be buried. But it's important to note that many people would not be able to replicate this insurance themselves.

MEMBER LINDLEY: Tim here. If I can clarify. I'm definitely against eliminating it. Definitely. That was just a point of reference from when I started the state service.

MEMBER KELLEY: I realize that. I was holding you out as the trophy boy. That's good.

MS. RICH: Okay. So if there's no more questions on that, I'll move to 8.7, which is the elimination of the long-term disability benefits. This benefit only will affect active employees. Obviously retirees would not be eligible for this benefit anyway.

The benefit is designed to help protect against loss of income in the event of a disability that results in the ability to work for an extended period of time. If you look at the utilization here, you had 21 claims in Plan Year 20 and 25 claims in Plan Year 19. We have a total number of access claims of 117.

There's two things here that I want to emphasize. One, this would be made available, as was spoken to the standard, this could be made available as a voluntary option through a voluntary platform for more employees to purchase separately. And, two, any of these should just be eliminated any of the active claims today would not be affected whatsoever. So I just want to make sure that those two things are highlighted. And I'll stop there for questions. I know this is --

MEMBER AIELLO: I have a couple of questions, comments. As mentioned in some of the public comments, state employees aren't eligible for social security disability. And if you worked anywhere else, you are eligible for social security disability, so you do have some income. I'm not sure though if our disability is a richer plan than social security, if it's paying more. Because some of these others we did have reduction option versus just total elimination, as we've heard. So I don't know if ours is richer if it could be a potential savings if we brought it in line with social security. But because social security isn't an option, it may only be a few people, thank goodness, families that have to have this, but it can devastate the families that do.

MEMBER LINDLEY: Betsy, Laura did mention that the 117 active claims would not be affected. Is that correct, Laura?

MEMBER AIELLO: If you were to become disabled tomorrow and you weren't an active claimant and we eliminated this, you wouldn't have social security, disability income, or this disability income.

MY background is an occupational therapist. I worked 20 years in inpatient physical rehabilitation. So I did see how many families. And at least the majority of the families did have social security disability. And the state employees don't. But that's just -- that's kind of my personal background. And so that's what I was wondering if we're paying a richer benefit because I'm concerned for those young families that may have something happen.

MEMBER LINDLEY: I agree with you, Betsy. So I guess the question is can we get away with not eliminating it but keeping it in line with social security?

MS. RICH: So I do have -- For the record, Laura Rich. I do have Kurt Kemp. Hopefully he's on the line. He represents The Standard, who offers this product. Kurt, are you available to kind of discuss this option? I know that at the last minute you had sent a few things that -- some options that were not lined out in the board report due to training. Again, we had 13 days to come up with this. So Kurt, do you happen to be on?

MR. KEMP: I am. Hi. So, thanks. Kurt Kemp for the record. Nice seeing all of you. I know this is a tough, tough meeting. So thanks for including me. And sorry for my voice.

So, regarding social security, you know, that's really a moving target in the sense of, you know, depending on years you qualify, dependants, that kind of thing. I would say in general the plan that the state provides is probably more generous than what social security offers. Traditionally a group plan will offset a social security. So if a member is awarded down the road social security, the group plan would alt that amount. Your benefit is 60 percent of earnings up to 7,500. So it's a good plan, especially since your average wage earner, as I heard earlier, is 40,000, which equates to about a $2,000 monthly benefit. So, yeah, so that's kind of my response regarding social security.

So, yes, you know, is it possible to design the plan where it's a little bit more even with a potential social security buy-out? Sure, we can definitely look at that and provide some options.

As Laura mentioned, we also provided a few options -- And I'm looking it up here -- as far as ways to continue to offer the plan but pare down the benefits. And there's a lot of ways to look at this. You can, you know, you have a 60 percent plan, so you could change that to 50 percent and pay ten percent less. It's kind of like what

Laura said earlier about levers. Premium is based on levers, which is LTD plan, so everything has a cost associated to the plan design element.

So one option we provided was producing a 60 percent benefit to 50 percent, lowering the maximum from 7500 to 5,000. You know, continuing to have your 180-day benefit waiting period. And your current benefit duration goes through age 65. And that does allow some payout beyond 65 if you were to become disabled towards your retirement years. But, again, this is an active benefit. But that would result in an estimated savings of about 1.5 million by making that plan change.

And, again, you can look at this a lot of different ways. So I just provided a few.

And another option, the same 180-day benefit waiting period would change the benefit duration from a benefit that would pay out to age 65 and make it a five-year duration. So most people will come back to work within that five years. But the potential of someone who becomes -- has a major illness or, you know, becomes disabled and it's not something they can come back from, that could affect those employees. But it would capture most people who traditionally do want to come back to work. You know, no one really wants to sit at home and be disabled.

A couple of other options. Keep the 60 percent benefit to 7500 and you can reduce the benefit duration to two years. And the five-year duration with 50 percent plan, that would save an estimated two million dollars of annual premium, okay. And then that last option where you keep the 60 percent to 7500 and reduce the benefit duration, meaning we stop paying claims after that two years. That results in about a 1.8 million dollar savings.

So you can really slice and dice this a number of different ways and keep people -- keep, I'd say, the majority of the PEBP population pretty whole as far as depending on what their income is. It would affect -- By decreasing the maximum, you're going to be hurting your higher wage earners. By reducing the benefit percentage, you're going to -- you know, you're going to affect more the normal PEBP employee. So any questions on that?

MEMBER LINDLEY: Tim here. Thank you very much for that, Mr. Kemp.

MR. KEMP: Sure.

MEMBER AIELLO: I do know that, again, PERS has a disability retirement. But people in their beginning years wouldn't, even if they had been over five years, it would be a very small benefit unless they had worked a fair amount of years before they became disabled.

MEMBER KELLEY: And just for the information, for the rest of the committee -- It's Michelle Kelley from the Nevada System of Higher Education. Faculty at the Nevada System are not necessarily in PERS. The majority do not have access to Nevada PERS. They are in a designed contribution retirement plan. And that has no such disability retirement component built in to it. So the long-term disability insurance is largely important to the Nevada System of Higher Education employees.

CHAIRWOMAN FREED: This is Laura Freed. I have one question about utilization as opposed to access claims. In the item it says utilization is 25 in year 19 and 21 and then active claims was 117. So, if all of those were closed, we would have a utilization for 21 of 117?

MS. RICH: Right. So there's 117 active claims. So those are people that, you know, could have been eight years ago for this benefit and are still eating this benefit.

CHAIRWOMAN FREED: I see. Got it. Thank you.

MEMBER LINDLEY: Mr. Kemp, Tim here. Our benefit is 60 percent and you mentioned reducing to 50 percent. What is the typical market for percentage payout for benefit?

MR. KEMP: That is a very difficult question to answer. It depends on what type of, you know, if you're a state employer, if you're a county, a city. And the standard does have a very large percentage of municipalities in covering them from an LTD perspective.

I would argue that it's not uncommon to have a lesser plan design. I think this is a good benefit. You know, from my experience in the public -- in the private sector even higher benefits. But, again, you're dealing with some executives that make a lot of money, right. So they tend to steer the benefits toward the higher wage earners. So I definitely see voluntary plans out on the market as well with some municipalities.

I know you're not the only public entity to be exploring all of these options. So you're not alone. I don't know if that makes you feel any better. But we're dealing with this across the nation. And so I think everything is on the table.

But you do have, in my opinion, a rich benefit. And, keep in mind, this benefit is taxable, okay, because it's sponsored by PEBP, it's taxable as well. So the maximum is there. And then by the time the benefit once approved it will be taxed.

But I would argue that I think the plan is a very good plan. It covers I would say most of your higher wage earners as well and definitely covers the majority of your population. So, you know, if you were to change the plan, I think it would capture most PEBP employees. But, again, it's a matter of being able to decide, you know, which lever you want to the pull, right. Do you want to decrease the benefit percentage on everyone? Do you want to look at just the max benefit duration? It sounds horrible, but honestly, most people do return to work within five years. But there are people that won't, right. So if you make a change, you know, again, those employees probably aren't working for PEBP anymore. It could affect them.

MEMBER AIELLO: Mr. Kemp, Laura had mentioned it was something that we could offer that people could buy in themselves. Were you saying that the average salary was around 40,000? Are you able to give us what a premium would be that someone bought in themselves? And is that just like with life insurance, does it go up with age, the premium?

MR. KEMP: So the way we traditionally, like, right now, the benefits are on a per employee per month basis. Typically with voluntary we like to age rate it. And the reason that is, is that we want to get participation in the plan. So if you get a level set of premium we can expect it will offset the claims. And so we want to position the plan to be successful so we don't have any rate fluctuations because it's employee money, right.

So we have not priced out the plan yet because we need to get demographics and make sure we have the most accurate salary information. I was using the $40,000 from an earlier example. So I don't have pricing for you. With age-banded rates, the older you are, you will move in every five or ten years in to a higher rate in order to -- Because, ideally, the older you get, the likelier you are to become disabled, unfortunately. And I'm moving in to that category. I moved in to that category myself. So the idea is to get the younger population to want to enroll in a plan like this, the rates are going to be lower. And then as you get older, the rates will fluctuate. And it's kind of similar to the way the voluntary life is structured, where there's moving age bands. And so I would have to go back and kind of -- I have asked for some estimated cost to give you an idea of what it could cost a member. But, again, it really depends on what age bracket you would fall in. So it's kind of a moving target. So I can work toward that for you, but, unfortunately, I don't have that today.

MEMBER KELLEY: Michelle Kelley from -- It's Michelle Kelley. Just a follow-up question on that then, Mr. Kemp. So, potentially, when -- So when we first go out with this and it's age rated, if you don't get the younger employees signing up because they can't afford the premium, then how often do you reassess the rates and increase the rates aside from the age band disabled? Because what I'm hearing is if we don't get our young people to sign up, the people who did sign up are going to just continue paying more and more and more and more, right, to make sure that you guys are covering your claims cost.

MR. KEMP: So the idea with age banded is, you know, again, yes, you can, especially during a time like this, right, when you're dealing with people trying to decide what they want to spend their money on. So, we would -- our actuaries would come up with what percentage we feel would probably enroll in the voluntary LTD. We would try to structure it based on a participation requirement. So say we would like to have 20 percent of the population enroll and we do an effective communication and we work with your new benefit partner, and we really talk about the need for long-term disability, right.

And so we will base it on certain targets. And the cost will be -- The way we'll structure it is the cost will move up as you get older. And that's a pretty standard type of plan for voluntary LTD. So you're capturing more premium from the older employees in kind of a natural way. And so we're not banking on a bunch of younger employees to take it. But we want to make it palatable enough to where, you know, when I was 25, I'm not going to get disabled.

There's no way, right. I don't need this.

So we want to make it cost-effective enough to where it's something they may wind up buying. But, again, it's important, right. And so that's the mentality behind it.

From a rate impact standpoint, it's a group contract. So it will be based on, say, we quoted and give you three or four years and it's locked in at that point. And then we'll look at the experience at that renewal period and then work with Laura and her team to decide, you know, this is how it's running.

And then we will look at everything as a whole to make sure that -- The biggest thing we don't want to do is raise employee cost, okay. So that's, as an insurer, that's one thing. It's much easier to ask you guys, hey, you're running really poorly and this is PEBP-funded money, you guys can make the decision on that, versus if an employee, if you're going to raise their rates, that means you probably didn't price it accurately, you didn't communicate it accurately, or it is just running poorly and then you're going to have to go tell the members that, hey, by the way, sorry, your plan is running bad. And so we want to avoid that at all costs. So we've worked to make it -- to communicate it well.

So, again, it's not perfect, but we do guarantee it for a certain renewal period, similar to what we do with basic life, long-term disability, you know, the employer-sponsored coverages. So that's a long-winded answer to that question. I'm sorry.

UNIDENTIFIED SPEAKER: Do you mind if I ask a question of Kurt? In regard, if this would be a group, as a voluntary long-term disability package, it would be a group contract, would employees be -- would it be guarantee issue for those employees?

MR. KEMP: So we would probably want to make it guarantee issue. There would be a pre-existing condition provision in there to kind of protect the plan from someone who -- You know, we don't want -- We want people to buy insurance. And this is a hard one. We want them to buy insurance for something that may happen in the future, right. And so we definitely want to try to avoid having to go through evidence of insurability up front. Because any time you put that hurdle in front of somebody, how many of you like to cancel a medical appointment, right? So we want to offer it in a way that we will -- But there is that pre-existing exclusion limitation. But you have a 312 in there, so a new hire who gets the benefit right now. We can look back in the first three months before their employment to see if they were getting treatment for a certain condition or if they just had a stroke and this disability is specific to that stroke. So there are protections in the plan that will help that. But, yeah, I would envision us going to do a GI offer because I think it will just make it more difficult.

UNIDENTIFIED SPEAKER: Similar to when we implemented the short-term disability. We did that for during the initial enrollment. It was a guarantee issue. So we had done that. Thank you.

MEMBER KELLEY: Mr. Kemp, it's Michelle Kelley, for the record again. I'm just switching gears and thinking about your -- the idea of capping the amount of time a person can be paid through this product. So say for an employer that you work with that cap it at two or five years, what happens to those employees, or participants, I guess, at that point, they're probably not employees anymore, what happens to those individuals once the benefit stops?

MR. KEMP: So basically they would no longer get the benefit. And for those companies we work with that have this that are eligible for social security, we typically help them achieve that. If they are, you know, eligible for social security. So that is something, you know, with your employee population that you have to consider. But benefits would stop.

MEMBER KELLEY: Okay. Thank you.
CHAIRWOMAN FREED: All right. This is Laura Freed. I'm not hearing any more questions about 8.7. So we should move on to 8.8.
MS. RICH: Okay. So, for the record, Laura Rich. 8.8 is the elimination of the Part B subsidy. Right now retirees who are covered under the PEBP plan, so those are those pre-Medicare retirees, this is who this affects. They're required to purchase Medicare Part B. PEBP provides a Part B premium to offset this cost.
And right now about 1100 members are currently receiving that $135 using that premium credit. Eliminating that premium credit but still requiring those pre-Medicare retirees to purchase that Part B will save the plan about 1.7 million dollars. So I'll stop there.
CHAIRWOMAN FREED: No questions.
MS. RICH: Okay. So, next, 8.9 is eliminating retiree dependant subsidies. This also affects those pre-Medicare retirees. So These are retirees who are not on the exchange who are on the PEBP plan. Under this option, PEBP will continue to offer retirees coverage. However, those dependants will not be subsidized by the plan. Right now we have -- the dependant coverage count is 2106. However, that is for 1500 retirees. So 1500 retirees

covering 2100 dependants. And that will save the plan 4.5 million dollars.

The next one is the unbundling of dental premiums. What we're doing here is the current scenario today and how it has been in the PEBP plan is dental is embedded. Dental is a part of your medical premium. Those people that participate on the PEBP plan with the exception of the Medicare exchange retirees who can purchase dental separately do not have the option today. It comes as a bundled option, medical and dental.

What we're doing here -- And, sorry. Let me back up. This affects the actives and pre-Medicare retirees on the PEBP plan.

What we are proposing here is to essentially unbundle dental. And what we would do is allow participants to opt out of dental. But if you do elect to stay in to dental, we would impose essentially a dental surcharge for this. So, at the rate of $5 for an employee only. $10 for an employee plus spouse or child/children. And then $15 for an employee with family. That would bring us about 4.2 million dollars in savings.

Now, there's a little asterisk here because if 8.9 is chosen to prioritize before this option, then that reduces it to 2.6.

As I mentioned earlier, if we choose a plan design that has higher premiums, this is tacking on another premium on top of that. So that's very important to highlight in this scenario.

The next one is 8.11. And that is premium increases. So this is -- This varies. Let's say that we choose an option, whether it's A, B, or C, and it gets us to that 20 million dollar mark and then we choose a variety of options out of all of these, but we've only gotten to 30 million out of the 36 million. At that point we can -- Again, it goes back to, you know, what's more important, benefits or premiums. You're either going to reduce benefits or you're going to increase premiums.

So in the scenario we choose several of these options that the board is adamantly opposed to the remainder of the options. And let's say we're at 30 million and we need to get to that 36 million. The remaining six million will then have to be factored in to the rates.

And we have Stephanie from Aon here who can probably give us a good idea of what that would look like, depending on, you know, where we land. So that is -- that's definitely something that we have to choose from if these options don't -- if the board chooses to not get to that 16 million dollar mark on these options.

The last one is the possible transition of non-Medicare retirees to the Silver State Health Insurance Exchange. So this option obviously is -- didn't fit in to my little box here, so I have a couple of pages on this. And, additionally, I also have representatives from the Silver State Health Insurance Exchange. I have (unintelligible) as the director and Jamie Sawyer from the Health Insurance Exchange to answer any questions should their expertise be needed.

But, similar to actions that PEBP took in 2011 as a result of the recession, this option will require retirees that are either not of Medicare age or do not qualify for Medicare to purchase coverage through Nevada's individual market place and Silver State Health Insurance Exchange, otherwise known as Nevada Health Link.

Because retirees, it's no secret, retiree health care is expensive, many public sector employers are starting to move toward not offering health care to retirees or at least not subsidizing health care to retirees. In fact, during the 76 -- 2011 session, legislative session, the decision was made that employees hired after January 1st, 2012, would no longer be able to receive a retiree benefit subsidy.

So, in many instances, those employers that do provide retiree benefits have transitioned to providing retirees with financial assistance in the form of an HRA. Retirees can then seek and purchase their own health care coverage using that HRA to offset premiums and/or out-of-pocket cost.

And then by leveraging the Silver State Health Insurance Exchange will help reduce PEBP's cost while continuing to subsidize retirees with funding determined by their years of service.

So, there's obviously advantages and disadvantages to this, and I'll kind of cover a little of both here. Some of the advantages. Retirees will have more access to more plan options. On the exchange there's obviously, there's a lot more plan options than the two we have available on PEBP today.

Also, lower income retirees, so those that are under the 400 percent federal poverty level, which is also referred to as FPL, may qualify for federal subsidies on the exchange and have access to cheaper premiums and reduce out-of-pocket expenses than what they currently receive through PEBP.

So in the case of someone that is, let's say, in the 250 percentile FDL, not only do they have reduced premiums, but they also have reduced out-of-pocket expenses through federal subsidies as well. Sometimes, in many cases, those subsidies will be more advantageous than the subsidies that PEBP would offer.

Additionally, the exchange can offer the services of brokers and navigators to help retirees located in Nevada to transition. So we would be working very, very closely with the exchange to use those resources and to make sure that the 4900 or so pre-Medicare retirees that fall in to this bucket would receive the assistance necessary to make this transition.

The option also provides flexibility to the state to reduce or raise subsidies based on economic conditions.

So going to the disadvantages. We all know that the ACA has been challenged repeatedly. I think even up to two weeks ago it was sitting on the steps of the Supreme Court. It has been upheld. But it is being continuously challenged. So there's always the risk that the ACA could go away. You know, it's been around since the exchange was -- we went live. I was there at the time. It was 2013. And we are now in 2020. So it's managed to remain alive for about seven years now, even through all of the challenges. But there's always that chance.

Also, all the retirees in Clark and Nye County will experience less of an increase. Premiums will likely increase for most retirees living in Nevada. Due to the high cost of care in the rurals especially and the age banding on the exchange, those living in the rurals with higher income, so those over that 400 percent FDL, will be hit. Their premiums and out-of-pocket costs will increase. Unfortunately, the impact is unknown for retirees residing outside of Nevada, because every exchange is different. Every exchange offers different plans, different premiums. And so we have to go through and do an analysis state by state.

This will definitely require a very significant undertaking by PEBP. It's going to involve mass communication, a lot of planning, a lot of coordination with the exchange staff as well. This is almost impossible to roll out in Plan Year 22. There is just no time. There is -- This would be -- There is just no way that it's feasible to do in Plan Year 22. So this would be a Plan Year 23 option. And, as I will go in to details later, this will require legislative details.

So I went through and we put together some -- the makeup of these non-Medicare retirees and kind of went through and provided some information that I think is valuable in looking at those options. So you can see we went through and out of the 4900-ish members, you would receive a makeup of the retirees and where they sit as far as age.

The majority of the 65 plus, I'll tell you, they're probably on the plan because they are what we call anchors. So these are folks who have already reached Medicare age but they have a dependant who is not of Medicare age. And so they will be -- they are allowed to stay on the plan until their dependant reaches Medicare age. So, for example, if someone -- if a retiree, the primary retiree, turns 65 but their spouse is 62, they will be able to stay on the plan until their spouse turns 65. And so that's where you see a lot of these plans.

There is a small portion of this, as you heard in public comment, of those people who will never be Medicare eligible. Those are people that never paid in to Medicare who will be on the PEBP plan forever and ever.

If you look at the federal poverty level chart, this is the 2020 federal poverty level chart, on page six, you'll see that 250 percent FPL is about 31,000 for a household of one, 42,000 for a household of two.

So, what I wanted to do was I was interested to see what exactly are PEBP retirees making, because that really tells us where these people fit and whether they would be eligible for subsidies or not. And so the first thing I did was I asked PERS. PERS, are you able to provide me information on State of Nevada specific aggregate salaries for retirees. And, unfortunately, PERS has a lot of confidentiality limitations where they are not allowed to release anything, specifically on employer-specific salary even if it's aggregate. So I was not able to get anything from PERS.

So I went to the next best source, which is the Nevada Department of Administration, and asked for central payroll to provide just some general information on retirees. So they were able to provide me with the last five years of retirees. So, when the income of salary, ending in -- ending salary of a retiree. So what did that person make when they retired. And it was only retirees. Not for immediate employees, just retirees.

As I went through, and I have five years of records on that, and I was able to find the median income for the salaries that were provided to me by the Department of Administration. Now, that median income was $40,419 for the last five years. That is assuming that -- There's a lot of assumptions in to this, and so I want to make sure I emphasize that this is not scientific data of any sort but it is at least helpful data. So that assumption is that when a person retired, they retired under their highest three years -- that was their highest salary is the three years highest salary. While there's definitely people who may decide that, you know, I've reached my highest salary, I'm going to spend my last three years being a mail clerk at a reduced salary until I hit my 30 years, that's typically not the case. And then on top of that, we don't know those people that the median salary was 40,000, but we don't know if these people have five years of service, 20 years of service, or 30 years of service.

So, under the assumption that the median salary is $40,000, and that's the -- the income at a 75 percent PERS benefit, you're looking at -- and 30 years, 75 percent and 30 years. You're looking at an average retiree salary of about $30,000. Again, not scientific, but it's the data that we have to go from.

If you look at that FPL, if you're in a household size of one single person, retiree, you're at that 250 percent FPL. You would definitely receive very substantial subsidies through the exchange. Not only for the subsidies, premium subsidies, but out-of-pocket subsidies as well.

Moving up again to a household of two, those that are earning lower income would definitely benefit from it. Again, legislative changes would need to be necessary for this option to be implemented. Although, you know, again, I keep going back. We have 13 days to come up with the analysis for all of this. We have not had the opportunity to bat this through to legal.

However, there's two clear changes to the statute that need to be identified. The first one has to do with the commingling of the risk pool. So if you don't have a risk pool of pre-Medicare retirees, you no longer need to commingle them. That would need to be addressed.

And the second one is the statute that addresses how PEBP subsidizes retirees. In this situation we would actually be proposing to subsidize retirees at a higher level because of the higher premiums on the exchange. So retirees would definitely get -- there would be a different subsidy proposal. And you'll see this is just the current and proposed non-Medicare. There is a state retiree subsidy. It's just a proposal that we have come up with essentially subsidizing those pre-Medicare retirees at a higher rate.

And on the last page here, on page eight, I provided an example of where this could be beneficial and where it is obviously not advantageous. So a 56-year-old retiree with 20 years of service with over the 400 percent FPL, obviously, and not receiving any subsidies, in Clark County today, someone living in Clark County, would pay a PEBP premium of $54.28, pre-Medicare retiree. Should they move to the exchange, their premium would actually be zero.

And the reason for that is because the PEBP subsidy would be higher than what that premium would be on the exchange.

In Carson City the same does not hold true. You see that today they pay $54.28. And a premium for a comparable plan would be $315.78. In Reno it goes from $54.28 then to 163.35. And then, again, you heard me say over and over that the rurals are expensive. This is where the high cost of care is. And you see it right here where in Elko on the exchange that premium would go up to $537 for someone who did not qualify for any federal subsidy.

So I will stop right there. I'm sure there's going to be a lot of questions. I'll stop right there.

CHAIRWOMAN FREED: This is Laura Freed. Whew. That is a lot and is a lot of work just to get 12.6 million dollars in subsidy dollars. I don't -- I'm just going to say it. I don't think this is a great option. I mean, I don't, and I don't support it. The reason I say that is because --

Well, let me back up. The board finds itself in a situation where in 8.1 we've got three choices to save approximately 20 million dollars in subsidy. If we took 8.1, one of those, and 8.12, well, that would get you there. But there is so much in the way of implementation and there are so many uncertainties that I have a hard time supporting this, which forces us back in to the position of patchwork of things, 8.1 plus some combination of 8.2 through 8.10.

Those are my thoughts. But if board members have questions about the details of the health insurance exchange, fire away.

MEMBER VERDUCCI: Tom Verducci for the record. I want to point out, I think 8.12 is absolutely horrible. I don't think it's doable. We don't know what's going to happen with the Affordable Care Act. I just think that one is the worst on the entire list.

What I see as the best options would be Option B, 8.2, 8.3, 8.4, and then 8.5 option one, 8.6 option one, 8.10, and perhaps it would be a slight surcharge if we can get quite to the number, just my initial thoughts here.

MEMBER KELLEY: And it's Michelle Kelley here. I'm with you, Tom. I think that you've kind of encapsulated my thoughts as well.

So I do actually have some questions around the -- I just wanted to kind of get some -- fill in a couple of gaps in my knowledge. So, Executive Officer Rich, when you talk about transitioning kind of the non-Medicare retirees, can you clarify for me are you talking about just the age, like the people who haven't yet become Medicare eligible? Are you also including in that the people who will never become Medicare Part A eligible?

And then just a follow-up question. And I guess I would really -- And I hear Chairperson Freed saying that, you know, this sounds like it all started with most of us. But I also am challenged after seeing some of the public comment. I'm really challenged with reconciling the decision to provide data on a 56-year-old retiree versus when, you know, I think PERS allows for ten years of service and 60 and then they monitor 65. So if a person is 56 years old feels like it's cherry picking. So can you perhaps respond to that as well? To be clear, cherry picking a nice premium that you could show some benefit, versus a 63 year old. I don't know.

MS. RICH: So this -- You are correct. This does encompass the pre-Medicare retirees who are on the PEBP plan and who you are on -- who will never either have not reached the age of 65 who will at one time become Medicare eligible. But then there's that small group of people who are on the PEBP plan forever and ever because they have never paid in to Medicare. And so those people for sure would fall in to this bucket as well because they are still considered that pre-Medicare retiree population. It does not exclude those.

Why we chose the 56 year old, I don't know if it was, you know, intentionally cherry picking. It was more to as you look at the age bucket there from 56 to 65, most of those people are within that range. And so I think that's what the thought process was on that.

MEMBER LINDLEY: Tim here. If I may comment. The negatives tend to outweigh the positives in this example. Requires legislative changes, significant undertaking by PEBP, and it wouldn't even show any benefit until Plan Year 23. And when Plan Year 23 rolls around in a year from now, when we reevaluate, all of this may not even be necessary.

CHAIRWOMAN FREED: This is Laura. Thank you for that -- those comments. Board members, I mean, I started it off and I didn't mean to unduly influence you. But I think I hear loud and clear that moving the non-Medicare retirees to Silver State Health Insurance Exchange is a non-starter.

MEMBER KELLEY: Michelle Kelley. I agree.

CHAIRWOMAN FREED: Don't all of us agree at once. Thank you, Member Kelley.

So, again, we refer to one of the plan designs in 8.1, plan design, balance by increased premium or -- And. Excuse me. Some combination of the sort of one-off changes. Because the other thing that I think bears mentioning here is that we can't get this savings again if we move to the 140 percent Medicare model, for instance, Smart 90 for the EPO. Unfortunately, some of those are one-time savings. But we will patch it together the best way we can.

MEMBER AIELLO: This is Betsy. I do have a question on the rankings. There are some, as I already heard Tom, I think it was Tom said, that would be something that I would not want to do that currently says eliminate. So I wouldn't even want to rank them as number ten, 12, whatever, unless they could be a reduction instead of an elimination. And so I don't know in our numbers if some we just say, I say no, or we say, I'm okay if PEBP does this if they can come up with X or something. I'm not sure.

CHAIRWOMAN FREED: So, if I hear you correctly, you want to take elimination of some of these things off the table as an option and just say reduce it one level or reduce it another level?

MEMBER AIELLO: Yeah. Like I said, I would not want to prioritize the elimination of the long-term disability benefit at all in any of my numbers. But if we, say, went from 60 to 50 percent, if that made a difference that really we could maybe do this without an additional premium increase, then that would be something different. But then we're sending PEBP so many different options, I don't know how that would work. But, for me, that would be a killer to totally eliminate it. So I don't know how we want to -- how you want us to proceed.

CHAIRWOMAN FREED: Well, okay. I think, well, first, I want to talk about ranking, because the staff recommendation on page eight of the staff report is approve Plan Year 2022 proposed plan benefit design as illustrated in Section 8.1. And we've already talked through 8.1-A, B, and C, so one of those would be staff's recommendation. Correct me if I'm wrong.

Rank options 8.2 to 8.10, let's say, in order of preference from most to least desirable for Plan Year 22 as necessary to meet budgetary goals established by GFO for 22. And then pre-approve staff budget reserve options in order of preference.

So, members, when you rank something number one, what I mean by that is that's the thing I think imposes the least pain, not the things that I think imposes the most pain. So least pain, second least pain, third least pain, and down the line. Just so we're clear.

And if you want to all agree -- And I don't think we need to take a motion on this -- that you don't want to eliminate any one benefit from 8.2 through 8.10, we can agree to that, and then just deal with reduction and hope that we get there. I'm seeing some nods. Any affirmative feeling about that? Okay. All right. So let's do that. So that would take care of 8.6 option three. That's off the table.

And then that would ultimately take 8.7 off the table, because I don't think we have, frankly, the time for

PEBP to analyze the fully -- the fiscal impact of equalizing the LTD benefit with social security disability income. I mean, we had a nice long conversation with Mr. Kemp. But I felt like the sum total of that was it would be require more study. PEBP staff, correct me if I'm wrong about that.

MS. RICH: So The Standard did provide us with this options as far as what those estimated annual savings are, and I do have that in front of me to lower that long-term disability.

Now, Stephanie, I know that there's a component in this that would be factored in to, you know, whether that -- that would be realized completely or not. I don't know if you want to weigh in on this. And I know, Stephanie, you don't have it in front of you, so I don't know if you can weigh in on it or not.

MS. MESSIER: Yeah. I mean, I would need to see it in order to know if we can loop it in.

MEMBER AIELLO: This is Betsy. I think I probably agree with you, to equalize it with social security is out of the question. There's just not enough time. But a couple of those things he proposed, like going from 60 percent to 50 percent, because he did say we currently had a rich benefit, he said or five years or two years. I might still have a problem with that, but I think there were some options that maybe Stephanie needs to relook at. But there were some potential options that maybe could be prioritized down lower than if some money was still needed, you know. I don't know.

CHAIRWOMAN FREED: Okay. I --

MEMBER AIELLO: He said ten percent with a 60 to 50, which isn't a lot of money, but it's the same amount as one of the pharmacy plans was.

MS. RICH: So, yes. Bringing it down to -- And, Stephanie, I just sent this to you. But bringing it down to a 50 percent and continuing to keep the age 65 duration is about 1.5 million in savings.

MEMBER KELLEY: Executive Officer Rich, do you have The Standard provide for if instead of reducing to 50 percent we keep it at 60 but cap it at 5,000 or 6,000?

MS. RICH: Let's see. I'm looking. And, Kurt, if you want to the jump in here, I'm happy to allow you to do that. I'm looking at it myself here.

MR. KEMP: Kurt Kemp for the record. I have not provided that. Again, there's so many options you can provide. But, let me, while we're chatting, let me see if I can get my underwriter to get me that and I'll see if I can get that done quickly. But 60 percent to 5,000; right? Is that the request?

CHAIRWOMAN FREED: 60 percent to 5,000. And, Laura, you said 1.5 million in subsidy savings?

MS. RICH: No. That -- So 50 percent to 5,000 and keeping the age benefit to 65 is 1.5 million.

CHAIRWOMAN FREED: Okay. While Mr. Kemp -- We're probably going to take up some time doing our individual rankings anyway, so I think you have a few minutes.

MR. KEMP: Okay. Wish me luck. Thank you.

CHAIRWOMAN FREED: All right. I would suggest that -- PEBP staff, do you have your score sheets out? I would suggest we just simply go in alphabetical order. I don't want to make anybody -- I don't want to ask for volunteers, because nobody would ever volunteer for ranking budget cuts for fun. So, whenever you are ready, again, I'm asking members to provide a ranking of, number one, for least pain and suffering down to most pain and suffering for 8.2 through 8.10.

MEMBER FOX: Excuse me. This is Linda Fox. So are we going to include 8.7 or we're not going to vote on that? I know that's the one he's looking at right now.

CHAIRWOMAN FREED: Right, right, right. I think if you wished to rank -- I think we should skip it for now. We can omit it until maybe Mr. Kemp returns with some more info. But knowing that if we have 50 percent age 65 at 1.5

million dollars in subsidy savings and staff feels pretty confident with that, staff and Aon, we could leave that to the end and then you can insert that in your own ranking.

MS. RICH: Chair, do we want to start out with maybe plan design first? I don't know if that's --

CHAIRWOMAN FREED: I think that would be fine if we went back to plan design. I was just trying to make this easy in bite-size chunks. So, now that we've been through everything, we can turn back to 8.1 and talk again about A, B, and C.

MEMBER VERDUCCI: Chair.

CHAIRWOMAN FREED: Yes, Mr. Verducci.

MEMBER VERDUCCI: Yes. In looking these over, I like Option B. I think it's going to cause the least amount of pain, the least amount of damage. I don't like any of them, but if I had to choose A, B, or C, my choice goes towards B.

CHAIRWOMAN FREED: Okay. Is that a motion?

MEMBER VERDUCCI: Well, I don't know if you're going to take these altogether. This is a very uncomfortable meeting. I like discussing increasing benefits and reducing costs. But, if I look at my notes here, I could summarize it real quick. I like B. And then I like 8.2. I won't say I like it, but this is the way I would go. 8.2, 8.3, 8.4, then

8.5 option one, 8.6 option one, 8.10. And we're looking at reducing as opposed to eliminating on 8.7, maybe that gets us there. And if we have to jump in to 8.11, I'm hoping it's a very small nominal COVID surcharge is my initial thoughts from hearing testimony so far.

CHAIRWOMAN FREED: Staff, did you get all of that or should he repeat that?

MEMBER VERDUCCI: Would you like me to read it back?

CHAIRWOMAN FREED: Yes. Why don't you read it back slower.

MEMBER VERDUCCI: Okay. Okay. Thank you. That's Option B, I think it's the least damage of Option A, B, and C. And then I think everybody concurred, from what I heard, that 8.2, 8.3, and 8.4 were acceptable cost-cutting measures. And, 8.5 option one, I'm not real crazy about that. But I know it's a give and take with both the retirees and the actives. 8.6-1. Excuse me. That's the life insurance. And then 8.10, which is the dental. To readdress 8.7, if there could be a reduction as opposed to an elimination. And if there's a slight shortfall on 8.11 which could be called a COVID surcharge.

That's what I think is the least painful. And none of this is enjoyable to me at all today here to cause any disruption for any Nevada citizen. But, we're mandated to do this, so it appears to be the rational choice from what I can gather at this stage.

MS. RICH: This is Laura Rich. You can see that Stephanie from Aon is -- she shared her screen here, so she's showing the rate and she's showing the first one as 8.1-A and the difference with 8.1-B, which is on the bottom. And so these are the rates that include if you choose these options.

CHAIRWOMAN FREED: Okay.

MS. RICH: She's essentially plugging in those options and it is showing what the rate would be in Option A and B.

CHAIRWOMAN FREED: I gotcha.

MEMBER LINDLEY: Thank you very much for showing this.

MS. MESSIER: Yes. I figured it would help to show it in black and white.

MS. RICH: Keep in mind too that I think with 8.10, Stephanie, did you add the five, ten, 15 on to participant premiums?

MS. MESSIER: These are rates with dental. If people did not select the dental, you could subtract the five, ten, 15 accordingly, to get the non-dental medical rates.

CHAIRWOMAN FREED: This is Laura Freed. I have a question. I don't think Mr. Verducci's ranking got us to 36 million. So is the difference then made up in increasing the premium?

UNIDENTIFIED SPEAKER: You're correct. Both of these will save the plan 36 million. It's just move into the premium.

CHAIRWOMAN FREED: Okay. Gotcha.

MEMBER AIELLO: So this is Betsy. So what looked like 70 -- the employee-only premium was going to be 74 is now 23 because it needed additional premium to get to the 36; is that correct?

MS. MESSIER: Yes, that's correct. I've selected 8.2. 8.3, 8.4, 8.5 at $12, 8.6 at that first option, 20K and 10K at 8.10, and at the end of the day you're still short enough that I had to change the premium to 124 to save the plan 36 million dollars.

MEMBER URBAN: Marsha Urban for the record. What would happen if we went with Option B in 8.6?

CHAIRWOMAN FREED: That is a great question I was just going to pose myself. Thank you.

MEMBER URBAN: Great minds.

CHAIRWOMAN FREED: Uh-oh, Stephanie, did we lose your screen?

MS. MESSIER: Just a second. I'm recalculating and then I'll copy and paste it back. Just a moment.

Okay. So this is again A and B but losing the life insurance at 10K and 5K. I believe that was the question; is that correct?

MEMBER URBAN: Yes, that was the hypothetical, yes.

MEMBER AIELLO: Is this including the long-term disability going down to 5,000 cap at 50 percent?

MS. MESSIER: No, it does not.

MEMBER AIELLO: I don't know if other people would be open to that or not.

MEMBER LINDLEY: Betsy, Tim here. I'm open to the 50 percent 5,000 cap until age 65.

MEMBER AIELLO: That's what I -- Because I would like to see the premium going down but I hate getting a million different scenarios so we get all confused.

MEMBER KELLEY: Michelle here. Can I just clarify regarding the cap, the $5,000? That's benefits paid, not maximum compensation; right? So it's not the $5,000 compensation looked at so the maximum payout is $2500 a month. Rather, the maximum payout is $5,000 a month?

MS. MESSIER: Correct.

UNIDENTIFIED SPEAKER: Can we see what would happen too if we changed Option 8.5 to option two? And then I'm just going to say that I am really more in favor of looking at all of these in Option A for the plan design. Because in Plan Year 23 and beyond there's a very high probability that rates won't continue to go up. And so if we change the participant premium, say, to the CDHP to 117 but then it goes up to -- for an employee only, but then it goes up another 30 to $40 for Plan Year 23 because of the subsidy, it's really going to make the insurance prohibitive, even if we have the lower for benefit design.

MS. MESSIER: Okay. So, for 8.5, you would like to see it at the $11 and you want to leave the life insurance at the ten and the five? Or do you want me to put that back?

UNIDENTIFIED SPEAKER: No, no. Keep it at the ten and the five. So option, for both 8.5 and 8.6, where we have options, take them both to option two, please.

MS. MESSIER: Okay. One moment.

MEMBER VERDUCCI: Tom Verducci here. I don't know if it's okay if I chime in here. But, you know, looking at the life insurance, going from 25 let's just say for the actives to 20, it just seems much more palatable than going from 25 to ten. I mean, that's a pretty big drop. I was more comfortable with one. And that would be my input as far as the life insurance. It's just such a big drop.

CHAIRWOMAN FREED: Thank you, Mr. Verducci. One of the things I want to note for historical context is that back in the great recession days of 2011, the life insurance benefit was also reduced as a budget-cutting measure, but after the recession passed it was put back, so that's how we got back to 25,000 actives, 12,000 retirees. So it's one of those things that we could reduce for a biennium and then put back. Or it's one of those things that we could say if the GFO wanted to put something back in to the budget, it is one thing we could say that would be the first thing to put back. So, Board Members, think about that.

MEMBER LINDLEY: Chairman, Tim here. Just chiming in, I think we can all agree that 8.2, 8.3, and 8.4 are okay.

CHAIRWOMAN FREED: Yes. That seems to be the emerging consensus. So I think we don't need to worry about 8.2, 8.3, and 8.4 in terms of ranking. I think you're right, our discussion points are 8.5, 8.6, and whether we want to go with some reduction in 8.7. I actually don't even hear a lot of dissension at 8.10. Members, correct me if I'm wrong.

UNIDENTIFIED SPEAKER: I agree with that.

CHAIRWOMAN FREED: Okay. All right. Moving on the record, so just for Stephanie's -- We're solid on 8.2, 8.3, 8.4, and 8.10.

MEMBER URBAN: Marsha Urban for the record. On 8.10, if that was unbundleable, if you were only -- the E only, you pay an additional five dollars a month and then you would get the normal four cleanings, the basic, you know, whatever you're getting now. Is that how I understand it?

UNIDENTIFIED SPEAKER: Yes. And, to be clear, this number here, that $62, means you elected dental. So the five dollars right now is included as you haven't had chance to bill that separate column. It would be $57 if you chose not to do dental. But, yes, the plan design remains the same as it is today. It's simply that you're paying a dental premium now of five dollars. So five of this $62 is for dental.

MEMBER URBAN: And, Stephanie, is that Option B right there?

MS. MESSIER: On the bottom on the --

MEMBER URBAN: You know, we have 8.1-A.

MS. MESSIER: Yes.

MEMBER URBAN: I'm kind of lost here.

UNIDENTIFIED SPEAKER: This is what happens when we all pile stuff on A and B.

MS. RICH: This is Laura Rich for the record. So two things. We have Capitol Reporters who they're transcribing this meeting and so they're asking please if people will state their names before they speak.

UNIDENTIFIED SPEAKER: I'm so sorry.

MS. RICH: And second --

CHAIRWOMAN FREED: I am sorry as a chair that I have not followed that nor have I enforced it. Please forgive me, Capitol Reporters.

MS. RICH: And, second, Madam Chair, they're also requesting a quick break.

CHAIRWOMAN FREED: All right. Then, in that case, it's 2:50. I will see everyone at 3:00 o'clock. I apologize.

(Recess was taken)

CHAIRWOMAN FREED: Thank you, Stephanie Messier, for making your presentation bigger. The people on YouTube very much appreciate that.

All right. So let's go ahead. So, Board Members, as you can see, we have -- if you take 8.1-A, so it would be plan design originally in the packet, and add in 8.2, 8.3, 8.4, 8.5 at $11 per month per year of service, 8.6 that the life insurance is 10,000 active, 5,000 retirees, and then 8.10 incorporating the dental premium in the rates, that's what you get. And on the bottom is Option B with all of those other things the same.

MEMBER KELLEY: Chairperson Freed, it's Michelle

Kelley here. I just have a question about the rates and what's presented on the screen right now. And I think it's for Executive Officer Rich. You've indicated in an earlier e-mail that to save the full 36 million per year that we needed, it would cause a surcharge of around $100 per month per member, per employee. So, I guess when we're trying to reconcile the numbers that are appearing, if we're any kind of short around the five million that needs to be made up.

So, Option B, if you use the pricing provided in that addendum 8.1, incorporate all the other items that you've got listed out here, it looks like we're only short about five million, which should be around $14 a month surcharge versus what we're seeing. So I think Stephanie is doing something with the tiering or something. Maybe she could talk to that.

Just basically the rates appear to be going up more than we would have expected them to, using the figures that are provided in the agenda item.

MS. RICH: This is Laura Rich. I think, Michelle, the number you were -- And I'm going to apologize ahead of time because we've thrown around so many numbers that I can't remember what's been quoted and what it was quoting because sometimes, you know, it was the current plan design, sometimes it's one of the three plan designs here that are presented here. So I can't remember what that was specifically referring to.

MEMBER KELLEY: Well, my understanding is it's just referring to if we give no plan design changes and we reach the basic million dollars of savings purely through premium increases, if you will, that that increase, it would have been around a hundred dollars a month for the employee for us to save the 36 million. But it seems like even after we've entered all of the kind of different reductions to benefits that the rates have still gone up more than that would look like.

MS. RICH: Okay. So if we do no plan design changes whatsoever, that 36 million dollar number goes up to I believe -- And Stephanie can correct me if I'm wrong -- but I think it was somewhere between 44 and 45 million.

MS. MESSIER: Yeah. I thought it was around 44 million. This is Stephanie Messier.

MEMBER URBAN: Marsha Urban for the record. Stephanie, is that Plan B and Plan C that you have up there?

MS. MESSIER: This is Stephanie again for the record. No. This is Plan A, which was in the original board packet. So in green this is the one being presented for the first time at this meeting. The blue section at the bottom is the design that was presented at the July board meeting, which I believe Ms. Rich had labeled as Option B in the addendum.

I do not have Option C up here, which is to go all the way back to the one that would need 44 million dollars of savings, because of the current design being richer.

MEMBER URBAN: Okay. Marsha Urban for the record. On that one that was in the original packet, it had 44.60 as the rate in the red. Would that add the increase in the --

MS. MESSIER: Yes.

MEMBER URBAN: So if this A -- I mean, I'm just kind of lost. I'm sorry.

MS. MESSIER: So in the packet that was only to save 20 million. And it was recognizing that you needed to make choices in 8.2 through I believe 8.12, I think is the last one, in order to get to that additional 16. So, because of the choices, 8.2, 8.3, 8.4, 8.5 at $11, 8.6 at the ten and the five, and 8.10 didn't get you all the way to 16. The rest of it comes on to the participant premium in order to still get to a 36 million dollar savings. So that's why these numbers are different than the 46. The 46 was only saving 20 million dollars. And I mean only. But, obviously, unfortunately, the task ahead of us today is 36 million dollars and this is the number that gets to 36 million dollars.

MEMBER URBAN: I understand now. Thank you.

MS. MESSIER: You're welcome. In response to the tiering, no, I am not toggling anything on tiering. These are the exact same. I have an option tab where I simply flip yes or no or I flip it from 13 to 12 or 11. So the only two differences between those spreadsheets is the plan designs that underlie the base underwriting for each of these and the rest of it flowing through. And I have to toggle those options just yes or no based on what you all are telling me you're voting on or would like to see. I'm not doing anything with tiers.

And so I think the hundred dollar figure you're talking about there, the reason you're only seeing it at $70, right, today you would pay about 34 for the -- And then it's going up to 114. So it's not the full hundred. So it is getting spread across the tiers.

But I'm not changing anything from Option A to Option B in terms of plan design. All of the structure of the rates is remaining the same. I'm simply changing which plan designs I'm picking from. So those are the exact same spreadsheets. So it's different starting points for plan design, if that makes sense.

MEMBER KRUPP: I have a quick question. If these numbers, Stephanie, that you have up include the dental premium in them, even though we're discussing unbundling the dental premium, on the board packet that we received with Option A, do these premiums include the dental premium if it's unbundled as well?

MS. MESSIER: No. So, given the packet, again, it was just trying to show what that option itself represents to the 20 million dollar savings. So then when we're talking about the dental, I'm showing here what the rates are with that dental surcharge. So, again, if we were actually to be producing rates today, there would be a separate table saying I'm electing medical only. So my benefits premium, if the board decides to go with Option A, would be $67.49. If I was a family and I was not electing dental, it would be $307.31. If I'm choosing dental, that's the rate you're saying here is the rate shown with the dental amount on it. So, certainly, the rates could go down if the person chose not to elect dental going forward. Just for me that's showing you 700 numbers on one page. I'm just showing you the rates. And these rates are with the dental loaded right now because you have said yes to 8.10 and its current illustration of numbers.

MEMBER KRUPP: Okay. So my question though is in the Option A for the CDHP plan, the high deductible plan, the proposed rate is $44.60. Does that include the unbundling of the dental premium? So it would be higher; right?

MS. MESSIER: Right. So what was in the board packet was literally only looking at a reduced head count and a plan design change. So it didn't say yes or no to anything else. And it only saves the plan 20 million dollars. So, again, there was 160 million dollars of savings that had to come somewhere. And, if there's not enough of these other options selected, the difference goes to the participant premium, which is why you're seeing a difference from that 46 to 62.

MEMBER KRUPP: Thank you.

CHAIRWOMAN FREED: This is Laura Freed. One more reminder to please identify yourselves for the benefit of the reporter. That was Jennifer Krupp having a conversation with Stephanie Messier of Aon.

MEMBER KRUPP: Thank you.

MEMBER AIELLO: This is Betsy. I have a question. In regards to the dental premium, we're adding in to the savings the money that people would pay us if they bought in the dental premium. Do we have claim savings for those that we think might not? And is that how we're getting the total savings? Or is that just based on income?

MS. MESSIER: This is Stephanie Messier for the record. So what we're doing here with this savings estimate is we're doing a more conservative approach. We're assuming everyone wants to stay on the dental plan. So this is how much those surcharges helps to reduce PEBP cost because they're now getting five dollars, for example, for every single person who has dental. There would be additional savings to the plan, potentially, when claims go down. However, if everyone leaves the plan who never uses it, then obviously those folks are now out of the plan and the plan is actually being rated to low because the people that are left on a per person per month basis will be spending more than they do today.

So, there is an additional change that will be happening, yes, if we unbundle the dental and claims change. However, based on your utilization of your plan today it is fairly heavily utilized, so we feel pretty comfortable that your cost won't go up further. We just didn't want to get overly aggressive and say there's another two to three million dollars of claims savings. There very well may be. But folks leaving the plan we just didn't want to bank on it, if that makes sense. So what you're seeing right now is just the savings is really just that additional surcharge that the participants are selecting when they select dental.

MEMBER LINDLEY: Tim here. Can I make a general statement?

CHAIRWOMAN FREED: Mr. Lindley, is that you?

MEMBER LINDLEY: Correct. I just want the board members to realize that as an active employee we see what comes out of our paycheck. And Option B effectively doubles every active employee's participant premium. And I don't doubt that we will hear a lot of employees commenting on the increase in premium.

MEMBER KELLEY: It's Michelle Kelley here. I have just a question about the rates as we're seeing up there, to Stephanie, I think. I'm just wondering and just looking at employee only in the CDHP, we don't have enough time for me to go through them all, so I'll just keep it simple for you. When I look at the papers that we got for Option B and I look at the illustrated premium there, it was 74.65. This is Option B. So then, given the premium that I'm seeing on the screen of 114.64, that's a difference of around $40 for the different benefits here.

If I understand this page correctly, if I go up to the ranks that are indicating 1-A, which was in the prime board packet, the illustrated rates there were $44.60. So pulling out changing the benefit to somebody who is already incorporated to that and then changing kind of the pieces around it, when I do the math, what I'm seeing is a difference of 17.89. So why when we're removing or when you're plugging in all of the same actions, whether it be Plan Design A or Plan Design B, because the rates already included that plan design change, why is there a difference in how that rate is coming out? Shouldn't they both be 17.89 if that's the cost of the different benefits showing that are being reduced? Is that clear? I'm sorry. It's a bit convoluted.

I'm just wondering why -- Shouldn't the difference in premium for Items 8.2, 8.3, 8.4, 8.5, shouldn't that be the same whether you've gone with Plan Design A or B, the change in cost?

MS. MESSIER: This is Stephanie. It's very hard for me to follow your 17.89 and where you're starting and where you're ending. If you want, I can get in to my spreadsheets and we can start going through those. I guess it's up to you as to where you want to go.

MEMBER KELLEY: Well, I guess the numbers aren't working for me. So if you take the agenda -- the actual information provided in Item Number 8, and you look at option, I guess we're calling it Option 1-A, which is exactly what kind of the executive officer presented in the report, right. The -- Looking at the modified CDHP, which had all of the benefit reduction proposals, the approximate employee-only rate for CDHP is $44.60 in that document, right.

So then we've gone and we've looked at Items 8.2, 8.3, 8.4, 8.5, 8.6, and 8.10 and you've incorporated those savings, it's -- but you've incorporated the rest of the savings to a premium increase. So that's where I'm seeing a $62.49 on Plan 1-A, right. So that's a difference from what was in the agenda to what's been presented of $17.89. That is an increase to make up for keeping LTD, for keeping some of these benefits and retiree health insurance.

But when you do the same math on the plan design Option B, the rate was 74.65. And now I'm seeing 114.64 as the employee only rate. So that's a difference in 40 for the same benefits, for the same reduction in benefits. Because it includes the 8.2, 8.3, 8.4 savings that makes up those shortfalls. But I guess what I'm asking is why is the shortfall different depending on whether it's Plan Design 1-A or 1-B?

MS. MESSIER: The one thing that definitely changed from when Laura had posted the packet to when we were able to create the numbers on Sunday evening was that she was getting information from the GFO, I believe, on the head count reduction, so we did make that change. We no longer feel good about the two and a half percent number, which is what you saw in the packet for Option A. It included a two and half percent pay cut reduction. We moved that back to two. Again, we were worried about banking on numbers that won't come to fruition once everybody submits their budgets. With their updated head count, a lot of folks are not saying that they're going to reduce staff. So we have changed that number. So that 44.60 in the board packet is likely not 44.60 with a two percent head count change. This one does include it now, so I want it to be apples to apples to show you. I don't want to artificially influence one or the other. So, again, everything but tying the seams on these two is exactly the same, except for the plan designs are different from their actuarial values.

MEMBER AIELLO: This is Betsy. I think another way of putting the question is why wouldn't the rate on 8.1-B not be 92 or $93?

MS. RICH: This is Laura. I think what we're missing here is that the assumption in the board report is that the board is choosing the entire 16 million on top of the proposal here. So you're choosing a plan and you're choosing 16 million.

But, in this scenario, the board has not chosen 16 million. You're short. You're short of that 16 million.

So that number is being added in to the rate. And that is why you see a -- that higher premium, because we have not attained the -- achieved the entire 16 million.

MEMBER AIELLO: Laura, this is Betsy. I think what she's saying is though more is being added in to Plan 8.1-B than is being added in to 8.1-A with that assumption. That's what it appears to be.

UNIDENTIFIED SPEAKER: All I can tell you is that the functionality is identical. These options are being priced identical for the 8.2, 8.3, 8.4, 8.5, 8.6, and 8.10. The rest of the difference I would have to stall for via changing the state subsidy in order to get the one sell to equal 36 million dollars. In order to do that, I have to change the state subsidy for AEGIS and for REGI and then these are the rates that result from that.

CHAIRWOMAN FREED: This is Laura Freed. Now that we chewed on this for a few minutes, I would like to return to the LTD benefit reduction possibility and see if Mr. Kemp has had time to consult with his underwriter and give us some possible additional savings.

I don't see him turning on his video or unmuting, so that remains an outstanding item, I think.

MR. KEMP: Sorry about that. This is Kurt Kemp for The Standard for the record. So I was able to get a hold of my underwriter. So thanks for your patience. Unfortunately, the most of the savings in the plan is coming by that benefit reduction from 60 percent to 50 percent. Simply changing that maximum from 7,500 to 5,000 only really only drives about 20,000 in savings. The rates about five cents less per employee per month. And that's because almost all PEBP members are falling under that $5,000 max. So there weren't enough people over that 5,000 to help bring that cost down. So I hope that helps.

CHAIRWOMAN FREED: This is Laura Freed. Thank you. That does help. I appreciate your consultation.

So, Board Members, I think there is not -- with that new information, it's not like there's not a great feeling to pursue 8.7. Is that a correct understanding of the consent of the board?

MEMBER LINDLEY: Chair Freed, quick clarification. Mr. Kemp said it was just a reduction from 50 percent, 7500, to 50 percent, 5,000. How about for 50 percent 5,000 to age 65? I think we said it was 1.9 million.

MR. KEMP: This is Kurt Kemp for the record. Yes. An estimated 1.5 million to change the plan to 50 percent up to $5,000 maximum, 180-day benefit waiting period to age 65 benefit.

MEMBER LINDLEY: Thank you. Chair Freed, this is

Tim. I would say to do that.

CHAIRWOMAN FREED: You would? Okay. All right. PEBP board -- I'm sorry. PEBP staff and Aon staff, can you take a moment and put that in to your spreadsheets and tell us the effects on the rates or is that a longer term undertaking?

UNIDENTIFIED SPEAKER: So with that 1.5 million it is a little bit longer because it was pre-programed to remove or to keep.

CHAIRWOMAN FREED: Okay. I was sort of afraid of that.

MEMBER URBAN: Marsha Urban for the record. What if you just did the 8.8, just to give us a ballpark? If you put in 8.8, that's 1.7 million. So it would just give us a ballpark for it.

CHAIRWOMAN FREED: Oh, okay. That's a good idea. This is Laura Freed. That's a nice idea as a proxy.

MS. MESSIER: This is Stephanie Messier. That is much easier.

MEMBER LINDLEY: Thank you, Marsha.

MS. RICH: While Stephanie is doing that -- This is Laura Rich -- I just want to state that there has been no recommendation from staff on these options, Option A, B, or C on 8.1. You know, obviously there's -- it's a choice.

Again, I went back to you either choose higher premiums or better benefits or with lower premiums or -- I'm sorry. The other way around. Lower benefits with better premiums or vice versa. And, so, you know, none of these options are great.

But, you know, I want to say that we're not preferring one or the other. Stephanie is merely plugging in numbers. And so she has it set up so that if you plug in numbers this is what it shows. So, you know, we're not trying to sway the decision of the board with these options by making one look more palatable than the other. This is merely math. And we know that whatever is chosen is not going to be a good option regardless.

MEMBER KELLEY: This is Michelle Kelley. Thanks for that, Executive Officer Rich. I guess my concern is that I have -- so as we work through kind of the -- I'm going to pull a peripheral, but I don't really like that term because it makes them seem unimportant. But as we work through Agenda Items 8.2 through 8.12 we look like we made significant savings and there was probably only around 1.1 million dollars left outstanding. And so then to see the premiums increase at such a large rate, I guess I'm having issues processing that change and so on kind of the information we were given earlier. And so I don't mean to question anyone's integrity. But, once again, you know, you did the math. The math isn't working for me. And I just don't understand why. Sometimes it's because I prefer the details. But it seems like given that we've almost made the full 36 million in savings without having to increase premium, that the premium even with Option B where we saw an illustrated premium, it seems like the rates have gone up a lot based on what we thought and based on the numbers that we had before.

And so that's the only reason I keep questioning. It's not because -- It's more because I'm looking for an error in the spread sheet. It's not about the human person. But the rates just seem to have gone up exponentially to make up for maybe a 1.1 million shortfall in the savings. That's what I can't reconcile.

MS. RICH: And remember that Stephanie did mention, and it was a last minute decision to change this because of the information that we're receiving from the governor's finance office, that head count number does have a significant impact as well. Keeping that at two and a half percent we could do that. But I just don't feel comfortable. I don't feel comfortable that we're going to reduce that number by two and a half percent. I am actually optimistic with two percent still. So it's just something that we have to keep in mind that, you know, there is other variables at play here as well.

MEMBER KELLEY: Just a point of clarification on that. So reducing head count to a benefit plan is bad, right, because it's a smaller hole. Okay. So if I'm going from 2.5 to two percent head count reduction should have actually benefitted the rates, not created more increase.

MS. MESSIER: This is Stephanie Messier. So we're doing a simple 299 million needs to go down by 36 million. So when you reduce head count and we give on average six, $700 per active employee per month, any employee you get rid of is $700 a month savings. That is the difference. So, right now, reduced head count does help because PEBP is not being asked to reduce how much it pays per person. It's asked to be reduced a very set figure of 36 million dollars a year.

CHAIRWOMAN FREED: This is Laura Freed. I want to talk a little bit just for the board's edification about the active employee, actually both, the active employee group insurance subsidy, AEGIS, and the retired employee group insurance subsidy, REGI. AEGIS is charged on field position. So if agencies all across the bureaucracy have submitted on Friday night, including my own, budget reductions that would entail keeping positions vacant, in which case PEBP would not get the AEGIS subsidy, or eliminating positions or even laying people off. Again, not getting the AEGIS subsidy. REGI, in contrast, is charged on gross payroll. Well, if gross payroll goes down, then the REGI subsidy pool to provide to retired people who use group insurance also goes down.

So the 2.5 percent reduction in head count, I think that was active head count, that the executive officer got from the GFO, I think may in fact be a little conservative based on things that I've heard through the grapevine. So, Board Members, spare that in mind. When we keep positions vacant to save money we hurt the AEGIS subsidy.

MEMBER KELLEY: So can I ask a next-step question? So once we're done with today's meeting and, you know, the recommendation goes forward, when it comes back, I mean, can we continue to have input in to the plan design or what we decide here today is it? Because my understanding is it was just a budget recommendation. So the PEBP will -- You know, the legislature will do what they'll do. But does the board itself once we know, for example, what's happening with the state fiscal situation in December and the various milestones that we have coming out that talk about revenue and then perhaps the final decision on what the revenue looks like, do we get more input on plan design or is it your intent that this is it and that the next time we talk about this is just to determine rates?

UNIDENTIFIED SPEAKER: You unmuted yourself, so I was giving you the chance. But I'm happy to answer.

CHAIRWOMAN FREED: I know. I felt like there was standoff on who should be first. This is -- I feel like this is a board process question and a budget process question. And I feel like I'm more qualified to answer the budget process question, so I'll start with that.

The -- You know, the unfortunate thing is that the budget process is -- runs off one track and the board schedule runs on another track. And so we are at the point right now where the agency request was due on September 1st and PEBP already turned that in. So what they have -- and that's been made public. It was made public on October 15th. And so that's final, really, and no changes can be made to that.

So now we are in the development process for the governor's recommended budget. As was said earlier in the meeting, the board's next meeting is in January and -- However, the budget as recommended by the governor for the next two years has to be finished before then.

So, the input, I mean, these reductions are scenarios, as the governor's finance office put it in its memo, that they will consider when putting together the governor's recommended budget. Are they guaranteed to take them? No.

As both board members and public comment has noted, the economic forum might put the governor's finance office in an even bigger bind or it might not. And so does the board have input on plan design, not specifically in the budget process. The executive officer will certainly be consulted. Behind the scenes of gov rec remains under development. But so from a budget process perspective, this is ultimately the last stop. From a plan design perspective it's not based, because, of course, the board has the March, traditional March rates meeting upcoming, and that's where I'll hand it off to Laura Rich to talk about the PEBP board track of this.

MS. RICH: So this is Laura Rich. It's not only the PEBP board track, but there's also the PEBP staff track and open enrollment. You know, as you know, we have a very limited window where we can make plan design decisions and have the actuaries be able to come to the March board meeting and present those rates in March. If we are making plan design decisions in January, it ultimately is going to conflict with what has been submitted in the governor's recommended budget. And so we're put in a really difficult situation here.

As the executive officer, I have to defend what is in the governor's recommended budget. And so in making those plan design changes that are conflicting with what has been included in that recommended budget is -- it puts me in a very awkward spot.

Additionally, we do have to work towards open enrollment. And so that window of opportunity between March and open enrollment is very, very busy for PEBP staff. We not only have to load rates in to the system, we've got to test them, we have to make sure that the system is working correctly, we have to update, you know, plan benefit guise, we have to update master plan documents, the website, all kinds of communications that are going out to members. There is a lot of work that goes into -- We are in scramble mode after the March board meeting essentially.

And so, unfortunately, it comes down to timing and, like Chair Freed said, there's different tracks. And, unfortunately, they're not on the -- they're not parallel or perpendicular or whatever you want -- however you want to use that metaphor. It's definitely a -- It's a scramble when we make any plan design decisions after November.

MS. MESSIER: This is Stephanie Messier. I did just want to report that it looks like Option B of the addendum from this morning was not set to a 20 million dollar savings. It was set only to it looks like five million dollars. We didn't carry it through to the final steps, as we were trying to get that out this morning. So that's why you're seeing the difference and your math is not changing. So, again, I apologize. The rest of the spreadsheet is hanging right, with yes and nos with your options. But when we copy and pasted the rates this morning, it was only savings the plan it looks like actually six million dollars. So there was 14 million dollars that still needed to be saved by changing the AEGIS and REGI amounts to get to the full amount of savings needed. And it's looks like we sent out the wrong one this morning to Ms. Rich.

So the rates we're showing now are the correct rates for toggling these options to make Option 1-A and 1-B on a similar basis. What was included in the addendum this morning was only a six million dollar savings, not a 20 million dollar.

MS. RICH: Stephanie, we can't see -- This is Laura Rich. We can't see your screen.

MS. MESSIER: Yeah. I'll switch it. Here you can see the numbers are similar -- Again, this is Stephanie Messier -- to what was sent out this morning. But the savings to -- This red number here, I don't know if you can see it, is the key that we're trying to get to 36 million. And right now with all the options set to no and being as the plan is today with designs in July, the rates are assist similar to what you saw on the board packet and your addendum. But this is the key number that we're looking at and that's six million dollars. That's not set to 20, which is what it should have been in order to be included in that addendum to be on a similar apples-to-apples basis with the other design.

MEMBER KELLEY: I appreciate you going back and looking at that. That makes a lot more sense.

MS. MESSIER: Yes. I apologize. It is hard to follow numbers live and on the screen. So thank you for your patience.

CHAIRWOMAN FREED: This is Laura Freed. Thank you, Stephanie. So is it possible to go back to your 8.1-A and 8.1-B table knowing what we know now?

MS. MESSIER: This one is still valid. So this is based on your choices that we most recently discussed and it's two differences.

CHAIRWOMAN FREED: This is Laura Freed. Did we put in 8.8 as a proxy for the 1.5 for 8.7?

MS. MESSIER: Yes.

CHAIRWOMAN FREED: Okay. Great. Thank you.

MS. MESSIER: I'll double-check it though just to be sure. Yes, that's correct. So with the proxy on the Part B subsidy, yes, as to Model B impact of the augmented LTD. Stephanie Messier for the record.

CHAIRWOMAN FREED: Laura Freed for the record. Thank you. Okay. Board Members, can you all see that? So 8.1-A with all of those choices, employee following coverage becomes 58.04 per month. Employee plus family becomes 312.03. Again, that's ballpark figure based on many assumptions, but it's close. And then in Plan Design B, employee only, $111 per month. And employee plus family 437.80.

So we have brought ourselves back to the essential choice now between Plan Design A -- 8.1-A or Plan Design 8.1-B. I heard Mr. Lindley say he prefers A. I heard Mr. Verducci say he prefers B. And I don't think I heard definitive statements from other members. So I will ask for that.

MEMBER KRUPP: This is Jennifer Krupp for the record. I prefer Plan Design A.

MEMBER FOX: Linda Fox for the record. I also prefer A.

MEMBER KELLEY: Michelle Kelley here. You know, we've talked about no good options. But I believe Plan Design B is better for my constituents.

CHAIRWOMAN FREED: Laura Freed. Thank you.

MEMBER URBAN: This is Marsha Urban for the record. My constituents said they didn't want to lose the benefit. So I would go with Plan B.

CHAIRWOMAN FREED: Laura Freed for the record. Betsy Aiello, I'm sorry to put you on the spot.

MEMBER AIELLO: Yeah. I was going to say that I hate to give up the benefits. But I'm just a little worried about the young families in the program, the level of the lowest premium per month. But, overall, I think Plan Design B is better for max out of pocket, so I think I'll go with that.

CHAIRWOMAN FREED: This is Laura Freed again. Let's see if I have -- Laura Rich, do you -- did you catch count of that? I have two, but I want to cross-check my numbers. You guys know how bad I am at this.

MS. RICH: Laura Rich. I have three A's and four B's.

CHAIRWOMAN FREED: I have Betsy Aiello for B, Marsha Urban for B, Michelle Kelley for B, Tom Verducci for B for a total of four. And then under A, I have Tim Lindley and Linda Fox and Jennifer Krupp. So four B's and three A's.

MEMBER KELLEY: I guess, Chairperson Freed, I would just like to put one thing out there. And I know there's a time crunch and all the rest of it. But I did just want to perhaps request that the vote be delayed until early December. My concern is that just because of the numbers kind of changing from I think what we were working on with our constituents it would be great to go back to them and actually get some feedback before finalizing.

CHAIRWOMAN FREED: This is Laura Freed. You know, the problem with that is that GFO is already waiting on this. The rest of us had to turn in our budget reductions, which was great fun for us directors, last Friday evening. And as soon as this memo dropped, the executive officer was on the phone to me brainstorming options. So she has been working on this since November, early November, November 3rd I believe is when it -- I was just looking at my calendar -- when it dropped, and it's now November 23rd. So she's been working on this for basically 20 days, as has the vendors.

And actually we had to go to the GFO and say we can't make that deadline because there's a board meeting after your deadline. And so she got a special extension that everybody else didn't get. And so to extend this until December, first of all, puts pressure on the GFO who has to do things in the budget in a very methodical and scheduled way and I think causes PEBP staff to have to get us all together again, which is pretty difficult to do. So I'm frankly not receptive to that.

We, unfortunately, all are appointed by the governor. I don't say it's unfortunate the governor appointed me. We are all appointed by the governor. And, unfortunately, we get appointed to do hard things in this kind of a fiscal climate. It would be great if we got to be PEBP board members in a time of increasing revenues and all we had to do was enrich the plan design. But we don't get that. That is not our lot in life. And so I'm, frankly, unwilling to do that right now. We have to make a choice and it has to be an unpleasant resource choice.

MEMBER KRUPP: I just have a question. This is Jennifer Krupp for the record. I'm looking back that we had four votes for Plan B and then three for Plan A. And I'm looking at the differences really. And what Stephanie Messier had put up was that for the CDHP plan, it would take for the one employee only enrollment up to $110 a month. And, looking at the benefit design that was sent in Addendum 8.1 as well as the board packet, really the only differences that I'm seeing is an out-of-pocket max of 5,000 and 10,000 for Option B versus 6,000 and 12,000 for Option A. And then a difference of $200 for the HSA account for the HSA contribution would go to 500 in Option B versus 300 in Option A.

So, correct me if I'm wrong, but I'm not seeing a difference in, you know, almost what, 60 -- $40 for those -- for that difference in benefits.

MS. RICH: So this is Laura Rich for the record. I'm sorry. I'm sure Stephanie is on the same page as I am right now going from one option to the other. And the board has seen these three options. We've actually seen, like, 38 other ones. And so we're trying to keep them all straight.

(Michel Loomis took over as the court reporter)

MS. RICH: So we -- it -- I think -- let me compare the two here and bring them up. I believe we did something to the HMO as well. Let's see. Stephanie did. We add -- it looks like we added the deductible. Now, just the out of pocket on that one, I think we did a few other things with the HMO and the co-pays.

UNIDENTIFIED SPEAKER: Yeah, I think the biggest changes were like for the inpatient hospital and for ER visits, like applying the deductible in addition to a co-pay based on talks with HPN.

MEMBER AIELLO: This is Betsy replying to Jennifer, because I was so on the fence. If you want to go the other way, I'm sorry, I saw that back and forth, because

I am really worried about some of the pre-Medicare retirees and the families with the younger workers with the higher premiums. And I think I just didn't get enough time, really, to see all of these. So I'm sorry, let me -- maybe I should switch and I hate to be so wishy washy, but I'm looking at the other one again.

Because with the added from 300 to 500, that does decrease what the premium would be, but not by 40 a month, because that does give people more money. And then it is just the max out of pocket that's the difference and the cheapest of the plans. So I think I'd like to switch. I'm sorry. It's just one of these where it's hard to know. We wish could go out and poll the people.

MS. RICH: Betsy, is this is Laura Rich. You're switching then to A?

MEMBER AIELLO: Yes, I'm sorry. I'd like to switch to A based on Jennifer's input and I just looked, myself, to see the differences. So I'm just worried about such -- I know everybody is.

CHAIRPERSON FREED: All right. This is Laura Freed. So that brings us to four A's and two B's by my count. Laura Rich, is that what you have?

MS. RICH: (Inaudible response).

CHAIRPERSON FREED: Okay. So with that, I think we have reached a decision, a very unpleasant decision that nobody likes, that nobody wants to suggest, and I think I need to underscore here that the Governor's finance office and the Governor's office are aware of how ugly this is, and I believe that they are watching and they have heard some if not all of these deliberations. And, you know, it's always possible that they could choose to make up a budget shortfall with furloughs or pay cuts or something else that doesn't hit benefits as -- and I'm not saying they will, I don't have any inside information. But I do believe that they understand what a contentious and sensitive issue health benefits are for employees. That, I can say. So . . .

MS. RICH: Madam Chair, not to --

CHAIRPERSON FREED: Yes?

MS. RICH: Not to make this worse, but in case we are asked to -- we've gotten to the 16 million. In case we are asked to -- let's say we need 14 percent instead of 12 percent, rather than calling a board meeting in December, during the holidays, it might be good for the Board to make a decision too as to what if we are asked to make that, you know, 13, 14, 15, who knows what that number is going to be. Do we want to just look at increasing premiums? And if that is the option, then I think it needs to be spelled out so that it gives us that flexibility.

MEMBER AIELLO: This is Betsy. I'm -- and I'm just throwing out this, the option of, again, 8.8 and 8.9 that were the elimination, is there like dropping them by 25 percent instead of totally eliminating? I don't know if that's an option or if it's just nickel and dime, so would it really help you?

MS. RICH: So this is Laura Rich. I guess, Betsey, that all depends on how far into that elimination the Board is willing to go. If it's ten percent, then it's really nickel and diming it. If it's, you know, 50 percent, maybe that's something that, you know, we can look into, especially if it's 8.9.

MEMBER KELLEY: It's Michelle Kelley here. I think that given the extent of the cuts so far and the things that we haven't -- that we have not prioritized, I would prefer to come back in a special meeting. I'm not -- I don't believe the three items that we have -- that we have not prioritized should be considered. So, you know, whether it be premiums or other plan design, you know, I'm not prepared to prioritize 8.7, 8.8 or 8.9 at all today.

MEMBER URBAN: Marsha Urban for the record. I agree.

CHAIRPERSON FREED: All right. Executive Officer Rich, I think -- much to your chagrin, I think if the public employees benefits program is asked to make something more than 12 percent, we may have to shoot more in a December emergency meeting and that's okay. We'll just see what happens at the economic forum and let's -- let us go with what we have today and hope that that is the only thing that they ask of PEBP.

With that, I'll see if I can make this motion to make sure that it is clear on the record. I move that the PEBP Board, in order to meet the lower targets established by the Governor's finance office, direct the PEBP staff to amend the budget such that we go with Option 8.1.A in terms of plan design and include as additional savings measures 8.2, 8.3, 8.4, 8.5 Option 2, 8.6 Option 2, 8.7, reduce the LTD benefit to 50 percent 5,000 max up to age 65 with a waiting period and 8.10. And anything that does not then reach the 16 million is made up in the premiums. Thank you, Stephanie. I can --

STEPHANIE: Laura Freed, Stephanie needs to jump in here because I think there's a small error.

CHAIRPERSON FREED: Okay.

MS. MESSIER: Yep. This will teach me, Stephanie Messier for the record, to try to show numbers on the fly without peer reviews. This is why we don't do this.

So during the meeting I had flipped one of them to '23, trying to show what we would see in '23 with an extra year of trend. So as you might imagine, that makes an additional difference. So before you vote and move forward on A versus B, I wanted to take this opportunity to interrupt. These are now both on plan year '22, and I apologize.

CHAIRPERSON FREED: All right. This is Laura Freed again. Okay. Let's go back to the drawing board then. All right. Board Members, take a look at this. Does anybody wish to change their feeling now based on this?

MEMBER LINDLEY: Tim here. Knowing that rates will potentially increase, I'm going to maintain my decision for option A, 8.1A.

MS. MESSIER: Okay.

CHAIRPERSON FREED: This is Laura Freed. I'm not hearing anybody change their feeling on this one. So again, let me try and make the -- see if I can state the motion correctly for posterity.

I move to present budget reduction scenario involving plan design changes as reflected in 8.1.A, including the savings measures in 8.2, 8.3, 8.4, 8.5 Option 2, 8.6 Option 2, 8.7 to reduce the long-term disability benefit, but not eliminate it and 8.10 unbundling of the dental premium. And to the extent that that does not get the Board to its $36 million subsidy target, make up the reductions in the B participants share of the total premium.

Do I have a second on that motion and does it make sense to you all?

MEMBER LINDLEY: Tim here. I second the motion.

CHAIRPERSON FREED: All right. Thank you. You heard the motion, it's been seconded. Is there any discussion on this motion?

Okay. Hearing none, I will ask Ms. Rich or her staff to do a roll call so that this is clear for the record again.

Nicole, are you able to do a roll call vote, please?

MS. PLUTA: Yes, I can go ahead and do that roll call.

CHAIRPERSON FREED: Okay.

MS. PLUTA: Linda Fox?

MEMBER FOX: Aye.

MS. PLUTA: Linda Fox?

MEMBER FOX: You didn't hear me? I vote yes.

MS. PLUTA: Betsy Aiello?

MEMBER AIELLO: Yes.

MS. PLUTA: Michelle Kelley?

MEMBER KELLEY: No.

MS. PLUTA: Jennifer Krupp?

MEMBER KRUPP: Yes.

MS. PLUTA: Tim Lindley?

MEMBER LINDLEY: Yes.

MS. PLUTA: Marsha Urban?

MEMBER URBAN: Yes.

MS. PLUTA: Tom Verducci?

MEMBER VERDUCCI: Yes.

MEMBER URBAN: For the record, is the -- with all the 8.2 and the rest of them, isn't that 16.4 million there?

CHAIRPERSON FREED: This is Laura Freed. I believe you are correct that 8.2 through 8.10, it is more than 16 million. And I'd have to do the arithmetic real fast, but I believe you're right.

MEMBER URBAN: Marsha Urban for the record. So that's been reflected on Stephanie's A and B plans here; right?

CHAIRPERSON FREED: This is Laura Freed. I'm not sure I understand your question because --

MEMBER URBAN: Marsha Urban for the record. Is that 1.5 that we had, is that now in the plans A and B? I know when we changed it, we ball parked it at 1.7. But is it now correct in there at 1.5?

CHAIRPERSON FREED: This is Laura Freed. I think it is still in there at 1.7 as a substitute for the 1.5. So there might be some small adjustment of a few hundred thousand dollars there.

MEMBER URBAN: Okay.

MS. MESSIER: And this is Stephanie Messier for the record. So the one thing about that line item is because it's a part D savings and the LTD is just in addition to the active rates, you're not going to see it reflected correctly. So it changed your overall savings to 36 million because of where the three different buckets are. But the way we had it modeled right here, it's not going to flow through to the active side, which is where it really would be reflected in actuality when you change the LTD. If I would flip the LTD toggle right now, it would do it correctly, but not by the right amount because you're not talking about eliminating the LTD.

MEMBER KELLEY: So, Stephanie, these rates -- based on what your explanation just now, these rates will actually go down if that was the only influencing factor.

MEMBER MESSIER: The change in LTD is your question? This is Stephanie Messier.

MEMBER KELLEY: Yes.

MEMBER MESSIER: Yes, that's correct. So if -- when I toggle the LTD to yes, you will notice the state active rates will go down because it's a savings on the state active employees, whereas the retiree rate would not change nor obviously would the Medicare exchange amount change.

CHAIRPERSON FREED: All right. This is Laura Freed. Any other final questions?

MEMBER LINDLEY: Tim here. So as an active employee, the goal is -- the next step would be to try to increase the subsidy if we wanted to lower our premiums; is that correct? I will be an active member in the next step.

CHAIRPERSON FREED: Okay. All right. Unless Ms. Rich has something else, I think that brings us to the end of Agenda Item 8.

MS. RICH: The only thing that I want to make sure is -- on the record is on the dental option. I want to make sure that it's on the record it is an opt out. You cannot opt in to dental without being on the medical plan. So dental is not just a -- you know, $5 gets you dental. So I just want to make sure that's on the record that that's not on -- that's not going to be a plan benefit change.

MEMBER KELLEY: It's Michelle Kelley here. At the risk of blowing this whole thing up or being shut down, why -- I guess when I see the rates, why would we even separate dental out? The rates we were looking at were dental intact; right? Dental there and it was $58 per employee. You know, dental is important. So I'm just wondering, does the Board still want to separate it out as a separate premium if we're not going to be doing COVID subsidies or anything exotic like that, is the point still valid? No one wants to take it? Okay.

CHAIRPERSON FREED: I'm not even sure how to answer it. Sorry, this is Laura Freed for the record. I'm not sure how to answer it. Using the $58 hypothetical premium and I were to opt out, I'd pay $55. And so the savings is generated by the estimated -- correct me if I'm wrong, please PEBP staff. The actuarially estimated number of people who would opt out of the dental cost.

MS. RICH: Opt into the dental cost, I believe, is the correct -- so we're charging that extra 5, 10 or $15 -- for the record, Laura Rich. We're charging the 5, 10, $15 and so essentially that is where you get that extra savings.

CHAIRPERSON FREED: All right. This is Laura Freed. I think -- thank you for putting the -- that on the record, Ms. Rich. I think we should move to Agenda Item 9, public comment. And so I will let PEBP staff take it over.

MS. PLUTA: Okay. And for public comment I'm about to share. On the side it says how to enter public comment, what phone number you need to dial as well as the meeting ID number. If you do have public comment, please be sure to state your first and last name for the record.

Just as a reminder, when I unmute your line, you will be asked to select star six to unmute your line. Again, for those who call during public comment, I will state the last three digits of your phone number and I will advise you that your phone line has been unmuted.

Kent Ervin, your line has been unmuted.

MR. ERVIN: Hello, this is Kent Ervin, K-E-N-T, E-R-V-I-N, Nevada Faculty Alliance. I've had a very long day and I don't have prepared remarks. I thank everyone for going through this process and that at least we avoided some of the worse cuts elimination of benefits for various groups and retirees.

However, as you know, we're not in a good place with the plan design or the premiums, for that matter, and I fear if these are selected by the Governor's and the Governor's recommended budget, that particularly the plan design changes will be very hard to reverse in the future.

I had more hope that we could possibly work on the State funding amounts to increase the employer contributions. But anyway I appreciate everyone doing all this hard work. I do have -- put on the record that it was very disturbing that decisions are being made without taking the time to get the numbers right. I know that's very difficult. I don't fault the numbers being wrong, but it's a matter of not having the time to take a break to get the numbers right and so that's very disappointing. Thank you very much.

MS. PLUTA: Line ending in 0013, your line has been unmuted. Line ending in 404, your line has been unmuted. Line ending in 947, your line has been unmuted. Line ending in 987, your line has been unmuted.

Doug, your line has been unmuted.

MR. UNTER: Am I on Zoom or --

MS. PLUTA: You're on Zoom. You're on the public comment.

MR. UNTER: Yes. Okay. Sorry, I've got a -- I've got a feedback going on here.

MS. PLUTA: Hey, Doug, can you mute your computer? It sounds like we're having feedback.

MR. UNTER: I'm sorry. There was feedback going on here. This is Doug Unter, U-N-T-E-R. I'm a member of the UNLV employee benefits advisory committee, chapter president of NFA also, chapter past counsel faculty senate chair and I've been attending PEBP board meetings for nine years.

I originally got involved in advocating for restoring our benefits from the last recession because I knew in administering the system, because of high out of pocket medical costs, actually lived in a car at our University for more than three months. And I've known many, many, many others who have suffered greatly because of the high deductibles and high out-of-pocket maximums.

There are a couple of things that came out of the meeting today, which were misrepresentations about the CDHP plan. One was that it was said that mainly only younger people who don't really need it are using it and that is not true. The old adage in southern Nevada is if the ambulance picks you up, don't tell them to take you to the hospital, tell them to take you to McCarran airport, because you get better treatment out of state than in the state.

I have personal experience with this with my wife who suffered from a condition from which she would have died if she had not gone out of the state because there was no medical provider in Nevada who could do the specialized surgery that she needed. And if we had not been the CDHP plan, I shudder to think how we would have ever been able to pay the costs. And fortunately we had it even though we were out of pocket $18,000, not the $3,900.

This has been a really terrible meeting after nine years of advocacy to restore benefits to see what's happened now. I want to inform the PEBP board that this is unacceptable, that despite all your good work and all your good will, what the Governor has asked you to do with our health benefits is unacceptable and will be unacceptable to faculty and staff of the Nevada system of higher education.

I see no other option now left for us than to do what we have been talking about doing for years, but have avoided pushing doing, and that is right now to commit ourselves as a system with our independent board of regents to try to separate ourselves out from the Public Employee Benefits Program. We have researched plans. We can get far better plans with our constituency group than is being offered by PEBP at this time.

PEBP should seriously consider and should seriously inform the Governor's office that we will begin to push to separate ourselves out. The reason is that we can get a better plan, but there are also other reasons. We can develop our UNLV medical school clinical practice, UNR can develop its clinical practice and we will all be better off.

I'm very sorry to tell the Board this, but the Governor needs to know. He will wear -- he will wear what he's doing to our health care benefits like he won't wear the furlough or any other cut that we're going to suffer.

After nine years of working to restore benefits, to see what has happened in this meeting, to see them stripped so down to a C minus medical plan, that we will not be able to hire. We won't be able to hire quality faculty for our University with this health plan. It just won't work. So I'll get with Michelle Kelley. Thank you very much for your advocacy on this board and all the Members of the Board for your good work. I know it was very unpleasant and I appreciate everybody's work, but this is just basically unacceptable. And I'm hearing from members right now, my emails lit up. We'll just have to work now to try to separate ourselves out from PEBP and that's all I've got to say. Thank you very much.

MS. PLUTA: Line ending in 111, your line has been unmuted.

MR. SUELL: Hello, this is Sean Franklin Suell for the record, and I'm the chair of the UMLB employee benefits advisory committee. I have several things to bring up in public comment. The first thing is that I want to echo what Doug's said, that only young people with the least expensive healthcare on the CVHP is a misstatement. Many people who are on specialty medications choose CVHP because the coinsurance is ten percent more on the other plans.

Secondly, by choosing Option A today, you cost employees on the CVHP $3,170. Those are people who are employee only coverage and that is in benefit cuts and additional premiums.

Third, Chair Freed referenced our surcharge idea as a simple rhetorical device. I would like to point out that it might be a rhetorical device, but it's one with real consequences for our future benefits and premiums. By calling it a surcharge, that means the possibility that it would be removed if held out there.

Let's see. Fourth, I find it objectionable to say the least that the numbers changed today from what we received in the report. The amount of attrition, if you will, went from 2.5 percent to 2 percent. Other numbers changed, the spread sheets were all incorrect.

I believe that the meeting should have been halted and that either a break should have happened while the numbers got correct, while documents were represented and then we could all look at them or the meeting should have been moved or adjourned until December in order for that to happen.

I understand that the Governor's office wouldn't allow that, but maybe this meeting should have been scheduled earlier once we knew what was going to happen to give staff and advocates enough time.

And finally I also have a major problem with the chair not allowing public comment before the vote on Agenda

Item 8. For the past three to four years, that has been the practice in these meetings and we were told that that would likely happen again today. It did not.

So I do want to thank all of you for your work. I know this has been hard. I do want to thank Laura Rich for her help with all of this and I also want to thank Michelle Kelley for her advocacy for during her first meeting with the public employee benefits board. Thank you very much.

MS. PLUTA: Line ending in 118, you have been unmuted.

MR. GARCIA: For the record, this is Jose Garcia. First, I wanted to thank the Board for all your work today. I know there wasn't any chance of a good outcome and that's certainly not your fault. I, too, am disappointed with what has happened today.

As I said earlier in the day or earlier this morning, the benefits have been stripped away year after year for one reason or another. Some things we got back, a lot of things we did not. Right now is a really bad time to be stripping away benefits. You know, the furloughs that are coming, it's just not good. And while there was no good option, again, I thank you guys. You did the best you could with the data and resources that you were given. So thank you for your time and thank you for hearing me.

MS. PLUTA: Brian, your phone has been unmuted.
Kevin Ramp, your line has been unmuted.
MR. RAMP: I'm sorry. Can you hear me?
MS. PLUTA: Yes, we can. Thank you.
MR. RAMP: Good afternoon, Chairwoman Freed and committee members. Again, my name is Kevin Ramp, representing ASFEME Local 4041, active state employees.

I'd first like to thank everyone for your hard work during these difficult times. More could be done clearly in this situation. State employees are extremely disappointed with the cuts approved today. There will be numerous unintended consequences based off of the various increases to -- potential increases at this point to the premium rates and then the dramatic cuts to the benefit package overall.

There's clearly going to be that unintended consequences that we would hope this Board would come back when they find out the possible revenues, what that's going to look like and make a determining factor based off of that revenue stream. We hope an emergency board meeting could be called in December to address some of these plan design issues.

State employees live pay check to pay check. We all know this. There's -- time and time again, we have nothing but State employees moving out of the state, calling us and letting us know that they need to adjust the healthcare plan. We're talking the last ten years, even longer, and that was when the times were good. Now our times are bad and now they have extremely difficult choices to make: Put food on the table, pay their bills or get healthcare. Very disappointing.

We understand this is very difficult times, but you know, I would have hoped that respectfully every single board member would have contacted the Governor's office and said personally that these -- 12 percent is not viable, not sustainable and something that the Governor's office should reconsider and ask for a lower percentage to work with, something that we could have all lived with. And respectfully that's not what happened today.

I do ask, going forward, if there is an opportunity to do an emergency board meeting in December, to do and adjust plan design based off of new revenues, potential stimulus package or whatever else could be done, that be taken into consideration, because again, we want to ensure that benefits are the last thing we cut, not the first. I appreciate your time and thank you.

MS. PLUTA: Margaret, your line has been unmuted.

MS. MILLER: Yes, I'm -- this is Margaret Miller and I'm not really 100 percent sure what happened today or what actually was decided. But as a retiree that is not eligible for Medicare in any form, I'm not really sure what this is going to actually do to me or the people that are in the same position I am, how many other changes. It sounded to me like you were taking away -- you were taking away some of the subsidy. And if you take the subsidy away, I know you got to raise rates, I get that. I just don't understand, I guess. But you were talking about eliminating -- and I don't know the part B subsidy and I'm not sure exactly where you ended up with on that. So are you cutting that back or is that going to stay the same?

You only -- I worked 30 years for you guys and you only give me credit or a subsidy for 20 years. So to start off, I am ten years in the hole with the subsidies. So -- and I was listening to find out, you know, where we were going on the premiums and I -- like I said, I'm still not very sure how all that came out. I know they're going to be going up. How much they go up, I don't know. I figured I was going to -- are you still putting us on the exchange or what? I figured if you raise them too much, I won't be able to even afford insurance either.

So I'm -- it's really tough, I understand that and that. But I think the Governor's office should not be trying to balance the budget in the shortfall that we have going on. And a lot of it is not through their things, it's just something that happened with the COVID, but you still should not -- my opinion has always been, even when I was a state employee, an active employee, that you should not be balancing the budget for the State on the backs of not only the state employees, but now you're doing it on the backs of the State retirees.

And we're people -- at our age, because I'm 78, we're people that have not got the option to go out and earn a living, buy insurance and take up -- we live on a restricted income anyhow and I'm a widow. So -- but I thank you for everything that you've tried to do and I know it's a hard thing to do. So hopefully some good news will come out of this at some point in time. Thank you very much. Appreciate it.

MS. PLUTA: Brian, your line has been unmuted.

MR. BRIAN: Good afternoon, Chair Freed. I'd like to thank you and the Members of the Board and the staff of PEBP for all your hard work. I know it was very difficult to make all those cuts that had to be made, but you know, having been, you know, employed in the State as a budget person for a long time before I retired, I know that it -- a lot of times you are faced with difficult decisions. And so

I do appreciate how much time and effort you put into this and I especially appreciate how you protected the State retirees with your actions today.

We were, you know, looking at some of the options that you have on your agenda for the State retirees. It left a real pit in my stomach, but I think you -- I think you really did the best you could to keep retirees with coverage. So again, I'd like to thank you for all your efforts.

MS. PLUTA: Line ending in 441, you have been unmuted. I know this particular member was having a hard time, so just a reminder to hit star six to be unmuted.

MS. LIVINGSTONE: Hello, my name is Alejandra Livingstone. And on and off I've been watching the Board meeting today, but because of work, I really could not pay full attention.

And I wanted to let you know that I submitted some comments in writing just because in the morning when I phone in for some reason, I was not called to testify. And I am not fully aware of what is the process for designing the plan and making a final decision on it. I wish I had more time to look into. I got home on Friday night and I received an email from -- ask me, of which I am a member, and I am a State employee for 24 years. And I have a background in business and economics and public policy.

And the one thing in addition to the comment that I submitted that I want to say that I don't feel like enough people were aware of these decisions. I got to work this morning and I talked to a few people in the office, many of them who are not there either because they are in a quarantine or because they are on their Thanksgiving vacation.

So when a drastic measure like this is being proposed like proposing to cut subsidies for retirees, dependants and trying to take non-Medicare employees out of the benefits that we all worked for for so many years, it seems to me like there should have been more awareness. It's just part of the democratic process and I don't feel -- I may be incorrect, but I don't feel like that happened. And a lot of decisions were made today without having everybody's comments.

So I just don't feel like that's right and like many have suggested today, I feel like we are being cheated, because a year and a half ago, we were promised a state where there would be focus on family and children. And some of us have children that are young adults and are in college and like me, I'm about to retire two years from now, and I have children in college for my benefits. I have three chronic medical conditions for which there is no cure and I have one to five medical appointments per week and twice in my career, I was very close to going on disability.

And the reason I am not on disability is because I believe that I have decent healthcare. I have intermittent FMLA with the State and with FLEX time and the medical appointments and so forth, I've been able to stay on the payroll without having to go on disability, because once you are going on disability, you're not approved to go to work elsewhere part time and so forth. So it's a huge decision.

And my children also have medical conditions and have ongoing medical appointments. And I'm not sure what final decision was made today, but I would urge you to please reconsider some of those public measures to make sure that more people have the opportunity to provide input. And if this is a decision being made because of the coronavirus emergency, just like some people suggested earlier, maybe this is something that needs to be just temporary because every single recession, they propose to cut more and more and more from us and there will be more recession.

I am trained in economics. I know the economy cycles. We already legalized divorce, gambling, prostitution, marijuana, all measures that are compromising values for some of us. And those measures have not raised enough revenue to raise -- to -- for -- to have more reserves, so that every time that there is a recession that we -- you guys don't take it or not. I work in less than desirable working condition and I'm effect -- that by hiring freezes and every since last recession, I am doing three people's jobs.

And now because of coronavirus, one of those positions that I got back, that position is in a quarantine. So I'm, again, doing three people's jobs. And not all the agencies are being -- are allowing their employees to work from home. I am not being allowed to work from home, although I have a chronic condition.

So it is unfair that on top of the furloughs, that we're going to have to assume as of next month or a month and a half, then on top of that, we'll have to pay more for insurance. It seems to me like Nevada needs to put more effort into restructuring its economy, diversifying it so that every time there is a recession, you don't have to take from us, from the employee.

Recessions are going to continue to happen. The next one is going to be a climate change recession. So what are we -- what else are you going to take away from us? I know you all work very hard today and you have to make very bad -- very difficult decisions. I totally understand that. But I feel like it isn't right that all these decisions are being made without sufficient input from the employees and the retirees, and that we were promised a State that was focused on family and children, and we're being told yesterday that an eight year old committed suicide because that child can't go to school.

Well, so is the college students. College students right now are doing University work from their rooms and they don't have their parents around to provide them support and the last thing that they need to hear is that the State might take away their medical benefits. Thank you very much.

MS. PLUTA: Line ending in 338, you have been unmuted.

MS. MALONE: Good afternoon. I know it's been late. This is Priscilla Malone again with the AFSEME retirees. Can the Board members and Chair Freed hear me?

MS. PLUTA: Yes, we can.

MS. MALONE: Thank you. I would like to correct some things on the record today that were said specifically on -- there was a global generalized discussion under Item -- Agenda Item 8.5 about the Medicare exchange retirees not using a certain proportion, not using their max allotment of the employer contribution to their premium costs on the Medicare exchange.

So I'd like to refer you back to Agenda Item 4 on your April 27th, 2020, meeting wherein this issue, as Ms. Freed touched -- or I'm sorry, Ms. Rich touched today was fixed in the sense that there was -- there were caps involved. I'd like to state for the record some facts because we've -- as other public commenters have noted, we've been very hasty on the facts and, in fact, even had to have some corrections from our actuarial AEON in the middle of this meeting, and then have the Board members put in the difficult decision of voted on the issues where the facts were literally moving while they were trying to ascertain what their vote would be.

So back to April 27th, 2020, this is at page -- this is Agenda Item 4 and it's a PowerPoint presentation and it looks like the pages were not numbered. But it -- it's in there and they talk about how they're going to cap the HRA rollover amounts. We've agreed and we had discussions during that meeting that many of the exchange retirees purchased Medicare advantage plans and sometimes there is a zero premium.

So steps were taken back in April of this year. I would like to put on the record that the amount, and it's on this PowerPoint that's in your archive, the amount of the retirees on the exchange is approximately around 11,000.

This was 3,178 who were not using their max allotment. That is not a suggestion that this is poor policy to give them the allotment they have. So we've gone down to $13 to 11 now by the vote today.

The AFSEME retirees are very disappointed in that because that may not sound like a lot when you're putting it in the abstract, but these are people on a fixed income. They are already capped at 20 years service. So if there's a 30-year service person on the exchange, it's already in the statute in your appropriations, bill from last session, you can check it, any funds that are not used by that retiree go back into the -- to the fund. They do not go to their HRA account necessarily.

So I would just like to clarify that for the record. Again, we are very disappointed, but we do -- in the decisions today, we do look forward, though, to working with both the executive and legislative branch in regard to these cuts and we will hopefully have some productive discussions around this at the interim benefits and retirement benefits committee meeting in December. Thank you.

MS. PLUTA: Clarabel, your line has been unmuted.

MS. ZECENA: Hi, my name is Clarabel Zecena, last name is spelled Z-E-C-E-N-A. So I have been a State employee now for nine years and I'm actually the AFSEME cochair of the

PEBP and first committee for the AFSEME Local 4041. And I -- first, I want to thank everybody for your time. I know you guys had to make some really hard decisions. However, I want to echo my fellow members in describing my frustration with what PEBP continues to do.

I understand that we have to make sacrifices, but the fact that we keep losing benefits makes it hard to stay in state service. So the State eventually is going to start losing it's qualified staff. We're going to leave. If you work to the County, the County covers your premium. They put you in a high deductible plan, but you don't have to pay anything out of (indiscernible) to keep (indiscernible) they're getting better wages than we are. We're getting worse or lower pay. We get into that (indiscernible) continue to suffer during (indiscernible) of economic hardship.

So I understand where it was, but this option (indiscernible) had the option of postponing to December, the ability to vote and to send a message to the Governor to say, no, we can't do this. Our employees are -- this is asking too much. Can we come back and see like -- and if we have to take a cut, that can we negotiate that, because we're already facing furloughs. We're already going to face who knows what when it comes to the next budget.

But the fact is that you already are digging more and more into our pockets. That makes it hard to continue to provide the service to this -- to our state. We're already sacrificing ourselves because we know what -- we enjoy the services that we provide and the services that we help our fellow citizens of Nevada, but we just keep getting hit over and over again.

So I really hope that this Board can send a message to the Governor's office to say really -- to send its discontent of where we are at. I appreciate that we are in a hardship, but it has to start making other decisions on diversifying this economy because we can't keep doing this. Not every single recession, we can't keep doing this.

So, again, thank you for your time and thank you for everything that you did. It was a long meeting, so I appreciate it. I've been on the other end of these meetings and so I can see when it takes -- when it -- they last this long, how it can be a toll on you. So thank you.

MS. PLUTA: Jody, your line has been unmuted.

Madam Chair, that seems to be the end of public comment.

CHAIRPERSON FREED: Okay. This is Laura Freed. Thank you very much for all of that. All right. So it's -- good grief. This was a long one, my friends. It is time for adjournment.

As a final note, I just want to thank everybody on the Board for their spirited discussion. It's been -- I've been watching the Board for a lot of years previous to being on the Board and I -- it's -- this is the most engaged I have seen a PEBP board in a very long time. And I know I've said that in past meetings and I mean it. And this is the awful part of being on the PEBP board. I hope you're all on the PEBP board long enough in the future that we can do fun plan design enrichment in the future,our future fiscal years. So thank you for your work today. Thank you for managing to surreptitiously to eat your lunches while you continued to participate. I know it's no fun to not get a lunch break.

So it's 4:52 by my clock and I think we are adjourned. Thank you, everybody.

UNIDENTIFIED SPEAKER: Thank you.

(Audio concluded.)

STATE OF NEVADA)
)ss.
CARSON CITY)

I, CHRISTY Y. JOYCE, Official Court Reporter for the State of Nevada, Public Employees' Benefits Program Board, do hereby certify:

That on Monday, the 23rd day of November, 2020, I was present, via teleconference, in Reno, Nevada, for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 212, inclusive, includes a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Reno, Nevada, this 25th day of November, 2020.

CHRISTY Y. JOYCE, CCR
Nevada CCR #625

STATE OF NEVADA)
)ss.
CARSON CITY)

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

That on Monday, the 23rd day of November, 2020, I was present, via teleconference, in Reno, Nevada, for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 212 through 243, inclusive, includes a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Reno, Nevada, this 25th day of November, 2020.

MICHEL LOOMIS, CCR
Nevada CCR #228

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