In The Matter Of:

PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD vs

TRANSCRIPT OF PROCEEDINGS

TELEPHONIC OPEN MEETING

March 31, 2020

Capitol Reporters

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

TELEPHONIC OPEN MEETING

TUESDAY, MARCH 31, 2020

CARSON CITY AND LAS VEGAS, NEVADA

The Board:	LAURA FREED - Chair LINDA FOX - Vice Chair LEAH LAMBORN- Member DAVID SMITH - Member TOM VERDUCCI - Member JET MITCHELL - Member MARSHA URBAN - Member DON BAILEY - Member HEATHER KORBULIC - Member
For the Board:	BRANDEE MOONEYHAN Deputy Attorney General
For Staff:	LAURA RICH Executive Officer WENDI LUNZ Executive Assistant NIK PROPER Operations Officer CARI EATON Chief Financial Officer NANCY SPINELLI Quality Control Officer BRETT HARVEY Chief Information Officer
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TUESDAY, MARCH 31, 2020, TELECONFERENCE

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THE OPERATOR: Ladies and gentlemen, thank you for standing by and welcome to the PEBP Board meeting. At this time all participants are on a listen only mode. If you should require assistance during the call please press star then zero. As a reminder this conference is being recorded.

I would now like to turn our conference over to our host, Laura Freed, Board Chairman. Please go ahead.

CHAIRWOMAN FREED: Thank you. It is 8:34 a.m. on March 31st. I will call the meeting of the Public Employees' Benefit Program Board to order. And I will call the role.

Laura Freed. I'm here.

Don Bailey?

MEMBER BAILEY: Here.

CHAIRWOMAN FREED: Linda Fox?

CO-CHAIR FOX: Here.

CHAIRWOMAN FREED: Heather Korbulic?

MEMBER KORBULIC: Present.

CHAIRWOMAN FREED: Leah Lamborn?

MEMBER LAMBORN: Here.

CHAIRWOMAN FREED: Jet Mitchell?

MEMBER MITCHELL: Here.

CHAIRWOMAN FREED: David Smith?

MEMBER SMITH: Here.

CHAIRWOMAN FREED: Tom Verducci?

MEMBER VERDUCCI: Here.

CHAIRWOMAN FREED: And Dr. Marsha Urban?

MEMBER URBAN: Here.

CHAIRWOMAN FREED: Wonderful. We have a quorum.

So I will now move to public comment and our wonderful operator Grace will, who we need to thank her for managing all of this traffic, will tell us who is going to comment.

And, Board members, if you would put yourself on mute when you're not talking that would help to minimize background noise.

THE OPERATOR: And, ladies and gentlemen, if you wish to ask a question please press one and then zero on your telephone keypad. You may withdraw your question at any time by repeating the one zero command. If you are using a speaker phone, please pick up the handset before pressing the numbers. Once again, if you wish to ask a question or make a comment please press one and then zero at this time.

And our first question is from Wendy Kelly. Please go ahead.

MS. KELLY: Yes. My question is yesterday I got

a call from my doctor's office and they are starting teleconference meetings with patients. I want to know why PEBP has not approved teleconference communications with patients to their doctors. Instead you're making us go into their offices. Why?

CHAIRWOMAN FREED: Okay. Thank you. During -- this is Laura Freed. Sorry.

During public comment Board members are -- are not to respond but during -- but the PEBP staff may wish to respond in the course of the rest of the agenda. So thank you for that.

THE OPERATOR: Thank you. And our next line is from Douglas Unger. Please go ahead.

MR. UNGER: Good morning. This is Doug Unger. I'm a representative of the UNLV Benefits Advisory Committee and the UNLV Faculty Senate.

I just want to thank Laura Freed and Executive Officer Laura Rich for conducting the meeting under these circumstances. Thank the Board for their service and wish them well during this difficult time.

I would also like to state that, you know, regarding Agenda Item Number Nine and the rate hikes, I understand and we understand why that they are being anticipated today. They did come as a surprise, quite a

shock actually to Nevada state employees and to our constituents.

I appreciate very much the Boards and Executive Officer Rich's efforts to mitigate them as much as possible, but I think what they bring up is an overall issue of rising costs with the HMO and EPO and possible deficiencies in our accounting.

Longer term I think the Board should consider a whole redesign of the plan and our letter from the Employee Benefits Advisory Committee basically requests that. So thank the Board for keeping that in mind and just wish you all well and, you know, we're with your decision and we're thinking of you as you make it. Thank you very much.

THE OPERATOR: Thank you. Next we have Priscilla Maloney. Please go ahead.

MS. MALONEY: This is Priscilla Maloney. Can you hear me all right?

CHAIRWOMAN FREED: Yes, we can.

MS. MALONEY: Yes. Priscilla Maloney for the record representing the AFSCME Retiree Chapter of Local 4041.

I just want to thank the Board for putting this together in these extraordinary times. We appreciate all of the difficult circumstances that the system is laboring under, and I'm just here to give you a thank you very much.

I won't be submitting written public comment at this time, but what I will do is reserve my right to do so after the Board meeting is concluded to be included in the next Board presentation packet. Thank you so much.

THE OPERATOR: And just as a reminder, if you do wish to ask a question or make a comment you may press one and then zero.

And next we'll go to the line of Kevin Rand. Please go ahead.

MR. RAND: Yes. Good morning. My name is Kevin Rand representing AFSCME Local 4041 for the active employees.

I just have a quick question for the executive officer. Are we doing individual public comment on action items?

CHAIRWOMAN FREED: This is Laura Freed. I'm sorry. Can you repeat the question.

MR. RAND: Yes. Good morning, Laura Freed. This is Kevin Rand.

And just trying -- do you guys have -- are you guys doing the public comment on individual action items or do you want it all on this morning's public comment, opening comments?

CHAIRWOMAN FREED: I think I'm going to stick to public comment under this agenda item and then public comment

under Agenda Item 12 at the end of the meeting. So we welcome public comment on any of the items on the agenda.

MR. RAND: Thank you.

THE OPERATOR: And I have no further questions in queue at this time.

CHAIRWOMAN FREED: All right. Thank you. This is Laura Freed.

So I'll move to Agenda Item Three, PEBP disclosures for applicable Board meeting agenda items, and I will throw it to Deputy Attorney General Brandee Mooneyhan.

This is Laura Freed. Is Brandee on the line?

THE OPERATOR: One moment. We do have two other questions in queue.

CHAIRWOMAN FREED: This is Laura Freed.

Sure, let's go back to Item Two and take some public comment.

THE OPERATOR: Okay. We'll go to the line of Kent Ervin. Please go ahead.

MR. ERVIN: Hello. This is Kent Ervin. Can you hear me?

CHAIRWOMAN FREED: We can here you loud and clear, Mr. Ervin. Thank you.

MR. ERVIN: Okay. Thank you. I was on hold and my computer was not able to make the signal. Now I'm on a

cell phone. My name is Kent Ervin, K-e-n-t E-r-v-i-n for the Nevada Faculty Alliance.

Thank you and welcome to the new Board Marsha Urban and Heather Korbulic. Thank you all. I'm very impressed and I'm grateful with how everyone, State government and university system is pitching in to deal with the Coronavirus health emergency.

To conserve time I'll limit my remarks to Item Nine. In the proposed rates the employee premium for the CDHP increases by 53 percent. While the employee premium for the EPO/HMO plan increases by 23 percent, that's even before considering the deferral or cancellation of the 125 HSA contribution which represents another $12 per month for the CDHP only.

So how did we get here? In part it's because of higher expenses but it's also because the legislative appropriations for PEBP increased only three percent for FY21 over FY20 compared with the 5.4 percent increase in PEBP's budget request based on Aon's projection. This was indeed foreseeable.

The legislature's -- the legislature's budget closing for PEBP in May 2019 mandated a 95 percent pay state contribution rate for the CDHP plan for both FY20 and FY21. The proposed rates in Agenda Nine got that percentage to

92.6 percent. So it dropped 2.4 percent in the state contribution or subsidy.

Part of the reason for the percentage dropping so much is that the EPO/HMO expenses are increasing significantly faster than for the CDHP. Also the state contribution percentages for the EPO and HMO relative to the CDHP will increase several years ago during the Sandoval Administration to keep the premium stable, but that's probably no longer affordable.

It may still be possible to maintain the CDHP contributions at 95 percent as mandated by the legislature for the employee at 75 percent for the dependent with more modest increases to the employee premiums than in the proposal.

That can be done by allowing the EPO/HMO percentages to decline closer to historical levels. That would be unfortunate but is no longer affordable to subsidize the EPO/HMO at a much higher dollar amount than the CDHP plan for the same tiers.

You as Board members should use your full authority to ameliorate these premium increases especially for the based CDHP employee premium which effects the most employees. If maintaining that means dipping a little further into the catastrophic reserve that may well be

appropriate. After all, the catastrophic reserve used to be called the state stabilization reserve.

In accompanying budget crunch due to the Coronavirus crisis State employees should not again bear the brunt of cuts. Salaries and benefits for state employees have still not caught up after the great recession and PEBP is still dealing with that as I see today. Thank you very much.

CHAIRWOMAN FREED: This is Laura Freed. Does the operator have anyone else standing by for public comment?

THE OPERATOR: We do have a couple of more. We'll go back to the line of Kevin Rand.

CHAIRWOMAN FREED: All right.

MR. RAND: Good morning. This is Kevin Rand. Can you hear me?

CHAIRWOMAN FREED: We can hear you.

MR. RAND: Good morning. Respective Board members, this is Kevin Rand, labor representative with AFSCME Local 4041. We represent thousands of state employees across the state.

During this uncertain time it's very difficult for state employees to hear the fact that health insurance is going up and not just for the reasons stated within the packet but for potential concerns with how these contracts

came to be.

And, you know, I think it's an opportunity for this Board to really take a look at the bigger picture going forward and potentially what past individuals put these contracts together PEBP's really done for the future of increases. We have to take a look at how to maintain the healthy rates, something the state employees could actually absorb and afford and potentially at the same time keeping the benefits of something they utilize, find out what, maybe what potential benefits they don't utilize. This is a great opportunity.

And during these uncertain times state employees and their families during the COVID-19 pandemic, some state employees spouses have even been laid off. This is not a time to increase the burden on them financially. On behalf of State of Nevada employees we ask that this Board keep the rates flat. We know the current premium rates that are set for fiscal year 2020, along with the employer pay contributions can sustain the cost for fiscal year 2021 starting July 1st, 2021 -- 2020.

There will be an opportunity for further projections to come forward and data costs we feel could help remain flat for this current fiscal year. We would just like to try out this fiscal year. So my apologies, kind of

difficult doing this over-the-phone, and I would like to say in speaking with over 100 employees just recently, calling our office concerned about the PEBP Board increases, we could have asked probably 1,000 to come on here and speak. That's something we chose not to do due to the fact that you guys have a Board and an obligation to conduct business that would take all day.

But their message is real simple. Review the current -- the current contracts, review the Board, past Board decisions, look at where the reserves are and find out can we absorb this. Can we sustain to maintain flat rates for fiscal year 2021, and I encourage you to. And I thank you and appreciate your time.

THE OPERATOR: Thank you. We have one more in queue. Marlene Lockard, please go ahead.

MS. LOCKARD: Thank you. Good morning, Board members. My name is Marlene Lockard representing RPEN.

I just want to say on behalf of RPEN retirees that we are very interested in the proceedings this morning. And like others that have stated, we're concerned about raising rates at this critical time and will look with interest for the information provided this morning. Thank you all very much.

CHAIRWOMAN FREED: This is Laura Freed. All

right. With that, I'll see if we can go back to Agenda Item Three with Deputy Attorney General Mooneyhan. Okay. I've been advised -- this is Laura Freed again. I've been advised that Deputy Attorney General Mooneyhan is waiting to get in with the operator. So I think I will pause for a second and appreciate everyone's indulgence while we wait for the technology to catch up with us.

THE OPERATOR: Brandee Mooneyhan has joined us.

CHAIRWOMAN FREED: Oh, great. Thank you.

MS. MOONEYHAN: Good morning.

CHAIRWOMAN FREED: Hello, Brandee.

MS. MOONEYHAN: Hi.

CHAIRWOMAN FREED: So we're on Agenda Item Three, PEBP Board disclosures for applicable Board meeting agenda items.

MS. MOONEYHAN: Thank you, Madam Chair. And I apologize for the difficulties. For the record my name is Brandee Mooneyhan, deputy attorney general and counsel to the Board.

This agenda item allows me to make disclosures for the Board members per Nevada ethics law. All Board members except Mr. Verducci and Ms. Zack are eligible for PEBP benefits which means that they, their spouses and their dependents may receive health, substantial life insurance and

other benefits through PEBP. So this disclosure is made on behalf of PEBP eligible Board members.

Several items on today's agenda relate directly to benefits available to members, specifically Item Number Five, regarding emergency COVID-19 plan benefit design changes. Item Number Six, regarding PEBP's contract with its Pharmacy Benefits Manager, Express Scripts Incorporated. Item Number Seven, regarding plan year 2021 plan and policy design changes. Item Number Eight, regarding a bill draft request that proposes amendment to its statute regarding reinstatement to the PEBP program for certain retirees. And Item Number Nine, regarding plan year 2021 rates for participants and all plans administered by PEBP.

When these Board members vote on matters effecting benefits for themselves, their spouses or their dependents that may trigger the disclosure requirement set forth in NRS 281A.420. I know that the law does not preclude these Board members from voting on items that may effect their benefits as long as the benefit or detriment to them is not greater than that to similarly situated members.

Thank you, Madam Chair, for allowing me to make this disclosure on behalf of the PEBP eligible Board members, and I invite any member who has anything to add to this disclosure to do so now. Thank you.

CHAIRWOMAN FREED: Thank you. This is Laura Freed. Thank you, Attorney General Mooneyhan.

Board members, do you have any disclosures you might wish to add? Okay. Hearing none, I will move on to Agenda Item Four, which is the consent agenda.

And before I do that, I -- if I may take a moment as the Chair to specifically welcome our new Board members, Heather Korbulic and Dr. Marsha Urban. Thank you for joining us in this extraordinary meeting. I don't think we've ever done a public meeting quite like this, but I appreciate you bringing your talents and professional experience and wisdom to the Board, and I appreciate the Governor's appointment of you both, and I appreciate all of the Board members hanging in there, as well as all of the advocates and members of the public who might be listening for hanging in there in a very strange, probably the strangest reg meeting we've ever had. I hope we never have to do it again but we will see, and I hope everyone is staying safe at home.

So with that, I will ask the Board if they -- any of them wish to pull any of the items under Agenda Item Four for discussion with the PEBP staff?

MEMBER VERDUCCI: Yes. This is Tom Verducci for the record, and I would like to pull 4.3.3.

CHAIRWOMAN FREED: All right. Are there any

other Board members who wish to pull any other items off the consent agenda for discussion?

Okay. Hearing none, why don't we discuss Agenda Item 4.3.3.

Mr. Verducci, would you like to pose questions or would you like the PEBP staff to go into more detail on the Willis Towers Watson report.

MEMBER VERDUCCI: Yes. I just wanted to discuss the two performance guarantees were not met.

CHAIRWOMAN FREED: Okay.

MEMBER VERDUCCI: As well as the trend with the abandonment rate and the speed to answer calls to see what the different from December of '19 versus December of 2018. So I'm not sure who would like to address that, maybe Laura Rich.

CHAIRWOMAN FREED: This is Laura Freed. I expect Laura Rich may -- may want to comment.

MS. RICH: Hi. This is Laura Rich for the record. And sorry, Tom, I didn't get the second part of your question but the first part, the 2,000 dollar penalty was assessed and because we do not pay the Willis Towers Watson for any fees, any administrative fees, they are -- they will be if they haven't yet cut us a check for those 2,000 penalties.

MEMBER VERDUCCI: Yes. And also I notice there's a very large abandonment rate in terms of a speed to answer and take care of calls, and this seems like a recent trend that has developed that was not on the report one year ago. So do we know why the calls are not being serviced properly than the whole time speed to answer?

MS. RICH: That's a good question and one that I will take up with Chris. He is I believe on the line, on the public line listening. I will send him a quick e-mail and see if I can get a quick explanation of that and hopefully can get you an answer, Tom.

MEMBER VERDUCCI: Okay. Do we need to make any motion in terms of the performance guarantee or is that already built into the agreement of the contract?

MS. RICH: That is part of the contract and does not require part of the performance guarantees are a part of that contract.

MEMBER VERDUCCI: Okay. Thank you, Laura.

MS. RICH: You're welcome.

CHAIRWOMAN FREED: Okay. This is Laura Freed. With that I will take a motion to accept all of the items on the consent agenda, Item Four. Don't all jump in at once.

MEMBER BAILEY: This is Don Bailey. Can you hear me?

CHAIRWOMAN FREED: I can.

MEMBER BAILEY: I would like to make a motion to accept Item 4, 4.1, 4.2, 4.3, you know, right down the line with the exception of 4.3.3. We can accept the rest of them and once one vote that would be great for the Board.

CHAIRWOMAN FREED: Do I have a second?

MEMBER LAMBORN: This is Leah Lamborn. I second the motion.

CHAIRWOMAN FREED: All right. Thank you, Ms. Lamborn.

Any discussion on the motion to accept Items 4.1, 4.2, 4.3, with the exception of 4.3.3, 4.4, 4.5. Okay. All those in please say aye.

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

CHAIRWOMAN FREED: Any opposed say no. Okay. Motion carries. Thank you everyone.

Moving on to Agenda Item Five, discussion and possible action of emergency COVID-19 plan benefit design changes and implementation. I will turn it over to Executive Officer Rich.

MS. RICH: Thank you very much. For the record Laura Rich.

And before I get into this I actually want to

address the public comment that was made earlier regarding telemedicine. That is actually covered, and so that's -- that is covered by the plan regardless of when whether you're on the CDHP or EPO. So I just wanted to clarify that.

CHAIRWOMAN FREED: This is Laura Freed. Thank you for that. All right.

MS. RICH: All right. So moving on to Agenda Item Five is the report on the COVID-19. So on March 5th Governor Sisolak adopted a regulation that requires health plans to cover COVID-19 testing, office visits and related treatment at 100 percent. It also put us in for immunization when one becomes available and requires coverage for non-formulary drugs if a formulary drug is not available for treatment.

Those regulations, however, only covered those plans regulated by the division of PEBP's insurance and because PEBP EPO and CDHP are self-funded plans they are not regulated by the DOI and, therefore, do not fall under those emergency regulations that were adopted.

But when I realized this I immediately reached out to the Governor's office and made them aware that PEBP is not covered by these regulations, and that it would require Board approval to change the plan benefit design. So it was placed on the agenda for today's meeting.

In the meantime, however, things, as you know, escalated quite quickly, and PEBP was already receiving calls from members asking about COVID's coverage, and I was afraid if we didn't do something PEBP would fall behind the curve, and if we didn't implement what every health plan already implemented we would -- we would be behind everyone else.

So I had HealthSCOPE move forward with implementing the coverage shown in option one which most closely mirrors the emergency regulations passed by the Governor on March 5th. The purpose of the agenda item today is for the Board to approve the already implemented coverage that are backdated to March 5th.

So basically option one is the most comprehensive. It covered the testing office visit and treatment of COVID-19. Option two offers slightly less coverage and only covers the testing office visit but excludes the treatment.

And then there's that third option but that really goes against what the Governor hopes to achieve which is to remove the barriers to fighting this virus by eliminating the out-of-pocket expenses that may lead to those not getting tested.

I do want to emphasize though that option one although it is the recommendation, it is important that we

realize that this could potentially be very costly to the plan. As of yesterday PEBP only had 19 COVID-19 claims, totaling about $13,000 in bill charges. Those are bill charges not pay charges, but obviously that can change at an instant, and at this point it's very difficult or even impossible to determine the impact of the COVID-19 once all is said and done.

So with that I will take any questions.

CHAIRWOMAN FREED: This is Laura Freed. You said how many claims with $13,000 in bill charges?

MS. RICH: 19 total claims.

CHAIRWOMAN FREED: Okay. Thank you.

Okay. So, again, this is Laura Freed for the record. Does PEBP staff or Aon staff have any estimate of the fiscal impact of options one versus option two?

MS. RICH: This is Laura Rich for the record. I did speak to Aon this morning. Unfortunately, at this point everything is just so fluid. It's very difficult right now to really come up with a fiscal impact.

CHAIRWOMAN FREED: Okay. This is Laura Freed again.

How does option one and option two compare to the newly tasked Family's First Coronavirus For Spouse Act? I know that there is like from my perspective we're going

through it on the human resources policy side, but I know there's some coverage for testing involved in that. Is PEBP going farther than the federal law is?

MS. RICH: So this is Laura Rich.

I think we have Mary Catherine from HealthSCOPE on the line.

Mary Catherine, do you have any idea, you know, what -- what is happening on a federal -- on a national level and how we compare to that?

MS. PERSON: Yes. This is Ms. Mary Catherine Person for the record with HealthSCOPE Benefits.

So option one does include the treatment at 100 percent. That is a little bit, that's further than the federal law has gone to to this point in time. Currently the federal law requires the testing and associated testing related services to be covered, and so that would actually expand it beyond this language, again, as Laura indicated was put together very early on. And so at the time, you know, we were saying office visits, but today it would be any type of visit, testing in any type of visit regarding the testing and then the first option does include the treatment.

The other thing I would note when you asked about the difference in option one versus option two, the real difference financially for PEBP between those two is that you

would be covering the member's deductible and out-of-pocket maximum cost related to COVID in option one versus in option two, those costs could go to the member.

Then one last thing, I apologize, is also when Ms. Rich mentioned the 19 claims, under 19 testing claims, just to clarify that as well.

CHAIRWOMAN FREED: This is Laura Freed.

19 testing claims. So we don't yet have any treatment or hospitalization claims that we're aware of?

MS. PERSON: That is correct.

CHAIRWOMAN FREED: Thank you. This is Laura Freed again.

Board members, do you have any questions? Any thoughts?

MEMBER SMITH: This is David Smith. Can I jump in?

CHAIRWOMAN FREED: I'm sorry, Mr. Smith, was that you?

MEMBER SMITH: Yes, it is.

CHAIRWOMAN FREED: Okay. Go ahead.

MEMBER SMITH: And I'm not sure if HealthSCOPE or Laura who might be able to answer this. Did the federal government put any cost containment place regarding the testing or will we be on the hook paying 100 percent of the

bill charges since there are no negotiated rates or reimbursement rates for any of this that I'm aware of anyway.

MS. PERSON: So, Laura -- this is Mary Catherine Person for the record.

Actually, the networks do tend to have rates that are available. There are Medicare rates also that come out specifically around the testing component. And then for the treatment component, obviously, those would fall under the normal contractual rates of the network provider as well.

MEMBER SMITH: Okay. Just a follow-up. The -- based on the 19 claims at $13,000 I think you said, that comes out to like 684 per test. Do you expect that that's going to be the actual cost per test?

MS. PERSON: Mary Catherine Person for the record.

No. The testing is actually about $50, 50 to 100 probably tops. What we're seeing now is obviously people, that this is also incorporating testing related services so when it gets tested through an ER or, you know, things of that nature, and so that's where some of the additional costs are coming in.

MEMBER SMITH: Okay. Thank you. And I was just trying to get it into my head what the potential is. Hopefully, you know, the Governor's action is going to really

minimize exposures, and that's our best hope I guess.

MEMBER LAMBORN: Chair, this is Leah Lamborn for question if David is done.

MEMBER SMITH: Yes, I'm done. Thanks.

MEMBER LAMBORN: Thank you.

CHAIRWOMAN FREED: Go ahead.

MEMBER LAMBORN: Madam Chair, thank you.

So just looking and seeing what's on the news, I'm a little concerned without any budget projections and I don't think that the cost is going to be, even though the quantity will be very high and the testing, I think where the real costs are going to come in is in the treatment portion that is not currently the -- under the new emergency law. And so when we start seeing people going to the hospital and potentially being on ventilators for 20 to 30 days I think that's really where the cost is going to hit the hardest, and so I'm just concerned about that.

I'm concerned about authorizing more than we need to to really align with the emergency law, and I would recommend we just skip with the testing and total alignment of the new law as of now, and at some point depending on budget numbers we can always go back and add treatment at a later date.

CHAIRWOMAN FREED: Thank you, Ms. Lamborn. This

is Laura Freed.

So you're feeling like option two, testing and office visits?

MEMBER LAMBORN: Right. However we -- again, Leah Lamborn for the record.

Just right now be a little concerned -- conservative and just align with the current regulations rather than going a step further and agreeing to covering the -- all of the treatment without caution, yes.

CHAIRWOMAN FREED: Okay.

MEMBER LAMBORN: I would recommend that.

CHAIRWOMAN FREED: Okay. Thank you. This is Laura Freed again.

A question for Laura Rich or -- or perhaps Mary Catherine Person. If we went with option two, would associated office visits include urgent care and ER?

MS. PERSON: This is Mary Catherine Person for the record.

I would ask I think just for us all to have clarity around that, when someone made the motion that it be for testing and testing related services so that then it could cover any place of service where the testing occurs.

CHAIRWOMAN FREED: All right. Thank you.

Other Board members?

MEMBER MITCHELL: This is Jet Mitchell.

I have a question about the 100 percent coverage, whether it's the testing or treatment, would that be an in-network or out-of-network or both?

CHAIRWOMAN FREED: This is Laura Freed.

I think that's both. Correct me if I'm wrong PEBP staff.

MS. PERSON: Correct. No, that is correct.

CHAIRWOMAN FREED: Okay.

MEMBER SMITH: Madam Chair, David Smith again. I have another question.

CHAIRWOMAN FREED: Sure.

MEMBER SMITH: Laura, do you know if there are any provisions in the two trillion dollar stimulus to reimburse states for costs related to treatment?

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

I am not 100 percent certain. Mary Catherine maybe may know. However, my first thought is that we're a self-funded plan. I don't think that money would be coming to our plan directly.

Mary Catherine, if you want to chime in there.

MS. PERSON: I don't believe at this point that that has occurred. There are lots of folks who are hoping some of those type of things transpire, but I don't believe

based on what I understand today that there is. However, I will say there are hundreds of pages and there could have been something specifically related to states that I missed but I don't believe so. I don't know if anybody from Aon can help me on that one.

MS. DALY: This is Amy Daly from Aon. That's our understanding as well, Mary Catherine, at this point.

MS. PERSON: Okay.

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

CHAIRWOMAN FREED: Go ahead.

MEMBER VERDUCCI: We have a huge pandemic here, and I believe that it's our duty to take care of the treatments for state employees. We don't know what's in front of us here. I just think if we face a catastrophe we need to support state employees that have to go through treatments so that they are not wiped out financially. So I'm in support of option one.

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

Board members, what other information would you need to come to a decision or are you all feeling like you have it in your head?

MS. MESSIER: Madam Chair?

CHAIRWOMAN FREED: Yes.

MS. MESSIER: This is Stephanie Messier with Aon. Can I just give you a couple of high level numbers that might help with the Board members.

CHAIRWOMAN FREED: Yes.

MS. MESSIER: Okay. So while I can't give you a total impact to your calculation, our current understanding in terms of an estimate for if you would go with testing only, we estimate that's like 150 to 250 per case.

CHAIRWOMAN FREED: Okay.

MS. MESSIER: It can be as low as like Mary Catherine was saying the $50. If somebody is actually diagnosed, our current best estimate is that's about 1,000 to $1,500 per patient that can include additional testing that happened at that time, labs, imaging, in terms of chest CT'S or X-Rays.

CHAIRWOMAN FREED: Okay.

MS. MESSIER: That could be administered in the more expensive hospital or ER setting. So the 1,000 to 1,500 is average for people also getting that done at a doctor or urgent care.

CHAIRWOMAN FREED: Okay.

MS. MESSIER: And your severe and critical cases, our best estimate at this time is 30 to $80,000 per patient,

depending on about an average ten to 14-day inpatient stay, recognizing that changes by the day, and some people are saying up to 21 days or longer. So that's our, kind of our best range, if that helps the Board at all.

CHAIRWOMAN FREED: Thank you for that.

MEMBER URBAN: Madam Chair, this is Marsha Urban. I'm new at this time so I want to clarify something. The difference between one and two so is that in two they would have to pay their co-pay and deductibles, correct, for treatment?

CHAIRWOMAN FREED: Well, this is -- this is only applicable to the CDHP and EPO. HMO I think would be same as it is.

MEMBER URBAN: Okay. So no matter how -- I mean, when we're talking about 14-day stay and everything.

CHAIRWOMAN FREED: Right.

MEMBER URBAN: Would number two cover that as well once the deductible was paid?

CHAIRWOMAN FREED: Correct. Then you would go to co-insurance, 80/20.

MEMBER URBAN: Okay. So at a certain point it does become 20 percent that they will be paid. So they could have -- they would have, number two have the deductible and then maybe a 20 percent.

CHAIRWOMAN FREED: And until they hit their out-of-pocket maximum for the year, yes.

MEMBER URBAN: Okay.

CHAIRWOMAN FREED: Then it would go to 100 percent.

MEMBER URBAN: Okay. So roughly in the worst scenario how much would it cost a patient in number two?

MS. RICH: So this is Laura Rich for the record. It depends on what plan they are on and also what tier they are in as well. So if you are a former employee on the high deductible plan on the CDHP, you have a 1,500 dollar deductible and at that point you go into co-insurance, so then you're paying 20 percent up until you reach your out-of-pocket max which is 3,900.

If you are on a family plan and you've got your family on, covered on the CDHP you have a 3,000 dollar deductible, so you're paying 100 percent up until that $3,000, and then you have got a 7,800 dollar maximum out-of-pocket, so you're paying 20 percent until you reach that $7,800. At that point the plan starts paying 100 percent. So that is, yes, worst case scenario for the CDHP.

With the EPO you have co-pays, right, so it would just depend on what kind of office visit you had, if you went

to the urgent care, if you went to the emergency room, if you went to your doctor.

MEMBER URBAN: Okay. Thank you.

MEMBER KORBULIC: Madam chair?

CHAIRWOMAN FREED: Yes.

MEMBER KORBULIC: This is Heather Korbulic. Just a couple of clarification questions here.

In option one, just for the perspective I'm looking for here, this is the same reg that's being applied statewide to carriers that are in the individual market and in small group; is that correct?

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

And just so we're -- for clarification. Health plans are interpreting that regulation differently. It is written very vague and doesn't necessarily require treatment, but the way that it's interpreted by different health plans throughout the state is different and some health plans are covering treatment at 100 percent. Others are going with option two.

The -- the Governor's office, the message that PEBP received was option one is probably more along the lines of, you know, what they would consider the, what is in the emergency regulation. However, that we have option one or

option two, either one would be adhering to them.

MEMBER KORBULIC: Sorry. This is Heather Korbulic for the record.

I'm curious in just thinking about guidance that the Division of Insurance put out yesterday encouraging individual market and small group markets to cover care and testing in nontraditional settings, I'm wondering if this might be a space to include more prescriptive language or if you feel like that is covered under either one or two.

MS. RICH: So this is Laura Rich for the record.

The Board has the authority to approve any plan benefit design that is at this point part of this package, right. And Brandee Mooneyhan, our DAG, can correct me if I'm wrong, but I think that, you know, if we wanted to get more descriptive we could do that as long as it is related to the COVID-19 coverage.

MS. MOONEYHAN: So this is Brandee Mooneyhan. I agree with Laura Rich's interpretation.

MEMBER SMITH: Madam Chair, it's David Smith again.

CHAIRWOMAN FREED: All right.

MEMBER SMITH: My personal belief is we should do option one, but in doing that we should be looking at any way that we can to obtain reimbursement funding from the federal

government on COVID-19. So I don't know if the -- if all of the treatment is being coded in a manner that can be tabulated if the government is reimbursing state or local governments or hospitals in Nevada for any treatment but I think option one, particularly since their there are reimbursements and, you know, the federal government has mandated that coverage for testing, et cetera be covered at 100 percent.

I do believe there will be reimbursements and I would rather -- you know, if somebody is going to end up being on a ventilator spent being inpatient, the 3,000 or 6,000 dollar cost to the plan is going to be, you know, that would go to the participant would be insignificant to the overall costs. So that's just my thought.

CHAIRWOMAN FREED: Okay. Thank you.

MEMBER LAMBORN: Madam Chair, Leah Lamborn for the record. I have another question.

CHAIRWOMAN FREED: Go ahead.

MEMBER LAMBORN: Thank you. So we just heard testimony from Mary Catherine, our vendor, that option one was actually more than what the State of Nevada's emergency law requires. And when I'm looking at it on the website I don't see anything on, related to treatment, and so I think that we should get some clarification on that, number one.

And also number two, does anybody have any idea what's in the rescue or stimulus packet that was just passed for hospitals and let's just be clear. I'm concerned about the hospital treatment, not just your normal treatment from the doctor's office. So no big long hospital stays and the ventilators. And so do we know out of that packet that was just passed, the stimulus rescue, whatever you want to call it, all those millions of dollars going to the hospitals what that entails? Are hospitals going to be allowed to forgive the co-payment from the patients and they got funding for that already. I mean, is that something that we can research?

I'm still really leaning towards option two with putting on our next Board meeting this is an agenda that we can vote to open it up to treatment once we have a better idea what is required, what's in the stimulus packet for hospitals already so that we're not double dipping and, you know, for getting the co-payments when the hospitals are to be doing that.

So, again, just getting that on the next meeting or even have an emergency meeting to add treatment later notifying properly something we would be voting on.

CHAIRWOMAN FREED: Okay. This is Laura Freed.

PEBP staff, do you have any or the vendors, do

you have any information to offer to Board Member Lamborn?

MS. RICH: So this is Laura Rich for the record.

Oh, go ahead.

CHAIRWOMAN FREED: Go ahead, Laura. Sorry, Ms. Rich.

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

So like Stephanie and Mary Catherine both said, it's -- right now there's nothing that we know of that any federal dollars or any federal assistance coming, you know, hospitals, to PEBP. I think, you know, it's very fluid. Things are changing daily. When we meet back in May it's going to probably be hopefully a different situation, whether it's, you know, better or worse, you know, only time will tell.

But I think at this point what we're looking at is -- is just treatment. I think that's the sticking point at this point. Do we want to include treatment or do we not want to include treatment?

Like I said, there's different interpretations of that emergency regulation. Either option one or option two will adhere to that emergency regulation. It is whether or not the Board chooses to -- to provide that 100 percent coverage.

Again, we are still covering that. It would just

be that we're eliminating the barriers to treatment, right, the cost barriers. With option one we are eliminating the co-pay. We are eliminating the deductible and the co-insurance, and so that's -- that's really the difference.

I think where the costs are going to come into play is in-network versus out-of-network. If, you know, there are hospitalizations that occur and out-of-network facility that can definitely increase costs dramatically to the plan.

MEMBER LAMBORN: And then, Madam Chair, if I may. Leah Lamborn. Just one more.

CHAIRWOMAN FREED: All right.

MEMBER LAMBORN: Really a statement but please, if I'm incorrect, Laura, let me know. So basically, I mean, if we were to cover everything and our costs increased then it could impact the participant rates basically because that's how we would make up the difference when we come into a shortfall. We would have to increase the premium rates across the board for all participants for the members; is that correct?

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

You are correct unless the state were to pick up a higher percentage of that contribution. If that contribution is larger next session then that could

definitely I guess lower the burden on as far as the rates go. But, yes, whatever the state does not cover that would -- that would be borne on to the participants.

MEMBER LAMBORN: And I'm sure --

MS. RICH: Sorry.

CHAIRWOMAN FREED: Leah, go ahead.

MEMBER LAMBORN: I'm sorry just one more follow-up.

CHAIRWOMAN FREED: Oh, it's fine.

MEMBER LAMBORN: And, again, I'm just sure the state with revenue shortfalls and all of this that there's going to be many areas within state government they are going to be short they will be looking for, you know, to make up huge shortfalls and lots of different agencies. So I just think we need to keep that in mind. So as far as taking the state is going to come forth with additional funding. Being in state budgeting I don't see that happening but you never know. Thank you.

CHAIRWOMAN FREED: This is Laura Freed.

I completely concur with Member Lamborn's comments. You know, if we do option one we -- we don't know what some catastrophic hospital stays might cost us, but that's what catastrophic reserve is for. But Member Lamborn is absolutely right, if we do any kind of catastrophic

reserves all of that needs to get made up in the rates for '22 and '23.

And so it's -- and I don't know that the PEBP will be allowed to expand its state subsidy revenue if we are looking to budget reductions which I suspect we are. So, I mean, in -- I just want to make the members -- I just want to underscore Member Lamborn's comment and make the members aware that we can -- you know, option one will relieve a lot of worry and stress for our members, but it has a potential to increase the fiscal pressure in '22 and '23.

CHAIRWOMAN FREED: So having said that, Board members --

MEMBER MITCHELL: Jet --

CHAIRWOMAN FREED: I'm sorry.

MEMBER MITCHELL: Jet Mitchell for the record.

I wanted to just also make a comment from the financial -- financial perspective that many of the COVID-19 claims may also be for individuals that have already reached out-of-pocket maximums. So from a financial responsibility as far as what PEBP would be responsible for is for any costs above all of the out-of-pocket maximums reached.

So the Delta as far as PEBP would be needing to pay would be for an individual of $3,900 contribution or the $7,600 per pace. So in other words, we're not looking at

option one or option two in a vacuum. We're also looking at it from the standpoint of the individual and/or family hitting their out-of-pocket maximum. I want to throw that in from a financial perspective. That we're not just looking at this as COVID-19 only treatment from a patient perspective. We're also looking at will I have already reached my out-of-pocket maximums and then from going back to PEBP's responsibility, it would be above and beyond those maximum reaches -- reached PEBP would be fiscally responsible for that in any way.

CHAIRWOMAN FREED: Okay. Thank you.

MEMBER SMITH: Madam Chair, David Smith again.

CHAIRWOMAN FREED: Go ahead.

MEMBER SMITH: That's a really good point that Jet made and it just kind of triggered a thought, and I'm just speaking out loud. But can all of the -- could we do option one and have it be carved out of the plan itself so it's not -- it doesn't effect the deductible or the out-of-pocket maximum for just regular treatment?

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

Mary Catherine, I think this is a question for you. Is this something that HealthSCOPE can do? Are you able to carve that out completely?

MS. PERSON: I guess I'm not 100 percent clear.

I apologize. Mary Catherine Person for the record.

As far as what is being asked, are we saying for someone who has COVID-19 treatment then they we would pay 100 percent for that treatment, meaning and that's what we're meaning by cashing out their deductible or out-of-pocket maximum.

MEMBER SMITH: David Smith for the record.

Basically sort of like wellness. Wellness doesn't, you know, cost for wellness don't go against the deductible or out-of-pocket maximum.

CHAIRWOMAN FREED: Uh-huh.

MEMBER SMITH: So if we place COVID-19 treatment sort of as a wellness benefit, this way the charges are not reducing at 100 percent. The charges are not reducing the deductible or out-of-pocket maximum for other regular healthcare.

MS. PERSON: Yes. Yes. I apologize. That is exactly the way under option one we would be suggesting to do it. So the services would be paid at 100 percent. They would not be used to satisfy the deductible or out-of-pocket maximum if you chose option one. Option two is an option where it would go against the deductible or the out-of-pocket maximum.

Did that answer the question?

MEMBER SMITH: Yes, it does for me. Thanks.

MEMBER BAILEY: Madam Chair?

CHAIRWOMAN FREED: Sure.

MEMBER BAILEY: This is Don Bailey.

CHAIRWOMAN FREED: Please go ahead.

MEMBER BAILEY: I'm suggesting that maybe we take a look at option one. Make a motion and that we can in May's meeting readdress the issue because so many unknowns in this country right now.

CHAIRWOMAN FREED: Right.

MEMBER BAILEY: Particularly mingled with the federal government, and so and then the state governments are reacting the same way. So I'm suggesting maybe we just go ahead and take a look at option one, have a motion on the floor, get a second, move it on, and then we can readdress the issue. This giving PEBP enough time to make the adjustments that are going to come down from the federal government and also intermingle with state government. So I think that's the best way. We at least get protection between now and May for our members, and then we can readdress the issue and make sure we are safeguarding our members in the May meeting.

CHAIRWOMAN FREED: Thank you, Mr. Bailey. Is that a motion?

MEMBER BAILEY: That is a motion.

CHAIRWOMAN FREED: All right. I will -- I will second that motion and I will try and re -- recapitulate it for the Board.

So Member Bailey has moved that we accept option one to cover all testing, associated office visits and treatment for COVID-19 at 100 percent of the plan's maximum allowable charge with the caveat that we would like it re-agendized for the May meeting to see where we are on plan spent on COVID-19 testing office visit and treatment and see if we have anymore intelligence from the federal government about to -- about whether they would provide hospital direct relief or something, other things like that; is that correct?

MEMBER BAILEY: My words exactly.

CHAIRWOMAN FREED: Thank you, Mr. Bailey.

MEMBER BAILEY: Thank you.

CHAIRWOMAN FREED: Any discussion on the motion? Okay. All those in favor signify by saying aye everyone.

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

CHAIRWOMAN FREED: Any opposed no.

MEMBER FOX: No, Linda Fox.

CHAIRWOMAN FREED: Okay. Linda Fox votes no. All right. So the motion carries. Thank you everybody.

And we'll move to Agenda Item Six, discussion of possible action under the Express Scripts Pharmacy Benefits Manager contract amendment to reduce fees and implement greater drug discounts and guarantee drug rebates. Ms. Rich?

MS. RICH: For the record Laura Rich. This agenda item should be a lot easier than the last one.

Every year PEBP requests a market check to be performed on the Express Scripts and so this year was no different. PEBP had Aon perform a comparison between PEBP contracted rates and guarantees against similarly positioned programs and for other national business. And based on that negotiation took place to reduce the existing rates to more closely match the market conditions.

And as a result, EFI has agreed to an additional 4.5 million dollars a year in negotiated discounts. So PEBP is recommending that the Board authorize staff to amend the contract to include the new pricing proposals in that contract and that is it.

CHAIRWOMAN FREED: All right. Thank you.

Board members, do we have a motion to authorize staff to complete a contract amendment?

MEMBER SMITH: Madam Chair, this is David Smith. I actually have some questions.

CHAIRWOMAN FREED: All right. Go ahead.

MEMBER SMITH: And, Laura, I'm not sure how much you can answer about this, but are we contracted Express Scripts and, well, here's why I'm getting this question. If my understanding is the Pharmacy Benefits Manager should be passing on a substantial amount of the rebates and everything to the plan but in looking at this, it looks like they are reselling the pharmaceuticals, the drugs and just because they charged us more and our members more based on an audit of what everybody else charged, we're asking for a 4.5 million dollar rebate or, you know, money back to us.

When, you know, I believe in the past we had a Pharmacy Benefits Manager who passed on something like 90 percent of the rebates that were 100 percent, they didn't keep any of it. They weren't doing -- spread pricing. We just paid a per member per month fee, and we as a plan and the members actually saved money, but this looks like they are -- they are actually re -- you know, they are negotiating with the pharmacies, and then they are billing us and taking portions of the profit of the rebate for themselves and adding a cost to us and our members. Is that -- I mean, how much transparency is there with Express Scripts and the rebates?

MS. RICH: So this is Laura Rich for the record.

PEBP does get 100 percent of the rebates. So

that for sure is happening. Now, there's, with these contracts what Aon is doing is they are comparing some of the -- the guarantees that we get for discounts and things like that and additionally like some different kinds of administrative fees. That wasn't part of this negotiation, but there are different administrative fees and things like, you know, guaranteed discounts and things like that that we look at.

And so when we compare PEBP to the rest of the business they are looking at, you know, how do we compare. What are the -- what kind of guarantees are other similarly placed organizations receiving versus what PEBP is receiving, and so this market check really just aligns us with what is happening, the conditions on the market at the time.

And so, no, it does not -- we do receive 100 percent of those rebates and that is -- that's where -- we have an auditor that goes in and does verify that all of those rebates are coming into PEBP and that those discounts are being received, and so we're just adjusting those guarantees that we currently have to meet those market conditions through, you know, other -- other similarly placed organizations like PEBP.

MEMBER SMITH: Thanks, Laura. David Smith again.

And when you say, and it's good to know we get

100 percent of the rebates. But when you say the market conditions, is that based on, you know, cost per employee per month or what exactly do you mean by market conditions?

MS. RICH: They are looking at many different -- many different categories. They are looking at for example guaranteed discounts. What is another organization getting for their guaranteed discounts versus what PEBP is getting, right, and so dispensing fees, things like that, they are looking at that, and they are doing a comparison throughout their national book of business and looking to see, you know, how -- how we compare.

And if, you know, we're -- we're getting -- because we're working with the State, right, and so when we find out, right, okay, the current conditions on the market are basically saying that, you know, the guaranteed discounts should be X that we adjust our contract to show that those guaranteed discounts should be X, right, and so those are the negotiated points that we worked with ESI on, Express Scripts and -- and we were able to leverage another 4.5 million dollars that's given from that contract.

MEMBER SMITH: Okay. That's really good. Now, this contract went in in 2016. When does it expire, if you know? If you don't know that's okay.

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

We're checking. I think it's '23, is it?

MEMBER SMITH: Okay. And I believe that Express Scripts was just purchased by Cigna and, you know, Cigna being an insurer, is there any way to see if we are receiving at least what the, you know, the Cigna contracts are getting? I mean, if -- now that they are owned by somebody who's out, you know, to make a profit I want to make sure that we're -- and obviously this is making sure that we're not getting over-billed, but we may need to be a lot more attentive since they are owned by a large insurer who's going to want to make a profit.

MS. RICH: So this is Laura Rich for the record. It's actually June 30th of '22, the expiration date for that, that contract. And the second part of your question is yes.

So what Aon does when they do this analysis is they take a look at what, you know, all PBM's are charging across their book of business, right. And so they are doing a comparison across, all PBM's across all their book of business and they are comparing what other plans that, you know, look like PEBP are getting.

MEMBER SMITH: Okay. You know, my only thought on that is that it may not be -- you know, 4.5 million is great but it may not be the best way to get the best pricing because just by comparing what everybody else, all everybody

else has to do is raise the prices, and then we are accepting those prices based on what everybody else is carrying as opposed to, you know, linking it to something that is, you know, the -- it has the most benefit or the least cost.

MS. RICH: And so this is Laura Rich for the record.

You're correct. This is why we do a market check every year. The alternative is to go out to bid. That's the other way to see where we really stand in the market and what kind of proposals we would get.

Now, obviously, going back to bid is, it's something that can be disruptive to the population to the members if we do it every year. It would also be operationally a lot of work, but it is something that had these negotiations not come to a point where PEBP was comfortable we wouldn't be recommending -- instead of recommending the amendment we would be recommending going out to bid.

MEMBER SMITH: Okay. And I understand going out to bid on these is a huge labor, and so I appreciate that, and I'm okay with this. And I appreciate the explanation you've given me.

MS. MESSIER: And this is Stephanie Messier for the record for Aon.

Ms. Rich did a great job describing our process, but I just want to give you some assurances that some of these that we're comparing you to are new rates that just got started on January 2020. So some actually had gone out to market and gotten what we call like, you know, straight from the street, right. They really are essentially doing a soft marketing without going through the process of an actual marketing by doing this market check.

And PEBP previously, before being with ESI was really in contract for a five-year period and as we all know, pharmacy contracts quickly get out of date, and there was no mechanism within that five years to adjust the prices. Whereas now, the ESI when they implemented this contract, they are able to do this annual market check every year to basically do a soft go to the street for the best pricing, and that's really helped PEBP realize a lot of savings in the last few years. I just wanted to add that.

MEMBER MITCHELL: Jet Mitchell for the record.

I have a question for Laura Rich or a clarification I should say. The 4.5 million dollars that's referenced here, that's already built into the rates, correct?

MS. RICH: For the record this is Laura Rich. That sure is.

MEMBER MITCHELL: Okay. Thank you.

CHAIRWOMAN FREED: Okay. This is Laura Freed. Any other questions on this item?

MEMBER VERDUCCI: Madam Chair, Tom Verducci.

CHAIRWOMAN FREED: All right.

MEMBER VERDUCCI: I just had a question for Laura Rich. Is there any disadvantage to the members in terms of giving up any rebates or financial impact to them if we adopt this?

MS. RICH: For the record this is Laura Rich.

No. It's actually the opposite. We are -- this is all savings over the plan and so they are on the back end, right. They're discounts. They are dispensing fees, things like that, and so this would be a benefit to the overall plan with no member negative effect.

MEMBER VERDUCCI: Thank you, Laura. That's exactly what I wanted to hear, and I think this is a very good recommendation to adopt this.

CHAIRWOMAN FREED: This is Laura Freed.

Mr. Verducci, is that a motion?

MEMBER VERDUCCI: Yes, it is.

CHAIRWOMAN FREED: All right. Do I have a second?

MEMBER SMITH: This is David Smith. I'll second

it.

CHAIRWOMAN FREED: All right. Any discussion on the motion? All in favor say aye.

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

CHAIRWOMAN FREED: Any opposed say no. Sorry. Okay. Motion carries unanimously from what I heard. Okay. Thank you.

Moving on to Agenda Item Seven, discussion and possible action regarding plan year '20-21 plan and policy stages. I will throw it again to Executive Officer Rich.

MS. RICH: Okay. For the record Laura Rich.

This report provides information and recommendations on additional plan year '21 plan benefit design and policy changes. We will start with the CDHP, HSA and HRA supplemental funding. That's health savings account and health reimbursement arrangement and supplemental funding.

So during the 80th Legislative Session the legislature approved PEBP's budget with plan year '21 CDHP enhanced HSA and HRA funding of $125 primary participant. If you recall in plan year '20 it was $400. So that was reduced $400 to $125. This is the supplemental funding that occurs after that state funding on the CDHP, right.

The Board also approved this enhanced funding at the November 2019 PEBP Board meeting. So this funding is -- it will cost the plan about $3,000,000. It has a 3,000,000 dollar cost attached to it. And even though it was approved during the PEBP budget it was approved using excess reserves.

And so we're sitting at a point right now where we are very tight on excessive reserves. There may not be $3,000,000 to fund the 125 dollar supplemental funding. And so because of that what we're recommending is we are -- we are recommending deferring that to January, that decision to fund it to January. So we would bring it back to the November Board meeting, and at that point I think we'll have a much better idea of where our reserves are sitting at and if we have the $3,000,000 to fund it. We would not fund it until January just because of the IRS contribution limits that are attached to those -- to the HSA.

And because it's at the end of the calendar year you don't want to fund an additional $125 which may potentially put people over that limit and have potential tax implications. So we would fund it in January and -- and that would be at the beginning of the calendar year.

So at this point PEBP is recommending deferring the $125 enhanced HSA and HRA funding to be reconsidered at

the November 2020 Board meeting. At that point we'll have a better idea if we -- if we have the excess reserves to fund that and if we do, we'll go ahead and make that recommendation to fund it at that time. If not then we make the recommendation to not fund the supplemental HSA and HRA funding.

And so with that I'll stop right there and give the Board members an opportunity to discuss this item.

CHAIRWOMAN FREED: This is Laura Freed.

I think I will take this as like three separate motions so we can just discuss them in turn. Unfortunately I think this is the wise recommendation from PEBP staff because it's, you know, I know the Board members have all read Agenda Item Nine thoroughly and in that -- in that presentation from Aon, it notes that excess reserves to end '20 may be anywhere from 1,000,000 to minus 1,000,000. So we just -- I would love to give this supplemental early next calendar year, but I do think it's the wise choice.

Board members your comment.

MEMBER BAILEY: Madam Chair?

CHAIRWOMAN FREED: Yeah.

MEMBER BAILEY: Don Bailey. I was cut off. I -- I was cut off at Item Seven. So can you tell me. They just redid my line.

CHAIRWOMAN FREED: Oh, no. Okay.

MEMBER BAILEY: So what item are you on now?

CHAIRWOMAN FREED: We are on Item Seven, the HSA and HRA supplemental funding for --

MEMBER BAILEY: Okay.

CHAIRWOMAN FREED: -- FY21. The discussion is to defer the 125 dollar enhanced funding and have the Board reconsider it at the November meeting once we see how FY20 shakes out and closes out.

MEMBER BAILEY: Okay. Thank you. I'm caught up.

CHAIRWOMAN FREED: Okay.

MEMBER VERDUCCI: Tom Verducci for the record.

CHAIRWOMAN FREED: All right.

MEMBER VERDUCCI: I think especially in light of the COVID-19 I think it is a good idea to wait until November so we can see the impact of the pandemic.

CHAIRWOMAN FREED: Okay. Board members, any other thoughts?

MEMBER SMITH: This is David Smith. I agree. I think it's a wise move at this point.

CHAIRWOMAN FREED: Okay.

MEMBER SMITH: I don't know because the legislature approved it, you know, with the budget ramifications for deferring that or not, but I'm sure you

guys would check into that to make sure that it's within our authority to do so.

So I make a motion to accept the PEBP recommendation to defer the 125 dollar enhanced funding and consider it at the November 2020 PEBP Board meeting.

CHAIRWOMAN FREED: Okay.

MEMBER MITCHELL: Jet Mitchell for the record. I second the motion.

CHAIRWOMAN FREED: All right. This is Laura Freed.

Any discussion on that motion? Hearing none, all in favor say aye.

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

CHAIRWOMAN FREED: Any opposed say no. Motion passes unanimously.

Okay. So we'll move on to the second policy change, chronic kidney disease pilot program update.

MS. RICH: All right. So for the record this is Laura Rich.

In November of last year the Board approved a chronic kidney disease pilot program and the entire intent of the program was to provide specialized case management to those diagnosed with CKD and the case management would

increase things like early identification and steers more appropriate facilities which would in turn produce a return on investment to the cost.

Since then PEBP and our utilization and case management partner, American Holdings, has done further analysis on this population, and we have determined that there really isn't much of an opportunity for ROI because most of these members have already participated in or are participating in today or have turned down an existing case management already so leveraging specialized case management doesn't really make any sense.

We also looked at the claims cost of the 45 of the top 100 CKD patients that may have claims less than $36,000. So even if PEBP were able to offer additional coaching the opportunity to produce any savings there would really be minimal. And because the further analysis doesn't render an ROI, implementing this benefit would incur costs and since this was not built into the PEBP budget it would require legislative approval.

So the recommendation is to cancel the private program for now. We are exploring other options, including the possibility of mandated case management for certain conditions, and this is as well as other ideas will be brought up for consideration at a future time, but at this

point PEBP is recommending cancelling the CKD pilot program previously approved for plan year '21 because without guaranteed savings the program incurs a fiscal cost that has not been accounted for in the PEBP budget and, therefore, will require legislative approval through the Interim Finance Committee. So I'll stop there.

CHAIRWOMAN FREED: All right. This is Laura Freed.

I think this is a fairly sensible recommendation honestly. Board members, any thoughts?

MEMBER VERDUCCI: Yes. Tom Verducci for the record.

I wanted to ask a question. What is the impact of the patient? Would they be incurring additional costs if we adopt this recommendation?

MS. RICH: For the record this is Laura Rich.

So the recommendation originally was, it was brought up in November and it was going to be an enhanced benefit. So basically what we were going to do is take a look at these CKD patients and try to provide coaching and specialized case management. So it would be like an enhanced benefit. It would be a lot of hand-holding for CKD patients which would be a benefit for them but also a benefit for the plan because the hope was to even though it was -- there was

a cost associated with it, it would ultimately reduce claims.

And when we did some further analysis on that we could see that we had already exhausted all of those, the coaching and the case management and things like that and those that, you know, had not received it really had low enough claims that we weren't going to realize a return on investment, and so really this is no change for the member because what we anticipated it to be a member enhancement but, you know, it comes at a cost and it's not included in the budget we cannot -- we can't incur that cost.

MEMBER VERDUCCI: So the original intention was a cost savings to the plan and at this point it does not appear that we are going to be assuming any cost savings here. So it becomes kind a moot point to even have this as part of the program. Is that what I hear you saying?

MS. RICH: For the record Laura Rich.

Yes, you are correct, Tom.

MEMBER VERDUCCI: Okay. Thank you, Laura.

MEMBER LAMBORN: Madam Chair, Leah Lamborn for the record.

Typically in my experience these types of programs you don't see any kind of return in investment of cost savings to claims for three to five years, and Laura just stated that it appears that we've exhausted a lot of

these efforts already implemented, and so I'm ready to make a motion unless you want further discussion on this. The motion would be to cancel the program.

CHAIRWOMAN FREED: All right. This is Laura Freed. Do I have a second?

MEMBER BAILEY: This is Don Bailey. I second the motion.

CHAIRWOMAN FREED: All right. Thank you.

Any discussion on the motion? All in favor say aye.

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

CHAIRWOMAN FREED: Any opposed no. Motion carries unanimously. Thank you.

Okay. We'll move on to the Express Scripts Save-On program.

MS. RICH: Okay. So this one is not as easy and simple and a little bit more complicated than the other ones. For the record Laura Rich.

So I brought this back to the Board back in January to be considered as a cost saving opportunity to be included in next biennium budget submission. But the more I thought about it the more I thought it would make sense to include it as part of pan year 2021 because not only is it a

cost saving opportunity to the program but it's also a benefit enhancement to the member.

So I have Amy Daly on the line from Express Scripts, and she's going to do a better job at explaining the Save-On program than I will. But in a nutshell Save-On program eliminates the cost barriers to those vital high costs that members were forced to take on last plan year after the Board approved the co-pay assistance from -- sorry, after the Board approved that co-pay assistance from the drug manufacturers would no longer apply to accumulators.

So prior to last plan year members who received co-pay assistance were frequently absolved from having to meet their deductibles and out-of-pocket maximums because the drug manufacturer's assistance would be a part of those deductibles and out-of-pocket maximums.

In this scenario PEBP wasn't able to leverage the amount of dollars that those drug manufacturers were willing to put forth because the manufacturer would stop providing co-pay assistance after in the case of a single employee after that 3,900 dollar max out-of-pocket was missed. There was no incentive for those drug manufacturers to continue helping the member because the member was already paying zero at that point.

So if they were willing to pay $1,000 a month for

12 months, so that's $12,000 in manufacturer's drug assistance fund PEBP would essentially miss out on approximately about $8,100 of that. So this current plan year many members were required to pay out-of-pocket costs because the co-pay assistance would no longer be applied to the deductible. That was a Board decision made back in the November meeting prior to last plan year. So although members frequently had to pay out-of-pocket costs for these drugs the plan leveraged a lot more manufacturer dollars than those dollars were never applied to the deductibles.

So with Save-On we're essentially getting the best of both worlds. Most members receiving co-pay assistance will no longer have an out-of-pocket cost associated with that drug. They can get their drug at zero or close to zero co-pay and their drug dollars still do not get applied to the deductible and out-of-pocket max so they still need to meet their deductible and out-of-pocket max, just like everybody else does.

So if they go to -- if they go to the doctor, if they get another prescription, those members will continue to have to meet their out-of-pocket, their deductible and out-of-pocket max, just like everybody else does, but at least that drug specifically has a zero cost share associated with it.

At the same time the plan still gets the most out of the dollars of the drug manufacturers willing to cough up. So the co-pay assistance policy that the Board implemented last year for the CDHP -- CDHP plan saved the plan approximately $2,000,000. That was last year's policy that the Board implemented last year. Implementing Save-On on top of this to both the CDHP and EPO is projected to save another 1.9 million dollars.

So with that I'm going to turn this over to Amy Daly with Express Scripts and she can go into some more detail on this program. So, Amy, are you on?

MS. DALY: I am. Can you hear me?

MS. RICH: We can.

MS. DALY: Perfect. And, Laura, we're going to be going over some slides and I just want to make sure where to reference them before I get started.

CHAIRWOMAN FREED: Board members, this is Laura Freed.

I think what Amy is referring to is the power point was Co-Pay Assistance Program and Solutions and probably starting on page two.

MS. DALY: Okay, perfect, and that is the title.

CHAIRWOMAN FREED: Okay.

MS. DALY: All right. Thank you, Laura. That

was a great segue.

One of the things I wanted to do today is just provide more detail and some examples of how these programs would work for the purpose of today's session, I just outlined some examples following the CDHP plan design, not the EPO, but it's meant to serve as an example of how it would apply to both plans.

So if we go to slide two, I wanted to spend a little bit of time talking about co-pay assistance. I wasn't personally aware of what co-pay assistance was until, you know, we started really digging into some of these programs and the availability of the pharmacy assistance available.

A lot of people, one of the first things I want to do is make the distinction between a pharma coupon versus what we're going to talk about today which is co-pay assistance.

So sometimes members can walk out of their doctor's office with a coupon for a medication as well, and typically those are for traditional drugs like diabetes, asthma potentially versus co-pay assistance which really applies to specialty drugs which are the high cost drugs for cancer, hepatitis C, cystic fibrosis. So, first of all, just the drugs that coupons apply to versus co-pay assistance, I want to point that out.

Second of all, some of the coupons are offered from pharmaceutical companies to also help members pay for their co-pays. Typically those don't have the dollars behind them that you do in the specialties. So those are for lower cost medications. They will typically expire potentially throughout the year, and Express Scripts doesn't have a lot of visibility into their coupons.

So typically the members takes their vin to the pharmacy and the pharmacy will adjudicate them as co-pay payments. So sometimes they are in the form of a credit card and they will just take that as payment for the co-pay, and ESI will have no visibility into those transactions.

On the co-pay assistance side because Nevada PEBP has a select network for specialty so Accredo, which is our specialty pharmacy, is dispensing all of the specialty medications for PEBP as well as through the Save-On program. Accredo is really able to leverage these co-pay assistance programs on the members we have to make sure that they can pay their medications, but also we're following the clinical rules behind them. We're making sure the drug is formulary.

On the coupon side those things don't necessarily happen. So the present coupon should help the member pay for a higher cost share members are able to get nonpreferred drugs so potentially drugs that require part off through the

coupon. So manufacturers are using coupons to kind of work around PEBP's plan design. Whereas, with the co-pay assistance program, we're talking about today Accredo really only leverages those for the clinically appropriate medications and the medications that follow PEBP's plan design.

So you will see here that there is 15 billion dollars in pharma money available in these co-pay assistance programs. So these are alive and well. Pharma has definitely been putting marketing dollars towards these co-pay assistance programs for specialty drugs, and really they are tying these so that they create brand loyalty with the members who are taking their medications. So they want the members to stay on these drugs throughout the year which Save-On does help encourage.

One of the other things I want to point out is that 80 percent of all specialty programs, so coupons can be targeted to specific drugs, but on a specialty side pharma is really investing in these dollars for most of the specialty drugs that are available.

So if we move into an example which is on slide three, this was PEBP's benefit structure prior to putting that out-of-pocket protection program in place last year. So as Laura was pointing out, in this example we have a 5,000

dollar drug and the manufacturer will pay $1,000 per claim for 12 claims per year, and what we've done is apply the CDHP plan design here. So you'll see after the first three fills, so the first fill met the member's deductible. Member did have to pay $500 towards that deductible, the other 1,000 with co-pay assistance.

And then as you move through the fills, on the fourth fill the member had completed both a deductible and out-of-pocket, and after the fourth pill PEBP was paying the entire cost of the medication but also any medical services that the member receives. So PEBP was becoming the full sponsor of all medical services after that fourth fill in that particular medication.

Then if you go to slide four we wanted to show you what the member experience after we put out-of-pocket protection in place on 7-1 for the CDHP plan, and you'll see here the plan benefit. So now the member is not needing their deductible or out-of-pocket max on the third fill, and so the plan is continuing to see the benefit of the co-pay assistance for the members continuing to see the benefit of the co-pay assistance available for additional fills.

So previously the member was benefiting only from $3,000 worth of $3,600 worth of co-pay assistance. Now, with out-of-pocket protection program we can take advantage the

additional dollars pharma has for the member by continuing to tap into that $1,000 per month.

Now, in this situation these -- the $1,000 does not apply to the member's out-of-pocket max. And this -- this is what the member is still receiving co-pay assistance. So you'll see that they are still paying zero, but these dollars weren't -- were no longer applying to their out-of-pocket. So they had to meet the out-of-pocket and the deductible through other means.

And I do want to just point out if we had a diabetic patient for example, these type of co-pay assistance dollars aren't necessarily available to those patients. So we wanted to make sure that when the member wasn't actually paying the dollars that they weren't actually applying to the out-of-pocket maximum when we put this in place. Just like a diabetic member who didn't have access to the co-pay assistance, these member would have to meet the deductible and out-of-pocket with other services, other than the pharma money that they were receiving.

And then the last example I want to show you, and I'll pause. Laura, do you want me to do all of the slides and then ask for questions or ask for questions throughout the slide?

MS. RICH: I didn't know which Laura you were

referring to but this is Laura Rich.

MS. DALY: I'm sorry. Laura Rich.

MS. RICH: I would pause because I think that this is, it's pretty complicated, and I think when this was presented in January it was Board members were a little confused by it. So it's -- it's something that I think maybe we can pause and ask questions as we go along.

MS. DALY: Okay.

CHAIRWOMAN FREED: This is Laura Freed.

My question is about slide four. Okay. So we changed effective plan year '20 to maximize our gain from co-pay assistance. So we continued through fills one through five to get that $1,000, and then and I see member pays 500. I'm not following the members deductible column because the member would have met their deductible by the third fill. So the member's deductible on fourth and fifth would go to zero, would it not, or am I misreading your slide?

MS. DALY: It's saying the 500 applied on the first claim and then nothing applies after that. So it's just carrying the 500 down.

CHAIRWOMAN FREED: Okay. I see, okay.

MS. DALY: Through the other.

CHAIRWOMAN FREED: I got it.

MS. DALY: Okay. And same with the

out-of-pocket.

CHAIRWOMAN FREED: Okay.

MS. DALY: So the member actually paid those dollars so it's applying to the deductible and out-of-pocket but the -- and continuing that number down.

CHAIRWOMAN FREED: Okay.

MS. DALY: Because nothing additional is applying at least based on the processing of this particular drug.

CHAIRWOMAN FREED: Right, okay. Got it. Thank you.

MEMBER FOX: Amy, I have a question. This is Linda Fox. The list of drugs that are included, where can I see that and does that change?

MS. DALY: It does. So there's over 150 drugs that are targeted through the Save-On program. Are you asking for, so I want to be clear too. I've only gone over the out-of-pocket protection not the Save-On example. So I do want to ask the question for -- the targeted drugs or Save-On, out-of-pocket prescription, any medication that the member seeks co-pay assistance for would be -- would work similar to this example here. So there's a much bigger scope with out-of-pocket protection than the 150 plus drugs on Save-On that are targeted.

MEMBER FOX: Okay. I think I got ahead because I

was on the next slide, slide six.

MEMBER MITCHELL: Jet Mitchell for the record.

I have a question for Laura Rich. On slide two it says your CDHP members use 2,000,000 in specialty co-pay of assistance from July to December 2019. So that's not included in the rates, correct?

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

Everything, and Stephanie would have to chime in here on what is included, up to what date is included in their actuarial analysis. But, yes, any savings that is incurred after a certain date is included in that -- in the rates.

And, Stephanie, can you chime in and maybe detail out until, you know, what time in the plan year that you use.

MS. MESSIER: Yeah. I'm pulling it up now just to make sure I quote it properly. So we typically are setting rates very heavily in February which means we have data pegged through December. But on the medical side because those payments are immature we don't include the incurred dates of December. We use incurred dates through November, but I believe the pharmacy because it does pay so quickly, we did include service dates through December.

So what we're doing too is in terms of what claims were actually paid, so if there was a savings on the

claim we're just getting the amount that was actually paid out. So we definitely, we're seeing those reduced payments from this program that there was a 2,000,000 dollar savings, and we also retroactively apply that to your historical claims. So that way all of your claims are on the state basis saying if PEBP had only been on this program, because we know it's going to be on this program going forward, the out-of-pocket protection rate because it was implemented, we don't want to carry forward something higher which trends into the future.

So we reduced the historical claims when the out-of-pocket protection was not in place so that we have 24 months of experience assuming an out-of-pocket protection plan that's always in place and then we project that into the future, and I hope I didn't confuse you.

MEMBER MITCHELL: And I -- this would be one more step. Jet Mitchell for the record.

This will be very basic. The 1.9 million dollar savings or $2,000,000, let's just say 2,000,000 to round to the PEBP particularly for July to December 2019 and then on slide six it has the estimated savings of 1.9 million, so let's just say those two numbers just for my clarification, is that savings just a member herself or himself and/or their families realized or is that savings to PEBP?

MS. RICH: For the record this is Laura Rich. Go ahead, Amy.

MS. DALY: Amy Daly for the record.

That's actually how many co-pay assistance dollars that those members received. What gets complicated here is I don't know that you can directly attribute that to savings just because those members then would have then had to apply different services to the deductible and the out-of-pocket. So we use that as an estimate of what was saved by PEBP, but Stephanie's numbers would reflect the actual savings because it was reflecting all of the out-of-pocket calculations that result after those dollars and deductible calculations that result after those dollars have not been applied to those accumulators.

MS. MESSIER: Correct. We're using -- this is Stephanie Messier. We're using anything that PEBP is paying for when we do our claims projection. And then I believe the second part was the 1.79 million coming up from doing the Save-On program and that has not been incorporated into the rates that you're going to see in the next agenda items to come because the Board needed to either approve or disprove implementing that program. So nothing was taken into account in our rates for the Save-On program if you guys decide to go that route.

MEMBER SMITH: Madam Chair, David Smith. If I could ask a question about slide four.

CHAIRWOMAN FREED: Sure thing.

MEMBER SMITH: Okay. I'm not clear on slide four. It shows that on the first fill of a 5,000 dollar drug the member only pays 500. But it's my understanding with the current co-pay accumulator the plan member has to pay the entire deductible plus the co-insurance, and the co-pay assistance does not count towards that; is that correct?

MS. DALY: So if you look at that first fill the member is paying -- the manufacturer in this example is paying up to $1,000 per claim for 12 claims per year. The co-pay assistance will vary from drug to drug. But for the purpose of this example the drug manufacturer was paying 1,000 per claim.

So on that first claim pharma funded 1,000. That left 1,500 of the member's -- I'm sorry. That left 500 of the member's deductible that the member had to pay because pharma wasn't covering that additional 500. So, again, that would change drug to drug, but it is fairly common for manufacturers to cover, you know, at least 1,000 per claim on some of these higher cost specialty drugs.

MEMBER SMITH: Okay.

MS. DALY: Potentially even more.

MEMBER SMITH: Yeah. What I'm trying to figure out is at what point in this plan -- okay. I guess I'm not seeing the accumulation of the out-of-pocket maximum. You're saying that on the first fill the member will pay 500 and the 500 goes to the member's deductible, what the member pays and the 500 goes to the out-of-pocket max.

On the second fill the $1,000 is just the co-pay assistance but that doesn't go towards the deductible. What does the member pay?

MS. DALY: The member is paying zero because that, the 20 percent of the total cost of the 5,000 dollar drug. So the manufacturer is saying they are willing to pay that 1,000 which is the member's co-insurance in that second fill. So they have --

MEMBER SMITH: Okay. That -- okay. From the public comment that we had in the January meeting that wasn't how I understood that to be. But if that's -- if that's how it's being applied then that is not significantly terrible, but I don't know if this is a common amount that people are, how it's being applied to people, how people are effected by it.

When you say 80 percent of the specialty drugs have a co-pay assistance program is this -- so the 80 percent -- I think it was 356 people were effected by it. So

80 percent of them, they are only paying $500 for their -- their specialty drugs for the entire plan year?

MS. DALY: I think most and, again, every plan member is going to have a different experience because there's different pharma funding for every plan. This was just, again, an example. But I think what the number -- the member will still potentially be is the dollars from there could not be used potentially depending again on what pharma pays.

MEMBER SMITH: You completely cut out. I didn't hear a bunch of what you said at all.

MS. DALY: Okay. Sorry about that. Can you hear me now?

MEMBER SMITH: Yes, that's better. Thanks.

MS. DALY: Okay. So I think where this really impacts the members is that they no longer have these dollars applying to the deductible and OOP. So previously they were getting to that third fill and then PEBP paid for everything. Now they have to pay into the deductible and the OOP on those other drugs and other medical services that they are receiving. So that's where their additional dollars come in, not necessarily from out-of-pocket expenses tied to the medication with co-pay assistance are on because they are still getting the benefit of those co-pay assistance dollars.

MEMBER SMITH: Okay. So with respect to, I mean it looks like the only difference between the Save-On program and the current co-pay accumulator is that with the Save-On program a member would, they would just not pay $500 a year but that's not how I understand the current practice is.

MS. DALY: So the benefit of the Save-On program is that the member pays zero throughout the year. So this example only follows through five fills. So you're only seeing the 500 dollar impact.

Also this is, again, just a standardized example. Some pharma manufacturers may run out of money before the twelfth fill. So members are having to pay that $1,000 perhaps for the eleventh fill, the twelfth fill.

MS. RICH: Amy, can I interject. This is Laura Rich.

So, David, just maybe to simplify it a little bit. The difference between what is happening now versus if we implement the Save-On program is today those members potentially have to meet their out-of-pocket costs that everyone else has to meet, right, but they have to meet those out-of-pocket costs to, even if they are getting those -- getting those -- the drug manufacturer's assistance, they have to meet those out-of-pocket costs to get those drugs that in the past they have been able to receive with no

cautionary because the drug co-pay assistance is applied to it. So that's today.

If we implement Save-On's -- if we remove those cost barriers it removes the cost barriers of the immediate cost barriers just for that drug, and so those members that are receiving co-pay assistance for that drug now -- now can receive it without those cost barriers because the Save-On program then, and Amy will explain this, but it lowers that deductible artificially so that just for that drug they are paying zero out-of-pocket.

Now, if they continue to go, let's say they go to see their specialist or they get another prescription for a different drug they still have to meet those out-of-pocket deductible or the deductible and out-of-pocket just like everyone else does, but at least for this drug that is vital to them because most of these are, you know, high cost drugs, specialized drugs, they are able to receive it with no cost barrier. So that's kind of the difference, just simplified.

And, Amy, I mean, did I say that correctly?

MS. DALY: Right. Yeah. They are guaranteed no cost on their medication throughout the year.

MEMBER SMITH: Okay. This is David Smith again for the record.

But this would only apply to those drugs that

have a certain amount of co-pay assistance from the manufacturer?

MS. DALY: So the way Save-On targets the drugs they work with, they are looking for medication but have pharma assistance available for an open population. So some typical funding requires, you know, limitation or demographic characteristics. Save-On goes out there and signs the programs that are really open to all patients in the categories, and the easiest to in term enrollment.

And then there's a bunch of other criteria that they follow, but it isn't necessarily based on the dollar amount of the assistance available. It's really, you know, are we able to safely enroll everyone within the clients we serve to get the pharma assistance from the manufacturers and they do -- they do change the drug on a semiannual basis.

MEMBER SMITH: Okay. So but I guess what I'm trying to look at what is the negative and who is -- who would be negatively effected if the co-pay assistance was going to be a small amount, let's say 2,500, would those employees or participants still get the -- the Save-On benefit of not paying anything or is it because the co-pay assistance falls below a certain threshold. You're going to carve them out and not let it apply towards the deductible and then they are required to pay for the difference.

MS. DALY: So the members on the targeted drugs will experience a benefit. They will now have a guaranteed zero cost for these medications throughout the year. So for example, when I spoke to the patient who did tell her story to the Board last year when I explained that and that her medication when she was part of this program, she was happy to know she would continue to get that medication at zero cost to her throughout the year while saving money.

MEMBER SMITH: Okay. And I'm just looking for unanticipated consequences to -- because this is listed at 80 percent of the specialty drugs received some sort of co-pay assistance, does that mean that all 80 percent of those drugs that go through the specialty program, the members receiving those drugs would fall into the same program where they don't pay anything?

MS. DALY: When -- when you list that the, if you want to look at slide seven, when we looked at the medications that are targeted for this and, again, remember that we're going to run this program on the CDHP and EPO plan. 481 members that were on one of these targeted medications, they had about 3,700 claims. So these are not every single one of your specialty patients, but it does capture a majority of the specialty patients.

And if -- members are still able to use co-pay

assistance if it's available and not part of the Save-On program. So that's not something that goes away. If there's pharmaceutical assistance available Accredo is always going to proactively try and enroll the patient in that, especially if they are saying they have a hardship paying.

So co-pay assistance and availability doesn't go away but Save-On does target limited drugs, and what those drugs, really what we're trying to do is maximize the co-pay assistance for the member which is what we do outside of the program but also for PEBP. So we're really making sure that all of the dollars that are available for these targeted drugs help you and the member.

MEMBER SMITH: Okay. Thank you. And I want to make a disclosure. I have -- I did a very expensive drug, and I received a third-party co-pay assistance, but my -- the drug that I receive, it goes 100 percent towards my deductible. So I haven't been carved out because the co-pay assistance that I got that I have received is -- isn't part of this program. It's not part of this thing.

I do -- I participate monthly in -- in sort of like a case management thing because they are doing studies on it, so but I also know that there are other co-pay assistance that are based on need by a participant. So if a participant were to go out because they only make -- they

make a lot less than somebody else in this plan, and they qualify for a third-party co-pay assistance, are they going to be -- is that going to be applied to the accumulator so it doesn't help them at all or will they be able to use that third-party, you know, co-pay assistance?

MS. DALY: So that's a tough question for me because I'm not really sure if you fall into OOP availability versus co-pay assistance on specialty drugs. I don't know if you're on the CDHP versus EPO plan. So there's a lot of variables but if we're simply --

MEMBER SMITH: I'm sorry. You're cutting out again. And I'm not asking for me. I'm just making the disclosure because I -- I do receive co-pay assistance that has not been carved out and it's because it comes from my participation in a separate program. But my concern had to deal mainly for if the co-pay accumulator program was going to continue side by side the Save-On program, if there are plan participants who obtain need base co-pay assistance from a third-party will they -- will that be taken away by the co-pay accumulator?

MS. DALY: No. Adding the Save-On program just has the co-pay assistance not apply to the deductible and out-of-pocket for these targeted drugs. I hope that answers your question.

MEMBER SMITH: I just want to make sure that the participant that had the greatest need with respect to the drugs, I don't want to have our participants rationing the drugs so that they can afford them because they are not part of the Save-On program and they are -- they end up being part of the co-pay accumulator. And, you know, when I saw they only pay $500, that kind of changed my mind on it.

In my experience, you know, for three years in a row I just put money in my health savings account and every bit of it came out to pay my costs because I would hit my out-of-pocket maximum. And my expectation was because of the co-pay assistance or the co-pay accumulator that started in 2019 that when I did receive some co-pay assistance that it would not apply to my deductible or out-of-pocket maximum and it did, but I think it's because it's not the same type. It's I'm having to work for it. I have to participate in this study to get it. It's not just a manufacturer opinion. I don't know if that's the difference.

But the other one, the co-pay assistance programs on a need base that people can apply for based on their income, and those third-party co-pay assistance programs pay, you know, go to offset the cost of the deductible and out-of-pocket maximum. So that's kind of what I'm trying to figure out.

And I brought it up in the January meeting because I didn't think it was equitable to all of the members of the plan because some people got it and some people don't. But in your slide four, if the only cost is $500 or I guess if somebody had a family plan of 2,800 it would be 2,800, then it's not as bad as I thought it was going to be. The impact wouldn't be as bad.

But because my co-pay assistance wasn't carved out I didn't -- I didn't understand how it was working for the rest of the members who are carved out based on the co-pay accumulator.

MS. DALY: So some of these programs are not taking any assistance away from members. They also have access. All the assistance programs are available to them. What we are trying to do is maximize the assistance, the dollars that pharma has out there for members and for plans, and they -- members are really benefiting from the dollars and we're trying to extend that to PEBP as well.

MEMBER SMITH: Okay. My personal review of this, I like the Save-On, the way the Save-On program is structured here in slide five. I still don't really have a good understanding of the current accumulator in the plan looking at slide four. I don't understand that it's only costing the member 500, you know, by not applying the co-pay assistance

to their deductible or out-of-pocket maximum. I don't understand how that is working currently.

But, I mean, is what you're saying is that the co-pay assistance and the co-pay accumulator now only results in the member having to pay $500?

MS. DALY: In this example yes because they are getting pharmaceutical money of 1,000 per claim. So when that deductible hits, the 1,500 deductible pharma is paying 1,000, and they only have to pay 500. If they actually pay that 500 it applies to the deductible and out-of-pocket max. The other 1,000 which pharma is funding does not.

MEMBER SMITH: And what you're saying --

MS. DALY: So then --

MEMBER SMITH: The $1,000 that pharma pays from here on out and the, what the plan pays the member is not paying anything so it's not going to the out-of-pocket maximum, but the initial payments go towards the deductible?

MS. DALY: Yeah. The 500 goes to the deductible and out-of-pocket because the member is actually paying it versus --

MEMBER SMITH: Okay.

MS. DALY: -- the pharmaceutical.

MEMBER SMITH: All right. So in this example on slide four, if the pharmaceutical, if the co-pay assistance

paid 1,500, how -- would the member pay nothing then because it covers the entire deductible?

MS. DALY: Yes, exactly.

MEMBER SMITH: Okay.

MS. DALY: And then the member's deductible and out-of-pocket would have been zero all the way down, and they would have had to meet that deductible and out-of-pocket and other drugs or other medical services.

MEMBER SMITH: All right. Gotcha. My understanding, you know, based on the comments and reading the plan design was the co-pay accumulator didn't function like this at all. So this makes me feel a lot better with the manner in which it's being set up.

CHAIRWOMAN FREED: This is Laura Freed.

Amy, are you going to move on to slide five and explain the -- explain the nonessential health benefit designation of these drugs?

MS. DALY: Sure.

CHAIRWOMAN FREED: Okay.

MS. DALY: So basically what Save-On does is use affordable care definitions of essential and nonessential benefits, and what that means is that through Obama Care they say you have to have so many, a certain number of essential drugs on your -- that apply to the deductible and

out-of-pocket accumulator. Those are labeled essential.

And then the other medications can be labeled nonessential and, therefore, do not have to apply to the deductible and out-of-pocket. So basically they wanted to make sure you had a certain number of drugs in each category where there were multiple options available. So that is how Save-On is able to classify certain drugs in certain categories and why there is a targeted list as nonessential. And what that allows them to do is truly maximize the pharmaceutical assistance available because these do not have to apply to the deductible or out-of-pocket throughout the year. So that's a critical part of what they are doing.

It doesn't mean that the drugs labeled nonessential are nonessential to these members. It's, no, they are using legal definitions through the Affordable Care Act to say we are labeling these drugs as nonessential so they do not have to accumulate towards the member's deductible and out-of-pocket, and what that allows you to do is set the co-pay such that you can maximize the dollars available from each manufacturer.

CHAIRWOMAN FREED: Okay. This is Laura Freed again.

Okay. So on slide six, it says targets 150 plus specialty drugs in 19 therapy classes. I checked with PEBP

staff to see how many of our participants this effects and apparently it's approximately 300 participants.

Do all of these specialty drugs that are available for co-pay assistance cover all of the drugs, the specialty drugs that our 300 participants use, are there any --

MS. DALY: So and I'm not sure where that 300 came from but when we looked at the targeted drugs for Save-On you have 481 members that are currently on one of these medication in both the CDHP and the EPO plan.

CHAIRWOMAN FREED: Okay.

MS. DALY: So that's on slide seven and there would be and there are some members that are on a specialty drug with co-pay assistance that are not a part of Save-On. So some of the members will not be participating in Save-On again because of the targeted list. But if they are using the co-pay assistance programs they can continue to do that. Those dollars will not go away and our specialty pharmacy will continue to encourage members to sign up for those dollars if they are available.

CHAIRWOMAN FREED: Okay.

MS. DALY: And just to touch on Linda Fox's question. They do change. They do reevaluate. Just like we look at PEBP's pricing every year, they reevaluate the co-pay

assistance available every year. They will add programs. They will have to occasionally delete programs because either the pharma assistance goes away. The drug goes off the market or, you know, it's just not a good program to have as part of the Save-On program anymore. And when that happens, we reached out to the members proactively. If there is still co-pay assistance available we want to make sure they are part of that program, but it would just -- if the assistance is no longer available then the member would revert back to the standard plan design.

CHAIRWOMAN FREED: Okay.

MS. DALY: There wouldn't be any co-pay. Yeah.

CHAIRWOMAN FREED: Okay.

MS. DALY: And the one other thing I'll review before I just close because I've taken a lot of your time today is just slide nine and how we approach these numbers and communicate with these members. So the first thing we do is send out a co-branded letter letting them know that Express Scripts and PEBP are working with Save-On together on this program and that helps when Save-On links phone calls to them later to try and get their approval to enroll them in the co-pay assistance program through Save-On.

Once the letter goes out we reach out, Save-On reaches out to the members up until the implementation date.

So they start 60 days out. They try to get as many members as possible enrolled prior to the effective date. They will reach a good majority of members but they will not reach everyone. So I've never had an incident where we had everyone enrolled before the effective date, and I do have -- I have a number of other clients on this program. I have a lot of experience with it. It's been around since 2016. So it's not a new program, and this is all Save-On does is, you know, call and work with these members to make sure they are comfortable and enrolled in these co-pay assistance programs.

So after the effective date, if we haven't actually spoken to a member we agree to proactively call these numbers for a refill. So these are special, really expensive medications. We need to schedule every shipment. So Accredo will proactively reach out to these members on these medication for their refills.

And in that discussion, if the member has not yet talked to Save-On or enrolled with Save-On, they will transfer the member over to Save-On in that process. A member can get enrolled before the refill can be processed. So that can be processed by with the engaged members with the program.

MS. RICH: So this is Laura Rich for the record.

I just want to add that there was -- there was

previously a question about the legality of this program and just so that it's on the record, I do want to say that this, Deputy Attorney General Brandee Mooneyhan did review this and found nothing that would be considered against the law.

CHAIRWOMAN FREED: This is Laura Freed.

Thank you for that clarification. I was puzzled as to how a pharmaceutical company would magically adjust the cost of a specialty drug to -- due to it being nonessential to accurately match the co-pay assistance available such that the members share zero dollars, so thank you.

Okay. Board members, having absorbed all of that do you have any further questions? Do you need further clarification on implementing the Save-On program? How do you feel?

MEMBER FOX: This is Linda Fox. I don't think I need further clarification. I mean, it is a lot to understand. I like the program and I think we should implement.

CHAIRWOMAN FREED: Okay.

MEMBER SMITH: This is David Smith.

And based on the way it's been explained it looks like it's a benefit to the participant, particularly not having to pay, you know, towards the deductible on the specialty drugs. So I'm still a little bit apprehensive that

we're not getting the total picture but I'm going to take it that this is a benefit to the participants and not going to result in the detriment or increased cost sharing to those plan participants who are going to be mainly effected by it so I'm okay with it.

CHAIRWOMAN FREED: All right.

MEMBER SMITH: As presented.

CHAIRWOMAN FREED: This is Laura Freed. If no one has any other questions or statements to make I'll accept a motion for approval then.

MEMBER FOX: This is Linda Fox. I will make that motion.

CHAIRWOMAN FREED: All right. Do I have a second?

MEMBER KORBULIC: Heather Korbulic. I second.

CHAIRWOMAN FREED: Thank you.

Any discussion on the motion?

All right. Hearing none, all those in favor signify by saying aye.

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

CHAIRWOMAN FREED: Any opposed no. Motion passes unanimously. We will implement Save-On for plan year '21. Thank you.

All right. We're moving on to Agenda Item Eight, discussion and possible action of the bill draft request to make changes to NRS 287.0475. I'll turn it over to PEBP staff.

MS. RICH: Okay. So for the record Laura Rich.

This agenda item discusses the bill draft request to resolve a significant issue involving the earned benefits of non-state -- non-state retirees participating in the program, in the PEBP program.

So since 2011 PEBP required retirees over the age of 65 with some exceptions to enroll in the Medicare Exchange through Via Benefits, and although this process is somewhat complicated the majority of retirees managed to get through with no problem. They get on the Exchange and those retirees on the Exchange are then eligible for an HRA which is a health reimbursement arrangement, and that is funded based on years of service.

So currently a retiree with 20 years of service gets $240 a month towards their HRA. Those funds can be used to receive, reimburse for their Medicare plan premiums, their dental plan premiums or any eligible medical expenses that are not covered by Medicare such as hearing aids. In order to be eligible for HRA and other benefits like life insurance retirees are required to maintain participation in the PEBP

program which in this case is the enrollment in the plan through the Via Benefits.

What ends up happening though is that every year during the Medicar Open Enrollment period retirees are often approached by carriers who are offering either better rates or different options, and they choose to enroll directly through that carrier. Which means that when they do that the agent of record changes from Via Benefits to the carrier.

So now back to February, after that Medicar Open Enrollment period is closed Via Benefits alerts PEBP that the member is no longer on the program, and PEBP stops the HRA funding and sends out termination notices. It usually isn't until the end that the retiree realizes what they have done. And then at that point the state retiree according to NRS 287.0475 has one chance to come back to the plan. It's referred to in the statute as a period, and they come back to the plan as a late enrollee. That means that they have to wait for PEBP's open enrollment in May to come back on and then reinstate in July.

They have to fill out life insurance because in statute that cannot be reinstated, but they can at least re-enroll in VS and get their HRA funding back. They lose their HRA funding from about January to July when they are reinstated but at least they do have that opportunity to

reinstate that and get that back.

If you are a millen state retiree though you do not have that chance. The statute as written today does not give non-states, so those are PEBP participants from local governments who do not participate in PEBP today the ability to reinstate. That means that a little mistake like this can cost them their life insurance and then a permanent loss of their HRA funding. So there's a situation that's even worse.

Every year insurers choose not to renew certain health plans. They are mandated when they do this to notices that are enrolled in that plan so that they have the choice of enrolling in another plan but if they don't, by law those carriers must enroll those members into a similar plan.

So those people that don't take any action on a plan if their plan is ending are what is called a crosswalk onto a similar plan through the carrier. When the carrier rolls that PEBP member into that similar plan in January when they are required to do, again, that agent of record changes. They are no longer enrolled Via Benefits and now they are enrolled directly through the carrier.

So in this situation the member has done absolutely nothing yet this has resulted in the termination from the PEBP program. If you're a state retiree, again, you do have one shot to come back and rectify it, but if you are

a non-state you do not have that.

So PEBP worked directly with our Deputy Attorney General Brandee Mooneyhan to add language that essentially gives those non-states a one-time opportunity to come back to the program similar to what those state retirees have. And because the associated local governments paid the respective HRF funding the possibility of returning non-state retirees to the plan does not increase costs to the state and reinstates the benefits to the retiree that they would have anyway had the disenrollment not occurred.

PEBP believes that with the statute was written the details and intricacies of the Medicare Exchange were unknown and at the time and the intent was not to permanently eliminate benefits that these members were entitled to over really such fine print language.

So what we're asking is PEBP is recommending that the Board approve the BDR so that it can be submitted by PEBP by the May 20th deadline. With that I'll take any questions.

MEMBER VERDUCCI: Yes. Madam Chair, Tom Verducci.

CHAIRWOMAN FREED: All right.

MEMBER VERDUCCI: Yes. Thank you. How many retirees does this effect? Do we have a number on that in terms of the membership of retirees?

MS. RICH: Yeah. For the record this is Laura Rich.

We have we think based on a report that our enrollment and eligibility vendor provided, we believe that it is somewhere around 750 non-state retirees since 2011 that have been terminated from the program because of this.

THE MOTHER: Okay. And when would the member enroll? Would this be the typical May enrollment period? So we can opt back into the program what would be the process for that?

MS. RICH: Correct. So it's the same process -- again, this is Laura Rich for the record.

It would be the same process that a state retiree currently follows. They then re-enroll back on to the program in May and it then becomes effective in July.

THE MOTHER: And how would the notification work for the 750 membership group? Would there be a mailing or posted on the website? How would they know this has been done?

MS. RICH: So first I would like to clarify. For the record Laura Rich.

I would like to clarify that even if the Board approves this, this is a BDR. So it would have to go through the next legislative session and be approved through the

session. So this is the first step in that. There would be, definitely be a communication, you know, process that would be developed. We have not gotten to that point yet, but I anticipate there being a pretty extensive communication between PEBP and we probably enlist the help of RPEN and some of the other partners to spread the word as well as mailings and things like that.

MEMBER VERDUCCI: Thank you, Laura. And also who would be the sponsoring agency of the bill?

MS. RICH: So for the record Laura Rich.

This would be part of the Governor's, and I can't remember how many bills it is, but, you know, one of his bills that goes in, the agencies can contribute as part of the Governor's full bills.

CHAIRWOMAN FREED: This is Laura Freed.

I can answer that. It's 110 limit on the bill draft for the Governor.

MS. RICH: Perfect. Thank you.

CHAIRWOMAN FREED: You're welcome.

So, again, this is Laura Freed.

So the non-state retiree would have to demonstrate that they had once been covered under PEBP in order to have that one shot to come back; is that correct?

MS. RICH: For the record Laura Rich. Yes, and

we actually have, you know, in our enrollment and eligibility system we can see what happened.

CHAIRWOMAN FREED: Okay. Okay.

MS. RICH: Yes.

CHAIRWOMAN FREED: Got it. Thank you. All right.

MEMBER BAILEY: Madam Chair?

CHAIRWOMAN FREED: Yes.

MEMBER BAILEY: Don Bailey. This has been a problem over a number of years now and I'm glad to see that we're going to correct or try to correct NRS, getting it through the Governor's office and Legislative Counsel Bureau. So, Laura, the changes in the NRS, maybe this is for the Attorney General, this will make this problem go away forever?

MS. RICH: Well, so what this does, I don't think it's a -- I don't think it's a perfect fix at this point. I think that the perfect fix is a much bigger problem to solve, but what this does is basically gives those non-state, so right now if one of those non-states accidentally terminates from the Medicare Exchange, which can happen like I just explained a couple of examples, that can happen very easily, that is it. PEBP cannot make any at this point today, we cannot make any exceptions to that because it is a statute.

We can't make exceptions to statute.

So it, really what it does is it gives those non-states the same opportunity to have that one-time oops that the state retirees have.

Now, you know, keep in mind that in statute again, it does not -- PEBP is not able to reinstate life insurance. So regardless of a state retiree or non-state retiree that licensure goes away as well, but at least you're able to come back, reinstate, come back on to Via Benefits and enroll into a Medicare plan and you then get your HRA funding reinstated as well. So, you know, that's a 200 and -- potentially a 240 dollar benefit. So it just, it depends on the year of service but that's where it maxes out.

MEMBER BAILEY: Okay. So really technically the problem will still be in existence even if this goes through everybody's approval? We'll still -- we'll still -- they will get the one-time shot to go re-enroll and get the benefits and then if they miss that they will be out again, correct?

MS. RICH: So for the record Laura Rich.

Yes. However, most of the time the first time they do it they are usually unaware of the situation and the requirement they don't do it a second time typically. I can't say there have been no instances of this where someone

has done it a second time, but typically most members realize the importance of staying on the Medicare Exchange and re-enrolling through a carrier on the Medicare Exchange and so they don't do it a second time.

MEMBER BAILEY: Okay. All right. Thank you, Madam Chair.

CHAIRWOMAN FREED: Thank you. This is Laura Freed again. I am supportive of allowing PEBP staff to move forward with requesting this bill draft in order to treat the non-state retirees the same way that we treat the state retirees that is giving them one chance to come back.

Any Board members, any thoughts?

MEMBER SMITH: This is David Smith.

I agree it's something that should be done. I did have a question. If a plan participant, you know, inadvertently switches to somebody else, is there a grace period to switch back? I mean, if they get notified that they are not going to be covered anymore, I guess it would be like on a calendar year, like January, would they be able to undo it so they don't lose all of that or once they make that choice they are out?

MS. RICH: For the record Laura Rich.

So since, if they do it during the Medicar Open Enrollment period they are able to switch plans, you know,

during that time, and if they recognize that before the end of the open enrollment period they can rectify that situation.

The problem is that most of the time they don't because it takes a termination letter from PEBP or it takes, absent of HRA funding to alert them that uh-oh something is wrong, and so usually it takes time for that to happen. And so it's, you know, two months later where Medicar Open Enrollment program open, end of December we process those terminations, PEBP processes the termination and, you know, in the month of January typically.

And -- and then so, you know, those letters and termination start trickling out and HRA funding stops and that's when those members realize what they have done, and at that point they are stuck in a Medicare plan. It is outside of that open enrollment period and so they are unable to, you know, make any changes.

MEMBER SMITH: Okay. So and my feel on that, you know, this group, you know, as we age we become more vulnerable to making mistakes. And when it comes to health insurance, you know, there's -- there's nothing simple about it.

And I'm wondering if, you know, I think this suggestion that you made from the legislative change for

non-state employees go, but is there a way we can protect those people who make a mistake because I think it's something very simple to do that they are able to -- I mean, that they are notified or they, you know, they have to act within 30 days to switch back so they don't lose their coverage because people work their entire lives to get these benefits, and a simple mistake can eliminate it. And but my thought is can we go farther and put something in to protect that from happening to those participants?

MS. RICH: And for the record Laura Rich.

Yes, there is. This is the first step. You know, this is basically the -- the biggest bang for your buck, right. We can do this pretty quickly. You know, this BDR addresses the biggest problem. That is not to say that there are not other problems that exist, especially with the Medicare retirees. You know, it is -- it's definitely something that we need to start looking at.

We can do it as a -- as a Board, as staff, something that, you know, I thought maybe we can even include strategic planning, you know, during, we do it in the August/September time frame. It's something to look at, but I believe that this is really the biggest bang for your buck, right. If we do this, it really helps a lot of those non-state retirees who are having to deal with permanent

consequences, lifelong permanent consequences of a simple mistake. So, I mean, I think this is just the first step in the process.

CHAIRWOMAN FREED: Okay. This is Laura Freed. Any other comments from the Board members? All right. Hearing none, do I have a motion from anyone?

MEMBER BAILEY: For the record, Madam Chair, I recommend that we approve the recommendation by the PEBP staff on the bill draft request.

CHAIRWOMAN FREED: Okay. Thank you. Do I have a second?

MEMBER SMITH: This is David Smith. I'll second it.

CHAIRWOMAN FREED: Okay. Any discussion on the motion? Hearing none, all those in favor -- did I hear somebody? Nope, okay. All those in favor say aye.

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

CHAIRWOMAN FREED: Any opposed no. Okay. The motion carries. Thank you everybody.

Now we move on to Item Nine, discussion and possible action of the plan year '20-21 rates.

MEMBER SMITH: Madam Chair?

CHAIRWOMAN FREED: Yeah.

MEMBER SMITH: Can we take a five-minute break.

CHAIRWOMAN FREED: Yes. If everyone needs to get a drink of water and use the bathroom, yes. It's 11:12. Why don't we -- don't hang up anybody because you might not get back in, but why don't we come back at 11:20.

MEMBER SMITH: Sounds good. Thank you.

CHAIRWOMAN FREED: Okay. Meeting is recessed until 11:20.

(Whereupon, a brief recess was taken.)

CHAIRWOMAN FREED: Okay. Ladies and gentlemen, this is Laura Freed. It is 11:20 so I'll call the Board meeting back to order.

So and let us go forward on Agenda Item Nine, the FY21 rates. I'll turn it over to either Executive Officer Rich or Stephanie Messier with Aon, whoever wants to take it away first.

MS. RICH: I'm going to have Stephanie take over.

CHAIRWOMAN FREED: Okay.

MS. RICH: Go ahead, Stephanie.

MS. MESSIER: I'll catch that hot potato.

So fortunately yes, we are in a position today where the fees are not as favorable as they have been in years past. So I am starting with Agenda Item Nine, and I'm going to be doing a bunch of numbers via the phone which is

always extra fun. I'll try to keep referencing page numbers as I go along, and I'll definitely pause at the end of each page just to make sure all of the Board members are able to ask their questions as they come about.

Okay. So moving on to slide two, first very exciting, and I want to take a moment to thank both Laura Rich and Cari Eaton for allowing Aon to kind of hope step through PEBP's financial. This is very unprecedented for us, and we very much appreciated the opportunity to help them, that advice through both financial historicals as well as how they currently report on financial matters today. So that's where we'll start.

Second, we're going to be able to go through the plan year '21 year rate and, again, usually typically Aon is involved in the base rate setting, but this year we were able to get additional access in helping look at admin fees and then we're also going to be presenting on the overall rates and what that means to the members in terms of premiums.

And then finally, as we kind of alluded to at some prior Board meetings there's policies the Board has set forth in terms of required reserves both on the, both on the IBNP and catastrophic. Some changes may need to be made there, not only in order to cover any potential shortfall coming up in this current plan year but as well as to try to

get PEBP on a better footing so what we might be seeing in plan year '21.

I also want to preface today's presentation with the fact that at Aon we typically are asked to set rates starting in January. So we start gathering data and the majority of our work occurs in February, and typically we're preventing PEBP with those base claim rate projections at the very end of February, very early couple of days of March.

So as you all might imagine in early March COVID-19 wasn't really much of a blip on anyone's radar. So none of these rates in terms of our projecting out of rest of plan year '20 or looking at plan year '21 really include any financial impact that COVID may or may not have. Now, there's some good news in the current month. You most likely saw a decrease in plan spends, so people not going to get elected procedures or because they are staying at home, right, they are cancelling doctor visits and other things. So you may see a little bit of a decrease in cost from that which might help a little bit in terms of testing or treatment. However, certainly as we all know from watching the news there's a lot of potential infections and treatments coming up on the horizon that certainly has not been built into the plan rates.

Any questions of that before I dive in?

CHAIRWOMAN FREED: This is Laura Freed. I do.

So, yeah, you touched on something that I have been thinking about. What we hear anecdotally is that participants are, you know, having procedures or tests moved out until June or May or something and so is -- is Aon working on modeling for all of its clients the reduction in regular consumption of healthcare and offset by the increase in COVID-19 consumption of healthcare. And how long do we think it might take to see that shake out?

MS. MESSIER: So to answer your first question. It has not been their focus yet. They are definitely recognizing that there is going to be kind of that hush happening right now.

But as you might imagine the bigger question that we've been getting and the actuarial think team has been working day and night on is trying to project future COVID costs. They haven't been as focused on the thing that's occurring today from the elected procedures and those other items.

CHAIRWOMAN FREED: Okay.

MS. MESSIER: But unfortunately I think you're right. Some of it is not something you can avoid, right. It's something that you're still going to have. You're just not having that happen today.

CHAIRWOMAN FREED: Right.

MS. MESSIER: So additional people having COVID and hospitalizations happening throughout the summer, you may start to see some of these elected procedures come back into play. So it's not like somebody is just no longer going to get their knee replaced. They are just delaying it by a few months. So it may be a doubling of impact later in plan year '21 when COVID has kind of died down and the hospitals have kind of flattened the curve, right, some then you may start to see some of those elected surgeries pick up.

I'm sure Aon will be looking at that next. It's just first their focus has been on trying to present a modeler that helps with those costs. And setting those as we went through a presentation yesterday, all of our actuarial team on the new model that's getting released hopefully later this week, and then I'll be able to start running yours current in order to try to get that estimate for you, and I do apologize that we don't have it today, but as you might imagine --

CHAIRWOMAN FREED: No. Things are busy.

MS. MESSIER: Yes.

CHAIRWOMAN FREED: I completely understand. Thank you, Stephanie. I appreciate it.

MS. MESSIER: Yeah, not a problem.

Any other questions? Okay. Hearing none, I'm going to jump right in to slide four. I apologize. Those numbers are pretty tiny at the bottom of the page. So we wanted to start off, again, we put in so much work in the last couple of months. And, again, I cannot thank Laura Rich and Cari Eaton and that's for allowing us to kind of get into the weeds here in term of the finances.

So we have gone back on this slide to fiscal year '10 to say what does PEBP's revenue look like? What were their obligations? What we do here is we take the revenue and we take out those obligations, the plan cost, the cost they have to pay to the vendors, the cost that they give to the fully insured premiums, the claims cost that arise, and that gets to the ending cash that the CFO includes in their board report. I believe it's in the September report when they close out the year.

Then what happens is the ending cash is then used to fund the required reserves and required reserves are made up of the IBNP, the catastrophic which I believe used to be called the rate stabilization reserve, as well as then the HRA reserve. So those are required reserves, and what you're left with is those excess reserves that has been certainly a hot topic over -- over the history of the PEBP plan.

I wanted to read this chart. The orange and gray

bars are your revenue and obligations. And then the colors in the mountains kind of looking behind that chart is that amount of ending cash that you've seen, and then you'll see that blue bar kind of grow and on top of that yellow mountain to absorb more of that ending cash. And conversely starting with fiscal year '14 you see that excess reserves going down and then most recently in plan year '20 we're currently projecting based on Cari's latest estimates and the data that we've gotten from the vendors. And some of the claim payments, we think PEBP is going to end the year between negative million and a positive million, and right now that number is coming in a little bit closer to the negative one.

But certainly if COVID really is reaching recurrent elective procedures and having an impact there, it may pull it back closer to a positive number. Just right now that's kind of where the projections are ending up.

Any questions on this slide? Okay. I know this one -- most of these may be new for you towards the beginning of this presentation. So I just really want to allow everybody a moment to ask questions.

Okay. Moving on to slide five, here we wanted to break down the required reserves and why have they gone up so much over time. I think certainly it's a question I will be asking, you know, sitting in Board meetings over the years.

So the most notable change has come in HRA reserves. When it was first introduced in fiscal year '13, it was about $15,000,000 and it's grown 6.2 times that amount to be estimated to end fiscal year '20 at about the 40,000,000 dollar range. And this is really the money that PEBP's members have earned to HRA dollars but have not spent. So PEBP is reserving 100 percent of those dollars. They also have unlimited dollars that are able to roll-over from one year to the next.

So if people have not used those HRA funds, for example let's say they have $5,000 in that account and then they get another funding next year and they don't tap into any of that money of the 5,000, plus the additional funding they got in that current plan year will then roll-over to the next, and PEBP is keeping a reserve for all of those money in that HRA grade section.

And you'll see the IBNR has also gone a little bit over time in the most recent years, most notably because we added the EPO or premier plan and that's just because when we moved from fully insured to self-funding you are not now required as we discussed in the November meeting to have a reserve on hand, an IBNP. So that's increased that over the last couple of years, as well as you've had the claims volatility occurring with those large claims which have a

longer time to pay and that's increased your IBNR, and then you'll see the catastrophic amount has varied a little bit over time. It kind of shrank around fiscal year '14 and it's gotten slightly larger again in the more recent period because again the EPO also has its own catastrophic reserves, but they are very stable. But, as I mentioned before, the gray is really seeing the most dramatic growth.

Any questions there?

CHAIRWOMAN FREED: This is Laura Freed. And this may be a question for PEBP staff.

In general as on a percentage basis what do we spend on health reimbursement arrangement as opposed to the budgeted HRA reserves? Do we spend 60, 70, 80 percent of our reserves in actual HRA or does it vary?

MS. EATON: It does vary, and I can look into that and get those numbers for you.

This is Cari Eaton for the record.

CHAIRWOMAN FREED: Okay. Thank you.

Questions? Any other questions?

MEMBER VERDUCCI: This is Tom Verducci. If we could spend a minute discussing, you know, I see the EPO/HMO plan increased required reserves but does the CDHP plan have any effect on the required reserves? Where I'm going with this is the -- is the EPO plan creating a burden on the

funding of our entire program?

MS. MESSIER: Good question. So this is, again, Stephanie Messier with Aon for the record.

So if you wanted to look at just the CDHP IBNP catastrophic reserves that is the blue and the orange at the bottom of the bars, but you will see those have grown a little bit again as most recent to fiscal year '19 and '20 and a lot of them is due to those large claims that you're seeing popped back up for your plan in '19 and '20. And so then the yellow and the lighter blue at the very top is the EPO amount.

What normally happens when you move from fully insured and you're paying 12-month premium for full coverage on those incurred dates and switching to a self-funded plan and the first two months when you switched over to a self-funded EPO plan, you saw very little payment going out the door, but yet you were collecting money from the state for to go on that plan. Really those monies were set aside in order to build up what would be claims run-out if you would ever end self-funding the EPO plan and go back to either a fully insured plan or if that's because the state no longer offered health insurance, you would still have a run-out of claims and that's what the IBNP is set aside to cover.

So I wouldn't say that's a particular amount that's overly burdensome to required reserves. A lot of that funding came from those two first months of being self-funded, the July and August that you first switched over. Does that make sense?

MEMBER VERDUCCI: Yes. And just as a follow-up, going in the future will the EPO plan have a continued drain in terms of increased expenses or is that going to taper off?

MS. MESSIER: In terms of required reserves specifically your question or more broadly?

MEMBER VERDUCCI: Yes. Specifically with the increased required reserves is the EPO causing us to have to place more dollars in required reserves in the future?

MS. MESSIER: There's nothing specifically about it that would require you to have more just because you have membership in that plan, but you need to have those funds set aside. Now, if you continue to have people that have very large claims that take longer to pay and that creates a longer lag time you will have to increase the IBNP poll or EPO out of those required reserves and it would increase it larger if that was happening.

But all other things being equal, it's the risk of a member is the same health lets say on the EPO as the CDHP. You're setting aside the same dollars for that person

regardless if they are on the CDHP or EPO. So what you have seen and PEBP knew this going into it people that are on the HMO or co-pay plan typically are a little less healthy. They require a little bit more medical services so they have more claims and that typically will result in a little bit larger of an IBNP than you would see for a CDHP member.

MEMBER VERDUCCI: So if the 95 percent confidence interval was reduced would that have any positive effect on the reserves?

MS MESSIER: It would. So if you would move from the 95 percent comparable on the IBNP to something a little bit more typical but yet still slightly conservative let's say a ten percent margin, you would be able to reduce the current required reserves projected for June 30th of 2020 by about $7,000,000.

MEMBER VERDUCCI: Is the 95 percent confidence interval, is that conservative in comparison to similar sized programs?

MS. MESSIER: It is. So if you go back to the November Board meeting where I presented on what other states are doing we don't typically see anything more than let's say a ten percent margin. Some typical plans like yourselves don't have any margin. They just try to set it close. It depends in terms of their IBNP estimate whereas someone would

be a little bit more conservative and go with the ten percent. I would say you are very outside of the norm by having that 95 percent competence interval on the IBNP.

MEMBER VERDUCCI: So the 95 percent what would be the reasonable percentage to change that to 85, 90?

MS. MESSIER: Yeah.

MEMBER VERDUCCI: Go ahead.

MS. MESSIER: Yeah, what I would say, going with a ten percent margin you're probably getting somewhere closer to, and I haven't done this analysis to back it up, but I would still say you're in a conservative realm. Most likely what we try to do with IBNR is closest to a 50 percent anyway. So by adding a ten percent on top of that instead of 25 percent that you have, you're still going to be covered, I would say probably closer to 70ish percentage confidence interval. You're just not going to be at the 95 but, again, 95 is much higher than I have seen with any other plan.

MEMBER VERDUCCI: Okay.

THE WITNESS: Well, thank you. I mean, that's something I believe that we should look into if it does free up reserves that we need to have on hand.

MS. MESSIER: I agree, and that's definitely something we're going to cover here on the third section of the presentation. This is probably one of the easier

sections to say does this make sense to have. Turning on the catastrophic, we're all kind of living through why you have one, right? We had talked about if there was a pandemic or something happening right in the Vegas area a lot of your members get exposed and come down with something.

But I think this one is more, it really is supposed to be a reserve if you shut the plan down, what is your liability in terms of a claims lag and having a 95 percent confidence interval on that is going outside of the norm.

MEMBER VERDUCCI: Okay. Thank you.

MS. MESSIER: Yeah, good question. Anyone else?

Okay. Moving forward to slide six. This one doesn't have too much of a direct effect in terms of your rates. But as, again, we were diving through all of the design stated elements in terms of PEBP plan and history, I thought it was interesting and I wanted to be sure to include it to help give the same education to the Board members, but I was able to get myself.

So the PEBP population as a whole has been fairly stable in terms of size. So that's the numbers you're seeing on the left-hand side of this chart. You have been between $40,000 and 45,000, I'm sorry, that's employee count. Non-state participation, not surprisingly, has been dropped

23 percent of the population in fiscal year '10 to 14 percent in fiscal year '20, and a lot of that is because, again, people were able to take their actives out of the plan. You saw that decreasing. You can at least still see a little bit of blip in plan year '10 but almost nonexistent when we got to fiscal year '13.

The non-state retirees as well, they were a larger percent of your population until about plan year '13 and they have become smaller over time.

The dark blue line that kind of floats through the chart there and relates to the numbers on the right-hand side is what percent of your population is made up of retirees. For a lot of public sector plans, they are now saying that they actually have retirees that make up more then 50 percent of their plan. So they have fewer and fewer workers that are on the plan versus how many they are covering in retirement.

So the good news from a financial perspective from PEBP is that your retirees are pretty consistently floated between basically 40 and 42 percent of your population over the past decade, but they haven't grown to being more of the population than people who were actively working.

Any questions here?

In summary in this first section, what does this all mean? So as Ms. Rich alluded to earlier, for the first time in literally over a decade as the reserve probably exists today PEBP is going to start plan year '21 with little to no excess reserve dollars. We've already covered the next bulleted item which was the need to most likely to delay the funding of that HRA and HSA for the supplement of the legislature to remove.

The other item I wanted to point out here was that if we had currently projected that the shortfall was more than a billion dollars, let's say when we were looking at in February we were thinking it was a 5,000,000 dollar deficit in excess reserves after we took that ending cash and subtracted out the required reserves, we would have needed to add that 5,000,000 back into the rates in order to put that money back into the plan.

So I just wanted to recognize that because it was negative but less than a million dollars we made the decision to not load an additional million dollars to try to make up for that into the rates. We then took a more aggressive approach and just said let's assume there was -- it broke even in plan year '20 and we're starting plan year '21 with no excess reserves, but we also don't have any deficit our way out of and, of course, it's yet to be seen three months

out where we really will in plan year '20.

Any questions on that piece of it?

CHAIRWOMAN FREED: This is Laura Freed.

Yeah. So if we lower to the ten percent margin on the IBNP or, and/or change the catastrophic confidence interval to something less than what it is that money is just to work with actuarial determined reserves, in other words it's not plowed into the '21 rate field; is that correct?

MS. MESSIER: That is correct.

CHAIRWOMAN FREED: Okay.

MS. MESSIER: Basically it would give you starting excess reserves to have starting going into plan year '21 is nothing that's built into the rates today. We certainly want to discuss it.

CHAIRWOMAN FREED: Okay.

MS. MESSIER: In those last kind of three items on the slide basically.

CHAIRWOMAN FREED: Okay.

MS. MESSIER: Good question.

Anyone else before we move on to the second section?

Moving on to slide nine, this is very high level basic refresher on how rates are set. We take PEBP's experience and then we move the projected trend that we

talked about at the January Board meeting to supply PEBP with the base rates. PEBP has a worksheet where they put in the base rate card that we provide to them. They add on their administrative costs, as well as the HSA and HRA funding in order to build what is known as the oral rate. The overall rates are then taken and then the employers contributions are also known the subsidy are subtracted out to get to the final member share which has also been called premiums.

Well, first we take your claims data from your different vendors and, again, we use data through the end of December incurred through the end of November for medical with one year, sorry, not one year, one month of payment run-out, and we also conduct a pharmacy market check at the same time as previously presented.

The market check was able to help reduce our cost on the pharmacy by about nine percent, at $4,000,000 with about a nine percent savings on the pharmacy side. So that is reflected in the rates that are being presented today.

We did that past experience and moved it forward to plan year '21, and then as I walked through already, staff will take those rates and do the administrative fee load to create the overall rates.

Then the PEBP's financial staff already has budget approved employer contributions from AGIS to REJ in

order to calculate the member share premiums, and those dollar amounts per person are applied as we set those premiums.

Moving on to slide ten, if there are no questions. Okay. So taking a look at the plan experience, as we're comparing what we're projecting for plan year '21 versus plan year '20, we definitely saw an increase on the medical pharmacy side for both the CDHP and EPO plan per state participants. The non-state folks because they are becoming such a small population are less credible in their experience and increasingly volatile. The good news being is that their most recent experience was definitely much more favorable than it has been in years past where they were seeing much larger increases to the state side. Still overall on a per person basis they do cost more than the state participants, but those costs, as I mentioned before, have been coming down. So they saw a negative trend in the upper chart.

The dental experience came in very favorably. So even though we're projecting moving it forward at the one to two percent trend rate, the PEBP Board experience has been good enough that overall this was only increasing by .1 percent for the state population and by half a percent for the non-state population.

So the total change that we're seeing in terms of a constant on claims and, again, this is outside of anything COVID may have in terms of an impact to the plan is about 8.8 percent for the CDHP membership, a 13.1 percent increase on the EPO membership. HPN sent over their rate increase at seven percent earlier in the year, and so that number is going through there. With dental added on it pulled it down a little bit to overall being a .6 percent increase.

I did just want to talk about the final bullet on this slide. Per PEBP's Board direction where extra conservative in terms of how we set the IBNP and the catastrophic reserves, over time because of those excess reserves that have been generated and were not being depleted as quickly as people had hoped, we had been instructed and we continue to follow our instructions that if the 50 percent chance these rates will be sufficient to cover claims cost and there's a 50 percent chance they won't.

With most plans, as actuaries we're not asked to be aggressive and our nature tends to be a little bit more conservative, but definitely for PEBP we have been instructed to be more aggressive and we have done so, and I think you've seen that a little bit in terms of the claims cost. When we do that lookback analysis, a couple years we were over and that trend presentation as well and most recently our rates

have been under projection.

Any questions on that piece?

MEMBER VERDUCCI: Yes. Tom Verducci for the record.

So if the 15 percent chance does occur then we'll be short. How do we make up for that? Where does it come from? Does it come from catastrophic reserves?

MS. MESSIER: I think in terms of when Cari is paying the bills, it does have to -- she does have to pull the funding I believe. And, Cari, jump in if I'm misstating, has to pull that number so the catastrophic reserves in order to pay plan costs.

Then when we're setting next year's reserves we're including that underestimate in the next year's rate. So it's really kind of what we're seeing here, and we talked about it before. You've been in a good cycle of like underwriting typically kind of, you kind of see this happen. You'll have like three good years followed by three bad years of experience, and PEBP certainly has been in a swing of prior to fiscal year '19 was in periods of very good years. So starting in fiscal year '19 and fiscal year '20 your actual experience is coming in higher than what we had anticipated was setting the rates.

So not only do we have to move your rates forward

to account for trends of next year, we also have to account for the fact that your current year's rates are below what we think the current year is going to come in at. So we have to move that forward and make up for that shortfall in terms of where we're trying to get to what we think plan year '21 rates will be.

So that's kind of what you're seeing here like on that 9.6 percent. We're applying trend rates closer to six and a half percent as we talked about at the January Board meeting, but that three percent additional money that we're trying to take back on the CDHP is really accounting for the fact that plan year '20 is running worse than the rates were set. The rates were set too low for plan year '20. That was the 50 percent we went over versus in fiscal year '18 and '17 the rates that we had set were too high.

MEMBER VERDUCCI: So if we do find ourselves in the 50 percent chance where we're going to be short what is the process to look into the catastrophic reserves? Does that go before the GFO, the IFC and does it go before the Board to make the determination at that time?

MS. MESSIER: Laura or Cari, are you able to address that?

MS. EATON: This is Cari Eaton for the record.

This is a fiscal process that would go through

GFO and likely go in front of the Interim Finance Committee. Typically we don't need Board approval to do that. It's just moving authority from one category to another to make sure we can pay our bills, but there are -- you know, we have to plan for that if we use catastrophic reserves which I don't believe we've ever had to do before, but there is a possibility that we may be doing that for the first time this year.

MEMBER VERDUCCI: Okay. Well, thank you for your help in understanding that. That 50 percent does raise a concern for me and I just want to understand the methodology if we had to go that route in the future, so thank you.

MS. MESSIER: Yeah, and I would agree that I think the 50/50, you know, made sense in the days where PEBP was running with the 40 to $50,000,000 excess reserves in addition to the very conservative IBNP and the catastrophic reserves. But given where we're certainly seeing ourselves today and it's worth noting maybe for the upcoming budget that you may not want to continue to set rates for the 50/50 chance of being short, especially because you're on the biennium basis in terms of your budget and the state's amount that they are providing to you is set so far in advance, it really puts you at risk in that second year that you're going to see a larger impact to your membership because the state

amount has already been set.

If you're extra aggressive in the rates in that first year and come up short, it just puts additional pressure on that second year, and you have no mechanism with which to get more money from the state just because of how the state's budget is set on a two-year cycle. Does that make sense?

MEMBER VERDUCCI: Yes, it sure does. Could we perhaps be in a position right now where we should be requesting for catastrophic reserves?

MS. MESSIER: I do think that's what Cari was saying. Like, it's possible even before you end plan year '20 that she may need to pull some out of there in order to cover plan year '20 cost.

MEMBER VERDUCCI: Okay.

MS. EATON: Yeah. This is Cari Eaton for the record. We are projecting a shortfall in our state retiree category just as compared to how we budgeted two years ago. And so with our lack of excess reserves we would have to tap into catastrophic reserves to fulfill those expenses.

MEMBER VERDUCCI: Thank you, Cari. That answers my questions. Thanks.

MS. MESSIER: Any other questions on slide ten?

Okay. Moving forward to slide 11, I wanted to

get a little additional clarity here in terms of what is happening about your admin fees, as well as your HRA/HSA load. So I do believe this is still for any Board member that maybe was here in years past.

Administrative fees are meant to made up of PEBP's, both their operating fees, as well as any contract obligations they have to the different vendors. These are the PEPM amounts for both the CDHP and the HMO plan. You will notice the retirees are less than your CDHP actives, as well as HMO, and the difference there is related to that double asteric at the bottom of the page.

The actives receives LTD coverage, as well as a larger life insurance coverage, and so the difference in those premiums are added separately. So the actives are paying for the coverage that they are getting for both life and LTD, and that's a larger additional amount, the admin fee.

The other item that is important to know is the pharmacy rebates are being subtracted out of your admin fees for both self-funded plans, the CDHP and the EPO. Historically those rebates, I would say probably five or six years ago were a very small amount. But as you notice, I think over time and with the change to ESI and these additional way that pharmaceutical companies are running

money through the rebate, PEBP is getting 100 percent of those, which is great news, but it does pull out a lot of money in terms of admin fee.

Some of my other clients will use that instead to actually reflect the claims cost of the pharmacy claims and that part of the process rather than reflecting it in the admin fees, but I just wanted to be clear that PEBP is accounting for it here in the admin fees rather the non, what we could call the claims pick or the claims projection.

Any questions about that?

Okay. The other thing I wanted to bring up before we move on from administrative fees is PEBP is definitely seeing some volatility here. And as we were trying to dive in and sort of figure out what is kind of going on in terms of the excess reserves, we were seeing some large volatility on the admin fee side that was definitely generating some of those additional excess funds as well as adversely pulling from it.

In certain years we haven't been able to dive all the way through that to figure out why there was such a large discrepancy in certain years but definitely historically, probably two to three years ago we were seeing some larger swing that would need I would say some additional research, but currently we feel confident with the numbers that are in

there for the upcoming plan year '21.

Any questions before I go to slide 12?

Okay. Moving on to slide 12. Here is the base rate that has been loaded for both the PEBP's obligations on the admin fees, as well as the HRA/HSA funding for the CDHP membership. Certainly that's not added on the EPO/HMO. They do not get those funds. It's typically a function of those who are on the CDHP plan.

As you can see, the dollar differences here in terms of how much more the EPO/HMO blended rate is and once again we are blending that rate together. So we have except the rate from the EPO plan the other rates on the HMO, we blended together based on membership and both of those plans to get these to these blended EPO/HMO rates.

Here we are showing you the three main categories that you see and historically the state employees, the state retirees, as well as the non-state retirees. I believe you still have maybe four non-state actives but given there's four of them, we chose to simplify this slide and not show those rates.

Any questions here?

We're almost done. Slide 13 is the state employee premiums. So this is after the state subsidy which again is set during that biennial budgeting processing so a

couple of years back. Once that part of share is taken out, this is how much the state employees will be asked to pay for plan year '21. And certainly full PEBP staff and Aon recognizes that this is a larger change than seen in years past, and that's something we've taken lightly. So the employee only rate is going up by about $16 on the CDHP plan and $32 on the EPO and HMO plans. For a family that increases $52.59 on a CDHP plan and $105.65 on the EPO/HMO plan and this is for state active.

Questions?

MEMBER URBAN: This is Marsha Urban.

MS. MESSIER: Okay.

MEMBER URBAN: I do have a question. If you look at the proposed changes, your employee only, and I want to say I am one of these people, is getting a 53 percent increase and this is a person who is working for the state and lives alone and a person who is employed, the employee and spouse and that is someone working for the state and has a spouse that isn't is only getting a 25 percent rate. That's a huge difference in percentages, and I want to ask why.

MS. MESSIER: I would agree with you, and I would also say and I hate to give this answer, but Aon is not in charge of the subsidy percent calculations or the methodology

or the strategy behind it. That is something that is set within PEBP structure, as well as I believe they are getting a set dollar amount from the state. And so when it's weighted across these different amounts you take out what the state is willing to pay and the difference then falls straight to the employee.

And so you're right, the employee only in terms of percentage is getting a much larger percentage change than the employee's spouse coverage line but as a function of how the PEBP financial sheets are set up and approved, this is the result that comes out of it. And I apologize for if Cari or Laura wants to address that.

MS. EATON: This is Cari Eaton. The dependent subsidy is reduced by 20 percent from the active primary. So in this instance I believe the active is getting a 92.6ish percent subsidy. So an active dependent would get 72.6 on that plan and it's calculated out in that way.

MEMBER URBAN: This is Marsha Urban again.

It still seems like people, employee only is getting penalized in the PPO. In the EPO it's only going up 23 percent.

CHAIRWOMAN FREED: This is Laura Freed and I full disclosure. I'm an active, and I'm an employee only coverage tier. So I'm not thrilled about 53 percent increase which is

as most Board members and maybe know but the public maybe doesn't, employee only is our, by far our largest coverage tier.

And I did a little bit of historical analysis of the participant share the past five years and in FY2017 and 2018 it was $41.91 a month and that was 92 or 93 percent subsidy of the total premium. In plan year '19 it was reduced by 24 percent using excess reserves to $31.73 which really wasn't a true cost, a true picture of the cost per month. In FY20 it was reduced again by two and a half percent to $30.95 and both 2019 and 2020 were in the 95 percent subsidy range.

And so for '21 we're talking about a 92.6 percent subsidy of the total premium as Cari noted, but it is about over that five-year that's a 13.1 percent increase which is actually less over five years than the employee plus child or children tier which is our second biggest tier and the employee plus family tier which is our third biggest coverage tier, who are both sustaining about a 20 percent increase over the five years. So while it's -- it's not great, it is also within historical norms for cost growth and health plans I would say.

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

CHAIRWOMAN FREED: Okay.

MEMBER VERDUCCI: How did we get the 92.6 percent? I remember for employees we were at 95 and dependents were at 75. Were those numbers that came back from the legislature or how did we get to 92.6?

CHAIRWOMAN FREED: Oh, well, I mean, that's just arithmetic. It's based on the -- sorry. This is Laura Freed, and I'll let Laura Rich and Cari Eaton with the much more technical explanation.

But since the numbers of subsidy dollars we get are fixed every two years by the legislature that's -- that's an immovable target unlike when the legislature is in session and we can discuss what we would like the subsidy percentage to be. Now, your recollection, you've been on the Board long enough, you remember the days when subsidy policy was in the Board's policies and procedures. And then when the last executive officer was in his job, he changed the Board policies and procedures to make it such that subsidies could be set yearly by a Board. So that's why they have bounced around a bit rather than adhering to strict subsidy policy because it wasn't outlined in the Board's policies and procedures.

MEMBER VERDUCCI: Yes. So the 92.6 and 72.6 for dependents, those are six members but in terms of requesting

a different member, I believe that would go through the GFO and the IFC, and if we went that direction what would the procedure be?

MS. RICH: So this is Laura Rich for the record.

Tom, every legislative session you have the legislature that every board does PEBP budget and in that budget it has an employer contribution. So that employer contribution is a set amount and that is what we were given to cover the costs of covering an individual or a family member, depending on what tier, for that plan year, and so they do this every other year obviously during the legislative session.

And so the problem we find ourselves in on that off year which is what we're in today is that its experience is, you know, it's -- if the plan is more costly than what we have projected it to be during that odd year, we don't have the mechanism to increase the employer subsidy during that odd year. So what ends up happening is the employee has to bear that burden during the odd year because that is the only place that we're able to increase.

So those rates, increasing rates if that is what we need to do ends up being borne on the employee just because of the math, right, we don't have the ability to go back to the legislature and ask for more money because that's

what is done during the legislative session when that budget is approved. Does that make more sense?

MEMBER VERDUCCI: Yes, it does. It seems in terms of percentage that the increase the employee is paying is going up rapidly than the percentage of the State subsidy. And I'm looking at the example here from say $31 to 47, and trying to brainstorm on how we can get it back to a more reasonable level of, you know, maybe $41, $42 and especially in light of, you know, the shutdown that we're going through.

You know, I don't see employees right now, a lot of them can't afford that big of an increase, and I know a lot of this is beyond our power, and I'm trying to see how much flexibility and what we can do fiscally responsibly to build this into the rates if possible.

CHAIRWOMAN FREED: This is Laura Freed.

We could cut into the reserves to get the rates down. However, you know, as I mentioned when we were talking about COVID-19 coverage under Item Five, that all goes into the rate bill for '22 and '23, and I don't honestly foresee where we're going to get a whole lot of allowance for the GFO for increased state subsidies.

So what you might see in '22 and '23 is rate shock where in order to make all of our actuarial determined reserves whole and pay for claims costs and increase over

that 50/50 aggressive target for the rates covering the experience, you're going to see higher rates for participants in '22 and '23.

MEMBER VERDUCCI: So what other components would we be able to pull from in terms of changes in reserves that would provide the additional cash to give some relief to the employees having this 53 percent increase? Is there other buckets of money or steps that we can take to free up some cash flow?

MS. RICH: For the record this is Laura Rich.

Tom, the problem with that is what Laura Freed just said, wherever we get this bucket of money or if we are able dig into, you know, any bucket of money, it is artificially lowering the rates which then will just make the problem that much worse next year because we're going to have to make up that money, and we're going to have to raise rates again, and so we're essentially just putting off the problem by another year and making it worse.

MEMBER LAMBORN: Go ahead, Tom. I'm sorry.

MEMBER VERDUCCI: You know what, I think I'm through. I'm really just trying to brainstorm because this is such a big increase and the claims that we're in right now, you know, I think of the employee who just simply cannot afford it right now, and I'm trying to find other places to

pull from and I realize it could cause a drain in the future.

But, you know, during the crisis, this pandemic that we're in right now, you know, I'm trying really hard to come up with some ideas to keep these rates somewhat flat without spiking them so high. Any ideas I'm very open to.

MEMBER LAMBORN: Madam Chair, this is Leah Lamborn for the record, if I may. I have a question, Tom, if you're done.

MEMBER VERDUCCI: Yes, I'm done.

MEMBER LAMBORN: Thank you. I'm going back to and I'm sorry. I should ask this but on page 11, slide 11 and saying administrative fees, is that correct that the administrative fees for the CDHP is 40 percent, oh, $40, okay. What is a percentage? What are the administrative costs on an overall percentage to the medical claims. Do we have that down? I'm just wondering why the --

MS. MESSIER: Yeah, in actuality the administrative fees are closer to $65 I want to say off the top of my head. They are being reduced by $25 because of those rebates. But in terms of a percent I would have to get another spreadsheet open really quickly because I can do it off of the employee only rate. But obviously, you know, $40 off the employee only rate is a different percentage than those on the family plan, and they do have a higher load on

both because they get more money from the HSA.

MEMBER LAMBORN: Okay. I'm just wondering why those are increasing, just a side note there.

MS. MESSIER: Why the admin fees are increasing, is that your question?

MEMBER LAMBORN: Yes, uh-huh.

MS. MESSIER: I'll go back. The admin fees are mostly made up of amounts paid to PEBP spenders, as well as the life insurance and the LTD. I do believe that went up in plan year '20 I want to say from 2019. And that's, again, where I do feel like when we've been looking at the history of the admin fees over the years, as much as they have kind of wavered up and down, I do think it might make sense to do a deeper dive into what's driving that because it's not what I would typically see. It's a little bit more consistent, and I know some of that is because of the rebates they pulled out or the estimates of what those rebates might have been where PEBP has motive for the admin fees.

MEMBER LAMBORN: Well, and I'm wondering, and this is Leah Lamborn as a follow-up.

Why were the rebates for drugs being pulled out of admin fees and not the medical and who made that decision? I just think it really kind of skews the numbers.

MS. MESSIER: I agree. Laura, Cari, do you have

the history on the PEBP side? I just know that's how it was handled before, and I've been on it for about five or six years now, but.

MS. EASTON: And this is Cari Eaton for the record.

From what I can see that is how it's always been done since we started getting prescription rebates. But like Stephanie said earlier, the rebates we used to get were very minimal and it's only been for the past few years that they have been pretty significant. So now it's actually making a difference in the admin load. So I think in the future looking at offsetting claims is, might be a better way to go.

MEMBER LAMBORN: Well, and, again, Leah Lamborn for the record.

I think it should be in the very near future. I don't know what the process is to change, but here's the problem, when you're putting in to offset to your admin cost it skews the numbers, and then it's really hard to compare our rates with other state rates, other packages available out there basically because we're doing it differently.

MS. MESSIER: Agreed, yeah. And that's something, yeah, we definitely have been talking with Cari and Laura about and that was one of our earlier recommendations is to see like for, especially for the next

year budget setting, as we're about to go into that, if we can change how the spreadsheet is done in order to pull that out and get it back into the claims where we feel it more typically revised basically with all of our other clients.

MEMBER LAMBORN: Yes, if there's no objection to that. And I just think for comparing it to other insurance, you know, plans that are available it will really help us to compare.

And I would also like to see presented in future what the overall percentage of the admin fee is to the medical, the ratio there.

MS. MESSIER: Right now I'm not able to do the weighted blend. So it's about a six percent load on the employee only rate. It's about a three percent load for the spouse and family rate and a five percent load for the children, and that's just for active employee CDHP, and that's, again, after we've taken out the rebate, as you mentioned, a little more skewed than what is actually a true admin fee.

MEMBER LAMBORN: Thank you. And, again, Leah Lamborn.

MS. MESSIER: Sure.

MEMBER LAMBORN: And then, again, that's just the admin fee of like PEBP costs and contract. That doesn't

include any administrative fees of the HMO plans are charging. That's separate; is that correct.

MS. MESSIER: Well, right. So their rates that they have for their specific admin fees, you're right, are already included in their premiums. Then PEBP does load on an additional amount, again, for the same thing PEBP is doing on that side. So they still get a load factor as well from PEBP fees. But, yeah, the true admin fees that the HPN is charging are not reflected in these admin fees that you saw on the slide.

MEMBER LAMBORN: Do you mean those rates on the percentage basis, the admin fee HPN is charging. Do you know that offhand?

MS. MESSIER: I don't believe I've seen their annual workup, have a calculation. I don't know if Cari does.

MS. EATON: Can you repeat the question. I'm sorry.

MEMBER LAMBORN: What is the administrative fee the HPN is charging in their overall capitated rate.

MS. EATON: This is Cari Eaton for the record.

They don't break that out. They build it into their rates that we pave for their premiums. So we're not aware of the actual percentage of their admin charges.

MEMBER LAMBORN: Okay. Is that something we can break out in future contracts? Usually that's something that plans keep an eye on to make sure it's reasonable.

MS. MESSIER: We used to help negotiate those. So, Cari, if you maybe have the underwriting workup it might be on there. If not we can request it from HPN.

MEMBER LAMBORN: Great. Again, on the same line that Tom is going through, I'm trying to see if there's anything we can do to reduce the rates overall.

MS. MESSIER: Yeah. I definitely agree, and I would say I was probably being even more, when I was trying to set these rates knowing that it is a large impact, right, and a large change. Certainly in the last couple of years, as Chair Freed mentioned, decreasing rates while it's great for the employees to get that benefit for the last two years, it just makes it harder when you are sitting at today and now needing to get back to more than what you had historically, right.

So if PEBP had lasted at the $40 for the last couple of years, yes, it would have accrued from additional funding in terms of access, but then also you would have had a little bit more to help manage the second year of a biennium where that state amount is fixed and now everything is getting pushed to the employees. So unfortunately while

it felt good for PEBP to have made those decisions I would say for, you know, plan year '19 year to have that reduction on what the employees were paying, it's just making that impact of today's change just magnifies that much more.

MEMBER LAMBORN: Okay. Thank you.

MS. MESSIER: That's certainly something we would advise as an overall go forward strategy. It's a little bit better to try to keep things flat when you can. It's hard to get back after you get a decrease.

MEMBER LAMBORN: Exactly, yes. Thank you.

MS. MESSIER: Yeah. Not to sound cold hearted, I love decreases and people paying less. It just makes it harder.

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

CHAIRWOMAN FREED: Uh-huh.

MEMBER VERDUCCI: So in looking into the consideration as far as the move to a ten percent margin on the IBNP.

CHAIRWOMAN FREED: Yes.

MEMBER VERDUCCI: I think we all, you know, considered going from 62 days down to 60. That saves 1.4 million. Would that have any effect if we did those two items on the rates that we're seeing here or could the

62 days move down to 58 days and still provide reasonable protection in the program, free up additional cash flow?

CHAIRWOMAN FREED: This is Laura Freed.

I think I'm going to let Laura Rich and Stephanie Messier field that one, but I think you might be conflating the two reserves. I think you're talking about dropping catastrophic below 62 days as a separate decision from reducing the margin load on your IBNP, IBNR, two different dollar amounts, but I'll let them answer that.

MS. MESSIER: Yes. I think if you go to slide 16, I think that's what those numbers what you're trying to speak to, just so we can all have the numbers in front of us. The IBNP, if you move to a ten percent margin would release 7.04 million from the current year end required reserves. And then changing catastrophic from 62 days to 60 would release the 1.4 million.

MS. RICH: And this is Laura Rich.

Just to clarify, by doing both of these we reach the rates that are being presented today. So if these considerations change the rates will obviously change as well. And given, you know, the COVID-19 situation which was not on the radar at the time when these rates were developed, doing anything more drastic I think is -- is risky just because do we really want to touch catastrophic reserves not

knowing the landscape that is in front of us.

CHAIRWOMAN FREED: This is Laura Freed.

I would second that idea. Since the Board already voted to cover testing office visits in treatment for COVID-19, you know, the catastrophic reserve was setup for issues like that. So if we were to bring more money out of catastrophic to keep the rates down or reduce the rate growth, that's less that we have to handle any COVID-19 catastrophic claims.

MEMBER VERDUCCI: So yes, Tom Verducci, for the record.

So in looking into the consideration for the rates, I want to point out that the CDHP plan percentage wise to the employee, the increase is much more drastic than the EPO plan is. Is there any way of leveling those out between the two programs so one population group is not hit harder than the other?

MS. MESSIER: So the EPO plan is seeing a 32 dollar increase which is I would say a harder impact to the paycheck than a 16 dollar increase on the employee only side. Are you trying to get a more equitable percent change?

MEMBER VERDUCCI: Yes. I was looking into the percentage change. I notice there was a 53 percent change for the CDHP. And if you go into EPO/HMO plan and it's

closer to, let me calculate this, 23 percent increase, so we have one program that's changing 53 percent and another that's changing 23. So it seems to me it should be a little more equitable between the two programs.

MS. MESSIER: Yeah, I think a lot of that has to do with subsidization strategy. My clients take different approaches. Some of them just get like a set dollar amount from their employees and that weighs the part of the care which side they pick, right? Say they are just going to give you $100. If you're employee only you get to pick which plan you want and then, you know, the employee pays the difference.

PEBP is definitely not set up that way, and so I would say -- and I guess I shouldn't probably be talking about what PEBP can do from a policy and procedure perspective because I do agree with Ms. Freed. The prior executive officer did change how things worked and I used to know the old method with the prior executive officer Jim Wells much better than what we had changed over the last couple of years and the percentages weren't quite as straight forward as they had been in years past.

Part of the EPO I think and the PPO differential too as we saw on the earlier slide, the CDHP and the EPO are increasing by a larger percentage than the HPN. So the

blended cost impact and increase needed on the EPO/HPN side is being helped by the fact that they only needed a seven percent increase for the HPN folks. Obviously, the EPO folks had a larger, the largest percent increase at 13.8 percent. You're seeing some of that flow through as well as the subsidization strategy that gets applied at the end.

MEMBER VERDUCCI: Tom Verducci for the record.

So at what point in the future would we be looking at an RFI or an RFP to shop the market in terms of competitive pricing? When does that come up on our radar?

MS. RICH: For the record Laura Rich.

Tom, this is probably something we need to start looking at again in strategic planning because we talked about migration from the HMO over to the CDHP, right. And in the past several years HPN has really worked with PEBP to keep those rates down. Because of the blending of rates between the north and the south either they're -- they are subsidizing the north essentially, and so they really work with PEBP to keep those rates down and to offset those costs.

But, you know, there's only so long that they are going to be willing to do that, right. And so at some point you're going to have rates on that HMO and EPO increase and migration, as a result move over to the CDHP. And while we can mitigate that on the EPO side because it is a self-funded

plan through PEBP, HPN may be in a position where, you know, we're going to have to look at that is whether or not this is something that is sustainable, what can we do to make it sustainable, if anything.

You know, so these are really big picture items that we need to start looking at in terms of, you know, do -- is what PEBP is offering today does it make sense to continue offering it? Should we look at other options? Should we look at enhancing plan options? Should we look at just eliminating and replacing certain ones? These are all things that we need to start considering in the near future because as you can see the landscape is changing and we're going to be forced to make these changes sooner than later.

MS. MESSIER: Yeah, just to add onto that, you know, revisiting this strategy would also make sense at that time too as you're looking at different plan designs and different offerings in the future.

CHAIRWOMAN FREED: This is Laura Freed.

I just wanted to make an information request to PEBP staff and Aon staff. One of the things that, you know, we have brought up in public comment was the idea that the trend was recommended and approved too low for what our experience was.

And so I went through some old rate items because

I teach those and I was looking at the '18, '19, '20 experience in each of those rate items and -- and then I was looking at what was recommended and approved, but I had some trouble putting all of it together. So what I really love to see and I think would be illuminating for everyone is for the past several years the trend that was recommended by Aon, the trend that ended up in the Gov rec budget and the trend that was ultimately ledge approved and then actual trend, actual experience for that year so we can see what was recommended and how close we actually came.

Because, you know, part of the way we got here is that both, you know, utilization and -- and claims cost are up and, you know, they are more than what was recommended and approved but it was not unreasonable to expect that they might be since recent years experience for, you know, somewhere in the, you know, in FY18 plan -- plan year item it was, you know, the trend had been minus five percent overall and -- and what we saw in recent past plan years was, you know, medical was, you know, kind of close to flat but RX was going up significantly.

And so I -- I think it would be useful to tell that story, especially as we get into budget building and making the case that, you know, we -- we're going to need to build in claims experience that is higher than, expected

claims experience I should say that's higher than what it has been. Because I think that the -- the assumptions made about this biennium's trend were kind of following on, you know, the immediate couple previous plan years and, you know, now we're just kind of, you know, now our claims experience is worse than it was.

So that's -- that's an information request. It doesn't have to be done any time quickly. I think it would be helpful certainly for me and I think it would be illuminating for a lot of people.

So I want to pose a question to PEBP staff. Do you want us to consider the IBNR and catastrophic and then the rate part in three sort of separate decisions or all at once or?

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

In order for the rates that are being presented to be approved those two items for consideration on those required reserves must be approved first.

CHAIRWOMAN FREED: Okay.

MS. RICH: So that's something that, you know, maybe in -- in two different motions I guess.

CHAIRWOMAN FREED: Okay. Got it.

All right. So, Board members, would you like to consider the reserves -- the reserve options before us first

then? Let me put it this way, what is the Board's appetite for accepting PEBP's recommendation to move to a ten percent margin load on the incurred but not paid from the current 25 percent thereby releasing 7.04 million dollars from the year end required reserves?

MEMBER VERDUCCI: Tom Verducci for the record.

As far as that component I like the $7,000,000 that's -- that's freed up. I'm just not sure on number two here, if we can go more conservative than the 60 days. I read the footnote at the bottom of page 16 and it reads if we move to 50 days that would free up 8.4 million, but I do have a concern with the COVID-19 virus future claims that would be coming in. But I'm wondering if we could be a little bit more modest on the 60-day, well, holding the 60 days and maybe drop that down to 55 or 58 if it might make sense. I would like to hear Laura Rich's opinion on that because I don't want to get too aggressive on this either.

CHAIRWOMAN FREED: All right.

MS. RICH: So Laura Rich for the record.

Two things on this. As I said earlier, I don't know how much we really want to move. This was a very conservative move on the catastrophic reserve moving it to 60 days. If we go much lower we are -- you know, we're again, facing a world of unknown. I don't know if this is

something that really is live for the plan to use to move -- to move much more than those two days. I think the recommendation that's on the table right now, the very conservative move, it puts us into a situation where, you know, we can get the rates where they are today.

And, again, we worked -- again, these rates are not -- what you're seeing today is much much much better than what we originally started with. So we have gotten them down to, you know, to what you're seeing here today versus, you know, it could have been a lot worse but that is by doing these two things to the, you know, to the required reserves.

I do want to emphasize though that making any changes to what the recommendations are will make -- will eventually change the rates as well and so then we will not be able to approve rates today because those -- those rates will change and the actuaries will have to go back and do the math and present new rates.

So if -- if the Board chooses to not approve what is being presented today then we're going to have to go back and do the rates again based on those new Board recommendations.

MS. MESSIER: And this is Stephanie Messier. I apologize. I dropped off.

I just want to make sure those two considerations

under IBNP and catastrophic are not included in the rates. Those are additional actions it would take that would free up those monies, but I did not assume you were doing those two things when I set those rates. I just want to make sure that was clear and that it looked like it was a little confused when I dropped off, but I did miss the last couple of minutes trying to get back on.

CHAIRWOMAN FREED: Okay. This is Laura Freed.

So I was confused. I had asked earlier in the discussion, the ringing out of the 7,000,000 from IBNP and 1.4 from catastrophic would be used to sustain actuarially determined reserves in FY21 not used -- not used in rates and the answer was yes. So -- so I'm asking I think if Laura Rich, why then do we need to decide on the reserves prior to deciding on the rate table.

MS. RICH: So for the record Laura Rich.

I apologize. I was wrong. I was confused as well. I thought that this was required in order to -- I thought it would change the rates, so that was my bad.

CHAIRWOMAN FREED: Okay. Okay. Got it.

MS. MESSIER: Yeah. Sorry. That's where I was -- yeah, I got cut off at the wrong time. Sorry.

CHAIRWOMAN FREED: But the fact remains that if, you know, if we were to, you know, decide something different

than a ten percent margin load on IBNP and 60 days on catastrophic for the purpose of softening the rates then we would not be able to vote on the rate table that's before us; is that correct?

MS. MESSIER: Yes.

CHAIRWOMAN FREED: Okay.

MS. MESSIER: Even if you wanted to move to ten percent margin and use that money to change rates we would have to change the rates.

CHAIRWOMAN FREED: Okay.

MS. MESSIER: Right now the rates assumed you changed nothing in terms of required reserves.

CHAIRWOMAN FREED: Okay. Got it. Okay. So okie dokie.

MS. RICH: And this is -- this is Laura Rich for the record.

Not -- so changing those reserves, you know, considerations, that would potentially also put us in a situation, if we don't do that it puts us into a situation where we may need to dip into catastrophic reserves in the near future.

CHAIRWOMAN FREED: Yeah. Right.

MS. RICH: So, yeah.

CHAIRWOMAN FREED: Right. Well, and the other --

I think the other consideration -- sorry. This is Laura Freed again.

For me the fact that we approve rates in March and April so that PEBP staff has enough time to load the rates into the enrollment and eligibility system, test them, communicate with the membership so I'm -- you know, if we were to change the rates we would have to have another unscheduled Board meeting I think.

MEMBER LAMBORN: So, Madam Chair, this is Leah Lamborn.

I guess I'm getting a little confused. So if I understand correctly, the rates that are presented to us today are based on what we have current in the budget. It's not based on reducing the margin load to ten percent, any of the things we could do to offset. Those two items under consideration if we approve them would actually offset the impact that we have on the -- on the rate increases on the prior page, 12, which is good news I believe.

But with that said, if we approve those two items under consideration to offset this to lessen the impact of the rate, we wouldn't be able to approve the rate as of today and we would most likely have to have another meeting in the month so we can approve them but there -- what harm would that be for PEBP staff meeting?

CHAIRWOMAN FREED: Before our meeting.

MEMBER LAMBORN: Right. Is there a harm in holding these rates another 30 days for another meeting to lessen the impact and those rates in 30 days, what harm would that present in delaying these rates being approved for 30 days?

MS. EATON: This is Cari Eaton.

This is a big process for PEBP staff and Morneau staff to upload the approved rates into their system and then test it. Once Morneau tests their system then PEBP staff has to test the rates in their system just to make sure that everything is loaded correctly and being able to view -- being viewed correctly.

And then also there's the communications the participants in getting all of our open enrollment information generated and out quickly enough for participants to make decisions on what plan to choose. So delaying by a month will significantly impact that process.

MS. MESSIER: And just --

CHAIRWOMAN FREED: Okay.

MS. RICH: This is Laura Rich.

Just to add, we have requirements, noticing requirements that we have to meet in order to, you know, we -- we have to be able to communicate rates within a

certain time frame of open enrollment. And so by pushing this out it basically creates a similar problem. As what happened last year, operationally it becomes, I mean, for no better word, it's a fiasco. It's a chaos. There's a lot internally that goes on.

And like Cari said, by pushing this rate meeting to the 31st it has already created a condensed timeline for those rates to be loaded into the system so that members can have them available and tested and working and everything by May 1st open enrollment. So we're already pushing the timeline. So pushing it out another month we have to likely change the open enrollment period similar to what we did last year.

MEMBER MITCHELL: Jet Mitchell for the record.

I just have a follow-up real quick. I'm sorry. Then if we approve these items for consideration to free up this money, what would the money be used then for then if it's not going to be used to offset the impact to the rates? What would that money be freed up for?

MS. RICH: For the record -- for the record this is Laura Rich.

We are finding ourselves in a situation where we may have to dip into catastrophic reserves, and so this is essentially a safety net so that we are not having to dip

into the catastrophic reserves because, again, if we dip into the catastrophic reserves that is going to, you know, change when the actuaries next year look at setting rates, that definitely is going to impact that as well. And I don't know if Cari wants to add anything to that.

MS. EATON: Yeah. Cari Eaton for the record.

We are seeing a shortfall in one of our categories that we will need to fill. Usually we supplement that from -- from a category that we have excess from authority in or excess reserves. We're not in that same situation this time.

Also at the beginning of each year Aon provides updated required reserve estimates and we use whatever our balance forward funds are to fill those authorities. And so if those increase next year we would use the reserves to make sure we have authority to fill those as well.

MEMBER LAMBORN: So basically this -- this money is you're projecting a budget shortfall basically for the biennium and this money may be needed for that so they can keep the reserve levels pretty much at what they are now, especially due to COVID-19 and catastrophic. Is that what I'm hearing?

MS. EATON: This is Cari Eaton. Yes. Yes.

MEMBER LAMBORN: Thank you.

MEMBER SMITH: Madam Chair, it is David Smith.

CHAIRWOMAN FREED: Go ahead.

MEMBER SMITH: If I may.

CHAIRWOMAN FREED: Yeah.

MEMBER SMITH: Two things, so as far as the catastrophic reserve goes from my perspective that's there to be dipped in if there are substantial increase in claims that need to be paid that are not (phone cut out) and so if we have $30,000,000 in unexpected claims we can pay them, and then we can be looking at going to the legislature saying, hey, we don't -- we don't have a catastrophic reserve anymore, and we have to decide whether we're going to increase rates or if the state is going to increase funding so that we have a catastrophic reserve again.

In the past when there wasn't a catastrophic reserve and we had claims come in, there was one time when there was a special session to fund PEBP because it didn't have adequate reserves in the IBNR.

CHAIRWOMAN FREED: Right.

MEMBER SMITH: But so talking about, you know, the goal is not to fund the catastrophic reserve. The goal is to make sure all our claims get paid and our participants are covered with those claims getting paid and not incurred liability to the state. So I just wanted to make that point.

The second thing is I don't -- I'm not comfortable that we are being pressured to accept these rates as they are without the option to make changes. If 30 days is too far I think that maybe two weeks, if the -- if the calculations can be done, I'm not necessarily opposed to the rates as they have been presented, but I can hear there's a lot of concern.

And so if there's enough concern that the Board wants to look at, the other Board members want to look at reducing the percentage for particularly employee only rate by using the adjustment in the reserve amounts then I think we should come back and if it's two weeks instead of 30 days and that would make it easier for staff I would be okay with that.

CHAIRWOMAN FREED: Okay.

MEMBER MITCHELL: Jet Mitchell for the record. I was dropped and so I just came back and unfortunately when I came back they didn't give me speaker ability so I had to reenter again.

So, first of all, I wanted to say that I think David does make a couple of good points. Also I wanted to clarify an apology to backtrack on this, but I wanted to clarify for the considerations. If the 7.04 million is released that would be primarily used to pay COVID-19 claims.

Would that be -- would that be a fair assessment and then is the 1.4 million in excess just for potential shortfall. That would not have any bearing on rates. Is my understanding correct?

MS. RICH: For the record Laura Rich.

It's not necessarily just Covid-19 related rates, right. So there's obviously the potential, you know, that could be huge impact to the plan. We don't know yet. So it's not necessarily COVID-19 related claims. It could be catastrophic. It could be through potentially any kind of catastrophic type claim. If -- if the plan starts incurring costs that were not, you know, projected, right, so that's what the catastrophic reserves are for.

MEMBER MITCHELL: And I also want to emphasize to piggyback on the point, Jet Mitchell for the record. We are in unprecedented times right now and having a special meeting in seven days or ten days would not be out of the realm of these highly unusual circumstances, perhaps in a week or ten days we have even more information about a climate and what is happening in our state. We have never seen anything like this in our state before and hopefully never will again.

So a deferment as far as not having a vote today, I don't think as much as -- as wanting to have full communications I think it's critical and important in making

decisions promptly -- as promptly as possible is commendable in what we usually want to do in today's situation, and in light of what is happening I would echo the concerns of the rate increase but also templated onto the situation what is happening now in our state and in the country that I -- I know that we're facing extreme and uncertain times.

And so my thought is that perhaps in seven days or ten days we would have even more information that could potentially be of guidance to assist us during times that are extraordinarily challenging.

CHAIRWOMAN FREED: All right. This is Laura Freed.

So are the Board members wishing to see a second rate table that would reflect a drop in catastrophic reserves used specifically for rate. Is that what I'm hearing?

MEMBER LAMBORN: This is Leah Lamborn for the record.

Yes, I would like to see another option and using some of this money for that margin load drop and to be less conservative in our rate setting to offset maybe not all of it but some of it to lessen the intent of the increase.

CHAIRWOMAN FREED: Okay. So this is Laura Freed.

For myself I'd rather perhaps use IBNP reduction than catastrophic reduction because catastrophic we would

need for large claims, possibly COVID related expenses where it's, you know, IBNR is the reserves that would pay for claims run-out if PEBP ceases to function tomorrow, and PEBP is not going to cease functioning tomorrow, so that's why I would perhaps like to see that an option two, using some of that -- some of that margin load money.

So I'm posing this question to PEBP staff and Aon. How do you suppose you could get the Board a second rate table option to compare to this one?

MS. RICH: Stephanie, are you on?

MS. MESSIER: Can I ask a couple of clarifying questions on that?

CHAIRWOMAN FREED: Sure.

MS. MESSIER: Do you want me to, one, maintain the claims experience that went into building these rates recognizing I used claims that came in through December, and we now at least have one or two more months of claims experience so that I'm trending less.

Two, do you want me to maintain the aggressiveness that we set in your rates, the 50/50? In light of everything else do you want me to be just as aggressive as I already was or not?

CHAIRWOMAN FREED: I would say yes so that we have an apples to apples comparison between the rate table

that's in the packet today and what another option that might be presented to us in a week or so.

MS. MESSIER: Okay.

CHAIRWOMAN FREED: So I would say yes, keep the 50/50. I would say maybe add the extra month or two of claims experience into both if you could.

MS. MESSIER: Okay.

CHAIRWOMAN FREED: If it's not -- I mean, if it's not entirely like time intensive to do that.

MS. MESSIER: That's fine.

CHAIRWOMAN FREED: Okay.

MS. MESSIER: And do you want me to release the entire 7,000,000 into the rates so then we're artificially lowering them by 7,000,000? Is that my understanding on the IBNP release?

MEMBER LAMBORN: Madam Chair, if I may, this is Leah Lamborn.

CHAIRWOMAN FREED: Sure.

MEMBER LAMBORN: Can we have a couple of options? I don't -- I don't feel comfortable myself doing the full 7,000,000.

CHAIRWOMAN FREED: Yeah, me neither.

MEMBER LAMBORN: And so maybe just a, yeah, half of that or whatever the other Board members think, but I

certainly wouldn't do the full amount.

CHAIRWOMAN FREED: Yeah. Other Board members?

MEMBER MITCHELL: This is Jet Mitchell for the record.

It seems like in the discussion that I was able to hear before I did get dropped, the call got dropped, there was some substantial concern about the percentage of the employee -- in the difference in the employee contribution for the employee -- employee only coverages. So I would like to see and full disclosure and then employee only covered under the plan. So this would include me, but I would like to see options where there's a -- there's a lower premium on the employee only.

But echoing all, so not just my concerns about that but previous concerns that I heard about employee only being raised so significantly.

MS. MESSIER: Can I ask one more question about that? Is there a threshold the Board has in mind, like we would like to see how much of that IBNP we would need to use to take it to a 40 dollar rate for the employee only or let's -- we don't want to go any higher than 42.50, how much money would we need in order to get to that? Is there some sort of guidance you can provide me around that?

MEMBER URBAN: Marsha Urban for the record.

The reason that the employee only one is bothering me is so many of those people in that group are, and it's not me. I'm not young enough to say this. A new professional coming in and they are making less money, so when you look at that change it's a big change for them. And so if I could see something where -- I mean, when you're looking at 53 percent and the only one that's close to that is the employee and children at 35 percent, I would like to see something where the percentages are closer so that this group isn't -- I mean, even though they are paying less they are not paying as much, paying that higher percentage of increase.

MEMBER LAMBORN: And Leah Lamborn for the record.

I concur. I think we ought to look at the categories that are hit the hardest.

MEMBER MITCHELL: Jet Mitchell for the record.

If we would -- if you would say a number, I'm sure I would say 42, maybe $43 per person for employee only but that's just -- I'm just giving a number. I don't have that exact percentage of change saying that 42 number.

CHAIRWOMAN FREED: Okay.

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

I would like to see that one category employee

only, I think that's our most vulnerable group because they do not have a spouse. And if we could get that around the 41 dollar range, I think 42, you know, we're talking a dollar, I think that would bring some parody to these groups, and I would be fine setting up a second meeting as early as ten days from now as quick as it could be done.

MS. RICH: So this is Laura Rich.

I do -- I want to make sure that I put this out there as well, we will have to change open enrollment if this is the way that -- you know, if this is what we're going to do because it operationally without rates we can't load them into the system. We can't test them, and they will not be available by May 1st if that's the case. I have -- I have not spoken to our enrollment and eligibility vendor but this is -- I know what their timelines are, and it's impossible to, even in ten days we were able to get them rates we would not be able to load it into the system in time by May 1st, and so that's another consideration that we'll have to take. We have to move open enrollment. We can either truncate it like we did last year or move it out a little bit. Probably truncating it is the better choice.

CHAIRWOMAN FREED: Okay. This is Laura Freed.

Oh, go ahead.

MEMBER LAMBORN: Yes, Madam Chair, Leah Lamborn

for the record.

This question is for Laura Rich. What are our other options? I mean, could we load these as is and then come back in three months or six months and change the rates then and it would just be a break in the last six months at that point? How difficult is that?

MS. RICH: I'll let Stephanie speak to that, but I think you might have just given her a heart attack by mentioning that.

CHAIRWOMAN FREED: Sorry, Stephanie.

MS. MESSIER: I'm still breathing so that's good.

CHAIRWOMAN FREED: Oh, thank God.

MEMBER LAMBORN: Okay. Well, I guess that answers my question.

CHAIRWOMAN FREED: It's pretty difficult.

MEMBER LAMBORN: Thank you.

CHAIRWOMAN FREED: This is Laura Freed.

I wanted to weigh in on Stephanie's question. Do you want me to use the entire 7,000,000 to soften the rates? My feeling is no. Why don't we -- why don't we -- why don't we try three and a half million and see where that gets us.

MS. MESSIER: Okay.

CHAIRWOMAN FREED: And there was another -- wait. You had another question that I had an answer for. Now I

forget what your question was. Darn it. Oh, oh, the number, the employee only participant share, I have to disagree with some of my fellow Board members here who want to do 41 and $42 because 41 and $42 per month for employee only is what we were having people pay five years ago when we had excess reserves, and I don't think that's reasonable. Healthcare doesn't -- healthcare costs doesn't stay flat. As the participant group grows utilization grows. So, I mean, I'm -- you know, if I have to pick something that would give folks a break but actually be, you know, within historical norms I would say something in the 45 dollar range if I had -- if you held a gun to my head. So that's my feeling on that.

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

I completely agree that healthcare goes up, I think I was templating my comments in light of the current situation with so many dire and catastrophic events happening to so many Nevadans that may continue to test. So I completely agree with your assessment that utilization will go up. Costs will go up.

I'm making my comments specifically in light of 2020 and 2021, not in light of future years which I'm fully cognizant of your remarks and agree with that. So I'm -- I'm

just thinking in terms of the current climate, physical climate, political climate, financial climate for so many Nevadans right now.

CHAIRWOMAN FREED: No, I absolutely -- I mean, I think your empathy is absolutely to be commended but remember we just voted earlier in this meeting to cover people's treatment at 100 percent. So, you know, we're going to take care of our participants who have COVID claims and, you know, with all of our catastrophic claims like that could be covered so generously.

So, you know, I appreciate what you're saying but I -- I just remain concerned that, you know, have Board decisions to soften rates have made people feel like that, you know, their medical coverage should be $35 a month all of the time, and that's just not how fiscal realities work unfortunately.

So we may save some really difficult ugly choices heading into the fall as we approve the agency request budget. So I ask the Board to keep that in mind.

But having said that, I would -- I think, you know, to Laura Rich's comments I think if we do another meeting in a week or so we should probably just truncate open enrollment instead of May 1st, May 15th through the 30th, 31st. That's my thoughts on that, but.

MS. MESSIER: One other thing to mention. I had not included any savings for the Save-On program because that was up in the air at the time that I was setting these rates. I just wanted be clear that those savings are not reflected in today's as presented.

CHAIRWOMAN FREED: Okay. All right. So I think where that leaves us as a Board and the action we need to take is to approve or disapprove staff's recommendation on the incurred but not paid reserve and the catastrophic reserves with direction to come up with an option two as soon as possible. Does that make sense to everybody?

MEMBER LAMBORN: Yes.

CHAIRWOMAN FREED: Okay. So go ahead.

MEMBER SMITH: Yes. I agree with you.

CHAIRWOMAN FREED: Okay. So I'll entertain a motion from the Board to reduce the margin load on the incurred but not paid from the current 25 percent down to ten percent thereby releasing 7.04 million and then reduce the catastrophic to 60 days on hand from its current level thereby releasing 1.4 million. Not everybody raise their hand at once.

MEMBER FOX: I'll make that --

MEMBER LAMBORN: This is Leah Lamborn. I second.

MEMBER FOX: Okay. I'm not sure if I made that

motion. This is Linda Fox. If Leah made the motion then I'll second that motion.

CHAIRWOMAN FREED: Okay. Sounds good.

Any discussion on that motion? Hearing none, all those in favor signify by saying aye.

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

CHAIRWOMAN FREED: Any opposed no. Okay. Motion passes unanimously.

Okay. So that is what we will do. I assume that PEBP staff will be in touch as soon as possible about when we're going to schedule another telephone meeting to discuss rate options, and I'm sure PEBP staff will be in touch about the mechanics of open enrollment and getting -- getting rates loaded into the enrollment eligibility system as well. So everyone look for that and try and keep your schedules as loose as possible.

MEMBER URBAN: For the record, does that also -- will we be looking at Express Scripts when the rates are re -- recalculated?

MS. RICH: So this is Laura Rich for the record.

I would recommend not using those savings because while they're projected savings, you know, I don't know if I would bank on that just in case, right. Sometimes those

projected savings are less. They come in less other times they come in as more, and so I don't know if especially this first year if a program that we're implementing for the first year we don't know what the expectation. They are just projected. I wouldn't want to bank on that when we are forming rates.

MEMBER URBAN: All right.

MEMBER LAMBORN: Leah Lamborn for the record.

Laura, I totally agree with that.

CHAIRWOMAN FREED: All right. Are we ready PEBP staff to go on to Agenda Item Ten then?

MS. RICH: I think so.

CHAIRWOMAN FREED: So let's move to discussion and possible action of the LCB audit.

MS. RICH: Okay. So for the record Laura Rich.

In January of 2019 PEBP was notified by the LCB, that's the Legislative Counsel Bureau audit division, that it would be performing an onsite information technology and security audit of the agency. I reported on this I believe in January in light of the executive officer report.

So throughout the years PEBP staff has been working diligently to assist the auditors and we have been providing them with all of their requested data and information so that they can perform their audit.

On January 9th of 2020 the LCB provided the agency with an initial draft of the final findings to which PEBP was required to submit a written response indicating their acceptance or disagreements.

The report that you can see in the attachment A basically indicates PEBP -- the findings and PEBP acceptance of the these findings. So really the findings in a nutshell says that, you know, PEBP needs to strengthen the information of control to better protect its physical resources, minimize security form abilities and ensure continuation of critical services. PEBP accepted all 14 findings and now we have to produce a plan that will be then submitted to the LCB and to the Legislative Commission Audit Subcommittee as well.

So attachment A is that -- that the corrected action plan. I can say that this is pretty standard as far as IT audits go within the state. There was nothing huge or looming. The findings were, you know, were pretty standard findings, nothing outside of the ordinary. You can see from the attachment we're either in the process of making the corrections or we've already done it.

Most of what is in here, the findings are generally there are things that are already in policy. We just didn't have the appropriate mechanism to track it. And so for example, you know, maybe initially all of the staff

gets that security awareness training but then nobody follows up on it to see that we're getting it yearly, right. So there's no mechanism in place.

So we have instituted what we call Smart Sheet. It's an application. It's software that is able to manage some of these tasks that we need to do internally, and IT has performed several other functions to enhance the security, the encryption. We changed our fax machine process and things like that. So attachment A just kind of goes over the 14 findings and what are recommend or what the PEBP's acceptance and what PEBP actions have been to correct those findings.

So with that I'll take any questions.

CHAIRWOMAN FREED: Okay. This is Laura Freed. I'm not hearing any questions. Is there a motion to approve this corrective action plan?

MEMBER VERDUCCI: Yes. Tom Verducci for the record.

I think that is a very reasonable request and I would like to make the motion to approve staff's recommendation.

CHAIRWOMAN FREED: Okay. Do I have a second?

MEMBER URBAN: For the record Marsha Urban. I second that.

CHAIRWOMAN FREED: Okay. Thank you.

Any discussion on the motion? Hearing none, everyone in favor say aye.

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

CHAIRWOMAN FREED: Any opposed no. Motion carries.

All right. Agenda Item 11, Executive Officer Report.

MS. RICH: All right. For the record Laura Rich.

This report provides the Board participants public and other stakeholders information on the overall activities at PEBP. We'll start out with COVID-19, you know, what's on everyone's mind right now. How has that effected PEBP and the way we're operating and our staffing.

So on March 14th, Governor Sisolak held a press briefing which outlined a series of directives related to our state executive branch work force, and, you know, that all state offices would be making every attempt to wind down in-person public services and would transition to on-line and over-the-phone services. The Governor also issued a hiring freeze effective immediately and with the exception of certain identified positions, executive branch positions still classified and unclassified would not be filled in the

further notice.

Also recognizing that every agency is different and we all have different operations and different populations that we serve. The Governor's office offered additional guidance to each of the agencies and really delegated the authority to each agency had to decide what works best for the organization -- for the organization.

So in response PEBP changed quite a bit of what we're doing internally. We did move those who could work from home. We sent them with laptops, and now we have very limited amount of laptops. We were actually lucky we had three on order that were coming in, and so we were able to send additional folks home to work from home.

There are certain functions though that require, you know, we have notices and things like that that need to be mailed out. Those are physical functions that happen internally at the office. At this time we're having staff just kind of rotate in and out. We only have a handful of people in the office at any given time. We try not to have, you know, more than just a few in here handling the things that need to be handled internally, and you know, physically within the work space.

Everyone else we have granted administrative leave. So when you're not in the office, when you're not

working from home we've granted administrative leave, also to those employees determined to be high risk or those experiencing hardship due to school closures.

We had one employee which I'm a little bit sad about but, you know, she was retiring after 18 years at PEBP. She was retiring in just a few days, and we actually went ahead and let her retire early because of the situation. She was actually a higher cost risk group and so she retired.

We cancelled all in-person meetings, training and travel. We changed some of the call center functions. So right now we have -- typically we have ten people serving in our call center that handle all of the calls that come in for members. We have drastically reduced that just so we don't have people in the office. We have typically only two people answering the phones at any given -- on any given day. We have changed the call greeting to encourage members to e-mail in because we do have staff at home who can respond to e-mails and respond to member inquiries. So our call center has been reduced, and just in general we have many people as possible working from home.

The hiring freeze will have a significant impact on PEBP. Currently we have six out of the 34 positions at PEBP vacant. Three are in the call center, including a front desk receptionist. We have an administrative assistant in

eligibility, a management analyst in operations and a health program officer in quality control.

Luckily we were able to fill the operations officer position and IT profession position right before the hiring freeze went into effect. So we were lucky on -- on that end.

We're also in the process of reassessing our open enrollment meeting that happens every year prior to open enrollment. We're likely going to be cancelling those. If we do them, they will be via webinar only, and so I think we're going to look at just doing that. There's not a lot of plan design changes. The biggest change right now, obviously, is rates, and so it's not awful if we -- if we cancel the open enrollment meetings just because the plan is pretty much the same this year as it was last year.

Any other retiree meetings and in-person trainings have also been cancelled and will be transitioned to webinars as well.

I'm also very happy to announce that on March 2nd PEBP finally launched the new agency representative portal that we've been working on now for a long long time. The portal allows those HR representatives at different agencies to submit their employee information electronically. So this actually came at a great time because now those HR reps that

had to come into the office and fill out paperwork to send to PEBP no longer have to do that. They can do this from home.

So they are able to log into an on-line portal and report all those new hires and terminations and things like that via an electronic method versus having to fill out a paper and send it to PEBP via snail mail, like we've been doing for years and years in the past.

In conclusion I think, you know, we all know PEBP will certainly be facing from unprecedented challenges in the wake of COVID-19 crisis. There's a lot of unknowns right now. We're in the early stages, but as you know we'll be carefully monitoring the effects to the program and to the state, and that is it.

With that I'll take any questions.

CHAIRWOMAN FREED: This is Laura Freed.

Will you be seeking justification for your vacant call center position as well as any others?

MS. RICH: You know, there's no harm in doing that so I likely will. All they can say is no.

CHAIRWOMAN FREED: Right, exactly. Okay. Thanks.

Okay. This is Laura Freed again. This was agendized as an action item and yet the staff report is marked information only. So am I to just assume this is an

information item or should we -- do you want a motion on it?

MS. RICH: I think that was an oversight. There's no motion. This is information only.

CHAIRWOMAN FREED: Okay. Got it.

All right. So we will move on then to public comment. I'm going to ask the operator if there are people in the queue for public comment.

MEMBER LAMBORN: Actually, Madam Chair, I'm sorry.

CHAIRWOMAN FREED: Oh.

MEMBER LAMBORN: This is Leah Lamborn. I had one more request. I should have jumped in there sooner.

CHAIRWOMAN FREED: Go ahead.

MEMBER LAMBORN: This is an information item I would like to see on the next meeting, Board meeting, and I would like to know if it's possible for staff to do a feasibility study, you know, looking at sustainability of this program and keeping our costs down in the future, and I know budgets are happening now and so now might be a good time.

But a feasibility study on PEBP leveraging the contracts and HMO and basically the Nevada Checkup Program and that system as far as what PEBP can do to leverage a program that's already in place, what that might look like,

where is Medicaid currently on their contract. What would it look like PEBP fold into those programs utilizing even their typical agents or their HMO contracts, their system, and it would be more like a, you know, Nevada Checkup Plus kind of program where you pay Nevada Checkup rates plus 30 or 40 percent or something like that, realizing that the PEBP population is so much smaller but, again, I think just a feasibility study. What would it look like. Is it possible. What would be the impact through this -- the PEBP members, how many of our providers are currently Nevada Checkup and Medicaid providers. Would there be a big impact, that kind of a study.

CHAIRWOMAN FREED: This is Laura Freed.

The question for PEBP staff, is this something we can discuss at the Board retreat or are we having one, even the pandemic. I'm not sure.

MS. RICH: For the record this is Laura Rich.

Typically strategic planning is done some time during the month of August.

CHAIRWOMAN FREED: Okay.

MS. RICH: That's not a, you know, set date. We can do it in July. We can do it in September. We can do it whenever it is we want to do it.

CHAIRWOMAN FREED: Okay.

MS. RICH: It's definitely a bigger picture. It's something we can start looking at and having those, you know, starting that communication with Medicaid. I know that we've already done in internally here at PEBP where Medicaid has leveraged our resources, and so it's happening already just not on the scale I think Ms. Lamborn is talking about but definitely something we can start looking into.

This is probably, again, a big picture item. It's not something that we're going to have a lot of information on very quickly, and I don't expect to be able to bring this back in May, I think maybe July, at the July Board meeting.

CHAIRWOMAN FREED: Okay.

MEMBER LAMBORN: Okay. That would be great. Thank you.

CHAIRWOMAN FREED: Okay. If nobody has any other questions for the executive officer, we'll move to public comment once again. And I'll ask the operator to let us know if there's anybody in -- on hold waiting to make a public comment.

THE OPERATOR: Thank you. Just as a reminder, if you wish to ask a question or make a comment you may press one and then zero, and we do have a few in queue.

We'll go to the line of Priscilla Malone. Please

go ahead.

MS. MALONE: Good afternoon, everybody. I hope you can hear me. Just give me a cyber nod.

CHAIRWOMAN FREED: Yes.

MS. MALONE: Okay. All right. First of all, I have three points I want to cover with real briefly. Thank you for all -- thank you, Ms. Rich, for all of the, just doing navigating this crisis and to specifically direct my comments to item, Agenda Item 11.

So, yes, you are a psychic. You saw this coming or somehow intuitive to this. So there are several steps outlined there that are going to serve you well getting you through this crisis, you and your staff, and so that's just fantastic that that was just serendipity to that and your intuitiveness that brought that together.

I would say that on, I believe it's on page two of your report where you do discuss the reassessing how open enrollment is done, this may be an opportunity or a crisis and opportunity -- crisitunity to put that into actual practice. If you do have to change open enrollment date it's not the end of the world.

In my mind from a government affairs perspective we have a huge agency the size of the IRS that has been able to make this happen nationwide. So I've got every confidence

that that's the open enrollment issue is going to be handled.

The second thing I would like to bring up to the Board is it's a little concerning and honestly I understand that the CARES Act which is HR748 was just passed last Friday or signed last Friday. So I know we haven't had a chance as a state probably to get into the weeds of what this means. My international union asked me, federal government affairs team has sent out a five-page summary of the bill, but I do note that there's 150 billion dollar for state, tribal and local governments through a new Coronavirus relief fund, and I'm not guessing. I haven't read whatever hundreds and hundreds of pages either.

But I would love to see it if we could nail down between now and the next meeting a conversation with the finance office on whether there is something that you are particularly concerned about today, such as keeping a robust catastrophic reserve. That that reserve may have not, in fact, have some relief buried in this bill through this grant program. So that's just something to think about is to maybe nail down what, if any, relief in a real dire situation where our catastrophic reserve does get hit very hard going forward over the next year, what relief, if any, could be gleaned from that part of the bill.

And then finally I really appreciate the support

for a second meeting. Our members, of course, and our state work force is very concerned, very worried. Everybody is very frightened and wondering what will happen next. So I'm ready and able to participate in that next second meeting. I think this went off without a hitch. So thank you very much, and I'll yield the floor to my cyber colleague in the cyber background.

THE OPERATOR: Thank you.

The next question is from Kevin Rand, please go ahead.

MR. RAND: Yes. Can you hear me?

CHAIRWOMAN FREED: Yes, we can.

MR. RAND: Yes. Thank you. Good afternoon respective Chair and Board members. For the record my name is Kevin Rand representing AFSCME local 4041.

On behalf of the state employees we are very thankful for the actions you took today on action Number Item Nine, setting the rates. We know this is a very difficult time. By providing the -- the opportunity to have another meeting going forward, this clearly provides a viable option to lessen the cost on PEBP members.

State employees, as you know, are going through a lot of uncertainty at this time, and they look up to the Board members like yourself to be able to make these

difficult decisions but get it right. And with that, you know, it's very difficult to come to an agreement on rates and benefit designs, and the Board is making the due diligence and we're very grateful on behalf of state employees, and we look forward to working with you in the future to be able to do whatever we can. We have a research department within AFSCME federal and if that's ever needed that's open as well. So, again, we want to make sure this is a partnership.

And, again, I want to thank Laura Rich for her time and everything she put in today's meeting, and I also want to thank the Board, the Board members one last time. I appreciate everything, and you guys have a great day. Thank you.

THE OPERATOR: Thank you. And we have a question from Marlene Lockard. Please go ahead.

MS. LOCKARD: Thank you. And good afternoon members of the Board. I appreciate all your hard work and your conscientious discussion on all of our items on the agenda today.

But I want to particularly thank you for your approval of Item Eight, allowing the retirees to opt back into the system. That has been a very difficult issue for some of our retirees, and I think this echoes the days of the

orphan issue somewhat when we went through that. So putting everyone back on the same playing field I think is very helpful and appropriate. So thank you all. I appreciate it.

THE OPERATOR: And we have no further questions in queue at this time.

CHAIRWOMAN FREED: Thank you very much.

Okay. So we have arrived at the end and I will accept a motion to adjourn.

MEMBER SMITH: This is David Smith so moved.

CHAIRWOMAN FREED: Okay, great. Thank you. We are adjourned then. Thank you everybody. Stay safe out there.

MEMBER FOX: Thank you. Bye.

THE OPERATOR: Ladies and gentlemen, that does conclude your conference for today. Thank you for your participation and for using AT&T Executive Teleconference Service. You may now disconnect.

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

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

That on Tuesday, the 31st day of March, 2020, I was present on a teleconference for the Public Employees' Benefits Program, Carson City, Nevada, for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 194, is a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Carson City, Nevada, this 14th day of April, 2020.

KATHY JACKSON, CCR
Nevada CCR #402

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