In The Matter Of:

PUBLIC EMPLOYEES BENEFITS PROGRAM BOARD

ZOOM/TELEPHONIC OPEN MEETING

July 23, 2020

Capitol Reporters

123 W. Nye Lane, Ste 107

Carson City, Nevada 89706

Original File 7-23-20PEBP.txt

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

ZOOM/TELEPHONIC OPEN MEETING

THURSDAY, JULY 23, 2020

CARSON CITY AND LAS VEGAS, NEVADA

The Board:	LAURA FREED - Chair LINDA FOX - Vice Chair MARSHA URBAN - Member DAVID SMITH - Member TOM VERDUCCI - Member JET MITCHELL - Member DON BAILEY - Member JENNIFER KRUPP- Member
For the Board:	BRANDEE MOONEYHAN Deputy Attorney General
For Staff:	LAURA RICH Executive Officer WENDI LUNZ Executive Assistant BRETT HARVEY Chief Information Officer CARI EATON Chief Financial Officer NANCY SPINELLI Quality Control Officer NIK PROPER Operations Officer
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THURSDAY, JULY 23, 2020, CARSON CITY, NEVADA

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CHAIRWOMAN FREED: Good morning everybody. This is Laura Freed, and it is by my computer's clock it is 9:04 a.m. So I'm going to call the July 23rd, 2020 PEBP Board Meeting to order, and I will start by taking the role.

Linda Fox? Linda?

Okay. Don Bailey?

MEMBER BAILEY: Here.

CHAIRWOMAN FREED: Marsha urban?

MEMBER URBAN: Here.

CHAIRWOMAN FREED: Jet Mitchell?

MEMBER MITCHELL: Here.

CHAIRWOMAN FREED: David Smith?

MEMBER SMITH: Here.

CHAIRWOMAN FREED: Tom Verducci?

MEMBER VERDUCCI: Here.

CHAIRWOMAN FREED: Jennifer Krupp?

MEMBER KRUPP: Here.

CHAIRWOMAN FREED: Once again, Linda, are you -- are you on?

Okay. Well, we do have a quorum and I'm sure that Vice Chair Fox will join us when she can.

I wanted to pause here for a second and allow

Member Mitchell to make an announcement. She wanted to say a few words to the Board. Jet, it's up to you.

MEMBER MITCHELL: Thank you, Chair Freed. Jet Mitchell for the record.

And for those that can see me on video I am now completely bald. I am doing a new chemo that one of the side effects is hair loss and because I don't wear wigs or hats or scarves, I'm very open about being bald, and I just wanted to let everybody know that up front. This is my third head shave, and the good news is that I'm still in treatment, but I don't believe that metastatic cancer, any chronic disease should be with-heard about. So I wanted to put it out there and let everyone get comfortable and let everyone know and then we can move to the important business.

So thank you for your support. Thank you, Chair Freed, and I'll be having a no hair day today.

CHAIRWOMAN FREED: I think -- I feel like I can speak for the whole Board when we wish you the best in your course of treatment, and I think your bravery is really inspiring.

MEMBER MITCHELL: Thank you. And thank you all for your support. So just wanted to put that out there. I wanted everyone comfortable. We had a side bar conversation about treatment and, et cetera. I've been very vocal as a

patient and patient advocate. So just wanted to put that out there and thank all of you for your support. So onward and upward.

CHAIRWOMAN FREED: Excellent. All right. So with that we'll move to Agenda Item Two, which is public comment. There are two public comment periods. Depending on the amount of commenters we might have in the queue, I think I'm going to try and limit this to four minutes per person. And with that, I will turn it over to PEBP staff.

MR. CARROLL: Thank you, Madam Chair. I'm going to go ahead and share my screen here. And as Madam Chair said, this is the public comment portion of the meeting. So for those who are calling in during this period I'm going to read off the last three digits of your phone number. When I announce those you will be advised that your line is unmuted. You should hear an audible tone by Zoom saying that it's unmuted and at that time you can go ahead and proceed with your comments.

So I'll pull up the participants here. I do have quite a few numbers that have called in. So the first one that I have, area code starts with a four. Last three is 920. Your phone is unmuted. Okay. I think they are not saying anything.

Next one I have on the line is 198. Your line is

unmuted. Okay. I apologize. I got a message here that 198 that I just read off is actually Linda Fox. So let me go ahead and get her in here.

CHAIRWOMAN FREED: So, Mr. Carroll, while you're organizing the public comment I'll just note for the record that Linda Fox is present up in meeting. So thank you.

MR. CARROLL: You're welcome.

CHAIRWOMAN FREED: Okay. Next line that I have is 4029. Your line is unmuted.

The next one I have is 193. Your line is unmuted.

Next one is 511. Your line is unmuted.

The next one I have is 688. Your line is unmuted.

THE OPERATOR: You are muted. You are unmuted.

MR. CARROLL: 277, your line is unmuted.

THE OPERATOR: You are muted.

MR. CARROLL: 38 -- 338, excuse me, is now unmuted.

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

CHAIRWOMAN FREED: Yes, we can hear you.

MS. MALONEY: Thank you. I will save my public

comment for the end of the meeting because I believe we're going to go through some rather somewhat complex and detailed things around Agenda Item Nine, well, nine and ten really because the policy in ten meets the budgetary concerns. They intercept in nine as you know. So I will save my comments to the end. I just want to sort of register my presence in this meeting. Thank you very much. I'll mute myself now.

MR. CARROLL: And the last one we have, I apologize. It looks like the list is jumping on me here.

The last one I have is 404. You're now unmuted.

MR. RANFT: Yes. Can you hear me?

MR. CARROLL: Yes.

CHAIRWOMAN FREED: Yes, we can.

MR. RANFT: Good morning. Good morning, respective Chair and committee members of the PEBP Board. My name is Kevin Ranft with AFSCME Local 4041 representing active state employees.

We would like to be on the record as neutral on nine and ten. Although, we're really adamant about some of the budget changes. So we may look at opposing some things but as of right now we're neutral.

In regards to Item Nine, we understand and need to bring the plan design changes to build a budget for fiscal year '22 and '23 and adjust policies to create improvements

within PEBP on Item Number Ten.

However, we strongly feel that there's a lot of time to make improvements upon these policies and plan designs as our AFSCME members working with PEBP and make sure that, you know, there's a -- we kind of met all processes and policies even further than today just to try to push these through to get -- to create a budget.

It's kind of early in the year. We normally look at these things in November through March. And, again, we just want to know that the intent of today is really a concept design as stated and to kind of highlight some of the things we need to look at PEBP come November through March, and we're excited to work with you guys as a union that represents state employees.

The concerns that we really have is we have to ensure that we prevent any benefit losses or increase the future premiums. At the end of the day that's what we're all looking at. However, we feel that jumping to, you know, things that are not tried and through we have serious concerns with.

Ultimately there's, you know, some plans on the table. Members have been looking for stuff like that for many years so we appreciate the opportunity to vet that even further, but again we have to look at if today is just really

building around a budget or is this a solid policy plan going forward and that's what we're concerned with.

So we want nothing set in stone. We just want to make sure that you guys have a solid budget, allow the Governor to make the various changes, the legislators to kind of vet it and then come back to the PEBP Board for possible changes, and we just ask you to continue to look at within to us and others to ensure that changes can be brought forward and even potentially look at other plans possibly from other states.

These are difficult times, and other states are doing real good things, and we just want to bring those forward if we need to if this plan is not something that's going to be viable for the State of Nevada.

As a Board we ask you to take into consideration that state employees look to you to protect their health insurance benefits. State employees consider health insurance as part --

CHAIRWOMAN FREED: Mr. Ranft?

MR. RANFT: -- of their compensation packages.

CHAIRWOMAN FREED: Mr. Ranft, would you wrap up your comments.

MR. RANFT: Yes, I will. As really they're paid less than 30 percent of cities and counties and they really

have to have this package affordable. Any time the state employees are cut it's -- it's always on the backs of them. We are very grateful that AFSCME got to work with the legislators and the Governor's office on these last furloughs where they cannot afford benefit cuts or premium increases.

With that being said, I appreciate your time, and I may have more for public comment at the end. Thank you.

MR. CARROLL: Okay. It looks like we have one more and the line ends in 837. You're now unmuted.

MR. ERVIN: Thank you. Good morning. This is Kent Ervin, K-e-n-t E-r-v-i-n representing the Nevada Faculty Alliance, the independent statewide association of NSHE faculty.

Regarding Items Nine and Ten, the plan design and policy changes, we very much appreciate the thought and work that has gone into taking a fresh look at the PEBP plans and the restructure. Thanks very much to the Board members and staff involved in strategic planning. The Board needs to approve the PEBP agency budget request that must be submitted for September 1, and Item Nine appears to be the only means for Board input.

We are alarmed by the five percent and ten percent reduction proposals which would make the already high out-of-pocket maximums catastrophic for employees with

serious chronic conditions.

PEBP should calculate the base budget based on no change in benefits or plan design and then provide only those reductions required to meet the Governor's budget caps as negative enhancements.

Without comparing the cost and maintaining current benefits there's no way for either the Governor or legislators or advocates to gauge the true impact of the cuts.

The future economic environment is so uncertain that planning only for cuts is misguided. If there's a vaccine by January with effective national implementation the pinup demand for tourism, travel may well provide the positive outlook to the economic forum in May 2019 -- 2021. Of course, it could go the other way depending on politics that are out of our control. Nevertheless, it is prudent to plan for either scenario.

Regarding the new low deductible plan, we appreciate the intent, but as presented the deductible is not really low. To evaluate this plan structure and this is an item that we have supported to consider, we request that staff provide estimate of how rates and premiums would vary for the three plans. Even guesses would help evaluate whether the structure is truly beneficial to participants.

The Board also needs to see what the low deductible plan would look like at a zero percent, flat budgeting level with a true low deductible in place of the missing current plan in Agenda Item Nine.

For the policy changes in Item Ten we have the same request with explanations -- with the explanations, and the Board packet is hard to understand how they would effect the rates and premiums and overall budget. It's essential to bring back details in September, including markups of the rate tables based on current year rates and best estimates for the new low deductible plan. That's the only way we can truly evaluate these new ideas.

So thank you very much for your work, and we appreciate all that you do.

MR. CARROLL: Madam Chair, we have two more.

CHAIRWOMAN FREED: All right.

MR. CARROLL: 853, your line is now unmuted.

MR. UNGER: Hello. Can you hear me?

CHAIRWOMAN FREED: Yes, we can hear you.

MR. UNGER: This is -- good morning. This is Doug Unger with the UNLV Benefits Advisory Committee and the UNLV Faculty Senate, also president of the NFA chapter at UNLV representing the UNLV Faculty.

I would also like to speak to Item Number Nine on

the agenda, and I tried to write a -- a reason public comment last night but -- but couldn't do it because I was thinking back over the nine years of our advocacy and understanding that the most consistent point we've been making to the Board is that deductibles are too high and out-of-pocket maximums are too high.

I think about why I've got involved in health benefits advocacy in the first place and it was really because I got to know the stories on our campus, the administrative assistant who lived in her car for three months because she didn't have enough money to pay the out-of-pocket maximums for very high medical costs.

The UNLV photographer who walked around and worked with a back injury for more than a year and a half in order to save up the out-of-pocket maximum in order to have his back surgery.

And there are many many stories like this and especially stories that faculty who do not utilize the plan when the out-of-pocket maximum goes up too high because they can't feel that they afford it and then their medical condition gets worse and they end up costing the plan and everyone else even more money.

I would like to support the NFA position but please look at these different options without changing the

base benefits. Give us the news, what the premiums and everything else would look like before the budget cuts, and give us a chance also to advocate before the legislature and the Governor, not to reduce the state contribution to Nevada state employee healthcare.

We believe that during the pandemic we should not be punished by having our healthcare reduced. It's a retention problem for all state employees, and it's one of the most important factors in retaining and hiring competent state employees and competent faculty.

Same thing with the policy on Item Agenda Number Ten, please just give us in September a good idea of what the costs of evening out the tiers and -- and the administrative cost changes are going to be.

Thanks so much for being there. I really -- we really appreciate all of the good work the Board is doing, and a special shout out to Jet Mitchell. Please know you're in our thoughts and in our hearts. Thank you.

MR. CARROLL: The last one we have, Madam Chair, the phone number is 121. Your line is now unmuted.

That is all, Madam Chair.

CHAIRWOMAN FREED: Okay. Reminder to everybody listening that there is a second public comment period under Agenda Item 11. So if you didn't get into the queue or

something went technically wrong you have another shot.

Okay. Moving on to Agenda Item Three. I will throw it to Deputy Attorney General Mooneyhan.

MS. MOONEYHAN: Thank you, Madam Chair.

This agenda item, of course, is for me to make a disclosure on behalf of the Board members who are eligible for PEBP benefits which is everybody except for Mr. Verducci.

When PEBP Board members vote on matters effecting benefits for themselves or their family members it may trigger the disclosure requirement under NRS 281A.420. I know that the law does not preclude the Board members from voting on the items.

Of course, most of the items on this agenda are going to indirectly effect PEBP benefits but Item Number Nine regarding possible plan design changes for fiscal year 2022 to 2023 and Item Number Ten, regarding recommended policy changes for the same plan related directly, more directly to PEBP benefits.

So pursuant to NRS 281A.420 on behalf of the Board members eligible for PEBP benefits, I'm offering this disclosure that they will be voting on matters that may effect the benefits available for themselves or their family. I also invite any member who has anything additional to disclose to do so now. Thank you, Madam Chair.

CHAIRWOMAN FREED: Okay. Moving on to Agenda Item Four. Now, there are a lot of reports on this consent agenda. We have minutes from May 28th Board meeting, budget utilization reports under 4.2, and then we've got vendor reports under 4.3. So, Board members, you had a chance to peruse these. Is there anything that any Board wants to call for further discussion, and then we can vote to accept everything that nobody wants to call.

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

CHAIRWOMAN FREED: Okay.

MEMBER VERDUCCI: I would like to pull 4.2.1.

CHAIRWOMAN FREED: Okay.

MEMBER VERDUCCI: 4.3.5, 4.3.7.

CHAIRWOMAN FREED: 4.3.5 and 4.3.7, okay. All right. That sounds good.

Do I have a motion to accept everything on the consent agenda item except 4.2.1, 4.3.5 and 4.3.7?

VICE CHAIR FOX: I don't see a 4.3.7.

CHAIRWOMAN FREED: This was -- okay. This was on the revised agenda. I don't think it was, made it into the first version of the packet, but then the agenda was revised to add Health Plan of Nevada, the Southern HMO report. Did you not get that?

VICE CHAIR FOX: I think I'm probably working off -- let me look.

CHAIRWOMAN FREED: Okay.

VICE CHAIR FOX: My apologies.

MEMBER VERDUCCI: Tom Verducci for the record.

We do have a few different members here. Let's try scratching 4.3.7 and make it 4.3.6, one that is referring to Hometown Health.

CHAIRWOMAN FREED: Okay. So you want to just talk about Hometown Health not HPN, okay.

All right. So do I have a motion? Go ahead.

MEMBER MITCHELL: This is Jet Mitchell. Yes, can you repeat those numbers again, Tom. Jet Mitchell for the record.

MEMBER VERDUCCI: Yes. Thank you, Jet.

4.2.1, the budget report. 4.3.5, Tower Watson's One Exchange and 4.3.7, make that 4.3.6, Hometown Health.

MEMBER MITCHELL: Okay. Thanks.

CHAIRWOMAN FREED: Okay. Do I have a motion to accept everything but those three that Tom just read?

MEMBER MITCHELL: Jet Mitchell for the record. So moved.

CHAIRWOMAN FREED: All right.

VICE CHAIR FOX: I'll second that motion. This

is Linda Fox.

CHAIRWOMAN FREED: Great. All in favor?

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

CHAIRWOMAN FREED: That's unanimous I think.

All right. So with that, let's go back to 4.3.1, the budget report.

MEMBER VERDUCCI: Yes. Tom Verducci for the record. I think I'll point this towards Laura Rich, whoever would like to respond.

By looking at the operational budget we look at the fiscal year of 2019, and we look at the change in cash which was positive 11.9 million and the net realize funding available was positive 31.6, 31,600,000.

Then we go into fiscal year 2020. We look at the change in cash and we see a big minus sign, minus 28,300,000 and the net realized funding available minus 15,000,000, and I was wondering if perhaps we could have Laura Rich expand on that and discuss how that's going to have future implications on the program.

MS. RICH: For the record Laura Rich.

I think that this might be Cari Eaton. I think she can answer this question. I'm going pass it off to her. I think she's going to do a better job.

MS. EATON: Thank you. Cari Eaton for the record.

That number is, basically it's a timing issue. So basically at the same time last year we received more revenue from insurance than we did this year. So I think it's mostly the timing of our state subsidies that's causing that, and it's just timing at the point in time. Just a screen shot one time of our budget.

MEMBER VERDUCCI: Okay. Yes, because that's an alarming number, and I just want to make sure that we're addressing it and, you know, taking appropriate steps that, you know, we don't end up with a huge number that's going to be unbearable at the end of the year. So in terms of the timing issue I think I personally understand that but just want to bring attention to that, such a large number.

MS. EATON: Yeah. So basically it's 28,000,000. Our AGIS subsidy is about 20,000,000 a month. So if we don't transfer that before the 31st of March then it's not going to show up until April. So that's -- it's all about timing right at that point in time. So it's -- it's nothing to be concerned with.

MEMBER VERDUCCI: Okay. So with the future utilization report we should not see such a huge aberration between these two numbers.

MS. EATON: Correct.

MEMBER VERDUCCI: Is that correct? Thank you.

CHAIRWOMAN FREED: This is Laura Freed.

May I ask a question about the -- the plan's financial position as of June 30th, 2020. If you look at the last page of -- of the financial officer's report we've got -- we've got total revenues projected at the end of the year, and now we're on July 23rd, and so we're getting close to when we will be closing out fiscal year. Total revenue of 545.5 million basically and total expenses of 388.6 million. And then we've got restricted reserves for FY20 is 139.3 million and so we've got some excess cash.

Cari, can you say a little bit about where we expect to be when FY20 officially closes on August 31st.

MS. EATON: From what I can tell right now we did have some claim suppression which --

CHAIRWOMAN FREED: Right.

MS. EATON: -- makes our projected claim less. So --

CHAIRWOMAN FREED: Right.

MS. EATON: -- excess cash to balance forward at the end of the year, approximately, I'm guessing 14,000,000 more than what was budgeted for '21.

CHAIRWOMAN FREED: 14,000,000 more or 14,000,000

total? Because we had a budget of excess cash of six and a half million? Do you mean it changed about six or 14 total?

MS. EATON: I'm talk about the balance forward.

CHAIRWOMAN FREED: Okay.

MS. EATON: Yeah.

CHAIRWOMAN FREED: Okay. All right. So that plays into a little bit of our discussion of stuff down the agenda. I just wanted to get clear on the implications of where we might be at FY20, how that plays into the subsidy holiday that, you know, the legislature just voted for in the 31st Special Session and as well as policy decisions that are before the Board today. So thank you for that.

MS. RICH: And this is Laura.

I just want to add that we are, you know, to what Cari said. We are in this situation only because of the claim suppression. We would not have seen the, any excess cash or not be in that type of predicament had Covid-19 not have happened. I just want to emphasize that.

CHAIRWOMAN FREED: No. When we -- when we met in the spring we were looking at no excess cash and I know that you reported further down in the packet only about half a million dollars in COVID claims cost which is pretty darn low.

Okay. So we'll get to talking about that. I

don't want to, you know, offend Ms. Mooneyhan by taking agenda items out of order.

So with that, Board members, do we have any other questions on 4.2.1?

MEMBER VERDUCCI: Yes.

CHAIRWOMAN FREED: Okay.

MEMBER VERDUCCI: I do. This is Tom Verducci.

I also want to point out the total expenses and reserves, very last column on the table. We're showing a difference of 4.359 and that's at expenses and reserves. So is that indicating that we're seeing a decline in the reserves over the fiscal year?

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

No, Tom. That is based -- that is only the difference between what our projection is showing and what was budgeted for this year.

MEMBER VERDUCCI: Okay. Thank you.

MS. EATON: What was budgeted.

MEMBER VERDUCCI: Thank you for the clarification.

CHAIRWOMAN FREED: Okay. Board members, do you want to -- you know what, let's do this. Let's go to the other two items that Tom requested to be hold 4.3.5 and 4.3.6 and we'll take all three of them at once. So let's do that,

4.3.5.

MEMBER VERDUCCI: Okay. Tom Verducci again for the record.

And I just wanted to address the performance guarantee that was not met with Tower's Watson and it looks like it was a customer service average speed to answer issue and it looks like the outcome was 2.8 seconds, two minutes eight seconds. And I was wondering if Chris Garcia here that could perhaps address this issue. If you have any appropriate steps that are being taken to correct it in the future.

MR. GARCIA: Hi, Tom. This is Chris Garcia. Can you hear me?

MEMBER VERDUCCI: Yes, you're coming in loud and clear.

MR. GARCIA: Oh, perfect. And for the record again Chris Garcia with Willis Tower's Watson, individual marketplace. Thank you for the question.

I know that this measure was also one that was missed last quarter as well. As you look, the way that we measure these, I just want to add some clarity, and then we can kind of talk about what action steps happened. What we're doing going forward to make sure that this doesn't happen again and kind of lead to why this tends to happen

either in the last quarter of the calendar year or the first quarter of the calendar year.

So when we have this performance guarantee it's primarily based off of having a five-minute or less average speed to answer in queue four.

And then for queue one, we know queue one is a little bit busier and we'll talk about that in just a moment, and so that's two minutes or less of the average speed to answer, and unfortunately we missed that by eight seconds. As you mentioned, we had a two minute and eight second average speed to answer for queue one. So it did lead to a penalty which we have paid to PEBP. It was a 2,000 dollar penalty. It's $2,000 per quarter if there's a missed measure for this particular performance guarantee.

And what -- and what we've seen historically in January is it's really tied down to about the first 12 to 13 days of the month where we see an influx of calls that drives longer wait times and those longer -- that influx of calls and those longer wait times can tend to impact the entire quarter which is unfortunate because as we move into February and March we will tend to see lower wait times.

So as I look at specifics for January, we were looking at specific wait times and it was around January 1st through January 12th in which we saw much longer wait times

than what we would like to see. A lot of that is driven off of participants calling in to several things. One, they are checking on any new coverage that they may have enrolled in for the new calendar year. And, two, they are checking on the status of any claims that they have submitted for their new premiums for the calendar year.

So those tend to be the reasons why participants call us at the beginning of the calendar year and the first like two weeks of January.

What we also saw with the first quarter though was the rise in calls due to COVID-19 in March. We had an influx of calls not necessarily for Nevada PEBP participants but for other participants on our platform, for other clients on our platform that would lead to overall longer wait times for participants to reach our representative.

Now, we did staff accordingly based off of available customer service representatives and our benefit advisors. We did have some people due to COVID-19 who weren't able to come into the office but we were able to set them up so they could work remotely from home and still answer calls.

But we know there was a little bit of an impact there, position people from working in the office in March to being able to work remotely from home that could have led to

some, a little bit longer wait times in the month of March than what we may have seen in prior years.

So those are the main factors as to kind of what happened in the month of January. Again, primarily the wait times were impacted due to the first two weeks of January and then subsequent longer wait times that typically occur on Mondays or Tuesdays of each week. People tend to call us on Monday mornings and that leads to longer wait times during that period rather than calling say on a Wednesday afternoon or a Thursday afternoon where you won't have as long a wait time.

And what we're doing going forward, of course, is obviously we've been able to restructure our customer service representatives, our benefit advisors where we have flexibility to have them work from home without any disruption if necessary.

There are still some representatives and customer benefit advisors that work in the office, you know, based off of staffing availability, based off of the number of people that we can have in certain locations in the office to help minimize the spread of COVID-19. So that shouldn't be an issue going forward. That was something we did have to manage through, during the month of March. That was not expected, and I believe that led to us having a little bit

longer wait time and what we would normally have seen, and we may not have had this measure if that did not occur.

So that in going forward, Tom, that should prevent miss-measures in the months -- in the first quarter of each color year.

Does that answer your question? Did you have anything additional based off of what I provided?

MEMBER MITCHELL: Jet Mitchell for the record.

Can I please piggy-back on Tom Verducci question two. On that same note I see in January the abandoned calls, 244, which is an alarming number. So to piggy-back on Tom's concern about wait times would also be the abandonment factor of 244 which is quite substantial. And then in March it says 29S. I'm not understanding if it's 29 seconds before a call is --

MR. GARCIA: That's a typo.

MEMBER MITCHELL: So how many normally is --

MR. GARCIA: I'm happy to address that. That is a typo of 29 seconds. It should be a number of abandoned calls in that month was 29. The S is a typo.

To address the number of calls in the month of January, so what's interesting and I mentioned earlier how the, most of the volume or the increase in wait times that we would see where in the first 12 days, and I actually have

some data available. So out of the abandoned calls in the month of January, 192 of them occurred really from January 2nd, because we were closed on January 1st, but from January 2nd to January 12th. So that's where we had the largest number of people who would have quote, unquote abandoned the call.

And so the average wait time for those abandoned calls would tend to be about a five-minute wait time. So if people were calling in and they were, you know, waiting to speak to a representative. They waited five minutes and hung up and maybe they decided to call back later.

We also put messaging on our phone system. Where we have increase call volumes or longer than normal wait times that does try to prompt participants to contact us later because of the wait times that we're experiencing. And so we would see somebody call in. That call would start to count. They would get that messaging and then realize, oh, I can call back later. They are experiencing longer wait times. If I don't want to wait too long then I would be able to call back.

So, again, 192 of those abandoned calls occurred within less than a 12-day period of time where people were waiting probably on average of five minutes, in some cases a little bit less before they were to hang up the call and

maybe try back at a later point.

Historically that's -- it's not uncommon if you look on the report we have historical data a little bit later on. I would say on page nine and page ten of the report we have prior year historical call stats. And you'll see in the month of January we tend to have a little bit higher abandoned call rate than in other months outside of November, December which we're doing our Medicare open enrollment season.

So if you look at page nine of the report, so last year we had 89 abandoned calls in January. The wait times weren't as long, but we did have a larger number of abandoned calls. And if you go back to, you know, page ten you'll see for 2018 we had 223 abandoned calls, very similar to what we saw this past year.

So historically it's not -- it's not unusual to see a larger number of abandoned calls. It's just knowing that it all happened in those first two weeks of January just because of the influx of call volume and due to the reasons that I mentioned previously.

MEMBER VERDUCCI: Yes, Tom Verducci for the record.

So I believe the penalty in that was, it would be $2,000 and, you know, you were only eight seconds off but,

you know, this is a second quarter in a row and it sure would be nice to pull the next quarterly report, look at the performance guarantee met and see a clean slate with all yes's and two quarters in a row we kind of improve on the next report, so.

CHAIRWOMAN FREED: This is Laura Freed.

MR. GARCIA: Absolutely.

CHAIRWOMAN FREED: This is Laura Freed.

I want to remind Mr. Garcia, as well as Board members who are, and vendors who are on the phone. We have a court reporter trying to keep an accurate transcript of this. When you don't identify yourself for the record you make it harder for them and you make it harder for the public who is trying to keep track of who's saying what. Please identify yourself for the record.

MEMBER URBAN: This is Marsha Urban for the record.

MR. GARCIA: My apologies.

MEMBER URBAN: This is Marsha Urban for the record.

I mean, you're saying in two weeks in January you always have this problem. For some reason it was better in 2019 but it's gotten much worse in 2020. So then what are you doing to make those changes in that two weeks so that --

I mean, this is -- this is a historical problem. It's not like it's one year was an odd ball. I mean, this is something that happens yearly. So what are you doing to rectify that?

MR. GARCIA: Chris Garcia for the record. Thank you for the question. And my apologies for not introducing myself or restating who I am each time I've spoken in the past. I'll make sure I do that going forward.

To address those, I mean, part of the challenges we -- when we run into the month of January we maintain full staffing, and you can see the call volume in the month of January. And, you know, just looking specifically at the Nevada PEBP numbers they are higher than say the subsequent months so for February and March. So it's what we call all hands on deck.

And we have full staffing. All of our customer representatives are available. We have additional resources such as what we call our application data processors who are trained not only to process applications for enrollment but to also answer customer service calls.

They are taking those customer service calls, as well as processing applications. So we try to maintain full staffing in the month of January, and we -- when we look at hiring on customer service representatives, the hiring

process really begins all the way back in the summer and we gear up -- we bring on new representatives. We bring on additional benefit advisors and application data processors, and they are trained starting in the summer, gearing up from Medicare open enrollment which is really in October and November and then the last or the first part of December. Those customer service representatives that we've hired to what we call seasonal employees, they will come on and they will help us during the month of January and into February as necessary.

So we bring on as many representatives as we can when we staff as best as we can based off of available talent pool, based off of call projections, and we manage that way. So in regards to what we're doing, it's really looking at what potential impacts can we have that might drive call volume and staffing accordingly based off of that.

We did add messaging. I did mention this earlier. We did add messaging to our phone number or automated system to advise for businesses if they are calling in if they are longer than -- longer than normal wait times. That's something that is new this past year that we didn't have in prior years that hopefully will drive participants to if they call on a Monday morning for example or they call on a Tuesday morning where it's busier they can maybe call back

later in the week where it's not so busy and they are not having that longer wait time.

So while we certainly agree we don't want to have these long wait times and I don't want to have back to back quarters where we're missing the measure and granted we only missed the measure by eight seconds this past quarter, I agree 100 percent that it's still a miss-measure. It's not something that we're geared toward -- geared to happening but it's something that did occur.

We don't know -- we don't believe it's going to happen. You know, this past quarter that occurred, which is quarter two of the calendar year. It's not going to happen for two to three of the calendar year because in the summer the call volumes tend to taper off and we're able to manage those call volumes more successfully.

So in regards to what we're doing, I believe the correct answer is looking at staffing, looking at bringing those associates that we need to address the call volume accordingly. But other than that there isn't much else that we can do outside of bringing on the right resources to address the initial call volume that we target.

MEMBER VERDUCCI: Tom Verducci for the record.

Chris, I do want to ask does your call center provide for automatic callbacks during busy periods? You

know, when you call a call center and there will be some call wait, do you provide the ability of the member to leave their number and then get a call back or is that something --

MR. GARCIA: Oh, Mr. Verducci, Chris Garcia. Again, thank you for the question.

Right now we do not. There's a specific reason as to why. Medicare enrollment calls, so if somebody wants to enroll in a Medicare vantage plan or a prescription drug plan it has to be done by an inbound call. They cannot be processed through an outbound call. So that's one of the main reasons that we don't have that functionality in our system. It's something that we are exploring.

They have recently allowed us to do medi gap enrollments through an outbound call, as well as dental and vision enrollments. So that's something that could potentially -- we could see this coming open enrollment season but it's not something that's in the system right now.

MEMBER VERDUCCI: Okay. Thank you for addressing that, and it's good to know that it's something you're working on as well.

MEMBER MITCHELL: Jet Mitchell for the record.

I want to take you back to my previous comment about call abandonment, and I appreciate Chris Garcia's comments in January that we had 192 calls from January 2nd

through 12th that were abandoned calls, but that does not answer why there was 605 in November and six -- 68, excuse me, in December. So I'm not looking to Chris Garcia to make comment on that. I just wanted to note for the Board members that the call abandonment question that I raised was not a January only situation and as Marsha Urban well noted the historical problem earlier, I just wanted to make sure that that historical problem was noted as November being December 6th 668 abandonment and, again, not looking for specific explanation on that but just noting the abandonment trend was not just January 2nd through 12th.

And, again, this is Jet Mitchell for the record.

CHAIRWOMAN FREED: Thank you. This is Laura Freed. Thank you for those comments, and thank you for the insightful questions.

Board members, are there any other questions for Tower's Watson? Okay. Hearing none, I see a head shake from Mr. Verducci so that's a no.

Let's move on to 12.3.6.

MEMBER VERDUCCI: Okay. Tom Verducci again for the record. This would be in regards to Hometown Health and looking at the pass/fail, we have a fail that jumped out here in the claims repricing. The guarantee was 95 percent turnaround time, the repricing, the medical claims within

three business days of receipt from PEBP's third party administrator and it came in at 89 percent. So perhaps we have a representative from Hometown Health that would be wonderful.

MS. REIMER: Good morning. Can you hear me? Well, good morning. Perfect. Madam Chair, to the Board, for the record I'm Heather Reimer, director of self-funded programs at Hometown Health, and thank you for giving me the opportunity to speak to this item.

Hometown Health provides the PPO Network and reprices claims for the TPA and as part of that agreement we have performance guarantees. Under the EDI claims repricing guarantees the measure is 95 percent turnaround time for repricing claims within three business days.

During first quarter 2020 we failed that measure at 89 percent. During Q1 each year we load new fee schedules. This option requires us to pen the repricing file while we receive and process fee schedules for the new year.

In this quarter there was a delay in receipt of the Medicare fee schedule which resulted in missing a semester. All other measures for the quarter for Hometown Health were met.

Can I provide any further details to that for you, Mr. Verducci, or Board members?

MEMBER VERDUCCI: So Tom Verducci for the record.

So what steps are going to be taken next quarter? If you can expand a little bit more on that so when we get it reported as a pass.

MS. REIMER: Absolutely. Heather Reimer for the record.

This fee schedule and all of the fee schedules have been loaded and are currently working appropriately. So we don't anticipate failing this measure next quarter. This really is based on a dependency of an outside agency receiving those fee schedules, and we typically have this processed during Q1 of each year for each cycle so we can load those new fee schedules for the new year.

MEMBER VERDUCCI: Okay. So you anticipate getting a pass with the next quarterly results at this point or does this look like a problem that could be persistent?

MS. REIMER: Heather Reimer for the record.

I do not think it's persistent. We are really diligent about ensuring that our fee schedules are loaded as soon as we receive them and in order to provide the timely repricing file.

MEMBER VERDUCCI: Okay. Thank you so much for addressing these issues, and I think that's it on my comments there.

MS. REIMER: You're welcome.

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

Any other questions on 4.3.6 from the Board?

Okay. Hearing none, I would accept a motion to accept the report under 4.2.1, 4.3.5, 4.3.6.

MEMBER VERDUCCI: Tom Verducci for --

VICE CHAIR FOX: Linda Fox for the record.

CHAIRWOMAN FREED: I think Mr. Verducci spoke first so I'll give it to him.

Okay. It's been moved and seconded. All in favor say aye or raise your hand on your picture.

MEMBER KRUPP: Jennifer Krupp, aye.

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

CHAIRWOMAN FREED: All right. It passes unanimously. Thank you everybody for your questions and your testimony.

Let's move on to election of Board Vice Chair. This is Agenda Item Five. Let me open my packet. Okay. Since this is the first meeting of the new plan year, Nevada Administrative Code requires us to, again, elect a Vice Chair who presides over the Board when the Chair is unable to do so.

As the Board knows, Linda Fox, who's the current Vice Chair or was the Vice Chair for plan year 2020, I should say, and Ms. Fox has expressed interest in continuing. I have not received myself any other formal expressions of interest. So I want to -- as the agenda item notes, the eligible candidates are Mr. Bailey, Ms. Fox, Mr. Verducci, Ms. Urban, Ms. Krupp and Ms. Mitchell.

So if you would like to nominate someone you may. If you would like to nominate yourself you may. And if we have more than one nomination, I'll just ask each person who's interested to say a few words about why they would just love to be the Vice Chair of the PEBP Board. With that I will open it up.

MEMBER MITCHELL: Jet Mitchell for the record.

Chair Freed, I would like to nominate Linda Fox to continue her service as Vice Chair.

CHAIRWOMAN FREED: Do I hear any other nominations? Sorry. This is Laura Freed. I have to take my own medicine.

Okay. I'm not hearing anybody speak up. So with that I -- let's see, Ms. Rich, we officially have to vote on this, right, with a motion?

MS. RICH: Right.

CHAIRWOMAN FREED: Okay. Thanks. Got it.

Member Mitchell, would you like to move that Ms. Fox continue her service as Vice Chair for plan year '21 and also with a second from the membership?

MEMBER MITCHELL: Jet Mitchell for the record. Laura -- Chair Freed, yes, that's exactly what I would like to do.

CHAIRWOMAN FREED: Awesome. Do I have a second?

MEMBER URBAN: Marsha Urban for the record. I'll second that.

CHAIRWOMAN FREED: Great. All in favor say aye or raise your hand.

MEMBER KRUPP: Jennifer Krupp, aye.

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

CHAIRWOMAN FREED: Any opposed say no. All right. Sounds unanimous. Thank you so much members.

Congratulations, Ms. Fox.

VICE CHAIR FOX: Thank you.

CHAIRWOMAN FREED: You may get another shot. If we have another special session you may have to preside over a meeting or two, so.

VICE CHAIR FOX: Okay.

CHAIRWOMAN FREED: All right. With that, let's move on to Agenda Item Six, executive officer report.

Ms. Rich.

MS. RICH: All right. For the record Laura Rich.

This is Agenda Item Six, the executive officer report. It starts out with plan year '21 open enrollment. So typically after each open enrollment PEBP reports any -- any type of migration that occurs within the plan just to give the Board and the public some idea of, you know, what happens throughout open enrollment.

And long story short, there wasn't a lot of changes in -- in the member enrollment. I personally was expecting some migration given the higher premium cost of the HMO and EPO. But as you see in that chart there, I mean, the numbers are pretty steady. The numbers between each of the plans between plan year '20 and plan year '21 it almost went unchanged. So, again, there's some level of consistency there.

The next one is the COVID update. PEBP continues to encourage those staff who can work from home to work from home and to continue doing so, but we were able to purchase some laptops and get some BPM's, things like that. So we're able now to move people away from the office and work remotely to encourage that social distancing.

And it's been a little bit of a shift in the way we do things internally in the office, but I think that we're

doing really good and adapting, and we're looking at simply making some changes within the call center. That was their biggest -- our biggest challenge as far as, you know, having -- being able to have all staff be able to work remotely, but really we are adapting and things are looking good there.

So since the plan is also -- we're paying 100 percent of COVID-19 claims. We've been keeping a very close eye on claims costs. These are also being reported to the Governor's Finance Office just in case there's any applicable federal dollars that we can get back on that. And as of this week we do have a work program approved for $400,000 of COVID-19 related expenses. So we will be getting some federal dollars back from that.

So as of July 13th and actually I got the updated numbers yesterday. They are not that much different. The plan has paid approximately $550,000 in COVID-19 related claims. And I just want to put out there that that number does seem low, but you have to remember that these expenses, these COVID-19 expenses were incurred during a time where the state was shut down. Where we had, you know, stay-at-home orders and everything was typically, you know, in shutdown mode, and so cases at the time were reducing and -- and so the situation was different.

If you recall, Aon's COVID-19 modeling that was presented back in May, they presented this huge different -- a few different models. So it was best case scenario to worst case scenario and there were three different ones, right. So the best case scenario is it slowed down and everyone is social distancing and, you know, we've got -- we've got a state of shutdown type thing, and in that scenario PEBP actually, the program saved the money versus incurred costs.

But if you remember in their scenario where they assume that we moved to phase two, we opened, nearly a full open on July 1st which we actually did that before July 1st and then a -- a rise in claim or a rise in COVID-19 cases which then leads back to a stay-at-home order on August 1st.

Now, we don't have that stay-at-home order. We're not shutting things back down, but I wouldn't say that's out of the realm of possibilities. So I'm looking at the, Aon's model as a possibility, a real strong possibility of, you know, the kind of the worst case scenario.

And if you look at that chart, you're looking at if we have a low claims suppression and a low claims cost we're looking at best case scenario or I'm sorry, high claims suppression and low claims cost we're looking at a best case scenario of saving -- the plan saving about 2.7 million

dollars.

However, in a situation where it is worst case scenario where we have a low claims suppression and a high COVID-19 cost that could cost the plan about $20,000,000. So I guess the general message that I'm trying to relay here is that if this 500,000, half a million dollars that we have paid out in COVID-19 claims, I think this is, you know, really best case scenario right now, and that the situation could definitely change given what we're seeing right now as far as the rise in COVID-19 claims and hospitalizations not just in Nevada but across the country.

So I just wanted to make that clear. It's something that we continue to watch and it's something that we will have to continue to just keep a close eye on. I will have Aon present a new updated modeling at the September Board meeting. I think that will give us a little bit more insight into what is happening and what we can expect.

So moving on to the COVID-19 coverage, I just wanted to provide the Board an update that back on March 31st the Board did elect to align with the Governor's emergency regulation by covering all testing and office visits and treatment related to COVID-19. That's 100 percent of the plan's maximum allowable charge. That emergency regulation went into effect through July 3rd. However, staff was

provided the authority to extend that the regulations be extended, reissued and that is exactly what happened.

So that the regulation on attachment A you will see it was filed on July 2nd and was intended to replace the March emergency regulation. So PEBP is continuing to provide that coverage as we had been as of March 31st. So that's facilitation's update.

PEBP staff and Board members who, thank you very much, who have been out with this process, we are very very very busy with solicitations. Right now we have five solicitations that we are working on, actively really for one but the last one we have a little bit of extra time to work on, but four of them we are really in a time crunch and need to get them out and -- and really implemented by July 1st of next year.

So staff have been working really really hard around the clock to get these solicitations ready. We do have one out right now. The enrollment and eligibility budget analysis system is out, and there's going to be three more back to back that are coming out, you know, within the next month or so.

So that has been -- that's basically going to be what PEBP is going to be working on for the next -- the next year between -- right now we're developing those

solicitations. There will be the evaluations of those proposals and then following that there will be the negotiations. It will be presented to the Board and then approved at BOE, and then we have the implementation part of it as well on the communication to members and things like that. So long story short, we're going to be very very very busy for the next pretty much year.

The one thing that is not in this report that I did want to add is the special session update. That wrapped up on Sunday. So that was -- that's why it's not in this report. I wasn't able to add anything in there. The report was written before it wrapped up on Sunday, but I wanted to make some clarifications because I received many many e-mails on what exactly was PEBP's role in this.

And so in this special session, this was the bill that included all of the administration, the state administration, the furloughs, the -- the increase of annual roll-over. Thank you, Chair Freed. And there was also the part on PEBP.

And so really what this -- what the PEBP portion is to allow that subsidy holiday. So the PEBP Board voted back in May to -- it was about $25,000,000 in budget reserves, but we have a statute that doesn't allow PEBP to really to take that money and just give it to the state,

right. PEBP money stays within the program. And so the only way to go about moving that, those funds that we set aside for reserves into the general fund is to allow for a subsidy holiday.

So what this bill did is allow for the agency, not the employees, and that is the clarification that I want to make, is that agencies get a subsidy holiday for one month of the fiscal year. That month has not been identified yet, but they do get one month of a subsidy holiday, and so that's one month that PEBP does not bring in the -- the employer portion, so the employer contribution, and that's essentially how that $25,000,000 that we set aside goes back to the general fund or -- or that the programs to which, you know, those agencies that are paying that employer contribution.

So I wanted to clarify that because I know that there's a -- there's a language in that bill that does state that employees are not -- they are not responsible for that portion, and there was some confusion as to whether employees were responsible for the premiums at all, and really what it is saying is that employees are not responsible for the employer portion of that contribution.

So I just I wanted to put that on the record because I think it's helpful and really clarifies a lot of the questions that I've been getting coming into the office.

So with that I will conclude and give you guys the opportunity to ask some questions.

CHAIRWOMAN FREED: This is Laura Freed.

Thank you for clarifying the difference between a rate holiday, a subsidy holiday and a premium holiday because people who are not in PEBP world, except maybe a participant and people who are members of the press and certain members of the legislature use those terms interchangeably and they mean very different things to people who understand the plan. So thank you for that.

If I may, may I go back to page two and the Aon's illustrative chart. So tying the fact to a conversation earlier in the meeting about the fiscal officer's report, so again I know this is just a chart for illustration purposes, but the fact that we have excess cash that we hadn't planned on and projected earlier in the fiscal year or projected earlier in 2020 I should say. So just to be clear, we are low on COVID claims cost and high on claims suppression which is what explains the excess cash. Is that a fair statement?

MS. RICH: I would say that is a fair statement. Yes.

CHAIRWOMAN FREED: Okay. Thank you.

Board members, other questions for Ms. Rich?

MEMBER MITCHELL: Madam Chair, Jet Mitchell for

the record.

I have two questions on the report. First of all, I wanted a little clarification on the number, the 550,000. Do we have some kind of sense of where that is going, what is that -- what -- what does 550,000 represent? That's my first question.

MS. RICH: So that 550,000 is any Covid-19 related claims. So when a -- when a member goes in and refused an office visit or any testing or anything like that it is -- there's a CPT code that is associated with it that is -- that's COVID-19 related. So that is anything paid out that is related to that CPT code.

MEMBER MITCHELL: Actually I have three questions, sorry, so one, two, three. So to follow-up on that, your comment is we end up having more of a worst case scenario, the claim, the claims would be COVID related for hospital, I'm assuming hospitalization would drastically increase. Would that be a fair assessment?

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

Yes, I would say -- I would say that's a fair assessment. That is where, you know, the bulk of the cost rate. So the testing is costly on a volume basis but obviously hospitalization would be costly in general.

MEMBER MITCHELL: Okay. Jet Mitchell again for

the record.

I asked question two. I have a third question. On the special session update you had identified the subsidy holiday month. Do we have an idea as far as when that month will be identified or further color around the timeline of the holiday month? How does that look for us at this point?

MS. RICH: This is Laura Rich. If you recall, a lot of the significant percentage of what we put aside in reserves was it came out of the reserve's bucket, right, and so it's already there. But there's a portion of what we had set aside for those budget rate reserves that are going to accrue throughout the plan year, and some of them don't even accrue until or don't materialize until May.

If you think back to that HRA that we made that will not even happen until the end of May, and so my assumption, we will work with the Governor's Finance Office on this, but my assumption is it will be if not the last month of the fiscal year, it will be very close to it.

MEMBER MITCHELL: Jet Mitchell for the record. Thank you so much for the clarification.

And I know in discussing COVID I completely understand that we're in unprecedented times. So discussing -- we're discussing ranges of possibility that could be total claim suppression to no claim suppression

whatsoever and every scenario in-between. So I know we're asking -- as Board members we may be asking you to look into a crystal ball that may or may not know what that looks like at that point. I'm cognizant there's a lot of unknowns at this point and continue to be so.

CHAIRWOMAN FREED: This is Laura Freed.

May I key off of what Member Mitchell asked about what does that $550,000 consist of. When I'm reading the HealthSCOPE reports and all of us under -- for, you know, Agenda Item Four, is COVID considered classified as a disease of the respiratory system or the circulatory system or is it other or where would I look for that?

MS. RICH: You know, that is a very good question. Laura Rich for the record. I think we have Mary Catherine on the line and she may be able to --

CHAIRWOMAN FREED: Okay.

MS. RICH: -- speak to that. I don't know if they are -- I really don't know where they are incorporating that.

MS. PERSON: This is Mary Catherine Person for the record, and it could be incorporated in any one of those places. As you know, it really falls into a lot of different areas. In the current reporting you really wouldn't see it. You'll start to see more of it actually in the reports that

you'll probably see for the September Board meeting, but currently there's not a lot of data in there.

A lot of the initial cases really probably fell under the respiratory more than other places, but it is kind of a mixed bag today.

MEMBER MITCHELL: And Jet Mitchell for the record.

Mary Catherine, would it be fair to say as time goes on and we know more both of the COVID and treatment that certainly six months from now, maybe even a year from now the Board and all of the PEBP members would have a better look at how exactly how much was spent and exactly what month it was spent. Would that be a fair assessment?

MS. PERSON: That is fair. This is Mary Catherine Person for the record. We will be providing -- we are providing you guys and can continue to provide on an ongoing basis a rolled up view of just Covid-19 as well. So you can see the exact cost specific to COVID, specific to inpatient, how many patients were on ventilators. All of those different types of things are all things that we're tracking on your behalf, and we can provide that information and information on testing numbers and percentage of people who are actually positive, those who are presumed positive because, you know, there's been an interesting combination of

the way providers have actually sent in claims regarding COVID.

MEMBER MITCHELL: Jet Mitchell again for the record.

Mary Catherine, I'm also very interested in six months and a year how claims would look for other things. I specifically follow cancer patients for personal reasons, but for example many cancer patients are delaying deferring treatment and diagnostics, which is most unfortunate on a personal level, but it would be interesting to see claims that are not necessarily COVID specific but are COVID spillover effects, and I think PEBP may see that in the next year as we have other chronic diseases and other health issues bubble up that were suppressed, that had claim suppression and otherwise during this time.

So I'm hoping that's not the case but the research that I'm reading shows that it may be, that we'll see further increases in additional things in addition to COVID specific, and I hope I'm wrong.

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

I agree with you, Dr. Mitchell, and I agree that's very likely. And if it's, you know, something the Board would like to see, we can work with Aon to put together

some reporting for your September meeting that's specific to some of those things.

MEMBER MITCHELL: Jet Mitchell for the record.

I would work with -- my thought is I would defer to Laura Rich and Laura Freed as far as some specifics but it may even go beyond September. We may be looking well into 2021.

MS. PERSON: Yes.

MEMBER MITCHELL: I say spillover of other unintended consequences of this dreaded COVID that will effect PEBP -- the PEBP participants as a whole.

CHAIRWOMAN FREED: This is Laura Freed.

I -- yes. Yes to the September reporting. And I think if we don't have an imminent vaccine or vaccine candidate by the end of the calendar year, yeah, I think the Board would be very interested in continuing that as HealthSCOPE sifts through all of these various ways that providers have reported COVID claims to you guys. So thank you.

MS. RICH: This is Laura Rich.

Chair Freed, you bring up a good point. There are vaccines that are going to be a significant cost to the program as well as when that is developed. So that's something that we will need to, you know, track as well.

So, you know, we're hoping that, you know, there will be some federal assistance if it does come out that, you know, that's covered as well, but that's -- that's one of those things that we're looking at and making sure we watch.

CHAIRWOMAN FREED: Okay. Laura Freed again for the record.

Are there questions on the executive officer report? Okay. Hearing none, Board members, Agenda Item Seven has to be deferred because the LCB audit subcommittee that was scheduled for July was preempted by the 31st Special Session. So the PEBP staff does not have much to report to you about the progress of its audit. So we'll skip that, come back to it in September when we probably will have the meeting.

So let's move on to Agenda Item Eight, results to the RFI for actuarial review and benefits management system.

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

Back in January, at the January Board meeting, sorry, the further analysis, this is back when we were thinking about the budget and looking at possible enhancement request and when our fiscal situation was looking much different than it is today.

So there were some things that the Board had

approved to really infer PEBP staff to take back and start looking at and doing further analysis on and two of those were request for information. One was for the actuarial review and another one was for an eligibility and enrollment system.

So this report basically provides an update to the results on that. There's -- you know, this is really for information only because at this point there's very little chances that enhancement units are going to be approved in any budget at this point.

So the actuarial review services was, one of those was a budget enhancement request and it was received from the advocate groups. They wanted an actuarial review of Aon.

So the intent was to provide independent verification of the actuarial services provided by Aon to PEBP. And so in order to have a better understanding of the cost for this type of service we put out an RFI which is a request for information. We received some responses on this. We received responses from Blakely Consulting Group, Diamond Consulting Group and the Segal Group, so three responses.

And basically the cost proposals, the way that we received the cost on this was different for each one, but ultimately the average price overall, the way that they

priced them out overall, it's going to cost the program should we look at this option about $100,000, give or take.

So, again, it's -- this is for information only because this is likely not something that, you know, we have to even the opportunity to request at this point given the different budget scenario that we're in today.

The next one was eligibility and enrollment system, and the reason an RFI was requested for this is because we needed to prepare just in case that the two-year contract extension was -- was not granted or cancelled and that's, in fact, what we did.

I didn't go into a lot of detail on this one, on the results of this one because we have to remember that there is an active solicitation. We have an RFP out on the street and my assumption is that the -- those vendors who responded to the RFI will also be responding to the RFP. So I get this high level to, you know, maintain the present nature and the confidentiality of, you know, the solicitation process right now.

But we received eight responses on this RFI and really because this is an RFI and not an RFP there -- the responses as far as cost went were all over the board and there was -- because it's a very complex system with a lot of variables it's very hard to price unless you have all of the

-- unless the vendor has all of the information in front of them.

So we are expecting higher PMPM fees than what we're paying today but we don't know. This is something that, you know, where the solicitation is out right now. We have actually last night received the second set of questions. I think we're up to close to 100 questions on this, and so I'm excited and I think that this -- this solicitation will be positive for PEBP. But, again, there's not a lot I can divulge at this point as far as what the RFI results were just because I want -- I want to continue to maintain that confidentiality as the -- the RFP process that's out right now.

So in conclusion, things have changed. This pandemic has changed the economic landscape of the state and, you know, there's probably little chance that we can really leverage, especially the actuarial, the actuarial review RFI at this point, but at least we have a better idea of, you know, what the cost was for that.

So with that I will take any questions.

CHAIRWOMAN FREED: This is Laura Freed.

Board members, I'm not hearing anything. So this is an information item only. So without any questions we can just go ahead and move right on to Agenda Item Nine, possible

discussion of plan design changes for FY 2022 and 2023.

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

So each biennium state agencies must build and submit an agency to the Governor's Finance Office by the end of August. Budget request under those review and pretty often new modifications eventually becomes part of the Governor's proposed budget, Gov Rec is what or I'm sorry, Governor's recommended budget or Gov Rec presented in January prior to the start of the legislative session.

So under normal conditions agencies receive a set of instructions and general directives in the spring prior to the August budget submission deadline and that is exactly what happened, but the COVID situation changed everything, right. Now our revenues are different. The state is in a much different situation than we were back in -- in February I believe is when we had this meeting.

So the special session took place earlier this month and focused really solely on resolving the more immediate FY21 budget shortfalls but it hasn't really -- we don't have a lot of direction on the FY22 and '23 budget building.

What we can assume is that there will likely be some sort of cuts, but what we do know is that PEBP was

issued a basically tax to our program back in February and -- and that's really what we're working with.

So what we have decided to do here is we -- what is prompting the changes is that we're faced with a budget constraint, number one, and we don't want this to be worn on the backs of our members. So what we did was we had strategic planning session back in May, and we talked about the goals of the program. So this was staff. It was vendors and several Board members as well and we talked about, you know, one of the problems, issues facing the program and what can -- what we do to make improvements while still adhering to the budget limitations that we have today.

So we took this opportunity to kind of, you know, try to revamp the program. And in addition to everyone that we had participating at the time we had asked feedback from the advocacy groups as well, and we did receive some feedback with, you know, essentially the recommendation or the asks from the advocacy groups.

So what I want to start out with is first talking about all of the different variables that were being stayed and what can change this -- this scenario moving forward. As you know, there's a lot of unknowns right now in the program. So I wanted to just kind of set the stage and say, look, this is what we think is going to happen. We're going to present

some of this information, but there are so many variables that play that we need to, you know, keep in mind that there's -- there's significant changes or significant factors that can change what this looks like by July of next year.

So the first one is contracts. As you know, we have five contracts that are annual, one of those pretty significant. That is the medical network. And if that changes the cost could change dramatically, up or down. We don't know, and so this can definitely effect the outcome and the cost of the program, and, you know, what those -- what the claims cost are going to be. So this is definitely a big variable out there right now.

As you know, as I said, COVID-19, that is a huge unknown right now. We don't know what those costs are going to be. We don't know, you know, if COVID related claims are going to increase, if we're going to be faced with covering vaccines and hospitalizations and et cetera, et cetera. So that's a big unknown right now.

We also have trend. The pandemic will undoubtedly have an impact on trend. So medical carriers right now are anticipating, you'll hear Stephanie talk later about trend and rates and what, you know, what she's expecting.

But, you know, they are anticipating anywhere

from a half percentage to a one percent increase in '21 trend and that's basically because of claim suppression in 2020, right. That last quarter of 2020 we saw a lot of claim suppression. People were not going to the doctor. They were not getting medical services. They were postponing their surgeries and elected surgeries, things like that. So these are all things that can contribute to trend. Now, what is that going to look like a year from now, right. There's a lot of unknowns.

And then we have the state economic conditions. We don't know what the state fiscal situation really looks like at this stage. We don't know what topics and, you know, where -- where the legislature is going to stand come next session when we're talking budgets and what the state can, is able and willing to contribute towards benefits.

This is also something that is, you know, it's big. Right now the state, the employer contribution is anywhere from about 91 to 96 percent of the total premiums, so that's big. If that -- if that contribution is reduced then, you know, we are -- we're faced with some decisions on our side as well.

So that's just kind of level setting things and setting the stage or two. You know, there's a lot variables out there and there's a lot of things that can change, but we

are trying to be proactive and really make plan design changes that improve the program without cost. So this is really what we're working towards when we did this.

So the plan design changes that we are presenting today, the first thing I want to emphasize is we are only presenting the concept. We're -- we -- all of the numbers in there can change and probably will change because we have very premature data at this point. The -- what we need from the Board today is to really approve the concept because we have to build a budget based on that concept.

And so the preliminary plan benefit design that's shown, all those deductibles, co-pays and co-insurance are, you know, they are just there for an example. And in November, when we have more information, we can really start drilling down and looking at those numbers and figuring out what -- you know, where we -- where PEBP as a program stands and what we can -- what we can adjust and what -- you know, and how much we can adjust those levels at that point.

So when we were looking at revamping the program we identified some goals in that process. First we wanted to improve the plan option so that member -- members have more appropriate plan selection. You heard over and over that there's a low deductible. There's a desire for that low deductible. Members want another choice. You know,

sometimes there's -- there's a lot of members that neither of those plans meet their needs. They want something in the middle. So that is something we tried to work towards is how can we develop a third option that meets the needs of members.

The other one is we -- we really wanted to make things more simple for members, and right now the CDHP for a lot of members that really don't understand healthcare, the CDHP is pretty complicated. So when we thought about introducing a middle tier plan design we wanted to make it simple and kind of get away from the whole co-insurance option and really stick to co-pays.

And so that is really, even though there is a deductible in that -- in those middle option, the deductible really only applies for specialty meds. Everything else is a co-pay. So it's a fairly simple option for people to understand. You go to the doctor. You pay a co-pay. You go to a specialist. You pay a co-pay. You go get -- you go get your medication similar to the HMO and EPO. It's based on a co-pay model. So far that was -- those were the two goals that we identified.

The third one, of course, was reducing cost to PEBP. We weren't given a specific reduction. There's -- agencies have not been told this is what your, you know, what

your new target is. We've been given initial temps for a program back this, earlier this year, but we have not been given anymore direction from the Governor's Finance Office. I think at this point they're -- you know, they have been dealing with FY21 matters and are just starting to look at FY22 and '23. Unfortunately for PEBP, we don't have the luxury for waiting around. We must plan well in advance in order to -- to be able to, you know, to roll things out in July.

So what we did was we developed two plan designs. Basically one is at a five percent reduction and the other one is at a ten percent reduction. Both of these ideas get us to the -- the $299,000,000 cap that was identified earlier this year from the Governor's Finance Office for the Public Employees' Benefits Program.

So if you look on page four you'll see the proposed plan design changes. You'll see that we modified the CDHP, the high deductible plan, and really what we did there was we modified it by changing. We increased the deductible and the out-of-pocket max, depending on if you're looking at the five percent or ten percent fee. The deductible of five percent, it goes from 1,500 to 2,000 for an individual and 4,000 for a family, and then if you look at the ten percent it's up to 2,500 and 5,000.

In the five percent bucket there the HSA employer contribution is lower to $500 and in the ten percent there is no HSA contribution.

Now, the modified CDHP is really -- it's for those people who either want to have an HSA and want to contribute to the HSA and really want -- you know, they're healthy. They don't go to the doctor very often. They don't seek services. They are -- they need insurance and they want coverage because they are responsible individuals, but they don't need something that is so -- it's -- they don't need that -- that expensive coverage, right.

So then we have the low deductible PPO with co-pay. This is the new plan that we offered and it's kind of, it's in the middle, right. It's that middle tier option where you do see deductible. But, again, I want to emphasize that the only place that you're using or meeting the deductible is for specialty meds. Everything else is a co-pay.

And the five percent is you're seeing that some of these numbers, again, might change. This is just for -- just to get an idea of what this plan might look like. You're looking at your primary care visit, $30. Your specialty visit, 50. If you go to the ER, $750, right. Your generic meds, $10, formulary, 40, not formulary, 75. It kind

of gives you an idea of where we land in that -- in that co-pay plan.

And then you've got the EPO and HMO. So that was adjusted a little bit as well. We added a deductible to that. Again, that deductible really only applies for that specialty medication here. But the premiums, and I'm actually, I didn't put the premiums in here at the time because we didn't have them, but I had asked Aon to develop maybe what -- what those premiums are going to look like in today's numbers. Again, this is all premature. We don't have a lot of, you know, up-to-date data, but I wanted to provide something to the Board members or to the public so that you can get an idea of, you know, what these plans are going to cost with the information that we have today under the assumption of, you know, our current budget situation.

So in the -- in the report I have that the premiums, obviously the modified CDHP is going to be the least expensive premium. Then you have got that middle tier under the plan is going to be middle option. It's going to be priced between the CDHP and the HMO and EPO and then obviously the EPO and HMO which have the richest benefits are priced the highest.

So I'm going to pause right there because Stephanie from Aon is going to be -- she has some rates

available that she's going to present that stand kind of in a better idea of, you know, what this is going to look like should we, you know, roll this out today. Now, keeping in mind with that disclaimer that things will change between now and the time this is implemented.

So, Stephanie, I'm going to pause right there. Do you -- are you ready to share your screen and present on your -- on the rates?

MS. MESSIER: Yeah, I am. Can you hear me okay?

CHAIRWOMAN FREED: We can hear you.

MS. MESSIER: All right. I'll get my Excel pulled up. All right. Are you able to see it? Perfect. I see Laura Freed nodding. Thank you, Chair Freed. Again, for the record, my name is Stephanie Messier and I'm with Aon.

So as Ms. Rich alluded to, these are very much draft numbers, but we certainly understand it's very hard to talk about plan design changes without really knowing what that might be to employees.

So we have a couple of different scenarios that we wanted to go ahead and show you this morning. The first one I'm going to show is that modified plan design changes, so it's really those middle columns that Ms. Rich just walked you through. It's the five percent plan design change scenario.

Some other key assumptions that are going into the rate building is probably the largest one that's the most impactful and it's a little bit of a risk is that right now I've assumed that PEBP is able to keep medical, pharmacy and dental costs flat in total from where we set the plan rates today for plan year '21 going into plan year '22, definitely more aggressive than you've seen from us in the past, but I'm also trying to be mindful of the fact that when Nevada was coming out of the recession, probably around the time the CDHP plan was implemented, you all did see some pretty serious reductions in terms of utilization of the plan.

Certainly we recognize that when the economy is in a decline or industries are impacted, especially for all of you in Nevada, it can cause a pretty systemic shock to the system. So you may very well see people using the plan less in '21.

Conversely, as we talked about this morning, there's the COVID unknown out there, so a delay in care which as Board Member Mitchell indicated, that could also cause people to become sicker as they have been delaying care for the last three to six months and concerned about going into doctor's office or, again, worrying about maybe their paychecks or their spouse not coming in or currently being laid off or furloughed.

So there could be a bunch of claims reduction that you all see in plan year '21 that start to return in either January of next year or could roll into plan year '22, but there's certainly a chance that either we're also able to make some cost saving measures in terms of not just design changes but things like ESI had brought in the past that save us on pharmacy and those other items where HealthSCOPE Benefits could also find a way to save the plan money for plan year '22. So we did want to get a little bit more aggressive than we have in the past, and that's what you're seeing here in this particular assumption where we're seeing cost remains less for plan year '22 or '23.

And it's possible that you're going to see some claims depression throughout plan year '21. So any kind of trend you see over that, it's going to be incorporated to the fact that I'm going to set the plan year '22 rates at the same level we cut '21. Perhaps '21 was set too high with claims suppression coming in below that. So still giving you maybe a decent footing to start plan year '22, but as we keep alluding to, it's -- there's a lot of unknowns at this point in time.

The other assumption that's going in here is that the State subsidy needs to be kept in total at $299,000,000 which is a five percent decrease from plan year '21, and our

current indication is that the amount remains constant for everyone into plan year '23.

The difficulty there as that we all know medical costs continue to rise year over year. So if the state amount is banked for both plan year '22 and '23, any sort of increase that's out there gets fully pushed onto your employees but, again, that employer dollar is staying static.

The other assumption I've used in these rate builds that you'll notice from the plan year '23 column is I did move it forward with a modified trend rate of about five percent. When blended all of the three different products combined, the medical, dental and pharmacy for five percent. That's still a fairly aggressive number as well. It's possible we'll start to see higher numbers, but I really wanted to be cognizant of the fact that you all just generated excess reserves in the past. So we're getting a little bit more rosy, if you will, in terms of our prediction tier for plan year '22 and '23.

Below in the chart, you may be used to seeing this when we posted it, it shows the total and then the employer and employee. For the ease of trying to do this on the computer screen, I'm instead just showing the employee for the cost.

So currently in plan year '21 employee only on

the CDHP plan are paying about $44 today. Under the new plan design changes where we're shortening the HSA funding to $500 we're increasing the deductible and out-of-pocket maximums, as well as applying a five percent reduction in what the state is providing. That is just a little bit more cost to the employees and the ever so slightly about 50 to 60 cents for the singles. There's a little bit more. Seven dollar change for employee plus spouse.

And dependents are some of the other changes that we're going to get into in Agenda Item Ten. It's a reduction on the family side and a little bit more of an increase on the employee plus child tier, and some of that is the result of the tiering which we can get to later.

Then moving those numbers forward to plan year '23 because, again, there's a trend happening and the leveraging effects occur. The stated portions of those rates stays the same. So the full five percent increase on total medical claims is now put on the employee. So that causes a fairly sizable increase of $30 almost on the single coverage for that CDHP plan up to about $70 on the employee plus family.

Moving to the new co-pay plan, just so you can see the relativities as to where this plan may land in relation to the CDHP plan, it's going to be about a 61 dollar

plan along side of the $44.50 plan on the CDHP. So the benefit here again, members will be able to move to a co-pay structure. So if they have, like myself have kids on the plan and they need to take them into the doctor knowing that, you know, stuff happens during cold and flu season, it's a 30 dollar visit rather than to stay in that CDHP plan you could be paying up to $150 for taking your kid to the doctor on a non-wellness visit.

So we really have found with other states that had really encouraged HSA's and HRA's over the last decade, they are starting to move to a similar design of this new co-pay plan, trying to give employees first dollar protection than they have today when they are on a high deductible plan.

As Ms. Rich alluded to, yes, the deductible is out there but because you have co-pays for the most common services, it really is important to emphasize that this is a co-pay plan, and that's really going to provide also a benefit when people are going to fill their prescriptions. It's a co-pay. It's a set amount. They know what they can expect to pay as they go to get those filled.

So going back to the amounts on the screen here, so $61 for single. 267 for the employee plus spouse, up to about $315 for the employee plus family coverage. And if you look at these amounts it's also important to look over what

people on the EPO and HMO are paying today. Because of the way the plans have been underwritten and the filing that we've kind of seen when we did the blending of the plans and the subsidies that have kind of gotten out of alignment over the past decade, people are paying quite a bit on the EPO and HMO plan.

So what they are trying to restructure and offer three plan designs going forward with some decent separation in terms of the actuarial value the plans are offering to participants, we're also trying to make the shift, if you will, and kind of get everything back to a more actuarial alignment so that people are paying out of their pocket at time of payroll deductions offsetting what they are saving when they go to the doctor on average throughout the year.

So under this new scenario and with all of these assumptions, the plan design '22 premium for the EPO/HMO plan would be in savings of about $30 what those members are paying today. It is still $80 more than the co-pay plan because you're certainly getting a richer than on the EPO and the HMO, but you are still, you know, giving up some additional cost, but you're definitely seeing a savings from what you're paying today.

Even more so when you're covering a family member, family members, excuse me, it's a 508 dollar estimate

right now for the plan year '22 premium versus the 690 that they are paying. Today, of course, as we have that leveraging that occurs in plan year '23 there's a more sizable shift but it's still below the current levels on the EPO and the HMO plan.

Some other exceptions that are important to note is that I have not put any increase in admin fees. Certainly those items are out to bid. You may be paying more so figure that admin system in '22 and '23. Right now I've just kept your admin fees constant for plan year '21 as I move into '22 and '23, another reason why these are certainly not going to be the final amounts that is what you would pay if you move to this structure but definitely directionally this is what you could expect to see.

I think it's important to note, so if we are not so lucky to keep trends flat in '22 over '21, here is what that would look like if we did the five percent plan design change. So you're seeing no longer are you going to get the CDHP for the same price as you're getting it today. It's definitely putting upward pressure because the state subsidy is decreased by five percent. It's leveraging that cost back to the employee sooner than it was on the prior scenario where that leveraging didn't occur until plan year '23.

So you're seeing a 60 dollar cost for a single on

the CDHP plan, a 78 dollar cost to get to the co-pay plan, but you're still saving a little bit of money today on the EPO and HMO plan, but you will pay more than today when you get to plan year '23 of the EPO and the HMO as trend continues to rise, and the state is keeping their contributions flat.

Okay. Moving to the ten percent plan design change, a ten percent plan design change definitely puts you in a better position when it comes to plan year '23 cost because it's accessing the ability to have more of that state subsidy. It's picking up a larger percentage of the cost because the cost had decreased overall by ten percent.

So today you're paying the $44 on CDHP. When you make plan design reductions it brings total cost down by ten percent, but the state subsidy only goes down by five. Now you're getting reverse leveraging and a benefit to our employees, a benefit to an employee so now they make it even less because the State has picked up a larger portion when you drop the entire cost of the ten percent.

So here it goes down to $12 for the CDHP under plan year '22. It would be $34 which is still below what they are paying today on the CDHP for the new co-pay plan and it would be $120 on the EPO/HMO. You still will get that bounce back up in plan year '23 as trends move things

forward, but the state stays flat, but it is pretty darn close to what you're paying today on the CDHP plan.

Once again, this is a rogue year scenario. We're hopeful that trends remain flat for '22 over '21 but if they did not and let's say we saw a little bit of a trend, and currently I'm modeling two and a half percent medical, five percent pharmacy and one and a half on dental to get these numbers, you certainly could see five percent. You could see six percent. It could go higher than this. But, again, I didn't want to be overly the sky is falling, but I'm leaning more on the side of being a little rosy with these numbers.

So here is again a ten percent plan design change but it's assuming a little bit of trend to happen for you all with '22 over '21. Listed at $12 it's 28. It's still a reduction from today. But then conversely, when we push trend forward one more year, again, it gets leverage onto the backs of the employees' share and it becomes a 58 dollar rate on the CDHP plan.

Conversely for the co-pay it could be offered at $50 so a slight increase from today, and then it becomes $82 and you move that forward to plan year '23. And I know that's a lot of numbers so I will stop for any questions.

MS. RICH: Stephanie, this is Laura Rich for the record.

I just have a question. Is there any way that the plan can look at somehow -- look at somehow adjusting the rate so that we can soften the blow in year two and there's not a shock to the system? Is there any way kind to even them out the first and second year in the biennium knowing that this is going to be, you know, an issue?

MS. MESSIER: Yes. For the record Stephanie Messier with Aon. That's a great question.

I think historically that has not been PEBP's path, but I don't think there's anything preventing you from taking a new approach. So I definitely think you've seen the impact of your two-year budget cycle historically, right. You have a good year in the first year.

The second year is set almost three years out in terms of the state subsidy. And so if your plan has a high claimant cost year, if you're no longer able to find those cost saving measures with different products, if you will, that you put into place, you see a really large bounce up for that second year.

So something you might want to consider is knowing that it's going to change by let's say the leveraging because the state subsidy is staying constant, what you could do is try to artificially and really just preemptively increasing plan year '22 by let's say another ten percent on

the employee side.

That means you're going to probably generate a little bit of extra cash at the end of plan year '22, but knowing that you're going to put it only onto the employee portion. So it's really reallocating the state's money knowing that it's going to stay flat for both years. It's charging the employees a little bit more, but you're giving it back to them that second year so that they are not seeing such a large slaying when it comes to their payroll changes.

So for this example you could probably say, let's say I want to hold rates at $40, so charging $12 too much in the first plan year, it's not going to be the full 12 that you'll save on the back end but it will be close. So this maybe would come down to 48 from 40, right. So then you're only changing it by $8 rather than right now it's potentially going to be saying it's 12 which is basically almost double what they pay in plan year '22.

Does that answer your question?

MS. RICH: Yeah, it does. And for the record this is Laura Rich.

I just wanted to add to that. Consistency has been something that the legislature has been continuously monitoring, whether it's consistency on benefits, whether it's consistency on premiums. You know, this is something

that's important, and I feel that it is also important because shocking employees in one way or another, you know, from year to year is just, it's not fair. It doesn't make sense, and it's something that we need to start looking at the program.

MS. MESSIER: Yes, and I absolutely agree. I think especially because you have a biennial budget cycle, it's really not ideal to have to be going back to folks before plan year '23 to say now we have to change your deductible again. It also causes a lot of unknown plan usage when you have plan design changes mid -- mid budget cycle, if you will, and it's definitely unique to the State of Nevada. We have other sates that are doing it annually.

So it's a little bit easier to be able to get that increased money in the second plan year, but it doesn't mean that we can't employ a new strategy going forward that might help soften the blow and as you mentioned create some more stability in what the employees are seeing from one year to the next. At least every two years if you can keep those things constant I think there's definitely an added benefit to doing so.

MEMBER URBAN: Marsha Urban for the record.

These rates show a monthly of premium but when you're looking at the modified CDHP you're also looking at a

drop in the HSA. So in the current one it's $700. Five percent you're down to $500, so that's a 200 dollar loss. And then in the ten percent there's no HSA.

So even though it doesn't -- you know, like how do we look at that that people are paying less but they are losing this money from the HSA, so how do we reflect that so that they know when their rates are going up but their HSA are going down? How do -- how do we show that and actually let them know that there's some support there?

MS. MESSIER: This is Stephanie Messier.

I'm not sure how I can speak to the communication piece. I think probably Laura Rich can speak to that. But in terms of the change in the HSA funding, part of that comes about in terms of its reducing the plan's overall cost. So it's helping them get to a lower paycheck amount because it's slowing down the total cost of the plan and then, again, applying what the state is going to provide. So that way it saves.

If we would go back and put a higher funding in there that will again just go straight to the employees. So it's really the employees would be paying for any additional money above the 500 to get say back to the 700. It gets put all the way back to the paycheck. So it's almost as if you're budgeting from that number for them.

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

You are going to see if we introduce this as a mid level option, the co-pay option, you're going to see a significant portion of those on the CDHP move over to that co-pay option because it works better for them. That's going to be something that, you know, they appreciate and want to -- want to depend on the disability of, you know, the options versus the CDHP and co-insurance and maybe the deductible.

And, you know, the thing you're going to have those, the healthier population doesn't use their benefits very often and they are going to -- you're going to say, you know, this works. This works for me. It's a lower premium. I don't go to the doctor very often. I don't anticipate going to the doctor. And this is -- I'm going to stick to the CDHP. So this just introduces more choice. That -- that second plan, the new plan introduces more choice for members to really fit what options works for them best.

MEMBER URBAN: Marsha Urban for the record.

If you look at the $700 that they would not be receiving of the HSA at a ten percent decrease then that really translates to a little over $58 a month if you -- if you use that as a monthly thing, and it's just -- and then the rates go up to almost $58 -- almost $58 as well. So I just want to make that point.

CHAIRWOMAN FREED: This is Laura Freed for the record. May I ask a question about actuarial value and plan migration?

Looking at the approximately five percent column on page four of the staff report, the modified CDHP has an actuarial value of 80.4 percent. The co-pay or the PPO has an 83 percent value and EPO/HMO has 87.2 percent. These were designed to discourage adverse selection, were they not?

MS. MESSIER: This is Stephanie Messier for the record.

So part of it is we're also trying to give people meaningful choice, not just, you know, throwing plan designs out there to -- to offer more plans, right?

CHAIRWOMAN FREED: Right.

MS. MESSIER: So we're trying to delineate your current offerings, as well as secondarily, you know, help offset some of the savings five percent less.

The other thing that's a little more complicated when you're looking at actuarial values is the one thing to keep in mind is the EPO/HMO plan has a certain actuarial value but also has no out-of-network benefit.

So in terms of what the plan pays it doesn't pay anything when you go out-of-network. So we -- we're trying to stratify back out your rate. We're actually looking at

what is the plan likely to pay based on the design and as well as the mix from in and out-of-network.

CHAIRWOMAN FREED: Okay. Laura Freed again for the record.

Ms. Rich mentioned that she expected a significant number of people to move from the CDHP to the PPO if it's introduced. How much -- what's the definition of significant there?

MS. MESSIER: So for the modeling that I did here, and I don't know if you -- are you able to see row 20 on screen? I know I have a larger screen but I don't know.

CHAIRWOMAN FREED: Yeah.

MS. MESSIER: So here we used it based on our Aon architect model but, again, has world experience and data behind it to kind of say what have people done in the past, how are people behavior, how are they liking to perceive these different plans, and people are very focused on co-pays. Co-pays make people happier. Then they look at deductibles. Then they tend to look at out-of-pocket maximums and then co-insurance is kind of one of the lesser things they look at in terms of plan satisfaction.

So, and I actually just did this with one of my other larger state clients. They offered a co-pay plan for slightly higher cost than their CDHP and they did see about

50 percent movement.

CHAIRMAN FREED: Okay.

MS. MESSIER: At open enrollment in July of this year.

CHAIRWOMAN FREED: Okay.

MS. MESSIER: So that's what I did on the HSA. I do think the HRA folks are a little stickier because when you leave an HSA you still have that mind out there that you can use. But if you would move away from the HRA my understanding is they are not able to take those dollars with them potentially. So they are more likely to stay in the HRA. So I only moved 25 percent of the HRA active into --

CHAIRMAN FREED: Okay.

MS. MESSIER: -- the pay plan and then 85 percent of the HRA retirees I left alone.

CHAIRWOMAN FREED: Okay. Got it. Laura Freed again.

So you just mentioned in sort of ranked order people, participants care about co-pays, number one. Deductibles number two and co-insurance down the list three or four. Okay. Got it.

All right. So with that in mind, on the five percent column and, you know, I'll just -- I'll stipulate here. I mean, under -- under the current plan design PEBP

can't make its $299,000,000 for fiscal year of subsidies limitation cap that GFO has already placed on them. So that's why I'm discussing the minimum cut we can get away with in submitting an HP request budgeted in a month.

So, okay, going back to what I said. Co-pays, I'm comparing co-pays since that top most purchase specifically speaking, there's only about ten -- ten dollar, 20 dollar in some cases, okay, except for outpatient surgery differentiation between the PPO co-pays $3 versus 20 bucks for a primary care, specialty, $50 versus $40 ER visits, there's a differentiation of -- of inpatient. Hospital no difference, a little bit of out patient difference.

So I guess -- I guess my question would be what would be attractive about the EPO of when you have to pay higher premiums for, you know, relatively the same deductibles for the services people most often access.

MS. MESSIER: So when -- sorry. Stephanie Messier for the record.

So what you see there is the second element being deductible. You do have people that are very sensitive to it, whether they recognize the fact that they may not be likely to hit the deductible. They are tied for that.

You also have the group in the south with the HMO that I believe would lose their provider should they move to

the middle plan --

CHAIRWOMAN FREED: Got it.

MS. MESSIER: -- and I think that would be where they are going to be very sticky.

CHAIRWOMAN FREED: Okay. Got it. Thank you.

MS. MESSIER: Uh-huh.

CHAIRWOMAN FREED: Board members, I'm not hearing. Are we all stunned by the amount of information being presented today. I'm not hearing a lot.

MEMBER VERDUCCI: This is Tom Verducci for the record.

You know, just a couple of thoughts here. I know we're in the conceptual phase here, but it would really be nice to see the column in the middle plan complete so we can use it as a gauge in the future in terms of what the premiums would be today as opposed to the five and the ten percent. I think we heard that from one of the advocacy groups earlier.

But also I did want to ask do these changes we're looking at in terms of the rates, do these incorporate the recommended policy changes that we see in Item Ten or how would that effect these rates?

MS. MESSIER: This is Stephanie Messier for the record.

So my brain is best to remember your last

question and I may forget your first. So in terms of your last question, yes, this does include all of these changes. I will say that the majority of them are really housekeeping and getting you to actuarial standards that are more widely adopted I would say. So when it comes to like the admin fee there's no dollar impact to moving to the new recommended method of PEPM versus the way it was being tiered out and being applied today.

There is a little bit of an impact in terms of this curing, not much of it, and a lot of it is just kind of housekeeping cleanup items I would say, the majority of items in number ten.

The other thing you're seeing in terms of a benefit in Agenda Item Ten is the pooling of your experience on the self-funded plan. That is why you're seeing a reduction on the EPO and HMO plan. It's -- it's modifying everybody's claim experience into one group similarly to what you do with actives and retirees today. So you have everybody in the one group together. We all recognize that folks as they get older tend to need more services and definitely utilize more services, but you're underwriting everyone in a pool together so that's really what is being included here.

In terms of a total net net impact, it's really

kind of shifting money around in terms of the risk pool but it's to the benefit of the EPO/HMO kind of brining them in line. And then the Southern HMO is no longer being so heavily negatively impacted by being blended with the EPO's experience. So that's kind of a positive that you're getting from Agenda Item Ten.

And then your first question, oh, was showing that middle column. So for today's rate because you weren't offering the co-pay plan today that's why that column in the previous spreadsheet was showing NA's. But if I go to, for plan year '22 rates and I take out the five percent plan design savings and I put back the HSA contributions more closely to what they are today, as well as setting the state subsidy back to not being a five percent decrease, this is what those premiums would look like if you look at the gray columns. So it still would be going up if we did absolutely nothing.

If you were able to still get five percent more in terms of the state subsidy amount tomorrow that you're getting today and you didn't make any plan design changes and there's no trend this is the rates that you would be seeing, so $55. The co-pay plan would actually be cheaper because of the high level of HSA funding, this plan would now become a richer plan than the co-pay PPO. So you would be able to

offer the co-pay PPO above a 36 dollar rate and then the EPO plan would be about $112.

If you actually saw a trend in plan year '22, we'll change that real fast. You can see here how impactful trend is when you keep the state dollar amount the same, and this is again assuming the state is not going to cut your budget by five percent. The co-pay plan is $68 which is still higher than the 40 some dollars that the CDHP hopes to pay today but tomorrow the CDHP folks would have to pay $85. So if the PEBP Board did not want to make a five percent plan design cut and was still lucky enough to get five percent more from the state than is currently being communicated, you would still see an increase on the CDHP plan, pretty sizable. That's more than double than today's rate. So I guess it's a little more than double.

MEMBER VERDUCCI: Just as a follow-up. During the strategic planning session we initially had a deductible or excuse me, out-of-out pocket of the 10,000 that we discussed, what it would look like if we changed that to 9,000 and it did not seem like it was a real huge impact on those numbers. Would it be possible when these are presented again perhaps to take a look at the out-of-pocket maximum of ten down to nine or could you bring it up here?

MS. MESSIER: I don't have the actual value model

up. You're right. It is less because if you think about the terms of the total percent of your population that hit their out-of-pocket max, and I'm not sure if Mary Catherine or Laura can correct me here, but I know it's less than five percent if I'm not mistaken, and I think it's even less than we're going to have.

So a very small percentage of your population that hits that out-of-pocket maximum from one year to the next, so one of the other things at the strategic planning session that we talked about is we're trying to keep people's total liability the same regardless of which plan they pick, trying to really help protect the members. We don't want them to inadvertently pick the cheapest plan but not realize that should they have a catastrophic event, you know, that it could be a 15,000 dollar, for example, out-of-pocket maximum as seen on some other plans. So we're trying to be mindful of the fact that we have cuts to make and trying to be fair and equitable where we could.

MEMBER VERDUCCI: Okay. The only reason I'm pointing this out is we did hear public testimony from UNLV, Dr. Douglas Unger and, you know, it was a disturbing story of somebody sleeping in their car and the human aspects of individuals going from day-to-day expenses and dealing with pay cuts and furloughs, and it seems to me that there should

be some motivation for the individual that's not really using their health insurance to save where they can in terms of out-of-pocket maximums and deductibles if it's not a huge impact of the program. Just going forward I would like to see some choices as we get closer.

MS. MESSIER: This is Stephanie Messier.

We certainly appreciate that, and we understand the human element behind these numbers. But as you might imagine, the -- the biggest levers PEBP has to pull when they are looking for a five percent plan design change, the ones that are most impactful really are your deductible, your co-insurance and then your out-of-pocket maximum, and that was definitely one of the places I wanted to touch last with the out-of-pocket maximum. But in order to get to the five and to the ten those were numbers that we definitely unfortunately had to change but certainly options that we can bring back and tender.

MEMBER VERDUCCI: Thank you.

CHAIRWOMAN FREED: Okay. This is a Laura Freed.

Board members, as I said, the budget is due in a little bit over a month. And so obviously these are -- these rates and share amounts are pretty rough and we don't know how trend might effect them. So I hope we don't hyper-focus on that right now and we talk fundamentally about plan

design.

So I'm going to throw it out to the Board. Do you want to instruct PEBP staff to submit an agency request budget in a month that contains a PPO middle tier option in order to give participants more plan choices?

MEMBER KRUPP: This is Jennifer Krupp. I just wanted to ask one more question.

CHAIRWOMAN FREED: Sure.

MEMBER KRUPP: Looking at the middle tier with the new low deductible PPO with co-pay, I just wanted to ask you are the -- the co-pays for the clinic here and special, are those expenses paid by members included in the deductible or would those be separate?

MS. MESSIER: This is Stephanie Messier.

We currently have them going toward the deductible.

MEMBER KRUPP: Thank you.

CHAIRWOMAN FREED: This is Laura Freed again.

So I want to say that I appreciate very much the strategic planning session that we had earlier, and I appreciate so much the PEBP staff and Aon's work in developing this scenario. I personally like the middle option of a PPO plan because those of us who are long time state employees, and I think there's a lot of us, a lot of

folks listening, remember that world before the CDHP was implemented in 2012, and it's a familiar world to participants.

And we've been asked as a Board, while I've been on the Board and numerous years previous, to provide more choice. So this provides more choice, maintains the Southern HMO, who I know are the Las Vegas employees and retirees like HPN and allows those who aren't high consumer medical cost to pay low premiums or low participant share, lower and continue to accrue tax-free funds in a health savings account if they qualify for that.

So I support this and I would like to hear what other Board members think.

MEMBER KRUPP: This is Jennifer Krupp.

I agree, Laura, that this is a good option, and I do appreciate having additional options. I'm currently, just for disclosure purposes, but I currently am on the CDHP program, but my children actually are on my husband's health insurance because, you know, he has an HMO. It's easier when you have to train better for costs and stuff like that.

So the option that we're offering seems middle ground, potentially offering, some of these costs are a little more fixed, such as if your kid gets sick and you have to take them into the doctor, now if it's a 30 dollar co-pay

will be really really helpful to a lot of our members, particularly on a lot of our working moms who do have families. So I'm in support of this as well.

CHAIRWOMAN FREED: Thank you.

Go ahead, Mr. Verducci.

MEMBER VERDUCCI: Yeah, Tom Verducci for the record.

I just want to provide some input in terms of my thoughts here. I do think the middle plan here is very good. It's something that's been asked for. I'm very pleased we're looking into it. The dental buy up looks very interesting I think we need to continue to look at our financials. And as this comes up in future meetings I would like to see some choices in terms of pricing that's affordable.

We have a lot of unknown variables with COVID going on right now. So far there hasn't been huge COVID expenses. I think that, you know, going forward this is something that I think would benefit the membership, and I think it's something that we should go forward with.

CHAIRWOMAN FREED: Okay. All right. So I think how I would like to structure this. Sorry. Laura Freed for the record.

Is an up, down kind of a vote on, include in the budget, a budget that accounts for the PPO middle option,

that's number one. And number two, talking about the five and ten percent reduction. So I'm not hearing a lot of Board member consternation about submitting a budget that includes the PPO option. So I would be happy to accept a motion to -- that instructs the PEBP staff to build such a budget.

VICE CHAIR FOX: Linda Fox for the record. I would make that motion.

CHAIRWOMAN FREED: Okay. Thank you.

Do I have a second?

MEMBER KRUPP: This is Jennifer Krupp. I'll second.

CHAIRWOMAN FREED: Great. Thank you.

Members, I think I'll do this one by voice vote because I don't -- I don't know that I would need a role call on this one. So all in favor raise your hand or say aye.

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

CHAIRWOMAN FREED: Okay. Thank you. Any opposed nay. Okay. Action passes unanimously.

Okay. So we will go to PEBP staff. With Aon's assistance we'll build a budget for a submission to the GFO in August 31st that includes the accounts for a PPO middle tier option.

Now, moving to the five and ten percent, the

executive officer did a fine job explaining the concept of budget caps which those of us in the agencies all -- all have from the GFO. It was actually released March 19th, that all agency memo. So that was everybody who was in the middle of COVID response at that point. So that agency memo really slipped by a lot of us and we had to go back and look at it.

So the PEBP cap on the total amount of subsidies for the combined biennium of '22 and '23 is 598,174,098. Otherwise known as about $299,000,000 in subsidy dollars per fiscal year. And I asked PEBP staff, and I want to note, by the way, that does not include caseload adjustments. So if there were increases associated with enrollment growth that would be excluded from that cap and trend would be excluded from that cap.

However, having said that, I discussed with PEBP staff could we get there? Could we submit a request tier budget under the current scenario and get under that 299,000,000 in subsidies per year, and the answer is no. It's a resounding no. And you can see that if you go back to the current year expenditures in the financial officer's report. So I kind of thought I knew the answer, but I thought I would have to ask it because I knew the Board would be interested in that.

So all -- I'm sorry. Laura Rich has something to

say.

MS. RICH: Can I just interrupt you on that?

CHAIRWOMAN FREED: You may.

MS. RICH: And given the current benefit structure, now we could if we adjust the benefits but that would be a much different conversation, right. So we would have to adjust the, you know, the deductibles and the co-pays and the -- so it -- we could do it just with additional reductions to benefit levels.

CHAIRWOMAN FREED: Okay. Thank you. Laura Freed again. Okay. Thank you for the clarification.

But that -- that itself represents a plan design change much like what we are talking about here. You know -- you know, to Mr. Verducci's comment about deductibles and out-of-pocket max, could we -- could we submit something without changing any of that? No, okay.

So knowing that, members, I want to suggest that we get away with submitting the smallest cut we can get away with to get under the mandated cap, and I think I heard Ms. Rich say that this approximately five percent column gets us under that cap; is that correct?

MS. RICH: For the record Laura Rich.

I believe it's correct but I would --

CHAIRWOMAN FREED: Okay.

MS. RICH: -- want Stephanie from Aon to confirm.

CHAIRWOMAN FREED: Okay.

MS. MESSIER: It was taking me to get off. Sorry. Stephanie Messier.

So, yes, it's just as a matter of how much then to leverage to employees.

CHAIRWOMAN FREED: Okay. All right. So since the Board makes policy decisions we need to -- the way I see the policy choice is in order not to get, you know, not for -- for the PEBP staff to get punished by the Governor's Finance Office for bailing out on their cap, we need to submit an HC request budget predicated on that five percent column.

However, we all know, I think Ms. Rich has indicated that the GFO will evaluate the economic forum. The economic forum happens in December, as you all know. They will be looking at revenue projections all through the fall. So they may decide to say, PEBP, you need to consult your subsidies more.

So do we as a Board want to have that ten percent in our back pocket to give to GFO or not knowing that the risk we run is that the GFO may decide to make cuts themselves some time in the late fall, and the Board and PEBP staff might not like that. So I'm going to throw that policy

question out to the Board.

MEMBER URBAN: Marsha Urban for the record.

Things have been moving so quickly and so many times there's no real specific comment on it. So it's a done deal that they're going to -- that the State in the '22 is going to be looking for cuts from PEBP. I just want to verify that, right.

CHAIRWOMAN FREED: This is Laura Freed.

Laura Rich, do you want to field that?

MS. RICH: Sure. This is Laura Rich.

As far as we know that is -- that is the only direction that we have been given to this point and so, you know, given the caveat that, you know, there's been a lot that has been going on between the time that the direction was given to the time, to today and the pandemic and all of the fiscal situations that have occurred after the fact, we have not received any other indication or any other direction but that is -- that is the only thing we have to work with at this time.

CHAIRWOMAN FREED: This is Laura Freed.

To that I would add, you know, for my perspective as a department head myself coping with my own cap and my own possibility of additional cuts, to answer Member Ervin's question the best way I know how, the cap is a done deal.

Additional cuts beyond that are not necessarily a done deal. However, the -- in my experience the GFO makes these kinds of calls fairly last minute. So that leads to my question to the Board, do we want to have additional reductions in our back pocket that we're satisfied with or do we want to say no, we aren't going to do that and risk that they are going to go, you know, that's enough. We've taken enough out of PEBP.

MEMBER VERDUCCI: Tom Verducci for the record.

So I think the big question here is how it's going to impact the premiums and the cost for employees, and I always feel it's my responsibility that especially, you know, we're going through a pandemic to try to submit the request that's going to have the least financial impact on the employee that's within, you know, budgetary constraints, and I don't think we should be asking for bigger cuts that might not be on the horizon.

CHAIRWOMAN FREED: Okay.

MEMBER MITCHELL: Jet Mitchell for the record.

I have consternation about five percent and three percent because I am very aware and hear the advocates and the constituents discuss their personal stories and those reign very true and very saddened and burdened by those stories and overlaying the fact that we're in a current

pandemic.

Having said that, I think it does make sense fiscally to submit the five percent and have that align with the additional ten percent information not to say that we're expecting that as of -- as an alternative proposal in the cuts or changes on PEBP's terms, not on other terms. But I do have consternation about five percent. I do have consternation with ten percent.

But I think with the current climate I believe at least five percent seems like it will happen. I hope I'm wrong. I hope ten percent doesn't but in the free fall state that the state is in now ten percent is not realistic or more, and I would hate not present something that has already been articulated or false that out that's on PEBP's terms as on other terms.

So I do have high, high levels of heartburn and consternation and don't want a five percent order drastically ten percent, but I'm also aware of Stephanie's comments that constituents are very concerned with co-payment, out-of-pocket maximums, deductibles. Those things are incredibly near and dear to so many that I think making that smoothing effort, I think that that makes sense to make it as smooth as possible that although we're all in pain to keep the pain as consistent as possible.

So I like the idea of the middle, of the middle option premium, as discussed, and I like the idea of presenting five percent. I agree with Tom Verducci that we don't want to tell anyone that we want the ten percent, but I also think not having that information may make it appear that it wasn't thought through. So it's the way to communicate it was already thought through and articulated I think that may help.

CHAIRWOMAN FREED: This is Laura Freed.

I could not agree more with those comments, but I will say that GFO is watching this meeting. The cat's out of the bag already.

MEMBER VERDUCCI: Tom Verducci for the record.

You know, sometimes you give people the choice. You throw out five percent, ten percent, and they look at the ten percent and they say that works better in our budget. I like the idea of just submitting it at five percent, and if the financial condition in front of us gets worse then ten percent could be looked at later.

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

I think I'm hearing a consensus for -- for direction to PEBP staff that the Board seems to want to go ahead and, yep, submit with the five percent based on --

roughly based on this kind of plan design, knowing that trend is up in the air, you know. And then, you know, if GFO comes back to Laura Rich and Cari Eaton and says, no, we need more, they will kind of know what to do with that rather than leaving it to folks who might be less familiar with the contours of the plan.

MEMBER MITCHELL: Jet Mitchell for the record.

I don't know if there's a way that Laura -- Laura Rich and/or others at PEBP could include verbiage or Cari Eaton or as appropriate that says that five percent, ten percent is not what we want. It's not what we want to do. I prefer to put a footnote like you're killing us, some drastic, very strong language that I know our advocates are also being very vocal and that's appreciated to say this definitely has impact. These decisions are not being made in a vacuum, and these weigh heavily on all of us.

So I don't know if there's a way to put in the asterisk that says you're killing us and to -- to somehow articulate the level of pain and the level of consternation that it may be causing across the board.

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

Jet, I fully plan on having discussions with the Governor's Office, with the Governor's Finance Office and ensuring that everyone understands the effects of, you know,

these decisions that we're making and where the program is going and what member -- how members will be effected in the upcoming biennium based on this budget.

CHAIRWOMAN FREED: This is Laura Freed.

Okay. So I think I would accept a motion based on the consensus I'm hearing merge from the Board to submit an agency request budget, that PEBP submit an agency request budget that comports to the approximate five percent reduction reflected in Agenda Item Nine.

VICE CHAIR FOX: Linda Fox for the record. I'll make that motion.

CHAIRWOMAN FREED: Okay. Do I hear a second?

MEMBER VERDUCCI: Tom Verducci for the record. I'd go ahead and second that motion.

CHAIRWOMAN FREED: Thank you, Mr. Verducci.

All in favor signify by saying aye or waving on your video screen.

MEMBER KRUPP: Jennifer Krupp, aye.

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

CHAIRWOMAN FREED: Jennifer, thank you so much. You're coming in late when I try to talk over you. Sorry about that.

Any opposed nay. Okay. Motion carries.

And with that, you know, I feel sure that the PEBP staff will bring back at the September Board meeting both the submission for AC request, as well what that looks like in plan design terms. So I -- you know, the members will not be kept in the dark about what that means both in budgetary terms and what it means in plan design and hypothetical rate terms, so.

With that we're going to move on to Agenda Item Ten, discussion of possible actions of policy changes for plan year 2022. And I just want to note for Board members who have been easily at hand I would suggest pulling out your duties, policies and procedures document because this -- this staff report pertains to a number of the things that are articulated in policies and procedures that would change. So with that I'll turn it over to PEBP staff.

MS. RICH: For the record Laura Rich.

And just to add on what Chair Freed said, discussion with her, I don't think it was clear. Typically what we do with these policy decisions is the Board makes -- the decisions are presented. The Board makes the decisions and then PEBP staff comes back at a future meeting with the red line version of -- of the new policies and procedures and the Board approves that as well. So that's typically the process in that in what we will do in moving forward as well.

So this really piggybacks on, again, the, out of the May strategic planning meeting that we had regarding, you know, where the program is at and what kind of policy changes can we make or should the program make to, you know, to improve the program.

And what it really boiled down to is that historically PEBP has used a lot of calculations and processes that are outside of the norm of those -- of normal actuarial standards. And so what we've done is, you know, little by little we kind of baby step away by using, we employ an actuary to do the actuarial analysis of our program. Yet little by little we kind of baby stepped away from using those actuarial standards and doing our own calculations.

And the -- the analogy I used for this was, it's kind of like asking your CPA to do your taxes for you but then telling them to ignore certain tax laws or to change the tax laws so it works for you and submit your taxes based on that, right.

So it's kind of like the same thing we're doing within our program where we're asking actuaries to do their job, yet little by little change what they do. So it's no longer an actuarial sound decision, and I think some of these decisions that we're presenting today will improve the

program. It's going to make -- it's going to clean up the projections and things like that, and it's going to just make the program make better and sound decisions than what we're doing and there's going to be more consistency and -- and just overall better projections for the program.

So I'm going to go over some of these. I have Stephanie from Aon also here to go into more detail on some of these -- some of these policies that we're presenting because I know some of it is -- they are pretty complex. I think when you get down to it it's not as complicated as it sounds, but she will go through and maybe, you know, give the -- give the details that a non-actuary like me can give.

So the first one is underwriting the self-funded plan is one report. The idea here is that the PEBP plan, the self-funded PEBP plan, so in this situation it would be the EPO, the CDC and that new plan, the new middle level co-pay plan to, they are -- basically a PEBP member is a PEBP member and a PEBP claim is a PEBP claim. It doesn't matter to us as the program what -- what plan they are in or it shouldn't matter what plan they are in.

And so today the way that we currently do it is we look at each of those plans separately and and they are looked at -- they are -- they are looked at as separate risk pool. And this policy is basically saying, you know, maybe

we should look at underwriting all three of them together and let me explain -- let me give an example as to why that benefits the program.

So let's say you have a member, a high cost member who's -- you know, let's say they have cost the program, they are on the CDHP and they have incurred $7,000,000 worth of claim. That's a very significant cost to Board member. And so that member is on a CDHP and we ask Aon to go through and they price the plan out every year, right. We get the rates and they price that plan, that experience, that $7,000,000 in experience is -- it's going to be taken into account when they price that CDHP.

However, that member at open enrollment decides to change and goes to the EPO, and so we've got the -- we've got the CDHP priced according to that member's experience so that member goes to another claim.

And so the next year what happens is we raise those rates accordingly for the EPO and then the CDHP rates go down. They are reduced because those high cost claims are no longer in that bucket. And so you're -- right now we have this inconsistency between plans because we're rating them separately.

The reality is a PEBP member is a PEBP member is a PEBP member. We are responsible for paying that claim

regardless so we shouldn't care where these members go. In order to better stabilize the rates and better stabilize, you know, they get that consistency within all of the plans, we neutralize that movement in the migration and their high cost claims by looking at them all as one single risk pool but they are separate.

So I'm going to stop. I'm going to do these one by one because I think it's easier just to discuss all of them, you know, separately, but I'm going to give Stephanie the opportunity to kind of go in and maybe add to -- add to what I just said.

MS. MESSIER: Thanks. This is Stephanie Messier of Aon. And Laura Rich did a good job of explaining this concept.

The other thing I think I alluded to a little bit when we were on Agenda Item Nine is this is very similar to the methodology you're employing today when it comes to rating your actives versus your retirees. The insurance, you are pulling these risks together. You do not want to adversely price for the retiree, even though we all know they most likely are costing the plan more.

We are consciously pulling those groups of folks together today, and this is just a continuation on that policy. It becomes even more important when you move to

three different plans. The migration, again, at that one high cost member going from the co-pay plan to the EPO to the CDHP, now they have three different plans to choose from and go back and forth between. But, again, if they're a self-insured member they are PEBP's responsibility. So it shouldn't really matter to PEBP which plan that they are in. And so it really does, as Ms. Rich alluded to, increase the stability in your underwriting if you're underwriting all of your self-funded participants together, moving them forward with trend and then parsing those rates back out based on an average expectation of what the plan pays based on the plan design for those three different plans. That way it no longer matters which plan that member selects at open enrollment.

We priced appropriately for your total claims and aggregate and we parsed back out the cost of the plan in terms of rates based upon the average design with which each of those different plans are representing.

MEMBER MITCHELL: Jet Mitchell for the record.

Question for Stephanie. Is it fair to -- is it a fair assessment to say that a self-funded plan being underwritten as one risk pool, is that, is considered best practice for -- from an actuarial standpoint and doing it, and the other way is not best practice in allocating many

different buckets of tools is not actuarial best practice. Would that be a fair assessment?

MS. MESSIER: Stephanie Messier for the record.

That's fair. As you know, the layer of large number is definitely in play here. So the more you have a large group together the more stability that provides to your rates. So that's why it's considered the preferred approach because you're enhancing your credibility of that plan by leaving all of those folks combined. The more you separate it out and when you move to three different designs, it decreases which means the volatility increases.

So as actuaries we're -- you know, we're looking for ways to minimize that. So the more typical approach is to do one pool of underwriting, considering it of all of your risks and then separate out the plans by, again, their designs in terms of what the people are expected to use based on co-pays and deductibles and those sorts of things.

MS. RICH: Any other questions on this?

Okay. So moving on to the second policy which is the contribution strategy. So back in the day when the CDHP was originally introduced the intent was to price the HMO and the CDHP plan so that the total out-of-pocket expenses so that the co-pays, they were equivalent. Over the past decade this has not been maintained. We've, again, baby stepped our

way into really preferring one plan over the other. And today those HMO rates are -- are quite higher than they really should be.

The HMO participants are receiving a much less -- much less of the contribution than CDHP. So we're essentially preferring one plan over the other when the reality should be that we should be -- we should be agnostic to the plan choices. All of our plans, all of our self-funded plans are responsibility at PEBP and so it doesn't -- it shouldn't matter what a member chooses.

The way that we apply the contribution is really by a series of percentages and we can mess with the percentages up and down, reduce them, increase them and really, you know, we worked ourselves to that situation where now we are preferring one plan over the other in pricing things out. So that one plan is richer than the other, and really you're taking out the whole actuarial value of what Aon is doing when they develop those plans.

And so this contribution strategy is basically recommending that we apply a flat dollar amount that is consistent across all plans. So for example, you know, if a plan is -- let's say a plan is 900 -- one plan is $900 and the other plan is $1,000 and the state is contributing 700, the employee is paying that differential. We're giving $700

regardless of what plan they are choosing. They are paying the difference of those plans because they are getting richer benefits. If they pay that extra, you know, $300 versus the $200 they are getting a richer benefit.

And so under the strategy PEBP budget projections just become more stable, and it's no longer dependent on trying to guess where the members are going to land. If they are going to be in one plan or the other, and so it eliminates that variable when we're trying to project, you know, for our budgets and -- and just, you know, everything, whether it's enrollment, whether it's, you know, enrollment in each plan or, you know, the budget, any kind of projections that we're making.

So, Stephanie, I don't know if you want to add onto this. I know there are some questions regarding tiers and how all of that would be applied. So maybe you can go into a little bit more detail on -- on the tiers.

MS. MESSIER: Sure. So once again Stephanie Messier for the record.

So Ms. Rich has done a great job of explaining this concept as well. The other thing that this one kind of dovetails on the prior one is that it really has created a duck pile with today's practices in that EPO and HMO plan. And perhaps at the time when both of them were fully insured,

you're really making it a non-viable option for the long term where as we all know the south does a good job of managing your cost.

So it's been an unfortunate side effect of what has happened with the plan rates over time. So today for example, PEBP I believe saves $100 every time somebody moves out of the HMO or EPO plan just because of the way the contributions are priced today.

So, again, as Ms. Rich alluded to going forward, there's a lot more stability in budget setting when PEBP is giving $100 if you're in the HMO, if you're in the co-pay, if you're in the CDHP, you know, that for any single that they are covering it's $700.

Now, there is still some volatility in terms of the tiers, but what we are proposing is when we move to just tiering one different place, we're applying the same tier ratio when we do the subsidies strategy.

So in Ms. Rich's example, so we know under the 299,000,000 dollar cap, let me switch over to my spreadsheet real quick. The state is essentially paying an aggregate of about $735 per person but that is a mix of the different tiers. So within that tier we can set PEBP's contribution strategy to apply the exact same tiers that we're using to set the rates, but today they give a little bit less to

dependents. We can still do that going forward, but it's the same adjustment on each of the different tiers.

So, again, that way I think we all saw it with I believe it was an April Board meeting when we were then trying to reallocate the money in terms of the increase folks are seeing among the different plans and that's one of the instances in which we've gotten really sort of topsy-turvy in terms of actuarial practice and what it means to the members at the end of the day. This supplies a lot more stability on a go forward basis. And if it would help, I could bring up this spreadsheet. You could visually see the contributions from the state at the different levels. I think Chair Freed is nodding her head so I'm going to go ahead and do that for you all.

Any questions as I bring it up? Can everyone see my screen? Okay. So I realize there's a lot of numbers here, but I want to draw your attention to these boxes starting in row 14 and in column C. So here we have the different rates for three different plans in column C, G and K and those are differentiated by the value that the people are getting in terms of the richness of the plan design.

Here you'll see the state subsidy amount being applied, and you'll notice it's the exact same dollar to the penny for a single person. So, again, here's what we were

talking about. The state no longer will pay a different amount based on which plan you pick. It's going to give you $587. It doesn't matter which plan you're on. If you're covering a spouse it's giving you $1,000. If you're covering a child it's giving you 733. If you're giving a family member it's about $1,200.

In order to try to equalize the percentages by the dependent subsidy amount to be similar to what we had today so we're not making too many changes and really getting illogical results, I'm applying about 85 percent adjustment onto the tier ratio, but I don't want to get too technical here because I know there are some folks in terms of creating a state subsidy.

But the important point to note here is the subsidy is the same, again, across whichever plan you're picking. You will note today when we set rates we do spouse are two times what an employee is, and you have the X plus Y for child. So for children it's a .4 factor. They're 40 percent of the cost of an adult. Family is 2.4, but when you all apply subsidies, you get a little bit less because, again, PEBP is focusing on giving money to the employees, right, because they are the ones being employed by PEBP.

You're getting a little bit different then those tiers when it comes to a subsidy amount. Although, here it's

not quite two times the state subsidy of a single, but it's still a very good subsidy amount, similar to what you offer today but, again, it's still applying consistency. There is transparency on how these rates are being set, and there's no longer this exercise of we need to apply different tiers, subsidy percentages in order to try to get a more equitable, if you will, false equitable changes in terms of a renewal from one year to the next. It's cleaner. There's better accountability, better transparency in this process moving forward.

CHAIRWOMAN FREED: This is Laura Freed.

Just to solidify this in my brain. It is a -- you're suggesting here a flat contribution by plan but not by tier --

MS. MESSIER: Correct.

CHAIRWOMAN FREED: -- in other words. Okay. So and we would get -- and so would we also then change the dependent subsidy formula that's been produced and approved by the Board or is that not -- or is that okay actuarially?

MS. MESSIER: Good question. Stephanie Messier for the record.

It's okay because when we get to the subsidy part there really is no actuarial practice. It's very much specific client by client. Some clients actually want people

to go into a certain plan. So they give more money to the plan. However giving your public entity and the other issues of budgeting and all of those things, it's certainly more advantageous and more common to see a flat amount regardless of what plan they pick, and it's very typical to have different amounts based on which tier you're in.

If you imagine the state only getting $735, this plan has been three. This plan is three. Basically, you then have three for single but if you're a single parent on the plan, you're now paying, you know, much more going forward than you would be or if you have a spouse who is unable to work. Out-of-pocket you would be paying over $700 a month, and as you might imagine the employees and the hardships that would cause it's not ideal. So we don't typically see a flat amount by tier. It is usually tier to have increasing subsidies as you get higher in coverage.

CHAIRWOMAN FREED: Okay. Flat amount by plan but subsidies. So it gets away from the subsidy percentage discussions from a participant only standpoint but not from the other coverage tier standpoint. I'm mostly saying this to -- again, saying it out loud so I get it cemented in my head.

MS. MESSIER: Yes.

CHAIRWOMAN FREED: Okay. Okay.

MEMBER URBAN: Marsha Urban for the record.

I'm trying to get this in my head as well. So this is what we do with the money after we get it from the state; is that correct?

MS. MESSIER: Yes. This is Stephanie Messier.

You are correct. So you'll notice here this number. This number is what you're getting from the state, the 736 figure. When you roll that all up and apply it by the enrollment you get to $299,000,000 we've been discussing earlier today. So it's really a matter of how you're allocating that across the tiers. So for example if you wanted to only give 50 percent of the amount to dependents it would change the amount that gets supplied across these different amounts, and so it's giving less money to these other tiers.

MEMBER URBAN: Marsha Urban for the record. Okay Marsha Urban for the record.

Does that mean we get X amount of dollars from the state. This is how we're going to lay it out and what the proposal is and make it an even rather than changing it percentage by percentage for each group.

MS. MESSIER: That is correct.

MEMBER URBAN: Okay. I'm just trying to make it straight in my head.

MS. MESSIER: And so today what you would see in these columns would be a 550 figure here. And then on the HMO it's getting $650. So then you might imagine if you have 20 percent swing in enrollment at open enrollment you're going to have a hard time hitting the state budget because now you are giving $100 more for those folks enrolled in the HMO and vice-versa, and so that is where I think you've also seen a lot of volatility in terms of your excess cash over the years is because of that movement and because the state currently, the way the rates are set, it's giving very significantly different amounts from one plan to the next.

MEMBER VERDUCCI: Tom Verducci for the record.

I just want to point out that I'm very supportive of this. I think that wherever we can even out what's being paid, applied to the members' account is going to be -- it's going to get rid of discrimination between plans, and I do think the concept of it is -- it's a very good concept and I'm very supportive of it.

MS. RICH: Anymore questions?

MEMBER URBAN: Marsha Urban for the record.

Yes. I think giving people the same amount, employees the same amount is much better than playing around with different percentages. I have just seen so many numbers today I'm like -- I'm ready for a nap.

CHAIRWOMAN FREED: This is Laura Freed.

This is actually a good -- Member Urban raises a good point. We've been at this for over three hours. Does the Board want to take a brief break?

MEMBER BAILEY: No.

CHAIRWOMAN FREED: Oh, okay.

MEMBER BAILEY: No.

CHAIRWOMAN FREED: Okay.

MEMBER BAILEY: Let's get it done.

CHAIRWOMAN FREED: All right.

MEMBER BAILEY: Let's get it done.

CHAIRWOMAN FREED: Okay. Let's power through.

MEMBER URBAN: I agree.

MS. RICH: Chair Freed, I actually had one Board member text me and ask, I didn't see the text in time, but it sounded like there was a request for a break.

MEMBER KRUPP: Oh, I just snuck away for a few second so we're fine.

CHAIRWOMAN FREED: Okay.

MEMBER KRUPP: Jennifer Krupp for the record.

CHAIRWOMAN FREED: I'm sorry. You guys, the Board, members or PEBP staff, if you need to take a break please just, you know, throw something at me, text wise or in chat or whatever.

MS. RICH: Okay. So moving on to the next one, it is the HSA and HRA funding by dependent count. You know, first of all, I want to say that we may not actually be in a fortunate enough position to even consider HSA and HRA funding this year. There's no promises on that, but at the same time it's still something that we need to look at as a, kind of a house cleaning or housekeeping, cleaning up effort in terms of projections and kind of making everything more accessible for the program.

And so in this one what we are proposing here is that right now we fund -- we fund the HSA and HRA contributions based on dependents. And so we do one funding for an employee and then depending on how many dependents they have we will add -- we will contribute additional funding per dependent. This creates somewhat of a complexity and a projection nightmare because we have to -- from a PEBP perspective you have to basically guess how many dependents are going to be -- are going to be up for HRA funding this year.

And so I think the strategy here is just to make it more simple and have less of a guessing game and factor out that dependent number and look at maybe funding it in a much more simple way, and so there's three ideas here that have been put on the table as far as different funding

strategies.

The first one is just a small change from what we do today and that's really just funding it by tier. Are you on -- are you an employee only. Are you on the employee plus spouse. Are you on the employee plus children or employee plus family. And rather than doing it by dependent we're doing it by just the tier. So that's option number one.

Option number two is a single amount for employee only coverage, and then another amount for a dependent coverage tier. So employee gets X and employees and anything else get Y so that's number two.

Number three is just a single amount. Let's just make it as simple as possible. You are an employee. This is what you get regardless of if you have dependents, if you don't have dependents, you are an employee of the State of Nevada, you are a member of a PEBP program, and this is what we are going to provide to you as a member regardless of dependents.

And I think option number three is obviously the most simple option, the one that allows PEBP to make most accurate predictions and projections and probably with the most simple version overall. All I'm saying that, you know, there's -- that's -- there's definitely some politics behind all of these decisions.

This is -- there was no recommendation because I don't think there's a right or wrong in this -- in this recommendation. I think any of these will be an improvement to what we have today. I think that option number one is probably the, it's a baby step in the right direction but a very small one.

And then option three would be the most simple way to fund the HSA and HRA contributions and make those projections that much more sound.

So I will stop there and see if there's any questions.

MEMBER VERDUCCI: Laura, Tom Verducci for the record.

Can you remind me which one of these three options are we using today? That option one where it includes the spouse, children and family?

MS. RICH: For the record Laura Rich.

We are not using any of the options. So the options on the table to consider today, the option or that what we're doing today is closest to option one. Basically, the way we fund HSA and HRA contributions today is an employee gets a set amount and the dependents get a set amount, and so it just depends on how many dependents you have up to -- up to three dependents on the plan. So it

really just depends on how many dependents they have today. Does that make sense?

MEMBER VERDUCCI: Yes, it does. I'm trying to determine the difference between one and two. It seems like the single -- number two, the single employee only coverage, you know, it also would include another dependent. So, you know, could you maybe just speak to that, the difference of one and two.

MS. RICH: So the difference for one and two -- for the record Laura Rich.

So the first one is by tier, right. So this is by you get a certain amount for an employee only. You get a certain amount for an employee plus spouse. You get a different amount for an employee plus children regardless of how many children, and you get a different amount employee plus family regardless of how many dependents you have on that -- on your plan.

MEMBER VERDUCCI: So would there -- would there be a maximum limit under two, a maximum -- a maximum number of dependents?

MS. RICH: That's number one. So on number two that -- the proposal here is a single amount for an employee and a different amount for an employee and anyone else that they have on their plan regardless of what tier. So if they

have any dependents then it would be for an employee Y for an employee plus anybody else they have on there.

MEMBER VERDUCCI: And would two include a maximum number of dependents?

MS. RICH: It would be -- for the record Laura Rich.

It would be regardless of dependents because it wouldn't matter. It would be an employee by themselves and an employee with dependents regardless of dependents because you're not funding it per dependents. You are contributing that HSA funding by the tier.

MEMBER VERDUCCI: Okay. Okay. And thank you. That's very helpful in understanding this. It seems to me that it would be best if we always had children and family, you know, that they would -- they should, you know, indeed be receiving additional HSA/HRA funding. So that's just my thoughts.

CHAIRWOMAN FREED: This is Laura Freed.

I -- I have to say I like number two, the reason being it certainly instills more budget stability and accountability. I think the important thing to remember is the Board just voted to submit an agency request budget with the PPO middle tier, and I would suspect that a lot of the people who are in the CDHP now who get both employee and

dependent HSA contributions from the state would move over to the PPO.

And I think, I mean, you know, certainly Stephanie, and can you -- can correct me with her actuarial expertise but, you know, I think we would see a lot of employee only folks who are not great consumers at medical care and dental care stay on the CDHP and those with dependents who can now count on co-pay stability thereby easing their own individual budgeting might leave anyway, and this might become more of a, if we, again, have the money to provide HSA and HRA contributions, this would be become more of a thing for employee only, and as we all know employee tier is most of what the active group, active participant is.

So I -- I kind of like -- I mean, I agree with Mr. Verducci that we should probably provide HSA/HRA contributions for dependents but to provide budget, dependability of budget projections while still maintaining a contribution for dependents. That's why I like number two. Those are my thoughts.

MS. MESSIER: And this is Stephanie Messier for the record. If I could just interject also.

It's important to keep in mind the plan design going forward as well. So if you're a spouse or if you're in the family tier you're still hitting the same deductible

amount in aggregate and the same out-of-pocket maximum in aggregates. So in terms of giving people more HSA in funding if they're covering more folks, they still have the same deductible targets and the same family targets regardless of how many dependents they are covering. So that's why we see a lot of people just give a set amount regardless of which dependents you're covering because the plan design is the same. It's just how many more people in your unit are collectively trying to reach deductibles and out-of-pocket maximums.

But in terms of the group's out-of-pocket spend, right, it's still going to cap at the five and cap at the ten regardless of whether you're covering eight kids or you're covering one.

MEMBER KRUPP: This is Jennifer Krupp.

I have a really quick question too. So is the -- these contributions would only apply to the CDHP plan, correct? They wouldn't -- if somebody signed up for the new mid tier plan that we just approved to request they wouldn't be eligible for this?

MS. RICH: For the record Laura Rich.

You are correct. This is only for the high deductible plan.

MEMBER KRUPP: Thank you.

MEMBER MITCHELL: Jet Mitchell for record.

I actually favor three because the majority of PEBP participants are individual employee. I completely understand the comments made by Tom Verducci and Chair Freed regarding others covered, but since the majority of plan participants would fall under number three I think it would make sense to do a single amount for employee.

The other benefit that I think that having number three option would be if PEBP is in a position where there's limited has contribution, it makes it mathematically easier to also divide that per employee regardless of tier if we're in that situation for that plan year '22.

MEMBER VERDUCCI: Yes, Tom Verducci once again for the record.

You know, the reason I kind of favor one or two is, you know, we are a family centric program, and I do think that if employees have additional children their costs go up and this would provide them some relief. You know, just my thoughts as opposed to focusing on the group of people that are single.

CHAIRWOMAN FREED: This is Laura Freed.

Should we move on to streamlining tier factors or would you like to stop and choose one of these options? I'm throwing it out to PEBP staff or the Board, whoever.

MS. RICH: For the record Laura Rich.

I -- I guess my original intent was to go through all of these and then maybe one by one make motions and vote on each one of them separately after they were all discussed, if that works for the Chair and the Board.

Yeah, okay. All right. So the next one is streamlining the tier factors. This is, again, one of those housekeeping type efforts to really improve, you know, the program and its projections and its budgets and aligning ourselves with the actuarial practices or actuarial standard practices that is recommended by Aon.

So the changes here, I know that the example or the explanation is a little complicated, but really the change is minimal. The way that we have been doing this is, internally at PEBP is we have what Aon provides to us as the base rate, right. They give us -- they price the plans every year and say this is what it's going to cost your plan. This is what -- how you need to price your plan.

And then PEBP goes through and what we do is we add an administrative load onto it, and that administrative load is full of just the costs to PEBP, right. So we have PMPM fees for all kinds contracts and programs and things like that and just the cost of doing business. And so what PEBP does is we take that lump sum and we just kind of add it

onto each one of the plans based on where that administrative fee lands.

And so what we are adjusting here is really streamlining. Instead of this lump sum that we're just adding on and PEBP just tacks onto each plan is really we're going to line item them out, and we're going to follow a more traditional actuarial underwriting by using the per participant, per month factor for claims, also for the administrative fees and one year for or one tier for all plans and state and non-state and we're going to keep this factor, try to keep this factor static for at least a two-year budget cycle.

So I'm going to stop there and I'm going to let Stephanie add to this as well since this is, again, it's probably more complicated we're making it sound and maybe she might -- she might be able to explain it in a different way that may make sense to others versus what I just said.

Stephanie, why don't you take it away.

MS. MESSIER: Okay. I'll do my best. This is Stephanie Messier for the record.

So, again, as Laura alluded to previously, we would provide PEBP with what we call the base rate part. And what we were doing there was we were taking your claims experience, making plan design change, if you had any that

year, and then trending it forward to the plan year we were interested in rate setting.

And then we would take a look to see how much did your spouses cost you, how much did your children cost you and then do a tier off those rates based on your claim experience for both the state and then separately for the non-state, and then we would take a look at your dental claims and we go through the same practice.

And as you might imagine, kids use dental differently than they use medical. Kids are actually much more expensive when it comes to covering kids on the dental plan than it is covering kids on the medical plan. So we would have a separate set of tier factors when we gave you the dental rate.

So in the base card we have now tiered your state, medical and pharmacy rates at one set of factors. We've given you dental that's applied to both state and non-state by another set of tier factors, and then you have the non-state medical and pharmacy with another state of tier factors.

Then you have HPN, who's giving you a whole nother higher set of rates using what they prefer to be their tier factors and you mush it into making a sausage basically and their PEBP rate sheet. And then you have another set of

factors that Ms. Rich went through in terms of the admin fee. So at the end of day you're ending up with rates tiered at nothing that you can easily point back to you and say this is our tier factors. It's now become a conglomerate, almost five or six different entry points of different tiers to create a final result.

So, again, in the effort of transparency, getting things much more clean and then for PEBP to be able to look back and say where did our excess cash come from, there's just a lot of value in getting you on a more standard, unready approach which is let's move everything on a per employee basis. Let's take your claims and move it forward, project it, medical claims on a per employee basis.

How much are we going to spend on pharmacy on a per employee basis? How much do we spend on dental on a per employee basis? How much do our admin cost on a per employee basis? Coming up with a total rate that's on a per employee basis and then applying the tier factor then and then you're done. It's a beautiful thing when you go to the end just one time.

Questions? I know it's complicated.

CHAIRWOMAN FREED: This is Laura Freed.

Yeah, this is tough for me. And, I mean, I haven't personally worked that rates workbook. Okay. So one

question. If you're converting all of your various admin contract cost to a per participant per month basis in order to add them onto the base rates are we still having, as we have previously, various participant groups only paying for the admin cost that pertain to that coverage group or is everybody paying for a share of the total admin load for PEBP irrespective of their purchase of group or coverage tier?

MS. MESSIER: Stephanie Messier for the record.

So you have things in your admin today that are very specific to what plan they are in. Perfect example is the HSA admin fee. It is not fair for an HMO participant to pay for an administration of an HSA plan that they are not participating in.

So going forward we are going to apply a different PEPM by plan only because in that instance that you're only going to be charged $2.50 let's say per person for each person in that plan. So in the buildup of the rates, we're taking that into account, and we're saying we know if you're in a co-pay you're not going to cost us $2.50.

CHAIRWOMAN FREED: Right.

MS. MESSIER: Because you're not in an HSA plan. You have it in a couple of other different areas but overall there's those general PEBP just cost of operating PEBP to have the PEBP staff.

CHAIRWOMAN FREED: Sure.

MS. MESSIER: To have its own line, that is going to be applied.

CHAIRWOMAN FREED: Sure.

MS. MESSIER: It doesn't matter what plan you're in. Everybody is sharing that, but you're right. A couple of different things that are very very specific to a certain structure are getting applied to that structure only.

CHAIRWOMAN FREED: Okay. So it sounds like a -- okay. So we're maintaining the same policy decision about which group pays for what because you're right. Most of the participants pay for most of the contracts, as well as the staff overhead, staff and other overhead cost. So, okay, got it.

We're just converting the various units of measure for lack of a better term to a PEPM.

MS. MESSIER: Correct.

CHAIRWOMAN FREED: Okay.

MS. MESSIER: Yeah. And I know you're familiar with the PEBP sheet and probably all of the other Board members are not, but there's definitely so many places where you had to look to try to track things back. We're trying to simplify that part of the process but not overly changing the spend or anything like that. It's just keeping things clean.

MEMBER URBAN: Marsha Urban for the record.

So just to clarify in my mind. What you're doing is you're taking all of these administrative, how much it costs to run the thing and you're splitting it up evenly, and if there's something that's only pertains to one tier, one, I don't know if you want to call it tier, a group of things and that charge will be split between them.

MS. MESSIER: Stephanie Messier for the record.

So, yeah, it's very much plan specific as you mentioned. For example you have case management on your self-insured plan but you don't have it on the HMO. So we're not going to charge the HMO people for care management that they can't access. We're only going to charge it on the two plans that it would apply to, which is the co-pay plan and the CDHP plan.

And then by tier it gets tiered after that. So as you might imagine, if you have a spouse on the plan, you might be utilizing it at twice the amount of someone else who doesn't have two people needing utilization management or case management. So it gets tiered after that step. Rather than before it was getting tiered at multiple places so there was, again, multiple different areas where the tiers were being applied, and we're just trying to streamline it before then. Differentiate it by plan if it needs to be because,

again, certain things are not getting utilized by certain folks and then it's applying a tier after that just one time rather than five different places.

MEMBER URBAN: Okay. Marsha Urban for the record. Thank you for the clarification.

MS. MESSIER: Great question.

MS. RICH: Okay. Anything else on that one?

Okay. So I'll move on to the next one, excess reserves. This is one I wish we could skip. So excess reserves, this has been -- this has been something that I think the Board really really needs to, you know, develop a policy on it. It's my opinion that the Board should develop a policy on it because of the longstanding issues and arguments we've had regarding that such reserves.

In the past it's, you know, how -- how -- what defines what is an excess reserve and how do we use the excess reserves. And so I think since there have been nothing in policy regarding any of this, it's probably time that the Board takes up this topic and at least have some additional discussion, if not some final policies that -- that, you know, we come out with.

So one of the things that we've discussed is defining what is an excess reserve. And during strategic planning we did talk about this topic quite a bit at length,

and I think that the -- calling it a reserve is probably not the right terminology because it really isn't a reserve. What it is is it's excess cash. Ultimately it is your revenue minus your expenditures equals what is excess. That's either excess cash or a deficit, right. You're going to end up with one or the other.

And so I think calling it excess cash changes the -- the language and the terminology and really identifies it as what it is. So the first recommendation here is let's refer to it as to what it is. It's excess cash.

The second thing that we want to talk about is when are we going to identify what excess cash is. Those of you who have been on the Board for a while and definitely a lot of the advocates who come up for public comment, they have seen the budget reports.

We have seen that throughout, you know, at least the last several years, I mean, since I've been at PEBP projections for the excess reserves, they were up one month, down another month. You'll go from, you know, 20,000,000 to one billion, back to 50,000,000 and they are just kind of up, down, up, down, up, down, and we want to identify a point in time where we think this is the most found when it is no longer because it's always a projection. So when is it not really a projection? When is the best time to identify a

point in time to identify when these are -- this is actually excess cash to the program.

And so what we are recommending here is that PEBP reports excess cash in September. That is a point in time where we feel that, you know, it's the end of the fiscal year that has -- the end of the fiscal year has passed and closed, and it's the time when the most sound and consistent figures can be recorded, and it's more on an actual basis versus a projection because the rest of the year we're really working on projections and not to say that in September it's not a projection because there is a -- a component to that, but it's the best time to say this is what we think is the -- that the program has in excess cash and so that's the first part of it.

The second part of it is what do we use this for? What is appropriate for the program to use this excess cash for. This is something that I think the Board should discuss and develop a policy on how should the program use this excess cash. In my opinion I think it is probably a better -- it's a better decision to talk about what we don't think it is suitable to use for.

So for example ongoing cost to the program rather than pigeon holing the program and saying this is the only thing we can use it for. I think we need to start the

discussions of what is -- what is definitely inappropriate to use the excess cash once a year that is reported, what is it inappropriate to use it for and maybe what is it appropriate to be used for.

This one, the recommendation was fairly broad because I think it really necessitates a conversation and discussion by the Board and maybe just a deeper dive into it. So there was no real specific recommendation by PEBP. So I'll stop right there.

MEMBER MITCHELL: Jet Mitchell for the record.

I think the verbiage may matter on how we label this line item, and maybe instead of calling it something that has the word excess maybe just calling it differential amounts because if the differential amount is positive that by definition means it's more. And excess, it's a differential amount is a negative amount, it's a negative differential.

So I know we're not doing any deliberation, but my comment is it may make it more -- add more color around what is happening with that amount to call it cash differential or differential amount so that it isn't automatically labeled as in excess and it's not automatically labeled as a deficit. It's differential. What is different because that also encompasses the definition you just gave.

What is the difference, and then that's identified in that line item.

And I know that's over oversimplifying as far as when and where and what, which is as far as verbiage to start with, I think we should call it differential amount because it doesn't denote a positive amount of negative. It's a neutral language.

MEMBER VERDUCCI: Yeah, Tom Verducci for the record.

I think part of the problems we've been running into for the last several years that I've been involved with the Board is that Jet was saying the word excess seems like it's extra. And I think if you can get rid of the word excess and something more aligned with what Jet was pointing out the differential account or positive or negative cash flow, positive or negative cash on hand and we can even come up with an acronym and say positive or negative cash on hand could be P to P and CH account.

But I am leaning towards what Jet had brought up there towards differential account, the word excess we're going to be approached from individuals that are going to say that's extra and you should spend it, and we're going to get our hand slapped again in the future. Perhaps depending on ongoing expenditures in the program.

MEMBER BAILEY: And, Madam Chair? Madam Chair?

CHAIRWOMAN FREED: Yes.

MEMBER BAILEY: Madam Chair --

CHAIRWOMAN FREED: Yes.

MEMBER BAILEY: For the record Don Bailey.

CHAIRWOMAN FREED: Go ahead. Go ahead.

MEMBER BAILEY: Am I on?

CHAIRWOMAN FREED: Yes.

MEMBER BAILEY: Madam Chair?

CHAIRWOMAN FREED: Yes.

MEMBER BAILEY: For the record Don Bailey. Hello.

CHAIRWOMAN FREED: Go ahead.

MEMBER BAILEY: I agree with Tom. The wording has to be -- I think we have to take a look at the word on excess on cash. In the past numerous times we've been raked over the coal for the way the Board's usage, the way we got it and our fellow members even question excess revenues so and how we used it.

So the legislature I think in the last one before this one made some changes that we have to follow now. Is that correct? We can ask Laura on that one. I think we have to go to the advisory board now and we have to go back to the legislature on using -- using the excess funds.

So, Laura, maybe you can bring us up to speed on that.

MS. RICH: Laura Rich for the record. Yes, you're correct on that, Don.

So between sessions, if there are any major benefit design decisions by the Board they must be brought to the interim finance committee and -- and PEBP has been doing that. We've been presenting at IFC just so that they are aware. Sometimes it's informational items. Sometimes it is items that will require their input but, yes, you are correct.

MEMBER BAILEY: So I guess I caution the Board on taking a real hard look at this and what wording we use, agreeing with Tom and the Chair. What kind of wording we use, I think it needs a little more scrutiny on that particular item.

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

I agree that use of the term excess reserves is probably not the best idea. Yeah, personally I'm agnostic as to whether we call it differential amount or we call it year ending cash on hand or something else a little bit more anodyne. My question centers around as when we record it as opposed to when we might use it or not use it.

I think it's certainly fair for PEBP staff to say we'll record differential cash remaining from a fiscal year just ended at the September meeting because the fiscal year will have closed, and that's pretty coincident with to Mr. Bailey's point of the new changes to the law that they made, the legislature made in 2019, that basically say if you're going to use any of that cash and change plan design have your IFC and when you adjust your reserves you must do a work program for that.

Because PEBP got dinged because any actuarial adjustments to IBNR or catastrophic or any necessary reserves, any necessary changes in the HRA reserve, they were carried by the financial officer, you know, on the books, if you will, but they were not reflected in the accounting system so the legislature changed that.

So I think it's a good idea to report your cash remaining when you're doing that work program as necessary, but the question is the Board generally make plan design decisions in March at every rate setting meeting.

So is PEBP staff suggesting that we kind of sit on that cash until the next rate setting meeting and then determine what, if anything, to do with it or what?

MS. RICH: For the record Laura Rich.

So this is -- this is part of option two, the

second part of that decision, right. So how do we use it? We are identifying it in September, and generally in November is when we sit down to talk about plan design decisions, right.

So this is where the Board should take a stance on is there anything that should be off the table. What is not appropriate? So for example, let's say that we have 5,000,000 in, we're calling it differential now. So let's say we have 5,000,000 in excess differential and so is it appropriate to take that 5,000,000 and decide that for two years we're going to fund a benefit that is going to cost the plan $5,000,000. We know that we can't continue that benefit or there's no -- there's -- there's nothing to say that that benefit will continue beyond those two years.

So is that appropriate? Is that something that the Board would think it's appropriate to use excess differentials for or is it maybe something that is not appropriate? So there's decisions like that that need to be considered and that need to really be discussed because in the past this has been a really hot topic and something that not just the Board but the advocates and members, you know, there's a lot of different opinions on this, and I think that this is something that, you know, the legislature has taken up and --

CHAIRWOMAN FREED: Uh-huh.

MS. RICH: -- the Governor's Finance Office. I think all of the stakeholders have really been a part of -- of these discussions and decisions and everyone sits on a different -- they have a different opinion. So I think this is something that the Board needs to really take up and -- and identify as to where -- where should the program, if there are -- if there's some extra money laying around at the end of the year what should it be used for? What is the appropriate use for this? And there's some ideas on the table we can talk about.

You know, I just used one example of using it for a short-term benefit. Then there's another example of maybe a rate, a premium holiday for members. That's how we can give back the money.

CHAIRWOMAN FREED: Uh-huh.

MS. RICH: I don't know if it's the right move to pigeon hole ourselves into what do we use the money for? I think it's a better decision to really talk about what is not appropriate and what should we not even consider and a decision that the Board is not going to bring to the table because they will negatively effect the program, effect members or maybe just not something that the legislature has an appetite for. So I think that's kind of the direction

we're trying to head.

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

I like the idea of September being the date that we look at the balance there. And, you know, if you look at the history on the excess reserves it used to be a really big number, and we really did not have any sort of guidance, and I think that we've gone towards the direction of -- of recommending those funds be used for one time expenditures and not the ongoing expenditures.

But I do have a question. If we make a recommendation to use those funds do they have to go before the IFC and the Governor's Finance Office; is that correct? I believe that the answer we would make a suggestion or recommendation but the ultimate decision on that does lie on IFC and GFO.

MS. RICH: For the record Laura Rich.

Tom, you hit on two things actually. So the answer to your question is if we are between legislative sessions then, yes, if it's a benefit. If it -- if the money is being used for benefits then yes. That requires a -- that requires an approval by the interim finance committee.

The other thing that you touched on was in the past this was a big bucket. There was -- you know, we're

talking, you know, a hundred million dollars. We don't anticipate and especially after making a lot of these -- these policy changes that are being recommended today, we're hoping that that number is no longer, you know, a hundred million dollars. We're hoping that the discussion is closer to a few million in one way or the other, right. Hopefully a few million in excess versus a deficit.

But the goal -- the goal of today and changing these policies is to better get us to a place where we can make better projections and budget more effectively.

So in the future we're not expecting this to be a hundred million dollar question. It's going to be a much much smaller number. So we're not -- we're not talking about the big numbers we were in the past.

MEMBER VERDUCCI: Yes. And, you know, in the past, I mean, this would even show up in local newspapers and there was a lot of pressure given, you know, put on the executive director of PEBP at the time that I read about and it seems like that if we have a reasonable flow on this account and it's not always building up it shouldn't be an issue in the future.

But if it does have additional expenses -- reserves coming in and rightfully so. We should put recommendation into the government of GFO, IFC, and our rules

are one-time expenditures as opposed to ongoing where we're going to show artificial premiums, so be it. It could even be a rebate and premiums, holiday.

CHAIRWOMAN FREED: Yeah.

MEMBER VERDUCCI: I'm on board with everything you've said there.

CHAIRWOMAN FREED: This is Laura Freed.

I feel like, you know, I agree with Tom's comments. The Board has gotten eaten up by the public, the participants, certainly the legislature and the budget and fiscal staff, and, you know, I'm guilty of it myself. I mean, I'm me. So I'll own it.

I could not agree more that we should probably put into more policies that if we have excess cash or not calling it excess cash, whatever you guys decide to call it, when it's officially reported that we should specify that it should be used for one time expenditures, not things that are ongoing costs of the plan because, you know, the danger there is we could enrich the plan design a little bit, and then the people who use that and enjoy it lose it in the next biennium or the next fiscal year even if we have a bad claims year, and then, you know, we're back in trouble with, you know, some subset of the participant, and I don't want to be there.

And so I think, you know, we get into -- you

know, if we just have a few million dollars in differential cash at the close of a fiscal year, that's not going to buy you much in terms of enriching a plan design anyway. So if we get to where we need to be and in a 500,000,000 dollar budget a couple of million dollars is just not that much. So that's -- that's within the realm of reasonable for cash left over.

You know, it would serve the Board and PEBP staff to find kind of small, small dollar, relatively speaking, one time benefits that can be provided, and I'm not in tune enough with plan design cost to know what those might be but that's my suggestion. Because a plan, like a true rate holiday where the subsidy is not paid and the employee premium is not paid and the Board or the existing cash in the plan absorbs one month of costs, that's a pretty expensive concept but it's -- I mean, it's a great way to liquidate cash that's not needed, so as an example.

So that's why I suggest, if we're getting better in our projections, we have just a few million dollars to use, what can we do with a few million dollars is something we need to think about. But, again, I am totally on board with policy that says we don't use differential cash for ongoing costs of the plan.

MEMBER BAILEY: Madam Chair, for the record Don

Bailey.

CHAIRWOMAN FREED: Go ahead, Mr. Bailey.

MEMBER BAILEY: I totally agree with what you're saying. I only raised a red flag just to be a little cautious because a number of people, some of the people on the Board have been through this before numerous times and really the executive director usually took some pretty heavy flack over to LCB, and I would not like to see that happen, and I don't like -- I would like not the Board to be responsible.

I think the best what their policy change is, and I'm all for this policy change. I always have been on that cash thing. But to lay it out in black and white, maybe even put an amount on it that could be carried forward, certainly not $80,000,000 or $70,000,000. We have reached them high numbers, and at that time the Board decided we've actually made some dental changes. We made all kinds of things which probably is not really a sound way to go.

So I think what Laura wants us to do is probably help them put together what could we do and what we should not do. So I'm all for the policy change. Thank you.

CHAIRWOMAN FREED: Thank you.

MEMBER MITCHELL: Jet Mitchell for the record.

I agree with the comments that have been made and

for the reasons that they have been made. I would also add if the differential is a positive amount I would overlay the environment we're currently in and maybe have some verbiage that says forwarding emergency situations, this is the plan or forwarding X factors. Because the situation we're in now is the differential may be a negative differential or the differential may be positive but with the view of a claims from former claims suppression so the funds wouldn't be used because of that emergency situation.

So that's the only thing with that is some verbiage that would say these are some guidelines. We know we won't use it for ongoing cost. We know we will use it for this, this or this benefit, barring the emergency situation because this now if there is a differential, but if there is a differential but we're seeing a freight train in the horizon that's leading us to the --

CHAIRWOMAN FREED: Right. This is Laura Freed. You're actually right. We're sitting on a few million more I think to close out FY20 because of claim suppression. And so, you know, Stephanie could add more color to how much that claim suppression is going to last through FY21 and how -- and to what extent that boomerangs back on us in future claim cost.

And so is it wise to use the differential cash

because we may have a whole bunch of pent up demand for procedures that people just haven't had done this plan year or last plan year, and so we might need that money later. So it's -- I agree that there's -- you know, there's got to be some provisions for fiscal emergency of some kind, anyway.

CHAIRWOMAN FREED: Again, this is Laura Freed.

Board members, anybody that hasn't spoken up have some significant feelings to share about the idea of what we call excess cash, and what we do or do not do with it as a matter of Board policy.

MEMBER VERDUCCI: Madam Chair, Tom Verducci.

CHAIRWOMAN FREED: Uh-huh.

MEMBER VERDUCCI: I really like the name differential cash. I think we need to get rid of that word excess. It's going to be out there to the public and we're going to get continual requests to spend that down. I think it's at a reasonable level where it's not a highly contested -- contested issue as it was two years ago.

It should be a reasonable balance in that account and I think we see it growing. We do need to find a way of having it disbursed properly, not going into ongoing expenses.

CHAIRWOMAN FREED: Okay.

MEMBER VERDUCCI: So I would like to see the term

change to a differential account or differential cash.

CHAIRWOMAN FREED: Okay. Thank you.

Ms. Rich, did you want to end it there? Did you want to go into RX rebates?

MS. RICH: Let's wrap it up. I will -- for the record Laura Rich.

I will wrap it up with prescription pharmacy rebates. So this isn't necessarily a Board decision. It is something, it's a significant change though. I wanted to bring it out there and make sure that it is public.

In the past what we have done and you've heard advocates talk about this. You have heard staff also talk about it. The pharmacy rebates have -- they are significant. Right now we're looking at approximately $13,000,000 in rebates to the program. And so when they come in we actually have them today offsetting administrative -- administrative accounts, right, those fees.

The reality is they should offset claims and so the -- we're making that change and moving forward in this new budget or we're recommending that change and moving forward in this new budget to really just change the categories and offset -- have pharmacy rebates offset claims versus admin fees as really they should and it makes logical sense to do. So they really just provide some more accurate

reflection of the underlying and claims calculations as well.

Any questions?

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

On the rebates I would continue getting PEBP the -- PEBP the go ahead on that, and I like the part where we're going to be -- you're going to be working with the Governor's Finance Office. I think that's a very good move and they will know what is going on with the rebates.

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

Okay. Now that staff has gone through all of the topics that they want to cover in Agenda Item Ten I -- did you want to take these one at a time? I mean, this is an action item. So I assume here that we would need to move to approve the suggestions, not necessarily because they're -- I'm sorry. I take that back. There are recommendations one, two, three, four and five but within that there are a bit -- there are some specifics because on HSA/HRA funding recommendation number three there's no specific recommendation for the dependents.

And on number five, excess reserves, I think we need to -- it's not PEBP staff recommendation because we have some thoughts about calling it differential funding, and we

have some policy direction to give to the staff. So let me start then I guess -- I guess I just talked myself into it taking these one by one.

So on underwriting all self-funded plans into one risk pool but keeping the State and non-state risk pools separate in conformance with statute, do I have a motion to accept staff's recommendation?

VICE CHAIR FOX: Linda Fox for the record. I'll make that motion.

CHAIRWOMAN FREED: Thank you.

Do I have a second?

MEMBER SMITH: David Smith for the record.

MEMBER BAILEY: Madam Chair. Go ahead.

CHAIRWOMAN FREED: I heard Mr. Smith speak first so I'll accept Mr. Smith's second.

MEMBER BAILEY: Oh, okay.

CHAIRWOMAN FREED: I'll let you have a crack at it in a minute, Mr. Bailey.

All those in favor of on number one please signify by saying aye or raising your hand on your video screen.

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

CHAIRWOMAN FREED: Any opposed say nay.

Number two, apply a single contribution strategy across all plans. So you all saw Stephanie's spreadsheet with illustration of what it would look like to have a level contribution across all plan choices. Does anybody want to approve staff's recommendation and if so I'll accept a motion.

MEMBER VERDUCCI: Tom Verducci.

VICE CHAIR FOX: Linda Fox for the record. I'll make that motion.

MEMBER VERDUCCI: Yes, that would be a second. Tom Verducci for the record.

CHAIRWOMAN FREED: Okay, great.

All in favor signify by saying aye.

CHAIRWOMAN FREED: Any opposed say no. Okay. Thank you. That passes.

All right. Number three, so we had a little bit of -- I heard a little bit of divergence of opinion of on HSA and HRA funding. Again, provided if we have the money in the budget to actually provide a contribution between tier -- between number one based on tier employees, employee plus spouse, employee plus child or children, employee plus family.

Number two, a single amount for employee only coverage and another single amount for any independent tiers

or number three, single amount per employee regardless of tier.

So I wanted to get the sense of the Board and anybody who wants to move to approve any one of those things please feel free.

VICE CHAIR FOX: Linda Fox for the record. My motion would be that we approve number three.

CHAIRWOMAN FREED: Okay. All right.

MEMBER VERDUCCI: Yeah, Tom Verducci for the record. I just wanted to have a discussion on this.

CHAIRWOMAN FREED: All right.

MEMBER VERDUCCI: I have a real good grasp of this one. I want to make sure that the decision that we're making supports the families. Everything I'm reading is the plan has become family centric, and I want to make sure the employees that have spouses and children have adequate funding for medical expenses.

CHAIRWOMAN FREED: Okay.

MEMBER VERDUCCI: I'm not sure if we go with item three it's going to be one single amount that goes just to the employee themselves regardless of their family.

MS. RICH: Yeah.

MEMBER VERDUCCI: Discussion only.

CHAIRWOMAN FREED: Understood. Okay. So let

me -- now that Vice Chair Fox has moved adoption of number three, so let me -- let me see if I can hear a second for that.

MEMBER MITCHELL: Jet Mitchell for the record. I will second number three.

CHAIRWOMAN FREED: Okay. All right. Then knowing -- okay. Option three is the one on the table which is a single amount per employee regardless of whether that employee has dependents and has ruled in any coverage tiers or not.

So with that, all in favor signify by saying aye. Oops. I think I better do a recall call. Sorry about that guys.

So, Vice Chair Fox?

VICE CHAIR FOX: Yes.

CHAIRWOMAN FREED: Okay. Mr. Bailey?

MEMBER BAILEY: No.

CHAIRWOMAN FREED: Okay. Ms. Urban?

MEMBER URBAN: Yes. Aye.

CHAIRWOMAN FREED: Aye, okay.

Ms. Mitchell?

MEMBER MITCHELL: Aye.

CHAIRWOMAN FREED: Mr. Smith?

MEMBER SMITH: Aye. Sorry. You cut out. I

couldn't hear my name.

CHAIRWOMAN FREED: Sorry.

Mr. Verducci?

MEMBER VERDUCCI: No.

CHAIRWOMAN FREED: Okay. Ms. Krupp?

MEMBER KRUPP: No.

CHAIRWOMAN FREED: Okay. So one, two, three. Oh, man, I have to abstain because otherwise we deadlock. All right. We have four aye's and three no's. And I was -- I was going to vote no, and I don't think I should because this is not -- this is enough of a thing. So that motion fails unfortunately.

Going back to the idea of providing some kind of subsidy for dependents and yet providing budget and projection stability for PEBP staff to project, you know, claims costs and spent.

I heard some -- I heard some support for option two. And Mr. Verducci I think if I remember was having a, sort of a bit of a struggle between number one and number two. So what's the sense of the Board between those two ideas, number one and number two?

MEMBER KRUPP: This is Jennifer Krupp for the record. My sense would be that I think that number two would be --

CHAIRWOMAN FREED: Okay.

MEMBER KRUPP: -- the best choice.

CHAIRWOMAN FREED: Okay.

MEMBER VERDUCCI: Madam Chair, Tom Verducci. I'm on board with number two as well.

CHAIRWOMAN FREED: Okay. All right. Is anyone willing to move approval of number two, single amount for employee only coverage and another single amount for any dependent coverage tier?

MEMBER BAILEY: Madam Chair, for the record Don Bailey. I so move number two.

CHAIRWOMAN FREED: All right, Mr. Bailey.

Do I have a second?

MEMBER KRUPP: Jennifer Krupp for the record. I'll second.

CHAIRWOMAN FREED: Thank you. All right. I'm going to do my role call.

Ms. Fox?

VICE CHAIR FOX: I need to ask a question.

CHAIRWOMAN FREED: Okay.

VICE CHAIR FOX: Do I need to break at this point?

CHAIRWOMAN FREED: The motion on the table would be number two, approve number two, a single amount for

employee only coverage and another single amount for any dependent coverage tier.

VICE CHAIR FOX: I guess I'm a no.

CHAIRWOMAN FREED: Okay. Mr. Bailey?

MEMBER BAILEY: Yes.

CHAIRWOMAN FREED: Ms. Urban?

MEMBER URBAN: Yes.

CHAIRWOMAN FREED: Ms. Mitchell?

MEMBER MITCHELL: No.

CHAIRWOMAN FREED: Okay. Mr. Smith?

MEMBER SMITH: And for clarification this means if you are -- if you have one dependent, whether it be spouse or child, it would be the same rate, that's correct?

CHAIRWOMAN FREED: Correct. It would be the same contribution.

MEMBER SMITH: Yeah, I vote no.

CHAIRWOMAN FREED: All right. Mr. Verducci?

MEMBER VERDUCCI: Yes.

CHAIRWOMAN FREED: Ms. Krupp?

MEMBER KRUPP: Yes.

CHAIRWOMAN FREED: Okay. All right. That motion carries. We had four yay's and three nay's. And, again, the Chair abstains. I'm trying to stay out of this.

Okay. Thank you everybody. I know that was a

little bit of a difficult one.

Streamlining tier factors, okay, so this is the one basically about admin load, taking that base rate card that Aon has typically provided or always provided and the way that they load administrative costs of running PEBP and maintaining all of its contracts.

So what is the sense of the Board? I'll just say it. I think it's a -- I think it's a good idea. I'm particularly compelled by the idea that we could track back to where we are gaining and losing money. So the idea of being able to provide a little bit more of a forensic look how the plan got to the financial shape we're in is appealing to me.

MEMBER VERDUCCI: Tom Verducci for the record.

I think on this one we make a motion to approve that --

CHAIRWOMAN FREED: Okay.

MEMBER VERDUCCI: -- more is written here.

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

CHAIRWOMAN FREED: Okay. All right. So the motion on the floor is to accept the staff recommendation to accept streamlining the tiers, by following more traditional

actuarial underwriting process by using a per purchase settlement per month factor per claims, adding on admin fees per participant per month basis. Use one tier for all plans, products, state and non-state, keeping this factor static for a two-year budget cycle at a minimum.

All those in favor please signify by saying aye.

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

CHAIRWOMAN FREED: Any opposed no. Okay. That one passes.

Okay. Number five, what do we term any cash remaining at the close of a fiscal year and how should we establish a Board policy for what to do or not do with it.

MEMBER VERDUCCI: Yes, madam Chair, Tom Verducci.

CHAIRWOMAN FREED: Yes.

MEMBER VERDUCCI: I think the wording on this would be that the excess reserves should be defined as the differential cash account and only used for one time expenses. It's not a motion but my thoughts. And I just want to make sure, you know, there's other input. I would like to see if I'm actually hitting the nail on the head here or missing something.

MEMBER MITCHELL: Jet Mitchell for the record.

I think the only thing you're missing, Tom, was

the approximate date that the Board wanted to make that, excuse me, make that determination.

And the only thing that I would add to your verbiage on the differential to say barring emergency situation or barring emergency circumstances, just to keep that wiggle room open for unprecedented times which we are in.

MEMBER VERDUCCI: Yeah, Tom Verducci. Just to dovetail on your thoughts here. So if we add the September 30th and the language that Dr. Jet Mitchell had provided here, barring, how did you say it, unusual circumstances?

MEMBER MITCHELL: Jet Mitchell for the record.

I used the word barring emergency situations or barring an emergency circumstance or barring exigent circumstances or something to that -- to that effect. I'm not -- I don't care the exact verbiage.

MEMBER VERDUCCI: Got it. So Tom Verducci once again.

I think the way the motion reads on this one would be that excess reserves should be defined as the differential cash account only used for one time expenses, reassessed September 30th barring emergency circumstances, and I'll put that forward as a motion.

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

CHAIRWOMAN FREED: Okay. Thank you.

I have a question on the question. What's the definition of an emergency circumstance here?

MEMBER MITCHELL: Jet Mitchell for the record.

The reason I said the verbiage emergency circumstance is I made sure it is a highly unusual situation, like a global pandemic.

CHAIRWOMAN FREED: Okay.

MEMBER MITCHELL: So verbiage to Tom Verducci's motion could be verbiage including emergency circumstances which in the past has included events like a global pandemic. So it could be an example given of what an emergency circumstance were or is or just barring an emergency circumstance because I think that we'll kind of know it when we're in a situation. We wouldn't be in it otherwise. Most times are not an emergency situation or special circumstances. So it would be a very unusual and unique circumstances and I -- you're wanting to have a little bit more color around it.

CHAIRWOMAN FREED: Yeah.

MEMBER SMITH: Madam Chair?

CHAIRWOMAN FREED: Yes, Mr. Smith.

MEMBER SMITH: Yes, so I think the Board can define another time. I think that the motion is based on, you know, it's a one shot use. When, you know, if it's something appropriate, but if something comes up that is unforeseen and the Board needs to apply it to something that would be -- you know, I think that would be an emergency circumstance, but I think the Board can define it at the time if something comes up.

CHAIRWOMAN FREED: Okay. All right. So we have a motion and a second. I'm -- I'm almost scared to try to repeat this one to -- stop me if I'm wrong because I've already made a mistake and I'll go back to that in a second.

Okay. The motion on the table is to refer to excess reserves as differential amount and to establish it on the, at a point in time, and this motion specifies September 30th and to utilize the differential amount if it's positive up for things that are not ongoing expenses of the plan subject to possible emergency circumstances that the Board might define. Is that a correct restatement of the motion on the floor based on its maker?

MEMBER VERDUCCI: Madam Chair, the only thing that was different here is I didn't mention a differential cash account.

CHAIRWOMAN FREED: Oh, differential cash account,

okay.

MEMBER VERDUCCI: Yeah. Yeah. Just differential amount. I think we do need to get the word cash in there.

CHAIRWOMAN FREED: Okay.

MEMBER VERDUCCI: And if it's a one-time expense I don't believe it has to have that wording in there barring emergency circumstances because the funds will still be used for a one time expense, but I'm good with that either way. I don't want to make it too complicated.

MS. EATON: Chairman Freed, this is Cari Eaton.

CHAIRWOMAN FREED: Hi, Cari.

MS. EATON: I think it should be August 31st and we would bring it to the Board in September.

CHAIRWOMAN FREED: All right. So does the person -- does the member who made the motion agree to that amendment?

MEMBER VERDUCCI: Tom Verducci for the record. Yes, so be it.

CHAIRWOMAN FREED: Okay. You heard the motion on the floor. I'm going to do a motion on this one.

Vice Chair Fox?

VICE CHAIR FOX: Yes.

CHAIRWOMAN FREED: Mr. Bailey?

MEMBER BAILEY: Yes.

CHAIRWOMAN FREED: Ms. Urban?

MEMBER URBAN: Yes.

CHAIRWOMAN FREED: Ms. Mitchell?

MEMBER MITCHELL: Yes.

CHAIRWOMAN FREED: Mr. Smith?

MEMBER SMITH: Yes.

CHAIRWOMAN FREED: Mr. Verducci?

MEMBER VERDUCCI: Yes.

CHAIRWOMAN FREED: Ms. Krupp?

MEMBER KRUPP: Yes.

CHAIRWOMAN FREED: Okay. So thank you. That one passes. That was easy relative to the one I'm going to go back to.

Members and everybody listening, I need to apologize to everybody. On the -- on the HSA/HRA funding by dependent I believe I miscounted on that first motion. The first motion, as you will recall which I said failed, was to adopt number three, a single amount per employee regardless of tier.

I'm going to restate what I recorded in case I misheard it. Vice Chair Fox voted yes. Mr. Bailey voted no. Ms. Urban voted yes. Ms. Mitchell voted yes. Mr. Smith voted yes. Mr. Verducci voted no. And Ms. Krupp voted no. So by that count, one, two, three, four members voted yes,

and three members voted no, with the Chair abstaining. It actually did pass. So I wanted to let you know that that was actually the sense of the Board based on the first motion made, and that is going to be the recommendation to PEBP staff.

And I sincerely apologize that I'm a budget person who apparently can't count. So we made it through I think Agenda Item Ten.

CHAIRWOMAN FREED: Agenda Item 11 is the second public comment period. And so I'll turn it over to PEBP staff for public comment.

MR. CARROLL: Thank you, Ms. Chair.

So, again, this is public comment time frame. I'm going to go ahead and display the number on my screen, and then I will call out the last three digits of your phone, and then I'll be announcing that your phone is unmuted, at which time you'll hear the Zoom automated audible saying unmuted which you can proceed with your comment at that time.

The first number that I have here ends in 920, starting with the area code of 404. You're line is unmuted.

Okay. The next that I have is 511. Your line is unmuted.

The next one I have is 688. Your line is unmuted.

THE OPERATOR: You are unmuted.

MR. CARROLL: The next one that I have is 755. Your line is unmuted.

MS. LOCKARD: Good afternoon. This is Marlene Lockard, L-o-c-k-a-r-d, representing the Retired Public Employees of Nevada.

I saw that it might be helpful to just add a little bit of context surrounding the discussion of excess reserves. This really initiated after the 2011 major revamping of PEBP plans and benefit cuts due to the budget situation at that time. Thereafter early retirees were removed from the program. The Medicare retirees were shifted so to the exchange, and so that left a tremendous amount of money, with a tremendous cost saving measure.

Thereafter each year, then Executive Director Jim Wells, would report on the excess reserves and deliver to the Board a series of options and clearly marking what options would be a one time only benefit increase, alluding everyone that it could go away the next budget year.

So that began a series of clawing back. Some of the benefits that had been removed from the 2011 session and we were talking reserves at that time in double digit millions. I think one was even as high as 32,000,000.

And so it was clear over a period of time that

the 2011 benefit cuts were too much. So slowly those recommendations to add benefits back could be sustained year after year until finally they were put back into the base budget. So that that has been done so that's why we see reserves not accumulating the amount that they had in the past. And so I don't think on an ongoing basis that we're going to have the years of huge double digits of millions of dollars in excess reserves.

And for the record, almost all the benefits that had been cut had been reinstated, with the exception of life insurance for retirees and a couple of other items.

So hopefully this was helpful and I appreciate the opportunity to comment. Thank you very much.

MR. CARROLL: Okay. The next line that I have ends in 111. Your line is now unmuted.

MR. FRANKLIN-SEWELL. Yes, this is Shaun Franklin-Sewell. For the record S-h-a-u-n. Last name Franklin, F-r-a-n-k-l-i-n dash S-e-w-e-l-l.

I'm very disappointed in the Board for choosing to penalize people with dependents by choosing option three. On the policy changes, item number ten, HSA/HRA funding by dependent now because you changed the tier -- because you change the way you're writing the tiers you are doubly penalizing people with dependents.

So that's all I'll say right now, and I hope you reconsider that decision as you're moving towards making better policies for the organization. Thank you.

MR. CARROLL: The last one I have, the number ends in 404. Your line is unmuted.

MR. RANFT: Good afternoon everyone. This Kevin Ranft, R-a-n-f-t, for the record, representing AFSCME Local 4041 Active State Employees.

Again, I want to thank all of the entire Board and the Chair and Laura Rich in regards and her staff just as a whole. This is a very difficult time. Policies can turn out to be good and making unintended consequences.

So with that being said, this Board in the past has brought forward different changes to policies, and I just hope that these things are open to be able to correct any unintended consequences on Item Number Ten.

Again, I appreciate your time and support, and we look forward as an organization and advocates on behalf of our members to be able to come to this meeting and to continue to have these meetings to be able to adjust some of the things that may have been voted on today.

We appreciate your hard work and, again, we look forward to being in partnership with PEBP. Thank you very much.

MR. CARROLL: Madam Chair, that was all of the public speakers that were available.

CHAIRWOMAN FREED: Okay. Thank you very much.

So that takes care of the agenda for today. And with that it is 1:37 p.m. and we are adjourned. Thank you Board members for your participation. Thank you staff and vendors. Have a good day everybody.

VICE CHAIR FOX: Thank you, bye-bye.

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

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

That on Thursday, the 23rd day of July, 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 178, is a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Carson City, Nevada, this 2nd day of August, 2020.

KATHY JACKSON, CCR
Nevada CCR #402

CAPITOL REPORTERS (775)882-5322

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