In The Matter Of:

PUBLIC EMPLOYEES'BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

September 30, 2021

CAPITOL REPORTERS

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

ZOOM/TELEPHONIC MEETING NOTICE AND AGENDA

THURSDAY, SEPTEMBER 30, 2021

CARSON CITY AND LAS VEGAS, NEVADA

The Board:	LAURA FREED - Chair LINDA FOX - Vice Chair JIM BARNES - Member LESLIE BITTLESTON - Member APRIL CAUGHRON - Member TOM VERDUCCI - Member JENNIFER KRUPP - Member MICHELLE KELLEY - Member BETSY AIELLO - Member JENNIFER MCCLENDON - Member
For the Board:	MICHELLE BRIGGS Deputy Attorney General
For Staff:	LAURA RICH Executive Officer WENDI LUNZ Executive Assistant STEVE MARTIN Chief Information Officer TIM LINDLEY Quality Control Officer NIK PROPER Operations Officer
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THURSDAY, SEPTEMBER 30, 2021, CARSON CITY, NEVADA

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MR. MARTIN: Madam Chair, the meeting is now live.

BOARD CHAIR FREED: Okay. Thank you.

Good morning, everyone. It is Thursday, September 30th. It's 9:00 o'clock straight up, and I will call the meeting of the Board for the Public Employees' Benefits Program to order.

Before I ask staff to call the roll I would like to take a moment to welcome some new members and say goodbye to another member because you will notice when the roll call we have some new names.

Jim Barnes has taken the seat that was previously occupied by Don Bailey.

Dr. Jennifer McClendon is taking the seat that was previously by Marsha Urban.

And Leslie Bittleston is joining us in the seat that was previously occupied by Tim Lindley.

So welcome to all of our new Board Members. Thank you for serving. I hope you've been acclimated by the PEBP staff to your role with all of the Board policies and procedures, open meeting law, usual things that the staff provides to Board Members.

And I would like to take a moment also to thank Jennifer Krupp for her service on the Board. We understand this will be her last meeting. And the Governor will be appointing someone to take her seat.

And finally we have a new deputy attorney general. So I would like to welcome Michelle Briggs, our newly assigned DAG. Thank you for advising us.

And with that I will ask PEBP staff to call the roll.

MS. LUNZ: Thank you. Laura Freed?

BOARD CHAIR FREED: Present.

MS. LUNZ: Linda Fox?

VICE CHAIR FOX: Present.

MS. LUNZ: Betsy Aiello?

MEMBER AIELLO: Present.

MS. LUNZ: Jim Barnes?

MEMBER BARNES: Present.

MS. LUNZ: April Caughron?

MEMBER CAUGHRON: Present.

MS. LUNZ: Thank you. Michelle Kelly?

MEMBER KELLY: Present.

MS. LUNZ: Jennifer Krupp?

MEMBER KRUPP: Present.

MS. LUNZ: Leslie Bittleston?

MEMBER BITTLESTON: Present.
MS. LUNZ: Dr. Jennifer McClendon?
MEMBER MCCLENDON: Present.
MS. LUNZ: Tom Verducci?
MEMBER VERDUCCI: Present.
MS. LUNZ: Thank you. We have a quorum.
BOARD CHAIR FREED: Okay. Thanks.
Agenda Item Number 2 is public comment. Board Members, for those of you who are new, a reminder that the Board cannot take action on any item raised under public comment unless it is also agendized on this agenda, but it may be included on a future agenda.
I'm going to limit public comment to three minutes per caller. And if -- there is a second public comment period at the end of the meeting for folks who might have technological problems getting into the queue.
With that I'll turn it over to PEBP staff.
MR. MARTIN: Thank you, Madam Chair.
For those who have joined for public comment, your name or the last four digits of your phone number will be announced, and you'll be advised that you may now make your comments. Due to time considerations, as the Chair indicated, each call will be limited to three minutes.
Caller with the last four digits 2237, please

slowly state and spell your name for the record. Press star six to unmute.

MS. LOCKARD: Good morning. My name is Marlene Lockard representing the Retired Public Employees of Nevada. I would like to thank the outgoing Board Members for their many contributions to the PEBP system. And I would also like to welcome the new Board Members.

The action minutes of the July Board meeting cannot properly convey the robust and extensive discussion on the topic of the PEBP budget cuts and the direction the Board gave to staff regarding their wishes to apply for ARP funds to restore the budget cuts made during the 2021 Legislative Session.

Although, I am not listed in the minutes as speaking in public comment I can assure you that I did. The Executive Director's report reflect that an application for ARP funds was submitted but does not include the specific of the requested funds and the proposed use of those funds.

I respectfully request that the Board in full transparency provide a complete copy of the PEBP ARP request to ensure it adequately reflects the direction the Board communicated to staff with respect to Board priorities on the budget cuts.

RPEN also wishes to thank Nancy Spinelli for her

many years for service and dedication to ensure that PEBP remain true to its mission in providing, excuse me, the best quality of health care to its participants.

Because there are a number of new appointees to the PEBP Board over the last few years I felt it might be appropriate to point out that NRS 287.0426 specifically requires the director of the department of administration to appoint the quality control officer and define the duties of this position with concurrence of the PEBP Board.

For historical purposes I think it's important to note that this position was first established after the embezzlement of PEBP funds. The position was to report directly to the Board without filters and have quality control over contractors to ensure compliance and serve as the check and balance on past vulnerable practices.

I recommend the Board review the duties and responsibilities as described in the Executive Officer's report. The compensation and the original intent demands a much higher level of independent responsibility. The current lack of oversight of Aon in its 11 years of inaccurate projections clearly demonstrates the need of this position as originally intended.

These inaccurate projections have created million dollar profits for PEBP each year since 2011, this at a time

of increased benefit --

BOARD CHAIR FREED: Ms. Lockard, you've reached your three minutes. Please wrap up.

MS. LOCKARD: Thank you very much. Benefit costs and overly zealous cuts to benefits combined with the federal dollars, there are ample profits to restore benefits.

Finally, one last plea to eliminate the word subsidy and replace it with state contributions. Subsidy connotes a negative when, in fact, the subsidy is the state's contribution as outlined in the benefit package for employees. Thank you very much.

MR. MARTIN: Caller with the last four digits 7338. Please slowly state and spell your name for the record and please press star six to unmute.

MS. MALONEY: Good morning. I apologize. There was a little delay there. Priscilla Maloney, P-r-i-s-c-i-l-l-a M-a-l-o-n-e-y.

Good morning, Chair Freed, Members of the Board going out and Members of the Board coming -- coming in. So I want to first thank the outgoing Board Members for their service. Everything Ms. Lockard said so eloquently, ditto from the AFSCME retirees which is who I represent this morning. A big welcome to the new members of the Board coming on. And I know we're going to have some elections a

little bit later in the agenda. But, again, your service is so appreciated.

We know this is an extraordinary time and a lot of state entities to have a Board responsible for a health care plan in the middle of this historic pandemic is really something that is above and beyond service to Nevada. So we thank you from the bottom of our AFSCME hearts.

Real quickly, just saying ditto to everything Ms. Lockard said and also what was outlined in the written public comment from Dr. Ervin at the Nevada Faculty Alliance. Again, as Ms. Lockard said, all of the advocates are extremely concerned about what is being presented to the Nevada recoverers portal. We would like to know exactly what is asked for so we too can assist in that effort to get these benefits restored which were cut as a direct result of the COVID pandemic.

And then finally, the discussion of the excess reserves. Everything Ms. Lockard, again, so eloquently says about that going forward, I would remind especially for the purposes of maybe bringing the new Board Members up to speed. We have other catastrophic reserves incurred but not incurred -- incurred but not yet paid reserves. These excess reserves are a reflection of failure of -- of accurate forecasting a nonprofit self-insured health care plan should

not have excess reserves. They are in effect a profit.

And in that instance those funds need to be returned back to the members and back to their benefit plan so that they can have full -- full measure of money funded by the legislature to run this plan. So thank you. Looking forward to an exciting and lively meeting.

MR. MARTIN: Caller with the last four digits 8673, please slowly state and spell your name for the record. Press star six to unmute. And just a reminder to everyone, we have a three-minute limit on comments. Thank you.

MS. MAYLATH: Good morning. And thank you, Board, for listening. My name is Brook Maylath. That's B-r-o-o-k-e M-a-y-l-a-t-h.

And I would like to once again call attention to some of the discriminatory language that exists in several of the insurance offerings through the PEBP plan that are in violation of Title 7 as ruled under the post doc decision, as well as against the United Discrimination Nevada Revised Statutes.

The first theory is the Aflac extended hospital coverage that specifically denies any sort of coverage if the patient has been -- it requires extended stay due to a gender confirming surgery. That is blatantly discriminatory as this is a procedure that is covered amongst your plans for

employees and those covered lives that happen to be transgender and undergo a medically necessary gender affirming procedure.

The second thing is the language in the Consumer Driven Health Plan has specific barriers to accessing hormone therapy that are arbitrary and administrative and have no medical purpose that delay the ability for an individual to access hormone replacement therapy. Unlike the other plans, the career plans, the one deductible PPO plan and plans of that nature, and that language needs to be revised and replaced.

The third thing is that it is very important at the medically necessary procedures being expanded. There are specific exclusions that are in place that do not recognize the incredible medical necessity of certain procedures. This was discussed in legislation in the past session that unfortunately did not go through but the -- the issue is that these, for some individuals these types of procedures are indeed every bit of life affirming, life saving procedures as heart surgery or removal of an appendix or other issues of that -- of that nature.

MR. MARTIN: 30 seconds, 30 seconds remaining.

MS. MAYLATH: Last, I want to call attention to the Executive Officer's previous trans-phobic remarks. And I

would ask the Board to closely scrutinize whatever he's done to be able to make these things correct. I thank you for your time and your attention.

MR. MARTIN: Caller with the first name Joann. Please slowly state and spell your name for the record and press unmute to make your comment. Caller Joann, you may unmute and make your comment. Okay. We'll have to come back around.

Caller with the first name Kent. Please state and slowly spell your name for the record and press or rather unmute to make your comment.

MR. ERVIN: Kent Ervin, E-r-v-i-n. Can you hear me?

MR. MARTIN: Yes, we can. Thank you.

MR. ERVIN: I'm state president of the Nevada Faculty Alliance. My words for the record. Many thanks to the new and outgoing PEBP Board Members for your dedication and service to the state employees. I've submitted written comments which I hope you have read.

Ditto to all of Ms. Lockard's and Maloney's comments regarding making the ARP proposal public and the quality control officer position. The responsibilities of the QCO to oversee contracting seems to have been removed over the years, and we believe that contributed to the

problems found in the legislative audit of contracting procedures at PEBP.

On Agenda Item 9, we ask the Board to direct staff to prepare options to convert the excess reserves and to improve benefits for participants and for the use of potential American Rescue Plan Funds to fully restore benefits for FY 2023 and submit those proposals to the interim finance committee.

Current and recent past participants, not future participants, have paid for the excess reserves through higher out-of-pocket expenses, especially those employees with serious and chronic conditions or by foregoing treatment.

Our order of priority for restoration of benefits is lower out-of-pocket maximums, lower deductibles, elimination of deductibles and co-insurance on the HMO/EPO plan, long-term disability and restoration of basic life insurance, essentially returning to pre-pandemic benefits.

Finally, the repeated and now continuing annual generation of excess reserves far beyond projection and despite plans to spend them down every biennium is a serious problem. The excess reserves are euphemistically called differential cash. Actually it's the operating profit while participants' out-of-pocket costs are increasing.

It indicates the excess reserves rose again to 47,000,000, more than double the estimate that you got at rate-setting time. This indicates that the program is operating as a profit rather than using its full resources to provide benefits to employees.

Projections have been erratic and always seem to be low at rate-setting time and high at the end of the fiscal year. We again call on the PEBP Board to secure an independent audit of PEBP's actuarial, rate-setting and budgeting methods and to get to the bottom of this troubling pattern. Thank you.

MR. MARTIN: Caller with the first name Michael, please slowly state and spell your name for the record and press unmute to make your comment. Caller with the first name of Michael, you may press unmute and make your comment.

Caller with the first name of Tina, you may press unmute and make your comment. Please slowly state and spell your name for the record. Caller with the first name Tina, you may unmute and make your comment.

Caller with the last four digits 6503, please slowly state and spell your name for the record and press star six to unmute. Caller 6503, press star six to unmute and make your comment.

Caller with the first name Carter, you may unmute

and make your comment. Please state and spell your name for the record. Caller with the first name Carter, please press unmute and make your comment.

MR. BUNDY: This is Carter Bundy with AFSCME. Can you hear me?

MR. MARTIN: Yes, we can. Please slowly state and spell your name for the record.

MR. BUNDY: Carter, C-a-r-t-e-r Bundy, B-u-n-d-y. And I'm with AFSCME. I represent state employees. We want to echo the comments of Ms. Lockard and Ms. Maloney. We especially want to thank the outgoing Board Members and welcome the new Board Members. You don't get thanked enough for the work you do, and it is very appreciated. And we know we ask a lot of you but we do that because we know you care about state employees as well as we do.

One point, I don't want to be repetitive of previous points, but one thing that I really hope that the PEBP Board will do in advocating for RPEN funds is highlight the fact that we understand that PEBP is something that happens every year, and RPEN funds are one time funds.

But how are state employees any worse off if we face a lack of RPEN funds three years from now. Let's at least use this money now to restore the funds and then going forward either through reserves or general fund

appropriations we may be able to keep those benefits but at a minimum for the next three years because RPEN money is good until the middle of FY25. We ought to be restoring health care funds, and we hope that the PEBP Board will be an advocate for restoring those cuts. We will be a staunch partner with you. We thank you for your time and for your service and for advocating for state employees and retirees. Thank you.

MR. MARTIN: Caller with the last four digits 4404, you may press star six to unmute. Please state and slowly spell your name for the record.

MR. RAFT: Good morning, respective Board Members. My name is Kevin Ranft, R-a-n-f-t. I'm a labor representative with AFSCME Local 4041 representing active state employees.

I would like to ditto Ms. Lockard's, Ms. Maloney, Dr. Kent Ervin and Carter Bundy's comments. AFSCME Local 4041 welcomes the new Board Members. And we look forward to getting to know you and working with you to ensure the success of everyone. We also like to thank all the outgoing Board Members and dedicate them -- recognize them for their service. It's very appreciative.

The Board has numerous things going on in regards to upcoming opportunities to restore benefits. We strongly

ask that PEBP restore the benefits that were lost during the pandemic used in the ARP funds that must be done. There's no question, state employees cannot bear the burden during the pandemic on their backs. They have done it for years, no longer can this take place. State employees worked hard doing two or three jobs, and it's getting worse, especially with the mandates. There are going to be numerous employees potentially leaving. That has -- that work has to fall somewhere.

State employees need to be recognized for their hard work. It should not come out of their benefit plan. They were told when they got hired the benefit plans were come to the state. Come work for Nevada. We'll take care of you. We have great packages, benefit packages, retirement packages. Let's not let them down.

If regards to premiums we have to make sure that we lower the premiums to make it affordable. The cost of living has skyrocketed in the last year and a half. It's -- this is a difference between putting food on the table and paying for health care. This is something that employees really strongly are asking you through our office, through our organization to lower the premiums coming up in the next plan year and to restore those benefits and do whatever you can to make a difference. Thank you for your time.

MR. MARTIN: Caller with the last four digits 8853, please press star six to unmute and slowly state and spell your name for the record. Caller with the last four digits 8853, please press star six to unmute and make your comment.

It appears to be the end of the queue. For any callers who may have experienced a technical issue that prevented an opportunity to comment you will have another opportunity to speak in the final public segment at the end of today's meeting.

Madam Chair, the public comment has concluded.

BOARD CHAIR FREED: Thank you. Agenda Item Number 3, PEBP Board Disclosures for Applicable Board Meeting Agenda Items. For the benefit of the new Board Members this is a thing we do every meeting concerning the possibility that you yourselves as Board Members might be active employees or retired employees who are also on PEBP.

And with that I'll let Deputy Attorney General Briggs take it away.

MS. BRIGGS: Thank you, Madam Chair. Michelle Briggs for the record. This agenda item is to allow me to make a disclosure regarding conflicts of interests on behalf of Board Members who are eligible for PEBP benefits. Most of the items on today's agenda have an indirect effect on those

benefits.

But Item 9 in particular, regarding potential plan design changes for plan year 2023 relates more directly to PEBP member benefits.

Pursuant to NRS 281A.420 on behalf of the Board Members who are eligible for PEBP benefits or whose families are eligible for PEBP benefits, I offer this disclosure that they will be voting on those items that may affect the benefits available to them or their family members.

The law does not require abstention from voting merely because the Board Member or their family member is eligible for PEBP benefits. At this time I invite any of the other Board Members who have any additional disclosures to make to do so now. Thank you.

BOARD CHAIR FREED: Okay. Hearing none we will move to Agenda Item 4. This is the consent agenda. Typically what we do, new Board Members, is take any motion to approve all in one unless Board Members would like to pull individual items off for discussion.

So I trust you've all had time to read the reports that are in Agenda Item 4. Does any member want to pull one of these reports for further discussion?

MEMBER VERDUCCI: Tom Verducci for the record.

BOARD CHAIR FREED: Okay.

MEMBER VERDUCCI: I would like to pull 4.2.1, budget report.

BOARD CHAIR FREED: Okay. Okay. Anyone else?

MEMBER KELLY: Michelle Kelly here. I would like to pull 4.3.2, the Diabetes Care Management Report.

BOARD CHAIR FREED: All right. Okay. Anything else? Last call.

All right. So with that, I'll take a motion to accept all of the items on the consent Agenda Item 4, with the exception of 4.2.1, budget report and 4.3.2, the Diabetes Care Management Report.

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

BOARD CHAIR FREED: Thank you.

Do I have a second?

MEMBER KELLY: Michelle Kelly. I'll second.

BOARD CHAIR FREED: Thank you. All right. All those in favor say aye or wave your hand in your little box.

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

BOARD CHAIR FREED: Any opposed say no. All right. Motion carries.

With that, let's go back to Item 4.2.1, the budget report.

MEMBER VERDUCCI: Thank you. Tom Verducci for the record. I wanted to just ask a question on notification that we received that the total reserves for the year ending June 30, 2021 are projected to be 159,000,000. And, you know, I believe that 159,000,000 is actually cash on hand. But I wanted to see if we could hear from PEBP staff on the 159,000,000. Just, you know, a real big number there and a discussion on the reserves. I think that just give us a better understanding as we move through some of these other agenda items.

And I believe this, my question, inquiry will be directed towards Executive Officer Rich or if anyone else would be in a better position to address the budget, perhaps Aon, 4.2.1.

MS. EATON: This is Cari Eaton. I'll try to take this. The cash on hand is 159,000,000 and that is the difference between the expenditures and the revenue when we close the fiscal year. So that includes everything that we have for our required reserves and our differential cash. So that is where we end and balance that forward to fiscal year '22.

BOARD CHAIR FREED: Ms. Eaton, would you quickly run through the legislatively approved for FY22 IBNR, catastrophic and HRA reserves, and then talk about the excess

cash, differential cash, excess reserves as we used to call it.

MS. EATON: Yes. So the IBNR for fiscal year '22 is 52,286 -- 286,000. The catastrophic reserves are 34,875,000. And the HRA reduced down to $25,056,050 because that's an 80 percent balance of our ending HRA liability for fiscal year '21.

I can try to explain this. Sorry. It's very difficult. So for fiscal year '22, using the cash that's balanced forward, we subtract the required reserves and add the budgeted revenue and subtract the budgeted expenditures. The remainder is the new difference that we open fiscal year '22 for our excess for differential cash.

I'm not sure if that made sense. I'm sorry. What was the rest of your question?

BOARD CHAIR FREED: No. I just wanted to establish for the Board Members, yeah, 159,000,000 was brought forward into FY22, excuse me. And then you subtract the three actuarially determined or budget determined in the case of the HRA, and then you've got your excess of 38 -- 38.6 million.

MS. EATON: Point six, correct.

BOARD CHAIR FREED: Yeah. I checked the accounting system yesterday. And it was specific numbers I

see in category 86 is $38,555,339.

MS. EATON: That is correct.

BOARD CHAIR FREED: Okay, cool. Thank you.

Mr. Verducci, does that answer your question?

MEMBER VERDUCCI: Just a few additional remarks, perhaps a few questions. Is the 159,000,000, is this trend higher than in the past? It just seems like such a large number and I don't recall --

MS. EATON: No, it's actually not. So we began fiscal year '21 with 154.5 million. So it's pretty steady average. I believe fiscal year '20 was 150.3 million. So it is -- it's right there in the ballpark, and a lot of it does really depend on our required reserves.

MEMBER VERDUCCI: Okay. And then just as a follow-up, the 38.6 million in excess reserves is that ahead of projections, hearing the public testimony, public comment, you know, it appears that this figure is growing. But how much ahead of the actual projection are we in terms of real numbers where we're at?

MS. EATON: This is Cari Eaton for the record. Sorry. I've been forgetting to say that. I believe when we built our budget we were not anticipating reserves but with the COVID-19 claim suppression during legislative session I believe we told them it was going to be probably 32 or

35,000,000. I can't remember the exact number. So we are very close to what we were discussing during the legislative session.

MEMBER VERDUCCI: Yes. So Tom Verducci. Are we seeing any different trends in claim suppression in terms of no grabs. We have patients that are -- we can offer medical services. Do we see any trend in them returning and getting postponed items taken care of or are we still seeing claims suppression? Is there any trend there?

MS. RICH: So this is Laura Rich. Yes, Tom, we're actually going to be going into that a little bit and Aon is going to be talking about that in a future agenda item. So we can -- you know, if you're okay with that we can leave that discussion for I believe it's Agenda Item 9.

MEMBER VERDUCCI: Okay. Thank you very much. That's very good gaining all of the information that we can. I think it's a very important subject. So thank you for your time.

MEMBER KELLY: Chair Freed, Michelle Kelly here. I have a question about the budget report if you don't mind.

BOARD CHAIR FREED: Not at all.

MEMBER KELLY: Thank you. So -- so I'm looking at the report. I'm looking at the final paragraph. And I -- honestly I truly do not understand the budgeting. So this is

probably a very naive question, but I'm going to ask it anyway because I want to understand.

So the very final sentence is once all of the adjustments are approved through the state budgeting processing we end up with 38.6 million, but we started at 47,000,000. So that's a like $9,000,000 is a substantial amount of money. Where did it go?

MS. EATON: Cari Eaton for the record. It really is -- has to do with the difference in the fiscal year '21 budget and how the fiscal year '22 budget was built. So it's actually 8.2 million dollar difference, and really that variance is actually in our budgeted revenue and our budgeted expenditures for fiscal year '22. That is the exact difference.

MEMBER KELLY: So does that mean -- sorry. That was a lot. Michelle Kelly here. So when you say difference in the way the budget is built does that money still exist somewhere? Like, has it ended up in catastrophic reserves? Has it ended up in differential cash? Where is it because what we're seeing is 47 but really there's only 38.6. So I'm sorry. I'm just really confused, so.

MS. EATON: No problem. This is Cari Eaton for the record. It's difficult to explain without showing numbers and visual aids. But I believe it is just that those

funds are in our category budget. So it could be more claims budgeted for this year or things like that. So every year we budget different amounts and that's usually, that is always the variance between where we end one fiscal year and we begin the second.

MEMBER KELLY: Okay. So for example, can I just ask an example. So for example, if we have contracts out there that the goods are being delivered but they haven't invoiced us, is that the kind of thing that goes into that 9,000,000? So we're waiting on receipts to pay out. And obviously health insurance is more complicated than receipts, but is that kind of what it is?

MS. EATON: No, it's not that at all.

BOARD CHAIR FREED: Hey, Cari?

MS. EATON: Yes.

BOARD CHAIR FREED: This is Laura Freed. Is this an authority versus cash thing that I can take a shot with?

MS. EATON: Yes.

BOARD CHAIR FREED: All right. This is Laura Freed. I'm going to give this a shot. All right. So we end a fiscal year, and this is true of any state budget, my own included. We end a fiscal year. We spent whatever the money we spent on whichever expenditure categories we had. You know, '21 comes to a close. And fiscal folks like Cari end

up looking at the budgeted amount for every category in '22, and then they look at their ending cash and because PEBP has actuarial determined reserves they may go up or they may go down.

In this case HRA for instance went down from '21 to '22. IBNR and catastrophic went up. Correct me if I'm wrong about that, Cari.

And so when she is doing the paperwork with the GFO to carry that cash forward she is also truing up the authority to spend in each of these reserve categories that she's got in the PEBP budget and then -- and so she's adding authority based on or she may or may not, depending on whether, you know, whether the ledger approved budget for '22 had the right number, if you will, from -- for the actuarially determined IBNR and catastrophic and then she is truing up the HRA based on what that number was approved, and then she's putting the balance, if you will, into differential cash formally known as excess reserve.

And so the difference between the 47,000,000 and the ending of 38.6 is her truing up her budgeted authority to the cash she actually has and budgets with various reserve categories tend to do this. Does that help?

MEMBER KELLY: I think it does. Obviously, it's clear as mud to everyone, right. It's just one of those

things that happens and it's somewhat confusing. And I just -- in response to your explanation, Cari, and, Chair Freed, thank you very much.

I just have one last question. I'm sorry. So we've talked a lot about the reserves and the actuarial kind of calculations. Where do those come from? Who does them? And can we kind of see a more detailed report on that? Because it's just my struggling to understand the budgeting process, so because it's everything we do, right? So I appreciate that.

MS. RICH: So Laura Rich for the record. Ms. Kelly, there's a lot of different actuarial calculations that happen in PEBP. So I think when you ask can we see that, yes. Obviously, you know, we can produce to the Board whatever it wants to see. But I think we need more specifics as to, you know, what exactly are you referring to because there's projections, calculations that happen on a daily basis that involve, you know, very simple things to much more complex things. It just depends on, you know, what -- what exactly you're referring to.

MEMBER KELLY: I guess I'm just sensitive to the public comment, Executive Officer Rich. Thank you. Michelle Kelly for the record. I'm sensitive to the public comment about kind of the continuation of kind of, especially the

excess, the differential budget.

But I'm also -- I also want to understand for example the IBNR. You know, that obviously that is incurred but not reported. So there's a lot of guesses in that, right, because these are services, some of the things have been incurred but they haven't been reported yet. So that tells me maybe incorrectly but that this is truly projection or forecast. It's not based on any action necessarily but rather action from other participants and kind of what they are expecting.

So I just, once again for me it's just about understanding the different levels and how I'm assuming it's Aon who actually provides the data, how it's provided and just maybe honestly it could just be an overview. Obviously, I'm not an actuarial person. So I'm not going to understand the full report. But I think it would be helpful to me just to understand how all these figures are -- how they come up with them and then because what is so important what we're going to be talking about today, right, Item Number 9. But everything we do kind of revolves around the budgeting process. So thank you.

BOARD CHAIR FREED: This is Laura Freed. I believe we get yearly the report of Aon's predictions of IBNR and catastrophic, and I want to say it's in August of each

year; is that right? And it usually goes on like a fall Board meeting although this is Autumn. But is that something that Aon has completed and would we see that on the November meeting?

MS. RICH: It is, yes.

BOARD CHAIR FREED: Okay.

MS. RICH: This is Laura Rich for the record. Yes, we do get a letter from Aon that states the reserves, and that is actually produced to, as part of the packet that goes over to the interim retirement benefits committee.

BOARD CHAIR FREED: Yeah, okay.

MS. RICH: And so that will be put together here shortly and made public within I'm assuming the next couple of months.

BOARD CHAIR FREED: Okay.

MS. RICH: But it is something that can be brought to the Board as well.

BOARD CHAIR FREED: Has the interim retirement of benefits committee meeting been scheduled for December or January or something as it usually is?

MS. RICH: Not yet.

BOARD CHAIR FREED: Okay.

MS. RICH: We did -- we did get the letter requesting the information. So we'll be getting that to the

legislature by November 1st I believe the due date is, and it's expected that IRBC won't meet until Januaryish, but we don't have a date yet.

BOARD CHAIR FREED: Okay. Thank you.

MEMBER KELLY: Just a clarifying question then, Chair Freed. So is -- can that letter be provided to the Board prior to the interim benefit committee seeing it or if it's produced by November 1st, we've got a meeting in November, so can we see it at that point or when are we allowed to see it?

BOARD CHAIR FREED: Yeah, I don't see why not. And I think staff will put that on the usual consent agenda.

MEMBER KELLY: Thanks so much everyone for indulging me.

BOARD CHAIR FREED: No, no problem.

They are not taking their mic buttons off so that means we're okay. I lost track of where we are. Oh, we're on the budget report.

Okay. So does anybody else have questions on Agenda Item 4.2.1?

Okay. Hearing none, let us go to the 4.3.2 I believe it was. Is that it, Diabetes Care Management.

MEMBER KELLY: Yes. Thank you, Chair Freed. Michelle Kelly for the record. I just have a question. I

think it's for Executive Officer Rich. I'm curious about this program. Obviously, looking at the report we have a lot of people with diabetes. We only have around 400 participants in this program. So I'm just wondering what benefits does the program offer and how is it communicated to participants at the moment?

MS. RICH: So Laura Rich for the record. You are correct. There are a lot more participants with diabetes than those who participate in the Diabetes Care Management Program. This is a value based benefit where basically what it does is it provides insulin and other diabetes related materials and, you know, in services through a, at lower prices, right, so at much much lower prices. And it's a co-pay versus a co-insurance or, you know, you're paying a co-pay versus me taking that either 100 percent through your deductible phase or 20 percent through co-insurance. So it does provide a benefit.

Now members do have to enroll in that program, and they do have to follow certain requirements. So you have to see your doctor. You've got to get your lab work done, things like that.

I will admit that in the past this was a much more robust service. It was done through a previous vendor at a cost, and they did receive services through Health

Professionals. I think a nurse called them. This was several years ago. A nurse called them once a month, and there was like a monthly checkup on these individuals.

We had some issues with the vendor. We had data issues. We had enrollment issues and we ended up changing vendors and this went to now through the HealthSCOPE contract. And I believe, if I remember correctly, this was probably at least four years ago when this happened.

So HealthSCOPE is doing it now at no cost and it is -- it's just part of that contract. There hasn't been more than just that value based benefit that members are getting. There's not a lot of outreach. There's not a lot of hand-holding that was done in the past. It is something that we have looked at in terms of potentially bringing a diabetes, a more robust diabetes program.

But it is not something that I know prior to -- to being appointed Executive Officer this is something that was looked at. At the time there was no money for it, and I don't think that there was, the determination was made that the value, we couldn't reach an ROI. It does not mean that this is something that we won't pursue in the future because I believe especially with COVID -- in fact, we met with our PBM yesterday and we talked about some new weight loss drugs that are coming on the market and things like that.

This was -- this was a discussion that we had where it was, you know, something that health plans need to watch out for because some of these weight loss medications that are coming out are quite costly and might affect the plan. And so but with COVID and the fact that, you know, people have put on their COVID 20s. You know, there's definitely been a focus on weight gain and obesity, especially through the pandemic, and so this is something we're going to have to start to look at.

And this was a discussion, again, that we had with the PBM yesterday because our numbers on the pharmacy side versus the medical side, right, there are people that aren't in this program. Now, we don't know why. We don't know why they're, and this has been the case for as long as I've been at PEBP, we don't know why people aren't taking advantage of this value based program and -- and they are just getting their insulin without this co-pay. Basically it's a cost assistance.

So it is something that we're going to be looking at. Unfortunately, we just haven't had the bandwidth yet. This is -- we've got contract after contract after contract that's out right now. So it's not something we've had the time to explore, but it is something that we have -- that's kind of on the back burner as, you know, this is something we

need to look at moving forward.

MEMBER VERDUCCI: Thank you, Executive Officer Rich. So then in your mind is this program kind of very much linked with the obesity care management that I didn't pull out but so kind of it's two programs in conjunction you would be looking at going forward?

MS. RICH: Laura Rich for the record. Yes. We have also looked at the Obesity Care Management Program as well. There's some -- there's some differences there. They don't exactly overlap. You think that they would but they don't exactly overlap.

They do have some -- there's some challenges with the obesity care management because of the medical licensure requirements of the providers that are providing this kind of service. But it is something yet again that we need to really take some time and look at in the future as we get all of these contracts wrapped up, as we have new vendors as, you know, when we establish our -- our new partnerships and who exactly we're working with and then we can then -- and you'll hear this in one of my reports coming up that it's very difficult to bring ideas to the table when you don't know what vendors are going to be working with moving forward.

And so we've got to let the dust settle a little bit before we can really bring some of these things to the

Board and look at options and new implementations. And beyond that members are -- are experiencing and will continue to experience with all of these changes and vendors are going to be experiencing a lot of change. And so, again, we want to let the dust settle before we push more change on to them as well. So, you know, let's give them a little bit of a breather before we say we got this brand new thing too.

MEMBER KELLY: Right. Thank you.

So one last question. So for participants who might be interested in participating in diabetes care or the other program, I assume that there's detailed information on the benefits and the process for signing up in the master plan documents. Is it contained anywhere else? Like are their brochures available that people can source?

MS. RICH: There is. Laura Rich for the record. There is. There -- it's also on the HealthSCOPE website. It is in all of our enrollment materials. I believe the forms are on our website as well, not just the HealthSCOPE website, I believe they are. So there's mechanisms for people to enroll.

Again, it hasn't been because this is somewhat of a free service through our vendor today, there's not a lot of outreach and there's not a lot of proactive outreach, but we have done so in the past. We've reached out to people not

within the last couple of years. But I know since I've been at PEBP we have done an outreach campaign because the numbers of people on insulin in our plan did not meet or did not match with the numbers of people, the number of people on our Diabetes Care Management Program. And so that was a little bit of a concern to us.

Now, granted there are people that, you know, might be, you know, on different plans and things like that that, you know, they or perhaps they already meet their out-of-pocket max and so it doesn't really benefit them. So there's -- there's different reasons for it but I -- I will admit that we could be better at reaching out to these people.

MEMBER KELLY: Thank you.

MEMBER AIELLO: This is Betsy. I have a question. I believe we have a care management entity in American Health Holding. And I did have a diagnosis that tripped them to reach out to me. I don't know if this is one of the diagnosis that would reach them to trip them to reach out to a plan participant.

But my diagnosis, they called me and provided resources. So I'm wondering if that's a process and if that's a diagnosis that American Health Holdings would then contact somebody. Now, people a lot of times with all of

these bogus phone calls we get may not believe it but it was helpful to me when they reached out and provided resources.

MS. RICH: So Laura Rich for the record. American Health Holdings, they are a utilization management company and case management. They would typically reach out in complex or high cost cases. So an insulin or diabetes diagnosis is not one of those necessarily high cost cases that would prompt AHH to reach out.

They are more of a, you know, perhaps a cancer diagnosis or, you know, they are involved in our bariatric surgeries, things like that, some of those situations that would require a lot of hand-holding through or not require but could -- the member would benefit through that hand-holding process. So diabetes is not necessarily something that would fall into that category unfortunately.

BOARD CHAIR FREED: Okay. Were there other questions?

Okay. Hearing none, I'll accept a motion to accept Agenda Item 4.2.1, the budget report and 4.3.2, the Diabetes Care Management from HealthSCOPE.

MEMBER KELLY: Michelle Kelly here. So moved.

BOARD CHAIR FREED: Thank you.

Do I have a second?

MEMBER AIELLO: Betsy Aiello. I second.

BOARD CHAIR FREED: Great. Thank you very much.

All in favor say aye.

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

BOARD CHAIR FREED: Any opposed say no.

Okay. Thanks, guys.

We will move on to Agenda Item 5. Every year we have to elect a Board Vice Chair. And I have been advised that the only person who expressed an interest in being the Vice Chair was Member Fox but if that is not the case please speak now. I would be happy to have a discussion about it. And, of course, the duties of the Vice Chair involve, you know, running the meeting if I'm absent for some reason.

Okay. Awkward silence. I love it. Well, then I am happy to move to have Member Linda Fox continue as PEBP Board Vice Chair for the next year.

MEMBER AIELLO: This is Betsy. I second it.

BOARD CHAIR FREED: Okay. Thank you. All in favor say aye.

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

BOARD CHAIR FREED: Any opposed say no. Okay. Motion carries.

Thank you. Congratulations or condolences as you

see fit, Ms. Fox.

Agenda Item 6, Executive Officer Report.

MS. RICH: All right. Laura Rich for the record. This is Agenda Item 6, Executive Officer Report. Basically this report will provide the Board participants, public and stakeholders information on PEBP activities.

So the first update that I would like to provide is regarding the American Rescue Plan Funds. So PEBP did submit its request for the American Rescue Plan Funds through the every Nevadan Recovery framework link per the Board approved direction in -- at the July 2021 meeting. I know there was some comment regarding what was submitted.

And actually I attempted to get a copy of what was submitted but unfortunately the way this portal works, it does not provide that opportunity to print anything out once something is submitted.

I did actually reach out to the State Treasurer's office just to make sure that this request was received, and I did get confirmation on that. So the State Treasurer's Office has hosted many meetings throughout the state as part of what they call the listening tour. And it's expected that funding decisions will be made in the coming months, but that is pretty much as far as -- as, you know, the information that we have, it is we do not have any information. We just

do not.

I think, Chair Freed, did you want to say something?

BOARD CHAIR FREED: I can't. You've triggered me. I'm sorry, Laura. As somebody who has funding requests in that ARP portal for her own department I'm dying to know what coming months means. Because the sense that I've gotten is these decisions will not be made until well into next calendar year. Is that consistent with the sense that you've gotten from your discussion with the Treasurer's Office?

MS. RICH: That is consistent. However, I have made sure to emphasize PEBP's timing requirements both with the Governor's Office and with the State Treasurer's Office. I reminded them both that there are planning time frames that are necessary if we were to get these funds. Getting funds in March does not help PEBP whatsoever because we've already completed rate-setting, and so this has been emphasized.

I will continue to bring it up onto the radar as much as I can to the State Treasurer's Office and the Governor's Office but they are aware. I will do what I can on my side to, you know, prompt those conversations. But as we have not received any specific guidance or any other information. So, you know, at this point we are just kind of at a sit and wait.

Additionally, PEBP was also given instruction initially from the Governor's finance office the request for additional CARES Act funding would also have to be submitted in the same manner through that portal and so we did. We submitted it, a second request through the portal for the use of additional CARES Act funding for those COVID-19 costs that were or that have been incurred by the plan to date.

However, most recently PEBP and GFO, we were working together, and we've had follow-up discussions and there was new guidance that basically has, they indicated that PEBP would need to submit a work program for up to $5,000,000 in reimbursements.

And for those of you who have not seen that that is on the October IFC agenda. So we potentially will get an extra $5,000,000 for costs, COVID-19 costs to date and any future costs up to those $5,000,000.

To date PEBP has received about nine and a half million dollars in federal funds.

MEMBER KRUPP: I have a question.

MS. RICH: Go ahead.

MEMBER KRUPP: For the COVID costs, the COVID-19 costs incurred to date, is that plan year '22 or is that since the beginning of?

MS. RICH: So, yeah, to date. So up until -- so

the nine and a half million dollars have been already issued. Those $5,000,000 are for -- for the additional COVID cost that the plan will incur. So up through, you know, $5,000,000 which we're going to use all 5,000,000 of that. I don't have the numbers off the top of my head. But I know we already have COVID costs to cover part of that 5,000,000 if not all of that 5,000,000.

MEMBER KRUPP: So does --

BOARD CHAIR FREED: Oh, I'm sorry, Member Krupp. Please go ahead.

MEMBER KRUPP: Jennifer Krupp for the record. But so is this beginning with this plan year, so plan year '22 or fiscal year '22 or is this encompassing some other previous plan year, fiscal year as well? I'm unclear what the starting date is.

MS. RICH: So this is all COVID-19 costs to date. So this encompasses originally CARES Act funding. We thought CARES Act funding was going to end at the end of 2020. And so the claims costs that were projected, we try to project out as much as possible to get that, the funds in 2020, and then that was later extended.

And so when that was extended that kind of opened the doors up for PEBP to say, okay, we've got all of these future costs as well. And so they have provided -- they are

allocating $5,000,000 of COVID-19 reimbursement. So anything we use up to those $5,000,000 which my expectation is we're going to use them, all of them.

MEMBER KRUPP: Thank you for that clarification.

MS. RICH: So for staffing updates, as you heard through public comment, and I believe Nancy is not on, but I am 100 percent sure she's listening as a -- as a member of the public. So many PEBP members at one point have interacted with one of our long time staff members, Quality Control Officer Nancy Spinelli. She's been at PEBP for or had been at PEBP for over two decades, pretty much worked at every position at PEBP, starting from the bottom up. And most recently she was a quality control officer where she was responsible for handling member complaints and issues and a whole lot of other things.

She also dealt very closely with the retirees who came to know her very well because of her Medicare expertise as well. So she did announce last month that she would finally be retiring and that her last day would be September 10th. So she has since retired. She is most definitely missed and has left a significant gap on our team.

But I'm also happy to announce that we do have a new quality control officer, former Board Member Tim Lindley was appointed on September 20th. So he will be filling

Nancy's role, big shoes to fill there, although Nancy's shoes were very tiny. His -- his experience on the Board and also his auditing background will prove to be very useful in this role. So I'm really excited and happy to welcome him to this new role.

Another staffing change, which you will see later on in some of these future agenda items happened with our vendor partner Aon. So most of the Board Members are used to seeing Stephanie Messier, who had been very very crucial and played a vital role in all of, everything that PEBP does, and she recently left her position at Aon. So as a result we will see new Aon representatives take her role on and they all -- I'll leave it up to them to introduce themselves in a future agenda item. So that's been a major change as well.

So another update that I want to just bring to the attention of the Board and luckily we do have a solution. So I'm happy that I'm bringing a solution to the table as well. So since 2010 PEBP's master plan documents have required members to receive their routine lab services. And I say routine lab services because we're not talking about, you know, pre ops and things like that. We're just talking about routine lab services through independent labs such as Quest and LabCorp.

And the reason why we've done this, this is a

safety net in our plan document because the -- there are the fees that are charged by hospital based labs are substantially high compared to those that are charged for the same services through independent labs. And when I say substantially high it could be three to four times more. So -- so that is why we have this plan rule in our master plan document.

Before July 1st PEBP didn't really have to enforce this plan or this role because the relationship between Hometown Health which was in-network at the time and Renown maintained fees that were not those hospital based rates. They were the independent based rate fees or fee schedule that was -- that was applied. And so they weren't the hospital fee schedule. And so we were able to allow members to use Renown labs. And I'm saying Renown labs, there's also Saint Mary's, right, so anything that is a hospital based lab. I'm saying Renown labs because in the north they are such a major provider.

So after switching to the Etna network, contracted rates for Renown labs is now being billed at that higher hospital rate. So that would have increased plan costs dramatically if the plan requirement wasn't enforced. So we have had to enforce that plan.

It is important to note though that Renown labs

are in-network through Etna and members can still access them because they are in-network for hospital pre-admission and outpatient surgery. And in -- and if they wanted to pay out-of-pocket they could as well. The plan would because of that plan rule they would deny the -- the claim but because they are in-network they are still able to access them if they are willing to pay cash prices.

So to add to this the master plan document has some exceptions. One of the big exceptions is that because of the demographics of Nevada, we've got people that live further than 50 miles away from the nearest independent lab, right. So for example, members out in Fallon, they don't have access to an independent lab within 50 miles. And so we've made exceptions to the rule and what we've said is, okay, if you don't have an independent lab within 50 miles you get to use a hospital based lab in your area and we'll pay the claim as if it were a normal independent lab.

And so that's one of the exceptions. There's a few other exceptions to the rule but that's one of the major exceptions. So this can be confusing for members since the provider directory does display that Renown labs is an in-network provider, and we realize this. And PEBP released a lot of communication.

So leading into open enrollment, even after open

enrollment we've sent letters out. We have included this in all of the open enrollment materials. We've sent e-mails. We've sent -- we blasted members with as much education material as we can to let them know that -- that hospital based labs are not a covered benefit under the master plan document.

We've also coordinated with HealthSCOPE Benefits to allow a one-time exception and an education opportunity. So what we're doing is we're saying because people are so used to going to their Renown provider that we didn't want people to be surprised because we all know that people don't read their mail. Sometimes, you know, things go to your junk mail and so there's going to be people that don't understand and that end up going to their normal lab because this is what they've done, and so and they are not aware that this is not a covered benefit.

So what we've done is we've instituted a pay and educate and so that first claim will get paid. And -- and then we'll make sure to educate that member and say in the future you need to go to an independent lab because future claims for -- for your routine labs will not be paid through a hospital based lab.

So that has been -- that has been put in place. We're actually still working through some of the details with

HealthSCOPE, but we are -- we are working towards that so that at least members have a one-time opportunity to, you know, not get that surprise billing.

So PEBP has also been in discussions with Renown because Renown originally had some concerns that, you know, they heard of this situation. And so what they didn't want to end up with is a lot of angry members who are now stuck with bills that claims that are getting denied, right, with high cost bills.

And so what they did is they said, okay, well, since this is the case and Renown labs has been essentially carved out because of the hospital based lab fee schedule we're just going to tell patients that come through Renown, PEBP members that come to Renown that they -- you know, that they are not, unless they pay cash prices that they are not accepted patients.

And so there was a little bit of a, you know, there was some confusion, especially out in the Fallon area where, you know, they didn't have other alternatives and so PEBP and Renown met to try to come up with some options and some, you know, some alternatives.

After it was explained that we're going to do this pay and educate and they're not going to be stuck with a whole lot of angry members with high cost bills Renown has

opted to, you know, to work with PEBP and to allow members to access their labs and instead have PEBP and HealthSCOPE do what we need to do on our side to -- to ensure that labs or that members are getting, you know, have access to Renown labs and are getting their claims paid and are getting educated. And those who are for example in the Fallon area that have those exceptions were able to process those accurately.

So I think Renown was under the impression that operationally they would have to figure that out, and they didn't have the ability to figure that out operationally, you know, whether someone is -- is eligible for the exception or not. And so through these discussions we eventually landed on PEBP can do this on our end with HealthSCOPE coordinating and we will process the claims accordingly. We're going to try to mitigate the confusion by doing that pay and educate and hopefully that should reduce the amount of complaints and concerns that Renown has.

So I do have actually a member representative from Renown that is available additionally for questions because I know that there's been some concern that especially up in the, you know, Northern Nevada area that we've had some, you know, access issues and with Renown partnering with the university system up in the north yet the staff there do

not have access to the Renown labs. You know, services, that's been a little bit frustrating.

Unfortunately, you know, this is -- this isn't a plan rule. We did the -- we did an analysis and in that analysis we looked at plan year '20 Renown labs and I say plan year '20 because really anything after that is not good data because of the COVID situation. Those labs represented about 33 percent of overall lab claims which is about 64,000.

Had these been priced through Etna, the price between what we paid versus what we would have paid is about $1,000,000 more. So the cost is definitely, it's significant. It's -- it's a big cost just for, and this is just taking into consideration Renown, right. Like I said, there's, you know, hospital based labs across the country. There's just in the north there's also Saint Mary's. You know, so this rule protects us from those high cost labs.

So it is -- it's an inconvenience for sure, especially for those members up in the north, but it also is a big -- it's a significant cost to the program to if you take into consideration the difference in cost.

So I will stop there because I know I've had -- I've said a lot, and I know this issue has been, you know, escalated through, you know, through some of the university system channels. And so I wanted to give the Board an

opportunity to ask any questions or discuss anything on this matter.

MEMBER AIELLO: This is Betsy. May I ask a question.

BOARD CHAIR FREED: Go ahead.

MEMBER AIELLO: So I totally understand that inpatient is covered and outpatient surgery. Labs are covered and regular ongoing labs are not that difficult to get from a freestanding lab. I made the transition a few years ago myself because I had been told when I was in Carson City that I couldn't get it hospital based. So it wasn't that hard though I had been used to using Renown.

My question is that you mentioned during infusion procedures, so now this is kind of, I don't understand how that would work because I know during infusion procedures they usually run lab as part of the procedure, and I'm not sure how that's going to work if -- everything else makes sense to me, the outpatient surgeries and everything, but I'm wondering if we can understand that one.

MS. RICH: So this was -- and Laura Rich for the record. This is one of those exceptions, right. So we would pay that claim. However, in initial discussions with Renown we had some concerns because for them it was an all or nothing, right. We either service all your members or we

don't service any of your members.

And so operationally they said we can't -- we can't accommodate the exceptions. And so -- so that is why we have the solution is let PEBP accommodate the exceptions. We will figure this out on our end and Renown please just open it up, right. Like just accept -- accept patients and we will deal with it on our side. So that is what they're doing.

MEMBER AIELLO: So my understanding is at least in a functional manner the infusion procedure lab would run the same as outpatient surgery or inpatient lab?

MS. RICH: Correct.

MEMBER AIELLO: Okay.

MEMBER KELLY: Michelle Kelly for the record. Thank you for that explanation, Executive Officer Rich. So personally I just wanted to just kind of address the fact that PEBP did communicate this because I'm well aware that PEBP communicated your open enrollment.

I think the problem or the confusion comes because as you said yourself there's been a longstanding exemption to this because of the way Renown was billing their freestanding lab.

So, well, basically the message they sent out was the same message that was sent out when this change was made

and people just didn't understand because so to, you know, most of your way of thinking those Renown labs are freestanding, they are independent. So behind the scene participants don't see what they are billing and stuff. So I just wanted to put that out there.

But I also wonder -- you know, I wonder if -- it's curious to me I guess that Renown has set up this network of freestanding labs and yet under the Etna contract they are billing them as hospital labs because the hospital, when they are doing the labs they are obviously paying for all of that infrastructure. We've talked about that before, you know, that goes into running a hospital. So maybe it's a question for the Renown person.

So the setup is independent different labs in Reno and yet they are billing them as if they are attached to the hospital. I don't really understand that. And I wonder if it's a direct question to Renown, are they willing to negotiate a carveout for PEBP given the number of members that we have that could potentially be using these labs or would like to use these labs. Let's put it that way.

So I wonder if there's an opportunity. I know you've already been negotiating. But I would like to hear from them about whether or not they would be willing to negotiate this carveout or talk about their billing, you

know, their kind of billing practices. Why are they billing freestanding labs at hospital lab rates.

MS. RICH: So this is Laura Rich. So as I understand it, they are -- the freestanding labs are really draw stations, but the actual services are performed in the hospital. So the freestanding labs are just those draw stations.

I thought we had -- I did see Chris Bosse. Oh, she is here. Chris, do you want to chime in and maybe speak to that second part.

MS. BOSSE: Good morning. My name is Chris Bosse. I am the chief government relations officer for Renown Health. Laura, I appreciate the opportunity to join the meeting and especially on this important topic. We have -- Renown Health has been long-time partners with PEBP and the state and we're very proud of our history in -- in providing care to PEBP members.

As I think your question, I just want to make sure that I'm answering specifically, Michelle, that you're asking would we consider contracting differently for lab services. And my sense is Laura and I have had some small amount of discussion about this. The problem from an administration perspective is you -- prior to the Etna contract when you had a hometown contract we can manage from

a payer perspective specifics to a population and it's the rules for that payer.

Unfortunately when you become part of a commercial contract, our ability to manage the specifics that your plan is intending to look at, the complication is we have like Laura was saying more than 20 draw station locations and registration people at those locations.

So our ability to do -- to manage the contract specifics at those sites and do it well, not mess it up, is somewhat limited which is why we were leaning in on the turn it on turn it off perspective. So as long as you're under the Etna contract we have to treat you like Etna or at the employer level we can turn off access which is what -- but we can't do partial.

We can't say, oh, but what service are you having today and train 100 people to do that well. I hope that makes sense. So that's the struggle that we just entered into. And Laura and her team and HealthSCOPE I think have come up with a good process to manage the issue. But, you know, sadly and I think what maybe you were leaning towards is you -- you over time we're going to try to educate PEBP members to not use Renown labs. And at some point we may need to have a different contracting discussion.

But with the current framework we're unable to

administer kind of some benefits in certain locations for certain services at the employer level. We can do it for the -- an entire contract and that -- that can be system -- it can be managed through the system. I hope that makes sense.

MEMBER KELLY: I guess -- Michelle Kelly for the record. I guess that's what I'm asking is Renown willing to negotiate a contract directly with PEBP for these lab service. Because I'm somewhat confused by for example the lab -- the drawing station conversation because I now live in the south, but I did live in the north, and I've used the Renown freestanding facilities.

One of the uses, of course, is mammograms. So when I went off to the Renown mammogram I assume that's covered under the lab area there. No? I'm wrong, okay. Because so maybe we need some clarification there. So is it only blood work? Is it -- but my first question I guess is is Renown willing to negotiate in good faith to come up with better pricing for your freestanding labs for PEBP?

MS. BOSSE: Yeah. Chris Bosse for the record. I think that we're always willing to negotiate to try to better meet the needs of, you know, the people that we serve. Right now labs is part of an entire contract so it's difficult for us to pull out certain pieces because you don't like that

piece and you want a better price on that piece and these other pieces you've decided are maybe great prices which is why you entered into the Etna, you know.

So the contracting piece gets a little confusing, and but we're absolutely willing to sit down and talk about the components and figure out how we can -- how we can support our PEBP partners. And you guys have been partners to Renown Health for decades.

MS. RICH: This is Laura Rich.

MEMBER KELLY: Thank you.

MS. RICH: And, Michelle, I wanted to just address another piece too. That we -- we contract with Etna and so for -- for that network. Technically we are contractually not able to contract outside of the network contract. So that would have to be something that Etna would have to allow us to do if we did that and so there's -- there's a lot of moving pieces to this.

MEMBER KELLY: Okay. Thank you. And just to correct my misunderstanding out to anyone who's listening out there. Can you explain the difference between, because I referenced mammograms because that happens at a freestanding Renown facility. So can you maybe talk about what we're talking about so people can still use the mammogram facilities is what I heard. Can you maybe just explain the

difference between the lab draw stations and the other facilities that Renown has. And I'm sorry for the confusion.

MS. RICH: Sure. So this is -- so -- so when we refer to labs it's blood work, right. So you go in and get your -- your blood work for let's say your prostate screening or your thyroid screening or cholesterol, things like that, right. So mammograms are radiology and that -- so it's different.

MEMBER KELLY: And that would be true of prostate screening as well. So for mammograms and prostate screening our members continue -- can continue to use the Renown facilities as long as they are in network. So it's only blood work we're talking about.

MS. RICH: Correct.

MEMBER KELLY: I appreciate the clarification.

MEMBER AIELLO: And this is Betsy. As someone that made the transition, Michelle, I had always gotten my blood drawn at Renown for many many years. A couple of years ago I made the transition. But you can still have your PCP's through Renown. You still can go to Renown urgent cares and things like that. It's just strictly the lab.

And the interesting thing is that not in all cases but in some cases the Renown lab is on the left side of the hall in the building and the LabCorp or Quest or other

lab is on the right side of the hall in the building. And so that -- that helps too. Sometimes you can always -- not when you go to the hospital facility itself but freestanding they -- there's quite a few of them but it is a learning. If someone has been going 20 years to the Renown lab and gone to the same lab forever it will be a learning curve. And I do have to congratulate PEBP in the fact that I got e-mails. I got more than one letter myself. So they are trying.

And then with that training thing, I think that's a good idea to let someone do it once and then get a letter and say. So hopefully all of that will help. But it is a change. It is a change and it's hard to change after many years.

MS. RICH: And I do want to add.

MEMBER KELLY: I just want to put out there -- go ahead.

MS. RICH: I just want to provide clarification. It's not just blood work. It's urine as well.

MEMBER VERDUCCI: Tom Verducci for the record. So, you know, I wanted some help in understanding this. I don't know exactly who this is going to be directed to. But what I'm hearing is we had a relationship with Hometown Health and Renown. And since that relationship is gone we now have an extra $1,000,000 that we're paying, the employees

are paying that's going to and I believe Renown that's going to Etna. Please correct me. And myself personally, I've gone to these detached labs and sometimes they are closed. Sometimes they have you wait out in the car. They send you home and it's not quite the professional hospital, and we're going to have some employees that they're going to have one-time forgiveness and they are going to just want to get their lab work done and go home and have to be billed it.

But I think are -- when we switched from Hometown Health over to Etna there was a 4,000,000 dollar cost savings I believe. So here we have not merely a 4,000,000 cost savings, only 3,000,000. So we lost 25 percent of our cost savings through the RFP process. So, you know, if there's some negotiation which I'm sure can be done and, you know, perhaps we update the plan document, expand the 50-mile rule, look at anybody.

But it doesn't seem like the environment we're in right now, the employees who accidentally get their lab work done at the hospital have to incur extra expenses. We want to be able to provide the most competitive fee structure in the current environment that we're in. So I think there should be some direction. And I think I heard Ms. Bosse say they would be open to a negotiation of some -- some source of negotiating that. You know, I would like to see our fees go

down, not go up. Employees are already paying enough.

BOARD CHAIR FREED: This is Laura Freed for the record. Tom, where did you get your 4,000,000 dollar savings from Hometown to Etna? Are you referring to a past Board item or a contract or something that the rest of the Board isn't looking at?

MEMBER VERDUCCI: And thank you, Chair Freed. So I understand we went through Hometown Health RFP that during the process of replacing Etna, this would be my discussion with Executive Officer Rich when I was inquiring at a prior meeting as far as how much we have saved --

BOARD CHAIR FREED: Right.

MEMBER VERDUCCI: -- by going through the RFP process, that it was a 4,000,000 dollar contract savings. I think that was our --

BOARD CHAIR FREED: Oh, okay. You're referring to the total value of the life of the contract with Etna as opposed to the previous one with Hometown Health Network?

MEMBER VERDUCCI: Yes, Chair Freed, that's absolutely correct.

BOARD CHAIR FREED: Okay. Got it, all right. With that clarification I'll let you finish the question before you answer it.

MEMBER VERDUCCI: Sorry to make this long. But

$4,000,000 extra and let me just narrow it down to one question. Where does that $1,000,000 go?

MS. RICH: So Laura Rich for the record. Let me provide a little bit of clarification. So when the analysis was done during the RFP process the analysis projected that moving from the Hometown Health Network to the Etna Network would generate a projected $4,000,000 in savings. So that was partially and, again, I'm not part of the evaluation committee. So I -- but my assumption is that that is what partially won that bid.

So in that -- in that analysis it takes into account everything. It takes into account all of the claims, right. So that analysis did factor in the -- the Renown pricing. So this $1,000,000 is outside of that. The plan, the master plan document has this built in as a plan rule to protect us from those hospital based fee schedules or lab fee schedules. So this is outside of that analysis. So really that $1,000,000 would be if we were to, and this is not on the agenda.

So this is not something we can do today. But if that is something that the Board wanted to consider to remove that rule out of our master plan document which is, you know, probably not something that I would recommend it would come with a pretty hefty price tag of $1,000,000 just in the

north. And remember when I'm saying $1,000,000 just in Renown, there's -- we cover people across the country.

And so if you now open up hospital based labs to members to use them you're potentially, you know, tripling, you know, your cost for those labs. So that's -- it's something that we have as a safeguard, but it was not taken into account in the overall pricing of the analysis of the comparison of the two networks.

MEMBER VERDUCCI: Tom Verducci.

MEMBER AIELLO: And this --

MEMBER VERDUCCI: Just a real quick follow-up here. So I believe that I heard Ms. Bosse say that they would be willing to negotiate a contract like in prior discussions we've had where the negotiations were tied into RFP, you know, through the four-year RFP process I believe. But, you know, if it's possible to, you know, get this in negotiations and update the plan document that that would be the best outcome. So sorry for interrupting.

MS. RICH: So I just want to -- I want to clarify again. Laura Rich for the record. When we talk about negotiations it's direct contracting and it would only be direct contracting for this one service which would be labs. And, again, we don't have the ability to do that through our network contract. Contractually Etna would have to give us

the okay to be able to do that because Etna already has a contract with Renown. And so it would not be something we could do without that approval, and I don't know if we would get it. So there's some -- there's definitely some challenges to that.

And additionally would Renown be able to come down to those independent labs, you know, to that fee schedule. I don't know. That's something that we have to discuss. So there's -- there's challenges there.

The other thing I do want to point out is that during our, when we released, PEBP released the TPA RFP, the third party administrator RFP, we did, even though we just awarded this network to Etna we did include the option of TPA's to come to the table with a package deal that may include an in-state network that would potentially be better than what we have today.

And so while that contract is being negotiated today and all of that is confidential so there's no information that can be released on that end yet there is a potential that we would switch networks again next year.

MEMBER VERDUCCI: Just a follow-up. And I'll turn this over to Betsy. But, you know, I see the master plan document does allow exceptions to people within a 50-mile radius. You know, it makes sense to have an

exception for everybody. I just know if I was granted a one-time permission for going to and getting my lab work I would probably do it wrong the second time. And my wife would yell at me when I got home. That's going to happen to some poor soul at the department of transportation who's trying to get home and it will be an inconvenience. So I just think it does limit our access, high quality benefits.

And with that I'm gonna go ahead and conclude my comments. And thank you for letting me make the record.

MEMBER AIELLO: This is Betsy. If I may have Laura clarify. We keep saying Renown but I think I heard Laura say it's all hospital based labs and they have been being applied for a long time. Again, I said I made my transition a couple of years ago. It was based on walking into a hospital based lab that was not Renown in Carson City and them telling me you will have to pay a lot of money because this isn't for an outpatient surgery or inpatient care, and your plan only covers it for those two. So you need to go to either LabCorp or Quest.

And I was rather shocked. And I went out and used the telephone and called HealthSCOPE and they confirmed it. And so then I just made the application, well, that applies for Renown in Reno where I live. But the cost would be as my understanding as Laura said way more than 1,000,000

because everybody in Las Vegas could then get their draw at a hospital based lab, everybody all around the country. And so there would be -- this is pretty much been being applied from my understanding probably everywhere except Renown and it may be kind of unique that Renown has labs that are draw stations as opposed to looking like a freestanding.

So that was something I wanted to bring up that this might be a very big deal and it is a behavior change, but it is an out-of-network process in a way. That's where it's confusing I think is in the actual documents maybe that Etna prints that it says Renown is in-network. That may be where we want to try to make some changes there. Just throwing that out and trying to clarify a little bit.

BOARD CHAIR FREED: Thank you, Betsy. I appreciate that.

MEMBER KELLY: Michelle Kelly here. I just had one more question.

BOARD CHAIR FREED: Sure.

MEMBER KELLY: Executive Officer Rich, I'm just curious about the disruption report that was prepared during the RFP by Aon for members of the committee. I was not on that RFP. But I am curious about this, you know, the rights of overlap were very high. I believe they were in the high 90s, and in the north it was higher than in the south.

So I'm just wondering did Aon actually apply this particular plan limitation when they did that, when they did that disruption report because they should be applying the plan rule. So I'm just -- I wonder if this was considered by the committee or if it was just something that kind of went under the radar.

MS. RICH: So Laura Rich for the record. This plan rule was not taken into consideration. This is not -- so Aon isn't an expert in the plan rules, right. So that's something that HealthSCOPE would be an expert in. But Aon is not -- is not an expert in the plan rule.

So this was basically what Aon did is they took all of the claims that happened during a certain time period and ran them through these other networks to compare what the cost would have been had it gone through the different networks. And so they used the time period, actual PEBP claims and compared them and that is what the committee received is this is the projection of the, what those claims would have been had they been paid through X network, Y network, Z network.

MEMBER KELLY: Okay. So with that explanation then, the $4,000,000 was kind of the savings that was demonstrated by that analysis, that actually included using the Renown lab because they are in-network at the higher

cost. So, in fact --

MS. RICH: Correct.

MEMBER KELLY: -- PEBP savings will be greater than that because you're saying that 33, the same of all lab claims went through Renown so that should be a significant savings, right, on top of the 4,000,000?

MS. RICH: Correct.

MEMBER KELLY: Okay. In fact, you said it was a million more. So, in fact, the RFP savings are 5,000,000 as opposed to the 4,000,000 demonstrated by the analysis.

MS. RICH: Correct. Although depending on the different networks. So in this situation, yes, it would have been an additional million because that plan year was not applied. However, in other networks that may have been taken into consideration because Renown labs through those networks maybe has lower lab cost and higher hospital cost, right. So it just depends on, you know, there's -- there's a million levers to that analysis.

MEMBER KELLY: Right. I guess so just thinking forward, you know, for future purpose though, I guess I just how -- what is your solution for making sure I guess the gap because I see this as a gap, right, that when Aon was doing the analysis they didn't apply plan rules as well.

So do we have a solution going forward to make

sure this -- I know we don't go outside network very often but still this is a learning for all of us, right?

MS. RICH: So this is Laura Rich for the record. This first network from my -- and, again, PEBP isn't in the weeds with the analysis, the discount analysis that occurs. But there was a learning process not just for Aon but, you know, for all of the vendors in terms of what kind of data they were submitting. So there was a lot of lessons learned through that process.

And then so when we did this through the TPA contract it was a much smoother process. And unfortunately as well we've got, like I said, contract after contract after contract out there. And so a lot of this, especially those first contracts were rushed because of the timing that was necessary to get them in place and so there was a -- there was a very small time period to get a lot of work done so I think that was part of the problem.

I'm going to be honest. We are still rushed. We still have a lot of contracts out, and we are doing our best to put out the best RFP's that we can. And I know there have been Board Members that have been part of this, of building those RFP's and providing input and being on the, you know, RFP committee and things like that.

But with the sheer amount of, the volume

of contracts that we have out it -- there's some of these things have been rushed unfortunately. And so that was just a learning process that we went through. And this next one was definitely much improved. So it's just one of those lessons learned.

MEMBER KELLY: Just a follow-up in regard to that then because it also came up in public comment and it's in your report. So the quality control officer, it seems like that position has kind of -- and I'm sorry. I'm kind of changing gears so I can pen my question if people are still talking about the Renown, but it kind of led into it. So I'll -- I have a question but I'll leave it to Chair Freed to say if it's appropriate.

BOARD CHAIR FREED: Well, let me ask if anybody else has questions specifically about the Renown labs issue?

Okay. Well, hearing none, then please take it away about the staffing updates.

MEMBER KELLY: Thank you. And I appreciate it.

So I'm just wondering so it seems like that quality control officer has the position, I didn't know if it's changed over the years or if the intent of it has changed to what the public thought it was. But I wonder specifically to this discussion so does that -- is the quality control officer still the officer responsible for

contracts? I'm thinking about it in terms of, you know, I know we keep hearing from Executive Officer Rich how overwhelmingly the contract piece has been because of the order and whatnot so I understand that.

I'm wondering are you going to get some help from the new quality control officer or is that not part of the duty so we get a better understanding of what that role duties are because I think just member complaints and issues and retirees seems -- doesn't seem like a lot to flush out a whole position. But, you know, I know there's a lot of, you know a lot of discussion.

MS. RICH: So Laura Rich for the record. I'm going to try to answer this without bringing up old -- old dirt on PEBP. So back in the day you did have contracts that landed at the quality control desk. They were -- and that quality control officer was in charge of contracts. Yet contracts in most other state agencies fall under accounting and that makes sense because the -- there's a significant fiscal role. There's a significant -- the fiscal oversight that is involved with contracts, right. And so it makes sense for them to live in the accounting unit versus quality control.

Additionally, quality control has kind of morphed as our plan has gotten larger and more complex. We have a

lot of issues that come up that, you know, members are either appealing. They need -- there's exceptions that need to be made. There are -- there's just -- there's a lot of -- there's a lot of complexity that that lives in our master plan document in that it has to be applied consistently.

There are many many times where and, in fact, this is going to be something in the future as we move towards the budgeting preparation. I plan on asking for in-house counsel because there are so many pieces of -- so many appeals and complaints that come in where we are trying to decipher legalities within our master plan document and how to apply rules fairly.

One of the things that I'm working on is trying to identify the transgender policies that we have in place, if they are appropriate, if they are -- if we need to make changes. There's other appeals that come in. We just recently had one regarding, you know, dental anesthesia coverage and why is it covered for children but not adults and things like that.

So there's so many pieces of that master plan document coverage that we don't have the expertise or the ability in-house to -- well, we haven't had except for that quality control officer to kind of go through and really really make sure that we have -- you know, of course I've got

landscapers that just showed up that are right outside my window. So I might have to move here soon.

But essentially the quality control officer does that, but they're really really engrained that the coverage is applied fairly and appropriately and legally. And so we have a volume of work that has been put into that department recently, has increased pretty significantly, not just the volume but the complexities as well.

MEMBER KELLY: Okay. Thank you. So does that mean the job description has changed since the Board last saw it? And who does the position report to and who appoints it? How does that all work?

MS. RICH: So the position, the contract has actually moved over from quality control many years ago. There were some ethics complaints that came up and that were investigated as a result of a previous quality control officer and because of that they -- those -- the contracts went to accounting where there's a lot of oversight where there is -- there's -- there's definitely, it's a more appropriate role for those contracts to live there. So they have -- contracts have been at -- in accounting and away from quality control now for several years, many years, I would say at least five if not longer than that.

And then the -- so it's not that the quality

control duties have changed. They have just kind of expanded based on necessity. And so some of the -- you know, the more, for example the internal quality control, right, has -- the quality control team has been able to, quality control like for example the call center calls, things like that and so we've been able to kind of, you know, focus more on that kind of stuff and on the member side and helping the members and applying those coverage benefits appropriately, working with our legal counsel to ensure that the decisions that are made are, you know, are appropriate, are consistent and appropriate working with HealthSCOPE, working with, you know, outside entities that are involved in consumer issues and things like that. So it's grown out of necessity there. And so the duties haven't really just changed. They have just expanded a little bit and expanded in complexity as well.

And to also answer who does it report to, ultimately, you know, technically in statute it reports to the Board Chair. Now, on a day-to-day basis that just doesn't -- it doesn't operationally make sense. And so it's really on a day-to-day basis that position reports to me.

Now, that position, technically if I were to do something, you know, ethically or morally or, you know, anything wrong that position isn't protected because I cannot appoint that position. I cannot terminate that position.

That position reports to the Board Chair.

BOARD CHAIR FREED: So this is Laura Freed. The quality control officer being appointed by the department of administration director was a change made by SB502 in the 2017 session as a result as have people have alluded, ethical complaints against a former quality control officer who was far too immeshed with certain vendors for PEBP. The Executive Officer is of course right. You know, I've got 500 of my own plus employees. And I've got 17 of my own direct reports, and I don't even work in the same building as the quality control officer. So I have no ability to supervise that incumbent's day-to-day work or know if they are doing a fine job.

So really the statute serves as an ethical safeguard. If the quality control officer feels like the executive officer and the operations officer and other people on the senior PEBP staff are doing something they shouldn't be doing, with contracting inappropriate relationships with vendors or really anything else and actually that goes both ways, but the quality control officer can report that to me. But, of course, this Board hires and fires the executive officer. So if the executive officer has concerns about the quality control officer the same thing would apply.

And so, you know, I did appoint the quality

control officer, Mr. Lindley. And I guess that's all I had to say about that. I just wanted to clarify. It's a bit of a strange law because it sort of -- it seems to suggest that the director of administration has time or bandwidth to supervise somebody in another department entirely which I find a hilarious notion, but really it serves as an ethical hurdle to discourage what we've seen in the past.

MEMBER KELLY: Thank you. So just a follow-up given it is, and this is just more for my general information. So that position is a senior member of the PEBP staff or the executive level and so I'm just wondering generally when there's a vacancy in that senior level are those jobs advertised and where are they advertised?

MS. RICH: So Laura Rich for the record. Unclassified jobs do not typically -- and you're correct, that is a senior level executive position. It's an unclassified position. So unclassified jobs are a little bit different than the classified positions.

Classified positions are required to go through the HR process. There's minimum requirements. Those staff need to meet the minimum requirement or those candidates have to go through the HRA process where the resumes are reviewed and they get to determine, an HR person gets to determine whether or not they meet those minimum requirements.

With unclassified staff, those requirements are not always set in stone. For example, in -- for the executive officer that is set in stone. You have to meet certain requirements, educational requirements and experience requirements. For unclassified staff, depending on the position they are not always set in stone, and there is the flexibility of the hiring party to -- to appoint people that they feel meet those requirements or a -- a mix of those requirements. They are not required to be posted or advertised. You can appoint without any kind of posting, you know, job posting on any job board. You can post the job but you don't have to.

MEMBER KELLY: And does PEBP have policy about that? I find it somewhat concerning that senior level staff are being appointed without competitive review I guess. You know, if one person is appointing jobs they are appointing people that look like them, sound like them and look like them often so it's a real quelch on diversity which I know is a requirement for the state. So I don't know if the Board has a policy, but I think we should have a policy about competitive recruiting.

MS. RICH: So I can tell you that as operations officer I was appointed. I was not interviewed. As the previous quality control officer, that position was not, when

Nancy received the promotion that was not advertised as well.

It's typically, and I don't know, Chair Freed, if you kind of want to talk to it as far as some -- some directors choose to advertise positions. Others appoint because you have that flexibility.

BOARD CHAIR FREED: Right.

MS. RICH: And --

BOARD CHAIR FREED: You know, the -- you know, the comment about appointing people who, you know, look like you, are educated like you and sound like you resonates deeply because as the department that houses human resource management I've had occasion over the last several months to think a lot about diversity and hiring. You know, one of my greatest hopes is diversify my own leadership team, and I've thought a lot about how do that. And I've thought about, you know, anonymizing names on applications for instance as, you know, one small thing DHRN can do.

Having said that, you know, the unclassified pay bill, you know, is what it is for a reason. It was the -- you know, it's the legislature's determination that certain positions should be at the, you know, director of the agency's prerogative to have the leadership team that they choose to have which is why the civil service hiring process for positions in the unclassified pay bill doesn't apply.

And, you know, I appreciate the question, Executive Officer Rich, but I don't know that I have the breaths of knowledge across the entire bureaucracy about which directors tend to do what. You know, it just -- I mean, I also have staff hired unclassified positions, and I've put some of them out for recruitment in the regular process. So, yeah, it just really varies. But, you know, that's the -- that's sort of the policy determination of the legislature. I mean, we wouldn't have an unclassified pay bill if they hadn't determined certain positions in state governments should absolutely be at the discretion of the members of the cabinet.

MEMBER KELLY: I appreciate that. And I just want to say one more thing, please. My question about the process has -- were in no way were a reflection of my volatile consideration of Mr. Lindley so I need to separate comment.

BOARD CHAIR FREED: I understand. I appreciate that.

MEMBER KELLY: I just want Mr. Lindley to know my questions were not about his appointment at all, just generally. So thank you.

BOARD CHAIR FREED: Okay. With that, did -- shoot. Did we want to return back to the Executive Officer

Report with Board Member Training and COVID and Flu Shot Clinics or should we move along?

MEMBER VERDUCCI: Well, Tom --

BOARD CHAIR FREED: Mr. Verducci.

MEMBER VERDUCCI: Yeah.

BOARD CHAIR FREED: Okay.

MEMBER VERDUCCI: You know, I did have some remarks for the first part of this report. We did jump into the lab work and then we went in to Chris Bosse. And, you know, we didn't really have an opportunity to chime in on the ARP funding. And I remember I think I made a motion that went through unanimously requesting staff to request ARP funding. And I'm not real clear exactly what we were asking for. And I understand that, you know, some of these requests were going to have to wait for the coming months.

But, you know, I know the motion primarily was reverting the plan of the prior -- of the deductibles out-of-pocket costs to pre-pandemic levels. So are we going to have everything we need in order to address this in our November Board meeting and do the rate-settings in March? I mean, where are we as far as reverting back to the pre-pandemic levels?

MS. RICH: So Laura Rich for the record. Tom, it's -- that's a difficult question to answer. We are -- you

know, we are trying or I am trying my best to emphasize the timing requirements for PEBP on this, and but that's about all we can do. We don't have any say or authority in how the rescue plan funds are spent. And so we move forward under the assumption that we aren't getting any until we find out that we are.

And so at this point we will start planning assuming that there are -- that PEBP will not receive funding, but at the same time I will continue to -- to put this on the radar of the Governor's office and the State Treasurer's office so that they know the important timing of this.

MEMBER AIELLO: Laura, this is Betsy. I have a question. You had mentioned that what you put into the portal you were not able to get that report back out. But would there not have been a planning document or something that guided what was entered into the portal that might be able to be or is this something the Governor's office has said you can't share. I don't know.

MS. RICH: So -- so Laura Rich for the record. So the request that was entered into the portal was -- was essentially the request that was discussed at the Board meeting. There the way that this is set up is there's -- there's some form builds that have to be -- that have to be

filled out. And so those -- those forms, form builds or which agency is this. Where does -- what kind of category does your request fall into, et cetera, et cetera, right. And so and then we have the free form text that give you the opportunity to really say -- gosh, I hope the landscapers leave here soon. I'm sorry. They are at every part of the house.

So it gives you the opportunity, this free form field to say, to kind of give, expand on your request. And so the request was basically a brief synopsis of what we discussed at the Board meeting. We would like the -- the funds restored to or the benefits restored to pre-pandemic levels.

And, gosh. I'm sorry, guys. Hang on. I'm going to move here.

BOARD CHAIR FREED: So, Laura, while you're moving -- this is Laura Freed for the record. Sorry. So while you're moving I think what I would like at the next meeting is an informational item with the descriptions that you put into the portal and the cost because I think, you know, we talked about the prioritization. You got a clear prioritization if, you know, out-of-pocket max, deductibles and out-of-pocket max being the top two priorities. And then, you know, you guys were going to go cost that out with

Aon. So I think the Board would love to know what the price tag we asked for in our portal was.

MS. RICH: Right. So there is no price tag because there's -- and that was explained in the -- in the request. We can't model anything out until we understand what kind of -- what kind of funding we're going to get, right? So if they are willing to give us 5,000,000, we can take that 5,000,000 and direct it to increase exactly what the Board had discussed. So those deductibles or decrease deductibles and decrease out-of-pocket maxes, et cetera, et cetera. And so there is that ability for us to model it, but we can't model if we don't know.

So if -- we can model $1,000,000. We can model $20,000,000, right, and everything in the middle. So you can't really come with modeling. There wasn't a -- there wasn't really a mechanism to submit this. It's more of -- it's more of a discussion item, right. It starts -- it starts those discussions with the Governor's office, with the State Treasurer's office, you know, that here's the problem. It can cost anywhere from 1,000,000 to 30 to 20, whatever it is you want to fund, we're going to be able to restore this but we did have $36,000,000 in cost.

And so, you know, where in that -- in that span do you want to fall to restore these benefits and

additionally what it costs today it might cost more tomorrow, depending on experience, right. So modeling all of this early on doesn't really help the situation because as we start getting more claims experience, this is why we don't price the plans in November. We price the plans in March because we need as much claims experience as we can.

And so there -- it wasn't -- it was a very broad request. We would like to restore benefits, but we don't know the cost because it just depends on what it is that we can do, right. There's -- there's all sorts of different levers.

So really what that is going to take, and I did communicate this to the State Treasurer's office is it will take some discussions. And the modeling will happen after those discussions start taking place because if we have an idea, you know, if it's 2,000,000 or 20,000,000 the modeling is going to look a lot different, right. So this is what we're going to need. We need to have the discussion before we can put a price tag on it.

BOARD CHAIR FREED: Okay. With that in mind, would you please add to, I would assume it would be Agenda Item 4 as an info item for next meeting the narrative that you supplied to the Treasurer. Thank you.

Okay. Once again I find myself going where are

we? What have we done? Okay. Well, while Laura walks around her house I do believe we are on Board Member Training and COVID and Flu Shot Clinics.

MS. RICH: All right. I think the landscapers are gone now thankfully. I didn't take into account. I thought I would do this from home today. Next time I'll remember this.

Okay. So Board Member training, so historically the Attorney General's office and both the Attorney General's office and Commission on Ethics have provided Board Members with required open meeting law and ethics training year over year. That just makes for very very long Board meetings. And I think that both of these entities offer these types of trainings on your own. They have recorded trainings. They have got, you know, presentations that are readily available.

And so to make the best use of the public and the Board's time we decided to go ahead and just provide this to the -- to the -- the training material to the Board Members and Board Members will be responsible for completing this Board training.

So I'll move on to the COVID and flu shot clinics as well. So every year PEBP hosts a series of flu shot clinics for members in Carson City and Las Vegas. This year we also included the COVID vaccine as well. Although the flu

vaccine was not yet available when the PEBP first hosted its vaccine clinic in the Bryan building.

On August 23rd we -- we were able to respond to the State's newly implemented testing requirements for unvaccinated employees. So we offered that flu shot clinic. I mean, I'm sorry, the COVID-19 clinic initially. And then we had three additional flu shot clinics and COVID vaccine clinics which they're scheduled. We already had one in September and two in October, both in Carson City and Las Vegas.

So we are -- we just had the September one, the first September one or I'm sorry, the August one for the COVID vaccine, not too popular. We didn't have a whole lot of people visit that one. But we did actually see a pretty significant number when we added the flu shots. We had a whole lot of people show up to the one in Carson City a couple of weeks ago I believe it was.

So we'll be having -- we'll be hosting another two coming up and those are usually pretty popular. People do come to get their vaccines in the, both Carson and Las Vegas.

BOARD CHAIR FREED: Great. Thank you. Questions from the Board about either of those topics? Okay. Well, this is an informational item so there's no action required

by the Board. So I think that does it for Agenda Item 6.

Board Members, I think we've been at it for a couple of hours. So let's take a five-minute break. Get a snack and be raring to go on Agenda Item 7, 8 and 9.

(Whereupon, a brief recess was taken.)

BOARD CHAIR FREED: Okay, ladies and gentlemen, this is Laura Freed. We'll call the meeting back to order. We're on Agenda Item 7, which is COVID-19 update coverage options and potential surcharge, COVID surcharge for unvaccinated members of the plan. All right. I'll turn -- this is an action item. So I'll turn it over to the Executive Officer.

MS. RICH: All right. Laura Rich for the record. So just some background for especially some of the new Board Members. Back at the beginning of the pandemic, March 5th the Governor issued an emergency regulation that required all fully insured health plans regulated by the Division of Insurance which PEBP is not to cover all COVID-19 testing related cost.

So because PEBP is a self-insured program and we do not fall under the Division of Insurance authority, this was actually brought to the Board and was a Board item at the March 31st meeting.

The Board ultimately voted to approve option two

which made effective March 5th through July 3rd and it was later extended to cover all testing and associated office visits at 100 percent of the plan's maximum allowable charge regardless of network participation status with no cost sharing to the member.

So what that meant is that regardless of if you had a COVID-19 diagnosis you would not be subject to deductibles, to co-insurance, to co-pays. You would get all COVID-19 related services at zero dollar cost, so free services continuously.

So the elimination of cost sharing for COVID-19 testing was later strengthened on a federal level and that is now something that is a requirement on a federal level to at least cover COVID testing at no cost. Treatments are not covered under this so it's just COVID-19 testing that is at no cost.

However, PEBP does continuous -- or it does continue to have that coverage in place. Where anybody, if you end up in the hospital or if you have any treatment related to COVID-19, a COVID-19 diagnosis you are paying zero dollars for that treatment.

So going on to the report, I wanted to provide a little bit of background to what is going on in our plan and related to COVID-19. So I reached out to our partners and

tried to get some information as to, you know, what -- what exactly is going on in our plan. And what are the costs. Who's being affected. And really putting a story to COVID-19 because it is, it's -- you know, these are people that it's affecting. So I wanted to make sure, you know, just to kind of illustrate what's happening here in our plan.

So the chart here on page two provides an illustration of the COVID diagnosis among members in PEBP self-insured plan. So this does not include our Medicare Exchange people and does not include the HMO members as well. So you see that there's -- you know, there's quite a bit of confirmed COVID-19 diagnosis with ER visits and et cetera, et cetera.

18 PEBP members, again, just on our self-funded plans, this is not including our Medicare Exchange or HMO, 18 PEBP members have passed away as a result of a COVID-19 diagnosis. This is also people we do know, right. There's people potentially that didn't use our plan or that we didn't receive that diagnosis for.

Sadly one of those 18 people was a previous PEBP employee. She retired from PEBP several years ago and we learned that she did pass away from COVID.

Since the beginning of the pandemic the plan has paid and this is up through August numbers, a little over

$13,000,000 in COVID related costs, including claims for testing, treatment and vaccinations.

The plan has paid -- since the vaccine has been made available the plan has paid a little over $5,000,000 in medical claims only, so that's not including the vaccination charges that our plan receives.

There's a few case examples here I wanted to illustrate because we do have some high dollar costs that are -- that are incurred from COVID. So we've got a 61-year-old, a 70-year-old and a 28-year-old, all three of these members passed away as a result of their diagnosis. They were unfortunately, you know, very complex cases, ended up with very very high cost, almost $200,000 for the first one. $180,000 for the second one. And the third one we do not have all of the claims in yet.

But what we do know is that we have over $1,000,000 in bill charges. And, you know, unfortunately these are -- these all ended in the member passing away. So this is real. It is -- it's something that is -- that is happening among our members. And, you know, our members are severely affected but fiscal year our plan is well. So, you know, I thought that was something that needed to be told and needed to be illustrated so that we could have these discussions.

So cost sharing coverage, as the vaccine has become widely available to adults insurers have reverted to applying normal cost sharing towards the COVID-19 treatment. So, like I said, COVID-19 testing is required to be at no cost. But insurers have been going back and really treating COVID-19 treatment just like anything else. If you have the flu, if you broke a leg you would end up paying your deductible, your co-pays, your co-insurance.

And so PEBP is really, you know, one of the last ones to -- you know, to really, if we are to move back to, you know, to covering this just like any other -- any other disease or treatment, you know, where most insurers have already done this.

There's also the subject of COVID surcharges. So in August, Delta Airlines announced that they would be implementing a 200 dollar surcharge on health insurance premiums to their unvaccinated employees. They cited this as a way to recover the cost of insuring employees that get hospitalized with COVID because like PEBP, they are also self-insured. So they need to bring in enough money to pay the claims, right. So the money that they bring in in premiums pay the claims that they pay out.

They determined that on average they were paying approximately $50,000 for a COVID hospitalization. So two

weeks after that announcement 20 percent of their previously unvaccinated employees had been vaccinated. So it was hugely successful. It was a motivating factor. And from what I personally read out there there's two -- there's two ways that you -- you can motivate groups of people. You either have a carrot or you have a stick. And one way has been proven far more effective than the other and that is usually the stick is a lot more effective and convincing people than the carrot, especially when this comes to, you know, to money.

So after receiving just initial support from the Governor's office PEBP conducted some preliminary research in this area to see, you know, is this a road maybe we can go down. Is this something we should do? Maybe it's something we shouldn't do. And what we did bring out is that there's a lack of guidance. This is somewhat of a new area. There's some legalities. As you know, there's tobacco surcharges that we can impose, that health plans can impose.

There's, you know, there's different mechanisms to make this work. However, that there's also some, definitely some very complex legal situations that would need to be worked through in applying and implementing something like this.

So this is something that staff is happy to move

forward with. However, the reason that it is being brought up to the Board today is because it will require not just PEBP but it will require the Governor's office involvement. It is going to require, you know, some legal work, things like that. And so I didn't want to go down that road in coming to the Board with a, you know, full out plan to potentially implement this and get everybody involved if there was no appetite from the Board to implement a surcharge like this, whether it's something we do moving forward, this would be something that, you know, the Governor's office would need to be very very closely involved in. There's a lot of decisions that unknowns and there's also some knowns that would have to really involve the Governor's office and the legal staff if we were to go down this road.

So it is a possibility. It's something that can be implemented. It's -- it's a mechanism to recover some of these COVID costs that we have already incurred. Now, granted up until this point we have received a substantial amount of federal funding to cover the COVID-19 claims cost. That is not something that is guaranteed moving forward.

And so as you'll hear in another -- in a follow-up report there is -- there's a potential that, you know, COVID-19 is going to affect the plan moving forward. A very significant chance that it will affect the plan moving

forward and so especially if we continue to have unvaccinated people ending up in hospitals, especially if we end up, you know, and paying for claims such as the three examples that we -- that, you know, are in this report. And so it's something that we need to think about because there's no guarantee that we're going to get federal funding moving forward. And at some point those costs will need to be covered and who gets to cover those costs, right.

So this is something that the Board should consider. But, and staff is willing and able to go down this road and come to the Board with a plan. But I want to make sure that there's an appetite for this before we come back and -- before we involve everybody that needs to be involved to put something like this into place.

So with that, I will just say the recommendation is that we remove the 100 percent coverage benefit for COVID-19 related treatment, hospitalization and apply the plan rules effective immediately, and then permit PEBP staff to conduct further research on COVID surcharges and provide an update and potential options at the November Board meeting if possible.

BOARD CHAIR FREED: Thank you. This is Laura Freed for the record. Board Members, I think what I would like to do is have the cost sharing coverage and our

consideration and recommendation of a one separate if we can from the COVID surcharge recommendation number two discussion.

So I'll start it off. We received some very thoughtful public comment on this, and I would like to thank the public commenters who submitted e-mails to us. So for PEBP staff what is -- is your recommendation of removing 100 percent coverage for treatment and hospitalization but not testing applicable to -- to dependents under the age of 12 as well? Because as we know the feds have not approved any emergency use authorization for participants or, for participants, for anybody under the age of 12. So because they are not eligible to get a vaccine would you want to pay those claims at 100 percent or would you -- would this be for absolutely everybody insured as well as dependents?

MS. RICH: Are you asking Board Members or what are you asking me? I'm sorry.

BOARD CHAIR FREED: I'm sorry. I wasn't clear. I was asking PEBP staff.

MS. RICH: Okay.

BOARD CHAIR FREED: But, Board Members, I mean everybody chime in. You know, I love a lively meeting.

MS. RICH: So I guess the recommendation here is to apply it across the board but we can certainly apply it to

only those that are over the age of 12 and have a vaccine accessible for sure.

MEMBER AIELLO: This is Betsy. I have another question. When you say not testing it would be not for the vaccine also because that's preventative just like a flu shot; is that correct?

MS. RICH: Correct. Members do not pay for the vaccine either. PEBP does incur an administration fee for that, but PEBP members that receive the vaccine do not. They receive that at zero cost.

MEMBER AIELLO: And it would stay that way?

MS. RICH: Yes.

MEMBER AIELLO: Yes, because that I would not recommend at all.

BOARD CHAIR FREED: Oh, no. I'm sorry. This is Laura Freed. The feds have mandated that. And, of course, PEBP can sidestep the administration fee or its participants can by just going down to the local health department and PEBP is never involved anyway.

MEMBER KELLY: So Michelle Kelly here. So, Chair Freed, I'm very supportive of carving out the age population who aren't eligible for vaccines. I guess I would just caveat it's a really moving environment at the moment, and we do expect that, you know, the vaccines are going to get

emergency approval for those younger people soon.

And so maybe if -- when it's time for a motion if we can make it a more general statement about vaccine approval or, you know, vaccine availability as opposed to a specific age, demographic then PEBP staff --

BOARD CHAIR FREED: Okay.

MEMBER KELLY: -- could update the plan document as it goes.

BOARD CHAIR FREED: I think that's a great idea. Thank you.

MEMBER KELLY: My next question I guess is for PEBP staff because I wonder how -- how would we carve out those people as far as the, you know, in the self-insured plans, the deductibles and the max out-of-pocket to make sure it's fair across the board. Because if a family has a child who gets COVID how will that apply to their general out-of-pocket if they are not paying anything for that? So how would, I guess just the details, summary level details of how that might work.

MS. RICH: So I think what you're asking -- Laura Rich for the record. I think what you're asking is if we don't carve it out for a parent but we do carve it out for a while, right. So if -- if a parent ends up in the hospital for a COVID-19 diagnosis, then those -- their claims would be

processed just like any other claim, right? It would be -- it would go through, you know, they're either in their deductible phase. They are in their co-insurance or they are in their co-pays. So it would be processed just accordingly.

A child who is under the age of 12 and let's say that we do apply this exception to the under age of 12 then those claims that get processed for that child would then not be subject to any of their co-pays and out-of-pocket maxes and it would just -- it would be a zero out-of-pocket for those claims.

MEMBER KELLY: Right. But how would that then be calculated into the -- so if we have a family who seeks services both for non COVID related expenses and COVID related expenses for an under 12 say, that max out-of-pocket is a family out-of-pocket. So how administratively would we ensure that any of the costs that were covered not included in the max out-of-pocket or would that happen automatically?

So I just want to make sure that we can administer a carveout for those people who are not eligible for a vaccine yet because of their age and it not automatically pushing families into hitting the max out-of-pocket expenses and things as opposed to kind of other families that maybe don't have those COVID expenses.

MS. RICH: So Laura Rich for the record. And I

just realized, you know, I'm assuming that HealthSCOPE is going to be able to process this and apply this as we are discussing it. But I want to make sure and give them an opportunity to speak up just to confirm because I don't want to make any assumptions here.

Do we have either Rhonda or Denise, if you guys are on or even Nathan. I know that -- I think all three are on. So if anyone wants to speak up and just confirm that this is something that can be done and if administratively how this would be applied.

MS. SAUCEDO: Hi. This is Denise Saucedo. I'm the client relations manager with HealthSCOPE Benefits. For the record -- I'm sorry. I was on video and then I moved back into my office which has no camera so I apologize.

So this is something we have to take back to the team and make sure that it is something that we can do, but we are thinking about it and currently will be in discussion.

MEMBER KRUPP: This is Jennifer Krupp for the record. I have a question. Is it an action that has been considered or is it something that could be done to remove the coverage benefit, the 100 percent coverage benefit for treatment and hospitalization for those members who are unvaccinated but maintain it for members who have gotten the vaccine or could we identify it like those people from when

they cannot get the vaccine because of medical reasons along with children, just kind of a way to discuss provisional options and regulatory rules.

MS. RICH: So currently -- Laura Rich for the record. Currently PEBP does not have that data on our members. We can, we can definitely. This is something moving forward that we can once -- we've already had discussions with our new eligibility enrollment vendor that goes live in January, and we can certainly ask for vaccination records through our eligibility system if we want to go down that path. But currently no, we do not have that.

And for example if a -- if a patient goes into the hospital for a, you know, COVID diagnosis or even gets treatment, say goes to the emergency room, so in some of these cases like the three in this report we would know because it goes through, you know, the utilization management, right. These cases, they were all airlifted. There's a component of the utilization management in there so we would know of the vaccination status.

But if we -- if a member goes in and receives treatment at an emergency room because they have got COVID, no, their vaccination status does not come through that claim. And so currently we do not have the ability to determine that today. Moving forward there is a possibility

but we would then have to collect that information from -- from members.

I would assume this is -- and this is part of that second part of the conversation with the surcharges. But there's -- there's some administrative lift that needs to happen in order to get that. There's some mechanisms to get it already because I know that those members that receive the vaccine through the pharmacy side, we would have records of those people.

But for example I did not -- I received my vaccine outside of -- outside of a pharmacy. So there's no record of me receiving the vaccine in, you know, the PEBP records, right. So there's -- there's definitely some challenges to that today.

MEMBER AIELLO: This is --

MEMBER KELLY: This is a follow-up question. Go ahead.

MEMBER AIELLO: Okay. I was just going to say long-term, I mean what we're talking about a little bit is we've had COVID for about a year and a half now. Everyone never thought it would last that long. If it becomes a long-term chronic condition that could be continuing to occur and if the federal government doesn't want to continue to fund it then what I'm hearing is that it is going to raise

PEBP's costs a lot. Being self-funded that would then in turn raise people's premiums and -- and co-pays and deductibles or everything that we've just gone through and are trying to restore.

So if it becomes a long-term disease, and I don't know when that gets determined, it is affecting more people than the other long-term diseases in a way except for if, with the vaccine maybe. I don't know percentage wise, maybe not as much. So I'm just thinking that at some point, it might not be now, PEBP may need to start treating it like it does any other long-term disease. But at the same time the max out-of-pocket will be applied so people would hit the max out-of-pocket and not pay anymore, and our costs may still go up and require us to have to do things while this is staying high.

Because I'm not sure how much congress is going to be willing to continue, nobody knows, to add to the deficit to fund these things, so I guess I'm just throwing out thoughts going in my mind and not making a point.

MEMBER KELLY: Can I just ask a clarification question. Executive Officer Rich, are you recommending or is your recommendation saying for the next plan year? Because the language you used is going forward. So would that be part of a motion when we would put this in place because from

my perspective I -- you know, we always talk about the plan year and not making changes to the plan outside of kind of the plan year because of the adverse selection and stuff.

I would say this is one of those, right, that it should be pushed to, if we're going to do anything it would be effective July 1st of the next plan year, but I don't know what you're recommending. So could you clarify.

MS. RICH: Laura Rich for the record. The recommendation here is effective immediately. This went into effect the middle of the plan year. It's not something that would create any adverse determinations or anything like that. It's a coverage that was implemented in the middle of a plan year and it doesn't -- it affects all plans equally. And so this is not something that would trigger one of those open enrollment or, you know, any kind of event where people would have the ability to change plans. It's something that we can do and revert back to. Again, this is something that members have already done. We're one of the few that are left that are covering this 100 percent.

MEMBER KELLY: So you don't think a person on the high deductible plan would consider switching into the PPO if they learned that they're going to have to satisfy the deductible if they get COVID? I see it as a change that would actually have changed potentially a person's plan

selection.

So I guess I just -- I disagree with you there about it driving people's decision, but I think it absolutely will drive people's positions. Now, I understand you might have made the change which was an enhancement to the plan outside of the plan year ending but it was also -- you know, obviously it was a known. It was a pandemic. People were panicking. But I don't think that's necessarily the right model going forward when we're taking away from people but obviously that's my personal opinion. So thank you.

MS. RICH: And I don't disagree with that at all. I mean, this is something we can make effective July 1st there's some flexibility in that recommendation.

MEMBER VERDUCCI: Tom Verducci for the record. So I wanted to ask, I know the federal government started requiring employers with 100 or more employees that their staff had to either be fully vaccinated or provide a COVID check weekly. So our membership is primarily active employees. So wouldn't we have already some direction provided from the federal government approaching the unvaccinated active members or does this also, you know, require state involvement?

MS. RICH: So, Tom, I'm not sure I understand your question. Are you saying that has the state or has the

federal government provided guidance?

MEMBER VERDUCCI: Laura, my question would be the president had given some direction as far as new CDC requirements. And in the speech that he provided he had a mandate where employers that have over 100 employees, they required to remain employed that they are vaccinated or to provide once a week COVID testing showing that they're negative.

MS. RICH: Okay.

MEMBER VERDUCCI: So if that's already in place, my question is why would we have to have further mandates on employees that would affect their premiums if we already have guidance from the federal government.

MS. RICH: So, yeah the guidance has -- has been put in place. There's -- I think there's some -- there's definitely some legalities that are being explored and this is more Chair Freed's arena than my own as far as the testing and the, you know, the vaccination requirements.

BOARD CHAIR FREED: I knew you were going to do that.

MS. RICH: However, you know, we do -- we do have in place already the either get vaccinated or get tested with some exceptions because if your place of employment or if your job site is over that 70 percent threshold we do not

require the testing.

So that is, for example in the PEBP building, the Bryan building, we are over the 70 percent threshold and so no one in that building has to get tested weekly. So there are some exceptions to that.

However, this is -- this is different because while you can still, you know, test negative you can also test positive. That just means you can't come to work. So when you do test positive this is where the PEBP piece comes into play is does the health plan cover 100 percent of those costs or should they be subject to the cost sharing that every other diagnosis is subject to.

MEMBER VERDUCCI: Yes. So for the company that I work for in the private sector I've had to upload my vaccine card. And every time I go out in the field I have to answer specific questions how I feel today and I get approved by my company before I -- before I leave and it's a good control mechanism.

But I also wanted to inquire, in the future can we be asking for specific ARP funds for future COVID claims or just ones that we've already had?

MS. RICH: That's definitely a request that we can make. We're not limited to our request. And so we can -- we can suggest that ARP cover COVID-19 claims for the

plan moving forward and see where that request goes. That's not something that -- we can certainly do that.

BOARD CHAIR FREED: This is Laura Freed. I would add that our money is a little more restricted in what it could cover than CRF money was. CRF money was pandemic response more generally. You know, our money is pandemic response particularly as it targets underserved communities. There's a pot of money for broadband infrastructure projects, and I'm trying to think of the other criteria that was in the treasury's role.

So, you know, Laura is right. But also I think there are certain -- you know, the people who control how much ARP money each department gets have been reading the treasury's interim final rule as fairly strict. So, you know, a lot of the -- a lot of the Governor's pandemic recovery plans are every Nevadan Recovery Framework talks about capacity around public health and capacity around mental health.

So I -- I think we would have to probably go back and read the treasury rule to see if PEBP's claims costs are one of those things that can cover directly, much like CRF. But anyway I'm sort of thinking out loud.

But to answer Member Verducci's questions, originally, you know, I think we're talking about two

different things here. You know, the President's policy, the state actually implemented ahead of the President's announcement is about establishing an early warning system for outbreaks in state agencies and large employers. This cost sharing is really about claims cost containment.

MEMBER VERDUCCI: So Tom Verducci. Just as a follow-up. So I did like the idea that was proposed by Board Member Jennifer Krupp. And as far as fully vaccinated people, perhaps they do get their 100 percent coverage. Those that are not fully vaccinated then perhaps could bear the additional costs that are currently being 100 percent covered. If you're fully vaccinated then perhaps that group is 100 percent covered. I did like hearing that idea. So that's my thoughts there.

MEMBER KRUPP: Jennifer Krupp for the record. Thank you for that, Tom. I would like to clarify that question that I had asked was kind of for informational purposes and that you recognize that is not something we are going to deal with today. So thank you.

BOARD CHAIR FREED: Do we have any other thoughts on the cost sharing recommendation by the staff?

MEMBER AIELLO: This is Betsy again. Laura, have we done anything based on what we have been seeing, maybe the 5,000,000 since vaccinations have been around or whatever, we

still had that 5,000,000 in cost. If we don't get further monies past the one that's going through the IFC which would cover maybe that, are we thinking it would put us in such a hole it would prevent adding back any of the things we've requested to add back and/or make us even have to make more cuts next time so that if we don't do this, is the staff -- give us a little feel of.

And I know we have this great bend about having excess reserves that really aren't called that every year, taking that into consideration and stuff. If we said let's start it next plan year, do we believe there's going to be, and I know you can't say -- have a crystal ball, but do we think we'll be making this situation a whole lot worse next year? I don't know. Some feelings along that are the ideas.

MS. RICH: So Laura Rich for the record. We're going to be having this discussion exactly in, during Agenda Item Number 9, but basically there's a whole lot of things that go into this. For example right now, I mean, I know that, you know, all over the news, all over the nation I think in Nevada right now we're at like 90 percent capacity in our hospitals.

And so there's -- there's a potential for that example you've got COVID patients that are taking up the hospital resources, right. They are overwhelmingly hospital

staff, hospital resources, et cetera, et cetera, and so you've got people that need knee surgeries, shoulder surgeries, you know, things like that that are elective that can wait that are getting cancelled today because those -- there's no resources. There's no -- there's the -- you know, doctors can't use the hospitals. There's not enough resources to do those elective surgeries. So all of these are piling up, right. And so this is part of what is going to happen, you know, when COVID comes and you're going to see these rebound claims. That's what we're going to talk about, so there's that, right.

There's also the fact that people aren't getting in to get their cancer screenings. So, again, stage one discovery that could have been stage one discovery today, maybe we're not going to find out until stage three and there's a lot more cost involved. And so the plan experiences much more higher cost as a result of these diagnosis that went undiagnosed, right. So there's a lot of situations there that are not just COVID. It's the result of COVID.

And so like you said, there's no crystal ball. We don't really have a, you know, something to, you know, go back on and say, well, this happened back in, you know, 50 years ago or 20 years ago. There's no real comparison.

And so we're all kind of playing a guessing game to a degree. However, the actuaries have modeling that they have applied, and we are going to talk about that in that agenda item.

But when you ask is this going to affect the plan moving forward? Well, yes, it will because we do have -- we will see it impact the plan because we have these COVID claims. And so COVID claims right now are, most COVID patients that end up in the hospital are not vaccinated and so those, until we get the higher vaccinated population we're going to be seeing those costs.

And so on those patients, if we're not collecting the -- the cost sharing then, and granted the cost sharing, you know, in some cases it's not very much in the grand scheme of things. This, you know, million dollar patient, you know, if they were on the high deductible plan they paid, you know, $3,900 and that was it and out of the $1,000,000, right. And so ultimately it's a small chunk overall money or cost, but it does impact the plan when you apply it broadly, if that makes any sense.

BOARD CHAIR FREED: This is Laura Freed. You led into a question I was going to ask. So it sounds like PEBP's experience with COVID claims, particularly in the catastrophic realm, like this page three with $1,000,000 in bill charges has reflected the national experience which is

the vast majority of our COVID claims that were, resulted in hospitalization and possibly death were among unvaccinated participants.

So with that in mind, I have to say I find this a reasonable proposal because as an unvaccinated person we know from national experience that if you're vaccinated you may still catch COVID. You may very well get a breakthrough infection but you're almost guaranteed not to die and you're probably not going to go to the hospital with it. You're probably just going to feel miserable.

Meanwhile your colleague in the next office is unvaccinated, catches COVID and goes to the hospital and racks up a few hundred thousand dollars in PEBP claims costs. Is it fair then for the vaccinated PEBP participants to effectively have to subsidize the claims cost incurred by unvaccinated participants. You know, that is why I think this is a reasonable thing to return to treating this as we would any other illness that causes hospitalization.

And, you know, that's -- I'm trying to come at it from a cold eyed claims value perspective. There are -- of course, as I said in the initial part of the discussion, you know, we have people who can't get a vaccine because they're immune compromised and they rely on everybody else to get the vaccine to protect them. And we have, of course, children

that aren't eligible to get a vaccine yet. Anyway, that's my thoughts on this.

MEMBER VERDUCCI: Chair Freed, Tom Verducci.

BOARD CHAIR FREED: Sure.

MEMBER VERDUCCI: As we're looking at these two recommendations here and, you know, the way I can see this going perhaps is you remove 100 percent coverage but at the very end of number one you could be adding, this would be for unvaccinated patients, those who will receive medical recommendation not to be vaccinated and also would that apply to children. I think that would cover the --

BOARD CHAIR FREED: So, again, you know, it's -- it's been pointed out that PEBP doesn't have the capability as a normal operating thing to know of any given claim to know who's vaccinated and who's not. It comes through when, you know, case management kicks in, but it's not possible for us to put in a motion this only applies to unvaccinated people. It would have to apply to pretty much everybody.

And, of course, I mean the Executive Officer did say they could carve out people who are not eligible to be vaccinated, i.e., people under 12. But then Member Kelly said, well, why don't we make it more flexible because emergency use authorization might be forthcoming for that group.

So -- so your idea is good, but I'm not sure that precise wording is workable for the staff and HealthSCOPE.

MEMBER VERDUCCI: Yes. And Tom Verducci for the record. So, you know, we do receive a vaccine card, okay. I carry mine in my wallet. So if you're not -- you know, if you're submitting a claim and you have a vaccine card that does show demonstration that you have received the vaccine because it appears to me that the higher costs are coming from the unvaccinated group and that should be the group that should be incentivized to get the vaccine. So that's the higher cost group. I don't know if it's possible, so.

BOARD CHAIR FREED: I appreciate your commentary, I really do. I only laugh because if you have a way to incentivize vaccination the Governor's office is all ears. I think they have been thinking about this for weeks.

MEMBER VERDUCCI: I know I'm getting so sick of this stuff.

MEMBER KELLY: Michelle Kelly here.

MEMBER VERDUCCI: Go ahead, Michelle.

MEMBER KELLY: I was just going to say, you know, I'm supportive of moving COVID treatment back onto the normal plan rules. I'm supportive of it beginning in the new plan year, not immediately. And I'm also supportive of excluding the groups, the age groups who are not eligible for vaccines

at the time, you know, that they get the service. You know, I do think it's -- it's -- you know, we're trying to move to the new normal. COVID is going to be around just like the flu is around and people who have a severe flu they have to satisfy their deductible whether they had the flu shot or not.

So I think I have concerns about I guess treating people who are vaccinated and unvaccinated differently because there are people who legitimately can't get a vaccine. And so, you know, I think that by just moving it under the plan rules generally, COVID treatment, I think it's fair to everybody. You know, and eventually we're going to have to go there anyway.

So if we do it effective the next plan year that still gives, what, nine months for kind of the -- for the people who are eligible for vaccines to go ahead and get them for, you know, emergency relief for children to come out. And so like we'll catch more groups and perhaps and maybe a lot less administrative prevention to manage. And so I would be willing to make a motion that hopefully would be more concise to capture that.

BOARD CHAIR FREED: Okay. I think I understand the motion. Is there a second on that motion?

MEMBER FOX: Linda Fox for the record. But I

want to make sure I understood the motion. Was that to remove the 100 percent coverage for all, period?

MEMBER KELLY: It was to remove the 100 percent coverage for all people who are eligible to get a vaccine regardless of whether or not they have got them. So basically it would remove the 100 percent coverage for everyone today except for those under 12 and that would be effective July 1st of 2022.

MEMBER AIELLO: This is Betsy. And I would like to comment on that motion. And then also maybe Laura can speak if I'm speaking in old-fashioned times. It takes computer programming a tremendous amount of time, I hate to say that, but to play -- pay a claim that programming changed. So if it was programmed for July 1st to exclude 12 and then one month later they could get the vaccine down to five it may take six months to or even a year to reprogram that claims payment to pay different.

Am I correct in that assumption?

MS. RICH: This is Laura Rich. Yes and no. In many cases that is correct. In this case I have confirmed with HealthSCOPE that they can revert to the 100 percent coverage pretty easily. It's just that the 12 and under variable, that we would have to look into. And as you heard Denise say, they have to verify that they can program that

in. However, if we're making this effective July 1st that gives us sufficient time.

MEMBER AIELLO: And then let me ask again though, but if by March 1 people five and over can get the vaccine then that programming that was built for 12 and under would no longer be effective programming, correct?

MS. RICH: Correct. And I think at that point the programming would be easy, right, because now you're just changing the year. So you're adding a variable and you're just changing the parameters of that.

MEMBER AIELLO: So the motion as Michelle Kelly made them would -- sounds like it would be programmable and be able to be adapted as the situation changes is what I'm hearing.

MS. RICH: Tentatively yes because as we heard from HealthSCOPE, that's not confirmed but they could incorporate the 12 and under today into that, but that's something that we would take back and just make sure that's -- that is something that they can do eventually.

MEMBER KRUPP: Jennifer Krupp for the record. I have a quick question. Would PEBP be liable for programming costs to make this change, i.e., the 12 and under or five and under if the availability of the vaccine were expanded or if --

MS. RICH: And Cari can correct me if I'm wrong. I don't believe that they charged us for this to begin with.

Cari, do you know if that was something that was -- was that a work order that was submitted or is this something that was just done?

MS. EATON: It was something that was just done. Cari Eaton for the record. I'm not sure if they potentially could be and they just did not.

MEMBER VERDUCCI: Tom Verducci for the record. I'm not crazy about this. We're in the process of trying to restore benefits and we're in a wait and see mode on the ARP funds. And here we would be making a recommendation that would increase costs for state workers. So I just don't like voting on that just currently right where we're at, and it's just my thoughts. I'm just one of ten members here but that's my personal thoughts there.

MEMBER CAUGHRON: April Caughron for the record. I would just like to say I feel there's a lot of information we're still needing in order to make a decision around this. We -- it seems we still have a lot of unknowns with regards to system related changes. And I agree, I think that we need to maybe not make a decision on this today. That we need a bit more information.

MEMBER BARNES: Yes, this is Jim Barnes for the

record. I would agree with that too. I think we should look into this, but I don't believe we should make a decision on this today.

BOARD CHAIR FREED: Okay. Okay. This is Laura Freed. So Member Kelly actually put a motion on the floor. It will die for lack of a second if there isn't one.

MEMBER AIELLO: This is Betsy.

BOARD CHAIR FREED: Oh, Dr. McClendon, I'm sorry. I missed that.

MEMBER MCCLENDON: That's fine. I support Member Kelly's motion.

BOARD CHAIR FREED: Okay. So it's been moved and seconded. And for the benefit of the record, I'm going to try to restate this. Please holler if I get it wrong. The motion is remove 100 percent coverage for COVID related and existing plan rules to COVID related treatment and hospitalization effective July 1st of 2022 for participants and dependents who are eligible per the federal government for vaccination. Did I get that right?

MEMBER KELLY: Yes. Thank you.

BOARD CHAIR FREED: Okay. Is there discussion on the motion that's on the floor?

MEMBER MCCLENDON: This is Jennifer McClendon again. Not to get into the weeds on this.

BOARD CHAIR FREED: Uh-huh.

MEMBER MCCLENDON: But if we could go like six months post when they become eligible to actually get the vaccine I think that would be helpful or a certain amount of time. I'm just thinking I can't get -- I have an 11-year-old. I can't get him vaccinated the very day he's eligible and so a little bit of a time window just in case that's necessary at some point would be good, like three months post availability or something.

BOARD CHAIR FREED: PEBP staff, does that make operational sense to you?

MS. RICH: We can certainly work with HealthSCOPE to ensure we can do this operationally.

BOARD CHAIR FREED: Okay. Okay. So you've heard the motion. I'm going to call the question. All those in favor signify by saying aye. Raise your hand in your little box.

Any opposed say nay?

VICE CHAIR FOX: Nay.

MEMBER VERDUCCI: Nay.

MEMBER BARNES: Nay.

BOARD CHAIR FREED: All right. I think I'm going to do a roll call vote, ladies and gentlemen, just to make double sure because I thought I heard three but maybe that's

four. And we know that -- we've known from past experience that I myself should not be dong roll call votes because I miscount. So might I ask, Ms. Wendy, to do that for me.

MS. LUNZ: Absolutely.

Linda Fox?

VICE CHAIR FOX: Nay.

MS. LUNZ: Betsy Aiello?

MEMBER AIELLO: Aye.

MS. LUNZ: Jim Barnes?

MEMBER BARNES: Nay.

MS. LUNZ: April Caughron?

MEMBER CAUGHRON: Nay.

MS. LUNZ: Michelle Kelly?

MEMBER KELLY: Aye.

BOARD CHAIR FREED: Jennifer Krupp?

MEMBER KRUPP: Nay.

MS. LUNZ: Leslie Bittleston?

MEMBER Bittleston: Aye.

BOARD CHAIR FREED: Dr. Jennifer McClendon?

MEMBER MCCLENDON: Aye.

MS. LUNZ: Tom Verducci?

MEMBER VERDUCCI: Nay.

MS. LUNZ: So my count shows four aye and five nay.

Chair Freed, were you voting on this?

BOARD CHAIR FREED: Yes, ma'am. I'm an aye.

MS. LUNZ: Okay. Then we have five and five.

BOARD CHAIR FREED: We have a deadlock. Well, all right, then we do not have a majority support for the motion ergo I believe it fails. Tell me if my read of Roberts Rules or Masons Rules are correct.

MEMBER VERDUCCI: Tom Verducci for the record. Could I make a second motion?

BOARD CHAIR FREED: You may, sir.

MEMBER VERDUCCI: Okay. I would like to make a motion to permit PEBP staff to conduct further research of COVID surcharges and provide update and potential options at the November Board meeting.

BOARD CHAIR FREED: Okay. Is there a second on that motion? We just skipped right over that COVID surcharge discussion. So, you know, if anyone wants to talk about that please feel free.

MEMBER KELLY: I would definitely want to talk about that.

BOARD CHAIR FREED: Oh, I'm sorry, Dr. McClendon. I didn't hear that.

MEMBER MCCLENDON: I'm sorry. It was just a clarification on the motion. Is it to prevent or permit?

MEMBER VERDUCCI: Tom Verducci for the record. It's going to read exactly as item number two on the recommendation. The word would be permit PEBP staff to conduct further research of COVID surcharges and provide an update and potential options at the November Board meeting. Permit.

MEMBER KELLY: Michelle Kelly here.

BOARD CHAIR FREED: All right.

MEMBER KELLY: I would like to discuss before we have a motion.

BOARD CHAIR FREED: Okay. Please go ahead.

MEMBER KELLY: So I guess my question is just around as employers, the INCHE Board of Regents today is meeting today, in fact, to permit termination for people who are eligible and able to get the vaccine but who decide not to for whatever reason. So they are making exemptions for religious. They are making exemptions for medical conditions.

So -- so and I wonder firstly if the state is exploring similar things. And if that's so is really a 200 dollar surcharge a bigger stick than losing your job. That's my question. Because, you know, the PEBP staff are busy. They are stretched to the max. I understand we want to encourage vaccines. But it also feels like the state and

employer has moved past that point.

And so for me losing my job is the bigger stick than you charge me $200 extra a year. I don't know if that's true generally. But it does feel like maybe using PEBP staff time to explore something like that when employers themselves are currently looking at their options might not be a good use of time.

MEMBER AIELLO: This is Betsy. And I just wanted to ask the Chair if after we're done with this surcharge if we could go back to the first issue and just make sure because I don't think we want it to be dead forever. So we can discuss where we want to go with that one.

BOARD CHAIR FREED: Yes, absolutely. I'm not going to let this one just sort of lie. We didn't -- you know, we had a couple of competing ideas. We had, you know, move forward with treating COVID cases just like any other sort of disease that would cause hospitalization or get more information. So, no, we will return to that momentarily. But Mr. Verducci raced ahead with the motion on the COVID surcharges.

So where I think I want to go right now is discussion of Member Kelly's question about, well, is, you know, 200 bucks on your premium or whatever. I mean, again, we're not -- the Board is not being asked to approve a

surcharge. The Board is being asked to approve research on surcharges. And so, you know, I think her question is really valid. If we are as the executive department going through this process of, well, if you're not comporting with the testing policy and you're not getting vaccinated isn't that a bigger threat, you know, than your insurance premiums going up. It's a good question.

Member Kelly, to answer your question, INCHE is part of the executive department, and yet we call it the fourth branch of government colloquially because you all have these process that are so different from, you know, what we think of as the executive branch. Yes, departments are going through the process of sorting through the unvaccinated employees. And, of course, I'm just talking about actives right now obviously. Employees weekly test and if they fail to test why did they fail to test. Were they 100 percent tele-work? Were they on annual leave, sick leave or something else? And then if they don't have a valid excuse for skipping testing that week then, yes, they are going -- each department has its own tiered discipline process. Some departments start with forewarning, as mine does. And some departments start with written reprimand and it moves up to forewarning, written reprimand, suspension and then termination.

So the short answer to your question then is yes, there is in executive departments there are people who are going through that disciplinary process. I can't unfortunately give you a sense of how many, mostly because, you know, people's test results aren't anybody else's business. In my own department it is a very small minority of the total number of employees.

So I hope that helps provide a little bit of context for INCHE.

MEMBER VERDUCCI: Chair Freed, Tom Verducci for the record. If there's a different direction that the Board would like to go with this based on your comment that the motion was made a little too quick there, I would be happy to remove it and open it up and --

BOARD CHAIR FREED: Okay.

MEMBER VERDUCCI: -- see what direction it goes in.

BOARD CHAIR FREED: All right. So let's just -- let's just for the time being focus on the concept of asking PEBP staff to research COVID surcharges.

One question I have for PEBP staff is how many other state health plans via south that are or however you might know this are considering those kinds of surcharges or have implemented them?

MS. RICH: Laura Rich for the record. This is a relatively new landscape. You know, Delta Airlines doing what they did really set the stage. They are one of the first companies that did it.

I think, you know, as in most cases the private sector tends to really do the trailblazing as far as, you know, these kinds of things go, especially in a -- in an arena where there's not a whole lot of guidance.

I've done initial legwork already. Based on what some of our vendors are saying, there's a whole lot of interest in private sector and public sector, but no one has in the public sector has implemented this quite yet. Again, it's brand new. This is very fluid. I would not be surprised if this idea gets traction because health plans will need to recoup the cost in one way or the other. They are either going to need to pass it on to -- to members across the board or they are going to have to get it in premiums from their unvaccinated or, you know, there's different ways to do it. But this is -- it's still pretty premature as far as, you know, public sector entities, you know, moving forward or implementing this.

MEMBER KELLY: Michelle Kelly here. I'm sorry. Clearly I hate silence. Give me time for my brain to move. So I guess I'm challenged by the stick approach because

there's many conditions out there, you know, ranging from just, you know, overweight, all the way up to heart conditions, and we don't penalize people for sticking to a treatment plan for those conditions.

So on the one hand with COVID I just stated a motion to move into a business as normal, go forward position. But with a stick approach it's kind of stepping backwards because I say to Executive Officer Rich, and this isn't personal, but my question is as a participant, so COVID surcharge or COVID stick today, what are you going to punish me with tomorrow if the Board as a whole starts to look at sticks as being a way to manage the cost of our health plan, and I think that's problematic.

And my second comment is just around the legislative process that is that, you know, PEBP has used carrots before and employees got very upset at the carrots and went to the legislature and PEBP was barred from offering wellness programs, which is the carrot I'm talking about.

So I wonder, you know, you just talked about kind of being ahead of the curve which is always, you know, a good thing to be but maybe not in this area is my observation. I would prefer to wait and see how it goes because I am concerned about the stick approach. I don't think it's a good way to manage employee behavior. It might be effective

but it's not the best way.

MS. RICH: So Laura Rich for the record. This has been compared to the tobacco surcharge. So in the Affordable Care Act it does allow health plans to assess a tobacco surcharge. Now, there's all kinds of, you know, parameters and limitations around that. And so this is quite similar to that.

There -- but there is an ability for -- so smoking is a choice and that's how it's seen or perceived under the ACA. If someone chooses to smoke then they are able to, the health plans are able to impose a tobacco surcharge. This is seen in a, you know, similar way to that.

And you're right, because at what point? There's obesity. You know, there's all kinds of other decisions that you make in your life that lead to unhealthy behavior, right. And so, you know, where is the line that you draw and that's -- and I would argue that those types of scenarios are much more complex. They are -- you know, it can lead into mental health. It can lead into, there's all kinds of behaviors that aren't quite a decision of do I want to smoke or do I not want to smoke. Do I want to accept a vaccine or not take the vaccine, right.

And so it's a little bit more, the comparison there has been, again, this is new. It's, you know, new

territory. This is not something that's been imposed by some health plans. It hasn't been challenged. Will it be challenged? Maybe potentially. We don't know yet. So there's -- there's arguments both ways. And I don't disagree with you, Ms. Kelly. You know, what point do you, you know, do you stop using that stick approach.

But legally per the ACA we've been able to include a surcharge for smoking which is a choice and so this would be very similar to that.

MEMBER AIELLO: This is Betsy. And I agree with Michelle and everything she said. But I -- based on what your last sentence, do we impose the surcharge for smokers or we just could?

MS. RICH: PEBP does not.

MEMBER AIELLO: Okay.

MS. RICH: But under the ACA --

MEMBER AIELLO: You could.

MS. RICH: -- plenty of health plans do, yes.

MEMBER AIELLO: Okay. I tend to agree with Michelle Kelly because I do think once things start going one way and maybe smoking is what paved the way to allow this to be, a lot of us think we know what is right or not right but different people think they know what is right or not right also.

My druthers, because I don't want everybody to end up having to pay higher premiums and higher things because COVID is now part of the world and there will be the cost, but my druthers would be more on the issue number one and beginning to treat it like we do every other disease that people may get, lung cancer because you're smoking or whatever. You know, you're paying at least -- if you happen to get it you're paying the 100 percent of the co-pays that other people would or whatever. But I tend to feel like it's a little bit scary to start charging surcharges for not getting the vaccine.

BOARD CHAIR FREED: Okay. Thank you. Other comments? I'm not feeling like there's a huge appetite on the Board to accept staff recommendation number two. But please tell me if that's an incorrect sense of the Board.

MEMBER KRUPP: This is Jennifer for the record.

BOARD CHAIR FREED: Yes, Jennifer.

MEMBER KRUPP: I actually would be supportive of PEBP staff conducting more research.

BOARD CHAIR FREED: Okay.

MEMBER KRUPP: And again make the recommendation, staff recommendation is really just to provide an update --

BOARD CHAIR FREED: Yes.

MEMBER KRUPP: -- of potential options at the

November Board meeting. So I think it's important that we look at this.

BOARD CHAIR FREED: Okay.

MEMBER KRUPP: This may continue to come up as Member Aiello has indicated. You know, COVID is probably going to be a long-term choice, and we do have the option to charge a surcharge for tobacco use, so.

BOARD CHAIR FREED: Uh-huh.

MEMBER KRUPP: In my lack in looking at how this is part of the new normal I think it's important that we look at it early. There's nothing saying that surcharges need to be implemented.

BOARD CHAIR FREED: Okay.

MEMBER KRUPP: There's nothing to make that happen.

BOARD CHAIR FREED: Oh, absolutely.

MEMBER KRUPP: Information gathering and conducting research is incredibly important. If we don't do it now it more likely will come up later.

BOARD CHAIR FREED: Okay.

MEMBER CAUGHRON: April Caughron for the record. I will second that.

BOARD CHAIR FREED: Okay. So is -- you're seconding her comments, not seconding the actual motion.

MEMBER CAUGHRON: Yes. Yes.

BOARD CHAIR FREED: All right, cool. All right. Well, in that case I'm glad to be corrected by the Board. Then does anyone want to make a motion to approve the staff recommendation number two or modify it or do something entirely different?

MEMBER KRUPP: I'm happy to make a recommendation on number two.

BOARD CHAIR FREED: Okay.

MEMBER KRUPP: Before we do that, did we want to go back and address recommendation number one or take these in two different parts?

BOARD CHAIR FREED: I think I prefer to do in two different parts. So if -- okay. All right. Do I have a second to approve staff's recommendation number two, permit PEBP staff to conduct further research on COVID surcharges and report back at the November Board meeting?

MEMBER CAUGHRON: April Caughron for the record. I will second that.

BOARD CHAIR FREED: Okay. Discussion on the motion?

MEMBER KELLY: Michelle Kelly here.

BOARD CHAIR FREED: Sure.

MEMBER KELLY: I'll support -- I just want to be

on public record, you know, obviously I'm anti stick. But in this case I will support the motion to -- for further.

BOARD CHAIR FREED: Okay.

MEMBER VERDUCCI: You know, Tom Verducci for the record. I'm just kind of curious what the difference is between my motion and the motion that's on the floor?

BOARD CHAIR FREED: Nothing, actually. It's just that you withdrew your motion originally so I had to ask for a new one.

MEMBER VERDUCCI: Okay. I wanted to give everyone the opportunity if we're going in the wrong direction here. So thank you very much.

BOARD CHAIR FREED: You're welcome.

Okay. All those in favor of approving staff recommendation number two say aye.

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

BOARD CHAIR FREED: Any opposed? Okay. So with that, you know, per Member Aiello's suggestion, let's not leave the cost sharing discussion in the dust unloved. So there was not a majority of support for removing the 100 percent coverage benefit for COVID related treatment. But there perhaps was support for having the staff report back to answer some of the Board's questions. Do we want to pursue

an action in that vain?

MEMBER AIELLO: This is Betsy. And I think we do want to pursue getting the information people wanted. I think it's important that PEBP knows all of that information so we aren't at another meeting where there might be still added information that folks want looked at.

So I know that what I understood as one of the questions was the ability, the clear knowing for sure that the system can be programmed would be one. That the programming can be adjusted as the vaccines become available to more populations I think is another.

And then I don't think if either other Board Members have other things that they want PEBP to look at before they will become comfortable.

MEMBER KRUPP: This is Jennifer Krupp again for the record. And I would say not so much that I have any other recommendations for PEBP staff to look at, but just that I would actually be in favor of removing the 100 percent coverage benefit for COVID related treatment and hospitalization and apply, I'm reading directly from that recommendation, apply the existing plan rules to COVID related treatment and hospitalization claims moving forward just for the purposes it would reduce the amount of administrative burden that would be required if we do kind of

break this into, you know, the under 12 population who can't get vaccinated versus those populations that are greater than 12 and have that access and an improved vaccine available to them, but that really could be a lot to manage.

And then going about to Board Member Kelly's, you know, points with the previous recommendation, the previous item is that this becomes kind of a stick issue. You know, if we're segregating participant populations into whether or not they have to pay the 100 percent COVID or not treatment. So I think just in terms of keeping it in line with how we cover any other sorts of diseases or conditions within our beneficiaries I would recommend that we just move forward with removing the 100 percent coverage option for all populations. Long winded. Did that make sense?

BOARD CHAIR FREED: Kind of.

VICE CHAIR FOX: Linda Fox for the record. I actually support that. I prefer it that way without the details of separating out populations, but I wasn't sure if that was a motion. If that was a motion --

MEMBER KRUPP: I wasn't making it a motion. I was just stating my position not only for the record but also so that other Board Members were aware of what I was thinking, so.

BOARD CHAIR FREED: Well, and, you know, Board

Members you don't necessarily have to act on it. So if we're just asking for an informational report that answers questions raised about ability of HealthSCOPE to manage this, you know, we can just do that as a request. Unless Deputy District Attorney Briggs raises her hand and hollers at me I think we have the ability to do that.

So I'm not hearing anybody buzz in to make a motion that modifies recommendation number one to be more palatable to the Board. So I think my inclination right now is just to leave it there, just to instruct PEBP staff to come back to the November meeting with more information about the ability to implement this, you know, relative to turning it on and off and, you know, how much -- how much emergency you thought use of authorizations for groups that currently don't have it would play into PEBP's ability to do this. And does that sound okay to everybody?

All right. I'm seeing nodding heads so that's cool.

MEMBER VERDUCCI: Chair Freed, Tom Verducci for the record. You know, I just don't have it in my heart to charge somebody $200 more per month right now. I mean, we have state employees that have gone through furloughs and haven't seen pay raises in years. Again, I just can't push that button to charge them $200 more a month. I just don't

feel right about doing that.

BOARD CHAIR FREED: Well, that's good because we are talking about cost sharing not the surcharge. So that's good. You don't have to.

MEMBER VERDUCCI: So specifically on the cost sharing, do we know what the percentage would be or is that what we're looking into?

BOARD CHAIR FREED: We do in the sense that it would -- the COVID illness would be just like every other illness. In other words, it would just be -- you know, your claims would be processed and you would pay your deductible and you would accrue your out-of-pocket max just like anything else. There's no way to tell how it would affect an individual participant. It would just be treated like any other claim.

MEMBER VERDUCCI: I see. So it would no longer be at the 100 percent?

BOARD CHAIR FREED: Correct.

MEMBER VERDUCCI: Okay. That makes -- and I do apologize. Go ahead.

BOARD CHAIR FREED: That's okay. Go ahead. Finish your thoughts.

MEMBER VERDUCCI: You know, that's more reasonable. I think the, you know, they have a surcharge I

was really having trouble with. But, you know, I think it's worth looking forward, looking into at the November Board meeting, and perhaps something should be done there. This has been temporary. So that's my thoughts.

BOARD CHAIR FREED: Okay. So I think that's what we'll do, Board Members. At the November meeting we will re-agendize the cost sharing discussion with some more information about operationalizing it and we will move on down the road.

All right, friends, with that I think we can move to Agenda Item Number 8, which is our standing contract item.

MS. RICH: Cari, were you going to give that or do you want me to do that?

MS. EATON I can do that. Thank you.

MS. RICH: Okay.

MS. EATON: Cari Eaton for the record. There is no necessary action necessary for items 8.1 and 8.2. I will start with 8.3 where we have two contract amendments for ratification. 8.3.1 is for the contract with LSI Consulting. PEBP contracted with LSI Consulting for eligibility and enrollment systems services which became effective September 8th, 2020. Although, fees are not contracted to begin until January 2022.

This contract amendment is required to amend the

fee schedule to begin services and payments in December of 2021 due to requesting an overlap go live date to ensure a smooth transition. And then to add payment for COBRA management services and to add additional work order authority for a current and future change orders.

This amendment adds 1.4 million dollars to the current contract maximum. So PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and LSI consulting. And I can take any questions on that one.

BOARD CHAIR FREED: This is Laura Freed. I have a question. So we did not -- okay. Why are we moving ahead a month to begin services and payments. Are they just like ahead of schedule? And what -- their additional work order authority for future change orders, how many change orders -- how many change orders were originally anticipated and budgeted for and how many more does this mean?

MS. EATON: Thank you for the question. Cari Eaton for the record. The moving it up ahead one month is because we are a little ahead of schedule in implementation, and we decided that it would be better to have a dual month with our current system to ensure that the transition is smooth and everything runs accurately.

MS. RICH: This provides -- this is Laura Rich.

Sorry, Cari. I just want to add in here. It provides kind of a safety net. So everything we do at PEBP, billing, enrollment, eligibility, everything runs through the system and so the fact that we're able to kind of concurrently run the systems for at least a month to, because we know with any kind of implementation like this there's -- there's always going to be bugs in it. You just -- there's an expectation that something is just not going to go right. If everything goes right then that's amazing and great.

But usually in implementations of this magnitude we're going to find something that doesn't go right. And so having the side by side implementation and doing that currently for at least a month really provides a safety net for PEBP, for members, just in general to be able to, you know, transition a little bit more smoothly than if we were just to cut one system off on December 31st of 2021 at midnight and then turn the other one at 12:01 on January 1st, right. So it just provides a little bit of a safety net there.

MS. EATON: Thank you, Laura. This is Cari Eaton for the record again. On the second question, on the change orders, we did have more change orders than originally anticipated. But our change order authority in the original contract was not very much, especially for a contract of this

magnitude. So we did want to give a little bit more wiggle room even though I still think we're probably not having as much authority as we may need in the future. So there may need to be additional in the future, but we don't want to over project that either.

BOARD CHAIR FREED: Okay. Thank you. Other questions about 8.3.1, Board Members? Okay. Why don't we go on then to 8.3.2 and we'll take a collective motion on both of those.

MS. EATON: Okay. 8.3.2 is for the contract with Claim Technologies. PEBP contracted with Claim Technologies for health plan auditing services which began July 1st, 2021. This is the first amendment to the original contract to update the fee schedule to include an additional TPA audit for the second quarter of plan year 2021 that was inadvertently left out of the RFP and add authority for various focus audits at the request of PEBP. This amendment adds 144,000 to the current contract maximum, and PEBP recommends the Board authorize staff that complete this contract amendment.

And I can take questions.

MEMBER AIELLO: This is Betsy. And I'm sure your answer is yes. But I thought just both of these contract amendments that are adding money, the dollars are budgeted

for or available to PEBP, correct?

MS. EATON: Thank you. Cari Eaton for the record. We will either need to find savings in these categories or request that funds from our reserve category be used and that will have to be approved by the Governor's Finance Office and the legislature at IFC.

MS. RICH: I think just a correction. I don't think this would be an IFC approval necessary because it's not -- it's not a benefit that we are using. So I don't think it needs to go through IFC. But I would have to look at the clarifying language.

MS. EATON: Laura, this is Cari Eaton. I believe they do need to go through IFC just because they are adding authority to the contract over a certain dollar amount.

MS. RICH: Yep, you're right. You're right. That is true.

MEMBER KELLY: It's Michelle Kelly here. Just a quick question. I'm curious about the cost just for both recommendations. Like, so both of these procurements were through an RFP so competitive sourcing. And then we're adding -- basically we're adding projects. So how is the rate for those add-on projects determined? Have they already provided the figure through competitive pricing and now we're just adding them or are they just going to give up whatever

price they feel like giving up?

MS. EATON: This is Cari --

MS. RICH: Go ahead.

MS. EATON: This is Cari Eaton for the record. I can answer it for the claims technology piece. We are adding on one additional TPA audit and that's being added at the same price as what they had in their RFP response. And then we did request a cost on focus audits and we basically took kind of an average of what a typical focus audit might cost and then added in a few of those.

Go ahead, Laura. Sorry.

MS. RICH: And just on the LSI piece, like I just said, it's a very very significant contract in terms of complexity and just volume in general. And so when this RFP went out there's a whole lot. You can put out an RFP but it's not going to encompass every single piece of -- every single requirement, everything that's needed because, again, we've had our previous vendor or our current vendor actually, we've had him placed for over a decade.

And so what our current vendor has done for us is potentially not the industry standard. A lot of things have been done, you know, to customize our system and those things are just not available today. They are not -- they're not this kind of eligibility system in a box, right.

And so when this contract was awarded, yes, the COBRA piece was included in the RFP. And as we were discussing it through the negotiations we had to explain to the vendor who had not yet seen our system, this is what we do. This is what the system currently does today. And this is how we accomplish COBRA today. And so through those discussion it was determined, okay, you don't need our COBRA product. We can take that out and factor it out.

And so that was factored out of -- they took out implementation cost. That was negotiated out, and we negotiated down PMPM's. That was under the assumption that we didn't need this COBRA piece.

Moving forward as we got through the discovery process and the vendors started understanding what exactly it is that we do at PEBP and the functionality we need to meet to do -- to meet the COBRA requirements which are federal requirements, it was determined that, yes, we do, we need the package that they are offering the COBRA package. So we had to go back to the drawing board and negotiate a COBRA solution because it is a federal -- federally mandated function, you know, that we have to perform.

And so that was -- that is why this is coming up as an amendment because there's a lot of complexity through this and through the discovery process. And this is typical

of any IT project. Through the discovery process you just find things that the vendor assumed one thing. The client assumed another thing and now through the discovery process you're finding out something totally different, right. And so that's where the COBRA piece came into play.

MEMBER KELLY: Just a clarifying question then. So the price that is in your staff's recommendation today is equal or better than what was in the RFP?

MS RICH: That is correct, yes.

MEMBER KELLY: Thank you.

BOARD CHAIR FREED: Okay. If there are no additional questions on either of these contracts I'll accept a motion to approve the staff recommendation for 8.3.1 and 8.3.2.

MEMBER KELLY: Michelle Kelly. So moved.

BOARD CHAIR FREED: Thank you. Is there a second?

MEMBER AIELLO: Betsy Aiello. Second.

BOARD CHAIR FREED: Great. Thank you. All in favor signify by saying aye.

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

BOARD CHAIR FREED: Anybody say nay? All right. The motion carries.

We're on to Agenda Item 9 but I think since this might be a longer discussion and, again, we've been at it for a couple of hours, let's take another five-minute break and be back at --

MS. RICH: Chair Freed? Chair Freed?

BOARD CHAIR FREED: Yes.

MS. RICH: Before we move on can I just clarify. I just think it's important to bring it to the Board the status of the current solicitations just really quickly.

BOARD CHAIR FREED: Oh, I'm sorry.

MS. RICH: Before we close that out.

BOARD CHAIR FREED: Sure. Sure.

MS. RICH: I do want to bring to the attention of the Board that one of our larger RFP's, well, significant RFP's was completed. And while we are still in contract negotiations and that part is confidential the part that is public is that the notice of intent to award has been issued to UMR which is, essentially UMR bought out HealthSCOPE a couple of years ago so it's the incumbent without being the incumbent, if that makes sense. There will be some changes but it's essentially the incumbent.

And additionally the HSA/HRA administration was awarded to Webster Bank or HSA Bank as well. I do want to say -- oh, I can also say that the second opinion that

notice -- actually, I'm not going to say that yet because I am not positive that a notice of intent of award has been issued. So I will refrain from making that public until purchasing has made that public, but that decision was made earlier this week as well for that second opinion services.

I do want to just let the Board know that some of these are behind schedule as you see. There's a lot of RFP's. So we've got -- some of these should have already gone out. We are a little bit behind schedule on them, but we are still okay to be able to get everything implemented in time for a July 1st open enrollment. So just wanted to give that update.

BOARD CHAIR FREED: Thank you.

Okay. With that, if everybody can be back at 1:15.

(Whereupon, a brief recess was taken.)

BOARD CHAIR FREED: All right. We will move on to Agenda Item 9 which is Potential Plan Design Changes for Plan Year, Fiscal Year '23 Beginning on July 1st, 2022. Take it away.

MS. RICH: All right. For the record Laura Rich. So generally every plan year PEBP staff and vendors and Board Members, we start planning for the upcoming plan year before the current plan year even ends, right. So in past years

PEBP has kicked off plan year or plan design planning with strategic planning. We normally do that some time early summer, late summer and that's where Board Members and staff and we identify areas of opportunity and look for cost savings, look for, you know, part of the discussions that we had earlier about diabetes management. You know, things like that start to come up and we start to discuss this as a group and look for opportunities like this.

Then ideas are then typically presented to the Board in September and that provides staff a roadmap to come to the Board in the November meeting with ideas and modeling, et cetera, et cetera. The volatility that's been brought on by the pandemic coupled with the sheer volume of contracts which, you know, are being implemented or will be implemented, that's really really impacted PEBP's ability to, you know, to really do this and kind of come to the Board in September and say here's all these new opportunities. Here are all of these, you know, great new innovative solutions. And this is what we should do. And we've really been able to analyze the plan. And we've identified these areas of improvement.

But as I kind of touched on earlier we cannot do that this time around. We've got pretty much every single contract out there is out to bid. And so without

understanding what contracts are going to be in place, what vendors we're going to be working with, eventually the volatility that's been brought on just by the claims experience, right, we don't really have solid claims experience because of the claim suppression. It's really difficult to go -- to come to the Board with supporting data to support any kind of recommendation moving forward.

And then also as I explained earlier, members are already going to have to adjust to a lot of change with PEBP, a new eligibility enrollment system. They are going to have potentially, although I did say that UMR is the incumbent. There's going to be a lot of different -- differences that the members are going to experience, you know, member facing differences. There's going to potentially be a new PBM. There's a whole lot of change that's coming down the road. And so adding onto that just doesn't make sent right now.

So instead what we're doing is it's in our opinion that really in the best interest of our members, of staff and just of the program that we let the dust settle and really take some time perhaps next year to start implementing any of these major changes, major programs when we know the vendors that we're working with. We understand the contracts that we have in place. We understand the pricing, what's available to these members.

Right now there's just so much influx that we can't bring anything to the Board similar to what has been done in the past. So instead what we're looking at here is really just to take a look at our current situation and see. We do have some differential cash, excess reserves, whatever you want to call it, where are we at in the plan, what is happening and what we can do to maybe enhance some of the current benefits that we have today if the Board would like to move forward. And then additionally if we are to get any rescue plan funds then, you know, how is that going to play into the big picture as well.

So I would like to take the opportunity to -- I'm going to let Aon folks introduce themselves and that way we can -- the Board can get to know the new Aon team and they are going to go through their slide presentation, and then we'll get to my recommendations at the end.

So, Aon, do you -- I don't know who wants to start out there. Maybe, Colleen, if you want to start out.

MS. HUBER: Yeah. So this is Colleen Huber. I lead our public sector practice for Aon. I work with several other states across the country, as well as some large municipalities and state entities. I am an actuary by background. But I will introduce my team as well.

Steve, do you want to give a quick hello.

MR. CAULK: Hi, everyone. I'm Steve Caulk. I am also an actuary located out of Denver. I lead a lot of our national initiatives, including trend analytics and other actuarial topics around that.

I do recognize a few familiar faces. A few years back I had supported Stephanie on some of the actuarial modeling and analytics. So I'm happy to be back and work with PEBP and support you every way I can.

MS. HUBER: Okay. Cristie.

MS. LABUS: Hi. Cristie Labus. I am another actuary by background. I work with the public sector under Colleen as well and have two other large states I'm working with and a couple of other counties as well and look forward to working with you all.

MS. HUBER: Great. So what we -- I am going to share my screen with the presentation. Let me know when you all can see it. Can you all see a slide deck?

BOARD CHAIR FREED: Yes.

MS. HUBER: Great. Thank you. Let me run this. I apologize. Okay. Here we go. So Laura asked us during our discussions during plan design, you know, how to spend down the excess reserves or the differential cash available. We thought it was important to give an update on some of the conversation we had earlier regarding impact of plans trend,

especially as it relates to COVID.

What we're seeing across the country as well as the historical differential cash available or excess reserves and then some levers to help return it back to the plan and to the members themselves.

So on this slide, this is your historical claims trend adjusted for your head count. This is looking at it on a 12-month basis over the prior 12 months. So if you look -- oops, I'm sorry. The red line is where your medical claims trend. You'll see prior to -- prior to March of 2020 when we actually look back from June of 2019 to March of 2020 it was averaging right about six percent, actually at 6.1 percent which was very close to historical request for the budget office. It was using data from July of 2017 all the way to June 20th, 2021.

Now, what's interesting to note is as we heard earlier, you really see this decrease in claims really happen beginning of April of 2020 and continue on until about March of 2021. And then all of a sudden it's rebounding back up. This is consistent with what we're seeing across the country. We're seeing that the medical claims side was severely impacted by the lockdowns in place, by members putting off care, by them concerned about going back to the emergency rooms, putting off services, et cetera.

On the pharmacy side, which is your blue line, it was averaging, over time it was averaging about 8.1 percent and then accounting for rebates it was about 7.94 percent. So very close to again what was requested from the budget office as far as annual increases.

Then the black dotted line here is that 5.4 percent of what was actually achieved. The reason why we're showing this is we just want to illustrate what types of claim trends your plan is seeing today, especially as it relates to COVID-19. Again, really on the medical side you're seeing that the large suppression of claims decrease in utilization.

And then what's happening if you look at the most recent time periods of June '21 you see trend levels of about 12 percent. So it's coming out of the low based line into a very high rebound effect.

And on this next slide you'll see what we're seeing across the country. This is national experience. This is just more of a graph trying to help you all understand what happened in 2020 and how it's going to move forward going into '21 and into 2022.

So the red line is your baseline compared to the old trend. If your plan was trending as normal it would go right along this red and blue line. But what happened is at

the end of March of 2020 we saw the medical claims come down considerably. And then even if you look at second quarter of 2020, it fell almost all the way together. So this is what we're seeing across the country. Your plan operated very similar to what we're seeing. And this is not atypical for any of -- for any of our clients.

And you'll see in the fourth quarter there was some grounds made up. But what is interesting to note though is as you look at the second half of 2021 and into 2022 the reason why the claims were so low in second quarter is that they were put off. So think of all your hip and knee replacements, right. Nobody is going to go to the doctor during the COVID time lockdown time period. So they are trying to put off those services until they felt more comfortable and safe going back into the medical facilities. So we really saw that drop in the outpatient side.

Now, on this though you will see in second quarter of '21 what we are expecting is this rebound effect, so the fact that your claims trend is coming back up to about 12 percent. So if you look at this. Sorry. I keep trying to show you with my mouse. If you look at the top part of the bar chart in the red horizontal that's your deferred care so the claims that are coming back into the system.

And then there is a blue horizontal. So we're

still expecting COVID claims going forward. So when you hear about the long-hauler COVID claims, you're also hearing about members still being hospitalized for COVID. We are expecting that to continue into 2022.

And then the purple is your vaccination, the cost of administration of vaccinations as well as testing. I know we had the long discussion earlier regarding the member cost sharing. That all relates to the actual, as it relates to COVID and the vaccine and test would all continue into the future.

And then the green is your system recovery. This is actually suppressing claims trend. It is actually helping your overall claims costs. Because what's happening here is that the facilities and the providers do not have the ability to make up for all of the claims that were suppressed in the second quarter of 2020, all in really quick time frames. So they're spreading it out over several months.

So on this next slide what we're trying to do is break down the different components of what's happening with COVID. So if you look at the bottom half of the table, this is for the 2021 projection and, of course, it goes into 2022. Again, the system capacity is negative five to negative three percent. So, again, think of what we're hearing across the country as far as nurses shortages or people can't get the

care when they need to, providers being at capacity.

So we're actually seeing this impact be about negative five percent to negative three percent in '21 and similar results for 2022. On the other hand what we're seeing is the COVID impacts are actually increasing the cost by one to four percent in '21. So, again, it's vaccine and testing. It's the COVID claims and deferred cost. And overall we're seeing in 2021 claims suppression and claims capacity are even still slightly less than what we would have expected going into the year about negative four percent to positive one percent and then into 2022 is a similar result.

Now I will say a lot of this is dependent on your geography. So I've had some clients who opened up right away. And I've had some clients who were locked down. So really the impact of what's happened on the claims capacity and the COVID cost really does vary based on your geography. And that's the one nice thing about the public sector and being in state, you know what has happened in the State of Nevada. You're not a national company with offices throughout the country so you know what's happening in your backyard.

On slide six, so this is the suppressors and inflaters of cost. So on the left-hand side, this is what is going to continue to put pressure on your health care trend

is the rebounding of claims, claims coming back into the system as well as the conditions. So we know that some members put off care. We know they may have neglected some services and now the severity of their services as they come back into the system might be much higher than they would if they got the care when they needed it.

And, of course, there's direct cost that we talked about earlier with the ongoing testing and COVID claims and then the health system and economic conditions. Keep in mind we're coming off of a period where we had very low inflation rates and now we're starting to see inflation increase as well as for the providers to get the staff that they need they probably have to increase pay, salary and all of that.

On the left-hand or excuse me, on the right-hand side the suppressors, people are still avoiding care. They are not getting all of the care that they probably would have otherwise. At the same time there's continued precautions. Think of everyone still wearing masks. People are very conscientious about space, not hanging out in a crowded area.

There is an increase in virtual care we're seeing across the country. That's the one probably positive thing that happened with COVID is that it allowed our members to realize that there's other ways to get care at the time that

they need it. They don't necessarily need to go to the emergency room. Maybe they call their PCP and do a virtual care visit that way.

And then, of course, we talked about the health system capacity.

So on this next slide, slide seven, this is the historical differential cash available and I know you all refer to it as excess reserves as well. So this goes back to fiscal year 2010. You'll see that it did escalate over time to a peak of about, sorry, $99,000,000. But since then it has been decreasing. At fiscal year '20 it was about 10,000,000. And then fiscal year '20 it ended up about 38.6.

And I know that Cari had spent some time describing what all went into the 38.6 but that's the current differential cash available at this point with an expected 9,000,000 planning to be spent in fiscal year 2022. We'll talk about that in a second.

Other adjustments for other consideration, as you all look at the available cash is the expected rebound complaints. So we're expecting it to go in about four percent. That's worth about $12,000,000 for that claim suppression. And keep in mind everything right now. I mean, I know we're not setting rates right now and we're really here to help model plan designs and give options.

The good news is that we have more time before the rate-setting does occur, but that allows us to really fine tune and sharpen our pencil as we get more claims experience with the rebound effect of COVID-19. As you can imagine we have some clients in the hotbed of the Delta variant. We're seeing their plans escalate, the June, July, August time frame. And then some of our other clients, we haven't seen that rebound happen just yet. So this will allow us a couple of more months of experience to get under our belt as far as the COVID rebound happens. But if it is, if it continues at the current pace and it's that four percent higher that's worth about $12,000,000.

And I know that Laura had spent some time talking about the vendor contracts as far as there are -- there's the ones that have just put in place as of July 1st of 2021. So we have two months of experience and that's paid experience. It's not full run-out. We haven't seen the full run-out happen yet. So we're continuing to monitor that. As well as there's new vendor contracts coming into place for 7-1-22 which will be dependent on end year all actions as it relates to approving the contracts.

So this -- also this may impact some of the claims volatility, what happens as far as having your members utilize services and, of course, the reserve levels.

Sorry. I feel like I'm doing a lot of talking. I'm trying to be quick because I know it's at the end of the meeting, so. So on this slide, what we're trying to articulate here is if you have an available cash balance of 38.6 million, 9,000,000 of that is already being allocated towards buy down subsidies and Medicare HRA funds.

So that -- for the end of fiscal year '22 the projected balance at that point is just shy of $30,000,000 or 29.5. If the Medicare subsidy continues for fiscal year '23 that's another 5,000,000. And then we funded the excess per the legislature.

And then the next line, again, is if we continue to see that COVID rebound of about four percent that's approximately $12,000,000, and so that might -- we'll continue to monitor that, but that would leave the projected cash differential of about 12.3 million dollars.

This does not take into account any of the rescue funds or we know that it may be available but without knowing that exact amount we didn't want to incorporate it at this point. But the next two lines where if you were to take a long-term view of how you want to use the differential cash available or excess reserves over three years that would be approximately $4,000,000 or spend it down quicker over two years that would be about $6,000,000 per year.

And the thought process there is you would put a benefit enhancement or, and we'll talk to the different numbers in the next slide, but you put them in place for one year, but then you also allow that same type of benefit for the next several years for your members to realize the true impact of that.

This next slide is just discussing the levers of how to return the surplus. So on the left-hand side you'll see premium credits and holidays. And then on the right-hand side it's plan design enhancements. Obviously there's other options but these are the two most common approaches.

With the premium credits or premium holiday, some of the advantages here is that everyone will receive a return of the premium, including the non-utilizers who help contribute to the excess. And then obviously it will -- premium holidays are a little easier to implement than administrative leave, but in the fact you can choose the timing of them. So you don't have to stay on the plan year. You can put them throughout the time that you feel is most appropriate, and it will also allow you to monitor the excess surplus and put into place when you feel it's necessary.

A lot of times we hear cash is king. So our members, they know cash is king. They see it. It's one of the most visible rewards that they see as they get that

employee perception. The one downside of the premium holidays or the premium credits, it does retain the current out-of-pocket costs.

Now, on the right-hand side if we were to enrich the benefits, the major advantage here is the members that use the plan the most would also receive the most benefit. Some of the downsides are if you're not a heavy utilizer of the plan or you don't use it you might not see any difference in your -- your cost or your savings. So they might not see as much value as opposed to a premium holiday.

One other thing to keep in mind is if you do enhance your plan design in your benefits is that you may need to -- let's say for example you decrease an out-of-pocket max or deductible, you may have to raise that in a couple of years just to keep up with medical and health care inflation.

And then obviously the impact here is the members would realize the savings and deductibles and co-pays with the co-insurance and out-of-pocket maximums.

So were there any questions that you all wanted us to address or discuss?

MEMBER AIELLO: This is Betsy. And I just want to quickly ask from the slide before, the COVID rebound of four percent you're projecting would use up 12,000,000 of

that reserve cash and is that increases in the cost because we're having to pay for COVID or the rebound of delayed medical care or both? And is that for a one-year period?

MS. HUBER: Sorry. Did I lose you?

MEMBER AIELLO: No. I finished my question.

MS. HUBER: Oh, my audio went out. Can you repeat that. I'm sorry.

MEMBER AIELLO: Okay. I was asking -- did other people hear me?

BOARD CHAIR FREED: Yes.

MEMBER AIELLO: It's actually on the slide before that where you said the COVID rebound of four percent equals -- down one.

MS. HUBER: Okay.

MEMBER AIELLO: $12,000,000. And so my question was is that 12,000,000 money that's going to come out of that 38 that is expected to be spent on COVID costs in this coming year and deferred medical that would be now being -- would not be utilized. And is that for only one year so we're expecting to spend 12,000,000? That kind of relates to the question we were discussing earlier about if we should add part of that 100 percent back.

MS. HUBER: Right. That four percent is really -- if you look at this slide, it's really the top part

of the chart. So it's trying to make up for the long-term cost of COVID, as well as the deferred care, as well as COVID cost altogether. So it's not just one of those components. It would be -- it would be really all of those components added together.

MEMBER AIELLO: And is that being projected that it will cost us 12,000,000 in the next year, one year?

MS. HUBER: Correct. Sorry. This is Colleen Huber for the record. If the claims continue to trend at this higher rebound effect, the 12,000,000 is an annual number. It's about four percent higher trend which would equate to 12,000,000 in the annual health care claims.

MEMBER KELLY: Michelle Kelly here. Just a follow-up question on that then. Because when we built the current plan year it, from memory, the Executive Officer Rich, you indicated that we couldn't rely on the suppression of the claims that were continuing. So we were actually building -- we were using the normal trend, the higher trend anyway.

And so I guess my question would be if that is actually accurate then are you predicting double the normal trend or are you double counting for trends that we already built into projections for this calendar year anyway?

MS. HUBER: No. So we would be using -- so we

would say a normal medical trend, if you looked at your average medical trend was about six percent. So we're saying it would be in addition to the six percent which would happen in a normal year.

MEMBER KELLY: Okay. Thank you. I just have another question too because I struggle with this. Can you talk a little bit about the graphical representations of the bar graph. Can you talk a little more about that deferred care. So on this graph, obviously seeing how much the health care is made up, is that deferred care that's represented here already coming through because I see that we're from 2-2-21. So of the deferred care that's represented on this graph did we see it in 2-2 of '21, are those real costs or are they still projections?

And then I'm also curious about how you measure that. How do you say something is deferred care. You know, I think actuaries are putting a lot of value on all of these people suddenly coming back to the doctor and getting treatment and requiring more treatment than just the original doctor's visit. But is that playing out? Because I've read some studies where they are saying, well, maybe it's not going to play out because in this country we get more medical attention than is necessarily needed anyway.

So the despite the claims that people are

projecting they are not -- they are not really being borne out. Can you talk about that for me.

MS. HUBER: Sure. I know Cristie has some comments here as well. And so to that point -- again, I'm sorry. Colleen Huber for the record. So to that point, if you really look at second quarter, this is where we're starting to see the much higher trend come through, right. And if you were to break down the trend, using the trend is made up of mainly two components. You have the cost per services and you have the number of services.

And obviously the cost per services, when we start diving into the details are not increasing as much. It's just the number of services and the utilization is where we're seeing the largest increase and the main driver of health care trends across the country. So it's not just specific to Nevada. We're seeing it for all of our state clients.

Really if you start diving into the details, it's the number of services that are coming through because of the fact that they really did not occur. And there's other -- there's other slides out there that really show the utilization drop based on the type of procedure. So what we've seen across the country and, Cristie, on the source of this, I can't remember the name off the type of my head.

What you saw were the maternities and C-sections, heart attacks, all of those of services where you would not be able to predict when they happen or as far as control the fact they will happen. We saw their utilization continue like a normal pattern.

Where we saw the largest drop that was for everything that you can schedule or adjust in the future such as hip and knee replacement, all of those types of services, we saw that huge decrease in utilization. And now on the flip side now that we're looking at that rebound effect, what we start looking at what type of claims that those are, they are coming from the same type of claims that were deferred during that time period.

Not all of those claims will be able to come back. We are expecting some to be avoided forever. But we do know that we're starting to see some of those claims come back and that's why we're realizing this higher trend level on the right-hand side.

Steve, Cristie, did I miss anything?

MS. LABUS: No. This Cristie --

MR. CAULK: This is Steve --

MS. LABUS: Go ahead, Steve.

MR. CAULK: This is Stephen Caulk for the record. I think that was great. I just want to make two add-on

comments. Medical inflation is highly correlated with overall economic inflation. So I think the economic reports that you're seeing now that that just came out. They expect inflation to be a little longer than expected. We would expect that to clearly roll through the medical delivery system as well. They're not going to be immune to overall inflationary factors, and so that's another piece. Alongside of that, you think of the intense stress that they just went through.

There was a recent report showing that hospitals have lost a significant amount of money through the COVID pandemic. Hospitals do have their own revenue and expense and they need to cover their own expenses. So we're watching that closely in terms of that pressure as it builds. So there are a lot of factors.

And then I just want to say one more comment. I do -- we are aware, right, there is different points of view on some of the rebound, right. And so there's certainly studies that may think are we entering a new normal. And I think I would classify our models is as good as the inputs and assumptions. And so absolutely commit to being as transparent on these assumptions and what drives that.

And obviously historically the Board has come up with more aggressive or more conservative perspectives over

time but definitely want to work in tandem with that.

So, Cristie, sorry for cutting you off, if you want to add onto that.

MS. LABUS: Yeah, this is Cristie Labus for the record. The only other additional comment that I would add is, you know the other clientele that I work with are -- is with the health care industry and hospitals. And I would agree with everything Colleen and Stephen have said, certainly impact on the revenue side which has impacted their hiring.

And so when Colleen talks about that rebound that we're seeing starting in March of 2021 and into or at least through June of 2021, I think the unknown to the point of, you know, the information on slide three and four is the duration of that deferred care coming back and just how long.

And so, Michelle, to answer your question, yes, we're seeing the impact of the rebound coming back today. You can see that in the claims trend on slide three from March through June. And I think the information on slide four is just to inform the Board of the fact the we continue and expect this to continue.

I think it's the manner of how the population reacts to getting -- gaining confidence back into the system, going back and seeking some of those outpatient care

services. At the same time hospitals hiring back to pre COVID levels. To date hospitals nationally are not back to the hiring levels they were pre COVID. They are still below those hiring needs. And so we can't expect to have those systems with all of the shortage to, you know, see all of these services in one short period of time. It's certainly going to happen over the course of time. And in addition to that, give these unmanaged chronic conditions that are going to add to cost.

And unfortunately I'll know if they are unmanaged those are the folks that are hitting their out-of-pocket or who are going to see the higher cost members on the plan unfortunately. And in the unfortunate part of that all is it likely going to be emergency room visits and such and/or longer inpatient stays. So all of that is being considered. And so, yes, so we're seeing it today. And I think the point is that it's going to continue into future.

And Colleen mentioned this. We would like to have as much experience as we get further into this plan year, the current plan year to actually see the fruition of this rebound, right. So we continue to see double digit trend, the Delta variant impacts this and brings suppression back into the system, et cetera. And so unfortunately it's a volatile period and we're still in it.

MEMBER KRUPP: This is Jennifer Krupp for the record. I have a couple of questions on this site about how the system will recover from the pre COVID equilibrium. So this is national experience. So if you could give us some insight into the data sources that were used to compile this per member per day for the medical costs. Is this actually off of PEBP data? Is this national data that's being used?

MS. LABUS: So this is --

MEMBER KRUPP: Two, my other question is if you could please give us a little bit more insight into the difference between system recovery and deferred care and how those are broken out into two separate costs. I that will help at least me make better sense of this data we're presenting, so.

MS. HUBER: This is Colleen Huber for the record. So the data source is based on Aon's clients. So obviously as a national firm we have been, since the beginning of the pandemic and even prior, we look at all of our clients' data as well as we also look at, have different warehouses -- data warehouses that we utilize as well.

For the second question regarding deferred care and the system recovery, the deferred care, what we're saying here is if you put off a service. So if you were going to get your -- you know, you're going to get your knee replaced,

you're cancelling the service as of, you know, March of 2020 and then having to come back into the system let's say April of 2021.

The system recovery is actually holding down the claims trend. It's actually a negative trend. And this goes back to the fact that your providers can't make up for the number of services that were put off in second quarter of 2020 all at once. So they're spreading it out over the year. So the fact that to Cristie's point, the hospitals cannot and the providers cannot hire back at the levels that they were pre pandemic.

So think of an office visit or an outpatient facility, they were essentially shutdown in second quarter of 2020. They were furloughed. A lot of those individuals found other jobs. You know, some stayed home, et cetera. So now what we're seeing on a national front is that the providers cannot hire back to the same level that they were back at the beginning of 2020.

Does that answer your question, Jennifer?

MEMBER KRUPP: Not really. Because as I'm reading this graph, it's looks to me like system recovery is actually a factor that is increasing or per member per day medical costs and so I'm --

MS. HUBER: It's actually decreasing. This is

Colleen Humber for the record. Sorry. This actually is decreasing. So if you look at this page, slide five, this is where you'll see the different components broken out, and you'll see that the system recovery is actually a decrease to the cost of about negative three to five percent for 2021, similar patterns for 2022.

On the flip side, on the COVID for deferred care, coming back into the system we're thinking it's about a zero one percent in 2021 and zero two percent in 2022. Does that help?

MEMBER KRUPP: No.

MS. HUBER: Again, the system capacity is helping the fact that your members can't go back to the services as quick as they want to. Whereas deferred care, they want to go back so they're kind of pushing. The providers are saying we can't get you in what you want to get in. And the members on the other side are saying we need to get this deferred care that we put off during 2020. Does that make sense?

MEMBER KRUPP: Yeah, it does make sense. It doesn't necessarily help me understand like, you know, where we're getting these points for the per member per day for the medical costs because it's all kind of built in.

And so I was just looking at like the top of the bar chart is, you know, again Q3 of '21 are per member per

day medical costs were roughly at about $21.50. So chunking in like, you know, your new baseline, your system recovery, you're maxing your customer differential care as compared against the old normal. So that's kind of where as, you know, the old normal is $21.50 per day per member increase in the cost of medical care. So that's where I was a little unclear was in terms of like how the system recovery going to be, you know, negative or cost suppressor. Versus --

MS. HUBER: Right.

MEMBER KRUPP: -- a cost producer in that graph. And then so also as you said, these models are built off of all your Aon clients, and you have a couple of other data sources. But with those other Aon clients are they state health insurance plans or are we -- I mean, is this an apples to apples comparison or are we just, you know, whatever Aon actuarial services are provided to other benefit plans. Is that where this data is coming from?

MS. HUBER: So it's both. We do have other state clients in here and as well as other data sources from all of our other national clients and other public sector entities.

MEMBER KRUPP: Let me clarify. Are these only insurance carriers basically. Is this all insurance carrier data or is this all health, like health care claims or is this, you know, hospital claims, things like? That's what

I'm trying to ascertain.

MS. HUBER: This is Colleen Huber for the record. It's all health care claims. And this one is specifically, yes, it's all health care claims. This one is specific to the medical.

MEMBER KRUPP: Thank you.

MS. HUBER: Are there questions? I know you all have a lot on your agenda too as it relates plan design ideas. Any other questions for us at this point?

MEMBER KRUPP: I have one more. On the breakdown of differential cash available Board Member -- this is Jennifer Krupp for the record. Board Member Aiello had a question on this slide. But with that projected cash differential cash available, the 12.3 million dollars -- oh, I just kind of answered it myself. Never mind. Okay. I'm just asking with breaking it down, it's allocated over three or four years. Okay. Thank you.

BOARD CHAIR FREED: This is Laura Freed. I have a question. So we've had, at this Board we've had discussions of Aon's recommended trend, what ended up in the budget and what really happened. And for fiscal year, plan year '21 the budgeted trend was medical 5.33 percent, prescription 20.61 percent and dental was 3.13 percent.

I went back and looked at the '19 legislature's

discussion of what was originally recommended by Aon. What ended up in the first draft of the budget and then what was originally approved. And according to my research the legislatively approved trend that I just stated was based on a revised recommendation by Aon back in 2019.

So you've got on page three expected trend was 5.4 percent. And then, of course, I said medical was 5.33 per the budget. So how did we do? How close did we come to what was originally recommended by Aon of 5.33, your expected 5.4, and then what did we see in terms of actual trend over FY21 for both medical claims and prescription drug claims?

MS. HUBER: So I won't -- let me start off with saying prior to the pandemic, the medical claims were trending at 6.1 percent in the time period of June of 2019 through March of 2020. On the pharmacy side you all were trending at 8.1 percent gross of rebates. And 7.9 percent from the time period June of 2019 through June of 2000 -- 2021. I can pull up your actual trend.

Obviously, your medical claims went down considerably in 2020. And I don't think any actuary will say that they projected a negative trend to happen in fiscal '19 to happen in 2020.

I think we saw negative trend levels really happening in April of 2020 all the way through March of '21

which averaged about negative seven percent during that time period. And now, of course, what we talked about earlier, we're seeing that rebound. You know, it's peaking at 12 percent as of June of '21.

And that's why we do think it will be, to Steve's point, we want to be fully transparent is the next couple of months are very critical, right, of how this trend line is going to curve. Is it going to continue to go up or are we going to see this start to come back down. Hopefully we see it start to come back down prior to historical levels of, you know, that five to six percent range would be great compared to this 12 percent we're showing on the far right-hand side, but that's really where we're going to see the next couple of months be so critical, especially with the Delta variant.

People are still putting off the care but there's still care going into the system due to COVID. So we just need to be very mindful of what's going to happen and just be ready to react to it and look at everything on a month to month basis. Because the more we can get away from 2020 it will help us with all of our projections. It will help us much understand current trend levels, current utilization, what kind of services people are using. The longer we can get away from this time frame. Does that help, Laura?

BOARD CHAIR FREED: It does. I mean, the reason

I ask is because that discussion of claim suppression generating all of these excess reserves that the Executive Officer is going to talk about here in a minute, you know, informs our choices as a Board about how to use those excess reserves. Because, you know, FY22 and '23 budgeted trend is 3.52 percent for medical and four percent for RX, that's what's in the budget.

And so if, you know, you're right about these next months being critical because if we just keep tearing through our trend this Board needs to think about being conservative with its excess cash. And, I mean, I'm just going to guess that you all on the Aon team are not super comfortable with budgeted trend of three and half percent, four percent for prescription. You know, tell me if that's wrong. But anyway, I just, you know, I wanted to sort of get that on the record I suppose.

MS. HUBER: This is Colleen Huber for the record. And I would agree with you, Laura. And that's why we did want to show on slide eight, I should never be allowed to drive with slides. But that is why we did want to show if you were to take a longer duration, a longer term approach of spending down the reserves over to a two, three-year time period just so that you all will be more comfortable with what the current levels are.

If you are given the three and a half percent medical, four percent pharmacy claims trend you may be spending down the excess reserves just in your budgets alone, right, before the enhancements even come into place. And so that was the intent on the bottom half of this chart was just trying to show. If you want to do it incrementally without having too much of a whiplash effect for your members here's some dollar amounts that you might want to apply each plan year. Thank you.

MS. RICH: Colleen, can I just ask a quick question, just confirmation. So when we -- Laura Rich for the record. When we priced the plan last year, well, in March, we set rates and that included a trend and that was supposed to encompass a potential rebound in COVID plans. So I just want to confirm that the rebound that you're talking about right here, the $12,000,000 is in addition to the rebound that was incorporated in the rates that we used to price the plan out in last March.

MS. HUBER: Correct. This is Colleen Huber for the record. Correct. Great question.

BOARD CHAIR FREED: Board Members, if you don't have any other questions about Aon's presentation, it would be advisable to go back to the staff report and have the Executive Officer talk us through the recommendations,

suggestions, food for thought about using excess reserves in the next couple of fiscal years.

MS. RICH: Great. So I will -- unless there's any questions I will continue. So considering that we do have a productive surplus and we have experienced some recent benefit cuts, staff recommends that the Board consider spending down a portion of these funds similar to what is included there in slide eight in Aon's presentation.

Conservatively to ensure the benefits are restored and can continue to remain funded and that's the big part is that we can continue to fund those in the next biennium assuming that there's no drastic changes to PEBP's budget. Because as of right now, again, it's -- we're working on very little information. We don't know what the budget direction is going to be. And so -- and so we want to be able to afford, keep affording whatever we choose to restore of this plan year.

So by using the surplus in a phased approach it provides that safety net that's necessary for the long-term funding and sustainability of those restored benefits.

It also leaves the plan open to allocate any potential rescue plan funding as well. If we do get that we can increase those amounts and plan accordingly.

As mentioned earlier, Chair Freed, I think, did

you have something to say? No? Okay. It looked like you were trying to say something.

BOARD CHAIR FREED: No. I'm just sniffling.

MS. RICH: Okay. It's also important to know here as mentioned earlier that this is a benefit enhancement. We are using differential cash. And so statutorily these, whatever decision is made by the Board to restore benefits will need to receive legislative approval after those decisions are made in November.

So the way the staff has kind of separated out these recommendations is in two parts. So the first part is how does the Board choose to take this lump sum of money and how does it choose to appropriate, right. So we're talking about $12,000,000 in differential cash. And do we want to fund a benefit enhancement over two years, over three, over a different period of time. It's not ideal. It's not recommended that we take the whole $12,000,000 and apply it towards one benefit restoration, knowing that we may not be able to afford it next time around.

Then after that is decided then at that point, with that amount of money what is it the Board would like staff to model and to come to the November Board meeting with. So my assumption here is that the Board is going to prefer to take the same path it did with ARP request, right.

What is it that we want to prioritize?

So if the priorities are deductibles and out-of-pocket maxes and co-pays in lowering those then with that amount of whatever it is that we choose, we can come back and model something in November. And the Board can then make decisions based on that modeling. But we can't do any modeling similar to the ARP. We can't do any of the modeling until we know what amount of money we're working with, right.

So the two are separated for that reason. We need to understand what the Board -- how the Board would like to allocate the money and how many years and then that way we understand what we're working with per plan year and we can come back and model it for the Board in November.

MEMBER AIELLO: This is Betsy. And I'm hoping just to summarize a little bit of what I think I heard for an accuracy check. So our budget was made off of three and four percent trend. Our current trend, though it's only two to three months of data that we have in is around 12 percent. It could continue at that rate because of that pent up demand. But with Delta, maybe that's dropping down again.

But our historical trend if COVID hadn't happened per se would probably be about five percent, five to six percent. So the approved budget was below what would have been our historical already. So this 12,000,000 is going for

enhancements which would mean more spend. If we spent it right away we might be coming right back and making cuts again. If the trend remains high, I'm asking that I guess, and if we spent it over a longer period of time, we allocated it and some of it might not be spent. It would be able to help any deficit we had so we wouldn't have to make another plan design change. Are all those kind of correct statements?

MS. RICH: Laura Rich for the record. I believe so. The $12,000,000 is what staff feels comfortable recommending is a conservative yet realistic spend to restore at least some of these benefits. We feel confident that spending $12,000,000 we will be able to, depending on how that is spread out in the amount of years, we will be able to fund it with those $12,000,000, right. So now if we allocate the $12,000,000 to one year then that second year there's no -- there's no telling, right. We don't know what our budget looks like. We don't know what all of these contracts look like. We don't know what COVID looks like. There's too many variables there.

But I think that we definitely, we're comfortable with those $12,000,000 and spreading it out between two or three years and being able to fund benefits, those same benefits for those two or three years. And then at that

point then we're kind of hoping that we can continue with those -- with those restored benefits so and possibly even restore, more depending on what it looks like, what funding we get in and what kind of trend that we see in our plan.

MEMBER AIELLO: And I'm thinking staff is comfortable with that 12,000,000 because there's actually another 12,000,000 in Aon's presentation that says the COVID rebound of four percent. So that's giving us from our current four percent budget to a seven percent or three percent, four percent to seven or eight percent budget.

MS. RICH: Correct. That 12,000,000 in COVID rebound is our buffer, right. So for those increased claims that we know is going to come back or that we feel is going to come back, that's kind of the buffer for those claims. And then the rest is allocated for other -- other things.

MEMBER AIELLO: And one final thing. If we get any of the ARP or whatever it is money, that could then be added to the 12,000,000 and then you could make a higher level of restoration at that point, correct?

MS. RICH: Correct.

MS. HUBER: And this is Colleen Huber for the record. I know that we're coming back in the November Board meeting, and I know we obviously want to model and do all of that, but this will allow us to accommodate a couple of more

months of actual claims trend so that's a year concern of what that buffer or how the claims trend continues. It will give us a couple of more months of utilization that we can report back on.

MEMBER AIELLO: Thank you.

MEMBER KELLY: It's Michelle Kelly here. So I have a question on slide eight as well. So, Executive Officer Rich, in your report you talked about the $5,000,000 of CARES COVID money that you've been instructed to send a work request over to the Interim Finance Committee. I'm just wondering, so that sounds like it's approved. It's just kind of got to go through the process. So that 5,000,000 will then end up in the differential cash pile, right, because that's money already incurred and spent.

MS. RICH: Laura Rich for the record. Indirectly. And Cari can jump in here and correct me. But it's not -- that doesn't just end up in excess, right. It's supposed to be allocated to pay for claims, right. And so those -- that $5,000,000 will go to pay for claims that have already been incurred and future claims up to that $5,000,000, whenever that $5,000,000 is spent. And so it goes into a different operating account.

And -- and then so, yes, in the long run if things, you know, work out the way that we think they are

going to work out, yes, it does end up and now it's excess, right. But it doesn't just go from $5,000,000 approved now to now it's excess, if that makes any sense.

And, Cari, maybe if you want to jump in and explain it in more detail you are more than welcome to.

MS. EATON: This is Cari --

MEMBER KELLY: This is Michelle Kelly. I think I understand that.

MS. EATON. I think she got it pretty good.

MEMBER KELLY: But I think, Executive Officer Rich, you had indicated we already expended more than what we got in CARES and that the $5,000,000 you thought we already spent. So I'm just trying to understand. Like I understand it's not as simple as Peter giving to Peter. But if we've incurred $5,000,000 of expenses that no money has been given to us for, then even though it's a process, why did that money end up -- wouldn't some money end up in differential cash because we're getting $5,000,000?

MS. RICH: Laura Rich for the record. We've received 9.5 already and looking through my reports, let me see. I know I have the number here. We have incurred, and this is somewhat of a dated number, but it's probably pretty close, 13.2 million. So that 5,000,000, a lot of it is spent, right. So if you take 13 or I'm sorry, 9.5 plus

5,000,000, we're looking at 14.5. We've got about 1,000,000 more in claims to go to spend that $5,000,000. So after that the money runs out. And as of right now we don't know if we're going to get any other funding, federal funding. So, yes, a lot of that is already paid so we're getting those claims reimbursed.

However, there's timing that is involved with everything. The $13,000,000 that I'm getting through these weekly reports that I get from our TPA doesn't mean that we actually paid them out through the bank. And so and that's where, you know, there's timing involved and things like that. So there's definitely the state budgeting piece as well that can get somewhat convoluted.

MEMBER KELLY: So Michelle Kelly here. One of the other things I guess that I wouldn't mind talking about maybe as a committee is I think, you know, the page which is page nine of the Aon report and I think, you know, I guess I'm really challenged by one of the pros there of the premium credit holidays where it talks about the most important cost share element for employee exemption since it has the immediate impact. And I think it's also a perception that's being kind of given from the Governor's office and maybe the Treasurer's office and through PEBP before.

My concern about looking at that pros from

Ms. Huber is that's not what we hear from participants, right. So in the public comments, when I heard them today, I think there was one member who mentioned premium. But overwhelmingly the advocates and the employees are focused on that cost share, you know, and restoring some of the benefits as opposed to the premium holiday. And so I just kind of wanted to address that a little bit. Because I do think that the legislature did give, you know, PEBP members all of that, the premium holiday through the legislative session as a give-back.

My concern with that give-back is all give-backs are welcome. It really was, impacted different participants based on PEBP's plan design because PEBP's plan design doesn't allow thousands to be covered if they have all their insurance or nor if they're a staff member, right. And yet the premium holiday was given at basically at the premium level.

So for some employees who had a family, they got a 44 dollar premium credit. But other employees who had a family got $550 for that month, and so that was very troubling to me, especially when you talk to employees in the PEBP demographic. I don't know what the latest statistic is, but of course children can only be covered by one family, you know, if they're dual state employees and dual state

employees are covering themselves.

So the plan design really impacted how much which tier you can be in and therefore drove how much of the benefit you got from the reserves in that case.

BOARD CHAIR FREED: This is Laura Freed. You know, I tend to agree with you about the deductibles and out-of-pocket maxes and sort of restoring the plan design. I mean, everybody has got this -- it's so funny to hear people talk about, you know, they want to back to FY20 levels. And it's like, well, but do you remember like FY 2009 levels? Those were the good ole days.

Anyway, you know, the report is well taken. You know, if you -- the active employees group ensured its subsidy that's legislatively approved for '22 is $727. But if you're an active on participant only coverage your monthly premium is $45. It's like, you know, anybody would rather have their subsidy back. Thanks very much.

And so Aon, you know, certainly has a point that softening or reducing the deductible and out-of-pocket max benefits higher users and doesn't really benefit the nonusers. But at the same time, a premium holiday or participants share holiday is probably more precise, you know, benefits the people who are on the higher cost coverage tier when the vast majority of our participants are on

participant only coverage, whether they are actives or they're non Medicare retirees.

So honestly, you know, in favor of developing plan design enhancements that, number one, just as we did with the ARP request, prioritize deductibles and out-of-pocket maxes. And I'm in favor of doing it over a longer time horizon so as not to disrupt plan design. I mean, I like the idea of doing it over '23, '24 and '25, not just '24 because then you're not changing something the middle of the upcoming biennium. You know, something that would be a nice add-back through the membership through this biennium and through the next biennium is something that is appealing to me.

MEMBER AIELLO: And this is Betsy. And I agree with that. So I'm going to throw out a motion that people can then respond to that is a combination of recommendation one option number one and recommendation option two number one so that we develop a plan design enhancement using 4,000,000 to allocate towards funding the restored benefits through plan year '25, so 4,000,000 for each of three years and it be based on the previous Board guidance discussed at the July '22 Board meeting where the staff uses the above funding to determine the plan design restoration enhancements prioritizing deductibles, out-of-pocket maximums and co-pays.

BOARD CHAIR FREED: Okay. Thank you. Reactions? Seconds? Dissension?

MEMBER VERDUCCI: Tom Verducci for the record. Those are the two that I was looking at as well and I would provide a second for that motion.

BOARD CHAIR FREED: Thank you. All right. So it's been moved and seconded. You know, as is my want, I try to get this stuff on the record to take staff recommendation number one, 1.1, develop plan design enhancements using $4,000,000 in differential cash to allocate towards funding restored benefits through plan year '25.

And then recommendation 2.1, based on previous Board guidance discussed at the July 22nd, 2021, Board meeting. Staff will use that 4,000,000 to determine plan design restorations and enhancement prioritizing deductibles, out-of-pocket maximums and co-pays. Does everybody understand the motion or want to comment on the motion?

MEMBER KELLY: Michelle here. I just have a comment. I really struggle with the fact that the differential cash just keeps coming back and when PEBP has -- when I understand that, you know, we have to be financially responsible. So I'm not arguing against that. I'm very supportive of the priorities in the motion.

My challenge is doing it over three years instead

of two to spend it down. We've already talked about the $4,000,000 of COVID expenses that are already out there. But then I -- I also am just not very comfortable with spending it slowly because what happens is the legislature then spends it for us and they don't give it back to participants. They sweep it or they -- you know, they kind of doing -- and they can do that anyway, but I could be wrong.

But when they had this continual cash differential that just reoccurs year after year after year and, you know, I don't agree with public comment that it's kind of a profit. But it is concerning when you're trying to defend the construction of the benefit program and that we've had all of these cuts. We want to give back to participants and yet we're not spending the money that's budgeted. And so I'm very challenged by that.

And so my only request and, you know, it would be that we actually have the PEBP staff price out using it -- using our priorities over the two oldest and the three years and have a look of what it actually does. So that's my comment. Thank you.

MS. HUBER: This is Colleen Huber for the record. One suggestion maybe, if you are looking to do both, right, so if you do the plan design enhancements, the 4,000,000, you -- and, Laura and team, correct me if I'm wrong. But you may

also still be allowed to do the premium holiday. If you start to see the claims come back down you start to get additional CARES fund, the funding as well. But, Laura, correct me if I'm wrong in that.

MS. RICH: Laura Rich for the record. We can definitely do that. But I think the Board prefers to focus on restoring benefits rather than those premium holidays.

MEMBER VERDUCCI: Tom Verducci for the record. I think we also need to have approval with the GFO and the IFC, and it appears that we need to get a lot of numbers put together, costs and what we're going to get from federal relief. And I think it's going to be a little tricky in November, November meeting having all of that information in place in order to ultimately get this done.

But, you know, if there's any meetings that could occur, you know, with the Treasurer's office, the GFO and see where we are in terms of the federal relief funds, and I think that would help in November, the upcoming November meeting.

BOARD CHAIR FREED: This is Laura Freed. I don't want to get too far off the motion and the second that's on the floor. If Member Kelly is offering an amendment to the motion please clarify. But if that's just your feelings about the motion that's a different thing.

You know, we really cannot be worried about the RPEN money right now because, you know, my sense and the Executive Officer's sense is the same, that this is not going -- the process for even getting is not going to be revealed to us in a time frame that is comfortable for PEBP plan design. It's just not. And, you know, she affirmed she's going to keep, you know, sort of pressing the issue with the Governor's office, the GFO and the Treasurer's office.

But we -- it doesn't make sense for us to plan On ARP money any time soon because I have received absolutely no indication that they are working on that, rather they are wrapping up their spending of coronavirus relief monies that have to be spent by the end of this calendar year. So I will say that.

So I feel like there are Board Members that haven't weighed in on this who I think might normally do so. So if you folks would like to talk about the time horizon of plan design enhancements or the differing, you know, feelings out there about how to prioritize plan design enhancements speak now, please.

MEMBER MCCLENDON: I would be interested in learning about a little, like if we could add a little bit of number two to number one and just find out what the cost

would be for restoring long-term disability to see if that is something that might be feasible in addition to lowering out-of-pocket maximums and things like that. I think that would be good information to have. Sorry, Jennifer McClendon for the record.

BOARD CHAIR FREED: Okay.

MS. RICH: So Laura Rich for the record. The challenge with long-term disability is that there's two pieces of that. So first that is actually a contract that is out to bid. It has not been released yet. That solicitation should be released here soon. And so we don't have pricing for that. What we can get is current pricing which I feel is probably higher than what we'll get, you know, coming in from these newer solicitations or the proposal that we get from the solicitation. So with the information we have today it's going to be priced high.

Additionally, that was a benefit that was moved to our voluntary platform. And I know that through voluntary platform there is a minimum and through our contract there's a minimum amount of voluntary benefits that we need to provide through that platform in order to meet the contract obligations and so I would have to go back and just to make sure.

But if we're offering that as a voluntary product

and then somehow, you know, we don't align it with a plan year or I mean it gets messy when we're offering it as a voluntary product and then potentially funding it for a year or two and it just, it becomes a messy situation. So while we certainly can do that I just want to put it out there there's some -- there's some challenges to that LTD situation.

MEMBER VERDUCCI: Tom Verducci for the record. Just so I understand what we're voting on here. Under option two, based on the previous Board guidance and the July 22nd Board meeting, would that be the Item Number 8 from the last agenda, the motion for PEBP staff to request ARP funding and prioritize out-of-pocket max, deductibles, and it goes all the way on to read about long-term disability and restoring life insurance. So what are we voting on here?

BOARD CHAIR FREED: Yes. This is Laura Freed. Yes, that is correct.

MEMBER VERDUCCI: And then what will happen at the November Board meeting? Will we have different scenarios, how much restoration will be involved and different choices, will there be some wiggle room in terms of making the ultimate decision, you know, different choices that Aon would provide and what would be the methodology and processes and procedures?

MS. RICH: Laura Rich for the record. I think that's why we're having this conversation today, Tom, is to provide guidance because a lot of -- so this is going to require modeling. This is not something that can be done on the spot, right. And so staff will have to work with Aon to provide, to kind of guide them into what kind of recommendations are we going to bring to the Board in November.

And so the reason we're having this discussion today is because I personally don't want to make -- I don't want to come to the November Board meeting with my own ideas. I would rather propose this to the Board today to have these discussions to see where the Board stands so that if there's certain priorities that need to be -- to be prioritized, you know, with this money that we can come back with ideas on how to allocate this money and what it looks like.

So for example if we have $6,000,000 and we want to spread or we have $12,000,000 and we want to spread it out between two years, what does that look like if we lower deductibles and don't really touch out-of-pocket maxes too much but we focus it on deductibles or what if we just do a little bit of both and lower deductibles a little bit, lower out-of-pocket maxes a little bit, how does that look like? So we're going to come back with different ideas. But I need

to have really a focus so that the ideas we present are things that the Board wants to see versus just, you know, throwing some ideas out there.

MEMBER AIELLO: This is Betsy. In defense of the motion I would say we talked a lot about the guidance on the July 22nd Board meeting. So I like using what the Board determined at that point as the prioritization modeling for the benefits.

And I agree with Chair Freed with the 4,000,000. If we do that then hopefully we can get a baseline to finish out this biennium and go through the next biennium with the baseline. If more money comes in we can enhance it, but we won't be cutting back as quickly that could happen. So those are the two reasons I like to not have to keep changing things all the time unless it's for the better.

BOARD CHAIR FREED: Yep. Sorry. This is Laura Freed. Yep. Anyway, so with that it has been moved and seconded to develop plan design enhancements to allocate the $4,000,000 through plan year '25 using the prioritization that the Board expressed at the July meeting.

So if there's no more discussion on that motion, I will ask people to vote on that motion. So all in favor signify by saying aye.

(The vote was unanimously in favor of the

motion.)

BOARD CHAIR FREED: Any opposed nay. Thank you, everybody. And I look forward to seeing the range of ideas at the November Board meeting.

With that I think we're clear to go on to public comment. This is the second public comment period of the meeting and I'll hand it off to PEBP staff.

MS. RICH: Do we have IT? Hang on just a second.

Wendy, do you or Steve -- are you there?

MS. LUNZ: I'm trying to get Steve. One moment let me try.

MR. MARTIN: Hi. Sorry for that delay.

So caller with the last four digits 7832, please press star six to unmute your phone and make your comment. Please keep your comment to three minutes or less.

MS. LAIRD: Thank you. Good afternoon PEBP Board Members and staff. We welcome the new Board Member, including Jim Barnes, Dr. McClendon and Ms. Bittleston and hope they haven't been too overwhelmed by their first meeting.

My name for the record is Terri Laird. Spelled T-e-r-r-i L-a-i-r-d. I'm the Executive Director at RPEN, Retired Public Employees of Nevada. We appreciate all efforts this Board makes on behalf of all state employees as

well as the retirees in the Medicare Exchange, many of whom are members of RPEN. We know the work you've been tasked with since COVID came into the picture has been difficult.

But we believe all efforts must be made to make sure PEBP gets its share of the ARP funds and toward that point, remind the Board about the October 5th meeting of the IFC's subcommittee to advise on the expenditure of federal COVID-10 relief funding -- COVID-19 relief funding. I'm sorry. As well as the IFC's October 21st meeting where they will be discussing PEBP's request for CARES funding amounting to 5,000,000. We also hope to see those funds that PEBP receives used to reinstate as many benefits as possible.

I would also like to mention the discussion involving the appointment of Mr. Lindley to the quality control officer position, when Board Member Kelly made the remark about the Board having a say in regard to whether or not this position should have been posted, perhaps that request could come back at a future Board meeting.

And I would like to point out that NRS 287.0426, number three spells out qualifications for each appointed officer at PEBP, including those in charge of quality control, operations, finance or information technology that must be a graduate of a four-year college or university with an appropriate degree or equivalent experience.

Finally I would like to also recognizance Nancy Spinelli who retired in September. Nancy was a valued asset to RPEN and our members, especially when the Medicare Exchange was in its early days when so many retirees had huge issues. When those members called us we called Nancy and she got with the member immediately and was usually able to work it out. We will miss her greatly because it's comforting to our members to know someone cares about what they may be going through.

Thank you for your time and good luck with the future IFC meetings involving the federal funds. We hope information on those funds come in time for the important PEBP Board meetings ahead.

MR. MARTIN: Caller with the last four digits 8853, please press star six to unmute and make your comment. Please remember to keep your comment to three minutes or less.

MR. UNGER: Doug Unger, D-o-u-g U-n-g-e-r. Nevada Faculty Alliance Chapter President at UNLV and Southern Nevada Government Affairs Representative for the Nevada Faculty Alliance. I would like to thank the Board for its deliberations today. Welcome the new members of the Board and also echo the thanks to Nancy Spinelli for her years of service to PEBP which have been excellent in all

ways. And I hope she goes on and enjoys her years away in retirement.

Regarding excess reserves, our feeling is that there will be more excess reserves that PEBP and Aon have been consistently too conservative in calculating excess reserves as based on the last 11 years of excess reserves history.

We would hope that the Board would keep open future plan enhancement possibilities, also the possibility that our advocacy with the legislature will at some point restore the $24,000,000 that was taken back from the PEBP plan by legislature during budget crisis of this past legislative session. We hope you'll keep an open mind about developing a kind of sliding scale of possibilities for restoring plan benefits as future excess reserves come in.

Thank you again for your service. Thank you for this good meeting today. I would also like to report that the Nevada System of Higher Education has passed its vaccine mandate for all Nevada System of Higher Education employees which should significantly over time reduce costs to PEBP because of COVID, you know, as -- as this mandate gets implemented.

Thank you very much for your service and thank you, again.

MR. MARTIN: Madam Chair, that does conclude our public comment section.

BOARD CHAIR FREED: Okay. Thank you very much.

We have come to the end of our business. Thank you again, Board Members, for your discussion as always. Welcome once again to the new folks.

And with that it is 2:47 p.m. and we are adjourned. Thanks everybody.

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

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

That on Thursday, the 30th day of September, 2021, 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 208, is a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Carson City, Nevada, this 13th day of October, 2021.

KATHY JACKSON, CCR
Nevada CCR #402

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