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In The Matter Of:

*PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD
TRANSCRIPT OF PROCEEDINGS*

December 2, 2021

*Capitol Reporters
628 E. John St # 3
Carson City, Nevada 89706
775 882-5322*

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD
TRANSCRIPT OF PROCEEDINGS
ZOOM/TELEPHONIC MEETING NOTICE AND AGENDA
THURSDAY, DECEMBER 2, 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
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

Reported by: CAPITOL REPORTERS
Certified Shorthand Reporters
BY: KATHY JACKSON
Nevada CCR #402
123 W. Nye Lane, Suite 107
Carson City, Nevada 89703
(775) 882-5322

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1 THURSDAY, DECEMBER 2, 2021, CARSON CITY, NEVADA

2 -oOo-

3 CHAIRWOMAN FREED: With that then, again, it's
4 8:35. And this is the meeting of the Public Employees'
5 Program -- Public Employees' Benefits Program Board to order.

6 PEBP staff, if you would call the roll.

7 MS. LUNZ: Laura Freed?

8 CHAIRWOMAN FREED: Here.

9 MS. LUNZ: Linda Fox.

10 VICE CHAIR FOX: Here.

11 MS. LUNZ: Betsey Aiello.

12 MEMBER AIELLO: Here.

13 MS. LUNZ: Jim Barnes.

14 MEMBER BARNES: Here.

15 MS. LUNZ: April Caughron.

16 MEMBER CAUGHRON: Here.

17 MS. LUNZ: Michelle Kelley?

18 MEMBER KELLEY: Here.

19 MS. LUNZ: Leslie Bittleston?

20 MEMBER BITTLESTON: Here.

21 MS. LUNZ: Jennifer McClendon?

22 Tom Verducci?

23 MEMBER VERDUCCI: Here.

24 MS. LUNZ: And that is everyone. We have a
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1 quorum.

2 CHAIRWOMAN FREED: Great. Thank you very much.

3 Before we go into Agenda Item 2, public comment,
4 I want to I suppose establish the order of operations for
5 today. I'm going to be taking a couple of agenda items out
6 of order to accommodate a couple of people's schedules. So
7 Board Members if you got your agenda in front of you it's
8 going to be Item 1, 2, 3, moving 4 and 5 down below 6 and 7.
9 So it will be 3, 6, 7, 4, 5, 8, 9. So you'll want to make
10 that note.

11 And if you would silence, everybody, all of your
12 electronic devices that make noise that would be helpful.

13 I'm going to limit public comment because I think
14 there will be quite a bit of it to three minutes per person.
15 I want to remind everyone, if you didn't get to comment in
16 public or if you don't get to -- don't have the ability to
17 stay for the second public comment period, you can always
18 send your comment in written form. The PEBP staff is really
19 conscientious. They turn it around as fast as they get it.
20 And believe me, we do read it all.

21 When we're in this room, the folks in this room
22 not necessarily on Zoom, it is my expectation that everybody
23 keep their masks on. I know we all have coffee and water and
24 that's okay to take their sips and stuff, but the mask goes

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1 over your nose and that includes when you're testifying
2 unless we can't hear you. In that case we'll let you pull it
3 down a little bit.

4 So with that, I think I will go to Agenda Item 2,
5 public comment. And I will start with public comment here in
6 Room 4100.

7 DR. DAVIN: Good morning, hopefully you can
8 understand me with the mask.

9 CHAIRWOMAN FREED: We can. Please identify
10 yourself for the record.

11 DR. DAVIN: Pardon me?

12 CHAIRWOMAN FREED: Identify yourself for the
13 record.

14 DR. DAVIN: Yes. I'm Dr. Patricia Davin and I'm
15 going to read a letter that I submitted to the Board and that
16 I just have a couple of comments beyond that. Again, I'm
17 Dr. Patricia Davin. I'm a psychotherapist in private
18 practice in Carson City. I provided services to the State of
19 Nevada employees for over 40 years. I'm also a preferred
20 provider for many insurance programs.

21 I've been working diligently with Aetna Signature
22 Administrators to receive in-network provider status due to
23 the discontinuation of the contract with the Hometown Health.
24 It is important to me to continue to provide services to
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1 state employees.

2 I submitted my application to ASA, Aetna
3 Signature on May 5th. I was informed of the transition of
4 care from Hometown Health in mid April. I'm recognized by
5 Aetna as a credential provider but not in-network. I've been
6 repeatedly told by Aetna I will be receiving a contract via
7 e-mail. To date no such contract has been received. I have
8 further been unable to ascertain the reimbursement rate I may
9 expect to receive.

10 All phone calls are answered by a call center in
11 the Philippines, and there is no access to the actual
12 credentialing department. In my 43 years of practice I've
13 never experienced such unprofessional conduct and difficulty
14 navigating an insurance company. My patients are frustrated
15 and cannot get information from Aetna as well. I'm hopeful
16 you'll reevaluate this contract. My greatest hope is that
17 you may come to some agreement with Hometown Health and
18 reinstate that contract.

19 This has become an absolute nightmare, occupying
20 inordinate amounts of my time and energy. Claims submitted
21 for July 21 and forward have been denied due to Aetna's
22 horrid handling of this transaction -- transition. Thank you
23 in advance for your consideration in this matter.

24 To update you, this letter was written August 21.
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1 I signed a contract with Aetna on October 2nd. To date,
2 December 2, I still do not have a contract even though I
3 received a fax which was received into my office on the 26th
4 of November, which I got when I came back into the office on
5 Monday, the 29th, indicating that I had completed the
6 credentialing process and that a network representative would
7 be sending me an effective date. December 2nd I have no
8 contract.

9 So two understatements for you. One is I love my
10 work. Two, these are unprecedented times. In my over four
11 decades of work with patients I have never seen the severity
12 of symptoms that I'm seeing today, anxiety, depression, loss,
13 grief. And to compound it, my patients, many of which had
14 their co-pays doubled, for some of them that meant that they
15 had to see me less frequently in a time when they really
16 needed to be seen more frequently.

17 So I implore you to get rid of Aetna, number one.
18 And two, should you do that going forward, I would ask you to
19 seriously look at the details of a contract of any kind from
20 an insurance company in terms of this in-network.

21 CHAIRWOMAN FREED: Dr. Davin, please wrap up your
22 comments.

23 DR. DAVIN: Pardon me?

24 CHAIRWOMAN FREED: Please wrap up your comments
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1 so others can have a chance.

2 DR. DAVIN: Sure. I would implore you to really
3 look closely at the in-network, what that means, that is what
4 does it mean for state employees. What does it mean for
5 providers. How long does the process take. What does it
6 involve. And also, again, to look very closely at the
7 salient features of these things. Some insurance companies
8 have a behavioral health component. What does that mean?

9 Thank you. I appreciate your time.

10 CHAIRWOMAN FREED: Thank you.

11 Next commenter, please identify yourself for the
12 record.

13 MS. ELLIOTT: Okay. I'm Patricia Elliott, and
14 I'm a licensed clinical social worker. I've worked for three
15 decades in Carson City providing private practice
16 psychotherapy to people, and I have a large group of State of
17 Nevada employees. Patty and I ran into each other this
18 morning, and we both are doing something very generous where
19 we're providing services without a contract. We're not
20 getting paid from Aetna at all. I actually started the
21 process. I hired somebody so it would be expedited so I
22 could get on the list, the in-network list very quickly. I
23 don't have anything. I'm supposed to be getting a contract
24 tomorrow but we'll see what happens.

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1 So I'm seeing, and Patty said she's doing the
2 same thing, we're basically seeing clients for the co-pay
3 right now because we know our clients do not have the
4 financial ability to pay us. And my hope is that you will go
5 back and reimburse us starting July 1st because it's not our
6 client fault and it's not our fault for what's been going on
7 with this provider.

8 I also feel that my hope would be that you go
9 back to Hometown Health also. Not only is the mental health
10 issue really important but it's actually cost effective to
11 you to provide good providers because all the studies right
12 now are showing that if people have good mental health they
13 have much better physical health.

14 And I have people that need services and I can't
15 provide everything for \$40 an hour. So I -- I have nobody to
16 refer even to because there's -- there are so few people
17 available. So thank you very much for giving this attention.
18 And I do hope that you go into with a better insurance
19 company like Hometown Health. Thank you very much.

20 CHAIRWOMAN FREED: Thank you. Are there other
21 commenter's here in Room 4100? All right. Seeing none, I
22 will turn it over to LCB Broadcast and we will hear from
23 folks on the phone.

24 MS. TALENS: Thank you, Chair. To participate in
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1 public comment please press star nine or raise hand in Zoom
2 to take your a place in the queue.

3 MS. MAYLATH: Good morning. My name is Brooke
4 Maylath for the record. And I have submitted written
5 comments. And let me just thank you for the opportunity here
6 to speak quickly.

7 It's time that the PEBP administration end the
8 discriminating exclusions for covering transgender services
9 in the health plan. Unlike some people want to believe
10 suffering from gender dysphoria is not a choice but the
11 treatment to be able to help mitigate the impact of gender
12 dysphoria is the right thing to do for the -- for people
13 through an appropriate medical intervention plan that differs
14 for each individual.

15 We can go into detail in other areas as to what
16 really needs to be covered. We've been talking about this
17 now for a year. The resistance to this exclusion must stop.
18 We are talking about a 100th of a percent of the cost of the
19 -- of overall spending to be able to cover additional
20 treatments for gender dysphoria. Why are we trying to
21 balance a budget on the backs of the small number of people
22 who desperately need the services.

23 Please consider this. Please look at reversing
24 the exclusionary language that are in the health plans that
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1 prevent appropriate treatment for medically necessary
2 procedures for gender dysphoria. Thank you for your time.

3 CHAIRWOMAN FREED: Thank you. Next caller.

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

6 CHAIRWOMAN FREED: Yes, we can.

7 MR. ERVIN: Good morning, Chair Freed, Executive
8 Officer Rich and Board Members. Kent Ervin, K-e-n-t
9 E-r-v-i-n for the record representing the Nevada Faculty
10 Alliance, the Independent Association of Faculty of NSHE
11 colleges and university.

12 A strong benefits program is essential for the
13 recruitment and retention of high quality faculty and other
14 state employees, but unfortunately the cuts to PEBP have
15 undercut that goal.

16 For Agenda Items 6, Nevada Faculty Alliance is
17 neutral on COVID surcharges. All NSHE employees are required
18 to be vaccinated as a condition of continued employment after
19 the end of this year with medical and religious exemptions.
20 Therefore, NSHE employees should be exempted from any
21 additional requirements by PEBP to document their vaccination
22 status.

23 Agenda Item 7 states that 26,000,000 of the
24 47,000,000 excess reserves as of the beginning of the fiscal
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1 year available for enhancing benefits. That is a
2 conservative estimate. The proposal to stretch those funds
3 over three years is very conservative. Every biennium for
4 the past dozen years PEBP has made plans to spend excess
5 reserves down to near zero by the end of that biennium, but
6 even that has never happened. Projections that are overly
7 conservative hurt participants by forcing cuts to benefits
8 that then become permanent.

9 Option three in Agenda Item 7 comes closest to
10 restoring pre-pandemic benefits except for life insurance and
11 long-term disability and, therefore, is strongly preferred.
12 The estimated cost of 11,000,000 per year is well within the
13 available reserves for FY 2023 and beyond.

14 Option three should be recommended by the Board
15 and then let the Governor and Interim Finance Committee make
16 the final decision for section 21 of SB459. Option three as
17 amended, however, still does not fully restore the HMO, EPO
18 to zero percent co-insurance leaving a ten percent or 20
19 percent for I'm not sure which services. This should be
20 corrected even if it raises employee premiums back to FY 2021
21 levels.

22 Note that benefit changes to the middle and high
23 plan do not affect the cost to the state because the cost
24 differential above the now flat employer contribution across
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1 all three plans is formed by the participants. It is
2 important that the design for the low deductible and HMO, EPO
3 plans make the additional premiums that employees pay
4 worthwhile to them.

5 For FY22 the deductibles and co-insurance for
6 HMO, EPO plan has led to dissatisfaction and uncertainty and
7 cost. The whole idea and attraction of a high premium HMO
8 style plan is providing certainty and cost to fixed co-pays.
9 Thank you for your dedication and your consideration today.

10 MS. TALENS: Caller with the last three digits
11 338. You're unmuted and may begin.

12 MS. MALONEY: Good morning, Chair Freed, Members
13 of the Committee. This is Priscilla Maloney,
14 P-r-i-s-c-i-l-l-a M-a-l-o-n-e-y representing the AFSCME
15 retirees this morning.

16 Can you hear me, Chair Freed?

17 CHAIRWOMAN FREED: Yes.

18 MS. MALONEY: Thank you. Real quickly, I think,
19 Chair Freed, in the interest of efficiency what I'm going to
20 do is give you four bullet points of the following tracking
21 the actual agenda items in no particular order. The easier
22 one in a sense of none of these things are easy this morning.
23 However, the more straight forward ones I should say are on
24 Agenda Item 6, AFSCME Retirees Chapter 441 Retirees are
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1 neutral on this agenda item. That doesn't suggest that there
2 have been a brief or sketchy back discussions. There have
3 been extensive discussions. AFSCME International has
4 supported that all Americans get vaccinated as soon as
5 possible since the beginning, since the inception of the
6 pandemic. So we are neutral on Agenda Item 6.

7 On Agenda Item 7, again, in the interest of
8 efficiency and also recognizing the excellent work the Nevada
9 Faculty Alliance does, we agree and would like to piggy-back
10 on all the comments that Dr. Ervin just made and also within
11 the written public comments from Dr. Douglas Unger. We agree
12 that option three most -- most closely gets us back to
13 pre-pandemic levels with those adjustments as mentioned by
14 Dr. Ervin on plan design for the future for 2023.

15 And then finally on Agenda Item -- because these
16 two dovetail together, 4.2 the American Rescue Plan Funds
17 Request and Agenda Item 5, the Executive Officer report as
18 Ms. Rich has gone over already in advance with us, as you
19 know, on our pre-Board meeting on Monday. We are deeply
20 disappointed in what is represented as being the Governor's
21 office position on the American Rescue Fund funding to
22 restore PEBP cuts.

23 There's been much discussion of one-time monies,
24 but I would remind this body that in 2020 at AB3 the 31st
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1 Special Session, section 131.1 to be specific, this state --
2 the state government had no hesitation in sweeping PEBP in a
3 one-time act in direct response that was what was articulated
4 to the legislature in response to the shortfalls because of
5 the pandemic crisis. So there's an opportunity here,
6 2.7 billion as we all know to restore at a bear minimum what
7 was left in that special session and I would simply urge --

8 CHAIRWOMAN FREED: Ms. Maloney.

9 MS. MALONEY: Yes, I'm wrapping it up. I would
10 just urge --

11 CHAIRWOMAN FREED: Yes.

12 MS. MALONEY: -- this body to consider that fact.
13 Thank you so much.

14 CHAIRWOMAN FREED: Thank you.

15 MR. UNGER: Doug Unger, U-n-g-e-r, President of
16 UNLV Chapter and government affairs representative Nevada
17 Faculty Alliance. Thank you, Chair Freed, and PEBP Board for
18 your service and to Executive Officer Laura Rich for her good
19 communications.

20 For the record once again, and I won't waste your
21 time repeating other points, but just we really must express
22 how disappointed we are at the Governor's apparent lack of
23 support for restoring PEBP benefits for American Rescue Plan
24 Funds. Again, I would like to point out that the Governor

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1 and legislature do not even indicate they plan to put back
2 the 25,000,000 the legislature swept from the PEBP budget due
3 to COVID-19 economic crisis. And that this is the first time
4 in the history of PEBP that such a sweep has not been
5 restored. We are baffled as to why.

6 We appreciate PEBP Board support for our strong
7 request to the Governor and legislature to restore PEBP
8 budget and benefits to pre-pandemic levels.

9 Regarding the agenda for today for Item 6, the
10 COVID-19 surcharge as has been set the position for or
11 against. We do urge all state employees to get vaccinated
12 for personal health and for the safety of their workplace
13 communities.

14 For Item Number 7, the proposed plan designs for
15 FY23, we urge the Board to vote for option number three which
16 offers plans closest to restoring benefits, lowering
17 deductibles and out-of-pocket maximums. The most to bring
18 relief to those most in need. And if option number three
19 begins to appear unsustainable because of anticipated claims
20 there's time to make adjustments next year.

21 Regarding Agenda Item 8, the new contracts under
22 consideration, we can't express enough praise for and even
23 amazement at the dedicated work and due diligence that the
24 PEBP staff, Executive Officer Rich and the Board have devoted
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1 to stewarding so many contracts to the RFP process in a
2 single year. We support PEBP's recommendations. You all
3 deserve a bonus and extra vacation time. We wish we could
4 unwrap that for you as a gift but instead we'll simply wish
5 you happy healthy holidays. Thank you.

6 MS. TALENS: Caller with the last three digits
7 832 you are unmuted and may begin.

8 MS. LAIRD: Thank you. Good morning, Chair
9 Freed, other Board Members and PEBP Executive Officer Rich.
10 My name for the record is Terry Laird, spelled T-e-r-r-i
11 L-a-i-r-d. I'm the executive director at RPEN, the Retired
12 Public Employees Of Nevada. RPEN was formed in 1976, and we
13 currently have close to 8,000 dues paying members. The bulk
14 of our membership is retired public employees. Although, we
15 do have close to 1,000 members who are still working and who
16 would be directly impacted by Item 6.3 on today's agenda, a
17 surcharge on roughly 5,000 unvaccinated PEBP participants and
18 about 1,600 of their dependents.

19 Executive Officer Rich will speak on the reason
20 for the surcharge, and you will see a letter from one of our
21 members who has expressed a strong opinion on this matter as
22 well. RPEN being a nonprofit nonpartisan organization will
23 not take a position one way or the other.

24 At issue though is cost of the surcharge and
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1 what -- how it will burden many public employees who are
2 already dealing with escalating health care costs coming out
3 of their paychecks especially those who are in entry level
4 positions earning lower salaries and many of their
5 counterparts.

6 In addition because of the pandemic and the
7 impacts on the state budget Governor Sisolak eliminated
8 long-term disability and made other cuts to participants
9 amounting close to \$25,000,000 that RPEN and our advocacy
10 groups would like to see return to PEBP through the COVID
11 federal rescue funding that the state received earlier this
12 year amounting to nearly three billion dollars.

13 Unfortunately though as you heard in previous
14 public comment, we did hear this week that the Governor has
15 informed Ms. Rich that PEBP will not be receiving any of
16 those federal dollars. That is extremely disappointing in
17 light of so many other sacrifices these participants have
18 already made. It's as if PEBP through this surcharge is
19 being forced to come up with its own CARES fund to deal with
20 this issue that they face through no fault of their own.

21 So we urge this Board to seek other options to
22 help cover all COVID related costs rather than overburdened
23 state employees with more fees and instead look toward the
24 Governor's office for relief through that federal funding

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1 received earlier this year. I would also like to echo
2 remarks made earlier by Doug Unger and Kent Ervin relating to
3 option three under (technical issue) and looking out for the
4 hard working state employees in the great State of Nevada.

5 CHAIRWOMAN FREED: Thank you.

6 Next commenter.

7 MS. PARKER: Hi. My name is Stephanie Parker,
8 and I'm a member of AFSCME Local 4041 and a state employee
9 with over 13 years of public service with the State of
10 Nevada. I want to voice my dissatisfaction with the lack of
11 progress on the part of the Governor's Finance Office to
12 restore benefits of the public service workers who continue
13 to serve the communities of this state during the pandemic
14 with the ability that they have with the funds from the
15 American Rescue Plan.

16 This action or lack thereof is clear that
17 evidence -- clear evidence of the lack of respect of public
18 service workers. This coupled with the fact that furloughs
19 forced upon state workers without relief for performing their
20 same work levels have not been compensated. A great number
21 of employees like myself had to purchase our own equipment to
22 work remotely when our offices were closed due to the
23 pandemic.

24 I share the sentiments of the previous speakers
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1 in Item Number 7 when you're considering the three options to
2 go with the one that is less burdensome on the actual members
3 and that would be item number three or option number three.
4 I would like to see the PEBP Board take stronger stands to
5 restore the benefits that were taken and stop allowing them
6 to minimize the impact these cuts have had on employees who
7 are on the front lines. Thank you.

8 CHAIRWOMAN FREED: Thank you.

9 MS. TALENS: Ms. Garcia, please press star six or
10 raise hand to unmute yourself.

11 Sorry. Please standby as we are trying to
12 connect the caller.

13 CHAIRWOMAN FREED: Okay. I figured we might have
14 technical difficulties. Thanks, Broadcast.

15 MS. TALENS: Caller, you're unmuted and you may
16 begin.

17 Chair, it looks like the caller is having
18 technical difficulties connecting. Would you like to go on
19 to the next caller?

20 CHAIRWOMAN FREED: Yes, please, let's.

21 MS. TALENS: Caller with the last three digits
22 909, you're unmuted and you may begin.

23 MR. KENNEDY: Yes. Thank you. My name is Logan
24 Kennedy. That's L-o-g-a-n K-e-n-n-e-d-y. And I'm the
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1 chapter president for the Nevada State College chapter of the
2 Nevada Faculty Alliance. I'm here today to advocate -- I'm
3 here today for Agenda Item 7 to personally advocate for
4 option three of the revised plan design as these are closest
5 to the pre-pandemic plan.

6 The current PEBP benefit plan disproportionately
7 impacts those with families and those with chronic illnesses
8 who rely on specialty medications. No family should be
9 subjected to a maximum out-of-pocket cost of \$10,000 annually
10 or be subjected to paying thousands of extra dollars per year
11 in premium cost with reduced benefits.

12 As a parent to a five-year-old boy who has a
13 bleeding disorder, I'm especially troubled by these insurance
14 plans. My son, Grayson, has severe hemophilia A and requires
15 monthly intravenous infusions to prevent internal bleeding
16 and longer bleed times if he does get injured.

17 He relies on incredibly expensive medication to
18 ensure that he can live a typical life and play like his
19 other friends without the risk of an injury. Without access
20 to his medication, something as simple as falling and hitting
21 his knee on the concrete can be debilitating and prevent him
22 from being able to walk for a few days afterwards.

23 However, under the current plan we've experienced
24 an incredible amount of financial trust to obtain his
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1 medication which the co-pays can range anywhere from six to
2 \$8,000 per month. Because these astronomical co-pays are not
3 possible for the vast majority of Americans, we also have to
4 rely on financial assistance to partially offset the medical
5 cost associated with this.

6 However, under the current plan, this assistance
7 does not go toward our deductible or insurmountable 10,000
8 dollar max out-of-pocket cost, meaning we are essentially
9 having to pay extra to increase premiums for fewer benefits
10 from our insurance. Managing our son's bleeding disorder is
11 difficult enough without having to wonder whether or not we
12 would be able to afford his life saving medication on top of
13 that.

14 Now I understand that the PEBP Board can only do
15 so much with the funds they have been given, and I appreciate
16 all of their hard work on this matter. But on behalf of my
17 family and others in similar situations, I'm asking the PEBP
18 Board to please reinstate the previous PEBP benefits to
19 pre-pandemic standards. Thank you so much for your
20 consideration and time.

21 CHAIRWOMAN FREED: Thank you.

22 MS. TALENS: Caller, you're unmuted and you may
23 begin. Caller, you're unmuted and you may begin.

24 MS. GARCIA: Good morning. My name is Rosalie
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1 Garcia, R-o-s-a-l-i-e G-a-r-c-i-a. In reference to Agenda
2 Item 6, I strongly oppose applying surcharges on a specific
3 group of members due to their personal health preference.
4 There have always been health care costs associated with
5 individuals on their personal health preferences. However,
6 historical precedence has established that the PEBP
7 membership as a whole shoulder the burden or flipped a bill
8 for the entire membership regardless of health situations.

9 Outcome based health contingent programs as a
10 part of the PEBP health and wellness program have not been
11 implemented in previous years as they were looked at and
12 considered discriminatory and a stretch to comply with HIPPA.
13 Perhaps I'm out of touch. Do we apply a surcharge on
14 smokers, type two diabetics, obese persons due to excess food
15 intake, persons that have attempted suicide or any of the
16 other medical conditions that occur due to personal health
17 choices. If not then perhaps we should include those members
18 in this proposal as those types of health events have
19 historical data to support that those expensive health care
20 events can be avoided.

21 I agree, my proposal is ridiculous. But when
22 discussing reducing costs it is exactly what will be required
23 in order for PEBP to ensure that membership is treated
24 equitably and fairly and that a specific group of members are
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1 not targeted with fees under this proposal.

2 Also, why only charge non vaccinated? I know of
3 members that choose to test because they are fearful of being
4 asymptomatic and possibly spreading to family or friends. In
5 addition, many people are now traveling and testing is
6 required. Will vaccinated members, including retirees be
7 surcharged for testing? I submit that the program
8 maintenance of a monthly premium COVID surcharge would be
9 extremely cumbersome and costly to maintain more so than what
10 has been projected.

11 In addition to the continual maintenance of
12 employee and dependent COVID records, which executive PEBP
13 employee will make the determinations regarding legitimate
14 religious or health exemptions? Would PEBP need to hire one
15 or two consultants to review the exemption request or would
16 the PEBP Board need to convene for appeals? Who would cover
17 the lawsuits that are sure to be filed? Of all these are
18 added costs -- excuse me. All of these are added costs for a
19 program meant to eliminate costs.

20 Also, as more data becomes available, current
21 health reports indicate that vaccination does not permanently
22 guard against COVID-19 or the variants and does not stop
23 transmission. Will PEBP refund the fees when its determined
24 that all persons need to be continually tested to ensure that

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1 they too are not a danger to society?

2 Of the available options I sincerely hope that
3 the PEBP Board recognizes surcharges discriminatory, not
4 consider the PEBP staff recommended COVID testing surcharge
5 and instead say no should it come to vote.

6 I do want to also add that there's --

7 CHAIRWOMAN FREED: Ms. Garcia, you need to wrap
8 up.

9 MS. GARCIA: Thank you. I do also want to add
10 that do not be pushed by staff to make such an unprecedented
11 decision based on their calendar schedule. Take the time to
12 really consider it. And take the time to let this pandemic
13 flush out a little more before you start charging people for
14 unnecessary expenses. Thank you.

15 CHAIRWOMAN FREED: Thank you. Next commenter?

16 MS. TALENS: If you have recently joined the call
17 and would like to participate in public comment, please press
18 star nine or raise hand in the Zoom to take your place in the
19 queue.

20 MS. WOODWARD: Hello. Are you able to hear me?

21 CHAIRWOMAN FREED: Yes. Go ahead.

22 MS. WOODWARD: Thank you. My name is Janell,
23 J-a-n-e-l-l W-o-o-d-w-a-r-d. I'm a state employee
24 representing AFSCME Local 4041 state employees. Our union
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1 AFSCME fought very hard for the American Rescue Plan to
2 include aid to state and local governments. This was very
3 important to our collective recovery from this pandemic that
4 we are still in.

5 According to the guidance provided by the federal
6 government, ARP funds are intended to be used to restore cuts
7 caused by the pandemic. This includes cuts to the PEBP
8 budget that were done in response to the economic impact of
9 the pandemic to the state budget.

10 We are extremely disappointed that the Governor's
11 office has chosen not to use ARP funds to reinstate our state
12 employee benefits to pre-pandemic state. It is the right
13 thing to do and it is what those funds are meant for.

14 The current year's health care benefits have been
15 detrimental to many of my co-workers, to the point that many
16 are unable to utilize our health care coverage except for
17 basic things. We receive a bill for nearly every service we
18 get.

19 Some are paying thousands of dollars for diabetic
20 supplies that were above cost or free in the past. This is
21 unacceptable with the cuts to our pay this year.

22 Regarding the three proposed options for plan
23 changes for the coming fiscal year, AFSCME supports option
24 number three which provides the most benefit to all

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1 employees. We ask that ARP funds be requested to fill the
2 gaps in option three, allowing all cuts to be restored to
3 pre-pandemic levels.

4 We would encourage the PEBP Board to also not
5 only support the best option for employees but to push for
6 what is best for employees. Thank you for all of your work
7 and support of state employees.

8 CHAIRWOMAN FREED: Thank you.

9 Broadcasting, do you have anyone else in the
10 queue?

11 MS. TALENS: Yes, Chair, we have one more caller.

12 CHAIRWOMAN FREED: Okay.

13 MS. TALENS: Caller, you are unmuted and you may
14 begin. Caller, you are unmuted and you may begin.

15 MR. BORCHARDT: This is Robert Borchardt,
16 B-o-r-c-h-a-r-d-t. I'm a State of Nevada employee for the
17 last 23 years and four months. My comment is in regards to
18 Item 6.3. I believe option number two is the best for us to
19 continue 100 percent coverage for COVID-19 treatment related
20 claims.

21 As a single income family, the hike of the
22 insurance this last year has now caused me \$4,331.76 that I
23 have to pay now for my yearly insurance for my family. PERS
24 increase 24 percent. I just lost another \$20 per pay period
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1 so that comes out to 520. This 55 dollar a month surcharge
2 would be an additional \$660. So now I've worked for the
3 State of Nevada 23 years four months, and I'm going to be
4 losing \$1,899.64 per year.

5 We haven't had any raises. Your State of Nevada
6 employees that work very hard are normally paid 20 to
7 30 percent less than your city and county workers. We have a
8 high turn over rate according to the Las Vegas Review
9 Journal, with 135 percent turn over rate in 2020. People are
10 leaving due to pay and benefits. I believe this is going to
11 further hurt the State of Nevada. We have less employees.
12 Employees are being placed in immediate danger on a daily
13 basis in my area due to short staff.

14 I have some of the best state employees. I
15 actually am honored to be the supervisor of a State of Nevada
16 Employee of the Year. That person is looking to go
17 elsewhere, as 18 others are trying to leave also. So please
18 do not have the \$55 a month surcharge.

19 And I thank the Board for their time and
20 everything they do for us. And I would like to also thank
21 the caller Rosalie Garcia, last of G-a-r-c-i-a. I
22 100 percent agree with her statement also. Thank you for
23 your time.

24 CHAIRWOMAN FREED: Thank you.
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1 MS. TALENS: Chair, the public line --

2 CHAIRWOMAN FREED: If there's no more -- I'm
3 sorry.

4 MS. TALENS: I'm sorry.

5 CHAIRWOMAN FREED: Please go ahead. No. No.

6 MS. TALENS: The public line is open and working.
7 However, there are no more callers wishing to participate at
8 this time.

9 CHAIRWOMAN FREED: Okay. Thank you so much for
10 your help, Broadcast.

11 With that I'll close public comment and remind
12 everybody you can, of course, send it to us via e-mail to
13 PEBP staff. And, of course, there's a second commentary at
14 the end of the meeting.

15 So with that I don't know if the Attorney
16 General's rep for PEBP is on the line or not. So I think I
17 might have to skip Agenda Item 3. Oh, no. No. We have her.
18 Okay. So with that, we'll go to the AG's office for Agenda
19 Item 3.

20 MS. BRIGGS: Thank you, Madam Chair. This agenda
21 item is to allow me to make a disclosure regarding conflicts
22 of interest on behalf of the Board Members who are eligible
23 for PEBP benefits.

24 Of course, most of the items on today's agenda
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1 have an indirect affect on those benefits and particularly
2 Item 6 and 7, regarding COVID-19 coverage and potential
3 program design changes for plan year 2023 relates more
4 directly to PEBP Member benefits.

5 So pursuant to NRS 281A.420, on behalf of the
6 Board Members who are eligible for PEBP benefits or whose
7 families are eligible for PEBP benefits I offer this
8 disclosure. They will be voting on those items that may
9 affect the benefits available to them or their family
10 members.

11 The law does not require abstention from voting
12 merely because the Board Member or their family member is
13 eligible for PEBP benefits. At this time I invite any
14 members of the Board who has any additional disclosures to
15 make those now. Thank you.

16 CHAIRWOMAN FREED: Okay. Seeing none, then I
17 will move to Agenda Item 6. Like I said earlier, I'm going
18 to move forward down below 6 and 7. So let's go to Agenda
19 Item 6, everyone.

20 MS. RICH: All right. For the record Laura Rich,
21 Executive Officer with the Public Employees' Benefits
22 Program. Before I begin presenting this report, I do want to
23 start out by letting the Board know we have a few folks here
24 in attendance who will be available for questions. Director
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1 Dwayne Young, he's the policy director for the office of the
2 Governor is here. And we also have some representatives from
3 all of our vendor partners as well as a representative from
4 the Nevada System of Higher Education as well.

5 I'm going to deviate a little bit from this
6 report, at least the way it was written. There's a lot of
7 information in here. And all of the separate items sort of
8 bleed into each other. So I'm going to try to present it in
9 a way that flows a little bit better than the way it's
10 written in the report.

11 Also I plan to go over each option during the
12 presentation. But since they are so interrelated I think
13 it's best if I go through the entire report first and then
14 we'll take all of the action items all at once at the end
15 after discussion.

16 So I will start with 6.1, which is COVID cost
17 sharing. So at the beginning of the pandemic we know the
18 Governor's emergency declaration placed a requirement on
19 health plans to cover COVID testing at no cost. Although
20 PEBP was not subject to the requirements of the emergency
21 declaration the Board at the time opted to cover the COVID
22 testing consistent with the regulation. We followed that
23 pretty consistently and also treatment at 100 percent.

24 We discussed this at the September Board meeting
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1 because we had -- PEBP staff had brought to the Board the
2 option to restore cost sharing. And -- and after some
3 discussion this was tabled and asked to bring -- staff was
4 asked to bring this to the Board at this meeting.

5 So in that time PEBP reached out to public
6 employers throughout the country and the state and confirmed
7 that many of the plans out there, insurer's had done exactly
8 what we had done. They had suppressed or not enforced cost
9 sharing on COVID claims. However, out of 11 states only one
10 state, which is Hawaii, has indicated plans that they are
11 going to -- they have actually, most states have actually
12 ended that, and only Hawaii is continuing to waive the cost
13 sharing option.

14 So the remaining states, plus six of Nevada
15 public sector plans, as well as the culinary health plan have
16 ended that. And so they have reinstated cost sharing for
17 COVID claims. They either ended it recently, most recently
18 or even the beginning of 2021.

19 Cost sharing for members on PEBP's fully insured
20 HMO plan offered in Southern Nevada was waived by HPN
21 beginning in February of 2020. But at the end of December --
22 at the end of December of 2020 they actually returned that
23 cost sharing as well. So as a result there is already
24 inconsistencies among the PEBP plans.

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1 board regardless of health status. So it is, it's an all or
2 nothing type situation. We restore it or we do not.

3 So the options here are to restore cost sharing
4 for COVID-19 treatment related claims on January 1st of 2022
5 or to continue the coverage that we've been providing for
6 COVID-19 which is 100 percent coverage for these treatment
7 related claims under the declaration -- until the declaration
8 of emergency is repealed on a federal or state level.

9 So I'm going to go through -- is that okay. I'll
10 go through the entire report. So section 6.2, this is where
11 I'm going to refrain from the report a little bit so it flows
12 a little bit easier and is more easier to comprehend.

13 So first we're going to start with the testing
14 mandates. All service federal mandates because I think
15 that's -- it's easier to start with that and go through the
16 state mandates.

17 So on November 4th the Biden Administration along
18 with the occupational safety and health administration, which
19 is OSHA, published an emergency temporary standard, ETS.
20 This new rule requires that large employers, so that's
21 defined as 100 employers or more, administer weekly testing
22 for their unvaccinated workforce starting January 4th, 2022.

23 The rules here are clear that the cost associated
24 with testing fall either on the employer or the employee, and

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1 that the decision falls on the employer as to who gets to
2 absorb those costs. There is no indication here that the
3 feds have any interest in covering these costs.

4 Since then this has been challenged in the courts
5 and Fifth Circuit Court of Appeals granted a motion to stay
6 the ETS. So this federal mandate is now in limbo until
7 further action is taken.

8 However, let's move to the state mandate. The
9 state mandate, last August the state implemented a weekly
10 testing requirement for all unvaccinated employees. The
11 exceptions were for those employees considered fully remote
12 workers and those who worked in work places with a 70 percent
13 or above vaccination rate. So for example, PEBP is located
14 in the Bryan Building. No one at PEBP has had to test. No
15 unvaccinated employees have had to test since day one because
16 our building was designated as a building that was over that
17 70 percent vaccination rate since day one.

18 The division of public and behavioral health
19 secure on-site vendors to perform these weekly tests at
20 several locations throughout the state at a cost of about
21 \$130 a test. So the numbers of employees that tested varied
22 week by week, but the average was about 2,700 that were
23 testing a week, and that number has since dropped pretty
24 significantly because more and more work sites are meeting
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1 that 70 percent threshold.

2 So it looks like the state is going to continue
3 the weekly testing and to align with the direction being
4 taken or by the White House, it is likely that that 70
5 percent workplace threshold will be eliminated. So that's
6 leaving about 5,000 state employees required to submit to
7 weekly testing because they are unvaccinated.

8 Also DPBH's contract used CARES Act funding, it
9 is expiring on December 17th. Meaning the state will need to
10 figure out another funding source to cover those costs moving
11 forward. In addition, the Nevada System of Higher Education
12 is also exploring their own testing option because although
13 NSHE has imposed a vaccine mandate on their employees there
14 are a number of employees who have received medical or
15 religious exemptions and will be required to submit to weekly
16 testing as well.

17 The most recent numbers that I've received from
18 NSHE, and this may be updated since then, it shows that 813
19 remain unvaccinated and 341 employees have received
20 exemptions.

21 NSHE has a deadline of December 31st. So any
22 employees who have not been vaccinated or received an
23 exemption by then will be terminated.

24 So why is PEBP involved in the testing mandates?
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1 First, let me start off with providing some background on the
2 federal requirements on COVID-19 testing coverage. Section
3 6001 of the Family's First Act requires that health plans
4 cover COVID-19 diagnostic testing, we'll talk about
5 diagnostic and surveillance in a minute, at no cost to the
6 member during the national public emergency period. So the
7 FFA does not require plans to cover surveillance testing.

8 PEBP is currently covering all types of testing
9 plans. So what is the difference between diagnostic testing
10 and surveillance testing. Unfortunately there is not a whole
11 lot of clear guidance on this. But surveillance testing is
12 similar to, for example what the state is doing where
13 unvaccinated workers are required to submit weekly to -- to
14 receive a weekly test if they have not been vaccinated.

15 A diagnostic test is someone that is -- that has
16 symptoms, right. So you're coughing. You have a fever. Any
17 kind of symptom that is related to COVID-19, suspected you
18 have COVID-19 that is diagnostic. The difference here is
19 that a diagnostic test is mandated to be covered by insurers
20 whereas surveillance is not.

21 Most insurers nationwide do not cover
22 surveillance testing. The problem is that there's, again,
23 very little formal guidance on what qualifies as a diagnostic
24 test and what qualifies as surveillance. In fact, PEBP has
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1 seen only five surveillance claims come through our program
2 since the beginning of the pandemic.

3 So what I'm hearing from the industry is that
4 insurers are having to dedicate resources to identify
5 possible claims that are being submitted by providers that
6 are likely surveillance and not diagnostic. So what does
7 that mean? That means that when they see a provider
8 submitting a claim for John Smith for a COVID test week after
9 week after week, that is likely a surveillance test and not a
10 diagnostic test.

11 So providers are or insurers are having to
12 dedicate resources to sift through this and identify that and
13 push back on insurers. They are pushing back on providers
14 and without real clear guidance. I think it's easy to
15 understand why this can be a problem once more and more
16 employers begin implementing testing requirements.

17 Given that many employees were already testing
18 through other channels besides the state on-site option
19 likely using their insurance or the PEBP insurance, to be
20 tested through private providers, the Governor's office and
21 DPBH reached out to PEBP with the hope that PEBP may be able
22 to coordinate an alternative process at possibly a lower cost
23 option to the state. So PEBP's ability to leverage existing
24 resources and steer members may help contain costs and better
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1 project expenses associated with this testing.

2 This PEBP staff began to work with our partners
3 to research these efforts we discovered that failing for
4 COVID testing is anything but simple. It can vary widely and
5 providers have a lot of discretion on what and how COVID
6 related claims are billed. Testing can range anywhere from
7 zero dollars to hundreds of dollars.

8 So PEBP discovered was claims billed through
9 pharmacy or they can be billed to the feds through an
10 agreement between pharmacies and HHS. Since these claims
11 don't go through the PBM PEBP has no data on how many
12 employees, how many PEBP members have -- have had a test
13 administered through this option.

14 But there's an exception to that. We also found
15 that members who had accessed pharmacy mini clinics or
16 drive-thru testing they were being billed through medical.
17 These costs were somewhere in the 130 dollar range because
18 they included the testing and then also the associated
19 provider visit.

20 Then there's other options such as LabCorp or
21 Quest and they tend to be somewhere in the 75 dollar range
22 and then there's higher costs facilities. If you go to an
23 urgent care center, something like that it can be several
24 hundred dollars for a COVID test.

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1 Finally, there's other options that are free
2 because insurance information is never collected. So that
3 can be, you know, option such as health district testing
4 sites. So to come full circle, both NSHE and the state will
5 be conducting employer testing. Neither are funded to absorb
6 those costs moving forward. So shifting the cost on to the
7 employee potentially opens up a loophole.

8 Employees who are subject to pay for testing will
9 quickly realize that seeking a COVID test elsewhere will be
10 covered 100 percent through insurance at no cost to the
11 employee because, remember, providers are billing at
12 diagnostic rates, not at surveillance -- not using the
13 surveillance codes and, therefore, those costs are likely
14 going to end up being -- having to be absorbed by the plan
15 regardless.

16 So far the plan has paid about 3.4 million
17 dollars in testing costs. Again, that's just through the
18 medical side. We don't know how many have received testing
19 through the pharmacy side at zero dollars and how much that
20 has been paid by the feds.

21 This is not inclusive, that 3.4 million dollars
22 is not inclusive of the cost paid through the DPBH on-site
23 testing contract.

24 The delivering the weekly testing through
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1 insurance will allow PEBP to control and plan for cost. PEBP
2 has been exploring other options that replicate the state's
3 current on-site testing process, and we have several options
4 that appear to be very viable. One option is offering an
5 on-site solution which is about \$60 per test. And another
6 option we're looking at explores a self-administered at-home
7 testing service using a telemedicine type provider who
8 oversees the testing and then logs the results. That's about
9 half the cost, about \$33 a test. While these options have
10 yet to be flushed out it allows PEBP to pivot quickly and
11 better plan for future liabilities of the program.

12 So the options here really we're looking at, one,
13 is to deny coverage for surveillance testing. We can do
14 that, but we all know that no one is billing using
15 surveillance codes. Providers are billing using diagnostic
16 codes, and until that changes the plan is going to be really
17 liable for all those costs that come in for testing.

18 So the second option is to provide 100 percent
19 coverage for surveillance testing only through PEBP approved
20 solutions. So these are low cost solutions we can steer
21 members to and provide to better be able to plan for the cost
22 of the testing program.

23 And then the third option is to continue to
24 provide 100 percent coverage for all COVID testing. It's
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1 important to note here that no matter what the health plan
2 will likely assume increased cost related to this overall
3 increase in mandated testing not just for the state but other
4 employers who want to put this into place. If people use
5 providers who are billing this as a diagnostic test insurers
6 will be subject to pay for that because we are federally
7 mandated to pay for COVID-19 claims, testing claims.

8 So that leads me into 6.3 which is the COVID
9 surcharges. A recent survey indicated that about 70 percent
10 of unvaccinated employees would be motivated to get
11 vaccinated if surcharges were imposed on them. Delta
12 Airlines and several other private employers have implemented
13 surcharges already as a way to recoup COVID related costs on
14 their self-funded health plans.

15 Delta estimated that the average COVID
16 hospitalization costs on their plan is about \$50,000. In
17 some instances employers have reported that their vaccination
18 rates have increased about 20 percent after a surcharge was
19 imposed.

20 PEBP reached out to other public sector health
21 plans and while most have not implemented a surcharge of this
22 type many many were interested and expected to consider it at
23 some point. Those health plans that we reached out to were,
24 had asked PEBP to share with them what, you know, what PEBP

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1 discovers going down this track.

2 So why does PEBP need to consider surcharges?

3 The original intent of this proposal was to cover increased
4 claims associated with the treatment of COVID-19. And to be
5 clear, that is still a major concern. Just this week PEBP
6 had a claim come in for half a million dollars in bill
7 charges for a patient that was hospitalized from COVID who
8 later passed away. I've told this story before. I think at
9 every Board meeting there's several COVID stories that PEBP
10 has shared with the Board and the public. This is -- this is
11 not going away. These costs are here to stay.

12 And yesterday I happened to look at a report of
13 pending high cost claims, those are claims that have not yet
14 been paid and are over 100,000, \$100,000. And six out of the
15 top 20 highest cost claims were due to a COVID diagnosis. So
16 there's definitely, it's quite clear that COVID is a major
17 cost driver in terms of treatment and hospitalization costs.

18 Now we have an additional factor which is
19 employee testing cost. The combination of both of these
20 potential costs put the plan in a situation where we must
21 identify revenue sources to cover these increases. PEBP is
22 largely a taxpayer funded plan. Outside of employee premiums
23 it's a taxpayer funded plan. And since we do not have the
24 ability to adjust the state subsidy portion outside of

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1 legislative session we have no choice but to look at other
2 options.

3 The only revenue option that we exist with is the
4 employee premium side, right. So we do not collect
5 additional revenue to offset -- if we do not collect
6 additional revenue to offset the cost associated with COVID
7 hospitalizations and testing then those costs will have to be
8 absorbed by the plan in the form of either higher premiums
9 for all members or reduced benefits which in turn may impact
10 the discussion that we have in Agenda Item 7.

11 So to go over the legal requirements a bit, in
12 response to the overwhelming interest on this subject, the
13 department of labor recently released new guidance confirming
14 the legality of COVID surcharges. It's similar to smoking
15 surcharges that have been imposed by plans in the past.

16 And they also provided a clear roadmap for health
17 plans to use when considering the implementation of a
18 surcharge. HIPAA prohibits health plans from discriminating
19 against participants based on a health factor. A health
20 factor can be an individual's health status, a medical
21 condition or receipt of health care. Vaccination status
22 falls under that category as well. But despite this, HIPAA
23 permits different premiums for participants complying with
24 programs of health promotion and disease prevention, so

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1 a.k.a. wellness programs.

2 These are two types -- there are two types of
3 wellness programs at participatory which basically uses the
4 carrot method to incentivize a member to satisfy a health
5 requirement.

6 And then there's the health contingent. A health
7 contingent program is broken out into two categories,
8 activity based and outcome based. Requiring a member to pay
9 a higher premium to obtain a particular health status, like a
10 COVID-19 vaccination is an outcome based program. Outcome
11 based programs must offer reasonable alternatives. So in the
12 case of a COVID surcharge the plan will have to provide
13 another way for an unvaccinated member to avoid the surcharge
14 and pay the same premium as a vaccinated member. The most
15 common practice here is to offer a waiver option for health
16 or religious purposes.

17 For the dollar amount the plan can impose on a
18 surcharge there's several federal laws that must be taken
19 into consideration. Health insurance must still be
20 considered affordable under the Affordable Care Act, meaning
21 that the least expensive employee only, and that's important,
22 the employee only premium option must be less than the
23 9.83 percent of the employee's household income.

24 So since PEBP and most employers do not have
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1 access to this information the IRS provides some Safe Harbor
2 Rules to determine affordability. These Safer Harbor Rules
3 take into consideration things like poverty, federal poverty,
4 FPO and minimum wage. Ultimately though the surcharge is
5 limited to 30 percent of the total cost of the employee only
6 coverage. Using this information PEBP determined that the
7 limit for the employee surcharge is kept at \$55. So we
8 cannot impose anything more than \$55 on an employee.

9 While the dependent surcharges must still comply
10 with HIPPA wellness rules they are not subject to the same
11 limitations that employee surcharges are. So employers have
12 a lot more flexibility in dependent surcharges in that
13 amount. PEBP anticipates needing about \$175 for surcharge
14 for dependents in order to recoup sufficient revenue to
15 offset the expected expenditures of the plan.

16 So in this, we took some assumptions and, again,
17 there's a good possibility that these assumptions will change
18 because out of those 5,000 employees we don't know how many
19 have -- you know, will get vaccinated, how many will get
20 exemptions, how many are remote workers who are not subject
21 to this, right. So there is some assumptions here that we're
22 using.

23 The first one is cost. So originally we were
24 looking at, you know, the different types of testing and what
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1 we could expect these costs to come in at for the testing
2 cost. And we're looking at probably 40, 60, 80, so low,
3 medium, high, right, and that's based on our ability to steer
4 members to -- to our preferred cost options.

5 We're also looking at, you know, the 5,000
6 unvaccinated state employees. At the time that this report
7 was written, you know, the 1,250 unvaccinated NSHE employees,
8 95 percent of them being enrolled in PEBP. And then we're
9 looking at five percent surcharge exemption rate. This is
10 based on Aon internal tracking of experience using other --
11 other private sector health plans. They are looking at five
12 percent received in exemption or a waiver.

13 And then the dependent surcharge assumes
14 dependents 18 years of age or older. So we have no intent on
15 imposing a surcharge on any individual under 18. So it is
16 adults over 18, whether they are spouse or a dependent child.

17 So if you look at on page eight the table there,
18 it takes a look at the surcharge revenue, what we're
19 expecting and the testing cost. So this really -- I mean, in
20 looking at the medium here is we're looking at about
21 \$18,000,000 that we are anticipating of expenditures related
22 to this, and this is not including medical costs. This is
23 just including the testing.

24 And so through these surcharges, the 55 and the
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1 175, the expected revenue here would be about that 18,000,000
2 that is necessary to, you know, bring that revenue to meet
3 the expenditure cost.

4 So, like I said, it's important to note this is a
5 very fluid situation. And as PEBP receives more accurate
6 data around these numbers the projections and the tables may
7 likely change, and we do have the ability in the future to
8 make some adjustments moving forward, but we do need to make
9 a decision today at least to -- to have something to go on.

10 The following are just some of the dependencies
11 that can greatly impact plan cost in the coming months. So
12 the legality of the federal mandate, again the state mandate,
13 what we're looking at in terms of, you know, how many
14 employers are looking at surveillance testing, vaccination
15 numbers, remote workers and then also terminations, how
16 many -- how many of those NSHE employees that are left are --
17 will be terminated on December 31st.

18 Hospitalization costs, like I said, I mean, we
19 have got a whole lot of pending costs out there that are
20 COVID related.

21 And then we have that COVID pill that is likely
22 due to be released or approved hopefully in, you know, the
23 next coming months. And the cost to that could be if the
24 feds decide not to pick it up and insurers have to pick it up

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1 it could be a significant cost to insurers as well.

2 So as more data is gathered PEBP expects to
3 adjust the dependent surcharge amount. But, like I said, we
4 really do need to start somewhere, and this is from the data
5 we have today that the 175 and 55 is what we're looking at.

6 So the process, a lot of it is not flushed out
7 yet because, again, we're in the early stages, but PEBP's new
8 enrollment and eligibility system vendor has implemented
9 functionality that allows employers to administer a COVID
10 surcharges, similar to how smoking surcharges are managed.
11 Employees would have the ability to upload copies of their
12 vaccine cards beginning in January through the end of open
13 enrollment in May.

14 We are also looking at PEBP has the ability to
15 access the state's vaccination data as an insurer. And so to
16 make it easier on employees we may be able to absorb that
17 data and the vaccination data, and so those already received
18 vaccinations we'll have it on record.

19 The system can also accept vaccination data from
20 an outside source so we're exploring that. Members who have
21 not provided proof of the vaccine by the end of open
22 enrollment would be assessed the appropriate surcharge on
23 their plan year '23 premium so that is beginning July of
24 2022. As unvaccinated employees become fully vaccinated and

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1 provide the proof to PEBP the surcharge would be removed.

2 And so exemptions, to meet the reasonable
3 alternative requirement PEBP would allow unvaccinated members
4 to submit medical and religious exemption request. NSHE who
5 recently mandated vaccination among both staff and students
6 has already established an exemption process which requires
7 those seeking a medical exemption to submit a form completed
8 by a medical provider and those who may be seeking a
9 religious exemption. PEBP will be working closely with the
10 Governor's office and legal counsel and would likely
11 establish a very similar exemption process to the one that
12 NSHE put into place today.

13 So the recommendations here are to, one,
14 reinstate cost sharing for COVID related treatment and
15 hospitalization and apply existing plan rules to COVID
16 related treatment and hospitalization plans effective January
17 of 2022. Allow surveillance testing coverage only through
18 PEBP sponsored vendors. And three, implement a COVID
19 surcharge effective 7-1-22 for all unvaccinated primary
20 members of \$55 per month per employee and implement a 175
21 dollar a month COVID surcharge effective 7-1-22 for
22 unvaccinated spouses and domestic partners and dependents
23 18 years of age or older.

24 So I know that was a whole lot of information. I
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1 am willing to discuss and take questions.

2 CHAIRWOMAN FREED: Okay. Thank you for walking
3 us through that. I'm going to open it up to the Board for
4 questions because I'm sure there's a lot of them. But I want
5 to, something you said about page eight of the staff report
6 caught my ear and I wanted to get it sort of on the record.

7 In that box on page 18, we've got, using these
8 assumptions we got surcharge revenue and then 18.4 million
9 cost and then testing cost in the mid range assuming it's a
10 60 dollar test of 18.5 -- 18.6 million so a differential of
11 \$150,000 there.

12 But we also heard that COVID treatment is the
13 significant cost driver. You mentioned six out of 20 of high
14 cost claims. That's about -- that's 30 percent, if I'm not
15 mistaken.

16 So the recommendation is to impose a surcharge on
17 employees and unvaccinated employees and unvaccinated spouses
18 and dependents 18 and older to cover testing costs as
19 anticipated because we have a lot of uncertainty around
20 testing costs or is it testing plus treatment costs, claims
21 costs?

22 MS. RICH: So Laura Rich for the record. So
23 quite honestly, I mean, so we're limited in what we can
24 assess in a surcharge. So \$55 is what we're limited for the
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1 employee. So we have to pick up the rest of the cost through
2 the dependents surcharge. Now this is only addressing the
3 testing cost. We can certainly add in the anticipated COVID
4 hospitalization and treatment on this, but then we're looking
5 at very significantly high numbers for the dependent
6 surcharge, and staff wasn't prepared to really go above that
7 175.

8 CHAIRWOMAN FREED: Okay. Okay. Got it. So the
9 surcharge is to cover the testing costs. The cost sharing is
10 to bring PEBP in line with other health plan, tier health
11 plans in Nevada, as well as large public sector health plans
12 in other states and from that end tackle the claims cost
13 side?

14 MS. RICH: That is correct.

15 CHAIRWOMAN FREED: Okay. Thank you for
16 clarifying that. Understanding, Board Members, I want to
17 open it up for questions.

18 MEMBER BARNES: Chair Freed, for the record Jim
19 Barnes. I would like to ask a question of the Governor's
20 office representative.

21 CHAIRWOMAN FREED: All right. We'll give him a
22 second to get to the table.

23 MEMBER BARNES: Yes. My question is why aren't
24 American Rescue Plan funds being used to provide the required
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1 surveillance testing?

2 MR. YOUNG: For the record DuAne Young, policy
3 director for the Office of the Governor. So first thank you,
4 Chair Freed, and to the Board, for the opportunity to address
5 the Board and answer questions directly.

6 Answering Mr. Barnes' question, American Rescue
7 Plan funds have been used for the surveillance testing for
8 the last four months. The state put in about a 20,000,000
9 million dollar investment in state employees to make sure
10 that, one, we would be able to function properly, have
11 meetings such as this and be safe and secure our workforce.

12 Since then we were looking at about 50 percent
13 split of employees who are unvaccinated. Since then, we've
14 seen an increase of 5,000 employees who became vaccinated as
15 a result of this vaccination and testing surveillance policy.

16 What we know is that the state will continue
17 investment through our funds and standing up testing across
18 the state because as Director Rich mentioned, the Biden plan
19 has been stayed but the state is still supportive of that and
20 knows that testing needs to spread in support of many other
21 entities, including some small businesses who may not be able
22 to take this on, and so there will be a continued investment
23 of that.

24 But we would like to, as Director Rich has
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1 pointed out, one, it is quite cheaper for PEBP to cover it
2 than the state through our funds. And for every dollar of
3 our funds that we spend on these things it's a dollar taken
4 away from housing, childcare and many other initiatives that
5 we've heard from the over 4,000 submissions from the Every
6 Nevada Framework portal.

7 MEMBER BARNES: And just a follow-up on that, why
8 haven't American Rescue Plan funds been used to restore the
9 funds that were swept from PEBP due to the pandemic?

10 MR. YOUNG: Again, DuAne Young for the record.
11 That's a good question. One of the things, one of the
12 reasons is the treasury guidance has not been final. And so
13 we are waiting for the final treasury guidance. But as you
14 know, part of during this special session it was determined
15 that the calculation of what loss revenue was. However,
16 those funds have since been transferred and actually there's
17 an IFC subcommittee today that is overhearing those items.

18 So we have recognized that one of the things that
19 we have to do, I am a 14-year state employee, six in this.
20 Eight in another, one state in which I've only received one
21 raise in my entire career. One of the things we recognize is
22 we have to do something for state employees. Particularly
23 through the last two years the state of employees have worked
24 extremely hard, been flexible and sacrificed many things and

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1 has not kept our salaries, have not kept up with the pace of
2 the private market. We know this.

3 We have to do this in a way that, one, is
4 sustainable and does not drive us to a fiscal cliff. So the
5 hesitancy that you've seen in our funds in restoring the PEBP
6 benefits is because we have to be able to understand when,
7 where we're going to be economically as a state. We've seen
8 the recovery of Nevada and we've been very cautiously
9 optimistic, particularly in the gaming revenue being over a
10 billion each month for the last several months, and so we
11 hope that continues and we hope we're in a better position.

12 But one of the things is we cannot put ourselves
13 in a fiscal cliff where we restore benefits and then not be
14 able to sustain those in '23 and further drive state
15 employees from the state. And so what we are trying to do
16 is, one, focus on what kind of package and what better
17 benefits across the board can we put together for state
18 employees to entice them to stay, to entice others to take on
19 a life of state service without putting the state in a
20 position by doing it now where we've already closed the
21 budget to reopen it and reconsider restoring those benefits.

22 And so I understand that people need relief now
23 and I hear that. And I, myself, I looked at that situation
24 and I understand when I've had to switch providers. I

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1 understand that, but we have to do it in a way that is both
2 economical and smart and looks for the future of building the
3 state, and so that's why we've been cautiously optimistic
4 about doing anything like that.

5 MEMBER BARNES: Thank you.

6 CHAIRWOMAN FREED: All right. On the other side
7 of the dias I thought I saw Member Kelley and Member Aiello,
8 maybe even Member Caughron. So we'll take Member Kelley's
9 question. And then after that, Betsey, if you wish to go.

10 MEMBER KELLEY: Thank you, Chair Freed.

11 Okay. So my questions don't specifically put you
12 on the spot anymore. I appreciate your testimony. I guess
13 what we've heard overwhelmingly during public comment though
14 are employees have been squeezed now. We heard from a
15 supervisor all employees, that all of his employees are
16 looking to leave.

17 And so without legislative sessions that meet
18 every other year, what the due diligence you're doing is
19 costing is potentially all of our high flying employees. So
20 then when the state finally reinstates our compensation of
21 benefits package we've already lost the good employees. They
22 had to get back, right. It's going to be an incredibly
23 competitive labor market, it already is. At NSHE we're
24 having trouble hiring people today.

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1 And so I guess that's the challenge you're
2 tackling now but we're also tackling it everyday and we hear
3 it from employees. So as I say, thank you for talking about
4 that. I just hope that maybe it can be fast tracked a little
5 bit so we can keep our employees because training and
6 recruitment is an expensive endeavor so thank you.

7 Okay. So I actually have a question for
8 Executive Officer Rich. Around, just around the, I guess
9 more focusing on the COVID surcharge at the moment. You
10 talked about how this is kind of to recoup costs. And so I
11 just wanted to -- I wasn't -- I don't totally understand why
12 we're, if doing this not as a punishment but to recoup actual
13 costs, why would we not have the surcharge apply to everybody
14 who's unvaccinated, including minors because the vaccine is
15 available to children from 12 and up. But also why would we
16 exempt people with medical and religious waivers because they
17 still are costing the plan, right. They are still getting
18 tested. They are still potentially incurring costs at
19 hospital and stuff. So that's really my question. Thank
20 you.

21 MS. RICH: So Laura Rich for the record. So the
22 recommendation is to not impose surcharges over for
23 dependents under 18. However, we can certainly change that
24 if that's what the Board would like to do.

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1 As far as your second question and -- and the
2 ability to give an option for waivers, that is by law
3 something we would have to do. That is insurers in the
4 definition of, you know, how we can -- how we can impose
5 surcharges. We have HIPAA and ACA, department of labor, all
6 those rules that have to be followed. And there are very
7 clear reasonable alternatives that have to be offered. And
8 so that reasonable alternative is the most common practice is
9 to offer an alternative for either religious or medical
10 reasons.

11 MEMBER KELLEY: So just a follow-up. But isn't
12 the reasonable alternative the vaccine?

13 MS. RICH: It's the reasonable -- Laura Rich for
14 the record. It's the reasonable alternative to the vaccine.
15 So you can get vaccinated and not have the surcharge, but you
16 have to have a reasonable alternative to not receive the
17 vaccine and not receive the surcharge. So that reasonable
18 alternative is the medical exemption and that's why NSHE has
19 that as well, not for the same reason as a health plan would
20 but it's for similar reasons.

21 MEMBER KELLEY: Thank you.

22 CHAIRWOMAN FREED: Member Aiello.

23 MEMBER AIELLO: For the record this is Betsey
24 Aiello. And, again, I have a question for Laura Rich. And
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1 my question is just understanding one of the sentences that
2 is how we can allow to do the surcharge. This statement says
3 it's the health contingent broken into two main categories
4 you talked in outcome based. Requiring participant to pay
5 higher premium to obtain or maintain a health status.

6 It's hard for me to understand how that higher
7 premium would be the surcharge for not -- unless it's to
8 maintain not having -- it just sounds almost backwards to me,
9 and I know that it's probably been reviewed by legal, but I
10 was hoping to get some clarity. Thank you.

11 MS. RICH: Right. So Laura Rich for the record.
12 Right. So there's -- it's a requirement to -- the
13 requirement is to be vaccinated and so that is -- that's the
14 health contingent requirement, right, so that is the outcome
15 based. And so the requirement here is in order to not
16 receive the surcharge you must be vaccinated. So you have to
17 offer reasonable alternative to that outcome. So does that
18 make sense?

19 MEMBER AIELLO: Sort of. As long as it's
20 reviewed by legal and everything is okay. So sometimes
21 legalese is hard. Thank you.

22 CHAIRWOMAN FREED: I saw Mr. Verducci's hand up
23 unless, Member Bittleston, do you want to go? Please go.

24 MEMBER BITTLESTON: Thank you. Leslie Bittleston
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1 for the record. I have a question for surveillance versus
2 diagnostic that Member Rich or Executive Officer Rich talked
3 about. It seems very confusing that we have had this
4 pandemic for a long time and this virus for a long time, and
5 we can't figure out what the difference between surveillance
6 and diagnostic is.

7 And if we can somehow have like a surveillance
8 test for those people that are testing weekly that may have
9 caused, you know, drive costs down a little bit for testing.
10 Because looking at page eight on these testing costs it's
11 just incredible. So that's kind of a comment. I don't know
12 if it's a question, more of a comment.

13 MS. RICH: Laura Rich for the record. I can
14 address that. So just to be clear, surveillance and
15 diagnostic, and I'm not -- I can't say this for sure because
16 I haven't seen the cost, but our TPA is in the audience.
17 They can confirm. They come in basically the cost is a cost
18 regardless of, you know, what kind of test you're getting.
19 So, you know, if it's a rapid test it's one cost. If it's
20 PCR it's another cost, right. And so it's not -- the cost is
21 not different whether it's surveillance or diagnostic.

22 The difference is it's a code. It's how it's
23 billed. And so the insurer has to, we are federally mandated
24 to pay at 100 percent a claim that comes in with a code that
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1 is diagnostic. Whereas, a surveillance we are not. So a
2 claim that comes in with a code as a surveillance test the
3 insurer is not obligated to pay.

4 The problem is the provider community, and this
5 is something I've heard from other health plans, you know,
6 and it's been confirmed just, you know, across the board from
7 conversations I've had from people in the industry that
8 providers are largely billing everything as diagnostic. And
9 so when these claims come in insurers are obligated to pay
10 these claims. So the difference is not in cost. It's just
11 how it's billed and where we're obligated to pay or not.

12 CHAIRWOMAN FREED: Mr. Verducci.

13 MEMBER VERDUCCI: Yes. Thank you. Tom Verducci
14 for the record. You know, I wanted to point out that when I
15 start my workday I'm required when I go out in the field to
16 meet with anybody I have to be vaccinated. And I'm asked
17 questions how I'm feeling today, if I've had any exposure is
18 a very effective way of reducing the spread of COVID-19.

19 And, you know, I see that NSHE has implemented
20 vaccine requirements and the OSHA, department of labor is
21 requiring employees -- employers with over 100 employees be
22 vaccinated come January 4th. And even though it's pending
23 litigation, I think that it is required to have some kind of
24 plan in place to reduce the unvaccinated membership and the

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1 exposure that the plan will be paying with increased costs
2 and expenses.

3 So my question would be for Mr. Young. What is
4 the State of Nevada's plan with the OSHA and department of
5 labor requirements come January 4th?

6 MR. YOUNG: DuAne young for the record. And I
7 just want to clarify. Yes, the OSHA plan required -- didn't
8 require vaccination. It required employees who either be
9 vaccinated, and if they are not vaccinated they be tested
10 weekly.

11 The only portion of the plan that is a vaccine
12 mandate is for providers who bill Medicaid or Medicare
13 through the federal government. They must then select large
14 health care systems, hospitals. A few providers are exempt
15 such as schools, home and community health based providers
16 and physician offices but that is a large portion of the
17 medical community. That has had court challenges which have
18 not succeeded. So that is still in motion.

19 With the Biden plan or the OSHA plan being
20 stayed, the State of Nevada has already been in compliance.
21 In fact, we were one of the leaders in the nation in doing
22 this by implementing our vaccine or testing policy. The
23 difference between our plan and the federal plan is that we
24 said once a worksite achieves 70 percent, and 70 percent was

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1 based on the known available science that we had at the time
2 that moved us closer to a herd immunity, we have since
3 learned more that that is closer because viruses tend to
4 mutate as we've seen and with various variants as they grow
5 stronger as less people are vaccinated and so we know that
6 needs to move closer to the 90 percent mark.

7 And so our policy said 70 percent. Where we will
8 be moving is all unvaccinated employees. So those who
9 previously have not been tested because their worksite had
10 achieved that 70 percent will now have to be tested in
11 compliance with that plan. And so we, the White House this
12 morning as I was driving here has announced new plans to
13 really push this. But the focus is really, one, get people
14 vaccinated. That is the most safest and effective way to
15 stop the spread of this disease and for those who medically
16 cannot be vaccinated or it is against their closely held
17 religious beliefs then we pose the alternative of protect
18 those and everyone around you by being tested. Know your
19 status weekly.

20 We've had this conversation, and this is not any
21 different than what we've had in public health for years,
22 whether it's STD's, whether it's Tuberculosis, whether it's
23 chicken pox, know your status detected and protect everyone
24 around you.

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1 And so this conversation has not become any
2 different. I think some of the politicalization around this
3 particular subject has made it a bit more intense. But when
4 we get to the core of it it's common public safety measures
5 and protections.

6 And so in summary to answer your question, this
7 state will continue to lead. And so we have -- we will
8 continue to test unvaccinated state employees. What we are
9 asking you to consider today is so to help relieve some of
10 that burden on state employees by covering it through the
11 plan by doing that by having a surcharge on those that do not
12 choose to be vaccinated.

13 There are many people who feel strongly against
14 being vaccinated. They won't do it. And this pandemic has
15 been shouldered on the burden of everyone. And now this
16 particular, the testing should be shouldered on the burden of
17 those who refuse to do so.

18 Finally, in asking the -- in asking all of that,
19 it's -- it's simple. It's not a punishment. It's not a
20 retaliation. It's simply saying we have to move our state
21 forward. We have to reach the road to endemic. We have to
22 find our way out of this. And the way out of it is either be
23 vaccinated and if you're not vaccinated be testing and have a
24 way to understand that you will be surcharged to cover that

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1 testing at a cheaper cost than the state taking childcare
2 resources, housing resources, food security resources to pay
3 for that testing.

4 CHAIRWOMAN FREED: Wait a minute. Is there a
5 follow-up from Mr. Verducci?

6 MEMBER VERDUCCI: You know, I'll go ahead and
7 pass.

8 CHAIRWOMAN FREED: Okay. Mr. Barnes, do you have
9 a question?

10 MEMBER BARNES: Yes, for Mr. Young. As I
11 understand it you said that it's cheaper for PEBP than for
12 the state to do the surveillance testing. Did I understand
13 you correctly?

14 MR. YOUNG: Yes, that is correct.

15 MEMBER BARNES: Okay. Is that because the state
16 is not funding PEBP to do the surveillance testing?

17 MR. YOUNG: That is because PEBP is a health plan
18 and can leverage mechanisms as a health plan that the state
19 cannot.

20 MEMBER BARNES: I guess what I'm getting at, a
21 non funded mandate then. Is that what we're talking about
22 here?

23 MR. YOUNG: Yes, it was and that's why the state
24 put in initial resources because we wanted to protect the

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1 health and safety of our workers and so the state put in the
2 initial resources for testing to get us there. But we knew
3 that it was not long-term sustainable. So we looked through
4 other mechanisms such as health plans, the same as Medicaid
5 covers it, the same as culinary health plan would cover it
6 for their workers, and many other private plans that would
7 cover it that are employer based.

8 MEMBER BARNES: Okay. Thank you.

9 CHAIRWOMAN FREED: Member Kelley, would you like
10 to?

11 MEMBER KELLEY: I actually have a question that
12 kind of switches the gears a little bit. And I wanted to
13 actually -- so this basically three recommendations on the
14 table from Executive Officer Rich. So and I wanted to maybe
15 run through my notes.

16 The first -- I think the first choice is around
17 the cost sharing or the first vote. And so I'm -- one of the
18 statements you made was that we -- the Board either consider
19 going to the cost sharing model effective January 1st or not
20 going then and then waiting until the emergency declaration
21 ends. That's kind of extreme, right, because you're talking
22 about making a change to our plans mid plan year, which I
23 have always had issues with, couldn't the Board choose to go
24 to the cost sharing model on July 1st of 2022 when we -- when

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1 our plans update?

2 MS. RICH: Laura Rich for the record. We can
3 certainly do that as well, yes.

4 MEMBER KELLEY: Okay. Thank you. My next
5 question is more around the process for the waivers because I
6 think we've now been talking or we heard about waivers for
7 maybe three meetings so this is the third meeting. I think
8 we talked about it at the last one. You mentioned it at the
9 one before. So I'm somewhat concerned that you still don't
10 have a process flushed out.

11 So we're here today talking about actually
12 potentially putting in a COVID surcharge, but we've really
13 have no idea how that would work, and that's a concern to me
14 because I think the process is everything in health insurance
15 and that's often where participants get the most frustrated
16 with us is where we outline -- outline kind of a goal, but we
17 don't have a process flushed out.

18 So can you talk a bit about why we don't have a
19 process flushed out and when you expect to have that in place
20 so the board can review it.

21 MS. RICH: So Laura Rich for the record. First
22 I'll just say there was a lot of work and research involved
23 in just to get us to this point. And so the work and effort
24 involved to -- to come up with a process will also be a

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1 process in itself so we wanted to take this in steps. It
2 made sense to take it in steps, not do all the work that's
3 associated with flushing out all of the details unless the
4 Board made the decision to move forward with this.

5 While we do have high level details in place I
6 made sure our enrollment eligibility system vendor can
7 accommodate any of these recommendations. We've had all of
8 those initial conversations with public health in terms of
9 getting the vaccination data. We're already starting behind
10 the scenes.

11 But for example, the exemption process, right,
12 this is something that PEBP needs to work very closely with
13 the Governor's Office and legal counsel to ensure that, you
14 know, the exemption and that waiver process, we are following
15 the legal requirements and really meeting the, coordinating
16 with the Governor's office to ensure that we're aligning in
17 our -- in our path forward.

18 This does not go into place, it does not
19 implement until July 1, and so we have time to implement the
20 actual details of that process and move forward with that.
21 This is something that I had planned to bring to the Board in
22 January, in March. And, again, in May we'll be talking about
23 this at each Board meeting moving forward.

24 So this is -- it's definitely as we get more
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1 details. Like I said, in the report there's a lot of initial
2 data that we're working with that we have. But if that data
3 changes we'll have to come back to the Board with new
4 information and say for example, let's say that the 5,000
5 employees, it looks like now we're down to 3,000. Well, that
6 changes cost. That changes a lot of criteria. And so we can
7 come back to the Board in January or in March and say, look,
8 maybe the 175 was too much. We can probably bring it down
9 to, you know, 100 or whatever it is.

10 So we have time to flush out the details, but we
11 need to make a decision today so that we can move forward
12 with the -- the actual plan itself and start with the
13 implementation and move forward with those things.

14 MEMBER AIELLO: This is Betsey Aiello. And,
15 again, this is for Executive Officer Rich. I -- I'm going
16 back on to something that Michelle had just mentioned and
17 that has to do with restoring cost sharing for COVID-19 and
18 the date possibly to start or not start.

19 Actually, the -- by the Board not imposing cost
20 sharing of COVID, we are actually operating outside our
21 current plan design, correct, because the plan design itself
22 requires cost sharing for certain things. And we just said
23 in a vote, oops, I'm sorry. I'm Italian. I have to use my
24 hands. In a vote we decided we were going to operate outside
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1 the current plan and then you also said that when, because of
2 some things the federal government had said at time and we
3 decided to do it, but our health plan such as our HMO did
4 that for a while and they reversed it. So our own programs
5 are a bit operating in this discord also I think.

6 So I just wanted to get back to that because it's
7 not really a plan design change. It's implementing
8 something. Although, people might have gotten used to it, my
9 guess would be if you haven't had COVID and been in the
10 hospital you may not even realize that the plan is paying
11 100 percent because you haven't experienced it. I don't
12 know. We know it. We're sitting here, so thank you.

13 MS. RICH: Correct. And Laura Rich for the
14 record. It is -- it was a change that was made in midyear
15 when we made this exception to the COVID cost sharing. So
16 COVID is treated differently than any other disease today in
17 the cost sharing aspect. And so it was done midyear. It is
18 something we can change midyear. It is something we can
19 change, you know, in July if that's what the Board would like
20 to do. The recommendation is January of 2022. Because as
21 you said, we already have a misalignment within our plans
22 because the fully funded or the fully insured HMO plan, those
23 members are not receiving, so they are paying cost sharing
24 for any COVID related treatment. Whereas those on the

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1 self-funded plan are not subject to it.

2 And we are also with the exception of the State
3 of Hawaii one of the only public sector health plans that has
4 not reinstated cost sharing for COVID.

5 MEMBER KELLEY: Can I just ask a very quick
6 follow-up on that then. So I hear what you say. So just one
7 clarifying point. So COVID is not discussed in the plan
8 document and there's no reference to the differential
9 treatment of COVID in the plan document?

10 MS. RICH: I am not -- Laura Rich for the record.
11 I am not 100 percent certain. I would have to go back and
12 really get through that master plan document. I'm not the
13 one who updates it every year, but I will definitely -- I
14 don't believe that that was added. I will have to look at it
15 specifically.

16 CHAIRWOMAN FREED: This is Laura Freed. That's
17 not my recollection that we changed the MPD for two count for
18 COVID. And, you know, I have to say here, piling on what
19 Betsey had to say, I don't really enjoy the idea that we
20 would treat participants, you know, who do the same job in
21 the south and who are a member of the HPN and HMO has to pay
22 cost sharing if they contract COVID as opposed to somebody in
23 the north in the same job class making the same money who
24 gets their claims paid at 100 percent. And that is why I am

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1 in favor of reinstating cost sharing to treat COVID like any
2 other disease. But, anyway, I'll leave it to other members
3 with questions.

4 Oh, Ms. Fox, go ahead.

5 VICE CHAIR FOX: Linda Fox for the record. I
6 have a quick question regarding testing. So if we chose
7 option two to provide coverage for surveillance testing only
8 on-site employee testing it would still allow for a loophole,
9 right. So I guess this question is for Laura Rich. So you
10 could still go anywhere and say you had symptoms and that
11 would generate a higher cost, correct?

12 MS. RICH: Correct. So Laura Rich for the
13 record. So let's say that an employer decided to push the
14 cost on to the employees and an employee was subject to, you
15 know, let's say \$50 a week to be tested, the loophole here is
16 that insurers are required to -- to pay for at 100 percent a
17 test that is -- that is a diagnostic test.

18 And so playing, you know, devil's advocate, I'm
19 a -- I'm an unvaccinated employee who is subject to weekly
20 testing and I know that I have to pay \$50 a week to test and
21 through my employer. But I know that if I show up at the
22 nearest CVS and cough and say I've got symptoms it's paid at
23 100 percent for free. So how long do you think it's going to
24 take an employee to realize this and say, well, if I go to my

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1 employer and I'm subject to the \$50 out-of-pocket expenses
2 but if I go to CVS and get the 130 dollar test that's billed
3 to the insurance plan then I pay zero.

4 So that's -- that's the problem there is that
5 until industry wide we can figure out and maybe see amasses
6 going to potentially come out with much more stringent or
7 clear guidance on the definitions of surveillance and -- and
8 diagnostic testing but we're not there yet. Everyone is --
9 the providers across the board are billing as diag or as
10 diagnostic and not surveillance.

11 MEMBER AIELLO: Betsey Aiello for the record
12 again. Executive Officer Rich, so the question that I have
13 is that I understand where that could happen and over time
14 there might be some development of surveillance. But by
15 doing an option two it would build a process from what I
16 understand that you said and also Mr. Young that we might be
17 paying \$60 a test instead of \$130 a test. And I as an
18 employee that had to be tested, if I'm not vaccinated it
19 would be a whole lot easier for me to go to the site right
20 near my employer it would cost PEBP less.

21 So even if someone could still go to CVS and
22 pretend it's diagnostic we're developing an easier option
23 than number two would be I think.

24 MS. RICH: Laura Rich for the record. Correct.
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1 We're actually exploring a very viable option which is using
2 a telemedicine provider where we have actual tests that we
3 can distribute or mail to the employees and they using a
4 telemedicine provider that is virtual on their phone, they
5 self-administer the test. They -- the screener on the other
6 end will then log the results in. And so state staff have
7 the ability to see, okay, this person tested and is negative
8 and so we have -- we will have that information. So that's
9 even -- you know, you don't even have to show up anywhere.
10 You've got a test that you can self-administer at home.

11 So, yes, that's exactly what we're seeing is, you
12 know, that it's about a 33 dollar option for those tests.
13 And so we can -- by offering that we can control costs. We
14 can contain those costs and steer members into using that
15 instead of using the 130 dollar option or even more expensive
16 if you go through urgent care or something like that.

17 CHAIRWOMAN FREED: Mr. Verducci, go ahead.

18 MEMBER VERDUCCI: Yes, Tom Verducci for the
19 record. Do we know what the associated cost would be with
20 for exemption requests as well as vaccine documentation, what
21 the process would be to review the vaccine documentation? Is
22 there a process in place?

23 MS. RICH: Laura Rich for the record. PEBP is
24 actually looking at that. We are working with the division
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1 of public and behavioral health to potentially access the
2 vaccine data that is -- that the state already has access to.
3 And so insurers already do get that as well as other
4 organizations and entities that have been granted access
5 through statute, you know, to access that information. So we
6 are -- we would be getting that hopefully electronically
7 anyway.

8 Now that's just state data, right. So if you've
9 received your vaccination say in Texas then we don't have
10 that. And so those members that we wouldn't have access to
11 their, you know, their state vaccine data, you know, we would
12 allow them to upload through the eligibility and enrollment
13 system vendor they would upload their vaccine card, you know
14 just like they upload their birth certificate or marriage
15 certificate when they enroll into PEBP and they enroll their
16 dependents, it's similar to that so that's how that would be.
17 We see that process happening.

18 MEMBER VERDUCCI: And Tom Verducci again. Would
19 there be an additional cost to the program?

20 MS. RICH: Laura Rich for the record. No, that
21 is built into the eligibility and enrollment system, and we
22 have that ability to -- you know, it sounds like, again,
23 we're transitioning to a new vendor on January 1st. And so
24 this is a new vendor so it sounds like it's part of that

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1 system and something that can just be turned on and it's a
2 function of the system.

3 MEMBER VERDUCCI: Thank you.

4 MEMBER KELLEY: Michelle Kelley for the record.
5 So just a follow-up on recommendation number two, how long --
6 when would that -- when would that take effect? So obviously
7 there's a process involved in selecting the vendor. When
8 would you anticipate, if that was passed how long would that
9 take to implement?

10 MS. RICH: Laura Rich for the record. We are
11 already exploring those options. We've had a lot of
12 conversations already. It sounds like there's several week
13 runway for that. But we expect because it is through
14 existing vendors that we have in place already that we don't
15 have to -- there's not a lot of contractual work that goes
16 along with it. And so we're able to kind of pull the trigger
17 on that pretty quickly. There's I would say within the next
18 three to four weeks we could make it happen.

19 MEMBER KELLEY: And I'm not sure -- sorry.
20 Michelle Kelley for the record. I'm not sure who this
21 question is addressed to. But is there a required process
22 for notifying employees around kind of if we start to limit
23 the vendors? You know, I know they're used to having on-site
24 right now. But they are also used to being able to go to CVS

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1 and stuff. So is there a 30-day, 60-day notice period we
2 would anticipate?

3 MS. RICH: We would definitely -- Laura Rich for
4 the record. We would definitely be communicating this, not
5 just through PEBP but through the department of
6 administration through the Governor's office. We're also
7 working very closely with the Nevada System of Higher
8 Education who is not part of the state process in terms of,
9 you know, the on-site testing that we've provided for state
10 employees. But moving forward because they are part of the
11 PEBP system, I've been working very closely with them as well
12 to -- to secure options through the university system as
13 well.

14 And so -- so, yes, we are -- we would be
15 communicating this as much as possible. Again, we're looking
16 at, you know, potentially being able to mail these tests to
17 people's houses or distribute them through the workplace and
18 so I think this is going to be a coordinated effort between
19 agencies, between, you know, the state and the university
20 system. You know, so there's going to be a lot of
21 communications going to need to happen.

22 MEMBER KELLEY: Thank you.

23 CHAIRWOMAN FREED: Mr. Barnes, did you have a
24 question?

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1 MEMBER BARNES: Yes. I just wanted to clarify
2 then. Is it true that there's a 30-day notice required for
3 any change of coverage? Maybe that's the question for the
4 deputy AG.

5 MS. RICH: Laura Rich for the record. So
6 there's -- there's -- yes, but this isn't -- this wouldn't
7 really be a change in coverage. This is -- so it's not a
8 benefit, right. So this wouldn't qualify under that.

9 MEMBER BARNES: Okay. Because that was my
10 concern that if it is a change of coverage it couldn't be
11 done by January 1. And so we're sure it's not a change of
12 coverage then.

13 MS. RICH: Correct.

14 MEMBER BARNES: Okay. Thank you.

15 MS. RICH: And I do have to say -- Laura Rich for
16 the record. I did receive a response, Member Kelley. I have
17 actually a fourth staff member text me just now and say that
18 yes, it is the COVID-19 cost sharing is specifically in the
19 master plan document for this year, yes.

20 CHAIRWOMAN FREED: Darn it. I hate to be wrong.
21 Oh, man.

22 MEMBER KELLEY: I'm sorry. Right now we're not
23 cost sharing so that's what's in the plan document. I'm
24 sorry. I just needed to clarify.

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1 MS. RICH: Yes. Laura Rich for the record. It
2 was updated this plan year to ensure that -- that that was
3 something that was covered in the plan, yes.

4 CHAIRWOMAN FREED: Member Aiello.

5 MEMBER AIELLO: Betsey Aiello for the record.
6 With that statement then, Executive Officer Rich, has there
7 been a problem if our HMO has not been following it, if it's
8 in the master plan document, are they required to follow the
9 master plan? That's something that that brings up to me
10 then.

11 MS. RICH: So Laura Rich for the record. The
12 master plan document applies to our self-funded plans. And
13 so each self-funded plan has its own master plan document.
14 The fully insured HMO product does -- it does not fall under
15 the requirements in the master plan. They have their own
16 master.

17 MEMBER AIELLO: That's good to hear. Thank you.

18 MEMBER KELLEY: But that does change the
19 conversation. Michelle Kelley for the record. That does
20 change the conversation for the Board because there is a
21 notice requirement now, right? It's in the plan document
22 we're planning to take it away mid plan year.

23 MS. RICH: I would have to check with legal. We
24 didn't have to do that when we implemented. So I would have
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1 to check with legal on that one.

2 MEMBER KELLEY: When we implemented it was an
3 enhancement to the benefit so nobody was going to complain.
4 When we take it away it's something that's published. My
5 question would be can we even do it midyear given there's a
6 published document that states it.

7 CHAIRWOMAN FREED: This is Laura Freed. I'm
8 going to call on Deputy Attorney General Briggs to opine.

9 MS. BRIGGS: Hi. Michelle Briggs, chief deputy
10 attorney general. So if the plan document, I'm not quite
11 sure what the plan document says based on what has been
12 discussed. The plan document says right now that it is cost
13 sharing. Is that what you had said, Ms. Rich?

14 CHAIRWOMAN FREED: No. The plan -- the master
15 plan document apparently says -- apparently codified the
16 change the Board made some months ago to cover COVID
17 treatment at 100 percent rather than the typical cost sharing
18 that is normal for, you know, any infectious disease.

19 So the question is can the Board decide if it
20 chooses to reinstate cost sharing, is January 1st, 2022 too
21 soon because there's a 30-day notice to change the provisions
22 of the plan. So would we have to push it out?

23 MS. BRIGGS: Yes. You would have to follow all
24 procedures to change the plan if the plan currently says it
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1 is fully covered.

2 MS. RICH: So and I think we have I believe
3 Michelle Walker from Health Plan of Nevada. Michelle, if
4 you're available or maybe Mark, would you, either of you mind
5 speaking to how Health Plan of Nevada reinstated that and
6 what the process was. Do you know if Michelle or anyone from
7 HPN is on? They should be.

8 CHAIRWOMAN FREED: Broadcast Services, this is
9 Laura Freed. Do you have any folks on the Zoom from Health
10 plan of Nevada, our southern HMO?

11 MS. MERCADO-ROSAS: Hi, Chair. This is Cindi
12 with Broadcast. I only -- are you referring to Michelle
13 Briggs?

14 CHAIRWOMAN FREED: No. No. She's the chief
15 D.A.G. Laura Rich can help me with the names.

16 MS. RICH: It would be Michelle Walker or Mark.

17 MS. MERCADO-ROSAS: We do not have a Michelle
18 Walker on the Zoom.

19 MR. CARLTON: Mark Carlton, HPN for the record.
20 Just got a text. I was waiting to confirm. We did not
21 change the fully insured certificate of coverage when we made
22 that provision change. We knew it was somewhat of a
23 temporary adjustment to that plan to waive those -- those
24 flat co-payments for inpatient and outpatient treatments of

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1 COVID. So that plan document or, you know, in the case of a
2 fully insured plan the certificate of coverage was not
3 amended. And then, again, when we reverted back to applying
4 those co-payments it was also not adjusted. So it was simply
5 an administrative adjustment that was made to make that
6 change and that accommodation.

7 CHAIRWOMAN FREED: Thank you very much for that.
8 Member Kelley, do you have a follow-up for HPN
9 staff? Okay. Do you have a follow-up for Ms. Rich.

10 MEMBER KELLEY: I guess I have a question about
11 are we given the change in the COVID coverage was in the
12 master plan document, would it be safe to assume that some of
13 our more savvy covered members potentially switched from an
14 HMO to the PPO because they knew they would be covered at
15 100 percent.

16 If I would argue that potentially we have even
17 one member out there who did that and if we are going to
18 change that coverage even with notice we need to open
19 enrollment again to allow them to select a plan that better
20 suits their needs because that is the purpose of open
21 enrollment is to give people an opportunity. So I think --
22 anyway, I'm pro cost sharing. I just am concerned about the
23 procedure because it's my understanding we're obligated to
24 operate our plan in line with our plan document, so.

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1 CHAIRWOMAN FREED: This is Laura Freed. I guess
2 that would mean that member would have to be sitting there in
3 May and thinking who covers COVID and how may -- you know, am
4 I going to get COVID? And I don't know that anybody sits
5 around thinking I'm going to make a decision based on whether
6 I get a COVID case or not. So I'm not sure I agree with
7 that.

8 Mr. Barnes.

9 MEMBER BARNES: Yes. For Ms. Rich, if it's
10 determined that we need additional vaccines over and above
11 what we have now with the new variants emerging and that sort
12 of thing will PEBP need to implement additional surcharges if
13 we do need additional vaccines?

14 MS. RICH: Laura Rich for the record. At this
15 time that's not being considered. It's something that the
16 Board can definitely consider in the future. It's something
17 that, you know, the Governor's office can work with PEBP on,
18 but at this point that's not something we're considering.

19 MEMBER BARNES: Thank you.

20 CHAIRWOMAN FREED: Mr. Verducci.

21 MEMBER VERDUCCI: Yes. Tom Verducci for the
22 record. Are there any other states, we may have discussed
23 this, that are using a COVID surcharge or would we be the
24 only one out there?

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1 MS. RICH: Laura Rich for the record. We
2 obviously have not checked with every single state. We did
3 reach out to a resource that we have that does distribute
4 e-mails to different public entities, and we received a lot
5 of responses from public sector health plans that were very
6 very interested but had not implemented yet. They were
7 looking at it, but they had not implemented yet.

8 There was one public sector health plan, a small
9 one in, smallish one in Dallas that did implement a
10 surcharge, and they actually went above and beyond and
11 implemented some incentives as well, provided two extra dates
12 off for those that had gotten vaccinated. And, you know, so
13 they took some extra steps on top of that. So we do know of
14 public sector plans that have done it. But this has been
15 more common in the public sector with the larger employers,
16 like Delta and Bowing and, you know, several large employers
17 like that.

18 MEMBER VERDUCCI: Okay. So Tom Verducci for the
19 record. So we would be the only state that would actually be
20 implementing COVID surcharges?

21 MS. RICH: Laura Rich for the record.

22 MEMBER VERDUCCI: That we're aware of.

23 MS. RICH: That I know of we would be the first
24 state, yes.

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1 MEMBER VERDUCCI: Okay. And, you know, from a
2 risk management perspective, liability, unattended
3 consequences, especially the 175 dollar family charge, you
4 know, the state employees have been hit very hard with no
5 raises over a number of years.

6 And I think of the soul out in Lovelock working
7 for the department of corrections is paying \$800 a month in a
8 trailer with three kids. I have a hard time with this one, I
9 really do. And I just wanted to pass on my personal
10 comments. No question there. Just a few comments from
11 compassion of working with state employees in the '80s, '90s,
12 2000s, the 2010s and now the 2020s and meeting a lot of them
13 personally I just have a hard time with this hard dollar cost
14 after the cuts that they have incurred.

15 CHAIRWOMAN FREED: Thank you, Mr. Verducci.

16 All right. I'm not seeing a lot more questions,
17 raised hands. It looks like we're all discussed out. So it
18 feels like it's decision time, my friends.

19 So knowing what we know that the plan has to
20 provide notice, I think I'm going to do this, I'm going to do
21 this in chunks. And so I would like to tackle recommendation
22 number one first, reinstate cost sharing for COVID related
23 treatment and hospitalization and apply existing plan rules
24 that is the normal master plan document for the CDHP related
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1 to COVID related treatment and hospitalization claims
2 effective.

3 Now we at least need to push this out to
4 February 1st or we can do March 1st or we could do FY23.
5 What is the sense of the Board on that point?

6 Ms. Bittleston.

7 MEMBER BITTLESTON: Leslie Bittleston for the
8 record. I support pushing it out to March 1st of 2022 which
9 would give staff 60 days to notify.

10 CHAIRWOMAN FREED: Fair enough. Would you
11 consider that a motion?

12 MEMBER BITTLESTON: Leslie Bittleston for the
13 record. I move --

14 CHAIRWOMAN FREED: That's right.

15 MEMBER BITTLESTON: -- that we reinstate cost
16 sharing of the COVID related treatment, hospitalization and
17 all of that effective March 1st, 2022.

18 CHAIRWOMAN FREED: Okay. Is there a second?

19 VICE CHAIR FOX: Linda Fox for the record. I
20 will second that motion.

21 CHAIRWOMAN FREED: Okay. Thank you. All right.
22 It's been moved and seconded to reinstate cost sharing for
23 COVID related treatment and hospitalization for the CDHP
24 effective March 1st of 2022. All in favor say aye. Any
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1 opposed say nay. Oh, I'm sorry. Let me give you a second.
2 Any opposed say nay.

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

5 CHAIRWOMAN FREED: Hearing none the motion
6 passes. Thank you.

7 All right. Recommendations two, three and four,
8 let's take number two. PEBP staff recommends allowing
9 surveillance testing coverage only through PEBP sponsored
10 vendors only covered if you go through the vendor that is
11 ultimately worked out between PEBP staff and our medical
12 vendors, our pharmacy benefit manager.

13 Board Members, do you have a sense of your --
14 your direction on that?

15 MEMBER KELLEY: I'll make that motion.

16 CHAIRWOMAN FREED: All right. Thank you, Member
17 Kelley.

18 Is there a second to that motion?

19 VICE CHAIR FOX: Linda Fox for the record. I'll
20 second that motion.

21 CHAIRWOMAN FREED: All right. So it's been moved
22 and seconded to allow surveillance testing coverage only
23 through PEBP sponsored vendors.

24 Board Members, all in favor signify by saying
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1 aye. Any opposed say nay.

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

4 CHAIRWOMAN FREED: All right. Here it is,
5 friends, implement -- number three, implemented COVID
6 surcharge effective July 1st of 2022. Effective in plan year
7 2023 for all unvaccinated members of PEBP of \$55 a month per
8 employee. Board Members, how do you feel?

9 MEMBER VERDUCCI: Well, Tom Verducci for the
10 record. I'll be voting no on this one.

11 CHAIRWOMAN FREED: Okay. Thank you.

12 VICE CHAIR FOX: Linda Fox for the record. I
13 will make that motion that we implement a 55 dollar surcharge
14 for unvaccinated members.

15 CHAIRWOMAN FREED: Thank you.

16 Is there a second to the motion?

17 MEMBER BITTLESTON: Leslie Bittleston. I'll
18 second.

19 CHAIRWOMAN FREED: Okay. Thank you. All in
20 favor signify by saying aye.

21 Any opposed say nay.

22 MEMBER VERDUCCI: Nay.

23 MEMBER BARNES: Nay.

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

2 CHAIRWOMAN FREED: The record will reflect
3 Mr. Barnes and Mr. Verducci as nays. Motion carries.

4 Last but not least, the motion or excuse me, the
5 motion, jeez, the recommendation is to implement a 175 dollar
6 a month COVID surcharge effective again July 1st, 2022, so
7 plan year '23 for unvaccinated spouses, domestic partners and
8 dependents 18 or older.

9 And to this, given the uncertainty of testing
10 costs, if someone is going to move approval of this I might
11 suggest allowing PEBP staff to as testing costs are revealed
12 to us and to PEBP staff giving the PEBP staff the flexibility
13 to lower that surcharge, not increase it, but lower it so it
14 in essence making \$175 a month a cap and anything beyond that
15 would have to come back to the Board but that's my own
16 personal feeling.

17 So, Board Members, sense of the Board?

18 MEMBER KELLEY: Michelle Kelley. So moved.

19 CHAIRWOMAN FREED: All right. Thank you.

20 Is there a second?

21 MEMBER BITTLESTON: Leslie Bittleston. I'll
22 second.

23 MEMBER COUGHRON: April Coughron. I'll second.

24 CHAIRWOMAN FREED: I'll take Ms. Coughron. She
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1 hasn't got a second in.

2 All right. Board Members, you've heard the
3 motion, implement a 175 dollar a month COVID surcharge
4 effective July 1st, 2022 for unvaccinated spouses, domestic
5 partners and dependents 18 and older with approval to PEBP
6 staff to lower that surcharge if testing costs prove to be
7 lower for the plan. All those in favor say aye. Any opposed
8 say nay.

9 MEMBER VERDUCCI: Nay.

10 MEMBER BARNES: Nay.

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

13 CHAIRWOMAN FREED: All right. The record will
14 reflect the Mr. Verducci's and Mr. Barne's nays. The motion
15 carries. Thank you everybody.

16 With that we will move to Agenda Item 7. Oh, I'm
17 sorry. Of course, we can take a break. Sorry, guys. You
18 always have to remind me whether we're virtual or we're not
19 virtual, but you can always go to the bathroom no matter what
20 since we're in Carson. But, yes, let's come back at 10:55.
21 It's 10:47 now.

22 (Whereupon, a brief recess was taken.)

23 CHAIRWOMAN FREED: All right. Ladies and
24 gentlemen, we'll call this meeting of the PEBP Board back to
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1 order. All right. Thanks, everybody.

2 We'll move on to Agenda Item Number 7, discussion
3 and possible action on potential program design changes for
4 plan year 2023.

5 MS. RICH: All right. For the record Laura Rich.
6 Just to give a little background on this at the September
7 30th Board meeting, Aon had presented information regarding
8 plan trend and the impact of COVID and recommendations
9 related to PEBP's differential cash levels.

10 Aon's original recommendation expected, after all
11 of the expected trend and required expenditures such as the
12 Medicare HRA funding and premium buydowns, we were -- the
13 recommendation by Aon was to use \$12,000,000 in differential
14 cash. So the Board later approved that the \$12,000,000 be
15 used to develop plan design that could be funded over three
16 years with a primary focus of restoring deductibles and
17 out-of-pocket maximums.

18 So since the last Board meeting many changes have
19 taken place that have led PEBP and Aon to go back to the
20 drawing board to make new recommendations. Fortunately they
21 are much more improved recommendations.

22 Aon has been able to run a much more recent
23 utilization and apply a variety of very significant savings
24 that are projected to come to the program as a result of new
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1 contracts that are in the process of being awarded. Some of
2 them will be awarded today.

3 So after factoring additional CRF dollars and let
4 me go back since we have not -- we have not discussed or took
5 some items out of -- out of order but we are getting
6 additional CRF money from CARES Act funding on the IFC agenda
7 in December in addition to the \$5,000,000 that we received
8 last IFC as well.

9 So with those CRF dollars the recommendation has
10 increased from 12,000,000 to approximately 26,000,000.
11 Because some of the contracts such as PBM, they have not been
12 finalized. Approximate savings were used so it's -- we're
13 not necessarily completely on target because we don't know
14 about some of these. We know that there's going to be
15 savings. We just don't know how much because they haven't
16 been awarded yet.

17 So some of this was -- some of these approximate
18 savings were used in this figure. And so depending on the
19 outcome of the financial negotiated contracts this may impact
20 the actual savings and what our, you know, what that
21 differential cash would have been, that recommendation would
22 have done. But we feel like we're pretty close based on the
23 projected savings and what we think the outcome is going to
24 be on some of these future RFP's.

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1 So on page two you can see there's a chart there
2 that shows trend, and I think it's a very good visual example
3 of trend. And for those of you, I actually have a black and
4 white copy as well. But if you see, I think it's a green
5 line, right, on page two. So this one right here. On page
6 two I believe it's a green line and that is the -- the total
7 trend. So that is medical and RX combined. So you can see
8 that the black line there in the middle, the fairly flat
9 line, those are budgeted. That's what we have budgeted for
10 overall. That's what the plan has received in, you know, in
11 our legislatively approved budget.

12 And the cost there are, that green line is what
13 is actually happening in the plan, right. So you can see
14 that in 2020 you can see the suppression. You can see that
15 it just it dipped down and we -- this is where a lot of our
16 excess reserves or differential cash has been -- has come
17 from because people were not going to see their providers.
18 They were not seeing their -- they were not going to the
19 dentist. They were not seeking care in general because of
20 the shutdown. So we have those suppression, that suppression
21 in 2020.

22 And we've been talking about this spike in
23 claims, this comeback, right. So all of those -- all of
24 those folks that didn't go to the doctor are now seeking
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1 services, and so you can see there's a spike in claims and
2 this is happening.

3 So the differential here is between the black
4 line and the green line. This is what we're missing. And
5 this is the reason why we cannot use up all of the excess.
6 We have to have that bucket of money to -- to really take
7 into consideration the difference between the black line and
8 the green line.

9 So I note that that chart there just did a really
10 good example of illustrating the impact of COVID because it
11 highlights the claim suppression and the beginning of that
12 anticipated spike. We don't know how long that spike is
13 going to last and, you know, what that is going to look like
14 moving forward. So this is why the entire -- the entire
15 amount of our excess reserves or differential cash is not
16 being recommended to use.

17 So with the assistance of Aon, and we do have the
18 Aon team here in front of us, they have -- we have staff and
19 Aon have come up with some plan design options that use a
20 couple of different approaches. So in option one the plan
21 design basically takes a very conservative approach. So
22 we're looking at a recommendation is let's use \$26,000,000 in
23 excess cash, in differential cash and this plan design is --
24 this option one is using 21.7 million in differential cash.

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1 So if you look at the plan design, the focus here is on the
2 reduction of deductibles and out-of-pocket maxes just as the
3 Board had decided on at the last Board meeting.

4 So there were a few reductions there and
5 deductibles, out-of-pocket maxes, and on EPO, HMO there were,
6 you know, some changes there in the co-pays as well. So I'm
7 going to pull up my color copy just really quick. That way I
8 can see. Yeah. There we go, okay. All right. And so in
9 option two the plan design takes the moderate approach, and
10 that's where we are using approximately \$26,000,000 which is
11 what staff feels comfortable recommending in terms of how
12 much of a differential cash we feel is a safe amount to use.

13 And in this option you can see that those
14 deductibles and out-of-pocket maxes are reduced a little bit
15 more. You're looking at, you know, different co-pays on your
16 EPO and HMO and the cost sharing as well for RX. So that
17 uses \$26,000,000.

18 And then in option three, the plan design here
19 takes a more liberal approach. So here we're using more than
20 what staff is recommending that we feel comfortable with.
21 We're using 34,000,000 instead of that 26,000,000 in
22 differential cash. And what this plan does is restores plan
23 design back to pre-pandemic levels as close as possible. If
24 you recall, the lower deductible plan was introduced in plan

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1 year '22. So the low deductible plan did not exist
2 pre-pandemic. And because you've got to space out actuarial
3 values between three plans, you don't want three plans that
4 are exactly the same, we had to tweak the plan design a
5 little bit to closely mirror that pre-pandemic benefit level
6 by adjusting for the co-pay plan design as well.

7 So in this plan design here we do have, you know,
8 again, the restoration of the deductible back down to 1,500
9 and 3,000 for the CDHP. The co-pay at zero for the low
10 deductible plan. The EPO is at zero as well, and we've
11 adjusted those out-of-pocket maximums as well. So there's
12 some options here.

13 We also after speaking to some Board Members we
14 came back and what we did was kind of tweaked some of these
15 plan designs so that is the amendment that was distributed
16 yesterday. And so you can see that there's some options
17 there where instead of an option two we are -- we're keeping
18 the co-pay pretty low on the deductible, but we're making HMO
19 and EPO zero dollars. We've also looked at some other
20 options, right. And so those alternatives are alternatives
21 of options two and three for -- for those plan designs.

22 So keep in mind that a lot of this, you know,
23 obviously there's a lot of contracts that are out there right
24 now. There's a lot of volatility within our plan. We do

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1 feel as staff with the recommendation, again, of the Aon team
2 that \$26,000,000, we feel pretty comfortable with that
3 amount. Going over that is, we're not quite ready going over
4 that amount to reach our plan design because we don't know
5 what it's going to look like. We don't know what costs are
6 going to look like, what COVID costs are going to look like
7 with the spike is, when that's going to end, right. You
8 know, what medical trend is going to look like moving
9 forward. So those are all options to consider.

10 The other thing too is the Board, I'll have to
11 remind the Board that regardless of the recommendation that
12 or what is the action that is taken today it will require the
13 approval of the Interim Finance Committee because this is
14 using differential cash to fund benefit plan restoration and
15 so this will need to be brought back to IFC for final
16 approval by the legislature.

17 So with that I will take questions. I think that
18 there's -- we also have the Aon team here who's ready to
19 answer questions as well. So I'll leave it at that.

20 CHAIRWOMAN FREED: Thank you.

21 All right. So this is Laura Freed for the record
22 by the way. So at the last Board meeting, Board Members, we
23 voted to spend about \$4,000,000 in differential cash in FY23,
24 '24 and '25 to enrich design plan. This report is giving us
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1 options to increase. That for option two it will be about
2 8.6 million dollars per year. And option three would be
3 about 11,000,000 dollars per year over three -- the three
4 upcoming fiscal years. Questions on the details of what
5 would change in these options?

6 Mr. Barnes, yeah, go ahead.

7 MEMBER BARNES: I had a question. Now that the
8 COVID testing policy and the surcharge have passed how does
9 that change the calculation of available excess spots?

10 MS. RICH: Laura Rich for the record. It should
11 not change the calculation at this point because we are using
12 those -- the surcharge to cover the costs of testing. And so
13 had we not approved the surcharge we might not even be having
14 this discussion today because we would have to allocate other
15 funding for those testing costs, and so -- so it shouldn't
16 affect it.

17 Now, that being said, you know, we don't know
18 what the future looks like, and so there's definitely room to
19 potentially next year to reassess, right. So we're making a
20 three-year decision here because we don't want to apply all
21 of the funding to one year and this fiscal cliff that you
22 keep hearing about. So -- so we're spreading it out between
23 three years. That doesn't mean that next year in November,
24 this time next year that when we're discussing plan design

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1 again that this can't be reassessed based on new information.

2 MEMBER BARNES: So Aon didn't include this in
3 their -- these costs in their estimates then?

4 MS. RICH: The surcharges were not included in
5 that.

6 But, Colleen, I don't know if you want to speak
7 to that.

8 MS. HUBER: Correct. We did not -- Colleen Huber
9 with Aon Consulting. Correct, we did not include additional
10 surveillance testing or surcharges into our excess capital
11 reserve level.

12 MEMBER BARNES: Okay. Thank you.

13 CHAIRWOMAN FREED: Member Aiello.

14 MEMBER AIELLO: Betsey Aiello for the record.

15 And you had mentioned then that option three was about
16 11,000,000 of differential cash in each of three years. But
17 some of that would have been the CFR dollars and the savings
18 also, correct, so it isn't quite that much in differential
19 cash.

20 CHAIRWOMAN FREED: The coronavirus relief that
21 we're going to get coming up at IFC I expect is being used in
22 this plan year, '22. And after that you can't get CRF after
23 December 30th I believe it is. So this is -- I mean, we
24 don't expect to get any other federal money for COVID claims

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1 in '23 and beyond. I'll let Laura speak to that in more
2 detail.

3 MS. RICH: Laura Rich for the record. So, right,
4 so the CRF funds that we're receiving are specifically to be
5 reimbursed for COVID claims that have already been incurred,
6 right. And so those claims are through the end of
7 December 31st, so the end of the year, December 31st. And so
8 that CRF money that we are receiving, although it's being
9 factored into the overall picture here, it's because the plan
10 is receiving the money and it is being allocated directly
11 towards those claims.

12 But as it, you know, downstream affects, right,
13 it's still, it's money that the plan didn't spend on those
14 claims because we've been -- we've been reimbursed through
15 CRF, and so it adds to the potential differential cash that
16 we've got to play with at the end of the year.

17 MEMBER AIELLO: So this is Betsey again. So my
18 question is because I'm trying to figure out, the trend does
19 not account for between five and 15 percent. So at least
20 that's my understanding. And then we're taking differential
21 money and spending it either in one, two or three. How much
22 money do we have that's differential or we're planning to do
23 between the five and 15 or five and ten if it's that because
24 I'm thinking we have some money we're planning there for the
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1 added claims or am I off thinking here?

2 MS. HUBER: Colleen Huber for the record with
3 Aon. You are correct. If you go back to the trend it is
4 peaking at the 12 percent right now, but we don't expect that
5 to continue. The 12 percent is really coming off of where
6 the year prior the claims were suppressed so dramatically
7 because of COVID. So when we're expecting over time and
8 through the end of plan year '22 for trend levels to return
9 back to normal or historical levels so that's where our -- we
10 went back after the last Board meeting, analyzed all of your
11 claims, used as much information as we had at that point,
12 looked at historical trend levels and with the current trend
13 levels are today realizing that the prior year the claims
14 were suppressed. We don't expect to see 12 percent through
15 the end of July of '22.

16 So as it returns back to normal levels what do we
17 project as of June 30th of 2022. What will the excess
18 surplus be at that point. And then to Laura's point then we
19 factored in the available, the funding that was received
20 during this plan year or this calendar year as well as what
21 we knew at that point as far as contract savings as a result
22 of the procurements going on. Does that answer your
23 question?

24 MEMBER AIELLO: Yes. But, I mean, so you
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1 factored all those in. And so then is it projected if you
2 say we're going to spend 26 or 28 or 33 which one zeros out
3 the differential cash after three years?

4 MS. HUBER: The 26. So as of June 30th, 2022
5 we're expecting the excess -- Colleen Huber for the record.
6 Sorry. At the end of June 30th, 2022 we're expecting your
7 excess surplus to be \$26,000,000. If we were to spend that
8 surplus over a three-year period that would be option two.

9 CHAIRWOMAN FREED: This is Laura Freed. I have a
10 question probably for Colleen Huber. There's a footnote on
11 their revised, on the plan design summary that we got
12 yesterday. And it says based on incurred claims normalized
13 for claim suppression due to COVID-19 trended to plan year
14 2023 based on five percent medical and eight percent
15 prescription trend.

16 So this was done -- this was projected based on
17 five and eight for the next three fiscal years?

18 MS. HUBER: Colleen Huber for the record.
19 Correct.

20 CHAIRWOMAN FREED: Okay. Got it. Thank you.
21 Mr. Verducci.

22 MEMBER VERDUCCI: Yes, Tom Verducci for the
23 record. So what I understand, Laura Rich had mentioned that
24 the -- anything that's approved here has to go before the
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1 IFC, GFO; is that right? So let's say we went back to our
2 July motion to restore the benefits to the pre-pandemic
3 levels, and say we did suggest option three but say it was
4 cost prohibitive from the IFC and GFO, couldn't there be some
5 hybrid model? I mean, I'm just wondering why would we just
6 limit the option two and not try to enhance the benefits to
7 the best of our ability within our budget constraints and let
8 it go before the IFC and GFO to see what's affordable.

9 MS. RICH: Laura Rich for the record. It's
10 certainly something that the Board and action item that the
11 Board can take the, perhaps the Board can vote on let's say
12 option three should it not get approved then we would vote to
13 option two. But, again, this all would have to go through
14 IFC and it's a good question. I don't know because we don't
15 have long runway, and we do need to be able to price out the
16 plans in March. And so Aon needs to understand what that
17 plan design looks like by February in order to come to the
18 March Board meeting and be prepared for rate setting. And so
19 we don't have a lot of room and timing for that, especially
20 given that we're bound by the IFC schedule. So it's -- it's
21 really, it's risky.

22 MEMBER VERDUCCI: Tom Verducci for the record.
23 So I think any -- any decision where we go on this should
24 allow some technical adjustments in terms of some of these
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1 variations that we've made. Like, you know, for example I
2 don't understand how some of our co-pays had changed here. I
3 mean, where do these figures come from? Was this from Aon as
4 far as some of these technical amendments on the plan design?

5 MS. RICH: Correct. And if Aon wants to address
6 that.

7 MS. HUBER: This is Colleen Huber with Aon for
8 the record. Correct. So within the grid itself, I'm not
9 sure if the question is on the grid itself, but you have your
10 current level, your current plan designs with the column to
11 the right of it, the pre-pandemic --

12 MEMBER VERDUCCI: Uh-huh.

13 MS HUBER: -- plan designs as in the proposed is
14 the third column and that you can see the impact of the, how
15 much of that would cost over the three-year plan design. And
16 so we mild it out for the CDHP plan, the co-pay plan and then
17 the EPO and HMO plan on the far right-hand side. All of the
18 cells colored green. I don't know if you have the black and
19 white.

20 But the items that are green are the changes
21 where we're trying to enhance the plan design and make the
22 actuarial value where the plan pays a greater share of the
23 cost compared to the member. All of those changes are
24 outlined in the green font.

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1 MEMBER VERDUCCI: Okay. Thank you. Yes, I do
2 see variations here in deductibles. And I just don't ever
3 recall having a discussion of the plan design and coming up
4 with these figures. So I was just trying to ascertain where
5 the figures came from. So I do see it's a process of Aon
6 coming up with final numbers here.

7 MS. HUBER: Right. This is Colleen Huber.
8 Again, for the record, our goal here was trying to target
9 certain dollar amounts while we were also trying to value the
10 impact of the actuarial value so how we measure what the plan
11 pays as opposed to what the member is, we wanted there to be
12 enough spread such that the member would understand the
13 different benefit offerings and then make a decision as best
14 for them in the most transparent way possible.

15 MEMBER VERDUCCI: Thank you.

16 CHAIRWOMAN FREED: I'll go to member Kelley and
17 then Member Aiello.

18 MEMBER KELLEY: Michelle Kelley for the record.
19 I just have a question about the self-funded plans or
20 primarily the CDHP. What percentage of participants hit
21 their maximum out-of-pocket on a rolling three-year average?
22 And I know that this year excuse it, but I'm still kind of
23 interested in that three-year picture.

24 MS. HUBER: Colleen Huber. One second. We have
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1 that and we actually looked it up last Board meeting.

2 MEMBER KELLEY: Can I ask a follow-up while
3 you're looking for that then.

4 MS. HUBER: Yes.

5 MEMBER KELLEY: I'm just wondering. I'm also
6 curious in the cost of each \$100 of HSA employer contribution
7 on the CDHP.

8 MR. ZETTINGER: Yeah. This is Tim Zettinger for
9 the record. So we have last two years for PY20 and PY21 for
10 the CDHP about six percent of employees where contracts have
11 reached their out the out-of-pocket maximum. For the EPO we
12 have 1.2 percent for PY20. And for PY21 we have half
13 percent.

14 And then for the HSA, so for every \$50 of seed
15 that we give to the employees this costs about \$3,000,000.
16 So for \$100 of seeding it will be \$6,000,000 and that's over
17 the course of three years as well.

18 MEMBER KELLEY: I'm sorry. I just want to
19 clarify that. So it's \$50,000,000 for \$50 per year for three
20 years?

21 MR. ZETTINGER: \$1,000,000 for a 50 dollar seed
22 per year.

23 MEMBER AIELLO: So this is Betsey Aiello for the
24 record. And this is probably a very elementary question.

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1 But as we heard you'll come back in February or March and do
2 the rate setting, and the rate setting is based on the -- the
3 plans we've chosen. And so for sure if we choose option two
4 or option three, everything else remaining the same, the
5 premiums for option three will be higher than the premiums
6 for option two.

7 So one of the things we're looking at here is
8 we've heard a lot of testimony that people want the higher
9 benefits, but I'm not sure that people want higher premiums
10 if they realize that that's what it's doing. But February is
11 going to be February. And so option one would have the very
12 lowest premiums option two middle and option three higher for
13 all categories would be my guess.

14 Mr. Barnes.

15 MEMBER BARNES: Yes, Jim Barnes for the record.
16 I wonder how confident is Aon in these projections? I mean,
17 what's the range of likely outcomes? Are you confident that
18 these are on point because I know for a dozen years running
19 that it's always been overconservative and I wonder if that's
20 done on purpose or do you feel confident these are hard
21 figures?

22 MS. HUBER: So this is Colleen Huber from Aon.
23 So these are the best information we have at this point. So
24 we are using your most up-to-date claims experience with a
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1 trend level of five percent for medical, eight percent for
2 pharmacy and three percent for dental.

3 We also factored into account any contract
4 savings that were a result of your procurement at that time,
5 as well as we did take into account the potential savings
6 that is out there today as a result of potential procurements
7 once you award that business. Now if you don't award that
8 business that would directly impact our calculations.

9 The other -- the biggest unknown would be on the
10 trend side so and, again, with the COVID factors and anything
11 that could potentially impact your trends, we went back to
12 your historical levels realizing that is most likely the best
13 indicator of your trend that we can see at this point, not
14 taking into account what we've seen in the last few years as
15 a result of COVID, with the very large claim suppression and
16 then followed by the claims were being returned back into the
17 system. We're just trying to use the best information that
18 we can as we get.

19 So we realize when we come back in the spring we
20 would again refresh all of our numbers, taking into account
21 the most up-to-date information that we have whether it's the
22 inflation levels, whether it's current trends, whether it's
23 national trends, Nevada's trends specifically, we try to
24 factor those all into consideration as much as we can and

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1 then continually refresh our projection such that you all as
2 Board Members have information that you need to make those
3 decisions.

4 MEMBER BARNES: Okay. Thank you.

5 MS. HUBER: Sure.

6 CHAIRWOMAN FREED: This is Laura Freed. I think
7 it's worth pointing out that legislatively approved trend for
8 '22 and '23, medical is 3.52 percent and prescription is four
9 percent. So for, you know, Aon using five and eight as sort
10 of post COVID normalized it's higher than what PEBP has in
11 its budget for trend. And that's one of the reasons that,
12 you know, I feel a little bit less comfortable with option
13 three. I mean, this is tough for me because I would like to
14 restore benefits and, you know, make things sort of what they
15 use to be for participants as much as anybody else.

16 But to Member Aiello's point that, you know,
17 \$26,000,000 is the cash we have, and so it's got -- so the
18 differential between 26 and 33 has got to come from
19 somewhere, and it's not coming from subsidy dollars because
20 that's set in law so it's coming from premiums and that would
21 be -- that's the choice.

22 And we've got a trend in the ledge approved
23 budget that is less than what our actuaries think it is, it
24 really is or should be to the best of our knowledge. All

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1 right, sorry.

2 Ms. Bittleston, you had a question.

3 MEMBER BITTLESTON: Yes. Leslie Bittleston for
4 the record. On the addendum it says that this assumes an
5 80 percent vaccination rate. So when we start, we the
6 members start providing our vaccination information when we
7 start doing the COVID surcharge, my question is will these
8 plans change if we find out that there's an actual 60 percent
9 or actual 90 percent? Will the numbers change when we get
10 the actual vaccination rates?

11 MS. HUBER: This is Colleen Huber for the record.
12 The vaccination rate will not change the plan designs at this
13 point. So there would be no result of that. Thank you.

14 Mr. Verducci, go ahead. Thank you. Tom Verducci
15 for the record. I'm trying to figure out what we have in
16 differential cash, excess cash. We normally have a budget
17 and there's utilization reports in this binder. And I'm kind
18 of wondering why we have such thin material here. I mean,
19 it's usually a real thick packet that shows up. And we have
20 a thin packet today without utilization and budget reports.
21 I'm just wondering where did it go?

22 CHAIRWOMAN FREED: And, Mr. Verducci, this is
23 Laura Freed. I think I'll take the blame for this one. I
24 made a concerted effort thinking that Items 6 and 7 would
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1 take a long time and there would be voluminous public
2 comment, and I didn't want to make you guys commit nine hours
3 to this meeting. I removed from the agenda a lot of the
4 usual budget report and utilization report stuff that you're
5 correct we do see. I wouldn't normally do that, but I made
6 that decision based on time constraints because I don't want
7 you guys to starve to death and stay here all day.

8 MEMBER VERDUCCI: Tom Verducci. I actually
9 prefer the additional information just as an FYI.

10 CHAIRWOMAN FREED: Noted.

11 MEMBER VERDUCCI: Normally we have the
12 performance guarantees. And my question that I couldn't find
13 here is how much excess reserves to we currently have on
14 hand? I think I was reading 40,000,000, and I don't know if
15 that's overstated or understated but usually that comes out
16 of the budget report.

17 MS. RICH: I'm going to put our CFO, who's on
18 Zoom, on the record here. Cari, do you mind giving the exact
19 amount.

20 MS. EATON: Hello. This is Cari Eaton for the
21 record. I believe it is projected at this moment, let's see.
22 Sorry, it's not pulling up. I believe it was at around
23 30,000,000, but I will try and get it pulled up.

24 MS. RICH: So at the -- Laura Rich for the
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1 record. At the last Board meeting we were looking at close
2 to 40ish, but we made, obviously there's some buydown
3 subsidies and Medicare HRA and things that we are required to
4 use that differential cash for. And that has, you know, that
5 would bring down those numbers.

6 But what I do want to say is the projection,
7 again, overall, we have to keep in mind that the projected
8 savings from all of these contracts are taken into account
9 here and that is not part of the budget report. And so what
10 we're looking at is projected savings, and I can't go line
11 item by line item, and I have to aggregate it all because of
12 the confidential nature of -- of the solicitation process.
13 But there is a very insignificant amount of savings in these
14 contracts that have contributed to the higher amount.

15 And so, Mr. Verducci, it's not -- it's not
16 necessarily just the, what you would see on the budget
17 report. It's additional items that staff and Aon have taken
18 into consideration because of the projected savings that the
19 plan will likely experience next year as these contracts are
20 put into place.

21 MS. HUBER: And this is Colleen Huber. Just for
22 the record, Aon is working very closely with Laura and her
23 staff. Just with every type of negotiation or contract
24 change or procurement award we are always reevaluating and

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1 incorporating that into our projections just to ensure that
2 we are using the most up-to-date information possible. So we
3 try to work closely with Laura and her staff on that.

4 MS. EATON: This is Cari Eaton for the record
5 again. I did pull up that projection. And currently the
6 projection is at 13.5 million but it does change throughout
7 the year.

8 MS. RICH: And Laura Rich for the record. This
9 is all part of the discussion as to why we only discuss
10 differential cash one time a year. It's a snapshot in time.
11 It depends. There's -- it goes up and down throughout the
12 year, and so it is very difficult to take a point in time,
13 just like Cari said a month ago, it was probably a lot
14 different than it is today, right. And so it's just a
15 snapshot in time. That is why we have made a decision to
16 discuss that one time here and that is after the budget is
17 closed and we've closed the books for the year so that's at
18 the September Board meeting.

19 So really what we're using here is the September
20 Board meeting information and what we've done since then in
21 terms of projections and, you know, cost savings to the plan.

22 CHAIRWOMAN FREED: Member Kelley.

23 MEMBER KELLEY: Michelle Kelley for the record.

24 So I'm just looking at the different options which kind of
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1 expanded to six, right, from three to six and just with
2 slight tweaks. So, Executive Officer Rich, which is the
3 staff's recommendation at the moment?

4 MS. RICH: So the staff recommendation is really
5 any of the options that hover around that \$26,000,000, right,
6 and so that is what staff feels comfortable with. So in
7 terms of, you know, option two, we're looking at either
8 option two that was originally in the report or the slight
9 tweaks in option two that you see in the addendum, right, and
10 so really either one of those works.

11 You know, the option two in the addendum is more
12 closely to, similar to the plan that's in place today where
13 the EPO and HMO have lower or no co-pays to the co-pay plan,
14 right. And so the addendum is, it kind of tweaks it a little
15 bit to more closely relate to what we've got today. But
16 really, I mean staff is comfortable with anything that the
17 Board would choose that uses that 26,000,000 dollar option.

18 MEMBER KELLEY: Michelle Kelley for the record.
19 Just a follow-up on the CDHP. So none of the kind of option
20 for that is the same across upward different designs, you
21 know, I guess one and one on the revised. Can you talk about
22 why, kind of the choices you made here. I know the Board had
23 directed in September kind of bringing those deductible and
24 the OOP's down. And in this option you've done that but

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1 you've left the HSA stable between now and the 600 and 600.

2 Did you explore kind of looking at maybe keeping
3 the OOP a bit higher and offering members of that plan a
4 little more in HSA money? Did that end up being cost
5 prohibitive? Is there rhyme or reason to this choice I
6 guess?

7 MS. RICH: So I think that Tim or either Colleen
8 can address this. I know that they've looked into this and
9 have this information available as well.

10 MR. ZETTINGER: Yeah. So this is Tim Zettinger
11 for the record. We looked at what we could provide to each
12 employee on HSA seed to replace those out-of-pocket maximums
13 on each of those options. So for current plan designs we
14 have a 5,000 dollar out-of-pocket maximum, and for option one
15 we dropped that to \$4,400 for employee only.

16 Now we can provide each employee in the CDHP \$80
17 of HSA seed and that would have an equal cost for the CDHP
18 over three years.

19 Similar to option two we can provide \$160 in HSA
20 seeding and replace that 4,000 dollar out-of-pocket maximum.
21 And then in option three we can provide \$180 in seeding to
22 replace the \$3,900 out-of-pocket maximum. So all of those
23 options went back to 5,000 dollar, \$10,000. That's what we
24 can provide for the same cost over the three years in HSA

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1 seeds.

2 CHAIRWOMAN FREED: Mr. Verducci.

3 MEMBER VERDUCCI: So Tom Verducci for the record.
4 So what I'm reading here is option one would be \$33,000,000
5 for the next two plan years. And option two would be
6 \$26,000,000. So we have a difference of about 7,000,000.
7 And we just approved COVID surcharge that brings more money
8 in and if we don't end up with the full 33,000,000 there
9 could be some give and take as we get into the next meeting.
10 I'm going to support option three. I know 26,000,000 is more
11 in line with option two. But I like option three.

12 CHAIRWOMAN FREED: Is that a motion,
13 Mr. Verducci, or is that just a statement?

14 MEMBER VERDUCCI: If are we down to motion time
15 so moved.

16 CHAIRWOMAN FREED: Well, I don't know. I always
17 love when the questioning peters out and I'm sort of trying
18 to get a substantive or are we ready to make a decision?

19 MEMBER VERDUCCI: So Tom Verducci. I would like
20 to make a motion that we approve option three.

21 CHAIRWOMAN FREED: Okay. Board Members, is there
22 a second on that motion?

23 MEMBER KELLEY: I'll second.

24 CHAIRWOMAN FREED: All right. So the option
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1 before the Board is to use 33,000,000, in other words so
2 option three of the revised plan design that we got yesterday
3 not the original option three that we got in the original
4 meeting packet for a total of \$33,000,000 in differential
5 cash.

6 Oh, I'm sorry, yes, is there a question on the
7 motion? Go ahead.

8 MEMBER AIELLO: This is Betsey Aiello for the
9 record. And I just want to ask another question. We really
10 aren't going to run out of money because the -- this option
11 will be priced higher in premiums, correct, or we could run
12 out of money?

13 CHAIRWOMAN FREED: Oh, I would love to kick it to
14 Aon but I know from budget experience, I'll start talking --
15 yeah, I'll run my mouth, okay.

16 All right. We've only got one more fiscal year
17 of this current biennium, and we have cash in the bank, if
18 you will, more than what it would cost of one year of
19 enhancement at option three. But then we don't know what
20 happens in budget years '24 and '25. And if we end up with
21 less than the three-year total of \$33,000,000, right, that
22 would be an increase in subsidies during budget building or
23 an increase in premiums during plan design and rate setting
24 so you're right in that sense.

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1 Aon, would you like to add anything to that?

2 MS. HUBER: This is Colleen. I agree with
3 everything Laura Rich just said. Also keeping into account
4 and I'm not sure, these would be the plan design changes for
5 the next upcoming plan year. And I would imagine you also,
6 since this is a three-year look, you would be able to also
7 readjust if needed as well. That could be another option
8 too.

9 MEMBER KELLEY: Michelle Kelley here.

10 CHAIRWOMAN FREED: I'm going to throw it to
11 Ms. Bittleston first and then I'll go to Michelle Kelley.

12 MEMBER KELLEY: Okay.

13 MEMBER BITTLESTON: This is Leslie Bittleston.
14 I'm not supportive of plan, I mean premium increases. And I
15 think option three would increase premiums for all members.
16 And I'm also very concerned about sustainability. You know,
17 we talk a lot about sustainability and listening to Executive
18 Member Rich, you know, she provided those different options
19 and then what the Board was comfortable with.

20 So I would rather go with a more conservative
21 option rather than give members benefits for a year or two
22 and then run out of money and have to come back and say
23 sorry, no more money. We have to change again. So I'm
24 concerned about premiums, and I'm concerned about

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1 sustainability, and I won't be supporting option three.

2 CHAIRWOMAN FREED: Okay. Member Kelley?

3 MEMBER KELLEY: Michelle Kelley for the record.

4 So, you know, I think one of the struggles for everybody
5 involved in this process is that in the past Aon has done its
6 job very well, and its projections have been conservative.
7 Even the aggressive projections have been somewhat
8 conservative, and we have ended up with excess reserves that
9 have been swept by the state.

10 And so I think that given that the Board made the
11 very prudent decision in September to kind of try and spread
12 these giving back the money across three years for good
13 reason to say that we didn't have to increase premiums and we
14 also, you know, could keep plan design somewhat stable. I
15 acknowledge that. I think it's a really prudent decision.

16 But I also think that employees right now are
17 extremely challenged and that's why I'm supportive of this
18 motion. We have the option if claims projection gets worse
19 over the next few months it's going to start to tell a story,
20 right, people are starting to get services again. I think
21 the Board has the option every year to tweak plan design.

22 And I think that I'm supportive of the more aggressive
23 conservative option this time because I do think we have
24 options available to us in year two and year three, if it

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1 gets out of hand as in the trends get out of hand or we do
2 start to spend our money, and I think we can do that
3 prudently and think employees will understand.

4 But what I heard during public comment is that
5 employees need the relief now, and so that's kind of where
6 I'm coming from. Thank you.

7 CHAIRWOMAN FREED: Okay. So there is a motion on
8 the floor. It's been moved and seconded to approve option
9 three to use up \$33,000,000 in differential cash over the
10 next three plan years. All in favor signify by saying aye.
11 So I have Mr. Barnes, Mr. Verducci and Ms. Kelley. Do I have
12 -- and thank you, Ms. McClendon.

13 Okay. Nays say nay. So I have Ms. Bittleston,
14 myself, Ms. Fox, Ms. Coughron and Ms. Aiello.

15 (The majority of the vote was not in favor of the
16 motion.)

17 CHAIRWOMAN FREED: Okay. Motion fails. Do I
18 have an alternate motion?

19 VICE CHAIR FOX: Linda Fox for the record. I
20 will make an alternate motion and my motion would be option
21 two in the original packet.

22 CHAIRWOMAN FREED: Option two of the original
23 packet, okay. Do I have a second to that?

24 MEMBER BITTLESTON: Leslie Bittleston. Second.
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1 CHAIRWOMAN FREED: Okay. All right. So it's
2 been moved and seconded to approve. Option two, using
3 approximately \$26,000,000 in differential cash from the
4 original packet plan design, not the updated one from
5 yesterday. All those in favor signify by saying aye. Any
6 opposed nay.

7 MEMBER VERDUCCI: Nay.

8 MEMBER BARNES: Nay.

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

11 CHAIRWOMAN FREED: Okay. Motion carries.

12 All right. Okay. Since we took 6 and 7 out of
13 order now we're going back to Agenda Item 4, the consent
14 agenda. Board Members, you've seen the minutes and the,
15 PEBP's ARP, rescue plan funds request. Do you have any
16 questions on either of these consent items? Hearing none
17 I'll accept a motion to approve.

18 MEMBER BITTLESTON: Leslie Bittleston. So moved.

19 CHAIRWOMAN FREED: Okay. Do I have a second?

20 MEMBER CAUGHNOR: April Coughron for the record.
21 I'll second.

22 CHAIRWOMAN FREED: Thank you.

23 Okay. All those in favor signify by saying aye.
24 Anybody opposed say nay.

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

3 CHAIRWOMAN FREED: Motion carries.

4 Executive Officer Report, Agenda Item 5.

5 MS. RICH: All right. Laura Rich for the record.
6 The -- a lot of stuff we've already covered actually. The
7 federal funding update, as the Board knows in October the
8 Interim Finance Committee approved PEBP's 5,000,000 dollar
9 work program for the CRF funds so we will be receiving
10 \$5,000,000 for reimbursement of COVID related claims. But in
11 November PEBP was informed by the Governor's Finance Office
12 an additional \$5,000,000 would be made available to PEBP for
13 additional CRF money that is set to expire on 12-31 or 21.

14 The problem is that these claims have to be
15 reimbursed and so they have to occur and be reimbursed by
16 December 31st, and so we did not project that we were going
17 to have an additional \$5,000,000 in COVID related claims by
18 that point, and so we've reduced that amount to 3.6 million
19 dollars in CRF funding so that is on the December IFC agenda
20 for consideration.

21 And then, you know, you've heard also from
22 Director Young who even though we have received 14.9 million
23 dollars in CRF funds to date not inconclusive of that 3.6
24 million dollars that we are set to receive at the next IFC.

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1 It does not appear that PEBP will be receiving additional
2 funding through the American Rescue Plan appropriations.
3 There's apparently too many competing priorities. So that is
4 not something that the plan is going to receive as you heard
5 Director Young speak to earlier.

6 The enrollment eligibility system update, I just
7 wanted to talk about implementation issues. So around this
8 time last year LSI was awarded the contract for PEBP's
9 enrollment and eligibility system RFP. LSI also contracted
10 through the office of project management to oversee the Smart
11 21 statewide ERP implementation. This replaces the State's
12 legacy IT systems including finance, payroll and HR
13 management.

14 Although, LSI won the contract for enrollment and
15 the eligibility system the work with PEBP is mainly being
16 performed by their subcontractor benefit Focus. So with only
17 weeks until PEBP is due to go live with this new system, it's
18 become apparent that there's a significant chance with some
19 critical functionality that may not be ready by January 21.

20 A major component of the implementation of
21 involved assumptions involving PEBP's ability to integrate
22 with the new Smart 21 technology rather than the current
23 antiquated IT systems that the state has in place today. But
24 delays in the Smart 21 project have added additional

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1 unplanned for an out-of-scope integrations that have hindered
2 PEBP's progress on our enrollment eligibility system
3 implementation.

4 So in addition, the challenges experienced on the
5 Smart 21 implementation have taxed critical resources which
6 are also vital to PEBP, DHRM, and DHRM is the division of
7 human resource management and the office project -- project
8 management.

9 Throughout the implementation there's been many
10 assumptions that have been made, some lack of communication,
11 some lane changes and components that were not thoroughly
12 discussed and that has contributed to concerns about a
13 successful go live at the end of the year.

14 In several cases the issues causing concern were
15 not brought to our attention until very recently. And when I
16 say our attention it would be PEBP. Most importantly there's
17 concerns for payroll where they will potentially affect
18 PEBP's ability to collect premiums and -- and in the, and how
19 this is going to affect, you know, on the payroll side as
20 well.

21 So these issues have been escalated to LSI
22 leadership, and PEBP has been assured that the critical
23 payroll issues will be resolved, and that there will be a
24 successful go live of the new system on January -- on

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1 January 1st. The updates I've received so far is they are
2 making progress. But I think it is prudent for the Board to
3 understand that there's -- you know, we're down to the wire
4 and we are experiencing some very major concerns with this
5 implementation.

6 We do have a voluntary benefits update. Due to
7 the midyear eligibility system change from the life works and
8 Core Stream product that we have today to benefit Focus a
9 two-week voluntary benefit special enrollment period occurred
10 between November 8th and November 19th, and this period
11 allowed members to enroll or cancel their voluntary product.
12 So some new voluntary products were offered. Some of them
13 remain the same, and this allowed members to go in and make
14 changes during that time.

15 The below enrollment chart on page three reflects
16 approximately 72 percent of the total 2,960 additional
17 enrollments that occurred during this period. We have a
18 brand new plan offerings mostly with the standard who
19 replaced Aflac for accident and critical illness and hospital
20 indemnity plans, as well as the new long-term disability plan
21 that we offered in order to replace the benefit cut that was,
22 it came out of the last plan year benefit cuts. So this is
23 now the long-term disability plan is offered on a voluntary
24 function.

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1 This period also allowed members to create new
2 accounts and become familiar with the system before it goes
3 fully live at the end of the year with 2,370 new accounts
4 that were created and over 4,300 log-in's. So you can see on
5 that chart we do have quite a bit of enrollment. It shows
6 what people were enrolled in versus, you know, what changes
7 happened through this enrollment period.

8 We do have in the audience today Aon as well
9 joining virtually. Both members representatives from Benefit
10 Focus and from LSI here as well if the Board has any
11 questions for them.

12 CHAIRWOMAN FREED: Board Members, questions.
13 Ms. Bittleston.

14 MEMBER BITTLESTON: Leslie Bittleston for the
15 record. I have a question for LSI. According to Executive
16 Officer Rich's report it looks like there was some problems
17 and delays with implementation that were not communicated in
18 a timely manner.

19 So my question to the vendor is why were those
20 issues not communicated more timely and rather communicated
21 just before implementation. So that question is for the
22 vendor. Thank you.

23 MS. RICH: It looks like so Scott Muir is in the
24 audience and I see his jacket there but he's not in the --
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1 CHAIRWOMAN FREED: I do not see Mr. Muir from
2 LSI. That's disappointing.

3 MS. RICH: Is there anyone on Zoom that is
4 available either from LSI or Benefit Focus that can speak to
5 that?

6 MS. HUGUS: This is Meghan Hugus from Benefit
7 Focus. And I just want to make sure the question was more
8 specific for the model Smart 21 or was it for the Benefit
9 Focus payroll?

10 MS. RICH: I think the question was surrounding
11 the delays and why the delays on the Smart 21 project were
12 not communicated in a timely manner to the PEBP project and
13 specifically since LSI oversees both of these projects. So
14 they oversee the Smart 21 and they also hold the contract for
15 the PEBP implementation as well.

16 MS. HUGUS: Okay. Probably would need LSI or
17 need Scott to pipe in on the overall.

18 CHAIRWOMAN FREED: This is Laura Freed. Well, if
19 there's no one that can answer the question then I guess
20 we'll have to table it. And the Board can always ask
21 Ms. Rich and her staff to send a letter to LSI with the
22 Board's questions. For me the question, and I guess this is
23 more for PEBP staff. The staff report says these issues have
24 been out. Escalated LSI leadership and PEBP has been assured

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1 the critical payroll issues will be resolved, and there will
2 be a successful go live on January 1st. What in PEBP's
3 feeling is a successful go live? What does it look like?

4 MS. RICH: Laura Rich for the record. First I
5 would like to ask one of my staff, Nik Proper, would you mind
6 going out there and grabbing Scott. He's probably on the
7 phone out there. Yeah, thank you.

8 And to answer your question, Chair Freed, so when
9 there's an implementation, especially as complex and, you
10 know, in vast as the enrollment and eligibility system for
11 PEBP is we always expect that there's going to be some
12 hiccups, right. No IT implementation goes 100 percent
13 smoothly. You're going to expect some issues.

14 My expectation for a smooth go live is that
15 members are able to access their accounts. They are able to
16 enroll in health benefits, right, so in insurance and if they
17 are new employees. And that they are able to make changes to
18 their current enrollment as far as adding dependents or
19 taking dependents off, et cetera, et cetera, right. And then
20 also that the payroll components are performed smoothly.

21 And we have payroll deductions that occur in a
22 timely manner and do not affect employees in a negative way
23 to where, you know, now their paychecks are affected because
24 they do not have premiums taken out or, you know, we've got

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1 to take two out at a time or, you know, something like that.

2 So it really, what I'm looking for is overall
3 mitigation of any employee impacts to their paychecks and
4 their ability to enroll in health insurance.

5 CHAIRWOMAN FREED: How confident is PEBP staff
6 that all of those good things will happen by January 1st?

7 MS. RICH: So I don't want to put Mr. Proper on
8 the spot but he's the one who's been overseeing this project
9 and is knee-deep in this. I would like him to speak if
10 possible.

11 MR. PROPER: Nik Proper for the record. Thanks,
12 Ms. Rich. So at the time the Board report was written
13 there's been multiple daily meetings since and a lot of new
14 development work underway which I feel productive. I feel
15 we're in a good spot at this point.

16 At the time of this report and at the end of
17 October we were all scrambling because of the shift from
18 Smart 21 to continuing Advantage and Legacy systems which was
19 out of scope for this implementation with Benefit Focus.
20 That caused new files needing to be built this week and last
21 week, and we're at a very good point.

22 But this has also caused downstream effects for
23 internal PEBP processes with a lack of training and other
24 components that we've not finished discussing until this week

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1 and next week really.

2 CHAIRWOMAN FREED: This is Laura Freed. To
3 follow-up, Mr. Proper, so has the Benefit Focus files
4 compatible with Advantage been built, loaded into Advantage
5 and tested, and if not where are we in that process?

6 MR. PROPER: Thank you, Chair Freed. Nik Proper
7 for the record. Yes, they have been built. They have been
8 sent, and we are currently in the middle of testing these
9 files back and forth with DHRM.

10 CHAIRWOMAN FREED: Okay. It appears we have the
11 correct witness back in the room. So, Ms. Bittleston, if you
12 would like to pose your question once again that would be
13 good.

14 MEMBER BITTLESTON: Sorry. I tried to destroy my
15 microphone. Leslie Bittleston for the record. And this is
16 from Executive Officer Rich's report directed to the vendor
17 who is LSI. So in Ms. Rich's report there was some
18 discussion about some problems due to implementation and the
19 late or untimely communication of those problems.

20 So my question is why was there not more timely
21 communication around the implementation with, specifically
22 around the benefit piece of this. I hope I said that right.

23 MS. RICH: Yeah, Scott, if you would please
24 address that question. Thank you.

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1 MR. MUIR: Board Members, Scott Muir for the
2 record. I am the executive program manager for LSI on both
3 Smart 21 and the PEBP project. So to your question on
4 communications, I just want to make sure I captured it right.
5 On why there wasn't more pre-advanced notice around the delay
6 or the need to make the switch, if you will, to the Advantage
7 system.

8 MEMBER BITTLESTON: So as a long time state
9 employee, I mean I understand the RFP. And I understand you
10 were selected as vendor. So the question is as you began
11 your process as a vendor and you began to maybe identify some
12 problems that, you know, it sounds like those problems were
13 not communicated timely to PEBP. So my question to you is
14 why was there a lack of communication. And what could you
15 have done to do better, you know, because we have a
16 January 1st implementation, right.

17 MR. MUIR: Uh-huh.

18 MEMBER BITTLESTON: So what would be able to make
19 that on time.

20 MR. MUIR: Uh-huh.

21 MEMBER BITTLESTON: And my question why there
22 wasn't better communication.

23 MR. MUIR: Sure. And I defer to Nik as well. I
24 believe when we started to understand that there was going to
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1 be a delay -- let me back up one step. So the original plan
2 was to couple the PEBP project with a Smart 21 project as it
3 relates to being able to use a Smart 21 payroll platform and
4 not have to rely on the Advantage platform. And those
5 project dates at the time both contracts were awarded and
6 planned for all seemed to coincide.

7 I believe, and I'll go back through the records,
8 I believe when we started to understand that there were going
9 to be delays in the Smart 21 project we did communicate that
10 from the Smart 21 side. I think the OPM side started to
11 communicate that. I believe we communicated that as well.
12 We didn't know exact delays at that point, and I think it was
13 like midsummer to end of summer, but I'll get you the exact
14 dates.

15 But when we started to get closer to
16 understanding that Smart 21 was not going to go live from a
17 payroll perspective on January 1st as planned, we all worked
18 together, Benefit Focus, ourselves, OPM to then figure out
19 how we could continue to make the January 1st go live
20 successful. And as I think Nik pointed out where we are
21 right now, we've all come together as the parties. And I
22 just checked this morning before I came over. The testing is
23 going well.

24 And as we sit today, not to say there won't be
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1 things that will pop up, but the collective team, and I asked
2 Nik to kind of chime in here as well, the collective team
3 believes that we are on track and we will make the
4 January 1st go live for PEBP. And we will have that full
5 integration with Advantage for the time period that's
6 required until Smart 21 is live on January 1st, 2022.

7 MEMBER BITTLESTON: So as a follow-up -- thank
8 you. As a follow-up, having worked with vendors for a lot of
9 years, unfortunately I've experienced vendors that sometimes
10 bite off more than they can chew.

11 MR. MUIR: Uh-huh.

12 MEMBER BITTLESTON: So they say they can do this
13 but they can't.

14 MR. MUIR: Uh-huh.

15 MEMBER BITTLESTON: Or they can but it's going to
16 take more time.

17 MR. MUIR: Uh-huh.

18 MEMBER BITTLESTON: So as a vendor of PEBP we
19 would expect or I would expect any vendor of the State of
20 Nevada to be very communicative and to say, you know, we've
21 got some issues here.

22 MR. MUIR: Uh-huh.

23 MEMBER BITTLESTON: Maybe it's just with a piece
24 of it.

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1 MR. MUIR: Uh-huh.

2 MEMBER BITTLESTON: You know, to be more
3 proactive.

4 MR. MUIR: Uh-huh.

5 MEMBER BITTLESTON: Because this affects a lot of
6 members.

7 MR. MUIR: Uh-huh.

8 MEMBER BITTLESTON: And we want to make sure like
9 Executive Officer Rich said that we don't want to take two or
10 three premiums at once because the payroll system isn't
11 working.

12 MR. MUIR: Exactly.

13 MEMBER BITTLESTON: Or something like that.

14 MR. MUIR: Yeah.

15 MEMBER BITTLESTON: Because everybody has heard
16 it. Our members, we've heard it.

17 MR. MUIR: Uh-huh.

18 MEMBER BITTLESTON: So it's just we would expect
19 our vendors to, you know, be more proactive rather than less
20 proactive.

21 MR. MUIR: Uh-huh.

22 MEMBER BITTLESTON: So untimely communication
23 doesn't make me happy.

24 MR. MUIR: Okay.

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1 MEMBER BITTLESTON: So anyway, but so thank you
2 for your answer, and we look forward to a successful
3 implementation on January 1st.

4 MR. MUIR: And if I could just follow-up. I just
5 want to acknowledge that and that we have put remediation
6 steps in place both on the Smart 21 side and the PEBP side to
7 have that effective regular communications. And I would hope
8 that Laura and the team would all acknowledge that we have
9 tried to mitigate that. So thank you.

10 CHAIRWOMAN FREED: Mr. Barnes?

11 MEMBER BARNES: Yes. For Executive Rich, Jim
12 Barnes for the record, will the next open enrollment allow
13 members to buy long-term disability insurance without a
14 medical review?

15 MS. RICH: Laura Rich for the record. So
16 long-term disability is offered as a voluntary product. And
17 so I'm going to have to defer to Nik Proper because he is
18 much more familiar with the terms of these products than I
19 am.

20 MR. PROPER: Thank you, Ms. Rich. Nik Proper for
21 the record. To be able to qualify for a long-term disability
22 plan or other life insurance voluntary benefits they must be
23 approved through and evidence of insurability and medical
24 forms. We cannot bypass that requirement, and that is a
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1 requirement of the carrier.

2 MEMBER BARNES: Okay. Thank you.

3 CHAIRWOMAN FREED: This is Laura Freed. I have
4 one final question for PEBP staff. Does the contract with
5 LSI and Benefit Focus penalties that will be assessed if on
6 go live the wrong premium is deducted from a member's
7 paycheck or the data transfer doesn't work or one of those
8 other things that we are afraid of happening, i.e., the
9 option of what Ms. Rich described as a successful rollout
10 happens. And what are those penalties?

11 MS. RICH: Laura Rich for the record. That is a
12 very good question. I would actually have to pull up the
13 contract and look at specifically those.

14 CHAIRWOMAN FREED: That's okay. You can get back
15 to me.

16 MS. RICH: Okay.

17 CHAIRWOMAN FREED: Okay. Board Members, this is
18 a discussion not an action item. So if nobody has anymore
19 questions, comments we can move on.

20 All right. So we'll move to Agenda Item 8 and
21 here I want to -- I want to caution that if there are
22 detailed questions before I throw it to Ms. Eaton, if there
23 are detailed questions we may have to go into closed session.
24 And so depending on the questions I may call timeout and tell
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1 Broadcast that we need to go into closed session.

2 MS. RICH: So Laura Rich for the record. Ms.
3 Eaton usually gives this report, and she is on but she is on
4 vacation technically. So I don't want to make her do anymore
5 work than she needs to do. So I told her I would do the
6 report for her.

7 So 8.1, you guys have seen this. This is just
8 the contract's overview. This is the table that's included
9 in this report typically.

10 So I'll just move to 8.2 which is new contracts.
11 The PEBP Board approved the solicitation for a TPA third
12 party administrator to include TPA medical, dental and
13 national network as well as a statewide network and
14 subrogation services on January 28th of '21. At that same
15 Board meeting the separate solicitations for telemedicine, a
16 shopping comparison tool, second opinion services and HSA and
17 HRA administration services with those contracts -- with the
18 contracts being held by the TPA.

19 So the RFP's were released for the TPA, HSA and
20 HRA administrator second opinion services, telemedicine
21 service and telemedicine services and PEBP staff have
22 negotiated, successfully negotiated contracts for all of
23 these.

24 So the first one at 8.2.1 is the TPA. On
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1 April 26th, 2021 the Public Employees' Benefits Program
2 released the proposal for the TPA. What we were looking at
3 here is to acquire a health and dental benefits administrator
4 that would be a strategic partner in providing the services
5 in the scope of work.

6 And so we looked at requiring an out-of-state
7 medical network as well as an optional in-state network as
8 well. PEBP required that the winning TPA agree to hold
9 contracts for all ancillary services which is the HSA and HRA
10 administration shopping tool and the second opinion in
11 telemedicine services.

12 So vendor responses were scored based on minimum
13 qualifications and critical items, technical customer
14 service, financial network access and member disruption as
15 well as finalist presentations. On June 2nd PEBP received
16 seven proposals in response to this RFP, and the evaluation
17 period began on June 25th and ended on August 9th. The
18 evaluation committee was included to PEBP Board Members and
19 many other subject matter experts as well.

20 UMR received the highest score by the evaluation
21 committee and PEBP has successfully negotiated a contract.
22 And just to be clear, although HealthSCOPE Benefits is the
23 incumbent, they are -- they were bought out by UMR. And so
24 basically it's -- UMR is not the incumbent but is the closest
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1 to it really, and so it's not -- the transition would not be,
2 really they have got all our data. We would have the same --
3 the same account reps and so it's even though UMR submitted
4 the proposal it's still using the HealthSCOPE Benefits staff
5 with some changes, technology changes and things like that.

6 So some of the highest scoring areas by the
7 evaluators were the innovation and delivery system, network
8 access and management, account management, customer service
9 website and mobile app capabilities, communications, a
10 finalist presentations and vendor experience.

11 So UMR will be the new vendor for PEBP for TPA
12 services. However, since UMR is the parent company to the,
13 as I said to HealthSCOPE Benefits the transition is expected
14 to be overall less disruptive for members and will require
15 minimal implementation to -- you know, to move onto that
16 product.

17 As part of the proposal UMR submitted two network
18 options, one using the incumbent network which is Aetna and
19 another leveraging Choice and SHO. The Aon analysis shows
20 that minimal -- minimal in-state disruption, significant cost
21 savings with the latter. So additionally by leveraging the
22 proprietary networks members were able to take advantage of
23 self-service technology in the UMR portal but is currently
24 not available through PEBP today, such as shopping comparison

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1 tools, interactive provider searches and insight into prior
2 authorization requests.

3 So in order to use the Choice and SHO networks
4 and have access to the above, UMR also requires utilization
5 management and case management services to be incorporated
6 into this contract. And currently PEBP contracts with
7 American Health Holdings for these services. So that
8 contract is due to expire on June 30th of 2023. So PEBP must
9 issue a no cause termination in order to end that contract a
10 year early.

11 Additionally, PEBP will also need to issue no
12 cause termination to Aetna who currently holds that contract
13 for the in-state network as well. And although this contract
14 was recently awarded because, and just to give you a little
15 bit of background. So typically when the industry standard
16 is to RFP for a TPA that comes with a network, right, and so
17 it's kind of a bundle deal. Typically organizations don't go
18 out to bid for a TPA and then in-network. Because those two
19 are so closely associated it comes as a package deal.

20 PEBP was set up in a way that we had to -- we put
21 it in a place last year or two years ago now that we, our
22 contract was expiring and we had to go out to bid in order to
23 secure a new network. But we wanted to fix this by at least
24 allowing a TPA to propose a network and -- and taking it as a

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1 the evaluation committee's recommendation to contract with
2 UMR for third party administration and associate services
3 beginning July 1st, 2022.

4 CHAIRWOMAN FREED: Okay. Thank you.

5 My thanks to any Board Members who are on the TPA
6 evaluation committee because the TPA RFP is no joke. So
7 thank you whoever you are.

8 Questions, Board Members?

9 Member Kelley.

10 MEMBER KELLEY: I don't have a question but I do
11 wish to make a statement, but I'm not sure it's appropriate
12 in public forum.

13 CHAIRWOMAN FREED: Oh, I see. Well, we can go
14 into close session. I wonder if there will be other such
15 statements that we should cover on the HSA contract and the
16 amendments.

17 Okay. Well, with that, LCB Broadcast Services,
18 if we can go into closed session. Take the time to arrange
19 that I would appreciate it. And everybody who is in this
20 room who is not purchasing division staff or PEBP staff or
21 the actuaries I don't think, unless it's okay to have the
22 actuaries. Everybody else gets to leave for the time being.

23 MS. RICH: Do we want UMR reps in here as well?

24 CHAIRWOMAN FREED: We can. Why not. I'm
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1 generous. Oh, I'm sorry, no. Purchasing says no. They are
2 negotiating with them. Okay. Got it.

3 MS. MERCADO-ROSAS: Thank you, Chair. One moment
4 while we get situated.

5 If you are a panelist -- this is Cindi with
6 Broadcast. If you are a panelist and you are not intended to
7 be a part of the closed session we do ask you to leave at
8 this moment. And if you are an attendee we ask you to leave
9 at this moment.

10 CHAIRWOMAN FREED: Thank you, Broadcast. Once
11 again, the people who may remain in the room and in the room
12 on Zoom are Board Members, PEBP staff, purchasing division
13 staff and the actuary and that is all.

14 MS. MERCADO-ROSAS: We do still have attendees.
15 One moment, Chair, while we get them cleared out.

16 CHAIRWOMAN FREED: Thank you. Take your time.

17 MS. MERCADO-ROSAS: Okay. Chair, we do have
18 everyone cleared out. We do have Ms. Eaton on the line with
19 us.

20 (Whereupon, after the Board was in closed
21 session, the following proceedings were had in open session.)

22 CHAIRWOMAN FREED: Welcome back, everybody. Do
23 you need a couple of minutes to assemble everyone who wants
24 to be on Zoom or on the phone.

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1 MS. MERCADO-ROSAS: Chair, Broadcast is on and
2 holding and we're ready whenever you are.

3 CHAIRWOMAN FREED: Okay. Well, with that I would
4 like to call the, it's 2:03 p.m., and I would like to call
5 the open PEBP Board meeting back to order. When we went into
6 closed session we were discussing item 8.2.1, the
7 recommendation to ratify and approve the evaluation
8 committee's recommendation to contract with UMR for third
9 party administration and associated services beginning on
10 July 1st of 2022.

11 We had a productive discussion in the closed
12 meeting and without further ado I would accept the motion to
13 approve the evaluation committee's recommendation.

14 MEMBER KELLEY: So moved. Michelle Kelley for
15 the record.

16 CHAIRWOMAN FREED: Thank you.

17 Do I have a second?

18 MEMBER BITTLESTON: I'll second. Leslie
19 Bittleston.

20 CHAIRWOMAN FREED: Got it. Thank you.

21 All right. It's been moved and seconded to
22 ratify the evaluation committee's recommendation for UMR as
23 the TPA vendor. All in favor signify by saying aye. Any
24 opposed say nay.

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

3 CHAIRWOMAN FREED: Motion carries. Thanks.

4 Real quick, let's go on to 8.2.2, the HSA Bank.

5 MS. RICH: All right. Laura Rich for the record.
6 So on July 1st, 2021, the Public Employees' Benefits Program
7 released an RFP for a health savings account and health
8 reimbursement account HSA/HRA administrator services
9 contract.

10 So the objective of this RFP is to acquire an HSA
11 and HRA administrator that will be a strategic partner in
12 providing the services that are included in the scope of this
13 RFP.

14 I will say that with so many contracts out there
15 PEBP actually had some -- we had made a little mistake and we
16 forgot to include that in the RFP that the contract holder
17 would be the TPA. And so in this contract, typically this
18 would have been through the TPA as was identified in the TPA
19 RFP but when we released this RFP this was not included.
20 That was our oversight. And so when HSA Bank got word of
21 this, this contract we owned our mistake and really just
22 said, okay, we're going to instead of having this go through
23 the TPA contract it will be a direct contract with PEBP. So
24 it is unfortunate but not a huge mistake in the grand scheme
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1 of things.

2 So the vendor responses were scored on minimum
3 qualifications, technical, customer service, financial and
4 then some finalist presentations. And on July 30th PEBP
5 received 14 proposals in response to the RFP. The
6 five-member evaluation committee included two Board Members
7 and other subject matter experts, and HSA Bank received the
8 highest score by the evaluation committee. PEBP has
9 successfully negotiated the contract. HSA Bank will be the
10 new vendor. And the transition is expected to be rather
11 smooth. The effective date of the contract is anticipated to
12 be December 14th, 2021, upon BOE approval through June 30th
13 of 2026.

14 Services and fees are expected to begin on
15 June 1st, 2022. And the contract maximum is zero dollars.
16 So this is a zero dollar contract. It was a zero dollar
17 proposal that was proposed. And so the recommendation here
18 so ratify and approve the evaluation committee's
19 recommendation to contract with HSA Bank for the HSA and HRA
20 administrative services beginning July 21st, 2022.

21 CHAIRWOMAN FREED: Board Members, any questions,
22 comments? Okay. I'll accept a motion to ratify.

23 MEMBER AIELLO: This is Betsey. I move we ratify
24 the HSA Bank.

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1 CHAIRWOMAN FREED: Do I have a second?

2 MEMBER CAUGHRON: April Caughron. I'll second
3 it.

4 CHAIRWOMAN FREED: All right. It's been moved
5 and seconded to approve the evaluation committee's
6 recommendation to contract with HSA Bank for health savings
7 accounts, health reimbursement accounts beginning July 1st,
8 2022. All in favor signify by saying aye.

9 Any opposed say nay.

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

12 CHAIRWOMAN FREED: Okay. The motion carries.

13 Moving on to 8.3, contract and amendment
14 ratifications, since we just ratified the UMR contract I
15 think that makes 8.3.1, Aetna and 8.3.2, American Health
16 Holdings pretty quick and simple. They need to be
17 terminated. So I would accept a motion to approve PEBP staff
18 to serve term notices on Aetna and AHH in one motion if
19 that's okay.

20 MEMBER CAUGHRON: April Caughron. I'll go ahead
21 and make that motion.

22 CHAIRWOMAN FREED: Thank you.

23 Do I have a second?

24 VICE CHAIR FOX: Linda Fox for the record. I'll
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1 second.

2 CHAIRWOMAN FREED: Thank you. Okay. It's been
3 moved and seconded to process contract amendment
4 ratifications to term Aetna and American Health Holdings both
5 effective July 1st, 2022. All in favor signify by saying
6 aye. Any opposed say nay.

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

9 CHAIRWOMAN FREED: Great. That carries. All
10 right. Moving on to 8.3.3 Aon Consulting.

11 MS. RICH: Laura Rich for the record. So
12 previously the PEBP Board had approved staff to move forward
13 with a project involving the patient protection commission
14 and Medicaid to assist the Peterson Milbank for on the
15 project regarding sustainable health care cost. Previously
16 that contract, the original cost of that project was going to
17 be \$150,000. And the Board did approve that with potentially
18 getting it cost shared through the Peterson Milbank funding.
19 As we work through this we've been able to identify other
20 sources, data sources and Aon has actually dropped that the
21 cost due to the ability to leverage some already existing
22 processes that were in place already through HealthSCOPE
23 Benefit. So the new cost of this project is \$50,000. So we
24 were able to save quite a bit of money on this one.

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1 As a result we are no longer requesting the
2 additional outside funding. It's just -- it's -- the reality
3 is for \$25,000 it's a lot of work for PEBP and the state and
4 Peterson Milbank Foundation to go through to actually receive
5 those funds because of the contracting processes that are in
6 place. No one is really equipped to receive it.

7 And so because it is now such a low amount and it
8 does help PEBP, we are just assuming the responsibility
9 ourselves and the contract amendment is now \$50,000 rather
10 than the \$150,000. So I will stop there for questions.

11 CHAIRWOMAN FREED: Any questions? All right.
12 Okay. So the recommendation there is obviously to approve
13 that one. The next one is LSI Consulting. Again, this is a
14 reduction. On September 30th, 2021, the Board approved staff
15 to complete a contract amendment with LSI to begin services
16 and payments regarding their ability to manage the COBRA
17 responsibilities of the program and so we had to add
18 additional work order authority. After some additional
19 conversations LSI did agree to revise the cost of the COBRA
20 management being or being offered. And so the original
21 increase to the contract authority was -- oh, I'm sorry. The
22 original amendment to increase contract authority by 1.354
23 million was withdrawn and it's now revised to only increase
24 it by 479,000 approximately.

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1 So the recommendation here is for PEBP to -- the
2 PEBP Board to authorize staff to submit the updated contract
3 amendment between PEBP and LSI for the COBRA services and the
4 fee schedule and increase the contract maximum.

5 CHAIRWOMAN FREED: Okay. Board Members, I think
6 I'll do the same thing since we're -- we've got 8.3.3 and
7 8.3.4 both scaling back the amendments. I'll accept a motion
8 to approve staff recommendations for both of those at once.

9 MEMBER BITTLESTON: This is Leslie Bittleston.
10 So moved.

11 CHAIRWOMAN FREED: Thank you.

12 Do I have a second?

13 MEMBER AIELLO: Betsey Aiello. Second.

14 CHAIRWOMAN FREED: Thank you.

15 Okay. Motion is to approve staff recommendation
16 for 8.3.3 and 8.3.4. All in favor say aye. Opposed say nay.

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

19 CHAIRWOMAN FREED: Great. Thank you.

20 Last but not least, contract solicitation
21 ratification, except this seems to be the opposite.

22 MS. RICH: So the PEBP Board -- Laura Rich for
23 the record. The PEBP Board approved the solicitation for the
24 shopping comparison tool. For those of you who are familiar
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1 with it we currently use Healthcare Blue Book with the -- for
2 those contracts that are to be held by the TPA.

3 But as we got through the TPA RFP and the
4 negotiations for that contract we saw that the UMR offers a
5 comprehensive shopping tool that is part of the, their
6 services and part of the member portal that member can access
7 and use. And so since this is already part of the service
8 with no extra costs it just did not make sense for the, for
9 PEBP to pursue this contract or this or to release
10 solicitation.

11 So what we're asking for here is for the, to
12 allow PEBP staff to cancel that solicitation and not move
13 forward with the shopping comparison tool RFP.

14 CHAIRWOMAN FREED: Okay. Do I have a motion to
15 approve PEBP staff to cancel the solicitation? Mr. Verducci
16 so moves.

17 Any second? Thank you, Ms. Kelley.

18 All in favor signify by saying aye. Any opposed
19 nay.

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

22 CHAIRWOMAN FREED: And with that, if I'm not
23 mistaken, we are back on our second public comment period,
24 Agenda Item 9. And so is there any public comment here in
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1 the room, in Carson. Seeing none, I will turn it over to
2 Broadcast to see if there is public comment on the internet.

3 MS. TALENS: Thank you, Chair. To participate in
4 public comment please press star nine or raise hand in the
5 Zoom call to take your place in the queue.

6 MS. WOODWARD: Hello. Are you able to hear me?

7 MS. TALENS: Yes, we are.

8 MS. WOODWARD: Thank you. Good afternoon. My
9 name is Janell Woodward, J-a-n-e-l-l W-o-o-d-w-a-r-d. Again,
10 I'm a state employee representing AFSCME state employees. I
11 just want to add that we are very disappointed in the
12 decision to go with option two over option three which was
13 heard so much in the public comment in the beginning of the
14 meeting.

15 I want to publicly thank Mr. Verducci and a
16 couple of other people who have truly represented the state
17 employees and listened to the comments from the public and
18 pushed for us to get back what has been taken away. This is
19 a serious issue that -- that needs to be known. And I know
20 there are hard decisions, but we just appreciate the support
21 that we get from them. Thank you.

22 CHAIRWOMAN FREED: Thank you.

23 Next commenter.

24 MS. TALENS: If you have recently joined the call
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1 and would like to participate in public comment please press
2 star nine or raise hand in the Zoom call to take your place
3 in the queue.

4 Chair, the public line is open and ready.
5 However, there are no callers wishing to participate at this
6 time.

7 CHAIRWOMAN FREED: Okay. Thank you very much.
8 And thank you for all your hard work today, Broadcast
9 Services. It's been really really appreciated.

10 With that I believe we have reached the end of
11 our agenda and it is time to adjourn the meeting. So it's
12 2:18 p.m. and the PEBP Board is adjourned.

13 Thank you everybody for your testimony and help
14 today.

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1 STATE OF NEVADA,)
2 CARSON CITY.) ss.
3

4 I, KATHY JACKSON, Official Court Reporter for the
5 State of Nevada, Public Employees' Benefits Program Board, do
6 hereby certify:

7 That on Thursday, the 2nd day of December, 2021, I was
8 present on a teleconference for the Public Employees'
9 Benefits Program, Carson City, Nevada, for the purpose of
10 reporting in verbatim stenotype notes the within-entitled
11 public meeting;

12 That the foregoing transcript, consisting of pages 1
13 through 155, is a full, true and correct transcription of my
14 stenotype notes of said public meeting.

15
16 Dated at Carson City, Nevada, this 20th day
17 of December, 2021.

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24

KATHY JACKSON, CCR
Nevada CCR #402

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