

In The Matter Of:
Public Employee's Benefits Program Board
Telephonic Open Meeting

November 21, 2019

Capitol Reporters
123 W. Nye Lane, Ste 107

Carson City, Nevada 89706

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

TELEPHONIC OPEN MEETING

THURSDAY, NOVEMBER 21, 2019

CARSON CITY AND LAS VEGAS, NEVADA

The Board:

**LINDA FOX, Vice Chair
JOHN PACKHAM - Member
TOM VERDUCCI - Member
LEAH LAMBORN - Member
JET MITCHELL - Member
CHRISTINE ZACK - Member
DON BAILEY - Member**

For the Board:

**BRANDEE MOONEYHAN
Deputy Attorney General**

For Staff:

**DAMON HAYCOCK
Executive Officer
LAURA LANDRY
Executive Assistant
LAURA RICH
Operations Officer
CARI EATON
Chief Financial Officer
NANCY SPINELLI
Quality Control Officer**

Reported by:

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1 THURSDAY, NOVEMBER 21, 2019, CARSON CITY, NEVADA

2 -o0o-

3 VICE CHAIRWOMAN FOX: This is the time and place
4 for the Public Employees' Benefits Program Board meeting.
5 We're here at the legislative building here in Carson City,
6 video-conferencing to the Grant Sawyer Building in Las Vegas,
7 as well as video-streaming on the PEBP website.

8 I want to also introduce myself. I'm Linda Fox
9 and I'm the vice chair for this Board. We are between
10 chairpersons. So our chairperson was replaced. Peter
11 Longley is our now chairperson. So he was appointed this
12 week, but he was unavailable today. So in his absence I am
13 going to conduct this meeting today.

14 With that said, I'm going to go ahead and get
15 started with Agenda Item Number One, role call.

16 EXECUTIVE ASSISTANT: Linda Fox.

17 VICE CHAIRWOMAN FOX: Here.

18 EXECUTIVE ASSISTANT: Mandy Hagler is excused.
19 Leah Lamborn?

20 MEMBER LAMBORN: Here.

21 EXECUTIVE ASSISTANT: Jet Mitchell?

22 MEMBER MITCHELL: Here.

23 EXECUTIVE ASSISTANT: John Packham?

24 MEMBER PACKHAM: Here.

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1 EXECUTIVE ASSISTANT: Tom Verducci?

2 MEMBER VERDUCCI: Here.

3 EXECUTIVE ASSISTANT: Christine Zack?

4 MEMBER ZACK: Here.

5 EXECUTIVE ASSISTANT: And Don Bailey?

6 VICE CHAIRWOMAN FOX: We are expecting Don Bailey
7 but he is not here yet.

8 So before we go to public comment, I believe
9 Damon had a comment he wanted to make.

10 MR. HAYCOCK: Thank you, Madam Vice Chair. Damon
11 Haycock for the record.

12 The Board packet that was posted last week was
13 missing a certain item that was an attachment to the plan
14 benefit design agenda item, Item Number Seven. That was
15 rectified early this morning. We also have printouts of that
16 attachment here for the public and the audience if you would
17 like to see it.

18 There's also printouts. Thank you, Dr. Unger,
19 for bringing them to Las Vegas. It was in reference to the
20 UNLV Employee Benefits Committee and Nevada Faculty
21 co-designed, plan benefit designed recommendations and budget
22 recommendations moving forward for the program in the next
23 biennium. That was also sent to the Board previously. So
24 you all have seen it. However, it is, again, up on the
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1 website and if any Board member would like a physical copy,
2 Wendy I'm sure can provide it to you.

3 That's all I have. Thank you, Madam Vice Chair.

4 VICE CHAIRWOMAN FOX: Thank you.

5 And with that, we will go to public comment and
6 start here in Carson City. Is there any public comment here?

7 MS. LAIRD: Thank you and good morning. My name
8 for the record is Terri Laird, and it's T-e-r-r-i L-a-i-r-d.
9 I'm the executive director for RPEN, the Retired Public
10 Employees of Nevada, and we represent all public employees
11 retirees, as well as those still working.

12 First we want to express our thanks to Damon
13 Haycock for his years of cooperation with RPEN and our
14 colleagues that you see at this table nearly every meeting.
15 We greatly appreciated being brought back in for pre PEBP
16 Board meetings after his predecessor saw fit to eliminate
17 them, and we certainly hope the next executive officer will
18 be just as accommodating as Damon because PEBP and the
19 Medicare Exchange is quite important for our nearly 8,000
20 dues paying members. We also want to wish Damon success in
21 his future ventures.

22 We also again want to echo comments made during
23 the September Board meeting by our lead lobbyist, Marlene
24 Lockard, who is unable to be here today. We still are asking
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1 for an independent actuarial review of findings being
2 reported by PEBP's actuary Aon due to the fact that each year
3 at this time reserves are reported to be much more than they
4 actually end up being a few months later which could lead to
5 a dangerous situation in legislative years. And as Marlene
6 mentioned two months ago, PEBP has had nine years of excess
7 reserves since 2011 and in light of the change in leadership
8 ahead for PEBP, we hope this issue can be addressed with an
9 independent review at some point in the new year.

10 I'm also aware of Kent Ervin's written testimony
11 today submitted on-line, as he too is unable to be here, but
12 he is asking for the Board to table the enhancements to
13 PEBP's next meeting when more might be available as it
14 relates to the reserves, and we would also encourage that as
15 well.

16 Again, thank you, and I wish everyone a Happy
17 Thanksgiving and, again, good luck to Damon. Thank you.

18 VICE CHAIRWOMAN FOX: Thank you.

19 Anymore public comment?

20 MR. COSTA: Good morning. My name is Mark Costa.
21 I'm a state employee and a medical insurance plan user.

22 I wanted to go ahead and bring into the Board's
23 attention about a recent and severe problem that I've
24 experienced concerning continuing authorization for some
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1 durable medical equipment. Previously when I had a question
2 about a claim either for myself or for my wife, I could go
3 ahead and call up the medical insurance provider and get a
4 quick and easy answer and resolution. This time I was not
5 able to do that.

6 We received in the mail letters that amounted to
7 collection letters saying that we -- you know, our
8 authorization had expired and that we were going to go ahead
9 and have our account referred to collection, and we didn't
10 really understand what these letters were. There were a
11 variety of sources that were contacting us that we didn't
12 know, Pacific Pulmonary for example, Adapt Health which I
13 understand purchased Bennett Medical Services which is the
14 provider for durable medical equipment.

15 I tried a dozen different phone calls to
16 different people, and they were not able to help me.
17 Sometimes I was transferred not only to a different person
18 but to a different company. Apparently, there's a network of
19 subcontractors and contractors for authorization for medical
20 insurance benefits. And I understand that American Health is
21 the main person but was not able to get information from them
22 as to this problem.

23 I went to PEBP and the story has a happy ending
24 in that after a couple of weeks, PEBP employees were able to
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1 contact the appropriate person and found out what we needed
2 to do, and we needed to get an extension because now a letter
3 from a specialist is required to go ahead and continue
4 authorization for this medical equipment, and there's a plan
5 in place to do that. We were able to get an extension
6 instead of being cut off earlier because as all of you
7 probably know, it takes a couple, three months to get in to
8 see a specialist because they are booked up so heavily. So
9 we have a plan in place to correct this, and I'm optimistic
10 the problem will go ahead and be resolved.

11 I ask the Board to go ahead and keep that in mind
12 when we're approving medical contracts that this is explored
13 as to what are the recourses and a protocol is set for how
14 when clients or their spouses have issues they can go ahead
15 and get a fast response and certain procedures are in place
16 that are followed by the companies, whether they are
17 contractors or subcontractors to make this process easier and
18 to get responses quicker so action can be taken. Thank you.

19 VICE CHAIRWOMAN FOX: Thank you.

20 Is there anymore public comment in Carson?

21 Nancy, is there any comment in the south?

22 MS. SPINELLI: Yes. We do have two.

23 MR. UNGER: Doug Unger representing the Employee
24 Benefits Committee of UNLV and the UNLV Faculty Senate for
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1 the record.

2 I had had a different statement prepared for
3 today regarding the letter sent by our employee benefits
4 committee and our Faculty Senate and a prioritized list of
5 benefits that I'm very happy has been corrected and included
6 in your Board packets today.

7 I also would like to thank Damon Haycock,
8 executive officer of PEBP, for what I consider to be
9 excellent leadership of the Board. More than anything what
10 Damon has done is to rebuild the culture of PEBP as a truly
11 responsive state Board and organization to employee requests
12 and demands and collaborations. He's done a lot behind the
13 scenes to help us have much more confidence in PEBP, in our
14 benefits and in the possibility that there will be
15 improvements in the future.

16 Also, his efforts to keep premiums stable and
17 even lower than when possible is greatly appreciated by
18 Nevada state employees. We wish him well and all good
19 fortune in whatever he chooses to do next professionally.

20 There is in the Board packet attached to Item
21 Number Seven now our letter which represents not only UNLV
22 but also it's a collaboration with all of the Nevada System
23 of Higher Education, Faculty Senates and the Nevada Faculty
24 Alliance. We put in priority order a list of requested
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1 enhancements for the plan that we believe are modest enough
2 to be reasonable to consider.

3 Whether or not you are able within the available
4 resources of PEBP to make a commitment to such enhancements
5 now is, of course, up to the prudence of the Board. We do
6 request that if you cannot approve them today that you table
7 them or postpone them for the January meeting to consider
8 when we believe there will be quite possibly and quite
9 serendipitously enough accumulative excess reserves to cover
10 these requested enhancements.

11 Basically an order, it's a dental maximum
12 improvement benefit. We have not had an improvement for
13 30 years, and our plan is now approximately 29 to 30 percent
14 of what it was. That's our top priority.

15 Lowering the individual family out-of-pocket
16 maximum to be more competitive with high deductible plans and
17 surrounding states which really will help us with hiring and
18 retention of faculty and other state employees.

19 An unusual request, quite possibly to look at the
20 HSA/HRA contributions and to add more to cover families
21 because our constituents with families report to us that they
22 are suffering the greatest burden with the cost of
23 healthcare.

24 The preventive vision exam is a very small
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1 enhancement. It's a popular one that's requested by our
2 constituents.

3 The total amount of the enhancements we request
4 are \$5,000,000. Please know that under the new organization
5 of PEBP, with its approvals before the legislature we will be
6 there at interim finance committee meetings and interim
7 retirement and benefits committee meetings to advocate for
8 these enhancements should PEBP add them to their budget
9 request for the next plan year.

10 Thank you again to all of you for your public
11 service, and thank you for including these documents in
12 today's Board packet.

13 VICE CHAIRWOMAN FOX: Thank you.

14 Also for the record, did you know that Don Bailey
15 is now present?

16 MS. MALONEY: If the Chair is ready in Carson.

17 VICE CHAIRWOMAN FOX: Go ahead.

18 MS. MALONEY: Thank you.

19 VICE CHAIRWOMAN FOX: Yes.

20 MS. MALONEY: Good morning to the Board. That's
21 fine. Priscilla Maloney down here at Grant Sawyer
22 representing the AFSCME Retiree Chapter of AFSCME Local 4041.
23 We are the only union retiree chapter that represents all
24 public employees who are also qualified to be members of
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1 PERS. That's how our new amended bylaws and constitution
2 designate that.

3 To start out with, first of all, yes, absolutely
4 piggybacking on everything that Mr. Unger and Ms. Laird said.
5 We so thank Damon for not just his stint but his service to
6 Nevada for I believe it's the last 15 years. So we will miss
7 him. He has done a tremendous amount to move the needle
8 forward on -- on the overall health, internal health of the
9 organization itself, the PEBP organization. Well, I
10 shouldn't call it an organization, but I believe the Board
11 knows what I mean, and so we thank him from the bottom of our
12 heart. We enjoyed his outreach to us and allowing us to come
13 and meet with him before every scheduled PEBP Board meeting
14 and go over things on the agenda that we had concerns about.

15 Then moving on to the presentations already given
16 by Ms. Laird and Mr. Unger that the AFSCME Board has not yet
17 come to a conclusion on the efficacy of and wisdom of these
18 proposed design enhancements. They like the sound of them
19 very much, but they recognize that, first of all, we have a
20 fiscal situation where, and I believe when we get to Agenda
21 Item Number Six, we'll have a more deep dive into the
22 different reserve accounts and how they function.

23 So we understand that currently the current
24 figures from Aon are that we've got less than \$300,000 right
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1 now in the overflow reserves, and so our position right now
2 is we don't -- we don't want to say yay or nay on these
3 individual suggestions. We think they are great for instance
4 the dental max because the dental max is going to capture our
5 Medicare retirees, and so they think that they are good
6 ideas, but we would like to get more information from our
7 members and more feedback before we take a formal position.

8 But more to the point and this goes straight to
9 the heart of what the Faculty Alliance through Dr. Ervin and
10 Mr. Unger? Dr. Unger, I'm sorry. I am so sorry. Boy, you
11 earned it so you should say it. But what they reference
12 which is we still have an ongoing discussion on the table and
13 in theory on the -- on the agenda under Item Number Six about
14 our position in the coalition that we need a second opinion
15 on these reserves.

16 And so to make a -- we would ask the Board to
17 postpone as did Dr. Unger and Dr. Ervin postpone any action,
18 robust discussion, sure, on Item Seven, but let's wait until
19 we have settled the issue of whether or not this Board is
20 going to approve and then implement a second actuarial
21 assessment of these reserve accounts because it's my
22 understanding under -- under the new budget agreement with
23 the state through the last session is this body will be going
24 to IFC to ask for permission to use what excess reserves are
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1 available to do these things if we do them before the budget
2 period for the next biennium in which case we really need to
3 have accurate numbers of what we are talking about and how
4 much is actually available to implement some of these very,
5 you know, again, very positive suggestions. So that's our
6 position for this morning.

7 And, again, thank you so much, Damon. I'm sorry
8 I'm not there personally to say goodbye.

9 VICE CHAIRWOMAN FOX: Thank you.

10 Nancy, anymore public comment?

11 MS. SPINELLI: No other public comment.

12 VICE CHAIRWOMAN FOX: Okay. So we'll move on to
13 Agenda Item Number Three, PEBP Board disclosures for
14 applicable Board meeting agenda items. Brandee Mooneyhan
15 from the deputy attorney general.

16 MS. MOONEYHAN: Thank you, Madam Vice Chair.
17 Brandee Mooneyhan, Deputy Attorney General for the record.

18 As counsel for the Board and pursuant to Nevada
19 ethics law, I'm making this disclosure on behalf of the Board
20 members who are eligible for PEBP benefits. All current
21 Board members except Mr. Verducci are eligible for Public
22 Employees' Benefits Program. And Ms. Zack's situation is
23 unclear. She was adjunct faculty and may or may not be
24 eligible for PEBP, but she is not currently accessing PEBP
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1 benefits, but those that are eligible, they, their spouses,
2 their dependents may receive health, dental, life insurance
3 and other benefits through PEBP.

4 On today's agenda, Agenda Item Seven and Eight
5 relate directly to benefits available to PEBP members as they
6 concern possible plan and benefit changes. When PEBP Board
7 members vote on items effecting benefits for themselves,
8 their spouses and/or dependents they may trigger disclosure
9 requirements under NRS 281A.420. Pursuant to that law, I'm
10 offering this as a general disclosure on behalf of the Board
11 members who are PEBP participants and that will be voting on
12 these matters.

13 I want to note that they, those participants may
14 still so vote on items directly effecting benefits as long as
15 the benefit or detriment to them is not greater than that for
16 other similarly situated members.

17 Thank you, Madam Vice Chair, for allowing me to
18 make this disclosure, and I invite any member if they have
19 anything to add to do so now.

20 VICE CHAIRWOMAN FOX: Thank you.

21 Do any Board members have anything to add?

22 Moving on to Agenda Number Four, consent agenda.
23 Items will be considered together and acted on in one motion
24 unless an item is removed to be considered separately by the
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1 board. So there are four items here, and is there any that
2 any Board member would like to have separated to consider?

3 MEMBER VERDUCCI: Tom Verducci for the record. I
4 would like to pull 4.3.

5 VICE CHAIRWOMAN FOX: Okay. So we will consider
6 4.1, 4.2 and 4.4. So could I have a motion then to approve
7 those without 4.3?

8 MEMBER LAMBORN: Leah Lamborn for the record. I
9 make a motion to approve 4.1, 4.2 and 4.4 agenda items.

10 VICE CHAIRWOMAN FOX: Thank you.

11 So we have a motion. And is there a second?

12 MEMBER ZACK: Madam Chair, I'll second the
13 motion. Christine Zack for the record.

14 VICE CHAIRWOMAN FOX: Thank you.

15 Is there any discussion? Okay. So we have a
16 first and a second. All in favor say aye.

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

19 VICE CHAIRWOMAN FOX: Any opposed?

20 Okay. And, Tom, you wanted to discuss 4.3?

21 MEMBER VERDUCCI: Yes. Tom Verducci for the
22 record.

23 By any chance do we have a representative from
24 Casey Neilon here?

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1 MS. OLSEN: Good morning. My name is Suzanne
2 Olsen. That's S-u-z-a-n-n-e O-l-s-e-n, and I am a
3 shareholder and I was the partner in charge of the Casey
4 Neilon or the PEBP that was before Casey Neilon.

5 MEMBER VERDUCCI: Thank you so much for coming
6 here today.

7 MS. OLSEN: You're welcome. Thank you for
8 inviting us.

9 MEMBER VERDUCCI: I just had a few questions on
10 the variances in your report.

11 MS. OLSEN: Which report exactly?

12 MEMBER VERDUCCI: Specifically this is going to
13 be on the self-insurance trust fund.

14 MS. OLSEN: Okay.

15 MEMBER VERDUCCI: The balance sheet that was put
16 together. I had a few questions on the variances within this
17 report. Specifically, we show in 2019 a 3.6 million dollar
18 unearned liabilities and in 2000 -- I'm sorry, make that 3.6
19 million and in 2018 was 48,000.

20 MS. OLSEN: Yes.

21 MEMBER VERDUCCI: So I think it has something to
22 do with unearned revenue but I want to gain a better
23 understanding because the big variance in that number.

24 MS. OLSEN: Right.
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1 MEMBER PACKHAM: Can we reference a page number,
2 Tom?

3 MEMBER VERDUCCI: Yes. Okay. That would be page
4 three.

5 MS. OLSEN: It's on the statement of net
6 position, page three.

7 MEMBER VERDUCCI: And then it will be under the
8 column liabilities and the subcategory unearned revenue, and
9 it's broken down into two categories, 2019 and 2018. And
10 specifically in 2019 the unearned revenue is 3.6 --
11 3,662,898. In 2018 it was \$48,916. So it's a big difference
12 in the numbers, and I just want to gain an understanding of
13 the additional \$3,000,000.

14 MS. OLSEN: The difference has to do with in 2018
15 there was a shortfall reported, a major shortfall reported,
16 and in 2019 there was a surplus, and that is discussed in
17 note one, page seven and it is discussed under the
18 receivables heading even though for 2019 it was under the
19 unearned revenue due to it being a surplus. So for
20 comparative purposes we included it in that section.

21 The difference between the cash contributions and
22 revenue recognition resulted in surplus of contributions over
23 premiums of 3.1 million dollars and a shortage of
24 contributions over premiums of 2.4 millions dollars for the
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1 years ended 2019 and 2018.

2 The -- the short -- the shortage that we reported
3 in 2018 was recorded as receivable, and the surplus in 2019
4 was recorded as a payable which is why you're seeing that
5 difference. Normally there's a consistency between the
6 unearned revenue from one year to the next.

7 MEMBER VERDUCCI: Okay. So that was based on
8 shortfall of unrealized liability?

9 MS. OLSEN: That was based on a difference
10 between contributions coming in and revenue recognized to pay
11 the premiums.

12 MEMBER VERDUCCI: And then at what point would
13 the revenue actually be recognized?

14 MS. OLSEN: When the premiums have been earned.
15 When the money is needed to pay the premiums that have
16 been -- so revenue is recognized when it's earned, and
17 expenses are recorded when they are -- when they come due
18 when they are used. So at the time that the monies needed to
19 pay the premiums has warranted pulling from the surplus
20 that's when that money would be recognized or realized that
21 -- those contributions would be realized.

22 MEMBER VERDUCCI: Okay. Thank you --

23 MS. OLSEN: You're very welcome.

24 MEMBER VERDUCCI: -- for clarification. As we
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1 continue on to page four, we do go into a column called
2 operating expenses and under subcategory claims expense,
3 we're showing 2019, 314,000,000. In 2018 it was 227,000,000
4 and is a pretty big variation. Does that have to do with the
5 catastrophic claims? Specifically, why would there be such a
6 big variance from 2019 at 314,000,000 and 2018 at
7 227,000,000?

8 MS. OLSEN: I think when you're looking at this,
9 you really need to take two items into consideration. You
10 need to look at the claims expense and the insurance premiums
11 and contractual obligations.

12 And, Damon, and, Cari, if you need to step in
13 because I'm not explaining it correctly feel free to do so,
14 but there was a change that happened in fiscal year 2019
15 where PEBP implemented an exclusive provider organization
16 plan, and that changed the dynamics and the flow of those
17 transactions on the -- on the income statement. And so what
18 was reported previously in 2018 under insurance premiums and
19 contractual obligations has been, it's not the same. I don't
20 want to make it seem like it's the same but it's been kind of
21 reworked or rerouted and it's being reported under claims
22 expense just due to the nature of how those policies flow.

23 MEMBER VERDUCCI: Okay. So with the new plan
24 that was implemented that caused the variation there?

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1 MS. OLSEN: Yes, sir. That is how the -- how the
2 transactions flow through the claimed expense now versus the
3 actual contractual payments because you no longer are making
4 those contractual payments because they are being serviced --
5 they are being self -- thank you.

6 MR. HAYCOCK: For the record Damon Haycock.

7 Let me see if I can try to simplify this. I'm
8 not an accountant so I won't speak in accountese. But
9 basically we implemented the EPO plan last year and instead
10 of us pitching out premiums through our contract with
11 Hometown Health which is recorded in a different part of this
12 -- this statement, we are actually paying those claims
13 because we took on that self-insured risk.

14 So our claims increased almost \$100,000,000
15 because we're actually paying the claims instead of paying
16 the premiums to our fully insured provider, and that's where
17 it's being recorded.

18 And just to go back on the original question on
19 unearned revenue, the reason why we have deficits and
20 shortfall in our main accounts that Casey Neilon will often
21 or not often but annually audit is because when we get our
22 budget and we get our employer contribution dollar amount
23 that is taken out of every agencies' funding, that is
24 predicated on an enrollment that was projected to include an
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1 enrollment mix.

2 So if more people enroll on the family side or if
3 more people enroll on the single tier then that mix changes
4 and the total amount of subsidy needed to cover that will
5 falter, right, will change. And so when that changes in
6 certain years we will end up creating a shortfall, and in
7 certain years we will creating a surplus. That surplus
8 though will sit in that AIGS account until we need to draw
9 money from it. And if we don't draw it over the biennium it
10 will be used to offset the next biennium's contribution. And
11 so that's how it was reported in the Casey Neilon audit, and
12 really it's just a point in time shot at where our financial
13 position was as all balance financial statements should look,
14 and that's about as good as I can get in accounting right
15 now.

16 MS. OLSEN: That was a great job. Thank you.

17 Do you have any --

18 MEMBER VERDUCCI: One additional. On page -- on
19 page five of the reconciliation of operating income and we
20 get down to increase or decrease in payables and accruals,
21 we're showing for 2019 an increase of 30,760,000 versus 2018
22 was roughly 2.8 million. So there's a big aberration, and I
23 just want to have a better understanding of what those
24 numbers reflect in layman terms.

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1 MS. OLSEN: All right. I think we should look at
2 page -- now this report isn't going and I didn't -- I don't
3 have the 2017 information here with me today. So, but I can
4 compare the '18 and '19 but if we go to page --

5 MEMBER VERDUCCI: Page number five.

6 MS. OLSEN: If we go to page number 19, the
7 unpaid claims liabilities, so it's note seven under risk
8 management continued unpaid claims liabilities, the first
9 section of that page, if you compare there's two components
10 to the unpaid claims liabilities. There's the reserve
11 component and then the actual claims reserve component, and
12 then there's the HRA liability components. And you can see
13 where the increase happened. The HRA liability stayed, there
14 was about a 2,000,000 dollar, a little over a 2,000,000
15 dollar change there.

16 The reserve component increased from 37,000,000
17 to 58 or \$59,000,000 2018 to 2019. Prior to that, from 2017
18 to 2018, it was fairly consistent. This in my mind is
19 attributable to those claims, those additional claims
20 payments based on that new self-insured risk program that was
21 implemented. So that in my opinion is why you're seeing that
22 increase.

23 MEMBER VERDUCCI: So this would be an increase in
24 liabilities; is that correct?

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1 MS. OLSEN: Yes. It's an increase in liabilities
2 and increase in that reserve estimate number.

3 MEMBER VERDUCCI: Okay.

4 MS. OLSEN: Uh-huh.

5 MEMBER VERDUCCI: Thank you for clarification.

6 THE JUVENILE: For the record Damon Haycock.

7 So just to dovetail on that because we have
8 additional claims, we also had to approve additional
9 reserves, and those required reserves incurred but not
10 reported or incurred and not paid in catastrophic, and so
11 those are still considered future liabilities that must be
12 shown on an accounting balance sheet.

13 MS. OLSEN: That is correct. That is correct.
14 Do you have any follow-up questions to that?

15 MEMBER VERDUCCI: No.

16 MS. OLSEN: Okay.

17 MEMBER VERDUCCI: I just noticed a big aberration
18 in numbers, and I wanted to gain an understanding because
19 they are so huge and that was very helpful.

20 MS. OLSEN: Good. I'm glad.

21 MEMBER LAMBORN: I just have one quick question.
22 I'm not sure if it's for you or for Damon, but you made the
23 statement, I just want to clarify. The 58,000,000 in reserve
24 for incurred but not received claims, that's an estimate, a
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1 projection?

2 MS. OLSEN: It is an estimate which is why they
3 do hire the actuary to come in and perform those
4 calculations. They have the expertise behind them to
5 substantiate the rationale behind how those estimates are
6 built.

7 MEMBER LAMBORN: And then, of course, at some
8 point in time we can go back and get actuals, what it
9 actually was and can compare it to the estimates.

10 MR. HAYCOCK: For the record Damon Haycock.

11 The actual reserve need is in the, it's showcased
12 right now in Agenda Item Seven in that table for each of the
13 reserve buckets. It is inclusive all of the plans. PEBP has
14 been asked and we will move forward separate on those out
15 into the EPO versus the CDHP plan, but those numbers aren't
16 separated in this balance sheet per plan, and so it actually
17 ties in kind of nicely of what you're asking here today to
18 show what the actuals were.

19 VICE CHAIRWOMAN FOX: Are there any other
20 questions or discussion?

21 So I think we need to separately now vote on 4.3
22 to approve that item. So I need a motion for 4.3.

23 MEMBER VERDUCCI: Tom Verducci for the record.

24 I'll make a recommendation to approve section 4.3 and section
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1 4 of the report.

2 VICE CHAIRWOMAN FOX: We have a first. Is there
3 a second?

4 MEMBER MITCHELL: Jet Mitchell for the record,
5 second.

6 VICE CHAIRWOMAN FOX: Okay. So we have a first
7 and a second. Is there anymore discussion? So I'll ask for
8 a vote. Those in favor say aye.

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

11 VICE CHAIRWOMAN FOX: Any opposed? Okay. The
12 motion carries.

13 All right. So we'll move on to Item Five, update
14 on the Morneau Shepell improvement plan. Morneau Shepell.

15 MR. BORGOS: Good morning. Bruce Borgos
16 representing Morneau Shepell. Last name is B-o-r-g-o-s.

17 I'm here today to present a progress report on
18 the performance improvement plan that I summarized for the
19 Board in September and which addressed a number of issues. I
20 think you have the larger report in your handouts.

21 Since September we begun holding regular steering
22 committee meetings with Mr. Haycock and Ms. Rich to update
23 them on our progress and solicit their feedback. At a high
24 level, we have decided in consultation and agreement with
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1 PEBP that we will move the enrollment of voluntary benefits
2 to the Corestream Platform rather than maintaining some of
3 those enrollments on the Morneau Platform to provide a more
4 user friendly experience for PEBP members and increase the
5 participation in these valuable benefits.

6 The only possible exception to that right now is
7 the Standards Life product and potentially the STD product.
8 At some point in the future we're just going through some
9 discussions right now to see what's feasible in that regard
10 and whether or not we can move the standard over to
11 Corestream in time for next year's enrollment. We expect the
12 rest of that work on voluntary benefits to be completed by
13 April 1st, 2020.

14 Regarding another follow-up to the last Board
15 meeting, Morneau Shepell, Corestream and Unum are in active
16 discussions about integrating Unum's long term care product
17 information, as well as a link to Unum's enrollment site
18 through this product through Corestream. There are some
19 technical considerations that we're reviewing currently. We
20 have another meeting scheduled for tomorrow to discuss again
21 the feasibility of whether or not we can adhere to some of
22 the requirements that Unum has for this product, and I'll
23 have another update for the Board at the next meeting in
24 January.

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1 Additionally, we recently completed the
2 significant step on a major item of the improvement plan.
3 Rolling out Morneau's more robust co facts document
4 management system for the new benefit events requiring
5 supporting documentation. This will simplify work that PEBP
6 staff is doing on employee qualifying life event
7 administration. We also continue to make progress on
8 streamlining other work efforts of PEBP's various member
9 employers with the creation of a central HRA system. We have
10 completed two rounds of testing and expect a third round to
11 be completed prior to us bringing the system on-line by
12 March 31st of next year.

13 Also, a new portal agency reps will use to
14 automate data collection it's targeted to forego live data
15 February of 2020.

16 As I mentioned at the September meeting of this
17 Board, we have also been working on fine tuning our processes
18 to better provide service to PEBP plan participants and PEBP
19 staff. To that end and as promised, Morneau Shepell has
20 placed a representative on site at PEBP's office to expedite
21 issue identification and resolution and gain a deeper
22 understanding of the day-to-day operations of the PEBP team.
23 This collaboration seems to be working well at this point.

24 I'll have a further update on our progress in
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1 January and again in March, and I'm happy to take any
2 questions you may have now.

3 VICE CHAIRWOMAN FOX: Any questions from the
4 Board?

5 MEMBER VERDUCCI: Yes. Tom Verducci for the
6 record.

7 Mr. Borgos, I just wanted to ask you about the
8 one item that was listed in the report at risk in terms of
9 catch up and management of the backlog issues. I'm wondering
10 if you could maybe just address where you folks are in terms
11 of the backlog issues.

12 MR. BORGOS: Sure. Again, Bruce Borgos for the
13 record.

14 We have a ticketing system at Morneau Shepell in
15 which issues that are identified either by the staff at PEBP
16 or internally at Morneau Shepell get logged for purposes of
17 tracking and reporting. And they -- that way they get
18 escalated to the right individuals within Morneau Shepell who
19 actually have to do work.

20 So there was a backlog and there still is a
21 backlog of issues. Most of those tickets are very old
22 tickets which are now to some degree probably no longer
23 relative. So one of the things that we're doing right now is
24 assigning folks to going back and reviewing each ticket to
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1 determine which ones are still pertinent and/or which can be
2 automatically closed. So we have kind of a refreshed look at
3 the number of tickets that open. So there's been a little
4 bit of a delay just going through that backlog as some of
5 those actually go back a few years.

6 MEMBER VERDUCCI: So how is the progress going
7 and clearing up the backlog issues?

8 MR. BORGOS: So the progress is good at this
9 point. It's continuous. It's never as fast as we would like
10 it to be, but we have no expectation that we won't have those
11 cleaned up to -- that would result in any further risk to the
12 process improvement plan.

13 MEMBER VERDUCCI: Thank you very much.

14 MR. HAYCOCK: For the record Damon Haycock.

15 As Mr. Borgos said, Ms. Rich and I have been
16 meeting with Morneau Shepell. At this time we feel
17 comfortable with the progress that they have made and that
18 they are on track to meeting the requirements of this
19 performance improvement plan.

20 We will always reserve the right to be skeptical,
21 but they have worked diligently with us and have provided us
22 the right resources so we can address things immediately and
23 internally with those folks that they have sent to us in our
24 office. So we commend Morneau Shepell for continuing to
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1 provide us those resources.

2 We keep our fingers crossed. We want you to be
3 successful because we want to be successful with you, but we
4 will reserve the right to make final judgment later.

5 VICE CHAIRWOMAN FOX: Thank you.

6 Anymore discussion or questions from the Board?
7 Okay. Thank you.

8 All right. And we will move on to Agenda Item
9 Number Six, presentation on the development and history of
10 PEBP's incurred but not paid catastrophic and health
11 reimbursement arrangement reserves. Aon and Cari Eaton, our
12 chief financial officer.

13 MS. MESSIER: Good morning. My name and words
14 for the record is Stephanie Messier. Last name is
15 M-e-s-s-i-e-r, and I'm with Aon. I've been with Aon for
16 almost seven years now, and I've been in the actuarial
17 industry for about 18. And with me I have Kelly Wilson.

18 MS. WILSON: Good morning. My name is Kelly
19 Wilson. I'm a CPA, and I've been with Aon for about a year
20 and a half. Prior to that I was with the State of Oklahoma
21 as the deputy director of internal audit.

22 MS. MESSIER: So I've been asked to kind of move
23 through this a little bit quickly this morning. I did want
24 to provide you a little bit more details in terms of our
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1 presentation. I know the Board gets the packet about a week
2 in advance, and so that's why I gave you a little bit more
3 details for your readthrough. Today I plan to go a little
4 bit more high level. Certainly we are here to answer any
5 questions that the Board may have, and we are happy to do so,
6 but I just wanted to call that. I plan to go a little more
7 high level through the slides, but certainly if there is a
8 need for a deeper dive we are here and happy to do so.

9 I believe the impetus that we are presenting here
10 today are some comments we've heard this morning, as well at
11 the September Board meeting from NCHE and RPEN and others.
12 First about the -- are best practices being followed as we're
13 setting PEBP's reserves? Is the 95 percent competence level
14 on both the IBNP and catastrophic reserves appropriate? And
15 finally why do excess reserves keep being generated year
16 after year despite spend-downs.

17 We are fully capable and prepared today to talk
18 about those first two items, but I think it's important to
19 note for the public record given the comments that were made
20 again earlier today, AON has not been involved in the
21 projection or the reporting of excess reserves for PEBP.
22 That is done by PEBP staff. Aon has not been asked to report
23 on those items. We have not been asked to project those
24 items. We have been asked to project and work on your IBNP

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1 and catastrophic reserves, and those are the two items that
2 we'll be walking through today.

3 And we also thought it was important given our
4 industry knowledge and our work with other clients that we
5 talk to you about some benchmarks and industry best
6 practices. What are we seeing other states do, as well as
7 what are some other approaches that PEBP could adopt. So I
8 went ahead and added that as part of our last part of the
9 presentation, and I think that's a good spot for us to spend
10 a little more time on today. So I'm going to again breeze
11 through methodology portions and kind of get to the meat of
12 the presentation and which I think again really is what folks
13 are asking about. Is that 95 percent competence interval the
14 right level to have for PEBP?

15 This slide was just really included as to why do
16 you need to have an IBNP. And I think as Board member Tom's
17 questions earlier today for the auditor was getting at this
18 -- this question. Why did your IBNP reserves go up when you
19 had the EPO plan when you first implemented the self-funded
20 EPO plan. Really that was very light payments that first
21 month. If you were on a fully insured plan, you would have
22 had premiums to pay.

23 But when you switch to self-funded plans there's
24 naturally a lag in payment. When you go to a provider your
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1 provider doesn't immediately bill PEBP that day for your
2 visit. If your at a hospital the hospital will not send a
3 bill to PEBP that day for your visit. And if they do send it
4 to HealthSCOPE Benefits or to PEBP usually HealthSCOPE
5 Benefits is going to take a look. Is this everything
6 included in that claim? Are we missing anything? Are there
7 things that we need to negotiate? So bills don't get paid on
8 the same day they are incurred which is why you have an
9 incurred but not paid reserve when you do a self-funded plan.

10 So we also wanted to talk about the fact that as
11 Aon, an actuarial firm, we are using actuarial standards,
12 best practices when we're producing our IBNP estimates. In
13 our modeling we have included emerging of the two best
14 practice methods out there via actuarial standards. There's
15 the development method, as well as a projection method. So
16 the development method is going to take your historical
17 claim, like payment patterns, we're going to adjust it for
18 any large claims payments that may have come through that may
19 throw off those average estimates.

20 We then combine it with a projection method with
21 those more recent and immature months in order to come up
22 with a best estimate IBNP and again that's according to
23 actuarial standards. So it's important to note with most
24 clients what we do is we take a look and we really do provide

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1 our best estimate of what your incurred but not paid
2 liabilities as of a certain date.

3 Then there would be other things that the plan
4 would have to pay on that date for the runout of claims. You
5 would still have to pay HealthSCOPE Benefits to administer
6 any claim payments that may occur after that plan date. That
7 is why you have an expense load on your IBNP, and for PEBP we
8 use 1.025 factor to do a best estimate of how much fees
9 HealthSCOPE Benefits would charge you for paying those
10 additional runout of claims.

11 In addition to the expense load for your account
12 specifically, the Board has requested that Aon add on a
13 catastrophic reserve margin. So that PEBP can be assured in
14 19 out of every 20 years our estimate is enough to cover the
15 amount of claims outstanding. That is the 95 percent
16 confidence interval that, again, the PEBP Board has selected
17 I believe back in 2011, 2012 for us to add on to our best
18 estimate of IBNP. Again, that's not an industry standard.
19 That's not an actuarial set number that we have to follow.
20 That is something that you have directed us to load, and so
21 we have done statistical calculations to come up with an
22 assurance that out of 19 out of every 20 years we are
23 confident that the number we're providing you would be
24 sufficient to pay the amount of claims outstanding.

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1 And here we thought it might be helpful to show a
2 numerical example of how sometimes there's large claims that
3 will come in after a plan would end, and so that's what we
4 try to highlight along that yellow diagonal. Here in
5 February of 2018 a large claim was incurred of 1.3 million
6 dollars, but it wasn't paid until July of 2018. So that
7 would have been on Plan Year '19 that that claim was paid,
8 but it was incurred in Plan Year '18.

9 And typically as you move along the diagonal line
10 in month five, you tend to pay out about \$275,000 of claims.
11 If our IBNP estimate for just that month was 275,000, in that
12 particular year it would have been short by about a million
13 dollars to pay that outstanding claim that had been incurred.
14 So it is wise to include a margin on top of the best estimate
15 IBNP for such instances as the one that PEBP had seen in
16 2018. However, again, the 95 percent is larger than we have
17 seen with other clients.

18 And finally the last part of a best practice
19 actuarial IBNP analysis is really to do a historical reserve
20 adequacy study which is also called a lookback analysis.
21 Every year we take a look at how well did we do last year?
22 We estimated last June how much claims we thought were
23 outstanding, and now that we have a 12-month period has ended
24 we're able to see how close were we to that estimate.

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1 So in the first column of the numbers at the
2 bottom of this page, and I do want to spend just a little bit
3 of time on it, is in the green is your actual claims that
4 came in after the plan date, for anything incurred prior to
5 that date how much in claims was paid out after that date.
6 So you'll see in 2012 there was 28.4 million dollars in
7 claims that was paid out. And most recently in June of 2018
8 and the next 12 months you saw almost \$32,000,000 of claims
9 paid out.

10 And, again, here it's important to note you're
11 EPO plan started right after that date, and I don't have the
12 full 12 months of runout from that since we just ended that
13 first 12 months of the plan. So right now we only have three
14 to four months of runout. So we didn't include June 30th of
15 2019 because I don't have the actual runout to say how well
16 did the estimate do.

17 Our best estimate IBNP is in that second column
18 of numbers and that was what we had provided before we loaded
19 it for the administrative expense, as well as for the
20 95 percent competence interval. So you will see in most
21 years, especially from 2012 up until 2016 we -- our best
22 estimate IBNP was slightly above the actual claims IBNP. But
23 in our most recent two plan years, if we had just provided
24 PEBP with the best estimate IBNP, our best estimate would
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1 have been short. There was more large claims outstanding at
2 the end of the plan year than our models had indicated would
3 be outstanding. So if we had just given you the best
4 estimate IBNP, you would have been short.

5 However, because PEBP opted to load it at a
6 95 percent confidence interval, that's the first blue column
7 of numbers. Here you will see and the comparison is, so you
8 don't have to do the math yourself, is in that final column
9 that is also shaded in blue. It almost looks gray from here.
10 Gives you the difference between the claims loaded at the
11 catastrophic margin level and the actual claims that were
12 incurred and paid after the plan year ended.

13 So you will see on average PEBP is running about
14 \$5,000,000 over with that catastrophic load, and some years
15 you actually did need it, like in the most recent 2017 and
16 2018. Again, our best estimate was 25.5 million in 2017, but
17 the actual claims paid out was 27.9. So if you had only set
18 aside the 27.5 that would have been short by 2.4 million.
19 However, because it was loaded to the 95 percent you were
20 actually over by 4.8 million.

21 And I know that's a lot of numbers, and I
22 apologize to the court reporter.

23 Any questions on there? Do you want me to stop
24 right there for questions?

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1 MR. HAYCOCK: So for the record Damon Haycock.

2 First, Stephanie, thank you. That was very very
3 helpful. And for those that don't live and eat and breathe
4 this everyday, I think one of the most important things to
5 recognize is really why you have an incurred but not paid or
6 incurred but not reported reserve and a good example is today
7 we have the exclusive provider organization plan or EPO plan
8 in northern and rural Nevada. We self-insured it last year
9 and stopped our fully insured Hometown Health HMO plan.

10 If we were to go back to them next year we would
11 have a claims runout that we would have to pay. And those --
12 those bills that would have come in, really almost to the
13 beginning of the plan year because we have a one-year timely
14 filing requirement for provider claims. When those claims
15 would come in, we would have to pay them even though we
16 wouldn't be getting any premiums coming in to us because we
17 would be farming them back to Hometown Health for their fully
18 insured plan. Again, this is all hypothetical, but that's
19 what that incurred but not reported or incurred but not paid
20 reserve is for, and then we would have to pay HealthSCOPE to
21 adjudicate those claims even though we technically don't have
22 -- the contract would change to only payout that runout.

23 And so, again, all of our costs associated with
24 paying claims and fees continue past the end of a plan year
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1 when you shut the plan down. So that's what is really
2 important in this -- in this part of the incurred but not
3 reported reserve. I just wanted to add that. Thank you,
4 Stephanie.

5 MS. MESSIER: Thanks, Damon.

6 Any other questions before we move on to the
7 catastrophic reserve?

8 Okay. The second, it is fairly common with our
9 other public sector entities, as well as other state plans to
10 hold a set of reserves aside. Sometimes it's called the
11 contingency reserve, and sometimes it's called a
12 catastrophic, but basically they are trying to do the same
13 thing. It's covering any unforeseen circumstances that may
14 incur within that plan year.

15 There's -- it's possible that as we set your
16 actual medical trend rate in a given plan year, when we do
17 your underwriting at the March Board meeting, let's say we
18 assume that costs are going to increase 44 percent that year,
19 something could occur within the medical community. Other
20 new treatments could come about or there could just be a
21 sicker group of the population causing that trend to actually
22 come in higher than we had projected.

23 There's also utilization changes that I mentioned
24 in Medical Pharmacy Services. A good example of this is when
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1 the Hep C drug came out a few years back, PEBP's population
2 saw a very high utilization of that hepatitis C drug. That's
3 not something we would potentially know about when we were
4 setting your plan rates in the prior year. And those sort of
5 things will cause your rates within a given plan year to come
6 in higher than what you set your budget for at the time of
7 underwriting.

8 Other things can happen that we have seen in
9 other clients, such as demographic shifts, changes at open
10 enrollment. There could be a lot of people coming onto the
11 plan or if the state had again gone back to hiring which it
12 did a few years ago after it had not been hiring for a four
13 to five-year period because of the economic downturn.
14 There's a large group of people coming onto the plan.

15 As well as in the hypothetical situation here if
16 PEBP was to lose, let's say in the NCHE population, if they
17 decided to go out and get their own plan design, that would
18 cause a shift in the underlying risk that remains on the PEBP
19 plan, and that would change the PEPM's that you would see in
20 that given year.

21 You could see an unexpected rise as PEBP has seen
22 in the last 12 months in catastrophic claimants. This would
23 also cause our estimates of what you're going to see in that
24 given plan year to shift.

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1 When I was speaking with Mary Catherine yesterday
2 from HealthSCOPE, she mentioned that there's currently about
3 a 6,000,000 dollar claim outstanding for PEBP right now. So
4 should something like that come through, which it will be
5 coming, that was bill charges. So it will be coming in less,
6 but that's the sort of thing you have a catastrophic reserve
7 for. PEBP does not have stop loss insurance.

8 So and I have another colleague who's currently
9 adjudicating another 14,000,000 dollar claim for hereditary
10 edema. These claims are out there. So that is why it is
11 prudent for someone such as PEBP to maintain a catastrophic
12 reserve. So I just wanted to give a little history as to why
13 states kind of hold catastrophic or again sometimes you'll
14 hear it as contingency reserve.

15 And here we wanted to provide in the blue box
16 what PEBP's catastrophic reserve has been from again the same
17 time periods 2012 through 2019 and here because we're not
18 doing a true-up, there is no true-up here because you haven't
19 used your catastrophic reserve. So we were able to report
20 the most recent June of 2019 because, again, we are not
21 looking for 12 months of runout to see how good this
22 prediction was. This is something separate.

23 It did increase, as you noticed in your auditor's
24 report, because you introduced the EPO plan. So I broke out
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1 the two figures below. The CDHP is most recently at
2 \$31,000,000, and the EPO plan added an additional 11.4
3 million dollars. And, again, this is to protect against
4 unforeseen events such as the 6,000,000 dollar claim that
5 PEBP has currently coming its way.

6 Okay. Any questions about the catastrophic
7 reserve before we move on to best practices or what other
8 states are doing?

9 Okay, Tom?

10 MEMBER VERDUCCI: Yes. Tom Verducci for the
11 record.

12 In reading your report here, it seems the
13 95 percent catastrophic reserve was set after the financial
14 crisis. Does it appear to you today that we're being too
15 conservative on that number being that we've had a robust
16 economy, lots of economic growth and that was set nearly ten
17 years ago when we were in a complete different economic
18 environment?

19 MS. MESSIER: It certainly appears that we -- I
20 guess seeing different entities take a look at it now that
21 the economy has recovered and they are feeling a little more
22 optimistic of how much reserves they need to have on hand.
23 However, I think it's prudent to caution that it really
24 depends on how easy it is for that particular state to go
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1 back to the legislature and find additional monies should
2 they need it.

3 Because if you would have two or three of these
4 large claimants, again, it's very hard to predict who's going
5 to get sick and how sick they are going to get or where they
6 are going to get care and how much that care is going to
7 cost. Should PEBP have two or three in a particular plan
8 year if they were to preserve, I would say a 50 percent level
9 could maybe be confident they could go the legislature and
10 they could ask for more money and get it in order to pay out
11 the claims they would need to pay.

12 So it's very dependent each different state as to
13 how easy it is for them to go back to the legislature and get
14 more money in that instance, but certainly it's -- it's on a
15 state by state basis, and we have seen a lot of them move
16 away from that 95 percent. I do think it was pretty popular,
17 again, coming in 2010, 2012 era when we were all coming off
18 of the recession to have a 95 percent level, and some folks
19 have definitely moved off of it.

20 What I do think that you're doing is a little bit
21 different than the others is the 95 percent load on your
22 IBNP. That's the one we typically don't see that high of a
23 margin on the IBNP portion.

24 MEMBER VERDUCCI: Yes. We're certainly in a
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1 different economic environment and, you know, maybe there are
2 some ideas that could be put in place that could free up some
3 other requests that are being made to this Board. So thank
4 you.

5 MS. MESSIER: Yep. Absolutely.

6 So going to that part, the benchmarking data,
7 here we are seeing, I just want to give you some other
8 examples from states that are nearby. Arizona is holding
9 their contingency reserve at 1.5 months which is actually
10 75 percent confidence level. The rate that you're holding at
11 today is equivalent to about two full months of claims
12 payments which is 60 days on hand for that 95 percent
13 confident interval.

14 Oregon is only holding about ten percent of
15 annual expected claims. We have three other Aon state
16 clients who are only using an IBNP reserve. They do not have
17 a contingency reserve. Two of our other Aon state clients
18 does similar to what Oregon does. They are holding ten
19 percent of your annual claims as a contingency. One of them
20 is using 200 percent of risk based capital, and another one
21 is similar to you and is using 60 days.

22 So as you can see here, PEBP is definitely on
23 that very conservative end on what other states are doing.
24 These are in ascending order of magnitude, and PEBP would be
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1 again at that bottom, most conservative growth.

2 MEMBER MITCHELL: Jet Mitchell for the record.

3 Quick question about under what are other
4 industries doing.

5 MS. MESSIER: Yes.

6 MEMBER MITCHELL: The statement they typically do
7 not hold a separate contingency reserve, what is the
8 rationale behind not holding -- as a general rule what is the
9 rationale for that benchmark of not holding a separate
10 contingency reserve?

11 MS. MESSIER: I think with private sector folks
12 they have different ways. It's one of those things where you
13 can make more widgets. With a state it's different. It's
14 just a different organization. You have taxpayers in
15 different ways of funding items. Whereas with a private
16 sector entity, it's just a different organizational makeup as
17 to where they can go to get additional funding.

18 MEMBER MITCHELL: Thank you.

19 MS. MESSIER: Yeah, good question.

20 I mean, here it is important to point out there
21 usually -- it's like usually like a five, ten percent margin
22 we see on IBNP for them. Whereas yours is closer to 25,
23 upwards of 25 percent load on your IBNP. So your IBNP is
24 definitely being loaded at a much higher rate than we see for
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1 other entities.

2 So going to other approaches that I think PEBP
3 could consider. You definitely could look into lowering your
4 margin on the IBNP down to 50 or 75 percent confidence
5 interval. As Tom mentioned, this would be able to release
6 6.6 million up to 11,000,000 of reserves back to the plan.

7 Jet, do you have another question?

8 MEMBER MITCHELL: Jet Michelle for the record.

9 If that -- if that lowering was done, just to
10 clarify, that release of reserves would be a one time release
11 back into the plan?

12 MS. MESSIER: That is correct.

13 MEMBER MITCHELL: Thank you.

14 MS. MESSIER: Yep.

15 Next we wanted to provide you with a couple of
16 different options. It's important to know what the
17 catastrophic reserve too. There is no actuarial standard for
18 catastrophic reserves, and that's why I, again, you see
19 private entities aren't holding it. Whereas, when it comes
20 to an IBNP reserve it's an accounting standard that you're
21 required to hold, and there's actuarial standards around
22 setting the IBNP.

23 With catastrophic or contingency reserves,
24 there's multiple different methods out there that are being
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1 adopted either by states or public entities, and so some of
2 them, again, are using a days on hand measurement. If PEBP
3 decided to go with a 50 days on hand rather than current
4 60 days, you could release 8.2 million of reserves off of
5 your catastrophic back to the plan. Again, as to Jet's
6 question, that's a one time release.

7 You can also move to a risk based capital
8 approach. Some states are holding a 200 percent authorized
9 control level. Some states wanted to be more conservative
10 and down to the 400 percent. If you went to 200 percent,
11 that would release 15.5 million dollars of reserves back to
12 the plan. Conversely, if you wanted to go to the
13 400 percent, that would actually increase your catastrophic
14 reserves by 11.4 million or another option would be to just
15 go with ten percent, as we've seen other states do, such as
16 Oregon, as well as a couple of other of our state clients and
17 that would release 18.4 million back to the plan.

18 Ultimately, again, the margin levels and
19 methodologies are set at your discretion and based on your
20 own risk tolerance, and that's what we see in the private
21 sector.

22 And then finally in our appendix we wanted to
23 include just more details about the reserve calculations for
24 those of you who like the additional details. We provided
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1 that back to the -- based on an LCB audit request in April,
2 and we just wanted to include it here for completeness.

3 Any other questions?

4 VICE CHAIRWOMAN FOX: Anymore questions from the
5 Board?

6 MR. HAYCOCK: For the record Damon Haycock.
7 Again, thank you, Stephanie, for presenting on these two
8 reserves.

9 And before we turn it over to Cari, one of things
10 that I think is important to consider when we look at other
11 approaches to consider all of those returning funds back to
12 the plan, those reserves back to the plan, as Ms. Mitchell
13 asked Stephanie, which is one of the things I wanted to make
14 very clear is that it would be a one time money grab, and it
15 has not been prudent in the past to provide benefit
16 enhancements on one time funds.

17 And so this is only a depletion of the reserves
18 to give back a certain amount immediately. And so, yes,
19 there may come a point in time when the State is back in a
20 position where it needs money, and they may look to our
21 reserves to reduce that risk but recognize that if the state
22 needs money maybe it's pretty risky, and maybe it's a good
23 time to hold onto that anyway.

24 So there's a bunch of arguments to be made of is
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1 there a true benefit or advantage to change the reserve
2 levels and return funding back to the plan when as Stephanie
3 mentioned we had a very difficult time trying to go back to
4 the legislature in the off year to ask for additional funds,
5 right. They don't create a supplemental funding source large
6 enough at times for a big issue that PEBP can't solve, and
7 there is no real mechanism outside of going there with hat in
8 hand and saying you know what, we were wrong on our
9 assumptions and now we need money, and that will eventually
10 if it was funded which it would have to be because we have
11 claims would be taking away from other programs and services
12 already approved budgetarily for other agencies across the
13 state.

14 And so, yes, it may seem like PEBP is
15 ultraconservative to set the types of reserve levels that it
16 does but recognize it's set that way so we don't have to go
17 back to the legislature and ask for money. And if there was
18 a way to reduce our reserves to have continuous benefit
19 enhancements to return back to the employees, the retirees
20 and the families, you would be hearing me say something
21 different today, but one time funding is just a money grab
22 that goes away and it becomes an additional risk moving
23 forward.

24 That's all I wanted to add. Thank you, Madam
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1 Vice Chair.

2 VICE CHAIRWOMAN FOX: Thank you.

3 Anymore discussion? Jet?

4 MEMBER MITCHELL: No thank you.

5 MS. MESSIER: Thank you.

6 VICE CHAIRWOMAN FOX: Thank you.

7 Cari?

8 MS. EATON: Thank you. Cari Eaton, chief
9 financial officer for the record. I'm going to discuss the
10 HRA reserve. PEBP currently has two types of HRA accounts
11 available to employees and/or retirees. There's the CDHP HRA
12 and the Medicare Exchange HRA. I provided an overview of the
13 CDHP HRA on page two of the presentation.

14 Employees who are on the CDHP plan who are not
15 eligible for a health savings account or who failed to
16 establish an HSA and retirees covered under the CDHP plan
17 will receive a CDHP HRA account. Funds in this type of HRA
18 account may be used tax free to pay for eligible medical
19 expenses as defined by the IRS to include payments of
20 deductibles, co-insurance and other out-of-pocket qualifying
21 healthcare expenses.

22 Payment of premiums are not allowable on the CDHP
23 HRA accounts. HRA contributions for employees and retirees
24 on the CDHP plan are determined based upon the availability
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1 of funds and Board action.

2 HRA contributions are available for use by a
3 participant of a lump sum around July 1st of each year and
4 participants and dependents who become eligible for PEBP
5 coverage after July 1st each plan year will receive a
6 prorated base contribution for the participant and their
7 dependents based upon their coverage effective date and the
8 months remaining in the plan year. Participants cannot
9 contribute additional funding to their HRA account.

10 The next page is an overview of the Medicare
11 Exchange HRA. All retirees enrolled in the Medicare Exchange
12 who have five or more years of service will receive a
13 Medicare Exchange HRA account. Funds in the Medicare HRA
14 account may be used to reimburse eligible medical expenses
15 just like the CDHP one, except they do include payment of
16 premiums.

17 Retirees on the Medicare Exchange receive a
18 monthly contribution. That is determined based upon
19 available funds and Board action, and the approved monthly
20 amount is calculated on a per month per year of service
21 basis. So for example, the contribution amount for the
22 current plan year is \$13 per month per year of service. So a
23 Medicare retiree with 15 years of service will receive \$195
24 per month in available HRA funding.

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1 All HRA contributions for the CDHP and the
2 Medicare Exchange that are not utilized by the participant
3 will roll-over for use in the next plan year. All HRA
4 contributions that are available in an HRA account at the
5 time that a participant terminates coverage are reverts and
6 are no longer available for the participant's use and are no
7 longer a liability of PEBP.

8 You'll see the policy that is used for the HRA
9 reserve on page four of the presentation. The HRA reserve is
10 a fully funded reserve based on the total balance remaining
11 as of June 30th each year.

12 The Board has chosen for many years to provide
13 supplemental contributions to spend-down excess reserves, and
14 this does directly increase the HRA reserve balance. Page
15 five shows the enrollment history that also has an effect on
16 the HRA reserve balance. PEBP transitioned to the CDHP plan
17 and the Medicare Exchange beginning in fiscal year 2012.
18 This table outlines the enrollment as of July 1st each year
19 for CDHP participants on the HRA plan and the Medicare
20 Exchange retirees. With the exception of the fiscal year
21 2013 the total HRA has increased each year.

22 The next page outlines the HRA contribution
23 decisions from 2012 through the current fiscal year. So each
24 year the Board decides what the HRA contribution amounts will
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1 be depending on available funds. The Board has kept the base
2 contribution similar to years past and added a one-time
3 supplemental contribution to utilize excess reserves.
4 Additional contribution amounts will increase HRA reserve
5 balance if participants do not utilize their additional
6 available funds.

7 Page seven shows the HRA balance history since
8 fiscal year 2012 as compared to our legislatively approved
9 budget. Since 2012 the HRA reserve balances have varied from
10 what is budgeted and balances suddenly increased most years.

11 PEBP utilizes the total balance as of June 30th
12 of each even numbered fiscal year to project the amount to
13 budget for the following two years. So for the fiscal year
14 2020-2021 budget we used fiscal year 2018 actual fund
15 balances to project.

16 To summarize the main causes of the steady
17 increase to the HRA reserve CDHP employees and retirees and
18 Medicare Exchange retirees have been provided with a
19 significant amount of funding to allow them to offset their
20 medical expenses since 2012. HRA reserves continue to grow
21 each year because of additional contributions, enrollment
22 growth and participants not utilizing the funds that are
23 available to them, and I'm available to answer any questions.

24 VICE CHAIRWOMAN FOX: Any questions from the
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1 Board or discussion? I don't think so.

2 Thank you, Cari.

3 Okay. So I think we're ready for Agenda Item
4 Number Seven, discussion of possible action regarding
5 proposed plan design changes for the Plan Year 2021. Damon
6 Haycock.

7 MR. HAYCOCK: Thank you, Madam Vice Chair. Damon
8 Haycock for the record.

9 One of the things that wasn't discussed in the
10 last agenda item but you heard some discussion about it in
11 public comment this morning is what about excess reserves.
12 And one of the things that I wanted to bring up that I
13 quickly looked up while we were having this meeting today is
14 the reporting of excess reserves throughout the year can
15 change dramatically. And so one of the requests you heard
16 today from public comment was to table the decisions and see
17 what those excess reserves looked like in January.

18 So I'm going to give some reporting numbers that
19 we have reported in our budget reports every quarter for the
20 last plan year to show the dramatic variances that occur
21 based on the timing of funds and the timing of claims because
22 they are not all equal every month and every quarter.

23 So in January of this year, 2019, we reported the
24 first quarter of Plan Year '19s budget and -- budget and
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1 utilization report. And in that budget report we showed that
2 we were projecting about \$6,000,000 of excess reserves at the
3 end of the year. Then in March of 2019, we reported the
4 second quarter's excess reserve projection and that was up to
5 44.6 million dollars.

6 The third quarter report was provided in July of
7 this year, and that dropped it back down to 23.8 million
8 dollars. And the fourth quarter finalized it at about 22.4
9 million dollars which was provided at the very last Board
10 meeting. And I know the question is why on earth did it go
11 from six to 44 down to 23? And when we receive all of our
12 revenue and we pay all of our expenses, there are times when
13 we are ahead of the game in the revenue and there are times
14 when we are behind the game in the revenue and same with the
15 expenses. And so when we take a point in time on the last
16 day of every fiscal quarter, we report what we see.

17 Now, imagine we would have made decisions last
18 year based on -- actually, there were -- let me back up.
19 There were decisions based on excess reserves last year for
20 Plan Year 2020 this last, almost exactly a year ago today.
21 And imagine if we would have tabled those and waited for
22 January and said, oh, no, there's only \$6,000,000 left. A
23 lot of those decisions that we were contemplating would have
24 been invalid. And so what we try to do on excess reserves is
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1 come up with an exact point in time where we know we can
2 defend them based on a very simple ideology.

3 At the end of every fiscal year we close. We
4 close it on August 31st or some day a few days prior. And at
5 that day we know exactly what our new requirements will be
6 for our required reserves, our IBNP and our catastrophic and
7 if there's any changes, we make those adjustments. We
8 generally have to backfill them because they have been
9 increasing.

10 We know what has already been earmarked either by
11 the legislature or this Board or both for that plan year. So
12 we reduce that number of excess again. And then we also look
13 at what has been approved for the following plan year if
14 there was an idea to move forward with spending excess
15 reserves over the biennium. A good example is the
16 legislature approved enhanced HRA/HSA funding for both years
17 even though we look at approving benefits each year during
18 the November time frame.

19 And so the excess reserve decision, if we want to
20 table any of these conversations until January, if you used
21 January's number, chances are you're going to be wrong. If
22 you use March's number chances are you're going to be wrong.
23 And so the best recommendation that PEBP has is to utilize
24 the excess -- the true excess reserves that are reported on
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1 -- in our accounting when we close the fiscal year, and
2 that's a great segue into the very first page of this report
3 where we outline exactly that process.

4 So this was done in September and we copied it
5 over to the November report because the closing of the fiscal
6 year didn't change. We have way too premature data to talk
7 about any additional potential reserves and the fact that you
8 heard from AON today that we have a 5,000,000 dollar,
9 6,000,000 dollar claim on the books coming in, that isn't
10 taken into account into our utilization to show are we really
11 gaining or losing excess reserves.

12 So the first part of the report, of course, says
13 when you get down to it after there was a remaining available
14 12.9 million dollars, similarly to what we talked about in
15 September, that a large chunk of that has already been
16 earmarked, and we can tell you today that a lot of it has
17 already been spent. There was an about 9.6 million dollar
18 approval at the legislature to send out HSA/HRA funding to
19 replace some much needed equipment at PEBP and to reclassify
20 one of our positions. Those last two are very minor compared
21 to about nine and a half almost that went out, nine and a
22 half million to the HSA and HRA contributions.

23 So we also have a budget that is earmarked
24 \$3,000,000, again, in the second year which is the \$125
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1 enhanced HSA/HRA funding, additional, again, equipment
2 replacement based on the state's replacement schedule and,
3 again, we have to pay a little bit more for that personnel
4 reclassification.

5 So when all is said and done, we are reporting
6 again today about \$235,000. Now, I know right now if
7 Ms. Lockard was here she would call foul and say you report
8 low every September. Then in November it comes in higher.
9 We can show you today that we had no clue today that we would
10 be at \$235,000. We thought we would be somewhere in the
11 couple of million dollar range all throughout last year even
12 when the legislature decided to do a one -- a one-year
13 initial significant reduction to those reserves.

14 So this was a little bit surprising to us, and I
15 think we talked about it in the State of PEBP last Board
16 meeting as to why -- where did the money go. How did it all
17 get spent, and we can basically back into the final budget
18 report that we gave you last -- last Board meeting on what
19 happened to the \$23,000,000 and that's why we're back down to
20 the 235,000.

21 So you can table this entire discussion to
22 another some month, but I don't think it's going to change,
23 and I think that it would be -- I would caution the Board to
24 contemplate based on current reporting exactly how volatile
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1 that the -- that excess reserve number truly is because at
2 the end of the day, it is PEBP's opinion that an excess
3 reserve is the money that is left in our account, the cash we
4 have on hand after we've satisfied all of our obligations for
5 the year and we've earmarked all of our obligations for the
6 next. And if we can accept that or if we agree to accept
7 that then it becomes a very simple math perspective and
8 that's what we've been doing for the last three years
9 running.

10 So before I go into each one of these separately,
11 I do want to talk about what the overall recommendation is
12 because I think it's going to be important to start from the
13 back and move forward with one disclaimer and this is
14 something I think is very important that everybody keep in
15 the back of their head as we talk about plan design changes.

16 During the last legislative session the
17 legislature approved PEBP's budget by overruling some of the
18 decisions that this Board had made back in November and again
19 in March, decisions that were made in establishing rates,
20 decisions that were made in setting plan design, decisions
21 that were made in -- in the development of this program. I'm
22 not saying that's good or bad. I'm just saying it is.

23 And because the decisions were changed, it
24 appears at least to PEBP that the Nevada Legislature would
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1 like to have a more active role in the program design moving
2 forward, and that I have personally had to testify and defend
3 why PEBP and our Board has changed benefits after the budget
4 has been approved for the biennium. That has been a
5 consistent concern that I have had to address at the
6 legislative testimony table.

7 And so when we talk about what is available and
8 or what we recommend and what this Board can approve I think
9 it is prudent to keep that in the back of everyone's mind
10 that it may not make sense to make any changes to the plan in
11 the off year if we are going to have potential issues when we
12 have to justify our budget in the next session.

13 So with that in mind, we have looked at the fact
14 that we only have a couple of hundred thousand dollars of
15 projected excess reserves. That's what we closed the fiscal
16 year at. We don't know if that's going to change, go up or
17 go down, but we do know that's the number at the point in
18 time that we can honestly claim without a shadow of a doubt
19 that is the excess reserve level June 30th or August 31st of
20 this year.

21 So with that that is basically about the average
22 cost of one high cost claim. So in PEBP's mind we -- we
23 don't really feel we have excess reserves. So that could be
24 wiped out very quickly with one visit to the hospital for one
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1 of our members. And so -- so we looked at what were the
2 types of opportunities that would pay for themselves that had
3 an initial first year return on investments so we were not
4 over-obligating the plan's resources.

5 As I was told recently by folks at the
6 legislative counsel bureau, it is, let's see if I can say
7 this accurately. Any executive branch state agency who
8 knowingly increases their obligations after the legislature
9 has appropriated funds for those obligations does so at their
10 own risk.

11 So, again, with that in mind, we have a basic --
12 a basic recommendation today, and I'm going to read the
13 recommendation, and then we're going to go through each of
14 these separately because I think it's important we keep what
15 we're looking at ultimately moving forward.

16 And that is there are two items here that have no
17 or excuse me, that have an initial return on investment.
18 There is another item here that aligns the decision-making of
19 the Board what the legislature has already approved, and then
20 the rest of it is basically member education and looking at
21 pushing some of these requests from our advocates and some of
22 the requests that we have thought internally to the budget
23 building process that we can talk about in the next agenda
24 item.

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1 So the two issues or the two opportunities we
2 have today that don't cost PEBP anymore money than what we're
3 going to save is a piloted chronic kidney disease program or
4 set of services, as well as a second opinion opportunity to
5 utilize a third party to assist our members.

6 Again, I can be very strong in my
7 recommendations. I'm not strongly recommending anything
8 today. I think if we do nothing and continue with what we
9 have in the plan that we'll continue to be solvent. We'll
10 continue to be aligned with the Nevada Legislature, and that
11 we won't have to get up there and defend why we had made
12 changes to the plan in the interim.

13 So going back to the beginning, I'll take these
14 one at a time and then we'll pause, Madam Vice Chair, if
15 there's question or people want to vote or if we want to wait
16 until the end. But the first thing we looked at was
17 implementing the Smart 90 Network on the exclusive provider
18 organization or EPO plan.

19 For reference we implemented a -- the Smart 90
20 Pharmacy Network. It's a narrower network for 90-day fills
21 of maintenance medication on a voluntary basis last plan year
22 on the CDHP, but we also made it mandatory this year as more
23 folks had already started utilizing this network voluntarily.

24 We were able to save -- save money. Right now I
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1 think we're looking at about 194,000 was saved in Plan Year
2 2019, so not a whole lot, but it did create a savings to the
3 plan, and it was something that we wanted to research and
4 analyze if we could mimic it on the EPO plan, but the EPO
5 plan was designed differently. It's designed with co-pays
6 for the most part on the prescription benefit and only
7 co-insurance on the specialty drug side.

8 And so when we talked with our pharmacy benefits
9 manager Express Scripts and analyzed the data, it didn't look
10 like we could save any money at all. So why would we narrow
11 a network on a buy-up plan to not save any money and to just
12 add more hoops for those members who are paying more in
13 premiums to have a richer plan design. So we are definitely
14 not recommending today that we move forward with that. We
15 will continue to watch that and analyze and see if there are
16 savings.

17 RPM did, however, analyze the opportunity to do a
18 mandatory mail order program. A lot of states that I have
19 talked to have this in place to control costs. They force
20 the members for their 90-day fills to go through mail order
21 through their vendor. We do not have that program today. It
22 does have the opportunity to save the plan money. However, I
23 don't know if now is the time to -- to place a restrict --
24 restrictive process on our members, especially when that
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1 restrictive process has not been evaluated by our
2 legislature, and I don't know if we want to cause the turmoil
3 that that would occur for folks, especially the members I've
4 talked to in Las Vegas who don't want their medicine sitting
5 on their front porch in the 110-degree weather, and so it is
6 something that is available.

7 We're showing you this option just for
8 transparency sake to show that we did our due diligence, but
9 PEBP is not recommending either of those options, the Smart
10 90 Network on the EPO plan or a mandatory mail order option
11 today, and we recommend potentially looking at that mandatory
12 mail order as a budget enhancement to build into the next
13 biennium so the folks at the Governor's Office and
14 legislature can decide if they want to utilize that to save
15 some money.

16 And I'll stop there, Madam Vice Chair, and take
17 questions or comments.

18 VICE CHAIRWOMAN FOX: Is there any question or
19 discussion?

20 MEMBER VERDUCCI: Yes, Tom Verducci for the
21 record.

22 You know, I'm trying to understand what's
23 different from this year than from last year, and what I'm
24 reading here in this report is the 9.6 million dollars in the
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1 legislative approved excess reserves spend. Is that an
2 annual expense to the program and was that budgeted for a
3 year ago when we did our budgets?

4 MR. HAYCOCK: For the record Damon Haycock.

5 The 9.6 million was for specifically Plan Year
6 2020. It was not initially built in our agency request
7 budget but it did make it into the Governor's recommended
8 budget announced on January 15th of this year, and it did
9 make its way through the legislature for ultimate approval.
10 If you recall, I think it was the January Board meeting that
11 I brought it back to the Board for the Board approval to
12 align the decision-making, but excess reserves spent for HSA
13 funding has been pretty traditional here at the Public
14 Employees' Benefits Program all the way back to like 2013.

15 MEMBER VERDUCCI: And also as a follow-up, I
16 believe we had 34 catastrophic claims that totaled \$7,000,000
17 plus and I believe that's a one-time expense and that was
18 something that had changed the figures that we were looking
19 at from, you know, perhaps a year ago.

20 MR. HAYCOCK: Yeah, for the record Damon Haycock.
21 Thank you, Mr. Verducci.

22 The high cost claims had a significant increase
23 in utilization, and the increased amount was those additional
24 34 folks over the year prior. Yes, if we were to take the
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1 average high cost claim times those 34 folks it was about
2 seven and a half million dollars. I actually think the
3 reality, it was a little higher but because of averages it
4 was easier to hone down into that dollar figure. That didn't
5 reduce excess reserves. The way to look at it is excess
6 reserves occurred after all of our obligations. So that was
7 a standard claims payment that we would make regardless of
8 excess reserves or not. So the excess reserves intrinsically
9 were reduced but they really never should have existed
10 because of that claim. They only exist after the claims are
11 paid.

12 MEMBER VERDUCCI: So this was due to 34 high cost
13 claimants. So let's say for example we had a big flu
14 outbreak and there were now 3,000 claims, at what point does
15 it go into the catastrophic reserves?

16 MR. HAYCOCK: For the record Damon Haycock.
17 Thank you, Mr. Verducci.

18 We will utilize our catastrophic reserves when we
19 do not have enough revenue to meet expenses. That's probably
20 the easiest way to look at it. As we collect premiums, as we
21 collect funds, as we collect employer contributions, we still
22 have to pay our claims, and we pay them. To be truly
23 transparent, we're probably dipping into the excess reserves
24 and then building it back up throughout the year as the
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1 timing of the money comes in and the timing of the money goes
2 out.

3 So at the end of the year we will show -- let me
4 back up. Probably around July and August we'll know if -- if
5 our claims exceeded our projections and if they exceeded the
6 amount of funding that we assign to them, and that's when we
7 will have automatically reduced our excess -- our
8 catastrophic reserves.

9 MEMBER VERDUCCI: As far as getting a true
10 assessment of what the excess reserves are going to be, is
11 there any additional reports or gage that we can get? It
12 seems like every year around this time we look at the excess
13 reserves being low, and as we get into subsequent meetings
14 the figures look a little bit different. I'm wondering if
15 there's any special study or reports that can be produced
16 where we could gain an accurate assessment.

17 MR. HAYCOCK: For the record Damon Haycock.

18 As Aon mentioned today, PEBP has been the entity
19 that has looked at our revenue and expenses and at the end of
20 the day reported what we thought excess reserves would look
21 like. We can utilize their expertise and reserve
22 calculations and have them assist us in the projection of
23 excess reserves. I would just again caution that we spend
24 money before we have it. Even though we project that we're

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1 going to have it because you never know when the 6,000,000
2 dollar claim is going to come in and I think you're going to
3 kick yourself if you utilize that projection and the
4 projection is wrong.

5 A great example was the Aon presentation where
6 they said their best estimate of IBNP was a certain dollar
7 amount and they are off a couple of million dollars, that's
8 why we have some of the conservative policies at the Board.
9 And so if you want to spend the money before you have it, it
10 could come back and bite you.

11 MEMBER VERDUCCI: So to me it would make sense on
12 the no cost items here be approved and the other items that
13 we're not clear on, to me it makes sense they should be
14 tabled until the January meeting.

15 MR. HAYCOCK: For the record Damon Haycock.

16 I think that's pretty close to what our
17 recommendation is here. Although, the ones that require
18 funding, I can't imagine whoever is going to be here is going
19 to come back and then find excess reserves by January, but I
20 suppose they could, but I don't see it because it doesn't
21 appear we have it. Not only did we have those 34 high cost
22 claimants that soaked up on average seven and a half million
23 dollars, we also had to increase by about four and a half,
24 \$5,000,000 our required reserves because of the new exclusive
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1 provider organization plan and the utilization and the slower
2 payment of claims and the higher cost of those claims that
3 increased the catastrophic reserves.

4 And so back to that table on page one and page
5 two, you'll see that we had to increase our IBNR reserves by
6 4.4 million, and our catastrophic reserve, actually it went
7 down, which is nice, by about 400,000, but our HRA reserve
8 went up 2.4 million, and we gave out nine and a half million
9 dollars of HSA/HRA funding, cash went out out for the HSA,
10 but the liability was created on the HRA. So we have to have
11 cash and reserve to cover it.

12 And so every time we give away more HRA funding
13 people don't spend it immediate. Whereas we give away HSA
14 funding, we consider it expenditures of PEBP. It's just
15 gone. And so every time we give away HRA funding, those
16 balances increase, and we have to hold the cash in case they
17 use it. So, again, it's kind of a snowball effect. When
18 claims go up and costs go up, catastrophic reserves go up, if
19 we start paying a little bit slower for many good reasons why
20 we would, claim or IBNR goes up and then we also have to, if
21 we're giving away more money, then HRA goes up, and so all of
22 these reserves compound when we have years like we did last
23 year.

24 MEMBER VERDUCCI: Well, it makes sense what
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1 you're saying there that you want to see the money there
2 before it's spent.

3 VICE CHAIRWOMAN FOX: So are we okay with having
4 Damon go through all of this before we vote on any of it?
5 Yeah, okay. All right.

6 MR. HAYCOCK: For the record Damon Haycock. I
7 will then continue through.

8 So the next one is on second opinion services.
9 Today we have that plan offered or on our plan we offer those
10 services. We utilize the Mayo Clinic and the Cleveland
11 Clinic. There is a potential travel benefit for folks that
12 would like to utilize that second opinion service. However,
13 our partner, our third party administrator HealthSCOPE
14 Benefits has found another provider that can potentially
15 assist even more of our members to navigate through this
16 process and receive second opinions on a whole slough of
17 different types of services. I have them here on page three
18 of the report.

19 They include basically like musculoskeletal,
20 nervous system, oncology, digestive system, female
21 reproductive system and circulatory system types of services.
22 What this second opinion entity is willing to do is provide
23 expert medical opinions, treatment, decisions, support,
24 referrals to local high value providers and, of course,
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1 ongoing support. The company is called Second MD, but they
2 would be treated just like any other provider and bill the
3 plan a claim for services. So it's not like there's a
4 specific direct relationship we need to have with them, just
5 like we don't have direct relationships with doctors today or
6 with hospitals today, right? We have networks, and so this
7 would be a network addition, basically operated through the
8 HealthSCOPE contract.

9 They are guaranteeing a 1.25 to one based on
10 episode of care costs, the episode of care for the expert
11 opinion and with a member ultimately chooses. So if a member
12 is told they need to have a certain type of treatment and a
13 certain side of care and they get a second opinion and they
14 don't decide to utilize that -- that service, then the
15 difference in cost will be -- will be utilized for the
16 savings amount, and that savings will be matched against what
17 we pay in claims for the second opinions, and so they have
18 agreed to do 1.25 to one.

19 I think it will be viewed as a member enhancement
20 or a benefit enhancement so our members that would utilize
21 these services will see a richer benefit, but it's not like
22 we don't do this today in some fashion and so I'm not, you
23 know, ready to beat down the doors and say this is something
24 we need to do. This is the right thing to do. If this is
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1 something we want to wait on based on my initial disclaimer
2 at the beginning of this agenda item, I don't think we are
3 going to harm anybody because there already are second
4 opinions today.

5 Then there is a chronic kidney disease management
6 pilot program. We currently partnered with American Health
7 Holdings for our utilization management and large case
8 management, and they have a series of services that they
9 provide for chronic kidney disease for other clients
10 throughout their book of business. It was something we
11 didn't activate initially when we negotiated our contract.
12 However, they can as a typical provider also bill for this
13 service through -- through medical claims through HealthSCOPE
14 Benefits.

15 We -- we do have a high cost for chronic kidney
16 disease. About 7.4 million dollars we spent last year and
17 there are five stages, and I'm not a doctor. I'm not going
18 to try to pretend to be one, but my research shows there are
19 five stages of chronic kidney disease and as you move through
20 those stages, your health, of course, gets even worse, and by
21 the stage five you're in total kidney failure and you're
22 either looking at transplants, dialysis or both. So how do
23 we get people to avoid getting dialysis and transplants and
24 basically saving those kidneys.

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1 And so there is an opportunity through a disease
2 management process to try and pilot this. Though we would --
3 we would get a return on investment of one to one, and the
4 way that we would look and measure that return on investment
5 is those folks with chronic kidney disease in each of these
6 stages that seek care through this service would be matched
7 up against those similarly situated that didn't and the delta
8 or the difference between their cost would be recorded as
9 savings, and then we reduce the amount of those savings by
10 what we paid for the services, and if we pay more than what
11 we saved they would make us whole. That's the return on
12 investment.

13 If we save more than what we paid, well, then
14 there's a little bit of gain sharing involved there to try to
15 motivate them to continue to do better. And so if the
16 savings, it's that final bullet on page four, if the savings
17 outweigh the total annual spend, we'll share 25 percent which
18 is pretty standard of the savings up to -- up to a cap. It's
19 up to about \$100,000 of shared payment savings, and I show
20 some math in there. But basically if they save us a billion
21 dollars we're not going to give them a quarter of a billion
22 dollars, right. I mean, we're not going to do that. It's
23 not in our best interest. Do we think we're going to save us
24 a billion dollars, of course not, but that's just an extreme
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1 idea as to why you want to put caps on gain share so there's
2 an amount you share back but then if you get really good
3 savings, most of it or all of it stays with the plan.

4 So we can pilot it. Again, it's not something
5 that we can't put off. It's not something that we have to
6 put in place this next plan year. And if you followed,
7 again, my disclaimer at the beginning of this report, it may
8 be prudent to push this off into the next biennium and
9 present it as a value at a benefit addition, a richer benefit
10 design as part of our budget development through the
11 legislature next session.

12 The next items is CDHP HSA and HRA funding. We
13 basically said would you like to approve what the legislature
14 already did which is \$125 for primary participant in the next
15 plan year. When we voted on the \$400 that was approved for
16 this plan year, we only brought that portion for your
17 approval. So to clean it up, we're bringing it back again to
18 align the decision-making.

19 Then as far as centers of excellence, this was
20 for Ms. Mitchell. She wanted to know if there was a way to
21 increase the utilization of them. We currently have a
22 mandate to use them for bariatric surgeries and transplant --
23 transplants, and the provider recommending the service works
24 with PEBP's case management partner and third party

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1 administrator to ensure folks get access to those centers of
2 excellence.

3 We can develop a program that either incentivizes
4 the use of them or de-incentivizes the not use of them,
5 right. Similar to our reference based pricing program we
6 have for hips and knees where we pick champion locations and
7 say that's what we're going to pay off of and if people go
8 anywhere else they pay the difference. That can be looked at
9 as a benefit reduction. It can be a paying point to some of
10 our members who don't want to go to one of these locations.

11 Although, we think it's important to use a center
12 of excellence, it also may be more costly so we also have to
13 think about that as well because sometimes, not always but
14 sometimes quality incurs a higher cost. And so what we
15 recommend is pending the decision, of course, that you guys
16 decide on the second opinions because part of second opinions
17 is also steerage to centers of excellence. We think it may
18 be in our best interest to showcase what those centers of
19 excellence are and post them on our website, reference them
20 in our newsletter, send them out to -- send notices out to
21 our members so they know they have these benefits and know
22 where these designated centers of excellence are.

23 Something I should have said at the beginning of
24 this section, there is no like federal definition of a
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1 centers of excellence or a state definition. So it's
2 incumbent upon every health plan to kind of determine their
3 own, and so we utilize the Etna National Network, and they
4 have a series of centers of excellence for all types of
5 services that -- that they have provided us and we can -- we
6 can post them. We can educate our members on them, and
7 that's what we think probably is the right thing to do at
8 this stage.

9 Then moving onto the page six and into page
10 seven, these are mostly the requests of the Nevada System of
11 Higher Education, Nevada Faculty Alliance. These are talking
12 about reducing deductibles, eliminating co-pays for vision
13 exams, increasing the dental benefit maximums, and you'll see
14 different layers and levels and tiers of what it could look
15 like and what the costs would be to PEBP.

16 Normally we would have a deeper conversation
17 about these when we had a significant level of excess
18 reserves, but with \$235,000 I don't think we can do anything
19 on here. So our recommendation for these three items and the
20 one that isn't in here that was in Dr. Unger's attachment
21 which was increasing the HSA funding for dependents by \$100,
22 that additional cost and these costs we believe should be
23 built if you are interested into a budget enhancement unit,
24 and we'll talk a little bit more about that in the next
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1 agenda item.

2 Then there was another request at the last
3 meeting by Mr. Ervin from the Nevada Faculty Alliance. He's
4 not here today. He told me he wished he could be, but I'm
5 going to bring this up for him. That there was an
6 announcement that came out I think from the IRS about the
7 potential increasing to preventive benefits and if the plans
8 wanted to utilize that, we have a preventative drug benefit
9 today where we bypass the deductible to allow folks that need
10 preventive medicines and maintenance medicines, first dollar
11 coverage from the plan to help them pay for those much needed
12 prescriptions. There were basically five things that were on
13 that IRS issued update.

14 The first was the addition of selective
15 serotonin, reuptake inhibitors or SSRI's that's for
16 anti-depression. Then there's inhaler cortisone steroids for
17 more of those asthma, COPD folks, peak flow meters and asthma
18 assistant devices, diabetic medication and glucometers and
19 blood pressure monitors. So we already covered inhaler
20 cortisone steroids on our current list and diabetic
21 medications and glucometers are provided through our diabetes
22 care management program today.

23 The blood pressure monitors are available through
24 the medical benefits. So the only additions would be the
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1 anti-depressants and peak flow meters. And when we had that
2 utilization, the current utilization of those two on our
3 plan, our pharmacy benefits manager came back and said it
4 would cost 216,000. However, that's for current utilizers
5 only. So we don't know if additional utilizers would come to
6 the table and start utilizing this more because of this
7 preventive drug benefit.

8 A good example, we developed a preventive drug
9 benefit for a bunch of different drugs when we first created
10 that list a few years ago, and I sat in front of the Board
11 and said we anticipate a half a million dollars of cost out
12 of our excess reserves. It turned out to be 1.5 million
13 because more people started utilizing it, which is a good
14 thing, but it did drive up the cost by a factor of three with
15 new utilizers, utilizers and stopped taking it and then
16 started again.

17 So we don't feel there's enough excess reserves
18 available to cover the potential increase in costs for this
19 benefit, and a lot of these benefits are already covered
20 today. But if it's something you want us to continue to
21 analyze, we can either -- of course, you all can approve it
22 anyway or if you decide to put in our budget, we can put it
23 into our budget in the next budget build as a potential cost
24 increase to be offset by other cost saving activities.

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1 So that's really all of it in a nutshell. The
2 recommendation stays the same. Again, I'm not coming out
3 pretty strong on the two items. There is -- we don't feel
4 we're going to put the plan in jeopardy if we don't do them,
5 and it may be prudent to be patient and allow the process to
6 be built into the budget. So, therefore, it's -- it's
7 consistent every two years and both the Governor's Office and
8 the legislature know how the program will be moving forward
9 and they know what they are paying for every time they vote
10 and approve our biennial budget.

11 With that, I'll turn it back over to you, Madam
12 Vice Chair, for any questions or comments.

13 VICE CHAIRWOMAN FOX: So my only comment is the
14 SSRI's, if we can break one thing out of here, I would love
15 to see it. I mean, if we included generic SSRI's because
16 they are so cheap, I would love to see that included at this
17 point, but other than that I like PEBP's recommendations.

18 Does anybody, any other Board members have
19 questions or comments for Damon?

20 MEMBER MITCHELL: Jet Mitchell for the record.

21 I do have a comment about the second opinion
22 services for CDHP and EPO. So in addition to cost savings, I
23 don't have the site here of the research studies, but
24 research studies have shown that patients that do seek a
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1 second opinion persist in the treatment of that second
2 opinion more quickly and persist throughout their treatment.
3 Additionally, patients that seek second opinions tend to be
4 happier with their plan and with the fact that that has been
5 offered to them as a patient.

6 Also, in the extensive, on patient cancer
7 advocacy work that I've done, extensive conversation has been
8 around access to second opinions. So I have strong, firm
9 strong thoughts about having second opinions services
10 available through the plan not only for that cost savings
11 which is obviously something we should keep in mind to be
12 prudent fiscally but also from the high satisfaction that can
13 be gained from patients that not only have that option, even
14 for patients that don't use that second opinion. Knowing
15 that that is available can be very strong. And then as I
16 mentioned earlier, knowing that patients access that second
17 opinion then carry through with their treatment.

18 MEMBER LAMBORN: I wanted to go back to the
19 kidney, the chronic kidney disease management, the case
20 management, and I see here that it would be the company, the
21 case management company would sign an agreement with
22 HealthSCOPE. Where would the pay for performance and the
23 measuring of performance fall? Would that be an agreement
24 with PEBP directly or with HealthSCOPE?

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1 MR. HAYCOCK: Good question, Ms. Lamborn. Damon
2 Haycock for the record.

3 We have a similar arrangement with Healthcare
4 Bluebook, Doctor On Demand. We get reports directly from
5 those entities, and then we -- we do the -- we do the
6 internal look at savings. We can also as part of the Health
7 Claim Auditors, every 90-day audit to HealthSCOPE add those
8 audits so to validate those savings every 90 days as well.
9 So we can make sure whatever you guys agree to that no one is
10 pulling the wool over your eyes and that it's vetted.

11 MEMBER LAMBORN: Along that question, again, Leah
12 Lamborn for the record.

13 So that's kind of where I'm going with is
14 whatever we agree to, I have found that these pay for
15 performance type of arrangements, if it's not spelled out
16 exactly how it's measured and what's going to be taken into
17 account during that measuring of savings that it gets very
18 gray and that the contractor generally gets to get the pay
19 for performance.

20 MR. HAYCOCK: So for the record Damon Haycock.

21 I spend a lot of time working with American
22 Health Holdings and try to figure out how we're going to
23 return on investment because if there's one thing that I
24 dislike the most is bad return on investment metrics. And we
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1 -- anytime I come up here and present to you a potential
2 savings, it is my name and my recommendation and my
3 credibility on the line. So I take it very personally to
4 ensure that whatever savings that we project that if there is
5 a guarantee that that guarantee is upheld to the most
6 strictest standards.

7 And so the initial return on investment wasn't
8 going to be as detailed as what we wanted and we told them
9 this is the only way we're going to do it, and it's pretty --
10 it's not standard in this area but it's something that PEBP
11 already uses today. So for chronic kidney disease, the
12 savings methodology is going to mirror the savings
13 methodology for the obesity care management report. Again,
14 it's similarly situated people. Those that are on the
15 program versus those that are off the program, how much did
16 they incur in medical costs throughout the year and how much
17 did they incur in medical costs throughout the year and the
18 difference we can attribute to savings.

19 Now, there's always outliers we can talk about.
20 Well, this person incurred this major accident and it had
21 nothing to do with their chronic kidney disease, and we can
22 look at pulling those out, but on average we find that this
23 is a pretty fair way to look at these pay for performance.
24 And so if we do it on the negative end, if they don't meet
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1 it, then we can also use the same metrics on the positive end
2 if they exceed it.

3 MEMBER LAMBORN: Just one final follow-up on
4 that. So those outliers and that's where it gets really
5 gray, those are spelled out in this agreement and contract.

6 MR. HAYCOCK: So for the record Damon Haycock.

7 We anticipate HealthSCOPE Benefits doing is
8 signing a letter of agreement with American Health Holdings
9 for this specific process and the billing and the guarantees.
10 We'll make sure that any agreement has that spelled out and
11 if it doesn't we won't sign it.

12 MEMBER LAMBORN: Okay.

13 MR. HAYCOCK: Or they won't sign it. Excuse me.

14 MEMBER LAMBORN: Thank you.

15 MEMBER ZACK: Madam Chair, Christine Zack for the
16 record.

17 So, Damon, with these current agreements with
18 second opinion services, are those via telemedicine or via
19 phone or you actually travel to the Mayo Clinic and Cleveland
20 Clinic?

21 MR. HAYCOCK: For the record Damon Haycock.

22 My understanding, and I'll let Mary Catherine
23 correct me, but that we actually provide a travel benefit for
24 folks to attend, as well as the ability to do it from I think
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1 pier to pier, doctor to doctor but if you want to come up and
2 bail me out I appreciate it.

3 MS. PERSON: Mary Catherine Person for the
4 record.

5 The way that it's worked, actually there's the
6 ability to do an E-review. So if the patient wants their
7 records to be reviewed, they contact us. We help them
8 collect those records. We then provide them to Mayo or
9 Cleveland Clinic. And then based on that review, then they
10 make a travel or no travel recommendation based on the review
11 of those records.

12 MEMBER ZACK: Thank you.

13 MS. PERSON: Uh-huh. Can I have one other point
14 on that. The other component to the whole second opinion
15 story is the fact that today your members do have access to
16 the nationwide Etna Network. And so at any time we can work
17 with your numbers around getting a second opinion from
18 another provider. It's certainly in concert with American
19 Health Holdings. So that is also another option available to
20 all of your members today.

21 MEMBER ZACK: Thank you. My concern was more
22 over the travel cost and the cost associated with people
23 having to take off time from work, maybe arrange childcare
24 and whether or not this is a benefit that we actually don't
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1 currently have in that it could be done virtually. I still
2 support it but just had those questions about what we're
3 currently offering.

4 MS. PERSON: The -- excuse me, the additional
5 benefit that we were talking about was a fully virtual
6 program as well which would be really in addition to all of
7 the other things you have.

8 MEMBER ZACK: Great. Thank you.

9 MS. PERSON: Uh-huh.

10 VICE CHAIRWOMAN FOX: So any other questions for
11 Damon or discussion?

12 So, Mr. Verducci, you didn't actually make a
13 motion but had a suggestion that you liked PEBP suggestions
14 other than you wanted to revisit in January rather than at
15 the next budget cycle.

16 MEMBER VERDUCCI: Tom Verducci for the record.

17 Madam Vice Chair, I wanted to see if I could
18 clarify the suggestion that you were making because that
19 could perhaps be intertwined into a motion.

20 VICE CHAIRWOMAN FOX: Okay. So my suggestion was
21 simply regarding the IRS approved drug list that we actually
22 at this point include generic SSRI's. So I know there's a
23 list of five things here. Some have already been addressed
24 in our plan, but I would suggest we include the SSRI's at
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1 this point. I know this doesn't specify if they are generic
2 or not generic. I'm going to assume they are because the
3 cost was so low that you mentioned, but I would request if
4 they are generic that they be included.

5 MEMBER VERDUCCI: Thank you. I'm willing to make
6 a motion on this item.

7 VICE CHAIRWOMAN FOX: Okay. Let's hear that
8 motion.

9 MEMBER VERDUCCI: For the Plan Year 2021, the
10 motion would be that PEBP recommend implementing second
11 opinion services with second MD from the CDHP and EPO plans
12 to piloting chronic kidney disease services in the CDHP and
13 EPO plans. Three, approving the 125 dollar enhanced
14 individual HSA/HRA funding as approved by the legislature for
15 increasing member educational benefits of utilizing the
16 centers of excellence. And five, tabling all other analyzed
17 enhanced benefits above for possibly inclusion in the '22-23
18 budget development, plus the inclusion of the generic SSRI
19 suggestion as Vice Chair Fox has suggested.

20 VICE CHAIRWOMAN FOX: Thank you.

21 So we have a motion. Is there a second to that
22 motion?

23 MEMBER PACKHAM: John Packham. I'll second that.

24 VICE CHAIRWOMAN FOX: So I have a motion and a
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1 second. All in favor -- is there anymore discussion before
2 we vote? Okay. All in favor say aye.

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

5 VICE CHAIRWOMAN FOX: Any opposed? Okay. Motion
6 carries.

7 I'm going to ask that we take a short break
8 before we move on to Number Eight. Ten minutes.

9 (Whereupon, a brief recess was taken.)

10 VICE CHAIRWOMAN FOX: Okay. I'm going to call
11 our meeting back to order, and we're going to start with
12 Agenda Item Number Eight, discussion and possible action and
13 to approve benefit changes for Plan Year 2021, PEBP's master
14 plan documents for the CDHP and premier EPO plan. Damon
15 Haycock.

16 MR. HAYCOCK: Thank you, Madam Vice Chair. Damon
17 Haycock for the record.

18 So there's a couple of pieces to this report that
19 we need your approval on first, and we talked about it after
20 the last session ended back in June or at the Board meeting
21 in July. There was a couple of bills that passed that
22 addressed things like sickle cell anemia or gestational
23 carriers and things that our plan was not quite in compliance
24 with when these benefits are to begin on January 1.

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1 And so when a plan wants to change their master
2 plan documents or their summary plan documents, they -- for
3 the current plan year, they need to do it through an
4 amendment log and post it out there for all of the
5 memberships so they know a change has occurred.

6 This is the first time we made a change since
7 I've been here at PEBP. I don't know if my predecessors have
8 had to make changes but to -- to align our plan and our
9 benefits with legislative approval over the last session, we
10 need to do a couple of things.

11 And so the first section on page -- the first
12 page of the report talks about what we're going to revise for
13 this current Plan Year 2020 and for these amendment logs.
14 First we're going to talk about the benefit limitations and
15 exclusions. We used to just blanket exclude certain types of
16 fertility and infertility services.

17 And what we've done, I should have said this
18 earlier, we actually posted this report in the track changes
19 mode. So you're going to see exactly what we're doing to the
20 language in the document. The things that are crossed out
21 are things we're taking out, and the things that are
22 underlined red, if you don't have a color copy, they are the
23 underlying ones under key terms and definitions on page two
24 and page three, but those are the new language we're going to

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1 put into these plans.

2 And so under benefit limitations and exclusions,
3 you'll see starting out on page two that we're -- we're going
4 to take out of the exclusion maternity services related to
5 our participants serving in the capacity of a surrogate
6 mother.

7 And if you recall at the last session and
8 afterwards, we brought a report summarizing what happened.
9 That the legislature has now requirements of health plans to
10 cover surrogacy which we didn't before. So we need to take
11 these exclusions out of our plans to be -- to be in line. We
12 also want to define them in the key terms and definitions.
13 So we define what a gestational carrier is and we also define
14 sickle cell disease, and so that's the first part of this
15 report.

16 Then, again, in exclusions on the CDHP amendment
17 log, you'll see on page two we take out surrogate parenting
18 from that exclusion. So the first part of page one and the
19 top of page two is the EPO document. The bottom of page two,
20 into page three is the CDHP document. We're aligning the
21 benefits in accordance with law. Again, we're taking out
22 exclusions for maternity care and delivery expenses
23 associated with a surrogacy mother's pregnancy, and we're
24 adding those two definitions. So for that part we recommend
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1 that you approve and incorporate the revisions described so
2 we can go ahead and notice and announce and post for our
3 membership so they have an accurate document. These benefits
4 begin lawfully on January 1st.

5 Then the second section describes proposed
6 changes to the CDHP and EPO master plan documents for the
7 next plan year. We traditionally bring these to you in
8 March, but there was some pretty valid comments by the
9 advocates last March that said how come you're changing
10 benefits in your plans and you're not talking about them at
11 the November Board meeting. So we backed it up to be more
12 transparent and give everybody an opportunity. You can make
13 a decision today and technically undo that decision in
14 January or March. So there is some time so folks can digest
15 what we're recommending.

16 What you don't see here today are all of the
17 administrative housekeeping things, like we changed a date or
18 we updated the has amount from the IRS. Those things we'll
19 bring back to you in March, just a summary real quick of what
20 we've done because they don't change the benefits outside of
21 what we have to do when it comes to those contributions so
22 they're not a decision necessarily that is made by the Board,
23 but we do want you to continue to approve the things that
24 need to be approved.

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1 So the first thing that we're going to do in
2 section two is we're going to define, and this is on page
3 three, we're going to talk about a breast augmentation
4 benefits for the CDHP and EPO plan. And so right now we have
5 a blanket exclusion for breast augmentation, but there are
6 folks that are going through gender reassignment, I don't
7 want to say services, but gender reassignment therapy, and as
8 part of that therapy they are issued hormones to complete
9 that transformation. And if those hormones do not take
10 effect then there are benefits that are provided and, you
11 know, in other areas. Most importantly as a comparison,
12 Medicaid covers breast augmentation if someone had 12
13 continuous months of hormonal therapy and failed to result in
14 a certain level of tissue growth.

15 And so in order to be in compliance with the
16 trans or excuse me, the gender reassignment and transgender
17 laws, as long to align with Medicaid, we recommend adding
18 this benefit just really to kind of protect the plan and to
19 ensure that we're consistent across the state. Basically we
20 would -- the revision will remove the exclusion for medically
21 necessary breast augmentation related to gender reassignment
22 surgeries.

23 The second part is wanted to clarify the
24 Healthcare Bluebook incentive reward. If you recall, you
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1 approved Healthcare Bluebook last year for this, not only for
2 this current year but it was -- yeah, excuse me. It was
3 introduced with incentives. There are certain high quality,
4 low cost providers that are shown on the website that if
5 folks do select, they get an incentive check.

6 But one of the problems we ran into is some folks
7 weren't catching them, and they become a stale check and how
8 do we deal with that and how does that money come back. And
9 so we wanted to come up with a pretty standard accounting
10 practice which is participants earning a monetary reward from
11 Healthcare Bluebook will have 180 days from the date the
12 check is issued to cash it, and those that aren't cashed will
13 be forfeited and funds will be returned to the plan. So we
14 just want to make sure we aren't carrying this liability for
15 these very small checks year over year until the end of time.

16 Then as far as CDHP, HSA/HRA contributions, we
17 wanted to align with what we're actually doing in policy, but
18 it wasn't quite clear enough in our plan documents. This is
19 for the Consumer Driven Health Plan that we wanted to add the
20 language that under no circumstances will a participant or
21 dependent who received contributions during the plan year be
22 eligible for additional contributions due to reinstatement.

23 So if you are in our health plan on July 1 and
24 you are an employee and you have HSA, you get an HSA amount.

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1 If you have HRA, you get an HRA additional balance. If we do
2 supplemental funding, it goes out on July 1. Again, this is
3 strictly for the Consumer Driven Health Plan.

4 And then if it turns out that you have an HSA or
5 an HRA and you end up terminating from state service but then
6 you get rehired a couple of months later, we want to make
7 sure that we're very clear that you can't double dip. You're
8 not going to get it all back again, right. You're going to
9 be able to carry forward the HRA funds that were on the books
10 that were for the plan year and you're not going to get an
11 additional HSA amount because it was already provided back in
12 July. So this is just to clarify that part of the program.
13 We feel it's important that we make sure that we protect
14 ourselves by outlining it directly in our plan document.

15 That is also on page five, again, reinstated
16 employees who have active employment in the same plan year
17 and have an HRA. Traditionally we have the ability to, we
18 don't do this, but you could have accumulated thousands of
19 dollars of HRA funding, started the plan year with us, got
20 another supplemental from, you know, the legislature and the
21 Board and then you left state service. What's supposed to
22 happen immediately when you leave state service as Cari
23 mentioned earlier in the HRA reserve discussion, those funds
24 are forfeited and they go back to the state and the
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1 liabilities get reduced.

2 When a member gets reinstated within the same
3 plan year as a member benefit, we allow them to keep the
4 amount of money that they had in their HRA before. A good
5 reason for this is if you get an HSA, you get the cash in
6 your account. If you get an HRA you get balance. If both of
7 these people leave and come back, that person still has the
8 HSA money that was left there, but the person with the HRA
9 loses all of it.

10 And so to try to be a little bit fairer and
11 provide a benefit, especially for those that are retired and
12 on fixed incomes that are on our plan, it's something that we
13 have been doing in practice, but we have not really had it
14 outlined in the plan. So we would like to outline it in the
15 plan to protect the decision-making of the Board and PEBP.

16 Last but not least, we want to talk about the
17 dental anesthesia. This effects really all plans. If you
18 think about it, our dental program is offered to CDHP, EPO,
19 HMO. They are also offered to -- to the -- for the Medicare
20 Exchange, but this specific is for the CDHP and EPO plan
21 because it's when dental benefits are being accessed on the
22 medical plan.

23 And so we have current language, we show in the
24 2020 CDHP that if a patient is under the age of seven, that's
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1 the real important part because in -- we don't have that same
2 age aligned in the EPO, and so this benefit is provided to
3 folks under seven. I believe on the EPO it's for folks
4 under or it just says under 18 and has a physical, mental or
5 medically compromising condition. So basically this benefit
6 allows folks that have -- that need certain type of dental
7 services through the medical plan, say they need
8 reconstructive surgery or they were in a car accident and
9 need to get it done through an inpatient location, this is to
10 align the age requirements so that way we're giving both of
11 our plans the same benefit.

12 So at the top there or in the middle of the page,
13 on page five we tell you what the EPO plan language is, just
14 three bullets and then below that with the CDHP language, it
15 goes into more detail, and so we're recommending that we
16 align both of the benefits to the one singular benefit today.
17 That you are under 18, that you do have dental needs which
18 local anesthesia isn't effective because of infections or
19 anatomic anomalies or allergies that you documented mental or
20 physical impairment requiring general anesthesia, is under
21 the age of seven. So we clarify that and that no pain is
22 extended towards the dentist or assistant dental provider
23 under this plan. Refer to the dental benefits described in
24 the PPO dental plan for those.

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1 So we went over those pretty quickly. We're not
2 really recommending new benefits. We're not saying anything
3 that isn't already either approved by the legislature or
4 approved in practice but not delineated as well or clarified
5 as well in the plan documents. But for transparency we
6 wanted to bring them to you all today because these do
7 outline benefit changes that are different than what we have
8 in our documents today. They don't really outline benefit
9 changes that we're offering with the exception of the
10 surrogacy law that is going to into effect January 1.

11 With that I'll take any questions.

12 VICE CHAIRWOMAN FOX: So I'm going to ask, this
13 might sound like a silly question. How is eight different
14 from seven? Is eight just different than -- it's just
15 clarified language?

16 MR. HAYCOCK: For the record Damon Haycock.

17 So seven, it talks -- had you guys approved a
18 whole slough of new benefits then we would need to put them
19 into our master plan document, and so one kind of leads into
20 the other into the other. And so seven, Item Number Seven
21 talks about what do you want to do different in the next plan
22 year. And the only difference that I think you guys added
23 was the generic anti-depressants and then expanded the use of
24 second opinions and expanded the use of assistance for our
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1 chronic kidney disease program. Those that we can delineate
2 in our master plan documents, we'll add that documentation as
3 well, but think of it kind of like, I don't want to make
4 light of it, but think of it like a check the box thing. You
5 make a decision on a design, but then you also need to
6 approve the documents that we post and that will keep us safe
7 legally.

8 And so this is -- this is the kind of follow the
9 bouncing ball. You start with benefits, benefits get put
10 into document and then they get posted and sent to our
11 membership. So I hope that answers your question.

12 VICE CHAIRWOMAN FOX: It does. Does anybody have
13 any questions for Damon?

14 MEMBER VERDUCCI: Yes. Tom Verducci for the
15 record.

16 I just want to discuss the Bluebook checks. It
17 seems rather archaic that we are sending these small checks
18 to people and they are going un-cashed. You know, it's
19 costly generating a check. Is there any possibility or any
20 past discussion of maybe getting a routing and transit number
21 and setting up a direct deposit?

22 I just find in my line of work people, you know,
23 nowadays are much more willing to give their banking
24 information and it alleviates cost in the paper and checks

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1 going un-cashed?

2 MS. RICH: For the record Laura Rich.

3 Yes, you are right, Mr. Verducci. It is -- it is
4 costly to generate a check, and I personally get it. A 20
5 dollar check, it's not the, you know, it's not the easiest to
6 go and cash it and deposit it. It's, you know, somewhat
7 archaic like you say.

8 Unfortunately, a lot of members that receive
9 these checks are, they are receiving them as a result of a
10 service. So they -- they have that service that is
11 qualifying them for a 25 dollar, 50 dollar check from
12 Healthcare Bluebook. Healthcare Bluebook does not
13 necessarily know that they are going to receive that service,
14 and so we only know of them or Healthcare Bluebook only knows
15 of them after they receive that service a check is generated.

16 There might be a possibility to reach out to
17 Healthcare Bluebook and ask them if they have a process to
18 maybe reach out to these members and say, hey, can we do an
19 electronic deposit or how do you wish to -- to have this
20 money deposited? Would you like a check or but for the most
21 part these services are a result or these checks are result
22 of a service that we didn't know was going to -- were going
23 to occur and so they qualify for that -- for that check or
24 for that incentive check as a result of that. So I can

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1 certainly reach out to Healthcare Bluebook and see if they
2 have a process for that and let you know.

3 MEMBER VERDUCCI: I think that would make a lot
4 of sense. It seems like we're in a digital world nowadays,
5 and I just know from, you know, my work experience that
6 typically generating a check costs about \$10 minimum. If
7 it's a 25 dollar check it's a pretty big waste. I just don't
8 know if logistically if they are set up to do a banking, but
9 that would be a good thing to look into if they can capture
10 the banking information.

11 MEMBER LAMBORN: Leah Lamborn for the record.

12 Just to follow-up on that. I think the ideal
13 thing, if it's possible, is if our employees are getting
14 direct deposit payroll can that information be shared or can
15 Health Bluebook provide the information for our payroll
16 department I guess to deposit into their account if they have
17 that, if the information is available. I think that would be
18 more ideal.

19 MR. HAYCOCK: So for the record Damon Haycock.

20 Just a couple of things I want to talk about.

21 One, I'm going to do yours first, Ms. Lamborn. We have I
22 think 151 pay centers. So, yes, the bulk of our folks are
23 either in central payroll or in the Nevada System of Higher
24 Education. We have a descent amount in PERS as well, but we
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1 have a lot of one-person shops that have to do payroll
2 deductions and inclusions, and I don't know how well they are
3 set up to do that, and a lot of them are also local
4 governments as well that support our non-state retirees that
5 are still on our plan that have access to these services on
6 the CDHP today.

7 One of the things that I was surprised, surprised
8 me very much is when I did get a check, this was some time
9 last year, who still uses checks, and my wife picked up her
10 phone and took a picture of it and 30 seconds later it was in
11 my bank account. So there are some other technological
12 advances that people have access to today to be able to
13 instantly cash checks or receive them.

14 There's also a potential concern, and I wanted to
15 address your comment, Mr. Verducci. There are a lot of
16 people that have no problem giving out their banking
17 information but there are a lot of people who do, and I don't
18 know if folks are going to be okay with a third party that
19 works with -- a third party that works with PEBP to give them
20 routing numbers and a direct link to their bank account for,
21 again, a small check that they may or may not actually cash.
22 So just thinking both sides of the fence on this one.

23 I would be careful about trying to collect
24 anymore information from our members than we need to because
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1 our role is to be the health plan, right. So, you know, as
2 an example, I don't get to know anyone on my -- any retiree
3 or employees health status or what they are seeking services
4 for unless they reach directly out to me to do some
5 investigation, and so there's a great separation there that
6 protects their information, and so I don't know if you would
7 get pushed back. I think we've had a lot of pushback from a
8 few very vocal members, on, you know, Doctor On Demand and
9 required to enroll in electronic, you know, health benefits
10 process. Just some things to think about to weigh. There is
11 a great benefit and a cost savings to doing this
12 electronically, but there's kind of a personal disadvantage
13 to some folks.

14 VICE CHAIRWOMAN FOX: Okay. Anymore discussion
15 or questions for Damon?

16 So would anybody like to make a motion? I think
17 we would need a motion for staff to approve staff to make
18 required technical changes as well as approval for the staff
19 request for Premier EPO and changes that Damon went over. So
20 we would need a motion for both of those things when you are
21 ready to do that.

22 MR. HAYCOCK: For the record Damon Haycock.

23 There's a number missing in the staff
24 recommendation. So we request approval for the Premiere EPO
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1 and CDHP Master Plan Document amendments described in
2 sections one and two for Plan Year '20 and Plan Year '21, as
3 well as approval to make any required technical changes. We
4 do need to make those changes to the current plan year
5 documents as well.

6 VICE CHAIRWOMAN FOX: Okay. So with that change
7 noted would anybody like to make that motion?

8 MEMBER MITCHELL: Jet Mitchell for the record.
9 Motion.

10 VICE CHAIRWOMAN FOX: So we have a motion. Would
11 anybody like to make a second?

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

14 VICE CHAIRWOMAN FOX: We have a first and a
15 second. Is there any discussion? All right. So I will ask
16 that we now vote. All those in favor say aye.

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

19 VICE CHAIRWOMAN FOX: Any opposed? Okay. So
20 that motion carries.

21 That brings us to Agenda Item Number Nine,
22 discussion on PEBP's fiscal year 2022-23 budget development
23 and direction of staff on budget enhancements for submission
24 of PEBP's biennial budget August 2020. Damon Haycock.
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1 MR. HAYCOCK: Thank you, Madam Vice Chair. Damon
2 Haycock for the record.

3 This agenda is designed -- this agenda item is
4 designed to be more of an open conversation, an open dialogue
5 on potential processes moving forward. We did make it for
6 possible action just in case you decided you wanted -- you
7 felt very strong about something, you wanted us to do
8 something immediately, but there is no written report because
9 we wanted to really have a strategizing conversation and not
10 hone in too much on one specific avenue.

11 So in years past, we had followed a very similar
12 chronically or a similar set of steps that basically followed
13 this process. September, again, we would come up to you guys
14 and talk about potential plan design opportunities. You
15 would tell us if you wanted to add or change any of those,
16 and then we would go back with our partners and analyze them.
17 At this meeting every year we would bring them back to you,
18 what is available both in cost savings and benefit
19 enhancements, and then we would go ahead and make
20 recommendations. You guys would approve what you decided to
21 approve, whether it was our recommendations or not. I think
22 today was a great example as to how you guys differ which is
23 excellent as part of this process, and then we would go ahead
24 and get trend in January on how we're doing. In March we
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1 would get rates, make any final decisions if somehow
2 magically we felt money was -- there was more money on the
3 table and then we would implement by July 1.

4 Based on the conversation or in the reporting
5 earlier today at the meeting, I talked a little bit about how
6 the legislature and the Governor's Office has become more
7 involved in this process, and really this agenda item here is
8 to highlight again what I think we may have done in the past.

9 In my conversations with LCB and the Governor's
10 Finance Office recently, PEBP was reminded that in years past
11 this Board would select benefits that they wanted to either
12 cut or increase or change and they would do it on a cycle and
13 it would be on a cycle through the budget, the budget
14 development process. And since I got here, I've been a
15 little more, I don't want to say innovative but a little less
16 patient maybe in wanting to do things a little bit quicker
17 for our members to restore more benefits to them faster than
18 in the biennial process, and it has received some mixed
19 reviews by the legislature and the Governor's Office.

20 And so what we're wanting to talk about today is,
21 you know, is there a benefit and I think there is to going
22 back to that process of introducing new benefits but also
23 providing a more collaborative process with the Governor's
24 Office and the legislative counsel bureau and the legislature
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1 ultimately to decide what they want to fund as is their role.

2 And so before we would get a bunch of
3 recommendations and suggestions from advocates, from our
4 partners and then PEBP would go through and pick them apart
5 and cherry-pick the right ones and that would be our
6 recommendation. What we're suggesting today is we kind of
7 open up the table up a bit and say, you know, what do folks
8 want to do. We received a response from Dr. Doug Unger from
9 UNLV. I received a text during the meeting from AFSCME,
10 employee representative who said he's going to be submitting
11 what they feel that they want on behalf of the employees.

12 And really in this process maybe, maybe we put it
13 altogether, and we say here is all of the different options,
14 think of it ala carte style and present it in our budget, all
15 of these budget enhancements because there will be changes to
16 what we're currently funded for today and whatever makes it
17 in through the Governor's recommended budget process makes it
18 to the legislature, and then PEBP will go and defend that
19 Governor's recommended budget as we do every other year. And
20 at the end, if the legislature changes it they change it, if
21 they don't they don't, but it follows a pretty simple
22 streamline path.

23 As Board members throughout this process, if you
24 do it in this mechanism, utilizing this mechanism then
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1 everything is transparent, as it has been before, but that
2 you're not making final decisions on where the program is
3 going. Whether that's right or wrong is for someone else to
4 deal with later but for -- for the environment that we're in
5 today, it allows -- it allows the opportunity for folks to
6 have more influence on what we're building, and then the
7 decision-makers who are in charge of deciding what our budget
8 is and how we're funded at the legislature get to make that
9 ultimate decision I personally feel was the message of the
10 last legislative session. So if that's the message then
11 should we -- should we continue to go against the grain or
12 should we follow along as other state agencies do and present
13 our budgets accordingly for review, and I'm very much on the
14 latter at this point.

15 So my suggestion, and I've reached out to the
16 advocates and you've seen some of their stuff come in is that
17 we basically think of it like a jigsaw puzzle, right. We get
18 different pieces. These are cost savings activities. These
19 are benefit enhancements and we put it all into a multiple
20 set of budgeting enhancement units and we present it to the
21 Governor's Office and talk to them about it, and they kind of
22 pick and choose. Okay, we want to save money here. We want
23 to increase benefits there and, therefore, they kind of build
24 it the way they want it, and we move forward with defending

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1 it.

2 But if the legislature disagrees with the
3 executive branch they will have it all in public transparency
4 based on what the Board has built. And so to -- to take it
5 full circle, what is PEBP suggesting is that we start talking
6 about what we want to do with budget at the November meeting
7 in the odd year because if there's things for this off year
8 of the biennial cycle it may be more prudent as we have
9 talked about today to push them into the budget building
10 process. So one kind of leads into the other.

11 As an example, if we really think that it's
12 important to lower deductibles and lower out-of-pocket
13 maximums and decrease the dental benefit and get rid of the
14 co-pays for vision, all of the requests that UNLV document
15 requested, we can literally just build that unit by itself
16 and move it forward through the budget process.

17 And then we have a really awesome opportunity for
18 cost savings to address more of the manufacturer coupon issue
19 through a program called Save On through Express Scripts that
20 will adjust the benefit to meet the -- the coupon amount so
21 members pay nothing and we reap all of the benefits from
22 those coupons, and I don't have it flushed out for you today
23 and it's a significant change to the program, and we're
24 recommending no significant changes until it goes through the
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1 legislative process and the budget building process, but we
2 firmly expect to see from Express Scripts what that looks
3 like, and it could be -- it could be two or \$3,000,000 of
4 savings through our pharmacy cost.

5 So what I envision personally was that you would
6 have these cost saving activities as individual as
7 enhancements and you would have these benefit enhancements to
8 offset. Normally we would do that in this report today and
9 say, look, we're going to take money here and we're going to
10 put it here and it's all going to washout and this is what we
11 want to do, but now we are a little more collaborative with
12 the Governor's Finance Office and legislative counsel bureau
13 and ultimately the legislature.

14 And when I pitched this idea to the Governor's
15 Finance Office and LCB, it appeared and I don't want to speak
16 for them, but they were amenable to it. So it kind of laid
17 the groundwork if you're interested in this process, but all
18 of the things that everybody has asked for, we generally have
19 to say yes or no to, now we can kind of defer that to the
20 folks that are ultimately going to make that decision.
21 That's my idea that I wanted to present today and I'll turn
22 it back to you, Madam Vice Chair, for comments and questions.

23 VICE CHAIRWOMAN FOX: Would your idea be that we
24 start, like when we do the planning session in the summer, we
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1 start there and then coordinate our ideas systematically and
2 then some point we put our ideas together and put that forth
3 to the legislature and I mean, is that the path that I
4 understand?

5 MR. HAYCOCK: For the record Damon Haycock.

6 It's pretty close to what I envisioned. So in
7 August we have our strategy session, and we talk about the
8 things we can do next year and the things that doesn't
9 necessarily do dramatic diagram changes to the plan, like the
10 second opinions and the -- and the chronic kidney disease,
11 right. And we also talk about the really nice things that we
12 want to adjust, major design change, co-pays, whatever, and
13 we start circling the wagons on those, right, with our
14 partners, and we talk a little bit about them in November or
15 we continue -- and then we bring it back to you guys in
16 January, talk a little bit more about them, and then in March
17 we get final approval to move forward and build the budget.

18 In May we can give you an update but at the July
19 Board meeting, we'll come and say this is what we built.
20 This is exactly what we talked about. It's completely
21 transparent. And what that does is give multiple Board
22 meetings for you all to noodle on some of these things, as
23 well as ask additional questions, see if there's additional
24 items you want included. You talk to the various

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1 stakeholders and get their opinions, and so we're probably
2 premature talking about it today, but I didn't want to
3 discount all of the hard work that was done by our advocates,
4 our partners in analyzing these costs and we kind of shelve
5 them forever.

6 I wanted to talk a little bit about it today to T
7 it up, have a conversation that -- I mean, we can wait until
8 January. We can wait until March. It also leads into the
9 other process of the bill draft request process that we need
10 to talk about. Is there any BDR's that we want to bring
11 forth because policy BDR's without a budget impact have to be
12 approved by the Governor's Office well in advance of the
13 budget submission. Anything with a budget impact becomes a
14 budgeted BDR that goes with the budget in August of next
15 year.

16 And so as an example, please don't go run off and
17 say Damon wants to do this, but if you wanted to decrease or
18 increase the size of the Board that would be a BDR, that is a
19 policy BDR. And if there's something you wanted accomplished
20 we probably should talk about it well before the March Board
21 meeting. And I feel like the last couple of Marches that I
22 came to the Board and presented budgets, budget ideas that
23 maybe we didn't give all of the stakeholders enough time to
24 weigh in on that, and so we wanted to try to rectify that,

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1 and that's why we're talking about it as early as today.

2 MEMBER LAMBORN: I have a question. Actually, I
3 like the idea, the change, but I would like one thing added
4 to that, for the PEBP Board to have the ability to prioritize
5 those budget items. At least we can -- because we're --
6 we're hearing from our participants, and so we hear the
7 testimony. So we know what is more important than what is
8 just presented in a budget item. So I think we should have
9 the ability to prioritize the decision units enhancements.

10 MR. HAYCOCK: For the record Damon Haycock.

11 Ms. Lamborn, I think we can easily do that and
12 make sure as we build those enhancement units that we place a
13 statement for the Board that says this is the Board's number
14 one priority, number 12 priority and anything in-between both
15 for cost saving activities, as well as for benefit changes
16 and enhancements.

17 VICE CHAIRWOMAN FOX: Any questions?

18 MEMBER PACKHAM: I have one other thought.
19 Hopefully it's not a tangent, but I'm hoping since we can
20 walk and chew gum at the same time that we can have kind of a
21 parallel discussion of what I think has been presented as
22 pretty conservative reserve requirements. I feel that we're
23 a little boxed in when we see a reserve, excess reserve
24 figure in six figures versus seven or eight, and so I don't
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1 know if that's possible but maybe again have that ongoing
2 discussion as well if that makes sense.

3 MR. HAYCOCK: For the record Damon Haycock.
4 Thank you, Dr. Packham.

5 I think that the best mechanism to look at
6 adjusting reserves is through the budget building process,
7 right, is to allow those folks that are going to fund us,
8 especially if we miss the opportunity to weigh in on that,
9 that conversation as well because if we get too aggressive
10 and we miss our reserves and we don't just dip into
11 catastrophic reserves, we obliterate them, then it's PEBP
12 that has to go back and ask for more money, and I think that
13 conversation is probably best had at the table with the
14 legislature that we would be receiving that supplemental
15 request.

16 MEMBER VERDUCCI: Tom Verducci for the record.

17 So I'm going to try to analyze what I'm hearing
18 here. So this would be to move PEBP to develop a budget to
19 analyze the enhancements that the UNLV document, as well as
20 AFSCME is requesting us to review is number one. Number two
21 would be to look at the rebates through Save On and potential
22 savings through E-Scripts, is that how I see it? And also
23 three for the Board to prioritize what they see fit.

24 And I wanted to ask on number four, could that
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1 perhaps to dovetail on what Dr. Packham was saying to develop
2 a plan to independently review the excess reserves that the
3 program has. See with those four items in terms of what
4 we're discussing here.

5 MR. HAYCOCK: So for the record Damon Haycock.
6 Thank you, Mr. Verducci.

7 I would suggest that you don't limit it to that.
8 There are many opportunities that we haven't even really
9 touched the surface on that can go on into budget building.
10 Often agencies don't even start thinking about or building
11 budgets until February. We don't even get instructions from
12 the Governor's Finance Office until March, and so we can have
13 all of these ideas, but at the end we kind of need to know
14 what box we're in.

15 But if I could waive a magic wand, I would love
16 to have better partnerships with DHHS to cost allocate and
17 utilize their pharm deed that's on their staff and cost
18 allocate and utilize their chief medical officer because we
19 don't have clinicians at the plan level. We have to rely on
20 outside third parties. There's, again, do we have the right
21 staff? Do we need to look at outside counsel? No offense to
22 Ms. Mooneyhan. Do we need to look at, you know, Las Vegas
23 presence, you know, for staff. The sky's the limit to a
24 point when you think about building budgets, but then you get
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1 the instructions and then that's what you end up being able
2 to build too.

3 So I would -- like I said, I know now it feels
4 like, at least to me it's premature to start coming up with
5 decisions and direction. We're totally willing to take it
6 and move forward, but I would hope that we don't get so kind
7 of boxed in where we can't go look at other things that can
8 truly move the needle forward in our program for our
9 membership.

10 MEMBER VERDUCCI: So how about including the
11 wording other enhancements and cost savings which would be
12 just an open ending -- open ended inclusion?

13 MR. HAYCOCK: So for the record Damon Haycock.

14 PEBP will support any motion that the Board
15 decides. PEBP is not actually looking for one today. So we
16 just want to, again, have a conversation. I like, you know,
17 what Mr. Dr. Packham has said that we look at things and we
18 can as you mentioned walk and chew gum at the same time, and
19 we can look at these requests.

20 We can also if need be follow the requests that
21 we heard from RPEN and the Nevada Faculty Alliance and UNLV
22 to have an independent look from another set of actuaries,
23 right. Whether that's something you want to do in the future
24 can definitely be explored, but I'm really kicking myself for
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1 putting it on for possible action today, but really the goal
2 was just to -- just to kind of open eyes and say let's think
3 about this. Who do you want to be in the next session? What
4 do you want PEBP to be?

5 There's conversations about networking, and do we
6 want to have a more open access network in our network
7 contract, and our network contract ends June 30th, 2001. So
8 some time during next year, probably in May you're going to
9 get a report that says should we RFP and go out to bid and
10 what type of solicitation do we want? Do we want to increase
11 access too? Do we want to allow the cost savings of
12 exclusivity, right? These are things we have to figure out
13 who we want to be and what type of vision that you guys have,
14 and we have a strategic plan that outlines a lot of it, but
15 it doesn't mean you can't explore other avenues.

16 And so I think that there's -- this is the first
17 part of it. Our stakeholders are going to go back and say,
18 wow, maybe it's an open table. Let's see what we think is
19 the most important. One of the things that I did get
20 analyzed that I didn't put in today's meeting materials is an
21 increase to the life insurance amount through the standard as
22 the base amount for employees and retirees.

23 You heard through public comment I think last
24 meeting in July a request from Marlene Lockard that that be
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1 looked at. We did look at it. I actually sent it back to
2 her, so she saw it, but it's something that really should be
3 a budget enhancement so we can talk about that. So there's
4 opportunity that I'm trying not just to ramble on, but I
5 don't want -- I don't want to put too many constraints on
6 this for -- so that you only can go in one direction when I
7 think what's really important is a unified Board, you figure
8 out who you want to be and how you want this program to move
9 forward, and if it's move forward as is that's great. But if
10 there's changes that you want to make the time to make it is
11 next summer.

12 VICE CHAIRWOMAN FOX: I was also going to ask
13 like what action you're looking for here. So maybe there
14 just will be no action unless somebody wants to make a
15 motion, and maybe it's just something we continue to discuss
16 at a future meeting.

17 Any other comments regarding number nine?

18 MEMBER VERDUCCI: Tom Verducci for the record.

19 You know, I just want to point out there's been
20 some excellent suggestions made from UNLV, and it looks like
21 it's about a 5,000,000 dollar request, and this Board manages
22 multi millions of dollars and if there's a way going forward,
23 perhaps it's spring so at least throw those ideas out there.
24 We're going to look at it, if we don't restrict ourselves to
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1 this one small universal idea that we try to put forth the
2 potential budget to make an intelligent decision to see if
3 those funds are there, and I don't know if it's going to fit
4 into a motion here today that the Board is going to support,
5 but that was my thoughts.

6 VICE CHAIRWOMAN FOX: Thank you.

7 All right. So we'll move on to Agenda Item
8 Number Ten, executive officer report. Damon Haycock.

9 MR. HAYCOCK: Thank you, Madam Vice Chair. For
10 the record Damon Haycock. You're probably tired of hearing
11 from me today already.

12 I traditionally since I started with PEBP have
13 presented a written report. I almost didn't have anything
14 that really would apply to this. So far a lot of the things
15 that we have been talking have been covered in all of the
16 reports, but I wanted to reserve this item for a couple of
17 things. One, to respond to anything that was presented
18 either in public comment or in conversation that we could
19 provide some response or answer to and second of all, of
20 course, to provide an announcement that the Nevada Appeal
21 beat me to which is that I am, of course, moving on from the
22 Public Employees Benefit Program effective January 1 of this
23 year. It is -- it was a hard decision to make. It was -- I
24 made it in conjunction with my family, and I think it's time
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1 to have new leadership with new eyes and new focus.

2 I have not worked for a better organization or
3 around a better group of people, and I am leaving with a
4 heavy heart. The team that was built over the last four
5 years, they are in my opinion second to none. I will pit
6 them against any other agency in the state and any other
7 entity across the nation. The things that we've been able to
8 accomplish I never thought we could.

9 So to kind of recap my last four years, when I
10 walked into PEBP, you know, I was asked to come in and work
11 on culture, and I think you heard today from public comment
12 that a lot of that culture has been repaired which is
13 important to us, and it's important as we move forward
14 collectively.

15 I was told when I first got here don't worry
16 about the plan. The plan is solvent. It will work itself
17 and then I would find out that we have benefits we're going
18 to sunset. And I thought, wow, we do need to worry about
19 this plan, and I'm very proud of the team and our partners
20 and our ability to restore those benefits and move them
21 forward without question or argument again. I think that's a
22 testament to all of our hard work and the Board's leadership
23 and vision and really your allowance to let me get creative
24 and innovative to make that happen.

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1 We also kept rates down. For most of the time we
2 have kept them flat. Sometimes we've even lowered them. And
3 it was interesting. I went to lunch yesterday, and I spent
4 more on my lunch here in town than what a single employee
5 pays their monthly premiums on the CDHP. And most people
6 don't realize exactly how cost effective our program really
7 is for the member, and some of the reports that we gloss
8 over, our pharmacy benefits have been growing in cost to the
9 plan, but they have actually been going down in cost to the
10 member, and so we have made the member first. We've returned
11 to a strong strategic planning process, and I felt that it
12 has been one of the honors of my time to have served the
13 State of Nevada and to have served all of you and to serve
14 our membership, and I am looking forward to reading about and
15 hearing about what you guys do next.

16 With that I'll turn it over to the Vice Chair.

17 VICE CHAIRWOMAN FOX: Thank you, Damon, and I
18 have some comments about Damon, and I have some comments
19 about the position. But first I'm very sorry to see you go.
20 On a personal level I enjoyed working with you. Even before
21 I was a Board member we ran into each other a couple of
22 times, and I certainly understand and I'm happy for you, but
23 I am sorry to see you go just on a personal level.

24 As a Board member I'm sorry to see you go because
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1 it's really hard to replace somebody who is so motivated and
2 dedicated to their job and so available and knowledgeable. I
3 don't think that's going to be an easy thing to do. And even
4 as a member, someone who partakes of these benefits, I'm
5 sorry to lose you. It's good to know that somebody like you
6 is looking out for myself and my family. So I'm sorry -- I'm
7 really sorry to see you go.

8 I do have more comments, but I want to let the
9 other Board members weigh in, and then I want to talk about
10 the position itself. So does anybody else have anything else
11 they want to add?

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

14 I -- I was on the Board that hired Damon. So I'm
15 the oldest member on this Board right now in a way of years
16 and the way of service. I have to comment on Damon and his
17 excellent staff. The staff always makes the leader, but this
18 leader has helped the staff become 100 percent efficient, and
19 I've seen the changes over Damon's term of four years, and
20 I've seen the changes over my eight years.

21 So it's an outstanding organization and I was --
22 I am still proud to be on this Board, always have been. I
23 think we've done an excellent job for our membership.
24 Sometimes we've had squabbles with our membership but that's
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1 understandable. You cannot make everybody happy and most
2 cases I think we have.

3 We have tried to take our reserves and I bring up
4 reserves because it's something dear to my heart that we had
5 100 percent control on somewhat and that has changed and with
6 that change the Board will have to change with it, but the
7 members is where we took the benefits back to the members in
8 a way of benefits and that's dental, that's eyes, that's the
9 whole program. And under Damon's leadership we have become
10 nationally recognized throughout the United States on these
11 issues. In fact, we go to a conference and they want Damon
12 to speak and they ask other Board members who attend ten
13 million questions. So we should be proud of that, and I'm
14 proud of the Board. I'm certainly proud of Damon and his
15 staff. So I will miss you, but I have your phone number.

16 VICE CHAIRWOMAN FOX: Thank you.

17 MEMBER ZACK: Madam Vice Chair, Christine Zack
18 for the record.

19 I serve on a number of boards and what I can say
20 and putting and taking that into perspective these different
21 boards I'm involved with is that I never ever when I come to
22 a PEBP Board meeting need to worry about the expertise from
23 the staff or its leader. I never have to worry about the
24 thoroughness of the information that's being presented, and I
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1 certainly never have to worry about the accuracy of the
2 information, and that may be something that we just take for
3 granted as PEBP Board members or as people that attend these
4 meetings, but let me tell you that not every organization is
5 that lucky. And so I think that there's going to be a huge
6 gaping fall in PEBP with Damon gone, and I want to thank him
7 for his leadership and for displaying all of those qualities
8 that I just mentioned.

9 VICE CHAIRWOMAN FOX: Thank you.

10 MEMBER VERDUCCI: Yes, Tom Verducci for the
11 record.

12 Damon, do you think after that testimony you'll
13 change your mind? But, you know, I just want to thank you
14 for your loyalty, dedication. You've been there. We worked
15 on the weekends together. Your calls are awesome before the
16 meetings. Whenever I have questions, you're faster than
17 anybody, and I've met with employees, same employees in the
18 '80s, the '90s 2000s and 2010s. They don't come nicer than
19 Damon Haycock. It's going to be a true loss to this agency,
20 but you've put procedures in place that will benefit state
21 employees for years to come, and I'll truly miss you.

22 VICE CHAIRWOMAN FOX: Anybody else?

23 MEMBER BAILEY: If you don't cry.

24 MS. RICH: Laura Rich for the record.
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1 I just wanted to say from staff perspective I
2 would like to thank Damon as well. He's been a great leader,
3 a great mentor. We have all learned a lot from him. He's
4 been very inclusive. He -- he allows all staff to -- he has
5 an open door policy. He allows all staff, especially the
6 executive staff to really be involved in every step of the
7 process and be a part of all of the -- everything going on
8 within PEBP, and I think that's helped all of the staff at
9 PEBP just become better overall. So I just like to add that
10 and thank him.

11 VICE CHAIRWOMAN FOX: Thank you all.

12 So the one other thing I wanted to add is we're
13 going to have to have a couple of more meetings this year to
14 discuss, first of all, putting somebody in an acting position
15 for Damon's position and also what we do about recruiting for
16 his position or appointing for his position. So I'm not in a
17 position where I can ask for those meetings today.

18 As I mentioned before, we do have a chairperson
19 assigned to this Board. He's just not here today. So I
20 think we'll leave that to him to let him call those meetings,
21 but I think we can plan on having these meetings before the
22 end of the year. And as I understand, it will be two
23 separate meetings, one to appoint -- perhaps it can be one
24 meeting. I'm not sure. I guess -- is it going to be two
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1 meetings, Brandee? Okay. Probably two meetings. So one
2 meeting to appoint an enacting person and another meeting to
3 either appoint or recruit for a new executive director. So I
4 don't think I have anything more to add about that because I
5 don't know too much more about that.

6 Okay. So we will move on to public comment. All
7 right. So we'll start with public comment here in Carson
8 City.

9 MS. BOWEN: Well, I know we're coming close to
10 Thanksgiving, but I wasn't expecting that turkey to fly.

11 Mr. Damon Haycock, you cannot imagine with what
12 pride, maybe pride is not a good word, but with what pride I
13 had when watching the Today Show on national TV Channel 4 NBC
14 and hearing when other states were -- were dying with
15 their -- with their insurance policies for their employees
16 and they had gone bankrupt because programs had been rated by
17 others to use the money, and you have kept this program as
18 the model for the nation to use and -- and you with all your
19 staff, not you as an individual, you, when I say you as an
20 individual, you created an entity where we the consumer here
21 felt like we could come to you and ask questions and we
22 weren't bugging you. We were -- you were going to the extra
23 effort. You were looking up information at the drop of a hat
24 to help us or adding to the conversation and making sure

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1 things were on the agenda.

2 You made this our program and you as our
3 representatives, we're part of you and you're part of us.
4 You made us one. You as an individual cleaned up and you
5 said a few things. You cleaned up a mess, an absolute mess
6 where we weren't functioning, and there was a case where
7 things were going to be taken away from this Board where we
8 have a voice. Over at the legislature you get three minutes
9 at a podium maybe if you're lucky, and you might get a little
10 extension if you wait until midnight to talk again in public
11 comment, but you made it so this is -- is the panel where we
12 can come where the voices are heard, where department heads
13 are heard, where individual teachers are heard, whatever it
14 is where the public is heard so it is a public employee
15 program.

16 You have been an asset, and I hope you -- you go
17 and move and the wife and kids don't like the schools and
18 don't like the area in which they have to live and that you
19 can come back. And so instead of saying that giving your
20 notice January 1st, why don't you just take a little
21 sabbatical and get yourself in order like we teachers get
22 June, July and August and other professors get sabbaticals.
23 Think of it as why don't we plan a vacation for Mr. Haycock.
24 Let him take his breath. This man hasn't taken a breath
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1 since he's been here. It's been one fire after another, one
2 crisis after another. We ought to make him the captain of
3 the PEBP Board Fire Department because of all of the things
4 he's done and all of the people he brought together where he
5 made the people feel like they counted.

6 At the university, one suggestion for the future
7 for you all to consider is have -- have them hold meetings
8 and summits of their department heads to say what is it you
9 need for insurance in the chemistry department that you don't
10 need in the theater department? What does your plan need to
11 look like so they are more inclusive and more transparent.
12 Make transparency a disease catchable by all of the
13 stakeholders, please, please, please.

14 And -- and I guess I'm about my three minutes up,
15 but from my heart and soul thank you. Would you please thank
16 your family for sharing you with us because when you've been
17 with us you're not with them, and would you all, all please
18 totally, and that comment goes for all of you, would you
19 please have the most marvelous, fabulous, tremendous
20 Thanksgiving on the planet. Thank you. Thank you. Thank
21 you.

22 VICE CHAIRWOMAN FOX: Thank you.

23 MS. BOWEN: And thank you for the public comment
24 and letting me go over once in a while or like always.

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1 VICE CHAIRWOMAN FOX: Thank you, Peggy.
2 Is there any other public comment in Carson?
3 Nancy, in Las Vegas?
4 MS. SPINELLI: Yes, we do have one.
5 MS. CAMERON: My name is Vicky Cameron. I am a
6 PEBP participant and have been since 2006.
7 And I want to thank Damon for his wonderful
8 service. Prior to your coming here we had miscommunications.
9 We had wrong information. We had loss of benefits, and you
10 have restored most of those, and you have restored our
11 confidence in this system. Thank you very much, and I wish
12 you very well in any future endeavor.
13 MS. SPINELLI: No further public comment.
14 VICE CHAIRWOMAN FOX: Okay. Thank you, Nancy.
15 Well, I think we are on to Number 12, and we are
16 adjourned. Thank you everybody.
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6 STATE OF NEVADA

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9 Pursuant to NRS 239B.030

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13 1) Public Employees' Benefits Program Board
14 Regular Meeting, 11/21/19

15
16
17 KATHY JACKSON

18 DATE

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