1 RETIREMENT SYSTEMS OF ALABAMA
2 PUBLIC EDUCATION EMPLOYEES' HEALTH INSURANCE PLAN
3 BOARD OF CONTROL MEETING
4 201 South Union Street, Room 843
5 Montgomery, Alabama 36104
6 877.517.0020
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16 **VIDEOCONFERENCE PUBLIC EDUCATION**
17 **EMPLOYEES' HEALTH INSURANCE PLAN BOARD OF CONTROL**
18 **MEETING** reported by Jeana S. Boggs, Certified Court
19 Reporter and Notary Public, in the conference room
20 of the Retirement Systems of Alabama, 201 South
21 Union Street, Montgomery, Alabama, that was held on
22 Tuesday, September 15th, 2020, at approximately 9:00
23 a.m.

1
2 APPEARANCES
3 BOARD MEMBERS:
4 MR. LUKE HALLMARK, CHAIRMAN
5 MR. JOHN R. WHALEY, VICE-CHAIRMAN
6 MR. KELLY BUTLER
7 MR. JOHN MCMILLAN
8 DR. ERIC MACKEY
9 DR. JOSEPH G. VAN MATRE
10 DR. SUSAN WILLIAMS BROWN
11 MS. AMY CREW
12 MS. CHARLENE MCCOY
13 MRS. SUSAN LOCKRIDGE
14 MR. RUSSELL TWILLEY
15 MS. ANITA GIBSON
16 MS. PEGGY MOBLEY
17 MR. JEFF COLE
18 MS. KELLI SHOMAKER
19
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23

1 ALSO PRESENT:
2 DR. DAVID BRONNER, RSA CEO
3 MR. DON YANCEY, RSA DEPUTY DIRECTOR
4 MS. DIANE SCOTT, RSA CFO
5 MS. DONNA TOWNES, DIRECTOR PEEHIP
6 MR. DAVE WALES, ASST DIRECTOR PEEHIP
7 MS. EMILY EATON, RSA ASSISTANT
8 MS. ALISSA BENNETT, ACTUARY
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1 AGENDA

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1 **CALL TO ORDER**
2 MR. HALLMARK: All right. It's
3 9:00 and we are about to start our PEEHIP
4 Board meeting. I'd like to -- let's see.
5 Is Emily -- Emily, could you give us a roll
6 call, please.
7 **ROLL CALL**
8 MS. EATON: Luke Hallmark?
9 MR. HALLMARK: Here.
10 MS. EATON: Ricky Whaley?
11 MR. WHALEY: Here.
12 MS. EATON: Kelly Butler.
13 MR. BUTLER: Here.
14 MS. EATON: John McMillan?
15 MR. MCMILLAN: Here.
16 MS. EATON: Eric Mackey?
17 (No response.)
18 MS. EATON: Joseph Van Matre?
19 DR. VAN MATRE: Here.
20 MS. EATON: Kelli Shomaker?
21 (No response).
22 MR. HALLMARK: Kelli?
23 MS. SHOMAKER: I'm here.

1 MS. EATON: Susan Brown?
2 MR. HALLMARK: Susan's here.
3 MS. EATON: Amy Crew?
4 MS. CREW: Here.
5 MS. EATON: Charlene McCoy.
6 MR. HALLMARK: Charlene? She's
7 here. She may be on mute.
8 MS. EATON: Susan Lockridge?
9 MR. HALLMARK: I see Susan.
10 MS. EATON: Russell Twilley?
11 MR. HALLMARK: I see Russell.
12 MS. EATON: Peggy Mobley?
13 MS. MOBLEY: Here.
14 MS. EATON: Anita Gibson?
15 MS. GIBSON: Here.
16 MS. EATON: Jeff Cole?
17 MR. COLE: Here.
18 MR. HALLMARK: Okay. We do have a
19 quorum. You know, with this having kind of
20 a virtual meeting, you just have to be
21 patient with us. I would ask that you-all
22 that are virtual, go ahead and put your Zoom
23 on "mute" and when you have a question just

1 take it off mute and we will recognize you
2 to ask questions.
3 We have an agenda -- we have a
4 revised agenda that was placed in our
5 packets this morning. Was it anything in
6 particular changed? I know, other than an
7 additional person on the Oath of Office,
8 everything else was the same?
9 Okay. The only change was that
10 they added me on the Oath of Office, and
11 everything else is remaining the same from
12 what you would have received in the packet.
13 **APPROVAL OF AGENDA**
14 MR. HALLMARK: So, at this time, I
15 do need a motion to approve today's agenda.
16 Amy. Second? Ricky.
17 Any questions, discussions?
18 (No response).
19 MR. HALLMARK: All in favor say
20 "aye."
21 (Board members saying "aye".)
22 MR. HALLMARK: All opposed, like
23 sign.

1 (No response).

2 **OATH OF OFFICE**

3 MR. HALLMARK: The next will be
4 Item III, and it will be the Oath of Office,
5 so if I could get Ms. Gibson and myself to
6 come in and be sworn in.
7 (Oath of Office of Anita
8 Gibson and Luke Hallmark).
9 MR. WHALEY: Raise your right
10 hand, I -- state your name --
11 MR. HALLMARK: I, Luke Hallmark --
12 MS. GIBSON: I, Anita Gibson --
13 MR. WHALEY: -- do solemnly swear.
14 MR. HALLMARK: -- do solemnly
15 swear --
16 MS. GIBSON: -- do solemnly
17 swear --
18 MR. WHALEY: -- that I will
19 support --
20 MR. HALLMARK: -- that I will
21 support --
22 MS. GIBSON: -- that I will
23 support --

1 MR. WHALEY: -- the Constitution
2 of the United States --
3 MR. HALLMARK: -- the Constitution
4 of the United States --
5 MS. GIBSON: -- the Constitution
6 of the United States --
7 MR. WHALEY: -- and the
8 Constitution of the State of Alabama --
9 MR. HALLMARK: -- and the
10 Constitution of the State of Alabama --
11 MS. GIBSON: -- and the
12 Constitution of the State of Alabama --
13 MR. WHALEY: -- so long as I
14 continue --
15 MR. HALLMARK: -- so long as I
16 continue --
17 MS. GIBSON: -- so long as I
18 continue --
19 MR. WHALEY: -- a citizen
20 thereof --
21 MR. HALLMARK: -- a citizen
22 thereof --
23 MS. GIBSON: -- a citizen

1 thereof --
2 MR. WHALEY: -- and that I will
3 faithfully --
4 MR. HALLMARK: -- and that I will
5 faithfully --
6 MS. GIBSON: -- and that I will
7 faithfully --
8 MR. WHALEY: -- and honestly --
9 MR. HALLMARK: -- and honestly --
10 MS. GIBSON: -- and honestly --
11 MR. WHALEY: -- discharge the
12 duties --
13 MR. HALLMARK: -- discharge the
14 duties --
15 MS. GIBSON: -- discharge the
16 duties --
17 MR. WHALEY: -- of the office --
18 MR. HALLMARK: -- of the office --
19 MS. GIBSON: -- of the office --
20 MR. WHALEY: -- upon which --
21 MR. HALLMARK: -- upon which --
22 MS. GIBSON: -- upon which --
23 MR. WHALEY: -- I am about

1 to enter --
2 MR. HALLMARK: -- I am about
3 to enter --
4 MS. GIBSON: -- I am about
5 to enter --
6 MR. WHALEY: -- to the best of my
7 ability --
8 MR. HALLMARK: -- to the best of
9 my ability --
10 MS. GIBSON: -- to the best of my
11 ability --
12 MR. WHALEY: -- so help me, God.
13 MR. HALLMARK: -- so help me, God.
14 MS. GIBSON: -- so help me, God.
15 MR. WHALEY: Congratulations.
16 MR. HALLMARK: I appreciate Mr.
17 Whaley the Oath today and would like to
18 welcome Ms. Gibson on the Board. This is
19 her first official Board meeting.
20 And you are in the Retiree
21 position?
22 MS. GIBSON: Yes, I am.
23 MR. HALLMARK: Welcome.

1 **APPROVAL OF 5/14/2020 MINUTES**
2 MR. HALLMARK: Next is Item IV,
3 and we have the approval of the May 14th
4 Board Meeting Minutes. So, at this time, we
5 need a motion to approve. Mr. Cole.
6 MR. COLE: Second.
7 MR. HALLMARK: Ms. Crew. Any
8 discussion? Any corrections that need to be
9 made?
10 (No response).
11 MR. HALLMARK: All in favor say
12 "aye."
13 (Board members saying "aye")
14 MR. HALLMARK: All opposed, like
15 sign?
16 (No response).
17 MR. HALLMARK: Ayes carry. The
18 next item is Item V, and we will turn over
19 to Diane Scott for our financial update.
20 **FINANCIAL UPDATE**
21 MS. SCOTT: Good morning, Mr.
22 Chairman, and members of the Board. I
23 always love to come up here when I have some

1 -- what I think is good news. Okay? We've
2 had so much bad news during these last few
3 months with the coronavirus and what have
4 you.
5 So, let's turn to page 28, if you
6 will, in your book behind the financial tab.
7 This is my three-year projection. Okay?
8 This projection here I prepared on August
9 the 28th. Okay? I updated it yesterday
10 because we have paid out everything we are
11 going to pay out for this year. The only
12 thing remaining so far is my guess on the
13 remaining monies that I am going to get in.
14 Okay?
15 But this projection here showed us
16 to have about $241 million at the end of
17 this year -- okay? -- with an excess of
18 around $135.2 million over what we needed.
19 And if you look all the way out to 2023, it
20 says, well, we have got -- we'll have a
21 shortfall of $86.2 million. When I reran
22 the numbers yesterday, that came down by
23 about $5 million. Okay? Now, the main

1 reason that it came down to $5 million is
2 that I am getting coronavirus funds, and I
3 have gotten already $5 million worth of
4 coronavirus funds for those funds that have
5 been expended specifically for diagnosis of
6 coronavirus through July 31st. And then I
7 have another $3 million request out there
8 that I probably will not get until October
9 the 1st or sometime shortly thereafter.
10 So, that change of $5 million
11 would give the required increase to the per
12 active per month requirement, which is not a
13 member increase, but what we would ask for
14 of the Legislature if it happens by that
15 time of $69 rather than $73.
16 I am very -- let me use the word
17 "confident" in this that I have not
18 understated expenses. We never know when
19 that might happen, but I do have some fairly
20 good contingencies in there. I do have in
21 2023 $40 million coming from the Retiree
22 Trust. I don't have anything in '20. None
23 in '21. None in '22. But I did put

1 $40 million. Now, of course, that would
2 have to come from you-all as an approval
3 before I could move that money. Okay?
4 MR. HALLMARK: Ms. Scott.
5 MS. SCOTT: Yes, sir.
6 MR. HALLMARK: Does the $40
7 million, is that already in the $86.2
8 million, or is it reduced $86.2 million.
9 MS. DIANE SCOTT: It's already
10 baked in there.
11 MR. HALLMARK: Even with $40
12 $86.2 million.
13 MS. DIANE SCOTT: Yes. Uh-huh
14 (positive response).
15 Let's move on over to page 30,
16 which has got some of the assumptions and
17 the threats in there. I have gone over a
18 few those already, but one of the things is
19 the next to the last bullet there, the drug
20 price reduction bills that are in Congress.
21 There are two -- there are really three
22 bills there -- that we have been to
23 Washington, and they would increase our

1 costs. But as you know that on July 24,
2 President Trump issued an executive order on
3 drug rebates. That if it were to be
4 implemented, it would increase our costs.
5 They went back and pulled out something that
6 HHS, Health and Human Services, was going to
7 do in 2019. And the White House pulled it
8 back because it was -- it had increased
9 costs. Well, went back and issued that
10 executive order July the 24th.
11 However, the good news in this is
12 that the order instructs HHS to continue the
13 rule making to restrict rebates on Medicare
14 Part D only if it will not increase federal
15 spending, Medicare beneficiary premiums or
16 patients out-of-pocket. Okay?
17 Now, HHS actuaries have determined
18 that it's going to increase that. HHS hired
19 two private actuarial firms that have also
20 concurred with that. Since then, the
21 Congressional Budget Office, the
22 Governmental Accountability Office, and the
23 Office of the Inspector General have come

1 out and said that this would increase costs.
2 MR. HALLMARK: Mrs. Scott, could
3 you get a little bit closer to the
4 microphone.
5 MS. DIANE SCOTT: Okay. Is that
6 better? All of these agencies Federal --
7 DR. SUSAN BROWN: Diane is doing a
8 presentation, but I can't hear either.
9 MS. DIANE SCOTT: Can you all here
10 me fine?
11 MR. TWILLEY: I can't hear Kelli
12 and Susan, but I can't hear.
13 MRS. LOCKRIDGE: We can hear each
14 other, but we can't hear them.
15 MS. DIANE SCOTT: I don't know
16 what else to do.
17 MR. HALLMARK: Mrs. Lockridge, can
18 you hear me? Mrs. Lockridge, can you hear
19 me. Susan Lockridge, can you hear me?
20 (No response).
21 MR. HALLMARK: Russell, can you
22 hear me? Russell Twilley? Seems like we
23 are muted on this end.

1 MS. GAMBLE: Everything is wide
2 open. They said they were hearing earlier.
3 So, I'm not sure why it is not working now.
4 We have got a strong Internet connection.
5 Everything is okay.
6 MR. HALLMARK: Kelly, can you hear
7 me? We have got two Kellys. That's right.
8 Y'all want to reboot it or do something.
9 Charlene, can you hear me?
10 Russell Twilley can you hear me?
11 (No response).
12 MR. HALLMARK: Russell Twilley,
13 can you hear me?
14 (No response).
15 MR. HALLMARK: Joe Van Matre, can
16 you hear me?
17 (No response).
18 MS. GAMBLE: Somebody has got to
19 be able to hear you.
20 MR. HALLMARK: Charlene?
21 MS. McCOY: Yes, I hear you.
22 MR. HALLMARK: All right. Kelly
23 Butler, can you hear me?

1 (No response).
2 MR. HALLMARK: Russell Twilley,
3 can you hear me?
4 (No response).
5 MR. HALLMARK: Okay. Susan Brown,
6 can you hear me?
7 DR. SUSAN BROWN: I can barely
8 here you. It's low.
9 MR. HALLMARK: Susan Lockridge?
10 (No response).
11 MR. HALLMARK: Kelli Shomaker, can
12 you hear me?
13 (No response).
14 MR. HALLMARK: See, I can hardly
15 hear them. Do what? She said something
16 about mute.
17 MR. MCMILLAN: Can they call in on
18 a phone?
19 MS. GAMBLE: If you hear yourself
20 speak, put yourself on mute. So, a couple
21 of problems it looks like. They are saying
22 that when they are muted, they can't hear.
23 It doesn't make a lot before sense. We are

1 not muted. I understand that we are muted,
2 but they can't hear us, but we are not
3 muted. I have to mute the microphones for
4 the Board right now. If they say something,
5 it picks up the microphone, and then it
6 plays back.
7 MR. HALLMARK: You know, we had a
8 meeting in a small boardroom and had that
9 little gadget in the middle that they could
10 dial in. I mean --
11 MS. GAMBLE: If you can hear us,
12 give us a thumbs up. Can you hear us? Just
13 do this. Still not --
14 MR. HALLMARK: If y'all can hear
15 us, give us a thumbs up.
16 MS. GAMBLE: No. Still not.
17 Okay. We are working on getting on a phone
18 that they can call in.
19 MR. HALLMARK: Try again?
20 MS. GAMBLE: Yes.
21 MR. HALLMARK: If you can hear us,
22 give us a thumbs up.
23 MS. GAMBLE: All right. So that

1 is working. All right. We are not going to
2 be able to hear them because of the echo
3 problem. So, if they have any questions,
4 they will need to chat and Jodi will read
5 the question.
6 MR. HALLMARK: Okay. What's been
7 reported that you should be able to hear us,
8 but if you have a question, we not be able
9 to hear your question because of the echo.
10 So, they asking if you would not mind just
11 writing in the chat session your question.
12 And we can be slow and patient, you know,
13 while you do it. It may be easier if you
14 were to raise your hand to let us know that
15 you have a question and we can stop for just
16 a moment and allow you to type it in. Did
17 everybody hear that? Let me see your hands
18 if you did. Okay. Okay.
19 MS. SCOTT: Okay. Would you like
20 for me to start over?
21 MR. HALLMARK: Yes. They haven't
22 heard it.
23 MS. SCOTT: I will start over.

1 So, if you will turn to page 28 of
2 your presentation of your information, which
3 is behind the financial update tab, this is
4 the three-year projection for 2020 through
5 2023. I prepared what you are looking at as
6 of August the 28th.
7 As of August the 28th, looking all
8 the way down the pipe for 2023, it looks
9 like we might be short $86.2 million. I
10 recalculated this yesterday after every bill
11 has been paid that we are going to pay for
12 this fiscal year. The only variable I have
13 left is the money that will continue to come
14 in to me, that I had to make a good guess
15 on. Okay? We had improved by about $5
16 million. So, the $86.2 million amount is
17 down to $81 million.
18 Okay? Primarily, that is the $5
19 million I have received so far for the
20 Corona Virus Relief Funds. I have an
21 addition $3 million for the month of August
22 that I have applied for. We will probably
23 not get that until after October 1st. That

1 is for August. And then, September,
2 October, November, and through December 30th
3 I will apply for those as I have the
4 information from Blue Cross -- okay? -- and
5 as long as the funds remain available.
6 So, what that would look like in
7 2023, if everything stayed the same, is an
8 increase to the per-member/per-month. This
9 is not coming out of people's paychecks, but
10 what we would have to ask the Legislature
11 for would be from -- go from $873 down to
12 $869 as a projection.
13 Let me back up a couple of years.
14 I had to send to the Legislature about a
15 month ago --
16 MR. HALLMARK: Ms. Scott, Charlene
17 McCoy is raising her hand. Do you have a
18 question, Charlene? Are you just waving at
19 us? Okay. Ms. Scott, go ahead.
20 MS. SCOTT: Okay. So, about a
21 month ago, I had to send over how much we
22 wanted for 2022, and I asked for $800, so
23 this is in alignment with this budget here.

1 We are going to get $800 per active, per
2 month for 2021. We have been getting that
3 $800 for a number of years.
4 So, I feel really good about that.
5 I feel like I have good contingencies built
6 into this budget for '21, '22, and '23. In
7 '23, I have budgeted for a $40 million
8 transfer from the retiree trust. Of course,
9 I couldn't do that unless you approved. And
10 things may change between now and then and
11 we may not need it. But that's how I got to
12 the numbers that we have today.
13 Moving on along, over to page 30,
14 you will see that I have written out for you
15 the major assumptions and threats between
16 now, 2020 and 2023.
17 The next to the last one I want to
18 talk about a little bit more, which is the
19 threat from our national standpoint related
20 to Congress. You know I have come and
21 talked to you before about bills that may be
22 in Congress related to things that would
23 impact our cost, particularly on the

1 Medicare side, one in particular being
2 rebates. Well, on July the 24th, President
3 Trump signed an executive order requesting
4 and telling HHS, Health and Human Services,
5 to pull back the rebates and make changes
6 related to those for Medicare Part D.
7 But three things have to happen:
8 Federal spending cannot go up; Medicare
9 beneficiary premiums cannot go up; and
10 patient's costs cannot go up before that can
11 happen.
12 MR. HALLMARK: Okay. We have a
13 question. Dr. Brown has asked, why is the
14 4% to 7% non-Medicare trend, and a .5%
15 decrease in non-Medicare retirees, and a 2%
16 decrease in Medicare lead to the loss of
17 such a large amount?
18 MS. SCOTT: Okay. All right. So,
19 I'm -- she is asking -- she's on page 30,
20 and she is looking at the first, second,
21 third, fourth, fifth bullet. Some of my
22 assumptions are the reduced enrollment
23 growth projections from 1% to .5% for

1 non-Medicare retirees, and from 6% to 4% for
2 Medicare retirees. What that is is, when we
3 go to build a budget, or build a projection,
4 the number of people that we are building
5 that off of is really ground zero. Okay?
6 And that is -- those were assumptions that
7 we had made of how many people we were going
8 to have incurring our costs. Okay?
9 So, we had been running, with the
10 actuary, okay, looking at our early retirees
11 increasing by 1%, per year. And then we had
12 -- were looking at the number of Medicare
13 eligible retirees increasing by 6% per year.
14 So, we looked back over, together with the
15 actuary, the past, and said, hey, this
16 really isn't happening like this. What we
17 are doing is right-sizing what we believe to
18 be the number of people who are going to be
19 incurring taking our coverage in those
20 groups. Okay. One of the things with the
21 early retirees is, when the second sliding
22 scale -- I call it the second sliding scale
23 -- was implemented or began in 1/1/2012, it

1 was to be phased in over a five-year period,
2 or a period to end 9/30/2016. And what that
3 did was, the cost for health insurance for
4 the early retirees got bigger and bigger and
5 bigger and bigger and bigger. So, by the
6 time it got to 9/30/16, it was fully
7 implemented. What we solved is the behavior
8 change that was expected -- okay? -- when
9 the bill was written was to reduce the
10 number of people either retiring before they
11 became Medicare eligible, or if they did
12 retire, not taking our coverage because they
13 already had a job lined up, or could go onto
14 a spouse's, because it was so expensive
15 here. And that was really an expected
16 behavior change.
17 So, we had -- we wanted to ratchet
18 that down to what we were seeing now that it
19 was fully implemented. So, we made that
20 change. Then we really weren't seeing the
21 Medicare eligible retirees increasing by 6%,
22 so we rightsized that to 4%.
23 We look at these sorts of things

1 periodically. If we don't see a need to
2 change, we don't change. If we do see a
3 need to change, we do. What you are going
4 to see when the actuary talks about the
5 valuation, just after me here, you are going
6 to see that we made a lot of other
7 rightsized moves in our statistics like this
8 because of the behavior change that we see
9 that has kind of settled in after the change
10 in there -- in and that legislation and
11 those sorts of things, too. Okay?
12 Did I get that -- answer that
13 question? Did that make sense? Okay. All
14 right. Where was I? If you don't mind, I
15 will just continue; and if you have more
16 questions, you-all flag me down. Okay?
17 So, the next to the last bullet
18 talks about what was going on in Congress.
19 So, I think I was somewhere in there. And
20 July 24th, President Trump issued an
21 executive order talking about let's pull
22 back rebates and make a change with that.
23 But three things had to happen before that

1 could be effective, or three things were
2 contingent upon that. Number one, federal
3 spending couldn't go up. Number two,
4 Medicare beneficiaries' premiums, it
5 couldn't cause an increase in that. And
6 number four (sic), the out-of-pocket costs
7 for Medicare members couldn't go up as a
8 result of this change.
9 Well, this change is -- does not
10 -- is inversely -- inverse to those things
11 happening. So, Health and Human Services
12 actuarial department looked at it and said,
13 well, it's going to go up. They hired two
14 private firms. They said, it's going to go
15 up. The general -- the Governmental
16 Accountability Office actuaries analyze that
17 those are going to go up. The Congressional
18 Budget Office did. And there is one more.
19 Oh, the Office of Inspector General said it
20 was going to go up.
21 We knew it was going to go up. We
22 had already been to Washington now twice and
23 talked to the Alabama delegation and others

1 there to explain that this is going to go
2 up.
3 So, I'm really not real concerned
4 about this at that time, but I do have some
5 contingencies built in because something
6 will happen at some point in time; it's just
7 not the time right now. Okay? And I hope I
8 don't get back to my desk and find that
9 something has happened contrary to what I
10 just predicted. Okay?
11 So, I feel good about these
12 projections. I'm very happy to bring this
13 report to you today. And if you have any
14 other questions? If not, I am finished.
15 MR. HALLMARK: All right. You
16 heard Ms. Scott's report. By a show of
17 hands, does anybody have another question?
18 (No response).
19 MR. HALLMARK: Okay. Thank you,
20 Ms. Scott.
21 MS. SCOTT: Thank you.
22 MR. HALLMARK: Next on the agenda
23 is our PEEHIP benefit program updates, and

1 we'll ask Ms. Donna Townes to come forward,
2 please.
3 MS. SCOTT: Mr. Chairman? We have
4 an actuary next.
5 MR. HALLMARK: Oh, I'm sorry. My
6 fault. My fault. Excuse me.
7 The next part will be our Alabama
8 Public Education Employees' Health Insurance
9 Plan report of the actuary.
10 MS. GAMBLE: All right. Quick
11 instructions on how we are going to do the
12 actuary. I am going to unmute the computers
13 so that they can talk, but I am going to
14 have to mute all the microphones around the
15 Board. So, when -- if anyone on the Board
16 has questions, write it down and we will
17 take it at the end. Anyone on the WebEx
18 will be able to real-time ask him questions,
19 because they can hear each other.
20 So, I'm going to unmute the
21 computers so that they actuary can talk, and
22 then I am going to mute all these
23 microphones.

1 **PUBLIC EDUCATION EMPLOYEES' HEALTH INSURANCE PLAN**
2 **REPORT OF THE ACTUARY**
3 MS. BENNETT: Can I talk now?
4 Okay. Well, I am going to very quickly go
5 through the valuation results for the PEEHIP
6 actuarial valuation, OPEB valuation. So, I
7 am going to be looking on page 36, and I am
8 going to go through this quickly, so,
9 please, if there is any questions, feel free
10 to ask them and we can talk about it at the
11 end.
12 So, we are going to start on page
13 36 of the Board book, which is page one of
14 the valuation. At the very top, just
15 quickly, the membership data. Our number of
16 retirees and surviving spouses has gone up a
17 little bit from last year. You can see last
18 year is the one all the way over to the
19 right. We had 87,000 retirees last year,
20 now we have 90,000, and that is an expected
21 result.
22 I did want to point out something
23 about the active membership. It looks like

1 we had a drop, but that's not really the
2 case. What it is is just the way we are
3 presenting it. Normally, in the past we'd
4 always just put the number of active members
5 equal to the number of active members in
6 TRS. But, there has always been several
7 groups -- employer groups that do not
8 participate in PEEHIP, so we never included
9 them in the liabilities, but we always just
10 left them in the headcounts.
11 So, this year we made a change
12 because for GASB you don't want to show
13 those members that aren't participating.
14 So, we want the numbers to match your
15 valuation report and the GASB report, so
16 that is why the number dropped from 137,000
17 to 133,000. It's not really a drop; it's
18 just a display item.
19 All right. So, the next thing to
20 look at is the market value of assets. You
21 can see those stayed pretty flat. We
22 actually had a 3.9% increase in the market
23 value. That's compared to what we assumed,

1 which is 5%. So, for our valuation, we
2 assume the assets will earn 5%. We've done
3 that in this for a very long time.
4 For GASB that number moves around
5 a lot because it's dependent on the bond
6 rate at the measurment date. So, the most
7 recent measurement date of September 30,
8 2019, our GASB rate was actually 5.5%. You
9 know, what we are going to get as of
10 September 30, 2020, we don't know. It
11 depends on the bond rate. But for the
12 valuation, we keep it pretty steady at 5%
13 per year.
14 So, your assets did not quite as
15 well as we expected. So, it did 3.9,
16 compared to the 5. But the good news, and
17 the thing I want to talk about is the drop
18 in the unfunded. So, you can see our
19 unfunded liability went from $7.2 billion to
20 $4.3 billion. And we'll talk about that in
21 the another page on here, the exact reasons
22 for the change from last year to this year.
23 But the big reason was the drop in the

1 Medicare Advantage rates. And the reason
2 for that was the repeal of the Affordable
3 Care Act's health insurance. So, that was
4 the fee that's paid by all fully insured
5 health plans, including Medicare Advantage
6 plans. So, when that was repealed in
7 December of last year, that really dropped
8 your Medicare Advantage rates, and you would
9 have some guarantees for the next few years
10 with those rates. So, that's a real big
11 deal because these benefits are paid for
12 life.
13 So, if you have somebody who
14 retires at, say, age 60, well, they get
15 pre-Medicare benefits which are relatively
16 expensive for five years. But then they are
17 getting Medicare eligible, Medicare
18 Advantage rates for the rest of their life,
19 which could be 20, 25, 30, or even more
20 years.
21 So, Medicare Advantage costs are
22 really big for your liability here. So,
23 that was a major reason for the drop, and

1 there are few other things, too.
2 But then if you will look on down
3 to the bottom of the page, we calculate and
4 actuarially determine contributions. So,
5 what that is is the amount that you would
6 need to contribute each and every year to
7 pay off your unfunded liability over the
8 amortization period, which you can see right
9 above that is 22 years. So, we calculated
10 that as of the new valuation, this is the
11 lower Medicare Advantage rates, that amount
12 would be $409 million.
13 Now, for context, what you
14 actually pay in pretty much pay-as-you-go
15 benefit payments is about $285 million. So,
16 I mean, what you are paying is less, but
17 that gives you an idea of how much more
18 would need to go in. But it is less than
19 what we calculated in the prior val due to
20 the good experience.
21 So, the prior valuation, you would
22 have to pay 9.5% of payroll for the next 23
23 years. Now, based on this valuation, it's

1 5.8% for the next 22 years.
2 Okay. So, the next slide -- or
3 next page, I want to look at is in page 47
4 in the Board book, which is page 12 of the
5 valuation report. And this is where we show
6 how we got from last year to this year in a
7 little more detail.
8 So, if you will look at last
9 year's unfunded of $7.2 billion, we add on a
10 normal cost. That means, it's the continued
11 accruals for the people who were still
12 working. So, when you are working, you earn
13 more and more benefits every year that you
14 work. So, that will always be a cost
15 because there's new accruals that come into
16 the plan. We subtract off the actual
17 employer contributions. That's what I was
18 saying, it's about $284 million, as compared
19 to what we would expect prefunded amount to
20 be, more like $400 million. You have
21 interest. So, if everything would have
22 happened just as we predicted in our
23 actuarial assumptions, your expected

1 unfunded would have been $7.6 billion. So,
2 what happened to get us down to the 4.3?
3 Well, the big one, like I just said, was the
4 gain due to the claims and premium
5 experience. Your pre-65s came in about as
6 expected, but your over 65 Medicare
7 Advantage rates made a huge difference.
8 So, that's a one time thing. You
9 aren't going to see a big gain like that
10 next year because we already knew about it.
11 So, you know, and Diane just mentioned some
12 different concerns with the Medicare
13 Advantage rates. But as of right now, what
14 we are seeing is you're going to get this
15 good gain.
16 The other thing we did was look at
17 assumptions, just like Diane said. Now that
18 we have more experience with all of the new
19 premium costs that come in, like the age
20 penalty if you are under age 65, things like
21 that. And we did see that your pre-65
22 participation is lower than what we had been
23 predicting, so we went ahead and lowered

1 that for an ongoing assumption.
2 We actually increased your
3 Medicare eligible participation assumption a
4 little bit to go along with the experience.
5 But overall, all the things we looked at and
6 the tweaks we made to our assumptions based
7 on actual experience coming in, is a gain.
8 So, it's another $246 million gain.
9 So, with all that stuff that we
10 knew was going to happen, we expected the
11 unfunded to be about $4.4 billion actually
12 came in about $4.3 billion. So, you also
13 had an experience gain. And what that means
14 is, you know, nobody's life expectancy is
15 exactly what we thought it would be based on
16 our assumptions. Retirement patterns,
17 terminations, all that have kind of stuff,
18 we expect fluctuations between expected
19 natural. That's just part of the process.
20 So, in this case, it's a gain.
21 That's just a coincidence that it's a gain
22 in the same year you had all these expected
23 gains. But we looked at the magnitude of

1 it, and it was about 1.26% of liability.
2 That's well within any kind of magnitude we
3 would expect in those kind of experience
4 fluctuations. So, it's just another piece
5 that brought your unfunded down just a
6 little bit.
7 And that's really all I want to
8 talk about with the valuation, unless you
9 have any questions. I did want to
10 address -- I know this comes up a lot -- is
11 what is COVID going to do to your valuation
12 costs? And, you know, there are obviously a
13 lot of uncertainties. We don't really know
14 what's going to happen going forward. Short
15 term, it seems to be, if anything, a wash
16 maybe, or even a cost savings because of all
17 the differed care.
18 So, for 2020 you will probably
19 find your claims are not coming in as high,
20 unless something happens towards the end of
21 the year to increase a lot of COVID costs
22 and COVID claims. But that differed care,
23 what's going to happen with that? I mean, a

1 lot of it is things like maybe a knee
2 replacement that's going to happen,
3 eventually. They just didn't do it right
4 now.
5 So, that could potentially
6 increase costs for 2021 -- excuse me, 2022.
7 Some of the deferred care might be
8 permanently deferred. I mean, things that,
9 you know, maybe the annual screenings that
10 just is not done, and then they will be done
11 next year, but they would have been done
12 next year anyway. Obviously, concerns with
13 things like preventive care or just, you
14 know, maintenance care that should be done
15 that people are just forgoing that could
16 cause increased costs as people get sicker,
17 because they put off their care.
18 The actual cost of COVID and a
19 vaccine, if there is a vaccine, everybody is
20 going to, you know, want to get that. That
21 should be probably fully paid for.
22 So, there are a lot of questions.
23 For this particular valuation, we really

1 didn't change anything. We kept the trend
2 rate as we would have done pre- or
3 post-COVID, but we are certainly keeping an
4 eye on it. And the Society of Actuaries is
5 really keeping us up to date. But, you
6 know, obviously the data is limited. This
7 has only been going on since last December.
8 So, you know, there is a lot of learn going
9 forward. But we will be keeping an eye on
10 it, and, you know, incorporating it as need
11 be.
12 And that's really all I have on
13 the valuation, unless there are questions.
14 (No response).
15 MR. HALLMARK: I don't see any
16 questions at this time. Is that -- Are you
17 finished with the report? Well, they can't
18 hear me, can they?
19 MS. BENNETT: Yes, I am finished
20 with the report. I actually thought of one
21 more thing I was meaning to say and that is,
22 speaking to the COVID: One thing that might
23 actually be a permanent cost savings of

1 people are very hopeful about is the
2 Telehealth. And especially with Medicare
3 Advantage, they are allowing more Telehealth
4 to -- to be paid for under the Medicare
5 rules. So, if that becomes a permanent
6 thing, that's potential for an ongoing cost
7 savings. So, you're trying to look for some
8 silver lining, and that maybe could be one
9 of them.
10 But other than that, yes, I am
11 finished. Thank you.
12 MR. HALLMARK: Okay. Thank you.
13 If we will move on to our next item on the
14 agenda, it's Item VI, and that is the PEEHIP
15 Benefit Program Update, Part I, with Donna
16 Townes.
17 **PEEHIP BENEFIT PROGRAM UPDATES (Part I)**
18 MS. TOWNES: Good morning,
19 Mr. Chairman and Board members.
20 MR. HALLMARK: Good morning.
21 MS. TOWNES: I have a couple of
22 updates for you, and I am going to start
23 with the Humana Medicare Advantage plan

1 updates. So, please turn to page 62. Can
2 everyone hear me okay? Okay. Great.
3 As you know, Humana Medicare
4 Advantage coverage is the coverage that we
5 offer our Medicare retirees and their
6 covered Medicare spouses. Humana has been
7 our carrier since January 1st of this year.
8 And everything -- I want to report that
9 everything is going very well with the plan.
10 Humana just got through, in July
11 and August, in conducting ten virtual
12 retiree informational webinars. We had
13 about 1,400 members to enroll and
14 participate in that. Normally we have those
15 in person. Normally we travel the state.
16 And last year we had about 100 of those.
17 And we usually have really good
18 participation. And these presentations are
19 excellent. It's an excellent way for our
20 members to understand the Medicare Advantage
21 benefit. And it's also a great way to be
22 apprized of any changes that are going to
23 occur for the upcoming year. And that's

1 what I am going to talk about in just a
2 minute, are those changes.
3 But I do want to note that the
4 recorded version of that presentation is on
5 the PEEHIP website. So, it's available for
6 our members to view at their convenience.
7 So, looking at page 62, these are
8 the changes that are going to occur
9 beginning January 1st of next year, starting
10 with the Medicare Part B deductible. That
11 is changing from $185 to $186, and I just
12 want to point out that the Part B deductible
13 amount is set by Medicare each year and not
14 PEEHIP. So, PEEHIP has no control over that
15 change.
16 Other changes that are occurring
17 are pertaining to the prescription drug
18 formulary. Every year Humana -- as well as
19 all of our other PBMs -- they take a look at
20 the drug list and they make appropriate
21 changes. And some of those appropriate
22 changes pertain to helping ensure the safety
23 of our members, controlling costs, and

1 mitigating pharmacy trends. And any change
2 that is negative to our member, Humana will
3 mail out a letter to the member at least 60
4 days in advance notifying them of the
5 change. And I have provided a bulleted list
6 of some of those changes that are going to
7 be occurring.
8 There were several over-the-
9 counter medications that were on our drug
10 formulary; and as you know, it's been a
11 long-standing policy with PEEHIP that we
12 don't cover medications that are available
13 over the counter. And it could be that some
14 of these medications were prescription, and
15 then they become over-the-counter. So,
16 those were taken off the drug formulary.
17 When a brand name medication loses
18 it's patent and generics become available,
19 the brand is still available, but many times
20 it moves from a Tier II to a Tier III
21 co-pay. And as you know, we have the
22 generic law that requires the pharmacists to
23 fill the medication with the generic

1 equivalent instead of the brand, unless the
2 doctor writes "dispense as written."
3 There are other drugs where we
4 look at the costs, and there are some drugs
5 where the costs increases drastically. And
6 we look at other drugs that are in that
7 therapeutic class that are lower costs that
8 work just as well, and there may be some of
9 those changes where they either move to Tier
10 III or they are excluded from the drug
11 formulary.
12 But I do want to point out,
13 members that were current utilizers of those
14 drugs, those members will not be impacted.
15 They will be able to continue to get that
16 newly excluded medication. So, they won't
17 be disrupted.
18 And then of course, there is new
19 medications that enter the market for the
20 first time, and so those drugs are actually
21 added to the drug formulary.
22 The rest of what I am going to
23 talk about are very positive changes for our

1 numbers. The Go365 Program, there is going
2 to be some positive changes there. And that
3 is Humana's version of the Wellness Program.
4 And it's designed to help keep our members
5 active and engaged. And today our members
6 can -- they have actually six options to
7 choose from from gift cards.
8 So, if they complete certain
9 preventative measures, like getting a
10 wellness exam or a colonoscopy, they awarded
11 in the form of a gift card. And currently,
12 they have six gift cards to choose from.
13 Humana is going to be expanding that to 16
14 different gift card options. So, I think
15 our members are going to like that.
16 And in addition to that, currently
17 our members have the ability to earn up to
18 $245 in gift card rewards, and beginning
19 next year they are going to have to ability
20 to earn up to $345 in gift cards rewards.
21 So, the increased earning
22 opportunities are mainly in the categories
23 of exercise and fitness activities and

1 social and live style activities. And some
2 of those include, like, if you attend a
3 nutritional seminar, you attend some healthy
4 living classes, even if you do volunteer
5 work and then if you do athletic events and
6 workouts and that's tied to an activity
7 tracker and you report that to Humana, you
8 can earn some more money and earn more gift
9 cards.
10 So, we thought that was a great
11 thing, a very positive change for our
12 members.
13 And other enhanced benefits for
14 2021, Humana has the Well Dine Program. And
15 that is where our members can get currently
16 up to ten meals delivered to their home if
17 they have had a hospital stay or a skilled
18 nursing facility stay. Well, human is going
19 to increase the number from 10 to 14 next
20 year. And these are provided at no cost to
21 our members. All they have to do is just
22 ask, and it's delivered to them.
23 And Telehealth: That's a

1 temporary benefit right now that was
2 implemented as a result of COVID, but Humana
3 is going to be able to extend that temporary
4 benefit through the end of 2021. And it's
5 going to remain as zero cost year for our
6 members if they use in-network providers of
7 primary care physicians, urgent care, and
8 outpatient behavioral health. So, that's
9 very positive. And I am going to show you
10 some stats on Telehealth in just a moment.
11 Yes, sir?
12 MR. HALLMARK: Dr. Brown has a
13 question. And the question -- she says, she
14 questions the Humana wellness is not
15 required, but just extra benefit if the
16 member was to do it; is that correct?
17 MS. TOWNES: That is absolutely
18 correct. They can do it on a voluntary
19 basis and be rewarded for it through the
20 gift cards.
21 Okay. So, Telehealth is going to
22 continue into all of 2021 for the Humana
23 Medicare Advantage plan. And when a

1 COVID-19 vaccine becomes available, it will
2 be available to our members at zero cost.
3 So, they can get it free of charge.
4 COVID testing and treatment, that
5 will continue to be a benefit through the
6 end of '21. And, again, that will be
7 offered at zero co-pay for our members. As
8 long as they use -- well, actually if it's
9 COVID related, whether they use an
10 in-network or out-of-network provider, they
11 would still be able to get the testing and
12 the treatment at zero co-pay.
13 Humana is going to be providing a
14 COVID care package. It's going to be 14
15 days of meals that will amount to two per
16 day. And we are still in the process of
17 finalizing the details on the distribution
18 of these meals, but we do feel like they are
19 going to be tied to a positive diagnosis of
20 COVID when they have had a hospital stay.
21 And then lastly Humana is
22 providing health essential -- a health
23 essential kit for all members at their

1 request. So, any of our over 76,000 members
2 that are enrolled in our Medicare Advantage
3 plan, if they desire to have this kit, they
4 can obtain it just by making a phone call to
5 Humana. And they have the essential kit is
6 scheduled to include a cloth face mask,
7 cough drops, hand sanitizers, disposal
8 non-latex gloves, Acetaminophen, and an oral
9 thermometer. And again, members will be
10 able to call and order the kit by contacting
11 Humana's customer care after January 1st.
12 And that number is on the back of their ID
13 card.
14 Okay. That's all I have regarding
15 the update for the changes that are going to
16 occur in the Medicare Advantage Plan for
17 2021. So, if there are no questions, I will
18 move on to the next update.
19 And the next update pertains to
20 COVID and the expanded benefits and enhanced
21 benefits that we provided that came about as
22 a result of COVID. I am also going to give
23 you some statistics relating to number of

1 Telehealth visits, the number of COVID tests
2 that have been given to our PEEHIP members,
3 and the number of members who have tested
4 positive for the virus. So, all of this
5 information is on pages 63 through 71.
6 We have provided you with three
7 COVID benefit grids, and these grids show
8 the benefit expansions and enhancements.
9 And they start on page 63. So, there is one
10 for Humana, one for Blue Cross Blue Shield,
11 and one for VIVA; 63, 64 and page 65.
12 We worked very closely with our
13 carriers. Humana, Blue Cross Blue Shield,
14 MedImpact and VIVA in an effort to reduce
15 the financial burden of seeking treatment
16 for those that felt they may have been
17 exposed to COVID or had COVID. And they
18 also provided additional resources and
19 support for our members, and they also
20 provided this new option for seeking medical
21 treatment in the virtual setting. It's
22 Telehealth. And that is brand new.
23 At this time, it is a temporary

1 benefit under all three of our carriers.
2 And I am not sure how familiar you are with
3 a Telehealth visit, but it's where the
4 member can actually have a virtual office
5 visit with their own primary care doctor.
6 So, it's different from Teladoc or MDLive.
7 This is with their own physician. So, they
8 are having an office visit, but it's at home
9 rather than in person.
10 So, in addition to being able to
11 have this Telehealth visit with their
12 primary my care physician, they can also
13 have it with other providers such as, they
14 go to an urgent care facility, if they use a
15 specialist, if they need outpatient
16 behavioral health services, even if they
17 needed occupational, speech or physical
18 therapy.
19 So, it was a very generous benefit
20 to help our members stay safe and provide an
21 alternative method for seeking treatment
22 where they can limit their exposure to any
23 other illness or prevent -- if they are

1 sick, prevent them from giving it to others
2 in the office.
3 So, if you will turn to page 66,
4 and this slide pertains to Humana's Medicare
5 Advantage Plan, and it shows the number of
6 Telehealth visits, MDLive visits and
7 in-person office visits. And I want to
8 point out that 6% of the total visits during
9 the March through August period were done
10 virtually. So, this tells me that our
11 members have embraced our Telehealth benefit
12 because it is a safe alternative to seeking
13 medical treatment, without getting exposed
14 or exposing others to an illness.
15 If you will turn to page 67, this
16 shows the number of COVID-19 tests and a
17 distinct number of our Humana Medicare
18 members getting tested.
19 So, during this same period of
20 time, of March through August, there were
21 12,161 COVID tests given to our Medicare
22 members, and 10,992 distinct members tested.
23 So, what that tells us is that there were

1 some members that were getting tested more
2 than once.
3 And then if you will look at page
4 68, there were 1,042 of our Medicare members
5 who tested positive for COVID. And when you
6 do the statistics on that, that represents
7 1.4% of our Medicare population of members
8 who tested positive.
9 If you will turn to page 69, and
10 this pertains to our Blue Cross Blue Shield
11 plan, and it shows that we had 73,240
12 Telehealth visits. We had 14,414 Teledoc
13 visits, and 259,020 in-office visits. So,
14 the Telehealth visits alone represented 21%
15 of the total overall visits for the March
16 through July period.
17 And so, I started looking at the
18 2019 numbers of our in-office visits and
19 Teledoc visits, and when you compare those
20 in-office visits in 2020, they are
21 significantly lower. And that makes sense,
22 because the Teledoc visit -- the Teledoc --
23 the Telehealth option is available to our

1 members. And, again, looking at the slide,
2 you can tell our members -- our Blue Cross
3 Blue Shield members also embrace the new
4 Telehealth benefit.
5 If you will look at page 70, this
6 shows that we had 46,128 COVID tests done
7 and 37,646 distinct members were tested.
8 So, again, you can see some of our members
9 were tested more than once. And if you look
10 at page 71, it shows 4,830 of our Blue Cross
11 Blue Shield covered members tested positive.
12 And this represents 2% of our Blue Cross
13 Blue Shield covered members.
14 We are always concerned about all
15 of our members. So, even if one tests
16 positive, that's a concern to us. But as
17 you can see from the stats, with only 1.4%
18 of our Medicare members testing positive,
19 and 2% of our Blue Cross Blue Shield members
20 testing positive, we feel like our members
21 have been taking the necessary precautions
22 to protect themselves and their families
23 from exposure. And we are very pleased to

1 have Humana, Blue Cross Blue Shield, VIVA
2 and MedImpact working diligently with us in
3 helping us reduce the financial barriers to
4 treatment for our members, and provide these
5 safe alternative options for seeking the
6 appropriate medical care our members need.
7 MR. HALLMARK: Any questions at
8 this time?
9 (No response).
10 MS. TOWNES: Okay. All right.
11 The last update I have pertains to the drug
12 formulary changes that were made to our
13 commercial drug plan, and that is our plan
14 that provides coverage to our non-Medicare
15 members.
16 So, if you look at page 73, this
17 is a summary of the drug formulary changes
18 made during the quarter of April through
19 June of this year. And the details of all
20 those changes are on pages 74 through 97.
21 So, we continue to work very
22 closely with MedImpact and Artemetrx to
23 manage our drug formulary. And we have done

1 it successfully in a way where there's very
2 disruption to our members, but we continue
3 to be able to provide a very rich benefit.
4 So, they are very good business
5 partners with us, and we do this management
6 of the drug formulary with the goal in mind
7 of keeping our PEEHIP benefits rich, and the
8 cost of the premiums low to our members.
9 So, that concludes my updates.
10 MR. HALLMARK: Okay. You-all have
11 heard Mrs. Townes' updates, her reports.
12 Are there any questions or comments at this
13 time? And I will look up at the screen to
14 see if anyone wants to raise your hand and
15 ask a question through the chat?
16 (No response).
17 MR. HALLMARK: Okay. Thank you.
18 MS. TOWNES: Okay. Thank you.
19 MR. HALLMARK: Next on the agenda
20 is Item VII. That's PEEHIP Benefit Program
21 Update, Part II. And that will be Dave
22 Wales.
23

1 **PEEHIP BENEFIT PROGRAM UPDATES (Part II)**
2 MR. WALES: Hi. Good morning,
3 Mr. Chairman, members of the Board.
4 I have a couple of benefit
5 enhancements that we are bringing to you for
6 consideration vote today, and our Blue Cross
7 Blue Shield hospital medical plan. Then
8 after we walk through that, we will take a
9 look at had a couple of quick updates going
10 on in our Wellness Program.
11 So, to jump right into it, if you
12 don't mind turning to page 89 in your Board
13 book we will start by looking at our
14 inpatient rehab benefits. And so, before we
15 look at what our current benefits are in
16 regards to inpatient rehab and what we are
17 recommending as enhancements to inpatient
18 rehab, I want to first make sure that we
19 build a common ground in what the inpatient
20 rehab benefit specifically is.
21 So, when a member, or when a
22 patient experiences a traumatic health
23 event, such as a stroke or a brain injury,

1 obviously they go to the hospital, they will
2 receive treatment. And then after that
3 treatment, they often graduate to a rehab
4 facility, like an inpatient rehab facility.
5 These are sometimes stand-alone facilities.
6 These are sometimes part of hospitals. But
7 the idea is that they do just what the name
8 says, they are admitted there, and they
9 rehabilitate so that they can resume as
10 close to possible normal daily life before
11 they experienced that traumatic event.
12 So, we currently have benefits in
13 regards to inpatient rehab. However, we
14 have identified in working with Blue Cross
15 Blue Shield there are some room for
16 improvement in those benefits.
17 And so, speaking of that
18 improvement, if you will move forward to
19 page 90, we will take a look at what our
20 members currently have access to and line it
21 up against what we are recommending today
22 for your vote in terms of enhancing these
23 benefits.

1 So, if you look at the chart on
2 the left side of the page, you can see on
3 the left column the benefit structure is
4 laid out, and you look on the right side of
5 that chart, you can see what we are
6 recommending to alter in that current
7 benefit.
8 Most notably, the top line points
9 out there is a 60-day lifetime limit for
10 inpatient rehab treatment. And so, what
11 this means is that, if members have the --
12 the misfortune of having multiple traumatic
13 events in their lifetime -- a number of
14 strokes, car accidents, whatever it may
15 be -- then there is a hard stop out there,
16 currently, in their PEEHIP benefits where
17 they exhaust their available days in an
18 inpatient rehab facility. And if you think
19 back a moment ago, we were talking about how
20 these facilities provide this critical
21 interdisciplinary treatment, physical
22 therapy, occupational therapy, speech
23 therapy, working with a physician to try to

1 get that member, that patient, back to
2 normal life, back to independence.
3 So, it's a critical service to
4 provide to people that undergo these health
5 events. But currently, there is a 60-day
6 hard stop in PEEHIP benefit.
7 So, our first recommendation is to
8 remove that lifetime benefit so that there
9 is ample pathway out there for our members
10 who may need this, especially if they have
11 the horrible misfortune of actually needing
12 60-days or more.
13 Walking through the rest of the
14 benefit for completeness, the length of
15 treatment at an inpatient rehab facility is
16 contingent upon clinical documentation of
17 improvement. So, these are rehabilitation
18 hospitals. These aren't a long-term care
19 center or a nursing home. The idea is that
20 you get better in these hospitals. And so,
21 the physician who is managing that patient
22 will document and observe how the patient
23 progresses and meets criteria, and hopefully

1 graduates out of there.
2 So, we are not recommending any
3 change to that. That's simply how these are
4 clinically structured.
5 And then lastly, pre-
6 certification. So, before we look at
7 pre-certification, I just want to take a
8 half a second to define what that is, and
9 that is when a prescribing physician sees
10 that there is a certain treatment or course
11 of therapy that is -- or a procedure that's
12 needed for a patient. They will work with
13 Blue Cross Blue Shield who will analyze the
14 standards of medical care nationally to
15 determine is that the most relevant, most
16 helpful thing for that patient, and then
17 approve it for payment before the member
18 receives that treatment.
19 So, we currently require
20 pre-certification for inpatient rehab.
21 However, in working with Blue Cross and Blue
22 Shield and being in consideration of having
23 a reasonable and necessary guardrail to

1 protect against any potential fraud, waste,
2 and abuse and also in consideration of how
3 we want the physician to be connected to the
4 care team and to monitor the progress of
5 this, we are recommending moving to
6 seven-day increments of pre-certification,
7 which is in alignment with the State
8 Employees' Insurance Plan on how they
9 administer this benefit, which really is the
10 best thing for the member and the best thing
11 for the plan and is very close to what is
12 happening today in practice.
13 So, in summary, our
14 recommendations around inpatient rehab are
15 to remove the 60-day lifetime limit, and
16 continue to provide this benefit via
17 pre-certifications but in seven-day
18 increments. And a couple of other quick
19 notes, in talking with Blue Cross Blue
20 Shield, we have discovered that PEEHIP is
21 actually below par in other plans out there,
22 and that's not a good thing, to be below par
23 in this case. The quality of our benefits

1 currently is not up to standard of other
2 plans out there, not up to standard of other
3 PEEHIP benefits.
4 And so, one thing that I think we
5 all agree on is that PEEHIP never wants to
6 be below standard. We would rather set the
7 standard. And so, doing this would bring us
8 to that point.
9 MR. HALLMARK: Dave.
10 MR. WALES: Financially -- yes.
11 Yes, sir.
12 MR. HALLMARK: Dr. Brown asked,
13 "Why is the seven-day increment needed, and
14 can we make it at least a 15-day increment?"
15 MR. WALES: The seven-day
16 increment is what was recommended to us by
17 Blue Cross Blue Shield in matching what SEIB
18 has in practice with their plan. They have
19 had good success, no issues with that. And,
20 again, the whole point of this connected
21 care team is that the physician is
22 monitoring the progress of the patient in
23 the facility, working with the physical

1 therapist, the occupational therapist, the
2 speech therapist so that they are making
3 sure that that member, that patient, is
4 getting exactly what they need, as close to
5 real time as possible. So, that's where we
6 came from the seven-day recommendation.
7 MR. HALLMARK: Thank you.
8 MR. WALES: So, financially
9 speaking, Blue Cross Blue Shield also ran an
10 analysis on if we make this change and
11 estimate the additional costs to be $675,000
12 to $945,000 per year. So, that's our first
13 recommendation for your consideration and
14 Board vote.
15 MR. HALLMARK: Okay. You have
16 heard Mr. Wales' report on the inpatient
17 rehab. I need a motion to approve.
18 Ms. Mobley. I need a second.
19 MS. GIBSON: Second.
20 MR. HALLMARK: Ms. Gibson. Any
21 discussion, comments at this time?
22 (No response).
23 MR. HALLMARK: All in favor say

1 aye."
2 (Board members saying "aye").
3 MR. HALLMARK: All opposed, like
4 sign.
5 (No response).
6 MR. HALLMARK: Ayes carry.
7 MR. WALES: Okay. Thank you,
8 Mr. Chairman.
9 Moving on to page 91, we are going
10 to stay in the rehabilitation space but
11 drill down further into a specific kind of
12 rehabilitation called "occupational
13 therapy."
14 So, occupational therapy often
15 occurs in an inpatient rehab facility, and
16 this is when an occupational therapist works
17 with a patient to work on those fine motor
18 skills, like with your hand, and cognitive
19 skills to reconnect them to the independence
20 of doing things that are important in daily
21 life, such as feeding yourself, cooking,
22 dressing yourself, so forth.
23 And so, again, this goes

1 hand-in-hand with inpatient rehab, and it's
2 a critical service to recapture that
3 independence for someone that is recovering
4 after a traumatic event, like a brain injury
5 or a stroke.
6 So, just like inpatient rehab, we
7 have current benefits available today for
8 occupational therapy. However, we do have a
9 significant barrier that is blocking a lot
10 of members from connecting to this therapy
11 when they need it.
12 And so, speaking of that barrier,
13 if you will take a look at page 92. The
14 chart on the page both illustrates what that
15 barrier is, what that limitation is and our
16 recommended change. And if you will look at
17 the first line, you will see that
18 occupational therapy currently, under PEEHIP
19 benefits is limited just to services to the
20 hand and lymphedema.
21 Did you have a question,
22 Mr. Chairman?
23 MR. HALLMARK: Yes. Dr. Brown

1 asked, "Would it be the patient's personal
2 doctor to do the report of clinical
3 documentation of improvement?"
4 MR. WALES: For inpatient rehab?
5 Is the question, whose documenting
6 improvement on inpatient rehab, or --
7 MR. WHALEY: On the seven-day, I
8 think, is what she is asking.
9 MR. WALES: I understand. Yeah.
10 I would have to get back to you on that
11 question. I think the question is: Who is
12 keeping track of the improvement as they
13 progress through the rehab hospital. My
14 understanding is that that's done by the
15 attending clinicians at the hospital, in
16 working with the prescribing physician. But
17 I would like to get you a much more
18 comprehensive answer by working with Blue
19 Cross Blue Shield, if that's okay with you.
20 Okay. So, good question, though.
21 Thank you for that.
22 So, back to occupational therapy,
23 the barrier that we have from delivering

1 this service to our members today is that
2 currently in the PEEHIP benefits the
3 services are only provided if the diagnosis
4 is related to the hand or to lymphedema.
5 Now, oftentimes, occupational therapy does
6 work with the hand. They are teaching you
7 to redo those fine motor skills with the
8 hand. But if you think about what we are
9 talking about here, we are talking about
10 people that have had a stroke or people that
11 have had some kind of brain trauma. So,
12 their diagnosis is stroke. Their diagnosis
13 is not something about their hand, even
14 though they need help with their hand. So,
15 the issue is, when these claims come through
16 and the diagnosis is coming through as
17 stroke, it's currently blocking and
18 rejecting because of how these benefit are
19 set up.
20 So, our first recommended change
21 to this benefit is to remove that limitation
22 that limits it only to the hand and
23 lymphedema, so that the people that need

1 this have easy access to it.
2 Moving forward, walking through
3 the benefit, we currently don't have any
4 predefined visit limit on occupational
5 therapy. We are not recommending adding a
6 visit limit to occupational therapy. We do
7 currently require precertification for
8 occupational therapy, and we would like to
9 continue to do that. But to further
10 clarify, for example, say if a physician
11 prescribes four weeks of occupational
12 therapy but at the end of that four weeks it
13 is apparent that additional time and
14 additional visits is needed, we want to make
15 sure that there is a path to provide that.
16 So, we want to clarify the
17 precertification by saying precertification
18 is required. And then if additional visits
19 are needed, precertification is available
20 route to get there, as well.
21 So, to summarize our recommended
22 edits for occupational therapy, we want to
23 remove the limitation of services related

1 only to the hand and lymphedema, and then
2 clarify precertification required for the
3 needed visits, and then additional
4 precertification if more visits are needed
5 over and above that initial allotment.
6 Just like inpatient rehab, we are
7 currently below the bar on what other plans
8 in our state offer for occupational therapy.
9 And this brings us into alignment with the
10 other plans out there.
11 Financially speaking, Blue Cross
12 Blue Shield also ran an analysis for us if
13 we make this change, and expect the impact
14 to be less than $180,000 per year. So, this
15 is the second benefit enhancement we bring
16 before you today.
17 MR. HALLMARK: Okay. You have
18 heard -- and I have another question from
19 Dr. Brown. But we will have to do it at the
20 inpatient rehab. But you heard Mr. Wales'
21 report on the occupational therapy. At this
22 time, I will need a motion to approve.
23 Mrs. Crew. Second? Ms. Mobley. Any

1 questions or comments?
2 (No response).
3 MR. HALLMARK: All in favor at
4 this time, say "aye".
5 (Board members saying "aye").
6 MR. HALLMARK: All opposed, like
7 sign?
8 (No response).
9 MR. HALLMARK: Ayes carry.
10 The question from Ms. brown is --
11 on Dr. Brown is, "On the inpatient rehab,
12 what happens if the patient report is not
13 positive in improvement? Where does the
14 patient go if they are not able to go home?"
15 MR. WALES: So, an inpatient rehab
16 facility, the patient is -- again, this is
17 not had a facility that is meant for
18 longterm. There are facilitates that are
19 meant for longterm, but an inpatient rehab
20 facility is designed to rehabilitate a
21 patient to get back to as close to normal
22 life as possible.
23 So, specifically of where the

1 rehab is failing and where they are going to
2 go, that's something that I would have to
3 take back and try to pull some real life
4 examples for you to give you a good answer
5 on that. But I can tell you quite
6 transparently, the point of these facilities
7 is to rehabilitate, and the length of stay
8 is contingent upon, you know, either the
9 success or the failure of that
10 rehabilitation.
11 MR. HALLMARK: Okay. All right.
12 We want to move into the Wellness Program.
13 MR. WALES: Okay. So, now that we
14 have completed the benefit enhancements, I
15 will just take a couple of seconds to talk
16 with you about some updates in the Wellness
17 Program.
18 MR. HALLMARK: One other question:
19 Does the patient pay for it, or will the
20 insurance pay for the other care?
21 MR. WALES: For "the other care,"
22 meaning, if they leave the inpatient rehab
23 facility?

1 MR. HALLMARK: Yeah.
2 MR. WALES: I think we just have
3 to look at a specific answer -- a specific
4 example to give you a good example on that.
5 So, I am happy to connect with you
6 after the meeting, and we can walk through
7 an example of all the different ways that it
8 could branch out.
9 MR. HALLMARK: Okay.
10 MR. WALES: Okay. All right. So,
11 if you will turn to page 94, we will do a
12 quick recap of what happened -- what was
13 this Board approved in the last Board
14 meeting. And so, the chart illustrates
15 that.
16 Beginning this upcoming plan year,
17 starting October 1, there is only one
18 required activity in the Wellness Program,
19 which is the wellness screening. This is a
20 change from previous years when health
21 coaching was an additional required
22 activity. Now it's just the wellness
23 screening for every member regardless of

1 what their health is, regardless of what
2 happens at their screening. It's just, the
3 simple wellness screening is the only
4 required activity every year.
5 We do still offer health coaching
6 as optional programs; participation in them
7 is not required. If a member does not sign
8 up for them, there is no penalty. If a
9 member does sign up for them and then drops
10 out, there is no penalty for doing that.
11 But they are there, optional, for our
12 members' benefit because we know that these
13 programs work. We know that members, if
14 they participate in them, they do achieve
15 the goals that we hope that they achieve.
16 So, we have them out there as available
17 resources for our members if they want to
18 self-select into them.
19 So, that's looking forward. But,
20 as another reminder for today, and we have
21 done a lot of communication over the last
22 several months about this, in light of the
23 coronavirus pandemic, we waived all required

1 activities this plan year in the Wellness
2 Program. So, for those members that had not
3 gotten their current year wellness
4 screening, that was waived. For those
5 members that had not completed their health
6 coaching, that was waived. We wanted to be
7 very cognizant of how this Wellness Program
8 affected people who were navigating new life
9 through the pandemic, and we especially
10 didn't want a requirement out there that
11 caused them to leave their house to go get a
12 wellness screening, especially in light of a
13 stay-at-home order.
14 So, a couple of quick notes about
15 wellness screening to -- I am sorry, about
16 health coaching to wrap this up, if you will
17 turn to page 95, we will start by looking at
18 Naturally Slim. This is a program that we
19 looked at before. If you will remember,
20 it's a primarily a weight-loss program.
21 It's video based. It teaches participants
22 in this program more how to eat and the
23 behaviors around eating more so than what to

1 eat.
2 They are offering four
3 opportunities this year for our members to
4 sign up for this program. It's a ten-week
5 program and space is limited. Our members
6 have already gotten a postcard invite to
7 this. That first class starts October 12.
8 So, coming up fairly soon. And this week we
9 are also going to be sending out an email
10 reminder about that first class of Naturally
11 Slim starting up.
12 Moving on to page 96, Natural Slim
13 isn't the only coaching program we have
14 available. We also have non-video options
15 from Pack Health and Blue Cross Blue Shield.
16 Pack Health offers a dedicated health
17 advisor to members, however they want to
18 connect with that person whether that's over
19 the phone, text message, email, that health
20 adviser sets up a path to better health for
21 the member, and it does so by small steps,
22 achieving small goals that add up to better
23 health.

1 Blue Cross Blue Shield is also
2 going to be offering their general health
3 coaching, like diet and exercise, as well as
4 disease management, for things like coronary
5 artery disease and diabetes. These are
6 available on demand any time throughout the
7 year. But space is also limited in these,
8 so we encourage our members who want to take
9 advantage of these benefits to sign up
10 quickly to ensure they get a spot.
11 Okay. So, on page 97 is the last
12 thing I want to draw your attention to
13 today, and this is an advertising campaign
14 put on by Blue Cross Blue Shield of Alabama.
15 And it's called Chews Wisely Alabama. We
16 have looked at this before. The idea of
17 Chews Wisely Alabama is to use videos and to
18 use entertainment to get us to think
19 differently about the food choices that we
20 make, about how we cook, how we grocery
21 shop, what we order off of menus. And the
22 idea is to preserve the culture of food we
23 have here, because we have really good food

1 in Alabama, but to do so in a slightly
2 healthier way so that we start to change the
3 trajectory of our health overall as a state.
4 A quick reminder about Chews
5 Wisely Alabama, this is something completely
6 produced and funded by Blue Cross Blue
7 Shield, so PEEHIP doesn't have any
8 management over this and doesn't invest any
9 money in this. However, as Alabamians, you
10 know, we like to see this effort from Blue
11 Cross Blue Shield of Alabama.
12 So, the update that I have for you
13 today regarding Chews Wisely is that they
14 have secured a local celebrity chef; this
15 individual you see on your page. Her name
16 is Kelsey Barnard Clark. She is a chef with
17 a successful restaurant out of Dothan,
18 Alabama. She was also on a Top Chef
19 National Cooking Competition show. She
20 shares the ideology of, hey, let's keep
21 eating the good food that we have, but let's
22 do so slightly healthier than we've been
23 doing.

1 So, that concludes the update I
2 have for you today on the Wellness Program.
3 MR. HALLMARK: Okay. Any comments
4 or questions for Mr. Wales?
5 (No response).
6 MR. HALLMARK: Okay. Thank you,
7 Dave.
8 MR. WALES: Thank you.
9 MR. HALLMARK: You know, before I
10 turn it over to Mr. Yancey for closing
11 comments, I think I can speak for the Board
12 members and those past Board members present
13 about Donna Townes. You know, I just -- I
14 think we would all be remiss if we didn't
15 say how much we appreciate the knowledge,
16 your values, the leadership that you have
17 provided PEEHIP with.
18 We all know you had some big shoes
19 to fill when you took this position, and in
20 any type of leadership position, you always
21 want to feel that the program is a little
22 better than it was when you got it. And
23 this is not being a slight to the person

1 that you replaced; it just shows that you
2 have taken the program and wanted to make it
3 even better.
4 I think we all can say that you
5 have always answered our questions in a way
6 that we could understand. I mean, I know
7 PEEHIP is a different language, but you have
8 broken it down in a way that we could pick
9 up the phone and call you, and you could
10 explain it to us in a way that we could
11 explain it to the people that have called
12 us.
13 We always have known that you have
14 kept our members in the forefront, whether
15 it's through our program, and especially
16 their health, and that you have always
17 created ways of making the program better
18 for them.
19 You know, it amazes me sometimes
20 the way you and Diane work together, that we
21 have been able to keep our premiums where
22 they are. You know, people throughout this
23 state and other states, I'm sure, just

1 marvel at how -- what a wonderful program
2 that we have. And we are probably so easy
3 to take it for granted, but it is not
4 something to be taken for granted, and we
5 want to thank you for that. You've just
6 always been there. I mean, really have
7 been. I know the person that you are, being
8 as humble as you are, you would want to pass
9 the credit along with your staff, which is
10 just the type of person that you are. But
11 we know where the leadership is, and we know
12 that you have been the captain of the ship.
13 And I just want to say, speaking for
14 everyone, just thank you for everything that
15 you have done for PEEHIP.
16 (Applause).
17 MS. TOWNES: I am humbled by that,
18 I truly am. But I do want to say thank you
19 to every one of you for the support that you
20 have given me over the years. I want to
21 thank my boss, Don. I want to thank Dr.
22 Bronner. If I didn't have your support, I
23 couldn't have done the job that I am tasked

1 with doing.
2 I do want to thank my staff. I am
3 so blessed to have a great staff that's very
4 member-centric, cares about our members, and
5 tries to take care of our members. I have
6 been so blessed over the years to work for
7 such a great organization. And in my
8 opinion, it's the best state agency in the
9 whole State of Alabama because of the
10 leadership, and I do believe that we have
11 the best group health plan, not just in the
12 state, but in the nation. But I do have to
13 give all of you credit for that. Your
14 leadership in being member-centric, looking
15 after the members and giving us, the staff,
16 the ability to manage the plan in a way
17 where those benefits are kept rich and the
18 cost is kept low.
19 So, thank you from the bottom of
20 my heart, and I am going to miss you-all so
21 much. Thank you.
22 (Applause).
23 MR. HALLMARK: All right. Next

1 item is Item VIII, closing comments from
2 Mr. Yancey.
3 **CLOSING COMMENTS**
4 MR. YANCEY: Thank you,
5 Mr. Chairman.
6 To follow up to your comments,
7 part of being a great leader is having
8 backup to take your place when you leave.
9 We have got Dave Wales that will be taking
10 over as director of PEEHIP and Erica Thomas,
11 who will be taking the assistant director
12 position upon Donna's departure. And she
13 has taken very good care to get us a great
14 couple of people to move up in the
15 organization. So, appreciate that very
16 much.
17 I want to thank the Board for
18 their approving the benefit enhancements
19 that Dave requested. This is a benefit to
20 our members. It improves our plan, which we
21 strive to do year to year. I always want to
22 thank our partners. PEEHIP is a team
23 effort.

1 So, it is not only our PEEHIP
2 staff and accounting staff, but it's all the
3 partners that we work with: Blue Cross Blue
4 Shield Humana, MedImpact, VIVA, Alabama
5 Department of Public Health, and also
6 advisers. We have Segal and Artemetrx as
7 advisors helping us manage some of the plans
8 and programs that we have implemented to
9 save money.
10 Speaking of saving money in the
11 actuary's report, there were two key things
12 that I would like to point out. One, back
13 on page 36, the accrued liability, unfunded
14 accrued liability, dropped from $7.2 billion
15 to $4.3 billion. That's a significant drop.
16 And if you go further over to page 45, it
17 gives you a longer history. You can see
18 that about ten years ago that liability was
19 $10.8 billion. So, it's gone from $10.8
20 billion down to about $4.3 billion. That's
21 a huge, huge, amount of progress in that
22 funding for retiree health insurance.
23 Getting back to Diane's three-year

1 projection, as my final comment, the good
2 news is, I am still able to tell you we are
3 not going to have any out-of-pocket premium
4 increases for members, other than that
5 sliding scale that Diane explained that will
6 move some up and some down a little bit.
7 But the base premium is not changing. It is
8 not increasing. Again -- and I think this
9 is about six years that we've been able to
10 did that, five or six, and hopefully we will
11 continue. We have got it for this year and
12 at least one more year that we are not
13 projecting any increases. And hopefully, by
14 the time we get to 2023, we will be in a
15 position where we can continue without the
16 premium increases. But we will, you know,
17 have to see.
18 All of that is contingent on the
19 PEEHIP staff and accounting and our partners
20 continuing to do everything they can to hold
21 the costs down. We have done it in the
22 past, and we will continue to do our best to
23 do that.

1 As always, I appreciate the
2 Board's support in this program. So, thank
3 you very much, Mr. Chairman.
4 MR. HALLMARK: Thank you
5 Mr. Yancey.
6 Just a couple of closing comments
7 I want to make is, one, everyone needs to
8 certainly be aware of the weather conditions
9 out there. I mean, I know there are some
10 schools that have and I guess businesses, as
11 well, that have closed down the South part
12 of the state, and it's moving in our
13 direction. A lot of the school districts in
14 my area will be closed tomorrow, but let's
15 think about everyone during these tough
16 weather conditions.
17 Also, COVID-19 has not gone away.
18 And that I do appreciate and I respect those
19 that are coming -- being at the Board
20 meeting virtually. I know it's not the
21 easiest thing in the world, but we do
22 appreciate you-all finding time to attend.
23 And I do appreciate those that are here in

1 person. That means a lot, as well.
2 Dr. Bronner, it's good seeing you.
3 DR. BRONNER: Thank you, sir.
4 MR. HALLMARK: Good seeing you.
5 And I -- I have always read your comments or
6 your letters in the editorial, but the one
7 that you put this past month really hit home
8 with a lot of us, and it just goes to show
9 us how important life is and the people that
10 support and pull for you in times of need.
11 And it's just good to see you
12 looking good. And I know your golf game is
13 getting better. And I will find out soon.
14 And -- but, anyway, is there any
15 final comments at this time?
16 (No response).
17 MR. HALLMARK: All right. Well, I
18 need a motion to adjourn. Mr. Cole.
19 Second? Ms. Crew. All in favor say "aye."
20 (Board members saying "aye").
21 MR. HALLMARK: All opposed, like
22 sign?
23 (No response).

1 MR. HALLMARK: Ayes carry. We are
2 adjourned.
3
4
5 (Conclusion of PEEHIP Board
6 of Control meeting at 10:30
7 a.m.)
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1 REPORTER'S CERTIFICATE
2
3 STATE OF ALABAMA
4 COUNTY OF ELMORE
5
6 I, Jeana S. Boggs, Certified Professional
7 Reporter and Notary Public in and for the State of
8 Alabama at Large, do hereby certify on Tuesday,
9 September 15th, 2020, that I reported the meeting
10 of the PUBLIC EDUCATION EMPLOYEES' HEALTH INSURANCE
11 PLAN BOARD OF CONTROL; that the foregoing
12 colloquies, statements, questions and answers
13 thereto were reduced to 92 typewritten pages under
14 my direction and supervision; that the above is a
15 true and accurate transcription of said meeting set
16 out herein.
17 I further certify that I am neither of
18 relative, employee, attorney or counsel of any of
19 the parties, nor am I a relative or employee of
20 such attorney or counsel, nor am I financially
21 interested in the results thereof. All rates
22 charged are usual and customary.
23

1 I further certify that I am duly licensed
2 by the Alabama Board of Court Reporting as a
3 Certified Court Reporter as evidenced by the ACCR
4 number following my name found below.
5 This 15th day of September, in the year
6 of our Lord, 2020.
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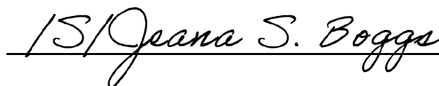
10
11 
12 Jeana S. Boggs, CCR
ABCR NO. 7, 9/30/2021
13 Certified Court Reporter and
Notary Public
14 Commission expires: 8/9/2022
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