In The Matter Of:

Public Employees' Benefits Program Board
Videoconference Open Meeting

Tuesday
January 26, 2016

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

VIDEOCONFERENCE OPEN MEETING

TUESDAY, JANUARY 26, 2016

CARSON CITY AND LAS VEGAS, NEVADA

The Board:	LEO DROZDOFF, Chairman JACQUE EWING-TAYLOR, Co-Chair CHRIS COCHRAN - Member ROSALIE GARCIA - Member ROBERT MOORE, Member ANA ANDREWS - Member JUDY SAIZ - Member JIM WELLS - Member
For the Board:	DENNIS BELCOURT Deputy Attorney General
For Staff:	DAMON HAYCOCK Executive Officer CELESTENA GLOVER Chief Financial Officer KARI PEDROZA Executive Assistant NANCY SPINELLI Public Information Officer
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TUESDAY, JANUARY 26, 2016, CARSON CITY, NEVADA

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VICE CHAIR EWING-TAYLOR: I would like to bring this meeting of the and Public Employees' Benefits Committee I'm Jacque Ewing-Taylor, vice chair, and I will be chairing some portion of the meeting today in that our Chairman had another obligation and won't be here for some time, as yet to be determined. So we'll all be pleasantly surprised when he shows up.

Because of that, we're going to do things in a slightly different order. I want to go ahead and go through the role call first which is not out of order.

Kari?

MS. PEDROZA: Anna Andrews?

MEMBER ANDREWS: Here.

MS. PEDROZA: Don Bailey?

MEMBER BAILEY: Here.

MS. PEDROZA: Bob Moore?

MEMBER MOORE: Here.

MS. PEDROZA: Jim Wells?

MEMBER WELLS: Here.

MS. PEDROZA: Judy Saiz?

MEMBER SAIZ: Here.

THE CLERK: Rosalie Garcia?

MEMBER GARCIA: Here.

THE CLERK: Chris Cochran?

Jacque Ewing-Taylor?

MEMBER GARCIA: Not yet.

VICE CHAIR EWING-TAYLOR: I'm here.

MS. PEDROZA: Okay. And Jeff Garofalo has been excused for this meeting.

We have a quorum.

VICE CHAIR EWING-TAYLOR: Thank you, Kari.

The next item on the agenda is public comment. And before I open for public comment here and in Las Vegas, I just want to let you know that I'm sure that there are a number of comments or people who would like to comment on Agenda Item 10. We will have a separate public comment period for that item.

So for this particular public comment period, please feel free to come forward if you're here in Carson and speak on any other agenda item.

And, Rosalie, I'll let you moderate down south if there are any public comments down there.

MEMBER GARCIA: Thank you, Jacque. I do want to note that Chris Cochran is here.

VICE CHAIR EWING-TAYLOR: Great. Thank you.

I don't know who got here first. You're on.

MS. LOCKARD: Good morning. My name is Marlene Lockard, L-o-c-k-a-r-d, and I'm representing RPEN, the Retired Public Employees of Nevada. I would like to say just for the record for those of you that may not know, Marty Bibb has retired as executive director as of the end of the year of RPEN, and I think you know he's a tremendous loss to our organization after 25 years of dedicated service, and he will be absolutely missed by all of us.

Terri Laird, who is in the audience today, has been named the new executive director of RPEN, and you'll be hearing from her, I'm sure, as well.

The first item I would like to comment on is the audit results in your packet of the various different programs and the -- in particular your chart that shows the number of complaints logged by both PEBP's and in the various vendors. And I think if you take a look at that, you can see that there are modest complaints from in different categories.

But in the case of Towers Watson what by now at this place and time with this contract, we should have a decreasing trend in complaints. You will see it continues to escalate. For this year alone what started out as a few complaints has steadily risen throughout the year, and we're very concerned about that because from day one, we've been

talking about customer service, and they have testified various efforts to correct and improve customer service, but all you have to do is take a look at that chart, and you see it's ascending, not descending. And, as I stated, by this time in the contract, we think the reverse should be happening.

And so in conjunction with that, as you know, PEBP's implemented pilot program for meeting with Medicare retirees in both Southern Nevada and now later this month they are going to be in Northern Nevada and I think if you take a look at the numbers of those that have filled those appointments and the numbers that have come in to take advantage of having the face-to-face opportunity with their representative, it more than justifies having a permanent person full time in this state to have ongoing customer service both in the south and then the north.

And we believe that there is precedent set already. PEBP houses another vendor who deals with the public, and we think PEBP could absorb both here in Carson City and in Las Vegas a place to have a person that would have the ability to have an ongoing customer service present.

So we have been sounding like a broken record on this, and we will continue to be a broken record until we see those numbers headed in a different direction. Thank you.

VICE CHAIR EWING-TAYLOR: Thank you, Marlene.

Any questions from the Board for Marlene?

MS. FLOREY: Hi. My name Janice Florey, J-a-n-i-c-e F-l-o-r-e-y.

First I would like to thank PEBP staff for the newsletters. You could miss a meeting and still know what was going on. Although, I would miss the banter back and forth. Something that came in the mail the other day that I'm not sure all of you have received from Carson Valley Medical Center, which is an affiliate of Hometown Health got this newsletter and talks about telemedicine. The downside side of it also identifies some wellness opportunities, as well, so I'm going to pass this on to the Board as an FYI.

I notice too when you were interviewing for the new HMO's, I remember Hometown Health mentioning they were working in conjunction with UNR's medical school, and I did go on-line and I did check, and there are both state and federal loan forgiveness plans for medical students who have a lot to pay back, and they can be assigned to what's called an underserved population. So Nevada is not the only state that's in this state. There's many other states too to my surprise.

And the only other question that I had is I looked through the whole packet, and I see that our numbers

are as was predicted for non-state retirees continues to decrease, and it looks like projection for 2016 were at 1,214 people in that non-state retiree group, and I was just wondering if some sort of calculation would be done during -- down the line just to see what the fiscal impact would be if non-state retirees would be commingled now? I know that is not something the PEBP Board can do. I fully understand that. That's the legislative action, but I was just curious in terms of what that would be in terms of dollars and cents. Thank you very much.

VICE CHAIR EWING-TAYLOR: Thank you, Janice.

And I believe I'm going to look to Jim for this. We did those calculations for if not the last, the one, the session prior to that because there was a BDR that attempted to address that.

Jim, do you remember that? Did we do those calculations?

MEMBER WELLS: If I recall correctly, we did them before last session so in the fall of 2014, maybe before the 2015 session, and my recollection is that the volume of them, plus the increased cost as we move forward continued to have a significant -- a fairly significant impact for a better part of a decade.

VICE CHAIR EWING-TAYLOR: Sort of my

recollection, as well, but I think the calculation was done, and I'm sure it's available in the archives at least, but perhaps a staff member could get those numbers for you fairly quickly. I don't want to add anything at the moment to a very full plate that staff has.

MR. HAYCOCK: For the record, Damon Haycock.

Yes, Dr. Ewing-Taylor, we will again assess this situation prior to the next budget cycle and see what the impact is and, of course, bring it to the Board.

VICE CHAIR EWING-TAYLOR: Thank you.

I'm going to go to Vegas. Is there any public comment in Las Vegas?

MEMBER COCHRAN: No, we don't have any.

VICE CHAIR EWING-TAYLOR: Okay. Thank you, Chris.

Flip a coin.

MS. MALONEY: Thank you and thank you. Because I'm going to be brief, first of all, my name is Priscilla Maloney with AFSCME, A-F-S-C-M-E American Federation of State County Employees, here for the AFSCME retiree group today. I always feel like I'm piggybacking on the wonderful Marlene Lockard who does all of the work and comes up here and I feel lazy.

So everything that Ms. Lockard said about the

Towers Watson customer service issues, it's hard to look at this packet and really analyze, and I spoke with Mr. Haycock briefly before we got started about this, it's hard to look at those now and know someone is reporting a problem because in their perception, it actually happened more recently. I know that these audits, especially when you get to subsection 5.1, Towers Watson audits have some real specific examples of not only things that the audit, samples that the audit fixed but overall global tweaks that they are trying to do.

But I'm still getting feedback again with all of that big caveat around it of everything that Ms. Lockard said which is clearly we need customer service. One of the board members mentioned to me the other night, you know, when you look at the pie chart, which is on page two of Mr. Haycock's presentation, we've got almost 11,000 folks in -- in that category of being on the Medicare Retiree Exchange that are served by Towers Watson.

I am hoping that we can be creative at this point, at least consider having somebody like an ombudsman, I know we have had the pilot program in place, and I know staff is overburdened, but if there is someway to have somebody be a liaison created from some source, either from the side of PEBP, from the state or from Towers Watson that is -- that is a dedicated person, is an ombudsman to meet some of these

complaints and challenges, that might be something to be creative with as we go forward.

The second thing that -- and everything that Ms. Lockard said, I got an e-mail here that talks about the wait times. Even though the audits may show that those calls are being picked up within, you know, under a minute, again, people's perception is I was on hold.

And Mr. Haycock and I talked about the whole nature of how numbers work in this context. If you get 1,000 calls, your auditing is a very small sample and in that audit sample, you're getting an average wait time of a minute. This person's perception is they literally hung up and gave up after like 30 minutes, so hard to know how to marry that into a coherent policy position, but I'm simply bringing that to the Board's attention because I promised I would.

Then the other issue that was brought to me by my board was again at page 55 of your packet, I'm sorry, page 60, Towers Watson subcontractor PayFlex and how they cut those reimbursement checks has been explained in the packet, but the perception from more than one person I talked to is that it's very hard for the average person, and again 11,000, we have folks of -- some folks aren't computer savvy. Some folks are quite elderly but they're probably arguably the oldest by age group you have in PEBP, for these folks, it's

very hard for them to marry their EOB's to their EOP's, and your EOP example is at page -- it's in Exhibit A, page 83 of the packet, and it shows you actually what it looks like, how to read an EOP statement.

And while I applaud the efforts to communicate and educate, I'm still getting, again, the problem is if you get that check for $15 and then you get an EOB that says $15 was paid, they are two separate things and it's hard for people to figure out. For one thing, we may have people who are in the -- happier or unhappy circumstance where they have to itemize this for the IRS. These expenses get to be deductible. They need to be able to prove that they met that threshold for their tax year of going above and beyond what was covered and what is now part of their IRS calculations, if that makes sense.

So just those two things, and I appreciate -- I know Peggy is probably going to say this too, I appreciate all the good work, she always does, that the Board is doing in trying to struggle with these problems.

VICE CHAIR EWING-TAYLOR: Thank you, Priscilla.

Does anybody on the Board have any questions, comments?

I know this is an ongoing issue, and I know that staff is addressing it and will continue to work on it.

MS. MALONEY: No, that's great. That's the two things.

VICE CHAIR EWING-TAYLOR: I appreciate it.

MS. MALONEY: Thank you.

MS. BOWEN: Good morning, and I do appreciate all of the hard work you all do. My name and my words for the record, my name is Peggy, P-e-g-g-y Lear, L-e-a-r Bowen, B-o-w-e-n, no dash, no slash, no hyphen. It makes it hard for people to trace the comments when you're going back to the archives. Lear is my middle name.

I had one issue this morning and, well, actually two, and then one just came up because of a previous speaker. We need to have when you're investigating and checking the comparisons of an HMO provider Anthem Blue Cross Blue Shield, you need to check to see what they actually pay their specialist and that if their service provider list, provider list is actual in terms of are they accepting new clients? Only saying this because of visiting a specialist and saying that things may have changed for the HMO for this state, and I was told that that specialist bore -- their provision receives $35 in pay from -- they pay nothing was the response and $35 was the figure given.

Also in that same realm when comparing what is being provided, when you have a situation and you are trying

to still say are these comparable, do we still want to negotiate and in the contract if you require in any part of the state for your service for the HMO that there be a referral, then you need to add that to the cost of what is being provided by that company to the -- to the plan. The actual cost of going to the doctor to get a referral, to go to the specialist is an increased doctor's visit, is an increased amount that is charged to not only the plan but also to we, the clientele, and that makes smoking mirrors sort of thing where they say, oh, well, you can go for a whole lot less, and we do these sorts of things.

But when you're trying to make comparable what is being offered, what is being saved, what is being expended, you need to include all the real expenditures and all of the real savings and if the providers are there, so I did both sides, so I was being fair this morning.

Based on what was said by a previous speaker, a little bit of history here, when we were paying over $600 a month into the plan because of the orphans or now the ghosts, as I've now started calling them, the orphans were being not only in the law, I'm trying to make this brief, in the law to keep separate so they can realize how much the -- the non-state employees were actually costing the plan that were remaining in the plan because they didn't go to the A and B

Medicare, the actual orphans.

And what the law never said is that we were supposed to be separated out by benefit. They only said separated out for accountability and, therefore, we should be able to join in your pool numbers as in a larger pool for paying for our medication, for paying for our doctor's visits, for paying for the hospital visits and et cetera, and that at that point in time when I brought that up to PEBP Board, they went back and reconfigured and that we were less expensive than even the actives at that point in time.

Because the separation is now being considered going back a bit and separating us out and saying how much we're costing the Board as if we were a separate pool of three, whatever our number is now, attrition and dying take place there, and our pool shrinks, but we were never to be separated by cost for benefit of drugs, for doctor visits, for all of the benefits, only by notifying the legislature how much in reality we were costing the -- that how many of us were in the pool, how many of us went and with the benefits being equal to that of non orphans what were we expending. Yes, we can do that, but we shouldn't have to pay more because we were separated out not only for reporting but also for how much we had to pay, and that was clarified years ago.

And Mr. Wells when he spoke at the Nevada State Legislature on the record when asked the questions are all of the rates flat and he said yes, and then he listed the state and he listed spouses and he listed everyone -- he listed three groups when he said all rates are flat. And then when Mr. Wells went in the hall and was asked are the rates flat for the orphans, the non-state retirees, he said no, they are going up expediential, and so you have to be very clear and that's on the record, and it's on the record again for today that that was what transpired during those years at the legislature.

So as a reflection of that, the legislature acted. In your minutes today, you talked about the -- the fact that the wellness program was cancelled, but it might have been more helpful, and you weren't here so you probably weren't aware of it, that this Board voted that this last legislative session when submitting their budget that the $50 a month, $600 a year was not going to go back in -- it was a 600 dollar paycheck in actuality because we would no longer for the last go around receive the $50 of the wellness program when we achieved it to be in our paychecks and reflected in our paychecks. That, in fact, that you voted that that $50 was going back into the plan for future, in like a savings almost for a future meeting of any catastrophe

down the road for employees.

And this Board maybe did not do a very good job of explaining to the members of this insurance policy that you provide that in no way, shape or form did this Board see that $50 going back into every paycheck into every community into this state. That that $50 had been taken away, whether we kept the wellness program or not, was going to be taken away, not in the paycheck but, in fact, be kept by this entity in a savings account or however it was going to be mechanized, and that it was unfair for people for this Board to come forward and say call your legislators, do this, do that because this is what is happening if they cancelled the wellness program, and it was through guidance that you did that but in reality, you all have worked very hard.

In the loss of that wellness program was not because of anything other than the legislature felt that the directions that they had given this Board were not followed and they weren't followed because of the direction this Board was given by whomever to accomplish the 50 dollar wellness program incentive, and that's for the record. So everybody can go back and check previous Board meetings, check previous legislative statements and be on board because we have to really reestablish our trust and our acceptance of this Board's actions and the importance of this Board with this

legislature that's coming up because they are still reeling with how they felt they were treated.

And you can go back to the record of many years of the executive director of this Board at that time sat before a legislative committee, joint committee and told them that they -- that that -- the legislature was -- that this Board can do as they pleased, and they weren't responsible to the legislature, at which point the chairman of that legislative committee that was meeting that day reminded the presenter that this Board's responsibility with the legislature, they held the purse strings, and all that is on the record and can be researched and stated.

We need to work really hard to reestablish ourselves as a board for and by our members and that we are there for them, and you all truly reflect because none of you were to my recollection, and I could have a problem there, but none of you to my recollection were present on those days when those statements were made, and I think that it might behoove this Board during legislative session that you have members of the Board present during any time this Board is represented in there, and I don't mean just staff. I don't mean just executive directors, I mean that they see different members of this Board at all times, so they know you have a hands-on and especially now because you've established it,

transparent, open, public and complete in the record.

You have done an amazing job since Mr. Hayock's coming on board, absolutely amazing, and you're much more appreciated now, and more trust is established now because your actions have spoken volumes, and now we're beginning to accept your words, and I want to thank you for that, and I didn't mean to go so much into the history.

But please when you consider today, look at the cost of the specialist and look at the true providers and the true cost of everything that you're looking at in going out for -- in accepting a bid or accepting a contract.

Thank you. Thank you, and I thank you for allowing me that little bit of extra time to give you that history. They say I'm older than dirt. Thank you.

VICE CHAIR EWING-TAYLOR: Any questions for Peggy?

Okay. Is there any further public comment here in Carson or in Las Vegas?

MEMBER COCHRAN: None in Vegas.

VICE CHAIR EWING-TAYLOR: Thank you, Chris.

In that case, we're going to skip Item Number 3 and move to Number 4, which is the Health Claim Auditors quarterly reports.

MR. CARR: Thank you, Madam Dr. Vice Chair.

Members of the Board, I was told years ago that's always to present by Madam Dr. Vice Chair.

This past October -- for the record, my name is Robert Carr, and I represent Health Claim Auditors, Inc.

This past October, Health Claim Auditors performed an audit of claims administered by HealthSCOPE Benefits for PEBP's second quarter of fiscal year 2016. A random selection included a valid selection of 500 medical inpatient, outpatient and dental claims, plus numerous large dollar claims that were audited on bias cases which are not included because the fiscal calculations in your report.

This report finds that HealthSCOPE passed the ability and guarantee component levels with the exception of 99 percent financial accuracy guarantee where they came in at 98.9 percent.

The larger dollar amount errors that were detected within this audit were caused by incorrect coordination of benefits with Medicare, claim not adjusted of a denied services after a physician's statements for medical necessity was received, incorrect application of precertification penalty and medical services paid as routine benefits.

Other nonchargeable errors detected were PPO providers provided as non PPO, incorrect rates applied in

multiple surgical guidelines not being applied.

It remains an ongoing concern that claims both recent and past from specific hospital providers containing contract claim with revenue 390 which is blood products are not being repriced by Hometown Health and are caused to not be paid by HealthSCOPE Benefits because of the lack of cost invoices not being received from the providers.

We recommend that this issue be addressed by Health -- HTH for resolution or deleted from their contract with this provider to avoid a more serious issue that may be coming to PEBP if it's not addressed.

This audit found all customer service levels within the agreement guarantees satisfied. Identified overpayments were at 1.6 million dollars, and open subrogation cases were at $3,000,000, well within the levels agreed to by PEBP.

Research of the 3,071 soft denied claims find that HealthSCOPE is following the proper protocol and found no negative exceptions. However, at the time of our audit, the 13,000,000 dollar soft denied claim level was at the highest value since being serviced by HealthSCOPE. And per our visit last week, when we were there, it's currently in excess of $15,000,000.

Keep in mind that these values are measured in

change dollars and would be reduced by the reduction of discounts and benefit applications, of course.

Our personnel team that were dedicated to the -- that are dedicated to the PEBP plan had no changes during this audited period. All issues identified in the previous audits that you, the Board, accepted our recommendations for have been implemented and/or resolved.

It is our recommendation at this time that PEBP collect a penalty for the financial accuracy under performance. Our calculation for this penalty comes in at $26,289.

And as a very important final note of our report, it remains our opinion that HealthSCOPE remains a very qualified administrative vendor and a very good partner for PEBP.

Madam Vice Chair, the report.

VICE CHAIR EWING-TAYLOR: Not the whole thing this time, Bob, come one.

MR. CARR: I'll pick it back up. I can make up for it.

VICE CHAIR EWING-TAYLOR: Any questions from the Board?

Go ahead, Bob.

MEMBER MOORE: Thank you, Madam Chair.

For the record, Bob Moore.

VICE CHAIR EWING-TAYLOR: You're not on.

MEMBER MOORE: I know I'm not on. I haven't been on for years. Do we need to start over?

Tell me a little bit about subrogation. You have 3,000,000 in the pipeline. Do we use a third party vendor to pursue subrogation? At what point do we say, okay, this is not going to happen? Do we write it off? Just real briefly, what for my benefit is the subrogation process?

MS. PERSON: For the record, this is Mary Catherine Person, HealthSCOPE Benefits.

From a subrogation perspective, there are several different layers that occur. So claims that are large dollar so over $1,000 and especially things like motor vehicle accidents, malpractice cases, all kinds of things like that fall under subrogation, and those would only be held until such point that we receive information regarding the other insurance that's available, and then at that point in time then those are released.

There happens to be a handful of fairly large dollar cases in there. Again, from Bob's perspective, those are charge dollars. They are not pay dollars. So in your world, you can produce pretty much any of those numbers. Even when you're thinking about the dollars for the soft

denials, you can reduce that by 75 percent basically to get the real number but as a result of that, then those will come in. It's just that it popped up in this quarter because of some larger cases that are sitting out there that we hadn't received information from.

MR. CARR: Mr. Moore, in our experience, we see obviously hundreds of different administrators, and I will tell you that HealthSCOPE is in probably the top handful of the way they do it, their process. They do the ICD-9, they do the now ICD-10 sweeps, and the third parties that they do are involved with. So we watch the ones that are going on and the ones that are going off and when they are going off, why they are going off, and we've been very satisfied with the internal policies.

MEMBER MOORE: Thank you.

VICE CHAIR EWING-TAYLOR: Any questions from the Board?

Chris, or, Rosalie? No, okay.

Then the next item would be to -- for possible action on assessing a penalty for missing the financial accuracy portion of the guarantees. I guess we didn't actually get your formal report, did we? I beg your pardon.

MS. PERSON: It's okay. For the record, Mary Catherine Person.

We were disappointed to have missed the audit this quarter. As Bob indicated, it was a fairly small dollar but what happened and I think that actually this is a good -- it was a great learning opportunity for us and we put some nice additional processes in place because the claim that was impacted was there was a person who had a large number of claims that we were requesting additional information on, and we had an analyst who missed one of hundreds.

And Bob, because he is that good of an auditor, found the one that we missed, so he's very good at finding those, but we do apologize for that issue, but I think we put in really good processes around that issue to prevent that from happening in the future which I think that's a positive outcome from this audit. We did miss it, but I think we have made some nice corrections regarding that and appreciate the opportunity to work with you guys as well as Bob around that.

Regarding the soft denial, I will comment on that as well. That is impacted by the subrogation. Soft denials go up as a result of that. Other types of denials we have and around things like precertification or things of that nature, coordination of benefits that then drive those numbers up. We do think that some of those numbers are going to come down probably in the first quarter of this year, as well the third quarter of the plan year as well.

MR. CARR: I wasn't going to make a comment but I think following up with Mary Catherine on the soft denials, one of the things I neglected to tell you, one of the major causes for HealthSCOPE that creates a soft denial is an adjustment on the repriced claim, and we did notice quite an increase and adjustments from the networks in this particular quarter, so that's caused HealthSCOPE to also back up several hundred claims.

VICE CHAIR EWING-TAYLOR: Okay. Thank you both.

Any comments or questions from the Board?

Jim?

MEMBER WELLS: Thank you, Madam Vice Chair.

Two questions, on page 19, it talks about updating reasonable care four times a year with the last update being April of 2015. It seems like that was a little bit long ago.

MR. CARR: Only you would catch that, I apologize. We do check on it. Actually, it was just brought up to date this month. We were there last week, and you'll find in the next report already adjusted that and it is there up to date.

MS. PERSON: We have done it every quarter.

MR. CARR: They had.

MS. PERSON: We both missed it as Bob put

together his report.

MEMBER WELLS: You answered my question on the reasons behind the increase and the soft denial claims.

The last thing I had a question on, where are we with the price estimator tool? I mean, are you seeing utilization? Is it more robust now?

MS. PERSON: So the references regarding the Health Spark Tool, so we've gone through several durations in the last probably eight weeks with them. There was some issues with how they ingested the file. The last file we had sent, which was an updated file, as well as we sent some components of the file, as well, which caused some errors.

We do believe that actually now the data is far more accurate than it was previously displaying. There were some significant issues with it displaying frankly local rules. If you were in Las Vegas, it actually worked pretty well but if you weren't there, it didn't work very well.

We have the data now has been updated for the north, and it's far more reliable than it was previously. We're continuing to work with Health Spark around the display of the data and a few other things, but we do believe that very soon will be a situation where Nancy and her team can really promote that again because the results will be much better.

MEMBER WELLS: Thank you.

MS. PERSON: You're welcome.

VICE CHAIR EWING-TAYLOR: Anything else?

Okay. Then we will move to 4.3 which is consideration -- discussion and consideration of any possible assessment of penalties. So what would the Board like to do?

MEMBER WELLS: I'll move that we accept the audit findings in the report and assess the penalties as provided by Mr. Carr.

VICE CHAIR EWING-TAYLOR: We have a motion.

Is there a second?

MEMBER ANDREWS: I second it. Anna Andrews for the record.

VICE CHAIR EWING-TAYLOR: Thank you.

Is there any motion for discussion?

All those in favor of the motion, please signify by saying aye.

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

VICE CHAIR EWING-TAYLOR: Are there any opposed?

Motion carries.

Thank you both.

Mr. Carr, you're still on the hot seat. Item 5 is your annual audit of Towers Watson Exchange and PayFlex.

We'll go right through those.

MR. CARR: Yes, ma'am. Thank you again, Madam Dr. Vice Chair. Again, for the record Health Claim Auditors.

This past September, we performed an audit on behalf of PEBP for the retirees health reimbursement claims administered by Towers Watson for PEBP's fiscal year of 2015. This audit was conducted at PayFlex location, Towers Watson subcontractor located in Omaha, Nebraska.

The audit was conducted with a valid random selection of 400 claims with no more than 200 claims audited on a bias basis or other historical claims which are not included with statistical calculations in your report.

The audit detected 11 types of errors. The results of the performance for the claims process and precision portion of the agreement reflect that Towers Watson met the 98 percent payment accuracy guarantee right at 98.0 percent.

For the financial accuracy, the agreement reflects that 98 percent of all dollars are to be paid and done correctly. Unfortunately, applying the most accurate math that I could, they came in at an under-performance at 97.995 percent accuracy.

The majority of the error dollars detected concerned dental claims paid with the providers itemized

statement which reflected the charge amount and the amounts the dental insurance companies pay, however did not display the write-offs for the network discounts.

Audits commonly observed, that we do commonly observe providers that deduct the insurance network payments but whether deliberately or not do not deduct the contracted discounts and collect the full billed charges versus only the contract rates and patient responsibility from your members, so we're very conscious of looking for those.

Other errors that were included within our audit, incorrect date of services applied, duplicates, incorrect denials for the lack of reimbursement form, other insurance EOB's, detailed receipts or proper documentation.

A large number of member claims were incorrectly denied in July of 2015 is not eligible due to a PayFlex system programming issue. This was discovered by Towers Watson and all claims were correctly re-adjudicated within a month after the discovery.

Average claim turnaround time was 1.3 days and measurements for customer service performances show that Towers Watson and PayFlex met the guarantee telephone responses, abandonment rates and website services. The customer service -- customer service satisfaction survey that was conducted for 2015 had 1,738 participants, achieving an

average score of 4.1 -- 4.1 on a five point scale which was an increase from the 3.8 on last year's survey.

Audit to the timing for participation funding to their accounts found no exception to no recurrence of issues that were found in last year's audit.

Audit of claims on focused basis helped us to understand the many or at least some or many of the participant complaints and to investigate the source and cause of the problems. In all of these cases, the issues were identified and resolved by either PayFlex or Towers Watson. However, we did see a common thread, and that was participants believed that they did not receive explanations that they could either understand or the resolution of the initial cause of the problem on the first call resolution.

So, Madam Dr. Vice Chair, in conclusion, it is our opinion, un-bias opinion that all metric measurements for this audited period were equal to or better than the agreed values within the service performance standards related to the HRA services agreement with the exclusion of the claim financial precision.

It is our opinion that PEBP has a right to apply and collect the two percent penalty of total fees for the time period being audited at an amount of $8,555. This audit observed the addition of the previously recommended

definitions to their EOP or explanation of payment since the last audit. These additions appear to produce a noticeable improvement in those communications so PEBP participants could better understand their funding and the payment methodologies. Review of multiple calls and communication from participants within the PayFlex files reflect that they had inquiries regarding the information identified as roll-over calculations on their EOP.

Since this is not an essential information to the participant, it would definitely be our recommendation that this data be eliminated from the EOP thereby making the EOP easier to understand and less confusing to the participants.

As I previously stated, this audit's finding of under-performance for the financial guarantee was greatly due to the use of dental providers, itemized statements that did not contain all of the elements to be in compliance with your requirements.

PayFlex stated for dental claims that they either require a dental EOB or an itemized statement which is sufficient if it reflects the payments made by insurance and discounts. We do not disagree with their statement. However, the audit detecting claims in which the itemized statement and/or insurance documents reflected the charge amount and the amounts the dental insurance company paid.

However, again, did not display the write-off amounts for the network discounts, and that's extremely important because of what the providers will do to your numbers. If they are in the audience, I apologize straight up, but that's the way it is.

HCA recommends in the cases of coordination of benefits that PayFlex obtain a copy of the primary insurance carrier's EOB before considering reimbursements to provide the administrative protection for PEBP members when the provider does not record the network discount.

Madam Chair, that concludes my report.

VICE CHAIR EWING-TAYLOR: Thank you, Mr. Carr.

Any questions from the Board?

MEMBER WELLS: I would like to hear from Towers first.

VICE CHAIR EWING-TAYLOR: Okay. Any questions before we go to Towers? Okay. I'll hold mine until you've responded. So, please, go ahead.

MR. SEEGRIST: That will be fine. For the record, I'm John Seegrist. I'm the vice president of funding administration for Willis Towers Watson OneExchange.

On those, while we always appreciate our partnership with PEBP and the improvements we made to our auditing process, we're happy to be able to continue to

provide the services that we do for you on here.

The only thing we met with Mr. Haycock a few months ago to be able to address the issue with requiring the EOB's to be able to be provided on the dental claims as they come out and in our commitment to him was we looked into that to see what the impact that would have on our process.

Part of the concerns we had with increasing that standard is what that does to the members on being able to get the reimbursement. While it's a minimum amount of the time, there are some dental providers and one of the claims specifically that failed in the audit on here came back with no EOB on there was for a company that only provided preventive care and does not always provide EOB's for any other service. So if they were looking for reimbursement for something else, not all of the carriers will provide an explanation of benefit for a benefit that's not covered.

The other consideration there also is if we are looking for a write-off amount, a contract amount that's different on there, in this specific situation, also Nevada statute put into effect three years ago a code that said that dental providers are no longer required to be able to honor a discount if there is not an insurance coverage for that.

So in this situation on the claim that had failed on this one, it was a small amount, no less than $30, that we

were looking at on here, it was only a preventive care benefit, and there was a discount that was requested from during the contracting from the insurance company but according to Nevada statute, it's not required for them to provide that.

We wanted to look into this more to see if we could find what the common practice is on that, and so what we did is we selected about four dozen dental providers in the Carson, Reno area and Las Vegas, Henderson area to be able to give a little bit of a sample of how many of them are actually honoring those write-off discounts in the situation where it isn't covered since the law allows them to not be required to be able to do that, and 100 percent said they are not honoring those discounts.

So in this kind of situation, we feel that even though if the majority of them have a regular dental coverage, there is some coverage there. And if there is some coverage from the insurance company, they do have to honor that discount on there.

But to put this additional burden onto the retirees to come back and say instead of just a statement from the dental provider, you also have to have a statement from the insurance carrier would put an additional burden on them. Granted, it is more information. It would increase

accuracy to be able to do that. However, we have not been able to identify dentists where this would actually become an issue for us to be able to increase that standard, so that was the additional research that we had dug into that.

We have not come to a firm decision on how we're going to process it. We have not changed our process and currently feel that would just be an extra burden that we would be putting on the retirees that is not currently in the industry on there.

Now, that being said, outside of the dental way, where you see this, it does become an issue with some providers, especially when you get into larger amounts on medical on those. So I'm not trying to minimize Bob's recommendation of it being a concern. I'm just saying we're right now we're not seeing justification for it in this situation to be able to change the policies of how we process anything on there.

As far as the explanation of benefits over the last year, we did make another change in our explanations of trying to give more detail about why claims were denied, and we increased that explanation, and we're happy to continue to review those. I know that it came up again in the report this year asking for that. That's something we will continuously review to make sure we want to make sure our

statements are as clear as possible, even if it's just from our point of view of saying it decreases calls which is much better for the retirees and for us to be able to have that explanation that's there.

The issue with including the rollovers are on the statements and how the money moves from year to year, that is an issue we're addressing. While the information that goes on those statements talking about the rollover, that's where funds from one year can move to the next. To be able to do that, it is entirely accurate on the statement on there. We agree it can be confusing and sometimes it's just not of interest to the participants in seeing that it is something on our development to try to be able to take that off.

Oddly enough, we also have other employers that are requesting more detail onto the statements. And so what we're looking at is an ability to be able to try to customize the statement a little bit more to address that. We have not come to a good solution for that of how to balance that out of removing those and maintaining consistent statements while meeting both of those objectives on there.

Let's see if I missed anything else.

I think that's everything. That's the main thing we wanted to be able to point on there. We wished that we had met all of the goals. I think we came about as close as

you could at a .995, excuse me, .005 or five one thousandth of a percent from meeting it there, and hopefully you take that into consideration in your decision on what you do with the report for this audit.

VICE CHAIR EWING-TAYLOR: Thank you.

Mr. Carr?

MR. CARR: Yes, thank you. For the record, Robert Carr of Health Claim Auditors.

I want to make some clarifications on what John was talking about. Our recommendation is not to ask for other insurance EOB for every dental claim that comes through. The ones that were most particular through our concern with are the ones that show in network discount because we know there's insurance out there, and we know what's going on and quite honestly, it's cheating your members of their HRA monies, so I'm not recommending that they do it for across the board.

They do do it and when they do it, they do it well, but they are very inconsistent, and that's one of the problems that I'm trying to point out here, and many of the dentists that do, we understand the internal discounts. We don't disagree with that. It's when other insurance is involved. And when the other insurance -- or when the insurance or the dentist bills at the allowable rate, there

won't be any but in most cases, they on their statement will put discount zero so we know it was recognized, okay. So, again, we're only looking at those items that have that information neglected on there.

The other thing on the rollover, my point with the rollover information on there, it's totally irrelevant to your participants. It's just confusing. Quite frankly, they have come a long ways with their EOP's. I may say EOP. They made a lot of nice changes, what have you, but it's still confusing.

I've been doing this for 30 years. A lot of times I look at them and I can see the members going what is going on. So there is some confusion on there. They have come a long way. There is still a long way to go. And I think just the pure elimination whether his other clients want it or not, I think it's confusing to our members, so I think it should be eliminated.

VICE CHAIR EWING-TAYLOR: Thank you, Mr. Carr.

Jim, I think you had some questions?

MEMBER WELLS: Thank you, Madam Vice Chair.

I want to be clear about these two claims that are talked about on page three first of all. For number 23, the $577.53 overpayment, was there a discount that was provided by the carrier that created this overpayment?

MR. CARR: Yes. Basically this is -- this is what it really comes down to is they were given -- actually, Towers Watson was given a benefit here because what happened is the claim came through, and the claim should have been denied wholeheartedly for the $1,300 until they received that information.

But to be fair, if they would have done their job, what happens is they would have went out, got the other information and then they would have made the reduction, so we only charge the difference. We did not charge the full $1,300. Otherwise, that would -- but to be fair and in the proper auditing technique and methodology, we won't charge that difference.

So long story short, Mr. Wells, is that information was not obtained at the time that it was audited. It went back out and came back in, and so it was the difference of whatever you said it was. Look at in detail, what was the number on that?

MEMBER WELLS: 23. And here -- I guess here's the crux of my question. Did the participant get $577.53 that they did not pay to the dentist?

MR. CARR: Yes, to answer your question.

MEMBER WELLS: Thank you. Then on number 267, which is the 22 dollar preventative only policy.

MR. CARR: Uh-huh.

MEMBER WELLS: The two -- they were paid $22 is what I take it from the --

MR. CARR: Mr. Wells, yes, and to define this, there were actually three different lines. Two of them were very large, okay. They had nothing on it.

Our problem with this one, the reason it was only charged at $9 is the third line was the 30 dollar charge or 31 dollar charge, whatever it was, and there actually was an EOB showed the allowable was $22, so that was proof in the pudding, okay. So they were only charged for that little 31 dollar one, but the same thing goes through for the other $1,050 and the other $250, same process, we could only charge the $9.

MR. SEEGRIST: Yeah, and on the nine dollar one, this is the same situation where this was covered on a preventive only plan. The nine dollar discount was for a service that was not preventive, so the dentist is not required to be able to return that $9. Granted, we would have recognized that if we had seen the EOB, we didn't see that at the time of processing, but Nevada doesn't require them to return that difference on there.

MR. CARR: But it was there. Otherwise, we wouldn't have seen it.

MR. SEEGRIST: Yeah, it was there. The dentist just isn't required to return it, but there is some argument that the dentist may need to do that but the statute does not require it, so.

MEMBER WELLS: Okay. I guess my overall issue with this is that, I mean, your policy, your statement of practice says that you want to make sure these are reflected for any discounts and obviously in this case it wasn't, that's actually a taxable event to the participant of $577.53 which has probably not been related to them that they now owe taxes on that $577. That one is a problem for me.

I have a couple other questions if I can, Madam Chair?

VICE CHAIR EWING-TAYLOR: Sure.

MEMBER WELLS: Thank you. It talks about on page nine that overpayments and increase in overpayment and look at the detail for the possible causes and solutions for the increasing overpayments. Has that been related to staff and if so, is staff looking at that to find whether that's actionable?

MR. SEEGRIST: We do communicate those overpayments to your staff, that's correct.

MEMBER WELLS: I get that you provide them to them. Have you provided a detailed report which is looking

at the causes and potential solutions for mitigating these overpayments?

MR. SEEGRIST: We have. We have looked into that in the past. The report indicates what types of overpayments. We've looked at those. The majority of the overpayments we find in these situations have to do with the end of line on there, so these are claims that are paid out and delays and depth notification on those generally is what creates the bulk of these on those, and we still attempt even after that point, we send out notices.

However, the collection rate from the estate to the deceased are very poor to be able to recover those funds, and that's where the majority of those come from. There's a smaller percentage of those that have to do with the ways in communication of the qualification from carriers, and that's usually what happens is there is somebody, for example, may not pay their premium. The policy cancels. They lose qualification to the plan, and we remove their eligible incurrence period. Anything reimbursed in that time period would then become an overpayment.

When we identify those, we do an overpayment. We do a letter. There's a letter that mails out to participant. We also do an outbound phone call to them. And then when it goes into overpayment, we send monthly reminders or notices

requesting the fund back. The first is called a payment notice that goes out with a tear off coupon, asking for the funds back, and then we send a monthly letter out asking for the funds back for as long as the account is open out there, plus three months, so that's the only extent of those. We do not do any aggressive measures to be able to recover overpayment from the retirees.

MEMBER WELLS: Okay. Thank you.

The last two on page 22, number 279, in this -- this is a comment. I don't know that you need to respond to that. When a participant attaches a two-page letter and files something incorrectly, I find it objectionable that you would not reach back out to that person to see if you can resolve whatever issue it was that they had.

And the last question I have is actually for staff and that is on number 201 on page 20, it was overridden, the denial of this particular claim was overridden by staff, and I would like some detail as to why staff overrode this particular claim.

MR. HAYCOCK: For the record, Damon Haycock.

I'm going to have to do a little research to find out who approved this, and I can bring it back to you and the Board.

MEMBER WELLS: Thank you.

MR. SEEGRIST: I'm sorry. Off the top of my head, I don't remember the reason that was -- an appeal was approved on that.

VICE CHAIR EWING-TAYLOR: Bob?

MEMBER MOORE: Madam Chair, if I might, for the record, Bob Moore.

I want to pursue claim 23 some more because I'm confused. This is a situation -- let's do a hypothetical. You have a coverage service. It's a preventative service. It's 100 bucks, and so you will -- and it's properly discounted and merrily skips through the system just fine. But tandem to that service, there was some other services, fillings and drillings and things that of nature that weren't covered. So the member submits that for, that is the qualified, the 213 expense, so I submit that claim for reimbursement, and the dentist refuses to give a discount.

So Bob is saying that that 200 dollar non coverage should be discounted, and you're saying you really can't do that. Okay. So that's basically the terrain that we're talking about. That's not the terrain?

MR. CARR: No, it actually goes a little different than that. In this particular case, you can't give that benefit of the thought because you don't have -- of your ideal because what I'm seeing is without the primary

insurance network's EOB, you don't know what that discount is.

MEMBER MOORE: Okay. I'm not talking about discount at this point. I'm saying there was a preventive service for 100 bucks. It was discounted and paid. There was some other services provided tandem at -- to the tune of $200 that weren't discounted. The dentist has given you the ole one finger salute. So we're paying this one, but we're not paying these over here. What in the summary plan description for the HRA, is that subject addressed?

MR. SEEGRIST: As far as in the summary plan description on those, I don't think we addressed that specific situation. I don't believe there's anything -- any detail on that.

MR. CARR: There is, and that's the reason it's an issue, okay, is that PEBP does describe that it requires the other EOB, okay. And so we can identify the discount in all of those monies that should be reduced, okay. What they are saying is we don't have to get the EOB. We can take it off the dentist's statement.

The problem is the dentist's statements don't always have it because sometimes they are not always above board or they have bad bookkeeping or whatever so they are saying, hey, guess what? I'm going to take the discount and

not pass it through, so I'm going to collect from your member the full amount, that's my problem.

MEMBER MOORE: It's a real catch --

MR. CARR: In this particular case, it doesn't come down to primary or preventative services on 23. It does on the second one but it doesn't on 23.

MR. SEEGRIST: On this one, we don't disagree with this one.

MEMBER MOORE: I understand what you're saying, but the problem is there's a real catch 22. It's a covered qualified section 213 of the expense which this plan pays for, but there's a caveat that you have to provide a piece of paper to get the claim recognized, and I'm saying that's probably not realistic when the dentist is saying we're not giving you a piece of paper.

There's a systematic problem that needs to be discussed in greater detail to get the issue resolved. Otherwise, the members are not getting a good deal.

MR. SEEGRIST: I appreciate what you're saying there and most dentists are above board or they're fine giving the statements but you're right, some of the dentists, like Bob has indicated, Mr. Carr has indicated on those, do not give statements that are detailed enough so they may not indicate all of the detail there.

And so I agree with you, it is a catch 22 and that's one thing we're concerned about with the retirees is not so generally willing to take that statement or take the EOB. We don't require that they have to have the EOB to be able to do it and that's to be able to make it easier for the participants. We'll take one statement or the other.

MEMBER MOORE: I'm going to suggest that if I come to you with appropriate documentation that I have received a bill for section a 213 of the expense, I'm going to expect to get reimbursed for it. I don't care what the other insurance company did. I'm giving you proof that I have incurred a 213 to the expense. I expect to get reimbursed for it.

MR. SEEGRIST: So, okay.

MEMBER MOORE: I would submit, Madam Chair, this topic needs to get reviewed and maybe you guys were smarter than me, certainly can come back with a solution because I don't think the plan participants are getting a square deal here.

If the dentist won't give them an EOB because -- just because they are nasty and ornery, then let's not cheat them for that.

MR. SEEGRIST: We would be happy to review it with our staff.

MEMBER MOORE: If that's appropriate, Madam Chair.

MR. CARR: The good news is where they do do an EOB and have that, they do a fine job.

MEMBER MOORE: Great, perfect.

VICE CHAIR EWING-TAYLOR: I think we maybe need one point of clarification. I want to be sure that we all understand that the dental insurance that we're talking about is not the PEBP dental insurance.

MEMBER MOORE: Correct.

VICE CHAIR EWING-TAYLOR: It's other carriers.

MEMBER MOORE: Correct.

VICE CHAIR EWING-TAYLOR: I think that needs to be clarified, so I'm not sure how much we can dictate to other carriers.

MEMBER MOORE: Exactly.

VICE CHAIR EWING-TAYLOR: But I do think it's something that we can certainly discuss in the ongoing conversation that we have.

MR. SEEGRIST: We're always happy to try to improve the participants.

VICE CHAIR EWING-TAYLOR: Any other comments or questions?

Judy?

MEMBER SAIZ: Just a couple of questions. Customer service, the survey that you performed, 4.1, was it the same survey that you got 3.8 last year?

MR. SEEGRIST: Yes.

MEMBER SAIZ: Off the top of your head, questions that were asked, I asked for this one before but didn't receive the list of questions. If you don't know them, can I get a copy of that?

MR. SEEGRIST: Yeah, there's only five of them. It's called net promotor score, industry standard one that's on there. I'm trying to remember the order. Chris Bates is here. She can probably answer it for them. One of the questions is would you refer us to a friend, would your call answer, I can't remember the exact wording. I would be happy to provide you that.

MEMBER SAIZ: And then the other one, the other question is that Bob commented that they didn't receive answers on the first call that they could understand and so they needed to have multiple calls. Your comments on that, why -- just your comments in general.

MR. CARR: I'll answer it for you if you want.

MR. SEEGRIST: I'm sorry. I thought you said Bob. You know, we always try to answer. I thought it was his question. I thought you were looking at him. We always

try to answer everything on first caller resolution on there, and we do review everything on those.

As far as the calls, when we have our reps that we run, we have about 500 of them to take calls that potentially we take call from the population on those. We monitor at least two calls a week from those reps to be able to identify training opportunities. If we find ones that are not explaining things, they are pulled over and coached or we bring back and do re-training.

Our intention is for them to always be able to explain everything clear enough to understand on a first call resolution to be able to do that. That being said, that is quite a challenge to be able to make sure that everybody understands exactly what you're explaining every time.

We also have a process where we monitor multiple calls and so if we have people calling back too many times within a short period of time, we do an outreach to them. If it looks like they are just not quite getting it, there's a struggle on there, then we try to do an outreach to help them understand that, so.

MEMBER SAIZ: You know, I would be interested in knowing what's like a number one call, is it the EOP's or, you know, where they don't understand. I don't know if you can provide that or?

MR. SEEGRIST: Our number one call has to do with a duplicate claim submission, it's on there, and so we have most of the claims that we process are auto reimbursements. So we take the receipt from the insurance carrier and submit it for reimbursement for premiums. We have a lot of retirees that don't understand that or for just good measure submit a paper claim also, and that's our number one call driver is people wondering why their claim was denied, and it was denied because they had already automatically submitted it once and then they submitted it once manually, and so they will call in confused about why they got a notice of denial for a duplicate claim, that's our number one drivers.

We can give you those. We do a report that we provide to the staff here, also identifying our top five call drivers that we do a regular report on, but we're happy to share more detail on that if you would like to see what they are. We try to make sure that we don't have anything out of the norm. We try to -- we monitor that, and sometimes we do outreach based on that.

I know that we haven't done one for a little while, but we have done proactive mailings with your population based on higher volumes and specific call dispositions that we'll see. If we see peaks in certain questions that we think we need to address, we'll do an

outreach.

Usually when we do that, we combine that. We have a computer that calls out that tells them a letter is coming and to watch for this letter and then when the letter comes, it has the explanation in it, and we try to pair those two together because we get a lot higher response of people actually reading the letter if we tell them it's coming.

If we just do the phone blaster only, they will be less picking up or hang up, and so we pair those together because we get a lot better response.

MEMBER SAIZ: Thank you.

VICE CHAIR EWING-TAYLOR: We'll go to Damon next and then Don.

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

Just a couple of questions and then another response to Judy's question. You know, later on, you'll hear on the consent agenda, we have our complaint report and so the calls we have received on behalf of Towers Watson, the 62.1 percent of those calls are directed to HRA funding and HRA reimbursement issues. Another 21 and a half percent are to enrollment issues, and so not quite the same answer that you gave, but those are what we're receiving here. What you guys are receiving, of course, you know more than we do.

A couple of questions, when under customer service, right, there's an average speed to answer and it shows in the audit to 24.3 seconds. I'm going to assume, but I would like confirmation, that's how quickly your IBR picks up versus somebody talks to an individual.

MR. SEEGRIST: No, that's actually at the end of the IBR, and so they go to the IBR. Once at the phone menu and once they select the option -- so if you go in, if you want to go to the funding department, it's option three. However, three is the first number they get to choose on there.

If you go in there, from the moment they make that selection until a live person is on the phone, that is the span we measure on those, so they are welcome to stay on as long as they want on the IBR until they actually decide where to go, we don't. We do measure how long they are on the IBR but it's not included in that number.

MR. HAYCOCK: Thank you for that clarification.

And, second, I know it's not part of the measurements here, but do you -- are you at liberty to discuss what your average hold time is right now?

MR. SEEGRIST: Our average hold time?

MR. HAYCOCK: How long are retirees or participants sitting on the phone, waiting to talk to an

individual?

MR. SEEGRIST: Well, an ASA would be until we actually get to an individual, so we don't actually have a hold time because that average speed to answer once they know they are on with a live, we don't use the two tier approach to be able to do that. The only time we would have a hold time, we do monitor that, is if the call is misdirected.

So if they come on there and they select option one, which is enrollment, they will get someone that can answer questions about enrollment. That's really what -- if that's really not what they wanted, they know -- we call it a hold time, but it's a warm transfer, and that person will stay on the line with them until we get them to the right department, and that is a number we monitor also, but those are for misdirected calls is how we watch those.

And so if it's directly -- as long as they pick the right one, there really isn't a hold time for them because we don't have a two tier approach to answering the phones.

MR. HAYCOCK: You don't use an automated call management system that tracks all of those like traditional call centers?

MR. SEEGRIST: We monitor all of our stats, we do. We watch the handle times, the hold times. We measure

everything very closely on what we're doing on there. But if a participant was to call in and push option three and go to the funding department with questions, we -- our focus is to have a single point to be able to answer all of their questions on there, so we wouldn't put them on hold.

The only time we may put them on hold is if they needed to get asked a question of their supervisor or something like that, we might be able to put them on hold, but they are still on with that same person where we're not transferring them anywhere else. We keep them there.

MR. HAYCOCK: So the last question I have, and then I'll turn it over. I'm sorry, Madam Chair. So if we send Health Claim Auditors out the next time you do an audit and do a focus audit on the hold times, they will be able to gather that information and report back to us, and then you'll be able to address any issues, correct?

MR. SEEGRIST: You can look at those. The hold times would be recorded between transfers so, yeah, that's nothing they have ever audited before, but that data is all available if they would like to see transfers and how long they take.

MR. HAYCOCK: That's all I have. Thank you.

VICE CHAIR EWING-TAYLOR: Don?

MEMBER BAILEY: For the record, Don Bailey. I

think Damon just asked all my questions, but I thank you for that.

I guess we're hearing from the membership actually or some of the membership this morning, and we're still getting calls, at least I am, about your call in and them trying to get some subject matter corrected.

MR. SEEGRIST: Uh-huh.

MEMBER BAILEY: You immediately answer the phone within a second or two seconds by your own reports, but then the member stays on the line for 40, 45, sometimes almost an hour. I find that sort of absurd. I wouldn't hold on a line to talk to you that long, to tell you the truth, but the point is they are.

And what are you really doing to cut them hold times down?

MR. SEEGRIST: Yeah, it's really not hold times. They do talk to a live person under 30 seconds. So within a matter of seconds, they get to a live person.

MEMBER BAILY: But then they go on hold.

MR. SEEGRIST: No, we don't put them on hold at that point. We don't have a two tier approach. Once they get to that person, that is who they will talk to. But the length of calls, sometimes they do go longer. We do not have what's called a handle time. We do not have a handle time

requirement for our representatives. In other words, some centers will say you have to within five minutes end the call. You have to push that through. We don't have a requirement on our reps. So they are welcome to stay on as long they want to make sure the member gets the question answered that they need. Right now we are running about 11 minutes for a call, that's about how long it takes to run.

Now, if we were to put that into a setting for a call center that puts more motivation for the reps to end the calls, we run about 25 percent longer than industry standard would be because we leave that open approach for the members, and so it is accurate that they are welcome to stay on as long as they like until they get to the point where the rep feels, you know, they have a good level of understanding, and I hope they are not seeing too many 45-minute calls, but we do see sometimes longer calls, and we don't cut them off if they go longer, if they need that to understand their questions.

MEMBER BAILEY: Okay. I would agree with all that on the call times because no matter what you call it, members are on the line a long time and they are complaining.

Now, I commend you for you doing your meetings now. In fact, I think you got two of them coming up, don't you, on the 28th and 29th?

MR. SEEGRIST: We have two of them this week, tomorrow and the next day. I have two of my staff coming.

MEMBER BAILEY: Yeah, I commend you for that and maybe that would be an issue you could address with the members and maybe make them better understand how your system works. I mean, because of the age people that we're talking about, sometimes they don't comprehend that and sometimes they just agree with that, but we are getting complaints about it, and I think you just need to address -- that seems to be the biggest issue for the Towers right now, at least in my mind, at least what my members are saying.

So you need to keep certainly on them meetings because I think the meetings have made a big impact on the membership. I think they like them. I don't know how many are showing up. I heard one number, and then I heard another number, but the bigger the number the less you're going to get complaints. So you really need to drive home that membership and take care of them.

MR. SEEGRIST: Yeah, we appreciate that and appreciate the compliments of doing this pilot project on those. We do have meetings in the northern and here coming up in the next two days. We will have two people on site, Cindy and Stacy from my team, that will be here. We have received very positive responses on those.

We've been -- as a pilot group, we have been interested in seeing what the impact is on, so we're monitoring that very closely. We're interested in seeing the type of questions coming and what they would like to know. Some of the things we're learning is the questions that are coming are not difficult questions. They are ones that you could resolve on the phone really quick a lot of those, but what it seems to be where we're getting more positive response is a frustration with being on the phone with a lot of those and not seeing a person face-to-face.

And I think that's where we're getting the most benefit out of those is some people were asking questions as far as turning on auto reimbursement that they didn't know. They have been on the plan a couple of years and they didn't know that all they had to do was call and we would just turn it on and had to submit another claim, and they just didn't know. And they had never -- even though we had tracked that they had called, they were not getting it until they actually talked to somebody face-to-face, and we're learning some things like that in coming back, and we had some very positive responses on that.

So I think as we continue with the rest of this pilot and looking at those, I think we'll come up with some recommendations at the end that will help the population to

be able to do that, so I appreciate the compliments on that.

I've been really pleased with the responses we're getting and also what we're learning from it and how we're doing that. So this is the first time that we've really done it. We've mostly been down in Henderson, doing them up there. We thought, well, there's not as much population. It may not fill up as fast. The two days we scheduled were full before noon once the announcement went out about it, letting us know there's a slot.

So rather than all of the slots were full for those dates, we did an outreach, telephone calls to anybody we couldn't schedule until we could schedule another meeting to be able to accommodate them, and actually those outreach calls have been pretty good because they had a chance when they called in to say if they could come in and meet with us, they told us what they were calling for.

So when we had my reps call out on an outbound, they already had a chance to look up. They didn't have to -- the retirees didn't have to wait while somebody read what was going on in their document. They had already researched it before they called, so it made the calls nice and short so they didn't have to read the data.

Anyway, I appreciate your comments.

MEMBER BAILEY: That is excellent and I will

follow-up on it if I were you.

Earlier we did hear that that call complaint side was sliding upward instead of downward. So in the testimony, maybe you can take some attention to that too also.

MR. SEEGRIST: I'm happy to look at that. We are monitoring that really closely.

MEMBER BAILEY: I know you do.

MR. SEEGRIST: We watch that real closely. This time of year, we see a slide this time of year. The first of the year, the first quarter, really, January is our worst because the first of the year, money, everybody has policies. Our call volume shoots, all kinds of questions. It slides. We have added on 300 seasonal staff just to handle January, more people on there, but that being said, it's just a difficult time of year. So we do that, and we're very concerned about that, making sure that we address that, and we watch that very very closely.

And we as part of the survey we do, they are allowed to be able to leave comments. Those comments get entered. They say it on the phone, and types it up for us, so we review those. And on the scale from one to five, anything gets a one or a two gets an outbound, that means they're pretty unhappy, so we want to talk to them. So we try to reach out to those individuals if they are really

unhappy and find out why and try to talk to them and see. Obviously, if they are rating us that low, something didn't get resolved, and we don't want them to go away without, that kind of thing. So hopefully that kind of an outreach on those lowering scores count.

MEMBER BAILEY: Okay. Thank you.

VICE CHAIR EWING-TAYLOR: Thank you, Don.

If there are no other questions or comments for either Mr. Carr or Mr. Seegrist, we'll move on to 5.3 which is any discussion about accepting the audit report and assessing the penalties.

MEMBER SAIZ: Judy Saiz for the record.

The motion that we accept the audit for findings and assess the penalties $8,555.

MEMBER BAILEY: I second that motion.

VICE CHAIR EWING-TAYLOR: We have a motion and a second.

Is there any discussion?

MEMBER ANDREWS: I just have one more question.

VICE CHAIR EWING-TAYLOR: Go ahead.

MEMBER ANDREWS: Anna Andrews for the record.

I'm sorry, I wasn't passing off asking prior to this. I echo the comments and I'm concerned because time and again I have listened to the comments under the public

comment section, and it concerns me because time and again, it looks like customer service is not being provided.

I have one key question and it's my personal experience, not with this, but in general, when you call a toll free number, it's one of those that answers for such and such, press one, for such and such, press two and so forth and so on because I don't know about the rest of you, but I know that the older I get, my patience is a little bit less and less, and I know that that could probably also be part of complaints that we are receiving.

MR. SEEGRIST: And I can address that for you also. We do have what's called an IBR so that is the menu option on there. When a person calls in on that, our system tries to look at what the person -- we try to guess what they may be calling for.

The very first time they call in, they haven't purchased a plan, so they don't need customer service. Their account is not funded. They don't have any funding, questions. They need to enroll. So when they first call in, option one is the only one that should be there, and we don't give it to them because it's only one option.

So when a person very first calls, until they have enrolled in a plan, they don't have an IBR, just goes right it. Now, after that, when they have enrolled in a

plan, then they may need to talk to customer service, and then they get two options. Either they still have an enrollment question or they have a question about that policy they just bought.

And then once their account is funded, we add the third option so then they have three. So they can either ask about their policy, other customer service or funding, so we try to keep that as short as possible.

Now, the only other thing on there that there is a menu on there is when they first call into the funding one on there, there's a second menu that just asks would you like to set up direct deposit, and they can either say yes or no and that's all it is on there. And so if they do, we'll just -- the computer will set it up. We don't allow live people to collect bank account information. They have to enter it on the phone. We don't want a person to actually have access to the bank account, so that's the only reason we have that other one. That's the whole menu structure, and we try to keep that as simple as possible and try to be predictive as much as we can, so.

MEMBER ANDREWS: Thank you.

MR. CARR: But your call is very important to us.

MR. SEEGRIST: That's right. Please listen, the menu options have recently changed, is another one we always

hear used to get.

VICE CHAIR EWING-TAYLOR: Okay. Is there any other discussion on the motion?

Then all those in favor, please signify by saying aye.

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

VICE CHAIR EWING-TAYLOR: So now what I would like to do, Mr. Carr, with your indulgence is take a quick break. You're still in the hot seat --

MR. CARR: Yes, ma'am.

VICE CHAIR EWING-TAYLOR: -- for Item 6.

We're going to take a ten-minute break. We'll come back at 20 minutes until 11:00.

(Whereupon, a brief recess was taken.)

VICE CHAIR EWING-TAYLOR: We'll bring this meeting of the Public Employees' Benefit Program back to order as orderly as we ever get and move to Agenda Item 6 which is yet another lovely report from Mr. Bob Carr. This is his audit of Catamaran, our Pharmacy Benefit Manager.

So, Mr. Carr, take it away.

MR. CARR: Once again, thank you, Madam Dr. Vice Chair, thank you. For the record, Robert Carr of Health Claim Auditors.

This August and last September, we performed an audit of claims administered by Catamaran for PEBP's fiscal year 2015.

100 percent of the prescription drug claims processed during this time period were reviewed to assure PEBP that Catamaran was applying policies and procedures to control prescription costs while also paying claims accurately within a reasonable period of time and in compliance with your contract of service with them.

To start off, the results of this audit reflect that, PEBP, you should be congratulated on the 82 percent plus distribution of generic drug utilization of all retail and mail order claims. This distribution certainly help the drive of overall costs to the participants and the plan itself.

The audit found that Catamaran is conducting policies and procedures within expected industry standards in the areas of drug utilization review, case management, system clinical edits, quality assurance, training, security applications and applying the actual prescription cost paid to each pharmacy by your PEBP members.

Catamaran was found to be in compliance of the PEBP agreement for the measurable categories of the telephone abandonment rate, mail order shipping turnaround times,

application of plan benefits, zero balance pricing, administrative fees, reporting and disclosure of any data breaches.

With this audited period, Catamaran was found to underperform in multiple financial and customer service related measurable categories that are guaranteed within your agreement.

At this time it's very imperative that I express and emphasize that the PEBP members' cost to the prescriptions were in no way affected by any of the under-performance amounts that I'm presenting to you today.

The passthrough cost methodology utilized for your claims means that every prescription cost reported by Catamaran was the actual payment made to the dispensing pharmacy, but they did not meet the specific negotiated agreement or aggregate guaranteed rates.

The categories identified with the under-performance measurements are as follows, number one, the retail generic discount from an average wholesale cost was below the aggregate contracted rate. We calculate the PEBP plan under-performance of a little over $70,000 for this category. The retail main brand aggregate dispensing fee was above the contracted rate which resulted in a PEBP plan under-performance of $8,092.

Specialty drug claims had a dispensing fee applied above the guaranteed rate resulting in $2,501 of an under-performance.

100 percent of problem resolutions must be documented within two business days. The annual measurement of this issue reflects that Catamaran documented 99 percent within the two business day guarantee or below the benchmark.

95 percent of mail order claims must be shipped within -- to participants within two business days. Only 92 percent of claims were shipped within the two business days in quarter one, definitely below the guarantee.

We calculated the manufacture rebates at the time of this audit for the first three quarters of plan year '15 to reflect an amount of $49,000 less than your guarantee. However, again at the time that we did this report, the fourth quarter rebates had not -- weren't all fully received at that time. So the total plan rebates will have to be reconciled very shortly for your contract compliance.

We concluded this audit with the following findings and recommendations, we find that PEBP is due no monies for the discounting or dispensing fees under-performances, as the PEBP agreement with Catamaran contains language with what is called a TRUA (phonetic) for financial performance guarantees.

The agreement states when evaluating and reconciling guarantees, Catamaran will look at the overall annual performance of its rates and report on the net performance. We applied this methodology to our calculations and after adding the discount category under-performances that I presented to you with the over-performances of $195,000, no penalty is due on that piece of it.

Results of calculating the over and under-performances for dispensing fees, PEBP is due $802. PEBP is also due $22,611.30, for the under-performance mail order claim shipping and $7,537.10 for the under-performance of participant problem documentation for a total of $30,950.40. It is our recommendation that PEBP collect these funds.

PEBP or HCA also verified that PEBP had received the approximate $565,000 for the under-performance as identified in last year's audit. These monies were received by PEBP in April of 2015 and are now considered satisfied.

So with that, Madam Chair.

VICE CHAIR EWING-TAYLOR: Thank you, Mr. Carr.

Any questions for Mr. Carr?

Mr. Moore?

MEMBER MOORE: Madam Chair, I beg your indulgence. For the record, I need to disclose my son is a

corporate officer of United Health Group that owns Optimum, that owns Optimum RX, Catamaran. However, I have received advisory opinion from the commission on ethics that his position is so far removed from the operations of Catamaran Optimum RX that I can vote on the issue. There is no conflict of interest. However, I do need to disclose that relationship and I will recuse myself.

Thank you, Madam Chair.

VICE CHAIR EWING-TAYLOR: Thank you, Mr. Moore.

Las Vegas, did you hear that? I know Bob didn't have his mike on. Okay. Good, they did. I just want to make sure.

Any other or any questions or comments for Mr. Carr? If not, we'll move right into the next sub item which would be the response from Catamaran.

MS. ROSS: Hello. For the record, my name is Shannon Ross, R-o-s-s. I'm with Catamaran, now Optimum RX, as Mr. Moore indicated. Thank you all for your time.

In response on behalf of our organization and as our response letter in the Board packet indicates, we are very honored to be able to respond and thank the Board for the opportunity.

As Mr. Carr indicated, the overall financial guarantees do allow for offsetting between the respective

channels and when taking an aggregate, the overall financial performance to PEBP is $135,000 above the guarantees. We do result in net a deficiency on dispensing fees of $802. That amount will be paid to PEBP upon the Board's approval of the audit findings.

In addition, there were two customer service issues which were not met to the performance guarantees. The first is the response time relative to mail order turnaround time of clean requests and the processing of those claims. And the second was relative to documentation of customer service complaints.

So to rectify those deficiencies and to work towards a better audit for the future, we have done a number of steps, which I would like to just touch on briefly, if I may.

For the mail order component, Las Vegas opened a facility this year. So June of 2015, there was a brand new facility in Las Vegas which is specific to both specialty and mail order claims, so it will give us additional banding to fill those claims and that meet guarantees moving forward. We actually toured that facility with both Mr. Damon and Ms. Rich last week, but that would obviously be for future claims, nothing for past claims obviously.

And then relative to documentation of customer

service complaints coming in and resolving those, we have enhanced our customer service intake requirements and the system with which those calls are documented so that we may respond to those in a more timely fashion, and that's to meet that guarantee moving forward.

In addition, we have worked with PEBP staff at the request of Mr. Haycock to log the types of calls and provide a monthly report to staff indicating the types of call at a summary level so that way we can start to see any trends so we can get ahead of those that may be duplicative or indicative of recurring issues, and that report provided for July through December, early this month and obviously January's will be provided in the coming month moving forward and on that same cycle moving forward. So those -- those issues then attempt we'll work to rectify those topics moving forward so that we can look forward to a clean audit in the future.

Do you have any other questions that I may address?

VICE CHAIR EWING-TAYLOR: Board, any questions for Ms. Ross?

Chris? Rosalie?

MEMBER COCHRAN: No questions.

VICE CHAIR EWING-TAYLOR: Okay. Then we'll move

on to 6.3, which would be discussion about accepting the audit report and assessing the penalties.

What's the Board's pleasure?

MEMBER ANDREWS: Madam Chair, Anna Andrews for the record.

I move to accept the audit report findings and assess penalties as applicable -- if applicable in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors.

VICE CHAIR EWING-TAYLOR: Thank you.

We have a motion. Is there a second?

MEMBER SAIZ: I'll second.

VICE CHAIR EWING-TAYLOR: We have a motion and a second.

Is there any discussion?

If there's no discussion, then please signify your approval of the motion by saying aye.

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

VICE CHAIR EWING-TAYLOR: Are there any opposed?

MEMBER MOORE: Madam Chair, I will abstain.

VICE CHAIR EWING-TAYLOR: Thank you.

All right. That motion carries.

Thank you, Mr. Carr, and, Ms. Ross.

I think what we'll do now since Leo is still AWOL is move to the consent agenda, and what I would like to do is ask the Board if there are any items that any Board member would like to remove from the consent agenda so that they can be discussed?

MEMBER WELLS: Madam Chair, I would like to remove Items 1 and 2 because I will be not voting on those two items.

VICE CHAIR EWING-TAYLOR: 9.1 and 9.2?

MEMBER WELLS: Correct.

VICE CHAIR EWING-TAYLOR: Anyone else?

Okay. Why don't we go ahead and discuss 9.1 and 9.2. We'll take 9.1 first, approval of the action minutes from the January 12th, 2016, PEBP Board meeting. Take a moment for all of you to review those if you have not had a chance to do so and when you're ready, I will accept a motion.

MEMBER MOORE: Madam Chair, are you looking for a motion to approve the consent agenda which the exception of 9.1, 9.2?

VICE CHAIR EWING-TAYLOR: Yes.

MEMBER MOORE: Madam Chair, I move we include the consent agenda with the exception of Item 9.1 and 9.2.

VICE CHAIR EWING-TAYLOR: Is there a second?

MEMBER BAILEY: I second that.

VICE CHAIR EWING-TAYLOR: Is there any discussion?

All those in favor of accepting the consent agenda Items 9.3, 9.4 and 9.5, please signify by saying aye.

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

VICE CHAIR EWING-TAYLOR: Any opposed?

All right. That motion carries, so we will move to 9.1, approve the action minutes and is there any discussion about those?

Hearing no discussion, what is the Board's pleasure? We'll take a motion.

MEMBER MOORE: Do you have a watch on?

MEMBER SAIZ: Madam Chair, Judy Saiz for the record. I will make a motion to approve the minutes from January 12th, 2016, PEBP Board Meeting.

VICE CHAIR EWING-TAYLOR: Bless your heart.

Is there a second?

MEMBER BAILEY: Second.

VICE CHAIR EWING-TAYLOR: Second by Don Bailey.

Is there a discussion? If not, then all those in favor please signify by saying aye.

(The the majority of the vote was in favor of the

motion.)

VICE CHAIR EWING-TAYLOR: Any opposed?

MEMBER MOORE: Madam Chair, I will abstain.

VICE CHAIR EWING-TAYLOR: From 9.2?

MEMBER MOORE: 9.1.

VICE CHAIR EWING-TAYLOR: Oh, you abstain, excuse me.

MEMBER WELLS: Same thing for me, Madam Vice Chair, I will be abstaining as well.

VICE CHAIR EWING-TAYLOR: So for clarification, for the record, there were two abstentions. Thank you.

Moving to 9.2, ratification of the evaluation for these decisions to award a contract for the financial statement auditor services, effective July 1st, 2017, to Casey Neilon and Associates under RFP 3217.

MEMBER MOORE: Madam Chair, I move we adopt the recommendation of staff.

VICE CHAIR EWING-TAYLOR: So moved.

Is there a second?

MEMBER ANDREWS: Anna Andrews, second.

VICE CHAIR EWING-TAYLOR: There's a motion and a second.

Is there any discussion?

All those in favor of the motion, please signify

by saying aye.

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

VICE CHAIR EWING-TAYLOR: Are there any opposed? Are there any abstention?

MEMBER WELLS: Madam Vice Chair, due to my department's role in the contracting process, I'll be abstaining from this.

VICE CHAIR EWING-TAYLOR: Thank you, Mr. Wells.

All right. It appears that that motion also carries. So we are then going to move back to your report.

MR. HAYCOCK: Let's do Agenda Item 8.

VICE CHAIR EWING-TAYLOR: Agenda Item 8.

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

I will be presenting the executive officer report for this January 26th, 2016, Board meeting. This, of course, is an ongoing report that provides participants, public, the Board and other state folks on our overall day to day activities.

One disclaimer, and as I get to that point into the report, you'll see that one of the items is considered inaccurate at this time. This report was posted by Tuesday morning of this week and by Wednesday, the world had changed a bit so I will be addressing that, of course, in further

Agenda Item Number 10.

But to begin this report, a little bit about our agency culture, I'm not necessarily going to read this whole thing, but we took a survey internally to determine as a baseline how we're going to show the culture has improved. It talks in here anecdotal responses, and I think everybody here can attest to, sometimes you only hear bad responses and not the good responses.

As an example, on that consent agenda, the Board just approved the complaints for the year, and I think there were over 500, but we cover 69,000 lives. Unfortunately, we don't always remember that the other thousands and tens of thousands of people may actually be pleased with their services and their health plan and what we do here as a Board and as staff. And so I just want to preference that, yes, we received a lot of negative responses at the beginning, but we needed to start with a baseline so we can show improvement moving forward.

One of the things that we were able to ascertain is that there were a couple of key areas in the culture that need to improve, empowerment, giving the power, the authority, as well as the responsibility to handle folks' day to day operations, as well as improving communication, and I think that that has been a mantra of this agency as far as

how we want to be transparent and improve communication globally, but internally we need to do a better job of that as well.

We only had about 50 percent, just under 50 percent response. So hopefully we'll be able to have a higher response rate when we repeat this. But one of things we did was we held internal working groups to allow the staff to develop solutions to the problems that they brought forth. It's one thing to say I have a problem. It's another to say I have a problem, here's a potential solution. So through brainstorming efforts and the abilities of our staff to come together and work as a team, they presented some options and some opportunities for some successful implementation of increasing the culture.

We then brought everyone back together again and listened to them and listened exactly what they wanted and as an executive staff, we met afterwards to discuss how, if possible, could we implement their recommendations.

Finally, we brought back to the staff the process on how we plan to implement some of those recommendations, and we're looking to see what the results are. We want to make sure that we don't do a quick survey and then another quick survey. So after open enrollment, we will repeat the exact same survey, and I'm looking forward to bringing those

results back to the Board and to the public to show that there is a data driven way to determine if -- if our culture has improved, not necessarily just from my words and the statements in these Board meetings.

But I'm very optimistic that we will show improvement. I believe staff are doing better and doing well, and I hope that if they are approached that they will confirm that statement as well.

As far as staffing, I'm very pleased to announce that as of yesterday, we were completely staffed at 32 individuals here at PEBP. We will be sending out an organizational chart to everybody on the Board here shortly. They just started yesterday so they are getting their feet wet. We hired an individual as the open management analyst two position and also another one in our eligibility section of operations. We're very excited to have them aboard and at our next Board meeting, we'll go ahead and bring them in and introduce them to everybody.

As far as contracting, here's where I said my disclaimer is going to have to prove true. There were four major requests for proposals that were under review by designated evaluation committees in the last two months, and that's not something that is generally done in this state at one level with such a small array of staff and Board members.

And my sincere apologies for you all spending your Christmas vacations reading request for proposals, but these are very critical to the agency, critical to the plan, critical to our participants. They, of course, include the health maintenance organization services, our pharmacy benefits manager services, our actuary and consulting services and our financial statement auditor services.

So I was informed and it's, you know, I will take ownership of this that the notice of intent had gone out after the committees had selected or the Board had selected the winning vendors. However, the one for Anthem for statewide HMO services has not gone out. That will be part of the discussion under Agenda Item Number 10. However, the ones for Express Scrips and Casey Neilon and Associates have gone out, and we are in the process of setting up and performing negotiations.

As of this Thursday, the actuary and consultant RFP evaluation committee will meet, and they will select again their vendor, and we will move forward with a notice of intent and negotiation as well.

The financial statement auditor services will be effective upon the board of examiner approval, but the other contracts we anticipate to be effective as of July 1st or the next plan year.

A little bit more about communication, since our December Board meeting, we have begun sending monthly bulletins, and we appreciate the public comment acknowledging those. It is something that we are attempting to do on a regular basis. However, I will admit that the one I sent in December, three days later, the federal government delayed the Affordable Care Act Excise Tax Implementation two years, so it kind of took the wind out of the sails of that one.

And then, of course, the one that I just sent out after the last Board meeting, we are now re-looking at the HMO vendor selection and so depending on the results today, that may need to be revised as well, but we are very dedicated to sending out consistent communication, and those bulletins are just one of those ways that we will do those.

Additionally, we have developed a draft communication plan. It was one of the things that the Board asked for that the strategic plan included that the advisory committee said was very important. It's attached to this -- to this report here. We're very proud of this report. Nancy Spinelli, our public information officer, did I feel an amazing job at putting this together and really getting into the intricacies of the planning process and not just goals and schedule but really how we analyze communication and where we feel that we can make some improvements, where there

are some strengths, where there are a few threats but most importantly where there are opportunities.

And so this is a living document. It is something that we will revise constantly as new information comes in, as we implement certain communication strategies and they either fall short or they exceed expectations, we will continue to update this information. But one of the most important things for participants is, of course, that schedule that's attached at the end of it, and so we will continue to provide multiple mediums of communication to all of our stakeholders, but this is just yet another way to show that, number one, we heard what the Board wanted and we wanted to meet that requirement, but we also wanted to do a really good job in doing so as well.

And then finally, in communication, we are still moving forward with the overhaul of our web page. KPS3 has been contracted. They have developed the original architecture in coordination with our teams. They performed focus groups with retirees, with state employees, with other stakeholders, with the state employee benefits advisory committee, and we took all of that input to help develop what the process is going to create.

And we anticipate in early April a relaunch of that website, and we will have KPS3 here available to provide

a presentation to the public and to the Board on how that new look and feel will affect their use of that communication medium moving forward.

We're also, of course, in the process of finalizing our ACA reporting. We are on track to meet the IRS requirement forms to participants that show, of course, that they are enrolled in minimum essential coverage or what I hear the federally mandated health insurance. We have purchased the software. It has been installed. It has been configured. We are running our tests now to verify the information is accurate and appropriate.

The IRS has given some leeway to large employers to implement this. Of course, any new process at the Affordable Care Act requires has some glitches or bumps along the way all the way out until March 31st. We will be able to produce those forms either by the end of this month or early next month and plan to send them out in February. And so at this time point in time, I can't share that there's any issues. Although, we are still in the process of testing and making sure that we don't have to send out one round and then another round of complete revised forms.

Last but not least, the expectations for 2016, we are aggressively negotiating with all of our new contracts, and we'll continue to do so to ensure the effectiveness and

appropriateness of those transitions to our new vendors. If we do have new vendors, it is something that we don't want to spring upon our participants. We want to ensure that through that implementation, it's not just a technological implementation, but there's a communication strategy on how we're going to let our participants know that things are changing. As the Board has reviewed some of the RFP materials and the RFP's that they have participated in, many of those include those types of strategies so you'll see how that should play out.

And then the legislative process, of course, will begin at the agency level and there will be bill draft requests being brought to the Board. We anticipate at the March Board meeting, it's my understanding that Board members may also wish to bring additional bill draft requests, and so we look forward to that process as we look together to implement our legislative strategy for next year.

And then in April, the budget request framework will be provided to the Board, so you'll see what we're looking at as far as our recommendations and suggestions. And after deliberations, we'll take your feedback and input it and create the agency request budget, and we will, of course, be able to present it next year.

And with that, that's the sum of my report, and I

would be more than willing to answer any questions.

VICE CHAIR EWING-TAYLOR: Thank you.

Any questions from the Board for Damon?

Judy, go ahead.

MEMBER SAIZ: Damon, just a couple of questions. I take it in the order of your report, under your contracting, normally how early do you send out a notice of intent once the Board votes on a vendor?

MR. HAYCOCK: So Damon Haycock for the record.

To answer that specifically, it's my understanding that this was the first time that the Board actually voted to select a vendor. That in previous periods or previous times, they ratified the contract as it was either presented or was to be presented to the board of examiners. So traditionally, the RFP evaluation committee will designate their selective vendor and then a notice of intent will go out soon after, depending on if there's any major concerns with that awarded vendor, if there's any what I like to call deal breakers.

But I don't know if, Tina, you can confirm that because you were on most of these.

MS. GLOVER: So typically -- this is Celestena Glover for the record.

So typically when it's just the standard

evaluation committee, purchasing will go back and review all of the scores, make sure that there was no errors or problems and once they have confirmed that, they will have another individual confirm that. Once that's confirmed, they will send out a letter of intent. They typically go out within a couple of days assuming no problems.

MEMBER SAIZ: And so the one for Anthem didn't go out in a couple of days after the Board voted and selected them, it didn't.

MR. HAYCOCK: Damon Haycock, that is correct and as I think -- I think we'll get into that exact process a little bit more in Agenda Item 10.

MEMBER SAIZ: Okay.

MR. HAYCOCK: I don't necessarily want to get into it, but my hope is Leo would be here so he could participate in that conversation. But are you correct, the notice of intent did not go out within a few days. Some of us thought it would and some of us thought it wouldn't, and there was some concerns from multiple parties but, again, we'll go ahead and get into that agenda item, if that's okay with you, Judy.

MEMBER SAIZ: That's fine. One more question about that topic. Was Anthem contacted that we have this on the agenda and this could, the RFP could be withdrawn, were

they ever contacted?

MR. HAYCOCK: Damon Haycock for the record.

They were. I will tell you that they weren't contacted as timely from my office as I would have liked. I'm not going to make excuses. I was in Vegas when this all went down. When I came back last week, I did reach out to them and respond that this was on the agenda, and we shouldn't move forward with negotiations until the final decision was made.

MEMBER SAIZ: Okay. And under communication, when did we select KPS3, that's hard for me to say, how did we select them and when did we select them? All of a sudden I knew we had website vendor, but I don't know the process.

MR. HAYCOCK: Damon Haycock for the record.

We -- when I first arrived here, we were looking at ways to improve communication. I'm going to give you the long story because I think it's appropriate. I worked with Nancy, our PIO to determine what is the best way to get information to our participants and to our stakeholders. So right off the gate, we instituted in-person assistance, right, we wanted her and other staff to go out into the communities to provide that one on one communication. That is so very vital to folks that don't live and breathe on their iPhones that they want to be able to have that face to

face conversation over the table.

I looked at the website and staff looked at the website, and we thought there's got to be a way to improve it, as well as we looked at the strategic planning update that went to the September, I believe September 17th Board meeting, along with the Board's duties and policies and procedures.

From that, we looked at what is the best way to implement what the Board wanted, right, to make continuous updates to the PEBP website and improvements. We looked at other agencies around the state who had contracted before and we thought about doing a full on request for proposal. However, the same request for proposal had basically been recycled through a multitude of state agencies over the last couple of years, and so we reached out to purchasing and asked them is there a need to continue to regurgitate the same RFP if the state is the contracting entity that continues to pick the same vendor for the same services.

And we wanted to utilize the same -- the same process that our sister agencies, the department of health and human services, the division of insurance, business and industry, DETR, or the department of employment training and rehabilitation and our own here in this building, department of conservation and natural resources, all of them using the

same vendor to do the exact same thing, to modernize and bring forward the websites of their agency to improve communication to their stakeholders and the folks that deal with them on a day to day basis.

And so instead of going through administratively burdensome RFP process that had been repeated throughout the last three, four years, we reached that person and said if we're going to do something very similar to a contract that has been awarded, is there something that we can go ahead and basically pick back on.

And where I'm a big proponent of doing things from the beginning and following steps one through 100, even if they take months and months and months and months and months, we had a golden opportunity to implement a new website by open enrollment. And if we didn't get it done by open enrollment, that really strategically didn't matter if we got it done in June or if we got it done in October or if we got it done in December, if you can't have a medium for folks to get in there and to see the plan differences, to be able to look at the different offers, if we couldn't direct people based on their type, you know, certain retirees didn't need to see, certain things that -- or may not want to see, certain things that other state participants would want to see.

And so we reached out to our partners at DCNR that had the most recent contract, and we reached out to purchasing, and we asked them, you know, we want to do the same thing. What is your experience with the vendor and what do you think, and everyone agreed that this was a good idea to do this piggyback, and we were able to perform this contract by I think that's on November or December. I'm trying to remember, late November or early December -- no, it was in November because we went right in focus groups. And from those focus groups, we were able to determine that there was a need, a need by different parties, different entities that wanted to see different pieces of information without seeing these smorgasbord of information that exists out there today.

And so from that, we went back to the vendor and we asked them, so what do you recommend, and they gave us a list of recommendations, and we took those recommendations and we amended the contract through the board of examiners, and we were there this month in January, and the board of examiners approved our ability to do that.

Hindsight, I will take responsibility, that is something that I should have brought to the Board earlier and said this is our suggested approach. In technical policy, it wasn't an RFP, and I don't want to get into that, but long

story short, I believe that it was the right thing to do and that everyone is going to benefit by the timing we saved and the administrative burden that we reduced on purchasing, on the agency, and everyone will be able to see a new web page that will work for them come the beginning of April.

So I don't know if that answers your question, Judy.

MEMBER SAIZ: I agree, I think we should have been notified sooner. Thanks for the explanation.

I have one more question on communication plan. It's a pretty detailed communication plan, and either for you or for Nancy, the state employee benefit advisory committee, I just am curious, how are they selected, the people that participate in this community, in this committee?

MR. HAYCOCK: So Damon Haycock for the record.

We wanted to ensure on the state employee advisory committee or benefits advisory committee was that we didn't have larger waiting of any agency than another. We wanted to have an equal opportunity of input from the major departments across the state. We knew that we couldn't manage a committee this size of 300, 400, 500 people because we would never get anything done with a committee that large.

And so I -- I reached out to every department director of the major departments, the cabinet positions that

existed at the state and requested that they submit folks to -- that they get to self select who those members would be and from there, from those responses, from those selections, we then created this committee. So it wasn't anything that PEBP necessarily stated. We just wanted to limit the amount of individuals so we could have a very fluid flexible and quick working group of people.

MEMBER SAIZ: Thanks.

VICE CHAIR EWING-TAYLOR: Anything else from anybody else?

Mr. Moore?

MEMBER MOORE: Thank you, Madam Chair. For the record, Bob Moore.

Point of clarification, the subcommittee that was charged with responsibility reviewing the duties of policies and procedure first met two years ago and worked hard to redraft that document. Special thanks to Chris, Rosalie, Anna and I have had privilege of serving as chairman of that committee. That work product has never come to this Board.

And it's a little disappointing that -- and I think I can speak on behalf of my committee members that the Board has never seen fit to review that document. So to implement things in a document that's never been presented or approved is some what presumptuous. I appreciate the effort,

but I would hope in the very near future that document will get to the Board and get discussed.

Secondly, the selection of KPS3 to do a website, you know, we have a consultant in communication practices as part of their current contract. So I'm a little bit surprised that we would go out and award a contract to an external party when we already have a contract with our consultant who is already contracted to do that work and they specialize, that's what they do for a living is employee benefit consulting. My preference would have been to contract, ask our current consultant who has specialized expertise in that particular area to do that website, and it would have been up and running probably a month ago.

So those are my comments, Madam Chair.

VICE CHAIR EWING-TAYLOR: Thanks, Bob.

Damon, did you have a response?

MR. HAYCOCK: Yeah, real quick, Damon Haycock for the record.

A couple of things, and I thank you for stating those, Mr. Moore. I want to make a couple of clarifications. I believe, and I will go back and check and I don't have it in front of me, that I did inform the Board that we would be revamping the website months ago. I just didn't bring the contract for ratification, so I want to clarify that

technical statement.

Secondly, and I looked at it before I wrote my report, in the September Board meeting, the duties, policies and procedures and something that was a list of bulleted items for the strategic plan was presented, and they were agenda items and although the duties, policies and procedures were taken away to have additional items placed on there or some edits. The other one by at least the action minutes showed the motion was approved. And so my understanding is that from that motion -- that approved motion by the Board that was direct -- direct orders basically to implement those statements, and I can get those, you know, at a break or something.

But if I misunderstood or misjudged that response, my sincere apologies. I thought from that Board approved action that we as staff were to take action and implement on your behalf.

And so those were my only -- oh, and then finally as KPS3, I know they are not here. KPS3 not only does -- you know, they don't just build websites. They are a full marketing firm, and they have built websites and marketing plans for the Nevada Division of Insurance, as well as for the Silver State Health Insure Exchange, although they are not with them anymore. I think Penna Powers is right now,

and they actually won an award for their -- an actual award for their website that for their insurance participants.

And so I'm not saying that our current contractor doesn't have the expertise or skill, I do know that the state has made, I believe, an undisclosed policy that who they continue to choose will be consistent statewide. And although we are the Public Employees' Benefits Program, I think you'll see some consistencies from our state employees and retirees that when they go to one website, it will be very similar to another because you get to keep that process. But, again, I'm not here to advocate KPS3. They have awards on their own.

With that, that's my response.

VICE CHAIR EWING-TAYLOR: Thanks, Damon.

Actually, that had been the issue of the duties, policies and procedures had also been something I wrote down is wanting to ask about, and I do remember that meeting well, and it seems to me that there was a very long and wide ranging discussion about the document that was presented. I honestly cannot remember exactly what happened. I know there were a number of revisions that I had and that I gave to Kari for inclusion. And to be honest, I don't remember if we adopted them, ratified them, whatever you want to say.

I do know that this has been a topic of

conversation several times since, and there is a feeling by some members of the Board, I'm not going to say a majority, that it's unfinished business, so I would like to get to the bottom of it. I don't want to keep hearing that, you know, we need to finish this, so let's just do it however we need to make that happen because I do know that Bob and Chris and Rosalie and Anna spent a great deal of time going over them, holding meetings about it, looking at, you know, different options and how we can do things better and how to streamline the document and the processes.

So I would -- I would ask that at the next meeting or even before that you provide us some definitive information perhaps about where -- what we think we did or what you believe that we did in September and how that might differ from what the rest of the Board thinks that we did, and let's bring that to conclusion however we need to do that.

The other question that I had is, and I would echo Judy's comments about communication plans, very comprehensive and I think it's -- I think it's overdue frankly, but I know there have been several times in the last couple of months that I've gotten copies of something that PEBP sent out to various members, most often, frankly, the retirees that I know nothing about. And for a Board member

to not know anything, well, it's probably not unusual, but it is at the very least uncomfortable. So I would ask that we get copies of whatever is sent out so that when the employees do come to us, we can say, oh, yeah, I know what that is rather than I don't know but I'll find out.

So congratulations on that to both you and Nancy. I think it's exciting.

Chris, Rosalie, any comments or questions on this agenda item?

MEMBER COCHRAN: Just on the strategic plans, I'm going over the minutes from the September meeting because I wanted to, you know, jog my memory. It does indicate here that we -- we adopted the revised duties, policies and procedures as recommended and also that we adopted the strategic plan as prevented with modifications.

So, you know, just for the point of clarification, I am assuming -- now I don't know -- I don't know if we got the final modification. I think that would be something that needs to be investigated. But in terms of the -- in terms of the Board's action on the plan, we did take action on the plan according to the minutes.

VICE CHAIR EWING-TAYLOR: Okay. Thanks, Chris, and I suspect given the way you just read that or presented it and based on what Damon said that we were expecting a

final version with all of the revisions, and maybe that's why it feels unfinished.

So if those are available, Bob, would that be amenable to you and your committee?

MEMBER MOORE: Yeah, I'm not going to -- Bob Moore for the record.

I'm not going to speak on behalf of the committee, but I'll speak for myself. We submitted the draft. There was several significant modifications, and my recollection was the instructions were to incorporate those into that draft document, come back and we visit the document, and that's never been done.

VICE CHAIR EWING-TAYLOR: Okay. So I think that's where -- sort of where we stand, so I'll let staff handle that.

Okay. This is not an action item, so we will move on.

Now, we had intended that or had hoped, I guess, that Leo would be here. There are a couple of agenda items left, only a few, one of which is critical and that he very much wants to participate in. It's a little early for lunch, but I'm going to suggest that we go ahead and do agenda Item 3.

MR. HAYCOCK: Okay.

VICE CHAIR EWING-TAYLOR: And then we'll break for some time and hope that Leo can come back before we head into 10, okay?

MR. HAYCOCK: Okay. All right. So Agenda Item 3, for the record, Damon Haycock.

This is the report, the 2016 report to participants and stakeholders. It's my understanding this is provided to the Board every year. I took what I believe Mr. Wells did in the past and tried to follow somewhat of the same format. I'm going to go through this and then, of course, try to answer questions as best I can, but I want to level set the information here with the exception of one or two statements that the calendar year are based on a plan year basis, and that plan year ended June 30th, 2015, and so I will do my best to answer questions, and I know my staff will as well, but we're very lucky to have Mr. Wells here, who can also answer hopefully some questions from the time that he participated in that plan year.

Obviously, it begins with our mission and vision and then we talked a little bit about the overview here on page two. We are in our fifth year of providing Consumer Driven Health Plan, along side Health Maintenance Organization for, of course, active employees, non Medicare retirees while covering Medicare retirees through an

individual market exchange but we know that.

There is a graph or a picture at the bottom that shows the breakdown of the enrollment by plan as of July 1st, 2015, and just to give you an example of where we were then compared to where we were the year prior is that we basically grown about 1,000 individuals in the CDHP as of the end of plan year '14. Although, today, we've grown another 700ish. We're at 21,666 members.

As far as the Medicare Exchange, at the end of plan year '14, there was or, excuse me, yeah, since the end of plan year '14, we've grown 500 by the end of plan year '15. Now today, we are at 10,928 or another jump of about 50 people.

And then the HMO's, we have from one plan year to the next, we reduced the amount or there has been reduced enrollment by about 800 folks. Although, today we are at 95 29 which is another 60 from the time the plan year ended. So that's the basic breakout of where we are as enrollment.

I mean, I can give you total covered lives if you would like to hear a little bit more about that. I sent them out to the Board that broke it out that we will be sending something out every month.

Under the accomplishments, one of my staff brought to me as we were talking about accomplishments, you

know, this is an opportunity to share. We had three different leaders in the same 12-month period, and so it is very interesting, but I want to share that we've had three executive officers in calendar year 2015, of course, Jim Wells down the table there on the Board. I believe he left at the end of February for the Governor's office or at the time the budget office and then as the interim or acting department director of environment administration. Did I say that right, Jim?

And then we had Kateri Carraher, who came back off of retirement from my understanding the second time to come assist PEBP, and she held the torch to act as interim executive officer from March through almost the end of August, when I started on August 24th.

Some things that you have heard in the past but we'll summarize here, the 78th Legislative Session concluded in May, and there was some changes. There was a reduction to the new hire 60 day waiting period to the first day of employment, if it's on the first day of the month or the first day of the month following if it's after the first day of the month. We have an actual workshop to discuss that new regulation that we will implementing to meet this requirement next month.

There's also -- there was also a bill where there

was a two-month holiday from collecting the subsidies from the state and that, of course, has -- has some folks confused, thinking that the state had swept subsidies, but they had not. We had collected additional reserves in our account, and those were the state's monies and they passed a bill to recoup those at the end of the fiscal year.

There was also the subsidy provided to retirees enrolled in Medicare that they could also use that for Tri-Care and so that as well was a result of the 78th Legislative Session.

Now, here's where you're going to catch me and, Jim, I'll do it before you do, there's a typo. It should say regulation not regulators. I have the updated copy that I will be sending back out again. I'll update it on our website. It should say regulations. I don't know why I didn't catch it.

But specific regulations we adopted, the regulations back in April of last year to determine or to really describe how calculating the subsidies require to be paid by the local governments for certain retired public officers and employees, so basically those local governments would pay the same subsidy as the state does for state retirees.

In the past, it was a dollar amount that was

assessed directly to those or in the subsidy bill, it was a dollar amount that was interpreted to be assessed to the local governments, but in essence we charged the state a percentage of premium, and so we then incorporated and re-clarified that that percentage should be equal between state entities and non-state entities to develop parody.

The wellness program and a lot of folks have said, you know, as I've gone around and talked with them, when are you going to bring back the wellness program? Why is there no more wellness program? It's a point of clarification of technicality but wellness did not go away. It's part of the Affordable Care Act. You get preventative screenings and tests every year that are at no cost to the participant per the law. So there is still wellness that exists at the Public Employees' Benefit Program. What I believe most folks are referring to is when are we going to be able to have a subsidy to our premiums or a premium reduction.

But in April, at the April Board meeting last year, there was an approval for the termination of the wellness contractor, US Preventative Medicine or USPM and the cancelled request for proposal for wellness services and so as of July 1st, that was discontinued.

Now let's talk a little bit about contract

awards. So all the way back in September of 2014, PEBP awarded a new contract for eligibility enrollment system administration to Mario Chapell.

In June of last year, there was a new contract to Towers Watson OneExchange to continue to provide that individual market Medicare Exchange and HR administration services, to, of course, our PEBP Medicare eligible retirees.

There were also multiple contract extensions that were awarded for plan year 2015. Catamaran was given a one-year extension for Pharmacy Benefits Manager Services that will expire through June of this year.

Additionally, HealthSCOPE's contracts were extended for multiple years to provide third party administrator, dental claims administration, voluntary flexible spending account and the national preferred provider option or PPO network services.

As far as customer service, we received just over 42,000 phone calls in plan year 2015. Our average time to answer was 18 seconds, and our abandoned call rate was 1.42 percent. Of course, these exceed industry standards, as you heard from other discussion today, and performance guarantees that we included in our own vendor contracts.

We have also received, this was reported before, but it's interesting to know, that 1,720 walk-ins during the

same period. So we're not just a telephone in a phone bank and either somewhere in Nevada or in another state across the country but actually do provide walk-in services to individuals that come and see us here.

We also provide statewide educational sessions during that plan year regarding the Medicare Exchange and HRA administration for retirees, as well as HSA and HRA administration for our employees.

So moving on to page five, fiscal year performance indicators, you'll see that there's a goal and then there's the actual one and a couple of numbers I will highlight, the actual expense ratio increased over the goal, and this is -- the expense ratio measures the efficiency of PEBP's administration by comparing the administrative costs to the premium revenue.

And the change in the ratio is primarily due to the fact that we have an increase in expenditures due to our HCA fees and that actually increased our operating cost by approximately $3,000,000.

Additionally, the claims loss ratio, the goal was 102.56 and we're at 118.64. What that means is that anything over 100 is basically your expending reserves. You're not -- you're not taking enough revenue to cover your claims, but that's exactly how we were set up to burn down those reserves

over the last few years. So 118.64, it's not alarming, it's actually doing what it's supposed to do.

As Mr. Carr mentioned in his audit that we should be commended. We're at 82 percent drug utilization. That is our goal. We kept, again, last plan year.

We also had -- we are also above by one percent in medical in-network utilization and another one percent in dental in-network, and our appeals have stayed relatively flat at .1 percent.

As far as our program finances, you'll see another pie chart that shows how we get our cash. We have premium cash, beginning cash, state subsidy and, of course, all other. Just as a comparison to last plan year, we received about 8.3 million dollars less last year. And then if you look at expenses, they, of course, must meet our balance budget. We also spent 8.3 million dollars.

As far as financial overview, we continue, of course, to maintain our financial solvency. We're fully funded and current but not paid reserves for each of the last 12 plan years and, of course, the fully funded catastrophic reserves for each of the last ten years. So in a nutshell, this plan is very solvent, and we can maintain that with the policies and procedures that my predecessor and this Board has produced over the last decade.

As of the end of June 30th, 2015, we had 52.2 millions dollars in the program above those that were required reserve levels on our budgetary basis. Those are essentially known as our excess reserves. To give an example, at the end of plan year '14, that number was 74.4 million. So we reduced those by to 22.2 millions dollars of plan year '15, and that's, of course, as of 6 or June 30th, 2015. And as of today, if we just stopped everything we're doing right now, we were at 36.4, and so we are continuing to expend those down based on the policy decisions of this Board.

We derive our revenue, again, from state subsidies, contributions and carry forwards, and we only spend our program revenues on program expenses, self-funded administration, claims and health savings account and health reimbursement or HRA contributions, and fully insured premiums and agency operations are at that two percent.

One of the interesting notes, and I don't -- I think it's at the end of June 30th, so I think it still applies, that we asked our consultants to come up with what is our MLR, our medical loss ratio, and they said the number I got back for, I believe it's accurate for the end of June 30th or the end of last plan year was 97.1 percent.

And so not to get into a huge discussion on MLR

or medical loss ratio, but it's supposed to be indicative of how the revenues are put towards claims and claims associated expenses. The higher the number the more money you're paying towards claims, the more money you're providing directly back to the participants. The lower number the more money the plan is keeping in-house.

Traditional fully insured plans may, so if you're here as a fully insured plan, you can fill this out later but may keep funding outside of that to do things like marketing or advertising or any of their operating costs that did not go directly back into claims or payments or the support of those claims.

And so the Affordable Care Act requires large groups to have an MLR of at least of 85 percent. We're at 97.1. And on a very quick look at the centers for Medicare and Medicaid services, as we are compared to other health plans in the state, many of our health plans in the state, and I won't call them out specifically, are in the low 90s, and so that basically says that we are somewhere between five and seven percent more efficient than our next best alternative if we were to go today and be fully and shift all of our folks to go into the fully insured model. So we are very definitely good stewards of state dollars and participant premiums.

Finally, and I think we talked a little bit about reserve utilization on page seven. As we all know, we have continued to provide the same enhanced benefit design. In November of 2014, the Board approved that plan benefit design which included the continuation of the decrease to the Consumer Driven Health Plan deductibles, the increase to the co-insurance rates, the one annual vision screening for free.

I know we talked about that earlier. If you don't know, you can go get your one annual screening for free on your vision benefit through the Consumer Driven Health Plan. The increased dental annual maximums, the increase basic group life insurance benefit, the additional HSA and HRA contributions and the Medicare Part B premium credits, all of those were, again, approved at this November or 2015's meeting, as well. So it's staying the course. It's continued to provide those enhanced benefits because we continue to burn down excess reserves.

Future challenges, I left this in here, I know people are probably tired of me saying this. The ACA excise tax, just because it was delayed doesn't mean it's going away. We hope it does. I'm sure all health plans across the nation do that, provide this large group of health insurance. You know, it was passed in 2010, and it was supposed to put a 40 percent tax on all health plan total premium costs owe

certain thresholds.

We were looking at potentially a million dollar liability had we made no changes for the beginning of 2018 when it was supposed to go into effect. The fact that it has been pushed down the road to 2020 buys us time and gives everyone the opportunity to continue to plan for it, but I would imagine the worst time to plan for it is the November meeting at the -- in 2019 for 2020 implementation.

So it's something that I think we still need to look at and make sure that thresholds for our health plan, whether it's the ones we offer our Consumer Driven Health Plan are for those that we contract with our HMO plan, recognize that this tax is there and what are the mitigation strategies to insure? We don't pass this undue burden to our participants and to the state and any other entity that provides these subsidies to offset the cost.

So, finally, projected complete reduction of excess reserves, you know, it depends on who you talk to. Everyone has a different opinion. Eventually we are going to run out, as you saw from 2014 and 2015 the drop 22 point I think it said two million dollars, and I don't want you to necessarily hone in on 36.4 million. We're not sure until the end of year where we're going to be, but we are spending those -- those excess reserves down, and those are being put

directly back into benefit design, and there needs to be a decision, whether it's this year, next year, two years from now, however long it takes to get those excess reserves back into something that is more appropriate.

What do we do then when that drop off hits and you have an enhanced benefit design or maybe it won't be considered enhanced at the time. It will be considered standard, but you have a benefit design that you can't maintain. You can't maintain long term sustainability, and then how do we relay that to the participants that we knew it was coming but we just -- we rode this train as far as we could and we went off the cliff, and I guarantee that's not what anybody wants to do.

So with that, I'll go ahead and end the state of business and do my best to answer for that previous plan year and hope you found this helpful.

VICE CHAIR EWING-TAYLOR: Thank you, Damon.

Any comments or questions for Damon from the Board?

MEMBER COCHRAN: Madam Chair?

VICE CHAIR EWING-TAYLOR: Yes, Chris, go ahead.

MEMBER COCHRAN: Chris Cochran for the record.

I'm going to ask my strategic plan committee members for their memory of this, but I believe we had in our

strategic plan changed the mission for PEBP. The current mission statement as stated in this plan I don't believe reflects what we had proposed. And if they were adopted in September, I think that that mission needs to be accurately reflected. If that mission that we did for the strategic plan is intended to be strictly for the strategic plan, then I'll be -- then I stand corrected on that.

The other issue regards the expenditures that we're hitting at about 97 percent which is, you know, is on the surface an excellent -- an excellent goal in recognizing what the ACA requires. And I'm -- there's no proposal here but I think one of the things, you know, that we need to be looking at our reserves and how long we can keep our reserves or if we need to at least maintain reserves at a level that we're comfortable with where we may want to look at that, at that ratio in terms of what we're paying out in terms of what we're paying out to what we're taking in.

I don't know that that would be something that our members would actually want us to do or even if the legislature would be on board with that, but it is something worth considering if we look at the private sector market, and that's the end of my information.

But if there are any other Board members who are on the committee, and Rosalie has stepped out, who are on

that strategic planning committee to jog the memory about the mission, that can be confirmed or not.

VICE CHAIR EWING-TAYLOR: Thanks, Chris.

Bob, did you or Anna want to respond to that?

MEMBER MOORE: It's my recollection it was significant change to the draft document that was submitted. I don't remember if the mission statement, Chris, was a part of that significant change, but that was the reason we were supposed to, you know, throw it in the hopper, mix it up and bring it back so we could get the entire document. That hasn't happened.

MEMBER COCHRAN: Well, I went back and looked at it yesterday. I'm sorry, this is Chris Cochran, for the record again.

I went back and looked at it yesterday. The language was a little bit different so I would like -- that's our private secret entrance here so bear with us for just a second.

Our -- so I will after the meeting confirm this as well but if we're going to -- if we did make that change, then I would like Damon's report to reflect -- to reflect that change in the mission.

VICE CHAIR EWING-TAYLOR: Okay. Chris, I think we can do that, and that will be part of the ongoing

conversation that we're going to have finalize the work that your committee did.

MR. HAYCOCK: Yes, for the record, Damon Haycock.

Thank you, Dr. Cochran. I struggled -- I'll be honest with you. I struggled with the time frame of information as to what should be in this report. I always want to share the most recent and current information up to the date that I have it. However, you know, a lot of reports are done from a certain time frame, whether it be a fiscal year basis or from a calendar year basis, and I agree with you. You know, I'm looking at it right here and there was some changes to that mission, and I have no problems changing that in this report.

The reason I chose the older version is because from my understanding of this process, this was supposed to show plan year '15 and during plan year '15, we hadn't met yet to change that mission, so I used the older one, but I have no problem whatsoever getting this changed and resending it out with a new mission statement if that is what the Board would like.

VICE CHAIR EWING-TAYLOR: Any other comments or questions from the Board for Damon?

MEMBER MOORE: Madam Chair?

VICE CHAIR EWING-TAYLOR: Bob, go ahead.

MEMBER MOORE: For the record, Bob Moore.

Page six, Mr. Haycock, math was never my strong suit, arithmetic was even worse. I'm looking at your pie chart here. I'm seeing self-funded administration, two percent, 9.075 million. Do you see it?

MR. HAYCOCK: Yes, sir.

MEMBER MOORE: Right underneath that I see self-funded administration, ten percent, 9.05 million.

MR. HAYCOCK: I will fix that, sir.

MEMBER MOORE: Okay. So I hit a home run. There is a problem there?

MR. HAYCOCK: Yeah, I can't imagine ever there being two pie charts the same size with the same dollar amount. Let me address that.

MEMBER MOORE: Then I'm seeing operations over here, two percent or 8.413 million.

MR HAYCOCK: And those are the numbers, my understanding, and unfortunately I am going to punt this, and I'm sorry, but these were the numbers that I was -- that I was told worked for fiscal year '15. And so, again, the admin ones are I'm sure a typo. Operations I believe are still at 8.4. If I could look over to my CFO here, if you could confirm that those were indeed the actual numbers. I know, right, you didn't walk in here with your --

MS. GLOVER: This is Celestena Glover for the record. I will have to go back. These are not my original charts, so I'll need to go back and see if there was a change from what I originally submitted to what actually ended up in the report.

MEMBER MOORE: I'm seeing operation, 8.4.3 million and then self-administration -- self-funded administration at 9.075 million and add them up, I get 22,000,430. Add that to self-funded claims, 159,000,000, gives me a total of 181,000,000 so that gives me an MLR of 12.4 percent. The MLR, go to the top of that but 12.4 percent which is a touch different than the three percent I represented.

MS. GLOVER: Can I take that, Damon?

MEMBER MOORE: Unless I screwed it up, which is entirely possible.

MS. GLOVER: This is Celestena Glover for the record.

So when we determine our administrative as opposed to claims cost, the operations is our salary IT assessment we pay the state, so that would be in the operations cost. That typically is around two percent. The self-funded admin cost, those are the costs we pay for TPA services PBM and they are generally included as part of our

claims total, so we actually look at those as two.

MEMBER MOORE: In the real live world, that's the cost of doing business. So those are called retention in the real life world. It's not a claims cost. So trust me on this one, your cost of doing business is about 12.3, 12.4 percent, something in that neighborhood.

VICE CHAIR EWING-TAYLOR: Mr. Wells?

MEMBER WELLS: Not exactly.

MEMBER MOORE: Precisely.

MEMBER WELLS: For us you have to include the fully insured product in.

MEMBER MOORE: I excluded that.

MEMBER WELLS: But you can't. It's part of what we pay. That's part of what we pay out to buy insurance for a large block of our membership. If you don't want to do that, then you have to subtract out certain parts of the administration.

MEMBER MOORE: If you wanted to do that, Mr. Wells, you look at the fully insured cost of 100, I can't read that.

MEMBER SAIZ: 113.

MEMBER MOORE: 113,000,000, you peel out their retention, their cost of doing business which would include premium taxes, rent, power, phone, salaries and all of that

stuff.

MEMBER WELLS: But part of those costs that you referred to in self-funded administration and operations relate to costs that are associated with the people who are in fully insured plans.

MEMBER MOORE: Okay. I'll buy that.

MEMBER WELLS: But you would have to reduce yours under the administration and operations and come up with --

VICE CHAIR EWING-TAYLOR: Bob, she can only take one at a time.

MEMBER MOORE: But she has two hands. I apologize. If you're -- we won't belabor the point. But if you want to throw the entire in the bucket, you would look at the self-insured retention and fully insured retention to get your total cost of doing business which is a far crime from three percent. That's my point. It's not worth belaboring the issue.

VICE CHAIR EWING-TAYLOR: You two can have lunch and hash it out.

MEMBER WELLS: Again, Madam Chair?

VICE CHAIR EWING-TAYLOR: Go ahead.

MEMBER WELLS: On the table on page five, there's a similar problem between premium cash and all other. You pick up wrong fields out of your table to create your graph.

MR. HAYCOCK: Yes.

MEMBER MOORE: Oh, yeah, I see it.

MR. HAYCOCK: We will do a complete -- Damon Haycock for the record.

We will do a complete relook at our pictures to make sure they are accurate, the numbers, we don't want to misrepresent as the state of business, and we'll make sure that that gets done by the end of this week, and we'll resend it out and repost it.

VICE CHAIR EWING-TAYLOR: Anything else, Jim?

MEMBER WELLS: No.

VICE CHAIR EWING-TAYLOR: Chris, Rosalie, anything from Las Vegas?

MEMBER COCHRAN: No, we're good. Thank you.

VICE CHAIR EWING-TAYLOR: Okay, thanks. If there's nothing further up here, okay, then I think --

Stephanie, how much time do you need, do you think?

MS. MESSIER: Madam Chair, I can go as slow or fast as you need. I don't feel like there's anything earth shattering that we would need to spend a lot of time on. I would say 15 minutes is probably sufficient.

VICE CHAIR EWING-TAYLOR: Okay. Why don't we go ahead and do Agenda Item 7 then, and then we'll take a break

for lunch.

MS. MESSIER: Okay, sounds good.

VICE CHAIR EWING-TAYLOR: Whenever you're ready.

Thank you, Madam Dr. Vice Chair. Did I get that correct? And I do apologize, it looks like we are without a computer, so we won't be able to put anything up on the screen, but it should all be in your packets, and I will try to bless our court reporter by not going too fast through a bunch of numbers. I know I've done that to you in the past, and I do apologize.

So very similar to last year, we are here. Everybody is excited about rates and I know that, but here we are to talk about trend which is what we will use to set rates and that will be coming to you in the March meeting.

Starting with very much similar to last year, we're going to go through what your historical trend has looked like, both from a medical, pharmacy perspective, as well as dental, different plan designs changes that you have made that has impacted those rates over time, as well as trying to compare how has PEBP done versus other published trend numbers, just to give you a good look at your plan versus others, as well as the S&P National and Nevada specific results.

As well as we did try to appease the Board by

trying to give you a sneak peak of what rates could potentially look like. But, again, it's early, and we would like to have more data. The more experience we have for you the better. The less I have to move your plan experience forward by trend the better. So, again, it's a very early look, and please keep that in mind.

Moving on to slide four, I think we're all fairly much aware of what the changes that have been made but as we are looking at your historical trends, you will remember plan year '14. There was increased funding into the HSA, HRA. Plan year '15 had the more significant plan changes. The benefit plans were enriched both on the medical and dental side. I don't know that I need to get into the specifics there. They were all very aware of the changes.

Slide five, here is your medical, pharmacy and dental plans combined. I did want to make a change this year from what you've seen in the past. We are adding what we really consider to be the expected trends. You'll notice in that last set of bar graphs a new number that popped up in the middle.

And, basically, that is -- we know that you made some plan design changes and so while we may have used a three percent trend number for medical that year and pharmacy, and dental brought it down to 2.9, we did not

expect that to happen. The Board made that decision that year to go with a three percent trend rate as part of the reserve burn down. Six percent was the recommendation.

So our expectation was that trends would go up by six percent plus the benefits were enriched by 2.6, 2.8 percent. That's why we were saying our expected number for that year was 8.8 percent. In total, the plan came in at 9.8 so it did come in above expectations, but we certainly did not expect that three percent trend number that you're seeing on the first one, but that is what was put into pricing again to burn down reserves. So I just wanted to get that extra clarification.

Any questions on that before I move on? Okay. Vegas is okay?

The next slide is for your medical separated out. So, again, you're seeing that three percent trend number. The expectation was actually 8.4. You came in slightly higher at nine percent. For those of you that are wondering what is in the current plan year rates, we had used five percent for the state and seven percent for non-state and, again, that was to 50 percent high, 50 percent chance of being low. As an actuary, I prefer not to be 50/50, but I totally understand the Board and things that have happened in the past and the need to be at 50/50.

So we will see as the plan is continuing to merge how we're doing so far in the current year. This is all very much a historical look, and so we're really just talking about how your results came in through June 30th of 2015, slightly higher than expectation and higher than all of us put into pricing. So that's important to keep in mind as we have experience roll into the rates, we only expected them to move forward at three to burn off reserves. At some point, we have to do that catch up game and it's coming at some point when the excess reserves are gone.

Any questions? I do apologize. I try not to speak too quickly.

Okay. Next page is pharmacy, slide seven. Similar numbers here, pharmacy has definitely seen some significant double digit trend numbers. It's important to keep in mind prior to that, you saw some very significant negative numbers. So your plan was seeing a lot of volatility on the pharmacy side. So I'm not overly concerned that you had close to 20 percent in plan year '14.

I do think you kind of see the shift sort of the settling in, and most recently you saw an 11 percent trend rate. Clearly, we saw a lot of those block buster drugs come through last year, particularly in the specialty arena, Pepsi drugs most notably, so you did see an 11 percent trend versus

the 8.4 percent that was put into pricing.

Okay. Moving on to dental, where it's a little bit more of a rainbow here, the request has been of us that we also report for you not just your total actual trend, which is going to be your middle bar, but they want us to break out for you your active 365 versus those that are on the Medicare Exchange able to buy into your dental plan.

So that is why the middle one is what you're typically seeing on the prior slide as being on the last as your actual. It's really just breaking out that actual into how are the active group doing, 365 versus the Medicare Exchange folks.

So most recently, Medicare Exchange folks are a little bit worse but not significantly than your active 365 population. And historically in plan year '13 and in plan year '14, they were performing better than your active 365 group.

And you will notice here, there's a lot of volatility on these graphs. This is the plan design changes that have been made. The plan was enriched. The plan was reduced. The plan was re-enriched. That lifetime or not lifetime, the annual max is definitely swinging by 11 percent with an 11 percent enrichment that you're seeing come through in your experience.

Questions?

Moving on to slide nine, this is where we are showing how PEBP has done and in the orange bar, the very far right of the different colors on the graph, that is how PEBP has done. And the prior colors are really showing different consulting houses and what they have been reporting, as well as Kaiser and Price Waterhouse Cooper in terms of overall net trends, post plan design changes.

You will notice that PEBP is definitely moving in an opposite direction perhaps as other folks out there. A lot people have been trying to take plan design changes to reduce costs whereas PEBP has been in the fortune position of excess reserves and has been able to enrich plans which does drive that higher trend rate which we have seen in the more recent plan year of the 9.3 percent in that third year.

If we take a three-year average rate, you are definitely still coming in lower, but I would expect -- if I was sitting here at this time next year, you're probably going to see another higher year coming in for the most current plan year that we're currently in because again the benefits have been enriched. People are seeing more care than other carriers or, excuse me, other employers or benefits are being reduced and utilization is coming down, as well as plan costs because they are making plan design

changes to take benefits reductions.

Any questions on this one?

Okay. On slide ten, we had introduced this slide to you last year. The S&P is now doing medical and pharmacy indexing trends, so they combine those two products together. So you will notice from some of the other slides, I am taking out your dental. This is just your medical and pharmacy so it's on a comparison basis.

The blue line is a national trend rate and it's been somewhat more stable over the last three years than what you've seen here in Nevada, which is the darker trend line on the bottom. It's kind of seeing more valleys and peaks than what we're seeing on a national basis.

Most important to note here, when we were sitting here at this time last year, it looks like Nevada was kind of on a downward movement again, away from national trends, and right now it looks like it's starting to merge up to the national level, so just something else that you're going to see in your economy here in Nevada and something to keep in mind as we're going forward into this new plan year.

And the box on the right is just giving you those numbers. Basically, those are as of fiscal year. Those are going to be June 30th if you're trying to match them to the graph. And at the top, I just wanted to give you how many

lives are in there so you are aware.

Moving on to probably the most important slide besides the final one, what does this mean for the upcoming rates and the upcoming Board meeting that we'll be discussing those rates. Currently our client base is indicating a trend rate of seven and a half percent for policy year '17. A lot of insurance carrier surveys are saying they are using anywhere between six and a half to eight, so they are coming in about a 7.3 percent average.

Here is your six over six trends, and you're 12 over 12. So six over six is taking, like, let's say January to June over the prior January to June. The 12 months is obviously a running 12-month average in claims, and you'll see most recently the six-month is kind of taken a little bit of a dip. Your 12 percent is still slightly on the rise here. So definitely movement is going north and not south. You're not seeing decreasing trends, as you would expect as enriching plan design.

So I know it's a large range but currently what I'm projecting for your trend when I'm setting your rates here in the next month, medical, pharmacy will be somewhere in the six to nine percent range, and dental will be two to four percent. Last year we used two percent for dental. This year, it looks like a slightly higher rate, probably

closer to the three, possibly as high as the four. And, again, this was also done before we knew anything about what if there would be a loss of the SHO Network or not and certainly if that happens, I'll need to include that in the pricing. That's going to be something that's above trend that would be added to the expectation.

Similarly, if you have a new PBM coming on, which I think that one is still a go, if there's any sort of cost savings, that will be factored in as well, but it's not part of the trend. Again, I'm going to take your experience, move that forward and then make any kind of adjustments similar to what we do when we take your 1,500 dollar plan design experience and then we move it to that 1,900, so there's still that shift that we caused to make sure you're burning through the excess reserves that you still have. So those are the sorts of things we'll be doing again to try to incorporate the additional cost savings that you may be seeing from those RFP's.

Then to put some hard numbers, I know Mr. Moore usually asks us for these type of numbers, so we added in a slide here at the end. Typically, we just do the base rate and Tina will add on the admin cost and those things. So we've incorporated Tina's spreadsheets here to try to say if we would just move forward today's base rates by nine

percent, this does not include any kind of updated experience. As you remember from the first slide, your experience ran higher than what we priced for. So when I true up your experience and then move that forward by the trend, it could potentially be a number larger than nine just because if the experience ran six percent higher previously than we put in, I have to true that up as I put in experience.

The same thing happens when I put in experience runs well, that true up happens, and I bring the experience brings your rates down. And, again, loss of SHO Network, other things is not included here. This is just a move base rate forward nine percent number.

VICE CHAIR EWING-TAYLOR: Okay. Stephanie, good job, 12 minutes.

MS. MESSIER: Was it less than 15?

No questions.

VICE CHAIR EWING-TAYLOR: I'm sure Bob has a question.

Bob, go ahead.

And then, Jim, did you have some?

MEMBER MOORE: Thank you, Madam Chair. For the record Bob Moore.

A couple of questions and a comment. The hardest

thing for plan participants to understand, and I certainly sympathize with this, is conveying the concept that if your medical market basket next year is identical to what it was last year, your costs are going to go up nine percent and it's just -- it's just a tough concept to sell and it's just -- it's like explaining gravity. You know, it's just because and it's a tough sale. It's tough to understand, and it's a tough pill to swallow to our membership. I apologize, but that's just the way it is. I can't explain gravity either.

So having said that, your note at the bottom of the page, if -- that assumes that we don't lose the SHO Network, if you lost the SHO Network and went to another network, whether it be Anthem or HHP, I understand is the network down there, or, you know, somebody, Fred's Auto Body and pizza shop probably has a network, do you know what impact that might have notwithstanding Fred's Auto Body? How would SHO compare to Anthem or HHP's network?

MS. MESSIER: So based on market information that I have received, I would say there is a significant gap in the discount that the SHO Network has been able to get because they have been in existence for a while, and that's my understanding. So I feel like it's significant enough and I know some numbers we floated out in the fall, I'm going to give you a wide range, but it would be I think between seven

and 17.

MEMBER MOORE: Dollars or percent?

MS. MESSIER: Percent.

MEMBER MOORE: Okay. So in your judgment, SHO's Network is considerably more aggressive and robust than perhaps Anthem or?

MS. MESSIER: Yes, that is my currently understanding. I would definitely recommend like a discount analysis or perhaps HealthSCOPE Benefits would have some data that can substantiate that percentage, but that is my current market understanding. That's the range we're looking at. And, again, not all claims are hitting that SHO Network in the south but of those that are, that's kind of last year potentially looking at.

MR. MOORE: Page 12, if I might, I'm looking at the state non meds care retirees, let's look at the '17 rates, the crystal ball rates, six to 18.

MS. MESSIER: Yes.

MEMBER MOORE: And the non-state non Medicare, of 1028, that assumes not quite but almost double. Does their claims experience indicate that their claims experience is almost double?

MS. MESSIER: So I would say their claims experience on a PEPM basis is nearly double. However, in

most recent years as they have continued to have attrition in that closed group, they are moving forward at a lower trend rate most recently. They are definitely a non-credible group because of the size. But on a PEPM basis, what I'm seeing is that they are still, in fact, more expensive. It may not be as much as two times currently, but they have certainly been that historically.

MEMBER MOORE: That's what I was looking for. The group is not credible.

MS. MESSIER: Absolutely.

MEMBER MOORE: Number two, looking at the financial reports back in the consent agenda, it looks like their claims experience is running about 15 percent, roughly plus or minus higher than the state nonmedical, certainly not double but, nevertheless, it's not a credible group anyway so the discussion is up to them.

MS. MESSIER: Right.

MEMBER MOORE: Great. Thank you.

MS. MESSIER: That's correct.

VICE CHAIR EWING-TAYLOR: Any other comments or questions for Stephanie?

MR. HAYCOCK: So for the record, Damon Haycock. I've been approached before after presentations like these. People telling me why are we doing this and why are we doing

that. I want to reiterate that the rate table that is on page 12 is not the end all be all. Don't expect that to be your end rate. Please don't go home and think that we're here trying to raise rates $37.38 for state employees and $71.22 for non-state retirees.

You know, this is just -- this is part one of a multi part exercise that lands on a rate that this Board will pick in March, and so please don't be fixated on these numbers, and I get a call again from another reporter saying why are you raising rates. So please recognize that this is part of the process, and we're here to -- the most important -- and maybe I'm stepping -- I think the most important part is to understand that our trend is increasing, and that we need to be cognizant of it and that's what I want to say. Thank you.

VICE CHAIR EWING-TAYLOR: Thanks, Damon, and I do think that's a good caution for everyone. These are by no means our rates. They are not going to be our rates. They are not intended to be our rates. It's information, and it's valuable information that we have, and that we will be getting up to the point where we actually do have set rates which won't be these one more time.

Okay. We have reached the witching hour. We are going to make an attempt to find our Board Chair so that we

can address final and the probably most significant agenda item that we have today which is Agenda Item 10. So I would like to break until 1:00 o'clock and at that point, whoever shows up, we're going to do Agenda Item 10.

So we'll see everybody back here at 1:00.

(Whereupon, a lunch recess was taken.)

CHAIRMAN DROZDOFF: Good afternoon everyone. How was your morning?

I certainly appreciate Jacque and the Board getting through the bulk of the agenda, and I think we have just a couple of fun ones left.

So I think as was explained with regard to Agenda Item 10, I think it's fair to say that there have been various levels of questions or concerns associated with the HMO RFP. I believe we made the point this morning that we would take public comment specifically on this item, and the way we're going to go about that is we're going to get a presentation from Damon and from Jeff Haag, head of purchasing, that can talk a little bit about their perspectives and their experience through this process and, you know, hopefully their candid assessment on concerns. Then we'll take public comment, and then we'll treat the agenda item as we would any other.

Does that make sense?

So, Damon, I'll turn it over to you, and then we'll let Jeff chime in.

MR. HAYCOCK: Thank you, Mr. Chair. This is Damon Haycock for the record.

This agenda item, as Mr. Chair mentioned, is on HMO or Health Maintenance Organization contract considerations. It's intended to provide the Board here and the public information and, of course, a recommendation to reconsider the contract selection that was made by this body on January 12th, 2016, at the last Board meeting.

I'm going to briefly go over the background and not necessarily read the entire report, but back in May of last year and my understanding traditionally at the May Board meeting, the upcoming contract discussion is brought to the Board. The scope of work or the notification of which RFP's that will be released are brought for Board approval and then staff take that information back and develop those requests for proposals and go through that process that's outlined in NRS 333 and the Board's duties, policies and procedures.

Some key information that was in the report that was provided to the Board just for reference, there was three statements that I want to key in on. PEBP's preference is to be able to contract for HMO services on at a least statewide, parentheses, Nevada basis.

Two, the proposals may include one Nevada statewide vendor or separate vendor proposals covering specific Nevada geographical areas or joint venture between multiple vendors. And three vendors are encouraged to submit creative solutions regarding plan design to compliment to PEBP and state of Nevada's current budget constraints.

The Board approved the recommendation, and we moved forward with the RFP now known as RFP 3202 was initially released on September 8th of last year, and it did include a little bit of revised language to it. There was a statement added that said that however regional proposals will be considered to that first statement that I just mentioned, I think that continues to support the original intent that was brought to the Board.

On November 19th, PEBP provided the Board with a report that requested the elimination of the second level review process, citing that there was some potential drawbacks. There was a potential for delays, that it also may devalue the original RFP committee's recommendations and that if we were to include additional support by Board members, it may be more appropriate to have more Board members on those RFP committee evaluation teams.

The request made to the Board was to have no more than five Board members to ensure we don't break any open

meeting laws. However, the motion that was approved by the Board was that a minimum of two no more than five would be included.

Unfortunately, the very next day is when the RFP committee was to meet and evaluate the HMO proposals and so there wasn't enough time to designate a second Board member, as well as to provide them with the appropriate amount of time to read the proposals to be able to appropriately evaluate that process. So this was potentially a one and done or one time option for the Board to do a second level review until they met and decided again if they wanted to reinstitute them.

The evaluation committee, again, like I said, mentioned on November 20th and then they scored the various proposals based on evaluation criteria, and I'll get into a little bit more of that later.

On December 7th, the Board met to perform the second level review, and there was a few hiccups, as we all remember, and they could not perform the entirety of that review, and so there was still the opportunity to hear presentations by the four vendors, and they came up here and provided those, and purchasing instructed the Board and PEBP to ensure that those were created for the next period, as well as the complete review of the RFP submissions.

On January 12th, the Board met, reviewed the proposals. Each vendor was scored against preselected criteria and, of course, an overall score was tabulated by purchasing at the meeting. The Board then made a motion. They discussed the vendors and a vote occurred which resulted in Anthem receiving the statewide HMO selection.

There was a caveat that the proposed rates would be reduced to an acceptable level or negotiated down during contract negotiations.

However, Hometown Health did receive the highest overall tabulated score, but the decision to utilize a statewide vendor meant that Hometown Health Plan would not be selected as they did not provide a statewide proposal.

So a little bit about the Board second level reviews, I think you heard this in the last couple of Board meetings, but NRS 287.04345 does outline this process where the Board shall review recommendations for awarding based on a series of items.

One of them, of course, and I believe it was Ms. Bruchette from purchasing who went over the process at the January meeting, went in order to disclose the review by the Board the vendors' proposals, who scored the highest, specifying the criteria it will use to evaluate the high scoring proposals.

Third, to consider the ranking given to a proposal by a committee appointed to evaluate the proposal, if any.

Four, with regard to request for proposals, evaluate the responses of the vendors interviewed by the Board.

And, five, here's the key issue, award the contract based on the best interests of the state.

And last but not least, the last part of this statute says the Board is not bound by the recommendation of the administrator of the purchasing division or the committee appointed to evaluate the proposal.

So the meeting did follow this process. However, there were some concerns that immediately followed the meeting. Before I go into those concerns, I want to share real quickly what the evaluation criteria was. This was discussed at the Board. However, just for reference, there was conformance with the terms of the RFP. There was expertise and performance of comparable engagements. There was demonstrated competence and implementation, expertise and availability of key personnel, reasonableness of cost and financial stability.

Now, as all other contracts, the financial stability section was reviewed by PEBP CFO, and all vendors

passed that section equally. It's a pass, fail. But as far as the other criteria, there was a potential for confusion, as vendors submitted multiple options. One vendor submitted three options with six different plan benefit designs.

And so to compare them utilizing each iteration and collecting them all into one vendor score area was reported to be difficult. I believe that there were a few Board members who expressed some difficulty. I spoke with the RFP committee evaluation members, and they reported some difficulty. How do you literally compare apples to apples when you have a fruit basket full of options.

And so basically once that occurred and Anthem was selected, we started receiving calls. We started receiving calls, and we started receiving correspondence, not only here at PEBP but from other agencies, from other entities, wanting to know if, one, are we going to raise rates by a significant amount, two, why was certain vendors selected. Three, and when I spoke with some of the vendors, they were concerned that had they known that we were looking for a specific policy or specific type of HMO, they would have bid a different product.

And so the way that the RFP was developed, I think was done in good faith by everybody involved, that their idea was to try to produce the best possible options

available for PEBP participants to receive very critical HMO services statewide. However, they left enough flexibility that almost everything was an option that could have been provided, and our vendors took advantage of that option and as they would and they presented a plethora of opportunities and how do you marry those up?

A couple of examples, conformance to the RFP, how do you determine what -- I'll back up. I won't say you. I don't know how I would determine if the conformance to the RFP, if one vendor bid a regional product and another vendor only bid a statewide product. When the RFP says we're looking and prefer a statewide product, we also said that we would entertain or we would consider regional products. So which one actually conformed better? And you can take that all the way down to the list of all of the different evaluation criteria, and I imagine that it's difficult as its best.

And so I'm going to give you my recommendation, and then I'll let Jeff jump in and give his thoughts on this process but to move the process along.

Due to the confusion surrounding the evaluation criteria and really how we needed to approach it collectively to evaluate these RFP's and the second level re process utilized for the very first time, which was confusing, I

think the points were well made at the December and January Board meeting.

And, again, most I think importantly concerns leveraged by our vendors, by our participants, by Board members and our evaluation committee members throughout this entire process that is recommended that the Board approve the following actions, and they are the three that you saw in the agenda, to withdraw request for proposal 3202 pursuant to NAC 333.170, to authorize staff to negotiate contract amendments with the current HMO vendors Hometown Health Plan through Health Plan Nevada through plan year 2017 and to, three, authorize staff to develop a new request for proposal for plan year 2018 and beyond for HMO services.

And if the Board decides to approve those recommendations, PEBP will bring back to the Board policy decisions to assist in the redevelopment of that RFP, to include but are not limited to, these are not my recommendations, these are just suggestions here, that does the Board want a single, statewide HMO plan or do they want multiple regional plans? Does the Board want open provider access or closed provider access? Does the Board want access to a national network for prospective participants residing outside of Nevada to access services? Does the Board want to put a premium ceiling on proposed rates or any of a plethora

of other policy decisions that we can bring back to help narrow the scope of this contract and really help our vendors develop a similar apples to apples approach on how they are evaluated.

And if that is what occurs and we bring back those -- that information, we will, again, follow suit in May and actually bring the scope of work of the RFP back to the Board for approval for input and its, of course, final approval.

And with that, I'm going to turn it over, unless you have questions, if you want to stop now, I can turn it over to Jeff.

CHAIRMAN DROZDOFF: I would recommend we let Jeff go.

MR. HAAG: Thank you, Mr. Haycock. Jeff Haag for the record. I'm the administrator of the purchasing division.

I concur with Mr. Hayock's statements that he's made and the recommendations. Our concern from state purchasing really surrounds the process, the integrity of the procurement process, and I think as Damon outlined, there are concerns by myself and my team as it relates to the true intent of the RFP, what the Board's objective was and what they would like to accomplish. I acknowledge there was a

statement stating that statewide preference was preferable. However, the evaluation criteria and the score didn't necessarily support that.

I also have concerns around the evaluation process, how the committee was given the opportunity to review the solicitations and how the Board was not given an equal opportunity to review the submissions by the respective vendors, and I know there was confusion around the material and how you got that material and your ability to review it or not.

And then, of course, as Mr. Haycock mentioned, I think the second level review also provided a lot of confusion both for the Board, for state purchasing and for our vendor partners that we're looking to work with here on this opportunity.

And should the Board choose to adhere to the recommendations that Mr. Haycock has presented to you today, I feel that we have a much better opportunity to work collectively with the Board, with Mr. Haycock's staff to put a solicitation out that truly meets the intent of this Board, meets the needs of the members and that we're tasked to work with.

CHAIRMAN DROZDOFF: So with that, are there any questions for either Damon or Jeff?

Go ahead.

VICE CHAIR EWING-TAYLOR: Thank you, Mr. Chairman. A quick question for Jeff. We have discussed a fair amount, the criteria that were listed that we were all to use to evaluate these and -- I don't understand how those get developed and where they get developed. Can you walk me through that process?

MR. HAAG: Yes, ma'am. Jeff Haag for the record.

That's a great question and I think the area of opportunity should we re-approach this in the future. The evaluation criteria to some extent is standard and other solicitations of this nature, it would be my recommendation and so let me preface first, I'm three months new to the state. And so like Mr. Haycock, there's a learning curve here for me, as well, but I was tasked with looking at things differently and evaluating our processes to ensure the needs of the state are met in the best way possible.

And so should we have another opportunity at this, I think we can be much more specific in the evaluation criteria and the scoring criteria to ensure that the outcome is conducive to what the Board feels is in the best interest of the members.

VICE CHAIR EWING-TAYLOR: So just to be clear, up to this point, to the best of your knowledge, criteria for

evaluating RFP's were fairly standard and didn't really take into account the vagaries of each RFP. Is that what I'm hearing?

MR. HAAG: Yes, ma'am, yes, in general that is correct. I think we can do a much better job at state purchasing and being more specific to the respective solicitation as it comes to the evaluation criteria.

VICE CHAIR EWING-TAYLOR: Okay. That's helpful. Thank you.

CHAIRMAN DROZDOFF: Anything else?

Anything in Las Vegas? Chris? Rosalie?

MEMBER GARCIA: This is Rosalie. I do have a question, and I don't know who to address it to so I'll just ask the question which how does this RFP differ or does it differ from when we originally sent out the RFP for the HMO years ago? Is it in the same format? Does it have the same language? Did we change it from the original because usually it's a templet.

MR. HAAG: So Jeff Haag for the record.

I don't know specific changes to the RFP that were made from four years ago when the original solicitation was issued and awarded. There have been changes to the contract, to the RFP that we're reviewing today and discussing. The levity of those changes is something that I

would have to go back with my team and review it and identify it for, but that's something we can do. There may be others in the room that may have additional insight.

CHAIRMAN DROZDOFF: Tina, do you have anything else to add?

MS. GLOVER: Celestena Glover for the record.

So part of what we do, the basic templet hasn't changed a lot but what we do inhouse is look at our scope of work and that can change. I can't tell you if we change every little thing in the RFP, but we do look at what did we have, what did we ask for in a previous RFP and what did we miss. So when we mark the new scope of work, we take those things into account and then update the requirements for vendors to respond to.

So some things may be the same if they have not changed but without me going back and pulling the old RFP's line by line, I couldn't tell you exactly what those things are.

MEMBER COCHRAN: Could I ask a follow-up?

CHAIRMAN DROZDOFF: Yeah, sure.

MEMBER COCHRAN: This is Chris Cochran.

Is it -- can someone explain, it would seem to me that perhaps, and I'm just speculating, one of the major changes in the difference between the RFP -- in the release

of the current RFP under which we're operating and the one that we had previously in awarding the previous contracts, is the statewide HMO component, is that a different piece that we didn't have in previous RFP's?

MEMBER ANDREWS: It's listed in the project of review.

MR. HAYCOCK: This is Damon Haycock for the record.

Honestly, we have to go back and look and we can pull that. I don't know. I don't know if you -- if the Board at the time was looking for a statewide vendor, but I know we selected two regional vendors, so I don't know if it was literally a copy and paste job from a previous one or if it had changed. My assumption at this point that it has changed.

MEMBER GARCIA: This is Rosalie Garcia. I don't believe that it would be very difficult to pull that old RFP out. The project overview from our current RFP clearly states that it was a -- looking for a statewide vendor because it says the project overview for the RFP states the proposals may include one Nevada statewide vendor or separate vendor proposals.

That is an important sentence. I do need some reference though because if our HMO from four years ago was

selected on the same verbiage, I don't understand why there would be any confusion from the vendors in providing their proposals.

MR. HAYCOCK: This is Damon Haycock for the record.

And I believe our vendors are here if you have questions for them, as well, and I don't want to put words into their mouths, but what I can relay from my understanding is that it wasn't just statewide versus regional, but it was type of HMO plan. There was no specifications that I know of that said that PEBP or the Board or the state was looking for a capitated gatekeeper, traditional HMO plan versus an open access plan, that it wasn't delineated.

And so one of the vendors that I spoke with said to me last week, you know, had I known that you wanted an open access, I could have given you one. We have that product on the shelf, and it wasn't specified in the RFP. So I'm -- just to give you a little bit of background.

CHAIRMAN DROZDOFF: Tina?

MS. GLOVER: Celestena Glover for the record.

I just received some additional information. So the last time around, the two -- the RFP's were a year apart so we bid for two -- we bid the north and the south separately, so it was a whole different process.

MEMBER GARCIA: This is Rosalie Garcia again.

Celeste, would that have occurred -- there had to be, I would assume, some driving force for us to solicit a north and a south. Would that have occurred after an original failed RFP for a statewide?

MS. GLOVER: This is Celestena Glover for the record. I don't know what the driver was the last time. I wasn't with PEBP at that point. I can tell you that they were done. It's two separate RFP's. We did extend one of the contracts so that they would end at the same time so we could go out with one RFP and give us an opportunity to get a statewide vendor in addition to considering the regional vendor, so there were some changes done since I've been here to address having separate vendors.

VICE CHAIR EWING-TAYLOR: So I'll be the old person on the Board again and all of the things that I remember. There was a period of time that actually predates Mr. Wells that the Board made some decisions about wanting to combine the contract so that we only essentially have one to deal with, and that's sort of how we ended up with the -- the statewide PPO network. We attempted that with the HMO's. There was no statewide HMO available. Nobody bid on it. There wasn't anybody around that was interested in the business, and that is my recollection at least of how we

ended up with two separate HMO's.

To my -- again, to my recollection, we have never as a Board had a discussion about whether we wanted a closed or an open network. Because, again, there were not that many options for us in the north and in the south, and everybody in the north was open and everybody in the south was closed. So it simply wasn't available for us to talk about that going forward. That may be something we want to discuss is another matter but, you know, historically, that is sort of how we got to this point.

CHAIRMAN DROZDOFF: So, Chris, I'll go back down to you and Rosalie for any kind of follow-up. I don't know whether the discussion was helpful or not.

MEMBER COCHRAN: Well, it helped me a little bit. I was also wondering whether or not there was some connection between this and the contracts being let out for the HMO's due to a change in our coverage where we went to the blended rates. I don't know -- I wasn't on the Board at that time so I don't know if that was a factor in the issue.

I -- I do have a question and I don't know if Dennis can answer this or not but from a legal perspective, after our actions in the last meeting, what are the potential ramifications with those that we identified that we were going to award the contracts to?

CHAIRMAN DROZDOFF: Well, I'll let Dennis talk, but I think the motion was to open -- to open up a negotiation, not necessarily to award a contract.

But go ahead, Dennis.

MR. BELCOURT: Chair, Dennis Belcourt, Deputy Attorney General for the record.

Yeah, what was decided the last time was to contingently award the contract to one of the vendors. What would have followed that would have been a negotiation notice of intent to award and then negotiation and then possibly an award. There was no contract at this point in time between, I mean, for, you know, 2016, plan year 2016 concerning HMO vendor.

You know, I would be hesitant to, you know, advise an open meeting law, what the litigation prospects are. There's always -- any decision of this Board potentially faces those. I would -- you know, that would be something I would advise a non-meeting to discuss if necessary.

CHAIRMAN DROZDOFF: Those non-meetings.

MEMBER MOORE: Only in government.

MEMBER COCHRAN: I withdraw the question.

CHAIRMAN DROZDOFF: Judy, do you have a question?

MEMBER SAIZ: No. Can I make some comments?

CHAIRMAN DROZDOFF: Okay. This disturbs me that we're thinking of withdrawing this RFP and my comments are this, I haven't heard either Damon or Jeff give solid facts of why -- what we've done wrong, what purchasing has done wrong, what PEBP has done wrong, what the Board has done wrong.

We followed the law, and I think that -- I also feel like we're searching for reasons to withdraw this RFP. Due to the confusion surrounding the valuation criteria, confusion, you know, no real facts. Second level review process utilized for the very first time, we did do second level review years back when I was at PEBP. You know, concerns leveled by vendors and participants and Board members concerns. We always have concerns. We always have an unhappy vendor that wasn't the winning bidder.

My other comments are that, you know, we talked about how do we score this. I remember saying how do I score this if we have a north and a south and we have a statewide. In fact, I said to Gail on the record that don't we need more scoring sheets than this. So we had to bite the bullet and decide what we thought was best. I as an insurance broker feel that I'm very qualified to do an assessment for an HMO, and I determined that Anthem was the best for the state.

The vendors are saying if we would have known.

Come on, you guys have done tons of RFP's. It was spelled out in the RFP. To me, it's almost searching for excuses, and this is my opinion that I feel that it's almost searching for excuses to throw out the RFP when we as a Board did nothing wrong. Purchasing didn't do anything wrong. PEBP didn't do anything wrong, and we're just going to throw out an RFP after all of those hours of work and decision-making because maybe we don't have happy bidders.

And that's probably -- let me look at my notes really quick. You know, the evaluation process was followed the entire time. It seems like most state agencies do follow that same process. The evaluation committee has, you know, rates -- rates these different vendors based on the certain evaluation sheet.

So I -- I for one have a really hard time throwing out an RFP when we haven't determined anything has been done that's been illegal or been wrong. Those are my final words.

CHAIRMAN DROZDOFF: Thank you. I know that was more of a statement than a question, but I guess I'll check with Jeff or Damon to see if there's anything you wanted to respond with or if not, just like I said, it's just a statement.

VICE CHAIR EWING-TAYLOR: Go ahead.

MR. HAAG: Jeff Haag for the record.

Thank you, is it Ms. Saiz, am I pronouncing that correctly?

MEMBER SAIZ: Uh-huh.

MR. HAAG: For your concerns, and I think you provided some specificity to the confusion that is shaping why we're here today in my personal opinion.

So the confusion around the evaluation criteria, if I could be specific, in my opinion is that the evaluation criteria does not specifically address a regional plan versus a statewide plan. That provides -- that in my opinion is confusing and can be confusing for those folks that are on the evaluation committee.

The second level review, the very nature of the second level review, again, in my opinion and my observation of the Board meetings both in the afternoon of December 7th and the meeting earlier this month provided a tremendous amount of confusion not only from my staff as to how we walk through that process, but I also sense that there was confusion amongst many of the Board members about how we continue through this process, what step is next, how do we proceed. And I think, again, that adds to the confusion around -- around the process and the totality of that.

You know, the concerns leveraged by the vendors,

I've only been contacted directly by one vendor. My concerns and the reason why I'm here today is because I have a vested interest in the integrity of procurement process in ensuring that the outcome is truly in the best need of the state. And based on the confusion that I've just shared, I don't feel that we've accomplished that, and I feel that we could be giving cause to our vendor community, our vendor partners in my opinion to ask questions and to -- to potentially continue to perpetuate a problem that wouldn't necessarily serve the members of PEBP or the state as a whole. And so that's why I feel and am in agreement with Mr. Hayock's recommendations.

CHAIRMAN DROZDOFF: Judy?

MEMBER SAIZ: Yeah, I still don't hear any specifics. We did this or we should have done that. It says statewide.

Rosalie, I think you said that it -- that RFP you're reading it, it does say statewide.

MEMBER GARCIA: This is Rosalie Garcia. I had my finger on the button. And, yes, it does state statewide. It does say statewide, with consideration to possible regionals. I have statements, that I don't know that now is the time so I'll hold them for now.

CHAIRMAN DROZDOFF: All right. I know Jacque had a question or a comment.

VICE CHAIR EWING-TAYLOR: Thank you, Mr. Chairman.

I just have a question, it's probably for Jeff. One of the processes that I don't understand is the appeal process and the associated timeline. And by that I mean we're we to stay the course, if you will, it may be reasonable to assume there would be a vendor appeal or more. What is the time frame in which that occurs and what happens when a formal appeal is made and how does that affect the process?

MR. HAAG: Thank you for the question. Jeff Haag, for the record.

And I'm going to describe this process to the best of my knowledge. After -- so first let me take a step back and that is the next phase in this process based on my understanding would be for state purchasing to issue a notice of intent to Anthem. That would then allow us to enter into negotiations, to negotiate the items that Anthem identified in their proposal, that they have concerns with through the contracting process and the costs that were addressed in the last Board meeting.

Provided those negotiations were successful, we would then move to a notice of award. Once that notice of award was issued, vendors have ten days to file a protest.

In order to file a protest, they have to put up a bond to support that, and then we would move through the protest process after that.

Outside of the protest process, there's also opportunities for vendors to enter into a litigation hold to take us right to court should they so choose, so there are outside of the process other ramifications that could come to the state in any solicitation, not just this one.

MR. HAYCOCK: Can you add the time frame for the -- once an appeal has been filed, what's the time frame purchasing has to adjudicate that appeal or I think it's 60 days is my understanding. I don't know if Dennis knows this. We don't have Jeff Manacucci (phonetic) here, who could have answered that, I'm sorry, but I believe it's 60 days is what I remember right.

MR. HAAG: That's my understanding as well.

MR. BELCOURT: Dennis Belcourt.

I think that's a ballpark range in terms of there are time limits on the appeal time. When the hearing officer gets together, the time limits leading up to all of those events, and I think our guesstimate it would probably take about 60 days to get to a decision of the appeal's officer which will, you know, be, what, end of March or end of -- end of March.

VICE CHAIR EWING-TAYLOR: If that were to start today essentially?

MR. BELCOURT: Correct.

VICE CHAIR EWING-TAYLOR: But if you add another let's say conservatively two weeks to get to the point where the appeal could be filed, then you're looking at 60 days beyond that; is that correct?

MR. BELCOURT: I think we built into the 60 day estimate, the negotiation process. The award, the negotiation process which we're going to expedite if it's going to happen this way, I'll be involved too and the appeal -- the appeals -- appeal period, there's a time period for notice of the award, a time period for the appeal and then time period for the appeal officer to render a decision roughly, so I think we're looking at 60 days for that entire process. So, yeah, we're looking at the end of March but that's -- you know, that's working pretty quickly in getting a contract negotiated in the first place.

VICE CHAIR EWING-TAYLOR: Right. So best case scenario, we're looking at April 1st having something resolved if there's an appeal; is that correct?

MR. BELCOURT: That's correct.

VICE CHAIR EWING-TAYLOR: So if I just look at the plan year, if we're looking at April 1st before we have

any idea who we're going to contract with or whether we're going to contract, we have open enrollment starting May 1st. That timeline scares me and I don't know but, Damon, maybe you or someone on your staff could address whether or not that is even possible.

MR. HAYCOCK: Damon Haycock for the record.

Our additional plan for implementation of the HMO contract was to have all contracts negotiated and signed and placed on the board of examiners meeting for I believe it's April 8th, I believe it's April 8th which means we have to have it by the first week of March to meet that deadline. That has gone through all legal on all sides, all of the review and the culmination of that contract. That was our original schedule.

VICE CHAIR EWING-TAYLOR: So when he changed to that schedule backs that up, what is the next BOE date, are they monthly, I don't know.

MR. HAYCOCK: Yes.

VICE CHAIR EWING-TAYLOR: So it will be the May date. So we couldn't even get that contract approved by the time we have to open open enrollment if there is an appeal?

MR. HAAG: So Jeff Haag for the record.

You're correct. If I could just state my opinion on the timing of this process. The timeline is very

aggressive. I think to be able to finish negotiations which in my experience can take a significant amount of time and there are significant issues that would need to be negotiated with the provider that's been voted on by this Board, it would be difficult to complete the negotiation, finalize the contract and have it ready for BOE submission in March.

And then if we miss that, of course, it would need to be submitted for BOE submittal in April, beginning of April to be on the May agenda which to your point gets us into the open enrollment period.

CHAIRMAN DROZDOFF: So I'm going to go quickly to Judy and then to Bob Moore.

MEMBER SAIZ: I've been thinking about this and solution, PEBP staff would cringe at this, but we've been known to do this when I worked here before is you could have extended open enrollment for a month or two depending on how long it takes. It could be an August or September open enrollment. They have what they call prior deductible credit where the plan year would still be July 1st, and you would go into the next plan year for open enrollment either August or September.

If we move forward with Anthem, Anthem would need to agree that they would accept that. They would have the prior deductible credit. We would have to get Hometown and

Health Plan Nevada to agree to an extension of a month or two months, but what I'm getting at is it could be done, and it would -- it wouldn't be that cumbersome to do it. We did do this in the past. We had short plan years. We had short plan years, but the plan year could stay the same. Open enrollment could just be pushed out a month or two months.

And I even have -- I even have a plan that I could work with Nancy on how that could happen as far as communications went to the members.

CHAIRMAN DROZDOFF: Bob?

MEMBER MOORE: Thank you, Mr. Chairman. For the record, Bob Moore.

I was going to wait until deliberations to do my standard disclosure but it sounds like we're already into deliberations. So, once again, I need to disclose that my son is an employee of United Health Group. Although, the commission on ethics has said I do not have a conflict of interest and the remoteness of that relationship with Sierra Health and Life, but I do need to disclose the existence of that relationship and may or may not declare a conflict of interest on this issue. Thank you, Mr. Chairman.

CHAIRMAN DROZDOFF: You're welcome.

Okay. So back to are there any other questions?

Go ahead.

VICE CHAIR EWING-TAYLOR: Well, Mr. Chairman, I think in light of what Judy said, I do remember the short plan year. In my 13 years, we've only done it once. I also remember it was a massive disruption to 70,000 of our covered people. I also remember it, maybe staff does or doesn't remember it being very disruptive for staff, very costly in that -- in that respect, and I would just personally really really not want to see us do that. I'm not sure -- I'm not convinced that that could even happen.

And, Damon, I don't know whether you or Tina want to address that. I guess Tina does.

MS. GLOVER: Celestena Glover for the record. So what Judy says about extending the open enrollment period or moving it, from a process standpoint, we can do that, but there are a lot of other considerations of how having a short plan year and a long plan year how that affects us in the future for developing rates and things like that because we're not just talking now the HMO plan. We're talking the CDHP plan, as well, to determine, you know, are you going to have one be open enrollment in May and one do open enrollment in August? Are you going to push them all to August? I mean, there's other things and then what does that do to members, so.

MEMBER SAIZ: Mr. Chair, I was thinking of

keeping the plan year the same, and you just have the open enrollment later, a month or two later, but you have a plan year the same.

Example, because Jim and I were just talking, we did this twice that there was a different plan year. During the extended open enrollment period, like a letter would go out to your participants. The PPO members would be told if you don't want to change, they would do nothing, simple. They want to switch to the HMO, the HMO is going to be X, whatever it is. The current HMO members would be told there's a new HMO. If you want to go to the new HMO, you do this. If you want to change to the PPO, you do this.

It doesn't have to be positive 100 percent open enrollment. It could be a letter to the PPO people who we have 20,000 of them or whatever just saying if you want to stay with that, you stay with that. We do nothing. It's the HMO people that would be affected, and they would have a chance to go with the new HMO or move to the PPO. It wouldn't be a positive open enrollment. It would be a change in the plan year.

CHAIRMAN DROZDOFF: So what I would suggest here is I think, you know, there's no correct right or wrong time, just like there is to make a disclosure. But, you know, I did -- I feel like before we get into anymore serious

deliberations, I feel like I want to offer the members of the public that may be here that want to say something on the record, and then we can resume where we were.

But I think it's important at this point to give an opportunity to folks that have been waiting a long time to make -- to make public comment if they would like. So I would like to start that, see if there's either in Las Vegas or in Carson City.

MEMBER COCHRAN: We don't have any public comment in Las Vegas.

CHAIRMAN DROZDOFF: All right. Is there anybody else? Is there a show of hands? Anybody planning to?

Go ahead Peggy.

MS. BOWEN: My name and my words for the record Peggy, P-e-g-g-y Lear, L-e-a-r Bowen, last name B-o-w-e-n. I had concerns during the last meeting when you determined what group you were going to vote on, and I quite frankly have questions in my mind today, would we be here asking these questions today had a different vendor been selected?

My concerns for last time are these, that you had a committee who moved all total 45 points for a vendor that was not accepted by this Board when you went with another vendor. And that with all of the discussions that took place, all of the presentations that you were presented and

when vendors said here, by here, by here, that when they were told that they had gotten zero points in certain areas that had they known they could have better explained that they did provide things that weren't reflected in their response to the RFP.

At the end of all of that discourse and at the end of all of the voting and even the prior meeting when that was discussed, we were still told last meeting 45 points and that that committee never met again to take into consideration things that they had been told in these two crucial meetings where points should -- where vendors felt they should not have received zero points. It's not that they didn't know to give or didn't want to give.

But there was also a memo that you all received that the gal who is sitting right there, I apologize, she read it to you, telling you not to consider Hometown Health I believe it was in your deliberations, that that had been taken place, and you didn't have to do certain things, and that she was contradicted or a person at the table was being contradicted and she at the table pulled out this memo that you all received telling you what to do and not to do and it was direct conflict with -- it had to do with the awarding of points. It was you. I'm sorry. I apologize. You were over here last time. You guys cannot move. I'm -- I had a

concussion and sometimes I just get things set in my head and that's my bad.

My concern is that I heard vendors say that they were shocked to understand in the scoring process by the committee that they receive zero points for something that they did provide in rural areas and could provide in southern areas. And the one outstanding thing I heard was some vendors saying that they absolutely would not work in conjunction with other vendors and, therefore, it denied access to our members, to medical facilities, especially in the north.

It drove us being only at one facility, and we were reminded during that meeting that we used to be able to go to any facility but by being narrowed down to one, and I've testified a few times about the one that we've been narrowed down to, and what they do or don't provide, and I've had more recent experience with what they do or don't provide and the idea of hospitalists and what they cause to happen to your medical, you're a captive prisoner in that hospital.

Once you go in, your doctors aren't notified. Nobody is told what is happening with you. And for -- you've met Joycie, the 97-year-old from Verdi, who's not a state worker and not in this plan, who was simply told because she's with one of the providers that you have on your A and B

Medicare group, Senior Care Plus that why didn't she go home and have a bigger event before she came back because everybody present determined that she needed care and a hospitalist decided it wasn't life threatening.

So what basically it came to was the almighty dollar, social security, A and B Medicare will pay 80 percent of the person's bill once they have met the social -- the Medicare deductible if they are not admitted to the hospital. If they are admitted to the hospital, your insurance pays 80 percent, and the 20 percent is left to you. Otherwise, it's 80 percent Medicare pays. The cheapest people you shipped off to Utah, your A and B Medicare folk, you only had to pay 20 percent of what was going on.

People's lives are hanging in the balance. Their care is hanging in the balance, and it's all because whether or not they are actually admitted to the hospital and the way the plan is set up now, no.

When last time you did all your review and that 45 percent never changed from the initial, there was never another meeting after more information had been given to the committee and we said to have two people on that committee and I don't care if they had ten minutes notice, two people, and we had a very experienced person on this Board suggest to be on that initial committee who was never brought into that

committee, and shame on us for allowing that to happen, and I don't care who did it or why. We needed to have more Board members than we had on that committee to represent the people, and that is my comment pertaining to why.

You made a decision. If it had been the other way, would you still be going through this because the confusion would have still existed. The RFP's may not have had the right answer on them, that would have still existed. There was nothing that changed except for which vendor was finally selected, and you followed all of the rules and it is shame on us if it appears to Peggy Lear Bowen that somebody has been pushing buttons for a -- since the last meeting and shame on you if you give in to buttons being pushed.

Go forward and concerns that were brought up in the first public comment about make sure when you negotiate this thing that they do have the providers and they are paying a decent rate to the providers regarding our members, and have the intestinal fortitude to do the right thing because you did it. You did what you felt was in the best interest of the state of Nevada employees, retired and actives, and you are to be congratulated on that, and you worked hard and long on that and shame for anything else.

Anthem could have sued based on the decision because they didn't think they got a good RFP last time, so

you're not dodging any bullets here. If those who have been in place wanted the same old, same old and we're discovering how much that same old, same old cost, how much we actually paid the people that handle the papers, not give the shots or medicine or care about the broken bones, we're having a discussion about paper pushers, and that needs to stop, and we need to get back to medicine, and we need to get back to care and life and health of our people. Thank you very much.

MR. MURPHY: Mr. Chair, Members of the Board. Thank you for the time. For the record, my name is Mike Murphy, M-i-k-e M-u-r-p-h-y. I'm the president of Anthem Blue Cross Blue Shield. I have prepared remarks and then just a couple of things as I've heard some of the comments I may add at the end.

You know, today we're respectfully requesting that actions outlined on Agenda Item 10 be postponed from any action today. Specifically, Anthem, we have serious concerns that the Board would be taking such significant action after an intended award to Anthem was publicly communicated.

In addition, we're aware of the critical information contained in the Board packet that was supplied today simply not accurate, and the record must be corrected prior to any Board action. Because of this recommended action item and the inaccuracies in the record, some of which

Damon addressed earlier and mentioned today, pertain to critical potential irregularities in the RFP process. We recommend that the purchasing division, the only proper point of communication between vendors and the state during the period right now in the process be given sufficient time to evaluate, must be what may be inaccurate in the record before the Board undertakes any further action. You know, I'll reiterate, the only proper communication place right now in this process is the purchasing department.

Lastly, we would point out that the inaccuracies only became known to us late after -- yesterday afternoon. There's been no communication to us from the purchasing division as to how or why they arose. And given the importance of this RFP to the PEBP participants, we believe it's in the best interest of the state in ensuring the issues are remedied before any Board action is taken.

Postponing any action in Agenda Item 10, I know as you've had some discussion causes concern, but we believe that while proceeding to dissolve a properly processed RFP at this late date with no notice would increase cost to the state, further confuse those involved and open up state to potentially significant procurement issues.

Just to add a couple of things that were discussed earlier or questions to the Board, the confusion

around the regional and the statewide RFP, I'll just add that I've been a resident here and involved in leading our organization for ten years now. The RFP in the way that it was issued around regional and statewide has been pretty much a staple on how the RFP has been issued throughout the past.

The confusion and those things that are being brought up are issues with every RFP that's ever issued, so I add those things that these are not new issues that have -- that have come up. Those regional versus statewide issues have been sitting out here.

So with that, I know if there's some questions, I'm more than happy to answer any questions if there are.

CHAIRMAN DROZDOFF: Are there any questions for Mr. Murphy?

MR. HAYCOCK: Can I ask one? For the record, Damon Haycock.

Thanks for coming up here, Mike.

CHAIRMAN DROZDOFF: Sorry, Chris, I didn't realize you had one.

MR. HAYCOCK: Just curious if you received the notification I sent Lisa Schromer on Friday?

MR. MURPHY: Yes, the notification that we received was we were trying to clarify whether or not a letter of intent was issued at that point. The inaccuracies

in some of the Board packet was only I guess noticed yesterday as I think there were additional board materials that were put on agenda items on the website. So, although, there was a response to our reach out around how we needed to proceed, we did not have all of the information that was put in the Board packet.

MR. HAYCOCK: Thank you.

MR. MURPHY: Yep.

CHAIRMAN DROZDOFF: Chris?

MEMBER COCHRAN: I just wanted to clarify Mike's request to the Board. You're asking us to table this matter?

MR. MURPHY: I believe that this -- what we are -- what we're asking in public comment is that the -- the action that is suggested and outlined being taken in Item 10 be -- be absolutely postponed until there is -- until all of the information that is in there can be clarified and some of the things that have been discussed today can accurately be resolved.

MEMBER COCHRAN: Okay. So postponing it in terms of us taking any action, does that include the current RFP that's out there that we're -- that we've tried to let?

MR. MURPHY: No, we believe that, you know, as of -- oh, as of January 12th, I mean the action that obviously that we would -- that we would want to proceed with is the

action that was outlined in the January 12th meeting.

If action -- if Item 10 is going to be moved forward, there are significant concerns that we have with the things that have -- that are providing a background for action on Item 10. So, again, just to make it very clear, we believe the action that the Board discussed, voted on on January 12th should be moved on.

Does that -- I want to make sure I'm being clear about answering your question.

MEMBER COCHRAN: Yes, yes, that clarifies it for me.

MR. MURPHY: Thank you.

MEMBER COCHRAN: Thank you.

CHAIRMAN DROZDOFF: Jacque?

VICE CHAIR EWING-TAYLOR: So you said a couple of times there are inaccuracies in this Board report. Can you tell us what they are?

MR. MURPHY: I guess what we want to be very respectful of the process right now and, again, in the process as we understand the outline, the proper place for us to have those discussions would be with the purchasing department right now about those inaccuracies because during the RFP process, it is laid out very clearly that any vendors are not to talk to PEBP, PEBP Board or all those

communications are to be handled through the purchasing department which we have -- which we have started to.

So I'm trying to be very respectful of the process. I understand your concern around -- you know, around wanting to understand those issues as you're debating.

VICE CHAIR EWING-TAYLOR: But you're asking us to make a decision based on inaccuracies that you won't divulge.

MR. MURPHY: I'm not trying not to divulge them. What I would say is the inaccuracies that were laid out today were one that and I'll just -- I'll outline a couple of them again just trying to be very very cautious of not getting into violating the RFP, so I'm not trying to be disrespectful by any means.

But the first inaccuracy which we noticed again today, Mr. Haycock addressed that we were awarded a letter of intent and were in active negotiations. I think there's an omitted portion of what happened at the Board meeting on January 12th that outlines a plan A and a plan B of what would happen if those negotiations were unsuccessful that are not reflected I don't believe in the minutes.

So those two I guess are examples of some things that we're walking through them. And, you know, again, as they were posted very recently, we want to work through those and make sure that you all have the accurate -- you know, the

accurate reflection of the facts.

So, again, I'm not trying to be disrespectful by any means in telling you that I -- just, we're trying to get through it as well in very quick time around how we address it.

Again, we believe that the process that -- that was walked through with the RFP, the response, the scoring and the procurement was all -- you know, was all within the bounds of exactly how the process is laid out. We have been, you know, again, on both sides of this in times in this procurement process. I don't know -- I don't know what other issues to address or to answer with issues in the notes.

MR. HAYCOCK: For the record, Damon Haycock.

I think what Mr. Murphy is referring to is my originally posted executive officer report which I don't know if you were in the room when I went over it earlier today.

MR. MURPHY: I was.

MR. HAYCOCK: Where I disclaimed that I was given misinformation, and I had to walk that back.

MR. MURPHY: Yes.

MR. HAYCOCK: And confirmed that Anthem had not received a notice of intent.

MR. MURPHY: Yes.

MR. HAYCOCK: And I can confirm that Anthem has

not entered into any negotiations with PEBP or with my staff at this point, and so that much is true. Although, I don't know if the omission of that is considered a falsehood, I don't know, that's up to interpretation.

MR. MURPHY: The omission that I was referencing was more around the -- the action items from the 12th around plan A as I'll represent it which was moving to a statewide versus a plan B was what was happening if the negotiations with us were unsuccessful.

The statement around the letter of intent was what I was referring to, so two separate issues. I'm just trying to make it clear.

CHAIRMAN DROZDOFF: Anything else? All right.

MR. MURPHY: Thank you very. I appreciate your time. Thank you.

CHAIRMAN DROZDOFF: Okay. Board, we can deliberate more. We can --

MEMBER GARCIA: Leo, this is Rosalie.

CHAIRMAN DROZDOFF: Go ahead, Rosalie.

MEMBER GARCIA: If I may, a couple of points. The Board knew going into this RFP that we were on a tight deadline so that's a non issue. I do not agree or believe that there were any inaccuracies in the RFP itself.

I do not believe -- you know, the word confusion

has been brought up several times, and I believe -- you know, it could be that the use of confusion, the word confusion is just easy but when it comes to evaluating the RFP, I don't believe that there was any confusion. I believe that some areas were difficult and were worked through but not to the point where anybody was massively confused with what it was that we were tasked to do or how we were doing it.

The Board at that time did discuss statewide versus regional and when we took the vote, it was to vote for statewide. I -- although, I did not -- my package was delayed for the review of the RFP. I believe that I was given enough time to evaluate the submissions, quite ample amount of time. Even if it was over the holidays, I still was able to review the RFP's to make a decision.

The current RFP clearly states the subject regarding statewide coverage versus regional. So for that even to be an issue for a vendor to bring up, I would not understand why they would state that.

The vendor coverage -- the vendors when they are submitting responses to the RFP always provide various services to entice the award. And the fact that we are in open meeting where we discuss what the various RFP's included makes it -- makes it more open for various vendors to state, well, if I would have known, but I still believe we all

evaluate it on an apples to apples kind of basis when it comes to evaluating a statewide HMO.

I think that's all my points. I as a Board member would feel very, I can't even think of the word right now, but I would feel very disappointed if we were to issue an award and not follow through on that based on hearsay or verbal complaints from the vendors that responded to the RFP.

And I am surprised that we did not submit a statement of intent immediately after our last Board meeting but it is what it is. I would like to hope that we all move forward on how our vote was instead of succumbing to innuendos and threats. Thank you.

CHAIRMAN DROZDOFF: Anything else?

MEMBER COCHRAN: For the record, if I may, Leo, Mr. Chair, and this is Chris Cochran.

I respectfully disagree with part of what Rosalie is saying only in terms of the idea that we were comparing everything on a statewide basis because it was clear to me based on the votes of members of the Board at that meeting that some of the preferred -- that some preferred a choice that was clearly not a statewide choice and based on the rankings that we submitted, that based on the rankings when Board members were told to -- to rank their -- the vendors that it was clear that some of the -- some of the Board

members did not look at it on a statewide basis.

If that was the instruction, I'm not sure that message was received by all Board members. I ranked -- I will say personally, I ranked based on a statewide selection. I'm not so sure I could say that of all Board members. So just in clarifying that with -- with Ms. Garcia that I just want to make -- I want to make that point from my observation. It didn't seem that Board members did it based on a statewide selection, all Board members I should say.

CHAIRMAN DROZDOFF: All right. Thank you.

Jim?

MEMBER WELLS: Thank you, Mr. Chairman.

First off, I'm going to disclose as I did earlier that due to my department's role in the process for procurement entering into contracts that I will not be voting on this particular item.

But I want to talk a little bit more about some of the history that Dr. Ewing-Taylor started with and that is that the concept of the statewide HMO has been around for a long time, but there were never a vendor who could provide a statewide option; therefore, we continued to do these regional options, but that preference has never been removed from the HMO contracts with one exception and that's the last part of what Dr. Ewing-Taylor talked about, when we split --

actually, I think it was Ms. Glover talked about when we had to split them so we had to terminate a contract early that kind of put us off cycle with having one RFP for one of the HMO's on a different cycle than the other.

At that point, we had to do regional because we were still in contracts or in a contract with the second vendor so we have gone back to the preference was always to have a statewide option.

Now it appears, and I was not party to this conversation or the review, but it does look like there's a statewide option, and so that was always part of the discussion for the history of the HMO process.

CHAIRMAN DROZDOFF: I appreciate the clarification.

Anybody else?

MEMBER ANDREWS: Yes.

CHAIRMAN DROZDOFF: Anna?

MEMBER ANDREWS: Anna Andrews for the record.

I don't know. I think mine is more of a statement than anything and in a way I think I might be playing devil's advocate, but I just want all of us trying to put this timeline, these things in our mind because to me as a Board member, our members come first. How we serve them, how we facilitate them having their insurance is the most

important part that our Board should be looking at and that the program is working towards.

Now, going back to Jeff Haag's comments earlier when he was asked about the time length -- the timeline of what if's. So the way I see the process going is not open to Anthem, proceed with negotiations, whichever way they go, notice of award, ten days to protest appeal, which I'm venturing to say I don't have a crystal ball but somebody will appeal. Some of the other vendors will appeal definitely.

MEMBER MOORE: Zero risk taker.

MEMBER ANDREWS: Yeah, I think that's a pretty good guess.

So then we have the 60-day timeline that we discussed earlier. Frankly, I'm a state employee and I know the wheels of government do not move that fast, even though we would like for them to, but I've been through the contracting processing in my own little world, and I know 90 days to me is more reasonable. I hope I'm wrong.

Then if they appeal, if HMO, A, B, C, whomever appeals, they have to post the bond, and then there is a potential for the litigation hold. Maybe this won't happen and my statements will be moot, but here is things to keep in mind, we still have the CDHP members. We have HSA's, HRA's,

allocations that we give that we have promised and provided to them.

So if my scenarios works out, let's keep in mind our HMO's contract all ends on June 30th of this year, correct, so we're going to have to scramble to try to extend them until such time as we did our other part of it fixed. For how long do we extend them?

Okay. Now, Judy said we've done this before, we can delay the open enrollment and all of that, yes, I remember that. I'm venturing to say we're going to have, again, the CDHP and the HMO pitted against each other because they are going to say, oh, they get this but we don't get that and how are we going to be delayed and why are we going to get less because our plan year is shorter and the others have the full plan year? Maybe I'm not making sense but that's just the way -- and you can dispute that.

But there's one more underlying issue in here. Do we all remember the SHO Network issue that we have with the CDHP because HPN has that network and they confirmed that that network will go away. Yes, we can get another network but, again, we're adding time and we are doing a disservice to our members. So take it for what it's worth. Thank you.

CHAIRMAN DROZDOFF: Thank you, Anna.

Jacque?

VICE CHAIR EWING-TAYLOR: Thank you, Mr. Chairman.

I would echo what Anna has just said, as I said earlier, but I do agree with her. The emphasis needs to be to the extent possible on the disruption to our employees and if we do what Judy is suggesting, this disruption will be significant.

It's also additionally significant for NSHE and for our campuses because the vast majority of our faculty are not on contract from the middle of May through the middle of August, so they will not in large part be paying attention, I know some of you think they never do anyway, during that period of time. They will be out in the field. They will be doing their research. Many of them are in other parts of the world and will be unable to make their selection, so we effectively remove the opportunity for an open enrollment for many of our university employees.

So you have that large disruption. You have the large disruption that Anna was discussing to the CDHP. I see at this point no reason not to step back and do this again, do it differently and do it cleaner, I guess, is where I am with less disruption to our employees and their families.

CHAIRMAN DROZDOFF: Judy?

MEMBER SAIZ: In response to Anna, you know,

maybe I didn't make myself clear but there wouldn't be that big of disruption. I'm sorry, if university people -- you know, it could be handled to where it would work to do an extended open enrollment and it wouldn't affect the high deductible people. The plan year would still be July 1st. In fact, it wouldn't affect them at all if they stayed with the high deductible plan.

Again, I'll just say it again that I just think the Board voted four to three to move forward with a different statewide HMO that had better access up north, access out of state. They had a lot of attributes, and I think that's why we voted for them, and it was four to three. I just would hate to see that withdrawn, and I can't condone that.

CHAIRMAN DROZDOFF: Well, I feel like everybody has had their chance to speak. My sense is that I've got at least two vendors that are going to abstain on this vote. Probably fair warning to -- to HPN, HHP and Anthem that depending on the motion made, I may ask for some folks to comment on the record but at this point, I mean, unless somebody has something more to say, I would entertain a motion one way or another.

MEMBER SAIZ: I'll make a motion.

CHAIRMAN DROZDOFF: Judy?

MEMBER SAIZ: Judy Saiz for the record.

I'll make a motion that we don't withdraw the request for proposal for three to zero and that we proceed with Anthem as the statewide HMO for 2016, '17.

CHAIRMAN DROZDOFF: Is there a second?

MEMBER GARCIA: Rosalie Garcia, second.

CHAIRMAN DROZDOFF: All right. Any comment on the motion?

Seeing none, I'll call for the question. All those in favor, please say aye.

MEMBER SAIZ: Aye.

MEMBER GARCIA: Aye.

MEMBER COCHRAN: Aye.

MEMBER BAILEY: Aye.

CHAIRMAN DROZDOFF: Okay. So that's four.

And any opposed?

MEMBER ANDERS: Nay.

VICE CHAIR EWING-TAYLOR: Nay.

CHAIRMAN DROZDOFF: That's four-two.

Any abstain?

MEMBER MOORE: I'll abstain, Mr. Chairman.

MEMBER WELLS: I also will abstain.

CHAIRMAN DROZDOFF: The vote is four-two.

Is there anything you need -- let's take a

five-minute break.

MEMBER GARCIA: Mr. Chair, did motion pass?

CHAIRMAN DROZDOFF: Yes, the motion passed four-two, with two abstaining.

MEMBER GARCIA: Thank you.

(Whereupon, a brief recess was taken.)

CHAIRMAN DROZDOFF: Mr. Murphy, can I ask you to come up. So I will tell you as Chair of this Board that I am -- I'm not just speaking to you at this point. I'm speaking to fellow Board members in the audience that it is with great -- I have great trepidation as to where we sit right now for a variety of reasons, many of which are not your doing, but nonetheless you are -- you know, you have now twice been on the receiving end of Board action favorable to pursuing negotiation with Anthem and that is -- and that runs counter advice we received from administration and purchasing, that gives me great pause, but that's where we find ourselves.

I'm going to ask you this question because I know there's going to be significant fallout and you heard what Ms. Andrews had to say about the timeline.

MR. MURPHY: Yes.

CHAIRMAN DROZDOFF: Which I think she nailed. I would like to know that if negotiations were opened up with

you -- with your company and PEBP in a very short time frame, two weeks, three weeks max that the Board can be advised from PEBP staff whether the negotiations were deemed successful or not. Is that a commitment that you can make on behalf of your --

MR. MURPHY: You're asking me if we can get to negotiations and complete them within two to three weeks, is that you're what asking me?

CHAIRMAN DROZDOFF: Yes.

MR. MURPHY: I believe so. What I need but, again, I'm going to say this and I'm sorry, Mike Murphy for -- you got the spelling.

I want to make sure because I don't have a list of what all those issues are. I know by verbiage of what we heard on the 12th what I think the majority of the issues are. Those issues, I absolutely believe we can have wrapped up one way or another because the last thing we want is to put either the state and the public employees in any situation that's bad for them, even if we can't get to an agreement in negotiations.

CHAIRMAN DROZDOFF: Right, and I appreciate that because here's what I'm thinking, Damon, and, Mr. Murphy, is that -- so two and a half weeks brings us to February 12th, okay, that's where we're talking about, and I really think

that that is given the time frame that Anna spelled out that is -- that really is the time frame.

So what I would ask, hopefully direct is that on or before the 12th, the Board is notified by you, Damon, or by PEBP staff with purchasing that a successful negotiation has occurred or it has not and if it has not, then what's our minimum public notice, three days, Kari?

MS. PEDROZA: Yes.

CHAIRMAN DROZDOFF: That we immediately schedule a special meeting that following week, three days hence, and we can continue to have negotiations with your company but the plan year -- but we would need to move the plan year a full year at that point because we simply would run out of time. So we would still have these discussions going on, but they would simply -- we would all have to agree that by, you know, by mid February, we either -- we either hammer something out or we have not. If not, the Board's vote stands but when it stands, it basically allows then we'll have to get back together and say, look, we're going to have to work with our current vendors, assuming they are willing, for an additional period of time and the negotiations with your company would continue.

That's -- I believe we're in a real quagmire right now. That is about the best idea that I can think of

given what the Board's preference clearly is and also given sort of the very strong direction that we received from purchasing which we -- which we did not take.

So does that make sense to you?

MR. MURPHY: Yes, it does.

CHAIRMAN DROZDOFF: Does that make sense to you? I want you to understand.

MR. MURPHY: As soon as we get awarded, absolutely I will be in touch.

CHAIRMAN DROZDOFF: Well, we just did or what I just did.

VICE CHAIR EWING-TAYLOR: Can I make a suggestion? You go ahead and schedule that meeting. It's easily cancellable. It's less easy to schedule.

CHAIRMAN DROZDOFF: Let's do that. Kari, we will schedule a meeting and do a head count and try to schedule a meeting the week of -- yeah, the week of the 15th. Yeah, the 15th is a holiday but some time that week, schedule it now and it would be a one -- it would be a one agenda topic if it has to happen at all and I will get together with -- I mean, we need to figure out what a successful negotiation is. We'll get together with purchasing to do that. Given all of the strange discussions, that's about the best that I can do.

Anybody have anything else, any other

suggestions?

Anything down south?

All right. Then that's what we'll do. Thank you.

MR. MURPHY: Anything else?

CHAIRMAN DROZDOFF: No.

MR. MURPHY: Thank you today for the vote. We appreciate it. We look forward to working with you. Thank you.

CHAIRMAN DROZDOFF: Okay. So let's move to public comment.

MS. BOWEN: Peggy Lear Bowen, my name and words for the record, thank you very much and have a great great time until the week of February 15th when we will gather again and Happy Valentine's day because we just miss it.

CHAIRMAN DROZDOFF: Anything down south?

MEMBER GARCIA: We have a comment.

CHAIRMAN DROZDOFF: All right.

MS. CAMERON: My name is Vicki Cameron for the record, V-i-c-k-i C-a-m-e-r-o-n.

First, I want to compliment you on a meeting today. You had some difficult decisions to make and I think you handled them well.

But going back just a little bit to your Towers

Watson, I am the president of the Retired Public Employees of Nevada, Henderson Chapter. I am still receiving complaints about poor customer service from Towers Watson. We are still having issues with the HRA and contacting them to get them resolved.

The people at the 800 number have very little or no knowledge to any one on one meetings that were either held here in the south or that are to be held in the north. We would like to know if there is a customer service number for PayFlex. If so, could we get that. Thank you.

MR. HAYCOCK: For the record, Damon Haycock.

Thank you for the comment. We had sent out information to the participants to my understanding but also to the former RPEN president, Marty Bibb, and so if for whatever reason information didn't filter down, we'll endeavor to do a better job, and we'll look in to the PayFlex number.

CHAIRMAN DROZDOFF: All right. Anything else?

Anybody down south?

Anybody up north?

All right. Meeting is adjourned.

STATE OF NEVADA,)
) ss.
CARSON CITY.)

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

That on Tuesday, the 26th day of January, 2016, I was present at the Public Employees' Benefits Program, Carson City, Nevada, for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 199, is a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Carson City, Nevada, this 6th day of February, 2016.

KATHY JACKSON, CCR
Nevada CCR #402

Kathy Jackson
Capitol Reporters
123 W. Nye Lane Suite 107
Carson City, Nevada 89703
(775) 882-5322

STATE OF NEVADA

PUBLIC EMPLOYEES' BENEFITS PROGRAM

AFFIRMATION

Pursuant to NRS 239B.030

The undersigned does hereby affirm that the following document DOES NOT contain the social security number of any person:

1) Public Employees' Benefits Program Board
Regular Meeting, 1/26/16

KATHY JACKSON DATE

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