STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING AND PUBLIC HEARING
The Richard Bryan Building
901 South Stewart Street Suite # 1002
Carson City, Nevada 89701

Video conferenced to:
The Nevada System of Higher Education
System Computer Services Room #s 304 & 306
4505 S. Maryland Parkway
Las Vegas, Nevada 89154

ACTION MINUTES (Subject to Board Approval)
January 26, 2016

MEMBERS PRESENT IN CARSON CITY:	Mr. Leo Drozdoff, Board Chair (joined the meeting at 1:00 p.m.) Ms. Jacque Ewing-Taylor, Vice-Chair Ms. Ana Andrews, Member Mr. Don Bailey, Member Mr. Robert Moore, Member Ms. Judy Saiz, Member Mr. James Wells, Member
MEMBERS PRESENT IN LAS VEGAS:	Ms. Rosalie Garcia, Member Mr. Chris Cochran, Member (joined the meeting at 9:02 a.m.)
MEMBERS ABSENT:	Mr. Jeff Garofalo, Member
FOR THE BOARD:	Mr. Dennis Belcourt, Deputy Attorney General
FOR STAFF:	Mr. Damon Haycock, Executive Officer Ms. Laura Rich, Operations Officer Ms. Celestena Glover, Chief Financial Officer Ms. Nancy Spinelli, Public Information Officer Ms. Kari Pedroza, Executive Assistant

1. Open Meeting; Roll Call

   Vice-Chair Ewing-Taylor opened the meeting at 9:01 a.m. Vice-Chair Ewing-Taylor stated that some Agenda items would be taken out of order and that there would be separate public comment period for Item 10.

2. Public Comment

   Public Comment in Carson City:
   - Marlene Lockard- Retired Public Employees of Nevada (RPEN)
   - Janice Florey- Retiree
   - Priscilla Maloney- AFSCME
   - Peggy Lear Bowen- Retiree Participant (see attached for comments)

Public Comment in Las Vegas:

- There were none.

4. **Action Item-**

Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe July 1, 2015 – September 30, 2015.

4.1. Report from Health Claim Auditors

Bob Carr of Health Claim Auditors, Inc. presented his audit report to the Board.

4.2. HealthSCOPE Benefits response to audit report

Mary Catherine Person of HealthSCOPE Benefits presented her response to the audit report to the Board.

4.3. Accept audit report findings and assess penalties, if applicable, in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors.

Board Action-

MOTION: Move that we accept the audit findings in the report and assess the penalties ($26,289) as provided by Mr. Carr.
BY: Member Wells
SECOND: Member Andrews
VOTE: Unanimous; the motion carried.

5. **Action Item-**

Health Claim Auditors, Inc. annual audit of Towers Watson Exchange Solutions/PayFlex Systems, Inc. for the PEBP Plan Year 2015 (July 1, 2014 – June 30, 2015).

5.1. Report from Health Claim Auditors

Bob Carr of Health Claim Auditors, Inc. presented his audit report to the Board.

5.2. Towers Watson Exchange Solutions/PayFlex Systems, Inc. response to audit report

John Seegrist of Towers Watson provided the audit report response to the Board.

5.3. Accept audit report findings and assess penalties, if applicable, in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors.

Board Action-

MOTION: Motion that we accept the audit report findings and assess the penalties of $8,555.
BY: Member Saiz
SECOND: Member Bailey
VOTE: Unanimous; the motion carried.

6. **Action Item-**

Health Claim Auditors, Inc. annual audit of Catamaran for the PEBP Plan Year 2015 (July 1, 2014 – June 30, 2015).

6.1. Report from Health Claim Auditors

Bob Carr of Health Claim Auditors, Inc. presented his audit report to the Board.

6.2. Catamaran response to audit report

Shannon Ross presented the Catamaran response to the audit report to the Board.

6.3. Accept audit report findings and assess penalties, if applicable, in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors.

DISCLOSURE: Member Moore disclosed that his son is a Corporate Officer of United Health Group that owns Optum RX that owns Catamaran. He received an advisory opinion from the Commission on Ethics that his son's position is so far removed from the operations of Catamaran/Optum RX that he can vote on the issue, there is no conflict of interest, but he needed to disclose the relationship.

Board Action-

MOTION: Motion to accept the audit report findings and assess penalties, as applicable in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors.
BY: Member Andrews
SECOND: Member Saiz
VOTE: Member Moore abstained; The motion carried.

9. **Action Item-**

Consent Agenda
Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

9.1. Approval of the Action Minutes from the January 12, 2016 PEBP Board Meeting.
9.2. Ratification of the evaluation committee's decision to award a contract for Financial Statement Auditor services effective July 1, 2017 to Casey, Neilon and Associates - Request for Proposal No. 3217.
9.3. Acceptance of the PEBP Chief Financial Officer Reports
9.3.1. Fiscal Year 2015 Audited Financial Statements Report.
9.3.2. Quarterly Budget Report for the timeframe July 1, 2015 – September 30, 2015.
9.3.3. Quarterly Utilization Report for the timeframe July 1, 2015 – September 30, 2015.
9.4. Acceptance of the Fiscal Year 2015 Other Post-Employment Benefits (OPEB) valuation rollover prepared in conformance with the Governmental Accounting Standards Board (GASB) requirements.
9.5. Acceptance of the annual PEBP Appeals and Complaints Summary for submission to the Division of Insurance.

Board Action-

MOTION: Move we accept the Consent Agenda with the exception of Items 9.1 and 9.2.
BY: Member Moore
SECOND: Member Bailey
VOTE: Unanimous; the motion carried.

9.1. Approval of the Action Minutes from the January 12, 2016 PEBP Board Meeting.

Board Action-

MOTION: Motion to approve the minutes from the January 12, 2016 PEBP Board Meeting.
BY: Member Saiz
SECOND: Member Bailey
VOTE: Members Moore and Wells abstained; the motion carried.

9.2. Ratification of the evaluation committee's decision to award a contract for Financial Statement Auditor services effective July 1, 2017 to Casey, Neilon and Associates - Request for Proposal No. 3217.

Board Action-

MOTION: Move we adopt the recommendation of staff
BY: Member Moore
SECOND: Member Bailey
VOTE: Members Moore and Wells abstained; the motion carried.

8. **Information Item-**
Executive Officer Report.
Damon Haycock presented his Executive Officer report to the Board.

3. **Information Item-**
Presentation on the State of PEBP.
Damon Haycock presented his State of PEBP report to the Board.

7. **Information Item-**
Presentation on self-funded claims trend experience and projections of the composite rate trend for Plan Year 2017.
Stephanie Messier of Aon Hewitt presented the trend report for Plan Year 2017 to the Board.

10. Chair Drozdoff outlined that Damon Haycock, PEBP's Executive Officer and Jeff Haag, Administrator of the Purchasing Division would give a presentation to the Board regarding this Item and then public comment would be taken on the Item.

Damon Haycock and Jeff Haag recommended that the Board reconsider the decision to award the contract to Anthem Blue Cross Blue Shield and authorize staff to amend the current HMO contracts to extend their services through Plan Year 2017 and issue a new Request for Proposal for the HMO services due to confusion surrounding the evaluation process.

DISCUSSION: Vice-Chair Ewing-Taylor asked Mr. Haag how the evaluation criteria are developed and where they are developed.
Mr. Haag responded to Vice-Chair Ewing-Taylor that the evaluation criteria, to some extent, is standard. If given another chance, the criteria could be more specific to the needs of the RFP by the Purchasing Division.

Member Garcia asked how this RFP differs from the original RFP that was sent out years ago.
Mr. Haag responded that he did not know any specific changes to the RFP but that there had been changes to the contract and the RFP being discussed today. He stated he would need to look at each RFP and distinguish the differences between the two and offered to do this and bring it back to the Board.
PEBP Chief Financial Officer Celestena Glover stated that the Scope of Work in the RFP was updated to include some language that may have been missed in the original RFP and needed to be incorporated in the current RFP.

Member Saiz wanted to comment that she didn't hear any facts about what was done wrong in previous meetings to necessitate a reconsideration of the

Board's previous actions regarding the selection of Anthem as the statewide HMO Vendor.

Vice-Chair Ewing-Taylor asked Mr. Haag about the specifics of the Vendor Appeal Process and the timelines associated with that process.
Mr. Haag responded that the next phase of this process would be for State Purchasing to issue a Letter of Intent to Anthem, which would allow Purchasing and PEBP to negotiate the items that Anthem identified in their proposal that they have concerns with the contracting process and the costs addressed at the last Board Meeting. Providing that negotiations were successful, then State Purchasing would move to the Notice of Award. Once the Notice of Award is 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 is also opportunities for Vendors to enter into a Litigation Hold to take us to court. There are outside of the process, other ramifications that could come to the State in any Solicitation.
Deputy Attorney General Belcourt provided an estimate of 60 days for the completion of the Appeals Process including the award and negotiation periods.

Vice-Chair Ewing-Taylor voiced her concerns about the timeline should we receive an appeal from one of the non-selected Vendors and that we wouldn't be able to bring the contract to the Board of Examiners for approval until May, which is the beginning of Open Enrollment.
Member Saiz suggested that PEBP could do an extended Open Enrollment to accommodate the timeframes for the HMO contract.
PEBP CFO Glover brought up that there are many factors (i.e. shorter plan years and how that would affect the trend when establishing rates, etc.) that PEBP Staff would need to consider as far as offering an extended Open Enrollment period.

DISCLOSURE: Member Moore disclosed that his son is an employee of United Health Group and although the Commission on Ethics said that he does not have a conflict of interest due to the remoteness of that relationship with Sierra Health, he does need to disclose the existence of that relationship and he may or may not declare a conflict of interest on this issue.

Public Comment on Item 10 in Carson City:

- Peggy Lear Bowen- Retiree Participant (see attached for comments)
- Mike Murphy- President of Anthem Blue Cross Blue Shield

Public Comment on Item 10 in Las Vegas:

- There were none.

Action Item-

Discuss, approve or take other action concerning procurement of Services of Health Maintenance Organization (HMO) Vendor or Vendors as follows:

10.1. Reconsider award decision taken at January 12, 2016 meeting on Request for Proposal 3202 for an HMO vendor, which was contingently awarded to Anthem Blue Cross Blue Shield but for which no contract has been entered into.

10.2. Withdraw Request for Proposal 3202 pursuant to NAC 333.170 or other provisions of law

10.3. Authorize staff to negotiate amendments to extend contracts for current HMO vendors Hometown Health Plan and Health Plan of Nevada through plan year 2017, and;

10.4. Authorize staff to take measures to issue a new request for Proposal or proposals for plan year 2018 and beyond for HMO services on a statewide or regional basis.

DISCUSSION: Member Garcia made a few points for the Board to consider, that she felt that the timeframe was a non-issue as the Board knew going into this that the timeframe would be tight. She stated that she did not believe that there was any confusion in regards to the RFP and how it was written. She also stated that she had ample time to review the proposals to make a decision. Member Garcia remarked that she believed that the Board all evaluated on an apples to apples comparison for the Statewide HMO.

Member Cochran did not feel that everything was compared on a State-wide basis by all Board Members.

DISCLOSURE: Member Wells disclosed that due to his position as the Administrator of the Governor's Office of Finance, he would not be voting on any item regarding contracts.

DISCUSSION: Member Wells provided some historical information to the Board in regards to the State-wide HMO services, in the past there wasn't a Vendor who could provide State-wide HMO services. He stated that historically the preference was always for a State-wide HMO service.
Member Andrews wanted to stress that the timeline for this process is lengthy. She raised concerns over how extending the Open Enrollment would disrupt the participants.
Vice-Chair Ewing-Taylor shared Member Andrews' concerns regarding disruption to the participants. She stated that she didn't see any reason not to step back and do this process over.

Board Action-

MOTION: Motion that we don't withdraw the Request for Proposal for 3203 and that we proceed with Anthem as the State-wide HMO for 2016/2017.
BY: Member Saiz
SECOND: Member Garcia
VOTE: Members Saiz, Garcia, Cochran, and Bailey voted 'Aye'.
Members Ewing-Taylor, and Andrews voted 'Nay'.
Members Moore and Wells abstained.
The motion carried.

BOARD DIRECTION: Chair Drozdoff addressed Mr. Murphy of Anthem Blue Cross Blue Shield and Damon Haycock regarding feedback of the negotiation process to Board. Chair Drozdoff asked that if negotiations were opened up in a very short time frame (two weeks, three weeks maximum) that the Board could be advised by PEBP Staff whether the negotiations were deemed successful or not. Mr. Murphy stated that he believed he would be able to negotiate with PEBP Staff within the given timeframe. Chair Drozdoff asked that on or before February 12th the Board be notified by Damon or PEBP staff with Purchasing that a successful negotiation has occurred or it has not. If it has not that there would be another meeting scheduled the following week to continue to have negotiations with Anthem but the Plan Year would need to be moved a full Plan Year at that point due to time constraints. Vice-Chair Ewing-Taylor suggested that we go ahead and schedule a tentative

meeting for the week of February 15th. Chair Drozdoff stated that it would be a one Item Agenda meeting. There would be discussions between Purchasing and PEBP to determine the parameters of a successful negotiation with Anthem.

11. Public Comment

Public Comment in Carson City:

- Peggy Lear Bowen- Retiree Participant (see attached for comments)

Public Comment in Las Vegas:

- Vicki Cameron- President of the RPEN Chapter of Henderson

12. Adjournment

Chair Drozdoff adjourned the meeting at 2:42 p.m.

Public Comment under Item 3:

Peggy Lear Bowen: Good morning and I do appreciate all 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 they're going back through 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 are investigating and checking the comparisons for your HMO provider, Anthem Blue Cross Blue Shield, you need to check to see what they actually pay their specialists 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 the state and I was told that that specialist for 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, or 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's being provided by that company 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 a smoke and mirrors sort of thing, where they say you can go for a whole lot less and we do these sorts of things. But when you are trying to make comparable, what's being offered, what's being saved, what's being expended, you need to include all the real expenditures and all the real savings and if the providers are there. So I went 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 will try to make this brief, in the law it said to keep separate so they can realize how much 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, so the actual orphans. 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 at a larger pool for paying for our medication, for paying for our doctors' visits, for paying for the hospital visits, etc. 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 3, 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's visits, for all the benefits, only by notifying the Legislature how much in reality we were costing the, 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 the rates flat and he said yes and then he listed the state and he listed the spouses and he listed everyone, he listed three groups when he said all rates are flat and then when Mr. Wells went out in the hall and was asked by a reporter, are the rates flat for the orphans, the non-state retirees, he said no, they are going up exponentially 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's what

transpired during those years at the Legislature. And so as a reflection of that the Legislature acted.

In your minutes today, you talked about the fact that the Wellness program was cancelled but it might have been more helpful and you weren't here so you probably were unaware 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, it was a $600 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 needing 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 be 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's 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 and the loss of that Wellness program was not because of anything other than the Legislature felt that their 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 Wellness program incentive and so that's for the record so that everybody can go back and check previous Board Meetings, check previous Legislative Statements and be on board because we have to really re-establish 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're still reeling with how they felt they were treated.

And you can go back through the record of many years when the Executive Director of this Board at that time sat before a Legislative Committee, joint Committee and told them that the Legislature was, that this Board could 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 of that's on the record and can be researched and stated. We need to work really hard to re-establish ourselves as a Board of, 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 that 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, especially now because you've established it. Transparent, open, public and complete in record. You have done an amazing job since Mr. Haycock's coming on board, absolutely amazing. You are 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 costs of the specialists and look at the true providers and the true cost of everything you are 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 that I am older than dirt. Thank you.

Public Comment under Item 10:

Peggy Lear 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 the discussion that took place, all the presentations that you were presented and when Vendors said, here by here by here, that when they were told that they had gotten 0 points in certain areas that had they known they could've better explained that that they did provide things that weren't reflected in their response to the RFP. At the end of all that discourse and at the end of all 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'd been told things in these two crucial meetings where Vendors felt they should not have received 0 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 was 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 that 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'd all received telling you what to do and not to do and it was in 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. Yes. And you guys cannot move. I'm just not, 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 received 0 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 we've had more recent experience with what they do or don't provide. And the idea of hospitalists and what they caused to happen to your medical, you're a captured prisoner in that hospital. Once you go in, your doctors are not notified, nobody's told what's happening with you and you've met Joycee the 97 year old from Verdi who was 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 the hospitalist decided it wasn't life threatening. So basically what it came down to was the all mighty dollar. Social Security, A and B Medicare will pay 80% of the person's bill once they've met the Medicare deductible if they are not admitted to the hospital. If they are admitted to the hospital your insurance pays 80% and the 20% is left to you. Otherwise it's 80% Medicare pays. The cheapest people you shipped off to Utah, your A and B Medicare folk, you only had to pay 20% of what was going. 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 that the plan is set up now, no.

When last time you did all your review and that 45% never changed from the initial, there was never another meeting after more information had been given to the Committee. And we said to have 2 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 suggested to be on that initial Committee who was never brought into that Committee and shame on us for not allowing that to happen and I don't care who did it or why. We need 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 consternation. Because the confusions would of still existed, the RFPs may not have had the right answers on them, that would have still existed. There is nothing that changed except for which Vendor was finally selected and you followed all the rules and it's shame on us if it appears to Peggy Lear Bowen that somebody's been pushing buttons for a long, for 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 that 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 that goes forward. Heck, Anthem could've sued ya, 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've been in place wanted same old same old and were discovering how much that same old same old cost us, how much we actually paid the people to handle the paper not give the shots, the 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.

Public Comment under Item 11:

Peggy Lear Bowen: My name and my words for the record. Thank you very much and have a very very great time until the week of February 15th when we will gather again and Happy Valentine's Day cause we just missed it.