In The Matter Of:

PUBLIC EMPLOYEES' BENEFITS PROGRAM

TELEPHONIC OPEN MEETING

May 19, 2016

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1 PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

2 TRANSCRIPT OF PROCEEDINGS

3 TELEPHONIC OPEN MEETING

4 THURSDAY, MAY 19, 2016

5 CARSON CITY AND LAS VEGAS, NEVADA

6

7

8 The Board: LEO DROZDOFF, Chairman
JACQUE EWING-TAYLOR, Co-Chair
9 CHRIS COCHRAN - Member
ROSALIE GARCIA - Member
10 CHRISTINE ZACK, Member
ANA ANDREWS - Member
11 JIM WELLS - Member
DON BAILEY - Member
12

13 For the Board: DENNIS BELCOURT
Deputy Attorney General
14

15 For Staff: DAMON HAYCOCK
Executive Officer
16 LAURA RICH
Chief Operating Officer
17 CELESTENA GLOVER
Chief Financial Officer
18 KARI PEDROZA
Executive Assistant
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action may be taken. Persons making public
7 comments to the Board will be taken under
advisement but will not be answered during the
8 meeting. Comments may be limited to three
minutes per person at the discretion of the
9 chairperson. Additional three minute comment
periods may be allowed on individual agenda
10 items at the discretion of the chairperson.
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1 THURSDAY, MAY 19, 2016, CARSON CITY, NEVADA
2 -oOo-
3 CHAIRMAN DROZDOFF: We're going to take role call
4 and see who is on the line.
5 MS. PEDROZA: Jacque Ewing-Taylor?
6 MEMBER EWING-TAYLOR: Here.
7 MS. PEDROZA: Ana Andrews?
8 MEMBER ANDREWS: Here.
9 MS. PEDROZA: Don Bailey?
10 MEMBER BAILEY: Here.
11 MS. PEDROZA: Jim Wells?
12 MEMBER WELLS: Here.
13 MS. PEDROZA: Leo Drozdoff?
14 CHAIRMAN DROZDOFF: Here.
15 MS. PEDROZA: Chris Cochran?
16 MEMBER COCHRAN: Here.
17 MS. PEDROZA: Rosalie Garcia?
18 MEMBER GARCIA: Here.
19 MS. PEDROZA: Christine Zack.
20 MEMBER ZACK: I'm here on the line. And I
21 apologize, I can only go for two hours of the meetings.
22 MS. PEDROZA: Okay. Thank you, Christine.
23 And Member Saiz and Verducci are excused today.
24 And we have a quorum.

1 CHAIRMAN DROZDOFF: Great.
2 And, Ms. Zack, we appreciate you're able to
3 balance at least the two hours, and we may be done by then
4 anyway.
5 Is there anything as a new Board member anything
6 you would like to say getting started? This is Leo Drozdoff.
7 MEMBER ZACK: I appreciate the opportunity, and
8 thanks for providing a call in number so I can make my
9 schedule work, that I look forward to meeting everyone in
10 person and working with you.
11 CHAIRMAN DROZDOFF: Great, thanks.
12 I thought I heard Mary Catherine on the line.
13 Are there any other participants on the line on
14 the call? I guess not.
15 All right. Okay. So we have a pretty somewhat
16 brief agenda for today. We'll go right to public comment.
17 We'll do public comment at the beginning and the end of the
18 meeting. Whenever you're ready.
19 MS. BOWEN: Good morning. My name and my words
20 for the record P-e-g-g-y L-e-a-r B-o-w-e-n. I speak quickly
21 because of points of concern. Went to a home -- a Senior
22 Care Plus meeting to discuss our insurance for this coming
23 year. CJ was a representative at the Senior Care Plus
24 meeting and explained to us very thoroughly that the A and B

1 Medicare folk through which people are working and have been
2 part of the group that was sent to Utah as an encapsulated
3 group had been sold to the Utah group. I thought slavery
4 went out with Lincoln, and the selling of human beings was
5 not something that we legally did anymore.
6 And that it made some sense when -- when asked
7 years ago, Mr. Wells was asked that if this program of the
8 Exchange did not work out, could we retrieve back those
9 participants who had been put in this capsule, and now I know
10 the word to use is sold. Would they be retrievable, and his
11 answer was maybe. It was not a yes or a no. It was maybe,
12 and maybe you can retrieve that which you sold to somebody
13 and do away with contracts of that selling if, in fact,
14 that's what happened.
15 If it -- the concern that we have here that those
16 people have hit a donut hole and it was explained to CJ at
17 the Senior Center Care Plus meeting that because of the donut
18 hole and the expense of diabetic medicines that are now being
19 handled differently by Senior Care Plus at least and others
20 that -- that they would just simply have to go home and not
21 have the medicine because they couldn't afford it and they
22 could just die.
23 I'm told at an early meeting on after these
24 changes were made to our insurance program back in about

1 2011, that even in an obituary, and it was read here at this
2 Board but probably not for the record, that the death was
3 hastened of that person who actually trusted and trusted
4 within the state of Nevada and their insurance benefits that
5 their debt was hastened by the change in the program and that
6 which they can no longer afford to do. I'm very concerned
7 about that.
8 I'm concerned that the hospitalists with Renown
9 and the concept that you will not see or deal with any
10 physicians or people that were known to you unless they are
11 -- will not be known to you unless they are the actual
12 hospitalist in the hospital at the time extends to rehab and
13 extended care.
14 You guys have met Joycie my 98-year-old. She was
15 commenced to have a pneumonia shot. 18 days later she went
16 into the hospital with life threatening pneumonia. She is
17 still in medical care, and it took an agreement by a doctor
18 and an agreement by her -- two of her doctors that they would
19 not charge for seeing her. That they -- the skilled care
20 center actually allowed Joycie to be seen by people who have
21 eyes on her before to make recommendations for her care.
22 They were treating her like a 98-year-old who was there to
23 die, not recovering from pneumonia, and now they are treating
24 her has one who is a person in recovery from pneumonia.

1 I am very concerned that we are being kept in a
2 spiderweb like situation where the strings go out. No one is
3 to see. I was told by a hospitalist in a phone call
4 pertaining to Joyce that her doctors would never see her in
5 that hospital or in the extended care because hospitalists
6 were in charge, period, and it took a lot of work to save
7 Joyce's life literally.
8 She was dying with the effects of pneumonia, and
9 they got their three days of medical care in the hospital so
10 the Medicare paid for three days. She was actually admitted,
11 life threatening, and then she was transferred to skilled
12 care where they said they could take care of it there and
13 they were able to admit CPR. She went into distress.
14 The hold that the insurance companies are having
15 on your southern HMO's down in southern Nevada are the type
16 you can't see our doctors if you don't do this. Well, let me
17 tell you, you cannot see your doctors on the high deductible
18 plan or on other plans that are involved. Joycie is not a
19 member of PEBP. I need to make that very clear. It is a
20 hold -- stranglehold where they determine what they want to
21 do with you.
22 They said in the hospital while she was hacking
23 so bad in skilled care that her roommate had to be
24 transferred because she couldn't sleep at night because

1 Joycie was choking on her own eternal fluids, and it has
2 taken everything we know how to do to overrule -- the
3 hospitalist told me on the phone before she left the hospital
4 that she didn't need to see a cardiologist, even though she
5 was in telemetry. She didn't need to see a pulmonologist,
6 even though her lungs were full of fluid and that's the way
7 it was going to be. You know, I don't take the first no as a
8 no.
9 And we finally get something taken care of and
10 the hospitalist to make the appointment for her to see her
11 cardiologist once she was transferred to the extended care
12 only to have extended care not transport her because they
13 didn't recognize what the hospitalist had done in Renown.
14 Well, we got that fixed.
15 I'm telling you -- please -- thank you very much,
16 and I know that was a lot to cover. Don't let -- don't let
17 people die because of following the dollar and them getting
18 paid what the insurance will pay and then kicking them out.
19 It is so important that you keep everyone on this Board
20 working hard to save and protect the lives of the state
21 workers, non workers and others. Please, please, please be
22 vigilant as you have, and thank you for all your hard work.
23 CHAIRMAN DROZDOFF: Thank you.
24 Anybody else? Come on up. Take your time.

1 MS. DYKE: Thank you. Hello there. I am Susan
2 Dyke. I have a 38-year history with you that started from
3 marriage to having a child. I recently just lost my husband.
4 He was retired 38 years from DOT. I cannot afford PEBP
5 anymore. I miss you guys. You helped me through breast
6 cancer. I'm a survivor four years. Unfortunately, my
7 husband did not survive his cancer. He recently died two
8 weeks before Christmas.
9 Where I had an issue was having the shakes, going
10 through trying to have a heart attack and after he died and
11 went down to 82 pounds so I'm in this gray area of losing
12 PEBP and getting once again it's been mentioned already
13 Senior Care Plus. I was not emotionally ready to make a
14 choice of insurances, and the little office here suggested
15 Senior Care Plus. The hardest thing that you ever have to do
16 in your life of marriage is hand somebody a death certificate
17 of a man and make your choices of insurance.
18 I think all of you in this room on this Board
19 need to take a long breath and say, I'm trying to do the best
20 for the state workers. I still have dental through the state
21 of Nevada. I don't like Senior Care Plus. I don't like
22 their out of pocket and their co-pays.
23 My husband was at Carson-Tahoe Hospital, that's
24 what I still call them. When he died, he was in a critical

1 care unit and let his body just pass away gently, and I think
2 that there's too much happening in the world of diseases.
3 There's too much insurance. There's too much co-pays. I
4 think that all of you here are trying to put this large
5 puzzle together without your glasses on. You're putting all
6 of these little puzzles together, and you're trying to make
7 it all come down and land at once.
8 And as the world changes and as all of these high
9 cost of drugs and meds are coming into our lives, we're not
10 able to -- I can't get them. I have rheumatoid arthritis,
11 and I can't afford any of the infusions and any Enbrel. I'm
12 stuck. I'm lost and take a breath. Go home tonight and be
13 glad that you're still alive, that you have insurance because
14 some of us are just struggling past the state, and I'm just
15 here to say thank you. Thank you for my 38 years with you
16 guys. I have a big history. Thank you.
17 CHAIRMAN DROZDOFF: We're very sorry for your
18 loss.
19 MS. DYKE: Me too. He worked very hard for
20 38 years.
21 CHAIRMAN DROZDOFF: Is there anybody else that
22 would like to make a public comment?
23 Okay. Seeing none, we'll go to Agenda Item
24 Three, approval of the minutes.

1 Any comments on the minutes? If not, I'm happy
2 to take a motion.
3 MEMBER WELLS: So move.
4 CHAIRMAN DROZDOFF: I have a motion from Jim
5 Wells. Is there a second?
6 MEMBER BAILEY: Second.
7 CHAIRMAN DROZDOFF: Second from Don Bailey.
8 Any further discussion? Seeing none, all those
9 in favor, please say aye.
10 (The majority of the vote was in favor of the
11 motion.)
12 CHAIRMAN DROZDOFF: Any opposed?
13 Anybody abstaining?
14 MEMBER GARCIA: Rosalie Garcia, abstain.
15 CHAIRMAN DROZDOFF: Okay. Motion carries.
16 All right. So then let's go to Item Four, and
17 this is the changes to the master plan documents and the
18 primary reason why we needed to be here today.
19 So, Damon, I'll turn it over to you.
20 MR. HAYCOCK: So thank you, Chairman.
21 Damon Haycock for the record.
22 I'm actually going to turn this over to Laura
23 Rich, chief operating officer. She worked part on this --
24 these revisions, but most of the effort really goes to Nancy

1 Spinelli, our public information officer, who painstakingly
2 went through each of these hundreds of pages to ensure that
3 we have the most appropriate language possible. And with
4 that, I'm going to turn it over to Laura.
5 MS. RICH: For the record, Laura Rich.
6 As Damon mentioned, this report really just
7 covers the revisions to our plan year 2017 master plan
8 documents. Those are the master plan documents for the
9 Consumer Driven Health Plan, also our dental plan, also the
10 enrollment eligibility requirement document and our HIPAA
11 privacy and security requirements of the master plan document
12 as well.
13 So to summarize, basically staff went through
14 with -- along with some HealthSCOPE recommendation, as well,
15 and made some changes to our -- some revisions to our master
16 plan documents.
17 The first one being the master plan document for
18 the CDHP. As you see, there's not a lot of major changes
19 here. A lot of them were just housekeeping items. You know,
20 a lot of language, clarification and things like that. So
21 I'm not going to go through each one of them, but I am going
22 to touch on some of the more significant plan changes.
23 As I said, some of them were recommendations
24 based on HealthSCOPE's recommendations, and I believe we have

1 Mary Catherine on the line to speak to some of those if there
2 aren't any questions.
3 So the first one is Item 4.1 and that's our CDHP
4 master plan document, and we really just went through -- the
5 Board approved changes. We went through and updated the
6 Pharmacy Benefit Manager information. So where it said
7 Catamaran, we changed it to Express Scripts, and then we went
8 through the plan document, as well, as with all of the other
9 ones to reflect an effective date of July 1st, 2016, through
10 2017, so we changed all of those dates.
11 Per HealthSCOPE, we made a few changes to both
12 the acupuncture and the chiropractic services to require
13 supporting documentation establishing medical necessity after
14 15 plan visits per year.
15 We also based on a HealthSCOPE benefits
16 recommendation changed ambulance services, so they are going
17 to be reviewed for medical necessity, and precertification
18 will be required for scheduled air transportation between
19 facilities.
20 We placed 120 dollar limit on one set of lenses
21 following any cataract surgery on the treatment of glaucoma.
22 We did this because there was no limit and, you know, we got
23 to the 120 dollar figure based on what other plans were
24 offering. So we took an average of the major carriers out

1 there and came up with that $120.
2 We also changed the -- based on the HealthSCOPE
3 recommendation, we changed the policy so that the first bill
4 procedure of the plan year for a colonoscopy will be
5 considered preventative regardless of the diagnosis.
6 And, let's see what else did we do here, the only
7 other major change was we had to align ourselves with the
8 Affordable Care Act requirement, so we changed the individual
9 family member out of pocket max to $6,850.
10 For Item 4.2, which is our dental plan, master
11 plan document, really, they were just housekeeping items. We
12 changed the dates. We changed a few definitions but that
13 was -- those were the only changes in that.
14 And 4.3, which is the enrollment eligibility
15 requirement, master plan document, again, we changed some of
16 the dates. The only major change to that was we updated the
17 qualifying events to include the ability of our PEBP
18 participants that are on Medicaid or eligible for Medicaid to
19 terminate coverage through PEBP, and we did the empers too.
20 So not only can they terminate coverage if they become
21 Medicaid eligible but they can also come back on to our plan
22 if they are no longer Medicaid eligible.
23 And then we just inserted some language regarding
24 our Medicare or regarding the provisions that allows retirees

1 with TRICARE to enroll without enrolling in our Medicaid --
2 Medicare Exchange medical plan.
3 And we just provided some clarification on
4 eligibility for retiree subsidies. Those that are hired
5 initially before January 1st, 2012.
6 And for Item 4.4, which is the HIPAA privacy and
7 security requirements master plan document, again, there were
8 no real major changes. We just changed the dates, and we
9 made one small revision where we replaced the quality control
10 officer with operations officer as the staff contact for
11 complaints.
12 And that's pretty much the gist of it.
13 Recommendations are that the Board approves these revisions
14 to the master plan documents and if there's any questions,
15 I'll take them or we also have Mary Catherine on the line as
16 well.
17 CHAIRMAN DROZDOFF: All right. Thanks, Laura,
18 and thanks, Mary Catherine.
19 I think what we will do is kind of go back to --
20 we'll do these in order, 4.1, 4.2, 4.3, and 4.4.
21 So are there any questions on Item 4.1?
22 Go ahead, Jacque.
23 MEMBER EWING-TAYLOR: Thank you, Mr. Chairman.
24 So 4.1 B, M, be sure and separate those letters, and maybe

1 this is best for Mary Catherine since it's a HealthSCOPE
2 recommendation. Can you sort of walk me through that, Mary
3 Catherine, and what the reasoning was behind this?
4 MS. PERSON: Jacque, this goes to some of the
5 issues we've had regarding folks who were eligible under the
6 PEBP plan. However, they were Medicare eligible or had, in
7 fact, had taken Medicare benefits and when that occurs, then
8 the reality, their HSA, they can no longer contribute to the
9 HSA, and so we were asking to put language in the MPD so that
10 it's clear that that is the rule but also making it more
11 clear because as you know, the language in the prior document
12 could be somewhat confusing to people regarding eligibility
13 so we felt like it would be better to indicate that they
14 would be able to enroll in the HRA in order to receive their
15 PEBP contributions as well.
16 MEMBER EWING-TAYLOR: So this is sort of a
17 clarification and an attempt to make it easier to understand
18 to avoid the issue that we had a year and a half ago relative
19 to I think there were about 60 people who were sort of caught
20 up in that --
21 MS. PERSON: Correct.
22 MEMBER EWING-TAYLOR: -- that mess, if you will.
23 MS. PERSON: Yes, that's exactly correct.
24 MEMBER EWING-TAYLOR: Okay. And could I skip out

1 of order while I've got Mary Catherine's attention?
2 CHAIRMAN DROZDOFF: Sure.
3 MEMBER EWING-TAYLOR: Okay. Mary Catherine, on Q
4 and R.
5 MS. PERSON: Uh-huh.
6 MEMBER EWING-TAYLOR: Could you just sort of
7 again walk me through that. Why are we changing this?
8 What's the -- I didn't have time to read all 200 pages of the
9 master plan.
10 MS. PERSON: I can imagine. All we're doing
11 there is we had our compliance department review the MPD to
12 confirm that the most up to date mental health parity
13 requirements, which mental health parity is a part of the
14 federal law not related actually to APA, but it's a separate
15 component regarding mental health parity, and we had
16 discovered that the plan document did not reflect very
17 specifically for behavioral health treatment facility. It
18 did not have the most up to date language that would be
19 compliant, so it's purely a compliance change there.
20 MEMBER EWING-TAYLOR: Okay. Is that true on both
21 of those?
22 MS. PERSON: The -- true for -- yes, for both of
23 those.
24 MEMBER EWING-TAYLOR: Okay. Okay. Then on the

1 next page in T, we talked -- the verbiage talks a lot about
2 the plan administrator, and I want to be sure we all
3 understand exactly who that is.
4 MS. PERSON: Okay. So the true plan
5 administrator is PEBP. And the reason for T, if you're
6 asking me, I think you were, is that there are specific
7 situations that we get into regarding providers and their
8 billing practices. And so both T and U were simply updates
9 that were our suggestion in order to manage costs of
10 provider. It is not in any way changing the network or
11 anything else, but there are situations where providers bill
12 far outside of what is reasonable or customary, and so that
13 is really what the -- those updates are doing, and part of it
14 is very largely around pharmaceuticals that are being paid
15 through the medical plan.
16 MEMBER EWING-TAYLOR: Okay. Thank you.
17 MS. PERSON: Does that answer your question?
18 MEMBER EWING-TAYLOR: Yeah, it did. That's what
19 I thought. I just wanted to make sure and that was really
20 clear for everybody that that plan administrator is, in fact,
21 PEBP and to have those decisions ultimately rest with the
22 agency as plan administrator.
23 So I think those are all of the questions I had
24 for Mary Catherine, but I do have a few if I could go on?

1 CHAIRMAN DROZDOFF: Yep.
2 MEMBER EWING-TAYLOR: Thank you. So back to N,
3 the updated MPD participants enrolled in the CDHP HRA who
4 change plans and so on and so forth. How many people do we
5 have who are in an HRA and then change to an HSA?
6 MR. HAYCOCK: That's a really good question.
7 This is Damon Haycock for the record.
8 That's an excellent question. And when I read
9 this, as well, I thought I don't know if we're a solution
10 looking for a problem.
11 MEMBER EWING-TAYLOR: Okay.
12 MR. HAYCOCK: Or if we have a problem that we
13 need a solution. I am going to pitch this to Mary Catherine
14 only because I don't have that exact number on hand, but I'm
15 hoping she has a ballpark.
16 MEMBER EWING-TAYLOR: I guess it is back to you.
17 MR. HAYCOCK: You know what, actually, really
18 quick, Damon Haycock for the record.
19 I think this could affect the problem. If people
20 are defaulted into the CDHP HRA, if they do not select the
21 health plan of their choice when they first are initially
22 hired and come to this state and the next year if they want
23 to make a change, then they will often come on to the HSA,
24 and I don't know how many those are either, but we can find

1 out for you, but I think that's one situation where this may
2 be applicable to, and so typically your health reimbursement
3 or arrangement is attached to your plan.
4 MEMBER EWING-TAYLOR: Right.
5 MR. HAYCOCK: That's per IRS. So when you move
6 from one plan to the next, even though it's technically still
7 under PEBP, there's a whole portability discussion I think
8 we're going to have at a future Board meeting. Until then,
9 right now we don't want folks to be under the impression they
10 have an HRA because they defaulted into a plan and if they
11 didn't use all of that and they are moving onto a new plan,
12 it's portable until that discussion comes back to the Board.
13 MEMBER EWING-TAYLOR: Okay. I hadn't even
14 thought about that particular instance. I guess that makes
15 sense except that I think it does go back to the discussion
16 that we were going to have today but has been pushed off to
17 the 17th about essentially portability of those.
18 But this one in particular, I think, doesn't make
19 sense to me. If I default into of the CDHP, I'm still in the
20 CDHP the next year even though I become eligible for an HSA
21 because I am in the CDHP, so it just makes sense to me that
22 those funds would roll into the HSA.
23 Again, it's essentially the same argument I'm
24 going to make on the 17th that, you know, we have told people

1 we're giving you this amount of money. We hope that you
2 saved it, but it's certainly available to be used for your
3 medical expenses except, oh, by the way, because you
4 defaulted in the first time, even though you're not changing
5 plans as far as you're aware, we're going to take the money
6 back, that just doesn't make sense to me.
7 MR. HAYCOCK: So for the record, Damon Haycock.
8 I think I have a potential solution, and my
9 suggestion would be that we -- we table end until we have
10 that conversation and then we can -- we can move forward with
11 a final change to the MPD pending the result of that
12 discussion.
13 MEMBER EWING-TAYLOR: I can live with that.
14 Thank you.
15 CHAIRMAN DROZDOFF: But before we move on from
16 that, since it is going to be a part of a larger discussion,
17 I'm just curious, is there another scenario, Mary Catherine,
18 maybe I'll look to you or to Laura or Damon. Is there
19 another scenario we're trying to fix with this or was that
20 it?
21 MS. PERSON: I think our recommendation was
22 really in M. I think N is really up to you guys regarding
23 how you want to manage that. But you do actually have a
24 little more than 200 folks who sort of fall -- who could fall

1 between this HRA versus HSA situation today. So, you know,
2 we're -- they are not -- so, you know, it continues to be an
3 item and that's the reason why I think it needs to be --
4 there needs to be some more clarification around it which is
5 really the intention of M and then obviously N is really
6 another discussion as well.
7 MEMBER EWING-TAYLOR: So, Mary Catherine, those
8 200 people, are they the ones that Damon was referring to who
9 possibly defaulted into the CDHP and have an HRA for that
10 reason or is this the group that comprises that Medicare
11 eligible group as well?
12 MS. PERSON: These are folks who are Medicare
13 eligible at some point who now also have an HSA. Now, that
14 doesn't mean they are not correctly where they are because it
15 could be that -- and these also include people, to include
16 people who are going to agents and Medicare in June. So this
17 is from a report that we produced for PEBP so that during
18 open enrollment this year, we can help eliminate some of this
19 problem by moving these folks back to an HRA during the
20 enrollment period.
21 MEMBER EWING-TAYLOR: Okay.
22 MS. PERSON: Did I answer your question, Jacque,
23 I'm sorry?
24 MEMBER EWING-TAYLOR: Yeah, I think so.

1 MR. HAYCOCK: So for the record, Damon Haycock.
2 I think this can become a very black and white
3 discussion on portability and if it isn't portable, then we
4 need to have this clarifying language in there. And if it is
5 portable, we need to clarify that language regardless if it
6 affects one participant or 10,000. I think we need to do our
7 participants justice by clarifying this. It's a very
8 confusing kind of nebulous situation sometimes.
9 Folks think certain things are a certain way. We
10 want to make sure we are always transparent and clear. So I
11 think, again, I'm going to stay with my recommendation that
12 we table end and we bring it back and we have that
13 conversation and from the Board's direction, we will update
14 the MPD accordingly.
15 MEMBER EWING-TAYLOR: Okay. I think,
16 Mr. Chairman, that's all I had on that first section.
17 CHAIRMAN DROZDOFF: Is there anybody else that
18 has questions on 4.1?
19 Ana?
20 MEMBER GARCIA: Mr. Chairman?
21 CHAIRMAN DROZDOFF: Who is that on the phone?
22 MEMBER GARCIA: Rosalie.
23 CHAIRMAN DROZDOFF: Okay. Rosalie, we'll go to
24 you.

1 MEMBER GARCIA: I may have missed this, but on
2 Item M, where discussion with regard to when the employee
3 will be eligible to enroll in the HRA to receive PEBP
4 contributions, would they be able to do that midyear? For
5 instance, the plan reserves the right to seek processing
6 employee contributions to the HSA for the remainder of the
7 plan year. At that time, would the employee then be eligible
8 to enroll in an HRA or would that employee have to wait?
9 MR. HAYCOCK: So for the record, Damon Haycock.
10 And I need Mary Catherine to validate this, but
11 my understanding is that when you select a CDHP at the end of
12 the year and you enroll in an HSA plan, you get your initial
13 HSA funds deposited into your account. If you lose
14 eligibility to contribute to the HSA, it doesn't mean that
15 you lose eligibility to receive distributions from the HSA,
16 and those distributions versus contribution is kind of the
17 crux of the issue. And so you can still use your HSA, even
18 if you were to go to say an HMO plan later on, but I don't
19 want to digress into something else.
20 My understanding is for -- for an operational
21 standpoint for you to have an HRA would mean that you would
22 have that credit limit, that available funding. Again, and I
23 think to eliminate the process of having two sets of funds
24 double dipped to that participant for that initial change

1 that year, that if you were provided your HSA funds that you
2 remain on the HSA plan, but you are just no longer allowed to
3 contribute to it and then on the next year, you will default
4 into the HRA plan if you do not select or positively enroll
5 in an HMO, but this will prevent you from having your HSA
6 dollars commingled with your HRA dollars.
7 Mary Catherine, is that how you see it as well?
8 MS. PERSON: Yeah. Mary Catherine Person for the
9 record.
10 I think that the main piece here is that the
11 folks aren't -- they enroll in the HSA plan, but the reality
12 of it is they are not eligible to put funds in an HSA and so
13 they -- and, in fact, their contribution even from PEBP
14 really can't go into their HSA. And the unfortunate thing is
15 that it's based on a way that eligibility rules work and plan
16 rules work, people, you know, during open enrollment really
17 need to make those changes or at the point of a qualifying
18 event, and so that's part of the reason why we're trying to
19 encourage those folks toward the HRA so that we're not making
20 contributions to an HSA that's not freely tax deductible and
21 can create other tax consequences.
22 MEMBER GARCIA: Rosalie Garcia again.
23 So in effect, we -- the employee would have
24 anticipated contributing money to an HSA but due to some

1 event, they would no longer be eligible nor would they be
2 eligible to continue making contributions for their medical
3 care towards an HRA; is that correct?
4 MS. PERSON: Mary Catherine Person for the
5 record.
6 Under an HRA, the employees cannot make
7 contributions, so they can only make contributions in the
8 HSA. But the issue and the problem is when they turn 65 and
9 begin Medicare Part A eligibility, is the issue that comes
10 into play and requires the fact that they can no longer
11 contribute to the HSA nor receive contributions in the HSA.
12 MEMBER GARCIA: Rosalie Garcia again.
13 Can you give any examples where a member would be
14 required -- where it would be detrimental to the member?
15 That's what I'm looking for. I'm looking to see how this
16 would hurt our members.
17 MS. PERSON: Mary Catherine Person for the
18 record. I think the issue here really is to Damon's point
19 around portability. So currently we're stuck. So both PEBP
20 and HealthSCOPE can do nothing with those folks that are in
21 an HSA plan. But the way the plan is written, the way the
22 IRS rules are written, we don't have the ability to give
23 those dollars to them in their HRA, and so we're just sort
24 of, we're stuck is my only good term for it.

1 So I think that that's really the conversation
2 around portability that if somebody would come non HSA
3 eligible in allowing the funds to go to go to an HRA or
4 something of that nature, I think it probably is the
5 conversation of Damon. Do you agree?
6 MR. HAYCOCK: Yeah. For the record, Damon
7 Haycock.
8 I do, but I think I want to answer Rosalie's
9 question a little bit differently. I'm going to try to
10 simplify because this is a very confusing topic for folks who
11 don't live and eat it everyday and even though they do, it
12 gets confusing.
13 What would be detrimental, so imagine Damon
14 Haycock enrolls in the CDHP plan here on July 1st with an
15 HSA. I get my HSA contributions from the employer. I start
16 making my maximum contributions, I can do that on July 1 for
17 the year. And on my birthday, on August 17th, I turn 65 and
18 I'm now eligible for Medicare. I -- once I'm eligible for
19 Medicare, nobody is allowed to contribute to my HSA, I can't.
20 PEBP can't contribute to it. No one is allowed to contribute
21 to it because it is attached to me, and so now I'm no longer
22 eligible for it, but I'm allowed to receive distributions
23 from it.
24 Now, what would be detrimental, Rosalie, is if

1 for some reason we collectively, HealthSCOPE, PEBP, we
2 collectively fail to inform and fail to ensure these people
3 do not contribute to their HSA, every dollar they contribute
4 after Damon Haycock turns 65 is considered taxable, and now I
5 have to report it on my taxes per the IRS at the end of the
6 year. If we don't have a mechanism to capture this, then
7 Damon Haycock may not even know that he has a taxable income
8 in his HSA.
9 So it's really an IRS rule that could be
10 detrimental to the participant, and it gets even muddier, and
11 I won't get into it, where you can pause or stop your HRA or
12 whatever, and I know --
13 MR. BELCOURT: Suspend.
14 MR. HAYCOCK: Yes, suspend. Thank you, Dennis.
15 I mean, there's other issues. But to answer your
16 question point blank, you know, if you think about it this
17 way, HSA has a lot more restriction requirements to be
18 utilized versus an HRA and the reason is you get to take that
19 HSA wherever you go.
20 So if you think of it more like income, your HRA
21 is like your credit card, your credit limit. You don't
22 really have cash on it, but you have the ability to spend it.
23 But once you leave, your -- today -- we'll talk about
24 portability another day, but once you leave, that credit

1 limit gets wiped clean. But if you leave PEBP today with an
2 HSA, you get to take it with you and use it for any
3 qualifying medical expenses per the IRS. So they treat those
4 two things differently, so it gets pretty muddy, and I've had
5 conversations before where it gets real confusing.
6 But to be detrimental is to allow -- knowingly
7 allow one of our participants to incur a tax burden that we
8 can prevent, and so I think that's the whole crux behind this
9 issue.
10 I hope that answers it a little better, Rosalie.
11 MEMBER GARCIA: Hi, this is Rosalie Garcia again.
12 Yes, thank you very much. That was very clear.
13 I appreciate that.
14 I would hope that when our members sign up or
15 re-enroll for their HSA that there is a box that they would
16 check with that kind of information before we allow them to
17 sign up for the HSA, but that's for another day, I believe.
18 Thank you for that. I appreciate it.
19 CHAIRMAN DROZDOFF: Anything else on 4.1,
20 Rosalie?
21 MEMBER GARCIA: Actually, yes, there is. On I,
22 Item I, I am weary about the limit of $120 for lenses. I
23 have -- being a lens wearer, I know they are very expensive,
24 and I know that HealthSCOPE considered all of these factors,

1 but I would hope that the 120 isn't just because that's
2 what everybody else is doing, and that we would have really
3 considered the actual cost for the first pair of lenses after
4 surgery. That's my only comments. Thank you very much.
5 CHAIRMAN DROZDOFF: All right. We'll come back.
6 Is there anybody else on the phone that has
7 comments on 4.1?
8 MEMBER COCHRAN: Mr. Chair?
9 CHAIRMAN DROZDOFF: Go ahead, Chris.
10 MEMBER COCHRAN: Just a question on F, ambulance
11 services.
12 CHAIRMAN DROZDOFF: Uh-huh.
13 MEMBER COCHRAN: A couple of things, if an
14 ambulance service is deemed not medically necessary, then
15 that charge falls back on the patient, correct?
16 Mary Catherine, you probably should answer that
17 question.
18 MS. PERSON: Mary Catherine Person for the
19 record.
20 Yes, it could, and really what we're adding here
21 is giving us the ability to look at these items for medical
22 necessity. But the larger piece here is really the last
23 sentence, it says precertification required for scheduled air
24 transportation which means facilities.

1 Because of the -- and this does not include --
2 let me make sure this does not include any type of emergency
3 situation. So we're not trying to pre-certify somebody on
4 the side of the road and we are saying we need to pre-certify
5 that. What we're trying to do is say a person is in a
6 facility and they are going to be transferred to another
7 facility, what we want to do is pre-certify that.
8 The real reason we want to do that is so then we
9 can negotiate a price up front because the difference between
10 negotiating a price up front and then if we receive any bill
11 for them back in, it's pretty dramatic to the point that you
12 all actually had an air ambulance bill more than $500,000
13 that the actual -- if it had been negotiated, it would have
14 been a little less than 25,000.
15 So, and you all have a good bit of your ambulance
16 use just because of the rural nature of the state, and so
17 that's the reason why we want to put that language in place
18 so that we have -- and remember that the MPD is used to
19 assist in the management of your claims and that's really the
20 reasoning for that.
21 MEMBER COCHRAN: Okay. Well, that speaks to my
22 second question on that topic on transportation between
23 facilities. So in the event that an individual had some sort
24 of emergency and was transferred to a facility and then

1 deemed it was -- then the patient is being transferred to say
2 a rehabilitation facility then that transportation to that
3 rehabilitation facility based on what it speaks to me in the
4 language in this would require precertification. And if that
5 is the case, who is responsible for doing that
6 precertification because I can't imagine that the patient in
7 the hospital or other facility is thinking, oh, I have to
8 call my PEBP to see whether or not they will pre-certify this
9 transportation. So that needs to be clear to me because
10 these things can happen after the fact.
11 MS. PERSON: Mary Catherine Person for the
12 record.
13 So the way that would typically transpire is that
14 in any type of precertification and ongoing concurrent review
15 in this discharge planning, any of these type of
16 conversations regarding transportation between facilities are
17 typically discussed.
18 And the type of situation where you were
19 referencing where you're moving from a facility to a rehab
20 facility, I do believe that's going to be ground ambulance.
21 So in those situations, they are fairly reasonable to start
22 with and some situations in Nevada, they are typically very
23 reasonable. So that's not really the area that we're focused
24 on.

1 It's much more transportation between facilities,
2 where it's acute care to acute care are really the areas and
3 so -- but it is not in any situation that would be emergent.
4 MS. ZACK: Chris, I apologize for interrupting,
5 but I have the same question that he does. Why doesn't it
6 say nonemergency ambulance services that it's really
7 incumbent to address the service?
8 MS. PERSON: Mary Catherine Person for the
9 record.
10 I believe that can be certainly added there as
11 well. So I don't think that would not -- from a legal
12 perspective, I don't believe that would be a problem at all
13 because that's truly what we're trying to work through are
14 non emergent situation.
15 MS. ZACK: Thank you. I apologize, Chris.
16 MEMBER COCHRAN: That's okay. Just as a
17 follow-up, then this only applies to nonemergent cases and,
18 again, though, you know, recognizing that somebody is
19 explaining the benefits, you know, you got a patient in the
20 hospital who is a PEBP member. You have a PEBP member in the
21 hospital and they are not thinking about things like that,
22 who they have to call.
23 So who -- who will be responsible for making
24 those inquiries for negotiating that transportation? Is that

1 going to be up to the patient?
2 MS. PERSON: Typically when -- I'm sorry, Mary
3 Catherine Person for the record.
4 Typically, in a situation where you require
5 precertification, a provider takes responsibility for that.
6 And most of the entities ask that question before they
7 transport a patient. So if it requires precertification that
8 starts a conversation.
9 MEMBER COCHRAN: Who do they ask the question to
10 because I'm just concerned the patient isn't going to know.
11 So who do they ask that question to? Do they call -- do they
12 ask the patient the name of the patient's insurance provider
13 and then call the insurance provider themselves or do they
14 ask the patient and the patient either knows or doesn't know?
15 MS. PERSON: Mary Catherine Person for the
16 record.
17 They would contact HealthSCOPE benefits in that
18 situation. They would call us to verify benefits. They want
19 to get paid, and so they are very diligent about calling to
20 confirm this money is actually eligible for the plan. And
21 then having this precertification requirement will assist us
22 in being able to receive that information on the front end
23 versus, you know, perhaps after the fact.
24 MEMBER COCHRAN: Okay. One final question on

1 this because, you know, there's always a lot of uncertainty
2 when it comes to the final billing after a patient has been
3 discharged. Let's say the -- I just want to make sure the
4 plan member is not going to be held liable for any additional
5 charges, say that the ambulance service doesn't contact PEBP,
6 PEBP says -- HealthSCOPE says, well, we're not going to pay
7 you for this. This has to be precertified and then the
8 ambulance service turns around and charges the patient for
9 the additional charges, so I just want to make sure that's
10 clear.
11 In these circumstances when people need to -- you
12 know, they are not even thinking about these types of things,
13 at least that's my guess, unless you're an insurance expert,
14 they're not thinking about these types of things. So I want
15 to make sure whatever happens in a situation like this is not
16 going to fall back on a PEBP member for additional charges or
17 having to hassle with additional charges.
18 MR. HAYCOCK: For the record, Damon Haycock.
19 Let me see if I can pinch hit for Mary Catherine
20 on this one. You are correct, Dr. Cochran, that in a typical
21 scenario, and I'm going to paint a different picture, an
22 individual wants to see a doctor outside of the network and
23 they are --
24 MEMBER COCHRAN: I want --

1 MR. HAYCOCK: I'm sorry?
2 MEMBER COCHRAN: Never mind. Go ahead.
3 MR. HAYCOCK: I was going to say that, you know,
4 when an individual, and this happened to us, wanted to go see
5 a specific doctor that was recommended to him and that was
6 not part of the network offering and then was very surprised
7 to find out that they have to pay non network costs.
8 But let's also not forget that these hospitals,
9 and we're really talking about these nonemergency type of
10 visits, but hospitals and providers aren't in the business to
11 try to balance bill patient knowing that the patients don't
12 have the money to pay them.
13 So I think a lot of these issues, as Mary
14 Catherine mentioned, are going to be worked out ahead of
15 time. It just sets the stage so we don't get a massive bill
16 like we did for 500 plus thousand dollars where we probably
17 could have bought the plane for that, let alone, you know,
18 flown one person from one state to another.
19 And so it's to protect. It's actually to protect
20 the participant, not to place them in any harm or any
21 requirement that PEBP doesn't want to pay and so, therefore,
22 we are pushing the burden onto the participant. It's really
23 to ensure that the billing practices are sound and in place
24 prior to the individual moving over there. And then if the

1 individual decides I still want that ambulance, I broke my
2 arm, and I'm at Carson-Tahoe and I want to go to Renown and I
3 want that ambulance and I'm okay with it, then, yeah, it will
4 be billed to the individual.
5 But most folks, it's my understanding, you know,
6 follow the guidance of their doctors and their providers and
7 their provider, as Mary Catherine said so eloquently, want to
8 get paid, and they don't want to get paid by participants.
9 They want to get paid by insurance plans. And so this is
10 just a mechanism, Dr. Cochran, to help this process and to
11 not tie our hands into accepting what comes down the line and
12 then fighting it out in court or through after the fact
13 negotiations. So I hope that answers some more.
14 MEMBER COCHRAN: Chris Cochran for the record.
15 Well, it doesn't necessarily answer for me. I
16 know that there are a lot of cases where individuals would
17 use an ambulance inappropriately and they will call EMS for
18 something that may be nonemergent and the ambulance takes
19 them to their nearest facility. And, you know, I'm all about
20 trying to control those types of things as well.
21 What I'm more concerned about is whether or not,
22 you know, because this requires some sort of understanding of
23 the types of things that patients can see under their plan,
24 and I'm just worried that the single IRS episode that you're

1 talking about certainly won't prevent those, but I have a
2 feeling there may be a whole bunch of littler cases where
3 they are transferred between facilities or who have
4 nonemergent care and they don't know.
5 And I just want to make sure that, you know,
6 there is some sort of contact between the plan administrator
7 and the provider in this case because I doubt that EMS is
8 going to say when it comes to somebody's house, well, this
9 really isn't an emergency, so but we will transport you, but
10 you need to contact your -- I don't know if I'm
11 misunderstanding, but you need to contact your insurance
12 provider to see if they will pay for this because I don't
13 think we can do that but -- go ahead.
14 MS. PERSON: I'm sorry, Mary Catherine Person for
15 the record.
16 What we're trying to work here is not those, you
17 know, ground ambulance from the person's house to, you know,
18 a local facility five miles away or something like that.
19 This is much more, and the single example that we talked
20 about is actually one of many examples that we could give you
21 recently regarding ambulance. I know a plan. There are
22 significant costs around that and so it's not to restrict
23 that type of care when it is appropriate.
24 The issue is that you have had situations that

1 were not appropriate and the provider, we need some kind of
2 teeth for the provider in order to keep the providers frankly
3 honest in the process.
4 MEMBER COCHRAN: Okay. I would just like to see
5 the language in that, you know, perhaps be a little bit more
6 clear. I don't know if it's possible to make it more clear,
7 but how you do that, you know?
8 CHAIRMAN DROZDOFF: Well, Chris, I think we've
9 gone round and round. If the language -- if you have some
10 language you want to propose, I think people would be
11 interested in hearing it. If you want to talk more off line
12 with Mary Catherine and Damon, as we are with 4.1 B, N, we
13 can table this and bring it back next time, this one specific
14 item. But, you know, I do want to try to move a little bit.
15 So you tell me what you want to do.
16 MEMBER COCHRAN: Well, I'll talk to -- I'll work
17 with Mary Catherine and Damon. I think it will be faster
18 because I'm not going to come up with any language.
19 CHAIRMAN DROZDOFF: So you would like to pull 4.1
20 B, F?
21 MEMBER COCHRAN: Let me see, yeah, probably.
22 CHAIRMAN DROZDOFF: All right. Anything else on
23 4.1?
24 MEMBER COCHRAN: No, that's it.

1 CHAIRMAN DROZDOFF: Ana?
2 MEMBER ANDREWS: Thank you, Leo.
3 Ana Andrews for the record.
4 I just want a clarification on 4.1 B and Rosalie
5 asked one of my questions but when an employee turns 65 and
6 transitions from the HSA to the HRA, is he or she made aware
7 of the balance left in their HSA? That's my first question.
8 And the second question is as the HRA kicks in,
9 do you have to use up those HSA funds first before the HRA
10 are used? That's my question on that one.
11 MR. HAYCOCK: So for the record, Damon Haycock.
12 I'm going to answer the first one, and I think I
13 know the answer to the second but I want Mary Catherine to
14 validate. But the answer to the first one is is an
15 individual made aware of their HSA? Every month that you
16 have an HSA, HealthSCOPE sends out a notification that says
17 go and check your balance basically if it exists, and so that
18 will be there.
19 From my own personal experience, I was on the
20 Consumer Driven Health Plan years ago, and I moved on to HMO,
21 and I still got those notices that said, you know, you still
22 have an HSA balance. When I came back to the plan, I was
23 able to keep that HSA balance because it's its own function.
24 It's its own separate living being right there.

1 Now, what gets tapped first is your second
2 question. I believe -- I believe that it starts with the --
3 with the HRA, but I want Mary Catherine to confirm.
4 MS. PERSON: I'm sorry, Mary Catherine Person for
5 the record.
6 If a person has both an HSA and an HRA, the
7 member actually would have the ability to make a decision
8 about where they wanted those dollars to come from. If they
9 are in a qualified plan and they still have HSA dollars, they
10 can send those dollars or they could save those dollars for
11 later in retirement. That would really be up to the member.
12 Currently under the rules, the reality is that it
13 would probably make more sense to use the HRA dollars first
14 and then hold onto the HSA dollars into the future because
15 the HSA dollars are their own funds versus the HRA dollars
16 are the plan funds.
17 MR. HAYCOCK: So for the record, Damon Haycock.
18 Actually, I have a question for you, Mary
19 Catherine. I think this may be very revealing. If an
20 individual has an HSA plan at the beginning of the year and
21 can no longer contribute mid year and they are on the HRA and
22 the next year they are on the HRA plan, you guys don't give
23 out two cards, right? It's one HealthSCOPE ATM style credit
24 card. What fund is defaulted to be spent first.

1 MS. PERSON: I believe, though I will need to
2 verify this, that for the HSA at that point and so the card
3 actually would work for the HRA at that point in time and the
4 HSA funds if they wanted to utilize those. I believe they
5 would have to utilize those on the more manual request, but I
6 will confirm that. Does that make sense? So the card then
7 becomes an HRA card. The HSA dollars then they would request
8 those funds to come out on a more annual basis so either with
9 a paper request or on the website request reimbursement
10 specifically from their HSA.
11 MEMBER ANDREWS: Thank you. Ana Andrews for the
12 record.
13 The reason I ask the question is because I know
14 someone who was told he had to use his HSA money first and
15 empty that and then start with HRA, but that's just a
16 comment. It hasn't happened recently. That happened two
17 years ago.
18 My second question is about M and this is also
19 just for my own information -- I'm sorry, on T, halfway down
20 T, it states that finding a provider with negligence and/or
21 malpractice is not required for services and or fees to be
22 considered reasonable.
23 And my question is about the malpractice part of
24 it. Who has the onus to pursue a malpractice claim? And the

1 reason I'm asking that is does the state, does PEBP
2 subrogate, how is that handled? And is it somewhere in the
3 plan that it is clarified that if I as a patient believe of
4 being a victim of the malpractice claim, is it the onus on me
5 to pursue that?
6 MR. HAYCOCK: So for the record Damon Haycock.
7 Go ahead, I figured you would chime in. So, Mary
8 Catherine, you can answer that first. I do know that when
9 PEBP is notified, we discover that there's potential, I'll
10 use another term, fraud, right, in submitting claims on
11 behalf of the participants, that we take those situations
12 very seriously, and that we actively pursue any type of
13 consequences. How that looks, I'm still trying to get my
14 feet wet on what that's going to look like, but I know we
15 have a current situation that we're looking into right now.
16 But, no, I can't imagine any opportunity where we would say
17 too bad so sad, go for it, participant, and figure it out on
18 your own type of scenario.
19 So, Mary Catherine, could you please answer the
20 other part of it on that malpractice and subrogation
21 specifically because you guys, we use, of course, your third
22 party entity to manage subrogation.
23 MS. PERSON: Yes, Mary Catherine Person for the
24 record.

1 When you have a situation that is regarding
2 provider negligence or malpractice, it is actually up to the
3 patient if they wish to file some type of specific suit
4 against the provider. However, in consultation with PEBP, if
5 there is a situation where we believe that that provider
6 negligence or perhaps malpractice costs the plan money but
7 this would also be in consultation with the patient, then it
8 is possible and we have in some situations, I don't believe
9 for you guys but for other clients, actually file suits in
10 those situations.
11 It is more typical in those situations that the
12 patient is the person who truly files in those situations,
13 and then we become -- the plan becomes a party to this. I
14 don't know that that's the correct legal terminology, Dennis
15 can tell us that, but that's typically the way it works. The
16 patient has a much better chance of those coming to fruition
17 than the plan does if we pursued it ourselves.
18 MEMBER ANDREWS: Thank you.
19 CHAIRMAN DROZDOFF: Anything else on 4.1?
20 MEMBER WELLS: Yeah.
21 CHAIRMAN DROZDOFF: Go ahead, Jim.
22 MEMBER WELLS: This is Jim Wells for the record.
23 Staying with that exact sentence, is that
24 sentence correct or should it be not reasonable at the end?

1 Finding a provider negligence and/or malpractice is not
2 required for service and/or fee to be considered reasonable.
3 I think it should be not reasonable.
4 MR. HAYCOCK: For the record, Damon Haycock.
5 I believe you are right, Mr. Wells, and it's a
6 grammatical issue, and we need to clean that up, but I think
7 the intent is understood that we are not going to pay a
8 reasonable cost if it's due to malpractice or negligence, and
9 we'll ensure that we clean that language to be a little
10 clearer.
11 MEMBER WELLS: Going up higher, if there's a
12 provider error mistake, it's basically that's going to be
13 determined to be not reasonable. So, therefore, if you have
14 a finding of negligence and/or malpractice, it's
15 automatically going to be not reasonable, but it may also not
16 be reasonable if you don't have a finding of malpractice or
17 negligence. So that was -- that was my question on that
18 particular one.
19 I do have a couple of others, Mr. Chairman.
20 CHAIRMAN DROZDOFF: So before you move on from
21 that one, can we try to fix that? Can we -- what would that
22 language look like?
23 MEMBER WELLS: I think you would just add not
24 between considerable and reasonable.

1 CHAIRMAN DROZDOFF: You have not then twice.
2 MEMBER WELLS: I understand or you could use
3 unreasonable, but they tried to use reasonable as a
4 definition, therefore, it's capitalized. Still using
5 unreasonable would be slightly.
6 CHAIRMAN DROZDOFF: Well, how about we change it
7 for not but direct staff -- well, hopefully when we get to
8 approving this, direct staff to give them the latitude to fix
9 this language, but I would like to at least catch it as for
10 now at least not reasonable so that it is clear moving
11 forward.
12 All right. Go ahead, Jim.
13 MEMBER WELLS: Thank you, Mr. Chairman.
14 Letter G under B, is that also part of the mental
15 health parity equity adjustments?
16 MR. HAYCOCK: I'm sorry, can you repeat that. I
17 apologize.
18 MEMBER WELLS: Letter G underneath B, staff
19 clarification, the HealthSCOPE benefit recommendations, is
20 that also part of the compliance with the mental health
21 parity act?
22 MR. HAYCOCK: Mary Catherine, this is Damon
23 Haycock for record.
24 Can you address that, please, as it is your

1 recommendation. I believe it is, but I don't want to speak
2 on their behalf.
3 Mary Catherine, you're on the phone still, right?
4 MS. PERSON: I'm sorry. I was on mute. So can
5 you clarify the letter that Jim is asking about. I'm hearing
6 D but that is not the correct one.
7 CHAIRMAN DROZDOFF: G as in George.
8 MEMBER WELLS: Yep, there you go.
9 MS. PERSON: G as in George, thank you, sorry.
10 Yes, G as in George is related to mental health parity as
11 well. So there were currently issues regarding some of the
12 intermediate level of care for those services and the
13 language that was in the MPD not being in compliance.
14 MEMBER WELLS: Perfect, thank you.
15 Letter P as in Paul, about midway through --
16 about midway through the paragraph, it says this plan of
17 allowable expenses shall in no event exceed the other plan's
18 allowable expenses. Can you give me an example of that? I
19 mean, what I'm thinking is you have a Medicare aid retiree
20 who is not eligible for part A but has purchased part B. So
21 they are -- so they are retired. They are not active, so
22 Medicare is primary.
23 So would you use in that case a Medicare
24 allowable as the plan allowable and does that create problems

1 for us inside the plan?
2 MS. PERSON: Mary Catherine Person for the
3 record.
4 No, this is not regarding Medicare eligibility.
5 This is regarding as far as coordination of benefits, this
6 would be utilized in a non Medicare coordination of benefits
7 type of situation.
8 So perhaps your plan member is covered by another
9 plan as well on a primary basis, say an Anthem plan and for
10 that particular service, Anthem's allowable is less than the
11 allowable through your statewide network and so in that
12 situation, we would use the Anthem allowable as the amount,
13 the base amount for what the allowable would be for that
14 particular claim.
15 It's a pretty typical way that we manage
16 coordination of benefits today. It's not been clear in some
17 of your prior documentation which is the reason we made this
18 suggestion.
19 MEMBER WELLS: But it does not apply if it's a
20 Medicare primary claim?
21 MS. PERSON: That is correct, it would not apply
22 for Medicare primary.
23 MEMBER WELLS: Do we need to clarify that in this
24 definition?

1 MS. PERSON: We certainly can.
2 MEMBER WELLS: Okay.
3 MS. PERSON: We can just add a sentence that says
4 not to apply to Medicare primary or something of that nature.
5 MEMBER WELLS: Okay. Under letter S, as in Sam,
6 would this have fixed the problem that we had with the bill
7 less than -- billed less than allowable on the St. Rose
8 Dominican or St. Rose Hospitals?
9 MS. PERSON: Yes, it would, especially given that
10 last part -- this is Marie Catherine Person for the record.
11 Given the last bullet blank, the actual bill
12 charges for the covered services, yes, that would, in fact,
13 assist with that.
14 MEMBER WELLS: And that wouldn't be a problem
15 underneath our -- the contracted rates.
16 MS. PERSON: As you know -- I'm sorry. As you
17 know, there are various contractual situations. I think, as
18 you also know in that situation, we use this level of
19 thinking though did not have this in the plan document.
20 MEMBER WELLS: Okay. That's all, Mr. Chairman.
21 CHAIRMAN DROZDOFF: Anybody else? All right.
22 Come on up. Let me check.
23 Are there any other Board comments on 4.1?
24 MS. LOCKARD: Thank you, Mr. Chairman, and I

1 apologize for not catching this earlier, but I have a
2 question on Item R on chiropractic services. It says the new
3 definition is medically necessary when all three are met.
4 And number three indicates improvement documented within two
5 weeks of chiropractic care, and that strikes me as a pretty
6 high threshold to reach that you would see improvement with
7 just two weeks of care on some chiropractic situations.
8 MR. HAYCOCK: For the record, Damon Haycock.
9 Mary Catherine, I know this is another one of
10 your recommendations but is that two-week time frame based on
11 industry standard or was it just trying to put a cap on folks
12 that may or may not necessarily meet the services but want to
13 use them, and I know what you're getting at, Marlene, and I
14 think that's a very fair question. Some folks require more
15 time and service to receive the results that they need. I'm
16 hoping you may be able to give us some of the background to
17 this specific two-week time frame.
18 MS. PERSON: Yes, Mary Catherine Person for the
19 record.
20 That is an industry standard. However, if you
21 guys wanted to change that to four weeks or something,
22 there's no issue around that. What we were trying to do
23 within the chiropractic benefit is the prior chiropractic
24 benefit was pretty generic, and so it was very specific that

1 maintenance services are not covered under the plan. And as
2 a result of that, it has been somewhat difficult for us to
3 get providers to provide enough clinical documentation to
4 confirm whether those services are maintenance services or
5 whether, in fact, those are treating an acute problem, and so
6 that's the reasoning behind adding this additional language
7 there, but the time frame is an industry standard number but
8 it can very easily be changed somewhat.
9 Again, because of the fact you don't cover
10 maintenance services, that was the reason it was more
11 aggressive probably than the two-week version, but there's no
12 reason that you couldn't make it four weeks if you would
13 prefer.
14 MEMBER EWING-TAYLOR: Mr. Chairman, it would seem
15 to me having been a former chiropractic patient 30 years ago
16 that it would be more appropriate to put the number of
17 visits. If you're only seeing a chiropractor once a week for
18 a problem, two visits which equates to two weeks or four
19 visits which would equate to the four weeks may not be
20 sufficient, so perhaps we should say before initial visits or
21 something along those lines.
22 CHAIRMAN DROZDOFF: So that's an idea. The other
23 idea is I'm wondering, Mary Catherine, if it makes sense to
24 just say what you just said in R which is that this is not

1 for -- you know, this is for an acute condition. This is not
2 for, you know, some sort of ongoing maintenance. I don't
3 know.
4 MS. PERSON: Mary Catherine Person for the
5 record.
6 If you also note, go back up, I believe it is
7 Number H, as in hand, we could also add the chiropractic
8 services were updated to require supporting documentation and
9 establishing necessity after 15 visits within the plan year.
10 And so honestly if you guys are more comfortable, as long as
11 you keep H, you could actually take that third component
12 either out of this for now or, you know, put out the time
13 period.
14 You know, part of the situation is that there are
15 some providers who are more aggressive with their treatment
16 and so they may actually do five treatments in the first week
17 or ten treatments even in the first two weeks of care, and so
18 that was part of the reason for using a time period when this
19 versus number of visits.
20 MR. HAYCOCK: For the record, Damon Haycock.
21 Perhaps a kind of a middle ground would be to
22 leave H as it is because I think having a cap has some
23 benefit and taking number three out. And if it turns out
24 that we start to see kind of a run on this, that we adjust it

1 next plan year or it becomes a major issue mid plan year, and
2 that would be my suggestion.
3 CHAIRMAN DROZDOFF: All right. Is there anything
4 else on 41?
5 MS. PERSON: I do have an answer back on the HRA,
6 HSA piece.
7 CHAIRMAN DROZDOFF: Sure.
8 MS. PERSON: If you would like to. So the card
9 actually does still work, but HRA dollars would be primary on
10 the card, and the HSA dollars would be -- would come in after
11 the HRA dollars were depleted unless the member chose to use
12 those HSA funds first which they could do on an annual basis.
13 CHAIRMAN DROZDOFF: That's a good clarification,
14 so that's good.
15 All right. So if we're done, I would say this,
16 here's sort of my tally on the notes that if someone was
17 interested in making a motion, what we've talked about doing
18 was pulling 4.1 B, F, 4.1 B, N. Clarifying in 4.1 B, P that
19 it should not apply to Medicare primary. That Item Three
20 under 4.1 B, R is stricken and that under 4.1 B, T, the word
21 not pending staff review is added to -- added in advance of
22 considered not reasonable.
23 MR. HAYCOCK: So for the record, Damon Haycock.
24 On that last one on part T, that whole section is

1 super confusing.

2 CHAIRMAN DROZDOFF: I just said that.

3 MR. HAYCOCK: Yeah, I just want to rewrite it.

4 CHAIRMAN DROZDOFF: Well, I said that. I said

5 that for now it's not giving staff the chance to rewrite it,

6 but I want the record clear that at least for now the word

7 not is there.

8 MEMBER ANDREWS: So moved.

9 CHAIRMAN DROZDOFF: Okay. Is there a second?

10 MEMBER EWING-TAYLOR: I'll second.

11 CHAIRMAN DROZDOFF: Any further discussions?

12 And, yes, the idea would be hopefully to staff

13 would clear up 4.1 B, T but for now, we at least have the

14 core value in there that is not to be considered reasonable.

15 Any other discussions? And seeing none, I'll

16 call for the question. All those in favor, please say aye.

17 (The vote was unanimously in favor of the

18 motion.)

19 CHAIRMAN DROZDOFF: Any opposed?

20 Any abstain?

21 And, Chris, I would encourage you to talk with

22 Damon and Mary Catherine to work on 4.1 B, F and 4.1 B, N.

23 We'll have a robust discussion next meeting.

24 Okay. So now we'll move to --

1 MEMBER COCHRAN: That's fine.
2 CHAIRMAN DROZDOFF: We'll move to 4.2. I'm
3 sorry, 4.2. Are there any questions on medical and long term
4 disability?
5 Anybody on the phone?
6 Anybody else, all right.
7 MEMBER WELLS: Mr. Chair?
8 CHAIRMAN DROZDOFF: Jim?
9 MEMBER WELLS: Thank you, Mr. Chairman. Jim
10 Wells for the record.
11 I would move that we approve Item 4.2 as outlined
12 with one additional clarification and that is that in Item
13 4.1, there was under B, C as in Charlie, they capitalized
14 everything for the definitions. I think if we're going to do
15 that, we need to be consistent through all of the MPD's. So
16 I would ask that staff -- that we approve 4.2 with the
17 requested staff capitalize the definitions as they did in the
18 MPD for medical.
19 CHAIRMAN DROZDOFF: That's a motion. Is there a
20 second?
21 MEMBER ANDREWS: Ana Andrews, second.
22 CHAIRMAN DROZDOFF: Ana Andrews, second.
23 Any other discussion on 4.2?
24 All right. Seeing none, we'll call for the

1 question. All those in favor, please say aye.
2 (The vote was unanimously in favor of the
3 motion.)
4 CHAIRMAN DROZDOFF: Any opposed?
5 Anybody abstain?
6 Motion carries.
7 All right. Let's go to 4.3. Any questions with
8 regard to enrollment and eligibility?
9 MEMBER EWING-TAYLOR: Thank you, Mr. Chairman.
10 I was wondering why on Item Three B, F, we were
11 doing that? Quick reference guide to me always seem like a
12 good idea.
13 MS. RICH: Laura Rich for the record.
14 There's no longer a waiting period so that
15 information was irrelevant.
16 MEMBER EWING-TAYLOR: The whole section?
17 MS. RICH: Yeah.
18 MEMBER EWING-TAYLOR: Okay, thanks.
19 And on J, what's the effect of this change?
20 MS. RICH: Laura Rich for the record.
21 Again, we actually -- this came up due to a
22 participant who wanted to terminate based on their ability to
23 hop on their -- their spouse's insurance, I believe it was.
24 This was not a group plan. It was not -- it was not

1 considered a group plan. It was not a -- we just had to
2 provide clarifying language to show that it was to define
3 that group plan. That participant did not quite understand
4 the qualifying event, and we had to provide that language to
5 clarify that.
6 MEMBER EWING-TAYLOR: So this is solely to
7 clarify what a group plan --
8 MS. RICH: What a group plan is.
9 MEMBER EWING-TAYLOR: It affects so far one
10 person?
11 MS. RICH: It has affected only one person that
12 we know of.
13 MEMBER EWING-TAYLOR: Okay. That's all I have.
14 CHAIRMAN DROZDOFF: Anybody else with questions,
15 I'm sorry, on 4.3?
16 Jim?
17 MEMBER WELLS: Thank you, Mr. Chairman. Jim
18 Wells for the record.
19 On K and L regarding the updating qualified
20 events, current language allows for a dependent to be
21 removed. If we have or they become eligible for Medicaid, I
22 am not in favor of adding that provision for participants
23 unless we start having the discussion about HSA contributions
24 being more frequent than annual.

1 CHAIRMAN DROZDOFF: All right. Damon, or, Laura,
2 you got --
3 MR. HAYCOCK: For the record, Damon Haycock.
4 And I spoke with Mr. Wells about this previously
5 and where I recognize and agree that there's a potential for
6 an individual to start on our plan, receive an HSA
7 contribution at the beginning of the year and then go through
8 some form of event that makes them eligible for Medicaid that
9 because as was mentioned earlier that your HSA stays with you
10 that that individual will be able to keep that HSA and then
11 go on to Medicaid.
12 I think the bigger issue, the bigger concern, at
13 least for me, is that we have an individual who qualifies for
14 expanded Medicaid and really needs help paying for their
15 health insurance, and there is a provision that allows them
16 in the state of Nevada, allowed for expanding Medicaid for
17 those childless adults or for those who qualify to receive
18 basically no cost, no premium healthcare.
19 And to make them remain on our plan and pay those
20 premiums while they qualify for no cost, no premium health
21 care I think is in direct contradiction to what the intent of
22 expanding Medicaid was for and it gets compounded when those
23 individuals are on a higher premium plan like our HMO plan.
24 Where if they have a family, they can be paying as much as

1 five or $600 a month for health insurance when they are
2 eligible for Medicaid to pay nothing per month. And to force
3 them to remain on our plan, I think is a tragedy, and I'll
4 leave it at that.
5 CHAIRMAN DROZDOFF: Jim?
6 MEMBER WELLS: You know, and I am going to repeat
7 what I just said. There's already a provision that allows
8 dependents to be removed from taking Medicaid that would
9 allow the participant to remain under participant only. I am
10 not -- I am not in favor of allowing this to be a qualifying
11 event for the participant. We do not allow people to move in
12 and out of our plan during the year for other -- to go to
13 other plans, we just don't, and I -- this is setting a
14 precedent that I'm not interested in setting.
15 CHAIRMAN DROZDOFF: For the record, Damon
16 Haycock.
17 And I have a question for you, Mr. Wells. When a
18 participant, a primary participant is on our plan and they
19 have an opportunity to join their spouse's plan and their
20 spouse receives new employment and they want to hop off our
21 plan and go on their spouse's plan, you know, do we allow
22 that participant to do that?
23 MEMBER WELLS: My recollection is no.
24 MR. HAYCOCK: So they can't hop off even

1 though they have an -- well, I get it, and that can be
2 another discussion for another time. And I apologize, my --
3 I'm used to -- let me try not to stutter. I'm used to the
4 Affordable Care Act minimum coverage definition where on the
5 individual market place, if you are eligible for minimum
6 essential coverage, you're allowed to change plans.
7 And the whole point of that process was to allow
8 people who needed help in paying for health insurance get
9 that insurance. I recognize that there is a danger. There
10 is a danger of hopping on and off Medicaid and coming on and
11 off our plan, but we're talking about people who can't afford
12 health insurance by the definition, and I think we're looking
13 at it from an HSA standpoint and not looking at it from
14 access to care and removing a costly barrier.
15 CHAIRMAN DROZDOFF: Ana and then Jacque.
16 MEMBER ANDREWS: So just so I'm clear to Jim's
17 question, on July 1, when the new plan starts, you get the
18 HSA money up front for yourself, for your dependents and all
19 of that. So let's say that in November, I decide that I
20 can't afford unless you say I go to Medicaid but I already
21 have all that HSA money that is mine, can you take it away
22 because you're going on to Medicaid? You can't. So I don't
23 know what Jim is going with, if you can explain it.
24 We are pawning up all this money and then per

1 your words, Damon, people can hop on and off, go back and
2 forth, back and forth, and I can see this happening
3 particularly with the entry level positions, the jobs that
4 don't pay that much that make employees, state employees,
5 university employees eligible for Medicaid.
6 MR. HAYCOCK: So for the record, Damon Haycock.
7 And you are correct, Ms. Andrews. We have to
8 look -- I believe when you look at it from an entire PEBP
9 program process, because we have folks that are on HMO plans
10 that don't get HSA's, that don't get HRA's that pay these
11 higher premiums.
12 And if we make a decision, if the Board decides
13 that they like this idea and they want to allow HMO
14 participants to do that and not allow the CDHP participants
15 to do that, well, then we have some form of discriminatory
16 plan benefit design. And so I don't believe that the idea
17 was designed initially around which entities offer high
18 deductible plans with HSA contributions. It's really a point
19 in time versus a year discussion.
20 At a point in time, what are you eligible for?
21 Are you eligible for programs that the state offers and if
22 you're no longer eligible for them, what are you eligible for
23 next? And right now -- and I understand Jim -- Jim's
24 statement, and I'm actually not against doing like a

1 quarterly HSA.

2 The problem is that if we were to not give the

3 full HSA amount on July 1, we have participants that rely

4 heavily on being able to offset their high deductible with

5 that on the first day of the plan year, so this becomes a

6 very tricky situation. But if this isn't the right answer,

7 what do we do for folks who had this?

8 We have an individual who calls that says I'm

9 paying five or $600 a month. I'm on the HMO plan. I'm

10 eligible for Medicaid. I would like to take myself and my

11 family off. And then we said, you can't. Now, your

12 dependents can if they qualify, and I recognize that. But

13 what do we do for that individual? We just tell them, well,

14 we'll reduce you down to participant only. You pay the $100

15 a month or $1,200 a year, and I'm rounding, so for care that

16 you should be eligible to receive for free and what do we do

17 for that person?

18 CHAIRMAN DROZDOFF: Jacque?

19 MEMBER EWING-TAYLOR: Thank you, Mr. Chairman.

20 I am concerned about this group, I have no clue

21 how big this group is. I've always been concerned that we as

22 an employer have employees that we pay so little to that they

23 qualify for Medicaid. That has always been a concern of mine

24 and then to compound that issue by doing what Mr. Wells is

1 suggesting just doesn't seem right to me either.

2 I do understand, you know, Jim, we had this

3 discussion in 2011, about whether or not we were going to

4 load, if you will, the HSA's fully on July 1 or whether we

5 would string out whether it was monthly or quarterly or

6 whatever, and I had no appetite for that at that time and I

7 still don't.

8 I just don't see that this is a big enough group

9 of people that it's something that would put the plan's

10 financial health in jeopardy. I just can't believe the group

11 is that big and before we were to decide not to allow this, I

12 would certainly want to see some sort of fiscal impact.

13 MEMBER WELLS: Mr. Chairman, so my understanding

14 is from talking to Medicaid, there are a couple of thousand

15 individuals that potentially this impacts.

16 CHAIRMAN DROZDOFF: Thousand.

17 MEMBER WELLS: Couple of thousands. It is not an

18 insignificant number.

19 MEMBER EWING-TAYLOR: And how many of theme are

20 hopping back and forth?

21 MEMBER WELLS: For right now none of them because

22 it's not allowed, but this would open the door to allow those

23 2,000 or so people to go back and forth between plans.

24 MEMBER EWING-TAYLOR: And, again, I think there

1 should be some sort of financial analysis done before we make
2 a decision of this import. It certainly is something I would
3 think that Aon could analyze for us.
4 MEMBER WELLS: Mr. Chairman, I'm not opposed to
5 removing these and having them part of the broader
6 discussion. I am not in favor approving them as part of this
7 today without significant changes to do business.
8 CHAIRMAN DROZDOFF: All right. Well, it seems --
9 MEMBER BAILEY: Why don't we just pull them.
10 CHAIRMAN DROZDOFF: It seems like this is a
11 pretty important discussion.
12 MEMBER ANDREWS: Very.
13 CHAIRMAN DROZDOFF: And, you know, I think we can
14 certainly make a motion that for now table K and L requiring
15 a follow-up in a couple of regards and one is to do the
16 fiscal impact, figure out how many people this truly is
17 effecting and take a look at what -- you know, what -- what
18 alternatives are out there. I mean, if I'm hearing Jim
19 correctly, what he's basically saying is, look, the plan --
20 the participant, him or herself, you know, that's -- that's
21 what the rule is. Damon and Jacque are kind of saying, well,
22 that still might be a little bit tricky. So why don't we do
23 that.
24 If somebody wants to make a motion to table K and

1 L, allowing for pretty in-depth follow-up, not only with
2 regard to fiscal impact but also with regard to alternatives,
3 that would be good.
4 MEMBER BAILEY: For the record, Don Bailey.
5 I make a motion we table K and L and get further
6 information, particularly information on the financial impact
7 of the system and also a correct number of employees that
8 this affects, and we can re-discuss those two issues.
9 CHAIRMAN DROZDOFF: So you want to approve the
10 balance of 4.3; is that correct?
11 MEMBER BAILEY: Yes.
12 CHAIRMAN DROZDOFF: All right. Is there a
13 second?
14 MEMBER COCHRAN: Second. This is Chris Cochran.
15 CHAIRMAN DROZDOFF: Second from Chris Cochran.
16 MEMBER WELLS: One comment.
17 CHAIRMAN DROZDOFF: Yeah.
18 MEMBER WELLS: Mr. Chairman, I would appreciate
19 it if the maker of the motion would add the provision for
20 capitalizing the definition that we did in 4.2.
21 CHAIRMAN DROZDOFF: Are you good with that, Don?
22 MEMBER BAILEY: I'm good with that.
23 CHAIRMAN DROZDOFF: Chris, are you good with
24 that?

1 MEMBER COCHRAN: Sure.
2 CHAIRMAN DROZDOFF: Okay. Any other discussions?
3 MEMBER GARCIA: Mr. Chair, this is Rosalie
4 Garcia.
5 CHAIRMAN DROZDOFF: Yes.
6 MEMBER GARCIA: I'm sorry to ask this one last
7 question but with regard to H, as in Harry.
8 CHAIRMAN DROZDOFF: Uh-huh.
9 MEMBER GARCIA: I just need clarification that
10 the changes, that the subsidy does not affect at all the
11 subsidy changes without having gone to a vote. The way I'm
12 reading the language states that the changes will occur on
13 the first day of the month concurrent with the date PEBP
14 received the audit results.
15 Is this something that PEBP Board would normally
16 vote on, changing the subsidy or am I misreading this
17 completely?
18 MS. GLOVER: Okay. This is Celestena Glover for
19 the record.
20 I will attempt to answer this. So when an
21 individual retires, we get a year's of service audit from
22 PERS so we know what subsidy the individual qualifies for.
23 That audit doesn't come on the day the person retires. It
24 usually takes a little bit of time. I believe this is

1 clarifying language to say that years of service subsidy will
2 be applied effective the first of the month we receive the
3 audit results, if that makes sense.
4 MEMBER GARCIA: I completely understand. Thank
5 you very much.
6 MEMBER WELLS: I will ask you another question.
7 Jim Wells, again, for the record.
8 So what are you doing in the interim, are you
9 going off the form that they submitted?
10 MS. GLOVER: This is Celestena Glover, again, for
11 the record.
12 So in the interim what we have been doing is that
13 typically we try to get it done within the first two months.
14 That first month, the individual is being billed full
15 premium. We typically tell them that we give them what we
16 believe it's going to be. We let them pay that or wait until
17 we get the year's of service and have them pay both months at
18 the same time at the appropriate rate.
19 So we typically allow the individual and the PERS
20 check is not hit until we get the final numbers so we know
21 what to actually charge them.
22 MEMBER WELLS: So in essence, you're actually not
23 going back to the day after you receive it. You're going
24 back to the day that they became eligible for retirement?

1 MS. GLOVER: Well, we are now, yes. This
2 language says it would be the first of the month that we
3 receive the audit.
4 MEMBER WELLS: Actually, now, I think that to be
5 problematic because now we're billing somebody for the first
6 month for the whole amount when they are entitled to subsidy
7 for that particular month. I think that's significantly
8 problematic.
9 MR. HAYCOCK: Well, for the record, Damon
10 Haycock.
11 I agree with Mr. Wells. And if you are eligible
12 for any form of service or program that PEBP offers, the day
13 that you become eligible should be the day that you receive
14 those services or programs, and so I think we can clarify
15 this language that says that.
16 MEMBER WELLS: Mr. Chairman, this is Jim Wells,
17 again, for the record.
18 There are times, and this is what I kind of
19 thought, I think I had a question mark next to this but
20 didn't think to ask the question. There are times where a
21 former employer will dispute the number of service credit
22 years that are associated to that employer and they basically
23 will have a re-audit done by the retirement system.
24 I think traditionally those re-audits have been

1 effective the date after -- the first of the month after
2 those are received and that's kind of what I thought this
3 was. If this is really about not giving somebody a subsidy
4 when they retire until such time as the audit has been
5 completed, that leaves the retiree at the mercy of PERS to
6 complete those audits on time, and I just -- I find that very
7 problematic.
8 CHAIRMAN DROZDOFF: All right. Well, so we have
9 a motion on the table, and now we have a relatively
10 significant issue that has been raised. I don't think we can
11 just -- I guess, my view is, Dennis, if you could help me
12 out. I don't know that we can just sort of say, yeah, we'll
13 just sort of fix that. That's not covered in the motion.
14 So what does the maker of the motion want me to
15 do? Do you want to call for the question? Do you want to
16 remove the motion and try another one? What would you like
17 me to do? Yeah, you're the maker of the motion.
18 MEMBER BAILEY: I withdraw the motion.
19 CHAIRMAN DROZDOFF: All right. So the maker of
20 the motion has withdrawn. The second also withdrawn; is that
21 correct?
22 MEMBER BAILEY: That's Chris.
23 CHAIRMAN DROZDOFF: Chris?
24 MEMBER COCHRAN: Sorry, yes.

1 CHAIRMAN DROZDOFF: All right. So now we're free
2 to try to talk about 4.3 a different way.
3 MR. HAYCOCK: So for the record, Damon Haycock.
4 I have some suggested language for section H that
5 I think may address what Mr. Wells was talking about
6 inserting, so I'll read it with the inserted language. But
7 changes to the year of the service premium subsidy, years of
8 service exchange HRA contribution, for audits after the
9 initial subsidy has been applied will occur on the first day
10 of the month concurrent with or following the day PEBP
11 receives the audit results from PERS or NSCHE, and I think
12 that may provide some leeway for us to apply the initial
13 subsidy. If there's a re-audit that any new subsidy will
14 have it on the date of or the first of the month after.
15 CHAIRMAN DROZDOFF: Jim, do you like that or do
16 you have your own idea?
17 MEMBER WELLS: Mr. Chairman, I think that pretty
18 much covers it. Typically, when you have those re-audits
19 from the employer side, they don't change the amount that the
20 employee pays generally. They just change the mix of which
21 employers pay the subsidy amount. So I think I'm okay with
22 that as long as we're clear that the -- that at retirement,
23 the initial subsidy goes into effect based on the initial
24 audit, and so I think as long as that can be interpreted out

1 of that, I think I'm fine.
2 CHAIRMAN DROZDOFF: If there's no reason to
3 interpret it, we can write it however we want. So if you
4 want it said that way -- like I said, I guess what I like
5 ultimately is a motion that addresses your concern. It seems
6 like everybody on the Board is kind of agreeing with that
7 concern but making it completely clear to your satisfaction
8 that it's addressed, and then we can still deal with K and L
9 the way we want to. That's what I would like at this stage
10 of the game.
11 So, you know, you've raised it. I think it's a
12 good issue. I would encourage you to give it some thought
13 about how we really want to characterize this in a motion.
14 MEMBER WELLS: Okay. Let me try this. A new
15 sentence, years of service premium subsidy and years of
16 service exchange HRA contribution are effective upon the date
17 of retirement based on the audit from either PERS or the
18 System of Higher Education.
19 Change to the years of service premium and/or and
20 the years of service HRA contribution resulting from a future
21 audit will occur on the first day of the month concurrent
22 with or following the date PEBP receives the audits from the
23 PERS system or Higher Education.
24 So, clearly, you're getting the first one as of

1 your retirement date. And if there's a secondary audit that
2 is requested from any person that it is effective on the
3 first of the month after the system or PEBP receives it.
4 CHAIRMAN DROZDOFF: And for purposes of a
5 complete motion, can you also then address K and L?
6 MEMBER WELLS: Sure. I'll go ahead and make a
7 motion that we approve 4.3, tabling K and L to be brought
8 back at a later date for additional discussion on fiscal
9 impact and potential alternatives, as well as the
10 capitalization of definitions throughout the document.
11 CHAIRMAN DROZDOFF: And adding the language that
12 you just described under H.
13 MEMBER WELLS: And adding the language that we
14 described under Item H, hotel.
15 CHAIRMAN DROZDOFF: Is there a second?
16 MEMBER BAILEY: I second that motion.
17 CHAIRMAN DROZDOFF: Are there any further
18 discussions?
19 Seeing none, I'll call for the question. All
20 those in favor, please say aye.
21 (The vote was unanimously in favor of the
22 motion.)
23 CHAIRMAN DROZDOFF: Any opposed?
24 Anybody abstaining?

1 Motion carries.
2 Okay. Let's try to finish 4.4.
3 MEMBER ANDREWS: Mr. Chair?
4 CHAIRMAN DROZDOFF: Yes.
5 MEMBER ANDREWS: Ana Andrews for the record.
6 I make a motion that we approve Item 4.4.
7 CHAIRMAN DROZDOFF: Is there a second?
8 MEMBER WELLS: Yeah, I'll second it. And, again,
9 the clarification of the language to define the
10 capitalization, is that included in there?
11 MEMBER ANDREWS: Yes, it is.
12 MEMBER WELLS: Thank you.
13 CHAIRMAN DROZDOFF: Are there any further
14 discussions? All right.
15 MEMBER EWING-TAYLOR: Thank you, Mr. Chairman.
16 Item 4.4 B, B, I understand, I think, why this is being
17 recommended. I am concerned that we are not appropriately
18 recognizing that there is still a quality control officer
19 position on the books to whom these duties most logically
20 fall.
21 In changing this in the master plan document, it
22 would seem to me to be premature and at this point not
23 entirely appropriate. I would suggest that we -- that the
24 Board wait until the quality control officer position has

1 been filled and that there be some further discussion about
2 where complaints most logically would reside. It seems to me
3 a quality control officer as it is currently designed is the
4 appropriate place for participant complaints to go.
5 I understand that since there has not been a
6 person in that position for the last six and a half some odd
7 months that those duties are being handled elsewhere, and I
8 think that they could continue to be held elsewhere until
9 that whole position has been more appropriately, A, filled
10 and redefined perhaps by the Board.
11 MEMBER WELLS: Can I ask a question?
12 MEMBER GARCIA: Mr. Chair, this is Rosalie
13 Garcia.
14 CHAIRMAN DROZDOFF: Okay. Rosalie and then Jim
15 Wells.
16 MEMBER GARCIA: I would find it difficult to make
17 a decision with regard to B, B because I do not have the job
18 description for both of those positions to adequately place
19 the responsibility or appropriately place the responsibility,
20 and I would like to see those before making a decision.
21 CHAIRMAN DROZDOFF: Jim?
22 MEMBER WELLS: Thank you, Mr. Chairman. This is
23 Jim Wells.
24 The way I read this might be slightly different

1 than what Ms. Ewing-Taylor read it. I was thinking that
2 these are appeals. This request for -- the review of appeals
3 and my concern is as we move to a true QC role, a QC operator
4 should not be making operational decisions and then be
5 reviewing those same operational decisions, that it would be
6 an operational person, operation officer being an operation
7 person that would make a decision and then the -- the quality
8 control officer would confirm that that operational decision
9 was in accordance with laws and the plan documents.
10 And so I get that if it's a true complaint
11 complaint that it probably should go to the quality control
12 officer but if this is really more dealing with the appeals,
13 under this whole bifurcated quality control discussion that
14 we've been having, that is an operational decision that the
15 QC officer would be responsible for reviewing, and so that's
16 kind of how I read this particular one as opposed to just a
17 generic complaint which probably does, in fact, need to go to
18 the QC officer as opposed to the operation officer.
19 CHAIRMAN DROZDOFF: Damon, or, Laura?
20 MR. HAYCOCK: So for the record, Damon Haycock,
21 and then I'll turn it over to Laura.
22 That was the intent, Mr. Wells, as mentioned.
23 Similarly, the sheer bulk of complaints that PEBP does
24 receive goes to our call center through our MSU because

1 that's where they reach out to and call.

2 And then based on the situation, it gets

3 elevated, put on issue logs, and it gets sent to our appeals

4 and complaints coordinator and if that appeals and complaint

5 coordinator runs into barriers to solve those problems, it

6 gets elevated currently to our chief or our operations

7 officer.

8 And so I think what was the intent of adding this

9 language in there was to just delineate that this does have

10 an avenue for resolution and although we still have the issue

11 with the quality control officer, we wanted to reassure

12 through our master plan document that we have somebody that

13 is dedicated and assigned to these decisions and that they

14 are at the appropriate officer level.

15 And so I don't know if this is premature, as

16 maybe Dr. Ewing-Taylor has alluded to, but we wanted to

17 ensure that we had something there that we could reference.

18 As Mary Catherine mentioned before, this master plan document

19 is kind of PEBP's Bible on how we operate and how we explain

20 and how we're able to hold others accountable.

21 And if it's not 100 percent accurate and clear

22 and thorough, any nebulous nature to it causes potential

23 legal issues, and I think Mr. Belcourt can agree to that as

24 well, and so we are constantly going through the master plan

1 document to make sure that it is appropriate and that it's
2 defendable in court, and so I'm not against pulling that out
3 if -- because the current process is if someone sends in a
4 complaint or an appeal to the quality control officer, it
5 hits that quality control officer's e-mail or phone and gets
6 bounced to the appropriate staff anyway. Operationally,
7 we're going to be okay.
8 But I agree with Mr. Wells, and that was kind of
9 the idea we wanted to start that process to really pound home
10 what quality control does.
11 CHAIRMAN DROZDOFF: Well, we have a motion.
12 Again, I'll say we have a motion on the floor. So if the
13 maker of the motion would like to change the motion, we can
14 do that.
15 MEMBER ANDREWS: Ana Andrews for the record.
16 Mr. Chair, I would like to amend my motion.
17 CHAIRMAN DROZDOFF: All right.
18 MEMBER ANDREWS: And it will be that we approve
19 Item 4.4 with the removal of Item Four, capital B, lower B.
20 CHAIRMAN DROZDOFF: All right. With the --
21 MEMBER ANDREWS: With the understanding that as
22 it is right now.
23 CHAIRMAN DROZDOFF: No, no.
24 MEMBER ANDREWS: The duties are being handled per

1 the executive officer's comments.

2 CHAIRMAN DROZDOFF: Okay. And you also wanted to

3 take up Jim's standing concern about definitions?

4 MEMBER ANDREWS: It was Rosalie's, I believe,

5 that had the description of the job.

6 MEMBER EWING-TAYLOR: She included in that.

7 MEMBER ANDREWS: Oh, yes, the capitalization,

8 yes, sorry.

9 CHAIRMAN DROZDOFF: All right. So I now have a

10 new motion on the floor.

11 Is there a second?

12 MEMBER BAILEY: Don Bailey.

13 I'll second that motion.

14 CHAIRMAN DROZDOFF: All right. Is there any

15 further discussion?

16 Seeing none, I'll call for the question. All

17 those in favor, please say aye.

18 (The vote was unanimously in favor of the

19 motion.)

20 CHAIRMAN DROZDOFF: Any opposed?

21 Any abstain?

22 The motion carries.

23 All right. Let's take a 15-minute break.

24 (Whereupon, a brief recess was taken.)

1 CHAIRMAN DROZDOFF: Okay. We're going to get
2 some new people dropping on and off. Can we --
3 Kari, can you do another role call to see who's
4 on, especially on the phone.
5 MS. PEDROZA: Chris Cochran?
6 MEMBER COCHRAN: Here.
7 MS. PEDROZA: Rosalie Garcia?
8 MEMBER GARCIA: Here.
9 MS. PEDROZA: And Christine Zack is unable to --
10 CHAIRMAN DROZDOFF: So she's gone.
11 So the rest of us -- just so the record is
12 straight, go through who else is here.
13 MS. PEDROZA: Jacque Ewing-Taylor?
14 MEMBER EWING-TAYLOR: Here.
15 MS. PEDROZA: Don Bailey?
16 MEMBER BAILEY: Here.
17 MS. PEDROZA: Jim Wells?
18 MEMBER WELLS: Here.
19 MS. PEDROZA: Ana Andrews?
20 MEMBER ANDREWS: Here.
21 MS. PEDROZA: And Leo Drozdoff?
22 CHAIRMAN DROZDOFF: Here, so there's seven.
23 All right. I've had a request to provide and at
24 last a brief public comment on Item Five.

1 Go ahead, and please stay on the topic.
2 MS. BOWEN: My name and my words for the record,
3 Peggy, P-e-g-g-y Lear, L-e-a-r, Bowen, B-o-w-e-n.
4 My concern regarding the benefits and coverage
5 documents involved, and we're at Item Number Five, and the
6 fact that we do not have to have to public access to make
7 public comment throughout, in the future that it would
8 behoove us for transparency purposes, not what's necessarily
9 required by law, but what is the proper and appropriate thing
10 when discussing any benefits that they be by the phone.
11 By -- Board meetings need to be how you have them, not
12 necessarily in any other way but public access to make public
13 comments for the record.
14 In the future, I would hope that this Board,
15 because this Board has in the past whenever it came to
16 benefits or whenever it came to evaluation of executive
17 director that the meetings were shut down and comments were
18 made, if I could figure out how to shut them down more, I
19 would and that when the last meeting of this nature was held
20 in Las Vegas, Nevada, and Board vote was going to be taken
21 there, and even the governor couldn't access the meeting
22 because he couldn't be present in the room at the time that
23 they were called, and it was suggested to the chair not to
24 take a vote until after it's brought back to the Board where

1 that access is of public comment and other access is
2 available.
3 We didn't get it always in the rurals, but we at
4 least got it north and south, and we need that precedent to
5 be reestablished and kept in place as what you do and how you
6 do so that the members actually have that access.
7 I'm not asking for it to be today because I know
8 of the legal ramifications of it. The documents are not --
9 it kills me to make -- to say this because I was going to ask
10 for it for today that we will be out of compliance with what
11 we have to do legally.
12 CHAIRMAN DROZDOFF: We are not out of compliance.
13 MS. BOWEN: I said it would make us if I asked
14 for a delay until the next Board hearing for this vote that
15 it would get you out of certain time structures that you have
16 to have. So I'm asking for future meetings that it's always
17 available with placement so people can go to the table and
18 make their public comment. It's not a legal requirement.
19 It's a moral requirement. Thank you very much.
20 CHAIRMAN DROZDOFF: You're welcome.
21 All right. Let's go to Agenda Item Five. Who is
22 going to pick this up? All right, Laura.
23 MS. RICH: For the record, Laura Rich.
24 We also -- staff also went through and made

1 revisions to the 2017 summary of benefits and coverage
2 documents. Those are for the Consumer Driven Health Plan,
3 both the individual and family, and we also included in here
4 the documents or summary of benefits and coverage documents
5 for the two HMO's, for Health Plan Nevada and for Hometown
6 Health.
7 I'm going to go through first our CDHP. There
8 were very minimal changes to this. We went through and
9 obviously did some housekeeping and changed some dates and so
10 on and so forth for both the individual and family documents.
11 The only real changes that we made again were to
12 update the cost sharing limits to meet the Affordable Care
13 Act requirement for the added individual family members out
14 of pocket maximum. And, I mean, basically, that's -- those
15 are housekeeping revisions throughout.
16 The summary of benefits and coverage for the
17 HMO's, for both HPN and Hometown Health are included in here,
18 and I know in the past I think the Board has voted to approve
19 these documents. However these documents are regulated and
20 approved by the Nevada Division of Insurance and, you know,
21 they are -- they are tasked with ensuring compliance with the
22 insurance laws and regulations. So staff did not recommend
23 any approval on that end. We're just recommending the
24 approval of the 2017 CDHP summary document for individuals

1 and for families as well.
2 With that, I'll take any questions.
3 CHAIRMAN DROZDOFF: Are there any questions?
4 MEMBER WELLS: I'll -- this is Jim Wells. I'll
5 move to staff recommendation.
6 CHAIRMAN DROZDOFF: Okay. We have a motion to
7 move to staff recommendation.
8 Is there a second?
9 MEMBER ANDREWS: Ana Andrews, second.
10 CHAIRMAN DROZDOFF: For 5.1 and 2 or just 5.1,
11 Jim?
12 MEMBER WELLS: My understanding is this would
13 just be for 5.1. 5.2 and 5.3 are predetermined documents as
14 approved by the individual HMO carriers, and so they are just
15 in the packet for informational purposes. We don't have the
16 ability to approve or change those.
17 CHAIRMAN DROZDOFF: Does everybody understand --
18 is that the motion now? So I have a motion and a second.
19 Are there any further discussions? Seeing none,
20 call for the question. All those in favor, please say aye.
21 (The vote was unanimously in favor of the
22 motion.)
23 CHAIRMAN DROZDOFF: Any opposed?
24 Anybody abstain?

1 Motion carries.
2 Okay. We'll go to six.
3 MR. HAYCOCK: For the record, Damon Haycock.
4 This agenda item doesn't have a specific report.
5 It's more to have a discussion at the Board level on what --
6 what future role that the Board wishes to have in getting
7 down to approving the specificity of these documents.
8 There is no intention whatsoever that staff is
9 recommending that the Board not approve policy changes. All
10 policy changes need to be approved at the Board. We
11 recognize and support that fully.
12 There are some other smaller things, housekeeping
13 items and some small adjustment that it's a precarious line
14 because we don't want to take that control because that's not
15 ours to take, and we frankly don't want it, but also we want
16 to make changes that are necessary to keep the plan not only
17 solid but appropriately managed and operated.
18 And so my understanding, doing a little bit of
19 history or research into the historical Board meetings is
20 that these documents weren't always brought to the Board for
21 approval, and that they have been more so over the recent
22 years, and I wanted to give an opportunity to revisit that
23 and see if this Board would like to continue to get into that
24 level of detail on processes and if so, we'll continue to

1 support them.
2 And with that, I will turn it back over to
3 Mr. Chairman.
4 CHAIRMAN DROZDOFF: Any questions?
5 So what are we being asked to do today?
6 MR. HAYCOCK: So for the record, Damon Haycock.
7 Two things, one, I wanted to or we wanted to give
8 an opportunity to have just a healthy discussion on this
9 process. What is -- what is liked, what is disliked? Is it
10 something that we want to continue/. Do we want to put some
11 parameters on it or do we want to leave it as is?
12 And I think the possible action is do you want to
13 base -- and I'm not trying to make a motion here, but do you
14 want to basically keep things as is or are you wanting to see
15 more information, less information? I believe now a previous
16 Board member had wanted some form of need assessment done
17 with the Board on what they wanted to receive on a monthly
18 basis or on a Board meeting basis. This kind of starts that
19 process.
20 Is this something that you guys want to see to
21 this level? Do you want us to include that we change plan
22 year 2016 to plan year 2017? Do you want to see that we
23 changed the Pharmacy Benefits Manager from Catamaran slash
24 Optimum RX to Express Scripts Inc.? Do you want to see those

1 changes? Is it -- you know, where is that line at that you
2 want to be involved because we want to support you as is our
3 agency goal.
4 And so do you want to know things that we're
5 going to curve the sixteenth visit to a chiropractor, is that
6 something that defines policy? Do you or do you want to do
7 more of the larger issues, like the qualifying life events or
8 hopping on and off Medicaid? And so this is an opportunity
9 to start that discussion, and it doesn't have to take action
10 today. It's not a requirement. We're not going to miss a
11 compliance issue.
12 But because this was brought here today, we had
13 to kind of do this quickly, and I apologize for that June 1st
14 deadline. Do you want us to continue this process or do you
15 want to talk a little bit about something different?
16 MEMBER COCHRAN: Mr. Chair?
17 CHAIRMAN DROZDOFF: Go ahead, Chris.
18 MEMBER COCHRAN: Yeah, I don't know why -- I
19 mean, I think it was looked at fine. I think we were able to
20 identify some issues in the plan document that, you know, we
21 needed clarification on and if changes are recommended that
22 the ones we made, we don't necessarily have to bring this up
23 for a discussion, but it certainly could be in a report,
24 submitted consent agenda to the Board regarding the changes

1 made that were requested. I don't think we have to rehash it
2 necessarily in another meeting with the exception of having
3 documentation that changes were made.
4 CHAIRMAN DROZDOFF: Jacque?
5 MEMBER GARCIA: Mr. Chair, this is Rosalie
6 Garcia.
7 CHAIRMAN DROZDOFF: All right.
8 MEMBER GARCIA: I -- the current process is fine.
9 I think it works and it allows for full disclosure. I don't
10 see a reason to change it.
11 MEMBER EWING-TAYLOR: Thank you, Mr. Chairman.
12 In taking kind of a broader view of this, it --
13 it seems to me that because this is the governing document
14 that it is critical that the Board understand the changes
15 that are being made to it.
16 I'm not going to disagree, Damon, that there are
17 housekeeping items that could be effected by the staff, and
18 my understanding is that they always have been. That, you
19 know, if you find a typo or need a date change or something
20 like that, there's a log of changes that is kept, and I -- I
21 think that has worked fine, and I would -- I would continue
22 that process.
23 But I think that, again, because this is the
24 governing document, it is incumbent upon the Board to

1 understand any changes that are being proposed, whether it's
2 policy or whether it's significant change to a section that
3 might need clarification.
4 But I also think that this is -- especially in
5 light of the Governor's action relative to this Board, it is
6 important that this type of conversation be had with the new
7 Board in a strategic planning session. These should be their
8 choices. These should be the types of questions that the new
9 members of the Board participate in and that will help them
10 understand better their role as a Board member and the issues
11 that confront the Board, as well as the participants.
12 So I know for a variety of reasons, we did not do
13 a strategic planning session this year, but I would encourage
14 the Board and the remaining Board members to spend the time
15 to do that and to take up this discussion at that point. I
16 think it's -- I think it would be beneficial to the plan, to
17 all of the participants especially, as well as the Board
18 members.
19 CHAIRMAN DROZDOFF: Anybody else?
20 Jim, do you have any thoughts?
21 MEMBER WELLS: Yeah. Thank you, Mr. Chairman.
22 Jim Wells for the record.
23 I think I'm kind of in line with what Jacque
24 Ewing-Taylor was saying that, you know, this is obviously a

1 discussion for a Board that is going to be somewhat
2 reconstituted over the next few months. So it might be a
3 little bit premature to have this discussion today and have a
4 new Board to have to adhere to what the old Board decision
5 was.
6 But I will tell you from, kind of from my
7 perspective, if they were to take a literal vote on this
8 action that, again, I agree with Dr. Ewing-Taylor, this
9 document is the document. This is -- this governs everything
10 this plan does and it is -- it doesn't just guide the Board.
11 It guides the participants. And to have every little change
12 identified in a document of what was going -- what is
13 changing from year to year, most people don't read this
14 document cover to cover.
15 So being able to go somewhere and see, like we
16 had today, a summary of what was seen, even as mundane of
17 things as dates and definitions, they seem mundane, but they
18 are -- they can be vitally important when it comes to a
19 participant being able to interpret and understand and abide
20 by the governing document of the plan.
21 And so I -- I would be a little leery of the
22 Board not having this document in front of it, and the other
23 piece of this becomes, if you say we don't want to see the
24 limitation on, you know, 15 benefit -- 15 chiropractic visits

1 but at the sixteenth one you have to see it, and at what
2 point do we say it is a benefit change which is a policy
3 change that is a Board responsibility as opposed to a
4 technical correction or clarification by staff?
5 You know, the Board had come along the line
6 before and said we want to have a limitation on chiropractic
7 for medical necessity and the staff needs to determine what
8 that medical necessity is, then maybe the theme is to
9 research and that's the number that's put in there. At least
10 the Board had the discussion about having that policy change
11 as opposed to not having that policy change at all.
12 And I think that it became very evident today
13 that some things that are considered minor and technical
14 aren't and are really larger policy discussions that need to
15 be discussed in front of this body and as part of the public
16 record. So the summary of benefits and coverage, I have a
17 completely different take on. Those are federally mandated.
18 The form and templet is not really changeable by
19 the -- by the plan. Those I think are more informational
20 type items that the Board could see, but they do not really
21 have any authority over. But I will tell you that from time
22 to time, the federal government changes what those templets
23 look like, and there's -- I thought it was this July,
24 apparently, it's next July, there are some fairly significant

1 changes coming down, and so they are the face of what the
2 participants sees.
3 They are much more inclined to read this six-page
4 document than they are the 200 -- 200 plus ones. And so,
5 again, the Board should see them and know what is going out.
6 But the approval role is kind of irrelevant because the
7 details in them should be coming directly out of the master
8 plan document which is -- which is what should be approved by
9 the Board. Those are my thoughts.
10 CHAIRMAN DROZDOFF: Anybody else care to weigh
11 in?
12 I take it you got your feedback.
13 MR. HAYCOCK: Yeah, for the record, Damon
14 Haycock. Thank you.
15 Just a point of clarification, the impetus for
16 this wasn't to do an all or nothing. It wasn't you either
17 get to see the MPD's and vote on them or you don't. There
18 are multiple mediums to communicate to the Board and to the
19 public transparently. And so as most, if not all, of our
20 documents are on-line and they are available. We can also,
21 as you mentioned, Jim, bring them as an information items as
22 well.
23 I just wanted to see if there was any -- any
24 desire to relook at exactly what should or shouldn't happen,

1 what could or couldn't happen, and I think you illustrated
2 that very eloquently by explaining the difference between the
3 MPD's and the summary of events with coverage, and that's
4 kind of what I was getting at, is to what degree is it
5 important to bring it to the Board for discussion.
6 And I think all of the things that have happened
7 today with the master plan document illustrate that, but then
8 similarly, the vote went like 12 seconds on the summary of
9 benefits and coverage. So is that something that we need to
10 bring back for approval or just for your information? So I
11 agree with what you said, and that's kind of the direction
12 that we were looking for, so thank you.
13 CHAIRMAN DROZDOFF: With the notice or eye to the
14 fact that it's going to be a different Board in the not too
15 distant future and some of these questions bear repeating.
16 All right. If there's nothing more on six, we'll
17 move to wrap the meeting up and final public comment.
18 MS. BOWEN: My name and words for the record,
19 Peggy Lear Bowen, P-e-g-g-y L-e-a-r B-o-w-e-n.
20 Thank you. And thank you, Mr. Wells, for
21 eloquently stating why it needs to come back before the Board
22 and in public and especially with more being able to act in
23 here and being directly involved in the master plan. Thank
24 you very much. It was a well stated comment that you made.

1 I would like to discuss one thing that has taken
2 place and that is inequity of benefits. That I as a member
3 of the orphan group do not hit a donut hole involved in my
4 insurance for paying for medical care or prescriptions or any
5 of those things. It has now been very very made apparent by
6 those who are participants in the A and B Medicare Exchange
7 that they hit the donut hole. If they can't afford their
8 medications, they literally don't have the wherewithal to get
9 especially, and I don't want to put one over the other
10 because any medication that keeps you alive is a beautiful
11 value, diabetic benefits being provided by our group.
12 And when he was told that the group had been sold
13 to the Exchange and that Nevada actually benefitted from the
14 group that is handling our A and B Medicare folks and that
15 the umbrella of PEBP over the A and B Exchange was merely
16 that an umbrella to facilitate the handling of payments for
17 process and the Nevada money going into and being made to the
18 company that's taking care of our A and B Medicare people.
19 That the PEBP umbrella is merely to facilitate payment and
20 not to present anything with benefit.
21 If these people's insurance is literally being
22 maintained by jobs they held other than that in for the state
23 of Nevada and their benefits are in reality not the best that
24 PEBP is offering to those who are still within the state and

1 in particular the donut hole people, the orphan people, that
2 you have in reality inequitable benefit. They aren't
3 receiving the benefits they should have for working for the
4 state of Nevada, and that needs to be corrected, and it's
5 not -- in addition to their paycheck and it's not an
6 additional taxable thing. It should not be. It's because
7 they worked for the state of Nevada and their lives and the
8 extension of their lives and covered through insurance
9 benefits should be there and that's important to me.
10 When I came and went to an urgent care, and this
11 is a second topic, and for an injury I received and I went to
12 the Reno Orthopedic Clinic which is part of the -- our
13 benefits in Reno that we can go to for our doctors and things
14 like that, and it was a sense of urgency because by paying, I
15 am now receiving letters from PEBP, not from Medicare or
16 anybody else but PEBP, in denial of those benefits for
17 attending the urgent care and wanting more information and
18 wanting medical necessity for going to urgent care.
19 And everybody was perfectly fine with Medicare,
20 paying that portion of the benefit but when it came to the 20
21 percent for PEBP to pay, all of a sudden I'm getting a denial
22 of claim. When I came down and asked to speak to someone, I
23 was told there was no one available. Just call the insurance
24 company. And my point to you is prior to this moment, that

1 would have been a seamless situation, and it was all handled
2 from within house by the insurance company talking to
3 whomever, and I'm concerned that it's no longer that way.
4 I would appreciate if it's not that way for me
5 and I speak to you, think of how many people it's not that
6 way and they don't come and make the effort to be here and
7 let you know.
8 CHAIRMAN DROZDOFF: Can we wrap it up.
9 MS. BOWEN: Thank you very much.
10 One final comment. When asked with the HRA or
11 HSA money roll-over, Mr. Wells, within the 2011 present day
12 response, it depends on who the insurance company is. So
13 when you develop into the way things are set up and who is
14 handling the money and the appearance of the money and you
15 can't spend it if your claim is over a year old, that we need
16 to go back. If my money is in my account and I need my money
17 to spend --
18 CHAIRMAN DROZDOFF: We'll be looking at that next
19 week -- next month.
20 MS. BOWEN: Thank you very much.
21 CHAIRMAN DROZDOFF: Is there any other public
22 comment? Come on up here. Your name for te record, okay.
23 THE WITNESS: Judith Maus, M-a-u-s, and I am a
24 school district retiree.

1 First, I have been as an active employee and a
2 retiree well well cared for. Thank you all for your service.
3 This is my first Board meeting, and it's mind boggling.
4 In the last two years, we, the school district
5 retirees, and I am one would elected to come on board with
6 PEBP in the summer of 2008 when it was the last chance to
7 retire and do so. I'm very glad I did.
8 In the last two years, we've had our Envision
9 Wellness program suspended which for me was a lot of a 50
10 dollar a month credit toward my premium.
11 Then the last legislative session, there was a
12 temporary cost cutting measure put into effect that
13 restructured our non-state subsidy amount. The direct impact
14 to me was overnight increase in my monthly health care
15 premium of $250 which was a big chunk out of my less than
16 $1,200 a month pension the first. I realize it was -- I'm
17 sure it was an effective cost cutting measure for the
18 legislature, but it was, like I said, a big cut to my
19 spendable income.
20 I don't know if you can answer this or if you
21 guide me to someone who might, was that, in fact, a temporary
22 cost cutting measure and now that times are better, will our
23 subsidy be restored?
24 CHAIRMAN DROZDOFF: I don't know that I can

1 answer that question for you. I'll say this, that the
2 issue -- the issue you raise is one that's been front and
3 center with this Board, with the legislature for years.
4 The issue is really simply this, the group of
5 non-state retirees is and, I mean -- you know, I don't mean
6 any disrespect by this, is a smaller and older group and when
7 it gets -- when it gets evaluated and it gets evaluated
8 separate and apart from the state group, it is much -- it is
9 subject to swings and increases at a greater rate.
10 The difficulty for this Board and I think the
11 legislature is that the history was -- was such that when
12 this decision was made to kind of keep people separate, there
13 was an understanding that, you know, state employees wouldn't
14 necessarily subsidize non-state employee groups. We are
15 clearly getting to the point though that the group that
16 you're in is smaller and more expensive to carry and we --
17 this has been an issue probably nearly every meeting that
18 we've had, and I'll just say that it's one that we're
19 continuing to work on.
20 Last meeting there was extensive debate about
21 options to deal with whether it's called the orphan group or
22 non-state group. Those discussions continue. So that's
23 where we're at. It's not an easy situation for everybody
24 involved. We do know that it has, you know, these kind of

1 cost increases that you described are real, and they have a
2 real impact to the participants.
3 The difficulty for the Board or at least this
4 Board member and I think others is that the history was such
5 that our current state employees, it was always the
6 understanding that they weren't necessarily going to pick up
7 the slack here. So we're looking at -- we're trying to find
8 approaches that would solve the problem in the most equitable
9 way possible and that's where we're at.
10 MS. MAUS: It happens frequently that something
11 that is temporary is really permanent. I'm not expecting to
12 get my subsidy back. Although, it was something that I was
13 told would be there for me as a benefit --
14 CHAIRMAN DROZDOFF: Uh-huh.
15 MS. MAUS: -- when I retired.
16 CHAIRMAN DROZDOFF: The subsidy is still there.
17 The problem is the plans cost more, that's the difficulty,
18 and that's what you have to figure out.
19 MEMBER WELLS: Could I ask a question? Are you
20 on the HMO plan?
21 MS. MAUS: Yes.
22 MEMBER WELLS: So the whole discussion around
23 non-state retirees had been predicated on the fact that other
24 plans, the Consumer Driven Health Plan is significantly more

1 expensive for non-state retirees than it was for state
2 retirees. And the solution was to go to a percentage of
3 premium as opposed to the old flat dollar amount subsidy that
4 non-state employees got.
5 There were cases for people on the HMO where
6 non-state retirees were actually paying less than their state
7 counterparts because of the way the subsidy was a flat dollar
8 amount for non-state and percentage of premiums for state.
9 When that was changed, now you are paying the percentage of
10 your premium instead of getting a flat dollar amount. So now
11 you are paying the same percentage of your premium that your
12 state counterpart.
13 Then you go back to Mr. Drozdoff's comments that
14 your premiums are higher than the state premiums and that's
15 the problem that we are trying to fix without negatively
16 impacting the state pool because the state pool did not get
17 the benefit of ensuring active non-state employees when they
18 were less expensive. And so to ask the state employees to
19 subsidize them now that they are older and retired is not
20 fair because their premiums will go up based on the age and
21 health conditions of that population where they did not get
22 the benefit of that group when they were younger.
23 And so it was not intended to be temporary. It
24 was intended to fix inequity for one group. Every time you

1 fix inequity for one group, you simply create an inequity for
2 another one.
3 MS. MAUS: I understand. I hope I haven't wasted
4 your time. I understand you all know this, and I'm the
5 uninformed one, but thank you for very much.
6 CHAIRMAN DROZDOFF: I appreciate you being here.
7 MS. MAUS: Thank you for letting me ask the
8 question. I understand your explanation, and no new curtains
9 for the refrigerator box this year.
10 CHAIRMAN DROZDOFF: Are there any other comments?
11 All right. Seeing none, I call this meeting
12 adjourned. See you next month.
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1 STATE OF NEVADA,)
) ss.
2 CARSON CITY.)
3
4 I, KATHY JACKSON, Official Court Reporter for the
5 State of Nevada, Public Employees' Benefits Program Board, do
6 hereby certify:
7 That on Thursday, the 19th day of May, 2016, I was
8 present at the Public Employees' Benefits Program, Carson
9 City, Nevada, for the purpose of reporting in verbatim
10 stenotype notes the within-entitled public meeting;
11 That the foregoing transcript, consisting of pages 1
12 through 102, is a full, true and correct transcription of my
13 stenotype notes of said public meeting.
14
15 Dated at Carson City, Nevada, this 6th day
16 of June, 2016.
17
18
19
KATHY JACKSON, CCR
20 Nevada CCR #402
21
22
23
24

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, 5/19/16

KATHY JACKSON   DATE

$

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