In The Matter Of:

Public Employees' Benefits Progam Board

Videoconferenced Open Meeting

June 17, 2016

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PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

VIDEOCONFERENCED OPEN MEETING

FRIDAY, JUNE 17, 2016

CARSON CITY AND LAS VEGAS, NEVADA

The Board:	LEO DROZDOFF, Chairman JACQUE EWING-TAYLOR, Member DON BAILEY, Member ANA ANDREWS, Member TOM VERDUCCI, Member JAMES WELLS, Member ROSALIE GARCIA, Member CHRIS COCHRAN, Member CHRISTINE ZACK, Member
For the Board:	DENNIS BELCOURT, Deputy Attorney General
For Staff:	DAMON HAYCOCK Executive Officer LAURA RICH Operations Officer CELESTENA GLOVER Chief Financial Officer NANCY SPINELLI Public Information Officer KARI PEDROZA Executive Assistant
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A G E N D A

FRIDAY, JUNE 17, 2016, 9:00 A.M.

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MEMBER EWING-TAYLOR: Good morning. I'm Jacque Ewing-Taylor. I'll be chairing this portion of the Public Employees' Benefits Program meeting. I see we have one member in Las Vegas. And I think we were expecting one more in a few minutes. Kari?

MS. PEDROZA: That is the room upstairs.

MEMBER EWING-TAYLOR: There's a room upstairs as well?

MS. PEDROZA: Yes. That you're seeing on the screen right now. Just in case.

MEMBER EWING-TAYLOR: This is not Vegas?

MEMBER GARCIA: Oh, this is Las Vegas. Hi. This is Rosalie Garcia. We also have a new board member with me across from the table.

MEMBER EWING-TAYLOR: There we are, okay.

MEMBER ZACK: Hi. Christine Zack.

MEMBER EWING-TAYLOR: Okay. Then I am going to ask Kari to call roll so we can establish a quorum.

MS. PEDROZA: Ana Andrews.

MEMBER ANDREWS: Here.

MS. PEDROZA: Don Bailey.

MEMBER BAILEY: Here.

MS. PEDROZA: Tom Verducci.

MEMBER VERDUCCI: Here.

MEMBER ANDREWS: Chris Cochran. Rosalie Garcia.

MEMBER GARCIA: Here.

MS. PEDROZA: Christine Zack.

MEMBER ZACK: Here.

MS. PEDROZA: Judy Saiz has been excused today. And Board Chair Drozdoff and Member Wells will be late, as well as Member Cochran.

MEMBER EWING-TAYLOR: Great. Thank you. So we do have a quorum. I would like to take this opportunity for the two new board members to say hello to everybody, introduce yourselves briefly, if you would. And I'll start here in Carson with Mr. Verducci.

MEMBER VERDUCCI: Tom Verducci for the record. It's quite an honor to be here today. And for many, many years I've worked with state employees and I've worked with the Hartford. I spent 15 years meeting face to face with employees. And I very much look forward to providing expertise and improving this program. And it's a pleasure to be on board.

MEMBER EWING-TAYLOR: Thank you.

Ms. Zack.

MEMBER ZACK: Hi. Christine Zack for the record. I've been a health care executive on the operations side for over a decade and I'm really looking forward to this

opportunity. And thank you for allowing me to join this fine group.

MEMBER EWING-TAYLOR: Welcome. We're pleased to have both of you.

The next item on the agenda is public comment. We're going to have several public comment periods during this meeting because we also have as the third item on the agenda the public hearing to take public comment on a proposed change in regulation. But we do have Item 2. And I would just like to invite anyone here in Carson or in Las Vegas who would like to make any public comment on anything on the agenda to come forward, please. Again, state your name and spell it if need be for the court reporter.

MS. BOWEN: Good morning. My name and words for the record, P-e-g-g-y space L-e-a-r space Bowen, B-o-w-e-n. Lear is L-e-a-r. I want to thank you very much for all the work you're doing and how hard you are to protect the state insurance program for the present day workers and for those who have retired and their spouses and significant others. I want to thank you very much. I also want to thank you for the work you've done regarding those who I nicknamed the orphans a few years ago during the legislative sessions who came from other entities to become part of PEBP at that juncture.

And when we were brought forward, we were brought

forward with the idea that if you have the retirees from other agencies within the state government and things like that, such as teachers, that you would maybe some day have your actives also in making a stronger program simply by the numbers.

Well, at the end of last meeting -- I've learned a few lessons in the years that I've been around. And the lesson that I've learned most recently is never make assumptions. Find out why people have the passion they have and the direction they're going because it's based on their background and never take anything personally.

Well, in the conversation with Mr. Wells after the last meeting, it was done in a public setting with other people hearing, I understood why we worked so hard regarding those who were not part of the state workers and such and related to the state workers as such, that Mr. Wells said very clearly, and he has substantiated this year after year by his actions, that he never wanted the retirees that were brought about in to the program because he felt, I'm going to say, and now I'm making an assumption, it would harm the program, that it would take the program's financial background down.

I want to suggest to you in the last motion that was passed for what you would be discussing and working on maybe at this meeting, probably at this meeting, of the idea

of bringing back that legislative packet that failed in the legislature last legislature about sending the workers back to where they came from, regardless of what that impact would be on those workers who joined the state after being enticed to join the state who were not state workers. He felt it was -- it harms the program, from his point of view, it makes other people in the program pay for people that didn't pay in to the system when they were working as such as teachers in Clark County, teachers across the state, and other entities that were brought in.

I'm going to suggest to you that this program as a whole made some commitments that I would hope that you would not put in your RFP. The idea of bringing back the concepts of sending people away and making the system stronger by, in fact, weakening it because you didn't keep the promises that brought people in in the first place. And it is very important that the privatization of your insurance company gets the State of the Nevada out of the retiree system. All of those people who work for the State of Nevada, the A and B folk that were sent across the lines to Utah, we heard were sold. And I made a comment last time of they were sold to a company. And I made a comment last time, well, what about are the role that is going to be there. Mr. Wells' response to me quite some time ago was it depends on who the insurance company is, which makes me believe that

the monies that the State of Nevada through their PEBP program provides to those people who work for the State of Nevada and earn this insurance as state employees that that money has been convoluted or transferred and that you are only the conduit of the money regarding your A and B Medicare folk. And you have other entities paying for their insurance in terms of handling what their benefits are, who they can do, what they can see, and how it's done. And it didn't come to light until we started looking at maybe not having Hometown Health being your carrier.

You must, must realize that if you indeed fact quoting Senior Care Plus in talking about their insurees with the state sold A and B Medicare folk, and that's beyond Hometown Health. I believe you have other entities that are covered by those people, sold those people to a company, and all you're doing is being a conduit. And the fact that the state provides other monies to help assist, those people are dying in the Medicare hold because the state is unable to -- After you've sold something I guess you can't affect the contract or maybe you can through whatever you negotiate or do. But it's only fair to those thousands of people that you have on A and B Medicare that the state has some responsibility for their insurance, for what their coverage is, what their benefits are. And you don't have people dying because they can't afford their medication, they can't

afford -- And diabetic medication is the one that has hit the level. As soon as something becomes very expensive, they cut the insurance coverage, but they get more payback from the Medicare, from Medicare for how sick their people are. You cut their medication, ability to pay for their medication, they get sicker, the insurance companies get more money.

And so I need you to maybe look at it in a little different perspective about what your responsibilities are for your A and B folk who other jobs are paying for their insurance basically by virtue of their Medicare coverage which with you -- the state does not offer. And I got a little wrapped up. But it is so important that you take back your folk either financially, fiscally, covering the doughnut hole, however possible, that you -- you may have sold them but you didn't sell the fact they worked for you for 27, 29, 35, 40 years. You didn't sell that. That commitment was to the State of Nevada and that responsibility still stands. If you want to have coverage for them through the A and B and the people you sold them to, fine. But you can't as an entity work on a benefit for them from the State of Nevada for their service that covers what is killing them right now.

MEMBER EWING-TAYLOR: Thank you, Peggy.

MS. BOWEN: Thank you.

MEMBER EWING-TAYLOR: Rosalie, are you going to have any public comment from Vegas?

MEMBER GARCIA: Yes, we have one public comment.

MEMBER EWING-TAYLOR: Okay. I'm going to go with Marlene up here and then we'll come back to Vegas.

MEMBER GARCIA: Thank you.

MS. LOCKARD: Good morning. Thank you, Madam Chairman. My name is Marlene Lockard, L-o-c-k-a-r-d, and I'm representing RPEN, Retired Public Employees of Nevada.

Just a couple of quick comments. On Item 7 that is in your packet, that will entail doing a participant survey, we would like to make sure that there is a specific date included when the participant is asked to compare 2012 benefits and costs to where we are now and would you like to increase, decrease cost or benefits that the information on what exactly the 2012 costs are or were are outlined and they know and can compare apples to apples. And it is my understanding that that's going to be done and a table provided. And so we just want to make sure that happens.

Additionally, we hope that he'll be able to carve out the participants by category so that we will know what the retiree responses are versus the actives and other respondents.

And finally, on behalf of Jack Harris, president of RPEN, he would like to convey his thanks and RPEN's thanks for staff and others at Towers Watson for helping go through specific problems he has outlined for some of the retirees

and he's grateful for that assistance in resolving some of those issues.

And then -- I forgot one other item. It will come to me in another public comment.

MEMBER EWING-TAYLOR: And you'll have more opportunity.

MS. LOCKARD: Thank you.

MEMBER EWING-TAYLOR: Thank you, Marlene.

Let's go to Vegas.

MR. WILSON: Yes. Hi. My name is Conrad Wilson and I'm the past chair of the classified staff counsel down here. And, you know, there's been some concerns with the premiums rates overall, especially with the HMO, and even for the actual deductible for the PPO. You know, when you're looking at a family and you're going to ask that family to turn around and pay I think it's $3200 or even more. You know, most of us don't have that sitting in our checking accounts. It's the same thing for the HMO. When you're asking a family to pay well over $600 in premium costs to be covered, it seems to me that that's -- that's a huge expense. And why are we asking that of our state employees when our state employees give so much back?

You know, we've been told over the years that, you know, that it was -- Well, it was because of data that we didn't have was the reason why our premiums have stayed so

high. Well, we've met those needs, but it still seems to be that we're not looking outside. You know, when you only, you know, carry six insurance carriers such as, you know, let's say Anthem and, you know, Hometown Health, you know, you know, Health Plan of Nevada, are there any exceptions out there? I think there are. But are we looking at that? That's what we have to begin to do. We have to make these people become, you know, basically competitive within themselves. So if you're not going to offer me a better premium then I'll take my business elsewhere.

I understand, you know, that we, you know, contracted these companies out. But at some point you have to make them start to see that our people need health care. A healthy employee is a better employee. A healthier employee isn't running to the doctor every day. They're not sitting on pills. They're not having to do that. And that's a huge perspective. That's what you guys have to, you know, begin to start to recognize is a healthy system is a better system. You can't keep relying on this if we keep band-aiding this, they told us this is what it costs. But my thing is hold them to it. Hold them to the grindstone on that. And again to make them to become competitive companies, not these companies that feel that I can keep offering -- I can keep raising premiums, I can keep doing these things, but these things are hurting our own state,

these are hurting our own people. These are hurting our own children. Our children are affected by this. I know some of you may sit there and, you know, and, you know, it doesn't matter but it does matter. If I have a child that's, you know, disabled, do I need to go broke? I don't think so.

I think that it's your obligation when you took the contract to run our system was to basically make us better, make us better every year, not make us better every now and then. That seems to be the case. It seems that we've kind of got lost and, you know, we've kind of got caught up in the fact that the insurance company kind of dictate over us. No. You dictate over the insurance companies.

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

MR. WILSON: That's your obligation when you took the position. When you took that position that was your obligation to every state employee was to make it better for us every single year. That's something that I want to hold you to. That's something that every classified individual, whether they be faculty, staff, pro staff or who ever within the state system has asked you to do. I'm asked to do my job. I'm just asking you to do yours.

MEMBER EWING-TAYLOR: Thank you, Mr. Wilson.

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

MEMBER EWING-TAYLOR: Rosalie, is there any more

comments in Las Vegas?

MEMBER GARCIA: No, not this morning.

MEMBER EWING-TAYLOR: Okay. Thank you. Is there any more comment here in Carson City? Okay. Then I will recognize that Board Chair Drozdoff has shown up and I will turn the meeting over to him.

CHAIRMAN DROZDOFF: We're on Agenda Item 3?

MEMBER EWING-TAYLOR: 2. No. 3, yes. Sorry.

CHAIRMAN DROZDOFF: All right. So let's -- Thank you, Jacque. I apologize for being late. So let's move to Agenda Item 3.

MR. HAYCOCK: Thank you, Mr. Chairman. For the record, Damon Haycock. And before you arrived we're going to do public comment, of course, on this adoption hearing. If it pleases the chair and the board, I will just go through the specifics of it and then we'll call for public comment.

So this begins the adoption hearing for Regulation R028-16. NRS 287.043, the existing law provides that certain public employees, state officers, and members of the legislature become eligible to participate in the program on, one, the date of hire or first day of the term of office of the public employee, state officer, or member of the legislature if that date is the first day of the month, or two, the first day of the month immediately following the date of hire or first day of the term of office of the public

employee, state officer, or member of the legislature.

This regulation makes conforming changes to certain sections of the Nevada Administrative Code. There are three sections to this regulation.

Section one eliminates the waiting period so that such employees are eligible to participate in a program again on that first day that he or she returns to full time employment for those that are on leave without pay or elect not to pay their program premiums while on leave and later return to work and eligible to participate in the program.

There is also a part on retired justice or judge who accepts re-employment as a justice of the Supreme Court or district judge that they're also eligible to participate on that first day of the month if it is the first day of the month when they become eligible or the first day of the month after -- or excuse me. The second month if they become eligible anytime after the first day of that previous month.

Section two talks about, again, effective dates of employment. And all of these are housekeeping. They are really aligning the regulations that we currently have here at PEBP to the Nevada Revised Statutes and they're all based on the waiting period.

Section three repeals certain obsolete regulations. You'll see that we have the exact language on pages two, three, and four where in red we line through those

pieces that are being eliminated. That's that 90-day waiting period. And the blue is the new information, those effective dates of either employment or re-employment.

And on page five, you'll see that NAC 287.3105 is the first requested repealed section. That, of course, is to do with that waiting period, again. And that we already have eligibility rules that we are utilizing within our current processes and our other regulations. So this is redundant.

287.500, again, talks about seasonal employees, biennial employees and at 90 days of full-time employment. So our current information, our current regulations already support this, and so these are just redundant and excessive.

The regulations that we are discussing today, on February 16th we held a workshop and we received public comment on a series of different parts to these regulations. These are the ones that we are bringing forth for adoption today. The other comments that came up were on defining a participant. There was discussion about surviving spouses and children of firefighters and police officers who lost their lives. Those you will not see here because those are already in place today. The participant, we were trying to define it with the deputy attorney general, but after discussions with the Legislative Counsel Bureau, it was decided not to bring that forward as a regulation because PEBP or any agency is not necessarily appropriate for us to

define another agency's definition.

And with that, I can take any questions or we can move on to public comment, Mr. Chairman.

CHAIRMAN DROZDOFF: We'll start with questions from the board. Are there any questions from the board?

Seeing none, we'll open it up for public comment.

MS. BOWEN: My name and words for the record, P-e-g-g-y Lear, L-e-a-r, Bowen, B-o-w-e-n. And it's only that included under repeal sections under section four on page four, because it was included as a person or critical labor shortage, are we -- do we have an addressed critical labor shortage person coming back in after being retired and receiving both? Are we eliminating whether a person with critical labor shortage needs to be defined, or is the fact that they're still retired and receiving the other retirement. In other words, if I go back to work and in a critical labor shortage area, will I still be able to be covered by insurance?

MR. HAYCOCK: For the record, Damon Haycock. Very good question, Ms. Lear Bowen. But that section is not being repealed. That section is staying in where it is. You're talking about on page four, section four, retired officer returns to full-time employment. The repealed sections are everything below that block. So on page five at the bottom --

MS. BOWEN: I see okay thank you.

MR. HAYCOCK: -- is the part. So that is still intact.

MS. BOWEN: Thank you very much.

MR. HAYCOCK: You're welcome.

MS. BOWEN: Thank you very much for pointing that out.

CHAIRMAN DROZDOFF: All right. So no more questions from the board, no more public comment. I'm happy to entertain a motion. What do you need?

MR. HAYCOCK: For the record, Damon Haycock. We just need a motion to approve and adopt the Regulation R02 dash -- R028-16.

MEMBER BAILEY: For the record Don Bailey. I move to approve the motion for R028-16 to be approved by the board.

CHAIRMAN DROZDOFF: That motion was made by Don Bailey. Is there a second?

MEMBER VERDUCCI: Here.

CHAIRMAN DROZDOFF: Second.

MEMBER VERDUCCI: Tom Verducci for the record.

CHAIRMAN DROZDOFF: Tom Verducci for the record. Any further discussion? Seeing none, call for the question. Those in favor please say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN DROZDOFF: Are there any opposed? Are there any abstentions? Okay. It carries unanimously.

For our new board members we'll move to Agenda Item 4.

MEMBER COCHRAN: Leo, just to let you know.

CHAIRMAN DROZDOFF: Yes, Chris.

MEMBER COCHRAN: Just that I'm here.

CHAIRMAN DROZDOFF: Oh, okay. Thanks, Chris. I just got here a little bit ago myself.

MS. LOCKARD: I'm sorry, Mr. Chairman. I remembered what my other item was. This is Marlene Lockard. And it's kind of important. It stopped me here. So first I want to thank the -- Mr. Haycock for being responsive in providing wireless service in this room now. But could you give us the password? Thank you.

CHAIRMAN DROZDOFF: Okay. So for our new board members, if you're at all familiar with the legislature or even other places, what we've done is we've got relatively consistent items that show up routinely and we give an opportunity to just approve all of these in a consent agenda and then allow --

MR. HAYCOCK: Yes.

CHAIRMAN DROZDOFF: -- and then allow for the -- anything that is of question or of special interest to simply be pulled off the consent agenda. So the way it works is if

it's not pulled off we'll approve it in one motion. If it is pulled off, we'll approve what is -- what we do want to approve on consent and then hear the others after that.

So we are on Agenda Item 4. Is there anybody that wants to pull anything from the consent agenda?

MEMBER VERDUCCI: I had one item for discussion on Section 4.1, approval of the minutes from the last meeting. Listening to the audio recording, two of the members were listed as absent, and I was going to request that the word excused that went along with the audio recording be added. I just think it's very important that the words that were at the meeting be included in the agenda or in the minutes.

CHAIRMAN DROZDOFF: All right. Well, we'll make sure we catch that. Is there anything else that needs -- Jacque.

MEMBER EWING-TAYLOR: Yes, Mr. Chairman, I would like to pull 4.2.

CHAIRMAN DROZDOFF: All right. Is there anybody else that would like to pull a consent item?

MEMBER ANDREWS: Mr. Chairman, Ana Andrews for the record. Yes. 4.31 and 4.33. I just have clarification questions on those.

CHAIRMAN DROZDOFF: All right. Anybody else?

MEMBER COCHRAN: Mr. Chair, this is Chris

Cochran.

CHAIRMAN DROZDOFF: Yep.

MEMBER COCHRAN: Since Ana has already pulled 4.31, I would also like to include 3.2 just for -- just to ask a question or ask a request.

CHAIRMAN DROZDOFF: Anything left? So it looks like with the one-word change for Tom on 4.1 as well as 4.34 and 4.35 are eligible for a consent agenda approval. Do I have a motion to that effect?

MEMBER EWING-TAYLOR: So moved.

CHAIRMAN DROZDOFF: Motion by Ms. Ewing-Taylor. Is there a second?

MEMBER BAILEY: Second.

CHAIRMAN DROZDOFF: Second by Don Bailey. Any further discussion? Seeing none, all those in favor please say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN DROZDOFF: Any opposed? Any abstentions? Okay. Motion carries.

So let's go to 4.2. Jacque.

MEMBER EWING-TAYLOR: Thank you, Mr. Chairman. I'm referencing the minutes as well and wanted to know if staff could clarify whether or not Mr. Cochran and Mr. Haycock and Mary Catherine worked together on that item as indicated on page two of the minutes, decided that Member

Cochran would meet with Executive Officer Haycock and Mary Catherine Person to work on the revised language to bring back at the next board meeting. Could you identify where in this particular item, in 4.2, where that would be?

MR. HAYCOCK: For the record, Damon Haycock. Thank you, Madam Vice Chair. We did work together immediately following -- actually during the last board meeting we received information from Member Cochran about his concerns of specific language that was sent to Mary Catherine Person at HealthSCOPE benefits and then we collectively reformatted that language. And I'm going to, because she wasn't here last time and I think she did a great job, I'm going to let Nancy go ahead and share exactly what was done and where it was at. Because it was done a lot clearer. And I think this answers those questions from the last board member -- or board meeting, excuse me.

MEMBER EWING-TAYLOR: So it was -- the section that Chris was talking about was 4.1, Section B, Subsection F. And there was some language that he wanted clarified. And I just wanted to know where that shows up in 4.2.

MS. SPINELLI: Nancy Spinelli for the record. It shows up in 1.A, so the non-emergent air transportation.

CHAIRMAN DROZDOFF: Can you repeat that, Nancy, for folks back there.

MS. SPINELLI: This is Nancy Spinelli for the

record. And this is -- The new language is in 1.A.

MEMBER EWING-TAYLOR: Okay. So then -- Thank you.

Chris, is that your understanding and are you happy with that language?

MEMBER COCHRAN: Yes, I saw it. I think it makes it more clear to have the air, non-emergent air transportation included in the title. Because originally it said non-emergent transportation and then later in the section refers to air transportation. So I just wanted it to be clear because I think it could create a big problem for us down the road if we didn't specify that. And I get -- I also get the reasons in looking at some of the costs based on the audit report that we have later. So I think it's important to specify that.

MEMBER EWING-TAYLOR: Okay. But the concern that you had at the last meeting has been addressed by this change or this document in 4.2?

MEMBER COCHRAN: Yes.

MEMBER EWING-TAYLOR: Okay. Thank you.

MEMBER COCHRAN: Yes.

MEMBER EWING-TAYLOR: And, Leo, to you, you wanted the intent of 4.1.b, lower case t, cleared up. And that so who ever on staff, Nancy, can you tell me if that was done and where that is.

MS. SPINELLI: That is in 1-B. And this is to add the non-Medicare plan when it pays -- I think it was Jim's request to have this in there for the non-Medicare information. I'm trying to make sure it's not a --

MEMBER EWING-TAYLOR: Thanks. I'm just trying to walk this back and forth and I was having a hard time doing that. So thank you for helping me work through this.

Then on page two, well, they're not numbered but it's page 2-D on the second full paragraph, I know in the past we have often used CDC guidelines for things. So should the CDC be listed in that list of evidence-based guidelines, findings, and assessments of the following entities?

MS. SPINELLI: That's a great question. And I need to defer that to Mary Catherine because this language actually came from HealthSCOPE enterprise.

MR. HAYCOCK: You know, for the record, Damon Haycock. While she's coming up here, I don't think there's anything negative about including that in there. I think it's a great idea. And regardless, we can make that change and make sure that it goes out in the MP before we post it.

MS. PERSON: Agreed. This is Mary Catherine Person for the record.

MEMBER EWING-TAYLOR: I'm so glad you walked up here for that. So I think that was all. There was another item that it applies to another agenda item, so I'll ask it

at that time. Thank you, Mr. Chairman.

CHAIRMAN DROZDOFF: Thank you. Are there any other questions? And if not, I'd accept a motion to approve 4.2 with the one change about CDC if that's the motion.

MEMBER ANDREWS: So moved. Ana Andrews.

CHAIRMAN DROZDOFF: Moved by Ana. Seconded by Jacque Ewing-Taylor. Any further discussion? Seeing none, I'll call for the question. All those in favor please say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN DROZDOFF: Any opposed? Any abstentions? Okay. Approved unanimously.

Okay. So let's go to 4.31. Ana.

MEMBER ANDREWS: Thank you, Mr. Chairman. Ana Andrews for the record. As I said, I just have a clarification. On the power point presentation for 4.3.1, page seven, is this just for plan year '15? Is this mislabeled and maybe it's plan year '16?

MS. PERSON: For the record this is Mary Catherine Person with HealthSCOPE Benefits. You are correct, it is mislabeled. It is plan year '16.

MEMBER ANDREWS: Thank you.

CHAIRMAN DROZDOFF: Is that it, Ana?

MEMBER ANDREWS: Yes, Mr. Chairman, that's it.

CHAIRMAN DROZDOFF: Anything else on this item?

Seeing none, I'll take a motion with clarifying that one change on plan year '16 on page seven.

MEMBER ANDREWS: So moved. Ana Andrews.

CHAIRMAN DROZDOFF: Moved by Ana. Is there a second?

MEMBER EWING-TAYLOR: I'll second.

MEMBER GARCIA: Rosalie Garcia. Second.

CHAIRMAN DROZDOFF: Seconded by Rosalie Garcia. Any further discussion? Seeing none, we'll call for the question. All those in favor please say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN DROZDOFF: Any opposed? Any abstentions? The motion carries.

We'll go to 4.3.2. Chris, I believe that's you.

MEMBER COCHRAN: Yes. I just need some clarification on -- I'm trying to catch up here. On the discussion on claims that -- on page 11 of the report and it talks about claims that are denied, I'd like to know what happens on just for an explanation to the board when claims are denied what is the next step? What happens with those particular claims and who's paying for them?

MS. CULVER-MOLEZZO: For the record, Windy Culver-Molezzo, Hometown Health. Board Member Cochran, actually when a claim is presented and it is denied, it goes through, you know, the mapping that goes to the plan

document. A member at the time of denial would be given notice in writing and within that it also includes all of their appeal language if they choose to move forward. And if they do go that route, then that appeal would be reviewed. It's reviewed on many different levels per their rights. If that helps.

MEMBER COCHRAN: It does a little bit. But so let me just ask on appeals because I didn't see any information on appeals in the report. If the report is showing claims denied, does that mean following all of the appeals process?

MS. CULVER-MOLEZZO: Typically claims denied would be the first round of denial. So that would be that the claim was presented, either it was an exception to services that would be covered or it's denied based upon medical necessity if it's an authorization. So this would be the first round of denial just for that particular claim.

MEMBER COCHRAN: And so when a claim is denied, and I'm assuming it's a claim that's submitted by a provider, so the provider is denied reimbursement, and let's say the provider ordered these tests for a particular patient, the provider doesn't get paid, does that provider then end up billing the patient for the services charged?

MS. CULVER-MOLEZZO: In many cases it can. In other cases the provider may choose to write off that member

balance depending on, you know, what that dollar amount may be and also conversations that the member may have with that provider. You know, we do see a lot of times where the provider does write off that number balance. If they are contracted by, you know, the network they're typically, you know, working with the member. But there are cases where the member does get balance billed and they would be responsible for that dollar amount.

MEMBER COCHRAN: Okay. So is there an appeals process for the member to go back to HealthSCOPE to appeal the charge? For example, if a patient didn't know what exactly the reason was that they were being provided a particular service and they're just following the recommendations of their provider, they don't know to say no, I don't want to have that test if it's not going to be covered by my plan? Are there options for the individual? And so how do we change that behavior of providers to make sure that the balance billing on these cases are not going to be charged off to our members --

MS. CULVER-MOLEZZO: Absolutely.

MEMBER COCHRAN: -- if they're unnecessary?

MS. CULVER-MOLEZZO: Right. Absolutely they have the opportunity to appeal. I think HealthSCOPE could speak better to their appeal process and what providers and members have opportunity to appeal that determination based upon the

claim.

MEMBER COCHRAN: Okay. So then on the case of appeals, can we in future reports get information on the number of appeals and the number of appeals that have been resolved?

MS. CULVER-MOLEZZO: Yes, absolutely. And would that be, just to clarify, appeals that are based on authorization for services or would that be claims or both?

MEMBER COCHRAN: Well, I think it needs to be both because I'd like to know what kind of resolution we have, you know, if a member -- Again, one of the issues I see potentially in the delivery of health care services is that members -- individuals are not necessarily medically literate to know what should be provided, what shouldn't be provided, what things cost, et cetera. And so, for instance, if a service is provided in the provider bills and it isn't reimbursed and it turns around and charges the member, those services could be pretty expensive for the member. So I just want to make sure that we're doing -- that everybody, you know, that it relates to that transparency issue on pricing, you know. And maybe it's an issue that the providers don't know that these services are not going to be reimbursed.

You know, it just creates -- I know it complicates the system. I understand that. But if part of this is to reduce waste and then I think that it's important

that the providers understand that and that the members understand that.

MS. CULVER-MOLEZZO: Absolutely.

MS. PERSON: If I can, this is Mary Catherine Person from HealthSCOPE Benefits for the record. Let me clarify as well. The report from Hometown Health is actually identifying pre-certifications that are denied. So typically with those pre-certifications that are denied, those services don't actually happen at that point, and then they provide additional clinical information or other things for that appeal to actually be -- or that to be overturned through the appeal process because those are considered actual emergent appeals. And so those are taken care of at the time. Versus in our world there are administrative appeals which are referred to and we do provide a quarterly report or actually a monthly report to PEBP on all appeals as well as all provider inquiries. We have that broken down by individual sort of categories as well. I believe often that is in the board packet and it can certainly be included as well. That information can be provided to the board.

MEMBER COCHRAN: Okay. I get that, Mary Catherine, on terms of the pre-certification. But on page 11, at the bottom of page 11, says third quarter data shows eight admission denials for a total of 11 days denied. Three admits with days were denied and not covered by the plan.

Three admits with five days were denied as not medically necessary by the plan. One admit with one day. So these people have been admitted and they've been provided services and, you know, so now it doesn't look like these are pre-certifications. Are you getting pre-certified or pre-authorized in order to be admitted in to -- for the care?

So that's, you know, that's really the crux of my question, because it looks like in this case at the bottom of that page that these are services that were provided, not pre-certifications that were required.

MS. PERSON: So what I would suggest is let us go back and confirm whether in fact these did occur or if it's truly a communication component with how it's being reported and then we can provide that additional information back to the board. We'll work on that.

MEMBER COCHRAN: Okay. Because I think that would be helpful because inpatient care is tremendously expensive. So if the care is being denied and then that -- and then the provider is going back to the patient for that, that could be a significant cost to the patient. So I would like to have that clarification.

MS. PERSON: Agreed. We'll take care of that. We'll work together on it.

MS. CULVER-MOLEZZO: And we can actually get more information today on what the criteria is for those who are

denied, especially if they're in the inpatient and staying. Typically those UR services at that facility are calling in, submitting information, trying to get additional days approved. And, you know, it's working back and forth with the case manager. So I will call our clinical team today and have an answer for you at the end of the board meeting.

MEMBER COCHRAN: All right. Thank you.

CHAIRMAN DROZDOFF: All right. So Chris, are you comfortable making a motion approving this with the clarification that you will be getting an update on admission denials in the near future?

MEMBER COCHRAN: Yes. I'll make that motion to approve the report as provided with additional information pending.

CHAIRMAN DROZDOFF: Regarding admissions denials. Okay. Is there a second?

MEMBER BAILEY: Second.

MEMBER ZACK: I'll second. Christine Zack.

CHAIRMAN DROZDOFF: Christine Zack, second. Any further discussion? Seeing none, call for the question. All those in favor please say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN DROZDOFF: Any opposed? Any abstentions? Motion carries.

Hello, Christine.

Yes. And I will note for the record that Mr. Wells, Jim Wells, also joined from our cabinet meeting earlier today. So please mark him here as well.

All right. So now we'll go to 4.3.3. Ana, I think that's back to you.

MEMBER ANDREWS: That's correct, Mr. Chairman. So I'll be referring to the power point presentation. I think this is mostly to get clarification so that we can see how successful the program is or not. So first of all, this pilot program is a statewide; correct?

MS. PUCKETT: No. This is Pam Puckett, Director of Clinical Integration at Carson Tahoe Health. This is a pilot program specifically for those members who have Carson Tahoe physician clinics as a primary care physician and who's on the self-funded plan with PEBP and who has diabetes. So it is not a statewide program.

MEMBER ANDREWS: Okay. Thank you.

Now, on the program participation summary I know it says quarter and it says eligible participants 53. Only 28 decided to go with the program.

MS. PUCKETT: Correct.

MEMBER ANDREWS: Would it be safe to assume that those 53 identified and 28 participating are just for that quarter, they're not cumulative or going back to the plan year?

MS. PUCKETT: It is cumulative. This is a two-year program and it is cumulative. So as of the first quarter there were a total of 53 people who were eligible to participate in the program. Out of those 53, we have 28 participating, for a percentage of 53 percent participating.

MEMBER ANDREWS: So this is calendar-year based not fiscal-year based or plan-year based? The plan year started July 1.

MS. PUCKETT: Right. This program started October of 2014. So it's a cumulative. So it's as of right now. Because those people could choose to sign up and participate at any time.

MEMBER ANDREWS: Okay. And I just have a comment because knowing about diabetes. The fact that the average A1C for those who have been participating greater than nine months has dropped from 7.5 to 6.8 is a success to me.

MS. PUCKETT: Correct.

MEMBER ANDREWS: So I would think that those who are participating would keep up the good work and continue to try and bring it down even lower. Thank you.

CHAIRMAN DROZDOFF: Thank you, Ana. Ana, are you comfortable making a motion approving this item?

MEMBER ANDREWS: Yes, Mr. Chairman. I make a motion to approve Item Number 4.3.3.

CHAIRMAN DROZDOFF: There's a motion. Is there a

second?

MEMBER BAILEY: Don Bailey. Second.

CHAIRMAN DROZDOFF: Seconded by Don Bailey. Any further discussion?

MEMBER COCHRAN: Mr. Chair, this is Chris again. I do have a question.

CHAIRMAN DROZDOFF: Okay.

MEMBER COCHRAN: On the chart that Ana referred to, because I had flagged that as well, when we're looking at -- So this is based on nine participants in losing the -- in having a reduction in the A1C. Do we know whether or not all of the patients had a reduction? Because it's showing an average. And I'm just kind of curious as to whether or not one or two people could have a big reduction and it brings the reduction down for everyone else. So since there are only nine, I think it would be helpful to have, you know, somewhat of a frequency distribution on those nine people so we can see how successful that is per individual. If we had, you know, 50 participants and showing that average loss I could be more comfortable with it. But when they're only nine as you're in, it could be a reflection of only one or two individuals. And I don't know. So I don't know how the A1C, you know, how difficult it is to lower it, you know, seven-tenths of a point and whether one person or two or if it would take the group as a whole to result in that type of

a loss.

So I agree with Ana that it's good that they're doing that. I just would like to know across the board are we seeing these participants doing this or is it just a couple within the sample?

CHAIRMAN DROZDOFF: All right. Let me ask her. Do you know the answer to that question?

MS. PUCKETT: It is an average. So it factors in some A1C may have gone up. Some may have, you know, gone down. But we can certainly break it out by individual if you guys want to see that as far as, you know, this is where they were at initially. I mean identified initially and then this is where they're at currently.

CHAIRMAN DROZDOFF: Okay. So for the nine people you can provide that information to PEBP and PEBP staff and get it out to the board?

MS. PUCKETT: Okay. Perfect. Thank you.

CHAIRMAN DROZDOFF: All right. Thanks, Chris.

Are there any other questions?

MEMBER ZACK: Yes. Christine Zack. I have a question. Do we have the associated cost savings data? Obviously this is my second board meeting, so I wasn't here when the program was implemented. But I would assume that in addition to the wonderful health benefits there's also a cost savings. Is that data available somewhere?

MS. PUCKETT: How the program, the agreement was structured is the diabetes education and care management that the PEBP participants and their dependants receive, there's no charge for that. At the end of the two-year program, this is a two-year program, so it ends October 31st 2015 -- '16. My apologies. That's when we will do a comparison. We'll work with HealthSCOPE and the staff here at PEBP to look at what their claims were prior to the people who participated in a program, what their claims were at the beginning of the program as opposed to at the end of the program. And if there are savings it's a 25 -- Carson Tahoe Physician Clinic would receive 25 percent of those savings. And there are some outliers or caveats in regards to that. I think there were certain cancer diagnosis with that were subtracted or someone has had a transplant. I can't remember them all off the top of my head. But it is outlined in the agreement.

MEMBER ZACK: Great. Thank you so much for the clarification.

CHAIRMAN DROZDOFF: All right. Thank you, Christine.

Any other questions? All right. Seeing none, we do have a motion on the table, so I'll call for the question. Those in favor please say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN DROZDOFF: Are there any opposed? Are

there any abstentions? Motion carries.

Okay. So let's keep going. Let's go to Agenda Item 5. Bob Carr and Mary Catherine, if you guys want to come up together, it would be great.

MR. CARR: Thank you, Mr. Chair, Members of the Board. For the record my name is Robert Carr and I represent Health Claim Auditors, Inc.

This past April we performed an audit of claims administered by HealthSCOPE Benefits for PEBP's third quarter of fiscal year 2016. This audit included a valid random selection of over 500 medical, inpatient, outpatient, and dental claims with numerous large dollar claims audited on a bias based which are not included within the statistical calculations and guarantees.

This audit found that HealthSCOPE passed all negotiated guaranteed performance levels with the exception of the 99 percent financial accuracy guarantee, which resulted in a metric measurement of 98.53 percent.

The HealthSCOPE adjudication system is functioning at a high efficiency level. However, of the 12 types of errors detected, the majority of the incorrect dollars paid within the financial accuracies statistics were within two issues that required minor intervention of HealthSCOPE personnel. The first was the incorrect application of medical/surgical guideline reductions as they

pertain to American Medical Association and Medicare rules.

The second was the incorrect application of allowing rate reductions for anesthesia services when both a CRNA and an anesthesiologist bill the same session.

As reported previously, this audit also detected claims from specific hospital providers that billed with revenue code 390, which is blood product services, that were not being priced by Hometown Health because invoices were not received by the providers.

We have been informed by Hometown Health that these contracts have been reopened for the purpose of resolution of this issue and we will follow up and report the outcome of this issue in our next audit report.

I think it is also very important to bring to the board's attention when a PEBP vendor like HealthSCOPE provides services beyond the normal contracted levels by actively seeking alternative methods to reduce egregious billing. It is very typical throughout our country and in every audit that we do to identify large claims audits that are considered non-PPO and are those that have no usual and customary or reasonable and customary rates associated with that service.

An example of this issue was found within this audit which included the excessive billings of air flight service providers. Multiple claims were identified but two

specifically were billed to PEBP at approximately $577,000, of which a reasonable amount was researched and these claims were reduced substantially, hopefully which will result in a possibility of over a half million dollar reduction.

We recognize that HealthSCOPE sought out the appropriate resource experts and applied reasonable application of these claims, which are beyond the efforts that we usually observe and conducted by most of the administrators throughout our country.

This audit found customer service levels within agreed levels, identified overpayments decreased by $330,000 to a 1.5 million dollar level and open subrogation cases remain steady at 2.3 million dollars. Both of these levels were agreed to by PEBP.

The soft denied claim level of 2,871 claims was reduced by 3.2 million dollars to a more reasonable level of 10.3 million dollars.

The personnel team dedicated to your plan had some changes during this audited period but none that should have affected any service levels to PEBP.

The biggest change was the deletion of four customer service representatives and the addition of four individuals.

All issues that were identified in my previous audits with the board that the board accepted the

recommendation for have been resolved.

It is our recommendation that PEBP collect the approximately $27,000 penalty for the financial accuracy under performance.

And as a final note, Mr. Chair, it remains our opinion that HealthSCOPE remains a very qualified administrative vendor and a very good partner for PEBP continuing.

With that, Mr. Chair, that completes my report.

CHAIRMAN DROZDOFF: Thank you, Bob. Thank you for your, as always, really good and helpful review.

For the new board members, what we typically do here is we -- you know, there is a recommendation, we typically allow for the vendor in this case, HealthSCOPE, to sort of respond in kind to what they have heard from, and read, from Health Claim Auditors and then we'll take an action after that.

So with that, Mary Catherine.

MS. PERSON: Mary Catherine Person for the record. As Mr. Carr noted, we did nail the financial accuracy this quarter by less than half a percentage point. And it was really two claims that caused that.

And to Mr. Carr's point, those really were regarding multiple surgery as well as anesthesia claims that are quite difficult. In a couple of these cases it's the

attaching of multiple claims that come in at very different times from varied providers as well. So it is somewhat of a manual process to capture some of those.

We have done some additional programming to be able to identify more of those on the front end as well as we have additional levels of review within the organization where our claim supervisors are reviewing all of those claims as well prior to those being released. So we have made those improvements.

To Mr. Carr's point as well, we are constantly looking at ways to help manage PEBP's money. And in the million dollars that we noted in the letter this time, that actually does not include any of the savings from the air ambulance claims that Mr. Carr noted, as well as HealthSCOPE benefits does not charge you in any way for the air ambulance piece. You're merely paying the vendor fee for the review of those claims. We do not in any way receive compensation for them.

CHAIRMAN DROZDOFF: Are there any questions for either Bob Carr or Mary Catherine? Jim Wells.

MEMBER WELLS: Thanks, Mr. Chairman. Excuse me. I noticed that there were a few claims that were in the errors that were related to the vendor fee schedule update, some processed before and some processed after the date the fee schedule was received. One was the fee schedule

retroactive and if so how far. And, two, how long did it take you to get those loaded and processing claims directly after you received them?

MS. PERSON: Mary Catherine Person for the record. So that schedule was received, I believe, January 21st. It was retroactive to January 1. And I believe it was the first week in February. It takes about two weeks to get those loaded. So I believe it was somewhere around the first week in February when it was actually loaded.

CHAIRMAN DROZDOFF: Anything else, Jim? Anyone else? All right, seeing none, I certainly appreciate the good work on the cost savings as we move to accept excess penalties. But we really do appreciate that significant cost savings and it does bear the PH.

So with that, we will move to -- I'll see if there's anybody interested in making a motion to accept the audit report and assess the penalties as outlined in Health Claim Auditors' report.

MEMBER WELLS: So moved.

CHAIRMAN DROZDOFF: Moved my Tom Verducci. Oh, by Jim Wells. Sorry. Seconded by Tom Verducci. Anything further discussion? Seeing none, I'll call for the question. All those in favor please say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN DROZDOFF: Any opposed? Any

abstentions? All right.

We'll move to Agenda Item 6.

MS. PERSON: Marry Catherine Person for the record. As we continue to look at cost containment strategies for PEBP, one of the items that we noted as we were looking at your membership is you have approximately 810 members who live outside of the State of Nevada. So these are members of the PEBP plan who do not live in Nevada. We're not talking about members who live right over the line in Utah or right over the line in California or places of that nature. These are folks who are flown throughout the country. Some of them are pre-Medicare retirees, but some are actually some of your folks who work in the state capitols around the country as well.

So as a result of that, one of the things that we noticed was that there was some significant cost savings that could come to the plan by looking at alternative options for network services for those members today. So these are members who truly live in these other states and so they are seeking care locally.

And as you can see, it's almost 11 million dollars -- a little over 11 million dollars of cost that would be considered in network. And you can see that that's broken down by facility and physician, with about 75 percent of it being facility.

When you look at it, and what we're trying to have the board approve today, is the fact that we would like to move to either Aetna or Cigna as an option for those members. The discounts will increase pretty dramatically over the existing national PPO network that we're currently using for those members. And it will also provide better access to care. So these members will actually at the very least their access to providers will increase by at least five percent as well.

One of the things and part of the reason we have not made a final decision between the two is there are some things that we're working with PEBP's CIO regarding data retention issues. We want to clarify those prior to making a final decision. And on the following page I'll show you the savings is almost equal between the two. So you can see that virtually there is really no difference between the two. It's slightly a little bit more access with Cigna but a little higher discount on the physician side with Aetna, which is what drives the differential there.

One of the components as well, with the Aetna arrangement, there is a stop/loss arrangement in there which will just be folded in to the PPO access fee if that was the direction we choose. In either of the situations we will have the utilization management. So the pre-certification would be conducted by either Aetna or Cigna in that case and

then we would provide the case, the information, to Hometown Health to follow those cases from a case management perspective. So just to fully disclose all of those different components as well.

So overall this is about a two million dollar savings to the plan on these 810 members. And it would be our intention to have this in place very soon, like July 1.

CHAIRMAN DROZDOFF: All right. Well, that may be -- that was going to be my question. So you have it down to two. You're still working on a couple of -- I guess my question was going to be should we wait until July, the July meeting, where you could have it presumably down to one and your reasons for it, either Aetna or Cigna, as opposed to, I guess we can somehow approve it saying, yeah, either one. But I'm just curious if there's a -- you know, what you think about that.

MS. PERSON: It would be our preference to go ahead and have the -- We have all of the details. I just need to have one final blessing with Chris regarding the items that have been provided by both to confirm.

CHAIRMAN DROZDOFF: So do you know who you are going to go with?

MS. PERSON: My probable suggestion is Aetna. But I want to confirm with Chris that he agrees based on the information that we have. So there are a lot of -- The whole

story around this revolves around record retention.

CHAIRMAN DROZDOFF: Okay.

MS. PERSON: And so that has been what I've been working with Chris on to try to resolve those issues as well.

But in part of the move to get this completed is also we're sending out ID cards to all members because of the pharmaceutical management change and so I think it would be confusing to these people to get one card and then to get another card within a month.

CHAIRMAN DROZDOFF: That's true. Okay. That's true. All right. Well, that's helpful. Are there any other questions? Jim.

MEMBER WELLS: Thank you, Mr. Chairman. My recollection is one of the reasons we didn't go this route before was exactly what you're talking about, and that's the contractual issues with the ownership and the deletion of the data by the carrier. So unlike the networks that we have now, Aetna and/or Cigna would be getting personal identifying information for our out-of-state participation. Has that been resolved and are they going to not receive it or have they agreed that it belongs to the state and will be deleted upon the termination of this contract?

MS. PERSON: So regarding -- I'll give you specifically regarding Aetna because -- So we did not have to provide eligibility to them at all. And when we send them a

reprised claim, which is a similar process to the EDI process that we have with HTH, we will actually not send the member name, member ID number. Any of that information will actually not be on the EDI file. So they will have the information that a person went to X facility, but they will not actually have the member information. They'll have the birth date but they won't know the name or the ID number or anything of that nature. So as a result of that, there's less communication of that information.

At the same time, we have an ability with them where the pre-certification calls will come to HealthSCOPE Benefits and we can actually do the intake components of that. And so we will also not have to provide them eligibility on the pre-certification cases. The only cases that they would then retain any information on would be a person who actually they conducted a true pre-certification regarding.

Aetna does have specific data retention policies. But they also have the ability to carve your data out so that at the point of termination then that data also could be -- they can't delete it, but they can house it separately specifically to you for -- and acknowledge that it is your data, if that makes sense.

The difference is on the Cigna side those claims go to them first and so they would in terms have more data

they have agreed that they would -- that it is your data and they have agreed to some requirements around the retention piece. But it's intrinsically they would house more of the data.

CHAIRMAN DROZDOFF: Does that answer your question, Jim? Are there any other questions? So obviously it's up to the board here. I would feel better about it if we would get a little bit of direction in the motion, like, you know, if it truly is Aetna with the lead to close the loop on the data questions, I think it would be better in my view if we made such a motion. Of course, we don't have to. We can simply leave it vague and say we approve the motion to go to one of these two moving forward. So I'll leave it up to you.

Dennis.

MR. BELCOURT: Chair, I will -- Open meeting law states, it's recently amended, that any administrative action regarding a person, you have to identify that person in an agenda. I think for purposes of this, either Aetna or Cigna would be a person. And so since we didn't agendize the name, I would recommend not making a motion specific as to any particular person.

CHAIRMAN DROZDOFF: Okay. I guess I stand corrected. All right. Well.

MEMBER EWING-TAYLOR: Could we make a motion to

direct Mary Catherine to make the selection based on her analysis as long as Mr. Wells' concerns were taken care of?

MR. BELCOURT: Certainly.

MEMBER EWING-TAYLOR: As long as we don't say who?

MR. BELCOURT: Well, as long as you don't make an action about a particular individual, you're fine, or entity.

MEMBER EWING-TAYLOR: Okay. I just wanted to clarify whether or not we could still do something. Thanks, Dennis.

CHAIRMAN DROZDOFF: All right. Anybody interested in making a motion?

MEMBER EWING-TAYLOR: I'll give it a shot.

CHAIRMAN DROZDOFF: All right. Go ahead.

MEMBER EWING-TAYLOR: Mr. Chairman, I would move that we allow Mary Catherine Person with HealthSCOPE Benefits to make a selection relative to a vendor -- Or actually technically I guess it's not a vendor. It's a network administrator for the external, the folks residing outside of Nevada or participants and allow her to make that decision based on her analysis and taking in to consideration Mr. Wells' concerns about who owns the data and who gets identifiable information.

CHAIRMAN DROZDOFF: Is there a second?

MEMBER BAILEY: I second it. Don Bailey.

CHAIRMAN DROZDOFF: All right. Is there any further discussion on the motion? Jim Wells.

MEMBER WELLS: Thank you, Mr. Chairman. I just want to be clear. I am not comfortable with sending a network PII, personal identifiable information. So I just want to make it clear that that's what my concern is, is that we are not as a matter of routine communications between HealthSCOPE and a proposed out-of-state network sending personally-identifying information that will no longer be under the control of or deleted by that particular organization. So that may restrict what Mary Catherine can or cannot do during that -- those statements.

CHAIRMAN DROZDOFF: All right. I think that's -- Well, the motion was that that satisfied your -- that satisfied your concerns.

All right. Any other questions or clarifiers? Seeing none, I'll call for the question. And this is in regard to Item 6.1. All of those in favors please say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN DROZDOFF: Are there any opposed? Any abstentions? The motion carries.

All right. Let's move on to 6.2. Mary Catherine is still on the floor.

MS. PERSON: Okay. So this is regarding telemedicine. And the board recently, some time in the fall,

I believe, had a presentation by Doctors on Demand regarding telemedicine. HealthSCOPE Benefits has had a contract with Doctors on Demand for several months and we have a significant number of clients who added that to their benefit plan for January 1 of 2016.

We are fully integrated with them from a system perspective and have real time eligibility and claims processing with them as well. And so as a result of that, one of the things that we had presented to staff was the fact that we believe overall there are some savings to be seen from the addition of the telemedicine provider for the PEBP plan. And we would process this as a PPO provider.

The way it also works is -- And the reason that we brought this to the table originally, actually sort of at the same time there were the other discussions going on, was that as we look at the data, which that's what's presented here, as you can see, we see about 46, almost 47 percent of your overall emergency room and urgent care spending is considered non-emergent just based on the diagnosis codes on those claims. In conversations with Doctors on Demand, it's probably a slightly smaller percentage of those folks who would truly use this type of product, which is the reason why we don't put this full amount as far as the expected cost savings from something like this.

But as you can see, there are significant

percentages and dollars spent on non-emergent visits. As well, the next page actually sort of breaks down the different types of those visits. One of the things to note with Doctors on Demand, there's several more slides in here which I will not bore you with, but they're here for those of you who are newer who might have not been at that board meeting, the product works either on your phone on a tablet or computer. This is totally voluntary, so the people can use it, not use it. But we do believe it will provide some cost savings as an additional way for people to access care and especially for the rurals as well.

CHAIRMAN DROZDOFF: Are there any questions for Mary Catherine?

MEMBER COCHRAN: Mr. Chair, this is Chris Cochran. I've got a couple of questions.

CHAIRMAN DROZDOFF: Go ahead, Chris.

MEMBER COCHRAN: Do we know how many -- How many doctors are we talking about in Doctors on Demand that would be available?

MS. PERSON: I just so happen to have a person from Doctors on Demand here, thankfully.

MS. PHILLIPS: Hi. I'm Lanette Phillips with Doctors on Demand, for the record. In our network we actually own and operate our own medical practice in every state and we have about 1400 providers that are in area and

300 for mental health.

MEMBER COCHRAN: So as a follow-up question. Are these providers licensed in the State of Nevada or would that matter?

MS. PHILLIPS: They are, absolutely. That would matter. They're actually licensed in whatever state the patient is calling from. So even if the 810 folks are outside of the State, whatever state they're contacting us from, the patient is routed to the physician.

MEMBER COCHRAN: Oh, I see. So this is targeted to the out-of-state and not necessarily to the in-state; is that correct?

MS. PHILLIPS: So I'm just saying as an example. I apologize. As an example, wherever the patient is contacting us from, the physician that is treating them will be licensed in that state.

MEMBER COCHRAN: Okay. So do we know how many that would mean in Nevada, since that's where most of our members are? How many physicians that would be?

MS. PHILLIPS: You know, I think we have probably ten to 12 staff for Nevada. I can personally say that I've used the service five times myself sitting in Nevada because I live here, and I was connected within three minutes.

MEMBER COCHRAN: That's great. I mean, I'm big supporter of this. You know, maybe you can put up billboards

like the hospitals do talking about the wait times, which I think misrepresents to patients that if you're sick go to the emergency room.

And you know, I also hear anecdotally on urgent care -- This is a pet peeve of mine. So urgent care is who a patient calls them or goes in to see them and they say well you need to go to the emergency room.

So I'm hoping we can improve patient behavior. I've used the telemedicine. It's a great opportunity for doing that. And it -- I think it's going to be in our best interest once if we move along this direction that we really need to educate our members about the availability of these services, the importance of these services versus using emergency rooms and potentially urgent cares. Urgent cares are a little less money than a PCP, but certainly much less than using the emergency room.

So, you know, I try to have this discussion all the time with people. When you're sick, you don't necessarily go to the emergency room. You start first with your doctor. So having these doctors available would certainly be a move in the right direction.

CHAIRMAN DROZDOFF: Go ahead, Mary Catherine.

MS. PERSON: For the record, one of the other items that I failed to mention is, that Annette mentioned, there are other health providers as a part of the Doctors on

Demand network as well. And so we do think that that may assist also on some of the access issues around that as well.

And to Chris' point, one other clarification is the only fee is there's a $40 per visit fee, which at the time of service Doctors on Demand pings us and confirms where somebody is in their deductible. And then if you have your deductible still to pay then you can either pay by credit card or you can use your HRA or your HSA card to actually pay the $40 visit right on the -- either the app or on your computer.

MEMBER COCHRAN: Okay. Which is helpful, Mary Catherine. It's an additional out-of-pocket. And this is a discussion we'll probably want to have further with staff. Because we talked about having telemedicine services available that I thought were going to be, you know, within network that wouldn't face any additional charges. But certainly $40 is a whole lot cheaper than if you walk in to an emergency room you're not coming out of there for less than $2,000 for an outpatient visit.

So, you know, I do think it's a move in the right direction. I would like to see us moving to telemedicine for our members where, you know, you have providers in there providing the services at the same rates that our current providers do on a visit. But it's a good start.

CHAIRMAN DROZDOFF: So let me move to Jacque and

then to Damon.

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

Chris, one of the things I wanted to confirm with Mary Catherine is when Doctors on Demand pings them about status of the deductible, if you've met your deductible, then my understanding is the co-insurance kicks in, so you would only be required to pay 20 percent of that $40.

MS. PERSON: That is correct.

MEMBER EWING-TAYLOR: Thank you.

MS. PERSON: And once you've met your out-of-pocket maximum then you would not be charged those dollars and then the plan would pay for that. It's just a $40 per visit charge, but it's fully integrated with the plan. So depending on where you are with the plan then will determine what the payments are.

CHAIRMAN DROZDOFF: Damon.

MR. HAYCOCK: For the record, Damon Haycock. Thank you, Mr. Chairman.

Chris, I think there might be a misunderstanding. The $40 payment is not in addition to a hospital visit. It is the visit to the doctor. And so it's actually a replacement cost.

So using a personal example, when I use my primary care physician or I use my physician here in this town, I pay $80 until I've satisfied my deductible. This

would give me the opportunity to spend only $40 and do it over my phone or my tablet or my computer and save me that initial out-of-pocket expense on top of those $40 going towards my deductible for my future health care needs. So this is a replacement cost. Not an additional cost.

MEMBER COCHRAN: Okay. Maybe I misunderstood in terms of, you know, with regard to the ER. I'm not quite sure where that's coming from. But it was my understanding that, and so you guys can correct me if I'm wrong, that if you use the service it's like a user fee that comes out of your -- that comes out of your deductible or comes out of your -- out of your co-pay. Am I correct on that? Isn't this $40 a user fee as opposed to necessarily the fee for the medical service that's being provided?

MS. PERSON: It is actually a fee for the medical service being provided.

MEMBER COCHRAN: Okay. So the fee is $40 without regard to additional medical charges.

MS. PERSON: Correct. Yeah. There aren't any additional medical charges, so it's just a flat $40.

MR. HAYCOCK: For the record, Damon Haycock. I do want to add one piece. If there's a prescription that is associated with the results of this visit, that prescription still needs to adhere to the payment of that prescription at the pharmacy. And so it's not an all-inclusive based on

whatever the treatment results are but it is for that office visit charge.

CHAIRMAN DROZDOFF: Right. It's analogous to an office visit. That's what it is.

Ana.

MEMBER ANDREWS: Thank, you Mr. Chairman. I'm going to ask the question that I believe I also asked it back in the fall when we had the presentation and it is for those members who do not have the ability to download and use a smart phone. And we discussed, I seem to recall, a booth that would be located in certain areas, and particularly I think we were talking about the rural areas, where these members can go in there and they can use the machine to do this actual telemedicine appointment, if you may. Is that going to be part of this?

MS. PERSON: I believe when we were talking about that, that was more related to some of the provider-based telemedicine. But certainly a computer could be used in any situation. So if the person was at their office or, you know, frankly you could probably even do it from a library or somewhere else where there is a computer.

MS. PHILLIPS: This is Lanette Phillips. Initially some of our folks that had that concern can simply just put an iPad or an iPad Mini in a separate room and have the kiosk version of Doctors on Demand deployed, which means

that the application version will shut done for PHI purposes within a certain amount of time.

MEMBER ANDREWS: Okay. I understand that. Forgive me for asking it again. But we're talking about people who might not have a computer, might not have a tablet, might not have the knowledge to use one of those. That's where I'm going with this question.

CHAIRMAN DROZDOFF: Well, why don't you answer the question directly. The bottom line though is that you are not proposing -- I mean, are you or are you not proposing, like, some sort of booth or anything like that?

MS. PERSON: We are not proposing that at this time. But if that's something that you guys feel like once it gets started and there's demand for those types of things then I think that would be obviously something that wouldn't be expensive to deploy.

CHAIRMAN DROZDOFF: So let's go to Tom and then to Damon.

MEMBER VERDUCCI: Tom Verducci for the record. I just want to point out that I'm very supportive of the telemedicine program. I think that in Nevada with the geographical distance to rurals, it's an excellent program, a likely cost savings. And more and more people are doing business through their iPhones now and it gives faster, more immediate access to physicians. I'm very supportive of it.

CHAIRMAN DROZDOFF: Damon.

MR. HAYCOCK: For the record, Damon Haycock. I just want to echo what Mary Catherine said. I believe this is the first phase of a potential multi-phased project. And so the first phase is to see if it works, to see who's using it, to get some data to determine demand and need. And from that we can research and creatively come up with solutions to continue to increase access in rural Nevada.

CHAIRMAN DROZDOFF: So to Ana's point that's not something that's being proposed but something that you will monitor the need for.

MS. PERSON: Absolutely.

MR. HAYCOCK: Yes.

CHAIRMAN DROZDOFF: Are there any other questions?

MEMBER COCHRAN: Mr. Chair, this is Chris again. I'm sorry. I should have asked this before. Just in terms of what you would normally see in an office visit for a patient, how do you do things like vital signs, blood pressure checks? I'm assuming you don't do that, because I don't know what tools are available to do that by a telemed. So are we going to see situations where the providers in this program are going to say, you know, you need to go see a physician or someone else where you're going to get referred to someone else to get more information for their diagnosis.

Say someone had strep throat, you couldn't take a throat culture, you know, over the phone.

MS. PHILLIPS: This is Lanette Phillips with Doctors on Demand. Very good question. They actually have about a 96 percent resolution rate. So there's actually, with our video technology there is a lot of visual instances where the doctor, for instance, with your example of strep throat literally can have the patient shine the light in their throat and see. And there's a lot of clinical things that are evident for around their evidence-based guidelines that actually don't require a strep test but can still lead to the diagnosis without clinical algorithms for strep throat.

So we do monitor our resolution rate and it is at about 96 percent because we do not want to, you know, have the client incur additional charges for a patient having to go get additional care.

MEMBER COCHRAN: Okay. All right. I just wanted to be clear on that. I still see it as a huge potential savings, you know. But I just wanted to be clear that, you know, because that, you know, some patients are not going to be as comfortable with, well, they're not going to take my temperature or they're not going to, you know, take my blood pressure, whatever. But these are really intended, if I'm not mistaken, for what a patient might consider to be an

urgent care situation, that they're sick now and they need to get resolution; correct? It's not like a regular office visit.

MS. PHILLIPS: Correct. This is not to replace the regular primary care physician. This is to provide a more convenient access to health care for these non-emergent situations. However, the folks are still going, unfortunately, to the urgent care or emergency room situations because they don't have that alternative.

MEMBER COCHRAN: Thank you.

CHAIRMAN DROZDOFF: Are there any other questions?

MEMBER ZACK: Yes. Christine Zack for the record. I'm also very supportive of telemedicine. I've been using it myself for years. I just have one question. And that is whether or not this is available to all ages? Because I think it will be a question we face whether or not children are eligible for this and what's the -- what's the starting point? Is it six months? Is it six years?

MS. PHILLIPS: This is Lanette Phillips with Doctors on Demand. It actually is available to all ages. So when you come in to the user experience you're going to ask if it's treating the child or the adult. And then of course that goes in to whether we route you to a pediatrician or an internist. But it is available to all ages.

MEMBER ZACK: Thank you.

CHAIRMAN DROZDOFF: Anything else? So before I ask for a motion, I guess I have a question for Damon, back to Chris' first series of questions. If the board does move forward with this, what efforts will PEBP make to make our participants know that this is a new tool available to them?

MR. HAYCOCK: Thank you, Mr. Chairman. For the record, Damon Haycock. We will refer back to our communication plan that we built up a while ago on how we're going to communicate to our participants. We will send out news letters. We will partner with Doctors on Demand, with HealthSCOPE benefits to jointly create a campaign to share this information with our participants and gently remind them from time to time that these services are available.

CHAIRMAN DROZDOFF: Well, okay. But maybe I guess I was looking for something, if you're looking to do something, this strikes me as, you know, I don't want to put anybody on the spot, but, I mean, a newsletter, like, when or if you want to get cards out, when?

MS. PERSON: We can put it with the cards next week.

CHAIRMAN DROZDOFF: Okay. That would be good. So did everybody hear that? Mary Catherine, can you say that a little bit louder?

MS. PERSON: Mary Catherine Person for the

record. We can include information on Doctors on Demand when we do the mailing for all the participants with their new ID cards in the next couple weeks.

CHAIRMAN DROZDOFF: I think that would be great as well as perhaps something on the website.

MR. HAYCOCK: Exactly. And I apologize, Mr. Chairman, for not being specific. We also sent out benefit-wide newsletters traditionally on a monthly basis. We were waiting to hear the results of this to send out our June letter. So I would imagine some time next you'll see it also mentioned in the newsletter that we're going to be implementing this process.

CHAIRMAN DROZDOFF: Okay. So you've got a newsletter, you've got the cards, and something on the website. That sounds pretty good.

All right. So if there are no other questions, I would take a motion on this Agenda Item 6.2.

MEMBER COCHRAN: Mr. Chair, just one more question. Sorry. Is there going to be an app available for this? Maybe you mentioned that. You know, because that would be the best way for members to have it is those who might use it are downloading an app that they keep either on their -- on any mobile device that they have, so that's the way they know they've got it.

MS. PERSON: Yes, there is an app, and that will

be part of the communication as well.

MEMBER COCHRAN: Okay. Thank you.

MEMBER EWING-TAYLOR: Mr. Chairman, I would move that we authorize our third party administrator, HealthSCOPE Benefits, to contract with the telemedicine vendor for virtual visits effective July 1.

CHAIRMAN DROZDOFF: Is there a second?

MEMBER ANDREWS: Second. Ana Andrews.

CHAIRMAN DROZDOFF: We have a motion by Dr. Ewing-Taylor. Second by Ana Andrews. Is there any further discussion? Seeing none, call for the question. Those in favor please say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN DROZDOFF: Any opposed? Any abstentions? Okay. Motion carries. So it is 10:40. Let's take a 15-minute break. That will allow for the surveys to get back. And we will meet promptly at 10:55.

(Recess was taken)

CHAIRMAN DROZDOFF: So before we go to Item 7, we have a couple things that we have to revisit. First is a question that we got during 4.3.2. I think Chris was asking. Anyway, we've got HHP with an answer.

MS. CULVER-MOLEZZO: For the record Windy Culver-Molezzo with Hometown Health. Thank you, Board, for letting me go back and gain additional information so that I

could answer your question pertaining to the Q3 utilization report, bottom of page 11. I did speak with our clinical team. And to better clarify what this means, the language at the bottom of the page, when we're referencing the three admits with four days denied, these are for pre-ops. So this is when the provider has called in and basically those services were or that authorization was denied based upon exclusion of services that aren't covered by the plan. So varicose vein or cosmetic procedures that were requested.

Looking at the three admits with five days that were declined, these were either pre-op requests or the member was in an inpatient facility. The member should not be billed for any days that are outside of that authorization.

What typically will happen then is Hometown Health reviews the information based upon medical necessity. They will approve days that would be appropriate for that request. Typically then what will happen is when the member is discharged, the claim is submitted to Hometown Health. It is paid based upon the authorized days. So the providers will usually bill, say it's five days, whatever they requested, three were authorized. The claim then would deny two of those days since they were not authorized.

At that time then the provider is able to appeal. They have appeal rights. And typically then they will submit

additional clinical which will be requesting review to reconsider those additional days.

At that time the appeal can either be overturned because additional information was provided to substantiate and approve that additional time or we will uphold the denial. So hopefully that answers your question.

CHAIRMAN DROZDOFF: I believe it does. Thank you.

Chris, is there any -- are you good with that answer?

MEMBER COCHRAN: Yeah. I mean I still wonder, because we don't know, whether in cases if the -- if it was denied on appeal if the provider is going back to the member and asking for reimbursement for those two days. Because two days in a facility could be quite expensive if the patient has to negotiate the reimbursement with them.

So, you know, I mean, on the surface it answers it. We just don't -- I guess the information is just not there as to say, okay, what happened in these claims and hopefully that it's not being -- especially if they're not allowed and it's not being put on the patient and the patient has to incur the fee.

CHAIRMAN DROZDOFF: Well, remember, this was just sort of the answer for today. Mary Catherine is going to do a little bit of homework on these specific issues. So I want

to be clear --

MEMBER COCHRAN: I do appreciate looking in it to. Yeah, I do appreciate looking in to it and getting back to is as quickly as they did.

MS. CULVER-MOLEZZO: Thank you.

CHAIRMAN DROZDOFF: All right. And then, as I mentioned earlier, Jim Wells and I were at a cabinet meeting this morning. So he got in a little after me. And so he has a question on item three, the public hearing, checked with Dennis, it's okay to go back. So Jim, I'm just going to allow you to since you weren't here for three to get in the issue that is of concern.

MEMBER WELLS: Thank you, Mr. Chairman. Jim Wells for the record. Looking at the bottom of page two of the section, on Section 1, Subsection 3, this is discussing an employee who got approved leave without pay who elects not to pay a premium or contribution from the program and then comes back to work.

The way this language is written is creating an exception to the first of the month rule. So it says -- If it says that once they return to full-time work the employee is eligible to participate in the program on the first date of the full-time employment. So if a person comes back on the 10th, then they would be eligible on the 10th. Well, that's not the way the program works. The program works,

other than birth or death first of the month, last of the month for coverage. So if they went out on the 10th, they would have had coverage through the end of that particular month. Then when they come back, they come back on the 1st then they can pay and have coverage effective on the 1st. If they come back on the 2nd or later, then they would have coverage effective on the first day of the following month.

So I just think that it needs to be clear in this section that when they come back from their approved leave, just like everything else that's written in these sections, it's the effective date if it's on the 1st or it is the first of the month after if it's on any other day.

CHAIRMAN DROZDOFF: That would require -- What you're saying is not what this says. So that would require a change. I guess before we consider whether we want to make that change I'll ask Damon to respond.

MR. HAYCOCK: Thank you, Mr. Chairman. For the record, Damon Haycock. I agree completely with Mr. Wells. For consistency sake, the intent was to continue to utilize the first of the month rule. And we proposed that we make this change of course after any public comment and the board's approval that we use a different set of language similar to what you see on the bottom of page three where the effective date, instead of re-employment it would be the effective date of return to full-time employment is the on

the first day of the month if it's the first of the month or on the first day of the month of the following month if it's the -- if it's after the first of the month. And that would be our recommendation.

CHAIRMAN DROZDOFF: All right. So that's -- That's out there. Since we did have public comment, I will invite public comment here on this issue.

MS. BOWEN: Peggy Lear Bowen. Speaking on this issue in terms of fairness, if I've already met my time first of the month or last of the month situation or first of the next month depending on when I came back to work, if I've met that requirement and I am covered by insurance and then for whatever reason I leave that, like Kateri, when she came to do this job, was she -- if she came back in to retirement after this job. When she was covered and met the covering requirement, all of a sudden, you're telling her --

CHAIRMAN DROZDOFF: This is just on leave without pay.

MS. BOWEN: I'm doing -- Say it.

CHAIRMAN DROZDOFF: This is just on leave without pay.

MS. BOWEN: That's where I am.

CHAIRMAN DROZDOFF: Kateri had nothing to do with it.

MS. BOWEN: Maybe that was a bad example. What

my concern is is if I've already met the one, the regular requirement for employment and that I leave employment without pay but then come back, I should be able to have my insurance reinstituted as to when I come back and not be uninsured for a period of time. My concern is, is there a period of time for somebody who has met the requirement that all of a sudden they're not insured again until a date is issued when the requirement had been met initially? I think if that's the case then this change that Mr. Wells is suggesting applying to new employment, because you're not a new employee. I see heads shaking. Not helping with the interpretation. I want to make sure they're insured, period. Thank you.

CHAIRMAN DROZDOFF: What this says if we make this change, it says, first of all, the employee has to be on approved leave without pay. And the employee has to then elect to not pay the premium. If the employee elects to pay the premium even though they're on leave without pay, there's not an issue.

MS. BOWEN: I'm not talking about while they're on leave without pay.

CHAIRMAN DROZDOFF: Well, that's all this is. That's all this is.

MS. BOWEN: But you said when they came back to employment that they would have to wait until the first or

whatever. That's what I was hearing. I'm making sure that with the interpretation of what you're doing so that it's on the record that the person when they come back in to employment, they've been gone with leave without pay that they are still insured as they would have insured had they not taken leave without pay.

CHAIRMAN DROZDOFF: Well, again -- Okay. Are there any other questions?

So, again, I guess I will -- As I said, I believe that Item 3 does need to be revised. We've heard some language and it sounds like staff is supportive of your suggestion. But if you want to make a motion.

MEMBER GARCIA: Mr. Chair.

CHAIRMAN DROZDOFF: Yes, Rosalie.

MEMBER GARCIA: I just wanted to bring the point up and have a little thought with regard to when employees have to take leave without pay I can certainly understand their not being able to make the premium payments to continue their health insurance. It's very costly on their own. But if an employee is returning to service and they're returning at their earliest available date, let's say it's the 10th or let's say it's the 5th, would it be -- how -- why would we not be able to accept them on that date and just make the date retroactive, the first of the date -- that month instead of the next following month? They're returning to work. I

mean, if they return to work on the 2nd, that would mean that they would be working for us and be unable to be covered under insurance. Would it -- I'm sure these -- I don't know, are these circumstances rare or not. But it's unusual. And would it -- Would we be able to do that?

CHAIRMAN DROZDOFF: I don't know the answer to that question. I don't know what the machinations are. I don't know. Jim or Damon, do you guys want to take a shot at answering that one?

MR. HAYCOCK: For the record, Damon Haycock. It's a very good question. I think what the critical piece of this discussion is when they elect to not pay. And let's not forget that if they are paying a family premium for an HMO plan or for our consumer-driven health plan that they can elect to reduce that down to self-only coverage to reduce those out-of-pocket costs because they aren't going to be subsidized while they're without pay. And when they return to work, they can put their dependants back on.

And so we do try to make some amends for those folks that elect not to continue to pay their premiums. But let's also not forget that the basics of health insurance are that there's premiums received for health insurance to exist. And so to do a lot of retroactive things can cause some administrative challenges to meeting these requirements.

As I haven't been here extremely long, I'd like

to hear from Jim Wells as well because I know you have experience with this too.

MEMBER WELLS: Yeah, this is Jim Wells again for the record. And I think that -- I mean, if the board's decision is to allow it to be retroactive to the first of the month in which they return from leave without pay is fine. But that still doesn't absolve them of the requirement to pay the premium for the month that they're getting coverage. And so they still have to pay for the premium for the month they're covered.

So if you have a person who comes back in the middle of the month, how do you do that? Do you prorate their premium? That becomes an administrative nightmare to try and bring back people in the middle of the month. That's why we have the first of the month rule to begin with.

MEMBER GARCIA: This is Rosalie again. I understand the administrative nightmare with people prorating health insurance. And that's why I would look at making it retroactive optionally for the employee to pay that premium for that month. It would -- It's better than -- To me it's better than just saying, no, you don't get it. It gives an employee an option. We don't know what their circumstances are. You know, life happens to people, and sometimes when they come back they do need their health insurance as soon as possible. And if we could provide that to them, that's a,

you know, service we could give.

MR. HAYCOCK: So for the record Damon Haycock. I have a clarifying question, Rosalie, if you don't mind. Is it your intent by what you just stated there that if an individual is provided the ability to retroactively pay for their health insurance if they return to work after the first, would that retroactive premium be the state subsidized premium or be the unsubsidized premium as they were on leave without pay?

MEMBER GARCIA: What would you recommend? Let me ask that.

MR. HAYCOCK: For the record Damon Haycock. I -- Honestly I would recommend the first of the month rule. And I know it's difficult. And it's not that I'm callous toward the state employee returning to work. There is a decision made when you electively take leave without pay. And that decision and all of the ramifications of that decision need to be -- they need to be thought about and determined when that decision is made. And I'm not saying that we shouldn't take care of our folks, because we should. But to allow somebody on leave without pay to retroactively have a subsidized health insurance premium when they elect not to pay their premiums, does that set a different precedent? And I think that's a discussion and a decision for the board.

MEMBER GARCIA: This is Rosalie again. Please

understand that leave without pay is not always an option. Leave without pay could purely mean that an employee is really sick or has had, you know, some kind of life-altering death in the family and they do not have enough sick or annual leave to cover their leave of absence from work. So it's not an election to do something always. I mean, I'm sure there's circumstances where it is. But there's usually, or sometimes, or many times that I have known, when an employee has had to take leave without pay due to a personal illness. So perhaps I look at it a little differently.

And my question -- I'm sorry. My question to you was which, you know, which did you believe or what would your recommendation be if we were to allow it to go back to the first of the month, would you want -- which one of those would you want, non-subsidy or subsidy? What was your recommendation with regard to your question to me?

MR. HAYCOCK: For the record, Damon Haycock. To be consistent, I would recommend a non-subsidized premium. Because those individuals who are on leave without pay, if they elected not to pay their premium, then they've elected to absorb their medical cost while they're on leave without pay. And so by definition, by default, they've agreed to during the time frame that they're on leave without pay, pay out of their own pockets the full unsubsidized premium. And so I think we can retroactively apply the rule, but that we

apply the rule consistently with their election.

MEMBER GARCIA: Rosalie Garcia again. And we're just, you know, going back and forth kind of discussing this a little bit. The non-subsidized -- The subsidy, was that already collected from the agencies or is that stopped? What I mean is, is it really that difficult to allow the employee to have the subsidy -- the subsidized premium?

MS. GLOVER: So this is Celestena Glover for the record. So a couple of things you have to consider. Assuming the agency notifies us fast enough that the individual is going on leave without pay, that agency no longer would be paying the subsidy if the individual, whether they elected to have coverage or not have coverage. So that's one. We're typically not getting that subsidy.

If it's a late notification, the agency has to pay us either way. The last piece of that is we have an 80-hour rule for full-time employment to qualify for coverage in the first place, subsidized coverage. That 80 hours is in a month. So using Mr. Wells' example, if they come back on the 10th of the month, if we make it retroactive, we're talking ten days. What if they come back on the 29th of the month? They're not going to get 80 hours in that month, so they wouldn't even be eligible for coverage until the 1st. So that's another role we have to look at. We have to look at 80 hours of employment once they return. So will they

effectively be eligible for coverage?

So using the first of the month rule that we use for everybody else keeps everything consistent, eliminates some of the -- or at least mitigates some of the issues with eligibility, what option the employee picked in the first place. As Mr. Haycock said, if they opted to absorb their own cost, you know, they went in to -- ideally they went in to that knowing that there was going to be a cost to them. So it's not just as simple as make it retroactive.

MEMBER GARCIA: Right. And that's why I was asking. Thank you very much.

CHAIRMAN DROZDOFF: All right. Well, you know, kind of two schools of thinking there. Happy to take a motion under either scenario.

MEMBER WELLS: Mr. Chairman, I would move that we amend Regulation R028-16 to incorporate language in to Section 1, Subsection 3, regarding coverage being effective of the 1st of the month on or after the date that they come back from leave without pay.

CHAIRMAN DROZDOFF: Is there a second?

MEMBER ANDREWS: Second. Ana Andrews.

CHAIRMAN DROZDOFF: Second by Ana Andrews. Okay. So any further discussion? None. Okay. I guess I'll call for the question then. All those in favor please say aye.

(All board members except Member Garcia vote aye)

CHAIRMAN DROZDOFF: Any opposed?

MEMBER GARCIA: Nay.

CHAIRMAN DROZDOFF: That's Rosalie Garcia. Make sure that's duly noted as a nay. Any abstentions? Motion carries.

All right. So now we go back to the agenda. Move to Agenda Item 7.

MR. HAYCOCK: Thank you, Mr. Chairman. Damon Haycock for the record. Agenda Item 7 is on the PEBP participant survey that in an effort to continue to be transparent and receive timely and critical information from PEBP participants we are proposing the utilization of a system-wide survey to assist PEBP and the board ultimately develop the plan benefit design.

The report you have in front of you was drafted and posted prior to additional conversations we had internally about branching this out to HMO care participants as well. And so what you'll see on this survey is that we've included those participants when I walk through it.

But as everyone hopefully is aware, we have been directed to develop multiple versions of our budget, a flat budget and a five percent cut budget, and that there is some critical decisions that the board we believe will need to make as far as how to balance that process with costs and benefit designs.

Also, we have repeatedly stated, even well before I arrived, that excess reserves were budgeted to be expired by the end of the next plan year. And with those excess reserves, the corresponding benefit design may need to be adjusted.

And so we're asking basically in a nutshell three very specific questions to help guide participants make the best decisions that they feel they can to provide input to PEBP and the board: That would you be willing to pay significantly more to have what you have today, would you be willing to pay moderately more to lose what you've had in enhanced benefits but to continue to have what you originally were provided back in 2012, and then would you prefer to pay no additional money. As we heard from public comment earlier today that there may be an appetite for no increased rates whatsoever. But that means that the plan benefit design may have to be cut even further.

And so before I go in to our recommendation, which, of course, is that you approve the release of a participant survey and, of course, provide us input and approval to the questions on it. I'm going to briefly walk through it here for everybody in the room and hopefully the folks can see this in Vegas.

But we wanted to initially begin with just a synopsis of the situation, thank you for participating, we

appreciate your feedback, and exactly what I just talked about there, that we are required to build budgets that are either flat or cut. And with answers provided will greatly assist PEBP and the board.

To address some of the things that I believe public comment asked about is who are you is the next part. Are you a state or a Nevada system of higher education classified employee. Are you a Nevada system of higher education faculty. Are you a state unclassified employee. Are you a state retiree or a non-state retiree. And these answers here don't change which questions you see. But I'm just going to go ahead and pick I'm a state retiree just to move through this process.

Then we're going to ask you about your health plan selection, all right. Are you currently enrolled or do you plan to enroll, because folks may change their mind from one year to the next. In the consumer-driven health plan, the health maintenance organization plan, Medicare exchange, or are you going to decline coverage. And the last two answers basically end the survey because this is not to solicit information on Medicare exchange plan benefit design. It's to do so for the PEBP plan benefit design.

So we'll do the easy one first, the HMO plan. If that is selected then we're going to ask you what region are you from, because we want to know a little bit more about who

you are to help determine what type of attitudes and behaviors are experienced in northern Nevada versus southern Nevada. Regardless of how you answer, you're going to see the same question. So let's say you're in southern Nevada, so you click on that.

So moving forward we talk about the fact of what's upcoming. And you're going to hear later today about the HMO RFP discussion. We will be negotiating HMO contracts that begin in plan year 2018 and we want to provide a similar plan benefit design in northern and southern Nevada. At least that's what's on here today. Again, we're not married to these words and we can change them. But we want to maximize access to care and cost management.

So, again, we ask you those three very specific questions. But we word them a little differently. Are you willing to pay moderately more to maintain what you have today. That's similar access levels, co-pays, referrals to specialists, if applicable. Are you wanting to pay significantly more per month to increase the plan benefit from today. Increased access to care, lower co-pays, out-of-area services, elimination of referrals. And this is just a small part of what can exist in a health plan benefit design discussion. And then, finally, you don't want to pay anymore and you're willing to allow the plan benefit design to be reduced. And we give some additional answers or

additional examples. These are not the sum total of what can occur, but we wanted to at least drive the concept to get some general input.

If I hit next, it will say thank you for participating in the survey, so I don't want to do that because then it bumps me out the way survey monkey is set up and that we're utilizing it. Once you finish the survey, you can't go back and take it again. And so I'm going to just go ahead and previous back a few and get to the consumer driven health plan.

So if now you click I am currently enrolled or plan to enroll in a consumer-driven health plan for plan year 2018, here's where we get those similar questions, significantly more to keep all your benefits, that's the standard, plus reserve enhanced benefits, moderately more per month but you're going to lose those enhanced benefits and pay no more per month but lose those enhanced benefits and cut them further.

And thanks to the meeting that I had with Marlene earlier this week, we made this a little bit more descriptive on this next part. So let's say we're willing to pay significantly more. We want to keep all of our benefits. They're important to us. So as you've asked Marlene, I think we met the requirement side by side, what are you getting. What is the original CDHP? What is the enhanced CDHP? And

what are you selecting in red? And so you've selected this option to pay significantly more to keep all your benefits and here's a summary of what you're selecting.

And then of course for those that aren't as knowledgeable about definitions, we didn't have too much space that we could put them in, but we tried to define the basics for deductible and co-insurance, and of course, that dental maximum.

And then finally, if you agree with them, say yes. You move forward. It ends. If you think, oh, my goodness, I don't want to pay significantly more and I hit no I don't agree, it takes you back. And say, well, I want to pay moderately more but lose those enhanced benefits.

So moving forward in the survey, we do the same thing, except, as you will see, we've shown the original CDHP as your selection in red. So you're making hopefully a conscious decision as to the type of benefit plan at least from these summaries is what you're accepting when you click yes I want to do this.

And so yes I agree or no I don't agree, I don't want to pay anymore. That's not what I want to do. I picked the wrong selection. So let's talk about paying no more. So if we're going to pay no more per month and cut them further, we have presented a few options. These are not the sum total of options but just to get people thinking about this

decision. There's the original consumer-driven health plan on the left. There's the enhanced one in the middle. And then we could adjust deductibles of it. We could adjust HSA contributions now. That's this 400. Sorry. It's not dragging the way I want it to. But that's reducing the HSA contributions. And technically we can reduce the co-insurance, PEBP's requirement to pay for part of the health care. We could even lower the dental maximum. We could even lower life insurance maximums.

So there's all kinds of things we can do to tweak this plan and based on the result that we get, I think this will provide information as a starting point for the board to determine plan benefits. That's really the ultimate goal.

So those are basically -- those are the questions. And then, of course, if yes, this is what I've decided, we've gone through the HMO, we've gone through the CDHP. Well, I'm not going to hit yes because I can't go back and if you have any questions and you want me to hit previous or next, I'm going to leave it right here and turn it over to the board and to you, Mr. Chairman, for any questions.

CHAIRMAN DROZDOFF: Thanks, Damon. I appreciate your work on that. I certainly appreciate you working with RPEN.

You know, this -- And I missed the public comment this morning, so I apologize. But this is a really important

effort. And I would hope that RPEN will -- and the faculty groups will really help us get this out. Because, you know, for the new board members in particular, we have artificially kept rates low over a period of years by using generated reserves that we have accumulated over the course of the years. But those reserves are committed to be spent in the -- and, of course, the health care inflation rate is doubling or tripling regular inflation. So this sort of day of reckoning or at least day of awakening that, you know, no reserves and the fact that we have, you know, two to three times greater inflation for medical inflation is going to get to a pretty important point. And we've heard public comment on all sides of this. We've heard public comment, and it sounds like we had it again this morning, we don't want our rates to go up because, you know, employees, state employees, retirees in particular, you know, they're not seeing raises, they're not getting a lot of things and so any increase is basically, you know, is very definite pay cut.

At the same point we have definitely heard things on the record, especially out of UNLV, that that group is willing to spend more for enhanced benefits.

So I think getting this survey done and getting good, hopefully good participation, we're never going to get a hundred percent, we're never going to get unanimity on it, but if we can see, you know, a clear trend or a clear

preference, I think that would help the board immensely as it deals with setting rates in the PPO but also in the HMO selections.

So I appreciate the work that's gone in to it. By way of background, I wanted to at least let our new board members know that that's sort of why this is happening.

With that, I'll turn it over to you all and see if you had any questions. Tom.

MEMBER VERDUCCI: Yes, Mr. Chair. Tom Verducci for the record. I do think it's a good idea to survey the membership. We need to hear from them what their needs are. One of my concerns would be on item number two under the proposed survey. If I was to read, would you be willing to pay a moderate increase in rates to lose all of the enhanced benefits you have the last three years and return to the original plan, plan year 2012, consumer driven health plan, my question would be what benefits am I losing? I think that could be outlined, as opposed to PEBP staff getting a lot of calls coming in after the survey, what would we be giving up. I think perhaps just enhancing the wording and describing what benefits would be given up under that scenario.

MR. HAYCOCK: For the record Damon Haycock. I appreciate that, Mr. Verducci. And we can definitely look to define it further. I don't know if you can see it up there, but I selected that number two, moderately more to lose the

enhanced benefits, and our intent, which I believe we need to do a better job after hearing your statements, is to show that what you're losing is the difference between the original and the enhanced. So you're selecting that original consumer driven health plan. But you're right, we're not quantifying. You're losing $400 of deductible. You're losing $800 of deductible for the family. You're losing five percent co-insurance. So I think we can clean this up a little bit and really kind of show the delta or the difference exactly in layman's terms.

MEMBER VERDUCCI: Thank you very much, Damon. And I think that that would be good for full transparency, so participants would know the answer that they are selecting. So thank you.

CHAIRMAN DROZDOFF: Down south. Did I hear a mike go on?

MEMBER ZACK: Yes, Mr. Chairman. Christine Zack for the record.

CHAIRMAN DROZDOFF: Hi, Christine.

MEMBER ZACK: I also agree -- Hi. I also agree with the concept of this survey, but it seems to be missing the premium, i.e., the payroll deduction for each option. And if it were me, I would want to know, well, how much more or less, or is it going to stay the same as being deducted from my pay. So I don't see a line for premium. Maybe I

missed it.

MR. HAYCOCK: For the record Damon Haycock. Thank you, Ms. Zack. And we tossed back and forth on if we should put forth a premium dollar amount. And, no, you did not miss it. We did not include it. And we did not include it on purpose. And it wasn't for a lack of transparency, but it was to ensure that we have accuracy.

It's very difficult for our -- it can be challenging to create a rate more than a year in advance and then adhere to that rate once the rate discussion occurs. And what we didn't want to do was to paint PEBP or the board in to a corner to have to stick to specific rates that we estimated back in July of 2016. And so it's been, at least I know my mantra that I don't want to put something out in to the public that I can't back. And I would be very concerned if we were to put a range in there and we were off by five dollars or ten dollars or 12 cents that we would incur some very unhappy participants because we couldn't meet those requirements. I hope that answers your question.

MEMBER ZACK: It does. I would still recommend a range. I understand not a hard number, but, again, if I were the person taking the survey and impacted, I would want to see what the premium difference would be.

CHAIRMAN DROZDOFF: Okay. So when you're sliding the mike, it's loud here.

MEMBER GARCIA: Oh, sorry.

CHAIRMAN DROZDOFF: That's okay. So before we go to Chris or Rosalie, let's see if we can -- I mean, is there anything based on what Christine is saying, is there any, you know, qualifiers, is there anything that you can do or do you feel strongly to not do anything?

MR. HAYCOCK: Damon Haycock for the record. We can do anything. We can estimate --

CHAIRMAN DROZDOFF: No, I know you can do anything, but I'm asking what do you want to do.

MR. HAYCOCK: I'd like to talk, if you don't mind me including our consultants because they also have to live and die on these numbers as well as we do. And so we initially had some numbers and we had a range. I suppose we could extend that range. It can be quite significant. And I'll give you some examples.

When we initially looked at this process, and we still have received additional information since then, so I can't go through these ranges on this survey, but we were looking anywhere on the significant from 80 to $200. And we were looking on the, depending on what tier you're in and what selection you made. And on the moderate anywhere from five to, like, $50. And so I'm using some pretty estimated ranges. But five to 50 is huge for somebody. Somebody may be willing to pay five dollars but they're not willing to $50

more. Or they may be willing to pay $80 but not willing to pay $200 more.

And so it's going to be really difficult for us to nail that down to give a true value, I think, that you guys are looking for. In a perfect world, we should be able to say this is what the rates are, make your decision. But we can't because we don't even have experience yet for the year we're about to start.

CHAIRMAN DROZDOFF: Jacque.

MEMBER EWING-TAYLOR: Thank you, Mr. Chairman. One of my concerns is what Christine brought up. And I think it's in your definition of significant. So if you're a classified employee making $25,000 a year, significant to you is going to be ten bucks. If you are a more highly paid employee, for example, the executive officer of PEBP, significant to you might be $200. So I think we need to be able to figure out some way of operationalizing those terms, moderate and significant, or we have to somehow take in to account the pay levels. And I'm not sure that the demographic information that you're collecting would allow you to do that. So that's really my big concern with this is the terms significant and moderate.

CHAIRMAN DROZDOFF: I don't think you can do the latter. I mean, I do think you can certainly -- I mean, Kirby, it sounds like Damon teed you up. But I think you

could say, you know, significant or moderate is, you know, $25 for our purposes, purposes of the survey, not to judge whether it's true or not. You know, we're viewing moderate as, you know, 20 to $30 range and significant as, you know, whatever. Or do you not see any of that. Stephanie.

MS. MESSIER: Stephanie Messier with Aon Hewitt for the record. Can I make a suggestion, maybe two more questions you have after this?

CHAIRMAN DROZDOFF: Sure. Go ahead.

MS. MESSIER: What tier are you currently in and what is that dollar amount to you. So if you said significant and you wanted to keep these enhanced benefits, you say I am in family coverage and $25 and you could aggregate the 25 over the tiers. And I think that would give you some more data points without locking you in to saying ranges. Just a suggestion. Because then you're getting what plan design they prefer and you're still getting that dollar attach, without needing to know what is their current pay. I could make 50, and 25 is significant. I could make 20 a year, and 25 is significant.

CHAIRMAN DROZDOFF: So Christine, does that sound like as opposed to us dictating terms giving somebody an opportunity to say what they think? Does that help you at all?

MEMBER ZACK: Yes, it does. Thank you.

CHAIRMAN DROZDOFF: All right. Well, then, Damon.

MR. HAYCOCK: Yes. For the record, Damon Haycock. We can add a couple of questions easily. And we can leave a text box open for folks to put how much they would be willing to pay more for this benefit plan or to keep this benefit plan. So we'll work with Stephanie and get some good information.

One of the things that I do want to present to the board, and hopefully you all agree, and tell me if you don't, the information that we're collecting on this consumer driven health care plan side of this survey we would like to get this out sooner than later. Once we approve it, or you approve it, then we like to bring it back to you sooner than later so you can start those discussions for the plan benefit design.

I'm hesitant to bring back HMO responses because we're going to have an open RFP and my concern is that HMO vendors will then take the responses and redraft their HMO, their HMO responses. And we really want to preserve the integrity of that request for proposal. And so I would like to be able to bring back those HMO responses after the RFP is closed but to bring back the consumer driven health plan responses sooner.

CHAIRMAN DROZDOFF: I think we can live with that

as long as we get the HMO results well in advance. I think we can live with not getting them before the RFP is out as long as we get them well in advance of when we have to decide on them. I don't see any downside to that. Do you all?

MEMBER GARCIA: This is Rosalie.

CHAIRMAN DROZDOFF: Go ahead, Rosalie.

MEMBER GARCIA: I do see a potential -- Sorry. Let me start again. I do see a potential with regard to the survey results being announced or shown before the RFP is completely awarded, only because there is that award process and some negotiation that does occur at the end of the RFP process. Just a thought.

CHAIRMAN DROZDOFF: Well, no. It's a valid thought. I mean, obviously Damon and I have had this discussion. But my view is -- And again, I'm just one board member. My view is that I would like to have some information before we actually start looking at the HMO results. Otherwise if we don't get them, I don't know what the point is, for me anyway, I don't know what the point of asking those questions would be. I would think that the board would like to know before it starts awarding contracts where our participants are. And I get, Rosalie, that there's some peril to this. But I would think that, you know, getting some results or having some sense of what our participants want in terms of either cost or design plan

features after the RFP is out but before we actually pick a vendor, I guess I see value in that. I get what you're saying. And I've heard from others that there is a risk of doing that. But as board members trying to be responsive to what our participants want, I guess that's where I fall. And if we don't do it, then I don't know why we would do the survey on the HMO side to begin with because we're not going to be -- those answers then won't help us. And then I would feel like maybe we missed the mark. You know, why raise expectations. But again, that's just my thought.

MEMBER GARCIA: What's our -- Excuse me. This is Rosalie again. What is our time frame for the survey?

MR. HAYCOCK: So for the record Damon Haycock. The time frame for the survey, we would like to send it out after we've cleaned it up and have applied all of the board's recommendations on July 1st. And we can leave it open for a significant amount of time or we can only close it down for a couple of weeks.

What I would like to do is address your concern, Mr. Chairman, that is this information going to be valuable or is this going to be an after the fact, gosh, I wish we would have done something different. And what I think would help the process is if we can, and I will work with purchasing to determine if this is still within their guidelines, regulations, and laws, but we can provide the

evaluation committee in a confidential setting, the results of the HMO survey. And so those folks dedicated to selecting the appropriate HMO vendor will have the information to better help them assess each of the bids. And then once we bring back the contract to the full board for ratification as we traditionally do, it will be a discussion item in there, this is what the committee thought about and this is what they utilized and here's the results of the survey and this is why they chose what they chose.

And so I think we can meet all of those added value benefit requirements and still preserve the RFP and the confidentiality of these results.

CHAIRMAN DROZDOFF: Does that help, Rosalie?

MEMBER GARCIA: Yes, it does. Thank you.

CHAIRMAN DROZDOFF: Is there anything else down south?

MEMBER COCHRAN: This is Chris Cochran. Just a couple of things. So I just want to be clear. We're looking at a separate survey for the -- to do an HMO survey as well as this CDHP survey; am I correct? Am I hearing that correctly based on the discussions?

MR. HAYCOCK: For the record this is Damon Haycock. It's one survey. You kind of choose your own adventure. You go which direction you want to go. And then the results will be reported separately.

MEMBER COCHRAN: Okay. So there is the option of choosing that, okay. So I'm clear on that.

And then the second issue is are there any questions regarding further demographics on the respondents, including things like age, health status, that might help us understand where some of these responses are coming from?

MR. HAYCOCK: For the record Damon Haycock. We can add whatever demographic the board would like to see to better assist this process. I'm usually hesitant about getting health status because there's protected health information that's involved, and how do you design the controls around it so that it doesn't accidentally get out, which normally they don't, but there's a specific IT security process for it. But I definitely think we can add age. We try to add the regions to it as well. But we can add whatever you'd like.

MEMBER COCHRAN: Well, you know, Berthus, which does annual surveys for the CDC, you know, send out these surveys asking individuals what their perception of their health status is. I'm not sure that that's something that I'm worried about getting out as far as violating any personal information, you know, because obviously one of the other things that we don't want to do is to let respondents think that their individual information on replying to the survey is going to be made public information anyway.

I do want to also point out that I think in terms of the HMO -- I know I saw an e-mail from -- at UNLV that they are doing their own HMO survey as well. They're asking people who are members of -- who are employees, I think it's just at UNLV, what their perceptions are of their current HMO plan and what they would like to see. I think they've had like 300 responded so far. So I'm looking at I think that's the correct assessment. And hopefully they'll be sharing with us that information as well that could also go in to -- in to whatever plan designs that we're looking at.

MR. HAYCOCK: For the record Damon Haycock. Yes, definitely. And I did hear about the UNLV survey and we anxiously await the results to help everyone get a better understanding of those participants at UNLV.

And let he dial something back. I apologize. I overthought when you said health status that you might have been considering do you have specific chronic diseases or those types of thing. So if it's do you feel relatively healthy or do you feel like you need to see the doctor multiple times per year or whatever types of those questions, we would be more than willing to work with you, Chris, to get those answers put on to the survey.

MEMBER COCHRAN: Okay. Thank you.

CHAIRMAN DROZDOFF: Ana.

MEMBER ANDREWS: Thank you, Mr. Chairman. I just

have a comment. I think all of this data that we're going to be getting out of the survey and all of that is going to be extremely helpful not only for the PEBP program and for our consultants. It will be very helpful because we're going in to a budget session with the legislature next year. So I know we were told all the state agencies, mine included, you only submit a budget flat or at a five percent reduction and all of that. At this point we don't know what that's going to look like. We don't know what the economic forum is going to say, how the legislative session is going to go. So let's keep in mind that these numbers are not going to be hard numbers by any means. Let's just think about that. Thank you.

CHAIRMAN DROZDOFF: Yeah. And I think that's in the survey. But if not we definitely want to make sure that it's just a survey and it's not -- we're not tying anybody's, you know -- that it's not bullet proof. That it's information that we'll use.

Is there anything else? So I guess what I would say is I would be happy to take a motion. And, again, we had a number of folks chime in with ideas. It didn't sound like any of those ideas were thrown out. So, you know, the motion would be to proceed with the survey as presented along with the -- all of the suggestions made by the board today, something to that effect. If there's somebody interested in

that, I would take that. Tom.

MEMBER VERDUCCI: Mr. Chair, Tom Verducci for the record. I would like to proceed with that motion.

CHAIRMAN DROZDOFF: Okay. Is there a second?

MEMBER ANDREWS: Ana Andrews. Second.

MEMBER GARCIA: Rosalie Garcia. Second.

CHAIRMAN DROZDOFF: All right. We'll go with Rosalie. Any further discussion? Seeing none, I'll call for the question. All those in favor please say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN DROZDOFF: Any opposed? Any abstain? All right. Motion carries.

MR. HAYCOCK: So for the record Damon Haycock. What I did not say at the beginning -- And this isn't going to change any motions -- is that we came up with this idea but it's migrated through multiple iterations. And my staff has done an amazing job at doing this. And I want to publically recognize Nancy Spinelli and her staff, Kathy McDonald. They have rebuilt this thing from scratch every time I come up with a wild idea. And so I wanted to thank them in that they will, I'm sure, include all of the results from this discussion. And I think this is going to be something you guys can be proud of. Thank you very much, Mr. Chair.

CHAIRMAN DROZDOFF: Well, we certainly appreciate

the work of Nancy and Kathy.

So let's move to 8. Before I turn it over to Jacque, just a couple of points. Dennis Belcourt told me he wanted to make some announcements. I'll let him do that first. And then I'll turn it over to Jacque. And then I may have a couple of things to chime in on before we start going through the results.

Dennis.

MR. BELCOURT: Dennis Belcourt, deputy attorney general. We have a couple new board members. And I figured I'm going to talk about the open meeting law in a training session next month, but I wanted to mention something because it kind of relates to this topic. This topic is about the agency personnel and things like that. There is a requirement in the open meeting law that if you're going to discuss somebody's competent, character, or misconduct, et cetera, you have to give them advanced notice. And nothing of that nature was done here. But my understanding is there was no intent to discuss competence, character, misconduct of any individuals, so I don't think that -- that's probably why we didn't give that kind of notice.

So just something -- One of the rules we're going to talk about next month, hopefully on July 21st if we have a meeting then, so I just wanted to mention that. And there's a lot of other rules we're probably going to go over next

month. But it's good to kind of sometimes plug it in to a fact situation, a teachable moment. Thank you.

CHAIRMAN DROZDOFF: You're welcome.

Jacque.

MEMBER EWING-TAYLOR: Thank you, Mr. Chairman. My apologies for getting this out to everyone so late. But in regards to that, I'm going to go ahead and read it, because I know the audience has not had an opportunity to look at this and many of the board members may not have had the opportunity to read it.

So this is the PEBP culture survey results. At its April meeting, the PEBP board approved a survey of all PEBP staff created by Dr. Jacque Ewing-Taylor, research professor at UNR, and vice chair of the board, and authorized her to conduct a survey using her corporate Survey Monkey account.

On May 11th, Dr. Ewing-Taylor met with PEBP employees to discuss the survey, the methodology, and answer any questions they might have about the survey process. In order to not affect the work of the agencies, there were five sessions scheduled for 30 minutes each held in the PEBP conference room.

The first session was with senior staff. The other four were with various members of the classified staff as their schedules would allow. Each group was assured of

the anonymity of their responses and encouraged to respond to the survey from a non-PEBP computer. This was done out of an abundance of caution because it had been reported that employees were distrustful of the attempt to gather this information. Employees were further assured that any and all identifying information contained in the textual responses would be removed and all responses would be reported only in the aggregate. Thus this report does not contain the verbatim responses to the text response options or open-ended items. Every effort has been made to ensure absolute anonymity of the respondents so as to ensure honest and open feedback.

However, because the survey was constructed without the ability to track IP addresses or any other identifying information, there appears to have been some inappropriate activity. Because there was no ability to track participation in any way, it may be that some employees took the survey more than once, since a rumor to this effect was recorded to Dr. Ewing-Taylor.

There were 30 survey responses to the survey. PEBP has 32 positions, two of which are currently vacant. The executive officer did not participate and he reported that one member of his senior staff did not participate, leaving 28 possible respondents. It therefore appears that there were duplicate responses but there is no way to know

for certain, as those who were asked whether they participated could have responded no when in fact they did participate.

A side-by-side comparison of the raw scores revealed no obvious duplicates and the aggregated results are not skewed in any one direction. Nonetheless, this is a limitation of the survey and interpretation of the data must take this possible unethical conduct in to account.

The survey was divided in to two sections. The first section addressed the working environment at PEBP and the second section addressed elements of the job performance of the executive officer.

The first section of the survey was comprised of 16 items, 15 multiple choice items, 12 of which allowed the respondent to elaborate on his or her response and one open-ended item. The second section was comprised of eight Likert style items where the choices were strongly disagree, disagree, neither agree or disagree, agree, strongly agree, and not applicable. The full survey is reproduced in the appendix, which I forgot to include.

Due to privacy concerns expressed, all of the open-ended responses have been stricken from this report and are not reported.

Section one, the PEBP work environment --

CHAIRMAN DROZDOFF: Can I stop right there? So

this is Leo. So this is sort of an important issue that Jacque just went over. So that the board members know and probably more importantly any staff that's listening knows, there were comment sections on this -- on this survey, and they exist. And Dr. Ewing-Taylor has them and she's given them to me. They're not included here due to the privacy concerns that were stated. But I also know that there's probably folks who made these comments are saying, well, wait a minute, why did I make these comments if they're not included.

Because this is Dr. Ewing-Taylor's last meeting and because I am in close proximity to the staff, being in the same building, I will give an opportunity to meet with whomever from PEBP wants to meet with me about their comments, whether they want them somehow addressed in the future, not want them addressed but just want people to know about it, et cetera. I will find some time on my calendar, make that time available. And again, this is whether it's, you know, to say great things or to say things or, you know, some sort of constructive criticism. So I just want to make that point.

Because I'm sure as Dr. Ewing-Taylor goes through these results, a lot of people are going to say -- well, some may be relieved that they're not reading their comments and some may be, like, well, why aren't my comments there. So I

just want to make that point known, that they're not there for a reason because we certainly didn't want to create any greater concern from anybody completing this survey, positive or negative. But I will find a way to meet with anybody who wants to meet with me from the PEBP staff to talk about their comments.

Back to you.

MEMBER EWING-TAYLOR: Thanks, Leo. And I just want to say that it had been my intention to analyze all of the qualitative data that was collected that is those comments in such a way that they would be completely aggregated and just report general themes. Unfortunately, from the time that the survey closed on May 24th to last night when I finally got Kari this report, I simply didn't have time to do that. So it's not out of an interest in analyzing the results. It's just I just ran out of time. And as Leo said, this is my last meeting, so I won't have an opportunity to do that going forward.

So section one, this section of the survey asked questions about the general working environment at PEBP. Items were developed through a review of surveys used routinely by the Society of Human Resource Management and were reviewed by senior human resource -- a human resource professional not affiliated with state government. 30 PEBP employees responded to the items in this section.

There were 15 items in the first section. The first seven used a response scale of strongly disagree, disagree, neutral, neither agree nor disagree, agree, or strongly agree.

Item one asked respondents to rate the statement "PEBP employees treat each other with respect." Figure one shows the distribution of responses. And while 17 employees agree or strongly agree that employees treat each other respectfully, it does bear noting that ten do not.

Item two stated PEBP senior staff and employees trust each other and offered respondent the opportunity to elaborate. Again, those response are not reported.

The second figure contains the results of the responses and shows that they were pretty evenly distributed on either side of the neutral option, with 13 responding disagree or strongly disagree and 13 responding agree or strongly agree. 13 employees offered comments on this item. Again, they are not reported due to expressed concerns over anonymity.

Item three asked about coworker relationships. 22 respondents agree or strongly agree that they have a good working relationship with their co-workers. This item also had a text box where respondents would elaborate. And those comments were eliminated from this report.

The fourth item in section one asked about

supervisory relationships. The results indicate that most employees feel they have a good relationship with their supervisor. The mean and mode of this item are identical to those in item three, and a side-by-side comparison of the raw scores revealed very few differences, thus it does seem that employees who are satisfied with their coworker relationships are also satisfied with their supervisory relationships. The open-ended responses to this, again, were not -- or are not reported.

Item five referenced PEBP management and asked about management's recognition of good job performance. 17 respondents or 57 percent replied agree or strongly agree in response to the statement "PEBP management recognizes strong job performance." The remaining 13, 43 percent, felt otherwise.

Item six asked about work autonomy. Figure six contains the results and the comments on this item. Again, those were redacted. 19 respondents or 63 percent agreed or strongly agreed with the statement, I'm able to make decisions affecting my work, indicating a majority of the staff feel empowered in their jobs and have some control over their work, usually a strong indicator of job satisfaction.

Responses to item seven are in figure seven. Half the respondents agreed or strongly agreed with the statement that communication between senior staff and

employees is good at PEBP, while the other half were neutral or disagreed at some level, 27 percent.

When asked how comfortable they feel about voicing concerns to their supervisor, employees were more positive than in their responses to other items. Responses to item eight showed that 21 of 30 respondents feel very or extremely comfortable voicing their concerns to their supervisor.

Figure nine contains the results of item nine, which asked about communication from supervisors when goals change. 24 of 30 respondents, or 80 percent, said they were informed of changes over half of the time. There was no opportunity to elaborate on this item. Similar to responses to the previous item, 24 of 30 respondents, or 80 percent, indicated that their supervisor handles employee problems moderately to extremely effectively. Again, this item allowed respondents to elaborate, but those have been redacted.

Responses to item 11 were similar in distribution to those in items nine and ten, where 80 percent of the responses fell in to the top three categories. On this item, 28 respondents, or 93 percent, indicated that their supervisor is somewhat to extremely committed to making PEBP a more comfortable place to work.

The work that PEBP employees do impacts directly

the lives of the states employees. Item 12 asked if employees feel whether that impact is positive. Only five people disagree or strongly disagree that the impact is positive.

Item 13 asked how secure in their jobs PEBP employees feel. The responses would indicate that most employees feel secure, although seven do not.

Figure 15 -- Item 14, rather, showing figure 15 asked whether PEBP work environment is safe. 29 of 30 responded neutral to strongly agree.

Response distribution to item 15 was perhaps the most even of all the items in section one, though slightly secured towards the positive. 14 respondents, or 47 percent, agree or strongly agree that they're satisfied with the culture at PEBP, whereas ten, or 33 percent, disagree to strongly disagree. And six, or 20 percent, are neutral.

The final item in section one, item 16, asked what senior staff needs to do to improve their overall effectiveness. All 30 respondents replied to this question, however, and again, the responses are not reported here due to expressed concerns over anonymity.

Do you want to take any questions on the first section?

CHAIRMAN DROZDOFF: Sure. Are there questions on the first section by any of the board members? Seeing none,

we'll move on.

MEMBER EWING-TAYLOR: Section two, the executive officer. This section employed the Likert type scale with eight statements about the job performance of the executive officer. The response options were strongly disagree, disagree, neither agree nor disagree, agree, strongly agree, or not applicable. The option to respond not applicable was added for those who may not have direct interaction with the executive officer, rather than force a response that doesn't fit that individual's situation. The items were based on issues that had been previously identified by the PEBP board and were developed and reviewed jointly by Dr. Ewing-Taylor and Board Chair Leo Drozdoff. There were no comment boxes available on the items in this section. There were 29 responses to these items, one fewer than in section one.

The distribution of responses to item number one in this section is by mogul. It can be seen in figure 16. That is equal number of people agree than disagree that the executive officer uses staff as a resource to make decisions that are consistent with PEBP's mission.

The second item in this section had to do with meaningful feedback from the executive officer to staff. And, again, here, the range of responses is by mogul, though slightly skewed towards the positive end of the scale as illustrated in figure 17.

Responses to item three shown in figure 18 reveal that 19 staff members agree or strongly agree that the executive officer makes them feel a meaningful part of the PEBP team.

A by-mogul distribution can again be seen in figure 19 where the responses indicate a split in feeling about the preferential relationships the executive officer might have with certain members of staff.

18 staff feel that the executive officer has made a positive impact on their work environment, whereas ten were neutral, strongly disagreed, or disagreed.

Results for the sixth item in this section were largely the same as those in the previous item. Figure 21 shows that 17 employees strongly agree or agree that the executive officer listens to them. And 11 are either neutral, disagree, or strongly disagree.

Item 7 asked if staff received good communication from the executive officer regarding decisions in future directions. The results shown in figure 22 or to the previous two items though there is a higher number of neutral responses.

The final item on the survey asked about the executive officer's working relationship with the board. The result shown in figure 23 indicate that 17 or 59 percent of the responding members of the PEBP staff disagree to strongly

disagree with that statement, the executive officer has a good working relationship with the board.

And that, Mr. Chairman, is the extent of the analysis I had time to conduct.

CHAIRMAN DROZDOFF: All right. Were there any other questions on the survey?

MEMBER BAILEY: I don't have a question but I have a statement.

CHAIRMAN DROZDOFF: Go ahead, Don. We're going to go with Don Bailey and then we'll go down south.

MEMBER BAILEY: For the record I would just like to compliment Jacque. I know this is your last meeting. You'll be missed big time. But I want to go on record as saying this took a lot of time, a lot of effort working with the staff and working with the individuals. And it's appreciated. And it's some pretty important information that I'm looking at here. And it's a little scary. It's a little positive. But we'll work it out. But thank you again on behalf of the board.

CHAIRMAN DROZDOFF: Chris.

MEMBER GARCIA: We have communication --

MEMBER COCHRAN: Yeah, we have microphone issues down here. So, Jacque, thanks for this work. Are you sure you can't do something like finishing up that qualitative information in terms of, you know, maybe coming up with

something that could be fed back to us even though you're not going to be on the board anymore? I'm speaking for myself. I would appreciate it if you could do that if you have the data or if you could share it with -- if that data could be shared with somebody who would do that.

MEMBER EWING-TAYLOR: Well, Leo does have the data, but, Chris, I would just say if that were the wish of the board, I could certainly do that, although probably not until August or September.

MEMBER COCHRAN: You know, I think you're more closely associated with it. It would probably be better for us for you to, if you could do that. So I'm just -- I'll just ask you as a going away favor. You don't owe us anything.

MEMBER EWING-TAYLOR: Again, I'll leave that up to the board.

CHAIRMAN DROZDOFF: Anybody else down south? Anybody else up north? Tom.

MEMBER VERDUCCI: You know, I just wanted to point out that my experience has been that when there's complications that come up within the organization that, you know, we all want to be happy with what we're doing. And I've seen where an advisory counsel was elected with maybe five members, you vote, and you have an advisory counsel that comes up with ideas such as how can we do things better. And

maybe they report back with an informal suggestion on a monthly basis to the executive director.

And I also want to point out my experience has been very good in the last month working with the executive officer here. And I appreciate the work that he's doing. That's what I have to say.

CHAIRMAN DROZDOFF: Thank you.

Damon, is there anything you want to say?

MR. HAYCOCK: Thank you, Mr. Chairman. For the record Damon Haycock. I want to echo Member Don Bailey's comments and thank Dr. Jacque Ewing-Taylor for going through this process. In my experience with surveys, they're never easy and they're never quick. And so I recognize the sheer amount of work that you've already put in to it and I want to thank you.

I think there is some very good information in here that really shows some positives that I'm inspired but also some areas where we need to continue to improve. And we welcome this type of feedback so we can move forward.

Similar to what Chris Cochran mentioned, I think this is being the first survey that the board has done is a really great baseline that says where are we at today. And it's been, again, my experience that moving forward, you start with where you're at and then to show improvement you repeat it. And so if Dr. Ewing-Taylor is all right with us

using her I don't know if it's intellectual property or however you want to call it, I think repeating the survey in the future will at least show what's the quality improvement strategies that the agency has put in to place, are they working. I'm sure everyone realizes almost a year ago when I started that I asked that question, how was the culture at PEBP, and I was told flat-out that it wasn't good.

And so I'm, again, inspired by some of these positive results, but I'm really looking forward to trying to swing the pendulum away from some of these splits. And I think we have our work cut out for us, but we're dedicated to the challenge. And, again, thank you, Dr. Ewing-Taylor.

CHAIRMAN DROZDOFF: I think that's actually a good suggestion, Damon. I do like the idea -- I certainly want to make sure -- As I said earlier, I commit to do a couple things. I commit to finding some time to, you know, to further meet with staff to review their comments, especially given the fact that Jacque is -- even if she did do us a favor is probably not able to do it until September. I might be able to help her with that process should the board want to endeavor down that path.

And, you know, I do want to hear, I guess, as a board chair obviously I am very reluctant to, you know, and I haven't micromanaged staff. I have a program to run. And, you know, so I respect that. At the same point, I know

people spend a lot of time on these, you know, submitting these results and completing the survey. And I want to make sure the folks know, the folks that are inspired with the change or the folks that are, you know, sort of demanding or requesting improvement, that they'll be heard and that these results just won't sit on the shelf.

So, as I said, I will reiterate what I said, I will find some time in the near future to meet with who ever wants to meet with me. I do like the idea that Damon said about repeating this at a later date and maybe put some scientific safeguards on it that, you know, that does not allow for repeated taking of the survey and yet not getting in to privacy issues, so we have to work with that.

And I think the last thing is, you know, to Damon, and I think you can see the results. I don't know that anybody -- They're not precisely scientific for the reasons mentioned earlier. But I think that, you know, you've read them and I think you can read them like everybody else and say, okay, there's things that I'm doing the right thing on and I can continue to do that, and there's other things that if I'm looking at that saying there's areas that I definitely could and should try to improve in. So there's nothing stopping you from just doing what you want to do with these results and seeing if we do this a year from now what they look like. So I guess I'll close with that.

So if there's nothing else -- Is there something else down south?

MEMBER COCHRAN: Just quickly on that request that I made of Jacque. I don't know if that needs a board motion if she's willing to do that. I think there might be -- I'm just saying I think there might be some useful information on that, that if compiled, taking that qualitative data and compiling it in to some good feedback that might help Damon or the board address if there are, you know, major issues along the lines of what those are that could be, you know, specifically targeted.

CHAIRMAN DROZDOFF: Yeah, I don't think that there is a specific board action. Jacque said she's willing to do it but not until August or September, so I think we'll leave her alone with that. If I do -- If I do --

MEMBER COCHRAN: Well, she asked us to get the board's input, so I'm just throwing that out there.

CHAIRMAN DROZDOFF: Well, I guess I'm just assuming that. I didn't hear anybody say no to that. But since it's not going to happen until August or September time frame anyway, like I said, I might be able to if I do -- if I do hear from staff, you know, either the staff that's very, you know, sort of in the agree category or the disagree category, I can certainly help feed that information to Jacque. And as I said, I do have the results. So, you know,

I think I can help her in that regard. And so unless there's somebody who doesn't want that to happen, I guess I'll just assume that we do. Okay.

What do you think? How would you like to do -- I'm looking at the Aon folks now. It's 12:20. We're obviously not going to get through all of this. Do we -- How do you want to do this? Should we get started on it? We've got a lot to do. I'd hate to --

MR. HAYCOCK: For the record Damon Haycock. I want to be mindful of anyone's flight. But this next discussion isn't a short one. So I would hate to start it and pause in the middle and then people go out and then come back. I think that it takes deliberate deliberation if that's appropriate. And so I would definitely think that if we start this next one we should start it and finish it if that's the desire before we break.

CHAIRMAN DROZDOFF: So then we're not going to do that. This is at least an hour; right?

MR. HAYCOCK: Yeah.

MS. BOSLEY: Potentially.

CHAIRMAN DROZDOFF: All right. So it is 12:20. Let's take an hour break for lunch and be back at 1:20.

(Lunch recess was taken)

CHAIRMAN DROZDOFF: We will hop right back in to it unless there's any housekeeping to do.

MR. HAYCOCK: No.

CHAIRMAN DROZDOFF: All right. So we'll get to Agenda Item 9, which is the discussion of the HMO. Who is going to start? Damon will start.

MR. HAYCOCK: Thank you, Mr. Chairman. Damon Haycock for the record. This report, of course, is on the HMO and EPO discussion. We'll go ahead and define those terms so we don't talk in acronyms the whole time. We'll start with an executive summary here that we were tasked by the board to provide a scope of work and evaluation criteria for health maintenance organization or HMO request for proposal as well as develop with an exclusive provider organization, and that's what an EPO is, plan may look like.

In a nutshell, we are recommending a single HMO RFP that prioritizes those things that the board and the participants have made very clear over time: Statewide services, a singular plan benefit design across the state so there's no more disparity, open access, out of area access, and lowest cost, highest value proposals through dedicated evaluation criteria and bonus points for PEBP's priorities. And we'll talk a little bit more about that when we get in to the evaluation criteria discussion.

By developing this RFP this way and not mandating specific PEBP priorities that prevent bidders from participating, we believe this will allow the opportunity for

all six licensed in Nevada HMO vendors the ability to bid and be evaluated equally and fairly on an apples to apples comparison. We are also recommending more time to fully analyze and vet a self-insured EPO plan as a possible alternative to HMO offering in the future if cost, of course, becomes unsustainable.

So moving forward, we will start and I will go through this rather quickly because I don't want to just read to you the entire presentation. But we wanted to ensure that folks understood the differences between health maintenance organizations or HMO, our preferred provider organization or PPO, and the exclusive provider organization or EPO.

So some of these key features on an HMO is that they require members often to select primary care physicians who determine what treatment is needed. This is the traditional gatekeeper or quarterback model where the individual that is assigned as your primary care physician will basically determine the different levels of care and refer you to those that can assist you. That's the classic HMO.

There's also often times when those are capitated with a PCP or a primary care physician referral is required. This is how it exists today in southern Nevada with our Health Plan of Nevada HMO plan we have in this current plan year, where it's required for specialist treatment, we need

those referrals, capitations, of course, are pre-payment to primary care physicians that provide incentives generally for the PCP to efficiently manage that patient care.

If you opt to see a doctor outside of the network, often you will have no coverage and therefore will have to pay complete out-of-pocket costs. Although this doesn't refer to emergent or urgent care.

And then outside of PEBP, because we're a little different here in Nevada, but outside of PEBP, generally premiums are lower for HMO plans, especially those capitated plans, because they use a smaller network and they don't offer those services outside of their areas.

So moving right along, in the inverse, preferred provider organization has more flexibility. And this is similar to our consumer driven health plan. They feature, of course, a network of providers at discounted rates, but there is coverage that is outside of network providers. Of course it's a lower reimbursable rate, but at least we still cover non-network services. You can see a doctor specialist without needing that PCP or primary care physician referral and you can obtain medical services outside the network and be covered, as was mentioned earlier, however, premiums often tend to be higher than classic capitated HMO plans. And benefits typically have that deductible and co-insurance reimbursement after the deductible is met. So, interestingly

enough, in PEBP today the premiums for our consumer driven health plan are actually lower than our HMO premiums.

Moving forward, definition of an exclusive provider organization or EPO plan, very similar to an HMO plan. The folks must use network providers, you know, those doctors and hospitals and other health care providers that participate in the plan. The only exception is, of course, like the HMO plan for urgent or emergent care or services not available in the network. However, unlike an HMO, members often need not select a primary care physician nor do they need those referrals. So you can look at this as kind of a hybrid model between the PPO and the HMO plan. They're often self-funded. They are not capitated. So there isn't often financial incentives to manage care between providers. Their design is similar to an HMO plan because they usually utilize co-payments and the networks are narrower.

And that's really one of the key features of an EPO is that it's kind of a niche type of plan. It's designed in places where you can truly narrow that network and provide services that are a hybrid between PPO and HMO plans.

Here's a quick side by side since today's discussion is between the HMO versus the EPO. And this kind of summarizes what we just talked about. Yes, there's primary care providers in a traditional HMO and there's referrals in a traditional HMO and there aren't in EPO's, but

they offer the similar type of services outside of the network, which is usually none unless it's emergent or urgent care. That there is traditionally no deductible on an HMO, however, there can be a low one on an EPO plan to help offset costs. Of course they both traditionally have co-pays. And one is capitated and one is not. And one is traditionally fully insured and one is self-insured. So that's really the summary of the difference between these two types of plan designs.

So when we approach this process, and I want to take a moment here off of the slide and discuss that, this isn't -- I wish I could take credit for this. This isn't Damon's idea. This isn't even necessarily all of PEBP's idea. We worked diligently with Aon Consulting, we worked diligently with the Nevada Department of Administration and their purchasing division to try to capture all of the things that we need to to present the best information to the board for your decision.

One of the things that we took very seriously is trying to determine what are all of the things that you guys have to deal with and how synergistic are those things. We don't want to present to you ideas that you will have to make decisions in a vacuum.

And so this slide right here is supposed to hopefully capture all of the things that you guys have been

making decisions on or still need to make decisions on. Now, regional plans versus the statewide plan. What types of access to specialists? Are you going to want out-of-state services, especially on the HMO plans? Should there be a singular statewide plan design so you don't have that disparity north and south? Do you want to continue providing fully-insured HMO's or lower in the slide do you want to move to a self-insured EPO? What type of cost controls do you want to promote, i.e., capitation? What happens when a decision is made on the HMO side and is there an opportunity to lose the Sierra Healthcare Options or SHO network because we may no longer have a fully-insured product with United Healthcare. Are there any appetites for rate increases or is there any opportunity to discuss subsidy levels? The ever important discussion, blended versus regional rates, and then ultimately if there is change that is incorporated, how much disruption to the network, how much disruption to the participant? How many people are we asking to go pick new doctors and specialists and so on.

So once we determine kind of the problem statement, what are we trying to accomplish and how best can we meet all of these requirements or at least try to answer some of these things that haven't been answered, and we fully recognize that some of them already have.

We want to talk about what should be considered

in developing an HMO RFP. And, again, I'm not going to go too far in to this because you just heard a lot of these in those other statements, but which ones specifically apply to an HMO RFP, regional versus statewide, current versus new vendor, how much disruption occurs when you add new vendors, do you want to use the current design, do you want a hybrid design, do you want a capitate, non-capitate? All of those same types of discussion that should be considered when moving forward.

Now, here's something that we're very excited to share because it's critical to this discussion. We feel very firmly that this is kind of the crux that should hopefully guide decision making in the future. So currently there are only six insurance carriers licensed to provide HMO services to large group employers. And we named them up there for you: Anthem, Aetna, Hometown Health, Health Plan of Nevada, Humana, and Prominence.

However, I think it's very important to know that through market analysis that we had performed by our consultants at Aon, that two of the six, or only one-third, of the carriers are actually licensed to offer statewide HMO services. Now, a third is willing to expand their certificate of authority statewide, however, as of today you only have one-third of the competitive marketplace able to respond to a statewide only RFP.

Again, a third of those carriers contract with all hospitals in northern Nevada and only one of the six carriers contract with all hospitals in southern Nevada. And so if the end goal is to have access to every hospital in the state, that next bullet really, really kind of pounds it home. There are zero carriers that offer it all, that statewide HMO services or all service areas in Nevada are contracting with all hospitals in northern and southern Nevada. And so there is no one carrier that fits all for access across the state.

And we feel this is very imperative to the decision on how to develop the HMO RFP, because if we ask for something and not one single carrier can meet it, what are we willing to give up to get the carrier that meets most of it. Or is it important to marry up multiple regional offers? And that's a decision, of course, for the board.

So let's talk a little bit about the HMO RFP overview. You've seen these before when we've provided them to you in a different format. And you'll see some more later from Tena when she goes over the standard May board meeting contract overview for those RFP's or those contracts that we want to continue with in the next year.

But we are, again, asking to develop one RFP to ensure that they're provided to -- the HMO services are provided to PEBP's participants across the entire state and

that our -- we're talking about doing it either through multiple regional offerings or one state-wide proposal. And we'll talk about how we're able to differentiate them here in a little bit.

This, of course, would start upon approval of the board of examiners. And we anticipate that that would happen hopefully in January, if not by February, of next year. And that services, of course, will begin on July 1st of next year, which is the plan year 2018.

PEBP is looking for cost saving measures to reduce rate increases. I think we've talked enough today about budget constraints, about flat budget, five percent cut budgets, and whatever. And so we want to make sure that we are cognizant and that those bidding on this are cognizant of our financial constraints, that we're going to follow all the rules and regulations outlined in Nevada Revised Statute 333 and Nevada Administrative Code 333, which is the division of purchasing's rules and regulations and loss.

And to meet the recent approval of the board's duties, policies, and procedures that an evaluation committee will be appointed by PEBP in purchasing to include a minimum of two PEBP board members and a maximum of three PEBP staff, one outside expert from another state agency, additionally our consultants at Aon, our actuaries, will provide financial as well as disruption analysis.

Now, it's important to note that the two PEBP board members that can participate on this RFP evaluation committee are not the sum total that can. We can have up to five before we start to break over the open meeting law and we have a quorum. And so a minimum of two but a maximum of five can participate on this committee for us to ensure that we have enough participation from interested folks.

As far as the traditional scope of work, and this is something that I think you've seen before, this is pretty basic, we've done this in the past, but we want to make sure that there's access to a comprehensive choice of providers within our service area as well as outside of Nevada for emergent and specialized care. That full compliment of qualified professionals and specialists, that this should include but not limited to all of the things that we want to have in a traditional fully insured plan that we contract with. So there's customer service, utilization review, concurrent review, disease management, wellness, vision, mandated health benefits, all the standard array of services that PEBP participants are used to receiving today.

Let's not forget the dental benefits are offered through our own self-funded PPO dental plan and will not be included in this request for proposal.

We also are very cognizant of the Affordable Care Act and the provisions that that Cadillac tax or that excise

tax that will place a 40 percent tax on all plan costs or premiums that exceed a certain threshold, and now that's been pushed to 2020. So regardless of who pays those subsidies subsidizes the total premium. So therefore we're looking for creative ways to reduce overall plan costs to ensure our participants are not on the hook to pay for this 40 percent tax.

And of course we want to, as was mentioned in the executive summary, prioritize those things that have been important to PEBP and its participants for many months and potentially years: Plan benefit design, cost, access, statewide services through additional weighting, and other scoring criteria. So this is the overall kind of scope of work that we're proposing.

Let's talk a little bit about evaluation criteria. And before we get into the nuts and bolts of this process, I put this slide together, I'm not going to read it to you. I know it's painful to go through a lot of legalese. But this is straight out of NRS 333.335. And what I would hope everyone would take away from is that bolded italicized statement at the bottom, that the weight of each factor must not be disclosed before the date proposals are required to be submitted. So although we can talk in concept about evaluation criteria sake, we cannot reveal exact criteria weight. And that is per law. Not per PEBP. Not per Damon.

Not per anyone. It's per law. So we need to be very cognizant of that confidentiality requirement.

However, here's some opportunity to talk about evaluation criteria. So we are recommending -- And we'll get in to it a little but later -- a defined preferred HMO plan benefit design. This is a change from what has been presented before, often in contracts we'll present a please send us your most creative designs and then they can evaluate it. But with one preferred HMO benefit design, and again we'll talk about in a few slides, we believe that that will solve that one problem, that one problem statement of a singular plan benefit design, do I get the same benefit in southern Nevada as I get in northern Nevada and who's paying for what.

We want to make sure that this also supports an apples to apples comparison, so it makes it easier for the evaluation committee to be able to score and appropriately weigh their responses.

Vendors, of course, and let's not forget, they have a right to take exception to any part of the RFP, and creative solutions will be accepted. And so we're not saying that this is a required plan benefit design, but these are our preferred. And if you come up with something that's even better, it doesn't mean that you're going to be necessarily punished. And so we want to make sure that that is very

clear at the onset.

So other evaluation criteria to be disclosed in the RFP. So we are proposing to do some form of additional weighting or scoring for meeting or exceeding the PEBP preferred plan benefits. Additional weighting or scoring for statewide versus regional proposals, additional weighting or scoring for open access versus closed access proposals. And that's basically discussing the required PCP referral to a specialist issue. Additional weighting or scoring for access to out of area HMO services, and of course, additional weighting or scoring for the best overall value.

And it's important we put a disclaimer at the bottom here that PEBP recognizes that there is an inverse relationship between additional access and lower cost. And the State of Nevada employees, retirees, and their dependants, as we have heard this morning due to public comment and repeatedly, they're very price sensitive. So all proposals should recognize PEBP's fiduciary responsibility.

So we've talked it to death, I think, already and we can continue to. But budgeting is very serious and we want to ensure sure that we don't come up with something that we can't afford or our employees and retirees can't afford.

Here's the proposed timeline that, this month, this board meeting that you all approve the concepts of this overview scope and criteria. But we also are going to do

something a little different this time. And I wish the administrator of purchasing was here. Unfortunately he could not, so he sent his apologies. But he wanted to, and we support him, participate in vendor meetings. And it's gathering some information on how best to meet some of the problems that PEBP faces, involving them in this process. We actually have those vendor meetings scheduled for next week to meet with all participating vendors that plan to bid on this RFP. Those will be hosted by Aon and will be completely above board and transparent with an agenda that I believe Kirby will be getting out here to us early next week.

We want to finalize the HMO RFP development with purchasing this month. And then we also want to, as we mentioned earlier, in July, release that participant survey. We want to start this process of gathering information and release the HMO RFP in July. Why do we want to do it in July and not wait until October or November? It's important to know that there's a significant runway to implement a new health plan and that it isn't just implementing by July 1 but it's making sure that all information is tested, validated, and appropriately set up in our systems by May 1, because that's when open enrollment begins, which means we need some time with that health plan in April to ensure that everything is where it needs to be and you all as a board need time to approve rates in April or in March. So we have to have

everything ready to go so we can present to you a final decision on rates, which then leads in to a final testing of the plan.

And as we kind of back our way up, we want to make sure that we provide with this new process an opportunity for our vendors to have the most amount of time to craft the RFP submissions to best position them to be competitive in this process.

September, we plan to receive proposals.

October, we would set up an evaluation committee meeting and they would select that winning vendor. At that time they would be able to review the results of that HMO survey so they would have that information, that first-hand information, from our participants.

In November or December, depending on how much negotiation has to exist, we want to concurrently have the Nevada Division of Insurance perform their review. We want to perform those contract negotiations. And we would like to hopefully bring back to you all a vendor contract to be ratified.

In January, and if not the latest February, is with the board of examiners' approval and that we kick off our implementation.

And in March, development and approval of the rates. And.

And April through July, we make sure that everything is ready to go seamlessly July 1.

So that's the generally proposed RFP timeline.

Let's talk a little bit about that high level plan design, that PEBP preferred benefit plan design. One of the things that we did first, and this is all information publically available on the summary of benefits and coverage on our website as well as at our current vendors, what are these specific comparison attributes, right. Primary care, physician visits, what does it cost for a specialist visit, emergency room visit, hospital inpatient services, the way they break down their pharmacy, what's the out-of-pocket limits, is there a PCP referral required, and then what is the overall actuarial value of our plans.

And so you'll see for the plan year 2017 what is going to begin here in about 14 days is Health Plan of Nevada has this setup on the left and Hometown Health, that's what HTH is on the right, and you'll see that there's some differences in those co-pays and that actuarial value. And so in an effort to try to create a singular plan benefit design where it is similar north and south, we are presenting today for discussion and deliberation from the board this preferred plan benefit design summary. And the reason why it appears that it's a little bit more geared towards our northern Nevada counterpart, it has nothing to do with the

fact that it's our northern Nevada counterpart. But it has to do with a cost and benefit ratio. And so if the desire is to open up this access model in southern Nevada, it's going to come at a cost. And since we know that everyone is very price-sensitive and we know that we've heard consistently from northern Nevadans that they like their northern Nevada HMO plan, that we went with this less aggressive, more conservative plan benefit design to hopefully curve any rate increases from going out of control by opening up this access model down south.

And so this is something, of course, we anticipate a lot of discussion on. But you'll see here that we basically took the northern plan and tweaked it a little.

Now, you asked us to do two things, come back with an HMO RFP scope of work and some criteria to ensure that we don't have issues in the evaluation process, and I think we've done that. But what does an EPO plan look like? So similar to the HMO plan, there's some consideration. You know, is it a hybrid design? Is it a mid-range design? How are we going to manage cost sharing? Are we going to account for adverse selection? Because anytime you introduce a new plan benefit -- or excuse me -- another plan, is it going to be the one that everyone migrates to or is it going to be the one that everyone migrates from. And so with that you've got to watch out for adverse selection that can add an immense

amount of cost to the plan.

How would it be managed? And so we are putting in here that it is anticipated it will be managed by our current third party administrator. They are on contract to perform services for our self-insured plans. And so to ensure that we get to maintain that entire risk pool regardless on if it's a PPO plan or an H -- a PPO plan or a consumer driven health plan, we get to have direct control over our own risk pool. And that provides us with a lot of benefits.

Which networks would we use and is there a disruption similar to the HMO offering if we don't have the current networks if they don't want to play with us after we select HMO plans, then we have to come up with new networks. And then, of course, that kind of leads over to the fact that if that does occur, we also have to worry about the consumer driven health plan network search as well.

And so as mentioned in the executive summary at the beginning, we recommend that you approve our overview concept, that you approve RFP scope, the HMO RFP scope of work concept, and you approve the HMO RFP evaluation criteria concepts. But that you allow us to continue to analyze the EPO option. Because we are not -- we realized as we were digging in to it, we needed more information and we did not want to present anything that we could not justify or back as

you make this decision. We want to make sure that we do our due diligence in analyzing this option further and have it ready. If that's what the board would like us to do, we want to make sure that it is vetted, it is accurate, and that is something that we can stand behind actuarially and financially.

And the reason why we've asked you to approve concepts is that we need a little bit of flexibility to make some technical adjustments to the HMO RFP based on these vendor meetings we're going to be holding and any additional analysis prior to its release. Because of this tight time frame, our concern is that if we find a very amazing idea that we can put in here that we didn't know about that will greatly enhance this process, we'll have to schedule another board meeting, we'll have to bring it back to you. And I think the concepts still ring true. High value, high quality, low cost, high access, statewide, we need to get rid of the disparity between north and south and provide the best overall HMO services to all of our participants.

And with that, I have Aon Hewitt up here with us to answer any questions. But I can move back and forth on this slide show. And I turn it back over to the chair. Thank you, Mr. Chairman.

CHAIRMAN DROZDOFF: Are there any questions for Damon before we move on to Kirby and Stephanie?

MEMBER ZACK: Yes, Mr. Chair. Christine Zack for the record. Damon, I just wanted to make sure that when you look at the evaluation criteria that number five encompasses some of my concerns, which is that the organizations that are bidding outside the plan itself that they're presenting, that they're also committed to improving both the access to care and the quality of care. And I know this is a particularly sensitive point for us southern Nevadans. Is that what you envisioned that number five would encompass that?

MR. HAYCOCK: For the record Damon Haycock. Thank you, Ms. Zack. And yes, that's kind of the catch-all there. We didn't want to get too specific and ride the chance that we started to breach the confidentiality requirements and the evaluation criteria. But, yes, that best overall value includes all of those factors that lead to adding value to participants in Nevada.

MEMBER ZACK: Thank you.

CHAIRMAN DROZDOFF: All right. Who's starting, Kirby?

MS. BOSLEY: Kirby Bosley with Aon Hewitt. And we don't have any particular prepared remarks. I would simply maybe refer us back to that honeycomb chart with all of the question marks in the middle and remind us of the conclusion here that no one plan has it all for us. And to some extent we can't ask to you make these decisions for all

of them right now because you don't know what you're going to get. And that I think kind of underscores what Damon is saying. We've got to be able to be nimble as we move through this process. And so I think this also points out how complex your market is in the State of Nevada, which is not new to you. But anyhow --

CHAIRMAN DROZDOFF: And there's honest disagreement on some of these.

MS. BOSLEY: Absolutely, right. And so let's see what it means when we get these proposals back in terms of cost, access, impact.

CHAIRMAN DROZDOFF: All right. Okay. So board, down south.

MEMBER GARCIA: Rosalie. I'm sorry. I missed the very beginning. But I want to just confirm that the RFP will include all of the previous variables that we had been looking for in the past, which allows for the vendors to make proposals on a statewide plan, a southern plan, and/or a northern plan. Is that true?

CHAIRMAN DROZDOFF: It's all true. I think what it's going to boil down to is between that honeycomb chart that they just had up and the bonus points, people are going to be able to submit what they want to submit. I think we're going to try to do a better job of sort of telegraphing our priorities. But there won't be any restrictions on what

people want to submit. But there may be greater incentives based on certain criteria.

MEMBER GARCIA: Yes. But I just wanted to clarify or confirm that the RFP when it goes out will actually have those variables available, just written out plain and simple that they can submit in any design.

MR. HAYCOCK: So for the record Damon Haycock. The short and sweet answer is yes, yes, it will have those things specified in the RFP so there will be no confusion on our bidder's part.

MEMBER GARCIA: Thank you.

MEMBER COCHRAN: Mr. Chair, this is Chris Cochran. Just to that point, one of the questions I have for Aon is, is there -- do we have a vendor out there that we're aware of that actually can provide a statewide plan?

CHAIRMAN DROZDOFF: Yeah. There's two.

MEMBER COCHRAN: There are that can -- When I say actually provide a statewide plan, I think in the past when we've looked at these there had been areas that they couldn't cover. So that's why I'm kind of raising that.

CHAIRMAN DROZDOFF: So if you look at this slide, Chris, there's two, and a third is willing to. So that's what you got.

MEMBER COCHRAN: Okay. All right. Then, you know, to Rosalie's question, if we -- we're not expecting

them to be able to cover all of those things if we list them in the RFP, correct, and that's part of that additional weighting/scoring for best overall value that Ms. Zack was talking about in terms of how we're going to review these just for clarification.

MR. HAYCOCK: For the record Damon Haycock.

MEMBER COCHRAN: Because if we list things in the RFP of things we'd like to see and they can't do that, we don't necessarily want to exclude them, I'm assuming, if they can't meet some of those what we'd like to see.

CHAIRMAN DROZDOFF: I think if all six -- I don't think we want -- I think if all six submitted RFP's in some way, shape, or form, that would be a good thing. I don't know that all six would. All six haven't in the past. But that would be a good thing. So, you know from there we'll, you know, we'll evaluate based on all of those criteria. But I don't think any of us want to try to limit it, you know, artificially limit who are these six might submit an RFP.

MEMBER COCHRAN: Okay. So I just want to be clear though that when we're doing these and if we're looking at value, we may -- I'm assuming we're going to see various proposals from various providers. For instance, they might say, well, for this proposal this is what you get and in this proposal this is what you're going to get. And there will be costs related to, varying costs, related to each rather than

saying, we're going to submit this proposal, this is our, you know, what we're proposing, this is how much we're saying it's going to be, versus, well, I didn't know I could provide that so I didn't include all of this. It needs to be clear to them that if we're offering them a variety of options in which to provide that we allow them to submit multiple plans that we could evaluate.

And I'm not sure if I'm expressing that correctly. But I think I am in terms of wanting us to be able to say, okay, well, you know, this one looks really, really nice but we can't afford it, so you're out. So we want to make sure that there are fall-back positions for any vendors out there that submit a proposal. And so I'm assuming there will be multiple proposals coming in from these vendors.

MR. HAYCOCK: For the record Damon Haycock. That's the exact intent, Dr. Cochran, on how we want to develop this RFP. The whole -- The burning issue, the critical issue, is how do we get what we want and still allow for the ultimate amount of competition. Because competition will drive price. And so we are not going to create artificially or purposefully an opportunity for a vendor to not participate. The idea is to put some prioritization so they know what we're looking for, but if they come up with something that we haven't seen or if they come up with

something that looks like it's going to benefit the state greatly, my anticipation is that the evaluation committee will take that in to account and score them appropriately.

MEMBER COCHRAN: Okay. So one last question. I'm sorry. This is Chris Cochran again. Is there going to be included in the RFP a statement pertaining to at a minimum the plan must include this?

MR. HAYCOCK: So yes is the short answer. And I'll see if I can find the slides. But with at a minimum is all plans should include the following services and plan provisions. So we have certain facets at a minimum all HMO plans should be providing anyway. But at least we want to ensure they provide them to PEBP. We need to have enough doctors, enough hospitals, enough utilization review. We want to make sure that they offer vision benefits. We don't have the separate vision benefits. And so we want to make sure -- Disease management, all of those things that we have similar on the consumer driven health plan, we are going to have at a minimum they need to meet certain criteria. But the minimum won't be tied to the priorities. They will just be priorities. Does that make sense?

MEMBER COCHRAN: Yeah, yeah. I just wanted to make sure there is at a minimal -- at a minimum clause in there. And I see that in your RFP scope of work. I guess I just want to make sure that this is what we would be looking

for for us at a minimum in case we don't have the resources to pay for the maximum. Thank you.

MEMBER GARCIA: Mr. Chair.

CHAIRMAN DROZDOFF: Go ahead, Rosalie.

MEMBER GARCIA: I would like to refer to slide or my page 16, the high level plan design.

CHAIRMAN DROZDOFF: Okay.

MEMBER GARCIA: My recommendation would be that the PEBP preferred plan benefit design look more like the HPN plan year 2017.

CHAIRMAN DROZDOFF: All right. Well, I mean --

MEMBER GARCIA: Because aren't we trying to -- isn't our goal to keep costs down? So when we have a preferred plan like a benefit design, we would want to tailor it more towards our least expensive costs where there is a lot of participants with more doctors than the higher end?

CHAIRMAN DROZDOFF: Well, I mean, this is the classic example, right. I mean, you know, what people like about this plan is what they don't like about this plan. They certainly like the lower costs, and you're right about that. But we have also heard repeatedly that, you know, the control, the capitated approach is something that isn't necessarily viewed positively. We've had UNLV show up at every meeting saying that.

Now, to be clear, there's nothing that's going to

stop -- For argument sake, if somebody submits a plan, if HPN submits a plan similar to the one they have, and it has a referral requirement, based on just the previous conversations that you and Chris had with Damon, that will be looked at and looked at fine. It's just, you know, what we're trying to do is not hide the ball from these folks and say, look, these are our priorities.

So you raise a valid question, which is if this board really thinks that, you know, sort of the gatekeeper model is something that we want, then we should change our plan design. So that's an open question.

So, you know, Rosalie asked a perfectly valid question. I mean, part of what we're trying to do here is give, you know, give enough assurance, enough head nods, enough whatever to say, okay, Damon, Aon, purchasing, go find us something that is going to match our wants and our needs. So people should speak away like she did. If that's what people want, great. If not, they should say that.

MEMBER EWING-TAYLOR: Thank you, Mr. Chairman. You know, I understand what Rosalie is saying. And in general I think there's clearly a group of people that would prefer the HPN plan year 2017 model. However, what concerns me is partly what you were saying about the UNLV faculty senate and their preference for the Hometown Health model, if you will, and that bottom line, that actuarial value.

What I would not want to see is us stick with a 93 percent actuarial value plan across the state only to have to radically change it in 2019 in preparation for 2020. So it would seem wiser to me to go effectively with the Hometown Health model at the lower actuarial value. And it seems like that accomplishes two things. It lowers your actuarial value and it responds directly to a very vocal group of folks down in Las Vegas.

CHAIRMAN DROZDOFF: All right. Anybody else want to weigh in on that, on this? This is a good discussion. Tom. I'll go to Tom and then I'll go down south.

MEMBER VERDUCCI: Well, thank you, Mr. Chair. Tom Verducci for the record. I just want to comment that during the final selection process, coming up with a vendor or vendors, if negotiations do fall apart, I think it would be a good idea to have a plan B in place to step in with a final solution. I know coming from the vendor community it costs a lot of money to submit bids, time, travel. And I think we would be very wise to have a concrete back-up plan that if the first selection or selections does not go through there could be a plan B.

CHAIRMAN DROZDOFF: I agree with that. And I believe that's the plan. Damon.

MR. HAYCOCK: For the record Damon Haycock. And purchasing is here, and they can correct me if I'm wrong.

But in a general evaluation criteria process, if the evaluation committee selects a vendor -- They rank all of them. They don't just select one. They rank them one through a million, whatever the number is. If there is a ranked number two, which will generally happen if there's multiple folks bidding, if negotiations fail with the number one vendor, it automatically defaults to the number two and you start negotiating with them.

We're also looking at if it turns out that there's no way whatsoever that we can get anything that's remotely going to work for PEBP, that's why we're going to continue to look at other options and continue to build other plan designs. But I'm pretty confident from what we received the first time that we're going to get something that we can live with. And secondly, we're building in a little bit more flexibility in to the RFP this time to allow us to negotiate a few more items that we weren't allowed to before to help drive cost down if that's what it comes to.

If we get a response back and the board agrees that we want to prioritize price and that's what happened, then if it comes in where no matter what we're stuck with a $40 increase, we may be able to negotiate down some of the plan benefits to get into something that's acceptable. We couldn't before because we didn't build that flexibility into the RFP, but we learned from that last one, and we're going

to build it in to this one.

MEMBER VERDUCCI: Thank you very much.

CHAIRMAN DROZDOFF: We'll go down south.

MEMBER GARCIA: Hi. It's Rosalie again. I just had a comment, and it was with regard to NSHE, Nevada System of Higher Education, statement of Jacque stated how NSHE faculty senate has made comments that they were willing to pay a little more. But I do want to beg that we keep in mind that on the other side there are State of Nevada classified support personnel who have come before us and said that they are not necessarily willing to pay a little bit more, that they indeed need their costs to be decreased. And I know there's such a fine line, probably several of them, but, you know, we need to keep that in mind also that I know NSHE faculty senate has a recommendation. But there are many classified support personnel who don't necessarily have that voice and we need to keep them in mind also. Thank you.

CHAIRMAN DROZDOFF: Well, that's why we get paid the big bucks. I do hope that the survey will help us in this regard too.

Anybody else want to weigh in on anything? Damon, maybe I'll look back to you guys now. How -- What would you like out of this -- out of this discussion?

MR. HAYCOCK: For the record Damon Haycock. I'll start. I want to address a little bit more about this

preferred benefit design. Number one, we're not married to it. We can make alterations and we're fine with it. Let's not forget that if we take a more, a more beneficial design, I'm afraid that we may push folks from wanting to participate because they don't have the same type of market place in northern Nevada that they have in southern Nevada.

So in southern Nevada they're able to use the capitated model. I'm not a hundred percent sure if they're able to float that model up north. I know today that it traditionally isn't used. And so we've had some obvious disparities in plan benefit design. And so if we make it the less rich plan and people can bid more rich plans, then people can come in and try to come in with something a little better. If we make it a more rich plan and people say I can't even meet that, I'm afraid that we'll lose some of that competitive advantage.

And then with that, I'll turn it over to Aon and see if you have anything you want to add. She's nodding her head.

MS. BOSLEY: Kirby Bosley with Aon. And that makes sense to us.

CHAIRMAN DROZDOFF: But -- Okay. But what about just in general? I mean, it's an agenda topic. You know, in an ideal world, what would you like to hear from, again, what would you guys like to hear? Just thumbs up? Go? There's a

little discussion on this from Rosalie. There hasn't been a whole lot more. I guess you got to use that that means sort of an acquiescence. But is there something in particular you want?

MR. HAYCOCK: For the record I would like you all to approve this slide. If you do that, we'll be able to move forward with the plan, the timeline, the concepts, and produce what we feel collectively and confidently is the best HMO RFP for the State of Nevada.

CHAIRMAN DROZDOFF: Does anybody have a problem with any of the elements on this slide?

MEMBER COCHRAN: I just have a question regarding number four, continue to analyze the EPO option. What does that mean in terms of this RFP? Does that mean, well, we're really not going to do the EPO in this plan or we don't have enough information yet as to whether or not we're going to include them in this RFP? Because that continue to analyze EPO option kind of looks to me that we're not going to consider that for the RFP for this time.

CHAIRMAN DROZDOFF: My view is, and again, Damon, correct me. My view is and as a board member I agree with this, that, you know, we are going to pursue the traditional HMO, and that is, you know, what this RFP is going to be all about. I think continue to analyze the EPO is sort of something to keep in the back pocket, should the HMO

discussion not bear fruit or be as productive as we think. That's as I see it. And I think that's why it's number four and not number one or number two. Is that how you see it?

MR. HAYCOCK: For the record Damon Haycock. Yes, I agree with Mr. Chairman. And let's not forget that we're looking at kind of a long-term solution, a multi-year HMO partnership. But no one knows what's going to happen in the future. No one knows what market changes will occur. No one knows if these HMO vendors or plans may have difficulty in meeting that excise tax or some of these other things that could eventually come to bear. And so it's imperative, we feel, to have these back-up plans, not just when you need them but when you don't need them. So that way when you need them, they're there. And I think that kind of echoes a little bit what Mr. Chairman said. But we do want to have this thing built. We want to make sure that it's the right idea. We don't want to shotgun something out to you guys and tell you you have a month to figure this out and you have to make a very difficult decision without appropriate analysis.

CHAIRMAN DROZDOFF: Anything else down south? Anything up north? Tom.

MEMBER VERDUCCI: Tom Verducci for the record. I think it's very important that we do have very clearly defined objectives with this RFP. And I think that's going to lead to the most successful outcome. And I think that it

has been narrowed down to these four items we have up on the screen here. And I'm comfortable with one, two, and three. And I'm also comfortable with one, two, three, and four, if staff feels four should be included.

CHAIRMAN DROZDOFF: Okay. Yeah. I mean, I don't see any downside to just continuing to understand -- I mean, and again, for your benefit and for Christine's benefit, this has been an on-again off-again topic. Some feel more strongly about it than others. But either way, I guess my view is I don't see any harm in continuing to do some work on it because it has shown up. And, you know, you can tell by some of the discussion, there's some that maybe would like to move it to the front of the line. I don't know that we're necessarily there yet. But, you know, doing some work on it and bringing the work to the board so that the board is -- better understands the concept, in my view anyway, I don't see any downside to it.

Don, did you have anything?

MEMBER BAILEY: No. I'm good.

CHAIRMAN DROZDOFF: Okay. Jim?

MEMBER WELLS: I actually think I have a question for Dennis. So we can't, according to this slide, we cannot put weight on the criteria that are on slide 14. Can we express our preference for which direction the weightings go?

MR. BELCOURT: Dennis Belcourt, deputy attorney

general. I think whatever, if you do openly that it wouldn't be necessarily binding on the evaluation committee. And I think that's what the weight is, is the evaluation committee is bound to assign something. And I'm not sure that there's a problem with it, but I'm not sure what it accomplishes.

MEMBER WELLS: Well, here's my thought. I mean, if we say that our preference is statewide, then that's where the bonus points should reside is with the statewide response.

CHAIRMAN DROZDOFF: Right.

MEMBER WELLS: So if you don't put in a statewide response then you would get -- you would not get the bonus points associated with that. Our preference is open access. So you only get the bonus points if you do open access. Our preference is access to outer area. And so, again, I think that we want to outline the board's preference on the criteria as well as -- I think as well as the three or four things that are on that slide at the end.

MR. HAYCOCK: For the record this is Damon Haycock. I think that's what the slide we have up is trying to allude to without crossing that boundary where we say, all right, board, tell me how many bonus points you want for this one and how many bonus points you want for that one. Because then that's truly revealing the criteria of the RFP. And I think that's, again, NRS 333.

And so saying that you want these things, as you just eloquently stated, Mr. Wells, I think is absolutely correct and that's what we try to capture here. But getting down in to the weeds and saying this one is worth two points, this one is worth 20, this one is worth 15, now you're establishing that confidential criteria.

MEMBER WELLS: I'm ready to make a motion. I would move that we accept the HMO RFP overview as outlined on slide ten, the scope of work as outlined on slide 11, and the criteria as outlined on slide 14 with the preferences for the meeting exceeding statewide, open access, out of area services and that we continue to evaluate the feasibility of an EPO option for some future date.

CHAIRMAN DROZDOFF: Is there a second? Tom Verducci with a second. Any discussion? Down south? No. Anything up north? All right. I'll call for the question. All those in favor please say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN DROZDOFF: Any opposed? Any abstained? Motion carries.

Let's go to agenda Item 10.

MS. GLOVER: For the record, my name is Celestena Glover. The item on Agenda Item 10 is the ratification of some contract extensions. We have -- Besides an HMO contract, we have three other contracts that will expire on

June 30th, 2017. We are asking that the board approve extensions of these contracts. The contracts in question, the Diversified Dental Services, we're asking for a four-year extension. They've agreed to maintain the rate at 68 cents per participant per month with a projected contract increase of approximately 1.7 million dollars.

The Liberty Mutual insurance contract, this is a voluntary contract, there is no cost to the state, as it is a voluntary program. So the individuals who sign up for it are the ones who pay for it. We're asking for a two-year extension on that contract.

And then lastly, the Health Claim Auditors contract, we are asking for an extension until June 30th, 2022. He has agreed to keep his rate at the year four level at 1.1 million dollars for five years. That's a pretty good deal, in my opinion. And, of course, Mr. Carr is a very good partner with PEBP and so we would like to retain his services if the board approves.

With that I'll take any questions.

CHAIRMAN DROZDOFF: Are there any questions for Tena? And if there aren't, I'd entertain a motion. We'll go down south and then we'll go to the north.

MEMBER GARCIA: Hi. This is Rosalie Garcia. I'm just with regard to Health Claim Auditors, I am curious as to why a five-year extension? Generally I understand that we,

you know, we do change our auditors. So if you can give me some background as to how long we've been with Health Claim Auditors, I would appreciate it.

MS. GLOVER: Megan Sloan is going to come up to the table and give us a little bit more history.

MS. SLOAN: Hi, Rosalie. This is Megan Sloan for the record. We have had a contract with Bob Carr I want to say for probably 15 years. When we have gone out to bid in the past for this service, we always declare in our scope of work how long if we were to entertain a contract extension, how long that would be. That's been the case this time. We are looking to extend this contract because, one, we have felt like it's a pretty specialized service. I don't know that we would find someone that knows this plan and the plan rules to the level that Bob does. And the fact that he agreed to keep his rate solid for the term is a huge cost savings to us.

And I would, you know, remind the board, some of you will remember that the very first audit that Bob did for us when his new contract started, he identified for us a $700,000 overpayment to one provider group. And in that first audit of that contract he almost paid for his entire thing. We get, you know, kind of spoiled in how it goes with that because he has been doing it a long time and he has really helped us save money over the years.

CHAIRMAN DROZDOFF: Does that help, Rosalie?

MEMBER GARCIA: Yes. Thank you very much.

CHAIRMAN DROZDOFF: You're welcome.

Okay. Jim, did you have one? I'm going to go Jim, Tom, Don.

MEMBER WELLS: First question is when did we enter in to this contract with Health Claim Auditors? What's the original term?

MR. HAYCOCK: For the record Damon Haycock. For those that don't know, Megan Sloan is our contract manager, which is why she keeps coming up and saving us. So thank you, Megan.

MS. SLOAN: Jim, I want to say it was 2012 because it terms in '17. And I will mention that that report says, and this might add, it says June 30th, but that contract actually terms September 30th of 2017.

MEMBER WELLS: And then it talks about a four-year extension. But '17 to '22 is five years. So is it a four-year or a five-year extension?

CHAIRMAN DROZDOFF: For which one?

MEMBER WELLS: Health Claim Auditors.

CHAIRMAN DROZDOFF: It's five.

MS. GLOVER: This is Celestena Glover for the record. In the paragraph it talks about the four-year amount. Yeah, it's the year four amount with a five-year

extension.

MS. SLOAN: Right. He agreed to keep his rates at the year -- at the last year of his contract.

MEMBER WELLS: At the 2017 level for an additional five years.

MS. SLOAN: Yes. Thank you.

CHAIRMAN DROZDOFF: Anything else, Jim?

MEMBER WELLS: No thanks.

CHAIRMAN DROZDOFF: Tom.

MEMBER VERDUCCI: Tom Verducci for the record. I just want to point out that I think all three of these contracts look very solid, looks like a very good package and good deal for the participants. I haven't heard anything to come up with any other conclusion but that.

CHAIRMAN DROZDOFF: Thanks Tom.

Don.

MEMBER BAILEY: I'd like to make a motion that the state have the authority to go forward extending the current contracts and the dental service, Liberty Mutual and Health Claim Auditors.

CHAIRMAN DROZDOFF: For the time frames specified?

MEMBER BAILEY: For the time frames specified.

CHAIRMAN DROZDOFF: Is there a second?

MEMBER ANDREWS: Second. Ana Andrews.

CHAIRMAN DROZDOFF: So we have a motion and a second. It sounds like somebody down south wants to say something.

MEMBER GARCIA: No.

MEMBER COCHRAN: We're getting ready to vote.

CHAIRMAN DROZDOFF: Oh, okay. Just trying to be inclusive here. All right. If there are no further comments or questions, I will call for the vote. All those in favor of that motion please say aye.

(All board members voted in favor of the motion, except Member Cochran abstained)

CHAIRMAN DROZDOFF: Any opposed? Any abstain?

MEMBER COCHRAN: Abstain.

CHAIRMAN DROZDOFF: Okay. Motion carries. Please indicate that Chris Cochran abstained.

Let's go to Agenda Item 11.

MS. GLOVER: Again Celestena Glover for the record. So the report in Agenda Item 11 is a discussion on the HRA portability. When I reviewed this report, I actually looked at some old data that PEBP has presented in the past and looked at the viability of making the HRA portable, meaning retirees on the CDHP that move in to the Medicare exchange, that they're carrying a balance in their HRA should that be portable to essentially their new plans.

So some of the things I wanted us to look at is

obviously inequities, whenever we make a change, whatever we do now isn't what we've done for other retirees. So do we cause a level of then equity between current and future Medicare retirees. Some of our internal discussions were if we make this effective July 1st what about the individuals that retire on June 28th.

Complexity in the administration of the HRA. We right now have two administrators. HealthSCOPE administers HRA for the CDHP. And Towers Watson's pay flex administers the HRA for the Medicare exchange.

There would be either we would transfer and one or the other vendor would have to administer everything, so how do you handle the claims that participants may submit. Who handles it? Is there a collaboration between the two vendors? How would we go about handling that process? Obviously a financial impact. That's my world.

We asked HealthSCOPE for some information on the individuals turning 65 between July 1st and June 30th, so the upcoming plan year. They gave us 603 participants who potentially will turn 65 and move on to the exchange. That cost for that group is 1.2 million dollars, approximately, depending on what their ending balances are. This is based on a balance they currently hold and it does not include whatever funding will go in to their accounts on July 1st.

When I looked at the file that HealthSCOPE sent

us, we had balances of as little as one cent and we've had balances, you know, with several thousand dollars. So depending on the individual situation, do we transfer a penny, do we set a threshold, what do we look at should the board decide to go ahead and make this portable?

And then lastly I considered it from an OPEB liability. Any benefit that we provide our employees and retirees going in to the future as those individuals retire, the employees retire, that affects our OPEB liability. To what level, I don't know what that dollar amount is. I did not ask Aon to analyze this for us to say what this looks like. I think we would have to look at how many people might decide to opt for a different plan, would they stay in the CDHP and purposely save money thinking that they're going to need it more when they move in to the Medicare exchange? Those individuals, as I said before, that didn't have that opportunity or, you know, would the question come up that we potentially make this retroactive?

And then this goes on until such time as it is changed again. So it's not just the 600 retirees that we're looking at here. How many of those retirees going in to the future?

So, in conclusion, after looking at all of this and considering all of the potential pitfalls, we're not certain that this is a direction that is viable with all the

changes that we are potentially looking at with budget constraints and increased cost to our participants. However, obviously whatever the board decides, that's where we'll go. And with that I'll take any questions.

CHAIRMAN DROZDOFF: So, Jacque, this has been an issue that you've wanted discussed. Perhaps I'll start with you if you're ready.

MEMBER EWING-TAYLOR: Sure. Thanks, Mr. Chairman. One of the first things that I would like to point out is that the request was specifically to have Aon do a financial analysis. So that that is not here frankly is a disappointment to me.

I think if we just look at the objections essentially that had been laid out here, you know, as far as creating an inequity between current and future Medicare retirees, frankly we do that all the time. Every time we make a plan decision, we affect some positively and negatively. So if we are going to start a new policy anywhere, it's going to negatively impact some people. I honestly don't think that's a particularly valid reason to not do this.

As for the complexity of administering the HRA accounts, I think Mary Catherine had to leave, but her comment when I first brought this up some months ago was that they already do this for a number of their clients. And she

said it was not particularly difficult. So I don't think, frankly, that that's an issue that we would need to worry about.

Clearly they have the experience. They can help us work through this. They have dealt with all of the issues I think that are contained in the report. So I don't put a whole lot of value, frankly, on that objection.

As for the financial impact to PEBP and the participants, we already carry it on our balance sheet. We already deposited the money. It's already a liability. If everyone, all 603 people, were to spend out their HRA's between now and whenever it is that their one year expires, we wouldn't have the money anyway. So, again, I don't see that as a really good reason not to do this.

As far as the increased OPEB, that's the only one that I can't answer or address and nor can we at this point because we didn't do the valuation. I don't know how, you know, if we've got 1.2 million now, if we have to include, you know, that amount and then all the amounts going forward, I don't know what that would do to the OPEB liability. I don't know whether it would increase it billions, millions, or thousands. So, again, I do understand that that's a concern. My gut feeling is that it would not increase that liability significantly.

And Kirby, I hate to put you on the spot, but can

you make any sort of projection?

MS. BOSLEY: Not really. Yeah, I would turn to Stephanie as the actuary. We could come up with a number pretty quickly for you and run that.

MEMBER EWING-TAYLOR: Like in the next three minutes?

MS. BOSLEY: Probably not that quickly. However, you have a large OPEB liability currently, so this won't -- it can't double it, right. So it's probably not thousands. It may not be billions. But it would not be insignificant. That's my gut feeling, right.

MS. MESSIER: Yeah. This is Stephanie Messier. I would concur with what Kirby said. We don't really think we need to see what the balance looks like today to do a good valuation for you. I wouldn't say it's insignificant. But, again, I agree it wouldn't double your already very large OPEB liability.

MEMBER EWING-TAYLOR: That's somewhat helpful. Again, it's not what the information I would like to have. And I'll just say, again, my feelings on this and the reason I've talked about this for a while now is that we created these HRA's so that people could -- would have some money to help defray their health care costs. And we initially talked to them about saving it for retirement. And so you've got some people who have in fact done what we wanted them to do,

plan for their retirement, plan for their health care expenses and retirement. And now because it wasn't widely publicized people were getting caught in a bind where they're like, wait a minute, I let my balances grow so I would have this when I retired. And we're pulling the rug out from under them, and I think it's wrong. And I would encourage if we don't want to make a decision today because of the issue about the OPEB liability, then I'll probably come back and talk to you in public comment about this. And I hope that's a threat.

CHAIRMAN DROZDOFF: Tom.

MEMBER VERDUCCI: Tom Verducci for the record. The problem that I see with the HRA is you must spend it, you have to use it or you lose it. And I think that we want to be looking out for future retirees so they have enhanced benefits. And I think there's a lot more that can be done here. If we have two employees that come to work, say one goes to work for the Department of Transportation, the other goes to work for the Gaming Control Board, they have a very competent HR representative that helps them sign up, but one choses HSA, health savings account, and the other goes HRA, health reimbursement account. At age 65 one loses all of their benefits and the other retains their balances. And I just don't -- I just want to make sure that all future retirees know what they get in to, it's communicated

properly, and that we're providing them the maximum benefits. I think that this is something that needs to be looked at in the future. I think looking at it during the time with the HMO RFP going out is going to be too much. But I would like to see this come back up and perhaps even form a subcommittee where there's an in-depth analysis on the different choices that could be done.

CHAIRMAN DROZDOFF: Anybody else want to weigh in? Anybody else want to weigh in?

MEMBER WELLS: Yep.

CHAIRMAN DROZDOFF: Jim.

MEMBER WELLS: These two HRA's were created for two entirely different purposes. The HRA for the CDHP was intended to offset the cost of medical services because we have a high deductible health plan. The exchange HRA was specifically created to offset the premiums that they pay to purchase the Medicare supplements and advantage policies on the exchange. The forfeitures are actually built in to the rates. We calculated out an amount that is expected to be forfeited every year as a result of people moving from one HRA to the other or just the same, they lose their HRA if they move from the CDHP to the HMO. So in any case those forfeitures are built in to the rates.

The second thing that -- The second concern I have is that the CDHP and HMO participants are paying for the

administrative costs associated with Medicare retirees. They get all of that for free. Their life insurance premiums and all their administrative costs are not billed to them. They haven't been since we implemented the exchange. And so if we're going to start talking about having the CDHP amounts roll over, I think that we have to revisit the whole issue. I am not in favor of this at this time without additional discussion and recognition that there's more to this than just saving money in your HRA.

CHAIRMAN DROZDOFF: Jim, not to put you on the spot, but you were kind of front and center when this decision was made. Is there any -- So you talked about the two paths, which is helpful. Is there anything else in the history? I mean, why you and the board sort of landed on this way back when?

MEMBER WELLS: So I have attempted to kind of go back. There was discussion about this particular topic in 2010, 2011. I found the vote. But there's another -- Unfortunately the website no longer goes back all that far. And so I, when I was trying to find this stuff last night I couldn't get back far enough to see minutes and transcripts and stuff like that. But this has been discussed. It was discussed in 2010. And there was a fairly lengthy discussion about the forfeiture of HRA funds as you -- as you move. And the vote was eight to one, I think, or seven to one. There

was only one person who was opposed to the calculation at the time. It wasn't Jacque.

MEMBER BAILEY: It wasn't you, huh?

MEMBER WELLS: It was Ms. Caterino who was opposed it to. And there's some confusion and then the transcript runs out, so I don't know --

CHAIRMAN DROZDOFF: But beyond the vote, what was your -- what was the equity issue that you thought was dealt with this way?

MEMBER WELLS: There were a couple of things that we talked about early on that kind of never come to fruition. One is that there was always an intent at least from me that HRA balances, that HRA liability would be capped at some point. It wouldn't be allowed to grow in perpetuity. The board has continued to vote that that's not what they wanted. But that was the intent when we put it together because it is a liability that sits on the financial statements of the program.

And at some point that liability is -- it continues to grow without any additional benefit because at the end of the day they forfeit it anyway. They cannot take it with them and give it to their family. So at the end of the day it's forfeited back to the program.

So there was always a discussion about having a cap on it. We haven't put a cap on it. I don't know that

based on what I've seen from the HRA balances, I don't know that a cap has been necessary because I think that for the most part they have -- PEBP stayed in a reasonable amount anyway. So maybe a cap wasn't necessary.

But I go back to there was a ton of discussion about the exchange HRA being available to pay for premiums. The CDHP HRA is specifically not allowed to pay for the premiums. It is only allowed to be paid for medical costs, medical claims that are incurred by the participant. So that, again, there were two different thoughts as to what the real use of those HRA amounts were, because the exchange HRA is specifically that. Most people are using it to pay premiums. They're paying for their Medicare part B premiums. They're paying for dental premiums. They're paying for their advantage or supplement premium. There are some people who use it for co-pays and stuff like that. But you see that that's a fairly insignificant number when you look at the usage of it.

So, again, they had totally different purposes. And that was why the termination and forfeiture when you move from plan to plan. And it was -- It didn't matter which plan you moved to. If you moved from the CDHP to the HMO, you lost -- even if you did adjust for a year, you lost -- say you could have a thousand dollars in your CDHP HRA, you move to the HMO, you lose that, you could go back to the CDHP that

next year and we didn't give you back the money that you had in your HRA then. You started over. So every time that we moved between plans there was the intent that it was forfeited. It was part of the plan, especially when it related to the CDHP, that it was to offset the high deductible. It's built in to the premiums to offset the high deductible plan.

CHAIRMAN DROZDOFF: I'll let you close or maybe not close.

MEMBER EWING-TAYLOR: Thank you, Mr. Chairman. So Mr. Wells obviously has a much better memory than I do and much better access to past records than I do. I would simply say that at that period of time when we were instituting the CDHP we were doing so basically under the gun. We had a massive amount of money that we had to find within the plan. It was a stunner, I think, to all nine of us on the board at the time. I guess you and I are probably the only two left who were on that board. And I'm not sure, frankly, because we had never had HSA's or HRA's that any of us fully understood all of the future ramifications of some of the decisions we were making. That has been true on this board for any number of decisions. We have revisited things. We have changed our minds. I will always reserve the right to change my mind about something if I have new information, additional information, some better understanding. So just

because we had a discussion about it and I voted for it at the time, in my mind, Jim, is irrelevant to this conversation.

Because the fact is in my mind, in my opinion, we have an inequity that I would like to see addressed by making the HRA's portable for people who are retiring. Again, we know that from what Mary Catherine has told us several months ago that they do this all the time, that it's not particularly difficult. I just think it's a good idea. We will agree to disagree, as we always have.

CHAIRMAN DROZDOFF: There is a need for -- Again, I want to -- How would you like to proceed? This is your last board meeting. This issue is undone at least as you described it. I mean, any recommendation moving forward?

MEMBER EWING-TAYLOR: Well, I certainly -- I would have been much more comfortable again, and I know I've said this three times already, with a better idea of how this affects the OPEB liability. But, again, I don't believe, and I have not been contradicted that it would make a massive difference in the already large OPEB liability that we have. So I suppose I would just go ahead and make a motion that we reject the staff recommendation and move forward with allowing portability of the HRA's for retiring people and have HealthSCOPE work with Towers to make that happen.

CHAIRMAN DROZDOFF: So there's a motion. Is

there a second?

MEMBER GARCIA: Second. Rosalie Garcia.

CHAIRMAN DROZDOFF: All right. A motion and a second. Any further discussion? I want to go back to Tena and staff. You've got the recommendations. I think it's fair. I mean, I want to give you an opportunity. You made a recommendation that we not do this. You know, if you want to deal with the -- all four of these things, like, you know, what do you think the past retirees would say. However you want to proceed, I want to give you an opportunity.

MR. HAYCOCK: Thank you, Mr. Chairman. Damon Haycock for the record. I'll start, and if Tena wants to join in, please do so. We'll take these, and I'm not going to regurgitate everything that was said. And I think the discussion has been very well so far. An inequity between current and future Medicare retirees. I think that Madam Chair is correct that as we make changes and they become prospective we just deal with them and that does happen. Although I also know that at least my pulse on the retiree population is that they feel that they're not being treated fairly. And if they're not being treated fairly are we giving them another unfair opportunity to say, I retired three months ago, six months ago, I didn't get to move my balance over but everybody starting in 13 days gets to.

CHAIRMAN DROZDOFF: Can I stop you right there?

Marlene, do you have any insight on that about what your members would say about this?

MS. LOCKARD: No. We have -- Thank you, Mr. Chair, for the opportunity to comment. We have not polled our members on this issue. But as I know all of you that have been here on this board recall, the move to the Medicare exchange from the PEBP system was very difficult and RPEN has always felt from day one that there was money left in the system by a large number of seniors. And I know Mr. Wells will dispute that comment.

And so we very much support Dr. Ewing-Taylor's position. And I say that representing them but not having polled our members.

CHAIRMAN DROZDOFF: Well, I think that's important. So I want to make sure. Because what we're hearing from staff is that he thinks some of your members will not be happy with this because there will be this, you know, inherent unfairness. And I don't want to unfairly put you on the spot, but I do think we're talking about -- we are talking about your folks and so I don't want to --

MS. LOCKARD: Right. And I understand. Thank you. I would like to think and believe --

CHAIRMAN DROZDOFF: Hey, folks down south, if you want to just turn your mike off if you're -- I'll get to you, I promise.

MS. LOCKARD: The better nature of individuals that maybe did not receive this proposed change and the benefits of it would not want to see their fellow seniors deprived who in that pool they all struggle. So that's the best I can say to that issue.

CHAIRMAN DROZDOFF: Okay. Well, that's -- Thank you.

All right, Damon, keep going. I'm sorry. I failed to --

MR. HAYCOCK: No worries. For the record Damon Haycock. Thank you, Mr. Chairman. And thank you, Marlene, for coming up and sharing that perspective. As far as the complexity of administering the HRA accounts, Mary Catherine may be able to perform that process on behalf of HealthSCOPE. I think we've seen that it's been difficult to even manage the regular HRA on behalf of Towers Watson. And so just to keep in mind that there's kind of a pitcher and a catcher to this process. And the pitcher may be good but the catcher may have difficulties. So just to keep that in mind. I'm not saying that it can't be done.

As far as the financial impact of PEBP, one of the things that I don't know has been truly discussed to its fullest is, you know, we can use this 1.2 million dollars. And I think Dr. Ewing-Taylor said it very eloquently. Well, what if they did a basic run on the bank, we would run it out

and it wouldn't be there anymore. I'm going to flip that coin and say what if they don't. That's 1.2 million dollars that goes back to the program that then funds the next 1.2 million dollars of HRA funds to future retirees or future plan participants. And so if you take that 1.2 million dollars and you say we're going to transport it away from the consumer driven health plan and we're not going to put it towards premiums to PEBP or to claims to PEBP, you're taking the funds that you're provided, as Mr. Wells has stated, to help offset the high cost of health care on our consumer driven health plan and now you're offsetting or potentially, my words, not yours, subsidizing a Medicare advantage plan or a Medicare supplement plan. And most importantly, if you're using 1.2 million dollars as a trigger, which we can say that analysis was performed, if it's 1.2 million dollars this year then if that 1.2 million dollars stays on the books for those folks and the next year 1.2 million dollars increases again, then the cost compounds itself and that's a liability that you have to decide if you're willing to absorb because this isn't just a one-shot decision, I think that we can reverse.

And finally, last but not least, the rates that were developed and approved by the board back in April or March was predicated on this liability not existing. And so we may end up having a shortfall or potentially have to dip in to catastrophic reserves if we didn't plan for this cost.

And so I'm not against this process of making things portable. I think it's fair. I just don't know if this is the appropriate time to do it. It's not a what. It's a when. And so with the issues that are affecting PEBP today, with the survey that we're automatically telling everyone, you're going to have to pay more or you're going to lose your benefits. Is today the right day to add another benefit that people don't already have and increase the liability to PEBP.

And with that, I'll turn it over to Tena to add anymore comments. If not, we'll go from there.

MS. GLOVER: Celestena Glover for the record. I don't have any additional comments other than to echo what Jim said with the rates are set based on the forfeiture of our -- of the balances for those who do transition, move out of the plan for whatever reason, whether they go to the HMO or go to Medicare exchange. Medicare retirees do not pay in to PEBP other than those who have the dental plan. So that would mean if, even if this liability only ended up costing a dollar per participant per month, it's those people that are on the CDHP. It's not everybody.

So just some things to consider when the board makes their decision as to who is actually going to pay for the cost, whether it's minimal or maximum. You know, but again, as I said, during the report, we'll go whichever way

the board wants.

CHAIRMAN DROZDOFF: We'll clarify here and then I'll head down to Las Vegas, okay.

MEMBER EWING-TAYLOR: Thanks, Leo. I just want to clarify that when you say that the forfeiture was built in to the rates, you took 1.2 million dollars, expecting that amount of money to be forfeited, and you deducted it essentially from the rates.

MS. GLOVER: So when I develop the rates and the budgets, I look at what the HRA balances are and then we request what we call a run-out date when these people have left the plan, when their ability to access those funds are going to expire, and we will get what that dollar amount is. And we look at both the Medicare exchange and the CDHP. It's one reserve because we keep that funding in the reserve. And so then we make adjustments. And so it may go up anyway because maybe the new people coming in exceed the people going out. So yes, we do take that in to account.

MEMBER EWING-TAYLOR: So was that 1.2 million?

MS. GLOVER: I don't know what the exact dollar amount is for this. This was based on this particular group of individuals, yes.

MEMBER EWING-TAYLOR: So the impact on the rates could be less?

MS. GLOVER: Could be, yes. Sorry. Could be.

CHAIRMAN DROZDOFF: Let's go down south.

MEMBER COCHRAN: Just for clarification. This is Chris Cochran. So on a retiree who has an HRA, when they retire, that amount that's in their HRA is automatically to be retracted at that retirement date or do they have a period of time in which to use that or lose it?

MR. HAYCOCK: For the record Damon Haycock. And I'm going to try to say this. I think there's people in this room who can say it better than I can, but I'm going to give it a shot, Chris. When an individual retires depending on whether they stay -- depending on if they're Medicare eligible for one thing. You know, if they're Medicare eligible and they're going to go on to the exchange, any balances they have, they have the availability for a year to pay any outstanding medical costs that are allowable per the IRS for that HRA for the time frame while they were eligible to participate in the plan with that HRA. I know it's kind of a roundabout answer.

When they retire then and they move on to Medicare exchange, they're going to get a new HRA for all of their new costs based on their years of service. I think it turns to $12 on July, $12 per year of service, and then of course is used often to satisfy the premiums.

But you have a year run-out to pay previous bills. But it's based solely on that eligibility date on

when you're either eligible to participate on the Medicare exchange and you move on to it or if you don't. I'm hoping that's simple.

CHAIRMAN DROZDOFF: Does that help, Chris?

MEMBER COCHRAN: Yes. I understood it. I understood the answer. So the question is, is that an option for us to tell people that upon retirement your HRA will run out at a certain date? Or are we, you know, is that something that we then just need to make sure that they are aware of as part of their retirement plan, that HR, for example, explains to them, okay, you have an HRA, when you retire, your HRA is -- does not carry on for those people to which that refers?

MS. SPINELLI: Chris, this is Nancy Spinelli. We do tell our retirees who are aging in to Medicare that once they transition to the exchange that the HRA -- HRA funds are forfeited by PEBP. And we do let them know in advance. Because typically they're going to get their Medicare approximately 90 days before their effective date. And we let them know at that time that when they transition their funds will be returned to PEBP and we encourage them to use those funds.

And I don't know why I'm -- too much Red Bull here. And we've also, just to clarify, since we implemented the HRA with the CDHP plan, we've always notified that the

funds would be returned to PEBP once they're no longer on the plan.

MEMBER COCHRAN: Okay. All right. So we could experience a run on the bank when they're informed of this anyway; right? So it's likely that if they've accrued a lot of money in their HRA that they don't have enough medical bills to spend it all down. It's probable probably. Probable probably. So that's just my point for clarification because, you know, because I was just wondering is there a way for us to extend that option for how long they have to spend down their HRA. But if it's a three-month transition here, is that transition set in stone?

MS. SPINELLI: The transition period basically that is, it's a 90-day time frame to get them enrolled in Medicare. And once they become enrolled in Medicare then they have 60 days to go to the exchange. So they actually have a 60-day period to spend down that money.

MEMBER COCHRAN: Okay. All right.

MR. HAYCOCK: For the record Damon Haycock. And again, I don't want to detract from the conversation. But we have a process in place that if you want to have your claims paid for you have a full 12 months to have them paid for. So that HRA balance that's on the account when they are supposed to forfeit it doesn't really get forfeited until they finalize any of their previous years payments or claims.

Does that make sense?

MEMBER COCHRAN: Right. But they -- Yes, yeah, I get that. But they couldn't, say, all of a sudden decide to go out and, you know, purchase some other health, you know, health benefit or, you know, buy glasses or get new dentures or whatever they might use that HRA for during -- You know, once they have transitioned they can't use it for that purpose. It can only be used for bills that were incurred prior to the end of that transition.

MR. HAYCOCK: Yes, Chris. Damon Haycock for the record. That is correct. Think about it this way: Your HRA assigned to your consumer driven health plan is only used for the time being that you're on a consumer driven health plan. And the moment you move off of it and you go to another plan, an HMO plan, a Medicare advantage plan, or so be it, you are now in to whatever current funding stream that supports. And if they go out and buy glasses or they go out and have a procedure done, it's now going to be under that new health plan with that new health plan funding source with that new health plan HRA, if applicable.

CHAIRMAN DROZDOFF: Anybody else down south? Anybody else up north? Tom.

MEMBER VERDUCCI: Just one final comment. My concern on the HRA is retirees at age 65 giving up balances in an environment of rising health care costs makes it really

difficult for the retirees. That's why I would suggest that we continue looking at this. And I also do understand it was very good conversation on how the premiums are funded in to the programs. As a new member, that's very helpful.

CHAIRMAN DROZDOFF: Okay. But we do have a motion on the table, which eventually I'll call for the question on. Is there any other -- Is there any other comment? I mean, I understand what you're saying, Tom. I don't know how you're going to vote. You can vote by saying I'm ready to do it but not right now or the like. But I just want to make sure that if anybody else wants to say something before I call for the question, now is the time.

MEMBER ANDREWS: Mr. Chair.

CHAIRMAN DROZDOFF: Ana.

MEMBER ANDREWS: Ana Andrews for the record. Given the fact that Marlene said that they really haven't polled their constituents and the fact that there are so many questions about this that we need -- well, we want an evaluation, I would be in favor of not voting for this, postponing this, getting the actual real numbers and particularly for the benefit of our new board members because if the rates that we voted on in March and April were contingent or counting on having some of this 1.2 million and now we're going to turn around and tell, okay, well, your increase is not going to be ten dollars, now it's going to be

15, I think we would be doing a disservice to our membership. Thank you.

CHAIRMAN DROZDOFF: Okay. Anybody else?

MEMBER ZACK: Mr. Chair, Christine Zack for the record. It just seems like there needs to be additional financial analysis done before we can vote on this issue.

CHAIRMAN DROZDOFF: Okay. Well, okay. So we have two choices at this point. We have a motion and a second. The maker of that motion and the second can pull their motion in lieu of a, you know, basically saying, look, as opposed to taking a straight up or down vote, we can do what Christine and Ana and others have suggested, which is do more analysis, or we could do the up and down vote. And what's interesting about this, of course, is that we have a board member whose last board meeting is today. So I'm going to defer to you, Jacque. How would you like to proceed?

MEMBER EWING-TAYLOR: Thank you, Mr. Chairman. Okay. I'm going to beat the dead horse one more time.

CHAIRMAN DROZDOFF: But then you're going to tell me what you want me to do?

MEMBER EWING-TAYLOR: Yes, I am. I will definitely do that. If staff had done what I had asked, we'd have that information. That's the last time I'm going to say it.

I would then withdraw my motion and ask that

whoever made the -- Who seconded it?

CHAIRMAN DROZDOFF: It was Rosalie.

MEMBER EWING-TAYLOR: Oh, it was Rosalie. Rosalie, ask that you. And then I'll make another motion.

CHAIRMAN DROZDOFF: Rosalie, are you willing to withdraw your second?

MEMBER GARCIA: Yes, because Jacque asked nicely.

CHAIRMAN DROZDOFF: Fair enough. All right.

MEMBER EWING-TAYLOR: Thank you, Rosalie.

So Mr. Chair, I would move that we ask staff to conduct the detailed financial analysis that has been discussed and bring this back to the next board meeting, at which time I'll see you in public comment.

CHAIRMAN DROZDOFF: Okay. And so before I -- before I ask for a second, can I just -- So detailed financial analysis means that you would like discussion on rates, discussion on OPEB liability. What else?

MEMBER EWING-TAYLOR: Those are the two financial analyses that I think seem to be a stumbling block for many people. And as Don is suggesting, I would ask that RPEN provide us with as much information as you can.

CHAIRMAN DROZDOFF: A more formal position. Now you have some time to do that. All right. Is there a second to that motion?

MEMBER BAILEY: Don Bailey. I second that

motion.

CHAIRMAN DROZDOFF: I'll have Don here. Thank you. Is there any further discussion on this motion?

MEMBER WELLS: Yeah.

CHAIRMAN DROZDOFF: Jim Wells. And then we'll go down south.

MEMBER WELLS: As part of the financial analysis, I would like the cost of the Medicare exchange retirees that is currently being borne by the CDHP and HMO participants.

UNIDENTIFIED SPEAKER: I can't hear you.

CHAIRMAN DROZDOFF: Say that a little louder, please.

MEMBER WELLS: I would like as part of the financial analysis that the costs that are being borne for the Medicare exchange retirees by the CDHP and HMO participants.

CHAIRMAN DROZDOFF: Okay. Can you get that?

MR. HAYCOCK: That admin cost and life insurance, I got it.

CHAIRMAN DROZDOFF: Okay. All right. With that clarification is there any more discussion down south or are we ready to call for the question? Seeing none I'll call for the question. All of those in favor please say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN DROZDOFF: Any opposed? Any abstained?

Motion carries.

So let me just ask a question, first of all, how are you doing?

(The court reporter responds)

CHAIRMAN DROZDOFF: How much longer are we going to go? We got two agenda topics.

MR. HAYCOCK: We do. We do. Towers -- For the record Damon Haycock. Sorry. We have Towers Watson. And I don't know -- they were on their way, so I don't see them in Las Vegas.

MS. RICH: He's on his way.

MR. HAYCOCK: He's on his way. And then my report is painfully fast. It's four paragraphs. And I can go through it super -- We can do it out of order if you want, take a break, and see if Towers shows up and then finish up.

MEMBER BAILEY: Was that painfully?

MR. HAYCOCK: Painfully.

CHAIRMAN DROZDOFF: Okay. Why don't you do yours and then if Towers misses it, I guess then we're done.

MR. HAYCOCK: Yep. We can push it to next month if you'd like.

CHAIRMAN DROZDOFF: Why don't you do yours.

MR. HAYCOCK: So for the record Damon Haycock. This is Agenda Item Number 13 taken out of order. This is my executive officer report. It's the standard report, of

course, that I've provided to the board, but it's been published under stakeholders for the status of PEBP. I changed the format a bit this time. I wanted it to be a little more succinct, a little more to the point, and really address it in these specific categories. It also allows me to get more input from staff in their specific areas in case they don't have an opportunity to present what's going on within their departments or divisions.

But basically operations, we had open enrollment that ended May 31st, 2016. And initial reporting from our eligibility vendor showed that we successfully enrolled 2,266 members through the system. That doesn't mean that we dis-enrolled the rest of them. It just meant that these are the positive re-enrollments or enrollments in to the system and we're still getting more data. And so that number may go up.

We also answered 4,337 calls, took 212 walk-ins, and answered 1,468 e-mails during that time frame. So we were very busy at PEBP as we always are during open enrollment. And, again, based off the last board meeting, we met the requirement to post the summary of benefits coverage documents on line on June 1st as required by law.

We also are finishing implementing the new pharmacy benefits manager, Express Scripts. Noticing and website information have already been posted timely and we

are on track to successfully kick of these new services here in 13 days. We're very excited to partner with them.

We've done data connectivity testing and we're sharing a seamless transition for those accumulators for that tracking of those prescriptions. That's that data connectivity between our third party administrator, HealthSCOPE, and Express Scripts to ensure folks that have a combined deductible are aware of what is left on it whenever they go and pick up their pharmacy or their medications at the pharmacy or whether the medical doctor receiving an office visit that will be able to be accumulated appropriately.

We also did a plethora of communication activities. We did in-person workshops, presented open enrollment workshops, and new hire orientations across the state. In Las Vegas and Henderson we did five meetings with about 86 attendees in total. In the Reno/Carson City area, another six meetings with 84 attendees in total. In Elko, Ely, and Winnemucca, we held three meetings with 23 attendees in total. And we did, of course, new hire orientation, this time for the Department of Motor Vehicles in Carson City, with 19 attendees in total.

And what you'll see here is that the attendee count seems a little bit low, lower than what we anticipated, however, we attribute that to a couple of things. One, we're

getting out there more. We're not just doing these rarely or off the cuff. We actually have a planned, in-person communication strategy. So I don't look at a lack of attendance as a bad thing, but more that less people potentially need this information as often as we're providing it.

And secondly, we didn't do a whole lot to the health plan, so there wasn't a whole lot of new updates that needed to be done to it. You guys agreed to stay the course back in November and confirmed that with the rates approval in March.

One of the things that we were very excited to do at the beginning, but I wanted to make sure that I transparently share that publically, is that we wanted to have a website plan and comparison total. We wanted to have something similar or akin to what you see those Affordable Care Act exchanges where you can see one plan versus the other and do a shop and compare and really make the best decision for yourself.

We wanted to launch that during open enrollment. We thought it would be really slick. We thought it would help a lot of folks until we started digging in to it and digging in to the results. And as we started to test this tool, we realized that although it would have been helpful for some participants, it could easily have pushed a

participant or lead them to believe a different and difficult financial situation would have existed had they gone one way or the other.

And it's really tied to the fact that we have multiple vendors that have real time information that today don't all collate in to one comparison tool. So if I want a specialty drug that costs thousands of dollars per month but my comparison tool does an average, I may make a decision thinking I'm going to benefit one way and then get hit with a bill on the other. And so in an effort to ensure that we protected the participant, we decided to cancel this tool. And until at such time that we can create a real time connectivity, we're not going to move forward with it, because it's going to mislead our participants and they, of course, are our highest priority.

As far as finance and budget development update, we really don't have a development update. That's why Tena hasn't told you anything today. We're still developing the budget in accordance with the governor's office on finance guidelines and we're still awaiting additional information as we move forward.

So, in conclusion, we believe or we've successfully navigated through another open enrollment period. We are making strides in on-boarding our new vendor. And we are moving along with developing our budget for the

next biennium. We continue to prioritize and utilize in-person assistance to help our participants. And we remain dedicated, of course, to providing high quality health care at affordable prices. And that is the sum of my report, Mr. Chairman.

CHAIRMAN DROZDOFF: Are there any questions for Damon? Jacque.

MEMBER EWING-TAYLOR: Thank you, Mr. Chairman. Damon, on the plan comparison tool, what are your plans going forward? Are we still working on this?

MR. HAYCOCK: Good question, Madam Chair -- or Vice Chair. Damon Haycock for the record. At this point we put it on the back burner. And the reason we've done that is in order for us to truly give it the attention that it's due, we need to make sure that -- I will use some examples -- Express Scripts can talk to PEBP, can talk to HealthSCOPE, and talk to the HMO plan. And we don't have that connectivity today.

MEMBER EWING-TAYLOR: Yeah, I understand that and I think that's a wise decision. I just want to make sure that you're not dropping it completely because I think it's really an important tool to have.

MR. HAYCOCK: And it is. As we on-board our now vendor, we'll be able to talk more about, and this kind of leads to something that you mentioned at the last meeting,

what's kind of the strategic plan process for the agency and for the board. This is one of those strategic plan outcomes that we can build in to and really partner and coordinate and collaborate with our partners to get this up and running. It is something that we didn't want to shove out the gate early and then it not be accurate.

MEMBER EWING-TAYLOR: I agree completely. Thank you.

CHAIRMAN DROZDOFF: Anything else? Okay. I still don't see them. So can I get a show of hands who is planning to do a brief public comment. One, two. Any down south? What do you think?

MS. RICH: He said he's on his way.

CHAIRMAN DROZDOFF: I guess he can -- Could he do it in public comment, I guess? I don't know.

UNIDENTIFIED AUDIENCE MEMBER: That in itself speaks volumes.

CHAIRMAN DROZDOFF: The irony isn't lost. What Elaine is referring to, of course, is that this is an opportunity for them to talk about their improvement plan.

MS. BOWEN: Could you take public comment out of order and then promise a public comment after his presentation if he gets here?

MEMBER ANDREWS: Mr. Chair, could we take that five-minute break that was requested?

CHAIRMAN DROZDOFF: The public comment is going to be brief. I think they're just going to have to miss.

MR. HAYCOCK: I agree.

CHAIRMAN DROZDOFF: Two public comments. Come on up, ladies, and then we'll be done.

MS. LOCKARD: Thank you, Mr. Chairman. Marlene Lockard with RPEN. My first comment is I was asked to make a comment by someone who had to leave early with respect to the Web M.D. or Doctors on Demand. And she was concerned that while we're informing participants and members she felt that it was very important that we also inform and train physicians because often a participant will call their doctor's office with the flu and they say don't come in here with the flu, go to the emergency. And she thinks that staff and physicians also need to be informed of Doctors on Demand.

CHAIRMAN DROZDOFF: Okay.

MS. LOCKARD: The -- Talking about dead horses, I will then bring up another dead horse that I never finished beating, and that's with respect to Mr. Wells' request that the amount that is subsidized Medicare retirees be factored in to the analysis.

I would also like to request that at the time that this whole Medicare exchange took place I asked on numerous occasions what was the tail being left behind. Because, as you recall, it's still ongoing at the end of the

session, the session bill allocates X-amount for actives, X-amount for retirees to pay. And I think at the time, if memory serves, it was around four hundred and something for a retiree per month. That was never the premium for retirees. So we felt all along during the time when reserves were being allocated it was hard to make those decisions on where the reserves and enhancements should go if we don't -- didn't know how much had been left behind from that wave of the exchange.

So I guess my request here is that can -- it's many rivers under the bridge by now, but can there be some consideration for what I call the tail that was left behind?

And then with respect to Towers Watson, we've read through their strategy plan and we were disappointed that there was not in part of their future plan a plan to have a permanent presence in this state. They offer the ongoing pilot program that's been a pilot. And I think folks agree it's been successful. So we would hope when and if they appear that that can be asked of them if that's in their future planning.

CHAIRMAN DROZDOFF: Well, we'll definitely be inviting them to the next meeting. This will be on record. And sure.

MS. LOCKARD: And thank you, Mr. Chairman. Finally on behalf of RPEN, Dr. Ewing-Taylor, we want to

commend you for the many years of service on this board, all of your hard work and your dedication, and always having the participants at heart and through some very difficult times. And you are very much appreciated and you will be missed.

MEMBER EWING-TAYLOR: Thank you.

CHAIRMAN DROZDOFF: Peggy. It's late.

MS. BOWEN: Yes. And short. My name and words for the record Peggy, P-e-g-g-y, Lear, L-e-a-r, Bowen, B-o-w-e-n. A few things that came up today. The discussion you had about people who are coming back from work after they were off work without pay. Much discussion in the lunch room, the concern is that if they start up on the 14th of the month, they haven't paid the premium from one to 13 of that month, and therefore they would be getting a gift, so to speak.

I would hope and pray that you would reconsider having an option available for them if they want to pay the premium beginning that month of when they were brought back to work or when they went back to work that they'd have the option for paying the premium that would have been due had they been a working person at that time instead of out of work without pay, that sort of thing. At least give them an option so that they have their insurance. That's number one.

Your telemed, I'm concerned that it is only for face time through technology with a doctor with telemed. For

those of us who are not going to get sick between eight to five on a weekday and who are not -- who are not connected that they don't get a bonus for using telemed because that would be a fine for others who don't telephonically or computer wise electronically connected, that it's kept as an equal basis. It's just another option for people to get help with their doctors.

For a lot of people this is the situation. We call the nurse. The nurse says you got to go to urgent care. You go to urgent care and they tell you you have to go to the hospital. And you get to the hospital and the hospital says, we don't have any reason to admit you. There are lots of bills that have been incurred because you followed direction. And I don't want them ever to be deemed as not payable and covered by our insurance because it wasn't determined as being urgent or an emergency by when you finally got to the hospital.

And so we need to word craft and work with that situation so that nobody is penalized for utilizing the options that they have available for them to use and not to assume that everybody is going to get the smart phone and all of that other stuff. Okay. Cancel that one.

And I've heard a lot of things about the reserves being used up. But I remember Ms. Marlene's comment a few meetings ago about, well, what about the new reserves. It's

like the piggy bank is empty but in fact from what I'm hearing that money is being built up in the accounts as we speak. And you're saying no. If that's not the case, then we need to put it by this board on the record what's happening with potential new reserves or any other reserves, not just the old ones.

Then the survey, again, pertaining to the technical part, I would hope that everyone would receive a survey. And I want it in writing, in print, and electronically so that people can do them. But I want -- I would hope and pray -- God, that was rude. I apologize. I would hope and pray that you would consider your survey so valuable that every single person receives it in a capacity that they can fill it out and return it to you and have it set up so that if, oh, if you're on the HMO, answer this part of the survey, and what if you're considering going to the high deductible. Well, what would your answers be over there and vice versa. So that you get a whole picture of a person who has options and that it is in writing and not just electronically done. Do both. Do a blend. Because you truly want your survey back and not necessarily the means by which it was sent.

And I love you all and I hope all is well. And I don't want anybody left behind. Everything is done and thank you for all your hard work.

CHAIRMAN DROZDOFF: Thank you, Peggy.

Jim, I believe you wanted to say something on behalf of yourself and the board.

MEMBER WELLS: Yes, Mr. Chairman. Certainly on behalf of myself.

CHAIRMAN DROZDOFF: And the board I believe.

MEMBER WELLS: So I guess I'm speaking on behalf of the board, but I'm speaking more personally for me. It has been an absolute joy to work with Jacque Ewing-Taylor over the last 13 years I think it's now been, for me it's been 13 because I came after you were already on the board. We don't always agree. But I find her to be always looking out for the best interest of the participants on a whole. And the debates have been great and they will be sorely missed. And your replacement has very big shoes to fill. So thank you so much for all that you've done for me personally and for the State of Nevada.

MEMBER EWING-TAYLOR: Thank you.

CHAIRMAN DROZDOFF: And I'll just echo that on behalf of the board. I would agree.

All right. Well, we will adjourn this meeting. We will definitely invite Towers Watson to our next meeting to talk about their improvement communications.

And to our new board members, Tom, it was a pleasure meeting you. Christine I look forward to meeting

you in person soon. And we'll see each other in a month; right?

MR. HAYCOCK: July 21st.

CHAIRMAN DROZDOFF: July 21. Meeting is adjourned.

(Hearing concluded at 3:32 p.m.)

STATE OF NEVADA)
)ss.
CARSON CITY)

I, CHRISTY Y. JOYCE, Official Court Reporter for the State of Nevada, Public Employees' Benefits Program Board, do hereby certify:

That on Friday, the 17th day of June, 2016, I was present at the Public Employees' Benefits Program offices, Carson City, Nevada, for the purpose of reporting in verbatim stenotype notes the within-entitled public meeting;

That the foregoing transcript, consisting of pages 1 through 201, inclusive, includes a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Reno, Nevada, this 5th day of July, 2016.

_____
CHRISTY Y. JOYCE, CCR
Nevada CCR #625

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