In The Matter Of:

Public Employees Benefits Program Board
Videoconferenced Open Meeting

September 22, 2016

Capitol Reporters
208 N. Curry Street

Carson City, Nevada 89703

Original File 092216.txt

Min-U-Script® with Word Index

PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

TRANSCRIPT OF PROCEEDINGS

VIDEOCONFERENCED OPEN MEETING

THURSDAY, SEPTEMBER 22, 2016

CARSON CITY AND LAS VEGAS, NEVADA

The Board:	PATRICK CATES, Chairman LEAH LAMBORN, Member DON BAILEY, Member CHRISTINE ZACK, Member JAMES WELLS, Member TOM VERDUCCI, Member CHRIS COCHRAN, Member
For the Board:	DENNIS BELCOURT, Deputy Attorney General
For Staff:	DAMON HAYCOCK Executive Officer CELESTENA GLOVER Chief Financial Officer NANCY SPINELLI Public Information Officer KARI PEDROZA Executive Assistant CHRIS DeSOCIO Chief Information Officer
Reported by:	CAPITOL REPORTERS Certified Shorthand Reporters BY: CHRISTY Y. JOYCE Nevada CCR #625 123 West Nye Lane Suite 107 Carson City, Nevada 89706 (775)882-5322

A G E N D A

THURSDAY, SEPTEMBER 22, 2016, 9:00 A.M.

---oOo---

CHAIRMAN CATES: Good morning. I'd like to call to order the meeting of the Public Employees Benefits Program. Can I get a roll call.

MS. PEDROZA: Don Bailey.

MEMBER BAILEY: Here.

MS. PEDROZA: Chris Cochran.

MEMBER COCHRAN: Here.

MS. PEDROZA: Leah Lamborn.

MEMBER LAMBORN: Here.

MS. PEDROZA: Tom Verducci.

MEMBER VERDUCCI: Here.

MS. PEDROZA: Christine Zack.

MEMBER ZACK: Here.

MS. PEDROZA: Jim Wells.

MR. WELLS: Here.

MS. PEDROZA: Patrick Cates.

CHAIRMAN CATES: Here.

MS. PEDROZA: And Members Andrews and Garcia are excused today. And we have a quorum.

CHAIRMAN CATES: Very good. Thank you. Before we get to Agenda Item Number 2, I just want to make a brief comment. This is my first meeting as chairman of the PEBP board. I'm humbled by the governor's appointment as

chairman. It was not expected. I feel a little bit unprepared on being new to this board and new to your issues and new to everyone. And so I ask everybody's patience with me as I get up to speed.

As a matter of order and how we're going to conduct business, one thing that I would like to point out is the three-minute rule on public comment that's in the agenda, I do intend to enforce that. I want to give everybody adequate time to provide their comments. But I also want to be respectful of everyone's time and make sure that we can conduct an efficient meeting. So I just want to give people a heads-up on that. If you have comments that you don't think you can complete in three minutes, I would encourage you to submit those in writing to the board.

And with that, we will move to Item Number 2, public comment. Do we have any public comment here in Carson City? Seeing none, we'll go to Las Vegas. I see somebody coming to the table. Make sure you push the button and identify your name for the record. Thank you.

MR. STEELE: Good morning. My name is David Steele. I'm the executive director of the Nevada Faculty Alliance. We're an organization representing faculty at NSHE institutions. I will be watching closely the discussion of survey results and possible plan changes. Our own internal surveys have revealed widespread faculty discontent with

health benefits. And on this basis we caution against worsening available options and hope that this is not the direction your discussions move you in. Thank you.

CHAIRMAN CATES: Thank you.

Comment in Carson City. Come to the table, please. Push the button and identify your name for the record.

MR. ZEMKE: Hello, distinguished board. My name is Richard Zemke. I'm the regional vice president for AFSCME State Employees Union. I have taken personal time because this is an issue that hits to my heart as an eligibility worker for welfare.

I feel that this material basically is pushing an agenda, basically saying that we need to examine private options for health insurance.

Well, basically, obviously I know eligibility rules and eligibility income in a household of four, Nevada Check-up is $4,000 a year. With this it seems to me this board is pushing families to work to be on the PPO. The PPO does not work for families. Kids get sick. We had a coworker yesterday, she told me about her kid with stomach pains. Her stomach pain that she explained about the child, well, I can't take my child to the doctor, I've already used up my PPO. And I said, why don't you join the HMO, you've got to get an HMO, you've got a child. I can't afford the

HMO.

The crux of my issue here is that issue itself. And the distinguished Damon Haycock spoke to us on Saturday where I was working a second job. I could not respond. I was on the phone via earplugs. My response to him would be -- He said, well, who is going to pay for this. My question to you then as a board then who is going to pay for this. The State of Nevada is going to pay for this and you're going to have to fund Medicaid. So you're going to have to either put the priority in funding Medicaid as more and more state employees become Medicaid-eligible or give us the dignity we deserve with the health plan that works for all of us. Thank you very much.

My name is Richard Zemke, vice president, region one, AFSCME state employees, but I'm also a worker and an employer for six years, totaling three out of the four of those years. Thank you very much.

CHAIRMAN CATES: Thank you for your comments.

Any other comments in the north? In the south? Seeing none, we'll close Agenda Item Number 2 and move to Agenda Item Number 3, consent agenda. So we have 3.1, approval of the minutes. 3.2, Health Claim Auditors quarterly audit of HealthSCOPE benefits. 3.3, Health Claim Auditors internal audit of PEBP's eligibility administration and operational processes. 3.4, receipt of the PEBP chief

financial officer quarterly report. 3.5, receipt of quarterly vendor reports for the period ending June 30. This is a consent agenda. Do any members wish to hear any of these items?

MEMBER COCHRAN: Mr. Chair, this is Chris Cochran for the record. On the matter of the minutes, I wish to abstain from that vote since I wasn't attending -- I wasn't in attendance.

CHAIRMAN CATES: Thank you.

MR. WELLS: Mr. Chairman, for the same reason, I will be abstaining from 3.1.

CHAIRMAN CATES: Thank you.

Any items anyone would like pulled?

Seeing none, I would ask for a motion to approve the consent agenda.

MEMBER VERDUCCI: Mr. Chairman, I'll make a motion to approve the consent agenda.

CHAIRMAN CATES: Okay. Motion by Tom Verducci. Do I have a second?

MEMBER BAILEY: For the record, Don Bailey. I second that motion.

CHAIRMAN CATES: Thank you. Any discussion? Seeing none, I'll call for a vote. All those in favor say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: Any opposed? Ayes have it unanimous.

Moving on to Agenda Item Number 4, discussion of possible PEBP approval of executive officer's recommendation to appoint Nancy Spinelli as PEBP's quality control officer. Damon.

MR. HAYCOCK: Thank you, Mr. Chairman. Damon Haycock for the record. Before I go in to a brief discussion about this recommendation, I just want to verify again that Ms. Spinelli is on the phone and is available to answer questions. Could you please sound off please, Nancy.

MS. SPINELLI: Good morning, Mr. Chair, members of the board, Mr. Haycock, and staff. I am on the line.

MR. HAYCOCK: Thank you very much, Nancy.

I want to just briefly give a background and history and some reasons for why I believe that Nancy Spinelli will be an excellent choice for the board to approve as the appointed quality control officer for PEBP.

Recently, the former quality control officer has retired, as of September 14th. And, as many know, we have not had an in-house quality control officer on site performing those duties for almost a year.

Nancy Spinelli has been with the Public Employees' Benefits Program all the way back since October of 2000. So I think she is our longest-running employee. She

has performed the duties as appeals and complaints coordinator, program officer over member services and eligibility. She has trained our agency representatives. And since 2008 has been our public information officer who has also performed statewide in-person, on-site outreach and education.

She provides updates to our master plan documents over multiple years and last year developed PEBP's robust communication plan.

Since the former quality control officer was not in the office, Nancy has taken over most -- or many of those participant advocacy requirements and has worked diligently with employees, retirees, and their dependants in learning about utilizing their benefits across all plans offered at PEBP.

She will fill the roll of the quality control and participant advocate and is the most knowledgeable person regarding our health plan benefits. I often have to ask her information to verify before I speak in front of public bodies. So that's how knowledgeable and trusted Ms. Spinelli is. She's also very well respected by the Retired Public Employees of Nevada and AFSCME for her years of dedication and is the go-to person by all of our state agencies with PEBP issues.

So I would like to turn this back over to the

board. But it's my honor and pleasure to recommend Ms. Nancy Spinelli to take the position of the quality control officer and I hope you will agree.

CHAIRMAN CATES: Any questions or comments from the members?

MEMBER VERDUCCI: Mr. Chairman, Tom Verducci for the record. I think Nancy has done an excellent job. I've seen her in action since the year 2005. I think she's a very good face of PEBP. And I would encourage the membership of the board to strongly consider her for the position. I think she's very deservant to be promoted in to that position. And I'm very impressed that Damon has identified the talent and he's moving in suggesting that she moves up from within the department. I think it's a very good move.

CHAIRMAN CATES: Thank you.

Mr. Bailey.

MEMBER BAILEY: For the record, Don Bailey. I concur with my colleague. And Nancy has done a very good job for this board and also staff. So I make a motion to approve her appointment.

CHAIRMAN CATES: Thank you.

Do I have a second?

MEMBER VERDUCCI: Tom Verducci for the record. I second the motion.

CHAIRMAN CATES: Thank you. We have a motion and

a second. Any discussion on the motion?

MEMBER COCHRAN: Mr. Chair, I would just like to ask Nancy a question while she's on the phone. What does she see her priorities being as the quality control officer for PEBP? Where do we need the most help?

MS. SPINELLI: Thank you for the question, Dr. Cochran. I think, number one, looking at opportunities for improvement both internally and externally with PEBP and take appropriate action to improve the quality of services. Looking at, number one, internal training for staff to -- so that they are able to provide appropriate answers and understand all of their definitive options and voluntary products so that they can become subject matter experts. And I think that's the number one priority for me is to identify education gaps within the agency and the employees. And then also the consumer advocacy for our participants to timely responses to questions, appeals, complaints, and being able to assist them after that first initial phone call. So those are kind of my priorities. Auditing the records and looking at areas where we can improve our performance internally.

CHAIRMAN CATES: Thank you.

Any other comments on the motion?

MEMBER COCHRAN: Thank you, Nancy.

MS. SPINELLI: You're welcome. You're very welcome.

CHAIRMAN CATES: Seeing no more comments from the members, all those in favor of the motion to accept Damon's recommendation to appoint Nancy Spinelli as PEBP's quality control officer say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: Opposed? Motion carries unanimously.

Okay. Closing Item Number 4. Moving on to Item Number 5, discussion regarding Health Intelligence on Demand data analysis annual report, presented by Aon Hewitt.

MS. BOSLEY: Good morning, Mr. Chair. I'm Kirby Bosley with Aon Hewitt. And I want to introduce you to Dr. Michael Cryer who is making his way to the microphones. He's going to go over our Health Intelligence on Demand analysis. And you will be seeing a lot of numbers. But this is not a financial analysis. This is an analysis of your health plans to understand underlying cost drivers and conditions in the population. That's the purpose of the analysis. Stephanie Messier is sitting also with Aon Hewitt sitting next to Dr. Cryer. She is PEBP's actuary. In case there are financial questions, I asked her to sit up front.

Thank you. I'll turn it over to Dr. Cryer.

MR. CRYER: Good morning. I'm Michael Cryer. I'm the national medical director for Aon Hewitt and I've been given the privilege of looking at your numbers for

several years now. And I'm going to talk to you today about the report coming off of what we call our health information on demand. I think the best place to start is kind of give you some background on what it is and how we use it. It's different from your financial reporting. And it's got a lot of similarities as far as the source of numbers because we use claims data from both, from medical claims and pharmacy claims. We use information, other information when we have it for, like, wellness and that type of stuff, which when we initiated this several years ago we did it for you. But those programs have been sunsetted, so now we're looking primarily at the claims data.

We also look at demographics and we try to cut it so that we look at it in a way so that we can find actionable groups of individuals so we can actually offer you some suggestions about benefit changes and benefit alternatives that might enhance care for certain high risk groups. And so that's kind of what we're going to talk about a little bit as we go through this.

Any questions? Please feel free to stop me anytime and I'll try to give you this information in a way that hopefully you won't have a lot of questions.

The first slide, which is slide two, generally when I start to look at these and analyze your data, I like to see what your demographics are. And the idea is to try

and understand exactly what the population is, how it's changed since the last time we looked at it, and try to see who within that population is driving your cost. We focus primarily on your actives because we can do more with them as far as programs and design for benefits. We do have some retiree data, which is a smaller group of people. And it will -- And we can also run that. But for this report we've focused on the actives.

In your cases what we found was that -- Oh, the other thing is we looked at your total population kind of as a baseline. That's kind of what we look at. And then we also look at the number of people who have been involved, been enrolled in your programs and in coverage for 30 months or longer. And the idea is to understand there's a lot of turnover for people coming in and going out. And if we can look at the core group that is with you for 30 months, that's the ones who we can say, well, basically if we can identify programs that really focus on that group, then we have a better chance of changing the overall health care trend over time. That's kind of the basis for the report.

The one thing that I think we want to point out on this report that's important is that -- And we see this normally because this population ages a year every year. We can't figure out a way to get out of that one. And your prospective risks go up. Prospective risk is basically a

calculation of your claims cost, your pharmacy use and pharmacy cost, and then your age and sex. And that then allows us to develop a risk number for your population. And so that's -- You're having a natural trend up.

But you'll also notice that the spouses, which we see with all clients -- I don't think I have a single client who had reversed this where the spouses tend to be sicker than the employees. And so that's kind of normal. So just so you kind of get a feel for that.

Your average prospective risk for your employees is about 1.4 for the ones who are 30 months, with you for 30 months and longer. That's a little higher than we would normally see. For your overall population is 1.14, which suggests to me that you've got a younger population that is offsetting some of your risk at that level. So any questions on that one?

All right. Let's go to the next page. This slide and the next few slides is to kind of give you a perspective on what the risks are for your independent code costs per member per year basis for these different risk groups.

So looking at your total active population, when we look at this, we're looking up through March of this year, so it's a 12-month rolling report. So it will not necessarily coincide with what you've had from financials for

last year. So just to kind of make sure. We're looking at different sets of numbers but we use a rolling 12 months because that gives us the ability to track the changes in utilization by condition better than if we just looked at snapshots.

And on the actives, the graphs themselves, and they're all going to be consistent, so you'll see, the blue column is basically representing what was allowed, total allowed claims for that group. The red column is the paid claims, so that's how much was basically paid after deductibles and co-insurance. And then the number represents the per member per year paid, converts everything that was paid to a per member per year number. So to kind of give you a feel for that.

And you can kind of see this as you look at your total population for this time period, the average PMPY for your total members was about $2700 per member per year. And for the ones who were with you for 30 months or longer it was about -- it wasn't that much difference, slightly lower. But when you start to break it out and you remove the children from this process, then you can start to see in recognizing that the adults tend to drive most of your chronic disease risk, then you start to see the dollars per member per year go up. And spouses, though they are a much smaller portion in your group of your population, they tend to drive

significant dollar increases. For your -- In your case, they are almost $1500 or somewhere in that range, about a thousand dollars difference. And that's not unusual. I've actually had some clients who run double. So they'll have employees at X and spouses will be at two X. And they have larger populations than you do. So this is actually -- it is just part of what you have to deal with.

And as you look at the conditions and we talk about the conditions, when you set up your programs and you identify the programs you want to implement, you have to think in terms of how do we address that smaller population that's a higher cost while we're managing a larger population who have similar conditions and how do we communicate that to them. Because they require different types of communication and different types of program approach. So that will kind of give you a perspective on what the actives are. Any questions on that?

We did the same thing for your high deductible health plan so we could kind of break it out to kind of see what was there. And, again, you start to see some differentiation in the total cost and in the per member per year cost for this group. And part of the reason is that the individuals in here are a different risk group. We're looking at people with different conditions. But they all are still having significant incidents of chronic disease.

So we're starting to see the dollar amounts be very similar.

Now, you will also notice, and I caught this when I was doing it, that the spousal per member per year is the same as it is for your total claims. And I looked that up and I verified it, and it's just coincidental. I don't know. It's just one of those things that happened. So it's not a typo. It's real.

And so, again, you can start to see here that the differential between the spouses and the employees is significant. And when you start to look at your total population, your total difference between the spouses and employees is $1500 per member per year.

When you go to your 30-month group, the ones that have been with you longer, that differential is a little lower. Again, partially because the employees have gotten older and they generally have a chronic disease themselves. And so their numbers have come up towards the spousal numbers. So that's not unusual to see that.

The other things that I think are important to begin to recognize and notice when you look at this information and the claims information is that I also begin to look at the number of claims that are related to chronic disease. And for this population, about 78 percent of the population of the claims that you pay today are related to some form of chronic disease for this population. And as we

look at the groups you kind of see they vary a little bit. Some have more chronic diseases than others.

The other thing is the number of prescriptions per member per year. There's a general number that we use, anything between eight and ten prescriptions on an average per member per year, and that's across whatever book of business we're looking at, that's normal. If it gets above that, then we know that we're dealing with a population that has a higher use of pharmaceuticals and there's generally chronic in nature. And so that's where we begin to dig down and see what are the things that we can actually begin to affect for that.

For this group, the primary conditions driving their dollars and your claims, they're all related to back pain, back-related surgeries, and that type of stuff, cancer and heart disease, heart attacks. That's what was in the data. Any questions on the CDHP group?

MEMBER COCHRAN: Actually I do have a question on that last comment. Is that -- Is that -- Do those rates coincide with other plans or are there any abnormalities in the use of those -- in the reporting of those for PEBP employees?

MR. CRYER: You actually have some very positive things. And I was going to talk about pharmacy when I get to it, but I'll go ahead and tell you now. When I looked at

your pharmacy, first, people with chronic disease use drugs. It's how we make -- we try to keep them stable or make them better. And so the numbers that I'm seeing here are not huge. The types of conditions I've seen are the same I see with most individuals. Your total pharmacy costs are really quite good. They're actually surprisingly good from during this 24-month period. Because my other clients are looking at 24, 27 percent increases. And yours kind of, you had a little bump but nothing really huge. And it was mainly because you didn't have some of the big drugs that others were hit with. So, again, you've got some real positives here.

So the numbers I'm presenting to you, they're definitely -- you're spending significant amount of dollars for the members. But, overall, things have not been radically different from last year.

MEMBER COCHRAN: Thank you.

MR. CRYER: Yes, sir. When you look at Hometown, again, the graphs are the same. We're still looking at allowed and paid and then the paid per member per year, so you can kind of get a feel for that.

Hometown, the dollars that are being spent for group, this is your highest cost on a per member per year basis. They have some other issues that drive their costs up. They have -- They do have -- They're -- They have 81

percent of their claims are related to chronic disease. And they have 21 prescriptions per member per year. So we're dealing with a population that is a higher risk. And when you look at their risk profile, it is a bit higher.

The programs that are being administered by this group need to be focused on the conditions that we'll talk about a little bit later but that they can do something about. But it's going to have to be related to heart disease, diabetes, and back pain, with some support for cancer. Because those are the big four that drive almost everybody.

There is one other -- In this group there were a large number of people with arthritis. And that was primarily driven by the pharmacy cost related to the adjustable pharmacy drugs. Are there any questions about Hometown?

Health Plan of Nevada, this group --

MEMBER ZACK: Excuse me. Christine Zack for the record. There's a note here about ER visits for this group are also an issue. Do you have data that breaks down the ER visits? Is it because individuals can't get in to see a primary care physician or is it because they're having a heart attack?

MR. CRYER: Oh, great question. The visits here, ER visits, anytime you get over 200 visits per thousand, we

consider that to be higher than normal use. And traditionally in the last four or five years most of our clients have had ER visits -- And I'll show you yours in a minute for the total population -- that are much below 200. So at 220 it suggests all the things may be an issue that you just listed. And it's really something that probably need to be addressed with Hometown to understand are they having access issues after hours. Who's going, when they go. This would normally -- Even at 220 you're getting a lot of use that's what we consider to be avoidable use. The heart attacks, you can't avoid that. That's no problem. The mother with the ear ache, that's really -- we consider that to be not necessarily avoidable in the middle of the night. But there are other issues with people going if they can't get in to see the doctor and they're referred to see the ER more often than not, those are all things that are important.

MEMBER ZACK: Yes, I agree. And I was surprised to see these for the northern population. I would expect to see it in the south where there are access to care issues.

MR. CRYER: Right. But actually it didn't show up there.

MEMBER ZACK: Thank you.

MR. CRYER: Yes, ma'am.

Health Plan of Nevada. This group has, like I said, you've still got the differentials here in your

membership of between the employees and spouses costs. The spouses are just generally sicker for this group. The average age here is about 49. And the percentage of claims that they have for chronic disease are about 77 percent. So their population seems to be a little less of a risk than we're dealing with with the Hometown group. So, I mean, that does help them a lot.

Their cost per member per year is on a member per year basis is significantly lower than the other group comparatively. So some of that is driven by risk. I mean, obviously they've got a healthier population. They're able to manage it in a different way.

This group only has about 18 prescriptions per member per year versus the 21 that we have in the Hometown. So again, all it's telling me is that you've got two different groups managing two different populations. They both are managing cardiovascular disease, heart disease, cancer, diabetes heart disease, and back pain. And so their programs need to be focused on those things that are driving your costs. Any questions about those?

So now we'll kind of break things out a little differently so you can kind of get a feel for the overall locations of where the money is going and how it's being addressed. One of the big questions that I always ask is okay, well, if this is a -- if this is a good year or bad

year, is it because I didn't have a lot of catastrophics or I did have a lot of catastrophics.

And so one of the things that we report on is your high cost claimants, so anything greater than $50,000. So any member who accumulates a claims cost of 50,000 or above, we look at that and we look at the dollars from year to year that way. You'll see it reported a number of ways by different groups. Sometimes they put it at a hundred thousand, sometimes at 75,000. The reason we use 50 is because we've been using it that way for, let's see, how many years? Since I started. So a long time.

And we know that -- And I can tell you -- Comparing you to my other clients, I can tell you exactly where you stand relative to the percentage of total claims. Your totals are in to the 35, the 35 percent range. That's dead even with what I see on an average. Anything that gets above that, it gets the -- I have clients who are in the 40's and 45 percent range. That means that they've had a really bad year. If they hit the 20's, 28 percent range, that's been a really good year. This is about an average year for you with these numbers.

So we can't really say that any changes in your total cost are really driven by catastrophics. They're just driven by your normal population risk groups.

Then we look at your inpatient costs. Inpatient

utilization over the last five years has basically gone down significantly. And partially that is because the hospitals have now geared to go to outpatient because they can bill it differently and because we just found ways to treat people outpatient in a much more efficient way.

But for you, the things we look at is your overall per member per year cost on an average. And it's gone up a little bit, and your total population, but nothing really significant. There's three to five percent increase in overall inpatient costs.

You know, the key things that we look at is how many admits per thousand we have. We use 60 to 70 as kind of the cut-off, and you're running about 33 to 34. It's really low. And so people are not going to the hospital for much. If they go in, it's usually for something fairly significant. And so it seems a bit high for your total population. It's at five and we look at about three and a half to four to be normal. But when I look at your breakouts from your employees and spouses for both groups, those are perfectly reasonable numbers. So based on this data and the data I saw in there, you've had some children go in for long periods of time, probably some neonates that drove up that number, so that helps there.

In the outpatient side this is where we looked at the ER across your total here. So you can see that your ER

use is really, really reasonable. It's all -- It's less than 200 across the board for these groups, these risk groups. And your ER cost is over a thousand dollars a visit for these populations. That to me means that basically the people are going there. They're getting significant amount of services. And that's a lot of dollars for that. If they were overusing it excessively, these populations, then what we would see is that we would see seven to $800 for an ER visit on average. So those are all things that tell me that things are pretty much the way they should be. Any questions?

MEMBER WELLS: This is Jim Wells. The last sentence, the comment, and then suggests that the contracts for hospital services have changed and then if you look at the cost per day on the inpatient we're at 4,060 for a total population, 5,017 for employees and spouses, and 5400 for employees and spouses 30 months or more, with 3800 being good. So is there anything that you saw in there that we can do to work on some of those contracted amounts?

MR. CRYER: Well, since I don't see -- I mean, I see the snapshots, so I don't see the trends over time. But this suggests that from at least from my looking at two periods of time over time -- And thank you for reminding me to do that because I forgot -- is that it suggests that there's been a change in the contracting or the way it's being paid. It could be in-service mix, which I can't really

get down in to that detail with the report I have.

So this just suggests that there has been some change between the two 12-month periods, and as a result, your unit price for those outpatient surgical visits have gone up. And some of my clients that's because the hospitals have bought the delivery sites and raised the rates. And using their -- they have the ability to bill extra things that most free-standing surgery centers don't have. And so those are one of the things that I think you'll have to kind of work with the data group and see with Mary Catherine. And I think she can get you the detail on that. Any other questions? Thank you for bringing that up.

All right. Pharmacy costs. This is really -- I mean, I have to tell you, you've done -- your pharmacy costs between these two periods have been really good. And, again, looking at these high risk populations, I look at your scrips per member, which we kind of laid out before, and your generic utilization. And any -- And generic utilization of the 80 percent is very good. I have clients who now have pushed generic utilization up in to the 86, 87 percent range. They've been very aggressive about it. And there may be some opportunities there for you. If you talk with your pharmacy or PBM, they may be able to help you identify ways to ease that up a little bit and still give members the same value and probably at a lower cost, which would be nice for the

member too.

Your overall drug costs, like I said, you know, it's been a real good 24 months. And I just didn't see the kinds of drugs that I see with my other clients. I didn't see a lot of hepatitis C drugs. And it was just a lot of things that were just -- You've got a healthier -- The population you've got has chronic disease, but they just don't have many of the ones that are high cost here. Any other questions about that group?

MEMBER COCHRAN: I actually do have a question on the pharmacy group because there's a lot of speculation that runs through this of brand pharmacy drugs are so expensive these days and obviously we hear the stories about the, you know, the huge increases in cost of some of the name brand prescriptions. So we've got a high generic drug use population in our state, which I'm sure speaks to the fact that the brand names are so expensive that the patient then opts for the generic drugs considering the out-of-pocket costs that they would be facing if they went with the brand names. Do we know whether or not this is related to a healthier population or that it's that the brand names are out of price for our members?

MR. CRYER: I'm not -- Generic utilization has gone up aggressively because of the conversion from brand to generic. And especially for high volume drugs and for high

volume chronic disease. So things like the hypertensive drugs, the diabetic drugs, those have all kind of converted over in to -- most of them are converted in to generics that have been received quite well. The type of treatment and as far as from a physician's perspective, the results are the same. It's the same drug. It's just packaged differently and sold differently.

So I would suggest that it probably doesn't have any relationship to the, what level of risk within the population you have. I think it's in the drug mix that's come to the market. So that's why your generics are up but your overall costs are relatively down.

I will warn you that coming up it's not going to necessarily be good. Because the new drugs coming out, especially in the next 18 to 24 months, they're based on -- the majority of them are asthma drugs. They are very, very expensive drugs. And asthma is a very prominent condition in Nevada, California, Texas. We all have it because of the environment we're in. And so those are going to be things that may drive your cost up significantly, so just to make you aware of that as they come out.

Additionally, we're seeing drug costs for things that we're used to paying for at a reasonable rate jump significantly. So I think it's good that we're doing good. I hope that it continues, but I'm not optimistic.

MEMBER COCHRAN: Thank you.

MR. CRYER: Yes, sir.

The last slide I have here is basically a summary of the top three conditions that you have. This is just to kind of give you an idea about your risk. I mean, just how many people in this population are driving costs. And it doesn't seem like very many people. This is not a large number of population. But as you begin to look at these things and you kind of look down, I gave you both the 2015 and 2016, so you can kind of see what the average cost is per member. And you can kind of see that for cancer it's going to be quite variable. So in 2016 you had cancer costs on a per member basis that were significantly higher than 2015. This is really not unusual because what will happen with cancer is you'll have a diagnosis of cancer and it will be a first six to eight months they'll be treating it. It will be high dollar cost. And then it usually as it goes to 24 months kind of periods, that cost will then taper off. So wherever you take your snapshot that may be where you see your dollars. But they do tend to run higher than most people. But the good news is it's usually 24 to 36 month window of cost for that group.

But this will kind of give you a summary of what you're looking at as far as your risk. And the other thing that I like to point out when I give you these informations

is the number of people that are having behavioral health issues with this condition because it's fairly high. And I think it's probably underreported because we do screen for it. And most of the programs that are out there screen for it and the docs ask about it. But people go undiagnosed with this. And when you have these conditions, there is always potential for depression and a lot of anxiety related to these conditions. Anyway, it's just so you can kind of get an idea. So your programs need to really keep those in mind.

Diabetics. You have a lot more diabetics than you had with people with cancer, which is normal. And you can kind of see what the average cost of -- This one kind of runs the same. So what I see in the normal population is the average cost for a diabetic is between seven and $8,000 if you look at a general population. Now, the ones who are sick are much higher and they kind of vary. And you're right in that range with this group.

So, again, you've got the part that when I look at this number it's a little lower in percentage of your total population than I would normally expect. I would actually expect you to have a much higher number than this in the nearly 2,000. And the reason is that six to eight percent of the population has diabetes and so this represents a much smaller population than that. So I wonder if there's a group that's not getting their preventive screening

especially in the 40 year old and plus groups. And so they may have diabetes and not even know it or they may have pre-diabetes, which is actually a condition that can be treated with exercise and weight management and can completely avoid diabetes. So those are the things that as I look at these numbers those are the key ones that I think are important for you to know about.

Heart disease, this is generally a very high cost environment, 20 to $30,000 on average for this group. It's not a huge number of people. But this is the end result of your diabetics and the people that are not managing themselves and are not aware of the fact that they have high risk for heart disease. So, again, this kind of gives you a feel for what your populations are.

One of the things that's important to think is when I look at your numbers and I look at all of my clients' numbers, what really impresses me is when I carve out the people with behavioral health issues, so they -- basically what I do is I look at chronic disease and I carve out members who have had one behavioral health visit.

Whenever I find those, their ER visits go out of sight. It's like there's just something going on with these people that's much more than their condition. It has to do with the fact that they're just not stable. So, again, anything we can do to encourage people to seek that because

it's a covered benefit, especially when you have chronic disease, I think is a benefit to you. Any questions? We're almost done, guys.

Oh, I'm sorry, Chris.

MEMBER COCHRAN: I'll let Jim go first.

MEMBER WELLS: Actually I have a couple questions on this slide. First, on the cancer for the medical claims, I'm taking it that's a typo that we didn't go from $1500 to $15,000 in one year in those claims.

MR. CRYER: No, it's not a typo. I checked it. You were, on an average, you were running -- you had a really good year where you were at the tail end of the cancer treatments. So they were monitoring them, but there was no real dollar amount. And so a large number of people. And then the next year you got several that were active, basically diagnosed and active.

MEMBER WELLS: Does that amount to what accounts for flat pharmacy claims for the same population?

MR. CRYER: Yeah. You won't see that in pharmacy. It comes through the oncology, so it comes through your medical claims.

MEMBER WELLS: And then on the diabetics, what do you attribute the large increase in pharmacy but the decrease in medical claims for that population?

MR. CRYER: Yeah, I can tell you that one. It

was cost of insulin and injectables. They tripled them. And that's what I'm afraid is going to happen with asthma and the other things too. As you follow through for the previous year, the jump and the cost for insulin was huge. And it affected about every client I've got. Even -- And there's no generic insulin. So they're paying a lot of money for that. Okay.

MEMBER COCHRAN: Yeah. I did have just overall on the earlier in the presentation you discussed the claims rates being higher in the north than in the south and the speculation that the folks in the south may be healthier, which is something I've never heard of in the south before, so good for us.

MR. CRYER: It's all relative.

MEMBER COCHRAN: Yeah. Is this potentially attributable to -- Is this an age factor or do you know? Do you drill in to this data and look at age groups?

MR. CRYER: The ages are different. The age group was 50 in one and I think it was 47 in the other. So three years makes a big difference. It's a mix. It's who elects the coverage as much as anything. And there are lots of variables. So how many families picked it up. If there are children, bigger children. And I didn't actually look there. It was pretty close. But if there had been more children in one than the other then that would have diluted

out the total cost.

Overall it looks like they both have a lot of chronic disease. 70 plus percent of the claims in the south are chronic disease and 80 percent in the north. That's significant. So I think it's a relative thing and the types of people electing it are driving that cost.

MEMBER COCHRAN: So it would be safe to say that we need to be working on chronic disease prevention within our plan?

MR. CRYER: Optimizing chronic disease management and I think that's the key. Prevention is great and there are some opportunities with diabetes, especially to get early diagnosis and do pre-diabetes, but once you got it you kind of got it. And at that point it's how do we keep people healthy, how do we get them the support they need and how do we deal with the pharmacies they need, and all of that stuff. And that's kind of where my recommendation is coming, I guess.

As you begin to look at your new year and think about your programs, I think it would be good to inventory the programs you got and see how they focus on the key conditions driving your cost. So most programs tend to be very broad, broad-based. And they tend to come out and say, well, I'm going to do disease management but I'm going to attack 15 different diseases. But the reality is they really

need to focus on about three or four for your groups and to make a difference and that would be easier to measure it if you got a benefit from it. So the idea is are your programs really focusing on those conditions and are they delivering the kind of results that you hold. And results can be both participation in the programs but they can also be compliance with drugs. They can be ER use being lower than what you would expect to see in unplanned emergency use and admissions being abated and readmission abatement. So there are a lot of things you can measure that would help you better feel out what you're doing in the programs that are in place.

I believe that it would be really good to kind of reintroduce your -- I mean, you had had a program at one period of time we initially started where you were doing a lot of communications for people about preventive care and preventive screening. I don't necessarily think you -- I think it could be done through the providers. Preventive screenings are paid at a hundred percent, so it's not an out-of-pocket issue. But getting people to be aware of that, go to their physicians and get those studies done, when it's appropriate, because you don't want to screen everybody. But there are appropriate ones to do and it would be good especially to identify pre-diabetes and pre-hypertension. Those are things that we can treat aggressively and avoid additional costs. And you kind of know if I can avoid one

diabetic, I've saved you $8,000 a year. Well, it's about 5,000 because the average cost is about 3,000 for general persons. So that's pretty good. If we can save that, that's good.

Your benefits. Possibly talking to a PPO about increasing generic use if it's possible. I think it's going to be important especially as the new drugs kind of flow in, you've got to look at every way we can to kind of keep the total costs for drugs as low as we can and avoid the spikes that are going to come from the new drugs. They're good drugs. They're not necessarily bad. It's just they're expensive.

And I did put at the bottom that trying to tie people back in with a primary care physician and getting engaged. You've got a really strong -- A couple of groups who are primary-care based, they tend to push people that way. But, again, anything you can do to encourage that alignment with people with chronic disease I think is going to benefit you in the long run for coordination of care and optimize that to care efficient. So there. That wasn't too long. Any questions?

CHAIRMAN CATES: Thank you.

MR. CRYER: Thank you, sir.

CHAIRMAN CATES: Seeing no other comments, we'll close this agenda item and move on to Agenda Item Number 6,

discussion regarding the PEBP participants survey results about plan year 2018 benefits.

MR. HAYCOCK: Thank you, Mr. Chairman. Damon Haycock for the record. I'm not going to go ahead and read all 16 pages of this out loud to everybody because I don't think that's what people really want to hear. But I will try to provide an overview and put in to some key findings and some key results. And then I want to spend a little bit of time talking about some of the concerns that various groups and participants and even some legislators had with with this specific survey type.

Some of the key findings is that we believe there was a high response rate, about 32 percent. We had just under 10,000 people respond to this, which ironically I was told that wasn't a good response rate. Although, if you Google it, I think it is. That's twice as much as any external survey usually gets. So we feel confident that we got significant input on this specific survey.

And that the highest responding demographics you'll see summarized in the bullets on page one that they were state or Nevada System of Higher Education classified employees. They were on the consumer driven health plan. They were between 51 and 65 years old. Their salary range was less than $50,000, which is going to be key later on in this conversation when we talk about the potential

willingness to pay more for health benefits. That most folks responding were on the participant only tier and that, generally speaking, for themselves and their dependants they reported that they were healthy. That the HMO responses were split north and south pretty close to the current split of our overall population.

But two of the key things to consider, not necessarily to just take to the bank and move forward with, but to consider, is that there was folks on the CDHP, they were willing to pay significantly more to keep all of their benefits and on the HMO that they were willing to pay moderately more. And, of course, every one's definition of significant and moderate is different. So we allowed for an entry box, a text box, saying exactly how much they were willing to pay. So we didn't assume that significant to Damon may not be significant to Patrick or vice versa. And those average amounts -- And I'll talk a little bit about them near the end -- are at $41 for the CDHP and $33 for the HMO plans.

The next series of pages discuss what questions were asked. When we initially brought this to the board, there were some requests. I believe it was Dr. Cochran who said can we get more demographics in here. So we were able to put those demographics, tell us about, you know, where you are, where you work, talk to us about your participant

status, your age range, your salary range. And what we were trying to do honestly was to validate the survey responses that it wasn't skewed towards one various group or another. And throughout this entire survey report, you'll see that on average the responses that were received were pretty close to a proportional demographic that we have across our plan today. So we feel that this survey and the results that came from it at least appropriately and accurately represent a sample that is proportional to our current plan participants today.

What you'll see is that some of the total responses have dropped off at certain sections. There was kind of a decision tree, matrix built in to it. If you are on CDHP you went one way. If you were on the HMO you went another. Some folks may have gotten frustrated with it and just stopped altogether. So although we had just under 10,000 responses, you'll see a lot of these totals here for these answers are less. And it's because folks either did not move forward or it didn't apply to them.

Moving forward, I'm going to go through this pretty quickly. If there's questions, of course, I'll answer any specific ones with all of this data here. But let's go right in to the specific rate responses on page ten where we ask, you know, keep the requirement for a flat budget or a potential five percent cut budget and the complete reduction

of excess reserves would you rather. And, again, at the end of this report I'll talk a little bit about how unpopular the would you rather questions really were. But would you rather pay significantly more, moderately more, or no more? And, honestly, the responses surprised me. I did not anticipate that folks would be willing to pay more for losing benefits or to pay a lot more for keeping all of their benefits and what that number would really look like.

But if you look on page ten under question nine, it's 86 percent of the folks on the consumer driven health plan who responded to this were willing to pay more money, period. And only 14 percent were not. Now, that doesn't mean that those 14 percent don't have a voice. It doesn't mean that their input isn't valuable. It doesn't mean we should discard that 14 percent. But it's important to know what the majority would respond with. And then, of course, what was the dollar amounts. And we took an average. We did the mode and we did a standard deviation.

And so just typical statistical reporting we were able to show what that average was. But that average may not provide a clear enough picture and so we broke it down on page 12 and showed basically what were the responses. And we came up with some basic categories. Zero dollars, one to five, six to ten, 11 to 20, 21 to 40, so you can see where the highest grouping of responses came from. And that's,

again, on page 12.

Moving on to page 13, we talked about the specific rate responses to the HMO plan. Here we had a very sizeable amount. 71 percent said they would pay moderately more and another nine percent of those folks said they would pay significantly more.

And what would they be willing to pay? And those folks on page 14 averaged out to be about $33.45. But, again, we broke those down to share with everybody where those specific categories of cost increases lie in those responses from zero dollar to five, six to ten, just like we did on the consumer driven health plan. And you'll see differently than the consumer driven health plan that more folks were on the lesser side if you look at the bar graph. But the average, again, was $33.

What I want to draw everyone's attention to is that last page, page 16, and I want to spend a little bit of time because it's important when we get input from our participants that we get the good and the bad and everything in between. And it was reported to us by multiple participants and advocacy groups from RPEN, AFSCME, and again a few legislators, that the survey looked people in to answering three unfair questions that we were asked to include a none-of-the-above response, a text box for open-ended comments, and an option to ask the legislature for

more money to subsidize the health plans and to continue the health plan benefits as they are today.

So had we included a none-of-the-above option, we believe we would have received a significant response. Who wants to pay more for health care if they're told they don't have to. None of the above we feel isn't quite appropriate because PEBP and the board are going to have to deal with dwindling reserves. We're going to have to deal with budget requirements from the state. And, therefore, none of the above doesn't provide participant input to the board. It doesn't give you all what the people want.

Had we included and asked the legislature for more money, again, we feel this would skew the results. Because, you know, if you have to have your health care costs increase wouldn't you want somebody else to pay for it? You don't want to pay for it. Who does?

And so we felt that we could get an overwhelming response to that as well. But what's really important about this is that we can't control what the legislature is going to provide us. We can recommend it. We can suggest it. We can beg. We can plead. We can coordinate and work with. But at the end of the day, at the end of the next legislative session, we're going to be provided a dollar amount per person and we're going to have to offset the cost of premiums with that. And we don't get to make that decision.

And so asking the legislature we felt that it would be an unfair option and it may get folks' hopes up high, and then if it turns out we didn't get that funding, well, then the board with the staff here at PEBP and our consultants would have to try and gauge in on what exactly people would want if they're faced with some difficult decisions on their health care. And we never asked them. And so we wanted to validate some of the decisions that we hope are considered in this process.

So, again, one of the other concerns, and this is something that it was by the design, that as it grew from initial three questions to over 20 with dynamic questions appearing for certain demographics and not for others, we feared that the survey was already complicated enough without adding a comment section. And trust me, we received comments. We received e-mails. I received phone calls. I got called in to offices and had to explain why we did what we did. So we are very aware that this frustrated a lot of people and they didn't like to hear that they may have to pay more for their current health care or cut their benefits or a combination of both.

Now, one of the flaws of the design also was that it was unable to connect the dollar amounts that respondents entered with each demographic data element. If you've ever designed anything in Survey Monkey, there's a logic that has

to happen where if you answer this question, it takes you to this next question. And if we were to try to tie the dollar amount that people were willing to pay with each and every one of those demographics, you can imagine this decision tree matrix that would come down. It would probably be about 5,000 questions when you use this demographic all the way down to the end and then if you chose this all the way down at the end, and each time you have to repeat the questions in the design. And so it would have been an overwhelming project. And in hindsight if we had the money and time, I would have loved to outsource this to another group so we could have gotten a little bit more tie-in between the dollar amount people are willing to pay and the specific demographics, but we did what we could. So there was no really way to know.

Which, of course, leads to the final, the final decision or the final discussion point about how much people were willing to pay. So I wanted to illustrate in this process that when people say on average they're willing to pay up to $41 more on a consumer driven health plan, for a family that increases that tier by about 18 and a half percent. But for a single participant it doubles. And so I think we need to be very cognizant when we discuss potential rate increases and realize that some folks may have responded thinking that they were willing to pay more on one tier

versus another and that we can't have a one size fits all.

But I want to address some of the public comment about this and it's the same story that I've been giving everybody because it's true. There was no agenda when we sent out this survey. We simply wanted to receive input. If people have to make a decision and the decision is difficult with negative outcomes, we felt it was imperative that those that would be affected by that decision have appropriate and timely input. And although it may not have been the answers that they wanted to see, at least they had an opportunity to choose which difficult scenario that they could respond to. And that way the board and staff and our consultants could analyze and develop solutions to try not to breach some of those types of decisions.

So we are hoping that this will help with the discussion. We're not looking for any action today on this. We're not asking for any motion to approve that we can raise rates. As is standard with PEBP before I got here, and I assume it will happen every year thereafter, that we will talk about potential plan benefit design today and talk about what we want to analyze and in November the board will be provided an opportunity to approve a plan benefit design and then rates won't be approved until next spring. So this discussion here can tee that up but it's not meant to be a finality. And with that I'll take any questions.

MEMBER COCHRAN: Mr. Chair, this is Chris Cochran for the record.

Damon, this is -- I do have some questions regarding the survey. I'm not sure I agree with not including a none of the above or at least a zero amount rather than a none of the above because, you know, we're forcing our members to say, well, I am willing to pay this much more when they may not actually be willing to pay X amount more. So we have to be aware that there is a feeling out there that you want to give them that option to say that. And it's our responsibility as board members in presenting our budgets to be able to communicate that information to the decision makers at the state level.

But I do have a question regarding the age range that was on page four. Do you know whether or not that range is representative of the Nevada employees population in general? Because if you look at the highest response rate group, which is almost half of the survey, are those folks that are between 51 and 65 years of age, which, you know, in referring to the near old population who have a higher tendency to be using, I would assume, our health plan benefits and therefore may have a greater interest in responding to this survey versus the rest of the population. So that can also skew the results that we're getting back from these folks. Because if they're more likely to be using

the benefits, they're more likely to respond to the survey versus younger, healthier members who, you know, we don't pay attention to them until we start using them. So I think we need to take the survey in to account with that particular aspect in mind.

I know when we've done these types of surveys in the past -- And, Jim, you and I worked on one or a couple of them a few years ago. And we also know there is potentially the tendency for only those people -- You know, we don't see surveys, for instance, on are you satisfied with how much you're getting paid. So, you know, one thing that I will say for us is that it does give the state employees as probably one of the only surveys that state employees get that ask them about their, the environment in which they're working. So, you know, you may get more negative respondents to a survey that we're doing because we're the only ones necessarily allowing that. I know that at the university level we typically do a state of the university type survey as well to rate the mood of the employees. But, you know, keeping all of those things in mind, I do think that these types of surveys have to -- that we are going to hear from those people who are more typically affected by, you know -- affected by the outcomes of our surveys.

MR. HAYCOCK: For the record Damon Haycock. Thank you, Dr. Cochran. I'm going to attempt to address I

think there was three things in there. First, a none of the above or a pay no more option was provided in the survey. If you'll look at, let's see, page ten under the CDHP rate options, that table, it says pay no more and lose enhanced benefits from further cuts. Now, again, we added a contingency to it.

MEMBER COCHRAN: That's pay no more and lose benefits is not really a choice. You're biasing the response then. You know, you're saying, well, you're going to lose benefits if you don't pay anymore. And I would rather let us interpret those decisions. So when you put that in there, that's obviously going to bias the response as well.

MR. HAYCOCK: And we did have -- I won't say a significant, but a percentage of folks who did put zero dollars, right. You had on the HMO we had 672 or 20 percent of those folks said they would want to pay no more and on the consumer driven health plan 14 percent. So we did capture some of that, but I recognize the difficult contingency part of that question and where that may lead folks to be a little bit frustrated with it.

As far as age range goes, the highest was between 51 and 65. What's interesting to note is the average participant age on the consumer driven health plan and the HMO is 48.6. So it's close. It's not exactly the specific year but it's within I would feel a ballpark. It's not

grossly different where the average age is 48 but the average response was 25 or the average response was 65. I would think we would definitely say there's some skewed results here. And so that's on the age side of it.

Again, this wasn't meant to be a decision-making tool. It was meant to provide some answers and some input. I recognize from being a participant as well, that I would love to not have to pay anymore for my health care. I just don't know if that's feasible anymore with health care costs increasing across the nation and it's in double digit numbers in certain areas and with the high cost of pharmacy drugs. I did ask the question to AFSCME. And I didn't mean it to be derogatory or inflammatory. It was more of a philosophical question. When health care costs rise, who pays for them? Does the employer -- And on an employer-sponsored health care, does the employer pay for them? Does the participant or employee pay for them or is it cost share between the two? Who is going to pay for those? Because it has to be paid.

Now, we're doing everything we can, and I won't go off on a tangent here, because I don't think that's what you want me to do yet, that we're doing everything that we can to control the cost of claims. And as Dr. Cryer mentioned earlier on the report that there could be some opportunities that we could do even better with some of our disease management. But we'll be looking at all of those

things. But I think it's inevitable that costs are going to go up. And I don't know if it's something that we can get away from, hoping that those costs will be absorbed by somebody other than us.

So with that, I appreciate the comments and hopefully I've given you appropriate responses.

CHAIRMAN CATES: Go ahead, sir.

MEMBER BAILEY: For the record, Don Bailey. I would just like to make a positive comment. I agree, I think 32 percent return is remarkably well for a survey. Because normally they're very poor in responding to your request.

Also, I want to make a comment to the PEBP staff that created this survey at the request of the board who has requested it several times around. And I found it very informative. I don't agree with everything in it. But I understand what the members are saying. And they have been saying this through RPEN and the other organizations. They're willing to pay a little more but they want their benefits really left alone. That is coming to an end probably for all of our memberships. Unfortunately, that's not the case when it comes to the financial differences with drugs and the program itself, the insurance companies, the pharmaceuticals, they're pressuring all the time.

And so I just want to comment on the survey. I felt pretty good about it. I really looked at the numbers.

And we old folks, Doctor, we are a high number of people, we are at risk. And so we take a stand in answered surveys probably better than a 20 year old who works in the state government.

But I just want to comment that I think you've done a good job, PEBP staff, and who ever numbers put this together. We also want to continue to do this every year; is that correct? And give us that information.

The board sits here and tries to make decisions for the members 100 percent in your corner. But it's difficult to do when you don't have the numbers. So this helps. So thank you.

CHAIRMAN CATES: Any other questions or comments? Mr. Wells.

MEMBER WELLS: Thank you, Mr. Chairman. A comment that Dr. Cochran made, made me think of something, and that's that this is one of the few surveys that we do that are given opportunity for state employees to have a voice in what their benefits package is. And we did a survey in May of 2015 that went -- had 8500 responses from state employees on what their priorities were for their benefits package. And pay or cost of living increases was number one and health insurance was number two. And so keep in mind that everything is competing priorities. But keep in mind, this is very important to a vast majority of the population.

CHAIRMAN CATES: Anyone else? Any other comments? Hearing none, I guess we'll close this item.

We're now on to Agenda Item Number 7, discussion regarding the employer-sponsored on-site and near-site health clinics presentation.

MS. BOSLEY: Hello. This is Kirby Bosley again from Aon Hewitt. And now I would like to introduce you to a brand new subject and a new face. This is Tim McDonald. And he is Aon Hewitt's expert on on-site and near-site clinic, so we are really shifting gears here in the discussion.

And we've been asked to present to you a little background on clinics, how they work, what different considerations make sense when thinking about the development of an employer-sponsored health center and pros and cons and kind of an outline of what's entailed in doing something like this.

So I'm just going to turn it over to you, Tim, and maybe you can spend 30 seconds on your background too. It might be helpful to the board.

MR. MCDONALD: Thank you, Kirby. Thank you very much, Kirby. And good morning, board members and PEBP staff members and folks in the audience. As Kirby mentioned, my name is Tim McDonald and I've been with Aon Hewitt for about five years. But by way of background what has led me to the consulting that I do is I have been a physician's assistant

for the beginning of my career, became a hospital administrator. I have my Master's in health service administration. I worked in the manufacturing industry with General Motors for 20 years and I was in charge of a number of programs, including their wellness health promotion program, but also in charge of the operations of all of General Motors' occupational health clinics, which were about 150 around the US.

I worked and then moved over to work in a researching group, which is a data warehouse company, and did studies for employer clients on their wellness programs and on their on-site clinic programs, trying to answer the question about whether or not these things added value.

And then, finally, I was hired by Walgreen's at their corporate headquarters where I was the director of clinical health services. And in the process of that, I was responsible for all employee facing health programs. But primarily I was also asked to oversee the construction of two on-site health centers, one at their large distribution center and the other at their corporate headquarters. And I did provide high quality primary care to the employees and their families.

So it's with that I entered in to working with Aon Hewitt and then five years ago primarily to come in and do wellness consulting. But what we found quickly is that

there's been a rather rapid explosion or interest, a growing interest, among the employer population about getting involved directly with health care and actually in the form of primary care clinics that they sponsor themselves.

So that leads us up to my presentation today. My purpose of this presentation today is really just to educate you about employer-sponsored on-site health centers, make you familiar with what are some of the trends that I see going on around the country, and then talk to you a little bit about what is the process if you -- should PEBP decide to go forward in any kind of an organized fashion. Any questions?

So, typically, I start with a little bit of macro trends. And I don't know how to make it to be the whole slide. Never mind. Okay. So first of all, as I mentioned, this has been growing increasingly over the last several years. And one of the drivers of this was when the Affordable Care Act was coming in to being and the experience that had taken plus up in Massachusetts where it seemed like there was problems accessing primary care providers, a lot of employers decided that they needed to get out in front of that and that stimulated a lot of interest in creating employer-sponsored clinics for primary care.

And so the idea was I didn't want my employees to have to wait, three, six months to get in to see their primary care provider for their annual exam, et cetera.

Instead I'm going to bring it in house and I'm going to do it myself. And so that, I think, was one of the pieces that was driving a lot of it.

The other thing had happened to be in the course of the last few years has been a lot more economies have occurred in terms of how an employer-sponsored health center can be staffed and provided. And so now the threshold or the -- the break-even point has shifted and it's now within the reach of a lot more employers to provide this type of care.

And with that is that second bullet about what we used to call the perfect company to have this has changed. And it used to be that you would have to have at least 2,000 employees. Now we're seeing companies with 750 employees being able to have a positive business case.

The other things that are driving this is that companies along the way now probably for at least the last ten years have been making major investments in their health management programs. I think the message has been communicated and received by employers that we have to pay attention to our work force and do whatever we can to make them healthy. And so they've made a lot of investments in to well-being programs. And then I think the same thing that has come back to them is, okay, I'm doing this great job and these annual events and I do screenings and identify people

with high blood pressure and high cholesterol and I say now you need to go out in to the community and see your doctor. And what happens, unfortunately, is that people don't follow up and there's this big gap there. And a year later another screening is done. The same person comes through. The same risk factors are identified and nothing really has taken place. So I think a lot of employers are saying, look, we need to complete an end-to-end solution here if we're going to go down the road of doing health management programs or screenings, we also need to be able to make sure that people have convenient, easy access, affordable access to high quality primary care.

And so I think employers have also said that I've already made this big investment in my health management programs because I care about my population's health, but I've got this problem here with about 30 to 40 percent of my employees that don't have primary care providers, what about them. And so this is maybe one of those solutions that can fill that gap.

Now, just to further expand on this idea of who are good candidates for this. And I think -- I want to make sure that I'll try to keep in mind some of the comments that we just heard from Dr. Cryer and weave them in to this slide here. But if you're seeing high emergency room utilization, which we just heard from Dr. Cryer, is one of the issues that

PEBP faces, that would be something to be looking at. And if you see also high urgent care utilization, which you have, what that tells me in a lot of ways, because we know that nationally about 30 percent, maybe 40 percent of ER utilization is avoidable or is not urgent and could be taken care of in another setting.

So when you see a lot of that high utilization, you have to wonder is it because people didn't, like your question earlier, is it a problem with access to primary care, is it a lack of convenience, is it poor management of the condition and that people now see the ER as really their clinic? Similar now seeing a big increase into utilization of urgent care centers. There's nothing wrong with that. They probably provide very high quality care. But with both solutions, ER and urgent care, what they don't have is not this idea of continuous -- continuum of care and be able to stay to take care of the patient on an ongoing basis.

You have good utilization of your preventive care services, but some companies don't. High absence or lost time for unscheduled medical-related issues. And low generic substitution rate. You have a nice generic substitution rate. It's about 84 percent.

Community care. High cost in the community would be a driver for some companies. Yours seems to be about average. Workers spending time traveling to and from

community care providers. That's something we'll have to talk about.

And then timely access to primary care. As I mentioned, this is probably the single biggest driver of why employers are trying to get in to the primary care business and providing it on-site or near-site.

Lastly, and I think these are probably the issues that mostly resonate with this board from what I've been able to hear today, is that there's long-term care about the population's health. What should be our -- If we're going to make an investment, what should that be because we care about the population.

They're committed to member health improvement and not -- and savings is not necessarily the big driver. But there is this awareness that, well, we have a lot of people with chronic care, chronic conditions. What is the best way, the best way, if we're going to offer some help to those employees or those workers or their families to manage those chronic conditions.

And, lastly, is that there's a lack of -- of not being bound by, if you will, a single paradigm of how health care has to be delivered but to be open to innovations. And I say this because what I've been seeing on a nationwide scale, as my consulting practice is coast to coast, is that employers when they get in to the employer-sponsored health

centers don't have to provide, if you will, a clone doctor's office in the community. It can be much more than that. And depending on what the company or the employer or the work force is really calling for and they can build those or bake those services in to the product.

I show this slide here primarily just to kind of acquaint you to the continuum of when somebody talks about a clinic, an employer-sponsored clinic, it's kind of important to ask the next question, well, what do you mean and what kind of clinic. Because, as I said when I was at General Motors, we had occupational health clinics. And so very different. There's a lot of reasons why you have health clinics. People get hurt on the job, sick on the job, or you're doing a lot of OSHA-related exams and it just makes sense to be doing it yourself instead of sending people in to the community for hearing tests or respirator fits or whatever the particular OSHA exam that's required or surveillance exam that's required. So we see occupational health as being a big driver in the past.

But now as work places have gotten more safe, the surveillance exams now have become so scrutinized and they can be handled so easily, companies have said, wait a minute, what I really need is somebody to take care of my people when they have a headache or a sore throat. And that gets us in to this next bucket of acute episodic care. Think of that as

being what you see when you go to a convenience care clinic like a Minute Clinic or Walgreen's has clinics on site in their stores. That's what acute episodic care is. It's kind of a menu-driven type of care.

But in my experience with working with occupational health clinics, almost 60 percent of the time a person comes in to the occupational health clinic for something that would fall in to the bucket of acute episodic care. They just don't feel good that day and they want to take something or get some help with it.

What has emerged in the last five years though has been this idea of providing primary care. And it goes back to those reasons I was naming that people, you know, we have -- I don't know what the percentage is in your population, but you have a significant number of people who don't have any claims in the health care system. None. No claims. So does that mean that they don't have a doctor or does that mean that they're very healthy? I don't know.

But I can tell you that nationally about over 30 percent of most work forces do not have a primary care provider. And I think for a lot of employers that's not good enough. We're providing these benefits. We have these well-being programs, health management programs. We really want you to take care of yourself, so they've now made it as part of the scope of services of the clinics they offer. So

primary care has emerged now as being probably the single most common thing that is vacant to an employer-sponsored clinic.

I show the patient centered medical home as being the aspiration of where a lot of employers are trying to get to. Obviously if it's employees only then the idea of a medical home doesn't make a lot of sense. But if it's an employer-sponsored health center that's going to be open to employees, spouses, and dependants, all of a sudden then that becomes a possibility. And because of the fact that the employer and the constituents have so much say on what that scope of services is going to be and what it looks like, it's a very attractive option. And so people can go there and take a whole family. And there is this team-based, physician-lead, team-based approach to the ongoing care of that individual and their family.

So what are the success factors? So, as I say, this is what I do for a living is I do consulting for our employer clients who are considering on-site health centers or near-site health center or even shared health centers.

What are the key success factors? Well, one is to have a very strong leadership support, and that means you. And that if this is the -- if the board ever decides that this is something that they would like to pilot or try to go down the road on, it's going to be important that everyone is

on board with that idea and that we are able to stand tall and be able to answer the questions that come up.

Member communication. Once a health center has been -- If it's -- First of all, if it turns out to be feasible and then the -- who the partner is going to be to actually staff and operate the health center, then it comes time to be communicating it. And so that communication has to be important. And it can't be just simply announcing the grand opening. It's got to be something done on a regular basis because there has to be this communication about this actually adds value and it is something that is going to be uniquely different than what you might receive in the community.

It's got to be part of a strategic plan. I've heard a lot of things talked about -- You folks are very forward-facing and looking ahead and the strategy is very important. And so if this were to be adopted or approved to go forward in any way, how does this fit inside of the big multi-year plan that the PEBP is considering?

The next one is data-driven. And I'm very pleased that you all have a very vested interest and make a lot of investments in to data at this point. We just heard Dr. Cryer talk about your health information on demand, Health Intelligence on Demand report, and it just, you know, it reinforces the idea that there's things that are being

called for or being asked for in the data. And with this type of solution that I'm talking about, an on-site health center or a near-site health center that's employer-sponsored can be flexible enough and agile enough to really go after and address those particular issues.

For example, Dr. Cryer talked a little bit about some of the chronic conditions that are driving a lot of the costs. And there is an assumption that people with those chronic conditions are getting all the care that they need and they're getting the right care. And there's, you know, I heard mention of disease management, that that's something to be looked at.

But what we do know about people and their behavior is that if there's a trusted clinician and the opportunity to have face-to-face counseling or face-to-face interchange is available, that is a much more favorable solution than a telephonic or a web-based product.

So this on-site health center or near-site health center offers that opportunity to work with a coach for those people with chronic conditions. And, in my opinion, when you do a feasibility study and you look at the various costs associated with, that's where the savings are, that's where the money. The fact that 70 percent of the folks in the northern half of the state and 80 percent was what I heard earlier have a chronic condition, this could be a very

interesting and a very smart innovation that you would apply. Again, it's data-driven.

The staff of the clinic is very important. And so once a decision has been made based on, let's say, the data that the feasibility says this is a good product, a good opportunity, then who is actually hired to staff that health center becomes very important.

Once that staff gets in place and everything, making, you know, reducing staff turnover, making sure that they are on board and they are engaged with the services is very important because they become very trusted. People start to rely on them, as you would expect.

And then, finally, it's just asking about the keys to success of how does this integrate with all of the other strategic elements that are in the bigger plan.

I know I'm taking probably more time than I should. Am I doing okay? I'm a talker. I'm sorry about that.

The potential value to the employers, I mentioned, is one and it's this medical plan savings. It's not to say that there's anybody is going to get care denied. It's just the idea that the care that you receive on an employer-sponsored health center if the priority is to make it very personal, to make it not rushed, to make it so that you feel welcome in there and that you have this opportunity

to sit face to face with a trusted clinician.

Good things can happen. For instance, if you are a person with chronic conditions, let's say asthma, and it's not being well-managed, the idea of getting that managed will have an impact on emergency room utilization especially among children.

If a person has enough time -- And let me just give you a statistic that if I were to go out for bid right now for any on-site health center, let's say, anywhere in Nevada or anywhere in the country and I asked the leading vendors in the country how many people do you schedule per hour, they would tell you it's about two to two and a half people per hour per provider. Think about that compared to what you're accustomed to in the community where there is, you know, it's more like at least six, probably ten people per hour. And that's just because of the demands.

So when you're an employer-sponsored health center, you have the opportunity to sort of settle it down a little bit, so now that a person could come in. So things like specialist visits, you know, if a person comes in with a rash, there's enough time for you to look at the rash, spend a little time with the person, try something, whatever. Instead of automatically referring that person out to a specialist. There's still going to be specialist referrals, but it just maybe not be needed if the provider had enough

time to spend with the person and they're not perhaps being rushed. It's nothing against the way care is provided in the community other than that there is sometimes so much demand that the person doesn't have all of the time they wish they had to spend with that patient.

The other thing would be about productivity. And if we were to talk about a near-site clinic, the idea of saving time becomes a little less compelling. When it's on-site, there's a little bit more compelling evidence to say that by walking down the hall instead of getting in to your car and driving, there is a lot of time saved. However, if it's some place that's convenient and is accessible from a number of different locations so that the drive time is very short, there will be a productivity boost.

But the big thing is that an employer-sponsored on-site health center or near-site health center has the ability to schedule the way you want it to be. So if you want there to be walk-in access, they can make sure that they save a certain number of slots. If you want there to be next-day scheduling, you can arrange for that. The idea is that where the productivity savings comes in is less time in the waiting room.

So I do this quite a bit and so with writing up contracts and writing up performance guarantees often the employer says, look, we don't want anybody in the waiting

room for more than five minutes. Just think about that. That's mind-blowing. That kind difference in the care the way it's being delivered really speaks loudly to the fact that an efficiently run health center with the proper scheduling can really accommodate people who are busy who may even have to be a walk-in that they don't spend a lot of time in the waiting room. So it's an interesting concept because you're always juggling between excess capacity of staffing with people in the waiting room. That's the balance that any clinician or any clinic has to work with.

The big thing with the health status improvement is another big employer. We talked a little bit about some of the chronic conditions that the PEBP is dealing with. How can those kind of concerns be brought in to the health center and made a priority and a focus for what we're going to try to do.

I bring up quality of care here because I think it's very important. As you know, more and more clinicians in the community now have electronic medical records and behind those frequently are algorithms that help with the primary care providers to practice evidence-based guidelines.

It is a -- You cannot be in the employer-sponsored health center business unless you have those pieces in place, I am happy to say. So any company that you would ever entertain would already have electronic

medical records. They would also have a practice management system that also has a patient portal. But behind it are the evidence-based guidelines that drive quality of care.

Also built in to the process with an employer-sponsored clinic -- And, again, I say this because we put these things in to our contracts, is that for every month at least ten records are being reviewed by the next highest person in the organization. So if it's a physician, the medical director from that company reviews ten records of that physician per month. Various things like that. And they're reviewed against evidence-based guidelines. So there's this very important idea that they can say that they're providing quality of care and in fact it's being backed up.

The other thing I will just mention about quality of care is that, you know, we talk about policies and procedures. And you have policies and procedures probably for every job category within the State of Nevada. Similarly, if you're going to have an on-site health center or near-site health center, they ought to be guided by a policy procedure manual and then they should be audited to see if, in fact, they are practicing according to those policies and procedures. And that also is imbedded in to the selection of who ever you end up with as the provider. So I just say quality of care becomes a very important thing.

The value to the members and then I'll stop for questions. The value to the members is it's convenient and it's accessible. And I talked about a few things like less time in the waiting room, same day scheduling, next day scheduling.

The other thing is optional use of technology, what has become, again, a norm in the clinic spaces is to be able to have a smart phone application that you can do on line scheduling, you can get reminders about your appointments coming up. There can be secured e-mails, et cetera. But the big thing that I've mentioned about the evidence-based guidelines but I've also mentioned the fact that within the electronic medical record there is also the practice management system. And why does that matter? Well, that's where the scheduling is, but that's also where the reporting is. So any investment that an employer is making in to a clinic, they have an opportunity to look at the reports. Am I other getting what I pay for? So often it's hit or miss on the data that comes back. What we want to know is is it doing what we originally intended. Are we seeing people with chronic conditions or not. You don't want to get in to any personal individualized data. I'm not talking about that. I'm talking about at the aggregate level. These are the goals. This is why we did it. I want reports to tell me if we're hitting the target. And that's

one of the things that's available.

And, finally, is this a patient centric staff? Again, what we strive for is a physician-lead team of providers so that when a person comes in, it's team-based care. I don't always have to see the physician or the nurse practitioner. I'm really here today to talk to the nurse about my -- I have some questions or I just need to get my blood pressure rechecked. But I feel comfortable going there. I feel like it's a place that they know me, they know my condition, and I can do this.

A lot of these things I'm talking about happen on a regular basis in community-based providers. But community-based providers don't get reimbursed for these things. So they're doing it, but they don't get reimbursed. Whereas we can build it and bake it in to the actual scope of services. There won't be any reimbursement. There's no charge for these kinds of services. A person can come in, get their blood pressure checked and get their blood glucose measured, and they can get their hemoglobin A1C, whatever is needed for them on a very convenient, easy, accessible way. Maybe then they say, okay, you know, your records said it's time for you to see the provider. Let's make an appointment and have you go in and see the nurse practitioner or the physician.

I know I said a lot and I apologize because I

talk kind of fast. But do you have any questions about this or is this making any sense?

CHAIRMAN CATES: Questions from the members?

MEMBER ZACK: Hi. For the record Christine Zack. I actually have personal experience with a clinic model and I'm a huge proponent of it. I think it's the next best thing to concierge medicine, which, of course, is far more costly. I think that lack of immediate access to primary care increases costs because it increases ER visits. It increases the severity of an illness once you are seen. It increases the number of missed opportunities to diagnose a disease early on or to treat something like pre-diabetes before it becomes diabetes. So all of those things I'm sold on.

The one question I have is were you intending to find local market partners? Because I work for a company that's involved with health care operations. No clinics, hospitals, skilled nursing facilities for the most part. And the regulatory issues, the HR of managing the staff, the liability claims, you know, there's entire teams devoted to defending medical malpractice cases. It seems to me that we would be best served looking for partners in each local market community to run these clinics. Have you given any thought to that?

MR. MCDONALD: Yes. Thank you very much for the question. It's a great question. And I don't want to get

the cart ahead of the horse. But when the time came for if the board decided that they wanted to go out and do solicitation for clinic operators, we typically include in that RFP, if you will, the request for proposal, a lot of the questions which are named here that you've identified relative to the state rules and regulations -- For example, what comes up often times is with, let's say an employer wants to have an on-site health center and they want to have pre-packaged prescription drugs, which is a very cheap way of providing -- like it's nine dollars for an Amoxicillin prescription and they can just write your name on it and give it to you and get you started. You don't have to stop on the way home, okay.

Well, almost state by state there are different laws relative to whether or not a nurse practitioner can prescribe. A lot of times they can prescribe but they're not allowed to dispense. So you have to make sure that there's a physician in the process.

So what I'm pointing out is there are variations from state to state. And so what we bake in to our request for proposal would be making sure that who ever the respondents are that they have taken in to consideration Nevada's unique laws relative to what a provider can do and who can prescribe, who can dispense, all of those kinds of questions.

The other piece that you mentioned though has to do with local providers, local providers. And it's very, very important that there be a tremendous amount of sensitivity to that. Because my experience has been working particularly with municipalities that this conversation -- And, again, this is just an educational conversation. But that, you know, some folks might take this as we're trying to take business from the local providers and then there would be a lot of resistance. So it's very important at some point down the road if it's decided that this is something that the board wants to pursue that conversations begin with the local medical society, especially among primary care providers to see, you know, are they interested, are any of them organized enough that they could actually be the kind of supplier that you're looking for eventually. Not all of them are. Some of them are not very well organized and they would not be a suitable candidate to provide that. But that's something that's very important, that mindfulness about the relationship with the community-based providers. A lot of times community-based providers are stretched beyond their limits and something like this is not going to affect them very much, especially when you think about we got 30 percent of our people who don't see a doctor at all, you're not involved in the delivery system at all except to use the ER. This is something they're not even on the local community

provider's radar. And so the conversations need to take place. It's a very sensitive issue. But I've had those conversations and usually we're able to find that place.

MEMBER ZACK: I can't speak for northern Nevada, but in southern Nevada there are all sorts of variations of clinics that already exist and that's what I was thinking. Why reinvent the wheel? Why not partner with someone who already runs one?

MR. MCDONALD: Again, there's a lot of definitions, whether it's a convenient care client, urgent care client, and then you have your doctors' offices. So there's lots of different flavors.

The thing that you want to make sure is that when one of your members are going out for care that they're involved with somebody that is going to handle their care over a period of time, that if a condition is discovered that there's somebody who is going to take it to the next step and help do the work-up and do the follow-up.

I think the shortcomings with urgent care centers and with convenient care centers, they're really focused on that day's event. They're not really focused on the long term care. So I agree with you that there are a lot of flavors.

And what I see in Texas, for example, Dr. Cryer's home state, is that we had -- yesterday there was an urgent

care center on every street corner. Today they are called urgency -- they're morphing in to emergency rooms. And so what we used to think of as urgent care is now morphing in to an emergency room. And so what happens is that it goes from in your case a little under a hundred dollars a visit to $1600 a visit. So we have to -- Clinics are clinics, but there's also some business-finagling going on that we have to be mindful of.

MEMBER ZACK: And just so you know, to my recollection, under the NRS, clinic is not defined in Nevada. Rural clinic is. But not clinic. So there are a lot of variations here.

MR. MCDONALD: So just to kind of move along and wrap up. To say that this conversation that we're having right now would be the start of a strategy session to sort of get you to think about how this may fit with your overall plan going forward. And then we try to, if you wanted to, we could have a working meeting. And this is what I've done with some municipalities that come in and do a workshop for half a day, where we start to talk about, okay, not saying we're going to do it or not, but if we were going to do it, what would be the parameters, what would we look at? So we look at things like where is the best location? Who is eligible? Should it be just actives? Should it be pre-Medicare retirees? Should it be spouses and dependants?

What should be the scope of services? I mean, how big is it going to be? Should we be thinking about dental and vision and some of those other services? What should be the staffing? Because we can only have doctors or are you amenable to have a doctor-lead group with nurse practitioners and physician assistants? What are the best hours of operation? How can this work with incentives that you may already have imbedded in to your health plan? Or should there be additional incentives to help people drive more volume in to the employer-sponsored health center?

And who are the existing vendors and what ways can those things be integrated? And then we would -- That would be sort of what would come out of that strategy session. And, again, this page, and hopefully it's in your hand-out material, would be what the agenda of that strategy meeting would be. Every one of these bullets has to be sort of acknowledged and addressed to say, like, okay, so when we say this is a clinic in northern Nevada for PEBP members, this is what we mean. And so the answer to that question is somewhere imbedded in the bullets that you end up choosing or the ones that you throw out. So that's how a strategy meeting works.

Once we have that completed, then the question is is it feasible, does it make sense for us to do it? It's going to cost a lot of money. Am I really going to get any

savings?

So typically what I do is I lead a team and we do a feasibility study for our client companies who are interested. This is usually the first step and that's a first step that I recommend that people do. Because it's an unbiased approach to try to say, here, this is the truth here, this is the unvarnished truth. This is how much it's going to cost you based upon benchmark data or from many, many RFP's and getting the responses back, I can tell you pretty much to the dollar what a health center with three providers and three nursing staff is going to cost you on the course of a year, how many supplies you're going to use, what the management fees are.

So we can start to do data. We can take your data from the health -- HSB and put in that information, look at where people live because we also know that if you drop a pin in a certain area and say we're going put the clinic there, within five miles, those family members are likely to use it. Within ten miles they're still likely to use it. But when you start getting out past 20 miles, it starts to get on the bubble. So when we look at the spouses we say anybody who is 15 miles or out we're not going to count them. We're only going to count the 15 miles and in as being potentially users of the health center. Because otherwise they probably already have relationships with providers out

there in the community.

And then we have to use a lot of assumptions. If you were going to, for example, build a health center or renovate let's say a shopping center or a shopping building that may be vacant and renovate that or take a vacant PEBP facility or room that's out there, how much space is it. And then that is a very big contributor to the feasibility study.

And then we make other assumptions. We assume that on a worst case scenario only 20 percent of the population is going to use it. Likely it's going to be more like 30 percent of the people are going to use it. Great would be we're going to have 40 percent of the people to use it.

So based on those three scenarios do I break even, does it now become feasible, is there now a positive return on this investment or not? And so we look at that.

And then let's just say, for example, in the best case scenario we don't quite break even, however, if we were to reduce our hours of operation instead of five days a week to four days a week, does it now become feasible? So we can tweak the model according to different designs, again, based upon the feedback. It's an iterative process.

So then we provide an analysis of it showing what the direct savings and indirect savings are, what we think the staffing requirements should be, what the implementation

and the cost of the ongoing operating costs are going to be. And then based on that, as I say, determine if there's a net present value.

If the board sees fit to want to go any further, we would do that strategy meeting and then we would do a feasibility study and this is to show you what that feasibility study would cost. And let's just say we did it here in the north, that would be the first line. But then based upon our findings and what we see, to do the second one would be a lot easier just because we now have built a highway, if you will, in to the HSB data. We have a good system of using your eligibility data to do the geo-access type of information. So we would be able to do it for less money.

And then, finally, if there are some rural areas, let's say not Las Vegas and not Reno or Carson City but some other areas within Nevada that you would like to look at, those would be, again, lesser cost.

And I would be the person that would be in charge of it. I have a team of people I have chosen for this process if I were to go forward with an analyst by the name of Sarah Chen. And then I would work hand in glove with Kirby as your account executive to make sure that we take in to consideration all of the cumulative knowledge and history we have with PEBP.

And I'll stop there. Did I hit all the questions or did I hit everything that I was supposed to cover? Do you have any questions?

CHAIRMAN CATES: Questions or comments from the members?

MEMBER COCHRAN: Mr. Chair, this is Chris Cochran. I had an opportunity last year to tour a facility in southern Nevada that did this very service. They were brought in by a large, well-known employer in southern Nevada trying to remodel downtown. And then they ended up taking on I think Nevada Co-op members to be included in that. Of course, we know what's happened with Nevada Co-op. But I think it's a great -- it's a terrific idea. They did have the drop-in type visits available for the employees. And I do think that if we ever really wanted to do any kind of strategy or implementation on a trial basis, there are other options besides this one particular clinic, and potentially also asking our contractors out there who provide our member services whether or not they would be interested in starting up any of these types of clinics for PEBP members.

But, you know, at the university levels and college levels, they typically have health and wellness clinics -- I know we do at UNLV. I know they do at UNR -- that may provide an opportunity for doing some pilot study of a project like this. I know UNLV offers the opportunity for

employees to use their clinic, but it doesn't go on -- PEBP doesn't pay for it. So it's an office visit that the employee pays out of pocket. So what they're really doing is they're paying for the convenience of being able to use the clinic.

But these types of things where you don't have to worry about finding a -- you could drop in. And, for instance, the one that I was talking about that I toured last year, they had people who would just drop in. And they offered the wellness services in that program, they had meditation services, dealing with people who may be going through some behavioral health issues, those types of services were available for them as well. It was a wonderful clinic. And I can't tell you right now whether or not it's still in operation because they did lose some of their big employers.

But I do think that the opportunities are out there even to do these on a trial basis if we wanted to scale it in, you know, and see how well it might work. It would require some PEBP changes and policies in order to do that. That's my comment. I do think these are really good opportunities for the future.

CHAIRMAN CATES: Mr. Wells.

MEMBER WELLS: Thank you, Mr. Chairman. Do you see the employers who are opening these clinics continuing to

provide or also providing the occupational health services or do you see these being kept pretty separated?

MR. MCDONALD: That's a great question. Because I recommend that no matter what that there are two record-keeping systems no matter what as a minimum. I prefer that they be kept separate. I prefer that there be either two separate locations or when you walk in the same door you go in two different directions, if it's an occ health visit or a personal care visit. And my reason for saying that is that the records associated with occupational health are held -- it's not that they're public, but they are -- the expectation of privacy is a little bit lower compared to personal care records where there's much higher standards and much more tougher regulations.

But in my reason for mentioning that is let's say somebody has injured themselves at work and they come in with a laceration from a lawn mower or whatever, that's going to require a safety investigation. There's going to be workers comp issues that come up. So there will be people needing access to that medical record for that occupational injury. That is not the case over here on the personal side.

So mainly from the standpoint of making sure that the records are secure is my number one priority. Beyond that, the staffing, I mean, to have really high quality occupational health you would hire different type of staff.

For example, you would hire certified occupational health nurse. You would probably hire -- have access to a board certified physician from the American College of Occupational and Environmental Medicine. On this side you would want to have more of a family practice nurse practitioner, family practice physician on this side.

So my answer is to keep it simple. And I know I'm giving a long answer. It's a very good question. It's something that has to be thought of in advance whether it's going to be in the scope of services or not. But my advice is that whatever we do in that regard, we do it with a lot of thought about the records. Because what will kill an employer-sponsored clinic is any breach of security. People have to know that their information is secure. That as the employer, the employer cannot see those records. And so there's a lot of layers that have to be built in to make sure that those things are safe.

CHAIRMAN CATES: Tom.

MEMBER VERDUCCI: Tom Verducci for the record. Tim, if you could just speak for a moment in terms of start-up costs and how long, you know, would it take before it actually results in a cost savings to the participant.

MR. MCDONALD: Okay. That's a very good question and probably the answer to that question rests primarily with the employer. The facility has the longest timeline in terms

of -- So let's just say hypothetically that we said let's go today. It's probably to get a facility up and running, depending on if you already had an existing space and were just transitioning the provider, you could do that in 90 days, 120 days. But if you have to renovate a facility or construct a facility, that's going to be more time. So that would be the biggest variable.

And then the next big variable is in terms how long it takes to get things going is hiring the staff. And so if we needed to get occ health people and primary care people, it would be a heavy work load on getting those people. They have to notify their practices that they're leaving. There are certain requirements that they have to follow, et cetera. So they would have to be built in. So that's the second longest thing.

And then the third longest thing really is in terms of getting everything ready is basically once you've got the -- you're doing the recruiting and you're doing that is then the training and actually installing the information technology and then getting fit and finish and all the furniture. So those would be the three big line items that have to go in to the answer to your question.

Once the clinic goes live -- And so let's just say we have a facility and we can get it renovated in six months and it's feasible based upon the feasibility study,

so, again, this is a good idea, let's do it. Then we go out for bid and go out and try to find a vendor, using local vendors as well as national vendors, to get a good comparison and a good idea of what's out there. That takes about three months from start to finish where to the point you would have a recommendation and say this is what it's going to cost.

And then you would have your -- And then you have another 90 days to 120 days for implementation.

The answer to your question what you can expect. So this is a great question that comes up all the time. I've done a lot of studies about trying to figure out what is the return on the investment. And essentially it's about well managed because there are some clinic providers that I would not recommend that don't know what they're doing. So I would say the ones that we would recommend or the ones that meet our criteria, within three years you would have a 1.6 to one return on investment is what I see when it's a personal care primary care clinic. I'm not talking about occ health. Occ health you would never do for a return on investment. Occ health you're doing for completely different reasons that have to do with safety and have to do with compliance with OSHA and compliance with surveillance exams and convenience and other things like that.

But looking at a primary care clinic, you would look at about 1.6 to one return on investment. And some will

say within one year. I would say within two years. But certainly by the third year you're well inside of that.

But it has to do with the fact that there's a commitment on the fact of communications, that there's a serious concern -- serious discussion has taken place that how does this integrate with the benefit plan, making sure it's recognized by the carriers, et cetera, those kinds of things.

MEMBER VERDUCCI: Thank you for the detailed answer.

MR. MCDONALD: I just love to talk about this stuff.

CHAIRMAN CATES: Damon.

MR. HAYCOCK: Real quick. Damon Haycock for the record. Tom, I think one of the things you asked is when will the participants save money. And it depends really on how you want to define that savings. Do you want to define it as when will they save it in their monthly rates because the overall plan costs have achieved savings, that's when that return on investment discussion comes in to play.

But what about day one savings? So we currently have a consumer driven health plan. And I'll give you my own personal experience so I don't breach anyone else's PHI. But if I go to my local doctor today and I haven't satisfied my deductible, I have to pay about $80 for that visit. It is my

understanding, and I'll ask Tim to confirm this for me, that when we design a co-pay process and because we have a health savings account on a high deductible health plan we would have to, that we have to use the usual and customary cost and then we get to reduce it by the overhead. And so if you think about it, whatever the overhead is built in to my $80 visit gets to reduce that $80 down. And I'm not going to throw out a number here that I think we should stand up to, but if that dollar amount goes from 80 to 60, if that's a fair number to go with, well, then right out of the gate participants are paying 25 percent less for the same visit, day one.

So it just depends on how you want to define savings. Is it out-of-pocket savings on the first day of service or is it how do my rates become lower or how do I reduce those increased rates we know are coming because we found cost savings and situations that can save the plan money. I think that might answer it a little bit better.

MR. MCDONALD: If I can add to that, Damon. That's great. Thank you. And I kind of missed the boat on the answer. I gave a long answer but it wasn't to the right question.

But, as Damon has mentioned, there is this thing called the fair market value that has to be applied to anybody with a high deductible plan with a health savings

account for significant medical services. And so in the world of employer-sponsored health centers, significant services would fall in the category of it's a provider visit. So somebody who sees a nurse practitioner or a physician in that visit would qualify for that. So that's where the fair market value would have to be charged. And so as long as it's not your annual exam or preventive service or occupational health, for those there are no charges. But for those other primary care visits, if you see a provider, you can expect to be charged the fair market value.

But as Damon was saying is that because it is employer-sponsored and the employer already is paying all the overhead, number two is based upon the demographics of the population. And three, based upon the fact that it is being provided by perhaps a mid-level practitioner, there are opportunities to reduce the fair market value. And the fair market value, generally speaking, is whatever the Medicare approved rate is. And that essentially that you can make it discount from that. So an example of 80 to 60 is a very good example. When you take away the fact that you don't need to be billed again for overhead, you've already paid for it. You don't have to be -- Your provider was less expensive than a physician by 50 percent. The demographics are much healthier because these are people who go to work every day compared to, let's say, Medicare eligible people. So there

are opportunities to reduce that price.

Most of my clients who are with high deductible plans with health savings accounts try to get to the point where they have a flat rate, a flat price, so that when a person walks into the health center, they know in advance that there's going to be a $50 charge if I see the provider, not 55, not 60, maybe this, maybe that. It's $50. And that also helps a lot in the communication. So people know up front what it's looking at.

But the other thing is that those non-provider visits, which I think again when you talk about going to a health coach, sitting down and having a consultation about my chronic condition, my coming in for a blood draw, my coming in for just getting my blood pressure checked, you don't have to charge for that at all. That falls -- That is not -- That's okay. You don't have to charge for that according to the IRS language about high deductible plans with health savings accounts, which, again, it's just a real advantage. If you make it convenient and now it's free, maybe people will get their blood pressure followed up on and take care of those kinds of things.

CHAIRMAN CATES: Thank you.

Any other comments from members?

MEMBER ZACK: Christine Zack for the record. One final question. You talked about the order of events being

preparing the physical structure of the plan of the facility first and then finding a local market partner. And I guess in my mind I was always thinking about doing it in reverse. So you find that local market partner first who --

MR. MCDONALD: May have space?

MEMBER ZACK: -- may have space, may be willing to bear those start-up costs of creating the physical structure and the facility. And so I was just wondering if you had any experience doing that in reverse.

MR. MCDONALD: Yeah. I have. I have. With a very large grocery store chain in Texas. They wanted to do -- They did an RFI just to see if there's even interest out there with the local providers. So they sent it out to an RFI to a lot of providers just to see who out there is even positioned to enter in to a conversation about providing staffing and running and operating an employer-sponsored health center, because they are different.

And so there are -- That would be a way to if you wanted to see -- And what you'll find is that some local, they have lots of space. They have minimally or underused space and so they might step right up. And that's what happened in this case in this company in Texas is that the local providers had suites, I mean, really nice space that it was just sitting there empty and they were willing to do the renovation.

The problem is -- Not the problem, but the challenge is that they don't have a lot of experience with employer-sponsored health centers. And employer-sponsored health centers, you're the customer, you know, not the health system. You're the customer. And they have to turn, you know, change their focus that they're serving you and not serving the health system. And that's -- That comes with time. But there has to be an understanding that you may have to do some training. It may be a little bit of a process to get there. Whereas some of the companies that just do employer-sponsored health centers, they know that the client is the employer and they don't have any loyalties to one health system or another. So that's the piece that we have to work with. But an RFI would be one way to find out just what's available out there and what are some of the possibilities in the community.

MEMBER ZACK: Thank you.

CHAIRMAN CATES: Thank you. Anyone else? Seeing none, we'll close this item. We will be taking up this issue as part of the Agenda Item Number 8.

So it is now five minutes after 11. What is the pleasure of the committee? Should we take a break or should we plow forward? I see nods for a break. Let's take a 15-minute break and reconvene at 11:20. Thank you.

(Recess was taken)

CHAIRMAN CATES: I would like to call the meeting back to order. I do have one request for the members just to ensure that we proceed in a proper orderly fashion, I would ask that you seek recognition before the chair before providing comment or asking questions just to make sure that we're giving everybody proper opportunity to speak.

So with that, we'll open Agenda Number 8, discussion and possible direction from the board to staff on potential program design changes for plan year 2018, for which the board requests additional information and cost to be presented at the November 17th 2016 meeting. Damon.

MR. HAYCOCK: Thank you, Mr. Chairman. And there was a request from one of the members, not board members but one of our participants who is down in southern Nevada who wondered if we were going to entertain public comment specifically for this section. I didn't know if you wanted to do that and then when. Do you want me to present first and then the board talk or how would you like to do that, sir?

CHAIRMAN CATES: Why don't you go ahead and present and then we'll take public comment and then have discussion.

MR. HAYCOCK: Excellent. Thank you, Mr. Chairman. Again, Damon Haycock for the record. As what happened last September and I assume the Septembers before,

this is an opportunity for PEBP and our partners and our consultants to gather input from board members on what options and opportunities you all would like to see at the next board meeting when you will make a decision on hopefully on the plan benefit design for the next plan year.

One of the things that I want to start out with by framing this discussion is PEBP, like all state agencies -- I think I'm becoming a broken record -- we're facing flat or potentially five percent cut budgets in the next two plan years. That was the budget. Instructions provided back at the budget kickoff. And that's excess reserves that were originally approved by this board for a three-year payout basically. But that three years is scheduled to end on June 30th of next year. So this final plan year is supposed to have exhausted the bulk of but not all of those excess reserves.

Now, I can tell you today that we are looking at a starting amount for plan year 2018 with 11.6 million dollars of excess reserves. But before you say, that's awesome, where can we spend it or what can we do with it, if you ask me what that number is or you ask my excellent CFO what that number is a month from now, it will probably change. If you ask a month after that, it will probably change again. And the reason is is that we don't necessarily know what our ending balance of excess reserves is until the

end of the plan year. And sometimes six months to a year thereafter as we have that timely filing and payment of claims.

And so it's a moving target. And, therefore, I want to really disclaim the heck of out it, that 11.6 million dollars today may not be 11.6 million dollars next month. And that that excess reserves could be used for a multitude of things that may already be earmarked. And one of those could be balancing our budget submission to the legislature. So if there's going to be a shortfall somewhere in our budget, often that excess reserves is the first place we go to to make up that shortfall.

So if we recognize that that 11.6 million dollars is not necessarily the right number but we'll use it as a starting point, I wanted to illustrate to everybody again, not necessarily the board who may already know, but also the public, what those consumer driven health plan enhanced benefits were provided for the last three years and what those costs are, what the sticker price was projected for this year and what needs to be hopefully recognized is the sticker price for these enhanced benefits for this plan year is not necessarily the sticker price for next year because population is increasing, the utilization may be going up. And so if you look at that table that starts on the first page and moves to the second, you see the end-all figure of

28.75 million. But I don't think it's unfair or inappropriate to say that in plan year 18 that may be 30 million, because, again, we are projecting a population increase.

And, specifically, if you look at the HSA/HRA additional contributions, that is a per employee amount that's going to happen. So if our population increases, we're out that money July 1 on the HSA side and we have to make sure we have enough reserves for the HRA side to make up for that as well. So that 28.75 million could easily increase based on our population increases and again our utilization.

So last September PEBP brought to the board a table of categorized options to consider for further analysis. That's on page three and four. We thought the format seemed to work well for the board then. So we repeated it this time. This is not the sum total of all options and opportunities that we may be looking at. Every single day that we have conversations with our stakeholders, with the legislature, with our consultants, we hear about something that may be new and innovative with another member or another entity in their book of business and we want to be able to capitalize on those opportunities and bring them to the board for approval.

So, again, even if you approve every one of these

or a portion thereof, we still would like to reserve the right to bring additional opportunities back to the November meeting, especially if they're going to do the things that I think we all hold dear, increased access to high quality health care and to either lower or reduce those or control those costs associated with them. So we want to be able to bring additional cost saving opportunities to the board.

But going through starting on page three, we talk a little bit about the plan design. And in reality, as has been stated, and we talked about this at our budget presentation I believe it was in April, that the excess reserves for the enhanced benefit design are projected to be gone. So that says that if we're not provided additional funding then we need to reduce those enhanced benefits.

And so you'll see kind of the inverse that we can talk about do we keep any of these and do we want to fund them. And this also goes back and ties in to that participant survey if we have to fund them and it has to all be paid for by the participant, do we feel that's an affordable option for them. Does the board feel it's an affordable option for them and what do you want to place on to those participants to have to pay for these enhanced benefits.

And so going through the first, you know, four, five, six of them, you know, they're all keeping them. Do we

want to keep them. We have those preliminary costs. That's that sticker price, right, that's on each of those, on the previous pages, again, knowing that they will have to be further analyzed and we will have them analyzed by our partners to trend them forward. So we have some preliminary cost available, but again, that participant may bear the entire cost of those benefits in increased rates. So that's one, two, three, four, five, and six.

Seven is kind of a repeat from last year. If you remember, we did a survey through our state employee benefits advisory committee and asked what they would want to include in the health plan. And there was a significant amount of response rate. I think it was 90 percentile range or a little bit higher. They wanted a vision hardware benefit. And that was also requested by a board member, so that was put on there.

We originally had some analysis for plan year 16. But if this is something that you would like us to pursue, we will work back with our TPA and our consultants to get an idea of what percentage of people seeing the eye doctor may need glasses and then what's the average cost and come up with a benefit limit for that.

One of the ones that I think this board has contemplated but may never have implemented, for good reasons, I'm sure, is to implement the HRA rollover caps.

And I want to go in to a little bit of detail on this one. There are balances on various participant's health reimbursement arrangement accounts and those balances need to be carried as a liability to the cost of the health plan. We need to make sure that if participant A needs to go to the doctor or has a qualifying expense that would like reimbursement that that limit, that credit limit that they have, that account balance, is accessible for reimbursement and that PEBP has the cash on hand to pay.

Well, we can agree that population has been increasing every year and folks -- That means we're providing more HRA dollars or available HRA dollars, then our HRA reserves have to increase as well. And depending on how we're able to fund those increases, eventually it boils back down to the participant.

So you have folks that are using this HRA just as well as they use their health savings account religiously and they have very low balances, some in the pennies, some a couple hundred bucks, some in to the thousands. But we feel that to help this process in reducing increased rates moving forward, those that choose not to utilize their HRA at a high level -- And I'll get in to that in a minute -- if we maintain that liability then we have to keep increasing our reserves every year for money that nobody is spending.

So we are potentially faced with increasing our

rates to backfill a reserve for care that people aren't utilizing or at least they're not getting reimbursed for it. And with dwindling reserves and the potential cut to benefits, we feel that there's an opportunity to put a cap on this, and a very liberal cap. I would suggest a $5,000 cap. And there are only so many accounts that have more than a $5,000 cap today. The latest data I looked at, the total amount of folks that have balances that if we capped them at 5,000 we would be able to return back to the plan the effectiveness of 1.8 million dollars. So it's not massive, but every dollar counts. We go back and look at the sticker price of an annual vision exam at 1.4 million and you kind of get to see the comparison here.

And what we would want to do is to be ultimately cognizant that our participants would not want something implemented or inflicted upon them irrationally. So my suggestion would be that if you were willing to entertain an HRA rollover cap that we would be able to go and do this analysis but that we would implement it for plan year 18 but we wouldn't cut the cap off until June 30th in 2018. So that gives everybody well over a year to utilize their HRA and get it back down to $5,000 if that's their choosing, if they want to go back and look at how many claims that they've had that are still less than a year.

And we would create an outreach campaign to those

folks that have balances at or above 5,000 and remind them that they have a year from the latest claim that they had to pay for that to receive reimbursement and that we are going to be capping it on July 1 of 2018.

So we feel that with enough notice and enough communication that this is fair and it also continues to help us manage our budget and our reserves for money people aren't spending right now. And so logically we would like the board to consider at least analyzing that and bringing back the final numbers.

Number nine is a little tricky here. Requiring Medicare exchange participants to get life insurance premiums. I think Director Wells had brought up something when we were talking about portability of HRA funds at one of our previous meetings. But today we do not require Medicare exchange participants to pay PEBP directly for their life insurance premiums. It is offset by other participants throughout the program.

And from a strictly apples to apples, every participant pays a premium for their insurance, whether it be life insurance, health insurance, dental insurance, what have you, we feel that the costs associated with those retirees paying for it is fair and appropriate and it aligns those folks with the pre-Medicare retirees that exist on our plan today, that everyone pays their premium to offset the cost of

life insurance claims.

That's something that we can look in to, how many folks this would apply to. I think I'm going to give you a rough number. We have around 12,000-ish people on the Medicare exchange. And so 12,000 people times I think it was something like seven dollars and we can do some quick math and that's what it would be. But we'll come back with the complete analysis if the board is interested in pursuing this process.

Number ten is something that we've been kind of tackling for a while. Benefit limit on hearing aids. We have no desire to ensure people can't hear. That's not the point of this. But right now our master plan document is designed where people can request reimbursement for or have claims paid out for hearing aids. And there is some gross disparities between cost of the same hearing aid from one provider to the next.

And so all we're thinking about doing is recommending and suggesting once we do the analysis is just putting a benefit cap on this to control wastage and abuse and high cost of certain providers that are basically getting the, I don't know, the Lamborghini of hearing aids when it's not necessary. Of course, if it is necessary, we're here to provide all forms of health care to our participants to include hearings aids that are medically required.

Number 11. Number 11 is an interesting one as well. If you remember, the previous board chair, Leo Drozdoff, myself, and our chief operating officer, Laura Rich, went to Towers Watson in Salt Lake City back in I believe it was March and we had a conversation about what's going on with overpayments and how do we have such a high dollar amount. You'll see in a future -- or in a later report, I believe, from Towers Watson that they discussed I think it's around $700,000 now for the lifetime of the program. And that's paying HRA reimbursement that technically shouldn't have been for a myriad of reasons without pointing fingers as to who did what, when, or whatever.

But one of the issues is that folks on the Medicare exchange will be approached by carriers directly and told would you like to have a different plan that may be more cost effective to you, save you money and give you something you're interested in. And they're not aware that if they accept that plan they're actually no longer part of Towers Watson One Exchange. And when that happens, Towers Watson is no longer the agent of record. They are no longer eligible for the health reimbursement arrangement. They are no longer eligible for any of this stuff, the dental plan, the life insurance, what have you.

And when they find their error then we apply the

policy that says if you want to return, and we've been giving you this HRA, we need you to pay some of that back because it was for ineligible expenses because you weren't on the exchange, especially if it was for premiums. And so it becomes a very murky situation because a retiree doesn't necessarily always understand the ramifications of this decision. And then there's a statute that says that we can reinstate people on PEBP and we can reinstate any line of their insurance that they have with the exception of life.

And so if someone hops off for a couple years and then finds out that, wow, I'm really not on Towers Watson, I thought I didn't have to be, I would like to go back on, I want my HRA. And we finally catch up and find out what's going on, we can reinstate them, but then they don't get their life insurance. And these are folks that work for the state or the local government diligently for years and now we can't give them a benefit because the statute says you can't give it to them.

And so when we talked to Towers Watson -- I know I'm giving you the really long, drawn-out story, and I apologize to our court reporter who is typing it all. But they said, well, if you want to solve some of your overpayment problems, why don't you eliminate the requirement that people need to remain with Towers Watson to keep their health reimbursement arrangement. We'll still manage it for

you. And we can still do all of the auto reimbursements with all of the carriers that still participate. We can -- We'll collect and pass through the admin fee because that admin fee is specifically for the HRA administration and therefore if we stayed with their TPA or went with another, we're still out similar costs. But why not just reduce that? We have other clients that say they don't have that.

And so I would like to offer that as an opportunity that folks that happen to inadvertently hop off Towers Watson or decide they don't want to be on One Exchange, that we continue to provide them that HRA and we do it through our current set-up through Towers Watson through their third party administrator, Pay Flex, because it's already set up today and that we don't penalize them and they can still participate with the rest of the program, the life insurance, dental plan, what have you.

But to control cost, because when they hop off, right, that HRA is supposed to come back to PEBP, that's another reason to cap rollovers.

And so just something to think about. We would like to do a little bit more analysis on it and bring it back to the board for approval. But, again, I know it made it sound misleading that we're talking about plan year 18. This is for plan year 18, but we wouldn't implement this cut-off until the end of plan year 18. So really people would see it

the first day of plan year 19.

So that's the first 11. And I think what I'll do now if you're alright, Mr. Chairman, is I'll pause for questions and then we'll go on to some of these other ones.

CHAIRMAN CATES: Any questions from the members?

MEMBER VERDUCCI: Tom Verducci for the record. Damon, could you speak in terms of how much the vision hardware costs would be per participant and if we were to enhance the hardware costs and provide that benefit, how much would that increase the average premium cost per participant?

MR. HAYCOCK: So for the record, Damon Haycock. I'm going to attempt to answer this but I need to put some caveats out here. First of all, we need to pull the claims and we need to look at how many folks are actively utilizing their vision benefit and come up with a probable amount of individuals that would take that.

Second, we have to come up with a dollar amount, per se, or a percentage cost share. And if we were to, I don't know, say a hundred dollar limit and then if we figure X amount of people times a hundred bucks is what the total cost of the plan would be. If we were to take that in a vacuum and apply that directly to the rate, you divide it out by all the tiers. And we can provide all of that in November because it's going to be kind of hard to do right here on the spot. But the last time we looked at it I think it was 1.6

million dollars is what the total cost -- I'm looking at my CFO. She's nodding her head. But we hadn't figured out exactly what dollar amount that would be because at the time we had excess reserves that would be able to cover it, and so it wouldn't necessarily directly hit the participant.

I've done some preliminary numbers before and I was trying to come up with for every million dollars that we included in plan additions what would that equal in rates. But here's the rest of the story. Who pays for those rates, the overall rates? Is the state willing to subsidize -- I don't want to say willing, because that's unfair. Does the state have money to subsidize plan increases? And if they don't, then that million dollars is going to be directly costed by the participants. If not, well, then there's a percentage of subsidy and then that gets a heck of a lot smaller.

So I don't have exact numbers. I don't want to throw something out there and frighten anybody right now, but I would like to be able to do the analysis and just bring it back and say this is what it's going to cost, this is what logic is going to be applied to who pays for it, and is this something you want to move forward with. And hopefully that answers your question.

MEMBER VERDUCCI: It sure does. That 90 percent is a big number. So it seems like there is a huge request

for vision hardware. So thank you very much.

CHAIRMAN CATES: Any other questions from the members?

Why don't you proceed.

MR. HAYCOCK: Consumer resources. We talked about last year the opportunity of second opinion doctors. There is firms and vendors out there that will utilize a cadgeree of experts across the country where individuals are diagnosed and then are told that they need to have a certain procedure done. And sometimes they don't feel comfortable about it. They're not sure if it's truly what they need. And these vendors provide a service where they can connect the participant directly to that subject matter expert, that high-ranking, highly-accoladed doctor in their field to review their medical records, review all the options, and then present to them maybe some alternatives. Sometimes people are required to go have surgery that they may not necessarily need yet. Sometimes they need it.

And there is some cost savings to the plan and ultimately to the participant in the form of rates and out-of-pocket expenses if they can avoid something that is costly and intrusive with a lot of recovery time if it's unnecessary. I'm just giving you one kind of suggestion or one type of illustration on second opinion doctors.

But we've had some vendors reach out to us over

the year that I've been here, and I know that it's happened before, and they're talking with our third party administrator to see is there some cost savings and if there's something you would like us to look in to we would like to bring something back to the November report. Excuse me. The November board meeting.

The next one, network bundle pricing reference base pricing. This is -- I don't want to say this is kicking off because I think it's existed for a long time. People have often used Medicare as a benchmark and a form of reference pricing on certain procedures or certain codes that Medicare Plus or Medicare Minus or whatever. But there is some opportunities here. We have some huge disparities in the cost of care and locations. I'll give you kind of an interesting statistic and hopefully I'm not wrong. I haven't looked at this in a while.

But a knee replacement say out in far eastern Nevada, I won't pick on any providers specifically publically, but may cost $80,000 in the plan. That same knee replacement costs, like, 15, 20 in the urban environment.

And so why do we pay that much money for the same type of care at the same type of facility that's simply a couple hundred miles away? Why are we doing that? Is there an opportunity to develop a reference-based price?

Another good one is infusions. Infusions are

those types of drugs that are infused either through intravenous IV or, you know, through the stick in the arm that are often administered by a physician or an infusion center because they could have some pretty nasty side effects and they want to make sure that the participant can recover and doesn't fall out on their way out of getting these services. But they differ from infusion and drug to drug, cost to cost, and they're billed through the medical plan.

Well, you know, we've toyed with the idea, and I think there's a lot of merit to it, of referenced-based pricing infusions, this is what we'll pay for this drug. And so there isn't any more gaming. There isn't any more abuse. There isn't any more profiteering on Nevada participants and ultimately the State of Nevada taxpayer.

And let me give you a quick example. Last month we were able to renegotiate a long-standing agreement with one provider in Las Vegas for one individual who goes to an infusion center who receives one infusion twice a month. And this provider was willing to allow us to sign an agreement with them that they cut almost $15,000 per infusion. Saved us $350,000 a year. No change in care. No change in drug. No change in frequency. No change in dosage. $350,000, one person, one infusion.

Now, multiply that times however many folks are getting infusions right now and you start to get a picture

painted that says are we paying too much for health care and can we reference base price and say we're only going to pay this level and we're going to be bringing to the board in November a request by one of the members who isn't here today to talk about how we've been dealing with infusions and how we've been dealing with our pharmacy benefits manager who's been partnering very well with us to try to save these costs and some of the successes and some of the challenges that we've experienced.

But that's just one illustration of the cost disparity and the high profit -- This guy, I don't want to pick on him, so please don't take this personally, but this provider probably made about a million and a half dollars off of PEBP over the last four years because we didn't do this four years ago. And I'm not blaming anybody or saying that people should have known better. But as we find these cost savings, you know, maybe we can, instead of having to negotiate one provider after one provider after one provider, maybe we can come up with a reference-based price and say this is what we're paying. We make it fair and we make it appropriate and we don't stop the continuum of care for our participants.

So I'll get off my soap box now and move on to the next one.

Last but definitely not lease is on-site

near-site clinic development. I'm a firm believer in crawl, walk, run, all right. But I'm more than willing to run if that's where we need to go, if that's what the board would like us to do.

But I think there's some definite opportunities here, as you heard from Mr. McDonald from Aon here earlier today, to at least investigate and do a feasibility study on what it would look like, what are the start-up costs, is there seed money, do we have local providers that want to partner with us. What can we do to leverage our current resources and really make something more specific for our participants.

There is somewhere in the vicinity of 5,000 employees in this city right now and there's about 55,000, maybe a little more, population of folks who live and work in Carson City. So using Carson City as an example, 55,000 people are sharing all of the providers. Now, imagine one provider for all of PEBP. So you don't have to get in the queue with all of those.

And so if it can work, I think it's a really good opportunity, but we want to see the numbers and we would like permission to as part of this agenda item be allowed to move forward with that feasibility study. That feasibility study would not be ready by November 17th or 19th or whenever the next one is, sorry. It won't be ready by then. But it will

be ready that we can be back at least by January. We don't want to rush this process. If it's something that we feel is going to be beneficial, we don't want to just gather some quick information and then just run with it and then it doesn't work.

But one of the decisions I think that can be discussed and made here today as a board is, one, do you want to do it, at least a feasibility study, and two, how many of them do you want to do.

You saw on the slides that Aon provided that they can be one location, two locations, three locations, whatever. Do you want us to look at all of the locations that have high concentration of employees and retirees and dependents or do you want us to concentrate on a pilot in northern Nevada? That's the discussion, obviously, to the board. And with that, I will take any questions.

CHAIRMAN CATES: Any questions or comments from the members before we go to public comment?

MEMBER COCHRAN: Mr. Chair, this is Chris Cochran for the record. Just a couple things. First of all, in pilot studies, we always seem to be left out in southern Nevada in terms of looking at pilot studies. And there may be opportunities down there. I'm not saying that we don't do something in the north, but it would certainly be beneficial to look at some, if we're going to do something like that, to

do some comparisons.

I do have a question on this second opinion doctors recommendation, which I'm not opposed to. I like the idea of having second opinions. I get a little weary if these are going to be plan-required second opinions as opposed to patient seeking a second opinion and we're willing to pay for that second opinion because the patient wants to get another opinion.

So I would hate to see a situation where we may have a patient who has got something that has been recommended to him or her from his or her physician and we say, well, we want you to go get another opinion on this. Because I think that walks a slippery slope in relationships that patients have with their care givers are typically pretty good relationships. So -- And, you know, worrying about other times where participants or some of our providers may say, you know, I'm just not going to work with PEBP anymore, you know. So we have to be careful about those types of situations.

It's my understanding that these are things that we want to look at and consider. We are not saying this is what our plans are going to do. So, you know, getting in line with that, I am fully aware that when we look at the enhanced benefits that we did that those were enhanced benefits based on surpluses that we had in our plans at the

time. So what we were paying for the HSA and for the members as well as their dependants, we were able to do this because we had -- we had huge surpluses and if we didn't do a good enough job in explaining that to our beneficiaries that this is something that we are able to do now but we have a based plan here, you know, I think that we need to start communicating that out better instead of saying, well, we were able to enhance your benefits and we want you to keep them. If we're keeping them, this is what it's going to cost.

At the same time, I do think that the idea of -- I would have my priorities on things that we would want to have. So an enhanced HSA or HRA, whatever we're doing, may not be as high a priority for me as, say, maintaining lower deductibles or maintaining out-of-pocket costs, you know, to offset those. So, anyway, so I'm assuming that we would be tackling these one by one as we look at this in the November meeting. Am I correct?

MR. HAYCOCK: For the record Damon Haycock. And for those that can't hear on the phone or see on the phone, I'm nodding my head yes. Everything that you've mentioned is correct, Dr. Cochran. One, I realize my mistake. I should have put voluntary second opinion doctors. So I apologize for that. I don't believe that it would be a requirement. I can't see the reason to it. We have a prior authorization

process in place with our medical plan, our utilization management, case management vendor. We have our checks and balances for medically necessary. So to require it I think would be unnecessary. So voluntary for sure.

Yes, to reiterate, no decisions made today are going to determine plan year 18 benefits. That's that deep in-depth conversation that we're going to have in November. But we want to make sure that we can bring you the information that you need to be successful.

And, so, like I said, we mentioned some of these things in here. They're not the sum total of everything. But we're definitely here to help provide these. And, yes, we will have better pricing on each of these enhanced benefits. So if the decision of the board is to take what excess reserves we have left and apply them to saving as many enhanced benefits as possible, then we'll move forward with that.

But I want to real quickly offer up just a different way of looking at it. And I'm not lobbying. I'm not trying to convince anybody. But I just want to share a different opinion. If you have 11.6 million dollars today, and we don't know if we do, and you go through this list and say I want to save 11.6 million dollars in benefits, there's no guarantee that there will be 11.6 million dollars at the end of the year. And so those benefits you are given for a

year go away. So Damon's opinion, not the board's, that that's kicking the can down the road. And if that's what we need to do, I'm all for it, and I will implement that wholeheartedly.

But if we look at it instead of do we have some surpluses, can we put it back in to the infrastructure of the plan to make things more affordable for next decade, how do we lower the cost for everybody? A good example is the reference-based pricing. Maybe we look in to more disease management programs.

You heard from Dr. Cryer today there's asthma medicine that's coming out in the next two years that may be extremely expensive. Well, if we can get people on a regimen of compliance on asthma and pay a little bit of money to do this, maybe we can offset those high costs moving forward. Maybe we need some seed money to be able to partner with a clinic.

So, again, there's always opportunities. And I'm not trying to say today which direction I think the board should go. But I want to kind of frame it that you can -- you can take what you have and you can give it back to the participants directly in HSA funding or you can save some of these benefits, which all have merit, or you can build the infrastructure of the plan and make it more cost-affordable so that rate increases in the future are a little bit more

level. So just another way of looking at it. But I will implement exactly what you all want.

CHAIRMAN CATES: Any other questions or comments?

MEMBER LAMBORN: Thank you, Mr. Chair.

Damon, so my understanding is you'll be evaluating after today's meeting this list and kind of putting a newer price tag to it or potential savings, go forward, so we're not voting on anything now. But can we add to the list, like, for number eight you said the HRA rollover cap set at 5,000. Can you do a 3,000, 4,000, 5,000, so we can see the savings overall?

And then on number ten for the hearing aids also, if you're going to do reference-based pricing, can that be also included in that are competitive bid pricing, same idea, pretty much. That would be a cost savings. So some of these items would actually be a cost savings that would offset or help to meet that budget requirement of five percent reduction. And that's the goal as well, correct, with this list?

MR. HAYCOCK: For the record Damon Haycock. Yes. Thanks, Ms. Lamborn, for those clarifications. And it is to meet budgetary requirements. It's also to continue to provide high quality health care at affordable prices. So we don't want to lose the participant in all of this because we're talking about dollars.

So we can definitely add some tiers to some of these things and break it out. I actually have a report that does exactly what you said. I had my consultants already pull HRA balances in $500 increments. So, I mean, we'll be able to bring it. It's not just going to be a regurgitating of this list. We'll put a full-on analysis report together on each of these or some of them we may group together so you can see kind of the pluses and minuses and you guys can make the decision on this.

But one of the things that I think for timing sake is potentially necessary is if you do decide that you want us to investigate an on-site near-site clinic, we will need an official approval to move forward on that feasibility study. Other than that, the benefit design we can just reanalyze and bring back to everybody.

MEMBER LAMBORN: Thank you, Mr. Chair. Just a follow up to the Item D, the on-site. Also is it possible to get more data on return on investment and how that's analyzed for other states that have implemented such a program?

MR. HAYCOCK: I believe so. I'm going to speak on behalf of Tim McDonald. I think he's nodding his head. He gave me the thumbs up. So, yes, we'll be able to do some form of benchmarking. And I think he alluded to it already with the two to three-year return on investment. I think he has some financials that are seen across the board. As you

all know, working for the state for forever that we often don't meet the mold of the nation. And so it's unfortunate when we try to fit ourselves in to this process where the nation is doing this so Nevada must be doing this as well. So I would be cognizant about that. But I'm sure Mr. McDonald can do that and we can at least have that at the November meeting if we move forward with a feasibility study while they're doing all the legwork and data mining and all of those things.

CHAIRMAN CATES: Anyone else? Okay. I think we'll open it up to public comment since this is an action item. Do we have anybody up north that would like to provide public comment? Please come forward.

MS. MALONEY: Yes, I was looking to see if it was afternoon yet. We're getting close. So good afternoon to the board and our new board members, our new chair. Pricilla Maloney representing the AFSCME retirees.

Just a couple of brief comments in my understanding, I was listening in the car on my way down, was that we have a three-minute limit, so I'll try and keep it as brief as possible even though this is an enormously complex situation, as Mr. Haycock and the rest of the board understand. Managing health care systems today in our challenging environment is an overwhelming task at times.

Just a couple of things. I would like to remind

the board, and I know that some of our long time folks will be aware of this, but our new members might not, even though I represent the AFSCME retiree chapter, I don't see anybody here from the actives. There may be somebody down south giving public comment. But I would like to remind the board that during the last legislative session our state employees, for example, only got a one percent COLA for the first year of the biennium and a two percent COLA for the second year of the biennium. If the request from the governor's office has been to keep budgets flat for the next legislative session, those requests and or five percent reduced, it is unlikely that they will have an opportunity to have more income that's going to offset this.

And I know that Mr. Haycock is painfully aware of this. And I know that it probably keeps him up at night. I do think though that I recall, and this is of concern to me, whether we're talking about the actives or the retirees, although again I'm just here today officially for the retirees that I think Ms. Bosley brought out the point in the June meeting I think it was that this $41 mean average increase in premiums, and that's found at page 11 for item number six, page 11 on Mr. Haycock's presentation. So something between 40 and $50 a month is kind of a moving target too. Because as I recall Ms. Bosley, and she can correct me if I'm wrong, Aon prepared a guesstimate that

these premiums could go up as high as a hundred dollars a month given certain circumstances. So I'm sort of pulling that back from June. I know we've been actually talking about this for quite some time. And, again, the AFSCME retirees' position is this is the responsible thing to do, to talk about the what if.

But I will simply close with this. And forgive me if it gets close to sounding like a little bit of an editorial. On Agenda Item Number 6, page 16 document, Mr. Haycock did mention here that there was not the option on the survey of asking the opinion piece of asking the legislature for more money. I would simply like to suggest that that's not entirely a pie in the sky option, given that we are officially going in to a special session. So there are things that the State of Nevada is willing to step up and consider paying for. I would like to see the state's health care program, PEBP, have the same status in that regard, the same seriousness with any request. I realize these budget talks are already -- they're not a fait accompli, but they are in the works. I would simply like to suggest to this board to consider that in the climate that we are in when we are heading in to a special session to consider a sports stadium at the behest in large part of a single private individual that we give the NV PEBP system the same kind of consideration and seriousness with its fiscal challenges that

we do other projects for the benefit of the entire State of Nevada. Thank you.

CHAIRMAN CATES: Thank you.

Any other public comment up north? How about down south?

MR. FRANKLIN-SEWELL: We do have public comment down here.

CHAIRMAN CATES: Go ahead and push the button and state your name for the record.

MR. FRANKLIN-SEWELL: For the record my name is Shaun -- Can you hear me?

CHAIRMAN CATES: Yes.

MR. FRANKLIN-SEWELL: Excellent. For the record my name is Shaun Franklin-Sewell. And I'm the chair of the newly-formed UNLV Employee Benefits Advisory Committee.

Since January 2015, I've learned a lot more about insurance than I ever desired. And since Executive Director Haycock came aboard, I also learned much more about PEBP and the difficult positions in which board members often find themselves.

One lesson I have learned is that we must always be careful about what we are comparing. Southern Nevada HMO participants have often compared our plan to the north. We have often said that northern Nevada's plan is better. However, in May, we learned that while northern Nevada

participants might not have the access to care issues that we have, they pay significantly more than we do in terms of co-pay and co-insurance. They pay more for ER visits, hospital stays, and doctor visits, and pay significantly more for drugs and even for MRI's.

In the recent RFP process, PEBP requested a basic statewide plan design using northern Nevada's plan year 16 benefit structure.

What I would request from the board now is that you allow staff to negotiate regional plans with added benefits in addition to the statewide plan ultimately selected through the RFP process in order to help southern Nevadans keep our co-pays and co-insurance low.

And, finally, related to the consumer driven health plan, I would simply urge the board to do whatever it can to keep premiums as low as possible while including as many of the enhanced benefit design options as possible. Thank you very much.

CHAIRMAN CATES: Thank you.

Any other public comment?

Seeing none, I'll bring it back to the board. Go ahead, Jim.

MEMBER WELLS: Thank you, Mr. Chairman. You know, I've thought about this a lot. And frankly one of the first questions that I'm going to have as we move in to

November is if I look at the financial report that was submitted by -- under Agenda Item 3, I think I show a lot more than 11 million dollars at the end of FY 18 -- 17. Excuse me. So that's the first thing that I think I want to get a better handle on where we think we're going to be at the end of '17. Because those numbers are not panning out, the 11.6, for me.

Second, I think that in addition to putting caps on the HRA, which was frankly originally part of the proposal that was postponed by the board and no caps have ever been put in place. I'm at the point where I don't know that 1.8 million dollars is worth it. I think that putting a cap in place at the end of the fiscal year will show just a run on the money that is above the whatever threshold we put it at. What I would like to ask Damon to do is work with the actuaries and find out what the average amount of the HRA money we're spending and instead of having the full cash set aside for that we just have a portion of the cash set aside that covers the amount that we expect to be paying in the next fiscal year, recognizing that there could always be more than what that amount is.

But, you know, we've got -- we're going on five years now experience on what we're paying out. I think we can get a better handle on what that average annual spending is, recognizing liability is always there. We also have the

catastrophic reserve if we need to, to dip in to. I'm not really worried about dipping in to that catastrophic reserve and having to build it up in the future years.

I think that we need to look at hundred dollar increments in the deductible and HSA changes like we have in the past. I think we need to look at co-payments for the vision exams. I think that we need to have a lot more information on some tiered information for the different benefit levels that were included in the current enhanced benefit levels. And, frankly, I think that a $400 deductible for an individual and a $1600 deductible for a family unit is pretty low. And I think we need to start making progress back to the $1900 deductible. I think we need to start making progress back to the $700 HSA based on allocation. I don't think we need to do it all at once. I think there's a way to phase some of this in so it's not done all at one time. But I think it's time to start recognizing that those enhanced benefits need to start being reduced. And my preference would not be to have all of it done at once if we can. And based on what I'm seeing in the information in today's packet, I don't know that we need to.

CHAIRMAN CATES: Thank you.

Other comments?

So, Damon, what would you like out of this board? Do you want us to take action on all of these items?

MR. HAYCOCK: For the record Damon Haycock. Yes, Mr. Chairman, individually or an aggregate and then a special consideration for D for that on-site clinic. If there is a motion to either move forward or not move forward on the feasibility study and at what level do you want it at if you decide you want it. Do you want the one location, two locations, all locations that feasibly would work with enough employees however that would help. I've got the notes from Jim. I've got the notes from Leah. And so we'll do those regardless. But a motion for the rest. Thank you.

CHAIRMAN CATES: Okay. Why don't we take the pilot as a separate item and have a discussion about that. Personally I'm intrigued by the idea. I definitely need a lot more information. I think it's worth doing a feasibility study on if we can. I think it would be very helpful to do pilots in the north and the south. Obviously in Carson City you have a lot of state employees in a confined area that might make it feasible. Vegas may be a little more challenging, but between the Grant Sawyer building and the Sahara complex, we should have enough people to make that. Those are my comments on that. Anyone else have any other thoughts?

MEMBER ZACK: Thank you, Mr. Chair. Christine Zack for the record. I agree with moving forward with the feasibility study. I think minimally we need to look at

Carson City and the Las Vegas metro area. I'm not sure if I understood that it was only an additional $10,000 to add a third site or was that considered a phase-in? I remember there were three different -- It was location one, location two, location three.

MR. HAYCOCK: For the record Damon Haycock. The cost proposal from Aon included I believe it was $35,000 for one location, 25,000 for a second. But with the economy, the scale, each additional location we look at is reduced to 10,000 because they're replicating the process.

MEMBER ZACK: So at $10,000 I think it makes sense to also add in Carson City.

MR. HAYCOCK: Reno?

MEMBER ZACK: Reno. I'm sorry. Yes, Reno. So, yes, Las Vegas, Carson City, and Reno.

CHAIRMAN CATES: Any other comments?

MEMBER WELLS: Mr. Chairman, if you're willing, I'll try to make a motion on this to look at doing a feasibility study for an on-site or near-site clinic with three sites, one in Carson City, one in Reno/Sparks, and one in Las Vegas. But I'm going to add the caveat I would like to have it done within the limit of Aon's existing contract value for the FY 17.

CHAIRMAN CATES: Do we have a second?

MEMBER BAILEY: I'll second that. For the record

Don Bailey. I'll second that motion.

CHAIRMAN CATES: Okay. We have a motion and a second. Any discussion on the motion? Hearing none, I'll call for a vote. All those in favor of the motion say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: All opposed? Motion carries unanimously.

Okay. We have one down. On the rest of the items on page three and four, anybody want to make a motion to accept those? Do you want to have further discussion? Do you want to take no action?

MEMBER BAILEY: Mr. Chair, I do have a question.

CHAIRMAN CATES: Go ahead.

MEMBER BAILEY: For the record Don Bailey. This would be for PEBP. You're going to give us additional information on the remaining items; correct?

MR. HAYCOCK: For the record Damon Haycock. That is correct, Vice Chair Bailey. We will analyze these in their individuality and come back and present a full report on each one of those to include the additions that were asked for by Mr. Wells and Ms. Lamborn, those hundred dollar increments on the deductibles and HSA/HRA contributions, co-pays for annual vision exams as well as looking at, you know, for the HRA rollover caps also providing an additional item to look at the average HRA spend on the last five years

and figure out what percentage are we paying of the overall limit to come up with a recommendation to better manage that HRA reserve. Last but not least to reference price or competitively bid those benefit limits for hearing aids, to address Ms. Lamborn's request.

MEMBER BAILEY: Mr. Chair, I'd like to make a motion that we allow PEBP to add additional information for the PEBP meeting for the board one through 11 and consumer resources B and C. D has been already addressed.

CHAIRMAN CATES: Do we have a second?

MEMBER COCHRAN: I'll second that motion. Chris Cochran for the record.

CHAIRMAN CATES: Okay. We have a motion and a second. Any discussion on the motion?

Go ahead, Jim.

MEMBER WELLS: Thank you, Mr. Chairman. Can you also bring back a couple others? The life insurance by the thousands. I'd also like to understand especially if we're going to consider the elimination of the requirement to remain inside the exchange, the costs that are associated with administration of the Medicare exchange participants, so that would include not just their life insurance coverage but their administration cost for the balance of the system as well. And I think those are the two that I wanted to add.

CHAIRMAN CATES: Okay. Any other comments? Do

we need to amend the motion to that?

MEMBER BAILEY: I'll accept that amendment.

CHAIRMAN CATES: And the second?

MEMBER COCHRAN: Second.

CHAIRMAN CATES: Okay. Is everybody clear on the motion as it stands now? Any further discussion? Seeing none, I'll call for a vote. All in favor of the motion say aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: Opposed? The motion carries unanimous.

Okay. So moving on to Item Number 9, discussion and possible action on improving PEBP staff recommendations to help mitigate non-state retiree increasing premium cost. Mr. Haycock.

MR. HAYCOCK: For the record Damon Haycock. Thank you, Mr. Chairman. We brought this initially to the board at the last board meeting as an option and opportunity to try to assist our non-state retiree population afford their monthly premiums. As has been since, you know, for many years, the non-state retirees and their corresponding employees, which I think today we're at eight, they are one risk pool. And the state employees and retirees are another risk pool. And so as those non-state retirees have high cost drivers currently, that is increasing their rates every year

and it doesn't appear to have any relief in sight.

We want to make sure that we looked at every opportunity available. And what we looked at was seeing if there was other programs that the State of Nevada already either sponsors or partners with to help folks in this exact situation, right. We expanded Medicaid in this state. We built a state-based individual market place for folks that can qualify for federal subsidies. And we wanted to offer an opportunity to analyze and then partner with those programs to see if they will help our non-state retirees afford their health care.

We didn't anticipate a huge turnout and we didn't get a huge turnout. This is an opt-in voluntary process where folks who sent us some basic information on household income and household size, which is used to determine the necessary inputs for federal subsidies and if you qualify for Medicaid -- And we are not Medicaid or health insurance exchange experts. We're not eligibility experts. But we did some basic math to see if we would move those on to those experts.

And we sent out a letter to approximately 1600 non-state pre-Medicare retirees, those existing in the State of Nevada. We didn't want to look at outside of Nevada because we would have to partner with those exchanges and understand their Medicaid programs and that was simply beyond

our scope of knowledge.

We gave those folks an opportunity to sign and opt in and also to stop at any time. They could go and speak with a broker here in the State of Nevada, and if they don't like what's happening, they can say I'm done and they can walk out of that office and no harm no foul. They are with our plan.

But we did receive I think just over a hundred, 108 responses. And more have filtered in. Even though we had a deadline, we're still going to work with those. And 33 of them, approximately 30 percent, may be eligible for federal subsidies and even four of them may actually be eligible for Medicaid. And for those that don't know, if you are eligible for Medicaid, that's premium free health care. So folks that may be spending six, seven, eight, 900 hundred thousand -- not a hundred thousand, excuse me -- a thousand dollars a month in premiums may have the option to pay zero.

And so we, at their behest through this process, we'd like to continue and partner with our other stakeholders but not at the level that we anticipate would be necessary if, say, a thousand people responded. And so with only 33 and we'll see from the others that have come in. Since we actually posted the report, we got some in earlier this week.

We would like to reach out directly to the Nevada Association of Health Underwriters, the group that has worked

with the exchange on trying to place folks in to health insurance plans and also know about how to see if we can qualify for Medicaid. There are split families for those that don't know that some may qualify for a state -- excuse me -- a federal subsidy on the exchange while other family members may qualify for Medicaid and another family member may qualify for Nevada Check-up. And so it's a very intricate type of situation. Although I don't know if non-state retirees would have children that would qualify for Nevada Check-up. I know we would all like to farm our kids off sometimes.

But we will see by sending it to those folks and partnering with them. They are the experts. They are licensed. They are managed and regulated by the Nevada Division of Insurance. And they should know what they can put people in to and see if they're interested. And we as a health plan that offers life insurance and dental insurance will provide information on the cost of our program to those brokers and say, if you're going to talk these folks in to potentially leaving our program, you need to explain to them that they are leaving the program and they're leaving dental and they're leaving life and they need to have a comprehensive package. And we will take very long strides of assuring that that occurs. And we will reach out to these 33 folks and say this is the process. This is what we

anticipate. You can stop at anytime. Call us if you need help. So we'll still advocate on their behalf.

But as promised, we are bringing this back to the board at this meeting for your input. And if you would like us to move forward, we will. If not, we won't. It's your call.

CHAIRMAN CATES: Thank you, Damon.

Any questions or comments from the members? Leah.

MEMBER LAMBORN: Thank you, Mr. Chair. Leah Lamborn for the record. So, Damon, this is totally voluntary for these recipients. And then if their situation changes financially in the future they have the option to come back to PEBP?

MR. HAYCOCK: And that is a good question, Ms. Lamborn. Damon Haycock for the record. Currently they can come back but they can come back at a certain time. And when they come back, the only thing that we can't reinstate, as was mentioned earlier, is life insurance. And so there's an opportunity for folks to leave our plan and come back after but it's only at certain times that they're allowed to do this.

So this could potentially lead folks, and I don't want to pull the veil over anyone's eyes, this could lead folks away from our program and then they may never be able

to or never want to come back because of the stipulations of returning. But it is completely voluntary.

CHAIRMAN CATES: Go ahead.

MEMBER WELLS: Thank you, Mr. Chairman. You're going to have to look at that again. I don't think non-state retirees can come back. These people if they leave will be gone forever. And I will say I have a little bit of concern over turning this over to a broker community without some stringent requirements for that discussion, because, as Mr. Haycock said, once they leave, you know, and give up their life and dental and everything else, they cannot come back. This group cannot come back.

And so I think there needs to be work in the legislature with these. We have talked for years about trying to figure out how to deal with this population. And there is no easy answer. Putting them in to a private plan could be an answer. But I think the other part of that is that they lose whatever subsidy is being provided by their non-state employer. We have tried for years to get them to go and be able to leave and still have some semblance of that amount paid by the former employer. It's not the state's responsibility. It's the former employer's responsibility. Or for them to go back to the former employer and have the subsidization stay at the same level for them going back to the employer.

I mean, I'm all for wherever we can helping out this population. But I think it's critical to keep in mind that there is just no easy solution for this group.

CHAIRMAN CATES: Thank you.

Damon, you wanted to comment.

MR. HAYCOCK: Yeah. For the record Damon Haycock. Thank you, Mr. Wells. I misspoke. I 100 percent agree that they cannot come back. I remember that it's the one way ticket between 2003 and 2008 and once you leave then you've left. So I apologize. Thank you very much for presenting that correction.

I will say this, that if folks are eligible and qualify and decide to enroll in individual market place on the exchange in our state or if they're eligible and enroll in Medicaid in our state, they are getting a subsidy from somewhere. So whether they're not getting it from their employer, they're getting it from tax dollars that we all pay in to the feds for the federal subsidy, which also covers a portion of the Medicaid dollars and then the state tax dollars on their match.

And so I think the reason why it's difficult to look at an employer subsidy for this group of folks if they leave the employer-sponsored plan is that they're leaving it for a state-sponsored plan, a state-subsidized plan, Medicaid, which is primarily federally-subsidized, and so the

concern is the double-dipping of receiving assistance.

But I agree with Mr. Wells a hundred percent. There's no easy solution. Or if there was, this wouldn't be here when I got to PEBP. It would have been fixed, right.

And, so, I think what we're attempting to do and I'm all for adding stringent requirements, is to leave no rock unturned to try to assist this population. And then it becomes a legislative decision.

CHAIRMAN CATES: Thank you.

Any other comments? Tom.

MEMBER VERDUCCI: Tom Verducci for the record. Damon, I just had a question. Do we know how RPEN and the retiree group feel about this issue?

MR. HAYCOCK: For the record Damon Haycock. I hate speaking publically about another entity especially when they're not here. But when I went over this option with RPEN, they didn't think that there would be a lot of opportunity for folks because of the thresholds. But as long as we made it voluntary and we communicated appropriately and put in those controls, I think similar to what Mr. Wells was saying, that they weren't outright against it.

MEMBER VERDUCCI: So Tom Verducci again for the record. So, let's say we did move forward with it, just hypothetically, is it possible to have some sort of disclosure put in place where bullet points would be covered

and they sign off on benefits that they're giving up and potential reentry in to the PEBP system.

MR. HAYCOCK: For the record Damon Haycock. I think so. But I want to pitch this to our lawyer, Dennis Belcourt.

MR. BELCOURT: I would be happy to -- Dennis Belcourt for the record, deputy attorney general. I'm always concerned about, you know, legal advice to -- advising people about potential rights. And I think we would want to have a disclaimer if we were going to work with people and then help them know about their other options. But I think I need to have a discussion with you, Damon, at some later date about that.

CHAIRMAN CATES: Let's start down at the end and work our way up.

MEMBER LAMBORN: Thank you, Mr. Chair. Leah Lamborn again for the record. So what would it take? Is that an NRS change that would allow them to come back if they were to go off and go on Medicaid, income changes, so a bill draft request?

MR. HAYCOCK: That's my understanding that any changes to statute, of course, has to be submitted by a bill draft request. PEBP had two opportunities to present bill draft requests. The non-budgetary ones, I think, were due by June, somewhere in June. And the budgetary ones were due at

our budget submission on September 1st.

I don't believe -- And I'll let Jim correct me again if I'm wrong. I don't believe PEBP has a mechanism to submit an additional bill draft request, but it doesn't mean that other groups cannot.

CHAIRMAN CATES: Anyone else? Go ahead.

MEMBER COCHRAN: This is Chris Cochran for the record and it's more a comment than anything else. I'm moving in to some of these exchange programs or subsidized programs. I hope that these members will then be informed as to some of the potential pitfalls. Qualifying for Medicaid is one thing. Finding providers under Medicaid is quite another. And you may lose your provider if you have a current provider because that provider will not accept Medicaid. So that is a potential pitfall for anyone that we say that to.

We already know that the Medicaid population has a devil of a time finding providers, especially with the expanded Medicaid services that we have, which is why we see -- one of the reasons we're seeing an over-utilization of hospital emergency rooms for primary care by Medicare or Medicaid -- to provide Medicaid patients.

So if we're going to do stuff like that, if we're going to go down that road, I would hope that we can do whatever we can to inform these members as to the -- what

they're going to be looking at. At least be honest because we know it and we should let them know it.

MEMBER BAILEY: For the record Don Bailey. I echo the doctor's comments. But I also think we need more information. Obviously you communicate with RPEN. But that was the leadership; correct? The general membership I do not think has any knowledge of this. I may be wrong.

Now, there's another organization in the room today that did we recognize them and have we communicated with them? Because I'm sure some of their constituents are in that category.

MR. HAYCOCK: So for the record Damon Haycock. And, yes, we have Pricilla Maloney here from AFSCME. If I recall correctly, I think it might have came from my e-mail. I shot it out to both entities and said this is what we're looking at, do you have any concerns or issues with it.

Secondly, I cannot guarantee if they've shared it with all of their membership. But I do know that if of the 1600 folks we sent it to any members were part of their membership then those members in that membership got the same notice. So communication went out to them directly. I don't know what information might have been filtered down from their leadership yet. I don't know if you want to have Pricilla.

CHAIRMAN CATES: I think that's probably a good

segue to public comment, so why don't you go ahead.

MS. MALONEY: Just to clarify, yes, AFSCME's status with this problem. And thank you very much. Pricilla Maloney again for the record with the AFSCME retirees. The AFSCME retirees right now, Board Member Bailey, we are the state work force retirees. So these folks who were originally the employee of a water district or something else, they are not in our membership. We do have a couple small bargaining units that are, I believe, the city out on the Utah border. And this is the actives' bailiwick, so I'm not really familiar with this.

And then up in Storey County, we represent, at least my understanding as of today is we still represent a group of, small group of not police and fire but the other support government employees for Storey County. So it might affect those two groups.

I know that in the 2013 legislature there was a bill draft that I know Mr. Wells remembers that bill draft, I believe. We tried to work this out, as I recall. And, again, there was not money in the budget was my understanding to -- I think it was Senate Bill 34 if that sounds about right. Mr. Wells, you'll have to correct me.

Anyway, so bottom line is there was an attempt and our membership in general, including those bargaining units, would have gotten e-mail blasts about the status of

Senate Bill 34 and how it didn't, you know, come to a resolution. I certainly do communications through our web site and I say, you know, if something comes up on the PEBP agenda, we're still trying to work out the so-called orphan problem. But the vast majority of our membership, again, our state employees, that may change in the near future. But RPEN covers a wider because they're not a 501 C5. They're not a union. They are a 501 C3, a non-profit representing anyone I believe who is a retired public employee of Nevada.

MEMBER BAILEY: What was the response from the small membership that you represented?

MS. MALONEY: If there was one I don't recall because, again, it doesn't -- it only -- it only can impact our memberships concerns as it did in 2013 when there was a possible implication like I was trying to elude to you in my earlier comments. Anything that could possibly affect the general fund, yes, that does -- you know, that interests us, that concerns us.

So I don't want to represent that my group had a position one way or another back in 2013. We were certainly part of a coalition looking, supporting of all public employees, supporting that Senate Bill to try and -- I'm pretty sure it was Senate 34 -- but to try and get a solution. But it never came to not. And we really haven't been engaged in that, this question, since then. It didn't

come up at all in 2015, as I recall. I think we were trying to do something on a regulatory basis to solve the problem and I don't know if that ended up ultimately. So if there are any other questions. Does that help, Mr. Bailey?

MEMBER BAILEY: That's fine. Thank you.

MS. MALONEY: Okay.

MEMBER BAILEY: Now, we've been trying to solve this problem, like Mr. Wells alluded to, for months, years. And it's just not -- we don't seem to come to a conclusion. This sounds like it might work. But I'm a little concerned about the membership understanding that they could go off our program and never come back. That frightens me.

MR. HAYCOCK: For the record Damon Haycock. Vice Chair Bailey, that's a very valid concern and I think I have a potential solution. We have 33 people today that we feel may qualify for an additional type of program. Instead of sending these 33 people to the Nevada Association of Health Underwriters and pitching them to a broker, maybe we just send out direct communication, give them a call. There's 33 people. We can do this. And walk them through that they have other options and that we suggest that if they're having difficulties paying for their health premiums that they contact a licensed professional to help them. But here are all of the things that you have to keep in mind: You will lose your life insurance, you will lose your dental

insurance. So if you're going to talk to a broker, you need to compare the complete package of programs that PEBP is providing you to whatever it is that they are providing. And they do, they have the ability to offer a package, not just here's your health insurance exchange health plan, but they can bundle it with life insurance and dental insurance and what have you. But as long as we communicate to these folks that there is another option for them and tell them what they would be losing, then maybe we put it back in to their hands and it doesn't appear that we're trying to push them anywhere. I don't know if that's a viable alternative.

MEMBER BAILEY: That sounds like it might work. I'm just leery about starting a program and then all of a sudden 9,000 people wake up to the fact that, wow, they can't come back. I think we've had an incident like that. I'd rather not go through another. Thank you.

MEMBER VERDUCCI: Tom Verducci for the record. Let's say we did nothing. What type of financial impact does this have to the entire program? The reason I ask that is we're speaking of a handful of participants, maybe 33. I'm sure it's more than that. But is this an item that has a big financial impact or what would your thoughts be there?

MR. HAYCOCK: For the record Damon Haycock. As far as plan costs go, we haven't pulled the claims on these 33 folks to see are they 33 high utilizing, high cost claims

folks, are they 33 folks that never use the health plan or anywhere in between. I'm going to go out on a limb and say I don't think it would truly affect this population so much because 33 out of 1600, unless they are 33 high cost claimants with claims over a hundred thousand dollars a year, I don't think even if they are the healthiest of groups it's going to really dramatically change the program.

I think the intent of this wasn't to farm anyone out to anywhere else. It wasn't to get rid of people. It was to answer the question that I received that I think some of you all have received as well and some of us over many years, I can't pay my health insurance premiums, my mortgage, and buy food. What do I do? And so it wasn't meant to be a catch-all to solve the non-state retiree problem with the high cost. It was meant to kind of help people and advocate for the programs that the state has already invested time, money, energy, information, staffing to that if it works for these folks, and it has to work on a myriad of categories, if it works should they know that there's a program available to help them? And I think that's what the whole intent was for.

MEMBER VERDUCCI: So if we had inquiries coming in from the non-state retiree group requesting that this is something that we look in to for their benefit or as a new member where do the discussions initially stem from?

MR. HAYCOCK: For the record Damon Haycock. I'm

going to regurgitate some of this stuff because I think it's important. This is stemmed from years of concerns of this risk pool becoming more expensive every year, alright. And there's been various legislation presented and there's been various discussions at the board levels, at staff levels, consultants, stakeholders, AFSCME, RPEN. Everyone is trying to figure out how do we make things more affordable for this group of folks. This is just something that where this specific process came in mind is something from a previous life of mine where we used to do this for people that didn't have employer-sponsored health care or couldn't afford it and they were allowed to move on to an individual plan. And so we just wanted to look again at no stone unturned, is there anything we can do for folks, even if we only help one person, if that's one person that can afford health care and they're willing to lose the rest of the program's processes -- the rest of the program's insurance products, maybe it is the right thing for them to do. We don't want to make that decision. So we just want to offer up an opportunity.

We did a pull instead of a push. We didn't wait for them to contact us. We tried to pull information from them. We sent out a letter saying, you know, we would be willing to look at this for you to see if you may qualify and if you're interested in trying to save money on your health

insurance, similar to how a broker or anyone else would do a cold call and say, hey, are you interested, do you like your plan or do you want to change it? Of course, we're not going to get any commissions. We're not brokers. But we just wanted to try to find a kind of out-of-the-box solution for some of these folks because the law does not require that retirees have health insurance provided by their employers, so they're allowed to hop off if they want to, if they can go get a better deal on the individual market place or maybe they have some other state-sponsored program.

So it was kind of a hail Mary, to be frank and candid, that if it worked, it worked. If it didn't, it didn't. We can leave it exactly where it is today and just stop this whole process and allow people to do what they do. And for most folks I think our plan is the better choice. Or we can do an outbound outreach to them and say we've done this, we've assessed this, we recommend you talk to these folks, but here's all the caveats. Or we can directly go to those folks that would take care of them and say here's what we want you to do and hope they do it. So I think we have those three options on the table. There may even be more.

CHAIRMAN CATES: Go ahead, Jim.

MEMBER WELLS: Thank you, Mr. Chairman. I guess for me there's nothing that is preventing any of those 33 people from doing this on their own. They could actually go

out, call a broker, go meet with the exchange people, go meet with Medicaid. There is a mechanism already for these 33 people to go and do this.

I get leery of anything that has our name on it is ours. And we've had this problem with a couple of other specific issues that has led to in some cases to a litigation against us. I'm leery of putting my name on something that has this kind of ramifications that these people may or may not understand when they make a decision. That's my comment on this.

I will say that for the newer board members there was a presentation in September of 2014 on this issue back to the beginning. So there is a lot of additional information. This is not just a new issue. This issue dates back to the sixties.

MEMBER LAMBORN: Thank you, Mr. Chair. Leah Lamborn for the record. I agree with Mr. Wells. I think this needs to be done right. It needs to be done through an NRS change. These participants can go right now at any time and seek either Medicaid or through the exchange.

Also, sometimes when people are in situations, financial situations, they'll make a decision on a short-term basis and not look at the long-term ramifications. That's my concern.

CHAIRMAN CATES: Any other comments? This is an

action item, so let's go back to public comment. Is there any member of the public who would like to say anything on this issue, north or south? I don't see anyone coming forward.

Anybody like to make a motion or not make a motion so this just dies? Anyone?

MEMBER VERDUCCI: Tom Verducci for the record. I would like to make a motion to table this motion.

MEMBER COCHRAN: Second.

CHAIRMAN CATES: Okay. Why not? So we have a motion to table the motion. Any discussion on the motion?

MEMBER COCHRAN: Mr. Chair, this is Chris Cochran. I just seconded that. But this has been, as everybody has mentioned, we've been talking about this I think since I've been on the board, and I started in I think December of 2012, so this is not something that has been easy for us to resolve.

But I share in some of the comments that Jim mentioned. We have to be vary careful with how we work with the folks who are in this plan. And, you know, eventually I would like to see the legislature do something about this. It's really, you know, it keeps getting dumped back in to our lap. And they're not going to like any of our solutions either. So, you know, it is something that we, I think we just need to be real careful about.

CHAIRMAN CATES: Any other comments? Seeing none, I'll call for a vote. All those in favor of tabling this item signify by saying aye.

(The vote was unanimously in favor of the motion)

CHAIRMAN CATES: Opposed? The motion carries unanimously.

Okay. Moving on to Item 10, information item, executive officer report. Damon.

MR. HAYCOCK: Thank you, Mr. Chair. For the record Damon Haycock. I'm going to do this kind of quickly because there's not an immense amount of information and I think you're all probably tired of hearing me talk today.

Just a couple of updates. Towers Watson has provided some on-site support. They're going to talk a little bit more about this in their presentation, I believe, next. But we are very excited to have one of their HRA specialists on site with us. She arrived September 12th and spent the week with us and we got nothing but good reviews from our participants. And they feel that -- or it appears that they are getting good feedback from her. And so this is something that will be replicated every month. And we have dates that are already sent out to folks. We are going to update our website with it. And I'll talk a little bit more about our website update in a minute.

But this is something that PEBP is not paying

for. It is something that we are, again, pleased to have and hope that this addresses more of the on-site issue.

I won't speak for RPEN because they're not here. But I sufficiently would say that that week is great. We wanted full time. But I don't want to put words in to anyone else's mouth, but I think this is a step in the right direction and we will continue to evaluate and report.

As far as our website, it's always interesting to see the statistics. When we relaunched our website back in April, we ensured that we had Google Analytics tied to it so we can present some fancy numbers, right, to everybody to show if it's being effective or not. And we had 114,000 visits to it already, which is pretty significant. And unique visits, that's the specific, you know, folks going in. It doesn't matter how many times they go in, they're counted as one. So 58,000 people have looked in to our website.

So it is being used. It's a good communication media. We feel that it's being effective. Over 400,000 page views. So what's really interesting is that most folks are looking at just over three and a half pages. So they're not just going to our website, getting frustrated, and leaving. They're actually digging further in to the website and getting the information that they need. And that the average time someone is looking at our website is almost four minutes. So, again, it's not a catch and release, you know,

one and done, you get on the PEBP website and think, wow, I'm not getting the information I need and move off. They're actually spending some time on there, which is good.

I put sessions by device typed in there because it's interesting to note that almost 15,000 sessions are from mobile, right from the phone. So people are using their smart phones, they're looking at our website. We made sure when we relaunched our website that it was mobile friendly. And I think that that attests to those numbers.

Our top visited pages. Of course the home page. Everyone starts there. But they then go down in to benefit documents, finding providers, and then contacting us, which if you look at our website today, you see two big monster buttons out there that says, you know, find provider and explore your benefits, so it's kind of a no-brainer as to why they're going there, but it's important that they are. Because we want our participants to understand our health plan, to be able to use their benefits and find the providers that they need to seek health care. So we feel that those are good numbers to share.

But that's not enough. We thought that we didn't need a what's new section because we didn't think things would be changing as rapidly as they have been. We implemented doctor on demand recently. We changed our out-of-state network for folks residing outside of Nevada.

And we are looking at, you know, sending out newsletters and additional communication that may or may not have gone out in the past. But there's no real one space for that so folks go to our website and see, oh, look, there's something new, I need to look in to it more.

So we're going to be adding another section directly below those big buttons because we still really want people to explore their benefits and understand what their benefits are and we want them to find their providers. That is our highest priorities for this mode of communication.

But we're going to add a what's new and quick tips section that we're going to update regularly so folks will be able to go back and see what's happening with PEBP and get the latest and greatest news.

On the finance side for our contract update, the health maintenance organization and request for proposal closed September 13th. And that those proposals have been sent to the evaluation committee for review. I believe a selection will be made on or about November 3rd. Our goal is to bring back I think at the November meeting the gratification of that vendor while we finalize the negotiations.

The Health Claim Auditors and diversified dental contract extensions were approved at the August 9th 2016 board of examiners meeting. What, of course, was great about

those two contracts is they kept their last year rate flat for the entirety of the contract. So we got the same price that we're getting this year for the next four or five years of paying for the contract. So we felt very fortunate to be able to lock that in.

For budget development update, we submitted our budget, our 2018-2019 budget, to the governor's office on finance, of course, by the due date of September 1st. And once those budgets become the governor's recommended budget in January 2017 we'll bring you the final results to that January board meeting. That is our anticipation, so we don't miss any confidentiality requirements of the process.

So, in conclusion, we do continue to provide opportunities for participants to receive the best customer service. Our website, we're partnering better with our vendors, and ensuring that they have on-site presences. We want to make sure that we continue to have appropriate and efficient tools. We are not done playing with the website yet. We have other single website updates coming down the pipe where people can quickly access comparison tools, like our health spark tool, so you'll be able to determine if you want to go to provider A or provider B based on the cost tied directly to your account, your deductible, and your out-of-pocket amounts.

But we're not done yet. We continue, of course,

to contract with affordable, high quality vendors like Health Claim Auditors and Diversified Dental. And with dwindling reserves and budgetary requirements, we are dedicated to developing creative cost-savings measures. We're going to keep bringing these back every time until we have found every right way to build a better mouse trap, right. We want to try to reduce those claim costs and increase access to high quality, affordable health care. And so we want to make sure that service levels remain at, of course, their highest quality. And with that, I will take any questions.

CHAIRMAN CATES: Any questions from the members? I don't see any.

Thank you, Damon.

Okay. We'll move to Item Number 11, discussion and possible action regarding Towers Watson's One Exchange service improvement plan.

MR. GARCIA: Chris Garcia with Towers Watson for the record. I want to thank the board, again, for an opportunity to come and speak to you about our service improvement plan and provide you with this update. If you have the service improvement plan in front of you, I'm going to start on page three. There's an executive summary.

MR. HAYCOCK: Sorry. For the record Damon Haycock. Chris, do me a favor. Slow down just a little bit because I'm going to break my court reporter's hands.

MR. GARCIA: And I got that last time. I'm going to try to slow down. So starting on page three, I added an executive summary section to the document, and this is the section that we'll update as we progress probably through the rest of this year as well as next year and so we make updates to the service improvement plan. I'm going to highlight certain areas. I'll read certain sections of the document. Please feel free to stop me if you have any questions.

For our update for this board meeting, we wanted to go ahead and talk about our Medicare open enrollment readiness presentation. In August of this year we recently met with PEBP and did a presentation where we discussed the upcoming 2017 Medicare open enrollment period and the preparation of that One Exchange is making to improve on the service experienced during the 2016 open enrollment period, last year. Open enrollment is from October 15th through December 7th. And below are some highlights of what we discussed in our presentation.

Staffing updates is the first item that I think is a great highlight for us. We are adding more full time employees that have been hired to manage the attrition that was experienced with seasonal staff during last year's open enrollment season. So adding those additional full time members -- full time employees will help mitigate some of the seasonal attrition that we had last year.

We are on target to have the following staff during the open enrollment period for this year. We'll have 1,350 benefit advisors, 869 customer service representatives, 520 applications data processors, and 150 what I call hybrid employees, who are both application data processors as well as customer service representatives so that they can float between the two areas, depending on where the need is based off of a certain day.

From a training perspective, refresher training is being completed for every existing customer facing representative. So particularly for our existing customer service representatives that were with us last year, a full six-week training course happens for those that are brand new staff.

And then also for training there's a focus on improved and increased client specific training. That's an area that we feel that this year we can focus on. Every client is a little bit different and PEBP obviously has some nuances and we are focused on making sure that our customer service representatives or benefit advisors can speak clearly to the callers regarding those specific client needs or specific client requirements.

The telephone system, so we talked in the last board meeting that the Genesis system that we're bringing on isn't going to be live until January of 2017. But for the

existing telephone system, we have done some stabilization testing for the existing system that's helped us manage to increase call volume and expand our capacity, provide faster response times and fewer dropped calls.

For the HRA or health reimbursement arrangement administration, we're looking to increase our staffing with the HRA funding department. That was effective as of September 1st. It improved communication material, such as documentation instructions and explanation of payment wording to better explain why a claim would be, say, denied or approved. And then adding electronic notification of the receipt of a request. And then the release of an approval or denial of a claim.

In the presentation, as we met with PEBP, we talked about our expectations and what PEBP can expect from One Exchange during the open enrollment season. And so a big challenge last year, we talked about this in detail before, was the wait time that participants experienced when they called in to One Exchange during the open enrollment season. This year we do expect our wait times to be much more in line with what we've experienced in the past. During what we would consider our regular day we would expect a participant to have on average a two-minute wait time before they speak to a customer service representative or a benefit advisor. We do expect to have peak call volume days. And those peak

call volume days we expect the average wait time to be four minutes. Again, peak days are typically going to be Mondays and then also the last week of the open enrollment period.

We've talked about this in the past as well, the Fall newsletter, and we have a new enrollment reminder communication that are being mailed to participants to, one, advise them of the open enrollment season, as well as remind them of the requirement to enroll with One Exchange to maintain their HRA subsidy. Those have already started to mail, actually in the last week, September 12th, and they will be mailing through October 10th.

And then we also talked about how One Exchange is going monitor call volumes and wait times closely during open enrollment and we will provide biweekly reporting to PEBP with call statistics.

Are there any questions on the discussion that we had with PEBP regarding the open enrollment season?

CHAIRMAN CATES: Any questions from members? Tom.

MEMBER VERDUCCI: Tom Verducci for the record. Chris, I first wanted to thank you very much for your presence in Carson City. And I did want to ask a question. How has the turnout been with the availability of your staff? Are they busy while they're here or are they having a lot of idle time?

MR. GARCIA: And thank, sir, for asking that question. With the new program that we started, our HRA specialist being in Carson City for the week long out of the month, it probably wasn't as busy as we were expecting. What we plan on doing is each month or each week out of that month to have a larger retiree meeting occur during that week, similar to what we've done in Las Vegas as well as in Reno and Carson City in the past. So she was doing individual appointments. She had maybe a little less than a dozen individual appointments that occurred during the first week. But she was able to also assist people -- I know that she had several calls transferred to her from PEBP staff for people that were calling in asking questions and she was able to assist them right there on the phone as well. So she was doing in-person appointments as well as assisting other folks that were calling in to the PEBP staff.

So I think for the first week I think it went relatively well. I would like to see in the next several months when we do the larger retiree meeting if that will drive other folks to have additional appointments set up with her.

MEMBER VERDUCCI: Thank you very much. I realize that's time away from her family and appreciate the efforts that you guys are making to improve the services that you're providing PEBP participants.

MR. GARCIA: Thank you. We appreciate the feedback.

The next section is retiree meetings prior to open enrollment. So each year One Exchange will hold three meetings that are four retirees prior to Medicare open enrollment. There's typically two types of meetings that are held, one for participants who are aging in to Medicare and one for those who are already Medicare-eligible. And that focuses on making changes during open enrollment as well as the HRA.

The dates and the locations of the meetings are below. October 5th will be in Las Vegas. October 6th in Carson City. And October 7th in Reno.

The next item is the HRA on-site assistance. And this is the item that we were just speaking about. This is a little bit more detail as far as how we set this up and in the upcoming weeks per month that we'll be doing for the rest of this calendar year. So we have agreed with PEBP to have the HRA team specialist available to assist PEBP participants one week per month starting in September in the PEBP office in Carson City. As I mentioned, we'll do at least one retiree meeting during that week. We didn't do a retiree meeting in September because there was one on August I think it was the 26th or the 24th, so it was right before she was there, so we felt it was redundant to do it for the first

week that she was going to be there in September. But I know that in October and subsequent months she'll have that larger retiree HRA meeting during the week that she is there.

The office hours will be available throughout the week to hold one-on-one appointments. Walk-in appointments will be welcome as well based off availability.

And then we have the list of the following weeks. So October 10th through the 14th. November 14th through the 18th. And December 12th through the 16th. We are working on what weeks for 2017 will become available and we'll provide those to PEBP in agreement with PEBP once we finalize that.

Any additional questions regarding the on-site preference for the HRA specialist at the PEBP office?

And then the last part of the update that I want to provide was we added -- I added some historical paul stats to the back of the presentation going back to 2015 as well as through August of 2016. The purpose of that was to show that the average wait time for callers to One Exchange service center for the last six months has been well under half a minute. And even better than if you go back and compare it to last year, obviously we know that during open enrollment 2016. So last October 15th through December 7th we know that there were challenges. But we have made improvements this year when you compare directly to the same period of time last year, so I'm talking really March through August we've

seen less than half a minute wait on average for participants contacting One Exchange.

We'll continue to add those stats. I think it's important for the board to see the call volumes that we're having, the wait times that we're seeing. This information is shared with PEBP on a monthly basis. We started doing that a few months ago. We just want to make sure that we are meeting the delivery, the service delivery that you expect from us, that we're meeting that expectation.

Any additional questions on any of that material? That was all that I had.

CHAIRMAN CATES: Thank you, sir.

Okay. On to Agenda Item Number 12, public comment. Do we have any public comment here in Carson City?

How about down in Las Vegas, any public comment? Seeing none, I'll close Agenda Item Number 12.

And Agenda Item 13 is adjournment. I don't have to do a motion for that, do I? Okay. Meeting adjourned.

(Hearing concluded at 1:06 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 Thursday, the 22nd day of September, 2016, I was present at The Legislative Building, 401 South Carson Street, 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 164, inclusive, includes a full, true and correct transcription of my stenotype notes of said public meeting.

Dated at Reno, Nevada, this 3rd day of October, 2016.

_____
CHRISTY Y. JOYCE, CCR
Nevada CCR #625

D

E

M

N

S

T

U