

In The Matter Of:
Public Employees Benefits Program Board
Videoconferenced Open Meeting

September 22, 2016

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

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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

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

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

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

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

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

4 CHAIRMAN CATES: Thank you.

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

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

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

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

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1 HMO.

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

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

18 CHAIRMAN CATES: Thank you for your comments.

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

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

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

9 CHAIRMAN CATES: Thank you.

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

12 CHAIRMAN CATES: Thank you.

13 Any items anyone would like pulled?

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

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

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

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

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

25 (The vote was unanimously in favor of the motion)
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1 CHAIRMAN CATES: Any opposed? Ayes have it
2 unanimous.

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

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

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

14 MR. HAYCOCK: Thank you very much, Nancy.

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

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

23 Nancy Spinelli has been with the Public
24 Employees' Benefits Program all the way back since October of
25 2000. So I think she is our longest-running employee. She
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1 has performed the duties as appeals and complaints
2 coordinator, program officer over member services and
3 eligibility. She has trained our agency representatives.
4 And since 2008 has been our public information officer who
5 has also performed statewide in-person, on-site outreach and
6 education.

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

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

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

25 So I would like to turn this back over to the
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1 board. But it's my honor and pleasure to recommend Ms. Nancy
2 Spinelli to take the position of the quality control officer
3 and I hope you will agree.

4 CHAIRMAN CATES: Any questions or comments from
5 the members?

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

15 CHAIRMAN CATES: Thank you.

16 Mr. Bailey.

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

21 CHAIRMAN CATES: Thank you.

22 Do I have a second?

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

25 CHAIRMAN CATES: Thank you. We have a motion and
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1 a second. Any discussion on the motion?

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

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

21 CHAIRMAN CATES: Thank you.

22 Any other comments on the motion?

23 MEMBER COCHRAN: Thank you, Nancy.

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

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

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

6 CHAIRMAN CATES: Opposed? Motion carries
7 unanimously.

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

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

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

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

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

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

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

23 The first slide, which is slide two, generally
24 when I start to look at these and analyze your data, I like
25 to see what your demographics are. And the idea is to try
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1 and understand exactly what the population is, how it's
2 changed since the last time we looked at it, and try to see
3 who within that population is driving your cost. We focus
4 primarily on your actives because we can do more with them as
5 far as programs and design for benefits. We do have some
6 retiree data, which is a smaller group of people. And it
7 will -- And we can also run that. But for this report we've
8 focused on the actives.

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

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

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

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

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

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

22 So looking at your total active population, when
23 we look at this, we're looking up through March of this year,
24 so it's a 12-month rolling report. So it will not
25 necessarily coincide with what you've had from financials for
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1 last year. So just to kind of make sure. We're looking at
2 different sets of numbers but we use a rolling 12 months
3 because that gives us the ability to track the changes in
4 utilization by condition better than if we just looked at
5 snapshots.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 MR. CRYER: You actually have some very positive
24 things. And I was going to talk about pharmacy when I get to
25 it, but I'll go ahead and tell you now. When I looked at
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1 your pharmacy, first, people with chronic disease use drugs.
2 It's how we make -- we try to keep them stable or make them
3 better. And so the numbers that I'm seeing here are not
4 huge. The types of conditions I've seen are the same I see
5 with most individuals. Your total pharmacy costs are really
6 quite good. They're actually surprisingly good from during
7 this 24-month period. Because my other clients are looking
8 at 24, 27 percent increases. And yours kind of, you had a
9 little bump but nothing really huge. And it was mainly
10 because you didn't have some of the big drugs that others
11 were hit with. So, again, you've got some real positives
12 here.

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

17 MEMBER COCHRAN: Thank you.

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

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

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

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

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

17 Health Plan of Nevada, this group --

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

24 MR. CRYER: Oh, great question. The visits here,
25 ER visits, anytime you get over 200 visits per thousand, we
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1 consider that to be higher than normal use. And
2 traditionally in the last four or five years most of our
3 clients have had ER visits -- And I'll show you yours in a
4 minute for the total population -- that are much below 200.
5 So at 220 it suggests all the things may be an issue that you
6 just listed. And it's really something that probably need to
7 be addressed with Hometown to understand are they having
8 access issues after hours. Who's going, when they go. This
9 would normally -- Even at 220 you're getting a lot of use
10 that's what we consider to be avoidable use. The heart
11 attacks, you can't avoid that. That's no problem. The
12 mother with the ear ache, that's really -- we consider that
13 to be not necessarily avoidable in the middle of the night.
14 But there are other issues with people going if they can't
15 get in to see the doctor and they're referred to see the ER
16 more often than not, those are all things that are important.

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

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

22 MEMBER ZACK: Thank you.

23 MR. CRYER: Yes, ma'am.

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

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

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

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

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

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

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

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

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

25 Then we look at your inpatient costs. Inpatient
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1 utilization over the last five years has basically gone down
2 significantly. And partially that is because the hospitals
3 have now geared to go to outpatient because they can bill it
4 differently and because we just found ways to treat people
5 outpatient in a much more efficient way.

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

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

24 In the outpatient side this is where we looked at
25 the ER across your total here. So you can see that your ER
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1 use is really, really reasonable. It's all -- It's less than
2 200 across the board for these groups, these risk groups.
3 And your ER cost is over a thousand dollars a visit for these
4 populations. That to me means that basically the people are
5 going there. They're getting significant amount of services.
6 And that's a lot of dollars for that. If they were overusing
7 it excessively, these populations, then what we would see is
8 that we would see seven to \$800 for an ER visit on average.
9 So those are all things that tell me that things are pretty
10 much the way they should be. Any questions?

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

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

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

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

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

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1 member too.

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

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

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

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

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

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

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

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1 MEMBER COCHRAN: Thank you.

2 MR. CRYER: Yes, sir.

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

23 But this will kind of give you a summary of what
24 you're looking at as far as your risk. And the other thing
25 that I like to point out when I give you these informations
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1 is the number of people that are having behavioral health
2 issues with this condition because it's fairly high. And I
3 think it's probably underreported because we do screen for
4 it. And most of the programs that are out there screen for
5 it and the docs ask about it. But people go undiagnosed with
6 this. And when you have these conditions, there is always
7 potential for depression and a lot of anxiety related to
8 these conditions. Anyway, it's just so you can kind of get
9 an idea. So your programs need to really keep those in mind.

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

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

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

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

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

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

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

4 Oh, I'm sorry, Chris.

5 MEMBER COCHRAN: I'll let Jim go first.

6 MEMBER WELLS: Actually I have a couple questions
7 on this slide. First, on the cancer for the medical claims,
8 I'm taking it that's a typo that we didn't go from \$1500 to
9 \$15,000 in one year in those claims.

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

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

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

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

25 MR. CRYER: Yeah, I can tell you that one. It
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1 was cost of insulin and injectables. They tripled them. And
2 that's what I'm afraid is going to happen with asthma and the
3 other things too. As you follow through for the previous
4 year, the jump and the cost for insulin was huge. And it
5 affected about every client I've got. Even -- And there's no
6 generic insulin. So they're paying a lot of money for that.
7 Okay.

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

14 MR. CRYER: It's all relative.

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

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

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1 out the total cost.

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

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

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

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

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

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

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1 diabetic, I've saved you \$8,000 a year. Well, it's about
2 5,000 because the average cost is about 3,000 for general
3 persons. So that's pretty good. If we can save that, that's
4 good.

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

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

22 CHAIRMAN CATES: Thank you.

23 MR. CRYER: Thank you, sir.

24 CHAIRMAN CATES: Seeing no other comments, we'll
25 close this agenda item and move on to Agenda Item Number 6,
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1 discussion regarding the PEBP participants survey results
2 about plan year 2018 benefits.

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

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

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

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

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

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

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

11 What you'll see is that some of the total
12 responses have dropped off at certain sections. There was
13 kind of a decision tree, matrix built in to it. If you are
14 on CDHP you went one way. If you were on the HMO you went
15 another. Some folks may have gotten frustrated with it and
16 just stopped altogether. So although we had just under
17 10,000 responses, you'll see a lot of these totals here for
18 these answers are less. And it's because folks either did
19 not move forward or it didn't apply to them.

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

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

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

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

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

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

16 What I want to draw everyone's attention to is
17 that last page, page 16, and I want to spend a little bit of
18 time because it's important when we get input from our
19 participants that we get the good and the bad and everything
20 in between. And it was reported to us by multiple
21 participants and advocacy groups from RPEN, AFSCME, and again
22 a few legislators, that the survey looked people in to
23 answering three unfair questions that we were asked to
24 include a none-of-the-above response, a text box for
25 open-ended comments, and an option to ask the legislature for
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1 more money to subsidize the health plans and to continue the
2 health plan benefits as they are today.

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

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

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

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

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

22 Now, one of the flaws of the design also was that
23 it was unable to connect the dollar amounts that respondents
24 entered with each demographic data element. If you've ever
25 designed anything in Survey Monkey, there's a logic that has
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1 to happen where if you answer this question, it takes you to
2 this next question. And if we were to try to tie the dollar
3 amount that people were willing to pay with each and every
4 one of those demographics, you can imagine this decision tree
5 matrix that would come down. It would probably be about
6 5,000 questions when you use this demographic all the way
7 down to the end and then if you chose this all the way down
8 at the end, and each time you have to repeat the questions in
9 the design. And so it would have been an overwhelming
10 project. And in hindsight if we had the money and time, I
11 would have loved to outsource this to another group so we
12 could have gotten a little bit more tie-in between the dollar
13 amount people are willing to pay and the specific
14 demographics, but we did what we could. So there was no
15 really way to know.

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

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

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

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

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

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

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

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

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

24 MR. HAYCOCK: For the record Damon Haycock.
25 Thank you, Dr. Cochran. I'm going to attempt to address I
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1 think there was three things in there. First, a none of the
2 above or a pay no more option was provided in the survey. If
3 you'll look at, let's see, page ten under the CDHP rate
4 options, that table, it says pay no more and lose enhanced
5 benefits from further cuts. Now, again, we added a
6 contingency to it.

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

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

21 As far as age range goes, the highest was between
22 51 and 65. What's interesting to note is the average
23 participant age on the consumer driven health plan and the
24 HMO is 48.6. So it's close. It's not exactly the specific
25 year but it's within I would feel a ballpark. It's not

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

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

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

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

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

7 CHAIRMAN CATES: Go ahead, sir.

8 MEMBER BAILEY: For the record, Don Bailey. I
9 would just like to make a positive comment. I agree, I think
10 32 percent return is remarkably well for a survey. Because
11 normally they're very poor in responding to your request.

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

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

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

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

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

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

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

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

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

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

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

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

20 MR. MCDONALD: Thank you, Kirby. Thank you very
21 much, Kirby. And good morning, board members and PEBP staff
22 members and folks in the audience. As Kirby mentioned, my
23 name is Tim McDonald and I've been with Aon Hewitt for about
24 five years. But by way of background what has led me to the
25 consulting that I do is I have been a physician's assistant
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1 for the beginning of my career, became a hospital
2 administrator. I have my Master's in health service
3 administration. I worked in the manufacturing industry with
4 General Motors for 20 years and I was in charge of a number
5 of programs, including their wellness health promotion
6 program, but also in charge of the operations of all of
7 General Motors' occupational health clinics, which were about
8 150 around the US.

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

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

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

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

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

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

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

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

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

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

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

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

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

20 Now, just to further expand on this idea of who
21 are good candidates for this. And I think -- I want to make
22 sure that I'll try to keep in mind some of the comments that
23 we just heard from Dr. Cryer and weave them in to this slide
24 here. But if you're seeing high emergency room utilization,
25 which we just heard from Dr. Cryer, is one of the issues that
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1 PEBP faces, that would be something to be looking at. And if
2 you see also high urgent care utilization, which you have,
3 what that tells me in a lot of ways, because we know that
4 nationally about 30 percent, maybe 40 percent of ER
5 utilization is avoidable or is not urgent and could be taken
6 care of in another setting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 to sit face to face with a trusted clinician.

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

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

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

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

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

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

23 So I do this quite a bit and so with writing up
24 contracts and writing up performance guarantees often the
25 employer says, look, we don't want anybody in the waiting
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1 room for more than five minutes. Just think about that.
2 That's mind-blowing. That kind difference in the care the
3 way it's being delivered really speaks loudly to the fact
4 that an efficiently run health center with the proper
5 scheduling can really accommodate people who are busy who may
6 even have to be a walk-in that they don't spend a lot of time
7 in the waiting room. So it's an interesting concept because
8 you're always juggling between excess capacity of staffing
9 with people in the waiting room. That's the balance that any
10 clinician or any clinic has to work with.

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

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

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

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

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

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

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

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

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1 one of the things that's available.

2 And, finally, is this a patient centric staff?

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

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

25 I know I said a lot and I apologize because I
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1 talk kind of fast. But do you have any questions about this
2 or is this making any sense?

3 CHAIRMAN CATES: Questions from the members?

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

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

24 MR. MCDONALD: Yes. Thank you very much for the
25 question. It's a great question. And I don't want to get
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1 the cart ahead of the horse. But when the time came for if
2 the board decided that they wanted to go out and do
3 solicitation for clinic operators, we typically include in
4 that RFP, if you will, the request for proposal, a lot of the
5 questions which are named here that you've identified
6 relative to the state rules and regulations -- For example,
7 what comes up often times is with, let's say an employer
8 wants to have an on-site health center and they want to have
9 pre-packaged prescription drugs, which is a very cheap way of
10 providing -- like it's nine dollars for an Amoxicillin
11 prescription and they can just write your name on it and give
12 it to you and get you started. You don't have to stop on the
13 way home, okay.

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

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

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1 The other piece that you mentioned though has to
2 do with local providers, local providers. And it's very,
3 very important that there be a tremendous amount of
4 sensitivity to that. Because my experience has been working
5 particularly with municipalities that this conversation --
6 And, again, this is just an educational conversation. But
7 that, you know, some folks might take this as we're trying to
8 take business from the local providers and then there would
9 be a lot of resistance. So it's very important at some point
10 down the road if it's decided that this is something that the
11 board wants to pursue that conversations begin with the local
12 medical society, especially among primary care providers to
13 see, you know, are they interested, are any of them organized
14 enough that they could actually be the kind of supplier that
15 you're looking for eventually. Not all of them are. Some of
16 them are not very well organized and they would not be a
17 suitable candidate to provide that. But that's something
18 that's very important, that mindfulness about the
19 relationship with the community-based providers. A lot of
20 times community-based providers are stretched beyond their
21 limits and something like this is not going to affect them
22 very much, especially when you think about we got 30 percent
23 of our people who don't see a doctor at all, you're not
24 involved in the delivery system at all except to use the ER.
25 This is something they're not even on the local community
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1 provider's radar. And so the conversations need to take
2 place. It's a very sensitive issue. But I've had those
3 conversations and usually we're able to find that place.

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

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

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

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

24 And what I see in Texas, for example, Dr. Cryer's
25 home state, is that we had -- yesterday there was an urgent
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1 care center on every street corner. Today they are called
2 urgency -- they're morphing in to emergency rooms. And so
3 what we used to think of as urgent care is now morphing in to
4 an emergency room. And so what happens is that it goes from
5 in your case a little under a hundred dollars a visit to
6 \$1600 a visit. So we have to -- Clinics are clinics, but
7 there's also some business-finagling going on that we have to
8 be mindful of.

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

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

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

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

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

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

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

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

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

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

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

23 So then we provide an analysis of it showing what
24 the direct savings and indirect savings are, what we think
25 the staffing requirements should be, what the implementation
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1 and the cost of the ongoing operating costs are going to be.
2 And then based on that, as I say, determine if there's a net
3 present value.

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

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

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

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

4 CHAIRMAN CATES: Questions or comments from the
5 members?

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

21 But, you know, at the university levels and
22 college levels, they typically have health and wellness
23 clinics -- I know we do at UNLV. I know they do at UNR --
24 that may provide an opportunity for doing some pilot study of
25 a project like this. I know UNLV offers the opportunity for
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1 employees to use their clinic, but it doesn't go on -- PEBP
2 doesn't pay for it. So it's an office visit that the
3 employee pays out of pocket. So what they're really doing is
4 they're paying for the convenience of being able to use the
5 clinic.

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

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

23 CHAIRMAN CATES: Mr. Wells.

24 MEMBER WELLS: Thank you, Mr. Chairman. Do you
25 see the employers who are opening these clinics continuing to
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1 provide or also providing the occupational health services or
2 do you see these being kept pretty separated?

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

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

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

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

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

18 CHAIRMAN CATES: Tom.

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

23 MR. MCDONALD: Okay. That's a very good question
24 and probably the answer to that question rests primarily with
25 the employer. The facility has the longest timeline in terms
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1 of -- So let's just say hypothetically that we said let's go
2 today. It's probably to get a facility up and running,
3 depending on if you already had an existing space and were
4 just transitioning the provider, you could do that in 90
5 days, 120 days. But if you have to renovate a facility or
6 construct a facility, that's going to be more time. So that
7 would be the biggest variable.

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

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

23 Once the clinic goes live -- And so let's just
24 say we have a facility and we can get it renovated in six
25 months and it's feasible based upon the feasibility study,
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1 so, again, this is a good idea, let's do it. Then we go out
2 for bid and go out and try to find a vendor, using local
3 vendors as well as national vendors, to get a good comparison
4 and a good idea of what's out there. That takes about three
5 months from start to finish where to the point you would have
6 a recommendation and say this is what it's going to cost.

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

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

24 But looking at a primary care clinic, you would
25 look at about 1.6 to one return on investment. And some will
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1 say within one year. I would say within two years. But
2 certainly by the third year you're well inside of that.

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

9 MEMBER VERDUCCI: Thank you for the detailed
10 answer.

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

13 CHAIRMAN CATES: Damon.

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

21 But what about day one savings? So we currently
22 have a consumer driven health plan. And I'll give you my own
23 personal experience so I don't breach anyone else's PHI. But
24 if I go to my local doctor today and I haven't satisfied my
25 deductible, I have to pay about \$80 for that visit. It is my
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1 understanding, and I'll ask Tim to confirm this for me, that
2 when we design a co-pay process and because we have a health
3 savings account on a high deductible health plan we would
4 have to, that we have to use the usual and customary cost and
5 then we get to reduce it by the overhead. And so if you
6 think about it, whatever the overhead is built in to my \$80
7 visit gets to reduce that \$80 down. And I'm not going to
8 throw out a number here that I think we should stand up to,
9 but if that dollar amount goes from 80 to 60, if that's a
10 fair number to go with, well, then right out of the gate
11 participants are paying 25 percent less for the same visit,
12 day one.

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

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

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

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

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

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

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

22 CHAIRMAN CATES: Thank you.

23 Any other comments from members?

24 MEMBER ZACK: Christine Zack for the record. One
25 final question. You talked about the order of events being
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1 preparing the physical structure of the plan of the facility
2 first and then finding a local market partner. And I guess
3 in my mind I was always thinking about doing it in reverse.
4 So you find that local market partner first who --

5 MR. MCDONALD: May have space?

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

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

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

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

17 MEMBER ZACK: Thank you.

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

21 So it is now five minutes after 11. What is the
22 pleasure of the committee? Should we take a break or should
23 we plow forward? I see nods for a break. Let's take a
24 15-minute break and reconvene at 11:20. Thank you.

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

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

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

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

23 MR. HAYCOCK: Excellent. Thank you,
24 Mr. Chairman. Again, Damon Haycock for the record. As what
25 happened last September and I assume the Septembers before,
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1 this is an opportunity for PEBP and our partners and our
2 consultants to gather input from board members on what
3 options and opportunities you all would like to see at the
4 next board meeting when you will make a decision on hopefully
5 on the plan benefit design for the next plan year.

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

17 Now, I can tell you today that we are looking at
18 a starting amount for plan year 2018 with 11.6 million
19 dollars of excess reserves. But before you say, that's
20 awesome, where can we spend it or what can we do with it, if
21 you ask me what that number is or you ask my excellent CFO
22 what that number is a month from now, it will probably
23 change. If you ask a month after that, it will probably
24 change again. And the reason is is that we don't necessarily
25 know what our ending balance of excess reserves is until the
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1 end of the plan year. And sometimes six months to a year
2 thereafter as we have that timely filing and payment of
3 claims.

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

13 So if we recognize that that 11.6 million dollars
14 is not necessarily the right number but we'll use it as a
15 starting point, I wanted to illustrate to everybody again,
16 not necessarily the board who may already know, but also the
17 public, what those consumer driven health plan enhanced
18 benefits were provided for the last three years and what
19 those costs are, what the sticker price was projected for
20 this year and what needs to be hopefully recognized is the
21 sticker price for these enhanced benefits for this plan year
22 is not necessarily the sticker price for next year because
23 population is increasing, the utilization may be going up.
24 And so if you look at that table that starts on the first
25 page and moves to the second, you see the end-all figure of
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1 28.75 million. But I don't think it's unfair or
2 inappropriate to say that in plan year 18 that may be 30
3 million, because, again, we are projecting a population
4 increase.

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

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

25 So, again, even if you approve every one of these
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1 or a portion thereof, we still would like to reserve the
2 right to bring additional opportunities back to the November
3 meeting, especially if they're going to do the things that I
4 think we all hold dear, increased access to high quality
5 health care and to either lower or reduce those or control
6 those costs associated with them. So we want to be able to
7 bring additional cost saving opportunities to the board.

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

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

24 And so going through the first, you know, four,
25 five, six of them, you know, they're all keeping them. Do we
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1 want to keep them. We have those preliminary costs. That's
2 that sticker price, right, that's on each of those, on the
3 previous pages, again, knowing that they will have to be
4 further analyzed and we will have them analyzed by our
5 partners to trend them forward. So we have some preliminary
6 cost available, but again, that participant may bear the
7 entire cost of those benefits in increased rates. So that's
8 one, two, three, four, five, and six.

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

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

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

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

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

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

25 So we are potentially faced with increasing our
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1 rates to backfill a reserve for care that people aren't
2 utilizing or at least they're not getting reimbursed for it.
3 And with dwindling reserves and the potential cut to
4 benefits, we feel that there's an opportunity to put a cap on
5 this, and a very liberal cap. I would suggest a \$5,000 cap.
6 And there are only so many accounts that have more than a
7 \$5,000 cap today. The latest data I looked at, the total
8 amount of folks that have balances that if we capped them at
9 5,000 we would be able to return back to the plan the
10 effectiveness of 1.8 million dollars. So it's not massive,
11 but every dollar counts. We go back and look at the sticker
12 price of an annual vision exam at 1.4 million and you kind of
13 get to see the comparison here.

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

25 And we would create an outreach campaign to those
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1 folks that have balances at or above 5,000 and remind them
2 that they have a year from the latest claim that they had to
3 pay for that to receive reimbursement and that we are going
4 to be capping it on July 1 of 2018.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 the first day of plan year 19.

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

5 CHAIRMAN CATES: Any questions from the members?

6 MEMBER VERDUCCI: Tom Verducci for the record.

7 Damon, could you speak in terms of how much the vision
8 hardware costs would be per participant and if we were to
9 enhance the hardware costs and provide that benefit, how much
10 would that increase the average premium cost per participant?

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

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

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

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

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

24 MEMBER VERDUCCI: It sure does. That 90 percent
25 is a big number. So it seems like there is a huge request
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1 for vision hardware. So thank you very much.

2 CHAIRMAN CATES: Any other questions from the
3 members?

4 Why don't you proceed.

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

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

25 But we've had some vendors reach out to us over
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1 the year that I've been here, and I know that it's happened
2 before, and they're talking with our third party
3 administrator to see is there some cost savings and if
4 there's something you would like us to look in to we would
5 like to bring something back to the November report. Excuse
6 me. The November board meeting.

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

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

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

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

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

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

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

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

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

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

25 Last but definitely not least is on-site
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1 near-site clinic development. I'm a firm believer in crawl,
2 walk, run, all right. But I'm more than willing to run if
3 that's where we need to go, if that's what the board would
4 like us to do.

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

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

20 And so if it can work, I think it's a really good
21 opportunity, but we want to see the numbers and we would like
22 permission to as part of this agenda item be allowed to move
23 forward with that feasibility study. That feasibility study
24 would not be ready by November 17th or 19th or whenever the
25 next one is, sorry. It won't be ready by then. But it will
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1 be ready that we can be back at least by January. We don't
2 want to rush this process. If it's something that we feel is
3 going to be beneficial, we don't want to just gather some
4 quick information and then just run with it and then it
5 doesn't work.

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

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

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

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

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1 do some comparisons.

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

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

20 It's my understanding that these are things that
21 we want to look at and consider. We are not saying this is
22 what our plans are going to do. So, you know, getting in
23 line with that, I am fully aware that when we look at the
24 enhanced benefits that we did that those were enhanced
25 benefits based on surpluses that we had in our plans at the
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1 time. So what we were paying for the HSA and for the members
2 as well as their dependants, we were able to do this because
3 we had -- we had huge surpluses and if we didn't do a good
4 enough job in explaining that to our beneficiaries that this
5 is something that we are able to do now but we have a based
6 plan here, you know, I think that we need to start
7 communicating that out better instead of saying, well, we
8 were able to enhance your benefits and we want you to keep
9 them. If we're keeping them, this is what it's going to
10 cost.

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

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

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

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

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

18 But I want to real quickly offer up just a
19 different way of looking at it. And I'm not lobbying. I'm
20 not trying to convince anybody. But I just want to share a
21 different opinion. If you have 11.6 million dollars today,
22 and we don't know if we do, and you go through this list and
23 say I want to save 11.6 million dollars in benefits, there's
24 no guarantee that there will be 11.6 million dollars at the
25 end of the year. And so those benefits you are given for a
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1 year go away. So Damon's opinion, not the board's, that
2 that's kicking the can down the road. And if that's what we
3 need to do, I'm all for it, and I will implement that
4 wholeheartedly.

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

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

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

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

3 CHAIRMAN CATES: Any other questions or comments?

4 MEMBER LAMBORN: Thank you, Mr. Chair.

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

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

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

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

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

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

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

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

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

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

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

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

14 And I know that Mr. Haycock is painfully aware of
15 this. And I know that it probably keeps him up at night. I
16 do think though that I recall, and this is of concern to me,
17 whether we're talking about the actives or the retirees,
18 although again I'm just here today officially for the
19 retirees that I think Ms. Bosley brought out the point in the
20 June meeting I think it was that this \$41 mean average
21 increase in premiums, and that's found at page 11 for item
22 number six, page 11 on Mr. Haycock's presentation. So
23 something between 40 and \$50 a month is kind of a moving
24 target too. Because as I recall Ms. Bosley, and she can
25 correct me if I'm wrong, Aon prepared a guesstimate that
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1 these premiums could go up as high as a hundred dollars a
2 month given certain circumstances. So I'm sort of pulling
3 that back from June. I know we've been actually talking
4 about this for quite some time. And, again, the AFSCME
5 retirees' position is this is the responsible thing to do, to
6 talk about the what if.

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

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

3 CHAIRMAN CATES: Thank you.

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

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

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

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

12 CHAIRMAN CATES: Yes.

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

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

21 One lesson I have learned is that we must always
22 be careful about what we are comparing. Southern Nevada HMO
23 participants have often compared our plan to the north. We
24 have often said that northern Nevada's plan is better.

25 However, in May, we learned that while northern Nevada
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1 participants might not have the access to care issues that we
2 have, they pay significantly more than we do in terms of
3 co-pay and co-insurance. They pay more for ER visits,
4 hospital stays, and doctor visits, and pay significantly more
5 for drugs and even for MRI's.

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

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

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

19 CHAIRMAN CATES: Thank you.

20 Any other public comment?

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

23 MEMBER WELLS: Thank you, Mr. Chairman. You
24 know, I've thought about this a lot. And frankly one of the
25 first questions that I'm going to have as we move in to
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1 November is if I look at the financial report that was
2 submitted by -- under Agenda Item 3, I think I show a lot
3 more than 11 million dollars at the end of FY 18 -- 17.
4 Excuse me. So that's the first thing that I think I want to
5 get a better handle on where we think we're going to be at
6 the end of '17. Because those numbers are not panning out,
7 the 11.6, for me.

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

22 But, you know, we've got -- we're going on five
23 years now experience on what we're paying out. I think we
24 can get a better handle on what that average annual spending
25 is, recognizing liability is always there. We also have the
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1 catastrophic reserve if we need to, to dip in to. I'm not
2 really worried about dipping in to that catastrophic reserve
3 and having to build it up in the future years.

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

22 CHAIRMAN CATES: Thank you.

23 Other comments?

24 So, Damon, what would you like out of this board?

25 Do you want us to take action on all of these items?

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

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

23 MEMBER ZACK: Thank you, Mr. Chair. Christine
24 Zack for the record. I agree with moving forward with the
25 feasibility study. I think minimally we need to look at
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1 Carson City and the Las Vegas metro area. I'm not sure if I
2 understood that it was only an additional \$10,000 to add a
3 third site or was that considered a phase-in? I remember
4 there were three different -- It was location one, location
5 two, location three.

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

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

13 MR. HAYCOCK: Reno?

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

16 CHAIRMAN CATES: Any other comments?

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

24 CHAIRMAN CATES: Do we have a second?

25 MEMBER BAILEY: I'll second that. For the record
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1 Don Bailey. I'll second that motion.

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

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

6 CHAIRMAN CATES: All opposed? Motion carries
7 unanimously.

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

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

13 CHAIRMAN CATES: Go ahead.

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

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

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

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

10 CHAIRMAN CATES: Do we have a second?

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

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

15 Go ahead, Jim.

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

25 CHAIRMAN CATES: Okay. Any other comments? Do
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1 we need to amend the motion to that?

2 MEMBER BAILEY: I'll accept that amendment.

3 CHAIRMAN CATES: And the second?

4 MEMBER COCHRAN: Second.

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

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

10 CHAIRMAN CATES: Opposed? The motion carries
11 unanimous.

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

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

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

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

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

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

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1 our scope of knowledge.

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

8 But we did receive I think just over a hundred,
9 108 responses. And more have filtered in. Even though we
10 had a deadline, we're still going to work with those. And 33
11 of them, approximately 30 percent, may be eligible for
12 federal subsidies and even four of them may actually be
13 eligible for Medicaid. And for those that don't know, if you
14 are eligible for Medicaid, that's premium free health care.
15 So folks that may be spending six, seven, eight, 900 hundred
16 thousand -- not a hundred thousand, excuse me -- a thousand
17 dollars a month in premiums may have the option to pay zero.

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

24 We would like to reach out directly to the Nevada
25 Association of Health Underwriters, the group that has worked
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1 with the exchange on trying to place folks in to health
2 insurance plans and also know about how to see if we can
3 qualify for Medicaid. There are split families for those
4 that don't know that some may qualify for a state -- excuse
5 me -- a federal subsidy on the exchange while other family
6 members may qualify for Medicaid and another family member
7 may qualify for Nevada Check-up. And so it's a very
8 intricate type of situation. Although I don't know if
9 non-state retirees would have children that would qualify for
10 Nevada Check-up. I know we would all like to farm our kids
11 off sometimes.

12 But we will see by sending it to those folks and
13 partnering with them. They are the experts. They are
14 licensed. They are managed and regulated by the Nevada
15 Division of Insurance. And they should know what they can
16 put people in to and see if they're interested. And we as a
17 health plan that offers life insurance and dental insurance
18 will provide information on the cost of our program to those
19 brokers and say, if you're going to talk these folks in to
20 potentially leaving our program, you need to explain to them
21 that they are leaving the program and they're leaving dental
22 and they're leaving life and they need to have a
23 comprehensive package. And we will take very long strides of
24 assuring that that occurs. And we will reach out to these 33
25 folks and say this is the process. This is what we
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1 anticipate. You can stop at anytime. Call us if you need
2 help. So we'll still advocate on their behalf.

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

7 CHAIRMAN CATES: Thank you, Damon.

8 Any questions or comments from the members?
9 Leah.

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

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

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

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

3 CHAIRMAN CATES: Go ahead.

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

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

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

4 CHAIRMAN CATES: Thank you.

5 Damon, you wanted to comment.

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

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

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

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1 concern is the double-dipping of receiving assistance.

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

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

9 CHAIRMAN CATES: Thank you.

10 Any other comments? Tom.

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

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

22 MEMBER VERDUCCI: So Tom Verducci again for the
23 record. So, let's say we did move forward with it, just
24 hypothetically, is it possible to have some sort of
25 disclosure put in place where bullet points would be covered
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1 and they sign off on benefits that they're giving up and
2 potential reentry in to the PEBP system.

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

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

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

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

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

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1 our budget submission on September 1st.

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

6 CHAIRMAN CATES: Anyone else? Go ahead.

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

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

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

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

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

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

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

17 Secondly, I cannot guarantee if they've shared it
18 with all of their membership. But I do know that if of the
19 1600 folks we sent it to any members were part of their
20 membership then those members in that membership got the same
21 notice. So communication went out to them directly. I don't
22 know what information might have been filtered down from
23 their leadership yet. I don't know if you want to have
24 Pricilla.

25 CHAIRMAN CATES: I think that's probably a good
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1 segue to public comment, so why don't you go ahead.

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

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

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

23 Anyway, so bottom line is there was an attempt
24 and our membership in general, including those bargaining
25 units, would have gotten e-mail blasts about the status of
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1 Senate Bill 34 and how it didn't, you know, come to a
2 resolution. I certainly do communications through our web
3 site and I say, you know, if something comes up on the PEBP
4 agenda, we're still trying to work out the so-called orphan
5 problem. But the vast majority of our membership, again, our
6 state employees, that may change in the near future. But
7 RPEN covers a wider because they're not a 501 C5. They're
8 not a union. They are a 501 C3, a non-profit representing
9 anyone I believe who is a retired public employee of Nevada.

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

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

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

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

5 MEMBER BAILEY: That's fine. Thank you.

6 MS. MALONEY: Okay.

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

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

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

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

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

23 MR. HAYCOCK: For the record Damon Haycock. As
24 far as plan costs go, we haven't pulled the claims on these
25 33 folks to see are they 33 high utilizing, high cost claims
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1 folks, are they 33 folks that never use the health plan or
2 anywhere in between. I'm going to go out on a limb and say I
3 don't think it would truly affect this population so much
4 because 33 out of 1600, unless they are 33 high cost
5 claimants with claims over a hundred thousand dollars a year,
6 I don't think even if they are the healthiest of groups it's
7 going to really dramatically change the program.

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

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

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

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

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

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

22 CHAIRMAN CATES: Go ahead, Jim.

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

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

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

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

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

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

25 CHAIRMAN CATES: Any other comments? This is an
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1 action item, so let's go back to public comment. Is there
2 any member of the public who would like to say anything on
3 this issue, north or south? I don't see anyone coming
4 forward.

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

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

9 MEMBER COCHRAN: Second.

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

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

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

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

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

5 CHAIRMAN CATES: Opposed? The motion carries
6 unanimously.

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

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

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

25 But this is something that PEBP is not paying
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1 for. It is something that we are, again, pleased to have and
2 hope that this addresses more of the on-site issue.

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

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

17 So it is being used. It's a good communication
18 media. We feel that it's being effective. Over 400,000 page
19 views. So what's really interesting is that most folks are
20 looking at just over three and a half pages. So they're not
21 just going to our website, getting frustrated, and leaving.
22 They're actually digging further in to the website and
23 getting the information that they need. And that the average
24 time someone is looking at our website is almost four
25 minutes. So, again, it's not a catch and release, you know,
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1 one and done, you get on the PEBP website and think, wow, I'm
2 not getting the information I need and move off. They're
3 actually spending some time on there, which is good.

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

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

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

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

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

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

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

23 The Health Claim Auditors and diversified dental
24 contract extensions were approved at the August 9th 2016
25 board of examiners meeting. What, of course, was great about
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1 those two contracts is they kept their last year rate flat
2 for the entirety of the contract. So we got the same price
3 that we're getting this year for the next four or five years
4 of paying for the contract. So we felt very fortunate to be
5 able to lock that in.

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

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

25 But we're not done yet. We continue, of course,
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1 to contract with affordable, high quality vendors like Health
2 Claim Auditors and Diversified Dental. And with dwindling
3 reserves and budgetary requirements, we are dedicated to
4 developing creative cost-savings measures. We're going to
5 keep bringing these back every time until we have found every
6 right way to build a better mouse trap, right. We want to
7 try to reduce those claim costs and increase access to high
8 quality, affordable health care. And so we want to make sure
9 that service levels remain at, of course, their highest
10 quality. And with that, I will take any questions.

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

13 Thank you, Damon.

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

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

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

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

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

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

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1 We are on target to have the following staff
2 during the open enrollment period for this year. We'll have
3 1,350 benefit advisors, 869 customer service representatives,
4 520 applications data processors, and 150 what I call hybrid
5 employees, who are both application data processors as well
6 as customer service representatives so that they can float
7 between the two areas, depending on where the need is based
8 off of a certain day.

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

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

23 The telephone system, so we talked in the last
24 board meeting that the Genesis system that we're bringing on
25 isn't going to be live until January of 2017. But for the
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1 existing telephone system, we have done some stabilization
2 testing for the existing system that's helped us manage to
3 increase call volume and expand our capacity, provide faster
4 response times and fewer dropped calls.

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

14 In the presentation, as we met with PEBP, we
15 talked about our expectations and what PEBP can expect from
16 One Exchange during the open enrollment season. And so a big
17 challenge last year, we talked about this in detail before,
18 was the wait time that participants experienced when they
19 called in to One Exchange during the open enrollment season.
20 This year we do expect our wait times to be much more in line
21 with what we've experienced in the past. During what we
22 would consider our regular day we would expect a participant
23 to have on average a two-minute wait time before they speak
24 to a customer service representative or a benefit advisor.
25 We do expect to have peak call volume days. And those peak
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1 call volume days we expect the average wait time to be four
2 minutes. Again, peak days are typically going to be Mondays
3 and then also the last week of the open enrollment period.

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

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

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

18 CHAIRMAN CATES: Any questions from members?
19 Tom.

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

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

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

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

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

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

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

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

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

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

7 And then we have the list of the following weeks.
8 So October 10th through the 14th. November 14th through the
9 18th. And December 12th through the 16th. We are working on
10 what weeks for 2017 will become available and we'll provide
11 those to PEBP in agreement with PEBP once we finalize that.

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

14 And then the last part of the update that I want
15 to provide was we added -- I added some historical paul stats
16 to the back of the presentation going back to 2015 as well as
17 through August of 2016. The purpose of that was to show that
18 the average wait time for callers to One Exchange service
19 center for the last six months has been well under half a
20 minute. And even better than if you go back and compare it
21 to last year, obviously we know that during open enrollment
22 2016. So last October 15th through December 7th we know that
23 there were challenges. But we have made improvements this
24 year when you compare directly to the same period of time
25 last year, so I'm talking really March through August we've

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

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

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

12 CHAIRMAN CATES: Thank you, sir.

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

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

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

19 (Hearing concluded at 1:06 p.m.)

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1 STATE OF NEVADA)
)ss.
2 CARSON CITY)

3

4 I, CHRISTY Y. JOYCE, Official Court Reporter for
5 the State of Nevada, Public Employees' Benefits Program
6 Board, do hereby certify:

7 That on Thursday, the 22nd day of September, 2016,
8 I was present at The Legislative Building, 401 South Carson
9 Street, Carson City, Nevada, for the purpose of reporting in
10 verbatim stenotype notes the within-entitled public meeting;

11 That the foregoing transcript, consisting of pages
12 1 through 164, inclusive, includes a full, true and correct
13 transcription of my stenotype notes of said public meeting.

14

15 Dated at Reno, Nevada, this 3rd day of October,
16 2016.

17

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CHRISTY Y. JOYCE, CCR
Nevada CCR #625

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